

2013

Kentucky Minority Health Status Report



Kentucky Public Health

Office of Health Equity
Prevent. Promote. Protect.

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EXECUTIVE SUMMARY

The Kentucky Office of Health Equity (OHE) was established in September 2008 through funding from the United States Department of Health and Human Services (DHHS), Office of Minority Health. The Office of Health Equity addresses health disparities among racial and ethnic minorities, low-income, and geographically isolated populations in the Commonwealth. The Minority Health Status Report is a biennial report mandated by Kentucky Revised Statute (KRS 216.2929 Section 6) which states the following:

“The cabinet shall report at least biennially, no later than October 1 of each odd-numbered year, on the special health needs of the minority population in the Commonwealth as compared to the population at large. The report shall contain an overview of the health status of minority Kentuckians, shall identify the diseases and conditions experienced at disproportionate mortality and morbidity rates within the minority population, and shall make recommendations to meet the identified health needs of the minority population.”

The primary function of OHE is to promote the understanding of the root causes of these health disparities and how these root causes perpetuate health inequities at the community level. Healthy People 2020 (<http://www.healthypeople.gov/2020/default.aspx>) defines a *health disparity* as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage [1]. In addition, Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities [2].”

Historically, efforts to eliminate disparities and achieve health equity have focused primarily on the disease or illness and health care services. However, the absence of disease does not equate to good health. The Kentucky Department for Public Health is working to understand the relationship between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels and legislative policies. These factors that can influence an individual’s or population’s health are known as the social determinants of health.

EXECUTIVE SUMMARY cont.

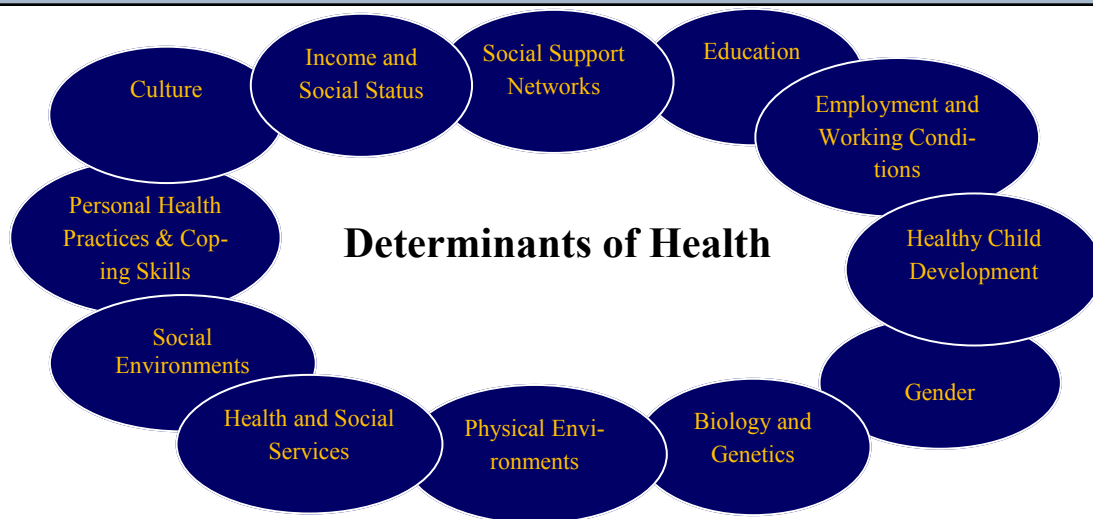


Fig 1. Social Determinants of Health

The Minority Health Status Report (MHSR) provides the most current and accurate data describing disparities that exist in the Commonwealth using multiple data sources including the Behavioral Risk Factor Surveillance System (BRFSS), American Community Survey (ACS), U.S. Census and other sentinel surveillance systems. The MHSR serves as a document that can be used to engage communities in understanding the social determinants of health and their relationship to health inequities.

This report highlights health determinants and health outcomes for minority Kentuckians in comparison to the white population. The key findings are listed below:

- Racial and ethnic minority groups in Kentucky have younger populations than their white counterparts.
- While blacks live throughout the commonwealth, the majority of Kentucky's black population lives in just two counties: Jefferson and Christian.
- With the exception of Hispanics and American Indians, over 80% of most racial ethnic groups in Kentucky have attained at least a high school education.
- Asian and white households in Kentucky are more likely to have higher incomes than Hispanic, blacks and American Indians.
- Blacks are more likely to receive mammograms and pap tests than their white counterparts.

EXECUTIVE SUMMARY

KEY FINDINGS cont.:

- Hispanics have higher colonoscopy screening rates than their white and black counterparts.
- Racial and ethnic minorities are less likely to own their own homes in Kentucky.
- Blacks and Hispanics are more likely to have no health insurance coverage in Kentucky.
- Hispanics have the highest rate of teen pregnancy; however, teen pregnancy rates for all races have declined over the past five years in Kentucky.
- Blacks in Kentucky have the highest smoking rates among all races and ethnicities.
- Cancer and heart disease are the two leading causes of death in Kentucky for all races and ethnicities.
- In general, blacks have higher cancer rates compared to whites.
- Blacks have higher infant mortality rates in Kentucky than whites.
- Blacks have the highest rates of gonorrhea, while Hispanics have the lowest rates of all reported sexually transmitted infections.
- Blacks have the highest HIV diagnosis rates in Kentucky: eight times higher than the white population and two times higher than the Hispanic population.
- Blacks have the highest prevalence of diabetes in the state of Kentucky.
- Blacks have the highest obesity rates in Kentucky.

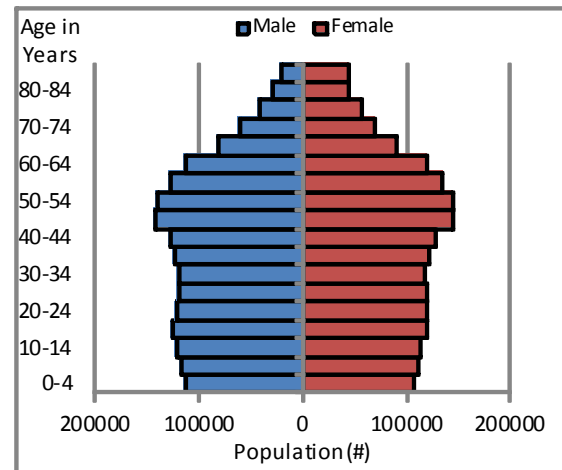
RACE AND ETHNIC DEMOGRAPHICS

According to the Kentucky State Data Center, Kentucky's largest population age groups for males and females in the white population are 45-59 years. Racial and ethnic groups have younger populations than whites. The black population in Kentucky is generally younger with peaks between ages 18-24. The Hispanic population had a greater amount of males, compared to females. Among the Hispanic population there is a drop off in density in the 10-14 age groups for the male and female populations.

3 Largest Kentucky Race / Ethnic Groups

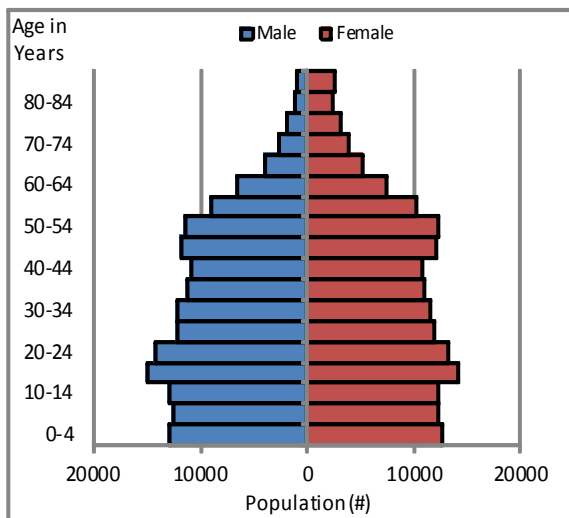
- Kentucky's white population is 3,745,655 persons or 86.3% of the total.
- Kentucky's black population is 333,075 persons or 7.7% of the total.
- Kentucky's Hispanic population is 132,836 persons or 3.1% of the total.

**Age and Population:
White, non-Hispanic, 2011**



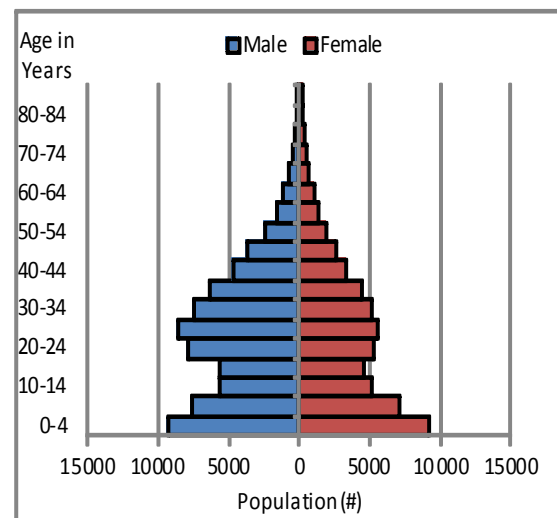
Source: Kentucky State Data Center, 2011

**Age and Population:
Black, non-Hispanic, 2011**



Source: Kentucky State Data Center, 2011

**Age and Population:
Hispanic, 2011**

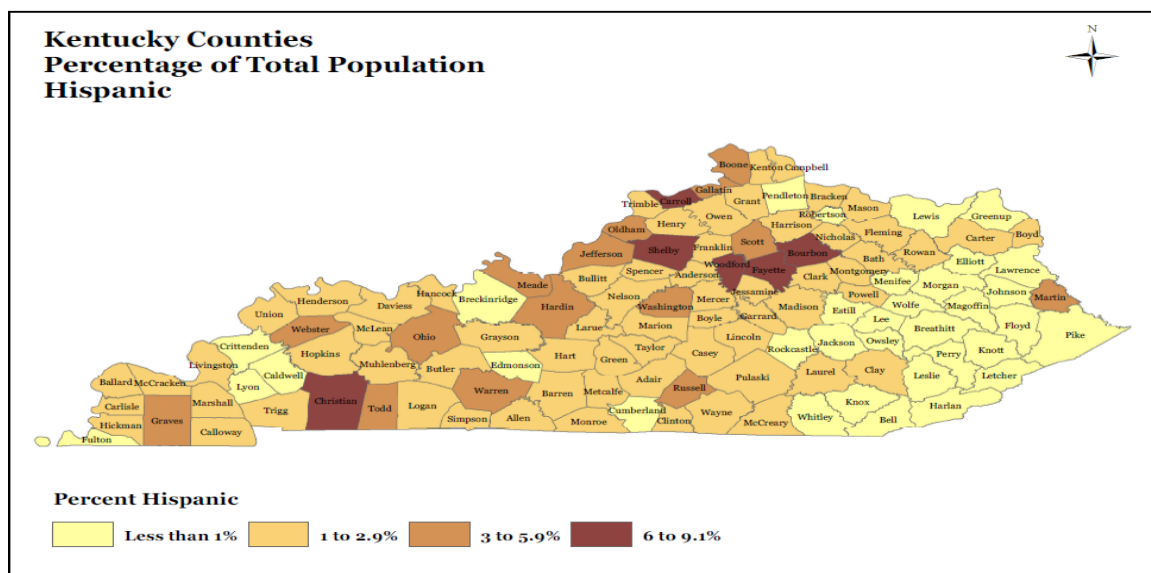
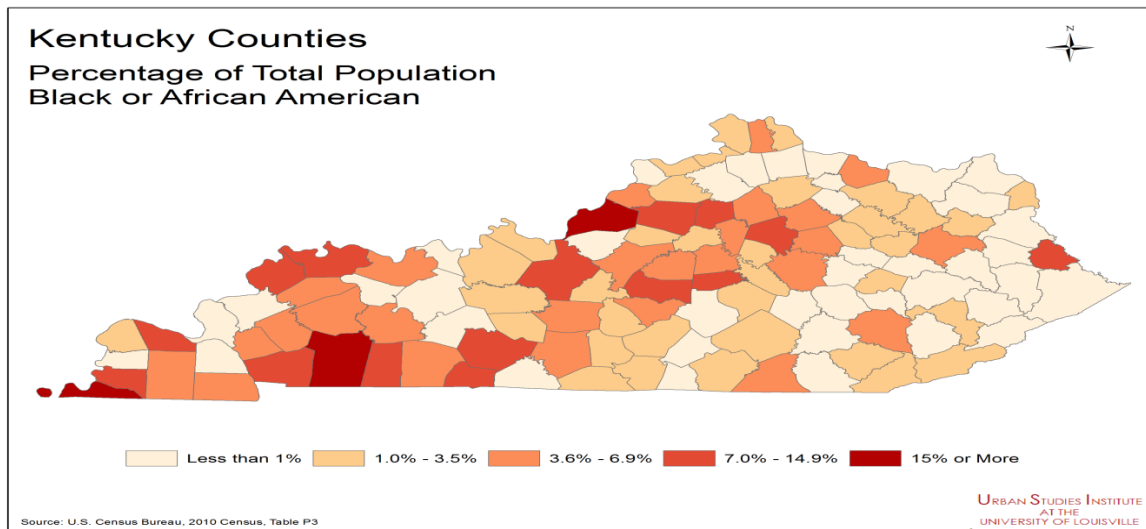


Source: Kentucky State Data Center, 2011

RACIAL AND ETHNIC DEMOGRAPHICS

Minority Populations by Counties

In 2011, a majority of the black population in Kentucky resided mainly in the Louisville area and the western and southern regions of the state. Fulton, Christian, and Jefferson counties' total populations are made up of more than 20 percent African Americans. According to the 2010 Census, much of the Hispanic population in Kentucky was located in the central and western regions of the state. Fayette, Bourbon, Christian, Woodford, Shelby, and Carroll counties had the largest percentages of Hispanic residents.



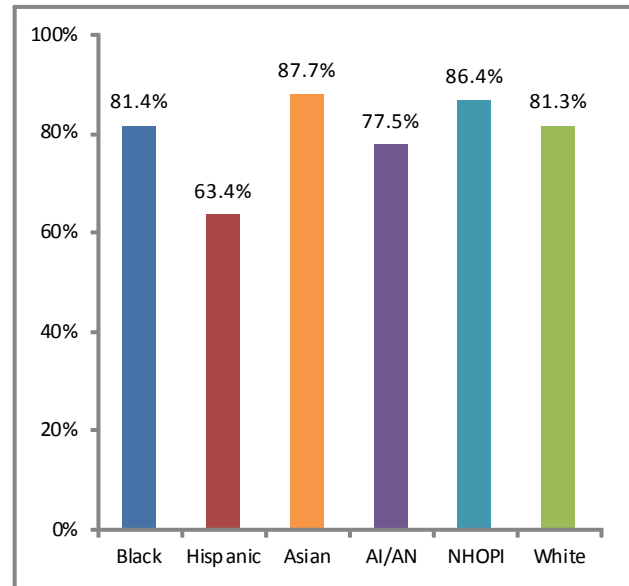
Sources: Urban Studies Institute at the University of Louisville and U.S. Census, Kentucky Behavioral Risk Factor Surveillance System

RACIAL AND ETHNIC DISPARITIES RELATED TO SOCIAL DETERMINANTS

EDUCATION

With the exception of Hispanics and American Indians, 4 out of 5 adults in most racial and ethnic groups have recorded at least a high school education. Asians have the highest percentage and Hispanics the lowest percentage of those attaining a high school education. Educational attainment has been shown to influence health decisions and further affect health outcomes. Studies from the National Institute of Health have established that education yields the strongest influence over health of any socioeconomic status indicator [3].

Percentage of Kentuckians with at Least a High School Education, by Race and Ethnicity, 2006-2010



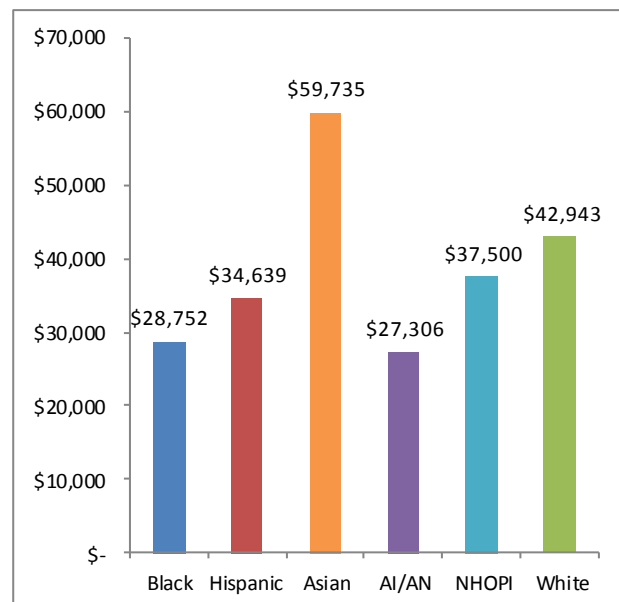
Source: U.S. Census Bureau, American Community Survey, 2006-2010, 5 year estimates.

Notes: AI/AN: American Indian/Alaska Native; NHOPI: Native Hawaiian-other-Pacific Islander

INCOME

Significant disparities exist among races and ethnicities in terms of earning power. Asian and white households are more likely to have higher incomes than Hispanics, blacks, and American Indians. Income can influence the ability to have the resources to attain and sustain optimal health.

Median Household Income in Kentucky in the Past 12 Months, by Race and Ethnicity, 2010



Source: U.S. Census Bureau, American Community Survey, 2006-2010, 5 year estimates.

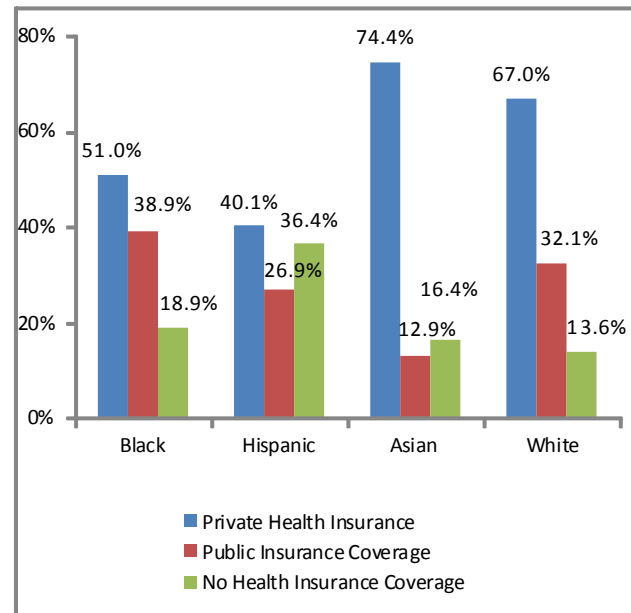
Note: AI/AN: American Indian/Alaska Native; NHOPI: Native Hawaiian-other-Pacific Islander

RACIAL AND ETHNIC DISPARITIES RELATED TO SOCIAL DETERMINANTS

INSURANCE STATUS

Blacks and Hispanics are much less likely to have health insurance coverage. Lack of health insurance coverage could result in decreased access to care for those populations. While the majority of Kentuckians have private insurance, blacks have the highest percentage of persons with public health insurance and Hispanics are least likely to be insured.

Health Insurance Coverage in Kentucky, by Race and Ethnicity, 2009-2011

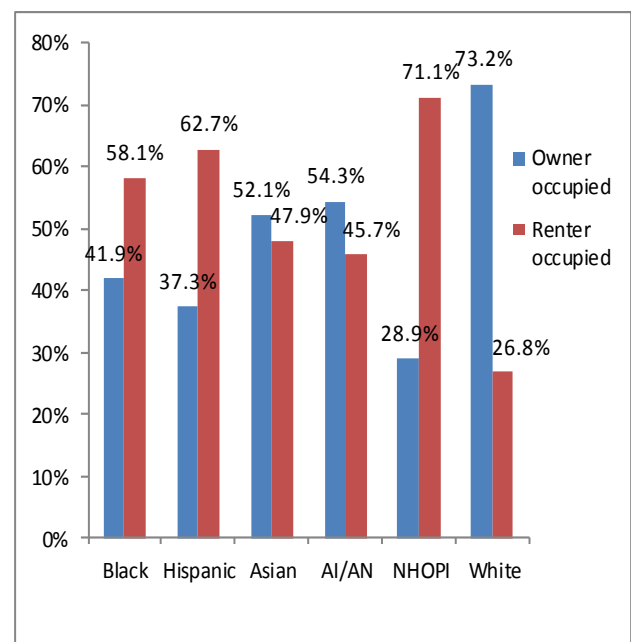


Source: 2009-2011 American Community Survey 3-Year Estimates.

HOME OWNERSHIP

This five-year collection of data shows that ethnic and racial minorities are less likely to own their own homes in Kentucky when compared to their white counterparts. Many studies have shown that homeowners generally achieve better physical and mental health outcomes than renters even when those homes were in less than desirable neighborhoods [4][5]. Researchers have postulated that homeowners experience higher levels of self-esteem, which may be related to improved health and health outcomes. Homeowners living in higher-quality housing have more freedom to adapt their surroundings to their needs, which may reduce stress and lead to greater levels of satisfaction [4][6].

Home Ownership in Kentucky, by Race and Ethnicity, 2006-2010



Source: U.S. Census Bureau, American Community Survey, 2006-2010, 5 year estimates.
AI/AN: American Indian/Alaska Native; NHOPI: Native Hawaiian-other-Pacific Islander

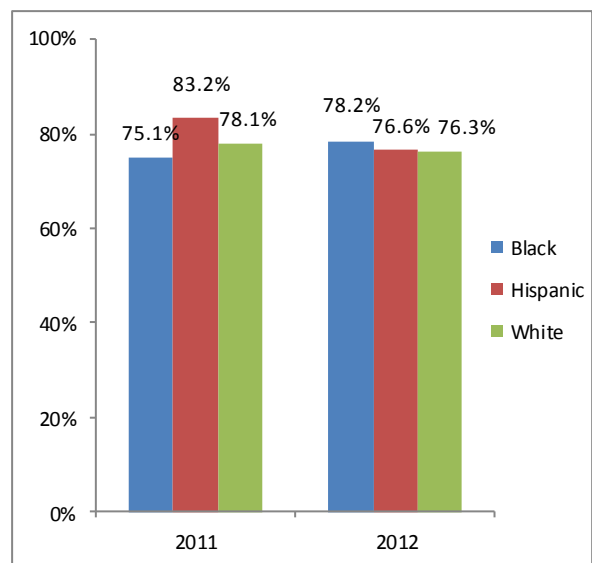
LIFESTYLE/BEHAVIORAL RISK FACTORS

Historically health behavior and lifestyle factors—smoking cigarettes, being overweight, and being physically inactive - are just a few of the risk factors that have often been cited as the major determinants of premature and preventable morbidity and mortality. Behavioral health risk factors play a major role in mortality across all races and ethnicities [7]. The results of a national 19-year prospective study of U.S. adults, looking at socioeconomic and behavioral risk factors for mortality, linked the important role that the risk behaviors of smoking and lack of physical activity play in mortality risk across all social strata [8].

GENERAL HEALTH

When looking at data for good or better health across race and ethnicity, all groups reported feeling generally good about their health. No real differences in health perception were noted between whites, blacks and Hispanics in Kentucky. However Kentucky percentages are lower when compared to demographically similar states such as Hawaii, Connecticut and Massachusetts. The Robert Wood Johnson Foundation Commission To Build a Healthier America report found that the perception of well-being of individuals and populations results in better health and longevity.

Percent of Kentucky Adults, Self-Reported Good or Better Health, by Race and Ethnicity, 2011 and 2012



Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

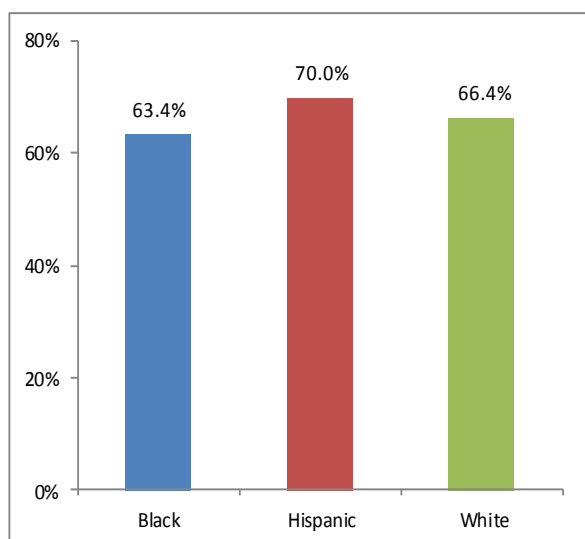
Robert Wood Johnson Foundations Commission report <http://www.commissiononhealth.org/>

LIFESTYLE/BEHAVIORAL RISK FACTORS

CLINICAL PREVENTIVE SCREENINGS

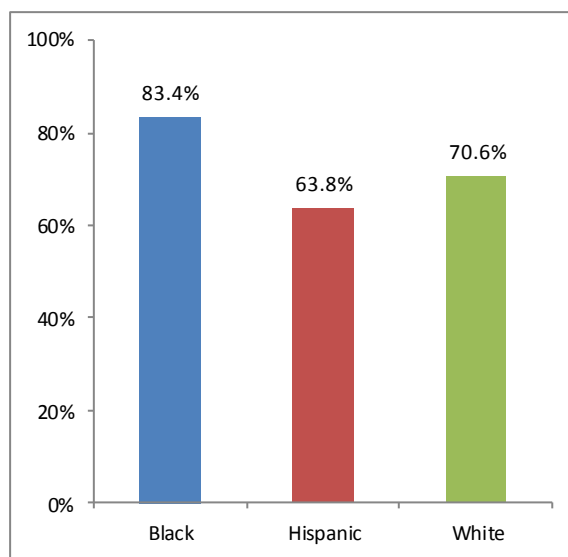
Early detection, followed by treatment and good control of a health condition, can often result in better outcomes and lower the risk of serious complications. Regular health exams and preventive screenings can help find problems before they start. Finding a problem early usually increases the chances for a better health outcome. In 2012, 66.4% of white Kentuckians aged 50 and over reported having had a colonoscopy, while 63.4% of blacks in Kentucky reported having had a sigmoidoscopy or colonoscopy. Hispanics in Kentucky had the highest rate of colon cancer screenings at 70%. According to BRFSS in 2012, 83.4% of black women in Kentucky reported receiving a mammogram compared to 70.6% of white women and 63.8% of Hispanic women. In 2012, 84.0% of black women reported getting a pap test performed within the past three years. White women in Kentucky had the lowest percentage of women receiving pap tests at 76.5%.

**Sigmoidoscopy or Colonoscopy (age 50+years),
by Race and Ethnicity, 2012**



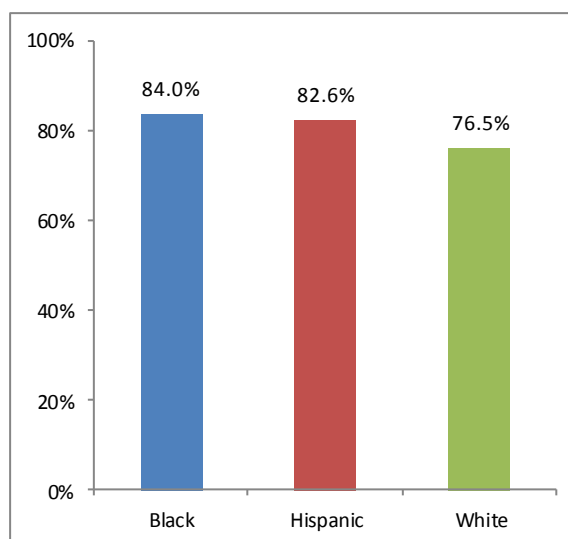
Source: Kentucky Behavioral Risk Factor Surveillance System, 2012

**Mammogram in the Past Two Years (Women age
40+years), by Race and Ethnicity, 2012**



Source: Kentucky Behavioral Risk Factor Surveillance System, 2012

**Pap Test in the Past Three Years (Women age
18+years), by Race and Ethnicity, 2012**



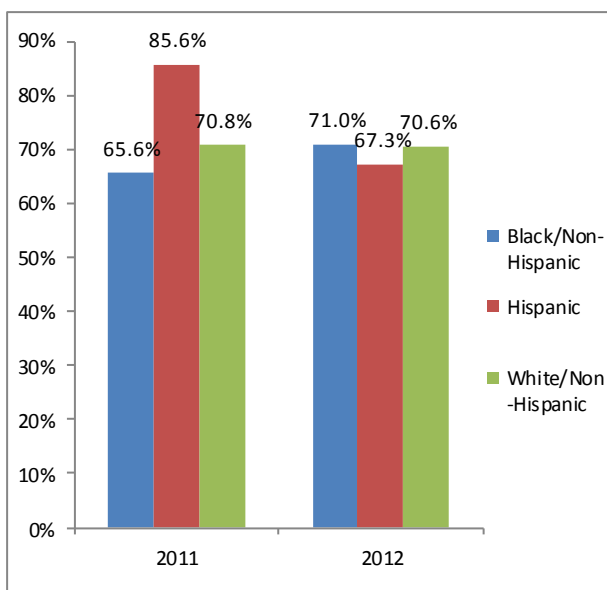
Source: Kentucky Behavioral Risk Factor Surveillance System, 2012

LIFESTYLE/BEHAVIORAL RISK FACTORS

PHYSICAL ACTIVITY

In 2011, Hispanic adults in Kentucky reported exercising most frequently within a 30 day period; 85.6%, followed by whites at 70.8% and blacks at 65.6%. However, in 2012, there was not much difference in prevalence among all racial and ethnic groups in terms of recent exercise. All three groups surveyed reported that about 70% had exercised within the past 30 days.

Kentuckians who Exercised in the Past 30 Days, by Race and Ethnicity, 2011 and 2012

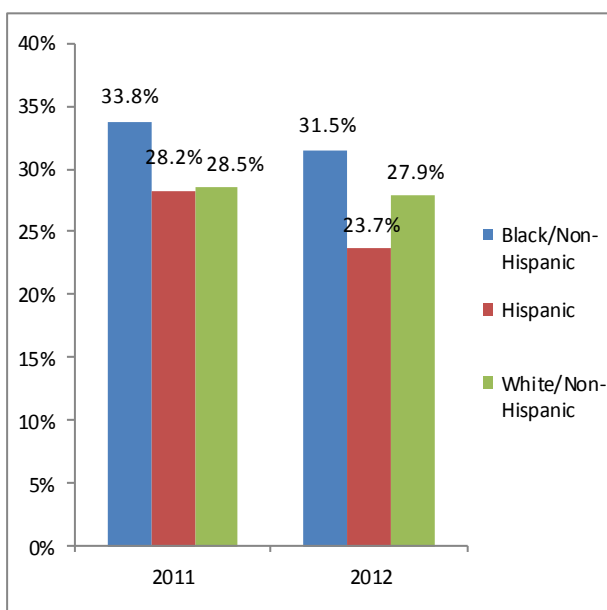


Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

TOBACCO USE

According to the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), 28.3% of Kentuckians currently smoke tobacco compared to 19.6% in the United States. In Kentucky, all racial and ethnic groups for which data are available report higher percentages of smoking tobacco than the national average. However, blacks have higher smoking rates compared to whites and Hispanics. All races and ethnicities in Kentucky reported slightly lower rates of tobacco use in 2012 than in 2011.

Tobacco Use in Kentucky Adults, by Race and Ethnicity, 2011 and 2012



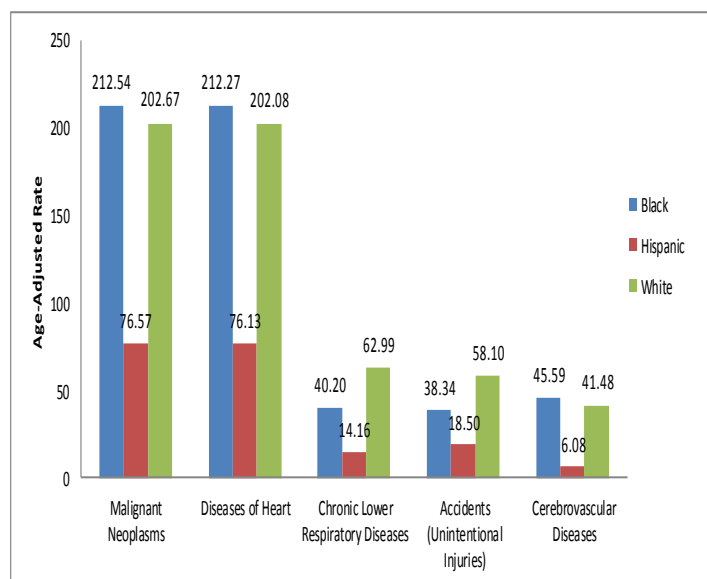
Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

HEALTH OUTCOMES

LEADING CAUSES OF DEATH

The Centers for Disease Control and Prevention (CDC) lists heart disease and cancer as the leading causes of death among whites, blacks and Hispanics. Kentucky data mirrors the national picture with cancers (malignant neoplasms) and heart disease as the two major causes of death. In 2012 blacks and whites had much higher rates of death than Hispanics. The low rates of Hispanic deaths could be attributed to the younger population of Hispanics in Kentucky.

Top Five Leading Causes of Death in Kentucky, by Race and Ethnicity, 2012*†



Source: Kentucky Department for Vital Statistics

*Death data for the year of 2012 are preliminary. Age-Adjusted Rates are per 100,000 U.S. 2000 standard population. Rates are considered unreliable when there are fewer than 20 deaths in the numerator.

†Race and Hispanic origin categories may not add up to the total number of deaths due to other racial categories that are not represented in this table. Also race and ethnicity are not mutually exclusive categories.

CANCER

Cancer is one of the state's leading causes of death for all races and ethnicities. Blacks have higher cancer rates in all cancer sites shown (colorectal, lung and bronchus, prostate, breast and cervix) compared to their whites counterparts. The cancer incidence rate among blacks in Kentucky was 529 per 100,000 from all cancer sites, while the incidence rate among whites was 522 per 100,000 during 2006-2010.

Top Cancer Incidence Rates in Kentucky, by Race, 2006-2010

Cancer Sites	KY	Black	White
All Sites	523.23	529.11	522.2
Colorectal	53.83	61.89	53.39
Lung & Bronchus	99.6	106.85	99.76
Prostate	134.58	190.76	129.19
Breast	121.29	129.35	120.9
Cervix	8.83	9.28	8.77

Source: KY Cancer Registry <http://cancer-rates.info/ky/index.php>

Note: All rates are per 100,000. Rates are age-adjusted to the 2000 U.S. Standard Million Population.

HEALTH OUTCOMES

CARDIOVASCULAR DISEASES

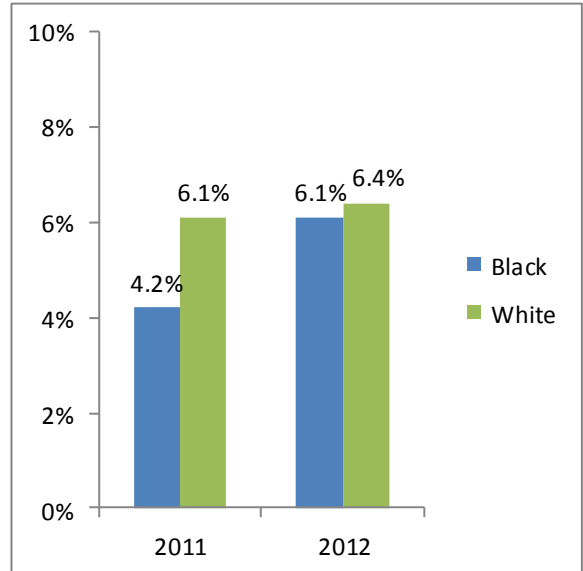
In 2011, whites had the highest prevalence of heart attacks in Kentucky at 6.1% compared to blacks at 4.2%. However in 2012, rates in Kentucky were similar across both races.

Blacks are more likely to be hospitalized for cardiovascular disease (CVD), which predisposes to heart attacks and strokes [9], than whites. The age adjusted cardiovascular disease hospitalization rates are reported for adults age 18 years or older.

In 2012, the prevalence of stroke was higher among whites in Kentucky: 4.2% of whites had had a stroke compared to 3.9% of blacks.

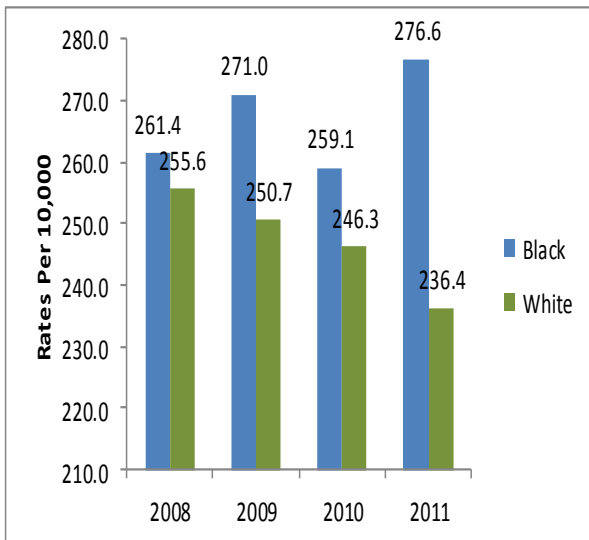
Note: Hispanics are not included in these health outcomes because the data are not statistically reliable (i.e. Relative Standard Error >0.3).

Adult Heart Attack Prevalence in Kentucky, by Race and Ethnicity, 2011-2012



Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

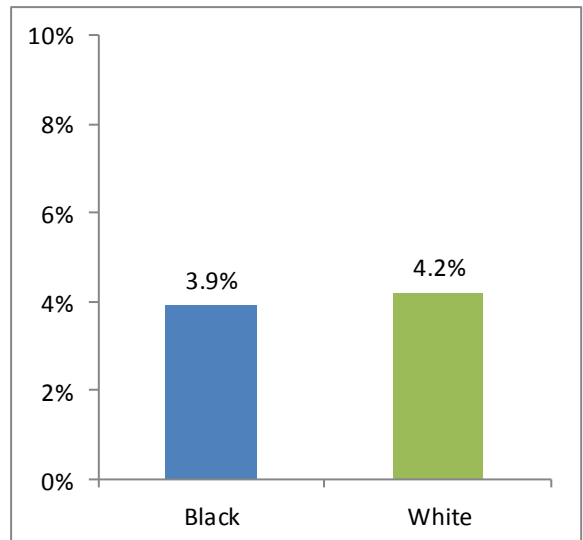
Cardiovascular Disease Age-Adjusted Hospitalization Rates, by Race and Ethnicity, 2008-2011



Source: Office of Health Policy, 2008-2011 Kentucky

Note: Rates are adjusted to the U.S. 2000 Standard population

Stroke Prevalence in Kentucky, by Race and Ethnicity, 2012



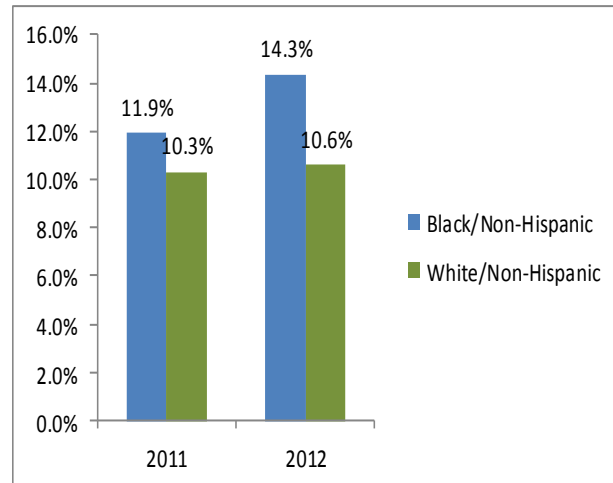
Source: Kentucky Behavioral Risk Factor Surveillance System 2012

HEALTH OUTCOMES

ASTHMA

In 2011, asthma prevalence in Kentucky was 10.5% versus 9.1% in the U.S. as a whole. In 2012 the prevalence for Kentucky was 11.1% versus 8.9% in the U.S. Blacks in Kentucky had the highest prevalence rate of asthma at 14.3% in 2012, compared to whites at 10.6%.

Current Asthma Prevalence in Kentucky, by Race, 2011 and 2012



Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

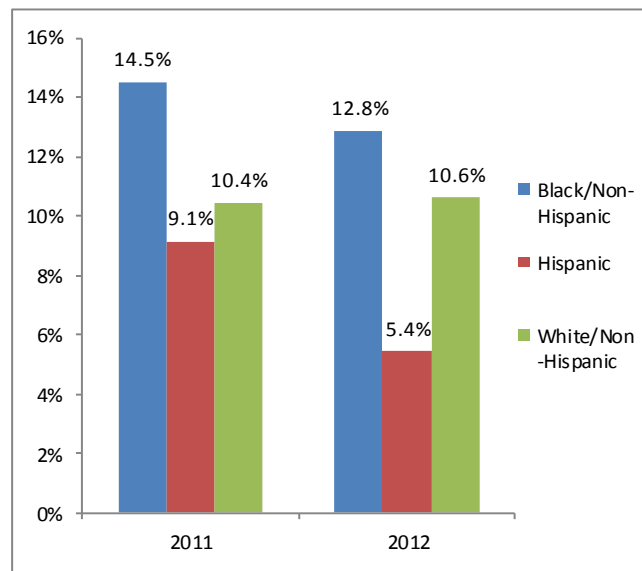
Note: Other ethnicities not available as Relative Standard Error (RSE) was >0.3.

DIABETES

The 2013 Kentucky Diabetes Burden Report lists diabetes as the 6th leading cause of death by disease in the U.S. and Kentucky. Besides leading to premature death, both type 1 and type 2 diabetes are associated with long-term complications that threaten quality of life.

In Kentucky, blacks have the highest prevalence of diabetes, 14.5% and 12.8% in 2011 and 2012 respectively. Hispanic Kentuckians have the lowest prevalence of diabetes, 9.1 % and 5.4% in 2011 and 2012 respectively.

Diabetes Prevalence in Kentucky, by Race, 2011 and 2012

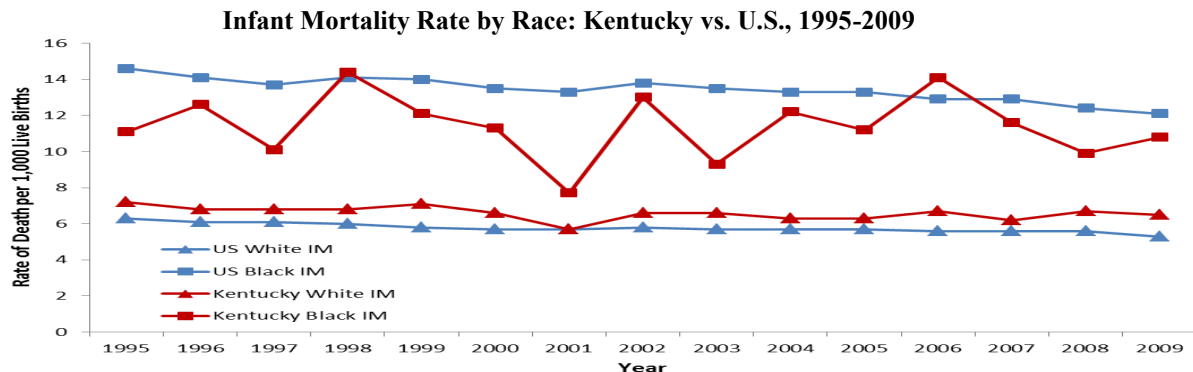


Source: 2013 Kentucky Diabetes Burden Report; <http://chfs.ky.gov/NR/rdonlyres/03F86F3B-93E2-4BEA-89C0-25DD9C1FB1FC/0/ReporttotheLRCFINAL1172013totheSecretary.pdf>

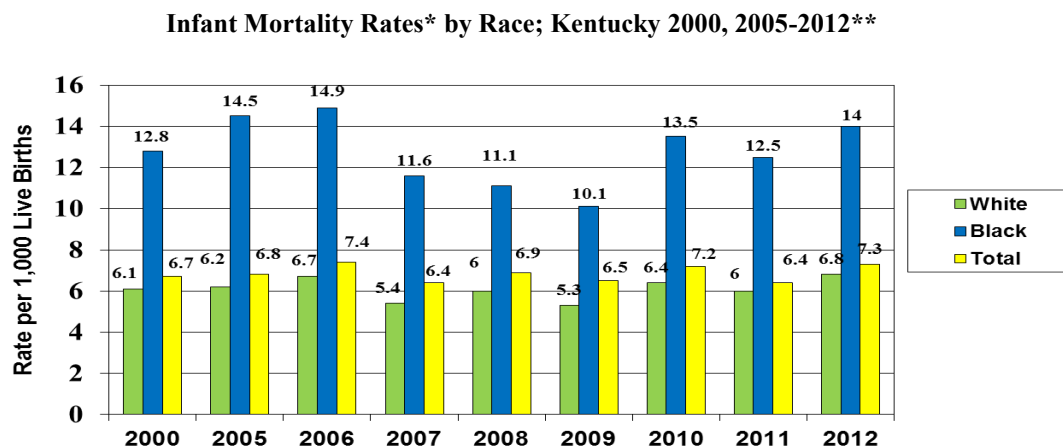
HEALTH OUTCOMES

INFANT MORTALITY

Infant mortality, which is classified as the death of a child any time during the first year of life, is an important health measure. It not only reflects the current health status of a population but also provides an indication of maternal health, quality of care, access to care, socioeconomic conditions and public health interventions. Kentucky's infant mortality rate among blacks has fluctuated over time but has been consistently higher than the rate among whites. Between 1995 and 2009, Kentucky's black infant mortality rate remained essentially the same while the nation's infant mortality rate among blacks decreased by 17%. Preliminary data from 2012 suggests an increase in the total infant mortality rate to 7.3 per 1,000 live births due to an increase in neonatal infant deaths.



Source: United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS), Linked Birth/Infant Death Records, 1995-2009 on CDC Wonder On-line Database. Accessed at <http://wonder.cdc.gov/lbd.html> on July 26, 2013



Infant death is a death occurring at any time between 0-364 days of age

*Rates are per 1,000 Live Births per specified race **2009 – 2012 data are preliminary and numbers could change

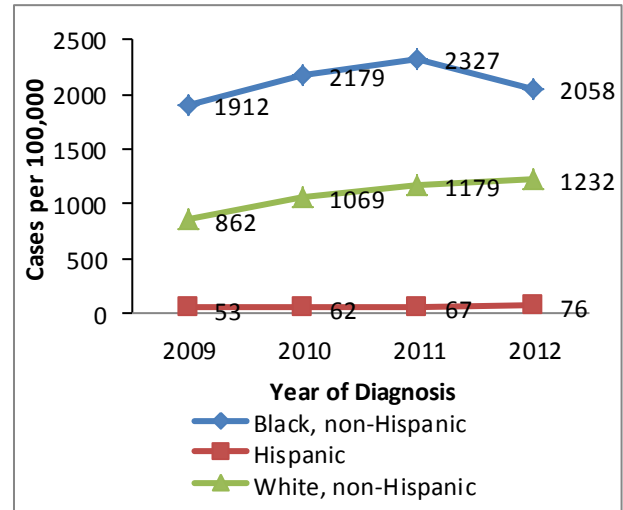
Source: Kentucky Vital Statistics Files, Death Certificate Files, & Live Birth Certificate files, Years 2000, 2005-2012; Medicaid Claims Data Warehouse, Years 2010-2012

HEALTH OUTCOMES

SEXUALLY TRANSMITTED INFECTIONS (STI)

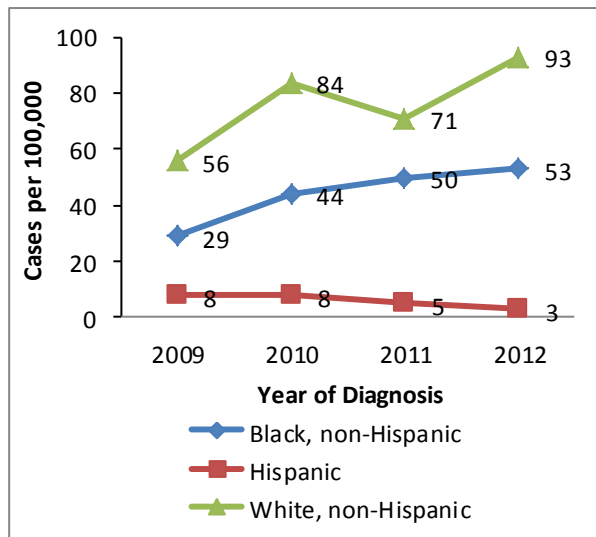
Rates of selected sexually transmitted infections (STI's) vary by disease and race and ethnicity. National data indicate that racial and ethnic minorities make up the majority of sexually transmitted infections [10]. In Kentucky, reported rates of syphilis and chlamydia are highest among whites. However, blacks have higher reported rates of gonorrhea. Hispanics have the lowest rates of all three selected sexually transmitted infections.

Gonorrhea Cases in Kentucky, by Race and Ethnicity, 2009-2012



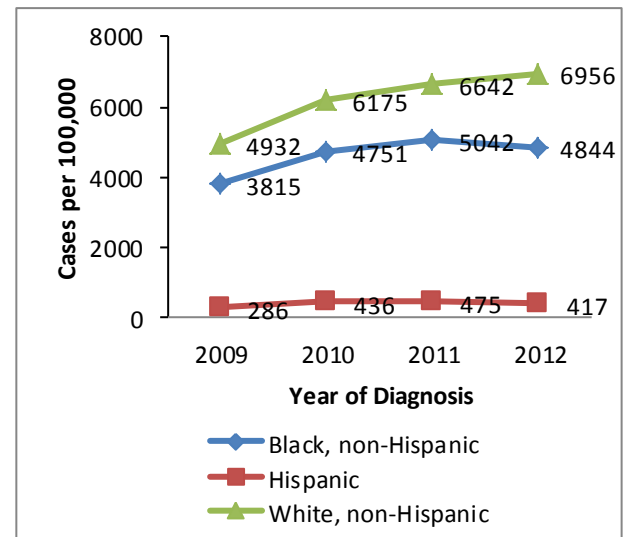
Source: Kentucky Sexually Transmitted Disease Program Data, 2009-2012

Primary and Secondary Syphilis by Race and Ethnicity 2009-2012



Source: Kentucky Sexually Transmitted Disease Program Data, 2009-2012

Chlamydia Cases in Kentucky, by Race and Ethnicity, 2009-2012



Source: Kentucky Sexually Transmitted Disease Program Data, 2009-2012

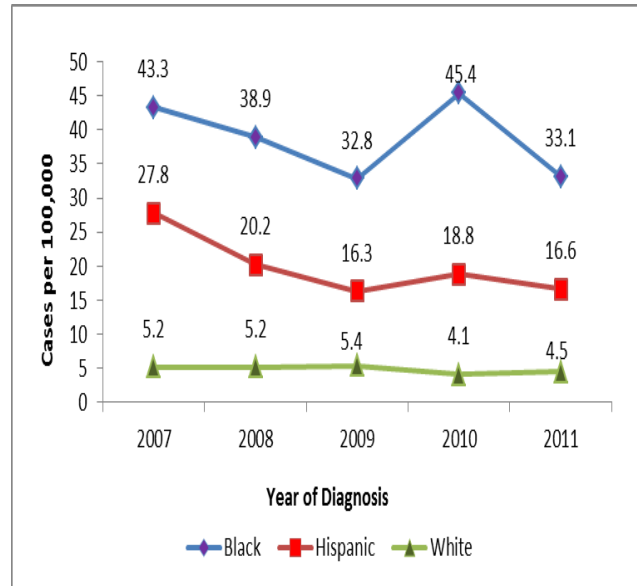
HEALTH OUTCOMES

HIV

Blacks continue to experience the heaviest burden of HIV compared with other races and ethnicities. Nationally blacks represent approximately 13.1% of the U.S. population but accounted for an estimated 46% of the new HIV diagnoses in 2011. [11]

Blacks also have the highest rates of HIV infections in Kentucky. Blacks had almost eight times higher HIV diagnosis rates than whites and rates twice those of Hispanics in 2011. Black and Hispanic rates of HIV were variable from 2007 through 2011 but have generally trended downward. HIV rates in whites stayed consistent over the 2007-2011 period.

HIV Disease Diagnosis Rates by Race and Ethnicity and Year of Diagnosis, Kentucky, 2007-2011

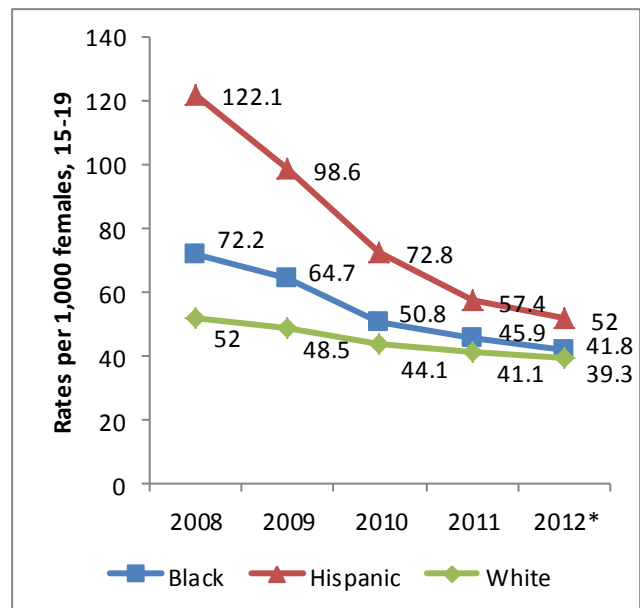


Source: Kentucky HIV/AIDS Surveillance Report: June 30, 2012

TEEN PREGNANCY

Teen pregnancy rates are declining for whites, blacks, and Hispanics in Kentucky. Though teen pregnancy rates are higher for Hispanics and blacks, rates among Hispanics have fallen considerably and at a faster pace than teen pregnancy rates have fallen among blacks and whites.

Kentucky Teen Pregnancy Rates, by Race and Ethnicity, 2008-2012



Source: Kentucky Office of Vital Statistics, 2008-2012

Note: 2012 data is preliminary data

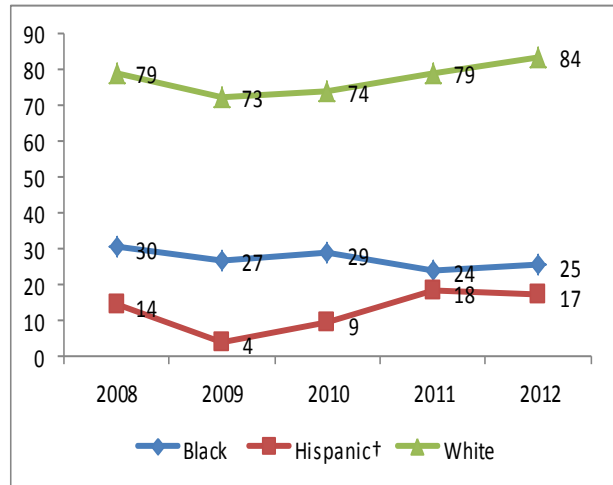
HEALTH OUTCOMES

SUICIDE

Suicide deaths in Kentucky over a five year period have remained fairly constant among all races and ethnicities. Whites have the highest numbers of suicides; Hispanics and blacks the lowest.

Suicide is used as an indicator for the status of mental health among populations maybe a helpful indicator of the adequacy of health care for mentally ill people[12].

Kentucky Suicide Deaths, by Race and Ethnicity, 2008-2012

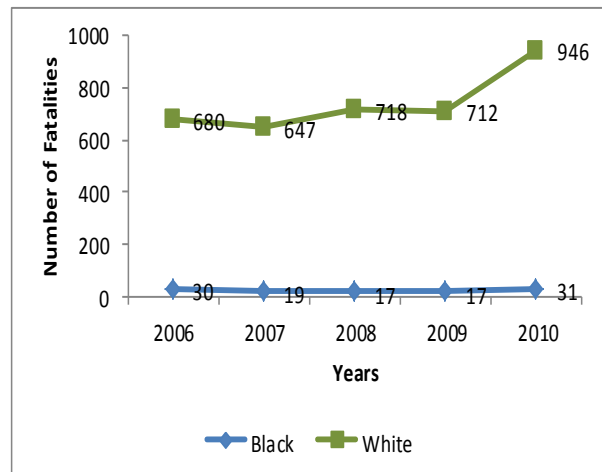


Source: Kentucky Office of Vital Statistics, 2008-2012

DRUG OVERDOSE FATALITIES

Drug overdose occurs in individuals who commonly report high levels of anxiety, depression and diagnosed mental health issues. The Epidemiologic Catchment Area studies conducted by US National Institute of Mental Health found that over half of respondents with a drug-misuse disorder also had a psychiatric disorder; most commonly major depression or anxiety [13]. Over a recent five year period the majority of the drug overdose fatalities were among white Kentucky residents.

Drug Overdose Fatalities by Race, Kentucky Residents, 2006 – 2010



Source: Kentucky Injury Prevention and Research Center, Drug overdose morbidity and mortality in Kentucky, 2000-2010

HEALTH OUTCOMES

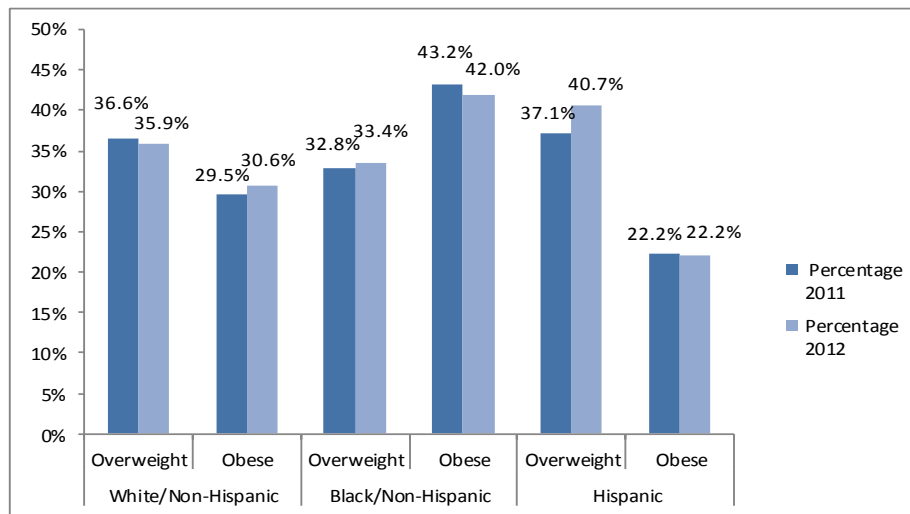
OVERWEIGHT AND OBESITY

Public health recognizes overweight and obesity, not only as chronic diseases based on International Classification of Diseases (ICD) code designations, but also as risk factors for other chronic diseases. Research has linked obesity and overweight as risk factors with reproductive and respiratory issues, as well as diabetes, heart disease, and some cancers. [14] Overweight and obesity contributes to many aspects of health by affecting multiple pathways and decreasing quality and length of life.

According to the CDC, Kentucky is one of the top 10 states with the highest rates of obesity in the nation. About one-third of U.S. adults (35.7 %) are obese and overweight. In 2012, no state had a prevalence of obesity less than 20%.

The prevalence of obesity in Kentucky in 2012 was 31.3%, one of the highest prevalence rates in the nation. Blacks in Kentucky have the highest rates of obesity. In 2012, 42% of blacks were considered obese compared to 30.6% of whites and 22.2% of Hispanics.

Overweight and Obesity Prevalence in Kentucky, by Race and Ethnicity, 2011 and 2012



Source: Kentucky Behavioral Risk Factor Surveillance System, 2011-2012

SUMMARY

Data presented in this report indicate that health disparities exist among racial and ethnic populations in the Commonwealth of Kentucky. Differences in social determinants of health across racial and ethnic lines can lead to such health disparities. In Kentucky, black and Hispanic populations are younger than the white population and are more likely to earn less, not be homeowners, and lack health insurance. However, in terms of high school graduation, blacks, Asians and whites have similar rates in reaching their educational milestones. Hispanic adults trail their counterparts in this achievement.

Interestingly, even though many health outcomes examined are worse for minority populations in Kentucky, blacks and Hispanics in the state self-report feeling similar or better about their health than their white neighbors. Black women over 40 years of age are more likely to have had preventive screenings for breast and cervical cancer than white women of the same age, while older Hispanics report the highest percentage who have received colon cancer screening with a sigmoidoscopy or colonoscopy. Blacks, Hispanics and whites in Kentucky describe similar rates of exercise and all use tobacco at a rate higher than the national average, though blacks are somewhat more likely to smoke than white and Hispanics.

Cancers and heart disease are by far the leading causes of death for all Kentuckians, regardless of race or ethnicity. But blacks generally have a higher incidence rate of cancers at all sites compared with whites in the state. Adult blacks are also more likely to have been hospitalized for cardiovascular disease. Unfortunately, infant mortality rates for blacks remain high, about twice the rates of whites.

Health outcomes associated with sexual activity also vary by race and ethnicity. Blacks in Kentucky have the highest rates of HIV and gonorrhea, though whites lead in rates of syphilis and chlamydia. While rates of teen pregnancies are still somewhat higher for blacks and Hispanics than for whites, teen pregnancies in Kentucky have decreased for all these groups, most dramatically among Hispanic teenagers.

In some behavioral health indicators, minority populations fare well compared to whites. Blacks and Hispanics are less likely to die from suicide, and drug overdose fatalities are much lower among blacks than whites in Kentucky.

However, chronic diseases hit black Kentuckians particularly hard. In addition to higher rates of cancers, blacks are more likely to have asthma, experience diabetes and be obese. Hispanics, though, have a lower prevalence of diabetes than whites.

RECOMMENDATIONS

In order to improve health for all Kentuckians, more advances are needed in specific areas that close gaps in health indicators between racial/ethnic minorities and whites. Those include not only accessible and affordable quality health care, but the reduction of systemic and physical barriers to care and increased awareness of prevention and screening for optimal health. The Office of Health Equity (OHE) in Kentucky is working to eliminate social and economic barriers to good health by focusing on efforts that go beyond the individual to influence population health. Research continues to support the theory of social determinants—where we live, learn, work, and play— as contributing factors for positive health outcomes. The social determinants of health are a foundational step in addressing the social inequities and their relationship to health outcomes. Housing, education, community planning, transportation, law, and economic development are just a few areas where partnering with public health programs could influence practices and policies which could positively impact the health of individuals, families and communities. The infusion of health equity across these social determinants could reap common goals, identify complimentary roles and foster long lasting relationships between public health and other sectors.

Increasing health care access through the Affordable Care Act is one example of a strategy to help reduce inequities. The Kentucky Health Benefit Exchange and Kentucky’s expansion of Medicaid are providing health care coverage to more working poor, men, non-pregnant women, children, single individuals, and families. This is a major step in keeping Kentuckians healthy and reducing the health disparity gaps in Kentucky.

OHE has adopted the federal Office of Minority Health’s strategies for the elimination of racial and ethnic disparities. The following recommendations are proposed to continue to eliminate health disparities and inequities among racial/ethnic groups in the state:

- Increase capacity within local communities by establishing collaboratives and partnerships to address health inequities.
- Encourage initiatives that increase social capital and resource availability within communities and reduce physical and social barriers to healthy lifestyles; e.g., increase pedestrian friendly design of neighborhoods, and increase access to and subsidization of healthy food options.

RECOMMENDATIONS

- Prioritize the commitment of eliminating health inequities by continued dialogue and allocation of resources for staff and funds to continue state and federal programming.
- Improve collection methods and surveillance of health disparities by incorporating consistent methodology for data collection on race and ethnicity as well as the new data elements required by the Affordable Care Act.
- Complement demographic and statistical data analysis with research targeting the cultural, sociological and generational implications of health disparities.
- Establish a multidisciplinary task force of policy makers, researchers, executive leadership, healthcare workers and community leaders working together in addressing the link between the social determinants and health outcomes.

While this complex issue lacks a quick solutions, fundamental changes to our health care delivery system, policies, practices, and communication strategies could realize some immediate changes.

1. Incorporate the elimination of health care disparities in each organization's mission, strategic plans, goals and objectives.
2. Conduct community health needs assessments, forums and other evaluation tools to assess the impact of meeting goals and objectives in the strategic plan.
3. Provide health literacy and cultural competency training for the state's public health workforce.
4. Increase awareness by communicating with staff and community leaders on the barriers to care and other social determinants of health and their connection to poor health outcomes.

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STRENGTHS AND LIMITATIONS

The data used in the Minority Health Status Report (MHSR) come from the U.S. Census, statewide surveys, and surveillance systems. Kentucky does not have a defined methodology for collecting data on race. Data presented in the section about social determinants include information on more racial/ethnic groups than data in the outcomes section. Small sample sizes, undercounting and undocumented residents in many minority populations can result in unreliable data. In these cases, data for these groups were not presented. Additionally, census data allow persons to self-identify race/ethnicity, and the MHSR data does not take into account those persons who identify as more than one race or ethnicity due to small numbers.

Surveillance data of different kinds afford the opportunity to follow trends in the health status of a population over time, detect and respond to epidemics, establish health care and public health priorities, and evaluate the effectiveness of programs and services. However, under-reporting and misclassification are features common to all surveillance systems. Surveillance data are captured by county of residence, not county of exposure, which may not give an accurate picture of where the disease is occurring. Surveillance data are dependent upon the ability to capture and classify cases. Consequently, a sudden or marked change in reported cases may not represent a true change in disease incidence and should not be construed as such without knowledge of the historical surveillance practices.

Self-reported data captured in surveys like BRFSS allow for ease of analysis, the ability to study trends, gather data from large numbers of people across a large geographic area, and provide background and historical data on specific groups of people and insight into practices and behaviors. Since 1984, BRFSS has been a major source of state-based health risk behavior data and is the nation's premiere system of health surveys that collects state data about U.S. residents regarding their health-related risk behaviors and events, chronic health conditions, mental health and use of preventive services. BRFSS also collects data on emerging public health issues by measuring the prevalence rates which can be instrumental in program development, implementation and evaluation, and targeting resources to reduce behavioral risks and consequent illness. The standardized questions allow for more precise measurements by applying the same definition for all participants. Though BRFSS is Kentucky's leading source of data on health behaviors, there are limitations regarding the data captured in a survey year. BRFSS data are self-reported, and the information captured about a particular population at one point in time might not reflect the same results as another point in time. BRFSS is a telephone survey; capturing only adults who live in households. Persons without a telephone and individuals living in a group setting, such as a nurs-

STRENGTHS AND LIMITATIONS

ing home, the military, or prisons, are not included in the sample. In addition, all large population health surveys that depend on telephone interviews have had to adjust to the rising increase in cell phone over land line use. In 2011, BRFSS implemented the BRFSS survey with cell phones and adjustments were made in sampling methodology. While this does not allow accurate comparison of data from prior years, from 2011 forward trends can be viewed over time.

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