

October 2008

Prepared by the Alabama Department of Public Health
Health Disparities Advisory Council
&
The Minority Health Advisory Council

Funded by
Alabama Department of Public Health
Office of Minority Health

Revised 10/1/08

TABLE OF CONTENTS

Table of Contents	II
Letter from State Health Officer	III
Executive Summary	IV
Content Guide	V
Where We Are (Statistical Data)	
What We Are Doing (Existing Programs)	
Program Services and Community Outreach	
What We Are Going To Do (Call to Action)	
Policy Implications	
Recommendations	
The Need for A State Plan of Action	
 Historical Efforts to Reduce and Eliminate Health Disparities	1
 Perspectives of Racial and Ethnic Health Disparities	4
A National Perspective.....	4
The Disparity Burden in Alabama.....	6
 Risk Behaviors: The Impact	10
Obesity in Alabama.....	13
Tobacco in Alabama.....	18
 Health Disparities Burden in Alabama: A Call to Action	21
Cardiovascular Disease and Stroke in Alabama.....	22
Cancer in Alabama.....	26
Diabetes in Alabama.....	32
Infant Mortality in Alabama.....	37
HIV and AIDS in Alabama.....	46
Mental Health in Alabama.....	51
Asthma in Alabama.....	55
 The Need for A State Plan of Action	61
 2007 National Healthcare Disparities Report—At a Glance	67
 Charts	68
 Glossary	69
 References	71
 Acknowledgements	74

LETTER FROM STATE HEALTH OFFICER

The Alabama Department of Public Health is charged with ensuring that Alabama citizens receive caring, effective and quality health care services from health care professionals. In keeping with this goal, the reduction and elimination of health disparities in Alabama is necessary. Each and every day, too many Alabamians struggle to maintain a quality standard of living because of the inequities they have experienced due to inadequate health care. Today more than ever, alarmingly high figures indicate that in Alabama chronic diseases such as diabetes, cancer, cardiovascular disease, infant mortality and HIV/AIDS are very prevalent in minority populations.

The reality of the existence of chronic diseases within minority populations is that many can be prevented if we, as health providers, work together with Alabama citizens toward the goal of improving the overall health status of all Alabama citizens. Race, ethnicity, geographical location, socioeconomic status, gender and age must no longer be the foundation of health disparities, which are a reality for thousands of Alabamians.

The Department will continue to be diligent in its crusade to work toward the goal of every Alabamian having access to equal and quality health care. This goal can not be achieved alone. It can only be accomplished through collaboration and cooperation throughout the State. This collaborative effort must include community leaders, health care providers, universities, research institutions, businesses, private and non-profit organizations, state and national agencies, and faith-based outreach, all joining together for the dedicated cause of reducing and eliminating health disparities.

United together, we can make a difference!

Sincerely,

Donald E. Williamson
State Health Officer

EXECUTIVE SUMMARY

Over the last decade, the U.S. population grew by 13 percent and increased in diversity at an even greater rate. Racial and ethnic minorities are among the fastest growing communities in the country and today comprise 34 percent of the U.S. population. By the year 2030, racial and ethnic minorities are projected to represent 40 percent of the U.S. population. In the midst of this increasing diversity, improvements in the overall health status of Americans are linked to improvements in the health status and health outcomes of minority populations.

Despite the great advancements in health care, racial and ethnic minority populations continue to experience poorer health outcomes resulting in higher levels of illness and death. Minorities comprise 52 percent of the uninsured and suffer from illness and death at a greater rate than Caucasians. Eliminating health disparities will require new knowledge about the factors that contribute to these disparities, such as poverty, unequal access to care, and education. It also will require enhanced methods for disease prevention and health promotion, as well as new approaches to engage and mobilize affected communities by creating new health partnerships aimed at eliminating health disparities.

Eliminating health disparities is a priority for the Alabama Department of Public Health. *The Preliminary State Plan of Action to Reduce and Eliminate Health Disparities in Alabama* was developed to implement a comprehensive, realistic and uniform approach to improving the health of all Alabamians. To make this truly a plan for the entire State, new partners are encouraged to join. With all partners working together, all Alabamians can have access to quality health care and health disparities can be reduced.

CONTENT GUIDE

This report outlines the importance for reducing and eliminating health disparities by providing historical information and perspectives about issues associated with racial and ethnic health disparities.

Risk Behaviors: The Impact

Outlines the affect of obesity and tobacco on the health of Alabamians.

Health Disparities Burden in Alabama

Explains how cardiovascular disease, cancer, diabetes, infant mortality, HIV/AIDS, mental health, and asthma are major health disparities in Alabama. Each section begins with statistical data which explains *WHERE WE ARE* in reducing and eliminating health disparities. This section is followed by discussing *WHAT WE ARE DOING*, by providing information on existing program services and community outreach. Each section ends with *A CALL TO ACTION* which addresses *WHAT WE ARE GOING TO DO* and discusses policy implications and recommendations to reduce and eliminate health disparities.

The Need for A State Plan Action

Gives a foundation for the basis and need for establishing “*A Preliminary State Plan of Action to Reduce and Eliminate Health Disparities in Alabama*” and overviews the policy initiatives and recommendations to reduce and eliminate health disparities in Alabama.

HISTORICAL EFFORTS TO REDUCE AND ELIMINATE HEALTH DISPARITIES

The mission of the Alabama Department of Public Health (ADPH) is to serve the people of Alabama by assuring conditions in which they can be healthy. In keeping with the mission, former State Health Officer, Claude Earl Fox, M.D., M.P.H., established the Alabama Office of Minority Health in 1991. The impetus for creating the office was Dr. Fox's concern over the great differences in the health status of minorities and Caucasians in Alabama, and the urging of the Alabama Legislative Black Caucus. The State Office of Minority Health's (SOMH) mission is to improve the health status of minority populations by:

- Enhancing and promoting public awareness of health care needs of minority populations.
- Disseminating disease prevention and health promotion education information.
- Promoting minority presence and participation in health planning and policy development.
- Forming partnerships with minority community groups and organizations.

The SOMH initial efforts to address minority health and health disparities were limited to advisory and consultative roles. A Minority Health Task Force was established in 1991 to address improving the health outcomes of minority populations. *Narrowing the Gap in Alabama* summarized the health status of Alabama's most vulnerable populations, racial, and ethnic minorities. Members of the Minority Task Force identified the major health related concerns and gave recommendations on the following: infant mortality, out of wedlock teenage pregnancy, black males' high morbidity and mortality, violence, access to adequate health care, and under-utilization of available preventive health services.

Building on the foundation established in 1991, the SOMH continues to advocate for system changes as a solution to eliminating health disparities. Concerted efforts have focused on partnering with health department disease programs, other State agencies, academic

institutions and community-based organizations to raise the awareness of health disparities. In 2000, the SOMH partnered with ADPH staff in the Center for Health Statistics (CHS) to produce a document on racial and ethnic mortality disparities. In June 2002, the *Alabama Atlas of Racial Disparities in Mortality* was produced.

Regional health education seminars were held to discuss the findings in this document and to share the information with the communities and policy makers. Public health staff listened as community members shared their insight on health problems in their geographical areas. The seminars were pivotal in forming discussions to formulate health policies, address risk behaviors, and promote healthy life style changes.

The local communities wanted more data on health disparities. In 2003, *Alabama Chart Book of Regional Disparities in Mortality* was published. This document addressed the increasing interest in health disparities at the State level. Through the receipt of federal funds in 2005, issued by the U.S. Department of Health and Human Services Office of Minority Health, the SOMH increased its capacity for developing a State plan to eliminate health disparities and improve minority health. The State Partnership Grant funds promoted the collaboration with other public and private agencies such as the Federally Qualified Health Care Centers (FQHC), Historically Black Colleges and Universities (HBCU), local multicultural coalitions, the Children's Health Insurance Program, and other State agencies including the Alabama Indian Affairs Commission, Alabama Medicaid Agency, the Department of Human Resources, the Department of Senior Services, and other entities interested in decreasing or eliminating health disparities. This collaboration helped to expand the knowledge of disparities among Alabama's population groups and led to an expansion of intervention, policies and the coordination of service programs for underserved and minority populations. The collaboration also stimulated the formation of a Health Disparities Advisory Council within ADPH.

Many of the health disparities identified in 1991 are still prevalent in Alabama today. Some of the disease prevention strategies, service interventions, and recommendations

outlined in this State plan stem from the original 1991 document. The editorial comments made by former Office of Minority Health Director, Barbara Harrell, are still relevant today:

“This document represents Alabama’s acknowledgement of its diversity of peoples and its awareness of the challenges it faces to use the data collected to identify the greatest needs and disparities, establish relevant objectives, plan and coordinate appropriate health care activities, and commit resources to responding to the changing demographics of the State. The burden is on public health in concert with the affected populations to identify the barriers for appropriate utilization of health care resources and to develop and initiate strategies to overcome them. The barriers may be cultural, linguistic, religious, or social. Unless considerable efforts are made to elevate the health status of those at the bottom, the objective of having “healthy people in healthy community” will not be reached.”

PERSPECTIVES OF RACIAL AND ETHNIC HEALTH DISPARITIES

A NATIONAL PERSPECTIVE

The Nation is at crossroads where the health and well-being of this generation and future generations will be determined by the actions that we as a society undertake today. According to the Centers for Disease Control and Prevention (CDC), the current chronic disease epidemic will radically change the quality of life of our citizens. Chronic diseases such as cancer, diabetes, heart disease, and stroke account for 70 percent of all deaths in the United States, and more than 90 million people in the United States live with chronic illnesses. Despite significant progress in the prevention of these diseases, some populations continue to endure a disproportionate burden of disease. Disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system.

Although varying in magnitude by condition and population, disparities are observed in almost all aspects of health care, including: preventive care, treatments of acute conditions, management of chronic disease, and special health care needs.

According to the 2006 National Health Conference Disparities Report, racial and ethnic minorities make up approximately one third of the U.S. population but disproportionately comprise 52 percent of the uninsured. Suffering from illness and death also occurs at a greater rate in minority populations, according to the Kaiser Family Foundation.

According to the U.S. Department of Health and Human Services, Office of Minority Health, the following statistics apply for minority populations:

- In 2004, African American men were 2.4 times as likely to die from prostate cancer compared to non-Hispanic white men.
- In 2003, African American women were 10 percent less likely to have been diagnosed with cancer; however, they were 36 percent more likely to die from breast cancer compared to Hispanic white women.

- Although African Americans made up only 13 percent of the total U.S. population, they represented 47 percent of HIV/AIDS cases in 2005.
- In 2004, African Americans had 2.4 times the infant mortality rate of non-Hispanics. African Americans infants were almost four times as likely to die from causes related to birth weight, compared to non-Hispanic white infants.
- Hispanics have the highest uninsured racial or ethnic group within the United States.
- Asian/Pacific Islander men and women have higher incidence and mortality rates and liver cancer.
- American Indians and Alaska Natives have an infant death rate double the rate for Caucasians.
- American Indians and Alaska Natives were twice likely as non-Hispanic whites to have diabetes in 2003.
- American Indian and Alaska Natives have a 40 percent higher AIDS rates than non-Hispanic counterparts.
- Mexican American adults were two times more likely than non-Hispanic white adults diagnosed with diabetes by a physician.

As the nation's disease prevention agency, CDC has a mandate to prevent unnecessary death, disease, and disability. Support from CDC is paramount and critical for helping States develop comprehensive and sustainable prevention programs. However, States need comprehensive plans directed at their State populations with the greatest need.

THE DISPARITY BURDEN IN ALABAMA

Alabama's diverse population is one of its greatest resources. However, the health status disparity between the various population components is not allowing the benefits of this diversity to be maximized. Health status disparity involving the conditions of primary interest to the National Office of Minority Health (cardiovascular disease, cancer, HIV/AIDS, asthma, mental health, and diabetes) exist in Alabama.

According to the ADPH Division of TB (Tuberculosis) Control, there are clear differences among persons with tuberculosis in Alabama. Specifically, white persons with TB tend to be older, and their disease is more likely due to activation of infection acquired in the past. Conversely, TB disease among persons of color is more likely due to recent transmission, as suggested by the historically higher incidence of active TB among African American children. The table below provides a snap-shot of the distribution of reported TB cases by race / ethnicity in 2007.

Reported Tuberculosis in Alabama - 2007	
White/Hispanic	21
White/Non-Hispanic	57
Black	82
Asian	14
Other Pacific Islander	1
Total cases: 175	
Source: ADPH Tuberculosis Control Division	

African American Population

According to the U.S. Census Bureau, in 2007, African Americans comprised 1,224,496 of the U.S. population, and comprised 26.5 percent of Alabama's total population. Selected characteristics of Alabama's African American population health status disparity include the following:

- Life expectancy at birth for African American males was 67.7 years in 2006 compared to 73.0 years for white males, and life expectancy for African American females was 75.8 years compared to 78.9 years for white females.
- The infant mortality rate was 14.6 deaths per 1,000 live births for African Americans compared to only 8.0 for whites.
- While Alabama's African American population comprises only 26.5 percent of the total estimated population, 46.9 percent of the new tuberculosis cases in 2007 occurred in African Americans.

American Indian Population

Alabama's American Indian and Alaska Native population was reported as 7,583 in the 1980 Census, 16,506 in the 1990 Census, and 33,171 in 2000. Alabama currently has nine tribes recognized by the State, with only one of these being recognized by the Federal government. Unfortunately, variations in the self-reporting of American Indian or Alaska Native, along with other historical inadequacies of data collection and data collection systems do not currently allow for much information on the health status of this group. It is known that Alabama's American Indians and Alaska Natives are experiencing what is considered to be alarming high rates for many health conditions which are known to be disparities nationally. Unfortunately, statistically valid life expectancy and the infant mortality rates can not currently be calculated for components of Alabama's population other than whites and African Americans due to small numbers and data limitations. Other known differences or concerns are:

- 24.9 percent of all births to American Indian and Alaska Native women involved instances where the mother received less than adequate prenatal care during her pregnancy compared to 19.0 percent for white women.
- Deaths due to motor vehicle accidents accounted for 6.1 percent of all American Indian and Alaska Native deaths and there were only 2.8 percent of all white deaths.

Asian American Population

Alabama's Asian population was reported as 31,346 in the 2000 Census. The SOMH plans to analyze the health status of the various population groups within Alabama's Asian population (Asian Indians, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.). Known health status concerns involving Asians include the following:

- In 2006, the leading cause of death among Asian Alabamians was cancer, with heart disease being second.
- While Alabama's Asian population comprises approximately 0.7 percent of the total estimated population, 8.0 percent of the new tuberculosis cases in 2007 involved this population component.

Hispanic/Latino American Population

Alabama's Hispanic population was 24,629 in the 1990 Census and increased by nearly 208 percent to 75,830 in 2000. This was the seventh highest percentage increase among all 50 States. Alabama's Hispanic/Latino population was estimated to be approximately 124,741 in 2007. The following health status disparities have been revealed:

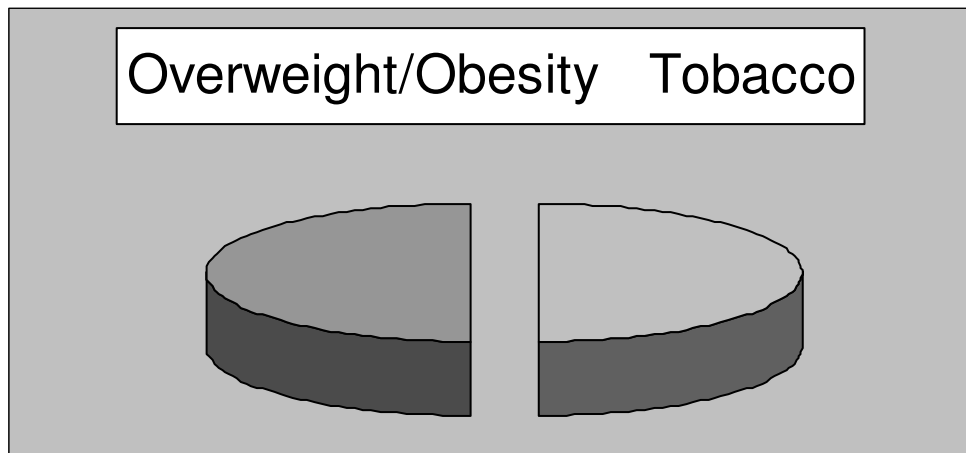
- According to 2007, estimates of Alabama's uninsured population, 22.0 percent of all Alabama Hispanic/Latinos did not have health insurance compared to 10.2 percent for whites.

- While Alabama's Hispanic/Latino population comprises approximately 2.5 percent of the total estimated population with 7.5 percent of all resident births, 12.0 percent of the new tuberculosis cases in 2007 involved this population component.
- Causes of death where significant disparity exists between Alabama's Hispanic/Latino and white population include the following: congenital anomalies, motor vehicle accidents, and assault.

RISK BEHAVIORS: THE IMPACT
OBESITY IN ALABAMA
TOBACCO IN ALABAMA

RISK BEHAVIORS: THE IMPACT

TWO MAJOR HEALTH RISK FACTORS



According to Healthy People 2010, two of the leading health risk behaviors that impact major public health problems in the United States are overweight/obesity and tobacco use. Obesity and tobacco usage contribute to higher rates of disease, disability and premature death than environmental and genetic factors. Overweight and obesity substantially raise the risk of illness from high blood pressure, high cholesterol, type 2 diabetes, heart disease and stroke, gallbladder disease, arthritis, sleep disturbances and certain types of cancers. Obese individuals also may suffer from social stigmatization, discrimination, and lowered self-esteem.

The ADPH Obesity Task Force's web site gives the following definitions for overweight and obesity. Obesity is defined as an excessively high amount of body fat or adipose tissue in relation to lean body mass. Body Mass Index (BMI) is a common measure expressing the relationship (or ratio) of weight-to-height. It is a mathematical formula in which a person's body weight in kilograms is divided by the square of his or her height in meters squared ($wt/(ht)^2$).

The BMI is more highly correlated with body fat than any other indicator of height and weight. Individuals with a BMI of 25 to 29.9 are considered overweight and are approximately 20

pounds above appropriate weight for height. Individuals with a BMI of 30 or more are considered obese and are 30 or more pounds over appropriate weight for height. For adults over 20 years old, BMI falls into one of these categories:

BMI CHART

Adult (21 and over)	
BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese
Children and Adolescent (2-20)	
BMI	Weight Status
Underweight	<5th percentile BMI for age
Normal weight	≥5 to <85 BMI for age/gender
At risk for overweight	≥85th to <95th BMI for age/gender
Overweight	≥95th BMI for age/gender
Obese	Not used in children/teens

Source: ADPH, Obesity Task Force

OBESITY IN ALABAMA

STATISTICAL DATA

Obesity is linked to many preventable chronic health diseases. Cardiovascular disease and cancer, especially lung cancer, have been strongly associated with obesity.

Adults are not the only persons having a problem with excessive weight which affects the health status of individuals. Childhood obesity has become the most prevalent pediatric nutritional problem in the United States. Results from the 1999–2002 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicated that an estimated 16 percent of children and adolescents aged six to 19 years were overweight. The prevalence rate has been rising steadily in all age groups, with overweight being seen at younger ages. According to the National Center for Health Statistics' 2007 publication, *Chart Book on Trends in the Health of Americans*, 17.5 percent of adolescents 6-11 years of age were overweight, and 17.0 percent of the 12-19 years of age group, were overweight.

OVERWEIGHT/OBESITY CHART

	Overweight	Obese	Overweight and Obese
White Male	43.9%	26.9%	70.8%
White Female	29.6%	27.1%	56.7%
Black Male	35.3%	39.2%	74.5%
Black Female	29.9%	45.8%	75.7%
Alabama's Obesity		Ranks 2 in the nation	
Obesity Prevalence		29.7%	
Overweight Prevalence		34.4%	
Diabetes Prevalence		10.2% among the top five in the nation	
Source: 2007 ADPH, BRFSS Data (Adults)			

THE DISPARITY

The prevalence of overweight and obesity correlates with race and ethnicity, gender, age, and socioeconomic status. For example, overweight and obesity are particularly common among minority groups and those with a lower family income. The prevalence of overweight and obesity is higher in women of minority populations than in Caucasian women. According to the National Center for Chronic Disease Prevention and Health Promotion, 2007 Behavioral Risk Factor Surveillance System (BRFSS), the prevalence of overweight and obesity is higher in women of minority populations than in Caucasian women. Among men, Mexican Americans have a higher prevalence of overweight and obesity than Caucasians or African Americans. For non-Hispanic men, the prevalence of overweight and obesity among Caucasians is slightly greater than among African Americans. Among school aged children, there is a higher occurrence of obesity in African American, Native American, Puerto Rican, Mexicans, and Native Hawaiians. Data from CDC show the prevalence among African American children at 21.5 percent, Hispanic children are at 21.8 percent as compared to 12.3 percent of Caucasian children.

According to the 2007 ADPH BRFSS health assessment, the Hispanic population is more likely to be overweight, while African Americans are more likely to be obese. Contributing to these rates are the facts that African Americans report the lowest rates of physical activity and Hispanics report the lowest level of fruit and vegetable consumption. Results reported in the 2007 BRFSS show an increased need to promote physical activity and nutrition among the older population. Alabamians 65 and older reported the highest rates of being overweight and Alabamians 55 to 64 had the highest rates of obesity. Rates of physical activity among Alabamians decrease with age, as do rates of fruit and vegetable consumption.

Data collected by the ADPH Nutrition and Physical Activity Division for the 2007 “*Alabama – One Choice at a Time*” project revealed some alarming statistics about overweight and obese individuals in Alabama. From 1995 to 2006, the rate of obesity increased by 63

percent. When overweight and obese categories are combined, the groups with the highest rates of overweight/obesity in Alabama are males (71.9 percent), 35-44 year olds (71.8 percent), African Americans (72.9 percent), and those with less than a college education. Comparing overweight/obesity rates from 1995 to 2006, the age groups with the greatest change in rates are 25-34 year olds and 35-44 year olds (41 percent and 23 percent increase, respectively).

PROGRAM SERVICES AND COMMUNITY OUTREACH

The Office of Women's Health currently partners with other statewide agencies to offer a train the trainer program, *New Leaf Intervention Training* in all 67 counties in Alabama. *New Leaf...Choices for Healthy Living*, is evidence-based structured nutrition and physical activity assessment program for cardiovascular disease risk reduction through weight reduction. The Heart Truth for Women Campaign targets African American women and women in rural counties aged 40-64 by using health education symposium sessions and radio media to increase awareness of cardiovascular disease and encourage them to control risk factors. The program expanded to include American Indian and Latina women.

Body Works is a program designed to help parents and caregivers of young adolescent girls aged 9-13 improve family eating and activity habits. Using a toolkit, the program focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to prevent obesity and help maintain a healthy weight. The Office of Women's Health and the Alabama Department of Public Health Cardiovascular Health Branch have provided the training and distributed the Body Works Toolkits to community-based organizations, State health agencies, non-profit organizations, health clinics, and health care systems.

The Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition education and counseling in the prevention of childhood obesity through the annual nutrition education plans and counseling at certification visits and subsequent visits. Various

incentive items such as books, pedometers, frisbees, measuring cups, etc, have been distributed to patients to reinforce the nutrition and physical activity messages provided during education and counseling.

To address the obesity epidemic in Alabama, the Alabama Department of Public Health, Nutrition and Physical Activity Division and University of Alabama at Birmingham (UAB) formed the State Obesity Task Force. The goal of the State Obesity Task Force was to develop and implement a comprehensive, realistic state plan which would address the worsening obesity epidemic in Alabama. The plan provides various approaches to address the impact of obesity on Alabama's citizens including education and awareness, lifestyle and behavioral choices, community-based environmental strategies, school and worksite improvements, and policy development or changes.

Under the partnership developed by the ADPH Nutrition and Physical Activity Division, the following organizations have spearheaded efforts to address obesity in the State: Office of Women's Health, The Alabama Hospital Association, Alabama Cooperative Extension System, Steps to a Healthier US, and Deep South Network for Cancer Control. Programs such as Scale Back Alabama and the State Wellness Program offer adults strategies to lose weight in a healthy manner by exercising and eating sensibly.

Risk reduction and disease prevention are desperately needed to impact obesity, diabetes, and heart disease. What is needed in addition to Scale Back Alabama, are community-driven, community-supported, and community-based train the trainer programs such as New Leaf Intervention, Heart Truth, and Body Works. These health promotion programs are designed to help families, communities and congregations utilize community lay workers to promote health and disease risk reduction through structured nutrition and physical activity.

POLICY IMPLICATIONS

Excess weight in childhood is frequently a precursor to adult obesity. Efforts to maintain a healthy weight should start early in childhood and continue throughout adulthood. Increased obesity rates and decreased physical activity impact the quality of life and pose serious health issues and economic costs to Alabama. Individuals, families and communities are responsible for positive, sound, lifestyle behavior choices that promote a healthy body. However, the choices people make are shaped by the choices they have available to them. A plan to promote healthy lifestyle choices must take into consideration the economic, environmental, social and institutional barriers posed in the community, the family and the individual. Public health policies can improve health by targeting factors related to individuals and their environment, including access to nutritious food, and safe outside areas for physical activity. Alabama policy makers should support local and State level policies and laws creating opportunities for healthy eating and physical activity.

RECOMMENDATIONS

- 1) **Healthy Alabama 2010 Objective 1.1** - Increase to 25 percent or more the proportion of adults aged 18 and older who engage regularly, preferably daily, in sustained physical activity for at least 30 minutes per day.
- 2) **Healthy Alabama 2010 Objective 1.2** - Increase to 60 percent or more the proportion of students in grades 9-12 who engage in moderate physical activity for at least 20 minutes a day for three days per week.
- 3) **Healthy Alabama 2010 Objective 1.3** - Reduce to 20 percent or less the prevalence of being overweight (defined as BMI at or above 27.8 for men and 27.3 for women) among adults aged 18 and older. In addition, community support is necessary to make eating healthy and being physically active natural and easy choices.

TOBACCO IN ALABAMA

STATISTICAL DATA

The 2006 Surgeon General's Report indicated that smoking is the single greatest avoidable cause of disease and death. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control. Tobacco use in Alabama is a major public health concern. Alabama has the eight highest smoking rate in the country and over 7,000 people die annually from tobacco-related causes. Approximately 22.5 percent of Alabama's adults are regular smokers. Among the youth, 22.1 percent of high school students smoke, and 10.9 percent of high school males use smokeless tobacco. Nearly 12,400 Alabama youth become daily smokers each year. In addition to problems resulting from smoking and chewing, serious adverse health effects result from exposure to secondhand smoke or environmental tobacco smoke. The public health challenge before us is to improve the health of Alabama citizens by reducing the rates of illness and death caused by tobacco use.

THE DISPARITY

Tobacco-related disparities impacting cigarette usage have been identified based on gender, education level, race, and age. According to BRFSS data for Alabama adult populations in 2007, lower levels of education completed were associated with higher smoking rates: 34.5 percent of adults with less than 12 years education smoked cigarettes compared to 26.5 percent of individuals with 12 years of education; 22.1 percent of individuals with some post high school; and 11.6 percent of college graduates. The percentage of smoking among whites was 22.8 percent and 21.2 percent for blacks. The Alabama Hispanic Tobacco Survey conducted in 2005 identified that 41 percent of those surveyed were current smokers.

PROGRAM SERVICES AND COMMUNITY OUTREACH

In April 2005, ADPH launched the first statewide Tobacco Quitline available to all Alabamians free of charge. The 1-800-QUIT-NOW toll-free line offers counseling referrals and up to four weeks of free nicotine replacement therapy for tobacco users who would like to quit. Callers also receive a “Quit Kit” information packet to assist them as they set a quit date and develop a plan to give up cigarettes or chewing tobacco. Data shows that with counseling, users are twice as likely to be able to quit tobacco for good. The line takes live calls from 8 a.m. to 8 p.m. Monday through Friday. Callers can leave a message 24 hours a day to receive information or a call back.

Currently, State government resources to prevent and control tobacco use in Alabama are primarily included in three agencies: ADPH, the Alabama State Department of Education (ALSDE), and the Alcoholic Beverage Control Board (ABC) Board.

Through the Safe and Drug-Free Schools Program, schools are monitored to enforce the Alabama Administrative Code that requires school campuses to be tobacco free. Safe and Drug Free School coordinators also participate on local tobacco control coalitions and provide tobacco use prevention programming in their schools. The ABC Board is responsible for enforcing youth access to tobacco products by providing merchant education, permitting for tobacco vendors, and by enforcing State laws regarding sales of tobacco products to minors.

POLICY IMPLICATIONS

According to Tobacco Prevention and Control Branch, smoking is a major cause of heart disease and stroke among both men and women. Smokers have twice the risk for heart attack of non-smokers. Smokers who have a heart attack are more likely to die, and to die suddenly, rather than nonsmokers. Cessation of smoking can substantially lower the risk for heart attack and stroke. Organizations across the State have formed local coalitions and are working within

their municipalities to strengthen clean indoor air laws. Since 2003, 62 cities have passed or improved their no smoking ordinance to create greater restrictions in smoking in public places to include work places, restaurants, bars and parks. At the State level, a Clean Air bill was introduced in the 2008 legislative session to ensure that restaurants, bars, and work places across the State are smoke free. The bill had overwhelming support in the Senate and is expected to be introduced again in the 2009 legislative session.

RECOMMENDATIONS

- 1) **Healthy People 2010 Objective 1.5** - Reduce to 13 percent or less the proportion of adults aged 18 and older who smoke cigarettes and reduce to three percent or less the proportion of adults aged 18 and older who use smokeless tobacco.
- 2) Increase Alabama's capacity to reduce smoking, and the burden of tobacco-related cancers among minorities and populations of low socioeconomic status by building new and sustainable collaborations within and outside the field of tobacco control. Bridge tobacco control policy to broader social policies in order to enhance the policies' effects.
- 3) Successfully advocate for public policy that aims to reduce tobacco use through protecting the public from exposure to secondhand smoke and increasing the State tobacco excise tax.

**HEALTH DISPARITIES BURDEN IN ALABAMA:
A CALL TO ACTION**

**CARDIOVASCULAR DISEASE AND STROKE IN ALABAMA
CANCER IN ALABAMA
DIABETES IN ALABAMA
INFANT MORTALITY IN ALABAMA
HIV AND AIDS IN ALABAMA
MENTAL HEALTH IN ALABAMA
ASTHMA IN ALABAMA**

HEALTH DISPARITIES BURDEN IN ALABAMA: A CALL TO ACTION

CARDIOVASCULAR DISEASE AND STROKE IN ALABAMA

STATISTICAL DATA

Cardiovascular disease (CVD) is the leading cause of death in Alabama. Cardiovascular disease, which includes heart disease and stroke, accounts for almost 40 percent of Alabama deaths each year. Alabama ranks fourth in the nation in deaths due to stroke and fifth in the nation in death rates due to heart disease. Stroke is the third leading cause of death in Alabama. Nearly one-fifth of all deaths from heart disease, or about 180,000 deaths each year are attributable to smoking. According to the 2007 BRFSS survey results, adults in Alabama reported the following risk factors for heart disease and stroke: 33.1 percent had high blood pressure, 39.4 percent reported having high blood cholesterol, 10.3 percent had diabetes, 22.5 percent were current smokers, 66.6 percent were overweight or obese, and 29.8 percent reported no exercise in prior 30 days.

CARDIOVASCULAR CHART ADULTS IN ALABAMA REPORTED THE FOLLOWING RISK FACTORS FOR HEART DISEASE AND STROKE	
High Blood Pressure	33.1%
High Blood Cholesterol	39.4%
Diabetes	10.3%
Current Smokers	22.5%
Overweight/obese	66.6%
No exercise in past 30 days	29.8%
Source: ADPH, BRFSS Survey Results, 2007	

THE DISPARITY

According to the American Heart Association, while great strides have been made in treatment of cardiovascular disease, those advances have not reached minorities and underserved populations due to geography, race, gender and economics. Nationally, a large study of gender and racial disparities found that 76 percent of white men and 71 percent of white women had blood pressure controlled to an optimal level, while only 63 percent of both black men and women had blood pressure optimally controlled.

According to the ADPH Cardiovascular (CVD) Division, the disparities between Alabama's racial/ethnic groups in terms of CVD mortality are striking. Overall mortality rates are higher for blacks than for whites.

Rates are also substantially higher for blacks under the age of 75 years, compared to their white counterparts, for myocardial infarction, stroke, and hypertension.

PROGRAM SERVICES AND COMMUNITY OUTREACH

The mission of the Cardiovascular Health Branch is to provide leadership in the prevention of death and disability from heart disease and stroke, and eliminate disparities in health and health care. The program staff works with its many partners to improve access to health care by addressing barriers to cardiovascular health services.

The CVD Branch works to raise awareness of signs and symptoms of heart attack and stroke through community outreach. The CVD Program offers mini-grants to churches, neighborhood associations, senior centers, and beauty and barber shops to educate the community on risk factors, early detection and warning signs and symptoms of CVD.

Through the Alabama Cardiovascular Health Coalition oversight, the CVD Branch set three overall goals for CVD prevention and control in Alabama: 1) increase awareness of cardiovascular disease in Alabama including the prevalence and burden of disease, 2) minimize cardiovascular disease-related risk behaviors and promote positive heart health and heart-

healthy lifestyles, and 3) promote access to and utilization of early detection and rapid treatment options for cardiovascular events throughout the State.

POLICY IMPLICATIONS

Disability related to Cardiovascular Disease has a great economic impact on Alabama. Hospital emergency department visits to address CVD complaints, chest pain, and to provide diagnostic and treatment procedures are also impacting Alabama's economy. (National cost: \$500,000 billion in 2008). A major risk factor for stroke is uncontrolled hypertension. Treating and controlling high blood pressure is essential in preventing strokes and other conditions.

RECOMMENDATIONS

- 1) **Healthy People 2010 Objective 12.8** (Revised 2007) - Increase to 83 percent the proportion of persons who are aware of the warning symptoms of stroke and the need to telephone 911 immediately if someone appears to be having a stroke.
- 2) Advocate for funding and legislation at the State and local level to provide availability of wireless E911 capabilities.
- 3) Advocate for State and federal rules or standards to require that Advance Life Support (ALS) units be equipped with electrocardiograph (ECG) monitoring device and other resources necessary to properly care for stroke patients.
- 4) Advocate for State and federal policymakers to support EMA (Emergency Management Agency) personnel in rural areas to ensure the availability and quality of the emergency response system.
- 5) Strengthen existing partnerships and form new partnership at the community level to create "Health Universities" within settings where people, work, live and worship. Utilize peer educators, such as national fraternal and civil rights programs to increase health promotion and

disease prevention practices. Develop health ministry toolkits containing health education materials needed for local presentations.

CANCER IN ALABAMA

CANCER IN ALABAMA

STATISTICAL DATA

Cancer is the second leading cause of death in Alabama and the U.S. and is responsible for one in four deaths. According to Alabama Cancer Facts & Figures 2007, Alabama's cancer incidence rate is 462.8 cases per 100,000 population, age-adjusted to the 2000 U.S. Standard Population and using 19 age groups, lower than the U.S. rate of 471.9. However, Alabama's age-adjusted cancer mortality rate of 208.7 deaths per 100,000 standard population is higher than the U.S. Rate of 185.7.

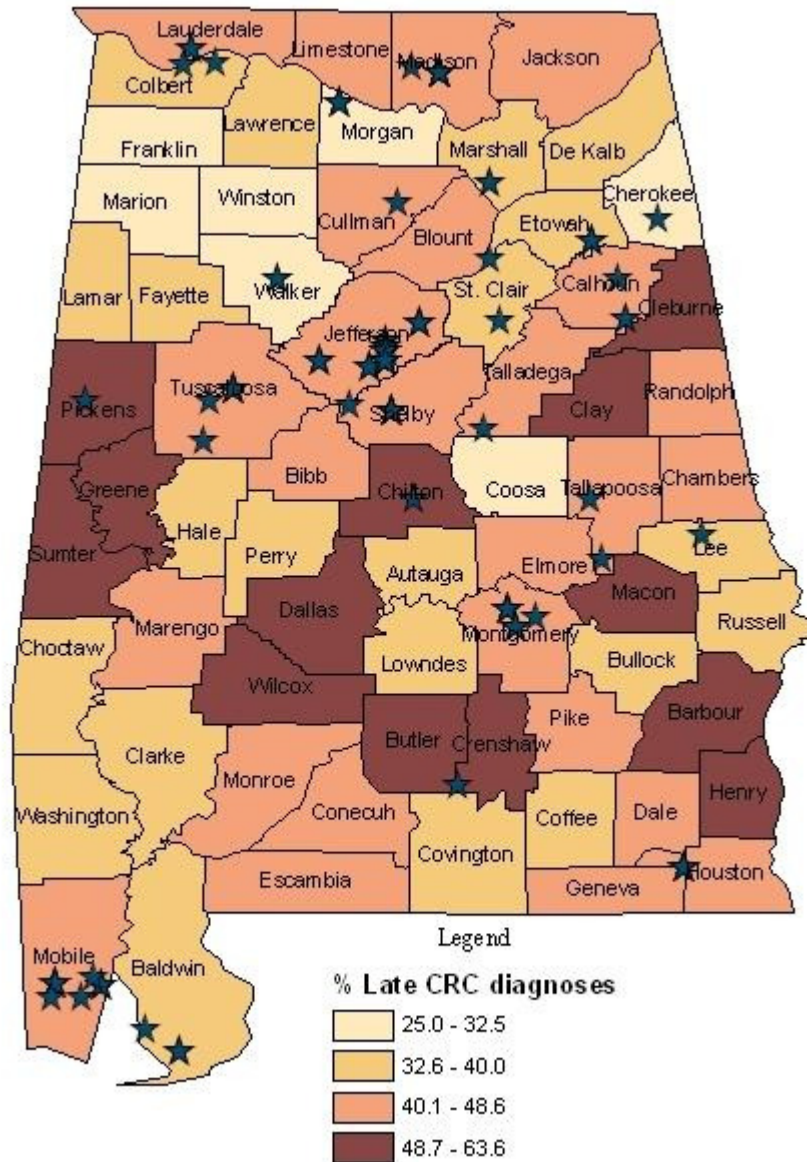
In Alabama, males have a higher cancer incidence rate than females. Among males, black males have a higher cancer incidence rate than white males, with a rate of 589.1 compared to 536.2, respectively. Among females, white females have a higher cancer incidence rate than black females, 412.9 compared to 372.3, respectively.

According to the CDC, the number of new cancer cases can be reduced and many cancer deaths can be prevented by adopting healthier lifestyles, such as avoiding tobacco use, increasing physical activity, achieving a healthy weight, improving nutrition, and avoiding sun overexposure.

One of the most important ways to reduce the impact of cancer is early detection. Following recommended screening guidelines for breast, cervical, prostate, colorectal, and skin, for instance, would save tens of thousands of lives. The next map shows areas of the state where Alabamians are being diagnosed for colorectal cancer at stage four when treatment options are limited and the cancer has spread to other organs. In the darkest areas of the map, over 40 percent of the cases are diagnosed at late stage; a stark finding because with early detection, colorectal cancer is extremely preventable and curable.

COLORECTAL CANCER MAP

Percent Late Stage Colorectal Cancer Diagnoses, All Races,
and Location of Gastroenterology Practices in Alabama,
1999-2003



The stars are representative of 160 locations where physicians with specialties in gastroenterology (internal medicine) or digestive disorders (gastroenterology-internal medicine) have practices.

Source: Alabama Statewide Cancer Registry and the Health Provider Database

THE DISPARITY

The incidence and mortality rates of cancer show disparities among minority populations within Alabama. According to CDC Wonder (1999-2005), males in Alabama have a higher five year age-adjusted cancer mortality rate than females, with a rate of 270.8 compared to 163.9 deaths per 100,000. When comparing race and gender, black males (343.0) have a higher cancer mortality rate than white males (256.0), and the cancer mortality rate for black females (178.7) is higher than the rate for white females (160.3).

A recent study of hospice utilization among Alabamians dying from cancer, conducted by the Alabama Comprehensive Cancer Control Program, shows that hospice facilities are widely available throughout the state including rural areas, but African Americans are less likely to receive hospice care than whites (47 percent compared to 54 percent). African American males living in rural areas had the lowest rate of hospice use at 40 percent.

PROGRAM SERVICES AND COMMUNITY OUTREACH

The Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) provides free screening services for breast and cervical cancer for eligible women in Alabama. The program is funded through a cooperative agreement with the CDC that targets women who meet an age requirement, are underinsured or uninsured, and are at or below 200 percent of the federal poverty level. Women who meet these guidelines are eligible for a free Pap test, pelvic exam, clinical breast exam, and mammogram. The program also provides free diagnostic services if needed. Women diagnosed with cancer through this program are eligible for Medicaid coverage for treatment. ABCCEDP has helped to increase breast cancer screening rates among minority women. The ABCCEDP offers screening services in all 67 counties of the State.

Additional screenings are funded through grants from Susan G. Komen for the Cure and the Joy to Life Foundations. The ABCCEDP collaborates with the Alabama Comprehensive Cancer Control Program and Coalition, American Cancer Society, UAB Division of Preventive Medicine, REACH US, Deep South Network for Cancer Control, UAB Comprehensive Cancer Center, UAB School of Public Health, Alabama Cooperative Extension, the Alabama Quality Assurance Foundation, and a host of other partners to educate Alabamians on the importance of breast, and cervical cancer screenings.

The Deep South Network for Cancer Control works to eliminate disparity in cancer death rates by targeting poor rural areas in the Black Belt of Alabama. The Network provides cancer awareness activities using the Community Health Advisor (CHA) model. CHAs, men and women who are natural helpers in the community, are trained to provide cancer awareness messages, and develop resources for their communities. The CHA receives additional training as research partners (CHA-RPS) to enhance African American participation and enrollment in clinical trials.

Racial and Ethnic Approaches to Community Health 2010 (REACH 2010) is a CDC-funded project focused on promoting breast and cervical cancer screening among community leaders and policy makers. Utilizing the CHA model, community lay persons are trained as a core working group, along with church representatives and health care professionals, to build community capacity to eliminate cancer disparities. Sowing Seeds of Health is a lay health program tailored to Alabama Latinos, empowering natural leaders in the Hispanic/Latino community with the resources and knowledge about health services. They help educate the community on health-related topics such as cancer and diabetes.

POLICY IMPLICATIONS

According to the Alabama Comprehensive Cancer Control 2006-2010 Plan, the incidence and mortality rates of cancer show disparities among rural and minority populations. Within the 45 Alabama counties classified as rural, health insurance enrollment rates are low and health care facilities and providers are sparse. The lack of accessible locations for health care facilities and providers creates a burden for those who seek cancer services, screening, and treatment. Many areas have only one or two primary care physicians within the county.

RECOMMENDATIONS

- 1) Advocate for legislation and funding to provide basic health plan coverage for uninsured Alabamians between the ages of 19 and 64.
- 2) Decrease access barriers that prevent men and women from obtaining recommended cancer screenings and early detection by a) increasing minority populations' awareness of risk factors for breast and cervical cancer, colorectal cancer, and prostate cancer and b) educating primary care providers to follow established screening guidelines.
- 3) Advocate for policies and funding to support worksite wellness programs, physical activity in local communities, and other safety features for outside areas for physical activity.
- 4) Educate women and girls aged 9 to 26 about the availability and importance of the HPV (Human papillomavirus) vaccine to prevent cervical cancer.

DIABETES IN ALABAMA

DIABETES IN ALABAMA

STATISTICAL DATA

Diabetes is a serious chronic disease that affects millions of people of all ages in the United States and Alabama. According to the American Diabetes Association (ADA), current estimates indicate that more than 20 million people in the United States have diabetes. Almost one in 10 people in Alabama has been diagnosed with diabetes, according to the BRFSS. Alabama ranks among the top five States in the nation for the prevalence of diabetes and it is the seventh leading cause of death in the State, according to the ADPH, Center for Health Statistics. Diabetes directly contributes to the incidence of heart disease and strokes; it is the primary cause of kidney failure, non- trauma related limb amputations and adult-onset blindness.

***Almost one in 10 people in Alabama
has been diagnosed with diabetes.***

Source: ADPH, BRFSS, 2007

THE DISPARITY

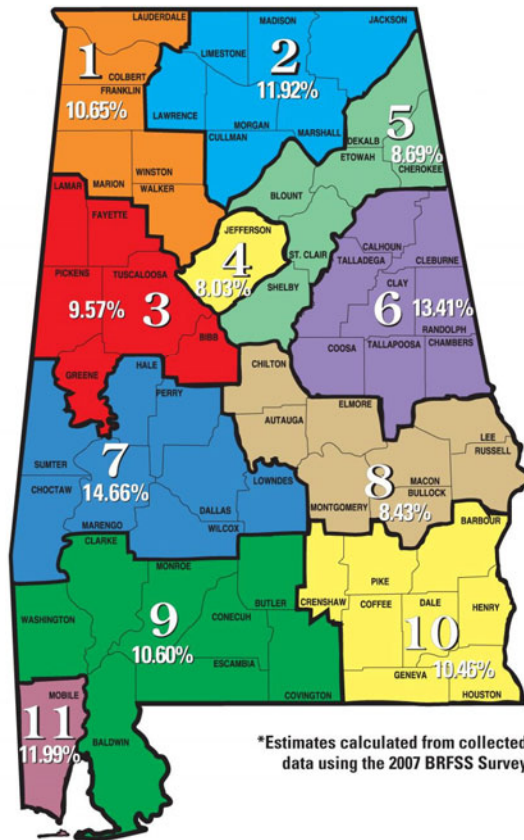
In the 2007 BRFSS, diabetes was reported more often among older age groups. The prevalence of diabetes increases with age. The proportion of persons aged 45 to 64 reporting diabetes is approximately five times higher than the proportion of persons aged 18 to 44.

Diabetes prevalence is very similar among men (10.2 percent) and women (10.4 percent) in Alabama.

The prevalence of diabetes among blacks is more than the prevalence of diabetes among whites within every age group. A particular concern is the disparity that exists in diabetes mortality in Alabama by race. In 2006, the overall diabetes mortality rate was 31.1 per 100,000.

The diabetes mortality rate for whites was 27.1 per 100,000.

2007 Alabama Public Health Area Diabetes Estimates*



*Estimates calculated from collected data using the 2007 BRFSS Survey

The diabetes mortality rate for blacks was approximately 44.7 per 100,000. This disparity among blacks and whites is even more striking at the county level. Diabetes is also the leading cause of end-stage renal disease (ESRD). Diabetes contributes to high blood pressure, stroke, kidney disease, blindness, lower extremity amputations, depression and other complications.

PROGRAM SERVICES COMMUNITY OUTREACH

The Diabetes Branch of the Alabama Department of Public Health, works in collaboration with many other programs within and outside of the Department, to prevent the development of diabetes, and to reduce complications related to the disease. The program does not provide direct patient services but works to increase the percentage of person with diabetes having access to primary care services such as foot exams, eye exams, influenza and pneumococcal vaccines, and the HbA1c (glycosylated hemoglobin A1c) test., which measures the number of glucose molecules attached to hemoglobin, a substance in red blood cells.

Through its diverse membership on the Alabama Diabetes Advisory Network, which consists of diabetes advocates from the public and private sector, the Diabetes Branch is able to assess needs and to improve diabetes prevention and care efforts, and to reduce racial disparities related to the incident, treatment and complications of diabetes. The program also promotes good nutrition, physical activity, weight loss and smoking cessation as key factors in preventing or delaying diabetes. The *Diabetes Today* coalitions, located throughout the State, are a major part of the community outreach efforts. Goals identified by the program include improved quality of life, access to care, reduction in obesity and the promotion of health professional training and education. Use of the National Diabetes Education Program materials is an integral part of the program activities.

POLICY IMPLICATIONS

A correlation between mortality and diabetes is increasing over time. While the national rates appear to be stabilizing, Alabama's diabetes mortality rate continues to climb. It is well-documented that early diagnosis of diabetes and the control of blood sugar levels are important components in the fight to reduce the burden of diabetes in Alabama. Prevention of diabetes, and the serious potential complications of disease, including heart, kidney and eye disease, will improve the quality of life for persons with diabetes and reduce the costs associated with care over the lifetime.

RECOMMENDATIONS

- 1) Bring State level diabetes prevention programs into the community by developing partnerships with community-based organizations and faith organizations.
- 2) Enhance existing community-based prevention programs through the implementation of faith-based risk reduction education provided by the American Diabetes Association, Alabama Diabetes Education Association and the evidenced-based CDC recommended programs. such as ADA's Project Power, *NDEP's (National Diabetes Education Program) Power to Prevent: A Family Lifestyle Approach to Diabetes Prevention*, *NDEP's New Beginnings, Body and Soul, Heart Truth, and Search Your Heart*.
- 3) Advocate for legislation to fund an increase in community-based prevention, in order to build the capacity and infrastructure for community intervention.
- 4) Encourage community representation on policy planning boards at the State level to advocate for appropriate transportation services and access to medical providers in rural areas of the State.

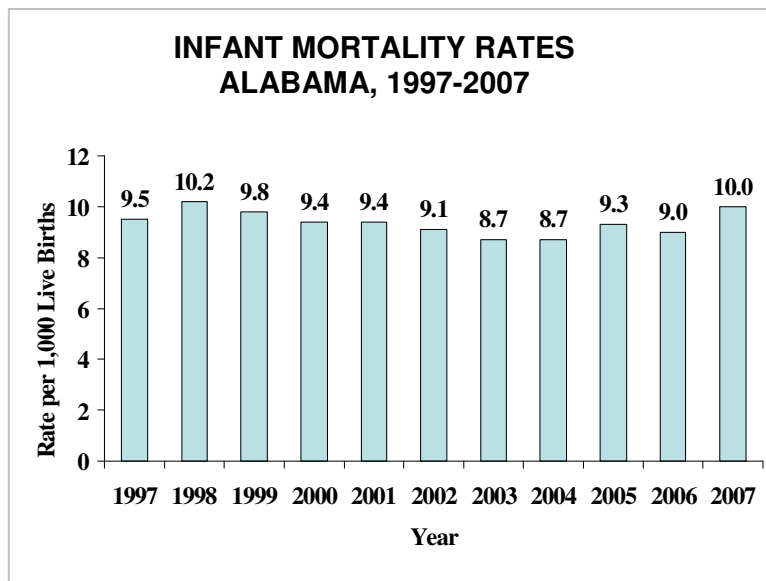
INFANT MORTALITY IN ALABAMA

INFANT MORTALITY IN ALABAMA

STATISTICAL DATA

Infant mortality is an indicator used to characterize the health status of communities and states. According to the ADPH, Center for Health Statistics, Alabama's 2007 infant mortality rate of 10.0 deaths per 1,000 live births was considerably higher than the 2006 infant mortality rate of 9.0.

Also in 2007, there was a decline in the percent of births to mothers receiving adequate prenatal care. Only 72.8 percent of mothers had adequate care, the lowest level in the past decade. Adequate prenatal care is calculated using the Kessner Index, a standard measure of prenatal care based on information provided on birth certificates. The index combines information on the month prenatal care began, gestational age at birth, and number of prenatal visits.

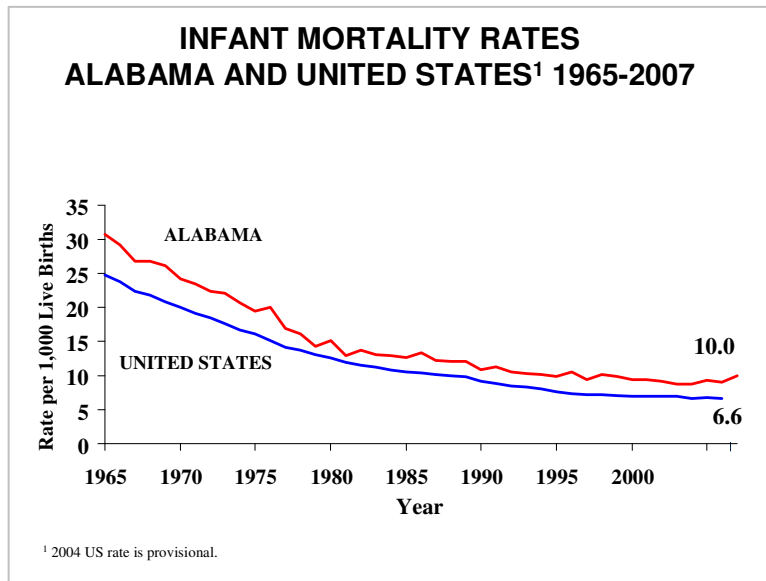


Source: Infant Mortality, Alabama 2007, ADPH, Center for Health Statistics

Factors contributing to infant mortality are: maternal chronic health conditions existing prior to pregnancy, short birth intervals, teen pregnancies, previous preterm births, and drug abuse. Birth weight of the infant is one of the most important predictors of infant mortality. Infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth are much more likely to

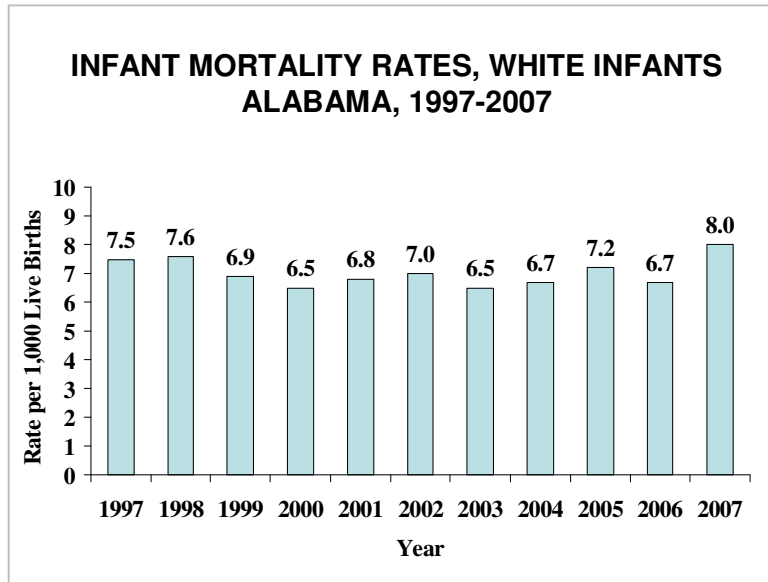
die than normal weight infants. In 2007, the number of births weighing less than 500 grams also rose to its highest level in the past decade, 171.

An important indicator of infant morbidity is the number of newborns being admitted to neonatal intensive care units (NICU). Alabama has seen a more than ten-year trend of increased NICU admissions.



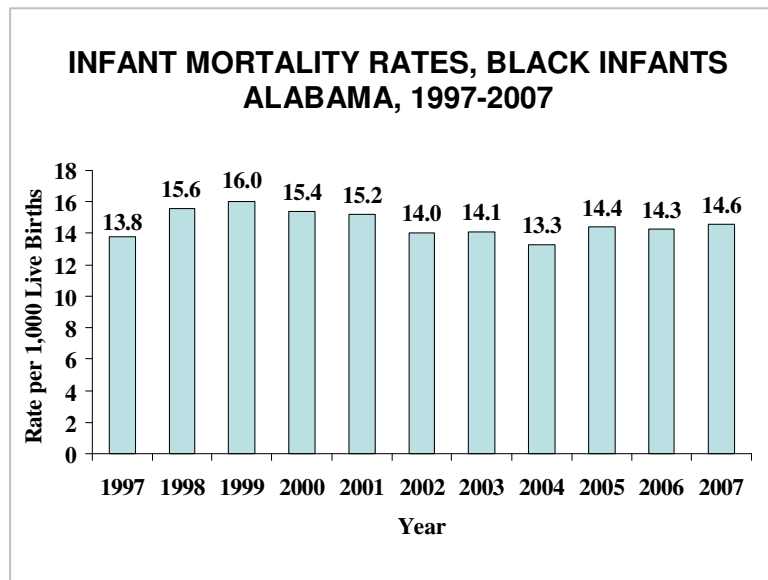
Source: Infant Mortality, Alabama 2007, ADPH, Center for Health Statistics

THE DISPARITY



Source: Infant Mortality, Alabama 2007, ADPH, Center for Health Statistics

The difference between Alabama's IMR for black infants and white infants continues to be significant. The infant mortality rate for white infants increased from 6.7 to 8.0 percent, the highest rate in more than a decade. For black infants, the rate increased from 14.3 to 14.6 percent. For Hispanic infants, who may be of any race, the rate was up slightly from 7.2 to 7.3.



Source: Infant Mortality, Alabama 2007, ADPH, Center for Health Statistics

PROGRAM SERVICES AND COMMUNITY OUTREACH



The Alabama Newborn Screening Program (NBS) expanded its series of new tests designed to provide improved detection for Alabama's infants and their families. The Alabama NBS program tests infant blood and hearing for signs of unseen inherited or acquired disorders that potentially could have disastrous results if left undetected and/or untreated. Using trained collectors, a screening panel of 29 disorders is conducted in all 55 birthing hospitals in the State.

Breastfeeding is an important public health issue that affects the health of infants and mothers. The Women, Infant and Children Program (WIC) provides breastfeeding education and support in all health department clinics statewide. In 2005, the ADPH Supplemental Nutrition Program for WIC initiated a Breastfeeding Peer Counseling Program in three of the health department's clinics through a special USDA Grant. The grant provided funds to support and promote breastfeeding to reduce the incidence of ear infections, pneumonia, diarrhea, urinary tract infection and necrotizing enterocolitis.

Breastfeeding rates increased in clinics that had peer counselors. The Breastfeeding Peer Counseling program expanded to ten sites in 2008. In addition, the WIC Program provides

breastfeeding education and support in all clinics statewide. The Alabama Pregnancy Risk Assessment Monitoring System (PRAMS) is designed to help State health departments establish and maintain a surveillance system of selected maternal behaviors. Maternal behavior and pregnancy outcomes have been strongly associated. The state-specific data generated from the surveillance system is used for planning and assessing perinatal health programs. The Alabama Perinatal Program was established to identify and recommend strategies that will effectively decrease infant morbidity and mortality. Perinatal nurse coordinator positions were created in 2002 for each of the perinatal regions across the State.

The coordinated regional network system was designed to improve access and quality of services for pregnant women, mothers and infants. The State Perinatal Program partners with the March of Dimes to address premature births. The staff provides education to physicians, office staff, and maternity hospital staff regarding preconception, prenatal and infant care, to improve outcomes.

The Alabama Family Planning Program provides services in 87 public health clinics to approximately 100,000 clients annually. Medical services are augmented with case management for Medicaid Plan First and Patient First clients which allows for enhanced education and support on appropriate use of chosen contraceptive methods and further assurance of correct and continued usage. The mission of the program is to assure the availability of services to meet the needs of the population with priority given to special populations: low-income, adolescents, and minorities at risk for unintended pregnancy. The goals of the program are to increase the proportion of pregnancies that are intended, to reduce the proportion of births occurring within 24 months of a previous birth, and to reduce pregnancies among adolescent females aged 15-17; thus, resulting in a reduction in infant mortality.

PROGRAM SERVICES AND COMMUNITY OUTREACH

The Alabama Child Death Review System (ACDRS) continues to strive to prevent unexpected, unexplained, and unnecessary child deaths through the study and analysis of all preventable child deaths that occur in Alabama. Targeted outreach and public education efforts such as Back-To-Sleep efforts, hospital-based Shaken Baby Syndrome Prevention, and Cribs for Kids are used to prevent child deaths and injuries. Strategic partnership and collaborative efforts with advocacy groups, which include the Children First Trust Fund, Gift of Life, VOICES for Alabama's Children and Alabama Suicide Prevention Task force strengthen the program's effectiveness.

According to ACDRS, system data was published in the first annual report, showed that in 1998 and 1999 approximately 500 infant/child deaths per year met criteria for case review. New data show that since 1999 the number of infant and child deaths that have met the review criteria has decreased by approximately 40 percent.

The sixth annual report for the system, containing final review data for 2004 and a first five-year trend analysis of ACDRS data, was completed in late 2007 for distribution to the governor and the State Legislature, as well as to other citizens and agencies in Alabama and around the country early in 2008. The next annual report, containing final 2005 data, is being developed and is on schedule for publication in late 2008.

In addition to hosting the regular quarterly meeting of the State Child Death Review Team, ACDRS staff also visited several local child death review teams and coordinators throughout the state in an effort to improve communication and team performance to the best possible levels. Staff made a special effort to visit with the newly elected district attorneys and newly appointed local team coordinators who were new to the child death review process. This personal interaction with volunteer contributors, at the local level, is so vital to the program that visits have been added such as a programmatic performance measure for the first time in 2008.

ACDRS also conducted its biennial Statewide Training Conference, which was a great success, in 2008.

The infant/child death scene investigation training curricula, developed in 2002 by the ACDRS-formed Child Death Investigation Task Force, continues to be taught to all new recruits at the state's police academies. Plans are being made to improve and expand such training by collaborating with the State Medical Examiner's Office for the implementation of the Sudden Unexpected Infant Death Initiative, which will include regionalized trainings for first responders.

POLICY IMPLICATIONS

According to the Alabama Department of Human Resources (Monthly Statistical Report, March 2007), 36 percent of Alabama's low income working families have at least one parent without health insurance. Lack of insurance can lead to significant loss of income for routine medical problems. Uninsured pregnant women are less likely than insured women to receive proper health and preventive care. Poor families are most likely to be uninsured. Access to adequate early prenatal care may be determined by the availability of health insurance coverage for the pregnant mother.

According to the Center for Health Statistics, in the Alabama Department of Public Health in 2007, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 18.3 percent per 1,000 live births. Medicaid babies had an infant mortality rate of 11.0 percent and those whose mothers had private insurance had the lowest infant mortality rate at 7.7 percent. Based on the birth certificate data, the number of live births to Hispanic residents increased ten-fold in 16 years: from 346 in 1990 to 4,709 in 2006. To provide appropriate health services for the increasing Hispanic population, more interpreters, bilingual staff and appropriate written literature are needed.

RECOMMENDATIONS

- 1) **Healthy People 2010 Objective 3.2** - Reduce the infant mortality rate to at least 7.9 per 1,000 live births. Reduce the African-American IMR to at least 10.9 per 1,000 live births.
- 2) **Healthy People 2010 Objective 3.4** - Reduce to 8.4 percent or less the percentage of live-born babies who have low birth-weight. Reduce to 12.0 the percentage of live-born African-American babies who have low birth-weight.
- 3) **Healthy People 2010 Objective 3.8** - Increase to 90 percent or more the proportion of all live-born infants whose mothers receive adequate prenatal care.
- 4) Build community capacity to respond to the outcome data by developing and establishing community partnerships to include those directly impacted by infant mortality as part of the local FIMR team.
- 5) Conduct geographical and social mapping to determine geographical areas to target.
- 6) Develop county specific infant mortality data profiles and user friendly data/maps that identify IMR and share with community to obtain involvement.
- 7) Strengthen perinatal nurse services by providing training for lay community health advisors on low birthweight, and preconception health care of mothers.

HIV/AIDS IN ALABAMA

HIV/AIDS IN ALABAMA

STATISTICAL DATA

The eye of the HIV/AIDS storm has shifted to the South, where coping with the epidemic may be tougher than anywhere else in the country. According to the Southern AIDS Coalition's "Southern States Manifesto Update 2008," HIV/AIDS in the south has multiple challenges. Rural areas frequently pose different and even greater challenges than urban areas in addressing a number of health issues. Critical shortage of health care practitioners, lack of public transportation, and an inadequate number of rural emergency medical services are just a few of the challenges well-documented. According to the Division of HIV/AIDS Prevention and Control, at the end of December 2007, a total of 15,486 Alabama residents were diagnosed with HIV/AIDS and reported to ADPH. Males made up 74.58 percent of the total cases in Alabama. Persons aged 25-34 represented 35.21 percent of the persons living with HIV/AIDS in Alabama. Men who have sex with men represented 41.74 percent of the cases, while the next highest exposure category was the heterosexuals representing 28.50 percent of the cases.

THE DISPARITY

According to the Division of HIV/AIDS Prevention and Control, the rate of HIV/AIDS diagnosis continues to be highest among blacks followed by Hispanics and whites. The rate of HIV/AIDS diagnosis among blacks in 2007 was seven times greater than among whites. Since 1998, the rate of HIV/AIDS diagnosis in Hispanics has exceeded that of whites and has increased by four times since 1998.

HIV AND AIDS CASES BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY, ALABAMA

Demographic Group/Exposure Category	HIV/AIDS Incidence* 01/01/07 to 12/31/07		HIV/AIDS Prevalence as of 12/31/07		HIV/AIDS Incidence* 01/01/08 to 06/30/08		Cumulative HIV/AIDS 1982 - 6/30/08	
	Cases	% of Total	Cases	% of Total	Cases	% of Total	Cases	% of Total
White	231	25.67	3107	31.64	108	24.60	5322	33.93
Black	617	68.56	6356	64.73	299	68.11	9918	63.24
Hispanic	31	3.44	201	2.05	11	2.51	244	1.56
Asian	1	0.11	14	0.14	4	0.91	14	0.09
Native Hawaiian/Pacific Islander	1	0.11	5	0.05	0	0.00	4	0.03
Legacy Asian/Pacific Islander	0	0.00	12	0.12	0	0.00	15	0.10
American Indian/Alaska Native	2	0.32	12	0.17	1	0.32	17	0.15
Multi -race	15	5.47	48	1.67	10	7.69	79	1.98
Unknown	2	0.22	65	0.66	6	1.37	70	0.45
Total	900	100.00	9820	100.00	439	100.00	15683	100.00

* Incident HIV and AIDS reflects cases whose first known HIV diagnosis or AIDS diagnosis occurred during the specified time period.

PROGRAM SERVICES AND COMMUNITY OUTREACH

The mission of the Division of HIV/AIDS Prevention and Control, in collaboration with community partners, is to reduce the incidence of HIV infections, to increase life expectancy for those infected, and to improve the quality of life for persons living with or affected by HIV. As the Ryan White Grantee, the Alabama HIV/AIDS Direct Care and Services Program provides direct medical services and health-related support services to monitor HIV-related illnesses in the State.

The Alabama Drug Assistance Program (ADAP) provides HIV medications to low income, uninsured Alabama residents living with HIV/AIDS. ADAP is approximately 95 percent federally funded. There are an estimated 13,000 people living with HIV/AIDS in Alabama at a cost of approximately \$10,000 to \$11,000 per patient per year. The cap for Alabama's Drug Assistance enrollment was increased from 1,100 to 1,200 individuals, which helped to eliminate the need to reinstate a waiting list in 2007. Increased funding has allowed for the expansion of the programs' formulary to add a limited number of medications and to accept applications electronically.

The statewide Peer Mentoring Program consists of HIV positive mentors and aims to identify HIV positive persons in the community who are not receiving direct care services. The mentors provide information and referrals to approximately 1,500 clients infected or affected by HIV. The mentors provide support services that include providing referrals to clinics, testing sites, drug treatment centers, housing programs and food pantries. The mentors also provide emotional support, harm reduction skills, and patient advocacy services.

The HIV/AIDS Waiver Program provides services to individuals with HIV/AIDS who are at risk for nursing home placement. By providing such services as personal care, skilled nursing, companion services, homemaker services, respite and case management, individuals with HIV/AIDS can remain at home in a safe and healthy environment rather than going to a nursing home. The Waiver Program can provide services for 150 individuals who meet the medical and financial criteria for admission.

The HIV Prevention Planning and Development Branch oversees state supported prevention education activities in the State. The branch awards community-based organizations funds for HIV prevention and testing programs. All 67 county health departments in Alabama offer HIV counseling and testing as well as screening for STDs. All ADPH funded HIV prevention programs are required to include an HIV counseling and testing component and referral to medical services for clients testing HIV positive.

POLICY IMPLICATIONS

The CDC's new surveillance technology reveals that the HIV epidemic is and has been worse than previously known. Results indicate that approximately 56,300 new HIV infections occurred in the United States in 2006. This figure is roughly 40 percent higher than the CDC's former estimate of 40,000 infections per year. The CDC estimated that one quarter of HIV infected people are unaware of their HIV infection and that these persons account for more than half of all new infections. Alabama Public Health Law pertaining to HIV/AIDS infection does not

require laboratories to report CD4 cell count or viral load test results to ADPH. As a result, there is not an accurate estimate of unmet need within Alabama's HIV infected community.

According to the Southern States Manifesto Update 2008, "Rising infection rates coupled with inadequate funding, resources, and infrastructures have resulted in a disparate and catastrophic situation in our public health care systems in the South. The impact of HIV/AIDS on populations that also disproportionately reflect vast poverty and inadequate support continues to fuel the challenges of 1) reducing new infections; 2) identifying infections as early as possible; and 3) providing adequate care, treatment, and housing."

RECOMMENDATIONS

- 1) **Healthy People 2010 Objective 4.10** - Reduce the incidence of diagnosed HIV infection in adolescents and adults to at least 8.0 cases per 100,000 people.
- 2) Address the disproportionate impact of HIV/AIDS among the African American population by targeting prevention and direct care programs to this population group.
- 3) Increase community-based funded initiatives to reach high-risk seronegative people to help them stay uninfected.
- 4) Provide more train-the-trainer workshops on testing to enhance screening and testing services offered by community organizations and other partners that serve populations at highest risk for HIV infection.

MENTAL HEALTH IN ALABAMA

MENTAL HEALTH IN ALABAMA

STATISTICAL DATA

The Center for Mental Health Services (CMHS) in August 2008 reported 5.4 percent of Alabama's adult population has or will experience a *serious* mental illness in their lifetime, accounting for some 188,504 individuals. CMHS reports that as many as 20 percent of Alabama's adult population has or will have a mental illness during their lifetime.

According to the landmark "Global Burden of Disease" study, mental disorders are the second leading source of disease burden in established market economies. Major depression takes an enormous toll on functional status, productivity, and quality of life, and is associated with elevated risk of heart disease and suicide. Approximately 20 percent of the U.S. population is affected by mental illness during a given year. Of all mental illnesses, depression is the most common disorder. More than 19 million adults in the United States suffer from depression. Major depression is the leading cause of disability and is the cause of more than two-thirds of the suicides each year.

According to Substance Abuse and Mental Health Service Administration (SAMHSA), in 2005 there were an estimated 24.6 million adults aged 18 or older who experienced Serious Psychological Distress (SPD), which is highly correlated with serious mental illness. The research showed that 18 to 25 year olds have the highest prevalence of mental health problems, but is the age group with the lowest rate of help-seeking behaviors.

The Division of Substance Abuse Services has the responsibility for development, coordination, and management of a comprehensive system of treatment prevention services for alcoholism/drug addiction and abuse.

THE DISPARITY

According to the American Association of Suicidology, in 2005, Alabama ranked 28th in the nation in the rate of suicide deaths. In 2007, 586 Alabama deaths were lost to suicide. Because of the tragic implications of suicide, family members and friends have to deal with the stress of their loss.

PROGRAM SERVICES AND COMMUNITY OUTREACH

The Alabama Department of Mental Health and Mental Retardation (ADMHMR) is the agency responsible for serving Alabama citizens with mental illness, mental retardation, and substance abuse addiction. Over 230,000 people are served annually through a broad network of State mental illness and mental retardation outpatient, and prevention programs. Currently there is one developmental center for persons with mental retardation and seven facilities for persons with mental illness. Through community-based services the department contracts with hundreds of local service providers in all 67 counties.

The (ADMHMR) Division of Mental Illness provides a comprehensive array of treatment services through seven State operated facilities, and contractual agreements with community mental health centers across the State. Over 4,000 individuals are served annually in the State-operated facilities and over 100,000 receive services in certified community-based programs.

The (ADMHMR) Division of Mental Retardation is organized to provide a comprehensive array of services and supports to individuals and their families in the State through the State-operated residential developmental center, or through regional community service offices. The Division of Mental Retardation provides services for children with cognitive disabilities and diagnoses of Mental Retardation, which includes an adaptive functioning assessment for service eligibility. Services and support may range from information and referral, to very minimal direct such as case management or hourly services, to maximum support that provides 24-hour care.

Some individuals may request assistance to address immediate needs, or to plan for the future, or to obtain assistance to apply for special benefits such as Social Security or Medicaid, through other agencies.

The Division of Substance Abuse Services has the responsibility for development, coordination, and management of a comprehensive system of treatment prevention services for alcoholism/drug addiction and abuse.

POLICY IMPLICATIONS

Stigma presents a barrier to individuals seeking mental health services. ADMHMR partners annually with the National Alliance for the Mentally Ill of Alabama (NAMI-AL) to produce mass media campaigns to reduce stigma.

RECOMMENDATIONS

- 1) **Health People 2010 Objective 4.14** - Reduce the suicide rate to at least 10.0 per 100,000 people.
- 2) **Healthy People 2010 Objective 18.9b** - Increase the proportion of adults with recognized depression who receive treatment.
- 3) Expand statewide consumer-run mental health organizations offering services to adults, particularly the 18-25 year olds. Introduce legislation to fund the proposed services.
- 4) Build on the current efforts to reach young adult communities by developing radio and print public service announcements to address mental health awareness among the Hispanic American, African American, Chinese American, and Native American populations.

ASTHMA IN ALABAMA

ASTHMA IN ALABAMA

STATISTICAL DATA

Asthma is a chronic disease affecting the airways and lungs. In an asthma attack airways become swollen and constricted, causing a potentially life threatening sequela. In the United States, asthma's impact on health, quality of life, and the economy are large.

According to the CDC:

In 2005, an estimated --

- 22.2 million people had asthma
- 12.2 had an asthma attack in the last year

In 2004, asthma accounted for --

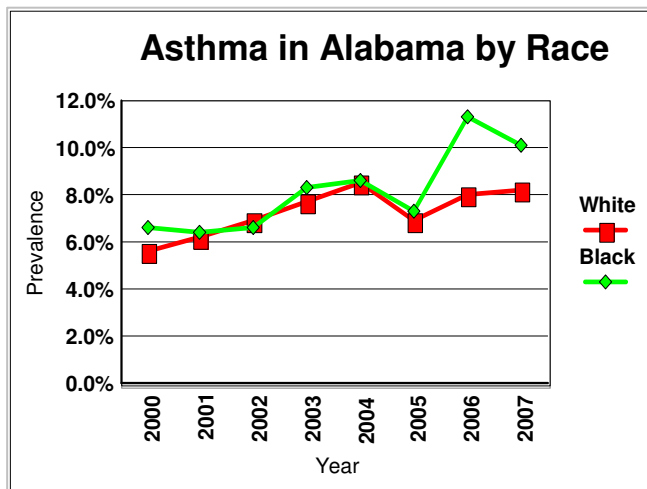
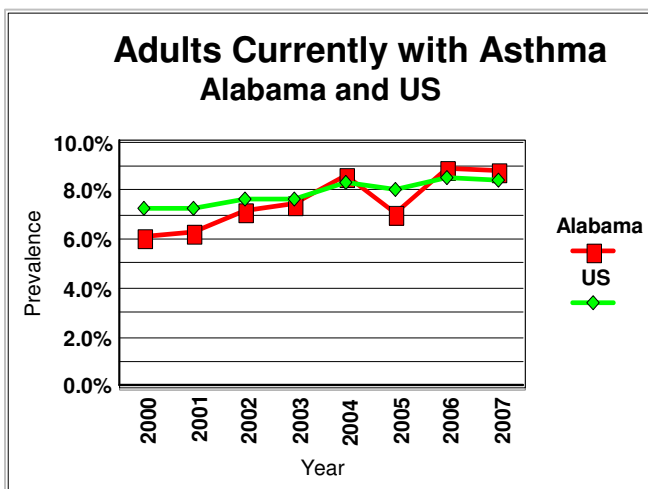
- 13.6 million doctor visits
- 1.8 million emergency department visits
- 497,000 hospitalizations

Asthma frequently interrupts daily activities, including attending school and going to work. According to the Asthma Prevalence, Health Care Use and Mortality United States, data from CDC for 2003-05 in 2003, children aged 5-17 missed 12.8 million days of school and adults missed 11.8 million days of work.

Asthma onset cannot be prevented, and asthma cannot be cured. However, it can be controlled. Everyday exposures to agents such as cigarette smoke, mold, dust mites, pet dander, and pollens can trigger asthma attacks. Agents encountered by workers can also cause allergic problems that include asthma. The CDC provides comprehensive information on effective interventions for asthma control, including identifying symptoms, diagnosis, medical management, and medications.

Asthma is on the rise in Alabama, increasing among males and females, in all age groups and among all ages. According to 2007 Behavior Risk Factor Surveillance System, 17.3 percent of adults reported they had asthma, up from 6.1 percent in 2000. Among youth in grades 9-12 in 2005, 24.0 percent reported they had ever been told they had asthma by a health care professional according to the 2005 Youth Risk Behavior (YRB) Survey. In 2006, there were 58 deaths from asthma in Alabama, according to the ADPH, Center for Health Statistics.

ASTHMA CHARTS



THE DISPARITY

According to BRFSS, disparities in asthma exist in segments of the adult population in Alabama based on race and ethnicity, gender, education, and income. In 2007, the self-reported prevalence of asthma was greater among blacks (10.1 percent) than whites (8.2 percent). The prevalence was higher in women (8.7 percent) than men (6.9 percent). Those with the least education (no high school diploma) reported more asthma (12.8 percent) than those with higher levels of education (5.5 percent among college graduates). Similarly, those with the lowest incomes (less than \$15,000 per year) had three times the prevalence than those with annual incomes over \$75,000 (16.2 percent versus 5.0 percent). Disparities also exist among Alabama youth with asthma. Black youth suffer more from asthma than white youth. However, in both races youth males report more asthma than females.

PROGRAM SERVICES AND COMMUNITY OUTREACH

In 2004, the ADPH Chronic Disease Division was awarded a five-year CDC Cooperative Agreement Program. This program, *Steps to a Healthier Alabama* (Steps Program), targets asthma, diabetes, and obesity in seven counties of the State. This community-based program provided schools, teachers and staff with *Asthma 101: The Basics* training to ensure staff understood the disease and could assist a child with asthma. Children with asthma in the third and fourth grades received *Open Airways* training to learn self-management skills. These trainings were conducted annually in Pike and Barbour counties. In addition, an annual Asthma Safari was conducted in Pike County for children with asthma in kindergarten through second grade to learn self management skills. The Steps Program staff in Pike and Barbour counties worked with local medical doctors to promote the use of asthma action plans for every child with asthma.

In 2007, Alabama Medicaid implemented an asthma care coordination project to reduce fragmentation in the claims and processing system, and improve patient outcomes. The program, Alabama Medicaid Together For Quality (TFQ) partners with ADPH to provide care coordination by licensed social workers to encourage patient compliance and utilization of community resources in 11 pilot counties. The care coordination includes monitoring use of medications, emergency department visits, and hospitalizations.

In January 2008, the Steps Program collaborated with the Alabama Department of Environmental Management (ADEM) on initiatives for its 2008 Environmental Justice Plan which targeted asthma. A Governor's Proclamation and press release in May highlighted asthma issues. ADEM created health education brochures and magnets and distributed them to schools. In July 2008, a website with education for teens was created.

In August 2008, the Steps Program convened a statewide asthma coalition to bring community advocates, policy makers, health care providers, and persons with asthma together to address the burden of asthma in Alabama. A detailed asthma burden document will be written as well as a comprehensive state plan. These are projected to be completed by January 2009.

POLICY IMPLICATIONS

Asthma can be controlled with proper diagnosis, appropriate asthma care, and management activities. Policies to reduce the burden of asthma among both adults and youth with asthma must include access to quality health care, asthma care coordination services, medications, and patient education on asthma self-management skills. School policies should address students' permission to carry and self-administer quick-relief inhalers, on-site school nurses, asthma action plans for all students with asthma, student education on asthma awareness, and faculty/staff education on asthma.

RECOMMENDATIONS

- 1) Bring stakeholders together to create a State Asthma Coalition to develop a comprehensive State plan to reduce the burden of asthma in Alabama.
- 2) Support expansion of Alabama Medicaid TFQ asthma pilot project to statewide care coordination services.
- 3) Partner with ADEM, and others throughout the state, to support policy and environmental changes to reduce the burden of asthma.
- 4) Seek potential funding streams, such as CDC and U.S. Environmental Protection Agency (EPA) to fund sustainable community initiatives to reduce the burden of asthma.

**THE NEED FOR A STATE PLAN OF ACTION TO REDUCE
AND ELIMINATE HEALTH DISPARITIES IN ALABAMA**

THE NEED FOR A STATE PLAN OF ACTION

A State Plan of Action is needed to give momentum to the reduction and elimination of health disparities and to make priority health issues visible through health policies, program services, prevention efforts and community outreach. The priority health issues to be addressed in the *State Plan of Action* are cancer, cardiovascular disease, diabetes, infant mortality, and HIV/AIDS. In addition, asthma and mental health are addressed in this document because asthma is the leading cause of school absenteeism in Alabama and mental health is indispensable to personal well-being and family relationships.

The State Plan of Action will also provide feasible and applicable recommendations for priority health issues. It is hoped that the State Plan of Action will: strengthen the existing partnerships at the State and community level; focus on policy discussions to gain insight on effective and ineffective actions toward health disparities elimination; and promote the public's engagement in the discussions to obtain informed input and ideas on how to make the health system work for those who are disproportionately affected by the burden of the health disparities.

To address the need of minority populations, the State Plan of Action should have the following overarching goals:

- 1) The burden of health disparities experienced by the racial and ethnic populations in Alabama will be reduced.
- 2) The morbidity and mortality rates in cancer, cardiovascular disease, diabetes, infant mortality, HIV/AIDS will be decreased.
- 3) Parity in mental health will be achieved with improved access to services at the State and local level.
- 4) School absenteeism rates due to asthma will be reduced.

A State Plan of Action is also needed to guide the planning, development, implementation, evaluation, and maintenance of the following initiatives:

- 1) Outcome measures which will be evidence-based, and health indicators will be benchmarked, tracked, monitored, and evaluated to assist in the production of an annual report card. The report card will be used to provide feedback to improve and strengthen the State Plan of Action.
- 2) A State database is needed to accurately track the diverse population in Alabama. The actual number of Alaska Natives/American Indians, Latinos/Hispanics, Asian Americans, Pacific Islanders, and African Americans being served in the community health centers, health departments, hospitals, and rural clinics must be collected and recorded. The database should capture the race and ethnicity and health insurance status of those being diagnosed and treated for cardiovascular disease, cancer, HIV/AIDS, asthma, mental health, or diabetes. Mortality data is needed by specific population groups.
- 3) Health assessments should be developed to identify the health status concerns of the multicultural population groups.
- 4) Health status outcome reports cards will profile the health status (by indicators) of each of the minority racial and ethnic groups in Alabama.
- 5) A comprehensive evaluation of health service delivery at all sites of health care must be conducted to adequately measure performance and compliance with guidelines and standards of care.

A statewide wellness and disease prevention approach is needed to eliminate health disparities. A statewide approach is the most effective way to tackle such a monumental public health concern. Lifestyle choices will be the health focus for the 21st century. Peer education, community-based interventions, and better access to preventive health care will support Alabamians in making better lifestyle choices. By tailoring educational messages to groups where the greatest disparities exist and by increasing screening, early detection and treatment

for the underserved, the State should see progress. The State's current surveillance and data monitoring systems do not provide sufficient data to tabulate differences. A profile of these racial and ethnic differences will greatly expand the knowledge of disparities between Alabama's minority and Caucasian populations.

This State Plan of Action must be flexible to allow for revisions, updates, and enhancement by State agencies, community members, policy makers as well as members of the Health Disparities Advisory Council of the Alabama Department of Public Health. The State Plan of Action and any needed alteration to the plan will be discussed at the Advisory Council's quarterly meetings. It is anticipated that this State Plan of Action will encourage participation by more individuals and entities with the ability to make a difference and will create partnerships and collaboration networks under the guidance of the common initiative of eliminating health disparities. One of many outcomes expected through the partnerships and collaborations with educational institutions is an increase of minorities in health professions, particularly in medicine, dentistry, nursing and allied science fields. Impact measures will evaluate the changes in the number of minorities choosing careers in health care over time. Additional health care professionals in underserved areas of Alabama should work toward the reduction and elimination of health disparities.

Minorities are more likely to be uninsured, working poor, or enrolled in lower end health plans that offer fewer benefits such as preventive health services. Available funds can be used to stimulate community-based and neighborhood-based projects implementing preventive strategies, provide technical assistance and training, and recruit minorities in health professions. Funds can also be used for the production of an annual report card to be developed to evaluate the health status for each of the targeted minority groups, in comparison with Healthy 2020 Objectives for Alabama's minorities.

RECOMMENDATIONS

POLICY INITIATIVES

- 1) Appoint, legislatively, a Health Disparities Commission to draft legislation to advance the understanding of minority health and health disparities.
- 2) Fund community-based grants supporting minority health and wellness programs that focus on prevention of illness and health education.
- 3) Advocate for legislation and funding to provide basic health plan coverage for uninsured Alabamians between the ages of 19 to 64.
- 4) Advocate for policies and funding to support worksite wellness programs, and physical activity in local communities, and safe outside areas for physical activity.

PROGRAM SERVICES AND COMMUNITY OUTREACH

- 1) Strengthen the Alabama Department of Public Health's (and the State's) capacity to provide preventive services to racial and ethnic minority communities.
- 2) Establish in-service training for ADPH staff on customer service, cultural competence and diverse populations so that program impact on health disparities can be determined.
- 3) Work to build trust between the ADPH staff and the community to promote community outreach.
- 4) Encourage members of the community to seek appropriate services including health insurance and monitor access to ensure equitable services for all.
- 5) Develop a role for ongoing training for cultural diversity within health agencies and community organizations to better achieve overall improvements in reaching minority populations.
- 6) Improve the coordination and collaboration among State and county public health offices, and other State agencies providing health services to minorities.

- 7) Improve linkages among public and private entities disseminating information on minority health and health disparities.
- 8) Develop disease prevention messages with culturally sensitive media campaigns to increase health literacy that target minorities and communities of color. Health promotion messages should be culturally appropriate and environmentally relevant, taking into consideration limited access to healthy food choices and safe outside areas for physical activity.
- 9) Utilize community and tribal leaders to evaluate and distribute health promotion messages.
- 10) Decrease access barriers that prevent men and women from obtaining recommended screenings by: a) increasing minority populations' awareness of risk factors for diabetes, cardiovascular disease, HIV/AIDS, breast and cervical cancer, colorectal and prostate cancers, and b) educating primary care providers to follow established screening guidelines.

2007 National Healthcare Disparities Report—At a Glance

The National Healthcare Disparities Report (NHDR) describes the quality of and access to care for multiple subgroups across the United States, and also represents a source of information for tracking the Nation's progress over time. The observed disparities vary by condition and population.

Overall, disparities in quality and access for minority groups and poor populations have not been reduced since the first NHDR. Based on 2000 and 2001 data compared with (the) year's 2004 and 2005 data (depending on the data source), the number of measures on which disparities have gotten significantly worse or have remained unchanged since the first NHDR is higher than the number of measures on which they have gotten significantly better for Blacks, Hispanics, American Indians and Alaska Natives, Asians, and poor populations.

While some of the biggest disparities in quality remain, progress has been made in reducing disparities. Some examples of disparities that have been reduced include:

- The disparity between Black and White hemodialysis patients with adequate dialysis was eliminated in 2005.
- The disparity between Asians and Whites who had a usual primary care provider was eliminated in 2004.
- The disparity between Hispanics and non-Hispanic Whites and between people living in poor communities and people living in high income communities for hospital admissions for perforated appendix was eliminated in 2004.
- Significant improvements were observed in childhood vaccinations for most priority populations.

In 2007, the NHDR also reports on the biggest disparities in quality documented over the years where there has not been improvement:

- Blacks had a rate of new AIDS cases 10 times higher than Whites.
- Asian adults age 65 and over were 50% more likely than Whites to lack immunization against pneumonia.
- American Indians and Alaska Natives were twice as likely to lack prenatal care in the first trimester as Whites.
- Hispanics had a rate of new AIDS cases over 3.5 times higher than that of non-Hispanic Whites.
- Poor children were over 28% more likely than high income children to experience poor communication with their health care providers.

The relationship between access to care and quality of care is complex. The 2007 NHDR shows that the uninsured face greater challenges than the insured in getting access to high quality health care. Moreover, based on analyses of a set of core quality measures, the factor most consistently related to better quality is whether a patient is insured.

Source: National Healthcare Disparities Report 2007 / Agency for Healthcare Research and Quality (AHRQ) / website: www.ahrq.gov

CHARTS

2007 Alabama Public Health Area Estimates, Alabama Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS) Survey, 2007. (p. 34)

Asthma Charts, Alabama Department of Public Health, Behavioral Risk Factor Surveillance System (BRFSS). (p. 58)

BMI Chart, Alabama Department of Public Health, Obesity Task Force. (p. 12).

Cancer Map, Alabama Department of Public Health, Alabama Statewide Cancer Registry and Health Provider Database. (p. 28).

Cardiovascular Chart, Alabama Department of Public Health, Behavioral Risk Factor Surveillance System. (BRFSS) Survey Results, 2007. (p. 22).

HIV and AIDS Cases by Demographic Group and Exposure Category, Alabama Department of Public Health, HIV/AIDS Division. (p. 48).

Infant Mortality Charts, Alabama Department of Public Health, Center for Health Statistics, Statistical Analysis Division (p.38-40).

Reported Tuberculosis in Alabama, Alabama Department of Public Health, Tuberculosis Control Division (2007). (p. 6).

GLOSSARY

ABC Board – Alcoholic Beverage Control Board

ABCCEDP – Alabama Breast and Cervical Cancer Early Detection Program

ACDRS – Alabama Child Death Review System

ADA – American Diabetes Association

ADEM – Alabama Department of Environmental Management

ADPH – Alabama Department of Public Health

AIDS – Acquired Immune Deficiency Syndrome

ALS – Advance Life Support

ALSDE – Alabama State Department of Education

BMI – Body Mass Index

BRFSS – Behavioral Risk Factor Surveillance System

CD4 Marker – Cluster of Differentiation Marker

CHA – Community Health Advisor

CHA–RPS – Community Health Advisor–Research Partners

CMHS – Center for Mental Health Services

CVD – Cardiovascular Disease

ECG – Electrocardiograph

EMA – Emergency Management Agency

ESRD – End Stage Renal Disease

FQHC – Federally Qualified Health Care Centers

HbA1c – Glycosylated hemoglobin A1c

HBCU – Historically Black Colleges and Universities

HIV– Human Immunodeficiency Virus

IMR – Infant Mortality Rate

LBW – Low Birth Weight

MMWR – Morbidity and Mortality Weekly Report
NAMI-AL – National Alliance for the Mentally Ill of Alabama
NBS – Newborn Screening Program
NCI – National Cancer Institute
NDEP – National Diabetes Education Program
NHANES – National Health and Nutrition Examination Survey
NICU – Neonatal Intensive Care Unit
PRAMS – Pregnancy Risk Assessment Monitoring System
REACH 2010 – Racial and Ethnic Approaches to Community Health
SAMHSA – Substance Abuse and Mental Health Service Administration
SOMH – State Minority Health Office
SPD – Serious Psychological Distress
TB – Tuberculosis
TFQ – Together For Quality
UAB – University of Alabama at Birmingham
WIC – Women, Infants and Children Program
YRB – Youth Risk Behavior Survey

REFERENCES

Alabama – One Choice at a Time, a non-funded grant (2007), Alabama Department of Public Health, Nutrition and Physical Activity Division.

Alabama Atlas of Racial Disparities in Mortality, Alabama Department of Public Health, Center for Health Statistics, 2002.

Alabama Cancer Facts & Figures, 2007, Alabama Statewide Cancer Registry.

Alabama Cardiovascular Health State Plan 2001, Alabama Department of Public Health, Cardiovascular Health Program (2001).

Alabama Chart Book of Regional Disparities in Mortality, Alabama Department of Public Health, Center for Health Statistics, (2003).

Alabama Department of Environmental Management.

Monthly Statistical Report, (March 2007), Alabama Department of Human Resources.

Alabama Department of Public Health, Alabama Breast and Cervical Cancer Early Detection Program, (ABCCEDP).

Alabama Department of Public Health, Behavioral Risk Factor Surveillance System.

Alabama Department of Public Health, Cardiovascular Health Program.

Alabama Department of Public Health, Center for Health Statistics.

Alabama Department of Public Health, Comprehensive Cancer Control Program.

Alabama Department of Public Health, Alabama Child Death Review System.

Alabama Department of Public Health, Alabama Family Planning Program

Alabama Department of Public Health, Diabetes Branch.

Alabama Department of Public Health, HIV/AIDS Division.

Alabama Department of Public Health, Alabama Newborn Screening Program (NBS)

Alabama Department of Public Health, Obesity Task Force.

Alabama Department of Public Health, State Perinatal Program.

Alabama Department of Public Health, STEPS Branch.

Alabama Department of Public Health, Tobacco Prevention and Control Branch.

Alabama Department of Public Health, Tuberculosis Control Division.

Alabama Department of Public Health, Women, Infant and Children Program (WIC).

Alabama Hispanic Tobacco Survey, (2005).

American Association of Suicidology, (2005).

American Heart Association.

Behavioral Risk Factor Surveillance System (BRFSS), National Center for Chronic Disease Prevention and Health Promotion, (2007).

CDC Wonder, Centers for Disease Control and Prevention, 1999-2005.

Centers for Disease Control and Prevention (CDC).

Chart Book on Trends in the Health of Americans.

Comprehensive Cancer Control 2006-2010 Plan, Alabama Comprehensive Cancer Control Coalition, Alabama Department of Public Health (2005).

Global Burden of Disease Study.

Healthy Alabama, Alabama Department of Public Health, Bureau of Health Promotion and Information, 2000.

Healthy People 2010: Understanding and Improving Health, U.S. Department of Health and Human Services.

Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, (October 19, 2007).

National Healthcare Disparities Report, U.S. Department of Health and Human Services, (2006).

National Healthcare Disparities Report 2007/Agency for Healthcare Research and Quality (AHRQ).

Narrowing the Gap-Minority Health in Alabama: A Summary of Recommendations by the Alabama Minority Health Task Force, Alabama Department of Public Health, Office of Primary Care and Rural Health, Minority Health Section, (1998).

National Health and Nutrition Examination Survey (NHANES), 1999-2002.

Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health Care, Race, Ethnicity & Health Care, Issue Brief (March 2005), The Henry J. Kaiser Family Foundation.

Southern States Manifesto Update, 2008.

Strategic Plan for the Prevention and Control of Overweight and Obesity in Alabama, Alabama Obesity Task Force, (2005).

U.S. Surgeon General's Report, (2006).

Tobacco Control Policies, National Cancer Institute (NCI).

U.S. Census Bureau.

U.S. Department of Health and Human Services, Office of Minority Health,

Uninsured Children In The South (November 2007), Southern Institute on Children and Families.

Youth Risk Behavior (YRB).

ACKNOWLEDGEMENTS

A Preliminary State Plan of Action to Reduce and Eliminate Health Disparities in Alabama is the result of work performed by a group of dedicated community, and State level people. The individuals and their respected agencies are listed below. We wish to acknowledge their commitment to works toward parity in health care and health outcomes in Alabama.

Alabama Department of Environmental Management
Alabama Department of Mental Health and Mental Retardation
Alabama Department of Public Health
Alabama Department of Public Health, Health Disparities Advisory Council
Alabama Department of Rehabilitation
Alabama Department of Senior Services
Alabama Indian Affairs Commission
Alabama Medicaid Agency
Alabama Cooperative Extension System

Alabama Alliance for Latino Health
American Association of Retired Persons
American Heart and Stroke Association
Alabama Medical Education Consortium
Alabama Minority Health Advisory Council
Alabama Minority Health Task Force
Alabama Primary Association
Alabama Quality Assurance Foundation
Alabama Rural Health Association

Boat People SOS Bayou LaBatre
Community Care Network
Congregations for Public Health
Deep South Network for Cancer Control
Alabama AIDS
Alabama Arise
Mid-Alabama Coalition for the Homeless
Montgomery AIDS Outreach

Alabama A & M University
Alabama State University
Tuskegee University National Center for Bioethics and Research
University of Alabama at Birmingham School of Public Health
University of Alabama at Birmingham
University of Alabama at Tuscaloosa
University of South Alabama

ALABAMA MINORITY HEALTH COUNCIL MEMBERS, 1999

- Legislators.....Representative Laura Hall
Senator Vivian Figures

- Academia.....Dr. B. Lee Green (University of Alabama at Birmingham)
Dr. Marian Secundy (National Center for Bioethics in Research)

- Hispanic/Latinos.....Sylvia Delongchamp

- American Indian.....Wilford Taylor, (Chief, MOWA Band of Choctaw Indians)

- Asian American.....Dr. Naresh Kaushik
Dr. Richard Wang

- African American.....Ms. Marilyn Hall

- Health Professional.....Sandra Hullett (Primary Care Physician)
Kathy Sawyer (Mental Health Commissioner)

- Clergy.....Rev. Joseph Davis
Father Manuel Williams
Rev. Louis Caballero, Hispanic Ministry

ADPH Health Disparities Advisory Council

Marilyn Archibald, M.S.N., R.N., C.L.N.C., *Nurse Consultant*, Bureau of Children's Health Insurance

Carolyn Battle, M.S., R.D., *Director*, WIC Division, Bureau of Family Health Services

Diane Beeson, M.B.A., *Director*, Tobacco Prevention and Control Branch, Bureau of Health Promotion and Chronic Disease

Carolyn Bern, *Rural Health Outreach Coordinator*, Office of Primary Care and Rural Health

Kathryn Chapman, Dr.P.A., *Director*, Comprehensive Cancer Control Program, Bureau of Health Promotion and Chronic Disease

Jane B. Cheeks, J.D., M.P.H., *Director*, Division of HIV/AIDS Prevention and Control, Bureau of Communicable Disease

Valerie Cochran, M.S.N., R.N., NE-BC, *Assistant State Nursing Director*, Bureau of Professional and Support Services

Laarni Cox, M.P.H., *Youth Cessation Program Coordinator*, Tobacco Prevention Branch, Bureau of Health Promotion and Chronic Disease

Carol Ann Dagostin, B.S., M.T., A.S.C.P., *Research Analyst*, Comprehensive Cancer Control Program, Bureau of Health Promotion and Chronic Disease

Barbara Davis, R.P.T., *Rehab Consultant*, Bureau of Home and Community Services

Geraldine R. Daniels, J.D., M.H.S., *LEP Coordinator*, Office of Minority Health, Bureau of Professional and Support Services

Wendy Dixon-Flamand, B.F.A., *Public Information Specialist*, Office of Minority Health, Bureau of Professional and Support Services

Charlena Freeman, L.C.S.W., *Social Work Consultant/Assistant Director*, Women's Health Division, Bureau of Family Health Services

Miriam Gaines, M.A.C.T., R.D., L.D., *Director*, Nutrition and Physical Activity Division, Bureau of Professional and Support Services

Sherry George, M.P.A., *Director*, Women's Health Division, Bureau of Family Health Services

Debra Griffin R.N., B.S.N., *Nurse Coordinator*, Diabetes Branch, Bureau of Health Promotion and Chronic Disease

Heidi Hataway, M.S., R.D., L.D., *Director*, Steps Branch, Bureau of Health Promotion and Chronic Disease

Jessica Hardy, R.N., M.P.H., *Director*, Office of Women's Health, Bureau of Professional and Support Services

John Hankins, R.N., M.B.A., *Director*, Nursing Division, Bureau of Professional and Support Services

Katherine Dixon Hert, *Financial and Special Program Manager*, Office of Emergency Medical Services and Trauma

Scott Jones, B.A., SrPHA, *Interim Director*, Tuberculosis Control Division, Bureau of Communicable Disease

Sharon V. Jordan, B.S., M.P.H., *Assistant Director*, Division of HIV/AIDS Prevention and Control, Bureau of Communicable Disease

Frances B. Kennamer, M.P.A., *Director*, Bureau of Professional and Support Services

Kyle King-Reynold, Ed.D., *Director*, Diabetes Branch, Bureau of Health Promotion and Chronic Disease

Sandra Langston, M.P.H., *Director*, STD Division, Bureau of Communicable Disease

Gwendolyn Lipscomb, R.N., M.S.N., *Director*, Office of Minority Health, Bureau of Professional and Support Services

Greg Locklier, *Assistant General Counsel*, Office of General Counsel

Vontrese McGhee, B.S., *Surveillance and Evaluation Coordinator*, Tobacco Prevention Branch, Bureau of Health Promotion and Chronic Disease

Eric Morgan, B.S., M.P.H., DIPM, *Statewide Coordinator for Minority Health*, Tuberculosis Control Division, Bureau of Communicable Disease

Kalai Mugilan, M.A., M.P.H., Ph.D., *Mortality Analyst*, Statistical Analysis Division, Center for Health Statistics

Carolyn O'Bryan, L.C.S.W, P.I.P., *Home Health Social Work Consultant*, Bureau of Home and Community Services

Molly B. Pettyjohn, M.S., R.D., L.D., *Assistant Director*, Nutrition and Physical Activity Division, Bureau of Professional and Support Services

Sondra Reese, M.P.H., *Chronic Disease Epidemiologist*, Bureau of Health Promotion and Chronic Disease

Ava Rozelle L.C.S.W., *Regional and Professional Services Director*, Children's Health Insurance Program

Melanie J. Rightmyer, R.N., B.S.N., *Director*, Cardiovascular Health Branch, Bureau of Health Promotion and Chronic Disease

Bernice Robertson, M.A.C.T., M.P.A., *Director*, Compliance and Contracts Division, Bureau of Home and Community Services

Brandi Robinson, M.P.H., *Epidemiologist*, Statistical Analysis Division, Center for Health Statistics

Mary Scisney, R.N., M.S.N., *Infertility Prevention Coordinator*, STD Division, Bureau of Communicable Disease

Fern Shinbaum, R.N., M.S.N., *Special Projects*, Bureau of Children's Health Insurance Program

Julia Sosa, M.S., R.D., *Assistant Director*, Office of Minority Health, Bureau of Professional and Support Services

Janice M. Smiley, M.S.N., R.N., *Director*, State Perinatal Program, Bureau of Family Health Services

Kathy Vincent, L.C.S.W., *Staff Assistant to the State Health Officer*

Nancy Wright, M.P.H., *Director*, Breast and Cervical Cancer Division, Bureau of Family Health Services

A Preliminary State Plan of Action to Reduce and Eliminate Health Disparities in Alabama was published by the Office of Minority Health, Bureau of Professional and Support Services, Alabama Department of Public Health.

**Donald E. Williamson, M.D.
State Health Officer**

**Gwendolyn Lipscomb, R.N., M.S.N., Director
Office of Minority Health**

For additional copies of this report, contact:

**Office of Minority Health
Alabama Department of Public Health
Office of Minority Health
The RSA Tower, Suite 710, 201 Monroe Street
P.O. Box 303017, Montgomery, AL
(334) 206-5226**

Information materials in alternative formats will be made available upon request.

This document may also be obtained through the Alabama Department of Public Health's web site at www.adph.org