

***The Interagency State
Council on Black and
Minority Health
2012 Annual Report***



Presented by
The Interagency State Council on Black and Minority Health
Members

November 1, 2012

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The Interagency State Council on Black and Minority Health

IC 16-46-6

Chairman: James Garrett, FSSA

Vice-Chairman: Teri Cardwell, IMHC

Governor: Mitch Daniels

Lt. Governor: Becky Skillman

11/1/12

Over twenty years ago, the leadership of Indiana started on an important journey by the creation of the Interagency State Council on Black and Minority Health. Because of the establishment of the Council from Indiana's legislation, the Council has been tasked to produce a report and recommendations that gives details on the progress and trouble areas needing attention in order to improve the health of racial and ethnic minorities in Indiana.

This report demonstrates an aggressive state-wide effort to solicit and recruit input and experiences from many different areas of expertise and representative populations. As chairman and co-chairman, we salute and recognize all the work of the Council members and advisors.

Our continued hope is that the legislative body will find this report both informative and more importantly, a valuable resource guide in the fight to in reducing health disparities and creating health equity for all Hoosiers. Thank you for your support to the council and their dedication to serving Hoosiers.

Sincerely,

James E. Garrett Jr.

Chairman

Sincerely,

Teri Cardwell

Vice Chairman



The Interagency State Council on Black and Minority Health

Overview of the Interagency State Council on Black & Minority Health

In 1992, legislation was passed to adopt the first five-year Strategic Plan on Minority Health for Indiana, as well as the appropriation of a budget to carry out programming. The Indiana General Assembly also passed legislation creating the Interagency State Council on Black and Minority Health (IAC). *Indiana Code 16-46-6* directed the Indiana State Department of Health (ISDH) to establish the IAC with representation from the Indiana House of Representatives, Indiana Senate, and Governor's Office, as well as various other agencies and organizations (Table 1).

<http://www.ai.org/legislative/ic/code/title16/ar46/ch6.html>.

Table 1. The Interagency State Council on Black and Minority Health Members –2011-2012

Statutory appointees:	
Two (2) members of the House of Representatives from different political parties appointed by the Speaker of the House of Representatives.	Rep. Charlie Brown Rep. Bob Morris
Two (2) members of the Senate from different political parties appointed by the President pro tempore of the Senate.	Senator Veneta Becker Senator Jean Breaux
The Governor or the governor's designee.	Jamal Smith
The State Health Commissioner or the commissioner's designee	Dr. Gregory N. Larkin Antoniette Holt (Proxy)
The director of the Division of Family Resources or the director's designee	James Garrett , Jr.
The director of the Division of Mental Health and Addiction or the director's designee	Kevin B. Moore Lynn Smith (Proxy)
The commissioner of the Department of Corrections or the commissioner's designee	Edwin G. Buss Tim J. Brown & Rose Vaisvilas (Proxy)
Governor's appointments:	
One (1) representative of a public health care facility appointed by the governor	Jose M. Pérez

One (1) member appointed by the governor based on the recommendation of the Indiana State Medical Association	Dr. Meredith Cousin
One (1) member appointed by the governor based on the recommendation of the American Medical Association	Lili A. Leavell-Hayes, M.D. (Indpls.)
One (1) member appointed by the governor based on the recommendation of the Indiana Hospital and Health Association	Dr. Edward Williams
One (1) member appointed by the governor based on the recommendation of the American Heart Association	Lynne Griffin
One (1) member appointed by the governor based on the recommendation of the Black Nurses Association	Maple Murrell
One (1) member appointed by the governor based on the recommendation of the Indiana Minority Health Coalition	Teri Cardwell
Invited Advisors:	
Nancy Jewell, Indiana Minority Health Coalition Edwin Marshall, Indiana University Margie Fort, National Kidney Foundation	
Staff	
Leisha Bostick, Indiana Minority Health Coalition Calvin Roberson, Indiana Minority Health Coalition Shanta Harris, Indiana Minority Health Coalition JoeAnn Gupton, Office of Minority Health, ISDH Adrienne Durham, Office of Minority Health, ISDH	

Year-end Review

In 2011, the Interagency Council on Black & Minority Health (IAC) examined and recommended preventive measures concerning growing health disparities. That same year the United States Department of Health and Human Services produced and released the National Plan for Action to End Health Disparities. In this plan, there were five goals presented to address health disparities and health equity. They were awareness, leadership, healthy system and life experience, cultural and linguistic competency, and data, research and evaluation. With these national precedence set, it allowed the IAC to evaluate what Indiana was doing and what was successful. The following are the initiatives connected to last year's recommendations, which IAC and member agencies sponsored and/or supported during 2011.

Goal1: Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.

Recommendation 1.1: Establish and maintain collaborations with institutions and community-based organizations, such as the Indiana Minority Health Partners, to focus on improving the health of racial and ethnic minorities in Indiana.

Action 1.1: The ISDH/OMH will continue to actively recruit new organizations, facilitate monthly meetings, and support the annual Minority Health Conference. The goal of the conference is to provide information on minority health issues that are rapidly growing but are not addressed in the day-to-day community, education and business environments, as well as by governmental leaders.

1.1.1 Progress towards the goal:

Members of the Interagency Council on Black & Minority Health were successful in maintaining and expanding collaborations with local, state, and national partners that included but were not limited to; Institutions of Higher Learning, health care organizations, divisions of government, and local and statewide community based organizations. (Please refer to appendix A for detailed listing of organizations and description of partnership)

Goal 2: - Strengthen and broaden leadership for addressing health disparities at all levels.

Recommendation 2.1: Promote workforce diversity by supporting efforts to recruit and retain minority students, especially those from underserved areas, into health professions.

2.1 Action 2.1: The ISDH/OMH will lead efforts to increase funding for the EMPOWERED program to expand the program to other counties.

2.1.1 Progress:

Through collaborations with local and statewide curriculum systems, (health, Science Technology Engineering Math, etc.) we have enhanced opportunities for underserved student populations from middle schools through secondary education. ISDH/OMH was able to increase community involvement recruiting students within regional counties. (Please refer to appendix B for detailed listing of organizations and description of collaborations with community entities)

Goal 3:- Improve health and healthcare outcomes for racial, ethnic, and underserved populations.

Recommendation 3.1: Support the expansion of existing health coverage programs to minority populations.

Action 3.1: Each year the ISDH sponsors the INShape Indiana Black & Minority Health Fair during the Indiana Black Expo Summer Celebration. This event provides approximately \$1,000 worth of free health screenings. Over a four day period, more than 25,000 people are in attendance. ISDH/OMH will lead efforts to increase funding to expand the screenings offered at the INShape Indiana Black & Minority Health Fair.

3.1.1. Progress: Health outcomes for minority and underserved populations were improved through increasing consumer awareness of programs that benefit families to ensure access including, but not limited to insurance, birth outcomes, health access, prescriptions that are affordable rather than unbearable. Advocating continuously ensuring health equity is being practiced among health care and health care insurance. (Please refer to Appendix C for listing of programs that exist to improve health and healthcare outcomes for racial, ethnic, and underserved populations.)

Recommendation 3.2: Support efforts to improve health literacy in the state.

Action 3.2: The IMHC will continue, with support from ISDH-OMH, to conduct a health literacy study to determine the extent of the problem in Indiana.

3.2.2. Progress: The IMHC academic and community partners collaborated on a Health Literacy study. The purpose of the study was to assess health literacy among racial and ethnic minority adults in selected Indiana counties, to learn about experiences that community members may have when communicating with health care professionals, to learn about real and perceived issues and factors that affect health literacy and communication of health information among minority populations, and learn about opportunities that may help promote and enhance health literacy and communication of health information among minority populations. The methods used for data collection included the use of standardized health literacy assessments, focus groups and key interviews.

Goal 4: Improve cultural and linguistic competency and the diversity of the health-related workforce.

Recommendation 4.1: Continue to support current cultural competency trainings with health care professionals. Indiana's health care workforce should be culturally competent and reflect the state's racial and ethnic composition.

4.1.1. Progress: The IMHC and ISDH-OMH have partnered to increase cultural and linguistic appropriate knowledge and skills to health care providers via the annual cultural competency conference, webinars, and one-on-one technical assistance, as well as introductory, intermediate, and advance level trainings. ISDH-OMH and IMHC continue to collaborate with area hospitals, healthcare facilities and local AHEC organizations to provide quality training to providers on the cultural implications in healthcare. Some of the healthcare trainings in 2012 included IUPUI School of Public Health, IUPUI School of Health and Rehabilitation, Indiana Primary Health Care Association and Indiana State Department of Health. ISDH-OMH and IMHC continue to be key organizations for dissemination of information on cultural competency best practices.

Recommendation 4.2: Support efforts to create new language translation services and expand existing services to health professionals and patients.

Action 4.2: The ISDH-OMH will continue to identify new language and translation services to health professionals and patients, as well as continue to partner with existing service providers.

4.2.2 Progress: ISDH-OMH and IMHC and their partners continue to provide information resources and technical assistance to healthcare organizations to support compliance with federally mandated Cultural and Linguistically Appropriate Services (CLAS, 2000) and relevant Joint Commission accreditation standards. ISDH-OMH, IMHC and its partners and coalitions make available translated health information materials at health fairs throughout the state and on their respective websites. IMHC and ISDH-OMH advocate for the expansion of medical interpreter services for non-English speaking patients in the healthcare industry.

(Please refer to appendix D for detailed listing of organizations and description cultural competency efforts by IMHC and ISDH-OMH)

Goal 5: Improve data availability, and coordination, utilization and diffusion of research and evaluation outcomes

Recommendation 5.1: Support entities like the IMHC's Racial and Ethnic Minority Epidemiology Center (REMEC) and other organizations, which provide the state data and information for reducing of health disparities through research and program evaluation. Currently, the ISDH-OMH, Family and Social Services Administration (FSSA), and the Indiana University Bowen Research Center are partnering on the State Master Research Plan. The goal of the project is to assess and improve collection and distribution of quality

health care data on minorities in Indiana. Key stakeholders throughout the state were identified and convened to develop priority areas.

Action 5.1: The State Master Research Plan steering committee will continue with the following next steps of the project:

- Transition to a minority health research consortium
- Identify, develop and implement joint research projects
- Identify resources to support research projects
- Create a forum for sharing research
- Influence policies

Action 5.2: IMHC will continue to lead efforts on assessing race, ethnicity and language data collection and standardization.

5.2.2. Progress: IMHC created the RE^AL (Racial, Ethnicity, and Language) Online Training Series: Collecting and Using Patient Real Information to Promote Health Care Equity. The training will help health care institutions and professionals implement a standardized system for collecting racial, ethnicity, language information, which the federal Affordable Care Act requires to be in place by 2014. This series was supported by a grant from the Robert Wood Johnson Foundation to the Central Indiana Alliance for Health.

(Please refer to appendix D for detailed listing of organizations and description of efforts being done in Indiana to address racial and ethnic data collection)

Dashboard: Indiana's Progress in Health

The Indiana State Department of Health (ISDH) recreated the Indiana Minority Health Advisory Committee (InMHAC) in 2000 under the Indiana Minority Health Initiative. The purpose of the InMHAC was to provide advice and guidance to the ISDH in addressing racial and ethnic minority health disparities. In 2001, the InMHAC was charged with developing a plan for eliminating health disparities in Indiana. As a result, the Healthy Indiana – A Minority Health Plan for The State of Indiana – **H**Health **E**quality **A**ccess **L**eadership (HEAL) the Gap was created with heart disease, cancer, stroke, asthma, diabetes, HIV/AIDS, and infant mortality as its focus areas. The Minority Health Plan objectives were based on the Healthy People 2010 objectives and they serve as the framework of the plan (Indiana State Department of Health, Minority Health Advisory Committee, Healthy Indiana - A Minority Health Plan for the State of Indiana **H**Health **E**quality **A**ccess **L**eadership (HEAL) the Gap).

The Interagency State Council on Black and Minority Health 2012 annual report examines the state's progress on the (focus areas of the Healthy Indiana – A Minority Health Plan for The State of Indiana – HEAL the Gap).

Heart Disease Objectives	Current Value	Trend	Current Data Source
1. Reduce coronary heart disease deaths among Indiana's black or African American population from 224.2 coronary heart disease deaths per 100,000 (2000) to 170.5 deaths per 100,000 (reduce to InMHAC target of 30% improvement).	147.2 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
2. Reduce coronary heart disease deaths among Indiana's Hispanic Latino population from 159.5 coronary heart disease deaths per 100,000 Hispanic/Latino persons (2000) to 161.1 deaths per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 7% improvement)	55.7 age-adjusted deaths per 100,000		CDC Wonder – 2009 Mortality Data
3. Reduce the proportion of adults among Indiana's black or African American adult population aged 20 years and older (2001) with high blood pressure from 35.6% to 16.0% (reduce to HP2010 target).	36.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
4. Reduce the proportion of adults among Indiana's black or African American population with high total blood cholesterol levels from 20.5 % (2001) to 17.0 % (reduce to HP2010 target).	31.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)

<p>5. Reduce the proportion of adults among Indiana's Hispanic/Latino population with high total blood cholesterol levels from 28.4 % (2001) to 17.0 percent (reduce to HP2010 target).</p>	<p>29.8% of Hispanic or Latino adults , 18 years and older</p>		<p>2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)</p>
<p>6. Increase the proportion of adults among Indiana's black or African American adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 68.5% (2003) to 85% (increase to InMHAC target)</p>	<p>68.0% of black or African American adult population, 18 years and older</p>		<p>2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)</p>
<p>7. Increase the proportion of adults among Indiana's Hispanic/Latino adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 47.4% (2003) to 85% (increase to InMHAC target).</p>	<p>51.7% of Hispanic or Latino adults, 18 years and older</p>		<p>2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)</p>

*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Stroke Disease Objectives	Current Value	Trend	Current Data Source
1. Reduce stroke deaths among Indiana's black or African American population from 92.3 to 55.4 deaths per 100,000 (reduce to InMHAC target of 40% improvements).	62.2 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
2. Reduce stroke deaths among Indiana's Hispanic/Latino population from 62.5 to 53.1 deaths per 100,000 (reduce to InMHAC target of 15% improvement).	23.2 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
3. Reduce the proportion of adults among Indiana's black or African American adult population aged 20 years and older (2001) with high blood pressure from 35.6% to 16.0% (reduce to HP2010 target).	36.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
4. Reduce the proportion of adults among Indiana's black or African American population with high total blood cholesterol levels from 20.5 % (2001) to 17.0 % (reduce to HP2010 target).	31.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
5. Reduce the proportion of adults among Indiana's Hispanic/Latino population with high total blood cholesterol levels from 28.4 % (2001) to 17.0 percent (reduce to HP2010 target).	29.8% of Hispanic or Latino adults , 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)

<p>6. Increase the proportion of adults among Indiana’s black or African American adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 68.5% (2003) to 85% (increase to InMHAC target)</p>	<p>68.0% of black or African American adult population, 18 years and older</p>		<p>2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS)</p>
<p>7. Increase the proportion of adults among Indiana’s Hispanic/Latino adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 47.4% (2003) to 85% (increase to InMHAC target).</p>	<p>51.7% of Hispanic or Latino adults, 18 years and older</p>		<p>2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS)</p>

*Hispanic can be of any race.

Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Cancer Objectives	Current Value	Trend	Current Data Source
1. Reduce the overall cancer death rate among Indiana's black or African American population from 274.9 cancer deaths per 100,000 to 192.4 deaths per 100,000 (reduce to InMHAC target of 30% improvement).	227.1 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
2. Reduce the trachea, lung and bronchus cancer death rate for Indiana's black or African American male population (2000) from 110.7 deaths per 100,000 to 86.3 deaths (reduce to HP2010 target of 22% improvement).	94.6 age-adjusted deaths per 100,000		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.
3. Reduce the trachea, lung and bronchus cancer death rate for Indiana's black or African American female population (2000) from 53.7 deaths to 41.9 deaths per 100,000 (reduce to HP2010 target of 22% improvement).	50.4 age-adjusted deaths per 100,000		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.
4. Reduce the breast cancer death rate for Indiana's Black or African American female population from 34.7 deaths per 100,000 (2000) to 31.9 deaths per 100,000 (reduce to HP2010 target of 20% improvement).	31.1 age-adjusted deaths per 100,000		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.
5. Increase the proportion of women aged 40 years and older among Indiana's Black or African American population who have received a mammogram within the preceding 2 years from 85.2% (200) to 90.0% of Black or African American women aged 40 years and Older (increased to InMHAC	71.0%		2010 Indiana Behavioral Risk Factor Surveillance System (BRFSS)

target)			
6. Reduce the death rate from cancer of the uterine cervix among Indiana's Black or African American population from 4.9 cervical cancer deaths per 100,000 Black African American females (reduce to HP2010 target of 33% improvement)	*2.8 age-adjusted black female cervix uteri deaths per 100,000 * Rates based on fewer than 20 cases are unstable.		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.
7. Increase the proportion of women among Indiana's Black or African American population who receive a Pap test from 96.4% (2000) to 100.0% of Black or African American women aged 18 and older who received a Pap test within the preceding 3 years (increase to InMHAC target)	96.5%		2010 Indiana Behavioral Risk Factor Surveillance System (BRFSS)
8. Reduce the colorectal cancer death rate for Indiana's Black or African American male population from 43.6 colorectal cancer deaths per 100,000 (2000) to 28.3 deaths per 100,000.	33.4 age-adjusted deaths per 100,000		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.
9. Reduce the colorectal cancer death rate for Indiana's Black or African American female population from 21.4 colorectal cancer deaths per 100,000 (2000) to 14.1 deaths per 100,000 (reduce to HP2010 target of 34% improvement).	21.2 age-adjusted deaths rate per 100,000		Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.

<p>10. Increase the proportion of adults among Indiana’s Black or African American population who receive a colorectal screening examination from 38.7% (2001) to 50.0% of Black or African American adults aged 50 and older who received sigmoidoscopy (increase to HP2010 target)</p>	<p>63.7%</p>		<p>2010 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked even-numbered years only)</p>
<p>11. Reduce the prostate cancer death rate among Indiana’s Black or African American male population from 70.8 deaths per 100,000 (2000) to 44.3 deaths per 100,000 (reduce to InMHAC target of 40% improvement).</p>	<p>44.6 age-adjusted deaths per 100,000</p>		<p>Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.</p>
<p>12. Reduce the oropharyngeal cancer death rate among Indiana’s Black or African American population from 5.1 oropharyngeal cancer deaths per 100,000 Black or African American persons (2000) to 3.1 deaths per 100,000 Black or African American Persons (reduce to InMHAC target of 40% improvement).</p>	<p>*3.8 age-adjusted deaths per 100,000</p>		<p>Indiana Mortality Report – 2009 Data compiled by the Indiana State Cancer Registry 11 September 2011.</p>

*Rates based on fewer than 20 cases are unstable.

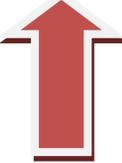
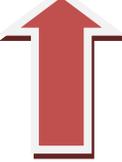
Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Diabetes Objectives	Current Value	Trend	Current Data Source
1. Reduce the diabetes death rate among Indiana's black or African American population from 58.7 deaths per 100,000 (2000) to 29.3 deaths per 100,000 (reduce to InMHAC target of 50% improvement).	42.9 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
2. Reduce the diabetes death rate among Indiana's Hispanic population from 51.7 deaths per 100,000 to 25.9 deaths per 100,000 (reduce to InMHAC target of 50% improvement).	20.1 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
3. Reduce the prevalence of diabetes among Indiana's Black or African American population from 53.0 cases to ** 26.5 cases per 1,000 (reduce to InMHAC target of 50% improvement). Change to prevalence % instead of cases per 1000?	12.8%	The data source used for the original targeted objective is not known. It does not appear to be the same data source. Therefore, the two measures cannot be compared to each other.	2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS)

*Hispanic can be of any race.

cases per 1,000 **cannot be compared to percent of adults 18 years and older

Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

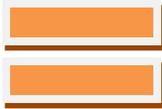
HIV/AIDS Objectives	Current Value	Trend	Current Data Source
1. Reduce the prevalence of HIV/AIDS among Indiana's black or African American population from 416.6 cases of HIV/AIDS per 100,000 (2000) to 250.0 cases per 100,000 (reduce to InMHAC target of 40% improvement).	636.5 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
2. Reduce the prevalence of HIV/AIDS among Indiana's Hispanic/Latino population from 131.9 cases per 100,000 (2002) to 79.1 cases per 100,000 (reduce to InMHAC target of 40% improvement).	200.2 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
3. Reduce the prevalence of AIDS among Indiana's black or African American population from 346.6 cases of AIDS per 100,000 (2002) to 232.2 cases per 100,000 black or African American persons (reduce to InMHAC target of 33% improvement).	329.9 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
4. Reduce the prevalence of AIDS among Indiana's Hispanic/Latino population from 104.0 cases of AIDs per 100,000 Hispanic/Latino persons (2002) to 69.7 cases of AIDS per 100,000 Hispanic/Latino persons (reduce to InMHAC target of 33% improvement).	118.8 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS

*Hispanic can be of any race.

Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission. Division of HIV/STD.

Asthma	Current Value	Trend	Current Data Source
1. Reduce asthma deaths among Indiana's black or African American population from 6.3 to 3.8 deaths per 100,000 (reduce to InMHAC target of 40% improvement)	4.4 age-adjusted deaths per 100,000		Indiana Mortality Report - 2009
2. Reduce the number of school or work days missed among Indiana's racial and ethnic populations by persons with asthma due to asthma.	Data not available		None

Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Infant Mortality Objectives	Current Value	Trend	Current Data Source
1. Reduce infant deaths (within 1 year of birth) among Indiana's black or African American population from 15.9 per 1,000 live births (2000) to 6.7 per 1,000 live births (reduce to rate for Indiana White population).	16.1 infant deaths per 1,000 live births		Indiana Mortality Report - 2009
2. Reduce low birth rate (LBW) among Indiana's black or African American population from 12.7% of live births (2000) to 6.7% of live births (reduce to rate for Indiana White population).	13.8% of live births		Indiana Natality Report - 2009
3. Reduce low birth rate (LBW) among Indiana's Asian/Pacific Islander population from 7.3% of live births (2000) to 6.7% of live births (reduce to rate for Indiana White population).	8.9% of live births		Indiana Natality Report - 2009
4. Reduce very low birth rate (VLBW) among Indiana's black or African American population from 2.9% of live births (2000) to 1.2% of live births (reduce to rate for Indiana White population).	3.0% of live births		Indiana Natality Report - 2009

Source: Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

Data Limitations

Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team follows the "Rule of Twenty" when examining rates. There should be at least twenty events in the numerator in order to produce a stable rate. When the numerator is less than 20, the rate is unstable, meaning that a small change in the numerator can lead to a large change in the rate from one year to the next. Unstable rates do not lend themselves to being used to make decisions and how data are interpreted is very important to the decision-making process. Misinterpretation of the data can lead to incorrect assumptions about health status.

Blacks or African-Americans are the largest minority group in Indiana. Much of the data available is limited to this racial group. There is limited published data on American Indians, Asians, and Hispanics, due to their smaller numbers. Data on these minority groups are often suppressed and referred to as "statistically insignificant", because the rates are so low. Therefore most of the data in this report focuses on blacks or African-Americans.

Accurate and quality data are needed to detect and eliminate health disparities. Therefore, health disparities data is impacted by the lack of standardized collection and reporting of race, ethnicity, and language

End Notes

Age-Adjusted Rate – When comparing rates over time or across different populations, crude rates (the number of deaths per 100,000 persons) can be misleading, because differences in the age distribution of the various populations are not considered. Since death is age-dependent, the comparison of crude rates of death can be especially deceptive. Age adjustment, using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in population composition. According to the National Center for Health Statistics (NCHS), age adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time.

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys created by the Centers for Disease Control and Prevention (CDC) in 1984 to gather information on the health of adults ages 18 years and older. State health departments conduct the BRFSS surveys continuously through the year using a standardized core questionnaire and optional modules, plus state-added questions. More than 400,000 adult interviews are conducted annually. The BRFSS is the sole source of state-level health risk factors, behaviors and prevalence of certain chronic conditions. Beginning with data collected in 2011, two significant changes have been made to the methodology used with the BRFSS survey. Cell phone interviews are now included, and a new weighting procedure has been implemented. These changes were brought about to maintain the accuracy and validity of the BRFSS. Use of the new methodology will result in prevalence estimates that will be different from estimates achieved with the previous post-stratification procedure. These differences will vary by survey question and state, with the results determined by state variations in demographic variables used for raking plus the proportion of respondents who use cell phones. The CDC has determined that some of the BRFSS indicators will increase for the majority of the states. This increase is most likely due to the addition of cell phone respondents and the new raking method and is not a “real” change in the prevalence from 2010.

(Source: Indiana State Department of Health, Indiana Epidemiology Newsletter. Volume 20, Issue 4, July/August 2012)

Infant Mortality is deaths in children under the age of 1 year.

Life Expectancy at birth represents the average number of years that a group of infants would live if the infants were to experience throughout life the age-specific death rates present in the year of birth.

Low Birth Weight is an infant weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.

Reliability of Rates refers to some of the rates shown in this report, which are based on small populations, a small number of deaths, or both. The rates based on small numbers may be unstable due to random chance factors and should be used with caution. Rates for counties with small populations also may vary considerably from year to year. In addition, allowances must be made for differences in age distributions, etc., when rates are not age-adjusted.

Very Low Birth Weight is an infant weighing less than 1,500 grams (3 pounds, 3 ounces) at birth.

Recommendations/ Action Strategies 2013

Current Problems that Exist throughout Indiana:

Rationale 1.1: After researching pressing problems that exist within the parameters of minority health, the IAC has decided to focus on the following issues for 2013:

- Data availability for racial and ethnic minority statistics. The lack of key information for certain classification of races and our state's current data dissemination process. It is difficult to collect and utilize trending data. At present, for most data driven reports and information, the racial categories that are available are: Black, Hispanic, White, and Other. Because of the low number of Asian/ Pacific Islanders, American Indians, and Multiracial statistics being reported, they are all designated into the "Other" Category. This problem causes obstacles to HIPPA and data collection requirement, as well create barriers for producing health outcomes for certain populations.

Recommendation 1.1: Mandate the standardization of collecting, recording and disseminating race, ethnicity, and language data. It is key that the state understands and knows who they are serving in order to tailor programs that best fit the different residents of the cities, towns, and counties within Indiana.

Action Strategy 1.1: It is imperative that we train our frontline workers and those who gather information on how to correctly obtain this information. Indiana must be culturally appropriate and sensitive to our residents. This will ensure that we get the needed information to continue programming and not offend or deter people from seeking health care. It is key that data collecting entities know the importance of collecting data and the correct process of collecting.

Rational 2.1: There is a lack of morbidity data collected for racial and ethnic minorities. Currently, there are codes which legislatively mandate chronic disease registries. These registries are supposed to assemble key data, but information is not being collected.

Recommendation 2.1: Improve compliance with mandated registries.

Action Strategy 2.1: Work with the Medical Care Organizations and others to establish relationships to better collect morbidity information.

Rationale 3.1: Access to quality health care is a necessity for all Hoosiers. It is a limitation in the ability to manage the diseases making it difficult to eliminate health disparities and increase health equity among all Hoosiers, specifically those underserved populations.

Recommendation 3.1:

Inadequate access to healthcare limits the ability to manage disease and makes it harder to work toward elimination of disease, thereby increasing wellness among all Hoosiers, specifically underserved populations. To effectively address Health Disparities for racial & ethnic minorities, there is a great need to promote and implement prevention services.

Action Strategy 3.1:

Health Disparities can be reduced by focusing on those groups/individuals at greatest risk. Targeting prevention services will lead to improvement of health for racial, ethnic and underserved populations. Prevention initiatives must be developed and implemented to ensure the reduction and elimination of Health Disparities.

Conclusion:

There is still much work to be done in addressing the cradle to grave health disparities that exist in Indiana. As Indiana becomes more racially and ethnically diverse and its populations live longer, the gaps in health status and health outcomes among racial and ethnic minorities will continue to widen. The Interagency State Council on Black and Minority Health has developed recommendations centered on the present needs in minority health that will allow the state to continue its progress in reducing health disparities and meet the objectives outlined in the Healthy People 2020. The Interagency State Council on Black and Minority Health commits to supporting partners, stakeholders, and leaders in carrying out these recommendations.

Appendices

Appendix A: Detailed listing of organizations and description of partnerships that exist among the Interagency State Council on Black & Minority Health Council

The Indiana Family and Social Services Administration (FSSA) and National/local health officials recognize that HIV is a growing health problem that is disproportionately affecting women, minority populations and youth throughout Indiana and the nation. Spearheaded by FSSA, a number of organizations came together and developed a program to address this disease that has been devastating to persons across the globe as well as in Indiana. The Annual Statewide HIV Awareness program is sponsored through a collaborative effort of the Indiana Family and Social Services Administration, Indiana State Department of Health, Indiana Minority Health Coalition, local and State agencies and a number of community organizations. The purpose of this annual event is to provide an opportunity to educate the public (individuals, families, groups, advocates, concern citizens, etc.) about prevention and early detection of HIV. A high profile speaker serves as the keynote during the event along with locally based advocates, educators, and entertainers that creatively communicate health messaging through poetry, rap, song, drama, and other artistic expressions

Minority Health Partnership

In order for the ISDH-OMH to be most effective, the office strongly relies on its ties and partnerships with national, state, and local organizations. On a monthly basis, ISDH-OMH meets with several organizations to get feedback of what is going on in different communities and creates an opportunity for minority leaders to meet and network and collaborate on projects to help eliminate health disparities and raise awareness.

Community and Universities Addressing Health Disparities (CUAHD) – Through its Center on Multicultural Programs and Initiatives, IMHC partners with the Purdue University and its local affiliates in Lake and Marion Counties to employ the culture centered approach model to address health disparities associated with heart disease targeting the African American community. The culture centered approach engages community involvement at every level of the research process including the research design, implementation, evaluation, and dissemination. This is funded by the Agency for Health Care Research and Quality at \$1,499,427 over a three-year period. The following includes the phases of this research project: 1) form community advisory board, 2) conduct key informant interviews, 3) conduct focus groups, 4) develop a information technology HUB to serve as a resource and place of on-going dialogue, 5) develop the intervention, 6) pilot the intervention, 7) evaluate the intervention, and 8) disseminate the findings.

Appendix B: Detailed listing of Strengthening and broadening leadership for addressing health disparities at all levels.

EMPOWERED Project

The purpose of the Indiana State Partnership Grant is improving access to health care for racial and ethnic minorities in Indiana. Our objective, that through the Enhancing Minority Partnership Opportunities; Working to Eliminate Racial and Ethnic Disparities (EMPOWERED) project, Indiana will have increased diversity within future healthcare workforce, allowed health care professionals and students to have access to culturally competent and appropriate training to provide better qualitative care to Indiana residents, and that data collection efforts for racial and ethnic minorities will improve and increase. ISDH partners through IMHC's Capacity Development and Training Center, Marion and Allen County Area Health Education Centers, and Marion, Lake county local minority health coalitions to increase the number of minorities that pursue a health career. This initiative targets middle school aged youth in Allen, Lake, and Marion counties in Indiana. These youth participate in the following: 1) Kids In Health Careers program that exposes them to the variety of opportunities that are currently available and emerging in healthcare and 2) Enrichment activities that is geared towards strengthening participant interest in healthcare through job shadowing, summer camps, field trips, mentorship, and other student engagement strategies. EMPOWERED is a three year project funded by the U.S. Department of Health and Human Services, Office of Minority Health.

EMPOWERED is based on the latest research and continuing efforts to eliminate health disparities. Funding in the amount of \$140,000.00 per program year (3 year maximum with the grant) is requested for implementation, collaboration, staffing, training, and evaluation.

Appendix C: Improve health and healthcare outcomes for racial, ethnic, and underserved populations.

Black & Minority Health Fair

Each July, ISDH-OMH sponsors the INShape Indiana Black and Minority Health Fair, which provides free health screenings, education, resources, and consultations valued at \$1,000.00 per participant, during Indiana Black Expo's Summer Celebration. The core goal of the health fair is to increase minority awareness of chronic diseases, and how to prevent them. Increasing minority awareness of diseases, such as diabetes, heart disease, stroke, hypertension, and cancer is not just the goal of the Office of Minority Health or of the Health Fair. The goal is also at the heart of the Indiana State Department of Health's mission, which is to support Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.

Identifying and assessing the health needs of minority populations who experience problems in gaining access to preventive and basic health care helps all of Indiana's citizens.

Text4Baby – is a free opt-in text service offered nationwide to pregnant and recently pregnant women, was launched by the National Healthy Mothers, Healthy Babies Coalition and the wireless telephone industry in February 2010. A woman enrolls in the service by sending a text message to a specified number. In return she receives free weekly text messages containing helpful information tailored to her stage of pregnancy and continuing through her child's first year of life. Messages cover a range of topics critical to maternal and child health, including: labor and delivery, nutrition, breastfeeding, safe sleep, prenatal care, infant care, oral health, immunization, mental health, smoking cessation, developmental milestones, exercise, family violence, and safety. Indiana has been honored for enrolling the most pregnant mothers into the Text for Baby Program for eleven consecutive weeks within the Tier 2 Category of states which is based on size.

The Indiana Commission on the Social Status of Black Males would like to thank all those who participated in the 2012 Indiana Black Barbershop Health Initiative making it a statewide success. The initiative impacted nine cities, over thirty community partners, forty five barbershops and most importantly seven hundred forty eight screened participants.

In addition the Commission would like to acknowledge the one hundred thirty volunteers that helped make the event a success. The goal of the initiative was to ensure screenings that improve the health and well being of men across the state and provide resources that will assist in maintaining a focus on preventative health.

Too Sweet for Your Own Good

Is a Diabetes Initiative that takes place in Marion County and Lake County. It is an all day conference were we along with national, state, and local partners, educate, empower, and equip diabetics, their care givers, and those interested in learning about the disease information regarding Diabetes Management.

Bienvenido Program is an education program that is available in Spanish. The Bienvenido classes are designed to increase access to mental health services, improve mental health, and quality of life for Latino immigrants. The Bienvenido curriculum is focused on three goals to obtain good mental health: to reduce alcohol and drug use and related outcomes; increase access to and use of mental health services; to increase sense of belonging and participation in the community. The core services offered in this program include educational sessions and administration of posttests. The program consists of nine sessions (each session lasts for one and half-hours) to cover the program topics. The classes are implemented in a community-based organization. Class format provides participants with an opportunity to identify strengths, needs, and establish goals for their new life in another country. Participants are also encouraged to become more involved in community activities.

Appendix D: Detailed listing of organizations and description of cultural competency efforts by IMHC and ISDH-OMH

IN-OMH offers employees of the Indiana State Department of Health, and its partners, cultural competency in health training. The IN-OMH follows, and recommends to all partnering agencies, the same cultural competency guidelines used by the National Office of Minority Health, American Medical Association, American Nursing Association, American Association of Pediatrics, and the American Psychological Association.

The goal of IN-OMH's cultural competency training service is that 80% of program participants will demonstrate increased knowledge of cultural differences among minority populations and will indicate intent to apply cultural competency skills and knowledge in their professional capacity, within one year of completing the competency training.

The Indiana Minority Health Coalition is committed to providing the best quality programs to minorities throughout the state of Indiana. In order to effectively provide these programs, IMHC and its community partners collaboratively work together to assess, design, develop, implement and evaluate programs that are culturally and linguistically appropriate for each minority group represented.

Appendix E: Detailed listing of organizations and description of efforts being done in Indiana to address racial and ethnic data collection.

State Master Research/Minority Health Epidemiology Plan

The *State Master Research Plan* project is a coordinated effort to determine the direction, focus and interest in the strategy to affect health disparities among minorities in Indiana. The overarching goal is to assess and improve collection and distribution of quality health care data on minorities in Indiana.

Vision: Existence of a strong epidemiological research network to support efforts to eliminate health disparities.

Mission: Establish a consortium of key researchers to better understand and address the health disparities.

Goals:

Develop a functioning inventory of data

Monitor prevalence, incidence and trends of health outcomes

Develop and test interventions and strategies to reduce disparities

Translate research findings into practice

Jointly apply for funding to address disparities

Health Literacy Study - The Indiana Minority Health Coalition (IMHC), academic and community partners collaborated on a Health Literacy study. The purpose of the study was to assess health literacy among racial and ethnic minority adults in selected Indiana counties, to learn about experiences that community members may have when communicating with health care professionals, to learn about real and perceived issues and factors that affect health literacy and communication of health information among minority populations, and learn about opportunities that may help promote and enhance health literacy and communication of health information among minority populations. The methods used for data collection included the use of standardized health literacy assessments, focus groups and key interviews.

Native American Indian Health Needs Assessment – IMHC, in collaboration with the American Indian Center of Indiana, has performed an assessment of American Indian Health Needs in Indiana. This is the first assessment of American Indian Health Needs in Indiana since 1992. Surveys were developed and distributed at Powwows across the state to collect the necessary data and report Indiana specific findings.

Race, Ethnicity, and Language (RE^AL) – Through its REME Center, IMHC in collaboration with the Indiana University School of Medicine Bowen Research Center and the Central Indiana Alliance for Healthcare Quality has been funded by the Robert Wood Johnson

Foundation to develop training modules to assist healthcare providers in collecting standardized race, ethnicity and language information. This standardization not only includes the categories used throughout the system to collect RE^AL data, but it also includes the way or manner that the RE^AL data is collected. Also, a RE^AL tool kit has been developed for healthcare providers to use when introducing RE^AL within their organization for both patients and healthcare staff.

Refugee Health Needs Assessment – IMHC has worked with a variety of community- and faith-based organizations to conduct a health needs assessment of the Burmese population in Indiana. Multiple methodologies will be employed based on feedback from each community.