Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State Department of Health

An Equal Opportunity Employer

December 17, 2008

Attached you will find the Interagency Council on Black and Minority Health's 2008 report. Research like this report will help Indiana Legislators, the State Department of Health, health providers, community organizations, and residents to develop effective strategies to identify Hoosiers and residents at-risk of health disparities and help us to create effective interventions.

The three focus areas are:

A. Long term Disability and Aging
   Seniors face barriers in their every day lives. These include the cost of living, health care, limited resources, poor health, prescription cost, lack of support systems and so many other obstacles that it makes it hard to endure. If you add lack of cross-cultural sensitivity on the part of health issues you see even a greater problem on racial and ethnic minorities.

B. Adolescent Births/ Teenage Pregnancy
   Teen pregnancy is a vital issue for Indiana. There are health risks for the baby and children born to teenage mothers. These births often result in health, social, and emotional problems. Women who become pregnant during their teens have an increased risk for complications, such as premature labor and socioeconomic consequences as well. Black women have the highest teen pregnancy rate (134 per 1,000 women aged 15-19), followed by Hispanics (131 per 1,000) and non-Hispanic whites (48 per 1,000). (Guttmacher Institute)

C. HIV/AIDS
   HIV/AIDS has devastated racial and ethnic minorities in the United States and in Indiana. According to the Centers for Disease Control and Prevention, racial and ethnic minorities accounted for almost 66 percent of the newly diagnosed cases of HIV and AIDS in 2006. In the Black community, HIV/AIDS has become an epidemic. Blacks accounted for 47% of all HIV/AIDS cases diagnosed in 2006. Black men are more than nine times more likely to die of AIDS than non-Hispanic White men.

The intent of these recommendations and focus areas is to reduce health status disparities among minority communities and individuals. I hope this report empowers you and inspires you to make effective changes needed in order to ensure equality and accessibility for all Hoosiers in their health and health care needs.

For a Healthier Tomorrow,

JUDITH A. MONROE, M.D.
STATE HEALTH COMMISSIONER

Attachment

The Interagency Council on Black and Minority Health

2008 Annual Report

Indiana State Department of Health
Office of Minority Health
November 2008

The Interagency Council on Black and Minority Health 2008 Annual Report

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Executive Summary

The United States is a diverse nation. According to 2000 Census data, the U.S. population grew by 13 percent over the last decade, and it has increased in diversity at an even greater rate [1]. Racial and ethnic minorities are among the fastest growing of all communities in the country today and comprise approximately 34 percent of the total population. It is projected that by 2030, 40 percent of the population will be non-White [1, 2],

In 2000, United States Public Law 106-525, also known as the "Minority Health and Health Disparities Research and Education Act," which authorized the National Center for Minority Health and Health Disparities, provided a legal definition of health disparities:

> "A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population."
> Minority Health and Health Disparities Research and Education Act
> ***United States Public Law 106-525*** (2000), p. 2498

Despite advances in health care and medical technology over the past decade, these inequities in health status continue to exist. Inadequate access to care due to lack of resources, money, education, and transportation all contribute to the growing health disparities in the minority populations. In addition, health disparities exist because of substandard care due to discrimination, prejudice, stereotyping, and overall cultural incompetence [3].

The quality of the health care provided and received by Indiana residents is vital to bridging the ever increasing health disparity gaps and preventing increases in minority deaths due to lack of access to health care. As Indiana becomes more racially and ethnically diverse, the need for bridging the health disparities gaps in Indiana will continue to increase. In order to meet the health needs of its changing population, Indiana must address the issue of health disparities. Indiana must come together in a collaborative effort and be willing to review and amend current health policies at all levels of Indiana government as well as set new health policies as needed.

In an effort to address health disparities in Indiana, the Indiana General Assembly ratified legislation creating the Indiana Council on Black and Minority Health. *Indiana Code 16-46-6* directed the Indiana State Department of Health to establish the Interagency Council on Black and Minority Health with representation from the Indiana House of Representatives, Indiana Senate, Governor's Office, State Commissioner's Office, and various other state agencies. Indiana has been a national model in developing approaches to eliminate health disparities among its minority populations. In 1988, the Indiana General Assembly ratified legislation creating the Indiana Council on Black and Minority Health. *Indiana Code 16-46-6* directed the Indiana State Department of Health to

establish the Interagency Council on Black and Minority Health with representation from the Indiana House of Representatives, Indiana Senate, Governor's Office, State Commissioner's Office, and other state agencies.

Interagency State Council on Black and Minority Health Members and Advisors:

Members:

Jean Breaux
Indiana State Senate (D) (**Chair Elect**)

Edward L. Williams, M.D.
Indiana Hospital and Health Association (**Co-Chair**)

Charlie Brown
Indiana House of Representatives (D)

Jim Buck –
Indiana House of Representatives (R)

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Indiana University

Javier F. Sevilla Martir, M.D.
Indiana University
Department of Family Medicine

Sally Tuttle
Native American Indian

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

(1) Identify and study the special health care needs and health problems of minorities.
(2) Examine the factors and conditions affecting 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.

The Interagency Council on Black and Minority Health is required legislatively to review and assess the health status of racial and ethnic minorities in Indiana and submit a report by November 1 of each year. The report must include findings, conclusions, and recommendations of the Council.

The Interagency State Council on Black and Minority Health understands eliminating racial and ethnic health disparities is a process which requires identification, planning, and collaborative efforts of public and private partners. The Council, therefore, will select a few areas outlined in Indiana Code 16-46-6 to report on each year. *The Interagency Council on Black and Minority Health 2008 Annual Report* will examine the impact of long-term disability and aging, adolescent pregnancy, and human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) among Indiana's racial and ethnic populations.

The following are highlights of *The Interagency Council on Black and Minority Health 2008 Annual Report:*

- Heart disease is the leading cause of death for all racial groups in Indiana and the second leading cause of death for Hispanics/Latinos following accidents. Blacks have the highest age-adjusted death rates for heart disease, cancer, and stroke.
  Source: Indiana State Department of Health , *2006 Mortality Report*, published July 2008. Retrieved from http:www.in.gov/isdh/reports/mortality/2006.

- In addition to chronic disease, the elderly are likely to have a disability.
  In Indiana, Hispanic/Latino and Black residents age 65 and older reported having more activity limitations due to physical, mental, or emotional problems compared to White residents age 65 and older.

Source: Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007. Retrieved from http://apps.nccd.cdc.gov/BRFSS/.

- Black residents age 65 and older were less likely than Whites and Hispanic/Latinos to describe their health status as "excellent," "very good," or "good."
  Source: Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007. Retrieved from http://apps.nccd.cdc.gov/BRFSS/.

- Indiana Hispanic/Latino and Black teen birth rates, in 2006, were twice that of White teens.
  Source: Indiana State Department of Health , *2006 Natality Report*, published July 2008. Retrieved from http://www.in.gov/isdh/reports/natality/2006/index.htm.

- Hispanic/Latino and Black teens are less likely than White teens to receive prenatal care during the first trimester of their pregnancy.
  Source: Indiana State Department of Health , *2006 Natality Report*, published July 2008. Retrieved from http://www.in.gov/isdh/reports/natality/2006/index.htm.

- Blacks make up less than nine percent of Indiana's population but account for 35 percent of the state's HIV/AIDS cases.
  Source: Indiana State Department of Health, HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007. Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf.

- Blacks have the highest number of years of potential life lost due to homicide than any other racial and ethnic group in Indiana.
  Source: Centers for Disease Control and Prevention, Nation Center for Injury and Prevention Control. Retrieved from http://webapp.cdc.gov/sasweb/ncipc/ypll10.html.

Introduction

Life expectancy and the overall health of Americans have improved over the years, due to advances in health care and medical technology [4]. Despite this progress, racial and ethnic minorities continue to suffer disproportionately from disease, disability, and premature death than non-minorities. The two main factors are inadequate access to health care and substandard health care [3]. These inequities have resulted in minorities bearing a much larger burden of morbidity and mortality in the U.S., which are highlighted by the data below.

- Blacks have the highest infant mortality rate in the nation.
  Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/databrief/db09.htm#arethere.

- Overall, minority and low-income populations have a disproportionate burden of death and disability from cardiovascular disease.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/cardio.htm.

- Blacks have the highest rate of high blood pressure of all groups and tend to develop it younger than other racial and ethnic groups.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/cardio.htm.

- Compared to Whites, Blacks and Hispanics/Latinos are twice as likely to have diabetes.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/diabetes.htm.

- American Indians ages 10-19 years have the highest prevalence of type 2 diabetes in their age group.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/diabetes.htm.

- Elderly minorities with diabetes are less likely to have their blood glucose levels under control compared to their White counterparts.
  Source: Kaiser Family Foundation.
  Retrieved from http://www.kff.org/minorityhealth/upload/6069-02.pdf.

- Blacks, overall, have more malignant tumors and are less likely to survive cancer than the general population.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/cancer.htm.

- White women have a higher rate of breast cancer morbidity, yet Black women have a higher mortality rate.
  Source: Centers for Disease Control and Prevention, Office of Minority Health. Retrieved from http://www.cdc.gov/omhs/AMH/factsheets/cancer.htm.

- Black men have higher rates of lung cancer than Whites in all age groups
  Source: Indiana Cancer Facts & Figures 2006.

- Black men have higher rates of developing and dying from prostate cancer than men of other racial or ethnic groups in the United States.
  Source: Center for Disease Control and Prevention, Prostate Cancer.
  Retrieved from
  http://www.cdc.gov/cancer/prostate/publications/aadecisionguide/index.htm#aa.

- In 2007, tuberculosis rates among Hispanics, Blacks, and Asians were 7.4, 8.3, and 22.9 times higher than among non-Hispanic whites, respectively.
  Source: Center for Disease Control and Prevention, National Center of HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; Division of Tuberculosis Elimination.
  Retrieved from http://www.cdc.gov/tb/default.htm.

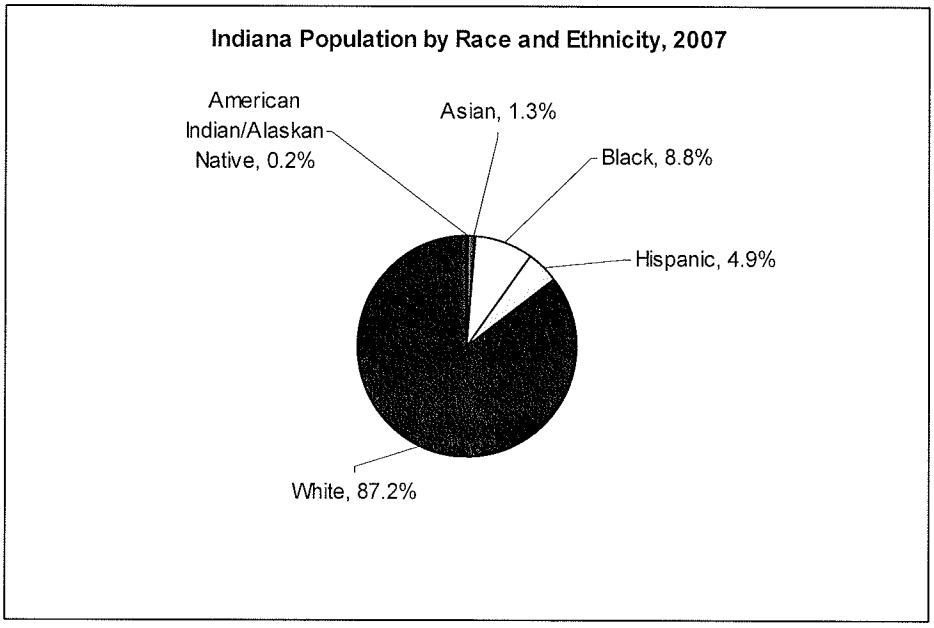
- Black Medicare recipients are more likely to have no supplemental coverage (18 percent) compared to Whites (11 percent).
  Source: Kaiser Family Foundation.
  Retrieved from http://www.kff.org/minorityhealth/upload/6069-02.pdf.

Demographics

Currently, racial and ethnic minorities encompass approximately one-third of the U.S. population. The U.S. Census Bureau predicted minorities will make up 54 percent of the U.S. population by 2050, with the Hispanic/Latino population expected to triple [5].

According to the U.S. Census Bureau, Indiana's total population increased from 5,544,159 in 1990 to 6,080,485 in 2000, and the 2007 population estimate was 6,345,289. Racial and ethnic minorities made up 15 percent of Indiana's total population [6]. Figure 1 shows the percentages of each racial and ethnicity group in Indiana.

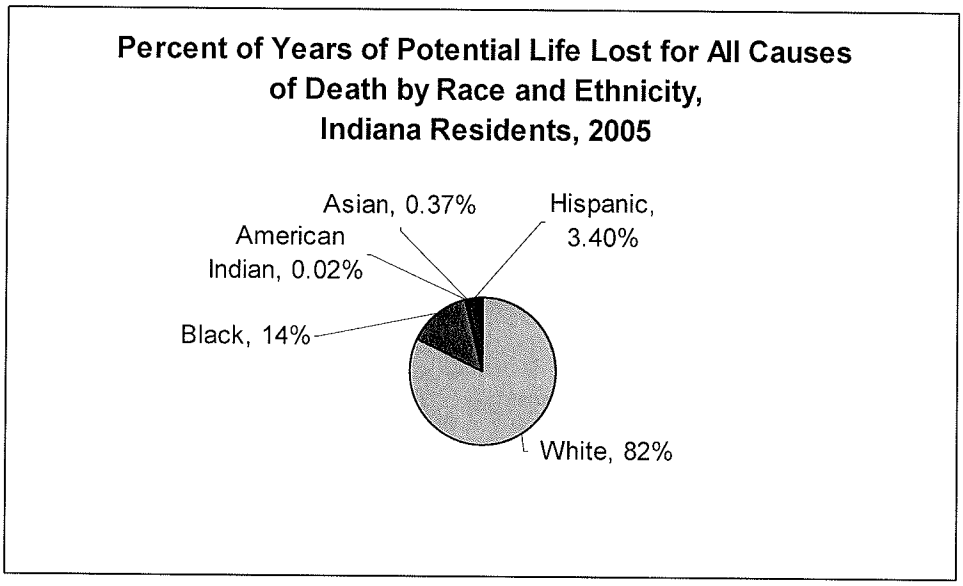
Figure 1. Indiana Population by Race and Ethnicity, 2007



Hispanic may be of any race.
Source: U.S. Census Bureau, 2007 American Community Survey 1-Year Estimates
Retrieved from http://factfinder.census.gov/

Figure 2 illustrates the percent of years of potential life lost (YPLL) for all causes of death by race and ethnicity in Indiana residents for 2005. Blacks made up nearly nine percent of Indiana's population yet had 14 percent of YPLL for all causes of death in 2005.

Figure 2. Percent of Years of Potential Life Lost for All Causes by Race and Ethnicity, Indiana Residents, 2005



Populations are Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian, Non-Hispanic Asian
Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: Centers for Disease Control and Prevention, National Center For Injury Prevention & Control, WISQARS Years of Potential Life Lost (YPLL) Reports, 1999-2005. Retrieved from: http://webapp.cdc.gov/sasweb/ncipc/ypll10.html.

The majority of Indiana's Black population resided in the central, northeast, and northwest regions of the state with the highest percent living in Lake and Marion counties. Miami and Wabash counties had the highest percent of American Indians/Alaskan Natives while Monroe and Tippecanoe counties had the highest percentage of Asians/Native Hawaiians/Other Pacific Islanders. The largest percent of Hispanics/Latinos lived in Lake and Elkhart Counties during 2007. Tables 1 through 4 highlight the counties with the highest proportion of minorities in Indiana.

Table 1. Counties with the Highest Percent of Black Population, Indiana, 2007

County	Total Population	Percent of Black Population
Allen	349,488	11.8%
Clark	105,035	7.3%
Delaware	115,419	6.8%
Elkhart	197,942	5.5%
Grant	68,847	6.8%
Howard	83,776	6.7%
LaPorte	109,787	10.3%
Lake	492,104	26.1%
Marion	876,804	25.8%
St. Joseph	266,088	12.1%
Vanderburgh	174,425	8.6%
Vigo	104,915	6.4%

Black alone
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: Birth data and birth rates calculated by ISDH, ERC, Data Analysis Team, Population data from U.S. Census Bureau

Table 2. Counties with the Highest Percent of American Indian/Alaskan Native Population, Indiana, 2007

County	Total Population	Percent of American Indian/Alaskan Native Population
Grant	68,847	0.5%
Miami	36,641	1.1%
Owen	22,398	0.5%
Wabash	32,918	0.8%

American Indian/Alaskan Native alone
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: Birth data and birth rates calculated by ISDH, ERC, Data Analysis Team, Population data from U.S. Census Bureau

Table 3. Counties with the Highest Percent of Asian/Native Hawaiian/Other Pacific Islander Population, Indiana, 2007

County	Total Population	Percent of Asian/Native Hawaiian/Other Pacific Islander Population
Allen	349,488	2.0%
Bartholomew	74,750	3.0%
Decatur	24,959	1.7%
Hamilton	261,661	3.6%
Hendricks	134,558	1.6%
Johnson	135,951	1.6%
Marion	876,804	1.7%
Monroe	128,643	4.8%
St. Joseph	266,088	1.8%
Tippecanoe	163,364	5.5%
Vigo	104,915	1.6%

Asian/Native Hawaiian/Other Pacific Islander alone
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: Birth data and birth rates calculated by ISDH, ERC, Data Analysis Team, Population data from U.S. Census Bureau

Table 4. Counties with the Highest Percent of Hispanic Population, Indiana, 2007

County	Total Population	Percent of Hispanic Population
Cass	39,193	10.7%
Clinton	33,795	12.9%
Elkhart	197,942	13.8%
Kosciusko	78,115	6.8%
Lake	492,104	14.3%
Marion	867,804	7.0%
Marshall	46,698	8.7%
Noble	47,526	10.3%
Porter	160,578	6.5%
St. Joseph	266,088	6.1%
Tippecanoe	163,364	7.1%
White	23,819	7.6%

Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: Birth data and birth rates calculated by ISDH, ERC, Data Analysis Team, Population data from U.S. Census Bureau

Years of Potential Life Lost

Years of Potential Life Lost (YPLL) is a measurement of premature mortality. Blacks made up nearly nine percent of the Indiana population yet their percentage of years of life lost for all causes, except suicide, exceeded nine percent. Hispanics/Latinos were approximately five percent of Indiana's total population, and their percentage of YPLL due to conditions originating in the perinatal period and congenital anomalies was 11 percent and eight percent, respectively. Table 5 shows the number and percent of YPLL lost due to the leading causes of death by race and ethnicity for 2005.

Table 5. Number and Percent of Years of Potential Life Lost Before Age 75, for 10

Causes of Death	Number YPLL White	Percent YPLL White	Number YPLL Black	Percent YPLL Black	Number YPLL American Indian	Percent YPLL American Indian	Number YPLL Asian	Percent YPLL Asian	Number YPLL Hispanic	Percent YPLL Hispanic
All Causes	376,384	82%	66,678	14%	465	.02%	1,722	.37%	15,500	3.4%
Heart Disease	64,533	85%	9,727	13%	72	.10%	334	.44%	813	1.1%
Cancer	87,859	89%	9,608	9.7%	24	.02%	264	.27%	1,285	1.3%
Homicide	5,834	37%	8,304	52%	54	.34%	112	.70%	1,595	.10%
Perinatal Period	15,811	61%	7,125	27%	75	.29%	150	.58%	2,775	11%
Unintentional Injury (Accidents)	57,994	85%	6,244	9%	91	.13%	254	.37%	3,187	5%
Stroke	9,227	75%	2,732	22%	U	U	71	.58%	242	2%
Congenital Anomalies	11,789	78%	1,835	12%	U	U	75	.50%	1,268	8%
Diabetes	8,072	80%	1,673	17%	U	U	70	.69%	302	3%
Chronic Low Respiratory Disease	12,981	88%	1,527	10%	18	.12%	47	.32%	118	.80%
HIV/AIDS	1,750	53%	1,268	38%	24	.73%	41	1.2%	212	6%
Suicide	21,072	92%	1,234	5%	U	U	64	.28%	454	2%
Alzheimer's Disease	478	90%	51	10%	U	U	U	U	U	U
Nephritis	3,218	69%	1,176	25%	U	U	17	.37%	241	5%
Influenza and pneumonia	3,643	77%	781	17%	U	U	13	.37%	167	5%
Septicemia	4,492	80%	840	15%	U	U	32	.57%	240	4%

Leading Causes of Death by Race and Ethnicity, Indiana 2005

U – Unavailable data
Non-Hispanic White, Non-Hispanic Black, Non-Hispanic American Indian, Non-Hispanic Asian
Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health,
October 2008. Original data from Source: CDC, National Center for Injury Prevention and Control (NCIPC), Web-based Injury Statistics Query and Reporting System (WISQRS), 2005

Socioeconomic Status and Health

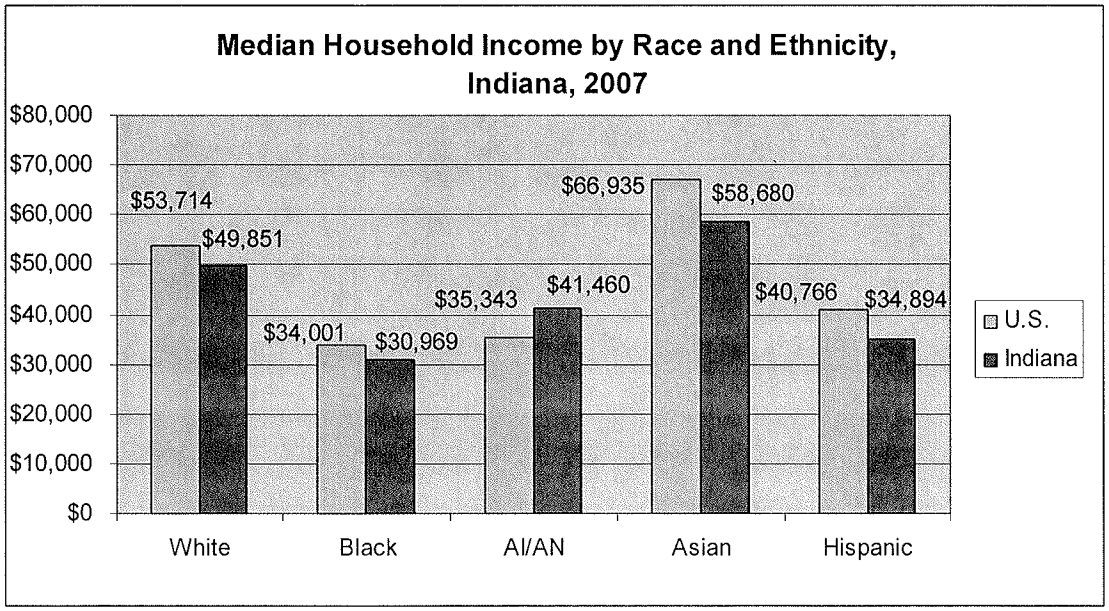
Socioeconomic factors such as, income, unemployment, housing, and educational attainment are determinants of health. These variables can compromise health status by limiting access to health care and information that promote positive health behaviors [7]. While issues of low socioeconomic status and poverty affect individuals of all racial and ethnic backgrounds, their impact disproportionately affects the morbidity and mortality of minorities [7]. This section of the report examines the socioeconomic indicators for racial and ethnic minorities in the United States and Indiana.

Income

In 2007, the U.S. median household income was $50,740. Hispanic/Latino and Black households had the lowest median incomes of $40,766 and $34,001, respectively. In comparison, the median income for non-Hispanic White households was $53,714. Asian households had the highest median income, $66,935 [8].

Indiana's median household income in 2007 was $47,448 [8]. Figure 3 shows Indiana's median household income by race and ethnicity. These figures were similar to the national trend.

Figure 3. Median Household Income, by Race and Ethnicity, U.S. and Indiana 2007



AI/AN – American Indian/Alaskan Native, alone
Hispanic can be of any race
*Median household in the past 12 months (in 2007 inflation-adjusted dollars)
Source: Census Bureau, 2007 American Community Survey 1-Year Estimates, Detailed Tables
Retrieved from http://factfinder.census.gov/

Low-income families or the working poor may not participate in employer-sponsored health insurance plans because they often use all of their income to pay for other needs such as, housing, food, and childcare. In 2006, 51 percent of Indiana's low- income

working families spent one-third of their income on housing. Of the 28% of Indiana's low-income working families, 44% were minorities. In comparison, there were 24% non-minority low income working families. A third of low-income working families in Indiana included a parent without health insurance [9]. The Kaiser Family Foundation reports the disparity of uninsured children among Hispanic/Latino and Blacks to be at a disproportionate rate compared to non-white uninsured children. Hispanic/Latino children had the highest rate of uninsured children at 25%while the number of Black uninsured children was 16% compared to that of uninsured Non-Hispanic White children of nearly 15% during 2007 [10]

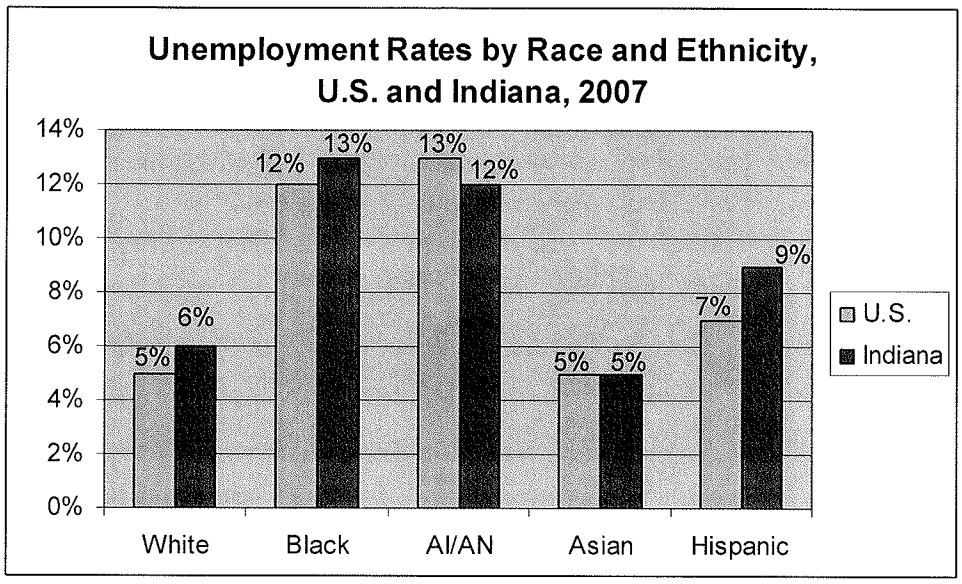
Due to the high cost of health insurance, employers cut the amount of coverage, passed the increase on to their employees, and/or stopped providing it altogether. Small businesses with two to 50 employees are not required to provide employee health insurance [11]. *Premiums versus Paychecks: A Growing Burden for Indiana's Workers* reports health insurance premiums for Indiana's families rose 7.3 times faster than median earnings from 2000 to 2007 [12].

Unemployment

Employers are the principal source of health insurance for the majority of U.S. workers, including racial and ethnic minorities. Consequently, job loss for most workers means loss of income ***and*** loss of health care. The unemployed may delay or not seek medical treatment, due to lack of insurance and money [11].

According to the U.S. Census Bureau, the unemployment rate for the U.S. population 16 years and older was 6.3% during 2007. In comparison, the unemployment rate for the Indiana population 16 years and older was 6.6% for the same period [13]. Minorities were impacted the most by unemployment, as shown in Figure 4. In 2007, Blacks and American Indians had the highest unemployment rates among all racial and ethnic minorities at the state and national levels [13]. Both the U.S. and state unemployment rates for Blacks and American Indians were twice that of Whites. The unemployment rates for Hispanics/Latinos and Asians were among the lowest for all minorities at both the national and state levels [13].

Figure 4. Unemployment Rates by Race and Ethnicity, U.S. and Indiana, 2007



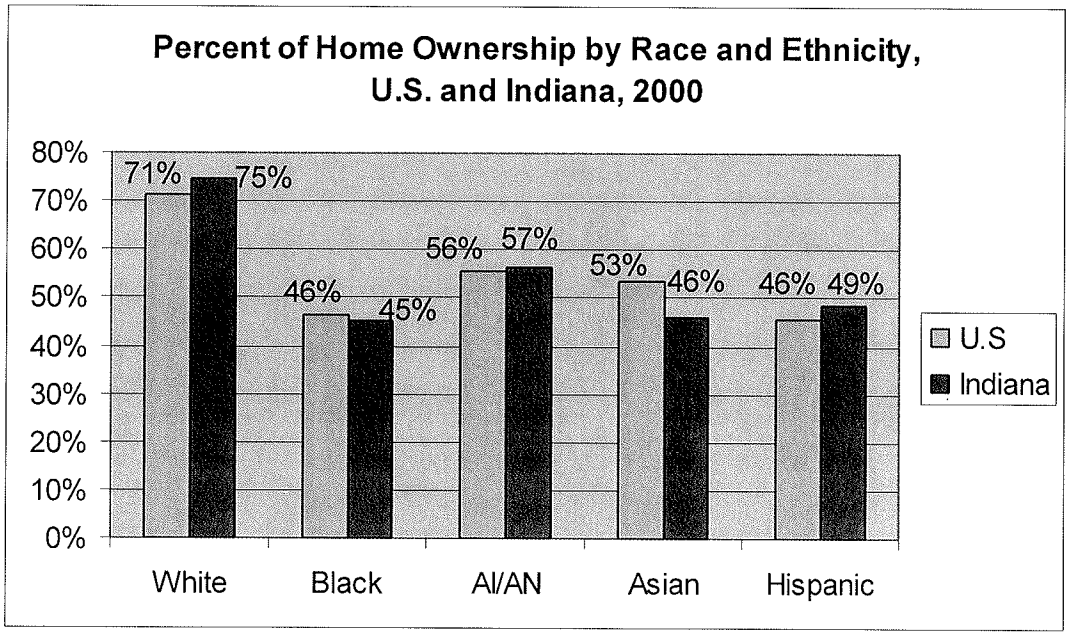
AI/AN – American Indian/Alaskan Native, alone
Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Census Bureau, 2007 American Community Survey 1-Year Estimates, Detailed Tables
Retrieved from http://factfinder.census.gov/

Home Ownership

In the United States, home ownership is an indicator of wealth, financial security, and a key source of asset building. Assets can be used to invest in the future by providing money for education, unexpected financial storms, and financial safety nets. While the gap in home ownership between Whites and minorities continues to narrow, home ownership rate among Whites remains greater than that of all racial and ethnic minorities.

Based on the 2000 census, the overall percentage of home ownership in the U.S. was 66.2%. At 71.4%, Indiana had a higher percentage of home ownership than the rest of the nation during 2000. Whites had the highest percent of home ownership at both the state and national levels, followed by American Indians and Asians. In contrast, Blacks and Hispanics/Latinos had the lowest percent of home ownership among all racial and ethnic groups [14]. Figure 5 shows the disparities in the distribution of assets and wealth in the U.S. and Indiana.

Figure 5. Percent of Home Ownership by Race and Ethnicity, U.S. and Indiana, 2000



U. S. Census Bureau, 2000
AI/AN – American Indian/Alaskan Native
Hispanic can be of any race
Source: U.S. Census Bureau, 2000
Retrieved from http://www.census.gov/hhes/www/housing/census/historic/ownershipbyrace.html

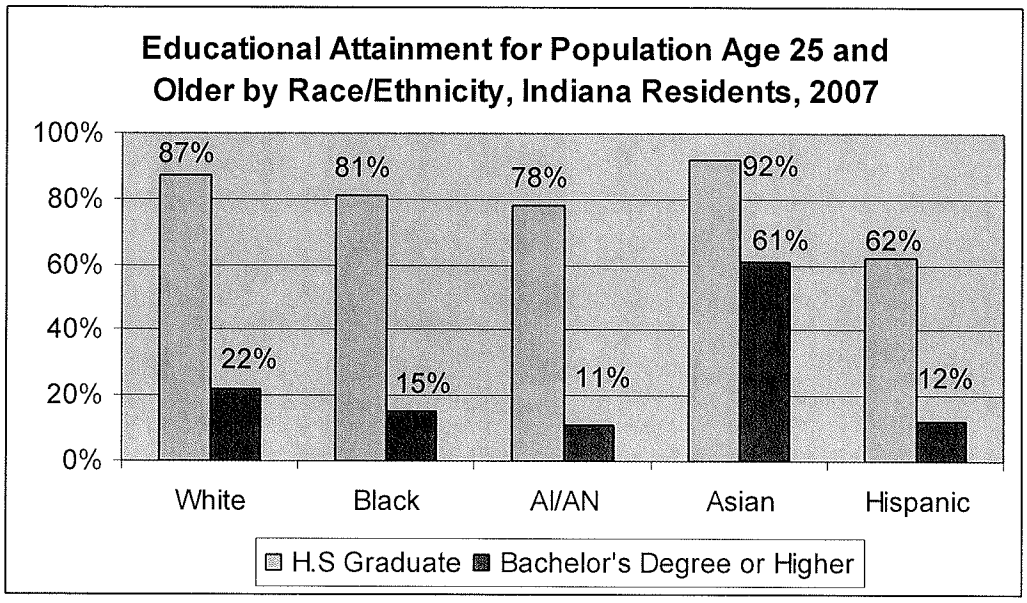
Educational Attainment

Quality of life is linked to health status. Similarly, educational attainment is an indicator of an adult's quality of life. Education contributes to future earnings and employment opportunities. Generally, as educational levels of Americans increase their earnings and income increase [7].

In 2007, 84.5% of the U.S. population 25 years and over were high school graduates (includes equivalency) and 27.5% had a bachelor's degree or higher. During the same period, 85.8% of Indiana residents 25 years and over were high school graduates (includes equivalency) and 22.1% had a bachelor's degree or higher [15]. U.S. Census data shows that as educational attainment increased median earnings increased. Conversely, data shows that as education levels increased, poverty levels decreased [15].

Figure 6 shows the educational attainment of Indiana residents 25 years and older for 2007. Asians had the highest proportion of educational attainment followed by Whites and Blacks [15].

Figure 6. Educational Attainment for Population Age 25 and Older by Race/Ethnicity, Indiana Residents, 2007



AI/AN – American Indian/Alaskan Native
Hispanic can be of any race.
Source: U.S. Census Bureau, 2007 American Community Survey 1-Year Estimates
Retrieved from http://factfinder.census.gov/

Update on 2007 Recommendations

During 2007, the Interagency Council on Black and Minority Health focused its attention on heart disease, obesity, and tobacco use. The following are updates on a few of the recommendations made by the council.

Heart Disease

Recommendation: Work with local coalitions to market heart disease programs and services offered by local coalitions and their partners.

The Fort Wayne community has been chosen as one of five Heart2Heart pilot sites in the nation. The Heart2Heart project is a new pilot program of the American Heart Association. The program was designed to engage existing volunteers and recruit new individuals to serve as "heart guides" by providing individualized support for cardiovascular disease patients, caregivers, and people at high risk for heart disease and stroke. The American Heart Association trains and matches volunteer resource guides with participants who are facing similar situations and need guidance. The goal of this one-to-one connection is to have participants find the resources they need to help them make lifestyle changes. Source: American Heart Association website http://www.americanheart.org/

Obesity

Recommendation: Identify a pool of nutritional experts and social marketers.

During 2007, the Centers for Disease Control and Prevention began offering training through monthly conferences. The program is designed for public health professionals who are involved in planning and management of nutrition and physical activity programs. Topics cover legislative issues, research findings, funding opportunities, program planning, and the best practice models. Registered dietitians who participate in this program receive one hour of continuing education (CPE). Certification of Completion and CPE applications are available after each conference. This program is administered through the Community Nutrition/Obesity Prevention Division (CNOP) at the Indiana State Department of Health.
Source: ISDH
Retrieved from http://www.in.gov/isdh/

Recommendation: Work with local coalitions to market obesity prevention programs and services offered by local coalitions and their partners.

Indiana State Department of Health, Community Nutrition/Obesity Prevention Division developed a regional outreach program. WIC clinics, MCH clinics, and local health departments are the baseline for initial outreach contacts. This program is designed as a grass-root movement tool to provide educational information and technical assistance to local communities in order to assist development of local coalition and community-based

plans in terms of healthy living, healthy life choices, and overweight and obesity prevention.
Source: ISDH Retrieved from http://www.in.gov/isdh/

Tobacco Use

Recommendation: Work with local coalitions to market tobacco cessation programs and services offered by local coalitions and their partners.

During this reporting period, Indiana Tobacco Prevention and Control Agency (ITPC) launched its "Quit to Win" contest. Smokers signed up to quit for 30 days for the chance to win prizes. Smokers had the opportunity to sign up at the INShape Indiana website, IBE Summer Celebration, and Indiana State Fair, as well as, other venues.
Source: ITPC
Website: http://www.in.gov/itpc/

ITPC has minority coalitions and partners which focus on tobacco control in communities of color. Each coalition develops activities targeting minorities in their communities. One of ITPC's minority partners is the Minority Health Coalition of Madison County. They participated in the "Healthy Beginnings Nutrition Graduation" to education the community about the harmful effects of tobacco use, encourage prevention, and cessation. The Minority Health Coalition of Madison County informed them of the ill effects of secondhand smoke and attempted to get the community involved in local smoke free efforts.
Source: ITPC

Recommendation: Develop a resolution requiring a pledge towards "healthy living."

The Indiana Latino Institute (ILI) is also one of ITPC's minority partners. During this period, ITPC collaborated with ILI on promoting a Hispanic Soccer League Tournament and Health Fair, which was promoted on Hispanic radio and television. Attendees were educated on the tobacco prevention and control and asked to sign smoke free pledge cards.
Source: ITPC

Key Data Findings

Mortality

Mortality data is often used to monitor and evaluate the health status of the U.S., as well as, identify populations that may be at greater risk of death due to specific diseases and injuries. Differences in death rates vary among racial and ethnic populations. These differences may reflect factors such as socioeconomic status, access to health care, and the prevalence of specific risk factors of a particular group [16].

In 2005, there were 2,448,017 deaths among U.S. residents. Heart disease, cancer, and stroke were the three leading causes of death for all racial and ethnic groups in the United States during 2005, with the exception of American Indians and Hispanics/Latinos. The leading causes of death for these two groups were heart disease, cancer, and accidents. Blacks had the highest number of deaths and age-adjusted death rate due to all causes, including heart disease, cancer, and stroke followed by Whites. Their age-adjusted death rate was nearly 1.5 times higher than that of Whites; nearly 2 times higher than Hispanics/Latinos and American Indians; and nearly 3 times higher than that of Asians. Unlike other racial and ethnic groups in the U.S., homicide and HIV/AIDS were among the top 10 leading causes of death for Blacks, for 2005 (see Tables 6 and 7) [16]. Heart disease is one of the top two leading causes of death for all racial and ethnic groups in Indiana. Blacks have the highest age-adjusted death rates for heart disease, cancer and stroke followed by Whites. In contrast to other racial and ethnic groups in Indiana, homicide is among the ten leading causes of death for Blacks and Hispanics/Latinos [17].

Table 6. Age-Adjusted Death Rates for Selected Leading Causes of Death by Race and Ethnicity, U.S. Population, 2005

Causes of Death	American Indian	Asians/Pacific Islander	Black	Hispanic	White
All Causes	663.4	440.2	1,016.5	590.7	785.3
Heart Disease	U	U	217.3	157.3	207.8
Cancer	U	U	222.7	122.8	182.6
Stroke	U	U	65.2	35.7	44.7
Diabetes	U	U	46.9	33.6	22.5
Chronic Lower Respiratory Diseases	U	U	30.6	19.3	45.4
Accidents	U	U	38.7	31.3	40.1
Nephritis, Nephrotic syndrome and Nephrosis	U	U	29.7	12.0	12.9
Influenza and pneumonia	U	U	20.0	16.8	20.2
Chronic liver disease and cirrhosis	U	U	7.4	13.9	12.7

Rate per 100,000 population
U – Unavailable data
Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: National Center for Health Statistics (NCHS), National Vital Statistics System
Retrieved from http://www.cdc.gov.nchs/data/nvsr/nvsr56/nvsr56_10.pdf

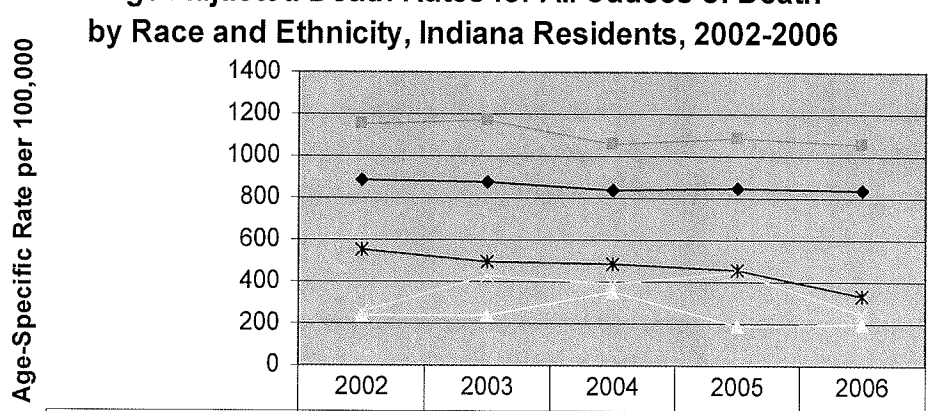
Table 7. Age-Adjusted Death Rates for Selected Leading Causes of Death by Race and Ethnicity, Indiana Residents, 2006

Causes of Death	American Indian	Asians/Pacific Islander	Black	Hispanic	White
All Causes	199.71	251.09	1,052.53	329.47	837.45
Heart Disease	*	67.47	275.22	66.72	213.72
Cancer	U	47.04	241.37	53.65	196.59
Stroke	U	*	63.13	20.84	48.04
Diabetes	U	U	50.05	22.28	24.31
Nephritis, Nephrotic syndrome and Nephrosis	U	*	35.2	*	19.89
Accidents	U	*	26.88	25.40	39.62
Essential (primary) Hypertension and Hypertensive Renal Disease	U	U	20.69	U	U
Certain Conditions Originating in the Perinatal Period	U	U	16.05	*	U
Homicide	U	U	33.22	9.49	U

Rate per 100,000 population
U – Unavailable data
Hispanic can be of any race
***Number is less than the 20 and the rate is unstable.**
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Figure 7 shows the age-adjusted death rates from 2002 to 2006 for all causes among racial and ethnic groups in Indiana. Similar to the 2005 U.S. death rates, Blacks have the highest number of deaths and age-adjusted death rates followed by Whites. In 2006, Blacks had an age-adjusted death rate nearly 1.5 times higher than that of Whites; nearly 4 times higher than Hispanics; and nearly 5 times higher than American Indians and Asians [17].

Figure 7. Age-Adjusted Death Rates for All Causes of Death by Race and Ethnicity, Indiana Residents, 2002-2006



	2002	2003	2004	2005	2006
White	881.91	877.03	839.37	846.13	837.45
Black	1,151.46	1,173.18	1,058.44	1,088.56	1,052.53
American Indian	237.19	239.35	352.57	188.96	199.71
Asian	258.45	428.17	394.03	452.13	251.09
Hispanic	549.14	493.55	482.2	461.51	329.47

Hispanic can be of any race
Age Adjusted Rates are calculated using the 2000 standard million population, U.S. Bureau of Census.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Infant Mortality

Infant mortality is one of the most important health indicators of the United States population. It is associated with a variety of factors such as maternal health, quality and access to health care, socioeconomic conditions, and public health practices. In addition, infant mortality is used to compare the health and well-being of racial and ethnic populations in the U.S. In 2006, the overall U.S. infant mortality rate was 6.7 per 1,000 live births [18]. The infant mortality rate in Indiana was 7.85 per live births for 2006 [19]. Table 8 shows the number and rate of infant death in Indiana by race and ethnicity for 2006. The infant mortality rate for Blacks was more than 3 times that of Hispanics/Latinos [19].

Table 8. Numbers and Rates of Infant Death from All Causes by Race and Ethnicity, Indiana Residents, 2006

Race/Ethnicity	Number	Rate
White	495	6.4
Black	188	18.1
Hispanic	44	5.2
Asian	1	*
American Indian/Alaskan Native	2	*

Deaths per 1,000 live births
Hispanic can be of any race.
***Less than 20 deaths and the rates are unstable. Use caution when interpreting this data.**
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Risk Factors

Chronic health conditions negatively affect quality of life; contribute to declines in functioning; and the inability to be cared for in the home by family and friends. Fortunately, many chronic conditions can be prevented or modified with behavioral interventions. Tobacco use, poor nutrition, physical inactivity, and obesity are all behavioral risk factors for most chronic diseases.

Tobacco Use

An estimated 10,000 Indiana adults die each year, from smoking related illnesses [20]. Tobacco use harms almost every organ in the body [21]. Cigarette smokers are 2 to 4 times more likely to develop heart disease than a non-smoker. A smokers' risk of having a stroke is twice that of a non-smoker. Smoking is attributed to nearly 90% of all lung cancers [21, 22]. In Indiana, lung and bronchus cancer rate for Blacks during 2000-2003, was 78 per 100,000. In comparison, the lung and bronchus cancer death rate for Whites was 64.4 per 100,000, from 2000 to 2003 [22].

In 2007, the prevalence of adult smoking was 24.1%, compared to 27.4% in 2001. Despite the downward trend, Indiana's adult smoking rate remains higher than the U.S. adult smoking rate of 20%. In addition, Indiana continues to rank among the top ten

states for adult smoking prevalence [23]. Table 9 compares Indiana and U.S. adult smoking rates by race and ethnicity.

Table 8. Smoking Prevalence by Race and Ethnicity, Indiana and U.S, 2007

Race Ethnicity	Indiana	United States
Black	22.9%	21.7%
Hispanic	25.1%	16.7%
White	24.0%	19.4%

Hispanic can be of any race.
Source: 2007, BRFSS

The smoking rate among pregnant women in Indiana continues to decline. However, the rate of mothers in Indiana who reported smoking during pregnancy (17.3%) during 2006 was higher than the national average (10.7%) [24, 25]. Smoking during pregnancy has been linked to the following poor birth outcomes: premature birth, low birth weight, and sudden infant death syndrome (SIDS) [21].

Nutrition

Research has shown diets rich in fruits and vegetables may decrease the risk of cancer and other chronic diseases, such as heart disease and diabetes. Fruits and vegetables provide crucial vitamins, minerals, fiber, and other substances needed to maintain optimal health [264]. In addition, most fruits and vegetables are naturally low in fat and calories. In the U.S, 24.3% of adults reported consuming fruits and vegetables five or more times per day, during 2007 [23]. By comparison, 22.8% of adults in Indiana reported consuming fruits and vegetables five or more times per day, during 2007 (see Table 10) [23].

Table 10. Percent of Adults Consuming $\geq$ 5 Fruits and Vegetables Daily, by Race and Ethnicity, Indiana and U.S. 2007

Race Ethnicity	Indiana	United States
African Americans	23.4%	23.1%
Hispanics	U	22.6%
Whites	22.1%	24.5%

U – Unavailable data
Hispanic can be of any race
Source: 2007, BRFSS
Retrieved from http://apps.nccd.cdc.gov/BRFSS/

In order to improve their health status, Indiana residents and Americans in general need to improve their nutritional habits.

Obesity

Overweight and obesity are described by ranges of weight that are greater than what is generally considered healthy for a given height. Body Mass Index (BMI) is an indicator of body fat. BMI is calculated from an individual's weight and height. A BMI of 25.0 to 29.9 is considered overweight and a BMI of 30 or greater is regarded as obese [26].

During the past 20 years, there has been a dramatic increase in obesity in the United States [26]. Indiana ranks among states with high rates of obesity. In 2007, the prevalence of adults in Indiana with a Body Mass Index (BMI) of 30 or greater was 27.4%. The overall obesity rate in Indiana is higher than the national median of 26.3% [23]. Table 11 shows that Blacks and Hispanics/Latinos have higher obesity rates than Whites, in Indiana and nationally.

Table 11. Body Mass Index of 30 or Greater by Race and Ethnicity, Indiana and U.S. 2007

Race Ethnicity	Indiana	United States
Blacks	36.9%	36.8%
Hispanics	28.2%	26.7%
Whites	27.0%	25.7%

Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: 2007, BRFSS
Retrieved from http://apps.nccd.cdc.gov/BRFSS/

Physical Inactivity

Regular physical activity is important when trying to maintain normal weight or when trying to lose weight. In addition to controlling weight, regular physical activity reduces the risk for many diseases and strengthens muscles, bones, and joints. Most adults in Indiana do not engage in moderate or vigorous physical activity. CDC recommends the following amounts of physical activity for adults:

- A minimum of 30 minutes of moderate-intensity physical activity per day (such as brisk walking) most days of the week
  or
- A minimum of 20 minutes of vigorous-intensity physical activity (such as jogging or running) 3 days a week [26]

In 2007, 28.1% of U.S. adults reported engaging in 20+ minutes of vigorous physical activity three or more days per week. In comparison, 26.5% of adults in Indiana reported engaging in 20+ minutes of vigorous physical activity three or more days per week, during 2007 [23]. Table 12 shows the percentage of adults in Indiana and U.S., by race and ethnicity, participating in 20+ minutes of vigorous physical activity three or more days per week, during 2007.

Table 12. Adults With 20+ Minutes of Vigorous Physical Activity Three or More Days per Week, by Race and Ethnicity, Indiana and U.S. 2007

Race Ethnicity	Indiana	United States
African Americans	27.6%	24.0%
Hispanics	25.7%	24.9%
Whites	26.5%	29.2%

Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: 2007, BRFSS
Retrieved from http://apps.nccd.cdc.gov/BRFSS/

Focus Areas

The Interagency State Council on Black and Minority Health understands that eliminating racial and ethnic health disparities is a process that requires identification of health care issues; planning to address inequities; and collaborative efforts of public and private partners. Therefore, the Council selects a few areas outlined in Indiana Code 16-46-6 to report on each year. This year the *Interagency Council on Black and Minority Health 2008 Annual Report* examines the impact of long term disability and aging, adolescent births, human immunodeficiency virus, and acquired immune deficiency syndrome (HIV/AIDS) on minorities in Indiana.

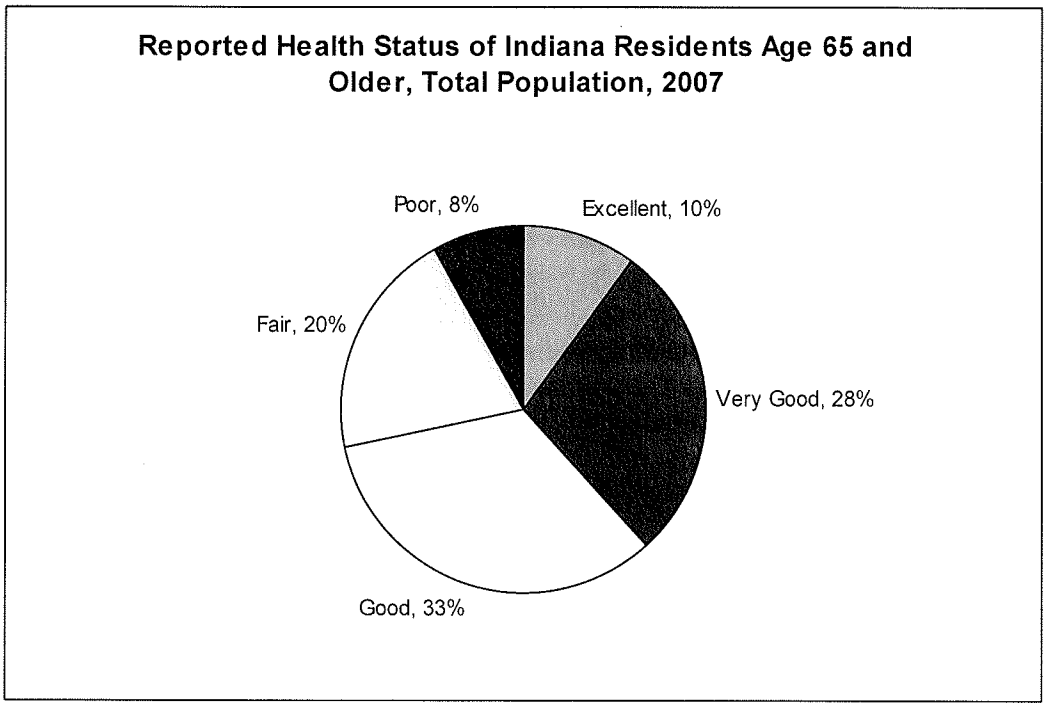
Long-term Disability and Aging

In addition to chronic diseases, the elderly are more likely to have a disability. Some disabilities may be relatively minor, while others might require assistance with personal self-care needs [29]. In 2007, nearly 29% of Indiana adults age 65 and older reported being limited in any activities because of physical, mental, or emotional problems. During the same period, 37% of Black elderly adults age 65 and older reported limited activities. In comparison, 29% of White elderly adults age 65 and older reported limited activities [23].

Data from the 2007 Behavioral Risk Factor Surveillance Survey revealed there was an association between disability and health status. The elderly are less likely than the non-elderly to give themselves a positive health rating. During 2007, 84.2% of Indiana's elderly residents reported being in "good or better health." In comparison, 72% Indiana residents age 65 and over reported being in "good health or better" [23].

Over one third (35%) of all Indiana residents surveyed rated their health as being "very good" during 2007. In comparison, only 28% of Indiana's population 65 years and older indicated their health was "very good" (see Figure 8) [23].

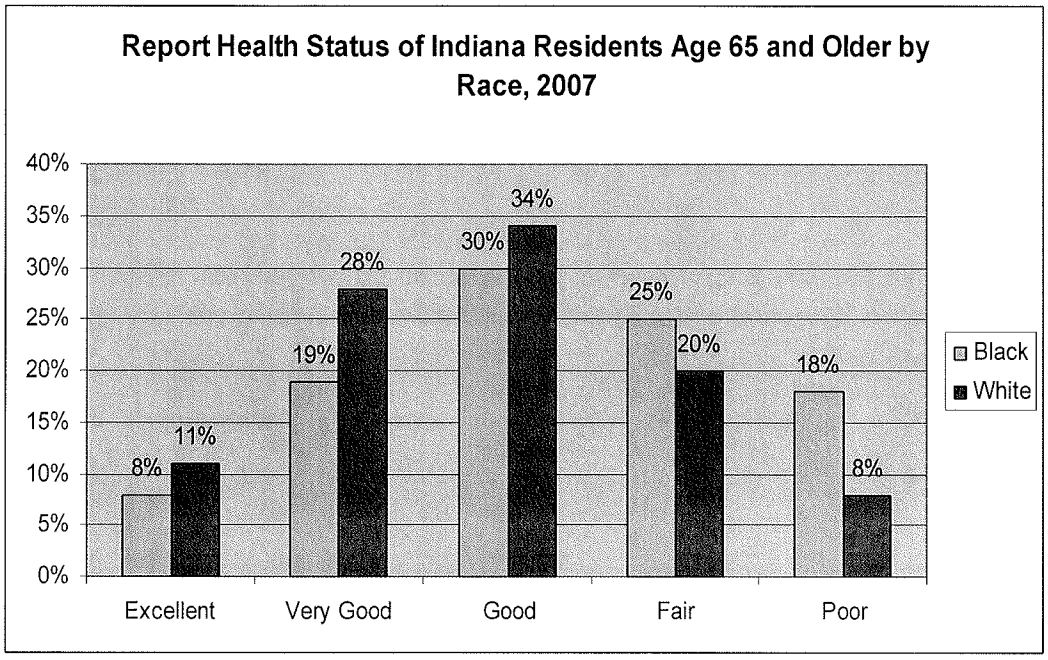
Figure 8. Reported Health Status of Indiana Residents Age 65 and Older, Total Population, 2007



Source: 2007 BRFSS
Retrieved from http://apps.nccd.cdc.gov/BRFSS/

Figure 9 shows reported health status by race during 2007. Elderly Blacks were than twice as likely as elderly Whites to rate their health status as "poor" [23].

Figure 9. Reported Health Status of Indiana Residents Age 65 and Older by Race, 2007



Source: 2007 BRFSS
Retrieved from http://apps.nccd.cdc.gov/BRFSS/

Adolescent Births

The overall birth rate for Indiana teens, age 15-19 years per 1,000 females, was 43.8 in 2006 [25]. The highest rates of teen births occurred among minority teens. Indiana's Hispanic/Latino and Black teen birth rates were more than twice that of Whites [25]. The following table depicts the teen birth rate in Indiana by race and ethnicity from 2002 to 2006 (see Table 13).

Table 13. Age-Specific Birth Rate per 1,000 Females by Race and Ethnicity, Indiana Residents Age 15-19, 2002-2006

	2002	2003	2004	2005	2006
White	41	39.7	39.9	39.8	40
Black	84.7	83.8	80.9	77.3	82.3
AI/AN	32.5	*	*	*	*
Asian	12.8	11.3	15.5	12.2	11.7
Hispanic	97.5	105.7	102.8	103.7	94.8

AI/AN – American Indian/Alaskan Native
Hispanic can be of any race
Interpret with caution, as Hispanic women may have been coded as other Non-White
*** Numerator is less than 20 and the rate is unstable. Use caution when interpreting this data.**
Note: Used 2000 population for 2001 population to be consistent with what was used in the 2001 Natality Report for birth rates.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Birth data and birth rates calculated by ISDH, ERC, Data Analysis Team, Population data from U.S. Census Bureau

Teen births are linked to low birth weight infants. Table 14 shows that Black teens are one and a half times or more likely as White teens than and twice as likely as Hispanic/Latino teens to have low birth weight infants [19].

Table 14. Percent of Low Birth Weight Infants of Mothers Age 15-19 Years by Race/Ethnicity, Indiana Residents, 2006

Race/Ethnicity of Mother Race/Ethnicity of Mother	Percent of Low Birth Weight Infants
White	9.0%
Black	13.8%
American Indian	*
Asian	*
Hispanic	6.9%

Hispanic can be of any race.
***Numerator and /denominator are less than 20 and the rate is unstable. Use caution when interpreting this data.**
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Black and Hispanic/Latino teenagers are less likely that White teenagers to receive prenatal care during the first trimester of pregnancy (see Table 15) [19].

Table 15. Percent of Females Age, 15-19 Years Who Received Prenatal Care in the 1st Trimester by Race/Ethnicity, Indiana Residents, 2006

Race/Ethnicity of Mother	Percent Prenatal Care in 1st Trimester
White	67.3%
Black	56.5%
American Indian	*
Asian	*
Hispanic	53.6%

Hispanic can be of any race.
***Numerator and/or denominator are less than 20 and the rate is unstable.**
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

According to the 2007 Indiana Youth Risk Behavior Survey (YRBS), teen girls who initiate sexual intercourse early "are more likely to have a greater number of lifetime sexual partners [30]." The percentage of female high school students who reported ever having sexual intercourse was highest among Hispanics/Latinos and Blacks. Hispanic/Latino female high school students were three times as likely as White female high school students to report having had sexual intercourse for the first time prior to age 13. Black female high school students were twice as likely as their White counterparts to had sexual intercourse for the first time prior to age 13. Black and Hispanic/Latino girls were more likely to have had one or more sexual partners in the past three months (see Table 16 to 18) [30].

Table 16. Percent of High School Females Who Ever Had Sexual Intercourse by Race/Ethnicity, Indiana Residents, 2007

Race / Ethnicity	Percent Who Ever Had Sexual Intercourse
Black	58%
Hispanic/Latino	52%
White	48%

Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, 2007 Indiana YRBS
Retrieved from http://www.in.gov/yrbs

Table 17. Percent of High School Females Who Had Sexual Intercourse for the First Time Before the Age of 13 Years by Race/Ethnicity, Indiana Residents 2007

Race / Ethnicity	Percent Who Had Sexual Intercourse for the First Time Before the Age of 13 Years
Black	8%
Hispanic/Latino	12%
White	4%

Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, 2007 Indiana YRBS
Retrieved from http://www.in.gov/yrbs

Table 18. Percent of High School Females Who Had Sexual Intercourse with One or More People During the Past Three Months by Race and Ethnicity, Indiana 2007

Race / Ethnicity	Percent Who Had Sexual Intercourse with One or More People During the Past Three Months
Black	45%
Hispanic/Latino	40%
White	38%

Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, 2007 Indiana YRBS
Retrieved from http://www.in.gov/yrbs

Teen sexual activity is associated with increased unwanted pregnancy. Every day in Indiana, thirty-one girls between the ages of 10 to 19 years become pregnant [30]. In

2006, the overall age-specific pregnancy rate for females 15 to 19 years was 51.2 per 1,000 females [24].

Marion, Lake, Allen, Elkhart, and St. Joseph counties had the highest number of pregnancies for females 15 to 19 years in 2006 [24]. Tables 23 to 25 show the number and rate of pregnancy for females 15-19 years by race and ethnicity. Black and Hispanic/Latino females 15 to 19 years had the highest number and rate of pregnancy for the above mentioned counties.

Table 19. Counties with the Highest Number and Rate of Pregnancy for Black Females 15-19 Years, Indiana, 2006

Counties	Number of Pregnancies	Rate of Pregnancy
Allen	242	10.0
Elkhart	54	2.2
Lake	530	21.9
Marion	1057	43.7
St. Joseph	178	7.4

Rate per 1,000
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Table 20. Counties with the Highest Number and Rate of Pregnancies for Hispanic/Latino Females 15-19 Years, Indiana, 2006

Counties	Number of Pregnancies	Rate of Pregnancy
Allen	91	8.4
Elkhart	120	12.0
Lake	182	16.8
Marion	309	28.8
St. Joseph	55	5.5

Rate per 1,000
Hispanic can be of any race
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Table 21. Counties with the Highest Number and Rate of Pregnancies for White Females 15-19 Years, Indiana, 2006

Counties	Number of Pregnancies	Rate of Pregnancy
Allen	435	2.3
Elkhart	404	2.1
Lake	481	2.5
Marion	1273	6.7
St. Joseph	360	1.9

Rate per 1,000
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

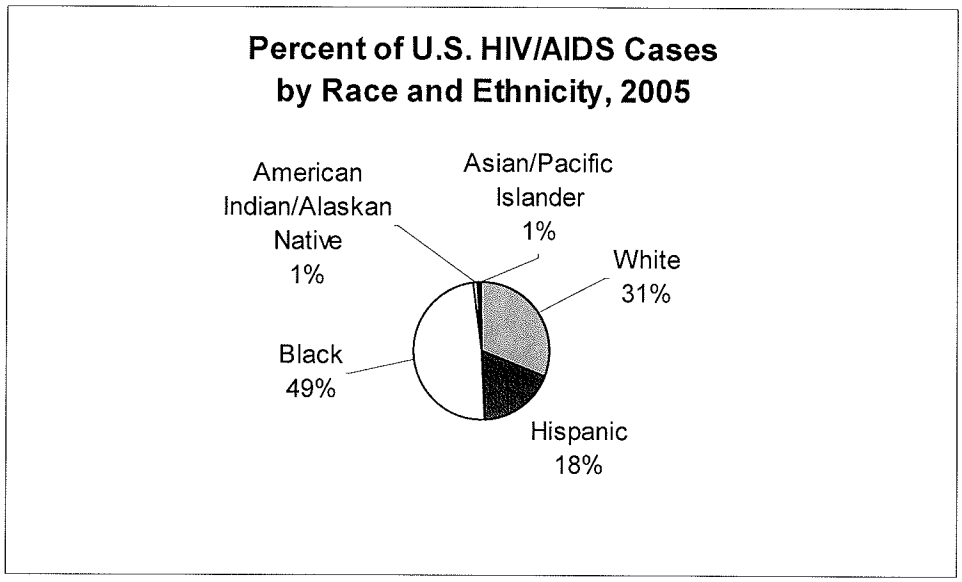
In addition to high birth rates and unwanted pregnancies, early sexual activity has other negative outcomes for teenage girls.

- Teen pregnancy costs Indiana taxpayers approximately $195 million in 2004 [31].
- The costs of childbearing are greatest for younger teens. In Indiana, the average annual cost associated with a child born to a teen 17 years and younger is $3,953 [31].
- Teens with children are less likely to graduate from high school than their peers who do not have children. Studies suggest that most adolescent mothers have already dropped out of school, even before they become pregnant [30].
- Teen increase their risk of contracting sexually transmitted diseases (STD) and HIV/AIDS [30].

HIV/AIDS

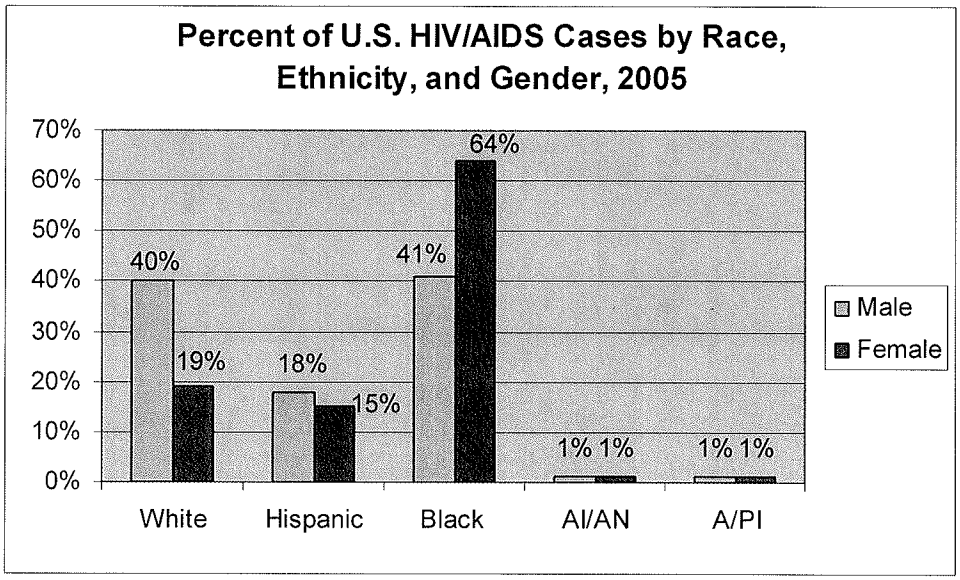
Due to advances in treatment, more people than ever before are living with HIV/AIDS. An estimated one million people in the U.S. are living with HIV/AID and 25% of them are unaware that they are infected. This puts them at risk. Recent research in 2006 revealed that approximately 56,300 individuals in the U.S. were newly infected with HIV. Racial and ethnic minorities, particularly Blacks, in the U.S. are disproportionately affected by HIV/AIDS. Blacks made up only 13% of the U.S. population, yet they accounted for almost half of the estimated number of HIV/AIDS diagnoses [32]. Blacks account for about half of all people living with HIV/AIDS with Black women being impacted the most (see Figures 10 and 11) [32].

Figure 10. Percent of U.S. HIV/AIDS Cases by Race and Ethnicity, 2005



Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Retrieved from http://www.cdc.gov/hiv/

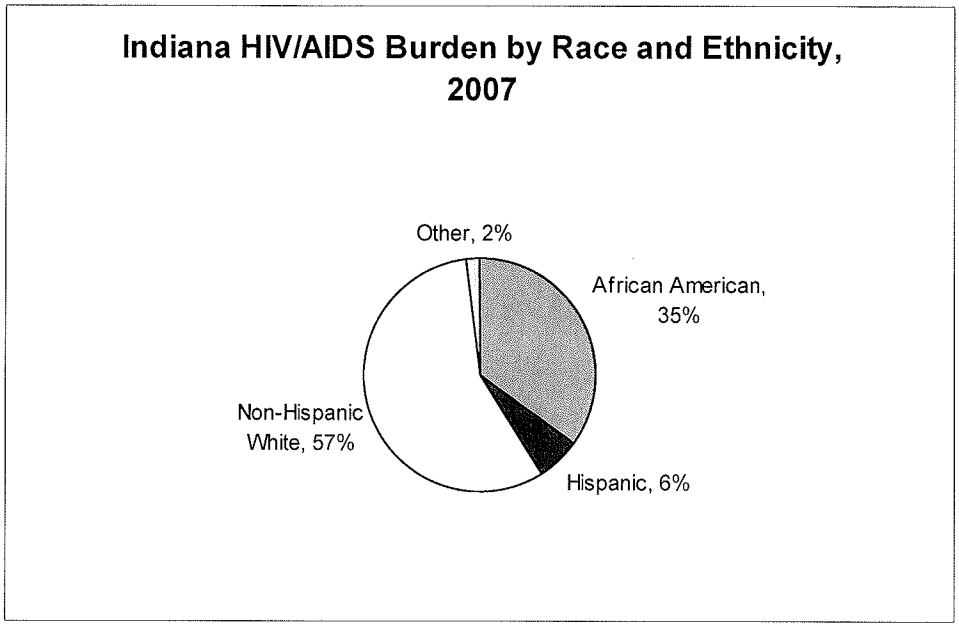
Figure 11. Percent of U.S. HIV/AIDS Cases by Race, Ethnicity, and Gender, 2005



AI/AN – American Indiana/Alaskan Native
A/PI – Asian/Pacific Islander
Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2005
Retrieved from http://www.cdc.gov/hiv/

Blacks represent approximately 9% of Indiana's population but account for 35% of the state's HIV/AIDS cases (Figure12) [33].

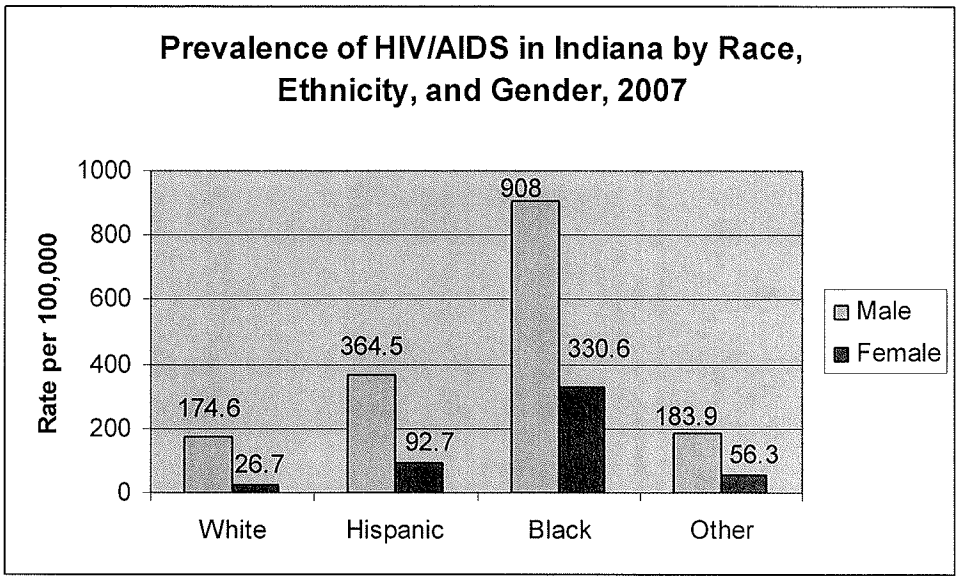
Figure 12. Indiana HIV/AIDS Burden by Race and Ethnicity, 2007



Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008. Original data from: ISDH, Spotlight on HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007
Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf

In 2007, there were 9,168 Indiana residents living with HIV/AIDS. Of those living with HIV/AIDS, 81% were male and 19% were female. Figure 13 shows the Indiana HIV/AIDS prevalence rate by race, ethnicity, and gender as of December 2007 [33]. Blacks in Indiana are affected by HIV/AIDS more than any other group. The HIV/AIDS rate in Black women is more than 10 times that of White women. Likewise, the prevalence of HIV/AIDS among Black men is more than 5 times that of White men [33].

Figure 13. Prevalence of HIV/AIDS by Race, Ethnicity, and Gender, Indiana Residents, 2007



Rate per 100,000
Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: ISDH, Spotlight on HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007
Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf

The number of Indiana residents living with HIV and AIDS in 2007 was 3,871 and 4,132, respectively (Table 19) [33].

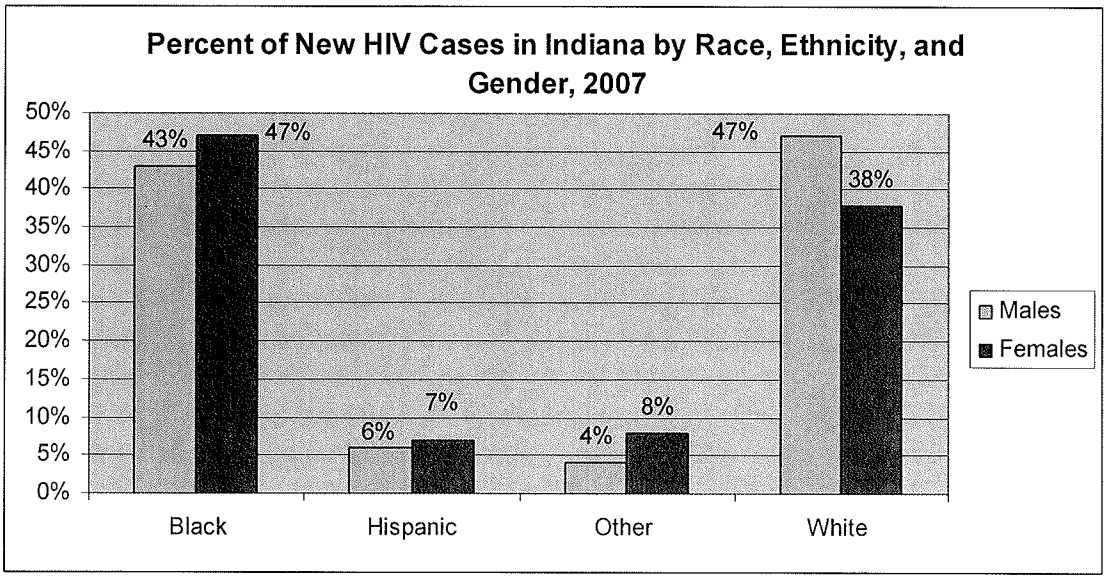
Table 22. The Number of HIV/AIDS Cases, Indiana Residents, 2007

HIV/AIDS Cases	Persons with HIV (without an AIDS diagnosis)	Persons with AIDS
New Reports	412	333
Number of HIV/AIDS Cases Living	3,871	4,132
Number of HIV/AIDS Cases Living and Dead	4,234	8,458

Includes people diagnosed in Indiana.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: ISDH, Spotlight on HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007
Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf

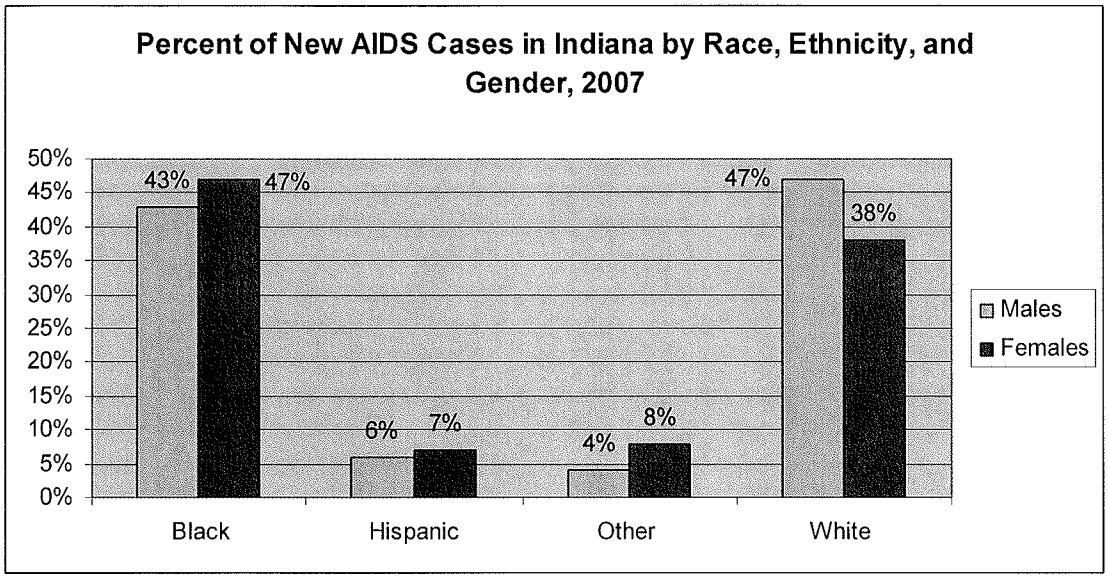
Of the new cases of HIV (412) reported in 2007, 74% were male and 26% were female. During the same period, 77% of new AIDS cases were male and 23% were female. The majority of newly diagnosed HIV and AIDS cases were Black males. Figures 14 and 15 compare HIV and AIDS cases by gender, race and ethnicity [33].

Figure 14: Percent of New HIV Cases in Indiana by Race, Ethnicity, and Gender, 2007



Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: ISDH, Spotlight on HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007
Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf

Figure 15. Percent of New Cases of AIDS in Indiana by Race, Ethnicity and Gender, Indiana Residents, 2007



Hispanic can be of any race.
Source: Indiana State Department of Health, Office of Minority Health, October 2008.
Original data from: ISDH, Spotlight on HIV/STD/Viral Hepatitis, Indiana Semi-Annual Report, December 2007
Retrieved from http://www.in.gov/isdh/files/spotlight_index_dec07.pdf

Conclusion

Health issues and diseases continue to disproportionately affect minorities. One example we witnessed was the HIV/AIDS epidemic. In the 2008 Center for Disease Control HIV/AIDS Surveillance Report, racial and ethnic minority populations in the United States, primarily African Americans and Hispanics, constitute 58 percent of the more than 928,188 cases of AIDS reported, has greatly increased since the epidemic began in 1981.

The goal for this annual report is to illustrate to the Indiana legislative body the issues that affect primarily their racial and ethnic constituents. The only way to better serve all Hoosiers is to ensure equality and accessibility of health care services and the necessary resources to empower and evoke change within these communities. Our goal is to one day see health disparities as a small minority rather than a great majority of individuals.

Unfortunately, Indiana is behind, but is making immediate strides to improve, but we are making day to day strides to improve health for all. Focusing on disability and aging, teenage pregnancy, and HIV/AIDS shows a portion of the health disparity issues that are affecting daily living for many Indiana residents. The report showed how chronic health conditions negatively affect quality of life and how high numbers among certain racial and ethnic populations are intensifying. The listed barriers for each disease provide examples to show what steps need to be considered to lower disability, lower adolescent births, and decrease the spread of HIV/AIDS.

It is imperative that Indiana law makers, families, and society in general keep health disparity issues in the forefront. In order to eliminate health disparities in Indiana, we need to find ways including developing innovative culturally sensitive behavioral programs, collaboration with faith-based institutions and healthcare professionals to meet the health needs of all Indiana residents.

Recommendations

The Interagency Council on Black and Minority Health formed a subcommittee on data and another to make recommendations based on the data. The following are the Council's recommendations based on data gathered on the three focus areas 1.) Long term disability and aging; 2.) Adolescent pregnancy; and 3.) HIV/AIDS:

Long-Term Disability and Aging

- Increase awareness and understanding of services, such as prescription assistance programs, navigating the Medicare system, etc.
- Support policies that endorse increasing health insurance coverage, particularly for individuals 65 years and over.
- Offer affordable and accessible transportation.
- Provide safe and clean environments for recreation and socialization.
- Encourage family members of elderly minorities to become more aware and involved in the health of their elders.
- Provide cultural competency training for health care providers and support staff.
- Educate elderly minorities on why it is necessary for them to be active members of their health care team.
- Educate and encourage elderly minorities on self care management and talking with their provider, especially about issues such as end of life care.

Adolescent Births

- Include sex education as part of the regular educational curriculum.
- Promote and support medically accurate, science-based comprehensive sex education curricula.
- Educate and empower parents on how to talk to their adolescents and teens about sex
- Collaborate with organizations, such as, Indiana Commission on the Social Status of Black Males, on developing and conducting effect programs to reach and teach minority male teens about equal responsibility concerning sex.
- Provide resources to expand the Indiana R.E.S.P.E.C.T. program
  This program is an example of what education can do for our Indiana minority teenagers. R.E.S.P.E.C.T. provides technical assistance workshops to assist local youth serving agencies in their efforts to fight teen pregnancies in their communities.

Also, this program agrees that educating these at- risk teens with positive physical, emotional and social gains can only result in the decrease teenage pregnancies in Indiana especially among at-risk minority groups.

- Encourage law makers to support Resolution 08-33 Comprehensive Sexuality Education submitted by the Indiana State Medical Association.

HIV/AIDS

- Provide resources to expand current testing counseling services, especially in counties with the highest number of HIV/AIDS cases.
- Educate minorities about the AIDS Drug Assistance Program (ADAP).
- Increase access to HIV/AIDS medications.
- Provide cultural competency training for health care providers and support staff.
- Increase access to basic HIV/AIDS medical care and specialty medical care.
- Educate minorities regarding HIV prevention.
- Encourage HIV testing in minority communities.
- Encourage policymakers to support Resolution 08-10 Routine HIV Testing During Pregnancy submitted by the Indiana State Medical Association.

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. According to the National Center for Health Statistics (NCHS), age 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

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 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 2000 standard has implications for race and ethnic differentials in mortality.
Source: National Vital Statistics Report, Volume 47, Number 3
Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr47/nvs47_03pdf

Behavior Risk Factor Surveillance Survey (BRFSS) - The Centers for Disease Control and Prevention (CDC) developed the BRFSS. It is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year making the BRFSS is the largest telephone health survey in the world. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Indiana uses the system to monitor statewide progress toward *Healthy People 2010* objectives in tobacco use, cardiovascular disease, weight, physical activity, fruit and vegetable consumption, breast and cervical cancer, and immunization.
Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.
Retrieved from http://www.cdc.gov/brfss/

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.

One-Year Population Estimates – The U.S. Census Bureau 2007 American Community Survey (ACS) one-year estimates are based on data collected between January 2007 and December 2007. The ACS one-year estimates are published for selected geographic areas with populations of 65,000 or greater and represent the average characteristics over calendar year 2007. Source: U.S. Census Bureau Retrieved from http://factfinder.census.gov/

The Indiana mortality rates and age-specific birth rates were calculated using population data from the U.S. Census Bureau for each year.

Race/Ethnicity – Unless otherwise noted, all data on race/ethnicity in this report includes one race only. All data and charts are based on U.S. Census Bureau classification of race and ethnicity. Persons of Hispanic origin may be of any race.

In 1997, after a lengthy analysis and public comment period, the Federal Office of Management and Budget (OMB) revised the standards for how the Federal government would collect and present data on race and ethnicity. The new guidelines reflect "the increasing diversity of our Nation's population, stemming from growth in interracial marriages and immigration." Race is a self-identification data item in which respondents choose the race or races with which they most closely identify.
These new guidelines revised some of the racial categories used in 1990 and preceding censuses and allowed respondents to report as many race categories as were necessary to identify themselves on the Census 2000 questionnaire. It included the minimum 5 race categories required by OMB, plus the 'some other race alone' included by the Census Bureau for Census 2000: White alone; Black or African-American alone; American Indian or Alaska Native alone; Asian alone; Native Hawaiian or other Pacific Islander alone; and some other race alone. (Census 2000 race data are not directly comparable with data from 1990 and previous censuses.)
Source: U.S. Census Bureau
Retrieved from http://factfinder.census.gov/

Reliability of Rates – Some of the rates shown in this report are based on small population, a small number of deaths, or both. The rates based on small numbers may be unstable due to random chance factors and should be used with caution. Rates for counties with small populations also may vary considerably from year to year. In addition, allowances must be made for differences in age distributions, etc., when rates are not age-adjusted.
Source: Indiana State Department of Health, Public Health Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Years of Potential Life Lost - Years of Potential Life Lost (YPLL) is a measurement of premature mortality. According to the CDC, YPLL is presented for persons under 75 years of age because the average life expectancy in the United States is over 75 years. For example, the death of a 25-year-old would account for 50 years of lost life, while the death of a 60-year-old would account for 15 years.
YPLL-75 is calculated using the following eight age groups: under 1 year, 1-14 years, 15-24 years, 25-34 years, 35-44 years, 45-54 years, 55-64 years, 65-74 years. The number of deaths for each age group is multiplied by the years of life lost, calculated as the difference between age 75 years and the midpoint of the age group. For the eight age groups the midpoints are 0.5, 7.5, 19.5, 29.5, 39.5, 49.5, 59.5, and 69.5. For example, the death of a person 15-24 years of age counts as 55.5 years of life lost. Years of potential life lost is derived by summing years of life lost over all age groups.

YPLL rates can assist in the performance of three basic public health functions:

1.) The establishment of research and resource priorities;
2.) The surveillance trends in premature mortality, over time and;
3.) The evaluation of the effectiveness of program interventions.

YPLL can be used at national, state, and local levels to target public health efforts toward populations at risk for certain diseases or conditions.
Source: CDC, NCIPC, WISQARS, YPLL Reports, 1999-2005.
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