BACKGROUND ON NEW PUBLIC HEALTH INDICATORS

AIR QUALITY

The Public Health Indicators Workgroup will determine the threshold for this indicator which was previously defined as percent of days at least one monitor in the jurisdiction exceeded the threshold. The choices to conform to a threshold used elsewhere are as follows:

- The US National Ambient Air Quality Standard (NAAQS) is 35 ug/m^3. This is a political threshold, not a health-based one. The Washington Tracking Network uses this threshold, but they might be required to conform to national Environmental Public Health Tracking Network standards.
- The Washington State Department of Ecology has a health-based goal of 20ug/m^3 based on health for sensitive populations.
- WHO uses 25 ug/m^3.
- Canada uses 30 ug/m^3.

Another determination that also needs to be made is whether to present a single year of data or average multiple years. Unlike most of the indicators where it is possible to average over multiple years, air quality can swing widely from year to year depending on atmospheric conditions, forest fires, etc. Important information might be lost by averaging. On the other hand, if any days above the threshold is an indication of potential air problems that need additional scrutiny, averaging over years might work.

POVERTY

If the American Community Survey (ACS) is used, it is possible to get 3-year averages (2007-2009) for 27 LHJs. For the remaining 8 LHJs, 5-year averages (2005-2009) are available. It seems somewhat counterproductive to use 5-year averages for all LHJs, given that the poverty situation is currently somewhat volatile. Assuming that using ACS is chosen, the following options merit consideration:

- 3-year averages for the 27 LHJs, leaving the others blank
- 3-year averages for the 27 LHJs and 5-year averages for the remaining 8 LHJs with footnotes describing which LHJs have which data
- If 3-year averages provided, 2008-2010 data are due to be released in October 2011. 2007-2009 data could be used now or wait for the November release of this indicator with the 2008-2010 data. (The new 5-year averages are not due until December 2011, which might argue for the 1st bullet above)

The 2009 annual poverty estimates by county are the Small Area Income and Poverty Estimates (SAIPE) that the US Census Bureau develops annually - www.census.gov/did/www/saipe/about/index.html. The Census Bureau feeds data from a variety of sources [e.g., American Community Survey (ACS), SNAP (aka food stamps), tax info, population estimates] into regression models and develops estimates with 90% confidence intervals. Counties could easily be combined for LHJs, as needed.

The most current SAIPE estimates are for 2009, using data from 2007-2009 depending on the source. Because the estimates use the ACS, the Census Bureau likely won't update the estimates until the 2008-2010 ACS file is released and they might actually wait until after the 2006-2010 file is released in December (they use all three ACS file types depending on the county size). There might also be delays due to the need of data from other sources, as well.

- The advantage of ACS is that the data would be somewhat more recent for the 27 LHJs for which the 3-year estimates are available. 'Somewhat' because 2009 population estimates still might be used or 2008-2010 averages could be taken.
- The advantages of SAIPE are:
  - Same data sources for all LHJs
  - Easier to compile (smaller workload issue)

ACES

It seems that the ACES question will not continue to be on the BRFSS and information in future cycles will not be available. Additionally, ACES measures what happened to adults in THEIR youth, not what's happening to youth now. ACES might give information about the environments of youth since some adverse childhood events have intergenerational aspects, but as far as known ACES has not been validated to be used in this way. Also, if looking at people with kids, there would be greater small number issues than with the child health insurance module. Because there are so many questions in the module, there would be both cost and space issues with adding it to both Form A and Form B as is done with the child health insurance questions. In 2011, the module cost about $35,000 to be on Form A.