

**Behavioral Risk Factor Surveillance System
Fact Sheets
Tennessee, 2005**

Tennessee Department of Health
Office of Policy, Planning and Assessment
Surveillance, Epidemiology and Evaluation

INTRODUCTION

Established in 1984 by the Centers for Disease Control and Prevention (CDC), the Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. The data collected helps to identify high risk populations that can be targeted by intervention programs. In addition, the data can also be used to track changes in the prevalence of risk factors and diseases over time and to assess the impact of health promotion and disease prevention programs.

The BRFSS is a cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC. Every year, states conduct monthly telephone surveillance using a standardized questionnaire to determine the distribution of risk behaviors and health practices among non-institutionalized adults. Adults 18 years or older are asked to take part in the survey. Only one adult is interviewed per household, and participants are not compensated. In 2005, approximately 4,700 Tennesseans participated in the survey. BRFSS data are directly weighted for the probability of selection of a telephone number, the number of adults in a household, and the number of telephones in a household. A final post-stratification adjustment is made for non-response and non-coverage of households without telephones. The weights for each relevant factor are multiplied together to get a final weight.

The data presented in these fact sheets includes comparisons across gender, race, age, education, income and other variables. The confidence intervals provided in the fact sheets should be considered when comparing the prevalence of variables across groups -- if confidence intervals overlap, differences may not be statistically significant. It should also be noted that the terms “white “ and “black” used in the fact sheets refer to individuals of non-Hispanic origin.

Source:

The Centers for Disease Control and Prevention, “Behavioral Risk Factor Surveillance System,” <http://www.cdc.gov/brfss/> (accessed 13 April, 2007).

Alcohol Consumption

Arthritis

Asthma

Breast Cancer Screening

Cervical Cancer Screening

Cigarette Smoking

Coronary Heart Disease

Diabetes

Diabetes Management

Flu and Pneumonia Vaccination

Fruit and Vegetable Consumption

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High Blood Pressure

High Cholesterol

Overweight and Obesity

Physical Activity

Sexual Violence

Stroke

Symptoms of Heart Attack and Stroke

Vision Impairment

BRFSS Fact Sheet

Alcohol Consumption



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A substantial proportion of the population drinks alcohol.¹ Although light-to-moderate drinking may have beneficial effects on the heart, particularly among those at greatest risk for heart attacks, heavy drinking can increase risk for high blood pressure, stroke, liver disorders and certain forms of cancer.¹ In addition, alcohol is an important factor in motor vehicle crashes, homicide, suicide, marital violence, child abuse and high-risk sexual behavior.¹ Two of the Healthy People 2010 objectives are to decrease the proportion of adults who exceed guidelines for low-risk drinking and the proportion who engage in binge drinking to 50% and 6%, respectively.¹ Reaching these goals is important for increasing the quality and years of healthy life for all Tennesseans.

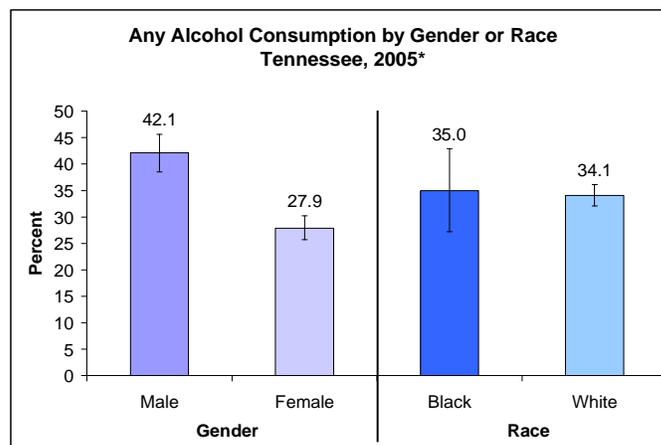
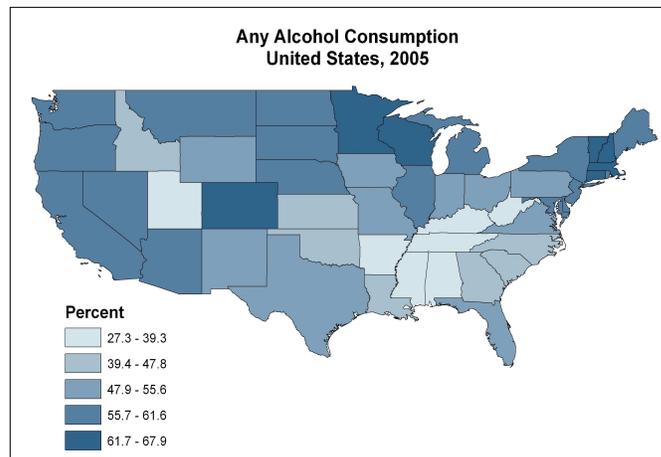
- In 2005, 34.7% of adult Tennesseans reported drinking at least one alcoholic beverage (beer, malt beverages, wine or liquor) in the past 30 days, compared to 56.2% for the United States.² Among all 50 states, Tennessee had the 3rd lowest prevalence of alcohol consumption.

- The prevalence of heavy drinking in Tennessee was 3.4%, and the prevalence of binge drinking was 8.6%. This was slightly lower than for the United States as a whole (4.9% and 14.4%, respectively).²

- The prevalence of any alcohol consumption was similar in blacks (35.0%) and in whites (34.1%). Binge drinking was more common in blacks (13.6% ± 6.5)* than in whites (7.7% ± 1.1).

- Alcohol consumption was more common among males (42.1%) than among females (27.9%).

- Although the legal drinking age in Tennessee is 21 years, 21.5% of 18-20 year olds reported that they had at least one alcoholic beverage in the past 30 days.



Definitions:

Heavy Drinking:

Men having more than 2 drinks per day and women having more than 1 drink per day.

Binge Drinking:

Having more than 5 drinks on one occasion.

References:

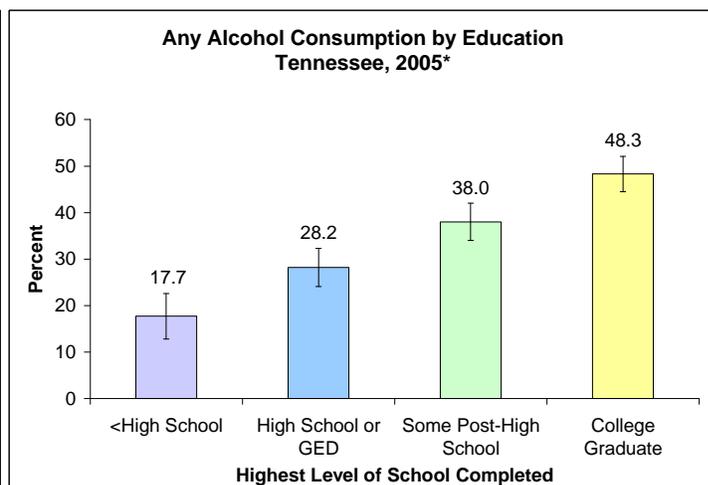
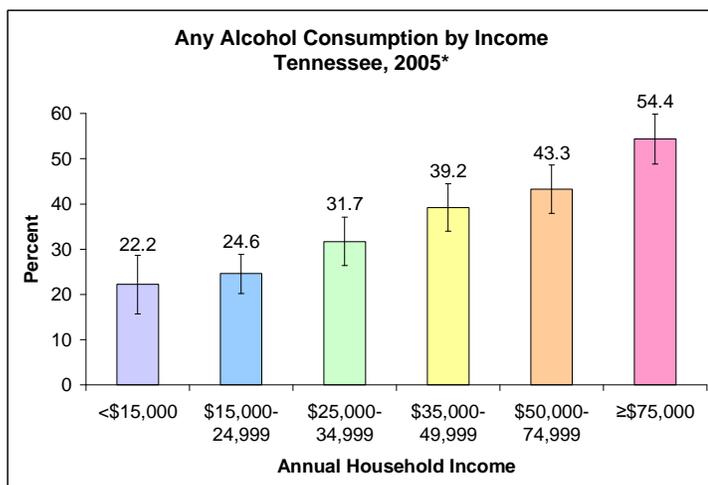
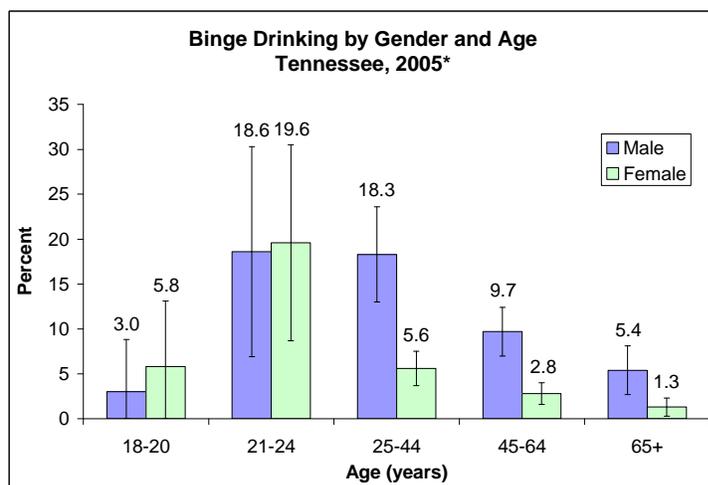
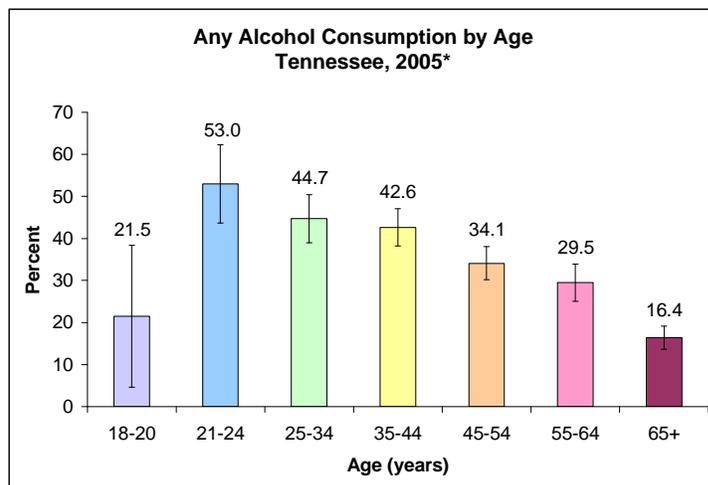
1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
2. Centers for Disease Control and Prevention (www.cdc.gov/brfss)

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

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Alcohol Consumption

- Alcohol consumption decreased with increasing age, from 53.0% among 21-24 year olds to 16.4% among those 65 years and older.
- Among females, binge drinking was most common among those 21-24 years of age. Among males, binge drinking was most common among those 21-44 years of age.
- Alcohol consumption increased with increasing education level, from 17.7% among those who did not graduate from high school to 48.3% among college graduates.
- Alcohol consumption also increased with increasing annual household income, from 22.2% among those with an income of less than \$15,000 to 54.4% among those with an income of \$75,000 or more.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Arthritis



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Arthritis is highly prevalent among U.S. adults and is the leading cause of disability.¹ As the population ages, arthritis is expected to affect an estimated 67 million adults (25% of the adult population) by the year 2030.² This estimate may be conservative as it does not account for current trends in obesity which may contribute to future cases of osteoarthritis.² Early diagnosis and appropriate management of arthritis can help decrease pain and improve function and quality of life. Management may include maintaining a healthy weight, physical activity, medications and surgery.² Appropriate management is important for increasing the quality and years of healthy life among all Tennesseans with arthritis.

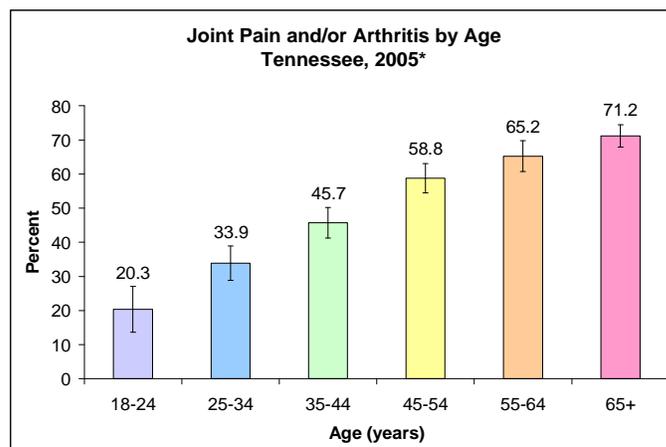
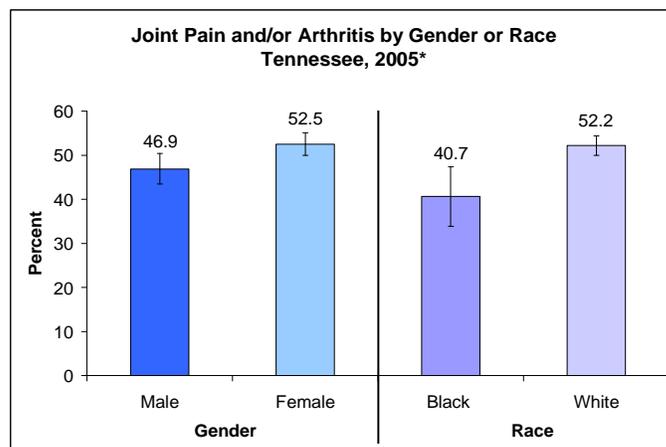
- In 2005, 45.2% (± 2.1)* of Tennessee adults reported symptoms of pain, aching or stiffness in or around a joint during the past 30 days. 29.7% (± 1.7) reported having been diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus or fibromyalgia, compared to 27.0% for the United States.³
- 75.5% (± 2.4) of persons with joint pain in the past 30 days reported that their symptoms began more than 3 months ago, and 75.5% (± 2.9) reported that they had seen a health care provider about their symptoms.

- The prevalence of joint pain and/or arthritis was slightly higher among females (52.5%) than among males (46.9%).

- The prevalence of joint pain and/or arthritis was higher among whites (52.2%) than among blacks (40.7%).

- The percentage of persons with joint pain and/or arthritis increased with increasing age. Approximately three-quarters of adults aged 65 years and older reported they had joint pain and/or arthritis.

- The prevalence of joint pain and/or arthritis was highest among those with less than a high school education (66.0%).



References:

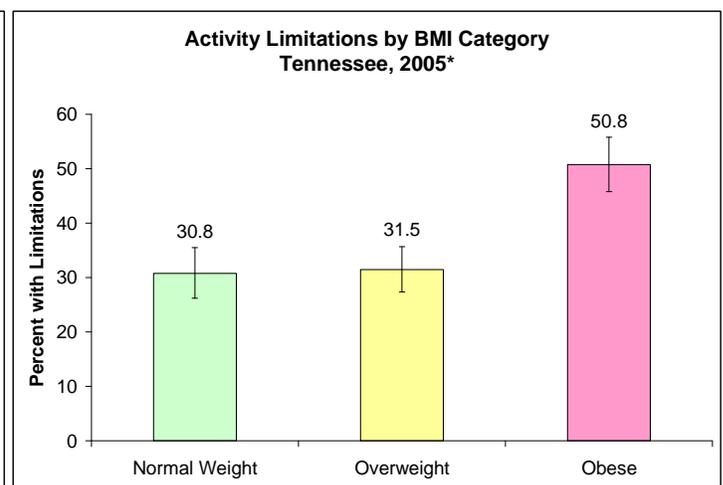
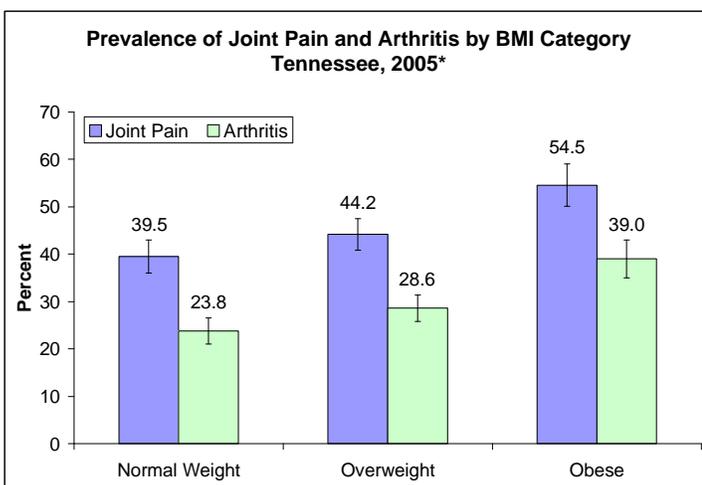
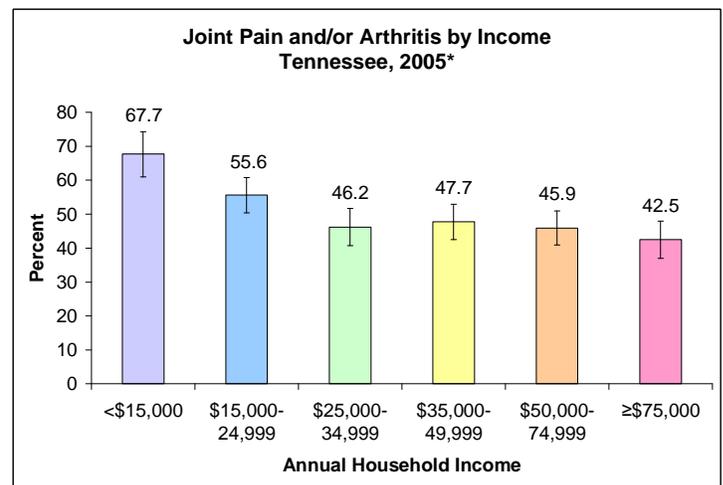
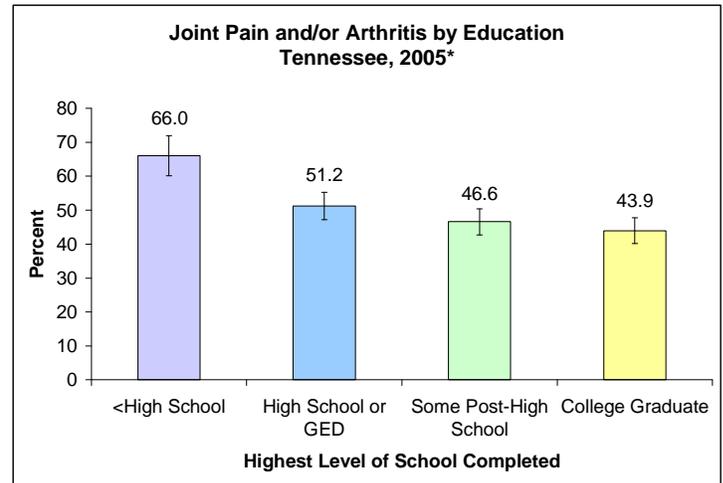
1. CDC. Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation – U.S., 2003-2005. *MMWR* 2006; 55(40).
2. Centers for Disease Control and Prevention (www.cdc.gov/arthritis)
3. Centers for Disease Control and Prevention (www.cdc.gov/brfss)

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Arthritis

- Adults with an annual household income of less than \$15,000 had the highest prevalence of joint pain and/or arthritis (67.7%). There were only small variations in the percentage of persons with these conditions among those with an annual income of \$25,000 or more.
- The prevalence of joint pain and of arthritis increased with increasing BMI. Adults with normal weight had the lowest prevalence (39.5% and 23.8%, respectively) and those who were obese had the highest (54.5% and 39.0%).
- 37.8% of adults with arthritis and/or joint pain reported limitations in their usual activities. Activity limitations were more common among obese persons (50.8%) than among those who were normal weight or overweight (30.8% and 31.5%, respectively).
- Physical activity can decrease pain, improve function and delay disability in persons with arthritis.² 55.7% (± 3.1) of adults with arthritis reported engaging in physical activity or exercise in the past 30 days, compared to 72.0% (± 2.5) of those without arthritis.
- 31.0% (± 2.3) of adults with joint pain and/or arthritis reported being in fair or poor health, compared to just 8.1% (± 1.6) of those without these conditions.



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BRFSS Fact Sheet

Asthma



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In 2002, an estimated 20 million Americans had asthma, and the disease was responsible for 11.8 million lost work days, 1.9 million emergency room visits and 4,261 deaths.¹ Yet most of the problems caused by asthma could be averted if persons with asthma and their doctors managed the disease according to established guidelines.² Effective management of asthma includes regular doctor visits, taking asthma medications as prescribed and limiting exposure to asthma triggers such as tobacco smoke, dust or perfumes.³ One of the Healthy People 2010 goals is to promote respiratory health through better prevention, detection, treatment and education efforts.² Appropriate care and improved education of asthma patients are important for reaching this goal and for increasing the quality and years of healthy life among all Tennesseans with asthma.

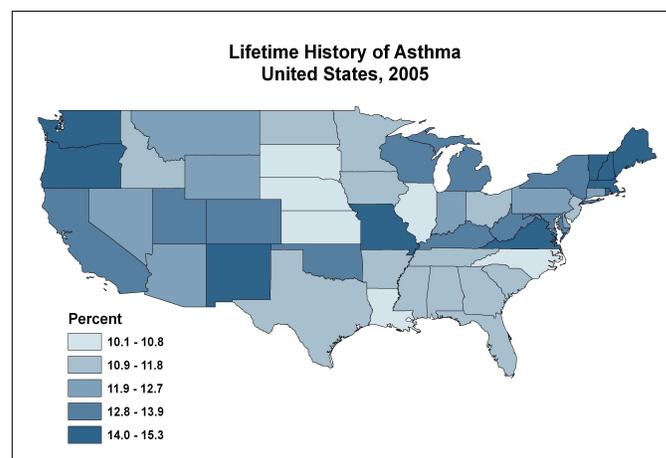
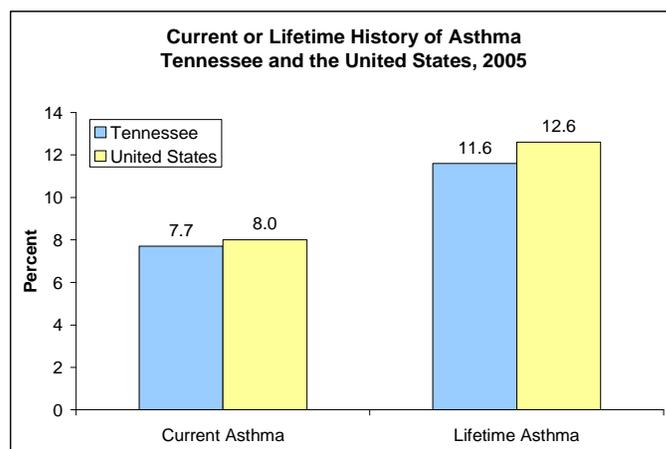
- In 2005, 11.6% of adult Tennesseans reported having *ever* been told by a healthcare provider that they had asthma (i.e. lifetime history of asthma), compared to 12.6% for the United States.⁴ 7.7% reported that they *currently* have asthma, compared to 8.0% for the United States.⁴

- Among all 50 states, the prevalence of ever having asthma ranged from 10.1% in Louisiana to 15.3% in Rhode Island.⁴

- Among adults with a lifetime history of asthma, 67.7% (± 6.2)* reported that they *still* have asthma.

- The percentage of persons who had ever been told they had asthma was highest among black females (18.8%), followed by white females (12.8%) and by black and white males (9.5% and 9.4%, respectively).

- There were only small variations in lifetime history of asthma among different age groups.



References:

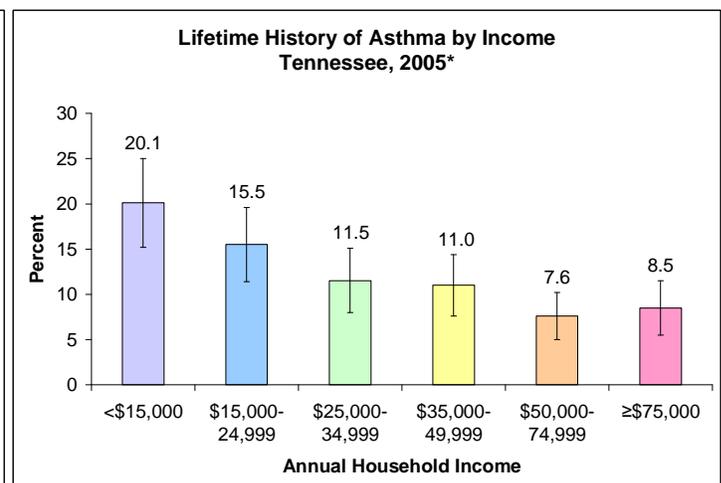
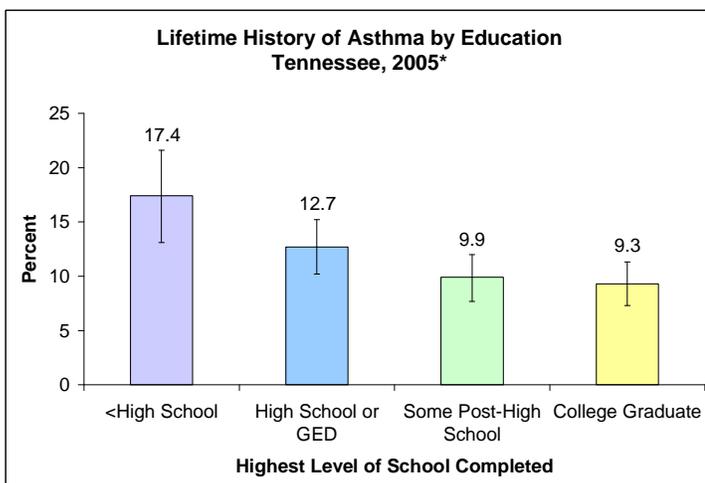
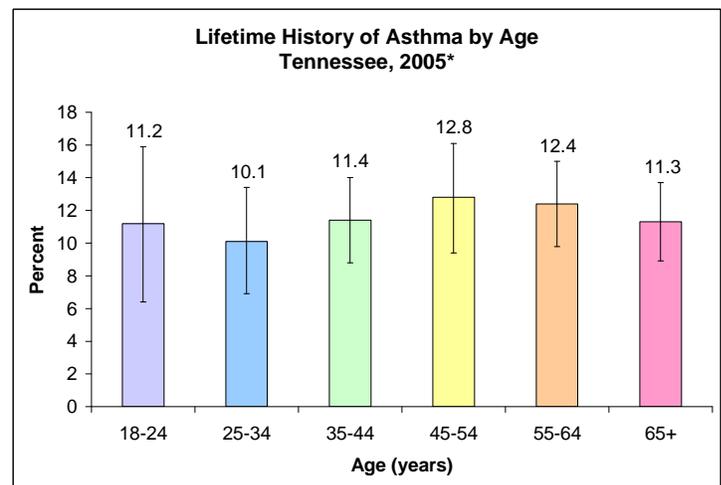
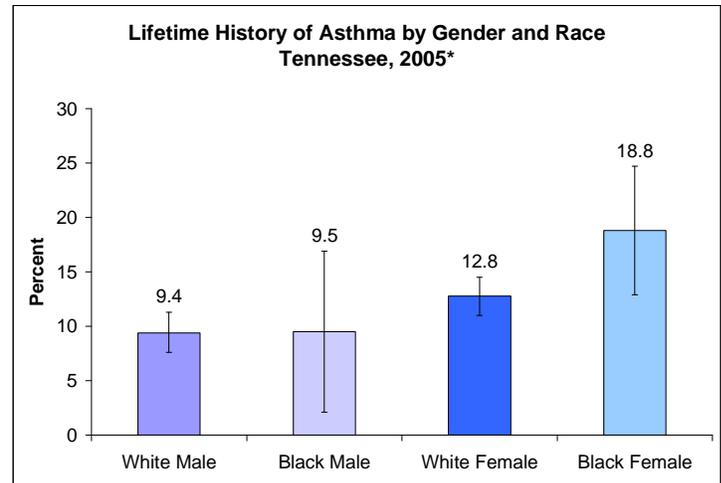
1. National Center for Health Statistics (www.cdc.gov/nchs)
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
3. American Lung Association (www.lungusa.org)
4. Centers for Disease Control and Prevention (www.cdc.gov/brfss)

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Asthma

- The percentage of persons who had ever been told they had asthma decreased with increasing education level, from 17.4% among those with less than a high school education to 9.3% among college graduates.
- The percentage of persons who had ever been told they had asthma decreased with increasing annual household income, from 20.1% among those with an income of less than \$15,000 to approximately 7-9% among those with an income of \$50,000 or more.



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Breast Cancer Screening



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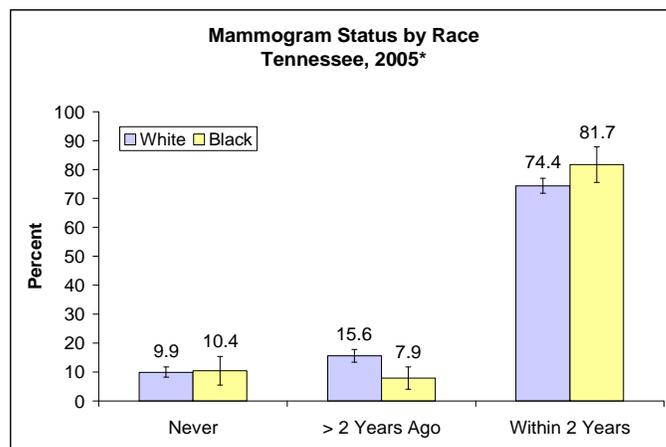
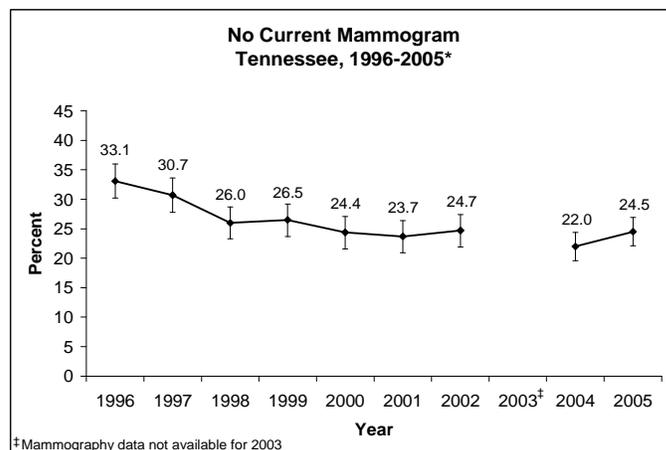
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Between 1999 and 2003, breast cancer was the most common form of cancer and the second most common cause of cancer death among women in Tennessee.¹ A mammogram is an x-ray of the breast that is used as a screening tool to detect early breast cancer. Finding breast cancer early means greater treatment options and a better chance of cure and survival.² The United States Preventive Services Task Force recommends screening mammography, with or without a clinical breast exam, every 1-2 years for women aged 40 and older.³ Meeting this recommendation is important for increasing the quality and years of healthy life of women in Tennessee.

- In 2005, 75.5% (± 2.4)* of Tennessee women aged 40 and older reported they had a current mammogram (i.e. within the past 2 years). 14.3% (± 1.9) reported they had had a mammogram more than 2 years ago, and 10.2% (± 1.4) reported they had never had a mammogram.
- Between 1996 and 2005, the percentage of women *without* a current mammogram (i.e. they had never had a mammogram or it had been more than 2 years since the procedure was last done) decreased from 33.1% to 24.5%.
- The percentage of women *without* a current mammogram was higher among whites (25.6% ± 2.6) than among blacks (18.3% ± 6.2).

- The percentage of women *without* a current mammogram decreased with increasing level of education, from 34.6% among women with less than a high school education to 17.4% among college graduates.

- Approximately 27-31% of women with an annual household income of less than \$50,000 did not have a current mammogram. 19.9% of women with an annual income of \$50,000-74,999 and 11.9% of those with an income of \$75,000 or more did not have a current mammogram.



References:

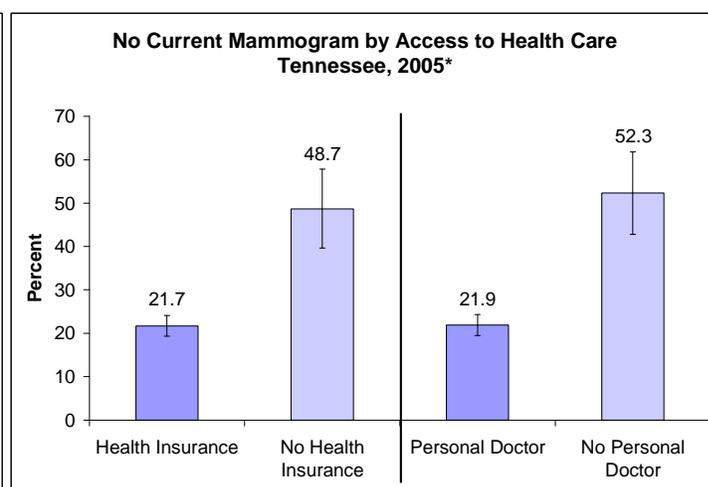
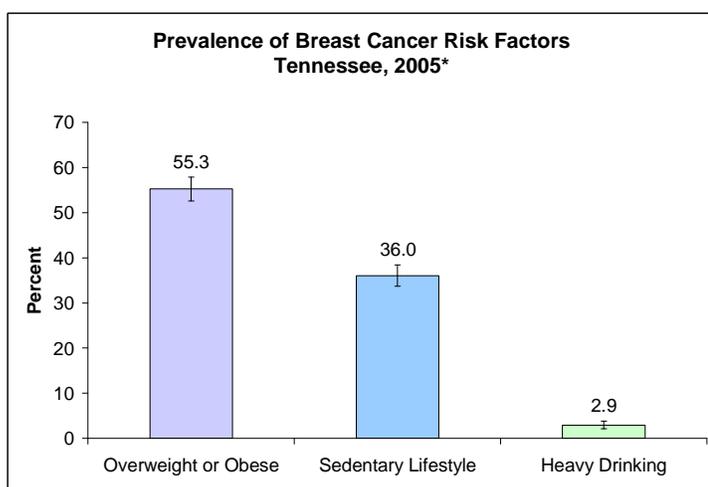
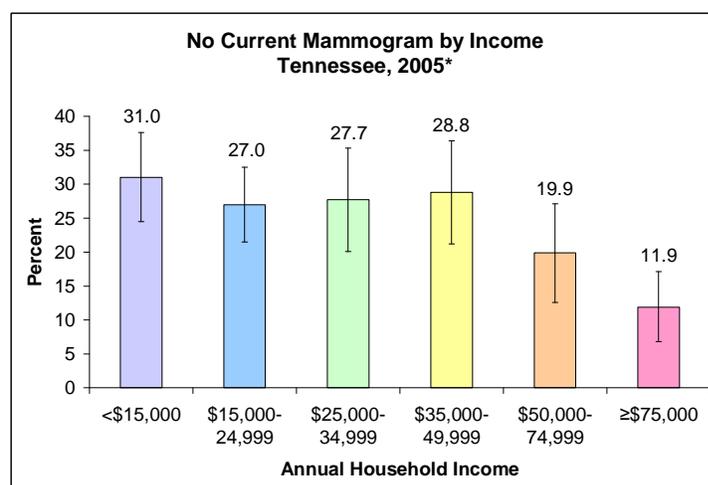
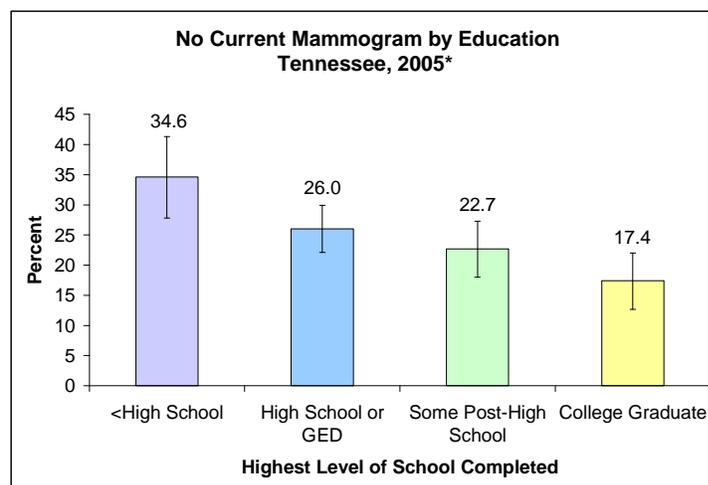
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2. U.S. Department of Health and Human Services (www.womenshealth.gov/faq/mammography.htm)
3. U.S. Preventive Services Task Force (www.ahrq.gov/clinic/uspstfix.htm)
4. Centers for Disease Control and Prevention (www.cdc.gov/cancer/breast)

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Breast Cancer Screening

- Women without health insurance were more than twice as likely as those with health insurance to be *without* a current mammogram (48.7% vs. 21.7%, respectively).
- Similarly, women without a personal doctor or health care provider were more likely to be *without* a current mammogram than those with such a person (52.3% vs. 21.9%, respectively).
- Modifiable risk factors for breast cancer include being overweight, lack of regular exercise and drinking more than one alcoholic drink a day.⁴ Among women aged 18 years and older, 55.3% were overweight or obese, 36.0% had a sedentary lifestyle and 2.9% reported having more than one drink a day.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

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Cervical Cancer Screening



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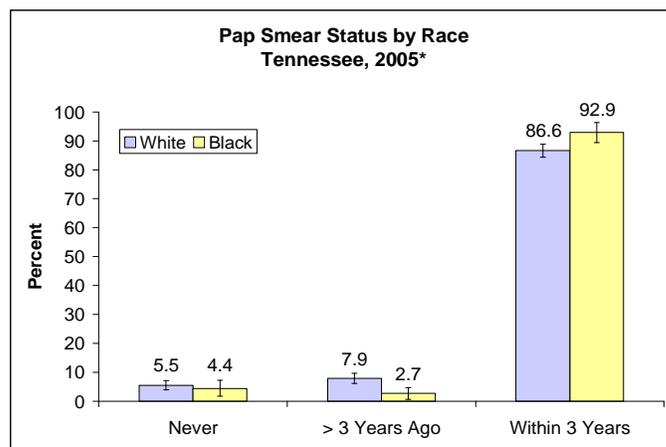
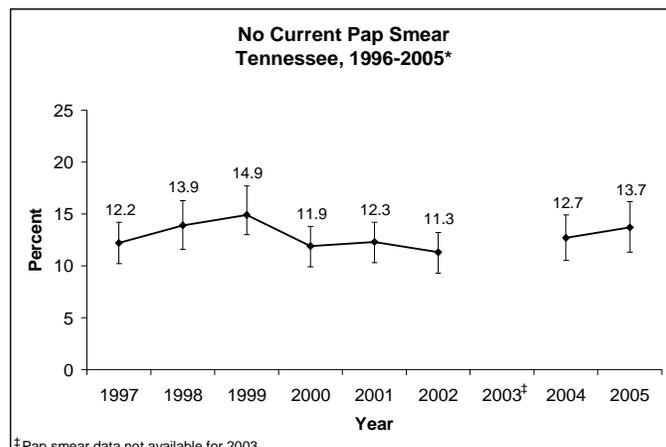
Approximately 100 women die of cervical cancer in Tennessee each year. A Pap smear is a microscopic examination of cells scraped from the cervix. Regular Pap tests decrease a woman's risk for developing and dying from cervical cancer because they can detect precancerous cervical lesions at early, treatable stages.¹ The United States Preventive Services Task Force recommends cervical cancer screening at least every 3 years beginning within 3 years of onset of sexual activity or at age 21 (whichever comes first).² Meeting this recommendation is important for increasing the quality and years of healthy life of women in Tennessee.

- In 2005, 86.3% (± 2.4)* of Tennessee women aged 18 and older reported they had a current Pap test (i.e. within the past 3 years). 6.9% (± 1.4) reported they had had a Pap test more than 3 years ago, and 6.9% (± 2.1) reported they had never had a Pap test.[†]
- Between 1997 and 2005, the percentage of women *without* a current Pap test (i.e. they had never had a Pap test or it had been more than 3 years since the procedure was last done) remained fairly constant at approximately 11-15%.

- The percentage of women *without* a current Pap test was higher among whites (13.4% ± 2.3) than among blacks (7.1% ± 3.5).

- Young women aged 18-24 years (22.7%) and women 65 years and older (32.3%) had the highest prevalence of individuals *without* a current Pap test.

- The percentage of women *without* a current Pap test decreased with increasing level of education, from 27.7% among women with less than a high school education to 5.5% among college graduates.



References:

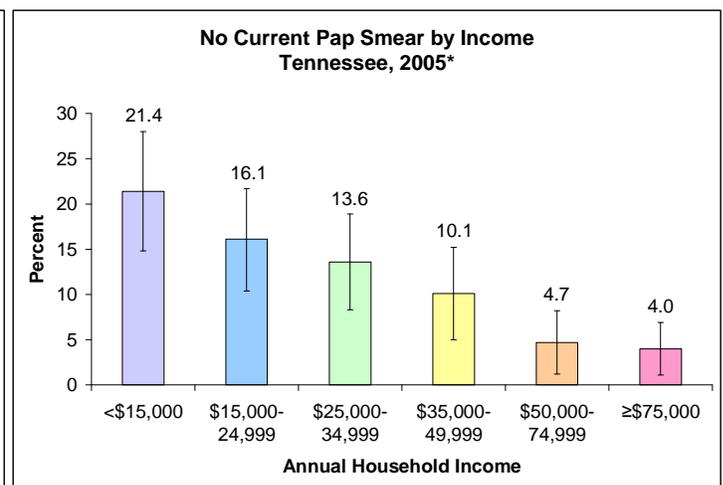
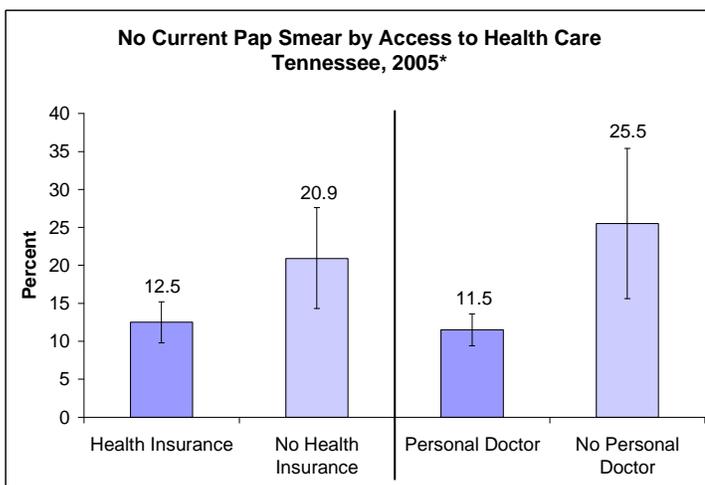
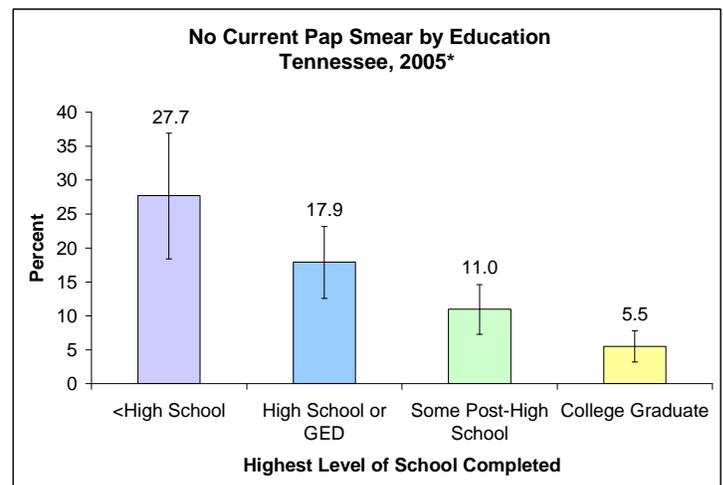
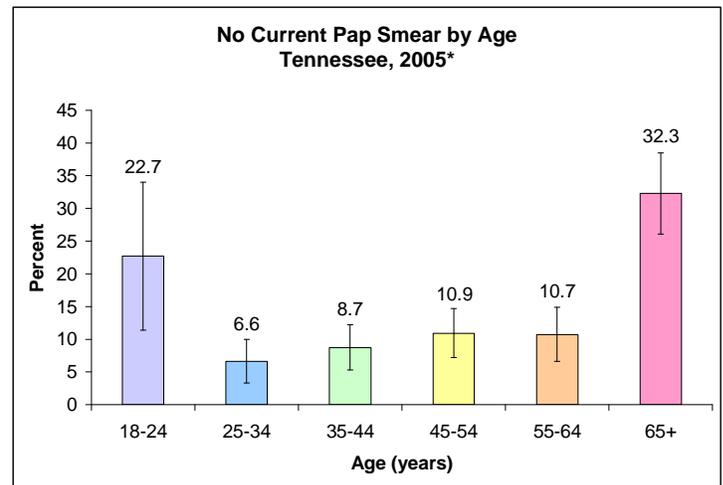
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BRFSS Fact Sheet

Cervical Cancer Screening

- The percentage of women *without* a current Pap test decreased with increasing annual household income, from 21.4% among those with an income of less than \$15,000 to 4.0% among those with an income of \$75,000 or more.
- Women without health insurance were more likely than those with health insurance to be *without* a current Pap test (20.9% vs. 12.5%, respectively).
- Similarly, women without a personal doctor or health care provider were more likely to be *without* a current Pap test than those with such a person (25.5% vs. 11.5%, respectively).
- Modifiable risk factors for cervical cancer include smoking and eating a diet low in fruits and vegetables.¹ Among all women aged 18 years and older, 24.4% (\pm 2.2) were current smokers, and 72.4% (\pm 2.3) reported eating less than 5 daily servings of fruits and vegetables.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

¹Women who reported they had had a hysterectomy were excluded from the analysis.

BRFSS Fact Sheet

Cigarette Smoking



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Definition:

Current Smoker:

At least 100 lifetime cigarettes smoked and currently smokes every day or some days.

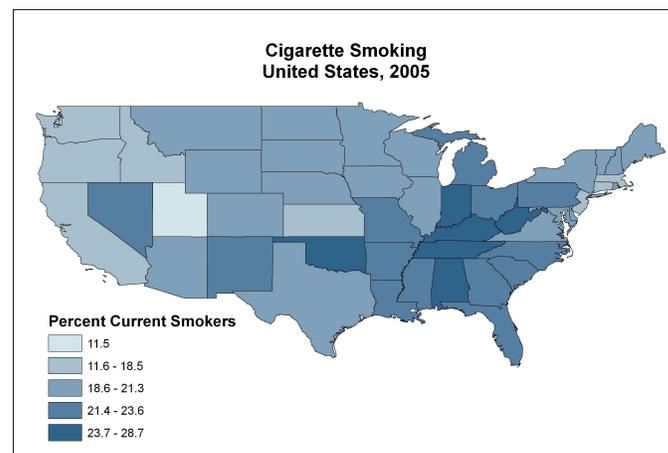
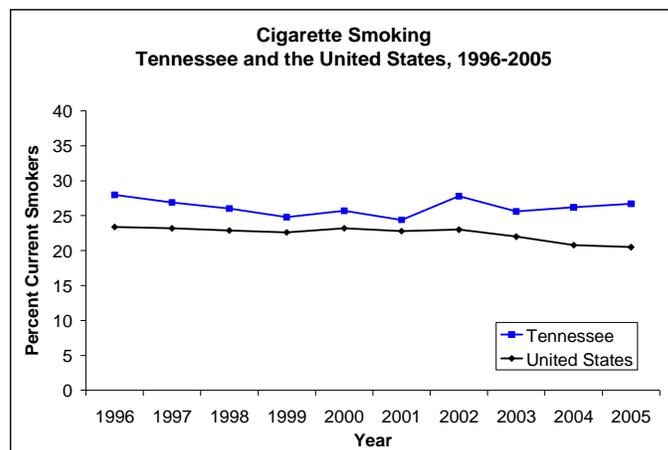
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3. Centers for Disease Control and Prevention (www.cdc.gov/brfss) U.S. data includes DC and territories.

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Smoking is a major risk factor for heart disease, stroke, and lung cancer, and is the single most preventable cause of disease and death in the United States.¹ Tobacco-related deaths number more than 430,000 per year among U.S. adults.¹ Smoking harms more than just the tobacco user – secondhand smoke causes disease and premature death in children and adults who do not smoke.² Smoking during pregnancy causes spontaneous abortions, low birth weight, and sudden infant death syndrome, and tobacco smoke triggers or worsens asthma and other respiratory conditions.¹ One of the Healthy People 2010 objectives is to reduce cigarette smoking by adults to 12%.¹ Reaching this goal and reducing all forms of tobacco use are important for increasing the quality and years of healthy life for all Tennesseans.

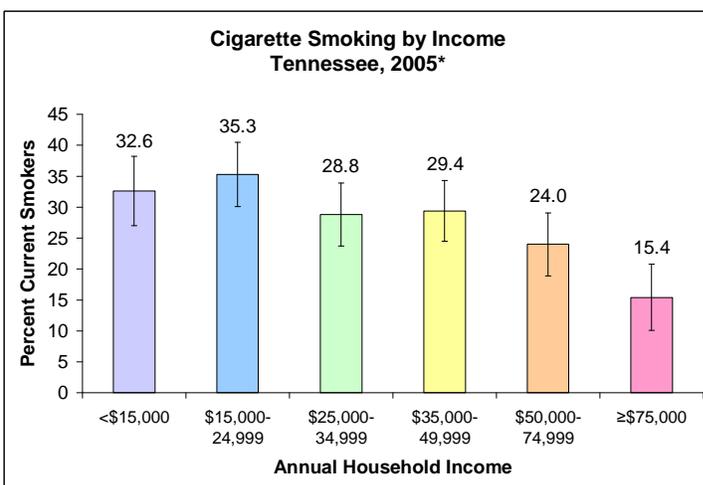
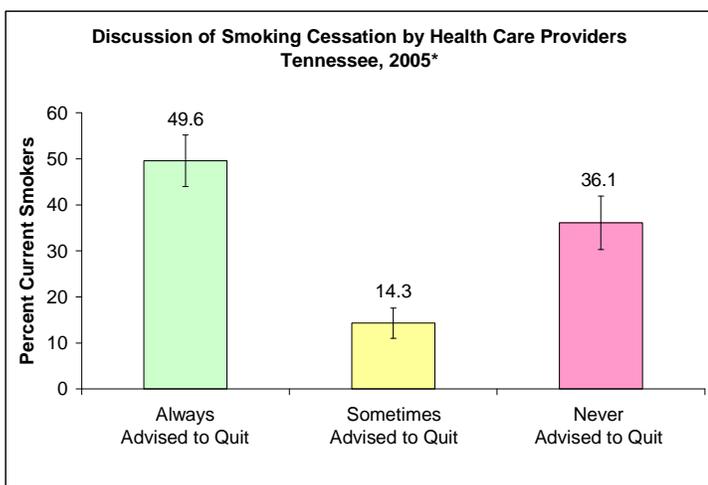
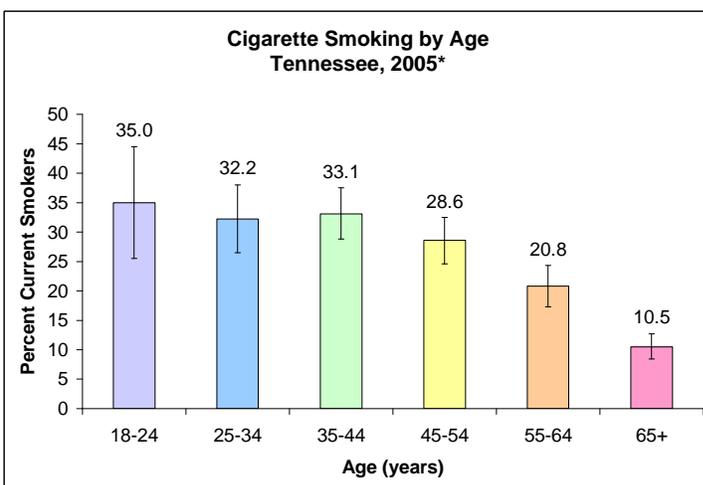
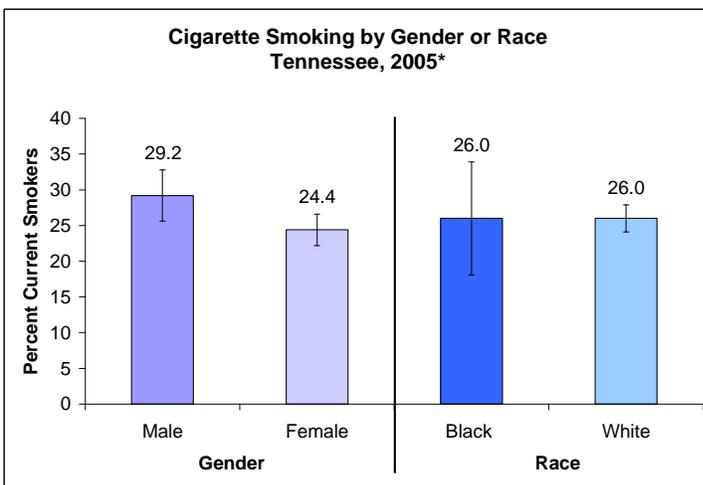
- In 2005, 26.7% of adults in Tennessee reported being a current cigarette smoker, compared to 20.5% for the United States.³ Among all 50 states, the percentage of current smokers ranged from 11.5% in Utah to 28.7% in Kentucky.³ Compared to other states, Tennessee had the 3rd highest percentage of current smokers.
- Current cigarette smoking among Tennessee adults did not decrease substantially between 1996 (28.0% ± 1.8)* and 2005 (26.7 ± 2.1).
- The percentage of current smokers was higher among males (29.2%) than among females (24.4%). 19.4% (± 14.8) of women who reported being pregnant were also current cigarette smokers.
- The prevalence of smoking was the same for blacks and for whites (26.0% for each group).
- The prevalence of smoking decreased with increasing age, from 35.0% in 18-24 year olds to 10.5% in those 65 years and older.
- Adults with less than a high school education (39.8% ± 5.9) had the highest prevalence of smoking. As education level increased the percentage of current smokers decreased: high school graduate or GED 32.7% (± 4.2), some post-high school 26.3% (± 3.7), and college graduate 13.1% (± 2.6).



BRFSS Fact Sheet

Cigarette Smoking

- The prevalence of current cigarette smoking among those with an annual household income of less than \$15,000 (32.6%) was approximately double that of those with an annual income of \$75,000 or more (15.4%).
- Approximately half of all current smokers (55.5% ± 4.7) reported that they stopped smoking for at least one day or longer during the past 12 months because they were trying to quit smoking.
- Among smokers who had seen a health care provider in the past 12 months, 49.6% reported being advised to quit smoking at every health care encounter. 14.3% reported being advised to quit at some, but not all, health care encounters and 36.1% reported never being advised to quit.
- Among smokers who had been advised by a health care provider to quit smoking, 63.3% (± 5.4) reported that medications to assist with quitting were never recommended or discussed, and 62.8% (± 5.7) reported that methods and strategies to assist with quitting were never recommended or discussed.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Coronary Heart Disease



Tennessee
Department of Health

Cordell Hull Bldg.
425 5th Avenue North
Nashville, TN 37243

<http://state.tn.us/health>

Definition:

Coronary Heart Disease: A type heart disease characterized by narrowing of the blood vessels supplying blood and oxygen to the heart.

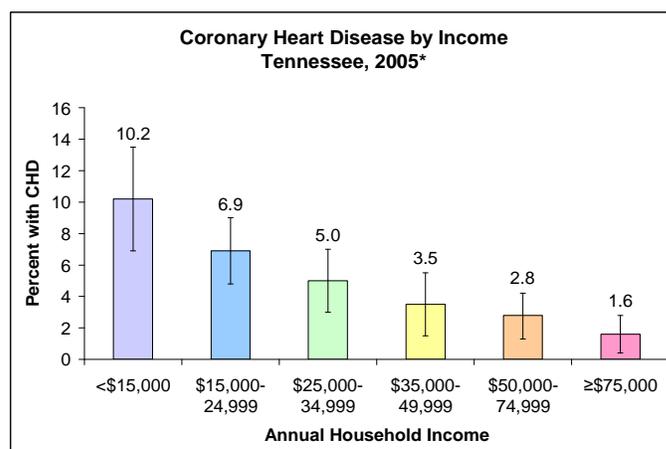
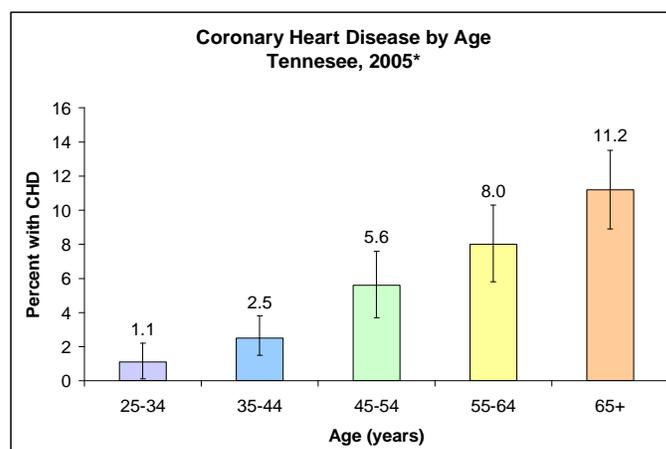
References:

1. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

Coronary heart disease (CHD) affects approximately 13 million Americans, and despite decades of declining heart disease mortality rates, it remains the number one cause of death in the U.S. and Tennessee.¹ According to the American Heart Association, someone dies of this disease every sixty seconds in the U.S.¹ One of the Healthy People 2010 objectives is to reduce CHD deaths to 166/100,000 population.² Reducing risk factors for CHD (overweight/obesity, high cholesterol, high blood pressure, diabetes, sedentary lifestyle, and smoking) is important for reaching this goal and for increasing the quality and years of healthy life for all Tennesseans.

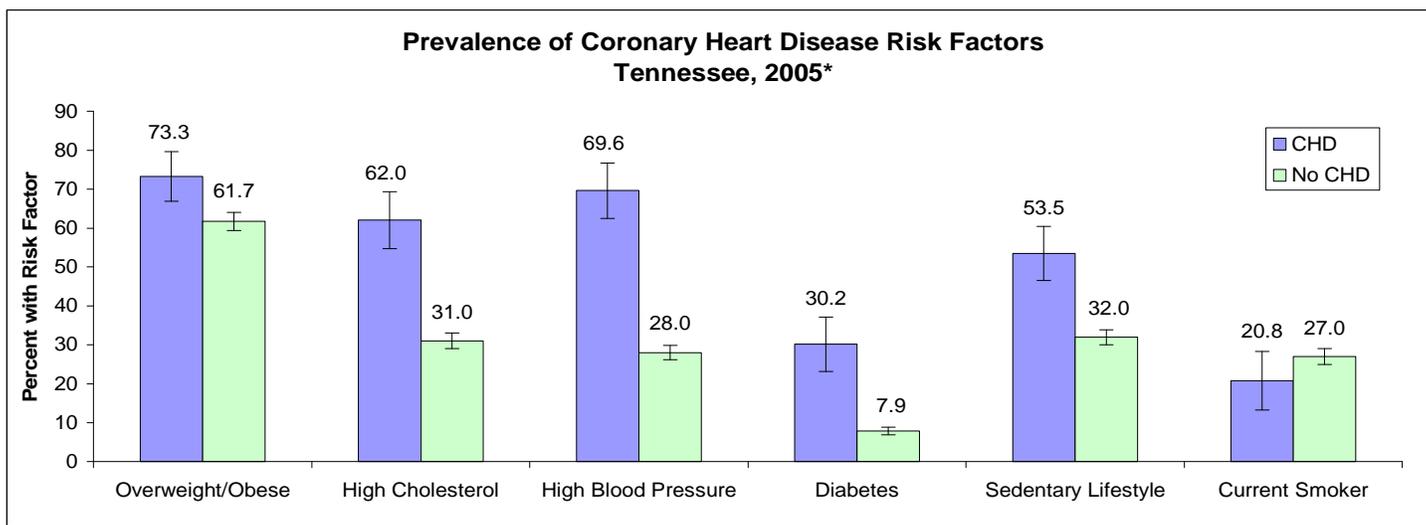
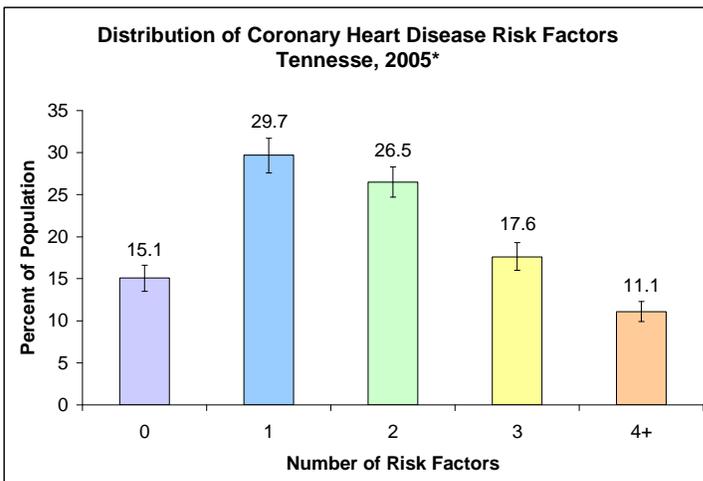
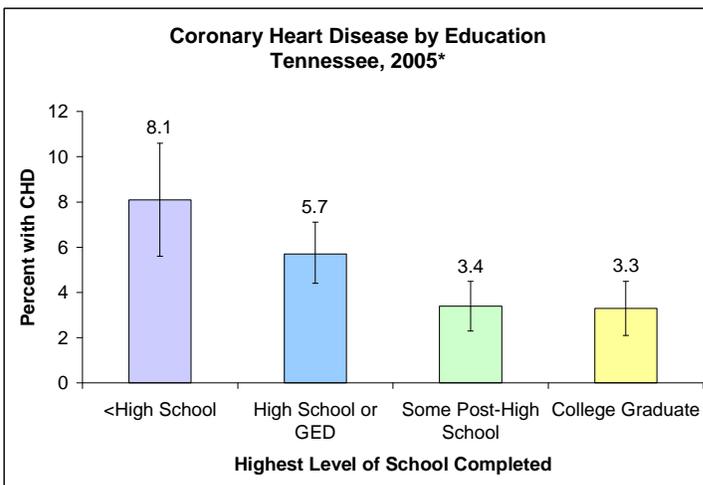
- In 2005, 4.7% of adult Tennesseans reported that they had been told by a health care provider that they have coronary heart disease.
- Heart attacks are a serious form of CHD and occur when narrowed blood vessels slow or stop the flow of blood to the heart. Among persons with CHD, 41.4% reported that they had had a heart attack.
- The percentage of persons with CHD was highest among white males (6.1% ± 1.5)*, followed by white females (4.3% ± 1.0), black females (3.6% ± 2.1) and black males (1.6% ± 1.3).[†]
- The prevalence of CHD increased with increasing age, from 1.1% in 25 to 34 year olds to 11.2% in those 65 years and older.
- The prevalence of CHD increased with decreasing annual household income, from 1.6% among those with an income of \$75,000 or more to 10.2% among those with an income of less than \$15,000.
- The prevalence of CHD increased with decreasing education, from 3.3% among college graduates to 8.1% among those with less than a high school degree.



BRFSS Fact Sheet

Coronary Heart Disease

- Among the total population, only 15.1% of adults had *none* of the following modifiable CHD risk factors: overweight/obesity, high cholesterol, high blood pressure, diabetes, sedentary lifestyle, and smoking. 29.7% had one risk factor, and 55.2% had 2 or more risk factors.
- Persons with coronary heart disease were more likely than those without the disease to be overweight/obese (73.3% vs. 61.7%, respectively) and to have a sedentary lifestyle (53.5% vs. 32.0%, respectively).
- High cholesterol and high blood pressure were 2 and 2.5 times as common in persons with CHD as in those without the disease. Diabetes was almost 4 times as common in those with CHD as in those without it.
- Although smoking is an important risk factor for CHD, the prevalence of smoking was not found to be higher in persons with versus those without the disease.



*The number above each column indicates the value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

[†]Other surveys have found higher rates of CHD, especially among blacks. For example, the National Health and Nutrition Examination Survey found that the prevalence of CHD in 2003 was 8.9% in white males, 5.4% in white females, 7.5% in black females and 7.4% in black males.¹

BRFSS Fact Sheet

Diabetes



Tennessee
Department of Health

Cordell Hull Bldg.
425 5th Avenue North
Nashville, TN 37243

<http://state.tn.us/health>

Definitions:

Diabetes: Group of diseases marked by high levels of blood glucose resulting from defects in insulin production and/or action.

Pre-Diabetes: Blood glucose levels are elevated but not high enough to be classified as diabetes.

References:

1. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
3. Hoyert DL, et al. *Deaths: Final Data for 2003*. National Vital Statistics Reports; Vol 54 No 13. Hyattsville, MD: National Center for Health Statistics. 2006.
4. Centers for Disease Control and Prevention (www.cdc.gov/brfss) U.S. data includes DC and territories.

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

Approximately 20 million Americans have diabetes and almost a third of them do not know they have it.¹ An additional 14.7 million people are pre-diabetic and at increased risk of developing the disease.¹ In the United States, diabetes is the leading cause of non-traumatic amputations, blindness among working-aged adults and end-stage renal disease, and it is the sixth leading cause of death.^{2,3} Two of the Healthy People 2010 objectives are to reduce the rate of clinically diagnosed diabetes to 25 per 1,000 population and to reduce diabetes-related deaths to 45/100,000.² Reducing risk factors for diabetes (obesity, sedentary lifestyle) and improving diabetes management are important for reaching these goals and for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 9.1% of adults in Tennessee reported having been told by a health care provider that they have diabetes, compared to 7.3% for the United States.⁴ Among all 50 states, the percentage of diabetic adults ranged from 4.4% in Alaska to 10.4% in West Virginia.⁴ Compared to other states, Tennessee had the 6th highest percentage of diabetic adults.

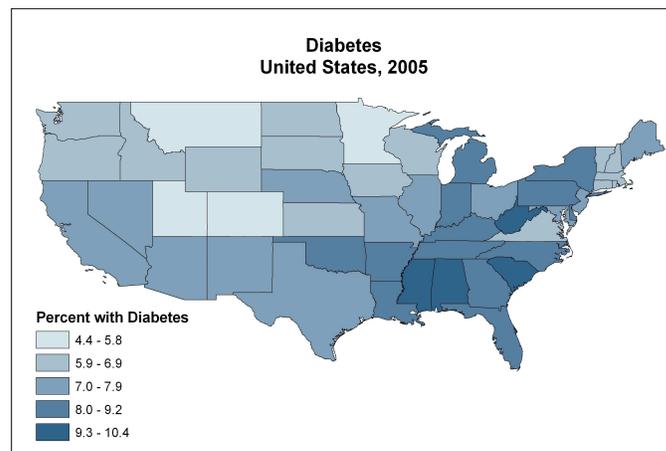
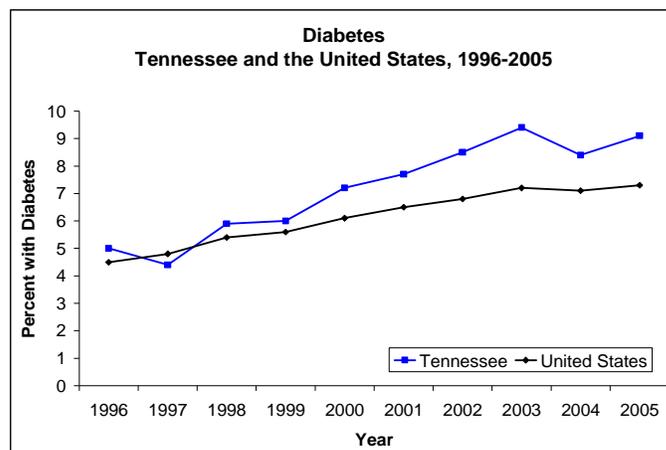
- The percentage of Tennessee adults with diabetes almost doubled between 1996 and 2005, from 5.0% to 9.1%.

- The prevalence of diabetes was highest among black females (13.2%), followed by white males (9.0%), white females (8.8%) and black males (8.4%).

- The prevalence of diabetes increased with increasing age, from 0.8% in 18 to 24 year olds to 19.0% in those 65 years and older.

- Age at diagnosis with diabetes ranged from 6 to 87 years, with a mean of 49 years.

- 17.2% of diabetic adults were diagnosed within the past year, and 44.0% were diagnosed within the past 5 years.

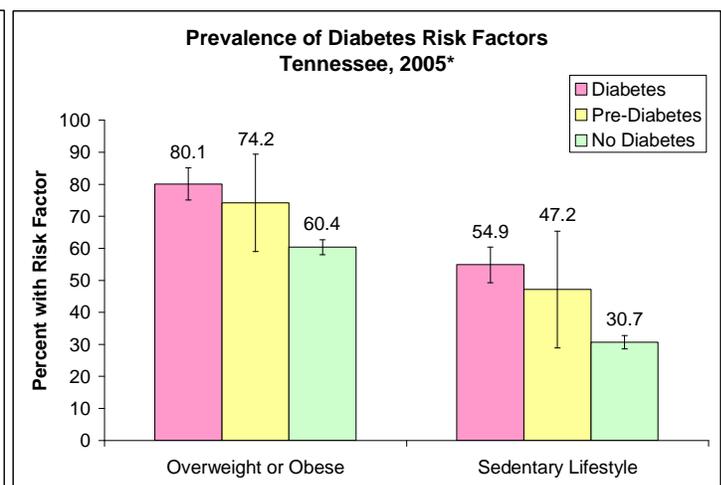
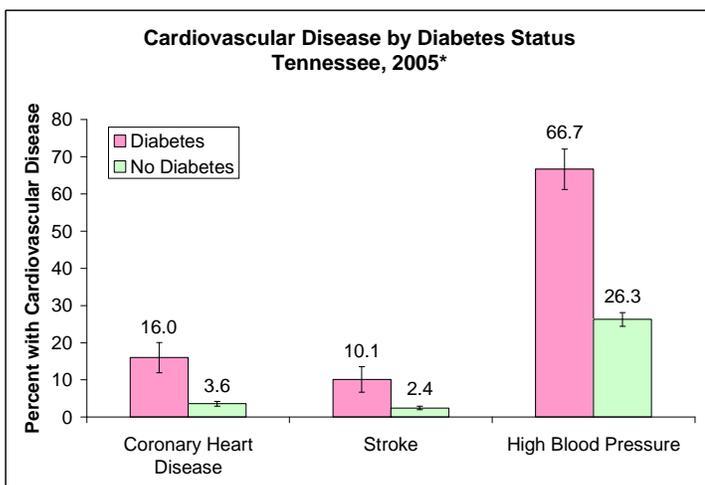
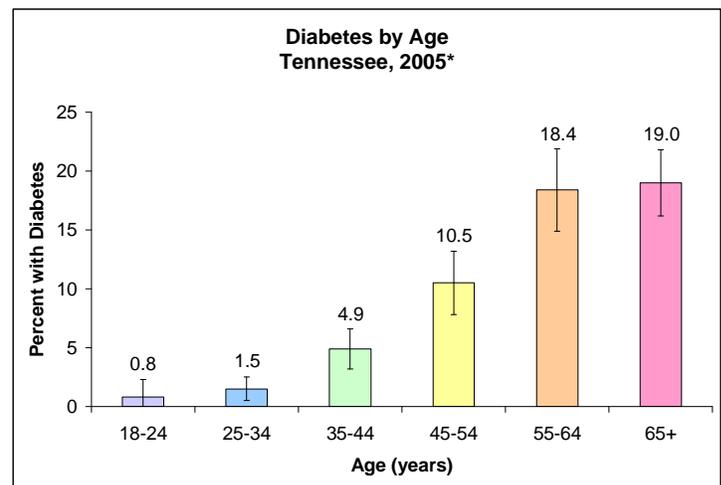
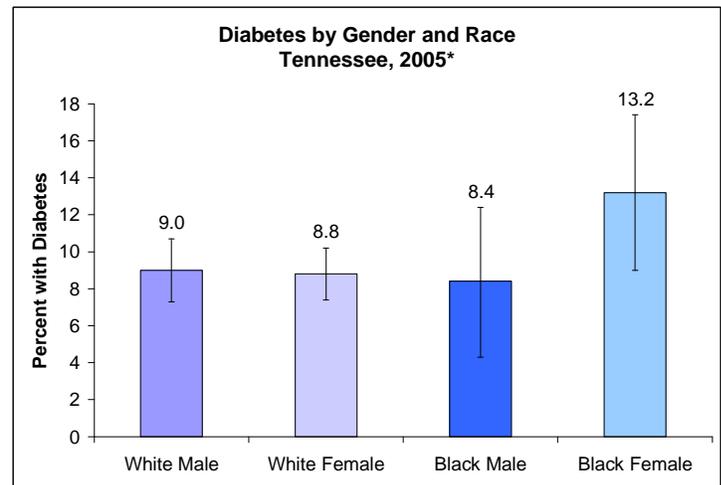


BRFSS

Fact Sheet

Diabetes

- Adults with less than a high school education (16.7% ± 3.5)* had the highest prevalence of diabetes. Among those with higher levels of education the prevalence was: high school graduate or GED 9.6% (± 1.7), some post-high school 7.9% (± 1.9), and college graduate 6.1% (± 1.7).
- The prevalence of diabetes decreased with increasing annual household income, from 15.8% (± 4.2) for those with an income of less than \$15,000 to 4.9% (± 2.2) for those with an income of \$75,000 or more.
- Coronary heart disease and stroke were approximately 3 times more common in persons with diabetes than in those without the disease. High blood pressure was one and a half times more common in those with diabetes.
- Persons with diabetes were more likely than those without the disease to be overweight or obese (80.1% vs. 60.4%, respectively) and to have a sedentary lifestyle (54.9% vs. 30.7%). The prevalence of overweight/obesity and of sedentary lifestyle among pre-diabetic adults was intermediate to the other two groups.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Diabetes Management



Tennessee
Department of Health

Cordell Hull Bldg.
425 5th Avenue North
Nashville, TN 37243

<http://state.tn.us/health>

Definition:

Diabetes: Group of diseases marked by high levels of blood glucose resulting from defects in insulin production and/or action.

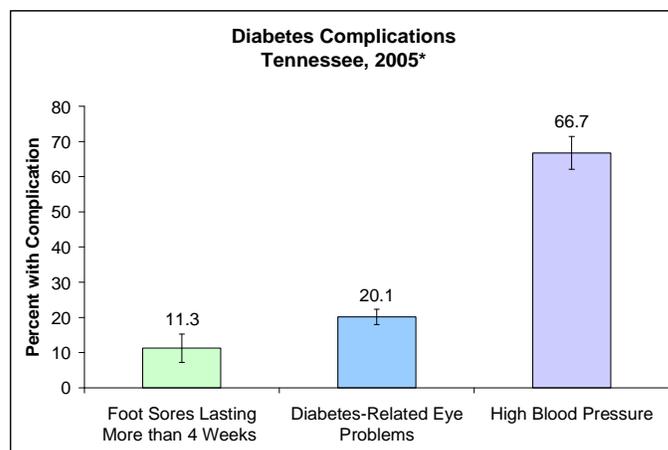
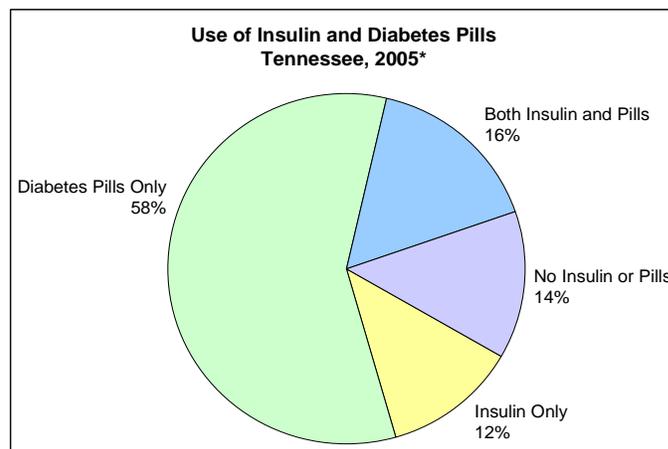
References:

1. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
3. Hoyert DL, et al. *Deaths: Final Data for 2003*. National Vital Statistics Reports; Vol 54 No 13. Hyattsville, MD: National Center for Health Statistics. 2006.
4. National Diabetes Information Clearinghouse www.diabetes.niddk.nih.gov

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

Diabetes is the sixth leading cause of death in the U.S. and is the leading cause of non-traumatic amputations, blindness among working-aged adults and end-stage renal disease.^{1,2,3} Effective and economical strategies exist for controlling diabetes and preventing serious complications such as those mentioned above.² These strategies include controlling glucose, lipid and blood pressure levels, getting regular foot and eye exams, and getting an annual flu vaccine. Unfortunately, these strategies are not used routinely in clinical management of persons with the disease, resulting in unnecessary illness, disability, death and expense.² One of the Healthy People 2010 objectives is to reduce diabetes-related deaths to 45 per 100,000 population.² Improving diabetes management is important for reaching this goal and for increasing the quality and years of healthy life for all diabetics in Tennessee.

- In 2005, 12.1% of adult diabetics in Tennessee reported taking only insulin for their condition. 58.2% reported taking only diabetes pills, and 16.1% reported taking both insulin and pills. 13.6% were not taking insulin *or* pills for their diabetes.
- Two-thirds of diabetics reported a history of high blood pressure. 11.3% reported having had foot sores lasting more than 4 weeks and 20.1% reported being told by a doctor that diabetes had affected their eyes or that they had retinopathy.
- Over three-quarters of Tennessee diabetics examined their feet for sores and irritations at least once a day (79.4%). 9.3% reported that they *never* check their feet. Among those with a history of foot sores, 4.3% (± 5.0)* did not check their feet daily.
- Approximately three-quarters of diabetics reported doing self glucose testing at least once a day (75.4%). 3.5% reported that they *never* check their glucose.
- A higher percentage of blacks than whites reported doing daily self foot exams and glucose testing. A similar percentage of males and females performed these tasks daily.
- The mean number of doctor visits for diabetes in the past twelve months was 3.8, with a range of 0 to 48 visits. 7.8% (± 2.9) of diabetics reported not having seen a doctor for their diabetes in the past twelve months.



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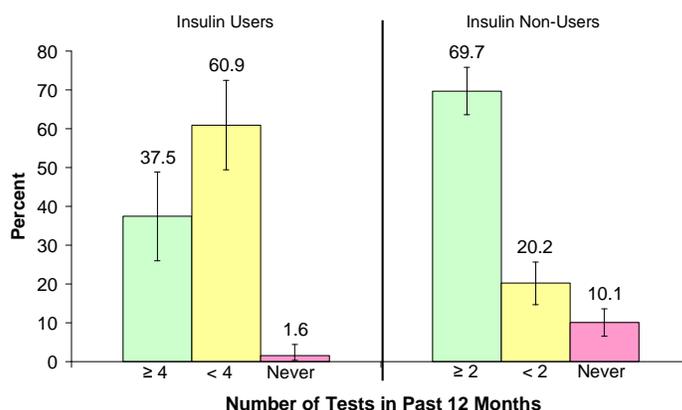
Diabetes Management

- 34.5% of diabetics reported not having had a foot exam by a health care provider and 31.0% reported not having had a dilated-eye exam in the past twelve months.
- 58.5% of diabetics aged 18 and older reported not having received a flu vaccination (injectable and/or nasal spray) in the past twelve months compared to 72.6% (± 2.0) of non-diabetics. 51.2% reported never having received a pneumococcal pneumonia shot, compared to 80.3% (± 1.6) of non-diabetics.
- 43.4% of diabetics in Tennessee reported never having taken a diabetes management class.
- Among diabetics taking insulin, 37.5% reported having had a hemoglobin A1C test at least 4 times in the past twelve months. 1.6% had never had an A1C test. Among diabetics not taking insulin 69.7% reported having had a hemoglobin A1C test at least twice in the past twelve months. 10.1% had never had an A1C test.[‡]

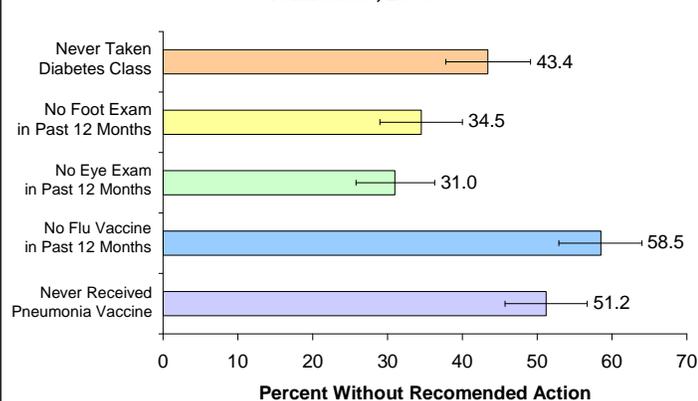
Diabetes Management Recommendations⁴

- Daily self glucose testing
- Daily self foot examination
- Eat healthy, exercise and don't smoke
- Take medicines as directed
- Brush and floss teeth daily
- Annual foot exam by health care provider
- Annual dilated-eye exam
- Annual cholesterol/lipid screening
- Annual kidney function test
- Annual flu vaccination
- Pneumococcal pneumonia vaccination
- Biannual dental exam
- Hemoglobin A1C test every 3 months (if taking insulin) or every 6 months (if not taking insulin)

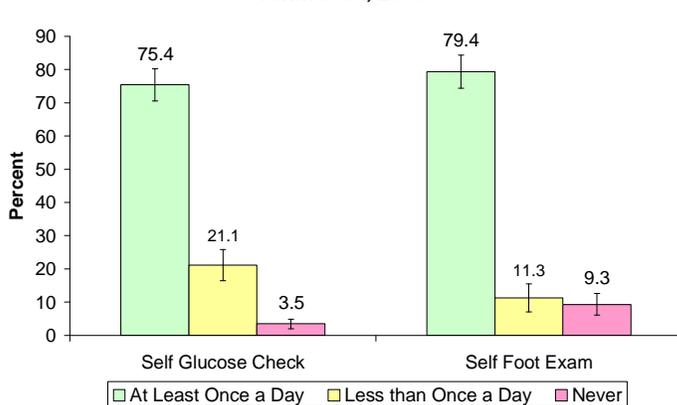
Frequency of Hemoglobin A1C Testing in Past 12 Months
Tennessee, 2005*



Diabetes Management
Tennessee, 2005*



Diabetes Self-Management
Tennessee, 2005*



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

[‡]A hemoglobin A1C test is used to determine the amount of sugar in the blood over the past 2-3 months.

BRFSS Fact Sheet

Flu and Pneumonia Vaccination



Tennessee
Department of Health

Cordell Hull Bldg.
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Nashville, TN 37243

<http://state.tn.us/health>

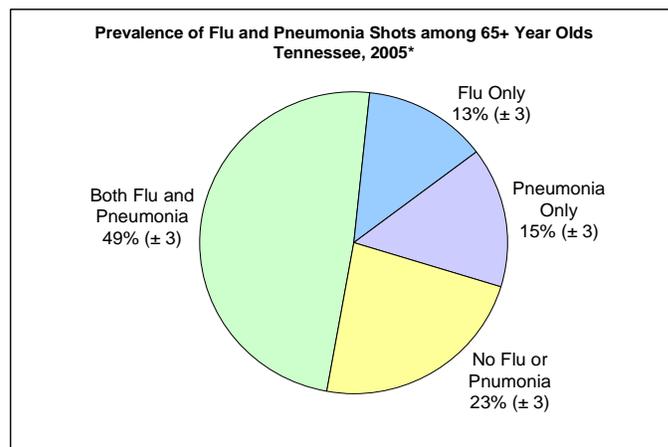
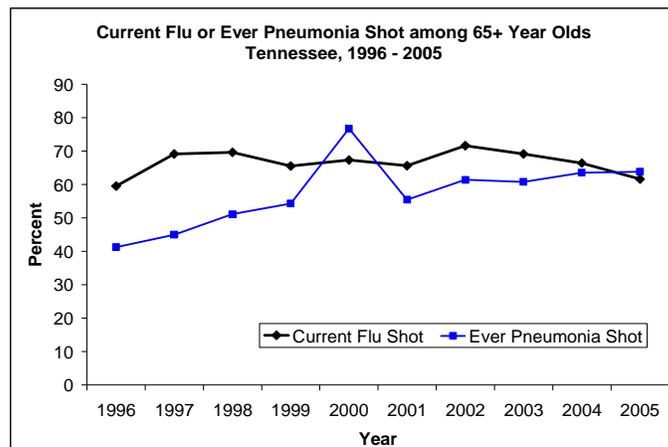
In 2004, influenza and pneumonia were the 8th leading cause of death in the United States and in Tennessee.¹ Each year, approximately 1,800 people die from flu and pneumonia in Tennessee. An important way to prevent flu and pneumonia is through vaccination.² Two of the Healthy People 2010 goals are to increase to 90% both the proportion of adults aged 65 and older who are vaccinated annually against influenza and the proportion who have ever been vaccinated against pneumococcal disease.³ Improving adherence to vaccination recommendations is important for reaching these goals and for increasing the quality and years of healthy life among all Tennesseans.

- In 2005, 61.6% (± 3.5)* of Tennessee elderly (i.e. 65 years and older) reported they had received a flu vaccine in the past 12 months, compared to 65.5% for the United States.⁴ This was the lowest percentage with a current flu shot since 1996.
- In 2005, 63.8% (± 3.5) of Tennessee elderly reported they had ever received a pneumonia vaccine, compared to 65.7% for the United States.⁴ Between 1996 and 2005, the percentage of elderly who had ever had a pneumonia shot increased from 41.3% to 63.8%.

- Approximately half of adults aged 65 and older had both a pneumonia vaccine *and* a current flu vaccine. Approximately a fifth had not received either shot.

- A higher percentage of elderly males (65.1%) had a current flu shot than did females (59.1%). However, a higher percentage of females than males had ever had a pneumonia shot (66.5% vs. 59.8%, respectively)

- A higher percentage of elderly whites had a current flu shot or had ever had a pneumonia shot (63.4% and 66.4%, respectively) than did blacks (51.9% and 46.9%).



References:

1. National Center for Health Statistics. Deaths: Final Data for 2004. (www.cdc.gov/nchs)
2. National Foundation for Infectious Diseases (www.nfid.org)
3. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
4. Centers for Disease Control and Prevention (www.cdc.gov/brfss) U.S. data includes DC and territories.
5. National Immunization Program (www.cdc.gov/nip)

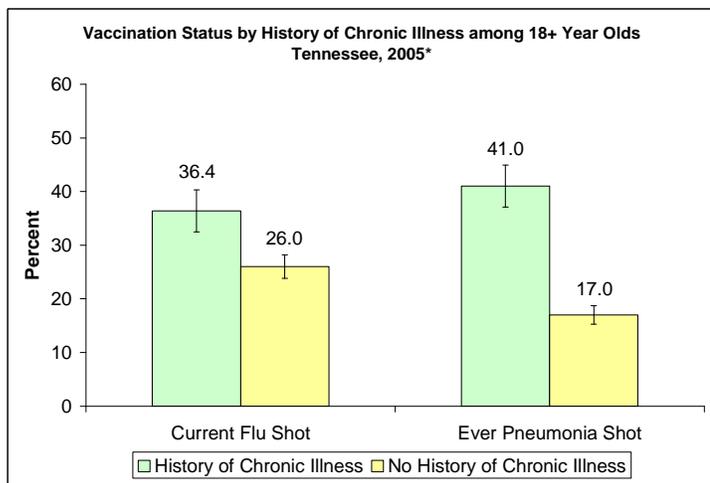
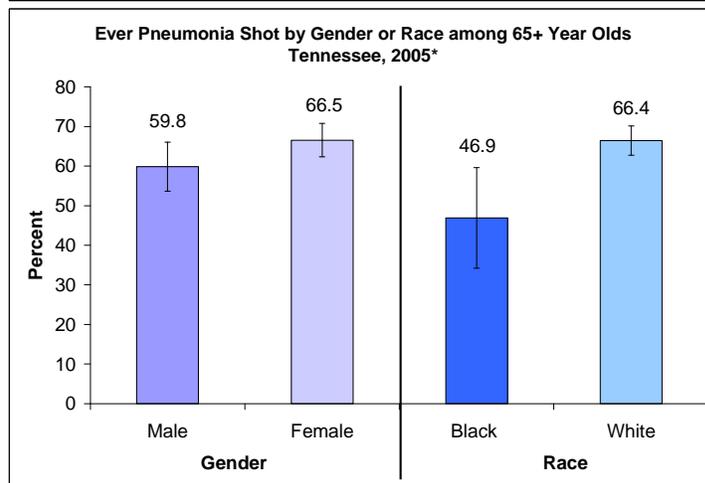
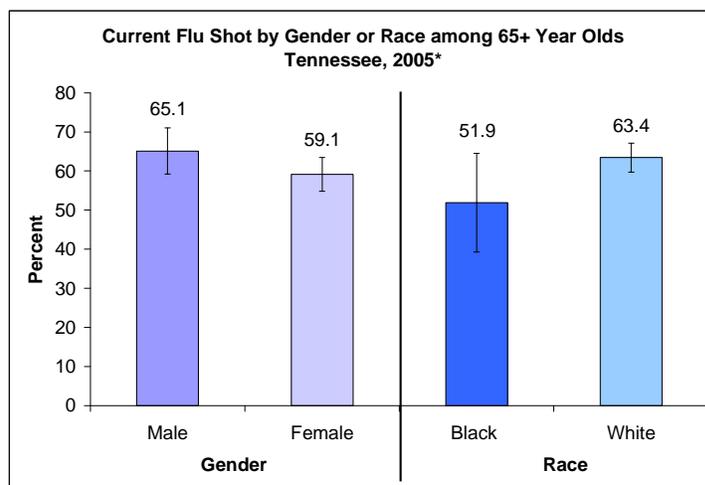
Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

BRFSS Fact Sheet

Flu and Pneumonia Vaccination

- Flu and pneumonia shots are recommended for persons with certain medical conditions, regardless of age (see box at right).
- Among adults aged 18 and older, 36.4% of people with a history of diabetes, coronary heart disease and/or asthma had received a flu shot in the past 12 months, compared to 26.0% of those without a history of these chronic health conditions.
- Among adults aged 18 and older, 41.0% of people with a history of diabetes, coronary heart disease and/or asthma had ever received a pneumonia shot, compared to 17.0% of those without a history of these chronic health conditions.
- A new nasal-spray flu vaccine was licensed in 2003 for use in healthy people between the ages of 5 and 49 years. Among adult Tennesseans aged 18-49 who reported receiving a flu vaccination in the past 12 months, 93.8% (± 4.9) received the flu shot, 2.5% (± 1.5) received the flu nasal-spray and 3.6% (± 4.7) received both the shot and nasal-spray.

Who should get an annual flu shot? ⁵
<ul style="list-style-type: none"> • Children 6-59 months of age • Women who will be pregnant during flu season • People 65 years of age and older • People with weakened immune systems • People with certain chronic medical conditions such as heart, lung or kidney disease, asthma, or diabetes • People who live in nursing homes and other long term care facilities • People who live with or care for those at high risk for flu
Who should get a pneumonia shot? ²
<ul style="list-style-type: none"> • People 65 years of age and older • People with weakened immune systems • People with sickle cell disease or without a spleen • People with certain chronic medical conditions such as heart, lung, liver or kidney disease, diabetes, or alcoholism



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Fruit and Vegetable Consumption



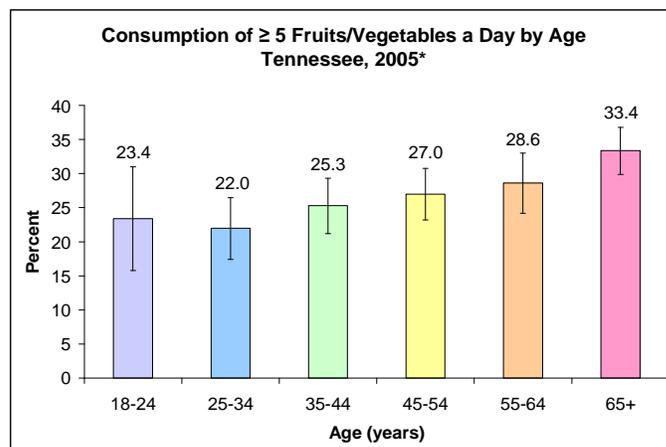
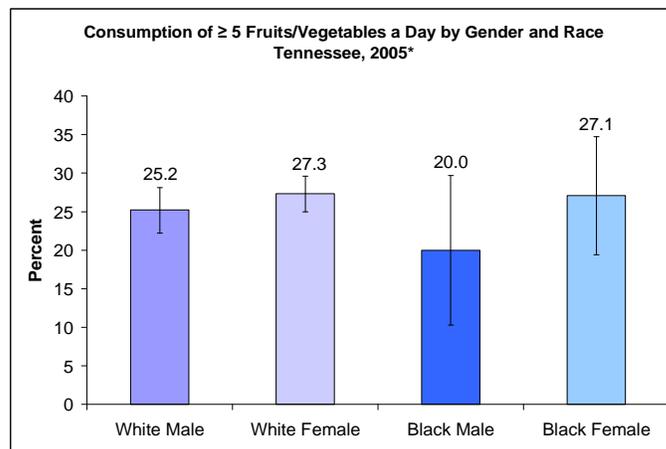
Tennessee
Department of Health

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Nashville, TN 37243

<http://state.tn.us/health>

Poor diet and physical inactivity are important factors contributing to the increase in overweight and obesity in the U.S.¹ In order to reverse this obesity trend, many Americans need to consume fewer calories, be more active, and make wiser food choices, including eating more fruits and vegetables.¹ Persons who eat generous amounts of fruits and vegetables are likely to have a reduced risk of chronic diseases, including stroke and certain cancers, compared with those who consume only small amounts.¹ Increasing the consumption of fruits and vegetables is important for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 26.5% of adults in Tennessee reported eating the recommended servings of fruits and vegetables (i.e. five or more servings of fruits and/or vegetables a day), compared to 23.2% for the United States.²
- Among all 50 states, the percentage of adults who consumed the recommended servings of fruits and vegetables ranged from 15.7% in Oklahoma to 30.8% in Vermont.² Compared to other states, Tennessee had the 9th highest percentage of adults consuming the recommended amount of fruits and vegetables.
- The percentage of people eating the recommended servings of fruits/vegetables was slightly higher among females (27.6% ± 2.3)* than males (25.4% ± 3.0).
- The percentage of people eating the recommended servings of fruits/vegetables was slightly higher among whites (26.3% ± 1.8) than among blacks (23.6% ± 6.2).
- As age increased the percentage of adults consuming five or more daily servings of fruits and vegetables also increased. Less than a quarter of those less than 35 years of age met serving recommendations compared to approximately a third of those 65 years or older.



References:

1. U.S. Department of Health and Human Services and U.S. Department of Agriculture. *Dietary Guidelines for Americans 2005*. 6th ed., Washington, DC: U.S. Government Printing Office, January 2005.
2. Centers for Disease Control and Prevention (www.cdc.gov/brfss)
3. National Cancer Institute (cancercontrol.cancer.gov/5aday)

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

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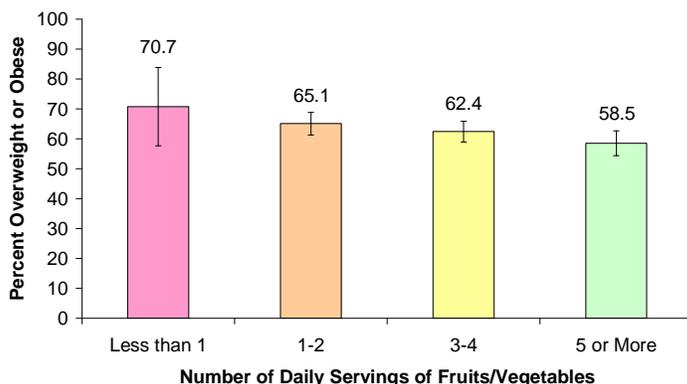
Fruit and Vegetable Consumption

- Consumption of five or more daily servings of fruits and vegetables increased with increasing education level, from 21.3% among those not completing high school to 32.0% among college graduates.
- 28.1% of persons with an annual household income of less than \$15,000 met fruit/vegetable serving recommendations. Among those with an income of greater than \$15,000, the percentage of adults consuming the recommended servings increased from 22.9% among those with an income of \$15,000-24,999 to 31.8% among those with an income of \$75,000 or more.
- The percentage of adults who were overweight or obese decreased with increasing consumption of fruits and vegetables. 70.7% of adults eating less than one daily serving of fruits and vegetables were overweight or obese, compared with 58.5% of those eating five or more servings.

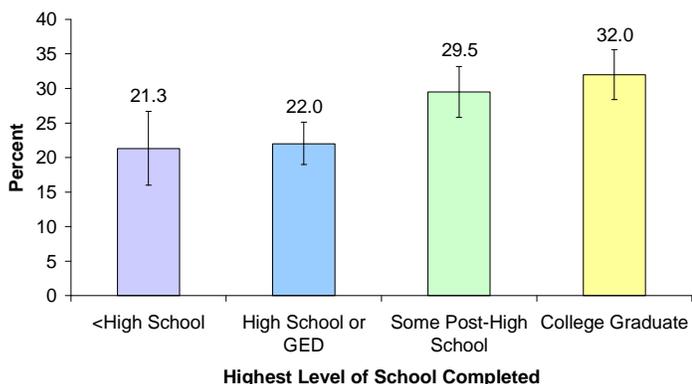
What is a Serving of Fruits/Vegetables?³

- 1 medium piece of fruit (apple, orange, banana)
- ½ cup fresh or canned cut-up fruit
- ¼ cup dried fruit
- ¾ cup 100% fruit juice
- ¾ cup 100% vegetable juice
- ½ cup raw or cooked vegetables
- 1 cup raw leafy vegetables (lettuce, spinach)
- ½ cup cooked peas or beans (lentils, pinto beans, kidney beans, etc.)

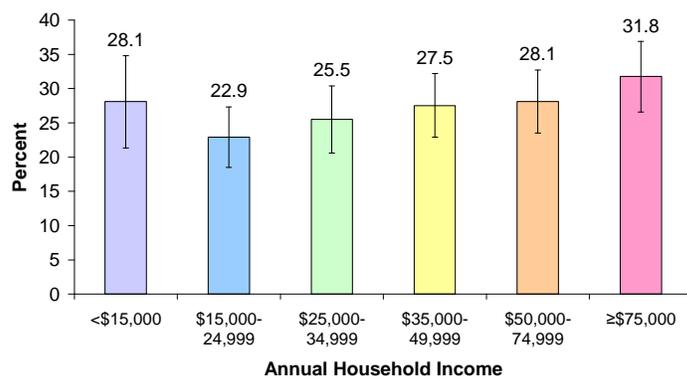
Overweight and Obesity by Fruit/Vegetable Consumption
Tennessee, 2005*



Consumption of ≥ 5 Fruits/Vegetables a Day by Education
Tennessee, 2005*



Consumption of ≥ 5 Fruits/Vegetables a Day by Income
Tennessee, 2005*



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Health Care Access



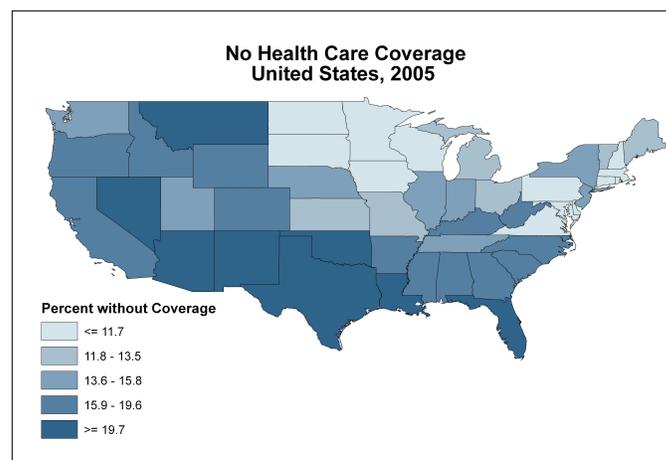
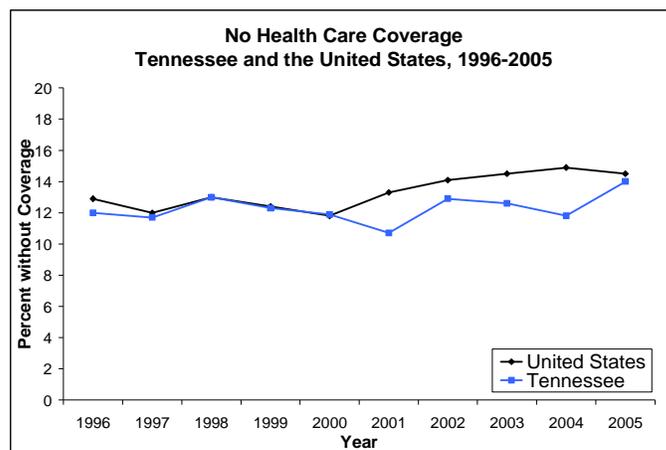
Tennessee
Department of Health

Cordell Hull Bldg.
425 5th Avenue North
Nashville, TN 37243

<http://state.tn.us/health>

Access to health care services often depends on whether a person has health insurance.¹ Uninsured people are less likely to have had a recent medical visit.¹ They are more likely to be in poor health and have an increased risk of premature death.¹ One of the Healthy People 2010 objectives is to increase the proportion of persons with health insurance to 100%.¹ Improving access to and utilization of care is important for eliminating health disparities and increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 14.0% of adults in Tennessee were uninsured, compared to 14.5% for the United States.² This was the highest percentage of adults without health care coverage in Tennessee in the past 10 years.
- Among all 50 states, the percentage of uninsured adults ranged from 28.5% in Texas to 7.0% in Minnesota.² Compared to other states, Tennessee had the 28th highest percentage of uninsured adults.
- The percentage of uninsured males (14.8%) was slightly higher than that of females (13.2%).
- Blacks (17.8%) were more likely than whites (12.5%) to be uninsured.
- Young adults aged 18-24 (27.4%) were more likely to be uninsured than older adults. Approximately 14-16% of persons 25-54 years old were uninsured, followed by 10.7% of 55-64 year olds, and 3.5% of those 65 years and older.
- The percentage of adults without health care coverage decreased with increasing annual household income, from 30.4% among those with an income of \$15,000-24,999 to 1.8% among those with an income of \$75,000 or more. 22.0% of those with an income of less than \$15,000 had no health care coverage.



References:

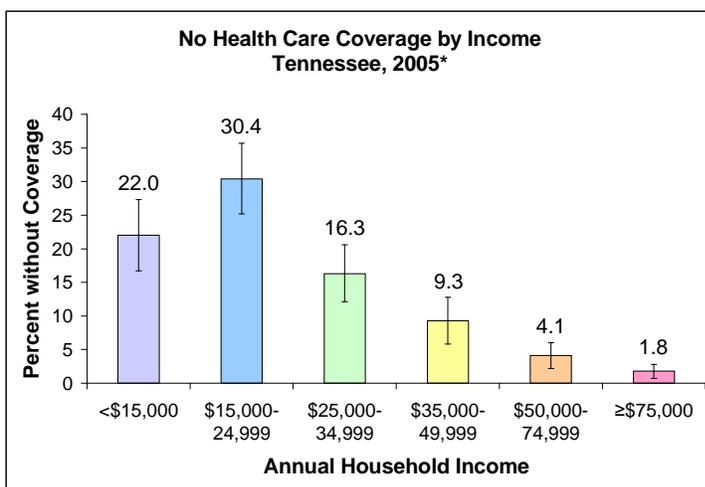
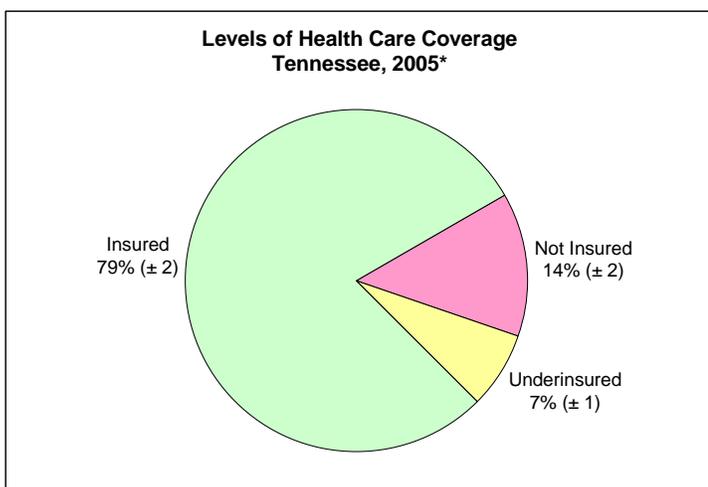
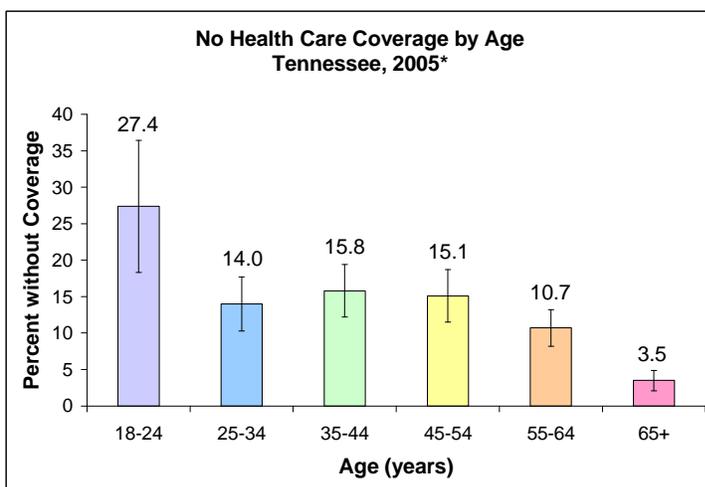
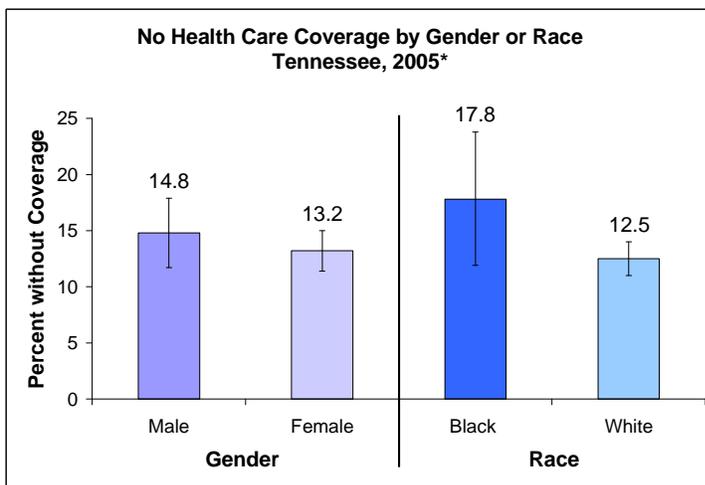
1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
2. Centers for Disease Control and Prevention (www.cdc.gov/brfss) U.S. data includes DC and territories.

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

BRFSS Fact Sheet

Health Care Access

- The percentage of adults without health care coverage decreased with increasing education, from 21.3% (± 5.5)* among those with less than a high school education to 6.8% (± 1.8) among college graduates.
- 8.5% (± 1.3) of persons *with* health insurance reported that they were unable to see a doctor within the past 12 months because of cost (i.e. they were *underinsured*). This represents approximately 7.4% (± 1.1) of the total population.
- The percentage of persons reporting a routine medical checkup in the past 12 months was greater for those with health care coverage (79.0% ± 1.9) than for those without health care coverage (60.7% ± 6.5).
- The percentage of persons reporting their health status as fair or poor was similar in those with health care coverage (19.3% ± 1.6) and in those without coverage (20.5% ± 4.6).
- Participants were asked if they were unable to see a doctor during the past 12 months because of cost. Among those who said yes, 33.5% (± 5.4) reported their health status as fair or poor, compared to 17.4% (± 1.4) of those who said no.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

High Blood Pressure



Tennessee
Department of Health

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<http://state.tn.us/health>

Definition:

High blood pressure:

Blood pressure of 140/90 mmHg or higher.

References:

1. American Heart Assoc. (www.americanheart.org)
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
3. Centers for Disease Control and Prevention (www.cdc.gov/brfss)
U.S. data includes DC and territories.

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

One in three adults in the U.S. has high blood pressure (also called hypertension), and nearly one-third of them do not know they have it.¹ High blood pressure is called the “silent killer” because it usually has no symptoms. Yet it is a major risk factor for stroke, heart attack, heart failure and kidney failure, and when it coexists with obesity, smoking, high cholesterol or diabetes, the risk of heart attack and stroke increase several times.¹ Although the cause of high blood pressure is often unknown, certain lifestyle choices can help prevent and control it.¹ One of the Healthy People 2010 objectives is to reduce the proportion of adults with hypertension to 16%.² Reducing risk factors for high blood pressure (obesity, sedentary lifestyle, high salt diet, heavy drinking, and stress) is important for reaching this goal and for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 30.2% of adult Tennesseans reported that they had been told by a health care provider that they have high blood pressure (HBP), compared to 25.5% for the United States.³ Among all 50 states the percentage of adults with HBP ranged from 18.4% in Utah to 33.3% in Mississippi.³ Compared to other states, Tennessee had the 5th highest percentage of hypertensive adults.

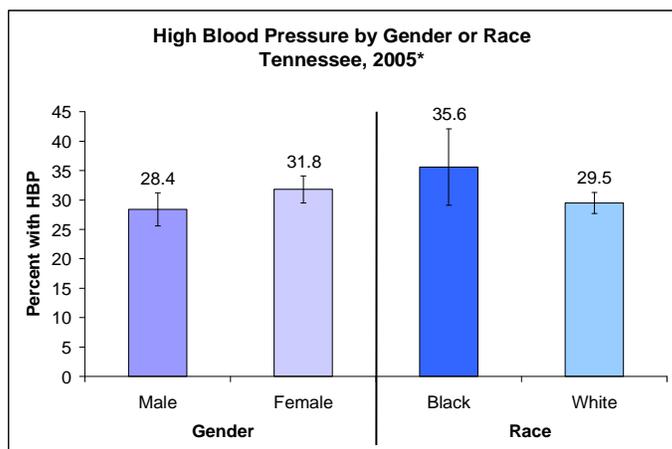
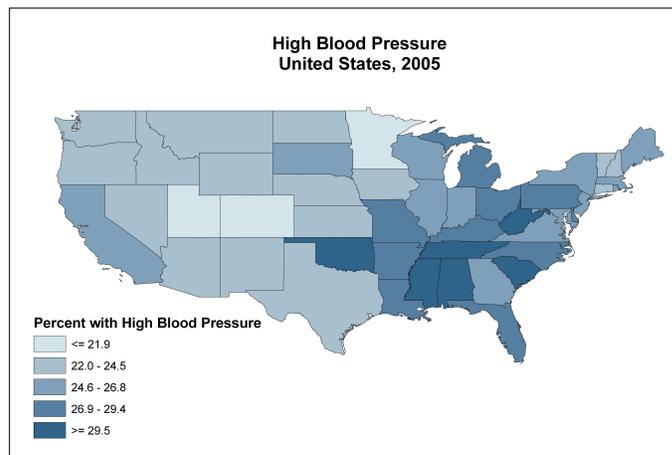
- The percentage of adult Tennesseans with HBP increased steadily from 26.8% in 1995 to 30.2% in 2005.

- The percentage of females (31.8%) with HBP was slightly higher than that of males (28.4%).

- The prevalence of HBP was higher in blacks (35.6%) than in whites (29.5%).

- The prevalence of HBP increased with increasing age. Over 50% of adults aged 65 years and older had high blood pressure.

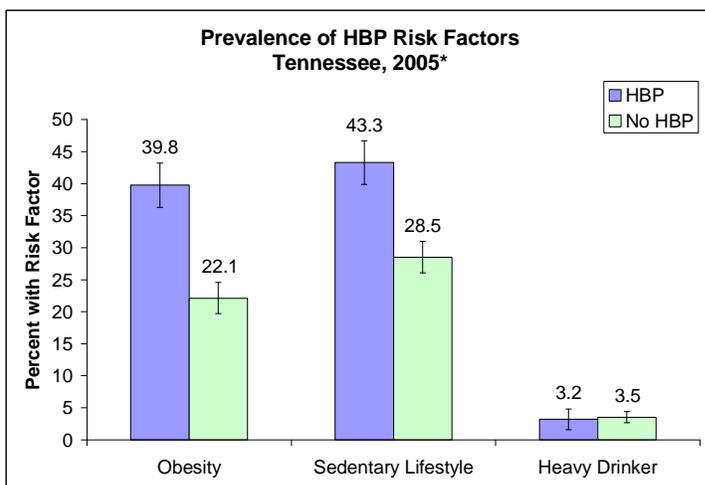
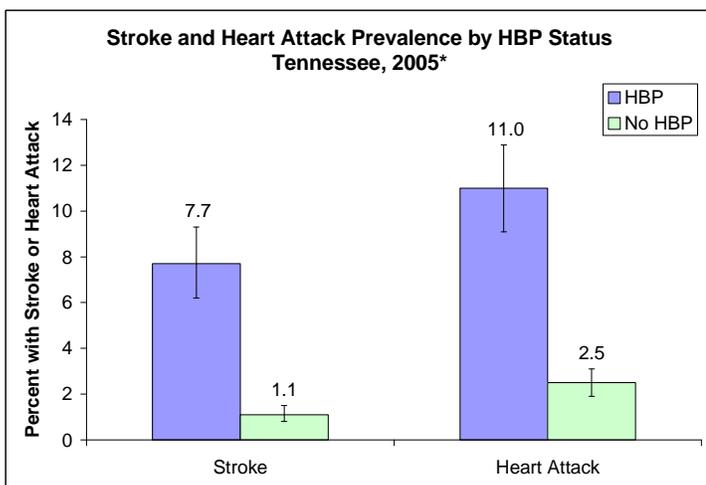
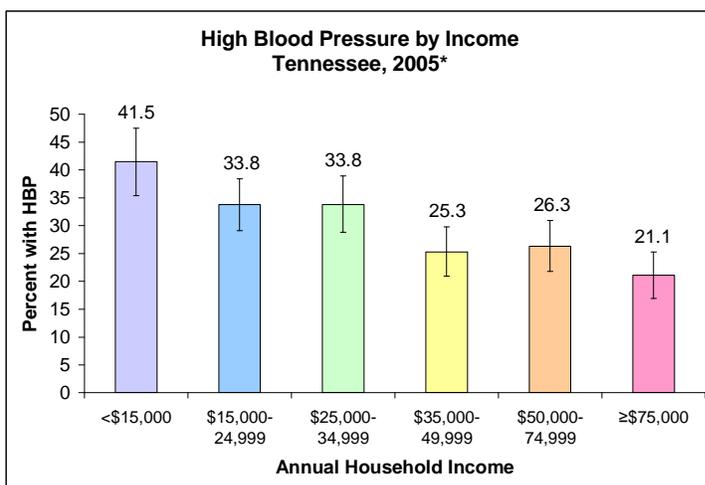
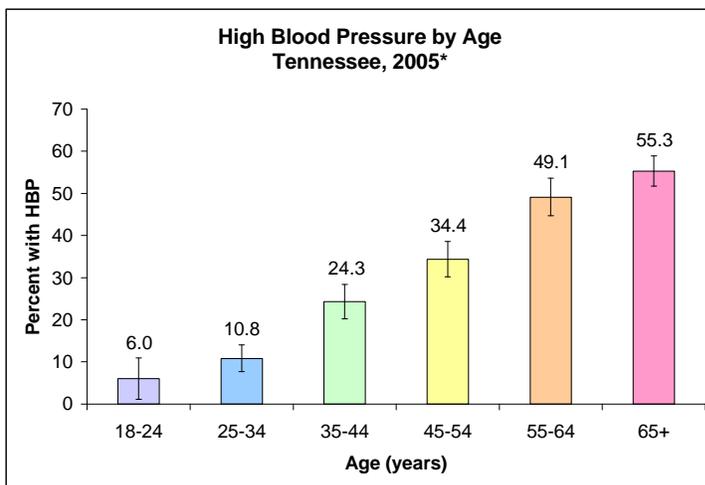
- The percentage of persons with HBP decreased with increasing education: less than high school 44.6% (\pm 5.5), high school graduate or GED 32.2% (\pm 3.4), some post-high school 26.2% (\pm 3.2), and college graduate 25.2% (\pm 3.2).



BRFSS Fact Sheet

High Blood Pressure

- The percentage of persons with high blood pressure decreased with increasing income, from 41.5% among those with an annual household income of less than \$15,000 to 21.1% among those with an income of \$75,000 or more.
- 83.4% (\pm 3.1) of people with high blood pressure reported that they are currently taking medicine for their condition.
- A history of stroke was 6 times more common in persons with high blood pressure than in those without it. Similarly, a history of heart attack was over 3 times more common in those with high blood pressure.
- 39.8% of adults with high blood pressure were obese, compared to just 22.1% of those without HBP. Similarly, the percentage of persons who reported no physical activity or exercise in the past 30 days was higher in those with high blood pressure (43.3%) than in those without it (28.5%).



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

High Cholesterol



Tennessee
Department of Health

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Nashville, TN 37243

<http://state.tn.us/health>

Definitions:

Cholesterol: A waxy, fat-like substance made by the body and found in some foods.

Borderline High Cholesterol:

200-239 mg/DL

High Cholesterol:

≥ 240 mg/DL

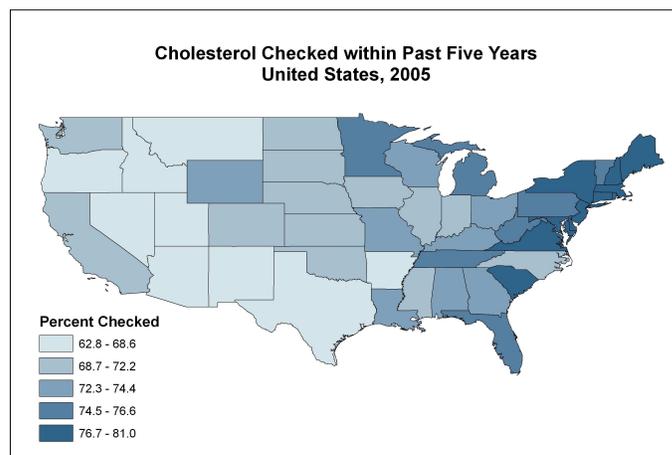
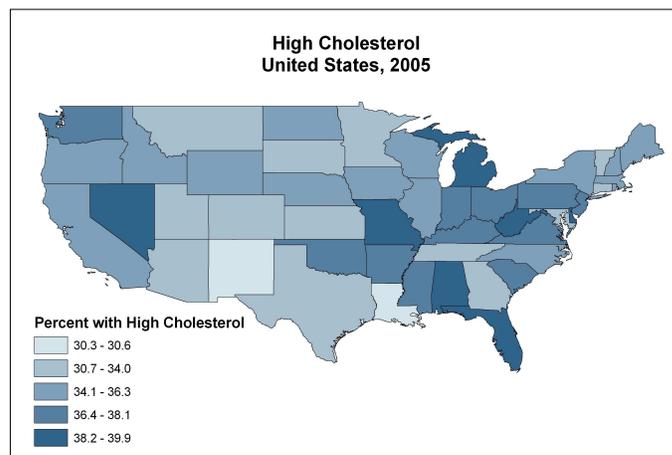
References:

1. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
2. National Heart, Lung and Blood Institute (www.nhlbi.nih.gov)
3. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
4. Centers for Disease Control and Prevention (www.cdc.gov/brfss)

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

Nearly 100 million American adults have borderline high cholesterol and 34.5 million have high cholesterol.¹ High blood cholesterol does not usually cause symptoms – many people are unaware that their levels are too high.² Yet it is a major risk factor for developing heart disease and having a heart attack.² Two of the Healthy People 2010 objectives are to increase the proportion of adults who have had their blood cholesterol checked within the past 5 years to 80% and to reduce the proportion of adults with high cholesterol to 17%.³ Reducing risk factors for high cholesterol (obesity, sedentary lifestyle, and diet high in saturated fat and cholesterol) is important for reaching this second goal and for increasing the quality and years of healthy life for all Tennesseans.

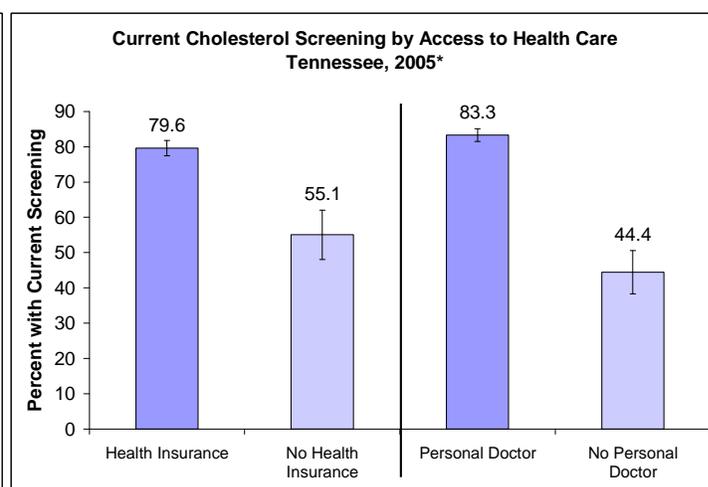
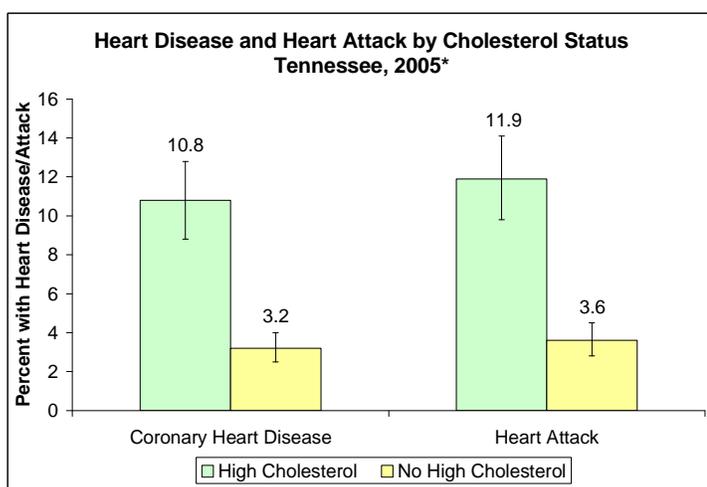
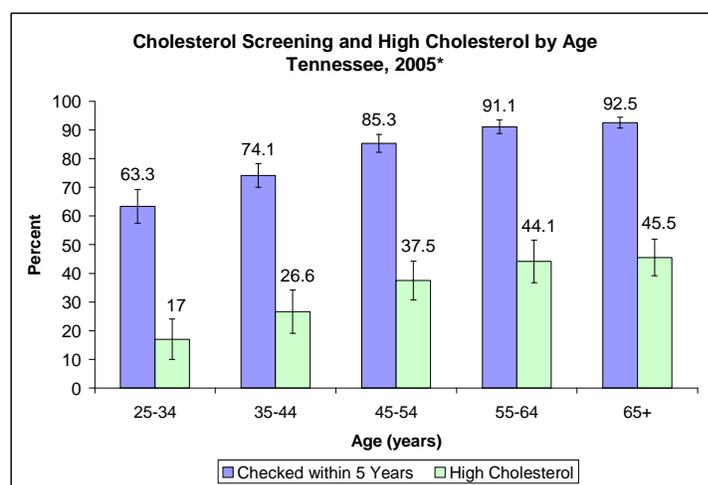
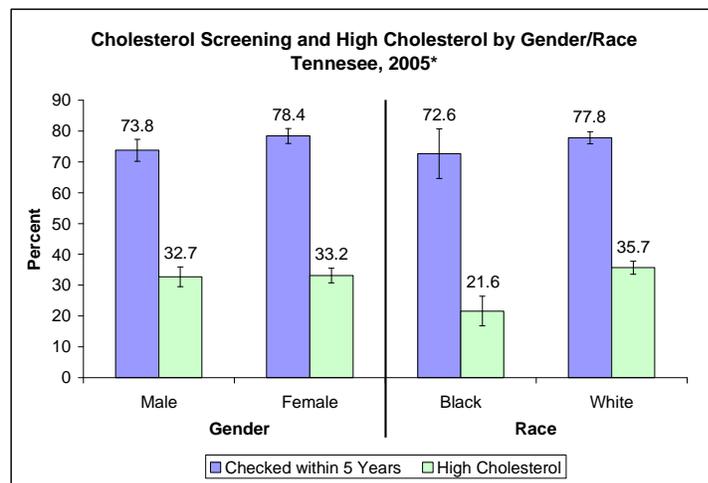
- In 2005, 32.9% of adult Tennesseans reported that they had been told by a health care provider that they have high blood cholesterol, compared to 35.6% for the United States.⁴ Among all 50 states the percentage of adults with high cholesterol ranged from 30.3% in Louisiana to 39.9% in West Virginia.⁴
- 76.1% of adult Tennesseans reported having a current cholesterol screening (i.e. their cholesterol was checked within the past 5 years), compared to 73.0% for the United States.⁴ Among all 50 states the percentage of adults with a current screening ranged from 62.8% in Utah to 81.0% in New Hampshire.⁴
- From 1995-2005, the percentage of adult Tennesseans with high cholesterol increased from 26.8% (\pm 2.2) to 32.9% (\pm 2.0). The percentage with a current cholesterol screening did not increase substantially between 1999 and 2005.
- A slightly higher percentage of females (78.4%) than males (73.8%) had a current cholesterol screening. However, the percentage with high cholesterol was similar for both genders (33.2% vs. 32.7%, respectively).
- Whites were more likely than blacks to have a current cholesterol screening (77.8% vs. 72.6%, respectively), and to have high cholesterol (35.7% vs. 21.6%, respectively).



BRFSS Fact Sheet

High Cholesterol

- Both the percentage of adults with a current screening and the percentage with high cholesterol increased with increasing age.
- As income and education levels increased, the percentage of adults with a current cholesterol screening increased and the percentage with high cholesterol decreased.
- A history of coronary heart disease or heart attack was over 2 times more common in persons with high cholesterol than in those without it.
- 35.3% (± 3.4) of adults with high cholesterol were obese, compared to 24.5% (± 2.5) of those without high cholesterol. Similarly, the percentage of persons who reported no physical activity or exercise in the past 30 days was higher in those with high cholesterol (40.6% ± 3.3) than in those without it (28.2% ± 2.5).
- Having a current cholesterol screening was more common in those persons with health insurance (79.6%) than those without it (55.1%). Similarly, those reporting that they had a personal doctor or health care provider (83.3%) were more likely to have a current screening than those without such a person (44.4%).



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Overweight and Obesity



Tennessee
Department of Health

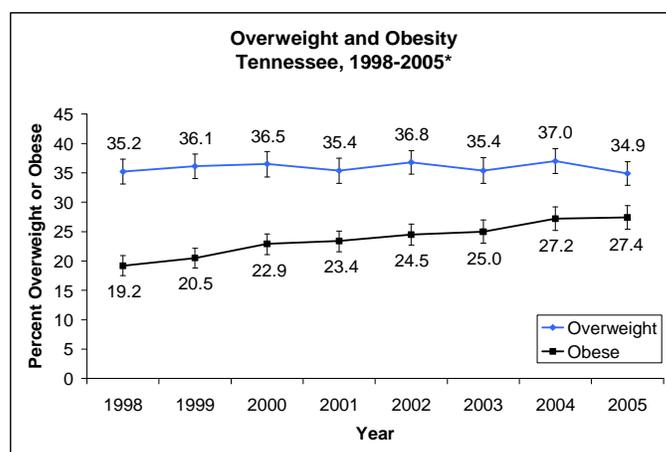
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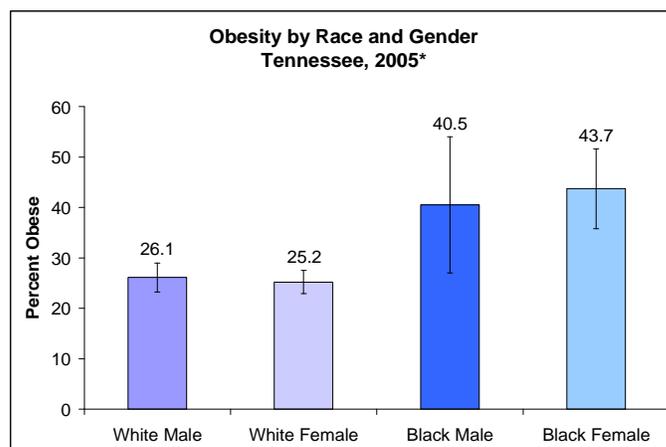
Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease, stroke, and arthritis.¹ In addition, higher body weights are associated with higher mortality rates.¹ One of the Healthy People 2010 goals is to reduce the proportion of adults who are obese to 15%.¹ Maintenance of a healthy weight is important for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 62.3% of adults in Tennessee were overweight or obese, compared to 61.1% for the United States.² Among all 50 states, the percentage of overweight/obese adults ranged from 53.0% in Hawaii to 67.3% in Mississippi.² Compared to other states, Tennessee had the 21st highest percentage of overweight/obese adults.
- The percentage of obese adults in Tennessee increased steadily, from 19.2% in 1998 to 27.4% in 2005. A similar trend in the percentage of overweight persons was not observed.
- Obesity was most prevalent among black females (43.7%), followed by black males (40.5%), white males (26.1%) and white females (25.2%).

- Obesity increased with increasing age (from 15.8% in 18-24 year olds to 32.9% in 55-64 year olds). There was a decrease in obesity in the oldest age group (22.8% in those 65 years and older).



- The prevalence of obesity was lowest among college graduates (21.3% ± 3.8)*. Among those with lower levels of education the prevalence was: less than high school 27.5% (± 6.0), high school 31.6% (± 3.4), and some post-high school 27.7% (± 4.1).



- The percentage of obese adults decreased with increasing income.

Definitions:

Body mass index (BMI): BMI is used as an indicator of healthy weight, overweight, and obesity. It is calculated by dividing weight (in kilograms) by the square of height (in meters).

Overweight: 25 ≤ BMI < 30

Obesity: BMI ≥ 30

References:

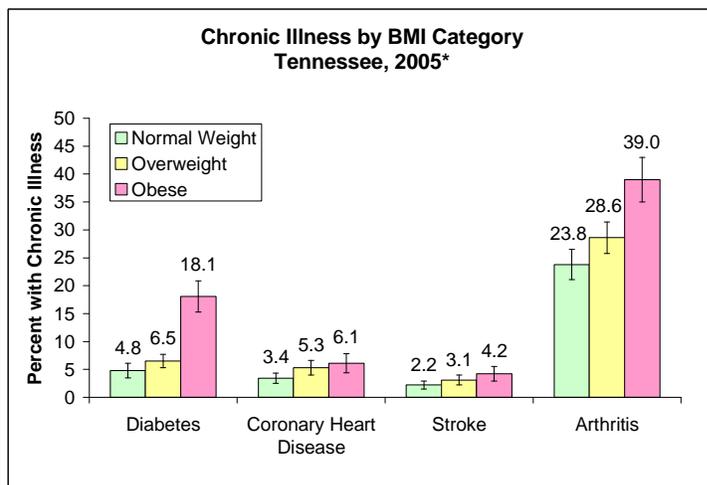
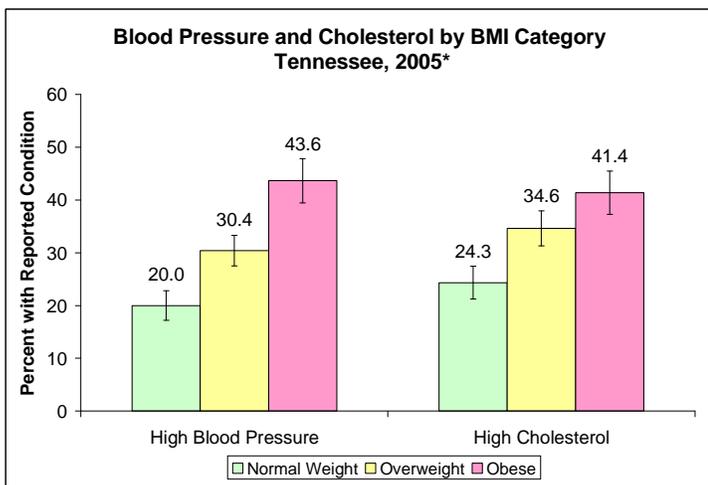
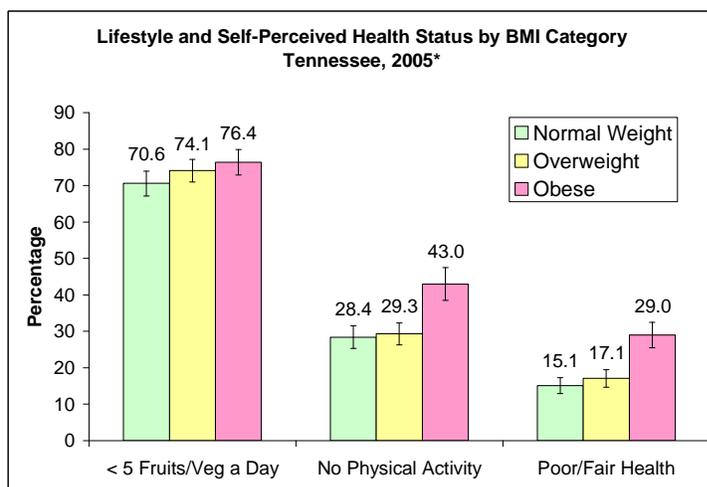
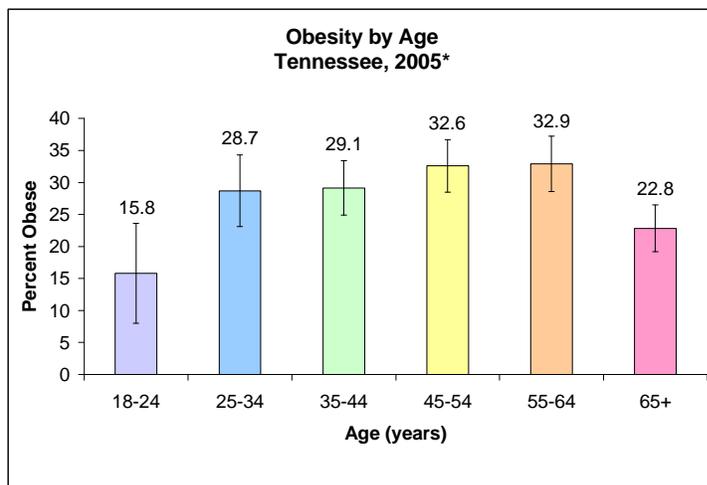
1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
2. Centers for Disease Control and Prevention (www.cdc.gov/brfss)

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

BRFSS Fact Sheet

Overweight and Obesity

- The percentage of overweight and obese individuals reporting they ate less than 5 servings of fruits and vegetables a day was slightly higher than for normal weight persons.
- The percentage of obese persons reporting no physical activity or exercise in the past 30 days was approximately 1.5 times that of normal weight and overweight persons.
- A higher percentage of obese adults reported their health status as fair or poor compared to those that were normal weight or overweight.
- High blood pressure was more prevalent in overweight and obese persons than in those with normal weight. A similar trend was observed for high cholesterol.
- Diabetes, coronary heart disease, stroke and arthritis were all more common in obese individuals than in those that were not obese. In the case of diabetes, the percentage of those with the disease was almost 3 times higher in obese persons than in those with normal weight.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Physical Activity



Tennessee
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<http://state.tn.us/health>

Definitions:

Moderate Activity: Causes small increases in breathing and/or heart rate (example: walking)

Vigorous Activity: Causes large increases in breathing and/or heart rate (example: jogging)

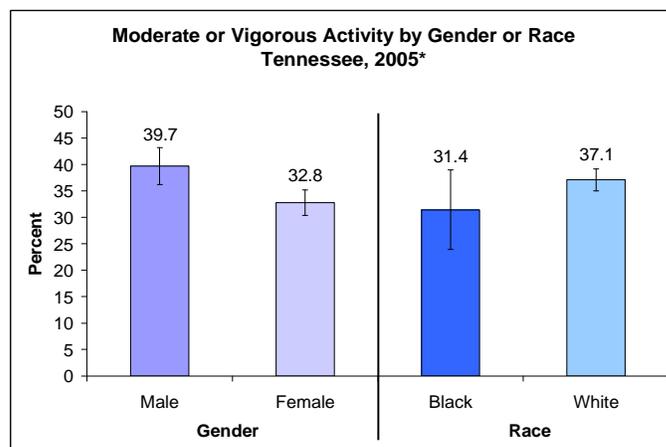
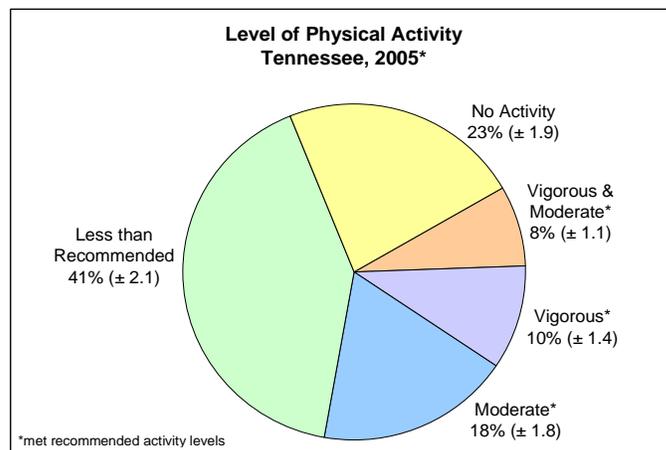
References:

1. U.S. Department of Health and Human Services and U.S. Department of Agriculture. *Dietary Guidelines for Americans 2005*. 6th ed., Washington, DC: U.S. Government Printing Office, January 2005.
2. Centers for Disease Control and Prevention (www.cdc.gov/brfss)
3. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

Regular physical activity contributes to one's health, sense of well-being, and maintenance of a health body weight.¹ Conversely, a sedentary lifestyle increases risk for overweight, obesity and many chronic diseases, including coronary heart disease, high blood pressure, diabetes, osteoporosis and certain types of cancer.¹ Furthermore, mortality rates from all causes of death are higher in sedentary people than in those who are physically active.¹ It is recommended that adults engage in at least 30 minutes of moderate physical activity on most, and preferably all, days of the week.¹ Meeting this recommendation is important for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 36.1% of adult Tennesseans reported getting the recommended level of physical activity (at least 30 minutes of moderate activity five or more days per week or at least 20 minutes of vigorous activity three or more days per week), compared to 49.1% for the United States.²
- 18.3% of adults in Tennessee reported engaging in the recommended level of moderate activity, 10.0% in the recommended level of vigorous activity and 7.8% in the recommended level of both moderate and vigorous activity.[†] 41.0% exercised at less than the recommended level and 22.9% did not engage in any physical activity.
- The percentage of males (39.7%) engaging in the recommended level of physical activity was higher than that of females (32.8%).
- The percentage of whites (37.1%) engaging in the recommended level of physical activity was higher than that of blacks (31.4%).
- Engaging in the recommended level of moderate or vigorous activity was more common among those less than 55 years of age than among those 55 years and older.

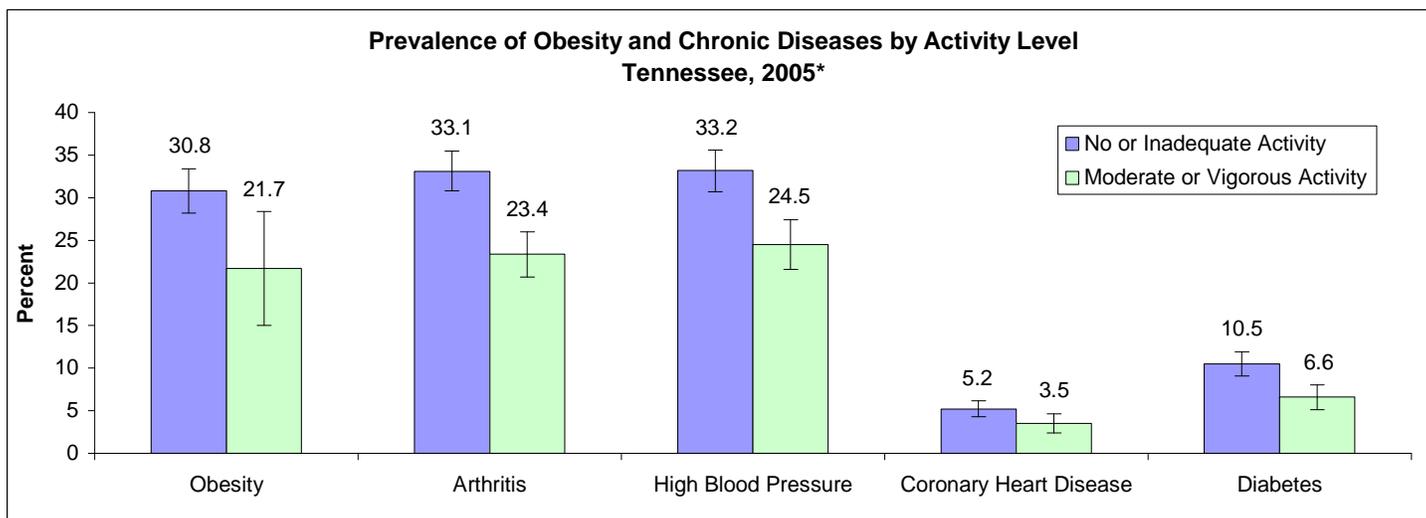
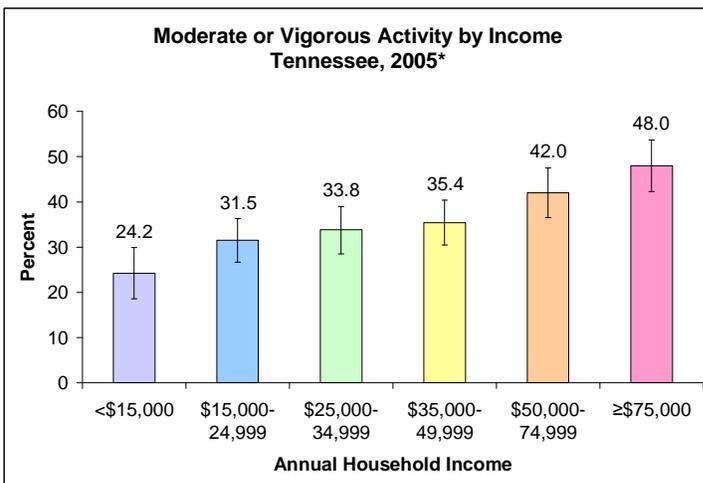
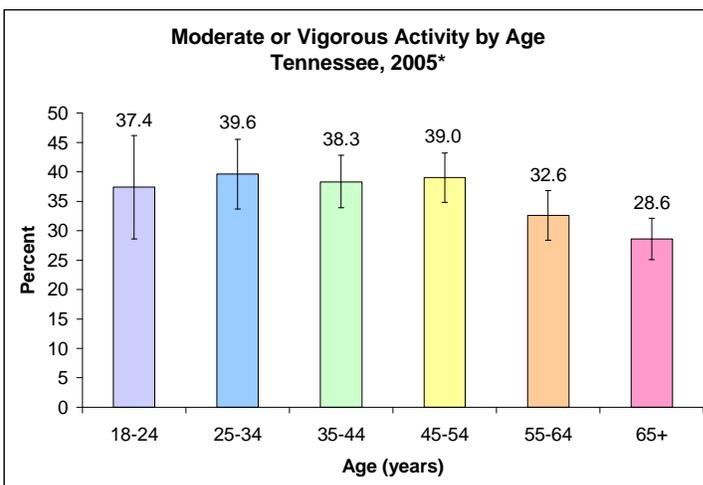


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Fact Sheet

Physical Activity

- The percentage of persons engaging in the recommended level of activity increased as education increased: less than high school 25.3% (± 6.0)*, high school graduate or GED 32.2% (± 3.8), some post-high school 40.8% (± 4.1), and college graduate 41.5% (± 3.7).
- The percentage of persons engaging in the recommended level of activity increased as annual household income increased, from 24.2% among those with an income of less than \$15,000 to 48.0% among those with an income of \$75,000 or more.
- The prevalence of obesity was higher among persons getting no or inadequate physical activity than in those getting the recommended level of moderate or vigorous activity.
- Persons getting no or inadequate physical activity were more likely to have arthritis, high blood pressure, coronary heart disease and diabetes than those getting the recommended level of moderate or vigorous activity.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text and charts.

†Other surveys have found much lower rates of physical activity. For example, the National Health Interview Survey found that the prevalence of moderate physical activity in the U.S. was just 15%.³

BRFSS Fact Sheet

Sexual Violence



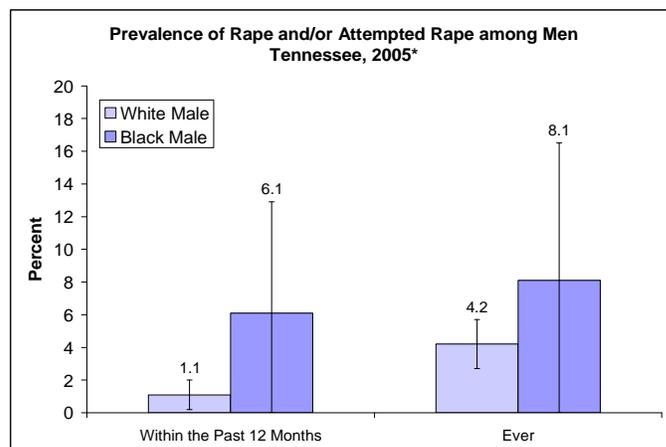
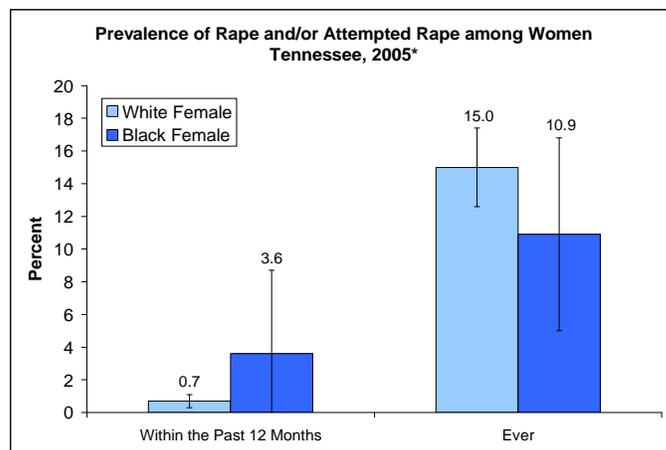
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Nashville, TN 37243

<http://state.tn.us/health>

Sexual violence is a serious problem that affects millions of people every year.¹ Available data greatly underestimate the true magnitude of the problem – rape is one of the most underreported crimes.¹ For example, only 39% of rapes and sexual assaults in the U.S. were reported to law enforcement officials in 2002.¹ Sexual violence can have very harmful and lasting consequences for victims and their families. These include sexually transmitted diseases, pregnancies, immediate and long term psychological consequences, and strained relationships with family, friends and intimate partners.¹ Much remains unknown about the factors associated with sexual violence, but they are likely to involve individual, relational, community and societal factors.¹

- In 2005, 9.5% (± 1.4)* of Tennessee adults reported being the victim of rape and/or attempted rape at some point during their lifetime (i.e. lifetime prevalence).
- 1.7% (± 0.9) reported being the victim of rape and/or attempted rape during the past 12 months (i.e. 12-month prevalence).
- 1.7% (± 0.7) of adults reported that in the past 12 months they had been exposed to unwanted sexual situations that did not involve touching (e.g. flashing, peeping, sexual harassment) and 2.0% (± 1.1) reported that sexual parts of their body were touched without their consent.
- The lifetime prevalence of rape and/or attempted rape was three times as high among women (14.0% ± 2.1) as among men (4.8% ± 1.7).
- The 12-month prevalence of rape and/or attempted rape was higher among black women (3.6%) than among white women (0.7%). However, the lifetime prevalence was higher among white women (15.0%) than black women (10.9%).
- Both the 12-month and lifetime prevalence of rape and/or attempted rape were higher among black men than among white men.



References:

1. National Center for Injury Prevention and Control (www.cdc.gov/ncipc)
2. Rape, Abuse and Incest National Network (www.rainn.org)
3. The National Women's Health Information Center (www.womenshealth.gov)

Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

BRFSS Fact Sheet

Sexual Violence

- The 12-month prevalence of rape and/or attempted rape decreased with increasing age, from 5.4% among 18-24 year olds to approximately 0.2-0.3% among those aged 55 years and older.
- Among 18-24 year olds, the 12-month prevalence of rape and/or attempted rape was higher among women (8.1% ± 7.9) than among men (2.6% ± 4.1). Among those older than 24, the prevalence was higher among men (1.7% ± 1.3) than women (0.4% ± 0.3).
- Persons with a lifetime history of rape and/or attempted rape were more likely to report one or more days of poor physical health or mental health during the past 30 days (53.2% and 50.3%, respectively) than those without a history of rape (32.2% and 27.4%).

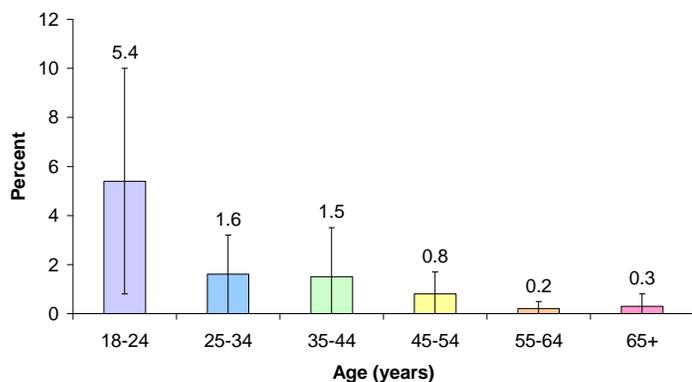
What do I do if I've been sexually assaulted?^{2,3}

- Get away from the attacker and to a safe place as fast as you can
- Call a friend or family member you trust, or call a crisis center or hotline to talk with a counselor
- Do not change clothes or wash, comb or clean any part of your body so that hospital staff can collect evidence
- Go to the nearest hospital emergency room as soon as possible so that you can be examined, treated for any injuries and screened for possible sexually transmitted diseases.
- You or the hospital staff can call the police to file a report
- Ask hospital staff about possible support groups
- Remember it wasn't your fault

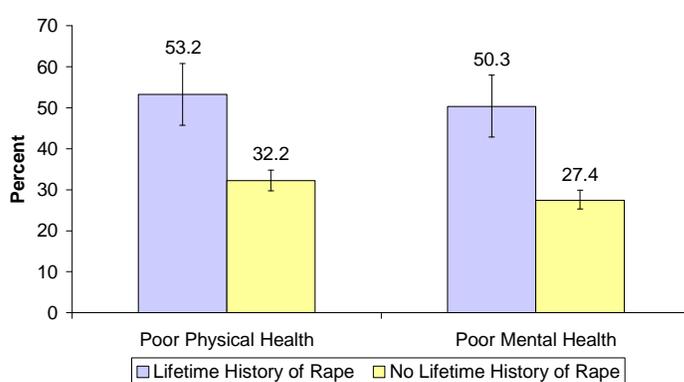
National Sexual Assault Hotline 1-800-656-HOPE

The Rape, Abuse and Incest National Network (RAINN) operates the National Sexual Assault Hotline, which provides free and confidential counseling 24 hours a day, 7 days a week. In addition, the RAINN website (www.rainn.org) provides listings of local sexual assault crisis centers and hotlines by zip code and state.

12-Month Prevalence of Rape and/or Attempted Rape
Tennessee, 2005*



Perceived Health Status Among Sexual Violence Victims
Tennessee, 2005*



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Stroke



Tennessee
Department of Health

Cordell Hull Bldg.
425 5th Avenue North
Nashville, TN 37247

<http://state.tn.us/health>

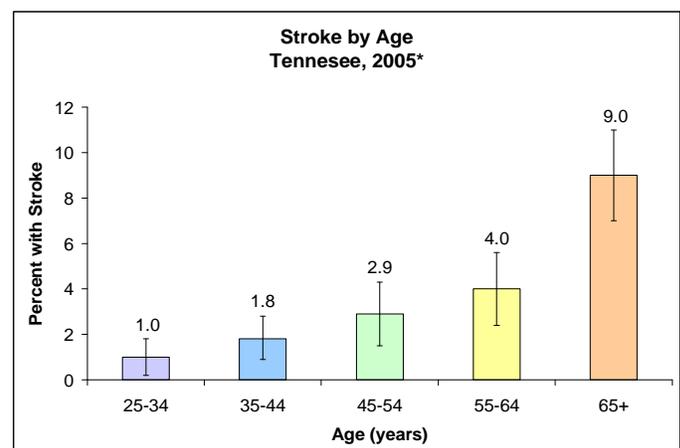
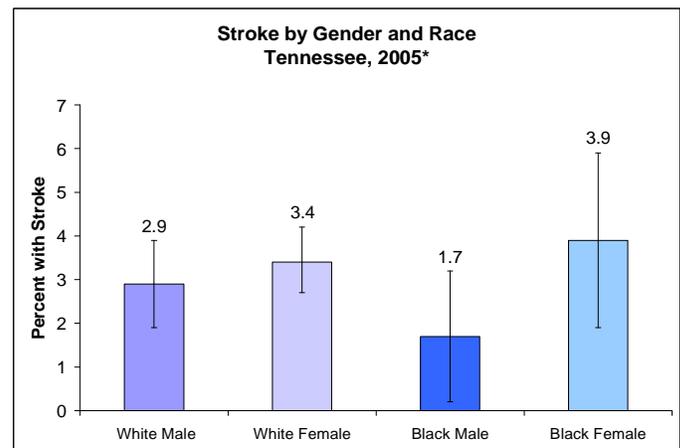
Approximately 700,000 strokes occur in the United States each year, and despite declining stroke mortality rates over the past 30 years, it remains the third leading cause of death in the U.S. and in Tennessee.¹ According to the American Heart Association, someone dies of this disease every three minutes in the U.S.¹ One of the Healthy People 2010 objectives is to reduce stroke deaths to 48/100,000 population.² Reducing risk factors for stroke (high blood pressure, high cholesterol, coronary heart disease, diabetes, overweight/obesity, smoking and excessive alcohol consumption) is important for reaching this goal and for increasing the quality and years of healthy life for all Tennesseans.

- In 2005, 3.2% of adult Tennesseans reported having ever been told by a health care provider that they had had a stroke.
- The percentage of persons having ever had a stroke was highest among black females (3.9%), followed by white females (3.4%), white males (2.9%) and black males (1.7%).[†]

- The prevalence of stroke increased with increasing age (from 1.0% in 25 to 34 year olds to 9.0% in those 65 years and older).

- Adults with less than a high school education (6.9% ± 2.2)* had the highest prevalence of stroke. The percentage of persons having had a stroke was lower in those with higher levels of education: high school graduate 2.9% (± 1.0), some post-high school 2.8% (± 0.9) and college graduate 2.1% (± 1.0).

- The percentage of persons having had a stroke decreased with increasing income.



Definition:

Stroke: A type of cardiovascular disease that occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts.

References:

1. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
2. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
3. American Stroke Ass. (www.strokeassociation.org)

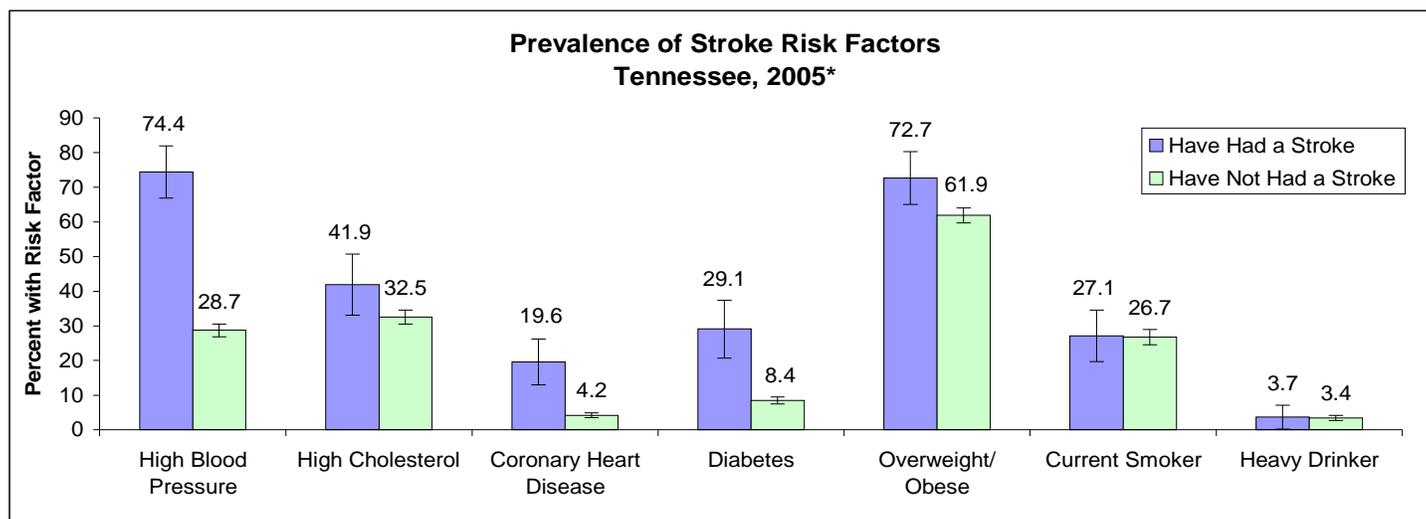
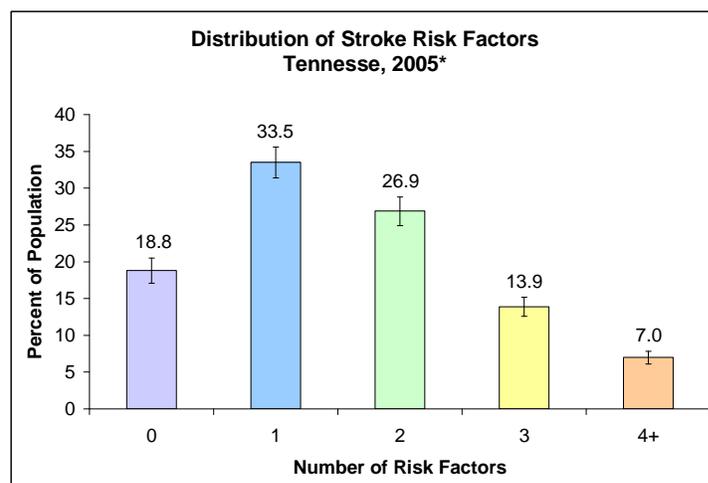
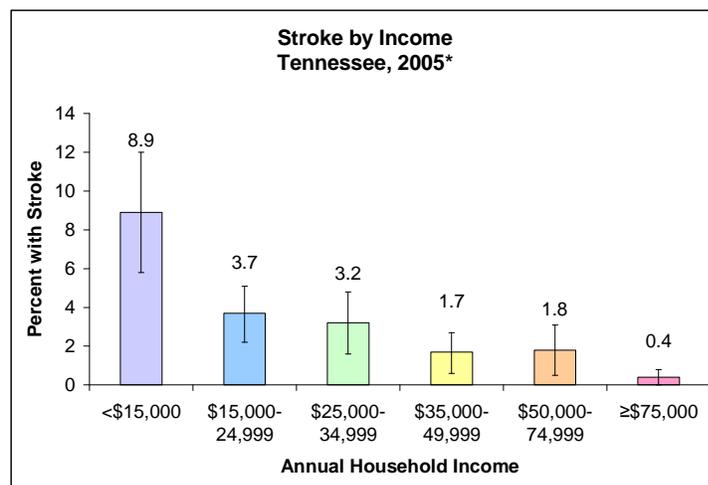
Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

BRFSS

Fact Sheet

Stroke

- Among the total population, only 18.8% of adults had *none* of the seven modifiable stroke risk factors examined in this fact sheet (high blood pressure, high cholesterol, coronary heart disease, diabetes, overweight/obesity, smoking and excessive alcohol consumption). 33.5% had one risk factor, and 47.7% had 2 or more risk factors.
- High blood pressure is the most important risk factor for stroke.³ 74.4% of persons who had ever had a stroke had high blood pressure, compared to just 28.7% of those who had not had a stroke.
- Coronary heart disease was approximately 3.5 times more common in persons who had ever had a stroke than in those who had not. Diabetes was approximately 2.5 times more common.
- Although smoking and heavy drinking are important risk factors for stroke, the prevalence of these behaviors was not found to be higher in persons who had ever had a stroke compared to those who had not.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

[†]Other surveys have found higher rates of stroke among black males. For example, the National Health and Nutrition Examination Survey found that the prevalence of stroke in 2003 was 2.3% in white males, 2.6% in white females, 4.0% in black males and 3.9% in black females.¹

BRFSS Fact Sheet

Symptoms of Heart Attack and Stroke



Tennessee
Department of Health

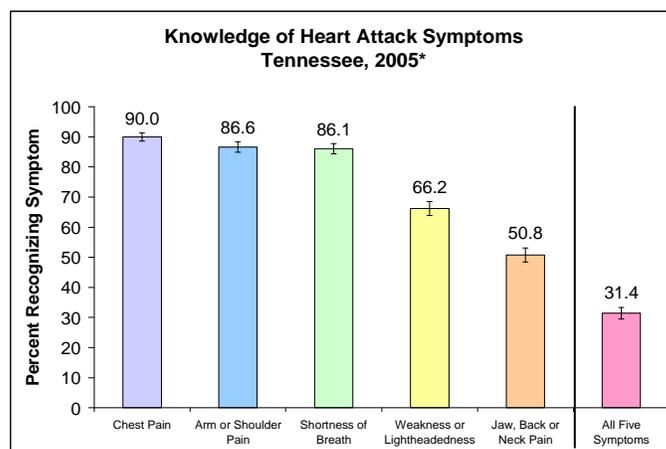
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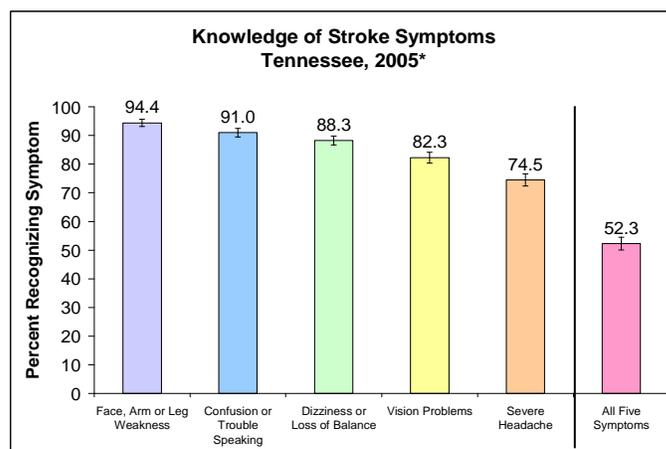
Approximately 480,000 people experience a fatal heart attack in the United States each year, and more than half of these deaths occur outside of a hospital, within one hour of symptom onset.^{1,2} Similarly, nearly half of the approximately 160,000 fatal strokes that occur each year happen before patients are transported to the hospital.^{2,3} Effective treatments for heart attack and stroke do exist. For example, clot-busting drugs can stop some heart attacks and strokes in progress. But to be effective, these drugs must be given relatively quickly after heart attack or stroke symptoms first appear.⁴ By recognizing the symptoms of heart attack and stroke and by calling 911 immediately, death and disability due to these diseases can be reduced.

- In 2005, 90.0% of adult Tennesseans correctly identified chest pain as a symptom of heart attack. A high percentage of people also correctly identified arm/shoulder pain (86.6%) and shortness of breath (86.1%). However, only 50.8% of people recognized jaw, neck or back pain as a symptom of heart attack.
- Numbness or weakness of the face, arm or leg was the most readily identified symptom of stroke (94.4%). Each of the other four warnings signs of stroke was correctly identified by at least three-quarters of adults.

- More people could correctly identify all five symptoms of stroke (52.3%) than could identify all five symptoms of heart attack (31.4%). Only 24.4% (± 1.8)* of adult Tennesseans could correctly identify all ten heart attack and stroke symptoms (listed on next page).



- 88.9% (± 1.4) of respondents correctly identified calling 911 as the first thing to do when you suspect someone is having a heart attack or stroke. 21.5% (± 1.6) could identify all ten heart attack and stroke warning signs and recognize 911 as the most appropriate first response option.



References:

1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.
2. American Heart Association. *Heart Disease and Stroke Statistics – 2006 Update*. Dallas, TX: AHA; 2006
3. CDC. *Awareness of Stroke Warning Signs – 17 States and the U.S. Virgin Islands, 2001*. MMWR 2004;53
4. American Heart Assoc. (www.americanheart.org)

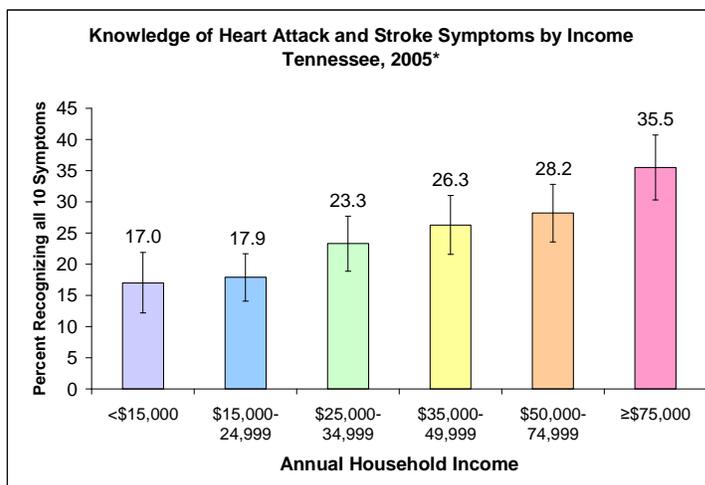
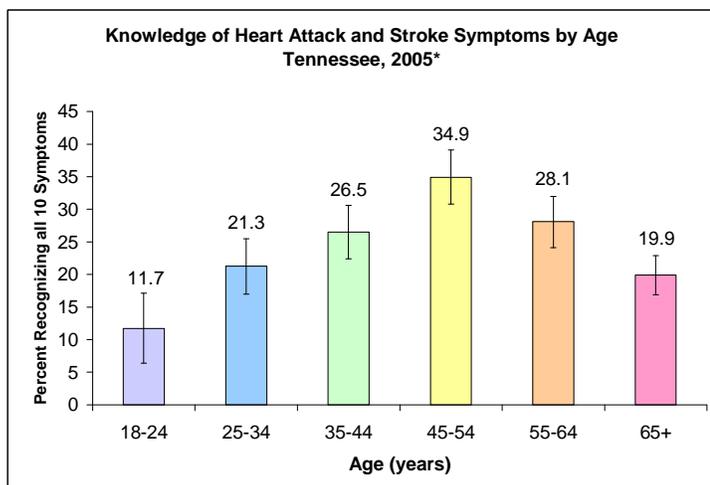
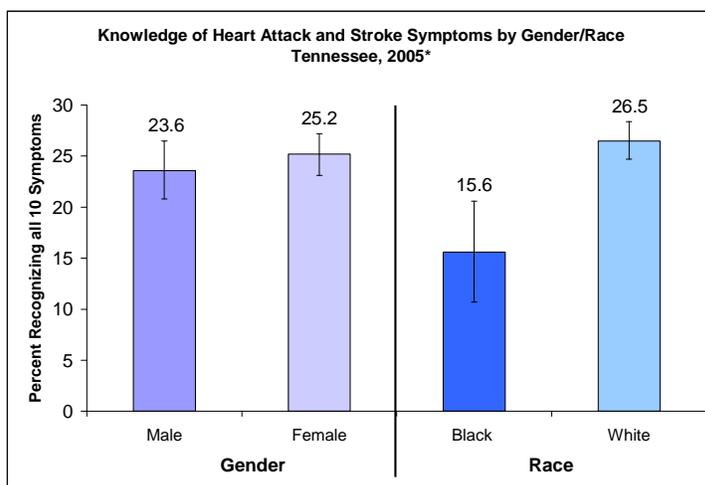
Prepared by the Tennessee Department of Health; Office of Policy, Planning and Assessment; Surveillance, Epidemiology and Evaluation section based on 2005 TN Behavioral Risk Factor Surveillance System data.

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Symptoms of Heart Attack and Stroke

- The percentage of adults recognizing all ten symptoms of heart attack and stroke was similar for males (23.6%) and for females (25.2%).
- Whites (26.5%) were more likely than blacks (15.6%) to correctly identify all ten symptoms.
- Persons aged 18-24 years old (11.7%) were *least* likely and those aged 45-54 (34.9%) were *most* likely to identify all ten symptoms. Only 19.9% of those 65 years and older could identify all ten warning signs of heart attack and stroke, even though cardiovascular disease is the number one cause of death in this age group.
- The percentage of adults that could recognize all ten symptoms increased with increasing education levels: less than high school 13.3% (± 3.9), high school graduate or GED 18.4% (± 2.7), some post-high school 27.2% (± 3.5) and college graduate 34.4% (± 3.7).
- The percentage of persons that correctly identified all ten warning signs of heart attack and stroke increased with increasing income.

Heart Attack Warning Signs ⁴	
1.	Chest discomfort that can feel like uncomfortable pressure, squeezing, fullness or pain
2.	Pain or discomfort in one or both arms or shoulders
3.	Pain or discomfort in the jaw, neck, back or stomach
4.	Shortness of breath
5.	Weakness, nausea or lightheadedness
Stroke Warning Signs ⁴	
1.	Numbness or weakness of the face, arm or leg, especially on one side of the body
2.	Confusion, trouble speaking or understanding
3.	Trouble walking, dizziness, loss of balance or coordination
4.	Trouble seeing in one or both eyes
5.	Severe headache with no known cause



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text.

BRFSS Fact Sheet

Vision Impairment



Tennessee
Department of Health

Cordell Hull Bldg.
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<http://state.tn.us/health>

In the United States an estimated 80 million people have potentially blinding eye diseases, 3 million have low vision and 1.1 million are legally blind.¹ More than two-thirds of visually impaired adults are over the age of 65, and as the population ages the number of people with visual impairment is expected to increase.¹ The leading causes of visual impairment are diabetic retinopathy, cataract, glaucoma and age-related macular degeneration.¹ Blindness and visual impairment from most eye diseases can be reduced with early detection and treatment.¹ Most eye diseases, however, lack symptoms until vision is lost.¹ Early intervention through regular eye exams is therefore important for maintaining healthy vision and for increasing the quality and years of healthy life for all Tennesseans.

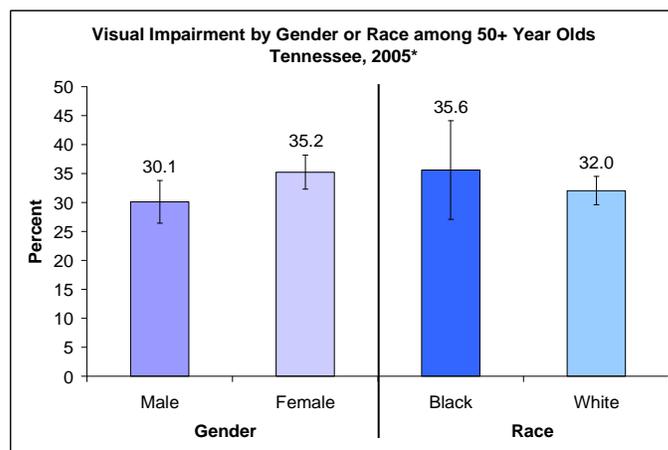
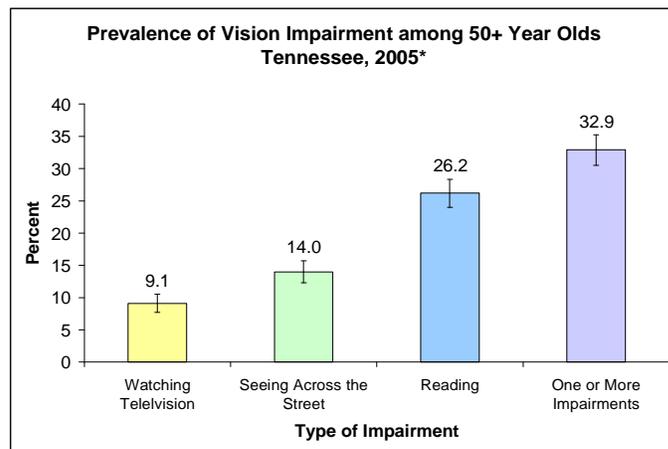
- In 2005, 32.9% of Tennesseans aged 50 and older reported that they had one or more visual impairments (i.e. they were unable to or had some difficulty reading, watching television and/or seeing a friend across the street because of eyesight).[†]
- 9.1% reported difficulty watching television, 14.0% reported difficulty seeing a friend across the street and 26.2% reported difficulty reading.

- A slightly higher percentage of females (35.2%) had visual impairments than did males (30.1%).

- A slightly higher percentage of blacks (35.6%) had visual impairments than did whites (32.0%).

- The prevalence of visual impairments decreased with increasing education, from 48.2% among those with less than a high school degree to 26.0% among college graduates.

- 31.2% (± 2.4)* of adults aged 50 and older had not had an eye exam in the past 12 months. 42.7% (± 2.8) had not had a *dilated* eye exam in the past 12 months.



Reference:

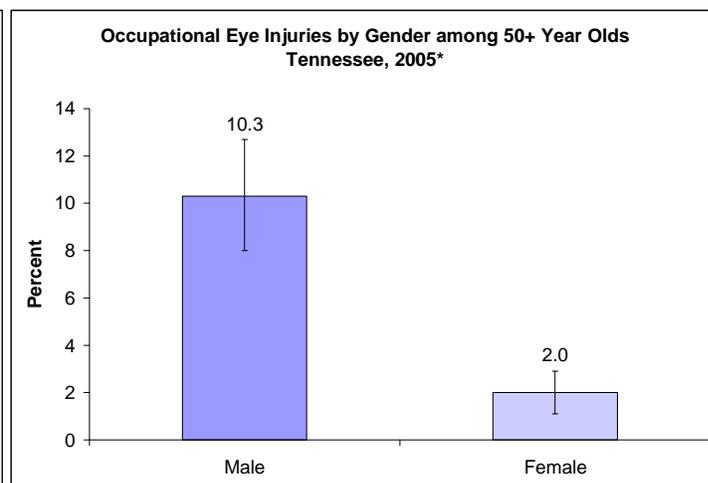
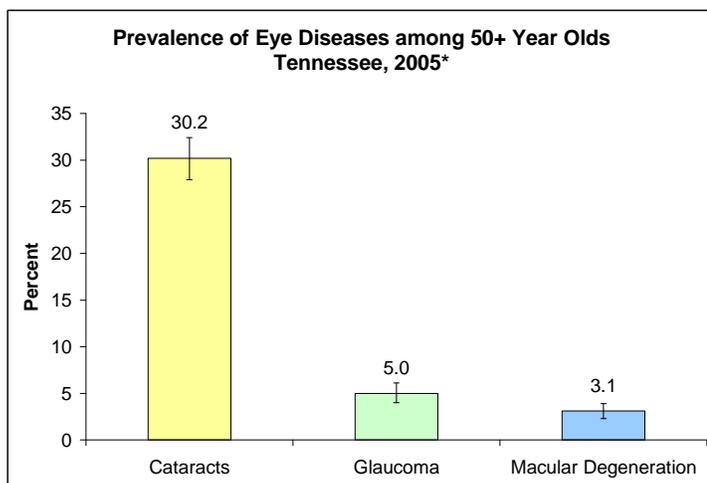
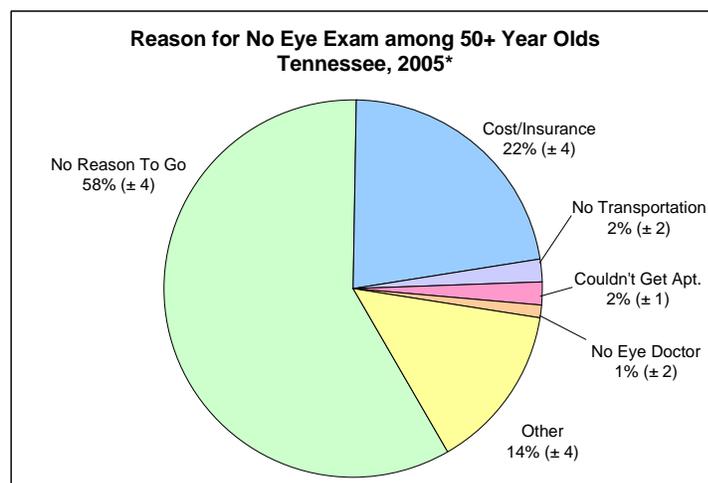
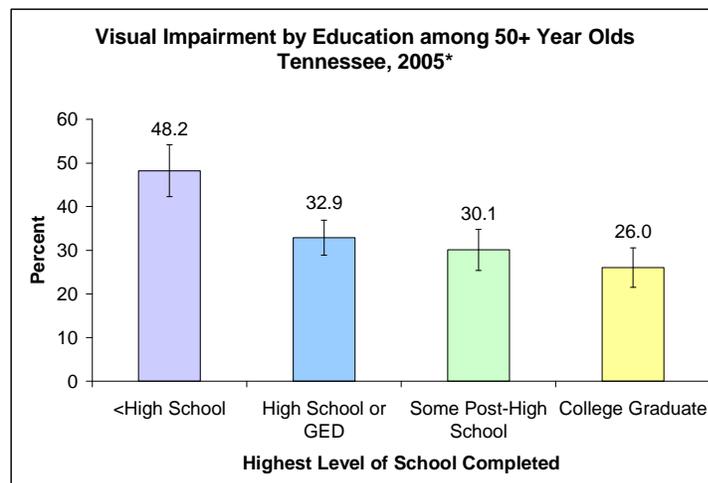
1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000.

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Vision Impairment

- The most common reason given for not having had an eye exam in the past 12 months was not having a reason to go or not thinking of going (58.0%). 22.1% reported they had not had an exam because of cost or lack of insurance.
- 55.0% (± 2.6) of adults aged 50 and older reported that they did not have insurance coverage for eye care.
- The prevalence of cataracts was 30.2%, that of glaucoma was 5.0% and that of macular degeneration was 3.1%. 23.0% of diabetics reported a history of diabetic retinopathy.
- 41.3% (± 4.3) of persons with a history of cataracts reported they had had their cataracts removed.
- The prevalence of occupational eye injuries was 5.8% (± 1.2). Males (10.3%) had a higher prevalence of occupational eye injuries than females (2.0%). 49.6% did not miss work as a result of their injuries. 32.7% missed 1-3 days of work and 17.7% missed greater than 3 days.



*The number above each column indicates the percent value for that column. Error bars represent 95% confidence intervals, as do ranges for percentages given in the text and charts.

† All data presented are for persons 50 years and older.