

Health Disparities in Delaware

2004

prepared for

Delaware Healthcare Commission

by

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Introduction

The issue of health disparity is of concern to all of us. It affects each of us as individuals and as a society in general. Differences in the length of our lives and the quality of life are largely influenced by health. Both impact the contribution that any member of society is likely to make.

At the outset it is important to understand that there are two different views of what is meant by health disparities, and both views are valid. The first view deals largely with early death. Longevity differs by race as can be seen in Figure 1.1 below.

Figure 1.1
Life Expectancy in Delaware by Race and Gender

Year	All Races			White			Black		
	Both	Male	Female	Both	Male	Female	Both	Male	Female
2001	76.3	73.9	78.7	77.1	74.6	79.5	72.1	69.5	74.4
2000	76.5	73.9	79.0	77.1	74.5	79.6	72.5	69.4	75.5
1999	76.8	73.9	79.6	77.6	74.7	80.3	72.6	68.8	76.2
1998	75.9	73.3	78.4	77.0	74.5	79.4	70.3	66.9	73.5
1997	75.8	73.3	78.2	76.7	74.2	79.1	71.0	68.3	73.5
1996	75.4	72.5	78.1	76.7	73.9	79.4	68.8	65.2	72.2
1995	75.5	72.5	78.4	76.8	74.2	79.4	68.9	64.4	73.5
1994	75.1	71.4	78.7	76.1	72.6	79.6	69.5	65.0	74.1
1993	75.2	71.9	78.5	76.5	73.6	79.3	68.5	63.4	73.6
1992	75.4	72.4	78.2	76.3	73.5	78.9	70.3	66.2	74.3
1991	75.0	71.9	77.9	76.0	73.0	78.9	69.4	66.2	72.4
1990	75.0	71.9	77.9	76.0	73.2	78.8	69.3	65.4	73.1
1989	74.3	71.1	77.3	75.3	72.2	78.2	68.4	64.4	72.4
1988	74.2	70.9	77.3	75.1	71.9	78.2	68.8	65.0	72.6
1987	74.3	71.0	77.5	75.1	71.8	78.3	69.7	66.1	73.1
1986	74.0	70.5	77.5	74.9	71.4	78.3	68.9	65.0	72.8
1985	73.9	70.5	77.1	74.9	71.7	78.0	68.3	64.2	72.6
1984	74.6	71.3	77.8	75.5	72.2	78.7	69.1	65.8	72.4
1983	74.6	71.1	78.0	75.5	72.1	78.8	69.4	65.5	73.4
1982	73.7	70.1	77.2	74.6	70.9	78.3	68.4	65.2	71.5
1981	73.6	70.1	77.0	74.3	70.9	77.6	69.4	65.1	73.9
1980	73.1	69.5	76.7	74.0	70.5	77.5	67.6	63.3	72.4
1979	73.1	69.2	77.1	74.0	70.0	78.1	67.6	64.1	71.2

Source: Delaware Health Statistics Center, Division of Public Health

A black newborn in Delaware is expected to live 72.1 years, while a white newborn is expected to live 77.1 years, a difference of five years. A black female newborn is expected to live 74.4 years as opposed to a white female newborn, who is expected to live 79.5 years. A black male newborn has the lowest life expectancy at 69.5 years compared to a white male newborn at 74.6. As Figure 1.1 shows, life expectancy for both black males and black females has steadily climbed since 1979. Both black males and black females improved far more than their white counterparts but still lag significantly behind both whites and the all race, all sex averages. While the black female trails the average white female life expectancy by just over four years, it is the black male who is behind all of the groups, including black females, by almost five years. The differences in life expectancy are directly related to differences in mortality for a wide range of diseases. This report is intended to highlight the problems and challenges associated with health disparities among the races.

Improving health promotion in all areas is achieved by educating the general public of the long-term benefits of a healthier lifestyle. J. Michael McGinnis writes that ninety-five percent of all funding in this country put towards health is spent on the medical services, leaving only five percent for health promotion.¹ But it is estimated that forty percent of deaths are caused by specific behavior problems that could be prevented with more education, while only ten to fifteen percent of deaths could be avoided by better access to, or availability of, health care.

Behavioral choices are the biggest determinant in an individual's health in the United States. The way we eat, whether we smoke or drink, and having unprotected sex are just a few of the many choices that affect our health. McGinnis believes through better health care promotion, there would be a dramatic improvement in the mortality and morbidity of all races. This is shown through the Healthy People initiative started in 1990, which showed large improvements in Infant Mortality, Childhood Death Rates, Adolescent Death Rates, and Adult Death Rates.

As health disparities grow in certain areas such as HIV/AIDS and Diabetes, it is important that education of the masses takes place in the regions of most need. As blacks continue to lag behind whites in many health areas, it is important to examine a wide array of causal factors including behavior, genetics, social, environmental conditions, and shortfalls in medical care.

¹ McGinnis, J.M., Pamela Williams-Russo, James R. Knickman. "The Case for More Active Policy Attention To Health Promotion", *Health Affairs*, Vol. 21, No. 2, 2002.

Shortfalls in medical care are central to the second view of the health disparity issue. Differences in the delivery of health care along racial/ethnic lines are of concern and need to be examined. In many respects this is a subset of the broader early death view.

The most influential recent study is the congressionally commissioned Institute of Medicine (IOM) 2003 report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” This study’s conclusion is not new, but it seems to have made a lasting impression on the nation’s health policy dialogue. Despite steady improvement in the overall health of the U.S. population, racial and ethnic minorities, with few exceptions, suffer higher rates of morbidity and mortality when compared to non-minority populations. While the causes of these disparities are complex and not easily identified, the IOM report indicates that some may be attributed to socioeconomic status, culture, language, environment, and behavioral risk factors.

The IOM study committee reviewed more than 100 studies, and “was struck by the consistency of research findings,” indicating that minorities are “less likely than whites to receive needed services, including clinically necessary procedures.” These disparities were found to exist across a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness.

The key difference in these two views is the focus of the effort to reduce these disparities. Should it broadly focus on areas such as personal behavior or more narrowly on health care delivery? Currently we spend most of our resources on the latter. This report provides background information that will help inform local policymakers as they struggle with this critical issue.

Following this brief introduction are four substantive sections. The first section describes 12 health disparity indicators such as comparative death rates from heart disease, cancer and stroke. Due to small sample sizes for other racial and ethnic groups, the discussion focuses on the differences between the rates for white and black Delawareans.

The second section addresses potential behavioral reasons for health disparities. It uses interviews with more than 16,000 adult Delawareans over the past five years to shed light on some areas that might prove fruitful for reducing the observed disparities.

The third section provides information regarding the current thinking about health disparities and the potential causes and likely strategies for reducing them. The material is largely focused at the national level but has wide applicability to the State of Delaware.

The final section looks at the interaction of individuals with the health care system and the problems they have observed obtaining quality care. This analysis also relies on survey data gathered from nearly 9,000 adult Delawareans over the past five years. Using the suggestions from the first section, it looks for differences that would indicate strategies for improving the quality of care received by minorities in particular.

There are two appendices provided. The first provides information about the construction of several quality of care scales. The second summarizes information about programs being developed and implemented to reduce health disparities around the country.

Health Disparity Indicators

There were 12 indicators used in this study to outline the degree of disparity that exists between blacks and whites. The three data sources for these indicators were birth records, death records, and inpatient hospital discharge records.

Heart Disease Death Rate represents the number of heart disease deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. Heart disease was the leading cause of death in Delaware for 1998-2002 accounting for over 9,800 deaths.

Cancer Death Rate represents the number of cancer deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. Cancer was the second leading cause of death in Delaware for 1998-2002, accounting for over 8,300 deaths.

Stroke Death Rate represents the number of stroke deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. Stroke was the third leading cause of death in Delaware for 1998-2002.

Diabetes Death Rate represents the number of diabetes mellitus deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. Diabetes represents the sixth leading cause of death in Delaware for 1998-2002.

HIV Infection/AIDS Death Rate represents the number of HIV Infection/AIDS deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. HIV Infection/AIDS was the thirteenth leading cause of death in Delaware for 1998-2002.

Homicide Rate represents the number of homicide deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. Homicide was the seventeenth leading cause of death in Delaware for 1998-2002.

Alcohol-Induced Death Rate represents the number of alcohol-induced deaths per 100,000 population. Rates are age-adjusted to the 2000 U.S. population standard. The category alcohol-induced deaths includes not only the deaths from dependent and non-dependent use of alcohol, but also accidental poisoning by alcohol. It excludes unintentional injuries, homicides, and other causes indirectly related to alcohol use.

Infant Death Rate represents the number of deaths of children less than one year of age per 1,000 live births.

Teen Birth Rate represents the number of births to teens 15-19 years of age per 1000 females in that age group.

Late or No Prenatal Care represents the percent of all women giving birth who received their first prenatal visit in the third trimester of pregnancy or received no prenatal visits.

Percent of Low Birth Weight Babies represents the percent of all babies weighting less than 5.5 pounds (<2500 grams) at birth.

Asthma Hospitalization Rate represents the number of inpatient hospitalizations for asthma per 100,000 population. Rates are adjusted to the 2000 U.S. population standard.

For each death rate, birth rate, or hospitalization rate there will be two graphs that will represent a specific geographic region. The values in each graph show the five-year moving average for each period designated on the horizontal axis. These regions will consist of the rates for the entire state or one of the three Delaware counties, Kent, New Castle, or Sussex. The first graph will track the rates over a designated set of years for both blacks and whites within the specified region.

The second graph will show the black/white disparity ratio, which is the black rate divided by the white rate. The black/white disparity ratio will represent the percentage of disparity in the specified region as well as any progress that is being made in regard to disparity between blacks and whites. The further the ratio is from one, the higher the disparity between blacks and whites in that area. For example, in Sussex County there are 297.5 Heart Disease deaths per 100,000 for blacks and there are 249.4 Heart Disease deaths per 100,000 for whites. The black/white disparity ratio would be 1.2 because the amount of black deaths divided by the number of white deaths equals 1.2 (risk is 20% higher for blacks than for whites).

The rates are age adjusted to the 2000 U.S. population standard and the data was compiled by the Delaware Health Statistics Center.

The Delaware 2002 disparity ratios for the 12 indicators are summarized in Figure 2.1 below.

Figure 2.1
Delaware and US Health Disparity Ratios

Indicator	DE 2002	DE 1997	US 2002	Trend
Heart Disease	1.16	1.11	1.30	Increase
Cancer	1.20	1.45	1.25	Decrease
Stroke	1.39	1.57	1.40	Decrease
Diabetes	2.33	2.33	2.14	No Change
HIV/AIDS	15.56	8.23	8.65	Increase
Homicide	3.94	3.56	5.67	Increase
Alcohol Induced	1.34	1.57	N/A	Decrease
Infant Death	2.41	2.63	2.48	Decrease
Teen Births	2.35	2.74	1.86	Decrease
Prenatal Care	2.19	3.11	N/A	Decrease
Low Birth Weight	1.95	2.08	N/A	Decrease
Asthma Hospitalization	2.93	2.53	N/A	Increase

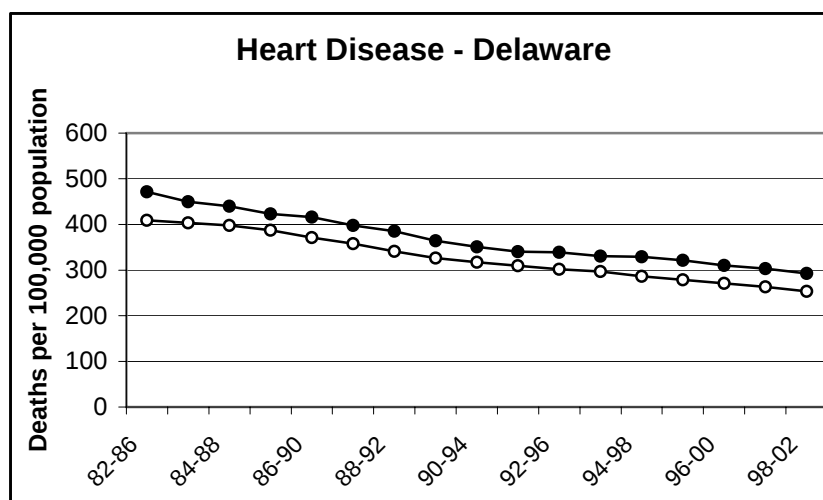
Heart Disease

Heart disease remains the leading killer in both the United States and in the state of Delaware. The 2002 black/white disparity ratio is at 1.16, meaning Delaware blacks are about 16% more likely than whites to die of Heart Disease. This is an increase from 1997, where the black/white disparity ratio was 1.11.

However, Delaware's black/white disparity ratio is significantly lower than that of the United States at 1.30. With blacks being 30% more likely to die of heart disease nationally than whites, Delaware is well ahead of the curve compared to the rest of the nation. Still, due to the large number of deaths from heart disease there can be a larger cumulative effect.

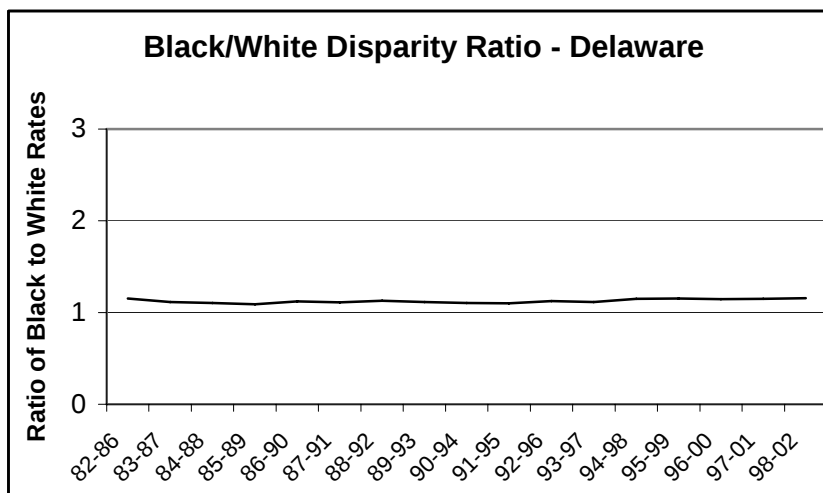
Kent, New Castle, and Sussex have all shown drastic improvement in the last twenty years in the number of deaths per 100,000 for both blacks and whites. In all three counties the changes in the amount of deaths per year mirrored each other. Kent County has had so much success that they have a black/white disparity ratio that is below 1. But while there have been vast improvements in New Castle and Sussex counties in the totals deaths, the black/white disparity ratio has remained fairly constant for the past 20 years.

Figure 3.1
Heart Disease Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

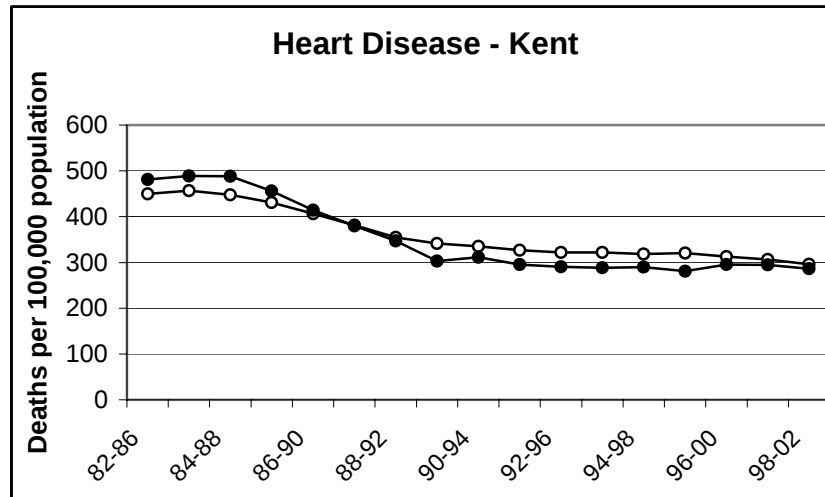
Figure 3.2
Heart Disease Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

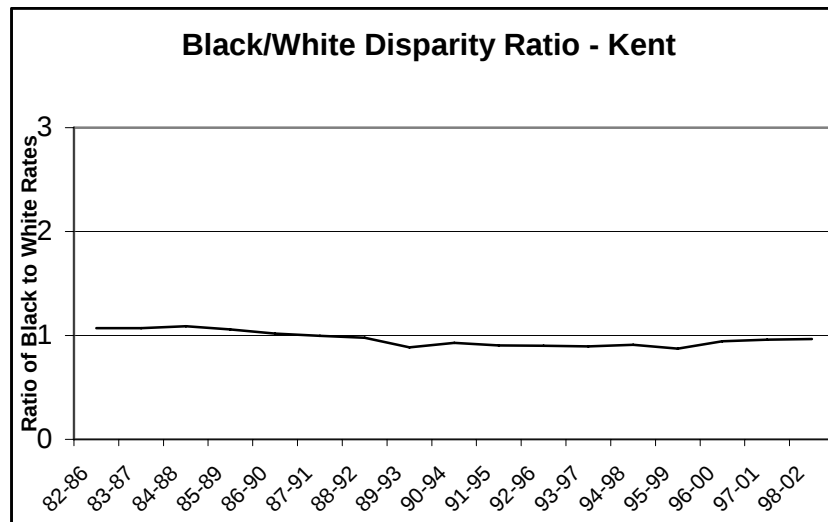
Since 1982-86, there has been a steady decrease in the amount of deaths per 100,000 in both blacks and whites with a leveling off around 1991-95. But there has been little change between blacks and whites with the ratio staying just above one. The state information provides a much better look at the black/white disparity because the counties tend to offer more active changes year to year, while the state shows gradual trends.

Figure 3.3
Heart Disease Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

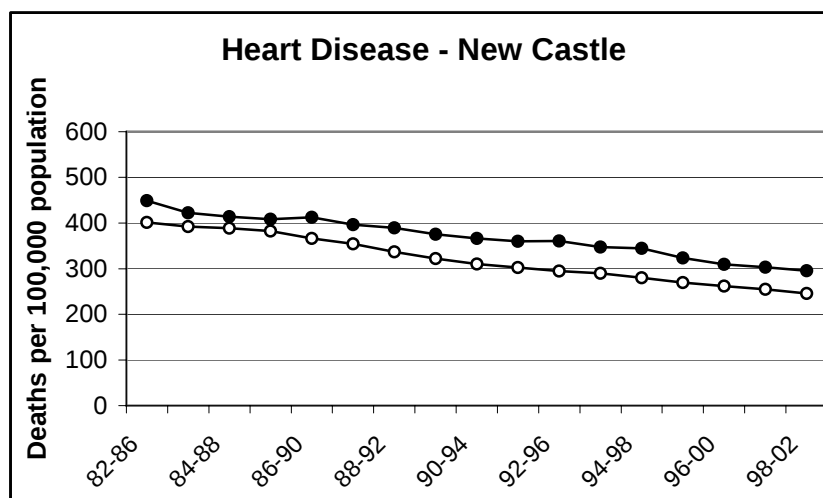
Figure 3.4
Heart Disease Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

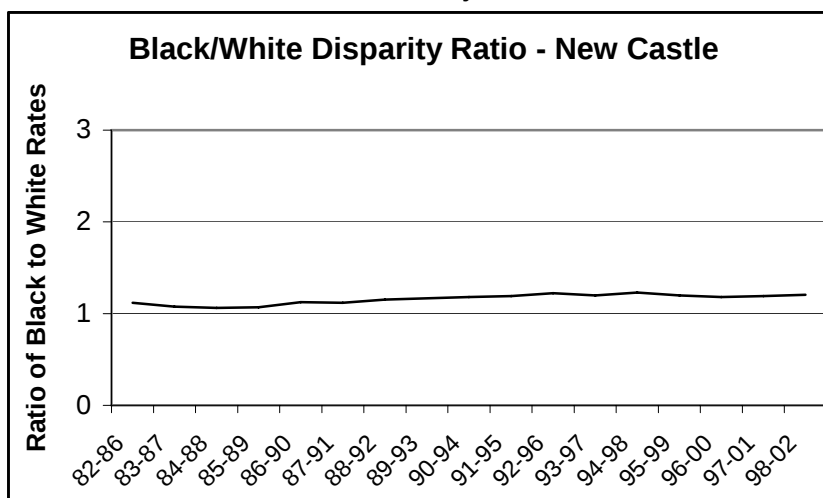
Kent County has shown sharp decreases in the rate of heart disease deaths per 100,000 in both races between 1982-86 and 1990-94. Around 1995 the ratios level off and remain static to this point around 300 deaths per 100,000 for both races. The dramatic changes do not translate into the black/white disparity ratio where the numbers remain constant around a ratio slightly below one (meaning there are fewer deaths per 100,000 for blacks than whites).

Figure 3.5
Heart Disease Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

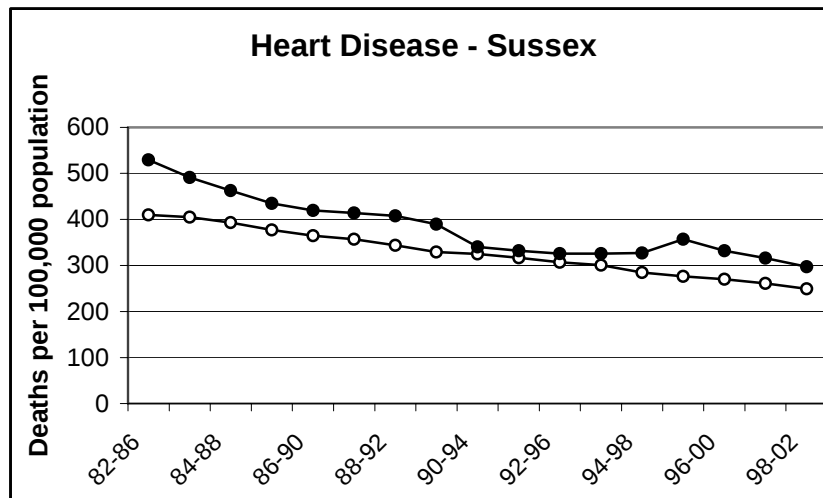
Figure 3.6
Heart Disease Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

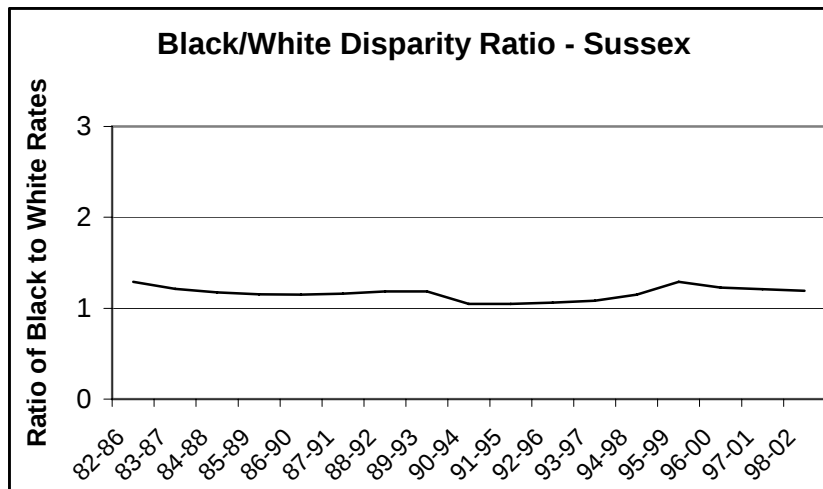
Much like the state, New Castle County has shown gradual but significant changes since 1982-86 in both blacks and whites. The steady year-to-year progress shows that there have been improvements in treatment that have extended to both races. However, the black/white disparity ratio shows that there exists room for improvement with blacks remaining more likely than whites to die of heart disease.

Figure 3.7
Heart Disease Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 3.8
Heart Disease Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

Starting in 1982-86 there were disparities of over 100 more deaths per 100,000 between blacks and whites. The ratio between the two races slowly started to decrease between 1982-86 and 1991-95 where they became virtually even. Around 1996-00 there was a steep increase in the amount of deaths per 100,000 in blacks, which caused an increase in the black/white ratio. Since then, both blacks and whites have been decreasing with the black/white ratio slowly decreasing again. The sporadic behavior of the black/white ratio may be partially due to the small black population in Sussex County.

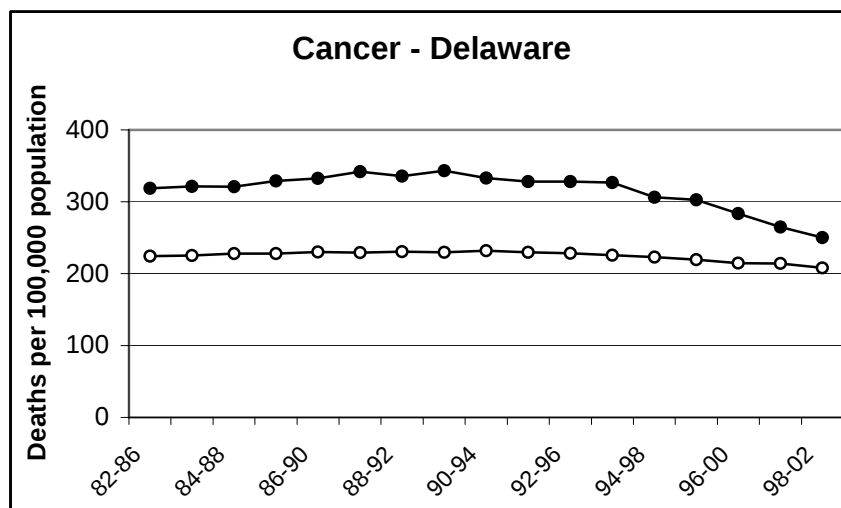
Cancer

The black/white disparity ratio for cancer in Delaware has been greatly improved from 1997 to 2002. The ratio was at 1.45 in 1997 but has now been reduced to 1.20 in 2002. This small decrease in disparity will have a large effect because of the unusually high cancer rates in Delaware. There was a brief increase in the amount of black deaths in the state during the mid-eighties to early nineties but since then there has been a gradual decrease, while the amount of white deaths has remained fairly consistent.

Delaware's black/white disparity ratio at 1.20 is slightly lower than that of the United States at 1.25. Delaware has shown vast improvements state wide in the last 6 years in the rate blacks are dying of cancer, but still needs to improve the overall death rate for all races.

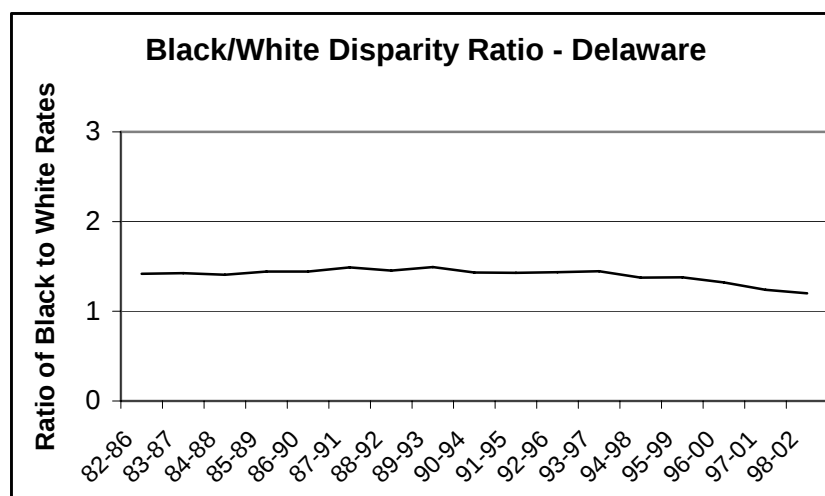
Kent and Sussex counties had sporadic changes in the deaths from cancer between 1988 and 1995. New Castle County mimicked the state with blacks showing steady improvements in the last ten years, while whites showed improvement by moving from 232 to 209.2 deaths per 100,000.

Figure 4.1
Cancer Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

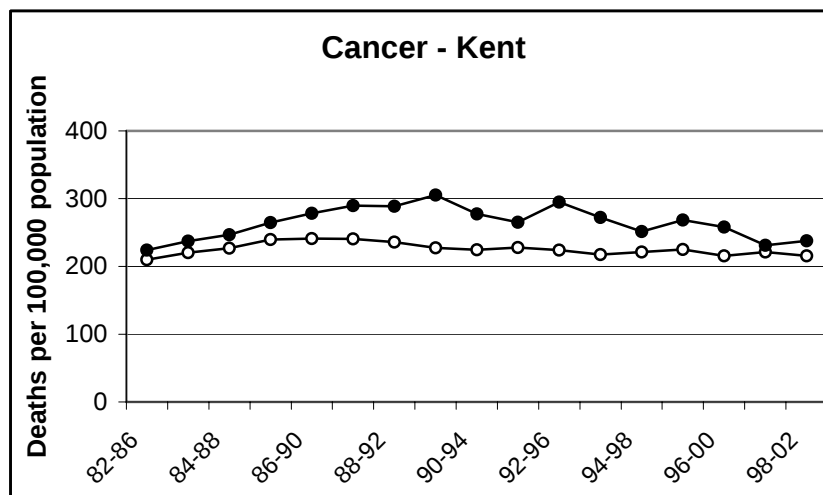
Figure 4.2
Cancer Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

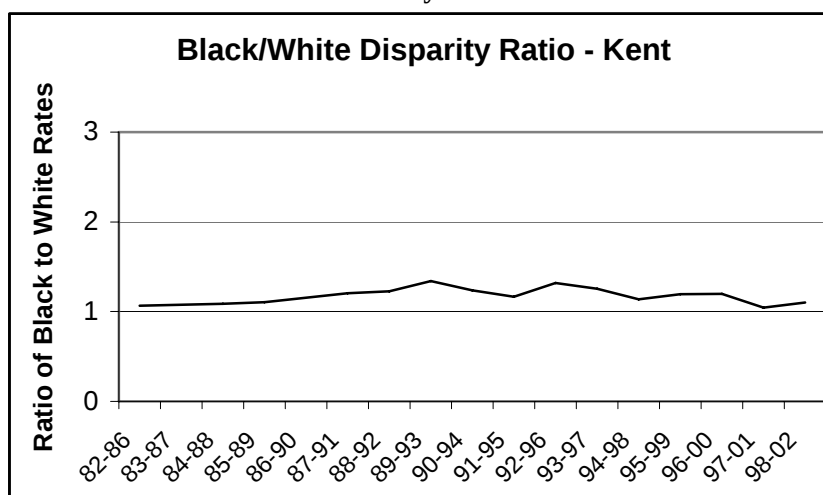
In 1982-86 there were over 100 more deaths by blacks per 100,000 than whites due to cancer in Delaware. This trend continued until 1994-98 where the ratio slowly started to decline. The amount of deaths by cancer from whites has remained static since 1982-86 to the present, hovering around 200 deaths per 100,000, while blacks have started to make a steady improvement in cancer deaths since 1995-99. The black/white disparity ratio has steadily been declining for the past five years.

Figure 4.3
Cancer Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

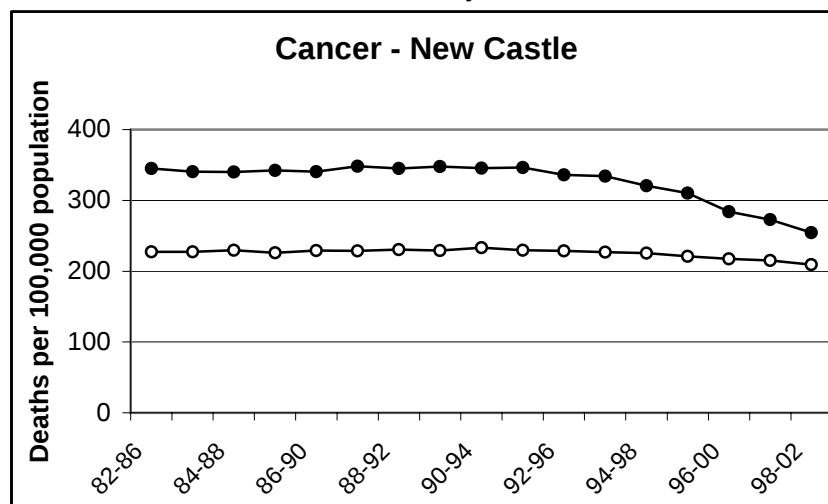
Figure 4.4
Cancer Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

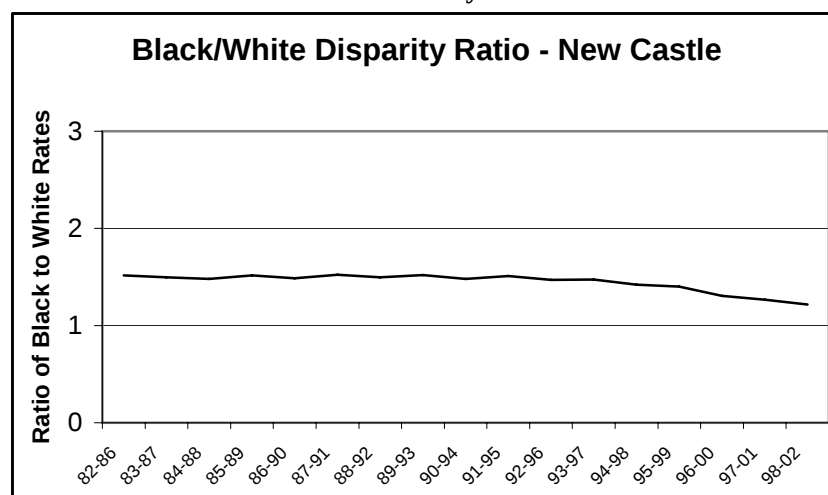
The death rates of blacks and whites were relatively even in 1982-86 but then started to gradually grow apart as cancer deaths increased in the county. The increase in deaths for whites was halted and started to decline in 1986-90. Black cancer death rates continued to increase for another three years before finally starting to decline. Because of the sporadic jumps in cancer deaths for blacks, the black/white disparity ratio is characterized by up and down peaks until finally starting to level off around 1.1 disparity between blacks and whites.

Figure 4.5
Cancer Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

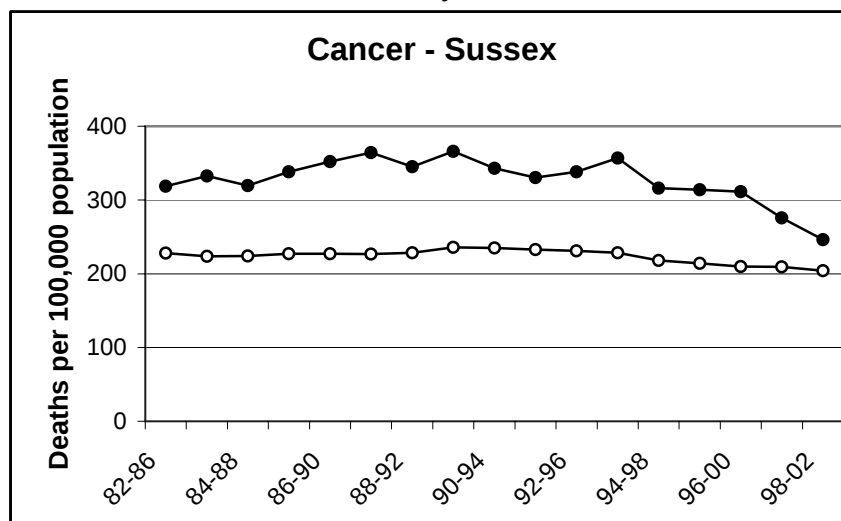
Figure 4.6
Cancer Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

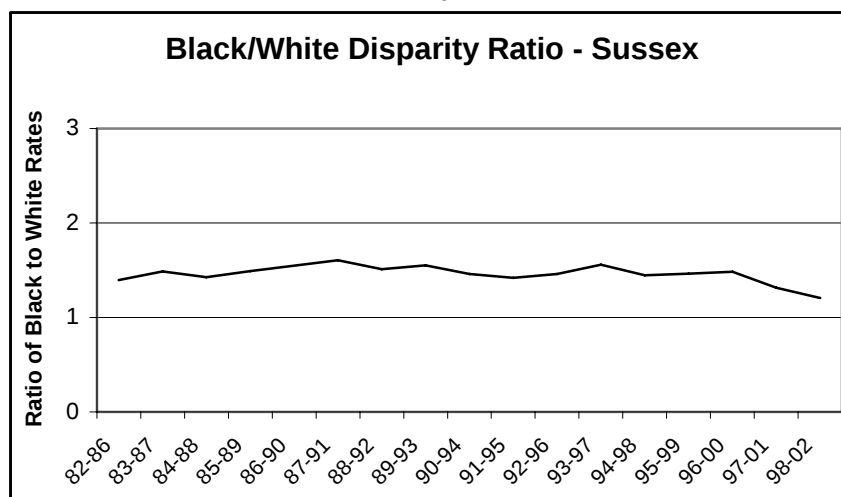
From 1982-86 to 1991-95 there was a gap of over 100 more cancer deaths per 100,000 for blacks than for whites in New Castle County. This trend continued until a steep decline started in 1992-96, which is still continuing today. Because there was a significant gap in cancer deaths, the black/white disparity ratio hovered around 1.5 for much of the time but has now started to decrease steadily since 1992-96. There has been little change in the cancer rates for whites from 1982 to 2002 in New Castle County, where the number of deaths has only been reduced from 232 to 209.4 deaths per 100,000.

Figure 4.7
Cancer Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 4.8
Cancer Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

The cancer death rate for blacks between 1982 and 1997 was very sporadic showing a lot of up and down movement, but showing little progress. The cancer death rate for blacks started to level out and eventually decline around 1998. The cancer death rates for whites remained stagnant at just over 200 deaths per 100,000 during the previous twenty years. Because the cancer death rate for blacks was erratic and the white death rate was stationary, the black/white disparity ratio also reflected that with several peaks until the ratio gradually started to decline around 1996-2000.

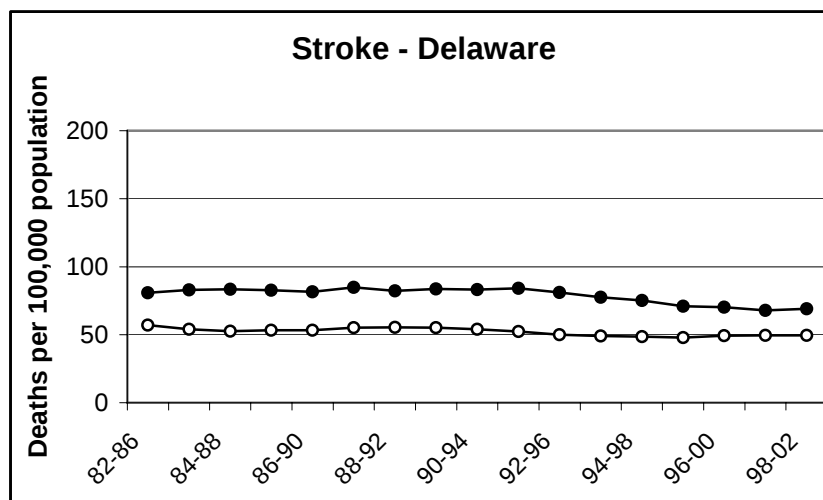
Stroke

As the third leading killer in Delaware, stroke has shown only a small improvement in the number of deaths for both blacks and whites in the past 20 years. Despite these small changes, the black/white disparity ratio has improved slightly since 1997. The 1997 disparity ratio was 1.57 and the 2002 ratio is 1.39.

The U.S. black/white disparity ratio at 1.40 is virtually even with the Delaware disparity ratio at 1.39. While Delaware is even with the United States, there is still much to improve because there has been very little change in the amount of deaths, unlike many of the other diseases.

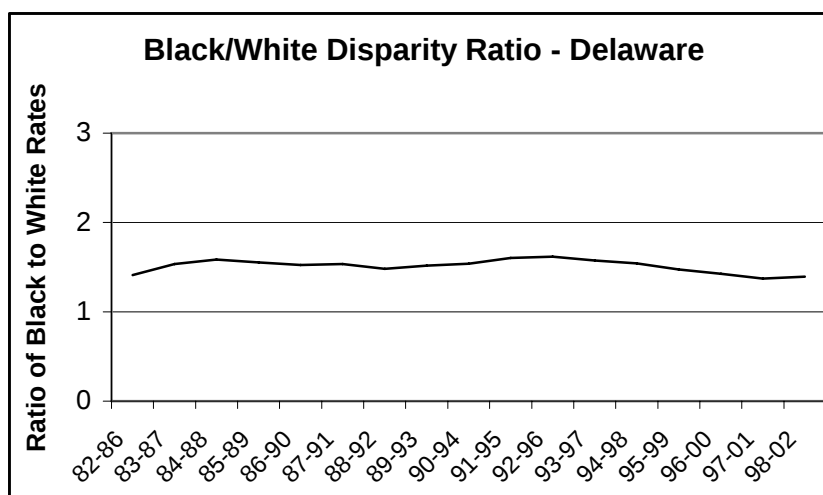
Kent County blacks had a large increase in stroke deaths between 1988 and 1993. Starting in 1994, the death rates declined back to rates that were comparable to that of whites. Sussex County has made vast improvements in both the number of stroke deaths and the black/white disparity ratio in the past 20 years. Sussex has gone from disparity ratios that were above 2 to levels that are well below the national average.

Figure 5.1
Stroke Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

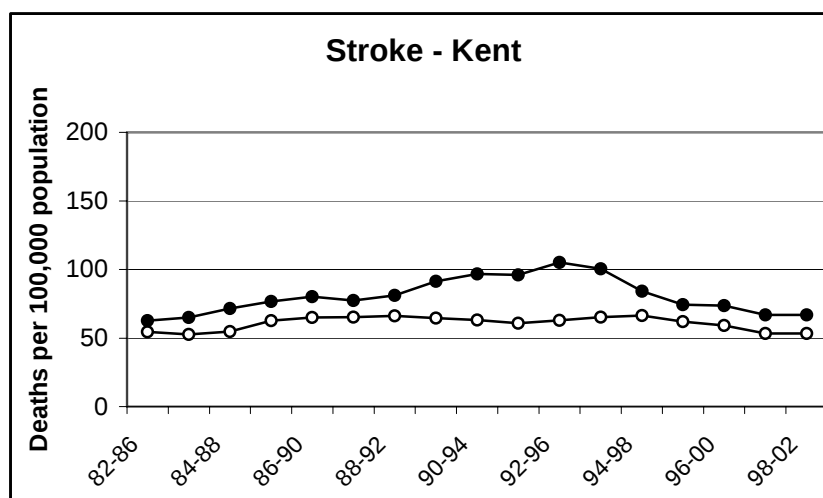
Figure 5.2
Stroke Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

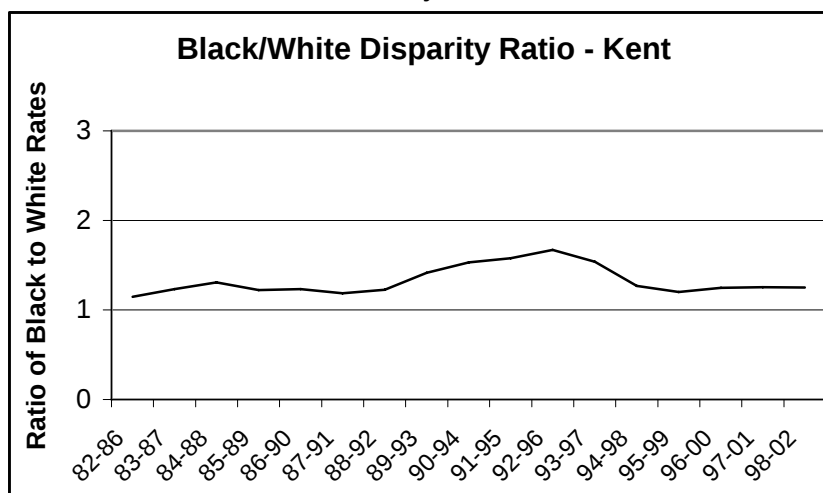
From 1982-86 to 1991-95, there was a difference of about 25 more stroke deaths per year for blacks than for whites in Delaware. The stroke deaths for blacks gradually started to decrease in 1996 and have steadily moved closer to the death rates of whites. The black/white disparity ratio remained around 1.5 for most of the last twenty years and has recently started to decline somewhat. The number of stroke deaths for whites has remained around 50 per 100,000 in Delaware for the last twenty years, while the blacks have shown improvement in the last five years.

Figure 5.3
Stroke Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

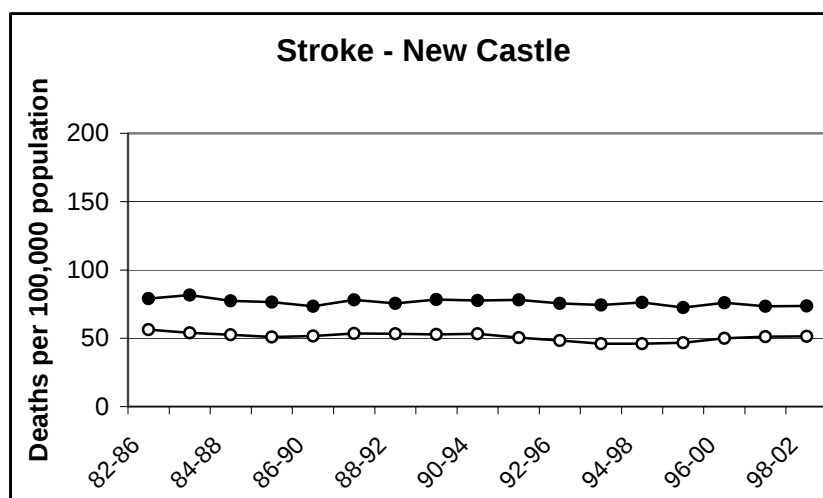
Figure 5.4
Stroke Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

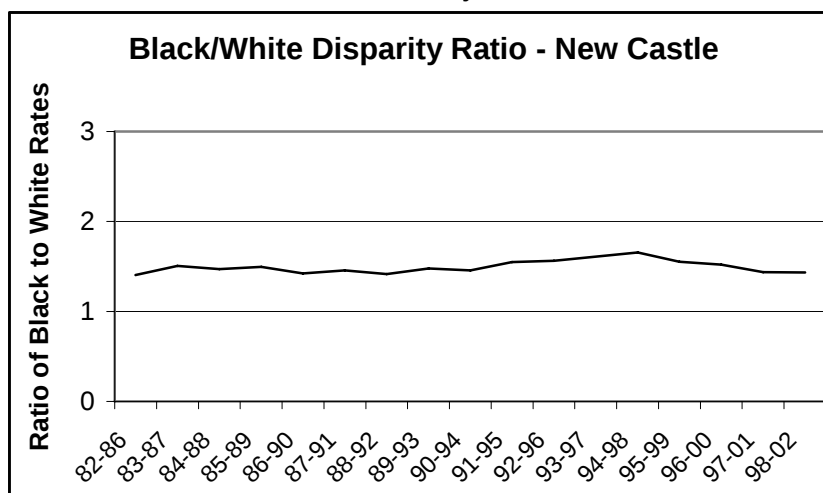
While blacks had slightly higher rates of death than whites, the two races mirrored each other from 1982-86 to 1987-91, until there was a sharp increase in the amount of stroke deaths for blacks. The increase lasted for five years and then gradually moved back to the level that was previously sustained. Again, the amount of stroke deaths for whites remained stable. Because of the spike of black stroke deaths in the middle five years, there was a large spike in the black/white disparity ratio. Besides the spike in deaths, the black/white disparity ratio remained close to 1.25.

Figure 5.5
Stroke Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

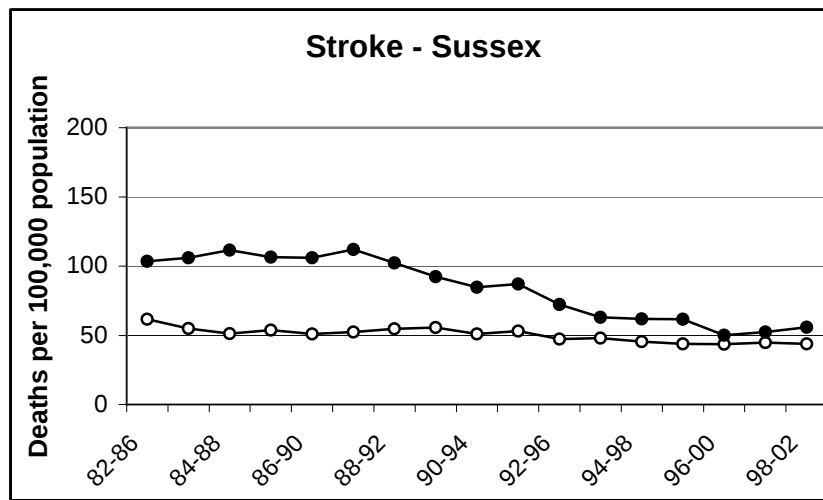
Figure 5.6
Stroke Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

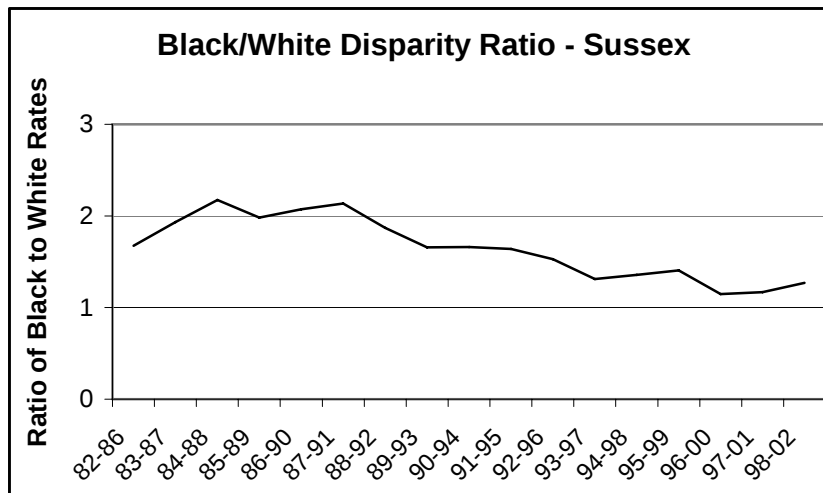
The stroke death rates in New Castle remained the same for all twenty years with a separation of about 25 additional black stroke deaths per 100,000. Both blacks and whites remained at the same level, which in turn led to the black/white disparity ratio being rather stagnant for all twenty years with only one small peak happening around 1994-98. The stroke death rates of New Castle County closely resemble those of the entire state most likely because there is more of a representative sample of blacks in New Castle than in the other two counties.

Figure 5.7
Stroke Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 5.8
Stroke Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

Sussex County has shown the most dramatic improvements of all three counties with stroke death rates for blacks. In 1982-86 Sussex had the largest difference in the counties with 50 more black stroke deaths than whites per 100,000. By 1998-2002 they are almost even in the amount of deaths per 100,000. The black/white disparity ratio also does a good job of showing the lengths to which Sussex has gone to improve the disparity between races in stroke deaths. There were times where the black/white disparity ratio was higher than two and it is now very close to being even at one.

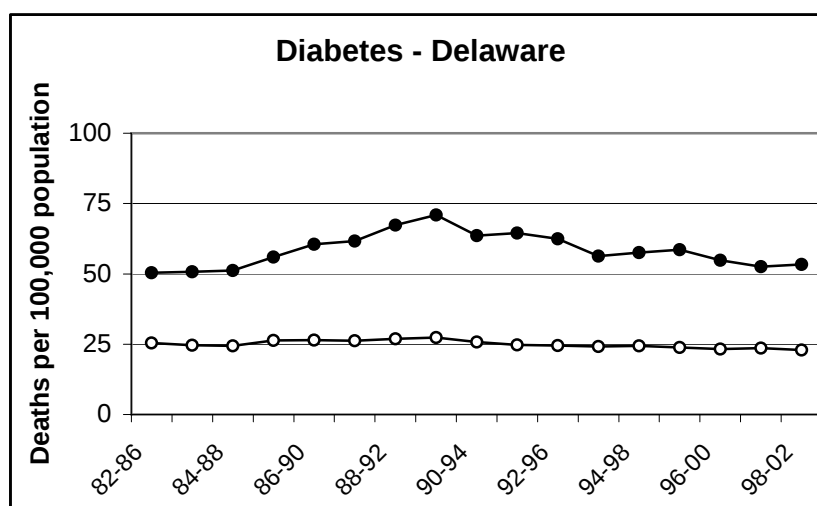
Diabetes

Between 1984 and 1989, there was a sharp increase in the amount of deaths attributed to diabetes for blacks in Delaware, while whites showed little or no change. This caused an increase in the black/white disparity ratio, which is still very high. There was no change in the disparity ratio from 1997 to 2002 with both years at 2.33, meaning Delaware blacks are more than twice as likely to die of diabetes as Delaware whites.

The Delaware disparity ratio is higher than the U.S. disparity ratio of 2.14. This is especially concerning because of the lack of improvement in the amount of deaths for both blacks and whites. While there was a significant jump in the mid to late eighties, Delaware blacks are dying of diabetes at the same rates they were 20 years ago.

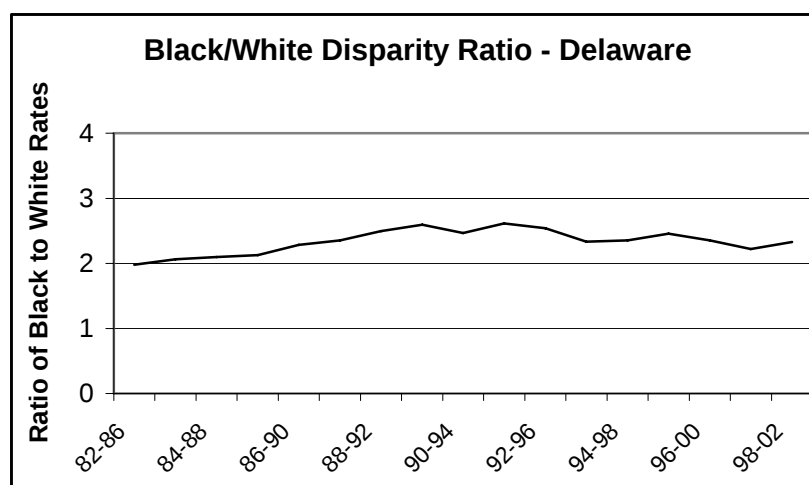
Kent County experienced the same jump in diabetes deaths that the state did but has shown gradual improvement in the black/white disparity ratio. New Castle County has also had sporadic highs and lows in both deaths and the disparity ratio but has leveled off since 1997. Sussex County has had very little success in controlling the diabetes rates of blacks with increasing death rates and increasing disparity ratios.

Figure 6.1
Diabetes Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

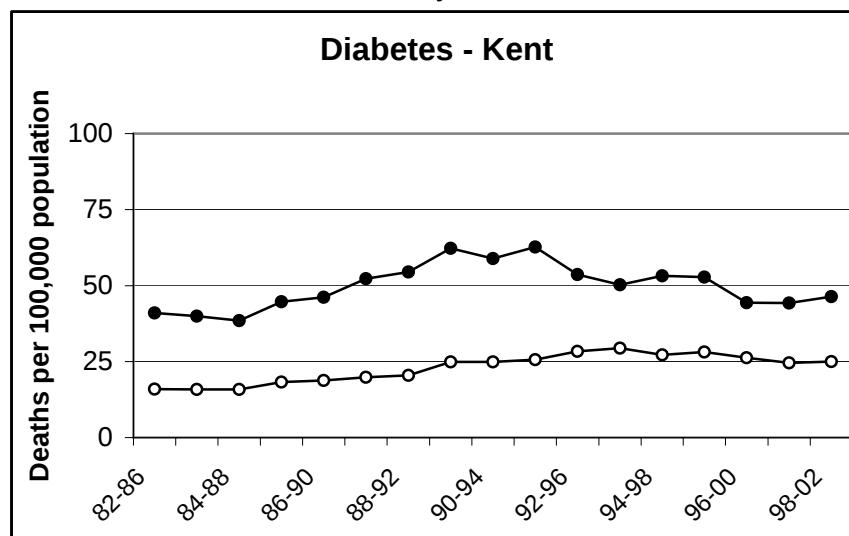
Figure 6.2
Diabetes Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

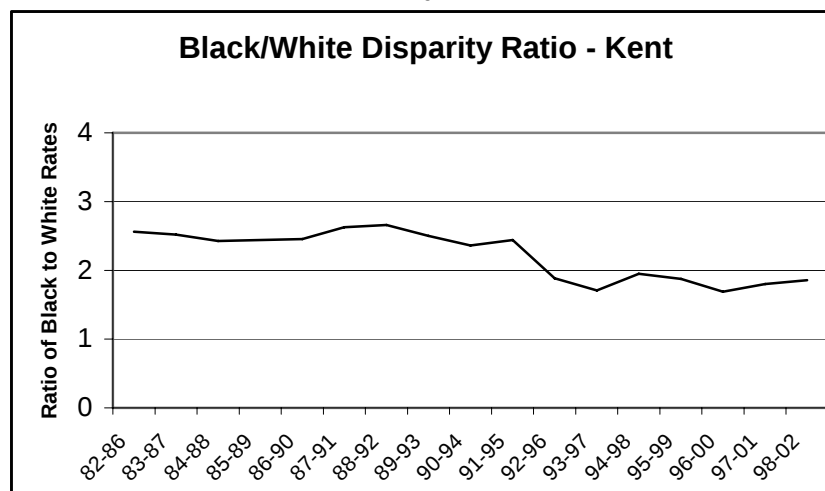
While death rates for whites have remained around 25 per 100,000 for the last twenty years, death rates for blacks have not improved at all. In fact there was a sharp increase in diabetes deaths from 1985-89 to 1993-97 in blacks and has since come back down to the previous rate around 50 deaths per 100,000. Because of the higher rate of diabetes deaths for blacks, they are more than twice as likely as whites to die from diabetes, as stated in the black/white disparity ratio. There have been slight ups and downs in the ratio but it has consistently been double that of whites.

Figure 6.3
Diabetes Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

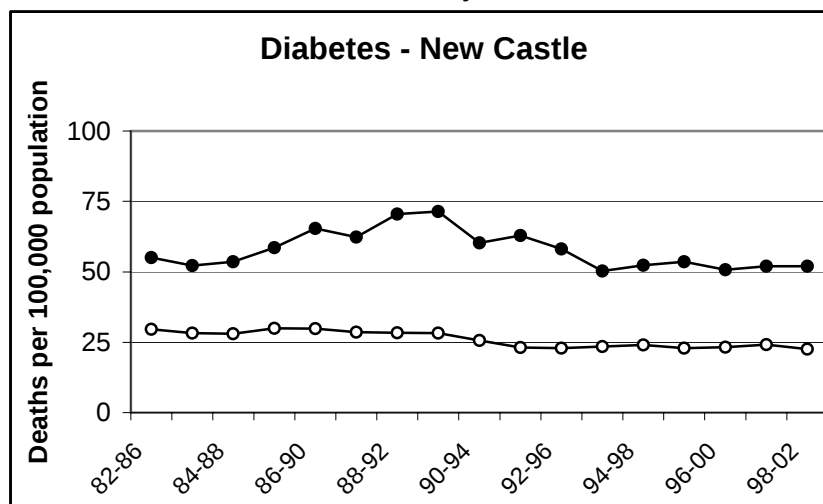
Figure 6.4
Diabetes Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

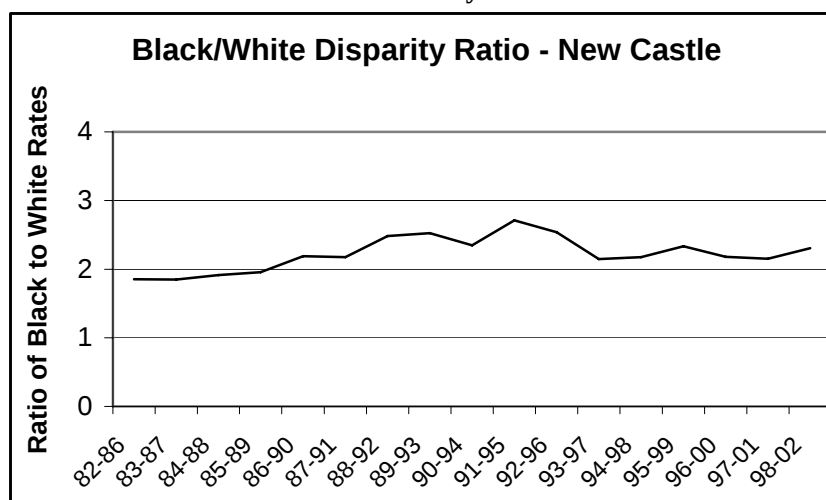
The death rate from diabetes for both blacks and whites was at its lowest in 1982-86 and has risen steadily. Even when the diabetes death rate for blacks was at its lowest in 1982-86, blacks were still 2.5 times more likely than whites to die from diabetes. Despite the increases of death from diabetes for blacks, the black/white disparity ratio slowly decreased until it settled at blacks being twice as likely as whites to die from diabetes.

Figure 6.5
Diabetes Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

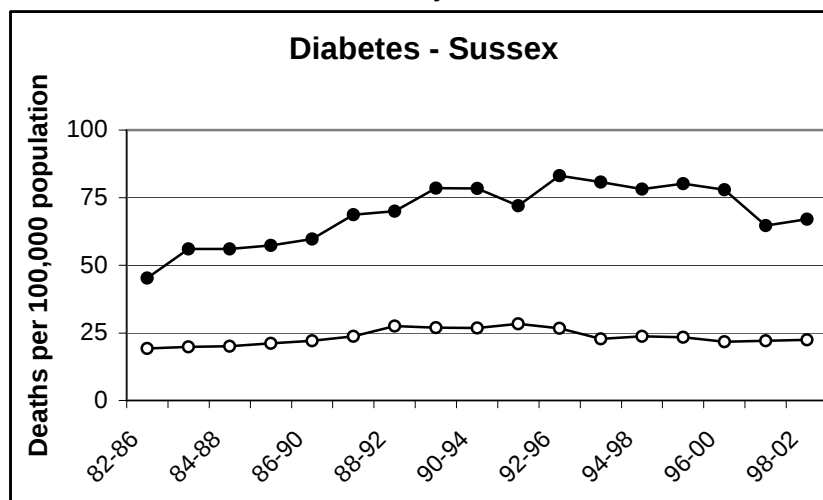
Figure 6.6
Diabetes Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

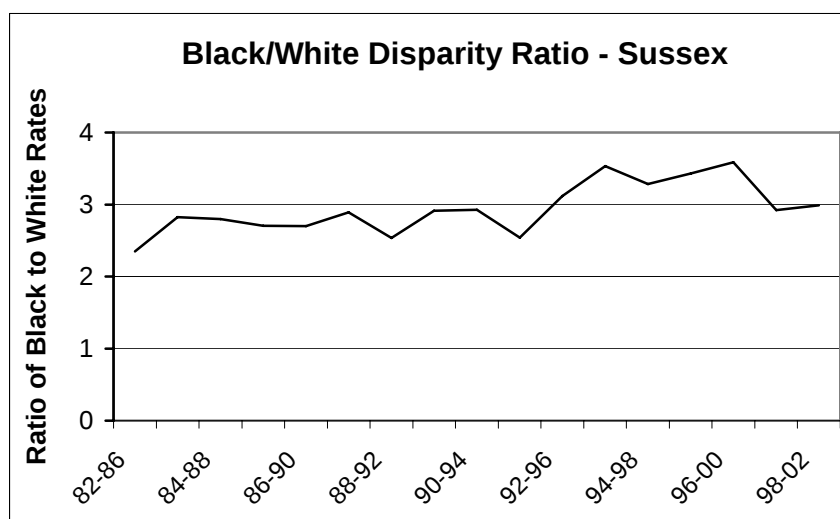
While diabetes death rates were consistent for whites during the twenty years, blacks experienced ups and downs during the first fifteen years. Because diabetes rates of death flattened for blacks in the previous five years, they have not made any gains in the black/white disparity ratio and have even lost ground in the previous year. Again, the death rates of New Castle closely mirror those of the state, most likely because of the more diverse population that is more representative of the state.

Figure 6.7
Diabetes Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 6.8
Diabetes Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

Like Kent County, Sussex was at its lowest diabetes death rates from 1982-86 and has steadily increased for blacks ever since. At this point the black/white disparity ratio shows that blacks in Sussex County are three times more likely to die from diabetes than whites. The diabetes rate of death for whites has consistently hovered around 25 per 100,000 while about 75 blacks per 100,000 are dying from diabetes. The death rate for blacks in Sussex is about 25 deaths higher per 100,000 than the state average for blacks.

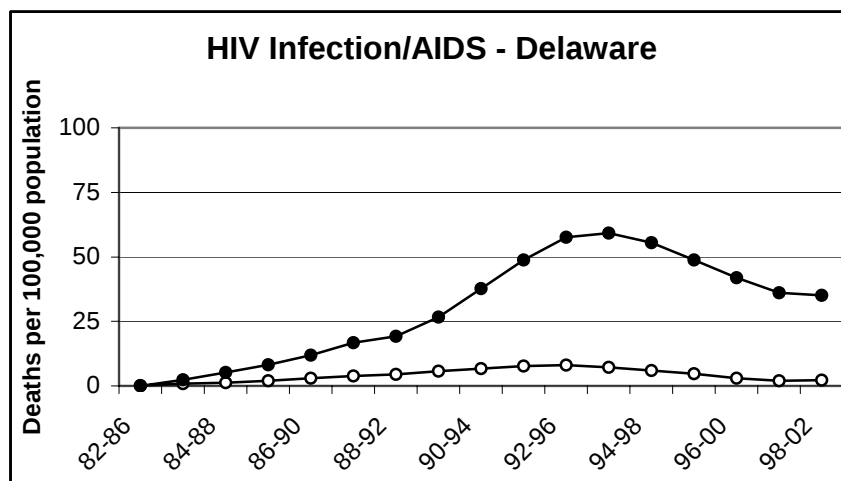
HIV Infection/AIDS

Delaware blacks had gradual increases in the HIV Infection/AIDS, which then led to sharp increases until 1997, when the death rates started to decrease. Whites maintained significantly lower levels of deaths than blacks, which led to large increases in the black/white ratio in Delaware. The disparity ratio in 2002 at 15.56 is almost double the 1997 ratio (8.23) despite the decreases in death rates for blacks in the last five years.

Delaware's disparity ratio is significantly higher than the U.S. disparity ratio at 8.65. This high ratio is most likely attributed to the very low death rate of Delaware whites coupled with extremely high death rates for Delaware blacks.

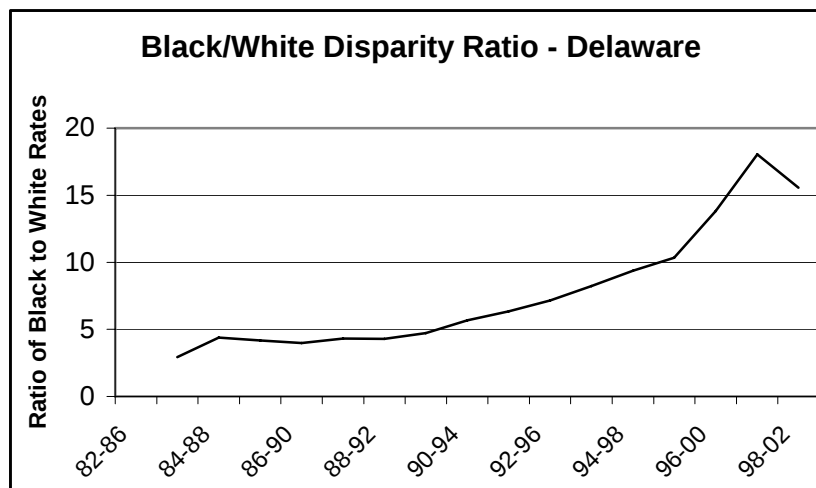
Kent County had a disparity ratio around 5 until 1992 but then saw sharp increases that are consistent with the rates for the entire state. New Castle County showed large increases that mirrored the states but did have higher death rates than Delaware. Compared to the rest of Delaware, Sussex had significantly lower death rates for both whites and blacks, which led to lower disparity rates than the other counties.

Figure 7.1
HIV Infection/AIDS Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

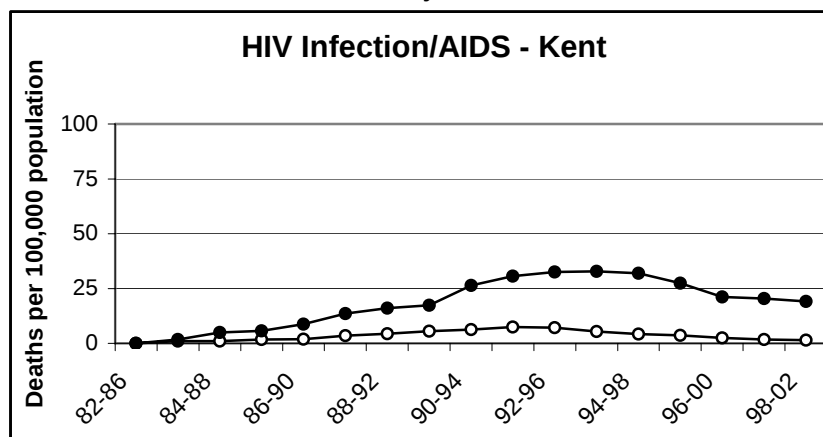
Figure 7.2
HIV Infection/AIDS Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

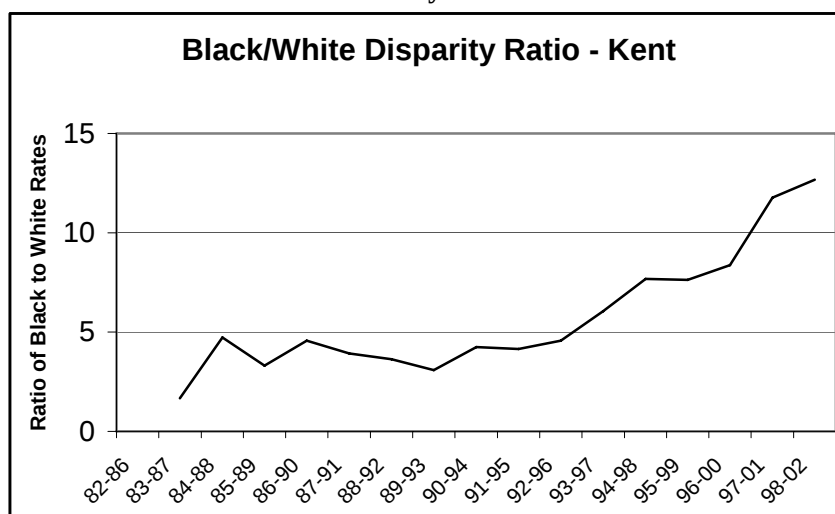
Measurable death rates for HIV Infection/AIDS did not start until 1984-88. Since that point Delaware saw a steep increase of HIV Infection/AIDS death rates in blacks and saw only a marginal increase in the white population. The HIV Infection /AIDS rates peaked in 1993-97 for blacks and since have steadily declined. However, the black/white disparity ratio has continued to climb since 1984-88 and has since peaked at a ratio of fifteen, meaning that blacks are fifteen times more likely than whites to die from HIV Infection/AIDS in Delaware. The deaths per 100,000 for whites in Delaware have never been over 10 per year, which is a likely explanation for the high ratio.

Figure 7.3
HIV Infection/AIDS Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

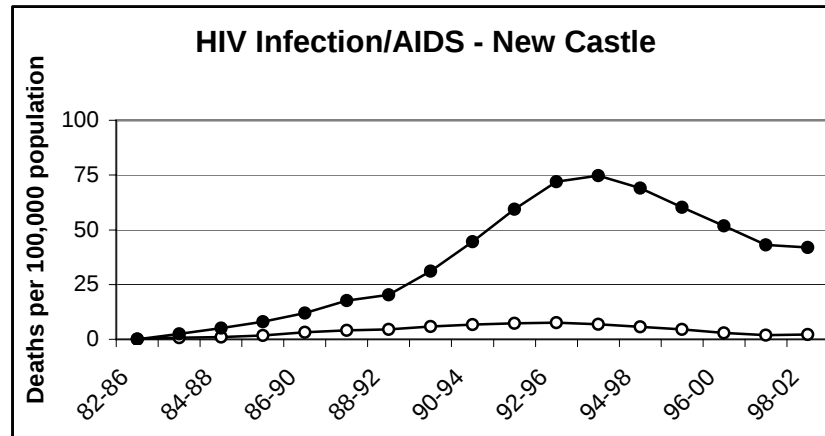
Figure 7.4
HIV Infection/AIDS Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

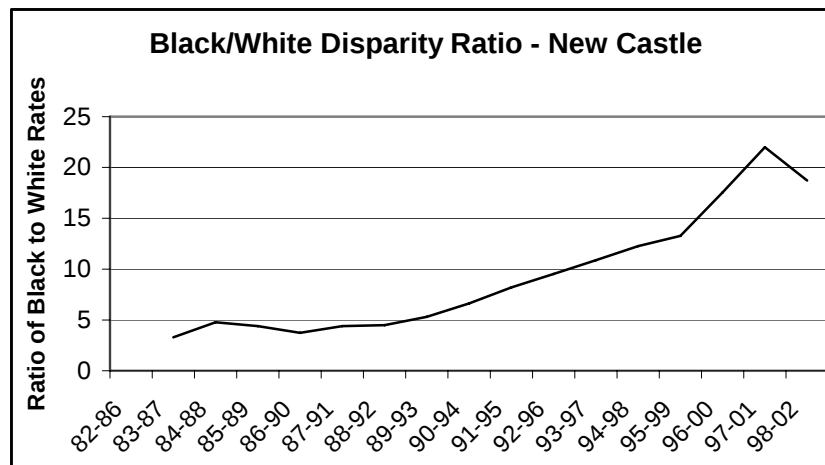
Starting in 1985-89, there started to grow a measurable difference between the black and white death rates from HIV Infection/AIDS in Kent County. Since then, there has been a steady increase in the black/white disparity ratio, which is now around 13 for Kent. Whites maintained a fairly low level of HIV Infection/AIDS deaths and closely resembled the death rates of the state, while black HIV Infection/AIDS deaths gradually increased until around 1993-97 also mirroring the state. The very low number of HIV Infection/AIDS deaths for whites most likely explains the large black/white disparity ratio.

Figure 7.5
HIV Infection/AIDS Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

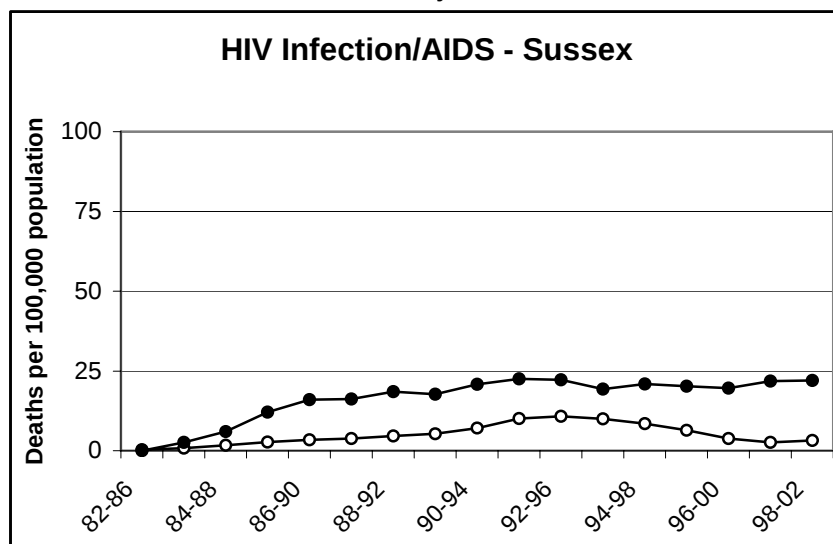
Figure 7.6
HIV Infection/AIDS Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

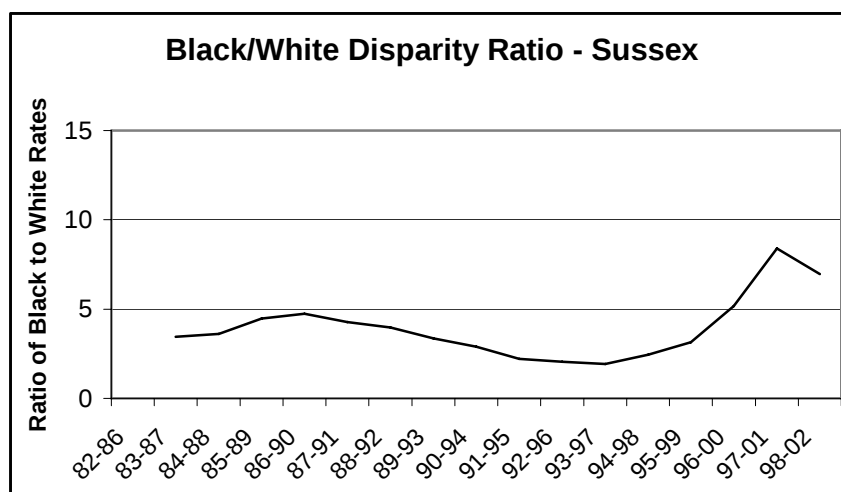
Similar to Delaware and Kent County, New Castle County blacks started to show increases in the HIV Infection/AIDS in 1985-89 and rapidly increased until 1993-97, reaching 75 deaths per 100,000 New Castle blacks. The number of black deaths from HIV Infection/AIDS has slowly started to decrease but so has the number of white deaths. Because of this, the black/white disparity ratio rapidly increased to levels that are above 20. While the black/white disparity ratio has been extremely high, blacks have started to show some signs of improving by decreasing from 21.9 in 97-01 to 18.7 in 98-02.

Figure 7.7
HIV Infection/AIDS Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 7.8
HIV Infection/AIDS Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

Unlike the rest of the state, Sussex showed only gradual increases in HIV Infection/AIDS death rates for blacks. The death rates for whites were similar to that of the rest of the state, never reaching above 10 per 100,000. Since 1991-95 blacks have hovered around 25 deaths per 100,000, while whites have shown a steady decline in the HIV Infection/AIDS deaths per 100,000. Because of the slight decline in deaths for whites, the black/white disparity ratio is still significantly higher but has started to decrease since 1997-2001.

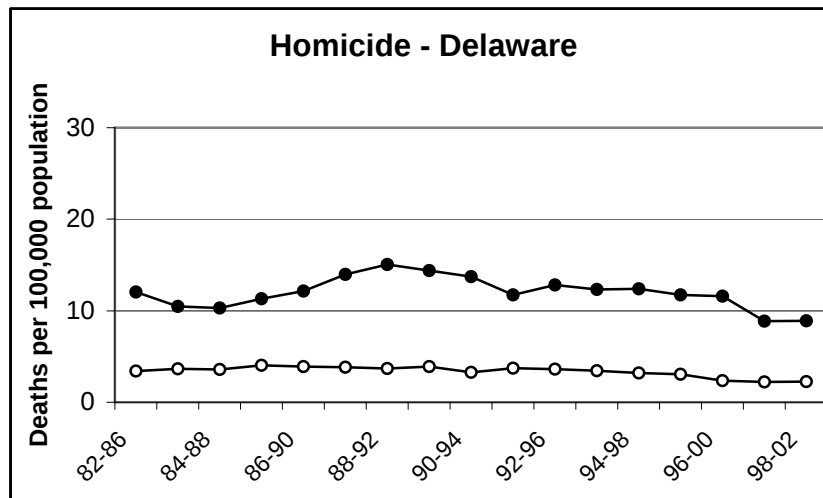
Homicide

Delaware whites have had slightly declining homicide death rates since 1995, while Delaware blacks have shown more steady declines since 1992. This had little effect on the black/white disparity ratio as it has moved up and down, never deviating too far from a ratio of 4. While Delaware blacks have made some significant gains, the very low rate of white homicides keeps the disparity ratio fairly high. The disparity ratio has actually increased since 1997 from 3.56 to 3.94 in 2002.

Despite increases in the disparity ratio, Delaware is well below the national black/white disparity ratio at 5.67. Even with Delaware's high violent crime rate, the disparity ratio is consistently lower than the national average disparity ratio.

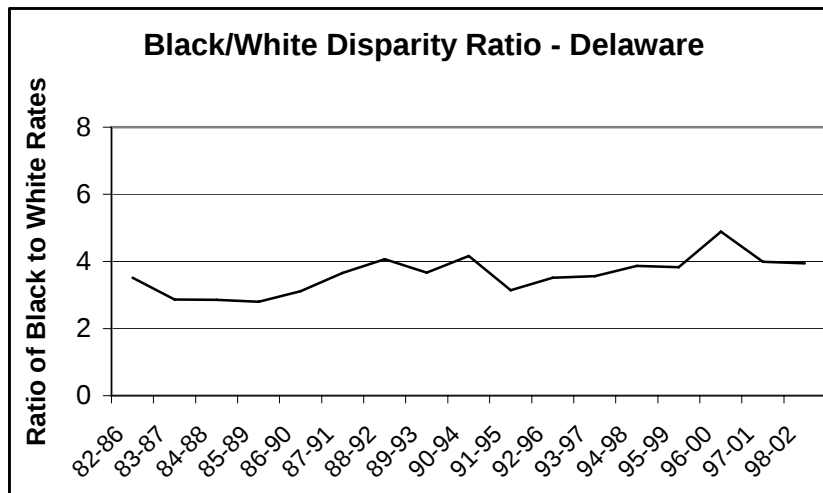
Kent County has had a very low black/white disparity ratio for the last twenty years and posted a ratio less than 1 in 2002, meaning whites are more likely to die from homicide than blacks. New Castle County posted similar disparity ratios to the state, with up and down numbers that linger around 4. While Sussex County's disparity ratio has shown little improvement, there has been drastic improvement in the death rate of blacks in the county.

Figure 8.1
Homicide Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

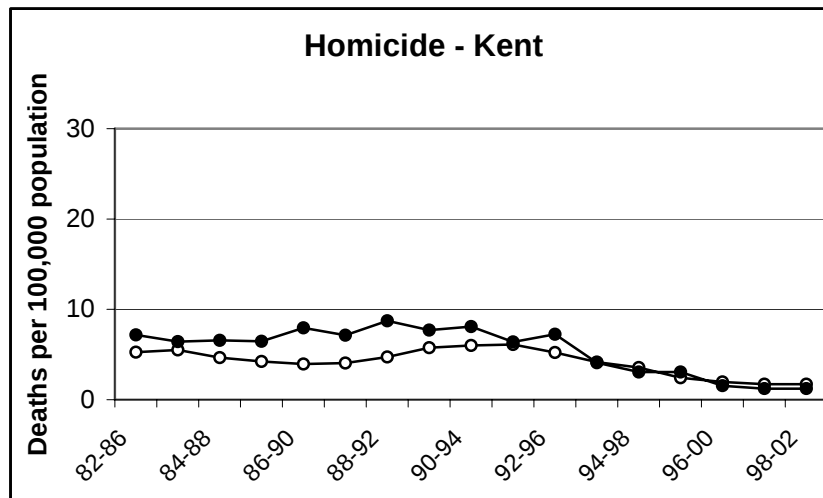
Figure 8.2
Homicide Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

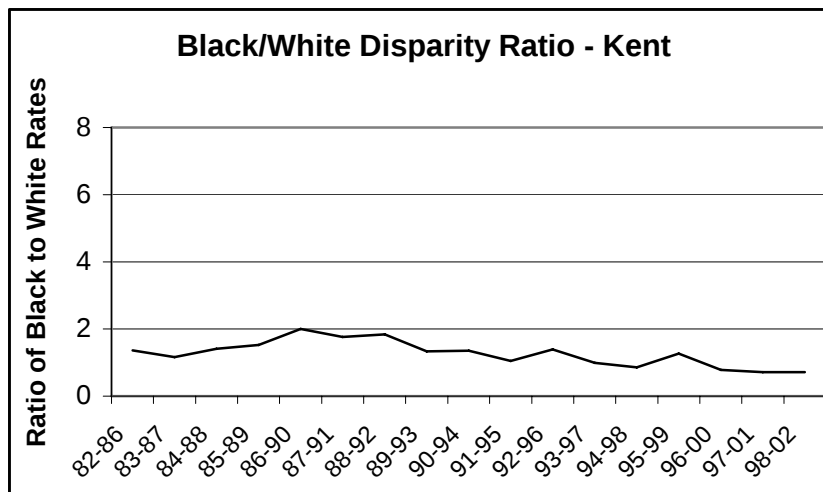
Since 1982-86 homicide death rates for whites have remained fairly constant in Delaware staying between 2.3 and 4.0 per 100,000. The number of black homicides has been up and down for the past twenty years with the rate leveling out slightly fewer than 10 deaths per 100,000. The black/white disparity ratio for Delaware has fluctuated due to the inconsistency of the black homicides year to year but has leveled out with blacks being about four times more likely to die from homicide than whites.

Figure 8.3
Homicide Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

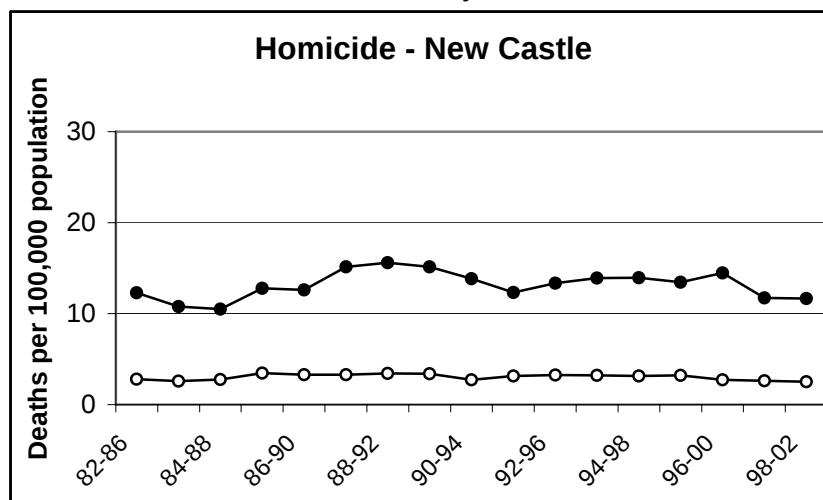
Figure 8.4
Homicide Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

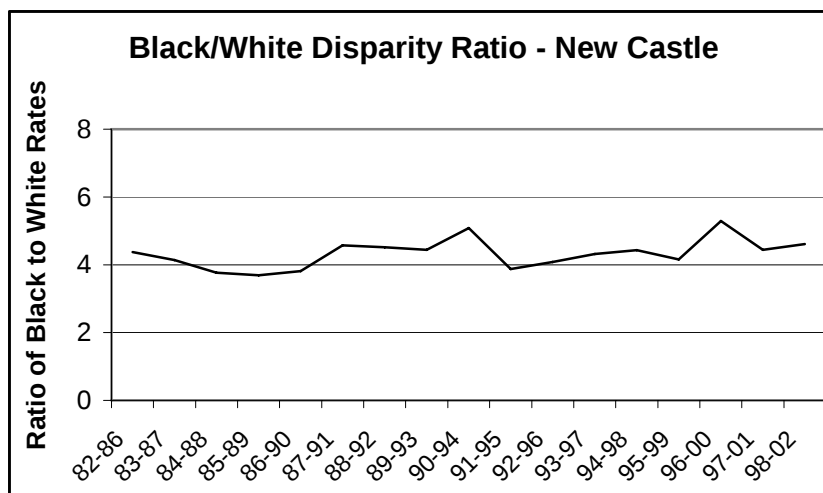
Despite the discouraging rates for the state, Kent County has shown very encouraging homicide death rates with very low levels for both blacks and whites. Around 1988-92 blacks started to decrease the amount of homicide deaths in Kent County until they were virtually even with whites. In fact the black/white disparity ratio is actually below one, showing that more whites die from homicides in Kent County than blacks per 100,000. It is important to note that both homicide death rates are below 2 per 100,000.

Figure 8.5
Homicide Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

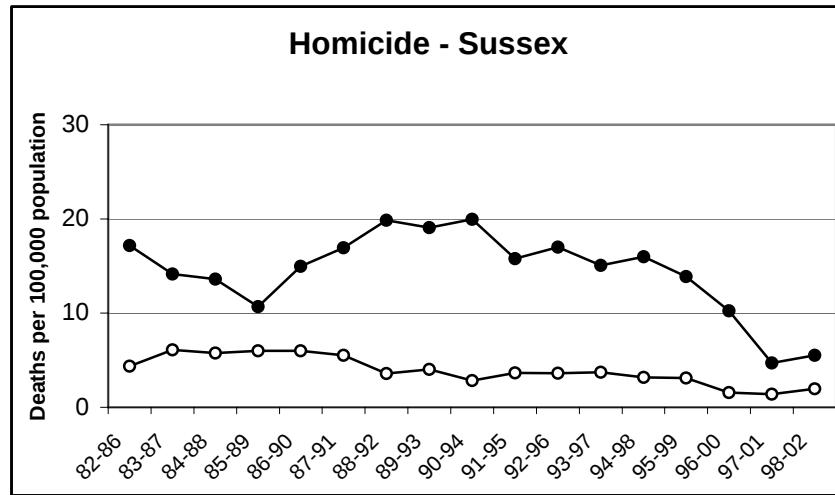
Figure 8.6
Homicide Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

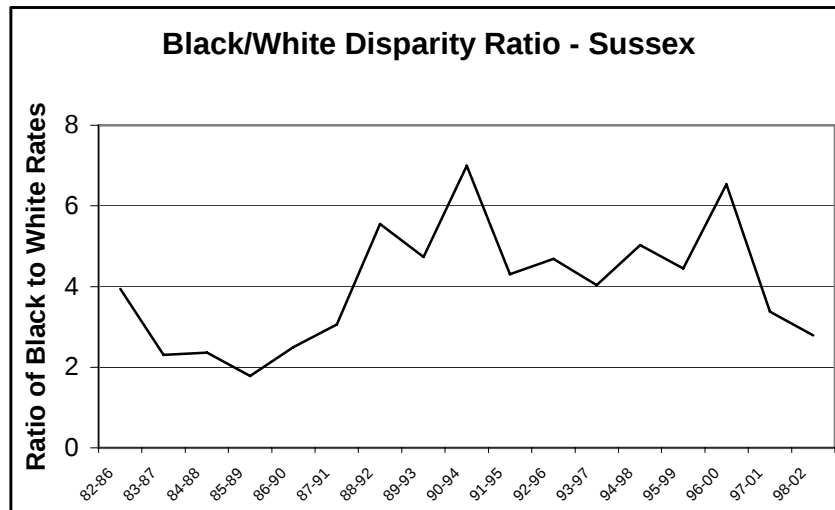
While the rate of death from homicide for whites has remained stable for the past twenty years in New Castle County, the homicide death rate for blacks has moved both up and down but never dipping below 10 deaths per 100,000. Because of the slight ups and downs, the black/white disparity ratio also has shown peaks and valleys until finally settling at blacks being four times more likely in New Castle County to die from homicide than whites.

Figure 8.7
Homicide Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 8.8
Homicide Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

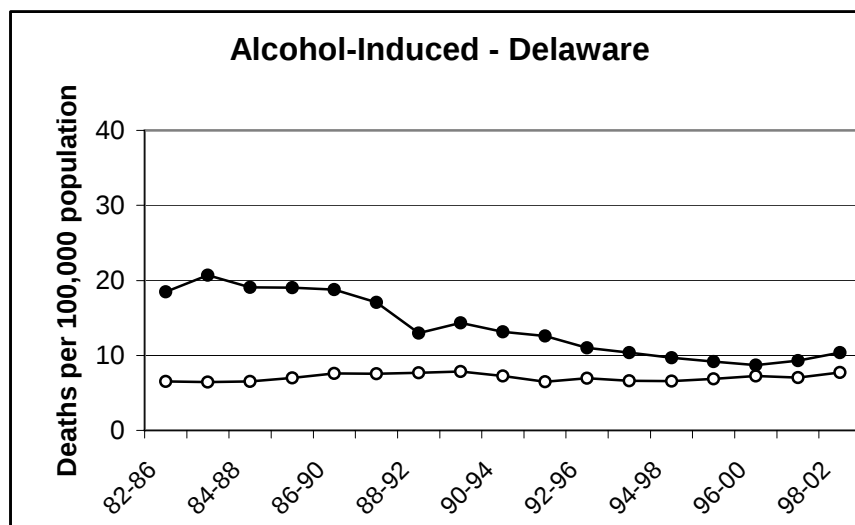
Like previous death rate models for Sussex, the homicide rate for blacks is sporadic and shows dramatic increases and decreases. Also holding to form, the white homicide rate in Sussex remained consistently low compared to blacks. The death rates of blacks coupled with the consistent death rates of whites created an erratic black/white disparity ratio over the last thirteen years. Although there have been dramatic improvements in the last five years, both the homicide rates and black/white disparity ratio have decreased dramatically in Sussex County.

Alcohol-Induced Deaths

Delaware blacks made steady progress from 1983 to 1989 in the amount of alcohol-induced deaths, while white deaths gradually increased over the last twenty years. The black/white ratio for alcohol-induced deaths in Delaware was slightly over 3 in 1983 but since has shown a steady improvement to a ratio that is currently around 1. This is characterized by the improvements of the 1997 black/white ratio of 1.57 and the 2002 ratio of 1.34.

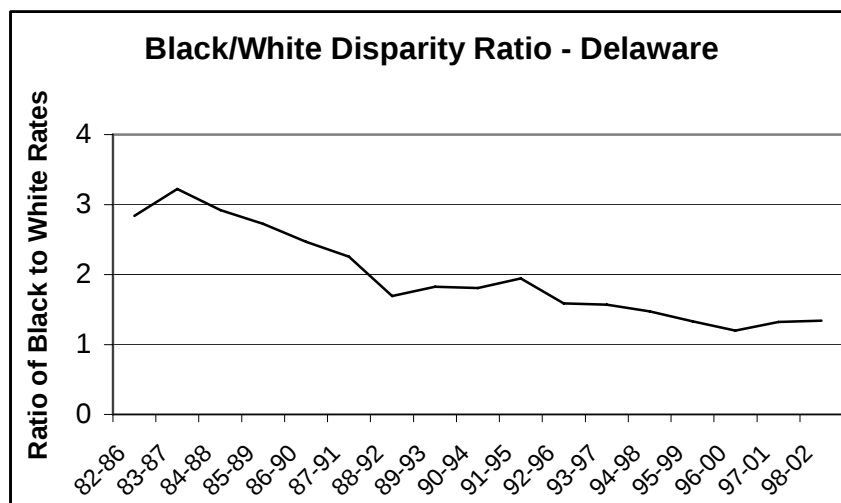
Kent County has had vast improvements in both the death rates and the black/white disparity ratio since 1994. Previous to 1994, the black/white disparity ratio lingered around 2.5 but has since declined dramatically to a ratio that is below 1. Again, New Castle County had a similar pattern to Delaware, with sharp declines starting in 1989 in both alcohol-induced death rates and black/white disparity ratio. Sussex County had large increases from 1984 to 1990 in black alcohol-induced deaths but has since declined dramatically to levels comparable to whites in the county.

Figure 9.1
Alcohol-Induced Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

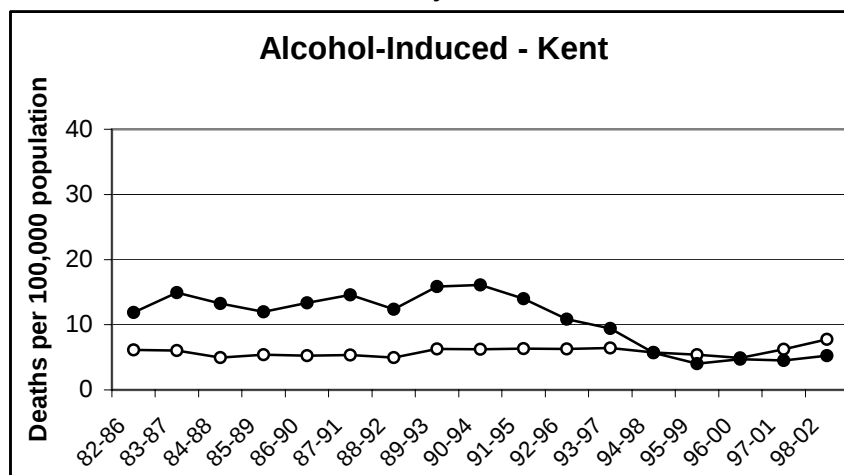
Figure 9.2
Alcohol-Induced Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

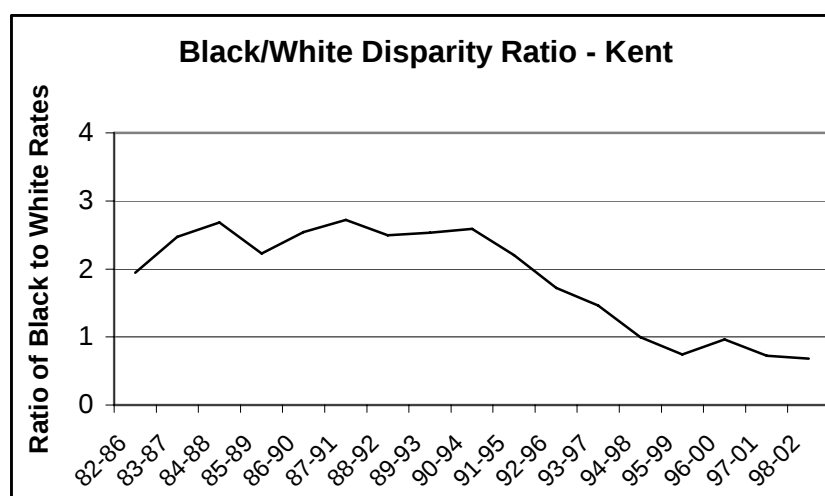
In 1982-86 blacks were about three times more likely in Delaware to die from an alcohol-induced incident than whites. For the next twenty years, the death rate for whites had little variance, while the death rate for blacks made steady improvements. This was also reflected in the black/white disparity ratio with a gradual decline to the present day number, which has dropped to about 1.34. In the past two years, there has been a slight increase in alcohol-induced deaths of both blacks and whites.

Figure 9.3
Alcohol-Induced Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

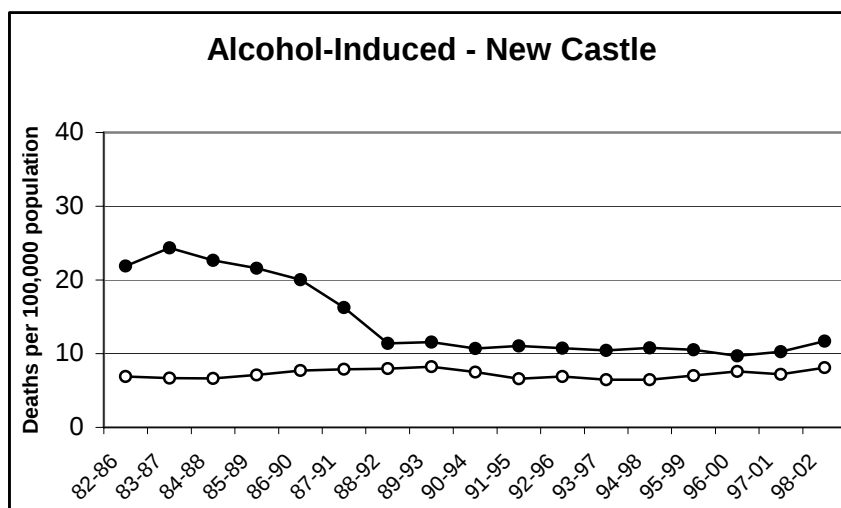
Figure 9.4
Alcohol-Induced Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

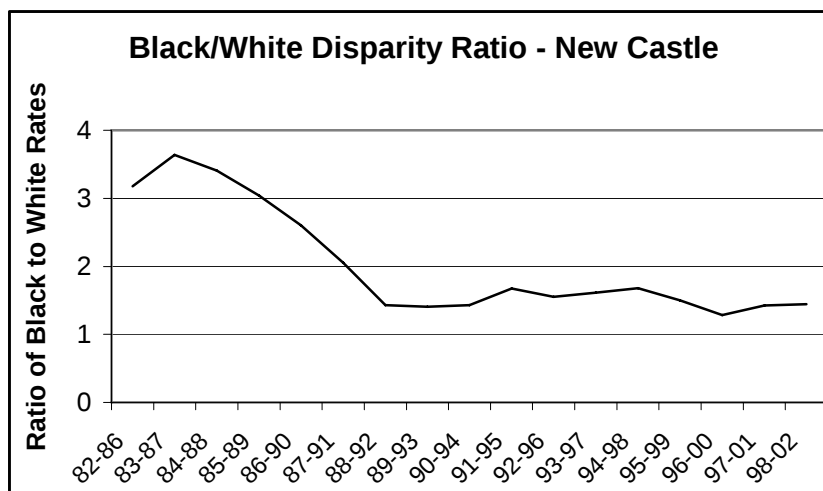
From 1982-86 to 1991-95 Kent County showed up and down alcohol-induced death rates for blacks while showing very consistent death rates for whites. After 1991-95 there was a sharp decrease in the alcohol-induced death rates for blacks, which actually dropped below white death rates in 1995-99 and continues to do so currently. While the black/white disparity ratio was quite high for Kent it has now dropped to below one, meaning that more whites per 100,000 die from alcohol-induced deaths than blacks.

Figure 9.5
Alcohol-Induced Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

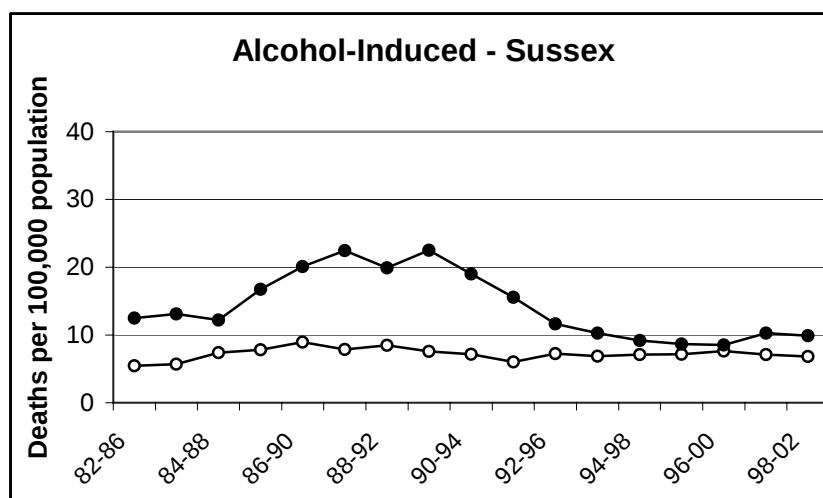
Figure 9.6
Alcohol-Induced Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

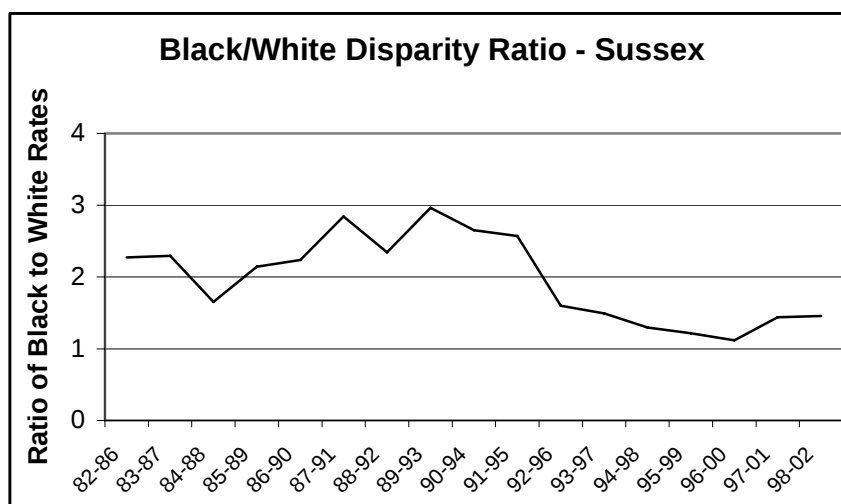
In 1982-86 blacks were far more likely than whites to die from alcohol-induced incidents. After 1983-87 there was a steady decrease in the death rate of blacks that lasted until 1989-93, which greatly reduced the amount of alcohol-induced deaths per 100,000. This same sharp decline is illustrated in the black/white disparity ratio with a sharp decline in the first ten years and a plateau around 1.5. Throughout the twenty years on the graph, whites maintained a consistent level at slightly fewer than ten deaths per 100,000.

Figure 9.7
Alcohol-Induced Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 9.8
Alcohol-Induced Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

From 1984-88 to 1990-94, blacks showed increasing rates of alcohol-induced deaths, but those numbers started to gradually decrease to the levels comparable to those of whites in Sussex County around 1991-1995. Because of the sporadic numbers in Sussex County, the black/white disparity ratio was very dynamic year to year until gradually leveling off around 1.5 in 1998-2002. As with most charts, the death rate for whites remained fairly consistent for the length of the twenty years, while the death rates for blacks were increasing and decreasing dramatically during the first 13 years on the chart.

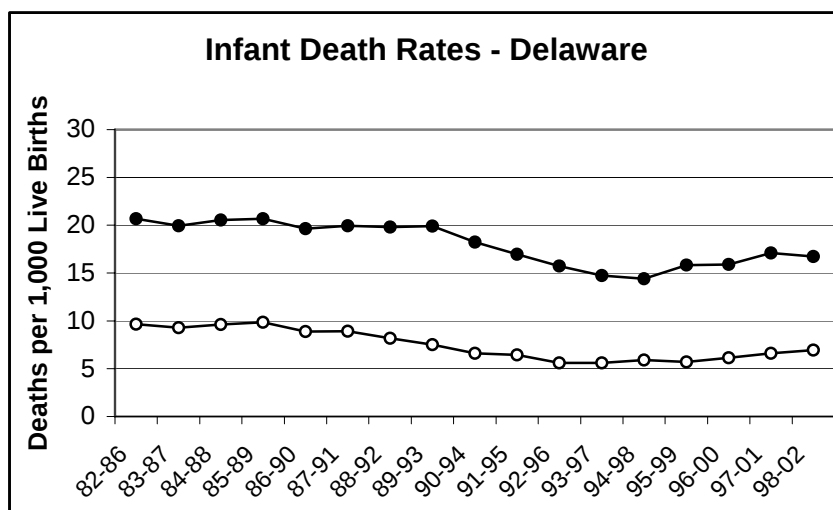
Infant Deaths

Delaware saw declining infant death rates from 1993 to 1998 for both whites and blacks followed by minor increases in the last five years. Black and white infant death rates mirrored each other so there was very little change in the black/white disparity ratio in the last 20 years. There has been a slim decrease in the black/white disparity ratio from 1997 at 2.63 to 2002 at 2.41.

However, Delaware is slightly below the national black/white disparity ratio, which is 2.48. This may be due to fewer births in the state, which could skew the death rates for the entire state.

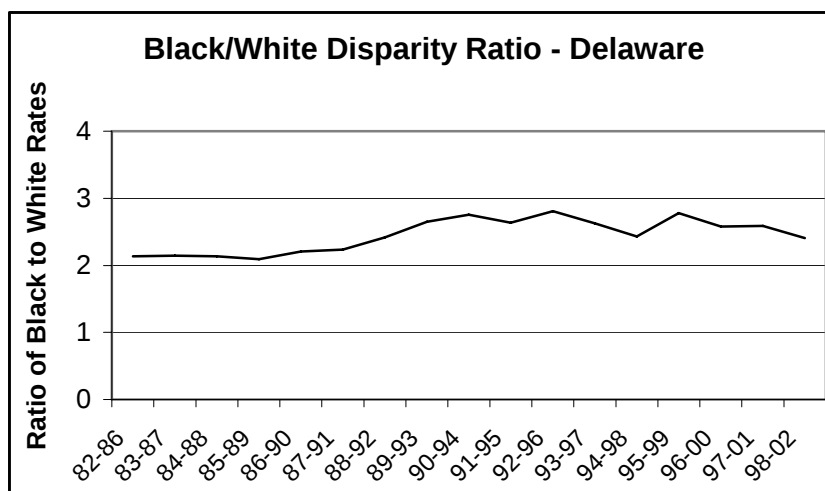
Kent County has seen increases in the infant death rate from 1983 to 1989, which was followed by steady improvements in the last 10 years with the exception of the most recent time-period, 98-02. These steady improvements in the death rates have led to a solid decline in the black/white disparity ratio in the county. New Castle County saw decreases in the death rate from 1982 to 1995 but has since seen minor increases in the last five years. Sussex County has also seen decreases from 1982 to 1995 but has recently seen increases in the infant death rate. Due to the recent increases in the death rate, the black/white disparity ratio has also seen increases.

Figure 10.1
Infant Death Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

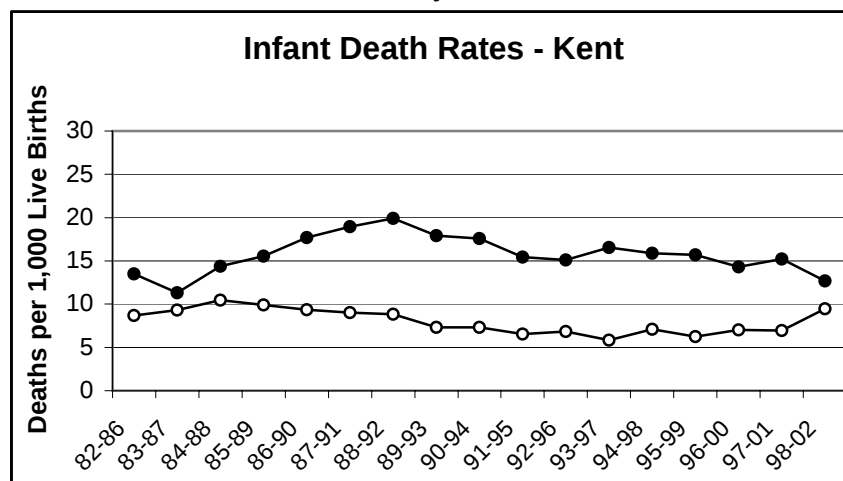
Figure 10.2
Infant Death Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

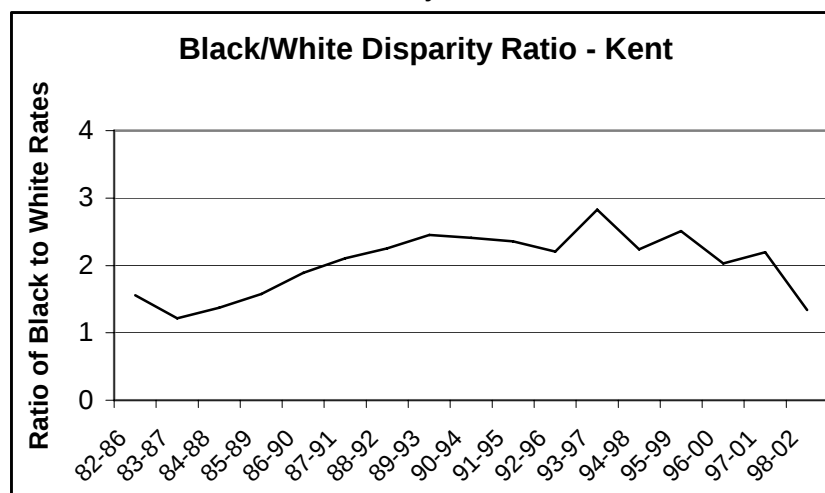
For the past 20 years, blacks have had infant death rates that were at least twice that of whites in Delaware. From 1982-86 to 1993-97 blacks and whites showed steady improvement towards reducing infant death rates. But since 1994-98, white rates have started to increase with black rates also increasing since 1995-1999. As mentioned previously, the black/white disparity ratio has remained well above two. While Delaware blacks remained much higher in the deaths per 100,000, the changes in yearly death rates closely mirrored each other.

Figure 10.3
Infant Death Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

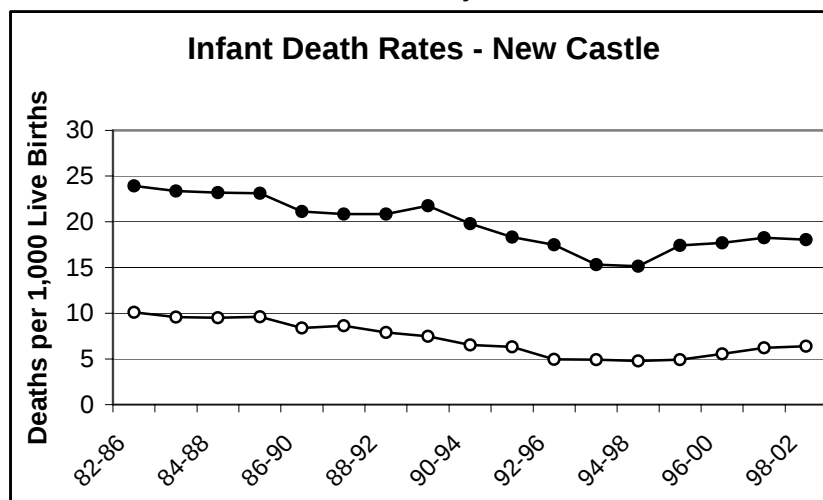
Figure 10.4
Infant Death Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

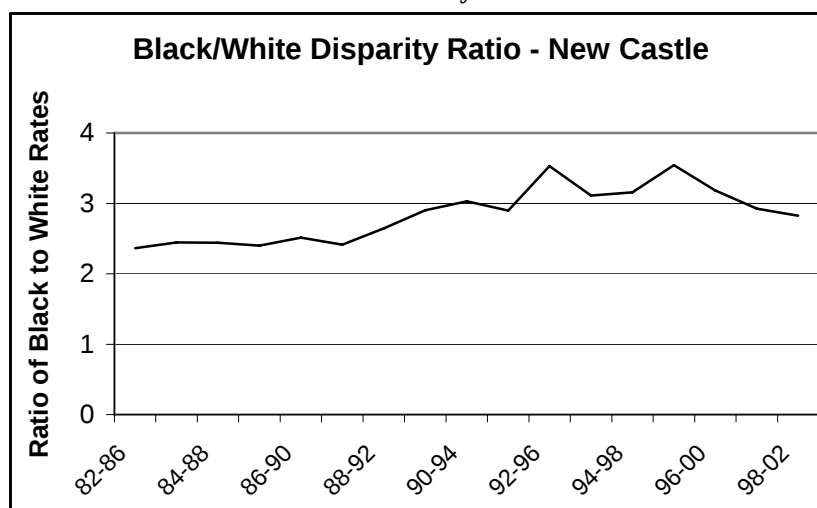
Unlike the entire state, infant death rates for blacks and whites do not mirror each other in Kent County. While for the greater part of the last twenty years blacks have seriously lagged behind whites in infant death rates, they recently started to close the gap due to a gradual decline in infant death rates for blacks and a continuing increase in infant death rates for whites. While the black/white disparity ratio hovered around two or higher for most of the twenty years, there has been a sharp decrease in the rate, which now is around 1.25.

Figure 10.5
Infant Death Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

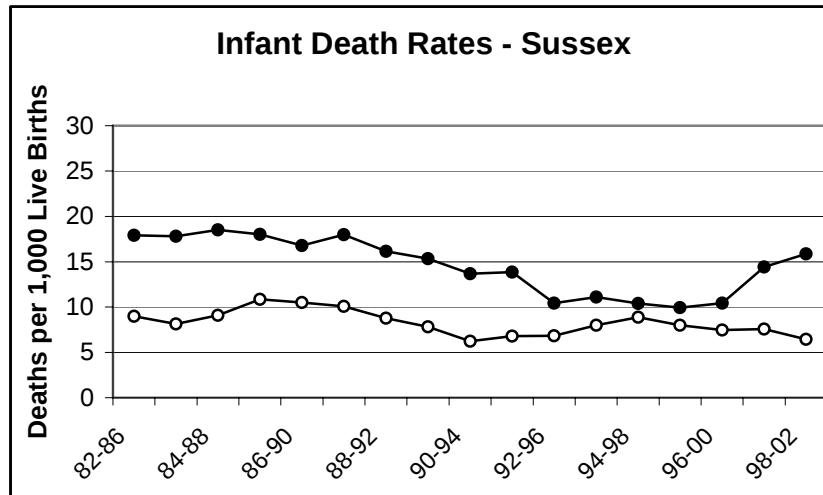
Figure 10.6
Infant Death Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

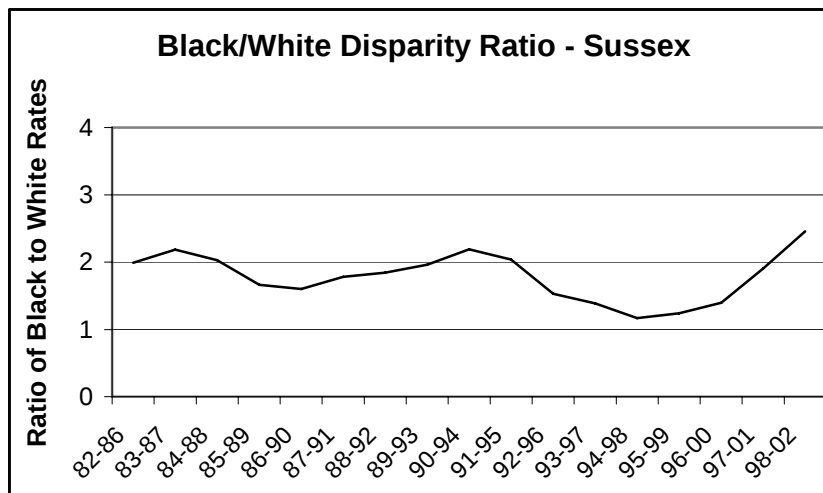
Similar to other death rates, New Castle County closely mirrors Delaware in regard to infant death rates with a steady decline in deaths per 100,000 from 1982-86 to 1994-1998 and a gradual increase starting in 1995-99 that is still continuing. Similar to the state, the changes in death rates for blacks and whites closely parallel each other but with blacks having higher rates. The black/white disparity ratio for infant death is highest in New Castle with a rate of death for blacks that is almost three times that of whites.

Figure 10.7
Infant Death Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 10.8
Infant Death Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

From 1982-86 to 1996-2000 blacks made considerable decreases in infant death rates, but they have started to sharply increase in the last two years. Whites have remained fairly consistent with death rates between 6 to 11 deaths per 100,000. Blacks had nearly closed the disparity gap in Sussex County until the sharp increases of the last two years. This is reflected in the black/white disparity ratio with a sharp increase in the last two years to a rate that is two and a half times higher for blacks than whites.

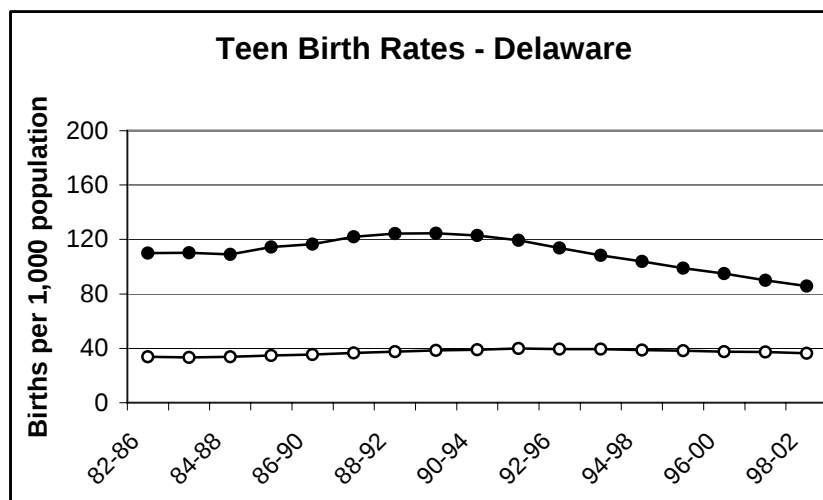
Births to Teens

Delaware blacks showed steady declines in the teenage birth rate from 1994 to 2002, while whites had fairly stagnant birth rates. Due to the declining black teenage births and sluggish birth rates of whites, there has been a steadily declining black/white disparity ratio for the past 10 years in Delaware. This gradual decrease is characterized in a comparison of 1993-97 at 2.74 to 2002 at 2.35.

The US disparity ratio is smaller than the Delaware rate at 1.86. While Delaware is trailing the national average, it has been making steady progress in the last ten years and has shown no signs of stopping.

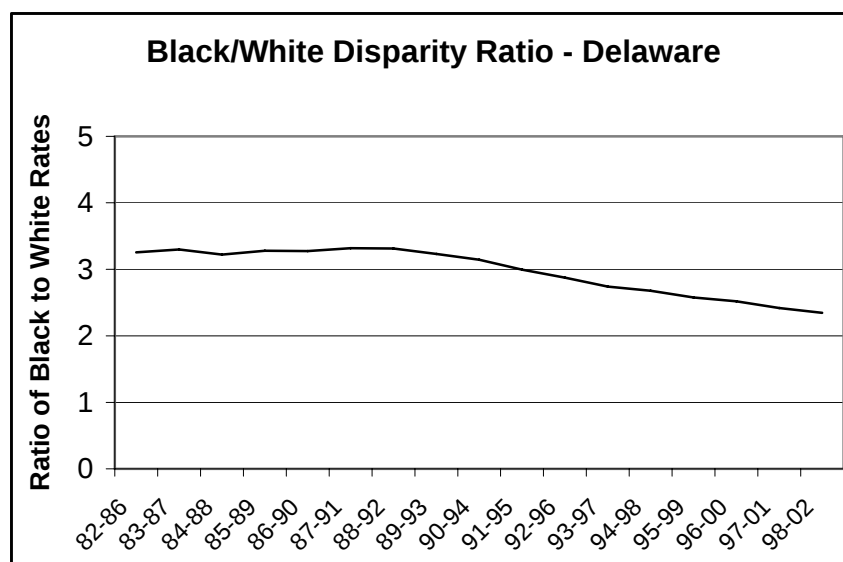
Kent County blacks had increases in the teenage birth rate from 1983 to 1990, but have since shown decreases, while whites have shown little change in their teenage birth rate. Because of the declining birth rates of blacks and stagnant rates of whites, there has been a declining black/white disparity ratio in Kent County. New Castle County has had declining teen birth rates for blacks since 1992, which has led to a lower black/white disparity ratio. Sussex County has seen decreases in black teenage birth rates and increases in whites teenage birth rates, resulting in a declining black/white disparity ratio over the last 20 years.

Figure 11.1
Teen Birth Rates by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

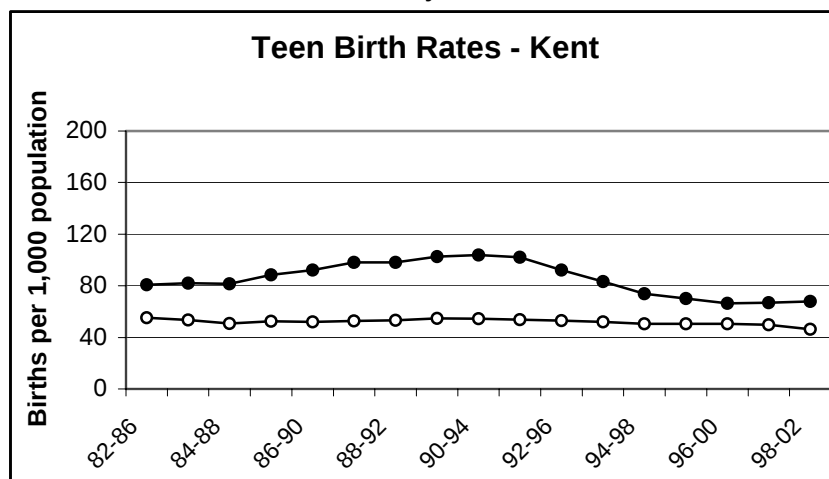
Figure 11.2
Teen Birth Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

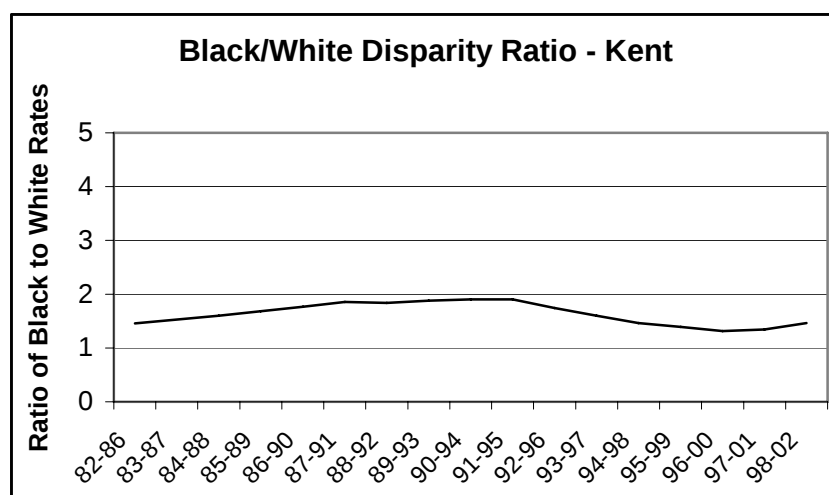
In 1982-86 teen birth rates for blacks were triple that of whites in the state of Delaware, and continued to increase gradually over the next seven years. Rates started to decline in 1990-94 and have continued to do so. Whites have maintained stable teen birth rates for the past twenty years in Delaware with about forty births per one thousand teenage girls. The black/white disparity ratio showed only slight reductions from just over three 20 years ago to a ratio of 2.35 currently.

Figure 11.3
Teen Birth Rates by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

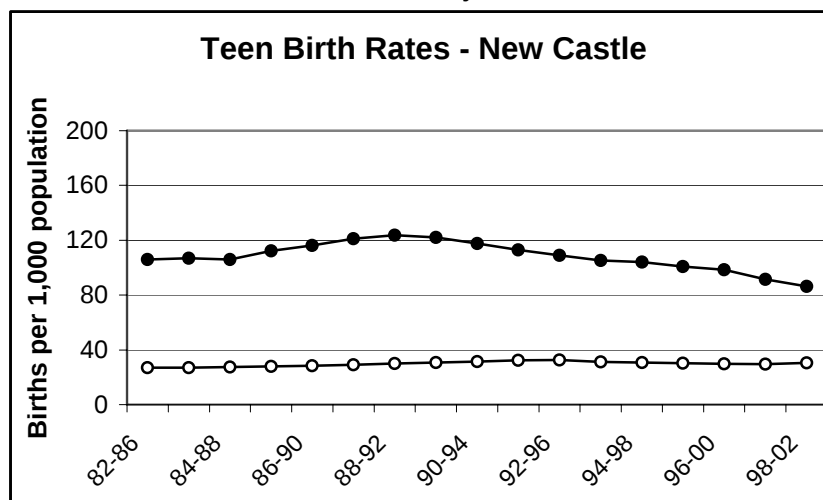
Figure 11.4
Teen Birth Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

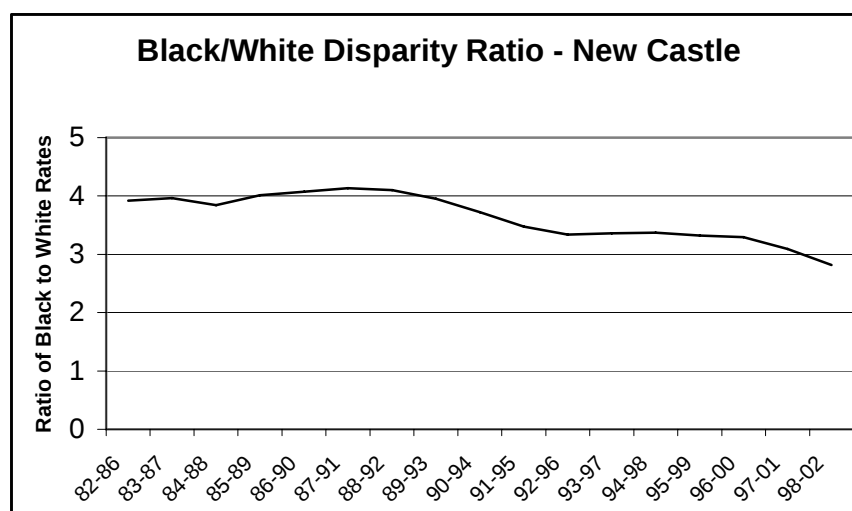
From 1984-88 to 1990-94 Kent County blacks were burdened with increasing rates of teen births but started to show steady decreases in the teen birth rates around 1991-95. Whites showed little or no improvement in the teen birth rates for the last twenty years, hovering over 50 per 1000 teen girls. Blacks were able to make significant gains in the black/white disparity ratio because of the reduction of black teen birth rates and the stagnant teen birth rate for whites.

Figure 11.5
Teen Birth Rates by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

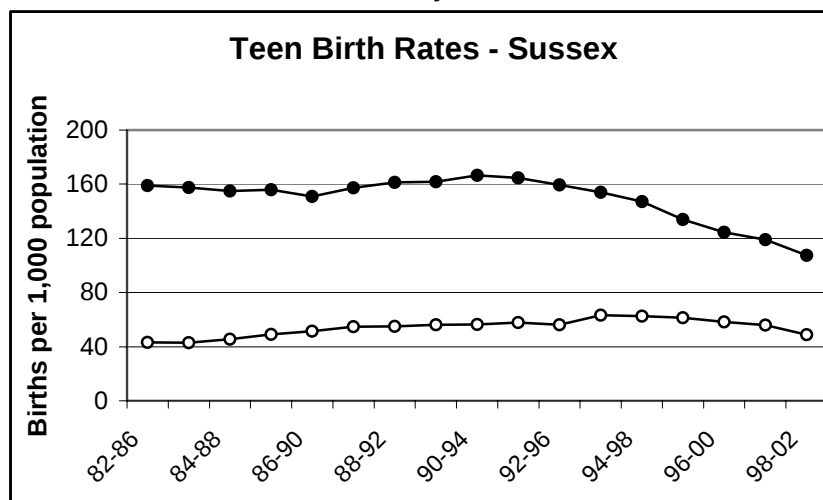
Figure 11.6
Teen Birth Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

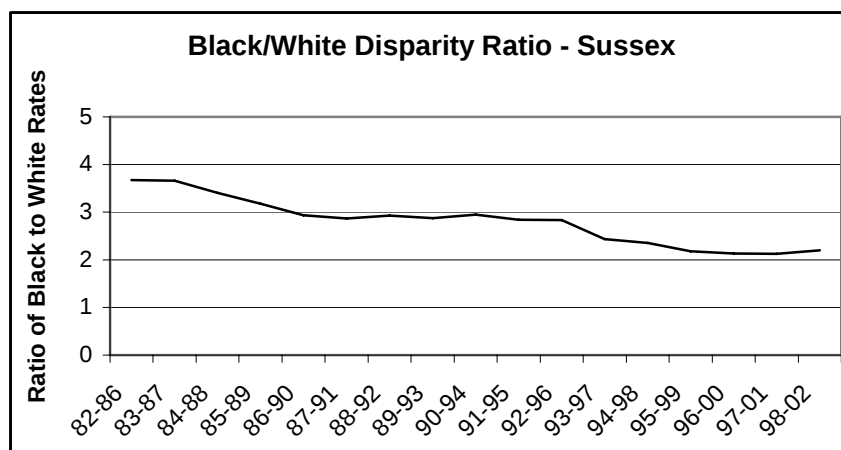
From 1982-86 to 1988-92 New Castle County had increases in the teen birth rate for blacks but showed steady improvement in the last ten years reducing the rate by one-third. Whites maintained a level that averaged around 30 teen births and showed very little change over the twenty years. The black/white disparity ratio shows that in 1982-86 New Castle County had the worst disparity between blacks and whites in Delaware and while they have improved recently, they still have the worst ratio in the state.

Figure 11.7
Teen Birth Rates by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 11.8
Teen Birth Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

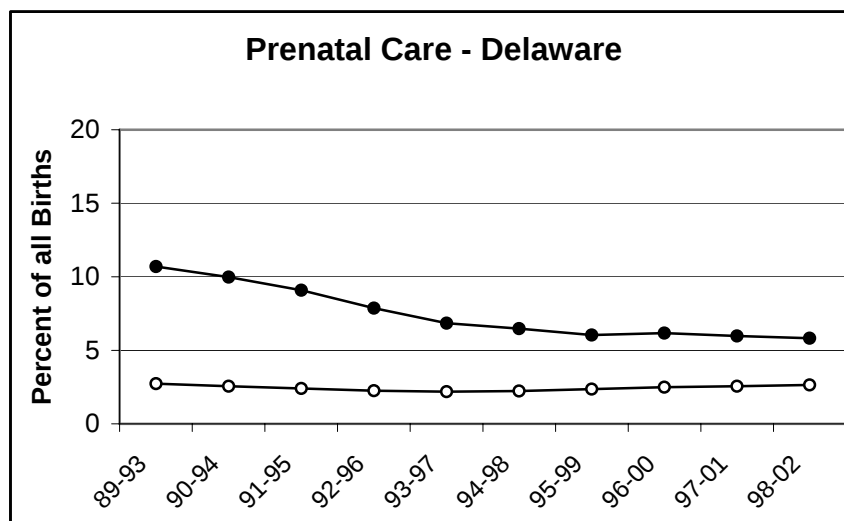
In 1982-86 Sussex County had the worst teen birth rates for blacks in Delaware with rates higher at 159 per 1000 teens. Whites in Sussex County have also struggled in the past with increasing teen birth rates from 1982-86 to 1992-96 but have since started to slowly reduce their rates also. Because of high rates for whites and declining rates for blacks, the black/white disparity ratio is only around two where it could be much higher because of the quantity of black teen births.

Late or No Prenatal Care

Prenatal data has only been kept in Delaware for the last ten years, so the trends are very limited. Since 1993 Delaware blacks have greatly reduced the number of births with little or no prenatal care, while whites showed very little change. Blacks saw the greatest decreases from 1993-1997 where the percentage was cut in half. Because of the improvements by blacks and little change made by whites, the black/white disparity ratio was greatly reduced in a short period of time. This is highlighted by the significant differences between 1997 at 3.11 and 2002 at 2.19.

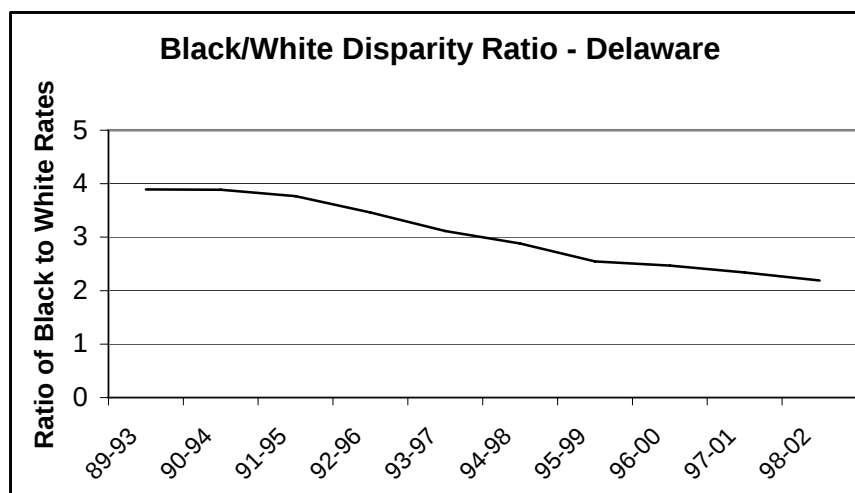
Kent County blacks showed some improvement from 1993 to 1997, but then saw rates increase in the last five years. Whites showed increases for the last ten years, resulting in a declining black/white disparity ratio, despite the rising prenatal rates. New Castle County is similar to the state with large improvements for blacks from 1993 to 1997, followed by more gradual improvements for the next five years. This also led to a diminishing disparity ratio for New Castle. Sussex County blacks had the highest rate of births with little or no prenatal care in the state in 1993 but have since shown large declines, giving them a rate comparable to the rest of the state.

Figure 12.1
Percentage of Late or No Prenatal Care by Race
Delaware 1989-2002



Source: Delaware Division of Public Health

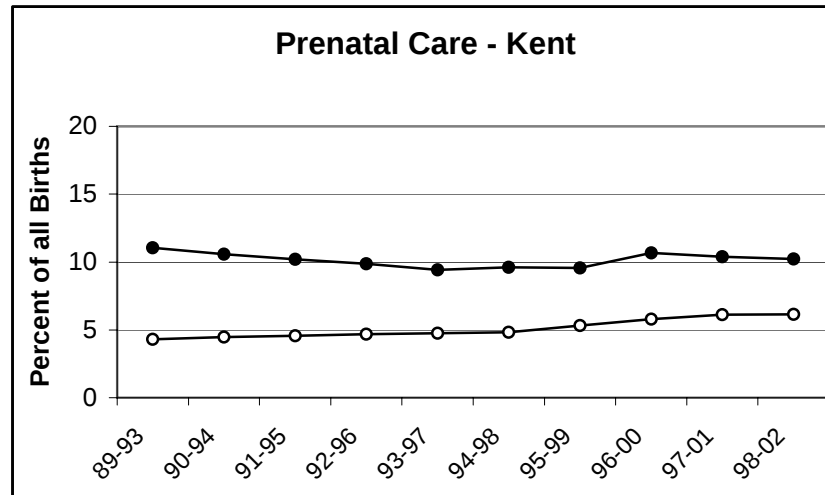
Figure 12.2
Late or No Prenatal Care Black/White Disparity Ratio
Delaware 1989-2002



Source: Delaware Division of Public Health

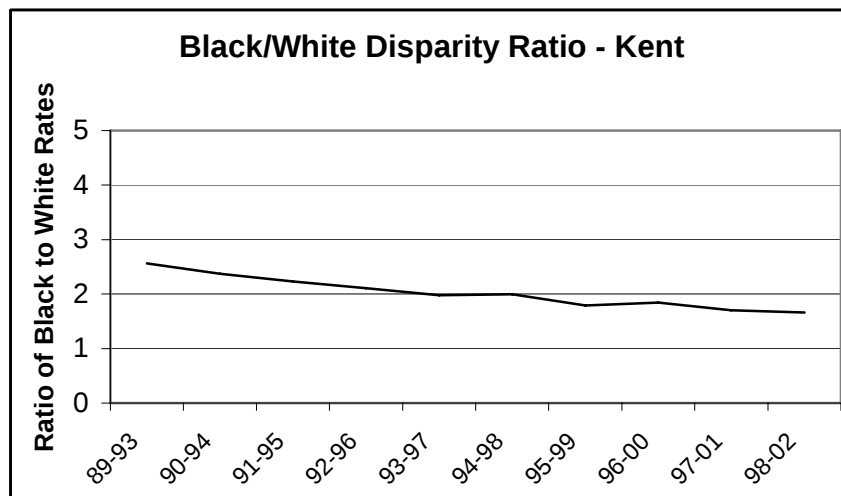
From 1989-93 to 1994-98 there was a steady decline in the percentage of births with little or no prenatal care in Delaware for blacks that has since plateaued from 1995 to the present. Whites remained at consistent levels that were well below the percentages of blacks. In 1989-93 blacks had a disparity ratio that showed blacks as being four times more likely than whites as having a birth with little or no prenatal care. The current level has since been lowered to just about twice the rate of whites and has been steadily falling for the last thirteen years.

Figure 12.3
Percentage of Late or No Prenatal Care by Race
Kent County 1989-2002



Source: Delaware Division of Public Health

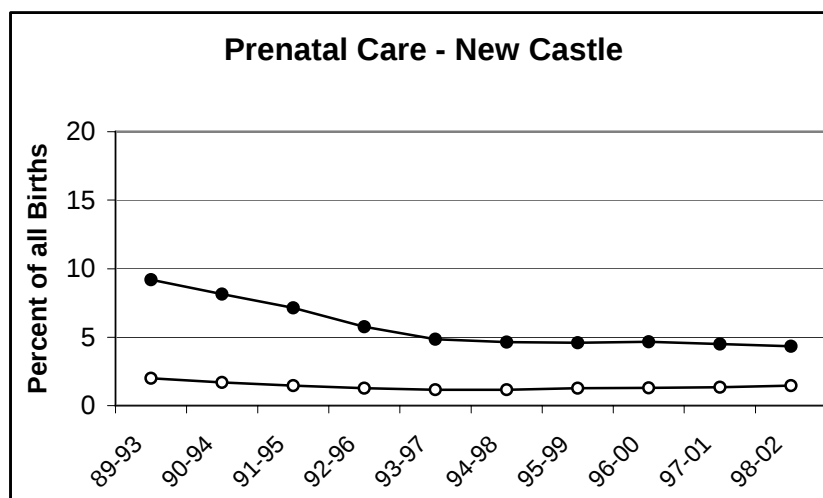
Figure 12.4
Late or No Prenatal Care Black/White Disparity Ratio
Kent County 1989-2002



Source: Delaware Division of Public Health

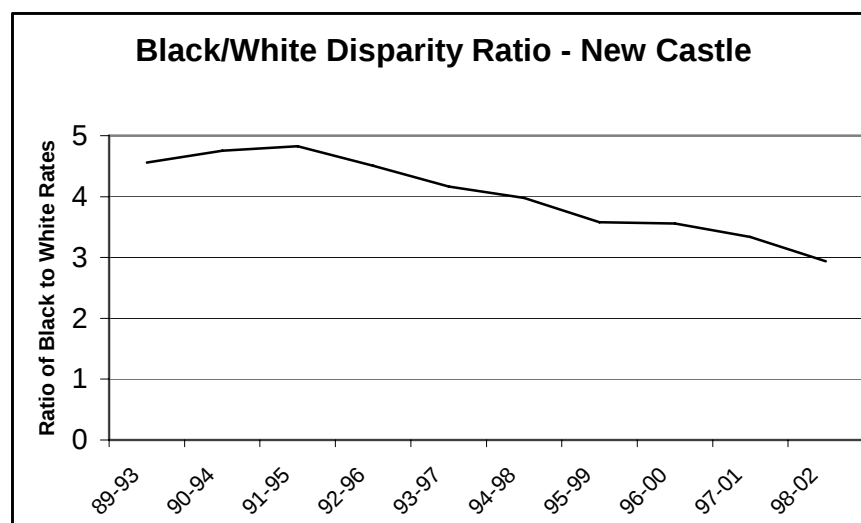
Blacks in Kent County have had little if any success in lowering the percentage of births with little or no prenatal care over the last thirteen years. Whites have also struggled with lowering the percentage of births with little or no prenatal care and in fact have increased their percentage over the last five years. Despite the lagging numbers for Kent County blacks, there has been a steady decline in the black/white disparity ratio. This has more to do with the increasing percentages for whites and less to do with great advances for Kent County blacks.

Figure 12.5
Percentage of Late or No Prenatal Care by Race
New Castle County 1989-2002



Source: Delaware Division of Public Health

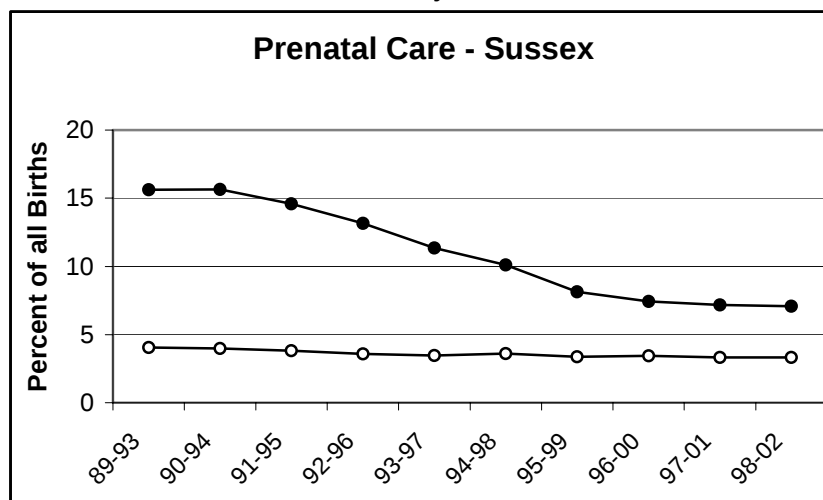
Figure 12.6
Late or No Prenatal Care Black/White Disparity Ratio
New Castle County 1989-2002



Source: Delaware Division of Public Health

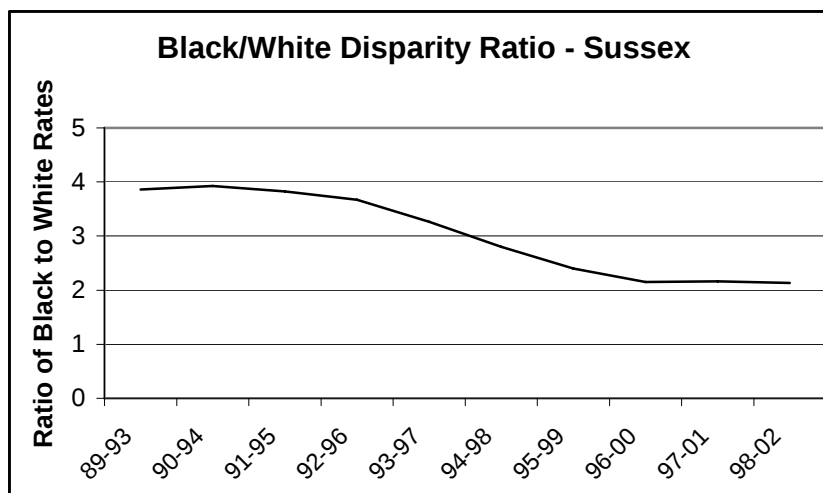
From 1989-93 to 1993-97 blacks showed considerable progress in reducing the percentage of births with little or no prenatal care in New Castle County. Throughout the past thirteen years, whites have maintained the same level of around one to two percent of births with little or no prenatal care in New Castle County. The black/white disparity ratio has shown a steady decline in New Castle County but is still relatively high with a rate for blacks that is three times that of whites. It is important to note that the rates for both blacks and whites are the lowest in the entire state in New Castle County.

Figure 12.7
Percentage of Late or No Prenatal Care by Race
Sussex County 1989-2002



Source: Delaware Division of Public Health

Figure 12.8
Late or No Prenatal Care Black/White Disparity Ratio
Sussex County 1989-2002



Source: Delaware Division of Public Health

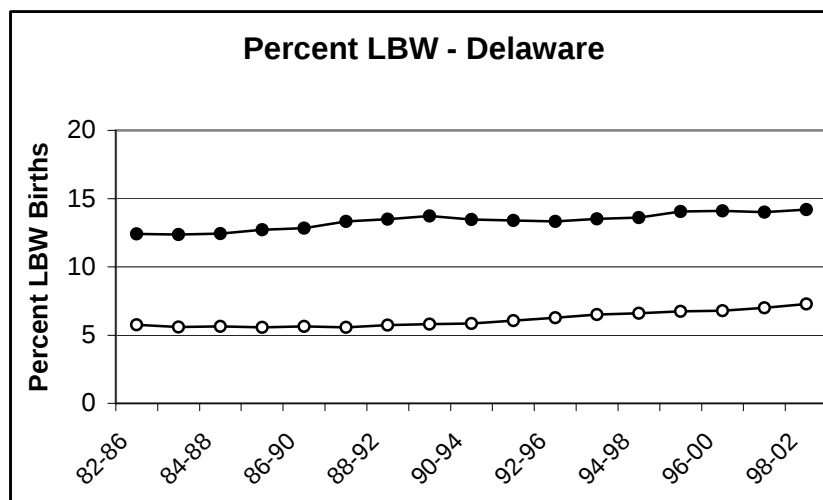
In 1989-93 Sussex County blacks had the highest percentage of births with little or no prenatal care in Delaware, but have since made sharp decreases in the previously high percentages. Whites maintained a level just fewer than four percent for the past thirteen years. Because of the sharp decreases in the percentage of births with little or no prenatal care for Sussex County blacks, there was also a decrease in the black/white disparity ratio, which currently shows blacks as being twice as likely as whites of having no or very little prenatal care.

Low Birth Weight Births

Delaware has seen increases for blacks and whites in the percentage of low birth weight births for the last twenty years. While both blacks and whites have been gradually increasing, whites have increased slightly more leading to a minor decline in the black/white disparity ratio. This is an example of why it is important to put improvements in the black/white disparity ratio into perspective because while blacks have made progress in the disparity ratio, they have made very little progress in regard to the actual health indicator.

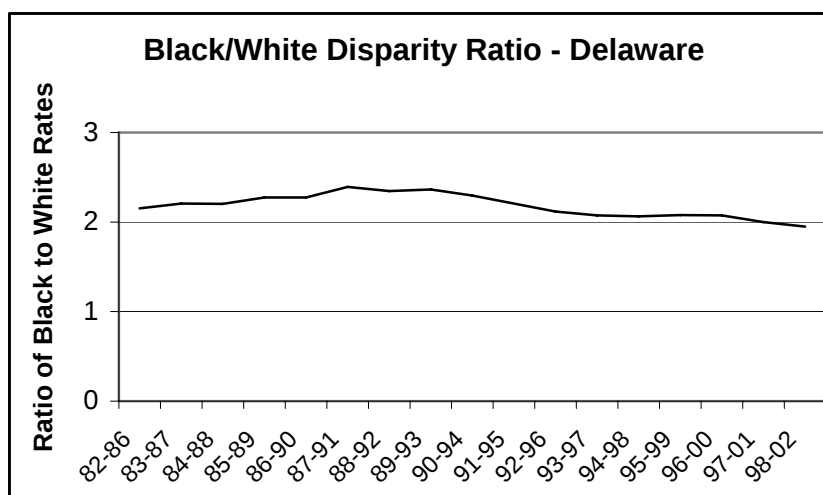
Kent County has seen increasing black percentages of low birth weight births, while whites have seen little change in the last twenty years. This has led to a small increase in the disparity ratio for the last ten years with the exception of 1998-02, the most recent year. New Castle County blacks have maintained a much higher percentage than whites but have had few changes in the last twenty years, while whites have started to increase their percentages. The increasing percentages for whites have caused a decline in the disparity ratio, despite the lack of change for New Castle blacks. Sussex County has seen little or no change for both races, leading to a fairly inactive black/white disparity ratio.

Figure 13.1
Percentage of Low Birth Weight Births by Race
Delaware 1982-2002



Source: Delaware Division of Public Health

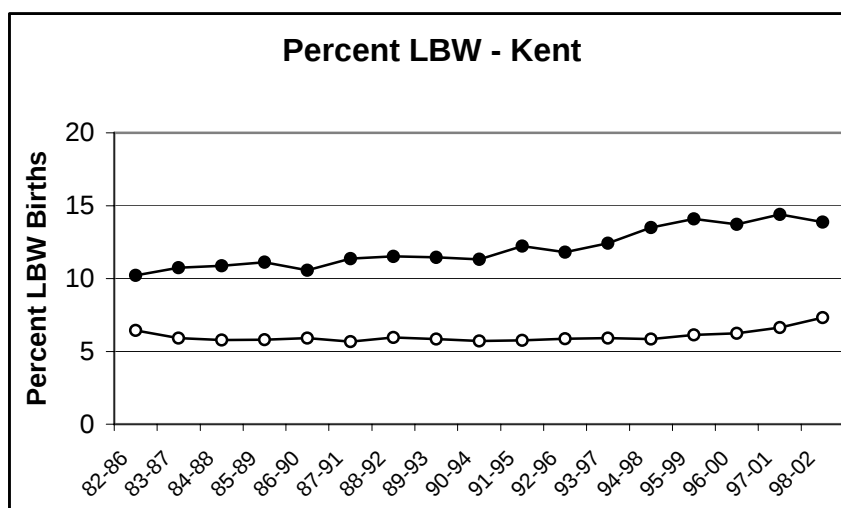
Figure 13.2
Low Birth Weight Black/White Disparity Ratio
Delaware 1982-2002



Source: Delaware Division of Public Health

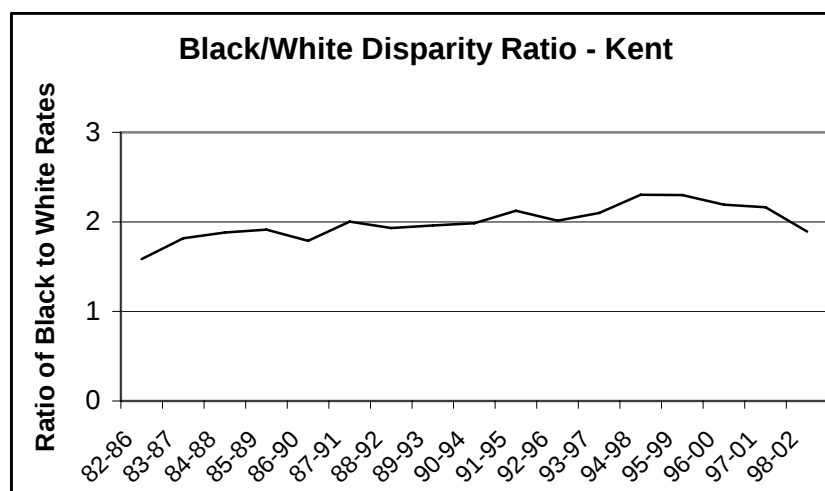
Both blacks and whites have shown measured increases in the percent of low birth weight births in Delaware for the past twenty years. While blacks have shown a steady climb, whites have shown increases that started in 1988-92 and continue to 1998-2002. The black/white disparity ratio has consistently shown blacks as being twice as likely as whites of having a low birth weight baby. Blacks have started to close on the disparity gap despite the increasing numbers because of the surging low birth weight births for whites in Delaware.

Figure 13.3
Percentage of Low Birth Weight Births by Race
Kent County 1982-2002



Source: Delaware Division of Public Health

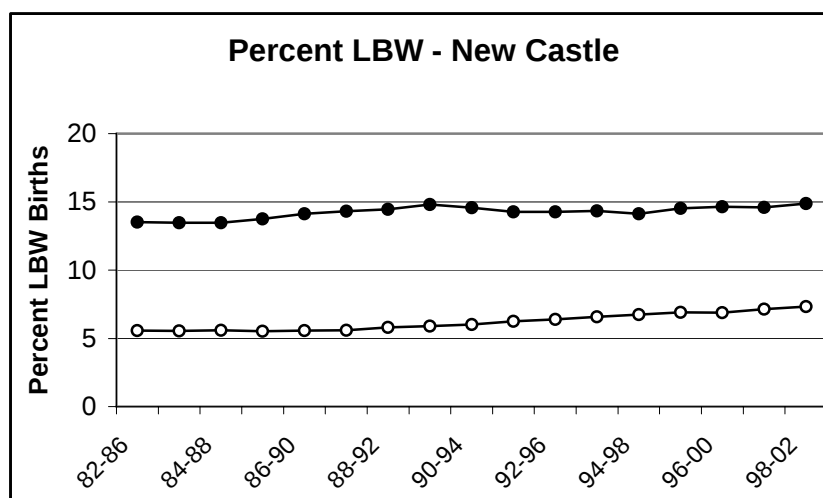
Figure 13.4
Low Birth Weight Black/White Disparity Ratio
Kent County 1982-2002



Source: Delaware Division of Public Health

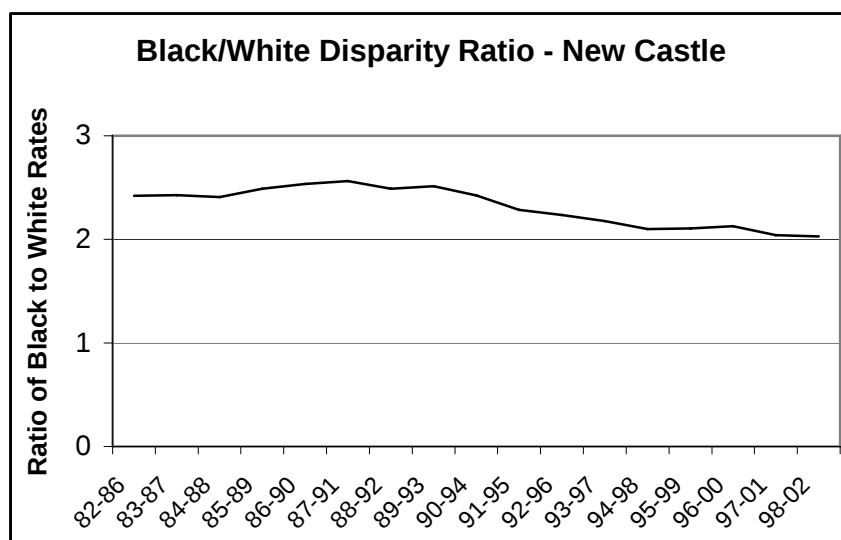
Kent County blacks have shown steady increases for the last twenty years in low birth weight births. Whites have only recently started to see increases in the amount of low birth weight births starting in 1995-99, and this trend continues with the latest data. Coupled with the steady increases in LBW's for blacks and a stagnant growth in LBW's for whites, the black/white disparity ratio has increased for most of the last twenty years and only recently has started to dip slightly.

Figure 13.5
Percentage of Low Birth Weight Births by Race
New Castle County 1982-2002



Source: Delaware Division of Public Health

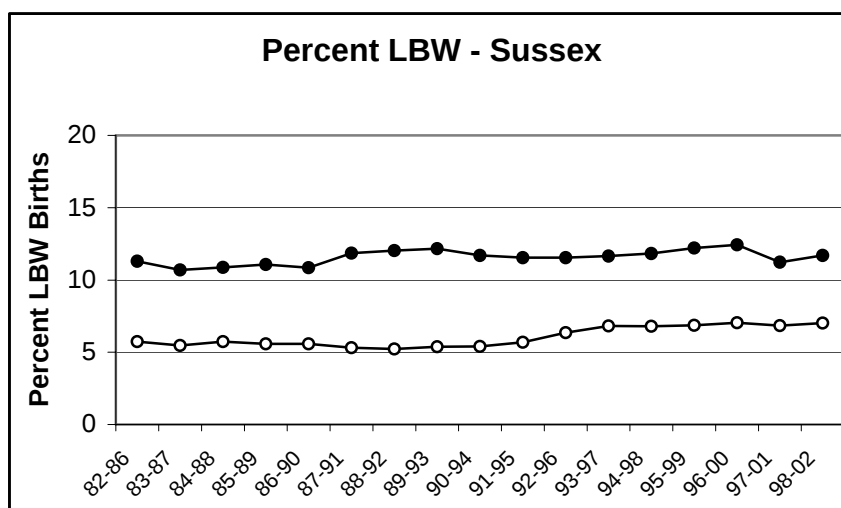
Figure 13.6
Low Birth Weight Black/White Disparity Ratio
New Castle County 1982-2002



Source: Delaware Division of Public Health

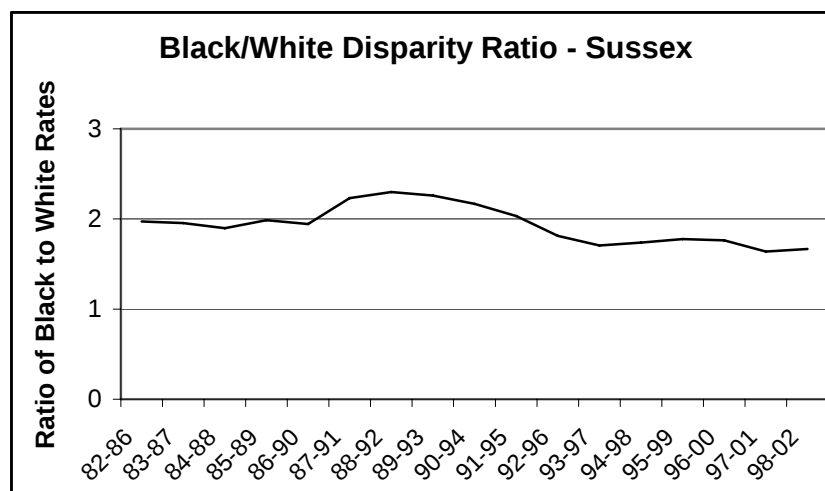
Both blacks and whites had a gradual increase in the percentage of low birth weight births. Both rates of growth were very slow but they were consistent in growth for the entire twenty years. Much like the state, the percent of white low birth weight births is growing slightly faster than blacks, so the black/white disparity ratio has slowly been declining, despite the increasing percentages.

Figure 13.7
Percentage of Low Birth Weight Births by Race
Sussex County 1982-2002



Source: Delaware Division of Public Health

Figure 13.8
Low Birth Weight Black/White Disparity Ratio
Sussex County 1982-2002



Source: Delaware Division of Public Health

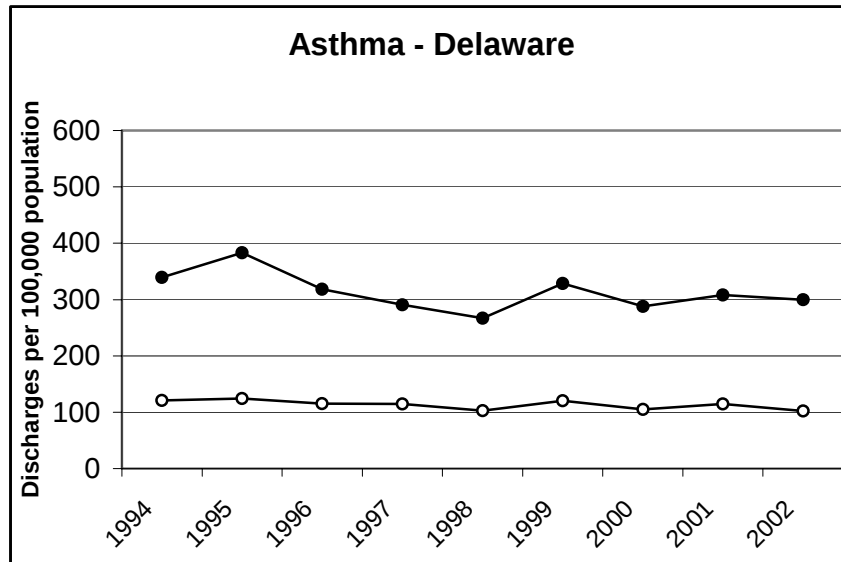
Sussex County blacks have had little long-term increases in the low birth weight births while whites have shown slight increases in the last ten years. Blacks have shown up and down percentages in the last twenty years but have deviated very little overall. The black/white disparity ratio has consistently been around two for the previous twenty years with minor changes in the last ten years.

Asthma Hospitalization

Delaware blacks showed improvement in asthma hospitalizations from 1995 to 1998 but since have shown inconsistent rates. Whites have maintained fairly stable ratings for the past nine years. Because the changes that were made by Delaware blacks were not very big, the black/white disparity ratio did not deviate far from the 2.75-3.10 range, which is very high and could be linked to environmental exposures. There has been an increase in the black/white disparity ratio from 1997 at 2.53 to 2002 at 2.93.

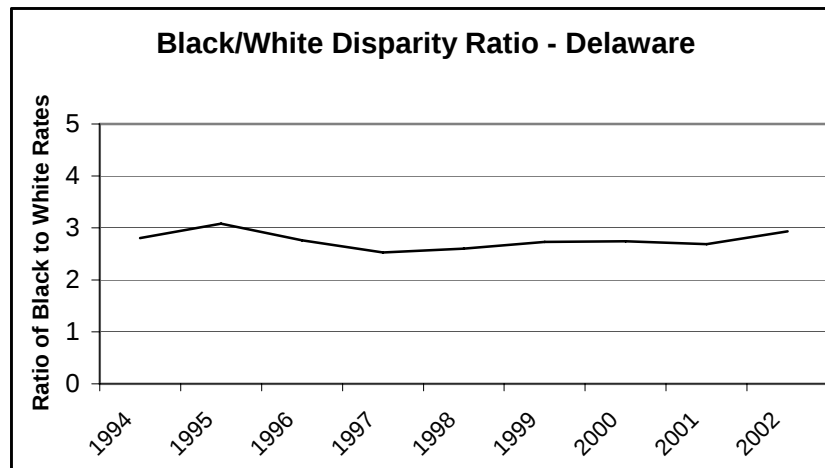
Kent County blacks and whites have shown very little movement in their hospitalization rates, which has led to very little movement of the black/white disparity ratio over the last nine years. New Castle County blacks made progress from 1994 to 1997, followed by a leveling off in 1998 through 2002. Despite these improvements, the black/white disparity ratio has been very sporadic in the last five years for New Castle. Sussex County also saw improvements in hospitalization rates for blacks that led to small improvements in the disparity ratio.

Figure 14.1
Asthma Hospitalization Rates by Race
Delaware 1994-2002



Source: Delaware Division of Public Health

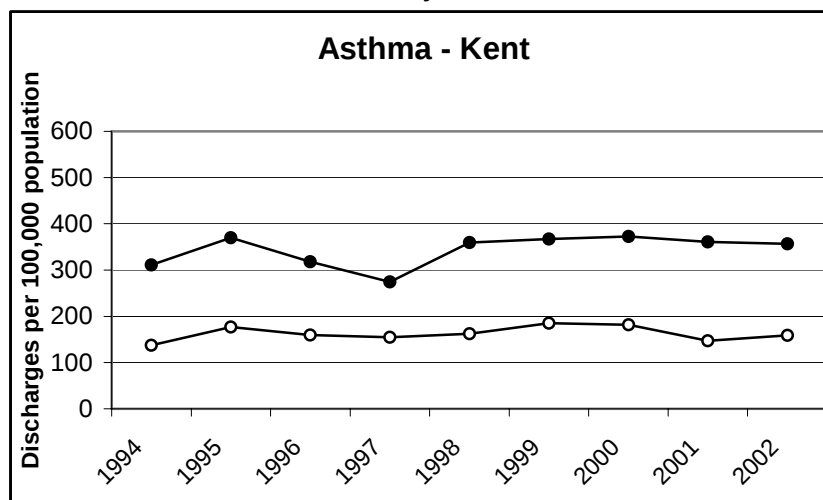
Figure 14.2
Asthma Hospitalization Black/White Disparity Ratio
Delaware 1994-2002



Source: Delaware Division of Public Health

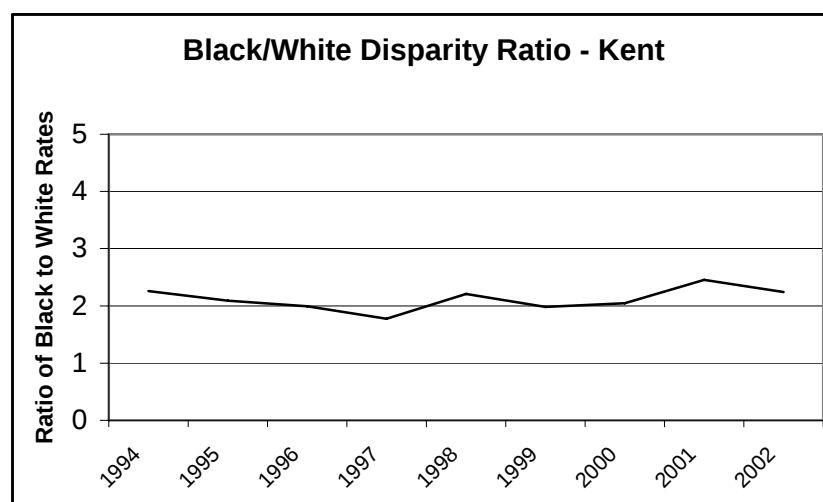
Blacks in Delaware have shown very little progress in reducing the asthma hospitalization rates per 100,000. Whites have also shown very little progress in reducing the asthma hospitalization rates, but whites maintain levels that are significantly lower than blacks. Over the last nine years blacks have shown both progress and recoil with asthma rates but still maintain about 300 asthma hospitalizations per 100,000. The black/white disparity ratio has also shown very little change over the past nine years and blacks are still at a rate of asthma hospitalization that is three times that of whites.

Figure 14.3
Asthma Hospitalization Rates by Race
Kent County 1994-2002



Source: Delaware Division of Public Health

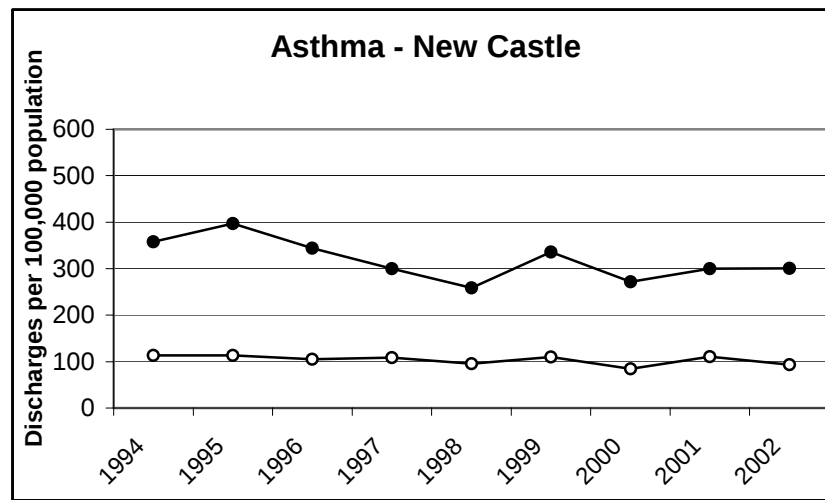
Figure 14.4
Asthma Hospitalization Black/White Disparity Ratio
Kent County 1994-2002



Source: Delaware Division of Public Health

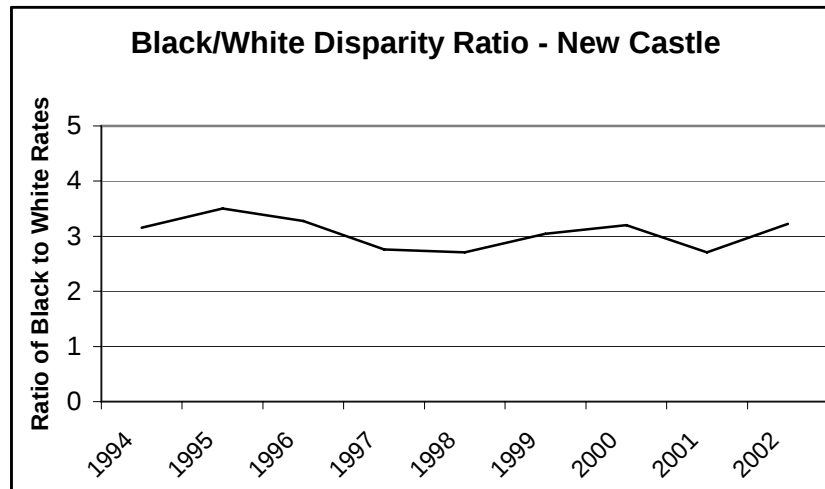
While blacks showed a two-year decline in the asthma hospitalization rates that ended in 1997, they are back to rates that are higher than the rates taken at the beginning of 1994. Whites had little change in the asthma hospitalization rates but have shown slight improvement over the last two years. The black/white disparity ratio has shown up and down movements over the last nine years but has remained at a rate that is around three.

Figure 14.5
Asthma Hospitalization Rates by Race
New Castle County 1994-2002



Source: Delaware Division of Public Health

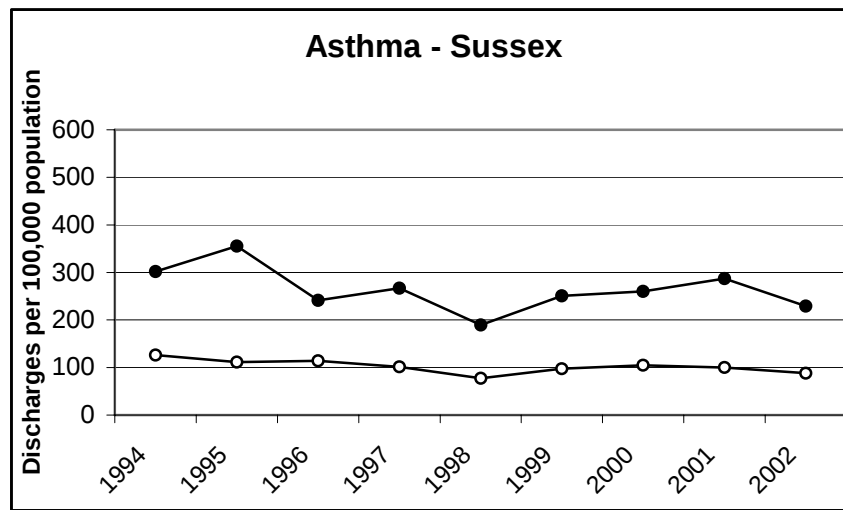
Figure 14.6
Asthma Hospitalization Black/White Disparity Ratio
New Castle County 1994-2002



Source: Delaware Division of Public Health

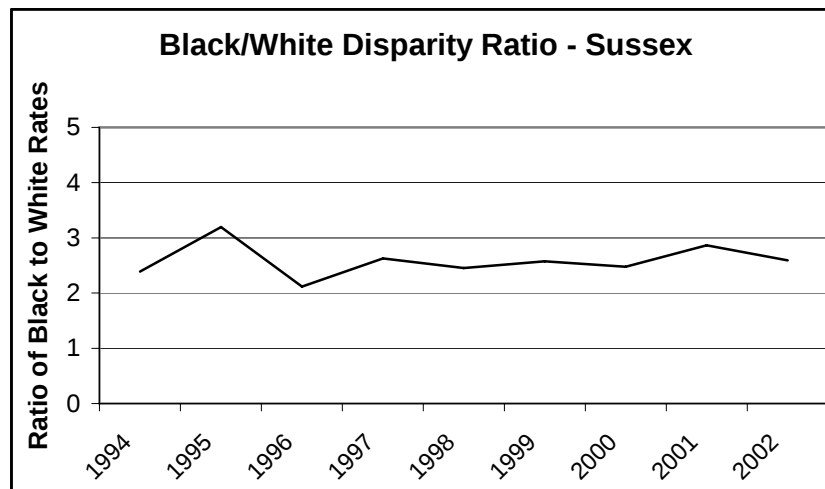
From 1995 to 1998, New Castle County blacks made firm progress towards lowering the asthma hospitalization rates and closing the gap between whites and blacks. But after a brief increase in the hospitalization rates, there has been a leveling off of progress. Whites maintained stability in the asthma hospitalization rates by staying around 100 hospitalizations per 100,000 throughout the nine years. The black/white disparity ratio showed some small decreases during the brief reductions for blacks but has since been around a ratio of three.

Figure 14.7
Asthma Hospitalization Rates by Race
Sussex County 1994-2002



Source: Delaware Division of Public Health

Figure 14.8
Asthma Hospitalization Black/White Disparity Ratio
Sussex County 1994-2002



Source: Delaware Division of Public Health

Sussex County also showed some progress in reducing the asthma hospitalization rates for blacks but the rates have shown some inconsistency in the past nine years. Blacks have reduced the amount of asthma hospitalizations from 300 to 200 per 100,000 in the past nine years, which can be considered fairly significant. Whites have shown slight decreases in the hospitalization rates but overall have made very little progress in the past nine years. Despite the decreases in the hospitalization rates for blacks, there was very little progress in the black/white disparity ratio, which continues to remain just under three.

Behavior and Health Disparities

There is ample evidence that personal behavior can affect the health of some people. The impact of the same behavior will vary from person to person largely due to sensitivities related to genetic differences. For example, smoking is generally known to cause cancer. However it does not have the same predictable effect for every individual. When we look at large groups of people, it is clear that a significant number will be affected.

If the personal behavior varies among groups, then to the extent the behavior is related to a disease process, disparities may result. In the previous section, it was shown that there is a measurable but not large difference in death rates between blacks and whites. If there was a significant difference in smoking between the races, then the disparity might be all or partially attributable to that behavioral difference.

In this section, data drawn from five years of the Behavioral Risk Factor Surveillance System (BRFSS) is examined. BRFSS is a survey research project that now reaches 4,000 Delaware adults annually. It is sponsored by the Centers for Disease Control and Prevention through the Delaware Division of Public Health. The survey is executed by the Center for Applied Demography and Survey Research at the University of Delaware.

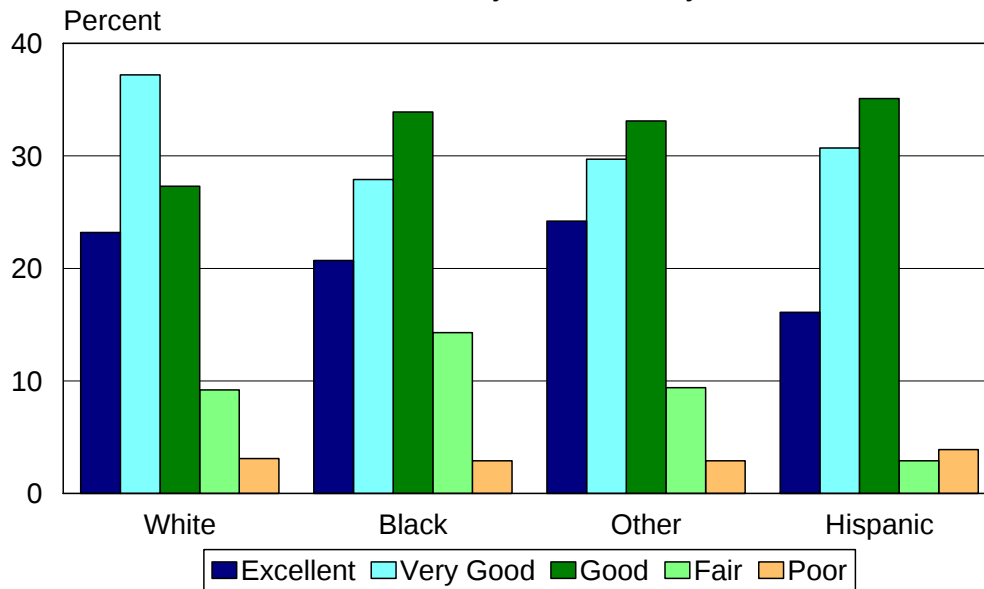
In this research, responses from 16,907 adults gathered over five years are used. These adults include 13,430 non-Hispanic Caucasians, 2,293 non-Hispanic African Americans, 572 non-Hispanic Others (largely Asian), and 479 Hispanics.

The sample size on any particular question will depend on a number of factors: whether the same question was asked every year, the population to whom the question applied, e.g. men/women, and the total number of adults who were interviewed in a given year.

The analysis presented in this section falls into three areas. First are questions dealing with access to the health care system. Second are questions about unhealthy behavior. Finally, questions about the utilization of preventative testing for particular conditions are addressed.

Before beginning with the three substantive areas, it is insightful to see how members of different groups view their own health. Some physicians have opined that if you feel good you probably are in good health. Survey respondents were asked about their general health. The results are found in Figure 15.1 below.

Figure 15.1
How is Your General Health?
by Race/Ethnicity



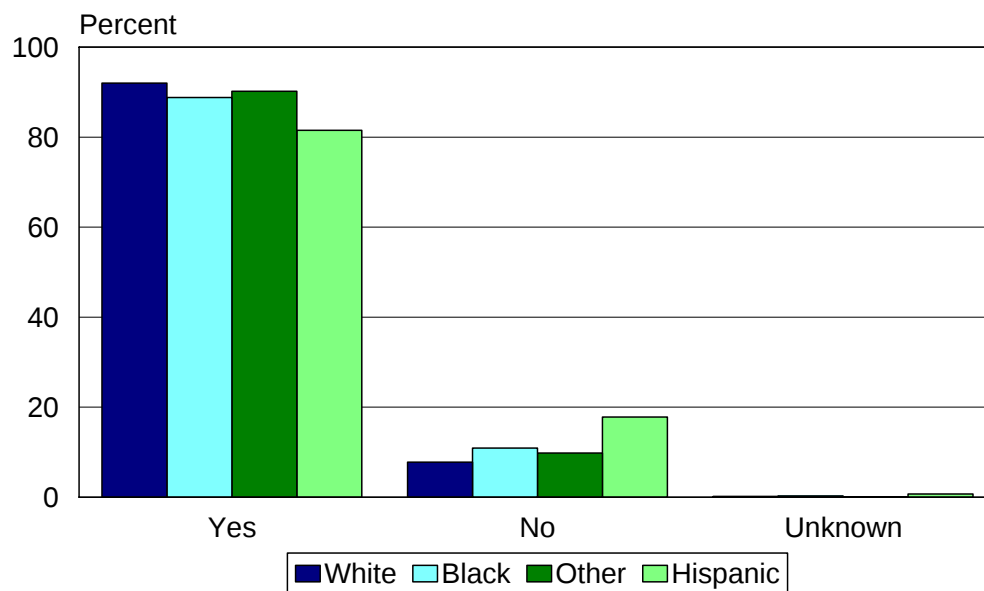
Source: Center for Applied Demography & Survey Research, University of Delaware

Clearly there are significant differences among the races in their general perception of their overall health. Caucasians and Others (primarily Asians) are more likely to consider themselves in excellent or very good health than either African Americans or Hispanics. All three minority groups had a larger percentage in the good health category than Caucasians. Finally, African Americans had by far the largest percentage in the least healthy categories (fair and poor) combined.

While having health insurance doesn't by any means guarantee that one will have good health, it does improve access to care. Access to care raises the probability of early detection and even prevention. Access, however, doesn't imply anything about quality or utilization by the individual. Availability of health insurance by race is shown in Figure 15.2, below.

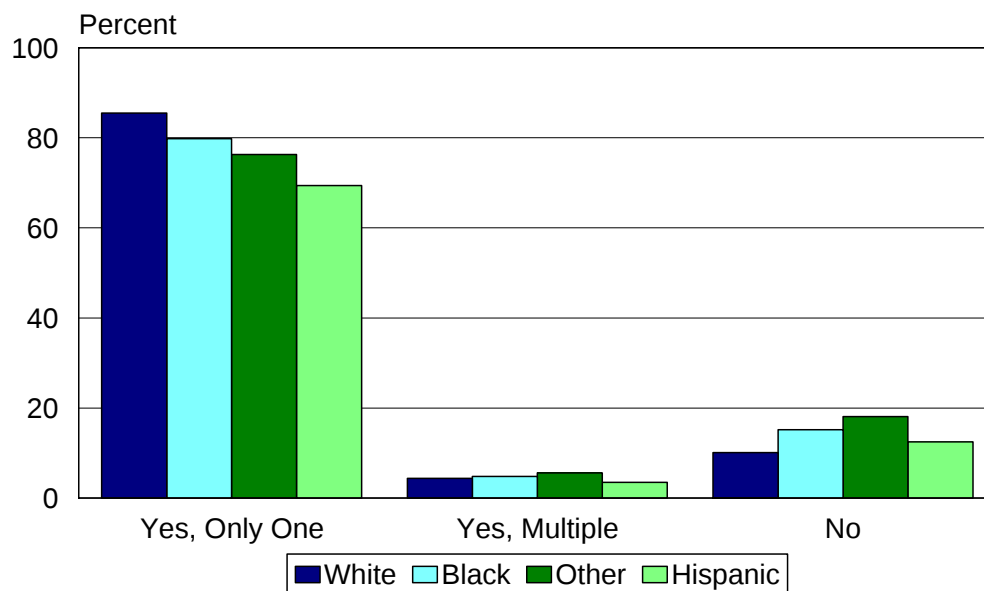
The figure shows that Caucasians have the highest percentage of health insurance. African Americans are lower but not substantially so. Hispanics are the group most at risk if they need access with almost 20% of adults without health insurance. If adults are without coverage, then it is likely a high proportion of their children are as well. Hispanics face other barriers as well. Language may be a problem for many. They also may not be comfortable with government programs for which they qualify if their residency status is unclear.

Figure 15.2
Do You Have Any Kind of Health Insurance?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

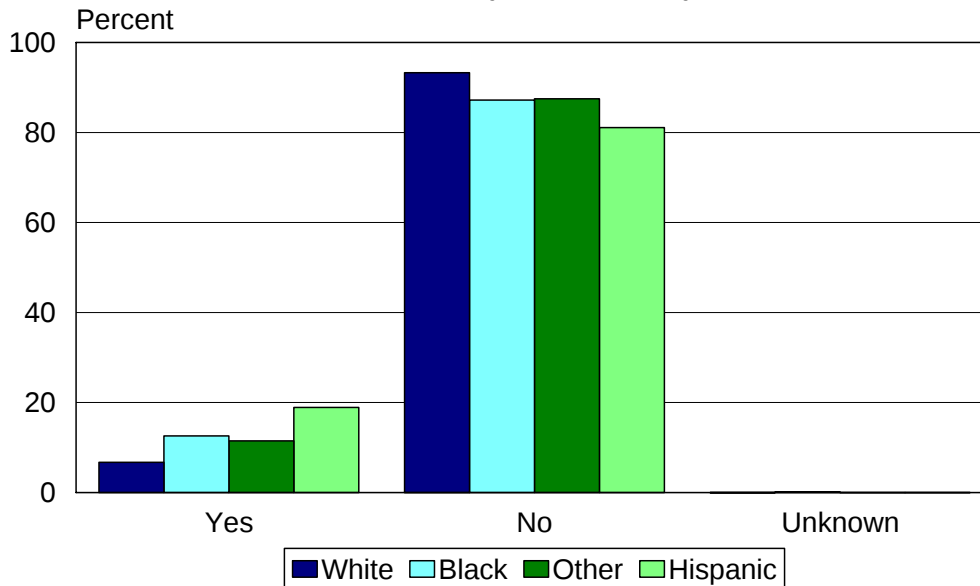
Figure 15.3
Do You Have A Personal Doctor or Health Care Provider?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

It is generally agreed that reporting having a “personal” doctor or health care provider is a useful indicator of access and quality of health care. (This assumes of course that the provider is competent and current on his or her medical practice.) Figure 15.3 shows how adults in the various racial/ethnic groups responded to that question. Caucasians were more likely to say they had a “personal” doctor. Hispanics were the least likely to answer the question affirmatively.

Figure 15.4
Did You Need to See a Doctor but Was Too Costly?
by Race/Ethnicity



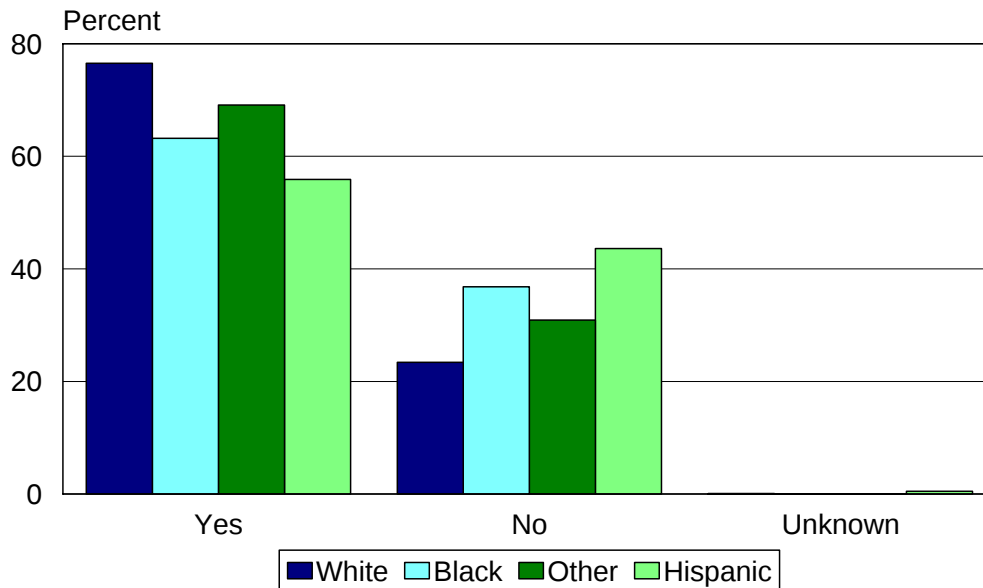
Source: Center for Applied Demography & Survey Research, University of Delaware

Another indicator of access is if the person has needed to see a doctor but found it too costly. This may be because of the lack of health insurance, insufficient coverage, or problems with co-pays. People with and without health insurance answered this question affirmatively. The results for this question are found in Figure 15.4, above. Once again, Caucasians have the smallest percentage with this characteristic and Hispanics have the largest.

In all the variations of the access issues addressed here, there are enough differences between races and ethnicities that one cannot say unequivocally that health disparities are unrelated to access to care. However, it is good to keep in mind that the differences in assessment of general health are probably larger than could be attributed to access to care. Other areas need to be examined.

One indicator of attention to personal health is the amount of exercise a person gets on a regular basis. The respondents to the survey were asked if they had exercised in the last 30 days. There are more detailed questions about exercise in the survey, but this one is a better gross indicator. The results are found in Figure 15.5, below.

Figure 15.5
Have You Exercised in the Last 30 Days?
by Race/Ethnicity

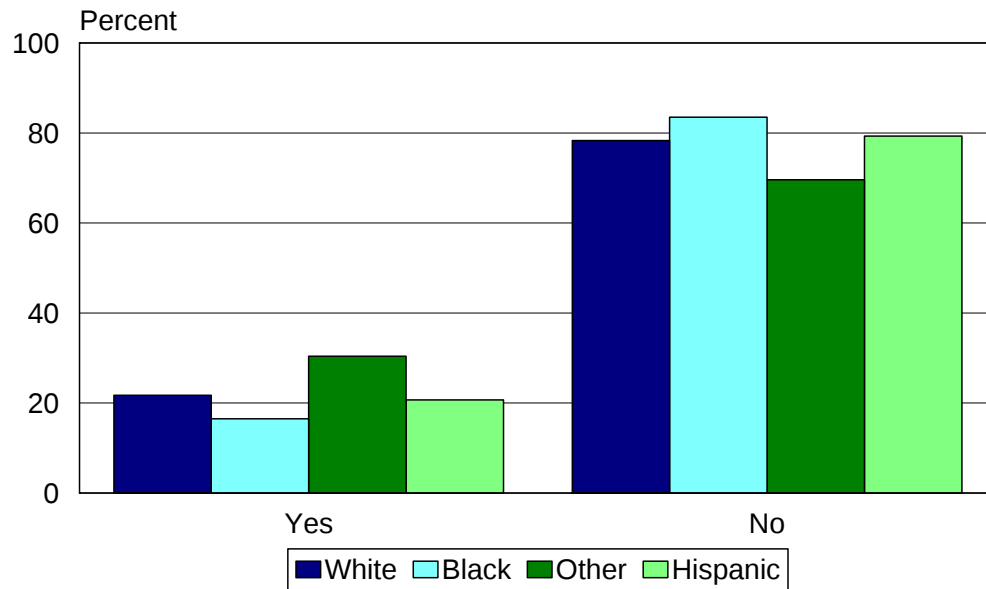


Source: Center for Applied Demography & Survey Research, University of Delaware

African Americans and Hispanics are substantially less likely to say they exercise than either Caucasians or the Other race category. To the extent exercise makes a difference to cardiovascular health, this behavior may account for some of the disparity between the races in heart disease and possibly stroke. These are complex issues so there are not simple answers. However, it is another piece of evidence as to why differences exist.

Diet is another area that can affect personal health. Eating behavior is measured in BRFSS through a series of questions. Using these questions, an index was derived that measures whether or not a person eats the recommended five servings of fruits and vegetables a day. Poor diet, especially when coupled with a lack of exercise, can have an effect on body weight and thus on overall health. The results for this question are found in Figure 15.6, below.

Figure 15.6
Do You Eat Five or More Servings of Fruits/Vegetables Daily?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

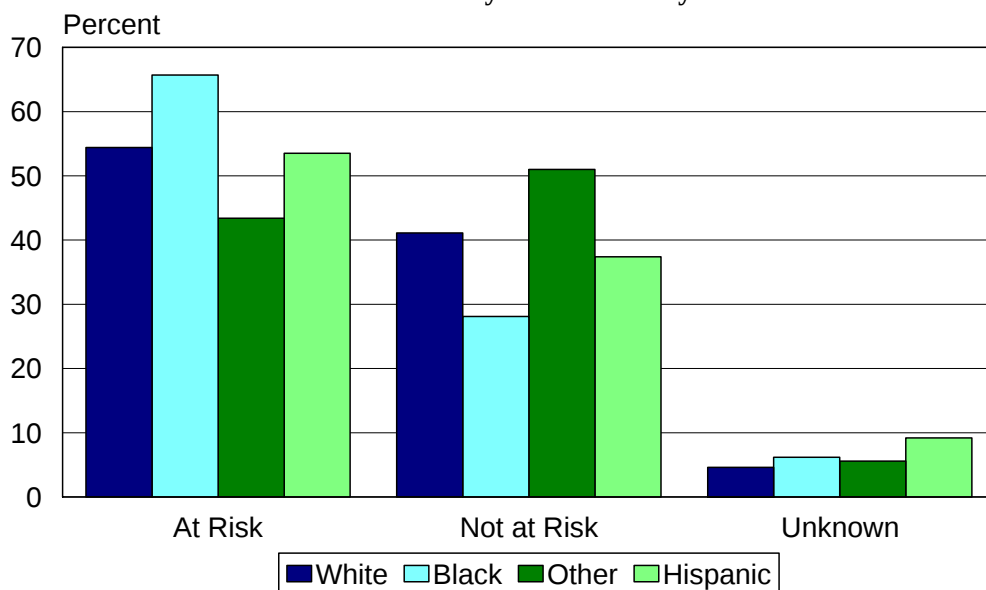
It is apparent from Figure 15.6 that only one in five adults follows the dietary guidelines promoted by the professionals in the field and the US government. African Americans are a few percentage points lower in following the guideline. This seems likely not to be a substantive difference, although coupled with other variables it may have a cumulative effect.

Diet and exercise can affect a person's weight. Additional pounds may lead to higher risk of heart disease, stroke, and diabetes. Respondents were asked a series of questions to determine if they were likely to be overweight as indicated by their body mass index. The results are found in Figure 15.7 below.

African Americans were the most likely of the racial/ethnic groups to be designated as being at risk for overweight. The Other category (largely Asians who were likely to exercise and eat their vegetables) showed the least risk for being overweight.

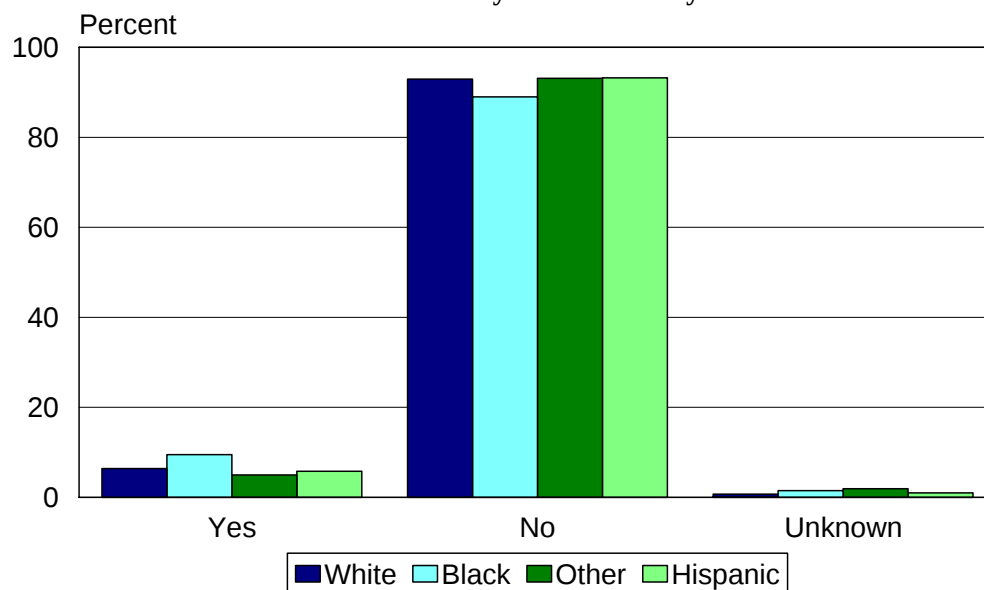
Being overweight is a risk factor for diabetes. In the previous section it was noted that the diabetes mortality rate for African Americans was more than double that for Caucasians. This difference is also observable in Figure 15.8 below where respondents were asked if they have ever been told they have diabetes.

Figure 15.7
At Risk for Being Overweight
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

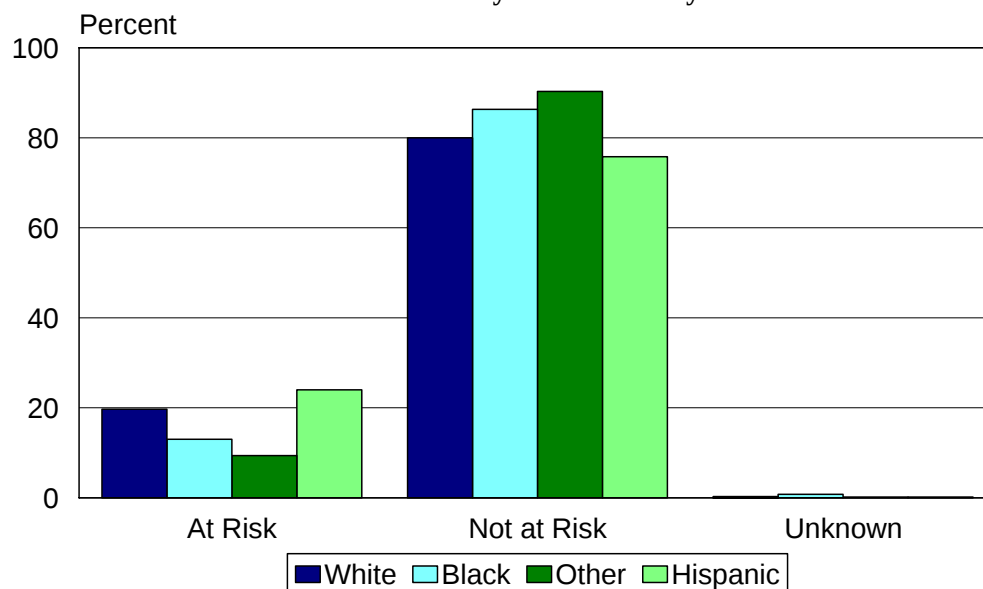
Figure 15.8
Ever Been Told You Have Diabetes?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

While reported diabetes is below 10% for all race/ethnic groups, the relative differences between African Americans and the other groups is measurable and significant. Looking at a time series from 1999 to 2003 (not shown), the rate reported for Caucasians has risen from 6% to 7% while African Americans have averaged 10% through the period. That differential is nearly 40%.

Figure 15.9
At Risk for Binge Drinking
by Race/Ethnicity

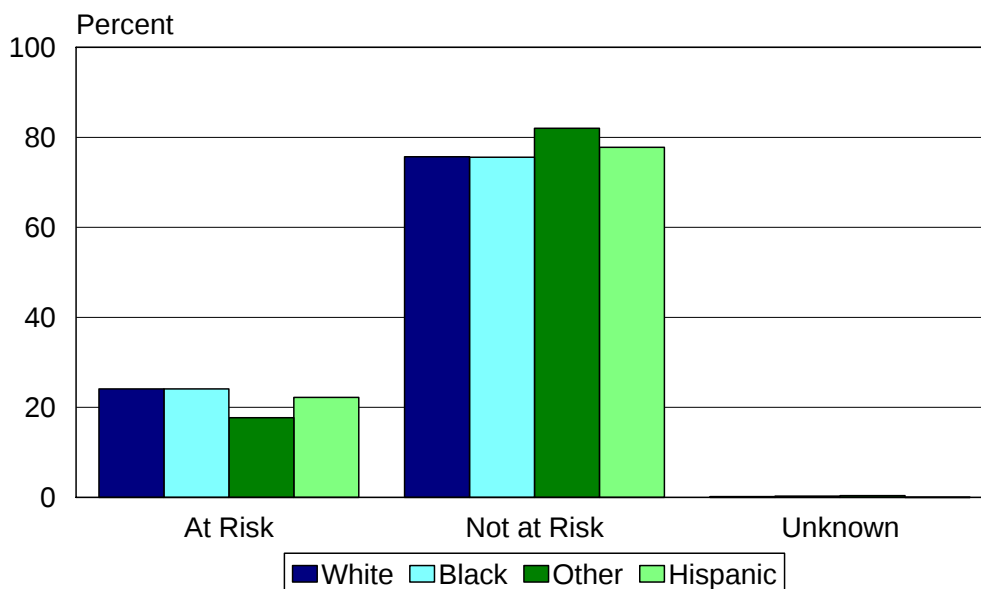


Source: Center for Applied Demography & Survey Research, University of Delaware

Since 1982, alcohol-induced mortality disparity has been reduced from a factor of three to nearly parity. All of that reduction was from a reduced rate for African Americans rather than an increase for Caucasians. One of the factors measured in the BRFSS is the risk factor for binge drinking that could lead to alcohol-induced mortality. In contrast to other charts, the risk factor for African Americans is now less than that for Caucasians. This is certainly consistent with the mortality data provided earlier.

There are many kinds of cancer that can lead to mortality. Certainly lung cancer is one of the more deadly. Smoking is a contributing factor to lung cancer. In Figure 15.10 below, the results for the smoking risk factor are shown. These data suggest that smoking is indistinguishable between Caucasians and African Americans. In fact, this has been the case for the five years from which these data were drawn. This may in part explain why cancer disparities are also converging as well.

Figure 15.10
At Risk for Smoking
by Race/Ethnicity



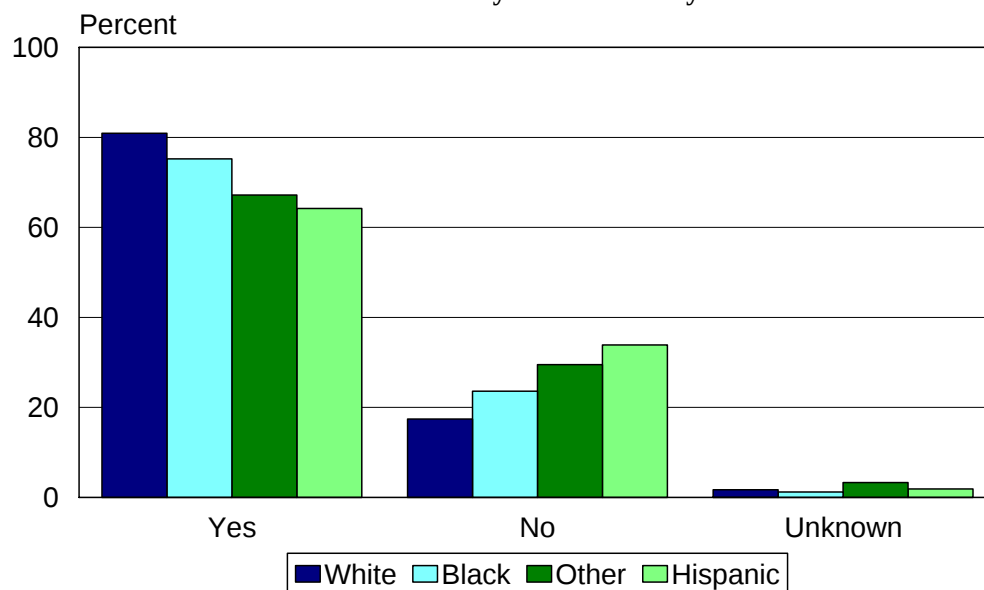
Source: Center for Applied Demography & Survey Research, University of Delaware

The last area that might provide some evidence for these health disparities is the use of tests for risk factors. High cholesterol is perhaps the most widely discussed problem associated with heart disease. The tests are routine and are widely available from physicians, wellness centers, and public health centers. The respondents were asked if they had been tested for high cholesterol. Their responses are displayed in Figure 15.11, below.

Very clearly, Caucasians have the highest rate of screening, and all of the minority groups trail. Hispanics and the Other category are substantially below Caucasians. African Americans are lower as well but only by about 5%. Still, the evidence accumulates that there are actions that can be taken that might reduce the current levels of health disparities.

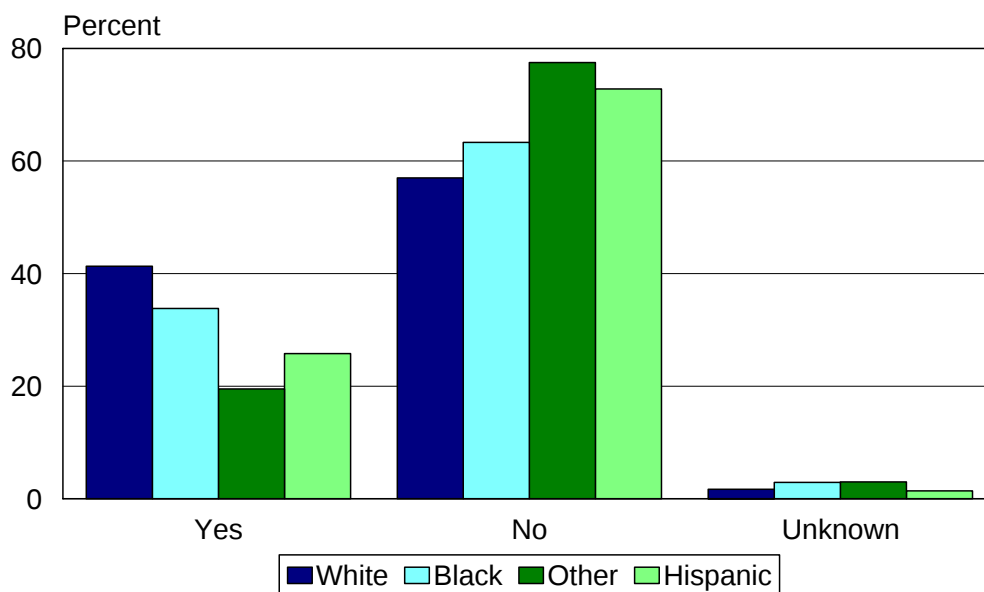
Respondents were also asked about using a blood stool home test kit. This could help with early detection of colon-rectal cancer or other related diseases. Here the utilization percentages were much lower than those measured for cholesterol by about half. The patterns were similar with all minorities reporting lower rates than those for Caucasians. The differences were also larger with the Other category showing only half of the percentage reported by Caucasians.

Figure 15.11
Ever Had Cholesterol Checked?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

Figure 15.12
Ever Had Blood Stool Test Using Home Kit?
by Race/Ethnicity



Source: Center for Applied Demography & Survey Research, University of Delaware

The data from BRFSS suggests that strategies for improving health literacy, promoting healthier behavior, and stressing simple diagnostic tests may prove beneficial for reducing some of the health disparities observed in Delaware. However, these are not quick fixes, but some strategies may yield results faster than others. Given that the risks of smoking have been well known since the 1960's and we still have 23% of the adult population smoking, it will not be easy.

National Perspectives

Research for this project included a review of the literature on health disparities and cultural competence. We focused on three areas in the literature review: 1) studies that have been most influential; 2) studies that offer policymakers a menu of policy interventions that have been implemented at the state level to address minority health and health care disparities; and, 3) studies that examine root causes (or sources) of health care disparities.

As a launching point for the full project, we identified seven national studies/programs that likely will be of particular interest to Delaware's health care community. These seven studies were picked from a preliminary list of more than thirty journal articles and technical reports. We narrowed the preliminary list after interviewing national experts from the Institute of Medicine, the federal Agency for Healthcare Research and Quality, the Center for Medicare and Medicaid Services, the US House of Representatives House Energy and Commerce Committee, and Blue Cross/Blue Shield. In addition we looked for "impact" (or how often a study is cited) by using library databases and Internet resources available from the *New England Journal of Medicine*, *Health Affairs*, and Kaiser Family Foundation.

Each of the following summaries presents a brief description of the report, and when not obvious, we explain why we included this report in our "top-seven" list. Interested readers and policy makers are encouraged to obtain copies of the full reports and supplemental Internet resources.

There is a somewhat technical but important point to make before proceeding. The literature is far from consistent in use of racial and ethnic categories; some studies, for example, focus only on black-white comparisons. The reports described below generally use categories consistent with – or similar to – the accepted national standard for data collection relies (and consequently analysis) specified in the Federal Office of Management and Budget's Directive 15: American Indian or Alaska Native; Asian; black or African American; Native Hawaiian or other Pacific Islander; white; and ethnic group: Hispanic or Latino. In the previous section, we had sufficient data to report results for three racial/ethnic categories: black, white, and Hispanic (and the "Other" group). In the next section, Quality of Health Care, we have enough data to separate the Asian respondents from the Other group. Our data analysis shows statistically significant differences among these categories in measures of consumer experiences and ratings.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (IOM).

The most influential recent study is the congressionally commissioned Institute of Medicine (IOM) 2003 report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” This study’s conclusion is not new, but it seems to have made a lasting impression on the nation’s health policy dialogue. Despite steady improvement in the overall health of the U.S. population, racial and ethnic minorities, with few exceptions, suffer higher rates of morbidity and mortality when compared to non-minority populations. While the causes of these disparities are complex and not easily identified (a topic for a future UD project update), the IOM report indicates that some may be attributed to socioeconomic status, culture, language, environment, and behavioral risk factors. Regardless of the sources of disparities, it is clear that the health gap has increased in recent years and many key stakeholders remain unaware of the problem.

Responding to a request from Congress, the IOM examined the extent of racial and ethnic disparities, identified potential sources of these disparities, and suggested interventions. The IOM study committee reviewed more than 100 studies, and “was struck by the consistency of research findings,” indicating that minorities are “less likely than whites to receive needed services, including clinically necessary procedures.” These disparities were found to exist across a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness. Information about potential sources of disparities and interventions can be found in other sections of our report.

The IOM provides a series of resources to increase awareness of the disparity issue. The complete 782-page report, a report summary, and a report brief, are available online at www.nap.edu/catalog/10260.html. In addition, the IOM offers a series of report summaries for different stakeholders:

- Report Brief for Healthcare Providers
- Report Brief for Healthcare Consumers
- Report Brief for Healthcare Consumers (in Spanish)
- Report Brief. What Health Care System Administrators Need to Know About Racial and Ethnic Disparities in Healthcare

These briefs also are available to download from the IOM web site at <http://www.iom.edu/report.asp?id=4475>.

REACH 2010/Healthy People 2010: Racial and Ethnic Approach to Community Health

REACH 2010 is a branch of Healthy People 2010, a health improvement program operating under the direction of the Centers for Disease Control and Prevention (CDC). Healthy People 2010 is a unique national health initiative that sets measurable goals intending to eliminate health disparities by 2010. Created in 1999, REACH 2010 focuses on specific targets to narrow disparities and improve health among racial and ethnic minorities in the United States.

REACH 2010 has identified the following six priority areas:

1. Infant Mortality
2. Deficits in Breast and Cervical Cancer Screening and Management
3. Cardiovascular Diseases
4. Diabetes
5. HIV Infections/AIDS
6. Child and Adult Immunizations

One objective, for example, is to decrease the breast cancer death rate for various racial and ethnic minorities by twenty percent from those found in 1998. We have investigated REACH 2010 initiatives in 24 states and have found widespread variations in the development of programs designed to meet the REACH 2010 goals. (This variation in state experience will be a topic for a future UD project update)

National Healthcare Disparities Report (DHHS)

On December 22, 2003, the US Department of Health and Human Services (DHHS) released its first annual comprehensive report on disparities in health care, the National Healthcare Disparities Report (NHDR). Produced in conjunction with the Agency for Healthcare Research and Quality (AHRQ), the NHDR identifies the scope and characteristics of differences in access and quality of health care associated with patient race, ethnicity, income, education, and place of residence. This report is unique in many aspects including: 1) providing a systematic overview of differences in health care for both racial and ethnic groups -- as well as by socioeconomic status, and 2) creating a framework, backed by community-level data, for better understanding and narrowing disparities -- at least at the national level.

The NHDR offers seven key findings to policymakers, clinicians, health system administrators, and community leaders:

1. Inequality in quality persists
2. Disparities come at a personal and societal price
3. Differential access may lead to disparities in quality
4. Opportunities to provide preventive care are frequently missed
5. Knowledge of why disparities exist is limited
6. Improvement is possible
7. Data limitations hinder targeted improvement efforts

A State Policy Agenda to Eliminate Racial and Ethnic Disparities (The Commonwealth Fund)

This report was developed to offer policymakers a menu of policy interventions that have been implemented at the state level to address minority health and health care disparities. The first half of the report focuses on system-wide programs developed to improve state infrastructure and capacity. Specific areas include: minimum standards for cultural competency, consistent data collection and analysis, expanded screening and insurance coverage, greater minority representation within the health care workforce, greater use of state purchasing leverage, expanded use of regulatory approaches, and enhancement of state infrastructure (e.g., minority health commissions and offices). The second half of the State Policy Agenda report turns its attention to priority health conditions. These conditions include the six emphasized by REACH 2010, plus asthma, injury prevention, mental health, obesity/ physical activity/tobacco use, and oral health.

The authors offer three to four page discussions for each category presented in the “health conditions” and “state infrastructure and capacity” discussions. Each category discussion includes important background information (e.g., low income children miss 12 times as many days of school due to dental problems in comparison to higher-income children), followed by a listing of promising practices currently in operation in states and localities, policy recommendations, and finally a short list of Web links for readers interested in additional resources.

For stakeholders looking to find and narrow (or eliminate) racial and ethnic disparities in their states and communities, the report underscores two current roadblocks, which the authors did not anticipate as they began this project. First, major inadequacies in data collection hinder

efforts to document, understand, and develop policy recommendations. And secondly, the authors abandoned the term “best practices” when they confronted a shortage of state-level research assessing cost-effectiveness -- or even effectiveness -- of various strategies. The authors do not mention that some clues to the relative effectiveness can be found in the academic literature. A 2003 study published in *Health Services Research*, “The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care” concludes that lack of health insurance, followed by income differences, were the two most important factors in white-Hispanic and white-African American differences in access to care. Community characteristics (e.g., availability of safety net providers) generally were much less important.

Primary Care Physicians Who Treat Blacks and Whites (Peter Bach et al., *New England Journal of Medicine*, August 5, 2004)

“Dramatic,” enough to “incite a fundamental shift in thinking,” is the way the *Wall Street Journal* (Aug 8, 2004, p W13) describes the findings of this research study. Based on data from more than 150,000 visits by black and white Medicare beneficiaries to 4,335 primary-care physicians across the United States in 2001, the research team found that most visits by black patients were with a small number of physicians. More specifically, 80 percent of the visits were made to less than a quarter (22 percent) of all physicians in the study panel. Although black patients were more likely than whites to receive care from black physicians, the large majority of their visits were with non-black doctors.

What is particularly disturbing is the strong evidence from the study showing that doctors (of any race) who disproportionately treat black patients are different from other doctors. And, clinicians who disproportionately treat black patients are less well trained and have less access to important clinical resources.

More specifically, physicians of any race who disproportionately treat black patients were significantly less likely to have been board certified (having passed a demanding certification exam in their specialty). And they were less likely to say that they could “always” or “near always” provide access to high-quality sub specialists, high-quality diagnostic imaging, high-quality ancillary services, and non-emergency admission to a hospital. These patterns of access to care reflect, to a large extent, geographic distribution. Primary care physicians, who lack board certification and face larger obstacles in obtaining specialized services for their patients, are more

likely to practice in areas where blacks receive their medical care, lower income neighborhoods as measured by median income.

So, black patients enrolled in the Medicare program – and presumably other black patients – receive treatment from a group of physicians who differ in clinically significant ways from physicians who treat white patients. Even given the limitations of this study (e.g., data based on subjective responses of physicians, data only for Medicare patients, etc...), the results give health researchers and policy makers reason to think that there are important structural differences in the delivery system. And, these imbalances may underlie disparities in the delivery of care.

Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches (IOM)

Joseph R. Betancourt from Massachusetts General Hospital and Harvard Medical School is the lead author of this 2002 report. Betancourt also consults with state organizations (e.g., Blue Cross/Blue Shield of Florida) looking to reduce health disparities. In this report, the authors set out to:

1. Evaluate current definitions of cultural competence.
2. Identify opportunities for improvement by reviewing the medical literature and interviewing health care experts in government, managed care, academia, and community health care settings.
3. Identify promising models of culturally competent care.
4. Determine the most critical components of cultural competence and develop recommendations to help government and organizations implement culturally competent interventions and improve the quality of health care.

Examples of recommendations include:

1. Provide on-site interpreter services in health care settings with significant populations of limited-English-proficiency (LEP) patients. Other kinds of interpreter services should be used in settings with smaller LEP populations or limited financial or human resources.
2. Develop health information for a patient that is written at the appropriate literacy level and is targeted to the language and cultural norms of specific populations.

3. Require large health care purchasers to include systemic cultural competence interventions as part of their contracting language.
4. Collect race/ethnicity and language preference data for all beneficiaries, members, and clinical encounters in programs sponsored by governments and private organizations. Systematic data analysis should be used to monitor racial and ethnic disparities in health care delivery, for reporting to the public, and for quality improvement initiatives. (A June 2004 article published in the Wall Street Journal reports progress: “A new survey released today finds that 51% of health plans either ask beneficiaries to provide their race voluntarily on enrollment and other forms, or use less direct methods to obtain aggregate data on the racial makeup of their members.”)

Health Literacy: A Prescription to End Confusion (IOM)

The IOM Committee on Health Literacy reports that 90 million US adults are unable to read complex texts, including many health-related materials, and consequently have difficulty benefiting from much that the health and health care system have to offer. The Committee Chair, David Kindig states, “It will become widely understood that efforts to improve quality, to reduce costs, and to reduce disparities cannot succeed without simultaneous improvements in health literacy.”

According to the IOM, health literacy is “the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. But health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of health information and care providers: our doctors; nurses; administrators; home health workers; the media; and many others.”

The IOM report and related literature offer many examples underscoring the need for a more health literate population:

A two-year-old is diagnosed with an ear infection and prescribed an antibiotic. Her mother understands that her child has an ear infection and knows she should take the prescribed medication twice a day. After looking at the label on the bottle and deciding that it does not tell how to take the medicine, she fills a teaspoon and pours the antibiotic into her daughter’s ear.

(IOM, p. 19, from: Parker, 2003. Health Literacy: A Policy Challenge for Advancing High-Quality Health Care, *Health Affairs*. 22(4): 147.)

We have included the IOM Health Literacy report in our top-seven reading list for three reasons: 1) An increasing body of literature (see Healthy People 2010, for example) suggests that health literacy can contribute to and be an underlying factor for socioeconomic health disparities. Moreover, many individuals with the greatest health care needs have the least ability to comprehend information required to navigate and function in our complex U.S. health care system. 2) Our preliminary analysis of Delaware consumer assessment data suggests that, along with other factors such as insurance status, language barriers likely are a key to understanding negative reports and ratings by certain subgroups of the population. And, 3) the IOM report includes strategies for improving health literacy, which is particularly important as more plan sponsors look to consumer-driven health plans* as the latest “answer” to skyrocketing health care costs.

*Consumer-driven health plans empower health consumers to make more decisions about their health care and health insurance plans.

Quality of Health Care

The Role of Quality Measurement

In a recent August 2005 editorial in *The New England Journal of Medicine*, Harvard professor and physician Arnold Epstein reminds readers that understanding health disparities requires a parallel investigation of health care quality: “We might also consider that efforts to improve the quality of care in general might reduce racial disparities in the quality of care. This is so because racial and ethnic disparities in care are, in some ways, just another manifestation of the broad problems in quality of care that exist throughout our health care system.”ⁱ Following Epstein’s suggested path, this section begins by explaining the link between the CAHPS data and its recent role in efforts to improve quality of care – and improving our health care system.

In an era of double-digit health care inflation, providing higher quality health care is seen as one way to stem exorbitant cost increases. Quality health care, typically defined as “doing the right thing right, at the right [appropriate] time,”ⁱⁱ has quickly become a critical priority in health policy. The movement to measure and improve quality has grown substantially. But why is this the case? Why do so many people care about *quality*? Two reasons. First, quality health care improves patient outcomes and decreases morbidity. Second, quality health care saves money. According to a recent National Committee for Quality Assurance (NCQA) report, this is the annual tally for failure to deliver appropriate, quality health care: 57,000 avoidable deaths, 41 million sick days, over \$11 billion in lost productivity, and billions in hospital costs. Put another way, more than one thousand Americans die each week because the care they get is not consistent with the care that medical science says they should get. When doctors operate on the wrong side of the brain, remove the wrong kidney, or fail to prescribe beta blockers to heart attack victims, patients suffer. And when diabetics, asthmatics, and heart disease patients die because their conditions are not adequately monitored and controlled, health outcomes suffer. Unfortunately, quality is elusive. As a recent study in *The New England Journal of Medicine* highlights, Americans typically receive only half of the care recommended by the current best medical practices.ⁱⁱⁱ The “quality gap” between care that is proven to work and the care that is actually delivered is astonishingly wide. It is also quite expensive.

George Halvorson and George Isham underscore the costs of poor health care quality in their new book *Epidemic of Care*. After all, the authors note, “It costs a lot more to do [health] care wrong. It saves a lot of money to do it right.”^{iv} The Kaiser Family Foundation (KFF) estimates that “Not providing the best treatments costs the United States more than \$1 billion per year in avoidable health care bills” (KFF Daily Report, 9/22/03). Avoidable episodes of congestive heart failure and preterm births create many billions of dollars in unnecessary and avoidable expenditures. Conversely, the tremendous cost savings that improved quality could generate are staggering. Some analyses estimate that closing the “quality gap” could generate cost-savings ranging from 15 to 30 percent of the country’s \$1.4 trillion annual health care tab (Wall Street Journal, 12/23/03). Moreover, geographic variations in the delivery of quality care are expensive. Dr. John Wennberg, known for his research in health care variation, predicts that “Medicare could trim 30 % of its \$285 billion budget by bringing the highest-spending regions of the U.S. in line with the rest” (WSJ, 12/23/03). Wennberg’s research argues that such a leveling of expenditures could be achieved without causing a decrease in health outcomes.

Thus, in the eyes of many, quality is the solution to health care’s chronic cost and access problems. Provide more right care, and less wrong care, and this country will save money while delivering better health for *everyone*. Of course, this is much easier said than done. But the quality proponents do submit compelling arguments, and efforts to measure and report quality have become increasingly prevalent. Halvorson and Isham submit that this is a positive step because, as they pointed out in *Epidemic*, “care improves when quality is reported publicly.”^v Taking quality information public improves quality of care because consumers—armed with quality data—will demand the best, while providers become incentivized to meet that demand. Doctors, for example, have a strong incentive to improve their management of diabetic patients when they know that their performance will be monitored publicly.

Recent quality measurement and reporting initiatives, like ones taken by CMS, Leapfrog Group, and NCQA, aim to narrow the “quality gap,” improving health care and saving money for all Americans. In Delaware, rigorous quality measurement and quality-improvement efforts are essential if Delawareans are to receive a better value for the more than \$3 billion spent annually on health care. Delaware’s Consumer Assessment of Health Plans Survey (CAHPS) represents one such effort at the state level. As if to punctuate the emergence of quality as a national issue, the Agency for Healthcare Research and Quality (ARHQ) recently published the first comprehensive, national report card to measure the quality of health care for the entire country. A measure of the current state of health care quality in the United States, this report card gauges

quality in everything from the screening for cervical cancer to the immunization of respiratory diseases to the chronic care provided in nursing homes. While AHRQ's initiative is itself encouraging, their findings are not. Finding high quality health care to be lacking, the report notes that 37 of 57 areas measured have either shown no improvement or have worsened.

Methodology: Data

This study analyzes survey data from the Consumer Assessment of Health Plans Survey (CAHPS) to investigate barriers to quality health care for Delaware's adult population. In particular, the analysis focuses on the following question: How do reports and ratings of health care vary by race and ethnicity? To generate a sample sufficiently large to permit analysis of experiences *within* this population, we pooled together data from the 1999, 2000, 2001, 2002, and 2003 Delaware CAHPS datasets.

CAHPS Background

CAHPS was created in 1995 by the Agency for Healthcare Research and Quality (AHRQ), in collaboration with Harvard Medical School, RAND, and the Research Triangle Institute. These organizations developed the CAHPS methodology and survey instrument. CAHPS examines health care quality by measuring patients' health care experiences. It is widely recognized as the standard for measuring consumers' experiences within the health care system. The standardized set of surveys allows researchers to gather comparative information about the experiences of enrollees with their health plans and health care providers. Since its inception, CAHPS has grown steadily into a major source of health care quality information. CAHPS surveys now assess everything from health plans to hospitals to nursing homes to physician group practices. Moreover, usage of CAHPS has increased from four users and three demonstration sites in 1997, to an active network of CAHPS users in all but four states. Today, CAHPS is used to assess the care provided by health plans covering more than 123 million lives across private, Medicaid, and Medicare markets.^{vi} Governments use CAHPS to help with purchasing decisions. The nonprofit National Committee on Quality Assurance (NCQA) uses CAHPS to accredit health plans.

As the use of CAHPS continued to grow, AHRQ promoted the development of the National CAHPS Benchmarking Database (NCBD). The NCBD is the central clearinghouse of CAHPS data, intended as a national database that can be used for benchmarking analyses. Health plans can use the NCBD to compare their own results to relevant national benchmarks in order to

identify performance strengths as well as opportunities for improvement. As if to underscore the ubiquity of CAHPS methods, AHRQ includes several measures taken from the NCBD in its National Healthcare Quality Report. This report, mandated by Congress, is the first comprehensive, national report on the current state of health care quality in the United States. It gauges quality in everything from the screening for cervical cancer to the immunization of respiratory diseases to the chronic care provided in nursing homes. The national report card uses CAHPS data to conduct state-level assessments of health plan performance, as measured in three areas: timeliness, patient-centeredness, and overall performance.

CAHPS in Delaware

Since 1997, the Delaware Health Care Commission has contracted with the College of Human Services, Education and Public Policy (CHEP) at the University of Delaware to administer CAHPS. The Delaware CAHPS survey collects information on issues related to Delaware's health care services and delivery systems. These reports on experiences with the health care system provide information to both consumers and policymakers in Delaware. One year of CAHPS data is collected over a period of twelve months, with approximately 150 monthly surveys of adults aged eighteen and older conducted throughout the state.

Measures

For the National Healthcare Quality Report, AHRQ chose data that is clinically important, scientifically sound, readily available, and regularly collected at both the national and state levels. That NCBD data met each of these standards, and that CAHPS measures are a part of this national health report card, is proof of the measures' validity and reliability. The survey instrument is designed to address reliability and validity concerns, so what is measured is both repeatable for other researchers, and a genuine reflection of the quality of care provided. This sets CAHPS measures apart from other measures that simply gauge satisfaction.

The dependent variables consist of CAHPS global rating items (personal doctor, specialist, health care, health plan) and multi-item reports of care (getting needed care, getting care quickly, doctor communication, courtesy and helpfulness of office staff). Health plan customer service is omitted. Respondents are limited to health care experiences of the past twelve months when surveyed. The four ratings questions are scored on a 0 to 10 scale, where 10 is the best possible rating. Questions included in the getting needed care composite are answered using a *Big Problem*, *Small Problem*, *Not a Problem* response scale; questions included in the

getting care quickly, doctor communication, and courtesy and helpfulness of office staff composites are answered using a *Never, Sometimes, Usually, Always* response scale.

The composite scores are calculated with a two-step process found in the CAHPS literature.^{vii} We linearly transform each item score to a 0 to 100 scale, then compute the mean score for items within each composite. Non-responses are coded as “missing” (not 0) and excluded from the calculation. To better enable comparisons between global ratings and composites the 0 to 10 ratings also were transformed to a 0 to 100 scale.

Race/ethnicity, and income are used to explore quality of care differences within the data. CAHPS survey respondents were asked to identify their ethnicity and race, then assigned an ethnicity (Hispanic/Latino or not Hispanic/Latino) and one of six racial categories: White, Black/African American, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, or Other. These racial groupings are employed by the U.S. Census Bureau for Census 2000.^{viii} As for ethnicity, according to the federal government’s Office of Management and Budget (OMB), ethnicity and race are two separate questions. They reflect separate characteristics, just as age and gender reflect separate characteristics, and are not mutually exclusive. A Hispanic/Latino individual may be of any race, just as a male or female may be of any age group. However, in recent CAHPS literature concerning racial/ethnic minorities, Hispanic/Latino is effectively treated as its own, mutually exclusive racial/ethnic grouping.^{ix} This analysis mimics the literature. That is, if a respondent indicates he or she is of Hispanic/Latino origin, he or she is *not* included in the analysis as a member of any of the six Census/OMB racial groups. Likewise, all individuals included in any one of the six race groups are not of Hispanic/Latino origin. This methodology disentangles ethnicity from race to examine quality variations.

Because survey respondents are able to check more than one box for race, a small percentage (1.4%) of respondents identify themselves as multiracial. For this analysis, only respondents who indicated a single race were included in the sample. Respondents who did not check a single box to identify their race (0.3%) were also omitted. To create satisfactory sample sizes, we combined Hispanic/Latino, Black/African American, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native, and Other into a single category. This creates a new dichotomous race variable, with categories “white” and “nonwhite.”

Analysis Plan

To ensure that the Delaware sample is representative and to adjust for sampling biases due to socio-demographic differences between respondents and non-respondents, responses are weighted according to the most recent U. S. Census data for county of residence, age, and gender.

For the purpose of this first phase of our analysis, we pool data and conduct preliminary data analysis. This analysis focuses on mean differences in CAHPS quality ratings and reports (variables), broken down by race/ethnicity.

Findings

This section examines mean differences by racial and ethnic subgroup. Detailed results are presented in Table 1 (below), and show the following results:

- For all 9 Delaware CAHPS quality ratings and report variables, there are at least 2 subgroups that show statistically significant differences (at the 0.05 or 0.01 level).
- For 8 of the 9 Delaware CAHPS variables, blacks report higher results than the whites (the reference group). Nearly all (7 of 8) are by statistically significant margins.
- For all 9 variables, Asians report lower results than whites, and 5 of 9 are by statistically significant margins.
- For 8 of 9 Delaware CAHPS variables, the Hispanic/Latino subgroup reports lower ratings and reports than whites. Three of these 8 differences are by statistically significant margins. If we had more Hispanic/Latino data, it is very possible that more of these differences would prove to be statistically significant.

Figure 17.1
Delaware CAHPS Health Care Quality Ratings
by Category and Race/Ethnicity

	<i>Doctor</i>	<i>Specialist</i>	<i>Health Care</i>	<i>Health Plan</i>	<i>Getting Needed Care</i>
Race					
<i>Hispanic/Latino</i>	82.623	79.206**	81.679	78.014	81.818**
White	83.914	85.152	82.561	76.175	89.834
<i>Black</i>	86.125**	86.025	84.196**	81.477**	87.987**
<i>Asian</i>	79.254**	80.938	76.667**	71.310**	89.263
<i>Combined/other</i>	81.690	79.286**	78.649**	73.810	84.465**
Total	84.155	85.015	82.690	76.965	89.262

* p<.10 ** p<.05

(Probability that the value is significantly different from White rating)

Figure 17.1
(continued)
Delaware CAHPS Health Care Quality Ratings
by Category and Race/Ethnicity

	<i>Getting Care Quickly</i>	<i>Health Plan Customer Service</i>	<i>Doctor Communi- cation</i>	<i>Helpful Office Staff</i>
Race				
<i>Hispanic/Latino</i>	66.722**	71.897	79.903**	82.323*
White	72.202	72.219	83.492	85.618
<i>Black</i>	71.102	78.687**	85.364**	87.531**
<i>Asian</i>	60.795**	72.884	79.412*	78.922**
<i>Combined/other</i>	72.583	71.635	82.320	82.658
Total	71.745	73.200	83.652	85.737

* p<.10 ** p<.05

(Probability that value is significantly different from White rating)

APPENDIX A

Definition of CAHPS Health Care Quality Ratings

Consumer Reports and Items	Response Grouping for Presentation
Getting Needed Care	
Q6: With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?	A big problem, A small problem, Not a problem
Q10: In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?	A big problem, A small problem, Not a problem
Q22: In the last 12 months, how much of a problem, if any, was it to get the care you or a doctor believed was necessary?	A big problem, A small problem, Not a problem
Q23: In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?	A big problem, A small problem, Not a problem
Getting Care Quickly	
Q15: In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?	Never + Sometimes, Usually, Always
Q17: In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?	Never + Sometimes, Usually, Always
Q19: In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?	Never + Sometimes, Usually, Always
Q24: In the last 12 months, how often did you wait in the doctor's office or clinic more than 15 minutes past your appointment time?	Never + Sometimes, Usually, Always
Health Plan Customer Service	
Q33: In the last 12 months, how much of a problem, if any, was it to find or understand information in the written materials?	A big problem, A small problem, Not a problem
Q35: In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	A big problem, A small problem, Not a problem
Q37: In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?	A big problem, A small problem, Not a problem
Doctor's Communication	
Q27: In the last 12 months, how often did doctors or other health providers listen carefully to you?	Never + Sometimes, Usually, Always
Q28: In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?	Never + Sometimes, Usually, Always
Q29: In the last 12 months, how often did doctors or other health providers show respect for what you had to say?	Never + Sometimes, Usually, Always
Q30: In the last 12 months, how often did doctors or other health providers spend enough time with you?	Never + Sometimes, Usually, Always
Courteous and Helpful Office Staff	
Q25: In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?	Never + Sometimes, Usually, Always
Q26: In the last 12 months, how often was office staff at a doctor's office or clinic as helpful as you thought they should be?	Never + Sometimes, Usually, Always

Consumer Ratings	Response Grouping for Presentation
Overall Rating of Personal Doctor	
Q8: Use any number on a scale from 0 to 10 where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible. How would you rate your personal doctor or nurse now?	0-6, 7-8, 9-10
Overall Rating of Specialist	
Q12: Use any number on a scale from 0 to 10 where 0 is the worst specialist possible, and 10 is the best specialist possible. How would you rate the specialist?	0-6, 7-8, 9-10
Overall Rating of Health Care	
Q31: Use any number on a scale from 0 to 10 where 0 is the worst health care possible, and 10 is the best health care possible. How would you rate all your health care?	0-6, 7-8, 9-10
Overall Rating of Health Plan	
Q38: Use any number on a scale from 0 to 10 where 0 is the worst health plan possible, and 10 is the best health plan possible. How would you rate all your health plan?	0-6, 7-8, 9-10

APPENDIX B

Summary of **Promising Programs to Eliminate Racial and Ethnic Health Disparities**

researched and compiled by Eric Jacobson, Sarah McCloskey, Erin Kennedy, and Michele Sloan at the
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December 2004

www.ipa.udel.edu/healthcare/disparities

This section provides Delaware policymakers with a series of approaches, or best practices, used in other states to address minority health disparities. Since narrowing health disparities has gained greater attention at the national, state, and local levels, this collection of policy options should be considered a work-in-process. In developing this compendium, the research team had the benefit of input and feedback from State of Delaware officials and representatives of the Metropolitan Wilmington Urban League. Shortly after IPA began researching promising practices, The Commonwealth Fund published a tremendously valuable 87-page report: *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* (June 2004). www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf

Many of the approaches described below are included in the aforementioned report from The Commonwealth Fund. Not surprisingly, there are similar kinds of information in both resources. However, IPA did not simply “cut and paste” from The Commonwealth Fund report. The material presented has been modified (and hopefully improved) in a few important ways: 1) rather than long narratives, it is presented in a tabular (more user-friendly) form and will be accessible online; 2) to ensure that the information is complete and up-to-date, IPA researched state/program websites and contacted program officials when necessary; and 3) included is additional information obtained through IPA’s own, independent search (to continue through fall of 2004) to identify promising programs.

Other important sources of information have been evaluated and included in this summary. Specifically, this summary includes programs and approaches from five other major disparities resources, including the American Public Health Association (APHA), Centers for Disease Control and Prevention (CDC), Association of State and Territorial Health Officials (ASTHO), National Association of County & City Health Officials (NACCHO), U.S. Department of Health and Human Services: Health Resources and Services Administration (HRSA), Robert Wood Johnson Foundation (RWJF), and the American Medical Association (AMA). IPA also examined a variety of resources from key states, including state departments of health and offices of minority or multicultural health.

- **APHA:** IPA studied at length a database of programs provided by the American Public Health Association (APHA) entitled Community Solutions to Health Disparities Database: www.apha.org/NPHW/solutions/. The database features a search engine where users can sort disparity programs by specific age groups, racial/ethnic groups, gender, and state.

In addition to the searchable database, APHA publishes facts sheets on eliminating health disparities entitled Communities Moving from Statistics to Solutions. Fact sheets can be found at www.apha.org/NPHW/pressroom/.

- **RWJF:** The Robert Wood Johnson Foundation is working with health plans, providers, and patients to design programs and approaches to eliminate disparities.

They also conduct research on data-collection methods, allocate grants, and present a program to eliminate cultural and language barriers (www.rwjf.org/programs/programArea.jsp).

- **CDC:** IPA examined the national initiative *Racial and Ethnic Approaches to Community Health* (REACH). A list of the 2004 REACH project sites can be found on the CDC website at www.cdc.gov/nccdphp/aag/aag_reach.htm.

The CDC also highlights several Exemplary State Programs specifically aimed at chronic disease prevention for racial and ethnic minorities. To be selected, these programs must be based on strong research, incorporate innovative approaches, and yield positive, measurable outcomes (www.cdc.gov/nccdphp/exemplary/).

- **ASTHO, NAACHO, HRSA:** IPA researched the collaborative publication *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health*. This resource presents dozens of model state and local programs that reflect diverse strategies being used to address health disparities. The report can be purchased at www.naccho.org/prod107.cfm.
- **AMA:** The American Medical Association's Minority Affairs Consortium examines minority health issues and professional concerns of minority physicians and medical students, and seeks to inspire minority children to pursue careers in the medical profession (www.ama-assn.org/ama/pub/category/20.html).

IPA has developed, organized, and presented programmatic information in a way that will help leaders think systematically about actions that work together to narrow racial and ethnic disparities. Policies and approaches can address both structural causes (e.g., data collection) and interpersonal factors (e.g., physician interaction and language competency). IPA presents two types of policy interventions: specific health conditions and system-wide (state-level) infrastructure and capacity options. To date, IPA presents information for 15 categories of best practices (nine health conditions and six system-wide interventions):

Health Conditions

- Asthma
- Cancer
- Cardiovascular Disease
- Diabetes
- HIV/AIDS
- Immunizations
- Infant Mortality
- Obesity
- Oral Health

System-wide Interventions

- Cultural and Linguistic Competency
- Data
- Regional Networking and Collaboration
- Purchasing
- State Infrastructure
- Workforce Development

<u>Health Conditions</u>	<u>No. of Programs</u>
Asthma	7
Cancer	5
Cardiovascular Disease	7
Diabetes	6
HIV/AIDS	6
Immunizations	6
Infant Mortality	7
Obesity	6
Oral Health	6
TOTAL	56
<u>State-wide Interventions</u>	<u>No. of Programs</u>
Cultural and Linguistic Competency	9
Data	5
Regional Networking and Collaboration	4
Purchasing	5
State Infrastructure	5
Workforce Development	6
TOTAL	34

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Asthma
Background:	In 1996, there were 14.6 million people with asthma in the United States, a 74 percent increase from 1980. Evidence shows that asthma is more prevalent among those with lower socioeconomic standing or minority status, possibly due to poor healthcare quality and access, environmental conditions, financial restrictions, and lingual/cultural barriers. Among minorities, there are significantly higher rates of diagnosis, hospitalization, and death from asthma. Nationally, African Americans have 40 percent higher rates of asthma induced office visits than whites, 125 percent higher asthma-related emergency room visits, and 220 percent higher asthma-related hospitalization rates. African-American children are four times as likely to die from asthma as white children.
State Programs:	Current state programs most frequently focus on distributing information to high-risk populations; allowing students to carry their medications in school; housing environment assessments; enhanced education, outreach and disease management; and other proactive measures that focus on prevention, rather than reaction to the condition (e.g., limiting exposure to environmental and housing stimulants like dust and animal fur.)
Illinois	Asthma Information Program – This program targets high-risk groups for distribution of information regarding asthma causes, prevention techniques, and treatment. Target groups include African Americans, Hispanics, the elderly, children, people with a family history of asthma, and those exposed to environmental factors associated with high risk of asthma. (20 ILCS 2310/2310-337) www.legis.state.il.us/legislation/ilcs/ilcs.asp Self-administration of Asthma Medication – State legislation that allows students to possess and use their asthma medications at their own discretion. (105 ILCS 5/ 22-30) www.legis.state.il.us/legislation/ilcs/ilcs.asp
New York	Action Against Asthma: Healthy Neighborhoods Program – Asthma education and management is promoted in households where a member has asthma. Seeks to cut asthma hospitalizations through proactive interventions such as dust control, pillow and mattress covers, and mold/mildew removal in the home. www.health.state.ny.us/nysdoh/asthma/ny_action.htm
California	California Asthma Public Health Initiative (CAPI) – State, local, and community efforts are coordinated to promote consistent and equal asthma management, education and trainings, treatment, and prevention. CAPI provides funding for community interventions, treatment services, and provider education. California law focuses greater attention on data surveillance, data analysis, and evidence-based care. www.dhs.ca.gov/ps/cdic/cdcb/Medicine/Asthma/
Mississippi	Caffee, Caffee, and Associates PHF Inc. Hattiesburg, Miss. – <i>The group developed partnerships with faith-based groups, NGOs, and tribes in order to address the issue of secondhand smoke. The program designs events to encourage the community to reduce exposure to secondhand smoke. Events motivate people to declare their homes and cars “tobacco-free” environments.</i>

	<i>This is an APHA Statistics to Solutions program example. For more information, contact Brenda Caffee at (601) 583-0599.</i>
Pennsylvania	Health Promotion Council: Smokeless Homes in Philadelphia, Pa. – <i>This program is geared toward educating African Americans and Latinos about the link between asthma and smoking. Program administrators attend community health fairs and distribute information about smoking to teachers, parents, and healthcare providers. This is an APHA Statistics to Solutions program example. For more information, contact Tawanda Hayes at (215) 731-6106. www.hpcpa.org/smokeless.htm</i>
Seven Major U.S. Cities: Results published in Sept. 9, 2004 issue of NEJM.	Results of a Home-Based Environmental Intervention Among Urban Children with Asthma – <i>This study was used to determine if an environmental intervention specific to a child's allergies would improve asthma-related health conditions over the course of one year. 937 children with asthma were randomly chosen from seven major U.S. cities. Their households received education and remediation for exposure to allergens and tobacco smoke. Each household was evaluated every six months, and the child's asthma-related health complications were evaluated every two months. The study concluded that, after each two-week interval, the intervention group had fewer days with symptoms and significant declines in the levels of allergens in the home. As a result, morbidity caused by asthma related illness was reduced.^x</i>

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Cancer
Background:	In 2003, approximately 556,500 people died in the United States of cancer, and the largest portion of them were African Americans, who have the highest rate of cancer incidence and death of all ethnic or racial groups. According to the NIH, socioeconomic levels are the biggest factor in the incidence of cancer. While African Americans have the highest incidence of all cancers combined, Hispanics have the highest incidence of cervical cancer. Asian/Pacific Islanders have the lowest incidence of all cancers combined, but they have the highest death and incidence rates of stomach and liver cancers. Disparities for minority cancer patients can be seen in the forms of less radiation care after surgery, less aggressive treatment, and fewer uses of new or more expensive treatment. In Delaware in 2001, cancer mortality rates were 216 per 100,000 for whites and 249 per 100,000 for African Americans. Both rates are higher than national averages of 194 per 100,000 for whites and 243 per 100,000 for African Americans. ^{xi}
State programs:	State programs tend to focus on prevention and awareness. Many programs offer screenings to high-risk minorities at low or no cost. Some provide mobile screening/testing centers, while others partner with health clinics and other community organizations.
New Jersey	<i>Bergen County Education and Early Detection Program, Paramus, N.J.</i> The program's purpose is to increase awareness of and screenings for prostate

	cancer among African-American men. This is done through the use of African-American celebrities and prominent pastors and community events where local hospitals give free screenings. This is an APHA <i>Statistics to Solutions</i> program example. bergenhealth.org
Maryland	Baltimore City Cancer Plan Prostate Cancer Screening – African-American men in Baltimore City experience three times the age-adjusted prostate cancer mortality of Caucasian men. This program partners with seven community-based organizations to help encourage age-appropriate prostate cancer screening for minority populations. The goal of this project is to identify and treat prostate cancer for high-risk underinsured Baltimore residents. The program also educates the community about prostate cancer screening, provides opportunities to participate in no-cost screening, and provide diagnosis and treatment to eligible individuals. Source: APHA insidehopkinsmedicine.org/oncology/ .
California	Increase Cervical Cancer Screening Among Vietnamese American Women – The Vietnamese Community Health Promotion Project organized a coalition to prevent cervical cancer among Vietnamese American women in Santa Clara County. Coalition members held community forums, meetings, and retreats to identify barriers to Pap testing, and designed ways to address each concern. Six strategies were implemented, including a media education campaign; outreach efforts using lay health workers; patient navigation; a low-cost Vietnamese-language clinic (staffed by a female Vietnamese physician); mailed screening reminders; and advocacy to re-establish a breast- and cervical-cancer-control program in the county. Results show that, after meeting with lay workers, 46.8 percent of women who had never received a Pap test obtained one, and more than 1,214 Vietnamese American women called to receive more information and assistance. CDC Exemplary Program: REACH www.healthisgold.org
Mississippi	Mississippi Breast and Cervical Cancer Program – The program targets women, specifically African Americans and the elderly, who are uninsured, medically underserved, and poor. Participants work to reduce differences in screening and access to care and eliminate fear about cancer or being screened for cancer. The Mississippi Department of Health and Early Detection Services provides this service through funding from state, federal, and CDC funds. Pap smear tests are available for uninsured women 18 years and older, and mammogram screenings are available for uninsured women 50 years and older. www.msdh.state.ms.us/msdhsite/index.cfm/41,0,103,html
Ohio	Breast and Cervical Cancer – The local health departments in Ohio have teamed up with the Breast and Cervical Cancer Early-Detection Program to help screen underserved populations. This program uses a mobile mammogram unit as well as a team of volunteer translators to target Amish, Asian, Hispanic, and African-American communities. Source: APHA www.odh.state.oh.us

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Cardiovascular disease
Background:	Cardiovascular disease (CVD) is the leading cause of death for all minority and ethnic groups in the United States. Multiple conditions, including hypertension, heart disease, and stroke, contribute to 62 million cases of CVD annually. Over \$350 billion dollars are spent on CVD-related health care each year. Racial minorities develop the conditions that lead to CVD more frequently, at a younger age, and they are less likely to seek treatment. For instance, 35 percent of African-American men develop hypertension, compared to 25 percent of all men. Similar statistics exist among ethnic groups for women. Mortality from CVD also varies by ethnic group, with mortality rates 40 percent higher for African Americans compared to those for whites. In 2001, Delaware's CVD mortality rates per 100,000 people were 251 for whites, compared to 302 for African Americans. ^{xii}
State programs:	Most states have some CVD-related programs, ranging from general education and awareness programs to those specifically aimed at reducing disparities in CVD development and treatment. Due to the nature of CVD and its importance as a healthcare issue, many programs collaborate with employers, academic, and community organizations.
Maine	Worksite High-Blood-Pressure Programs – The Maine Board of Health helps to fund and establish new programs at worksites that do not provide blood-pressure screening. The screenings detect high blood pressure and make referrals to physicians so employees can control blood pressure. The Board of Health will also periodically evaluate the effectiveness of the program. janus.state.me.us/legis/statutes/22/title22sec1697.html Community-Based Heart Attack– and Stroke-Prevention Programs – These programs provide education in schools, the community, and the workplace on how to prevent heart attacks and strokes. Programs that promote healthy behaviors, such as smoking cessation programs and blood-pressure and cholesterol screenings, are also offered to the public. janus.state.me.us/legis/statutes/22/title22sec1699.html
Illinois	Stroke Task Force – Stroke prevention education is presented to high-risk populations and areas with high incidence of stroke. Educational efforts concentrate mostly on the prevention, identification, and treatment of strokes. (20 ILCS 2310-372) www.legis.state.il.us/legislation/ilcs/ilcs.asp Atherosclerosis Prevention Act – Illinois enacted this legislation to increase efforts to prevent and reduce the incidence of, disability from, and death from atherosclerosis (a deadly heart condition). (410 ILCS 3/) www.legis.state.il.us/legislation/ilcs/ilcs.asp

	<i>Employee Wellness Program Grant</i> – Grants are given to employers for health-promotion programs. These can reduce the risk factors associated with CVD, and programs can include aerobic exercise, blood-pressure or cholesterol screenings, smoking cessation, weight-loss programs, and blood-pressure or nutrition education. Benefits from these programs include an increase in the overall health of the population and, consequently, lower healthcare costs. (30 ILCS 770/) www.legis.state.il.us/legislation/ilcs/ilcs.asp
Massachusetts	<i>Cherishing Our Hearts and Souls Coalition</i> – Created by the Harvard School of Public Health to reduce CVD among the African-American community, the coalition develops strategies to reduce risk factors, address racism, and enhance stress coping skills. It provides instruction through after school programs and trainings for healthcare providers. This program has been evaluated and extremely successful in educating not only the public but also community healthcare providers, about the issues of racism and heart disease. This is an APHA <i>Statistics to Solutions</i> program example. For more information, contact Autumn Allen at (617) 496-8073. www.hsph.harvard.edu/php/pri/pehd/cohs_summary.htm
Oregon	<i>Changing Community Norms to Address Cardiovascular Disease in African Americans</i> – The African American Health Coalition Inc., was created to address alarming differences in CVD rates between blacks and whites in Oregon. The state launched multiple programs to target the root cause of this gap. One program promotes physical activity and other heart-healthy behaviors among African Americans. Entitled “Lookin’ Tight, Livin’ Right,” it uses the relationships between beauty shop and barbershop operators and their clients to assess readiness to change and promote health behaviors. Another program, “HOLLA,” trains high school students to educate their peers about cardiovascular disease and the risk factors associated with it. Finally a program called “Wellness Within REACH” offers free physical activity classes to African Americans in order to help reduce some barriers to an active lifestyle. CDC Exemplary Program: REACH www.aahc-portland.org

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Diabetes
Background:	Although diabetes is the sixth leading cause of death in the U.S., many people are unaware that they have the disease until they develop the potentially life-threatening complications it can cause. These can include kidney damage or failure, blindness, nerve damage leading to amputations, or cardiovascular disease, which is the leading cause of death among diabetes patients. Annually, diabetes care totals \$132 billion, or 11 percent of national healthcare expenditures. Among adults, 17 million are diabetic; additionally 40 percent of adults are diagnosed as pre-diabetes, or at high risk for developing the disease. All minority groups are at greater risk of developing diabetes. African Americans and Hispanics are twice as likely to develop diabetes as whites, with

	the disease affecting 25 percent and 10.2 percent of each group, respectively. Native Americans are 2.6 times more likely to develop diabetes, and 15.1 percent of that population is diabetic. Among ethnic and racial minorities, children are also at high risk for developing diabetes. In 2001, diabetes mortality rates in Delaware for whites were 24 per 100,000 compared to 49 per 100,000 for African Americans. ^{xiii}
State programs:	On the national and state level, efforts have been made to educate people about diabetes and diabetes prevention. Many programs exist to ensure that diabetes patients receive proper care, treatment, and medication. As of 2002, 46 states had laws requiring some insurance coverage for diabetes patients.
California	<i>Viva la Vida! (Live Your Life!) San Francisco, Calif.</i> – A local program developed by a non-profit organization, Lumetra, <i>Vida la Vida!</i> increases awareness of diabetes among Hispanic Medicare beneficiaries through coordination with community groups and local healthcare providers. The program includes distribution of bi-lingual educational materials, fact sheets, and media campaigns that reach an estimated 10,000 people annually. This is an APHA <i>Statistics to Solutions</i> program example. For more information, contact Ana Perez at (415) 677-2142. www.lumetra.com/diabetesandlatinos/
New York	<i>New York Diabetes Prevention and Control Program (DPCP)</i> – Currently, 18 communities and three universities participate to improve access to diabetes care for African-American and Hispanic patients. The program aims to overcome socioeconomic, cultural, and linguistic barriers to care and emphasizes monitoring diabetes through controlling glucose levels. DPCP also assists schools and daycares with diabetic pupils, advises the Department of Motor Vehicles about issues for diabetic drivers, and establishes relationships with insurance companies regarding insurance coverage for diabetes. www.cdc.gov/diabetes/states/ny.htm
North Carolina	<i>Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together)</i> – The program targets the African-American community of southeast Raleigh through community-based interventions focused on decreasing disparities in diabetes prevention and care. Collaboration occurs among the CDC, North Carolina Department of Health, and county and community organizations. The project focuses on improving the quality of care and self-management, diagnosing diabetes, and maintaining access to care for diabetics. Prevention is promoted through reducing risk factors, specifically through encouraging more physical activity and better nutrition. www.ncdiabetes.org/ProjectDirect/

	<i>Bringing Together Community Partners to Improve Diabetes Care and Control for African Americans</i> – The Charleston and Georgetown Diabetes Coalition goal is to improve diabetes care and control for more than 12,000 African Americans. More than 40 organizations reach out to African-American communities where they live, worship, work, play, and seek health care. The plan links people to necessary services and medical supplies, creates learning environments where health professionals and people with diabetes can talk about the disease, and establishes walk-and-talk groups. This program has been evaluated and has already shown that disparities in diagnostic and annual testing have decreased. More African Americans are undergoing annual A1c tests, annual kidney tests, referral for dilated eye examinations, and blood pressure control. www.musc.edu/diabetes/reach/
Wisconsin	<i>The Wisconsin Collaborative Diabetes Quality Improvement Project</i> – In cooperation with Wisconsin’s Diabetes Prevention and Control Program, this project coordinates efforts among public health departments, minority groups, insurance organizations, and academic centers to share resources, strategies, and best practices in diabetes education, treatment, and prevention. Through emphasizing lifestyle changes, the project implements population-based interventions to target groups that are at high risk for developing diabetes. Efforts are also made to evaluate the implementation of Wisconsin’s <i>Essential Diabetes Mellitus Care Guidelines</i> and collect data on the effectiveness of diabetes control and prevention programs. dhfs.wisconsin.gov/health/diabetes/Diabetes_Collaborative_Improvement_Project.htm
Tennessee	<i>Working Together to Reduce the Burden of Cardiovascular Disease and Diabetes</i> – The Nashville project created four action teams that concentrate on specific risk factors, along with a Community Action Plan that stresses the connection between community leaders, residents, and health professionals. Programs include nutrition and exercise classes, walking clubs, Tai Chi classes, healthy cook-offs, and smoking cessation classes. All of the activities promote healthy eating, regular exercise, no smoking, getting regular check-ups, and getting screened for cardiovascular disease and diabetes. CDC Exemplary Program: REACH www.mwchc.org

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	HIV/ AIDS
Background:	In 2002, Delaware’s AIDS case rate per 100,000 people was 8.4 for whites, 113 for African Americans, and 36 for Hispanics. ^{xiv} Since 1981 the CDC has been tracking the AIDS epidemic, which has infected about 830,000 people in the United States to date. Of these 830,000 people, 61 percent of them are either African-American or Hispanic. However African Americans only make up about 12 percent of the overall population, and Hispanics make up 13 percent. In cases of women, 78 percent of them are African American or Hispanic. AIDS is currently the leading killer of African-American men ages

	25-44. Even though there have been significant gains in medicine and education about AIDS, it still dominates minority communities. ^{xv}
State programs:	State programs usually focus on HIV/AIDS awareness, education, testing, and prevention. Some operate through local churches and religious organizations, while others partner with community organizations to target at-risk populations.
California	<i>Los Angeles Centers for Alcohol and Drug Abuse: Latino HIV/AIDS Awareness Task Force</i> – The goal is to reduce the number of Latinos who contract the HIV/AIDS virus by providing education and awareness classes through the local churches. The task force provides churches with educational flyers, training sessions to educate pastors, and health fairs to recognize church involvement. This is an APHA <i>Statistics to Solutions</i> program example. For more information, contact Ruben Acosta at (562) 906-2676 ext. 120.
New Hampshire	<i>New Hampshire AIDS Prevention Program</i> – This program provides culturally competent prevention services with the goal of decreasing the spread of HIV, especially in minority populations. www.nhhealthequity.org/pro_hivaids.html
Pennsylvania	<i>Rapid HIV Teen Testing Program, Philadelphia, Pa.</i> – This program is sponsored by St. Christopher’s Hospital’s Pediatric and Adolescence HIV/AIDS organization, which targets African-American and Hispanic adolescents. Teens are provided with screenings, sexual-health education, and risk counseling from other positive teens in the community. The program encourages teens, especially in urban areas, to get tested and to learn about HIV/AIDS and how it affects the body. The program has been evaluated, and, though less than a year old, it has been successful in increasing teen awareness. www.apha.org/nphw/solutions/index.cfm?fuseaction=view&inventionID=43
Virginia	<i>Minority AIDS Projects</i> – The program provides funds to minority community-based organizations that will conduct HIV/AIDS prevention programs and education to minorities at risk for infection. Money is allocated to nine areas in which morbidity among African Americans, Latinos, and Asian/Pacific Islanders are the highest. www.vdh.state.va.us/std/PreventionProgram.asp
Mississippi	<i>Building Bridges</i> – The program targets African-American women, in order to educate and increase the knowledge about HIV and STDs. The main goal is to prevent or reduce the behaviors and practices that place individuals in risky situations. The program also works to increase the knowledge about HIV/AIDS support programs throughout the community.

South Carolina	<i>The South Carolina Minority HIV/AIDS Demonstration Project</i> – This is a three-year project to address the impact of HIV on African-American communities. The project identifies and then works with organizations that are community-based and serve the African-American population. These organizations will be provided with training, workshops, funding opportunities, and grant-writing seminars to help generate more resources for HIV/AIDS prevention and treatment. This initiative also helps in researching and collecting data from local communities in order to plan specific programs to meet the population’s needs. www.scdhec.net/hs/omh/mcbo.html
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Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Immunizations
Background:	According to the American Lung Association, minorities are particularly prone to influenza and pneumonia infections. About 36,000 people die from flu complications each year. African Americans and Hispanics are one-third less likely to receive vaccinations compared to whites. One out of four African-American children ages 19-35 months do not receive standard vaccinations.
State Programs:	Existing programs focus on at risk populations, specifically infants and the elderly. Many provide vaccinations free of charge in local churches and health clinics. An important aspect of immunization programs is the provision of information in many languages with the help of interpreters.
National Program:	<i>CDC National Immunization Program: Racial and Ethnic Adult Disparities Immunization Initiative</i> – The program’s goal is to increase immunization of Hispanic and African-American seniors by supplying vaccines, promoting immunization registry to Medicaid beneficiaries, and placing vaccine orders for providers and nursing homes. Focuses on immunization for the influenza and pneumococcal viruses. www.cdc.gov/nip/
Pennsylvania	<i>Hazeltown Immunization Clinic in Hazeltown, Pa.</i> – The program is designed to help immunize children from Hispanic and migrant-worker families. The clinic holds regular immunization opportunities in local churches, provides interpreters, and calls to remind families in their native language. This program has been evaluated and has been effective for the past five years. www.health.state.pa.us
Florida	<i>Florida Department of Health and the Bureau of Immunization</i> – These organizations work together to reduce racial and ethnic disparities among citizens receiving vaccinations. They provide grants to local counties and private organizations with the intent to increase community-based health-promotion and disease-prevention activities. The programs focus on both child and adult immunization, reaching more than 10,000 people per year. This program has been evaluated and found successful for the past five years. www.doh.state.fl.us/equopp/ctg/indexCTG.html

Missouri	<i>St. Louis Area African American Older Adult Immunization Project</i> – Coordinated by the St. Louis County Health Department since July 2000, the project focuses on improving influenza-vaccination rates among elderly African Americans (60 years and older.) Focus groups are held with the target population to identify key issues regarding attitudes, behaviors, beliefs, and knowledge regarding flu immunizations. The program recognizes the importance of time, trust, and community partnerships to achieve success. Source: NACCHO/ASTHO. For more information, contact Jocelyn Tobnick at (314) 615-1674.
California	<i>Immunizes LA Kids, Inglewood, Calif.</i> – This coalition links public and private agencies to the community in order to implement strategies to improve immunization among Latino and African-American children. Immunization practices in physician offices are supported through ongoing technical assistance and resources. The program also reaches out to the community through culturally appropriate materials and media messages. Source: APHA.
New York	<i>Migrant Health Immunization Initiative, Albany N.Y.</i> – The program works to increase the immunization rates in adult migrant farm workers and their children. It also educates the population on the purpose and benefits of up-to-date vaccinations. The initiative facilitates the distribution of vaccines to migrant programs and then tracks the systems to determine their efficiency. Source: APHA. For more info, contact Kathie Fazekas, Immunization Program, Albany, N.Y. www.health.state.ny.us/nysdoh/immun/immunization.htm

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Infant Mortality
Background:	In 2001, Delaware's infant-mortality rate was 107 deaths per 10,000 births. The rate for African Americans was 200 per 10,000, compared to 80 per 10,000 for whites in the same year. Nationally, the rate was 68 deaths for every 10,000 births ^{xvi} . The U.S. had the 28th highest infant-mortality rate among industrialized nations in 1998. Nationally, the infant-mortality rate is 14.1 among African Americans and 9.3 for Native Americans, compared to 5.8 for non-Hispanic whites. Conditions contributing to an infant's well-being include prenatal care, maternal health, access to health care, and socioeconomic conditions. Furthermore, the leading cause of infant mortality is Sudden Infant Death Syndrome (SIDS). Deaths from SIDS are 2-3 times higher for African Americans and Native Americans than for whites.
State Programs:	Current state programs focus on behaviors that affect infant health. These include distributing information and encouraging healthy behaviors among mothers. Of particular emphasis are prenatal care, smoking, substance abuse, and nutrition.

California	<i>Fetal and Infant Mortality Review (FIMR) Program of Alameda County</i> – Areas of the county with high infant-mortality rates were found to have high incidence of high-risk behaviors such as prone sleeping, not using cribs, co-sleeping, and maternal smoking and substance abuse. Information about SIDS and infant mortality was reworked so that it is consistent throughout the community and is available in the eight major languages spoken in the county. www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=145 <i>Seven Principles Project</i> – Created by the San Francisco Department of Public Health to address high infant-mortality rates for African Americans, the program provides social support and education to men and women of reproductive age. It includes a community-awareness campaign to educate healthcare providers and improve cultural awareness. This is an APHA <i>Statistics to Solutions</i> program example. For more information, contact Virginia Smyly at (415) 581-2400. <i>Black Infant Health Program in Los Angeles</i> – This program provides services to pregnant and parenting African-American women ages 18 and older who are at high risk of low-birth rates. These services include health education, doctor referrals, self-esteem classes, and networking with community outreach services. After a formative and summative evaluation of the program, it was shown to heighten community awareness, increase self-esteem, and reduce the rate of infant mortality. ASTHO/NACCHO program: www.lapublichealth.org/mch/BIH/bih.htm
Florida	<i>Northeast Florida Healthy Start – The Magnolia Project</i> – The federal Healthy Start initiative addresses infant mortality through increasing awareness of risks, and improving maternal and infant health. In Northeast Florida, Healthy Start aims to assess the health of clients and increase awareness of available prenatal/infant-care services. Healthy Start provides risk screenings for women/infants and prenatal/infant care, paying special attention to the needs of at-risk clients. Another project, the Infant Mortality Work Group, identifies risk factors leading to high rates of infant mortality among African Americans in Duval County. The results of this study led to the creation of the Magnolia Project, which targets preconception and prenatal care for African Americans to reduce risk factors leading to infant deaths. www.healthystartflorida.com/directory/coalition.asp?CoalitionID=HSNEF
Missouri	<i>Nurses for Newborns Foundation, St. Louis</i> – This project was implemented in all hospitals with neonatal units in Missouri and Tennessee, to help reduce infant mortality rates, specifically among black infants. The program provides home visits to families with limited access to health care from experienced RNs at no charge. The nurses provide intensive parent education, access to community resources, safe-home assessment, medical assessments, diapers, formula, and 24-hour on-call availability for a two-year period. Source: APHA. www.nursesfornewborns.org/index2.html

South Carolina	<i>Supporting Kids and Infants into the Next Generation, Columbia</i> – This program is aimed at reducing the prevalence of premature births and infant mortality among African Americans. The goals of the intervention are to reduce the racial disparity through education and implement strategies in the local congregations to support pregnant women and parents of infants. Another aspect of the program is called “Vitamins for Brides,” which gives new brides a kit with prenatal vitamins as part of their pre-marital counseling session. Source: APHA. www.scdhec.net
New Hampshire	Healthy Families: Minority Health Coalition – The Healthy Families program targets pregnant women and teens, educating them about the prenatal period and providing follow-up programs after the baby is born. These educational sessions are held in the participants’ homes so they feel comfortable and supported. Culturally sensitive and native-language-speaking nurses provide bimonthly visits during the prenatal period. Participants are also provided handouts with information on each stage of their baby’s development. www.nhhealthequity.org/pro_healthfam.html

Racial and Ethnic Health Disparities

Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	Obesity
Background:	According to the American Obesity Association, there is a higher prevalence of obesity in African Americans and Hispanics, especially women; this trend has continued to grow over the past decade. Asian/Pacific Islanders have the lowest incidence of obesity compared with other minorities and whites. Statistics show that 40 percent of African Americans and 34 percent of Hispanics are obese, with a BMI > 30. The incidence of obesity in minorities has lead to an increase in cancer, heart disease, hypertension, and diabetes.
State Programs:	The majority of current state programs focus on promoting nutrition, physical activity, and weight reduction. Most programs combine a physical fitness component to increase activity with nutrition education to improve diet and facilitate weight loss.
Illinois	Illinois WISEWOMAN Program – Sponsored by the State Department of Public Health, participants engage in a 12-week nutrition and physical-activity curriculum. Women receive informational newsletters and telephone support throughout the program. Goals are to improve diet and cardiovascular-risk profiles while reducing the amount of sedentary behavior. This is an APHA <i>Statistics to Solutions</i> program example. www.idph.state.il.us/about/womenshealth/wise.htm

Virginia	<i>Piedmont Health District: Partners for Healthy Lifestyles</i> – Local African-American churches are involved in activities that address chronic obesity in three ways: weight reduction, increased physical activity, and lifestyle changes. The program is implemented in areas of Virginia with populations greater than 40 percent African-American, low socioeconomic status, multiple health disparities, and a lack of healthcare providers and services. Of the five churches picked for the program, all showed improvements in patrons' overall cardiovascular health and significant decrease in BMI. Source: ASTHO/NACCHO. For more information, contact the Piedmont Health District at (434) 392-3984. <i>Praisercize</i> – The Virginia State Health Department and Central Virginia Community Health Center coordinate this program to address chronic obesity among African Americans. A network of 35 churches incorporates gospel music with low-impact exercise routines. Participants focus on weight reduction, increased physical activity, and lifestyle changes (including nutrition education). To date, more than 1,400 people have participated and health improvement results are positive. Source: ASTHO/NACCHO. For more information, contact Henry Murdaugh at (804) 786-3561.
New York	<i>Physical Activity and Nutrition Steering Committee (PAN)</i> – The committee focuses on five elements of a healthy lifestyle, including prenatal weight gain and breastfeeding, physical activity and TV viewing, fruits and vegetables, other dietary determinants, and obesity awareness and healthcare practices. Children are specifically being targeted especially those at high risk of obesity. The committee began a Child Health and Fitness Study, an intervention to improve nutrition and physical activity in childcare settings. www.cdc.gov/nccddphp/dnpa/obesity/state_programs/new_york.htm
Maryland	<i>The Nutrition and Physical Activity Program</i> – This very successful program, funded by the CDC, established the Maryland's Nutrition and Physical Activity Coalition, which includes more than 12 community partners. The organization hosts a regional meeting to expand and strengthen partnerships and to scan communities for current nutrition and physical activity programs and initiatives. It also identifies surveillance systems that monitor the risks and prevalence of overweight and obese populations in the state. www.fha.state.md.us/fha/cphs/npa/
* Great obesity program database	<i>Shaping America's Youth (SAY)</i> – Contains comprehensive information on programs and community efforts across the United States directed at increasing physical activity and improving nutrition for children. Partners include the American Obesity Association, American Academy of Pediatrics, and the American Diabetes Association. www.shapingamericasyouth.com

Racial and Ethnic Health Disparities**Current and Existing Programs Targeting Specific Health Conditions**

Health Condition:	Oral Health
Background:	Tooth decay is one of the most prevalent and preventable chronic diseases in the United States. Incidence of tooth decay is five times more common than asthma. By the time children reach 18 years of age, 80 percent have had some form of dental decay. Conditions leading to tooth decay can develop during early childhood, especially in minorities, as 60 percent of minority elementary school children do not receive proper dental care. Among African-American and Hispanic adults, 47 percent have untreated tooth decay, compared to 28 percent of whites. Similarly, 20 percent of African Americans and 11 percent of whites have untreated root decay. In Delaware, 74 percent of whites adults visited the dentist or a dental clinic within the past year, compared to only 58 percent of African Americans and 54 percent of Hispanics. ^{xvii}
Stage Programs:	Many state programs promote proper dental care to prevent and treat conditions detrimental to oral health. A variety of programs exist on the state, local, and community level, mostly concentrating efforts on increasing access to dental care for low-income and other high-risk groups.
Ohio	School-Age Sealant Program – In accordance with Healthy People 2010’s goal of having half of all eight-year-olds with sealants on their teeth, Ohio has implemented a sealant program in its schools. Sealants are plastic coatings applied to the chewing surfaces of teeth that help prevent tooth decay. Only 11 percent of African-American children and 10 percent of Mexican-American children have sealants, but in schools with sealant programs, 57 percent of minority students have sealants. School programs coordinate with dental health providers and allow states to reach high-risk populations. www.healthinschools.org/ohiosealant.asp
Washington	ABCD “E” Program – The Access to Baby and Child Dentistry “Expanded” Program provides dental care for high-risk children from when they grow their first tooth until the age of 19. The primary goal of the program is to reduce dental decay and oral health diseases through preventative care. Partnerships among the Department of Health, doctors, and universities, allow dentists to identify high-risk children and go to them to provide preventative dental care. Primary-care physicians and Head Start programs are also educated on basic oral health, oral-assessment techniques, and fluoride application. www.smileabcd.org/abcde.html
Missouri	Health Access Incentive Fund – The fund is used for loan repayment, liability insurance, start-up grants, and practice subsidies. Doctors who agree to practice in areas where there is a need for care, regardless of the patients’ ability to pay, receive the grants or subsidies for Medicaid payments as an incentive to provide care. In addition, Missouri law states that the Department of Health will recruit minorities for healthcare careers when implementing the program. www.ncsl.org/programs/health/oral.htm
Oregon	Oregon Department of Human Services – Oregon is working on expanding its preventative programs for low-income pregnant women and children to include oral health. This expansion comes from a million-dollar grant from

	the Robert Wood Johnson Foundation to improve oral health. This program offers risk assessment and fluoride varnish to children who are brought to a WIC appointment. The project has partnered with a wide range of public, volunteer, and professional members who are serving low-income families. They are working together to coordinate free and low-cost oral health services with the support of the Oregon Dental Association. Another component of the project is 24-hour “Baby Days” clinics for children 9–24 months of age. In its first five months, parents and their children made 725 visits, 701 children received fluoride varnish applications, and 29 received dental referrals. www.chcs.org
South Carolina	State Action for Oral Health Access – The South Carolina Department of Health and Environmental Control collaborates with the Seventh Episcopal District of the AME Church to provide oral-health education to African-American patrons. At various church events, more than 600 children have been screened and referred to dentists for further service. The church has integrated oral health into its overall Strategic Health Plan for minority communities. The church designated February 8, 2004, as “More Smiling Faces Sunday” and sponsored a large Dental Fair at three churches following Sunday services. Many parishioners received information about oral health services and the resources available to receive them. The state has also developed a curriculum for pediatric and special-needs oral-health training for general dentists, as well as curricula for pre-school-age children. The funding for this program was provided by the Robert Wood Johnson Foundation as a part of the State Action for Oral Health Grant program. www.chcs.org/grants_info3963/grants_info_show.htm?doc_id=206685
Colorado	Children’s Oral Health Outcomes Partnership, Colorado Community Health Network – This program helps to improve the health care and dental health of poor and underserved communities by fighting a disease-specific disparity. Through a partnership among the local health departments, the Colorado Oral Health Network, the clinician’s advisory network, and the Caring Foundation, a health-services team educates and supplies kids with the needed prevention tools, including access to regular medical check-ups, screenings, and dental-care supplies. www.cchn.org/activities/COHOP_Fact_Sheet.pdf

Racial and Ethnic Health Disparities Existing Programs Regarding System-wide Interventions

Program Area	Cultural and Linguistic Competency
Background	Cultural competence combines awareness of patients’ diverse values, behaviors, language, and needs, with the ability to provide responsive and effective health care. A successful culturally competent healthcare system and workforce is able to provide high-quality care to all patients, regardless of background. Barriers include a lack of diversity in the healthcare workforce and poor communication between patients and providers. Providers have difficulty understanding and working with lingual barriers and sociocultural factors, which results in patient dissatisfaction and poor health outcomes. However, when appropriate languages and approaches are used, diagnosis is accelerated and the likelihood of patient compliance increases.
State Programs	Existing programs address components of cultural competence, specifically language. Through translator programs, states hope to limit error in diagnosis and decrease healthcare costs. To date, many of the cultural competence programs have focused on services at the provider and insurer level.
Washington	Certification of Interpreters or Translators – The Washington Department of

	Social and Health Services provides and pays for certified interpreters for all health services patients, including Medicaid patients, receive. DSHS ensures the quality of interpreters through standardized written and oral examinations. Certifications are offered in eight languages: Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin, Cantonese, and Korean. www1.dshs.wa.gov/msa/ltc/itsvcs.html
Massachusetts	Competent Interpreter Services in the Delivery of Certain Acute Health Care Services – Acute-care hospitals must have an interpreter in the emergency room for any non-English speaking patients. The decision to hire interpreters or to keep one on-call is left to the discretion of the hospital. However, hospitals must provide interpreter services and cannot deny care to non-English speaking patients. (Acts of 2000) www.mass.gov/legis/laws/seslaw00/sl000066.htm Department of Public Health: Hospital Translation Services Poster – A sign is displayed throughout hospitals conveying in over 30 languages: “You have the right to a medical interpreter at no cost to you.” Patients and visitors can point to their language, and hospital officials will contact the appropriate interpreter. www.mass.gov/dph/omh/interp/interpreter.htm
New Hampshire	New Hampshire Minority Health Coalition – A Cultural-Competency Group works to develop leadership among minorities, train private- and public-sector educators, work with healthcare agencies to increase their awareness, policies, images, and resources, and assist in eliminating barriers. Counselors will come to an organization, specifically those in healthcare, human services, and outreach programs, to provide cultural education. Other programs include cultural forums, the Mental Health of Greater Manchester Cultural Competency Initiative, and the Weed and Seed Cultural Competency Priority. www.nhhealthequity.org/pro_cultcomp.html
California	Los Angeles County Office of Diversity Programs – Cultural and linguistic standards have been set for the Los Angeles County healthcare system by the L.A. Department of Health Services (DHS). Half of the households in the county speak a language other than English, with 83 different nationalities represented. DHS trains staff with cultural and linguistic competency and skills and tries to recruit bilingual and bicultural workers. Furthermore, services are available to document patients’ language of preference and records are kept of patients’ use of services. ladhs.org/odp/docs/dhsexecsumm.pdf
Oklahoma	Cultural Competency and Diversity Training – This program provides training that addresses cultural differences and barriers between minority patients and healthcare providers. The program works to help underserved populations, especially those who speak limited English. Employees of the Oklahoma Department of State Health are required to complete cultural-competency and diversity training as a part of their annual performance evaluations. www.health.state.ok.us/program/omh/
Texas	Hablenos de su Salud, Fort Worth, Tex. – This program seeks to eliminate language barriers that lead to health disparities. The project focuses on patient-provider communication and promotion of science-based standards for linguistic competence in the healthcare setting. Source: APHA. For more information, contact Dr. Holly Jacobson at 817-735-2365.
Managed Care	Kaiser Permanente – On the state and national level, Kaiser Permanente makes

	efforts to increase cultural and linguistic competence. Nationally, six Institutes for Culturally Competent Care focus on the areas of African-American Populations, Latino Populations, Linguistic and Cultural Services, Women's Health, Disabilities, and Eastern-European Populations. On the state level, programs in linguistic and cultural services have been especially effective. The California Endowment granted funds to Kaiser Permanente to assess outcomes and programs for linguistic and cultural services. Specifically, the San Francisco facility focuses on providing services to Chinese and Latino patients. An extensive translation unit offers 14 dialects and languages and ensures that clients are aware of and understand healthcare services. Additionally, all staff members, from clinical nurses to health educators, have undergone cultural understanding training and many are bilingual. *Note: Currently, Kaiser Permanente does not provide an external website for its Permanente National and Linguistics & Cultural Programs.
Robert Wood Johnson Foundation	<i>Hablamos Juntos</i> (Let's Talk Together) – This national program strives to improve access to quality health care for Latinos with limited English proficiency. It focuses on improving the availability and quality of interpreter and language services, allowing people to communicate orally. Another aspect is the promotion of multi-lingual medical-facility signage. www.rwjf.org/news/special/languageBarrier_1.jhtml

Racial and Ethnic Health Disparities

Existing Programs Regarding System-wide Interventions

Program Area	Data Collection
Background	Data collection is crucial in order to understand and eliminate healthcare disparities. National and state efforts should include the standardization of data-collection methods to facilitate sharing of information. Accurate and up-to-date data collection allows researchers and health plans to “monitor performance, ensure accountability to enrolled members and payers, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices.” ^{xviii} The Institute of Medicine recommends the collection of data on “healthcare access and utilization by patients’ race, ethnicity, socioeconomic status, and primary language.” ^{xix}
State Programs	States utilize a variety of methods to collect and interpret health-disparities data. A particularly useful source of information is the CDC’s Behavioral Risk Factor Surveillance System (BRFSS). States often coordinate with health-insurance companies and state Departments of Health Statistics to collect demographic and vital-statistics data.
Massachusetts	<i>Massachusetts Health Status Indicators by Race and Hispanic Ethnicity</i> – This compilation of state data provides information on the health status of residents by race and ethnicity. The purpose of the report is to provide data from a variety of sources in one place for convenient use by policy makers, public-health officials, advocates, and program planners. Each chapter of the report contains information on the agency or program responsible for collecting and reporting the health data and how the data were collected. Health status

	areas included are demographic data, maternal and infant health, mortality patterns, health status and risk behaviors, indicators of healthcare access, hospital discharge data, and AIDS-incidence data. The link below also contains information in a PowerPoint format regarding Mass. state data-collection and monitoring programs. www.mass.gov/dph/bhsre/resep/resep.htm#raceethnicity
Virginia	<i>The Health of Minorities in Virginia, 1999</i> – In the early 1990s, the State Minority Health Advisory Committee recommended that Virginia collect and evaluate health statistics data by racial and ethnic group. The fifth edition of this report covers calendar year 1999. It provides vital statistics information by race and ethnicity for each health district (city/county) in the state. Some data are collected from population estimates (birth, fetal deaths, pregnancy, and death). All vital events (births, deaths, induced terminations of pregnancy) are reported to the Center for Health Statistics at the Va. Department of Health. www.vdh.state.va.us/HealthStats/stats.asp
Rhode Island	<i>Policy for Maintaining, Collecting, and Presenting Data on Race & Ethnicity</i> Created by the R.I. Department of Health, Office of Minority Health, and Office of Health Statistics in July 2000, this report emphasizes the importance of collecting data by race and ethnicity for the purposes of research, public-health monitoring, program administration, and civil rights. These data are intended to help monitor trends of existing/emerging diseases, track health status among population groups, assess progress in improving health, and assure non-discriminatory healthcare access and treatment. www.health.ri.gov/chic/statistics/data%20policy%20guide.pdf
Kaiser Family Foundation	<i>50 State Comparisons on Minority Health</i> – The Kaiser Family Foundation (KFF) provides racial and ethnic data in a comprehensive, user-friendly website. The site includes information on demographics, health statistics (birth rates, death rates, immunization rates, smoking, obesity, and mental health), health insurance coverage, women's health, and HIV/AIDS. Data can be displayed as bar graphs, tables, and color-coded maps, or presented in individual state profiles. Data sources include the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), and the U.S. Department of Health and Human Services (DHHS). www.statehealthfacts.org/cgi-bin/healthfacts.cgi
America's Health Insurance Plans (AHIP) & The Robert Wood Johnson Foundation (RWJF)	In July 2004, America's Health Insurance Plans (AHIP) collaborated with the Robert Wood Johnson Foundation (RWJF) to assess the collection and use of racial and ethnic data by health insurance plans. Their findings indicated that plans that collect such data do so to identify enrollees with risk factors for certain conditions, develop disease-management programs, and facilitate communication among the plan, providers, and enrollees with translation services and multi-lingual websites. Plans that do not collect data do not because of barriers such as enrollees' reactions to collecting these data, enrollee misperception of the intended use of this information, and lack of standardization in data-collection techniques. www.rwjf.org/research/files/080504AHIPFinalSummary.pdf
Data Collection Limitations	No federal law exists prohibiting the collection of data on race and ethnicity. Only four states have laws or regulations that prohibit the collection of these

	data: California, Maryland, New Hampshire, and New Jersey. ^{xx}
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Racial and Ethnic Health Disparities Existing Programs Regarding System-wide Interventions

Program Area	Partnering Opportunities with Regional Organizations
Background	Regional coalitions and conferences provide opportunities to share health information and data-collection techniques between state/local policy makers, community organizations, researchers, and healthcare providers. Through these forums, leaders can also share best practices for programming and unique strategies or models for eliminating racial and ethnic disparities.
New England	<i>New England Regional Minority Health Committee</i> – The committee hosts a bi-annual conference on tools, skills, and networks for action to eliminate health disparities. Partnering states include Conn., Mass., N.H., R.I., Vt., and Maine. Next Conference: April 10-12, 2005. Portland, Maine. www.une.edu/chp/transcultural/conference.html
Various Conferences	<i>11th Annual Rural Minority and Multicultural Health Conference – “State of the States’ Rural Racial and Ethnic Health Disparities: Yesterday, Today and Tomorrow”</i> May 18, 2005. New Orleans, La. The conference will address innovative rural healthcare programs, service delivery models, policy issues, educational programs, clinical concerns, leadership development and skills training as they relate to rural racial and ethnic health disparities. www.nrharural.org/pagefile/NRHAconf.htm
	<i>Everyone Counts: State Infrastructure and Capacity to Eliminate Racial & Ethnic Disparities in New England</i> . December 6, 2004. Tufts University School of Medicine. Boston, Mass. Hosted by the New England Coalition for Health Equity. www.omhrc.gov/omhrc/ and www.neche.org/about/about.htm
	<i>Southeast Regional Civil Rights Training Conference</i> – May 3-5, 2005. Representatives from eight states (Ala., Ga., Fla., Ky., Tenn., Miss., N.C., S.C.) will meet in Nashville, Tenn., to discuss health disparities, mental health, immigrant access, community/faith-based initiatives, and social programming. www2.state.tn.us/health/minorityhealth/Civil_Rights050305.pdf

Racial and Ethnic Health Disparities Existing Programs Regarding System-wide Interventions

Program Area	Purchasing
Background	The purchasing of healthcare contracts through the states should ensure that providers are culturally competent and sensitive. In order to do this, states must encourage competitive bidding so that managed-care facilities address health disparities. Along with financial incentives, these requirements can greatly improve the quality of health care to minority patients.
State Programs	The following states have obtained healthcare contracts that address disparity issues and cultural differences in their populations. These contracts require that medical services, such as Medicaid, HMOs, and other providers, offer linguistically competent services. These healthcare programs must also be sensitive to the attitudes, beliefs, and practices of its patients and have

	caregivers that can appropriately address these issues.
California	In California, an anti-discrimination clause was added to the Medicaid managed-care contract prohibiting discrimination of minority patients. This clause also organized state agency reviews of discrimination complaints in order to better address health-disparity issues. This contract specifically prohibits discrimination in health services among Medicaid recipients on the basis of race, color, ancestry, national origin, or gender. The contract also forces Medicaid to copy all grievances concerning discrimination to the Department of Health Services in order for appropriate action to be taken. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa196.html
New Jersey	Contracts in N.J. require healthcare facilities to provide linguistically appropriate services for non-English speaking patients. Health providers also must have a diverse group of employees who reflect the ethnic/racial composition of patients, as well as be able to accommodate another language if 10% or more of the patients speak that particular language. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa162.html
Wisconsin	In Wisconsin the Medicaid contract is required to provide an interpreter service for patients who speak limited English. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html
Iowa	Iowa HMOs are required to provide information to patients about linguistically competent providers. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html
Colorado	Contractors in Colorado are required to determine if culturally sensitive services are being delivered to its members. They must also train their providers to understand and recognize healthcare attitudes, beliefs, and practices that affect the access and benefit of health services. Contractors also must try to employ a diverse faculty to address culturally sensitive situations. Finally Colorado healthcare contractors must respect the healthcare attitudes and practices of its members, regardless of their cultural affiliation. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa167.html

Racial and Ethnic Health Disparities Existing Programs Regarding System-wide Interventions

Program Area	State Infrastructure
Background	Recently, states have been more forward in addressing disparities in health care among their minority populations. In order to combat these disparities, states have come up with various state infrastructures such as councils, commissions, and advisory panels. States that do not have the resources to develop a formal Office of Minority or Multicultural Health can implement the help of analysts, special project officers, and specific activities to close the gap in disparities. These offices and analysts team up with state policymakers and community organizations to develop solutions, programs, and strategies for their state.
State Programs	State programs vary from Offices of Minority and Multicultural Health to individuals working for the Governor's Office or the State Department of Public Health, with a concentration in Minority Health. These initiatives all have the same overall goals, which are to have a formal group that addresses the issues concerning the minority populations in their state. Specifically, these offices work to reduce health disparities through community-based outreach programs that target various health conditions and diseases.
Arkansas	The state minority-health infrastructure is made up of the Office of Minority Health located within the Department of Health, as well as an independent commission that reports directly to the Governor's Office. Together this group has a statewide plan, advisory groups, task forces, and committees specifically targeted towards reducing health disparities. This initiative also works to include other state and private-sector minority-health programs and coalitions. www.achi.net/current_initiatives/health.asp
California	In order to help address health disparities for ethnic communities California has created the Office of Multicultural Health. The purpose of this office is to build a bond between the state health department and minority communities, in order to help the state health offices more effectively handle cultural-competency issues. Having an Office of Multicultural Health also encourages data collection and performance measurements of state healthcare providers. www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=00001-01000&file=150-152
Connecticut	Connecticut has created an Office of Multicultural Health (OMH) in hopes of eliminating differences in disease, disability, and death rates among minority populations. Federal, state, and private funds are used to carry out the objectives of the office such as providing education, activities, and health resources to minority groups. These funds can be used to create new programs or to help support existing ones that focus on minority health. The Office also created an advisory committee to represent diverse multicultural and multiethnic backgrounds. This committee meets quarterly to go over the preparation and implementation of reports and strategic plans. It also coordinates and discusses issues and policies related to the functions of OMH. www.cga.state.ct.us/2001/pub/Chap368a.htm
Florida	The state of Florida has a Commission on African American Affairs that is part of the executive Office of the Governor. This office is in charge of ensuring that

	African Americans in Florida receive adequate education, healthcare and welfare attention, as well as address economic and social issues. www.flsenate.gov/sstatutes/index.cfm?App_mode=Display_Statute&URL=Ch0014/ch0014.htm
Texas	The Texas Department of Public Health dedicated two million dollars toward the creation of a Minority Health Office. The office is designed to effectively address minority health and disparities issues. The structure of this office consists of a Minority Health Coordinator in the TDPH central office, staff support from the Office of Public Health Practice, and local/regional support within each office. The new office will work with communities at the local level to increase their capacity to implement strategies that improve the health status of minority and underserved populations. Additionally, it will provide and link community-based coalitions and networks with technical assistance and training for use in the development of community health plans. There is hope that links can be made with external partners to help support and finance minority programs. There will also be translator services available. The main goal of this organization is to create a link between the Department of Public Health and underserved communities. www.tdh.state.tx.us/minority/aboutus.htm#Background

Racial and Ethnic Health Disparities

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Program Area	Workforce Development
Background	Minorities make up 25 percent of the US population; however, they only account for 6 percent of physicians. Similarly, minority nurses only make up 14 percent of the workforce. Minority physicians tend to reside in federally designated shortage areas and are three times more likely to see minority patients and accept Medicaid. This promotes higher satisfaction, greater adherence to treatment, and better care outcomes for minority patients. The workforce should be representative of the population, which means creating more diversity in such fields as dentistry, nursing, medicine, and physical therapy. One of the ways to ensure this happens is to encourage minority students to pursue careers in the sciences and increase the number of minority students enrolled in medical schools.
State Programs	State programs focus on increasing diversity in the workplace, especially in the fields of science and medicine. States have come to realize that a diverse workforce leads to decreased racial and ethnic differences in health care, not only with diverse physicians, but also nurses, dentists, pharmacists, and physician assistants. Programs targeting minority students have been developed to encourage them to pursue careers in allied health fields. This includes increasing medical school admissions for minority students, specialized training in various languages for employees, and high school programs geared at encouraging students to pursue careers in the sciences.
Minnesota	The state of Minnesota has passed legislation in order to recruit professionals in underserved communities, specifically those that lack sufficient medical coverage. The Duluth School of Medicine has a federal grant to help recruit

	minority students and increase their awareness of careers in medicine. This program also operates an area health-education center designed to show the importance of supporting underserved areas. ^{xxi}
Maryland	Minority Health Careers Academy – This program was created by the Maryland Department of Health and Mental Hygiene, and is supported by Coppin State College and the Department of Social Services. It targets Baltimore City public-school students. The goal of the project is to get inner-city minority students interested in allied-health-profession careers. Students are introduced to various health-related fields to increase their motivation and awareness in pursuing these avenues. Source: ASTHO, NACCHO, and HRSA.
North Dakota	Project CRISTAL - A Program for Collaborative Rural Interdisciplinary Service Training and Learning – This collaborative project joins the University of North Dakota, Turtle Mountain Community College, and the CRISTAL group to provide interdisciplinary training for minority students in physical therapy, occupational therapy, social work, clinical laboratory science, and medicine. The program encourages minority healthcare workers to practice in underserved areas. Source: ASTHO, NACCHO, and HRSA.
California	Increasing Culturally Competent Workforce Capacity – California instituted a law allowing Mexican- and Caribbean-licensed physicians and dentists to practice without additional licensing in communities that are medically underserved. The law has helped create the Licensed Physicians and Dentists from Mexico pilot program, which authorizes a three-year, non-renewable license to those doctors.
Washington	Health Workforce Diversity – The Health Systems Quality Assurance Division is designed to develop a program that creates a diverse and culturally competent workforce within the Washington state healthcare field. This includes looking at a workforce-development continuum starting with the academic aspect of grade school and moving forward to a career in health care and policy. It will include a focus on recruiting minority employees to the healthcare workforce. Also, there will be new licensing rules, including the elimination of unnecessary barriers, clarification of licensing rules, and incorporation of multiple ways to show competency. www.doh.wa.gov/SBOH/Priorities/Disparities/HWDNActivities.htm
	Health Occupations Preparatory Experience (HOPE) – The State of Washington created HOPE to allow minority and rural students the opportunity to experience working in a healthcare field. The State Department of Health funds a student internship program to create a greater interest among a diverse group of high school and community college students. The program is designed to introduce these students to the variety of healthcare positions they may be unaware of, through first-hand shadowing, mentoring, and clinical rotations. www.doh.wa.gov/hsqa/ocrh/R&R/HOPE1.htm

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- ⁱ Arnold Epstein, "Health Care in America — Still Too Separate, Not Yet Equal," *The New England Journal of Medicine*. Vol 351, No 6, p. 603.
- ⁱⁱ David Blumenthal. "Quality of Health Care," *The New England Journal of Medicine*. Vol. 335, No. 12. p. 892. Blumenthal also notes that one of the more widely cited definitions of quality belongs to the IOM, which holds that quality consists of the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."
- ⁱⁱⁱ Elizabeth A. McGlynn, et al. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*. Vol. 348, No. 26. 2003
- ^{iv} George C. Halvorson and George J. Isham, M.D. *Epidemic of Care*. Jossey-Bass. p.18. 2003.
- ^v Ibid. p. 29.
- ^{vi} See <http://www.cms.gov/quality/hospital/HCAHPSqanda3.pdf>
- ^{vii} See Weech-Maldonado, Hays, et al. *Health Plan Effects on Patient Assessments of Medicaid Managed Care Among Racial/Ethnic Minorities, and Race/Ethnicity, Language, and Patients' Assessments of Care in Medicaid Managed Care*.
- ^{viii} See <http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf>. According to this document, *Census 2000* adheres to the standards for collecting and analyzing racial data as designated by the Office of Management and Budget (OMB) in 1997. Beginning with *Census 2000*, OMB requires federal agencies to use at least five categories (White, Black/African American, Asian, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native) in its data collection. OMB also approved the use of a sixth category ("Some other race") for those respondents unable to identify with any of the five race categories.
- ^{ix} See Langwell and Moser. "Strategies for Medicare Health Plans Serving Racial and Ethnic Minorities." *Health Care Financing Review*. Vol. 23, No. 4.
- ^x *New England Journal of Medicine* 9/9/04
- ^{xi} Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
- ^{xii} Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
- ^{xiii} Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
- ^{xiv} Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
- ^{xv} aidsinfo.nih.gov
- ^{xvi} Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
- ^{xvii} CDC: National Oral Health Surveillance System. Delaware Oral Health Profile. www2.cdc.gov/nohss/bystate.asp?stateid=10
- ^{xviii} *Unequal Treatment*. Institute of Medicine. 2003.
- ^{xix} *Unequal Treatment*. Institute of Medicine. 2003.
- ^{xx} Collection of Racial and Ethnic Data by Health Plans to Address Disparities: Final Summary Report. July 2004.
- ^{xxi} A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities. June 2004, The Commonwealth Fund.