Trends and Disparities in Mortality in Eastern North Carolina
Total Deaths, Premature Mortality and Deaths for Ten Leading Causes; 1990-2020

A Resource for Healthy Communities

Health Indicator Series - Report #2.201
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Health Systems Research and Development
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1. Introduction

Health Indicators Series:
A Resource for Healthy Communities
May 2023


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

Report Series #2 of the series focuses attention on two overarching goals—to increase the span and quality of life, and to eliminate health disparities. Using rate comparisons, this report describes the inequalities in mortality among Eastern North Carolina and other regions, and among four demographic groups. Premature mortality, the focus of Report Series #1, is included in the death from all causes section located at the beginning of this report. The measure used to quantify premature mortality is described in more detail in the Methods and Interpretations section.

This report describes the leading contributors to mortality, provides a geographic context, and examines trends and inequalities over a 31-year period (1990-2020), as well as the most recent 16 year period (2005 to 2020). The report begins with data highlights, provided as an introduction to the data, rather than a summary of it. Readers are encouraged to draw their own conclusions from the data and pose new questions suggested by what they see. The following section presents both the overall and five leading contributors to mortality by race and gender. In this section, pie charts describe the relative contribution of each of five leading contributors to the overall, general rate. These charts also make regional and demographic comparisons. The next section charts recent trends and disparities in mortality and provides projections to the year 2030. These charts place Eastern North Carolina’s health status in a historical context and provide a glimpse into the future.
The region *Eastern North Carolina* is comprised of 29 counties located in the extreme east of North Carolina and approximates the coastal plain physiographic province of the state. It includes the northern counties east of I-95. This region is characterized by its rurality, poverty, and some of the highest mortality rates in the nation. The name of the region is abbreviated as ENC29 or ENC. The rest of North Carolina is the remaining 71 counties; abbreviated as RNC71 or RNC.
2. Data Highlights

Trends and Disparities in Mortality in Eastern North Carolina

The following highlights of mortality in the 29 counties of Eastern North Carolina (ENC29) describe current status and trends in the causes of death from major diseases and how they vary across different population groups. The graphs, charts, and tables paint a picture of the region’s health with a broad brush. The study of mortality in populations should include consideration of time and geographic space as well as underlying demographic, political-economic, and socio-cultural conditions. Readers are encouraged to think of these factors as they consider the data presented in this report, formulate their own questions about the causes of mortality, and think about strategies to reduce mortality in the population described.

Current Disparities in Mortality by Geography, Race, and Gender

In 2020, the age-adjusted mortality rate for Eastern North Carolina is 963 deaths per 100,000. This rate is 12% higher than the state rate. Within Eastern North Carolina, the non-White rate is 25% higher than the White rate. The non-White male rate is 34% higher than the rate for White males. The non-White female rate is 19% higher than the rate for White females.

All cause mortality and premature mortality both increased in 2020 due to the impact of COVID-19. The marked increase is evident in Figures 5.1 i-v and 5.2 i-v. In 2020 COVID-19 was directly responsible for 1426 deaths in ENC29, but may have also indirectly led to increased mortality from other causes such as heart disease and cerebrovascular disease due to delayed care because of the pandemic. Because COVID-19 is a new cause of death with no trend data available this report does not include charts for it. For a look at the 2020 impact of COVID-19 in eastern North Carolina readers may refer to the report, COVID-19 in Eastern North Carolina, which is available on this web page.

The five general leading causes of mortality in Eastern North Carolina (2020) are:
1. Diseases of Heart
2. Cancer—All Sites
3. COVID-19
4. Cerebrovascular Disease
5. All Other Unintentional Injuries and Adverse Effects

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<tr>
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<tr>
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<td>Chronic Lower Respiratory Diseases</td>
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</tr>
<tr>
<td>5th Diabetes Mellitus</td>
<td>Cerebrovascular Disease</td>
<td>Diabetes Mellitus</td>
<td>Cerebrovascular Disease</td>
<td></td>
</tr>
</tbody>
</table>
Trends in Mortality from All Causes

- The 31-year and 16-year trend lines show all cause mortality rates increasing for ENC, NC and RNC, with very steep increases in 2020, likely due to COVID-19.
- The age-adjusted all cause mortality rate trends for ENC, NC, RNC and the US have been decreasing over the 31-year period, but all show large increases for 2020. The 16-year trend shows a very slight decrease.
- The non-White male mortality rate trend remains higher than other demographic groups. The 16-year trend for non-White males, White males and non-White females show slight decreases. The 16-year trend for White females is flat and is the lowest. All groups show a marked increase in 2020.
- The 16-year trend for non-Whites is decreasing, the trend for Whites is lower, but unreliable. Both groups show an increase for 2020.
- Over the 16-year trend there is a decrease in racial disparity, but there was a sharp jump up in 2020.

Trends in Premature Mortality from All Causes of Death

- The 16-year trend for premature mortality rates for ENC, RNC and NC are increasing but are unreliable. There was a sharp increase in premature mortality rates for all groups in 2020, likely due to COVID-19.
- The age-adjusted premature mortality rate trends for ENC, NC, RNC and US are all increasing but are also unreliable. All rates showed a sharp increase in 2020, likely due to COVID-19.
- The 16-year age adjusted rate trends for non-White males, White males and non-White females are unreliable. The rate for White females shows a slight increase. All rates jumped up in 2020. The rate for non-White males is the highest and increased the most in 2020.
- The 31-year rate trend for non-Whites is decreasing. The 16-year rate trend is flat but unreliable. The 16-year rate trend for Whites shows a small increase, in a moderately reliable trend. Both rates increased sharply in 2020.
- The 16-year trend for racial disparity shows a 22% decrease in a moderately reliable trend.

Diseases of the Heart

- ENC’s 16-year heart disease mortality rate is 27% greater than the RNC rate, but ENC’s rate trend is flat and not reliable.
- While ENC’s age-adjusted mortality rate trend is decreasing at a pace similar to RNC, NC and the US, the ENC rate remains 18% greater than the RNC rate in 2020.
- The non-White male rate trend remains slightly higher than the White male trend; both are declining. The non-White female trend is 7% greater the White female trend but is projected to drop below the White female trend.
- The non-White rate trend remains 8% greater than for Whites, but the 16-year trends for both are decreasing and convergence is suggested in the future.
- The 16-year trend line for racial disparity is decreasing in a moderately reliable trend.

Cerebrovascular Disease

- ENC’s cerebrovascular disease mortality rate has turned up in recent years and is 33% greater than RNC. The rate trend has increased 19% over the 16-year period.
- The ENC age-adjusted cerebrovascular disease mortality rate trend has decreased 12% over the 16-year period. It remains 23% greater than the RNC rate trend.
- Non-White males have the highest mortality rate for cerebrovascular disease, but the rate has decreased 15% over the 16-year period. The rate for non-White females has decreased 22% and is projected to converge with the trend for White males and White females.
• The cerebrovascular disease mortality rate trend for non-Whites is decreasing but is still 38% greater than Whites in 2020.
• The 16-year trend for racial disparity shows a decrease of 29% in a moderately reliable trend.

All Other Unintentional Injuries and Adverse Effects
• The mortality rate trend for unintentional injuries and adverse effects shows a sharp increase in ENC (147% over 16 years). The trends for RNC and NC are also up sharply.
• The age-adjusted mortality rate trends for ENC, RNC, NC, and the US are all increasing. During the last 16 years the ENC rate has increased 140% and it is now 10% greater than RNC.
• The trends are increasing for all groups, but the White male rate is the highest and shows the greatest increase (168% over 16 years).
• The White rate trend has increased 151% over the 16-year period. The non-White rate is 36% less than the White rate and increased 115% over the period.
• Over the 16-year period racial disparity has decreased but the trend is not reliable.

Cancer—Tracheal, Bronchus, Lung
• The 16-year trend line for cancer-TBL for ENC has decreased 15% over the period. The ENC rate for 2020 is 21% greater than the rate for RNC.
• In 2020 the age-adjusted rate for ENC is 13% higher than RNC. The 16-year trend for ENC has decreased 37%.
• The mortality rate trends for White and non-White males are decreasing and converged in 2020. The White male rate is now higher than the non-White male rate. The rate for non-White females is 31% less than the rate for White females.
• The non-White mortality rate trend for this cancer is consistently lower than the White rate (17% less than Whites). Both trends are decreasing over the 16-year period, but non-White is decreasing more quickly.
• The trend for racial disparity is not reliable.

Chronic Lower Respiratory Diseases
• The 31-year ENC trend for CLRD is increasing, as is the 16-year trend. In 2020 the ENC rate is 7% greater than the RNC rate.
• The ENC age-adjusted rate trend is converging with the RNC and NC trends. All three are higher than the US rate trend.
• The rate trend for White males is the highest but is decreasing. The rate for non-White males has decreased 24% over the 16-year period in a moderately reliable trend and is now below the rate for White females, which is increasing. The rate for non-White females is the lowest and is increasing in a moderately reliable trend.
• The 16-year trend for Whites is higher than the non-White rate, but both rates are flat. The non-White rate is unreliable.
• The disparity trend between White and non-White is unreliable.

Diabetes Mellitus
• The 16-year rate trend for ENC has increased 38% over the period and is 43% greater than the RNC rate.
• In 2020, the ENC 16-year rate trend for age-adjusted diabetes mellitus is 36% greater than RNC, but the trend is not reliable.
• The non-White male 16-year rate has increased by 22%. The non-White female trend has decreased 18%. The White male and White female trends are lower. The trend for white females is unreliable.
• In 2020 the non-White mortality 16-year rate trend is 123% greater than the White, but both are flat and unreliable.
• The 16-year trend for racial disparity is not reliable.
Alzheimer's Disease
- The Alzheimer’s mortality rate trend for ENC shows a steep increase over the 16-year period (175%). ENC’s rate of increase was larger than RNC and NC, but the rate for ENC is still 5% less than RNC.
- In 2020, the age-adjusted rate for ENC is 14% less than the rate for RNC. The ENC rate trend has increased 87% over the 16-year period and is 6% greater than the US rate.
- Rate trends are increasing for all groups, but non-White males and non-White females have the greatest increase (126% and 147% over 16 years, respectively). The trends for White females and non-White females are projected to converge in the future.
- The White and non-White rate trends have converged. Both trends are increasing over the 16-year period.
- The 16-year trend shows an 115% increase in racial disparity in a reliable trend.

Nephritis, Nephrotic Syndrome, and Nephrosis
- In 2020 ENC’s rate trend for nephritis, nephrotic syndrome and nephrosis is 13% greater than RNC, but the trend is not reliable.
- With age-adjustment, the ENC rate trend has decreased 25% over the 16-year period. It is 4% greater than the RNC rate and 3% greater than the NC rate. They are projected to converge soon.
- The 16-year trends for non-White males and non-White females are the highest but have decreased 22% and 34% over the 16-year period. The non-White male trend in 2020 is 124% greater than the White male trend and 221% greater than the White female trend. All trends are decreasing.
- The non-White rate in 2020 is 121% greater than the White rate. It has decreased 29% over the 16-year period. The White rate has decreased 23%.
- The trend for racial disparity is not reliable.

Unintentional Motor Vehicle Injuries
- The mortality rate trend for unintentional motor vehicle injuries in ENC has decreased by 20% over the 16-year period but has recently ticked up. In 2020 ENC’s rate trend is 23% greater than RNC.
- With age-adjustment, the ENC rate trend has decreased 22% over the 16-year period but has recently gone up. It is 23% greater than the RNC rate and 19% greater than the NC rate.
- The 16-year trends for non-White males and White males are the highest, but the White male trend line has experienced a 40% decrease over the 16-year period. The rate for non-White males is unreliable. Non-White females and White females are lower, with White females decreasing by 42% over the 16-year period. The trend for non-White females is unreliable.
- The non-White rate in 2020 is 61% greater than the White rate but is unreliable. The White rate is decreasing, 41% over 16 years.
- The 16-year trend shows a 365% increase in disparity that favors Whites and is projected to further increase in the future.

Pneumonia and Influenza
- The crude mortality rate for pneumonia and influenza for ENC is 13% greater than RNC in 2020 but the trend is not reliable.
- The age-adjusted mortality rate trend for ENC, RNC and NC are similar and are decreasing at about the same pace. The ENC rate in 2020 is 5% greater than the RNC rate.
- The age-adjusted mortality rate trends for all four demographics are decreasing around the same rate. The trends for non-White males and White males are the highest.
The non-White mortality rate and the White mortality rate are both decreasing and are converging. The non-White rate was 6% less than White in 2020.

The 16-year trend for racial disparity is unreliable.

### Cancer – All Sites
- The cancer-all sites mortality rate trends for ENC, RNC, and NC are flat and are not reliable.
- The age-adjusted cancer-all sites mortality rate trends for ENC, RNC, NC and US are all decreasing. The ENC rate is 9% greater than the RNC rate.
- The rate trend is decreasing for all groups. The rate for non-White males has decreased by 40% in the 16-year period and is set to converge with the rate for White males. White and non-White females are decreasing at similar rates.
- Both the White and non-White cancer mortality trends are decreasing over the 16 year period. The non-White rate decreased by 31% and the White rate decreased 21%. The non-White rate remains 7% greater than the White rate in 2020, but they are projected to converge.
- The 16-year trend for racial disparity shows a 70% decrease.

### HIV Disease
- The HIV mortality rates for ENC have been decreasing over the past 16 years but are still 37% greater than RNC in 2020.
- The age-adjusted rate trend for ENC, RNC, and the US are all decreasing and set to converge. The ENC rate is 47% greater than RNC in 2020.
- Non-White males continue to have the highest rate of age-adjusted mortality, but the rate has decreased 82% in the 16-year period. Non-White females have the second highest rate, but it has also declined. All demographics are projected to converge in the future.
- The 16-year age-adjusted HIV mortality rates have decreased for both Whites and non-Whites by 81% and 66% respectively. The non-White rate is still 620% greater than the White rate.
- The 16-year trend for racial disparity is unreliable.
3. Methods, Interpretation, and References

Data Sources
The data for mortality and premature mortality in Eastern North Carolina were obtained from death certificate data from the North Carolina State Center for Health Statistics and population data from the National Center for Health Statistics bridged-race population estimates. For the US, data were obtained from the CDC Multiple Cause of Death public use data file.

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

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

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

Age-adjustment to control for a population’s age structure requires an external reference or standard to weight the comparison populations by age groups. Currently, the US 2000 Standard Million Population (SMP) is used as the external reference. The US 2000 SMP is divided into a number of age groups whose sizes or proportions serve as weights to be applied to the corresponding age groups of the study population. This proportional redistribution generates new numbers of expected deaths in each of the corresponding age groups of the study population. These expected deaths are the number of deaths we would expect if the study population had the same age structure as the US 2000 SMP. The expected number of deaths are summed and normalized by the total population yielding an age-adjusted death rate. Once the effects of age structure are controlled, the way is paved for making comparisons among populations (Buescher, 1998).
The second measure, premature mortality, focuses on the burden of disease and death expressed in terms of accumulated person years lost before a benchmark age. We use 75 years of age as a benchmark because it approximates current life expectancy at birth in the United States and gives weight to deaths from chronic disease occurring in later life. It considers only deaths of people who die before age 75. To calculate the number of years lost, the mid-point age of the age group to which each decedent belongs is subtracted from 75 and the differences (the lost years) are summed. After all lost years are summed; the result is normalized by the population under age 75 and multiplied by 10,000. Premature mortality is expressed as a rate measured over a time interval, and it can also be age-adjusted.

Age-adjusted rates for both mortality and premature mortality have little intrinsic meaning, however, and can mask the burden and trends of mortality (or health event) that may be of local importance. A casual inspection of adjusted rates may divert attention from the actual health problems of a population and inappropriately guide interventions or resource allocation. Thus, it is important to consider the actual number of deaths (count data) in conjunction with the basic non-adjusted mortality rate first, and then use the adjusted rate only if one wishes to factor out age in understanding the pattern of mortality among populations and regions. For regions with larger populations the statistics presented here are for the year 2020. Smaller areas like counties will usually be aggregated into 5-year intervals (e.g., 2015 to 2020). A five-year interval is used because it provides a useful summary of the mortality experience while minimizing wide year-to-year fluctuations in the rate due to the effect of small numbers.

**Interpreting the Pie Charts**

Pie charts are provided as a visual representation of the burden of mortality. They depict the proportion of mortality accounted for by each of the leading contributors. (The leading causes of death are found in the table preceding the pie chart section.) The pie charts compare the relative levels of burden and proportions by region and demographic groups. Each regional and demographic set of pie charts is based on the observed mortality rate and the age-adjusted (expected) mortality rate.

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

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

**Interpreting the Trend Figures**

Four types of figures are used to show trends in mortality, for all causes combined, and for each of the ten leading causes in the region/county over a 31-year period. Premature mortality is described for deaths by all causes only. The first of the four types of figures depicts the observed mortality rates for the region/county and state. The second figure type shows age-adjusted mortality rates for the region/county, state, and nation allowing comparisons among geographical areas. The third figure type compares trends in age-adjusted mortality rates by race and gender. Adjustment is made for age structure differences among demographic groups, which permits observation on the effects of race and gender on these groups. The last figure type depicts racial differences (or disparities) expressed as a ratio (in percent) of age-adjusted mortality for non-Whites to the age-adjusted rates for Whites over the 31 year time series. Trend lines provide historical depth to mortality processes and a basis for prediction, future comparisons, and action.
Trends and Disparities in Mortality in Eastern North Carolina-29 Counties

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

The equation of the line is derived from a set of observation points. This line is an estimate of where each observed rate would be if the previous observation could predict with 100% accuracy the value of the next observation. In nature, this situation seldom arises and the degree to which individual observations deviate from this linear trend line is an indication of how well they “fit” or conform to the trend. The linear trend lines in the time series figures project expected rates to the year 2030 from known historical values (2005 to 2019) to provide a general idea about where mortality trends are heading.

The equation of the line allows the user to calculate an expected or fitted rate for any given year, x. For example, in figure 6.2 ii the year 2013 is the 9th year in the series, so 9 would be substituted for x in the equation of the line derived from ENC29’s age-adjusted mortality rate series for a selected cause of death. For cerebrovascular diseases (2005 to 2020), the 2013 expected or fitted age-adjusted rate is calculated to be 50.84 deaths per 100,000 people. The observed age-adjusted rate for 2013 is 46 deaths per 100,000 people. (The observed rates are the values found in the table that runs along the x-axis of the time series chart.) The numeric difference between the expected and observed rates for 2013 is 4.84—the model (the equation of the line) overestimates the observed value by 4.84 deaths. Each previous and subsequent year’s difference between the expected and observed rates will vary to a greater or lesser degree depending on the size of the population under study (see below). This variation can be measured to determine how well the line fits or models the observed data.

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

Coefficients of determination (R²) are provided to indicate how well the fitted line predicts or explains the observed rates. When variation in the observed rates is relatively high (the fitted trend line does not correspond well to the observed trend line) R² approaches 0.0, when the variation is low, R² approaches 1.0. A low R² implies low reliability and a larger R² indicates that a greater degree of confidence can be placed in the trend line. The trend lines are generally unreliable when R² is less than 0.10, moderately reliable when R² is between 0.10 and 0.35, and most reliable when R² is equal to or greater than 0.35. Graphically, data points, data lines and trend lines are weighted according to their reliability and significance. The thinnest trend lines are for those where R² is less than 0.10 and should be considered not reliable. The thickest lines are used for trends where the R² is equal to or greater than 0.35. In some cases, the trend lines do not fit the data well (i.e. small R²). In other words, the presentation of a trend line does not necessarily indicate a linear trend in the data line. In several instances a non-linear trend may be present. It should be noted that the linear trend modeling undertaken here is a major simplification of real world processes. These processes are dynamical in nature and can be modeled and fitted with certain limitations and assumptions. Time series of epidemic infectious disease mortality rates typically exhibit a curvilinear pattern. A marked curvilinear pattern is seen in the mortality series for HIV/AIDS mortality, general cancer mortality, and several others which can be approximated into at least two sequential linear segments. Each segment is joined to another in the sequence at a point in time or year. In this series (#2), we begin to explore alternative methods for examining trends that show discontinuities and reversals within the set of time series observations, particularly within the mortality time series for HIV/AIDS.
Percent change provides a measure of the estimated change in mortality over the most recent sixteen year period (2005-2020). The percent value is followed by the term increase or decrease to help denote the direction of the overall trend. This information is in boldface and included with the \( R^2 \) value and the equation of the line. Percent change and the direction of that change is provided on the graphs for trends where \( R^2 \) is greater than 0.10.

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

The final tool is the pair of comparison tables located in the lower portion of the page. The tables, found in every time series figure (except the ones showing comparisons by race and disparity) are structured so that the reader can make comparisons of rates derived from the equation of the line (i.e., the fitted rates) among all regions or demographic groups portrayed in the figure. The 2005 and 2020 tables compare the fitted rates calculated for the beginning and end of the observed time series in terms of percent difference. Returning to figure 6.2 ii, ENC29’s age-adjusted fitted rate for cerebrovascular diseases in 2005 is 8% greater than (GT) RNC’s fitted rate. In 2020, ENC29’s fitted rate is 23% greater than (GT) RNC’s fitted rate. The tables permit a quick assessment of trends calculated from observed time series data.

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

**Caveats about the Concepts of Race, Gender, and Geography**

Several caveats are offered about the concepts of race, gender, and geography as they apply to the analysis of mortality patterns. While we do intend to bring attention to the stark racial inequalities in mortality across North Carolina, we do not mean to imply that this is a biological phenomenon. Other factors such as differences in socioeconomic status, educational attainment, occupation, and lifestyle probably account for the large racial gaps in mortality rates. Likewise, gender inequalities may have less to do with biological differences between men and women than with socially structured gender roles, health behaviors, occupational exposures, and use of health services. Finally, it is important to consider that county borders may not always be the most appropriate way to look at specific health problems. Few of our health care problems begin or end at political boundary lines and many of our health problems in North Carolina are common to large groups of counties. Counties and larger regions composed of counties are convenient units of data collection and readers should not jump to conclusions about health
problems or possible solutions based solely on the way data appear when aggregated to this level. In some cases, data at multi-county, zip code, or minor civil division levels are a better way to understand problems and solutions. Similarly, consideration needs to be given to whether or not a county is characterized as rural or urban, as this can be an indication to the level of development and amount of resources available in a county.
Trends and Disparities in Mortality in Eastern North Carolina-29 Counties

General References


Cited References

4. Current Disparities in Mortality by Geography, Race and Gender, and Race: Total and Five Leading Causes of Death
Figure 4.1 i. General leading causes of death for ENC29 (2020), NC (2020), and US (2020). Mortality rate per 100,000 population.

- ENC29: 1223 deaths/100,000
- North Carolina: 1035 deaths/100,000
- United States: 1027 deaths/100,000

Slices without percentages constitute less than 5% of the deaths within that chart.

2020 NC rate is 19% higher than 2020 US rate
Figure 4.1 ii. General leading causes of death for ENC29 (2020), NC (2020), and US (2020). Age-adjusted mortality rate per 100,000 population.

ENC29: 963 deaths/100,000
North Carolina: 858 deaths/100,000
United States: 835 deaths/100,000

2020 NC age-adjusted rate is 15% higher than 2020 US age-adjusted rate

Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.2 i. General leading causes of death for ENC29 (2020) by race and gender. Mortality rate per 100,000 population.

Non-White Males

- Diseases of Heart: 45%
- Cancer - All Sites: 5%
- Cerebrovascular Disease: 16%
- Chronic Lower Respiratory Diseases: 11%
- Diabetes Mellitus: 5%
- COVID-19: 5%
- All Other Unintentional Injuries and Adverse Effects: 5%
- All Other Deaths: 43%

- 1378 deaths/100,000
- 2020 ENC29 NWM rate is 9% greater than 2020 ENC29 WM rate

White Males

- Diseases of Heart: 40%
- Cancer - All Sites: 6%
- Cerebrovascular Disease: 22%
- Chronic Lower Respiratory Diseases: 20%
- Diabetes Mellitus: 7%
- COVID-19: 6%
- All Other Unintentional Injuries and Adverse Effects: 5%
- All Other Deaths: 40%

- 1262 deaths/100,000

Non-White Females

- Diseases of Heart: 42%
- Cancer - All Sites: 8%
- Cerebrovascular Disease: 18%
- Chronic Lower Respiratory Diseases: 17%
- Diabetes Mellitus: 10%
- COVID-19: 5%
- All Other Unintentional Injuries and Adverse Effects: 5%
- All Other Deaths: 44%

- 1158 deaths/100,000
- 2020 ENC29 NWF rate is 1% greater than 2020 ENC29 WF rate

White Females

- Diseases of Heart: 64%
- Cancer - All Sites: 6%
- Cerebrovascular Disease: 18%
- Chronic Lower Respiratory Diseases: 19%
- Diabetes Mellitus: 6%
- COVID-19: 7%
- All Other Unintentional Injuries and Adverse Effects: 6%
- All Other Deaths: 6%

- 1142 deaths/100,000

Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.2 ii. General leading causes of death for ENC29 (2020) by race and gender. Age-adjusted mortality rate per 100,000 population.

2020 ENC29 NWM age-adjusted rate is 34% higher than 2020 ENC29 WM age-adjusted rate

1415 deaths/100,000

2020 ENC29 NWF age-adjusted rate is 19% higher than 2020 ENC29 WF age-adjusted rate

884 deaths/100,000

Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.3 i. General leading causes of death for ENC29 (2020) by race. Mortality rate per 100,000 population.

Slices without percentages constitute less than 5% of the deaths within that chart.
Figure 4.3 ii. General leading causes of death for ENC29 (2020) by race. Age-adjusted mortality rate per 100,000 population.

Non-White

2020 ENC29 NW age-adjusted rate is 25% higher than 2020 ENC29 W age-adjusted rate

- Diseases of Heart
- Cancer - All Sites
- Cerebrovascular Disease
- Chronic Lower Respiratory Diseases
- Diabetes Mellitus
- COVID-19
- All Other Unintentional Injuries and Adverse Effects
- All Other Deaths

1113 deaths/100,000

White

- Diseases of Heart
- Cancer - All Sites
- Cerebrovascular Disease
- Chronic Lower Respiratory Diseases
- Diabetes Mellitus
- COVID-19
- All Other Unintentional Injuries and Adverse Effects
- All Other Deaths

889 deaths/100,000

Slices without percentages constitute less than 5% of the deaths within that chart.
5. Trends and Disparities in Mortality in ENC29:
   All Causes of Death and All Causes of Premature Mortality; 1990-2020
All Causes of Death

- The 31-year and 16-year trend lines show all cause mortality rates increasing for ENC, NC and RNC, with very steep increases in 2020, likely due to COVID-19.

- The age-adjusted all cause mortality rate trends for ENC, NC, RNC and the US have been decreasing over the 31-year period, but all show large increases for 2020. The 16-year trend shows a very slight decrease.

- The non-White male mortality rate trend remains higher than other demographic groups. The 16-year trend for non-White males, White males and non-White females show slight decreases. The 16-year trend for White females is flat and is the lowest. All groups show a marked increase in 2020.

- The 16-year trend for non-Whites is decreasing, the trend for Whites is lower, but unreliable. Both groups show an increase for 2020.

- Over the 16-year trend there is a decrease in racial disparity, but there was a sharp jump up in 2020.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 5.1 i. All Causes of Death:
Trends in mortality rates for ENC29, RNC71, and NC
1990-2020 with projections to 2030

ENC29 16-yr trendline: 22% increase
R2 = 0.52
y = 12.16x + 877.07

RNC71 16-yr trendline: 17% increase
R2 = 0.61
y = 8.33x + 781.59

NC 16-yr trendline: 18% increase
R2 = 0.59
y = 8.74x + 796.22

Comparison of Fitted Rates in 2005
ENC29: 11% LT
RNC71: 9% LT
NC: ENC29

Comparison of Fitted Rates in 2020
ENC29: 14% LT
RNC71: 12% LT
NC: ENC29

2005 ENC29 rate is 12% greater than RNC71
2020 ENC29 rate is 17% greater than RNC71

2020 ENC29 rate is 17% greater than RNC71
Figure 5.1 ii. All Causes of Death:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
5% decrease
R² = 0.10
y = -2.95x + 888.74

RNC71 16-yr trendline
6% decrease
R² = 0.29
y = -3.33x + 820.75

NC 16-yr trendline
7% decrease
R² = 0.26
y = -3.39x + 831.40

US 16-yr trendline
6% decrease
R² = 0.14
y = -2.82x + 777.17

2005 ENC29 rate is 8% greater than RNC71
2020 ENC29 rate is 10% greater than RNC71
Figure 5.1 iii. All Causes of Death: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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Figure 5.1 iv. All Causes of Death:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
11% decrease
R² = 0.16
y = -6.67x + 1,013.54

W 16-yr trendline
R² = 0.07
y = -1.82x + 834.03

2005 non-White rate is 22% greater than White
2020 non-White rate is 13% greater than White
Figure 5.1 v. All Causes of Death:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
41% decrease
$R^2 = 0.21$
$y = -0.55x + 21.46$
All Causes of Premature Mortality

- The 16-year trend for premature mortality rates for ENC, RNC and NC are increasing but are unreliable. There was a sharp increase in premature mortality rates for all groups in 2020, likely due to COVID-19.

- The age-adjusted premature mortality rate trends for ENC, NC, RNC and US are all increasing but are also unreliable. All rates showed a sharp increase in 2020, likely due to COVID-19.

- The 16-year age adjusted rate trends for non-White males, White males and non-White females are unreliable. The rate for White females shows a slight increase. All rates jumped up in 2020. The rate for non-White males is the highest and increased the most in 2020.

- The 31-year rate trend for non-Whites is decreasing. The 16-year rate trend is flat but unreliable. The 16-year rate trend for Whites shows a small increase, in a moderately reliable trend. Both rates increased sharply in 2020.

- The 16-year trend for racial disparity shows a 22% decrease in a moderately reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 5.2 i. All Causes of Premature Mortality: Trends in premature mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
RNC71 16-yr trendline
NC 16-yr trendline

R2 = 0.08
R2 = 0.06
R2 = 0.06

y = 4.54x + 899.84
y = 2.03x + 769.64
y = 2.22x + 789.36

2005 ENC29 rate is 17% greater than RNC71
2020 ENC29 rate is 21% greater than RNC71

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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<td>21% GT</td>
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<td>18% GT</td>
<td>3% LT</td>
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Figure 5.2 ii. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

- ENC29 16-yr trendline
  \[ y = 3.31x + 861.99 \]
  \[ R^2 = 0.04 \]
- RNC71 16-yr trendline
  \[ y = 0.00x + 742.84 \]
  \[ R^2 = 0.00 \]
- NC 16-yr trendline
  \[ y = 0.24x + 760.84 \]
  \[ R^2 = 0.00 \]
- US 16-yr trendline
  \[ y = 1.12x + 683.90 \]
  \[ R^2 = 0.02 \]

2005 ENC29 rate is 16% greater than RNC71
2020 ENC29 rate is 23% greater than RNC71

Comparison of Fitted Rates in 2005

<table>
<thead>
<tr>
<th>ENC29</th>
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Comparison of Fitted Rates in 2020

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Figure 5.2 iii. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

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<th>Year</th>
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Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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<th>NWF</th>
<th>WF</th>
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<td>65% GT</td>
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</table>
Figure 5.2 iv. All Causes of Premature Mortality: Trends in age-adjusted premature mortality rates by race for ENC29, 1990-2020 with projections to 2030

2005 non-White rate is 57% greater than White
2020 non-White rate is 45% greater than White

NW 16-yr trendline
W 16-yr trendline
9% increase

R2 = 0.00
y = 0.29x + 1,134.24

R2 = 0.14
y = 4.02x + 723.58

2005 non-White rate is 57% greater than White
2020 non-White rate is 45% greater than White
Figure 5.2 v. All Causes of Premature Mortality:
Measuring disparity in age-adjusted premature mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
22% decrease
$R^2 = 0.11$
y = -0.79x + 56.50
Diseases of Heart

- ENC’s 16-year heart disease mortality rate is 27% greater than the RNC rate, but ENC’s rate trend is flat and not reliable.
- While ENC’s age-adjusted mortality rate trend is decreasing at a pace similar to RNC, NC and the US, the ENC rate remains 18% greater than the RNC rate in 2020.
- The non-White male rate trend remains slightly higher than the White male trend; both are declining. The non-White female trend is 7% greater the White female trend but is projected to drop below the White female trend.
- The non-White rate trend remains 8% greater than for Whites, but the 16-year trends for both are decreasing and convergence is suggested in the future.
- The 16-year trend line for racial disparity is decreasing in a moderately reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.1 i. Diseases of Heart:
Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
RNC71 16-yr trendline
NC 16-yr trendline

6% decrease
5% decrease
R2 = 0.05
R2 = 0.21
R2 = 0.12
y = 0.61x + 213.83
y = -0.69x + 185.76
y = -0.55x + 190.07

2005 ENC29 rate is 15% greater than RNC71
2020 ENC29 rate is 27% greater than RNC71
Figure 6.1 ii. Diseases of Heart:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline 22% decrease
R2 = 0.66
y = -2.93x + 216.55

RNC71 16-yr trendline 26% decrease
R2 = 0.88
y = -3.19x + 194.11

NC 16-yr trendline 26% decrease
R2 = 0.86
y = -3.18x + 197.63

US 16-yr trendline 24% decrease
R2 = 0.80
y = -3.08x + 204.08

2005 ENC29 rate is 12% greater than RNC71
2020 ENC29 rate is 18% greater than RNC71

Comparison of Fitted Rates in 2005
- ENC29: 10% LT, 9% LT, 6% LT
- ENC29: 12% GT, 2% GT, 5% GT
- ENC29: 10% GT, 2% LT, 3% GT
- ENC29: 6% GT, 5% LT

Comparison of Fitted Rates in 2020
- ENC29: 15% LT, 13% LT, 9% LT
- ENC29: 18% GT, 3% GT, 8% GT
- ENC29: 15% GT, 2% LT, 5% GT
- ENC29: 9% GT, 7% LT, 5% LT
Figure 6.1 iii. Diseases of Heart:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

NWM 16-yr trendline
23% decrease
R² = 0.49
y = -4.55x + 310.04

WM 16-yr trendline
21% decrease
R² = 0.64
y = -3.54x + 265.97

NWF 16-yr trendline
31% decrease
R² = 0.61
y = -3.81x + 194.08

WF 16-yr trendline
21% decrease
R² = 0.71
y = -2.15x + 160.68

Comparison of Fitted Rates in 2005

Comparison of Fitted Rates in 2020
Figure 6.1 iv. Diseases of Heart:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
- 27% decrease
- \( R^2 = 0.59 \)
- \( y = -4.00x + 240.23 \)

W 16-yr trendline
- 20% decrease
- \( R^2 = 0.68 \)
- \( y = -2.63x + 206.55 \)

2005 non-White rate is 16% greater than White
2020 non-White rate is 8% greater than White
Figure 6.1 v. Diseases of Heart:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
51% decrease
R2 = 0.14
y = -0.51x + 16.17
Cerebrovascular Disease

- ENC's cerebrovascular disease mortality rate has turned up in recent years and is 33% greater than RNC. The rate trend has increased 19% over the 16-year period.

- The ENC age-adjusted cerebrovascular disease mortality rate trend has decreased 12% over the 16-year period. It remains 23% greater than the RNC rate trend.

- Non-White males have the highest mortality rate for cerebrovascular disease, but the rate has decreased 15% over the 16-year period. The rate for non-White females has decreased 22% and is projected to converge with the trend for White males and White females.

- The cerebrovascular disease mortality rate trend for non-Whites is decreasing but is still 38% greater than Whites in 2020.

- The 16-year trend for racial disparity shows a decrease of 29% in a moderately reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.2 i.  Cerebrovascular Disease:
Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
RNC71 16-yr trendline
NC 16-yr trendline

19% increase
\[ R^2 = 0.27 \]
\[ y = 0.63x + 52.79 \]

R2 = 0.01
\[ y = -0.06x + 47.60 \]

R2 = 0.00
\[ y = 0.03x + 48.42 \]

Comparison of Fitted Rates in 2005

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<tr>
<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
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Comparison of Fitted Rates in 2020

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<tbody>
<tr>
<td>33% GT</td>
<td>25% LT</td>
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2005 ENC29 rate is 11% greater than RNC71
2020 ENC29 rate is 33% greater than RNC71

2005 ENC29 rate is 11% greater than RNC71
2020 ENC29 rate is 33% greater than RNC71
Figure 6.2 ii. Cerebrovascular Disease: Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
12% decrease
R2 = 0.19
y = -0.40x + 54.44

RNC71 16-yr trendline
23% decrease
R2 = 0.64
y = -0.74x + 50.60

NC 16-yr trendline
22% decrease
R2 = 0.58
y = -0.70x + 51.23

US 16-yr trendline
20% decrease
R2 = 0.60
y = -0.56x + 44.11

2005 ENC29 rate is 8% greater than RNC71
2020 ENC29 rate is 23% greater than RNC71

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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Figure 6.2 iii. Cerebrovascular Disease: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030.
Figure 6.2 iv. Cerebrovascular Disease: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030.

- NW 16-yr trendline: 19% decrease  
  \[ R^2 = 0.25 \]  
  \[ y = -0.84x + 72.34 \]

- W 16-yr trendline: 9% decrease  
  \[ R^2 = 0.13 \]  
  \[ y = -0.26x + 47.04 \]

2005 non-White rate is 54% greater than White
2020 non-White rate is 38% greater than White
Figure 6.2 v. Cerebrovascular Disease:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
29% decrease
R2 = 0.14
y = -0.98x + 53.73
All Other Unintentional Injuries and Adverse Effects

- The mortality rate trend for unintentional injuries and adverse effects shows a sharp increase in ENC (147% over 16 years). The trends for RNC and NC are also up sharply.

- The age-adjusted mortality rate trends for ENC, RNC, NC, and the US are all increasing. During the last 16 years the ENC rate has increased 140% and it is now 10% greater than RNC.

- The trends are increasing for all groups, but the White male rate is the highest and shows the greatest increase (168% over 16 years).

- The White rate trend has increased 151% over the 16-year period. The non-White rate is 36% less than the White rate and increased 115% over the period.

- Over the 16-year period racial disparity has decreased but the trend is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.3 i. All Other Unintentional Injuries and Adverse Effects: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030
Figure 6.3 ii. All Other Unintentional Injuries and Adverse Effects:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US,
1990-2020 with projections to 2030

ENC29 16-yr trendline
140% increase
R2 = 0.73
y = 1.74x + 19.86

RNC71 16-yr trendline
88% increase
R2 = 0.74
y = 1.26x + 22.90

NC 16-yr trendline
94% increase
R2 = 0.74
y = 1.32x + 22.51

US 16-yr trendline
97% increase
R2 = 0.85
y = 1.25x + 20.46

2005 ENC29 rate is 13% less than RNC71
2020 ENC29 rate is 10% greater than RNC71
Figure 6.3 iii. All Other Unintentional Injuries and Adverse Effects:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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</table>

NWM 16-yr trendline: 95% increase, \( y = 1.53x + 25.94 \)  
WM 16-yr trendline: 168% increase, \( y = 2.77x + 26.37 \)  
NWF 16-yr trendline: 103% increase, \( y = 0.64x + 9.95 \)  
WF 16-yr trendline: 118% increase, \( y = 1.28x + 17.38 \)  

R² = 0.47, R² = 0.76, R² = 0.44, R² = 0.73
Figure 6.3 iv. All Other Unintentional Injuries and Adverse Effects: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
115% increase
R2 = 0.52
y = 1.15x + 15.96

W 16-yr trendline
151% increase
R2 = 0.77
y = 2.04x + 21.67

2005 non-White rate is 26% less than White
2020 non-White rate is 36% less than White
Figure 6.3 v. All Other Unintentional Injuries and Adverse Effects: Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

\[ R^2 = 0.09 \]
\[ y = -1.23x - 42.53 \]
Cancer—Trachea, Bronchus, Lung

- The 16-year trend line for cancer-TBL for ENC has decreased 15% over the period. The ENC rate for 2020 is 21% greater than the rate for RNC.

- In 2020 the age-adjusted rate for ENC is 13% higher than RNC. The 16-year trend for ENC has decreased 37%.

- The mortality rate trends for White and non-White males are decreasing and converged in 2020. The White male rate is now higher than the non-White male rate. The rate for non-White females is 31% less than the rate for White females.

- The non-White mortality rate trend for this cancer is consistently lower than the White rate (17% less than Whites). Both trends are decreasing over the 16-year period, but non-White is decreasing more quickly.

- The trend for racial disparity is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.4 i. Cancer - Trachea, Bronchus, Lung:

Comparison of Fitted Rates in 2005

ENC29 16-yr trendline
15% decrease
R2 = 0.58
y = -0.63x + 68.61

RNC71 16-yr trendline
21% decrease
R2 = 0.89
y = -0.82x + 61.01

NC 16-yr trendline
21% decrease
R2 = 0.90
y = -0.80x + 62.16

Comparison of Fitted Rates in 2020

ENC29 16-yr trendline
15% decrease
R2 = 0.58
y = -0.63x + 68.61

RNC71 16-yr trendline
21% decrease
R2 = 0.89
y = -0.82x + 61.01

NC 16-yr trendline
21% decrease
R2 = 0.90
y = -0.80x + 62.16

2005 ENC29 rate is 12% greater than RNC71
2020 ENC29 rate is 21% greater than RNC71
Figure 6.4 ii. Cancer - Trachea, Bronchus, Lung:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
37% decrease
R² = 0.92
y = -1.53x + 66.11

RNC71 16-yr trendline
41% decrease
R² = 0.98
y = -1.58x + 61.95

NC 16-yr trendline
40% decrease
R² = 0.99
y = -1.58x + 62.60

US 16-yr trendline
41% decrease
R² = 0.99
y = -1.41x + 55.22

2005 ENC29 rate is 7% greater than RNC71
2020 ENC29 rate is 13% greater than RNC71
Figure 6.4 iii. Cancer - Trachea, Bronchus, Lung: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

NWM 16-yr trendline
52% decrease
R² = 0.89
y = -3.51x + 107.94

WM 16-yr trendline
41% decrease
R² = 0.84
y = -2.35x + 91.18

NWF 16-yr trendline
21% decrease
R² = 0.25
y = -0.42x + 31.85

WF 16-yr trendline
29% decrease
R² = 0.73
y = -0.92x + 50.69

Comparison of Fitted Rates in 2020

NWM 16-yr trendline
52% decrease
R² = 0.89
y = -3.51x + 107.94

WM 16-yr trendline
41% decrease
R² = 0.84
y = -2.35x + 91.18

NWF 16-yr trendline
21% decrease
R² = 0.25
y = -0.42x + 31.85

WF 16-yr trendline
29% decrease
R² = 0.73
y = -0.92x + 50.69
Figure 6.4 iv. Cancer - Trachea, Bronchus, Lung:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
41% decrease
R2 = 0.84
y = -1.56x + 61.09

W 16-yr trendline
35% decrease
R2 = 0.87
y = -1.49x + 67.85

2005 non-White rate is 10% less than White
2020 non-White rate is 17% less than White
Figure 6.4 v. Cancer - Trachea, Bronchus, Lung:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

R2 = 0.07
y = -0.52x - 11.59
Chronic Lower Respiratory Diseases

- The 31-year ENC trend for CLRD is increasing, as is the 16-year trend. In 2020 the ENC rate is 7% greater than the RNC rate.
- The ENC age-adjusted rate trend is converging with the RNC and NC trends. All three are higher than the US rate trend.
- The rate trend for White males is the highest but is decreasing. The rate for non-White males has decreased 24% over the 16-year period in a moderately reliable trend and is now below the rate for White females, which is increasing. The rate for non-White females is the lowest and is increasing in a moderately reliable trend.
- The 16-year trend for Whites is higher than the non-White rate, but both rates are flat. The non-White rate is unreliable.
- The disparity trend between White and non-White is unreliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.5 i. Chronic Lower Respiratory Diseases:
Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
29% increase
R2 = 0.65
y = 0.79x + 43.52

RNC71 16-yr trendline
12% increase
R2 = 0.52
y = 0.34x + 46.50

NC 16-yr trendline
14% increase
R2 = 0.59
y = 0.40x + 46.09

2005 ENC29 rate is 6% less than RNC71
2020 ENC29 rate is 7% greater than RNC71

Comparison of Fitted Rates in 2005
ENC29 RNC71 NC
6% LT 7% GT 6% GT ENC29
6% LT 1% LT RNC71

Comparison of Fitted Rates in 2020
ENC29 RNC71 NC
6% LT 7% LT 6% LT ENC29
6% LT 1% GT RNC71
6% GT 1% LT NC
Figure 6.5 ii. Chronic Lower Respiratory Diseases: Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

- ENC29: 12% GT, 7% LT
- RNC71: 10% GT, 1% LT
- NC: 2% GT, 8% LT
- US: 7% GT, 9% LT

Comparison of Fitted Rates in 2020

- ENC29: 2% GT, 7% LT
- RNC71: 1% GT, 8% LT
- NC: 0% GT
- US: 9% GT

ENC29 16-yr trendline: 7% decrease, R2 = 0.14, y = -0.18x + 44.64
RNC71 16-yr trendline: 16% decrease, R2 = 0.69, y = -0.48x + 49.81
NC 16-yr trendline: 14% decrease, R2 = 0.65, y = -0.44x + 49.01
US 16-yr trendline: 12% decrease, R2 = 0.61, y = -0.33x + 44.04
Figure 6.5 iii. Chronic Lower Respiratory Diseases: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

<table>
<thead>
<tr>
<th>Race/Gender</th>
<th>Comparison of Fitted Rates in 2005</th>
<th>Comparison of Fitted Rates in 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>NWM</td>
<td>23% GT 66% LT 15% LT</td>
<td>26% GT 47% LT 16% LT</td>
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<tr>
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<td>72% LT 31% LT</td>
<td>58% LT 8% LT</td>
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<tr>
<td>NWF</td>
<td>263% GT 149% GT</td>
<td>88% GT 137% GT</td>
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<tr>
<td>WF</td>
<td>46% GT 60% LT</td>
<td>14% LT 9% GT 54% LT 54% LT</td>
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</table>

24% decrease, 22% decrease, 23% increase, 7% increase

R² = 0.25, R² = 0.54, R² = 0.17, R² = 0.13

y = -0.76x + 50.88, y = -0.86x + 62.71, y = 0.25x + 17.27, y = 0.18x + 42.99

24% decrease, 22% decrease, 23% increase, 7% increase

R² = 0.25, R² = 0.54, R² = 0.17, R² = 0.13

y = -0.76x + 50.88, y = -0.86x + 62.71, y = 0.25x + 17.27, y = 0.18x + 42.99

Comparison of Fitted Rates in 2005

Comparison of Fitted Rates in 2020
Figure 6.5 iv. Chronic Lower Respiratory Diseases: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

- NW 16-yr trendline
  - R2 = 0.01
  - \( y = -0.07x + 28.79 \) [6% decrease]

- W 16-yr trendline
  - R2 = 0.15
  - \( y = -0.20x + 50.65 \)

2005 non-White rate is 43% less than White
2020 non-White rate is 42% less than White
Figure 6.5 v. Chronic Lower Respiratory Diseases:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

\[ R^2 = 0.02 \]
\[ y = 0.52x - 79.42 \]

Percentage difference - non-White to White

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</table>

% difference
Diabetes Mellitus

- The 16-year rate trend for ENC has increased 38% over the period and is 43% greater than the RNC rate.
- In 2020, the ENC 16-year rate trend for age-adjusted diabetes mellitus is 36% greater than RNC, but the trend is not reliable.
- The non-White male 16-year rate has increased by 22%. The non-White female trend has decreased 18%. The White male and White female trends are lower. The trend for White females is unreliable.
- In 2020 the non-White mortality 16-year rate trend is 123% greater than the White, but both are flat and unreliable.
- The 16-year trend for racial disparity is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.6 i. Diabetes Mellitus: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
38% increase
R2 = 0.60
y = 0.70x + 29.45

RNC71 16-yr trendline
40% increase
R2 = 0.61
y = 0.50x + 20.30

NC 16-yr trendline
38% increase
R2 = 0.62
y = 0.52x + 21.69

Comparison of Fitted Rates in 2005
ENC29 RNC71 NC
31% LT 26% LT ENC29

Comparison of Fitted Rates in 2020
ENC29 RNC71 NC
45% GT 7% GT RNC71
36% GT 6% LT NC

2005 ENC29 rate is 45% greater than RNC71
2020 ENC29 rate is 43% greater than RNC71

2005 ENC29 rate is 45% greater than RNC71
2020 ENC29 rate is 43% greater than RNC71

31% LT 26% LT ENC29 30% LT 26% LT ENC29
45% GT 7% GT RNC71 43% GT 6% GT RNC71
36% GT 6% LT NC 35% GT 6% LT NC
Figure 6.6 ii. Diabetes Mellitus:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline  RNC71 16-yr trendline  NC 16-yr trendline  US 16-yr trendline

R2 = 0.03  R2 = 0.06  R2 = 0.05  R2 = 0.06
y = 0.09x + 29.75  y = 0.09x + 21.48  y = 0.08x + 22.77  y = -0.07x + 22.59

Comparison of Fitted Rates in 2005

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<tr>
<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
<th>US</th>
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<tr>
<td>32% GT</td>
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Comparison of Fitted Rates in 2020

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<tr>
<td>30% GT</td>
<td>5% GT</td>
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</tr>
<tr>
<td>44% GT</td>
<td>6% GT</td>
<td>11% GT</td>
<td>US</td>
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</tbody>
</table>
Figure 6.6 iii. Diabetes Mellitus:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

NWM 16-yr trendline
22% increase
R² = 0.22
y = 0.72x + 51.46

WM 16-yr trendline
12% increase
R² = 0.12
y = 0.19x + 25.63

NWF 16-yr trendline
18% decrease
R² = 0.20
y = -0.55x + 49.61

WF 16-yr trendline
22% increase
R² = 0.02
y = -0.06x + 18.09

Comparison of Fitted Rates in 2020

NWM 16-yr trendline
22% increase
R² = 0.02
y = -0.06x + 18.09

WM 16-yr trendline
12% increase
R² = 0.02
y = -0.06x + 18.09

NWF 16-yr trendline
18% decrease
R² = 0.02
y = -0.06x + 18.09

WF 16-yr trendline
22% increase
R² = 0.02
y = -0.06x + 18.09

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Figure 6.6 iv. Diabetes Mellitus:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
W 16-yr trendline

R2 = 0.00
y = -0.03x + 50.64

R2 = 0.05
y = 0.08x + 21.35

2005 non-White rate is 137% greater than White
2020 non-White rate is 123% greater than White
Figure 6.6 v. Diabetes Mellitus:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

R² = 0.03
y = -0.82x + 136.71
Alzheimer’s Disease

- The Alzheimer’s mortality rate trend for ENC shows a steep increase over the 16-year period (175%). ENC’s rate of increase was larger than RNC and NC, but the rate for ENC is still 5% less than RNC.

- In 2020, the age-adjusted rate for ENC is 14% less than the rate for RNC. The ENC rate trend has increased 87% over the 16-year period and is 6% greater than the US rate.

- Rate trends are increasing for all groups, but non-White males and non-White females have the greatest increase (126% and 147% over 16 years, respectively). The trends for White females and non-White females are projected to converge in the future.

- The White and non-White rate trends have converged. Both trends are increasing over the 16-year period.

- The 16-year trend shows an 115% increase in racial disparity in a reliable trend.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.7 i. Alzheimer’s Disease: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

- ENC29 16-yr trendline: 175% increase
  - \( R^2 = 0.84 \)
  - \( y = 1.68x + 15.37 \)
- RNC71 16-yr trendline: 89% increase
  - \( R^2 = 0.86 \)
  - \( y = 1.29x + 23.33 \)
- NC 16-yr trendline: 98% increase
  - \( R^2 = 0.87 \)
  - \( y = 1.35x + 22.16 \)

2005 ENC29 rate is 34% less than RNC71
2020 ENC29 rate is 5% less than RNC71
Figure 6.7 ii. Alzheimer’s Disease:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline  
87% increase  
R2 = 0.75  
y = 0.97x + 17.81

RNC71 16-yr trendline  
47% increase  
R2 = 0.74  
y = 0.77x + 26.22

NC 16-yr trendline  
51% increase  
R2 = 0.77  
y = 0.80x + 24.93

US 16-yr trendline  
42% increase  
R2 = 0.74  
y = 0.58x + 21.81

2005 ENC29 rate is 32% less than RNC71  
2020 ENC29 rate is 14% less than RNC71

Comparison of Fitted Rates in 2005

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<thead>
<tr>
<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
<th>US</th>
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<tr>
<td>32% LT</td>
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<td>23% GT</td>
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<tr>
<td>18% LT</td>
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Comparison of Fitted Rates in 2020

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Figure 6.7 iii. Alzheimer’s Disease: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030
Figure 6.7 iv. Alzheimer’s Disease: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
142% increase
R² = 0.84
y = 1.23x + 13.92

W 16-yr trendline
71% increase
R² = 0.64
y = 0.86x + 19.36

2005 non-White rate is 28% less than White
2020 non-White rate is the same as White
Figure 6.7 v. Alzheimer’s Disease:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
115% increase
$R^2 = 0.42$
y = 2.21x - 30.83
Nephritis, Nephrotic Syndrome, and Nephrosis

- In 2020 ENC’s rate trend for nephritis, nephrotic syndrome and nephrosis is 13% greater than RNC, but the trend is not reliable.

- With age-adjustment, the ENC rate trend has decreased 25% over the 16-year period. It is 4% greater than the RNC rate and 3% greater than the NC rate. They are projected to converge soon.

- The 16-year trends for non-White males and non-White females are the highest but have decreased 22% and 34% over the 16-year period. The non-White male trend in 2020 is 124% greater than the White male trend and 221% greater than the White female trend. All trends are decreasing.

- The non-White rate in 2020 is 121% greater than the White rate. It has decreased 29% over the 16-year period. The White rate has decreased 23%.

- The trend for racial disparity is not reliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10.$
Figure 6.8 i. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
RNC71 16-yr trendline
NC 16-yr trendline

8% increase
7% increase
R2 = 0.00
R2 = 0.21
R2 = 0.14
y = 0.02x + 21.07
y = 0.09x + 17.59
y = 0.08x + 18.11

2005 ENC29 rate is 20% greater than RNC71
2020 ENC29 rate is 13% greater than RNC71

Comparison of Fitted Rates in 2005

ENC29 | RNC71 | NC
--- | --- | ---
17% LT | 14% LT | ENC29

Comparison of Fitted Rates in 2020

ENC29 | RNC71 | NC
--- | --- | ---
12% LT | 10% LT | ENC29

13% GT | 2% GT | RNC71

11% GT | 2% LT | NC
Figure 6.8 ii. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
25% decrease
R² = 0.42
y = -0.33x + 21.40

RNC71 16-yr trendline
16% decrease
R² = 0.56
y = -0.18x + 18.62

NC 16-yr trendline
17% decrease
R² = 0.60
y = -0.21x + 19.05

US 16-yr trendline
19% decrease
R² = 0.76
y = -0.18x + 15.31

2005 ENC29 rate is 15% greater than RNC71
2020 ENC29 rate is 4% greater than RNC71

Comparison of Fitted Rates in 2005

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Figure 6.8 iii. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030.
Figure 6.8 iv. Nephritis, Nephrotic Syndrome, and Nephrosis: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030.

NW 16-yr trendline
29% decrease
R² = 0.33
y = -0.66x + 36.52

W 16-yr trendline
23% decrease
R² = 0.41
y = -0.21x + 15.25

2005 non-White rate is 139% greater than White
2020 non-White rate is 121% greater than White
Figure 6.8 v. Nephritis, Nephrotic Syndrome, and Nephrosis: Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

R² = 0.04

\[ y = -1.29x + 141.17 \]
Unintentional Motor Vehicle Injuries

- The mortality rate trend for unintentional motor vehicle injuries in ENC has decreased by 20% over the 16-year period but has recently ticked up. In 2020 ENC’s rate trend is 23% greater than RNC.

- With age-adjustment, the ENC rate trend has decreased 22% over the 16-year period but has recently gone up. It is 23% greater than the RNC rate and 19% greater than the NC rate.

- The 16-year trends for non-White males and White males are the highest, but the White male trend line has experienced a 40% decrease over the 16-year period. The rate for non-White males is unreliable. Non-White females and White females are lower, with White females decreasing by 42% over the 16-year period. The trend for non-White females is unreliable.

- The non-White rate in 2020 is 61% greater than the White rate but is unreliable. The White rate is decreasing, 41% over 16 years.

- The 16-year trend shows a 365% increase in disparity that favors Whites and is projected to further increase in the future.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.9 i. Unintentional Motor Vehicle Injuries: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

- ENC29 16-yr trendline: 20% decrease, $R^2 = 0.19$, $y = -0.26x + 20.97$
- RNC71 16-yr trendline: 17% decrease, $R^2 = 0.20$, $y = -0.18x + 16.64$
- NC 16-yr trendline: 18% decrease, $R^2 = 0.21$, $y = -0.20x + 17.29$

Comparison of Fitted Rates in 2005
- ENC29 21% GT, 26% GT
- RNC71 18% LT, 4% GT
- NC 16% LT

Comparison of Fitted Rates in 2020
- ENC29 19% LT, 23% GT
- RNC71 3% LT, 3% GT
- NC 17% LT

2005 ENC29 rate is 26% greater than RNC71
2020 ENC29 rate is 23% greater than RNC71
Figure 6.9 ii. Unintentional Motor Vehicle Injuries:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

- ENC29 16-yr trendline: 22% decrease, \( R^2 = 0.23 \), \( y = -0.28x + 20.79 \)
- RNC71 16-yr trendline: 21% decrease, \( R^2 = 0.27 \), \( y = -0.21x + 16.74 \)
- NC 16-yr trendline: 21% decrease, \( R^2 = 0.27 \), \( y = -0.23x + 17.34 \)
- US 16-yr trendline: 21% decrease, \( R^2 = 0.36 \), \( y = -0.18x + 13.77 \)

2005 ENC29 rate is 24% greater than RNC71
2020 ENC29 rate is 23% greater than RNC71

Comparison of Fitted Rates in 2005

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Figure 6.9 iii. Unintentional Motor Vehicle Injuries: Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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Figure 6.9 iv. Unintentional Motor Vehicle Injuries: Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
R2 = 0.07
y = 0.23x + 18.47

W 16-yr trendline
R2 = 0.58
y = -0.57x + 22.10

41% decrease

2005 non-White rate is 16% less than White
2020 non-White rate is 61% greater than White
Figure 6.9 v. Unintentional Motor Vehicle Injuries: Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

365% increase

R2 = 0.51

y = 5.34x - 23.37
Pneumonia and Influenza

- The crude mortality rate for pneumonia and influenza for ENC is 13% greater than RNC in 2020 but the trend is not reliable.
- The age-adjusted mortality rate trend for ENC, RNC and NC are similar and are decreasing at about the same pace. The ENC rate in 2020 is 5% greater than the RNC rate.
- The age-adjusted mortality rate trends for all four demographics are decreasing around the same rate. The trends for non-White males and White males are the highest.
- The non-White mortality rate and the White mortality rate are both decreasing and are converging. The non-White rate was 6% less than White in 2020.
- The 16-year trend for racial disparity is unreliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 6.10 i. Pneumonia and Influenza:
Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

ENC29 16-yr trendline
RNC71 16-yr trendline
NC 16-yr trendline

R2 = 0.00
R2 = 0.06
R2 = 0.04

y = 0.02x + 20.08
y = -0.07x + 19.17
y = -0.06x + 19.32

2005 ENC29 rate is 5% greater than RNC71
2020 ENC29 rate is 13% greater than RNC71

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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Figure 6.10 ii. Pneumonia and Influenza: Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
23% decrease
R2 = 0.47
y = -0.30x + 20.53

RNC71 16-yr trendline
26% decrease
R2 = 0.62
y = -0.33x + 20.29

NC 16-yr trendline
26% decrease
R2 = 0.63
y = -0.33x + 20.33

US 16-yr trendline
33% decrease
R2 = 0.76
y = -0.40x + 18.92

2005 ENC29 rate is 1% greater than RNC71
2020 ENC29 rate is 5% greater than RNC71

Comparison of Fitted Rates in 2005

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Figure 6.10 iii. Pneumonia and Influenza:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

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Comparison of Fitted Rates in 2020

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Figure 6.10 iv. Pneumonia and Influenza:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline

19% decrease

R2 = 0.18
y = -0.23x + 18.70

2005 non-White rate is 12% less than White
2020 non-White rate is 6% less than White

W 16-yr trendline

25% decrease

R2 = 0.48
y = -0.33x + 21.27

2005 non-White rate is 12% less than White
2020 non-White rate is 6% less than White
Figure 6.10 v. Pneumonia and Influenza: Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

\[ R^2 = 0.04 \]

\[ y = 0.73x - 17.54 \]
7. Trends and Disparities in Mortality in ENC29: Cancer - All Sites and HIV Disease; 1990-2020
Cancer - All Sites

- The cancer-all sites mortality rate trends for ENC, RNC, and NC are flat and are not reliable.
- The age-adjusted cancer-all sites mortality rate trends for ENC, RNC, NC and US are all decreasing. The ENC rate is 9% greater than the RNC rate.
- The rate trend is decreasing for all groups. The rate for non-White males has decreased by 40% in the 16-year period and is set to converge with the rate for White males. White and non-White females are decreasing at similar rates.
- Both the White and non-White cancer mortality trends are decreasing over the 16 year period. The non-White rate decreased by 31% and the White rate decreased 21%. The non-White rate remains 7% greater than the White rate in 2020, but they are projected to converge.
- The 16-year trend for racial disparity shows a 70% decrease.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 7.1. Cancer - All Sites: Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

- ENC29: 14% LT
- RNC71: 12% LT
- NC: ENC29

Comparison of Fitted Rates in 2020

- ENC29: 16% GT
- RNC71: 2% GT
- NC: ENC29

2005 ENC29 rate is 16% greater than RNC71
2020 ENC29 rate is 16% greater than RNC71
Figure 7.1 ii. Cancer - All Sites:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline
R2 = 0.95
y = -3.23x + 211.82

RNC71 16-yr trendline
R2 = 0.98
y = -2.80x + 192.21

NC 16-yr trendline
R2 = 0.99
y = -2.89x + 195.25

US 16-yr trendline
R2 = 1.00
y = -2.72x + 187.76

2005 ENC29 rate is 10% greater than RNC71
2020 ENC29 rate is 9% greater than RNC71

Comparison of Fitted Rates in 2005
ENC29 | RNC71 | NC | US
--- | --- | --- | ---
10% GT | 9% LT | 8% LT | ENC29
8% GT | 2% GT | 2% LT | RNC71
13% GT | 2% GT | 4% LT | NC

Comparison of Fitted Rates in 2020
ENC29 | RNC71 | NC | US
--- | --- | --- | ---
10% GT | 8% LT | 7% LT | ENC29
8% GT | 1% LT | 3% LT | NC
11% GT | 2% GT | 3% LT | US
Trends and Disparities in Mortality in Eastern North Carolina - 29 Counties

Figure 7.1 iii. Cancer - All Sites:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030
Figure 7.1 iv. Cancer - All Sites:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
31% decrease
R2 = 0.87
y = -4.71x + 241.00

W 16-yr trendline
21% decrease
R2 = 0.93
y = -2.66x + 199.27

2005 non-White rate is 21% greater than White
2020 non-White rate is 7% greater than White
Figure 7.1 v. Cancer - All Sites:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity
70% decrease
R2 = 0.40
y = -0.94x + 21.54
HIV Disease

- The HIV mortality rates for ENC have been decreasing over the past 16 years but are still 37% greater than RNC in 2020.
- The age-adjusted rate trend for ENC, RNC, and the US are all decreasing and set to converge. The ENC rate is 47% greater than RNC in 2020.
- Non-White males continue to have the highest rate of age-adjusted mortality, but the rate has decreased 82% in the 16-year period. Non-White females have the second highest rate, but it has also declined. All demographics are projected to converge in the future.
- The 16-year age-adjusted HIV mortality rates have decreased for both Whites and non-Whites by 81% and 66% respectively. The non-White rate is still 620% greater than the White rate.
- The 16-year trend for racial disparity is unreliable.

Unless otherwise noted, trends are considered reliable if $R^2 \geq 0.35$, moderately reliable if $0.35 > R^2 \geq 0.10$, and unreliable if $R^2 < 0.10$. 
Figure 7.2 i. HIV Disease:
Trends in mortality rates for ENC29, RNC71, and NC, 1990-2020 with projections to 2030

Comparison of Fitted Rates in 2005

<table>
<thead>
<tr>
<th></th>
<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
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<tbody>
<tr>
<td>LT</td>
<td>30%</td>
<td>26%</td>
<td>ENC29</td>
</tr>
<tr>
<td>GT</td>
<td>43%</td>
<td>6%</td>
<td>RNC71</td>
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Comparison of Fitted Rates in 2020

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<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
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<tbody>
<tr>
<td>LT</td>
<td>30%</td>
<td>5%</td>
<td>ENC29</td>
</tr>
<tr>
<td>GT</td>
<td>37%</td>
<td>6%</td>
<td>RNC71</td>
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</tbody>
</table>

ENC29 16-yr trendline: 74% decrease
R2 = 0.82
y = -0.30x + 6.44

RNC71 16-yr trendline: 73% decrease
R2 = 0.91
y = -0.20x + 4.50

NC 16-yr trendline: 73% decrease
R2 = 0.94
y = -0.22x + 4.78

2005 ENC29 rate is 43% greater than RNC71
2020 ENC29 rate is 37% greater than RNC71

Report #2.201, May 2023
Health Systems Research and Development, Dept. of Public Health, ECU
Figure 7.2 ii. HIV Disease:
Trends in age-adjusted mortality rates for ENC29, RNC71, NC, and US, 1990-2020 with projections to 2030

ENC29 16-yr trendline 78% decrease
R2 = 0.84
y = -0.32x + 6.60

RNC71 16-yr trendline 77% decrease
R2 = 0.92
y = -0.21x + 4.41

NC 16-yr trendline 78% decrease
R2 = 0.94
y = -0.23x + 4.72

US 16-yr trendline 75% decrease
R2 = 0.93
y = -0.19x + 4.06

Comparison of Fitted Rates in 2005

<table>
<thead>
<tr>
<th>ENC29</th>
<th>RNC71</th>
<th>NC</th>
<th>US</th>
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<tr>
<td>49% GT</td>
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<tr>
<td>40% GT</td>
<td>6% LT</td>
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<tr>
<td>62% GT</td>
<td>9% GT</td>
<td>16% GT</td>
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Comparison of Fitted Rates in 2020

<table>
<thead>
<tr>
<th>ENC29</th>
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<tr>
<td>47% GT</td>
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<tr>
<td>39% GT</td>
<td>5% LT</td>
<td>6% LT</td>
<td>NC</td>
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<tr>
<td>49% GT</td>
<td>1% GT</td>
<td>7% GT</td>
<td>US</td>
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</table>
Figure 7.2 iii. HIV Disease:
Trends in age-adjusted mortality rates by race and gender for ENC29, 1990-2020 with projections to 2030

NWM 16-yr trendline
WM 16-yr trendline
NWF 16-yr trendline
WF 16-yr trendline

82% decrease
66% decrease
78% decrease
69% decrease

R2 = 0.80
R2 = 0.30
R2 = 0.66
R2 = 0.18

y = -1.19x + 23.18
y = -0.09x + 2.29
y = -0.55x + 11.36
y = -0.03x + 0.78

Comparison of Fitted Rates in 2005
Comparison of Fitted Rates in 2020
Trends and Disparities in Mortality in Eastern North Carolina-29 Counties

Figure 7.2 iv. HIV Disease:
Trends in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

NW 16-yr trendline
81% decrease
R² = 0.83
y = -0.84x + 16.71

W 16-yr trendline
66% decrease
R² = 0.40
y = -0.06x + 1.50

2005 non-White rate is 1011% greater than White
2020 non-White rate is 620% greater than White
Trends and Disparities in Mortality in Eastern North Carolina-29 Counties

Figure 7.2 v. HIV Disease:
Measuring disparity in age-adjusted mortality rates by race for ENC29, 1990-2020 with projections to 2030

Racial Disparity

\[ R^2 = 0.09 \]
\[ y = -39.22x + 1,343.77 \]
## 8. Appendix

<table>
<thead>
<tr>
<th>Diseases of Heart</th>
<th>ICD10 Code</th>
<th>ICD 9 Code</th>
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<td>I00-I09, I11, I13, I20-I51</td>
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<td>Cerebrovascular Disease</td>
<td>I60-I69</td>
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<td>Atherosclerosis</td>
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<td>Cancer - All Sites</td>
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<tr>
<td>Cancer - Lip, Oral Cavity, Pharynx</td>
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<td>Cancer - Stomach</td>
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<td>Cancer - Colon, Rectum, Anus</td>
<td>C18-C21</td>
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<td>Cancer - Liver</td>
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<td>Cancer - Pancreas</td>
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<td>Cancer - Trachea, Bronchus, Lung</td>
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<td>Cancer - Malignant Melanoma of Skin</td>
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<td>Cancer - Breast</td>
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<td>Cancer - Ovary</td>
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<td>Cancer - Bladder</td>
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<td>Pneumonia and Influenza</td>
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<td>Chronic Lower Respiratory Diseases</td>
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<td>Chronic Liver Disease and Cirrhosis</td>
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<td>Nephritis, Nephrotic Syndrome, and Nephrosis</td>
<td>N00-N07, N17-N19, N25-N27</td>
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<td>Unintentional Motor Vehicle Injuries</td>
<td>V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V29, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2</td>
<td>E810-E825</td>
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<td>All Other Unintentional Injuries and Adverse Effects</td>
<td>V01, V05-V06, V09.1, V09.3-V09.9, V10-V11, V15-V18, V19.3, V19.8-V19.9, V80.0-V80.2, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V87.9, V88.9, V89.1, V89.3, V89.9, V90-V99.9, W00-X59, Y85, Y86</td>
<td>E800-E807, E826-E829, E830-E848, E929.0, E929.1, E850-E869, E880-E928, E929.2-E929.9</td>
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