

# STATISTICAL NEWS

PA Department of Health ♦ Bureau of Health Statistics and Research ♦ Vol. 28 No. 6 ♦ November 2005

## Thyroid Cancer Incidence Rates Continue to Rise

*PA Incidence Higher Than U.S. and the Difference is Increasing*

Although thyroid cancer remains a somewhat rare type of cancer, a quick look at the statistics reveals an upward trend. Thyroid cancer diagnoses in both Pennsylvania and the United States have consistently increased throughout the period 1990 to 2002. However, despite increases, thyroid cancers accounted for only 2 percent of all cancer diagnoses among Pennsylvania residents in 2002.

Chart 1 on page 4 shows the Pennsylvania and United States age-adjusted incidence rates for invasive thyroid cancer. Between 1990 and 2002, data collected by the Pennsylvania Cancer Registry indicates that age-adjusted incidence rates for invasive thyroid cancer increased three-fold, from 4.1 in 1990 to 12.3 per 100,000 in 2002. During that period, the number of invasive thyroid cancers in Pennsylvania increased from 498 to 1,591. By comparison, thyroid cancer rates for the United States increased from 5.5 in 1990 to 9.0 in 2002, as reported by the National Cancer Institute's SEER (Surveillance Epidemiology and End Results) Program.

Age-adjusted incidence rates for thyroid cancer were

**...age-adjusted incidence rates for invasive thyroid cancer increased three-fold, from 4.1 in 1990 to 12.3...in 2002.**

lower in Pennsylvania compared to the United States from 1990 through 1996. However, since 1997, Pennsylvania rates have been higher than corresponding U.S. rates, and the rates for Pennsylvania are rising much faster than the national figures.

It is recognized that women are more susceptible to thyroid cancer than men. In fact, nearly 77 percent of all thyroid cancers diagnosed during the three-year period of 2000-2002 in Pennsylvania were among women. Chart 2 on page 4 shows that the age-adjusted rate among the female population in Pennsylvania was 16.8 per 100,000 compared to 5.5 among male residents. Similar discrepancies were observed among thyroid cancer rates for the United States.

Black men and women appear to have a lower incidence

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## Types of Outlets that Sell Cigarettes Profiled

*Convenience Stores and Gas Stations Sell Most Cigarettes*

Retail outlets that sell cigarettes over-the-counter come in many varieties in Pennsylvania. According to a study conducted in July and August of 2004, convenience stores and gas stations were the most prevalent types of cigarette outlets accessible to minors. With a statewide estimate of 41% ( $\pm 3$ ), the convenience stores/gas station category was more than twice as numerous as any other type of cigarette retail outlet. These types of outlets sold cigarettes to minors at a rate of 8% ( $\pm 3$ ). Convenience stores are outlets that sell a limited variety of food and convenience items, are usually open late and may or may not sell gasoline. An outlet is classified as a gas station if its major source of income comes from the sale of gasoline.

These results are based on the federally-mandated Synar survey. The survey protocol consisted of an underage person entering an outlet to attempt to buy cigarettes. The survey was conducted by male and female inspectors between the ages of 14 and 17.

The second most prevalent type of cigarette outlet was the

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**Restaurants were responsible for the highest percent sold to minors.**

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DEPARTMENT OF  
HEALTH

Edward G. Rendell, Governor  
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Secretary of Health

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# Quality Issues in Geocoding

## *Part 4 of a Five-Part Geocoding Series Appearing in Statistical News*

There is a saying that goes “garbage in, garbage out.” In a statistician’s world, that saying might refer to the fact that calculations, or decisions based on calculations, are only as good as the data that goes into them. Geocodes, which in this case refers to latitude and longitude coordinates, have some unique quality issues that arise during the geocoding process. Understanding the address locator settings can help to ensure that the geocoded data are high quality and that the geocodes are appropriate for the scope of the project.

Before someone geocodes any data, they need to think about the scope of the project that will be performed with the geocoded data. As an example, the military may need to know the location of a target within a few feet, so that, if they drop a bomb or shoot a missile at the location, the correct target is destroyed. The Department of Health, many times, works with data aggregated to some geographic level like county, census tract or minor civil division. In this case, the actual location of a geocoded point could be off by a few feet or a mile. It really doesn’t matter as long as the assigned county, census tract, or minor civil division codes are correct.

The military example has a very small scope, a single target, and the accuracy of that point is extremely important. They would probably use geographic positioning systems (GPS) to acquire their geocodes for latitude and longitude coordinates. The scope of the second example is much larger and the geocoded points do not need to be as accurate, which is why the Depart-

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**Address locators, used in address interpolation methods during geocoding, have a number of settings that can actually improve the quality of the geocodes.**

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ment of Health can mostly use address interpolation in the geocoding process to estimate locations.

Address locators, used in address interpolation methods during geocoding, have a number of settings that can actually improve the quality of the geocodes. Six of the most important settings are:

- Spelling Sensitivity
- Minimum Candidate Score
- Minimum Match Score
- Side Offset
- End Offset
- Match if Candidate Tied.

### **Spelling Sensitivity:**

The spelling sensitivity setting controls how much variation the address locator will allow when it searches for likely candidates in the reference data. A low setting would allow “Mane”, “Man”, or “Maine” to be considered a candidate for an address containing “Main”. The spelling sensitivity can have a value of 0 to 100 in the geocoding software used by the Bureau of Health Statistics and Research (BHSR). We currently have our settings at a minimum of 80, which allows very little discrepancy between

an address from one of our datasets and the address in the source file or street file used in geocoding.

### **Minimum Candidate Score:**

The minimum candidate score creates a list of possible candidates based on the spelling sensitivity score. It only allows candidates on the list if they are above the set value for minimum candidate score. The BHSR uses a value of 10, which allows many candidates to appear on the list. This does not mean that these candidates are considered a match when geocoding, but it does provide a longer list for the user to review in the interactive portion of the geocoding process.

### **Minimum Match Score:**

The minimum match score lets someone control how well addresses must match the reference data before it is considered a match and the record is geocoded. The default setting in the geocoding software is 60, but that setting is bumped up by the BHSR to 80. The Bureau of Health Statistics and Research has a great deal of confidence in the accuracy of the geocodes because of this high minimum match score setting.

### **Side Offset and End Offset:**

There are instances in geocoding where two streets may come together at an acute angle. If there was no end offset and a large enough side offset, the geocoded point could possibly be placed so that the spatial join process assigns the wrong geographic ID for boundaries like county, census tract, or minor civil division. Side offset set-

tings move the geocoded point off of the street centerline by a specified distance on the correct side of the street based on the even or odd address number. The end offset is used to move the point away from the node, or end point, of a given street towards the center of the line segment by some percentage of the total distance of the street.

### **Match if Candidate Tied:**

The sixth and final setting is the “match if candidates tie” setting. In some instances, there are two candidates that are returned with the same score. If the check box for “match if candidates tie” is checked, the address locator will simply take the first candidate in the list and consider it a match. The BHSR does not use the “match if candidates tie” setting. The geocoder always checks such situations in the interactive phase of geocoding and makes a decision based on all available information.

The Bureau of Health Statistics and Research uses very strict settings in their address locators, which means that the geocodes on various datasets are considered to be of high quality. Some of the terminology used in this article was covered in previous geocoding articles in this series. These articles can be viewed on the BHSR web pages at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats), then select the link button labeled “Statistical News”.

If you have any questions concerning the topics covered in this article or about geocoding or geospatial technologies, please contact the Bureau of Health Statistics and Research at 717-783-2548.

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# Health Status Indicators Reports Updated

## *Two Health Status Indicators Reports Can Be Used For Assessing And Comparing The Health Status Of The State And Local Areas*

### **County & Health District Health Status Indicators, 2005 Report:**

This report shows differences in the birth and infant death statistics among whites, blacks, Hispanics, and Asians. Blacks and Hispanics have much higher percentages of teenage births and no prenatal care in the first trimester compared to whites and Asians. Blacks also have higher percentages of low birth weight babies and much higher infant death rates than whites, Asians and Hispanics.

The health status indicators were developed by the Centers for Disease Control and Prevention in response to Objective 22.1 of *Healthy People 2000* and are cited again in Objectives 23-2 and 23-5 of *Healthy People 2010*. They are to be used for assessing and comparing the health status of state and local areas. This report contains health status indicators for the United States, Pennsylvania, counties and health districts. It includes 95% confidence intervals and the results of significance testing, which are graphically depicted by county outline maps. Thus, the report provides descriptive and analytical statistics at the county and health district level in one convenient publication for health data users.

The latest birth data in the 2005 report are for 2003. The most recent death and disease incidence rates are average annual rates covering the three-year period of 2001-2003. Three year average annual rates were used primarily because of the small annual numbers for selected dis-

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**Age-adjusted death rates for cardiovascular disease, heart disease, lung cancer, female breast cancer, stroke and suicide all declined...**

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eases and for specific causes of deaths in many counties of the state.

Data highlights for the 2005 report show that the percent of births to mothers having no prenatal care in the first trimester increased from 2002 to 2003 for Pennsylvania, while the percentage of low birth weight babies decreased. The percent of births to mothers less than 18 years of age did not change between 2002 and 2003.

Age-adjusted death rates for cardiovascular disease, heart disease, lung cancer, female breast cancer, stroke and suicide all declined from the three-year period of 2000-2002 to the three-year period of 2001-2003. The rates for homicide and motor vehicle accidents increased during the same time period. The infant death rate for Pennsylvania increased from 2000-2002 to 2001-2003, as did the incidence rate for syphilis and measles. However, AIDS and tuberculosis incidence rates both decreased during these years.

Significance or comparison testing was performed on most indicators to determine which county or Health District indicator was significantly higher or lower than the corresponding

state figure and which state indicator was significantly higher or lower than the United States figure. Confidence intervals were not calculated and testing was not conducted for disease incidence rates, work-related injury death rates and any rates dealing with race/ethnicity mainly because of the small numbers associated with these rates.

Another special feature of the health status indicator report is the Technical Notes. Within this section of the report, the user can find various statistical formulas used to compute the standard errors and confidence intervals that were used for significance or comparison testing. This section also contains a discussion about the reliability of the data as well as definitions of terms used throughout the report.

The appendix in the report lists additional statistics available at the city, borough or township level that can be used to compute local health status indicators. Much of this data can be obtained by going to our website at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats) and selecting "Vital Statistics" and then "Birth and Death Statistics, 1990-2003".

### **Maternal and Child Health Status Indicators for Pennsylvania and Major Municipalities:**

This report shows birth, death, infant death and childhood poverty statistics for 22 major municipalities and the state of Pennsylvania. These one page profiles provide those concerned with maternal and child health

with a perspective on the types of urban health problems facing Pennsylvania's major cities. All of the data are shown by race (white, black and Asian/Pacific Islander) and for those of Hispanic origin.

The report includes leading causes of death among residents ages 1 to 17, infant death rates and percentages of low birth weight babies, mothers with no prenatal care in the first trimester, teen births, and children below the poverty level.

The twenty cities and two boroughs included in the report are Allentown, Altoona, Bethlehem, Chester, Easton, Erie, Harrisburg, Hazleton, Johnstown, Lancaster, Lebanon, McKeesport, New Castle, Norristown, Philadelphia, Pittsburgh, Reading, Scranton, West Mifflin, Wilkes-Barre, Williamsport and York.

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**Both...reports can be accessed from the Health Statistics web pages at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats).**

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Both Health Status Indicators reports can be accessed from the Health Statistics web pages at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats). Select the link labeled "Vital Statistics" and then select the title for the report you wish to view. For questions about these reports, please contact the Bureau of Health Statistics and Research at 717-783-2548.

# Thyroid Cancer Incidence Rates Continue to Rise

rate for thyroid cancer than whites. In 2000-2002, the age-adjusted rate among blacks was 9.0 compared to 11.5 for whites. A similar disparity was also observed for the United States.

Like many other types of cancer, risk for thyroid cancer is greatly influenced by a person's age. In 2002, the majority of thyroid cancers were diagnosed among middle-aged (30-69) Pennsylvanians, accounting for 76.9 percent of diagnoses. Also, nearly 26 percent of thyroid cancers were diagnosed among Pennsylvania residents under the age of 40 in 2002.

The stage of a cancer is the most important factor in choosing treatment options and predicting the prognosis or chance for long-term survival. When cancers are diagnosed, the extent of disease is represented by four stages: in situ, local, regional and distant. In general, early stage diagnoses (in situ and local) are more treatable than late stage diagnoses (regional and late) when the disease has spread beyond the tissue or organ initially affected.

Chart 3 on the right shows that in Pennsylvania the majority of thyroid cancers are diag-

nosed at the local stage of the disease. During the period 2000-2002, 75.4 percent of thyroid cancers were diagnosed at the local stage, 16.9 percent were regional, 3.8 percent were distant and 3.7 percent were unknown. Because of the nature of thyroid cancers, diagnoses at the in situ stage were nearly non-existent.

According to the American Cancer Society (ACS), prevention of thyroid cancer may be difficult since the underlying causes are poorly understood. The ACS web site lists low iodine diets, radiation, hereditary conditions, gender and age as the major risk factors for thyroid cancer. (<http://www.cancer.org>)

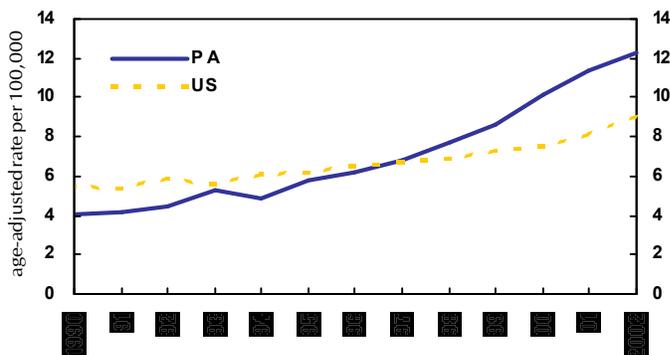
Unlike incidence rates, mortality rates for thyroid cancer have remained low in Pennsylvania for the period 1990-2002. Every year since 1990 through 2002 the age-adjusted mortality rate for thyroid cancer has been approximately 0.5 per 100,000. Low mortality rates in comparison to incidence rates indicate that the survival rate for thyroid cancer is better than other more deadly forms of cancer (e.g. lung, esophageal and liver).

For additional Pennsylvania cancer incidence and mortality statistics, visit the Health Statistics web pages at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats). Annual statistical reports and cross-tabulations can be accessed by clicking on the "Cancer Incidence and Mortality" link. Customized cancer data tables, charts, maps, county assessments/profiles can be created by clicking on the "EpiQMS" link.

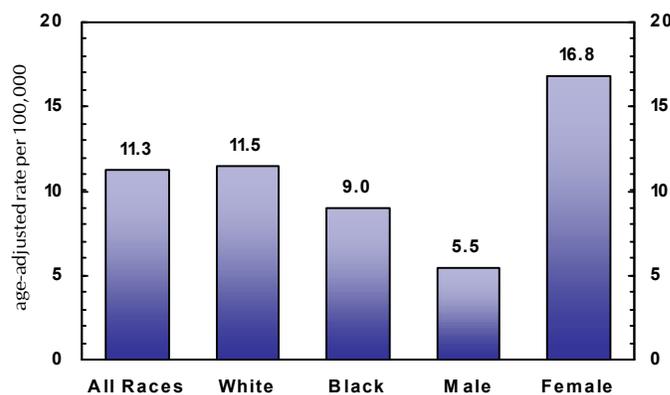
For questions about this article, please contact the Bureau at 717-783-2548.

**It is recognized that women are more susceptible to thyroid cancer than men. In fact, nearly 77% of all thyroid cancer diagnosed during the three-year period of 2000-2002 in Pennsylvania were among women.**

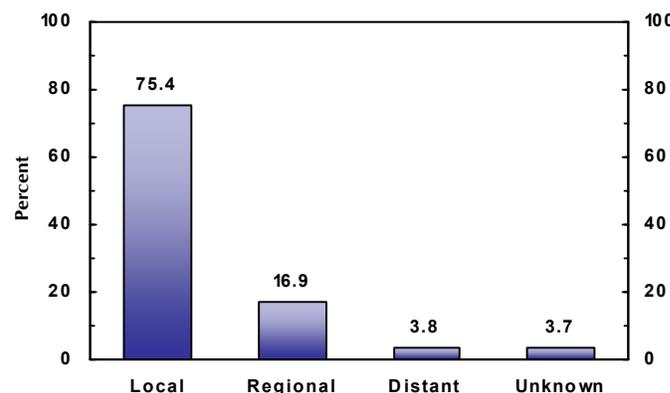
**Chart 1**  
Age-Adjusted Incidence Rates for Invasive Thyroid Cancer Pennsylvania and United States Residents, 1990-2002



**Chart 2**  
Average Annual Age-Adj Incidence Rates for Thyroid Cancer by Sex and Race, Pennsylvania Residents, 2000-2002



**Chart 3**  
Percent of Invasive Thyroid Cancer Cases by Stage Pennsylvania Residents, 2000-2002



# Profile of Outlets that Sell Cigarettes

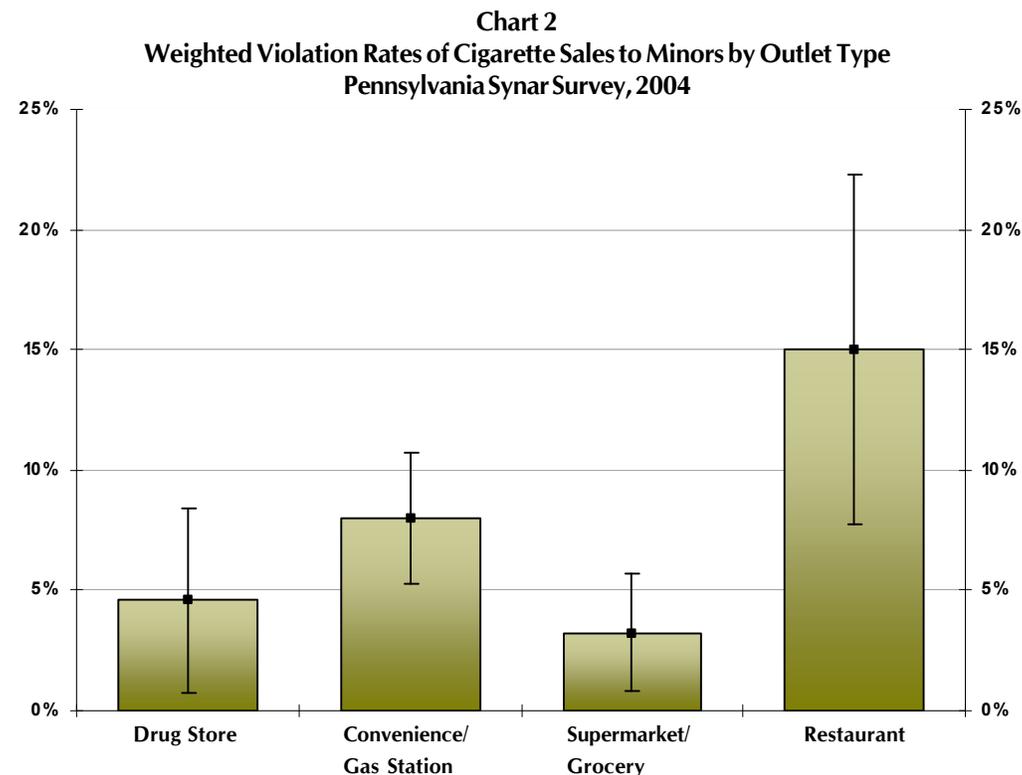
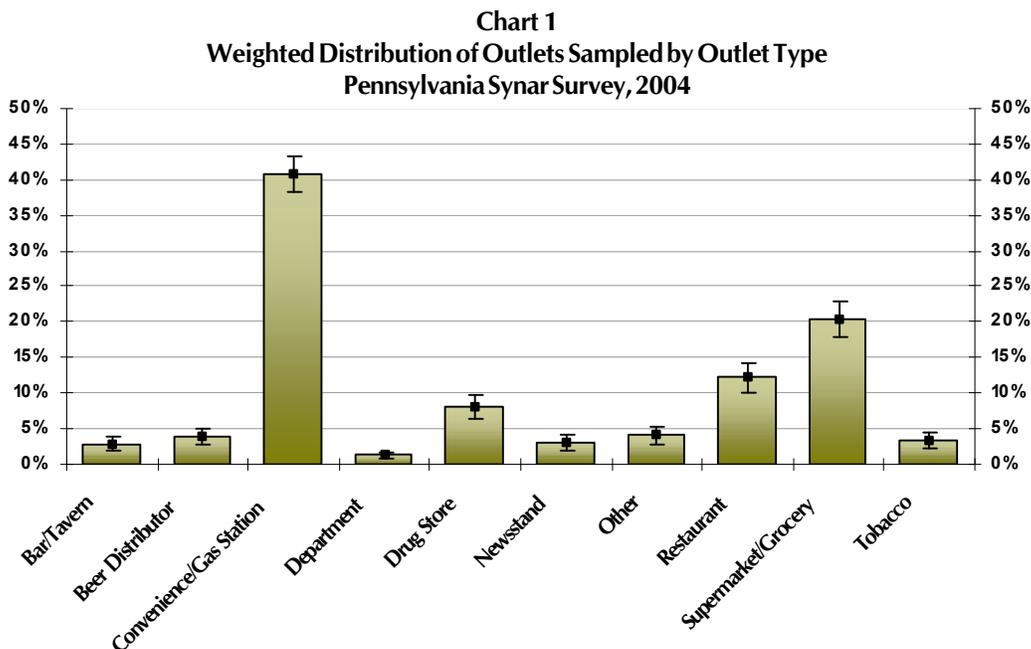
supermarket and/or grocery store. It was estimated that 20% ( $\pm 3$ ) of the accessible cigarette outlets were either a supermarket or a grocery store. These types of outlets sold cigarettes to minors at a rate of 3% ( $\pm 3$ ).

Restaurants were the third most prevalent type of cigarette outlet accounting for 12% ( $\pm 2$ ) estimated statewide cigarette sales. Restaurants sold cigarettes to minors at a rate of 15% ( $\pm 7$ ). This category includes both sit-down and takeout restaurants.

The remaining types of accessible cigarette outlets surveyed were drug stores (8%  $\pm 2$ ), beer distributors (4%  $\pm 1$ ), tobacco outlets (3%  $\pm 1$ ), bars (3%  $\pm 1$ ), news stands (3%  $\pm 1$ ), department stores (1%  $\pm 1$ ) and the undefined outlets in the other category (4%  $\pm 1$ ). The other category includes but is not limited to check cashing outlets, delicatessens, camp stores and golf shops.

The gender of the employee selling the cigarettes was also examined in the survey. It was estimated that 42% ( $\pm 2$ ) of the cigarette outlet employees were male while 58% ( $\pm 2$ ) were female. Male clerks sold cigarettes to minors 9% ( $\pm 3$ ) of the time, compared to 6% ( $\pm 2$ ) for female clerks.

Next, the age of the clerk working in the cigarette outlet was estimated. Surveyors were asked to guess the age of the clerk and place them in one of four categories: <18, 18-25, 26-40 or 40+. Most of the clerks were judged to be over the age of 26. It was estimated that 3% ( $\pm 1$ ) of the employees were <18, 26% ( $\pm 1$ ) were 18-25, 37% ( $\pm 1$ ) were 26-40 and 34% ( $\pm 1$ ) were 40 years of age or older.



Finally, the survey explored whether outlets that sell cigarettes were also serving alcohol for on-site consumption. It was estimated that 5% ( $\pm 1$ ) of the

outlets sold alcohol for on-site consumption.

Vending machines are not part of the Synar survey. According to state law, vending ma-

chines cannot be placed in any place accessible to minors.

To access national statistics on-line, go to <http://prevention.samhsa.gov/tobacco>.

# New Birth Certificate Data Highlighted – Breastfeeding

## Revised Birth Certificate Asks, "Is Infant Being Breastfed?"

This is the first of a series of articles appearing in *Statistical News* that focuses on the new data items collected via the 2003 revisions to the certificate of live birth. The revised birth certificate now contains the question, "Is infant being breastfed?"

Table 1 compares the 2003 breastfeeding status by age of the mother for the state. The table displays a direct correlation between the age of the mother and whether or not she initiated breastfeeding. Older mothers were much more likely to initiate breastfeeding, compared to younger mothers.

**Table 1**  
Number and Percent\* of Live Births by Breastfeeding Status and Age of Mother, Pennsylvania Residents, 2003

Age of Mother	Total Births	Is Infant being Breastfed?				
		Yes		No		Unknown Number
		Number	Percent	Number	Percent	
All Ages	145,485	81,863	61.2	51,982	38.8	11,640
Under 15	234	58	27.5	153	72.5	23
15-19	12,912	5,106	42.2	7,006	57.8	800
20-24	32,168	15,427	51.5	14,516	48.5	2,225
25-29	38,568	22,359	63.2	13,028	36.8	3,181
30-34	38,505	24,307	68.9	10,974	31.1	3,224
35-39	18,862	11,984	69.8	5,175	30.2	1,703
40-44	3,815	2,388	70.3	1,011	29.7	416
45 & Older	180	116	73.9	41	26.1	23
Unknown	241	118	60.2	78	39.8	45

\* Percent of total live births for each specified age group.

NOTES: Unknown ages included in total. Unknown breastfeeding status excluded in calculations.

**Less than half (44.0 percent) of the births to blacks involved mothers who breastfed their babies.**

Among all residents who gave birth in 2003, over 61 percent answered yes to the question, "Is infant being breastfed?". The percentages were much lower for mothers under the age of 25. However, mothers under the age of 25 accounted for over 31 percent of the total resident births in 2003.

Chart 1 is a bar chart that compares the 2003 breastfeeding status by the mother's race/ethnic category for the state. In 2003, Asian/Pacific Islanders had the highest percentage of births to mothers who initiated breastfeeding (75.1 percent) among the four race/ethnic groups. White mothers had the next highest percentage (63.8). Less than half

(44.0 percent) of the births to blacks involved mothers who breastfed their babies. Among Hispanics, the percentage was somewhat higher—58.5.

Beginning with the reporting of 2003 live births, the Commonwealth of Pennsylvania implemented the latest revision of the U.S. Standard Certificate

of Live Birth. Prior to 2003, the most recent revision in effect was put into practice in 1989.

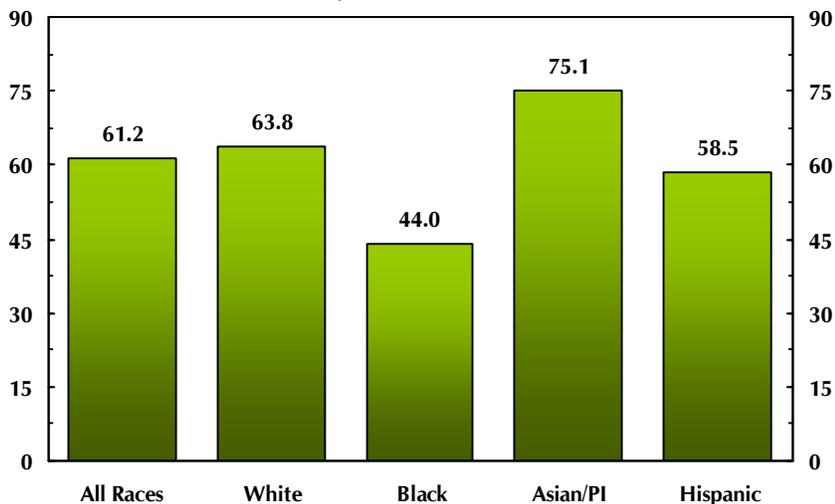
Information for the Certificate of Live Birth are typically collected within a few days of delivery. Therefore, the data on breastfeeding in this article only indicates if the mother initiated breastfeeding soon after the de-

livery. It does not provide any information on how long the infant was breastfed.

Look for additional articles that highlight new data items from the birth certificate in future issues of *Statistical News*. After more review and evalua-

***Goto Page 8 or click here...***

**Chart 1**  
Percent of Live Births To Mothers Who Breastfed by Race/Ethnicity Pennsylvania Residents, 2003



NOTES: Unknown breastfeeding status excluded in calculations. Hispanics can be of any race.

# Update: Healthy People 2010 Objectives

## Focus Area 15: Injury and Violence Prevention

### 15-13 - Reduce unintentional injury deaths.....HP2010 Target: 17.5

#### All Deaths and by Sex and Race/Hispanic Origin:

The age-adjusted death rate for unintentional injuries among all Pennsylvania residents increased between 1999 and 2003, from 34.5 to 37.5 per 100,000. Rates for males were more than twice those for females (e.g., 53.0 vs. 23.6 in 2003). The rates for males have been on the increase between 1999 and 2003, from 49.0 to 53.0. Death rates among female residents have also increased in recent years.

The 2003 age-adjusted death rate for whites (38.1) and blacks (38.8) were similar. However, with the exception of 2003, the rates for blacks have been declining, while the rates for whites have been on the increase. The 1999-2003 annual age-adjusted death rates for Hispanics showed no discernible trend.

The rates for all deaths, males, whites, blacks, and Hispanics are well above the national objective of 17.5 and the rates for whites and males seem

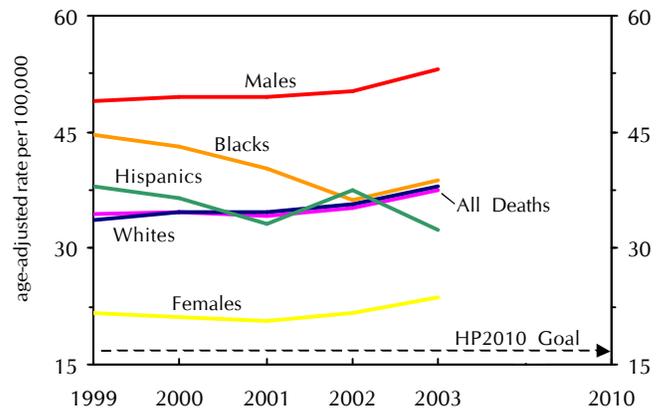
to be on the increase. Although the rates among female residents are closest to the national goal, they too have been on the increase in recent years.

#### Males by Race and Hispanic Origin:

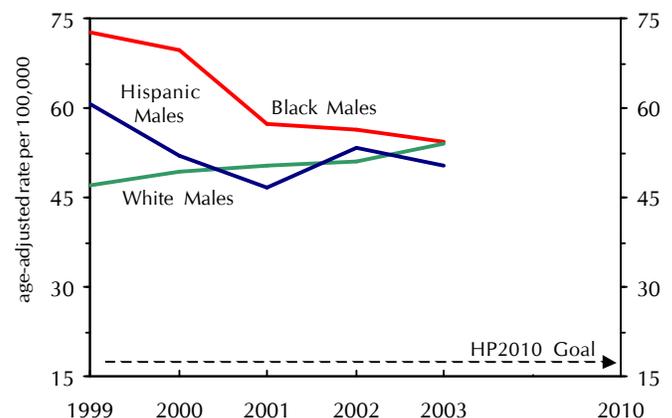
The bottom graph on the right depicts the age-adjusted unintentional injury death rates for black, Hispanic, and white males. The 2003 rate for black males was the highest at 54.5, but the rate for white males (54.1) and Hispanic males (50.3) were similar. However, the rates for black males have been declining during the 1999-2003 period while the rates for white males have been consistently on the increase. The annual rates for Hispanic males showed no obvious trend for the 1999-2003 period.

All of the age-adjusted death rates for males are far above the national Healthy People 2010 goal of 17.5 and only the annual rates for black males show a decline.

Unintentional Injury Age-Adjusted Death Rates\*  
All Deaths and by Sex, Race, and Hispanic Origin\*\*  
Pennsylvania Residents, 1999-2003



Males by Race and Hispanic Origin\*\*  
Pennsylvania Residents, 1999-2003



\*age-adjusted to 2000 standard million U.S. population  
\*\*Hispanic can be of any race

Unintentional Injury Age-Adjusted Death Rates\*  
By Sex, Race, and Hispanic Origin\*\*  
Pennsylvania Residents, 1999-2003

	2003	2002	2001	2000	1999
All Deaths .....	37.5	35.1	34.1	34.6	34.5
Males .....	53.0	50.3	49.4	49.6	49.0
Females .....	23.6	21.6	20.6	21.2	21.6
Whites .....	38.1	35.8	34.6	34.7	33.6
Blacks .....	38.8	36.2	40.2	43.2	44.7
Hispanics** .....	32.5	37.4	33.1	36.5	38.0
Black Males .....	54.5	56.4	57.3	69.6	72.6
Hispanic** Males .....	50.3	53.2	46.7	52.0	60.6
White Males .....	54.1	51.1	50.5	49.4	47.1

\*per 100,000 2000 U.S. standard million population  
\*\*Hispanic can be of any race

#### HP2010 State and County Data on the Web

To access the Department of Health's web page of Healthy People 2010 statistics for the state and counties, go to [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats). The latest available statistics as well as trend data are shown. You can view data for the state, all counties, a specific demographic element (age, sex, race, etc.) or just for a specific county. Complete data sets for the state and counties can be downloaded. There is also a link to the national HP2010 web site.

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Continued from Page 6...

## New Birth Certificate Data Highlighted – Breastfeeding

tion, the new data items will eventually be incorporated into our regular reports.

Please visit our web site at [www.health.state.pa.us/stats](http://www.health.state.pa.us/stats) to access additional birth statis-

tics. If you have any questions concerning this article, contact the Bureau of Health Statistics

and Research at 717-783-2548 or via an email link from our website ([www.health.state.pa.us/stats](http://www.health.state.pa.us/stats)).

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