

# ***Sharing Local Mortality Data with the Central Appalachian Health Improvement Partnership (CAHIP)***

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## ***RURAL APPALACHIAN CANCER DEMONSTRATION PROGRAM***

### **ABSTRACT**

The goal of the Rural Appalachian Cancer Demonstration Program (RACDP) has been to identify, describe, explore, and document regional cancer disparities. Grant research has included significant data aggregation and analysis efforts to understand health status of the central Appalachian region. Our grant objectives include the dissemination of our data to interested local and regional groups, as part of our health disparities education activities. The Central Appalachian Health Improvement Partnership is one of seven federally assisted projects to test development of regional health information organizations (RHIO) through DHHS Office of Health Information Technology. It is a two-state regional initiative (East Tennessee and Southwest Virginia) now in its strategic planning stages, looking to use patient care data exchange among health providers and development of physician decision systems to improve regional health status.

CAHIP has two near term objectives that parallel nicely with RACDP goals. The group wishes to benchmark current health status of the region, and communicate the need for exchanging patient healthcare data as part of an initiative to improve regional health outcomes. RACDP has played an active role in the strategic planning process of CAHIP. One of our contributions has been to share the data we have on local health status. The following sections excerpt key mortality trend data and subgroup mortality data from our presentation, and then outline researcher and community responses to the data. In all figures, "our region" indicates data specifically for the 17 county region in northeast Tennessee and southwest Virginia that is the catchments area for CAHIP.

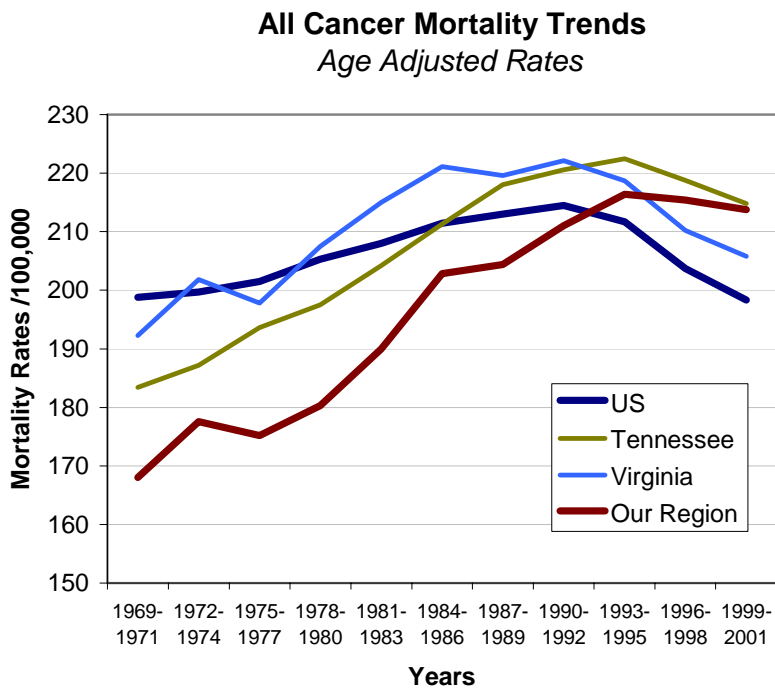
- One note is important. CAHIP is interested in a broader range of health indicators than just cancer. In fulfilling our obligation to identify and describe cancer disparities in the Central Appalachian region, it was also found that similar patterns exist for heart disease and diabetes. The graphs included in this report thus indicate that some of the issues uncovered about cancer may also be applicable to other chronic diseases that influence the higher than expected mortality rates present in the region.

**This material is a copy of a program report to the Centers for Disease Control and Prevention intended for the purposes of dissemination of results. This report has not been peer reviewed for the purposes of publication. This Program was supported in whole by grant # H57-CCH420134.**

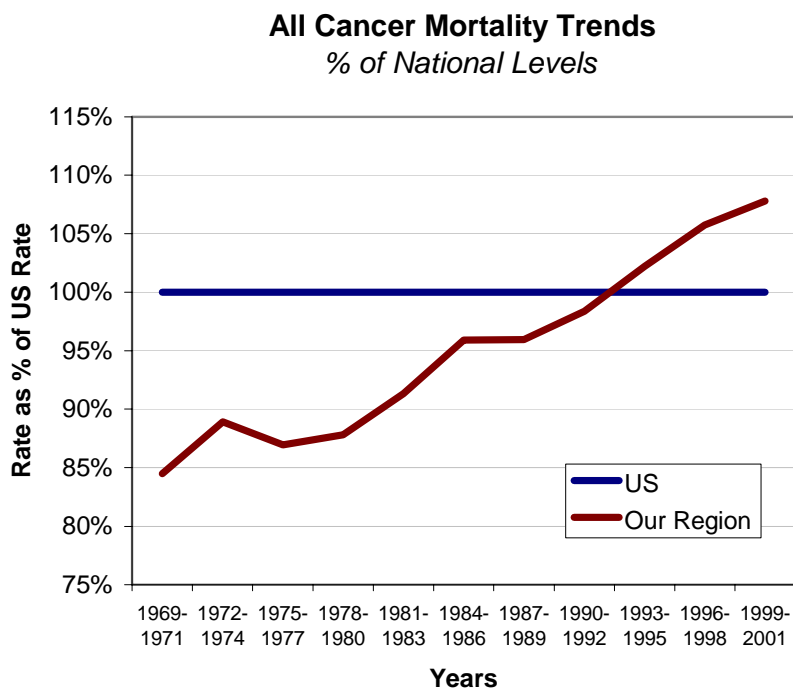
## MORTALITY TRENDS

### Data

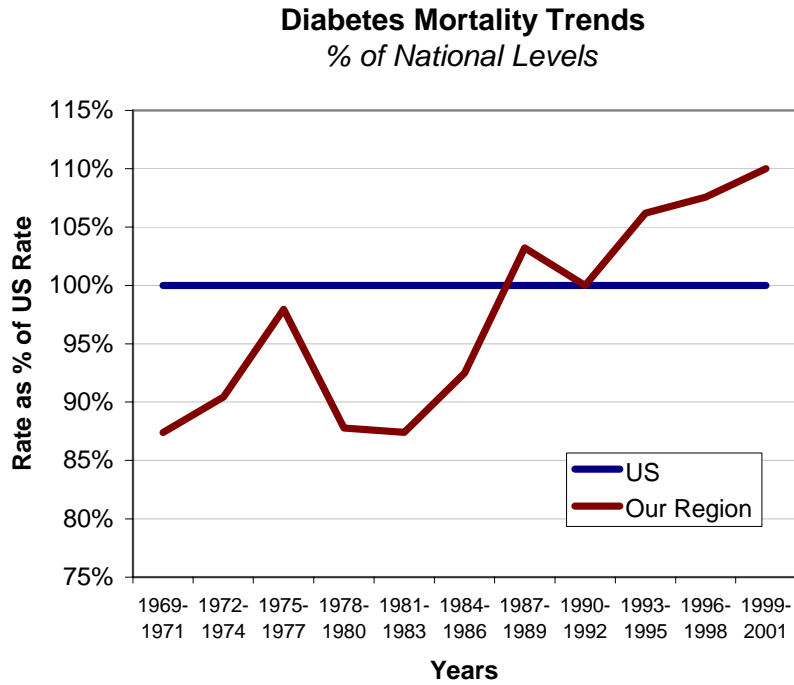
**Figure 1. 32 year trends in cancer mortality, comparing local region to state and national rates.**



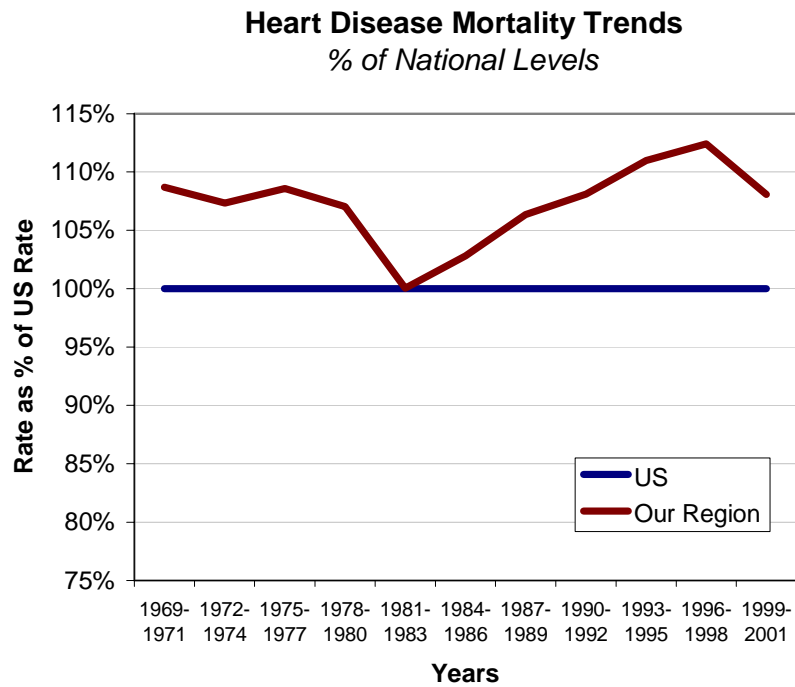
**Figure 2. Trend in local cancer mortality relative to national rates.**



**Figure 3. Same comparison of local mortality rates relative to national, for diabetes.**



**Figure 4. Same comparison of local mortality rates relative to national, for heart disease.**



**INTERPRETATION**

RACDP researchers looked at the above figures and noted that national mortality trends for various diseases look very different (some trending up, some down), and that this region compares poorly to national mortality trends for many major diseases

When CAHIP participants and other community members viewed this data, they clearly saw that the health status of the region is poor compared to the nation, and that the pattern is bad across many diseases. While this was not particularly surprising to our audiences, they were surprised that the trend is worsening. General public perception locally is that things were worse in the past, and that we now have more economic and medical resources in the region, so that should be helping our health status. The data was seen as providing strong support for the need to act soon to address our regional health outcomes.

### SUBGROUP MORTALITY

#### Data

**Figure 5. Local mortality rates for heart disease, cancer, and diabetes by age, compared to national rates.**

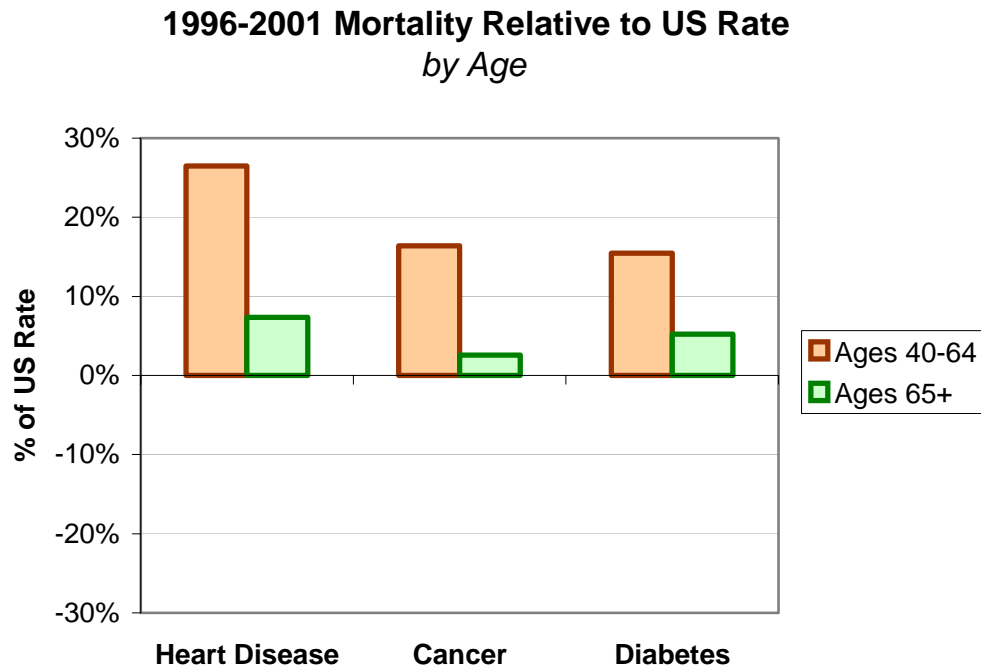


Figure 6. Local mortality rates compared to national rates, split by gender.

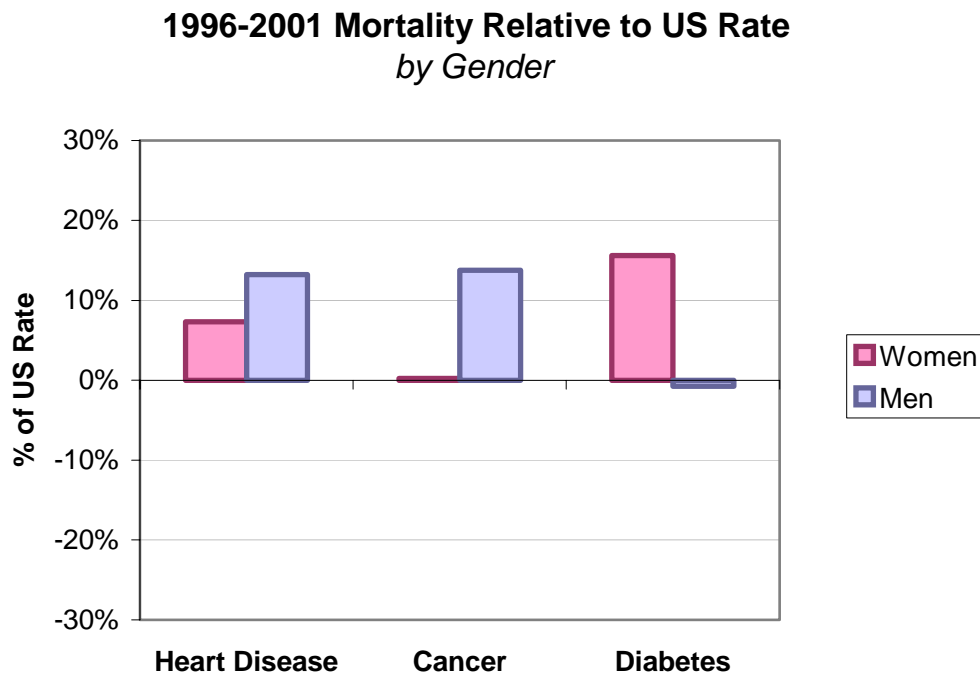
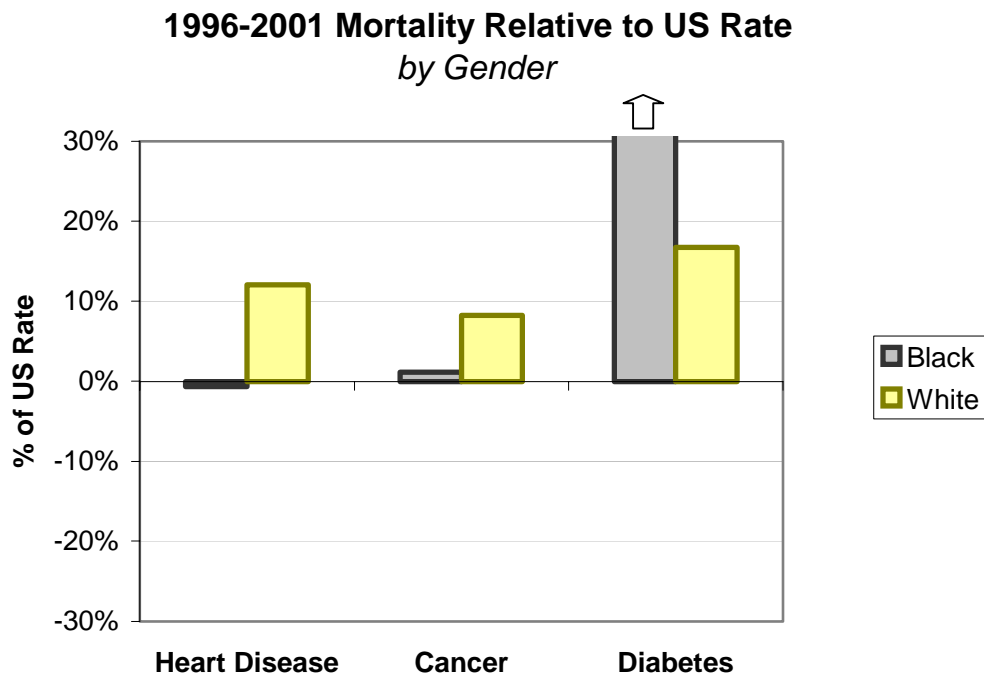


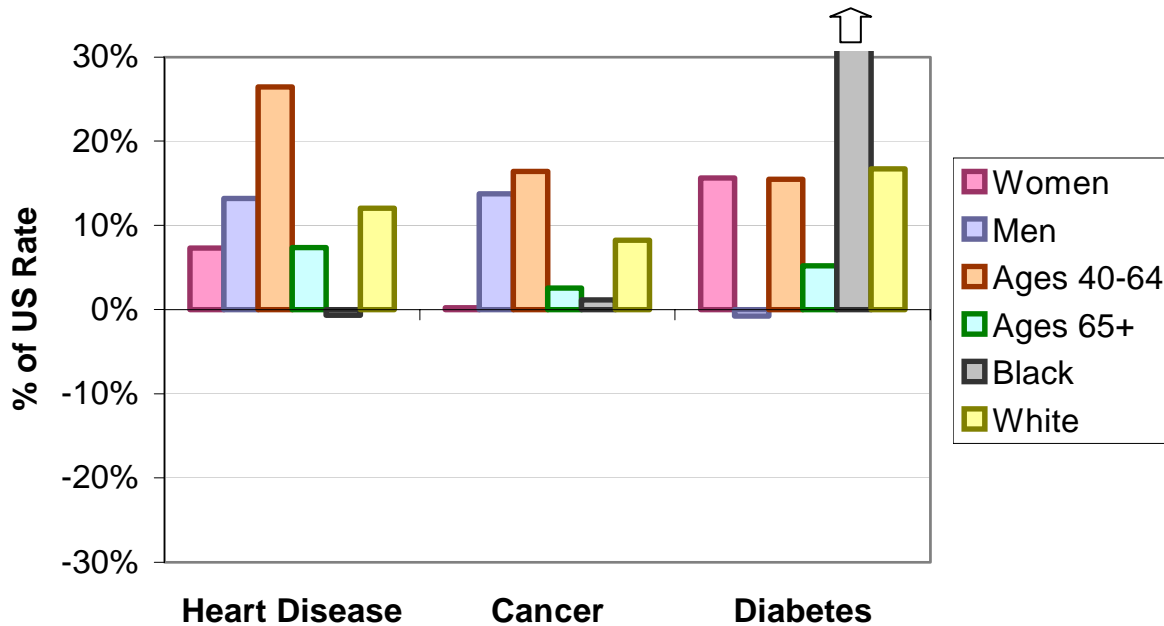
Figure 7. Same comparison as above, split by race (data is unreliable).



\*\* Nationally, African-Americans are a significant health disparity population.

Figure 8. All three analyses from above collected in to one figure.

**1996-2001 Mortality Relative to US Rate  
by Subgroups**



*\*\* Nationally, African-Americans are a significant health disparity population.*

**INTERPRETATION**

RACDP researchers looked at the above figures and noted that risk of excess mortality (compared to national levels) varies substantially for subgroups, and by disease. In addition, ages 40-64 are a clear disparity population for many major diseases in this region. When CAHIP participants and other community members viewed this data, they were surprised that at the variability – that women have excessive mortality for diabetes, but not for cancer, and it is the opposite for men. Most people tended to focus primarily on the data for their own gender, age, or race. Our audiences were also very surprised that it is the younger generations at highest risk, since that is the generation that should be benefiting from regional progress. However, it did not take people long to start identifying reasons why they believe this age group has poorer mortality outcomes, starting with lifestyle behaviors.

**RECOMMENDATIONS**

CAHIP and RACDP are continuing to work together to use this data, and other information on regional health status, to communicate the need for local efforts to improve our health outcomes. In particular, essential to the CAHIP mission is establishment of clear messages about the types of population-specific regional disparities that will help to support a regional vision for need for improvement that focuses both on inter-provider cooperation and engagement of people in their own health and care. During the final year of the RACDP these messages will be formulated in cooperation with CAHIP.