

Progressing Toward a Healthier Arkansas...

**Healthy
People
2010
Health
Status
Report**



2007

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INTRODUCTION

This report is designed to provide some insights into health disparities within the state of Arkansas as they currently exist. Key health status indicators, 60 in all, were selected from among the goals outlined in Healthy People 2010 (HP2010), and data were sought to identify the current status of the state's population overall and of three primary subgroups within our population: Whites, Blacks, and Latinos. The summaries that follow are organized by topic – that is, by chapter from the national Healthy People 2010 report – and highlight important areas of concern for the state's health and for the health of each of these subgroups.

First, for each chapter/topic area, we present the key indicators chosen, the national target for that indicator/goal, and the current status of each of the three groups. Immediately following in each section is a summary of current efforts by programs within the Arkansas Department of Health to address disparities in that topical area and assure access to health care and achievement and maintenance of good health for all Arkansans. Finally, a summary is presented at the end of the report, including an overall picture of disparities and some brief discussion of historic trends in disparities. Appendices that follow provide additional information about the state's health status overall (compared to national targets) as well as information about data sources and definitions of terms used within the report.

It is our hope that the information presented below will be a stimulus for awareness, discussion, and, ultimately, additional efforts to address health disparities in the state of Arkansas.



“As we move toward the conclusion of Healthy People 2010, we see that improving Arkansas's health status continues to require the dedication, concern and efforts of all our citizens. Behavioral changes as well as increasing physical activity will move our state in a healthier direction and Public Health is here to assist in these efforts with programs, resources, services, information, data and research. This health status report provides a glimpse into the work that has been accomplished and remains to be achieved as we continue to Progress Toward a Healthier Arkansas.”

***Paul K. Halverson, DrPH, FACHE,
Arkansas Department of Health Director
and State Health Officer***



”Thanks to each of you who have worked on Healthy People 2010 over the years. The Office of Minority Health & Health Disparities is committed to working toward the elimination of health disparities and encourages you to join us in this effort.”

***Christine B. Patterson, MSW, LCSW, Office of
Minority Health & Health Disparities Director***



“These data point to significant differences in the health status of segments of our population in Arkansas. We must redouble our efforts to achieve maximum health for all Arkansans.”

***Martha Phillips, PhD, MPH, MBA, Community
Health Senior Scientist for Community Health***

DATA LIMITATIONS, CHALLENGES

Data used to develop this report were drawn from multiple sources, including vital records, statewide surveys, and, for a few goals, specialized surveys of key target groups. As those data were compiled and reviewed, a number of challenges arose. First, data were not available at the state level for all of the national HP2010 goals. There are many national data collection activities for example, the National Health and Nutrition Examination Survey that can provide an excellent picture of health status at the national level but are not conducted in a way that allows the same picture to be drawn at the state level. This limited the number of goals that could be monitored at the state level and included in the report. Similarly, state level data collection activities are often designed to provide an estimate of disease burden at the state level but cannot provide estimates at a more refined level (such as county) or for population subgroups. In many of these cases, sample sizes are simply too small to provide reliable estimates of disease burden for groups other than Whites or Blacks.

Second, data on race, ethnic origin, or cultural identity has not always been collected with the disease information. Without that information, we are not able to create group-specific disease estimates for previous years, serious limiting our ability to track disparities over time.

A third issue related to the documentation and interpretation of health disparities is found in the changing definitions of 'race' for the purposes of data collection. In the past, survey researchers have utilized a single question that asked individuals completing a survey to indicate whether they were White, Black, Hispanic, Asian, or other race. This treatment of Hispanic origin as a racial category was typical and accepted for many years. As we have come to understand the influence of race and culture on health, however,

the US Census Bureau and other prominent federal and state survey research groups have changed their definitions and questions in two important ways. First, being of Hispanic origin is no longer considered a racial category, but rather has been more recently defined as an ethnic or cultural characteristic. Thus, survey respondents are now asked to identify first their race group (White, Black, Asian, etc.) and then to tell whether they are Hispanic or not. This generates combinations of race/ethnicity that have historically not been present that is, White Hispanic, Black Hispanic, and the like and that cannot be generated from older data for comparability. Second, questions are now being asked in a manner that allows for multi-racial groupings. That is, survey respondents are being asked to indicate all the racial groups to which they belong (rather than selecting a single one, as was the historical practice), making the identification of "traditional" racial groups (White, Black, Asian, other) more challenging. While both of these format changes reflect our growing understanding and the changing reality of our multicultural American society, they pose unique challenges for documenting and interpreting health disparities that may occur between and among racial/cultural groups.

A fourth and critical issue relates to the inclusion of population subgroups within data collection samples and the representativeness of the data that are obtained from those minority group informants. Two of our most important and most rapidly-increasing groups are Latinos and citizens of the Marshall Islands (the Marshallese). Both groups have strong linguistic and cultural differences from the mainstream Arkansas population groups, differences that make them harder to reach from a data collection standpoint. These two groups are less likely to have land-based telephones in the home, limiting our ability to include them in telephone surveys. There are also important issues of trust in government and health care systems that may

limit their willingness to participate in anonymous surveys. Considering these factors along with the linguistic and cultural issues that influence health and participation in health surveys, it is highly likely that the data obtained from the limited numbers of people in these groups who can and do participate in our surveys may not be representative of the group overall.

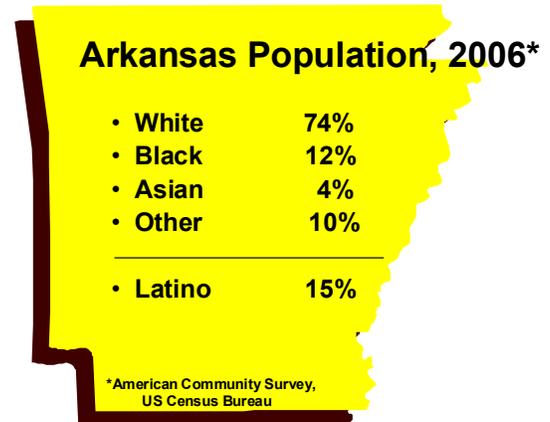
Implications for the Arkansas report. These overarching challenges have had an important impact on the contents of this report. First, the selection of HP2010 goals was affected by the availability of data that could be considered and interpreted at the subgroup level. Some important goals are not included in this report because subgroup estimates are not available. Second, it was sometimes the case that data could be obtained for Whites and Blacks but were not available for Latinos, because that portion of our state's population, while growing rapidly in many areas, continues to be small, relative to other groups. Data to describe the health status of the Asian population were similarly not available, because that population subgroup is even smaller than the Latino group.

Where data are available for those subgroups, it is imperative that we interpret the patterns cautiously, considering that those who respond may be systematically different from the group overall. To the extent that this is true that those Latinos who are available and willing to participate in a survey are, for example, more affluent, more educated, and more proficient in English than a large portion of their peers then the true pattern of disease burden in that group may be different more or less severe than indicated by the limited data we have. Some would choose not to present the data until these issues could be resolved; we have chosen to present those data for consideration and to caution the reader to draw conclusions carefully.

DEMOGRAPHICS

Information concerning health status cannot be understood outside of the demographic context. That is, we must be aware of and understand the characteristics of the groups and the differences between groups so that we can interpret the information about health status and outcomes more appropriately.

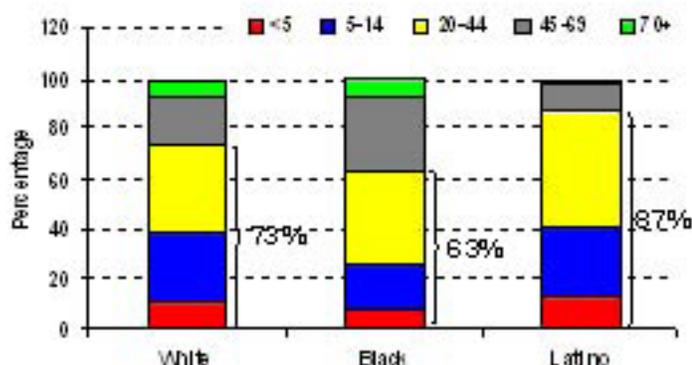
Overall, there are an estimated 2.8 million residents in the state of Arkansas. The majority (nearly three of every four individuals) identify themselves as White, while just over one in nine



identify themselves as Black or African American. The Pacific Islander group, which should include the Marshallese, is likely underrepresented in these estimates, which indicate approximately 2,000 individuals within that group, when other estimates place the Marshallese population at between 6,500 and 10,000 individuals.

Similar concerns are expressed about underrepresentation of Latinos in population estimates. The US Census Bureau in 2000 estimated that Latinos represented just under 5 percent of

Figure 2. Age distribution within population subgroups, Arkansas, 2000



the Arkansas population. In 2006, however, data from the US Census Bureau's American Community Survey estimate that Latinos account for nearly 15% of the state's population. The more recent estimate is more consistent with the informal estimates made by advocacy groups working with the population.

There are important age differences among the three groups being compared within this report. As shown in Figure 2, the Latino population is substantially younger than either Whites or Blacks. Just under 90% of Latinos are under the age of 45, compared to 73% of Whites and 63% of Blacks. Because they are younger overall, the pattern of disease seen in the Latino group

will likely be different that is, they will show fewer occurrences of diseases that are more common in older age groups (such as heart disease and some types of cancer) and more occurrences of diseases and conditions that are associated with employment or risk behaviors of youth (such as work-related injuries or motor vehicle crashes).

Latinos in Arkansas also report lower educational levels, with nearly 60% not having a high school diploma or equivalent certificate, compared to 23% among Whites and 34% among Blacks (Figure 3). Given that both occupation and income are strongly related to education, it is somewhat surprising that unemployment rates are highest among Blacks (13%), compared to Whites (5%) and Latinos (7%). Median household incomes are also lowest among Blacks (\$20,699); median household incomes among Latinos (\$28,275) are somewhat higher and incomes among Whites (\$34,603) are highest. It is not surprising, then, that Black children and adults are more likely to be living in poverty than children and adults in either of the other two groups (Figure 4).

Arkansas has seen a substantial immigration surge over the past 15 years. As noted above, the Latino population within the state is estimated to have tripled in the first half of the current decade from just under 5% in 2000 to just under 15% in 2006, and, as shown in Figure

Figure 3. Education distribution within population subgroups, Arkansas, 2000

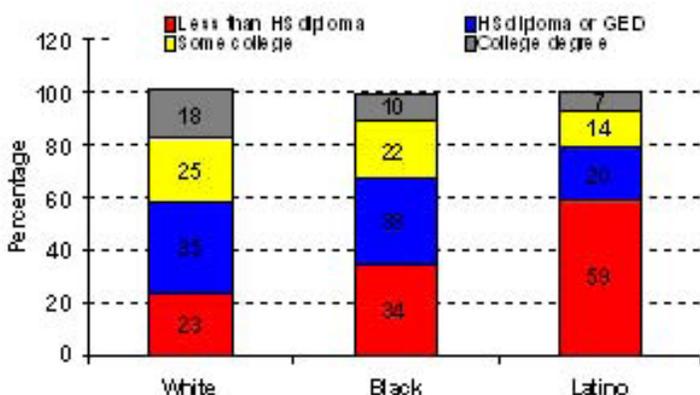
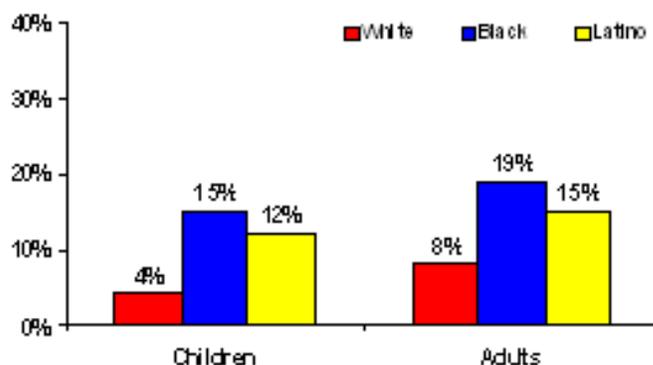


Figure 4. Persons living in poverty within population subgroups, Arkansas, 2000



5, nearly half of those individuals were born outside the US. Overall, the US Census Bureau has estimated, using Census 2000 data that approximately 3% of Arkansas residents were born outside the US. Of those foreign-born residents, approximately half were relatively recent immigrants, having entered the country in the period 1990 to 2000. In fact, within the group of foreign-born Arkansas residents, the majority born in Latin America and Africa had immigrated within the most recent decade, and nearly half of those born in Asia had immigrated in that decade as well.

Blacks who were born in another country were more likely to be naturalized citizens at the time of Census 2000 than their white counterparts. Latinos born outside the US were substantially less likely to be US citizens, with only 17% reporting themselves to be naturalized citizens. This may reflect, to a large extent, the youth of the group as well as the recent increase in Latino immigration into the state.

Decade of entry into US, by area of birth, Arkansas residents born outside US

	Latin America		
	Asia	Africa	
1990 – 2000	65%	46%	53%
1980 – 1989	25%	28%	23%
Before 1980	10%	26%	24%

US Census Bureau, 2000 Census

Figure 5. Place of birth within population subgroups, Arkansas, 2000

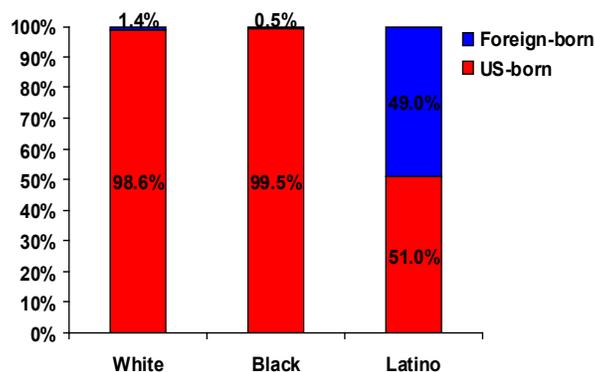
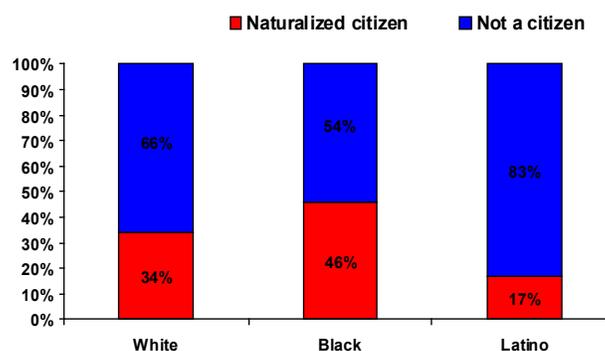


Figure 6. Citizenship status among foreign-born individuals, within population subgroups, Arkansas, 2000



SUMMARY OF RACIAL/ETHNIC GROUP HEALTH STATUS

Unless otherwise specified, all rates are crude rates per 100,000 population.

	Objective	Goal	White	Black	Latino
	ACCESS TO CARE				
1.1	Increase the proportion of people with health insurance	100%	83%	74%	39%
1.4	Increase the proportion of persons who have a specific source of ongoing care.	96%	77%	72%	45%
1.13	Increase the number of Tribes, States, and the District of Columbia with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring.	100%	No	No	No
	CANCER				
3.1	Reduce the overall cancer death rate	159.9	201.4	254.3	95.7
3.2	Reduce the lung cancer rate	44.9	70.4	73.6	13.0
3.3	Reduce the breast cancer rate	22.3	23.2	32.8	11.4
3.4	Reduce the death rate from cancer of the uterine cervix	2.0	2.8	7.8	0
3.5	Reduce the death rate from colorectal cancer	13.9	17.7	25.8	7.7
3.7	Reduce the prostate cancer death rate	28.8	23.7	63.3	17.5
3.11	Increase the proportion of women who receive a Pap test				
	Ever received	97%	95%	91%	DSU
	Within past 3 years	90%	82%	84%	DSU
3.12	Increase the proportion of adults who receive a colorectal cancer screening examination				
	Fecal occult blood test within past 2 years	50%	23%	26%	DSU
	Sigmoidoscopy ever	50%	55%	40%	DSU
	DIABETES				
5.5	Reduce the diabetes death rate	45.0	23.6	52.9	21.7
5.12	Increase the proportion of adults with diabetes who have an HbA1c measurement at least once a year	50%	84%	82%	73%
5.13	Increase the proportion of adults with diabetes who have an annual dilated eye exam	75%	64%	56%	48%
5.14	Increase the proportion of adults with diabetes who have at least an annual foot examination	75%	61%	71%	41%
5.17	Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once a day	60%	60%	63%	58%
	FAMILY PLANNING				
9.1	Increase the proportion of pregnancies that are planned	70%	56%	30%	62%
9.2	Reduce the proportion of births occurring within 24 months of a previous birth	6%	15%	19%	15%
9.7	Reduce births among adolescent females (births per 1000 teens)	10.0	21.3	44.0	71.1
9.9	Increase the proportion of adolescents who have never engaged in sexual intercourse				

■ meets or exceeds national target
■ within 15% away from national target
■ more than 15% away from national target

SUMMARY OF RACIAL/ETHNIC GROUP HEALTH STATUS

Unless otherwise specified, all rates are crude rates per 100,000 population.

	Objective	Goal	White	Black	Latino
	Females	75%	52%	61%	DSU
	Males	75%	49%	DSU	DSU
	HEART DISEASE				
12.1	Reduce coronary heart disease deaths	166.0	165.1	211.8	47.7
12.7	Reduce stroke deaths	48.0	54.6	91.7	13.7
12.15	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	80%	70%	62%	46%
	HIV				
13.14	Reduce deaths from HIV infection	0.7	2.0	10.8	2.5
	INJURY				
15.3	Reduce firearm-related deaths	4.1	10.1	4.8	3.6
15.13	Reduce deaths caused by unintentional injuries	17.5	47.7	45.2	37.0
15.14	Reduce deaths caused by motor vehicle crashes	9.2	25.8	19.1	24.8
15.27	Reduce deaths from falls	3.0	4.9	3.5	2.7
	MATERNAL, INFANT & CHILD HEALTH				
16.1	Reduce infant deaths (per 1000 live births)	4.5	6.6	14.7	6.8
16.2	Reduce the rate of child deaths				
	Ages 1-4 years	18.6	48.9	42.4	46.0
	Ages 5-9 years	12.3	20.3	26.1	0
16.3	Reduced deaths of adolescents and young adults				
	Ages 10-14 years	16.8	18.4	22.3	8.4
	Ages 15-19 years	39.8	93.7	103.7	90.7
	Ages 20-24 years	49.0	131.8	192.7	151.6
16.6	Increase the proportion of pregnant women who receive early prenatal care	90%	75%	65%	64%
16.11	Reduce preterm births	7.6%	11%	14%	13%
16.17	Increase abstinence from alcohol, <u>cigarettes</u> , and illicit drugs during pregnancy	99%	73%	87%	98%
	NUTRITION				
19.1	Increase the proportion of adults who are at a healthy weight	60%	37%	26%	DSU
19.2	Reduce the proportion of adults who are obese	15%	26%	37%	19%
19.3	Reduce the proportion of children and adolescents who are overweight or obese	15%	36%	41%	46%

■ meets or exceeds national target
 ■ within 15% away from national target
 ■ more than 15% away from national target

SUMMARY OF RACIAL/ETHNIC GROUP HEALTH STATUS

Unless otherwise specified, all rates are crude rates per 100,000 population.

	Objective	Goal	White	Black	Latino
	ORAL HEALTH				
21.1	Reduce the proportion of children who have caries experience	42%	44%	55%	61%
21.2	Reduce the proportion of children with untreated dental decay	21%	22%	24%	32%
21.3	Increase the proportion of adults who never had a tooth extracted because of dental caries or periodontal disease	42%	48%	36%	58%
21.4	Reduce the proportion of adults who have had all their teeth extracted	20%	22%	DSU	DSU
21.8	Increase the proportion of children who have received dental sealants on their molar teeth	50%	23%	10%	12%
	PHYSICAL ACTIVITY				
22.1	Reduce the proportion of adults who engage in no leisure-time activity	20%	27%	36%	38%
22.2	Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day	30%	46%	43%	40%
22.6	Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days	35%	59%	51%	DSU
22.9	Increase the proportion of adolescents who participate in daily school physical education	50%	29%	23%	DSU
	TOBACCO USE				
27.1	Reduce tobacco use by adults				
	Cigarette smoking	12%	23%	23%	23%
	Spit tobacco	0.4%	7%	4%	DSU
	Cigars	1.2%	5%	4%	DSU
27.2	Reduce tobacco use by adolescents				
	Cigarettes	16%	30%	12%	DSU
	Spit tobacco	1%	16%	6%	DSU
	Cigars	8%	17%	16%	DSU
27.5	Increase smoking cessation attempts by adult smokers	75%	54%	DSU	DSU
27.6	Increase tobacco use cessation attempts by adolescents	84%	61%	DSU	DSU

■ meets or exceeds national target
■ within 15% away from national target
■ more than 15% away from national target

These data highlight important differences among groups in achievement of national health goals. Of the 60 goals that are being monitored for disparities, 93 percent (56) have data for two or more groups. Just under half of those 56 goals with data that allow for monitoring of disparities (24 goals, 43%) showed differences among groups in terms of goal achievement.

The tables presented in the sections that follow summarize disparities across population subgroups in a more detailed manner. Values for each group are presented in numerical form in the appropriate box.

In addition, the standing of the group relative to the national target is indicated by the color of the box:

- Green – meets or exceeds target
- Yellow – approaching target (group value within 15% of target value)
- Red – not approaching target (group value more than 15% from national target in undesirable direction)

This color-coding provides for a rapid visual assessment of disparities among groups relative to a predetermined target.

The same color coding is used in the title box beginning each section to characterize the state’s overall standing on those indicators. Detailed information about the state’s status is presented in Appendix A.

In addition, it may be important to identify the population subgroups within the state experiencing the greatest challenges in particular goal areas. For each goal, the group(s) with the greatest difference from the target are indicated by stars within the box. Again, this provides for a rapid visual targeting of the group(s) at highest risk within each goal area

ACCESS TO CARE

1.1. Increase the proportion of persons with health insurance. Target: 100%

White	Black	Latino
83%	74%	***39%***

Year, Data Source: 2006 Behavioral Risk Factor Surveillance Survey

1.4. Increase the proportion of persons who have a specific source of ongoing care. Target: 96%

White	Black	Latino
77%	72%	***45%***

Year, Data Source: 2006 Behavioral Risk Factor Surveillance Survey

In the area of access to quality, affordable health care, the most striking disparities are found between Latino and non-Latino groups. Latinos are much less likely to have either health insurance or a specific source of ongoing care than non-Latino Whites or Blacks. This may be, in part, to differences in age and occupation among groups, since the Latino population in Arkansas is overall much younger than either the White or Black populations and are more often employed in migrant farming, construction, landscaping, or other industries that are less likely to offer health insurance as an employment benefit.

PROGRAM EFFORTS

The Arkansas Department of Health (ADH) offers clinical preventive health services in a number of areas to ensure that all Arkansas citizens have access to affordable health care. Local health units are located in each county to provide family planning, immunization, infection control, nutrition counseling, prenatal care, and other important services. Further, ADH works collaboratively with health care providers and third party payers throughout the state – e.g., Medicaid, the Arkansas Medical Society, the Arkansas Hospital Association, the Arkansas Children’s Hospital, and many others -- to effect policy and practices throughout the state so that all Arkansans can access to high quality preventive and interventional health care when they need it.

The Health Connections Branch of the ADH Center for Health Advancement actively works to link Arkansans who are low income, disabled or live in rural communities to health care by providing educational materials and 24-hour telephone support. Materials and telephone support are available in both English and Spanish and are developed and monitored for cultural appropriateness. The program works under contract to the state’s Medicaid program to provide support services to Medicaid and ARKids (SCHIP) recipients, helping to ensure that each program participant has a medical home, obtains age-appropriate immunizations, receives helpful health promotion information, and develops the skills necessary to interact effectively with the healthcare system.

During the 2007 legislative session the ADH worked with partners throughout the state in an attempt to secure passage of legislation that would have established a comprehensive trauma system for the citizens of Arkansas. The initiative attained broad, bipartisan conceptual support from the legislature but groups were not able to agree on a funding mechanism and, thus, the legislation failed. Efforts continue to find an acceptable funding source so that the legislation may be successfully enacted in the next legislative session (2009).

CANCER



3.1. Reduce the overall cancer death rate.
Target: 159.9 deaths per 100,000 population.

White	Black	Latino
201.4	***254.3***	95.7

Year, Data Source: 2005, ADH Health Statistics Branch

3.2. Reduce the lung cancer death rate.
Target: 44.9 deaths per 100,000 population.

White	Black	Latino
70.4	73.6	13.0

Year, Data Source: 2005, ADH Health Statistics Branch

3.3. Reduce the breast cancer death rate.
Target: 22.3 deaths per 100,000 population.

White	Black	Latino
23.2	***32.8***	11.4

Year, Data Source: 2005, ADH Health Statistics Branch

3.4. Reduce the death rate from cancer of the uterine cervix.
Target: 2.0 deaths per 100,000 population.

White	Black	Latino
2.8	***7.8***	0.0

Year, Data Source: 2005, ADH Health Statistics Branch

3.5. Reduce the death rate from colorectal cancer.

Target: 13.9 deaths per 100,000 population

White	Black	Latino
17.7	***25.8***	7.7

Year, Data Source: 2005, ADH Health Statistics Branch

3.7. Reduce the prostate cancer death rate.

Target: 28.8 deaths per 100,000 males

White	Black	Latino
23.7	***63.3***	17.5

Year, Data Source: 2005, ADH Health Statistics Branch

3.11. Increase the proportion of women (18 years and older) who receive a Pap test.

Target: Ever received: 97%
Within past 3 years: 90%

	White	Black	Latino
Ever	95%	91%	DSU
Within 3 years	82%	84%	DSU

Year, Data Source: 2005, Behavioral Risk Factor Surveillance Survey

3.12 Increase the proportion of adults (50 years and older) who receive a colorectal cancer screening examination.

Target: Fecal Occult Blood Test within past 2 years: 50%
Sigmoidoscopy ever: 50%

	White	Black	Latino
FOBT	23%	26%	DSU
Sigmoidoscopy	55%	***40%***	DSU

Year, Data Source: 2005, Behavioral Risk Factor Surveillance Survey

Substantial and important disparities are noted among racial/ethnic subgroups of the population in the area of cancer. Rates and proportions among the Latino population exceed targets (in the preferred/positive direction) for each of the mortality indicators, perhaps because, as noted above, the population tends to be younger than other subgroups. However, mortality rates for Blacks are higher than those for their White counterparts for all cancers combined and for each of the specific cancers. Mortality rates among Blacks are 26 percent higher for all cancers combined and more than 40 percent higher for breast and colorectal cancers, compared to rates among Whites. Further, mortality rates for cervical cancer and prostate cancer among Blacks are nearly 3 times the rates for Whites.

Interestingly, the proportions of Arkansas adults who reported receiving cancer screenings (Pap tests and mammograms for women; fecal occult blood tests for both genders) were not substantially different for Black and White groups, but Blacks were much less likely to report having had a sigmoidoscopy than their White counterparts.

PROGRAM EFFORTS

The Comprehensive Cancer Control Section provides a framework for action to reduce the burden of cancer in Arkansas. The Section's target population is all citizens that are affected by cancer, with special emphasis on the underserved residents of the state. Those underserved populations include racial/ethnic minority groups as well as those living in poverty. An emphasis is placed on partnering with other public and private health and healthcare entities to achieve goals in the areas of: public education and awareness; early detection, treatment and support; professional education and practice; and evaluation and cancer surveillance.

A primary focus of the Arkansas Cancer Coalition (ARCC) is the elimination of health disparities

in the area of cancer prevention, treatment and control. The Disparities Workgroup assists in planning and completing activities such as the Minority Cancer Awareness Week and works to ensure that the elimination of disparities is a focus area for the annual Arkansas Cancer Summit. In 2007, the Summit includes a focus on reducing the cancer burden among disadvantaged populations. The Prostate Cancer Workgroup partners with the Arkansas Prostate Cancer Foundation to promote the Campaign against Prostate Cancer, targeting 13 counties in the Mississippi Delta region of the state.

The ARCC is also a partner in the Colorectal Demonstration Project, which is designed to screen underinsured and un-insured Arkansans for colorectal cancer and ensure follow-up and treatment as necessary for those who screen positive.

BreastCare provides free screening, diagnosis and treatment services for breast and cervical cancer to women forty and over who are low-income, with special emphasis on reaching identified populations, including: uninsured or under-insured; geographically or culturally isolated; older; medically underserved; racial, ethnic, or cultural minorities, including American Indians, Alaska Natives, Blacks/African-Americans, Latinos, Asian-Americans, Pacific Islanders, lesbians, and women with disabilities. The program has established memoranda of agreement with community-based partners to assist in reaching the targeted populations. These partners work together to develop, implement, and evaluate strategies to promote breast and cervical cancer prevention and early detection, to increase access to necessary services, and to improve the quality and timeliness of the services. Grassroots programs, such as the Witness Project, Esperanza y Vida and Pink Carnation Sunday, focus on community outreach and awareness.

DIABETES



5.5. Reduce the diabetes death rate.
Target: 45 deaths per 100,000 population
Target: 100%

White	Black	Latino
23.6	*** 52.9***	21.7

Year, Data Source: 2005, ADH Health Statistics Branch

5.12. Increase the proportion of adults with diabetes who have an HbA1c measurement at least once a year.
Target: 50%

White	Black	Latino
84%	82%	***73%***

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

5.13. Increase the proportion of adults with diabetes who have an annual dilated eye exam.
Target: 75%

White	Black	Latino
64%	56%	***48%***

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

5.14. Increase the proportion of adults with diabetes who have at least an annual foot examination.
Target: 75%

White	Black	Latino
61%	71%	***41%***

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

5.17. Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once a day. Target: 60%

White	Black	Latino
60%	63%	58%

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

In the area of diabetes there are important differences between among racial/ethnic groups. Diabetes mortality rates for Blacks are more than twice the rates among either Whites or Hispanic/ Latinos. However, in terms of disease management and the prevention of complications, Latinos comprise the high risk group. It is important to note that the proportion of adults with diabetes who report that they have an HbA1c measurement at least annually and the proportion who report that they monitor their own blood glucose at least once daily are both above the national target for all three population subgroups, though Latinos show the lowest proportions of the three groups.

PROGRAM EFFORTS

The ADH Diabetes and Prevention Control program seeks to assess and reduce the burden of diabetes and its complications in Arkansas. Given the increased risk of developing diabetes seen among racial/ethnic minority populations and the greater incidence of complications among those groups, the program works to ensure that racial/ethnic minority populations (specifically, Blacks and Latinos) are included in all program activities. The program emphasizes secondary prevention among persons with diabetes, promoting regular patient and professional monitoring of blood glucose levels, regular foot examinations by both healthcare professionals and patients, and annual dilated eye exams. Specific activities to address minority issues and reduce disease disparities have included a media campaign completed annually in the Mississippi

Delta region of Arkansas using television and radio media to increase awareness of diabetes among minorities, encourage screening and diagnosis, and promote primary and secondary prevention strategies. Further, because Blacks are more likely to develop complications due to diabetes, particularly foot ulcers, the LEAP (Lower Extremity Amputation Prevention) program has been implemented throughout the state and particularly in those regions with greater proportions of Blacks. This educational program targets health care providers and emphasizes foot examinations, both professional and self exams, for early identification and treatment of potentially threatening lesions.

FAMILY PLANNING

- 9.1. Increase the proportion of pregnancies that are intended.**
Target: 70%

White	Black	Latino
56%	***30%***	62%

Year, Data Source: 2005, ADH Health Statistics Branch

- 9.2. Reduce the proportion of births occurring within 24 months of a previous birth.**
Target: 6%

White	Black	Latino
15%	***19%***	15%

Year, Data Source: 2005, ADH Health Statistics Branch

- 9.7. Reduce pregnancies among adolescent females (ages 15-17).**
Target: 10.0 births per 1000 teens

White	Black	Latino
21.3	44.0	***71.1***

Year, Data Source: 2005, ADH Health Statistics Branch

- 9.9. Increase the proportion of adolescents who have never engaged in sexual intercourse.**
Target: Females: 75%
Males: 75%

White	Black	Latino
52%	61%	DSU
49%	DSU	DSU

Year, Data Source: 2005, Youth Risk Behavior Survey

These data indicate disparities among population subgroups in the area of family planning. The proportion of planned pregnancies is lowest among Blacks and the proportion of births that occur within 24 months of the previous birth is highest among that subgroup. In addition, the teen birth rate among Black girls is nearly twice the rate among Whites. However, the proportion of female adolescents who report sexual abstinence is lowest among Whites.

PROGRAM EFFORTS

To address these gaps, the Abstinence Education Program within the ADH Child and Adolescent Health Section promotes and facilitates sexual abstinence until marriage. The program supports abstinence education for adolescents, youth and young adults from ages 12 to 29 years statewide, through grants awarded to local schools, communities, and faith-based organizations. The ADH Office of Minority Health and Health Disparities is heavily involved in these activities. The program reaches out to community-based organizations that want to teach abstinence until marriage, reduce high teen pregnancy rates, and have the capacity to administer the program and provides them with funding (as available), consultation and technical assistance, and evaluation.

In addition, local health units in each of the state's 75 counties provide family planning and maternity services to anyone who makes such a request. Family planning clinics serve as a "portal of entry" to the health care system for women of reproductive age, particularly for women who may not have the resources to access the private health care system. Comprehensive health assessments help identify acute and chronic illnesses and refer affected women to local providers for further care. These clinics are designed to serve low income women and have a streamlined process for eligibility determination for the Medicaid Family Planning Waiver.

HEART DISEASE



12.1. Reduce coronary heart disease deaths. Target: 166 deaths per 100,000 population

White	Black	Latino
165.1	*** 211.8***	47.7

Year, Data Source: 2005, ADH Health Statistics Branch

12.7. Reduce stroke deaths. Target: 48 deaths per 100,000 population

White	Black	Latino
54.6	***91.7***	13.7

Year, Data Source: 2005, ADH Health Statistics Branch

12.15. Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years. Target: 80%

White	Black	Latino
70%	62%	***46%***

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

Compared to other states, Arkansas has one of the highest heart disease mortality rates and the highest stroke mortality rate in the nation. Data suggest important disparities among population subgroups as well. Heart disease mortality rates among Blacks are more than 25 percent higher, and stroke mortality rates for the group are nearly 70 percent higher than among Whites. Similarly, the proportion of Blacks having a cholesterol check within 5 years is lower than the proportion

among their white counterparts, and the proportion among Latinos is the lowest among the three groups.

PROGRAM EFFORTS

The mission of the ADH Heart Disease and Stroke Prevention (HDSP) Section is to reduce the burden of heart disease and stroke and disabilities associated with these diseases. In all of the program's activities, eliminating disparities in access to and quality of care is a primary focus. Strategies include activities to control high blood pressure and cholesterol, improve emergency response, increase knowledge of the warning signs of heart attacks and stroke, and improve quality of care delivered to all Arkansans. Target audiences for the HDSP program include women, older adults, and Blacks, particularly those groups living in underserved areas of the state. Sites for activities include health care delivery sites, worksites, and communities. Interventions include professional and public education, culturally appropriate health education materials, health fairs, media campaigns, and community grants.

The Heart Disease and Stroke Prevention (HDSP) programs of Arkansas, Alabama, Louisiana, Mississippi and Tennessee have recently received collective funding by the CDC for the Delta States Stroke Network (DSSN). As the lead state, the Arkansas Department of Health's Chronic Disease Branch is responsible for managing these activities for the next 3 years. The primary goal of the DSSN is to increase collaborations across the five states – all of which feature high rates of stroke mortality and stroke risk factors – to combat the stroke problem in the region at a systems and policy level. The Network will assess the strengths and needs within the healthcare system and develop a Regional Stroke Action Plan to deal with identified problems, including disparities in access to and quality of care.

HIV

Program provides education and training on HIV transmission, ways to avoid infection, federal regulations regarding HIV in the workplace and education on federally-required counseling.

13.14. Reduce deaths from HIV infection. Target: 0.7 deaths per 100,000 population

White	Black	Latino
2.0	***10.8***	2.5

Year, Data Source: 2005, ADH Health Statistics Branch

Some of the most striking disparities among subgroups occur in the area of HIV/AIDS deaths. HIV death rates among Blacks are more than 5 times the rates for Whites and are 15 times higher than the national target.

PROGRAM EFFORTS

The HIV/STD (sexually transmitted disease) program assures provision of testing, counseling, education, referral and partner notification assistance for patients who have or may have HIV and STDs. Working with community-based organizations, the program conducts targeted testing of high-risk populations. In addition, the program provides funding for community-based organizations to support medical management and case management services, including reimbursement for physician services, insurance co-payments, mental health/substance abuse assessment, laboratory monitoring, dental care, vision care, transportation, and nutritional supplements. Medications for eligible patients are made available through the AIDS Drug Assistance Program (ADAP), and the Housing Opportunities for People With AIDS (HOPWA) program provides accessible housing and support services statewide for low-income individuals infected with HIV. The HIV Prevention

INJURY

15.3. Reduce firearm-related deaths.
Target: 4.1 deaths per 100,000 population

White	Black	Latino
10.1	4.8	3.6

Year, Data Source: 2005, ADH Health Statistics Branch

15.13. Reduce deaths caused by unintentional injuries.
Target: 17.5 deaths per 100,000 population

White	Black	Latino
47.7	45.2	37.0

Year, Data Source: 2005, ADH Health Statistics Branch

15.14. Reduce deaths caused by motor vehicle crashes.
Target: 9.2 deaths per 100,000 population

White	Black	Latino
25.8	19.1	***24.8***

Year, Data Source: 2005, ADH Health Statistics Branch

15.27. Reduce deaths from falls.
Target: 3.0 deaths per 100,000 population

White	Black	Latino
4.9	3.5	2.7

Year, Data Source: 2005, ADH Health Statistics Branch

In the area of injury, mortality rates are highest among Whites for each of the four goals. Disparities are most notable in firearm-related deaths, where rates among Whites are nearly 3 times the rates among Blacks. Mortality rates for motor vehicle crashes and falls are between 35 and 40 percent higher among Whites compared to Blacks, and are similarly high among Latinos.

PROGRAM EFFORTS

The ADH Injury Prevention and Control Branch has been instrumental in working with state and local partners and legislative champions to secure the passage of essential injury-prevention legislation in the state. These legislative initiatives include: a primary seatbelt law; legislation to establish and fund a comprehensive trauma system within the state; a graduated drivers' license law; legislation requiring motorcycle helmets; and other legislation to promote the safe use of all-terrain vehicles. These legislative efforts would help protect all individuals within the state and, thus, assist in reducing disparities associated with injuries of various types.

In addition, the Branch is working with community partners – in particular, local fire departments -- to install smoke detectors in low-income homes. Counties with the highest fire mortality rates are targeted for inclusion in the program.

MATERNAL, INFANT, CHILD HEALTH



16.1. Reduce infant deaths (within 1 year of life).
Target: 4.5 deaths per 1000 live births

White	Black	Latino
6.6	***14.7***	6.8

Year, Data Source: 2005, ADH Health Statistics Branch

16.2. Reduce rate of child deaths.
Target:
ages 1 - 4 years: 18.6 deaths per 100,000
ages 5 - 9 years: 12.3 deaths per 100,000

	White	Black	Latino
Ages 1 – 4 years	***48.9***	42.4	46.0
Ages 5 – 9 years	20.3	***26.1***	0

Year, Data Source: 2005, ADH Health Statistics Branch

16.3. Reduce deaths of adolescents and young adults.
Target: ages 10-14 years: 16.8
ages 15-19 years: 39.8
ages 20-24 years: 49.0

	White	Black	Latino
Ages 10 – 14 years	18.4	***22.3***	8.4
Ages 15 – 19 years	93.7	***103.7***	90.7
Ages 20 – 24 years	131.8	***192.7***	151.6

Year, Data Source: 2005, ADH Health Statistics Branch

16.6. Increase the proportion of pregnant women who receive early and adequate prenatal care.
Target: 90% of all live births

White	Black	Latino
75%	***65%***	***64%***

Year, Data Source: 2005, ADH Health Statistics Branch

16.11. Reduce preterm births.
Target: 7.6 percent of all live births

White	Black	Latino
11%	***14%***	***13%***

Year, Data Source: 2005, ADH Health Statistics Branch

16.17. Increase abstinence from alcohol, cigarettes, and illicit drugs during pregnancy.
Target: Cigarettes 99%

White	Black	Latino
73%	87%	98%

Year, Data Source: 2005, ADH Health Statistics Branch

Arkansas' mortality rates for infants, children, adolescents, and young adults show evidence of substantial disparities among racial/ethnic groups. Blacks have higher rates of mortality in 5 of the 6 age groups; the single exception was among children ages 1 to 4 years, where mortality rates were highest among Whites. Blacks also evidenced the highest proportion of preterm births and lower proportions of women receiving early (first trimester) prenatal care. Rates of death for children (ages 5-9 and 10-14 years) were lowest among Latinos and abstinence from cigarette use during pregnancy was striking among this group (98%). However, the proportion of Latino women receiving early prenatal care was low and the proportion of preterm births in this group was relatively higher.

PROGRAM EFFORTS

The Family Health Branch, the Office of Minority Health and Health Disparities, and the Immunizations Section within the ADH have a number of ongoing initiatives designed to promote health overall and reduce disparities. These initiatives include:

- **Sudden Infant Death Syndrome (SIDS) Program.** State law requires that all suspected SIDS occurrences be reported to the Arkansas Department of Health. The families of all infants under the age of one year who die of SIDS are offered a home visit by public health nurses, who provide information about SIDS and support groups that may be helpful to families.
- **Newborn Hearing Program.** The Newborn Hearing Program serves as a liaison to birthing hospitals for training and technical assistance for their newborn hearing screening programs. Program activities include media campaigns to promote awareness, distribution of educational materials (in English and Spanish) to physicians and parents, and the preparation and distribution of a Resource Guide for parents of children with a diagnosed hearing loss.
- **Newborn Screening Program.** Newborn screening is required for every newborn in the state of Arkansas. Laboratory specimens are analyzed in the Arkansas Public Health Laboratory, and the number of conditions assessed has recently increased from 6 to 29, with newly-screened conditions including cystic fibrosis, congenital adrenal hyperplasia, biotinidase deficiency, and a number of disorders classified as organic acid, fatty acid, or amino acid disorders. Prenatal counseling concerning birth defects is provided in local health unit maternity clinics, and follow-up counseling is offered to all parents of infants with positive screening results.
- **Immunizations.** The purpose of the Immunization Section is to protect Arkansas citizens of all ages against vaccine-preventable diseases. The Section places a special emphasis on age-appropriate immunization of children under the age of 24 months and on increasing immunization rates among high risk populations, including Blacks (who consistently evidence lower rates of adult immunization). Influenza vaccination clinics are offered seasonally each year by the local health units, and childhood immunizations are offered free of charge throughout the year.
- **Maternity services.** Pregnancy testing is available in all local health units in all counties. Women with positive pregnancy tests are referred to community-based providers or to a local health unit in their area offering prenatal services. Maternity services are provided through the Perinatal Program in local health units in 57 of the 75 counties in the state. These clinics diagnose pregnancy, initial prenatal care, assess the patient for Medicaid eligibility, and determine the presence of any pregnancy risk conditions that require immediate referral to a physician. Health units do not perform obstetrical deliveries, so all pregnant women plan their deliveries with a local physician or hospital.
- **High risk maternity referral.** ADH participates in the ANGELS program, which is administered by the Obstetrics Department of the University of Arkansas for Medical Sciences. This program develops evidence-based guidelines for obstetricians and clinics all across the state regarding early identification of high risk conditions in pregnancy, and appropriate referral of those women to specialty and subspecialty medical care.
- **Coordinated School Health Program.** The Coordinated School Health Program is a collaborative effort involving the ADH, the

Department of Education, and local school cooperatives and districts. The initiative supports school wellness committees and school nurses in efforts to assess their student populations for important health issues and to develop school policy to prevent illness and maintain health. Coordinated School Health brings special emphasis to issues such as smoking cessation, better nutrition, increased physical activity, early identification and access to care for chronic health problems among school children, particularly those most at risk for disease.

- Tobacco Cessation for Pregnant Women.** Family planning and prenatal services provided within the local health units include counseling about smoking cessation during pregnancy. In addition, the Tobacco Prevention and Control Branch is active in increasing media efforts in rural areas and in directing media campaigns to minority populations. The Stamp-Out-Smoking Quitline offers cessation assistance to all Arkansans who wish to stop smoking, including pregnant women.

NUTRITION

- 19.1. Increase the proportion of adults who are at a healthy weight.**
Target: 60%

White	Black	Latino
37%	***26%***	DSU

Year, Data Source: 2006 Behavioral Risk Factor Surveillance Survey

- 19.2. Reduce the proportion of adults who are obese.**
Target: 15%

White	Black	Latino
26%	***37%***	19%

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

- 19.3. Reduce the proportion of children and adolescents (ages 6-19) who are overweight or obese.**
Target: 15%

White	Black	Latino
36%	41%	***46%***

Year, Data Source: 2006, Arkansas Center for Health Improvement

Selected goals in the area of nutrition focus on the proportion of Arkansas children, youth, and adults who are overweight or obese. Proportions are highest among black children, youth, and adults; proportions of overweight or obese children are also relatively higher among Latinos.

PROGRAM EFFORTS

Activities designed to help Arkansans of all ages achieve and maintain a healthy weight are included in a number of specific programs throughout the ADH, including: Nutrition/Women, Infants, and Children (WIC) Branch; Child and Adolescent Health Branch; the Nutrition and Physical Activity program, within the Lifestage Health Branch; and Cancer, Heart Disease and Stroke Prevention, and Diabetes Control and Prevention, within the Chronic Disease Branch

Of particular importance, the mission of the Nutrition/WIC Branch is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients, assessing nutritional risk and providing nutrition education and counseling as appropriate, and providing referrals to other health and social services that may benefit the family. WIC is designed to have maximum impact on child development in the most critical periods of growth: pregnancy, infancy, and early childhood. Pregnant, breastfeeding and postpartum women, infants, and children under the age of 5 are eligible to participate in the program if they are living in Arkansas and meet income eligibility requirements (185% of federal poverty guidelines).

The Healthy Employees Lifestyle Program (HELP) was initiated by the ADH Nutrition and Physical Activity program to encourage employees within the Departments of Health and Human Services to exercise regularly, eat a healthy diet, abstain from tobacco use, and get age-appropriate health screenings as recommended by their physicians. This simple, web-based program – based on educational messages, web-based entry of individual lifestyle activity, and incentives -- was so successful that it is now being offered to employees of other state agencies.

ORAL HEALTH



21.1. Reduce the proportion of children and adolescents who have caries experience in their primary or permanent teeth.
Target: 42% (ages 6-8)

White	Black	Latino
44%	55%	***61%***

Year, Data Source: 2004-2006, ADH Oral Health Branch

21.2. Reduce the proportion of children and adolescents with untreated dental decay.
Target: 21% (ages 6-8)

White	Black	Latino
22%	24%	***32%***

Year, Data Source: 2004-2006, ADH Oral Health Branch

21.3. Increase the proportion of adults who never had a tooth extracted because of dental caries or periodontal disease.
Target: 42%

White	Black	Latino
48%	*** 36% ***	58%

Year, Data Source: 2004-2006, Behavioral Risk Factor Surveillance Survey

21.4. Reduce the proportion of adults (ages 65+) who have had all their teeth extracted.
Target: 20%

White	Black	Latino
22%	DSU	DSU

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

21.8. Increase the proportion of children who have received dental sealants on their molar teeth.
Target: 50% (age 8)

White	Black	Latino
23%	*** 10% ***	*** 12% ***

Year, Data Source: 2006, ADH Oral Health Branch

Data about the oral health of population subgroups suggest that Blacks and Latinos are at greater risk of having poor oral health than Whites. Among adults of all ages, tooth extraction because of decay or disease is more common among Blacks. Data are not available to assess disparities among groups with regard to the proportion of adults age 65 years and older who have had all teeth extracted. Among children, Latino children are most likely to show evidence of current or previous caries, and to have current untreated dental decay. Both Black and Latino children are less likely to have dental sealants than are White children.

PROGRAM EFFORTS

The overall goal of ADH’s Oral Health program is to ensure accessible, comprehensive and culturally-appropriate community-based oral health care, educational opportunities throughout life that allow individuals to make better decisions about their oral health; and informed and compassionate policy decisions at all levels of government to promote oral health for all Arkansans. The programs sponsored by the Office of Oral Health are population-based (e.g., community water fluoridation), designed to benefit all citizens and particularly those who are most reliant on community (rather than private) services. The dental sealant program targets children in lower socioeconomic groups, who most often are Black or Latino.

PHYSICAL ACTIVITY



22.1. Reduce the proportion of adults who engage in no leisure-time activity.
Target: 20%

White	Black	Latino
27%	*** 36% ***	*** 38% ***

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

22.2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day.
Target: 30%

White	Black	Latino
46%	43%	40%

Year, Data Source: 2005, Behavioral Risk Factor Surveillance Survey

22.6. Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
Target: 35%

White	Black	Latino
59%	51%	DSU

Year, Data Source: 2005, Youth Risk Behavior Survey

22.9. Increase the proportion of adolescents who participate in daily school physical education.
Target: 50%

White	Black	Latino
29%	*** 23% ***	DSU

Data Source: Youth Risk Behavior Survey

In terms of physical activity, Blacks show the greatest disparity compared to other groups. Black adults are more likely to physically inactive (less likely to engage in leisure time activity, less likely to engage in regular physical activity); Latino adults are similarly inactive, compared to Whites. Proportions of Black adolescents who report engaging in regular physical activity are lower than proportions among White adolescents and Black adolescents are less likely to report participating in daily physical education in school than are their White counterparts.

PROGRAM EFFORTS

The Lifestage Health Branch administers two key programs that show promise in reducing disparities. Both programs target older adults. First, the Peer Exercise Program Promotes Independence (PEPPI) program is an evidence-based peer-led physical activity program available in senior centers across the state. In the coming year, the program will be expanded to churches and community centers in neighborhoods where the burden of chronic illness is high and access to healthcare is low.

Second, the branch is partnering with the Area Agencies on Aging to implement the Chronic Disease Self-Management Program (CDSMP) in two regions of the state: Northwest, with its rapidly growing minority populations; and the rural Southwest. CDSMP is a workshop where people with different chronic diseases attend together to learn the skills needed in the day-to-day management of treatment and to maintain and/or increase life's activities. Physical activity, including appropriate exercise for maintaining and improving strength, flexibility, and endurance, is a featured component of the program.

TOBACCO USE



27.1. Reduce tobacco use by adults.

Target: Cigarette smoking 12.0%
Spit tobacco 0.4%
Cigars 1.2%

	White	Black	Latino
Cigarettes	23%	23%	23%
Spit tobacco	***6%***	4%	DSU
Cigars	***5%***	4%	DSU

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey; 2004, Adult Tobacco Survey

27.2 Reduce tobacco use (past month) by adolescents.

Target: Cigarettes 16%
Spit tobacco 1%
Cigars 8%

	White	Black	Latino
Cigarettes	***30%***	12%	DSU
Spit tobacco	***16%***	6%	DSU
Cigars	17%	16%	DSU

Year, Data Source: 2005, Youth Risk Behavior Survey

27.5. Increase smoking cessation attempts by adult smokers.

Target: 75%

White	Black	Latino
54%	DSU	DSU

Year, Data Source: 2006, Behavioral Risk Factor Surveillance Survey

27.6. Increase tobacco use cessation attempts by adolescents.

Target: 84%

White	Black	Latino
61%	DSU	DSU

Year, Data Source: 2005, Youth Risk Behavior Survey

As with other goal areas, disparities are noted in tobacco use among population subgroups. While there are no real disparities among groups in terms of adult cigarette smoking, the proportion of teens reporting current cigarette smoking is higher among Whites than either Blacks or Latinos. Spit tobacco use is also most common among White adults and teens than among either of the other two subgroups.

PROGRAM EFFORTS

The mission of the Arkansas Comprehensive Tobacco Prevention and Education Program (TPEP) is to protect all Arkansans from the harmful effects of cigarette smoking and decrease the use of other tobacco products. TPEP strives to address health disparities among all age groups and minority populations by implementing culturally relevant tobacco prevention and educational programs. The Stamp Out Smoking campaign seeks to educate Arkansas residents about the dangers of tobacco use and reduce disease, disability and death related to tobacco by preventing the initiation of tobacco use among young people; promoting quitting among young people and adults; and eliminating exposure to secondhand smoke. Campaign efforts have targeted rural and Spanish-speaking populations, spit tobacco users, and, more recently, Blacks. Collaborating with community-based organizations that represent specific minority populations – e.g., La Casa, serving the Latino population – the program has developed specifically targeted community activities. For example, TPEP has: worked with the Mex-Ark Hispanic Soccer League to produce Spanish-language banners and special trashcan labels to be used at all games; identified Asian-owned businesses and worked to inform those business owners about laws regarding tobacco sales to minors; developed the “Taking Care of Your Children’s Air” campaign to encourage smoke-free homes and cars within the Vietnamese community.

SUMMARY

PATTERNS AND TRENDS IN DISPARITIES

Patterns in Disparities

A review of the tables above reveals patterns in disparities within domains being monitored. Typically one population subgroup is lower than other groups within a domain, though the most disparate group varies across domains. The chart below summarizes the patterns.

Domain	Whites	Blacks	Latinos
Access to Care			2 of 2
Cancer		9 of 9	
Diabetes			3 of 5
Family Planning		2 of 4	
Heart Disease		2 of 3	
HIV		1 of 1	
Injury	4 of 4		
Maternal, Infant, Child Health		7 of 9	
Nutrition		2 of 3	
Oral Health		3 of 5	3 of 5
Physical Activity		3 of 4	
Tobacco	4 of 6		

Blacks are the dominant disparity group in seven of 12 domains being monitored; Whites and Latinos are each dominant in two domains. For one domain (oral health) Blacks and Latinos share the disparity dominance.

Trends in Disparities

The data presented above have been cross-sectional in nature; that is, disparities have been considered within a single year – the most recent

year for which data are available. To answer the question “Have disparities been reduced over time?” we investigated trends in disparities for Whites and Blacks for a selection of goals for which multi-year data were available. Results of this investigation, summarized in the table and sample graphs below, suggest a variable pattern. For example, the percentage of persons with health insurance is lower among Blacks than among Whites. Those percentages have decreased over time in both groups and the disparity between groups has not been substantially altered. Similarly, the proportion of adults who report engaging in regular physical activity has increased substantially in both white and black groups; in this instance, a 3-point difference between groups has been maintained, though the disparity ratio indicates that the disparity has been reduced somewhat. Most notably, in the area of smoking, the disparity between Whites and Blacks has been eliminated, with rates of smoking in both groups being equal in the most recent period. However, the reduction of the disparity is due to a significant rise in smoking rates among Blacks, which is not the preferred reason for reduction of disparity.

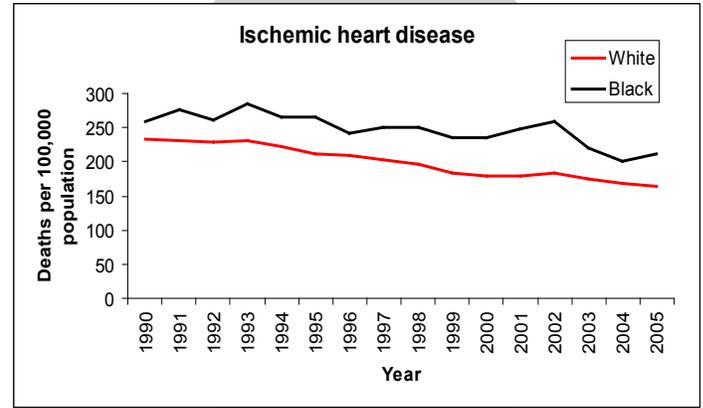
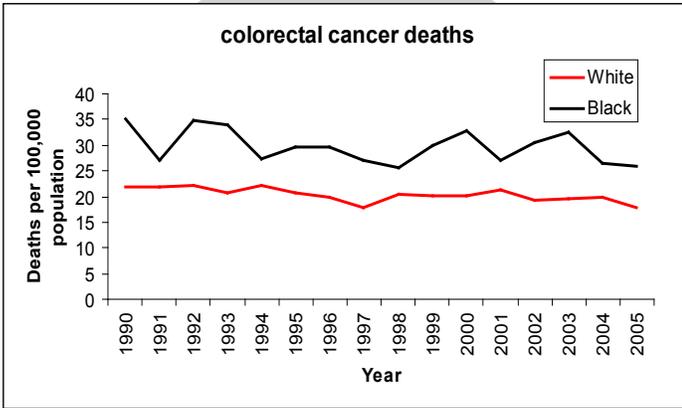
OBJECTIVE	Initial period*		Most recent period**	
	White	Black	White	Black
1.1 Increase the proportion of people with health insurance	86%	79%	83%	74%
Disparity ratio [£]	0.92		0.89	
Cancer				
3.5 Reduce the death rate from colorectal cancer [#]	21.9	35.0	17.7	25.8
Disparity ratio [£]	1.60		1.46	
Heart Disease				
12.1 Reduce coronary heart disease deaths [#]	232.7	258.5	165.1	221.8
Disparity ratio [£]	1.11		1.28	
12.7 Reduce stroke deaths [#]	82.4	127.6	54.6	91.7
Disparity ratio [£]	1.55		1.68	
Injury				
15.14 Reduce deaths caused by motor vehicle crashes [#]	26.0	28.4	25.8	19.1
Disparity ratio [£]	1.09		0.74	
Nutrition				
19.1 Increase the proportion of adults who are at a healthy weight	46%	35%	37%	26%
Disparity ratio [£]	0.76		0.70	
Physical Activity				
22.2 Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day	16%	13%	46%	43%
Disparity ratio [£]	0.81		0.93	
Tobacco Use				
27.1 Reduce cigarette smoking by adults	26%	16%	23%	23%
Disparity ratio [£]	0.62		1.0	

* Initial period = 1990 for death rates, 1995 for percentages

** Most recent period = 2005 for death rates, 2006 for percentages

£ Disparity ratio = value for Blacks divided by value for Whites

Deaths per 100,000 population

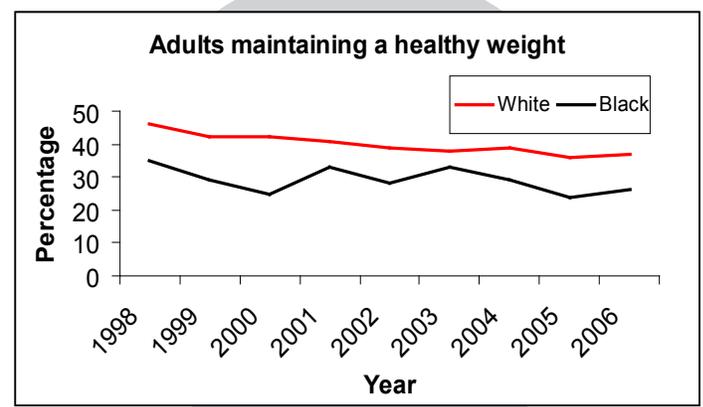
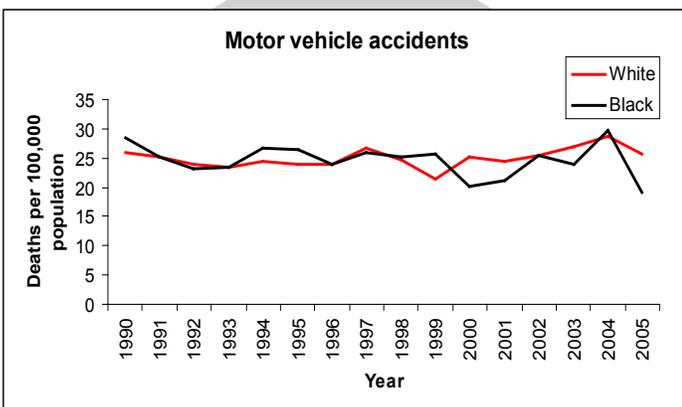


The graphs also indicate a variety of outcomes in terms of disparity reduction. For example, in 1990 rates of colorectal cancer death among Blacks were 60% higher than the rates among Whites. By 2005 rates among Blacks were 46% higher, suggesting a small reduction in disparity. The graph, however, depicts substantial variation in disparities across years, making the assessment of trend, even over the period of 15 years, difficult.

A different pattern is noted in disparities associated with heart disease mortality. Heart disease mortality rates in 1990 were 11% higher among Blacks compared to Whites. During the 15-year period, heart disease mortality rates decreased for both groups, but the disparity between groups has not been reduced. In fact, in 2005 heart disease mortality rates were 28% higher among Blacks than among Whites, indicating a somewhat greater disparity than in the initial period. The graph indicates a relatively steady decline in mortality among Whites but a more variable pattern among Blacks.

The data related to motor vehicle crash deaths suggest a reversal of the disparity, from 1990 when rates were higher among Blacks to 2005 when rates were higher among Whites. However, the graph indicates that this shift in direction of disparity has occurred several times throughout the 15-year period, making a trend difficult to assess.

Data concerning the proportion of adults maintaining a healthy weight suggest that those proportions have been reduced over time for both groups and that the disparity between groups has been slightly reduced but is still evident.



APPENDIX A

Graphs included in this section summarize the status of the Arkansas population overall in comparison to the national targets for selected Healthy People 2010 goals. Presented in the table below are the selected objectives in each category, along with the proportion or rate evident in the Arkansas population overall. The national target is specified for reference. Unless otherwise specified, all rates are per 100,000 population.

OBJECTIVE		National Target	Total Population
ACCESS TO CARE			
1.1	Increase the proportion of people with health insurance	100%	79%
1.4	Increase the proportion of persons who have a specific source of ongoing care.	96%	74%
1.13	Increase the number of Tribes, States, and the District of Columbia with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring.	Yes	No
CANCER			
3.1	Reduce the overall cancer death rate	159.9	206.1
3.2	Reduce the lung cancer rate	44.9	70.3
3.3	Reduce the breast cancer rate	22.3	24.3
3.4	Reduce the death rate from cancer of the uterine cervix	2.0	3.4
3.5	Reduce the death rate from colorectal cancer	13.9	18.6
3.7	Reduce the prostate cancer death rate	28.8	27.2
3.11	Increase the proportion of women who receive a Pap test		
	Ever received	97%	94%
	Within past 3 years	90%	81%
3.12	Increase the proportion of adults who receive a colorectal cancer screening examination		
	Fecal occult blood test within past 2 years	50%	23%
	Sigmoidoscopy ever	50%	53%
DIABETES			
5.5	Reduce the diabetes death rate	45.0	26.6
5.12	Increase the proportion of adults with diabetes who have an HbA1c measurement at least once a year	50%	82%
5.13	Increase the proportion of adults with diabetes who have an annual dilated eye exam	75%	63%
5.14	Increase the proportion of adults with diabetes who have at least an annual foot examination	75%	62%
5.17	Increase the proportion of adults with diabetes who perform self-blood-glucose-monitoring at least once a day	60%	60%
FAMILY PLANNING			
9.1	Increase the proportion of pregnancies that are planned	70%	52%
9.2	Reduce the proportion of births occurring within 24 months of a previous birth	6%	16%

■ meets or exceeds national target
■ within 15% away from national target
■ more than 15% away from national target

OBJECTIVE		National Target	Total Population
9.7	Reduce births among adolescent females (per 1,000)	10.0	28.7%
9.9	Increase the proportion of adolescents who have never engaged in sexual intercourse		
	Females	75%	54%
	Males	75%	54%
HEART DISEASE			
12.1	Reduce coronary heart disease deaths	166.0	169.3
12.7	Reduce stroke deaths	48.0	58.6
12.15	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	80%	68%
HIV			
13.14	Reduce deaths from HIV infection	0.7	3.3
INJURY			
15.3	Reduce firearm-related deaths	4.1	9.2
15.13	Reduce deaths caused by unintentional injuries	17.5	46.5
15.14	Reduce deaths caused by motor vehicle crashes	9.2	24.6
15.27	Reduce deaths from falls	3.0	4.7
MATERNAL, INFANT AND CHILD HEALTH			
16.1	Reduce infant deaths (per 1000 live births)	4.5	8.2
16.2	Reduce the rate of child deaths		
	Ages 1-4 years	18.6	47.1
	Ages 5-9 years	12.3	21.6
16.3	Reduced deaths of adolescents and young adults		
	Ages 10-14 years	16.8	20.4
	Ages 15-19 years	39.8	94.8
	Ages 20-24 years	49.0	142.1
16.6	Increase the proportion of pregnant women who receive early prenatal care	90%	72%
16.11	Reduce preterm births	7.6%	11%
16.17	Increase abstinence from alcohol, <u>cigarettes</u> , and illicit drugs during pregnancy	99%	79%

OBJECTIVE		National Target	Total Population
NUTRITION			
19.1	Increase the proportion of adults who are at a healthy weight	60%	36%
19.2	Reduce the proportion of adults who are obese	15%	27%
19.3	Reduce the proportion of children and adolescents who are overweight or obese	15%	37%
ORAL HEALTH			
21.1	Reduce the proportion of children who have caries experience	42%	60%
21.2	Reduce the proportion of children with untreated dental decay	21%	31%
21.3	Increase the proportion of adults who never had a tooth extracted because of dental caries or periodontal disease	42%	47%
21.4	Reduce the proportion of adults who have had all their teeth extracted	20%	23%
21.8	Increase the proportion of children who have received dental sealants on their molar teeth	50%	17%
PHYSICAL ACTIVITY			
22.1	Reduce the proportion of adults who engage in no leisure-time activity	20%	29%
22.2	Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes a day	30%	46%
22.6	Increase the proportion of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days	35%	56%
22.9	Increase the proportion of adolescents who participate in daily school physical education	50%	27%
TOBACCO USE			
27.1	Reduce tobacco use by adults		
	Cigarette smoking	12.0%	24%
	Spit tobacco	0.4%	6%
	Cigars	1.2%	5%
27.2	Reduce tobacco use by adolescents		
	Cigarettes	16%	26%
	Spit tobacco	1%	14%
	Cigars	8%	18%
27.5	Increase smoking cessation attempts by adult smokers	75%	55%
27.6	Increase tobacco use cessation attempts by adolescents	84%	61%
27.11	Increase smoke-free and tobacco-free environments in schools	100%	100%
27.12	Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas	100%	100%

■ meets or exceeds national target
■ within 15% away from national target
■ more than 15% away from national target

Overall, these data indicate that Arkansas has not achieved the national target value for the majority of the HP2010 goals that are being monitored (73%, 46 of 63 goals). We approach the target value for 6 (10%) of the goals, and have met or exceeded the target for 10 goals (16%). The areas of greatest success (goals met or exceeded) include:

- **Cancer**
 - Prostate cancer deaths
 - Sigmoidoscopy screening for colorectal cancer
- **Diabetes**
 - Diabetes deaths
 - At least annual HbA1c measurement
 - Daily self-blood-glucose monitoring
- **Oral health**
 - Adults with no tooth extractions
- **Physical Activity**
 - Adults who exercise regularly
 - Adolescents who exercise regularly
- **Tobacco**
 - Establishing smoke-free environments within schools
 - Establishing smoke-free worksites

- **Maternal, infant, and child health**
 - Infant deaths
 - Child deaths (ages 1-4 years)
 - Adolescent and young adult deaths (ages 15-19 and 20-24 years)
 - Adult and childhood obesity
- **Oral health**
 - Dental sealants for children
- **Physical activity**
 - Daily physical education in school for adolescents
- **Tobacco use**
 - Spit tobacco use among adults and adolescents
 - Cigar smoking among adults and adolescents

These areas were those in which the greatest discrepancies from target values were noted, but are not the only goals for which a deficiency was noted. Further, it must be cautioned that having met a target does not suggest that there is no need for further attention to that health area; rather, a new goal should be set to continue the work of improving the health of all Arkansans.

The areas of greatest need, however, included:

- **Cancer**
 - Lung cancer deaths
 - Cervical cancer deaths
 - Fecal occult blood test screening for colorectal cancer
- **Family planning**
 - Delaying subsequent pregnancy/birth for 24 months
 - Teen births
- **HIV**
 - HIV deaths
- **Injury**
 - Firearm-related deaths
 - Unintentional injury deaths
 - Motor vehicle crash deaths
 - Deaths from falls

APPENDIX B: Abbreviations, Data Sources, and Definitions

ADAP: AIDS Drug Assistance Program

ADH: Arkansas Department of Health

ADH Health Statistics Branch: That branch of the Arkansas Department of Health that is responsible for gathering and maintaining information regarding the health of citizens of the state. This branch registers birth and death certificates, marriage licenses, and divorce decrees, and collects data from hospitals concerning all admissions to hospitals in the state.

ADH Oral Health Branch: That branch of the Arkansas Department of Health that is charged with promoting and protecting the dental health of Arkansans. Personnel in the branch (including dentists, dental assistants, dental hygienists, and epidemiologists) complete surveys and dental examinations of children and adults in the state to monitor this important aspect of health.

Adult Tobacco Survey: A telephone survey of adults in the state of Arkansas that gathers information about tobacco use as well as knowledge, attitudes, and beliefs about tobacco and its health effects.

AIDS: Auto-immune deficiency syndrome, a condition in humans in which the immune system begins to fail, leading to life-threatening opportunistic infections.

ARCC: Arkansas Cancer Coalition

Behavioral Risk Factor Surveillance Survey: An annual telephone survey of adults (ages 18 and over) in Arkansas (and in other states in the country) that measures the prevalence of chronic diseases, risk factors, and behaviors.

BMI: Body mass index: A surrogate measure of body fatness expressed as weight (measured in kilograms) divided by height (measured in meters) squared.

DSSN: Delta States Stroke Network

DSU: Data statistically unreliable

FOBT: Fecal occult blood test – a test for blood in the stool (fecal matter) that can be a sign of cancer of the colon or rectum

HDSP: Heart Disease and Stroke Prevention Program

HIV: Human Immunodeficiency Virus -- a retrovirus that can lead to acquired immunodeficiency syndrome (AIDS)

HP2010 – Healthy People 2010: A set of national goals and objectives established to focus attention on health and coordinate efforts to improve health throughout the country.

Mortality rate: Death rate. Usually expressed as number of deaths occurring in every 100,000 persons

Normal weight: Neither overweight or obese (BMI < 25.0 but more than 18.5)

Overweight: BMI greater than or equal to 25.0 but less than 30.0

Obese: BMI greater than or equal to 30.0

Prevalence: The percent (proportion) of a population that has a disease or a risk factor at a given point in time.

Risk factor: A characteristic or behavior that is consistently associated with increased probability of disease or event.

SCHIP: State Children's Health Insurance Program, a federally-funded program to provide health insurance to children regardless of the parent's insurance status or employment

SIDS: Sudden Infant Death Syndrome

SOS: Stamp Out Smoking

STD: Sexually transmitted disease(s)

TPEP: Tobacco Prevention and Education Program

WIC: Women, Infants, and Children's nutrition program

Youth Risk Behavior Survey: A paper-pencil survey of randomly selected middle and high schools within the state of Arkansas (and other states) that provides information about adolescent behaviors that may put them at risk for disease or other bad health outcomes.

ENDNOTES

1. U.S. Department of Health and Human Services. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: U.S. Government Printing Office, November 2000

2. We recognize that individuals and groups may prefer alternative labels for racial/ethnic/cultural groups – i.e., Black versus African American, Hispanic versus Latino, White versus Caucasian or European American. We have chosen to use Whites, Blacks, and Latinos in this report.

3. US Census Bureau, 2000 census

4. US Census Bureau, American Community Survey

5. Data for Latinos have typically only become available within the past two to three years because of small sample sizes in that population subgroup or coding issues related to race and ethnicity variables; thus, trend comparisons are being made only for Blacks and Whites. Disparity ratios are calculated by dividing the value for Blacks by the value for Whites. The desired disparity ratio is 1.0, indicating that rates or proportions are equal for both groups.



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