

HEALTH PROFILE I

Health Behaviors, Morbidity, and Mortality



Alexandria Health Department
2015

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INTRODUCTION

INTRODUCTION

Building an ever-healthier city is the primary focus of the Alexandria Health Department (AHD), as reflected in our mission “Protecting and Promoting Health and Well-Being in Our Communities”. In an effort to make a difference in the lives of people who live, work, and play in Alexandria, AHD has compiled a summary list of key health indicators that focus on **health behaviors**, **morbidity** (rates of illness or disease) and **mortality** (rates of death). This is referred to as Health Profile I. Health Profile I may serve as a baseline for government, nonprofit and for-profit agencies and other stakeholders seeking to monitor and improve health in the City of Alexandria.

Data Sources

Demographic data were collected from the Census Bureau (www.census.gov). Health indicators reflecting health behaviors, morbidity, and mortality were chosen using existing data available from credible, vetted sources. The primary source of indicators and corresponding data was the Community Health Status Indicators (CHSI) 2015 web application, established by the U.S. Centers for Disease Control and Prevention (CDC). For most adolescent health indicators, data from the CDC Youth Risk Behavioral Surveillance System (YRBSS) and the 2013-2014 Alexandria Youth Risk Behavior Survey (Alexandria YRBS) were used. A summary of each major health indicator data source is presented below.

Community Health Status Indicators (CHSI) 2015

The Community Health Status Indicators (CHSI) 2015 is an online web application managed by CDC that produces health status profiles for each of the 3,143 counties in the United States and the District of Columbia. AHD utilized CHSI because it focuses on key health indicators that are considered important to public health, are actionable, and are regularly reported.

Health indicators were selected by CDC for inclusion in CHSI 2015 by consulting with subject matter experts. CHSI utilized data from a number of sources, including, but not limited to:

- Behavioral Risk Factor Surveillance System (BRFSS)
- CDC Wonder
- Health Indicators Warehouse (HIW)
- Interactive Atlas for Heart Disease and Stroke
- National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) Atlas
- National Diabetes Surveillance System (NDSS)
- National Environmental Public Health Tracking Network (NEPHTN)

A key feature of CHSI 2015 is the ability for users to compare the value of each indicator with those of demographically similar “peer counties,” as well as to the U.S. as a whole, and to Healthy People 2020 (HP 2020) targets. CHSI provides peer county groupings so that each county can be compared to communities with similar characteristics from across the country. CDC determined that Alexandria belongs to a peer group of 43 jurisdictions in 24 states; these are referred to as Alexandria’s peer counties. Peer county selection is based on a time-tested, in-depth process and analysis, with input from relevant subject matter experts looking at factors including, but not limited to: population size and density; percent of children and elderly in the population; percent foreign-born; median home value; unemployment and other economic and demographic indicators.

For more information on CHSI indicator selection and peer county groupings, please visit: www.cdc.gov/CommunityHealth/home.

2013 CDC Youth Risk Behavioral Surveillance System (YRBSS)

The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults and the prevalence of obesity and asthma. The national survey, conducted by CDC, provides data representative of students in grades 9 through 12 in public and private schools in the United States. For more information about YRBSS, please visit:

www.cdc.gov/healthyyouth/data/yrbs/index.htm.

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2013-2014 Alexandria Youth Risk Behavior Survey (Alexandria YRBS)

The 2013-2014 Alexandria Youth Risk Behavior Survey (Alexandria YRBS), based on YRBSS, is a voluntary, anonymous, self-reported survey administered to adolescents in grades 8, 10 and 12. The goal of the survey is to obtain information on youth behaviors in six risk areas identified as contributing to the leading causes of death, disability, and social problems among youth in the United States. The sampling frame for the 2013-2014 Alexandria YRBS included all students in grades 8, 10 and 12 attending school at George Washington Middle School, Francis C. Hammond Middle School, Jefferson-Houston School, and T.C. Williams High School. For more information about the Alexandria YRBS, please email inquiries to: Alex_Epi@vdh.virginia.gov.

Indicator Selection

Many of the health indicators that were included in CHSI 2015 were included in this Health Profile. For some topic areas, additional indicators that were not included in CHSI 2015 were added to provide a more comprehensive overview of the topic area. Where possible, the same data source and years of data used in CHSI 2015 for related indicators were used in this Health Profile to allow for comparisons. Since adolescent indicators were not included in CHSI 2015, corresponding adolescent indicators were added from youth behavioral surveys (YRBSS/Alexandria YRBS) to provide a broader overview of the topic area, where applicable.

About Community Preventive Services Task Force Recommendations

The Task Force (TF), created by the U.S. Department of Health and Human Services, identifies, reviews and makes recommendations regarding population health interventions for a wide variety of health issues. The TF seeks out interventions that are scientifically proven to improve health, quality, and length of life, and also notes where for some efforts evidence correlated with progress may be lacking. TF recommendations are meant to serve as a guide for public and private local, state, and national agencies as they seek out effective interventions to improve health outcomes. Every three years, the TF prioritizes what to review. For more information on the Task Force and its processes, please visit: www.thecommunityguide.org/about/aboutTF.html.

Limitations

While CHSI was the primary source of indicator data for this report, not all indicators presented in Health Profile I were included in CHSI 2015; for those indicators, it is not possible to present peer county comparisons; state or national data were used as reference for these indicators. For some health indicators in CHSI 2015, the peer group rankings were not based on the most recent data available. In addition, Healthy People 2020 (HP2020) targets were not available for all health indicators.

For some indicators, the national data may not be directly comparable to Alexandria data due to differences in the population sampled, methodologies used in data collection, or the timing of the study.

The data presented in this report are not stratified by demographic characteristics. Stratification may show results that diverge from the overall picture presented here with regard to health behaviors and outcomes. AHD considers health equity to be an important issue and will look more in depth at differences within the diverse Alexandria community in future AHD Health Profiles.

Next Steps

AHD will produce additional Health Profiles, focusing on topic areas including:

- Physical Environment
- Social Determinants of Health
- Healthcare Access
- Health Equity

For more information on AHD Health Profiles, please email inquiries to: Alex_Epi@vdh.virginia.gov.

INTRODUCTION: How to Navigate This Document

How to Navigate This Document

The health indicators in each focus area (Health Behaviors, Morbidity, and Mortality) are organized by topic. To help the reader better understand the content presented, below is a guide to the information contained in each section in the Health Profile.

1) Introduction to the Health Indicator

Topic Area

Significance

The public health significance of each topic area is summarized. Answers the question “why is this important?”

Status in Alexandria

The status of each indicator is discussed with regard to how Alexandria compares to national estimates, and where available, to CHSI peer counties and Healthy People 2020 (HP2020) goals. Unless otherwise noted in the report, HP2020 goals were obtained from HealthyPeople.gov (www.healthypeople.gov) and peer county ranking data were obtained from the CDC Community Health Status Indicators website (<http://wwwn.cdc.gov/CommunityHealth/home>).

2) Health Indicator Data

A. Tables Presenting Data From The CHSI 2015 Report

a.

b.

- a. Data from CHSI 2015
- b. If data from CHSI 2015 were not the most current data available for an indicator at the time of this report, then those data for Alexandria are presented
- c. Cross-hatched cells indicate that data from CHSI 2015 were the most current data available

c.

B. Graphs Presenting Health Indicators Not Included In CHSI 2015 Report

d.

- d. Alexandria values are bold
- e. National and/or state estimates used as reference

e.

INTRODUCTION: How to Navigate This Document

3) Community Preventive Services Task Force Recommendations

A. TF Recommended Interventions Identified

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of the TF recommended interventions for this indicator is available in Appendix B; a summary of interventions is shown in Table X.

Table X. Community Guide Recommendations for Topic Area Indicators

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Health Indicator Name	f. N	n1	n2								i.

f. Total number (N=n1+n2) of active TF recommended interventions for each indicator with strong (n1) or sufficient (n2) evidence of effectiveness. Total does **not** include inactive reviews or interventions with insufficient evidence of effectiveness. Total may include TF interventions referenced for each indicator on www.healthindicators.gov.

g. Strength of evidence of effectiveness (**strong** or **sufficient**) is **not** directly related to the expected magnitude of benefits.

h. Categorizes recommended interventions by the primary focus of the intervention by design, setting, or involved partners. Some interventions may fit into multiple categories, but the primary focus is identified.

i. Notes other topic areas in the Health Profile where the TF recommendations may apply. Cross-hatched cells indicate that listed intervention(s) may not apply to other topic areas.

Community Guide Recommendations Table Definitions

- **Recommended intervention:** indicates the TF agrees that there is enough evidence to show an intervention has beneficial effects.
- **Inactive** interventions: Reviews not scheduled for an update, though they may be updated in the future. Findings become inactive when reviewed interventions are no longer commonly used, when other organizations begin systematically reviewing the interventions, or as a result of conflicting priorities within a topic area.
- Intervention with **insufficient evidence** of effectiveness: Does not indicate that the intervention does not work, but rather more research is needed to demonstrate effectiveness.
- Intervention with **strong evidence** of effectiveness: Meets established TF criteria for strong evidence of effectiveness regarding design, execution, number of studies, consistency, and effect size. For more information on how the TF assesses the strength of evidence, please visit: www.thecommunityguide.org/about/strengthofevidence%20assessment.pdf.
- Intervention with **sufficient evidence** of effectiveness: Meets established TF criteria for sufficient evidence of effectiveness regarding design, execution, number of studies, consistency, and effect size. For more information on how the TF assesses the strength of evidence, please visit: www.thecommunityguide.org/about/strengthofevidence%20assessment.pdf.
- **Intervention Focus**
 - **Workplace:** Implementation of intervention occurs primarily in the workplace
 - **Community:** Implementation of the intervention may include many players in the community and may be effective in different community settings
 - **Home-based/Individually-adapted:** These interventions focus on customizing programs for individuals to make changes and may include self-management of conditions. These interventions may be initiated by the healthcare system for implementation in the home or individual setting.
 - **School-based:** Implementation of intervention occurs primarily in a school setting
 - **Environmental Design:** Intervention includes making changes to the built environment
 - **Health System:** These interventions primarily involve action from health care providers, insurance companies, or other members of the healthcare system
 - **Policy:** These interventions include supporting or enacting regulations and laws

B. No TF Recommended Interventions Identified

Summary of Community Preventive Services Task Force (TF) Recommendations

j. No recommended interventions for these indicators were identified by the Task Force.

j. **No TF recommendation** does **not** indicate a lack of available public health interventions; the TF may not have reviewed that health topic or sufficient evidence to demonstrate effectiveness was not available.

INTRODUCTION: How to Navigate This Document

4) Indicator Definitions

Indicator Definitions

Health Indicator Name: Provides more information about how each health indicator was measured

5) CHSI 2015 Ranking Dashboard

Health Indicator	Data Years	Alexandria	U.S. Median	m. CHSI Peer County Comparison
Health Indicator Name	20xx-20xx	xx	yy	●
Health Indicator Name	20xx-20xx	xx	yy	◆
Health Indicator Name	20xx-20xx	xx	yy	■

m. 43 peer county values were ranked and then divided in quartiles for each indicator.

- Alexandria value for indicator is in the most favorable quartile ("Better")
- ◆ Alexandria value for indicator is in the middle two quartiles ("Moderate")
- Alexandria value for indicator is in least favorable quartile ("Worse")

Please Note: Peer county comparisons are based on data from the years specified in CHSI 2015, which may or may not be the most currently available data for each indicator. Indicators from alternate data sources are not shown in this dashboard since peer county comparisons are not available.

6) Appendix A

Lists Alexandria Peer Counties as defined in CHSI 2015.

7) Appendix B

Lists recommended TF interventions for each topic area in the Health Profile.



DEMOGRAPHICS

DEMOGRAPHICS

Overview

Alexandria is a densely populated and diverse community. Nearly one in four residents are foreign-born and approximately one in three residents speaks a language other than English at home. Alexandria's population is highly educated, has a greater proportion of singles and young couples in their later twenties and thirties, and a smaller proportion of school-aged children and seniors compared to the U.S. population. This is a reflection of Alexandria's role as a place for residents to enter the job market in the Washington, D.C. region. While median household income in Alexandria exceeds state and national averages, 8% of residents live below the Federal Poverty Level. Unless otherwise cited, information presented below are Census estimates or from the American Community Survey (ACS).^{1,2}

Population Estimates and Growth

According to 2010 Census estimates, Alexandria is the most densely populated city in Virginia, with over 8800 residents per square mile. Since 1960, population growth in the City has been relatively stable, averaging about 1% a year. Between 2000 and 2014, the City's population increased by about 16%. In 2014, the Census estimated that the population was 150,575 (Figure 1).

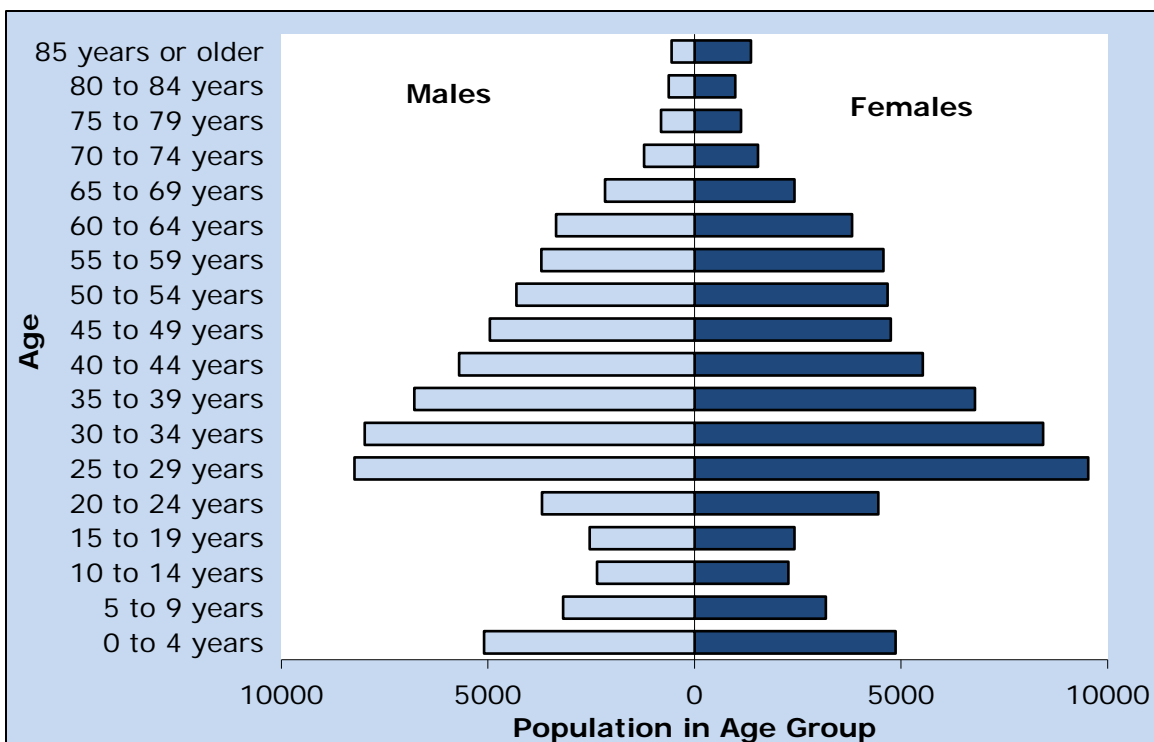
Figure 1. Alexandria Population: 2000-2014 Intercensal Estimates



Age and Sex Distribution

In 2010, the median age of residents was 35.6 years old. The 25 to 44 year old age group represented approximately 42% of the population; this proportion has remained relatively stable since 2000. Between 2000 and 2010, the 60 to 69 year old age group saw the largest rate of growth (72%); this age group represents approximately 8% of the population. Alexandria's 2010 age profile is shown in Figure 2.

Figure 2. Alexandria Population by Age and Sex 2010 Census Estimates



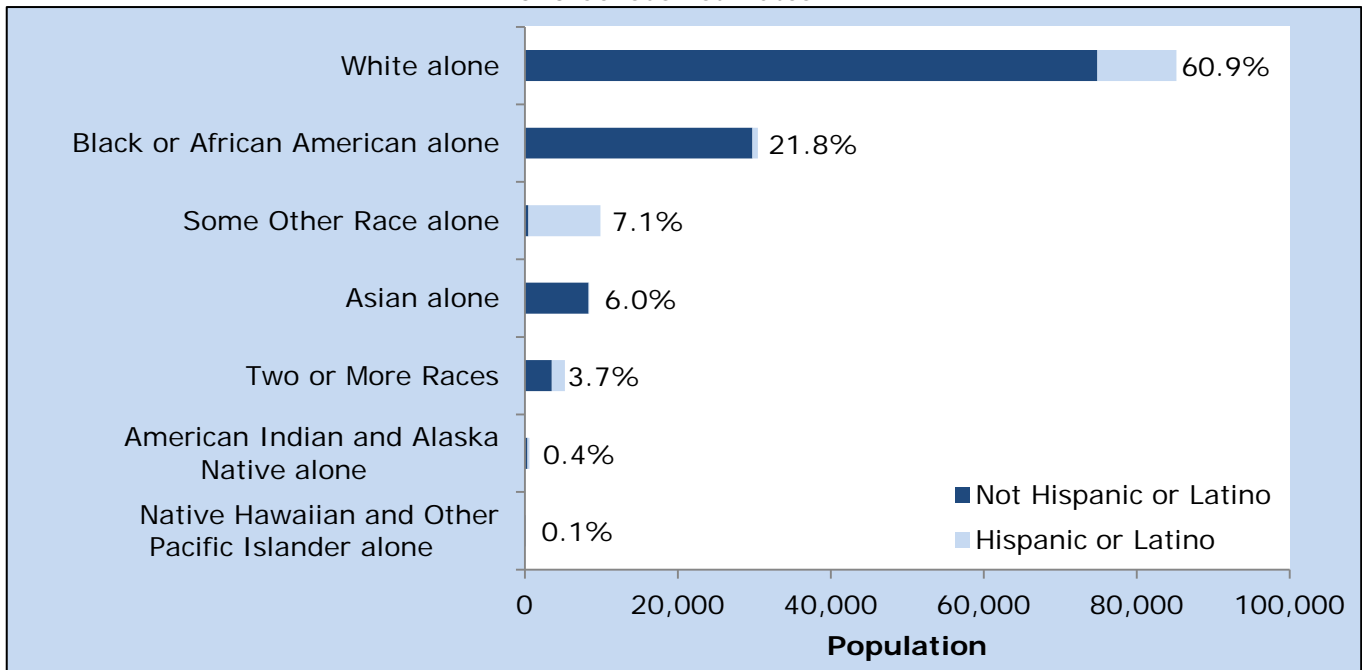
DEMOGRAPHICS

Racial and Ethnic Composition

In 2010, Alexandria's population was approximately 61% White, 22% Black or African American, and 6% Asian (Figure 3). Overall, 53.5% of the population identified as White, non-Hispanic. Since 1980, the proportion of Black or African American residents has remained relatively constant around 22%.

Overall, 16.1% of the population identified as Hispanic or Latino. Forty-six percent of the Hispanic population identified as White and 42% identified as some other race.

Figure 3. Alexandria Population by Race and Ethnicity (% of total)
2010 Census Estimates



Immigration/Language Spoken at Home

According to 2009-2013 ACS 5-year estimates, approximately 26% of the City's population is foreign-born compared to 12.9% nationally. The foreign-born population in Alexandria comes from three main regions of the world: Latin America (35.4%), Africa (29.9%), and Asia (25.1%). Currently, about one third of the Black or African American population in Alexandria is foreign-born, compared to 8.7% nationally. Approximately 54.5% of the Hispanic population is foreign-born with 49.3% reporting their origin as Central American. Only 18.3% of Hispanics in Alexandria identify as being of Mexican origin, compared to 64.5% nationally.

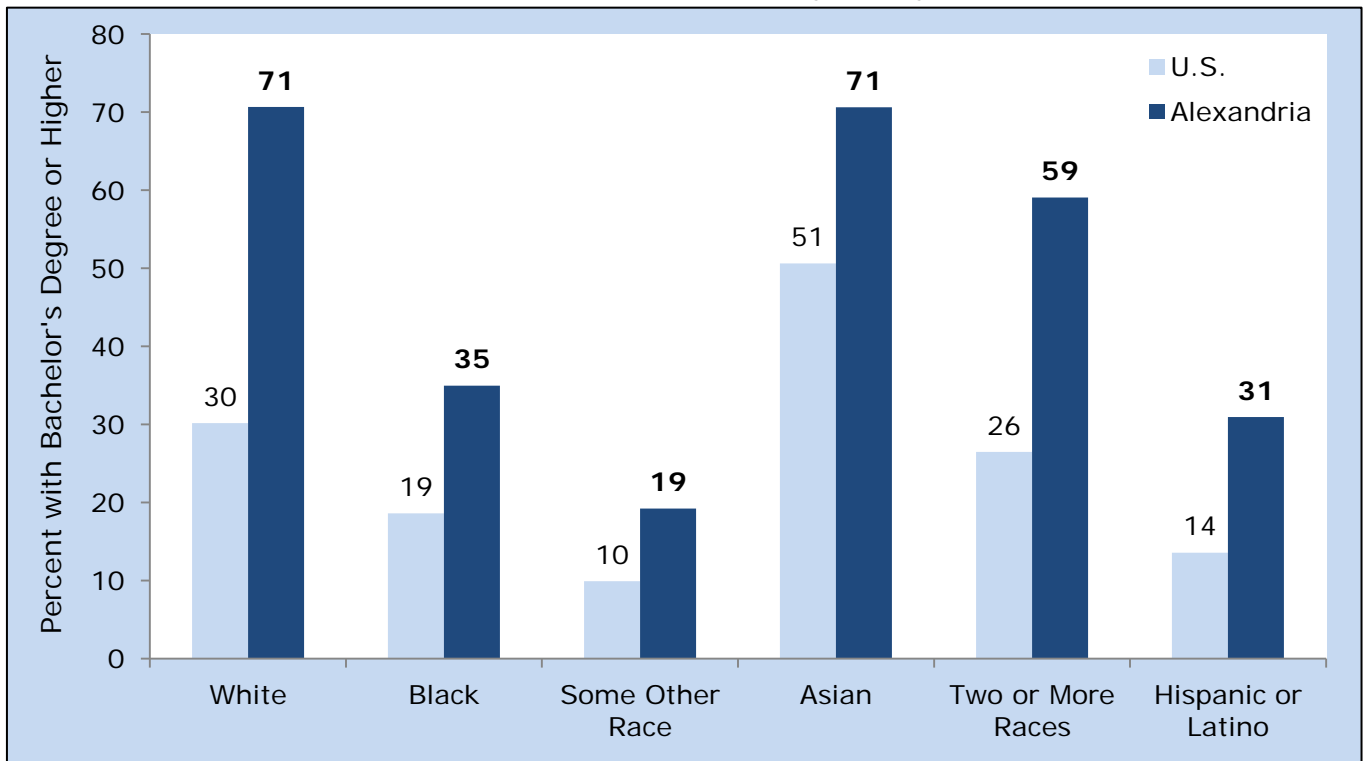
According to 2009-2013 ACS 5-year estimates, 31% of the City's population speaks a language other than English at home. After English, Spanish is the second most common language spoken at home in Alexandria. Of those that speak a language other than English at home, 62% reported speaking English "very well"; however, nearly half of those who speak Spanish at home reported speaking English less than "very well". As of September 2014, students in Alexandria City Public Schools (ACPS) were born in 125 countries and speak 87 native languages; approximately 28% of students enrolled in ACPS were receiving English Language Learners (ELL) services.³

DEMOGRAPHICS

Education

According to 2009-2013 ACS 5-year estimates, Alexandria is highly educated with 61.4% of residents 25 years of age and older having a four-year college degree or higher compared to 28.8% nationally. Figure 4 shows educational attainment by race and ethnicity among those 25 years and older. Individuals in Alexandria who are White, Two or More Races, or Hispanic or Latino have attained a Bachelor's degree or higher at more than twice the national average.

Figure 4. Percent with Bachelor's Degree or Higher among those 25 years and older by Race and Ethnicity
2013 American Community Survey



Income

According to 2009-2013 ACS 5-year estimates, the median household income in Alexandria was \$85,706. Table 1 shows differences in median household income by race, ethnicity, and household composition.

Even though the City has a high median income compared to the U.S., approximately 8.4% of residents had an income that was below the poverty level in the past 12 months. Approximately 4.6% of the population was estimated to have received Food Stamp/SNAP benefits in the past 12 months, compared to 12.4% nationally. In 2014, 60% of students enrolled in Alexandria City Public Schools were eligible for free and reduced priced meals.³

DEMOGRAPHICS

Table 1. Median Household Income by Race, Ethnicity, and Household Composition
2009-2013 ACS 5-year average

	Total	Median income (dollars)
TOTAL HOUSEHOLDS	65,369	85,706
RACE		
White	69.2%	103,741
Black or African American alone	19.6%	53,885
Asian	5.5%	80,774
Two or more races	3.0%	76,756
Some other race	2.3%	51,604
American Indian and Alaska Native	0.3%	68,088
ETHNICITY		
Hispanic or Latino origin (of any race)	11.3%	60,119
White alone, not Hispanic or Latino	61.2%	109,040
FAMILIES		
Total	30,863	107,511
With own children under 18 years	41.5%	88,523
With no own children under 18 years	58.5%	119,353
Married-couple families	75.6%	137,063
Female householder, no husband present	16.8%	48,253
Male householder, no wife present	7.6%	50,443
NONFAMILY HOUSEHOLDS		
Total	34,506	73,912
Female householder	54.6%	70,031
Living alone	45.7%	64,644
Not living alone	8.9%	104,000
Male householder	45.4%	77,483
Living alone	35.7%	71,682
Not living alone	9.7%	111,163

DEMOGRAPHICS: References

- ¹ U.S. Census Bureau. 2000, 2010 Summary Files. Available at www.census.gov. Accessibility verified July 23, 2015.
- ² U.S. Census Bureau. 2013 American Community Survey. Available at www.census.gov/programs-surveys/acs/. Accessibility verified July 23, 2015.
- ³ Alexandria City Public Schools. Fast Facts. Available at www.acps.k12.va.us/fastfact.php. Accessibility verified July 23, 2015.



HEALTH BEHAVIORS

HEALTH BEHAVIORS: Physical Activity

Physical Activity

Significance

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. More than 80% of U.S. adults do not meet the guidelines for both aerobic and muscle-strengthening activities.⁴

Status in Alexandria

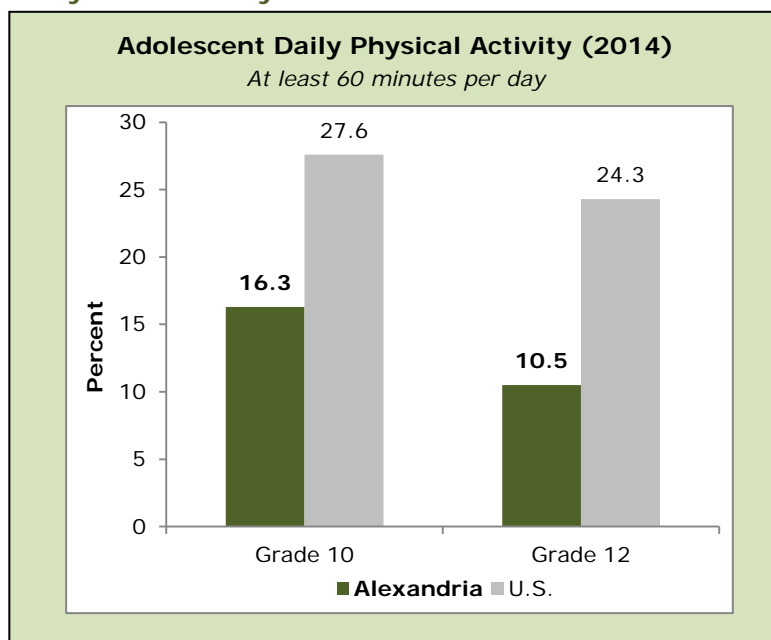
The percentage of adults in Alexandria that reported physical inactivity (no leisure-time activity) in the past month is lower than the U.S. median (Table 2). Alexandria ranks fourth out of 43 peer counties for this indicator (Range: 14.5-30.0) and currently meets the Healthy People 2020 (HP2020) goal of 32.6% of adults who engage in no leisure-time activity.

The percentage of students in Alexandria reporting at least 60 minutes of daily physical activity during the week prior to the survey was lower than national estimates for students in grades 10 and 12 (Figure 5). CHSI peer county comparisons are not available for this adolescent indicator. For adolescents in grades 9 through 12, the HP2020 goal is for 31.6% of students to meet the federal physical activity guideline of at least 60 minutes of daily physical activity; Alexandria students currently do not meet this goal in either grade 10 or 12.

Table 2: Adult Physical Activity Indicator Data⁵

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Adult Physical Inactivity (%)	2006-2012	15.2	25.9		

Figure 5. Adolescent Physical Activity Indicator Data^{6,7*}



*U.S. data from the 2013 CDC Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies and sample populations.

HEALTH BEHAVIORS: Physical Activity

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for physical activity is available in Appendix B; a summary of interventions is shown in Table 3.

Table 3. Community Guide Recommendations for Physical Activity Indicators⁸

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Adult Physical Inactivity	8	6	2	1	2	1		4			Some interventions also apply to adult obesity, adult diabetes, coronary heart disease, and stroke
Adolescent Physical Activity	1	1					1				Intervention also applies to adolescent obesity, coronary heart disease, and stroke

Indicator Definitions

Adult Physical Inactivity: Percentage of adults 18 years or older that reported no leisure-time exercise in the past month. Estimate age-adjusted to standard census age-groups.

Adolescent Physical Activity: Percentage of Alexandria City Public School students that reported a total of at least 60 minutes of physical activity per day for 7 out of the past 7 days (grades 10 and 12 only)

HEALTH BEHAVIORS: Alcohol Use

Alcohol Use

Significance

Excessive alcohol use, including underage drinking and binge drinking, can lead to increased risk of health problems such as injuries, violence, liver diseases, and cancer. Approximately 80,000 deaths in the U.S. are attributed annually to excessive drinking. Excessive drinking is the third leading lifestyle-related cause of death in the United States.⁹

Status in Alexandria

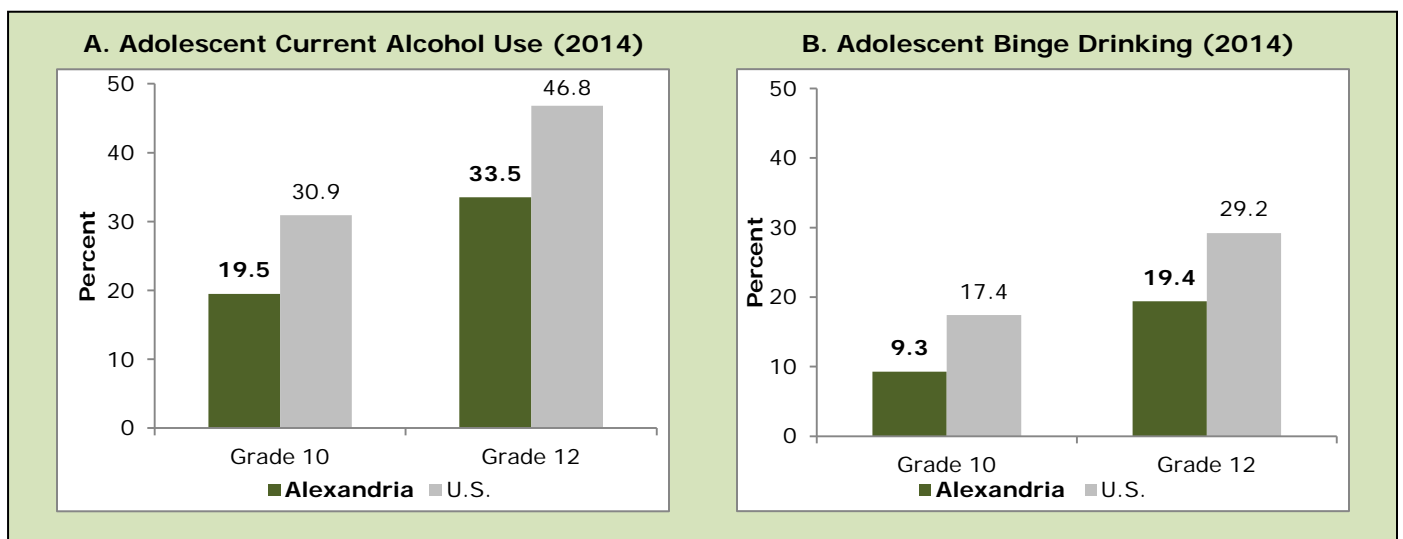
The percentage of adults that reported binge drinking in Alexandria was higher than the U.S. median (Table 4). Alexandria ranks 35th out of 43 peer counties (Range: 10.0-20.6) and currently meets the HP2020 goal of 24.4% of adults that binge drink.

The percentage of students in Alexandria reporting current alcohol use and binge drinking were lower than national estimates for students in grades 10 and 12 (Figure 6). CHSI peer county comparisons are not available for these adolescent indicators. An HP2020 goal has not been established for adolescent current alcohol use. The HP2020 goal for adolescents aged 12 to 17 years old that binge drink is 8.6%; students in Alexandria currently do not meet that goal in either grade 10 or 12.

Table 4. Adult Alcohol Use Indicator Data⁵

Health Indicator	Data Years	CHSI 2015 Values		Updated Value (if available)	
		Alexandria	U.S. Median	Data Years	Alexandria
Adult Binge Drinking (%)	2006-2012	18.5	16.3		

Figure 6. Adolescent Alcohol Use Indicator Data^{6,7*}



*U.S. data from the 2013 CDC Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies, and sample populations.

HEALTH BEHAVIORS: Alcohol Use

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for alcohol use is available in Appendix B; a summary of interventions is shown in Table 5.

Table 5. Community Guide Recommendations for Alcohol Use Indicators⁸

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Adult Binge Drinking	8	5	3	1	2					5	Workplace intervention also applies to smoking, coronary heart disease, and stroke
Adolescent Current Alcohol Use											
Adolescent Binge Drinking	1		1		1						

Indicator Definitions

Adult Binge Drinking: Percentage of adults aged 18 years or older that reported binge drinking on one or more occasions during the previous 30 days. Binge drinking is defined as drinking 5 or more alcoholic drinks (men) or 4 or more drinks (women). Estimate age-adjusted to standard census age-groups.

Adolescent Current Alcohol Use: Percentage of Alexandria City Public School students that reported having at least one alcoholic drink in the past 30 days (grades 10 and 12 only)

Adolescent Binge Drinking: Percentage of Alexandria City Public School students that reported drinking 5 or more alcoholic drinks in a row on at least one day in the past month (grades 10 and 12 only)

HEALTH BEHAVIORS: Smoking

Smoking

Significance

Tobacco use is the single most preventable cause of death and disease in the United States. Each year, approximately 443,000 Americans die from tobacco-related illnesses. For every person who dies from tobacco use, 20 more people suffer with at least one serious tobacco-related illness.⁴

Status in Alexandria

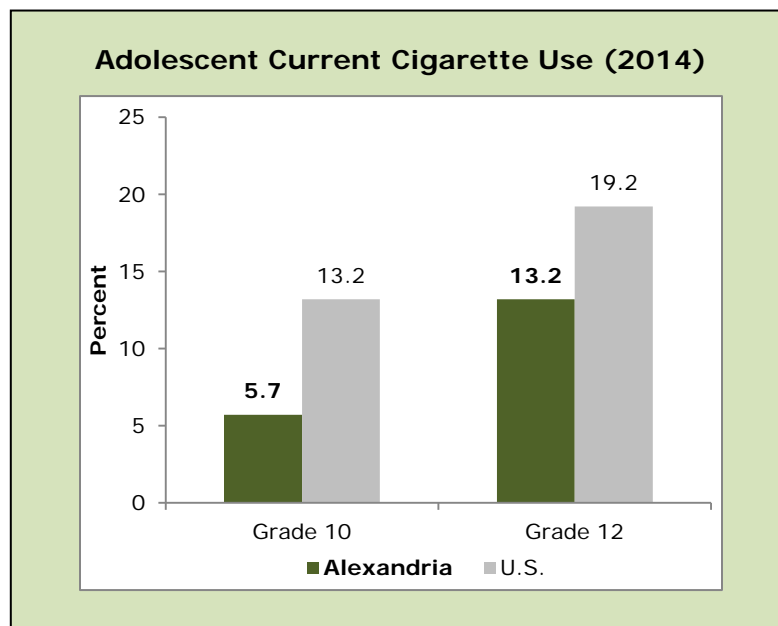
The percentage of adults that smoke in Alexandria is lower than the U.S. median (Table 6). Alexandria ranks first out of 43 peer counties (Range: 9.1-24.0) and currently meets the HP2020 goal of 12.0% of adults who are current cigarette smokers.

The percentage of students that smoke in Alexandria is lower than national estimates for students in both grades 10 and 12 (Figure 7). CHSI peer county comparisons are not available for this adolescent smoking indicator. Alexandria students in both grades 10 and 12 currently meet the HP2020 goal of 16.0% of adolescents in grades 9 through 12 who smoke cigarettes.

Table 6. Adult Current Cigarette Use Indicator Data⁵

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Adult Smoking (%)	2006-2012	9.1	21.7		

Figure 7: Adolescent Current Cigarette Use Indicator Data^{6,7*}



*U.S. data from the 2013 CDC Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies and sample populations.

HEALTH BEHAVIORS: Smoking

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for smoking is available in Appendix B; a summary of interventions is shown in Table 7.

Table 7. Community Guide Recommendations for Smoking Indicators⁸

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Adult Smoking	9	8	1	2	4				1	2	Some interventions also apply to adolescent smoking, chronic lower respiratory disease, and lung cancer. Workplace intervention also applies to adult binge drinking, coronary heart disease, and stroke.
Adolescent Smoking	1		1		1						Intervention also applies to lung cancer

Indicator Definitions

Adult Smoking: Percentage of adults 18 years or older that reported smoking cigarettes on all or some days at time of survey. Estimate age-adjusted to standard census age-groups.

Adolescent Current Tobacco Use: Percentage of Alexandria City Public School students that reported smoking cigarettes on at least one day in the past 30 days (grades 10 and 12 only)

HEALTH BEHAVIORS: Teen Pregnancy and Births

Teen Pregnancy and Births

Significance

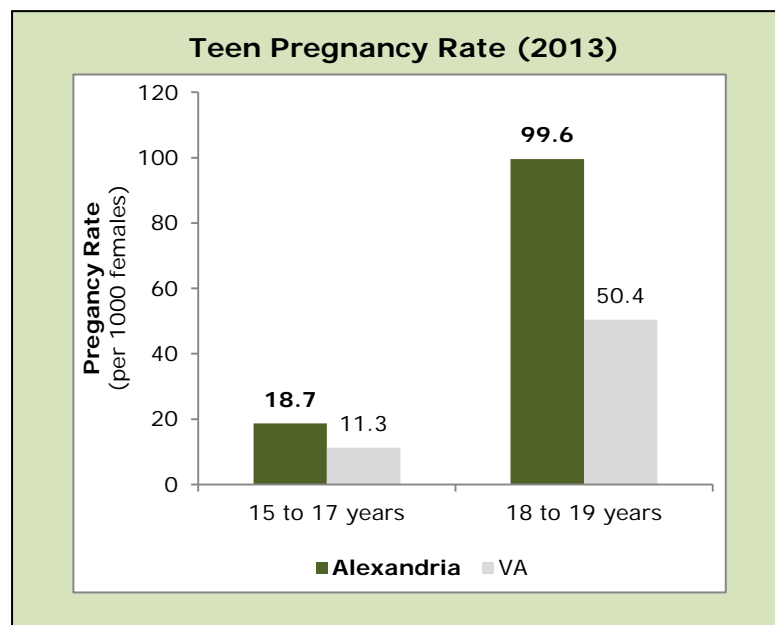
Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children. Pregnancy and birth are significant contributors to high school dropout rates among girls. In the United States about 50% of teen mothers receive a high school diploma by 22 years of age, versus approximately 90% of women who had not given birth during adolescence. The children of teenage mothers are more likely to have lower school achievement and drop out of high school; have more health problems; be incarcerated at some time during adolescence; give birth as a teenager; and face unemployment as a young adult.¹⁰

Status in Alexandria

The teen pregnancy rate is higher in Alexandria compared to Virginia for females aged 15 to 17 years and 18 to 19 years (Figure 8). CHSI peer county comparisons and national estimates are not available for this indicator. Alexandria currently meets the HP2020 goal of 36.2 pregnancies per 1000 females aged 15 to 17 years and 105.9 pregnancies per 1000 females aged 18 to 19 years.

The overall teen birth rate in Alexandria is similar to the U.S. median (Table 8). Alexandria ranks 23rd out of 43 peer counties (Range: 15.4-65.0). An HP2020 goal has not been established for this indicator.

Figure 8. Teen Pregnancy Indicator Data¹¹



HEALTH BEHAVIORS: Teen Pregnancy and Births

Table 8. Teen Birth Indicator Data (birth rate per 1000 females)¹²

Health Indicator	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Teen Births (15 to 19 years)	2006-2012	41.2	42.1	2007-2013	38.1
Teen Births (15 to 17 years)	2006-2012	21.4	20.3	2007-2013	19.1
Teen Births (18 to 19 years)	2006-2012	74.3	66	2007-2013	69.9

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for teen pregnancies and births is available in Appendix B; a summary of interventions is shown in Table 9.

Table 9. Community Guide Recommendations for Teen Pregnancy and Birth Indicators⁸

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Teen Pregnancy	2		2		2						Interventions also apply to gonorrhea, chlamydia, syphilis, and HIV
Teen Births											

Indicator Definitions

Teen Pregnancy Rate: The total reported number of births, induced terminations of pregnancy, and fetal deaths that occur per 1000 females, by age group

Teen Birth Rate: The total number of reported births that occurred per 1000 females aged 15 to 19 years

HEALTH BEHAVIORS: CHSI 2015 Ranking Dashboard

The following dashboard displays indicator data from CHSI 2015 and a symbol indicating how Alexandria ranks among the 43 peer counties. Please note that peer county comparisons are based on data from the years specified in CHSI 2015, which may or may not be the most currently available data for each indicator. Indicators from alternate data sources are not shown in this dashboard since peer county comparisons are not available.

Table 10. CHSI 2015 Indicators and Peer Rankings: Health Behaviors ¹³

Health Indicator	Data Years	Alexandria	U.S. Median	CHSI Peer County Comparison
Adult Physical Inactivity (%)	2006-2012	15.2	25.9	●
Adult Binge Drinking (%)	2006-2012	18.5	16.3	■
Adult Smoking (%)	2006-2012	9.1	21.7	●
Teen Births (birth rate per 1000 females)	2006-2012	41.2	42.1	◆

HEALTH BEHAVIORS: References

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MORBIDITY

MORBIDITY: Self-Assessed Health Status

Self-Assessed Health Status

Significance

Health-related quality of life measures of perceived physical and mental health and function have become an important component of health surveillance and are generally considered valid indicators of service needs and intervention outcomes. Self-assessed health status also proved to be a more powerful predictor of mortality and morbidity than many objective measures of health.¹⁴

Status in Alexandria

The percentage of adults in Alexandria reporting fair or poor health is lower than the U.S. median (Table 11). Alexandria ranks third among 43 CHSI peer counties for this indicator (Range: 8.9, 19.5). Physically and mentally unhealthy days were not included as primary indicators in CHSI 2015 so peer county comparisons are not available. Healthy People 2020 (HP2020) goals have not been established for these indicators.

Table 11. Overall Health Status Indicator Data¹⁵

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Adult Overall Health Status (%)	2006-2012	10.4	16.5		
Adult Physically Unhealthy Days	2006-2012	2.6	3.7		
Adult Mentally Unhealthy Days	2006-2012	2.1	3.5		

Summary of Community Preventive Services Task Force (TF) Recommendations

No recommended interventions for this indicator were identified by the Task Force.¹⁶

Indicator Definitions

Adult Overall Health Status: Percentage of adults that report fair or poor health.

Adult Physically Unhealthy Days: Average number of reported physically unhealthy days per month among adults 18 years of age and over. Physically unhealthy days include days when a respondent's physical health, including illness and injury, was not good.

Adult Mentally Unhealthy Days: Average number of reported mentally unhealthy days per month among adults 18 years and over. Mentally unhealthy days include days when a respondent's mental health, including stress, depression, and problems with emotions, was not good.

MORBIDITY: Depression

Depression

Significance

Depression is characterized by depressed or sad mood, diminished interest in activities which used to be pleasurable, weight gain or loss, psychomotor agitation or retardation, fatigue, inappropriate guilt, difficulties concentrating, as well as recurrent thoughts of death. Depression is more than a “bad day”; diagnostic criteria established by the American Psychiatric Association dictate that five or more of the above symptoms must be present for a continuous period of at least two weeks. As an illness, depression falls within the spectrum of affective disorders.¹⁷

Status in Alexandria

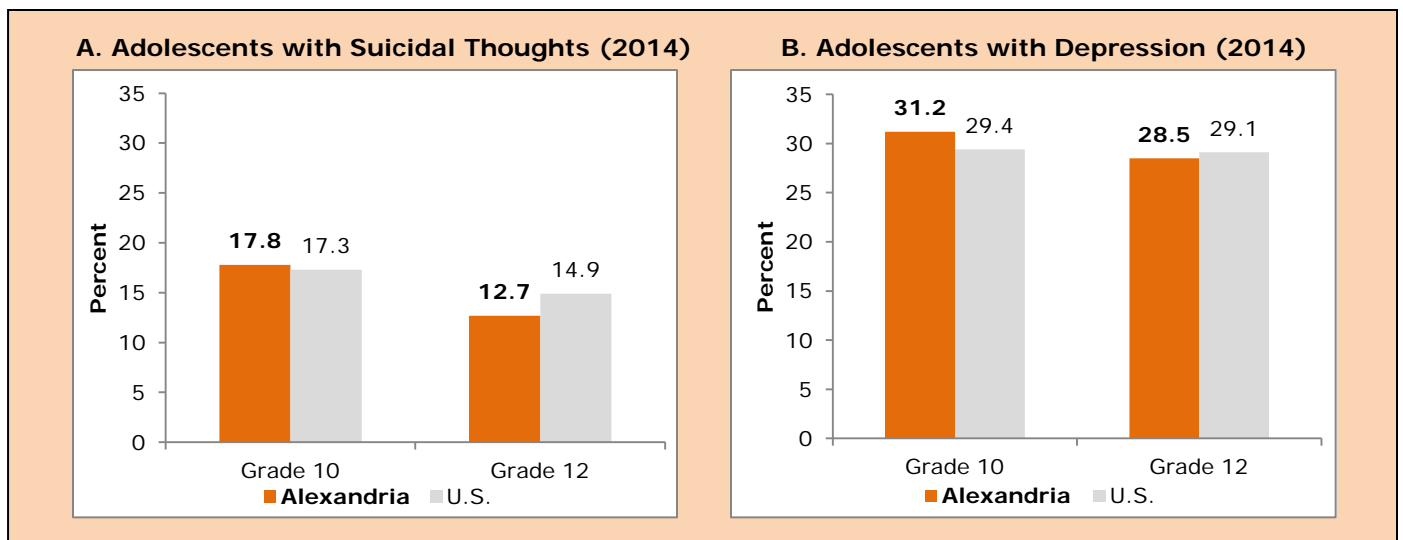
The percentage of older adults living with depression in Alexandria is lower than the U.S. median (Table 12). Alexandria ranks fifth among 43 CHSI peer counties for this indicator (Range: 8.6, 17.0). An HP2020 goal has not been established for this indicator.

Compared to national estimates, the percentage of students in Alexandria reporting suicidal thoughts during the past 12 months was similar for students in grade 10 and lower for students in grade 12 (Figure 9). Compared to national estimates, the percentage of students in Alexandria experiencing depression during the past 12 months was higher for students in grade 10 and similar for students in grade 12 (Figure 9). CHSI peer county comparisons are not available and HP2020 goals have not been established for these adolescent depression indicators.

Table 12. Older Adult Depression Indicator Data¹⁸

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Older Adult Depression (%)	2012	10.3	12.4		

Figure 9. Adolescent Depression Indicator Data^{19,20*}



*U.S. data from the 2013 CDC Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies, and sample populations.

MORBIDITY: Depression

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for depression is available in Appendix B; a summary of interventions is shown in Table 13.

Table 13. Community Guide Recommendations for Depression Indicators¹⁶

Health Indicator	Summary of TF Recommendations			Intervention Focus						Notes	
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System		Policy
Older Adult Depression	4	2	2			1			2	1	Interventions also apply to suicide
Adolescent Suicidal Thoughts											
Adolescent Depression											

Indicator Definitions

Older Adult Depression: Prevalence of depression among Medicare fee-for-service Beneficiaries (%)

Adolescent Suicidal Thoughts: Percentage of Alexandria City Public School students who seriously considered attempting suicide during the prior 12 months (grades 10 and 12 only)

Adolescent Depression: Percentage of Alexandria City Public School students that felt so sad or hopeless almost every day for at least 2 weeks in a row during the prior 12 months that they stopped doing usual activities (grades 10 and 12 only)

MORBIDITY: Dementia

Alzheimer's Disease/Dementia

Significance

Dementia is an umbrella term for a group of cognitive disorders typically characterized by memory impairment, as well as marked difficulty in the domains of language, motor activity, object recognition, and disturbance of executive function – the ability to plan, organize, and abstract. Generally speaking, dementia is an illness of older adults, which suggests that as successive cohorts of our population live longer, the urgency to better address dementia increases. Alzheimer's disease is perhaps the most common form of dementia, although several others exist. As many as five million Americans have Alzheimer's disease. Younger people may get Alzheimer's disease, but it is much less common than in older adults. The likelihood of developing Alzheimer's doubles about every five years after age 65.²¹

Status in Alexandria

The percentage of older adults living with Alzheimer's Disease/Dementia in Alexandria is higher than the U.S. median (Table 14). Alexandria ranks 14th among 43 CHSI peer counties for this indicator (Range: 7.9, 15.5). An HP2020 goal has not been established for this indicator.

Table 14. Alzheimer's Disease/Dementia Indicator Data¹⁸

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Alzheimer's Disease/Dementia (%)	2012	11.3	10.3		

Summary of Community Preventive Services Task Force (TF) Recommendations

No recommended interventions for this indicator were identified by the Task Force.¹⁶

Indicator Definitions

Alzheimer's Disease/Dementia: Prevalence of Alzheimer's Disease and Dementia among Medicare fee-for-service Beneficiaries (%)

MORBIDITY: Asthma

Asthma

Significance

Currently in the United States, more than 23 million people have asthma. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Annual health care expenditures for asthma alone are estimated at \$20.7 billion.²²

Status in Alexandria

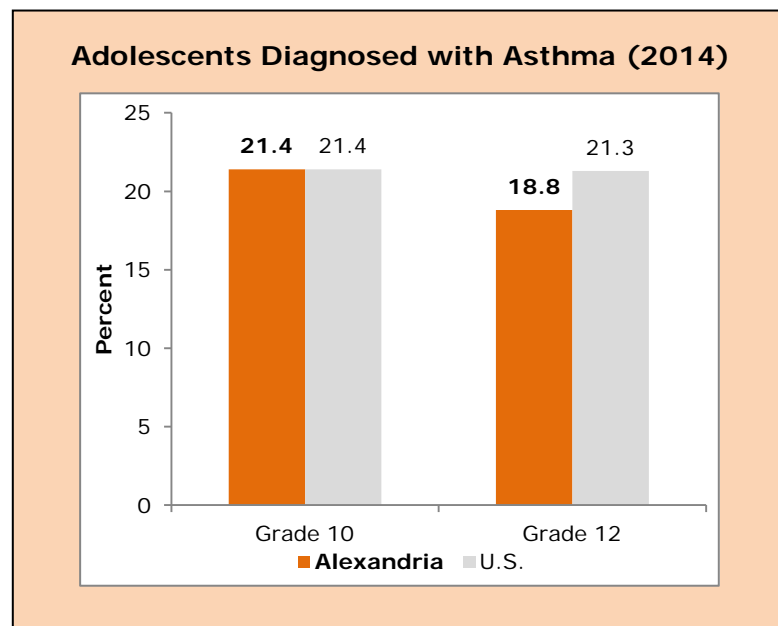
The percentage of older adults living with asthma in Alexandria is higher than the U.S. median (Table 15). Alexandria ranks 26th among 43 CHSI peer counties for this indicator (Range: 3.0, 5.6). An HP2020 goal has not been established for this indicator.

The percentage of students in Alexandria reporting that they have ever been told they have asthma is similar to national estimates for students in grade 10 and lower than national estimates for students in grade 12 (Figure 10). CHSI peer county comparisons are not available and an HP2020 goal has not been established for this adolescent asthma indicator.

Table 15. Asthma Indicator Data¹⁸

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Older Adult Asthma (%)	2012	4.7	3.6		

Figure 10. Adolescent Asthma Indicator Data^{19,20*}



*U.S. data from the CDC 2013 Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies, and sample populations.

MORBIDITY: Asthma

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of the TF recommended interventions for asthma is available in Appendix B; a summary of interventions is shown in Table 16.

Table 16. Community Guide Recommendations for Asthma Indicators¹⁶

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Older Adult Asthma											
Adolescent Asthma	1	1				1					Intervention also applies to chronic lower respiratory disease

Indicator Definitions

Older Adult Asthma: Prevalence of Asthma among Medicare fee-for-service Beneficiaries (%)

Adolescent Asthma: Percentage of Alexandria City Public School students that have ever been told they have asthma by a doctor or nurse (grades 10 and 12 only)

MORBIDITY: Obesity and Diabetes

Obesity and Diabetes

Significance

Obesity:

Obesity is common, serious, and costly. In 2009-2010, more than one-third of U.S. adults (35.7%) were obese. The estimated annual medical cost of obesity in the U.S. was \$147 billion in 2008 U.S. dollars; the medical costs for people who are obese were \$1,429 higher than those individuals of normal weight.²³

Diabetes:

Diabetes affects an estimated 23.6 million people in the United States and is the seventh leading cause of death. Diabetes lowers life expectancy by up to 15 years and increases the risk of heart disease by two to four times. Diabetes is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. In addition to these human costs, the estimated total financial cost of diabetes in the United States in 2007 was \$174 billion, which includes the costs of medical care, disability, and premature death.²²



Status in Alexandria

The percentage of adults who are obese in Alexandria is lower than the U.S. median (Table 17). Alexandria ranks second among 43 CHSI peer counties for this indicator (Range: 13.1, 32.1) and currently meets the HP2020 target of 30.5% of adults who are obese.

The percentage of adults living with diagnosed diabetes in Alexandria is lower than the U.S. median (Table 17). Alexandria ranks first among 43 CHSI peer counties for this indicator (Range: 4.3, 10.9). An HP 2020 goal has not been established for this indicator.

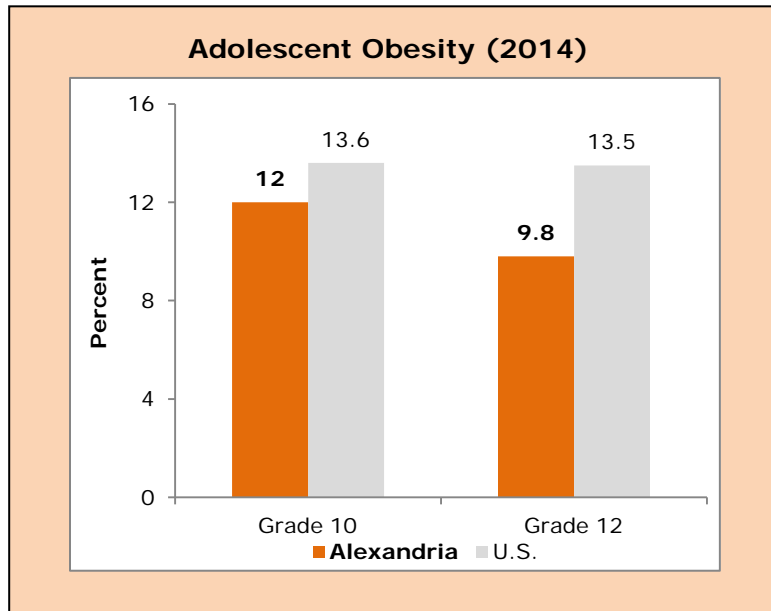
The percentage of students in Alexandria reporting that they are obese is lower than national estimates for students in both grades 10 and 12 (Figure 11). CHSI peer county comparisons are not available for this adolescent obesity indicator. The HP2020 goal is for 16.1% of adolescents aged 12 to 19 years to be considered obese; Alexandria currently meets this goal among students in grades 10 and 12.

Table 17. Adult Obesity and Diabetes Indicator Data^{15,24}

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Adult Obesity (%)	2006-2012	15.2	30.4		
Adult Diabetes (%)	2005-2011	4.3	8.1	2006-2012	4.4

MORBIDITY: Obesity and Diabetes

Figure 11. Adolescent Obesity Indicator Data^{19,20*}



Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for obesity and diabetes is available in Appendix B; a summary of interventions is shown in Table 18.

Table 18. Community Guide Recommendations for Obesity and Diabetes Indicators¹⁶

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Adult Obesity	9	6	3	1	2	2		4			Some interventions for obesity and diabetes also apply to physical activity, coronary heart disease, and stroke
Adult Diabetes	6	4	2	1	2	2		1			
Adolescent Obesity	1	1				1					

Indicator Definitions

Adult Obesity: Percentage of adults 20 years and over that report a body mass index (BMI) ≥ 30

Diabetes: Percentage of adults that report having been diagnosed as having diabetes

Adolescent Obesity: Percentage of Alexandria City Public School students that report BMI ≥ 30 . BMI was calculated based on self-reported age, height, and weight (grades 10 and 12 only)

*U.S. data from the 2013 CDC Youth Risk Behavior Surveillance Report are provided as a point of reference. Direct comparisons between Alexandria and national estimates are limited by differences in the survey year, methodologies, and sample populations.

MORBIDITY: Maternal and Child Health

Maternal and Child Health

Significance

Preterm Births:

In 2012, preterm birth affected more than 450,000 babies—that is 1 of every 9 infants born in the United States. Preterm birth is the birth of an infant before 37 weeks of pregnancy. Preterm-related causes of death together accounted for 35% of all infant deaths in 2010, more than any other single cause. Preterm birth is also a leading cause of long-term neurological disabilities in children. Preterm birth costs the U.S. health care system more than \$26 billion in 2005.²⁵

Low Birth Weight:

Low birth weight (less than 2500 grams) is the single most important factor affecting neonatal mortality and a significant determinant of post neonatal mortality. Low birth weight infants who survive are at increased risk for health problems ranging from neurodevelopmental disabilities to respiratory disorders.²⁶

Status in Alexandria

The percentage of preterm births in Alexandria is lower than the U.S. median (Table 19). Alexandria ranks 17th among 43 CHSI peer counties for this indicator (Range: 9.1, 16.2) and currently meets the HP2020 target of 11.4% of live births that are preterm.

The percentage of low birth weight deliveries in Alexandria is lower than the U.S. median (Table 19). Low birth weight was not included as a primary indicator in CHSI 2015 so peer county comparisons are not available for this indicator. Alexandria currently meets the HP2020 target of 7.8% of live births that are low birth weight.

Table 19. Maternal and Child Health Indicator Data²⁷

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Preterm Births (%)	2006-2012	11.4	12.1	2007-2013	11.3
Low Birth Weight (%)	2006-2012	7.4	7.9	2007-2013	7.5

Summary of Community Preventive Services Task Force (TF) Recommendations

No recommended interventions for these indicators were identified by the Task Force.¹⁶

Indicator Definitions

Preterm Births: Percent of live births that are preterm (<37 weeks of gestation)

Low Birth Weight: Percent of live births that are low birth weight

MORBIDITY: Sexually Transmitted Infections

Sexually Transmitted Infections

Significance

Approximately 19 million new sexually transmitted infections (STIs) occur each year—almost half of them among young people ages 15 to 24. The cost of STIs to the U.S. health care system is estimated to be as much as \$15.9 billion annually. Untreated STIs can lead to serious long-term health consequences, especially for adolescent girls and young women. CDC estimates that undiagnosed and untreated STIs cause at least 24,000 women in the United States each year to become infertile.²²

Human immunodeficiency virus (HIV):

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 out of 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.²²

Status in Alexandria

The rates of STIs in Alexandria are higher than the respective U.S. medians for each STI (Table 20). Among 43 CHSI peer counties, Alexandria ranks fifth for gonorrhea (Range: 32.3, 363.3), 36th for syphilis (Range: 0.8, 61.0), and 40th for HIV (Range: 204.0, 1976.6). Chlamydia was not included as a primary indicator in CHSI 2015 so peer county comparisons are not available for this indicator. HP2020 goals have not been established for these indicators.

Table 20. Sexually Transmitted Infections Indicator Data (rate per 100,000)²⁸

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Gonorrhea	2012	65.8	30.5	2013	80.7
Chlamydia	2012	337.5	280.6	2013	371.9
Syphilis	2012	13.2	0	2013	12.3
HIV Prevalence	2011	1082.3	105.5	2012	1078.7

MORBIDITY: Sexually Transmitted Infections

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for sexually transmitted infections is available in Appendix B; a summary of interventions is shown in Table 21.

Table 21. Community Guide Recommendations for Sexually Transmitted Infections Indicators¹⁶

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Strong Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Gonorrhea	2		2		2						Interventions apply to each STI and teen pregnancy
Chlamydia	2		2		2						
Syphilis	2		2		2						
HIV	4	1	3		3	1					Some interventions also apply to gonorrhea, chlamydia, syphilis, and teen pregnancy

Indicator Definitions

Gonorrhea: Gonorrhea rate per 100,000

Chlamydia: Chlamydia rate per 100,000

Syphilis: Primary and Secondary Syphilis rate per 100,000

HIV Prevalence: Persons living with diagnosed HIV per 100,000

MORBIDITY: CHSI 2015 Ranking Dashboard

The following dashboard displays indicator data from the CHSI 2015 report and a symbol indicating how Alexandria ranks out of 43 peer counties. Please note that peer county comparisons are based on data from the years specified in the CHSI 2015 report, which may or may not be the most currently available data for each indicator. Indicators from alternate data sources are not shown in this dashboard since peer county comparisons are not available.

Table 22. CHSI 2015 Indicators and Peer Rankings: Morbidity²⁹

Health Indicator	Data Years	Alexandria	U.S. Median	CHSI Peer County Comparison
Adult Overall Health Status (%)	2006-2012	10.4	16.5	●
Adult Physically Unhealthy Days	2006-2012	2.6	3.7	●
Adult Mentally Unhealthy Days	2006-2012	2.1	3.5	●
Older Adult Depression (%)	2012	10.3	12.4	●
Alzheimer's Disease/Dementia (%)	2012	11.3	10.3	◆
Older Adult Asthma (%)	2012	4.7	3.6	◆
Adult Obesity (%)	2006-2012	15.2	30.4	●
Adult Diabetes (%)	2005-2011	4.3	8.1	●
Preterm Births (%)	2006-2012	11.4	12.1	◆
Low Birth Weight (%)	2006-2012	7.4	7.9	◆
Gonorrhea (rate per 100,000)	2012	65.8	30.5	●
Chlamydia (rate per 100,000)	2012	337.5	280.6	●
Syphilis (rate per 100,000)	2012	13.2	0	■
HIV Prevalence (rate per 100,000)	2011	1082.3	105.5	■

MORBIDITY: References

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MORTALITY

MORTALITY: Leading Causes of Death

Leading Causes of Death in Alexandria

Significance

Information on mortality patterns is key to understanding changes in the health and well-being of a population. In the U.S. the top 10 causes of death account for about 75% of all deaths annually.³⁰ Below are the leading causes of death, in order, in Alexandria from 2005 to 2011 (average rate).

Cancer:

As it has been for many decades, cancer continues to be the second leading cause of death in the U.S., accounting for more than a fifth of all deaths in 2010. Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half are expected to be alive in five years.³⁰

Coronary Heart Disease and Stroke:

Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in health care expenditures and related expenses in 2010 alone.³¹

Septicemia:

Sepsis is the most common cause of death among critically ill patients in non-coronary intensive care units (ICU). It is estimated that the annual cost of hospital care for patients with septicemia is \$14 billion in the U.S. Sepsis may also worsen pre-existing chronic conditions.³²

Chronic Lower Respiratory Disease (CLRD):

From 2007-2009, 11.8 million adults were diagnosed with chronic obstructive pulmonary disease (COPD), the primary component of CLRD mortality. Previous research found that approximately equal numbers to those diagnosed with COPD had not yet been diagnosed.³⁰

Unintentional Injury:

Unintentional injuries are the leading cause of death for Americans aged 1 to 44 years, as well as a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status.³⁰

Chronic Kidney Disease (CKD):

More than 20 million people in the U.S. aged 20 years or older have CKD. CKD is an important risk factor for cardiovascular disease, including heart attacks, heart failure, heart rhythm disturbances, and strokes. CKD and end stage renal disease (ESRD) are very costly to treat. Nearly 25% of the Medicare budget is used to treat people with CKD and ESRD.³⁰

Alzheimer's Disease:

Up to 5.1 million Americans aged 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.³⁰

Influenza and Pneumonia:

Acute respiratory infections, including pneumonia and influenza account for approximately 56,000 deaths annually in the U.S. Respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the U.S. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year.³¹

Diabetes:

Diabetes affects an estimated 23.6 million people in the U.S. Diabetes lowers life expectancy by up to 15 years, increases the risk of heart disease by 2 to 4 times, and is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness. The estimated cost of diabetes in the U.S. in 2007 was \$174 billion, which includes the costs of medical care, disability, and premature death.³³

Suicide:

Mental health disorders are the leading cause of disability in the U.S. and Canada, accounting for 25% of all years of life lost to disability and premature mortality. Suicide accounts for the deaths of approximately 30,000 Americans each year.³¹

MORTALITY: Leading Causes of Death



Status in Alexandria

While Alexandria's top causes of death are similar to national trends, mortality due to several of the leading causes of death in the U.S. occurs at lower rates in Alexandria compared to the U.S. median; exceptions include mortality due to chronic kidney disease and septicemia (Table 23).

Alexandria ranks well among the 43 CHSI peer counties for the following indicators (rank): cancer (fifth), coronary heart disease (fifth), stroke (third), chronic lower respiratory disease (first), unintentional injury (first), Alzheimer's disease (sixth), and diabetes (fourth). Alexandria ranks 30th out of 43 CHSI peer counties for mortality due to chronic kidney disease. CHSI peer rankings are not available for septicemia, influenza and pneumonia, and suicide.

The following mortality indicators meet Healthy People 2020 (HP2020) goals (*HP2020 goal in deaths per 100,000*): cancer (161.4), coronary heart disease (103.4), stroke (34.8), and unintentional injury (36.0). HP2020 goals have not been established for the other leading cause of death indicators shown below.

Table 23. Leading Causes of Death Indicator Data (age-adjusted deaths per 100,000)^{34§}

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Cancer	2005-2011	152.7	185	2007-2013	143.1
Coronary Heart Disease	2005-2011	84.2	126.7	2007-2013	77.4
Stroke	2005-2011	31.4	46.6	2007-2013	29.3
<i>Septicemia*</i>	2005-2011	25.8	11*	2007-2013	22.2
Chronic Lower Respiratory Disease (CLRD)	2005-2011	23.5	49.6	2007-2013	23.2
Unintentional Injury (including motor vehicle)	2005-2011	23.2	50.8	2007-2013	22.1
Chronic Kidney Disease	2005-2011	18	17.5	2007-2013	17.2
Alzheimer's Disease	2008-2012	16.4	27.3	2009-2013	14.4
<i>Influenza and Pneumonia*</i>	2005-2011	15.3	17.3*	2007-2013	15
Diabetes	2005-2011	14.3	24.7	2007-2013	16.3
<i>Suicide*</i>	2005-2011	8.1	11.6*	2007-2013	8.7

*Since these indicators were not included in the CHSI peer rankings, the U.S. median was not readily available; the U.S. point estimate is shown as an alternate reference to the U.S. median. These indicators were included so that the leading causes of death are represented. All indicator estimates are from the National Vital Statistics System.

§ Mortality rates are sorted by Alexandria mortality rates (2005-2011)

MORTALITY: Leading Causes of Death

Leading Cause of Death

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for leading cause of death indicators is available in Appendix B; a summary of interventions is shown in Table 24.

Table 24. Community Guide Recommendations for Leading Cause of Death Indicators³⁵

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Cancer											
Coronary Heart Disease	17	12	5	2	4	3	1	4	3		Some interventions also apply to physical activity, adult obesity, and adult diabetes
Stroke	17	12	5	2	4	3	1	4	3		
Septicemia											
Chronic Lower Respiratory Disease (CLRD)	3	3			1	1				1	Some interventions also apply to adolescent asthma, adult smoking, and lung cancer
Unintentional Injury (including motor vehicle)											
Chronic Kidney Disease											
Alzheimer's Disease											
Influenza and Pneumonia	15	13	2	2	1		1		10	1	
Diabetes	3	2	1			1			2		
Suicide	5	3	2						4	1	Some interventions also apply to older adult depression

Indicator Definitions

Leading Cause of Death Mortality Rates: Deaths due to each cause per 100,000 persons, age-adjusted to Census population estimates

MORTALITY: Cancer

Top Cancer Sites

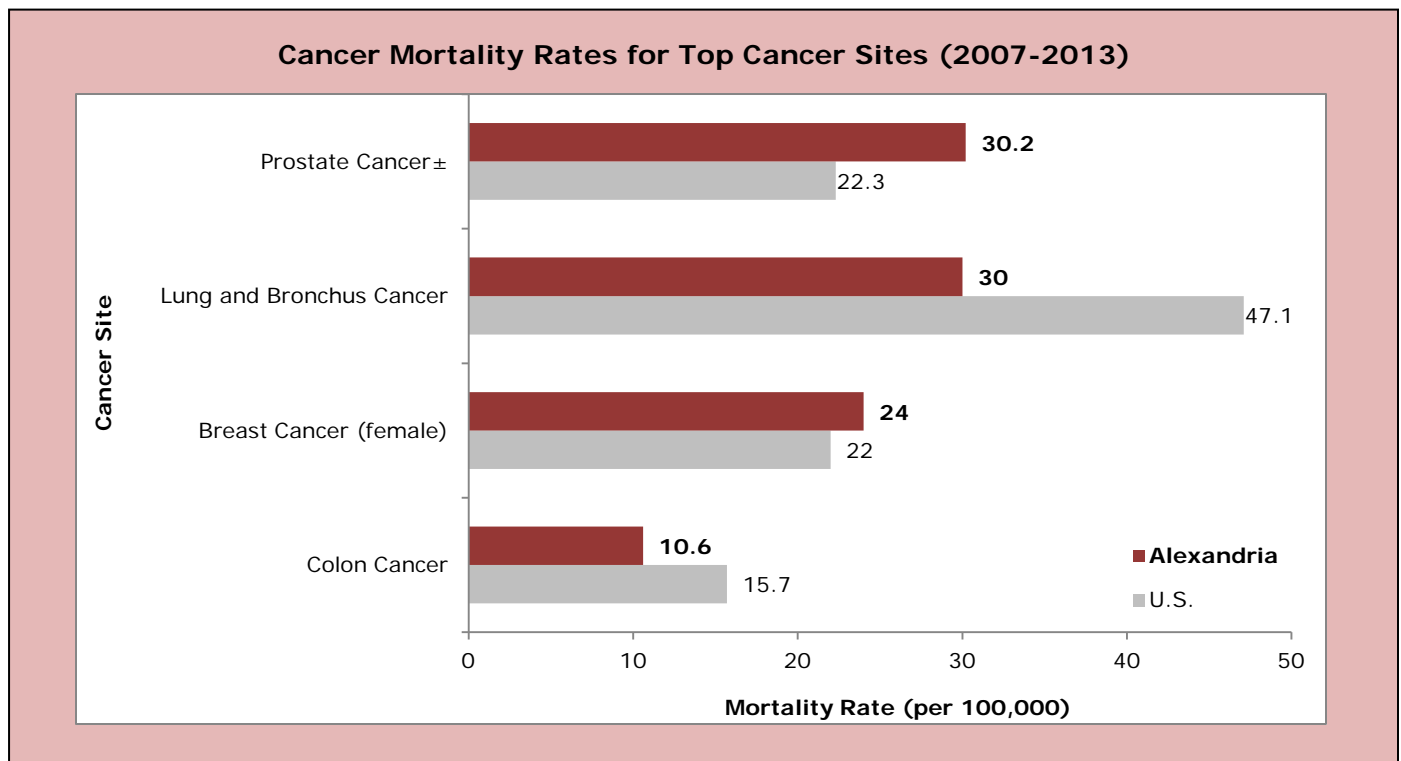
Significance

Cancer is the leading cause of death in Alexandria; mortality rates vary among the top cancer sites. Population age; differing risk factors and health behaviors; the availability and usage of diagnostic tests; and availability and quality of treatment options all have an effect on patient outcomes.³⁶

Status in Alexandria

The mortality rates due to lung and colon cancers in Alexandria are lower than the U.S. rate; prostate and breast cancers have a higher mortality rate than the national rates (Figure 12). These cancer indicators were not included in CHSI 2015 so peer county comparisons are not available. The following cancer mortality indicators meet HP2020 goals (*HP2020 goal in deaths per 100,000*): lung cancer (45.5) and colon cancer (14.5). The following cancer mortality indicators do not meet HP2020 goals (*HP2020 goal in deaths per 100,000*): breast cancer (20.7) and prostate cancer (21.8).

Figure 12. Cancer Mortality Rate Indicator Data (deaths per 100,000)^{34,37}



± County-level data were not available for prostate cancer directly from the National Vital Statistics System (NVSS). Prostate cancer data shown were calculated for 2007-2011 by the National Cancer Institute using death data provided by NVSS.

MORTALITY: Cancer

Top Cancer Sites

Summary of Community Preventive Services Task Force (TF) Recommendations

A list of TF recommended interventions for cancer indicators is available in Appendix B; a summary of interventions is shown in Table 25.

Table 25. Community Guide Recommendations for Cancer Indicators³⁵

Health Indicator	Summary of TF Recommendations			Intervention Focus							Notes
	Total Interventions Recommended by Task Force (N)	Interventions with Strong Evidence of Effectiveness (n)	Interventions with Sufficient Evidence of Effectiveness (n)	Workplace	Community	Home-based/ Individually-adapted	School-based	Environmental Design	Health System	Policy	
Lung and Bronchus Cancer	6	5	1	1	2				1	2	Some interventions also apply to chronic lower respiratory disease, adult smoking, and adolescent smoking
Prostate Cancer											
Breast Cancer (female)	8	5	3						8		Some interventions also apply to colon cancer
Colon Cancer	6	4	2						6		All interventions also apply to breast cancer

Indicator Definitions

Cancer Mortality Rates: Deaths due to cancer type per 100,000 persons, age-adjusted to Census population estimates

MORTALITY: Infant Mortality

Infant Mortality

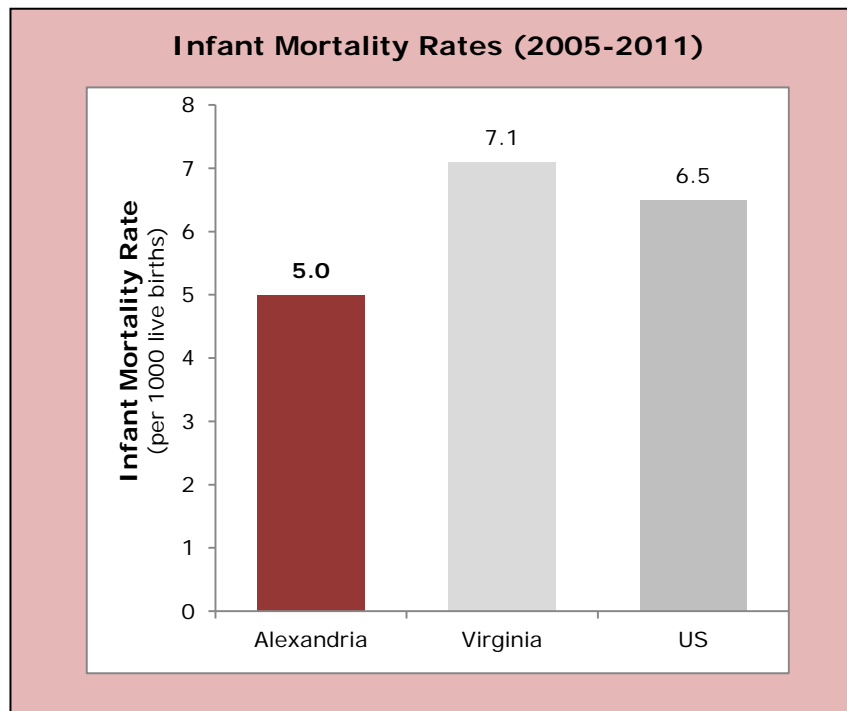
Significance

The infant mortality rate is generally regarded as a good indicator of the overall health of a population.³⁹

Status in Alexandria

The infant mortality rate in Alexandria is lower compared to the U.S. median (Figure 13). This indicator was not included in CHSI 2015 so peer county comparisons are not available. Alexandria meets the HP2020 goal of 6.0 infant deaths per 1000 live births.

Figure 13. Infant Mortality Indicator Data (deaths per 1000 live births)³⁴



Summary of Community Preventive Services Task Force (TF) Recommendations

No recommended interventions for this indicator were identified by the Task Force.³⁵

Indicator Definitions

Infant Mortality Rates: Infant deaths per 1000 live births, age-adjusted to Census population estimates

MORTALITY: Life Expectancy

Life Expectancy at Birth

Significance

Life expectancy at birth is an indicator used to assess the overall health of a population. As mortality patterns change by age, life expectancy is important to understanding changes in the health and well-being of the U.S. population.

Status in Alexandria

Overall life expectancy at birth for both females and males in Alexandria is higher than the U.S. median (Table 26). Alexandria ranks eighth among 43 CHSI peer counties for both female life expectancy (Range: 77.5-84.5 years) and male life expectancy (Range: 72.0-81.0 years). An HP 2020 goal has not been established for this indicator.

Table 26: Life Expectancy Indicator Data ³⁸

Health Indicator	CHSI 2015 Values			Updated Value (if available)	
	Data Years	Alexandria	U.S. Median	Data Years	Alexandria
Female Life Expectancy (years)	2010	82.5	79.8		
Male Life Expectancy (years)	2010	78.5	75		

Summary of Community Preventive Services Task Force (TF) Recommendations

No recommended interventions for this specific indicator were identified by the Task Force.³⁵

Indicator Definitions

Life Expectancy at Birth: The average number of years that a group of infants would live if the group was to experience throughout life the age-specific death rates present for the year of birth.³⁹

MORTALITY: CHSI 2015 Ranking Dashboard

The following dashboard displays indicator data from the CHSI 2015 report and a symbol indicating how Alexandria ranks out of 43 selected peer counties. Please note that peer county comparisons are based on data from the years specified in the CHSI 2015 report, which may or may not be the most currently available data for each indicator. Indicators from alternate data sources are not shown in this dashboard since peer county comparisons are not available.

Table 27. 2015 CHSI Indicators and Peer Rankings: Mortality⁴⁰

Health Indicator	Data Years	Alexandria	U.S. Median	CHSI Peer County Comparison
Cancer (deaths per 100,000)	2005-2011	152.7	185	●
Coronary Heart Disease (deaths per 100,000)	2005-2011	84.2	126.7	●
Stroke (deaths per 100,000)	2005-2011	31.4	46.6	●
Chronic Lower Respiratory Disease (deaths per 100,000)	2005-2011	23.5	49.6	●
Unintentional Injury (deaths per 100,000)	2005-2011	23.2	50.8	●
Chronic Kidney Disease (deaths per 100,000)	2005-2011	18	17.5	◆
Alzheimer's Disease (deaths per 100,000)	2008-2012	16.4	27.3	●
Diabetes (deaths per 100,000)	2005-2011	14.3	24.7	●
Female Life Expectancy (years)	2010	82.5	79.8	●
Male Life Expectancy (years)	2010	78.5	75	●

MORTALITY: References

- ³⁰ Murphy SL, Xu JQ, Kochanek KD. [Deaths: final data for 2010](#). *Natl Vital Stat Rep*. 2013; 61(4):1-118. Available at: Centers for Disease Control and Prevention, Atlanta, GA. Accessed June 24, 2015.
- ³¹ US Department of Health and Human Services. Healthy People 2020. Available at www.healthypeople.gov. Accessibility verified July 22, 2015.
- ³² Mayr FB, Yende S, Angus DC. Epidemiology of severe sepsis. *Virulence*. 2014 Jan 1; 5(1): 4–11. Published online 2013 Dec 11. doi: [10.4161/viru.27372](https://doi.org/10.4161/viru.27372) Accessed July 21, 2015.
- ³³ US Department of Health and Human Services. Healthy People 2020. Available at www.healthypeople.gov. Accessibility verified July 22, 2015.
- ³⁴ National Vital Statistics System-Mortality (NVSS-M) Accessed from: Centers for Disease Control and Prevention, National Center for Health Statistics. [Health Indicators Warehouse](#).
- ³⁵ Centers for Disease Control and Prevention. The Community Guide. Available at www.thecommunityguide.org/index.html. Accessibility verified July 22, 2015.
- ³⁶ American Cancer Society. Global Cancer Facts and Figures 3rd Edition. Available at www.cancer.org/acs/groups/content/@research/documents/document/acspc-044738.pdf. Accessibility verified July 22, 2015.
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- ³⁸ Institute for Health Metrics and Evaluation. Left behind: Widening disparities for males and females in US county life expectancy, 1985-2010. Available at www.healthdata.org/research-article/left-behind-widening-disparities-males-and-females-us-county-life-expectancy-1985. Accessibility verified July 22, 2015.
- ³⁹ Kochanek KD, Murphy SL, Xu JQ et al. [Mortality in the United States, 2013](#). NCHS data brief. 2014; 178. Available from National Center for Health Statistics, Hyattsville, MD. Accessed June 15, 2015.
- ⁴⁰ Centers for Disease Control and Prevention. Community Health Status Indicators (CHSI 2015): Alexandria Summary Comparison Report. Available at wwwn.cdc.gov/CommunityHealth/profile/currentprofile/VA/Alexandria/. Accessibility verified July 22, 2015.

APPENDIX A: Alexandria Peer Counties (CHSI 2015)

Alameda, CA
Alexandria, VA
Allegheny, PA
Bexar, TX
Clark, NV
Cook, IL
Cuyahoga, OH
Dallas, TX
Davidson, TN
Denver, CO
Duval, FL
Erie, NY
Franklin, OH
Fulton, GA
Hamilton, OH
Harris, TX
Hartford, CT
Hennepin, MN
Hillsborough, FL
Jackson, MO
Jefferson, AL
Jefferson, KY
King, WA
Maricopa, AZ
Marion, IN
Mecklenburg, NC
Monroe, NY
Multnomah, OR
Oklahoma, OK
Orange, CA
Orange, FL
Pinellas, FL
Ramsey, MN
Richmond, NY
Riverside, CA
Sacramento, CA
Salt Lake, UT
San Diego, CA
San Francisco, CA
Santa Clara, CA
Tarrant, TX
Travis, TX
Virginia Beach, VA

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention	
Health Behaviors	Physical Activity	Adult Physical Inactivity	Workplace	Obesity Prevention and Control: Worksite Programs	
			Community	Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings	
				Campaigns and Informational Approaches to Increase Physical Activity: Community-wide Campaigns	
			Home-based/ Individually-adapted	Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs	
			Environmental Design	Environmental and Policy Approaches to Increase Physical Activity: Community-Scale Urban Design Land Use Policies & Practices	
				Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities	
				Environmental and Policy Approaches to Increase Physical Activity: Point-of-decision Prompts to Encourage Use of Stairs	
				Environmental and Policy Approaches to Increase Physical Activity: Street Scale Urban Design Land Use Policies & Practices	
			Adolescent Physical Activity	School-based	Behavioral and Social Approaches to Increase Physical Activity: Enhanced School-Based Physical Education
			Alcohol Use	Adult Binge Drinking	Workplace
	Community	Preventing Excessive Alcohol Consumption: Dram Shop Liability			
		Preventing Excessive Alcohol Consumption: Electronic Screening and Brief Intervention (e-SBI)			
	Policy	Preventing Excessive Alcohol Consumption: Increasing Alcohol Taxes			
		Preventing Excessive Alcohol Consumption: Maintaining Limits on Hours of Sale			
		Preventing Excessive Alcohol Consumption: Maintaining Limits on Days of Sale			
		Preventing Excessive Alcohol Consumption: Regulation of Alcohol Outlet Density			
Preventing Excessive Alcohol Consumption: Privatization of Retail Alcohol Sales (TF Recommends Against)					
Adolescent Binge Drinking	Community	Preventing Excessive Alcohol Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors			

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Health Behaviors	Smoking	Adult Smoking	Workplace	Reducing Tobacco Use and Secondhand Smoke Exposure: Incentives and Competitions to Increase Smoking Cessation Among Workers (when combined with additional interventions)
				Assessment of Health Risks with Feedback to Change Employees' Health
			Community	Reducing Tobacco Use and Secondhand Smoke Exposure: Mass-Reach Health Communication Interventions
				Reducing Tobacco Use and Secondhand Smoke Exposure: Comprehensive Tobacco Control Programs
				Reducing Tobacco Use and Secondhand Smoke Exposure: Mobile Phone-Based Cessation Interventions
				Reducing Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
			Health System	Reducing Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments
			Policy	Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products
	Reducing Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies			
	Teen Pregnancies and Births	Teen Pregnancy	Community	Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents
Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents				
Morbidity	Depression	Older Adult Depression	Home-based/ Individually-adapted	Interventions to Reduce Depression Among Older Adults: Home-Based Depression Care Management
			Health System	Interventions to Reduce Depression Among Older Adults: Clinic-Based Depression Care Management
				Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders
			Policy	Improving Mental Health and Addressing Mental Illness: Mental Health Benefits Legislation
	Asthma	Adolescent Asthma	Home-based/ Individually-adapted	Asthma Control: Home-based Multi-trigger, Multicomponent Environmental Interventions

Visit www.thecommunityguide.org for more information on TF recommendations

Intervention Color Scheme Key:
 Dark Green Shading: Strong Evidence of Effectiveness
 Light Green Shading: Sufficient Evidence of Effectiveness

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Morbidity	Obesity and Diabetes	Adult Obesity	Workplace	Obesity Prevention and Control: Worksite Programs
			Community	Campaigns and Informational Approaches to Increase Physical Activity: Community-wide Campaigns
				Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings
			Home-based/ Individually-adapted	Obesity Prevention and Control: Technology-Supported Multicomponent Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss
				Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs
			Environmental Design	Environmental and Policy Approaches to Increase Physical Activity: Community-Scale Urban Design Land Use Policies & Practices
				Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities
				Environmental and Policy Approaches to Increase Physical Activity: Point-of-decision Prompts to Encourage Use of Stairs
		Environmental and Policy Approaches to Increase Physical Activity: Street Scale Urban Design Land Use Policies & Practices		
		Adolescent Obesity	Community	Obesity Prevention and Control: Behavioral Interventions that Aim to Reduce Recreational Sedentary Screen Time Among Children
			School-based	Behavioral and Social Approaches to Increase Physical Activity: Enhanced School-based Physical Education
		Adult Diabetes	Workplace	Obesity Prevention and Control: Worksite Programs
			Community	Diabetes Prevention and Control: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk
				Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings
				Campaigns and Informational Approaches to Increase Physical Activity: Community-wide Campaigns
			Home-based/ Individually-adapted	Obesity Prevention and Control: Technology-Supported Multicomponent Coaching or Counseling Interventions to Reduce Weight and Maintain Weight Loss
Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs				
Environmental Design	Environmental and Policy Approaches to Increase Physical Activity: Street Scale Urban Design Land Use Policies & Practices			

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Morbidity	Sexually Transmitted Infections	Gonorrhea	Community	Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents
				Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents
		Chlamydia	Community	Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents
				Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents
		Syphilis	Community	Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents
				Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents
		HIV	Community	Preventing HIV/AIDS, Other STIs, and Teen Pregnancy: Group-Based Comprehensive Risk Reduction Interventions for Adolescents
				Youth Development Behavioral Interventions Coordinated with Community Service to Reduce Sexual Risk Behaviors in Adolescents
				Interventions to Reduce Sexual Risk Behaviors or Increase Protective Behaviors to Prevent Acquisition of HIV in Men Who Have Sex with Men: Community-Level Behavioral Interventions
			Home-based/ Individually-adapted	Interventions to Reduce Sexual Risk Behaviors or Increase Protective Behaviors to Prevent Acquisition of HIV in Men Who Have Sex with Men: Individual-, Group-Interventions

Visit www.thecommunityguide.org for more information on TF recommendations

Intervention Color Scheme Key:
 Dark Green Shading: Strong Evidence of Effectiveness
 Light Green Shading: Sufficient Evidence of Effectiveness

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Mortality	Leading Cause	Coronary Heart Disease	Workplace	Obesity Prevention and Control: Worksite Programs
				Assessment of Health Risks with Feedback to Change Employees' Health
			Community	Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings
				Campaigns and Informational Approaches to Increase Physical Activity: Community-wide Campaigns
				Cardiovascular Disease Prevention and Control: Interventions Engaging Community Health Workers (Team-Based Care)
				Cardiovascular Disease Prevention and Control: Interventions Engaging Community Health Workers (Outreach, Enrollment and Information)
			Home-based/ Individually-adapted	Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs
				Cardiovascular Disease Prevention and Control: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Used Alone
				Cardiovascular Disease Prevention and Control: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Combined with Additional Support
			School-based	Behavioral and Social Approaches to Increase Physical Activity: Enhanced School-based Physical Education
			Environmental Design	Environmental and Policy Approaches to Increase Physical Activity: Community-Scale Urban Design Land Use Policies & Practices
				Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities
				Environmental and Policy Approaches to Increase Physical Activity: Point-of-decision Prompts to Encourage Use of Stairs
				Environmental and Policy Approaches to Increase Physical Activity: Street Scale Urban Design Land Use Policies & Practices
			Health System	Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems (CDSS)
				Cardiovascular Disease Prevention and Control: Reducing Out-of-Pocket Costs for Cardiovascular Disease Preventive Services for Patients with High Blood Pressure and High Cholesterol
				Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Mortality	Leading Cause	Stroke	Workplace	Obesity Prevention and Control: Worksite Programs
				Assessment of Health Risks with Feedback to Change Employees' Health
			Community	Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings
				Campaigns and Informational Approaches to Increase Physical Activity: Community-wide Campaigns
				Cardiovascular Disease Prevention and Control: Interventions Engaging Community Health Workers (Team-Based Care)
				Cardiovascular Disease Prevention and Control: Interventions Engaging Community Health Workers (Outreach, Enrollment and Information)
			Home-based/ Individually-adapted	Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs
				Cardiovascular Disease Prevention and Control: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Used Alone
				Cardiovascular Disease Prevention and Control: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control – When Combined with Additional Support
			School-based	Behavioral and Social Approaches to Increase Physical Activity: Enhanced School-based Physical Education
			Environmental Design	Environmental and Policy Approaches to Increase Physical Activity: Community-Scale Urban Design Land Use Policies & Practices
				Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities
				Environmental and Policy Approaches to Increase Physical Activity: Point-of-decision Prompts to Encourage Use of Stairs
				Environmental and Policy Approaches to Increase Physical Activity: Street Scale Urban Design Land Use Policies & Practices
			Health System	Cardiovascular Disease Prevention and Control: Clinical Decision-Support Systems (CDSS)
				Cardiovascular Disease Prevention and Control: Reducing Out-of-Pocket Costs for Cardiovascular Disease Preventive Services for Patients with High Blood Pressure and High Cholesterol
				Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention
Mortality	Leading Cause	Chronic Lower Respiratory Disease	Community	Reducing Tobacco Use and Secondhand Smoke Exposure: Mass-Reach Health Communication Interventions
			Home-based/ Individually-adapted	Asthma Control: Home-based Multi-trigger, Multicomponent Environmental Interventions
			Policy	Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products
		Influenza and Pneumonia	Workplace	Interventions to Promote Seasonal Influenza Vaccinations among Healthcare Workers
				Interventions to Promote Seasonal Influenza Vaccinations among Non-Healthcare Workers
			Community	Increasing Appropriate Vaccination: Community-Based Interventions Implemented in Combination
			School-based	Increasing Appropriate Vaccination: Vaccination Programs in Schools and Organized Child Care Centers
			Health System	Increasing Appropriate Vaccination: Home Visits to Increase Vaccination Rates
				Increasing Appropriate Vaccination: Reducing Client Out-of-Pocket Costs
				Increasing Appropriate Vaccination: Vaccination Programs in WIC Settings
				Increasing Appropriate Vaccination: Client or Family Incentive Rewards
				Increasing Appropriate Vaccination: Client Reminder and Recall Systems
				Increasing Appropriate Vaccination: Health Care System-Based Interventions Implemented in Combination
				Increasing Appropriate Vaccination: Immunization Information Systems
				Increasing Appropriate Vaccination: Provider Assessment and Feedback
				Increasing Appropriate Vaccination: Provider Reminders
		Policy	Increasing Appropriate Vaccination: Standing Orders	
		Diabetes	Increasing Appropriate Vaccination: Vaccination Requirements for Child Care, School and College Attendance	
			Home-based/ Individually-adapted	Diabetes Prevention and Control: Self-management Education
		Suicide	Health System	Diabetes Prevention and Control: Case Management Interventions to Improve Glycemic Control
				Diabetes Prevention and Control: Disease Management Programs
				Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders
			Interventions to Reduce Depression Among Older Adults: Clinic-based Depression Care Management	
Interventions to Reduce Depression Among Older Adults: Home-based Depression Care Management				
Policy	Reducing Psychological Harm from Traumatic Events Among Children and Adolescents: Cognitive-Behavioral Therapy (Individual and Group)			
Policy	Improving Mental Health and Addressing Mental Illness: Mental Health Benefits Legislation			

APPENDIX B: Recommended TF Interventions for Health Profile I Indicators

Focus Area	Topic Area	Health Indicator	Intervention Focus Area	Intervention	
Mortality	Leading Cause	Lung and Bronchus Cancer	Workplace	Reducing Tobacco Use and Secondhand Smoke Exposure: Incentives and Competitions to Increase Smoking Cessation Among Workers (when combined with additional interventions)	
			Community	Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products	
				Reducing Tobacco Use and Secondhand Smoke Exposure: Mass-Reach Health Communication Interventions	
			Health System	Reducing Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments	
			Policy	Reducing Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies	
				Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products	
			Breast Cancer (female)	Health System	Increasing Cancer Screening: Group Education for Clients
					Increasing Cancer Screening: One-on-One Education for Clients
		Increasing Cancer Screening: Reducing Client Out-of-Pocket Costs			
		Increasing Cancer Screening: Reducing Structural Barriers for Clients (mammography)			
		Increasing Cancer Screening: Client Reminders			
		Increasing Cancer Screening: Small Media Targeting Clients (mammography)			
		Increasing Cancer Screening: Provider Assessment and Feedback (mammography)			
		Increasing Cancer Screening: Provider Reminder and Recall Systems (mammography)			
		Colon Cancer	Health System	Increasing Cancer Screening: One-on-One Education for Clients (fecal occult blood testing)	
				Increasing Cancer Screening: Reducing Structural Barriers for Clients (fecal occult blood testing)	
				Increasing Cancer Screening: Client Reminders (fecal occult blood testing)	
				Increasing Cancer Screening: Small Media Targeting Clients (fecal occult blood testing)	
				Increasing Cancer Screening: Provider Assessment and Feedback (fecal occult blood testing)	
				Increasing Cancer Screening: Provider Reminder and Recall Systems (fecal occult blood testing)	

Visit www.thecommunityguide.org for more information on TF recommendations

Intervention Color Scheme Key:

Dark Green Shading: Strong Evidence of Effectiveness
Light Green Shading: Sufficient Evidence of Effectiveness

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