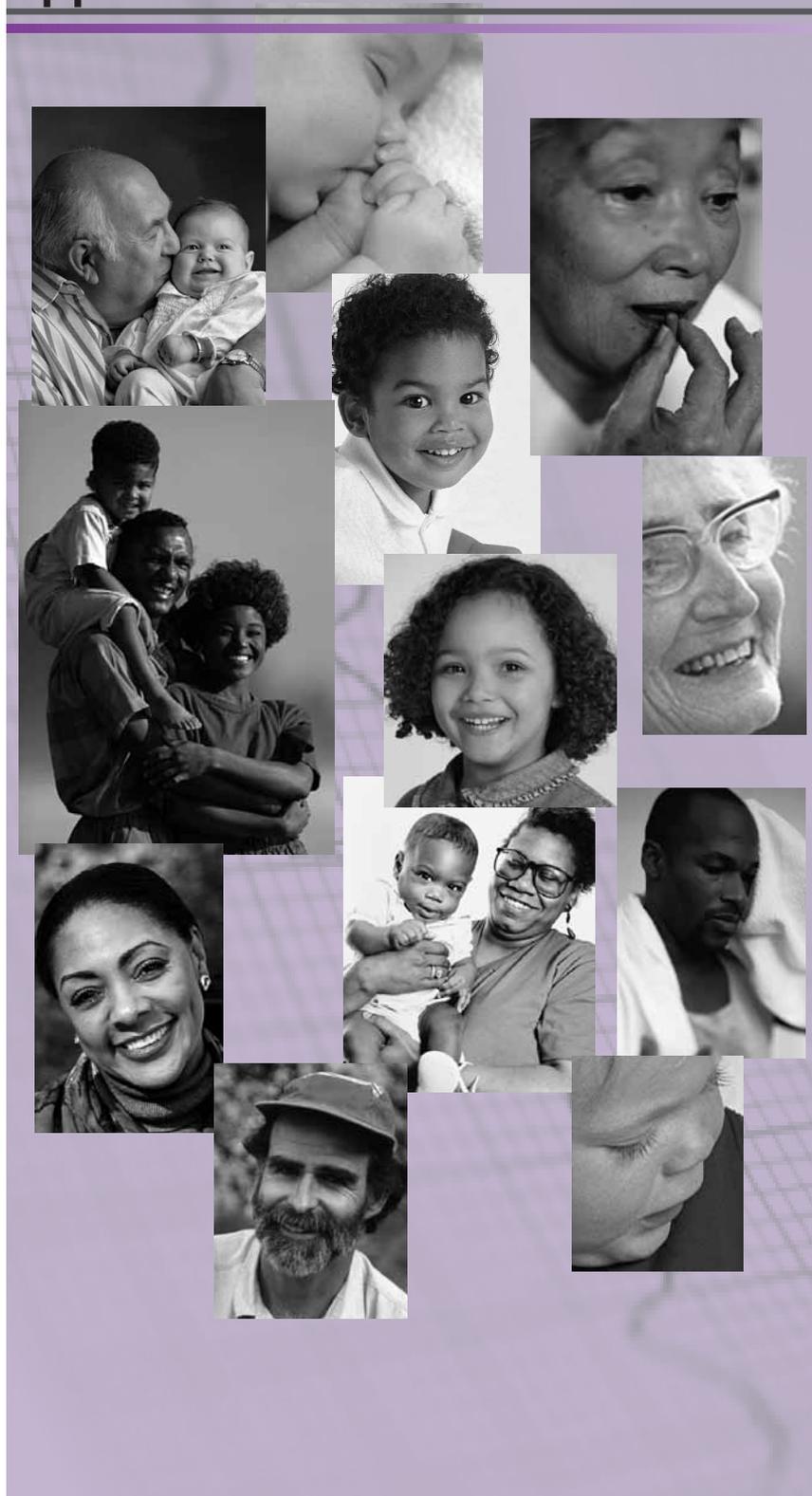


# Appendices



# Appendices

# Definitions

**Age-adjusted mortality rate**

Age adjustment is the process by which differences in the age composition of two or more populations are controlled. This type of measure eliminates differences that can occur because one population is older than another. Age-adjusted rates in this Profile use the U.S. 2000 standard population.

**Age-specific mortality rate**

An age-specific rate is a rate in which the number of events and population at risk are restricted to an age group.

**Fetal mortality**

A fetal death is death prior to the complete expulsion or extraction from its mother a product of conception, of at least 20 weeks gestation, which, after such expulsion or extraction, does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. NOTE: Fetal deaths prior to 20 weeks gestation and deaths due to Termination of Pregnancy are not included in fetal death calculations.

**Incidence**

Number of new disease cases per population at risk. High incidence implies high disease occurrence, low incidence implies low disease occurrence.

**Infant mortality**

An infant death is the death of a live born infant occurring within the first year of life. Infant mortality rate is the number of infant deaths divided by the number of births (per 1,000).

# Definitions

**Live birth**

A live birth is the complete expulsion or extraction from its mother a product of human conception that after such expulsion or extraction breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

**Low birth weight**

A low birth weight infant is a live born infant with a birth weight less than 2,500 grams or less than 5 lbs. 9 ounces.

**Maternal mortality**

Maternal deaths are those for which the certifying physician has designated a maternal condition as the underlying cause of death. The maternal complications are those assigned to deliveries and complications of pregnancy, childbirth and the puerperium.

**Moderate Physical activity**

Moderate physical activity in a usual week includes activities such as brisk walking, bicycling, vacuuming, gardening or anything else that causes small increases in breathing or heart rate for at least 10 minutes at a time.

**Morbidity**

The extent of illness, injury or disability in a defined population, expressed as general or specific rates of incidence or prevalence. Sometimes used to refer to any episode of disease.

## Definitions

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<b>Neonatal mortality</b>	A neonatal death is the death of a live born infant occurring within the first 27 days of life.
<b>Perinatal mortality</b>	A perinatal death is defined as a fetal death of 20 weeks or more gestation and infant deaths under 28 days of life.
<b>Physical activity</b>	During the past month, participated in any physical activity or exercise such as running, calisthenics, golf, gardening or walking for exercise.
<b>Post-neonatal mortality</b>	A post-neonatal death is the death of an infant between 28 days and 364 days of life.
<b>Prevalence</b>	Number of current cases per population at risk. Includes persistent active disease contracted previously and new onsets of the active disease.
<b>Very low birth weight</b>	A very low birth weight infant is a live born infant with a birth weight less than 1,500 grams or less than 3 lbs. 5 ounces.
<b>Vigorous Physical activity</b>	Vigorous physical activity in a usual week includes activities such as running, aerobics, heavy yard work or anything else that causes large increases in breathing or heart rate for at least 10 minutes at a time.

The majority of data presented in the Ohio Minority Health Profile were obtained from the Ohio Department of Health Office of Vital Statistics and the Ohio Behavioral Risk Factor Surveillance System (BRFSS).

## Vital Statistics

Unless otherwise noted, the data presented in this profile have been compiled from original certificates of birth, fetal death and death filed in the State of Ohio with the Office of Vital Statistics for calendar years 1993-2001.

All of the deaths reported in this profile are classified according to the list of International Classification of Diseases, 10th Revision.

All comparisons between mortality rates for different racial and ethnic groups were made relative to the white rate. Lack of reported disparity in mortality does not imply that the mortality rate of any racial or ethnic Ohio group is good relative to national or other standards. In cases where the racial/ethnic population was particularly small in the state (i.e. American Indian/Alaska Native), the racial/ethnic group may not be representative of the group nationwide. The data presented did not test for significance between minority groups.

It is important to note that reporting of racial and ethnic status is subject to misclassification. Particularly in the area of mortality, information is often reported by someone other than the individual. In the cases of infant data related to pregnancy, the information is obtained from the birth certificate, which assigns race and ethnicity solely based on the race and ethnicity of the mother. For these reasons, combined with small numbers for Ohio, we did not report further breakout of mortality rates for Asian/Pacific Islanders and Hispanics by subgroups. Mortality statistics nationwide may significantly underestimate the mortality of minorities, particularly Native Americans/Alaska Natives.

Maternal/infant mortality data presented in this profile are calendar-year specific. The data do not attempt to link information from the death certificate to information from the birth certificate for each infant less than 1 year of age. It is possible that race/ethnicity information could vary on the same infant from the birth to the death certificate.

Caution should be utilized when interpreting the Hispanic data from 1996-1998. Although there have not been any data errors identified, it remains possible that there may be a problem with the data that has not been determined. Such errors are more likely among smaller populations.

The Healthy People 2010 goal includes the elimination of health disparities among different segments of the population, including (but not limited to) differences that occur by race and ethnicity. In this section we have included groups that have already achieved the 2010 target goals. This does not imply that the goals may not be achieved or surpassed by other groups by the year 2010.

Based on work from the National Center for Health Statistics and the Census Bureau, Census 2000 respondents that identified themselves as being of an “other” race or of multiple races were assigned (bridged) to one of the following four race categories specified under the 1997 standards: white, black, American Indian/Eskimo/Aleut and Asian/Pacific Islander. As in prior years, there was also a separate question to assess ethnicity as either Hispanic or non-Hispanic. Hispanics may be of any race.

All calculated rates are based on population counts and estimates from the 2000 Census. Comparisons with mortality data calculated with the 1940 population standard should not be utilized.

Recommendations from the National Center for Health Statistics and the Family Health Outcomes Project were followed to produce the Ohio Mortality results by race. These recommendations included the following:

- In cases where there were fewer than 20 deaths, age-adjusted mortality rates are not presented. When rates are based on small numbers or events, random error can affect the usefulness of the data and associated confidence intervals can be relatively wide. Based on this rule, we did not present age-adjusted rates for American Indian/Alaska Natives for 2001, and were able to present only age-adjusted mortality rates for the top five or six leading causes of death in 2001 for Asian/Pacific Islander and Hispanics.

- In order to counteract the random error for small numbers (numerator less than 20); multiple-year data were utilized to obtain age-adjusted mortality rates. Three years of mortality data were combined to allow calculation of additional age-adjusted death rates for minority groups such as Hispanics and Asian/Pacific Islanders and American Indian/Alaska Natives.
- To test for statistically significant differences between groups, we employed paired comparison tests using the white race for each paired comparison. In instances where the number of deaths was 100 or above, we utilized a z-test to test for statistically significant differences. To test for statistically significant differences between groups when the number of deaths was less than 100, we utilized the confidence interval overlap method.
- Mortality trends by race were presented by combining three years of mortality data, calculating an age-adjusted rate and comparing the rates over distinct time periods (i.e. 1993-1995, 1996-1998 and 1999-2001).
- The Census Bureau reports that there is a problem with the employment status data from Census 2000. It reports that the problem “stems from the tendency of many working-age people living in civilian noninstitutional group quarters (GQ), such as college dormitories, worker dormitories and group homes (for the mentally ill or physically handicapped), to exhibit a particular pattern of entries to the employment questions.” The bureau also states that labor force data appear to have overstated the number in the labor force, the number unemployed and raised the national unemployment rate by 0.4 percentage points, probably because of irregularities in the data collection or processing systems. This problem may have greater impact on “areas below the national level depending on the relative size of the GQ population within the given area.” The bureau reports that it will continue to examine the problem.

### Behavioral Risk Factor Surveillance System (BRFSS)

Ohio is one of the 50 states participating in the BRFSS survey with the Centers for Disease Control and Prevention (CDC) to obtain data regarding the prevalence of selected behaviors among persons age 18 and older that can increase the risk of certain diseases and injuries. Ohio has participated in the BRFSS survey since 1984. The survey consists of telephone interviews conducted with randomly sampled households from all telephone-equipped dwelling units in Ohio. The data collected from the survey examine major behavioral risks among adults that are associated with premature morbidity and mortality. Such data are useful to measure health trends, develop health promotion programs, initiate health policies and examine areas for future research and initiatives.

In addition to the statewide BRFSS survey in 2002, the Center for Vital and Health Statistics contracted with ORC Macro to provide a statewide BRFSS over-sample of minority residents across Ohio. The supplemental data for minority populations resulted in 2,047 additional interviews, primarily with black Ohioans. Telephone exchanges were selected based on the exchanges' estimated non-white population. Samples for the statewide and minority over-sample were drawn independently. Following data collection, the two sets of completed sample interviews were weighted independently to population characteristics and then combined utilizing a method for combining weights from two independent samples. The dataset weighting followed the CDC method of relying solely on post-stratification to compensate for non-response.

The data reported in this profile utilized the original BRFSS 2002 dataset for Ohio combined with the over-sample minority BRFSS data set for 2002. In accordance with CDC methodology, we have reported all of the data collected including percentages, numbers of respondents and 95 percent confidence intervals. When interpreting this data, the reader should use great caution when interpreting small sample sizes ( $n < 50$ ). Small sample sizes are considered very unreliable and are usually associated with wide confidence intervals. All references to statistical significance in the profile refer to the  $p < 0.05$  level. Paired differences between race/ethnicity were calculated for each variable using t-tests.

# Technical Notes

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Due to very small sample size, Asian, Native American, Eskimo, Aleut and “other” races were included in the category called “other.” Persons of Hispanic ethnicity may be of any race.

It is important to note that the data presented in this profile do not control for selected variables. Controlling for variables such as education, income, age and marital status can demonstrate whether racial differences continue to exist after adjustment.

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# Minority Health Profile



## The Ohio Department of Health

<http://www.odh.ohio.gov>

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