



# Fact Sheet

## Using Data: A Guide for Community Health Activists

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# Using Data:

## A Guide for Community Health Activists

### I. Introduction

For most people, there are few words that inspire drooping eyelids more than the word “data.” It brings to mind stacks of computer printouts, mysterious charts, and dry language (when it can be understood at all). Not many people enjoy collecting data for its own sake.

*As you begin to get experience with data, you will discover that it is not a great mystery. There are many chances to use it creatively. Most important, you will be able to add this skill to the others you use to achieve your health reform goals.*

Yet there are ways to use data to serve community goals. It can even be fun and exciting. Many discussions about the health care system and health policy revolve around data. Examples are information collected as part of medical experiments, reports on health care spending, and surveys to determine whether there are barriers to receiving care in a community. Because data can play such an important role, you need to understand how to use it and how to interpret the data presented by others if you want to influence health policy.

This booklet is a short guide to the basics. It begins with a discussion of why data is important and when to use it. Next are some pointers about how to find and put together the right data, and how to present it effectively. A list of data sources follows, and the booklet concludes with examples of some actual data.

### II. What Is It Good For?

#### MISTRUST ABOUT HOW DATA WILL BE USED

**A. Many people are uncomfortable with "data"**

You might not trust data. Benjamin Disraeli didn't. He was the British politician who said there are three kinds of lies: lies, damn lies, and statistics. Many people agree. Data can be used in ways that are very misleading. During a policy debate people will often try to show data in a way that supports their position. “Data” — tables, charts, reports — has an authority that can put those who hold it at an advantage. That is why you need to understand how to view data critically and how to use it yourself.

Another reason you may not trust data is that numbers often come from “somewhere else” and may not match your own experience. This strengthens suspicions you might already have. Suspicion and mistrust are not the only reasons some people are skeptical about data, however. Some people simply find quantitative approaches uninteresting. For them, stories and discussion within the community paint as powerful a picture of what is “real” as any survey data. These qualitative methods can also be valid sources of data.

### IT'S OK TO BE UNCOMFORTABLE WITH DATA

The truth is that most people have some discomfort with quantitative information. It can be intimidating, and seem beside the point. It may distract attention from what you believe is the important issue. You should acknowledge these opinions, view data with a critical eye, and keep it in its place. It is one tool among many. But you should also realize that it is important in debates about health policy and health care. Some of the discomfort with data comes from unfamiliarity and the sense that others will exploit their access to and knowledge about “the numbers.” You can reduce that discomfort by developing your own access and knowledge.

B. "Data" just means "pieces of information" and can come in many forms from many sources

### QUANTITATIVE AND QUALITATIVE

Use data to describe a situation in order to explain why an issue is important (or to dispute someone else's description). To be most effective, use both qualitative and quantitative data. In simplest terms, this means words and numbers. Numbers alone can describe something in abstract terms, but words can give it life. Quantitative data counts groups:

***“20 percent of the county is uninsured.”***

Qualitative data adds accounts of experiences within the group:

***“A woman with no insurance was unable to get primary care near her home for her hypertension. Left untreated, her condition worsened to the point where she needed to be hospitalized.”***

Critics often dismiss personal stories as “anecdotes” that are unimportant to a policy discussion. Yet such stories can highlight problems within a system. You can also gather qualitative information through formal methods like focus groups. Powerful uses of data combine both the qualitative and quantitative.

## YOU ALREADY KNOW MUCH OF WHAT THE DATA WILL TELL YOU

Data should not replace your own experience. The reason you are probably looking for data in the first place is for support for what you already suspect to be the situation in your community. Look at data as a supplement. Use it to validate or clarify your impressions and to fill information gaps.

This isn't rocket science — it's using available information in a sensible way to strengthen your case. The data won't always be perfect. In fact, it almost never will be. Use it as a way to start or maintain a conversation among your allies or with other important players in the health care system. Many of them, for better or worse, respond to this approach.

### C. Why data is important

#### WITHIN A COALITION

##### Planning and priority setting

Your work would be much simpler if there were only one obvious issue in a community relating to health access. Chances are this is not the case. What's more, different members of a coalition may see different issues as important. While someone may see transportation as the largest barrier to access, someone else might think that it's cultural competence. The availability of primary care physicians might be an issue, but so might the stingy provision of free care by the local hospital.

With unlimited time and resources, a coalition could attack all of these issues together. In the real world, though, you have to make choices that take into account personal feelings about an issue, the political environment, potential allies and opponents, and many other factors. Gathering a common set of information on different issues gives coalition members an additional tool to discuss priorities.

##### Strategizing

Once you've selected an issue, the data can help you plan your approach. Which hospitals provide the most free care, and which the least? How many Spanish-speaking physicians, relative to the Spanish-speaking population, admit patients to area hospitals? Information like this can help lead you toward an effective strategy to reach your goals.

## OUTSIDE THE COALITION

Reports, newsletters, or press releases that use quantitative and qualitative data can also be very helpful with audiences outside your coalition. If you are going to use your data this way, it's still a good idea to go over it with your own group first. If these people see and understand the data, they should gain confidence about the position the group is taking and can help you send your message.

A case made with data can be very effective with certain audiences. Reporters, for example, like to write stories with a “human face,” but often welcome the addition of a sound bite or graphic to illustrate a larger trend. The charts in publications like *USA Today* and *Time*, and probably also in your local newspaper, show the value the media place on data in reporting a story.

Foundations are also impressed by data. Using data as part of a funding proposal can help make an objective case for a project. Using both quantitative and qualitative data to describe an issue for which you are requesting funding can improve your chances of getting a grant.

Data can also boost your power and credibility with other players in the community. Hospitals and insurers, for example, have volumes of data at hand, and are likely to counter your description of a situation or demand for action with a request to “see the numbers.” The ability to produce them will put you on equal footing by providing an alternative “reality” to the one they will describe with their own data.

## D. Pulling it together

### ASK THE QUESTIONS

This is the first step, often overlooked, in any data analysis. Define the question you are trying to answer, or the problem you are trying to solve. This will help you to focus your analysis and help those whom you are asking for data to give you what you need.

Start with a question, such as, “What are the health access concerns in our community, and where are they most severe?” This challenges you to define what you mean by access (insurance? income? proximity of physicians? all of these?) and points you toward the data you will need to answer the question.

## START ANSWERING WITH WHAT YOU KNOW

Try to answer as many of the questions as you can from your own experience and information at hand. Chances are you already have a good idea of what the major concerns are. List what you know or can easily learn through conversations in the community, newspaper articles, and so on. Then you can use the data you gather to fill in the gaps and to support your impressions with numerical precision. This will be important in making your points to policy-makers and the media.

## ACCESS PUBLIC INFORMATION IN YOUR COUNTY AND STATE

When you know what questions you want to answer and have some idea of what data you need to support your answers, it's time to start gathering the data. The first place to look is probably in public agencies, either local or state. Some federal agencies also collect certain data by state (see Section III). These are the organizations most likely to have what you are looking for. Most of what they do have is, by definition, public information.

Data can come in several different forms. Raw data is just that: an unprocessed collection of data points, such as birth certificates or hospital discharges. You most likely will need some computer skills to do any analysis. Most agencies tabulate the data they collect and publish reports. If none of the published data answers your questions, some agencies have the capacity to do special analyses on request (they may charge you for this). This may be a regular service the agency provides, or it may just be a matter of finding the right person. Finally, many public agencies now use the Internet to distribute publications, or even to make raw data available.

You will soon discover that much of the data, if it is available at all, is not very precise, particularly at the community level. You might find some comfort in the knowledge that this is true for anyone who tries to describe a local situation using data. The important thing is that you use what is available to paint the clearest picture you can and avoid getting into arguments over “dueling data.” Controversies over data are often manufactured to distract discussion from the real issue at hand — the problem that the data describes.

## Agencies and issues in general

<i>Public health</i>	<p>“Public health” means the health of the population. Every state has a public health agency that tracks (and collects data on) population trends in births, deaths, and certain diseases. These agencies also monitor environmental health issues and health care providers and undertake other activities. Some states have active county health departments that deal with these issues at a local level. Health departments might also run public hospitals and clinics from which data might be available.</p>
<i>Employment, income, and other economic information</i>	<p>States are very interested in employment and income statistics, for purposes of attracting and retaining businesses, tax collection, and planning. In order to compile these statistics, state agencies must gather data on jobs, people looking for jobs, earnings, and more, either from their own records or from federal sources. Much of this data might be available at the county level.</p>
<i>Health system</i>	<p>As part of its public health function, states have regulatory authority over certain health care providers. States regulate the finances of insurance carriers. They also directly purchase health care or health care coverage as an employer and as administrator of the state Medicaid program. Many states go beyond these functions and actively undertake health policy development, working with providers, purchasers, and consumers. All of these activities generate data, in areas such as:</p> <ul style="list-style-type: none"><li>▪ Facilities licensure</li><li>▪ Professional licensure</li><li>▪ Medicaid enrollment and expenditures</li><li>▪ Hospital and other service use</li><li>▪ Insurance plan enrollment</li><li>▪ Special surveys (for example, on health insurance, access to care, health expenditures)</li></ul>
<i>State universities</i>	<p>State universities often act as data and research arms of state government. They may undertake special research projects or hold the state's census data, for example. University research centers can be a rich source of state and county data.</p>

## Reports in libraries and on the Internet

Many of the reports you need may already be on the shelves at your local public library, or at a university library. A good reference librarian can be an invaluable resource.

Another increasingly valuable resource is the Internet. The tools for searching the “net” have improved so much that finding information on the World Wide Web is often as easy as using the Yellow Pages. Most states, and more and more counties, municipalities, and nonprofit organizations have Web sites, so the Internet is worth exploring. You will find not just quantitative data but also other information such as hearing notices and political news. Many elected representatives can be reached by electronic mail (E-mail).

### Dive right in

Don't be afraid to call government agencies. There are many public employees who are happy to help you find what you need (that's why they became public employees in the first place!). It may take a couple of tries, but you should be able to find someone to help. When you find someone who knows the data in question very well, he or she will also be able to help you refine your question and will know exactly what is available to answer it.

### "Public" information is just that

Remember that government information belongs to the public. If it exists, you are probably entitled to see it. The exception is data that might compromise an individual's privacy, such as information about enrollment in a public program or about a specific hospital stay.

## OTHER SOURCES

### *Federal government*

Federal agencies probably have more data than anyone else, and some of it is at the state or local level. Refer to Section III for some sources. One very good use of data from federal sources is as “benchmarks,” standards for comparison with your local situation. There is further discussion of this below.

### *Trade associations*

Your state's or region's association of hospitals, health plans, health centers, or businesses may collect data from their members. They use data for reports, grant proposals, lobbying, and so on. Some of these groups may be allies in certain circumstances, and therefore willing to help.

*United Way,  
planning agencies,  
and others*

Private nonprofit and quasi-public organizations may also be useful sources of information. Think about who is active in your area on the issues and with the populations in which you are interested. These sources may be less available than public sources, but it's worth finding out what they have.

#### ASSEMBLE THE DATA INTO INFORMATION THAT ANSWERS YOUR QUESTIONS

When you have found and collected the data you need, the next step is to assemble it in the most effective way. A strong temptation is to use every last piece of data in your analysis and presentation. It may have taken some effort to get it and it might seem that if a few numbers are good, then a lot of numbers must be great. Resist this "blizzard" strategy. Hardly anyone likes to be snowed under with data, and your main points might get lost in the storm. Keep it simple. Use what you have gathered for background and possibly to further your arguments later on.

Use "benchmarks" for comparison

One type of data you should include is "benchmarks," measures to compare to those of your community. A single point of data communicates a piece of information. Pairing that with another for comparison can communicate much more. Benchmarks allow you to highlight variation — circumstances that may be significantly better or worse in your community. For example, suppose the percentage of women receiving prenatal care in their first trimester of pregnancy is 75 percent in your community. While your "gut feeling" is that this is an unacceptable rate, it also helps to know whether your local experience is better or worse than some standard. Benchmarks can tell you that the national goal for this measure is 90 percent by the year 2000, and that the current national rate is 81 percent. You can then say in an objective way that the experience of pregnant women in your community is unsatisfactory, and that this is an indicator of a possible access problem.

Ideally, a benchmark should be an accepted standard, like a .300 batting average in baseball. That is often not possible. The selection of the right benchmark is important. Consider the following example:

A large private hospital creates great public fanfare by providing \$10 million in free care to low-income, uninsured patients, the highest dollar amount in the state. This amount represents only 2 percent of the hospital's total revenue, however. The Attorney General has established a guideline for free care of 3 to 6 percent of revenues, and the average hospital in the state provides 5.5 percent.

The hospital, by using a dollar value as a benchmark, offers misleading information. With a different benchmark, a strong case can be made that the hospital is not meeting the community's expectations. Select benchmarks carefully, and carefully examine those that others have selected.

Benchmarks can be measures of actual experience in a larger (state or national) area, or a target, such as the national "Healthy People 2000" goals. A sample of some benchmarks is in the Appendix, and Section III lists some other sources.

## E. Presentation counts

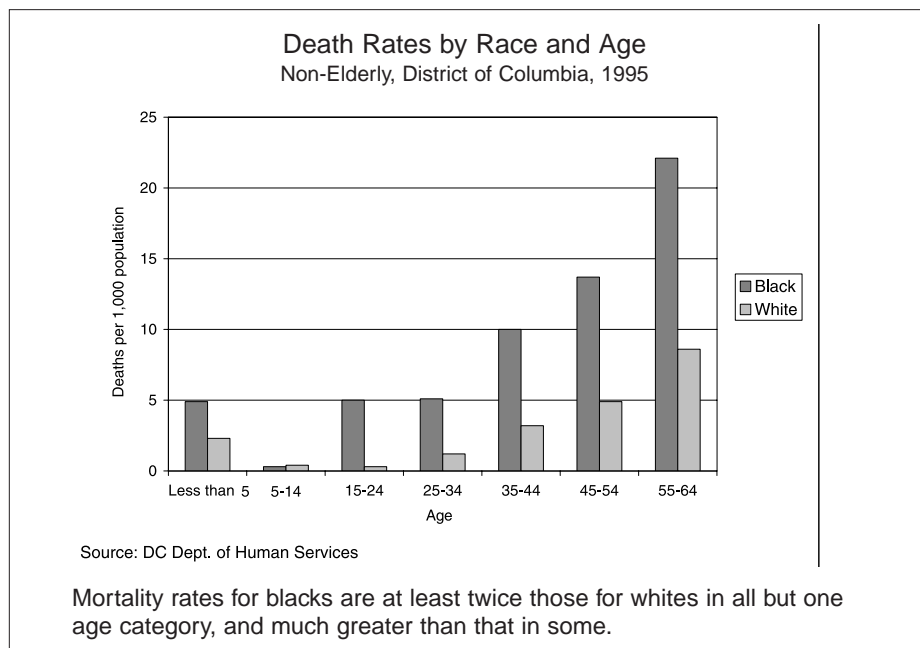
### GET YOUR MESSAGE ACROSS

A clever professor once said "A picture is worth a thousand words, and a graph is worth 1.2 pictures." This may seem overly precise, but the basic message is sound: a concise, well-conceived chart can be extremely effective in making a point. This is especially true when you are trying to communicate a few basic "takeaway points" to the media and the public. It's worth the time to think creatively about how best to do this.

### USE THE DATA TO TELL A STORY

The following examples illustrate a few ways to make your data sing, or at least speak. Be sure to include a caption with a chart, to communicate the main points you want to get across.

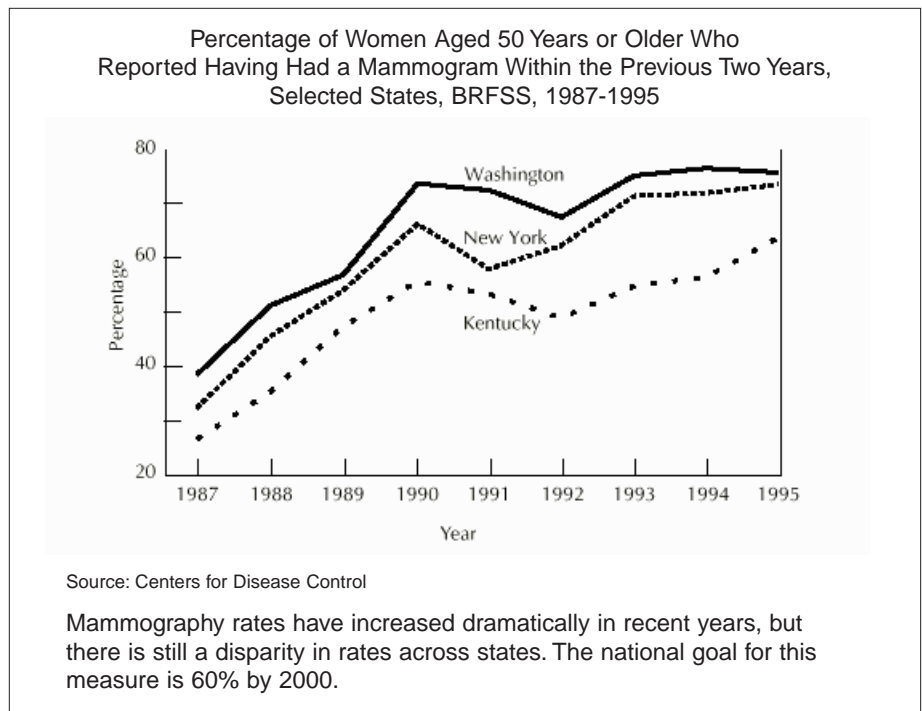
Bar chart  
Bar charts show relationships among discrete categories: for example, age groups or races.



A message like the one delivered by this chart can shock a community into activity. In addition to showing very clearly the enormous variation between death rates for blacks and whites, it can also be used as the starting point for a discussion of how to reduce that variation.

## Trend Line

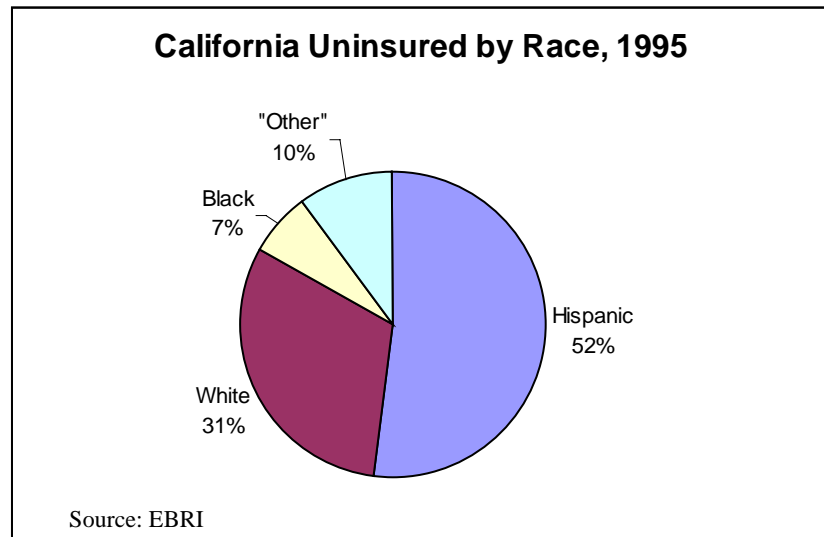
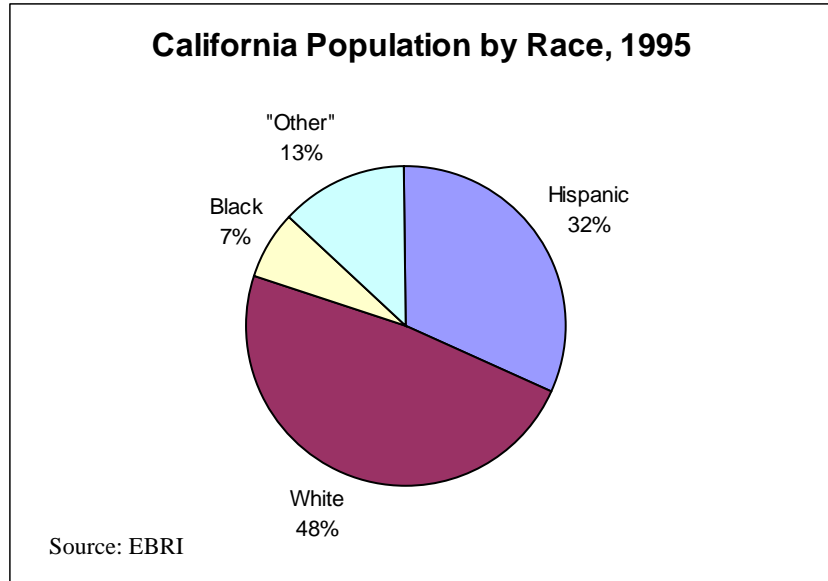
Trend lines show variation over time. More than one trend line plotted together can also compare different populations (demographic or geographic) over time.



This chart contains a great deal of information, but use care in interpreting it. For example, it is clear that rates for mammography are lower in Kentucky than in New York or Washington. It also shows that rates are steadily improving, except for a two-year decline from 1990–1992 (New York and Washington have reached something of a plateau in recent years). All three states have reached the Year 2000 objective. However, can we say that Kentucky is closing the gap between its rate and the other two states, or that the gap is widening? That depends on the starting point: the gap is narrower than in 1992, but wider than in 1987. Be cautious about over-interpreting.

## Pie charts

Use them to show and compare how populations are divided up along a single characteristic, such as race. You can compare pie charts to make insightful observations.

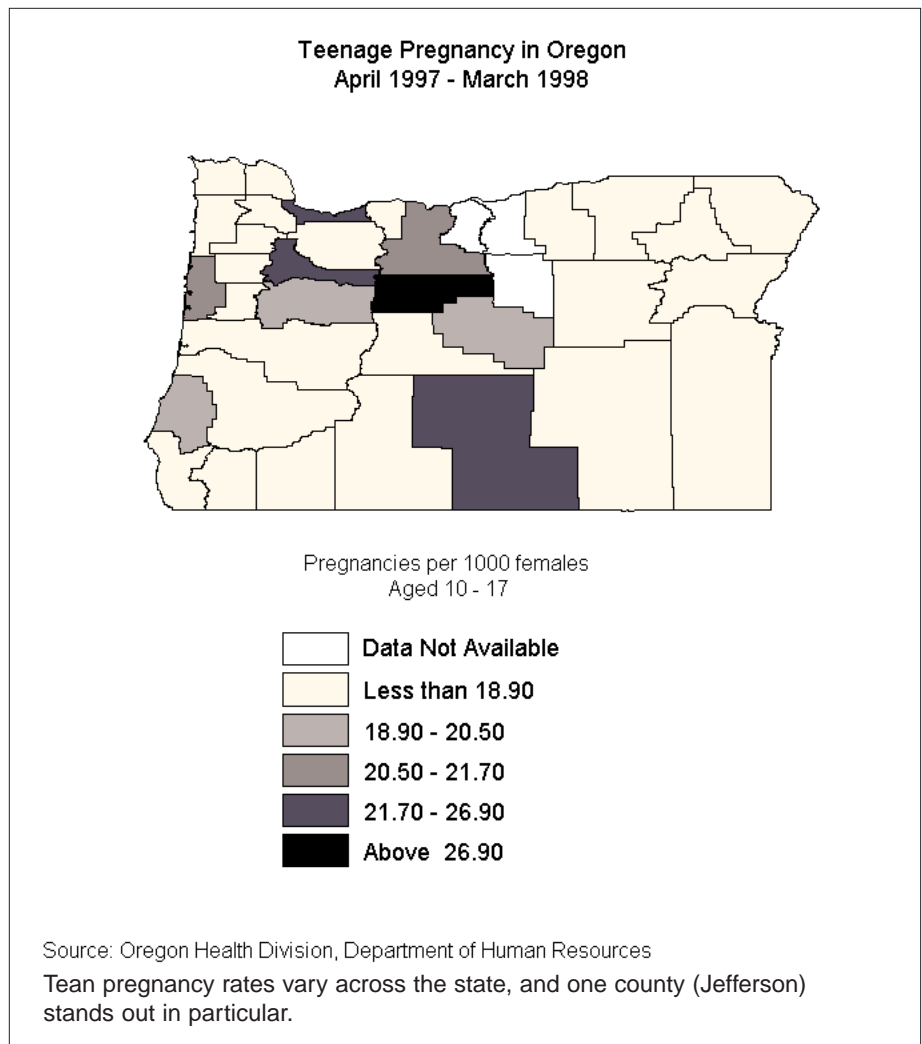


Hispanic Californians are represented among the uninsured in greater proportions than in the general population; the opposite is true of whites.

This display allows comparisons of proportions. In a completely equitable situation, each group's "piece of the pie" would be the same in both charts. The fact that Hispanics are over-represented among the uninsured might lead to other questions about that group, about things such as income, employment, places of residence, and health status. Each of these could be analyzed and compared in similar ways.

## Map

A map can show the same variation that a bar chart or table can, but with one added feature: geographical relationships. This extra information can give clues to patterns in access problems that might result from physical features, like proximity to major roads, barriers such as mountains or rivers, and so on. Maps don't have to be made on a computer; colored pencils on a service station road map work just fine.



This map shows an inflated rate of teen pregnancies in several counties in central Oregon. Comparisons and discussions among those counties, as well as between them and the counties with lower rates, could lead to ideas about how to reduce those rates.

## F. Need help or more ideas?

This booklet provides a very basic introduction to how to find and use data you need to support an initiative in your community. The more you do it, the better at it you will become. You might even enjoy it. If you get stuck on what data to ask for, how to use it, or how to present it, try putting together a group to brainstorm about possible solutions. If you need further help, contact The Access Project. We might be able to help out, either with direct assistance or a referral to someone in your area.

Have fun and good luck!

### III. Data Sources

The list of data sources that follows includes specific publications, organizations, and Internet locations, as well as general categories of agencies or institutions to approach. Every state is different, so it is not possible to list every public data source everywhere. Some states and localities collect data to a greater extent than others, so the task of assembling data will be easier in some places and more difficult elsewhere. The data sources hardest to find is local data, which, unfortunately, is often the data most critical to a community effort. Where local data sources are sparse, it may be possible to estimate, or to do some limited data collection, possibly in partnership with a university or local foundation.

Many of the specific publications listed below should be available at public or university libraries. Some libraries also provide public Internet access. Many federal government publications may be found at one of the 1,400 "Federal Depository Libraries." To find a depository library in your area, contact the Government Printing Office Access User Support Team at 1-888-293-6498 or 1-202-512-1530; fax 1-202-512-1262; Internet: [www.access.gpo.gov/su\\_docs/libpro.html](http://www.access.gpo.gov/su_docs/libpro.html). Most of the government and foundation publications are free or have a nominal charge. Publications from other private organizations (American Hospital Association, Urban Institute, EBRI) are more costly to own.

#### General

Internet:  
[www.kff.org/state\\_health](http://www.kff.org/state_health)

Internet:  
[www.hrsa.dhhs.gov/Newsroom/pubs.htm](http://www.hrsa.dhhs.gov/Newsroom/pubs.htm)

- The *Kaiser Family Foundation's site* on the World Wide Web includes a "clickable" map that provides basic information on demographics, health needs, insurance coverage, and the Medicaid program, as well as links to other online resources. You can also order a copy of *State Facts: Health Needs and Medicaid Financing* from the Foundation's publications request line at 1-800-656-4533 (ask for document #2041).
- Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, *State Profiles: October 1996 (#PC379)*. Data by state on demographics, health status, need for primary care services, and the distribution of Bureau resources.
- National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182; (800) 400-BPHC or (703) 902-1248; fax (703) 821-2098.
- American Hospital Association, *The Health Care Data Source Book: Finding the Right Information and Making the Most of It* (2d ed.) by John D. Fry, Diana B. McKinnie, and Robert W. Young. A directory of state data sources, studies and reports, and electronic resources published in 1995.

## Demographics/ Economics

Internet:  
[www.census.gov/statab/www/](http://www.census.gov/statab/www/)

Internet:  
[www.census.gov/sdc/www/](http://www.census.gov/sdc/www/)

Internet:  
[www.census.gov/prod/www/  
titles.html/income](http://www.census.gov/prod/www/titles.html/income)

## Health

Internet:  
[www.astho.org/](http://www.astho.org/)

Internet:  
[www.cdc.gov/nccdphp/brfss/  
coordina.htm](http://www.cdc.gov/nccdphp/brfss/coordina.htm)

Internet:  
[www.cdc.gov/nccdphp/brfss/  
96prvrpt.pdf](http://www.cdc.gov/nccdphp/brfss/96prvrpt.pdf)

- *Statistical Abstract of the United States*, U.S. Bureau of the Census. Contains information on population by state, broken down by age, race (also available by city greater than 100,000 population), metropolitan/non-metropolitan, urban/rural. Includes income by state: poverty rates, median income, and per capita income. Other various national statistics. An appendix lists sources for state statistical abstracts.
- Every state has at least one location that is a repository of decennial census and other data from the U.S. Bureau of the Census. For a list of Census State Data Centers, contact the Customer Liaison Office, U.S. Census Bureau, Room 3612-3, Washington, DC 20233. Phone (301) 457-1305; fax (301) 457-4784.
- U.S. Bureau of the Census, Series P60 reports. Published annually, around September. The latest are:
  - P60-197: "Money Income in the United States: 1996"
  - P60-198: "Poverty in the United States: 1996"
  - P60-199: "Health Insurance Coverage: 1996"
- Your state's Department of Commerce, Economic Development, Employment, or Revenue should have data on employment and unemployment, types of employers, income, poverty, and other economic topics.
- Your state's Department of Health (possibly called Health and Human Services, Public Health and Environment, Human Resources, and so on) will have information derived from birth and death certificates, other population-based health information, and possibly data on facilities like hospitals and nursing homes. The department may have a division of health statistics, policy and planning, or public affairs where you can access the data. Most state health departments now have sites on the Internet, many of which include data or at least phone numbers. For a link to all of them, go to the Association of State and Territorial Health Officers' Web site.
- Every state also participates in the Behavioral Risk Factor Surveillance System (BRFSS), coordinated by the federal Centers for Disease Control and Prevention. This monthly survey asks a sample of adults questions related to issues such as health status, access to care, tobacco and alcohol use, dietary patterns, injury control, women's health, use of preventive services, and HIV/AIDS. States may also add their own questions in areas of special interest. For more information on the BRFSS, contact your state's coordinator. A directory of coordinators is on the Internet, or ask at your state Department of Health. Reports such as the 1996 Summary Prevalence Report, containing state level data from the BRFSS, is available on the Internet or from the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K-40, 4770 Buford Highway NE, Atlanta, GA 30341-3717; phone (770) 488-5131.

Internet:  
<http://www.cdc.gov/nchswww/data/hus98.pdf>

Internet:  
[www.cdc.gov/nchswww/products/pubs/pubd/hp2k/review/review.htm](http://www.cdc.gov/nchswww/products/pubs/pubd/hp2k/review/review.htm)

Internet:  
[www.aecf.org/kc1998/toc.htm](http://www.aecf.org/kc1998/toc.htm)

## Health System

Internet:  
[www.urban.org/pubs/stdatabk.html](http://www.urban.org/pubs/stdatabk.html)

Internet:  
[www.ebri.org](http://www.ebri.org)

Internet:  
[www.hcfa.gov/stats/stats.htm](http://www.hcfa.gov/stats/stats.htm)

- National Center for Health Statistics, “Health, United States 1998” Comprehensive tables on the health care system and health status. State data on AIDS cases, low birthweight, death rates, expenditures, hospital capacity, infant mortality, Medicaid, Medicare, nursing homes, physicians, substance abuse, and the uninsured. Available as a book, or on the Internet. National Center for Health Statistics, 6525 Belcrest Road, Hyattsville, Maryland 20782. Phone (301) 436-8500.
- National Center for Health Statistics, “Healthy People 2000 Review 1997.” A good source for benchmarks. Publication # (PHS)98-1256 or on the Internet.
- “Kids Count” data from the Annie E. Casey Foundation. State indicators of child well-being, as well as demographic data and state contacts. The Annie E. Casey Foundation, 701 St. Paul St. Baltimore, MD 21202. Phone: (410) 547-6600; fax: (410) 547-6624.
- Urban Institute, *State-Level Databook on Health Care Access and Financing*. 3d ed. Distributed by University Press of America, 4720 Boston Way, Lanham MD 20706; phone (800) 462-6420.
- American Association of Retired Persons (AARP), *Reforming the Health Care System: State Profiles 1997*. Each four page state profile contains information on demographics, health status, utilization of services, health care coverage, managed care, resources available, expenditures and financing, and health systems change. Compiled from various sources by AARP's Public Policy Institute, 601 E Street NW, Washington, D.C. 20049. Phone (202) 434-3890.
- Employee Benefit Research Institute, EBRI Databook on Employee Benefits. Contains a large section with tables on health insurance coverage, including managed care and Medicaid, many by state. Raw data for states are also available on the internet. EBRI, 2121 K Street NW, Suite 600, Washington, D.C. 20037. Phone: (202) 659-0670.
- The Health Care Financing Administration (HCFA) has data on Medicare enrollment by state and county, Medicare managed care enrollment by state, county and plan, and Medicaid managed care enrollment by state, among many other statistics about the Medicaid and Medicare programs. Contact HCFA's Division of Health Care Information Services, (410) 786-3689, or by E-mail at [medicarestats@hcfa.gov](mailto:medicarestats@hcfa.gov) and [medicaidstats@hcfa.gov](mailto:medicaidstats@hcfa.gov).

Internet:  
[www.nahdo.org/](http://www.nahdo.org/)

- Hospital data. Many states collect detailed data on hospital use — often down to the diagnosis and ZIP code level — and finances. (Some collect data from other facilities as well.) The responsibility might lie with the Department of Health or a separate health care financing agency. The agency probably publishes reports based on this information. If you cannot locate the agency in your state that collects this data, a good place to try is the National Association of Health Data Organizations, 254-B North Washington Street; Falls Church, VA 22046-4517. Phone: (703) 532-3282; FAX: (703) 532-3593 E-mail: [nahdo@pipeline.com](mailto:nahdo@pipeline.com).

Internet:  
[www.naic.org/](http://www.naic.org/)

- Your state's department of insurance will have financial data on insurers, and perhaps enrollment and other information as well. There is a list of state health insurance contacts on the Web site of the National Association of Insurance Commissioners. NAIC's phone number is (816)374-7231.

Internet:  
<http://medicaid.apwa.org/nas-mdmembership.htm>

- State Medicaid agencies maintain a Medicaid Management Information System through which they track enrollment, process claims and compile statistics. The agency may already publish some of these statistics — try looking in your state's budget — or use reports for internal purposes that may be considered public information. If you do not know the agency that runs the Medicaid program in your state, contact the National Association of State Medicaid Directors, 810 First St. NE, Suite 500, Washington, DC 20002. Phone: (202) 682-0100; Fax: (202) 289-6555.

*Thanks to David Landers of  
Community Catalyst, Inc.,  
for contributions to this  
list.*

## IV. Appendix: Sources for Comparisons ("Benchmarks")

Actual data from some of  
the sources listed above

	SOURCE AND MEASURE	UNITED STATES	HIGH STATE	LOW STATE
CURRENT POPULATION SURVEY	Percentage of population uninsured (1996)	15.6	24.4 (NM, TX)	8.1 (WI)
	White (Non-Hispanic)	11.5		
	Non-white	26.4		
	Poverty rate (1996)	13.8	25.4 (NM)	5.9 (NH)
BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY	% reporting not seeking care b/c of cost (1996)	10.9	15.5 (TX)	6.7 (WI)
	% reporting general health "fair" or "poor" (1996)	13.0	22.8 (WV)	8.3 (AK)
HEALTH, UNITED STATES, 1998	Infant mortality rate per 1,000 live births (1994–96)	7.6	16.5 (DC)	5.4 (MA)
	White	6.3	7.8 (AR)	4.1 (HI)
	Black	15.2	19.5 (DC)	9.6 (MA)
	% Low-birthweight live births (1994–96)	7.33	13.94 (DC)	6.06 (IA)
	White	6.22	8.20 (CO)	5.03 (AK)
	Black	13.13	16.25 (DC)	10.64 (MA)
	Medicaid recipients (thousands) (1996)	36,118	5107 (CA)	41 (HI)
	% of Medicaid recipients in managed care (1996)	40	100 (TN, WA)	1 (ME, NC, WY)
	% Children 19-35 months with 4:3:1:3 vaccination series (1996)	77	87 (CT)	63 (UT)

	SOURCE AND MEASURE	UNITED STATES	HIGH STATE	LOW STATE
ANNIE E. CASEY FOUNDATION, "KIDS COUNT"	Teen birth rate (births per 1,000 females age 15 – 17) (1995)	36	78 (DC)	11 (VT)
	% of children living in poverty (1995)	21	39 (DC)	10 (NH, UT)
HENRY J. KAISER FAMILY FOUNDATION	Medicaid Spending per Beneficiary – children (1995)	\$1,451	\$2,701 (MA)	\$740 (ID)
	Medicaid Spending per Beneficiary – adults (1995)	\$2,080	\$3,280 (MD)	\$1,162 (MO)
AMERICAN ASSOCIATION OF RETIRED PERSONS, "REFORMING THE HEALTH CARE SYSTEM: STATE PROFILES 1997"	Hospital emergency unit visits per 1,000 population (1995)	380.0	781.1 (DC)	231.1 (HI)
	Hospital beds per 100,000 population (1995)	505.6	1130.5 (DC)	251.0 (WA)
HEALTHY PEOPLE 2000 GOALS TARGET 2000	HIV infection per 100,000 population (target 2000 = 400)	400		
	Cigarette smoking prevalence (%)	15		
	% of people with, asthma with activity limitation			
	Overall	10		
	Black	19		
	Prevalence of diabetes per 1,000 population (25; Amer Ind./Alask Natives 62; Blacks 32)			
	Overall	25		
	American Indian/ Alaska Natives	62		
	Blacks	32		
	Access to primary care (% with regular source of care)	95		

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