Trends and Disparities in Mortality in Eastern North Carolina
Total Deaths, Premature Mortality and Deaths for Ten Leading Causes; 1979-2012

A Resource for Healthy Communities
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1. Introduction

Health Indicators Series:
A Resource for Healthy Communities
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Health Indicators is a series of reports describing community health at the state, regional, and county level. Health Indicators supplements the Eastern North Carolina Health Data Explorer published online by the Center for Health Systems Research and Development at East Carolina University. These reports are intended to provide state policy makers, local health departments, hospitals, and community-based health planning groups with a wide range of information useful for diagnosing the health of Eastern North Carolina’s population and its local communities, evaluating the effectiveness of existing services, and envisioning and planning new interventions. The reports in this periodically published series can be used in conjunction with the County Health Data Book, produced by the North Carolina State Center for Health Statistics, as part of the Community Health Assessment Process. Individual reports in ECU’s Health Indicator Series are custom made for the counties of North Carolina. Reports in this series will describe trends in mortality, including premature mortality for all causes of death, mortality (crude) and age-adjusted mortality for leading causes of death, and measures of race disparities or inequalities in mortality rate.

Report Series #2 of the series focuses attention on two of the overarching goals of Healthy People 2020, the national blueprint for health improvement. The first goal is to increase the span and quality of life and the second is to eliminate health disparities. North Carolina’s companion plan, Healthy North Carolina 2020, has also embraced these two goals. Using rate comparisons, this report describes the inequalities in mortality among Eastern North Carolina and other regions, and among four demographic groups. Premature mortality, the focus of Report Series #1, is included in the death from all causes section located at the beginning of this report. The measure used to quantify premature mortality is described in more detail in the Methods and Interpretations section.

This report describes the leading contributors to mortality, provides a geographic context, and examines trends and inequalities over a 33-year period (1979-2012), as well as the most recent 14 year period (1999 to 2012). The report begins with data highlights, provided as an introduction to the data, rather than a summary of it. Readers are encouraged to draw their own conclusions from the data and pose new questions suggested by what they see. The following section presents both the overall and five leading contributors to mortality for the state by race and gender. In this section, pie charts describe the relative contribution of each of five leading contributors to the overall, general rate. These charts also make regional and demographic comparisons. Making the area of each pie chart equivalent to the rate for the population group helps convey the dimension of disparity across population groups. The next section charts recent trends and disparities in mortality and provides projections to the year 2020. These charts place Eastern North Carolina’s health status in a historical context and provide a glimpse into the future.
The region *Eastern North Carolina* is comprised of 41 counties located in the extreme east of North Carolina and approximates the coastal plain physiographic province of the state. It includes all counties east of I-95. This region is characterized by its rurality, poverty, and some of the highest mortality rates in the nation. The name of the region is abbreviated as ENC41 or ENC. The rest of North Carolina is the remaining 59 counties; abbreviated as RNC59 or RNC.
2. Data Highlights

Trends and Disparities in Mortality in Eastern North Carolina

The following highlights of mortality in the 41 counties of Eastern North Carolina (ENC41) describe current status and trends in the causes of death from major diseases and how they vary across different population groups. The graphs, charts, and tables paint a picture of the region’s health with a broad brush. The study of mortality in populations should include consideration of time and geographic space as well as underlying demographic, political-economic, and socio-cultural conditions. Readers are encouraged to think of these factors as they consider the data presented in this report, formulate their own questions about the causes of mortality, and think about strategies to reduce mortality in the population described.

Current Disparities in Mortality by Geography, Race, and Gender

In 2012, age-adjusted mortality rate for Eastern North Carolina is 831 deaths per 100,000. This rate is 6% higher than the state rate. Within Eastern North Carolina, the non-White rate is 12% higher than the White rate. The non-White male rate is 21% higher than the rate for White males. The non-White female rate is 7% higher than the rate for White females.

The five general leading causes of mortality in Eastern North Carolina (2012) are:
1. Cancer - All Sites
2. Diseases of Heart
3. Chronic Lower Respiratory Diseases
4. Cerebrovascular Diseases
5. All Other Injuries and Unintentional Effects

The five general leading causes of mortality in Eastern North Carolina by race and gender (2012) are:

<table>
<thead>
<tr>
<th>Race and Gender</th>
<th>non-White Males</th>
<th>White Males</th>
<th>non-White Females</th>
<th>White Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Cancer - All Sites</td>
<td>Cancer - All Sites</td>
<td>Diseases of Heart</td>
<td>Cancer - All Sites</td>
</tr>
<tr>
<td>2nd</td>
<td>Diseases of Heart</td>
<td>Diseases of Heart</td>
<td>Cancer - All Sites</td>
<td>Diseases of Heart</td>
</tr>
<tr>
<td>3rd</td>
<td>Cerebrovascular Disease</td>
<td>Chronic Lower Respiratory Diseases</td>
<td>Cerebrovascular Disease</td>
<td>Chronic Lower Respiratory Diseases</td>
</tr>
<tr>
<td>4th</td>
<td>Diabetes Mellitus, All Other Unintentional Injuries and Adverse Effects</td>
<td>Diabetes Mellitus</td>
<td>Cerebrovascular Disease</td>
<td></td>
</tr>
<tr>
<td>5th</td>
<td>Chronic Lower Respiratory Diseases</td>
<td>Cerebrovascular Disease</td>
<td>Nephritis, Nephrotic Syndrome, and Nephrosis</td>
<td>Alzheimer's Disease</td>
</tr>
</tbody>
</table>

Trends in Mortality from All Causes
- ENC’s all-cause mortality rate over the 14-year trend period is decreasing. ENC’s rate is not decreasing as quickly as NC and RNC, creating an increase in regional disparity.
- The age-adjusted, all-cause mortality rate for ENC is decreasing over the 33 year period. Over the 14-year period, the trend shows greater decrease, and suggests the ENC rate will converge with the RNC and NC rates. ENC’s fitted rate continues to remain 9% greater than the rate for RNC for 2012.
- The non-White male mortality rate remains higher than the other demographic groups but has had the greatest rate of decrease (30%) in the 13-year trend. Convergence of the non-White male rate with the White male rate is suggested in the near future.
The trends for all-cause mortality rates for both non-Whites and Whites are decreasing. The non-White rate is 14% greater than the White rate, but the recent 14 year trend suggests they will converge.

Over the recent 14 year period there is a 53% decrease in racial disparity, in a reliable trend.

Trends in Premature Mortality from All Causes of Death

ENC’s premature mortality rate has decreased by 25% over the 14 year period since 1999. However, this trend is diverging slightly from both RNC and NC, whose premature mortality rates decreased by 31% and 29%, respectively.

The age-adjusted premature mortality rate trend is also decreasing, but remains 24% higher than the RNC rate in 2012.

The non-White male rate is significantly higher than the rates for any other demographic group, but also has the highest rate of decrease (slope of trend). White females have the lowest rate, which has begun to level off.

The non-White rate remains 39% greater than the White rate.

A recent decrease in the premature mortality rate for non-Whites and leveling of the rates for Whites suggests a reduction in racial disparity.

Diseases of Heart

ENC’s heart disease mortality rate trend is decreasing but not as quickly as the decrease for RNC and NC, resulting in a slightly increased geographic disparity. In 1999, the fitted rate for ENC was 8% greater than RNC; by 2012 it was 16% greater than RNC.

While ENC’s age-adjusted mortality rate is decreasing at a pace equal to RNC, the ENC fitted rate remains 18% greater than RNC in 2012.

The non-White male rate remains the highest but convergence with the White male rate is suggested in the future. The non-White female rate remains slightly higher than the White female rate but is decreasing more quickly and is suggested to fall below White females in the future.

While the non-White rate remains 9% greater than the rate for Whites, the 14-year trends for both are decreasing, and convergence is suggested in the future.

While the 33-year trend suggests an increase in racial disparity, the moderately reliable 14-year trend line for racial disparity suggests a 42% decrease.

Cancer – Trachea, Bronchus, Lung

While the 33-year trends for Cancer—TBL indicate that all mortality rates are continuing to increase, the 14-year trend line suggests a slight decrease in all three regions. The rate of decrease for ENC is not as great as RNC and NC.

In 2012, the age-adjusted rate trend for ENC is 9% above the RNC rate and 19% above the US rate. During the period 1999-2012, the ENC rates have decreased at about the same rate as NC.

The mortality rates for males are decreasing. Female rates are increasing slightly, although the trend for White females is unreliable. In 2012 the non-White male rate was the highest, but is decreasing the most quickly and will likely converge with the trend for White males in the next few years.

The non-White mortality rate is consistently lower than the White rate. Both rates are decreasing over the 14 year period, but the non-White rate is decreasing a bit more quickly.

The 14-year trend for racial disparity shows a decrease, but it is not reliable.
Chronic Lower Respiratory Diseases
- CLRD mortality rates for ENC, RNC, and NC have leveled during the last 14 years. In 1999, the ENC trend was 1% greater than RNC; in 2012 the ENC trend was 10% less than RNC, but the trend is not reliable.
- The 14-year CLRD age-adjusted rate for ENC is decreasing at a faster pace than the US rate. In 2012, the ENC rate trend was 10% less than RNC compared to 1999 when the ENC rate was 9% greater than RNC.
- Fitted rates for non-White males and White males have decreased over 14 years by 38% and 31%, respectively. The rate for White males remains the highest although it is decreasing. The 14-year trends for White females and non-White females are unreliable.
- The 14-year White morality rates are greater than non-White rates and the rate of decline is less for Whites, leading to a divergence more favorable to non-Whites.
- There is a 30% decrease in the disparity between White rates and non-White rates in a reliable trend.

Cerebrovascular Disease
- ENC’s cerebrovascular disease mortality trend line is decreasing in a similar trend to RNC and NC.
- While the ENC age-adjusted cerebrovascular disease mortality rate is 5% greater than the rate for the rest of the state, it is decreasing and converging on the RNC and NC rates. The Healthy People 2010 goal of less than 48 deaths per 100,000 was achieved in the region in 2010. In 2012, ENC has a rate of 43 deaths per 100,000.
- Non-Whites have the highest mortality rate for cerebrovascular disease but the rate continues to decrease and converge with the other demographic groups. The greatest relative improvement in cerebrovascular disease mortality over 14 years is by White females who experienced a 56% decrease. The non-White male rate is decreasing and converging with White males, but is still 57% greater in 2012.
- The cerebrovascular disease mortality rate for non-Whites is decreasing and converging with that of whites but was still 49% greater than the White rate in 2012.
- The 14-year trend for racial disparity is unreliable.

All Other Unintentional Injuries and Adverse Effects
- Mortality from unintentional injuries and adverse effects is increasing in ENC (60% increase over 14 years). The trends for RNC and NC are also increasing and all are expected to converge in the near future.
- The age-adjusted mortality rate trend for ENC, RNC and NC are increasing. All three increased 33% or more over the 14 years.
- The 14 year trends for White males and White females are increasing significantly (67% and 126% increase, respectively). Mortality rates for non-White males decreased 19% over 14 years. The trend for non-White females is relatively level, but not reliable.
- White rates have increased 87% over the 14 year period. Non-White rates have dropped below white rates, and are decreasing 15% in a moderately reliable trend.
- Between 1999 and 2012, racial disparity has decreased by 419%, eliminating the unfavorable disparity in relation to whites, and favoring non-Whites.

Diabetes Mellitus
- According to the 14-year trend, all diabetes mellitus mortality rates are decreasing but the rate of decline is less for ENC suggesting a divergence from RNC and NC. In 2012, the rate trend for ENC was 45% greater than RNC. In 1999 ENC was 28% greater than RNC.
- The 14-year trend for age-adjusted diabetes mellitus mortality rates shows a decrease of 23% for ENC. In 2012, the ENC age-adjusted diabetes mellitus rate trend remained 46% greater than RNC and 34% greater than the US.
• Rates for all subgroups are decreasing over the recent 14 year period. Rates for non-White males remain the highest. The rate for White males is decreasing the least (11% over 14 years).
• The non-White mortality rate trend decreased over 14 years by 27% but remain 127% greater than the White rate in 2012.
• The decreasing trend for racial disparity is moderately reliable and suggests a 16% decrease.

Alzheimer's Disease
• The Alzheimer’s mortality rate for ENC shows a 96% increase over the 14 year period. ENC’s rate of increase was larger than RNC (38%) and NC (49%) but the rate trend for ENC still remains 30% less than RNC.
• In 2012, the age-adjusted rate trend for ENC has increased 64% over the 14 years. This is a larger increase than both RNC and NC (27% and 53% respectively), although those rates are higher.
• The mortality rates for females, both White and non-White, are greater than that of non-White and White males in an increasingly divergent 14-year trend.
• The non-White mortality rate for Alzheimer’s remains 3% less than the White mortality rate in 2012 but the 14-year trend suggests convergence in the near future.
• The 14-year moderately-reliable trend suggests a future increase in disparity that favors whites.

Unintentional Motor Vehicle Injuries
• ENC’s unintentional motor vehicle mortality rate trend is decreasing but is still 55% greater than RNC in 2012.
• The ENC age-adjusted rate trend is 55% greater than RNC and 60% greater than the US. Rates for ENC, RNC and NC are all decreasing.
• The trends for all groups are declining. The trend for non-White males is the highest. The trend for non-White females is the lowest and has decreased the most (42% over 14 years).
• The non-White rates have decreased by 34% over the 14-year period and converged with the White rates, suggesting a reversal in disparity within ENC.
• The trend for racial disparity is not reliable.

Nephrities, Nephrotic Syndrome, and Nephrosis
• Mortality due to nephritis, nephrotic syndrome, and nephrosis in ENC has increased by 26% over 14 years. While other regions have also experienced increases during this time period, ENC rates have increased more, and were 18% greater than RNC in 2012.
• With age-adjustment, ENC has increased by 9% over the 14-year period.
• The 14 year trends for non-White males and females are continually above those for White males and females but are not reliable. The demographic group with the greatest rate of increase is White males, increasing 29% over 14 years.
• In 2012, the non-White rate trend was 125% greater than the White rate, but it is not a reliable trend.
• The trend for racial disparity is moderately reliable and suggests a 19% decrease in racial disparity.

Pnuemonia and Influenza
• Mortality due to pneumonia and influenza is decreasing (32%) over the 14 year period for ENC, NC, and RNC. The rate trend for ENC is slightly below the rates for the others.
The age-adjusted mortality rates for ENC, RNC and NC are decreasing. For the 14-year trend line ENC has the largest decrease at 44%.

The trends for all demographic groups are declining. The decrease for non-White males was highest (52%), which was followed by White males (47%), non-White females (45%), and White females (40%).

In 1999 the non-White rate trend was 1% greater than the White rate, but by 2012, the non-White rate trend was 8% less than the White rate.

The trend for racial disparity is unreliable.

**Cancer – All Sites**

- The cancer – all sites mortality rates for ENC have decreased slightly (4%) over 14 years. The RNC and NC rates have decreased more than ENC, causing these rates to diverge.
- The age-adjusted cancer – all sites mortality rates for ENC, RNC, NC and the US are all decreasing at about the same pace, although the ENC rate trend is 8% greater than RNC, and 10% greater than the US.
- The rates for non-White males has decreased 31% over 14 years, and is projected to converge with the rate for White males, which show a 21% decrease. The rates for White females and non-White females show a slight decrease and are converging.
- Both White and non-White cancer mortality trends are decreasing over the 14 year period, although the non-White rate remains higher. Non-White rates decreased 24% and White rates decreased 15%, suggesting future convergence.
- The moderately reliable 14-year trend for racial disparity shows a 60% decrease.

**HIV Disease**

- The fitted HIV mortality rate for ENC has been decreasing over the past 14 years, but was still 67% greater than RNC in 2012.
- The 14 year age-adjusted rate trend for ENC had a 47% decrease. The 2012 ENC rate is 75% greater than RNC.
- Non-White males continue to have the highest rates of age-adjusted mortality, but this rate has also decreased 55% in a 14-year reliable trend. The White male rate decreased 46% during that same period and the rate for non-White females decreased 28%. A convergence of the non-White male rate with other rates is expected in the future.
- The 14-year non-White age-adjusted HIV mortality rate has decreased by 47% in a reliable trend. The age-adjusted mortality rate for Whites decreased by 49%, although the absolute rate for this group is much lower.
- In a moderately reliable trend, the 14-year period shows a 22% increase in racial disparity.
3. Methods, Interpretation, and References

Data Sources
The data for mortality and premature mortality in Eastern North Carolina were obtained from death certificate data from the North Carolina State Center for Health Statistics and population data from the North Carolina Office of State Planning. For the US, data were obtained from the Compressed Mortality File compiled by the National Center for Health Statistics.

Measures
Two types of mortality measures are covered in this report. The first, called mortality rate, is a rate based on the number of deaths per population (or, deaths normalized by the population that produced them) for a given unit area, such as the county, region, or state over a specified time interval. The mortality rate is expressed in two ways, the basic true (actual or observed) rate, and an age-adjusted rate (see below). Mortality rates are used to evaluate the impact and burden of mortality on a population and to make comparisons, where appropriate, among populations. Like the mortality rate, the second type, called premature mortality rate, is also a density measure, but instead of deaths, it is the number of person-years lost in a population before a specified age. In this report mortality rates are emphasized with premature mortality (YLL-75) shown only for the total number of deaths from all causes (general mortality). Premature mortality in detail is the focus of Report Series #1.

A simple count of deaths occurring in an area for a given time interval is useful for identifying potential problems or issues of public concern—particularly if the deaths result from a rare cause or they are believed to be an emerging problem for at-risk socio-demographic groups. In this sense, count data are used for sentinel surveillance. Because counts reveal nothing about the underlying population base from which deaths arise, the analytical or practical utility of count data is limited. The size of the underlying population will have an expected effect on the numbers of deaths that occur. Deaths measured in relation to a population, are an expression of density. When measured over a given interval of time (usually 1 to 5 years), the density is called a rate. (The rate is typically multiplied by 100,000 for ease in interpreting the usually small resultant value.) The mortality rate is an improvement over simple count data because it accounts for the relative size and effect of the underlying population. The chief advantage of the mortality rate is that it is useful for focusing attention on the burden of public health problems more rigorously than simple counts. However, the mortality rate is also affected by the age structure of the population, which can confound interpretation when making comparisons of rates among different areas.

Because aging is the greatest risk factor for death, the age structure of a population will have a substantial effect on the mortality rate. For example, two counties may have similar population sizes but one has a larger number of people over the age of 45 than the other. It is more likely that the older population will generate more deaths over an interval of time and this will be reflected in a higher mortality rate. Differing age structures among populations will confound any comparisons of mortality rates among those populations. Therefore, a method for controlling the effects of age structure on the mortality rate is required if any meaningful comparisons are to be made.

Age-adjustment to control for a population's age structure requires an external reference or standard to weight the comparison populations by age groups. Currently, the US 2000 Standard Million Population (SMP) is used as the external reference. The US 2000 SMP is divided into a number of age groups whose sizes or proportions serve as weights to be applied to the corresponding age groups of the study population. This proportional redistribution generates new numbers of expected deaths in each of the corresponding age groups of the study population. These expected deaths are the number of deaths we would expect if the study population had the same age structure as the US 2000 SMP. The
expected number of deaths are summed and normalized by the total population yielding an age-adjusted death rate. Once the effects of age structure are controlled, the way is paved for making comparisons among populations (Buescher, 1998).

The second measure, premature mortality, focuses on the burden of disease and death expressed in terms of accumulated person years lost before a benchmark age. We use 75 years of age as a benchmark because it approximates current life expectancy at birth in the United States and gives weight to deaths from chronic disease occurring in later life. It considers only deaths of people who die before age 75. To calculate the number of years lost, the mid-point age of the age group to which each decedent belongs is subtracted from 75 and the differences (the lost years) are summed. After all lost years are summed; the result is normalized by the population under age 75 and multiplied by 10,000. Premature mortality is expressed as a rate measured over a time interval, and it can also be age-adjusted.

Age-adjusted rates for both mortality and premature mortality have little intrinsic meaning, however, and can mask the burden and trends of mortality (or health event) that may be of local importance. A casual inspection of adjusted rates may divert attention from the actual health problems of a population and inappropriately guide interventions or resource allocation. Thus, it is important to consider the actual number of deaths (count data) in conjunction with the basic non-adjusted mortality rate first, and then use the adjusted rate only if one wishes to factor out age in understanding the pattern of mortality among populations and regions. For regions with larger populations the statistics presented here are for the year 2012. Smaller areas like counties will usually be aggregated into 5-year intervals (e.g., 2003 to 2007). A five-year interval is used because it provides a useful summary of the mortality experience while minimizing wide year-to-year fluctuations in the rate due to the effect of small numbers.

Interpreting the Pie Charts

Pie charts are provided as a visual representation of the burden of mortality. They depict the proportion of mortality accounted for by each of the leading contributors. (The leading causes of death are found in the table preceding the pie chart section.) The pie charts compare the relative levels of burden and proportions by region and demographic groups. Each regional and demographic set of pie charts is based on the observed mortality rate and the age-adjusted (expected) mortality rate. The area of each pie is based on the age-adjusted mortality rate for the year 2012—larger pie charts will represent larger mortality rates. For purposes of presentation, we set the smallest area of a circle on the lowest meaningful rate as a benchmark, the age-adjusted rate for White females in North Carolina. We then scaled up the circles for all other groups proportionately based on their rates.

The first two pie chart figures compare the proportions of leading causes of death across regions at the national, state, and regional/county level. The first figure in this set compares absolute mortality (the burden) using mortality rates, which sheds light on any differences in the burden of mortality by disease intrinsic to each region. The second figure, which is age-adjusted, allows for direct comparisons among regions. The same pattern is repeated in the following figures that show differences among demographic groups.

While comparing the pie charts, the reader should remember that the slices of the pie show differences in how much of the mortality rate (including age-adjusted) is accounted for by a specific cause. Finally, the reader will see that some pies are composed of different leading causes of mortality, so they have different colored slices. The variable sizes of pie slices demonstrate differences in the mortality patterns across populations and are of significant importance in studying inequalities and disparities in population health.
Interpreting the Trend Figures

Four types of figures are used to show trends in mortality, for all causes combined, and for each of the ten leading causes in the region/county over a 33-year period. Premature mortality is described for deaths by all causes only. The first of the four types of figures depicts the observed mortality rates for the region/county and state. The second figure type shows age-adjusted mortality rates for the region/county, state, and nation allowing comparisons among geographical areas. The third figure type compares trends in age-adjusted mortality rates by race and gender. Adjustment is made for age structure differences among demographic groups, which permits observation on the effects of race and gender on these groups. The last figure type depicts racial differences (or disparities) expressed as a ratio (in percent) of age-adjusted mortality for non-Whites to the age-adjusted rates for Whites over the 33 year time series. Trend lines provide historical depth to mortality processes and a basis for prediction, future comparisons, and action.

The trend line concept is borrowed from statistical modeling. However, unlike true modeling, we are not assuming the statistical independence of each sequential observation (the rate at time interval x). Instead, our assumption is that each observation is dependent to some degree on previous observations, forming a trend. If the degree of dependence is high, then the observations (rates) should lie close to the trend line. If observations appear to bounce around the fitted line in a random fashion (indicating high variability), then there is less dependence and less of a trend in the observations. We use trend lines to uncover any general patterns found in the data for the purpose of assisting the investigator in understanding the underlying processes which generate them.

The equation of the line is derived from a set of observation points. This line is an estimate of where each observed rate would be if the previous observation could predict with 100% accuracy the value of the next observation. In nature, this situation seldom arises and the degree to which individual observations deviate from this linear trend line is an indication of how well they “fit” or conform to the trend. The linear trend lines in the time series figures project expected rates to the year 2020 from known historical values (1979 to 2012) to provide a general idea about where mortality trends are heading.

The equation of the line allows the user to calculate an expected or fitted rate for any given year, x. For example, in figure 6.3 ii the year 2005 is the 7th year in the series, so 7 would be substituted for x in the equation of the line derived from ENC41’s age-adjusted mortality rate series for a selected cause of death. For chronic lower respiratory diseases (1979 to 2012), the 2005 expected or fitted age-adjusted rate is calculated to be 46 deaths per 100,000 people. The observed age-adjusted rate for 2005 is 47 deaths per 100,000 people. (The observed rates are the values found in the table that runs along the x-axis of the time series chart.) The numeric difference between the expected and observed rates for 2005 is 1—the model (the equation of the line) underestimates the observed value by 1 death. Each previous and subsequent year’s difference between the expected and observed rates will vary to a greater or lesser degree depending on the size of the population under study (see below). This variation can be measured to determine how well the line fits or models the observed data.

In the time series figures, the investigator will find several statistical tools to assist in the analyses of trend lines and fitted rates. These tools include the coefficient of determination, percent change values, and slope coefficients. These tools enable the investigator to form not only a mental picture of the comparative impact of mortality by cause on a region and population but to also gain insight into what the near demographic future holds for them.

Coefficients of determination ($R^2$) are provided to indicate how well the fitted line predicts or explains the observed rates. When variation in the observed rates is relatively high (the fitted trend line does not correspond well to the observed trend line) $R^2$ approaches 0.0, when the variation
is low, $R^2$ approaches 1.0. A low $R^2$ implies low reliability and a larger $R^2$ indicates that a greater degree of confidence can be placed in the trend line. The trend lines are generally unreliable when $R^2$ is less than 0.10, moderately reliable when $R^2$ is between 0.10 and 0.35, and most reliable when $R^2$ is equal to or greater than 0.35. Graphically, data points, data lines and trend lines are weighted according to their reliability and significance. The thinnest, dashed trend lines are for those where $R^2$ is less than 0.10 and should be considered not reliable. The thickest dashed lines are used for trends where the $R^2$ is equal to or greater than 0.35. In some cases, the trend lines do not fit the data well (i.e. small $R^2$). In other words, the presentation of a trend line does not necessarily indicate a linear trend in the data line. In several instances a non-linear trend may be present. It should be noted that the linear trend modeling undertaken here is a major simplification of real world processes. These processes are dynamical in nature and can be modeled and fitted with certain limitations and assumptions. Time series of epidemic infectious disease mortality rates typically exhibit a curvilinear pattern. A marked curvilinear pattern is seen in the mortality series for HIV/AIDS mortality, general cancer mortality, and several others which can be approximated into at least two sequential linear segments. Each segment is joined to another in the sequence at a point in time or year. In this series (#2), we begin to explore alternative methods for examining trends that show discontinuities and reversals within the set of time series observations, particularly within the mortality time series for HIV/AIDS.

Percent change provides a measure of the estimated change in mortality over the most recent ten year period (1999-2012). The percent value is followed by the term increase or decrease to help denote the direction of the overall trend. This information is in boldface and included with the $R^2$ value and the equation of the line. Percent change and the direction of that change is provided on the graphs for trends where $R^2$ is greater than 0.10.

Another tool is the equation of the line that fits a trend among the observed data points (the rates). The slope coefficient of this equation, $b$, is the estimated/expected number of deaths per unit of time ($x$) or the rate of change in deaths per annum. The direction of change is indicated with a negative sign preceding the $b$ and if positive, $b$ is unsigned. Visually, a negative slope shows a trend decreasing in annual rates from left to right and a positive slope will be rising (increasing) from left to right. An examination of the different slopes for regional or demographic group trends will quickly reveal that they are not equal. Visual inspection combined with slope coefficients also provides a means for making comparisons between any two trend line series in the time series figure. Trends will diverge, converge, or run parallel with one another indicating, respectively, increasing separation, decreasing separation, or very little change in rates between two trend lines. Setting two equations of the line equal to one another can yield an estimated year of convergence in the future (or the year the two trends diverged in the past). However, the investigator is cautioned to not put too much stock in the results if the forward or backward projections are very distant in time, especially when $R^2$ is low. Recent (or temporally adjacent) short term trends with good correspondence between the fitted trend line and observed trend line will be better indicators of rates in the near future or past (if historical rates are unknown).

The final tool is the pair of comparison tables located in the lower portion of the page. The tables, found in every time series figure (except the ones showing comparisons by race and disparity) are structured so that the reader can make comparisons of rates derived from the equation of the line (i.e., the fitted rates) among all regions or demographic groups portrayed in the figure. The 1999 and 2012 tables compare the fitted rates calculated for the beginning and end of the observed time series in terms of percent difference. Returning to figure 6.3 ii, ENC41’s age-adjusted fitted rate for chronic lower respiratory diseases in 1999 is 9% greater than (GT) RNC’s fitted rate. In 2012, ENC41’s fitted rate is 10% less than (LT) RNC’s fitted rate. The tables permit a quick assessment of trends calculated from observed time series data.

The reader should notice that some data lines in the trend figures fluctuate widely. This fluctuation is due to two main factors. In a small population, the number of deaths may vary widely from year-to-year and lead to large changes in annual mortality and premature mortality rates, a phenomenon known as the effect of small numbers. In addition, because mortality is based on the age of death, any fluctuation in the
distribution of deaths across age groups from year-to-year can cause rates to change dramatically. Both the number of deaths and the age of
decedents influence trends in mortality. The reader should evaluate all available data carefully before drawing conclusions about current, past
and future mortality patterns.

Caveats about the Concepts of Race, Gender, and Geography

Several caveats are offered about the concepts of race, gender, and geography as they apply to the analysis of mortality patterns. While we do
intend to bring attention to the stark racial inequalities in mortality across North Carolina, we do not mean to imply that this is a biological
phenomenon. Other factors such as differences in socioeconomic status, educational attainment, occupation, and lifestyle probably account for
the large racial gaps in mortality rates. Likewise, gender inequalities may have less to do with biological differences between men and women
than with socially structured gender roles, health behaviors, occupational exposures, and use of health services. Finally, it is important to
consider that county borders may not always be the most appropriate way to look at specific health problems. Few of our health care problems
begin or end at political boundary lines and many of our health problems in North Carolina are common to large groups of counties. Counties
and larger regions composed of counties are convenient units of data collection and readers should not jump to conclusions about health
problems or possible solutions based solely on the way data appear when aggregated to this level. In some cases, data at multi-county, zip
code, or minor civil division levels are a better way to understand problems and solutions. Similarly, as indicated in Healthy Carolinians 2020,
consideration needs to be given to whether or not a county is characterized as rural or urban, as this can be an indication to the level of
development and amount of resources available in a county.
General References


Cited References

4. Current Disparities in Mortality by Geography, Race and Gender, and Race: Total and Five Leading Causes of Death
Figure 4.1 i. General leading causes of death for ENC41 (2012), NC (2012), and US (2010). Mortality rate per 100,000 population.

2012 NC rate is 5% higher than 2010 US rate

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.1 ii. General leading causes of death for ENC41 (2012), NC (2012), and US (2010). Age-adjusted mortality rate per 100,000 population.

### ENC41
- Diseases of Heart: 41%
- Cancer - All Sites: 5%
- Chronic Lower Respiratory Diseases: 5%
- Cerebrovascular Disease: 4%
- All Other Deaths: 4%

832 deaths/100,000

### North Carolina
- Diseases of Heart: 41%
- Cancer - All Sites: 5%
- Chronic Lower Respiratory Diseases: 6%
- Cerebrovascular Disease: 5%
- All Other Unintentional Injuries and Adverse Effects: 23%

785 deaths/100,000

### United States
- Diseases of Heart: 38%
- Cancer - All Sites: 5%
- Chronic Lower Respiratory Diseases: 6%
- Cerebrovascular Disease: 5%
- All Other Unintentional Injuries and Adverse Effects: 24%

747 deaths/100,000

2012 NC age-adjusted rate is 5% higher than 2010 US age-adjusted rate

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.2 i. General leading causes of death for ENC41 (2012) by race and gender. Mortality rate per 100,000 population.

Non-White Males
- 23% Diseases of Heart
- 22% Cerebrovascular Disease
- 11% Cancer - All Sites
- 5% Diabetes Mellitus
- 5% Nephritis, Nephrotic Syndrome, and Nephrosis
- 5% Alzheimer's Disease
- 4% All Other Unintentional Injuries and Adverse Effects
- 4% All Other Deaths

White Males
- 24% Diseases of Heart
- 24% Cancer - All Sites
- 22% Cerebrovascular Disease
- 11% Chronic Lower Respiratory Diseases
- 6% Diabetes Mellitus
- 5% Nephritis, Nephrotic Syndrome, and Nephrosis
- 5% Alzheimer's Disease
- 4% All Other Unintentional Injuries and Adverse Effects
- 4% All Other Deaths

Non-White Females
- 21% Diseases of Heart
- 21% Cerebrovascular Disease
- 11% Cancer - All Sites
- 6% Diabetes Mellitus
- 6% Nephritis, Nephrotic Syndrome, and Nephrosis
- 5% Alzheimer's Disease
- 4% All Other Unintentional Injuries and Adverse Effects
- 3% All Other Deaths

White Females
- 22% Diseases of Heart
- 21% Cerebrovascular Disease
- 21% Cancer - All Sites
- 11% Chronic Lower Respiratory Diseases
- 7% Diabetes Mellitus
- 7% Nephritis, Nephrotic Syndrome, and Nephrosis
- 7% Alzheimer's Disease
- 4% All Other Unintentional Injuries and Adverse Effects
- 4% All Other Deaths

2012 ENC41 NWM rate is 6% lower than 2012 ENC41 WM rate
- 865 deaths/100,000
- 920 deaths/100,000

2012 ENC41 NWF rate is 15% lower than 2012 ENC41 WF rate
- 763 deaths/100,000
- 902 deaths/100,000

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.2 ii. General leading causes of death for ENC41 (2012) by race and gender.
Age-adjusted mortality rate per 100,000 population.

Non-White Males

2012 ENC41 NWM age-adjusted rate is 21% higher than 2012 ENC41 WM age-adjusted rate

1128 deaths/100,000

Non-White Females

2012 ENC41 NWF age-adjusted rate is 7% higher than 2012 ENC41 WF age-adjusted rate

739 deaths/100,000

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.3 i. General leading causes of death for ENC41 (2012) by race. Mortality rate per 100,000 population.

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.3 ii. General leading causes of death for ENC41 (2012) by race. Age-adjusted mortality rate per 100,000 population.

Non-White

2012 ENC41 NW age-adjusted rate is 12% higher than 2012 ENC41 W age-adjusted rate

White

Pie charts are proportionately scaled using the state age-adjusted mortality rate of white females (689 deaths/100,000 pop) as a standard. The areas are proportional to the rates. Slices without percentages constitute less than 5% of the deaths within that chart.
5. Trends and Disparities in Mortality in ENC41: All Causes of Death and All Causes of Premature Mortality; 1979-2012
All Causes of Death

- ENC’s all-cause mortality rate over the 14-year trend period is decreasing. ENC’s rate is not decreasing as quickly as NC and RNC, creating an increase in regional disparity.

- The age-adjusted, all-cause mortality rate for ENC is decreasing over the 33 year period. Over the 14-year period, the trend shows greater decrease, and suggests the ENC rate will converge with the RNC and NC rates. ENC’s fitted rate continues to remain 9% greater than the rate for RNC for 2012.

- The non-White male mortality rate remains higher than the other demographic groups but has had the greatest rate of decrease (30%) in the 13-year trend. Convergence of the non-White male rate with the White male rate is suggested in the near future.

- The trends for all-cause mortality rates for both non-Whites and Whites are decreasing. The non-White rate is 14% greater than the White rate, but the recent 14 year trend suggests they will converge.

- Over the recent 14 year period there is a 53% decrease in racial disparity, in a reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 5.1 i. All Causes of Death:
Trends in mortality rates for ENC41, RNC59, and NC
1979-2012 with projections to 2020

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Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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<td>7% GT</td>
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Mortality rate per 100,000 population
Figure 5.1 ii. All Causes of Death:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 5.1 iii. All Causes of Death: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 5.1 iv. All Causes of Death: Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

1999 non-White rate is 27% greater than White
2012 non-White rate is 14% greater than White

NW 14-yr trendline
26% decrease
R2 = 0.96
y = -22.77x + 1,208.64

W 14-yr trendline
17% decrease
R2 = 0.91
y = -11.56x + 952.67
Figure 5.1 v. All Causes of Death:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
53% decrease
R2 = 0.59
y = -1.04x + 27.45
All Causes of Premature Mortality

- ENC’s premature mortality rate has decreased by 25% over the 14 year period since 1999. However, this trend is diverging slightly from both RNC and NC, whose premature mortality rates decreased by 31% and 29%, respectively.

- The age-adjusted premature mortality rate trend is also decreasing, but remains 24% higher than the RNC rate in 2012.

- The non-White male rate is significantly higher than the rates for any other demographic group, but also has the highest rate of decrease (slope of trend). White females have the lowest rate, which has begun to level off.

- The non-White rate remains 39% greater than the White rate.

- A recent decrease in the premature mortality rate for non-Whites and leveling of the rates for Whites suggests a reduction in racial disparity.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 5.2 i. All Causes of Premature Mortality: Trends in premature mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41: 25% decrease, \( R^2 = 0.93 \), \( y = -8.53x + 1,172.88 \)

RNC59: 31% decrease, \( R^2 = 0.94 \), \( y = -9.34x + 1,033.96 \)

NC: 29% decrease, \( R^2 = 0.94 \), \( y = -9.28x + 1,079.34 \)

1979 ENC41 rate is 13% greater than RNC59
2012 ENC41 rate is 23% greater than RNC59

Comparison of Fitted Rates in 1979
- ENC41: 12% LT
- RNC59: 8% LT
- NC: 9% LT

Comparison of Fitted Rates in 2012
- ENC41: 12% LT
- RNC59: 4% GT
- NC: 9% LT

Comparison of Fitted Rates in 2012
- ENC41: 19% LT
- RNC59: 13% LT
- NC: 15% LT

Years of life lost per 10,000 population <75 years of age
Figure 5.2 ii. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
17% decrease
R² = 0.89
y = -12.55x + 1,007.66

RNC59 14-yr trendline
20% decrease
R² = 0.93
y = -12.17x + 838.82

NC 14-yr trendline
20% decrease
R² = 0.93
y = -12.47x + 888.88

US 12-yr trendline
10% decrease
R² = 0.95
y = -6.72x + 772.17

1999 ENC41 rate is 20% greater than RNC59
2012 ENC41 rate is 24% greater than RNC59

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Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Comparison of Fitted Rates
Figure 5.2 iii. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

NWM 14-yr trendline: 31% decrease
 WM 14-yr trendline: 12% decrease
 NWF 14-yr trendline: 27% decrease
 WF 14-yr trendline

R² = 0.82
y = -40.66x + 1,841.25

R² = 0.76
y = -8.89x + 1,045.35

R² = 0.84
y = -19.87x + 1,047.86

R² = 0.06
y = -0.78x + 573.51

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Note: LTH = Low Total Health, GT = Good Total Health, GTH = Good Total Health
Figure 5.2 iv. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates by race for ENC41, 1979-2012 with projections to 2020

1999 non-White rate is 73% greater than White
2012 non-White rate is 39% greater than White

NW 14-yr trendline
y = -28.52x + 1,407.40
W 14-yr trendline
y = -5.04x + 811.91

28% decrease
R² = 0.88

9% decrease
R² = 0.67
Figure 5.2 v. All Causes of Premature Mortality:
Measuring disparity in age-adjusted premature mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
51% decrease
R² = 0.77
y = -2.71x + 74.22
Diseases of Heart

- ENC’s heart disease mortality rate trend is decreasing but not as quickly as the decrease for RNC and NC, resulting in a slightly increased geographic disparity. In 1999, the fitted rate for ENC was 8% greater than RNC; by 2012 it was 16% greater than RNC.

- While ENC’s age-adjusted mortality rate is decreasing at a pace equal to RNC, the ENC fitted rate remains 18% greater than RNC in 2012.

- The non-White male rate remains the highest but convergence with the White male rate is suggested in the future. The non-White female rate remains slightly higher than the White female rate but is decreasing more quickly and is suggested to fall below White females in the future.

- While the non-White rate remains 9% greater than the rate for Whites, the 14-year trends for both are decreasing, and convergence is suggested in the future.

- While the 33-year trend suggests an increase in racial disparity, the moderately reliable 14-year trend line for racial disparity suggests a 42% decrease.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.1 i. Diseases of Heart: Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline
30% decrease
R2 = 0.94
y = -5.61x + 264.57

RNC59 14-yr trendline
35% decrease
R2 = 0.92
y = -6.12x + 244.23

NC 14-yr trendline
34% decrease
R2 = 0.93
y = -5.99x + 250.30

1999 ENC41 rate is 8% greater than RNC59
2012 ENC41 rate is 16% greater than RNC59

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Comparison of Fitted Rates in 2012

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Report #2.203, August 2014

Center for Health Systems Research and Development, ECU
Figure 6.1 ii. Diseases of Heart: 
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
40% decrease
R² = 0.98
y = -8.48x + 296.26

RNC59 14-yr trendline
40% decrease
R² = 0.98
y = -7.21x + 250.70

NC 14-yr trendline
40% decrease
R² = 0.98
y = -7.58x + 263.60

US 12-yr trendline
36% decrease
R² = 0.99
y = -8.31x + 274.71

1999 ENC41 rate is 18% greater than RNC59
2012 ENC41 rate is 18% greater than RNC59

Comparison of Fitted Rates in 1999
Comparison of Fitted Rates in 2012

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Figure 6.1 iii. Diseases of Heart: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

R2 = 0.88
y = -11.62x + 406.60

R2 = 0.96
y = -9.58x + 353.04

R2 = 0.96
y = -9.12x + 275.37

R2 = 0.95
y = -6.81x + 229.85

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 6.1 iv. Diseases of Heart:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline: 43% decrease, R² = 0.95
W 14-yr trendline: 39% decrease, R² = 0.97

- 1999 non-White rate is 16% greater than White
- 2012 non-White rate is 9% greater than White
Figure 6.1 v. Diseases of Heart:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
42% decrease
R2 = 0.17
y = -0.49x + 16.22
Cancer - Trachea, Bronchus, Lung

- While the 33-year trends for Cancer—TBL indicate that all mortality rates are continuing to increase, the 14-year trend line suggests a slight decrease in all three regions. The rate of decrease for ENC is not as great as RNC and NC.

- In 2012, the age-adjusted rate trend for ENC is 9% above the RNC rate and 19% above the US rate. During the period 1999-2012, the ENC rates have decreased at about the same rate as NC.

- The mortality rates for males are decreasing. Female rates are increasing slightly, although the trend for White females is unreliable. In 2012 the non-White male rate was the highest, but is decreasing the most quickly and will likely converge with the trend for White males in the next few years.

- The non-White mortality rate is consistently lower than the White rate. Both rates are decreasing over the 14 year period, but the non-White rate is decreasing a bit more quickly.

- The 14-year trend for racial disparity shows a decrease, but it is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.2 i. Cancer - Trachea, Bronchus, Lung:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline: 4% decrease
R = 0.13
y = -0.18x + 63.73

RNC59 14-yr trendline: 9% decrease
R = 0.62
y = -0.38x + 60.32

NC 14-yr trendline: 8% decrease
R = 0.56
y = -0.33x + 61.34

1999 ENC41 rate is 6% greater than RNC59
2012 ENC41 rate is 11% greater than RNC59
Figure 6.2 ii. Cancer - Trachea, Bronchus, Lung:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

**Comparison of Fitted Rates in 1999**

<table>
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**Comparison of Fitted Rates in 2012**

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<td>9% GT</td>
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<td>9% GT</td>
<td>19% GT</td>
<td>9% GT</td>
<td>12% GT</td>
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**ENC41 14-yr trendline**
- 17% decrease
- $R^2 = 0.75$
- $y = -0.84x + 67.33$

**RNC59 14-yr trendline**
- 16% decrease
- $R^2 = 0.78$
- $y = -0.70x + 60.84$

**NC 14-yr trendline**
- 17% decrease
- $R^2 = 0.81$
- $y = -0.74x + 62.73$

**US 12-yr trendline**
- 17% decrease
- $R^2 = 0.96$
- $y = -0.79x + 57.62$

1999 ENC41 rate is 11% greater than RNC59
2012 ENC41 rate is 9% greater than RNC59
Figure 6.2 iii. Cancer - Trachea, Bronchus, Lung: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

NWM 14-yr trendline

WM 14-yr trendline

NWF 14-yr trendline

WF 14-yr trendline

37% decrease
R2 = 0.68
y = -3.24x + 121.21

29% decrease
R2 = 0.86
y = -2.15x + 102.50

15% increase
R2 = 0.18
y = 0.30x + 26.79

R2 = 0.02
y = 0.10x + 45.26

Comparison of Fitted Rates in 1999

Comparison of Fitted Rates in 2012
Figure 6.2 iv. Cancer - Trachea, Bronchus, Lung: Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

1999 non-White rate is 9% less than White
2012 non-White rate is 15% less than White

NW 14-yr trendline
16% decrease
R2 = 0.69
y = -0.79x + 68.92

W 14-yr trendline
22% decrease
R2 = 0.53
y = -0.98x + 62.65
Figure 6.2 v. Cancer - Trachea, Bronchus, Lung: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity

R2 = 0.07

y = -0.55x - 10.48
Chronic Lower Respiratory Diseases

- CLRD mortality rates for ENC, RNC, and NC have leveled during the last 14 years. In 1999, the ENC trend was 1% greater than RNC; in 2012 the ENC trend was 10% less than RNC, but the trend is not reliable.

- The 14-year CLRD age-adjusted rate for ENC is decreasing at a faster pace than the US rate. In 2012, the ENC rate trend was 10% less than RNC compared to 1999 when the ENC rate was 9% greater than RNC.

- Fitted rates for non-White males and White males have decreased over 14 years by 38% and 31%, respectively. The rate for White males remains the highest although it is decreasing. The 14-year trends for White females and non-White females are unreliable.

- The 14-year White mortality rates are greater than non-White rates and the rate of decline is less for Whites, leading to a divergence more favorable to non-Whites.

- There is a 30% decrease in the disparity between White rates and non-White rates in a reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 

Figure 6.3 i. Chronic Lower Respiratory Diseases: Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

<table>
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Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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<tr>
<td>2012</td>
<td>10% LT</td>
<td>3% GT</td>
<td>RNC59</td>
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</table>

ENC41 14-yr trendline: R2 = 0.00, y = -0.01x + 44.64
RNC59 14-yr trendline: R2 = 0.36, y = 0.39x + 44.21
NC 14-yr trendline: R2 = 0.28, y = 0.28x + 44.32
Figure 6.3 ii. Chronic Lower Respiratory Diseases:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline: 14% decrease
R2 = 0.67
y = -0.49x + 49.58

RNC59 14-yr trendline: 5% increase
R2 = 0.16
y = 0.18x + 45.54

NC 14-yr trendline: 6% decrease
R2 = 0.00
y = -0.01x + 46.66

US 12-yr trendline: 6% decrease
R2 = 0.31
y = -0.22x + 44.61

1999 ENC41 rate is 9% greater than RNC59
2012 ENC41 rate is 10% less than RNC59
Figure 6.3 iii. Chronic Lower Respiratory Diseases: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020.
Figure 6.3 iv. Chronic Lower Respiratory Diseases:
Trends in age-adjusted mortality rates by race for ENC41,
1979-2012 with projections to 2020

1999 non-White rate is 38% less than White
2012 non-White rate is 44% less than White

NW 14-yr trendline
22% decrease
R2 = 0.47
y = -0.53x + 34.32

W 14-yr trendline
12% decrease
R2 = 0.60
y = -0.49x + 55.25
Figure 6.3 v. Chronic Lower Respiratory Diseases:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
30% decrease
R2 = 0.14
y = -1.31x - 61.48
Cerebrovascular Disease

- ENC’s cerebrovascular disease mortality trend line is decreasing in a similar trend to RNC and NC.
- While the ENC age-adjusted cerebrovascular disease mortality rate is 5% greater than the rate for the rest of the state, it is decreasing and converging on the RNC and NC rates. The Healthy People 2010 goal of less than 48 deaths per 100,000 was achieved in the region in 2010. In 2012, ENC has a rate of 43 deaths per 100,000.
- Non-Whites have the highest mortality rate for cerebrovascular disease but the rate continues to decrease and converge with the other demographic groups. The greatest relative improvement in cerebrovascular disease mortality over 14 years is by White females who experienced a 56% decrease. The non-White male rate is decreasing and converging with White males, but is still 57% greater in 2012.
- The cerebrovascular disease mortality rate for non-Whites is decreasing and converging with that of whites but was still 49% greater than the White rate in 2012.
- The 14-year trend for racial disparity is unreliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.4 i. Cerebrovascular Disease:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline
RNC59 14-yr trendline
NC 14-yr trendline

45% decrease
45% decrease
45% decrease

R2 = 0.93
R2 = 0.93
R2 = 0.94

y = -2.43x + 75.25
y = -2.37x + 72.89
y = -2.39x + 73.58

1999 ENC41 rate is 3% greater than RNC59
2012 ENC41 rate is 4% greater than RNC59
Figure 6.4 ii. Cerebrovascular Disease:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
54% decrease
R² = 0.95
y = -3.32x + 85.74

RNC59 14-yr trendline
50% decrease
R² = 0.96
y = -2.67x + 75.39

NC 14-yr trendline
51% decrease
R² = 0.97
y = -2.85x + 78.35

US 12-yr trendline
42% decrease
R² = 0.98
y = -2.29x + 64.93
Figure 6.4 iii. Cerebrovascular Disease: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020.
Figure 6.4 iv. Cerebrovascular Disease: Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline
53% decrease
R2 = 0.94
y = -4.07x + 108.33

W 14-yr trendline
56% decrease
R2 = 0.93
y = -3.05x + 76.98

1999 non-White rate is 41% greater than White
2012 non-White rate is 49% greater than White
Figure 6.4 v. Cerebrovascular Disease:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity

\[ R^2 = 0.04 \]
\[ y = 0.40x + 41.55 \]
All Other Unintentional Injuries and Adverse Effects

- Mortality from unintentional injuries and adverse effects is increasing in ENC (60% increase over 14 years). The trends for RNC and NC are also increasing and all are expected to converge in the near future.

- The age-adjusted mortality rate trend for ENC, RNC and NC are increasing. All three increased 33% or more over the 14 years.

- The 14 year trends for White males and White females are increasing significantly (67% and 126% increase, respectively). Mortality rates for non-White males decreased 19% over 14 years. The trend for non-White females is relatively level, but not reliable.

- White rates have increased 87% over the 14 year period. Non-White rates have dropped below white rates, and are decreasing 15% in a moderately reliable trend.

- Between 1999 and 2012, racial disparity has decreased by 419%, eliminating the unfavorable disparity in relation to whites, and favoring

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 


Figure 6.5 i. All Other Unintentional Injuries and Adverse Effects: Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline
60% increase
R2 = 0.88
y = 0.85x + 19.75

RNC59 14-yr trendline
39% increase
R2 = 0.80
y = 0.62x + 22.56

NC 14-yr trendline
44% increase
R2 = 0.89
y = 0.69x + 21.74

1999 ENC41 rate is 12% less than RNC59
2012 ENC41 rate is the same as RNC59

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 6.5 ii. All Other Unintentional Injuries and Adverse Effects:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
- 49% increase
- $R^2 = 0.85$
- $y = 0.74x + 21.24$

RNC59 14-yr trendline
- 33% increase
- $R^2 = 0.73$
- $y = 0.54x + 22.96$

NC 14-yr trendline
- 37% increase
- $R^2 = 0.86$
- $y = 0.59x + 22.53$

US 12-yr trendline
- 48% increase
- $R^2 = 0.93$
- $y = 0.74x + 18.50$

1999 ENC41 rate is 7% less than RNC59
2012 ENC41 rate is 3% greater than RNC59
Figure 6.5 iii. All Other Unintentional Injuries and Adverse Effects: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

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Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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<td>219% GT 88% GT NWF</td>
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<td>WF</td>
<td>70% GT 47% LT WF</td>
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Figure 6.5 iv. All Other Unintentional Injuries and Adverse Effects:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

- NW 14-yr trendline: 15% decrease, $R^2 = 0.11$, $y = -0.27x + 24.69$
- W 14-yr trendline: 87% increase, $R^2 = 0.94$, $y = 1.22x + 19.58$

1999 non-White rate is 26% greater than White
2012 non-White rate is 40% less than White
Figure 6.5 v. All Other Unintentional Injuries and Adverse Effects:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
419% decrease
R2 = 0.74
y = -6.77x + 22.63
Diabetes Mellitus

- According to the 14-year trend, all diabetes mellitus mortality rates are decreasing but the rate of decline is less for ENC suggesting a divergence from RNC and NC. In 2012, the rate trend for ENC was 45% greater than RNC. In 1999 ENC was 28% greater than RNC.

- The 14-year trend for age-adjusted diabetes mellitus mortality rates shows a decrease of 23% for ENC. In 2012, the ENC age-adjusted diabetes mellitus rate trend remained 46% greater than RNC and 34% greater than the US.

- Rates for all subgroups are decreasing over the recent 14 year period. Rates for non-White males remain the highest. The rate for White males is decreasing the least (11% over 14 years).

- The non-White mortality rate trend decreased over 14 years by 27% but remain 127% greater than the White rate in 2012.

- The decreasing trend for racial disparity is moderately reliable and suggests a 16% decrease.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.6 i. Diabetes Mellitus: Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline
11% decrease
R2 = 0.37
y = -0.25x + 32.93

RNC59 14-yr trendline
22% decrease
R2 = 0.68
y = -0.41x + 25.81

NC 14-yr trendline
19% decrease
R2 = 0.64
y = -0.38x + 27.94

ENC41 1999 rate is 28% greater than RNC59
2012 ENC41 rate is 45% greater than RNC59

Comparison of Fitted Rates in 1999
ENC41: 28% GT
RNC59: 8% GT
NC: 18% GT

Comparison of Fitted Rates in 2012
ENC41: 45% GT
RNC59: 13% GT
NC: 29% GT

Report #2.203, August 2014
Center for Health Systems Research and Development, ECU
Figure 6.6 ii. Diabetes Mellitus:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

1999 ENC41 rate is 37% greater than RNC59
2012 ENC41 rate is 46% greater than RNC59

Comparison of Fitted Rates in 1999

<table>
<thead>
<tr>
<th>ENC41</th>
<th>RNC59</th>
<th>NC</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>27% LT</td>
<td>19% LT</td>
<td>26% LT</td>
<td>ENC41</td>
</tr>
<tr>
<td>37% GT</td>
<td>10% GT</td>
<td>2% GT</td>
<td>RNC59</td>
</tr>
<tr>
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</tr>
<tr>
<td>35% GT</td>
<td>2% LT</td>
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Comparison of Fitted Rates in 2012

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<th>US</th>
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<tbody>
<tr>
<td>32% LT</td>
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<tr>
<td>46% GT</td>
<td>13% GT</td>
<td>9% GT</td>
<td>RNC59</td>
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<tr>
<td>29% GT</td>
<td>11% LT</td>
<td>3% LT</td>
<td>NC</td>
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<tr>
<td>34% GT</td>
<td>8% LT</td>
<td>4% GT</td>
<td>US</td>
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</table>

R2 = 0.74
y = -0.60x + 35.97

R2 = 0.74
y = -0.54x + 26.27

R2 = 0.76
y = -0.56x + 29.01

R2 = 0.80
y = -0.44x + 26.72
Figure 6.6 iii. Diabetes Mellitus:
Trends in age-adjusted mortality rates by race and gender for ENC41,
1979-2012 with projections to 2020

NWM 14-yr trendline
18% decrease
R² = 0.33
y = -0.80x + 62.60

WM 14-yr trendline
11% decrease
R² = 0.20
y = -0.22x + 28.80

NWF 14-yr trendline
33% decrease
R² = 0.71
y = -1.49x + 62.47

WF 14-yr trendline
28% decrease
R² = 0.56
y = -0.46x + 22.67

Comparison of Fitted Rates in 1999

<table>
<thead>
<tr>
<th>Race</th>
<th>NWM</th>
<th>WM</th>
<th>NWF</th>
<th>WF</th>
</tr>
</thead>
<tbody>
<tr>
<td>117% GT</td>
<td>54% LT</td>
<td>0% LT</td>
<td>64% LT</td>
<td>NWM</td>
</tr>
<tr>
<td>0% GT</td>
<td>54% LT</td>
<td>11% GT</td>
<td>21% LT</td>
<td>WM</td>
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<tr>
<td>176% GT</td>
<td>27% GT</td>
<td>176% GT</td>
<td>NWF</td>
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Comparison of Fitted Rates in 2012

<table>
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<th>WM</th>
<th>NWF</th>
<th>WF</th>
</tr>
</thead>
<tbody>
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<td>50% LT</td>
<td>17% LT</td>
<td>68% LT</td>
<td>NWM</td>
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<tr>
<td>21% GT</td>
<td>40% LT</td>
<td>66% GT</td>
<td>36% LT</td>
<td>WM</td>
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<tr>
<td>213% GT</td>
<td>56% GT</td>
<td>159% GT</td>
<td>NWF</td>
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</tr>
<tr>
<td>153% GT</td>
<td>56% GT</td>
<td>199% GT</td>
<td>WF</td>
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</tr>
</tbody>
</table>
Figure 6.6 iv. Diabetes Mellitus:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline
27% decrease
R2 = 0.72
y = -1.23x + 63.09

W 14-yr trendline
20% decrease
R2 = 0.52
y = -0.37x + 25.52

1999 non-White rate is 147% greater than White
2012 non-White rate is 127% greater than White
Figure 6.6 v. Diabetes Mellitus:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
16% decrease
R2 = 0.12
y = -1.70x + 149.62
Alzheimer’s Disease

- The Alzheimer’s mortality rate for ENC shows a 96% increase over the 14 year period. ENC’s rate of increase was larger than RNC (38%) and NC (49%) but the rate trend for ENC still remains 30% less than RNC.

- In 2012, the age-adjusted rate trend for ENC has increased 64% over the 14 years. This is a larger increase than both RNC and NC (27% and 53% respectively), although those rates are higher.

- The mortality rates for females, both White and non-White, are greater than that of non-White and White males in an increasingly divergent 14-year trend.

- The non-White mortality rate for Alzheimer’s remains 3% less than the White mortality rate in 2012 but the 14-year trend suggests convergence in the near future.

- The 14-year moderately-reliable trend suggests a future increase in disparity that favors whites.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.7 i. Alzheimer’s Disease:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>ENC41 Rate</th>
<th>RNC59 Rate</th>
<th>NC Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>50% LT</td>
<td>69% GT</td>
<td>ENC41</td>
</tr>
<tr>
<td>2012</td>
<td>30% LT</td>
<td>8% LT</td>
<td>RNC59</td>
</tr>
</tbody>
</table>

Comparison of Fitted Rates in 1999
- ENC41: 99% GT
- RNC59: 69% GT
- NC: ENC41

Comparison of Fitted Rates in 2012
- ENC41: 42% GT
- RNC59: 30% GT
- NC: ENC41
Figure 6.7 ii. Alzheimer’s Disease: 
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 
1979-2012 with projections to 2020

- ENC41 14-yr trendline
  - 64% increase
  - R² = 0.86
  - y = 0.69x + 15.09

- RNC59 14-yr trendline
  - 27% increase
  - R² = 0.54
  - y = 0.49x + 25.68

- NC 14-yr trendline
  - 33% increase
  - R² = 0.69
  - y = 0.55x + 22.82

- US 12-yr trendline
  - 53% increase
  - R² = 0.88
  - y = 0.76x + 17.23

1999 ENC41 rate is 41% less than RNC59
2012 ENC41 rate is 25% less than RNC59
Figure 6.7 iii. Alzheimer’s Disease:
Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

- NWM 14-yr trendline
  - 92% increase
  - \( R^2 = 0.42 \)
  - \( y = 0.68x + 10.27 \)

- WM 14-yr trendline
  - 38% increase
  - \( R^2 = 0.48 \)
  - \( y = 0.37x + 13.57 \)

- NWF 14-yr trendline
  - 117% increase
  - \( R^2 = 0.76 \)
  - \( y = 1.01x + 12.07 \)

- WF 14-yr trendline
  - 57% increase
  - \( R^2 = 0.80 \)
  - \( y = 0.73x + 17.84 \)

<table>
<thead>
<tr>
<th>Year</th>
<th>NWM</th>
<th>WM</th>
<th>NWF</th>
<th>WF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>24% LT</td>
<td>12% GT</td>
<td>3% LT</td>
<td>24% LT</td>
</tr>
<tr>
<td>2012</td>
<td>4% LT</td>
<td>27% GT</td>
<td>8% LT</td>
<td>24% LT</td>
</tr>
</tbody>
</table>

Comparison of Fitted Rates in 1999
- NWM: 32% GT, 18% GT, 74% GT, 5% LT
- WM: 3% LT, 32% GT, 43% GT, 10% LT
- NWF: 4% GT, 37% GT, 48% GT, 14% LT
- WF: 24% LT, 27% LT, 8% LT, 24% LT

Comparison of Fitted Rates in 2012
- NWM: 3% LT, 32% GT, 43% GT, 5% LT
- WM: 4% GT, 37% GT, 48% GT, 10% LT
- NWF: 24% LT, 27% LT, 8% LT, 24% LT
- WF: 30% LT, 33% GT, 8% LT, 24% LT
Figure 6.7 iv. Alzheimer’s Disease:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline
110% increase
R^2 = 0.83
y = 0.91x + 11.59

W 14-yr trendline
51% increase
R^2 = 0.77
y = 0.59x + 16.49

1999 non-White rate is 30% less than White
2012 non-White rate is 3% less than White
Figure 6.7 v. Alzheimer’s Disease: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity

100% increase

$R^2 = 0.41$

$y = 2.58x - 35.99$
Unintentional Motor Vehicle Injuries

- ENC’s unintentional motor vehicle mortality rate trend is decreasing but is still 55% greater than RNC in 2012.

- The ENC age-adjusted rate trend is 55% greater than RNC and 60% greater than the US. Rates for ENC, RNC and NC are all decreasing.

- The trends for all groups are declining. The trend for non-White males is the highest. The trend for non-White females is the lowest and has decreased the most (42% over 14 years).

- The non-White rates have decreased by 34% over the 14-year period and converged with the White rates, suggesting a reversal in disparity within ENC.

- The trend for racial disparity is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.8 i. Unintentional Motor Vehicle Injuries: Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020.

ENC41 14-yr trendline
30% decrease
R2 = 0.63
y = -0.59x + 27.27

RNC59 14-yr trendline
40% decrease
R2 = 0.83
y = -0.57x + 20.03

NC 14-yr trendline
37% decrease
R2 = 0.80
y = -0.59x + 22.19

Comparison of Fitted Rates in 1999
ENC41: 36% LT 19% LT ENC41
RNC59: 27% LT 11% GT RNC59
NC: 23% GT 10% LT NC

Comparison of Fitted Rates in 2012
ENC41: 36% LT 11% GT ENC41
RNC59: 36% LT 16% LT RNC59
NC: 34% GT 14% LT NC

1999 ENC41 rate is 36% greater than RNC59
2012 ENC41 rate is 55% greater than RNC59
Figure 6.8 ii. Unintentional Motor Vehicle Injuries: Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
31% decrease
R² = 0.64
y = -0.60x + 27.19

RNC59 14-yr trendline
40% decrease
R² = 0.83
y = -0.58x + 20.00

NC 14-yr trendline
37% decrease
R² = 0.80
y = -0.59x + 22.15

US 12-yr trendline
25% decrease
R² = 0.66
y = -0.35x + 16.62
Figure 6.8 iii. Unintentional Motor Vehicle Injuries: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

<table>
<thead>
<tr>
<th>Race</th>
<th>Trendline</th>
<th>Decrease</th>
<th>R²</th>
<th>Equation</th>
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<tbody>
<tr>
<td>NWM</td>
<td>14-yr</td>
<td>32%</td>
<td>0.40</td>
<td>y = -1.00x + 44.18</td>
</tr>
<tr>
<td>WM</td>
<td>14-yr</td>
<td>29%</td>
<td>0.47</td>
<td>y = -0.77x + 36.73</td>
</tr>
<tr>
<td>NWF</td>
<td>14-yr</td>
<td>42%</td>
<td>0.69</td>
<td>y = -0.50x + 16.40</td>
</tr>
<tr>
<td>WF</td>
<td>14-yr</td>
<td>29%</td>
<td>0.39</td>
<td>y = -0.35x + 16.46</td>
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</table>

Comparison of Fitted Rates in 1999:

<table>
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<tr>
<th>Race</th>
<th>17% LT</th>
<th>63% LT</th>
<th>63% LT</th>
<th>NWM</th>
</tr>
</thead>
<tbody>
<tr>
<td>NWM</td>
<td>20% GT</td>
<td>55% LT</td>
<td>55% LT</td>
<td>WM</td>
</tr>
<tr>
<td>WM</td>
<td>169% GT</td>
<td>124% GT</td>
<td>0% GT</td>
<td>NWF</td>
</tr>
<tr>
<td>NWF</td>
<td>168% GT</td>
<td>123% GT</td>
<td>0% LT</td>
<td>WF</td>
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Comparison of Fitted Rates in 2012:

<table>
<thead>
<tr>
<th>Race</th>
<th>14% LT</th>
<th>68% LT</th>
<th>62% LT</th>
<th>NWM</th>
</tr>
</thead>
<tbody>
<tr>
<td>NWM</td>
<td>16% GT</td>
<td>63% LT</td>
<td>55% LT</td>
<td>WM</td>
</tr>
<tr>
<td>WM</td>
<td>212% GT</td>
<td>168% GT</td>
<td>20% GT</td>
<td>NWF</td>
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<tr>
<td>NWF</td>
<td>160% GT</td>
<td>124% GT</td>
<td>17% LT</td>
<td>WF</td>
</tr>
</tbody>
</table>
Figure 6.8 iv. Unintentional Motor Vehicle Injuries:
Trends in age-adjusted mortality rates by race for ENC41,
1979-2012 with projections to 2020

NW 14-yr trendline
34% decrease
R2 = 0.62
y = -0.71x + 28.84

W 14-yr trendline
29% decrease
R2 = 0.48
y = -0.55x + 26.54

1999 non-White rate is 9% greater than White
2012 non-White rate is 1% greater than White
Figure 6.8 v. Unintentional Motor Vehicle Injuries: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity

R^2 = 0.02
y = -0.49x + 9.02
Nephritis, Nephrotic Syndrome, and Nephrosis

- Mortality due to nephritis, nephrotic syndrome, and nephrosis in ENC has increased by 26% over 14 years. While other regions have also experienced increases during this time period, ENC rates have increased more, and were 18% greater than RNC in 2012.

- With age-adjustment, ENC has increased by 9% over the 14-year period.

- The 14 year trends for non-White males and females are continually above those for White males and females but are not reliable. The demographic group with the greatest rate of increase is White males, increasing 29% over 14 years.

- In 2012, the non-White rate trend was 125% greater than the White rate, but it is not a reliable trend.

- The trend for racial disparity is moderately reliable and suggests a 19% decrease in racial disparity.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.9 i. Nephritis, Nephrotic Syndrome, and Nephrosis:
Trends in mortality rates for ENC41, RNC59, and NC,
1979-2012 with projections to 2020

<table>
<thead>
<tr>
<th>Year</th>
<th>ENC41</th>
<th>RNC59</th>
<th>NC</th>
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Comparison of Fitted Rates in 1999

<table>
<thead>
<tr>
<th>ENC41</th>
<th>RNC59</th>
<th>NC</th>
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<tbody>
<tr>
<td>10% GT</td>
<td>9% LT</td>
<td>ENC41</td>
</tr>
<tr>
<td>7% GT</td>
<td>3% LT</td>
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Comparison of Fitted Rates in 2012

<table>
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<tr>
<th>ENC41</th>
<th>RNC59</th>
<th>NC</th>
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<tbody>
<tr>
<td>18% GT</td>
<td>15% LT</td>
<td>ENC41</td>
</tr>
<tr>
<td>12% GT</td>
<td>5% LT</td>
<td>NC</td>
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</tbody>
</table>
Figure 6.9 ii. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
9% increase
R2 = 0.14
y = 0.13x + 19.18

RNC59 14-yr trendline
8% increase
R2 = 0.11
y = 0.10x + 16.03

NC 14-yr trendline
9% increase
R2 = 0.12
y = 0.10x + 16.92

US 12-yr trendline
16% increase
R2 = 0.86
y = 0.17x + 13.37

1999 ENC41 rate is 20% greater than RNC59
2012 ENC41 rate is 21% greater than RNC59

Comparison of Fitted Rates in 1999

ENC41 RNC59 NC US
20% GT 16% LT 12% LT 30% LT ENC41
13% GT 6% GT 17% LT RNC59
43% GT 5% LT 21% LT NC

Comparison of Fitted Rates in 2012

ENC41 RNC59 NC US
21% GT 17% LT 12% LT 25% LT ENC41
14% GT 5% LT 6% GT 10% LT RNC59
33% GT 11% GT 17% GT US
Figure 6.9 iii. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

NWM 14-yr trendline
WM 14-yr trendline
NWF 14-yr trendline
WF 14-yr trendline

29% increase

R² = 0.04
y = 0.18x + 36.74

R² = 0.32
y = 0.32x + 15.47

R² = 0.00
y = -0.02x + 32.10

R² = 0.00
y = 0.01x + 12.31

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 6.9 iv. Nephritis, Nephrotic Syndrome, and Nephrosis:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

1999 non-White rate is 148% greater than White
2012 non-White rate is 125% greater than White

NW 14-yr trendline
W 14-yr trendline
15% increase

R2 = 0.02
y = 0.08x + 33.63
R2 = 0.18
y = 0.14x + 13.55
Figure 6.9 v. Nephritis, Nephrotic Syndrome, and Nephrosis: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
19% decrease
R2 = 0.12
y = -2.03x + 150.86
Pneumonia and Influenza

- Mortality due to pneumonia and influenza is decreasing (32%) over the 14 year period for ENC, NC, and RNC. The rate trend for ENC is slightly below the rates for the others.

- The age-adjusted mortality rates for ENC, RNC and NC are decreasing. For the 14-year trend line ENC has the largest decrease at 44%.

- The trends for all demographic groups are declining. The decrease for non-White males was highest (52%), which was followed by White males (47%), non-White females (45%), and White females (40%).

- In 1999 the non-White rate trend was 1% greater than the White rate, but by 2012, the non-White rate trend was 8% less than the White rate.

- The trend for racial disparity is unreliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.10 i. Pneumonia and Influenza:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline: 32% decrease, \( R^2 = 0.72 \)
\[ y = -0.52x + 22.65 \]

RNC59 14-yr trendline: 32% decrease, \( R^2 = 0.74 \)
\[ y = -0.57x + 25.50 \]

NC 14-yr trendline: 32% decrease, \( R^2 = 0.77 \)
\[ y = -0.56x + 24.65 \]

1999 ENC41 rate is 11% less than RNC59
2012 ENC41 rate is 12% less than RNC59

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Figure 6.10 ii. Pneumonia and Influenza:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

- ENC41 14-yr trendline: 44% decrease
  \[ R^2 = 0.83 \]
  \[ y = -0.83x + 26.48 \]

- RNC59 14-yr trendline: 37% decrease
  \[ R^2 = 0.84 \]
  \[ y = -0.71x + 26.63 \]

- NC 14-yr trendline: 39% decrease
  \[ R^2 = 0.87 \]
  \[ y = -0.75x + 26.61 \]

- US 12-yr trendline: 39% decrease
  \[ R^2 = 0.92 \]
  \[ y = -0.83x + 25.44 \]

1999 ENC41 rate is 1% less than RNC59
2012 ENC41 rate is 10% less than RNC59

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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Figure 6.10 iii. Pneumonia and Influenza: Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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<td>GT</td>
<td>43%</td>
<td>33%</td>
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<td>13%</td>
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</table>
Figure 6.10 iv. Pneumonia and Influenza: Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline
49% decrease
R² = 0.67
y = -0.93x + 26.80

W 14-yr trendline
43% decrease
R² = 0.85
y = -0.80x + 26.42

1999 non-White rate is 1% greater than White
2012 non-White rate is 8% less than White
Figure 6.10 v. Pneumonia and Influenza: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity

\[ R^2 = 0.07 \]
\[ y = -0.91x + 2.08 \]
7. Trends and Disparities in Mortality in ENC41: Cancer - All Sites and HIV Disease; 1979-2012
Cancer - All Sites

- The cancer – all sites mortality rates for ENC have decreased slightly (4%) over 14 years. The RNC and NC rates have decreased more than ENC, causing these rates to diverge.

- The age-adjusted cancer – all sites mortality rates for ENC, RNC, NC and the US are all decreasing at about the same pace, although the ENC rate trend is 8% greater than RNC, and 10% greater than the US.

- The rates for non-White males has decreased 31% over 14 years, and is projected to converge with the rate for White males, which show a 21% decrease. The rates for White females and non-White females show a slight decrease and are converging.

- Both White and non-White cancer mortality trends are decreasing over the 14 year period, although the non-White rate remains higher. Non-White rates decreased 24% and White rates decreased 15%, suggesting future convergence.

- The moderately reliable 14-year trend for racial disparity shows a 60% decrease.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 7.1 i. Cancer - All Sites:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

ENC41 14-yr trendline
RNC59 14-yr trendline
NC 14-yr trendline

4% decrease
R² = 0.42
y = -0.64x + 206.95

9% decrease
R² = 0.68
y = -1.30x + 199.11

8% decrease
R² = 0.71
y = -1.12x + 201.46

1999 ENC41 rate is 4% greater than RNC59
2012 ENC41 rate is 9% greater than RNC59

Comparison of Fitted Rates in 1999

ENC41 | RNC59 | NC
--- | --- | ---
4% LT | 3% LT | ENC41

Comparison of Fitted Rates in 2012

ENC41 | RNC59 | NC
--- | --- | ---
8% LT | 6% LT | ENC41

6% GT | 2% LT | NC

Report #2.203, August 2014  
Center for Health Systems Research and Development, ECU
Figure 7.1 ii. Cancer - All Sites:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
18% decrease
R² = 0.92
y = -2.85x + 222.31

RNC59 14-yr trendline
16% decrease
R² = 0.95
y = -2.37x + 202.02

NC 14-yr trendline
17% decrease
R² = 0.96
y = -2.52x + 207.92

US 12-yr trendline
16% decrease
R² = 0.99
y = -2.75x + 204.37

1999 ENC41 rate is 10% greater than RNC59
2012 ENC41 rate is 8% greater than RNC59

Comparison of Fitted Rates in 1999

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1999 ENC41 rate is 10% greater than RNC59
2012 ENC41 rate is 8% greater than RNC59
Figure 7.1 iii. Cancer - All Sites:
Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

Comparison of Fitted Rates in 1999

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Comparison of Fitted Rates in 2012

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<td>24% LT</td>
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<td>278</td>
<td>176</td>
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R2 = 0.78
y = -8.12x + 371.50
31% decrease

R2 = 0.93
y = -4.21x + 275.81
21% decrease

R2 = 0.53
y = -2.30x + 185.17
17% decrease

R2 = 0.55
y = -1.31x + 167.82
11% decrease
Figure 7.1 iv. Cancer - All Sites:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

NW 14-yr trendline
24% decrease
R² = 0.77
y = -4.30x + 252.20

W 14-yr trendline
15% decrease
R² = 0.90
y = -2.31x + 210.27

1999 non-White rate is 20% greater than White
2012 non-White rate is 9% greater than White

Age-adjusted mortality rate per 100,000 population
Figure 7.1 v. Cancer - All Sites: Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
60% decrease
$R^2 = 0.32$
y = -0.87x + 20.43
HIV Disease

- The fitted HIV mortality rate for ENC has been decreasing over the past 14 years, but was still 67% greater than RNC in 2012.
- The 14 year age-adjusted rate trend for ENC had a 47% decrease. The 2012 ENC rate is 75% greater than RNC.
- Non-White males continue to have the highest rates of age-adjusted mortality, but this rate has also decreased 55% in a 14-year reliable trend. The White male rate decreased 46% during that same period and the rate for non-White females decreased 28%. A convergence of the non-White male rate with other rates is expected in the future.
- The 14-year non-White age-adjusted HIV mortality rate has decreased by 47% in a reliable trend. The age-adjusted mortality rate for Whites decreased by 49%, although the absolute rate for this group is much lower.
- In a moderately reliable trend, the 14-year period shows a 22% increase in racial disparity.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 7.2 i. HIV Disease:
Trends in mortality rates for ENC41, RNC59, and NC, 1979-2012 with projections to 2020

- ENC41 14-yr trendline: 44% decrease, $R^2 = 0.72$, $y = -0.23x + 7.28$
- RNC59 14-yr trendline: 63% decrease, $R^2 = 0.97$, $y = -0.28x + 6.28$
- NC 14-yr trendline: 57% decrease, $R^2 = 0.97$, $y = -0.27x + 6.58$

1999 ENC41 rate is 16% greater than RNC59
2012 ENC41 rate is 67% greater than RNC59

Comparison of Fitted Rates in 1999:
- ENC41: 14% LT
- RNC59: 10% LT
- NC: ENC41

Comparison of Fitted Rates in 2012:
- ENC41: 40% LT
- RNC59: 29% LT
- NC: ENC41
Figure 7.2 ii. HIV Disease:
Trends in age-adjusted mortality rates for ENC41, RNC59, NC, and US, 1979-2012 with projections to 2020

ENC41 14-yr trendline
**47% decrease**
R² = 0.76
y = -0.25x + 7.53

RNC59 14-yr trendline
**65% decrease**
R² = 0.98
y = -0.29x + 6.16

NC 14-yr trendline
**60% decrease**
R² = 0.97
y = -0.28x + 6.56

US 12-yr trendline
**50% decrease**
R² = 0.97
y = -0.24x + 5.78

1999 ENC41 rate is 22% greater than RNC59
2012 ENC41 rate is 75% greater than RNC59

Comparison of Fitted Rates in 1999

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<th>ENC41</th>
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Comparison of Fitted Rates in 2012

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Figure 7.2 iii. HIV Disease:
Trends in age-adjusted mortality rates by race and gender for ENC41, 1979-2012 with projections to 2020

- NWM 14-yr trendline: 55% decrease
  - \( R^2 = 0.82 \)
  - \( y = -1.14x + 28.85 \)

- WM 14-yr trendline: 46% decrease
  - \( R^2 = 0.52 \)
  - \( y = -0.10x + 3.14 \)

- NWF 14-yr trendline: 28% decrease
  - \( R^2 = 0.30 \)
  - \( y = -0.22x + 10.92 \)

- WF 14-yr trendline: 49% decrease
  - \( R^2 = 0.20 \)
  - \( y = -0.03x + 0.87 \)

Comparison of Fitted Rates in 1999

<table>
<thead>
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<th>Race</th>
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<td>818% GT</td>
<td>89% LT</td>
<td>62% LT</td>
<td>97% LT</td>
<td>NWM</td>
</tr>
<tr>
<td>164% GT</td>
<td>71% LT</td>
<td>72% LT</td>
<td>NWF</td>
<td></td>
</tr>
<tr>
<td>3214% GT</td>
<td>261% GT</td>
<td>1155% GT</td>
<td>WF</td>
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</tbody>
</table>

Comparison of Fitted Rates in 2012

<table>
<thead>
<tr>
<th>Race</th>
<th>NWM</th>
<th>WM</th>
<th>NWF</th>
<th>WF</th>
</tr>
</thead>
<tbody>
<tr>
<td>682% GT</td>
<td>87% LT</td>
<td>42% LT</td>
<td>97% LT</td>
<td>NWM</td>
</tr>
<tr>
<td>73% GT</td>
<td>78% LT</td>
<td>94% LT</td>
<td>NWF</td>
<td></td>
</tr>
<tr>
<td>2823% GT</td>
<td>274% GT</td>
<td>1585% GT</td>
<td>WF</td>
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</tbody>
</table>
Figure 7.2 iv. HIV Disease:
Trends in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

- NW 14-yr trendline: 47% decrease, \( R^2 = 0.73 \), \( y = -0.63x + 18.92 \)
- W 14-yr trendline: 49% decrease, \( R^2 = 0.68 \), \( y = -0.07x + 2.03 \)

1999 non-White rate is 834% greater than White
2012 non-White rate is 870% greater than White
Figure 7.2 v. HIV Disease:
Measuring disparity in age-adjusted mortality rates by race for ENC41, 1979-2012 with projections to 2020

Racial Disparity
22% increase
$R^2 = 0.16$
y = 13.12x + 790.77
# 8. Appendix

<table>
<thead>
<tr>
<th>Disease</th>
<th>ICD 10 Code</th>
<th>ICD 9 Code</th>
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</thead>
<tbody>
<tr>
<td>Diseases of Heart</td>
<td>I00-I09, I11, I13, I20-I51</td>
<td>390-398, 402, 404, 410-429</td>
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<tr>
<td>Cerebrovascular Disease</td>
<td>I60-I69</td>
<td>430-434, 436-438</td>
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<tr>
<td>Atherosclerosis</td>
<td>I70</td>
<td>440</td>
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<tr>
<td>Cancer - All Sites</td>
<td>C00-C97</td>
<td>140-208</td>
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<tr>
<td>Cancer - Lip, Oral Cavity, and Pharynx</td>
<td>C00-C14</td>
<td>140-149</td>
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<tr>
<td>Cancer - Stomach</td>
<td>C16</td>
<td>151</td>
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<tr>
<td>Cancer - Colon, Rectum, and Anus</td>
<td>C18-C21</td>
<td>153-154</td>
</tr>
<tr>
<td>Cancer - Liver</td>
<td>C22</td>
<td>155</td>
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<tr>
<td>Cancer - Pancreas</td>
<td>C25</td>
<td>157</td>
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<tr>
<td>Cancer - Larynx</td>
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<tr>
<td>Cancer - Trachea, Bronchus, and Lung</td>
<td>C33-C34</td>
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<td>Cancer - Malignant Melanoma of Skin</td>
<td>C43</td>
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<td>Cancer - Breast</td>
<td>C50</td>
<td>174-175</td>
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<td>Cancer - Cervix Uteri</td>
<td>C53</td>
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<td>Cancer - Ovary</td>
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<td>Cancer - Prostate</td>
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<tr>
<td>Cancer - Bladder</td>
<td>C67</td>
<td>188</td>
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<tr>
<td>Cancer - Brain</td>
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<td>189</td>
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<tr>
<td>Cancer - Non-Hodgkin's Lymphoma</td>
<td>C82-C85</td>
<td>200, 202</td>
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<td>Cancer - Leukemia</td>
<td>C91-C95</td>
<td>204-208</td>
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<td>HIV Disease</td>
<td>B20-B24</td>
<td>042-044</td>
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<td>Septicemia</td>
<td>A40-A41</td>
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<td>Diabetes Mellitus</td>
<td>E10-E14</td>
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<tr>
<td>Pneumonia and Influenza</td>
<td>J10-J18</td>
<td>480-487</td>
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<tr>
<td>Chronic Lower Respiratory Diseases</td>
<td>J40-J47</td>
<td>490-494, 496</td>
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<tr>
<td>Chronic Liver Disease and Cirrhosis</td>
<td>K70, K73-K74</td>
<td>571</td>
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<tr>
<td>Nephritis, Nephrotic Syndrome, and Nephrosis</td>
<td>N00-N07, N17-N19, N25-N27</td>
<td>580-589</td>
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<tr>
<td>Unintentional Motor Vehicle Injuries</td>
<td>V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2</td>
<td>E810-E825</td>
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<tr>
<td>All Other Unintentional Injuries and Adverse Effects</td>
<td>V01, V05-V06, V09.1, V09.3-V09.9, V10-V11, V15-V18, V19.3, V19.8-V19.9, V80.0-V80.2, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V87.9, V88.9, V89.1, V89.3, V89.9, V90-V99, W00-X59, Y85, Y86</td>
<td>E800-E807,E826-E829,E830-E848,E928,E928.2,E929.1,E850-E869,E880-E899</td>
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<td>Suicide</td>
<td>X60-X84, Y87.0</td>
<td>E950-E959</td>
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<tr>
<td>Homicide</td>
<td>X85-Y09, Y87.1</td>
<td>E960-E969</td>
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<tr>
<td>Legal Intervention</td>
<td>Y35, Y89.0</td>
<td>E970-E978</td>
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<tr>
<td>Alzheimer's Disease</td>
<td>G30</td>
<td>331.0</td>
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