Minority Health Assessment Report

September 2014

City of Portland Minority Health Program

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ACKNOWLEDGEMENTS

The City of Portland Public Health Division's Minority Health Program (MHP) would like to thank the individuals and organizations that contributed to the development and implementation of this community health needs assessment. Particular individuals, Community Health Outreach Workers (CHOWs), and groups helped to identify survey participants and provided key background information on the health care needs of the racial and ethnic language communities in Cumberland County.

We especially wish to thank Lucie Rioux and Rachel Horton White of the Opportunity Alliance; and, Donna Wilkens and Joy Zacharia of Metis Associates from New York, who collaborated with us to conduct an expanded, extensive study of the Parkside Neighborhood. We thank Metis Associate and Opportunity Alliance for analyzing and writing a separate complementary Parkside Neighborhood report incorporating the health needs assessment components.
We would also like to especially thank Rebecca Stabler for her expert analyses of the Cumberland County assessment data.

Special thanks and appreciations are offered to:

- The community leaders and representatives in the minority communities

All City of Portland Public Health Division's Minority Health Program Staff and Contract CHOWs:

- Nelida Berke, MLT, BS (Spanish CHOW and Contract CHOWs Coordinator)
- Malual Mabur, MD, MSc, DTM&H (Sudanese & Arabic CHOW)
- Siyad Ahmed (Somali CHOW)
- Jocelyne Ininahazwe, MA (French CHOW)

The network of Community Health Outreach Workers (CHOW) involved in this project and their community of focus:

- Saharo Sharif (Somali)
- Qamar Ahmed (Arabic)
- Gatdet Lul (Sudanese/South Sudanese)
- Florence Olebe (Sudanese/South Sudanese)
- Victoria Chicon (Spanish)
- Jennifer Hernandez (Spanish)
- Mohanad Mohammed (Arabic)
- Sarah Madhi (Arabic)
- Biljana Nedeljkovic (Serbian/Croatian/Bosnian)
- Mom Hoeung (Cambodian)
- Ricky Ho (Cambodian)
- Minh Canfield (Vietnamese)
- Tarlan Ahmadov (Russian/Azerbaijani)
- Marisa Crommett (Caucasian-English Speaking)
- Pious Ali (African American)
- Meryl Troop (American Sign Language/Hearing-Impaired)
- Asha Ali (Somali)

- Dirir Moulouko (Somali)
- Sandra Ricker (Spanish)
- Megan Sutherland (Caucasian-English Speaking)
- Godard N-Diambu (French)
- Joseph Kibukabayo (French)
- Philemon Dushimire (French)
- Ashraf Eldeknawey (Arabic)
- Antoine Bikamba (French)
- Jocelyne Kamijazi (French)
- Birch Hincks (Caucasian-English Speaking), and, Others.

- Apollo Karara, Executive Director, Maine Association of New Americans (MANA)
- Maine Center for Disease Control and Prevention's Office of Health Equity
- Toho Soma, MPH, Acting Director, Public Health Division; Health Equity & Research Program Manager

In addition, we would like to thank Tracy Chalecki for her time and administrative support during the project survey data processing.

We extends our gratitude to the residents, stakeholders, service providers, business owners and the faith-based agencies for their involvement and providing direct and technical supports for this project.

Finally, we send an unreserved appreciation and thank you to our funder – Maine Health Access Foundation (MeHAF)- for providing the grant for this assessment initiative.
The **Maine Health Access Foundation's** mission is to promote access to quality health care, especially for those who are uninsured and underserved, and improve the health of everyone in Maine. - See more at:
http://www.mehaf.org/about/#sthash.JD7hCWpq.dpuf

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ORGANIZATIONAL BACKGROUND

Public Health
Prevent. Promote. Protect.
Portland Public Health Division
City of Portland, Health and Human Services Department

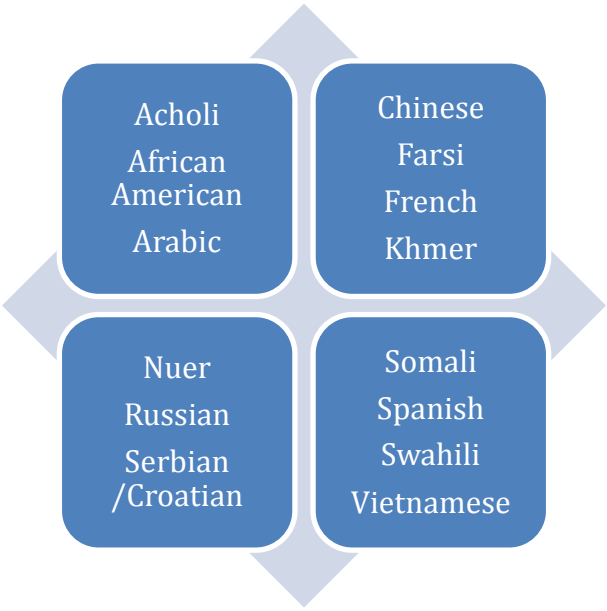
Minority Health Program

Who We Are

The Public Health Division (PHD), part of the City of Portland's Health and Human Services Department, has consistently demonstrated its commitment to ensuring the health of Portland's communities for nearly 120 years. All programming is guided by its mission to "improve the health of all people in the community by working together to prevent disease, promote health, and protect residents from environmental threats." To that end, the Division has developed a staff that is not only clinically competent, but also culturally competent regarding issues of health equity and disparities.

The Minority Health Program of the Public Health Division, Health and Human Services Department, City of Portland (MHP) addresses the health issues and needs of all minority communities in Cumberland County. MHP links people to needed health and social services and improves community health status through Community Health Outreach Workers (CHOWs) and clinical partnerships.

The Minority Populations served includes the following racial, ethnic, and language groups:



Our Vision

MHP's vision of a healthy community is one where:

- Diversity within the community is respected and valued by community members and institutions.
- Everyone has access to quality health and social services.
- Everyone has access to resources and conditions required for a healthy lifestyle.
- Institutions and policy makers are responsive to community residents.
- The assets and gifts of community residents are acknowledged and shared.
- Work is conducted in partnership with community organizations and service providers to identify and address health priorities of minority communities.

Our Mission

MHP's mission is to:

- Develop and provide evidence-based public health practices with services that enhance access to quality and affordable health care to improve the well-being of minority communities in Cumberland County.
- Identify, evaluate, and respond to community needs through innovative services.
- Encourage community-clinical collaborations and partnerships through leadership and advocacy.
- Promote quality of care and best practices in our community by providing consultation, education, and training.
- Promote quality of care and best practices in our hospitals and clinics by providing consultation, education, and training.

Our Objectives - MHP's objectives are to:

- Improve minority community health at the community, family, and individual levels.
- Increase the capacity of community groups to establish health and well-being priorities and to implement a locally defined community health agenda.
- Strengthen informal and formal social networks and sense of community focusing on the strengths and assets of Cumberland County's racial, ethnic, and language groups.
- Ensure that institutions, including the Public Health Division, are more accessible and responsive to community interests by building an integrated channel of information through the establishment of a network of community health outreach workers.
- Active participation in health policy forums, health plans, task forces, workgroups-/-committees on issues to improve the health for minority groups.

Our Values

We recognize that healthy individuals, families, and communities are vital to a healthy society. We recognize the racial, ethnic, and language diversity and inherent worth of each individual, who collectively forms the backbone of our community. We value the importance of public health preventive measures and policies that enhance health equity and reduce health disparities. We respect the wisdom of community members, healthcare providers, faith-based leaders, and policy makers and their efforts toward improving access to care for our minority communities in a safe and healthy environment.

Our Operating Principles

We are guided by these basic operational principles in all our services and activities:

- Acting with Integrity – Integrity, trust, honesty, confidentiality, respect, and fiscal responsibility.
- Satisfying our clients and patients – helping our clients identify their needs and working diligently to meet or exceed their expectations.
- Community Service – Ensuring that assets and resources of our community are utilized to improve the health and wellness of the minority communities for optimum public health indicators. Our goal is to reduce health disparities for every individual and family in our community who needs our help.
- Using Sound Business Practices – We will use proven, sound business practices to manage Agency activities in a competitive environment.

EXECUTIVE SUMMARY

In order to provide culturally appropriate public and clinical health services to the racial and ethnic minorities in Cumberland County, it is important to identify and describe community health needs and factors that affect their enjoying optimum health. This is very important to be able to developed community-informed public health interventions. This helps us improve our communication with the community, its members and other organizations addressing community health needs.

Between January 14 and June 30, 2014, the Portland Public Health Division's Minority Health Program administered a Minority Health Assessment to 1,264 members of the racial, ethnic, and language minority communities in Cumberland County. In addition, American-born individuals were included in this assessment to serve as a comparison group. This report represents the results of the assessment (excluding the Parkside Neighborhood assessment focus area) from the following groups: Somali, Iraqi, American-born (Caucasian), Great Lakes Region (Democratic Republic of Congo, Burundi, Rwanda, Kenya, Tanzania, Uganda, and Angola), Sudanese, South Sudanese, Russian, Latino, American-born (African American), Cambodian, Bosnian/Croatian/Serbian, and the hearing impaired/ASL, in Cumberland County.

The groups were chosen based on their demographic population size and their unique vulnerability in accessing public and clinical health services. The assessments revealed important health issues covering several important trends, the most significant of which were:

- Safety: Low crime/safe neighborhoods as the most important factor for a healthy community
- Chronic Disease: Diabetes as the most important health problems in the community
- Substance abuse: Alcohol abuse as the most important risky behavior in the community

Other trends or common themes that showed up from the assessment include:

- The presence of the uninsured and importance of the Affordable Care Act enrollment.
- Need for affordable housing, good place to raise children, good jobs, and healthy economy
- High blood pressure, mental health problems, domestic violence, dental problems and aging-related problems
- Lack of exercise and tobacco use habits

The outcomes of this project reiterate and complement findings of similar studies (e.g., Parkside Neighborhood, etc.) conducted elsewhere in the county and a set of interventions were designed to address the social determinants of health with specific health policy and programmatic interventions. These interventions also emphasize the importance of the use of Community Health Workers in the healthcare delivery system, community mobilization and engagement, and, preventive health promotion approaches to improve access to care for needed services.

Some of these interventions were designed to reduce barriers to accessing public and clinical health care services, especially to improve:

- Perceptions by the ethnic minority groups on the health care service system, through training and support of Community Health Outreach Workers.
- The health care service delivery to be more culturally appropriate, through capacity building for interpreters/care managers operating in the health sector, and provision of appropriate health resources.
- Recognition for the cultural approaches/holistic measures provided by the ethnic minorities themselves and strengthening the knowledge of providers concerning health patterns in the home countries of racial and ethnic minorities.
- Selected pilot interventions aimed at identifying useful innovations in practice management that would serve to reduce barriers to accessing care.

INTRODUCTION

According to the National Association of County & City Health Officials' (NACCHO) "Definition of an Ideal Community Health Assessment," by Julia Joh Elligers:

"A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community.
An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services.
Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans."

The City of Portland Public Health Division's Minority Health Program in partnership with other key stakeholders (Opportunity Alliance, Metis Associates, and the City of Portland's Health Equity and Research Program), conducted comprehensive community health needs assessments in Cumberland County and Portland's Parkside Neighborhood (separate reports aside from this report) with survey respondents from the following racial and ethnic groups - Somali, Iraqi, American-born (Caucasian), Great Lakes Region (Democratic Republic of Congo, Burundi, Rwanda, Kenya, Tanzania, Uganda, and Angola), Sudanese, South Sudanese, Russian, Latino, American-born (African American), Cambodian, Bosnian/Croatian/Serbian, and, the hearing impaired/ASL in Cumberland County.

The project activities were conducted under five stages over a period of twelve months (August 2013 to September 2014):

1. Partners and community engagement and survey development- August 1 - December 31, 2013
2. Implementation of the community health assessment – January 24 - May 1, 2014
3. Data entry, collation, and analysis – May 1 -31, 2014
4. Assessment reporting and dissemination stages – June 1 – September 12, 2014.

The main purpose of this study is to get communities' opinions about community health needs in Cumberland County with the intention of using results of the assessment survey to evaluate and address the most pressing needs through community action.

This is conducted with an anticipated accomplishment of the following six objectives:

- Determine what community members feel are important health issues
- Find out if different communities want different resources

- Assess whether our current programs are meeting the needs of our community members
- Modify existing programs or develop new programs to address emerging health needs
- Find out where we need to communicate better with other city and private organizations to assist them in ensuring that community health needs are met
- Inform communities of existing resources to address their health concerns

METHODOLOGY AND APPROACH

Background information on the partnership and stakeholders' development

The project began with mobilizing our current partners and collaborating with new ones to achieve the assessment purpose. To this, three agencies joined forces with the Minority Health Program to conduct the assessment, and these are the Maine Association of New Americans (MANA), Opportunity Alliance/ Metis Associates NY, and Maine CDC Office of Health Equity (through its Refugee Health Program).

Questionnaire development process

There were survey questions developed with a series of community meetings (four assessment meetings – two each at the Parkside Neighborhood and Portland City Hall) to ensure adequate sampling of preferred categories of groups. The surveys were pilot-tested with the community members for time estimate for survey implementation and cultural/linguistic appropriateness. The health need survey was submitted to the University of Southern Maine for Institutional Review Board (IRB) determination of project survey sampling and methodology and was approved. There were two separate types of surveys: One solely to focus on minority health needs in Cumberland County and another set with extended community needs assessment within the Parkside Neighborhood.

The questions for the surveys with the ethnic minority groups were derived from informal interviews with their community leaders, review of tested questions in similar settings, and consulting community health outreach workers and neighborhood residents (survey questions attached as appendices). The survey questions were prepared primarily concerning the following themes:

- Overall perceptions of community and personal health
- Specific perceptions concerning the most important factors for a healthy community
- Specific perceptions concerning the health problems in the community
- Perceived impressions on the most important risky behaviors in the community
- Identification of the socio-economic, educational, and insurance factors in the community as affecting accessing health care services
- Perceptions concerning the role played by culture, age, gender, and ethnicity in the utilization of health care services
- Needs for what it takes for them to experience optimum mental health

The questionnaire was developed initially in English, reviewed by stakeholders, residents and Community Health Outreach Workers, who then implemented it in various languages.

Implementation of the community health assessment process

Involved:
1. The recruitment of Community Health Outreach Workers (CHOWs) per the targeted sampling groups and expected numbers of survey. A total number of 43 CHOWs were utilized across the two focus coverage areas (Cumberland County and Parkside Neighborhood). The CHOWs being trusted, indigenous community members served as survey implementers in their respective communities.

2. A 2-day Community-based participatory research (CBPR) project data training was conducted with the CHOWs on January 24 and 25, 2014 with the assistance of Metis Associates, NY. The CHOWs were trained on the purpose of project, its implementation plan and methodology, how to implement the surveys, and other survey logistics and reporting (distribution of surveys, supporting materials & survey return plans). See details of sampling methodology in appendix.

3. Survey implementation: There were two concentration areas, the Parkside Neighborhood and Cumberland County (without Parkside). An individual plan for recruiting participants was developed with each CHOW that includes; criteria for screening, target number of respondents, locations and approaches. Our anticipated total surveys were 2,164 surveys (actual return: 1,768; 82% returns) with 1,624 from Cumberland County (actual returns: 1,264) and 540 Parkside neighborhood (actual returns: 504) respondents.

Methods of survey implementation included one-on-one personal and group implementations by the CHOWs. These were implemented at multiple outreach points, such as the faith-based congregations, schools, non-profit organizations, ethnic stores, community centers, Parkside neighborhood areas, homeless square, residential parks, etc. Our survey focused on the following communities; Somali, Sudanese, Spanish, Arabic, Serbian, French/Swahili, Cambodian, Vietnamese, Chinese, Russian, Native Americans, African Americans, Caucasian-English speaking, and the hearing-impaired /ASL communities.

Analysis

The City of Portland's Minority Health Program collected, collated and inputted the data in a structured database for analysis. The analysis of the Cumberland County surveys was done by the City's Health Equity and Research program consultant – Becca Stabler, while the Parkside surveys were analyzed by Metis Associates (a New York-based agency). This report provides a synthesis of the findings and their implications in the section below entitled "Discussion of findings."

Assessment reporting and dissemination stages:

This involved the drafting of reports by City of Portland's Minority Health Program for Cumberland County surveys and Metis Associates for Parkside surveys. Both

partners shared reports with various communities for feedback and review. The reports will be disseminated through various channels. All project partners are expected to be involved in the various disseminations of the assessment report. Disseminations within communities involve the community advisory committee (CAC) members' distributions in their communities, community meetings, faith-based leaders, and trusted community leaders and representatives. Disseminations with agencies that have interest in or already serving the minority communities will be sent a copy for their information to inform their programs and services delivery. Examples of channels include, the Greater Portland Refugee and Immigrant Healthcare Collaborative, Refugee Providers Multicultural Committee, Offices of Health Equity and Multicultural Affairs, Universities of Southern Maine and New England, Multicultural Resource Centers, Neighborhood Parks/ Centers, Medical Homes and health provider offices, and through Community-based organizations.

DISCUSSION OF FINDINGS

Between January 14 and June 30, 2014, the Portland Public Health Division's Minority Health Program administered a Minority Health Assessment to 1,264 members of the racial, ethnic, and language minority communities in Cumberland County. In addition, American-born individuals were included in this assessment to serve as a comparison group.

Using 2011 response rates and 2010 Census data, we determined the optimal number of respondents of each ethnicity that would allow us to reach at least 4% of the estimated current population of each target ethnicity. To provide the most accurate representation of the health concerns and interests of the whole population and each distinct ethnic group, we utilized a chain sampling approach. Utilizing a chain sampling approach, interviewers – who were recruited from the various ethnic communities – were asked to identify five diverse people in their community, taking into account different ages, genders, languages, residential locations, and political and religious views. Once our interviewers completed their first five interviews, they then asked the interviewees for a referral to another respondent within their target community. Respondents were limited to three referrals in order to help broaden the range of opinions in our response.

Section 1. Demographics

97% of respondents listed their zip code of residence. Respondents were then grouped by county with the exception of Portland residents, who were placed in their own group due to large numbers (Table 1). It is important to note that Parkside Neighborhood in Portland was excluded from the Cumberland County survey, due to the Parkside Neighborhood being surveyed under a separate, complementary community survey. The Parkside Neighborhood surveys include the same survey questions asked in the Cumberland County survey and a comparison report is being compiled.

Table 1. Place of residence

Residence	Count	Percent
City of Portland (excluding Parkside)	746	59%
Cumberland County (excluding Portland)	437	35%
York County	41	3%
Androscoggin County	1	0%
No Response	39	3%

All but 6 respondents had an ethnic group listed (Table 2). The most frequently cited ethnicities were Latino, Iraqi, and Somali, with each accounting for more than 12% of the total sample. The Great Lakes Region is comprised of the Democratic Republic of Congo (DRC), Burundi, Rwanda, Kenya, Tanzania, and Uganda.

American-born Caucasians, comprised 8% of the total sample and were included to serve as a comparison group. Additionally, hearing impaired/ASL individuals and American-born African Americans were also sampled as a comparison minority group, but the sample size for both is very small (n=15 for African Americans and n=14 for ASL). Therefore it is not advised to draw any strong conclusions about these groups based on this assessment. In subsequent years it would benefit the survey to include a larger sample of hearing impaired/ASL individuals and American-born African Americans to provide more robust samples.

Table 2. Ethnicity

Ethnic Group	Count	Percent
Latino	189	15%
Iraqi	182	14%
Somali	164	13%
Bosnian/Serbs/Croats	149	12%
Great Lakes Region	136	11%
American-born (Caucasian)	104	8%
South Sudanese	83	7%
Sudanese	58	5%
Russian	50	4%
Cambodian	43	3%
American-born (African American)	15	1%
Hearing Impaired/ASL	14	1%
Other	71	6%
No Response	6	0%

Additional analyses were conducted among the nine most common ethnic groups represented in the survey (shown in Table 3). Table 3 displays data related to participants' age and acculturation levels. The median age among the various ethnic groups ranges from 31 years for Somalis to 55 years for Bosnians, Serbs, and Croatians.

The Sudanese and Cambodians have spent the greatest proportion of their lives in the United States, at 37% and 52%, respectively. In addition, Sudanese have the third highest literacy rates among all ethnic groups, with only 15% unable to read and write in English; however, Cambodians have the second lowest literacy rate, at 72%.

Table 3. Age and acculturation indicators

Ethnic group	Median age	Average number of years living in the United States	Average percent of life in the United States	Percent unable to read or write English
Somali	31	7.6	25%	59%
Iraqi	34	3.2	9%	68%
Hearing impaired/ASL	36	43	95%	7%
American-born (Caucasian)	38	42.0	100%	0%
Great Lakes Region	38	5	13%	18%
Sudanese	39	12.6	37%	15%
Overall	**39**	**13.5**	**34%**	**46%**
Russian	41	9.8	25%	69%
Latino	42	14.1	33%	78%
South Sudanese	42.5	9.5	27%	13%
American-born (African-American)	47	42.7	100%	0%
Cambodian	47	23.9	52%	72%
Bosnian/Serb/Croat	55	14.2	29%	37%

Both Somali (40%) and Latino (38%) had a very high proportion of their population reporting that they did not complete high school (Table 4); these proportions are almost twice the overall proportion of the sample reporting not completing high school (20%). American-born African Americans had the highest proportion of individuals completing some college (80%), four times over that of the overall population (20%). In comparison, hearing impaired/ASL individuals (71%) and American-born Caucasians (70%) have the highest percentage of individuals with a college degree or higher.

Table 4. Highest level of education attained

Ethnic group	n	Less than high school	High school diploma or GED	Some college	College degree or higher
Somali	157	40%	35%	20%	5%
Latino	189	38%	40%	14%	9%
Cambodian	42	29%	62%	5%	5%
Iraqi	181	21%	41%	13%	25%
Overall	**1,246**	**20%**	**38%**	**20%**	**22%**
South Sudanese	82	18%	27%	30%	24%
Bosnian/Serb/Croat	148	17%	52%	18%	13%
Sudanese	57	16%	40%	17%	26%
Great Lakes Region	134	5%	54%	29%	12%
Russian	50	2%	18%	22%	58%
American-born (Caucasian)	103	1%	10%	19%	70%
American-born (African-American)	15	0%	7%	80%	13%
Hearing impaired/ASL	14	0%	21%	7%	71%

30% of Bosnians, Serbians, and Croatians reported an annual household income of over $50,000; this was 3 times higher than the overall percentage of respondents' whose annual income was over $50,000 (9%) (Table 5). Despite having spent the greatest percent of their lives in the United States, Cambodians have the fourth lowest annual income, with 84% reporting earning less than $20,000.

Table 5. Household size and income

Ethnic group	n	Average household size	Less than $10,000	$10,000 to $20,000	$20,000 to $29,999	$30,000 to $49,999	Over $50,000
American-born (Caucasian)	100	2.4	15%	13%	15%	18%	39%
Bosnian/Serb/Croat	149	2.9	3%	10%	23%	34%	30%
Hearing impaired/ASL	14	2.8	14%	29%	21%	14%	21%
Russian	47	3.4	23%	19%	19%	21%	17%
American-born (African-American)	14	3.3	7%	21%	50%	7%	14%
Overall	**1,207**	**3.5**	**33%**	**27%**	**19%**	**11%**	**9%**
Latino	179	2.8	25%	36%	24%	5%	5%
South Sudanese	78	4.3	12%	21%	33%	33%	1%
Great Lakes Region	134	3.3	35%	44%	20%	0%	1%
Iraqi	167	4.5	74%	25%	1%	0%	0%
Somali	153	5.0	48%	37%	12%	3%	0%
Sudanese	58	4.4	29%	16%	45%	10%	0%
Cambodian	43	3.3	44%	40%	14%	2%	0%

Section 2: Health

Overall, only 80% of participants responded to the question asking whether or not they had enrolled into health insurance through the Affordable Care Act (ACA) Marketplace (Table 6). Of those who responded to the question, the Great Lakes Region had the greatest proportion of individuals who had enrolled through the federal Marketplace (38%). American-born Caucasians had the lowest response rate of all ethnic groups, with only 38% of participants responding to the question. Of those American-born Caucasians who responded, only 5% said they enrolled in health insurance through the ACA.

Table 6: Enrolled into health insurance through the Affordable Care Act Marketplace

Ethnic group	n	Enrolled into health insurance through the Affordable Care Act MarketPlace
Great Lakes Region	109	38%
Sudanese	56	23%
South Sudanese	62	23%
Somali	129	22%
Overall	**1,008**	**13%**
Bosnian/Serb/Croat	144	7%
Latino	163	7%
American-born (Caucasian)	39	5%
Iraqi	162	2%
Russian	47	0%
Cambodian	40	0%
American-born (African-American)	6	0%
Hearing impaired/ASL	14	0%

Despite having the highest proportion of individuals enrolled into health insurance through the ACA, the Great Lake Region has the second highest proportion of uninsured individuals (52%). Latinos (63%) uninsured rates are over twice as high as the overall rate (30%). 77% of Bosnians, Serbs, and Croatians, compared to 73% of American-born Caucasians and 71% of American-born African Americans, have private health insurance.

Table 7: Health insurance status (multiple answers possible)

Ethnic group	n	Uninsured	Private insurance	Medicaid/MaineCare	Medicare
Latino	188	63%	14%	18%	20%
Great Lakes Region	135	52%	34%	6%	11%
Russian	50	48%	34%	24%	28%
South Sudanese	80	44%	46%	15%	40%
Overall	**1,238**	**30%**	**33%**	**24%**	**22%**
Cambodian	42	29%	19%	43%	48%
American-born (African-American)	14	21%	71%	14%	0%
Sudanese	57	21%	49%	9%	44%
Somali	157	17%	3%	30%	46%
American-born (Caucasian)	98	14%	73%	9%	7%
Bosnian/Serb/Croat	149	11%	77%	9%	3%
Iraqi	179	9%	1%	69%	9%
Hearing impaired/ASL	14	7%	50%	29%	71%

Respondents were asked to rate the health of their community and their own health on a four-point Likert scale, where 1 equals "Very unhealthy" and 4 equals "Very healthy" (Table 8). Over half of the surveyed ethnic groups, as well as the overall sample, rated their personal health higher than that of their community. With the exception of Bosnians, Serbs, and Croatians, those with a negative health rating are ethnic groups with the lowest average number of years living in the United States—Burundian (-5%), Somali (-1%), Iraqi (-1%), and Congolese (-1%). Conversely, those with the highest health ratings—American-born Caucasians (9%), Cambodian (7%), and Latino (6%)—have the highest average number of years living in the United States. American-born African Americans rated their community and their own health equally.

Table 8: Perceptions of community and personal health

Ethnic group	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Great Lakes Region	3.32	3.24	-2%
Somali	2.91	2.87	-1%
Iraqi	2.88	2.85	-1%
Bosnian/Serb/Croat	2.85	2.83	-1%
American-born (African-American)	2.93	2.93	0%
Sudanese	2.95	2.96	1%
Russian	2.92	2.96	1%
Overall	**2.89**	**2.94**	**2%**
Hearing impaired/ASL	2.93	3.07	5%
South Sudanese	2.81	2.95	5%
Latino	2.63	2.80	6%
Cambodian	2.79	2.98	7%
American-born (Caucasian)	2.83	3.09	9%

Tables 9-12 ask respondents to identify factors that contribute to and detract from a healthy community. To identify these factors we asked respondents to choose up to three responses. Below, each table identifies the top five most popular responses for all ethnic groups and the overall sample.

All ethnic groups except the Great Lakes Region and hearing impaired/ASL selected low crime and safe neighborhoods as one of their top five factors for a healthy community (Table 9). Of the ethnic groups that listed low crime and safe neighborhoods as a concern, three (American-born Caucasians, Cambodian, and Sudanese) as well as the overall sample, listed it as the top factor. A good place to raise children was also listed as a factor by all ethnic groups, except Latinos and hearing impaired/ASL individuals, and came in second in the overall sample. In

addition, a good place to raise children was the top priority for the Great Lakes Region and South Sudanese communities.

Affordable housing ranked third in the overall sample and was the top concern for Iraqis, Latinos, and Somalis. Good jobs and healthy economy ranked fourth among overall respondents and eight ethnic groups (American-born Caucasians and African Americans, Bosnian, Serbs, and Croatians, Great Lakes Region, Cambodian, Latino, Russians, and South Sudanese) also rate it highly. Good schools are cited as the fifth most popular overall factor, and figures into the top five among seven ethnic groups.

Table 9: Most important factors for a healthy community, by ethnicity (up to 3 answers possible)

Overall n=1,260		
1	Low crime/safe neighborhoods	38.8%
2	Good place to raise children	36.2%
3	Affordable housing	36.2%
4	Good and healthy economy	36.0%
5	Good schools	33.5%

Latino n=189		
1t	Affordable housing	42.9%
1t	Good jobs and healthy economy	42.9%
3	Good schools	36.0%
4	Low crime/safe neighborhoods	29.6%
5	Religious or spiritual values	21.2%

Iraqi n=179		
1	Affordable housing	39.7%
2	Good schools	36.3%
3	Good place to raise children	34.6%
4	Low crime/safe neighborhoods	34.1%
5	Clean environment	30.7%

Somali n=163		
1	Affordable housing	42.3%
2	Clean environment	35.6%
3t	Low crime/safe neighborhoods	35.0%
3t	Access to health care	35.0%
5	Good place to raise children	33.1%

Bosnian/Croat/Serb n=149		
1	Good jobs and healthy economy	63.8%
2	Low crime/safe neighborhoods	42.3%
3	Healthy behaviors and lifestyles	36.2%
4	Good place to raise children	33.6%
5	Strong family life	32.2%

Great Lakes Region n=136		
1	Good place to raise children	52.2%
2	Affordable housing	51.5%
3	Access to health care	44.9%
4	Good schools	33.1%
5	Good jobs and healthy economy	23.5%

American-born (Caucasian) n=104		
1	Low crime/safe neighborhoods	49.0%
2	Good jobs and healthy economy	35.6%
3	Healthy behaviors and lifestyles	33.7%
4	Good place to raise children	29.8%
5	Clean environment	25.0%

South Sudanese n=83		
1	Good place to raise children	59.0%
2	Low crime/safe neighborhoods	50.6%
3	Affordable housing	48.2%
4	Good schools	43.4%
5	Good jobs and healthy economy	34.9%

Sudanese n=58		
1	Low crime/safe neighborhoods	70.7%
2	Good place to raise children	67.2%
3	Good schools	53.4%
4	Access to health care	19.0%
5	Parks and recreation	17.2%

Russian n=50		
1	Good jobs and healthy economy	50.0%
2	Low crime/safe neighborhoods	48.0%
3	Good schools	42.0%
4	Good place to raise children	26.0%
5	Strong family life	22.0%

Cambodian n=43		
1	Low crime/safe neighborhoods	58.1%
2	Good jobs and healthy economy	46.5%
3	Affordable housing	39.5%
4	Access to health care	37.2%
5t	Good place to raise children	32.6%
5t	Strong family life	32.6%

American-Born (African American) n=15		
1	Affordable housing	53.3%
2t	Low crime/safe neighborhoods	40.0%
2t	Good jobs and healthy economy	40.0%
3t	Good place to raise children	33.3%
3t	Access to health care	33.3%
3t	Excellent race relations	33.3%

Hearing impaired/ASL n=14		
1	Healthy behaviors and lifestyles	42.9%
2t	Good schools	35.7%
2t	Clean environment	35.7%
2t	Affordable housing	35.7%
5	Arts and cultural events	28.6%

When asked to choose the three most important health problems in their community, diabetes was the top concern among the overall sample, as well as for five ethnic groups (Great Lakes Region, Latino, Somali, Russian, and Sudanese) (Table 10). All other ethnic groups, except for Bosnians, Serbs, and Croatians, hearing impaired/ASL individuals, and American-born Caucasians, listed diabetes as a top community health problem. Bosnians, Serbs, and Croatians and American-born Caucasians also report the highest numbers, over 70%, of individuals on private insurance, which is 37% higher than the overall sample response.

High blood pressure ranked second among overall participants, with seven ethnic communities (Bosnians, Serbs, and Croatians, Great Lakes Region, Somali, South Sudanese, American-born Caucasians, Russian, and Sudanese) listing it as a problem and two (Cambodian and Iraqi) listing it as a top concern. Dental problems ranked third among the overall sample, with all ethnic groups, except for American-born Caucasians and Cambodians, listing it as a top community problem.

Cancer ranked fourth overall, and was in the top five for six ethnic groups. Mental health problems ranked fifth overall, with American-born Caucasians listing it as their top concern.

Table 10: Most important health problems in the community, by ethnicity (up to 3 answers possible)

Overall n=1,257		
1	Diabetes	42.5%
2	High blood pressure	39.6%
3	Dental problems	35.2%
4	Cancer	28.5%
5	Mental health problems	27.4%

Latino n=188		
1	Diabetes	38.8%
2	Cancer	37.2%
3	Domestic violence	32.4%
4	Dental problems	21.8%
5	HIV/AIDS	21.3%

Iraqi n=179		
1	High blood pressure	61.5%
2	Diabetes	46.9%
3	Mental health problems	45.3%
4	Dental problems	44.1%
5t	Aging problems	29.6%
5t	Cancer	29.6%

Somali n=162		
1	Diabetes	57.4%
2	High blood pressure	51.9%
3	Dental problems	45.1%
4	Cancer	38.9%
5	Lung disease/asthma	17.9%

Bosnians/Serbs/Croat n=149		
1	Aging problems	71.8%
2	Dental problems	45.6%
3	High blood pressure	43.6%
4	Mental health problems	43.0%
5	Heart disease and stroke	31.5%

Great Lakes Region n=136		
1	Diabetes	61.0%
2	Cancer	53.7%
3	High blood pressure	40.4%
4	Aging problems	22.8%
5	Dental problems	21.3%

American-born (Caucasian)n=103		
1	Mental health problems	46.6%
2	Aging problems	36.9%
3	Heart disease and stroke	30.1%
4	Other	27.2%
5	High blood pressure	26.2%

South Sudanese n=83		
1	Dental problems	56.6%
2	Diabetes	48.2%
3	Domestic violence	44.6%
4	High blood pressure	34.9%
5	Mental health problems	33.7%

Sudanese n=58		
1	Diabetes	82.8%
2	Dental problems	67.2%
3	High blood pressure	48.3%
4	Domestic violence	31.0%
5	Aging problems	19.0%

Russian n=50		
1	Diabetes	56.0%
2	Cancer	54.0%
3	High blood pressure	42.0%
4	Aging problems	38.0%
5	Dental problems	26.0%

Cambodian n=43		
1	High blood pressure	60.5%
2	Teenage pregnancy	41.9%
3	Diabetes	34.9%
4t	Aging problems	30.2%
4t	Heart disease and stroke	30.2%

American-Born (African Americans) n=15		
1	Domestic violence	46.7%
2	Dental problems	40.0%
3t	Cancer	33.3%
3t	Child abuse/neglect	33.3%
3t	Diabetes	33.3%

Hearing impaired/ASL n=14		
1	Mental health problems	64.3%
2	Aging problems	50.0%
3	Domestic violence	35.7%
4	Dental problems	28.6%
5t	Heart disease and stroke	21.4%
5t	Teenage pregnancy	21.4%

Alcohol abuse was listed as the top risky community behavior overall, with all but Somalis listing it as a top concern (Table 11). Somalis ranked lack of exercise as their top community risky behavior. Lack of exercise ranked second overall and was chosen as a concern for seven other ethnic groups (Iraqi, Bosnian, Serbs, Croatians, Great Lakes Region, South Sudanese, Sudanese, hearing impaired/ASL, and Russian).

Drug and tobacco abuse ranked as the third and fourth most risky behaviors, respectively, for the overall respondents, with six ethnic communities (American-born Caucasians and African Americans, Great Lakes Region, Cambodian, Latino, and Somali) listing both as a top risky behavior.

Table 11: Most important risky behavior in the community, by ethnicity (up to 3 answers possible)

Overall n=1,256		
1	Alcohol abuse	56.8%
2	Lack of exercise	42.8%
3	Drug abuse	41.3%
4	Tobacco use	38.4%
5	Being overweight	30.6%

Bosnian/Serb/Croat n=149		
1	Lack of exercise	55.7%
2	Alcohol abuse	51.0%
3	Poor eating habits	47.0%
4	Being overweight	40.3%
5	Tobacco use	38.9%

Latino n=188		
1	Alcohol abuse	70.7%
2	Drug abuse	62.8%
3	Tobacco use	38.8%
4	Being overweight	26.1%
5	Racism	25.5%

Great Lakes Region n=135		
1	Alcohol abuse	69.6%
2	Drug abuse	55.6%
3	Tobacco use	42.2%
4	Lack of exercise	35.6%
5t	Being overweight	23.0%
5t	Racism	23.0%

Iraqi n=179		
1	Tobacco use	62.0%
2	Lack of exercise	57.5%
3	Being overweight	50.8%
4	Alcohol abuse	30.7%
5	Poor eating habits	29.6%

American-born (Caucasian) n=104		
1	Alcohol abuse	58.7%
2	Drug abuse	51.9%
3	Tobacco use	31.7%
4	Poor eating habits	26.0%
5	Other	22.1%

Somali n=162		
1	Lack of exercise	65.4%
2	Tobacco use	40.1%
3	Dropping out of school	37.0%
4	Being overweight	34.6%
5	Drug abuse	24.1%

South Sudanese n=82		
1	Alcohol abuse	92.7%
2	Drug abuse	74.4%
3	Lack of exercise	37.8%
4	Racism	25.6%
5	Dropping out of school	23.2%

Sudanese n=59		
1	Alcohol abuse	93.1%
2	Lack of exercise	60.3%
3	Drug abuse	36.2%
4	Not getting "shots" to prevent disease	34.5%
5	Dropping out of school	32.8%

Cambodian n=43		
1	Alcohol abuse	90.7%
2	Dropping out of school	53.5%
3	Tobacco use	46.5%
4	Drug abuse	37.2%
5	Not using seat belts/child safety seats	27.9%

Russian n=50		
1	Lack of exercise	64.0%
2	Being overweight	60.0%
3	Alcohol abuse	44.0%
4	Tobacco use	34.0%
5	Poor eating habits	22.0%

American-born (African American) n=15		
1	Alcohol abuse	73.3%
2	Drug abuse	66.7%
3t	Racism	53.3%
3t	Tobacco use	53.3%
4t	Being overweight	20.0%
4t	Dropping out of school	20.0%

Hearing impaired/ASL n=14		
1	Alcohol abuse	78.6%
2t	Being overweight	42.9%
2t	Lack of exercise	42.9%
4	Tobacco use	35.7%
5	Poor eating habits	28.6%

Overall, respondents cited dental problems as their most important health problem or risky behavior (Table 12). In addition, dental problems were a top concern for all ethnic groups, except American-born Caucasians and hearing impaired/ASL individuals. Lack of exercise ranked second among the overall sample, with four ethnic groups (American-born Caucasian, Bosnian, Serbs, and Croatian, Great Lakes Region, and Russian) citing it as a concern and three (Latino, Cambodian, and hearing impaired/ASL) ranking it as the top concern.

Alcohol abuse came in third as overall problems and was the most common top response, placing first amongst four ethnic groups (American-born Caucasians, Great Lakes Region, South Sudanese, and Sudanese).

Diabetes came in fourth overall. Of the six ethnic groups (Great Lakes Region, Iraqi, Latino, Somali, American-born African Americans, and Sudanese) that listed diabetes as a top concern, two (Great Lakes Region and Latino) have the highest rate of uninsured individuals. High blood pressure came in as the fifth most important concern overall and was listed as a problem for six communities (Great Lakes Region, Cambodian, Russian, Iraqi, hearing impaired/ASL, and Somali).

Table 12: Most important health problems or risky behaviors for the individual, by ethnicity (up to 3 answers possible)

Overall n=1,254		
1	Dental problems	26.1%
2	Lack of exercise	26.0%
3	Alcohol use	25.0%
4	Diabetes	24.6%
5	High blood pressure	24.1%

Latino n=187		
1	Lack of exercise	25.7%
2t	Dental problems	20.3%
2t	Diabetes	20.3%
2t	Poor eating habits	20.3%
5	Aging problems	17.6%

Iraqi n=179		
1	High blood pressure	39%
2	Mental health problems	34%
3	Dental problems	32%
4	Diabetes	29%
5	Being overweight	26%

Somali n=161		
1	Diabetes	44.1%
2	High blood pressure	39.1%
3	Dental problems	34.2%
4	Cancer	26.1%
5	Mental health problems	23.0%

Bosnian/Serb/Croat n=149		
1	Aging problems	44.3%
2	Lack of exercise	34.9%
3	Dental problems	29.5%
4	Being overweight	28.9%
5	Poor eating habits	26.8%

Great Lakes Region n=136		
1	Alcohol use	40.4%
2	Diabetes	33.8%
3	Dental problems	27.2%
4	High blood pressure	25.7%
5	Lack of exercise	22.1%

American-born (Caucasian) n=103		
1	Alcohol use	33.0%
2	Lack of exercise	30.1%
3	Aging problems	23.3%
4	Mental health problems	19.4%
5t	Poor eating habits	18.4%
5t	Other	18.4%

South Sudanese n=82		
1	Alcohol use	79.3%
2	Drug use	40.2%
3	Mental health problems	29.3%
4	Dental problems	28.0%
5	Domestic violence	26.8%

Sudanese n=58		
1	Alcohol use	53.4%
2	Diabetes	43.1%
3	Domestic violence	39.7%
4	Dental problems	36.2%
5	Drug use	20.7%

Russian n=50		
1	Lack of exercise	34.0%
2t	Dental problems	32.0%
2t	High blood pressure	32.0%
4	Heart disease and stroke	30.0%
5t	Being overweight	24.0%
5t	Cancer	24.0%

Cambodian n=43		
1	Lack of exercise	51.2%
2	High blood pressure	44.2%
3	Aging problems	32.6%
4	Alcohol use	30.2%
5t	Dental problems	20.9%
5t	Tobacco use	20.9%
5t	Other	20.9%

American-born (African American) n=15		
1t	Diabetes	26.7%
1t	Tobacco use	26.7%
2t	Being overweight	20.0%
2t	Dental problems	20.0%
2t	Poor eating habits	20.0%

Hearing impaired/ASL n=14		
1	Lack of exercise	42.9%
2	Being overweight	35.7%
3t	Aging problems	28.6%
3t	Mental health problems	28.6%
5t	Child abuse/neglect	21.4%
5t	High blood pressure	21.4%
5t	Suicidal thoughts	21.4%

We also compared health ratings by demographics, such as gender, relationship status, household status, education, and annual income. Overall, respondents grouped by demographics rated their personal health 2% higher than that of their community, with individuals making between $30,000 to $49,999 and over $50,000 having the greatest difference at 5% each. Only respondents with less than a high school diploma (-2%) and an annual income lower than $10,000 (-1%) rated their personal health lower than that of their community. Individuals on government insurance rated their personal health equal to that of their community.

Table 13. Health ratings by gender

Gender	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Female	2.91	2.95	1%
Male	2.87	2.93	2%

Table 14. Health ratings by relationship status

Relationship Status	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Married	2.90	2.93	1%
Not Married	2.87	2.96	3%

Table 15. Health rating, by household status

Household status	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Co-habitating	2.91	2.97	2%
Single/live alone	2.77	2.83	2%

Table 16. Health ratings by education level

Highest education level	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Less than high school	2.81	2.76	-2%
High school diploma or GED	2.90	2.96	2%
Some college	2.94	2.99	2%
College degree or higher	2.89	3.01	4%

Table 17. Health ratings by annual household income

Annual household income	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Less than $10,000	2.88	2.86	-1%
$10,000 to $20,000	2.91	2.98	3%
$20,000 to $29,999	2.83	2.90	3%
$30,000 to $49,999	2.86	3.00	5%
Over $50,000	2.97	3.11	5%

Table 18. Health ratings by insurance status

Insurance status	Average community health rating	Average personal health rating	Difference between personal and community health ratings
Uninsured	2.85	2.93	3%
Government insurance	2.81	2.82	0%
Private insurance	2.95	3.07	4%

When asked to identify the most important factors that contributed to a healthy community (Tables 19-24), low crime and safe neighborhoods was listed as one of the top five factors by all demographic groups and was chosen as a top response by eight groups. Affordable housing was the second most popular response, with five groups citing it as the most important factor. All other groups, except those with an annual income of over $50,000, listed affordable housing as a pressing factor. Other top responses were a good place to raise children and good jobs and a healthy economy.

Table 19. Most important factors for a healthy community by gender (up to 3 answers possible)

Female n=630		
1	Good place to raise children	37.5%
2	Low crime/safe neighborhoods	36.5%
3t	Affordable housing	35.6%
3t	Good jobs and healthy economy	35.6%
5	Good schools	34.3%

Male n=604		
1	Low crime/safe neighborhoods	41.7%
2	Affordable housing	36.8%
3	Good jobs and healthy economy	36.6%
4	Good place to raise children	34.3%
5	Good schools	32.9%

Table 20. Most important factor for a healthy community by relationship status (up to 3 answers possible)

Married n=723		
1	Good place to raise children	39.4%
2	Low crime/safe neighborhoods	39.1%
3	Affordable housing	36.4%
4	Good jobs and healthy economy	36.1%
5	Good schools	31.8%

Not Married n=480		
1	Low crime/safe neighborhoods	39.0%
2	Good jobs and healthy economy	37.5%
3	Good schools	36.5%
4	Affordable housing	34.6%
5	Good place to raise children	31.7%

Table 21. Most important factor for a healthy community by household status (up to 3 answers possible)

Co-habitating (e.g., roommates, family) n=961		
1	Low crime/safe neighborhoods	38.9%
2	Good jobs and healthy economy	36.9%
3	Good place to raise children	35.7%
4	Good schools	34.8%
5	Affordable housing	34.5%

Single/live alone n=193		
1	Low crime/safe neighborhoods	40.9%
2	Affordable housing	38.3%
3	Good jobs and healthy economy	35.2%
4	Good place to raise children	34.2%
5	Good schools	29.5%

Table 22. Most important factor for a healthy community by education level (up to 3 answers possible)

Less than high school n=252		
1	Affordable housing	38.9%
2	Good jobs and healthy economy	36.9%
3	Low crime/safe neighborhoods	36.5%
4	Good place to raise children	32.9%
5	Good schools	32.5%

Some college n=247		
1	Affordable housing	40.5%
2	Low crime/safe neighborhoods	40.1%
3	Good place to raise children	38.5%
4	Good schools	34.4%
5	Good jobs and healthy economy	32.0%

High school diploma/GED n=474		
1	Good jobs and healthy economy	38.4%
2	Affordable housing	38.2%
3	Good place to raise children	37.1%
4	Good schools	35.9%
5	Low crime/safe neighborhoods	34.8%

College degree or higher n=269		
1	Low crime/safe neighborhoods	48.0%
2t	Good place to raise children	36.4%
2t	Good jobs and healthy economy	36.4%
4	Good schools	29.7%
5	Affordable housing	26.4%

Table 23. Most important factors for a healthy community by annual household income (up to 3 answers possible)

Less than $10,000 n=399		
1	Affordable housing	43.1%
2	Good schools	34.6%
3	Low crime/safe neighborhoods	34.1%
4	Good place to raise children	33.6%
5	Access to health care	31.1%

$10,000 to $20,000 n=323		
1	Affordable housing	41.5%
2	Low crime/safe neighborhoods	38.4%
3	Good jobs and healthy economy	36.2%
4	Good place to raise children	35.3%
5	Good schools	33.4%

$20,000 to $29,999 n=232		
1	Low crime/safe neighborhoods	47.4%
2	Good jobs and healthy economy	40.9%
3	Good place to raise children	40.5%
4	Good schools	34.1%
5	Affordable housing	34.1%

$30,000 to $49,999 n=138		
1	Good jobs and healthy economy	42.8%
2	Low crime/safe neighborhoods	40.6%
3	Good place to raise children	36.2%
4	Good schools	34.1%
5	Affordable housing	30.4%

Over $50,000 n=111		
1	Good jobs and healthy economy	58.6%
2	Low crime/safe neighborhoods	42.3%
3	Good place to raise children	37.8%
4	Healthy behaviors and lifestyles	36.9%
5	Good schools	29.7%

Table 24. Most important factors for a healthy community by insurance status (up to 3 answers possible)

Uninsured n=334		
1	Affordable housing	45.5%
2	Good jobs and healthy economy	38.0%
3	Low crime/safe neighborhoods	32.9%
4	Good schools	32.6%
5	Good place to raise children	29.3%

Government Insurance n=519		
1	Low crime/safe neighborhoods	40.8%
2	Affordable housing	39.5%
3	Good place to raise children	36.4%
4	Good schools	32.4%
5	Good jobs and healthy economy	31.2%

Private Insurance n=403		
1	Low crime/safe neighborhoods	44.9%
2	Good jobs and healthy economy	43.2%
3	Good place to raise children	40.2%
4	Good schools	33.3%
5	Affordable housing	27.0%

When asked to identify the most important health problems in the community (Tables 25-30), all groups, except those with an annual household income above $50,000, cited diabetes as one of their top five concerns. High blood pressure was a top concern for five groups and was named as a concern for all. Other popular top community health problems were aging problems, such as arthritis and hearing and vision loss, and mental health problems.

Table 25. Most important health problem in the community by gender (up to three answers possible)

Female n=629		
1	Diabetes	44.7%
2	High blood pressure	37.7%
3	Dental problems	36.9%
4	Cancer	28.6%
5	Aging problems	27.5%

Male n=602		
1	High blood pressure	41.4%
2	Diabetes	39.7%
3	Dental problems	33.2%
4	Cancer	28.9%
5	Mental health problems	28.1%

Table 26. Most important health problem in the community by relationship status (up to three answers possible)

Married n=720		
1	High blood pressure	45.8%
2	Diabetes	44.6%
3	Dental problems	37.4%
4	Aging problems	29.7%
5	Mental health problems	28.5%

Not Married n=480		
1	Diabetes	38.1%
2t	Dental problems	31.0%
2t	High blood pressure	31.0%
4	Cancer	29.4%
5	Mental health problems	26.5%

Table 27. Most important health problem in the community by household status (up to three answers possible)

Co-habitating (e.g., roommates, family) n=960		
1	High blood pressure	41.8%
2	Diabetes	40.9%
3	Dental problems	35.7%
4	Aging problems	28.8%
5	Mental health problems	28.3%

Single/live alone n=192		
1	Diabetes	45.3%
2	High blood pressure	33.9%
3	Dental problems	30.7%
4	Aging problems	29.7%
5	Cancer	28.6%

Table 28. Most important health problem in the community by education level (up to three answers possible)

Less than high school n=253		
1	Diabetes	52.2%
2	High blood pressure	38.7%
3	Dental problems	33.2%
4	Cancer	30.4%
5	Mental health problems	21.7%

Some college n=245		
1	Diabetes	38.8%
2	High blood pressure	38.0%
3	Dental problems	35.1%
4	Cancer	30.6%
5	Aging problems	26.5%

High school diploma or GED n=473		
1	High blood pressure	41.4%
2	Diabetes	41.2%
3	Dental problems	38.9%
4t	Cancer	26.8%
4t	Mental health problems	26.8%

College degree or higher n=268		
1	Diabetes	38.1%
2t	High blood pressure	36.9%
2t	Mental health problems	36.9%
4	Aging problems	35.4%
5	Dental problems	29.9%

Table 29. Most important health problem in the community by annual household income (up to three answers possible)

Less than $10,000 n=399		
1	Diabetes	48.9%
2	High blood pressure	46.1%
3	Dental problems	37.1%
4	Cancer	30.8%
5	Mental health problems	29.8%

$20,000 to $29,999 n=232		
1	Diabetes	45.7%
2	Dental problems	40.1%
3	High blood pressure	32.8%
4	Cancer	29.3%
5	Aging problems	24.1%

$10,000 to $20,000 n=323		
1	Diabetes	44.6%
2	High blood pressure	41.5%
3	Cancer	33.7%
4	Dental problems	29.7%
5	Aging problems	23.2%

$30,000 to $49,999 n=137		
1	Aging problems	41.6%
2	High blood pressure	40.1%
3	Dental problems	39.4%
4	Mental health problems	35.0%
5	Diabetes	29.2%

Over $50,000 n=110		
1	Mental health problems	50.0%
2	Aging problems	49.1%
3	Heart disease and stroke	30.9%
4	Dental problems	26.4%
5	High blood pressure	24.5%

Table 30. Most important health problem in the community by insurance status (up to three answers possible)

Uninsured n=333		
1	Diabetes	38.4%
2	Cancer	36.3%
3	High blood pressure	29.1%
4	Dental problems	27.3%
5	Domestic violence	23.7%

Government insurance n=517		
1	Diabetes	48.9%
2	High blood pressure	46.0%
3	Dental problems	42.2%
4	Mental health problems	29.0%
5	Aging problems	23.2%

Private insurance n=403		
1	High blood pressure	37.2%
2	Aging problems	36.0%
3	Diabetes	35.0%
4	Dental problems	34.5%
5	Mental health problems	28.3%

All demographic groups listed alcohol abuse as one of their top five most important risky behaviors in their community (Tables 31-36). Alcohol abuse was listed as a top concern for all, except those with an annual household income of less than $10,000, who instead chose tobacco use as their top risky behavior. Other responses that were frequently cited in top five responses were lack of exercise (with 18 groups listing it among their top responses), drug abuse (17 groups), and being overweight (17 groups).

Table 31. Most important risky behaviors in your community by gender (up to 3 answers possible)

Female n=629		
1	Alcohol abuse	56.1%
2	Lack of exercise	44.2%
3	Drug abuse	38.6%
4	Tobacco use	38.0%
5	Being overweight	33.5%

Male n=601		
1	Alcohol abuse	58.2%
2	Drug abuse	44.1%
3	Lack of exercise	40.1%
4	Tobacco use	39.4%
5	Being overweight	27.8%

Table 32. Most important risky behaviors in your community by relationship status (up to 3 answers possible)

Married n=720		
1	Alcohol abuse	54.2%
2	Lack of exercise	47.8%
3	Tobacco use	39.9%
4	Drug abuse	39.7%
5	Being overweight	33.8%

Not Married n=479		
1	Alcohol abuse	62.4%
2	Drug abuse	46.6%
3	Tobacco use	37.2%
4	Lack of exercise	31.9%
5	Being overweight	25.3%

Table 33. Most important risky behaviors in your community by household status (up to 3 answers possible)

Co-habitating (ex. Roommates, family) n=960		
1	Alcohol abuse	57.1%
2	Lack of exercise	42.6%
3	Drug abuse	41.1%
4	Tobacco use	38.2%
5	Being overweight	32.4%

Single/live alone n=191		
1	Alcohol abuse	53.4%
2	Lack of exercise	45.0%
3	Drug abuse	41.4%
4	Tobacco use	30.4%
5	Being overweight	26.7%

Table 34. Most important risky behaviors in your community by education level (up to 3 answers possible)

Less than high school n=253		
1	Alcohol abuse	53.8%
2	Lack of exercise	43.9%
3	Drug abuse	42.7%
4	Tobacco use	37.9%
5	Being overweight	28.5%

Some college n=245		
1	Alcohol abuse	58.8%
2	Lack of exercise	42.9%
3	Drug abuse	41.6%
4	Tobacco use	36.3%
5	Being overweight	27.3%

High school diploma or GED n=471		
1	Alcohol abuse	56.5%
2	Drug abuse	41.4%
3	Tobacco use	40.3%
4	Lack of exercise	40.1%
5	Being overweight	32.7%

College degree or higher n=269		
1	Alcohol abuse	58.7%
2	Lack of exercise	44.2%
3	Drug abuse	40.5%
4	Tobacco use	35.7%
5	Being overweight	31.2%

Table 35. Most important risky behaviors in your community by annual household income (up to 3 answers possible)

Less than $10,000 n=398		
1	Tobacco use	49.2%
2	Lack of exercise	47.2%
3	Alcohol abuse	46.2%
4	Drug abuse	34.7%
5	Being overweight	31.7%

$20,000 to $29,999 n=232		
1	Alcohol abuse	65.5%
2	Drug abuse	47.4%
3	Lack of exercise	44.4%
4	Tobacco use	28.0%
5	Being overweight	27.6%

$10,000 to $20,000 n=323		
1	Alcohol abuse	57.3%
2	Drug abuse	47.4%
3	Lack of exercise	40.6%
4	Tobacco use	34.4%
5	Being overweight	27.9%

$30,000 to $49,999 n=136		
1	Alcohol abuse	69.1%
2	Drug abuse	47.1%
3	Lack of exercise	37.5%
4	Poor eating habits	31.6%
5	Being overweight	30.1%

Over $50,000 n=111		
1	Alcohol abuse	61.3%
2	Being overweight	45.9%
3	Tobacco use	37.8%
4	Lack of exercise	36.0%
5	Poor eating habits	33.3%

Table 36. Most important risky behaviors in your community by insurance status (up to 3 answers possible)

Uninsured n=334		
1	Alcohol abuse	64.4%
2	Drug abuse	56.3%
3	Tobacco use	36.5%
4	Lack of exercise	26.9%
5	Racism	24.9%

Government insurance n=515		
1	Alcohol abuse	51.7%
2	Lack of exercise	50.5%
3	Tobacco use	41.4%
4	Drug abuse	37.9%
5	Being overweight	32.6%

Private insurance n=402		
1	Alcohol abuse	66.4%
2	Drug abuse	42.5%
3	Lack of exercise	40.8%
4	Tobacco use	29.9%
5	Being overweight	28.4%

All respondents identified lack of exercise as a health problem or risky behavior most important to them personally (Tables 37-42), with three choosing it as a top response. Other top responses were alcohol use (chosen by 7 groups as the top response) and diabetes (4 groups). Dental problems were listed as the top concern for two demographic groups, and were listed as a top five concern for all groups except those with a household income above $50,000.

Table 37. Most important health problem or risky behavior for the individual, by gender (up to 3 answers possible)

Female n=629		
1t	Dental problems	28.46%
1t	Lack of exercise	28.46%
3	High blood pressure	23.4%
4	Diabetes	23.2%
5	Alcohol use	22.1%

Male n=599		
1	Alcohol use	27.9%
2	Diabetes	25.9%
3	High blood pressure	25.5%
4t	Dental problems	23.2%
4t	Lack of exercise	23.2%

Table 38. Most important health problem or risky behavior for the individual, by relationship status (up to 3 answers possible)

Married n=718		
1	High blood pressure	28.7%
2	Dental problems	27.0%
3	Lack of exercise	26.9%
4	Diabetes	26.7%
5	Alcohol use	22.7%

Not Married n=479		
1	Alcohol use	29.2%
2	Lack of exercise	25.1%
3	Dental problems	23.0%
4	Diabetes	20.5%
5	High blood pressure	17.3%

Table 39. Most important health problem or risky behavior for the individual, by household status (up to 3 answers possible)

Co-habitating (ex. Roommates, family) n=958		
1	Lack of exercise	27.9%
2	Dental problems	26.8%
3	High blood pressure	25.1%
4	Alcohol use	23.9%
5	Diabetes	22.1%

Single/live alone n=191		
1	Diabetes	27.2%
2	Dental problems	24.1%
3	Lack of exercise	23.6%
4t	Alcohol use	21.5%
4t	High blood pressure	21.5%

Table 40. Most important health problem or risky behavior for the individual, by education level (up to 3 answers possible)

Less than high school n=251		
1	Diabetes	31.1%
2	Dental problems	27.1%
3	High blood pressure	25.5%
4	Lack of exercise	20.3%
5	Mental health problems	19.5%

High school diploma or GED n=472		
1	Dental problems	30.1%
2	Lack of exercise	28.6%
3	Alcohol use	26.1%
4	High blood pressure	25.8%
5	Diabetes	23.7%

Some college n=245		
1	Alcohol use	25.3%
2	High blood pressure	24.5%
3	Diabetes	23.7%
4	Dental problems	22.4%
5	Lack of exercise	20.4%

College degree or higher n=268		
1	Lack of exercise	32.1%
2	Alcohol use	29.1%
3	Dental problems	20.9%
4	Diabetes	20.1%
5	High blood pressure	19.4%

Table 41. Most important health problem or risky behavior for the individual, by annual household income (up to 3 answers possible)

Less than $10,000 n=398		
1	High blood pressure	30.4%
2	Diabetes	30.2%
3	Dental problems	27.6%
4	Lack of exercise	25.1%
5	Mental health problems	24.9%

$10,000 to $20,000 n=322		
1	Diabetes	27.3%
2t	Alcohol use	25.8%
2t	Dental problems	25.8%
4	High blood pressure	24.5%
5	Lack of exercise	23.9%

$20,000 to $29,999 n=232		
1	Alcohol use	31.5%
2	Dental problems	30.2%
3	Lack of exercise	21.6%
4	Diabetes	20.7%
5	Being overweight	19.4%

$30,000 to $49,999 n=136		
1	Alcohol use	36.8%
2	Lack of exercise	30.1%
3t	Aging problems	25.0%
3t	Dental problems	25.0%
5t	Being overweight	19.9%
5t	Poor eating habits	19.9%

Over $50,000 n=110		
1	Lack of exercise	40.9%
2t	Aging problems	26.4%
2t	Alcohol use	26.4%
4	Poor eating habits	25.5%
5	Being overweight	23.6%

Table 42. Most important health problem or risky behavior for the individual, by insurance status (up to 3 answers possible)

Uninsured n=332		
1	Alcohol use	28.6%
2	Dental problems	25.0%
3	Diabetes	21.7%
4t	Lack of exercise	20.8%
4t	Mental health problems	20.8%

Government insurance n=515		
1	Diabetes	31.1%
2	Dental problems	29.5%
3	High blood pressure	29.1%
4	Mental health problems	24.9%
5	Lack of exercise	24.1%

Private insurance n=402		
1	Alcohol use	34.1%
2	Lack of exercise	29.4%
3	Dental problems	21.1%
4	Being overweight	20.6%
5	Aging problems	20.4%