

SECTION IV

PRIORITIZED HEALTH ISSUES & KEY HEALTH INDICATORS

The major component of each triennial Needs Assessment is the presentation of updated health data indicators for San Diego County. The selection of key indicators is driven by the health issues selected, community input, and availability of data at the local level. The priority health issues reviewed in this report were identified in the 1998 Needs Assessment, *Charting The Course II*, and refined from additional community input and deliberations of the Needs Assessment Committee.

This report begins with an overarching category: access to appropriate medical and dental care. The following sections, as listed below, are arranged and categorized by age group.

I. Overarching Health Issues: Access to Appropriate Medical and Dental Care

- Health insurance coverage—*adults, children*
- Dental insurance coverage—*adults, children*
- Unmet dental care needs—*adults*
- Regular primary care provider—*adults, children*
- Prenatal care

II. Infants and Children (0-14 years)

- Infant health—*infant mortality, low birth weight*
- Violent & abusive behaviors—*child abuse/neglect*
- Unintentional injuries—*drowning*
- Chronic conditions—*asthma*
- Health behaviors—*overweight children*

III. Adolescents & Young Adults (15-24 years)

- Substance abuse—*alcohol, tobacco, marijuana*
- Reproductive health—*teen births, teen sexual intercourse*
- Mental health—*suicide attempts*
- Healthy behaviors—*physical activity*
- Unintentional injuries—*overall deaths, motor vehicle related deaths*
- Violent and abusive behaviors—*homicide*

IV. Adults (25-64 years)

- Substance abuse—*smoking, alcohol, drug-induced deaths*
- Healthy behaviors—*physical activity, obesity*
- Mental health—*depression-distress*
- Violent and abusive behaviors—*domestic violence*

V. Seniors (65+ years)

- Cardiovascular disease—*coronary heart disease deaths, stroke deaths*
- Chronic conditions—*diabetes deaths*
- Mental health—*suicide*
- Cancer—*overall, colorectal, lung, breast, prostate deaths*
- Unintentional Injuries—*deaths from falls*

Data in this section are arranged by age group rather than by topic because health issues are different for different age groups. However, Data Tables in Appendix A are arranged topically and provide detail about data used in the charts; they contain both actual numbers of cases, incidents, etc., as well as aggregate percentages or rates. Technical notes for the data portion of this report can be found in Appendix D and should be consulted for data sources, limitations, and definitions.

I. ACCESS TO MEDICAL CARE— *HEALTH INSURANCE COVERAGE (ADULTS)*

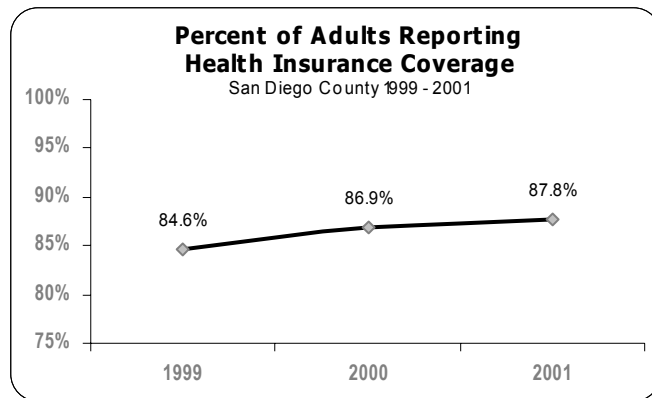
Overview and Data Summary

The percentage of San Diego County residents without health insurance continues to be an important measure of overall access to appropriate medical care services; it is also a general reflection of the state of the local economy as well as the effectiveness of state and local health and business-related policies.

Health insurance coverage data presented below are for persons aged 19 years and older, including Seniors and the Military, for the years 1999 to 2001. The data are based on the annual *Outcomes and Community Impact Program* produced by the United Way of San Diego County.*

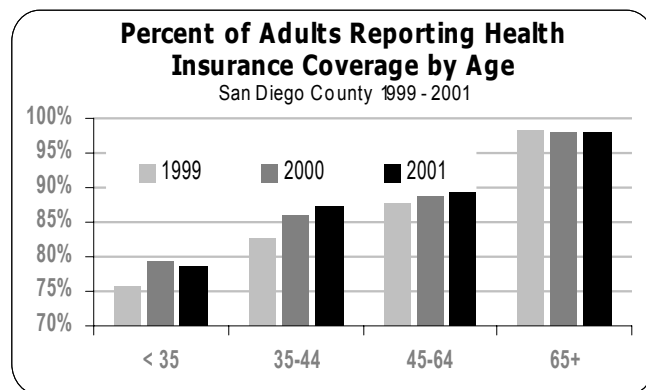
OVERALL TREND

- Insurance coverage increased from 84.6% in 1999 to 87.8% in 2001.
- The 2001 National Health Interview Survey found that the U.S. insurance coverage for all ages was 85.8% for 2001.
- No directly comparable national or state data are available.



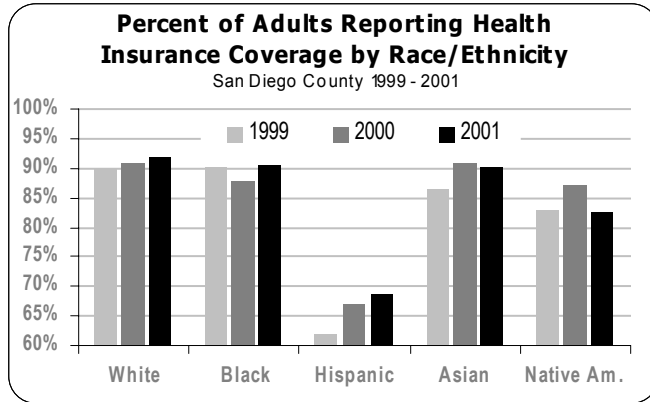
TREND BY AGE

- Coverage increased with age (nearly 100% of persons aged 65+ covered by health insurance).
- Persons younger than 35 were less likely than other age groups to have health insurance.



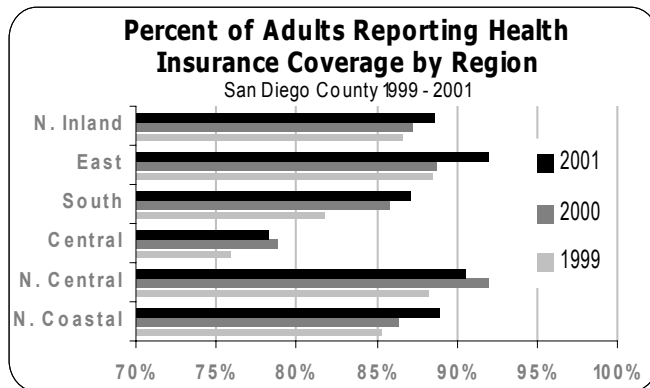
* Although not presented, other commonly cited data for insurance coverage come from the UCLA Center for Health Policy Research which uses the U.S. Census Bureau *Current Population Survey* to produce health insurance figures for the state of California. Because the most recent data available are 3 year averages, they were not included in the charts.

ACCESS TO MEDICAL CARE—HEALTH INSURANCE COVERAGE (ADULTS)
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Hispanics were less likely to have health insurance coverage when compared to all other racial/ethnic groups.
- A slight increase was noted for Hispanics from 1999 to 2001.
- Stable rates were observed for Whites, Blacks, and Asians.



TREND BY REGION

- Coverage in the Central region was significantly lower than all other regions.
- Increases in insurance coverage were observed for every region between 1999 and 2001.

Source(s):

- United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001.
- Family Core component of the 1997-2001 National Health Interview Surveys, National Center For Health Statistics.

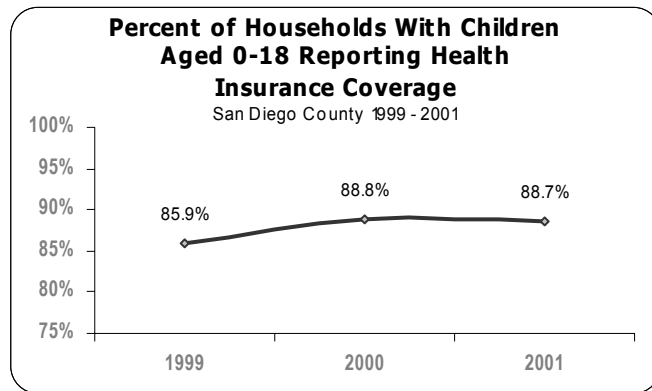
ACCESS TO MEDICAL CARE— HEALTH INSURANCE COVERAGE (CHILDREN)

Overview and Data Summary

The United Way survey asked adults aged 19 or older, who had children aged 0-18 living in the home, whether their children were covered by health insurance. Responses included military dependents. Data by age and gender for children are not available for this report.

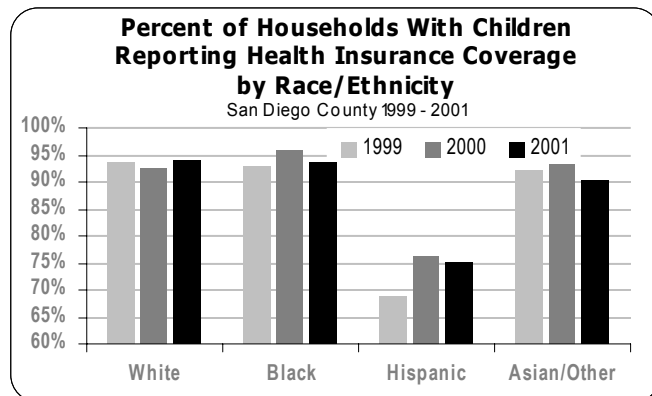
OVERALL TREND

- Coverage for children increased nearly 3% between 1999 and 2001.
- The 2001 National Health Interview Survey found the U.S. health insurance coverage was 85.5% for children aged 0-18 years.
- No directly comparable national or state data are available.



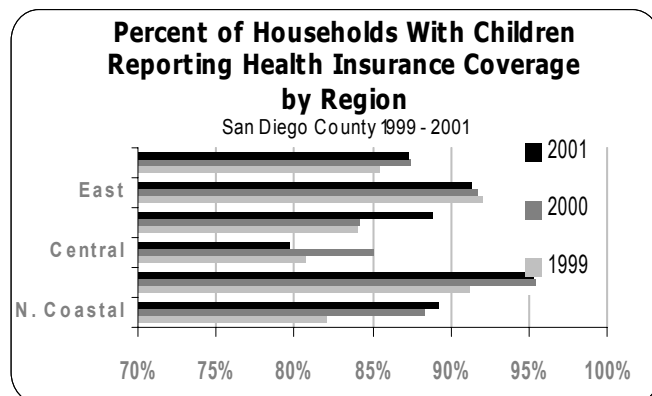
TREND BY RACE/ETHNICITY

- Hispanic children had less health insurance than all other groups for all years 1999—2001.
- No trends were observed for any group since 1999.



TREND BY REGION

- Respondents in the Central region reported lower percentage of coverage for children.
- Respondents in the N. Central region reported 95% coverage for their children in 2000 and 2001.
- The N. Coastal region reported the largest increase in coverage between 1999 and 2001.



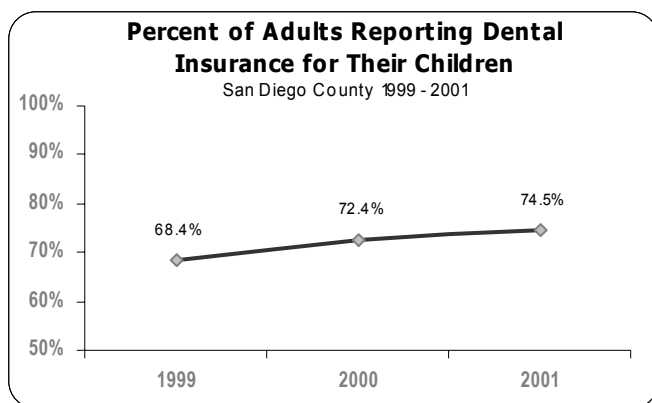
Source(s):

-United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001.

-Family Core component of the 1997-2001 National Health Interview Surveys, National Center For Health Statistics.

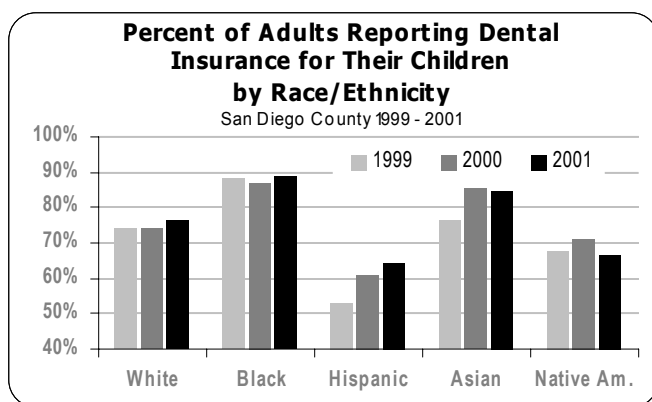
ACCESS TO DENTAL CARE—DENTAL INSURANCE COVERAGE (CHILDREN)
 Overview and Data Summary

The United Way Survey data presented below are for adults aged 19 years and older reporting dental insurance coverage for their children aged 0-18 years for 1999 to 2001. Responses include military dependents. Data by age and gender for children are not available in this report.



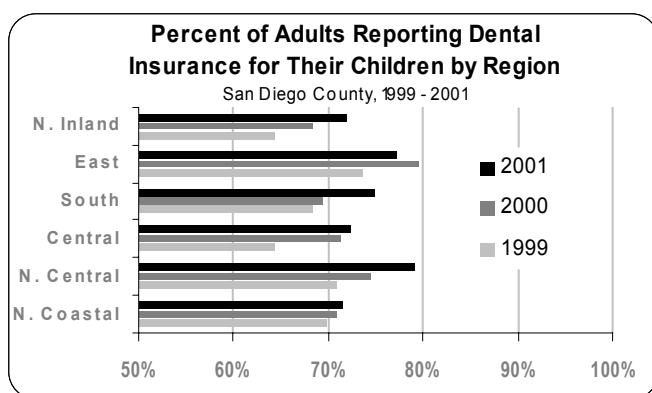
OVERALL TREND

- Dental insurance coverage for children increased from 68.4% in 1999 to 74.5% in 2001.
- No national or state comparative data are available.



TREND BY RACE/ETHNICITY

- Major disparity was noted for Hispanic children despite increasing trend.
- Highest dental coverage was reported among Black children.



TREND BY REGION

- Overall positive trends were observed in every region between 1999 and 2001.
- Largest gains for years reported were noted in Central (8.1%), N. Central (8.3%), and N. Inland (7.5%) regions.

Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001

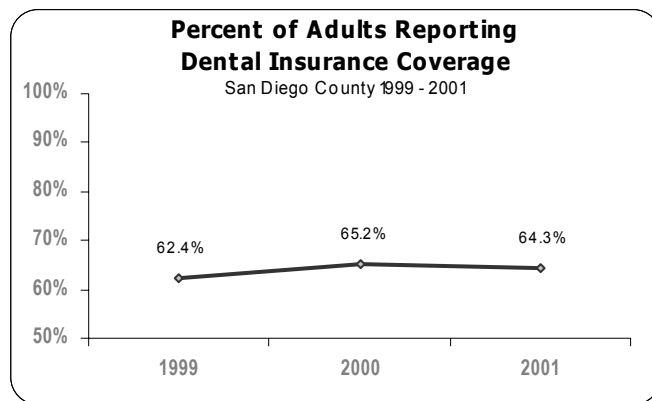
ACCESS TO DENTAL CARE—DENTAL INSURANCE COVERAGE (ADULTS)

Overview and Data Summary

Dental insurance coverage is an important indicator of oral health status in the community, but data show that it substantially lags behind health insurance coverage. Nationally, it is estimated that for every child under 18 years without health insurance, there are two children without dental insurance; for every adult without health insurance, there are three without dental insurance.¹ Dental insurance data presented below from the United Way Survey are for persons aged 19 years and older, including seniors and military.

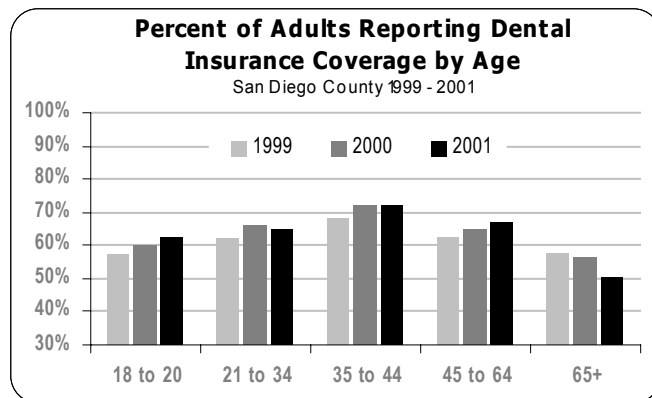
OVERALL TREND

- Overall coverage remained fairly consistent at 62% to 64% between 1999 and 2001.
- No comparable national or state data are available.



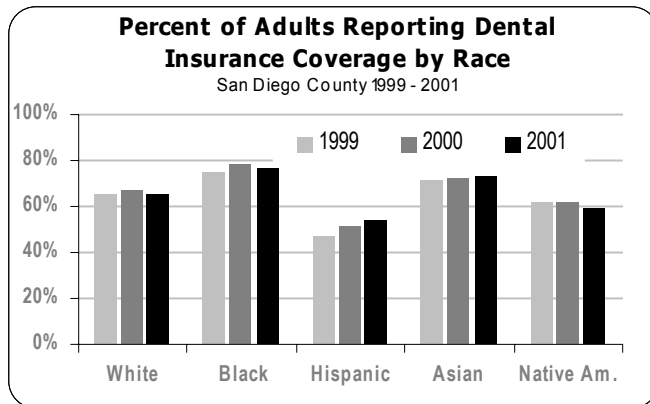
TREND BY AGE

- In 2001, coverage was lowest in the 65+ population.
- A downward trend was observed for the 65+ population since 1999.
- A slight upward trend was noted for groups aged 18-20 and 45-64.



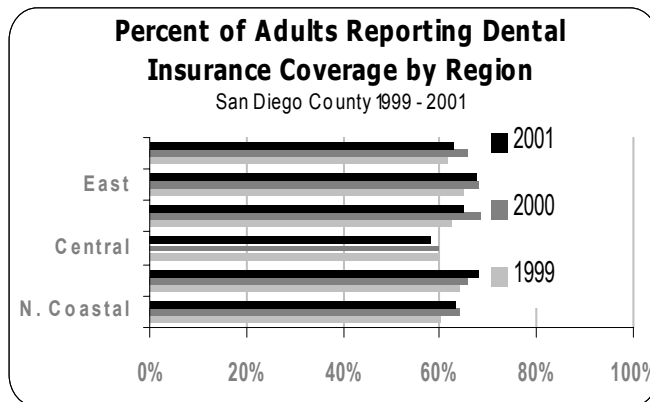
¹U.S. Department of Health and Human Services. *Oral Health in America: A Report to the Surgeon General—Executive Summary*. Rockville, MD: USDHHS, NIDCR, NIH 2000.

ACCESS TO DENTAL CARE—DENTAL INSURANCE COVERAGE (ADULTS)
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Highest insurance coverage reported was among Black adults.
- Lowest insurance coverage reported was among Hispanic adults.
- Increasing trend was observed for Hispanic and Asian adults.



TREND BY REGION

- Central region reported less dental insurance coverage than all other regions.
- No clear trends were noted within each region for the years reported.

Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001

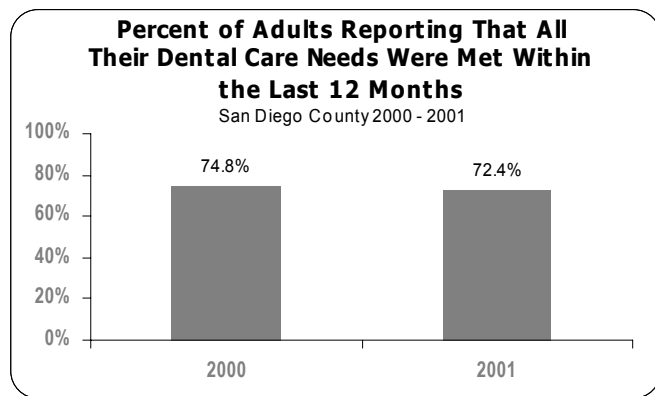
ACCESS TO DENTAL CARE—UNMET NEED FOR DENTAL CARE (ADULTS)

Overview and Data Summary

According to the United Way data, approximately three out of four San Diegans receive some type of dental care in any given year. This indicator measures the percent of people who had their dental care needs met. Data are only available for 2000 and 2001, representing adults aged 19 years and older, including the military.

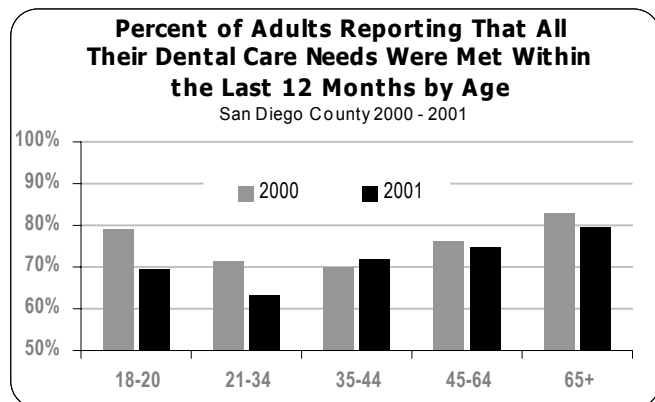
OVERALL TREND

- In 2000, nearly 75% of respondents indicated that their dental care needs were fully met.
- One in four respondents indicated that their needs were either partially met or not met at all.
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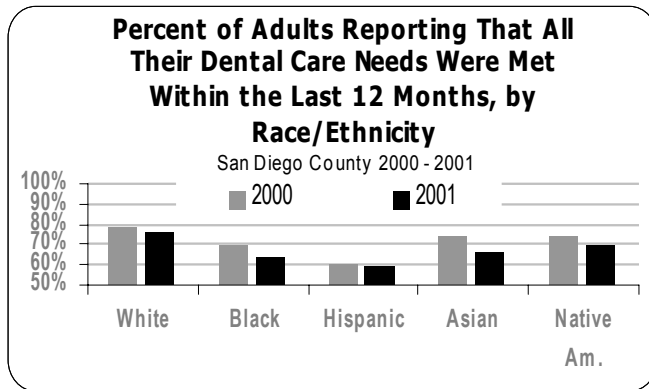


TREND BY AGE

- 80% of Seniors 65+ reported receiving the dental care they need, the highest percentage of any age group.
- Except for persons aged 35—44, all age groups reported a decline in the percent receiving the dental care they need.

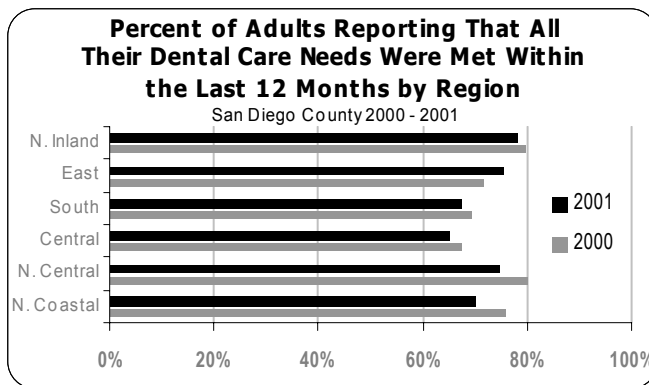


ACCESS TO DENTAL CARE—UNMET NEED FOR DENTAL CARE (ADULTS)
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Hispanics reported that all their dental needs were being met less often than any other race/ethnic group.
- Whites reported that all their dental needs were being met most often.
- Each group reported that all their dental needs were being met less often in 2001 than in 2000.



TREND BY REGION

- Central and South region residents reported that their dental care needs were being met less often than residents in other regions.
- Only the East region reported an improvement, from 71.8% in 2000 to 75.5% in 2001.

Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 2000-2001.

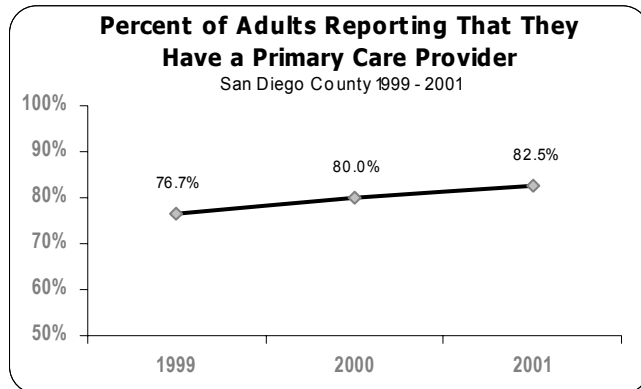
ACCESS TO CARE—REGULAR PRIMARY CARE PROVIDER (ADULTS)

Overview and Data Summary

An additional indicator of access to appropriate and timely health care is whether individuals have a usual source of care—a “medical home,” such as a primary care provider—for consistent health services. The data presented below are from the United Way Survey that asked respondents, aged 19 years and older, including the military, whether they had someone considered to be their primary care provider.

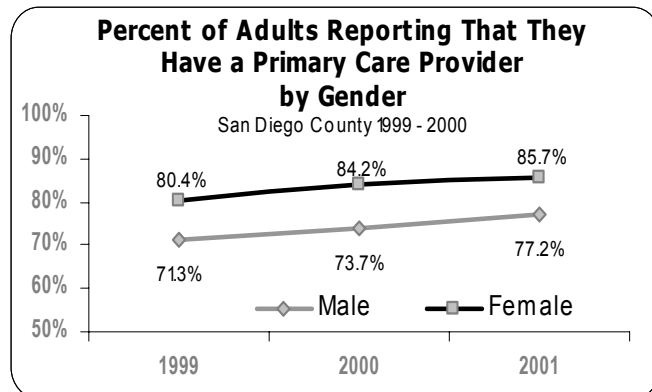
OVERALL TREND

- An upward trend was observed since 1999 (7.5% increase from 1999 to 2001).
- *Healthy People 2010** baseline was 77% for 1996.
- The *Healthy People 2010* goal is 85% for the entire population, including children, and is not directly comparable to these data.



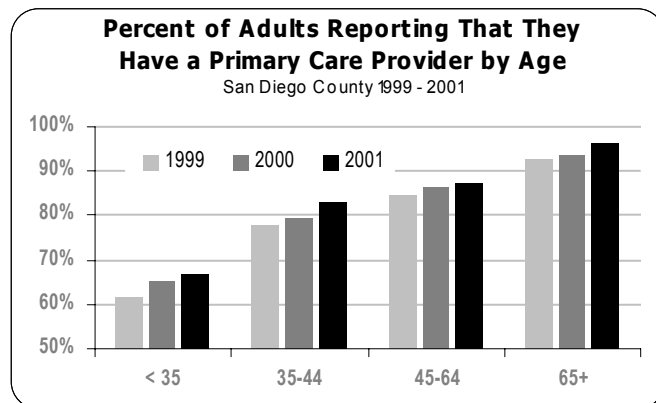
TREND BY GENDER

- Females more often reported having a primary care provider.
- Both gender reported an increase of at least 5% since 1999.



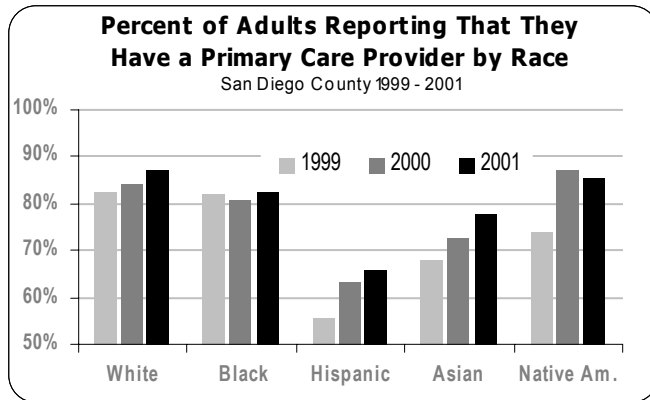
TREND BY AGE

- All age groups reported an increase since 1999.
- Seniors were more likely to have a primary care provider (96.4% in 2001).
- Persons aged 19-34 were least likely to have a primary care provider.



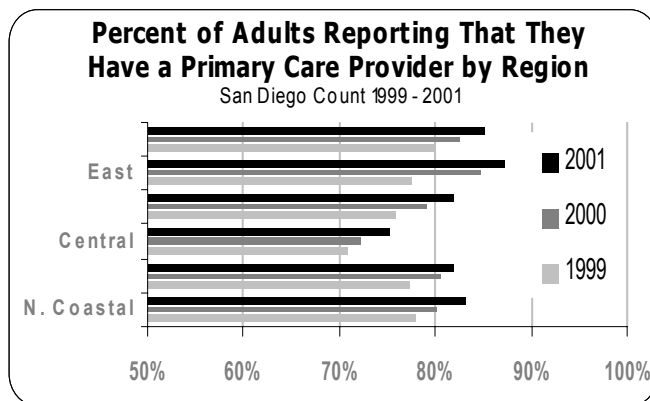
*Healthy People 2010. U.S. Department of Health & Human Services

ACCESS TO CARE—PRIMARY CARE PROVIDER (ADULTS)
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Hispanics were less likely to have a primary care provider than any other group.
- The percent of Hispanics reporting that they had a primary care provider has increased more than 10% since 1999.



TREND BY REGION

- All regions reported an increase of at least 6% since 1999.
- A 12% increase over the 3 years was noted in the East region.
- Residents in the Central region were less likely to report a primary care provider than all other regions.
- For 2001, the percent reporting a primary care provider was lowest (75.3%) in the Central region and highest (87.3%) in the East region.

Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001.

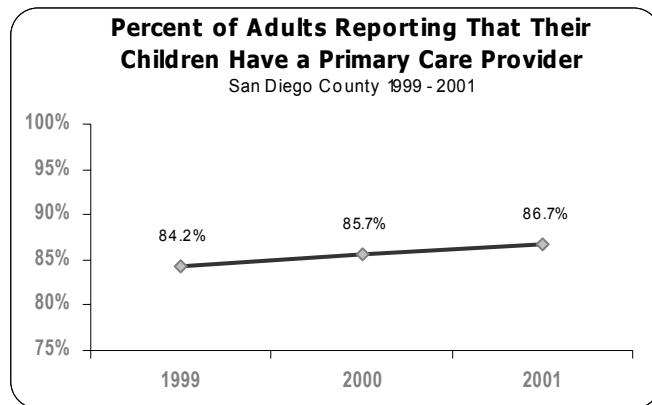
ACCESS TO CARE—REGULAR PRIMARY CARE PROVIDER (CHILDREN)

Overview and Data Summary

The data presented below are from the United Way Survey that asked respondents, aged 19 years and older, whether their children (aged 0-18 years) had someone considered to be their primary care provider. Responses include military dependents. Data by age and gender for children are not available in this report.

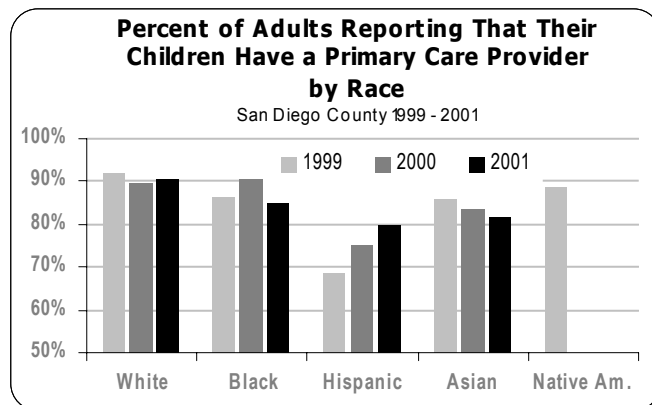
OVERALL TREND

- A slight increase was observed from 1999 to 2001.
- No *Healthy People 2010* objectives are available for children only.



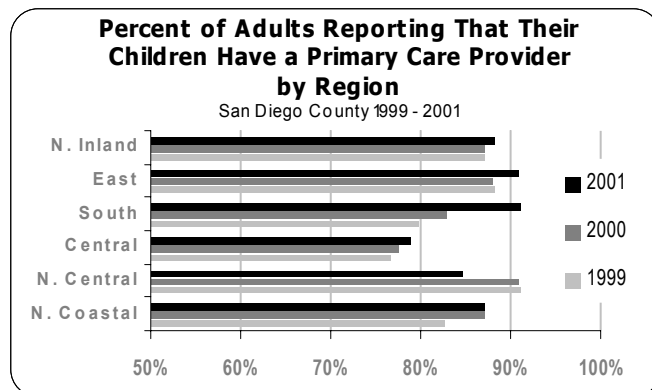
TREND BY RACE/ETHNICITY

- Hispanic children were the least likely of any group to have a primary care provider.
- Largest increase since 1999 was reported among Hispanics (16.7%).
- All groups except Hispanics reported overall decline between 1999 and 2001.
- Data for Native Americans were not available for 2000 and 2001.



TREND BY REGION

- The Central region was less likely to report a primary care provider for its children than any region.
- Largest 3-year increase was observed in the South region (14%).
- All regions except for N. Central reported an increase since 1999.

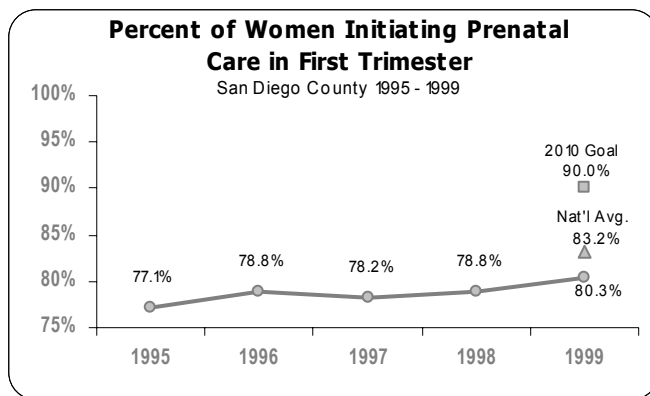


Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001.

ACCESS TO CARE—*PRENATAL CARE*

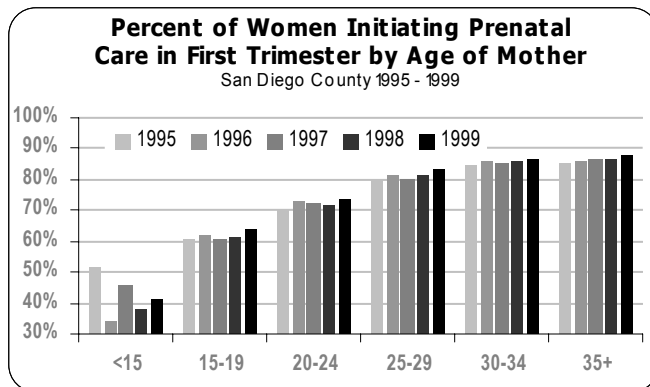
Overview and Data Summary

Prenatal care includes three major components: risk assessment, treatment for medical conditions or risk reduction, and education.¹ Early prenatal care is important in identifying factors that affect a healthy pregnancy and birth outcome. For example, identification of behavioral factors, such as smoking and alcohol use at an early stage of the pregnancy, increases the chance of successful interventions.



OVERALL TREND

- Slight upward trend in San Diego observed since 1997.
- National average in 1999 was 83.2%.
- *Healthy People 2010* goal is 90%.

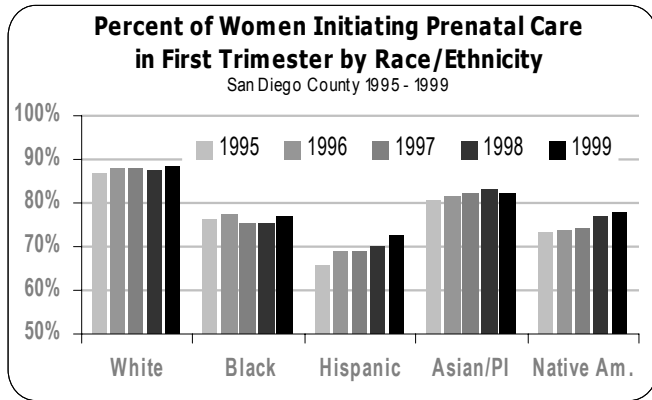


TREND BY AGE

- Early entry into prenatal care increased with age.
- Lack of early prenatal care was greatest among young mothers less than 15 years of age.
- Variability in the percentages of females younger than 15 years is due to the small numbers of females in this category.

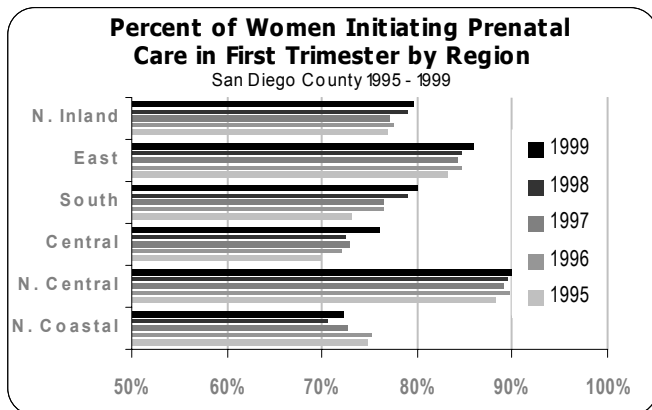
1. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington DC: Public Health Service, January 2000.

ACCESS TO CARE—*PRENATAL CARE*
 Overview and Data Summary—Cont.



TREND BY RACE/ETHNICITY

- Slight increase was observed in the Hispanic and Native American populations.
- Whites had the highest percent of early prenatal care, followed by Asians/Pacific Islanders.
- Largest increase was observed for the Hispanic population, (from 65.6% in 1995 to 72.8% in 1999).



TREND BY REGION

- N. Central region reported the highest percent of prenatal care, and Central region the lowest.
- Increasing trends were noted in all regions except N. Coastal.

Statistical Notes:

- Unknown prenatal care births are not subtracted from total births in calculation of percentages.
- Rates are not age-adjusted.
- Total for age groups and HHS Regions are less than the County due to events in which age or region could not be determined.

Source(s):

- State of California, Department of Health Services, Center for Health Statistics, Vital Statistics Section, Birth Statistical Master Files.
- National Vital Statistics Reports, Vol 48, No. 12, July 20, 2000, Centers for Disease Control & Prevention.

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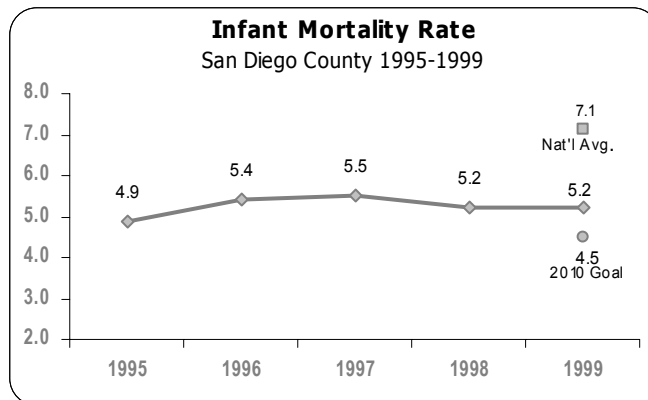
II. INFANT HEALTH—*INFANT MORTALITY*

Overview and Data Summary

The infant mortality rate is an important standard indicator of the health of a population. As of 1995, the U.S. infant mortality rate ranked 25th among industrialized nations.¹ In the past decade, critical measures of increased risk of infant death, such as new cases of low birth weight (<2500 grams) and very low birth weight (<1500 grams), have increased in the U.S.

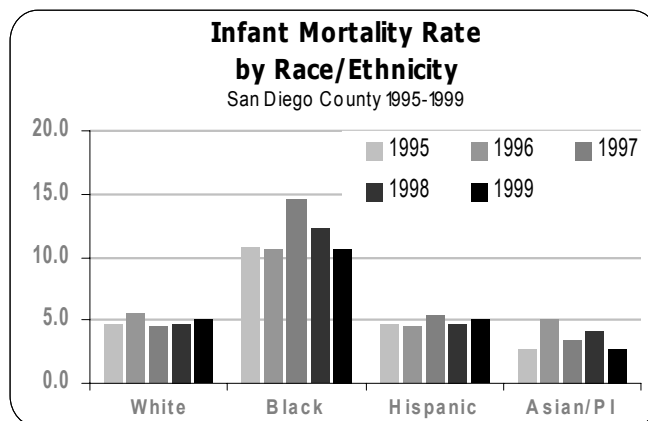
OVERALL TREND

- San Diego County rate remained relatively constant between 4.9 and 5.2 infant deaths per 1,000 live births between 1995 and 1999.
- U.S. rate was 7.1 infant deaths per 1,000 live births in 1999.
- *Healthy People 2010* goal is no more than 4.5 infant deaths per 1,000 live births.



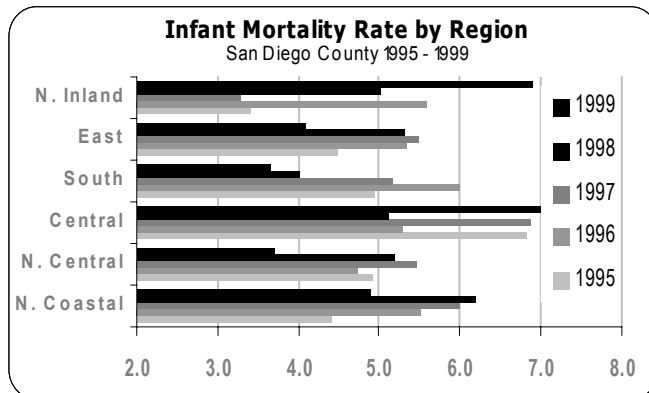
TREND BY RACE/ETHNICITY

- Infant mortality rate for Blacks was more than twice that of all other groups for years reported.
- No clear trend was observed for any group.
- Rates were not calculated for Native Americans due to the extremely small numbers of deaths in this racial/ethnic group.



1. U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington D.C.: Public Health Service, January 2000.

INFANT HEALTH—INFANT MORTALITY
 Overview and Data Summary—Cont.



TREND BY REGION

- There were few consistent trends across the regions.
- The highest rates were found in the Central region.
- Variability of data by region is due to relatively small numbers of infant deaths calculated by region.

Statistical Notes:

- Rates are calculated per 1,000 live births.
- Totals for HHS regions are less than the San Diego County total due to events in which specific region could not be determined.

Source(s):

- State of California, Department of Health Services, Center for Health Statistics, Vital Statistics Section, Birth Statistical Master Files.
- Centers for Disease Control & Prevention, National Vital Statistics Reports, Vol 48, No. 12, July 20, 2000.

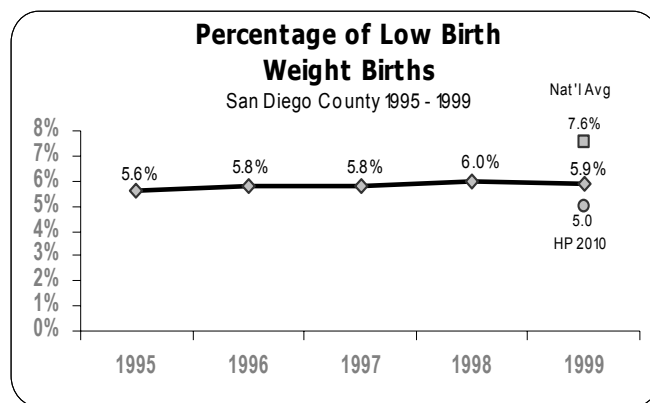
INFANT HEALTH—LOW BIRTHWEIGHT

Overview and Data Summary

Low Birth Weight (LBW) is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments, and other developmental disabilities. Despite the low proportion of pregnancies resulting in LBW babies, expenditures for the care of LBW infants total more than half the costs incurred for all newborns. LBW affects pre-term infants, those affected by intrauterine growth-retardation (IUGR), or fetuses with inadequate weight gain. Cigarette smoking is the greatest known risk factor for IUGR. Data presented below are for newborns weighing less than 2500 grams.

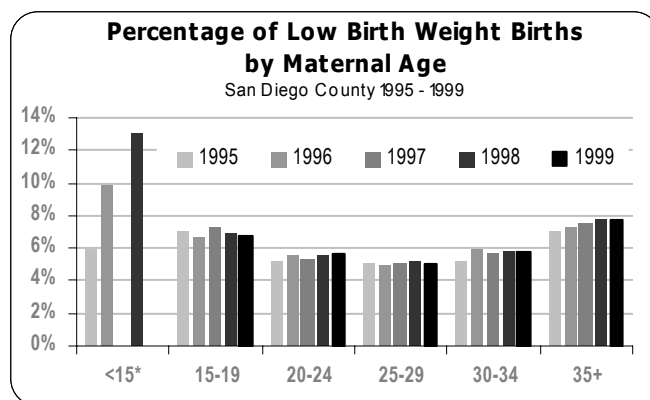
OVERALL TREND

- Percentage of LBW babies born in San Diego County was fairly consistent at between 5.6 - 6.0% for the years reported.
- The U.S. average rate of LBW births was 7.6% in 1999.
- The *Healthy People 2010* goal for LBW was 5.0%.



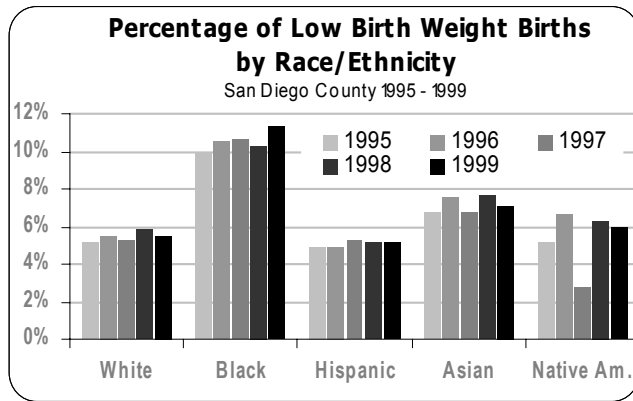
TREND BY AGE

- Higher percentages of LBW babies were born to younger mothers (≤ 19) and older mothers (35+).
- Slight increasing trend was noted for mothers aged 35+ between 1995 and 1999.



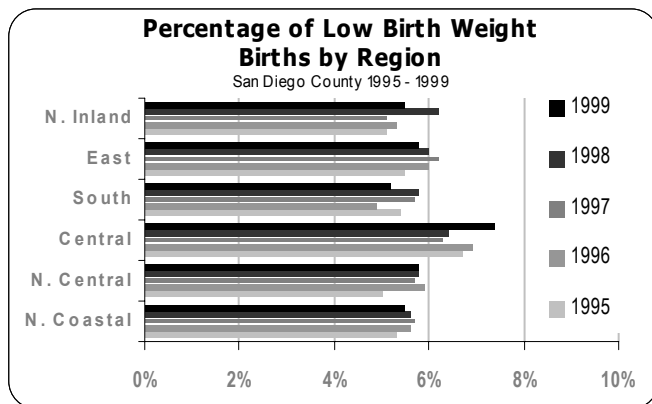
*Percentages not calculated for the <15 age group for the years 1997 and 1999 because of small numbers (See Data Table in Appendix A).

INFANT HEALTH—LOW BIRTHWEIGHT
Overview and Data Summary—Cont.



TREND BY RACE/ETHNICITY

- LBW for Blacks was roughly twice that of Whites and Hispanics for all years reported.
- No discernible trend was observed for any group.



TRENDS BY REGION

- Modest differences existed between regions.
- LBW in the Central region was slightly higher than other regions, especially in 1999.

Statistical Notes:

-Unknown birth weight births are not subtracted from total births in calculation of percentages.

Source(s): State of California, Department of Health Services, Center for Health Statistics, Vital Statistics Section, Birth Statistical Master Files.

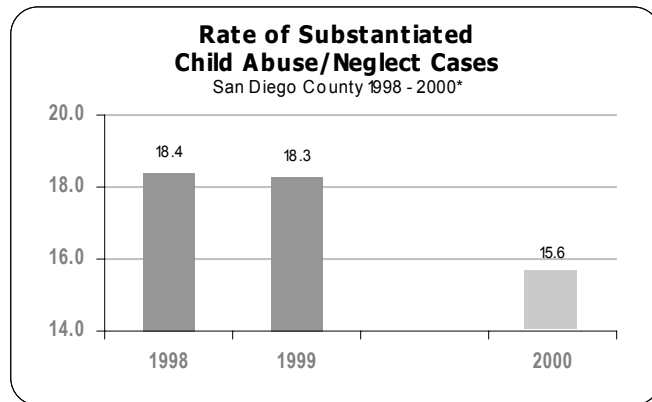
VIOLENT & ABUSIVE BEHAVIORS—CHILD ABUSE/NEGLECT

Overview and Data Summary

Data presented below are available by race/ethnicity and by region. Because of recent changes in the definition of categories of child abuse and neglect, Year 2000 data are not comparable to earlier years. Rates for 1998 and 1999 are presented only for the overall trend but are not comparable to the 2000 rate.

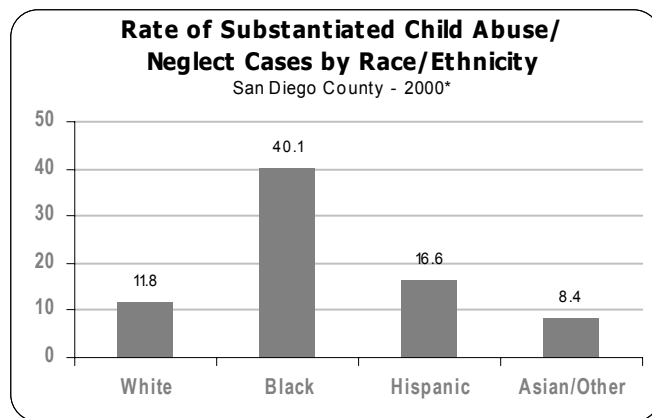
OVERALL TREND

- The rate of substantiated child abuse or neglect cases remained relatively stable between 1998 and 1999 (18.4 vs. 18.3 cases per 1,000 children).
- The rate for the Year 2000 represented a new definition for child abuse/neglect cases and was not comparable to earlier years.



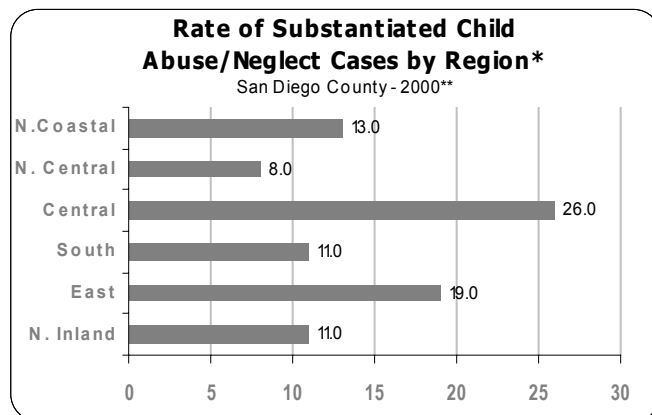
TREND BY RACE/ETHNICITY

- For 2000 only, the rate for Blacks was between two and five times the rate for other groups.
- Asian/Other had the lowest rate of all groups.



TREND BY REGION

- The Central region reported the highest rate of child abuse and neglect for the County, in 2000 followed by the East region.
- N. Central region reported the lowest rate of all regions.
- Data are not available by age or gender.



*Regional rates have been rounded and do not include cases with invalid or unknown zip codes.

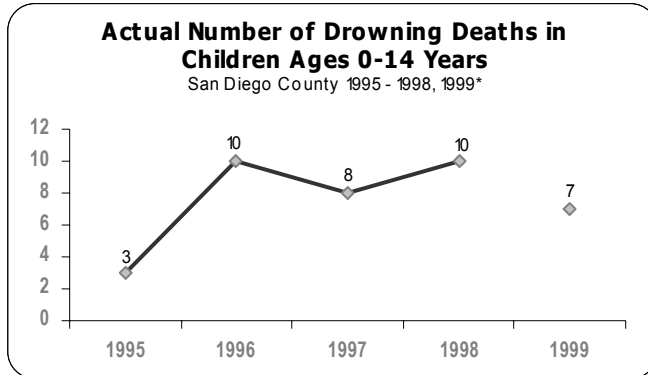
**Year 2000 data are not comparable to earlier years due to changes in definition.

Source(s): Children's Service Bureau, Health & Human Services Agency, San Diego County.

UNINTENTIONAL INJURIES—*DROWNING*

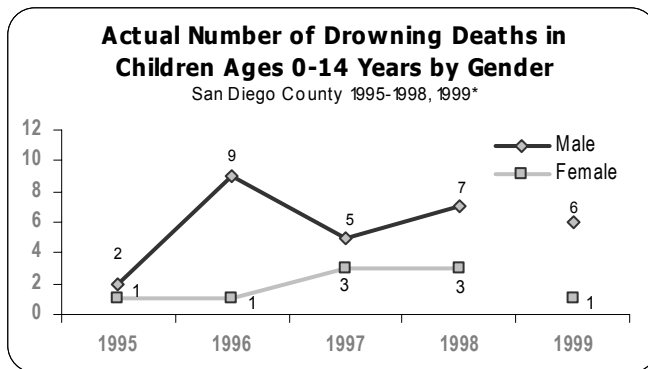
Overview and Data Summary

Drowning is the leading cause of injury deaths for children aged 1 to 4 years. Nationwide, approximately half of all drownings occur in residential backyard swimming pools. While drownings are highlighted here, the leading causes of injury deaths by age group can be found in the Data Tables in Appendix A.



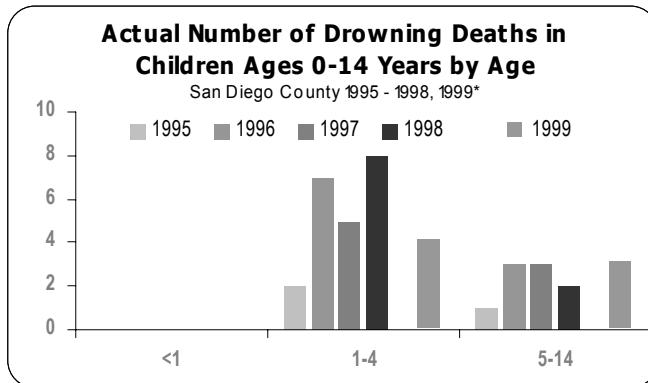
OVERALL TREND

- 38 deaths due to drowning occurred in children aged 0-14 years between 1995 and 1999.*



TREND BY GENDER

- Drowning deaths occurred more frequently among males than females.
- Between 1995 and 1998, 74% of the child drowning deaths in San Diego County occurred among male children.



TREND BY AGE

- No drowning deaths reported among children less than 1 year of age.
- 71% of the drowning deaths occurred among children aged 1-4 years.
- No *Healthy People 2010* goal established for drowning mortality among children aged 0-14 years.

*Note: The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death and differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from unintentional injuries are not directly comparable to previous years or to Healthy People 2010 goals because of the changes in death data coding.

Source(s): California Death Statistical Master File; San Diego Association of Governments January 1 1995-1999, Population Estimates

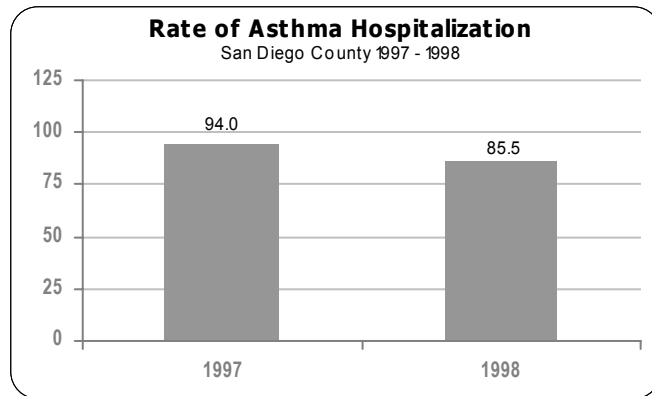
CHRONIC CONDITIONS—*ASTHMA*

Overview and Data Summary

Asthma is one of the most common chronic diseases in the United States, particularly for the very young, and has increased in prevalence nationally over the past two decades.¹ In California, it is estimated that 2.2 million people suffer from asthma, and approximately 40,000 people are hospitalized annually because of asthma.² Data depicted below are hospitalization rates due to asthma for 1997 and 1998.

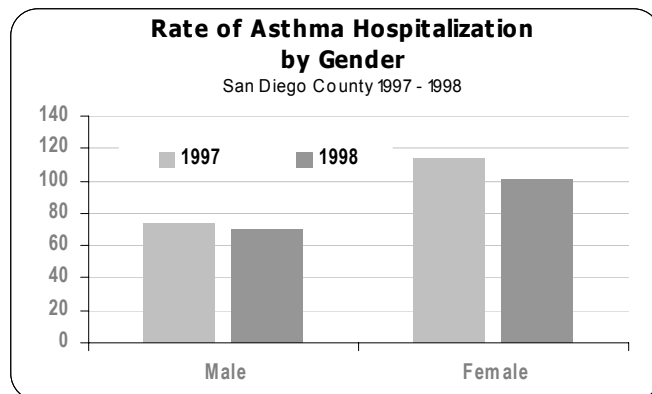
OVERALL TREND

- The age-adjusted hospitalization rate declined from 94.0 per 100,000 in 1997 to 85.5 per 100,000 in 1998.
- Although hospitalization rates do not reflect the true prevalence of asthma, these data are useful for surveillance purposes.



TREND BY GENDER

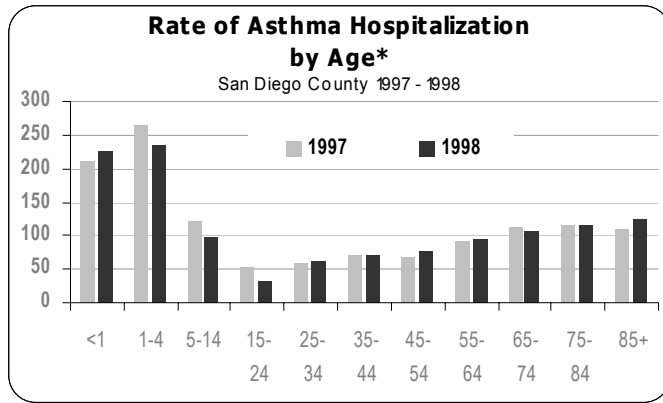
- Asthma hospitalizations occurred more frequently among females than males.
- Hospital admissions for asthma among females were 39% higher than for males in 1998 (all ages combined).



¹Mannino DM, Homa D, Pertowski CA, et al., Surveillance for asthma – United States, 1960-1995. Centers for Disease Control and Prevention *Surveillance Summary*. *MMWR* 1998;47 (No. SS-1).

²Centers for Disease Control and Prevention. Forecasted State-Specific Estimates of Self-Reported Asthma Prevalence – United States, 1998. *MMWR* 1998; 47.

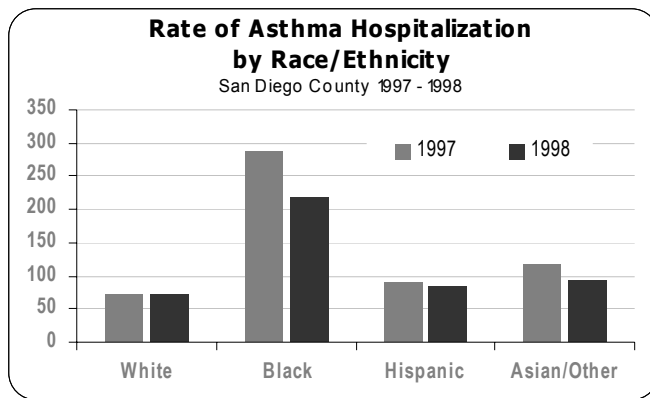
CHRONIC CONDITIONS—ASTHMA
Overview and Data Summary—Cont.



*Age-specific rate

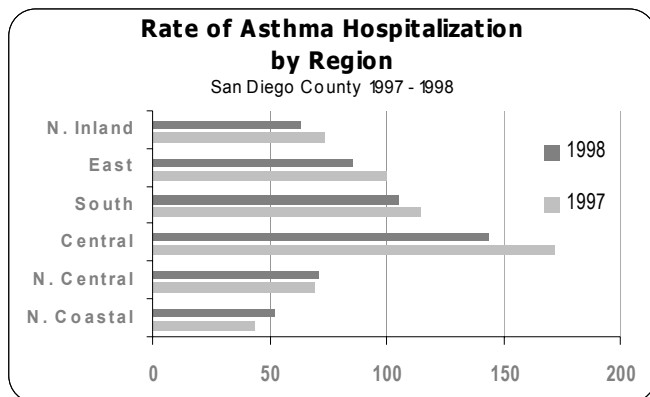
TREND BY AGE

- Highest rates were among the very young. Children younger than 5 years were hospitalized roughly 2-3 times more often than other groups.
- 38% of asthma hospitalizations occurred among children aged 0-14 years of age in 1998.
- *Healthy People 2010* goal to reduce asthma-related hospitalizations are no more than 250/100,000 (children 1-4), 77/100,000 (5-64), and 110/100,000 (≥ 65 years).



TREND BY RACE/ETHNICITY

- Rate of asthma hospitalization was greatest among Blacks, followed by Asian/Other and Hispanics.
- Rate for Blacks was roughly 2-3 times greater than other race/ethnic groups.
- Lowest rate for asthma hospitalizations observed among Whites.



TREND BY REGION

- Central region had the highest rate of asthma hospitalizations, followed by South region.
- N. Coastal region had the lowest rate of any region.
- A decrease between 1997-1998 occurred in every region except N. Coastal and N. Central.

Statistical Notes:

- All rates per 100,000 population, adjusted to 2000 Standard U.S. Population, except trend by age.
- Asthma was included if the primary discharge diagnosis was asthma.

Source(s):

- California Office of Statewide Health Planning & Development (OSHPD) Discharge Data.
- San Diego Association of Governments, January 1997 and 1998 Population Estimates used for calculating rates.

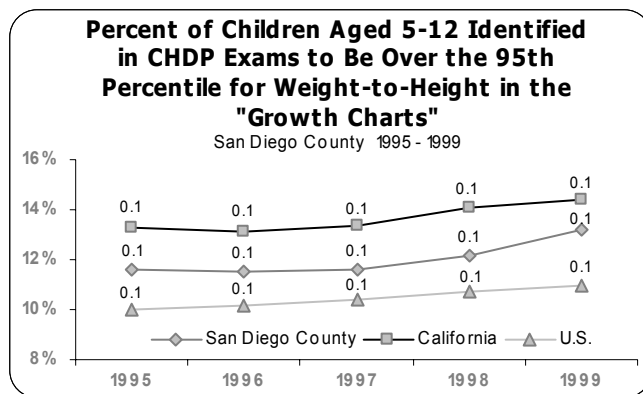
HEALTH BEHAVIORS—OVERWEIGHT CHILDREN

Overview and Data Summary

Obesity is linked to a number of health problems, including high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and problems breathing, and various forms of cancer.¹ Research indicates that overweight and obese children and adolescents are likely to become overweight and obese adults. Child Health and Disability Prevention (CHDP) exams provide one measure of overweight children in a limited population. Children qualify for CHDP well-child exams if family income is less than 200% of the Federal Poverty Level (\$35,300 for a family of 4 in 2001). Limitations are due to increasing infrequency of exams for older children as well as disproportionate representation among racial/ethnic groups compared to the entire County population. Caution is advised when applying the following data across the age spectrum.

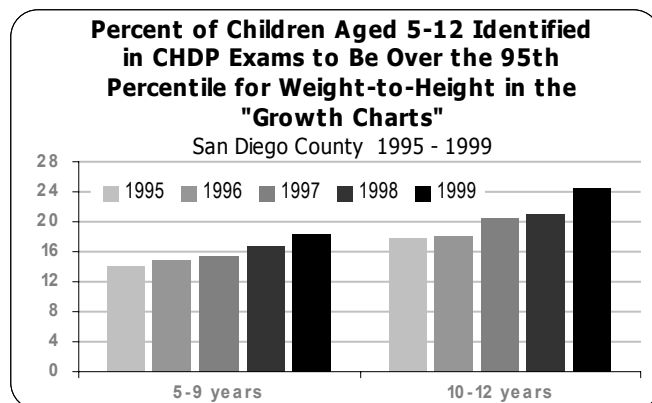
OVERALL TREND

- The percent of overweight children and adolescents seen in San Diego County CHDP exams was below California but above national figures.
- Slight increasing trend was observed for San Diego County, the state of California, and the U.S.
- The *Healthy People 2010* goal for all children and adolescents is 5%.



TREND BY AGE

- There was a greater percent of overweight children aged 10-12 years than children aged 5-9 years.
- An increasing trend was noted for both age groups from 1995 to 1999.



¹U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington DC: Public Health Service, January 2000.

Statistical Notes:

- Data are not available to provide breakdowns by racial/ethnic groups or region.

Source(s): Trends in prevalence of overweight in children aged 0-12 years, Pediatric Nutrition Surveillance System (PedNSS), California Department of Health Services, Children's Medical Services Branch.

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III. TEEN SUBSTANCE ABUSE—ALCOHOL

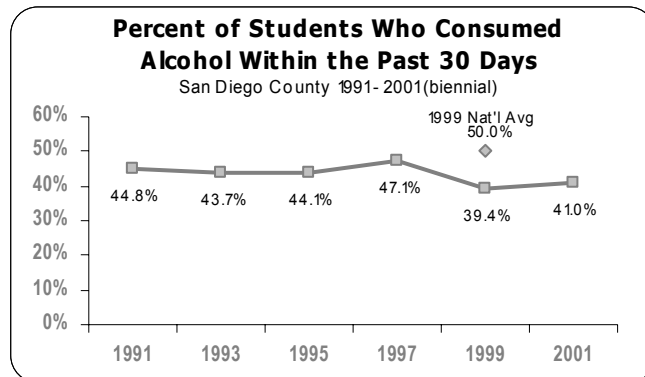
Overview and Data Summary

The Youth Risk Behavior Survey (YRBS) is a national school-based survey conducted biennially to assess the prevalence of and trends in health risk behaviors among high school students, grades 9 through 12. The priority health risk behaviors fall into the following six categories: (1) behaviors that result in unintentional and intentional injuries; (2) tobacco use; (3) alcohol and drug use; (4) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies; (5) dietary behaviors; and (6) physical activity.

For selected risk behaviors, local data are presented by age, gender, race/ethnicity, and year of survey. Where available, 1999 national estimates and *Healthy People 2010* objectives are presented for comparison.

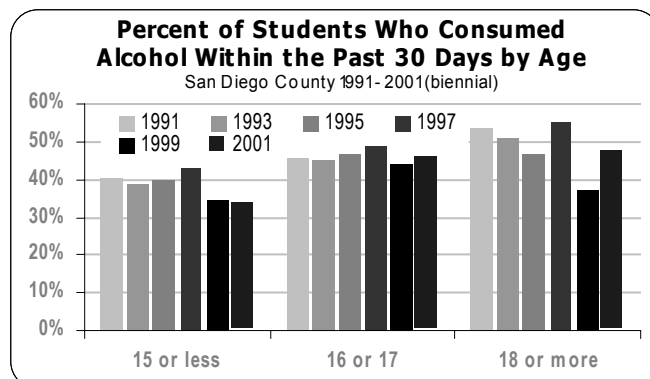
OVERALL TREND

- Data revealed a decline in alcohol consumption among San Diego high school students between 1997 and 1999 (from 47.1% to 39.4%), with a slight increase to 41.0% from 1999 to 2001.
- San Diego Unified high school students were below the national average in 1999 (39.4% vs. 50.0%).

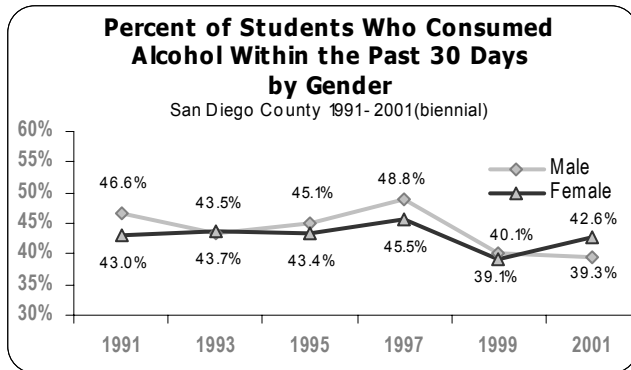


TRENDS BY AGE

- Except for 1999, alcohol consumption tended to increase with age.
- All three age groups declined in reported alcohol consumption between 1997 and 1999. Only among students 15 years and younger did alcohol consumption decline for all years reported.

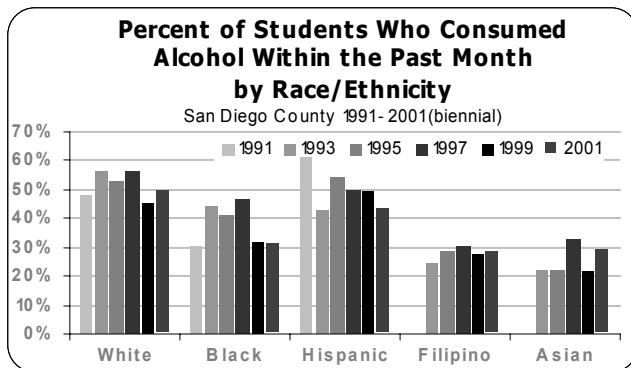


TEEN SUBSTANCE ABUSE—ALCOHOL
Overview and Data Summary—cont.



TREND BY GENDER

- Data revealed a decline in the percent of male students reporting alcohol consumption since 1997.
- The percent of consumption reported by both genders in San Diego Unified was well below the 1999 national averages (52.3% for males, 47.7% for females).



TREND BY RACE/ETHNICITY

- White and Hispanic students were more likely than Filipino and Asian students to report alcohol consumption.
- Continued declines were noted for Black and Hispanic students since 1997.
- San Diego Unified students by race were all below the 1999 national averages: 52.5% for Whites, 39.9% for Blacks, and 52.8% for Hispanics.

Source(s):

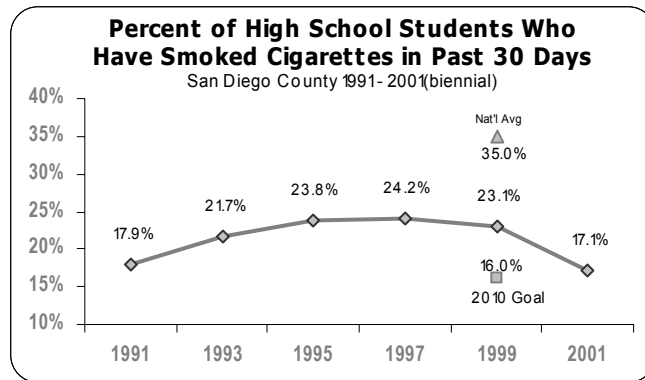
- Youth Risk Behavior Surveillance System (YRBSS), San Diego City Schools, 1991 to 2001
- Youth Risk Behavior Surveillance System (YRBSS), United States, 1999

TEEN SUBSTANCE ABUSE—TOBACCO

Overview and Data Summary

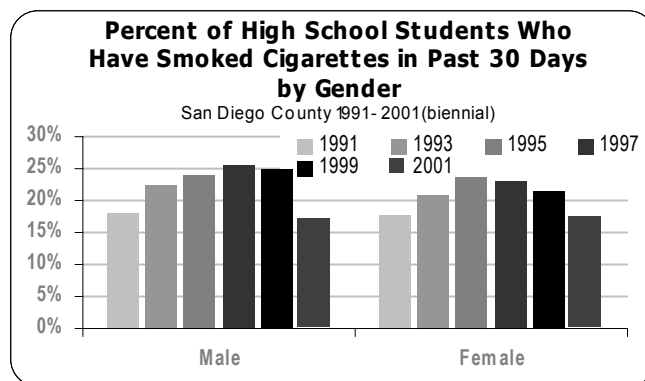
OVERALL TREND

- Smoking among high school students has declined since 1997.
- San Diego Unified students were well below the U.S. average of 35% for 1999.
- *Healthy People 2010* goal is 16%.



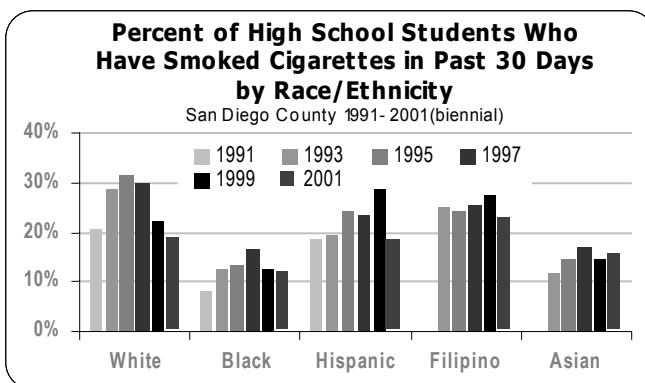
TREND BY GENDER

- Males reported slightly higher cigarette use than females for each year except 2001.
- Decline for both genders noted since 1997.
- 1999 U.S. average for males was 34.7% and 34.9% for females.



TREND BY RACE/ETHNICITY

- Decline observed for all races/ethnicities between 1997 and 2001.
- White students were more likely than Black students to report cigarette smoking.

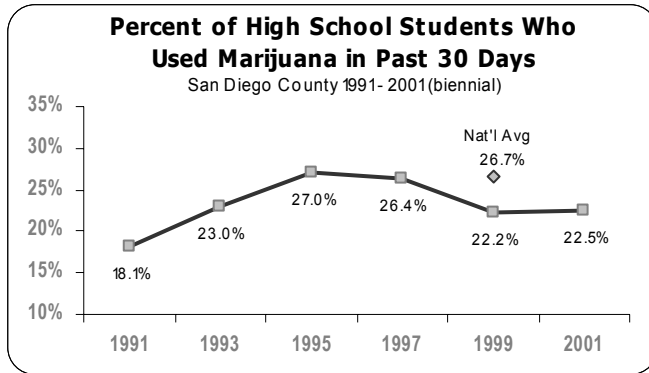


Source(s):

Youth Risk Behavior Surveillance System (YRBSS) - San Diego City Schools, 1991 to 2001

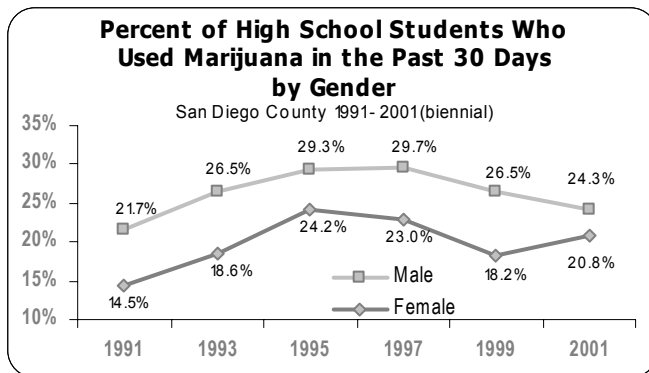
Youth Risk Behavior Surveillance System (YRBSS) - United States, 1999

TEEN SUBSTANCE ABUSE—MARIJUANA
Overview and Data Summary



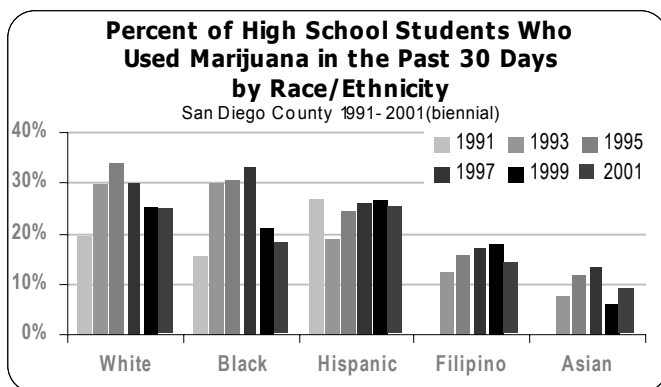
OVERALL TREND

- Marijuana use increased until 1995, then declined between 1997 and 1999.
- A 17% decline between 1995 and 1999 was observed.
- The 1999 U.S. average was 26.7%.



TREND BY GENDER

- Males consistently reported higher marijuana use than females.
- Declines males observed since 1997.
- Both genders reported lower marijuana use compared to the national averages: males 30.8% and females 22.6%.



TREND BY RACE/ETHNICITY

- Asian students were less likely than all other students to report marijuana use.
- A sizable decline was observed for White and especially Black students since 1997.
- 1991 data were not available for Filipino and Asian groups.

Source(s):
Youth Risk Behavior Surveillance System (YRBSS) - San Diego City Schools, 1991 to 2001
Youth Risk Behavior Surveillance System (YRBSS) - United States, 1999

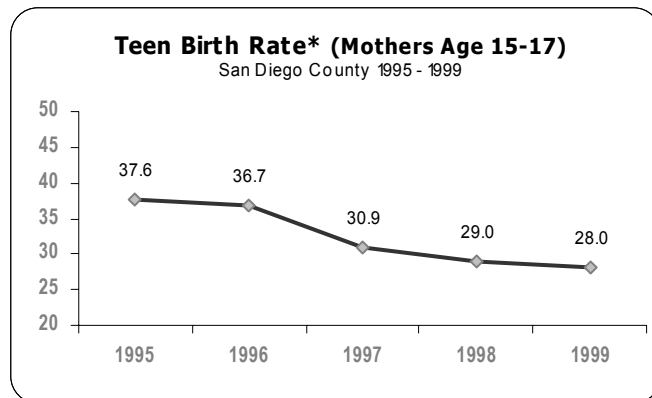
REPRODUCTIVE HEALTH—TEEN BIRTHS

Overview and Data Summary

Teenaged mothers are less likely to get or stay married, less likely to complete high school or college, more likely to require public assistance, and more likely to live in poverty than their peers who are not mothers. Infants born to teenaged mothers, especially mothers younger than 15, are more likely to suffer from low birth weight, neonatal death, and sudden infant death syndrome. These problems may be due, at least in part, to the low rate of prenatal care for teenage mothers.

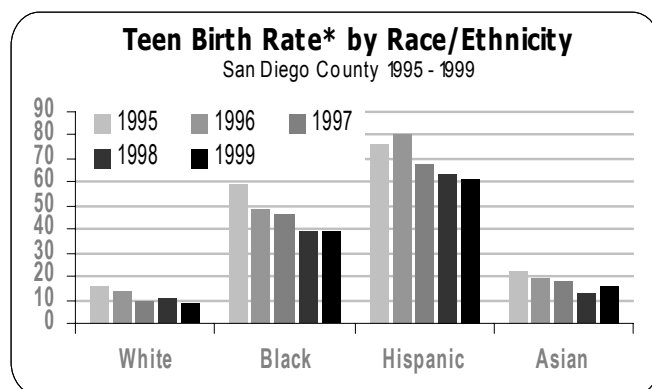
OVERALL TREND

- San Diego County’s teen birth rate has declined almost 10% from 1995 to 1999. (37.6% to 28.0% per 1,000 live births).
- The 1999 teen birth rate in California was 30.1 and the national average was 28.7 for the same year.
- *Healthy People 2010* objectives are available only for teen pregnancies.

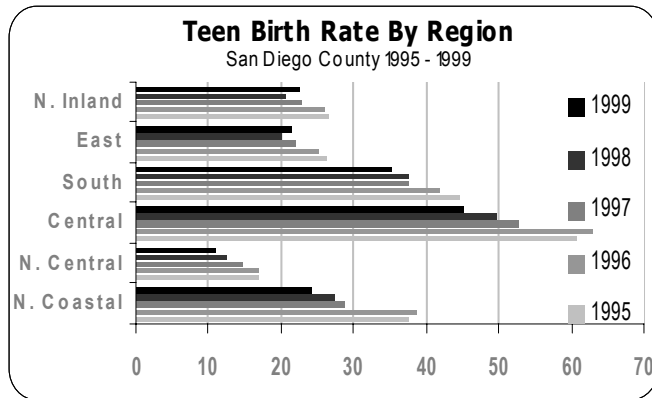


TREND BY RACE/ETHNICITY

- The Hispanic teen birth rate in San Diego County was 61.7 in 1999, down from a high of 80.7 in 1996.
- For 1999, the Hispanic rate was twice that of the overall rate (28.0) and nearly seven times the rate of Whites.
- The rate for Blacks was also above the overall rate.
- All groups showed a decline since 1995.



REPRODUCTIVE HEALTH—TEEN BIRTHS
 Overview and Data Summary—Cont.



TREND BY REGION

- The highest teen birth rates were in Central and South Regions.
- Lowest rate was in N. Central region.
- Declining trends were observed for every region since 1995.

Statistical Notes:

- * Rates are calculated per 1,000 females aged 15-17 years.
- Totals for HSA Regions are less than the County total due to events in which region could not be determined.
- No data are available for teen pregnancy rates. The rates below are for the number of live births to teenaged girls, 15-17, per 1,000 girls of same age group.

Source(s): State of California, Department of Health Services, Center for Health Statistics, Vital Statistics Section, Birth Statistical Master Files.

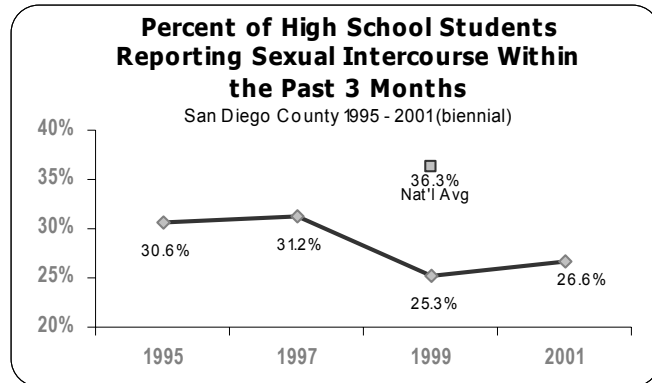
REPRODUCTIVE HEALTH—TEEN SEXUAL INTERCOURSE

Overview and Data Summary

Data for teen sexual intercourse are available for the years 1995, 1997, 1999 and 2001.

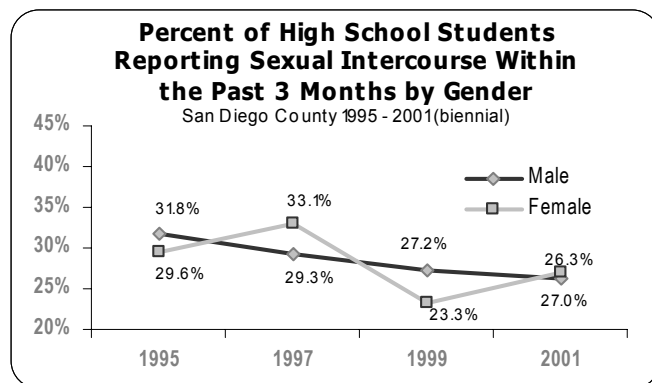
OVERALL TREND

- Overall percent reporting sexual intercourse increased from 25.3% in 1999 to 26.6% in 2001.
- National average for this behavior was 36.3% in 1999.
- No *Healthy People 2010* target is established for this specific measure.



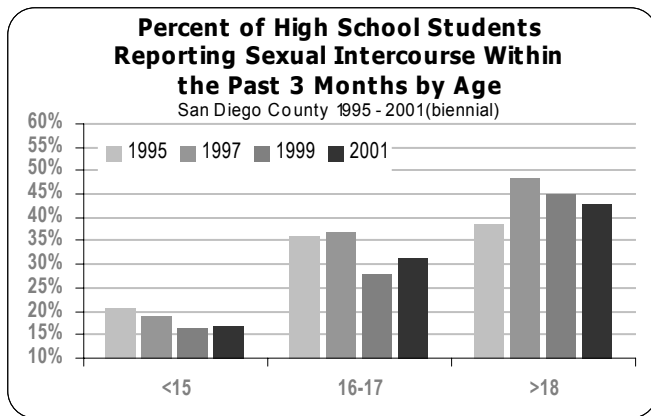
TREND BY GENDER

- Male students continue to report a modest but steady decline since 1995.
- After declining dramatically from 1997 to 1999, the percent of female students reporting sexual intercourse in the last three months increased in 2001.



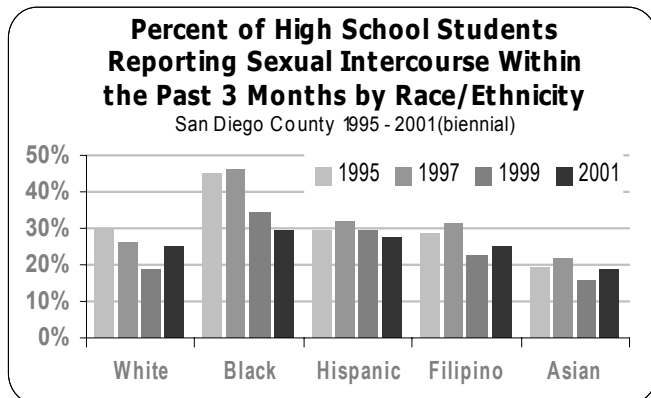
- National averages for females and males in 1999 were 36.3% and 36.2%, respectively.

REPRODUCTIVE HEALTH—TEEN SEXUAL INTERCOURSE
 Overview and Data Summary—Cont.



TREND BY AGE

- Sexual intercourse increased as students progressed through high school.
- The percent of students 18 years and older reporting sexual intercourse within the last 3 months continues to decline since 1997.
- Overall decline for each age group was observed since 1997.



TREND BY RACE/ETHNICITY

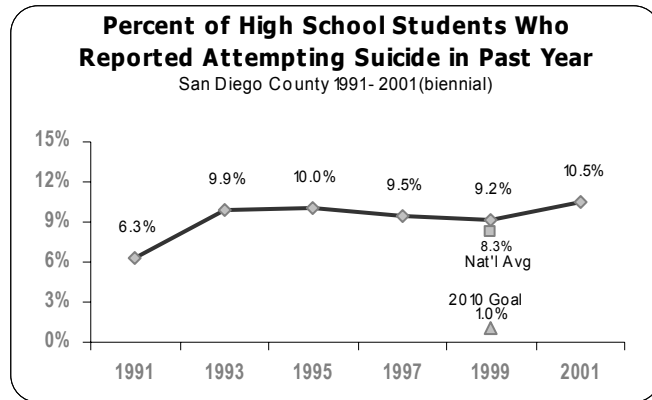
- Decline for all groups observed since 1997.
- Black students were more likely than other groups to report sexual intercourse in the last 3 months.

Source(s):
 Youth Risk Behavior Surveillance System (YRBSS), San Diego City Schools, 1991 to 2001
 Youth Risk Behavior Surveillance System (YRBSS), United States, 1999

MENTAL HEALTH—SUICIDE ATTEMPTS
Overview and Data Summary

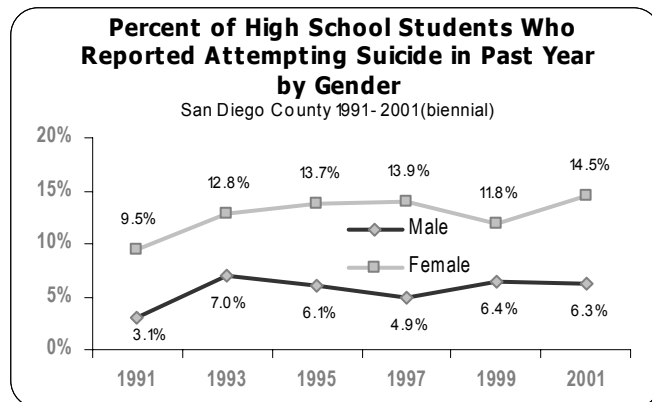
OVERALL TREND

- After some decline between 1993 and 1999, the overall percent of students reporting suicide attempts increased between 1999 and 2001.
- The 1999 U.S. average was 8.3%.



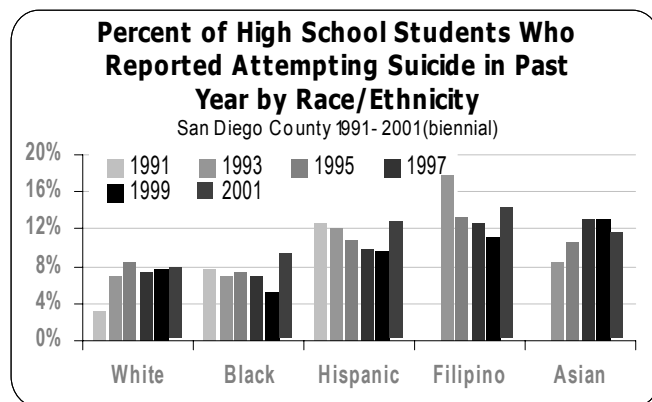
TREND BY GENDER

- Female students were more likely than male students to report suicide attempts, reporting the highest level of all years in 2001 (14.5%).
- Rates by gender in San Diego County were higher than the 1999 national averages (5.7% for males, 10.9% for females).
- No significant trends by gender were noted.



TREND BY RACE/ETHNICITY

- Increases since 1999 were observed among Black, Hispanic, and Filipino students.
- Highest rates were generally reported among Filipino, Asian and Hispanic students.
- 1991 data were not available for Filipino and Asian students.

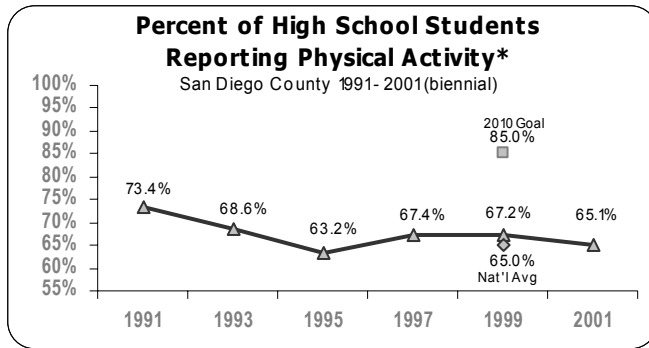


Source(s):

- Youth Risk Behavior Surveillance System (YRBSS) - San Diego City Schools, 1991 to 2001
- Youth Risk Behavior Surveillance System (YRBSS) - United States, 1999

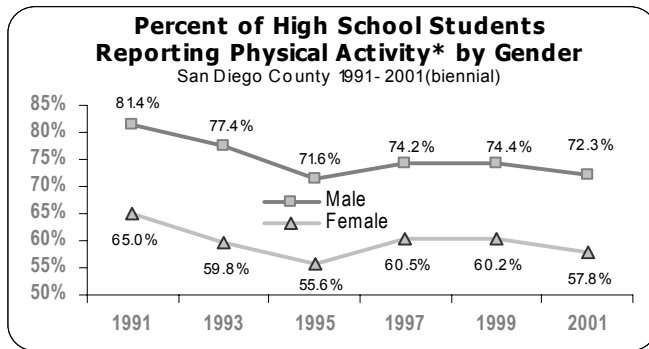
HEALTHY BEHAVIORS—PHYSICAL ACTIVITY

Overview and Data Summary



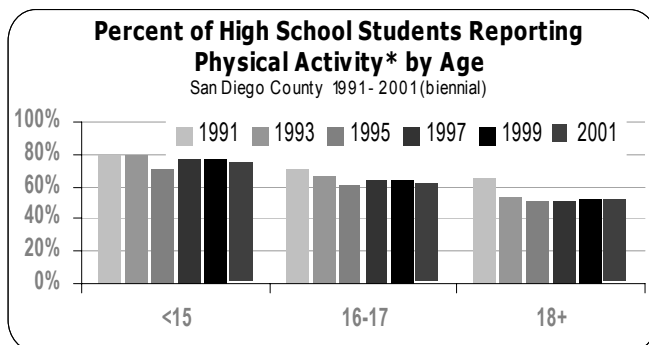
OVERALL TREND

- Overall decrease was observed between 1991 and 2001.
- The 1999 U.S average was 64.7%.
- The *Healthy People 2010* goal is 85%.



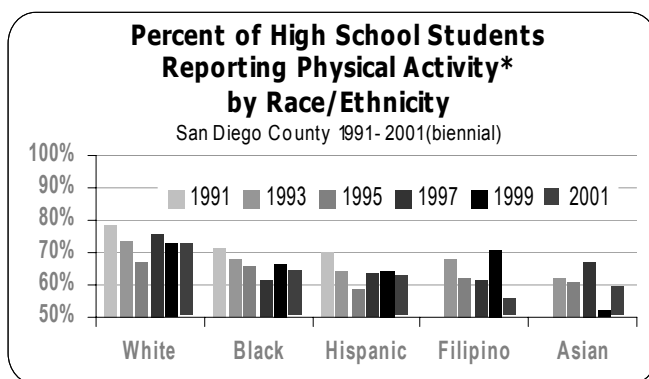
TREND BY GENDER

- Male students reported more physical activity than female students.
- Both genders were slightly above 1999 U.S. averages for males (72.3%) and females (57.1%).



TREND BY AGE

- Slight decreases observed for each age group since 1991.
- Physical activity tends to decline with increasing age.



TREND BY RACE

- White students generally reported more physical activity than other groups.
- 1991 data not available for Asian and Filipino students.

*Students were asked if they "did physical activities for at least 20 minutes per day that made them sweat and breathe hard on 3 or more of the past 7 days."

Source(s):

- Youth Risk Behavior Surveillance System (YRBSS) - San Diego City Schools, 1991 to 2001
- Youth Risk Behavior Surveillance System (YRBSS) - United States, 1999

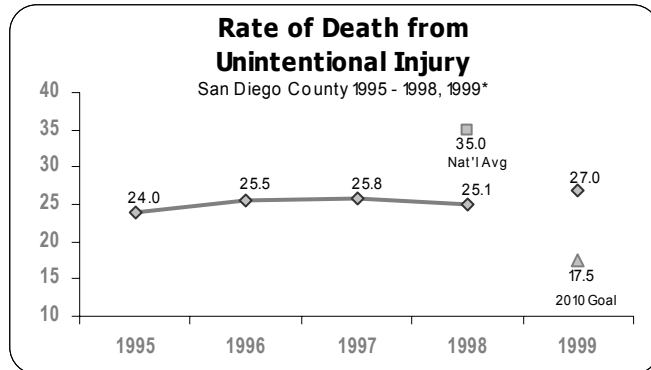
UNINTENTIONAL INJURIES— OVERALL DEATHS

Overview and Data Summary

Unintentional injury is the sixth leading cause of death in San Diego County and one of the main causes of death among young people nationwide. The National Center for Injury Prevention and Control reports that more people aged 1-34 years die of unintentional injuries than any other cause of death.¹ Leading unintentional injury deaths by age can be found in the Data Tables in Appendix A.

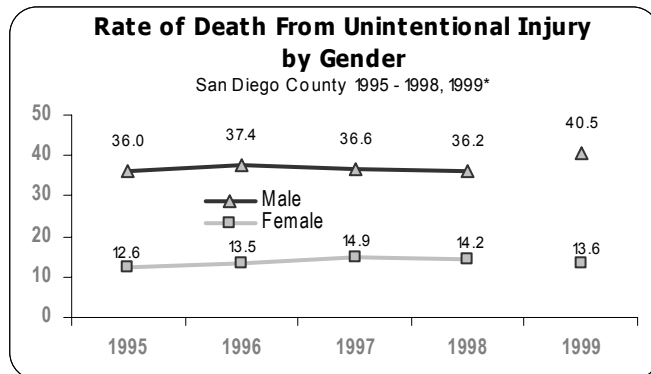
OVERALL RATE

- The death rate remained stable for the years reported.
- 1998 national average was 35.0 deaths per 100,000 population.
- The *Healthy People 2010* goal is no more than 17.5 deaths per 100,000.



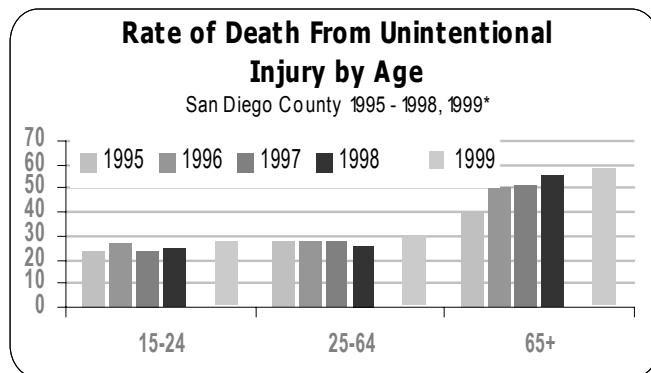
TREND BY GENDER

- The death rate for males was approximately three times that of females.
- Stable trends were observed between 1995 and 1998 for both genders.



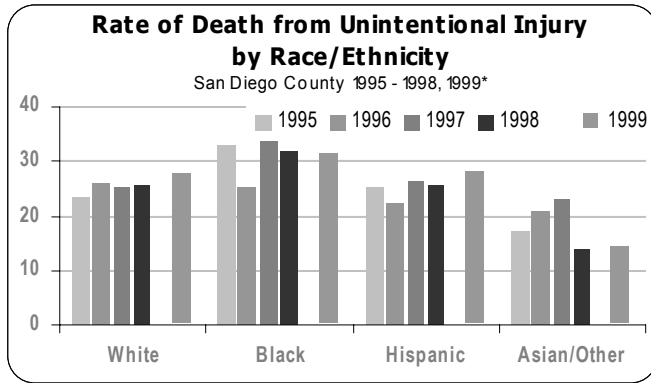
TREND BY AGE

- Highest age-specific rates were observed among seniors 65+ (nearly twice the rate of other reported age groups).
- Notable upward trend seen for persons 65+ since 1995.



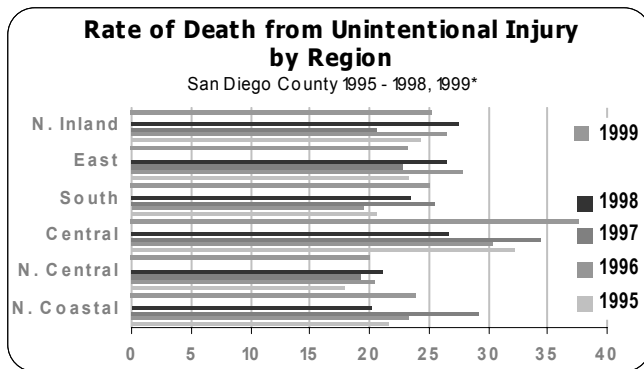
¹ National Center for Injury Prevention and Control. *Ten Leading Causes of Injury Deaths*. Health and Human Services, Centers for Disease Control and Prevention, 2000.

UNINTENTIONAL INJURIES—OVERALL DEATHS
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Blacks had the highest unintentional injury death rate for all years except 1996.
- No trends were observed.



TREND BY REGION

- Highest rate occurred in the Central region was from 1995 to 1997.
- Declines were observed between 1995 and 1998 in Central region (17.3%) and N. Coastal region (7.4%).

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from unintentional injuries are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

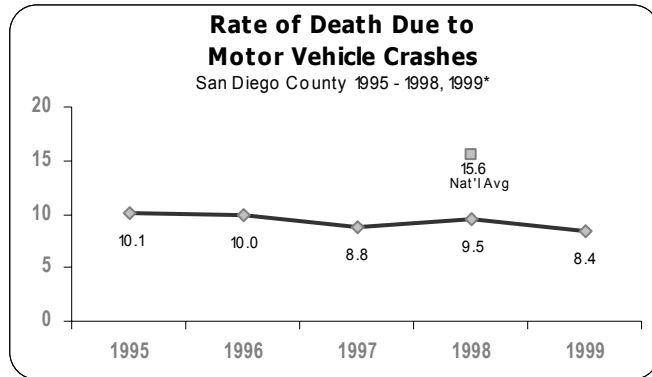
- State of California Death Statistical Master File, 1995-1999.
- SANDAG January 1, Population Estimates used for calculating rates.

UNINTENTIONAL INJURIES—MOTOR VEHICLE RELATED DEATHS
Overview and Data Summary

Deaths due to motor vehicle crashes (MVC) are among the leading causes of death in San Diego County and represent about half of all unintentional deaths for people of any age in the United States.¹

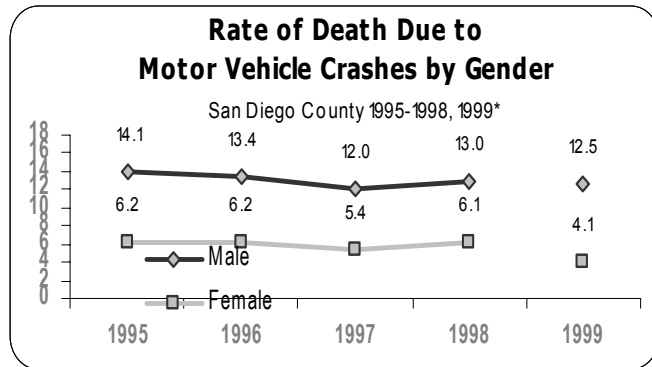
OVERALL TREND

- Overall trend was fairly stable for the years reported.
- The 1998 U.S. average was 15.6 deaths per 100,000.
- *Healthy People 2010* goal is no more than 9.2 deaths per 100,000 population (not directly comparable to 1999 data).



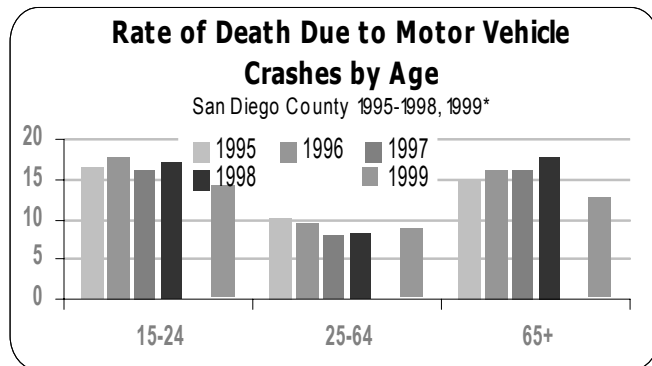
TREND BY GENDER

- The rate for males was more than twice that of females.
- A slight decline for males was observed between 1995 and 1998.
- The 1998 U.S. average was 21.6 for males and 10.1 for females.



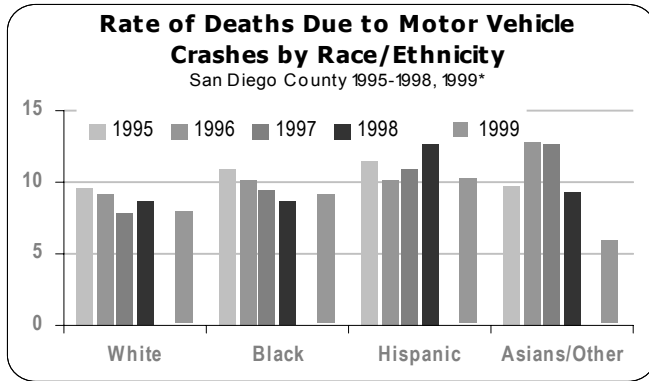
TREND BY AGE

- The highest rates were noted among persons aged 15-24 (13.9 in 1999) and 65+ (12.2 in 1999).
- A slight increase between 1995 and 1998 was observed for seniors 65+ (14.8 to 17.8 deaths per 100,000).



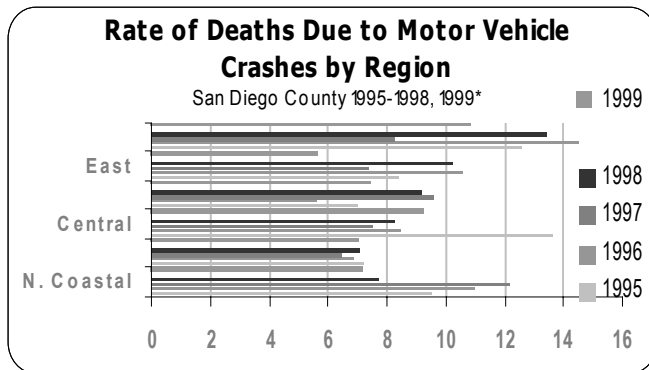
¹National Center for Injury Prevention and Control. *Ten Leading Causes of Injury Deaths*. Health and Human Services, Centers for Disease Control and Prevention, 2000.

UNINTENTIONAL INJURIES—MOTOR VEHICLE RELATED DEATHS
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- The highest rates occurred among Hispanics and Asians.
- A decline among Blacks was observed from 1995 to 1998.



TREND BY REGION

- No region had consistently higher rates between 1995 and 1998.
- Increases were observed among South, East, and N. Inland regions for the same time period.
- N. Central region had a fairly consistent rate for all years reported (6.5 to 7.2).

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from motor-vehicle-related crashes are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding (see Technical Notes for details).

Source(s):

- State of California, Department of Health Services Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

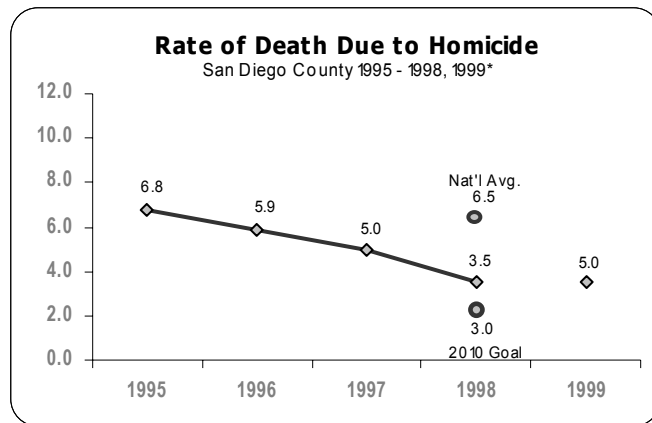
VIOLENCE & ABUSIVE BEHAVIORS—*HOMICIDE*

Overview and Data Summary

In 1999, homicide was ranked as the thirteenth leading cause of death in San Diego County. At the national level, it is the second leading cause of death for young persons aged 15 - 24 years and the leading cause of death among Blacks in the same age group.¹

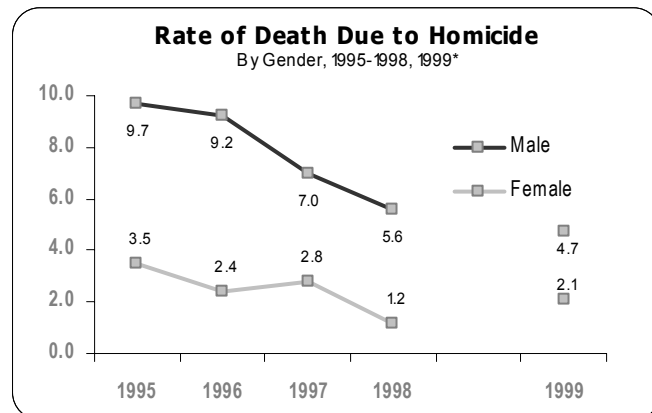
OVERALL TREND

- Overall decline was noted since 1995 (from 6.8 to 3.5 deaths per 100,000 in 1998).
- The 1998 U.S. average was 6.5 homicides per 100,000.
- *Healthy People 2010* goal is no more than 3.0 deaths per 100,000.



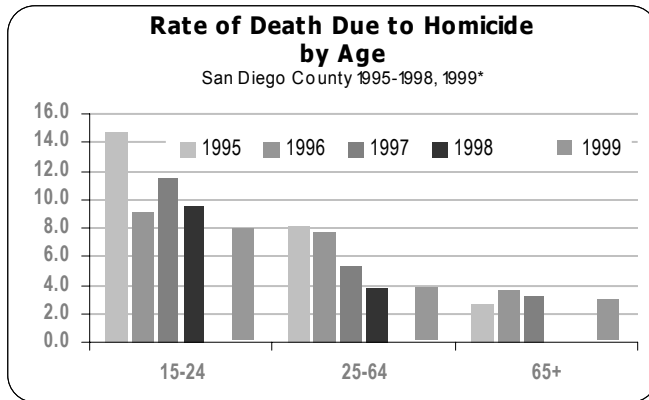
TREND BY GENDER

- The rate for males was 3.5 times that for females.
- A decline in the rate was noted between 1995 and 1998 for females (65.7%) and males (42.3%).



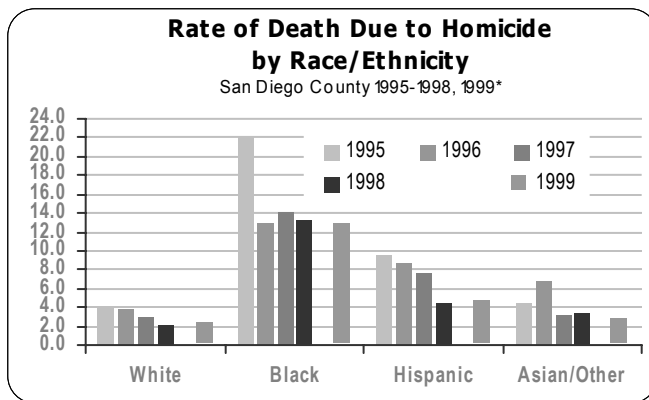
¹ Singh G.K., Kochanek K.D., and MacDorman M.F. Advance report of final mortality statistics, 1994. *Monthly Vital Statistics Report* 45(3S). Hyattsville, MD: National Center for Health Statistics, 1996.

VIOLENCE & ABUSIVE BEHAVIORS—HOMICIDE
Overview and Data Summary—cont.



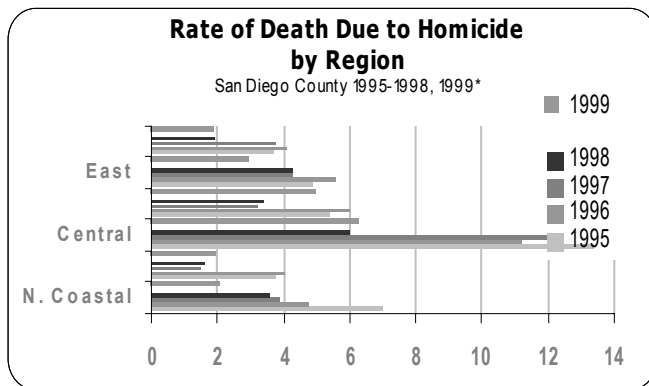
TREND BY AGE

- Rate was consistently higher for persons aged 15-24 than for other age groups.
- Declines were observed for persons aged 25-64 between 1995 and 1998.
- There were fewer than 5 homicides among persons aged 65 and older.



TREND BY RACE/ETHNICITY

- The homicide death rate for Blacks in 1995 was almost five times the rate for Whites and about twice that of Hispanics or Asians/Others.
- Rate for Blacks decreased 40.3% in San Diego County between 1995 and 1998.
- Note: Compare rates with caution since actual numbers per group are relatively small.



TREND BY REGION

- Declines in homicide rate were observed in every region between 1995 and 1998.
- Largest decrease (57.9%) was in N. Central region.
- Decreases of over 48% were also noted for Central, N. Coastal, and N. Inland regions.

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from homicide are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California, Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1 1995-1999, Population Estimates

IV. SUBSTANCE ABUSE—ADULT SMOKING PREVALENCE

Overview & Data Summary

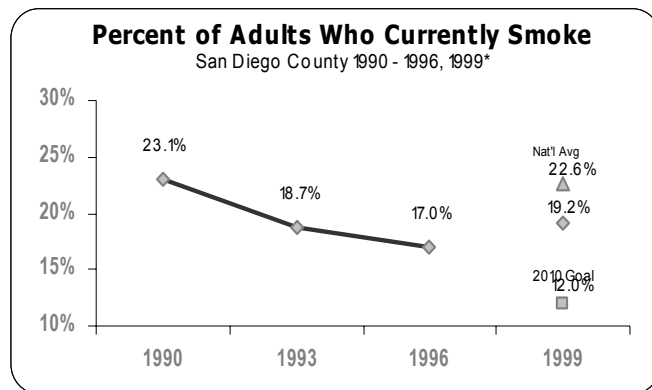
Cigarette smoking is the single most preventable cause of disease and death in the nation. Smoking results in more deaths each year in the U.S. than deaths caused by AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires combined.¹ In 1999, 22.6% of U.S. adults reported smoking compared to 18.7% in the State of California.¹ For 1999, there was a change in the survey question regarding adult smoking. Previous to 1999, the survey asked respondents: "Do you smoke now?" For 1999, the new question asked: "Do you smoke everyday, sometimes, or not at all?" Consequently, 1999 data are not comparable with previous years and represent the beginning of a new trend. The only 1999 data that have been released are for overall prevalence. Data by gender and age are included between 1990 and 1996 only.

Although local data are not available by race or region, national data suggest the following:²

1. American Indians, Alaskan Natives, blue collar-workers, and military personnel have the highest rates of adult smokers.
2. Rates of smoking in Asian and Pacific Island men are more than four times higher than for women of the same race.
3. Low income adults are about twice as likely to smoke as high income adults.
4. The percentage of people aged 25 years and older with less than 12 years of education who are current smokers is nearly three times that for persons with 16 or more years of education.

OVERALL TREND

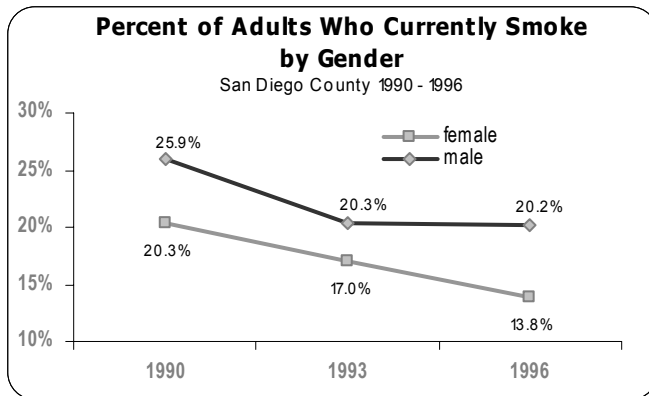
- Decreasing trend was noted 1990-1996.
- The 1999 U.S. average was 22.6%.
- *Healthy People 2010* goal is no more than 12% adult smokers.



¹Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System*, Atlanta, GA: CDC, 1999.

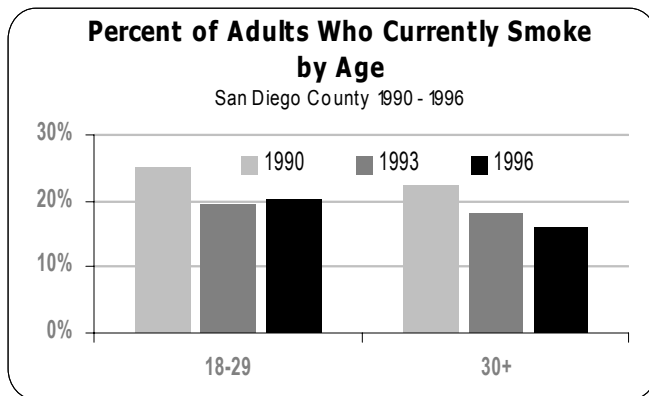
²U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington DC: Public Health Service, January 2000.

SUBSTANCE ABUSE—ADULT SMOKING PREVALENCE
 Overview & Data Summary—cont.



TREND BY GENDER

- Males reported smoking more often than women in San Diego County for all years.
- Declines were noted for males and females from 1990 to 1996.



TREND BY AGE

- Declining trend was observed for the 3 years reported for persons aged 30+.
- Reported smoking prevalence for persons aged 18-29 did not decrease between 1993 to 1996.

Source(s):
 - 1990, 1993, 1996, 1999: California Tobacco Surveys (CTS) - UCSD
 - California Department of Health Services, Tobacco Control Section

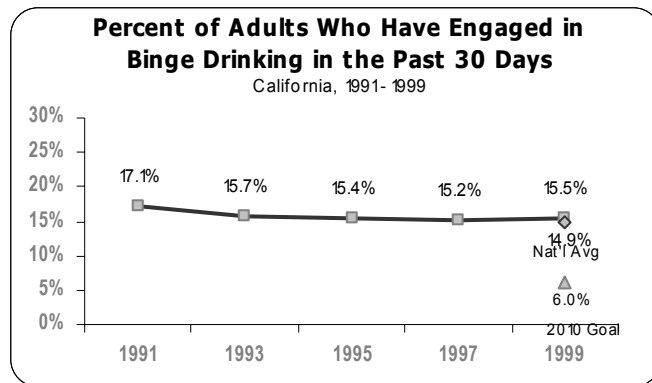
SUBSTANCE ABUSE—ADULT ALCOHOL ABUSE

Overview & Data Summary

One measure of adult alcohol abuse is binge drinking. The Behavioral Risk Factor Surveillance System (BRFSS) identifies the percent of adults who have engaged in binge drinking in the past 30 days, where binge drinking is defined as five or more drinks on any one occasion one or more times during the past month. Data presented below are for the State of California overall and by gender for the years 1991 to 1999.

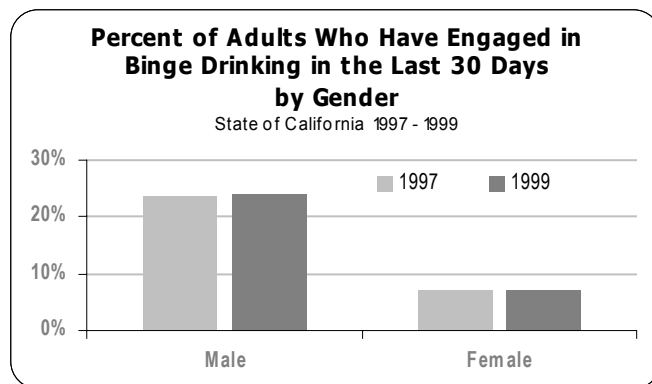
OVERALL TREND

- A slight decrease was noted between 1991 and 1993.
- The 1999 U.S. average was 14.9% for binge drinking.
- *Healthy People 2010* goal is no more than 6.0% for ages 18+ years.



TREND BY GENDER

- Males were more likely than females to report this behavior.
- Data by gender were available for 1997 and 1999 only.
- Little change was observed for the years reported.



Source(s):

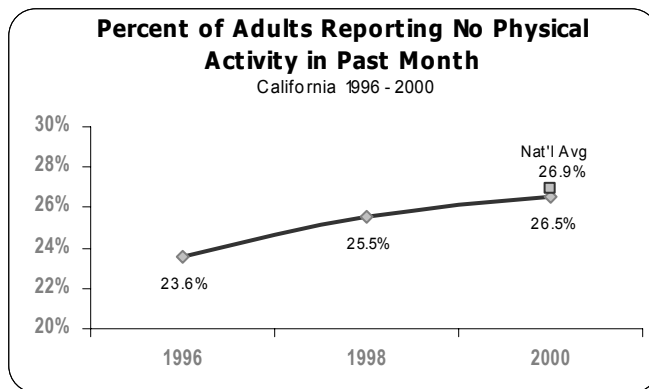
Behavioral Risk Factor Surveillance System (BRFSS); www.cdc.gov/nccphp/brfss

U.S. Department of Health and Human Services. *Healthy People 2010*; www.health.gov/healthypeople

HEALTHY BEHAVIORS—PHYSICAL ACTIVITY & OBESITY

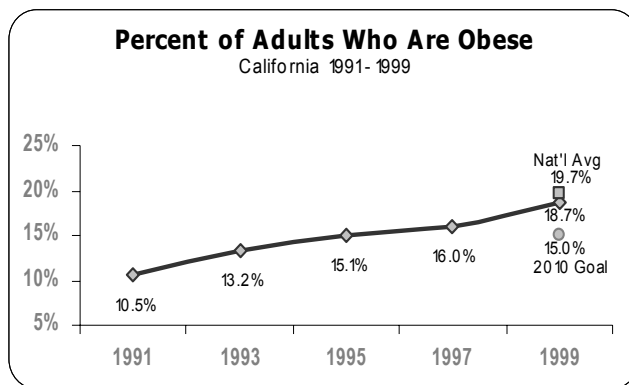
Overview & Data Summary

Throughout a person's lifetime, regular physical activity is important for maintaining a healthy body, enhancing psychological well-being, and preventing premature death. The research literature is replete with evidence that lack of regular physical activity is a major contributor to poor health and obesity. Obesity is determined from the body mass index (BMI) as weight in kilograms divided by height in meters squared (w/h^2) yielding a score of 30.0 or more. Rates of physical exercise and obesity are limited to overall rates for 1996—2000 and 1991—1999, respectively.



OVERALL TREND

- Data are available only for the state of California.
- Increasing trend was noted in the percentage of California's adult population reporting no physical activity in the past month.
- Year 2000 U.S. average of 26.9% was slightly lower than California average.
- No comparable *Healthy People 2010* goal is available for this measure.



OVERALL TREND

- Increase was noted in the percent of obese adults in California (10.5% in 1991 to 18.7% in 1999).
- The 1999 U.S. average for obese adults was 19.7%.
- *Healthy People 2010* goal for obesity in adults aged 20+ years is to reduce obesity to no more than 15%.

Source(s): Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System (BRFSS), 1991-1999.*
www.cdc.gov/nccphp/brfss

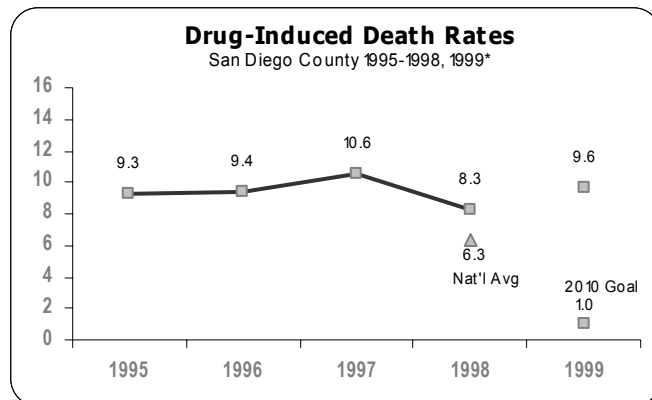
SUBSTANCE ABUSE—DRUG-INDUCED DEATHS

Overview & Data Summary

Drug-induced deaths include deaths due to drug psychoses, accidental deaths due to illicit drug overdoses, suicide by drugs, and accidental poisonings due to drugs, including medically prescribed drugs. At the national level, drug-related death rates are highest among Black populations, more than twice the rate among males as females, and particularly high among those with less than a high school education. Persons with at least some college education had the lowest drug-related death rates.¹

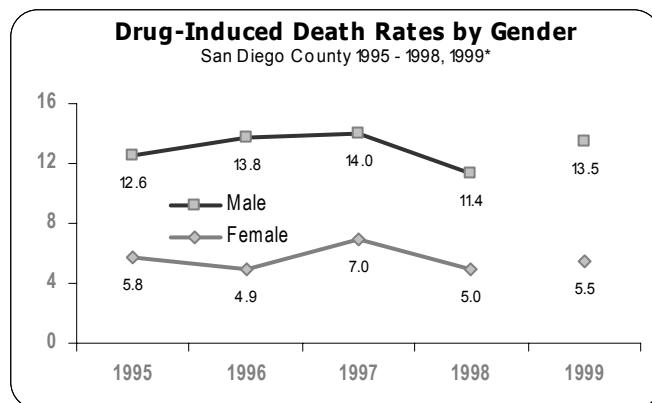
OVERALL TREND

- Death rates declined 10.8%, from a high of 10.6 in 1997 to 8.3 in 1998.
- The 1998 U.S. average was 6.3 deaths per 100,000 population.
- *Healthy People 2010* goal is no more than 1.0 death per 100,000 population.



TREND BY GENDER

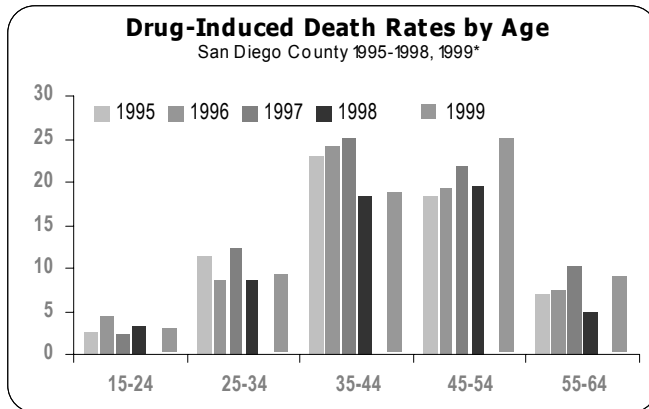
- Rate for males was more than twice that for females.
- Declines were noted for both genders between 1997 and 1998.



¹U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition, in Two Volumes): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington, DC: Public Health Service, January 2000.

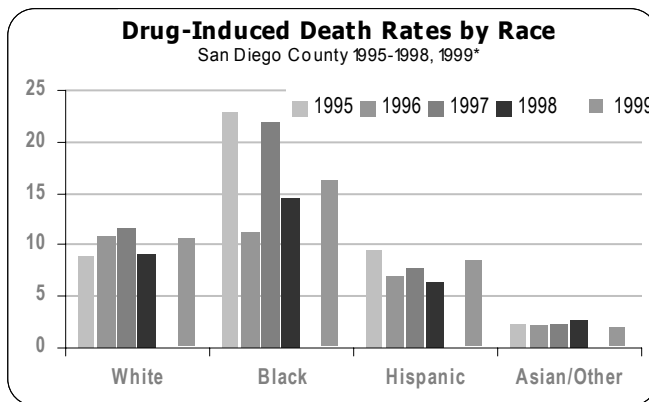
SUBSTANCE ABUSE—DRUG-INDUCED DEATHS

Overview & Data Summary—cont.



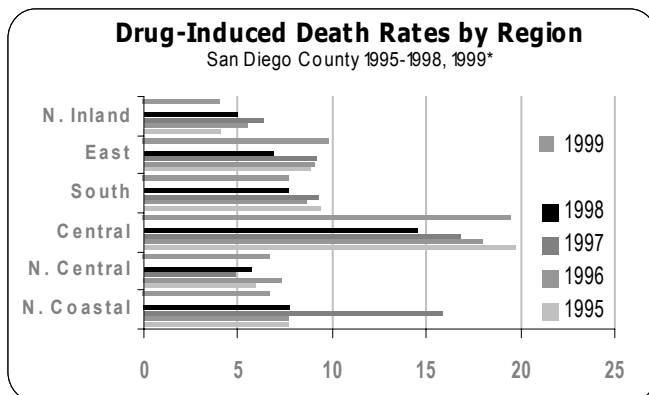
TREND BY AGE

- The highest age-specific rates for drug-related deaths were for adults between 35 and 54 years.
- A decrease between 1997 and 1998 was observed for all age groups except 15-24.



TREND BY RACE/ETHNICITY

- The highest drug-related death rates were for Blacks in 1995 through 1998, and consistent with national data.¹
- A decrease was observed for Blacks and Hispanics between 1995 and 1998.



TREND BY REGION

- The highest rates were in the Central region for each year reported.
- The lowest rates were generally found in N. Inland and N. Central regions.
- For 1999, the Central region had the highest drug-induced death rate (19.6) and N. Inland had the lowest rate (4.1).

Statistical Notes:

- All rates are per 100,000 population and age-adjusted to 2000 Standard U.S. Population
- Caution is advised when comparing rates by race/ethnicity due to the small number of drug-induced deaths among all minority populations in San Diego

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Drug-induced deaths in 1999 are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California, Department of Health and Human Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

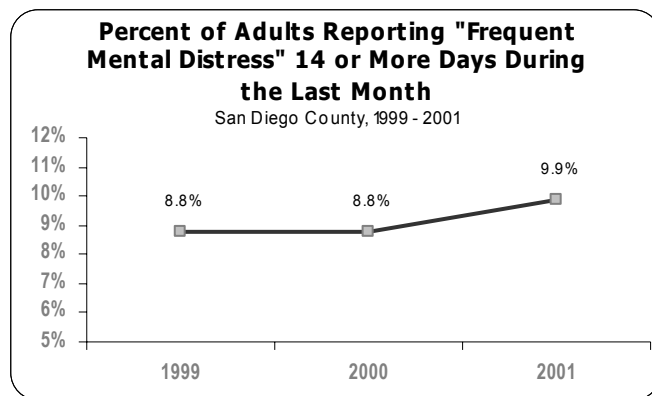
MENTAL HEALTH—DEPRESSION-DISTRESS

Overview and Data Summary

Depression is one of the nation's most chronic and debilitating conditions leading to lost productivity, pain, and emotional suffering, and it is a significant precursor to suicide. Data for this indicator was taken from the United Way annual survey in which all respondents aged 19 years and older were asked how many days during the past 30 days their mental health (including stress, depression, and problems with emotions) was not good. Referred to as "frequent mental distress" (FMD), data reflect the percentage of respondents reporting that their mental health was not good 14 or more days in the past month.

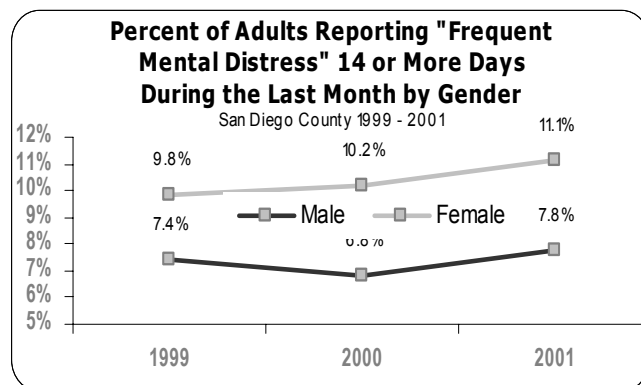
OVERALL TREND

- Slight increase was observed from 8.8% in 2000 to 9.9% in 2001.
- The 1993—1996 U.S. average was 8.6%.¹
- There are no *Healthy People 2010* objectives specifically for depression.



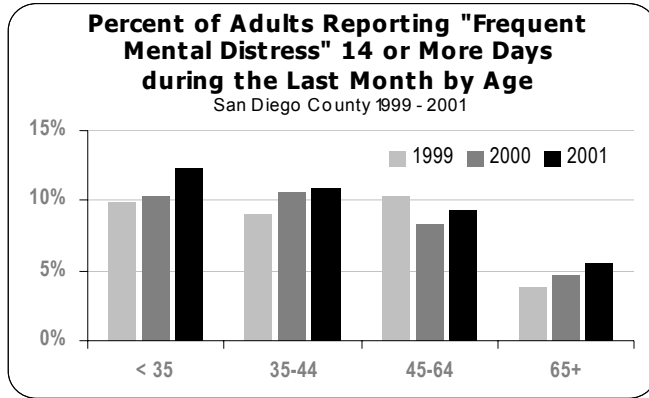
TREND BY GENDER

- Females were more likely to report FMD than males.
- A slight increase was observed for both genders since 1999.



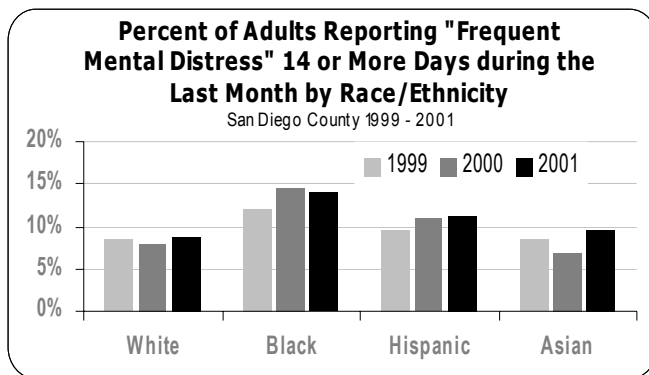
¹ Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*, 1998 May 1; 47(16):325-331.

MENTAL HEALTH—DEPRESSION-DISTRESS
Overview and Data Summary—cont.



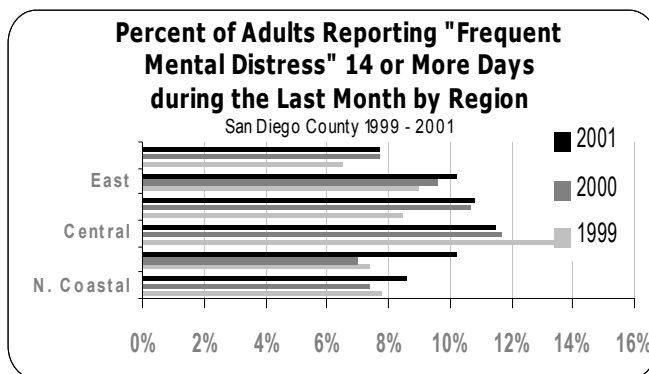
TREND BY AGE

- Increase was observed over the 3 years reported for all age groups except 45-64 year olds.
- Seniors reported the least FMD of any age group.
- Reported FMD decreases as people age.



TREND BY RACE/ETHNICITY

- Blacks reported more FMD than any other group.
- Each group, except Blacks, had a higher percentage of FMD since 2000.



TREND BY REGION

- The Central region had the highest percent of FMD.
- The Central region was the only region with a decrease in FMD since 1999.
- Respondents in the N. Inland and N. Coastal regions had the lowest percent of FMD IN 2001.

Source(s): United Way of San Diego County, Outcomes and Community Impact Program, 1999-2001

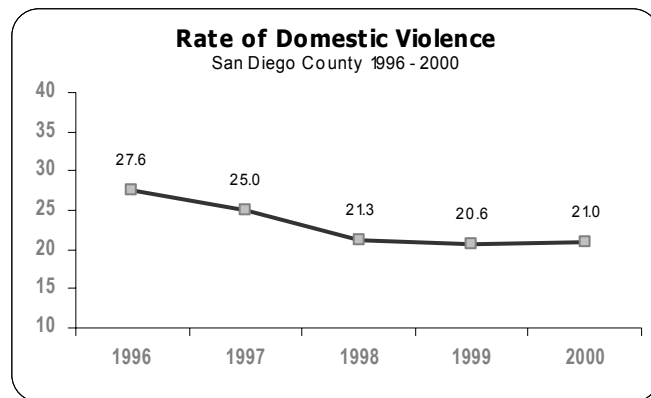
VIOLENT & ABUSIVE BEHAVIORS—DOMESTIC VIOLENCE

Overview and Data Summary

Domestic violence is defined as an actual or threatened act of physical/sexual violence or psychological/emotional abuse where the perpetrator and victim have a current or discontinued relationship with each other. For example, the victim may be a spouse, girlfriend, boyfriend, cohabitant, or other intimate partner.¹ The rate is defined as the number of domestic violence reports to law enforcement per 1,000 households. Data are not available by age, gender or race/ethnicity for this measure.

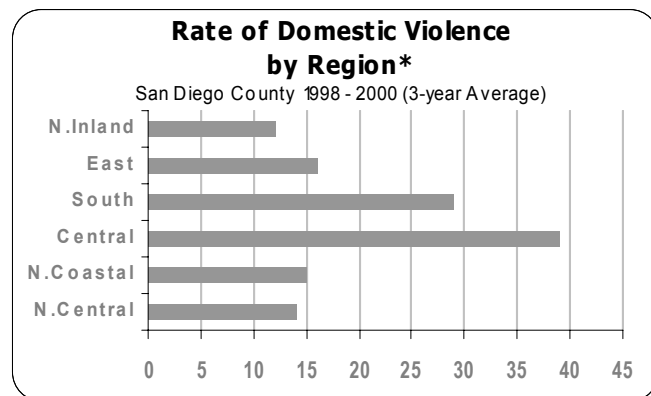
OVERALL TREND

- The rate of domestic violence in San Diego County declined from 27.6 per 1,000 households in 1996 to 21.0 per 1,000 households in 2000.
- The *Healthy people 2010* goal is to reduce physical assault only.
- No direct comparisons are available.



TREND BY REGION*

- The Central region had the highest rate of domestic violence for the 3-year average.
- The rate for South region was also higher than the rate for the remaining regions



¹San Diego County Health and Human Services Agency. *Child and Family Health and Well Being Report Card*, 2001.

Statistical Notes:

- Rates have been rounded and do not include reports with invalid zip codes (approximately 5% of reports). Rates represent reports of domestic violence to which law-enforcement responded.

- Rates are per 1,000 households.

* Rates were averaged over the 3-year period from 1998 to 2000

Source(s):

- Automated Regional Justice Information System (ARJIS), San Diego Data Processing Corporation.

-San Diego County household estimates used in rate calculations were obtained from SANDAG.

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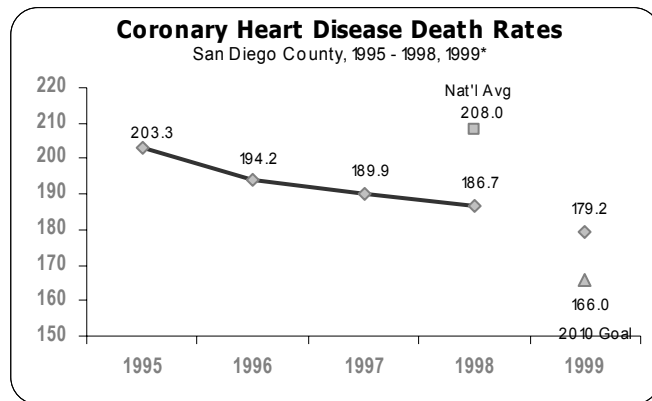
V. CARDIOVASCULAR DISEASE—CORONARY HEART DISEASE DEATHS

Overview and Data Summary

Heart disease is the leading cause of death among residents of San Diego County. Coronary heart disease (CHD) accounts for the largest proportion of deaths due to heart disease. Data presented below are mortality rates from CHD for the years 1995 - 1999 for San Diego County.

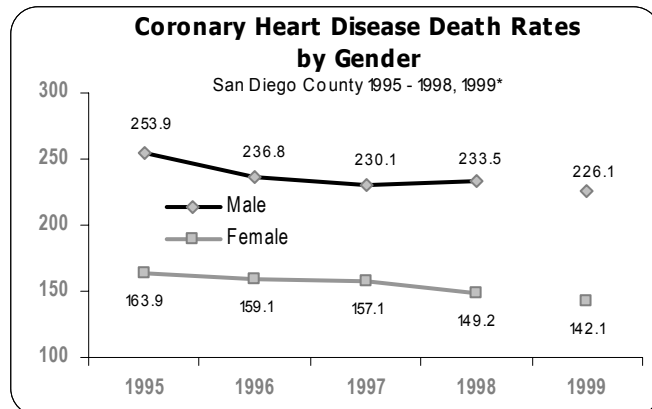
OVERALL TREND

- Decreasing trend was observed in San Diego County since 1995.
- The 1998 U.S. rate was 208.0 deaths per 100,000 population.
- *Healthy People 2010* goal is no more than 166 deaths per 100,000 population.



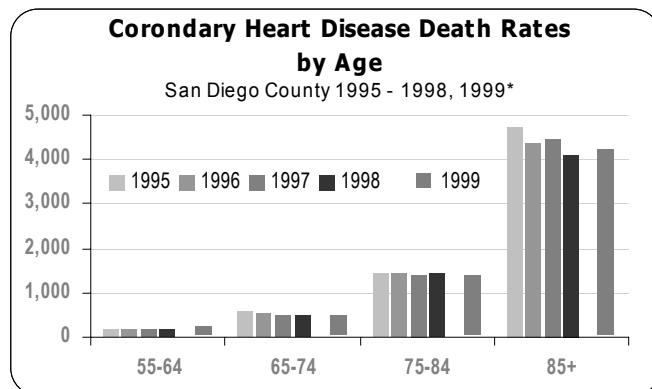
TREND BY GENDER

- The rate for males was consistently higher when compared to females.
- San Diego County was lower than the 1998 U.S. average of 265.0 deaths per 100,000 males and 165.0 deaths per 100,000 females.

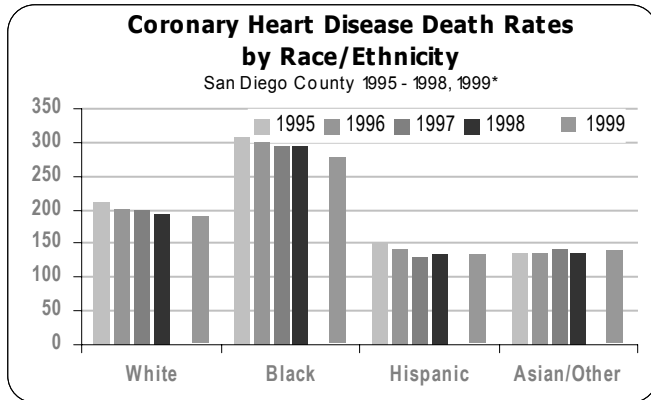


TREND BY AGE

- The mortality rate from CHD increases with age.
- The highest rate was among persons 85+ years.

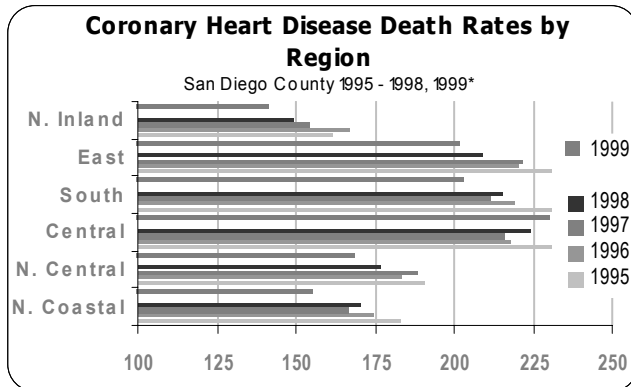


CARDIOVASCULAR DISEASE—CORONARY HEART DISEASE DEATHS
 Overview and Data Summary—Cont.



TREND BY RACE/ETHNICITY

- The highest rate was observed among Blacks.
- The lowest rates were observed among Hispanics and Asians/Other groups.
- Slight decreases were noted for Whites, Blacks, and Hispanics between 1995 and 1998.



TREND BY REGION

- The highest rates were noted in the Central and South regions.
- Decreases were observed for all regions between 1995 and 1998.

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from CHD are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California, Department of Health and Human Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

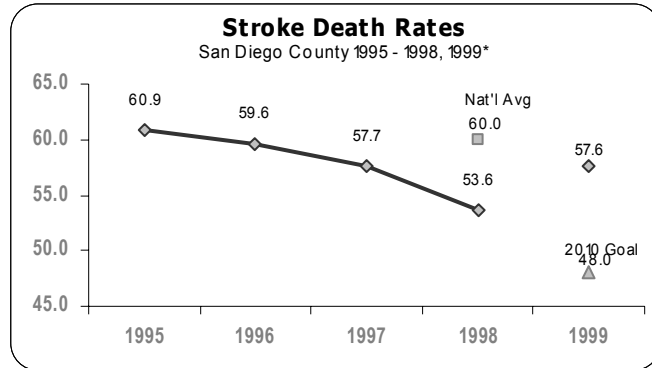
CARDIOVASCULAR DISEASE—STROKE DEATHS

Overview and Data Summary

Stroke (cerebrovascular disease) is the third leading cause of death in San Diego County, as well as in the United States.¹ Data presented below are for San Diego County for the years 1995 - 1999.

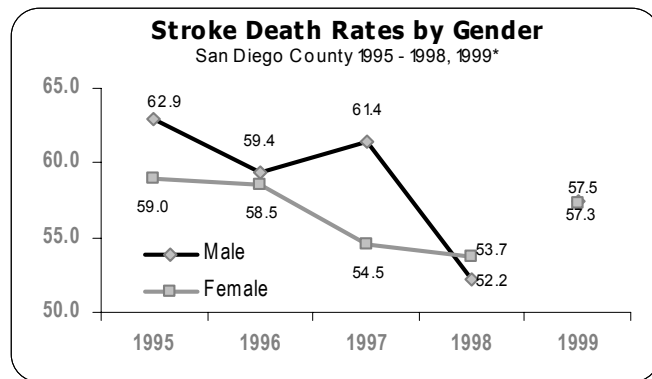
OVERALL TREND

- The death rate dropped 12%, from 60.9 deaths per 100,000 people in 1995 to 53.6 in 1998.
- The 1998 U.S. rate was 60 deaths per 100,000.
- *Healthy People 2010* goal is to reduce stroke deaths to no more than 48 deaths per 100,000.



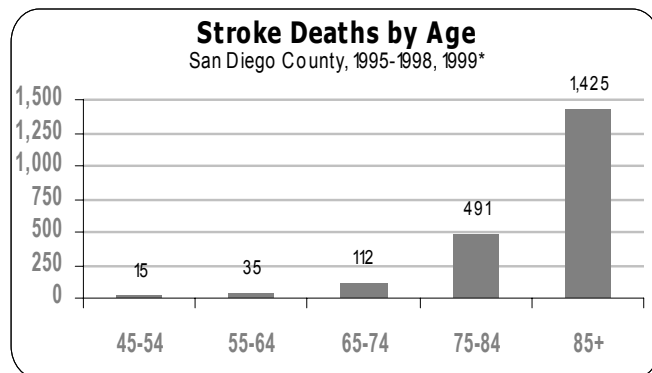
TREND BY GENDER

- Slight differences were noted between males and females.
- San Diego County was lower than the 1998 U.S. average for males (60.0) and females (58.0) deaths per 100,000.



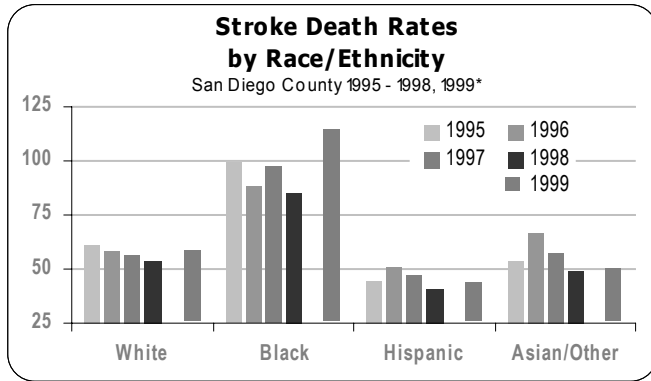
TREND BY AGE

- Risk of death from stroke increases with age.
- (1999 data displayed for simplicity. Refer to corresponding Data Table in Appendix A for age-specific mortalities and rates).



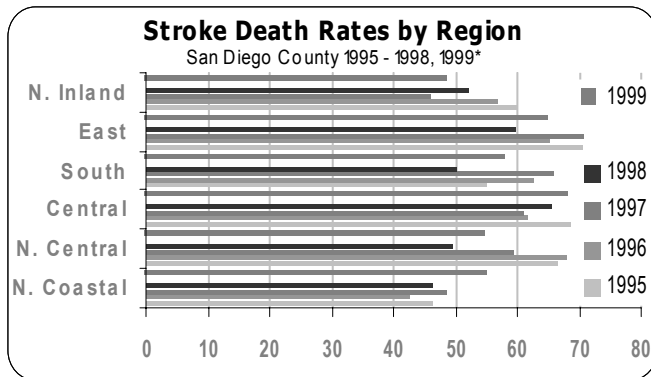
¹National Heart, Lung, and Blood Institute. *Morbidity and Mortality: 1998 Chartbook on Cardiovascular, Lung, and Blood Diseases*. Bethesda, MD: National Institutes of Health, Public Health Service, National Heart, Lung, and Blood Institute, October 1998.

CARDIOVASCULAR DISEASE—STROKE DEATHS
 Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Some decline were noted for every group between 1995 and 1998.
- The rate for Blacks was nearly twice that of Whites, Hispanics, and Asians/Other for the years reported.



TREND BY REGION

- Every region showed some decline in stroke mortality between 1995 and 1998 .
- The largest decline was noted in the N. Central region (25.9%) between 1995 and 1998.

Statistical Notes:

- All rates are per 100,000 population and age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; and differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from stroke are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health and Human Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

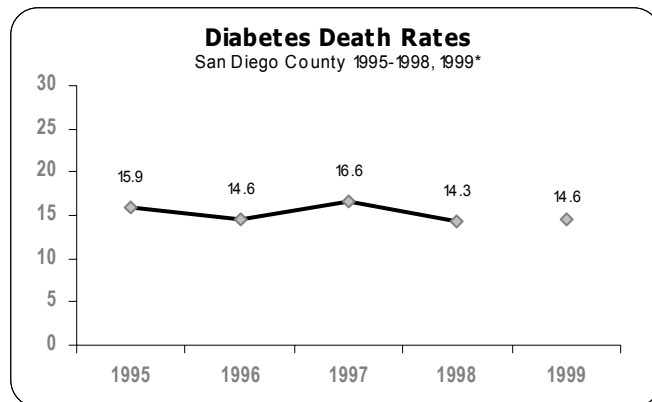
CHRONIC & DISABLING CONDITIONS—DIABETES DEATHS

Overview and Data Summary

In 1999, diabetes was the seventh leading cause of death in San Diego County and in the United States. A recent report on diabetes surveillance indicated that diabetes-related deaths are increasing for all ages and races. The highest diabetes death rates are found in minority populations and older Americans.¹

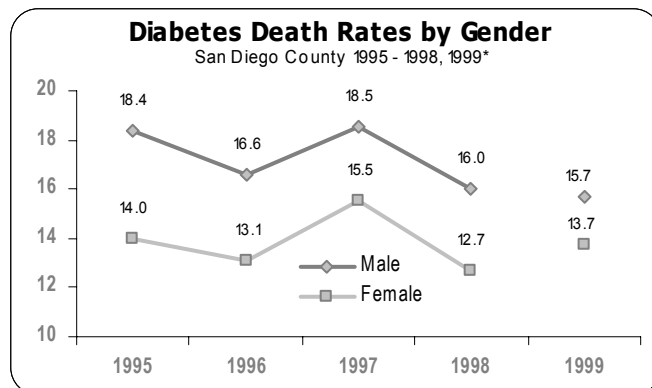
OVERALL TREND

- Diabetes death rates in San Diego County remained fairly stable between 1997 to 1998.
- The *Healthy People 2010* goals and baselines are not directly comparable to these data.



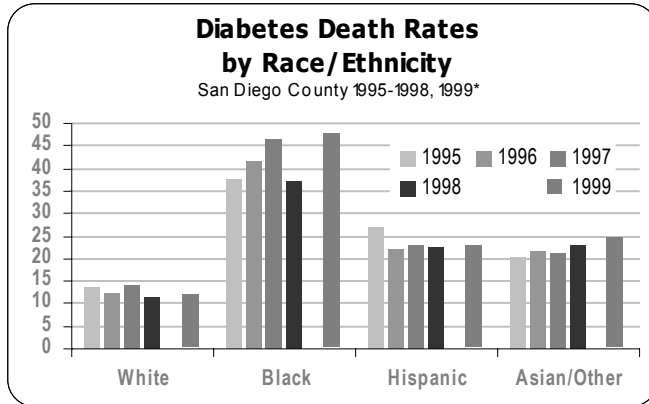
TREND BY GENDER

- Mortality rates were somewhat higher in males than in females for every year reported.
- A decline was observed from 1995 to 1998 for both genders (13.0% for males, 9.3% for females).



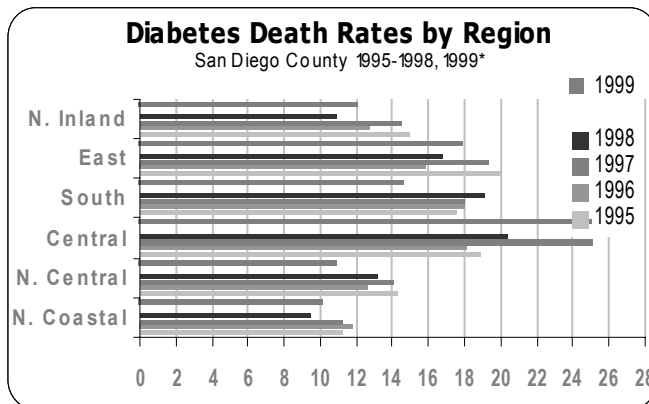
1. CDC Division of Diabetes Translation. *Diabetes Surveillance, 1997*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, August 1998.

CHRONIC & DISABLING CONDITIONS—DIABETES DEATHS
 Overview and Data Summary—Cont.



TREND BY RACE

- The rate for Blacks was three to four times the rate for Whites for all years reported.
- The rate for Hispanics and Asians/Other was roughly double that of Whites.
- Only Asians/Other saw an increase (12.7%) from 1995 to 1998.



TREND BY REGION

- No consistent patterns or trends were observed for any region.
- The largest decline was noted for the N. Inland and East regions between 1995 and 1998.
- Increases were noted in both South and Central regions from 1995 to 1998.
- The highest rate of diabetes deaths in 1999 was seen in the Central region (25.2); the lowest was in the N.Coastal region (10.2).

Statistical Notes:

- All rates are per 100,000 population and age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from Diabetes are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates

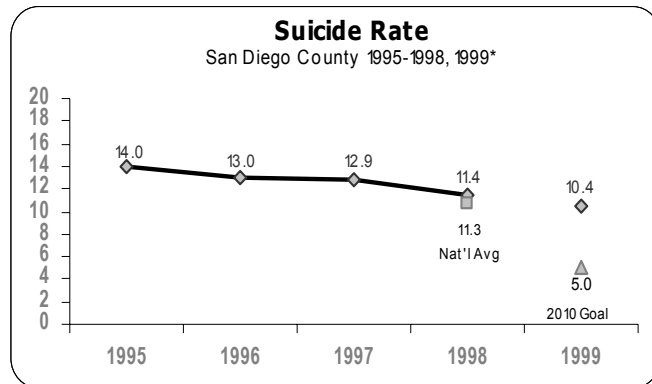
MENTAL HEALTH—SUICIDE

Overview and Data Summary

During 1999, suicide was the ninth leading cause of death in San Diego County and a major public health problem in the United States. At the national level, it is noted that at least 90% of all people who kill themselves had either a mental or substance abuse disorder or both.¹ Older males account for roughly 80% of suicides among persons 65 years and older in the United States.²

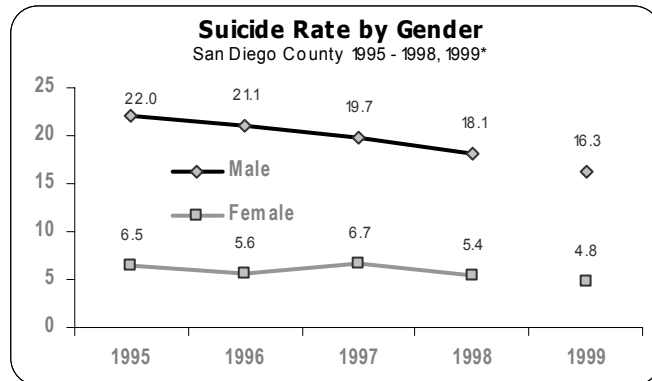
OVERALL TREND

- The rate of suicide in San Diego County declined 18.6% between 1995 and 1998.
- The 1998 U.S. suicide rate was 11.3 deaths per 100,000 people.
- *Healthy People 2010* goal is no more than 5.0 deaths per 100,000.



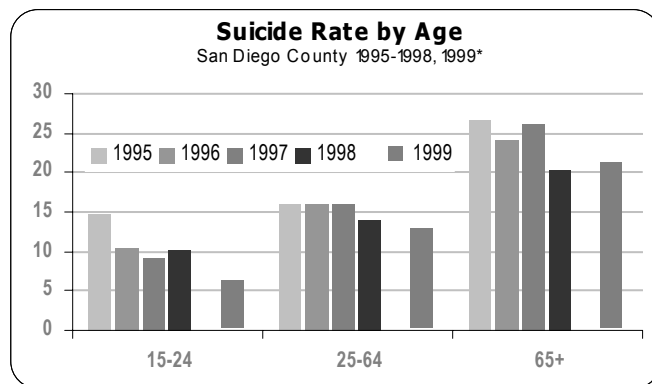
TREND BY GENDER

- The suicide rate among males was more than three times that of females in San Diego County for each year reported.
- Both genders saw declines of approximately 17% between 1995 and 1998.
- The rate for males was below the 1998 U.S. rate of 19.2.
- The rate for females was slightly higher than the 1998 U.S. rate of 4.3.



TREND BY AGE

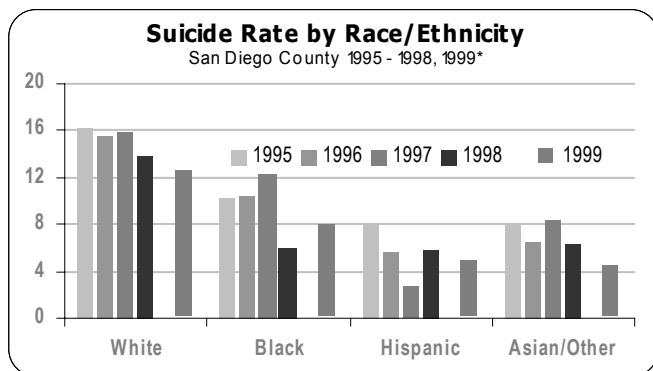
- The rate of suicide was highest among the elderly.
- No consistent trends by age were observed.



¹National Institutes of Health; Substance Abuse and Mental Health Services Administration, *Healthy People 2010, Conference Edition*, Vol. 2, 18.

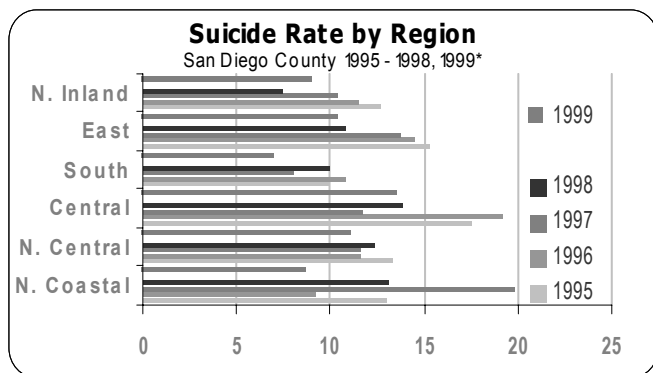
²Centers for Disease Control and Prevention. *Suicide Deaths and Rates Per 100,000*. www.cdc.gov/ncipc/data/us9794/Suic.htm. Retrieved November 23, 1999.

MENTAL HEALTH—SUICIDE
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- The highest suicide rate was observed for Whites.
- All race/ethnic groups showed a decline from 1995 to 1998.
- Caution is advised when comparing suicide rates by race/ethnicity in San Diego County because the average number of suicide deaths per year for every non-White group was very small (15-31 deaths).



TREND BY REGION

- Declining trend was noted for the N. Inland and East regions from 1995 to 1998.
- The largest decline was observed for the N. Inland region (40.9%) from 1995 to 1998.

Statistical Notes:

- All rates are per 100,000 population and adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from suicide are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

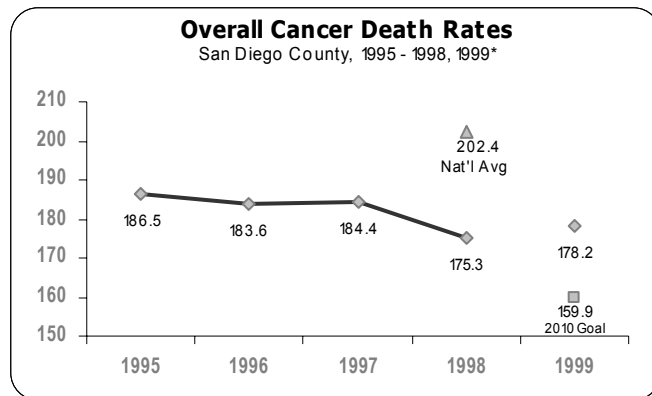
CANCER—OVERALL CANCER DEATHS

Overview and Data Summary

Cancer (malignant neoplasm) is the second leading cause of death among residents of San Diego County, accounting for nearly 25% of all deaths. The most common cancers include lung, prostate, female breast, and colorectal.

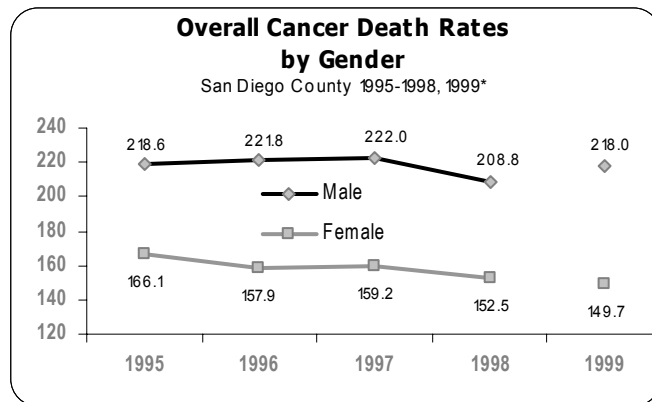
OVERALL TREND

- Overall cancer death rates in San Diego County remained fairly constant, with a slight decline from 1997 to 1998.
- The 1998 U.S. average was 202.4 deaths per 100,000 people.
- *Healthy People 2010* goal is no more than 159.9 deaths per 100,000.



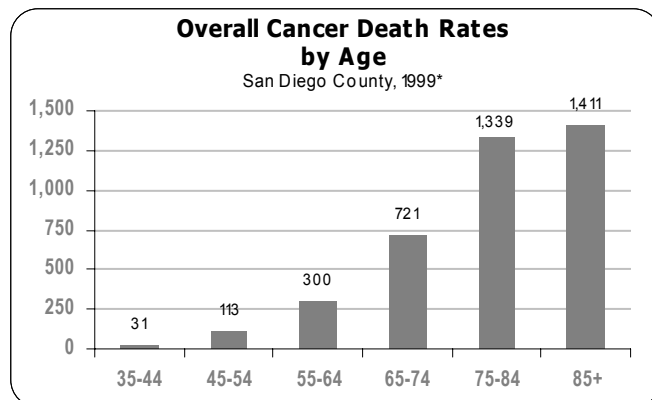
TREND BY GENDER

- Overall cancer rate was higher among males than females.
- Both genders were below their respective 1998 U.S. rates (152.0 for males, 169.0 for females).
- Some decline was noted since 1995 for both genders.

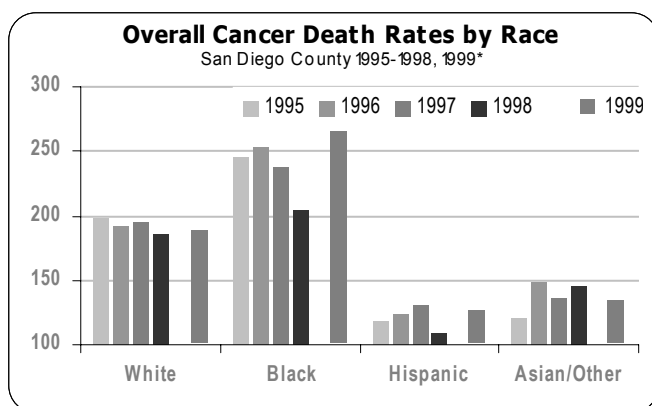


TREND BY AGE

- Overall cancer rates increased by age.
- (1999 data displayed for simplicity. Refer to corresponding Data Table in Appendix A for age-specific mortalities and rates).

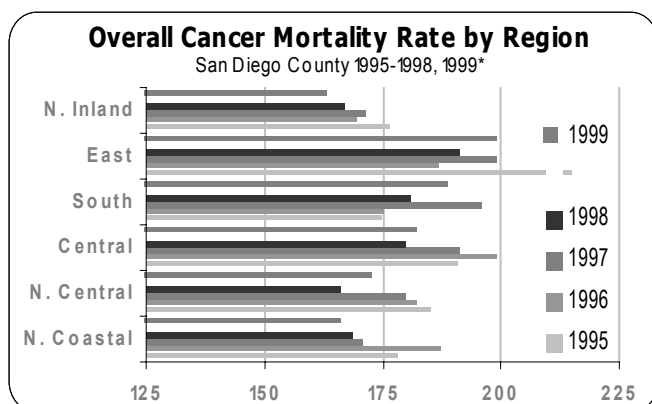


CANCER—OVERALL CANCER DEATHS
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Some decline in overall cancer rate was observed for each group except Asians/Other.
- The highest cancer rate was for Blacks and the lowest was for Hispanics, for all years reported.
- The largest decline was noted for Blacks (17%) between 1995 and 1998.



TREND BY REGION

- The highest overall cancer mortality rate was seen in the East region.
- Declines were observed in every region except the South between 1995 and 1998.

Statistical Notes:

- All rates are per 100,000 population and age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from cancer are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

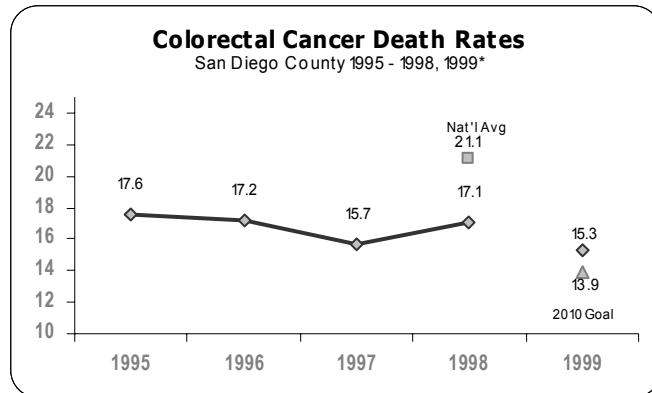
CANCER—COLORECTAL CANCER DEATHS

Overview and Data Summary

Colorectal cancer includes cancers of the colon and rectum. Colorectal cancer is the second leading cause of cancer death in the United States and among residents of San Diego County.

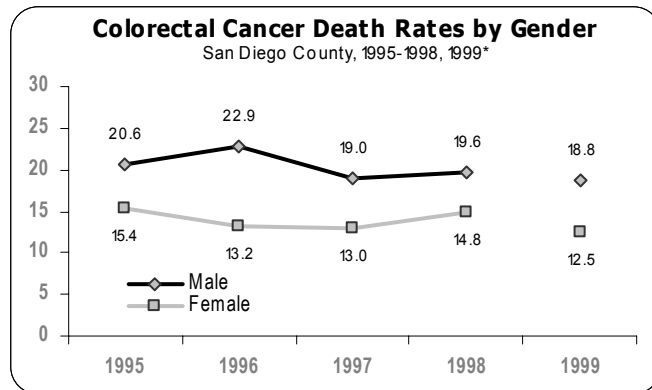
OVERALL TREND

- No major trend was noted for 1995 through 1998.
- The 1998 U.S. rate was 21.1 deaths per 100,000 population.
- *Healthy People 2010* goal is no more than 13.9 deaths per 100,000.



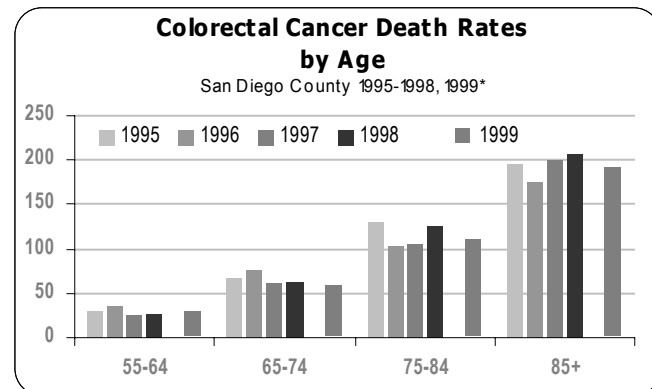
TREND BY GENDER

- The rate of death from colorectal cancer was greater among males than females.
- For 1999, the death rate was more than 50% higher for males than females.

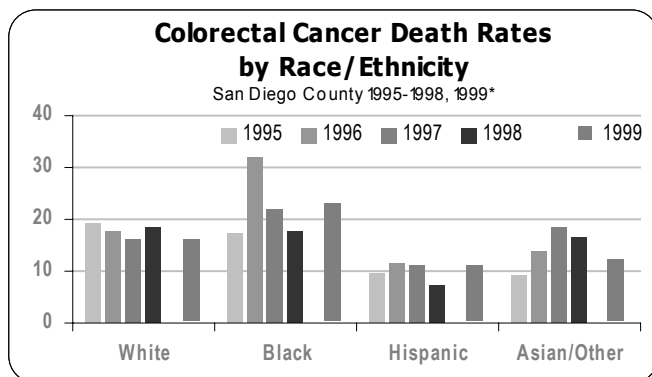


TREND BY AGE

- The highest death rate was for elderly persons age 85+ years.
- Nearly 90% of the colorectal deaths occurred among persons 55+ years.

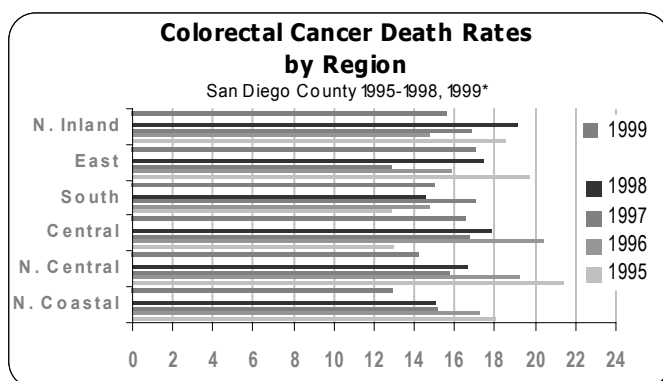


CANCER—COLORECTAL CANCER DEATHS
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Overall, the lowest rate was seen for Hispanics.
- An increasing rate was noted for Asians/Other between 1995 and 1997.
- Caution is advised when comparing rates by race/ethnicity due to small number of deaths each year.



TREND BY REGION

- There was no consistent pattern for comparison among regions.
- Declines from 1995 to 1998 were observed for N. Central and N. Coastal regions, 22% and 16%, respectively.
- Increase of 37.7% was observed between 1995 and 1998 for the Central region.

Statistical Notes:

- All rates are per 100,000 population and age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from colorectal cancer are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding .

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

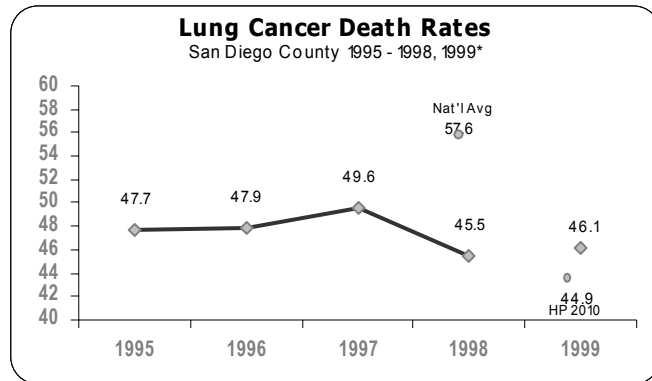
CANCER—LUNG CANCER DEATHS

Overview and Data Summary

Lung cancer is the leading cause of cancer deaths among San Diego County residents.

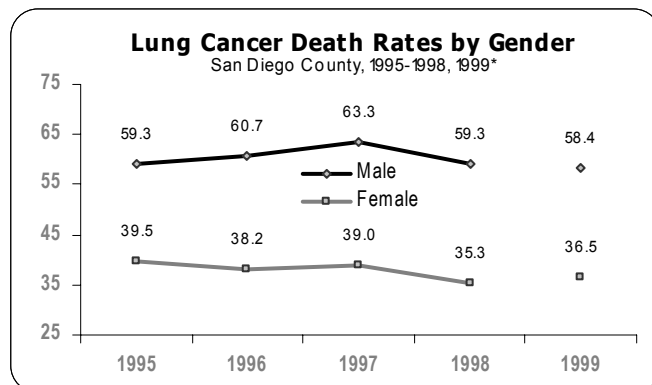
OVERALL TREND

- Little change was noted over the years reported.
- The 1998 U.S. lung cancer deaths rate was 57.6 deaths/100,000 population.
- *Healthy People 2010* goal is to reduce lung cancer deaths to no more than 44.9 per 100,000.



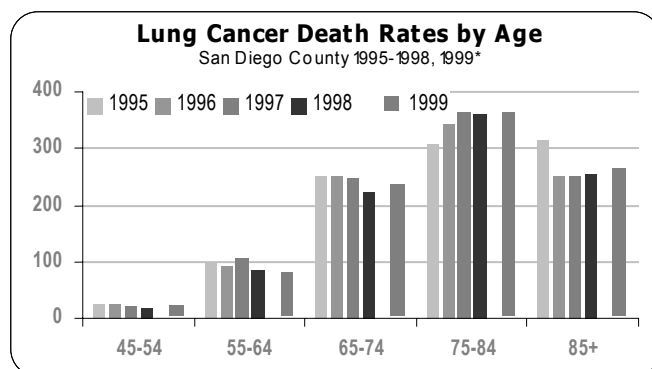
TREND BY GENDER

- The rate for males was consistently about 1.7 times greater than for females.
- The death rates by gender were well below the 1998 U.S. averages (79.9 for males, 41.5 for females).
- Both genders experienced a decline between 1997 and 1998.

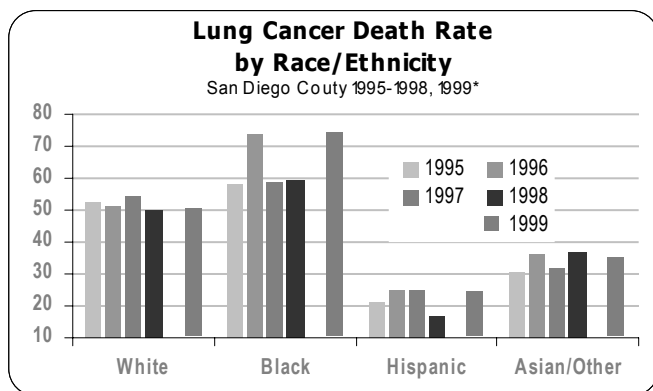


TREND BY AGE

- The highest rate was for persons aged 75-84 years.
- An increase of 16.8% between 1995 and 1998 was noted for persons aged 75-84 years—the only group to see an increase during this time period.

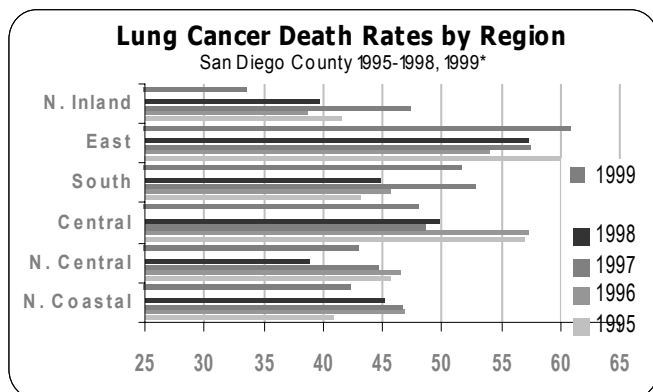


CANCER—LUNG CANCER DEATHS
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Slightly higher mortality rate for Blacks than Whites was observed for each year.
- The lowest rate consistently occurred among Hispanics and Asians/Other.
- Caution is advised when comparing rates by race/ethnicity due to small number of deaths each year.



TREND BY REGION

- Between 1995 and 1998, East region had the highest lung cancer death rate, followed by Central region.
- The rate increased between 1995 and 1998 in N. Coastal and South regions.

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from lung cancer are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding (see Technical Notes for details).

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

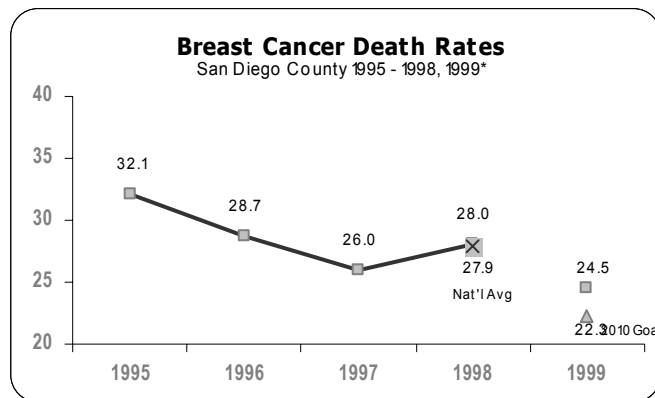
CANCER—BREAST CANCER DEATHS

Overview and Data Summary

Breast cancer is one of the leading causes of death in females in San Diego County and the United States. According to the annual report from the National Cancer Institute, breast cancer is 16.3% of all cancer cases and 7.8% of all cancer deaths in the U.S. Breast cancer death rates overall have declined due to improvements in early detection and treatment. At the same time, breast cancer *incidence* rates increased more than 40% between 1973 and 1998.¹

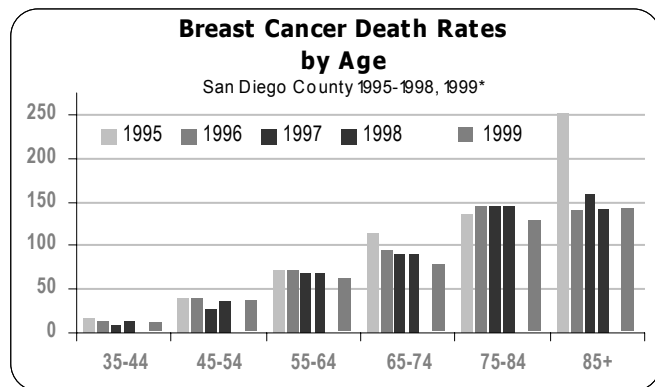
OVERALL TREND

- The breast cancer mortality rate declined 12.6% between 1995 and 1998 in San Diego County.
- The 1998 U.S. mortality rate was 27.9 deaths per 100,000 females.
- *Healthy People 2010* goal is no more than 22.3 per 100,000 females.



TREND BY AGE

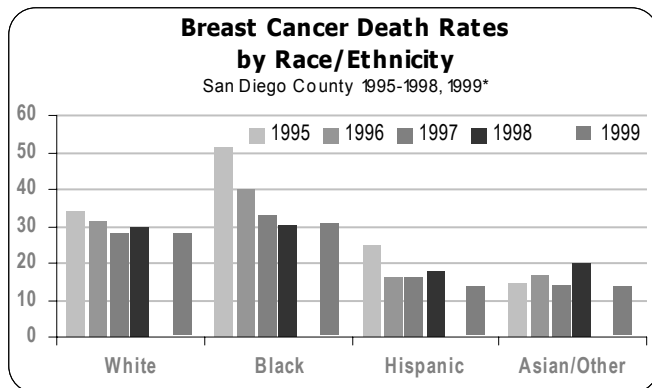
- The death rate from breast cancer increases with age.
- Highest age-specific breast cancer death rates consistently occurred among women aged 75+.
- There was a major decline (43.5%) in breast cancer deaths for women aged 85+ between 1995 and 1998



¹National Cancer Institute. News from the NCI, Annual Report shows overall decline in U.S. cancer incidence and death rates; feature focuses on cancers with recent increasing trends. June 5, 2001.

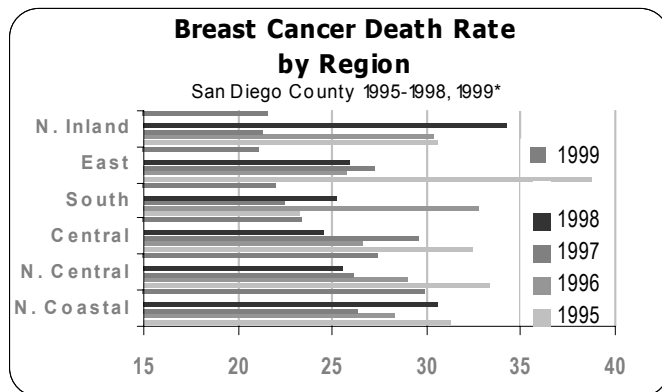
CANCER—BREAST CANCER DEATHS

Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- The breast cancer death rate for Black women has steadily declined to a rate comparable with White women.
- Rate for White and Black groups is nearly twice that for Hispanic and Asians/Other groups.
- Caution is advised when comparing rates by race/ethnicity due to small number of deaths each year.



TREND BY REGION

- Decreasing death rate was observed in N. Central and Central regions between 1995 and 1998.
- Largest decline (33%) was seen in East region between 1995 and 1998.
- Caution is advised when comparing rates by region due to small number of deaths each year.

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from breast cancer are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

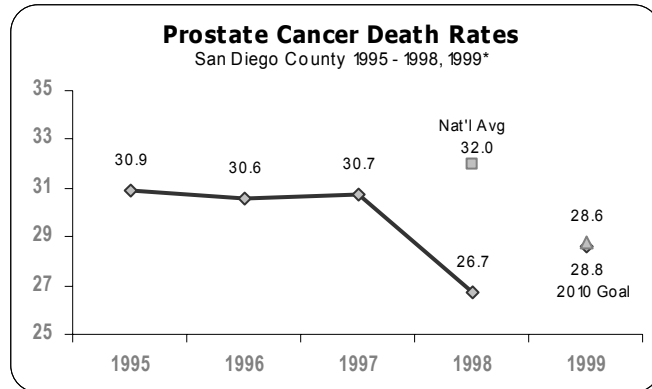
CANCER—PROSTATE CANCER DEATHS

Overview and Data Summary

Prostate cancer is the second most common cause of cancer deaths among men in San Diego County and the nation.

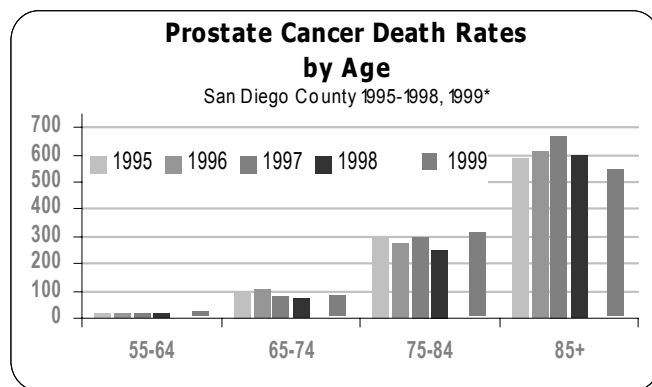
OVERALL TREND

- Overall decline was observed between 1997 and 1998 (30.7 to 26.7).
- The 1998 U.S. mortality rate was 32.0 deaths per 100,000 males.
- *Healthy People 2010* goal is to reduce the rate of prostate cancer deaths to no more than 28.8 per 100,000 males.

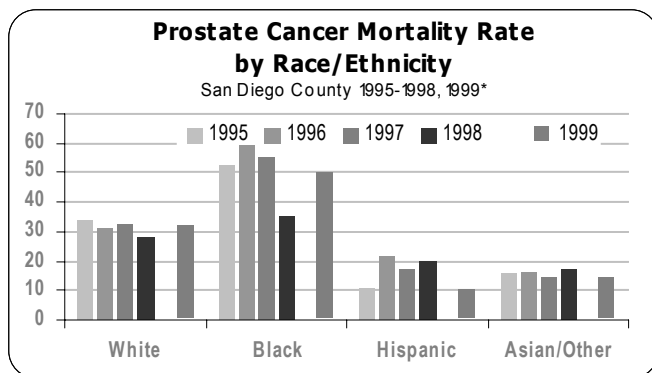


TREND BY AGE

- The mortality rate from prostate cancer increases with age.
- Slight decline for all age groups, except for persons 85+ was observed during 1995 to 1998.
- No deaths occurred among persons younger than 45 years between 1995 and 1999.

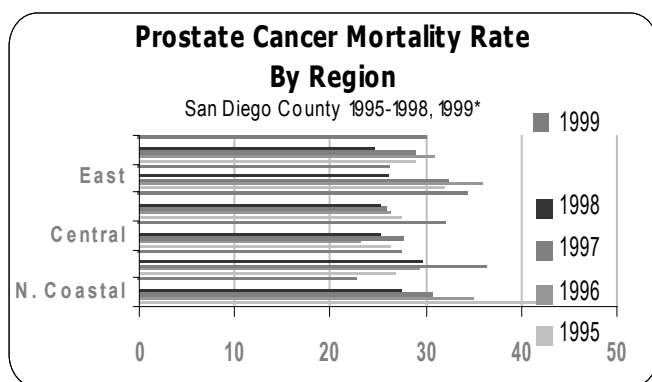


CANCER—PROSTATE CANCER DEATHS
Overview and Data Summary—cont.



TREND BY RACE/ETHNICITY

- Highest mortality rate was seen among Blacks, lowest among Hispanics.
- Decrease in rate was noted among Blacks (32.5%) and Whites (16.5%) between 1995 and 1998.
- Caution is advised when comparing rates by race/ethnicity due to small number of deaths each year.



TREND BY REGION

- No clear regional differences were observed for years reported.
- All regions saw a decrease between 1995 and 1998, except N. Central region.

Statistical Notes:

- All rates are per 100,000 population and are age-adjusted to 2000 Standard U.S. Population

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from prostate cancer are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.

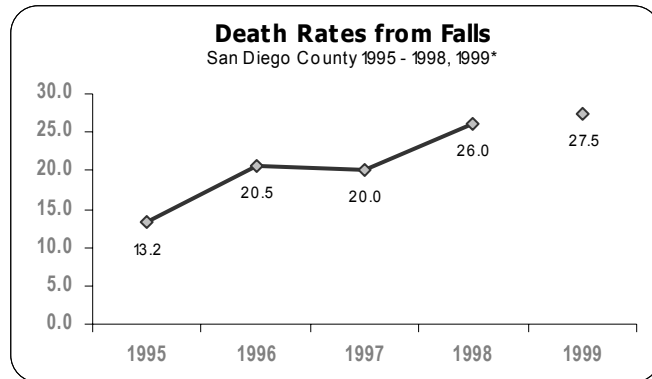
UNINTENTIONAL INJURIES—DEATH RATES FROM FALLS

Overview and Data Summary

Deaths due to falls is one of the leading causes of death in persons 65+ in San Diego County. In 1996, falls became the second leading cause of injury death among adults age 65+ in the United States.¹ For persons aged 65+, 60% of falls occur in the home, 30% occur in a public place, and 10% occur in health care institutions.¹ The data below present mortality rates from falls for persons 65+ in San Diego County.

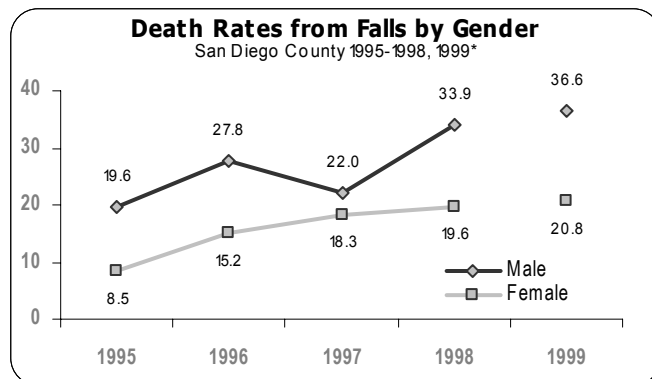
OVERALL TREND

- Mortality rate increased 71.5% between 1995 and 1998.
- *Health People 2010* goals are calculated for persons of all ages and are not comparable to these data.



TREND BY GENDER

- Death rates in San Diego County due to falls for males were generally greater than for females in the 65+ age group.
- An increase for males between 1997 and 1998 was noted.
- Increasing trend was observed among females between 1995 and 1998.
- Caution is advised when comparing rates by gender due to the small number of deaths each year.



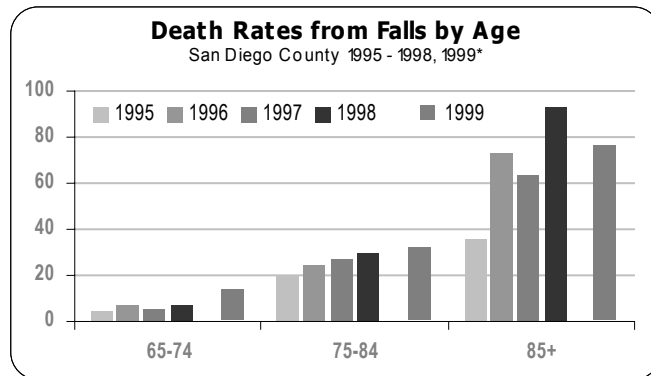
¹U.S. Department of Health and Human Services. *Healthy People 2010 (Conference Edition): National Health Promotion and Disease Prevention Objectives for the Nation*. Washington D.C.: Public Health Service, Vol. 1, 15 Injury and Violence Prevention, January 2000.

UNINTENTIONAL INJURIES—DEATH RATES FROM FALLS

Overview and Data Summary—cont.

TREND BY RACE/ETHNICITY

– Rates were not calculated by race/ethnicity due to small number (<5) of actual deaths for all race/ethnic groups for years 1995 through 1999. See Data Tables in Appendix A for detailed information.



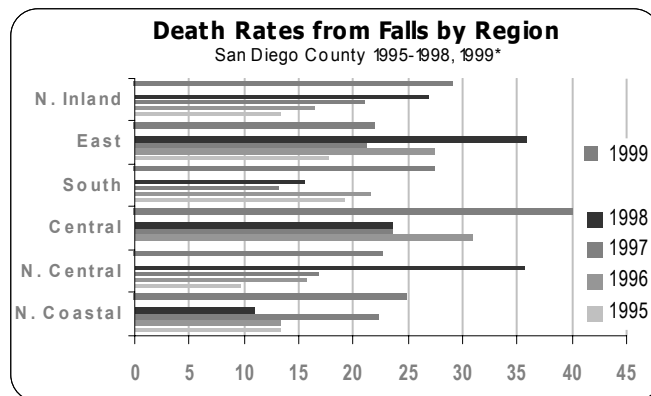
TREND BY AGE

– Mortality rates increased for persons aged 75-84 and 85+ between 1995 and 1998.

– The highest death rate for falls was seen among persons aged 85+.

– Increasing rate was observed for persons aged 75-84 (46.8%) and 85+ (160.4%) between 1995 and 1998.

– Caution is advised when comparing rates by race/ethnicity due to small number of deaths each year.



TREND BY REGION

– No clear pattern was noted by region.

– Caution is advised when comparing rates by region due to small number of deaths each year.

Statistical Notes:

– All rates are per 100,000 population aged 65+.

*The 1999 mortality data is the first release to use ICD-10 to code underlying cause of death; this differs from the ICD-9 classification used for the 1995-1998 data. Due to lack of comparability between the two ICD versions, the differences in deaths and rates between pre-1999 and 1999 may result in major discontinuities in trend data. Deaths in 1999 from falls are not directly comparable to previous years or to *Healthy People 2010* goals because of the changes in death data coding.

Source(s):

- State of California Department of Health Services, Death Statistical Master Files, 1995-1999.
- San Diego Association of Governments, January 1, 1995-1999 Population Estimates.