Minority Populations in Indiana: 2006 Health Status Report

INDIANA DEPARTMENT OF HEALTH

OFFICE OF MINORITY HEALTH

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Indiana State Department of Health

An Equal Opportunity Employer

January 17, 2007

We are pleased to present you with the Interagency Council on Black and Minority Health's 2006 report. The report outlines the key data findings of the council. In addition, the report contains a number of recommendations for improving minority health in the State, such as:

- Developing a Speakers Bureau
- Summits for Students/Mentoring and Partnerships
- Creating a State Minority Health Policy Report Card
- Placing more emphasis on obesity prevention at health fairs, e.g. Black Expo, International Festival, etc.
- Assuring that children are fully immunized by age 2 with $11 million to expand access to vaccinations
- Establishing a program that offers health insurance to 100,000 or more low income Hoosiers
- Initiating an aggressive smoking cessation and reduction campaign, aimed especially at reducing the number of kids who smoke. The plan would provide $24 million more annually to the Indiana Tobacco and Prevention Cessation Trust Fund (ITPC) for local tobacco cessation and reduction programs. This amount, plus the current budget of $11 million, would bring ITPC funding to the level recommended by the Centers for Disease Control

The intent of these recommendations is to help increase access to healthcare services and reduce health status disparities among minority communities and individuals.

We look forward to providing you with a report in November 2007 outlining our success in implementing this plan.

For a Healthier Tomorrow,

Judith A. Monroe MD

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The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.

The Interagency Council on Black and Minority Health 2006 Report: State of Minority Health for Indiana

Indianapolis, Indiana
November 2006

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Executive Summary

The purpose of this report is to provide information to Indiana legislators and residents on the current state of minority health in the state of Indiana. In addition, this report will provide recommendations on program improvements found in the *2004 Indiana Minority Health Report.*

Mortality

Large disparities exist among age-adjusted death rates for racial and ethnic groups in Indiana. Based on 2004 Indiana mortality data, the following are the age-adjusted death rates for each:

- African Americans/ Blacks 1058.4 per 100,000 population
- American Indians/Alaskan Natives 352.6 per 100,000 population
- Asian/Pacific Islander 394.0 per 100,000 population
- Hispanic 482.2 per 100,000 population
- White 839.4 per 100,000 population

As you can see, Blacks have a higher age-adjusted mortality rate than Whites and other racial and ethnic minorities. The following tables rank the 10 leading causes of death by race and ethnicity in Indiana and in the United States for calendar year 2004.

Cause	Rank	White
All Causes		49,683
Diseases of heart	1	13,504
Malignant neoplasms	2	11,558
Cerebrovascular diseases	3	3,192
Chronic lower respiratory diseases	4	3,019
Accidents	5	2,186
Alzheimer's disease	6	1,473
Diabetes mellitus	7	1,470
Nephritis, nephrotic syndrome and nephrosis	8	1,103
Influenza and pneumonia	9	1,087
Septicemia	10	717

10 Leading Causes of Death for All Racial and Ethnic Groups, Indiana, 2004

Source: Indiana Mortality Report 2004

Cause	Rank	African American/Black
All Causes		4,279
Diseases of heart	1	1,067
Malignant neoplasms	2	945
Cerebrovascular diseases	3	251
Diabetes mellitus	4	191
Assault (homicide)	5	175
Accidents	6	172
Nephritis, nephrotic syndrome and nephrosis	7	139
Chronic lower respiratory diseases	8	117
Septicemia	9	102
Certain conditions originating in the perinatal period	10	88

Source: Indiana Mortality Report 2004

Cause	Rank	Asian/Pacific Islander
All Causes		148
Malignant neoplasms	1	31
Diseases of heart	2	20
Accidents	3	19*
Intentional self-harm (suicide)	4	11*
Cerebrovascular diseases	5	10*
Diabetes mellitus	6	7*
Nephritis, nephrotic syndrome and nephrosis	7	4*
Influenza and pneumonia	8	4*
Certain conditions originating in the perinatal period	9	4*
Pneumonitis due to solids and liquids	10	3*

Source: Indiana Mortality Report 2004

*If there are fewer than 20 deaths, the data are considered **statistically unstable**. Populations most affected are the AIEA, API, and Hispanic. **Extreme caution** should be used in interpretation

Cause	Rank	American Indian/ Alaskan Native
All Causes		35
Diseases of heart	1	9*
Malignant neoplasms	2	5*
Chronic lower respiratory diseases	3	4*
Cerebrovascular diseases	4	3*
Accidents	5	2*
Diabetes mellitus	6	2*
Alzheimers disease	7	1*
Nephritis, nephrotic syndrome and nephrosis	8	1*
Influenza and pneumonia	9	1*
Intentional self-harm (suicide)	10	1*

Source: Indiana Mortality Report 2004

*If there are fewer than 20 deaths, the data are considered **statistically unstable**. Populations most affected are the AIEA, API, and Hispanic. **Extreme caution** should be used in interpretation

Cause	Rank	Hispanic/Latino
All Causes		578
Diseases of heart	1	102
Malignant neoplasms	2	84
Accidents	3	72
Cerebrovascular diseases	4	40
Certain conditions originating in the perinatal period	5	37
Assault (homicide)	6	23
Congenital malformations, deformations and chromosomal abnormalities	7	23
Diabetes mellitus	8	18*
Nephritis, nephrotic syndrome and nephrosis	9	14*
Septicemia	10	14*

Source: Indiana Mortality Report 2004

*If there are fewer than 20 deaths, the data are considered **statistically unstable**. Populations most affected are the AIEA, API, and Hispanic. **Extreme caution** should be used in interpretation

10 Leading Causes of Death for All Racial and Ethnic Groups, United States, 2004

Cause	Rank	White
Heart Disease	1	594,842
Malignant Neoplasms	2	481,556
Cerebrovascular Disease	3	134,705
Chronic Low. Respiratory Disease	4	116,917
Unintentional Injury	5	93,381
Alzheimer's Disease	6	59,184
Diabetes Mellitus	7	59,099
Influenza & Pneumonia	8	57,645
Nephritis	9	33,707
Suicide	10	28,485

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Cause	Rank	Black
Heart Disease	1	77,372
Malignant Neoplasms	2	62,660
Cerebrovascular Disease	3	18,806
Diabetes Mellitus	4	12,892
Unintentional Injury	5	12,351
Homicide	6	8,392
Nephritis	7	7,855
Chronic Low. Respiratory Disease	8	7,709
HIV	9	7,479
Septicemia	10	6,206

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Cause	Rank	American Indian
Heart Disease	1	2,712
Malignant Neoplasms	2	2,154
Unintentional Injury	3	1,573
Diabetes Mellitus	4	783
Liver Disease	5	570
Cerebrovascular Disease	6	552
Chronic Low. Respiratory Disease	7	512
Influenza & Pneumonia	8	390
Suicide	9	322
Nephritis	10	255

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Cause	Rank	Hispanic
Heart Disease	1	28,298
Malignant Neoplasms	2	24,070
Unintentional Injury	3	10,418
Cerebrovascular Disease	4	6,658
Diabetes Mellitus	5	6,179
Liver Disease	6	3,382
Homicide	7	3,355
Chronic Low. Respiratory Disease	8	3,174
Influenza & Pneumonia	9	2,948
Perinatal Period	10	2,628

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Cause	Rank	Asian/ Pacific Islander
Malignant Neoplasms	1	10,532
Heart Disease	2	10,163
Cerebrovascular Disease	3	3,626
Unintentional Injury	4	1,972
Diabetes Mellitus	5	1,445
Influenza & Pneumonia	6	1,256
Chronic Low. Respiratory Disease	7	1,244
Suicide	8	722
Nephritis	9	636
Septicemia	10	456

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

In this report, Alzheimer's Disease, Chronic Obstructive Pulmonary Disease (COPD)/ Chronic Lower Respiratory Disease (CLRD), Unintentional Injuries or Accidents, and HIV/AIDS were the causes of death in which Blacks did not have the highest age-adjusted death rates in 2004.

Premature Death

Years of Potential Life Lost (YPLL) is a measurement of premature mortality. When looking at specific state mortality rates, YPLL can be most helpful for planning and evaluating local public health interventions. Examining race-specific YPLL rates can be used to target and monitor those populations at highest risk.

In Indiana, the 2004 YPLL rate due to homicide for Blacks is 7,687, which is higher than that for any other racial or ethnic group.

Infant Mortality

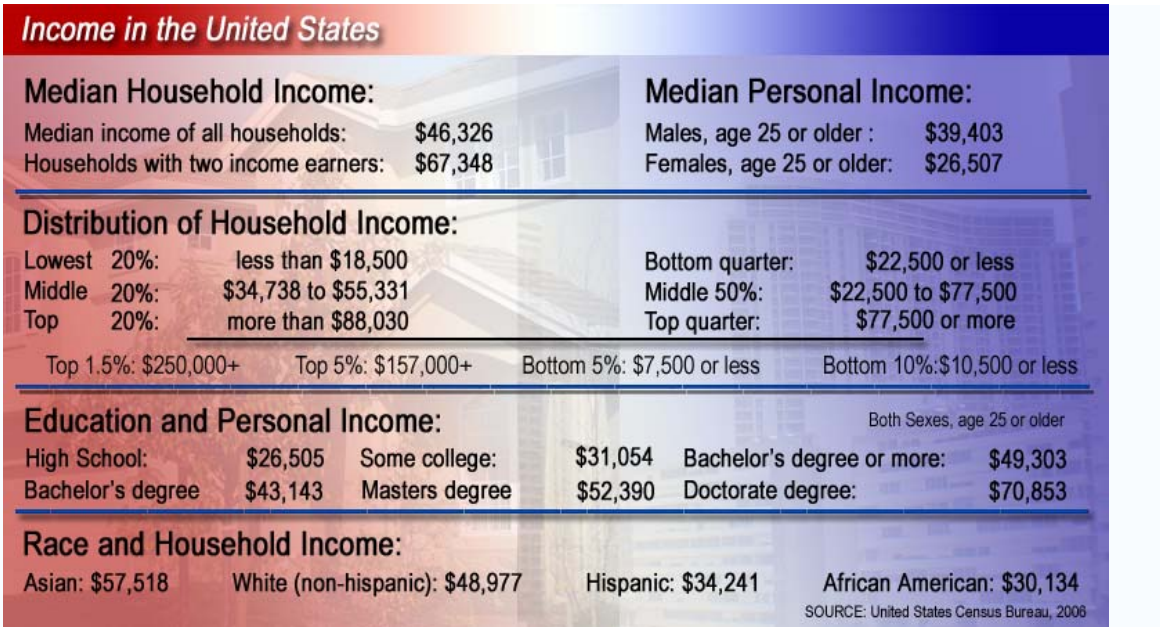
The infant mortality rate (IMR) for Indiana's Black infants (17.1 per 1,000 live births) in 2004 remains nearly 2.5 times higher than for Whites (6.9 per 1,000 live births). Although IMR has decreased for all population groups over the past two decades, the health disparity gap remains largely unchanged. An important note, IMR for Blacks is on the rise again, increasing by 3 percent since the 2002 rate cited in the *Indiana 2004 Minority Health Report*.

African American mothers have a higher incidence of low birth-weight infants and shorter gestation periods.

Economics

The Indiana State Department of Health (ISDH) and the Office of Minority Health (OMH) have compared the health disparities among different minority populations in Indiana. According to these data, minority populations are disadvantaged as measured by certain economic indicators, such as income, poverty level, employment, level of education, and housing status.

Despite the great advances that have been made to lift minorities out of poverty and that have enabled many African Americans and Latino Americans to join the middle class, there is still an uneven racial distribution among the income quintiles. Quintiles are income values which divide the population, when ranked by income, into five equally sized groups



In 2005, Whites in Indiana had a median household income of $45,943, which was only $299 less than the overall national median of $42,100, and was almost $2000 more than

the overall state median. The median household income for African Americans, however, was $17,842 less than the overall national average and $15,233 less than the state average. Asian households had a median income approximate to the median White household income, but the Hispanic median income was lower than the median White and Asian household incomes.

The national unemployment rate in 2005 was 4.5 percent. The White population was the only group in Indiana that met this average. Blacks, Asians, American Indians, and Hispanics, by contrast, all had unemployment rates higher than the national average, in general, and for their racial/ethnic group. The lowest unemployment rate in Indiana is found among Whites, contrasted with the highest rate found among African Americans. Employment status and income are often key factors in a person's decision to seek health care.

Health Risks

The Behavioral Risk Factor Surveillance System (BRFSS) is a Centers for Disease Control and Prevention (CDC) coordinated, state-based, continuously conducted, telephone-administered health survey that monitors risk behaviors related to chronic diseases, injuries, and death. Questions focus on health behaviors related to several leading causes of death and disease, for example: using condoms to prevent the spread of AIDS, taking medication for high blood pressure, smoking or using tobacco, getting a mammogram, and not exercising on a regular basis. The table below presents behavioral indicators (fruit and vegetable consumption, tobacco use, and physical activity) as reported on the 2003 and 2004 BRFSS.

Adults who have consumed fruits and vegetables five or more times per day (2003)

Race:	Consume 5 or more times per day	Consume less than 5 times per day
White	**21.8**% (1,065)	**78.2%** (3,685)
Black	**26.9%** (83)	**73.1%** (222)
Hispanic	**19.7%** (38)	**80.3%** (154)
Other	**23.3%** (26)	**76.7%** (82)
Multiracial	**20.0%** (15)	**80.0%** (61)

% = Percentage
Percentages are weighted to population characteristics.
Use caution in interpreting cell sizes less than 50.
N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Adults who are current smokers (2004)

Race:	Yes	No
White	**24.4% (1,313)**	**75.6%** (4,275)
Black	**22.9% (51**	**72.6% (**289)
Hispanic	**22.9% (51**	**72.6%** (289)
Other	**N/A**	**N/A**
Multiracial	**N/A**	**N/A**

% = Percentage
Percentages are weighted to population characteristics.
Use caution in interpreting cell sizes less than 50.
N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

During the past month, did you participate in any physical activities? (2004)

Race:	Yes	No
White	**75.8%** (4,192)	**24.2%** (1,400)
Black	**66.5%** (246)	**33.5%** (125)
Hispanic	**64.5%** (146)	**35.5%** (92)
Other	**80.7%** (90)	**19.3%** (25)
Multiracial	**82.0%** (72)	**18.0%** (17)

% = Percentage
Percentages are weighted to population characteristics.
Use caution in interpreting cell sizes less than 50.
N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year

Infectious Diseases

Although not traditionally at the forefront, infectious disease is a minority health concern that must be addressed to reduce the incidence of these diseases in Indiana's racial and ethnic minority communities. The following are just a few issues that are addressed in this report.

The current incidence rates per 100,000 population of HIV/AIDS in Indiana by Race/Ethnicity for 2004 are:

Race/Ethnicity	Rate 2004
Black	36.8
Hispanic	15.3
White	4.1
Other	2.7

Asian and Pacific Islanders only comprise approximately 1.2 percent of the population of Indiana but account for the highest incidence rate of tuberculosis (28.9 per 100,000 population)

Blacks have the highest number of gonorrhea, chlamydia, and syphilis cases in Indiana, but only comprise approximately 8.8 percent of Indiana's total population.

Community

Chronic disease continues to disproportionately affect minority populations in Indiana. To address this problem, the Office of Minority Health at the Indiana State Department of Health launched a new health initiative, "Bringing INShape to You," during Minority Health Month of April 2006.

The local discussion groups, which were held throughout the month of April, offered participants information and access to services that would help them to maintain a healthy diet and an active lifestyle, while staying free from tobacco.

Recommendations

Addressing Obesity

The issue of obesity is a growing epidemic among racial and ethnic minorities. As indicated in this report, Indiana has a high percentage of adults who are obese, which increases health risks in minority populations.

Governor's Plan for A Healthier Indiana

The Indiana Interagency Council wants to commit to supporting the Governor's Plan for a Healthier Indiana. The plan will lead to:

1. Protection of children from the dangers of smoking and other diseases,
2. Peace of mind for thousands of Hoosiers who currently have no health insurance, and
3. Personal responsibility to take control of health care decisions.

Convening a Summit with Faith-based Leaders Representing All Racial and Ethnic Minority Groups to Engage in Health Based Discussions

Training and a speaker's kit will be provided to faith-based leaders to aid in their congregations outlook on health and health care.

Develop a Speakers Bureau

A Speakers Bureau will provide Indiana organizations with an unparalleled range of speakers who specialize in diversity, cultural, and minority health issues.

Summits for Students/Mentoring and Partnerships

Mentoring has become an almost essential aspect of youth development and is expanding beyond the traditional one-to-one, volunteer, community-based mentoring. In order to ensure workforce diversity in health care among today's competitive environment, Indiana must create or seek programs that introduce health care careers to young people and encourage youth to continue to learn and grow.

Creating A State Minority Health Policy Report Card

A state minority health report card would be a vital tool for evaluating and promoting state policies to help eliminate health disparities.

Technical Notes

Age-Adjusted Death Rate – When comparing rates over time or across different populations, crude rates (the number of deaths per 100,000 persons) can be misleading, because differences in the age distribution of the various populations are not considered. Since death is age-dependent, the comparison of crude rates of death can be especially deceptive.

Age adjustment, using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in population composition. This adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time. (National Center for Health Statistics [NCHS])

The direct method of adjustment was used to produce the age-adjusted rates for this report. In this method, the population is first divided into reasonably homogenous age ranges, and the age-specific rate is calculated for each age range. Then, each age-specific rate is weighted by multiplying it by the proportion of the standard population in the respective age group. The age-adjusted rate is the sum of the weighted age-specific rates. Further information regarding the calculation of age-adjusted rates can be found in *The Methods and Materials of Demography*, by Henry S. Shryock, Jacob S. Siegel and Associates, U.S. Department of Commerce. Age adjustment by the direct method requires use of a standard age distribution. The year 2000 population replaces the 1940 U.S. population for age adjusting mortality statistics. The 2000 standard population also replaces the 1970 civilian non-institutionalized population and 1980 U.S. resident population, which previously had been used as standard age distributions for age adjusting estimates from NCHS surveys. The year 2000 standard has implications for race and ethnic differentials in mortality (National Vital Statistics Report, Volume 47, Number 3).

Cause of Death Classification – According to the NCHS, the International Classification of Diseases (ICD) is the classification used to code and classify mortality data from death certificates. NCHS serves as the World Health Organization (WHO) Collaborating Center for the Family of International Classifications for North America and, in this capacity, is responsible for coordination of all official disease classification activities in the U.S. relating to the ICD and its use, interpretation, and periodic revision.

The death statistics presented in this report were compiled in accordance with WHO regulations, which specify that member nations classify cause of death by the current International Classification of Diseases and Related Health Problems**.**

Data Limitations – Lack of consensus when defining and measuring race and ethnicity leads to limitations. Particular rates in this report are based on a small population size, a small number of deaths, or both. The rates based on small numbers may be unstable due to random variation and should be used with caution. For rates based on 20 or fewer deaths, the data are considered statistically unstable; thus, valid comparisons are not possible and usually are suppressed.

Race/Ethnicity – Data presented for the years 2000-2004 were collected using the standards for the classification of federal data on race and ethnicity that were in effect

prior to the 2000 Census: White; Black; American Indian, Eskimo, or Aleut (AIEA); Asian/Pacific Islander (API); and Hispanic.

Introduction

A review of the *2004 Indiana Minority Health Report*

The *2004 Indiana Minority Health Report* compared leading causes of death for each race, years of potential life lost, and areas with limited English proficiency. Recent population data, synopsis of the goals of the *2003 Healthy Indiana Minority Health Plan*, and current statistics at that time were also included. The report also examined the limitations that exist in relation to data collection among racial and ethnic minorities.

Indiana has been at the forefront of minority health concerns for over 16 years. In 1988, the Indiana General Assembly enacted legislation that created the Interagency State Council on Black and Minority Health. Indiana Code 16-46-6 directed the Indiana State Department of Health to establish the Interagency State Council on Black and Minority Health with representation from the Indiana House of Representatives, Indiana Senate, Governor's Office, State Health Commissioner's Office, and other State agencies.

The 2006 Council members are:

Dr. Judith A. Monroe, State Health Commissioner
Ms. Carolin Requiz, Office of Minority Health (Proxy for State Health Commissioner)
Rep. Jim Buck, House of Representatives (R)
Rep. Charlie Brown, House of Representatives (D)
Sen. Tom Wyss, State Senate (R)
Sen. Billie Breaux, State Senate (D)
Mr. Tony Kirkland, Governor's Office
Mr. James Garrett Jr, Indiana Family and Social Services Administration
Ms. Jackie Joyner Cissell, Office of Medicaid Policy and Planning
Mr. Lynn Smith, Indiana Division of Mental Health and Addiction
Mr. Dave Donahue, Indiana Department of Correction
Dr. Axisa Perez, Local Health Department
Mr. Jose M. Perez, Public Health Care Facility
Dr. C. Herbert Henry, Psychologist
Dr. Ramana Moorthy, Indiana State Medical Association
Dr. Lili A. Leavell-Hayes, National Medical Association
Dr. Edward Williams, Indiana Hospital and Health Association
Mr. George Flowers, American Cancer Society
Ms. Lynne Griffin, American Heart Association
Ms. Arvetta Jideonwo, American Diabetes Association
Dr. Rose Mays, Black Nurses Association
Rev. Manuel Hunt, Indiana Minority Health Coalition

Advisors:

Ms. Nancy Jewell, Indiana Minority Health Coalition
Dr. Edwin C. Marshall, Indiana University School of Optometry
Ms. Sally Tuttle, Native American Indian
Dr. Javier Sevilla Martir, Indiana University School of Medicine

The Interagency Council on Black and Minority Health 2006 Report: State of Minority Health for Indiana provides a more comprehensive picture of the health of racial/ethnic minority populations in Indiana. The report used multiple data sources including data on population characteristics, mortality and morbidity, behavioral health risks, and economics of health care. The *Interagency Council on Black and Minority Health 2006 Report: State of Minority Health for Indiana* reveals some key disparities in minority health.

Purpose

Purpose

The *Interagency Council on Black and Minority Health 2006 Report: State of Minority Health for Indiana* is designed to provide Indiana Legislature and Hoosiers with recommendations to help eliminate health disparities along with solutions to improve the collection and use of racial and ethnic data across the state and its agencies.

In order to accomplish Indiana's goal of everyone being INShape, there must be a commitment of time and resources by Indiana's legislators and State agencies if the recommendations in this report are to become a medium of change.

The goal of the Interagency Council on Black and Minority Health is to "heal the gap", as reported in the *2004 Minority Health Plan* developed by the ISDH Minority Health Advisory Committee, as well as to show the improvements or declines of the leading causes of death among racial and ethnic minorities.

All recommendations are based on data collected for this report as well as on a number of sources that, in turn, helped guide Council members in developing solutions, programs, and recommended policies to address the continuing disparity in death and illness experienced by Indiana's racial and ethnic minorities.

Background

The Indiana Interagency Council on Black and Minority Health was created to:

- Identify and study the special health care needs and health problems of minorities;
- Examine the factors and conditions that affect the health of minorities;
- Examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities;
- Study the State and federal laws concerning the health needs of minorities;
- Examine the coordination of services to minorities and recommend improvements in the delivery of services;
- Examine funding sources for minority health care;
- Examine and recommend preventive measures concerning the leading causes of death or injury among minorities, including: heart disease, stroke, cancer, intentional injuries, accidental death and injury, cirrhosis, diabetes, infant mortality, HIV and AIDS;
- Examine the impact of adolescent pregnancy, mental disorders, substance abuse, sexually transmitted and other communicable diseases, lead poisoning, long-term disability and aging, and sickle cell anemia on minorities;
- Monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.

The Council is mandated by law to review and assess the health status of minorities in the State of Indiana and submit those findings to the Governor and the General Assembly.

The Interagency Council on Black and Minority Health 2006 Report: State of Minority Health for Indiana is a joint effort of the Indiana State Department of Health and the Interagency Council on Black and Minority Health. The report includes data findings, a review of what has been done in Indiana since *the 2004 Indiana Minority Health Report*, and the recommendations and conclusions of the Council. The council formulated these recommendations and conclusions in order to make Indiana a better place for all Hoosiers.

These key issues in minority health include demographic information for Indiana's growing racial and ethnic minorities, current health disparities, and underlying determinants of health in racial/ethnic minority populations. Recommendations are provided to assure a healthier and brighter future for all Indiana residents.

Demographics

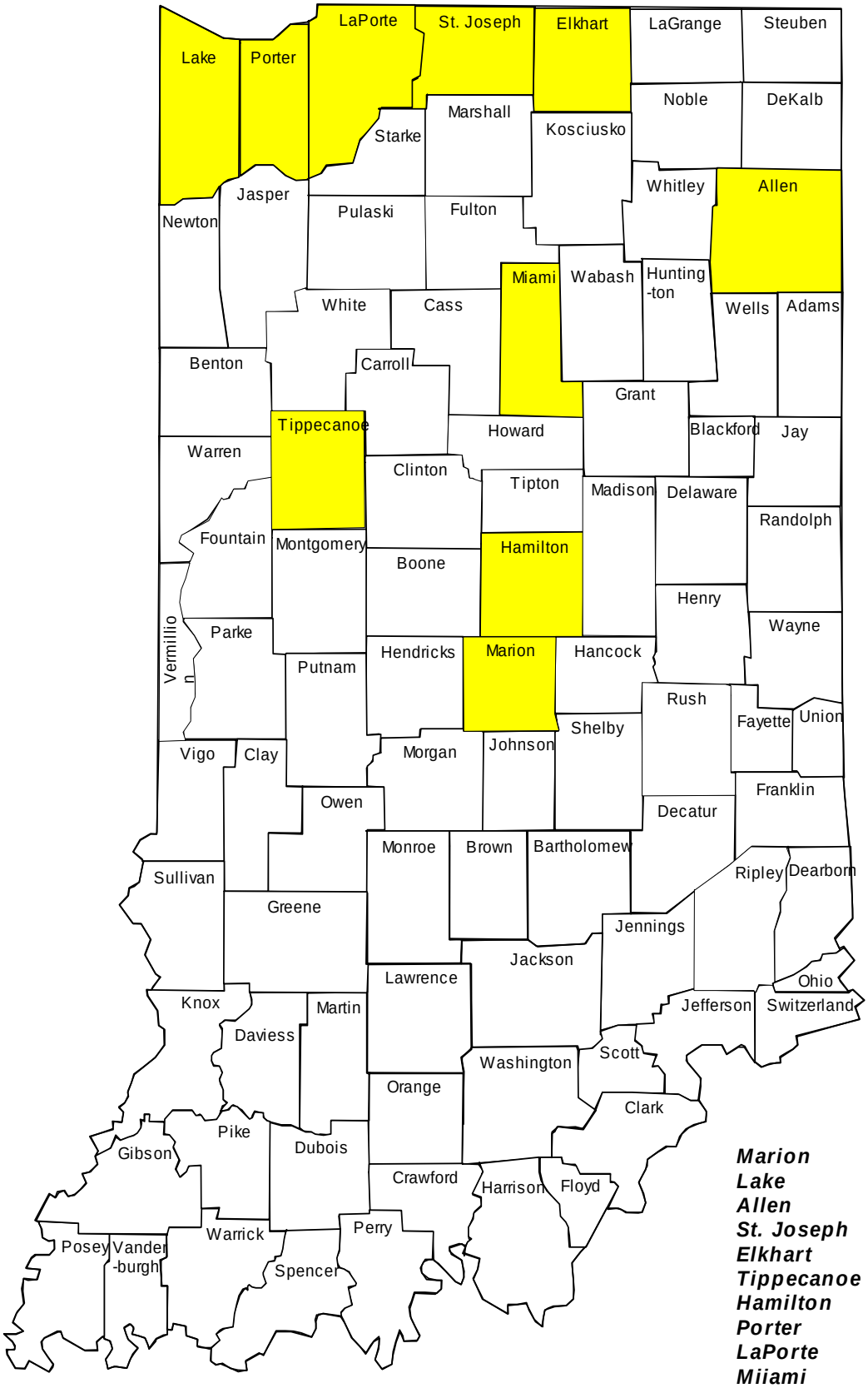
This section provides an overview of the demographics of Indiana's racial and ethnic minorities. In this update, maps are included for each racial and ethnic group to illustrate the geographic locations within Indiana that have the largest minority populations. These maps also show the areas with significant increases in minority populations, indicating a need for increased programming and services in those areas.

In the map key, the 10 highest population statistical numbers are based on information derived from the U.S. Census Bureau. Racial groups shown include African American or Black, American Indian and Alaska Native, Asian or Pacific Islander. The ethnic groups included are Hispanics or Latinos. Persons of Hispanic origin may be of any race. In this section and throughout this report, statistical data for racial groups exclude persons of Hispanic origin unless otherwise noted.

Racial and ethnic populations in Indiana make up more than 13 percent of the current population.

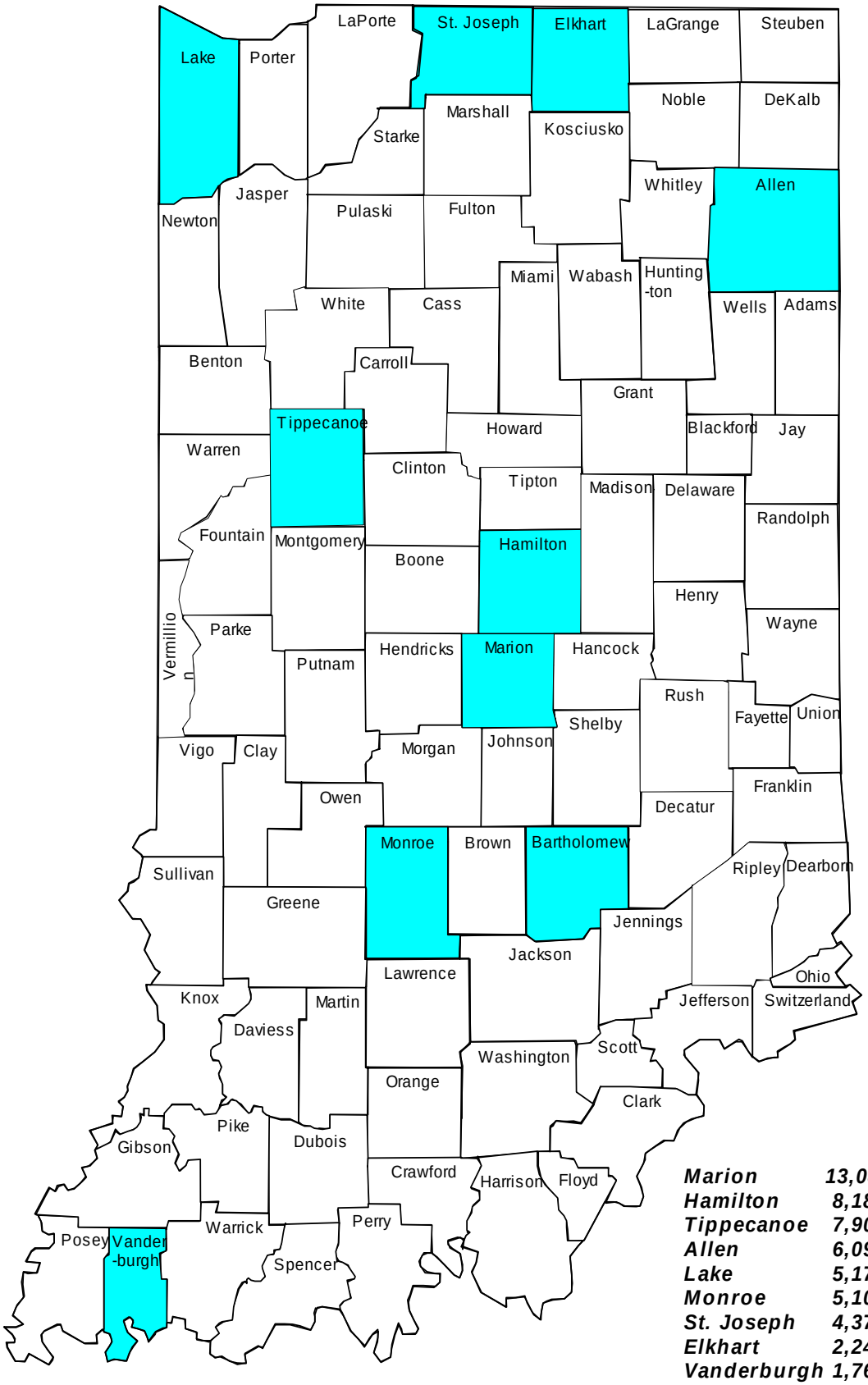
This section also examines multiracial reporting. Those individuals who choose more than one racial or ethnic category make a difference in how we view and interpret data.

10 counties with the highest American Indian/Alaskan Native Population



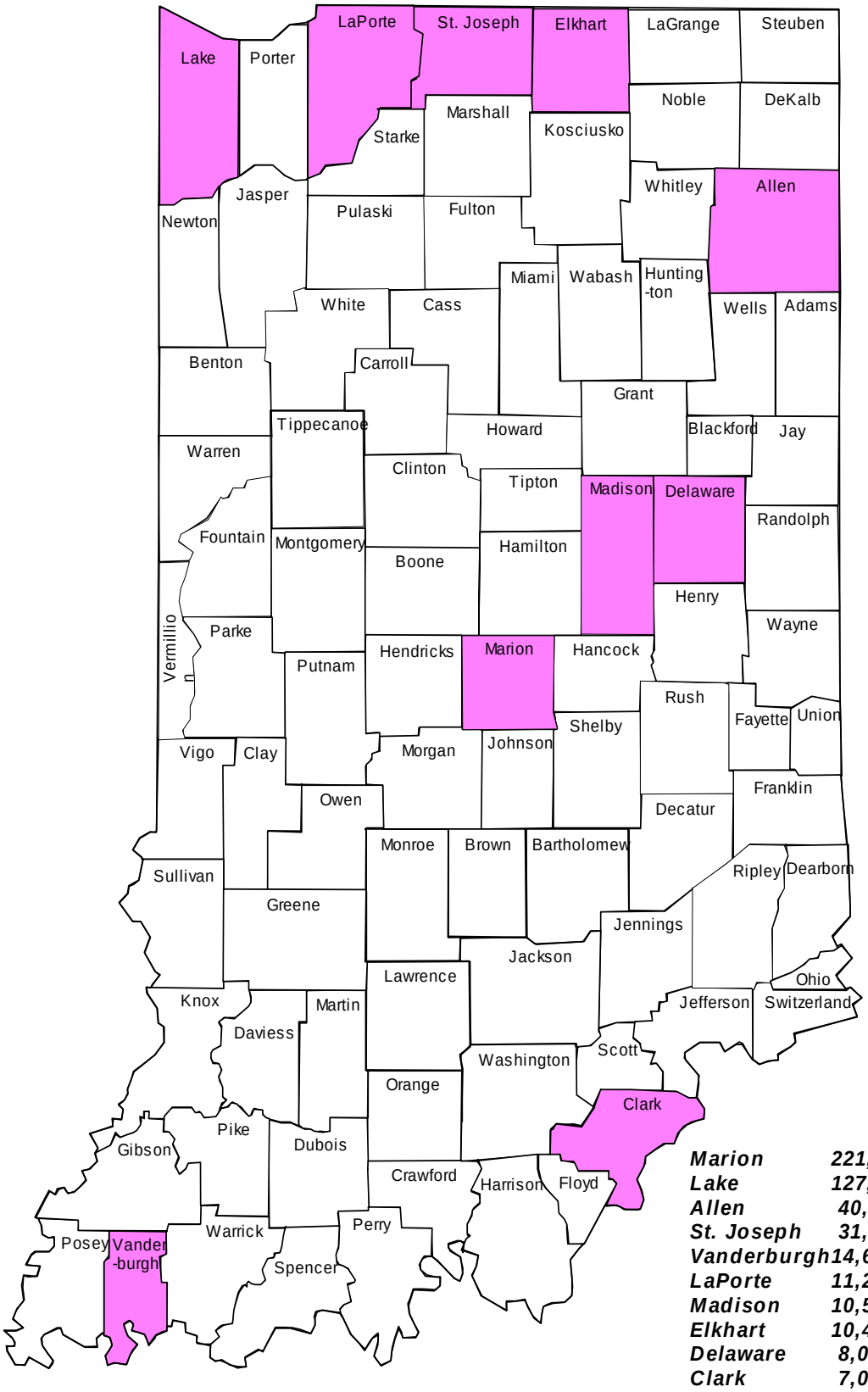
Marion	***2,492***
Lake	***1,667***
Allen	***1,287***
St. Joseph	***1,047***
Elkhart	***594***
Tippecanoe	***478***
Hamilton	***475***
Porter	***439***
LaPorte	***389***
Miiami	***386***

10 counties with the highest Asian/Pacific Islander Population



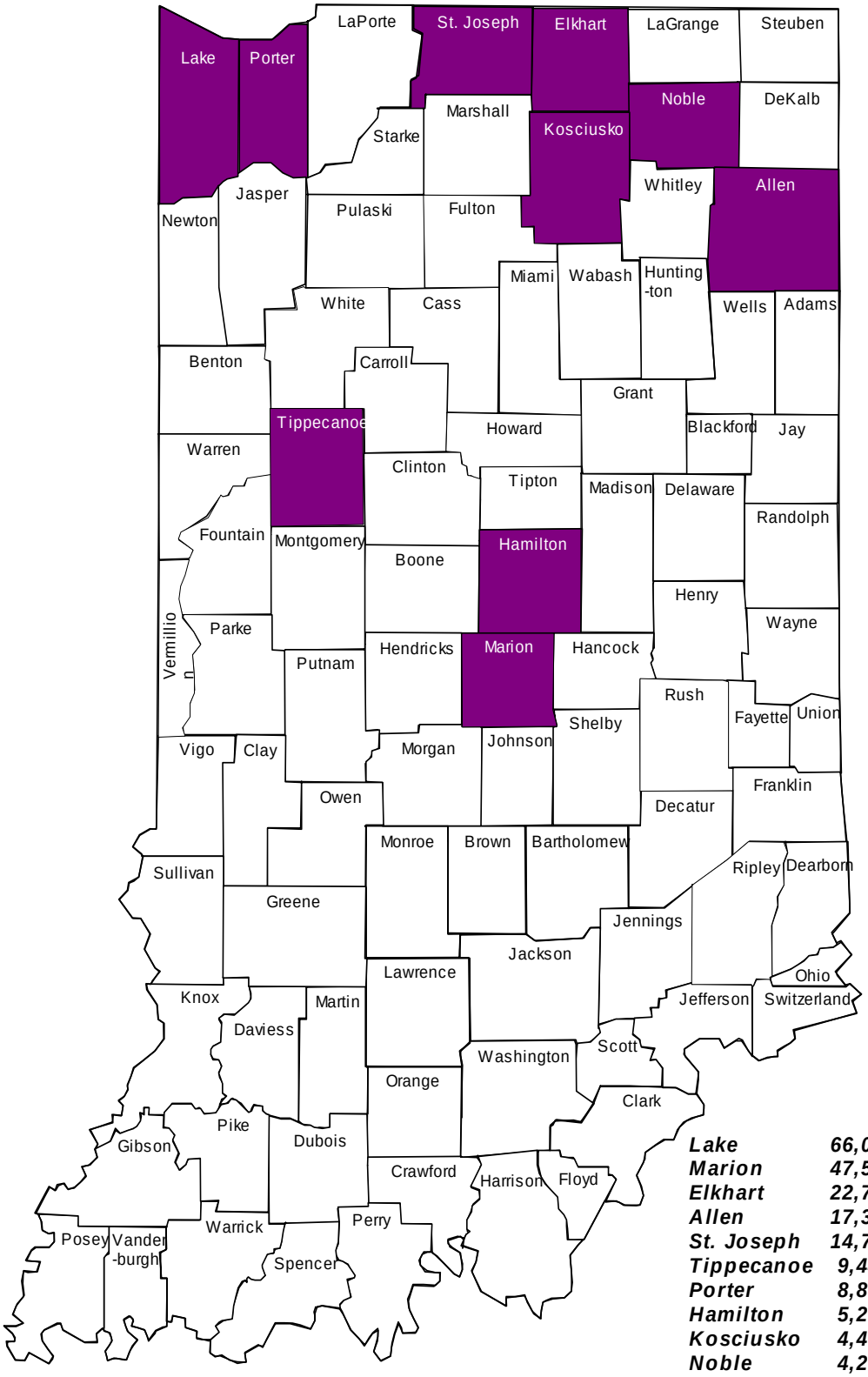
Marion	***13,085***
Hamilton	***8,184***
Tippecanoe	***7,903***
Allen	***6,095***
Lake	***5,171***
Monroe	***5,106***
St. Joseph	***4,374***
Elkhart	***2,242***
Vanderburgh	***1,768***
Bartholomew	***1,758***

10 counties with the highest African American/Black Populations



Marion	***221,189***
Lake	***127,962***
Allen	***40,061***
St. Joseph	***31,884***
Vanderburgh	***14,690***
LaPorte	***11,234***
Madison	***10,538***
Elkhart	***10,419***
Delaware	***8,091***
Clark	***7,098***

10 counties with the highest Hispanic/Latino Populations



Lake	***66,017***
Marion	***47,535***
Elkhart	***22,726***
Allen	***17,392***
St. Joseph	***14,729***
Tippecanoe	***9,446***
Porter	***8,854***
Hamilton	***5,213***
Kosciusko	***4,461***
Noble	***4,201***

Multiracial: Reporting Two or More Races

The last Census in 2000 allowed people to choose more than just one race. Each person could have chosen two or more races either by checking two or more race response check boxes, by providing multiple write-in responses, or by some combination of check boxes and write-in responses. This was to ensure that everyone had the right to self-identification. Because of this, when looking at multiracial categories such as two or more or etc., the population numbers tend to be more.

Another important note: When looking at statistical data such as death reports, remember that individuals cannot be separated into several categories. They must remain in a multiracial category.

Below are the Census numbers for those that reported one or more race:

Race alone or in combination with one or more other races	
Total population	**6,093,372**
White	5,328,437
Black or African American	564,483
American Indian and Alaska Native	45,276
Asian	84,991
Native Hawaiian and Other Pacific Islander	2,985
Some other race	161,964

2005, Source: U.S. Census Bureau, 2005 American Community Survey

Reporting Race at Death

Mortality records are based on information reported on death certificates as completed by funeral directors, attending physicians, medical examiners, and coroners.

Economics of Health

Economics of Health

The economics of health is the deductive study of the choices made by individuals and societies in regard to the alternative uses of scarce resources which are employed to satisfy wants. This means that there are simply not enough basic global resources (such as water, land, labor, capital, and vaccines) to provide for every person's wants. Therefore, populations must share scarce resources. Often, resource allocation is determined by an individual's or group's economic reality, habits, or choices.

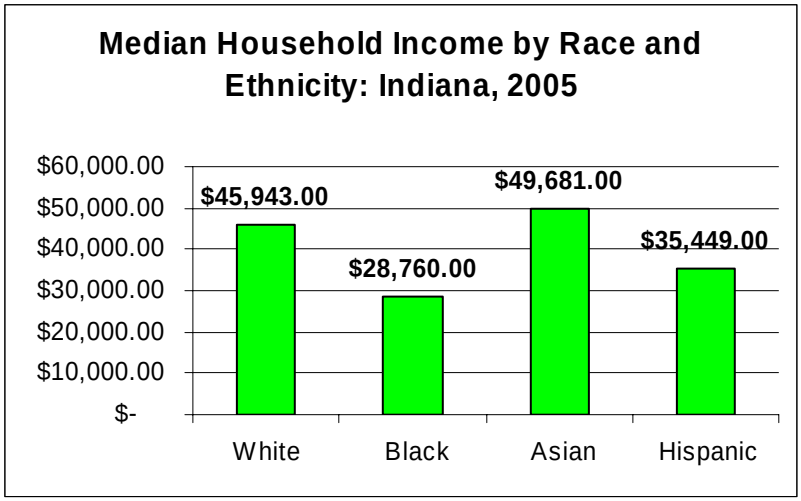
The Indiana State Department of Health and the Office of Minority Health have compared the health disparities among different minority populations in Indiana. According to these data, minority populations are constrained by certain economic indicators, such as income, poverty level, employment, education attainment, and housing status.

Median Household Income

Income often determines the broader racial disparities present in a population. For instance, the median household income is lower for Indiana's African American population than for any other population group. Income often determines an individual's quality of health. "Improvement in health and nutrition raises output in two ways: first, it brings people into the labor force that would otherwise have been unable to work, and second, good health status improves the productivity of those who are already working."[1] The result is increased health and nutrition that allows workers to work more, which increases their income.

There are clear racial disparities in household income in Indiana. Latinos, for example, have an income level that is only 80 percent of the Asian income level.

Figure 1: Household Income and Race



Source: IBRC using U.S. Census Bureau data

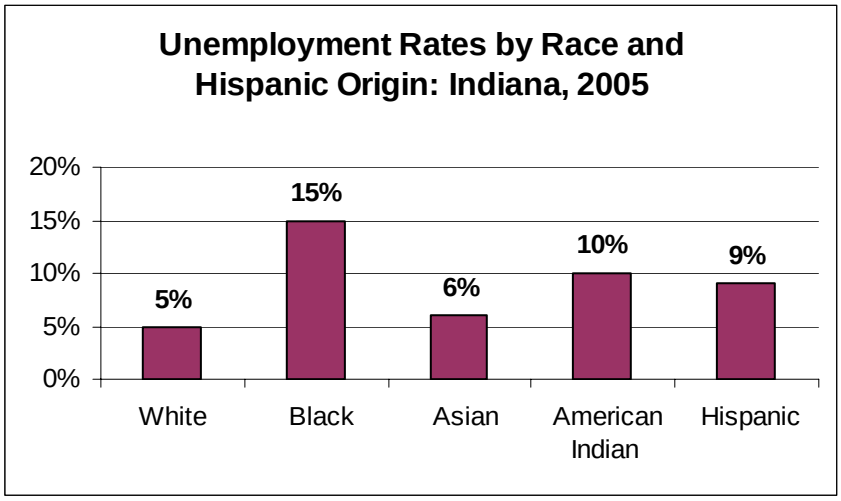
[1] Tennessee Department of Health, *Populations of Color in Tennessee: Health Status Report*

Whites in Indiana in 2005 had a median household income of $45,943, which was only $299 less than the overall national median of $42,100, and was almost $2000 more than the overall state median. The median household income for African Americans, however, was $17,842 less than the overall national average and $15,233 less than the state average. Asian households had a median income approximate to the median White household income, but the Hispanic median income was lower than the median White and Asian household incomes.

Unemployment Rate

Racial and ethnic minorities in Indiana experience a rate of unemployment that is several times higher than the rates for non-minorities. The lowest unemployment rate in Indiana is found among Whites, contrasted with the highest rate found among African Americans. Employment status and income are often key factors in a person's decision to seek health care. It is evident, based on Figure 2, that Whites and Asians typically have more employment opportunities than African Americans and Hispanics, which may potentially explain many of Indiana's health disparities.

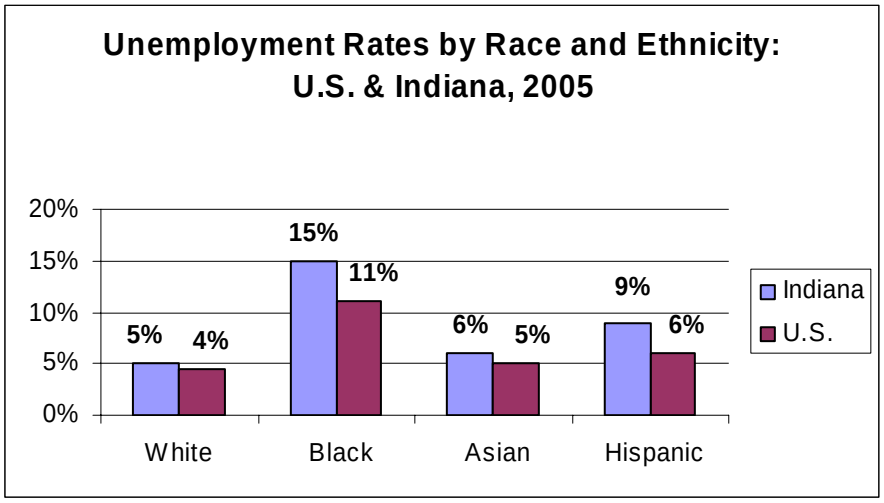
Figure 2: Unemployment Rates by Race and Ethnicity



Source: U.S. Bureau of Labor Statistics

The national unemployment rate in 2005 was 4.4 percent. Whites were the only population group in Indiana that came close to matching this rate. African Americans, Asians, American Indians, and Hispanics, by contrast, all had unemployment rates higher than the overall national average and higher than the national average for their racial/ethnic group (see Figure 3).

Figure 3: Unemployment Rates by Race and Ethnicity, U.S. & Indiana, 2005

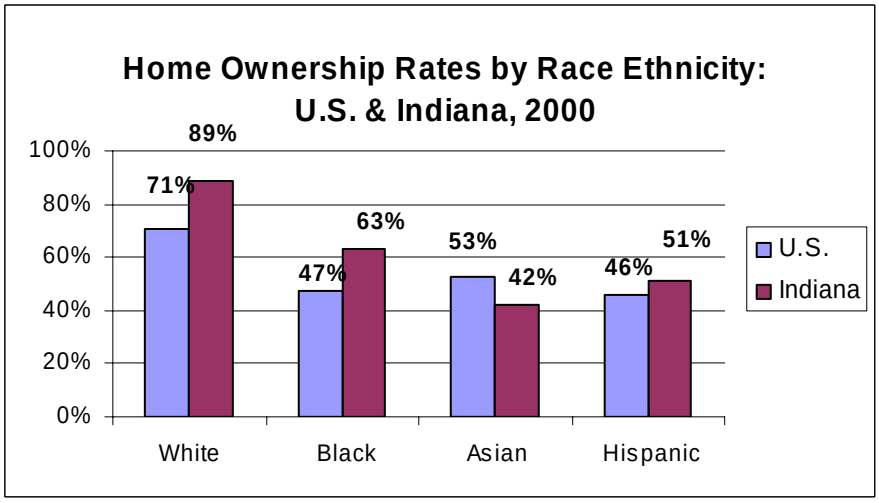


Source: U.S. Bureau of Labor Statistics

Home Ownership

Levels of home ownership are another area of disparity among racial groups. In Indiana, home ownership rates for racial and ethnic minorities, except for Asians, are above the national average. There is, however, a marked disparity between the level of White home ownership and minority home ownership (see Figure 4).

Figure 4: Home Ownership Rates by Race, U.S. & Indiana, 2000



Source: US Census Bureau Data

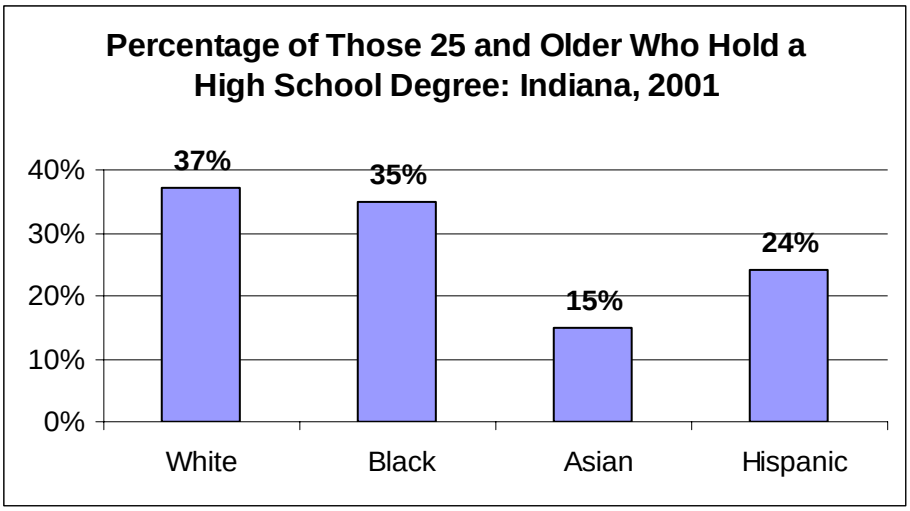
Home ownership demonstrates the way in which wealth is poorly distributed among minority population groups in Indiana. "Wealth is often accumulated through gains in equity and appreciation of real estate."[2] Lower levels of home ownership mean that minorities are less likely to accumulate capital and total overall wealth. This means that, in comparison, minorities spend a larger portion of their income on rent than Whites.

[2] Tennessee Department of Health, *Populations of Color in Tennessee: Health Status Report*

Education

In general, those with a higher level of education tend to have higher income levels. This does not mean, however, that education alone erases the economic disparity that exists between minorities and non-minorities. African Americans with a college education, for example, on average make less money than Whites with an equivalent level of education.

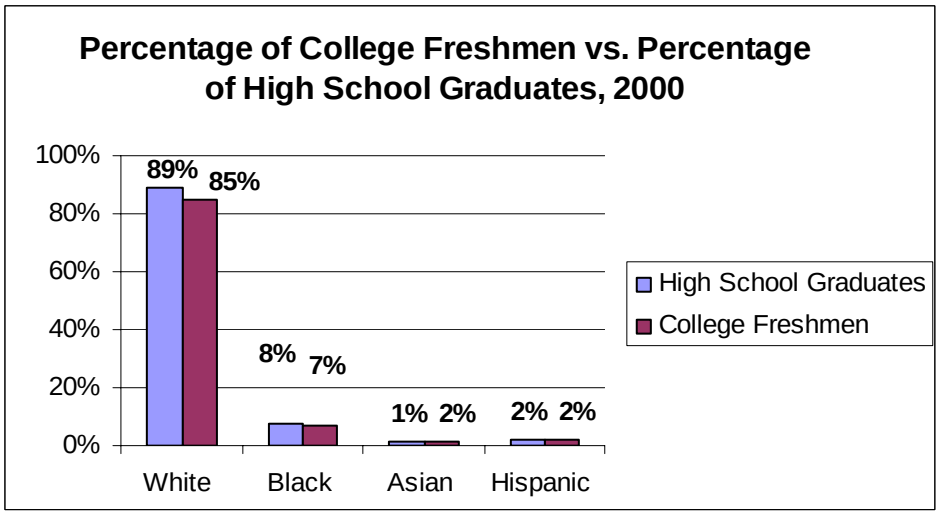
Figure 5: Percentage of Those 25 and Older Who Hold a High School Degree



Source: IU-Report on the Status of Minorities at Indiana University

- 37.0 percent of Whites aged 25 years and older had a high school degree in 2001.
- 35.2 percent of African Americans aged 25 and older had a high school degree in 2001.
- 24.3 percent of Latinos aged 25 and older had a high school degree in 2001.
- 15.4 percent of Asians aged 25 and older had a high school degree in 2001.
- 42.5 percent of American Indians aged 25 and older had a high school degree in 2001.

Figure 6: Percentage of College Freshmen vs. Percentage of High School Graduates



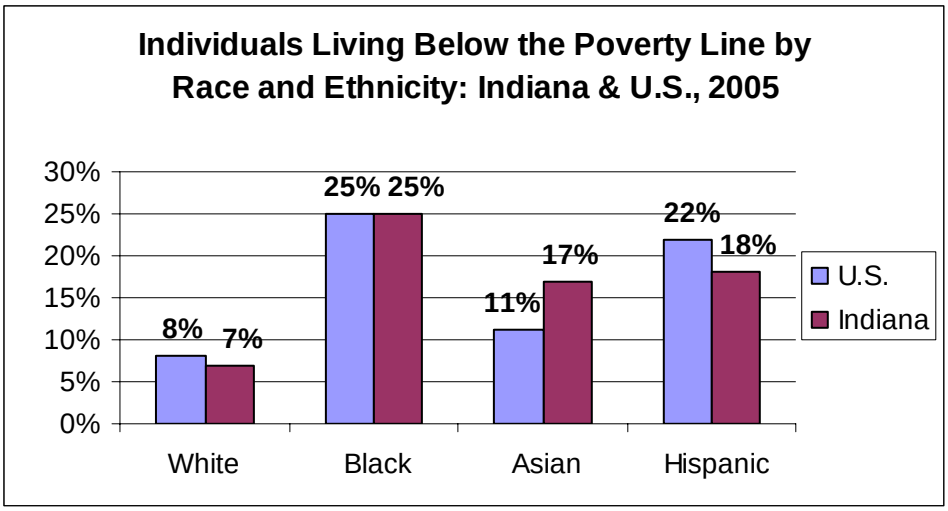
Source: IU-Report on the Status of Minorities at Indiana University

•Whites accounted for 89.1 percent of the high school graduates and 84.7 percent of the first-time college freshmen in 2000.
•African Americans accounted for 7.6 percent of the high school graduates and 7 percent of first-time college freshmen in 2000. However, the national high school dropout rate for African American students in 2000 was 13.1 percent (Source: National Center for Education Statistics).
•Latinos accounted for 2.1 percent of the high school graduates and 2.4 percent of first-time college freshmen in 2000 but dropped out of high school at a rate of 28 percent.

Poverty Line

Another good measure of the overall economic health and well-being of a population is the percentage of people who fall below the poverty line (Figure 7). Indiana's population is typically better off than the rest of the U.S. population. However, there is a clear disparity between Whites and minorities with regard to the level of existent poverty.

Figure 7: Individuals Living Below the Poverty Line by Race and Ethnicity



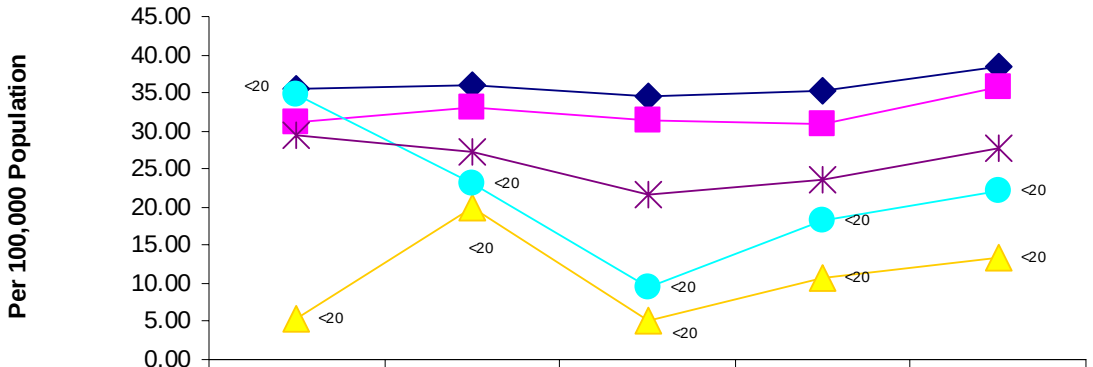
Source: U.S. Census Bureau-Income Poverty & Health Insurance Coverage in the United States: 2005

Mortality

Leading Causes of Death for Indiana

The *2004 Indiana Minority Health Report* focused on the leading causes of death for each racial and ethnic minority group and revealed what progress, if any, had been made in decreasing racial and ethnic disparities in age-adjusted death rates from 1995 to 2002.

With this 2006 updated report, the data will show the trend of change from 2000-2004. As always, the number of deaths used to compute the death rates were small for American Indian, Asian/Pacific Islander, and Hispanic populations. Because of this, the death rates may become statistically unstable. Therefore, to discourage misinterpretation and misuse of the data presented, the statistics should be used with extreme caution.

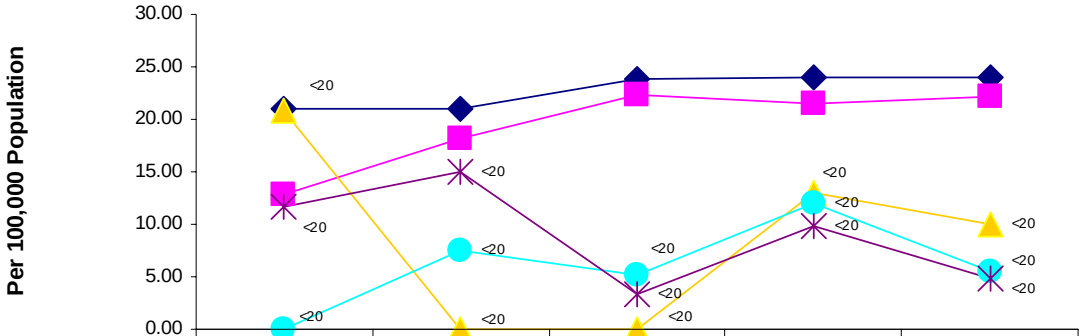


	2000	2001	2002	2003	2004
White	35.44	35.92	34.42	35.22	38.52
Black	31.10	33.16	31.43	30.78	35.85
AIEA	5.41	19.89	5.00	10.78	13.29
API	34.83	23.17	9.38	18.28	22.14
Hispanic	29.48	27.21	21.58	23.51	27.74

ICD 10: V01-X59, Y85-Y86

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
<20: Populations whose deaths are fewer than 20; the data used is considered statistically unstable. Populations most affected are the AIEA, API, and Hispanic.
Extreme caution should be used in interpretation.

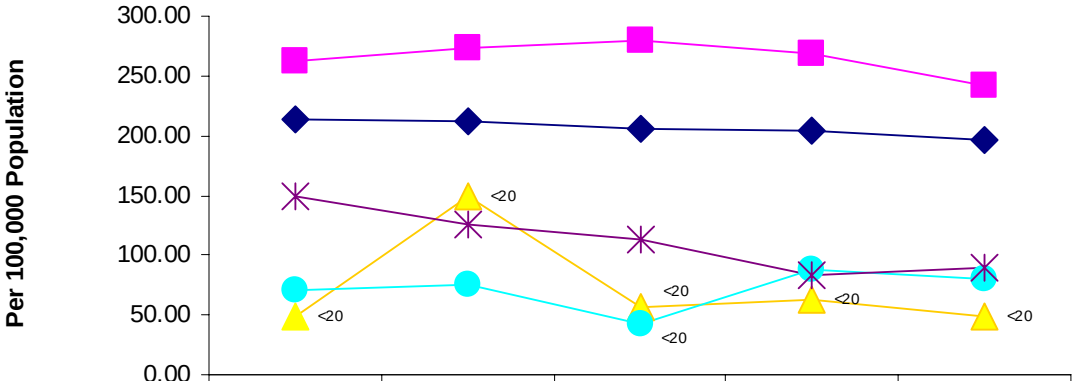
Age-Adjusted Death Rates for Alzheimer's Disease, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	20.97	21.04	23.89	24.08	24.05
Black	12.79	18.11	22.35	21.42	22.12
AIEA	20.76	0.00	0.00	13.03	10.07
API	0.00	7.55	5.20	11.97	5.48
Hispanic	11.61	15.07	3.35	9.88	4.91

ICD 10: G30

Age-Adjusted Death Rates for Cancer, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	213.52	211.87	205.42	203.95	196.97
Black	262.89	273.17	279.94	268.37	241.67
AIEA	48.05	148.75	56.19	63.45	48.15
API	70.47	75.36	42.74	88.32	79.43
Hispanic	148.90	124.97	112.80	83.41	88.95

ICD 10: C00-C97

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
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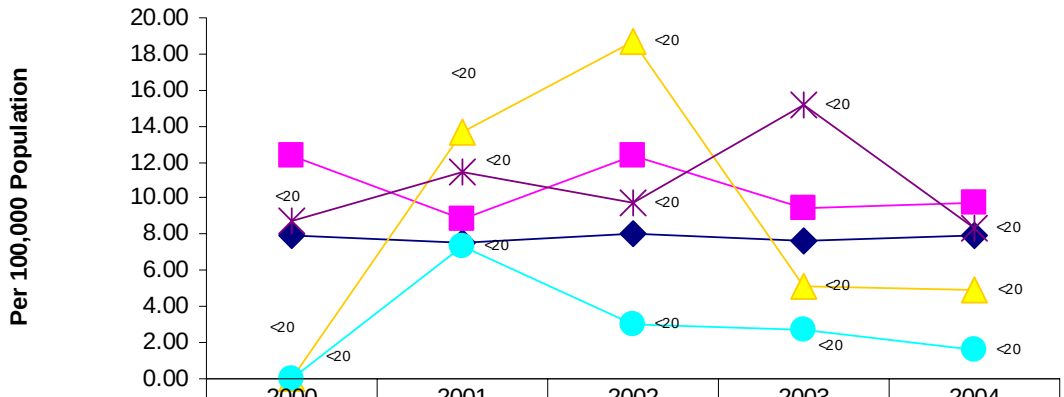
Extreme caution should be used in interpretation

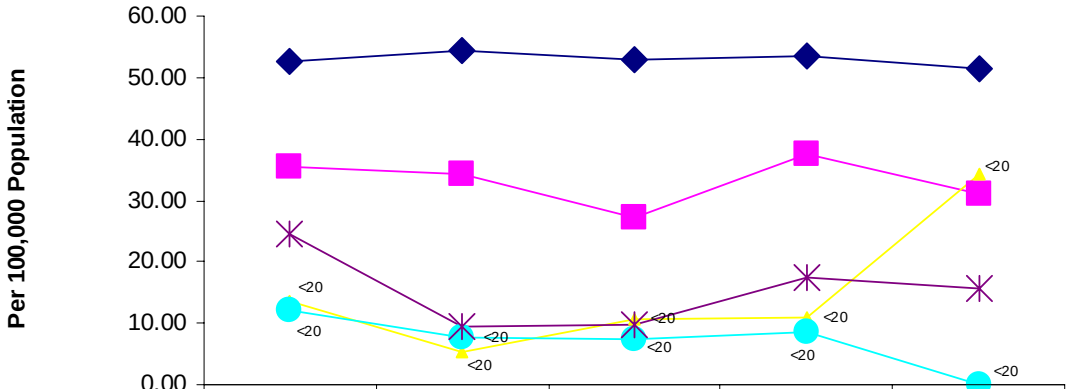
Age-Adjusted Death Rates for Cirrhosis, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	7.96	7.53	8.05	7.63	7.91
Black	12.35	8.87	12.38	9.44	9.72
AIEA	0.00	13.64	18.68	5.09	4.97
API	0.00	7.35	2.97	2.70	1.62
Hispanic	8.73	11.46	9.75	15.17	8.32

ICD 10: K70, K73-K74

Age-Adjusted Death Rates for COPD/CLRD, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	52.54	54.25	52.95	53.50	51.36
Black	35.48	34.19	27.14	37.43	31.10
AIEA	13.64	5.46	10.55	10.79	34.35
API	12.18	7.55	7.48	8.64	0.00
Hispanic	24.51	9.60	9.77	17.50	15.53

ICD 10: J40-J47

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
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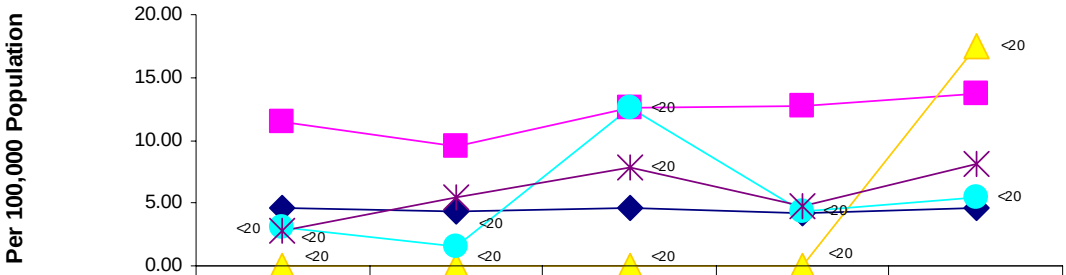
Extreme caution should be used in interpretation

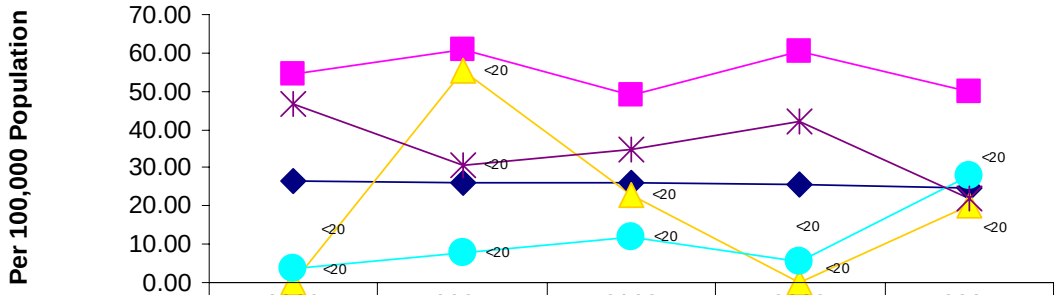
Age-Adjusted Death Rates for Conditions During the Perinatal Period, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	4.61	4.34	4.63	4.18	4.56
Black	11.43	9.58	12.63	12.73	13.68
AIEA	0.00	0.00	0.00	0.00	17.49
API	3.02	1.51	12.64	4.37	5.49
Hispanic	2.83	5.42	7.84	4.69	8.12

ICD 10: P00-P96

Age-Adjusted Death Rates for Diabetes, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	26.57	26.20	26.03	25.70	24.89
Black	54.54	60.73	49.17	60.33	49.77
AIEA	0.00	55.16	22.69	0.00	20.13
API	3.68	7.55	12.03	5.39	28.08
Hispanic	46.80	30.65	34.57	42.28	21.78

ICD 10: E10-E14

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
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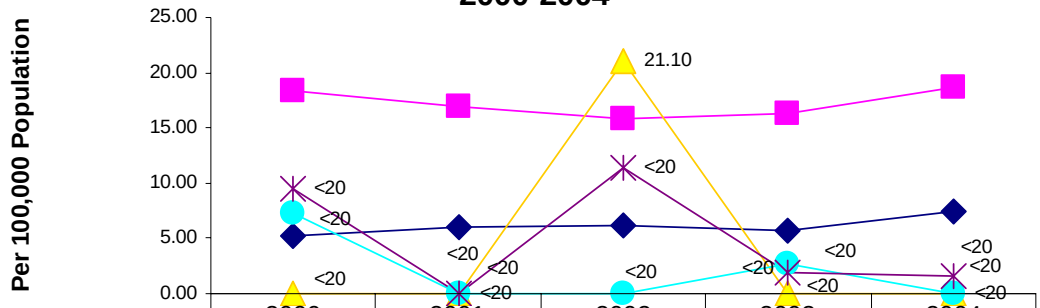
Extreme caution should be used in interpretation

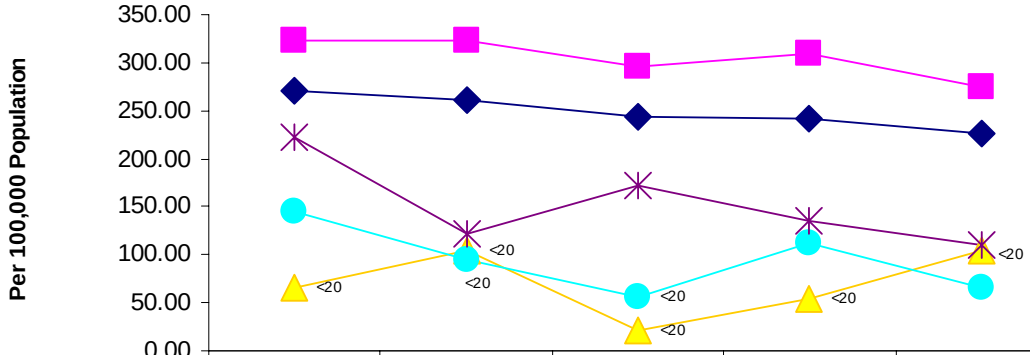
Age-Adjusted Death Rates for Essential Hypertension & Hypertensive Renal Disease, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	5.28	6.05	6.22	5.66	7.47
Black	18.38	16.88	15.90	16.37	18.70
AIEA	0.00	0.00	21.10	0.00	0.00
API	7.35	0.00	0.00	2.70	0.00
Hispanic	9.42	0.00	11.39	1.82	1.64

ICD 10: I10,I12

Age-Adjusted Death Rates For Heart Disease, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	270.27	260.12	244.27	242.46	225.79
Black	323.74	322.41	295.64	309.40	274.34
AIEA	66.68	104.78	21.53	54.78	105.05
API	145.38	95.16	56.17	112.42	65.82
Hispanic	222.05	121.56	172.68	135.77	110.99

ICD 10: I00-I09, I11, I13, I20-I51

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
<20: Populations whose deaths are fewer than 20; the data used is considered statistically unstable. Populations most affected are the AIEA, API, and Hispanic.
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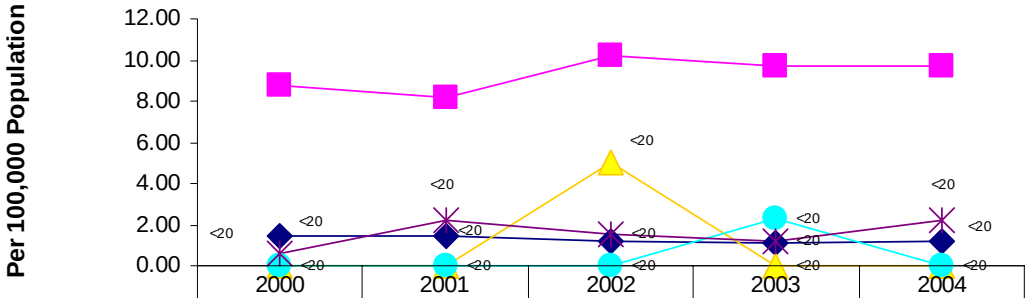
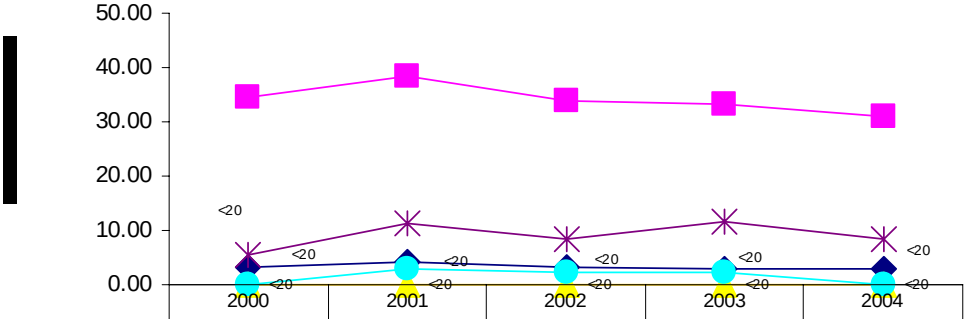
Age-Adjusted Death Rates for HIV/AIDS, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	1.43	1.47	1.21	1.14	1.19
Black	8.76	8.20	10.23	9.74	9.73
AIEA	0.00	0.00	5.00	0.00	0.00
API	0.00	0.00	0.00	2.30	0.00
Hispanic	0.58	2.19	1.49	1.19	2.23

ICD 10: B20-B24

Age-Adjusted Death Rates for Homicide, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	3.32	4.05	3.31	2.93	2.79
Black	34.48	38.31	33.79	33.23	30.89
AIEA	0.00	0.00	0.00	0.00	0.00
API	0.00	2.87	2.21	2.32	0.00
Hispanic	5.45	11.20	8.29	11.55	8.26

ICD 10: X85-Y09,Y87.1

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
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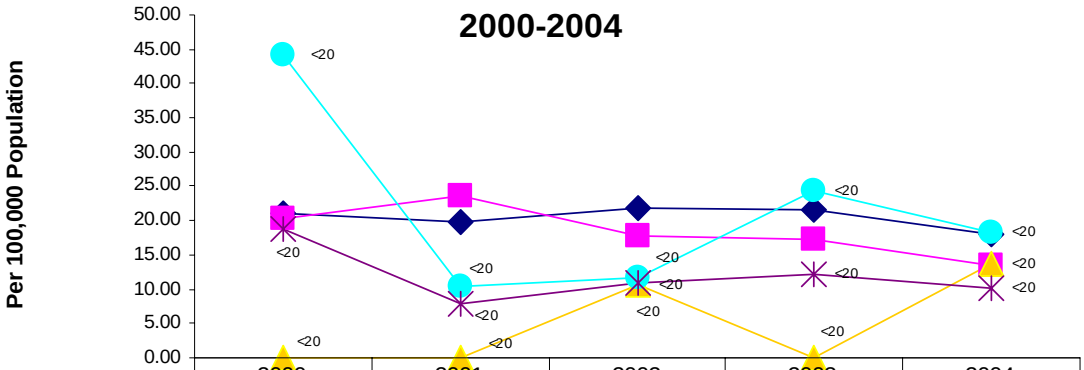
Extreme caution should be used in interpretation

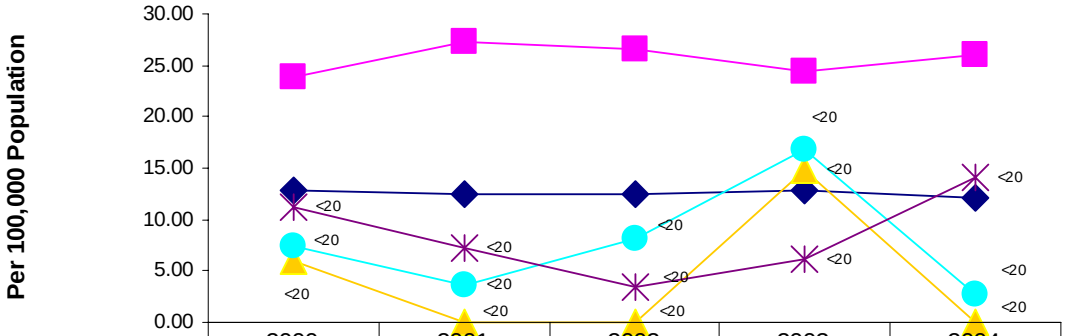
Age-Adjusted Death Rates for Pneumona and Influenza, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	21.18	19.84	21.90	21.66	17.96
Black	20.39	23.69	17.71	17.38	13.42
AIEA	0.00	0.00	10.55	0.00	13.63
API	44.13	10.34	11.74	24.26	18.32
Hispanic	18.83	7.86	10.87	12.28	10.09

ICD 10: J10-J18

Age-Adjusted Death Rates for Septicemia, Indiana 2000-2004

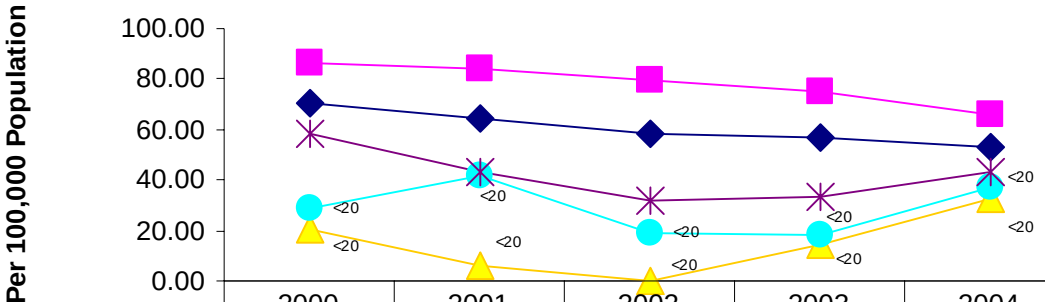


	2000	2001	2002	2003	2004
White	12.83	12.40	12.54	12.78	12.09
Black	23.77	27.20	26.59	24.45	26.11
AIEA	6.01	0.00	0.00	14.75	0.00
API	7.35	3.68	8.12	16.73	2.66
Hispanic	11.27	7.27	3.35	6.15	14.13

ICD 10: A40-A41

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
<20: Populations whose deaths are fewer than 20; the data used is considered statistically unstable. Populations most affected are the AIEA, API, and Hispanic.
Extreme caution should be used in interpretation

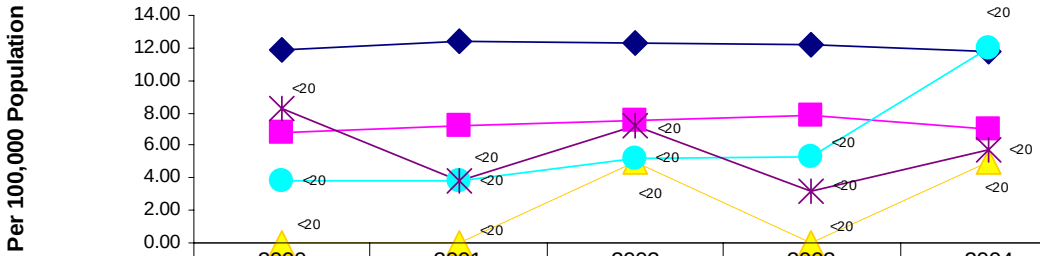
Age-Adjusted Death Rates for Stroke, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	70.39	64.10	58.36	56.44	53.07
Black	86.55	84.29	79.47	75.03	65.81
AIEA	20.76	6.01	0.00	14.75	32.23
API	28.77	41.34	18.93	18.04	36.96
Hispanic	58.47	43.56	31.93	33.39	43.09

ICD 10 I60-I69

Age-Adjusted Death Rates for Suicide, Indiana 2000-2004



	2000	2001	2002	2003	2004
White	11.89	12.37	12.26	12.23	11.73
Black	6.76	7.24	7.54	7.88	7.00
AIEA	0.00	0.00	5.00	0.00	4.97
API	3.79	3.78	5.19	5.29	12.02
Hispanic	8.22	3.82	7.23	3.13	5.68

ICD 10: X60-X84, Y87.0

Notes:
Numbers vary due to population of race or ethnic group being compared.
Rates are per 100,000 population.
Hispanic is an ethnicity and it includes all races.
<20: Populations whose deaths are fewer than 20; the data used is considered statistically unstable. Populations most affected are the AIEA, API, and Hispanic.
Extreme caution should be used in interpretation

Morbidity

According to Governor Mitch Daniels, improving the health of Hoosiers will place Indiana on the fast track for an energetic and successful future. INShape Indiana was created to help realize this goal. The main focus of INShape Indiana is to connect Hoosiers to existing programs, services, and events that are offered by many organizations and agencies in Indiana.

INShape Indiana includes three focus areas: 1) improve the amount and quality of physical activity in which Hoosiers engage, 2) increase the amounts of fruits and vegetables that Hoosiers consume , and 3) decrease Hoosiers' use of tobacco.

The following provides a brief overview of the current state of obesity, tobacco use, and consumption of fruits and vegetables in the State of Indiana. It is important to note that underlying determinants of health status include individual, environmental, social and cultural factors.

A recent Trust for America's Health report, *F as in Fat: How Obesity Policies Are Failing in America, 2006*, ranked Indiana 8th in the nation for the highest percentage of adults considered obese. Overall, when looking at health behaviors of Hoosiers, 25.5 percent were considered obese. Among those, 37.7 percent were Black, 24.2 percent were Hispanic, and 24.9 percent were White.

Indiana has a high prevalence of smoking. According to the Centers for Disease Control and Prevention (CDC), 27.3 percent of Indiana adults were smokers in 2005 (the national average was 20.6%). In 2005, among adult smokers in Indiana, 36.8 percent were Black, 22.9 percent were Hispanic, and 24.4 percent were White.

According to the 2005 Behavioral Risk Factor Surveillance System (BRFSS) data, adult Hoosiers responded to the question about consuming five or more servings of fruits and vegetables per day in the following manner:

- 19.5 percent of Blacks reported that they consumed five or more servings daily, and 80.5 percent reported that they consumed less than five servings daily.
- 19.8 percent of Hispanics reported that they consumed five or more servings daily, and 80.2 percent reported that they consumed less than five servings daily.
- 22.4 percent of Whites reported that they consumed five or more servings daily, and 78 percent reported that they consumed less than five servings daily.

Infectious Disease

Infectious Disease

The National Institute of Allergy and Infectious Diseases (NIAID) has been the forerunner in recognizing that minority populations bear a disproportionate burden of sickness and disease in the United States. Differences in racial and ethnic backgrounds can affect vulnerability to infectious and immunologic diseases, including acquired immunodeficiency syndrome (AIDS), asthma, sexually transmitted diseases (STD), and kidney disease.

In 2004, there were some significant differences in infectious disease incidence rates among racial and ethnic groups in Indiana. Minority populations often are not fully informed about infectious diseases, with the exception of AIDS and STDs. Moreover racial and ethnic minorities also do not fully benefit from research advances that have helped improve the health of other Americans.

The following table presents an overview of those infectious diseases that have the most impact on racial and ethnic minorities. A description of each infectious disease is located in Appendix A.

	Crypto	Hep A	Hep B	Hep C	Histoplasmosis	Meningitis	Meningococcal	Pneumo	Shigella	Tuberculosis	Chlamydia	Gonorrhea	Syphilis	HIV/AIDS
Race														
Asian/NH/PI	1.31	6.59	1.31	22.41	1.31	0	0	0	2.63	28.9	76.5	11.9	-	-
Black	0.36	0.18	2.19	161.05	0.36	2.01	1.09	11.67	14.77	8.0	1316.8	752.5	3.3	36.8
AI/AN	0	0	0	0	0	0	0	0	0	5.3	109.5	34.6	-	-
White	1.09	0.42	1.05	48.39	0.65	2.73	0.31	7.47	2.08	0.9	118.7	28.8	0.66	4.1
Other	1.25	0.63	0.63	25.69	0	3.13	0.63	0.63	2.51	-	-	-	-	-
Unknown	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ethnicity														
Hispanic	1.48	2.59	0.74	NR	0.37	1.85	0	3.34	2.97	8.7	324.5	60.9	2.59	15.3
Not Hispanic	0.63	0.33	0.8	NR	0.16	1.1	0.16	2.96	0.78	-	-	-	-	-
Unknown	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Data abstracted from the National Electronic Telecommunications System for Surveillance (NETSS)
Division of STD Prevention, CDC (ISDH HIV/STD Division)
Indiana's HIV/AIDS Surveillance Database
NH/PI = Native Hawaiian, Pacific Islander
AI/AN = American Indian/Alaskan Native
Hep = Hepatitis
Rates per 100,000 population

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) is a measurement of premature mortality. When looking at specific state mortality rates, YPLL can be most helpful for planning and evaluating local public health interventions. Examining race-specific YPLL rates can be used to target and monitor those populations at highest risk.

The determination of YPLL life expectancy takes into account race, sex, and or other characteristics using age-specific death rates for the population with that characteristic. The National Center for Health Statistics (NCHS) definition of YPLL is presented for persons less than 75 years of age, because the average life expectancy in the United States is just over 75 years (mean 76.7). YPLL for persons under 75 is calculated using the following eight age groups: less than 1 year, 1-14 years, 15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, and 65-74 years. The number of deaths for each age group is multiplied by the years of life lost, calculated as the difference between an age of 75 years and the midpoint of the age group. Summing years of life lost over all age groups derives YPLL (YPLL data provided by the National Vital Statistics System and the *Health, United States, 2003* CDC publication).

The following table shows the age-adjusted YPLL for specific diseases and by race and ethnicity to reflect a more accurate comparison of differences between each race and ethnicity.

YEARS OF POTENTIAL LIFE LOST TO AGE 75, FOR SELECTED CAUSES, INDIANA RESIDENTS, 2004

	Total	White	Black	AI/AN	A/PI	Hispanic
Alzheimer's Disease	685	657	22	6	0	17
COPD/CLRD	13,462	12,384	961	77	0	73
Cancer	99,181	89,029	9,611	47	412	933
Cirrhosis	8,023	7,102	880	26	16	179
Diabetes	10,617	8,941	1,644	11	21	84
HIV/AIDS	3,245	1,937	1,309	0	0	112
Heart Disease	80,288	68,993	10,984	27	136	1,132
Homicide	14,070	6,337	7,687.5	0	0	973
Hypertension	1,507	950	557	0	0	0
Nephritis	5,368	4,191	1,090	6	82	227
Perinatal Mortality	25,479	18,104	6,556	75	298	2,757
Pneumonia & Influenza	4,196	3,640	556	0	0	82
Septicemia	6,236	5,056	1,175	0	6	218
Stroke	12,431	10,024	2,345	26	38	564
Suicide	21,951	19,894	1,541	26	491	443
Unintended Injury	66,365	59,490	5,652	113	849	3,269
Other	85,361	71,531	12,900	103	618	3,599

COPD/CLRD = Chronic Obstructive Pulmonary Disease/Chronic Lower Respiratory Disease
YPLL is per 100,000 population
AI/AN = American Indian/ Alaskan Native
A/PI = Asian/ Pacific Islander

2004 Recommendations/ Current Situation

According to the *2004 Indiana Minority Health Report*, assessment of health disparities had been, and continues to be, hindered by data collection processes that are sometimes outdated or simply wrong. As a result, the interpretation of such data has been problematic.

The data limitations, barriers, and suggestions that appeared in the same report included the following:

Consistency in Reporting Data
Small Numbers, Primary Data Collection
Is Collection of Race and Ethnicity Legal?
Looking at More than Chronic Disease
Observational Data Collection
Importance of Collecting Primary Language Data
Workforce Diversity
Racial Bias in Health Care
Quality of Care

Current Situation

Workforce Diversity

The Indiana State Department of Health (ISDH) received a grant from the U.S. Department of Health and Human Services to fund a program entitled Partners Recruiting Opportunities for Minority Student Education or PROMiSE. The PROMiSE project was formed in order to eliminate health disparities, such as asthma, cancer, diabetes, heart disease, stroke, infant mortality, and mental health, from Indiana's underserved communities.

The reversal of these disparate trends in health care services comes from the focused efforts of INShape Indiana, the ISDH Office of Minority Health (OMH), the Indiana Minority Health Coalition (IMHC), the Indiana Area Health Education Centers (IN-AHEC), and the Indiana Department of Education (IDOE). The basic strategies/objectives for addressing these disparities are:

1. Provide opportunities for high school and college-age students to learn more about and successfully pursue health care careers. This plan is based on findings that the lack of practicing minority health professionals is a significant public health issue in working towards the elimination of health disparities.

2. Create enhanced cultural competency learning opportunities for health care professionals throughout Indiana. This strategy will help to improve the cultural competency of health care workers in Indiana to more effectively address the needs of minority populations.

Racial Disparities in Health Care

Governor Daniels' INShape Indiana health initiative was launched in July 2005 to motivate Hoosiers to engage in healthy lifestyles, including eating more fruits and vegetables, becoming more active, and quitting smoking. The INShape Indiana Web site, at www.INShape.IN.gov, was designed to empower individuals to adopt healthy behaviors and improve their quality of life.

Chronic disease continues to disproportionately affect minority populations in Indiana. To address this problem and eliminate health disparities and improve health within communities of color, the OMH at ISDH launched a new health initiative, "Bringing INShape to You," during Minority Health Month of April 2006. The purpose of Bringing INShape to You was to encourage discussion among racial and ethnic minority populations at the local community level of the principles of INShape Indiana, which encourage adopting the healthy behaviors of good nutrition, regular physical activity, and quitting smoking. To aid in this effort, the ISDH, in cooperation with Ivy Tech State College, hosted local discussion groups across the state.

According to state health officials, poor nutrition, sedentary lifestyle, and tobacco use are three major risk factors for heart disease, diabetes, stroke, and some cancers. More than 12 percent of African American adults and 6.4 percent of Hispanic/Latino adults in Indiana reported having diabetes in 2004.

In a 2004 health survey, 35.5 percent of adult Hispanic/Latinos and 33.4 percent of adult African Americans reported participating in no physical activity in the past month. In the same survey, 43 percent of African American adults and 42.6 percent of Hispanic/Latino adults reported smoking every day.

The local discussion groups, which were held throughout the month of April, offered participants information and access to services that would help them to maintain a healthy diet and an active lifestyle, while staying tobacco free.

Results from these area meetings are located in Appendix B.

Small Numbers, Primary Data Collection

The ISDH currently has an existing partnership with the Indiana Minority Health Coalition (IMHC) to help in improving primary collection efforts. Through IMHC's deliverables, the ISDH is able to get a better perspective on what is affecting racial and ethnic minority communities. The focus areas to date have been asthma, obesity, and diabetes surveillance systems.

Looking at More than Chronic Disease

This 2006 update provides brief information about some of the infectious diseases that disproportionately affect Indiana's minority populations. The Indiana State Department of Health will issue a use more detailed report in the spring of 2007 that will include a plan to address this growing health concern as well as awareness and preventive measures for use within racial and ethnic minority communities.

Indiana Interagency Council on Black and Minority Health Recommendations

Recommendations

Addressing Obesity

The issue of obesity is a growing epidemic among racial and ethnic minorities. As indicated in this report, Indiana has a high percentage of obese adults and this increases health risks among minority populations. Some solutions for obesity include:

1. Educate the public about the benefits of healthy diet and exercise.
2. Place more emphasis on obesity prevention at health fairs, e.g. Black Expo, International Festival, etc.
3. Provide incentives to remove junk food in vending machines from school cafeterias, hospitals, etc.

These obesity issues were important at the 2006 Legislative session of the Indiana State Medical Association in September.

Governor's Plan for A Healthier Indiana

The Indiana Interagency Council wants to commit to supporting the Governor's Plan for a Healthier Indiana. The plan will lead to:

1. Protection of children from the dangers of smoking and other diseases,
2. Peace of mind for thousands of Hoosiers who currently have no health insurance, and
3. Personal responsibility to take control of health care decisions.

Specifically, the Governor has proposed a plan that would:

- Initiate an aggressive smoking cessation and reduction campaign, aimed especially at reducing the number of children who smoke. The plan would provide $24 million more annually to the Indiana Tobacco and Prevention Cessation Trust Fund for local tobacco cessation and reduction programs. This amount, plus the current budget of $11 million, would bring funding to the level recommended by the Centers for Disease Control and Prevention.
- Assure that children are fully immunized by age 2 with $11 million to expand access to vaccinations.
- Establish a program that offers health insurance to 100,000 or more low-income Hoosiers.

The plan would be funded by an increase in Indiana's cigarette tax which is currently 55.5 cents per pack and the 36th lowest rate in the country and a variety of federal funds. The Governor suggested an increase of at least 25 cents but will ask the legislature to determine the precise amount. The number of uninsured hoosiers who could receive coverage would be dependent upon the size of the cigarette tax increase. With a 25-cent increase, it is estimated that up to 120,000 people could receive coverage. With a 50-cent increase, about 200,000 could receive coverage.

Convening a Summit with Faith-based Leaders Representing All Racial and Ethnic Minority Groups to Engage in Health Based Discussions

Training and a speaker's kit will be provided to faith-based leaders to aid in improving their congregations' outlook on health and health care. The Council would also like to identify health representatives of local minority health coalitions and agencies to engage these health concerns in Indiana's different communities with faith-based leaders on a local level.

Develop a Speakers Bureau

A Speakers Bureau will provide Indiana organizations with an unparalleled range of speakers who specialize in diversity, cultural, and minority health issues. With help from the Council, Indiana has immediate access to the most current and popular speakers, business visionaries, local media personalities, State celebrities, sports figures, and best-selling authors.

Summits for Students/Mentoring and Partnerships

According to a recent report, *Understanding and Facilitating the Youth Mentoring Movement*, "three million young people are in formal one-to-one mentoring relationships in the U.S., a six-fold increase from just a decade ago."

Mentoring has become an almost essential aspect of youth development and is expanding beyond the traditional one-to-one, volunteer, community-based mentoring. In order to ensure workforce diversity in health care among today's competitive environment, Indiana must create or seek programs that introduce health care careers to young people and encourage youth to continue to learn and grow.

Creating A State Minority Health Policy Report Card

A state minority health report card would be a vital tool for evaluating and promoting state policies to help eliminate health disparities. "Healing the Gap" is a major challenge facing Indiana. Since the causes of health disparities are multifaceted, the recommendations or interventions designed to eliminate health disparities will require diverse strategies and approaches.

The report card would be based on performance on four broad measures: equity in insurance coverage between whites and minorities, establishment of a diverse health professions workforce, collection of health data with detailed race/ethnicity categories, and creation of specific initiatives dedicated to reducing disparities. The data will show the widespread variations in Indiana's performance on all four measures of minority health.

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Appendices

Appendix A
Infectious Disease Definitions

Cryptosporidiosis	Cryptosporidiosis is a parasitic illness that causes diarrhea.
Hepatitis A	Hepatitis A is a contagious liver disease.
Hepatitis B	Hepatitis B is a serious infection of the liver.
Hepatitis C	Hepatitis C is an infection of the liver that can have serious, long-lasting health consequences.
Histoplasmosis	Histoplasmosis is an infection that varies in symptoms and seriousness. It usually affects the lungs. When it affects other parts of the body, it is called disseminated histoplasmosis.
Meningitis	Meningitis is an infection of the tissues (meninges) and sometimes the fluid (cerebral spinal fluid [CSF]) that surround the brain and spinal cord.
Meningococcal Disease	Meningococcal disease is caused by bacteria. Meningococcal disease can cause an infection of the covering of the brain and spinal cord (meningitis) or the blood.
Pneumococcal Disease, Invasive	Streptococcus pneumoniae is a bacterium commonly found in the nose and throat. Streptococcus pneumoniae is considered "invasive" when it is found in the blood, spinal fluid, or other normally sterile sites.
Shigella	Rod-shaped bacteria, certain species of which cause dysentery.
Tuberculosis	Tuberculosis, or TB, is an infectious disease that usually affects the lungs but can attack other parts of the body.
Chlamydia	Very common sexually transmitted disease or urinary tract infection caused by a bacteria-like organism in the urethra and reproductive system.
Gonorrhea	Gonorrhea is a common sexually transmitted disease caused by a bacterium, which can lead to infertility in women.
Syphilis	Syphilis is a sexually transmitted disease caused by the bacterium *Treponema pallidum*. It has often been called “the great imitator” because so many of the signs and symptoms are indistinguishable from those of other diseases.

Appendix B
Summaries of Local Discussion Group Sessions

EAST CHICAGOANS SHAPE UP INSHAPE DISCUSSION GROUPS

Students, faculty, and community leaders attended the Bringing INShape to You health and wellness discussion group on Tuesday, April 25, at Ivy Tech Community College, East Chicago, Indiana. Event participants received information on the principles of INShape Indiana and formulated ideas on how INShape Indiana could help improve the health of their community.

Bringing INShape to You is part of the Indiana State Department of Health's (ISDH) commitment towards addressing the health concerns of minorities by raising awareness of the principles of INShape Indiana at the local community level. INShape Indiana encourages adopting the healthy behaviors of good nutrition, regular physical activity, and quitting smoking.

Discussion group participants listened to a presentation on INShape Indiana by Carolin Requiz, Director of the ISDH Office of Minority Health. After the presentation, participants were asked to form groups and create a list of the barriers/challenges, needs, opportunities, and solutions for addressing the principles of INShape in their community.

Participants felt that some of the major barriers/challenges for addressing the principles of INShape were lack of funding for an on-site exercise facility, lack of child-care facilities, and lack of time. Their needs included more space, more motivation, and more partnerships. Opportunities already available to the community were listed as, "a public gym, the Boys and Girls Club, and Ivy Tech's Active for Life exercise program." Finally, the solutions that participants formulated to these issues included holding a fund-raiser for an on-site fitness center, putting healthier foods in the vending machines, and creating walking trails for the community.

Participants were eager to share their ideas for bringing the principles of INShape to their local community, because they said that the well-being of any community starts with the health of its people.

EVANSVILLE GROUPS GET INSHAPE INDIANA

Faith-based health groups and local businesses attended the Bringing INShape to You health and wellness discussion group on Thursday, April 27, 2006, at Ivy Tech Community College, Evansville, Indiana. Event participants received information on the principles of INShape Indiana and formulated ideas on how INShape Indiana could help improve the health of their community.

Bringing INShape to You is part of the Indiana State Department of Health's (ISDH) commitment towards addressing the health concerns of minorities by raising awareness of the principles of INShape Indiana at the local community level. INShape Indiana encourages adopting the healthy behaviors of good nutrition, regular physical activity, and quitting smoking.

Discussion group participants listened to a presentation on INShape Indiana by Carolin Requiz, Director of the ISDH Office of Minority Health. Requiz told attendees that INShape Indiana can help the Evansville community to improve the health of its citizenry by offering many pragmatic methods for incorporating INShape initiatives into their daily routines.

"One of the best ways for Evansville to promote INShape initiatives would be through local faith-based organizations and businesses. These local leaders could act as partners for the Indiana State Department of Health by promoting INShape initiatives locally," said Requiz.

She added that Evansville could reap many benefits by simply having local leaders and business owners encourage their fellow Hoosiers to eat more fruits and vegetables, exercise more, and quit smoking.

"Healthier people usually make better choices, work harder, and have more energy for their life at home and at work. And, if local leaders encouraged people to make simple lifestyle choices, such as eating just five fruits or vegetables a day, they could easily reduce the number of people suffering from diabetes, heart disease, and cancer in their community."

After the presentation, participants were asked to voice their opinions and offer suggestions on how the principles of INShape Indiana could be used to improve the health of their community.

Ronnie Cantu from Maseca Foods said that some of Maseca's employees have already lost weight by utilizing INShape Indiana's Web site. He also suggested an increased number of partnerships for bringing the principles of INShape Indiana to local groups concerned with minority health.

"One excellent way of getting all of the various groups in this city to communicate their thoughts and ideas with each other would be to create a listserv." Cantu believes that a

listserv, or an electronic discussion forum, would allow local groups concerned with community health care to stay in contact with each other and voice their concerns about local health issues.

The other major group in attendance was Impact Christian Health Center. Starr Martin, Executive Director of the Center, like Cantu, suggested that an excellent way of bringing the principles of INShape to the community would be to increase the amount of communication among local groups, businesses, and organizations. She added that one great way of helping to address the needs of underserved minority communities is with a health fair. She stated that her organization currently offers an annual health fair which administers 500 free inoculations each year.

The discussion group ended with the groups in attendance inviting Bringing INShape to You back for another discussion in August 2006.

"The Evansville community really needs more programs like Bringing INShape to You," said Cantu.

IVY TECH GARY, COMMUNITY GET INSHAPE

Students, faculty, and community leaders attended the Bringing INShape to You health and wellness discussion group on Tuesday, April 25, at Ivy Tech Community College, Gary, Indiana. Event participants received information on the principles of INShape Indiana and formulated ideas on how INShape Indiana could help improve the health of their community.

Bringing INShape to You is part of the Indiana State Department of Health's (ISDH) commitment towards addressing the health concerns of minorities by raising awareness of the principles of INShape Indiana at the local community level. INShape Indiana encourages adopting the healthy behaviors of good nutrition, regular physical activity, and quitting smoking.

Discussion group participants listened to a presentation on INShape Indiana by Carolin Requiz, Director of the ISDH Office of Minority Health. After the presentation, participants were asked to form groups and create a list of the barriers/challenges, needs, opportunities, and solutions for addressing the principles of INShape in their community.

Participants felt that some of the major barriers/challenges for addressing the principles of INShape were issues of lack of participation, lack of time, and lack of convenience. Their needs included more public support, better scheduling, and more partnerships. Opportunities already available to the community were listed as "exercising during one's lunch hour and Ivy Tech's Active for Life exercise program." Finally, the solutions that participants formulated to these issues included replacing Ivy Tech's soda machines with juice, reopening the facility's cafeteria and starting a community garden—so that members of the community could have easy access to fresh fruits and vegetables.

Discussion group participants said that they were glad to have attended the discussion, because it acted as a forum for their concerns about the health of their community.

STATE OFFICE OF MINORITY HEALTH SHAPES UP INDIANAPOLIS

Area health education groups and state health partners attended the Bringing INShape to You health and wellness discussion group on Friday, April 28, 2006, at Ivy Tech Community College, Indianapolis, Indiana. Event participants received information on the principles of INShape Indiana and formulated ideas on how INShape Indiana could help improve the health of their community.

Bringing INShape to You is part of the Indiana State Department of Health's (ISDH) commitment towards addressing the health concerns of minorities by raising awareness of the principles of INShape Indiana at the local community level. INShape Indiana encourages adopting the healthy behaviors of good nutrition, regular physical activity, and quitting smoking.

Discussion group participants listened to a presentation on INShape Indiana by Carolin Requiz, Director of the ISDH Office of Minority Health. Requiz told attendees that INShape Indiana can help improve the health of Indianapolis residents by offering many practical guidelines for incorporating INShape initiatives into their daily routines.

"You can, for instance, use the INShape Indiana initiatives as goals to work towards. For example, start by taking small steps towards eating healthier by weaning out higher fat foods from your diet and replacing them with more fruits and vegetables."

Requiz also discussed the need for more involvement from local community leaders and from faith-based partners in helping to encourage Hoosiers to participate in INShape initiatives.

"Indianapolis can benefit greatly from having local leaders and business owners encourage their fellow Hoosiers to eat more fruits and vegetables, exercise more, and quit smoking. After all, healthier people often make better decisions at home and at work." Requiz added that the INShape Indiana Web site can offer the Indianapolis community more than just basic health guidelines. She said that the Web site can also direct participants to resources available in their area.

"The INShape Web site offers Indianapolis residents a regional link to a number of local fitness clubs, organizations, and community partners," she said.

After the presentation, participants were asked to form groups and create a list of the barriers/challenges, needs, opportunities, and solutions for addressing the principles of INShape in their community.

The participants noted that Indianapolis offers its community a number of opportunities for physical fitness. One such opportunity is the Indy in Motion program. This program, according to the participants, offers public exercise programs for families, people with disabilities, and seniors.

The discussion group ended with the groups in attendance stating that they would like to see an increased level of communication among all groups involved in minority health care. They added that one of the best ways of keeping groups and communities informed of the benefits of healthy lifestyle is with programs like Bringing INShape to You.

Appendix C

Indiana Code 16-46-6

IC 16-46-6
Chapter 6. Interagency State Council on Black and Minority Health

IC 16-46-6-1
Council
Sec. 1. As used in this chapter, "council" refers to the interagency state council on black and minority health.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-2
Minority
Sec. 2. As used in this chapter, "minority" means an individual identified as any of the following:
(1) Black or African American.
(2) Hispanic or Latino.
(3) Asian.
(4) American Indian.
(5) Alaska Native.
(6) Native Hawaiian and other Pacific Islander.
As added by P.L.2-1993, SEC.29. Amended by P.L.194-1995, SEC.1; P.L.242-2003, SEC.1.

IC 16-46-6-3
Establishment
Sec. 3. The state department shall establish the interagency state council on black and minority health.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-4
Membership
Sec. 4. (a) The council consists of the following twenty-one (21) members:
(1) Two (2) members of the house of representatives from different political parties appointed by the speaker of the house of representatives.
(2) Two (2) members of the senate from different political parties appointed by the president pro tempore of the senate.
(3) The governor or the governor's designee.
(4) The state health commissioner or the commissioner's designee.
(5) The director of the division of family resources or the director's designee.
(6) The director of the office of Medicaid policy and planning or the director's designee.
(7) The director of the division of mental health and addiction or the director's designee.
(8) The commissioner of the department of correction or the commissioner's designee.
(9) One (1) representative of a local health department appointed by the governor.
(10) One (1) representative of a public health care facility appointed by the governor.
(11) One (1) psychologist appointed by the governor who:
(A) is licensed to practice psychology in Indiana; and
(B) has knowledge and experience in the special health needs of minorities.
(12) One (1) member appointed by the governor based on the recommendation of the Indiana State Medical Association.
(13) One (1) member appointed by the governor based on the recommendation of the National Medical Association.

(14) One (1) member appointed by the governor based on the recommendation of the Indiana Hospital and Health Association.
(15) One (1) member appointed by the governor based on the recommendation of the American Cancer Society.
(16) One (1) member appointed by the governor based on the recommendation of the American Heart Association.
(17) One (1) member appointed by the governor based on the recommendation of the American Diabetes Association.
(18) One (1) member appointed by the governor based on the recommendation of the Black Nurses Association.
(19) One (1) member appointed by the governor based on the recommendation of the Indiana Minority Health Coalition.
(b) At least fifty-one percent (51%) of the members of the council must be minorities.
As added by P.L.2-1993, SEC.29. Amended by P.L.4-1993, SEC.249; P.L.5-1993, SEC.262; P.L.194-1995, SEC.2; P.L.215-2001, SEC.89; P.L.242-2003, SEC.2; P.L.2-2005, SEC.59; P.L.145-2006, SEC.147.

IC 16-46-6-5
Appointments
Sec. 5. All appointments to the council are for two (2) years. A member may be reappointed to the commission for succeeding terms.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-6
Chairman
Sec. 6. The council shall select a chairman from the membership annually.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-7
Vacancy appointments
Sec. 7. Appointments to fill a vacancy are for the remainder of an unexpired term and are made by the authority who made the original appointment.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-8

Staff
Sec. 8. The state department and the Indiana Minority Health Coalition, Inc. shall provide staff for the council.
As added by P.L.2-1993, SEC.29. Amended by P.L.242-2003, SEC.3.

IC 16-46-6-9
Meetings
Sec. 9. The council shall hold at least four (4) meetings annually.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-10
Duties
Sec. 10. The council shall do the following:
(1) Identify and study the special health care needs and health problems of minorities.
(2) Examine the factors and conditions that affect the health of minorities.

(3) Examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities.
(4) Study the state and federal laws concerning the health needs of minorities.
(5) Examine the coordination of services to minorities and recommend improvements in the delivery of services.
(6) Examine funding sources for minority health care.
(7) Examine and recommend preventive measures concerning the leading causes of death or injury among minorities, including the following:
(A) Heart disease.
(B) Stroke.
(C) Cancer.
(D) Intentional injuries.
(E) Accidental death and injury.
(F) Cirrhosis.
(G) Diabetes.
(H) Infant mortality.
(I) HIV and acquired immune deficiency syndrome.
(J) Mental Health.
(K) Substance Abuse.
(8) Examine the impact of the following on minorities:
(A) Adolescent pregnancy.
(B) Sexually transmitted and other communicable diseases.
(C) Lead poisoning.
(D) Long term disability and aging.
(E) Sickle cell anemia.
(9) Monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.
(10) Develop and implement a comprehensive plan and time line to address health disparities and health issues of minority populations in Indiana.

As added by P.L.2-1993, SEC.29. Amended by P.L.194-1995, SEC.3; P.L.242-2003, SEC.4.

IC 16-46-6-11
Annual reports
Sec. 11. The council shall submit a report in an electronic format under IC 5-14-6 to the general assembly before November 1 of each year. The report must include the following:
(1) The findings and conclusions of the council.
(2) Recommendations of the council.
As added by P.L.2-1993, SEC.29. Amended by P.L.28-2004, SEC.142.

IC 16-46-6-12
Violations
Sec. 12. (a) Except as otherwise provided, a person who recklessly violates or fails to comply with this chapter commits a Class B misdemeanor.
(b) Each day a violation continues constitutes a separate offense.
As added by P.L.2-1993, SEC.29.

IC 16-46-6-13

Per diem compensation and traveling expenses

Sec. 13. (a) Each member of the council who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The council member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the council who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(c) Expenses incurred under this section must be paid out of the funds appropriated to the state department.

As added by P.L.152-1997, SEC.1.