DOWNLOAD PDF METROPOLITAN AREAS TABLE

Chapter 1 : Metropolitan Areas in California

The following sortable table lists the seven Metropolitan Statistical Areas (MSAs) of Puerto Rico with the following information: The MSA rank by population as of July 1, , as estimated by the United States Census Bureau [2].

An erratum has been published for this report. To view the erratum, please click here. Mack, PhD1; Christopher M. Jones, PharmD2; Michael F. Drug overdoses are a leading cause of injury death in the United States, resulting in approximately 52, deaths in Understanding differences in illicit drug use, illicit drug use disorders, and overall drug overdose deaths in metropolitan and nonmetropolitan areas is important for informing public health programs, interventions, and policies. Illicit drug use and drug use disorders during â€", and drug overdose deaths during â€" Respondents include residents of households and noninstitutional group quarters e. NSDUH uses a three-category system: Although both metropolitan and nonmetropolitan areas experienced significant increases from â€" to â€" in self-reported past-month use of illicit drugs, the prevalence was highest for the large metropolitan areas compared with small metropolitan or nonmetropolitan areas throughout the study period. Notably, past-month use of illicit drugs declined over the study period for the youngest respondents aged 12â€"17 years. Across both metropolitan and nonmetropolitan areas, the prevalence of past-year illicit drug use disorders declined during â€" In , approximately six times as many drug overdose deaths occurred in metropolitan areas than occurred in nonmetropolitan areas metropolitan: Drug overdose death rates per , population for metropolitan areas were higher than in nonmetropolitan areas in 6. The decline in illicit drug use by youth and the lower prevalence of illicit drug use disorders in rural areas during â€" are encouraging signs. However, the increasing rate of drug overdose deaths in rural areas, which surpassed rates in urban areas, is cause for concern. Understanding the differences between metropolitan and nonmetropolitan areas in drug use, drug use disorders, and drug overdose deaths can help public health professionals to identify, monitor, and prioritize responses. Consideration of where persons live and where they die from overdose could enhance specific overdose prevention interventions, such as training on naloxone administration or rescue breathing. CDC guideline for prescribing opioids for chronic painâ€"United States, RR-1] and facilitating better access to medication-assisted treatment with methadone, buprenorphine, or naltrexone could benefit communities with high opioid use disorder rates. Top Introduction During â€", annual age-adjusted death rates for the five leading causes of death in the United States heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke were higher in rural nonmetropolitan areas than in urban metropolitan areas 1. Many factors influence the rural-urban mortality gap, including socioeconomic differences, health-related behaviors, and access to health care services. Residents of rural areas in the United States tend to be poorer and sicker than their urban counterparts, with rural residents in the South and West experiencing some of the most adverse health outcome 2. Drug overdoses are now the leading cause of injury death in the United States, and although prescription drugs were primarily responsible for the rapid expansion of this large and growing public health crisis, illicit drugs heroin, illicit fentanyl, cocaine, and methamphetamines now are contributing substantially to the problem 7. Age-adjusted death rates for drug overdoses varied by the drug involved and the level of urbanization. For example, natural and semisynthetic opioid-related drug overdose death rates were highest and heroin-related drug overdose death rates were lowest in nonmetropolitan areas in compared with other levels of urbanicity 7. A growing body of literature describes various aspects of the drug overdose epidemic and population density 4,6,8,9. NSDUH collects information through face-to-face household interviews about the use of illicit drugs, alcohol, and tobacco among the U. An independent, multistage area probability sample design for each of the 50 states and the District of Columbia allows for the production of state-level and urban status county of residence estimates. Mortality data for U. Deaths of nonresidents e. Virgin Islands, and other U. This measure uses three segments of population density: The presence of a past-year illicit drug use disorder was defined using criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders, which include symptoms such as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference with major obligations at work, school, or home Respondents were asked questions about substance use disorders if they

had reported use of illicit drugs in the past 12 months. The full survey instrument is available at http: Location of death might be different from location of drug use. Deaths were categorized as metropolitan or nonmetropolitan based on the county of residence. Nonmetropolitan and metropolitan areas were identified using the NCHS county-based classification scheme The six NCHS classification levels for counties are: For a dichotomous measure, metropolitan urban combines categories 1â€"4 and nonmetropolitan rural combines 5 and 6. Data Analysis On the basis of NSDUH data, overall prevalence of past-month illicit drug use was estimated for four 3-year periods â€", â€", â€", and â€" , by CBSA designation, sex, age group, race, and annual household income. Prevalence of past-year illicit drug use disorder among persons reporting past-year illicit drug use was calculated by large metropolitan, small metropolitan and nonmetropolitan areas for the four periods, overall, and by sex. Years were pooled to improve the precision of estimates and enable comparisons across subgroups. Percentage change was calculated by comparing the early period â€" with the last period â€" The analysis of trends in age-adjusted death rates during â€" included all ages; death rates per , persons were adjusted to the U. Results National Survey of Drug Use and Health From â€" to â€", the prevalence of past-month use of illicit drugs was highest in large metropolitan areas Table 1. All three urban status groups large metropolitan, small metropolitan, and nonmetropolitan experienced significant increases in the prevalence of past-month drug use overall. Prevalence was higher for males than females during all time intervals in all urban status groups. However, in the large metropolitan group, the percentage increase in prevalence from â€" to â€" was greater for females The prevalence of illicit drug use among nonmetropolitan females remained stable during the study period. During â€", respondents aged 18â€"25 years had the highest prevalence of past-month use of illicit drugs for all urban levels Table 1. For respondents in this age group, the prevalence increased slightly from â€" to â€" in large metropolitan areas Past-month use of illicit drugs declined over the study period for the youngest respondents aged 12â€"17 years , with the largest decline among small metropolitan area youth. Prevalence of past-month illicit drug use increased among both non-Hispanic whites and other races for both large and small metropolitan areas Table 1. Prevalence did not change among non-Hispanic white nonmetropolitan respondents nor among nonmetropolitan respondents of other races. All three geographic groups experienced statistically significant declines in overall prevalence of drug use disorders during the study period. For residents in large metropolitan areas, prevalence declined For residents in small metropolitan areas, prevalence declined Among nonmetropolitan residents, the prevalence of past-year illicit drug use disorders decreased During â€", prevalence rates were similar across the three geographic groups. Males who reported illicit drug use in the past year consistently had higher prevalence of illicit drug use disorders compared with females. In general, females experienced consistently larger declines during the study period. The prevalence of illicit drug use disorders among females declined The prevalence of illicit drug use disorders declined significantly in metropolitan areas for males and females. The decline in prevalence of illicit drug use disorders among nonmetropolitan residents was significant overall and for males during the study period. National Vital Statistics System In , nearly six times as many drug overdose deaths were reported in metropolitan areas than in nonmetropolitan areas metropolitan: Although age-adjusted drug overdose death rates for metropolitan areas were higher than in nonmetropolitan areas in 6. The age-adjusted drug overdose death rate for females was higher in metropolitan areas during â€" and higher in nonmetropolitan areas thereafter Table 1. The difference in rates per , population between areas was greatest in metropolitan: The drug overdose death rate for males was higher in metropolitan areas in all years except and with the largest difference between metropolitan and nonmetropolitan rates occurring in metropolitan: Rates for white decedents metropolitan: Nonmetropolitan unintentional age-adjusted overdose death rates changed from 2. Metropolitan unintentional overdose death rates changed from 4. Rates of suicide overdose deaths were similar in metropolitan 1. All age group categories showed increases in drug overdose deaths from to Table 2. Nonmetropolitan drug overdose death rates in were higher than metropolitan rates for those aged 26â€"34 years. More age-adjusted drug overdose deaths occurred in a home versus in a medical facility or other location in each year for both metropolitan and nonmetropolitan areas Table 3. The distribution changed over time, however, and the percentage of deaths that occurred in a home increased from to in both metropolitan and nonmetropolitan areas metropolitan: The increasing trends for males and females in

age-adjusted drug overdose death rates varied by the six urban levels Figure 2. Converse patterns were observed for females range: At the beginning of the study period, death rates were higher in metropolitan areas than in nonmetropolitan areas, but the rates converged over time. Top Discussion This report presents an overview of illicit drug use, illicit drug use disorders, and drug overdose deaths for metropolitan and nonmetropolitan areas in the United States. The findings of this study indicate that trends varied. On the one hand, the decline in illicit drug use by youth and the lower prevalence of illicit drug use disorders are encouraging signs. On the other hand, the increasing rate of drug overdose deaths in rural areas, which surpassed rates in urban areas, is cause for concern. Declines in prescription opioid use disorders have also been demonstrated among persons aged 12â€”17 years The percentage change increase between and in overdose deaths among nonmetropolitan residents is concerning and carries across sex, race, and intent. Although past-month use of illicit drugs was lower in nonmetropolitan areas compared to metropolitan areas, the prevalence of drug use disorders among people reporting past-year illicit drug use in nonmetropolitan areas was similar to that in metropolitan areas. Studies have found that persons with substance use disorders are at higher risk for drug use-related morbidity and mortality Further, given research indicating that nonmetropolitan areas have less access to substance abuse treatment services 18 and other risk reduction strategies 19 , the similar prevalence of drug use disorders in this study underscores the importance of scaling up these critical interventions in nonmetropolitan areas. Because of the involvement of prescription opioids in the current epidemic 20 , monitoring prescribing levels along with understanding the local illicit drug trade is important for prevention efforts. Recent studies suggest that a leveling off and decline has occurred in opioid prescribing rates since and in high-dose prescribing rates since 7. However, overall opioid prescribing remained high in and the amounts prescribed varied by level of urbanization Reducing the number of persons initially exposed to prescription opioids might reduce the illicit use of opioids, the subsequent risk of addiction, and the use of illicit drugs Interventions for drug overdoses, such as naloxone administration, rescue breathing, or calling , are most useful when someone is present to administer them. In both metropolitan and nonmetropolitan areas, the majority of overdose deaths occurred in a home, and rescue care could fall to friends or relatives who might lack knowledge about naloxone administration and follow-up care. In private locations, such as homes, bystanders might not know to call for emergency services after giving naloxone Further, naloxone is less often administered by emergency medical technicians-basics persons trained to provide basic-level life support , who are more common in rural areas 24 than paramedics who can provide advanced life support care.

Chapter 2 : List of metropolitan areas by population - Wikipedia

Metropolitan and micropolitan statistical area tables are available here.

Summary What is already known about this topic? Firearm homicide rates in large metro areas are generally higher than for the nation overall, but rates for both had been declining. In contrast, firearm suicide rates in large metro areas are generally lower than those for the nation overall, but rates for both had been increasing. What is added by this report? Recently, firearm homicide rates in large metro areas and the nation overall began increasing, reaching levels comparable to those a decade ago. Firearm suicide rates have continued to increase in large metro areas and the nation overall. What are the implications for public health practice? Ongoing tracking of rates at all geographic levels can help support initiatives directed at reducing firearm-related violence. Firearm homicides and suicides represent a continuing public health concern in the United States. This report updates an earlier report 2 that provided statistics on firearm homicides and suicides in major metropolitan areas during â€" and â€", and places continued emphasis on youths, in recognition of the importance of early prevention efforts. Firearm homicide and suicide rates were determined for the 50 most populous U. In contrast to the earlier report, which indicated that firearm homicide rates among persons of all ages had been declining both nationally and in large MSAs overall, current findings show that rates have returned to levels comparable to those observed during â€" Although firearm suicide rates among youths remain notably lower than those among persons of all ages, youth rates have also increased both nationally and in large MSAs collectively. These findings can inform ongoing development and monitoring of strategies directed at reducing firearm-related violence. Firearm homicide and suicide counts were tabulated for county groupings forming the 50 largest MSAs by population rank mid-year Rates were similarly calculated for youths aged 10â€"19 years. Rates among persons of all ages were age-adjusted to the year U. However, such data were included in the calculations for all large MSAs combined. The rates of firearm homicide among persons of all ages during â€" varied widely among the 50 largest MSAs, ranging from 1. The rate for all large MSAs combined was 4. This represents an increase from â€", when the rate for large MSAs combined was 4. Among youths, the firearm homicide rate for large MSAs combined was 4. Similar to rates among persons of all ages, this represents an increase from â€", when the rate for large MSAs combined was 4. Firearm suicide rates among persons of all ages during â€" also varied widely by large MSA, ranging from 1. The rate for large MSAs combined was 5. The rate for this age group for large MSAs combined was 1. This also represents an increase from â€", when the rate for large MSAs combined was 1. Previously observed decreases in firearm homicide rates have not continued, with more recent rates showing an increase both nationally and in large MSAs considered collectively. Firearm homicide rates among persons of all ages and among youths in the large MSAs overall have both remained higher than corresponding national rates. Previously observed increases in firearm suicide rates among persons of all ages continued in recent years, both nationally and in large MSAs collectively; youth firearm suicide rates also increased both nationally and in large MSAs overall. In contrast to firearm homicide rates, firearm suicide rates among persons of all ages and among youths in the large MSAs overall have both remained lower than corresponding national rates. This is consistent with previous research showing that rates of suicide, considering all causes, have been persistently lower in more urban areas than in less urban areas 3. It is too soon to know whether recent increases in firearm homicide rates represent a short-term fluctuation or the beginning of a longer-term trend. From to , violent crime increased 3. Preventing firearm homicides can be a challenge for cities across the country; however, previous research has demonstrated that efforts to modify the physical and social environments in cities through abandoned building and vacant lot remediation, greening activities, street outreach and community norm change, low-income housing tax credits, and business improvement districts are significantly associated with reductions in gun assaults, youth homicide, and other violent crime 4. In contrast to homicide rates, which began increasing only recently, rates of suicide in the United States have been gradually increasing over the past decade and a half, across states, population groups, and in rural and urban settings 3,5,6. Rates of firearm suicide, in particular, began increasing coincident with the economic downturn of â€" and have continued to

increase, despite subsequent economic recovery. Urban areas recovered more quickly from the economic downturn than did rural areas, but the continued increase in rates of firearm suicide in large MSAs suggests that multiple factors are involved, and that a combination of prevention approaches might be necessary to reduce risks. Another factor likely affecting both firearm homicide and suicide is access to firearms by persons at risk for harming themselves or others. Previous studies have shown that the interval between deciding to act and attempting suicide can be as brief as 10 minutes or less, and that persons tend not to substitute a different method when a highly lethal method is unavailable or difficult to access 8,9. Reducing access to lethal means during an acute suicidal crisis by safely storing firearms or temporarily removing them from the home can help reduce suicide risk, particularly among youths 7. Preventing persons convicted of or under a restraining order for domestic violence from possessing a firearm has been associated with reductions in intimate partner-related homicide, including firearm homicide Efforts to strengthen the background check system to better identify persons convicted of violent crimes or at risk for harming themselves or others might also prevent lethal firearm violence, although these policies need further study The findings in this report are subject to at least two limitations. First, although statistics on nonfatal injuries associated with firearm assault or self-harm might have strengthened the report, population-based nonfatal injury data are not available for MSAs. Second, and notwithstanding the intended focus on youth firearm violence, a more expansive analysis might have addressed firearm homicide and suicide rates for other age groups not separately considered in this report. Understanding the patterns, characteristics, and impact of firearm violence is an important factor in preventing injuries and deaths. Ongoing tracking of firearm homicide and suicide rates at all geographic levels can provide important input for initiatives directed at reducing firearm-related violence.

Chapter 3 : List of metropolitan statistical areas - Wikipedia

One concept which measures the world's largest cities is that of the metropolitan area, which is based on the concept of a labor market area and is typically defined as an employment core (an area with a high density of available jobs) and the surrounding areas that have strong commuting ties to the core.

Chapter 4 : Table of United States Metropolitan Statistical Areas | Familypedia | FANDOM powered by Wik

Metropolitan & Micropolitan Population: Population Pyramids Includes data on age and sex structure for and for core based statistical areas (metro and micro areas) in the United States and Puerto Rico.

Chapter 5 : MSA Maps CBSA Maps - Geographic Information

Metropolitan statistical area tables contain expenditure data from major urban areas such as Boston, Chicago, Miami, San Diego, and others from each of the four regions of the country. Two-year tables from through are available in portable document format (PDF), Excel format (XLS.

Chapter 6 : Hispanic Population and Origin in Select U.S. Metropolitan Areas, | Pew Research Center

The Standard Metropolitan Statistical Areas (SMSA) table contains geographical boundaries that are used for statistical reporting. Agencies can query Table data, view documentation data, and generate reports; however, update authority is limited to authorized National Finance Center (NFC) personnel only.

Chapter 7 : CBSAs | Fastest Growing Metros | Metropolitan Area Demographic Economic Characteristics a

The tables below report rates of adult attendance (over a month period) at performing and visual arts activities for residents of the 32 states and 11 metropolitan areas captured by the SPPA.

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Chapter 8 : Statistics on foreign students who worked in the U.S. under OPT,

All geographic boundaries for the population estimates series except statistical area delineations are as of January 1, The Office of Management and Budget's statistical area delineations for metropolitan, micropolitan, and combined statistical areas, as well as metropolitan divisions, are those issued by that agency in July

Chapter 9 : Pennsylvania statistical areas - Wikipedia

Real gross domestic product (GDP) increased in out of metropolitan areas in The percent change in real GDP by metropolitan area ranged from percent in Odessa, TX to percent in Enid, OK.