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Indiana State Department of Health

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November 9, 2007

We are pleased to present you with the Interagency Council on Black and Minority Health's 2007 report. The report outlines key data findings of the council as well as three critical health focus areas to be addressed. These focus areas for improving minority health will act as a launching pad for action within Indiana on every level - residents, public health providers, community organizations, policymakers, and other stakeholders - to address health inequities and improve the health and environment of all Indiana residents. The three focus areas are:

- a. **Heart disease** is the leading cause of death in both Indiana and the U.S and is a major cause of disability. The broad term "heart disease" includes several more specific heart conditions including, but not limited to, coronary heart disease, heart attack, and heart failure. In the U.S., nearly 650,000 Americans die of heart disease annually (CDC).
- b. **Obesity:** Overweight and obesity result from an energy imbalance, which is caused by consuming too many calories and not getting enough physical activity. In addition to poor diet and physical inactivity, other factors that contribute to obesity include heredity, metabolism, behavior, environment, culture, and socioeconomic status.
- c. **Addictions:** Two common addictions include tobacco use and substance abuse. Tobacco use, particularly smoking, remains the number one cause of preventable disease and death in the U.S. For example, the risk of dying from lung cancer is more than 22 times higher among men who smoke cigarettes and about 12 times higher among women who smoke cigarettes compared with non-smokers.

The intent of these recommendations and focus areas is to help increase access to healthcare services and reduce health status disparities among minority communities and individuals. We look forward to providing you with a report in November 2008 outlining our success in implementing this plan.

For a Healthier Tomorrow,

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***The Interagency Council on
Black and Minority Health
2007 Annual Report***



Indiana State Department of Health
Office of Minority Health
November 2007

The Interagency Council on Black and Minority Health 2007 Annual Report

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Executive Summary

2007 Interagency Council on Black and Minority Health Annual Report

Introduction

Like the rest of the U.S., Indiana is growing more diverse culturally, racially, and ethnically. This change will continue to increase over the coming years and will enrich Indiana as a state and help to expand its global perspective. However, while there are many positive outcomes due to this growth, there also problems, such as adequate health delivery.

The National Institutes of Health states that “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US.” It is racial and ethnic minorities that are facing a disproportionately greater burden of disease, injury, premature death, and disability.

Health disparities cannot be addressed until they are identified. Likewise, in order to address health disparities, it is imperative to understand that there are many contributing factors that influence an individual’s health, such as environment, lifestyle choices, cultural beliefs, poverty, past experiences, insurance status, employment, etc. Furthermore, racial and ethnic minorities also experience barriers to health including but not limited to: access to care; limited English proficiency; no continual source of health care; health education; assumptions; and lack of diverse employment skills. Until existing disparities are identified, allowing for effective targeted interventions and solutions to be designed and implemented, health disparities in Indiana will continue to grow,

Purpose of the Report

This annual report from the Interagency Council on Black and Minority Health is a resource that gives insight to the present state of Indiana and its diverse populations. The Interagency Council on Black and Minority Health was established under the Indiana Code 16-46-6 to improve the overall health and well-being of racial and ethnic minorities in Indiana. More specifically, the Interagency Council on Black and Minority Health has been charged to do the following:

- A. Identify and study the special health care needs and health problems of minorities.
- B. Examine the factors and conditions that affect the health of minorities.
- C. Examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities.
- D. Study the state and federal laws concerning the health needs of minorities.
- E. Examine the coordination of services to minorities and recommend improvements in the delivery of services.
- F. Examine funding sources for minority health care.
- G. Examine and recommend preventive measures concerning the leading causes of death or injury among minorities.
- H. Examine the impact of diseases or conditions for minorities.
- I. Monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.

J. Develop and implement a comprehensive plan and time line to address health disparities and health issues of minority populations in Indiana.

Focus for 2007

Reducing health disparities among minorities in Indiana will require the cooperation of legislators, governments (both local and state), gatekeepers, and the community. Improved efforts in data collection, better access to care, essential preventative care, and community involvement will be necessary to improve current health status and conditions of all racial and ethnic minority groups.

The Interagency Council on Black and Minority Health is releasing this report to enlighten, inform, and offer solutions to eliminate health disparities. There are three areas of focus for the 2007 council year. The disease areas chosen were: heart disease, obesity, and addictions (specific emphasis on smoking and substance abuse).

Key Findings

A. The U.S. Department of Health and Human Services Office of Minority Health's National Action Agenda to End Health Disparities for Racial and Ethnic Populations

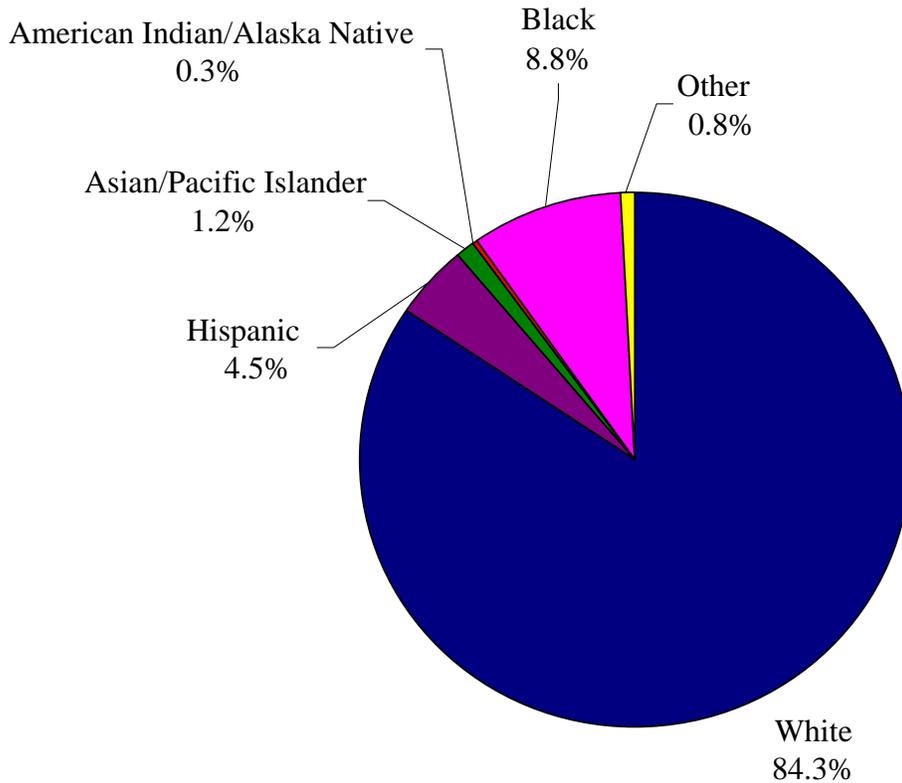
- 1) The mission of the National Action Agenda (NAA) to End Health Disparities for Racial and Ethnic Minority Populations is to work with individuals and organizations across the country to create a nation free of health disparities, with quality health outcomes for all.
- 2) In 2004, leaders from the public and private sectors of business and different levels of the Indiana community were brought together by the Indiana Minority Health Coalition (IMHC), Mays Chemical, Clarian Health, and the Black Legislative Caucus to discuss the widening gap of health disparities. The CEO Roundtable was born from this gathering as a way to assess community members' roles in addressing health disparities.
- 3) The National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health showed there is much work being done in communities all around the U.S. to eliminate health disparities among racial and ethnic minorities. One of the objectives of the NAA is to make sure all best practice solutions for reducing minority health disparities are published, so that all involved parties can learn from each other, apply proven solutions, and emphasize the flow of ideas from the grassroots to government and private policy-makers.

B. Demographics

- 1) Racial and ethnic populations in Indiana make up more than 15% of the current population.
 - a. Figure 1 shows the percentages of each racial and ethnic group in Indiana. This information is based on data derived from the U.S. Census Bureau, 2005 Population Estimate. Non-Hispanic racial groups shown include White, African American/Black, American Indian/Alaska Native, and Asian/Pacific Islander. The ethnic groups included are Hispanic/Latino (persons of Hispanic origin may be of any race). In this

section and throughout this report, statistical data for racial groups exclude persons of Hispanic origin unless otherwise noted.

Figure 1. Indiana Population by Race and Hispanic Ethnicity, 2005



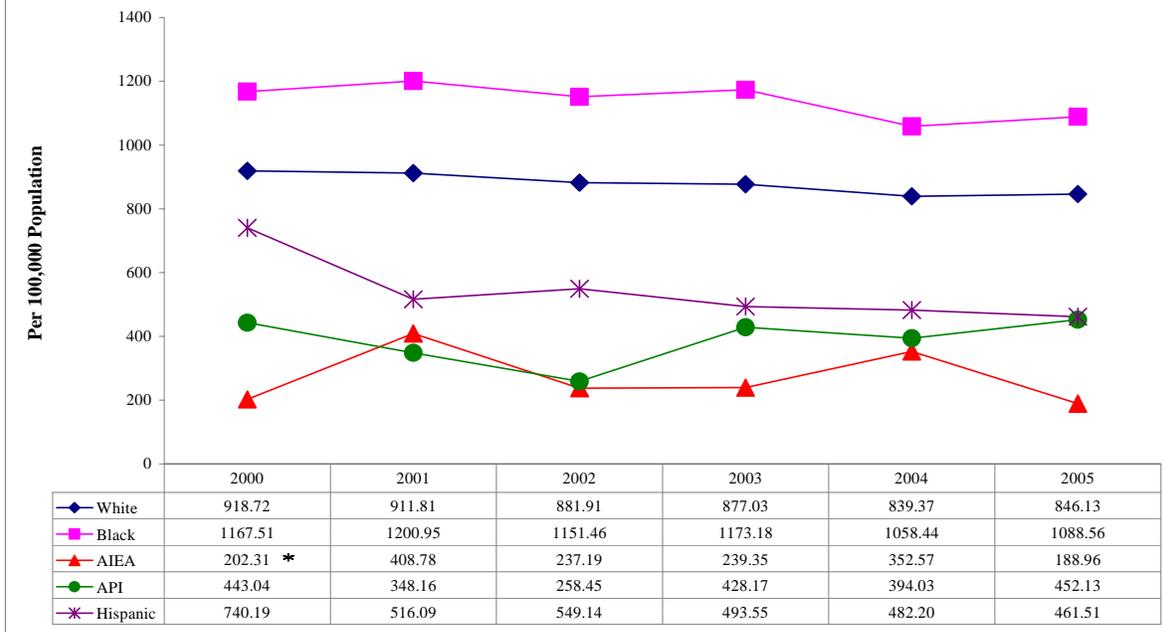
C. 2006-2007 State Initiatives and Programs Report

- 1) The Interagency council found several Indiana organizations and initiatives that are currently addressing heart disease, obesity, and addictions. Within this report you will see in detail the progress made during 2006-2007 and how these changes will eventually affect the data that is collected and the improvement of health outcomes for all Indiana residents.

D. Mortality

- 1) When looking for indicators of specific issues affecting different populations, data is relied upon greatly. Mortality data is one method that is used to detect disparities that affect the health of Indiana residents. Figure 7 compares the 2000-2005 age-adjusted death rates in Indiana for all causes of death by race and ethnicity. Overall, Blacks have the highest age-adjusted death rates, followed by Whites and Hispanics.

**Figure 7. Age-Adjusted Death Rates for All Causes of Death by Race and Ethnicity
Indiana, 2000-2005**



Source: Indiana State Department of Health, PHSDD, Data Analysis Team

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

E. Focus Areas

- 1) The Interagency Council on Black and Minority Health understands that eliminating health disparities is a process, and must be addressed one step at a time. Choosing these three focus areas allows Indiana to evaluate current conditions for heart disease, obesity, and addictions. Analyzing the data and conducting research allows for a better understanding of the barriers that exist within these areas and how they are affecting racial and ethnic minorities. Additionally, it is essential to assure the barriers that exist among different races, cultures, and beliefs are addressed in a manner specific to their cultural needs.

The following section breaks down each of the three focus areas identified by the Interagency Council on Black and Minority Health.

- a. **Heart disease** is the leading cause of death in both Indiana and the U.S and is a major cause of disability. The broad term “heart disease” includes several more specific heart conditions including, but not limited to, coronary heart disease, heart attack, and heart failure. In the U.S., nearly 650,000 Americans die of heart disease annually (CDC).

- In both Indiana and the U.S., Blacks have the highest age-adjusted death rates due to heart disease, compared with all other races and ethnicities, followed by Whites and then Hispanics. Nationally, nearly 34.1% of Black adults have high blood pressure. In fact, compared with Whites, Blacks have higher rates of high blood pressure, overweight or obesity, and diabetes, all risk factors of heart disease. For these reasons, two goals of Healthy People 2010 are to reduce deaths from heart disease among Blacks by 30% and to reduce deaths from strokes among Blacks by 47 % (CDC).
- b. **Obesity:** Overweight and obesity result from an energy imbalance, which is caused by consuming too many calories and not getting enough physical activity. In addition to poor diet and physical inactivity, other factors that contribute to obesity include heredity, metabolism, behavior, environment, culture, and socioeconomic status.
- In both Indiana and the U.S, Blacks have the highest age-adjusted death rates due to diabetes, compared with all other races and ethnicities. Likewise, Black adults also have the highest prevalence of obesity (36.7%) based on results of the 2006 BRFSS survey, with Hispanics (45.6%), Whites (34.9%), and Blacks (33.2%) having the highest prevalence of overweight (Table 13).
 - In regards to physical activity, Blacks, both nationally (58.2%) and in Indiana (55.3%), have the greatest percentage of adults not participating in adequate levels of physical activity. However, in Indiana, each race/ethnicity, except Whites, has a higher percentage of adults who are participating in adequate levels of physical activity than the national averages for each race/ethnicity (Table 15).
- c. **Addictions:** Two common addictions include tobacco use and substance abuse. Tobacco use, particularly smoking, remains the number one cause of preventable disease and death in the U.S. For example, the risk of dying from lung cancer is more than 22 times higher among men who smoke cigarettes and about 12 times higher among women who smoke cigarettes compared with non-smokers.
- Based on the results of the 2006 Behavioral Risk Factor Surveillance Survey (BRFSS), in Indiana Blacks have the highest prevalence of adults who are current smokers (27.0%) (Table 20). However, according to the 2005 Youth Risk Behavioral Survey (YRBS) results, Blacks, in both Indiana (7.8%) and nationally (5.2%), have the lowest percentage of students who ever smoked cigarettes daily (Table 21).
 - One example of substance abuse is alcoholism. Alcohol is a factor in approximately 41% of all deaths from motor vehicle crashes. Additionally, among youth, the use of alcohol and other drugs has also been linked to unintentional injuries, physical fights, academic and occupational problems, and illegal behavior. Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurological

damage as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder” (CDC).

Recommendations & Action Plans

These study findings suggest a variety of steps that public health and policymakers can take to help minimize the health gap that exists among all racial and ethnic minorities. Based on the interagency council’s analysis, we make the following recommendations and proposed action steps to be used in creating successful interventions and solutions.

A. Recommendations to policymakers and regulators

The purpose of this report is to act as a launching pad for action within Indiana on every level - residents, public health providers, community organizations, policymakers, and other stakeholders - to address health inequities and improve the health and environment of all Indiana residents.

To improve and maintain a community’s overall health, there is a need for increased social and economic changes that improve well-being and economic stability. The Interagency Council on Black and Minority Health, in participation with ISDH, realizes that it takes years to impact health risk factors and outcomes. However, through coordinated efforts, and required changes, Indiana can reduce health disparities and work towards creating health equality for all.

1) Heart Disease

- a. Work with local coalitions to market heart disease programs and services offered by local coalitions and their partners
- b. Assure that services are culturally and linguistically appropriate
- c. In collaboration with Indiana State Department of Health (ISDH) and the Indiana Minority Health Coalition (IMHC), will develop and disseminate culturally tailored heart disease awareness toolkits that can be used by the coalitions, community programs, or public health workers to raise minority awareness of the dangers of heart disease
- d. Develop and implement culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize avoiding the health risk factors for conditions affecting minorities and incorporate an accessible, affordable, and acceptable early detection and intervention component as set forth in IC 16-46-11. Culturally tailored programs to address ethnic/racial minority groups

2) Obesity

- a. Support of nutrition labeling requirements at fast food and other chain restaurants

- b. “Fat-tax” or “Twinkie-tax”: Controversial measure that is gaining momentum nationally that taxes processed foods and encourages purchases of healthy foods.
- c. Identify a pool of nutritional experts and social marketers.
- d. Develop clear and concise messages for dispersant populations
- e. Involve local health organizations and partners to provide technical assistance to the INShape Indiana program
- f. Develop a collaboration/network of stakeholders to transmit the message/shared-vision to the media
- g. Develop a resolution requiring a pledge towards “healthy living”
- h. Utilize existing education and literacy campaigns that promote healthy living
- i. Work with local coalitions to market obesity prevention programs and services offered by local coalitions and their partners
- j. Assure that services are culturally and linguistically appropriate
- k. In collaboration with ISDH and the IMHC, develop and disseminate culturally tailored obesity awareness toolkits that can be used by the coalitions, community programs, or public health workers to raise minority awareness of the dangers of obesity

3) Addictions

- a. Smoking bans in all cars to promote child safety
- b. Develop clear and concise messages for dispersant populations
- c. Involve local health organizations and partners to provide technical assistance to the INShape Indiana program for tobacco cessation
- d. Collaborate with other health organizations to develop a legislative agenda for media distribution
- e. Monitor for hearings, forums, and opportunities to present culturally appropriate messages for healthy living
- f. Involve small grassroots organizations
- g. Work with local coalitions to market their tobacco cessation or substance abuse programs and services so that they can be offered to their partners and staff

- h. Assure that services are culturally and linguistically appropriate
- i. In collaboration with ISDH, Smokefree Indiana, and IMHC, utilize and disseminate culturally tailored tobacco awareness toolkits that can be used by the coalitions to raise awareness of the dangers of tobacco use among minorities
- j. Recruit 30 individuals from each local coalition county to participate in tobacco prevention activities

B. Action Plan

The Indiana Minority Health Coalition (IMHC), under the IC 16-46-11, will coordinate and implement a comprehensive health plan that includes programs and activities to reduce health disparities that affect minority populations (African American, American Indian or Alaskan Native, Asian or Pacific Islander, and Hispanic/Latino) in the State of Indiana.

IMHC will review, approve, and fund no less than fifteen (15) FY 2008 county or multi-county minority health improvement work plans developed by local minority health coalition affiliated entities or other community based organizations. Each work plan will respond to needs and opportunities jointly identified by IMHC and the Indiana State Department of Health (ISDH), as legislatively outlined under the objectives of the Minority Health Initiative (IC16-46-11). Each plan will identify work and expected outcomes related to infrastructure maintenance and development. This will include program services, planning & assessment, and the leveraging of local resources towards assisting local coalitions in achieving their work plan goals. Each plan will also have a methodological outline for addressing health issues particular to each minority group (African American, American Indian or Alaskan Native, Asian or Pacific Islander, and Hispanic/Latino).

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Preface

The Interagency Council on Black and Minority Health was established under Indiana Code 16-46-6 to improve the overall health and well-being of racial and ethnic minorities in Indiana. More specifically, the Interagency Council on Black and Minority Health has been charged to do the following:

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

The council shall submit a report in an electronic format under IC 5-14-6 to the general assembly before November 1 of each year. The report must include the following:

- A. The findings and conclusions of the council
- B. Recommendations of the council

For the 2007 report, the Interagency Council on Black and Minority Health has decided to focus on the following areas:

- A. Heart disease
- B. Obesity
- C. Addiction
 - 1) Smoking
 - 2) Substance abuse

Introduction

In the United States (U.S.), wide gaps exist between the health of Whites and the health of racial and ethnic minorities. Disparities in health, health care, and access across racial, ethnic, and socioeconomic backgrounds in the U.S. are well documented. The following U.S. data from the U.S. Department of Health and Human Services' Office of Minority Health (OMH), show the effects and outcomes of health disparities:

- A. Heart disease is the leading cause of death across most racial and ethnic minority communities in the U.S., accounting for 27% of all deaths in 2004.
- B. African American men are 30% more likely to die from heart disease than non-Hispanic White males.
- C. Mexican Americans, who make up the largest share of the U.S. Hispanic population, suffer in greater percentages than Whites from overweight and obesity, two of the leading risk factors for heart disease.
- D. In the Asian/Pacific Islander community, 24.5% of deaths are caused by heart disease.
- E. Black women, with or without a high school education, have a high prevalence of obesity (48.4%). Hypertension prevalence is high among Blacks (41.2%), regardless of sex or educational status.
- F. African Americans are 1.5 times as likely as non-Hispanic Whites to have high blood pressure.
- G. American Indian/Alaska Native adults are 1.3 times as likely as White adults to have high blood pressure.
- H. Overall, Asian/Pacific Islander adults are less likely than White adults to have heart disease and they are less likely to die from heart disease.
- I. Premature death is higher for Hispanics (23.5%) than non-Hispanics (16.5%).
- J. Mexican American women are 1.2 times more likely than non-Hispanic White women to be obese.
- K. Serious health and social problems related to drug abuse and addiction affect minority populations at far higher rates than Whites.
- L. Minority drug abusers have disproportionately higher rates of illnesses associated with injection-drug abuse, such as hepatitis B, hepatitis C, and tuberculosis.
- M. The 2005 National Survey on Drug Use and Health showed that the highest rate of current (past month) illicit drug use was among American Indian/Alaska Natives (12.8%), followed by persons reporting two or more races (12.2%), Blacks/African Americans (9.7%), Native Hawaiians/Pacific Islanders (8.7%), Whites (8.1%), Hispanics (7.6%), and Asians (3.1%).
- N. African Americans accounted for 47% of all HIV/AIDS cases diagnosed in 2005. African American men are more than nine times more likely to die of AIDS than non-Hispanic White men.
- O. Hispanics accounted for 18% of AIDS cases in 2005, despite making up only 14% of the U.S. population. Hispanics are 3.5 times more likely to be diagnosed with AIDS than non-Hispanic Whites.

Erasing the divide in healthcare and health outcomes in Indiana will require the cooperation of legislators, governments, both local and state, gatekeepers, and the community. Improved efforts in data collection, better access to care, essential preventative care, and community involvement will be necessary to improve current health status and conditions of all racial and ethnic minority groups.

The Interagency Council on Black and Minority Health is releasing this report to enlighten, inform, and offer solutions to eliminate health disparities in the chosen three areas: heart disease, obesity, and addictions.

Background

Indiana has been at the forefront of minority health concerns for over 20 years. In 1988, the Indiana General Assembly enacted legislation that created the Interagency State Council on Black and Minority Health. Indiana Code 16-46-6 directed the Indiana State Department of Health (ISDH) to establish the Interagency State Council on Black and Minority Health with representation from the Indiana House of Representatives, Indiana Senate, Governor's Office, State Health Commissioner's Office, and other State agencies.

The Interagency Council on Black and Minority Health 2007 Report is a joint effort of ISDH and the Interagency Council on Black and Minority Health. The report includes data, a review of what has been done to reduce disparities in Indiana since *the 2006 Interagency Council on Black and Minority Health Report*, and the recommendations and conclusions of the Council.

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

National Initiative

The Department of Health and
Human Services Office of
Minority Health's National
Action Agenda to End Health
Disparities for Racial and
Ethnic Populations

Mission

The mission of the National Action Agenda (NAA) to End Health Disparities for Racial and Ethnic Minority Populations is to work with individuals and organizations across the country to create a Nation free of health disparities, with quality health outcomes for all.

NAA in Indiana

Efforts to end health disparities among racial and ethnic minorities have brought the state of Indiana to the national stage as they begin to select the first pieces of the puzzle.

With clear-cut plans broken down into timeframes and community members' support, leaders are sending the message that the state of Indiana is combating high rankings in negative categories and is determined to cultivate healthy Hoosiers.

In 2004, leaders from the public and private sectors of business and different levels of the Indiana community were brought together by the Indiana Minority Health Coalition (IMHC), Mays Chemical, Clarian Health, and the Black Legislative Caucus to discuss the widening gap of health disparities. The CEO Roundtable was born from this gathering as a way to assess community members' roles in addressing health disparities.

However, instead of tackling the topic as a whole, the issue was broken down into digestible pieces by subcommittees whose tasks were to tackle three disparities: obesity, tobacco, and mental health.

The efforts of Indiana's leaders resulted in the establishment of the Indiana Health Disparities Initiative.

Tobacco, obesity, and mental health were health topics chosen because of their impact on the state's minority population.

According to the 2006 Behavioral Risk Factor Surveillance System (BRFSS) data for obesity prevalence, Indiana was tenth in the nation with 27.8% of its population categorized as obese.

In 2006 the percentage of smokers in Indiana was 24.1% compared with the national median of 20.1%, according to the CDC. The percentage of smokers increased to about 33% for those who live below the poverty line, with a high percentage being individuals from minority groups who have less education and less money.

When it comes to mental health, the National Alliance on Mental Illness (NAMI) estimates that more than 40,000 Indiana adults have "serious mental illness."

To target these chosen areas, subcommittees of experts developed a plan of action regarding their topic, finding a way to involve community partners, access funding, educate the public, and bring about changes in behavior.

Now, a little more than two years after the initial meeting of the minds, IMHC is poised to set up an oversight committee that will request proposals for funding in the three target areas.

The U.S. Department of Health and Human Services Deputy Assistant Secretary for Minority Health Dr. Garth Graham was in Indianapolis on February 2, 2007, discussing the NAA and the Indiana Health Disparities Initiative.

What Are Health Disparities?

Data on health status point toward two significant health issues for racial/ethnic minority populations in the U.S.:

1. There is significant evidence of poor health status among racial/ethnic minority populations, with respect to premature death and preventable disease.
2. The poor health outcomes for racial/ethnic minorities are reflected in the health status and health care disparities – also known by the more precise but longer used term “disparities in health care and health status among racial and ethnic minority populations” – that are apparent when comparing health indicators for minorities versus the majority White population.

These health issues have been key public health concerns at the Federal level since the 1985 Secretary’s Task Force Report on Black and Minority Health under then Secretary of Health and Human Services Margaret Heckler. However, data demonstrate that these disparities remain formidable challenges today. Reports of progress on the “reducing health disparities” goal of Healthy People 2000 showed that, in many respects, racial/ethnic minority populations have remained in relatively poor health, and continue to be underserved by the health care system. In many cases, the health gaps identified in the 1985 Task Force Report have grown.

The need to address racial and ethnic minority health status and health disparities was reinforced in the two overarching goals of Healthy People 2010: (1) to increase the quality and years of healthy life for all U.S. populations; and (2) to eliminate health disparities, including those that affect racial and ethnic minorities. The dual challenge for the U.S. is to: (1) adequately address poor racial/ethnic minority health status and persistent racial/ethnic health disparities at a time of rapidly increasing racial and ethnic diversity; and (2) rein in health care costs while still maintaining health care quality for all. Successfully meeting this challenge will promote the continued strength and vitality of the Nation.

Promising Practices

The National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health showed there is much work being done in communities all around America to eliminate health disparities for racial and ethnic minorities. One of the objectives of the NAA is to make sure we all share in that bounty, so we can learn from each other, apply best practices, and emphasize the flow of ideas from the grassroots to government and private policy-makers.

The Business Case for Eliminating Health Disparities

Within the next decade, the Bureau of Labor Statistics predicts that 41.5% of the U.S. workforce will be members of racial and ethnic minority groups. At the same time, numerous studies have shown that racial and ethnic health disparities exist in various aspects of the health care system. Controlling for economic and health insurance status, differences still appear in the diagnosis and treatment of specific health conditions, the utilization of preventive services, and health outcomes.

Employers want to ensure quality health care for their workers and recognize its impact on employee health, productivity, performance and ultimately, business outcomes. However, employers may be unaware of inequities that exist in the health care system that can negatively influence one's health status. Awareness of these inequalities and of the diverse health care needs of the workforce is essential to employers when purchasing and planning appropriate health care services. This knowledge will allow employers to exercise their role as purchasers and leverage responses from health plans and providers.

Many employers are disturbed by the evidence of health disparities and their repercussions on the health and well-being of diverse workforces. Because few initiatives have homed in on the impact of health disparities on large employers, the business case for large employers to launch initiatives to reduce disparities in health and health care has yet to be outlined.

Also absent are the practical strategies that large employers can implement as the major purchasers of health care to reduce these disparities among their diverse workforces and within the nation as well.

Faced with these circumstances, the Office of Minority Health in the U.S. Department of Health and Human Services requested the National Business Group on Health to develop strategies for corporate audiences detailing why companies are making health disparities their business. These strategies will focus on the impact that racial and ethnic disparities in health and health care have on large employers. While the disparities that exist among diverse populations without insurance are extremely disturbing and important to reduce, they are less relevant to large employers who include health insurance as a component in the compensatory packages they offer their workforces.

Technical Notes

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

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

The direct method of adjustment was used to produce the age-adjusted rates for this report. In this method, the population is first divided into reasonably homogenous age ranges, and the age-specific rate is calculated for each age range. Then, each age-specific rate is weighted by multiplying it by the proportion of the standard population in the respective age group. The age-adjusted rate is the sum of the weighted age-specific rates. Further information regarding the calculation of age-adjusted rates can be found in *The Methods and Materials of Demography*, by Henry S. Shryock, Jacob S. Siegel and Associates, U.S. Department of Commerce. Age adjustment by the direct method requires use of a standard age distribution. The 2000 standard million population replaces the 1940 standard million population for age adjusting mortality statistics. The 2000 standard million population also replaces the 1970 civilian non-institutionalized population and 1980 U.S. resident population, which previously had been used as standard age distributions for age adjusting estimates from NCHS surveys. The 2000 standard has implications for race and ethnic differentials in mortality (National Vital Statistics Report, Volume 47, Number 3). For 2000-2005 data in this report, Indiana used the 2000 standard million population to age-adjust mortality rates.

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

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

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

Furthermore, according to the NCHS, age-adjusted death rates for Asians/Pacific Islanders and American Indians/Native Americans should be interpreted with caution because of reporting problems with respect to correct identification of race on both the death certificate and in population censuses and surveys. The net effect of the reporting problems is for the

Asians/Pacific Islanders age-adjusted death rate to be approximately 7% understated and for the American Indians/Native Americans age-adjusted death rate to be approximately 30% understated.

Race/Ethnicity – Data presented for the years 2000-2005 were collected using the standards for the classification of federal data on race and ethnicity that were in effect prior to the 2000 Census: White; Black; American Indian, Eskimo, or Aleut (AIEA); Asian/Pacific Islander (API); and Hispanic. The racial categories provided are only reporting one race and do not include ethnicity unless otherwise specified.

Data Sources-

Youth Risk Behavior Survey (YRBS)- The YRBS was developed in 1990 to monitor six categories of priority health risk behaviors among youth and young adults, including behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs); unhealthy dietary behaviors; and physical inactivity. In addition, the YRBS monitors general health status and the prevalence of overweight and asthma. The YRBS is conducted biennially in both public and private schools (9th-12th grade students) in all 50 states U.S. states and the District of Columbia. Both schools and students are chosen to participate in the YRBS by using probability samples and all surveys are anonymous and self-administered.

Behavioral Risk Factor Surveillance System (BRFSS)- The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the U.S. yearly since 1984. Conducted by the 50 state health departments as well as those in the District of Columbia, Puerto Rico, and the U.S. Virgin Islands with support from the CDC, BRFSS provides state-specific information about issues such as asthma, diabetes, health care access, alcohol use, hypertension, obesity, cancer screening, nutrition and physical activity, tobacco use, and more. Most states use the Disproportionate Stratified Sample (DSS) Method to select random phone numbers to interview and each state completes between 125 and 625 interviews a month of individuals age 18 and over (CDC). All data are self-reported by respondents.

National Center for Health Statistics (NCHS)

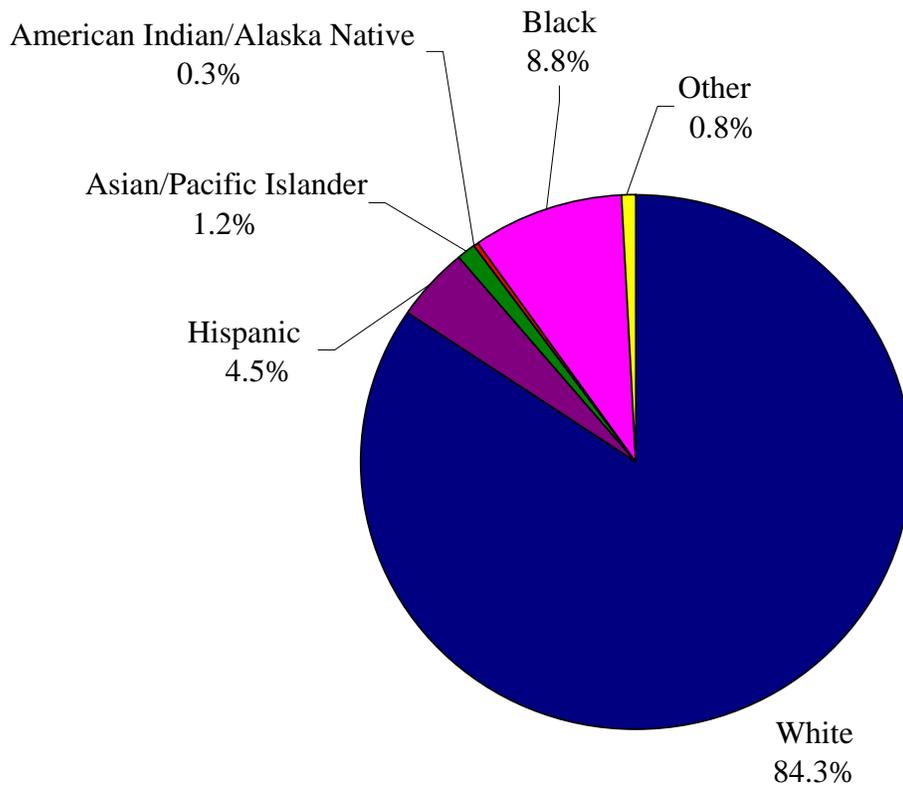
The NCHS is the health statistics division of the CDC. NCHS collects data from birth and death records, medical records, interview surveys, and through direct physical exams and laboratory testing.

Demographics

Racial and ethnic populations in Indiana make up more than 15% of the current population (Figure 1). It has been projected by the U.S. Census Bureau that by 2050, more than 47% of the U.S. population will be racial and ethnic minorities. An overview is provided in this section of the demographics of Indiana's racial and ethnic minority population. Maps are included for each racial and ethnic group to illustrate the geographic locations within Indiana that have the largest minority populations, indicating a need for increased programming and services in those areas.

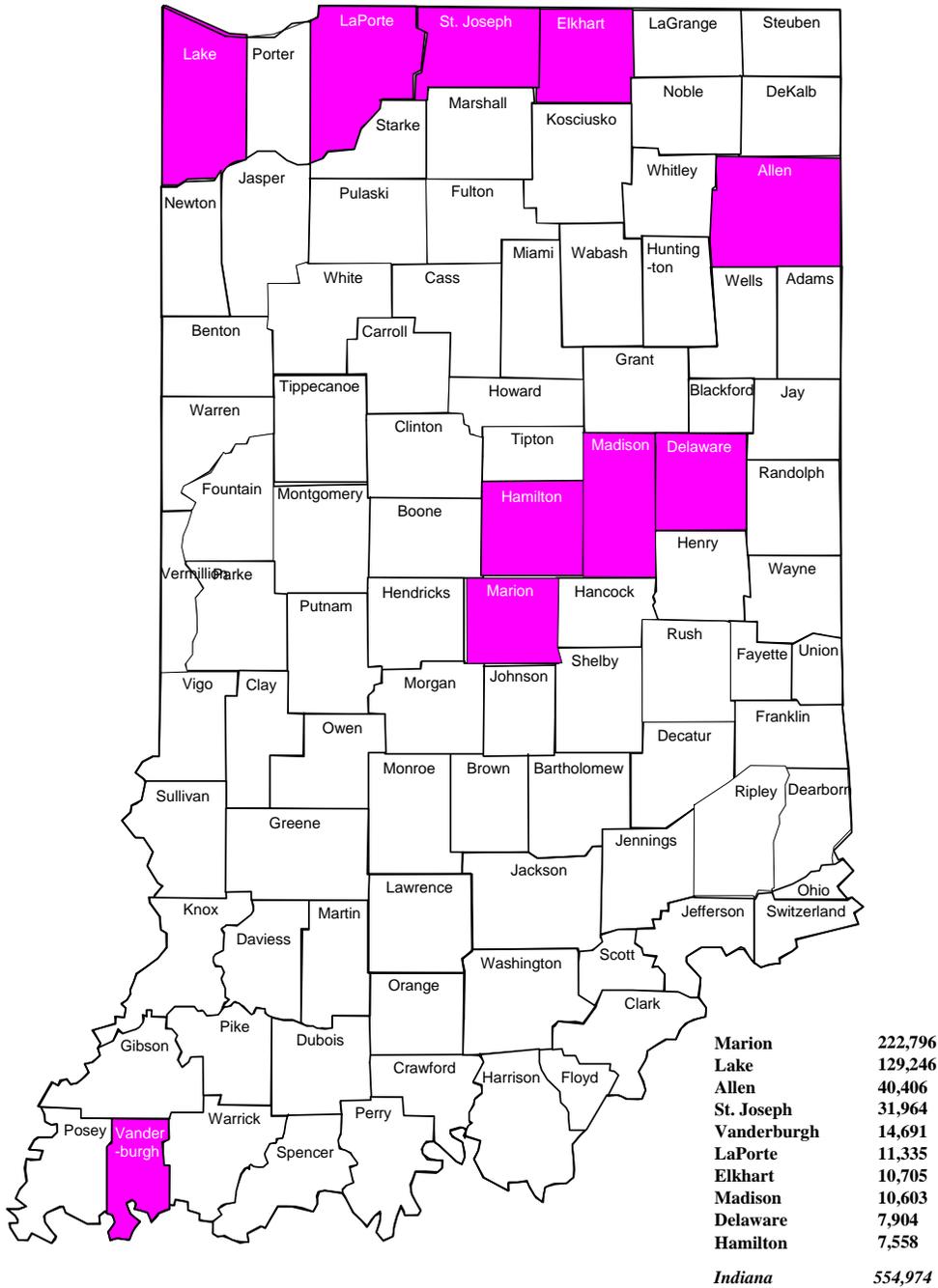
Figures 2-6 show the 10 counties with the highest population of each racial and ethnic group. This information is based on information derived from the U.S. Census Bureau, 2005 Population Estimate. Non-Hispanic racial groups shown include White, African American/Black, American Indian/Alaska Native, and Asian/Pacific Islander. The ethnic groups included are Hispanic/Latino. Persons of Hispanic origin may be of any race. In this section and throughout this report, statistical data for racial groups exclude persons of Hispanic origin unless otherwise noted.

Figure 1. Indiana Population by Race and Hispanic Ethnicity, 2005



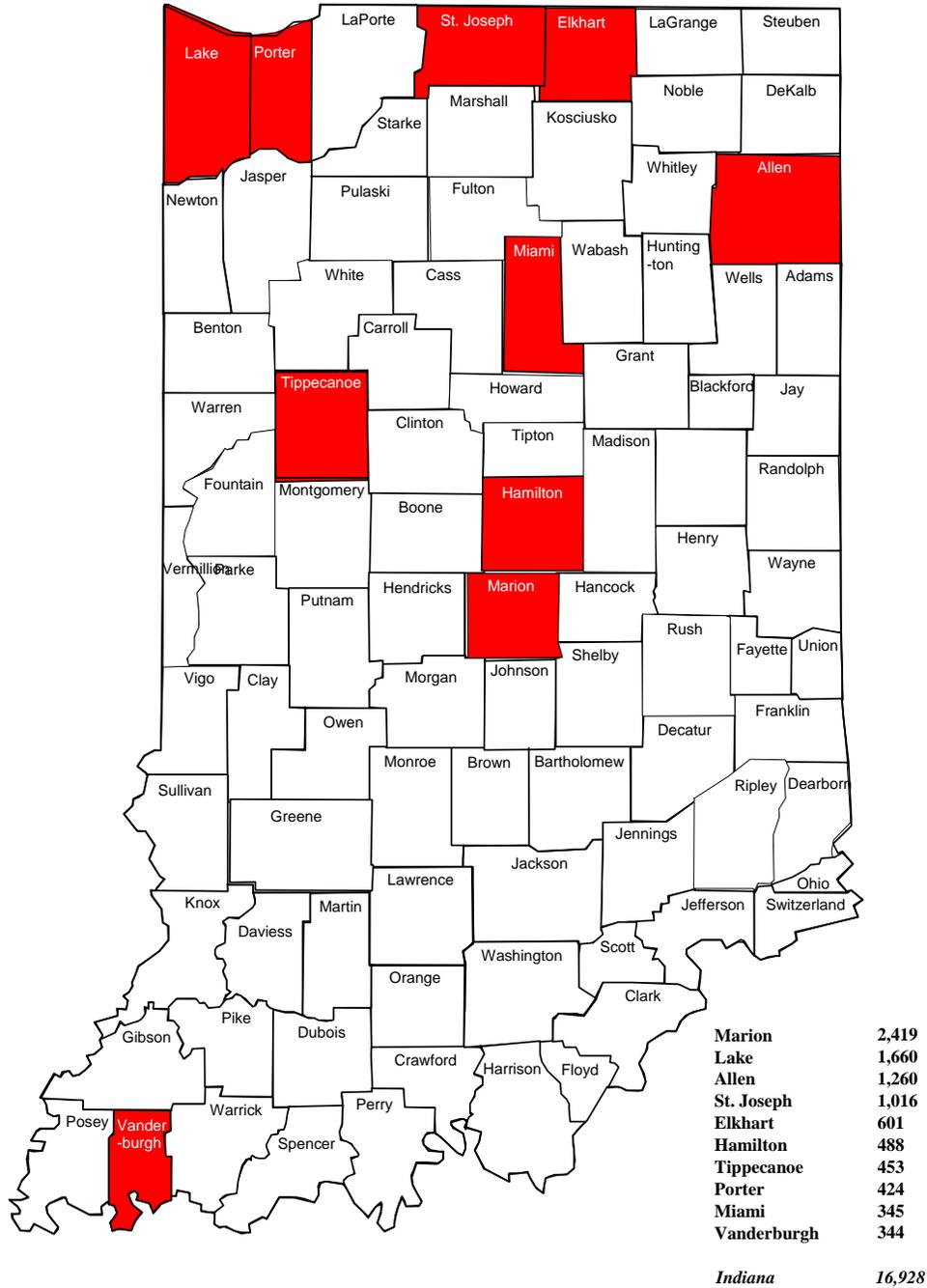
Source: U.S. Census Bureau, 2005 Population Estimate

Figure 2. Indiana: 10 Counties with the Highest African American/Black Populations, 2005



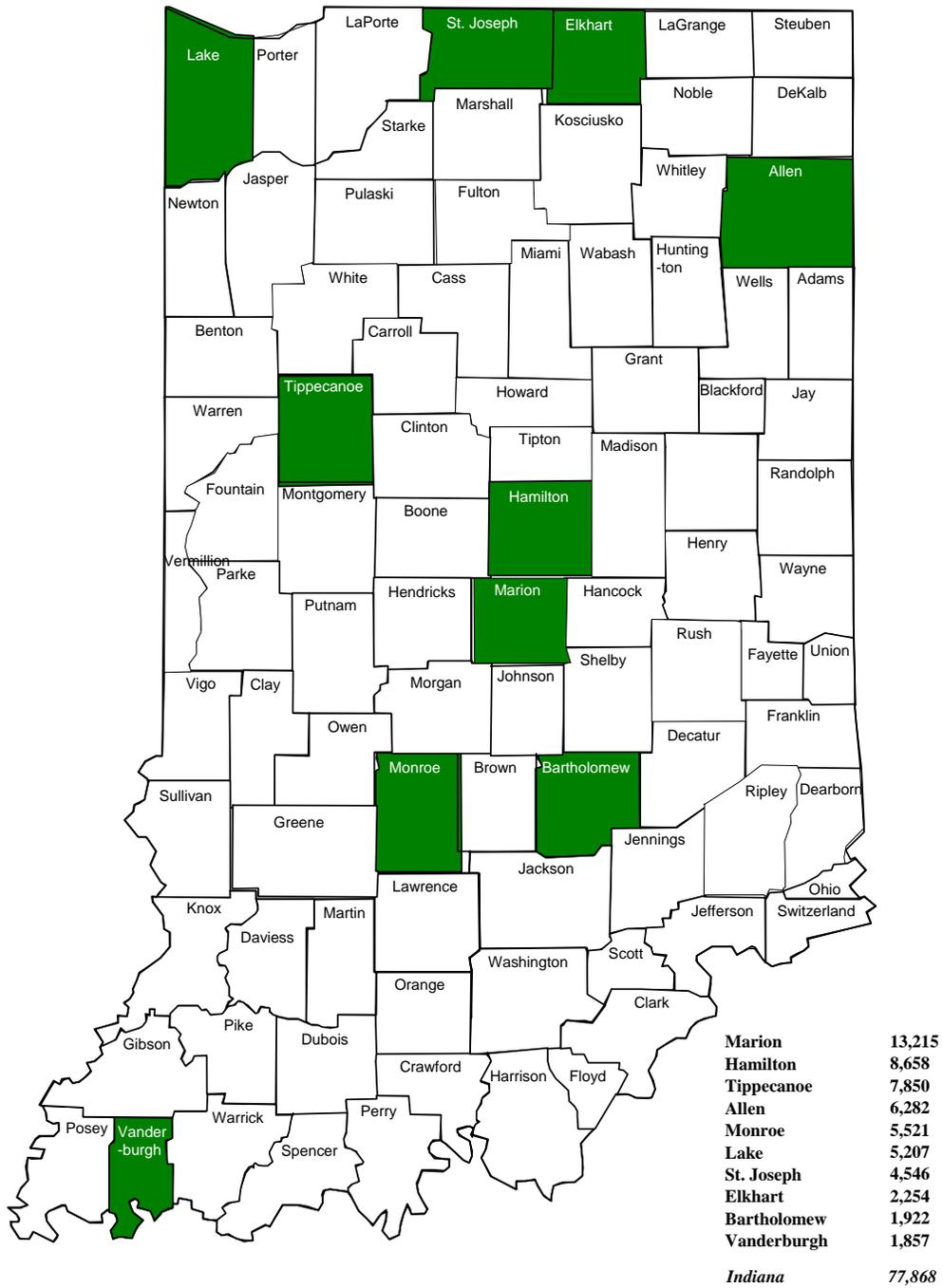
Source: U.S. Census Bureau, 2005 Population Estimate

Figure 3. Indiana: 10 Counties with the Highest American Indian/Alaska Native Populations, 2005



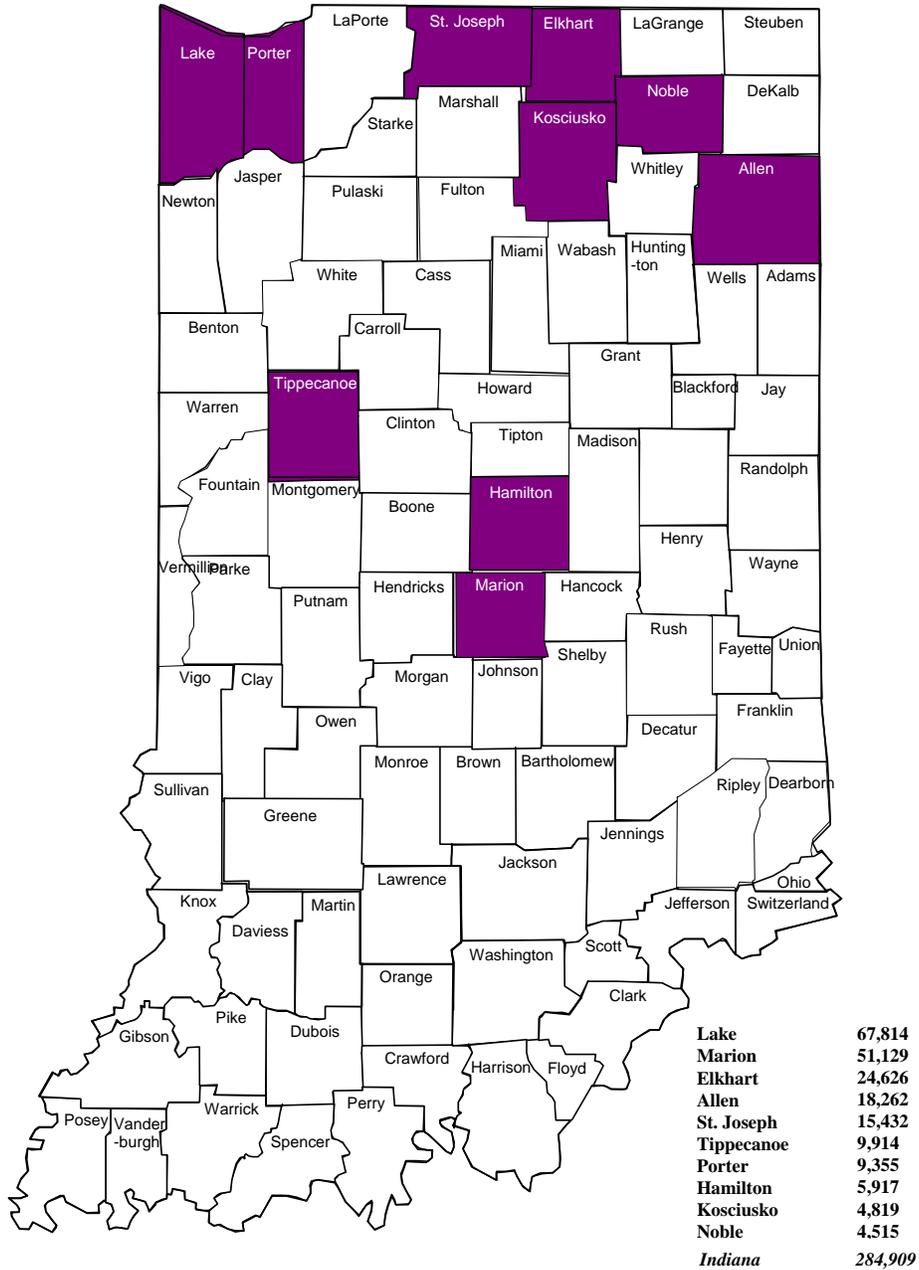
Source: U.S. Census Bureau, 2005 Population Estimate

Figure 4. Indiana: 10 Counties with the Highest Asian/Pacific Islander Populations, 2005



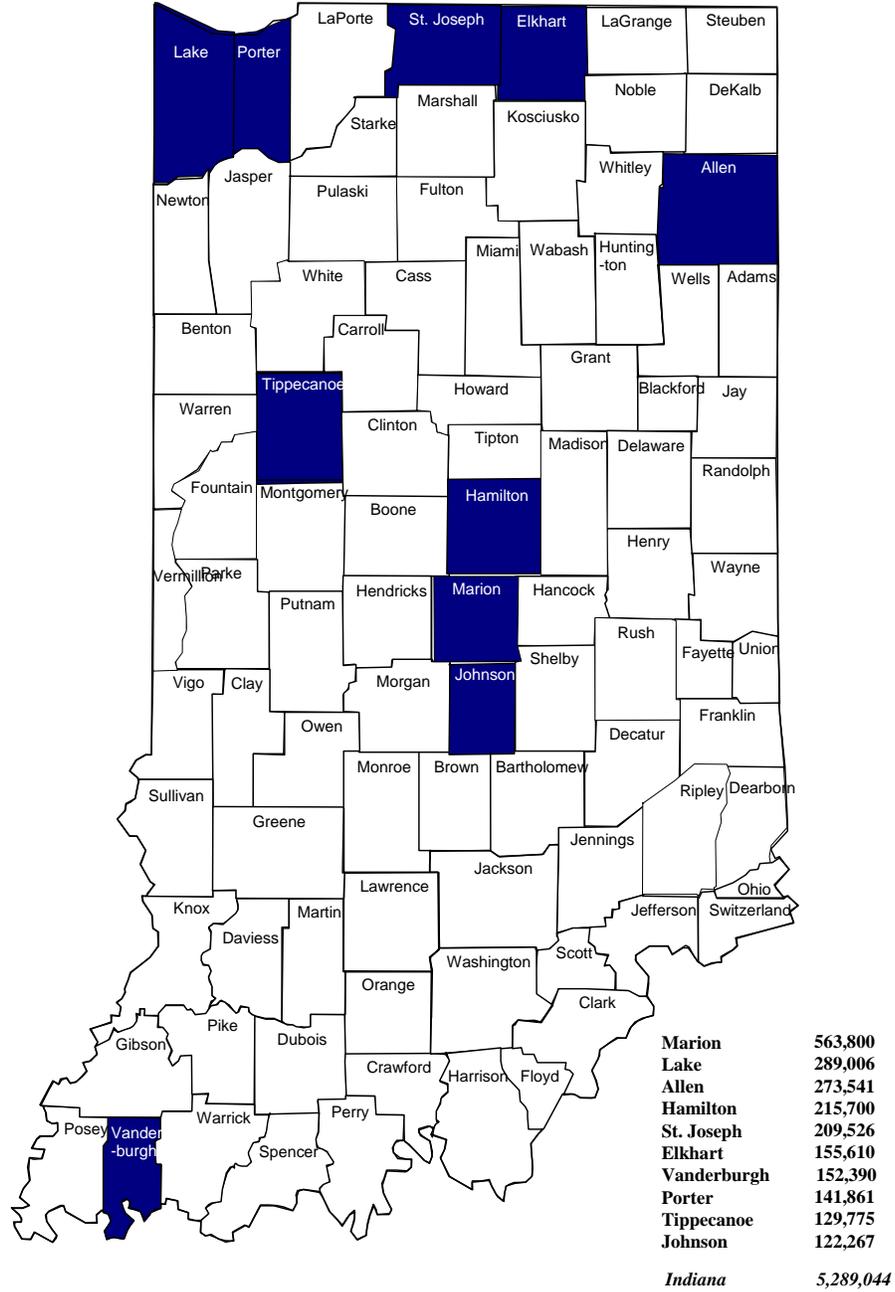
Source: U.S. Census Bureau, 2005 Population Estimate

Figure 5. Indiana: 10 Counties with the Highest Hispanic Populations, 2005



Source: U.S. Census Bureau, 2005 Population Estimate

Figure 6. Indiana: 10 Counties with the Highest White Populations, 2005



Source: U.S. Census Bureau, 2005 Population Estimate

2006-2007 State Initiatives and Programs Report

Heart Disease

A. American Heart Association

- 1) Mission: To reduce disability and death from cardiovascular diseases and stroke. Our impact goal is to reduce coronary heart disease, stroke, and risk by 25% by 2010.
- 2) Community Health Education Programs and Services
 - a. **Search Your Heart:** Since its inception in 1996, over 15,000 churches across the country have participated in the Search Your Heart program and it has reached over 1.5 million at-risk participants. By empowering these individuals with information, the program shows how to take necessary steps to reduce the risk of heart disease and stroke, including making healthy lifestyle changes and developing heart-healthy habits. The Search Your Heart educational program is divided into three sections: Heart Disease and Stroke, Nutrition, and Physical Activity.
 - b. **Power To End Stroke:** Be real. Be strong. Be proud. The power is in your hands to prevent and overcome stroke. This program targets African Americans and provides culturally sensitive activities and materials designed to raise awareness and educate African Americans with regards to stroke. Power To End Stroke offers the following:
 1. The Healthy Soul Food Recipes cookbook has an array of alternative recipes that are delicious and healthy
 2. Family reunion toolkit: Family reunions are a wonderful way to stay connected and to learn and teach about your family heritage and traditions. It is also a great time to inform and remind family members that stroke is a major health threat.
 3. Power Sunday: Encourages churches across the nation to participate in Power Sunday, any Sunday of the year, by discussing stroke awareness with their congregations
 4. Online power survey
 - c. **Alliance for a Healthier Generation:** To combat the obesity epidemic, the American Heart Association and the William J. Clinton Foundation, along with California Gov. Arnold Schwarzenegger (R-CA), have joined together to form the Alliance for a Healthier Generation. The Alliance's goal is to stop the nationwide increase in childhood obesity by 2010 by taking bold, innovative steps to help all children live longer and healthier lives. The Alliance will positively affect the places that can make a difference to a child's health: homes, schools, restaurants, doctors' offices, and the community. Since the Alliance formed in May 2005, it has laid the groundwork for major change in schools through the Healthy Schools Program (launched with support from the Robert Wood Johnson Foundation), brokered a landmark agreement with the beverage and snack food industries to offer healthier food and drink options in schools, and partnered with Nickelodeon to create the *Let's Just Play Go Healthy Challenge*, a television show, web and community-level campaign that empowers kids to take charge of their own health.

- d. **Go Red For Women:** Go Red For Women is the American Heart Association's nationwide movement that celebrates the energy, passion, and power we have as women to band together and wipe out heart disease. Thanks to the participation of millions of people across the country, the color red and the red dress have become linked with the ability all women have to improve their heart health and live stronger, longer lives. Sponsored by Macy's with additional support from the PacifiCare Foundation and Bayer Aspirin, Go Red For Women began in February 2004, and has since grown into a vibrant national movement as more women, men, celebrities, healthcare professionals, and politicians embrace and elevate the cause of women and heart disease. The movement gives women tips and information on healthy eating, exercise, and risk factor reduction, such as smoking cessation, weight maintenance, blood pressure control, and blood cholesterol management.
- e. **Start!:** The American Heart Association is proud to introduce Start!, a campaign that encourages, recognizes, and provides tools to companies to promote a culture of physical activity in the workplace. Start! can help businesses reduce costs and help employees reduce their risk for heart disease and stroke and lead longer, stronger, healthier lives.

Obesity

A. INShape Indiana

- 1) INShape Indiana is a web-based program and serves as a clearinghouse for:
 - a. Better Nutrition
 - b. Increased Physical Activity
 - c. Tobacco Prevention and Cessation
- 2) Increase the number of minorities in 29 targeted counties by 5% that participate in fitness and nutrition programs
 - a. IMHC, in collaboration with Indiana State Department of Health (ISDH) and universities, will provide education about obesity intervention and prevention. IMHC will, in collaboration with ISDH and universities: (i) educate local coalitions; (ii) develop tool kits; and (iii) develop list of resources for obesity intervention and prevention to be distributed to local coalitions
- 3) Governor Daniels' statewide health initiative
- 4) Hoosiers can register for free on-line
- 5) Administered by Governor's Council for Physical Fitness and Sports at ISDH
- 6) INShape Indiana Summit 2006
 - a. The 2006 INShape Indiana Health Summit took place on Monday, November 27 and was an incredible success. The Summit brought together 748 individuals from 82 counties, all of whom were committed to reinforcing the INShape Indiana message.
- 7) OMH-Bringing INShape Indiana To You!
- 8) INShape Indiana Black & Minority Health Fair

- 9) IMHC will ensure that each local coalition provides obesity intervention and prevention education, tool kits, and resources to:
 - a. 3 churches/ faith groups
 - b. 5 schools/ youth organizations
 - c. 5 minority serving health care providers
 - d. 5 minority businesses
- 10) IMHC in collaboration with ISDH will work with the local coalitions to develop culturally and linguistically appropriate media messaging about obesity intervention and prevention
- 11) IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University
- 12) IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives

B. Other State Initiatives

- 1) First INShape Obesity Summit in October 2005
- 2) State Health Commissioner's 10 Regional Meetings in 2006
- 3) The State Health Commissioner's Obesity Prevention Roundtable, Fall 2006
- 4) The State Health Commissioner/Deputy Health Commissioner's ISDH manager's meeting, January, 2007 – State and Agency Priority and Call to Action
 - a. The State Health Commissioner's Public Health and Medicine Day, May 2007
 - b. State Obesity Prevention Strategic Plan, 2007
 - c. Public Health Workforce Development, 2007
 - d. Local Health Department Capacity Building Pilot, 2007-2008
 - e. Obesity prevention grant application to CDC, 2008
 - f. State obesity prevention funding, available July 1, 2007-June 31, 2009
 - g. Community Nutrition/Obesity Prevention Strategy
 1. Our mission is to increase public awareness of healthy eating and increased physical activities, to promote healthy life styles, and to prevent obesity and related chronic diseases
 2. Program Areas
 - Ameri-Corps Program (built on previous Community Lay Health Worker Program)
 - CDC DNPA Continuing Education Program
 - Coordinated Healthy Senior Living Project
 - Community Health Education and Training
 - Data and Policy Development/School Weight and Height Collection
 - Eating Disorders
 - Extended Breastfeeding Program
 - Extended Farmer's Market and Senior Farmer's Market Program
 - National Fruit and Vegetable Program
 - Obesity Prevention Program
 - Worksite Wellness Pilot Program
 - Special projects (Healthy Vending and Snack Bar)

- OMH PROMiSE Program
- 5) OMH Town Hall Health Disparities Meetings
- 6) OMH Statewide Cultural Competency Awareness Training

Addictions

- A. Mental Health and Addiction Resources - Indiana Partners
- 1) Indiana Federation of Families for Children's Mental Health
 - 2) Circle Around Families, a system of care in Lake County, Indiana
 - 3) Dawn Project, a system of care in Marion County, Indiana
 - 4) The ACT Center of Indiana provides technical assistance regarding implementation of Assertive Community Treatment, Illness Management and Recovery, Integrated Dual Diagnosis Treatment, and other Evidence-based Practices in the field of mental health
 - 5) The Supported Employment Consultation and Training Center in Indiana provides information about Supported Employment and Supported Education programs and offers consultation and training about these practices to mental health centers
 - 6) The Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children is located in Indiana. This Center offers consultation, training, coaching, and other assistance to groups establishing a System of Care for children
 - 7) Indiana Prevention Resource Center provides information and technical assistance to Indiana's prevention professionals
 - 8) Provider Report Cards: Organized information on public mental health services for consumers and family members. Reports are compiled using information reported by providers, consumer phone surveys, and assessment instrument outcomes
 - 9) Indiana Federation of Families for Children's Mental Health: Actuarial Service Case rates established for adult consumers served by DMHA
- B. IMHC will, in collaboration with the HDI Mental Health Sub-committee and IDMHA: (i) work in collaboration with IDMHA to address access to care, perception of care, cost effectiveness and other areas of concern within the mental health arena; (ii) work in collaboration with IDMHA to identify at risk counties regarding mental health issues that impact racial/ethnic minorities; (iii) educate local coalitions; (iv) develop tool kits; and (v) develop list of resources for mental health awareness and identification to be distributed to local coalitions
- 1) Increase by 2% the percentage of minority adults and children who receive mental health services in 29 of the targeted counties
 - 2) IMHC will ensure that each local coalition provides mental health education, tool kits, and resources to:
 - a. 3 churches/ faith groups
 - b. Organizations providing services to racial/ethnic populations at risk for mental health issues
 - c. 5 minority serving health care providers
 - d. 5 minority businesses

- 3) IMHC in collaboration with ISDH and IDMHA will work with the local coalitions to develop culturally and linguistically appropriate media messaging about the importance of mental health and mental health awareness
- 4) IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University
- 5) IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives

C. INShape Indiana (Tobacco)

- 1) Quit line (1-800-quit now)
- 2) Quit 2 Win contest

D. Indiana Tobacco Prevention and Cessation

- 1) The Tobacco Use Prevention and Cessation Trust Fund Executive Board's vision is to significantly improve the health of Hoosiers and to reduce the disease and economic burden that tobacco use places on Hoosiers of all ages
- 2) The Tobacco Use Prevention and Cessation Trust Fund exists to prevent and reduce the use of all tobacco products in Indiana and to protect citizens from exposure to tobacco smoke. The Board will coordinate and allocate resources from the Trust Fund to:
 - a. Change the cultural perception and social acceptability of tobacco use in Indiana
 - b. Prevent initiation of tobacco use by Indiana youth
 - c. Assist tobacco users in cessation
 - d. Assist in reduction and protection from secondhand smoke
 - e. Support the enforcement of tobacco laws concerning the sale of tobacco to youth and use of tobacco by youth
 - f. Eliminate minority health disparities related to tobacco use and emphasize prevention and reduction of tobacco use by minorities, pregnant women, children, youth, and other at-risk populations
- 3) IMHC, in collaboration with Indiana Tobacco Prevention and Cessation (ITPC), will provide education about tobacco prevention and cessation. IMHC will, in collaboration with ITPC: (1) educate local coalitions; (2) develop tool kits; and (3) develop list of resources for tobacco prevention and cessation to be distributed to local coalitions
- 4) Goal: Increase by 5% of the number of minorities that are referred to or given information on smoking cessation programs in 29 targeted counties
 - a. IMHC will ensure that each local coalition provides tobacco prevention and cessation education, tool kits, and resources to: (i) 3 churches/ faith groups; (ii) 5 schools/ youth organizations; (iii) 5 minority serving health care providers; and (iv) 5 minority businesses
 - b. IMHC in collaboration with ITPC will work with the local coalitions and other ITPC minority partners to develop culturally and linguistically appropriate media messaging about tobacco prevention and cessation

- c. IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University
- d. IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives

5) 2010 Priority Areas

- a. Decrease Indiana youth smoking rates
- b. Increase proportion of Hoosiers not exposed to secondhand smoke
- c. Decrease Indiana adult smoking rates
- d. Increase anti tobacco knowledge, attitudes, and beliefs necessary for smoking behavior change to occur
- e. Increase Indiana's tobacco tax to reduce adult smoking and prevent youth smoking
- f. Maintenance of state and local infrastructure necessary to lower tobacco use rates and thus, make Indiana competitive on economic fronts

OMH Programs

A. PROMiSE

- 1) The purpose of the Partners Recruiting Opportunities for Minority Student Education (PROMiSE) program is to provide a set of academic enrichment activities for a target audience of interested ninth grade students from racial/ethnic minority populations. The goal of these activities is to improve students' awareness of health care professions, increase their academic preparedness for post-secondary education, and ultimately, increase the rate at which racial/ethnic minority students enroll in and graduate from health professions education programs. However, all students, regardless of race or ethnicity, are invited to participate.

B. INShape Indiana

- 1) INShape Indiana is Governor Mitch Daniels' statewide health initiative. INShape Indiana is about helping Hoosiers to make healthy choices by linking them to valuable resources and offering a fun challenge to improve their health and well-being. INShape Indiana is not another program; it is an initiative to coordinate the many efforts taking place across the state to combat obesity and smoking. OMH sponsors the INShape Indiana activities designed to reach the state's minority populations.

C. INside Out

- 1) INside Out is an optional, health education enrichment exercise for Indiana ninth graders who are taking part in ISDH's Partners Recruiting Opportunities for Minority Student Education (PROMiSE) program. Students who participate in the program will face the challenge of writing, producing, and directing a one-minute INShape Indiana television commercial or song/jingle. The projects must promote INShape Indiana's three focus areas of better nutrition, increased physical activity, and avoiding tobacco. The television commercial must target students' local communities.

- 2) There are two ways for you to get involved in INside Out. First, if you are a member of INSight Youth Corps, you can participate in INside Out. Youth Corps students who have completed a group project are encouraged to select an INside Out project as an additional project for Youth Corps. Or, if your school is hosting the PROMiSE program, you can select an INside Out project as your advanced project option.

D. Black and Minority Health Fair

- 1) The ISDH, Office of Minority Health, INShape Black and Minority Health Fair works in collaboration with private and non-private sectors to offer the largest Minority Health Fair in the country focusing on issues affecting minorities. The Indiana State Department of Health's mission is to ensure that all minority individuals who attend the health fair have access to preventive health screenings and gain information on healthier lifestyles. The annual event is held in conjunction with Indiana Black Expo's Summer Celebration.
- 2) In 2006, the health fair performed more than 129,800 screenings during the four-day event-10,641 blood screenings and 118,500 other screenings and distribution of information. The attendance of the health fair was around 40,000 people. A total of 29 sponsors (16 Optimum; 5 Platinum; 4 Great; and 4 Good) and 55 exhibitors participated in the 2006 health fair.
- 3) Other activities taking place during the health fair include: Opening Ceremony and Senior Citizens and Persons with Disabilities Night, Healthy Entertainment Stage, and Cooking Healthy Demonstrations.
- 4) Mechanisms used to market the health fair include TV, radio, billboards, banners, newsletters, newspaper, flyers, and by word of mouth. The ISDH/OMH recognizes that minority health disparities require additional attention to reduce premature deaths and prevent disease and disabilities in the minority population and, therefore, targets the minority and underserved populations for the health fair.

Mortality

Figure 7 compares the 2000-2005 age-adjusted death rates in Indiana for all causes of death by race and ethnicity. Overall, Blacks have the highest age-adjusted death rates, followed by Whites. Figure 8 compares the 2000-2004 U.S. age-adjusted death rates for all causes of death by race and ethnicity. Similar to Indiana, Blacks in the U.S. have the highest age-adjusted death rates, followed by Whites.

Tables 1-10 compare the 10 leading causes of death for Whites, Blacks, Hispanics, Asians/Pacific Islanders, and American Indians/Native Americans for both Indiana and the U.S. As shown in these tables, Whites, Blacks, Hispanics, Asians/Pacific Islanders, and American Indians/Native Americans in both Indiana and the U.S. are most commonly dying of the same two leading causes of death, which are diseases of the heart and malignant neoplasms (cancer).

In fact, Whites in both Indiana and the U.S. are dying of the same nine leading causes of death, but with the third and fourth ranked leading causes (chronic lower respiratory diseases and cerebrovascular diseases) reversed.

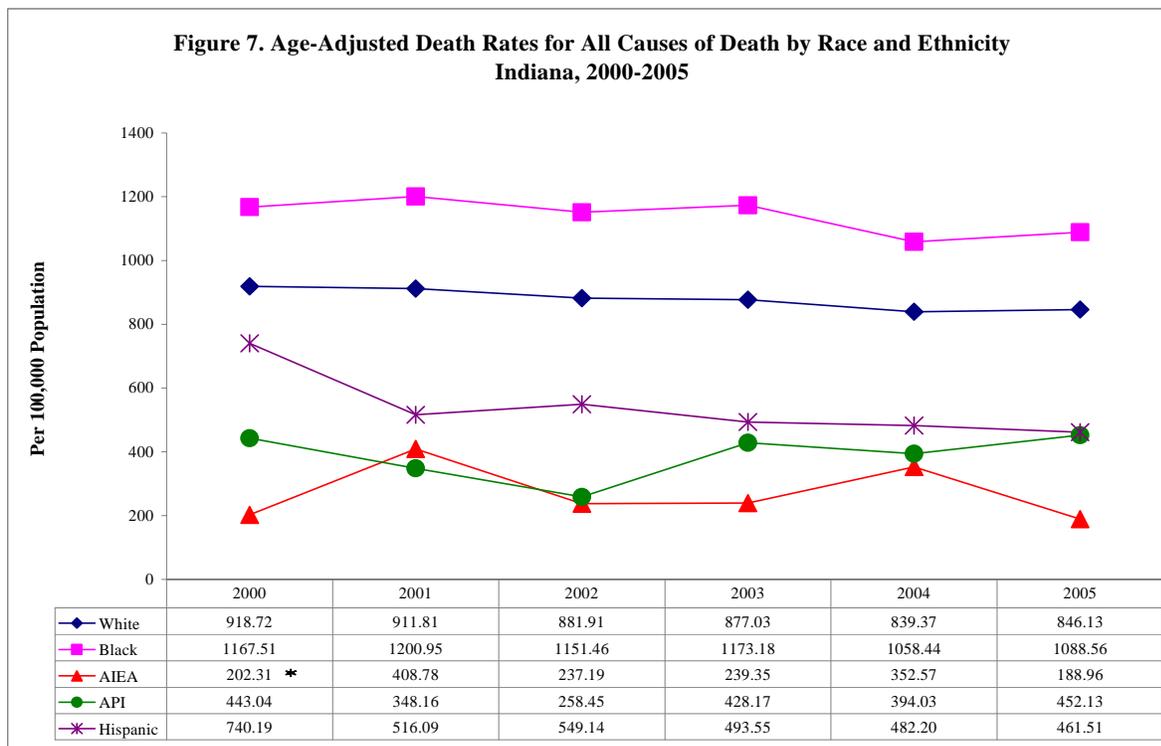
Similarly, Blacks in both Indiana and the U.S. are dying of the same eight leading causes of death, but with the fifth and sixth ranked leading causes reversed in addition to the seventh and eighth ranked leading causes reversed.

In regards to Hispanics in both Indiana and the U.S., eight of the ten leading causes of death are the same; however, the order of ranking of those eight causes are different, except for the three most common causes, which are diseases of the heart, malignant neoplasms, and unintentional injury.

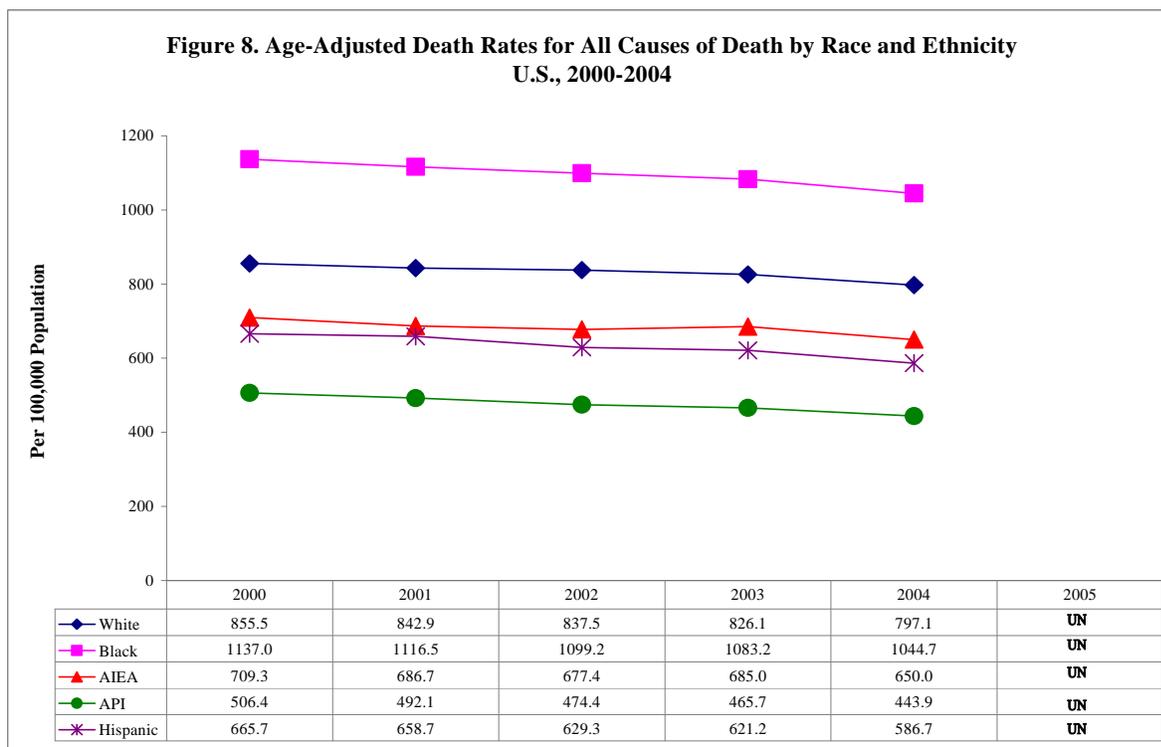
When comparing Asians/Pacific Islanders in Indiana with Asians/Pacific Islanders in the U.S., a majority of the ten leading causes of death are the same. However, once again, with the exception of the seventh leading cause of death, chronic lower respiratory diseases, the order of ranking is different for all other leading causes of death.

It is more difficult to make a comparison between the leading causes of death for American Indians/Native Americans in Indiana and in the U.S. due to few deaths in Indiana for this race group. However, it may be noted that six of the ten leading causes of death among American Indians/Native Americans in both Indiana and the U.S. are the same, but once again, only the rankings of the three leading causes of death (diseases of the heart, malignant neoplasms, and unintentional injury) are the same.

Comparison of Age-Adjusted Death Rates for All Causes of Death by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSDD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 1. 10 Leading Causes of Death for Whites, Indiana, 2005

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	50,888	846.13
1	Heart Disease	13,444	220.45
2	Malignant Neoplasms (Cancer)	11,738	197.41
3	Chronic Lower Respiratory Diseases	3,295	55.19
4	Cerebrovascular Diseases (Stroke)	2,976	48.67
5	Unintentional Injury (Accidents)	2,276	39.64
6	Alzheimer's Disease	1,555	24.74
7	Diabetes Mellitus	1,494	24.96
8	Influenza & Pneumonia	1,234	20.05
9	Nephritis (Kidney Disease)	1,109	18.24
10	Septicemia	734	12.15

Source: Indiana State Department of Health, PHSD, Data Analysis Team

Notes:

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 2. 10 Leading Causes of Death for Whites, United States, 2004

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	1,933,382	797.1
1	Heart Disease	537,512	216.3
2	Malignant Neoplasms (Cancer)	453,534	188.6
3	Cerebrovascular Diseases (Stroke)	121,065	48.3
4	Chronic Lower Respiratory Diseases	109,670	44.9
5	Unintentional Injury (Accidents)	85,466	39.7
6	Alzheimer's Disease	59,153	23.0
7	Diabetes Mellitus	52,101	21.5
8	Influenza & Pneumonia	49,456	19.6
9	Nephritis (Kidney Disease)	31,508	12.7
10	Intentional Self-Harm (Suicide)	27,001	12.9

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

Notes:

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 3. 10 Leading Causes of Death for Blacks, Indiana, 2005

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	4,470	1,088.56
1	Heart Disease	1,002	254.45
2	Malignant Neoplasms (Cancer)	994	249.86
3	Cerebrovascular Diseases (Stroke)	298	76.28
4	Diabetes Mellitus	214	55.24
5	Assault (Homicide)	180	30.37
6	Unintentional Injury (Accidents)	172	33.68
7	Chronic Lower Respiratory Diseases	160	41.12
8	Nephritis (Kidney Disease)	154	40.63
9	Perinatal Period	102	15.70
10	Alzheimer's Disease	89	25.71

Source: Indiana State Department of Health, PHSD, Data Analysis Team

Notes:

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 4. 10 Leading Causes of Death for Blacks, United States, 2004

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	283,859	1,044.7
1	Heart Disease	73,373	284.7
2	Malignant Neoplasms (Cancer)	61,842	231.1
3	Cerebrovascular Diseases (Stroke)	17,980	71.1
4	Diabetes Mellitus	12,685	48.7
5	Unintentional Injury (Accidents)	12,446	37.1
6	Assault (Homicide)	8,000	20.7
7	Nephritis (Kidney Disease)	7,759	30.1
8	Chronic Lower Respiratory Diseases	7,331	28.7
9	Human Immunodeficiency Virus (HIV)	7,163	20.9
10	Septicemia	5,945	22.8

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

Notes:

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 5. 10 Leading Causes of Death for Hispanics, Indiana, 2005

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	601	461.51
1	Heart Disease	108	114.68
2	Malignant Neoplasms (Cancer)	89	81.52
3	Unintentional Injury (Accidents)	67	25.55
4	Perinatal Period	37	7.36
5	Assault (Homicide)	32	9.42
6	Diabetes Mellitus	28	27.25
7	Cerebrovascular Diseases (Stroke)	24	24.59
8	Congenital Abnormalities	18	3.66*
9	Chronic Lower Respiratory Diseases	17	19.50*
10	Nephritis (Kidney Disease)	14	12.15*

Source: Indiana State Department of Health, PHSDD, Data Analysis Team

Notes:

***Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.**

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 6. 10 Leading Causes of Death for Hispanics, United States, 2004

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	122,416	586.7
1	Heart Disease	27,788	158.4
2	Malignant Neoplasms (Cancer)	24,522	121.9
3	Unintentional Injury (Accidents)	10,408	29.8
4	Cerebrovascular Diseases (Stroke)	6,781	38.2
5	Diabetes Mellitus	5,999	32.1
6	Liver Disease	3,383	14.0
7	Assault (Homicide)	3,271	7.2
8	Chronic Lower Respiratory Diseases	3,107	18.4
9	Influenza & Pneumonia	2,912	17.1
10	Perinatal Period	2,681	4.1

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

Notes:

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanic is an ethnicity. Hispanics can be members of any race.

Table 7. 10 Leading Causes of Death for Asians/Pacific Islanders, Indiana, 2005

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	147	452.13
1	Heart Disease	46	170.06
2	Malignant Neoplasms (Cancer)	27	65.69
3	Unintentional Injury (Accidents)	12	24.15*
4	Diabetes Mellitus	9	28.06*
5	Cerebrovascular Diseases (Stroke)	8	22.59*
6	Nephritis (Kidney Disease)	6	24.11*
7	Chronic Lower Respiratory Diseases	5	14.43*
8	Septicemia	4	14.14*
9	Alzheimer's Disease	3	15.81*
10	Influenza & pneumonia	2	7.20*
10	Intentional Self-Harm (Suicide)	2	2.26*
10	Assault (Homicide)	2	2.24*

Source: Indiana State Department of Health, PHSD, Data Analysis Team

Notes:

***Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.**

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 8. 10 Leading Causes of Death for Asians/Pacific Islanders, United States, 2004

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	40,533	443.9
1	Malignant Neoplasms	10,532	UN
2	Heart Disease	10,163	UN
3	Cerebrovascular Diseases (Stroke)	3,626	UN
4	Unintentional Injury (Accidents)	1,972	UN
5	Diabetes Mellitus	1,445	UN
6	Influenza & Pneumonia	1,256	UN
7	Chronic Lower Respiratory Diseases	1,244	UN
8	Intentional Self-Harm (Suicide)	722	UN
9	Nephritis (Kidney Disease)	636	UN
10	Septicemia	456	UN

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

Notes:

UN = Unavailable (age-adjusted rates for the U.S., 2004 are not yet available)

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Table 9. 10 Leading Causes of Death for American Indians/Native Americans, Indiana, 2005

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	22	188.96
1	Heart Disease	6	53.07*
2	Malignant Neoplasms (Cancer)	3	23.58*
3	Unintentional Injury (Accidents)	2	10.6*
4	Chronic Lower Respiratory Diseases	1	5.78*
4	Nephritis (Kidney Disease)	1	12.02*
4	Chronic Liver Disease & Cirrhosis	1	14.65*
4	Assault (Homicide)	1	4.92*
4	Perinatal Period	1	17.95*
4	Human Immunodeficiency Virus (HIV)	1	5.01*

Source: Indiana State Department of Health, PHSDD, Data Analysis Team

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

The sum of the 10 leading causes may not add up to the "All Causes" number due to other causes that are not considered to be leading causes.

Table 10. 10 Leading Causes of Death for American Indians/Native Americans, United States, 2004

Rank	Cause of Death	Number	Age-Adjusted Rate
	All Causes	13,124	650.0
1	Heart Disease	2,712	UN
2	Malignant Neoplasms (Cancer)	2,154	UN
3	Unintentional Injury (Accidents)	1,573	UN
4	Diabetes Mellitus	783	UN
5	Chronic Liver Disease & Cirrhosis	570	UN
6	Cerebrovascular Diseases (Stroke)	552	UN
7	Chronic Lower Respiratory Diseases	512	UN
8	Influenza & Pneumonia	390	UN
9	Intentional Self-Harm (Suicide)	322	UN
10	Nephritis (Kidney Disease)	255	UN

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

Notes:

UN = Unavailable (age-adjusted rates for the U.S., 2004 are not yet available)

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Focus Areas

In order to eliminate health disparities in Indiana, we must first determine what causes these differences. The Interagency Council on Black and Minority Health understands that eliminating health disparities is a process, and must be addressed one step at a time. Choosing these three focus areas allows Indiana to evaluate current conditions for heart disease, obesity, and addictions. Through analyzing the data and conducting research we are able to better understand the barriers that exist within these areas and how they are affecting the various racial and ethnic minorities. It is also essential to assure that the different barriers that exist among different races, cultures, and beliefs are addressed in a manner that is specific to the needs of these different communities and groups.

The following section breaks down each of the three focus areas identified by the Interagency Council on Black and Minority Health.

Heart Disease

Heart disease is the leading cause of death in both Indiana and the U.S and is a major cause of disability. The broad term “heart disease” includes several more specific heart conditions including, but not limited to, coronary heart disease, heart attack, and heart failure. In the U.S., nearly 650,000 Americans die of heart disease annually (CDC).

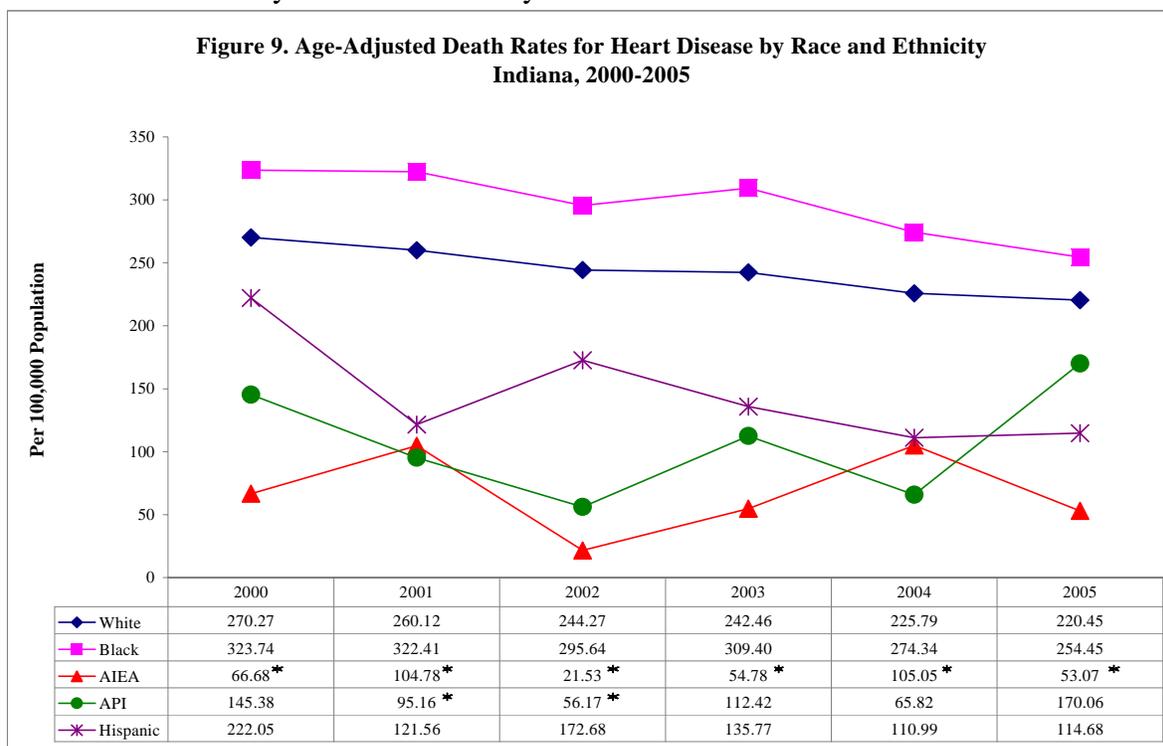
Certain conditions, as well as some lifestyle factors, may put individuals at a higher risk for developing heart disease. These risk factors include diabetes, high blood cholesterol levels, high blood pressure, metabolic syndrome, overweight and obesity, tobacco use, excessive alcohol use, diet, physical inactivity, and heredity.

As shown in Figures 9 and 10, from 2000-2005, there has been a gradual decline in the number of deaths due to heart disease. Additionally, in both Indiana and the U.S., Blacks have the highest age-adjusted death rates due to heart disease, compared with all other races and ethnicities, followed by Whites and then Hispanics. Nationally, nearly 34.1% of Black adults have high blood pressure. In fact, compared with Whites, Blacks have higher rates of high blood pressure, overweight or obesity, and diabetes, all risk factors of heart disease. For these reasons, two goals of Healthy People 2010 are to reduce deaths from heart disease among Blacks by 30% and to reduce deaths from strokes among Blacks by 47 % (CDC).

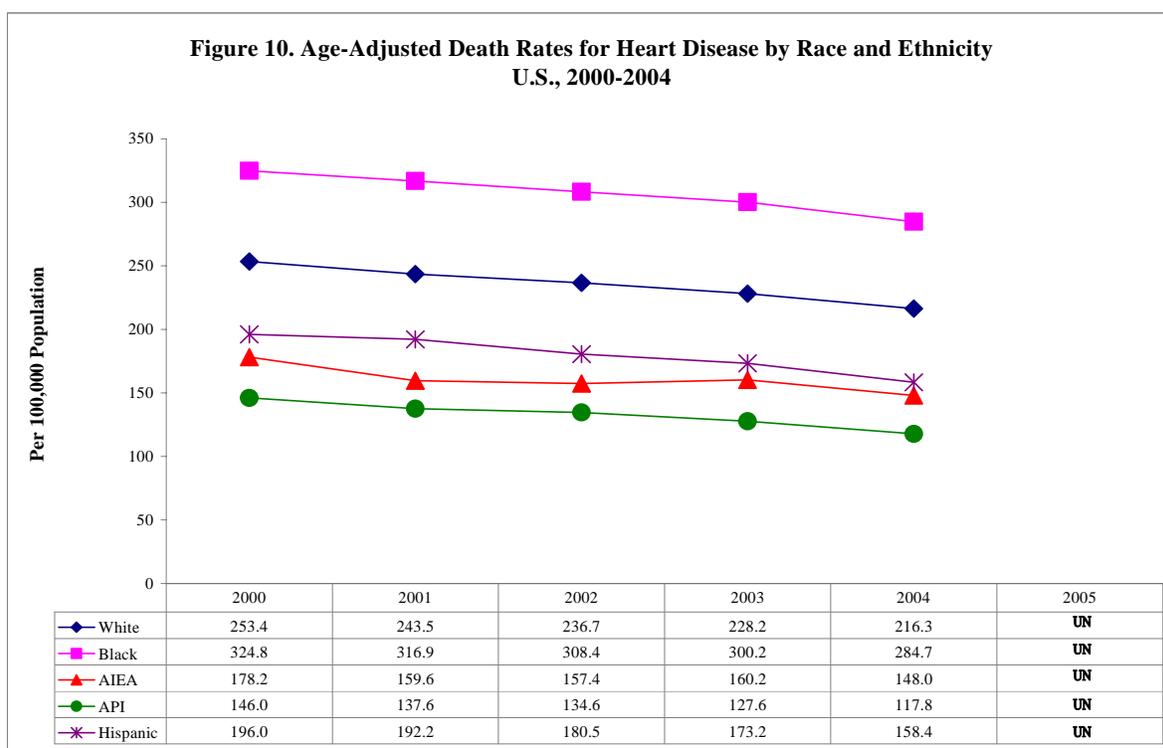
In addition, similar to national statistics, Multiracials in Indiana have the greatest percentage of individuals who have ever been told by a doctor that they had a heart attack (17.7%) (Table 11). Furthermore, Multiracials in Indiana also have the greatest percentage of individuals who have ever been told by a doctor that they had angina or coronary heart disease (9.3%) (Table 12).

The following graphs and tables display data on heart disease and allow you to compare both national and Indiana state statistics, in addition to trends in mortality due to heart disease.

Comparison of Age-Adjusted Death Rates for Heart Disease (ICD 10: I00-I09, I11, I13, I20-I51) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSDD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 11. Percentage Of Adults Who Have Ever Been Told By A Doctor That They Had A Heart Attack (Myocardial Infarction) By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	5.3%	4.4%
Black	5.3%	4.1%
Hispanic	2.8%	2.3%
Other	5.3%	3.7%
Multiracial	17.7%	5.2%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

Table 12. Percentage Of Adults Who Have Ever Been Told By A Doctor That They Had Angina Or Coronary Heart Disease By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	5.2%	4.9%
Black	3.7%	3.4%
Hispanic	1.4%	2.8%
Other	2.9%	2.8%
Multiracial	9.3%	5.5%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

Heart Disease: Recommendations

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

- A. Work with local coalitions to market heart disease programs and services offered by local coalitions and their partners.
 - 1) Affirm existing relationships or establish new partnerships to ensure empowerment of communities served through education.
- B. The Interagency Council supports educational initiatives for the public to help clarify the meaning of heart disease and its attributes.
- C. Assure that services are culturally and linguistically appropriate
 - 1) Take great measures in notifying the different racial, ethnic, and cultural communities of the dangers of heart disease and educate them on the importance of self preservation, health care's responsibility, and empowering the community towards change of present heart conditions.
- D. In collaboration with Indiana State Department of Health (ISDH) and the Indiana Minority Health Coalition (IMHC), both entities will develop and disseminate culturally tailored heart disease awareness toolkits that can be used by the community groups and programs to raise minority awareness of the dangers of heart disease.
- E. Develop and implement culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize avoiding the health risk factors for conditions affecting minorities and incorporate an accessible, affordable, and acceptable early detection and intervention component as set forth in IC 16-46-11. Culturally tailored programs to address ethnic/racial minority groups.

Obesity

“Although one of the national health objectives for the year 2010 is to reduce the prevalence of obesity among adults to less than 15%, current data indicate that the situation is worsening rather than improving” (CDC). In fact, data from National Health and Nutrition Examination Surveys (NHANES) show that among adults 20–74 years of age the prevalence of obesity increased from 15.0% (in the 1976–1980 survey) to 32.9% (in the 2003–2004 survey). Additionally, the obesity epidemic is also evident among young children and teens. According to the NHANES, for children 2–5 years of age, the prevalence of overweight increased from 5.0% to 13.9%, for those 6–11 years of age, prevalence increased from 6.5% to 18.8%, and for those 12–19 years of age, prevalence increased from 5.0% to 17.4%.

Overweight and obesity result from an energy imbalance, which is caused by consuming too many calories and not getting enough physical activity. In addition to poor diet and physical inactivity, other factors that contribute to obesity include heredity, metabolism, behavior, environment, culture, and socioeconomic status.

Moreover, when people are overweight or obese, they are more likely to develop health problems such as hypertension, high total cholesterol, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and some cancers (endometrial, breast, and colon) (CDC).

Obesity is the fastest-growing cause of disease and death in America and is completely preventable. “Overweight and physical inactivity account for more than 300,000 premature deaths each year in the U.S., second only to tobacco-related deaths. Obesity is an epidemic and should be taken as seriously as any infectious disease epidemic”, says Jeffrey P. Koplan, former director of the Centers for Disease Control and Prevention (CDC) and one of the authors of the article “A growing obesity epidemic is threatening the health of millions of Americans in the United States” (research published in the October 27, 1999 issue of *The Journal of the American Medical Association* [JAMA]).

“While obese individuals need to reduce their caloric intake and increase their physical activity, many others must play a role to help these individuals and to prevent a further increase in obesity,” Koplan says. “Health care providers must counsel their obese patients; workplaces must offer healthy food choices in their cafeterias and provide opportunities for employees to be physically active on site; schools must offer more physical education that encourages lifelong physical activity; urban policymakers must provide more sidewalks, bike paths, and other alternatives to cars; and parents need to reduce their children's TV and computer time and encourage outdoor play. In general, restoring physical activity to our daily routines is critical.”

Furthermore, overweight and obesity in the U.S. occur at higher rates in racial/ethnic minority populations such as African Americans and Hispanics, compared with Whites. It has been found that Asians have a relatively low prevalence of obesity. When considering sex and socioeconomic status, women and persons of low socioeconomic status who are members of racial and/or ethnic minority populations appear to particularly be affected by obesity, perhaps because cultural dynamics influence eating habits and physical activities and are also reported to play a significant role in excessive weight gain (American Obesity Association).

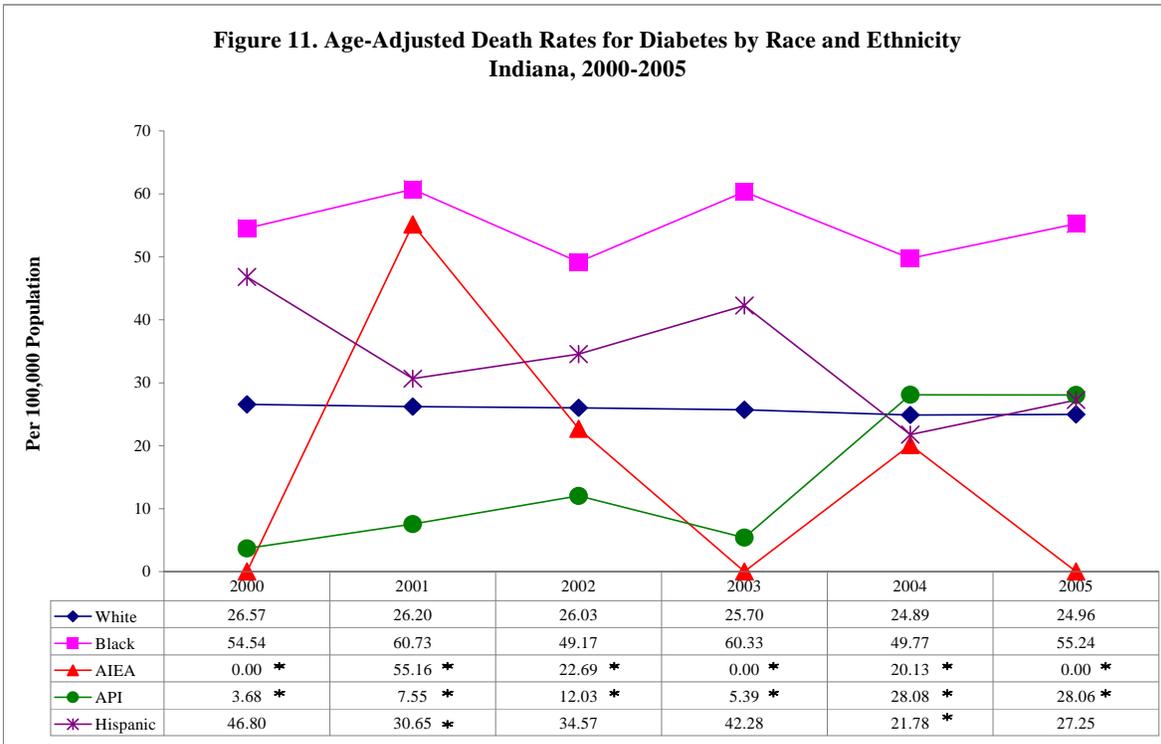
As shown in Figures 11 and 12, in both Indiana and the U.S, Blacks have the highest age-adjusted death rates due to diabetes (some cases of which are caused by obesity and overweight), compared with all other races and ethnicities. Likewise, Black adults also have the highest prevalence of obesity (36.7%) based on results of the 2006 BRFSS survey, with Hispanics (45.6%), Whites (34.9%), and Blacks (33.2%) having the highest prevalence of overweight (Table 13).

In regards to physical activity, Blacks, both nationally (58.2%) and in Indiana (55.3%), have the greatest percentage of adults NOT participating in adequate levels of physical activity. However, in Indiana, each race/ethnicity, except Whites, has a higher percentage of adults who ARE participating in adequate levels of physical activity than the national averages for each race/ethnicity (Table 15). Similarly, Whites are the only racial/ethnic group in Indiana to have a lower percentage of students who ARE participating in adequate levels of physical activity than the national percentages for each racial/ethnic group (Table 16).

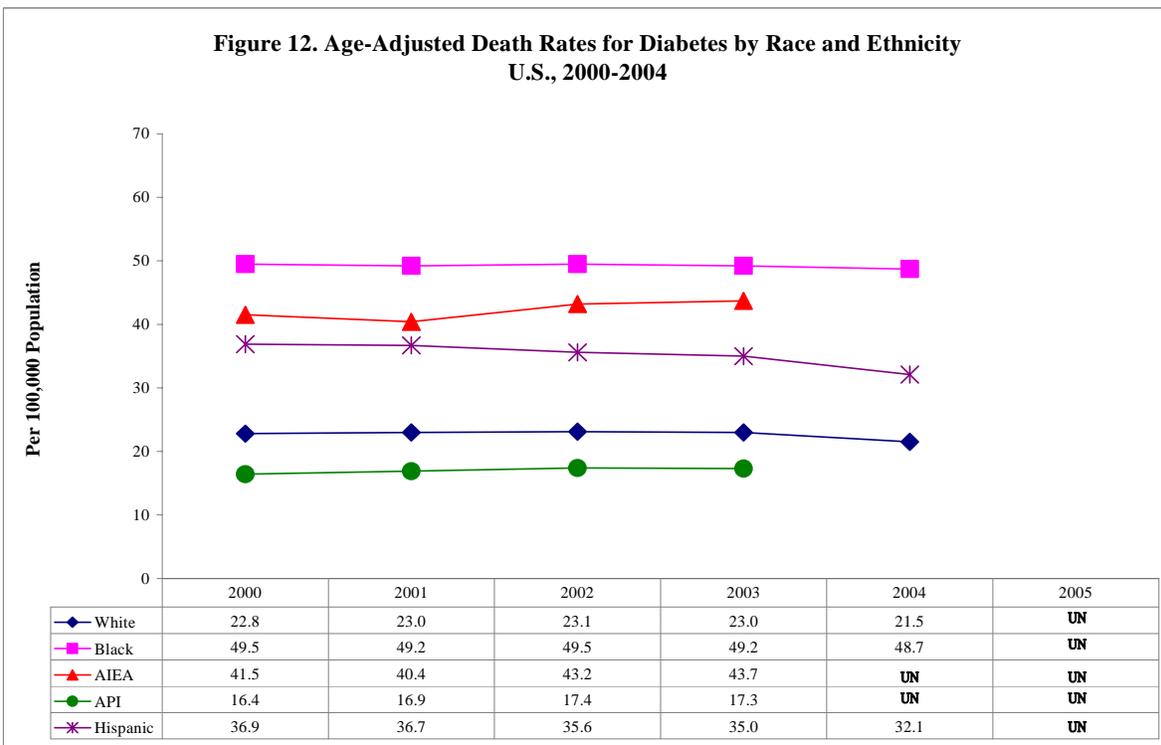
Furthermore, Americans in general lack in adequate fruit and vegetable consumption, and unfortunately Indiana is no exception. In fact, in all racial/ethnic categories, Indiana had lower percentages than the national percentages of both adults and students who consumed five or more servings of fruits and vegetables per day (Tables 17 and 18).

The following graphs and tables display data on diabetes and morbidity contributors such as inadequate physical activity levels and insufficient fruit and vegetable consumption, both of which are attributed to obesity. The graphs and tables allow you to compare both national and Indiana state statistics, in addition to trends in mortality due to diabetes.

Comparison of Age-Adjusted Death Rates for Diabetes (ICD 10: E10-E14)
by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSDD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 13. Weight Classification By Body Mass Index (BMI) By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Neither Overweight nor Obese		Overweight		Obese	
	Indiana	U.S.	Indiana	U.S.	Indiana	U.S.
White	37.6%	39.1%	34.9%	36.7%	27.6%	24.2%
Black	30.1%	27.7%	33.2%	35.1%	36.7%	36.8%
Hispanic	34.0%	36.8%	45.6%	37.6%	20.5%	25.5%
Other	N/A	49.8%	23.1%	31.8%	19.4%	18.6%
Multiracial	N/A	34.5%	N/A	34.3%	N/A	27.2%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Table 14. Percentage Of Students Who Described Themselves As Slightly Or Very Overweight By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	32.2%	31.1%
Black	31.7%	27.2%
Hispanic	N/A	37.1%
Other	30.6%	33.5%

Source: Youth Risk Behavior Survey, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 100 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Table 15. Percentage Of Adults With 30+ Minutes Of Moderate Physical Activity Five Or More Days Per Week, Or Vigorous Physical Activity For 20+ Minutes Three Or More Days Per Week By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	47.6%	51.1%
Black	44.7%	41.8%
Hispanic	50.7%	44.0%
Other	N/A	46.3%
Multiracial	N/A	59.7%

Source: Behavioral Risk Factor Surveillance System, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was >10 for any cell, or if the state did not collect data for that calendar year.

Table 16. Percentage Of Students Who Were Physically Active For A Total Of 60 Minutes Or More Per Day On Five Or More Of The Past Seven Days By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	32.4%	38.7%
Black	31.3%	29.5%
Hispanic	N/A	32.9%
Other	36.9%	32.1%

Source: Youth Risk Behavior Survey, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 100 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Table 17. Percentage Of Adults Who Have Consumed Fruits And Vegetables Five Or More Times Per Day By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	22.0%	23.4%
Black	19.5%	21.5%
Hispanic	19.8%	20.4%
Other	N/A	26.0%
Multiracial	N/A	20.4%

Source: Behavioral Risk Factor Surveillance System, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was >10 for any cell, or if the state did not collect data for that calendar year.

Table 18. Percentage Of Students Who Ate Five Or More Servings Per Day Of Fruits And Vegetables During The Past Seven Days By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	14.3%	18.6%
Black	20.0%	22.1%
Hispanic	N/A	23.2%
Other	21.8%	22.8%

Source: Youth Risk Behavior Survey, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 100 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Table 19. Percentage Of Adults Who Have Ever Been Told By A Doctor That They Have Diabetes By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	8.0%	7.2%
Black	10.0%	11.9%
Hispanic	4.0%	6.3%
Other	8.3%	7.7%
Multiracial	15.2%	8.8%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Obesity: Recommendations

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

- A. Support of nutrition labeling requirements at fast food and other chain restaurants.
 - 1) Improve awareness of caloric and food component intake for each item and for each meal package.
 - 2) The Interagency Council supports educational initiatives for the public to help clarify the meaning of this caloric and food component data.
- B. “Fat-tax” or “Twinkie-tax”
 - 1) Controversial measure that is gaining momentum nationally that taxes processed foods and encourages purchases of healthy foods.
 - 2) It was originally thought that this hurts economically impoverished citizens more than others; however, by putting the cheaper processed foods at the same level as healthier foods may encourage healthier approaches to eating habits and diet.
- C. Identify a pool of nutritional experts and social marketers
- D. Develop clear and concise messages for disparate populations
- E. Involve local health organizations and partners to provide technical assistance to INShape
- F. Develop a collaboration/network of stakeholders to transmit the message/shared vision to the media
- G. Develop a resolution requiring a pledge towards “healthy living”
- H. Utilize existing education and literacy campaigns that promote healthy living
- I. Work with local coalitions to market obesity prevention programs and services offered by local coalitions and their partners.
 - 1) Affirm existing relationships or establish new partnerships to ensure empowerment of communities served through education.
 - 2) The Interagency Council supports educational initiatives for the public to help clarify the meaning of Obesity and diseases associated with it.
- J. Assure that services are culturally and linguistically appropriate
 - 1) Take great measures in notifying the different racial, ethnic, and cultural communities of the dangers of obesity and educate them on the importance of self preservation, health care’s responsibility, and empowering the community towards change of present obesity conditions.

- K. Develop and implement culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize avoiding the health risk factors for conditions affecting minorities and incorporate an accessible, affordable, and acceptable early detection and intervention component as set forth in IC 16-46-11. Culturally tailored programs to address ethnic/racial minority groups.

Addiction

Tobacco Use

Two common addictions include tobacco use and substance abuse. Tobacco use, particularly smoking, remains the number one cause of preventable disease and death in the U.S. Smoking contributes to heart disease, emphysema, lung cancer, chronic lower respiratory disease, and other chronic lung diseases. In fact, the risk of dying from lung cancer is more than 22 times higher among men who smoke cigarettes and about 12 times higher among women who smoke cigarettes compared with never smokers. Furthermore, cigarette smoking increases the risk for many types of cancer, including cancers of the lip, oral cavity, pharynx, esophagus, pancreas, larynx (voice box), lung, uterine cervix, urinary bladder, and kidney. Finally, about 90% of all deaths from chronic lower respiratory diseases are attributable to cigarette smoking (CDC).

There is a stigma that is attached to addictions. Addictions are not seen as diseases, despite the fact that adverse effects of addictions are like any other medical disease. However, unlike other diseases, addiction poses many peculiar challenges to public health in the search for effective prevention and treatment strategies and policies. These challenges stem primarily from the fact that drug abuse and addiction are usually associated with illegal activity. This stereotype causes people who suffer from addiction to be viewed as morally corrupt or hopeless individuals who engage in voluntary self and socially destructive behavior.

The National Institute of Drug Research states that racial/ethnic minority populations are perhaps most adversely affected by this stigma and its effects leading to misperceptions about drug abuse and addiction in minority communities and the way in which prevention and treatment are delivered to them. For example, the common perception is that minority groups, particularly Blacks and Hispanics, use drugs more than Whites, even though epidemiologic data show little difference in overall use by race/ethnicity. In fact, in some instances minority groups are less likely to use legal or illegal drugs.

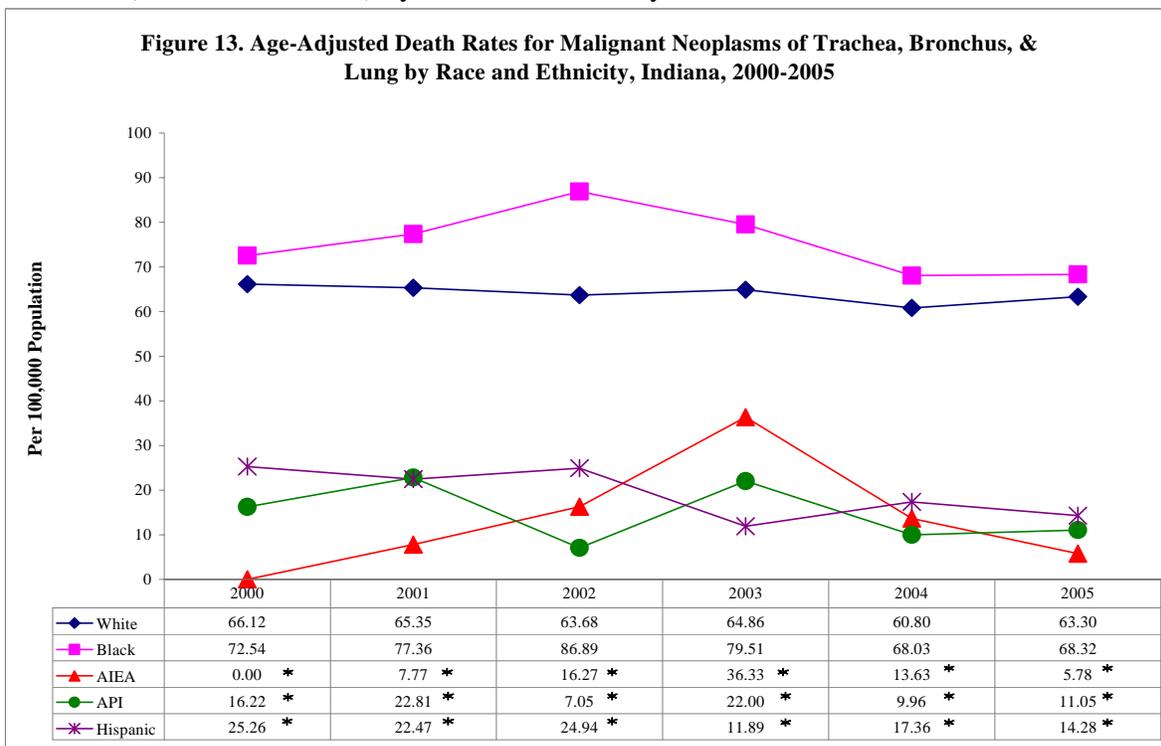
As shown in Figures 13 and 14, in both Indiana and the U.S., Blacks have the highest age-adjusted death rates due to malignant neoplasms of trachea, bronchus, and lung (lung cancer), compared with all other races and ethnicities. Overall, death rates due to malignant neoplasms of trachea, bronchus, and lung have remained constant in both Indiana and the U.S. from 2000-2005.

On the other hand, in both Indiana and the U.S, Whites have the highest age-adjusted death rates due to both emphysema and chronic lower respiratory diseases (Figures 15-18). In general, from 2000-2005, death rates due to emphysema and chronic lower respiratory diseases have remained constant in both Indiana and the U.S., with the exception of a gradual decline in the death rates due to emphysema in the U.S.

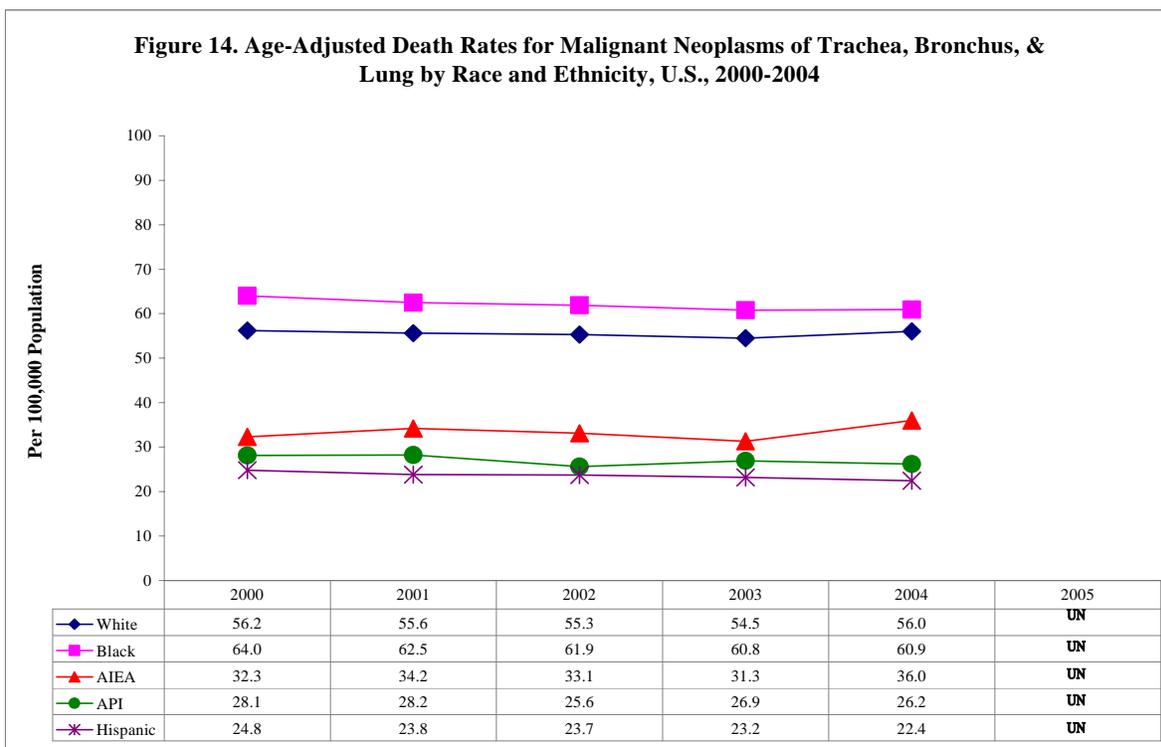
Based on the results of the 2006 BRFSS survey, in Indiana Blacks have the highest prevalence of adults who are current smokers (27.0%) (Table 20). However, according to the 2005 YRBS results, Blacks, in both Indiana (7.8%) and nationally (5.2%), have the lowest percentage of students who ever smoked cigarettes daily (Table 21).

The following graphs and tables allow you to compare both national and Indiana state statistics, in addition to trends in disease mortality related to tobacco use.

Comparison of Age-Adjusted Death Rates for Malignant Neoplasms of Trachea, Bronchus, & Lung (ICD 10: C33-C34) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

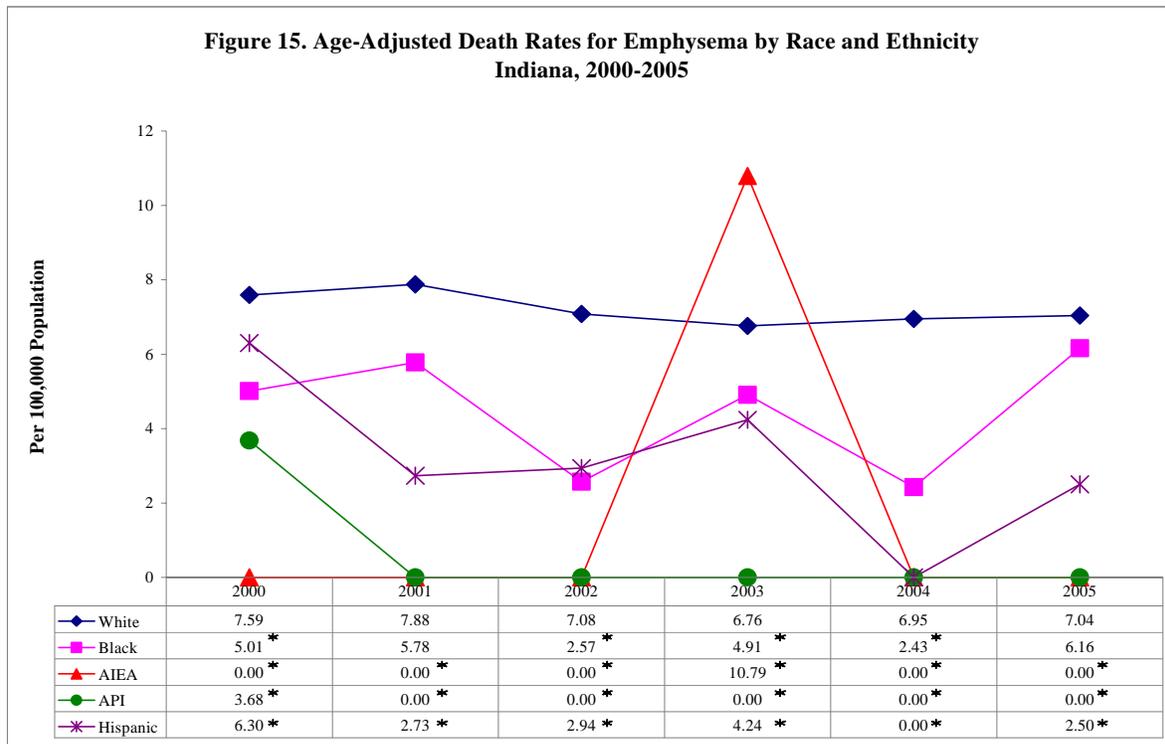
*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

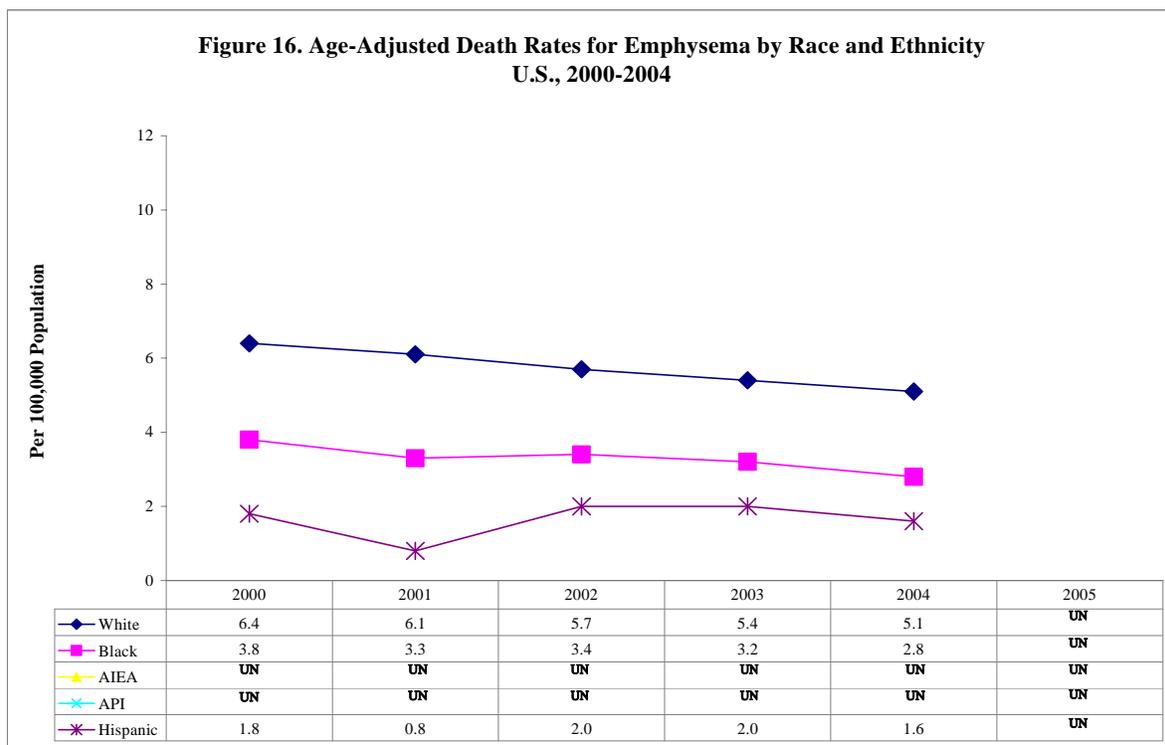
Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Comparison of Age-Adjusted Death Rates for Emphysema (ICD 10: J43) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

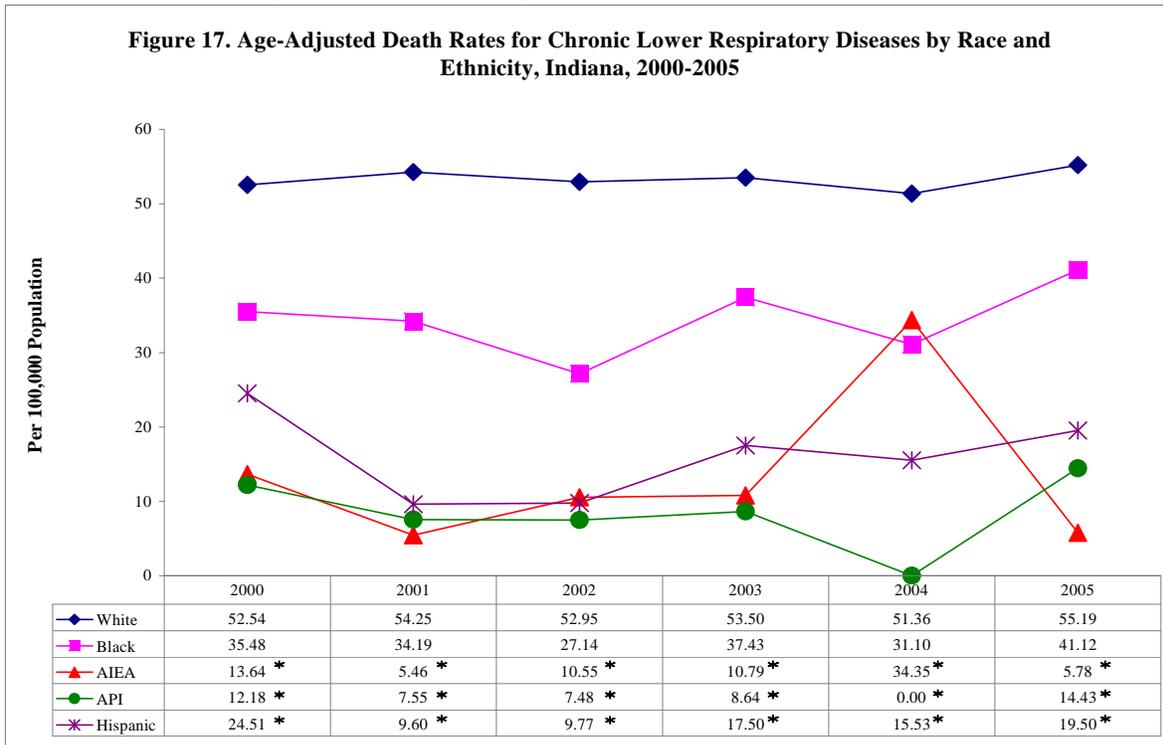
*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

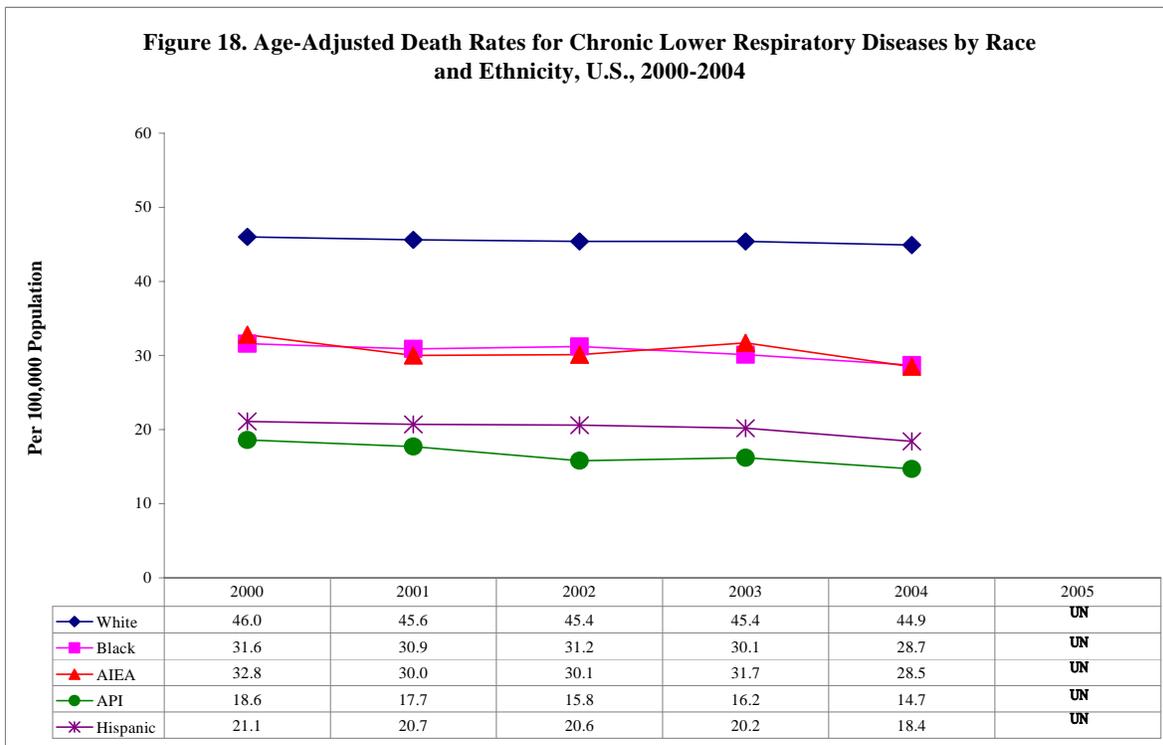
Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Comparison of Age-Adjusted Death Rates for Chronic Lower Respiratory Diseases (ICD 10: J40-J47) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 20. Percentage Of Adults Who Are Current Smokers By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	23.9%	19.5%
Black	27.0%	22.3%
Hispanic	23.1%	18.8%
Other	17.4	19.0%
Multiracial	N/A	31.6%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was >10 for any cell, or if the state did not collect data for that calendar year.

Table 21. Percentage Of Students Who Ever Smoked Cigarettes Daily, That Is, At Least 1 Cigarette Every Day For 30 Days By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	17.1%	16.1%
Black	7.8%	5.2%
Hispanic	N/A	10.4%
Other	18.0%	11.7%

Source: Youth Risk Behavior Survey, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 100 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Tobacco Use: Recommendations

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

- A. Smoking bans in all cars
 - 1) Promotes child safety – children at highest risk from secondhand smoke in the automobile.
 - 2) Addresses issues of smoking addiction
- B. Develop clear and concise messages for disparate populations
- C. Encourage local health organizations and partners to provide technical assistance to INShape
- D. Collaborate with other health organizations to develop a legislative agenda for media distribution
- E. Monitor for hearings, forums, and opportunities to present culturally appropriate messages for healthy living
- F. Develop a resolution requiring a pledge towards “healthy living”
- G. Utilize existing education and literacy campaigns that promote healthy living
- H. Involve small grassroots organizations
- I. Work with local coalitions to market tobacco cessation programs and services offered by local coalitions and their partners.
- J. Assure that services are culturally and linguistically appropriate
 - 1) Take great measures in notifying the different racial, ethnic, and cultural communities of the dangers of tobacco use and educate them on the importance of self preservation, health care’s responsibility, and empowering the community towards change of present tobacco conditions.
- K. In collaboration with ISDH, Smokefree Indiana, and IMHC, develop and disseminate culturally tailored tobacco awareness toolkits that can be used by the coalitions to raise minority awareness of the dangers of tobacco use.
 - 1) Develop and implement culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize avoiding the health risk factors for conditions affecting minorities and incorporate an accessible, affordable, and acceptable early detection and intervention component as set forth in IC 16-46-11.
 - a. NAATEN Project: The National African American Tobacco Education Network (NAATEN) has published *Be Free Indeed! Tobacco Prevention Tools of the African American Church*, a toolkit that includes a set of guides that educate on spiritually

grounded tobacco prevention and policy implementation specifically for women, men, youth and pastors. These toolkits are available free of charge while supplies last for churches who are interested in addressing tobacco use in their congregation.

M. Recruit 30 individuals from each local coalition county to participate in tobacco prevention activities.

Addiction

Substance Abuse

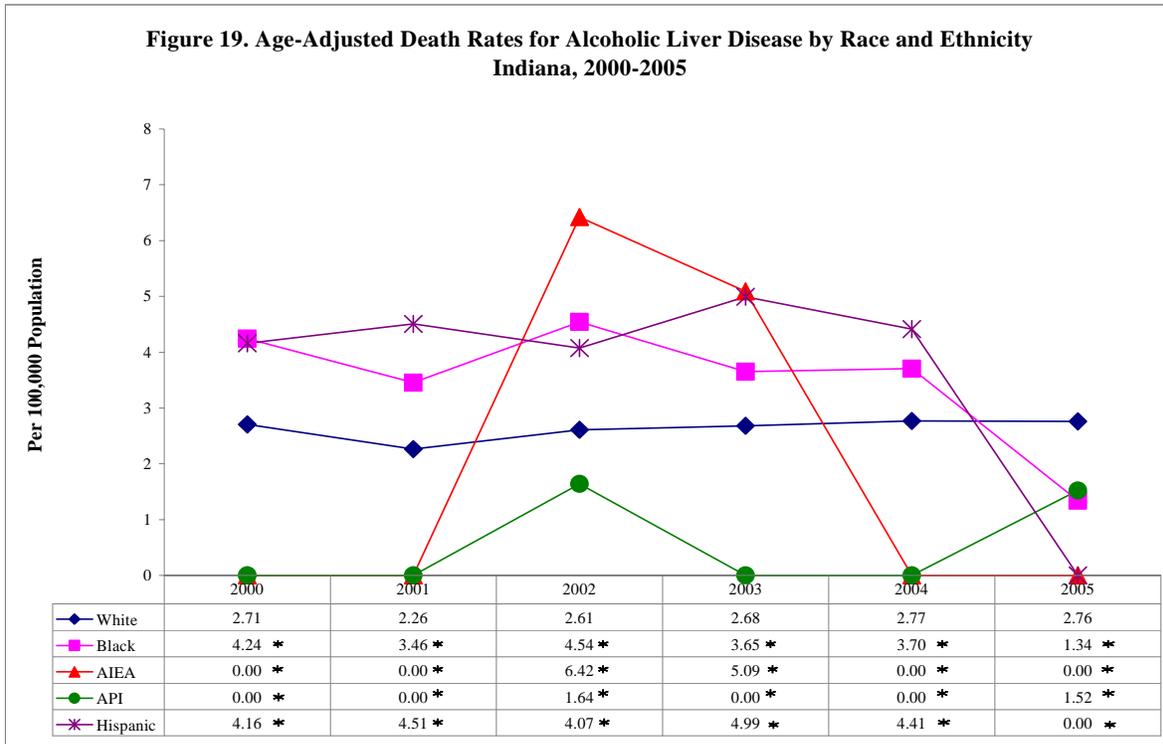
“Excessive alcohol consumption is associated with approximately 75,000 deaths per year. Alcohol is a factor in approximately 41% of all deaths from motor vehicle crashes. Additionally, among youth, the use of alcohol and other drugs has also been linked to unintentional injuries, physical fights, academic and occupational problems, and illegal behavior. Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurological damage as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder” (CDC).

As shown in Figures 19, 21, and 23, due to small population numbers, it is difficult to compare the age-adjusted death rates related to alcohol abuse among minorities in Indiana. However, according to national data, American Indians/Native Americans, Hispanics, and Whites appear to have the highest age-adjusted death rates related to alcohol abuse (Figures 20, 22, and 24).

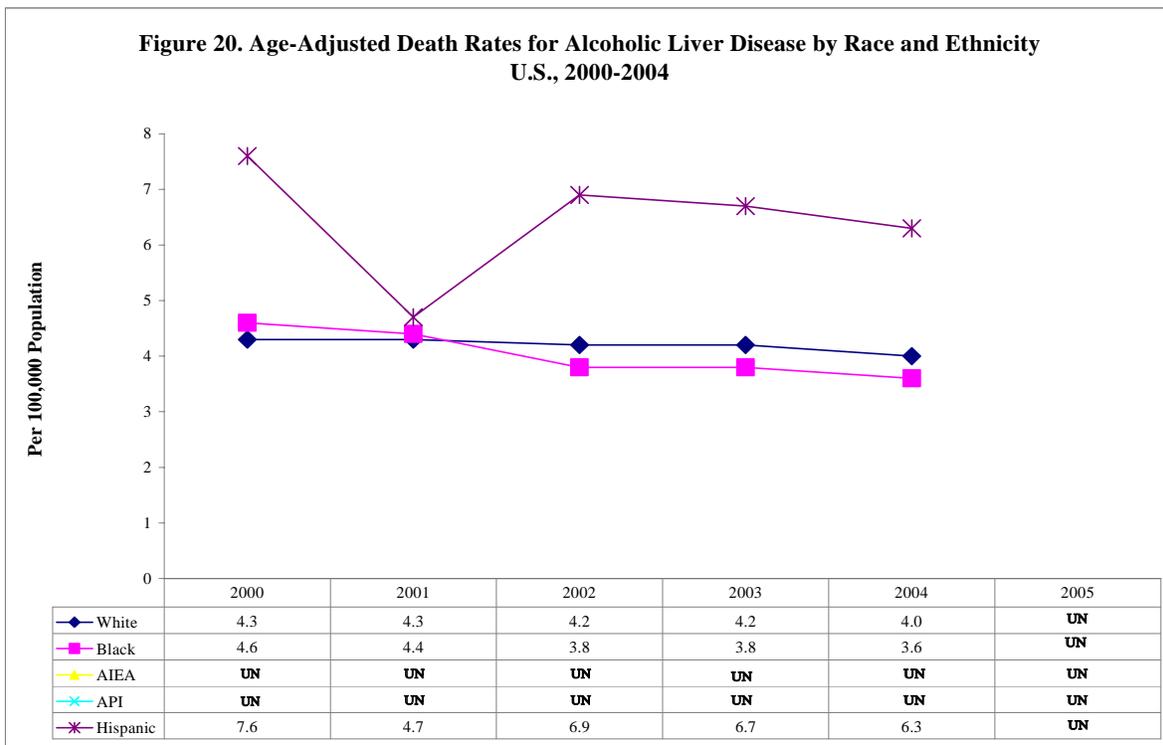
Furthermore, based on results of the 2006 BRFSS survey, in Indiana Multiracials have the highest prevalence of adult heavy drinkers (7.6%), followed by Whites (5.1%) and Hispanics have the highest prevalence of adult binge drinkers (18.0%), followed by Whites (16.5%) (Tables 22 and 23). Blacks in Indiana have the lowest percentage (11.3%) and “Other” races (30.0%) have the highest percentage of students who had 5 or more drinks of alcohol in a row, within a couple of hours, on one or more of the past 30 days (Table 24).

The following graphs and tables allow you to compare both national and Indiana state statistics, in addition to trends in disease mortality related to excessive alcohol consumption.

Comparison of Age-Adjusted Death Rates for Alcoholic Liver Disease (ICD 10: K70) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

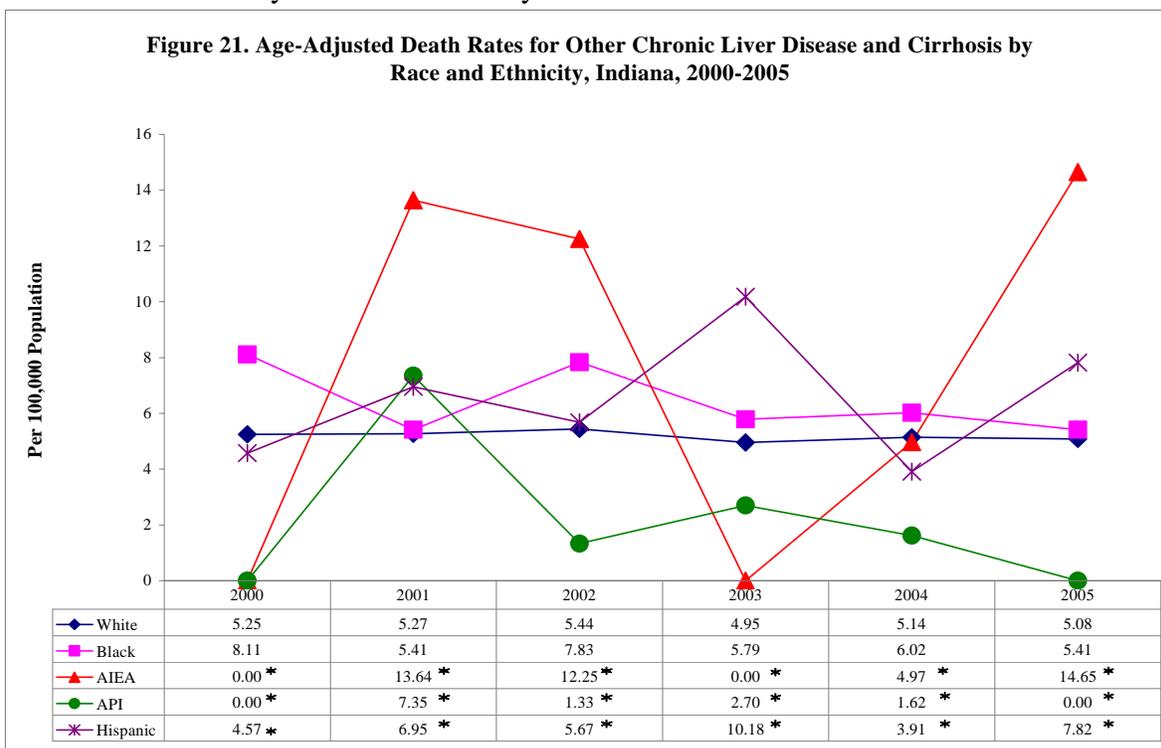
*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

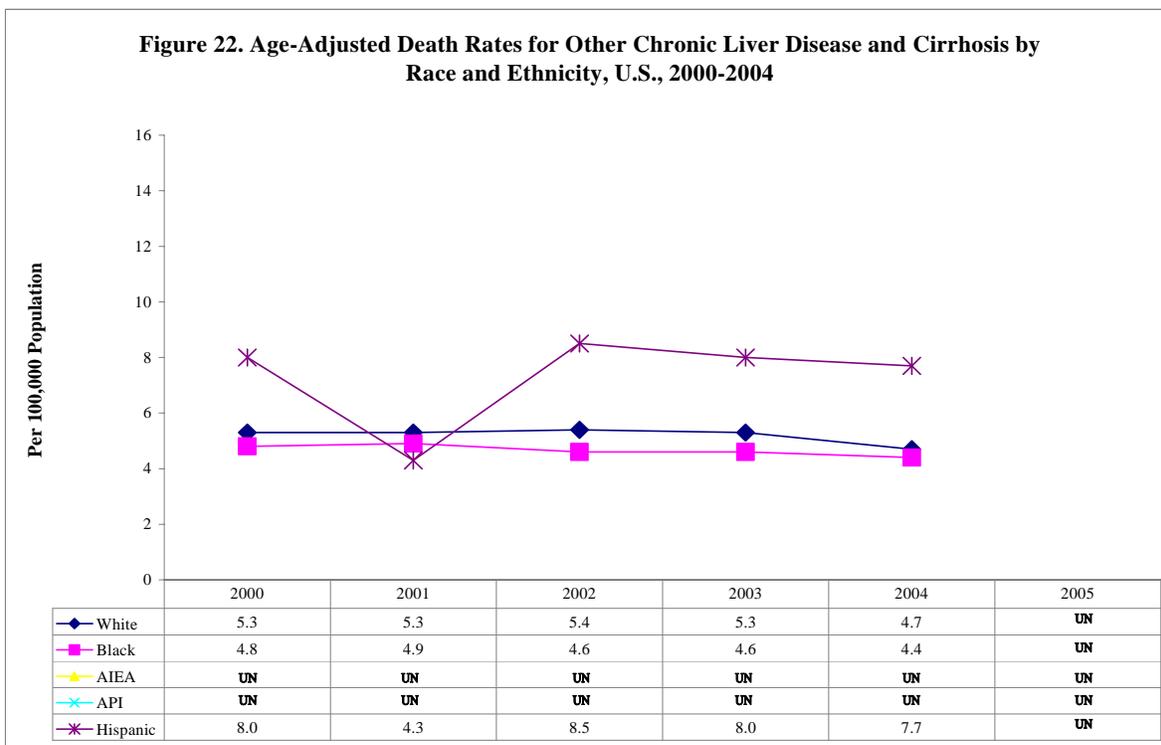
Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Comparison of Age-Adjusted Death Rates for Other Chronic Liver Disease and Cirrhosis (ICD 10: K73-74) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

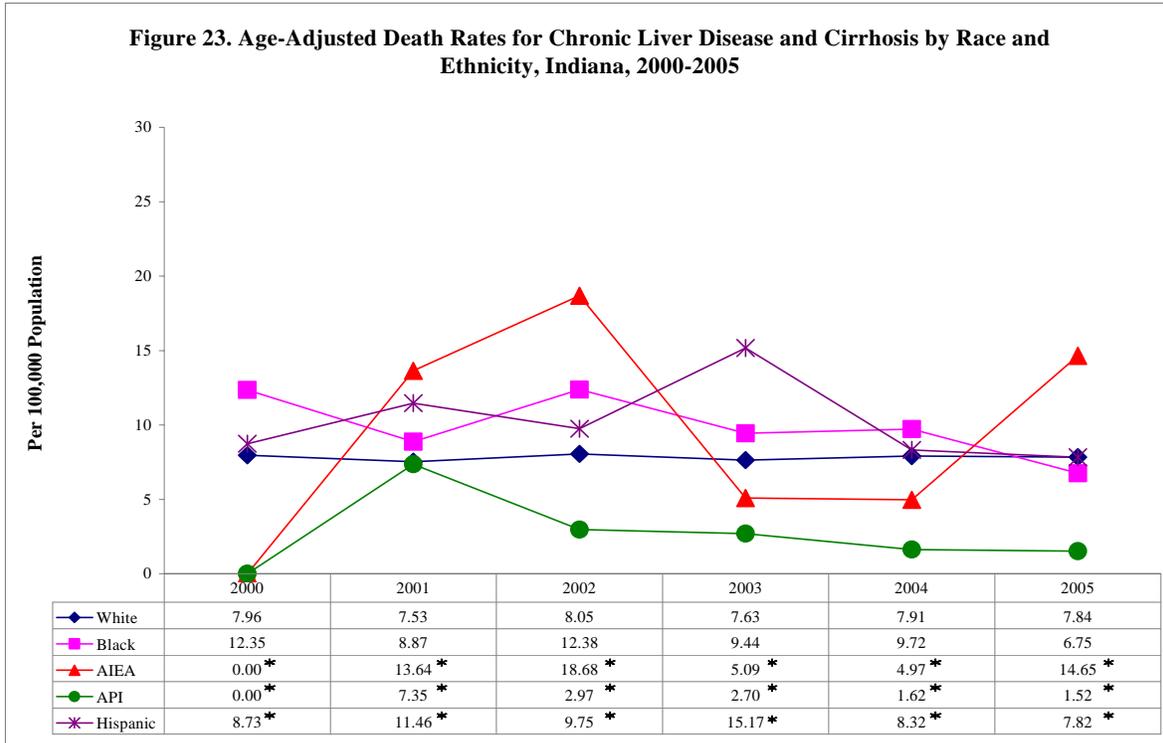
*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

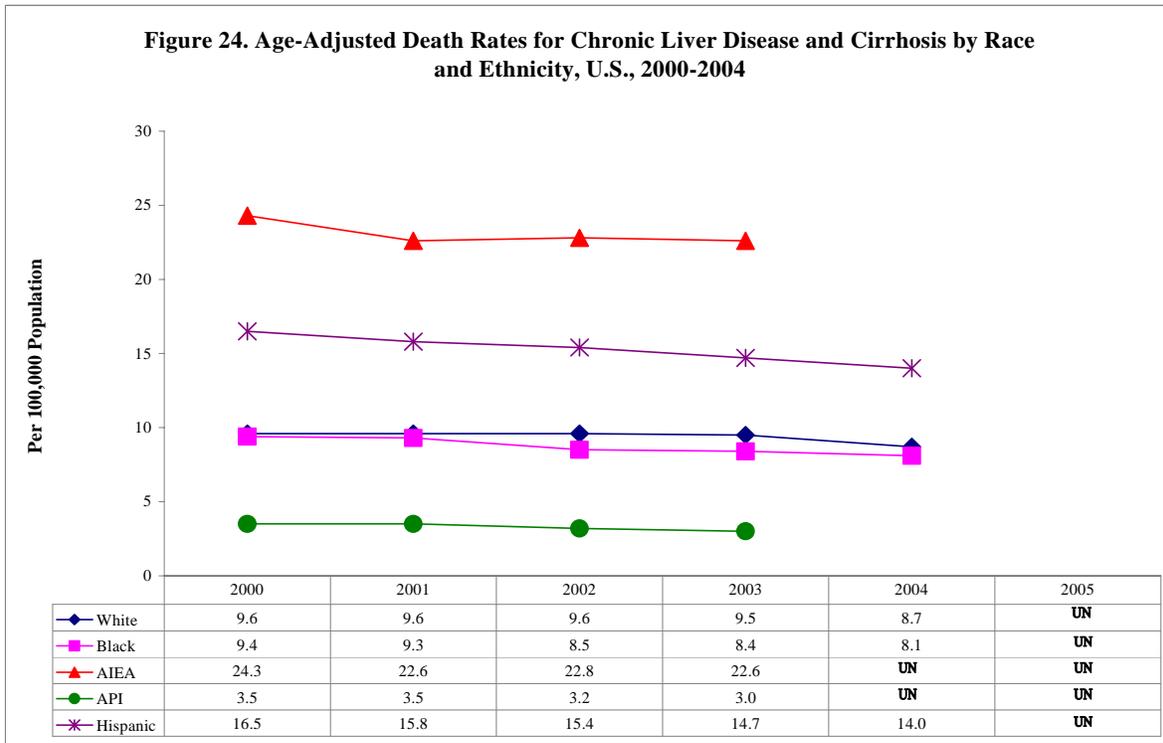
Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Comparison of Age-Adjusted Death Rates for Chronic Liver Disease and Cirrhosis (ICD 10: K70, K73-K74) by Race and Ethnicity Between Indiana and the U.S.



Source: Indiana State Department of Health, PHSD, Data Analysis Team



Source: National Center for Health Statistics

Notes:

*Number of deaths is less than 20, and the rate is unstable. Comparing unstable rates is not recommended.

UN = Unavailable data

Age-adjusted death rates are per 100,000 population. For additional information, see the Technical Notes.

Hispanic is an ethnicity. Hispanics can be members of any race.

Table 22. Percentage Of Adults Who Are Heavy Drinkers (Adult men having more than 2 drinks per day and adult women having more than 1 drink per day) By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	5.1%	5.3%
Black	4.9%	2.6%
Hispanic	4.8%	4.0%
Other	N/A	3.4%
Multiracial	7.6%	4.9%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was >10 for any cell, or if the state did not collect data for that calendar year.

Table 23. Percentage Of Adults Who Are Binge Drinkers (Adults having 5 or more drinks on one occasion) By Race And Ethnicity, Indiana And U.S., 2006

Race/Ethnicity	Indiana	U.S.
White	16.5%	15.8%
Black	11.2%	9.4%
Hispanic	18.0%	14.9%
Other	5.6%	11.3%
Multiracial	N/A	12.3%

Source: Behavioral Risk Factor Surveillance System, 2006

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 50 or the CI half width was >10 for any cell, or if the state did not collect data for that calendar year.

Table 24. Percentage Of Students Who Had 5 Or More Drinks Of Alcohol In A Row, That Is, Within A Couple Of Hours, On One Or More Of The Past 30 Days By Race And Ethnicity, Indiana And U.S., 2005

Race/Ethnicity	Indiana	U.S.
White	26.2%	29.9%
Black	11.3%	11.1%
Hispanic	N/A	25.3%
Other	30.0%	18.3%

Source: Youth Risk Behavior Survey, 2005

Notes:

U.S. = United States median, % = Percentage

Percentages are weighted to population characteristics

N/A = Not available if the unweighted sample size for the denominator was < 100 or the CI half width was > 10 for any cell, or if the state did not collect data for that calendar year.

Tables 25-27 display information in regards to Indiana substance abuse program completions, new admissions, and participants by race/ethnicity and gender for 2006.

Table 25. Indiana: Successful Completions of Substance Abuse Program, January 1, 2006 to December 31, 2006

Race/Ethnicity	Male	Female	Total
Black	1,362	112	1,474
Hispanic	120	8	128
White	2,314	293	2,607
American Indian	6	3	9
Pacific Islander	2	0	2
Asian	0	0	0
Multi-racial	0	0	0
Total	3,804	416	4,220

Source: Indiana Department of Corrections

Note: Successful completions = Therapeutic Community or a minimum of Phase 2 Treatment Component of Outpatient Services

Table 26. Indiana: New Admissions into Substance Abuse Programs, January 1, 2006 to December 31, 2006

Race/Ethnicity	Male	Female	Total
Black	2,369	222	2,591
Hispanic	194	7	201
White	3,599	498	4,097
American Indian	12	6	18
Pacific Islander	5	0	5
Asian	0	1	1
Multi-racial	0	2	2
Total	6,179	736	6,915

Source: Indiana Department of Corrections

Note: Successful completions = Therapeutic Community or a minimum of Phase 2 Treatment Component of Outpatient Services

Table 27. Demographics of Substance Abuse Program Participants, January 1, 2006 to December 31, 2006

Race/Ethnicity	Male	Female	Total
Black	3,380	295	3,675
Hispanic	299	15	314
White	5,375	721	6,096
American Indian	16	8	24
Pacific Islander	6	0	6
Asian	0	2	2
Multi-racial	0	2	2
Total	9,076	1,043	10,119

Source: Indiana Department of Corrections

Substance Abuse: Recommendations

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

- A. Work with local coalitions to market substance abuse programs and services offered by local coalitions and their partners.
 - 1) Affirm existing relationships or establish new partnerships to ensure empowerment of communities served through education.
 - 2) The Interagency Council supports educational initiatives for the public to help clarify the meaning of substance abuse and its attributes.

- B. Assure that services are culturally and linguistically appropriate
 - 1) Take great measures in notifying the different racial, ethnic, and cultural communities of the dangers of substance abuse and educate them on the importance of self preservation, health care's responsibility, and empowering the community towards change of present substance abuse conditions.

- C. In collaboration with ISDH, Smokefree Indiana, and IMHC, develop and disseminate culturally tailored tobacco awareness toolkits that can be used by the coalitions to raise minority awareness of the link between tobacco use and substance abuse.
 - 1) Develop and implement culturally and linguistically appropriate health promotion and disease prevention programs that would emphasize avoiding the health risk factors for conditions affecting minorities and incorporate an accessible, affordable, and acceptable early detection and intervention component as set forth in IC 16-46-11. Culturally tailored programs to address ethnic/racial minority groups.

- E. Conduct at least one community oriented town hall meeting, in collaboration with the ISDH appropriate staff, which emphasizes the importance of preventative care. Provide to ISDH the details of the town hall meetings.

- F. Involve local health organizations and partners to provide technical assistance to INShape
 - 1) Establish linkages with health and human service providers to refer community members for services.

- G. Develop a collaboration/network of stakeholders to transmit the message/shared vision to the media

- H. Monitor for hearings, forums, and opportunities to present culturally appropriate messages for healthy living

- I. Develop a resolution requiring a pledge towards healthy living

- J. Utilize existing education and literacy campaigns that promote healthy living

- H. Involve small grassroots organizations
 - 1) Provide assistance to local communities to obtain funding for the development of a health care delivery system to meet the needs, gaps, and barriers identified in the local plans.

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Mental Health in Indiana

- Indiana Federation of Families for Children's Mental Health:
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- Circle Around Families
<http://www.circlearoundfamilies.org>
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- The Supported Employment Consultation and Training Center in Indiana <http://www.sectcenter.org/>
- The Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children is located in Indiana.
<http://www.choicesteam.org/page/program/alias/TACenter&article=317&prog=317>
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- Consumer Survey Results of Treatment for Children and Adolescents with Serious Emotional Disturbance, 8-01, SFY2000
- Treatment Outcomes for Adults with Chemical Addiction, 8-01
- Provider Interview Results for Services for Adults with Serious Mental Illness, 9-01
- Provider Interview Results for Services for Children with Serious Emotional Disturbance, 9-01
- Provider Interview Results for Services for Persons with Chemical Addiction, 9-01
- Service Outcomes for Adults with Serious Mental Illness, 12-02
- Treatment Outcomes for Adults with Chemical Addiction, 12-02

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Appendix B

Minority Health Initiative

Outcomes	Tobacco	Obesity	Immunization	Mental Health
Metrics	Increase by 5% of the number of minorities that are referred to or given information on smoking cessation programs in 29 targeted counties.	Increase the number of minorities in 29 targeted counties by 5% that participate in fitness and nutrition programs.	Increase the rate of childhood immunizations in minority populations by 2% above 2006 rates in 29 of the targeted counties.	Increase by 2% the percentage of minority adults and children who receive mental health services in 29 of the targeted counties.
1	IMHC, in collaboration with Indiana Tobacco Prevention and Cessation (ITPC), will provide education about tobacco prevention and cessation. IMHC will, in collaboration with ITPC: (1) educate local coalitions; (2) develop tool kits; and (3) develop list of resources for tobacco prevention and cessation to be distributed to local coalitions.	IMHC, in collaboration with Indiana State Department of Health (ISDH) and universities, will provide education about obesity intervention and prevention. IMHC will, in collaboration with ISDH and universities: (1) educate local coalitions; (2) develop tool kits; and (3) develop list of resources for obesity intervention and prevention to be distributed to local coalitions.	IMHC will, in collaboration with ISDH and local health departments, work with locals coalitions to: (1) educate coalitions about importance of immunizations; and (2) develop list of locations in each coalition county where immunizations may be obtained.	IMHC will, in collaboration with the HDI Mental Health Sub-committee and IDMHA: (1) work in collaboration with IDMHA to address access to care, perception of care, cost effectiveness and other areas of concern within the mental health arena; (2) work in collaboration with IDMHA to identify at risk counties regarding mental health issues that impact racial/ethnic minorities; (3) educate local coalitions; (4) develop tool kits; and (5) develop list of resources for mental health awareness and identification to be distributed to local coalitions.

2	<p>IMHC will ensure that each local coalition provides tobacco prevention and cessation education, tool kits, and resources to:</p> <ul style="list-style-type: none"> A. 3 churches/ faith groups B. 5 schools/ youth organizations C. 5 minority serving health care providers D. 5 minority businesses 	<p>IMHC will ensure that each local coalition provides obesity intervention and prevention education, tool kits, and resources to:</p> <p>3 churches/ faith groups 5 schools/ youth organizations 5 minority serving health care providers 5 minority businesses</p>	<p>IMHC will ensure that each local coalition provides information, and resources to:</p> <ul style="list-style-type: none"> A. 3 churches/ faith groups B. 5 schools/ youth organizations C. 5 minority serving health care providers D. 5 minority business 	<p>IMHC will ensure that each local coalition provides mental health education, tool kits, and resources to:</p> <ul style="list-style-type: none"> A. 3 churches/ faith groups B. Organizations providing services to racial/ethnic populations at risk for mental health issues C. 5 minority serving health care providers D. 5 minority businesses
3	<p>IMHC in collaboration with ITPC will work with the local coalitions and other ITPC minority partners to develop culturally and linguistically appropriate media messaging about tobacco prevention and cessation.</p>	<p>IMHC in collaboration with ISDH will work with the local coalitions to develop culturally and linguistically appropriate media messaging about obesity intervention and prevention.</p>	<p>IMHC in collaboration with ISDH will work with the local coalitions to develop culturally and linguistically appropriate media messaging about the importance of immunization.</p>	<p>IMHC in collaboration with ISDH and IDMHA will work with the local coalitions to develop culturally and linguistically appropriate media messaging about the importance of mental health and mental health awareness.</p>
4	<p>IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University.</p>	<p>IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University.</p>	<p>IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University.</p>	<p>IMHC will ensure that appropriate representatives of the minority community from around the state are represented at the INShape Indiana Summit on October 15, 2007 at Purdue University</p>
5	<p>IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives.</p>	<p>IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives.</p>	<p>IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives.</p>	<p>IMHC will inform ISDH Commissioner's Office and Office of Minority Health, about the schedule of activities of the IMHC and affiliates so that ISDH may send representatives.</p>

