

The Interagency State Council on Black and Minority Health 2015 Annual Report



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

November 1, 2015

Table of Contents

Letter From The Chairman and Vice Chairman of the Interagency Council.....	3
Letter From The Legislative Representatives of the Interagency Council.....	4
Executive Summary.....	5
Overview of the Interagency Council and Updated Member List.....	10
<u>Info-Graph: A Picture of Minority Health In Indiana</u>	11
Recommendations.....	16
Conclusion	17
Data Limitations.....	18

The Interagency State Council on Black and Minority Health

IC 16-46-6

Chair: Lynne Griffin, American Heart
Association

Vice-Chair: Lynn Smith, FSSA

Governor: Mike Pence
Lt. Governor: Sue Ellspermann



11/1/15

The Interagency State Council on Black and Minority Health was established to identify and address health disparities, their impact upon the state of Indiana, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.

Through collaboration with key strategic institutions and community based organizations, the Interagency State Council on Black and Minority Health seeks to reduce health disparities and improve the health of racial and ethnic minorities within Indiana. As part of its service to the residents of Indiana, the Interagency Council is charged with the development of an Annual Report that provides the necessary data and foundation to guide and direct health efforts aimed at reducing health disparities and improving health of minority populations in Indiana.

This year's report is a little different, than past reports. Yes the report will highlight chronic illnesses, diseases and conditions that impact minority populations within the state as well as current state-wide effort and initiatives of community health partners to improve health literacy, create healthier environments and establish healthier lifestyles among Indiana's minority and underserved populations. But what will be different is the packaging. We will make the main portion of the report in a info graph and dashboard format. This is an opportunity to see firsthand where Indiana ranks and where minorities are affected the most.

The Interagency Council hopes the legislative body will review and receive this annual report as an informative and helpful resource in addressing health related issues as well as serve as a guide to address health disparities and share initiatives that have positively impacted the health of Black and Minority Hoosiers.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynne Griffin".

Lynne Griffin,
Chair

Senator Jean D. Breaux
Assistant Minority Leader
200 West Washington Street
Indianapolis, Indiana 46204
(317) 232-9534
s34@iga.in.gov

Committees:
Health & Provider Services, RMM
Utilities, RMM
Environmental Affairs
Ethics
Homeland Security, Transportation & Veteran Affairs
Joint Rules
Local Government
Rules & Legislative Procedure

November 1, 2015

Dear Colleagues:

Before you is a copy of this year's annual report of the Interagency Council on Black and Minority Health. Governed by State Statute, IC 16-46 6, 1-13, the Interagency Council on Black and Minority Health was legislatively introduced by Representative Charlie Brown and enacted into law in 1993. It has been my honor to serve as both Chair and member of this council.

Representative Brown and I encourage you to take some time to review the following report. This year we have adopted a new format that is a visual representation of the trends and issues affecting minority health conditions across Indiana. The report also provides recommendations members of the council believe to be important in addressing some of the many disparities that continue to plague communities of color throughout Indiana. Several recommendations, such as the need to update the chronic disease registry and a focus on cultural awareness in the delivery of health services, will be offered as bills this legislative session. It is our hope that you will consider support of these important legislative initiatives.

Lastly, this report and its new format is dedicated to our friend and mentor, the Honorable William A. "Bill" Crawford, whose committed leadership as a member of the Indiana Minority Health Coalition, and his passionate determination to address all areas of disparity, guided this organization and the work of this Council for many years.

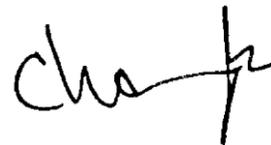
Thank you for your review and consideration of this document and the important information contained therein.

Sincerely,



Jean D. Breaux

Assistant Minority Leader
Indiana Senate District 34



Charlie Brown

State Representative
Indiana House District 3

Executive Summary

It is estimated by 2050 that racial and ethnic minorities will become the majority of the national population. From birthrates increasing among racial and ethnic minorities to the growing rate of immigrants and refugees, the United States is significantly changing daily. Here in Indiana we are following the same trend. Most racial and ethnic minorities are not getting the necessary help they need. This has created inequality in health care, treatment, and in our work force.

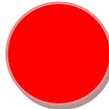
The Interagency State Council on Black & Minority Health Council has been tasked to give an overview of what is happening in the state with racial and ethnic minorities. This annual report will show where Indiana stands in regards to health disparities.

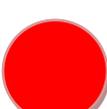
You will see a new format of data for your convenience. The new info graph format will offer an easier way to examine data that has been analyzed. The four areas that we present covers access, morbidities that are affecting racial and ethnic minorities, Indiana's strengths, and last Indiana's weaknesses. This new presentation will allow you to see where Indiana stands compared to other states.

Included in the executive summary is a table in dashboard form showing the impact of disparities for each health indicator that the Interagency State Council on Black & Minority Health Council selected for 2015.

The green circles indicate a positive impact. The yellow circles indicate progress is being made and the red circles indicate a negative impact.

Health Indicator	Black	Hispanic	White
Access to Health care Percentage of adults who report not having a personal doctor or health care provider			
Percentage of adults who report they have not visited a doctor for a routine checkup in the past year			
Percentage of adults who report not having any type of health care insurance			
Percentage of adults who report not seeing a doctor when needed because of cost			
Infant mortality Infant mortality rate greater than *6.0 infant deaths per 1,000 live births *Healthy People 2020 objective for infant mortality rate			

Health Indicator	Black	Hispanic	White
Obesity Percentage of adults who are considered to be obese based on self-reported height and weight.			
Cardiovascular Disease Percentage of adults who reported being told by a health professional they had angina or coronary heart disease			
Percentage of adults reported that they have ever been told by a health professional they have high blood pressure .			
Percentage of adults reported that they have ever been told by a health professional they had a stroke .			
Diabetes Percentage of adults who reported being told by a doctor they have diabetes			

Health Indicator	Black	Hispanic	White
HIV / AIDS (at first diagnosis)			
Cancer Incidence			
Mortality			
Violent Crime Homicides			
Suicide			

*Hispanic can be of any race

There is limited published data on American Indians, Asians, and multiracial groups, due to their smaller numbers. American Indians and Asians and persons of multiple races are sometimes combined and reported under the category of “other”. Data on these minority groups are often suppressed, because the cases/counts are so low, resulting in unstable rates. This is done to prevent misinterpretation of the data which can lead to incorrect assumptions about health status. Therefore, most of the data presented has been limited blacks or African-Americans and Hispanics, the largest minority groups in Indiana.

Another task that the Interagency State Council on Black & Minority Health has is to provide recommendations to the legislative body for 2015. Below you will find the overarching recommendations. For a more detailed account, please go to the recommendation section in the full report.

1. Improve access to health and behavioral health care for minorities by coordinating collaboration and partnerships of resources and services.
2. Improve cultural and linguistic competency and the diversity of the health-related workforce.
3. Dedicate resources and funding to implement the chronic disease registry.
4. Appropriate adequate funding for education, early intervention, screening and prevention programs that target disease-specific conditions.

Statutory appointees:	
Two (2) members of the house of representatives from different political parties appointed by the speaker of the house of representatives.	Rep. Charlie Brown – D Rep. Bob Morris - R
Two (2) members of the senate from different political parties appointed by the president pro tempore of the senate.	Senator Jean Breaux - D Senator Veneta Becker - R
The governor or the governor's designee.	Jamal Smith
The state health commissioner or the commissioner's designee	Dr. Jerome Adams Antoniette Holt (Proxy)
The director of the division of family and children or the director's designee	James Garrett, Jr.
The director of the office of Medicaid policy and planning or the director's designee	Vacant
The director of the division of mental health and addiction or the director's designee	Lynn Smith
The commissioner of the department of correction or the commissioner's designee	Vacant Tim J. Brown (Proxy)
One (1) representative of a local health department	Vacant
Governor's appointments:	
One (1) representative of a public health care facility appointed by the governor	Jose M. Pérez (Marion)
One (1) psychologist appointed by the governor who: (A) is licensed to practice psychology in Indiana; and (B) has knowledge and experience in the special health needs of minorities.	Vacant
One (1) member appointed by the governor based on the recommendation of the Indiana State Medical Association	Dr. Meredith Cousin
One (1) member appointed by the governor based on the recommendation of the National Medical Association	Vacant
One (1) member appointed by the governor based on the recommendation of the Indiana Hospital and Health Association	Dr. Edward Williams
One (1) member appointed by the governor based on the recommendation of the American Cancer Society	Vacant
One (1) member appointed by the governor based on the recommendation of the American Heart Association	Lynne Griffin
One (1) member appointed by the governor based on the recommendation of the American Diabetes Association	Vacant
One (1) member appointed by the governor based on the recommendation of the Black Nurses Association	Maple Murrell
One (1) member appointed by the governor based on the recommendation of the Indiana Minority Health Coalition	Vacant

Invited advisors: Nancy Jewell, Indiana Minority Health Coalition

Edwin C. Marshall, O.D., Indiana University School of Medicine

Council Staff:

JoeAnn Gupton, Indiana State Dept. of Health, Office Minority Health

Adrienne Durham, Indiana State Dept. of Health, Office of Minority Health

Calvin Roberson, Indiana Minority Health Coalition

Dash Board
2.0

A Picture OF Minority Health IN Indiana

The 2015 Interagency State Council on Black and Minority Health Annual report is presented in an info graph format. Illustrated in this report are the differences in the burden of the following diseases and conditions among racial and ethnic minorities in Indiana: infant mortality, diabetes, heart disease, homicide, suicide, HIV, cancer and obesity.

For the past 25 years, America's Health Rankings (AHR) has provided a year-to-year depiction of each state's health compared with that of all other states. According to 2014 America's Health Rankings (AHR) Annual Edition, Indiana's Overall Health Ranking is 41 out of 50 states (1 being the best and 50 being the worst) for all health outcomes.

 Source: America's Health Rankings, www.americashealthrankings.org



ACCESS TO HEALTHCARE

According to Healthy People 2020, limited access to health care impacts individuals' ability to reach their full potential and negatively affects their quality of life. Barriers to services include, but are not limited to the following factors: lack of availability, high cost and lack of insurance coverage. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services and hospitalizations that could have been prevented.



PRIMARY CARE PHYSICIANS

Indiana has 104.2 primary care physicians (including general practice, family practice, OB-GYN, pediatrics, and internal medicine) per 100,000 population. The ranking for this area is 37.

37

'Do you have one person you think of as your personal doctor or health care provider?'

39.6% of Hispanic and 27.7% of black non-Hispanic adults indicated "no" they do not have a personal doctor or health care provider compared to 17.0% of white, non-Hispanic adults.

'How long has it been since you last visited a doctor for a routine checkup?'

44.7% of Hispanic adults indicated they had not visited a doctor for a routine checkup in the past year compared to 26.9% of black, non-Hispanic and 35.2% of white, non-Hispanic adults.

 Source: Indiana, BRFSS 2013



LACK HEALTH INSURANCE

Indiana ranks 28 for lack of health insurance. 14.1% of Indiana's population does not have private health insurance through their employer or the government.

28

'Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, or Indian Health Services.'

46.0% of Hispanic and 25.3% of black, non-Hispanic adults indicated that they do not have health care coverage compared to 14.0% of white, non-Hispanic adults.

'Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?'

22.8% of black, non-Hispanic and 30.3% of Hispanic adults indicated that they did not see a doctor when needed because of cost compared to 13.4% of white, non-Hispanic adults.

 Source: Indiana, BRFSS 2013



FAMILY DENTIST

There are 48.6 dentists per 100,000 population, which gives Indiana a ranking of 42 for the number of dentist per 100,000 population.

42

'How long has it been since you last visited a dentist or dental clinic for any reason?'

52.9% of Hispanic and 48.0% of black, non-Hispanic adults indicated they had not visited a dentist, dental hygienist or dental clinic in the past year compared to 34.8% of white, non-Hispanic adults.

 Sources: America's Health Rankings, www.americashealthrankings.org
Indiana, BRFSS 2012



INFANT MORTALITY



INDIANA'S INFANT MORTALITY BY RACE AND ETHNICITY

Infant mortality is an accepted standard used to compare the health and well-being of racial and ethnic populations in the U.S. It is one of the most important health indicators of a population.



The Healthy People 2020 objective for infant mortality is 6.0 infant deaths per 1,000 live births.

Sources: MacDorman, et al 2013
Healthy People 2020
www.healthypeople.gov

Indiana ranks 39 for infant mortality. It is determined by the number of children who fail to survive to their first birthday per every 1,000 live births.

Birth weight is a major predictor of infant health. Infant mortality is highest for the smallest of babies and it decreases as birth weight increases.

Low birth weight (LBW) refers to an infant weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.

The percentage of low birth weight infants is higher among blacks (12.9%) than Hispanics (6.7%) and whites (7.3%).

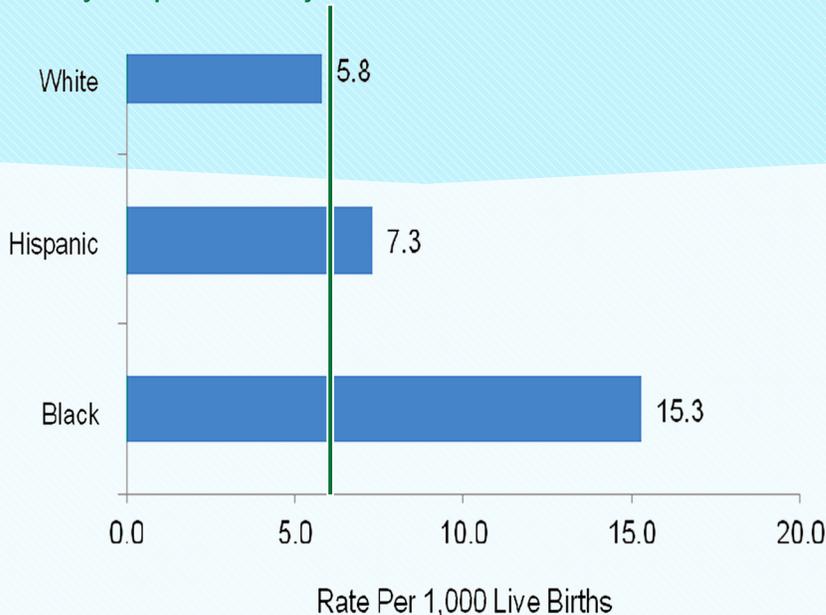
Premature or Preterm Birth is defined as an infant born at less than 37 weeks gestation. Blacks (13.2%) have the highest percentage of preterm births compared to Hispanics (9.1%) and whites (9.2%).

Early and continuous prenatal care helps identify conditions and behaviors that can result in low birth weight infants. Mothers who receive no prenatal care are three times more likely to give birth to low birth weight infants and five times more likely to die than mothers who receive prenatal care.

Black (56.8 %) and Hispanic (55.8 %) pregnant women are less likely than white pregnant women (69.9%) to receive prenatal care in the first trimester of pregnancy.

Sources: Indiana Natality Report – 2013
U.S. Department of Health and Human Services Fact Sheet Preventing Infant Mortality
www.hhs.gov/news/factsheet/infant.html
Ventura, S.J. Changing Patterns of Non-marital Childbearing in the United States. NCHS Data, Brief, No. 18. Hyattsville, MD. National Center for Health Statistics May 2009.

Healthy People 2020 Objective



Source: ISDH, Indiana Mortality Report 2013

Indicator	Indiana's Rank	Most recent data	Best State
Infant mortality Infants whose age at death was 0 - 364 days	39	7.2 number of infant deaths per 1,000 live	4.2 number of infant deaths per 1,000 live
Low birth weight Percentage of infants weighing less than 2,500 grams at birth	21	7.9%	5.7% AK
Premature births Percentage of infants born at less than 37 weeks gestation	20	9.6%	8.7% VT
Prenatal care Percentage of pregnant women who receive prenatal care in the first trimester	NA	67.4%	NA

Sources: ISDH, Indiana Mortality Report 2013
ISDH, Natality 2013
America's Health Rankings, www.americashealthrankings.org



OBESITY

Indiana ranks 42 for **obesity** and nearly one third (31.8%) of the population is obese. Obesity increases the risk of developing a variety of chronic diseases and health problems.



Indiana residents taking part in the survey for the 2013 Behavioral Risk Factor Surveillance System (BRFSS) were asked for their height and weight. Obesity is based on BMI calculated from self-reported height and weight.

A larger percentage of black, Non-Hispanic adults (41.7%) were considered to be obese compared to Hispanic (34.9%) and white, non-Hispanic (30.6%) adults. [The difference between black, non-Hispanics and Hispanics is not significant]

Source: Indiana, BRFSS 2013



HEART DISEASE

Indiana ranks 28 for **heart disease**. During 2013, **heart disease** was the leading cause of death for all populations in Indiana. 13,718 Indiana residents died of heart disease.



4.3% of Indiana adults responded "yes", when asked, "Has a doctor, nurse or other health professional ever told you had angina or **coronary heart disease**?"

A smaller percentage of black, non-Hispanic (2.6%) and Hispanic adults (1.2%) respond "yes" to the above question than white, non-Hispanic adults (4.7%).

Source: Indiana, BRFSS 2013



STROKE

Indiana ranks 32 for **stroke**. In 2013, one in three or 33.5% of Indiana adults reported that they have ever been told by a health professional they have high blood pressure.



Stroke is the fourth leading cause of death among Hispanics and whites and the third leading cause of death among blacks.

3.1% of Indiana adults responded "yes", when asked, "Has a doctor, nurse or other health professional EVER told you had a stroke?"

A larger percentage of black, non-Hispanic adults (4.4%) responded "yes" they have ever been told they had a **stroke** compared to white, non-Hispanic (3.0%) and Hispanic (1.1%) adults.

[The difference between black, non-Hispanics and white, non-Hispanics is not significant]

Source: Indiana, BRFSS 2013



DIABETES

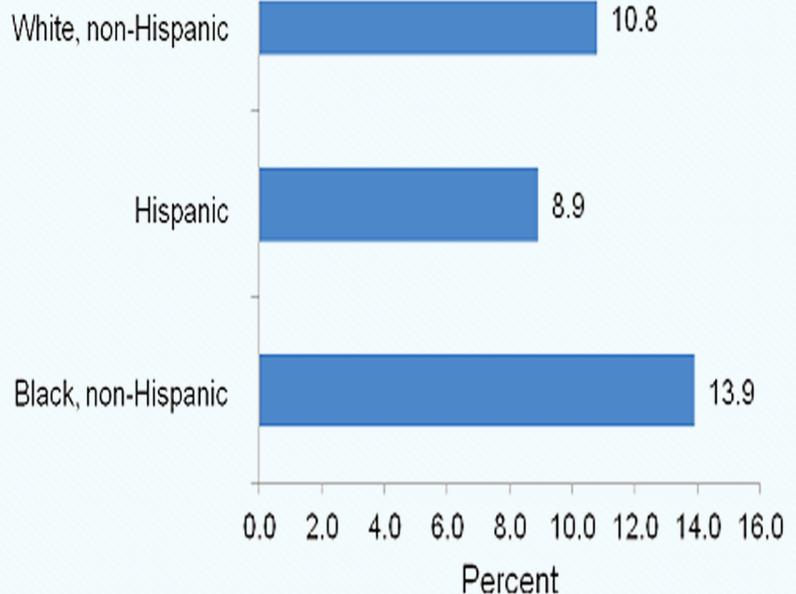
Nearly 500,000 or 11.0% of Indiana adults have diabetes.



Indiana ranks 39 for **diabetes** prevalence. Diabetes increases with age and it increases the risk of premature death, functional disability, and other conditions such as coronary heart disease.

Sources: Indiana, BRFSS 2013
America's Health Rankings,
www.americashealthrankings.org

Percentage of adults who responded "yes" to the question "Have you ever been told by a doctor that you have diabetes?" by race and ethnicity – Indiana, 2013 (Excludes pre-diabetes and gestational diabetes)



Source: Indiana, BRFSS 2013



HIV/AIDS



HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

As of December 2014, there were 5,376 total persons living with HIV (without an AIDS diagnosis) and 6,171 living with AIDS in Indiana.

Top graph:
Newly Reported Indiana HIV Cases by Race/Ethnicity and Gender, Reported January 1, 2014 – December 31, 2014

Bottom graph:
Newly Reported Indiana AIDS Cases by Race/Ethnicity and Gender, Reported January 1, 2014 – December 31, 2014

 Sources: Indiana State Department of Health, Office of Minority Health, September 2015. Original data obtained from Spotlight on HIV/STD/Viral Hepatitis, 2014 Indiana Annual Report, January 1, 2015.

Race/Ethnicity	HIV at First Diagnosis			
	Male	%	Female	%
White	125	37%	24	29%
Black	155	46%	6	55%
Hispanic	43	13%	8	9%
Other	14	4%	6	7%
Total	337	100%	84	100%
Gender	84%		16%	

Race/Ethnicity	AIDS at First Diagnosis			
	Male	%	Female	%
White	45	60%	4	21%
Black	20	27%	10	53%
Hispanic	7	9%	3	16%
Other	3	4%	2	10%
Total	75	100%	19	100%
Gender	73%		27%	



CANCER



VIOLENT CRIME



SUICIDE

Cancer was the second leading cause of death for all populations in Indiana, during 2013. The overall racial disparities in cancer incidence and mortality rates in

42

Indiana have decreased. However, African Americans still have a greater incidence of cancer and they have a higher death rate than whites. From 2007-2011, the overall cancer incidence rate for Indiana Hispanics (342.3 cases per 100,000) was significantly lower than the national rate for Hispanics (377.7 cases per 100,000).

The cancer death rate for Hispanic Indiana residents was 99.7 deaths per 100,000 people compared to 1901.1 deaths per 100,000 people for all Indiana residents.

 Source: Indiana Cancer Facts and Figures, 2015

Indiana ranks 26 for violent crimes which includes homicides, rapes, robberies and aggravated assaults per 100,000 population.

26

Homicide is the leading cause of death for black residents ages 15-34 with 165 deaths.

Homicide is the 5th leading cause of death for all blacks (229 deaths) and the 3rd leading cause of death for black males (204 deaths).

Homicide is the 7th leading cause of death for all Hispanics (27 deaths) and the 4th leading cause of death for Hispanic males (24 deaths).

 Source: Indiana Mortality Report, 2013

Indiana ranks 26 for suicide. The number of deaths due to self-harm per 100,000 population.

26

Suicide is the 9th leading cause of death for all Hispanics (22 deaths) and the 6th leading cause of death for Hispanic males (16 deaths).

A higher percentage of black (17.6%) and Hispanic (11.6%) youth reported attempting suicide one or more times in the past 12 months compared to white youth (9.8%).
Source: Indiana Youth Risk Behavior Survey, 2011

 Source: Indiana Mortality Report, 2013



INDIANA HIGHLIGHTS



In the past 2 years, smoking decreased by 14% from 25.6% to 21.9% of adults.



In the past year, binge drinking decreased by 6% from 15.9% to 15.0% of adults.



In the past year, children in poverty decreased by 40% from 24.7% to 14.7% of children.



In the past year, preventable hospitalizations decreased by 8% from 76.0 to 70.0 per 1,000 Medicare beneficiaries.



Since 1990, cardiovascular deaths decreased by 35% from 425.0 to 274.4 deaths per 100,000 population.



Sources: America's Health Rankings, www.americashealthrankings.org



INDIANA'S HEALTH STRENGTHS

According to information gathered by America's Health Rankings, Indiana has the following health strengths: low incidence of infectious disease, low percentage of children in poverty and high immunization coverage among teens.

Domain	Indicator	Indiana's Rank	Most recent data	Best State
Population health	Incidence of infectious disease Combined score using the incidence of Chlamydia, pertussis, and Salmonella per 100,000 population.	14	NO DATA	WV
Social and economic environment	Percentage of children in poverty Percentage of persons younger than 18 years who live in households at or below the poverty threshold.	13	14.7	9.2 UT
Public health and prevention	Percentage of immunization coverage among teens Percentage of adolescents aged 13 to 17 who have received 1 dose of Tdap since the age of 10 years, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV (females) (National Immunization Survey-Teen, 2012)	7	72.9	81.3 RI



Source: America's Health Rankings, www.americashealthrankings.org



PUBLIC HEALTH FUNDING

State dollars dedicated to public health and federal dollars directed to states by the



Centers for Disease Control and Prevention and the Health Resources and Services Administration.



Source: America's Health Rankings, www.americashealthrankings.org



INDIANA'S HEALTH CHALLENGES

According to information gathered by America's Health Rankings, Indiana has the following health challenges: high prevalence of obesity, high prevalence of physical inactivity and high levels of air pollution.

Domain	Indicator	Indiana's Rank	Most recent data	Best State
Population health	Adult obesity Percentage of adults who are obese, with a body mass index (BMI) of 30.0 or higher. (2011 BRFSS Methodology)	42	31.8%	21.3% CO
Population health	Adult physical inactivity Percentage of adults who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening or walking) other than their regular job in the last 30 days. (2011 BRFSS Methodology)	43	28.3%	16.2 CO
Physical Environment	Outdoor air quality Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5)	48	11.7	4.9 AK



Sources: Indiana, BRFSS 2013
America's Health Rankings, www.americashealthrankings.org

Recommendation from the Interagency State Council on Black & Minority Health

The council understands that the Indiana law makers have the authority to establish legislative policies that direct state officials to find ways to ensure equal access to health care services for all Indiana residents irrespective of employment, income, or health status. In this annual report, you have been given the data as to where Indiana presently stands and areas in which we need to improve. Below you will find the recommendations for 2015.

1. Improve access to health care and behavioral health care for minorities by coordinating collaboration and partnerships of resources and service.

Health outcomes for minority and underserved populations can be improved by reducing barriers that limit access to health care. Fully support or fund entities such as the Indiana State Department of Health, Indiana Minority Health Coalition, and the Family and Social Services Administration. These agencies and other organizations should be utilized for their expertise in partnerships. Collaboration between state and local entities create effective and coordinated operational linkages between programs and services available to racial and ethnic minorities. Prevention initiatives must be developed and implemented to ensure the reduction and elimination of health disparities

2. Improve cultural and linguistic competency and the diversity of the health-related workforce.

With legislative support of mandated cultural competency trainings for health and behavioral health care professionals, Indiana's public health workforce will become more culturally sensitive to everyone they serve. The council also recommends making our public health workforce more diverse, ultimately reflecting the state's racial and ethnic composition.

3. Dedicate resources and funding to implement chronic disease registry.

There is a lack of morbidity data collected for racial and ethnic minorities. Currently there are codes which legislatively mandate chronic disease registries. These registries are supposed to assemble key data. However, information is not being collected. The council recommends that the legislature consider providing sustainable funding and support for the creation or redesign and maintain a chronic disease registry system that collects chronic disease related data to measure and assess the health status of Indiana's high risk racial and ethnic minority populations.

4. Appropriate adequate funding for education, early intervention, screening and prevention programs that target disease-specific conditions.

It is a known fact that racial and ethnic minorities suffer a greater burden of the majority chronic diseases. Funding for these items will have a great impact on the lives of minorities living in Indiana. Inadequate access to health care limits the ability to manage disease and makes it harder to work toward elimination of disease, thereby decreasing wellness among all Hoosiers, specifically underserved populations. To effectively address health disparities for racial & ethnic minorities, there is a great need to promote and implement prevention services. Health disparities can be reduced by focusing on those groups/individuals at greatest risk. Targeting prevention services will lead to improvement of health for racial, ethnic and underserved populations.

Conclusion

Indiana has shown strengths and challenges in health care over the year. With the full support of Indiana's legislature, we can make great strides and impacts in the lives of each Indiana resident. By utilizing the data provided in this report to show a need for changes, heeding the recommendations given and putting them into action, Indiana can continue to be a leader in the efforts of eliminating health disparities. Let's live by the motto, that Indiana is a "State that Works".

Data Limitations

Indiana State Department of Health, Public Health Protection and Laboratory Services Commission, Epidemiology Resource Center, Data Analysis Team follows the "Rule of Twenty" when examining rates. There should be at least twenty events in the numerator in order to produce a stable rate. When the numerator is less than 20, the rate is unstable, meaning that a small change in the numerator can lead to a large change in the rate from one year to the next. Unstable rates are not useful when making decisions and how data are interpreted is very important to the decision-making process. Misinterpretation of the data can lead to incorrect assumptions about health status. Therefore, there is limited published data on American Indians, Asians, and multiracial groups, due to their smaller numbers. American Indians and Asians and persons of multiple races are sometimes combined and reported under the category of "other". Data on these minority groups are often suppressed, because the cases/counts are so low, resulting in unstable rates. This is done to prevent misinterpretation of the data which can lead to incorrect assumptions about health status. Therefore, most of the data presented has been limited blacks or African-Americans and Hispanics, the largest minority groups in Indiana.