RESOURCES

Where to Find More Data
There is still more Contra Costa data available online.

Visit Contra Costa Health Services' website
http://www.cchealth.org/health_data/

Find countywide and neighborhood level data including communicable diseases, chronic diseases, injuries, and maternal and child health topics. Call Contra Costa Health Services' Community Health Assessment, Planning, and Evaluation (CHAPE) Group at (925) 313-6171 for further assistance.

How do we compare to other California counties?
http://www.dhs.ca.gov/hisp/chs/OHIR/reports/healthstatusprofiles/default.htm

The California Department of Health Services' County Health Status Report presents yearly public health data that can be directly compared with national benchmarks and rates among all other California counties.

Visit the U.S. Census American Fact Finder website for 2000-2006 population, housing, economic, and geographic data. (http://factfinder.census.gov)

Population Data
http://www.dof.ca.gov/html/Demograp/DRU_datafiles/DRU_datafiles.htm

California Department of Finance provides current age, sex, and race data for California counties. Their site provides official population projections for all of Contra Costa's cities and unincorporated areas for the years 2000 to 2050.

Local Births & Deaths
http://www.dhs.ca.gov/hisp/chs/OHIR/reports

The California Department of Health Services' website provides many downloadable data files, including birth and death data by zip code. The website also features an interactive query system - producing customized data tables and statistical reports for individual counties or California as a whole. Found at, http://www.applications.dhs.ca.gov/vsq

Injuries
http://www.applications.dhs.ca.gov/epicdata/default.htm

The EPICenter allows users to calculate local fatal and nonfatal injury totals and rates by providing current California injury data online.

Risks, Behaviors & Health

http://www.cdc.gov/brfss/about.htm

The Centers for Disease Control's Behavioral Risk Factor Survey (BRFSS) is the primary source of information on health-related behaviors of Americans. Data is collected state-by-state through telephone interviews. Questions are related to chronic diseases, injuries, and infectious diseases.

http://www.chis.ucla.edu

The 2005 California Health Interview Survey (CHIS) contains data on public health topics including information on health insurance coverage and access to care. This information was collected through phone interviews and the survey sample was designed so that results could be generated for most California counties.

Schools, Children & Learning

http://data1.cde.ca.gov/dataquest/dataquest.asp

The Department of Education's Data Quest website contains data at the individual school level, and includes information on local test scores, English Learners, and eligibility for free or reduced breakfast/lunch programs.

Scientific Research Articles

http://www.ncbi.nlm.nih.gov/PubMed

Looking for published articles on a specific health topic or special population? PubMed is a service of the National Library of Medicine, provides online access to over 17 million MEDLINE journal citations dating back to the mid-1950's. PubMed includes links to many sites providing full text articles.

FREQUENTLY ASKED QUESTIONS

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1. Why is the rate high when the number is so low?

This may seem like a contradiction, but it's really not.

The number is an actual count, like the total number of recorded heart disease deaths.

The rate is a ratio; it is calculated with a formula. Rates are very important because they allow us to compare different populations.

For example, African Americans comprise only about 9% of Contra Costa County's population, but African Americans have the highest rate of heart disease deaths – almost twice the rate of Whites. Rates help you see big problems in small population groups. Without using rates to compare population groups, we could not uncover these health disparities and unfair differences.
(Note: For more information on calculating rates, see the Introduction.)

2. Which is more important to look at – the rate or the number?

The answer to this question depends on your interests and priorities — rates and numbers tell different stories.

The total number of deaths, cases or hospitalizations tells you how common or widespread the problem is in the community. In order to lower the overall county death or hospitalization rates, it may be better to target interventions to the communities that account for the greatest number of cases or deaths.

If social justice and reducing health disparities are important to you, pay close attention to rates. Rates allow us to make better comparisons between groups. Although one population group may have a lower number of deaths or hospitalizations, they may have the highest rate compared to the county and all other race/ethnic groups. This means that they are disproportionately impacted by the given disease or injury. In order to reduce unfair health disparities, it is important to target groups with the highest age-adjusted rates. Groups that are disproportionately impacted by a given disease or injury may be so due to poor access to health care or environmental and/or behavioral risk factors.

For example, if you are choosing a site for a health-screening program, you will likely need to look at both rates and numbers. At times, you may be asked to choose between those communities that have the poorest health outcomes and the greatest need for care (rates), and those places in which you could possibly reach a greater number of people (numbers and totals).

3. Sometimes your tables show rates that are much higher than others, but in the text you say there is no difference. Why?

If two rates appear different in the tables – one is higher than another – it doesn't mean that the difference is real or true. A rate difference of 10 deaths per 100,000 between groups may look impressive, but this difference may not be the same every year, and it may not be statistically significant based on the confidence intervals. If rates are not significantly different based on confidence intervals, we say in the text that there is no difference between the rates or that the rates are similar.

Throughout this report, when we state in the text that a rate is higher or lower than the county overall or than another race/ethnic group, we mean that it is **significantly** higher or lower. By **"significant"**, we mean that the difference between two rates is statistically significant based on 95% confidence intervals (see Glossary). If the confidence intervals for two rates do not overlap, we conclude with 95% certainty that the difference between the two rates is significant and not due to chance alone.

4. Can I compare these numbers and rates to those in earlier CHAPE reports?

No. A small difference between a rate in past reports and a rate in this report may or may not be significant and therefore cannot reliably show an increase or decrease of "events" over time.

The rates and numbers in this report represent a snapshot in time for the years 2002-2004 and are based on counts and population totals and estimations specific to this time period. The coding for disease, race/ethnic, and age group categories is also specific to this report. Thus, the methods for compiling this report are similar to those we used for past reports but not entirely identical. We advise that the numbers and rates in this report not be compared to those in past reports.

5. Why don't your rates and totals match other reports I've read?

Small differences in coding and statistical methods can lead to slight differences in reported rates. For example, a rate for "adults" in one report may pertain to adults 18-64 years while another report may include in its "adults" category individuals 18 years and older. Similarly, some reports may include Pacific Islanders in the "Asian" category for example, while others may categorize Pacific Islanders as "Other". Also, rates presented in one report may be crude versus age-adjusted in another.

Differences in what "counts" as an event or case will affect the totals and numerator for rate calculations. Using breast cancer as an example, one report may include all deaths due to breast cancer – both invasive and non-invasive – whereas another may include deaths due to non-invasive breast cancer only in its numerator. These different totals will translate into different rates.

In calculating rates we also use population estimates. The process by which other report writers calculate population totals may differ from what we used in this report. We used the most up-to-date population estimates for our denominators in this

report. We used the Department of Finance (DOF) 2002-2004 overall county estimate for Contra Costa. We calculated 2003 mid-year estimates from the DOF 2000-2004 totals multiplied by 3.

6. Why is the data three years old? Are there newer numbers?

The process of data collection, cleaning, coding and analysis is a time-consuming process. We used the most up-to-date death, birth and hospitalization data available at the time of writing this report. In a few cases, more recent count data for a particular "event" was available, however the corresponding year's population data was not, hindering our ability to calculate rates.

If you additional questions, CHAPE staff is available to discuss the analysis, tables and data sources found in this report. Contact Chuck McKetney at (925) 313-6171 or cmcketne@hsd.cccounty.us for assistance.

STATISTICAL METHODS

Statistical Methods: City-level Population Estimates

In order to calculate reliable local rates of death, disease and hospitalizations, we needed population data at the city level. The population data acts as the denominators in our statistical formulas and represents the populations at risk for illness and injury for a specific time period.

The Problem:

The *California Department of Finance* (DOF) does not provide the mid-year population estimates for cities by age group and gender.

Our Solution:

Based on the DOF city-level population estimates for January 1, 2002, January 1, 2003 and January 1, 2004, we calculated a 2003 mid-year population estimate for residents in each city.

We assumed the rate of population growth to be the same among men and women. We also assumed the population growth was the same in each age group. We calculated 2003 mid-year city-level population estimates for each group within each city.

These calculations were based on statistics from the 2000-2004 *California Department of Finance* (DOF) population estimates. These 2003 mid-year estimates were then multiplied by three in calculating 2002-2004 rates

These city-level estimates, by age group and gender, were used for the age-adjusted rates and for the analyses on specific topics such as teen births and injury hospitalizations. These additional denominators are shown in detailed tables with 95% confidence intervals, available online at:http://cchealth.org/health_data/hospital_council/

City–level population estimates
Calculated mid–year city–level estimates by gender
Table 1. Contra Costa & California, 2002–2004 (3–year totals)

	Men	**Women**	**Population size**
Antioch	147,282	153,492	300,774
Bay Point	35,070	34,878	69,948
Brentwood	53,613	55,144	108,757
Concord	185,647	190,232	375,879
Martinez	55,012	55,871	110,883
Oakley	41,459	40,602	82,061
Pinole	28,239	30,552	58,791
Pittsburg	90,585	93,816	184,401
Richmond	148,515	156,981	305,496
San Pablo	45,694	47,347	93,041
Walnut Creek	91,789	107,035	198,824
Contra Costa	1,474,351	1,531,087	3,005,438
California	53,865,026	54,023,662	107,888,688

Note: City-level denominators were extrapolated from the E-4 file to approximate the mid-year population estimates that are needed to calculate city-level rates. For more information, see our section on statistical methods.