Alaska Health Profile

2001

Each year, the Centers for Disease Control and Prevention (CDC) publishes a *State Health Profile* for each state and the District of Columbia. This publication series uses selected "health status indicators" to describe the health status of the United States on a state-by-state basis. This information is presented through' user-friendly graphics and narrative interpretation. The series also highlights selected demographic information, prevention and control efforts aimed at specific health conditions, and CDC funding for and partnership agreements with all 50 states and the District of Columbia.

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For more information regarding state data, please contact the state-based representative listed on page xiv. Electronic files of all data on which the graphic presentations in this publication are based can be obtained from the National Center for Health Statistic Data Warehouse Internet site at <http://www.cdc.gov/nchs/datawh.htm>.

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Preface

CDC has published a *State Health Profile* for each state and the District of Columbia every year since 1987. This publication series is designed to consolidate the most current data on the health of the U.S. population, the availability and use of health resources, and the distribution of CDC's health-care expenditures throughout the country.

The information presented in this publication series also highlights CDC's collaborative efforts with public health partners at the federal, state, and local levels, which have lead to a range of major public health achievements this century. These achievements include record low rates for many childhood vaccine-preventable diseases, healthier mothers and infants, safer and healthier food, safer workplaces, fluoridated drinking water, control of infectious diseases, declines in heart disease and stroke deaths rates, and the recognition of tobacco use as a health hazard.

By providing meaningful public health information to policymakers and the public through the annual *State Health Profile*, CDC strives to continue its efforts to improve the nation's health. We hope you will find this publication series useful.

This project is made possible each year by the contributions of staff members throughout CDC and in state health departments. We appreciate their invaluable support.

Health Status Indicators

Data presented in this publication are based on a list of 18 health status indicators established by a national committee.* These health status indicators are intended to ensure data comparability across the states and to help communities assess their general health status.

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* CDC. Consensus set of health status indicators for the general assessment of community health status – United States. *MMWR* 1991;40:449–51.

Alaska and CDC in Partnership

CDC works with state and local health departments, educational institutions, and other private and public organizations in Alaska to carry out CDC's mission to promote health and quality of life by preventing and controlling disease, injury, and disability. Listed below are some of the programs and projects that represent this partnership, as well as other programs and services provided by CDC throughout the United States.

- Provided technical assistance and a resource guide to all 50 states and the District of Columbia to develop, implement, and evaluate childhood lead surveillance programs.
- Collected and published data from all 50 states, New York City, and the District of Columbia on births, deaths, marriages, and divorces through the Vital Statistics Cooperative Program of the National Vital Statistics System.
- Provided training packets and teleconferences to all 50 states on asthma surveillance, interventions, education, and coalitions.
- Developed multimedia training tools for safety training for miners.
- Measured the effectiveness of prevention strategies to reduce the risk for robbery, assault, and homicide among taxi drivers.
- Funded the state to conduct population-based traumatic brain injury surveillance to characterize risk factors, incidence, external causes, severity, and short-term outcomes.
- Funded the state health department to develop arthritis activities by building partnerships, establishing surveillance and planning processes, and improving public awareness ($60,000).
- Provided technical and financial support for states to improve immunization coverage through provider-based Assessment, Feedback, Incentive, and Exchange (AFIX) activities, emphasizing private-sector immunization providers.
- Funded state efforts to prevent fire-related injuries by increasing the prevalence of home smoke alarms.
- Funded the state health department to implement tobacco-use control and prevention programs ($1,099,712).
- Examined the stability, physical design, and layout of commercial fishing vessels to develop feasible interventions to increase worker safety.
- Conducted infectious disease surveillance, provided and evaluated prevention services, and conducted applied research at CDC's Arctic Investigations Program on the Alaska Native Health Campus in Anchorage in collaboration with the Alaska Division of Public Health, Native Health Corporations, Indian Health Service, foreign ministries of health, industry, and universities.
- Continued a long-term study of the effectiveness of hepatitis B vaccine among Alaskan Native infants, children, and adults.
- Provided voluntary laboratory performance evaluation programs for human immunodeficiency virus (HIV) and multidrug-resistant tuberculosis testing.
- Implemented an educational campaign on judicious antibiotic use targeting health-care providers and the public in rural villages.
- Provided immunization materials to states in English and Spanish by mail, E-mail, fax, and the Internet.
- Provided technical and financial support for states to implement strategies to reach persons at highest risk for underimmunization.
- Supported the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences that occur before, during, and after pregnancy. PRAMS data have been used to develop and monitor health programs and guide policy.
- Provided Health Alert Network funds to support state and local health department bioterrorism preparedness.

Sample of Services Provided by

Health Information and Guidelines

- Developing recommendations and guidelines to create healthy workplaces.
- Developing the CDC Prevention Guidelines Database.
- Providing materials for a folic acid educational campaign to implement the Public Health Service (PHS) recommendation that all women capable of having children consume 400 mg of folic acid daily. Information is available in English or Spanish for two target audiences (i.e., women thinking about pregnancy and women not thinking about pregnancy) and can be ordered by E-mail from the following address: <Flo@cdc.gov>.
- Developing model language for asthma care that state Medicaid programs can use when contracting with health-care providers (e.g., managed-care organizations).
- Published *Best Practices to Prevent Violence by Children and Adolescents: A Sourcebook*, a planning guide for communities seeking practical, comprehensive guidance in building a program to prevent violence by children and adolescents through a public health approach.
- Providing quality counter-advertising materials (for television, radio, theater, print, and outdoor ads) and technical assistance in media planning and buying to states and nonprofit organizations nationwide through the Media Campaign Resource Center for Tobacco Control. Organizations in all states and the District of Columbia have used these materials as paid ads and as public service announcements.
- Providing training and guidance to state and local health departments, including helping public health laboratories develop comprehensive bioterrorism preparedness and response programs.
- Publishing health information for international travelers, including on the Internet at <http://www.cdc.gov/travel/>.
- Providing through SafeUSA a centralized source of safety-related information to inform U.S. residents of what injury prevention measures work and how to access resources designed to help persons and groups prevent injuries in their personal lives and communities.
- Helping prevent and control human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) through education, testing and counseling, and risk-reduction programs.
- Publishing the *Morbidity and Mortality Weekly Report*, *Recommendations and Reports*, and *CDC Surveillance Summaries*.

Investigations and Emergency Response

- Responding to national and international emergencies, including natural disasters (e.g., hurricanes, earthquakes) and displaced populations.
- Investigating outbreaks of an environmental nature (e.g., foodborne) for disease and clusters of other public health problems.
- Developed an interim communications system to alert state health departments of possible bioterrorism attacks and other health threats through broadcast fax and E-mail.
- Conducting field investigations of possible health hazards in the workplace in response to worker or employer requests.
- Investigating outbreaks of infectious diseases and clusters of other public health problems.
- Helping states investigate suspected bioterrorist events.

Public Health Surveillance and Statistics

- Providing technical and financial assistance for the Behavioral Risk Factor Surveillance System (BRFSS), a state-based surveillance system active in all 50 states and the District of Columbia. This system is the primary source for state-based information on risk behaviors among adult populations.
- Improving disease and vaccination surveillance by supporting systems that monitor disease trends, assess vaccine coverage, and monitor adverse events.
- Collaborating on state-based surveillance systems.
- Conducted a pilot test of the State and Local Area Integrated Telephone Survey (SLAITS) module on Children's Well-Being and Welfare with the Texas Department of Health. This module included a Medicaid-linkage experiment to establish a method of identifying current Medicaid enrollees.
- Funding capacity-building projects for disability-related health promotion, secondary condition prevention, and surveillance in the District of Columbia and 15 states (Alabama, Arkansas, Colorado, Iowa, Kansas, Massachusetts, Missouri, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Texas, and Washington), which use BRFSS data to identify persons with disabilities and collect data on their health status and quality of life.

CDC Throughout the United States

- Providing the State Tobacco Activities Tracking and Evaluation (STATE) System, an Internet-based electronic data warehouse of up-to-date and historical state-level data on tobacco use prevention and control. This user-friendly system, available to all states through the Internet, integrates multiple sources of comprehensive summary data to direct program efforts and demonstrate accountability.
- Collaborating with state and local health departments on effective surveillance and intervention programs, including those aimed at emerging public health problems.
- Coordinating PulseNet, a public health laboratory network for rapid identification of foodborne disease outbreaks.
- Collaborating with state and local health departments on effective surveillance and intervention programs, including ones aimed at emerging public health problems.
- Expanded the National Electronic Injury Surveillance System (NEISS) to begin collecting national data from emergency departments on nonfatal injuries from all causes. Previously, NEISS collected data only on injuries related to consumer products.

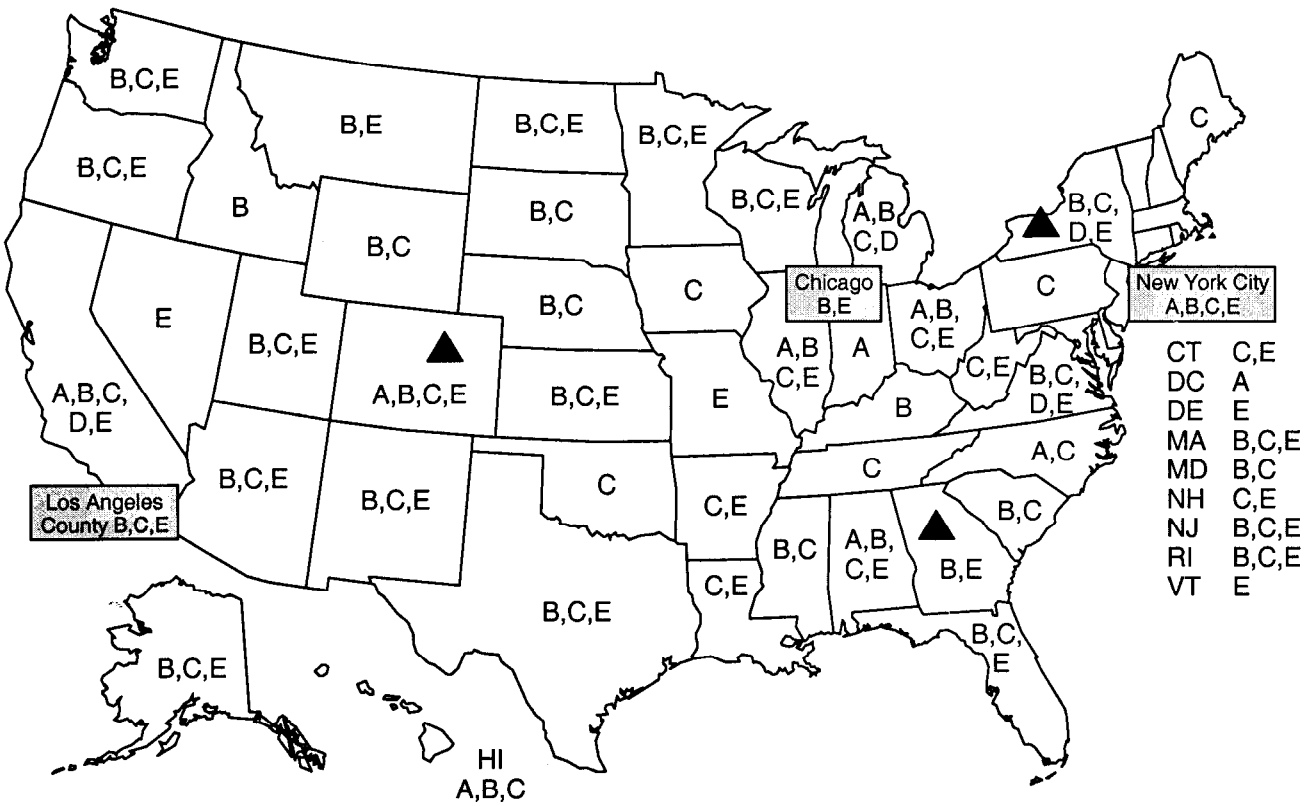
Technical Assistance and Funding

- Ensuring effective immunization services by a) offering programmatic, technical, epidemiologic, and scientific assistance to state and local areas, b) awarding grants to states and large local health departments, and c) providing funds and technical assistance to states for population-based immunization registries.
- Helped establish and improve birth defects monitoring programs, investigate clusters of birth defects, and implement prevention programs for selected birth defects.
- Providing funds for 11 extramural research grants designed to a) measure the magnitude of secondary conditions among specified populations of persons with disabilities; b) determine the risk and protective factors that contribute to or avert the occurrence of secondary conditions; c) conduct and measure the effectiveness of health promotion interventions designed to prevent secondary conditions; and d) understand the prevention effectiveness and cost-effectiveness of interventions.
- Providing expert testimony to state legislatures and state-based organizations regarding the scientific evidence supporting public health interventions to prevent tobacco use and issuing recommendations for a comprehensive public health approach to tobacco use prevention and control.
- Providing technical assistance and funds to support development of new electronic information tools for improved public health services.
- Providing technical assistance and consultation to state and local health departments to improve their effectiveness through the National Public Health Performance Standards Program.
- Administering the Preventive Health and Health Services Block Grant.
- Administering the Bioterrorism Preparedness and Response Cooperative Agreement.
- Assigning Public Health Advisors/Specialists, Epidemic Intelligence Officers, and Preventive Medicine Residents to state and local health departments.
- Provided financial and technical assistance to 39 states and 4 local health departments through the Epidemiology and Laboratory Capacity Program to strengthen public health capacity for infectious disease surveillance and response.
- Providing funds through cooperative agreements and technical assistance to all states and some cities for tuberculosis screening, prevention, and treatment services.

Training

- Providing all states with asthma training modules and teleconferences.
- Provided immunization training and education, including continuing education credits, to states through onsite courses, satellite broadcasts, and remote audio, video, and webcasts.
- Conducted the Tobacco Control Summer Institute to build the capacity of states and communities to implement state-of-the-art surveillance and intervention programs.
- Helping states and other countries strengthen their public health practices through laboratory, epidemiology, and communications training.
- Funding the West Virginia Training and Demonstration Center to implement a statewide program of education and applied research to improve the health and reduce the incidence of injury in rural West Virginia communities.
- Helping state and local partners prepare for and respond to bioterrorism by providing training in laboratory capability, preparedness planning, emergency response, surveillance, and information technology.

Bioterrorism Preparedness and Response
CDC Funding for Fiscal Year 2000



Funding Focus Areas
A = Preparedness Planning and Readiness Assessment
B = Epidemiology and Surveillance Capacity
C = Laboratory Capacity for Biologic Agents
D = Laboratory Capacity for Chemical Agents
E = Health Alert Network (HAN)/Training

▲ = Electronic Communications/HAN Exemplar Projects
Denver, CO
DeKalb County, GA
Monroe County, NY

Note: Federal fiscal year 2000 = October 1, 1999, through September 30, 2000.

Source: Bioterrorism Preparedness and Response Program, National Center for Infectious Diseases, CDC.

CDC Funds for State and Local Health Departments, Universities, and Other Public and Private Agencies Alaska, 2000*

Categories	Dollars
GRANTS/COOPERATIVE AGREEMENTS	
AIDS/HIV† Programs	1,643,929
Cancer Prevention	3,771,401
Chronic Disease Prevention/Health Promotion	1,963,816
Diabetes Control	362,090
Environmental Health	418,000
Immunization	5,555,631
Infant Health/Pregnancy	99,796
Infectious Diseases	810,443
Injury Control	167,788
Lead	17,349
Occupational Safety and Health	1,325,464
Other	25,000
Sexually Transmitted Diseases	468,452
Tobacco	1,279,717
Tuberculosis	852,704
Preventive Health and Health Services Block Grant	565,652
CONTRACTS	
Services	360,000
TOTAL	**19,687,232**

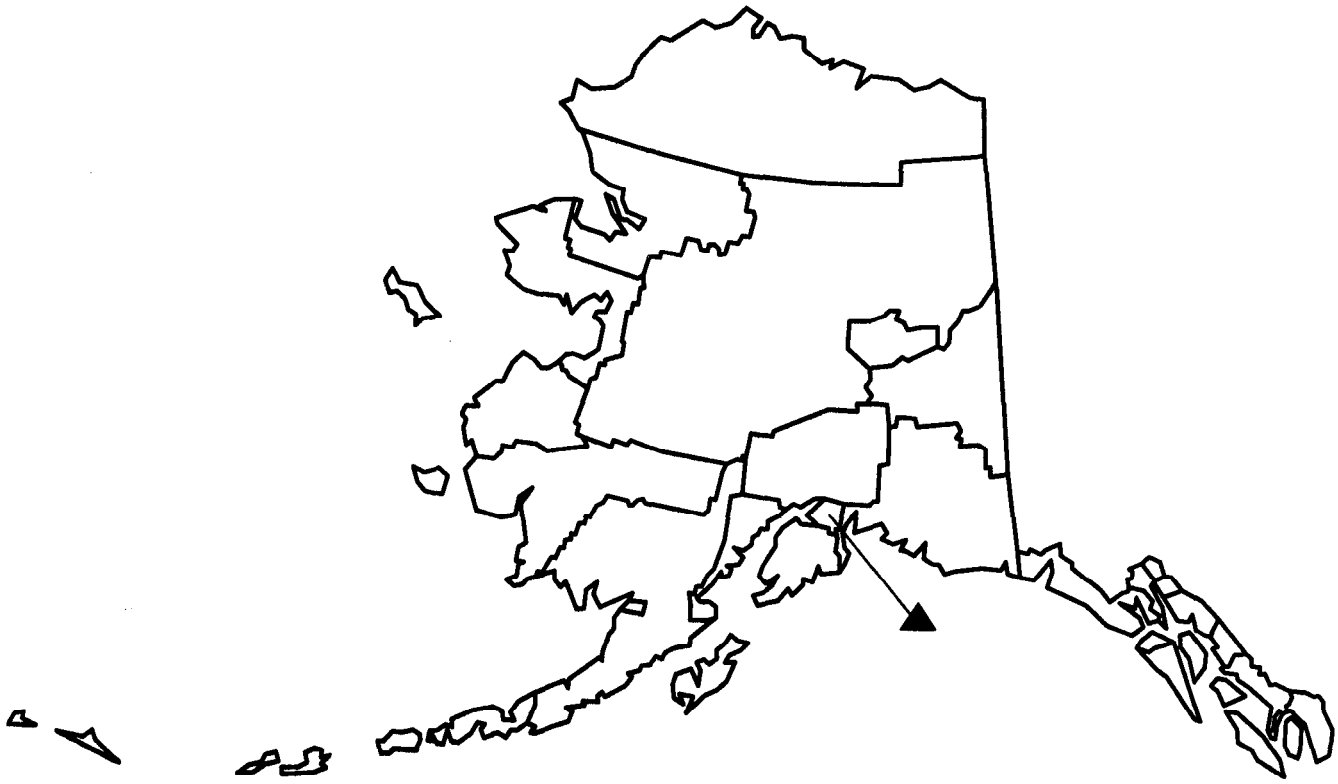
*Federal Fiscal Year = October 1, 1999, through September 30, 2000.
†Acquired immunodeficiency syndrome/human immunodeficiency virus.
Source: Procurements and Grants Office, Office of Program Support, Office of the Director, CDC.

Selected Demographic Information
Alaska and United States

	Alaska	United States
Population (1999)	619,500	272,690,813
Population Density (1999) (persons/square mile)	1.1	77.1
Median Age (1999)	30.9	35.5
Percentage of Population		
Age ≥65 Years (1999)	5.6	12.7
Age ≥85 Years (1999)	0.4	1.5
Percentage of Population Male/Female (1999)	55.4/47.5	48.9/51.1
Percentage of Population Below Poverty Level (1999)	7.6	11.8
Percentage of School-Aged Children Below Poverty Level (1999)	7.8	15.9
Percentage of Live Births to Females Aged 10–17 Years (1998)	4.0	4.6
Racial/Ethnic Distribution of Population (1999)		
Percentage White	75.2	82.4
Percentage Black	3.9	12.8
Percentage Asian/Pacific Islander	4.5	4.0
Percentage American Indian/Alaskan Native	16.4	0.9
Percentage Hispanic	4.0	11.5
Educational Attainment (1999) (Age ≥25 years)		
High school graduate or more	92.8	83.4
Completed bachelor's degree or more	25.5	25.2
Number of Counties (1999)	12	3,083
Number of Local Health Departments	2	2,930

Source: Most data are from the Bureau of the Census and are available on the Internet at <http://www.census.gov>. Percentage of live births to females aged 10–17 years are from the National Vital Statistics System (NVSS) of CDC's National Center for Health Statistics (NCHS), which derives its data from registrars in all 50 states, New York City, and the District of Columbia. Numbers of counties and local health departments are updated by state health officers.

Local Health Departments by Jurisdiction Alaska, 2001



▲ City health department

☐ No county health department

☐ Borough health department

Source: State health department.

Alaska State Health Agency

The state health agency in Alaska is called the Division of Public Health and is a component of a superagency, the Alaska Department of Health and Social Services. Its mission is to prevent disease and premature mortality through promotion of positive health practices and to minimize disability and the need for institutionalization through the early detection of disease and appropriate intervention.

The interaction among state and local public health agencies in Alaska is characterized as mixed centralized and decentralized organizational control. Under this arrangement, the state health agency provides local health services in some jurisdictions. In other areas, it provides grants for specific services, which are carried out by local governmental units or nonprofit agencies.

All 50 states and the District of Columbia have state health agencies, which are responsible for administering public health services within their jurisdictions. These agencies coordinate and oversee departments at the local level, usually through one of two organizational structures — as a component of a superagency or as a freestanding, independent agency responsible directly to the governor or board of health. The organizational structure between the state health agency and local agencies typically follows one of the following models: a) centralized organizational control, in which local health departments function directly under the state's authority and are operated by the state health agency or a board of health; b) decentralized organizational control, in which local governments directly operate local health departments with or without a board of health; c) mixed centralized and decentralized organizational control, whereby local health services can be provided by the state health agency, local governmental units, boards of health, or health departments in other jurisdictions; or d) shared organizational control, whereby local health departments are under the authority of the state health agency and the local government and board of health.

For this publication, definitions of state health agencies were derived from the *Profile of State and Territorial Public Health Systems: United States, 1990* (Atlanta, GA: US Department of Health and Human Services, Public Health Service, CDC; December 1991). This publication describes how public health services are organized and delivered at state and local levels, as well as how state and local components of the overall agency interact. This publication is intended as a reference for federal, state, and local public health officials and policymakers. More information is available on the Internet at the following address: <http://www.cdc.gov/phppo/inpho/profile/states.htm>.

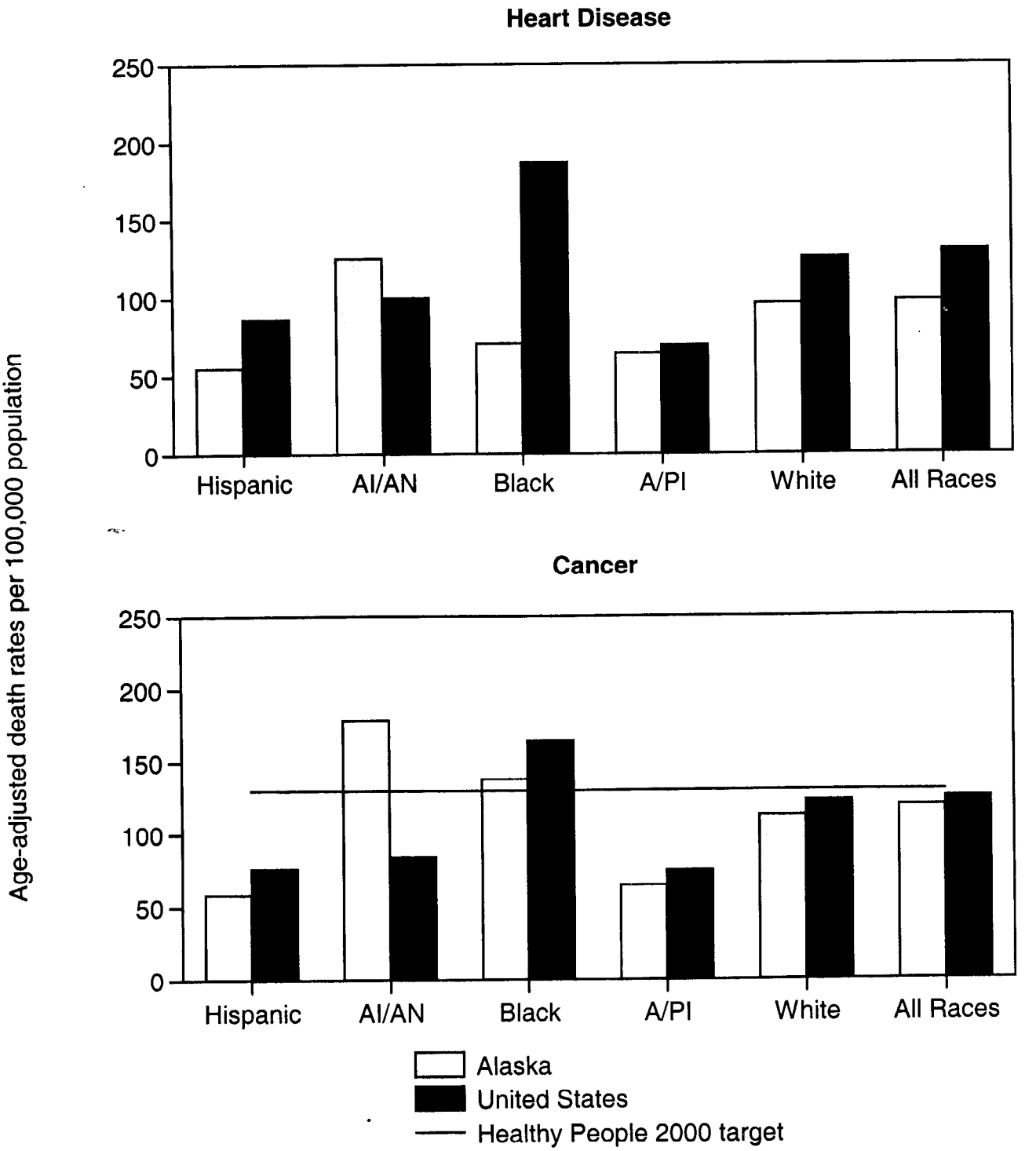
For more information, contact Peter M. Nakamura, M.D., M.P.H., director, Division of Public Health, Alaska Department of Health and Social Services, P.O. Box 110610, Juneau, AK 99811-0610; telephone (907) 465-3090; FAX (907) 586-1877; E-mail <petern@health.state.ak.us>.

Mortality

Leading Causes of Death

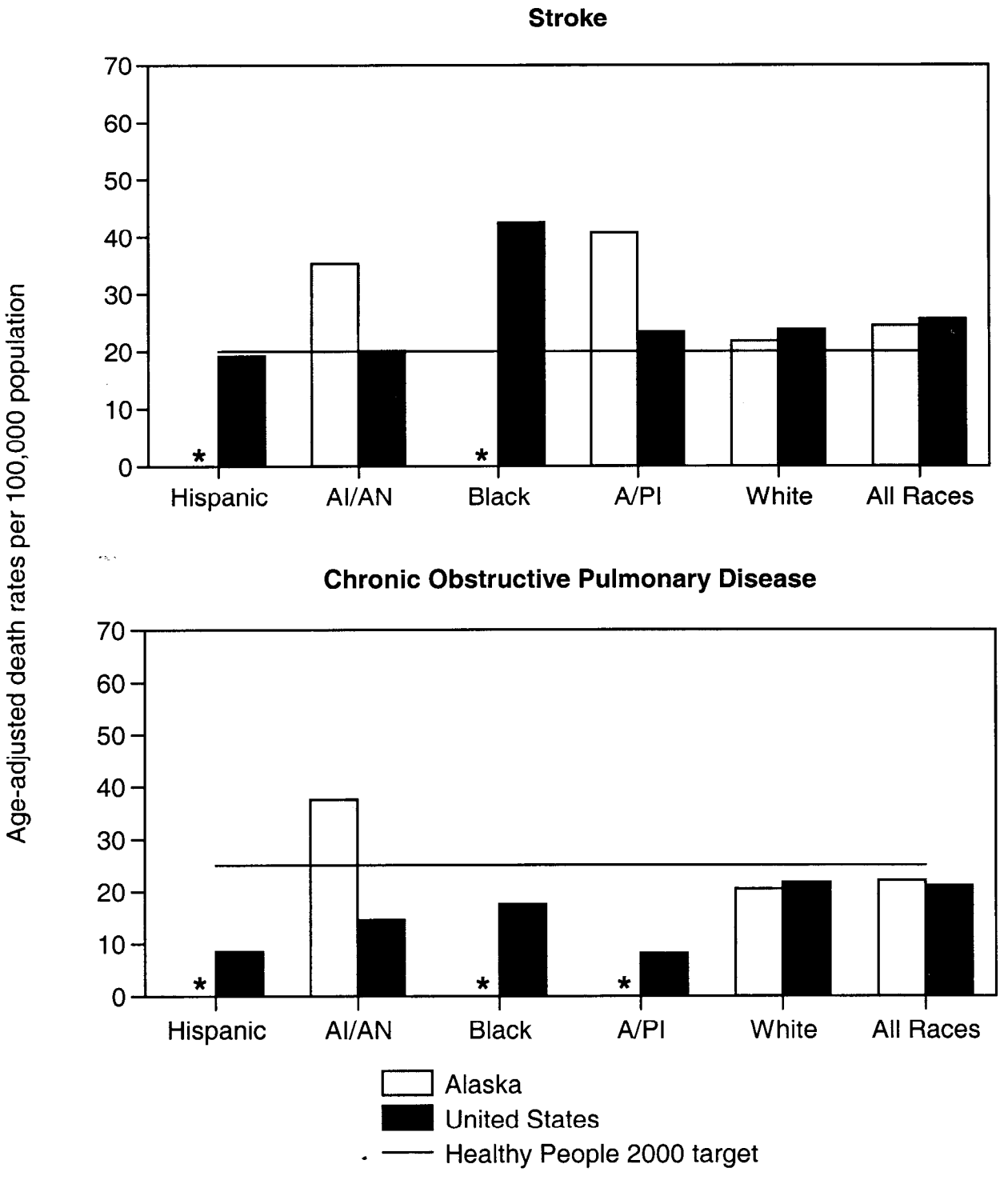
Years of Potential Life Lost

Leading Causes of Death by Race/Ethnicity
Alaska and United States
1996-1998



Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Leading Causes of Death by Race/Ethnicity
Alaska and United States
1996-1998

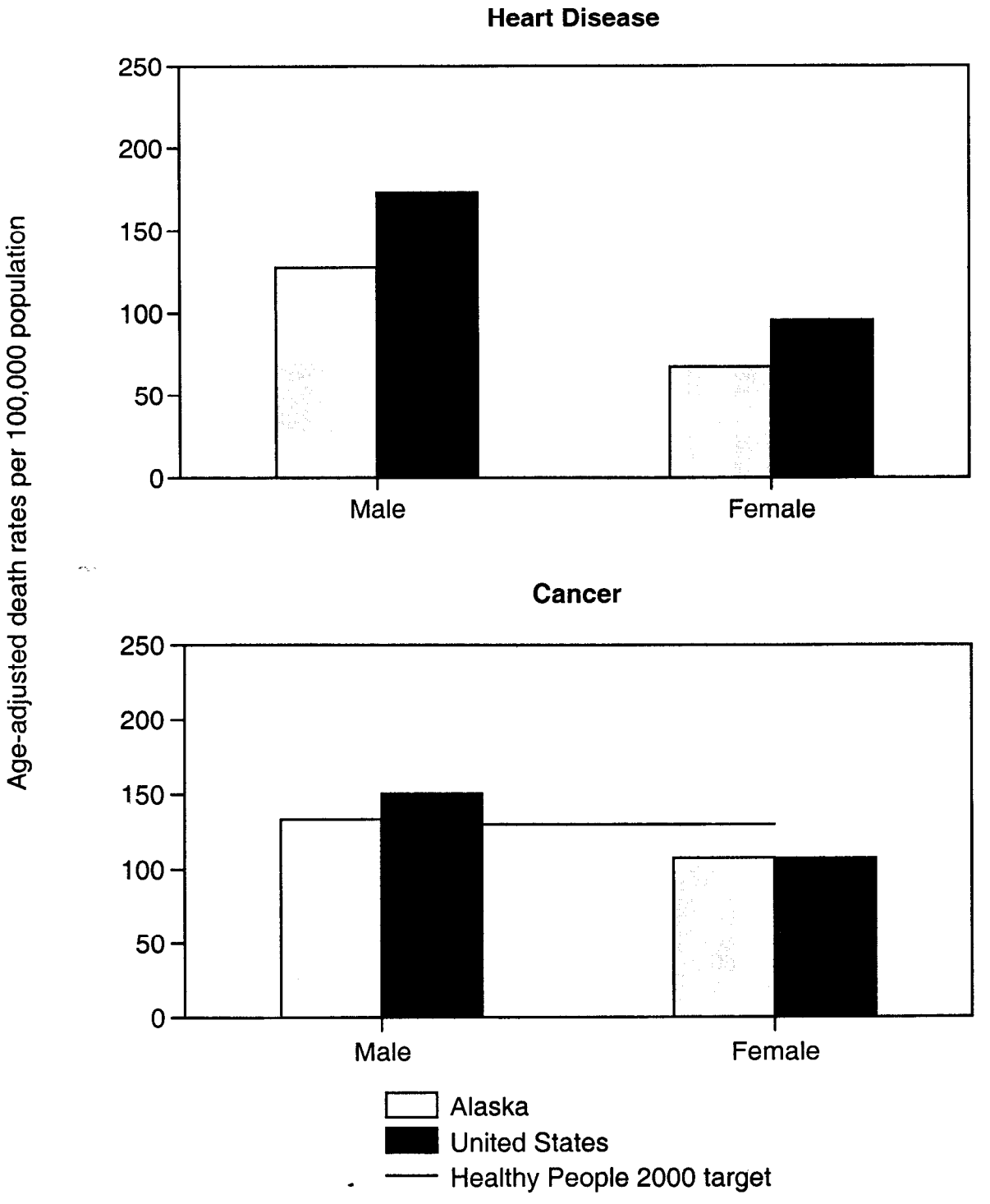


*Rate is based on <20 deaths and is considered unreliable.

Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.

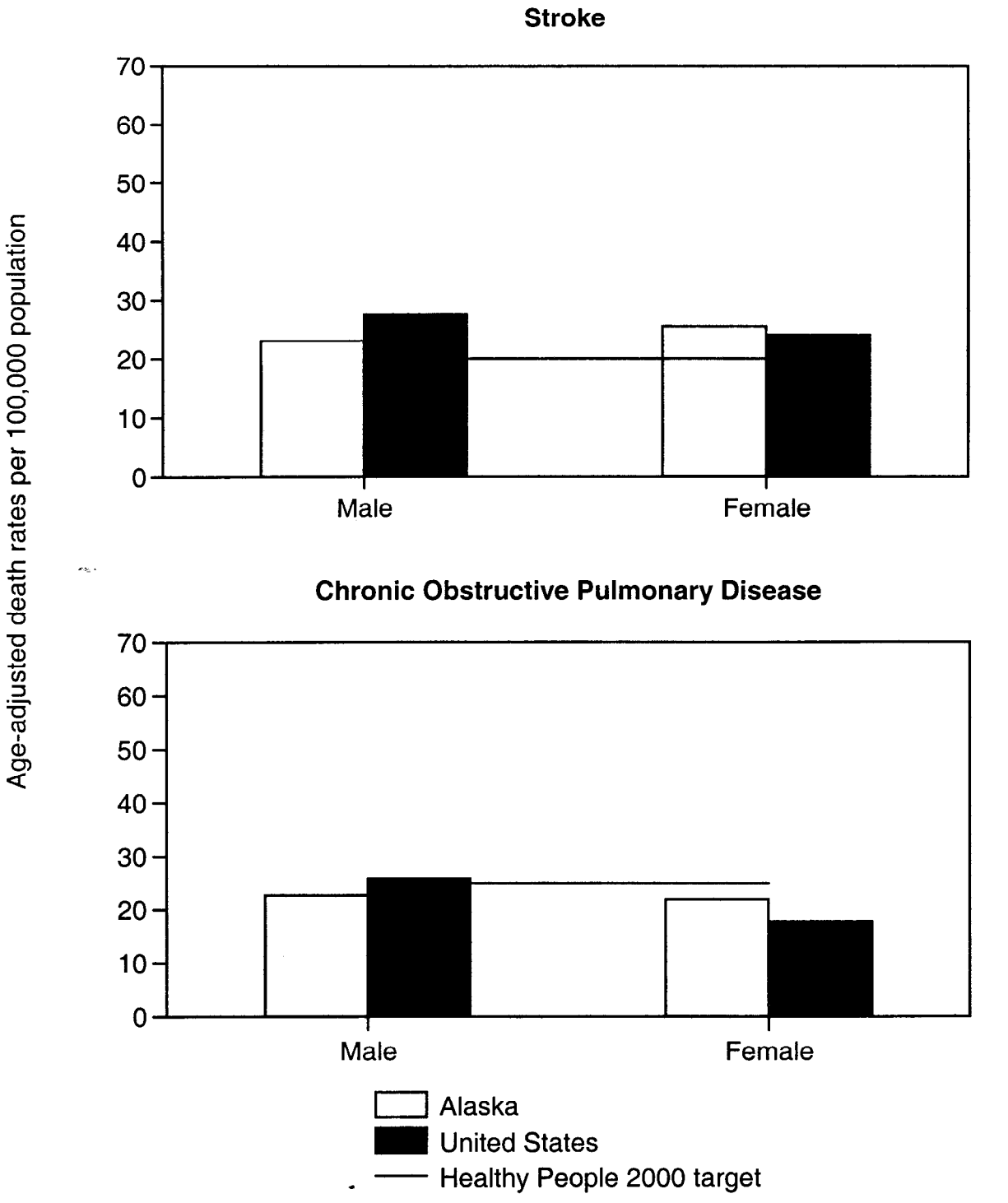
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Leading Causes of Death by Sex
Alaska and United States
1996-1998



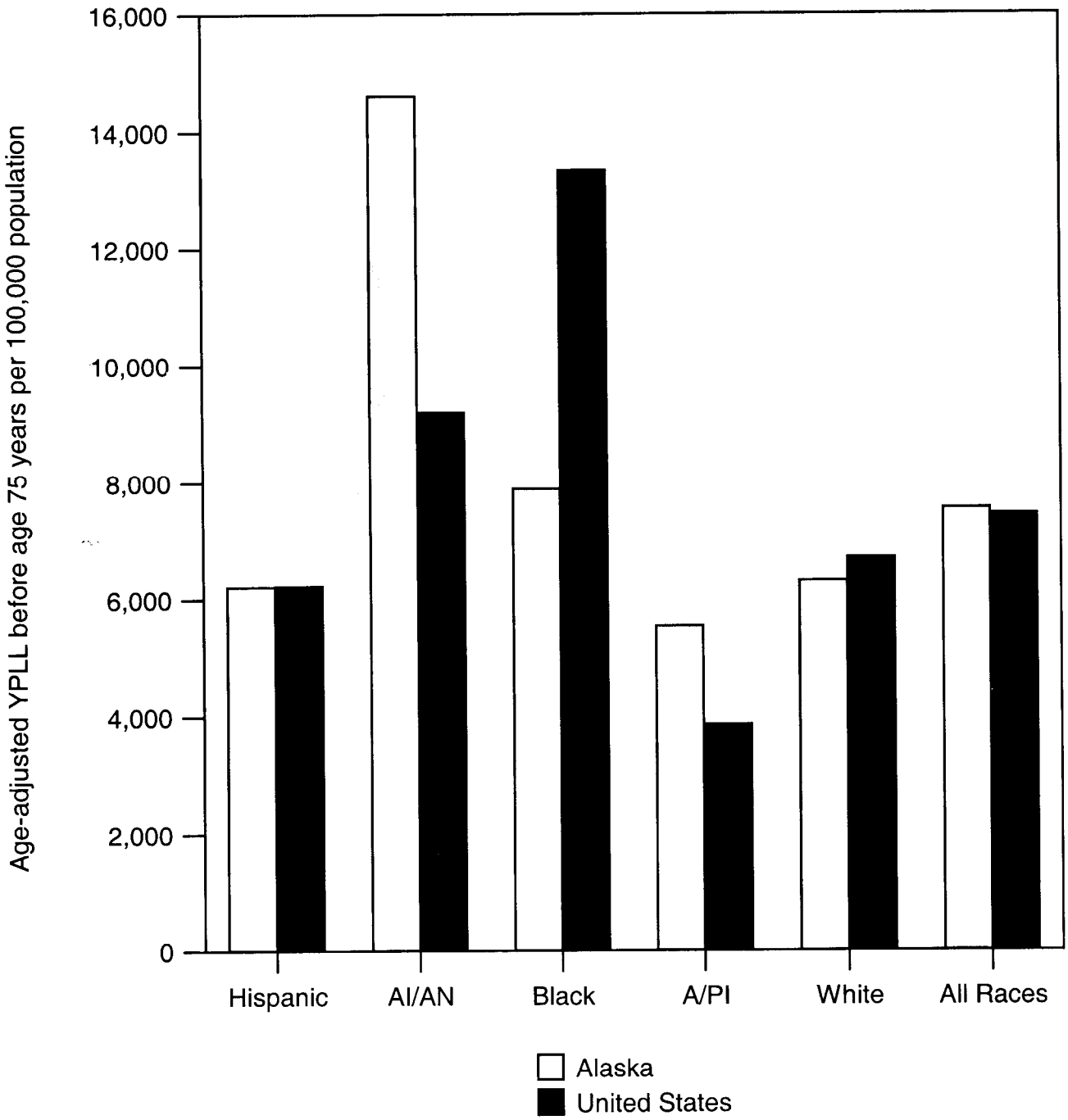
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Leading Causes of Death by Sex
Alaska and United States
1996-1998



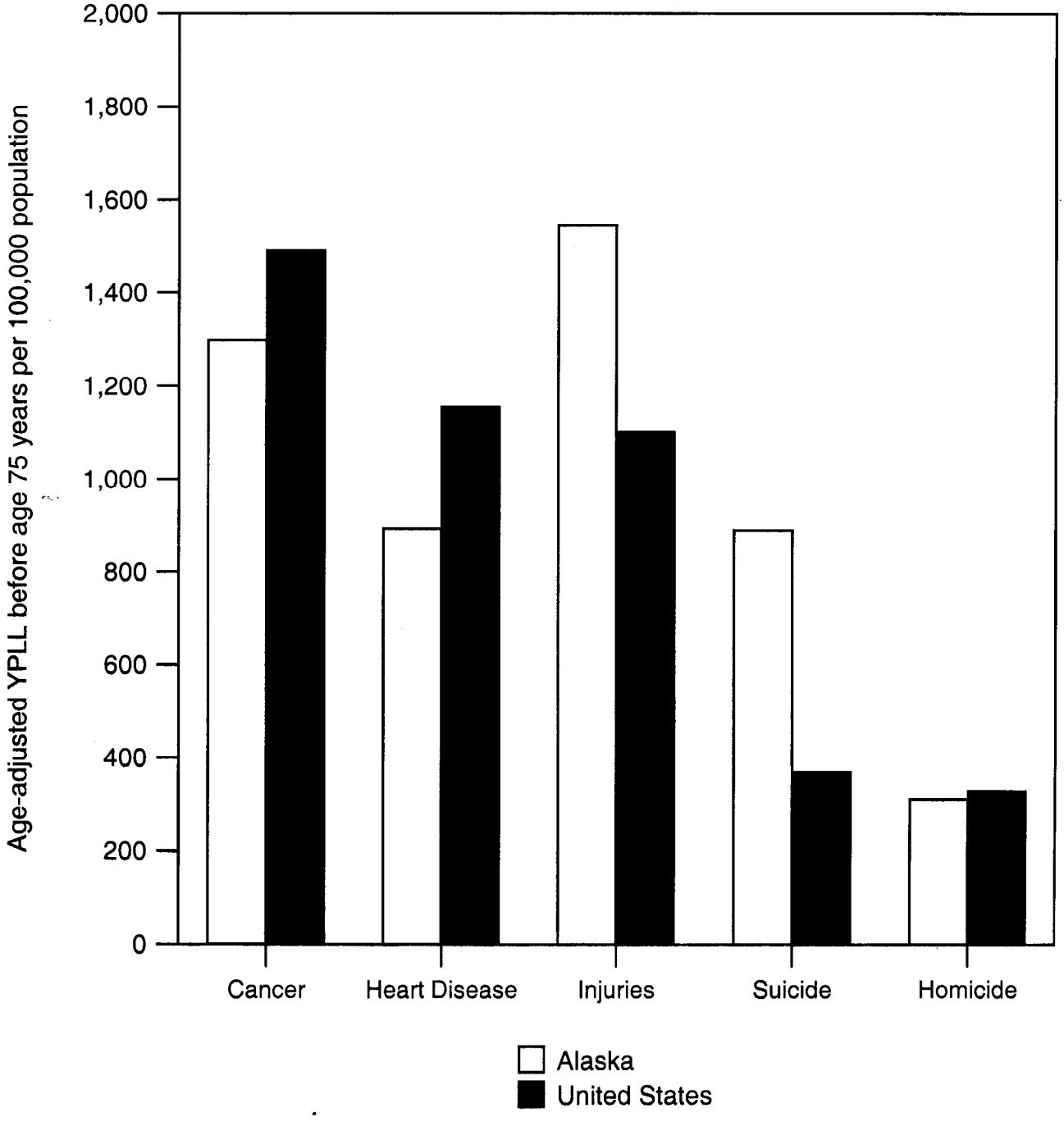
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Years of Potential Life Lost (YPLL) Before Age 75 Years
Alaska and United States
1996-1998



Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Years of Potential Life Lost (YPLL) Before Age 75 Years: Leading Causes Alaska and United States, 1998



Note: Injuries = Unintentional injuries.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Childhood Health Concerns

Developmental Disabilities

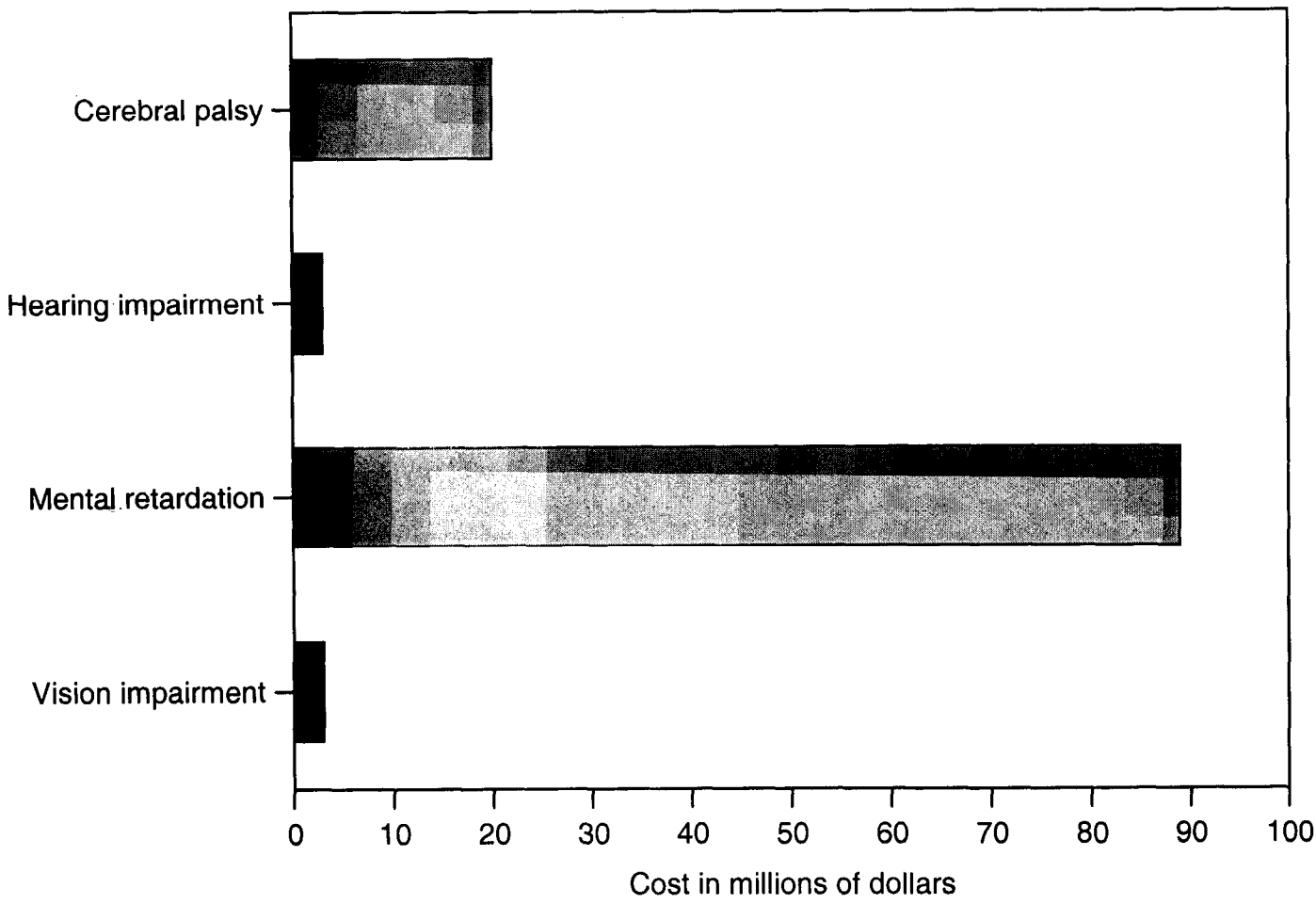
Vaccination Coverage

Infant Mortality

Prenatal Care

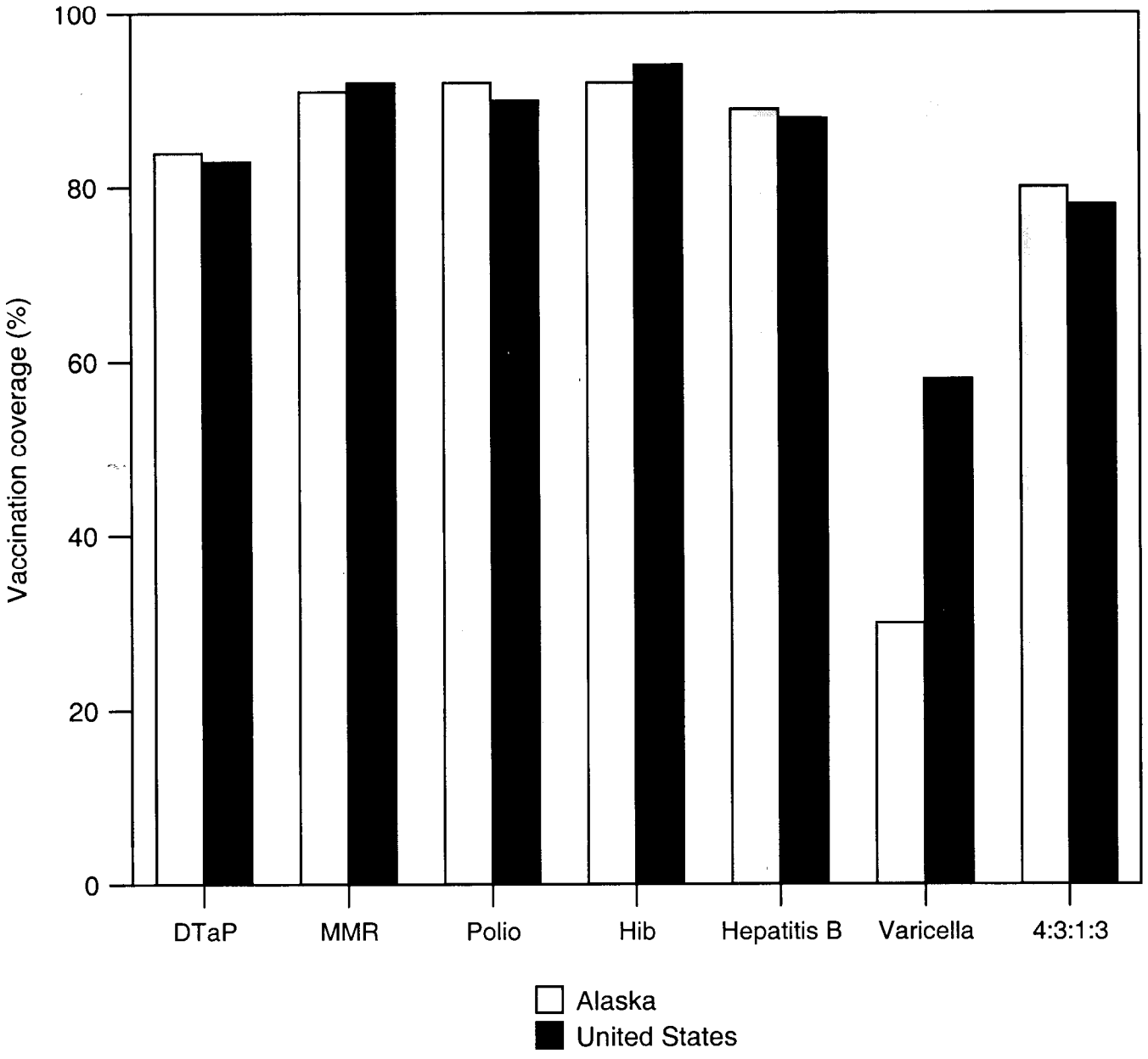
Birth Rates for Females Aged 15-19 Years

Developmental Disabilities: Estimated Lifetime Costs for Children Born in Alaska, 1998



Source: Division of Birth Defects, Child Development, and Disability and Health (proposed), National Center for Environmental Health, CDC

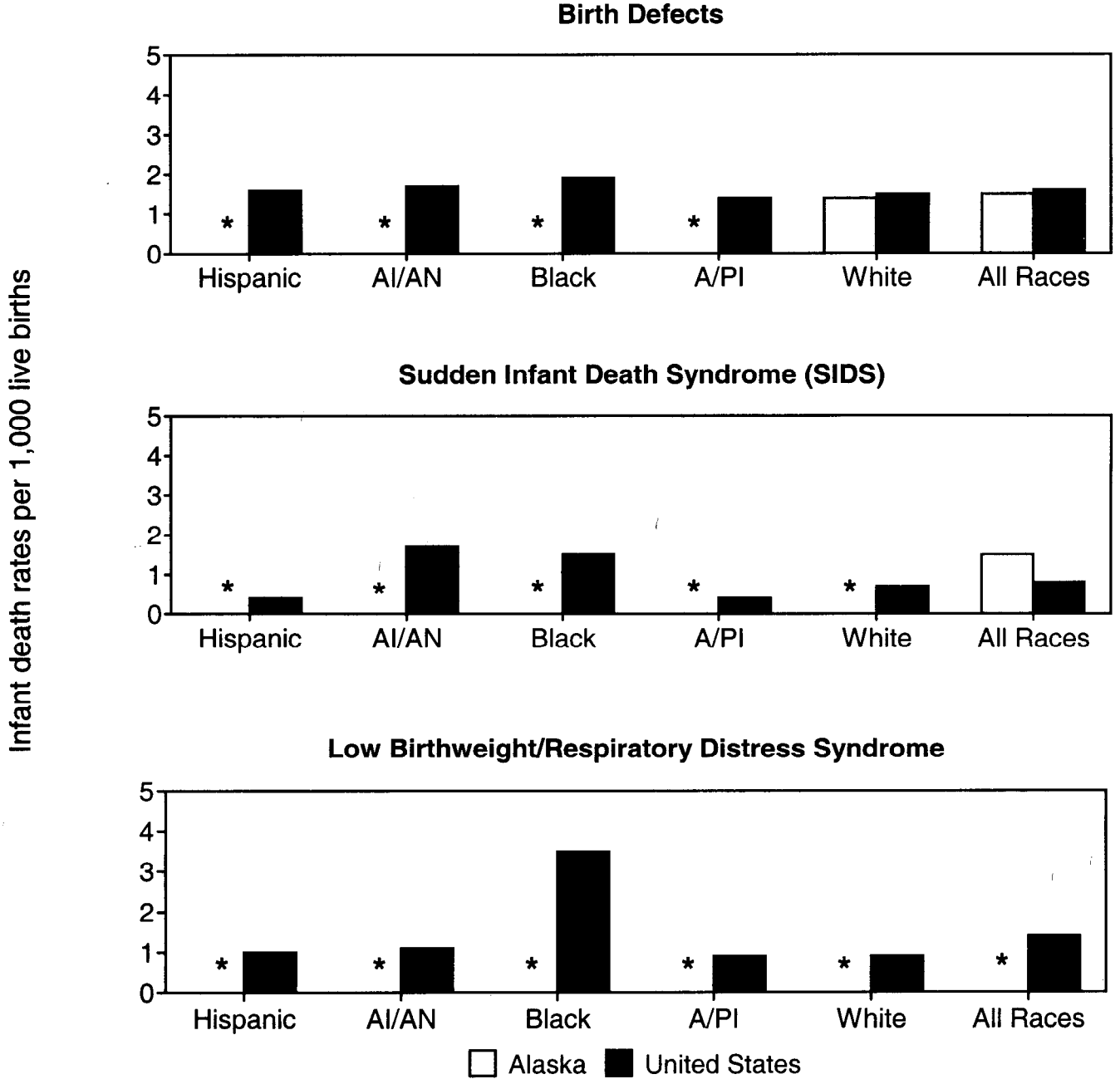
Vaccination Coverage with Measles and Other Vaccines Among Children Aged 19-35 Months Alaska and United States, 1999



Note: DTaP = Diphtheria and tetanus toxoids and acellular pertussis vaccine; MMR = Measles-mumps-rubella vaccine; Hib = *Haemophilus influenzae* type b vaccine; Varicella = Chickenpox vaccine; 4:3:1:3 = 4 DTaP, 3 Polio (inactivated polio vaccine), 1 MMR, 3 Hib.

Source: National Immunization Survey, CDC.

Infant Mortality: Leading Causes
Alaska and United States
1996-1998

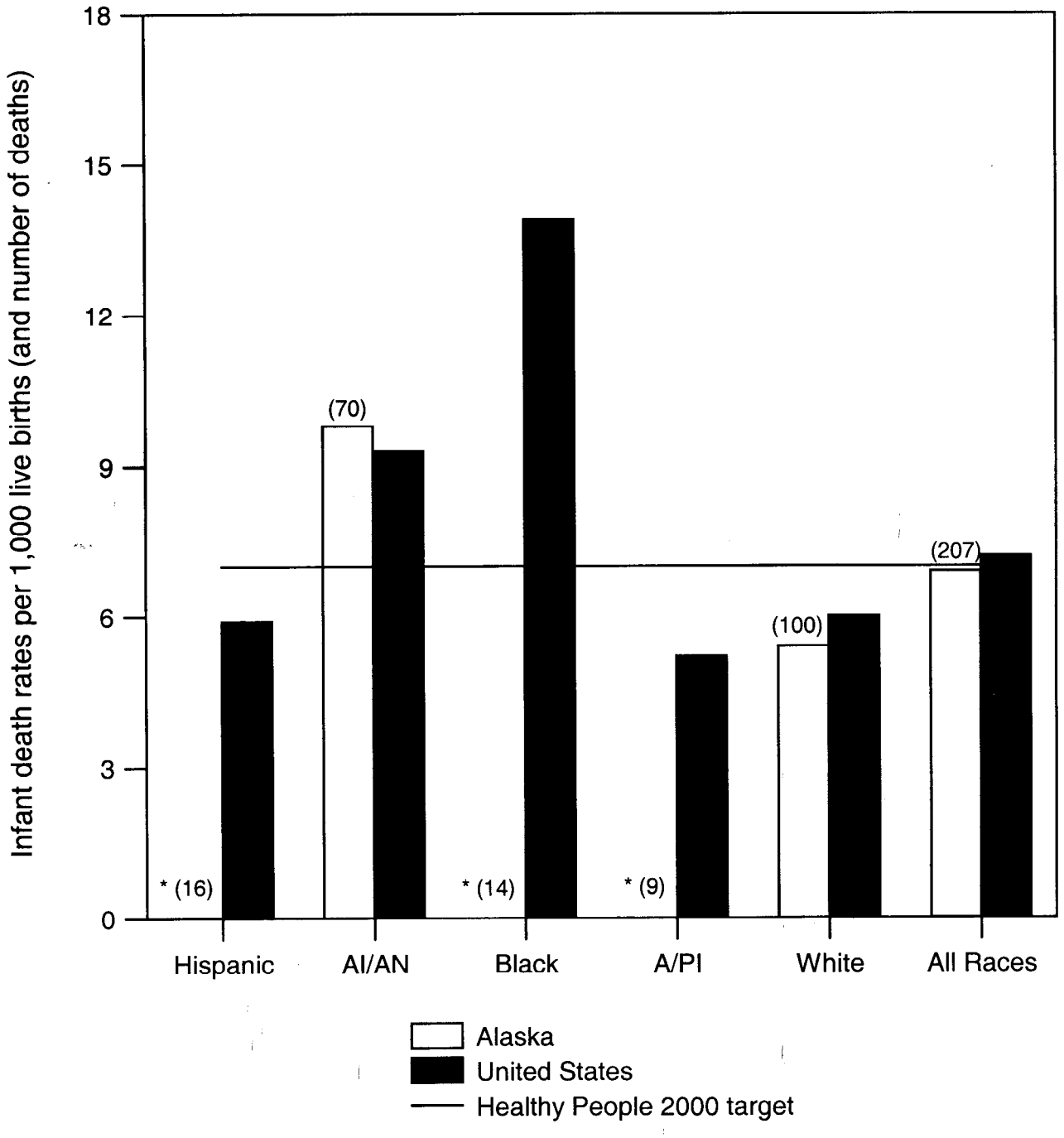


*Rate is based on <20 deaths and is considered unreliable.

Note: AI/AN = American Indian/Alaskan Native; Black = Black Non-Hispanic; A/PI = Asian/Pacific Islander; White = White Non-Hispanic.

Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Infant Mortality: Rates and Number of Deaths by Race/Ethnicity Alaska and United States, 1996-1998

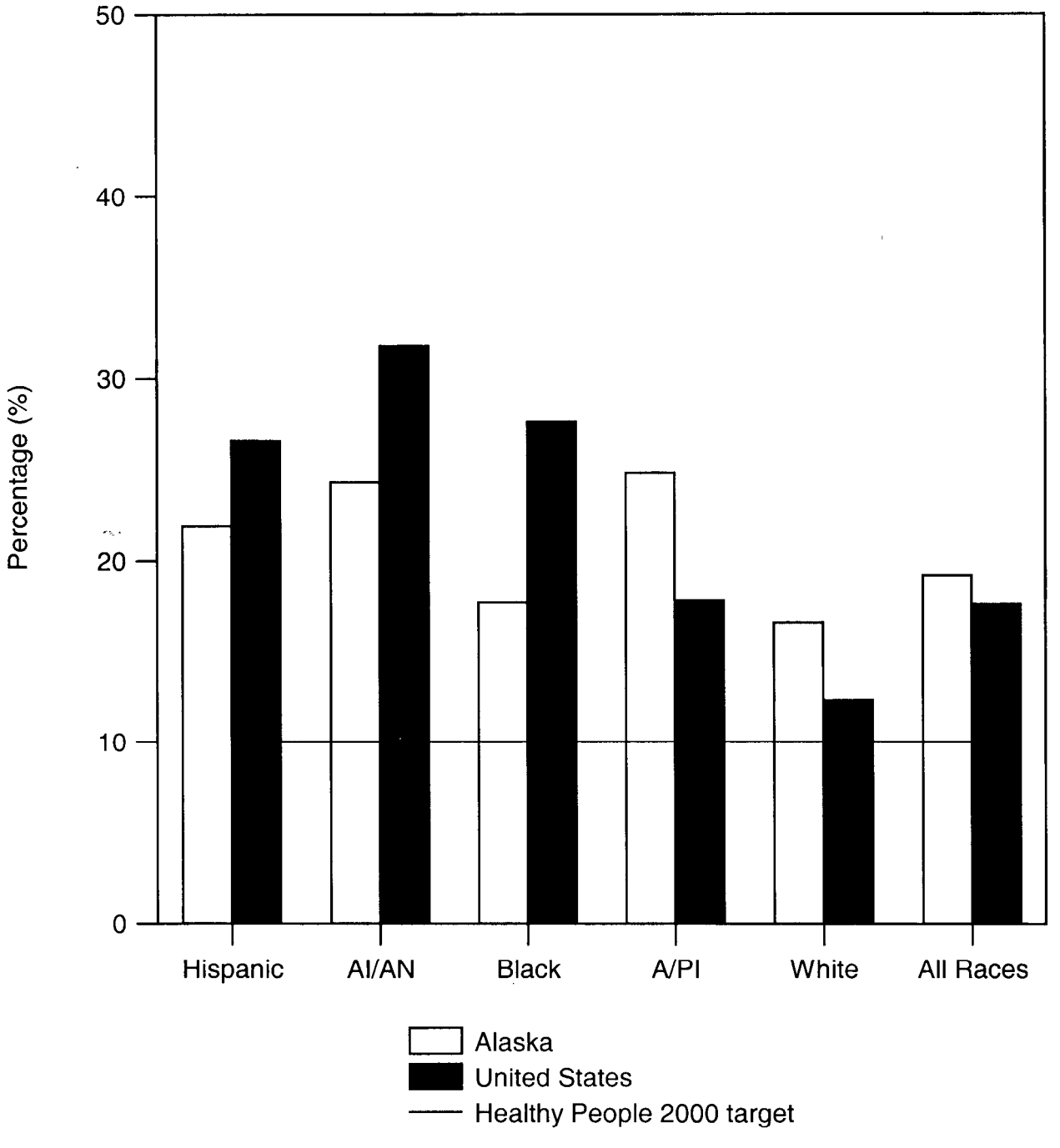


*Rate is based on <20 deaths and is considered unreliable.

Note: AI/AN = American Indian/Alaskan Native; Black = Black Non-Hispanic; A/PI = Asian/Pacific Islander; White = White Non-Hispanic.

Source: National Vital Statistics System, National Center for Health Statistics, CDC.

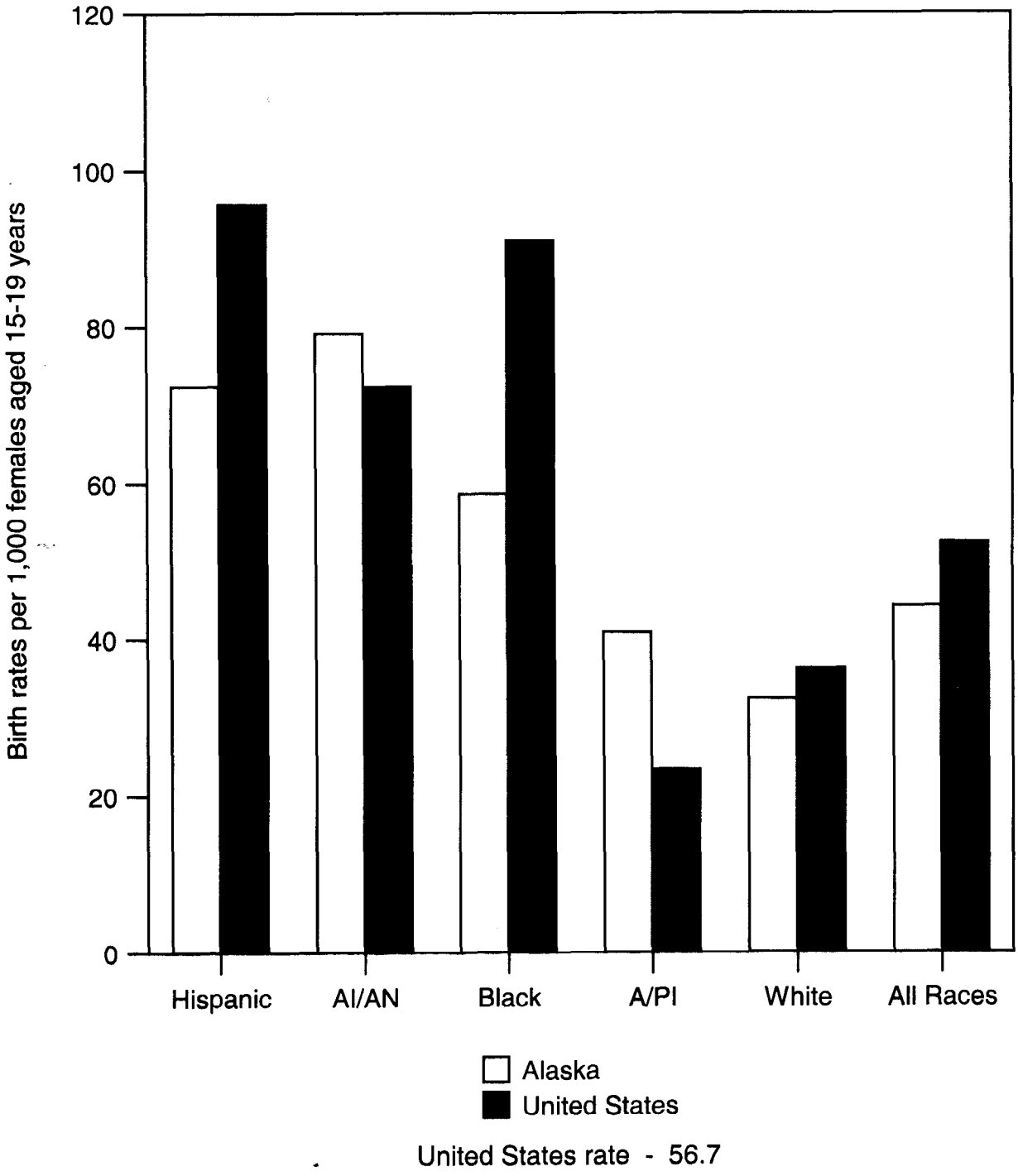
Prenatal Care: Women Who Did Not Receive Prenatal Care During the First Trimester of Pregnancy by Race/Ethnicity Alaska and United States, 1996-1998



Note: AI/AN = American Indian/Alaskan Native; Black = Black Non-Hispanic; A/PI = Asian/Pacific Islander; White = White Non-Hispanic.

Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Birth Rates for Females Aged 15-19 Years by Race/Ethnicity Alaska and United States, 1996-1998



Note: AI/AN = American Indian/Alaskan Native; Black = Black Non-Hispanic;
A/PI = Asian/Pacific Islander; White = White Non-Hispanic.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

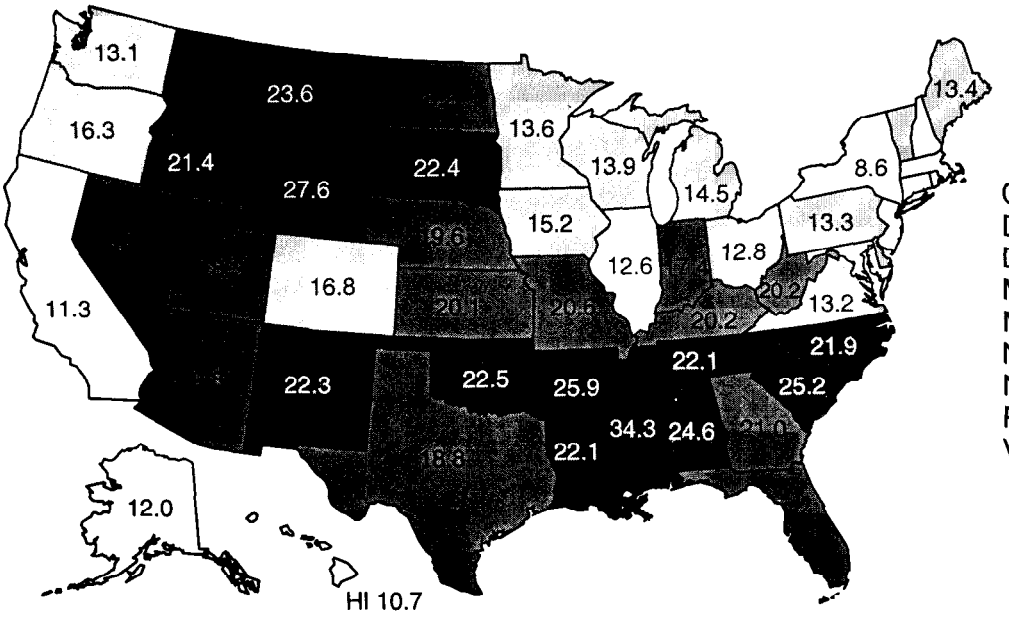
Deaths from Injuries

Motor Vehicle-Related Deaths

Suicide

Homicide

Motor Vehicle-Related Deaths
1998



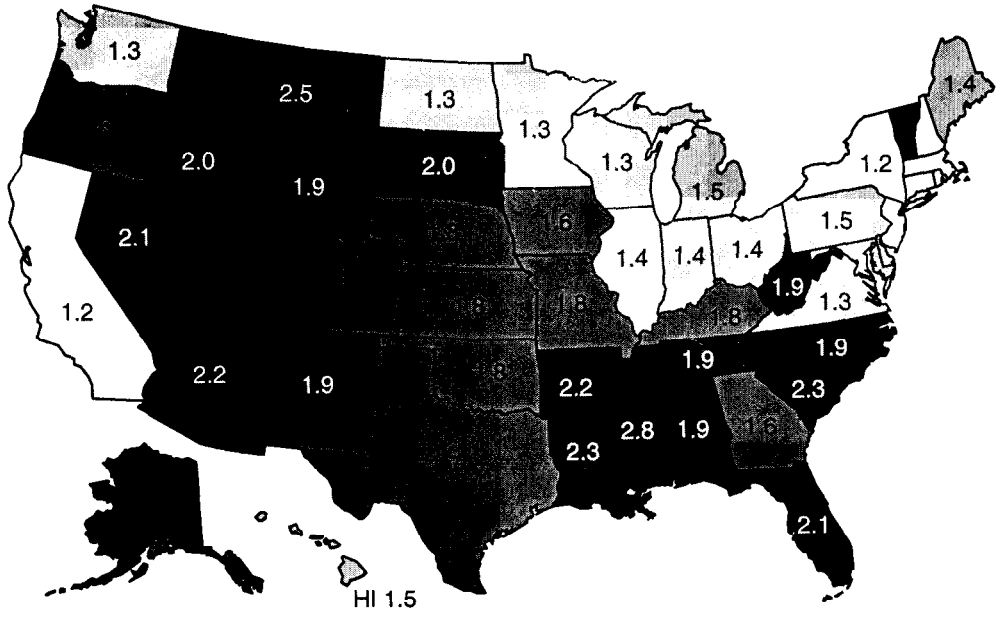
CT	10.1
DC	9.8
DE	15.2
MA	7.8
MD	12.3
NH	11.9
NJ	9.2
RI	8.7
VT	13.3

Age-adjusted death rates per 100,000 population

7.8 - 12.7 | 12.8 - 17.1 | 17.2 - 21.1 | 21.2 - 34.3

United States rate - 15.7; Healthy People 2000 target - 14.2

Source: National Vital Statistics System, National Center for Health Statistics, CDC.



CT	1.1
DC	1.6
DE	1.4
MA	0.8
MD	1.3
NH	1.1
NJ	1.2
RI	0.9
VT	1.6

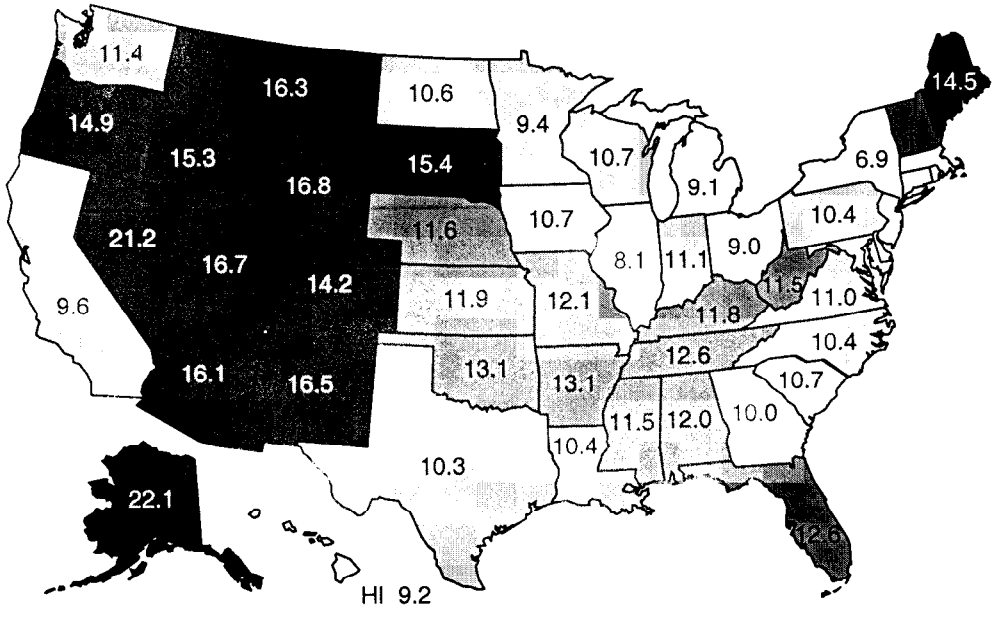
Death rates per 100 million miles traveled

0.8 - 1.2 | 1.3 - 1.5 | 1.6 - 1.8 | 1.9 - 2.8

United States rate - 1.6; Healthy People 2000 target - 1.5

Source: Fatal Accident Reporting System, U.S. Department of Transportation.

Suicide Rates, 1998



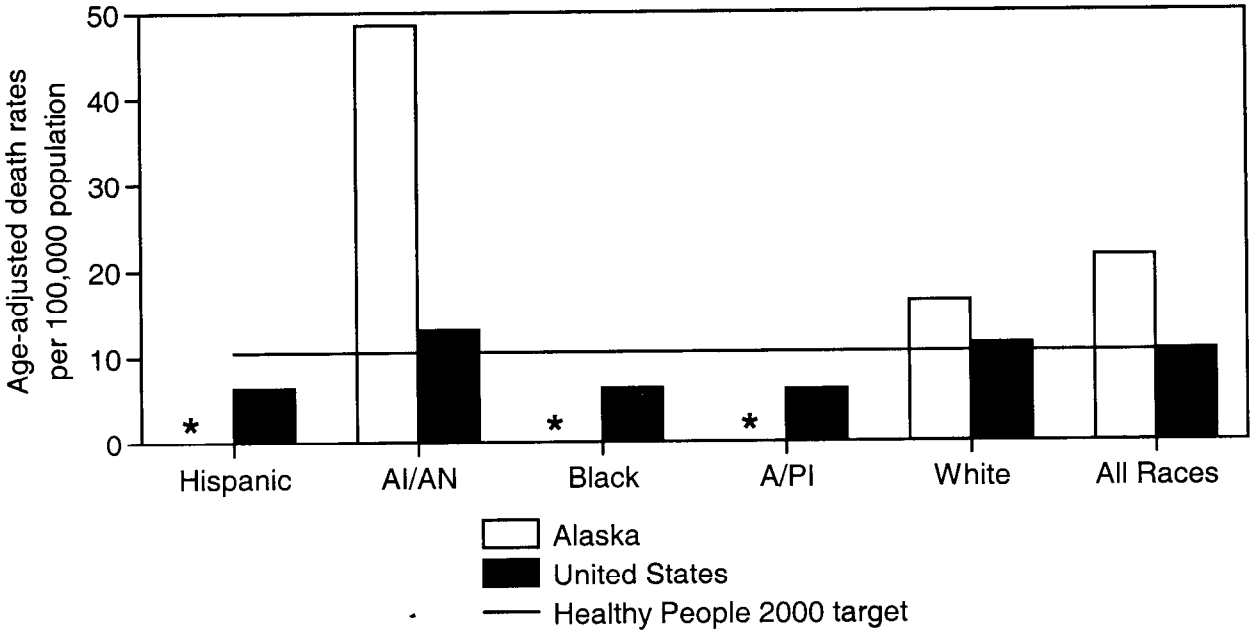
CT 7.2
DC 7.3
DE 8.0
MA 7.5
MD 8.9
NH 12.7
NJ 6.4
RI 8.1
VT 12.8

Age-adjusted death rates per 100,000 population

6.4 - 9.3 | 9.4 - 11.2 | 11.3 - 13.1 | 13.2 - 22.1

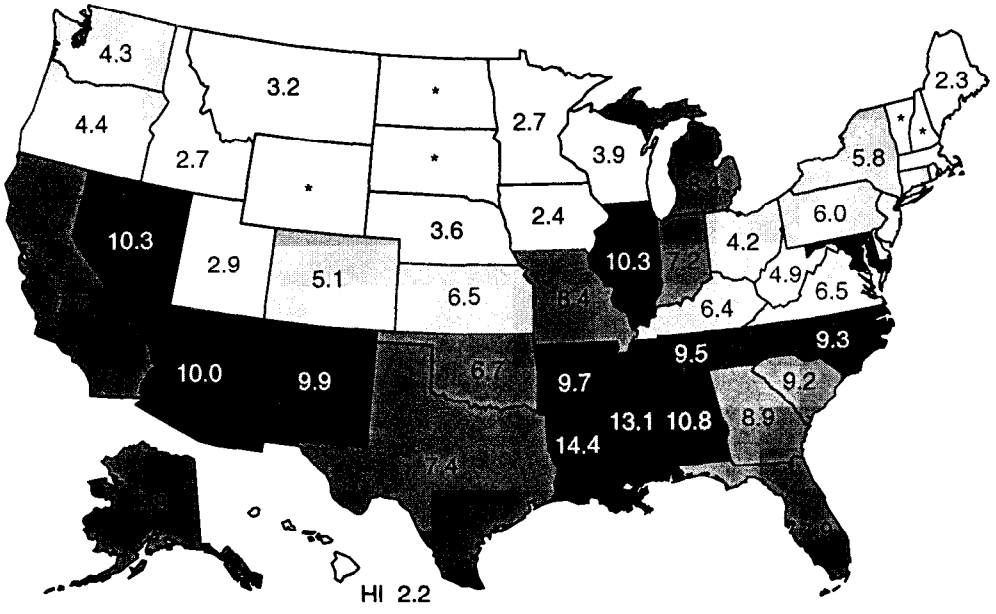
United States rate - 10.4; Healthy People 2000 target - 10.5

Suicide Rates
Alaska and United States, 1996-1998



*Rate is based on <20 deaths and is considered unreliable.
Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Homicide Rates, 1998

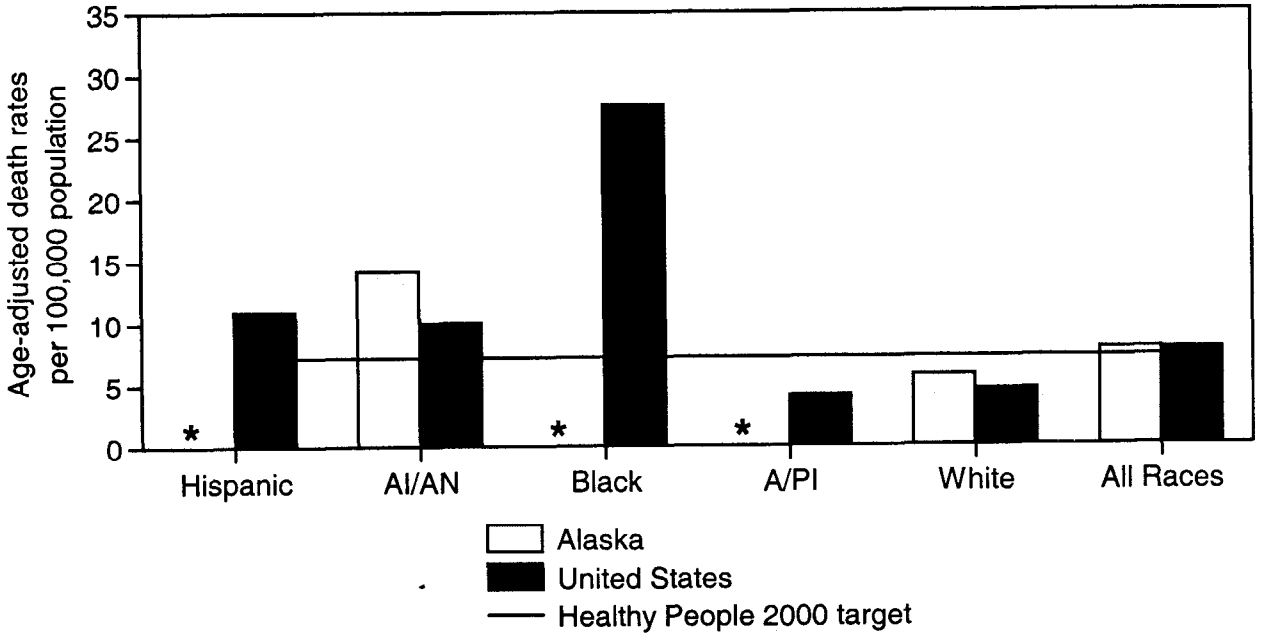


Age-adjusted death rates per 100,000 population

2.2 - 3.9 | 4.0 - 6.5 | 6.6 - 9.2 | 9.3 - 44.6

United States rate - 7.1; Healthy People 2000 target - 7.2

Homicide Rates
Alaska and United States, 1996-1998



*Rate is based on <20 deaths and is considered unreliable.

Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.

Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Environmental Health Concerns

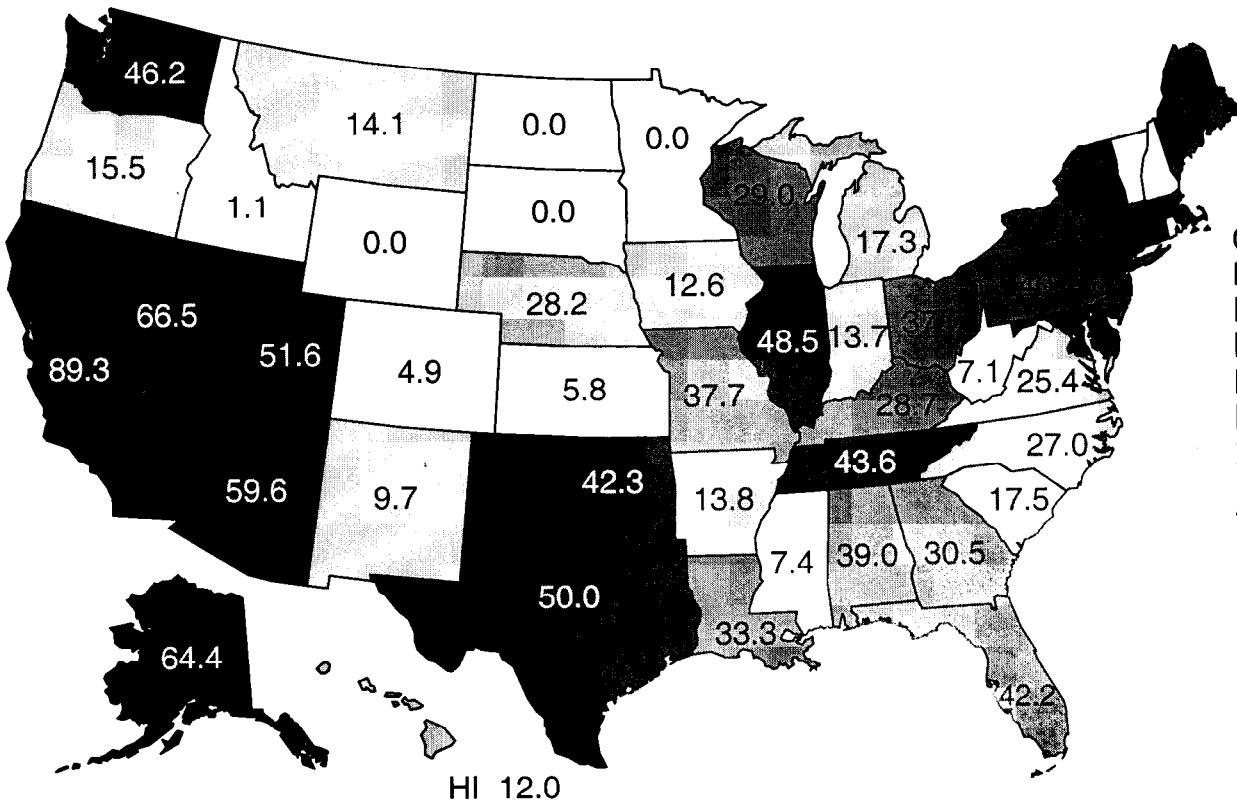
Air Quality Standards

Asthma

Disabilities

Childhood Lead Poisoning Prevention

Air Quality Standards
1998



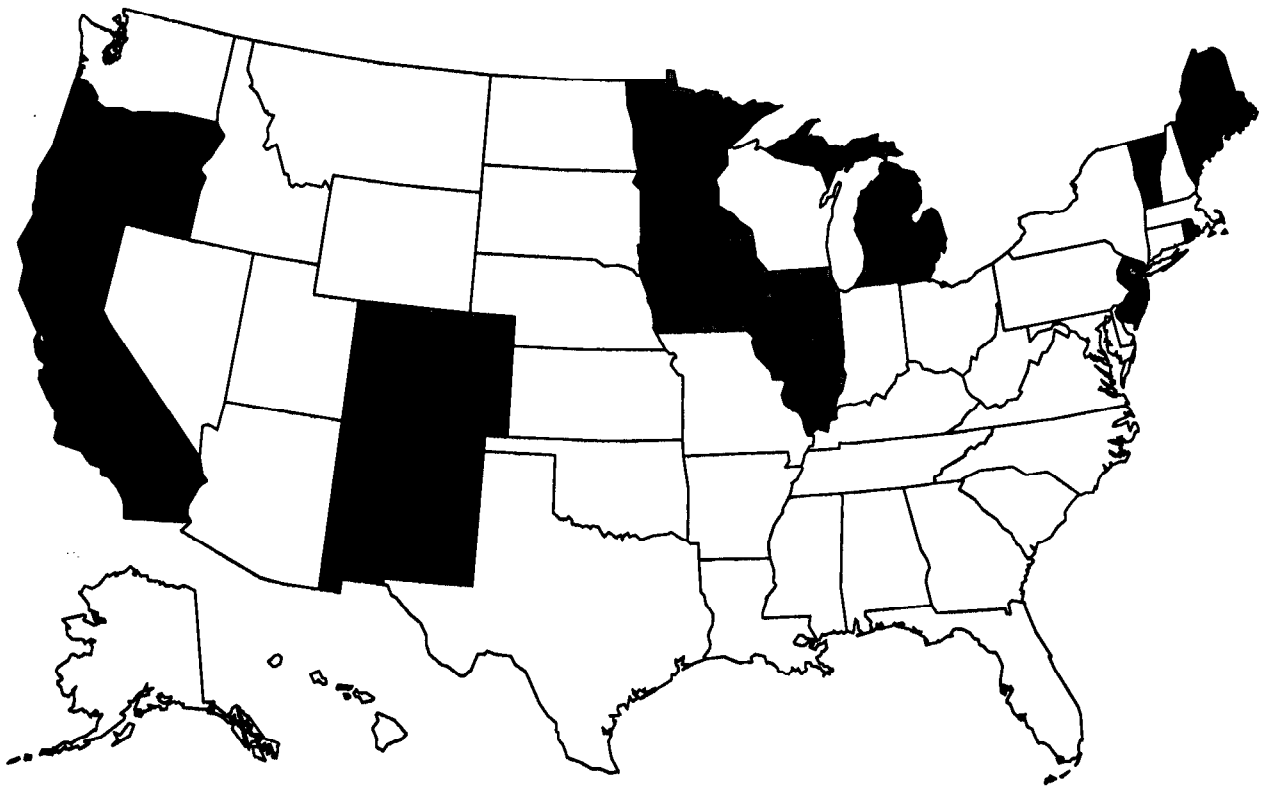
Percentage of persons living in counties not meeting
U.S. Environmental Protection Agency air quality standards

0.0% - 7.4% | 9.7% - 28.2% | 28.7% - 42.2% | 42.3% - 100.0%

United States - 40.6%

Source: Aerometric Information Retrieval System, U.S. Environmental Protection Agency.

Asthma: Projects Funded by CDC
Fiscal Year 2000

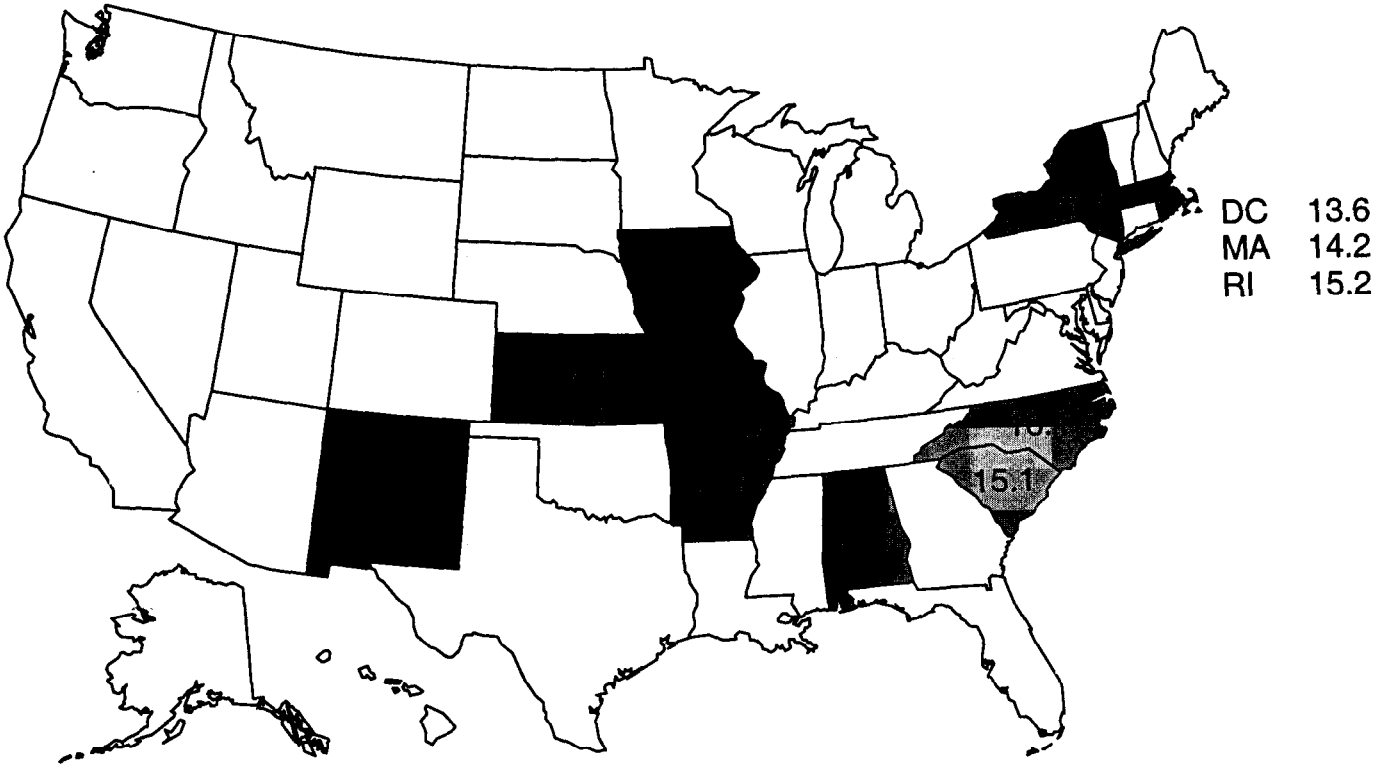


States with funded projects

Note: Federal fiscal year 2000 = October 1, 1999, through September 30, 2000.

Source: Air Pollution and Respiratory Health Branch, National Center for Environmental Health, CDC.

Disabilities Reported by Adults
BRFSS, 1998

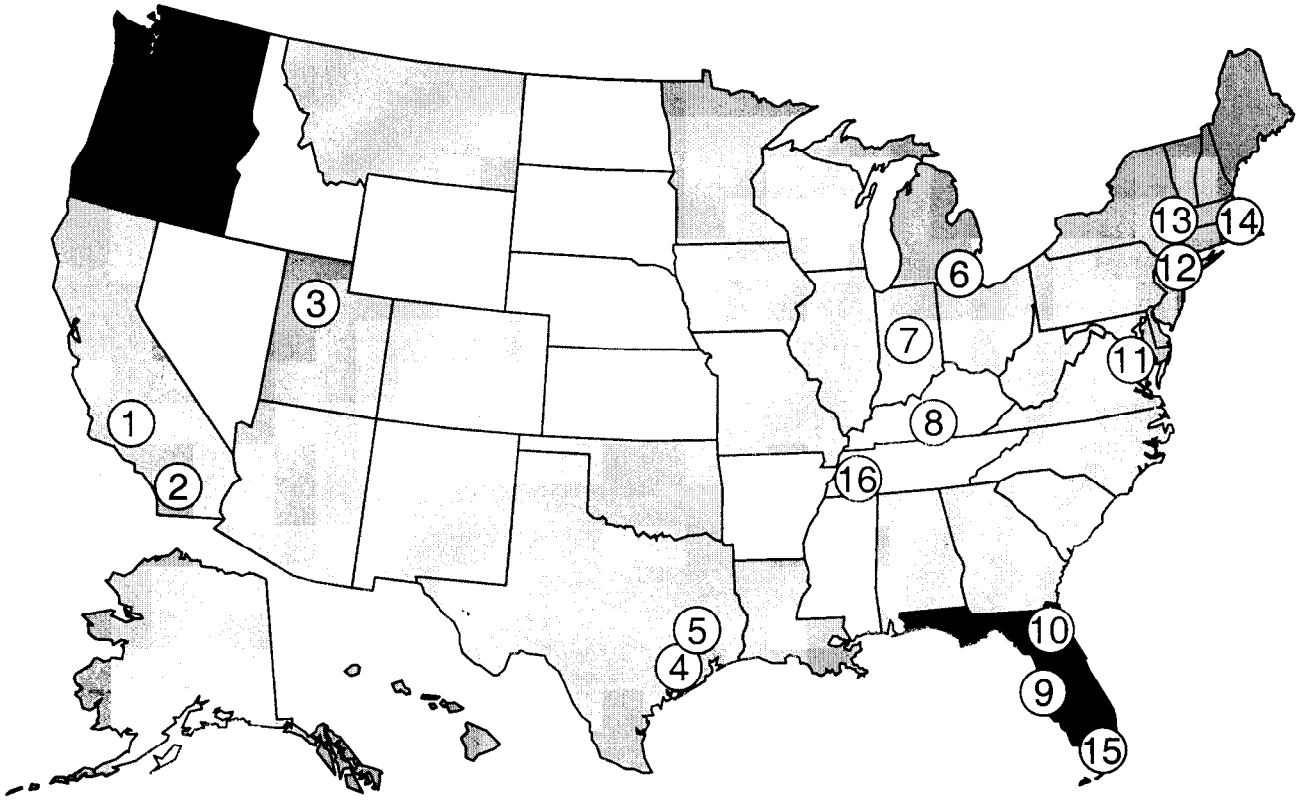


Rates per 100 persons aged ≥18 years (%)

■ States reporting BRFSS disability/quality-of-life data

Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Childhood Lead Poisoning Prevention Programs and Surveillance Grants Fiscal Year 2000



38 state programs (including DC)

3 surveillance grants

16 city or county programs (including DC)

1. Los Angeles County, CA
2. San Diego County, CA
3. Salt Lake City, UT
4. Houston, TX
5. Harris County, TX
6. Detroit, MI
7. Marion County, IN
8. Jefferson County, KY
9. Pinellas County, FL
10. Duval County, FL
11. Washington, DC
12. New York City, NY
13. Westchester County, NY
14. Boston, MA
15. Miami, FL
16. Memphis, TN

Note: Federal fiscal year 2000 = October 1, 1999, through September 30, 2000.
Source: Lead Poisoning Prevention Branch, National Center for Environmental Health, CDC.

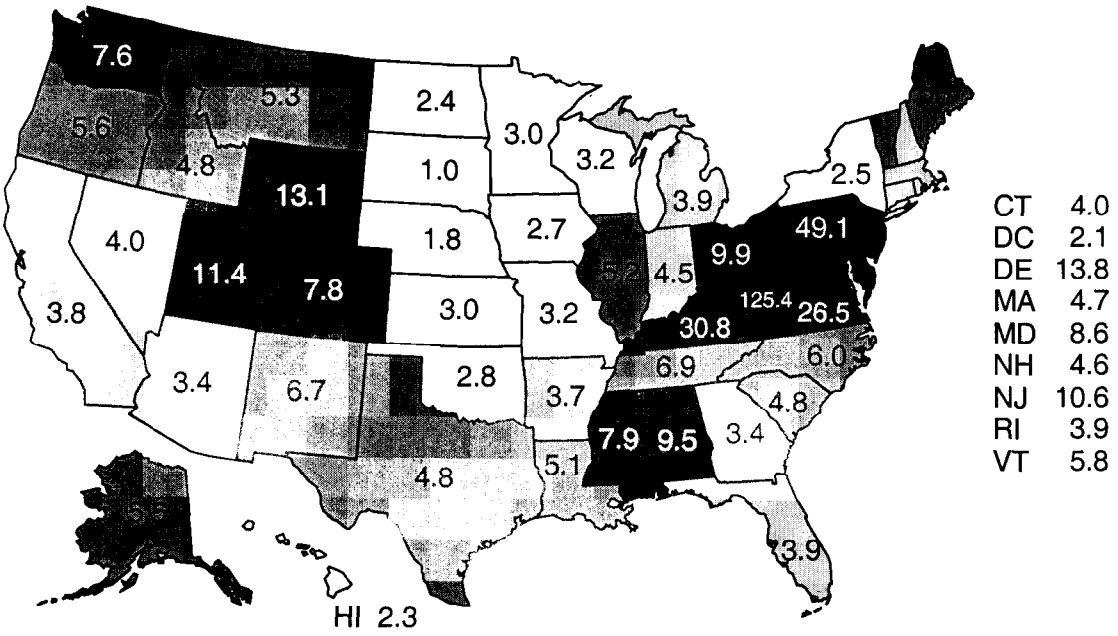
Occupational Health Concerns

Occupational Lung Disease Mortality

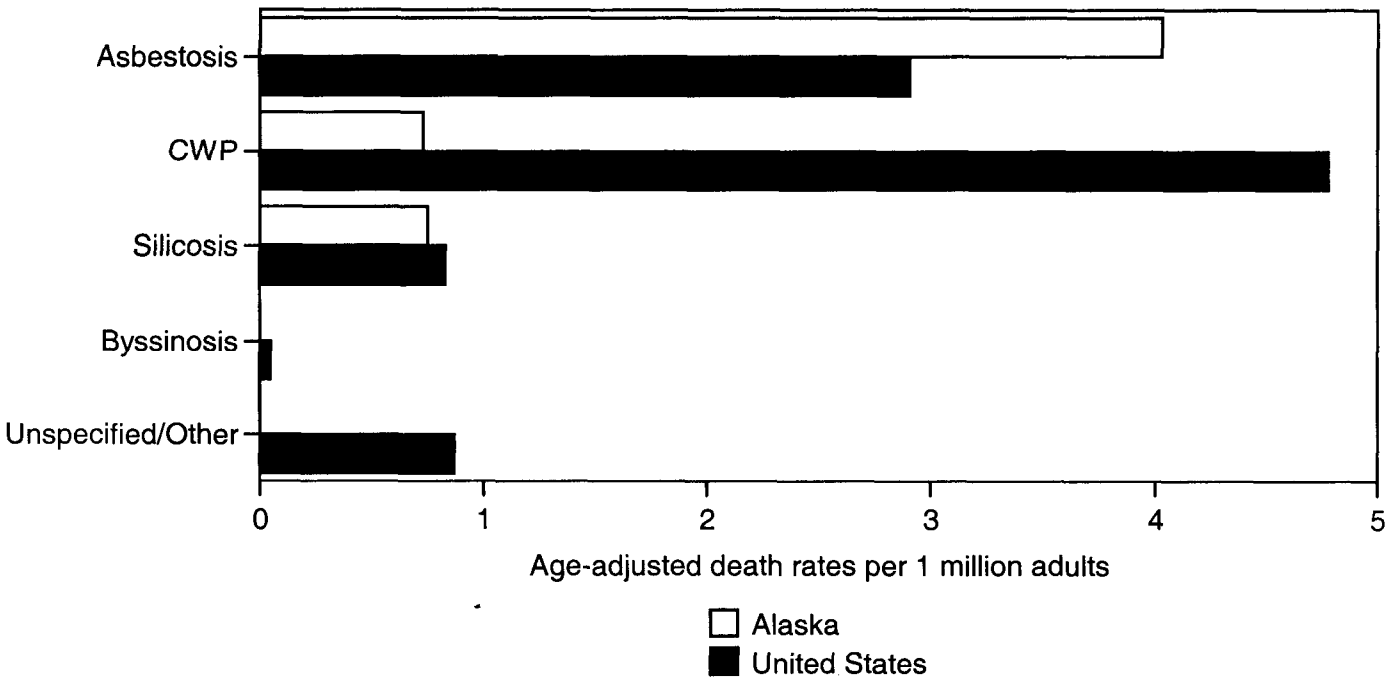
Traumatic Occupational Fatalities

Occupational Illnesses

Occupational Lung Disease Deaths 1987-1996

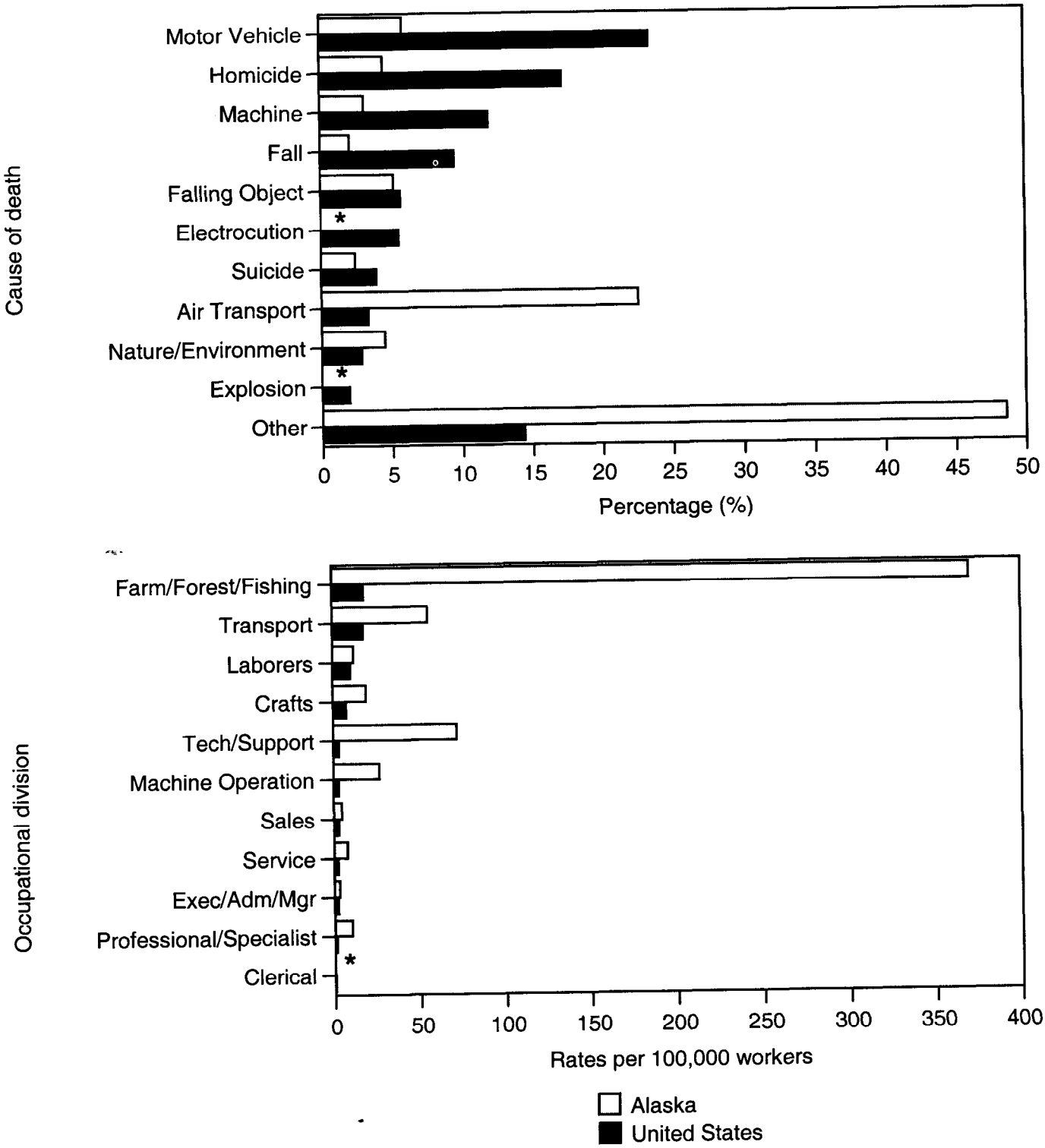


Occupational Lung Disease Deaths by Condition Alaska and United States, 1987-1996



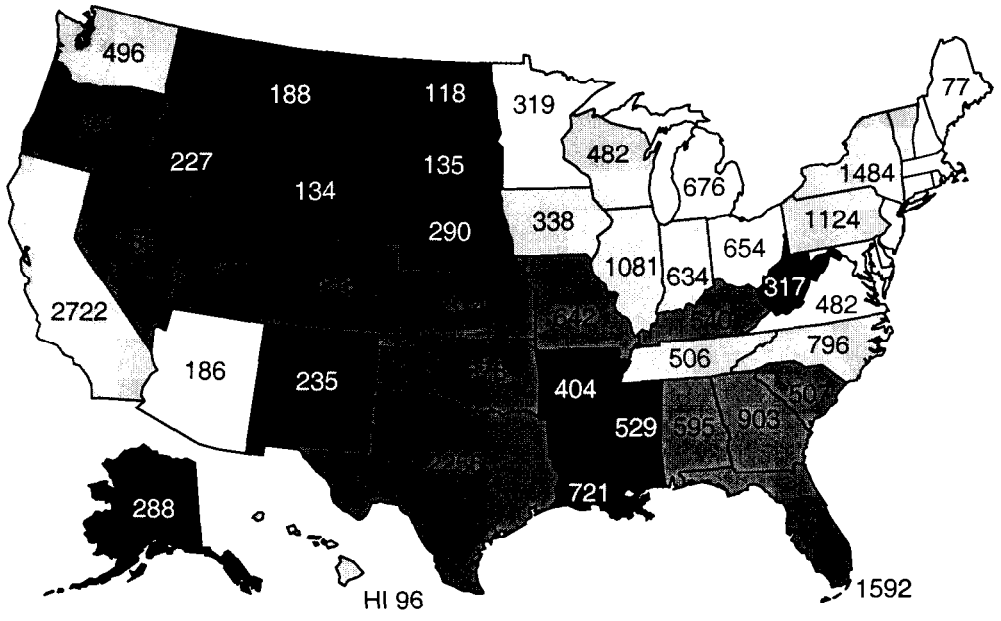
Note: Adults = persons aged ≥15 years; CWP = Coal workers' pneumoconiosis.
Source: National Surveillance System for Pneumoconioses Mortality, CDC.

Traumatic Occupational Fatalities by Cause of Death and Occupational Division Alaska and United States, 1991-1995



*Fewer than 3 deaths in this category.
Source: National Traumatic Occupational Fatalities Surveillance System, CDC.

Traumatic Occupational Fatalities: All Industries 1991-1995



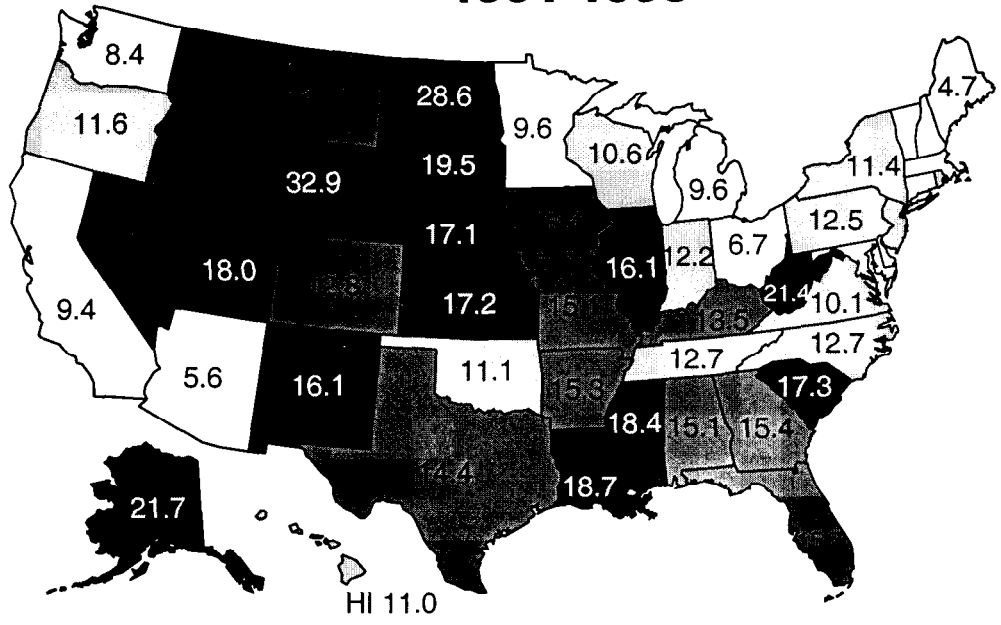
CT	154
DC	101
DE	48
MA	280
MD	306
NH	62
NJ	439
RI	59
VT	51

Number of deaths and average annual rates per 100,000 workers

1.9 - 3.1 | 3.4 - 4.7 | 5.0 - 6.4 | 6.7 - 21.3

United States - 26,257 (rate - 4.3)

Traumatic Occupational Fatalities: Construction Industry 1991-1995



CT	5.3
DC	25.6
DE	6.5
MA	9.0
MD	5.4
NH	7.4
NJ	10.5
RI	10.0
VT	5.8

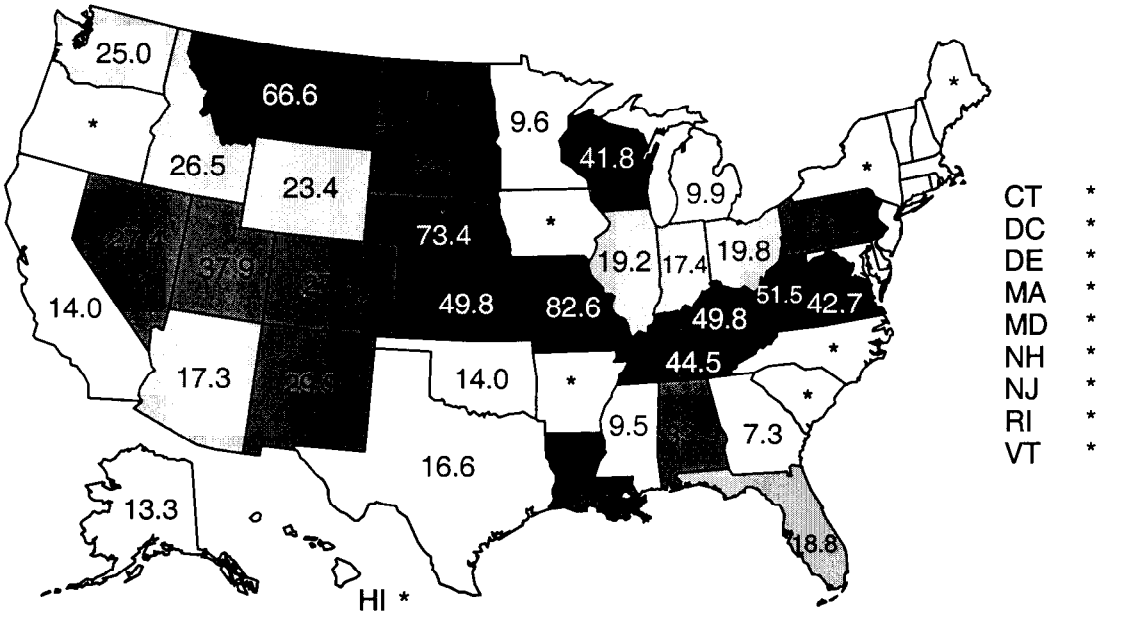
Average annual rates per 100,000 workers

4.7 - 9.6 | 10.0 - 12.7 | 12.8 - 15.7 | 16.1 - 32.9

United States rate - 12.2

Source: National Traumatic Occupational Fatalities Surveillance System, CDC.

Traumatic Occupational Fatalities: Mining Industry 1991-1995

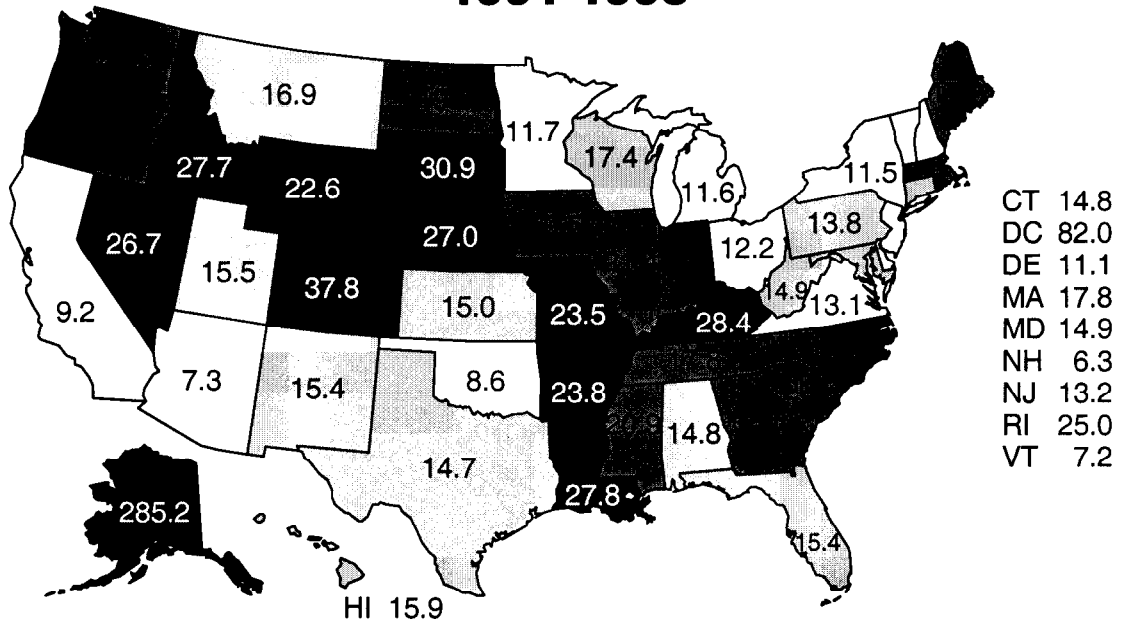


Average annual rates per 100,000 workers

7.3 - 16.6 | 17.3 - 26.5 | 27.4 - 37.9 | 41.8 - 82.6

United States rate - 24.3

Traumatic Occupational Fatalities: Agriculture Industry 1991-1995



Average annual rates per 100,000 workers

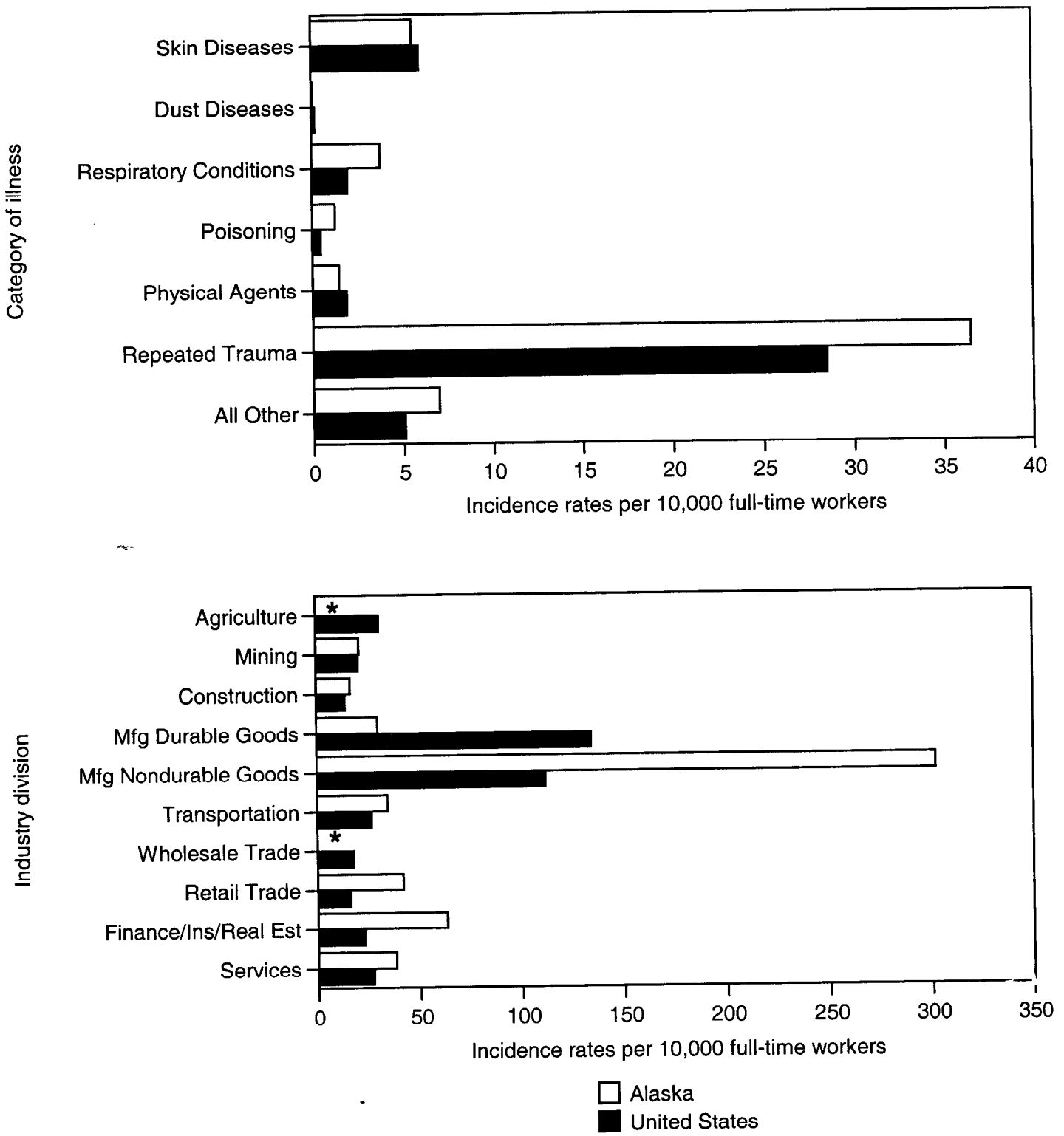
6.3 - 13.2 | 13.8 - 17.4 | 17.8 - 22.0 | 22.6 - 285.2

United States rate - 17.0

*Not available.

Source: National Traumatic Occupational Fatalities Surveillance System, CDC.

Occupational Illnesses by Category of Illness and Industry Division Alaska and United States, 1998



*Not available.

Source: Survey of Occupational Injuries and Illnesses, Bureau of Labor Statistics.

Infectious Diseases

Acquired Immunodeficiency Syndrome (AIDS)

Malaria

Chlamydia and Gonorrhea

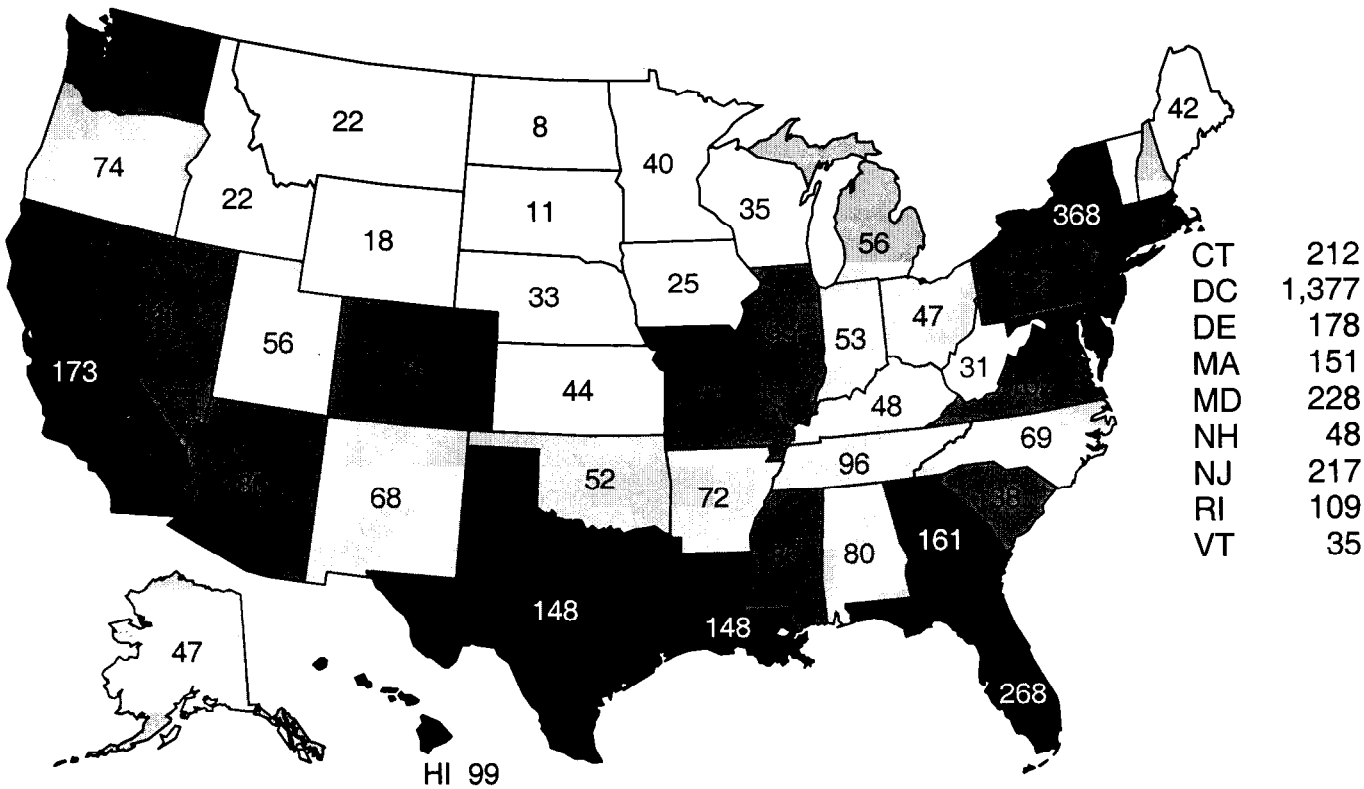
Primary and Secondary Syphilis

Pneumonia and Influenza Deaths

Lyme Disease

Tuberculosis

Acquired Immunodeficiency Syndrome (AIDS)
Estimated Rates of Adults/Adolescents Living with AIDS
December 1999



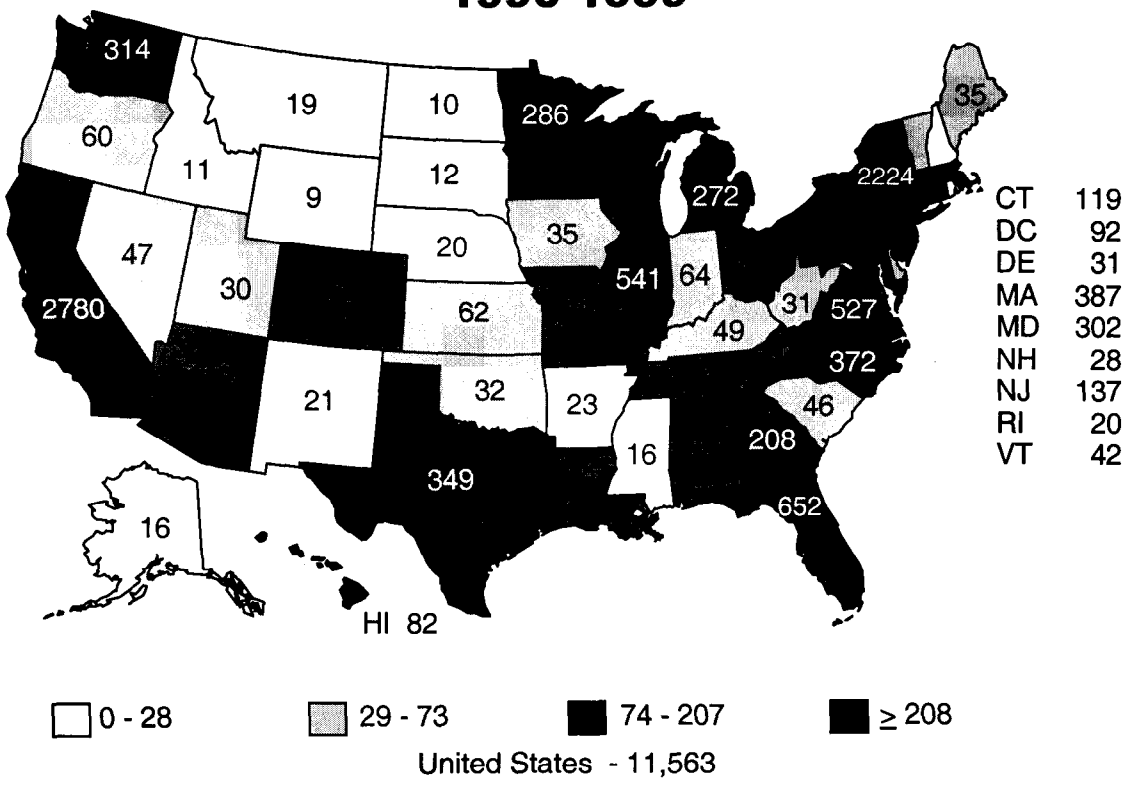
Rates per 100,000 population

8 - 45 | 46 - 81 | 82 - 144 | 145 - 1,377

United States rate - 141 (315,903 cases)

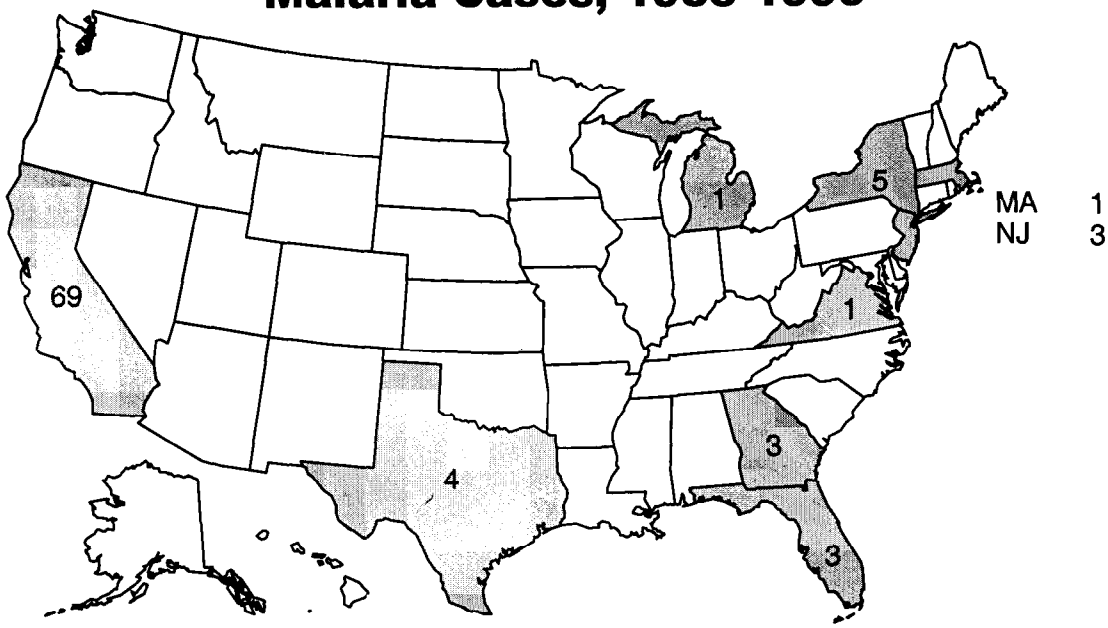
Source: HIV/AIDS Case Surveillance System, CDC.

Malaria: Reported Cases 1990-1999



Note: 1999 data are provisional.

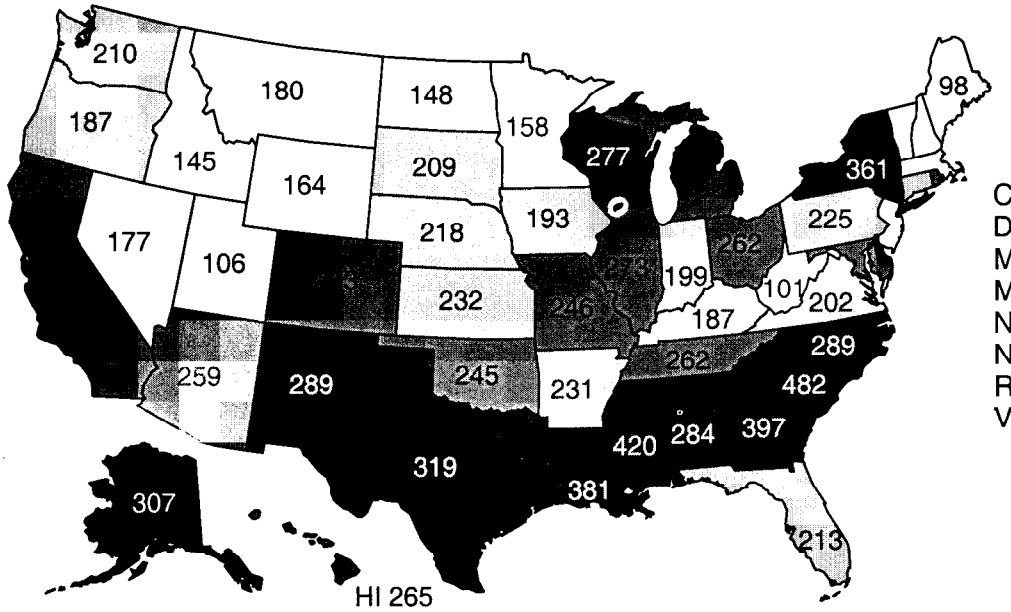
Locally Acquired, Mosquito-Transmitted Malaria Cases, 1985-1999



Number of cases

Source: National Malaria Surveillance System, National Center for Infectious Diseases, CDC.

Chlamydia, 1999



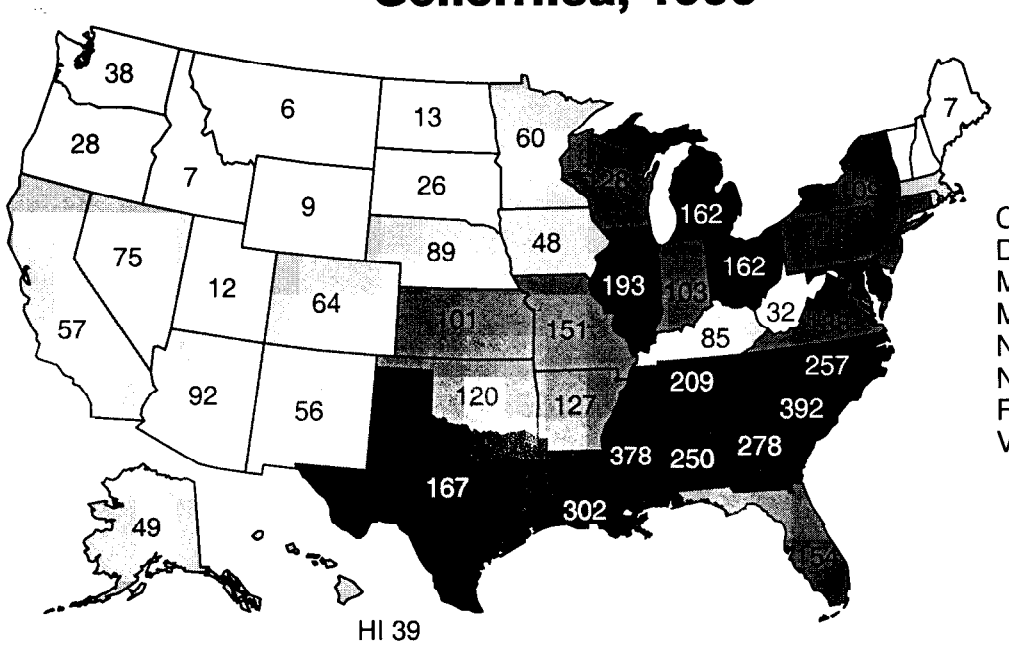
CT	227
DE	371
MA	143
MD	264
NH	82
NJ	153
RI	237
VT	82

Reported case rates per 100,000 population

82 - 186 | 187 - 234 | 235 - 276 | 277 - 482

United States rate - 251

Gonorrhea, 1999



CT	101
DE	224
MA	40
MD	203
NH	10
NJ	97
RI	61
VT	9

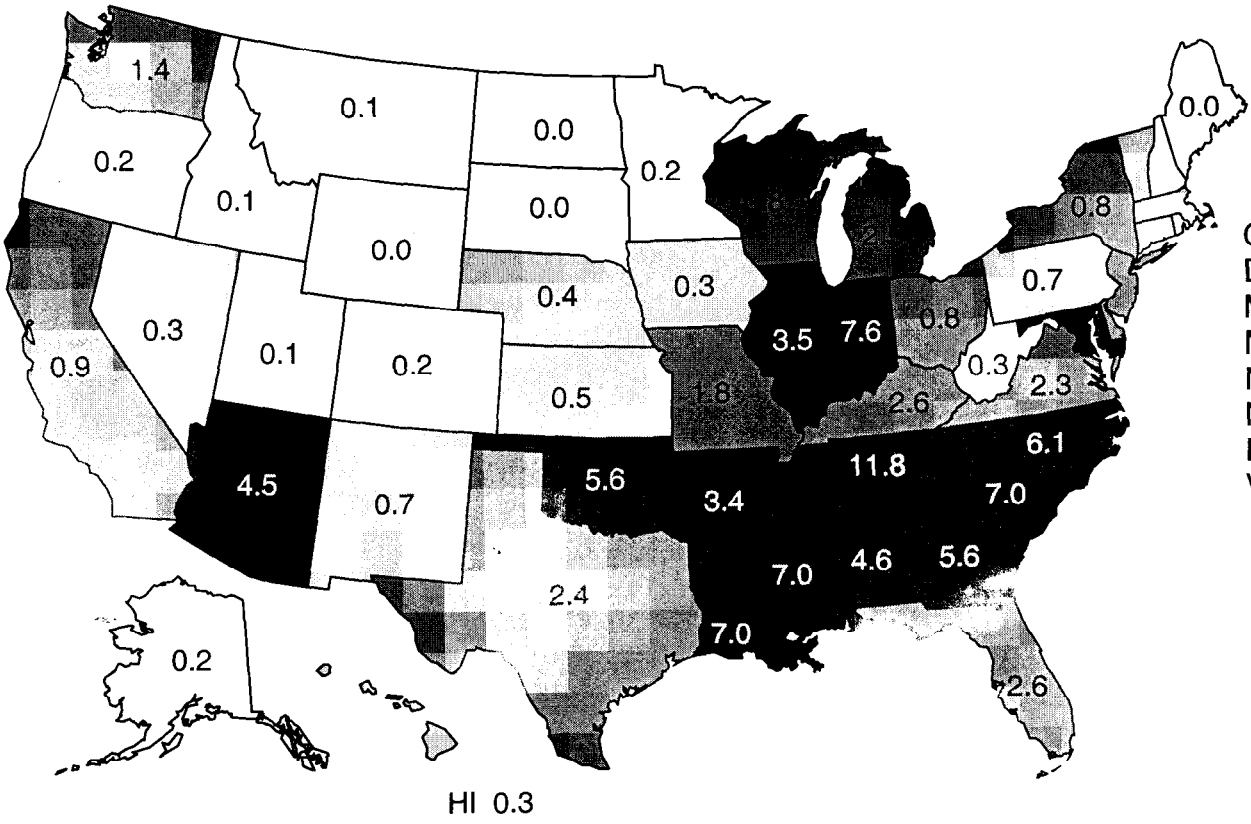
Reported case rates per 100,000 population

6 - 38 | 39 - 96 | 97 - 161 | 162 - 392

United States rate - 131; Healthy People 2000 target - 100

Source: National Center for HIV, STD, and TB Prevention, CDC, and state and territorial health departments and sexually transmitted disease control programs.

Primary and Secondary Syphilis
1999



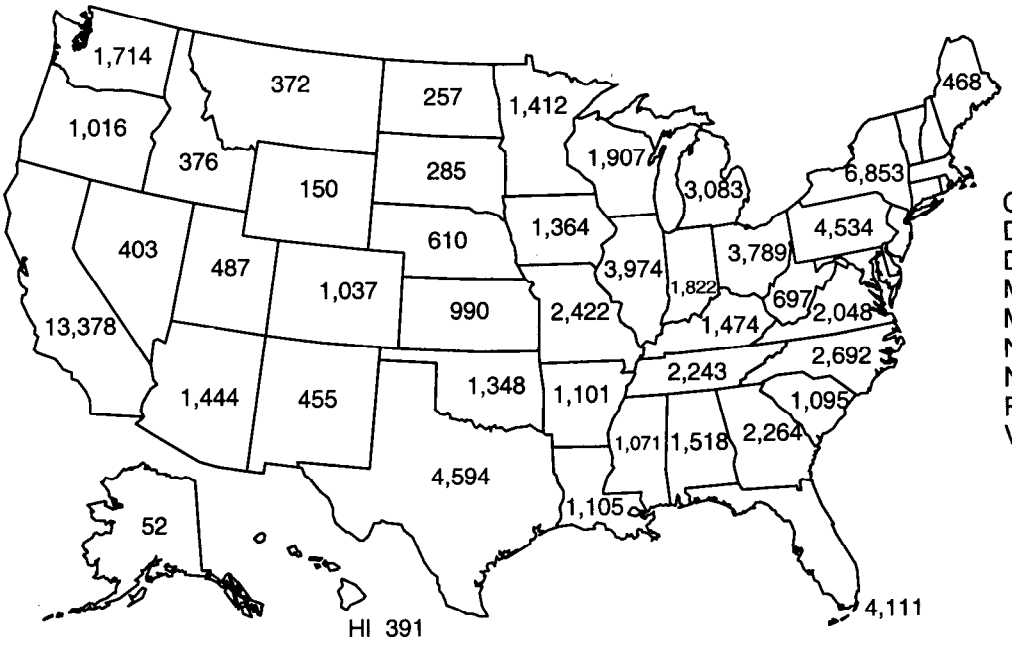
Reported case rates per 100,000 population

0.0 - 0.2 | 0.3 - 0.7 | 0.8 - 3.3 | 3.4 - 11.8

United States rate - 2.5; Healthy People 2000 target - 4.0

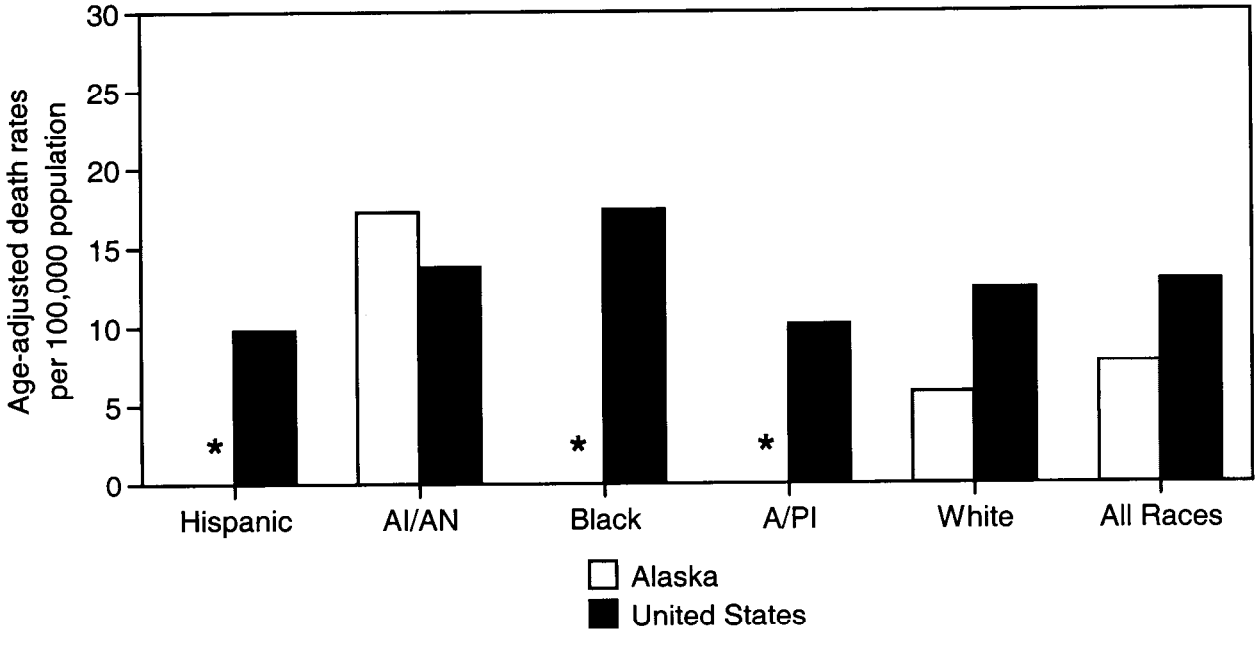
Source: National Center for HIV, STD, and TB Prevention, CDC, and state and territorial health departments and sexually transmitted disease control programs.

Pneumonia and Influenza: Number of Deaths, 1998



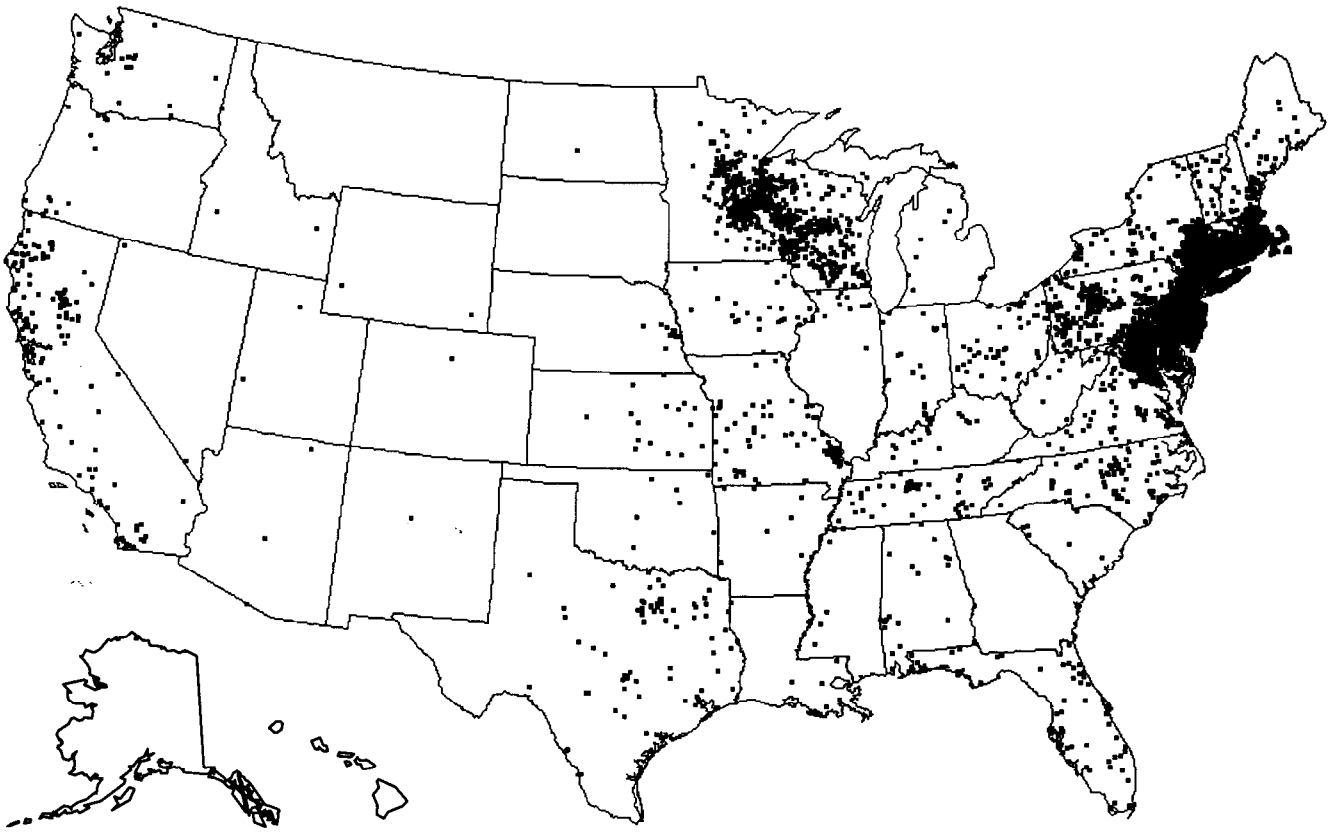
Number of deaths
United States - 91,871

Pneumonia and Influenza Death Rates by Race/Ethnicity Alaska and United States, 1996-1998



*Rate is based on <20 deaths and is considered unreliable.
Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

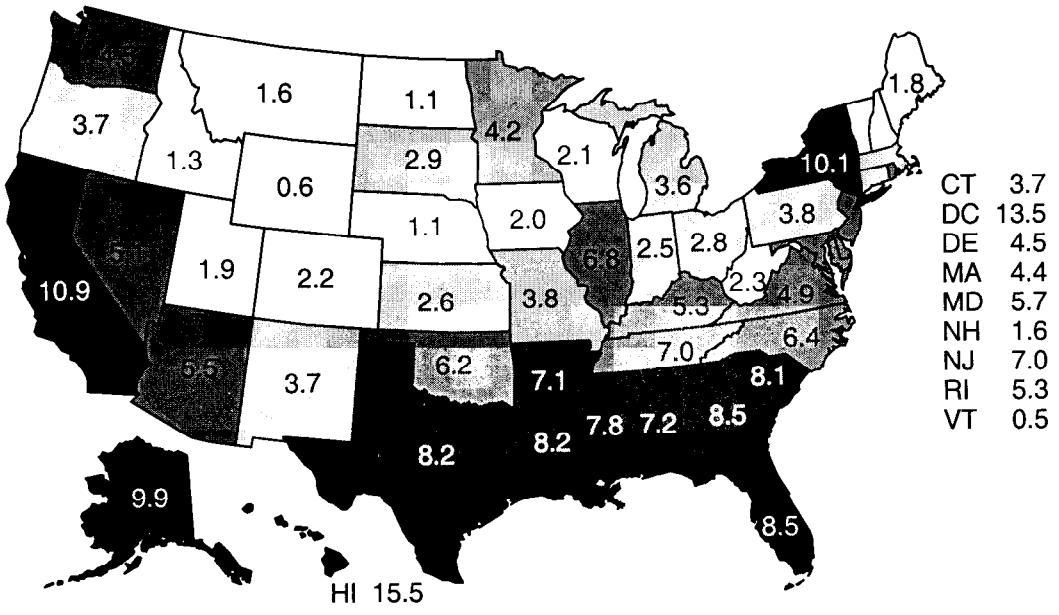
Lyme Disease:
Reported Cases, 1999



United States - 16,273

Note: 1 dot = 1 case randomly placed within county of residence.
Source: National Electronic Telecommunications System for Surveillance, CDC.

Tuberculosis: Case Rates, 1999

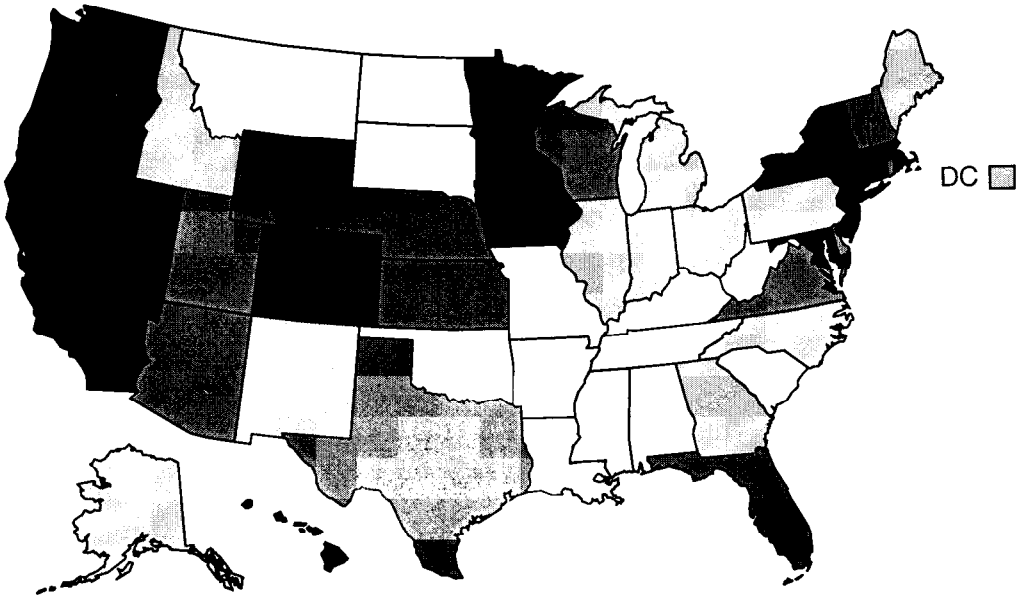


Reported case rates per 100,000 population

0.5 - 2.3 | 2.4 - 4.4 | 4.5 - 7.0 | 7.1 - 15.5

United States rate - 6.4; Healthy People 2000 target - 3.5

Percentage of Tuberculosis Cases Among Foreign-Born Persons, 1999



0% - 19% | 20% - 32% | 33% - 51% | 52% - 77%

United States - 43%

Source: National Center for HIV, STD, and TB Prevention, CDC.

Chronic Diseases: Conditions and Risk Factors

Oral Health

Prevalence of Diagnosed Diabetes

Prevalence of Physical Inactivity and Overweight

Total Cardiovascular Disease

Breast Cancer and Mammography

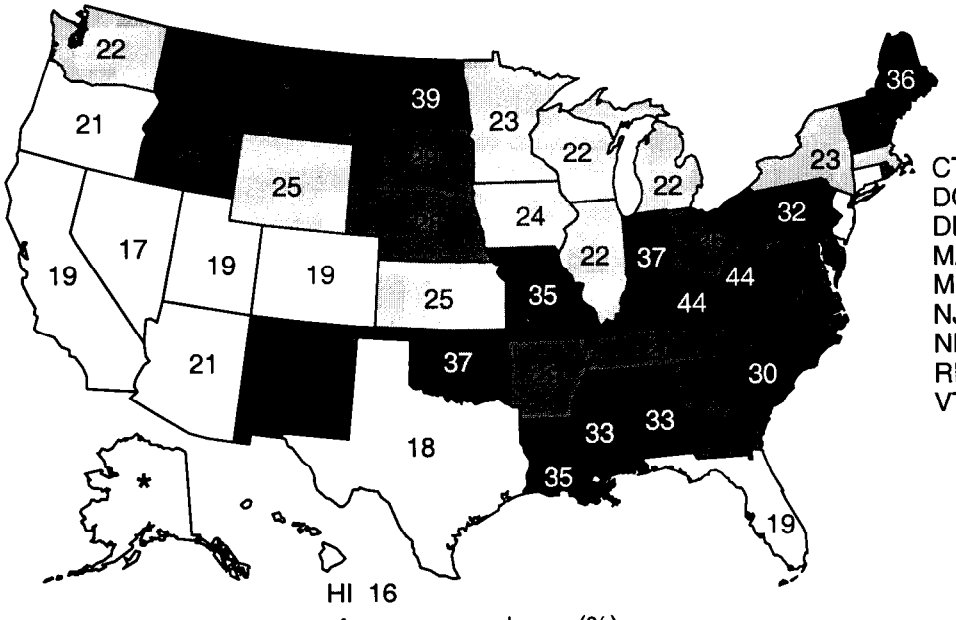
Colorectal Cancer and Proctoscopy

Lung Cancer and Current Smoking

Prevalence of Smoking

Prevalence of Health-Care Coverage

Adults Aged ≥65 Years Who Have Lost All Natural Teeth, BRFSS, 1995-1999

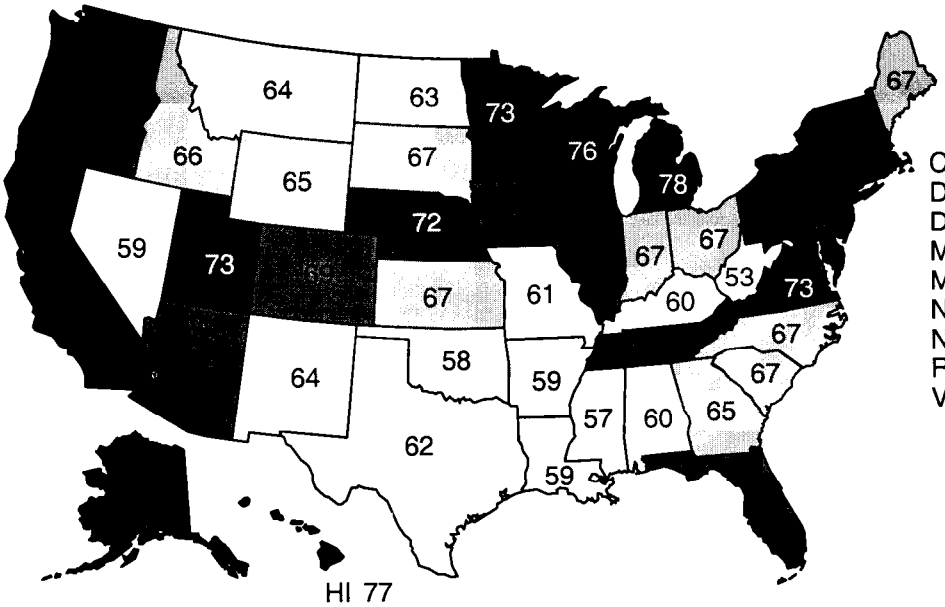


Average prevalence (%)

□ < 22% ▨ 22% - 25% ■ 26% - 29% ■ > 29%

BRFSS median - 26%; Healthy People 2000 target - 20%

Adults Aged ≥35 Years Who Have Visited a Dentist or Dental Clinic in the Last Year, BRFSS, 1995-1999



Average prevalence (%)

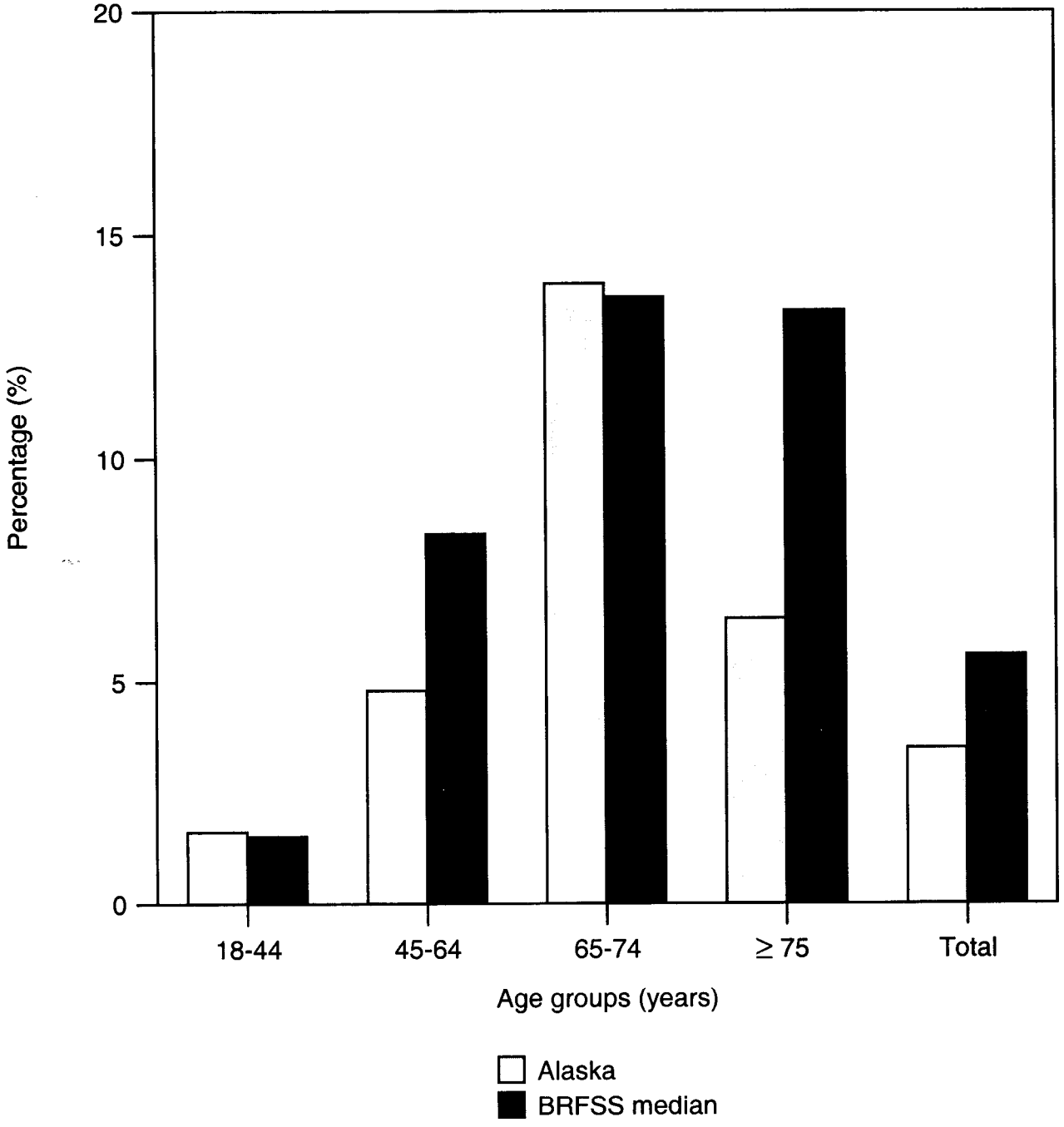
□ < 65% ▨ 65% - 67% ■ 68% - 71% ■ > 71%

BRFSS median - 69%; Healthy People 2000 target - 70%

*Data not available.

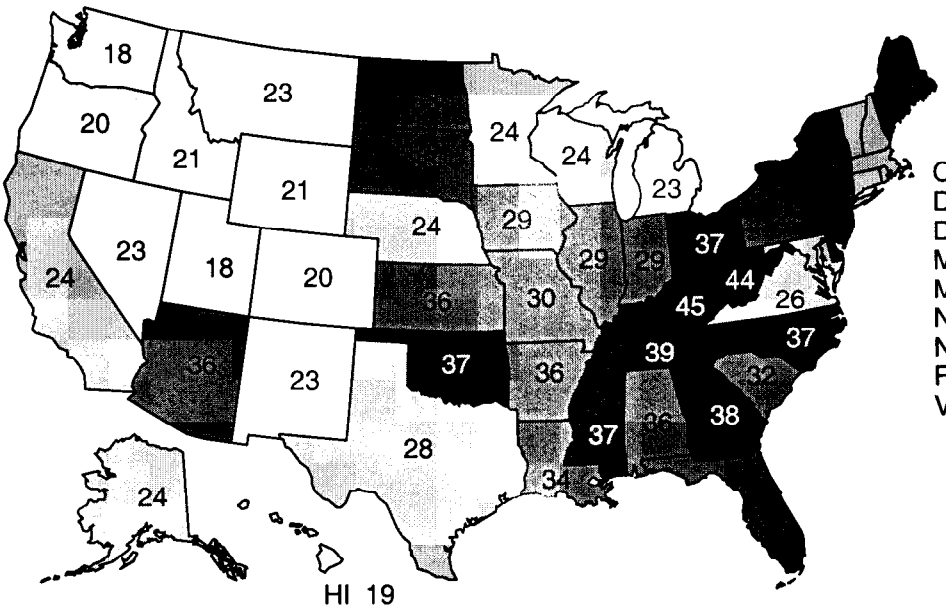
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Prevalence of Diagnosed Diabetes
Alaska and BRFSS Median
1997-1999



Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Prevalence of Physical Inactivity During Leisure Time
BRFSS, 1994, 1996, and 1998

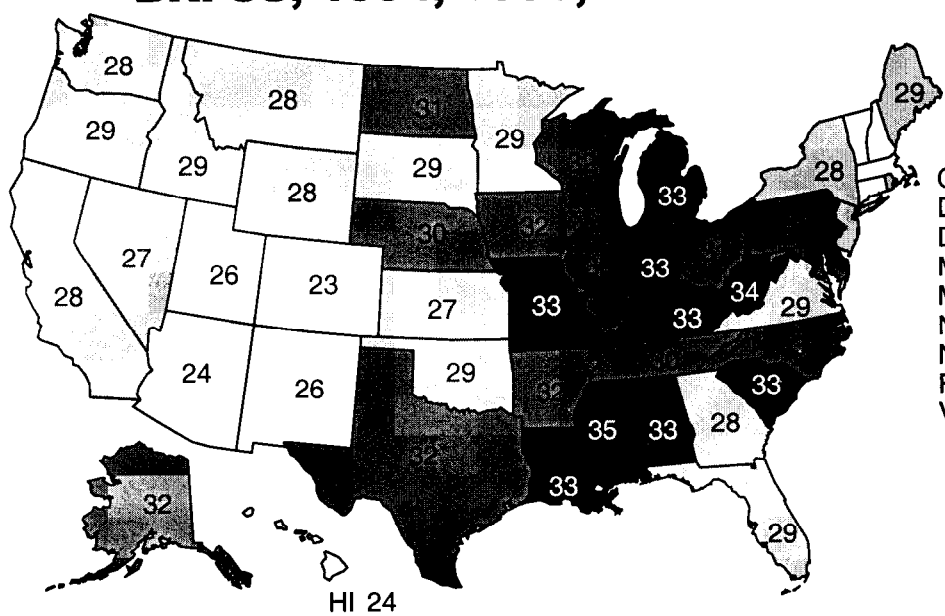


Average prevalence (%)

< 24% | 24% - 28% | 29% - 36% | > 36%

BRFSS median - 29%; Healthy People 2000 target - 15%

Prevalence of Overweight
BRFSS, 1994, 1996, and 1998



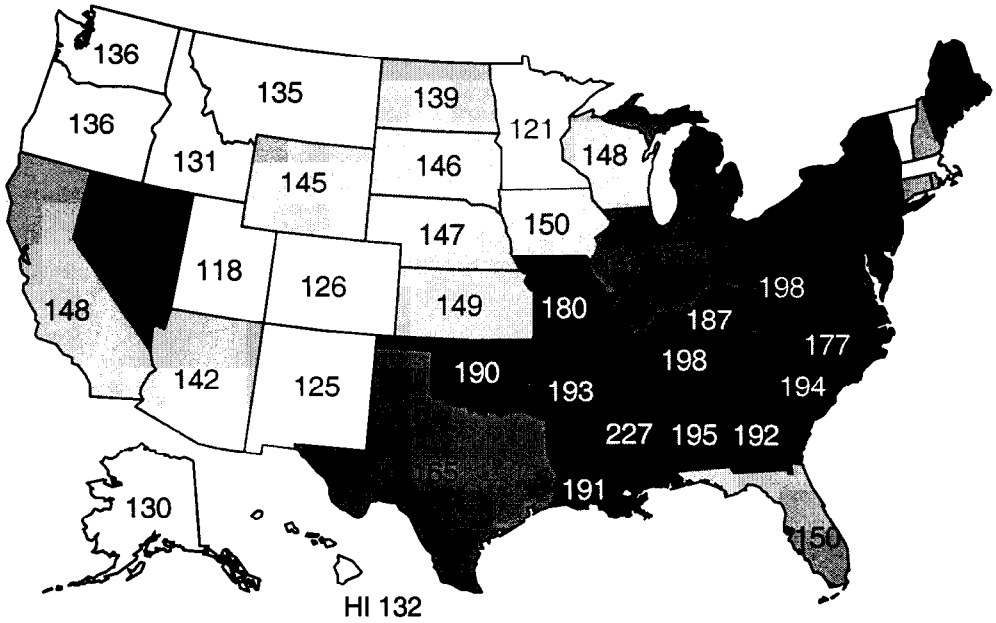
Average prevalence (%)

< 27% | 27% - 29% | 30% - 32% | > 32%

BRFSS median - 29%; Healthy People 2000 target - 20%

Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Total Cardiovascular Disease: Deaths, 1998



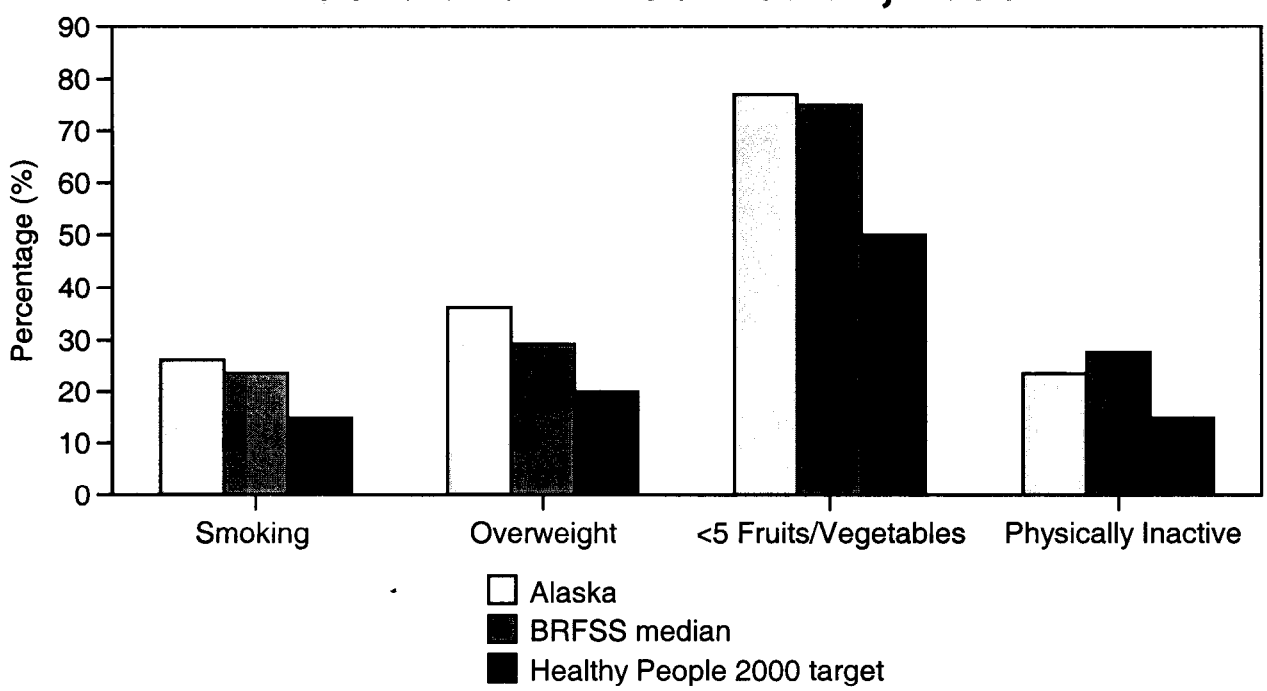
Age-adjusted death rates per 100,000 population

118 - 138 | 139 - 151 | 152 - 176 | 177 - 227

United States rate - 162

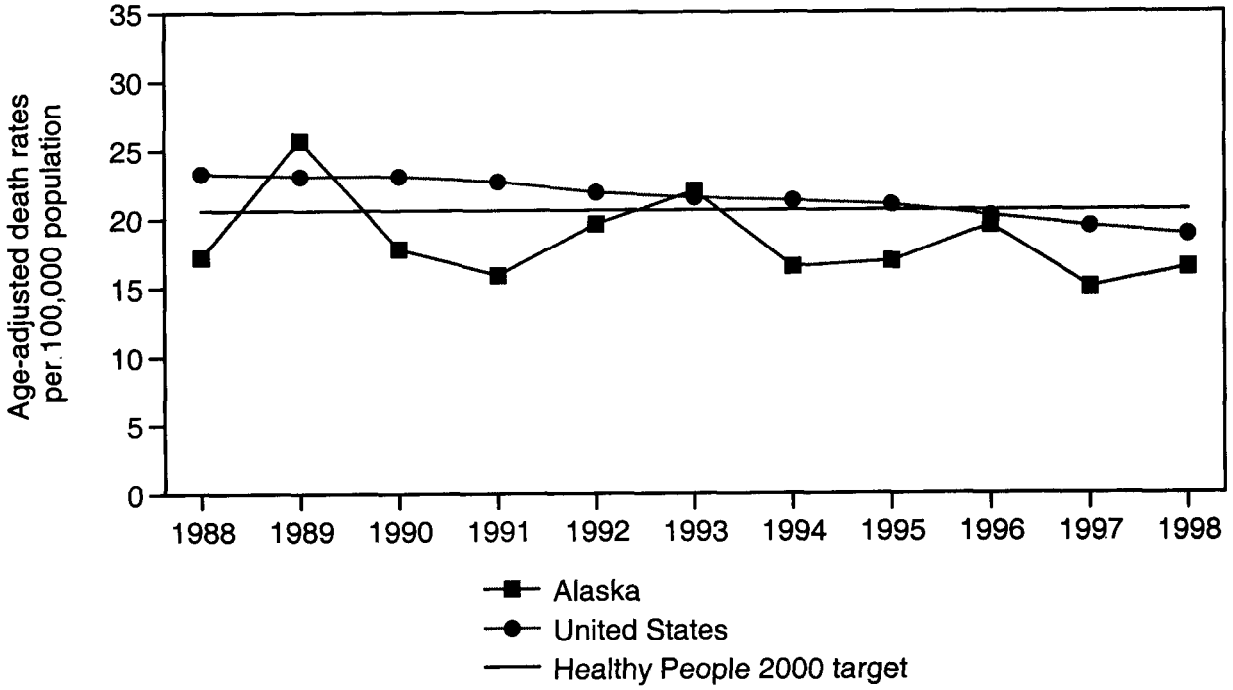
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Total Cardiovascular Disease: Behavioral Risk Factors Alaska and BRFSS Median, 1998



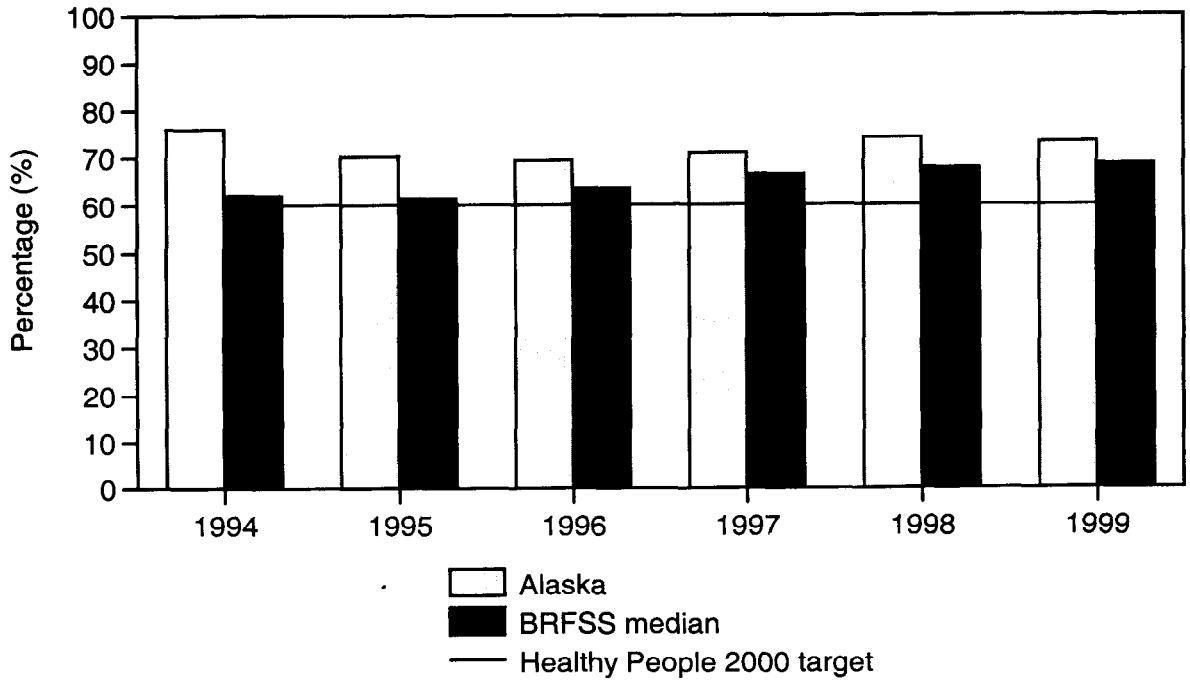
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Breast Cancer: Deaths Among Women Alaska and United States, 1988-1998



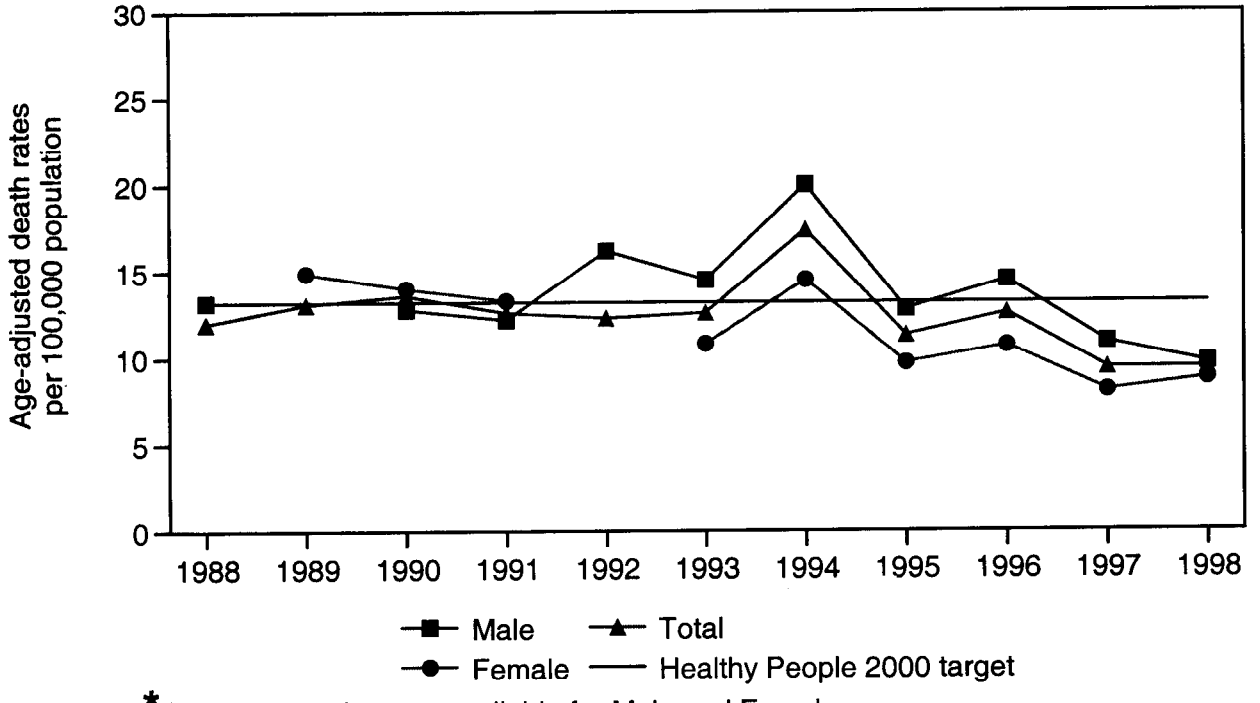
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Women Aged ≥50 Years Who Have Had a Clinical Breast Exam and a Mammogram Within 2 Years Alaska and BRFSS Median, 1994-1999



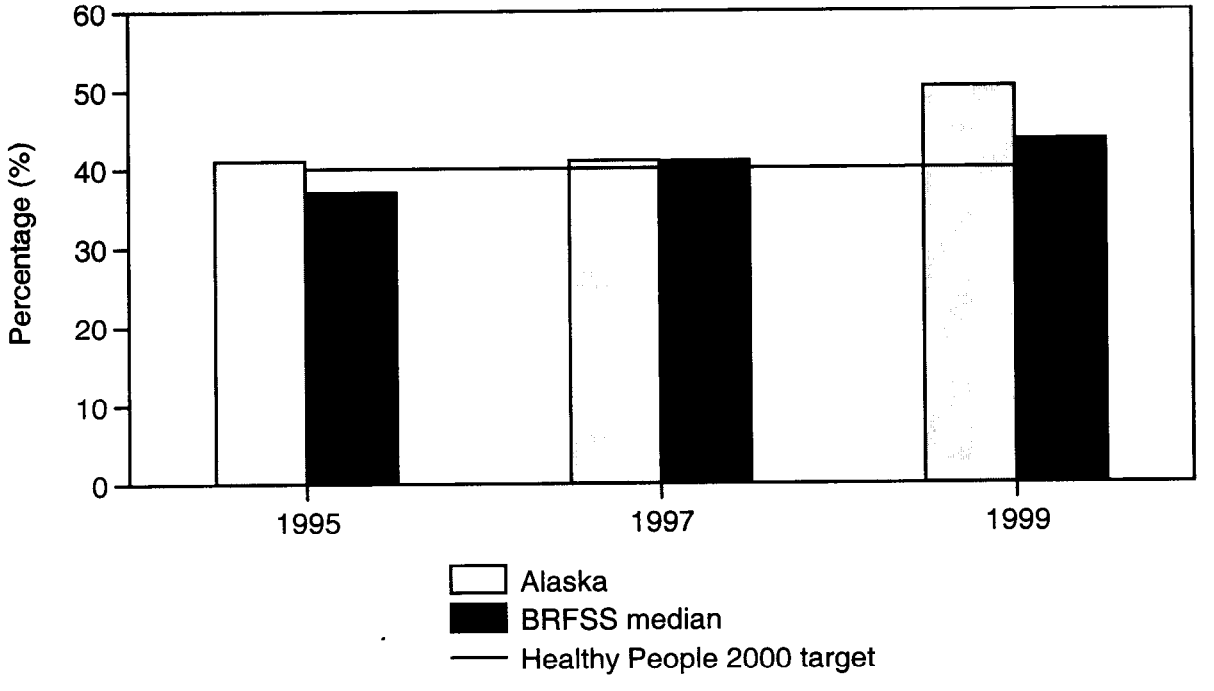
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Colorectal Cancer: Deaths
Alaska, 1988-1998*



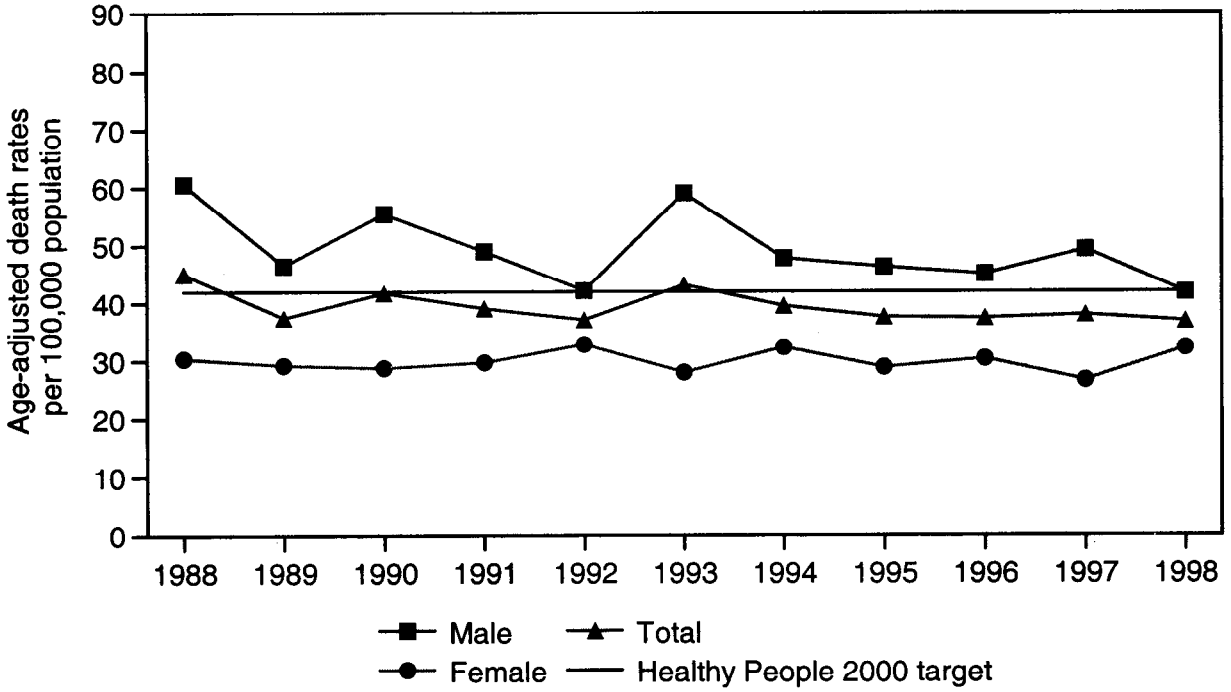
*Some data points not available for Male and Female
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Adults Aged ≥50 Years Who Reported Having a Sigmoidoscopy
Alaska and BRFSS Median, 1995, 1997, and 1999



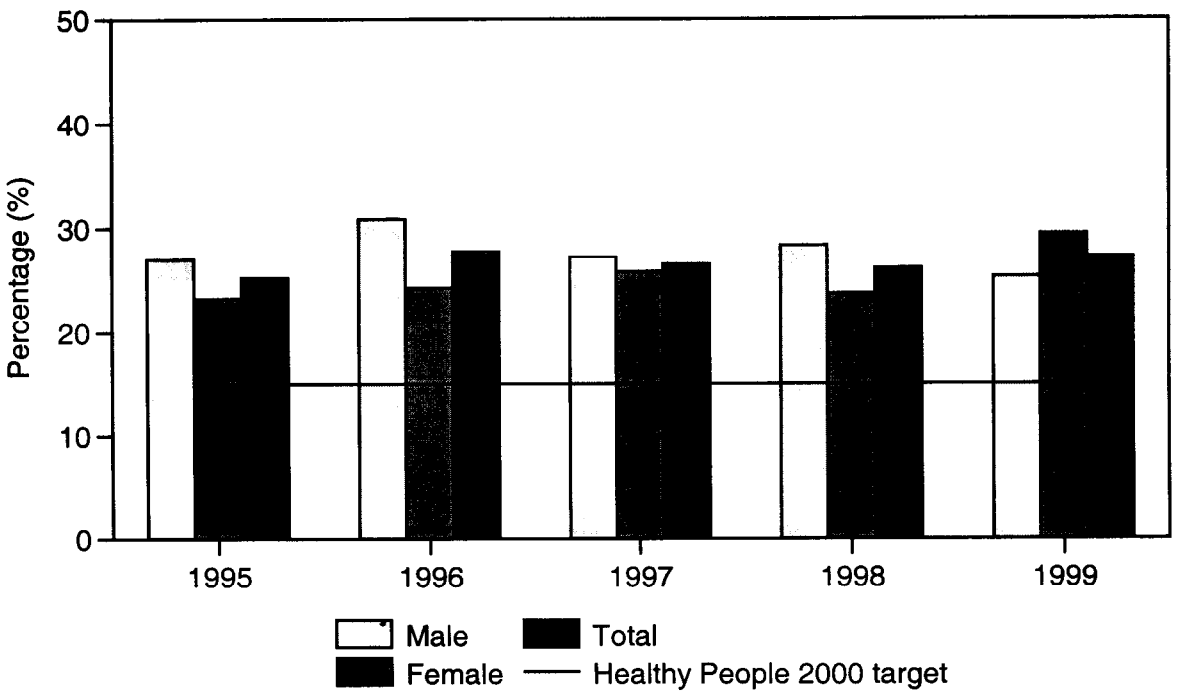
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Lung Cancer: Deaths
Alaska, 1988-1998



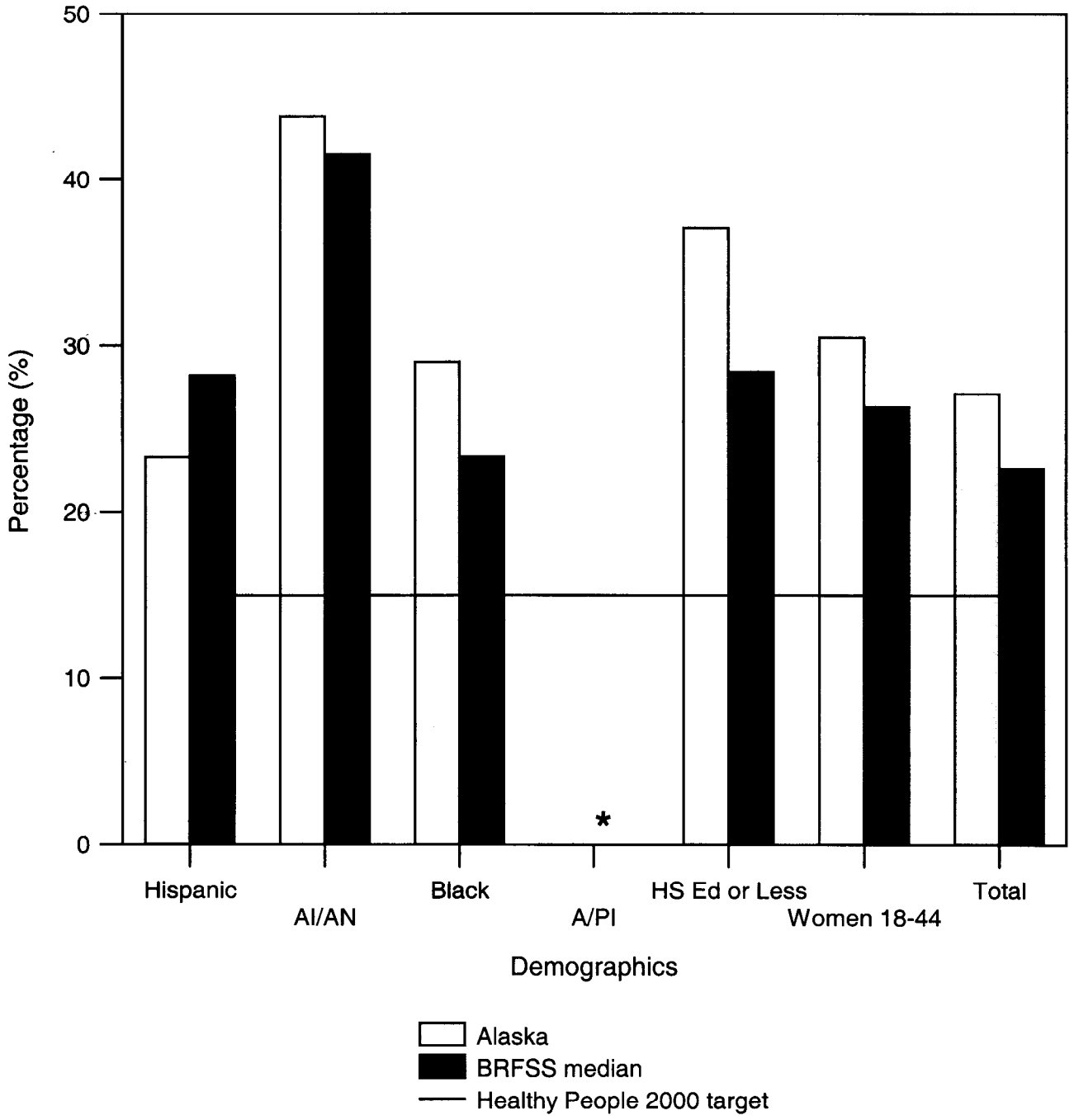
Source: National Vital Statistics System, National Center for Health Statistics, CDC.

Current Cigarette Smoking Among Adults
Alaska, 1995-1999



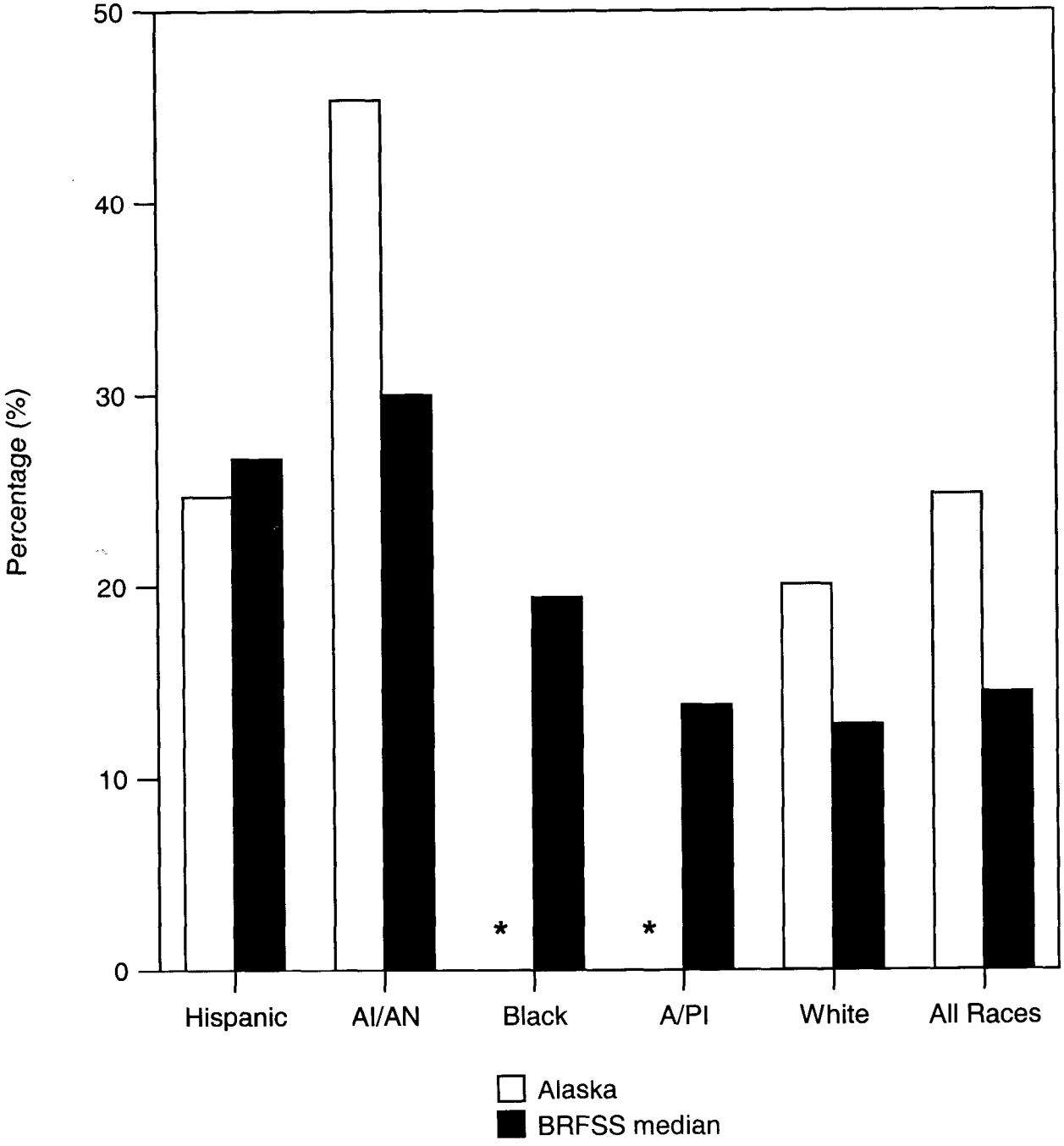
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Prevalence of Smoking Among Selected Demographic Groups Alaska and BRFSS Median, 1999



*Data not available.
Note: Data not available from all states for all racial/ethnic groups for median calculation.
AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Prevalence of Not Having Health-Care Coverage for Adults Aged 18-64 Years Alaska and BRFSS Median, 1999



*Not available.

Note: AI/AN = American Indian/Alaskan Native; A/PI = Asian/Pacific Islander.

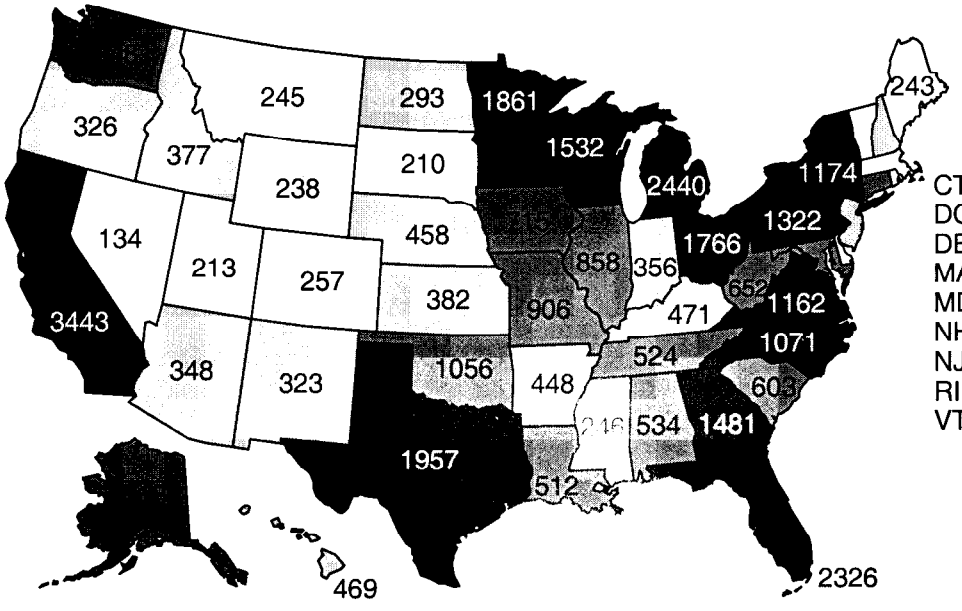
Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Health Promotion Strategies

Training Networks

Adult Vaccination Coverage

Public Health Training Network (PHTN)
Fiscal Year 2000

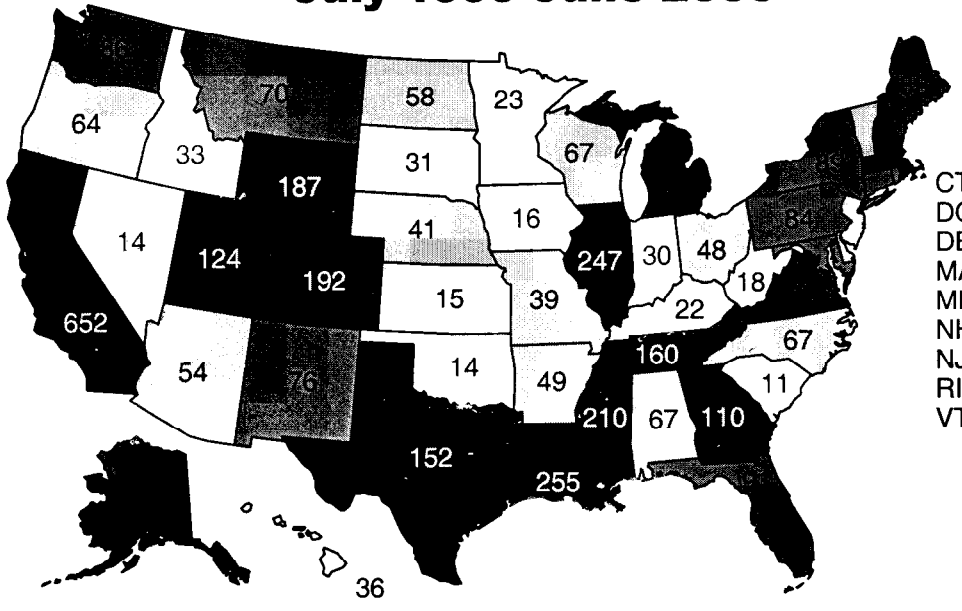


Number of registered health professionals receiving training through PHTN

84 - 280 | 293 - 471 | 512 - 1,056 | 1,071 - 3,443

United States - 38,720

National Laboratory Training Network (NLTN)
July 1999-June 2000



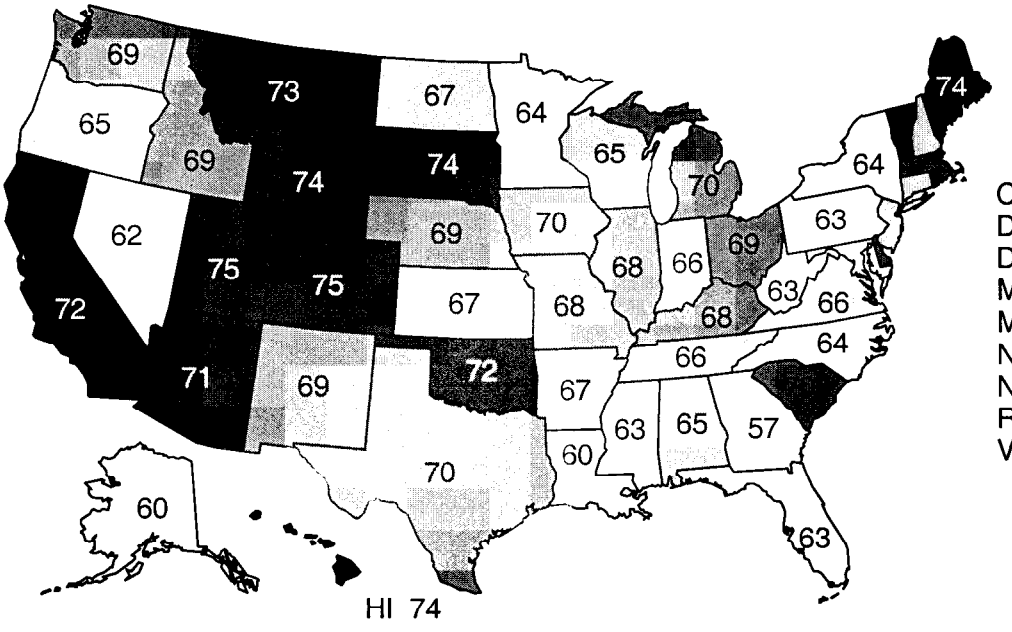
Number of health professionals receiving training through NLTN

11 - 36 | 39 - 67 | 70 - 92 | 110 - 652

United States - 4,782

Note: Federal fiscal year 2000 = October 1, 1999, through September 30, 2000.
Source: Public Health Practice Program Office, CDC.

Adult Vaccination Coverage for Influenza, 1999



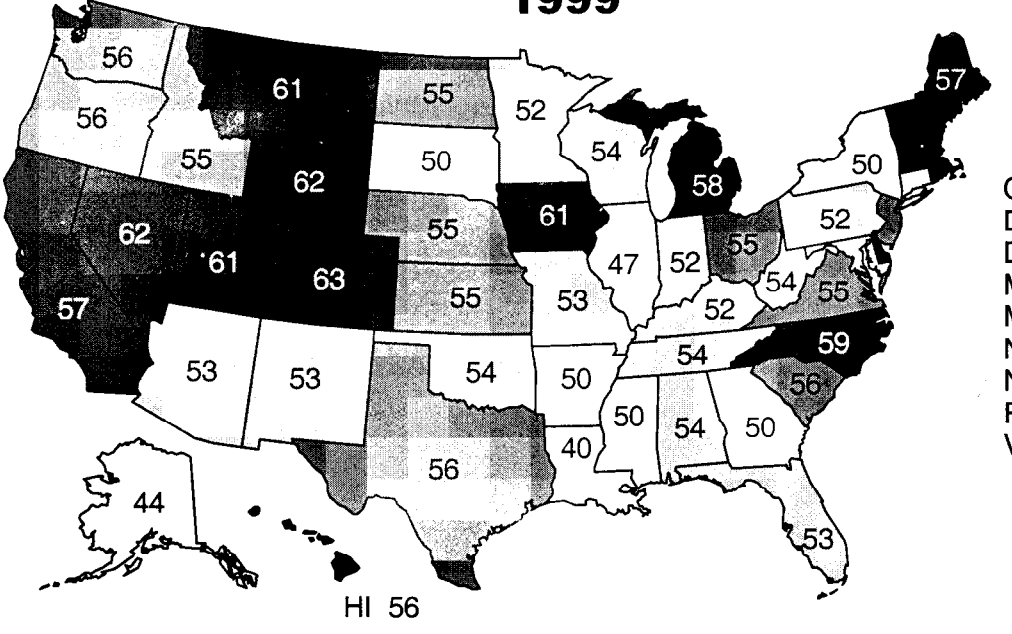
CT 65
DC 56
DE 68
MA 69
MD 63
NH 65
NJ 65
RI 76
VT 73

Vaccination coverage among persons aged ≥65 years (%)

≤ 64% | 65% - 67% | 68% - 70% | ≥ 71%

BRFSS median - 67%; Healthy People 2000 target - 60%

Adult Vaccination Coverage for Pneumococcal Disease 1999



CT 49
DC 35
DE 67
MA 57
MD 54
NH 60
NJ 55
RI 57
VT 57

Vaccination coverage among persons aged ≥65 years (%)

≤ 50% | 51% - 54% | 55% - 56% | ≥ 57%

BRFSS median - 54%; Healthy People 2000 target - 60%

Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.

Interpretation

Interpretation

INTRODUCTORY MATERIAL

Information in the annual *State Health Profile* publication series was obtained from data files or published reports of several governmental and nongovernmental agencies and organizations. In each case, the sponsoring agency or organization collected data using its own methods and procedures. Therefore, the data in this publication varies in terms of source, method of collection, definitions, and reference period.

Much of the information in this publication is from the ongoing data collection systems of CDC's National Center for Health Statistics (NCHS). An overview of these systems can be found in *Vital & Health Statistics* (1989;23:1–21). Data sometimes differ from those published by the states because a) the cut-off dates for accepting vital statistics records into the annual file for producing statistics can be different and b) the interstate exchange program through which states receive data on events that involved residents but occurred in other states might not include all records.

Electronic files of all data on which the graphic presentations in this publication are based are available on the Internet at the NCHS Data Warehouse, located at <http://www.cdc.gov/nchs/datawh.htm>.

Health Status Indicators

The Public Health Service's publication *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* establishes a framework for developing an explicit national prevention program (1991; DHHS publication no. [PHS]91-50212). As part of this program, a consensus set of 18 health status indicators was developed to help communities assess their general health status and focus local, state, and national efforts on tracking year 2000 objectives. These indicators were chosen, in part, based on whether relevant data were readily available and commonly used in public health.

The 18 health status indicators were developed by a committee through a consensus process involving local, state, and federal health officials and representatives from academic institutions and professional associations (*MMWR* 1991;40:449–51). These indicators are intended to ensure data comparability and facilitate use by public health agencies at all levels of government. They are not intended to supersede specific measures suggested in *Healthy People 2000*, but to give an indication of a community's general health status.

Bioterrorism

In 1999, CDC was designated by the U.S. Department of Health and Human Services (DHHS) to coordinate and lead overall planning to upgrade national public health capabilities at the federal, state, and local levels to respond to bioterrorism, which is the deliberate use of biological agents to harm civilians. CDC's program also addresses chemical terrorism, including plans to enhance laboratory capabilities and medical stockpiles. Building an effective and flexible public health infrastructure is the best defense against disease outbreaks, whether natural or intentional. Tools developed to respond to bioterrorist events also can be used to improve the recognition and control of other emerging disease threats.

During fiscal year (FY) 1999 and 2000, CDC awarded approximately $80 million to 55 state, territorial, and major metropolitan health departments to develop and maintain core capacity for five primary components of bioterrorism preparedness and response. These components are preparedness planning and readiness assessment, epidemiology/surveillance capacity, laboratory capacity for biologic agents, laboratory capacity for chemical agents, and communications/training. CDC's funding will help states and cities upgrade their capabilities in these areas and link their activities with other local, state, and federal emergency plans.

Preparedness Planning and Readiness Assessment

State and local public health communities will bear much of the responsibility for addressing the health aspects of a bioterrorist attack. State and local officials will be called upon to quickly evaluate a potential threat, identify public health response and prevention strategies, advise the public on protective actions, and outline procedures for first responders and health-care providers.

During the past year, CDC has conducted several projects in this area, including:

- Providing on-site support for the World Trade Organization meeting in Seattle, Republican National Convention in Philadelphia, Democratic National Convention in Los Angeles, and a West Nile encephalitis outbreak in New York City. CDC staff members helped identify causative agents, conduct epidemiologic investigations, and enhance existing surveillance systems to detect illness.
- Completing preliminary bioterrorism preparedness guidelines for hospitals, addressing topics such as mass casualty procedures, triage considerations, decontamination issues, and epidemiologic and detection recommendations.
- Developing curricula on clinical manifestations and treatments of illnesses caused by organisms and toxins on CDC's critical agents list.
- Completing and evaluating CDC's role in at least four simulated response exercises.

State/local projects include:

- Establishing three Exemplar Centers for Public Health Preparedness in Colorado (Denver City and County), Georgia (DeKalb County), and New York (Monroe County).

Epidemiology/Surveillance Capacity

CDC is working with state and local partners to ensure that local epidemiologic and surveillance capacities are established or enhanced across the nation. If health-care providers can detect unusual events early (e.g., injuries caused by chemical agents or disease outbreaks caused by pathogens likely to be used by terrorists), potential victims can receive appropriate medical treatment or be protected with prophylactic medicines or vaccines.

During the past year, CDC has conducted several projects in this area, including:

- Creating or updating case definitions for diseases or conditions caused by critical threat agents.
- Developing standard bioterrorism curricula and associated training materials.

State/local projects include:

- Developing a Rapid Syndrome Reporting System in New Mexico that allows physicians to quickly report symptoms (e.g., flu-like symptoms and fever with altered mental status) using a unique touch screen computer that is being pilot-tested in selected emergency departments.

- Initiating a web-based reporting system in New York that allows real-time data-gathering for disease surveillance. The state also is exploring using hospital claims data to detect bioterrorist events early.
- Developing MERLIN, a web-based disease reporting system in Florida that will allow the state health department to conduct mortality surveillance for unexplained and unusual deaths and electronic death certificate review.

Laboratory Capacity for Biologic and Chemical Agents

Rapid identification of a bioterrorist agent will be critical to ensuring that prevention and treatment recommendations are implemented quickly. CDC is working with state and local partners to enhance the country's current public health laboratory capacity to identify pathogens likely to be used for bioterrorism.

Major components of this effort include a) enhancing local ability to identify biologic and chemical agents likely to be used for bioterrorism; b) creating a rapid response and advanced technology laboratory capable of supporting local and state health departments and bioterrorism response teams 24 hours a day; and c) working with public health partners to build on the existing laboratory infrastructure to develop a multilevel network of laboratories with state-of-the-art capabilities for detecting a range of biological threats.

Laboratories are categorized according to their level of safety and containment standards. Level A laboratories are public health and hospital laboratories with low-level biosafety facilities that use clinical data and standard microbiological tests to decide which specimens and isolates should be forwarded to higher level biocontainment laboratories. Level B laboratories are state and local public health agency laboratories with core capacity for agent isolation and presumptive-level testing of suspect specimens. Level C laboratories can perform advanced and specialized testing, and they can be located at state health agencies, academic research centers, or federal facilities.

During the past year, CDC has conducted several projects in this area, including:

- Developing curricula on clinical manifestations and treatments of illnesses caused by organisms and toxins on CDC's critical agents list.

State/local projects include:

- Initiating electronic laboratory reporting in California for Level A, B, and C laboratories, which will allow rapid communication of laboratory results in the event of a suspected bioterrorist event.
- Modifying Iowa's state public health laboratory (the University Hygienic Laboratory) so it can serve as a confirmatory laboratory for suspected bioterrorism events in Iowa and other states needing Level B or C confirmation.

Communications/Training

CDC is working with state and local health departments to establish the Health Alert Network (HAN) for communications, information, and training related to bioterrorism. HAN is a nationwide, integrated system connecting the nation's state and local health departments through the Internet. This network will serve as the common electronic platform for national disease surveillance, epidemiologic investigation, electronic laboratory reporting, and rapid communications. When fully implemented with grants to state and local health departments, HAN will link local, state, and federal public health agencies and partners and will be used to protect communities against a range of public health threats.

During the past year, CDC has conducted several projects in this area, including:

- Developing and maintaining CDC's public website for nonsensitive bioterrorism information, which is available at <http.//www.bt.cdc.gov>.
- Funding 40 state and local areas for information systems projects related to bioterrorism, targeting three focus areas — Internet connectivity, distance-based–learning capacity, and broadcast communications capacity.
- Teaching eight Level A laboratory preparedness courses to approximately 700 professionals through joint training efforts by CDC, the FBI, and faculty members in selected states.

State/local projects include:

- Conducting information systems training and establishing Internet service in 27 local health departments in Connecticut.
- Connecting one private and one public hospital to Delaware's satellite-based training network. Delaware plans to connect all hospitals in the state by the end of the 3-year project period.
- Using HAN in Minnesota to report possible exposure of persons to asbestos containing vermiculite, then to provide rapid information from the state health department to the public, health-care providers, and others throughout the state.
- Conducting needs assessments of existing technology capacity at 12 local health offices in New Hampshire. Also providing training on the Internet, the state's Distance Learning Network, and online national and state information related to bioterrorism.
- Conducting three bioterrorism awareness training sessions via satellite for health and local government officials in Rhode Island.
- Establishing broadcast fax capability that allowed health officials in Vermont to rapidly inform local health departments about a hantavirus case in April 2000. Information distributed included CDC's website and locally generated response guidance.

National Pharmaceutical Stockpile Program

In addition to coordinating the overall public health response to bioterrorist events, CDC is mandated to develop and maintain the National Pharmaceutical Stockpile Program (NPSP). This program is being developed with DHHS's Office of Emergency Preparedness. In the event of a bioterrorism emergency, the federal government will use NPSP to give states rapid access to necessary vaccines, antitoxins, therapeutic drugs, and antidotes.

During the past year, CDC has conducted several projects in this area, including:

- Negotiating successfully with the Veteran's Administration to establish vendor-managed contracts that will allow NPSP to obtain, rotate, and rapidly deploy appropriate items after a bioterrorist event.
- Conducting a full field exercise to test readiness and distribution capabilities at the state and local level.
- Designing a delivery and distribution system for 12-hour push packages, which are caches of medical material (e.g., vaccines, antidotes, respirators, and bandages) necessary to treat patients exposed to biological or chemical agents. Push packages are located strategically throughout the United States and can be deployed within 12 hours of being requested.

For more information, contact Cyndi Shaffer by telephone at (404) 639-0131, by FAX at (404) 639-0382, or by E-mail at <csw3@cdc.gov>.

CDC Funds for States

This section lists financial assistance provided to and within states during FY 2000. Unobligated balances carried forward from previous years are not included. Most funds are provided to state and local health departments and to special university-based projects. In some cases, funds go to other state and nongovernmental agencies (e.g., state departments of education or community-based organizations for human immunodeficiency virus [HIV] and acquired immunodeficiency syndrome [AIDS] programs).

Local Health Departments by Jurisdiction

In most states, local health liaison officials provide the information needed to develop state maps of the numbers and types of local health departments. In states where no such position exists, other state officials are asked to provide or confirm the necessary information. This report uses the following definition of a local health department: "an administrative and service unit of local or state government, concerned with health, employing at least one full-time person, and carrying some responsibility for health of a jurisdiction smaller than the state" (*Am J Public Health* 1977;67:931–9).

For more information, contact Ed Vaughn by telephone at 770-488-2430 or by FAX at 770-488-8300.

MORTALITY

For data presented by race/ethnicity, persons of Hispanic origin can be of any race. Conversely, persons listed as white, black, American Indian/Alaskan Native, or Asian/Pacific Islander can be of Hispanic or non-Hispanic origin.

Numbers of deaths (numerators for death rates) are provided by the National Vital Statistics System (NVSS) of CDC's National Center for Health Statistics (NCHS). Data are derived from information provided by registrars in all 50 states, New York City, and the District of Columbia. These data sometimes differ from those published by the states because a) the cut-off dates for accepting vital statistics records into the annual file for producing statistics can be different; b) the interstate exchange program through which states receive data on events that involved residents but occurred in other states might not include all records; and c) the international rules for selecting the underlying cause of death is interpreted and applied differently in some states.

Population data (denominators for average annual death rates for 1996–1998) are 1997 postcensal population estimates from the Bureau of the Census. Age and race data have been modified to be consistent with Office of Management and Budget categories and historical categories for birth data. These modification procedures are described in a report from the Bureau of the Census (*Age, sex, race, and Hispanic origin information from the 1990 census: a comparison of census results with results where age and race have been modified. 1990.* 1991; CPH-L-74). Race and Hispanic origin data are self-reported or reported by a household member.

Death rates are age-adjusted by the direct method to the 1940 U.S. population using the standard million age distribution in 11 age groups (see Table, page 62). Direct age-adjustment is calculated by weighting the annual age-specific rates by the population distribution in the standard population.

For more information, contact Insun Kim, Dr.P.H., by telephone at (301) 458-4313 or by FAX at (301) 458-4036.

TABLE. Standard million age distribution used to age-adjust death rates

All ages	1,000,000
<1 year	15,343
1–4 years	64,718
5–14 years	170,355
15–24 years	181,677
25–34 years	162,066
35–44 years	139,237
45–54 years	117,811
55–64 years	80,294
65–74 years	48,426
75–84 years	17,303
≥85 years	2,770

Leading Causes of Death

Death rates are presented for several leading causes of death. Data are average annual age-adjusted death rates for 1996–1998 for men and women and for persons in the following race/ethnicity categories: white, black, Hispanic, American Indian/Alaskan Native, and Asian/Pacific Islander. Race and Hispanic origin are recorded on death certificates by funeral directors on the basis of information provided by the next of kin.

In this section, death rates for race/ethnicity are presented for states that meet one of the following criteria: a) at least 150,000 population in the designated group in 1997 or b) at least 100 deaths from the specified cause of death among members of the designated group during 1996–1998. Death rates based on <20 deaths during 1996–1998 are not shown. Data for persons of Hispanic origin are limited to the District of Columbia and the 49 states that reported Hispanic origin of decedent on death certificates and in which reporting was at least 80 percent complete for 1996–1998. Data for Oklahoma are not available because that state did not record Hispanic origin of decedent on death in 1996.

Data in this section are for the four leading causes of death in the United States in 1997 according to the *International Classification of Diseases, 9th Revision* (hereafter referred to as *ICD-9*): heart disease (*ICD-9* codes 390–398, 402, 404–429), cancer (*ICD-9* codes 140–208), stroke (*ICD-9* codes 430–438), and chronic obstructive pulmonary diseases (*ICD-9* codes 490–496). Leading causes of death are defined as those causing the greatest number of deaths in the United States. They are not necessarily the leading causes of death for specific states or specific racial/ethnic or sex groups.

Years of Potential Life Lost

Years of potential life lost (YPLL) is a measure of premature mortality, defined as the number of years between the age at death (for those who die before age 75 years) and age 75 years. YPLL is calculated from birth to age 75 years using the 1940 U.S. population and the following eight age groups: <1 year, 1–14, 15–24, 25–34, 35–44, 45–54, 55–64, and 65–74. The number of deaths for each age group is multiplied by the years of life lost, which is calculated as the difference between age 75 years and the midpoint of the age group. For example, the death of a person in the 15–24 group counts as 55.5 years of life lost. The total YPLL is all of the years of life lost over all age groups.

Data in this section are race/ethnicity-specific, age-adjusted YPLL per 100,000 population aged <75 years for 1996–1998. Numbers of deaths (numerators for YPLL rates) are from the NVSS. Population data (denominators for YPLL rates) are 1997 postcensal population estimates from the Bureau of the Census. YPLL rates are age-adjusted by the direct method to the 1940 U.S. population using the eight age groups cited previously. YPLL rates based on <20 deaths are not shown. Data for Oklahoma are not available because that state did not record Hispanic origin of decedent on death certificates in 1996.

Data in this section are for the five leading causes of YPLL in the United States in

1998: heart disease (*ICD-9* codes 390–398, 402, 404–429), cancer (*ICD-9* codes 140–208), unintentional injuries (*ICD-9* codes E800–E949), suicide (*ICD-9* codes E950–E959), and homicide (*ICD-9* codes E960– E969). They are not necessarily the leading causes of YPLL for specific states. Unintentional injuries include subcategories such as falls, drownings, fires/burns, poisonings, and motor vehicle injuries.

For more information on how to calculate YPLL, consult the *Journal of Preventive Medicine* (1988;4:268–73).

CHILDHOOD HEALTH CONCERNS

For the sections on Prenatal Care and Birth Rates for Females Aged 15–19 Years, data are from the National Vital Statistics System (NVSS) of CDC's National Center of Health Statistics (NCHS). Data are derived from information provided by registrars in all 50 states, New York City, and the District of Columbia. These data sometimes differ from those published by the states because a) the cut-off dates for accepting vital statistics records into the annual file for producing statistics can be different and b) the interstate exchange program through which states receive data on events that involved residents but occurred in other states might not include all records. Also, different organizations sometimes tabulate the race of the mother differently. For example, when the mother's race is not reported but the father's is, NCHS assigns the race of the father to the mother. When neither parent's race is reported, the race of the mother is listed the same as the immediately preceding record that did have the race of the mother specified. This listing was necessary for <1% of births during 1996–1998.

Developmental Disabilities

The total lifetime cost of a specific developmental disability for a given state (in 1996 U.S. dollars) is calculated using the following formula: the prevalence rate of the developmental disability multiplied by the number of 1998 live births in a given state multiplied by the per-person lifetime cost estimate associated with the developmental disability, based on a 3% discount rate.

Sample estimates of the per-person lifetime costs of specific developmental disabilities include $797,592 for mental retardation, $706,704 for cerebral palsy, $275,717 for hearing impairment, and $386,074 for vision impairment (*The Cost of Developmental Disabilities*. Research Triangle Park, N.C.: Research Triangle Institute, April 2000).

Mental retardation is defined as an intelligence quotient (IQ) of ≤70. Hearing impairment is defined as a measured, bilateral, pure-tone hearing loss at frequencies of 500, 1,000, and 2,000 hertz averaging ≥40 decibels, unaided, in the better ear. Vision impairment is defined as a measured visual acuity of ≤20/70, with correction, in the better eye. Cerebral palsy is defined as a group of nonprogressive but often changing motor impairment syndromes secondary to lesions or anomalies of the brain arising at any time during brain development.

Per-person lifetime cost estimates are based on a cost-of-illness approach that measures the value of all resources used or lost because of a disability (excluding home care costs). Resource categories analyzed included physician office services, prescription medications, hospital inpatient services, therapy and rehabilitation services, long-term–care services, home and auto modifications, special education services, and productivity losses resulting from increased illness and premature mortality.

The number of live births in each state for 1998 is reported from NCHS (*Natl Vital Stat Rep* 2000;48[3]). The average annual preva-

lence rates of specific developmental disabilities among 1,000 children aged 5–10 years during 1991–1994 were mental retardation, 11.29; cerebral palsy, 2.97; hearing impairment, 1.21; and vision impairment, 1.02. These data came from CDC's Metropolitan Atlanta Developmental Disabilities Surveillance Program. More information regarding birth and developmental disability rates is available on the Internet at <http://www.cdc.gov.nchs/data/nvs48_3.pdf>.

For more information, contact Marshalyn Yeargin-Allsopp, M.D., by telephone at (770) 488-7400.

Vaccination Coverage

Data in this section are from the National Immunization Survey (NIS) and include immunization coverage rates for the following vaccines: a) four doses of diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP); b) three doses of poliovirus vaccine; c) one dose of measles-mumps-rubella vaccine (MMR); d) three doses of *Haemophilus influenzae* type b vaccine (Hib); e) three doses of hepatitis B vaccine (HepB); f) one dose of varicella (chickenpox); and g) a 4:3:1:3 combined series that includes four doses of DTaP, three doses of polio vaccine, one dose of MMR (or other measles-containing vaccine,) and three doses of Hib for children aged 19–35 months.

The NIS is an ongoing survey conducted by CDC's National Immunization Program that provides estimates of immunization coverage for children aged 19–35 months for the United States as a whole, each of the 50 states, and selected urban areas. CDC implemented the NIS in April 1994 as part of the Childhood Immunization Initiative, a national strategy to achieve and maintain high immunization coverage in all 50 states, the District of Columbia, and 27 urban areas considered at high risk for undervaccination.

For more information, contact Wayne Stevens by telephone at (404) 639-8730 or by FAX at (404) 639-8613.

Infant Mortality

To provide race/ethnicity data on infant mortality, the linked files of births and infant deaths for 1996–1998 were used for racial/ethnic groups relevant to particular states. The national linked files of live births and infant deaths include vital records for infants who were born in a given year and died that same year or in the next year before their first birthday. Using linked files avoids discrepancies in the reporting of race between birth records and death certificates. Although discrepancies are relatively rare for white and black infants, they can be substantial for other races.

Data are provided for three leading causes of infant death for the three largest racial/ethnic groups for each state. For some states, data for fewer than three racial/ethnic groups are used because of the limited numbers of deaths. Rates based on <20 deaths are considered statistically unreliable, and caution should be used when comparing or interpreting such rates.

The underlying cause of death is identified by *ICD-9* code and ranked according to the three overall leading causes of death among infants in the United States: birth defects (*ICD-9* codes 740–759), low birthweight and prematurity (*ICD-9* code 765) combined with respiratory distress syndrome (*ICD-9* code 769), and sudden infant death syndrome (SIDS) (*ICD-9* code 798).

The rate of SIDS has declined sharply since 1989. Data for 1995 indicate that the SIDS rate declined 18.3% from 1994, representing the largest annual percentage decline since 1983. This downward trend could reflect changes in the prevalence of known risk factors or changes in the diagnosis of SIDS.

A strong association between SIDS and a prone sleeping position for infants has been established, and in 1992, the American Academy of Pediatrics began recommending that parents place infants on their backs or sides to sleep.

For more information, contact Michele Lynberg by telephone at (770) 488-7180.

Prenatal Care

Data in this section are the average annual percentages of women who did not receive prenatal care during the first trimester of pregnancy during 1996–1998. The data are reported according to the following race/ethnicity categories: white non-Hispanic, black non-Hispanic, Hispanic, American Indian/Alaskan Native, and Asian/Pacific Islander. Persons of Hispanic origin can be of any race. Percentages for racial/ethnic groups are provided for states with ≥200 births among mothers of the designated group during 1996–1998.

For more information, contact Insun Kim, Dr.P.H., by telephone at (301) 458-4313 or by FAX at (301) 458-4036.

Birth Rates for Females Aged 15–19 Years

Birth rates for females aged 15–19 years are the number of live births per 1,000 women aged 15–19 years in specified racial/ethnic groups that reside in each state. Data are average annual rates during 1996–1998 in the following groups: white non-Hispanic, black non-Hispanic, Hispanic, American Indian/Alaskan Native, and Asian/Pacific Islander. Rates have not been computed within states for racial/ethnic groups with <20 births to women or with <1,000 women aged 15–19 years.

Hispanic origin of the mother is reported separately on birth certificates and in the national census. For the 1% of records with no origin reported, the mother is assumed to be non-Hispanic, which means the reported rates for Hispanic women might be under-reported by this amount. Persons of Hispanic origin can be of any race.

Population data (denominators for birth rates) are 1997 postcensal population estimates from the Bureau of the Census, modified to be consistent with Office of Management and Budget categories and historical categories for birth data.

For more information, contact Insun Kim, Dr.P.H., by telephone at (301) 458-4313 or by FAX at (301) 458-4036.

DEATHS FROM INJURIES

Data in this section are a) age-adjusted death rates for 1998 for motor vehicle-related deaths, suicide, and homicide and b) race/ethnicity-specific, average annual age-adjusted death rates for 1996–1998 for suicide and homicide. They are age-adjusted by the direct method to the 1940 U.S. population using the standard million age distribution (see Table, page 62). Direct age-adjustment is calculated by weighting the annual age-specific rates by the population distribution in the standard population.

Numbers of deaths (numerators for death rates) are provided by the National Vital Statistics System (NVSS) of CDC's National Center for Health Statistics (NCHS). Data are derived from information provided by registrars in all 50 states, New York City, and the District of Columbia (except in Alaska, where the number of suicides are state data). These data sometimes differ from

those published by the states because a) the cut-off dates for accepting vital statistics records into the annual file for producing statistics can be different; b) the interstate exchange program through which states receive data on events that involved residents but occurred in other states might not include all records; and c) the international rules for selecting the underlying cause of death is interpreted and applied differently in some states.

Population data (denominators for annual death rates) are from 1998 postcensal population estimates from the Bureau of the Census. Estimates for 1997 were used for race/ethnicity-specific, average annual age-adjusted death rates for 1996–1998 for suicide and homicide. Age and race data have been modified to be consistent with Office of Management and Budget categories and historical categories for birth data. These modification procedures are described in a report from the Bureau of the Census (*Age, sex, race, and Hispanic origin information from the 1990 census: a comparison of census results with results where age and race have been modified. 1990.* 1991; CPH-L-74.). Race and Hispanic origin data are self-reported or reported by a household member.

Death rates for suicide and homicide are presented by race/ethnicity for states that meet one of the following criteria: a) at least 150,000 population in the designated group or b) at least 100 suicide- or homicide-related deaths among members of the designated group.

Data for persons of Hispanic origin are limited to the District of Columbia and the 49 states that reported Hispanic origin of decedent on death certificates and in which reporting was at least 80% complete during 1996–1998. Data for Oklahoma are not available because that state did not record Hispanic origin of decedent on death certificates in 1996. Persons of Hispanic origin can be of any race, and, conversely, persons listed as white, black, Asian/Pacific Islander, or American Indian/Alaskan Native can be Hispanic or non-Hispanic.

The number of deaths and subsequent death rates for 1996–1998 from suicide and homicide in Alaska are incorrect because NCHS did not receive changes from amended records for 1995 data and because errors were made when the cause-of-death data was processed. Differences are concentrated among selected causes of death, principally symptoms, signs, and ill-defined conditions (*ICD-9* codes 780–799) and external causes. Also, race/ethnicity-specific death rates for suicide and homicide might not be accurate because race and Hispanic origin are recorded on death certificates by funeral directors on the basis of information provided by the next of kin.

For more information, contact Lee Annest, Ph.D., by telephone at (770) 488-4804 or by FAX at (770) 488-1665, or Barbara Morrison by telephone at (770) 488-4936 or by FAX at (770) 488-4222.

Motor Vehicle-Related Deaths

The *ICD-9* codes for motor vehicle-related deaths are E810–E825. The *Healthy People 2000* goals (objective 9.3) for deaths caused by motor vehicle-related crashes are 14.2/100,000 population and 1.5/100 million vehicle miles traveled (VMT) (*Healthy People 2000: national health promotion and disease prevention objectives.* 1991; DHHS publication no. [PHS]91-50212).

Population-based data are tracked by the NVSS. Data for the estimated motor vehicle-related death rate per 100 million VMT are tracked by the Fatal Accident Reporting System (FARS) of the National Highway

Traffic Safety Administration, which is part of the U.S. Department of Transportation. This section provides motor vehicle-related mortality data per 100,000 population and per 100 million VMT by state, which demonstrates the relative magnitude of rates among states based on quartile distributions.

Suicide

The *ICD-9* codes for suicide are E950–E959.

Homicide

The *ICD-9* codes for homicide are E960–E969.

ENVIRONMENTAL HEALTH CONCERNS

Air Quality Standards

This section shows the proportion of persons living in states with counties that exceeded U.S. Environmental Protection Agency (EPA) standards for air quality in 1998. The EPA compiles data from each state in the Aerometric Information Retrieval System (AIRS) on ambient air levels of lead, carbon monoxide, sulphur dioxide, nitrogen dioxide, particulate matter smaller than 10 microns, and tropospheric ozone. Because these pollutants pose significant threats to public health, they were identified in the Clean Air Act of 1970 and its 1977 and 1990 amendments. The National Ambient Air Quality Standards (NAAQS) define maximum concentration levels (micrograms per cubic meter) that should not be exceeded during specific time intervals for each pollutant.

Data are collected at state and local air pollution monitoring sites. Each site provides data for one or more of the six pollutants. In 1998, there were 4,800 sites in the United States; most are located in heavily populated urban areas. Air quality for less-populated areas is assessed through a combination of data from supplemental monitors and air pollution models.

This section summarizes 1998 county-level estimates using the EPA methodology for calculating single-year NAAQS exceedances and 1990 population data from the Bureau of the Census. These data represent one of the health status indicators developed for national, state, and local monitoring; the converse of these proportions is addressed in *Healthy People 2000* (objective 11.5) (DHHS publication no. [PHS]91-50212).

For more information, contact Jeff Pearcy by telephone at (301) 458-4425 or by FAX at (301) 458-4036.

Asthma

During 1993–1994, asthma affected 13.7 million persons of all ages, including 6.8 million children aged <18 years. During 1979–1995, the prevalence of asthma increased 75%, from 30.7 cases/1,000 population to 53.8/1,000 population. During 1979–1995, the number of asthma-related deaths increased 98%, from 2,745 to 5,429, and the mortality rate increased 56%, from 11.5/million population to 17.9/million population. For persons aged <18 years, mortality increased 106%, from 1.7/million population to 3.5/million population. Mortality rates also are consistently higher among blacks than whites.

During 1993–1995, a total of 466,000 hospitalizations listed asthma as the first discharge diagnosis; children aged <15 years accounted for 164,000 (35%) of these hospitalizations. In 1990, the total cost of asthma was estimated at $6.2 billion; inpatient hospital services alone were estimated at $1.6 billion. The cost of hospitalizations increased by 47% during 1985–1990.

Children miss approximately 10 million school days each year because of asthma. The loss of productivity because of parents who lose work days to care for children with asthma is estimated at $1 billion. This figure does not include the cost of lost productivity of adults who miss work because of their own asthma.

A survey conducted by the Council of State and Territorial Epidemiologists (CSTE) in 1996 showed that 80% of states want comprehensive programs to reduce the burden of asthma, but do not have the resources to do so.

CDC monitors national trends in asthma morbidity and mortality and provides technical assistance on asthma prevention to state and local health agencies. CDC funds community-based demonstration pilot intervention programs and capacity-building projects in several states and urban areas. CDC also has developed a public/private partnership in Atlanta called ZAP Asthma, which uses community outreach workers to help families implement environmental control measures. This model can be replicated in other communities, and CDC has completed a national strategic plan for preventing asthma. This plan defines the health problem, identifies the determinants (causes and risk factors) and contributing factors, and describes the process objectives and activities needed to address each contributing factor.

Despite new regulations governing pollution, asthma continues to increase because most asthma triggers (e.g., indoor environmental pollutants and antigens) are not and cannot be regulated effectively. Reductions in such asthma triggers as dust mites, cockroach antigen, environmental tobacco smoke, animal dander, respiratory infections, and air pollutants — coupled with improved medical management, education, and sound public health practice — can substantially reduce asthma irritations and the need for emergency medical intervention.

For more information, contact Jim Rifenburg by telephone at (404) 639-2520 or by FAX at (404) 639-2560.

Disabilities

Data presented in this section are from the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual, state-based, random-digit–dialed telephone survey of health-related behavior among civilian, noninstitutionalized persons aged ≥18 years residing in the United States. In 1998, the BRFSS survey included a disability module in 16 states. This module consisted of 23 questions, including 4 health status questions, 10 optional quality-of-life questions, and 9 new disability questions.

Disability is determined based on a) limitations in activities or cognition or b) use of compensatory strategies (e.g., assistance or adaptive devices). Sample population sizes in the 16 states that administered the disability module were increased to approximately 3,200 to yield an expected 600–800 respondents with disabilities from each reporting jurisdiction. Respondents who gave a positive response to one of the disability questions were asked follow-up questions related to underlying impairment or health problems, duration of limitation, and need for assistance in activities of daily living and instrumental activities of daily living.

For more information, contact Don Lollar by telephone at (770) 488-7094 or by E-mail at <dcl5@cdc.gov>.

Childhood Lead Poisoning Prevention

Lead poisoning remains a major environmental public health problem for children

despite substantial progress in controlling and preventing the problem in recent years. During 1988–1994, the National Health and Nutrition Examination Survey (NHANES) estimated that approximately 1.7 million children in the United States had blood lead levels (BLLs) of ≥10 µg/dL. During 1991–1994, NHANES III-Phase II reported a decline in the mean BLLs for the nation.

Despite this decline, nearly 1 million U.S. children are still at risk for BLLs of ≥10 µg/dL. Public health strategies to identify children at greatest risk for exposure to lead hazards must be intensified and appropriate follow-up services must be provided. CDC provides financial assistance to state and local health agencies for childhood lead poisoning prevention activities and for the development of state surveillance systems. In 1999, a total of 54 state and local health agencies were funded for childhood lead poisoning prevention activities, and three states were funded for surveillance activities.

Prevention activities for state and local health agencies comprise a comprehensive statewide plan that a) assesses the risk for lead exposure, b) responds appropriately to the risks identified, c) oversees and evaluates programs and policies consistent with risk assessment, and d) monitors screening, follow-up, and public and professional educational activities.

Surveillance activities include a) collecting, analyzing, and disseminating lead-related data and b) monitoring and evaluating the effectiveness of screening, follow-up, lead hazard control, and primary prevention activities. CDC also provides technical and management consultation to state and local health agencies to develop and implement lead poisoning prevention activities and surveillance systems.

For more information, contact Jerry Hershovitz by telephone at (404) 639-2500 or by FAX at (404) 539-2555.

OCCUPATIONAL HEALTH CONCERNS

Occupational Lung Disease Deaths

Statistics in this section are from the National Surveillance System for Pneumoconiosis Mortality (NSSPM). This system was developed and is maintained by the Division of Respiratory Disease Studies of CDC's National Institute for Occupational Safety and Health (NIOSH). NSSPM contains death certificate information for 1968–1996 for all U.S. decedents aged ≥15 years identified with pneumoconiosis listed as an underlying or contributing cause of death. These data are a subset of national vital statistics prepared annually by CDC's National Center for Health Statistics (NCHS).

Age-adjusted pneumoconiosis mortality rates are presented for each state during 1987–1996 (*ICD-9* codes 500–505). Rates by specific types of pneumoconiosis (i.e., coal workers' pneumoconioses [CWP], silicosis, asbestosis, byssinosis, and other/unspecified pneumoconiosis) are presented for each state and compared with the U.S. rate. Population data (denominators for rates) are 1992 postcensal population estimates from the Bureau of the Census.

Death rates are age-adjusted by the direct method to the 1940 U.S. population. More information on pneumoconiosis mortality patterns during 1987–1996 are available in the *Work-Related Lung Disease Surveillance Report 1996*, which also provides data for other occupationally relevant respiratory diseases (e.g., occupational asthma, hyper-

sensitivity pneumonitis, malignant neoplasm of the pleura) (1999; DHHS publication no. [NIOSH]00-105).

Traumatic Occupational Fatalities

Occupational fatalities are identified by NIOSH through the National Traumatic Occupational Fatalities (NTOF) Surveillance System. Information from death certificates is collected from 52 vital statistics reporting units (all 50 states, New York City, and the District of Columbia) according to the following criteria: age ≥16 years, an external cause of death (*ICD-9* codes E800–E999), and a response that the injury occurred at work.

Because no standard guidelines exist for responding to the "Injury at work?" portion of a death certificate, the NTOF Surveillance System's numbers should be considered the minimum number of work-related deaths in the United States during the reporting period. To address this issue, NIOSH collaborated with NCHS, the National Association for Public Health Statistics and Information Systems, and the National Center for Environmental Health (NCEH) to develop guidelines for recording work-related injuries. These guidelines were implemented by the states in 1993 and should improve future surveillance for occupational fatalities based on death certificates.

Cause-of-death codes have been assigned according to the *ICD-9* supplementary chapter on the classification of external causes of injury and poisoning. Occupation narratives are coded into 11 divisions according to the 1980 and 1990 Bureau of the Census classification schemes. Denominator data for the calculation of rates were obtained from the Bureau of Labor Statistics (BLS) annual average employment data for 1991–1995. The rates presented in this publication are for the U.S. civilian labor force.

More information is available from NIOSH (*Fatal injuries to workers in the United States, 1980–1989: a decade of surveillance national and state profiles*. 1993; DHHS publication no. [NIOSH]93-108S).

Occupational Illnesses

Data on occupational illness are from the 1998 Survey of Occupational Injuries and Illnesses, conducted by BLS in cooperation with state agencies (available at <http://stats.bls.gov/oshhome.htm>). The survey provided state and national estimates of the number and frequency of nonfatal occupational injuries and illnesses based on logs kept by 169,000 private industry employers. It represents the most current data available. Data that conform to Occupational Safety and Health Administration (OSHA) definitions for mining operators in coal, metal, and nonmetal mining and for employers in railroad transportation are provided to BLS by the Mine Safety and Health Administration (U.S. Department of Labor) and the Federal Railroad Administration (U.S. Department of Transportation).

Independent mining contractors are excluded from data for the mining industry. The survey also excludes farms with <11 employees and persons who are self-employed or employed in private households.

Forty-one states participated in this project. Nonparticipating states include Colorado, Idaho, Mississippi, New Hampshire, North Dakota, Ohio, Pennsylvania, South Dakota, and Wyoming. The District of Columbia also did not participate.

Illnesses are reported by employers in seven categories. Industries are coded into 10 categories according to the 1987 edition of the *Standard Industrial Classification Manual*, published by the U.S. Office of Management and Budget (1987).

Overall, BLS reported that the U.S. rate for occupational injuries and illnesses in private industry was 6.7/100 full-time workers in 1998. Approximately 392,000 new cases of occupational illness were reported in private industry in 1998. Manufacturing industries accounted for three-fifths of these cases.

Disorders associated with repeated trauma (e.g., carpal tunnel syndrome and noise- induced hearing loss) represented 65% of the 392,000 cases of illness reported.

INFECTIOUS DISEASES

Acquired Immunodeficiency Syndrome

This section provides estimated rates per 100,000 population for adults and adolescents (i.e., persons aged ≥13 years) living with acquired immunodeficiency syndrome (AIDS) (i.e., AIDS prevalence) at the end of 1999, by state of residence. The prevalence of AIDS is a function of the number of incident cases and the length of time persons survive after an AIDS diagnosis. At the end of 1999, approximately 320,000 persons were alive and living with AIDS in the United States. Although the annual number of new AIDS diagnoses has decreased, largely as a result of recent developments in treatment for human immunodeficiency virus (HIV) infection, AIDS prevalence increased by approximately 25,000 persons from 1997 through 1998 and by approximately 27,000 from 1998 through 1999 because of longer survival times after diagnosis.

AIDS-related organizations at federal, state, and local levels of government, as well as some businesses and community groups, rely on current AIDS information to plan for the future. Because of decreases in AIDS incidence, recent data on the number of persons living with AIDS allow better planning for future fiscal requirements, along with medical and social service needs.

States report AIDS cases to the Division of HIV/AIDS Prevention (DHAP) of CDC's National Center for HIV, STD, and TB Prevention (NCHSTP). A uniform case definition and case report form are used, and rates are calculated on an annual basis per 100,000 population. Population data are 1999 postcensal population estimates from the Bureau of the Census.

Rates per 100,000 population also are included for, at most, the four largest Metropolitan Statistical Areas (MSAs) in states with the highest case rates for AIDS. For states that do not have MSAs with populations of ≥500,000, no MSA data are provided. MSAs sometimes cross state lines. In these instances, the data are assigned to the state with the largest proportion of the MSA's population. Definitions and descriptions of MSAs are available on the Bureau of the Census Internet site at the following address: <http://www.census.gov>.

For more information, contact a DHAP Information Specialist by telephone at (404) 639-2072 or by FAX at (404) 639-2007. Information also is available on the DHAP Internet site at the following address: <http://www.cdc.gov/hiv/dhap.htm>.

Malaria

The National Malaria Surveillance System is a passive reporting system operated by the Malaria Epidemiology Branch in the Division of Parasitic Diseases of CDC's National Center for Infectious Diseases (NCID). Laboratory-confirmed cases of malaria are

identified by health-care providers or laboratories, reported to local and state health departments, then reported to CDC. Approximately 1,500 cases of malaria are reported in the United States each year, but many additional cases might go unreported because of underreporting. Most infections are acquired outside the United States and its territories, in parts of the world where malaria is endemic. Typically, <10 cases each year are acquired inside the United States, usually from transfusion, needlestick, organ transplantation, congenital transmission, or an infected mosquito.

Travelers visiting countries where malaria is endemic can minimize their risk by taking an antimalarial drug for chemoprophylaxis and using personal protection measures (e.g., insect repellents, protective clothing, and mosquito nets). Information regarding malaria risk, antimalarial drug-resistance patterns, and recommended antimalarial prophylaxis is available in CDC's *Health Information for International Travel, 1999-2000.* Current recommendations are also available free on the Internet at <http://www.cdc.gov/travel>, by calling (888) 232-3228, or by calling (888) 232-3299 to request information by fax.

Although sustained malaria transmission no longer occurs in this country, anopheline mosquitoes capable of transmitting the infection are still found in all 48 of the contiguous United States. These insects rarely encounter malaria-infected humans, and they typically do not survive long enough to become infective, bite another person, and transmit the infection. However, when weather conditions are favorable (e.g., sustained periods of high temperature and humidity), these mosquitoes can survive longer and become infective more quickly. Mosquito-transmitted malaria occurs in the United States only when certain events coincide (e.g., a person with parasitemia, increased contact among humans and the anopheline vector, and environmental conditions that favor transmission) (*Emerg Infect Dis* 1996;2:37–43).

Annual reports from the National Malaria Surveillance System are printed in the *CDC Surveillance Summaries* (*MMWR* 1999;48[SS-1]). These reports include summary data on reported cases and their origins and information on locally acquired cases investigated during the year.

For more information, contact the Malaria Hotline by telephone at (770) 488-7788 or by FAX at (770) 488-7761.

Chlamydia and Gonorrhea
Primary and Secondary Syphilis

Data in these sections are from state and local health departments, which report cases of chlamydia, gonorrhea, and primary and secondary syphilis to the Division of Sexually Transmitted Disease (STD) Prevention, NCHSTP. Crude incidences (new cases/population) are calculated annually per 100,000 population. Rates for 1999 use 1998 population estimates from Bureau of the Census postcensal data. Because no cases of chlamydia were reported outside New York City, the rate of occurrence of chlamydia for the state of New York reflects only the occurrence of cases in New York City.

More detailed information on STDs is available in CDC's *Sexually Transmitted Disease Surveillance, 1999* (September 2000). Copies can be obtained from the Office of Communications, NCHSTP; CDC; 1600 Clifton Road, Mailstop E-06; Atlanta, GA 30333. The report is also available on the Internet at <http://www.cdc.gov/nchstp/dstd/Stats_Trends/1999SurvRpt.htm>.

For more information, contact Melinda Flock, M.S.P.H., by telephone at (404) 639-8356 or by FAX at (404) 639-8611.

Information also is available on the Division of STD Prevention website at the following address: <http://www.cdc.gov/nchstp/dstd>.

Pneumonia and Influenza Deaths

Data for the total number of deaths and age-adjusted death rates for pneumonia and influenza (P&I) (*ICD-9* codes 480–487) are from the *National Vital Statistics Report* (2000;48[11]). P&I death rates are presented by race/ethnicity for states that meet one of the following criteria: a) ≥150,000 persons in the designated group or b) ≥20 deaths among members of the designated group. Data for Oklahoma are not available because that state did not record Hispanic origin of decedent on death certificates in 1996.

Nearly all of the infectious diseases that were among the 10 leading causes of death in the United States at the beginning of the twentieth century are now under control (e.g., tuberculosis, diphtheria, and diarrheal diseases). However, P&I have continuously been among the top 10 leading causes of death since the beginning of the 1990s, and they remain a serious health problem. In 1998, P&I ranked sixth among the 10 leading causes of death.

Minor changes in the antigenicity of influenza viruses, known as antigenic drift, lead to influenza epidemics nearly every winter in the United States. An average of approximately 20,000 deaths, more than 110,000 hospitalizations, millions of visits for outpatient care, and tens of millions of lost work and school days occur each influenza season.

Influenza vaccine is the primary method for preventing influenza infection and its more severe complications. This inactivated (i.e., killed-virus) vaccine contains three strains (two type A and one type B), representing the influenza viruses likely to circulate in the United States during the upcoming winter. Vaccination is strongly recommended for all persons aged ≥6 months who are at increased risk for complications because of age or an underlying medical condition (*MMWR* 2000;49[RR-3]).

Active global and U.S. surveillance for influenza viruses is critical for formulating each year's vaccine and detecting new viruses. Surveillance for influenza-like illness and mortality caused by P&I is an important way to assess the impact of the circulating strain(s).

In addition to causing annual epidemics, new influenza type A viruses to which most of the world's population are susceptible can emerge unpredictably and lead to pandemics. In the twentieth century, three pandemics (during the 1918-19, 1957-58, and 1968-69 seasons) caused great increases in illness and more than 650,000 deaths combined. In 1997 and 1999, human cases of illness and deaths related to new influenza viruses were discovered but did not result in pandemics.

Pneumococcal infections are the most common cause of bacterial meningitis and of pneumonia leading to hospitalization. Each year, pneumococcus causes approximately 60,000 cases of bacteremic disease, 3,000 cases of meningitis, 125,000 cases of pneumonia requiring hospitalization, and 6 million ear infections. Approximately 1 in 10 persons with an invasive pneumococcal infection (i.e., infection of the blood stream or other normally sterile body site) die of the infection (range: from <1 in 100 children aged <5 years to approximately 1 in 6 adults aged >65 years) (CDC. *Active Bacterial Core Surveillance [ABCs] Report, Streptococcus pneumoniae, 1999*. Available on the Internet at <http://www.cdc.gov/ncidod/dbmd/abcs>).

Multidrug-resistant pneumococci are becoming increasingly common, making pneumococcal infections more difficult to treat. CDC surveillance data suggest that approximately one-quarter of invasive pneumococcal isolates are no longer susceptible to penicillin and approximately 1 in 7 are not susceptible to at least three drug classes (*New Engl J Med* 2000;343:1917–24). Infants and young children, persons aged ≥65 years, persons with immune system disorders, and persons with certain chronic diseases are at higher risk for pneumococcal infections.

A 23-valent pneumococcal polysaccharide vaccine is recommended for persons aged ≥2 years who are at high risk. A 7-valent vaccine effective for infants and young children was licensed in February 2000 and is recommended for all children aged <2 years and for some children aged 2–4 years at high risk (*MMWR* 2000;49[No. RR-9]).

The Public Health Service publication *Healthy People 2010* (objective 14–29) calls for increasing P&I vaccination levels to a) ≥90% among persons aged ≥65 years and persons of all ages in long-term–care or nursing homes and b) ≥60% among persons aged 18–64 years at high risk for complications from pneumococcal disease or influenza infection (*Healthy people 2010.* Conference ed, in 2 vols. Washington, DC: US Department of Health and Human Services, 2000). The *Healthy People 2000* goal (objective 20.11) for P&I vaccination was 60% for noninstitutionalized populations at high risk and 80% for long-term–care and nursing home residents (1991; DHHS publication no. [PHS]91-50212).

During 1989–1999, pneumonia and influenza vaccination levels in the United States increased. Analysis of data from the 1999 Behavioral Risk Factor Surveillance System (The BRFSS) indicates that 67% of noninstitutionalized persons aged ≥65 years reported receiving influenza vaccination during the preceding 12 months, which exceeds the *Healthy People 2000* objective. (BRFSS is an annual, state-based. random-digit–dialed telephone survey of health-related behavior. Each participating state selects a probability sample of its non-institutionalized civilian adult population aged ≥18 years who have telephones. During 1999, all 50 states, the District of Columbia, and Puerto Rico participated in the BRFSS.)

By contrast, influenza vaccination rates are lower among adults aged 18–64 years who are at high risk for complications. Based on 1997 National Health Interview Survey (NHIS) data, 1997 influenza vaccination coverage for persons in this age group at high risk was 26% (CDC, unpublished data, 1997).

Although pneumococcal vaccine coverage has increased during the 1990s, coverage in most states and the United States as a whole remains below *Healthy People 2000* goals. The 1999 BRFSS report notes that only 54% of persons aged ≥65 years reported ever receiving a dose of pneumococcal vaccine. In individual states, coverage ranged from 40% to 67%, and 8 states had ≥60% coverage. Based on the 1997 NHIS, pneumococcal vaccination coverage for persons at high risk aged 18–64 years was 13% (CDC, unpublished data, 1997).

For more information on pneumococcal infections, contact Cynthia Whitney, M.D., M.P.H., by telephone at (404) 639-2215 or by FAX at (404) 639-3970. For more information on influenza infections, contact Alicia S. Postema, M.P.H., by telephone at (404) 639-3747 or by FAX at (404) 639-3866. For more information on vaccine issues, contact James A. Singleton, M.S., by telephone at (404) 639-8257 or by FAX at (404) 639-8616.

Lyme Disease

Lyme disease is a multisystem, multistage disease caused by infection with the tick-borne spirochete, *Borrelia burgdorferi*, and the most commonly reported vectorborne disease in the United States. During 1999, a total of 16,273 cases of Lyme disease were reported to CDC (cases are reported by county of residence, which is not necessarily the county of exposure).

CDC initiated national surveillance for Lyme disease in 1982, and 11 states reported 491 cases. During 1992–1998, cases increased 70%, from 9,986 in 1992 to 16,802 in 1998, with a total of 88,967 cases reported to CDC's National Notifiable Diseases Surveillance System (NNDSS) during this period (*MMWR* 2000;49[No.SS-3]:1–11). Although cases were reported by all states except Montana, 92% were reported from only 10 states (Connecticut, Delaware, Massachusetts, Maryland, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, and Wisconsin) (*MMWR* 2000;49[No.SS-3]:1–11). The tick vector in these endemic areas is the deer tick or *Ixodes scapularis*.

A vaccine against Lyme disease was licensed in December 1998 for persons aged 15–70 years (*MMWR* 1999;48[No. RR-7]). CDC is funding community-based programs to prevent Lyme disease through health education, appropriate vaccination, and integrated strategies to reduce vector tick densities.

A skin rash that resembles the one caused by Lyme disease has been associated with bites by the lone star tick *(Amblyomma americanum)*, but this rash does not appear to be caused by *B. burgdorferi* infection (*J Infect Dis* 1995;172:470–80 and *Arch Intern Med* 1997;157:2635–41). CDC is conducting studies to determine the etiology of this condition, which occurs primarily in the south-central and southeastern United States and could be mistakenly reported as Lyme disease.

For more information, contact CDC's Lyme disease program by telephone at (970) 221-6400 or by FAX at (970) 221-6474. Information is also available on the Internet at <http://www.cdc.gov/ncidod/dvbid/lymeinfo.htm>.

Tuberculosis

Data in this section are from health departments in all 50 states, New York City, and the District of Columbia, which report tuberculosis (TB) cases to the Division of Tuberculosis Elimination, NCHSTP. Rates were calculated using postcensal estimates from the Bureau of the Census.

In 1999, a total of 17 states had TB case rates of ≤3.5 cases/100,000 population. This rate represents the interim target for the year 2000 established by the Advisory Council for the Elimination of Tuberculosis as part of its long-term goal to eliminate TB by 2010. Fifteen states and the District of Columbia had TB case rates higher than the 1999 national rate of 6.4 cases/100,000 population.

Eliminating TB in the United States will depend increasingly on eliminating TB among persons born in countries with high TB rates (*MMWR* 1998;47[No. RR-16]). The proportion of TB cases among foreign-born persons living in the United States increased from 27% in 1992 to 43% in 1999 and was ≥50% in 15 states.

For more information, contact Gloria Kelly by telephone at (404) 639-8117 or by FAX at (404) 639-8959. Information also is available on the Division of TB Elimination Internet site at <http://www.cdc.gov/nchstp/tb/default.htm>.

CHRONIC DISEASES: CONDITIONS AND RISK FACTORS

This section presents mortality data for total cardiovascular disease, breast cancer, colon cancer, and lung cancer, as well as related risk factor data for these and other chronic diseases. In 1999, CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) published *Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death* (December 1999). This report provides state-specific data for the major causes of death, cardiovascular disease, cancer, and diabetes, as well as for selected risk factors and the use of preventive services. A second report, *Unrealized Prevention Opportunities: Reducing the Health and Economic Burden of Chronic Disease* (November 2000), lists national priorities for preventing chronic disease and describes ways to reduce the health-care and economic burdens of chronic disease. Copies of both documents are available from NCCDPHP by telephone at (770) 488-5131.

For more information, contact Nora Keenan, Ph.D., by telephone at (770) 488-5414, by FAX at (770) 488-8151, or by E-mail at <NKeenan@cdc.gov>. Information regarding the major chronic diseases and their risk factors also is available on the NCCDPHP Internet site at <http://www.cdc.gov/nccdphp>.

Data for death rates are annual age-adjusted rates based on the underlying cause of death for the years indicated. The numbers of deaths (numerators for death rates) are from the National Vital Statistics System (NVSS) of CDC's National Center for Health Statistics (NCHS) and are based on data provided by registrars in all 50 states, New York City, and the District of Columbia. The numbers of deaths sometimes differ from those published by the states because a) the cut-off dates for accepting vital statistics records into the annual file for producing statistics can be different; b) the interstate exchange program through which states receive data on events that involved residents but occurred in other states might not include all records; and c) the international rules for selecting the underlying cause of death is interpreted and applied differently in some states.

Population data (denominators for death rates) are 1998 postcensal population estimates from the Bureau of the Census. Death rates are age-adjusted to the 1940 U.S. population by the direct method. Direct age-adjustment is calculated by weighting the annual age-specific rates by the population distribution in the standard population (see the Mortality section for more information on population data and age adjustment).

All risk factor data presented in this section, as well as the data on oral health, clinical breast exam, mammography, and proctoscopy, were obtained from the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual, state-based, random-digit–dialed telephone survey of health-related behavior. Each participating state selects a probability sample of its noninstitutionalized civilian adult population (i.e., persons aged ≥18 years) who have telephones. In 1999, all 50 states, the District of Columbia, and Puerto Rico participated in the BRFSS.

For more information, contact Ève Powell-Griner, Ph.D., by telephone at (770) 488-2524 or by FAX at (770) 488-8150. More information about the BRFSS is available on the NCCDPHP Internet site at <http://www.cdc.gov/nccdphp>.

National objectives for several behavioral risk factors discussed in this section are from the Public Health Service publication *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (1991; DHHS publication no. [PHS]91-50212).

These objectives include the following:

Objective 1.5 – Reduce to ≤15% the proportion of persons aged ≥6 years who engage in no leisure-time physical activity.

Objective 2.3 – Reduce overweight to a prevalence of ≤20% among persons aged ≥20 years.

Objective 2.6 – Increase to ≥50% the proportion of persons aged ≥2 years who meet the average daily goal of ≥5 servings of vegetables and fruits. The 50% target was added in the 1995 midcourse revision of *Healthy People 2000: Midcourse Review and 1995 Revisions*. The average daily goal of ≥5 servings of vegetables and fruits comes from the *Dietary Guidelines for Americans. Third Edition* (1990; DHHS publication no. 1990-273–930).

Objective 3.4 – Reduce cigarette smoking to a prevalence of ≤15% among persons aged ≥20 years.

Objective 13.4 – Reduce to ≤20% the proportion of persons aged ≥65 years who have lost all of their natural teeth.

Objective 13.14 – Increase to ≥70% the proportion of persons aged ≥35 years using the oral health-care system during each year.

Oral Health

Loss of all natural permanent teeth (edentulism) can have a substantial negative effect on quality of life, self-image, and daily functioning. Tooth loss can be prevented through education, regular dental care, and early diagnosis and prompt treatment of diseases and conditions that lead to tooth loss. The *Healthy People 2000* goal (objective 13.4) is to reduce to ≤20% the proportion of persons aged ≥65 years who have lost all of their natural teeth.

Prevalence estimates for total tooth loss among persons aged ≥65 years are based on 1999 BRFSS data. Participants were asked how many of their permanent teeth were removed because of tooth decay or gum disease.

Regular dental visits are opportunities for prevention, early diagnosis, treatment, and health education. Adults who do not receive regular professional care can develop oral diseases that lead to unnecessary restorative treatment and preventable tooth loss. Even edentate persons remain at risk for oral soft tissue lesions and denture-related problems. *Healthy People 2000* objective 13.14 is to increase to ≥70% the proportion of persons aged ≥35 years using the oral health-care system each year.

In states that administered the BRFSS oral health module, participants were asked how long it had been since they last visited a dentist or dental clinic. Estimates of the proportion of persons aged ≥35 years who reported that they saw a dentist during the preceding 12 months are presented for 48 states that administered the oral health module during at least 1 year during 1995–1999. To increase the precision of prevalence estimates, data from multiple years were aggre-

gated for states that administered the BRFSS oral health module during more than 1 year.

Estimates of the proportion of persons aged ≥35 years who reported visiting a dentist during the preceding 12 months are based on 1999 BRFSS data. Participants were asked how long it had been since they last visited a dentist or dental clinic.

For more information, contact William Konn, D.D.S., by telephone at (770) 488-6071, by FAX at (770) 488-6080, or by E-mail at <wak4@cdc.gov>.

Prevalence of Diagnosed Diabetes

This section presents age-specific and total prevalence of diagnosed diabetes for the state and for the BRFSS median value (50th percentile) for all states. The percentage of the population with diagnosed diabetes is a 3-year average of BRFSS data for 1997–1999. Persons with diagnosed diabetes are defined as those who report that a physician told them they have diabetes.

For more information, contact Linda Geiss, M.A., by telephone at (770) 488-1056, by FAX at (770) 488-1148, or by E-mail at <lsg2@cdc.gov>.

Prevalence of Physical Inactivity and Overweight

Physical inactivity and overweight are considered important risk factors for coronary heart disease and other chronic diseases. Reducing to ≤15% the proportion of persons aged ≥6 years who engage in no leisure-time physical activity and reducing the prevalence of overweight to ≤20% among persons aged ≥20 years are *Healthy People 2000* goals (objectives 1.5 and 2.3, respectively). The average 3-year prevalence of physical inactivity and overweight are presented for each state and the District of Columbia, in relation to *Healthy People 2000* objectives.

Leisure-time physical inactivity is defined as not participating in any leisure-time physical activities or exercises (e.g., running, calisthenics, golfing, gardening, or walking) during the previous month. Overweight is defined as body mass index ≥27.8 kg/m^2 for men and ≥27.3 kg/m^2 for women.

Estimates of leisure-time physical inactivity and overweight are calculated by taking the average prevalence for 1994, 1996, and 1998. These years were chosen because physical activity data are not available for 1995, 1997, and 1999.

For more information, contact Anita Blankenship by telephone at (770) 488-5680, by FAX at (770) 488-5473, or by E-mail at <aob4@cdc.gov>.

Total Cardiovascular Disease

The age-adjusted death rates for total cardiovascular disease per 100,000 population for 1998 are provided for all 50 states and the District of Columbia. The *ICD-9* codes for cardiovascular disease as the underlying cause of death are 390–459. These cardiovascular diseases include rheumatic fever/rheumatic heart disease (*ICD-9* codes 390–398); hypertensive heart disease (*ICD-9* code 402); hypertensive heart and renal disease (*ICD-9* code 404); ischemic heart disease (*ICD-9* codes 410–414); diseases of pulmonary circulation, including acute pulmonary heart disease, chronic pulmonary heart disease, and other conditions (*ICD-9* codes 415–417); other forms of heart disease, including heart failure (*ICD-9* codes 420–429), stroke (*ICD-9* codes 430–438), diseases of the arteries, arterioles, and capillaries (*ICD-9* codes 440–448), and diseases of the veins and lymphatics; and other diseases of the circulatory system (*ICD-9* codes 451–459).

The state-based, self-reported prevalence estimates for four behavioral risk factors for cardiovascular disease are based on the 1999 BRFSS. For each risk factor, the state value is compared with the BRFSS median value (50th percentile) for all states and the nu-

merical value from the corresponding *Healthy People 2000* objective. These risk factors and their objectives are current smoking (objective 3.4), overweight (objective 2.3), eating <5 servings of fruits and vegetables a day (objective 2.6), and physical inactivity (objective 1.5).

For this section, current smokers are defined as persons who report smoking ≥100 cigarettes during their lifetime and who report smoking every day or some days. Overweight is calculated based on self-reported weight and height and is defined as body mass index ≥27.8 kg/m^2 for men and ≥27.3 kg/m^2 for women. Persons classified as physically inactive reported not participating in any leisure-time physical activities or exercises (e.g., running, calisthenics, golfing, gardening, or walking) during the previous month.

For more information, contact Carma Ayala, Ph.D., by telephone at (770) 488-8072, by FAX at (770) 488-8151, or by E-mail at <cia1@cdc.gov>.

Breast Cancer and Mammography

This section presents annual age-adjusted death rates for breast cancer as the underlying cause of death for women during 1988–1998 for each state and the United States as a whole in relation to the *Healthy People 2000* target of ≤20.6 deaths/100,000 women (objective 16.3). The *ICD-9* code for breast cancer is 174.

The section on clinical breast exam and mammography presents BRFSS data for 1994–1999 for each state and the BRFSS median value (50th percentile) for all states. The BRFSS data for this section are based on women aged ≥50 years who reported having had a clinical breast examination and a mammogram within the preceding 2 years either as part of a routine check up or because of a breast condition (e.g., cancer or a lump in the breast). The denominator excludes respondents who refused to answer the questions on clinical breast exam or mammography and those who answered that they did not know or were not sure of the answer to these questions.

For more information, contact Steve L. Reynolds, M.P.H., by telephone at (770) 488-3075, by FAX at (770) 488-4760, or by E-mail at <slr6@cdc.gov>.

Colorectal Cancer and Proctoscopy

The annual age-adjusted death rates for colorectal cancer as the underlying cause of death are presented for 1988–1998 for the states by sex and by total deaths in relation to the *Healthy People 2000* target of ≤13.2 deaths/100,000 persons (objective 16.5). The *ICD-9* codes for colorectal cancer are 153.0–154.3, 154.8, and 159.0.

The section on proctoscopy presents BRFSS data for 1995 and 1997 for the states and the BRFSS median value (50th percentile) for all states. The BRFSS data for this section are based on survey respondents aged ≥50 years who reported ever having had a proctoscopic exam for signs of cancer or other health problems.

For more information, contact Steven L. Reynolds, M.P.H., by telephone at (770) 488-3075, by FAX at (770) 488-4760, or by E-mail at <slr6@cdc.gov>.

Lung Cancer and Current Smoking

The annual age-adjusted death rates for lung cancer as the underlying cause of death are presented for 1988–1998 for the states by sex and by total deaths in relation to the *Healthy People 2000* target of ≤42 deaths/100,000 persons (objective 16.2). The *ICD-9* codes for lung cancer are 162.2–162.9.

The section on current cigarette smoking among persons aged ≥18 years is based on

BRFSS data for 1993–1997. Current smokers are defined as persons who report smoking ≥100 cigarettes during their lifetime and who report smoking every day or some days. Results are presented by sex and total population in relation to the *Healthy People 2000* target of reducing cigarette smoking to ≤15% among this population (objective 3.4).

For more information, contact Pascale Wortley, M.D., M.P.H., by FAX at (770) 488-5848, or by E-mail at <PWortley@cdc.gov>.

Prevalence of Smoking

This section presents 1999 BRFSS data on current cigarette smoking by demographic groups in relation to the *Healthy People 2000* target of reducing cigarette smoking to ≤15% among current smokers (objective 3.4). Reported prevalences are BRFSS estimates for persons aged ≥18 years.

Current smokers are defined as persons who report smoking ≥100 cigarettes during their lifetime and who report smoking every day or some days. Demographic groups are based on self-reporting of age, sex, educational attainment, race, and Hispanic ethnicity. Women aged 18–44 years represent women of reproductive age. The lower age limit was used because the BRFSS does not survey persons aged <18 years.

Smoking prevalence for persons of Hispanic ethnicity and for black, American Indian/Alaskan Native, and Asian/Pacific Islander racial groups is not reported for states with <50 respondents in their BRFSS sample for those racial/ethnic groups in 1999. Thus, the BRFSS median for smoking prevalence for racial/ethnic groups is calculated based on data from states with ≥50 respondents from a particular group.

Survey respondents who declined to answer questions regarding smoking are excluded from the denominator of this analysis, which might explain slight differences between these and other estimates.

For more information, contact Pascale Wortley, M.D., M.P.H., by FAX at (770) 488-5848, or by E-mail at <PWortley@cdc.gov>.

Prevalence of Not Having Health-Care Coverage

This section presents 1999 BRFSS data on persons aged 18–64 years who do not have health-care coverage, by race and Hispanic ethnicity. Participants were asked, "Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?"

The prevalence of not having health-care coverage for persons of Hispanic ethnicity and for black, American Indian/Alaskan Native, and Asian/Pacific Islander racial groups is not reported for states with <50 respondents in their BRFSS sample for those racial/ethnic groups in 1999. Thus, the BRFSS median for health-care coverage for racial/ethnic groups is calculated based on data from states with ≥50 respondents from a particular group.

For more information, contact Nora Keenan, Ph.D., by telephone at (770) 488-5414, by FAX at (770) 481-5081, or by E-mail at <Nkeenan@cdc.gov>.

Training Networks

The Public Health Training Network (PHTN) information for this section is from a database of registrants in distance-based learning courses who later received continuing education credits. For more information, contact Dennis McDowell by telephone at (404) 639-3707 or by FAX at (404) 639-3982. Information is also available on the PHTN Internet site at the following address: <http://www.cdc.gov/phtn/>.

The National Laboratory Training Network (NLTN) information for this section is from a database of registrants in training activities sponsored by NLTN. For more information, contact Judy Delany, M.S., by telephone at (770) 488-8063, by FAX at (770) 488-8278, or by E-mail at <jdelany@cdc.gov>. Information also is available on the Internet at <http://www.phppo.cdc.gov/dls/nltn>.

Adult Vaccination Coverage

Data in this section indicate the percentage of persons aged ≥65 years who reported having a vaccination for influenza during the preceding year or ever having a vaccination for pneumococcal disease. Data are from the 1999 Behavioral Risk Factor Surveillance System (BRFSS), which is an annual, state-based, random-digit–dialed telephone survey of health-related behavior. Each participating state selects a probability sample of its noninstitutionalized civilian adult population (aged ≥18 years) who have telephones. In 1999, all 50 states, the District of Columbia, and Puerto Rico participated in the BRFSS.

For more information on pneumonia and influenza mortality, *Healthy People 2000* objectives, and other vaccination coverage data, see pages 73–74.

For more information on influenza and pneumococcal vaccination levels, contact James A. Singleton by telephone at (404) 639-8689, by FAX at (404) 639-8616, or by E-mail at <JSingleton@cdc.gov>.