• BUREAU OF MINORITY HEALTH ACCESS

Eliminating Health Disparities

'From A Grass-roots Perspective'

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'Eliminating Health Disparities through innovation, collaboration and evidence-based solutions'

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Bureau of MINORITY HEALTH ACCESS

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'From A Grass Roots Perspective'

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Executive Summary

In 2005, both hurricanes Katrina and Rita elevated the Bureau of Minority Health Access (BMHA) to a higher level by giving it an entryway to becoming an advocate for underrepresented, underserved and minority populations on the gulf coast of Louisiana. The BMHA secured the necessary resources and developed action plans to aid collaboration and partnership opportunities among state agencies, academic institutions and community groups to assist socioeconomically disadvantaged minority populations through recovery and re-entry efforts.

By advocating for the least of these, BMHA will help eliminate health disparities, and improve the health status of minorities and the medically underserved, including the uninsured and underinsured population statewide. It is the Bureau's intent to include the integration of evidence or practice-based public health and community-based participatory approaches to support and disseminate programmatic activities that are successful in the reduction of racial and ethnic disparities. The Bureau of Minority Health Access draws on the large pool of existing resources from state and community agencies in an effort to work together in planning, developing, and implementing multilevel systematic approaches to reduce racial and ethnic disparities in health for minorities and the underserved populations in Louisiana.

Louisiana is the 31st largest state in the United States with 51,843 square miles and an estimated population of 4,287,768 (Census Bureau 2004), down from 4,468,976 in 2000 and a population density of 98.6 persons per square mile. Louisiana a primarily a rural state, coupled with the sparse population in most areas, presents obvious geographical barriers to health care access; especially among the statewide groups of minority populations. In 2005, a Minority Health Needs Assessment was conducted in minority, hurricane-plagued areas.

The result of this assessment was published in the Bureau's report to the Office of Minority Health in Rockville, MD. The assessment served as a tool to identify and prioritize health disparities during the aftermath of both hurricanes Katrina and Rita. It also provided a view of the overall health status of minority communities in other parishes least affected by the storms. This report shows the need for: 1) encouragement of more in-depth examination of problems and possible solutions affecting disparities before and after the hurricanes, 2) providing a basis for obtaining funds to rectify these problems thereby implementing solutions, and 3) partnering with other health and social service entities to address health disparities within their program requirements.

Identifying health disparities in the wake of a natural disaster was the first step taken in order to outline steps needed to resolve health disparities, including but not limited to, conducting a needs assessment, creating a plan and strategies, developing specific goals and objectives, allocating resources, implementing actions, and evaluating the results. A review of national and statewide statistics indicates a significant increase in minority populations during the next decade. Louisiana, too, can anticipate an increase in diversity. The expectation is supported by the 2004 Behavioral Risk Factor Surveillance Survey (BRFSS) data along with economic development projections. Changes are needed to impact the expected increase in health disparities along with a possible decrease in resources. Enhancing services, through collaboration, is just one way to prepare for these expected changes.

In 2005, BMHA was awarded a contract from the national Office of Minority Health to implement ***Operation Safe Re-entry*** which was designed to determine the health status of minority communities and facilitate preventive and post-care through support for victims devastated by hurricanes Katrina and Rita. The Bureau led the charge by mobilizing health care stakeholders, community-based organizations (CBOs), Historically Black Colleges and Universities (HBCUs), faith-based organizations and local city and parish governments to assist minority communities with establishing mechanisms to improve access to health care, assist with hurricane relief efforts and community clean up. With natural disasters coming more frequently and violently from June to November each year, The Bureau of Minority Health Access received a grant award from the Centers for Disease Control Emergency Preparedness to implement a pilot program called the ***Community Preparedness Response Network (CPRN)*** that is designed to assist low-income communities with establishing their own community emergency preparedness plan in the event of a natural disaster or pandemic flu outbreak. This program will provide hard-to-reach populations a point of contact during natural disasters or pan flu outbreak and make available resources to assist them with relief and recovery efforts specific for their communities.

Louisiana's One-Two Punch

After conducting needs assessment surveys during the Operation Safe Re-entry campaign shortly after Hurricane Katrina in 2005 and recently after hurricane Gustav, the Bureau's results revealed the true culprits responsible for widening the health disparity gap among racial and ethnic populations in Louisiana and it starts and ends with two major health risks: obesity and mental health. The Bureau's activities recorded in this report will exemplify actual accounts from interviews and investigations that confirm how minority populations are facing near insurmountable odds in search of proper mental health care and how obesity crosswalks with so many major illnesses that continue to keep Louisiana's health ranking at the very bottom nationally.

Introduction

The purpose of this report is to detail the Bureau's progress toward creating a state action plan to eliminate health disparities among racial and ethnic minorities. This report will provide an overview of the Bureau and its responsibilities. In the following pages, information, diagrams, maps, and charts are included to demonstrate certain aspects of the health status and disease prevalence of Louisiana's citizens. This information can provide direction in assessing and planning for disease prevention as well as accessing health care and education for Louisiana's multicultural populations and communities. Lastly, this report will highlight supplementary activities that the Bureau has initiated or participated in that contribute toward the goal of improving the health and well-being of Louisiana, particularly communities of color.

BACKGROUND

• Health disparities refer to those *avoidable* differences in health that *result from cumulative social disadvantage.*

• Bureau of Minority Health Access research has demonstrated that a wide variety of health outcomes are influenced by social factors such as socioeconomic status, behaviors, social support, stress, discrimination, and environmental exposures. Health disparities are evidence of inequalities in these social factors.

• Racial and ethnic diversity is increasing in Louisiana. From 2000–2007, the state's Asian population increased by 0.3%, the Native Hawaiian or Other Pacific Islander population increased by 0.2%, and the Hispanic or Latino population increased by 3%. Hispanics or Latinos have shown the most growth of any Louisiana racial or ethnic subgroup in terms of overall numbers from 2000–2007.

• In 2007, the Hispanic or Latino population comprised 3% of the Louisiana population, Black or African Americans, 32%, and Asians, 1%.

• Compared with the White population in Louisiana, Blacks or African Americans were almost 1.2 times, American Indians or Alaska Natives about 0.5 times, Hispanics or Latinos about 0.7 times, and persons reporting "Some Other Race" about 0.4 times more likely to be living in poverty in 2003.

• Data in this report consistently show that there are striking health and social inequalities between racial and ethnic population groups in the state. Louisiana data provide evidence for health disparities, and mirror the findings of many such studies nationwide.

KEY FINDINGS

Mortality

• The mortality rate for all causes is a key measure of health status across populations. From 2000–2005, Black or African American Louisiana residents had the highest death rate from all causes, approximately 1-2 times higher than White residents. White residents had the second highest death rate from all causes followed by Hispanic and American Indian or Alaska Native residents, both of whom had about 0.8 times the all-cause death rate of Whites. Asian or Pacific Islander residents of Louisiana had the lowest death rate from all causes, which was approximately 0.4 times that of White residents.

Chronic Disease

• In 2000–2005, heart disease was the leading cause of death in Louisiana. Black or African American Louisiana residents had the highest death rate from heart disease, about 1.2 times higher than that of White residents. American Indians or Alaska Natives had similar heart disease death rates. Hispanic and Asian or Pacific Islander residents had lower heart disease death rates compared with White residents (0.7 and 0.4 times the death rate of Whites, respectively).

• In 2000–2004, cancer another leading cause of death in Louisiana where Black or African American Louisiana residents had the highest death rate from cancer, about 1.1 times higher than that of White residents. Hispanic, American Indian or Alaska Native, and Asian or Pacific Islander residents had lower cancer death rates compared with White residents.

• In 2000–2005, cerebrovascular disease or stroke is a leader in causes of death in Louisiana. Black or African American Louisiana residents had the highest death rate from stroke, about 1.4 times higher than that of White residents. Hispanic and Asian or Pacific Islander residents had lower stroke death rates compared with White residents (0.8 and 0.5 times the death rate of Whites, respectively). There were too few reported deaths due to stroke among American Indian or Alaska Native residents to calculate reliable rates.

• In 2004–2006, Louisiana adults have the highest rates of diabetes, and lower-income adults are more likely to have diagnosed diabetes than are adults with higher income. Black or African American and Hispanic adults have significantly higher age adjusted diabetes prevalence rates than White adults.

• Diabetes is one of the leading causes of death in Louisiana in 2000–2005. Black or African American Louisiana residents had the highest death rate from diabetes, about 1.2 times higher than that of White residents. Hispanics had about 0.5 times the death rate from diabetes compared with Whites. There were too few reported diabetes deaths among Asian or Pacific Islander and American Indian or Alaska Native residents to calculate reliable rates. In 2005, Black or African American Louisiana residents had the highest hospitalization rate for diabetes and lower-extremity amputations of all racial and ethnic groups.

Behavioral Risk Factors for Chronic Disease

• In 2004–2006, lower-income adults in Louisiana were much less likely to obtain recommended screening tests for certain types of cancers compared with those of higher income. Low-income women were less likely to receive a recommended mammogram in the past two years and a recommended Pap test in the past three years compared with higher-income women. Among Louisiana adults aged 50 years and over, those with low income were less likely to have had a colonoscopy or sigmoidoscopy screening for colorectal cancer compared with those of high income.

• Cigarette smoking has been linked to numerous chronic diseases including cancer, cardiovascular diseases, respiratory diseases, and pneumonia. In 2005, 16% of Louisiana adults reported being current smokers. Louisiana adult smokers are more likely to be younger (30% of youth aged 18-24 currently smoke) and have lower incomes and less education than non-smokers. The proportion of Louisiana middle school students who smoke is 55% higher than the national median. High blood pressure (HBP) is a major risk factor for heart attack and the most important modifiable risk factor for stroke. In 2004–2005 Black or African American adults experienced high blood pressure more than White and Hispanic adults. Black or African American adults were also more likely to report taking medication for HBP.

• Physical inactivity is linked to increased risk of several chronic health conditions, including cardiovascular disease, diabetes, some cancers, high blood pressure, overweight and obesity, back problems, and osteoporosis. Physical inactivity increases with age. 2005 Behavioral Risk Factor Surveillance Survey (BRFSS) data show that more than half of Louisianans adults aged 65 years and older did not meet the federally recommended physical activity levels.

Infectious and Sexually Transmitted Diseases

• Diagnosed cases of HIV/AIDS for 2001–2005 were most prevalent in Blacks. Blacks experienced 6.0 times the rates of HIV/AIDS diagnoses as Whites, respectively.

• During 2001–2005, African Americans in Louisiana disproportionately experienced chlamydia infection, gonorrhea, and syphilis compared with Whites and Hispanics.

• The incidence rates of invasive pneumococcal disease in Louisiana among Blacks and Hispanics were three and two times that of Whites, respectively, during 2001–2005.

Maternal and Child Health

• The infant mortality rate (IMR) is a key measure of population health status. Between 2001–2005, the IMR for White infants was 7.6, while for Black or African American infants, the IMR was 13.9, and Hispanics was 6.5 per 1,000 live births.

Access to Health Care; Health Care Workforce

• Lack of health insurance is an urgent health problem facing many state residents. In Louisiana, Hispanic residents are about 5.4 times more likely, and Black residents 2.7 times more likely, to be uninsured than White residents.

Other Vulnerable Populations

• Many other populations suffer from health disparities, including: rural residents, older and younger persons, sexual and gender minorities, persons with disabilities, immigrants and refugees, limited English proficient (LEP) populations, and homeless persons. Health data for these populations are inconsistently collected and often are not easily accessed. Therefore, public health professionals, health care providers, and policy makers have incomplete understandings of their health status and needs.

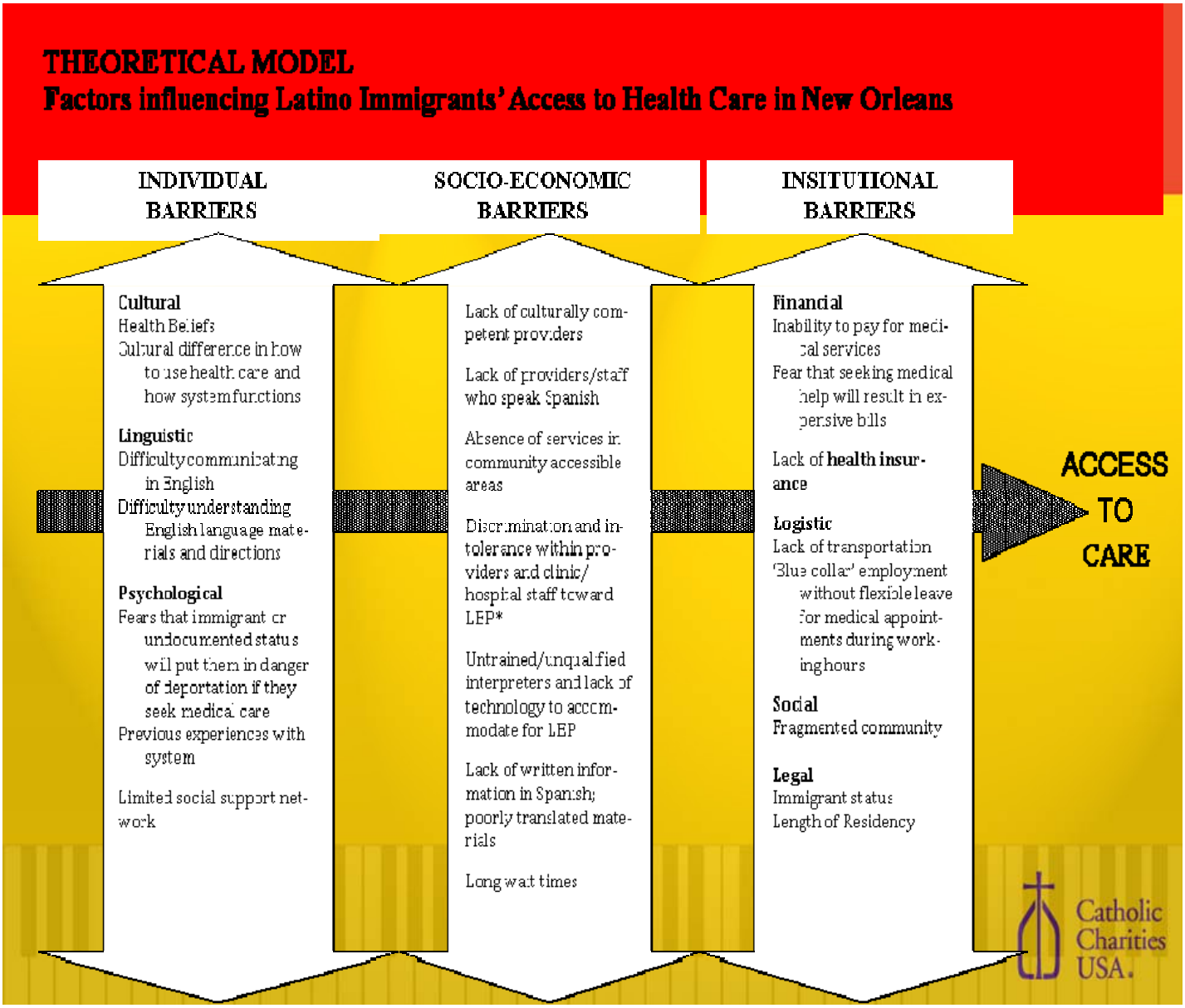
LIMITED ENGLISH PROFICIENCY (LEP) POPULATIONS

One source estimates that 90 million people in the U.S. have trouble understanding basic health information (National Library of Medicine 2004). People who do not speak, read or write English well will very often have limited or inconsistent access to healthcare and lowered health status. Medical histories, symptoms, diagnoses, treatment regimens, and illness belief systems are more likely to be misunderstood or incompletely described when there is language discordance between patients and health care providers (Smedley, Stith, and Nelson 2003). Increased patient mistrust or refusal of care, missed medication or office appointments, and reliance on emergency room services may result without proper interpretation, translation, and comprehension of medical information (Smedley, Stith and Nelson 2003; Hispanic Health Council 2006, 31). In 2005 shortly after hurricane Katrina, Louisiana doctors reported that they felt unprepared to treat patients with limited English proficiency as so many displaced people of Hispanic and Vietnamese origin entered emergency rooms and clinics for care.

In the last few decades, the federal government has repeatedly supported the use of linguistically appropriate social services, including health care. Institutions that receive federal funding must comply with the language access provisions of Title VI of the Civil Rights Act of 1964 (U.S. DHHS 2001, 1, 8–11; Meyers 2007, 19). The “culturally and linguistically appropriate services (CLAS) standards” are designed to provide meaningful access to health services (U.S. DHHS 2001). The only standards that are *mandated* are those that deal with the language needs of clients, such as competent and available interpreter and translation services, and the translation of health-related materials into commonly-used languages found in a service area (U.S. DHHS 2001, 8–11).

While most people in Louisiana’s LEP population speak Spanish, there are other persons who come from small language populations (i.e., Mexican indigenous languages, African ethnic dialects, Asian ethnic dialects) that may make it difficult to find qualified medical interpreters. Although hospitals and medical professionals frequently respond to the needs of LEP populations, there is a need for greater emphasis on better linguistic services (Louisiana Hispanic Apostolate 2006). Hospital and agency employees,

telephone interpreter services, community volunteers, licensed on-site medical interpreters, and multilingual picture cards in binders have all been used to help alleviate the problems of translation in medical settings (U.S. DHHS n.d.).



*Catholic Charities Archdiocese of New Orleans- Hispanic Apostolate Community Services Program/ Latino Health Access Net

HEALTH DISPARITIES: DEFINITIONS

The U.S. federal government has provided leadership in defining health disparities and priority populations, and in highlighting the underlying processes and consequences of health disparities. The National Institutes of Health (NIH) define health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (NIH 2000). One important mission of the NIH is to address health disparities by both improving knowledge about the underlying processes that give rise to and maintain health disparities, and disseminating interventions based on this knowledge (NIH 2006). *Healthy People 2010* define health disparities as health "differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation" (U.S. DHHS 2000a, 11). While the federal government recognizes these groups as "priority populations," not all of the 467 *Healthy People* objectives have specific target objectives for each of the groups identified (U.S. DHHS 2000a).

Other definitions of health disparities, particularly those for the World Health Organization (WHO), focus on health differences resulting from social disadvantages that are considered "avoidable, unfair and unjust" (Whitehead 1990, 5). In the United States, "disparity" has been the most common term used to express these health outcome differences. In other countries, the words "health inequities" or "health inequalities" are used to highlight the avoidable, unfair, and unjust aspects of health differences and their persistence (Carter-Pokras and Baquet 2002).

In addition to priority populations identified in national reports, there are other population subgroups likely to experience health disparities. These include immigrants, refugees, limited English proficiency populations, and homeless persons. Public health research has shown that these groups tend to have limited access to health care and/or adverse health outcomes relative to the majority population (Friedman 2005; Donohoe, 2004). While it may not be possible to provide detailed analyses of each population subgroup in our state, the Bureau of Minority Health Access (BMHA) has identified the above mentioned groups as priority population groups in its monitoring of health disparities. Although health disparities among racial and ethnic minority populations are a main concern of BMHA surveillance efforts, BMHA has recognized that multiple factors, such as socioeconomic position, discrimination, language spoken, and geography are inextricably intertwined with all health disparities.

Key Facts on Race, Ethnicity and Health Care in the U.S.

- Racial/ethnic disparities in health persist today even when comparing groups of similar Social Economic Status (SES). For example, the infant mortality rate for college educated Black women is higher than that for White women with similar education (11.5 vs. 4.2 per 1,000 live births).
- The rate of new AIDS cases in 2003 was 3 times higher among Hispanics and 10 times higher among African Americans than among Whites (26 and 75 per 100,000 vs. 7 per 100,000).

- At least 1 in 3 nonelderly Latinos (36%) and AI/ANs (33%) is uninsured, as compared with 22% of African Americans, 17% of Asian and Pacific Islanders, and 13% of Whites.
- Insurance matters, as evidence by the fact that uninsured adults across racial/ethnic groups are at least twice as likely to go without a doctor visit in the past year.
- Black and Latino adults are less likely to rely on a private physician for their medical care than White adults (62% and 44% vs. 77%).
- African American children have a rate of hospitalization for asthma that is 4 to 5 times higher than the rate for White children (527 per 100,000 vs. 144 per 100,000).
- Disparities in quality of care are not getting smaller. Over time, the gap between Whites and African Americans, Hispanics, Asians, and AI/ANs has either remained the same or worsened for more than half of the core quality measures being tracked.

EXPLAINING HEALTH DISPARITIES

Researchers employ different approaches to explain health, illness, and health disparities. The underlying approach that one takes to health disparities analysis is important since it frames the ways that health issues will be conceptualized, explored, and addressed. Researchers may focus on racial-genetic explanations of disparity, individual health decision-making and behaviors, inequalities in socioeconomic status, psychosocial effects of stress, or how structural inequalities in social institutions affect health outcomes (Dressler, Oths, and Gravelee 2005:236). When researchers or policy makers put into practice, or "operationalize," these approaches to data collection and explanation, they focus on certain ways to collect, analyze, and report data about people's health.

SOCIAL DETERMINANTS OF HEALTH DISPARITIES

Focusing solely on race and ethnicity may result in overlooking the negative health effects of social and economic inequalities. Individual and population health outcomes result from people acting in social, economic, political, and environmental contexts that overlap, interconnect, and shape each other. Health disparities are the products of these contexts and practices within medical and health care systems, as well as experiential, personal, and cultural realities in people's everyday lives.

Social determinants of health may be defined as "factors in the social environment that contribute to or detract from the health of individuals and communities" (Centers for Disease Control and Prevention [CDC] and Agency for Toxic Substances and Disease Registry 2005). According to a recent World Health Organization (WHO) report, the most important social determinants of health include: the "social gradient" of health (i.e., each level of a social hierarchy exhibits better health outcomes than lower levels), stress, early life conditions, social exclusion, work, unemployment, social support, addiction, food, and transportation (Wilkinson and Marmot 2003; National Research Council 2001).

Other research has pointed out the roles of health behaviors, individual biological susceptibility, environmental and occupational exposures, and access to power and decision-making (Williams and Collins 1996).

Discrimination, stigma, residential segregation, and everyday life experiences as a minority in America also can translate in people's bodies as various forms of stress (Adler et al. 2007; Williams and Collins 2001; Gee et al. 2007). Social determinants have inspired much health disparities work (California Newsreel 2008; Coburn 2000, 2004; Farmer 2004; McGregor 2001; Navarro 2004; Raphael 2008).

The persistence of health inequalities, despite national improvements and specially targeted interventions, must concern people involved with public health. There are many reasons for the persistence of health disparities, and not all of them are understood clearly. While race and ethnicity characteristics may be important pieces of the health disparities puzzle, they must be put into social, political, and economic contexts as we try collectively to assure the conditions in which people can be healthy.

Finally, studies that have examined national structures of social (in) equality have shown that "a country's level of egalitarian social and economic policy is linked to the nature of SES [socioeconomic status] differentials in health within that country" (Williams and Collins 1996, 33). That is, the more socially and economically egalitarian a society is, the less marked the health disparities are in that country (Williams and Collins 1996). A society's ideas about personal (or communal) responsibility and the economic and political structures of that society will affect opportunities for, and norms of, health care and health-seeking behaviors. Although difficult to measure quantitatively, these social determinants have inspired much health disparities work (California Newsreel 2008; Coburn 2000, 2004; Farmer 2004; McGregor 2001; Navarro 2004; Raphael 2008).

SOCIAL AND ECONOMIC CHARACTERISTICS

While race and ethnicity classifications play major roles in the way health and illness are experienced in Louisiana and the United States, socioeconomic factors in people's lives, such as income, educational attainment, occupation, and wealth, also greatly contribute to health outcomes. Public health and social science research have shown the connections between low socioeconomic position and increased levels of disease, morbidity, mortality, disability, and decreased access to routine and specialized health care (e.g., Smedley, Stith, and Nelson 2003; Berkman and Kawachi 2000; WHO 2008a).

As Wilkinson and Marmot note, "It is not simply that poor material circumstances are harmful to health, [but] the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters" (Wilkinson and Marmot 2003, 9).

Income, educational attainment, and occupation are the most commonly used measurements for understanding the relative economic and social statuses of populations, and have been

strongly linked to health outcomes and with people's access to and quality of health care. In this section of the report, the context and statistics for Louisiana state data on income levels, educational attainment, occupation, unemployment levels, and poverty status are reviewed. Other factors such as wealth, child poverty, residential segregation, and racial discrimination are also summarized in order to highlight their roles in health disparities.

SOCIOECONOMIC POSITION (SEP)

"Socioeconomic position" (SEP) refers to the material and social resources available to individuals, as well as their rank or status in the social hierarchy" (Washington State Department of Health 2007). SEP measurements (such as educational attainment and income) are quantifiable proxies for the nuanced ways in which social meanings about class, prestige, and power produce health consequences over time and in different places (e.g., Kreiger 2001; Wilkinson and Marmot 2003). If people change social positions throughout their life courses, they may have different incomes and occupations, which are given social meanings and have varying socioeconomic (and health) consequences. At both national and state levels, the impacts of SEP are striking. People with more wealth, higher education, and higher incomes get higher-paying jobs and live in healthier neighborhoods, and in healthier houses than others. They are more able to garner financial and social networks and resources. Racial and ethnic minority populations tend to have disproportionately lower levels of education, lower-paying jobs, lower incomes, lower wealth, higher unemployment, and live in unhealthier homes and neighborhoods than those of the majority population.

ECONOMIC MEASURES: INCOME, WEALTH, SELF-SUFFICIENCY STANDARD

Low income can be both a cause and a consequence of poor health. Higher income is associated with better health because it enables people to access education and better jobs, to afford better housing in healthier surroundings, and to obtain health care and better nutrition. Poor health can affect a person's ability to work and study, and constrains the types of employment available.

ECONOMIC MEASURES: EDUCATIONAL ATTAINMENT

Educational attainment, (i.e., the highest level of education completed), is a standard measurement that helps indicate economic standing and is a part of understanding socioeconomic position. Higher education is strongly linked to better health status, better health care access, and quality and increased income and job opportunities. Education can affect health outcomes, by increasing one's knowledge of and ability to access information about health and health systems, and by increasing the opportunities for higher paying jobs and higher income.

Higher educational attainment levels enable people to obtain safe and sanitary housing in safer and healthier neighborhoods, healthy food, safer work conditions, jobs with better benefits, and appropriate health care.

ECONOMIC MEASURES: UNEMPLOYMENT AND OCCUPATION

Unemployment

The *unemployment rate* is defined as the percentage of people in a population who do not have jobs, but who would like to have employment and are actively seeking work (Fedstats 2008). Rates of unemployment, poverty level, and lack of access to education have been consistently linked to health disparities (Williams 2007a, 2007b; Krieger 1999, 2004). Other aspects of personal and community health, such as violence, accidents, and crime have also been linked to unemployment and poverty (U.S. Government Accountability Office [GAO] 2007). In more subtle ways, the protective health effects of having a job (e.g., provision for self and family, dignity, and value to the community, self, and family) are placed in jeopardy when one cannot find employment. In 2006, the national rate of unemployment for the population 16 years and older was 6.4%, while for Louisiana, it is 6.2% (U.S. Census Bureau 2009). However, the overall Louisiana rates of unemployment mask racial, ethnic, geographical, and age differences. In 2009, of the entire Louisiana population 16 years or older, Blacks or African Americans had an unemployment rate of 9.4% compared to whites at 3.3% (U.S. Census Bureau 2006d).

Occupation

In the last few decades, the U.S. economy has experienced changes in the ways work is organized. Many people have shifted into working as individual contractors, part-time workers, working flexible hours, and even working from home (Harvey 1990; Regan 2007; Rozen 2007). Restructuring of employment affects workers' self-reported feelings of control over jobs, physical or psychological stressors or benefits perceived in changing jobs, the actual types of labor required, and the pace of work (Peter et al. 2002; Rahkonen et al. 2006; Smith et al. 2008). The amount of control workers feel they have over their working lives has been linked to adverse health outcomes such as incidence of coronary heart disease in men and women (Wilkinson and Marmot 2003,18). Moreover, studies have repeatedly shown that there are occupational class differences in life expectancy (Wilkinson and Marmot 2003, 10, 18–19).

In addition, difficult workplace conditions are known to increase the risk of illness. Different materials in the work environment (chemicals, toxins, air purification systems, location and type of industry, and structure of workplaces), as well as the skills needed and types of activities required (e.g., climbing, welding, farming, lifting) will help determine the health risks involved in certain types of jobs (National Institute for Occupational Safety and Health [NIOSH] 2008a, 2008b).

ECONOMIC MEASURES: POVERTY STATUS

Poverty has long been closely associated with increased morbidity and premature mortality (Berkman and Kawachi 2000; Kawachi 2000; Lynch and Kaplan 2000; Subramanian and Kawachi 2004). There is also evidence to suggest that poor health status can lead to "persistent poverty and poorer economic growth" (Subramanian and Kawachi 2004, 78).

The recent U.S. GAO *Report on Poverty* notes that lower labor force participation, worse health outcomes, loss of human capital, increased crime rates, and social unrest result from large percentages of people living in poverty (GAO 2007).

There are two basic measurements of poverty used by federal and state agencies and programs: poverty guidelines and poverty thresholds (see Appendix IV for definitions). *Poverty guidelines* are issued by the U.S. DHHS each year to help determine people's eligibility for federal programs (U.S. DHHS 2007a). The U.S. *poverty thresholds*, determined by the U.S. Census Bureau and used to calculate poverty statistics, are based on type of family and household structure (U.S. DHHS 2007a). The original threshold was developed in 1964 by Mollie Orshanksy of the Social Security Administration based on the estimation that families of three or more persons spent about one-third of their family budget on food, and was meant mainly as a guide for spending on nutrition (U.S. DHHS 2007a). Since then, food has gotten relatively cheaper, and housing, transportation, energy, and child care costs have gotten relatively more expensive for a typical family. It is generally agreed that the federal thresholds are too low to identify large segments of the population that do not have adequate economic means to provide for basic food, clothing, and medical care (Ali 2007; Pearce 2005; Polednak 1997; U.S. Census Bureau 2005b).

RACIAL DISCRIMINATION, RESIDENTIAL SEGREGATION, AND HEALTH

There is a long history of discrimination based on race, ethnicity, gender, and sexual orientation (among other things) in Louisiana and the United States. Discrimination takes many forms depending on how it is expressed, by whom, and against whom—from interpersonal discriminatory interactions to the more invisible and institutional biases of political, economic, residential, and educational establishments (Krieger 2000, 41). Discrimination exists in all facets of life. Individuals may experience multiple forms of discrimination concurrently—for example, sexism, racism and homophobia.

Discrimination by race and ethnicity has been shown to cause: 1) differences in socioeconomic position; 2) differences in physical and psychosocial neighborhood geographies (due to residential segregation); 3) differential access to, and experiences of, clinical encounters; and 4) the accumulation of detrimental physical and psychosocial effects (e.g., higher mortality rates, hypertension, stress, depression) (National Research Council 2001, 103,108–109; Smedley, Stith and Nelson 2003, 102; Krieger et al. 1993; Williams, Lavizzo-Mourey and Warren 1994). Residential segregation refers to the patterns of "unevenness, isolation, clustering, centralization and concentration" of populations in metropolitan areas (Acevedo-Garcia and Lochner 2003, 267).

Residential segregation based on race and ethnicity creates "differential neighborhood and community conditions […including] unequal access to municipal services and medical care, lower levels of social participation, higher levels of undesirable land uses, higher rates of crime, and poor-quality housing" (National Research Council 2001, 108; Massey and Denton 1993; Acevedo-Garcia and Lochner 2003). Such environments have economic, political, social, and health effects for the residents. Therefore, the concentration of poverty caused by the history of residential segregation must be considered when accounting for health disparities.

The *cumulative* effects of bias over the life course based on one's perceived race can also help explain health inequalities. The "weathering hypothesis" forwarded by Geronimus notes the cumulative effects of "chronic exposure to adverse living conditions" that may be found especially in older persons of vulnerable populations (Geronimus 2001; Williams and Collins 1996, 23). Psycho-physiological effects of accumulated stress of minor, daily discriminatory or prejudicial actions or remarks are being researched (Gee et al. 2007; Gee and Payne-Sturges 2004; Krieger 1999). Krieger (among others) has noted the various pathways by which societal, local, and individual characteristics can lead to disease or disability. These include: economic and social deprivation, exposure to toxic substances and hazardous conditions, socially inflicted trauma, and the inadequate provision and quality of health care (Krieger 1999, 332).

About The Bureau

The mission of the Bureau of Minority Health Access (BMHA) is to minimize health disparities among underserved racial and ethnic populations in the state through collaboration, advocacy, and education, and to promote culturally competent programs aimed at improving access to health care services. BMHA collaborates with a diverse group of professionals who are dedicated to understanding and improving health inequities that specifically challenge minorities and the underserved populations in Louisiana. Partnerships are established with community-based organizations, Historically Black Colleges and Universities (HBCUs), faith-based organizations and local city and parish governments to identify health care gaps, analyze data, and consult with health care professionals and policy makers in order to help build community skills, capacities and leadership. Exchange of information among partners is critical, whether formal or informal and this exchange allows everyone to learn how communities have addressed health issues in order to mitigate specific health disparities. Further, BMHA and its partners are made aware of and linked with existing statewide entities that might be able to provide information, education and resources addressing health disparities. Major functions of BMHA are:

- Assume a leadership role within the state policy development, coordination of planning, programming, monitoring, evaluation and coordination of minority health activities;
- Develop minority health initiatives including cultural competency standards and multilingual communications;
- Provide a central information and referral source;
- Provide input and/or coordinate conferences and other opportunities to increase skills among state and local agencies and government staff in management, and in the appreciation of improving the health status and profiles in racial/ethnic minorities and medically underserved populations in Louisiana;
- Submit recommendations to educational institutions, health providers, government agencies, local and state health and human services agencies on the recruitment and retention of minorities in health professions; and
- Increase public awareness by publicizing minority health issues through the media.

BMHA promotes opportunities to facilitate academic/community partnerships and collaboration to enhance the health of minority communities through the following infrastructure:
Maintaining databases on minority health (i.e., continue the developing of a clearinghouse or repository of health-related data, issues research, literature and academic information, as well as information on local and national public and private organizations addressing minority health).

Convening researchers, academicians, community leaders and policy makers to enhance the dialogue related to minority health (i.e., facilitating collaboration and partnerships, serving as liaison with internal and external groups addressing minority health).
Disseminating information related to minority health (i.e., translating and sharing the application of findings, via the media, Bureau publication reports, literature, lectures, and both academic and community forums).

Promoting health issues within minority communities (i.e., increasing health awareness by:

- Promoting minority health research conducted by both local and national scholars;
- Facilitating a process for bringing resources to underserved communities;
- Raising the awareness of critical health issues in minority communities;
- Developing strategies for addressing those issues through education and training.

Demographics and Disparities in Health Status Among Racial and Ethnic Populations

Demographics

For people reporting one race alone, 65 percent are White; 32 percent are Black or African American; one percent is American Indian and Alaska Native; one percent was Asian; less than 0.5 percent was Native Hawaiian and Other Pacific Islander, and one percent are some other race. One percent reported two or more races. Three percent of the people in Louisiana were Hispanic. Sixty-three percent of the people in Louisiana were white non-Hispanic. People of Hispanic origin may be of any race.

White	2,760,233	+/-4,740
Black or African American	1,356,981	+/-4,406
American Indian and Alaska Native	24,018	+/-2,173
Cherokee tribal grouping	3,147	+/-1,166
Chippewa tribal grouping	154	+/-183
Navajo tribal grouping	121	+/-129
Sioux tribal grouping	716	+/-455
Asian	57,084	+/-1,999
Asian Indian	8,069	+/-2,330
Chinese	9,438	+/-2,397
Filipino	3,599	+/-1,174
Japanese	2,076	+/-975
Korean	1,785	+/-695
Vietnamese	24,887	+/-3,619
Other Asian	7,230	+/-2,093
Native Hawaiian and Other Pacific Islander	715	+/-500
Some other race	47,211	+/-5,166
Two or more races	41,526	+/-4,168
White and Black or African American	10,745	+/-2,413
White and American Indian and Alaska Native	12,639	+/-1,999
White and Asian	6,104	+/-1,869
Black or African American and American Indian	2,779	+/-965

Race alone or in combination with one or more other races		
Total population	***4,287,768***	*****
White	2,797,107	+/-6,324
Black or African American	1,373,845	+/-3,383
American Indian and Alaska Native	41,093	+/-2,345
Asian	64,820	+/-1,719
Native Hawaiian and Other Pacific Islander	1,341	+/-760
Some other race	53,487	+/-5,294
HISPANIC OR LATINO AND RACE		
Total population	**4,287,768**	*****
Hispanic or Latino (of any race)	123,281	+/-1,821
Mexican	50,280	+/-3,905
Puerto Rican	8,165	+/-1,645
Cuban	8,808	+/-2,297
Other Hispanic or Latino	56,028	+/-3,689
Not Hispanic or Latino	4,164,487	+/-1,821
White alone	2,689,206	+/-1,773

Black or African American alone	1,351,044	+/-4,338
American Indian and Alaska Native alone	23,139	+/-1,980
Asian alone	56,414	+/-1,947
Native Hawaiian and Other Pacific Islander alone	715	+/-500
Some other race alone	8,102	+/-2,402
Two or more races	35,867	+/-3,703
Two races including Some other race	1,748	+/-947
Two races excluding Some other race, and Three or more races	34,119	+/-3,673

Languages Spoken in Louisiana

NATIVITY AND LANGUAGE: Three percent of the people living in Louisiana in 2006 were foreign born. Ninety-seven percent were native, including 80 percent who were born in Louisiana. Among people at least five years old living in Louisiana in 2006, 8 percent spoke a language other than English at home. Of those speaking a language other than English at home, 32 percent spoke Spanish and 68 percent spoke some other language; 30 percent reported that they did not speak English "very well." Three-fourths of Asians and nearly half of Vietnamese and Hispanics speak their native language other than English at home or in addition to English.

Special Population Estimates for Impacted Parishes in the Gulf Coast Area: Methodology

The impact of hurricanes Katrina and Rita in late August and early September of 2005 on the population of affected areas is without precedent. In an attempt to provide data users with some information on population size, the Census Bureau produced a special set of January 1, 2006 total household population estimates for the 117 counties/parishes in the Gulf Coast Area that were severely impacted by the hurricanes. These 117 counties/parishes were those eligible to receive Individual and Public Assistance (IPA) based on the disaster declarations issued by the Federal Emergency Management Agency (FEMA) through October 7, 2005 for Hurricane Katrina and through October 20, 2005 for Hurricane Rita.

Client Profile

Language:	59% do not speak English 41% speak English only 7.4% speak English well
Country of Origin:	43% Honduras 21% Mexico
Place of Residence:	71% Jefferson 22% Orleans
Health Insurance:	7.9%
Health Care Provider:	17.7%

To produce these January 1, 2006 estimates of the total household population, the Census Bureau designed a special methodology to modify the routine demographic estimates for the impacted counties/parishes. Because of the unique nature of the methodology and data employed, the resulting estimates are not part of the official estimates series. Rather, these special estimates for January 1, 2006, are designed to provide information and indications of the impacts of the events on the population size of the impacted counties. The special population estimates are a blend of the Census Bureau's extrapolated household population estimates to January 1, 2006 without any impact of the hurricanes and cumulative net migration estimates as of January 1, 2006, derived from a special Hurricane Katrina Change of Address File from the United States Postal Service (USPS).

Extrapolated Household Population Estimates without Impact of Hurricanes

The Intercensal Population Estimates Program produces annual estimates of the resident and group quarters (GQ) population for all counties using administrative records-based demographic components of change methodology. The July 1, 2005 set of estimates of total household population for counties released in March 2006, provide the base for the extrapolations to January 1, 2006 without the impact of the hurricanes. As a first step, the household populations for July 1, 2004 and July 1, 2005 are produced by subtracting the GQ population from the resident population in both years. The July 1, 2005 household population is extrapolated to January 1, 2006 by taking one-half of the numeric difference between the 2004 and 2005 household populations and adding it to the July 1, 2005 household population.

Cumulative Net Migration Estimates

The USPS provided a special Hurricane Katrina Change of Address File that contains the current address for residents of the Katrina-affected areas who, through January 2006, have chosen to report a "change of address" to the USPS. Using tabulations from this file together with Census 2000 data, several simplifying and conservative assumptions to develop an estimate of in-migrants to and out-migrants from the affected counties/parishes. The combination of the extrapolated January 1, 2006 estimates without the hurricane impacts and the cumulative net migration estimates developed from the special USPS file produced the special January 1, 2006 estimates.

Limitations

Because of the unique nature of the methodology and data employed, the resulting estimates are not part of the official estimates series. Rather, these special estimates for January 1, 2006, are designed to provide information and indications of the impacts of the events on the population size of the impacted counties. The official sets of population estimates for July 1, 2006, that begin with the release in late December 2006 of total state population, will include the measured cumulative impact through June 30, 2006, of these unprecedented events.

Median Family Income by Race/Ethnicity

Race/Ethnicity	**Annual Income**
Caucasians	**$45,765**
Asian or Pacific Islander	**$42,255**
Hispanics	**$38,137**
American Indian, Alaskan Native	**$35,835**
African Americans	**$23,917**
Other Races	**$11,924**

Black or African American householders reported household income levels that were 37.2 percent less than the all population median published in the 2000 Census, with a median of $23,917. The American Indian and Alaska Native householders in Louisiana had a median income of $35,835; this level was 5.9 percent less than the median level for total households in the area. Hispanic households in Louisiana recorded a median income of $38,137; this median is 0.1 percent greater than the median reported for all households in the area. According to the 2000 Census, the *Asian* headed households in the area have median household incomes of $42,255. This income level is 10.9 percent greater than the reported median for all households in the state.

In the state of Louisiana, White headed households reported household income (in 2005 Dollars) of $45,765 according to the Decennial Census of 2000. This was 20.1 percent greater than the median household income in 2000.When compared to other States throughout the United States, the State of Louisiana accounted a relatively low household income of $38,102 (Adjusted to 2005 Dollars).

This figure is 29 percent lower than the median household income level in the U.S. of $49,133. As the median income level saw a decline in the last five years in the state of Louisiana, the Race/Ethnicity category that saw the biggest decline in household income was the black or African American category. This category saw a decline of 39.1 percent since the year 2000. The White race/Ethnicity group has been least impacted by the median income decline in Louisiana, undergoing a 85 percent increase in median income, since the values reporting the 2000 Decennial Census. In 2006, 19 percent of people were in poverty. Twenty-eight percent of related children under 18 were below the poverty level, compared with 14 percent of people 65 years old and over. Fourteen percent of all families and 39 percent of families with a female householder and no husband present had incomes below the poverty level.

Poverty Status by Race

	U.S #	**U.S%**	**LA#**	**LA %**
White	**22,631,069**	**12%**	**355,675**	**13%**
Black	**11,676,826**	**32%**	**552,352**	**42%**

Disparities in Health Status

Women's Health Disparities

Key Facts:

- Black Women in Louisiana had the 2nd highest rate in the United States who has not visited a doctor due to cost from 2004-2006.

- Black Women in Louisiana had the highest rate in the United States who had no health insurance and ranked 3rd nationally among women that did not have a personal health care provide**r.** (2004-2006)

- Hispanic Women in Louisiana had the 3rd highest rate in the United States who has not had a Pap test in the past three years. (2004-2006)

- Black Women in Louisiana had the 2nd highest rate in the United States that lived in poverty. (2004-2006)

- Black Women in Louisiana had the 2nd highest percentage in the United States that did not have a high school diploma. (2004-2006)

- Hispanic and Black Women had the 3rd and 4th highest rates of cardiovascular disease in the United States. (2004-2006)

- Black Women in Louisiana had the 12th highest rates of obesity in the United States. (2004-2006)

- Black Women in Louisiana had the 7th highest cancer mortality rates in the United States. (2004-2006)

- Black Women rank 17th nationally with the highest rate of new HIV/AIDS cases (43.5 per 100,000) but outpaces white and Hispanic women with 3.3 and 14.3 per 100,000. (2004)

- Black Women in Louisiana had the 3rd highest rate in the United States for giving birth to low-birthweight babies. (2003-2005)

- Black Women in Louisiana had the 6th highest rate of diabetes in the United States. (2004-2006)

*Kaiser Family State Health Statistics: ***"Putting Women's Health Care Disparities on the Map"***

Louisiana: No Health Insurance Coverage, by State and Race/Ethnicity, 2004-2006

No Health Insurance Coverage, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.84	2.18
All Women	25.9%	17.7%
White Women	19.7%	12.8%
All Minority Women	36.3%	27.9%
Black Women	36.9%	22.4%
Hispanic Women	NSD	37.3%
Asian and Native Hawaiian/Pacific Islander Women	NSD	18.2%
American Indian/Alaska Native Women	NSD	33.7%

Louisiana: No Personal Doctor/Health Care Provider, by State and Race/Ethnicity, 2004-2006

No Personal Doctor/Health Care Provider, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.66	1.94
All Women	19.4%	17.5%
White	15.5%	13.2%
All Minority	25.8%	25.7%
Black	26.4%	17.3%
Hispanic	20.7%	36.9%
Asian and Native Hawaiian/Pacific Islander	NSD	18.9%
American Indian/Alaska Native	NSD	21.1%

Louisiana: No Dental Checkup in Past Two Years, by State and Race/Ethnicity, 2004-2006

No Dental Checkup in Past Two Years, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.31	1.43
All Women	32.1%	28.7%
White	29.0%	25.4%
All Minority	38.0%	36.4%
Black	38.8%	35.9%
Hispanic	30.0%	41.5%
Asian and Native Hawaiian/Pacific Islander	NSD	25.1%
American Indian/Alaska Native	NSD	35.0%

Louisiana: No Doctor Visit in Past Year Due to Cost, by State and Race/Ethnicity, 2004-2006

No Doctor Visit in Past Year Due to Cost, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.66	1.55
All Women	23.0%	17.5%
White	18.5%	14.7%
All Minority	30.6%	22.8%
Black	31.1%	21.9%
Hispanic	28.0%	27.4%
Asian and Native Hawaiian/Pacific Islander	NSD	12.1%
American Indian/Alaska Native	NSD	25.7%

Louisiana: No Pap Test in Past Three Years, by State and Race/Ethnicity, 2004-2006

No Pap Test in Past Three Years, by State and Race/Ethnicity, 2004-2006		
	LA	US
No Pap Test	1.12	1.27
All Women	13.6%	13.2%
White	12.7%	12.2%
All Minority	14.1%	15.5%
Black	12.9%	11.0%
Hispanic	21.4%	16.3%
Asian and Native Hawaiian/Pacific Islander	NSD	24.1%
American Indian/Alaska Native	NSD	18.2%

Louisiana: Late Initiation of or No Prenatal Care, by State and Race/Ethnicity, 2007

Late Initiation of or No Prenatal Care, by State and Race/Ethnicity, 2007		
	LA	US
Disparity Score	2.48	2.04
All Women	15.5%	16.2%
White	9.2%	11.1%
All Minority	22.9%	22.7%
Black	24.1%	23.9%
Hispanic	16.3%	22.9%
Asian and Native Hawaiian/Pacific Islander	11.7%	14.7%
American Indian/Alaska Native	15.6%	30.1%

Louisiana: Poverty, by State and Race/Ethnicity, 2004-2006

Poverty, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	2.18	2.18
All Women	23.7%	16.4%
White Women	16.5%	11.9%
All Minority Women	36.0%	25.8%
Black Women	37.4%	28.5%
Hispanic Women	NSD	27.4%
Asian and Native Hawaiian/Pacific Islander Women	NSD	15.0%
American Indian/Alaska Native Women	NSD	32.8%

Louisiana: Median Household Income, by State and Race/Ethnicity, 2004-2006

Median Household Income, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	2.22	1.82
All Women	$33,000	$45,000
White	$44,420	$54,536
All Minority	$20,000	$30,000
Black	$18,000	$26,681
Hispanic	NSD	$27,748
Asian and Native Hawaiian/Pacific Islander	NSD	$52,669
American Indian/Alaska Native	NSD	$24,000

Louisiana: Gender Wage Gap for Women who are Full-Time Year-Round Workers Compared to Non-Hispanic White Men, by State and Race/Ethnicity, 2004-2006

Gender Wage Gap for Women who are Full-Time Year-Round Workers Compared to Non-Hispanic White Men, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.37	1.21
All Women	63.0%	69.2%
White	70.2%	73.3%
All Minority	51.4%	60.8%
Black	51.4%	61.1%
Hispanic	NSD	50.9%
Asian and Native Hawaiian/Pacific Islander	NSD	77.4%
American Indian/Alaska Native	NSD	56.5%

Louisiana: Women with No High School Diploma, by State and Race/Ethnicity, 2004-2006

Women with No High School Diploma, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	2.50	3.11
All Women	15.1%	12.4%
White	9.7%	7.3%
All Minority	24.3%	22.8%
Black	24.8%	14.9%
Hispanic	NSD	35.8%
Asian and Native Hawaiian/Pacific Islander	NSD	10.9%
American Indian/Alaska Native	NSD	18.1%

Louisiana: Fair or Poor Health Status, by State and Race/Ethnicity, 2004-2006

	LA	US
Disparity Score	1.78	2.07
All Women	14.3%	12.8%
White Women	11.2%	9.5%
All Minority Women	19.9%	19.7%
Black Women	20.1%	16.9%
Hispanic Women	17.7%	26.9%
Asian and Native Hawaiian/Pacific Islander Women	NSD	7.9%
American Indian/Alaska Native Women	NSD	22.1%

Notes/Sources(show)

Notes: Data are for women ages 18–64. All Minority women includes Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention, 2004-2006.

Louisiana: Diabetes, by State and Race/Ethnicity, 2004-2006

Diabetes, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.90	1.87
All Women	5.3%	4.2%
White	4.0%	3.3%
All Minority	7.6%	6.2%
Black	7.8%	7.5%
Hispanic	8.1%	6.1%
Asian and Native Hawaiian/Pacific Islander	NSD	3.2%
American Indian/Alaska Native	NSD	8.6%

Notes/Sources(show)

Notes: Data are for women ages 18–64. All Minority women include Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention, 2004-2006.

Louisiana: Cardiovascular Disease, by State and Race/Ethnicity, 2004-2006

Cardiovascular Disease, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.85	1.46
All Women	4.5%	3.2%
White	3.5%	2.7%
All Minority	6.4%	3.9%
Black	6.6%	4.8%
Hispanic	6.1%	4.0%
Asian and Native Hawaiian/Pacific Islander	NSD	1.2%
American Indian/Alaska Native	NSD	8.7%

Notes/Sources(show)

Notes: Data are for women ages 18–64. All Minority women include Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention, 2004-2006. The cardiovascular disease module was only used by 8 states in 2004: DE, LA, OH, OK, PA, SC, VA, WV.

Louisiana: Obesity, by State and Race/Ethnicity, 2004-2006

Obesity, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	1.87	1.41
All Women	25.8%	22.7%
White	19.8%	20.1%
All Minority	36.9%	28.4%
Black	38.8%	37.8%
Hispanic	26.6%	27.3%
Asian and Native Hawaiian/Pacific Islander	NSD	8.4%
American Indian/Alaska Native	NSD	30.4%

Notes/Sources(show)

Notes: Data are for women ages 18–64. Obesity is defined by body mass index. All Minority women include Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention, 2004-2006.

Louisiana: Cancer Mortality, by State and Race/Ethnicity, 2000-2004

Cancer Mortality, by State and Race/Ethnicity, 2000-2004		
	LA	US
Disparity Score	1.14	0.86
All Women	179.5	162.2
White	170.0	161.4
Black	207.2	189.3
Hispanic	80.5	106.7
Asian and Native Hawaiian/Pacific Islander	108.1	96.7
American Indian/Alaska Native	68.0	112.0

Notes/Sources

Notes: Data are for women ages 18–64. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Data from 2000–2004 and provided by the National Vital Statistics System public use data file. Death rates calculated by the National Cancer Institute using SEER*Stat.

Louisiana: New AIDS Cases, by State and Race/Ethnicity, 2004

New AIDS Cases, by State and Race/Ethnicity, 2004		
	LA	US
Disparity Score	12.05	11.58
All Women	16.5	9.4
White	3.3	2.3
All Minority	39.2	26.4
Black	43.5	50.1
Hispanic	14.3	12.4
Asian and Native Hawaiian/Pacific Islander	0.0	1.8
American Indian/Alaska Native	0.0	7.0

Notes/Sources(show)

Notes: Data are for women ages 13 and older. All Minority women include Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Centers for Disease Control and Prevention. AIDS cases, by geographic area of residence and metropolitan statistical area of residence, 2004. HIV/AIDS Surveillance Supplemental Report 2006;12(No. 2). Available at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. SC-EST2007-agesex-res: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2007. Population Division, U.S. Census Bureau. Available at http://www.census.gov/popest/datasets.html.

Louisiana: Babies Born to Low Birth Weight, by State and Race/Ethnicity, 2004

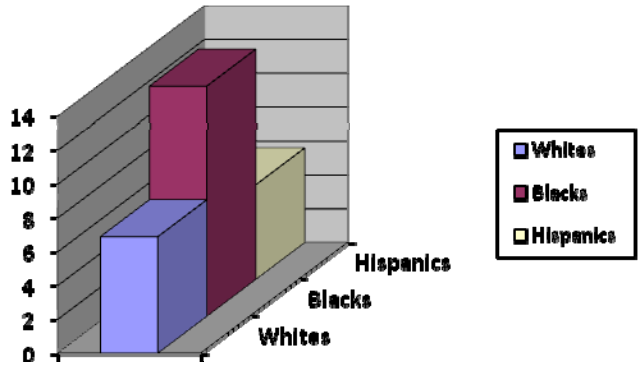
Percent of Live Births that are Low-Birthweight, by State and Race/Ethnicity, 2003-2005		
	LA	US
Disparity Score	1.97	1.38
All Women	11.0%	8.1%
White	8.1%	7.2%
All Minority	16.0%	9.9%
Black	15.3%	13.8%
Hispanic	7.6%	6.8%
Asian and Native Hawaiian/Pacific Islander	8.5%	7.9%
American Indian/Alaska Native	10.1%	7.4%

Notes/Sources(show)

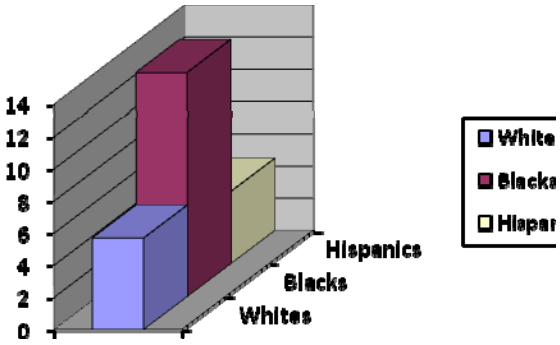
Notes: Percent of live births weighing less than 2,500 grams, in 2003-2005. Excludes live births with unknown birthweight. All Minority women include Black, Hispanic, Asian American and Native Hawaiian/Pacific Islander, American Indian/Alaska Native women, and women of two or more races. Disparity score greater than 1.00 indicates that minority women are doing worse than White women. Disparity score less than 1.00 indicates that minority women are doing better than White women. Disparity score equal to 1.00 indicates that minority and White women are doing the same. Data are derived from the Kaiser Family Foundation report, Putting Women's Health Care Disparities on the Map, available at: http://www.kff.org/womensdisparities/.

Sources: Health, United States, 2007. Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Birth File.

Infant Mortality Rate (Deaths per 1,000 Live Births) by Race/Ethnicity, 2006



United States



Louisiana

Infant mortality is defined as death during the first year of life. This measure excludes fetal deaths (abortions and miscarriages). The infant mortality rate is defined as the number of deaths within the first year of life per 1,000 live births. Children born to African American mothers (13.9 per 1,000 live births) tend to have higher infant mortality rates than those born of Caucasian mothers (7.1 per 1,000 live births), Hispanic (5.6) and Asian/Pacific Islanders (0.96). Rates are per 1,000 live births in 2006

Louisiana: Women in Female-Headed Households with Children, by State and Race/Ethnicity, 2004-2006

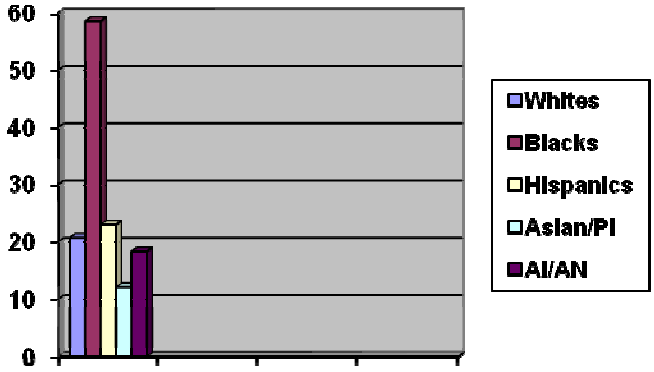
Women in Female-Headed Households with Children, by State and Race/Ethnicity, 2004-2006		
	LA	US
Disparity Score	2.57	1.70
All Women	25.7%	22.1%
White	15.6%	17.4%
All Minority	40.2%	29.6%
Black	42.8%	45.0%
Hispanic	NSD	23.0%
Asian and Native Hawaiian/Pacific Islander	NSD	9.2%
American Indian/Alaska Native	NSD	32.9%

Disparities in Health Status, by State and Race/Ethnicity

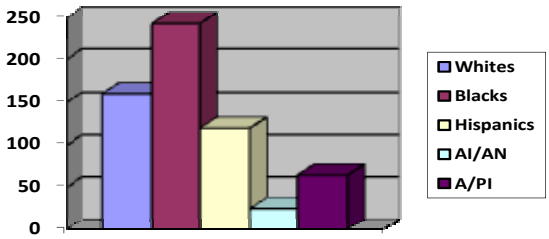
Number of Cancer Deaths per 100,000 Population by Race/Ethnicity, 2005

Nationally and statewide, malignant neoplasm or cancer is the second leading cause of death. African Americans are dying from cancer at a rate of 249.7 per 100,000 population group compared to whites at 197.3 per 100,000 and Hispanics at 76.6 population groups respectively.

Prostate Cancer Mortality Rates by Race and Ethnicity



About 350 men are expected to die from prostate cancer this year in Louisiana while 3,000 will be diagnosed. The nation as a whole is experiencing some good news when it comes to prostate cancer: deaths are down 10 percent while the number of diagnosed cases is up, signifying the annual early detection works and is saving lives. But African American death rate from prostate cancer is more than double (58.5 per 100,000) the rate for whites (20.7 per 100,000).



Incidence of Prostate Cancer by Race/Ethnicity

African Americans diagnosed with prostate cancer out paces all racial and ethnic groups with an incidence rate of 243.5 per 100,000 compared to 161.0 per 100,000 for whites. Hispanic men are closing the gap with 120.0 per 100,000 and Asian Pacific Islanders are at 26.1 and 64.4 for American Indians and Alaskan Natives.

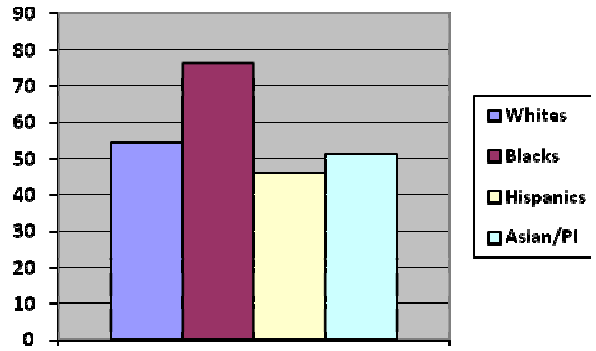
Number of Diabetes Deaths per 100,000 Population by Race/Ethnicity, 2005

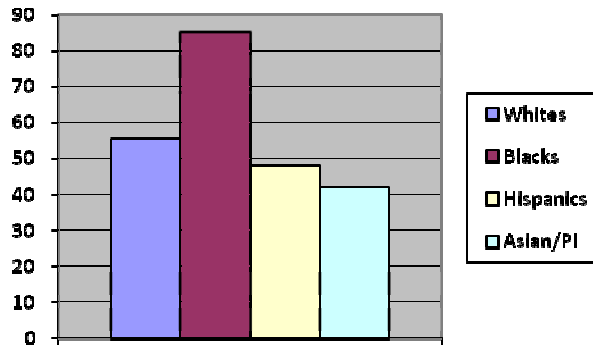
	White	Black	Other
United States	47.0	48.0	20.5
Louisiana	38.5	68.7	NSD

Number of Heart Disease Deaths per 100,000 Population by Race/Ethnicity, 2005

Louisiana	Rate
White	241.4
Black	284.5
Asian/Pacific Islander	134.4
Hispanic	149.7

Number of Stroke Deaths per 100,000 Population by Race/Ethnicity, 2005

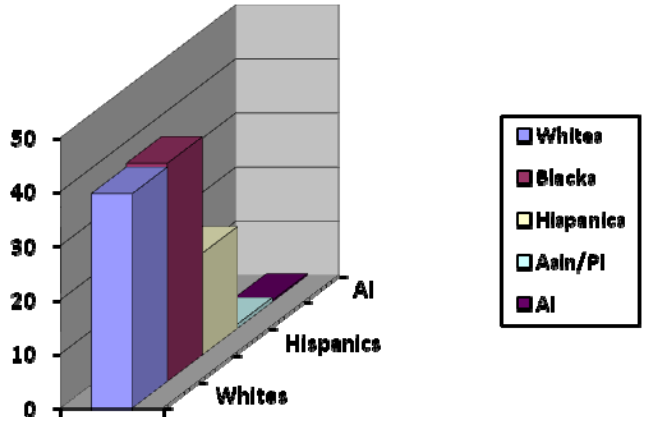




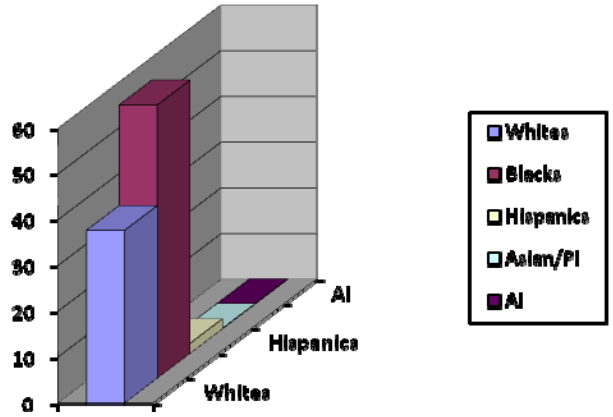
United States **Louisiana**

Cerebral Disease (stroke) accounts for the third highest number of deaths nationally and statewide. African Americans carry the highest rates of deaths due to stroke with 85.5 per 100,000 compared to whites with 55, Hispanics with 48.1 and Asian/PI suffer from death due to stroke 42.1 per 100,000 population group.

Distribution of Reported AIDS Cases, All Ages, by Race/Ethnicity, Cumulative through 2005

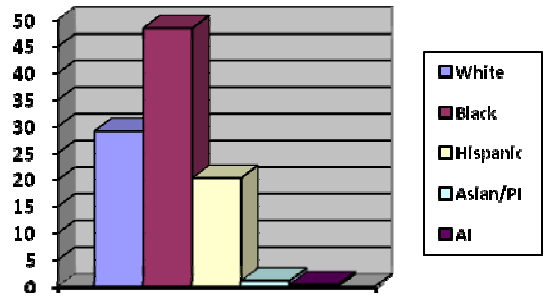


United States

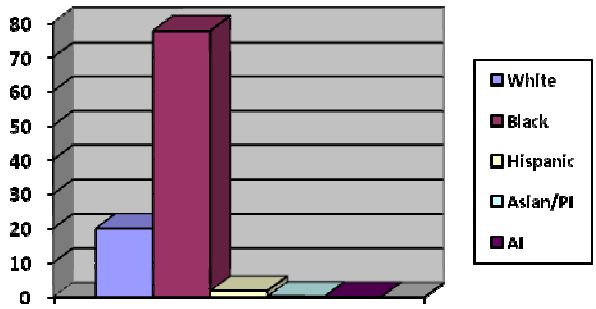


Louisiana

Distribution of New AIDS Cases by Race/Ethnicity, Reported in 2005



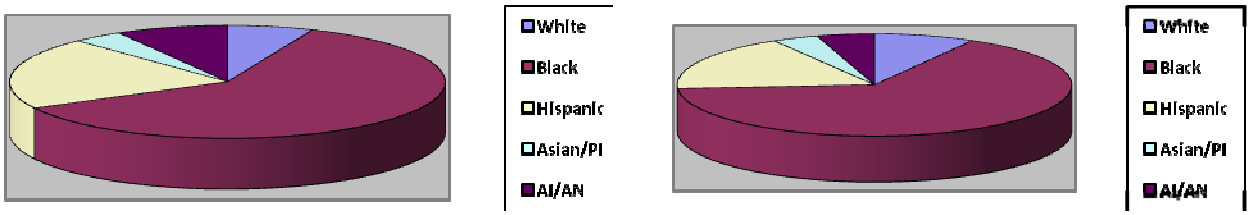
United States



Louisiana

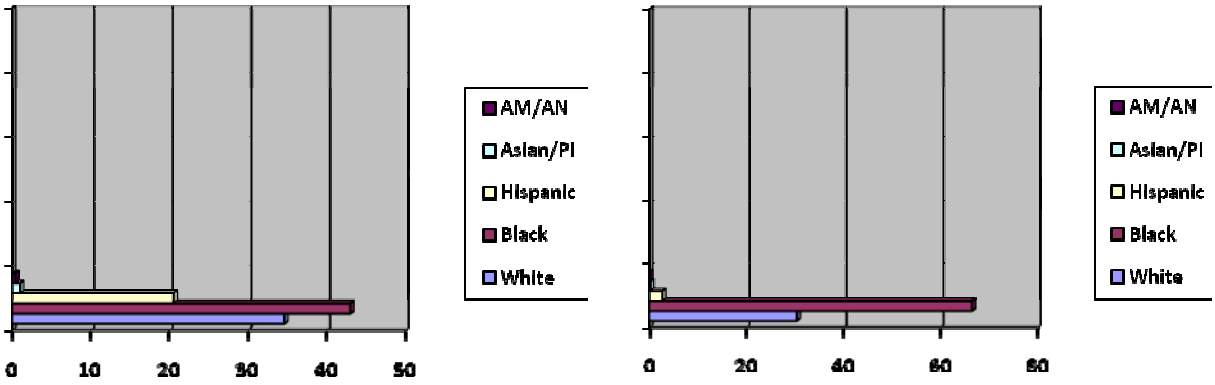
African Americans continue to be disproportionately impacted by HIV/AIDS. In 2005, nearly 80 percent of new HIV/AIDS cases were in African Americans (77.6 per 100,000 population group), while African American comprise only 32 percent of the population. The HIV rates from African American are six times higher than among Caucasians, including Hispanics.

Adult and Adolescent Annual AIDS Case Rate per 100,000 Population, by Race/Ethnicity, Reported in 2005



United States **Louisiana**

Distribution of Persons Estimated to be Living with AIDS, by Race/Ethnicity, at the End of 2005



United States **Louisiana**

African Americans living with HIV/AIDS rates are significantly higher than other racial and ethnic population groups with a 77.6 per 100,000 rate which doubles that of whites (30.6) and triples the rate for Hispanics (2.7 per 100,000). The annual adult and adolescent HIV/AIDS cases for African Americans is 64.0; 8.1 for whites; Hispanics 17.3; Asian/Pacific Islanders 3.7 and American Indians and Alaskan Natives are 4.6 per 100,000 population group.

Number of Deaths per 100,000 Population by Race/Ethnicity, 2003

United States	Rate
White	817.1
Black	1,065.9
Asian/Pacific Islander	460.9
Hispanic	613.9

Louisiana	Rate
White	943.5
Black	1,205.3
Asian/Pacific Islander	463.5
Hispanic	437.6

Number of Deaths Due to Firearms per 100,000 Population by Race/Ethnicity, 2004

United States	Rate
White	9.2
Black	19.3
Other	4.3
Louisiana	Rate
White	14.5
Black	28.8
Other	NSD

Percentage of Adults Who Reported Having High Blood Pressure

United States	Rate
White	26.2
Black	34.2
Asian/Pacific Islander	18.9
Hispanic	27.4
Louisiana	**Rate**
White	26.0
Black	32.2
Asian/Pacific Islander	18.0
Hispanic	25.0

Distribution of Medical School Graduates by Race/Ethnicity, 2005

	White	Black	Hispanic	Asian	Native American	Unknown	Foreign	Total
United States	63.7%	6.6%	6.0% [1]	20.1% [2]	0.6%	2.0%	1.1%	100.0%
LA	76.2%	8.0%	2.2%	11.9%	0.5%	1.0%	0.2%	100.0%

Distribution of Nonfederal Physicians by Race/Ethnicity, 2002

United States	Percent
White	49.4%
Black	2.6%
Hispanic	2.8%
Asian/Pacific Islander	9.3%
American Indian/Alaskan Native	0.1%
Other	2.5%
Unknown	33.4%

Louisiana	Percent
White	51.1%
Black	4.2%
Hispanic	3.4%
Asian/Pacific Islander	6.6%
American Indian/Alaskan Native	0.1%
Other	2.3%
Unknown	32.4%

Distribution of Medicare Enrollees by Race/Ethnicity, states (2004-2005), U.S. (2005)

Louisiana	Percent
White	70%
Black	27%

Percentage of Adults Who Reported Being Over Weight or Obese (2005)

United States	Rate
White	59.5
Black	68.9
Asian/Pacific Islander	37.7
Hispanic	61.7

Louisiana	Rate
White	60.3
Black	68.1
Asian/Pacific Islander	45.4
Hispanic	52.6

Employer-Sponsored Coverage Rates for the Nonelderly by Race/Ethnicity, states (2006-2005), U.S. (2007)

	LA #	LA %	US #	US %
White	1,442,140	63.2%	114,951,320	69.0%
Black	419,240	35.1%	16,207,080	48.8%
Hispanic	NSD	NSD	17,066,610	39.3%
Other	NSD	NSD	10,881,550	59.9%
Total	1,914,300	52.5%	159,106,560	60.9%

Louisiana: Distribution of the Nonelderly Uninsured by Race/Ethnicity, states (2006-2007), U.S. (2007)

	LA #	LA %	US #	US %
White	410,730	48.8%	20,264,170	45.1%
Black	356,150	42.3%	6,941,040	15.4%
Hispanic	58,870	7.0%	14,558,420	32.4%
Other	NSD	NSD	3,207,150	71.3%
Total	841,630	100.0%	44,970,780	100.0%

Louisiana: Health Insurance Coverage of Nonelderly 0-64, states (2006-2007), U.S. (2007)

	LA #	LA %	US #	US %
Employer	1,914,300	52.5%	159,106,560	60.9%
Individual	193,760	5.3%	14,347,160	5.5%
Medicaid	610,900	16.8%	36,359,410	13.9%
Other Public	84,260	2.3%	6,642,560	2.5%
Uninsured	841,630	23.1%	44,970,780	17.2%
Total	3,644,850	100.0%	261,426,470	100.0%

Death Rates as a result of Homicide by Race and Sex Ages 18-24, 2005

Sex	Race	Death Rate*
Male	White	6.13
	Black	**147.35**
	Other	24.11
Female	White	5.6
	Black	8.53
	Other	13.24

In 1996, the World Health Assembly declared violence a major public health issue. Although homicide is the fourth leading cause of premature mortality in the United States and the leading cause of death for young blacks, the health professions have been largely oblivious to violence. Prevailing explanations contribute to this neglect by emphasizing biological or psychiatric factors that make homicide unpredictable and cultural and environmental factors such as the emergence of a new "underclass" that link violence to race. Focusing on instances where no other crime is involved, it is believed "primary" homicide be reconceptualized as a by-product of interpersonal violence, a broad category of social entrapment rooted in the politics of gender inequality and including wife abuse, child abuse, and assaults by friends and acquaintances. The data show that blacks are no more violent than whites, though they are arrested and die more often as the consequence of violence.

In addition, a majority of homicides are between social partners or involve gender stereotypes, are preceded by a series of assaults that are known to service providers, and grow out of "intense social engagement" about issues of male control and independence. Professional failure to respond appropriately is a major reason why assaults become fatal, particularly among blacks.

Health Status of Low-income Adults in New Orleans Post-Katrina

A comprehensive survey of New Orleans' residents that was released in October of 2008 offered a continuing assessment of residents' needs, goals, and concerns to help inform recovery and rebuilding efforts. Conducted in the spring of 2008, the survey of 1,294 adults living in Orleans Parish followed up on the 2006 Kaiser survey. The 2008 survey found a city still struggling in numerous ways to recover nearly three years after Hurricane Katrina and the subsequent flooding from the levee breaches, with many residents dissatisfied with the pace of recovery. However, residents remained optimistic for the city's future even though many were dealing with difficult economic and health challenges. One group most affected by the aftermath of Katrina was the low-income population of New Orleans. Already dealing with limited family budgets and financial challenges before the storm, they lived in some of the most heavily flooded areas of the city and, as such, suffered some of the most significant damage. They also had the fewest resources and means to deal with the disaster and displacement caused by the storm. Yet, three years after Katrina, many low-income residents have found a way to return home. This brief provides an overview of the low-income population of New Orleans in 2008 and some of the key challenges they face.

KEY FINDINGS

- New Orleans in 2008, although smaller in size than pre-Katrina, continues to have a substantial low-income population—some four in ten (41%) adults report family income below 200% of poverty.
- Over nine in ten (92%) low-income adults living in New Orleans today are Katrina survivors. Among Katrina survivors, low-income adults are more likely than other adults to still be dealing with recovery challenges.
- Relative to other adults in the city, low-income adults are experiencing more worries about their current situation and their and their children's future, particularly around financial issues.
- Low-income adults are more likely than other adults in the city to have a health problem, to be uninsured, and to face barriers to accessing needed health care. In particular, adults who used to rely on Charity Hospital are facing access challenges.
- The high uninsured rate (27%) for low-income adults reflects a low level of private coverage and limited Medicaid eligibility for adults, in contrast to the substantial role Medicaid plays for children. Among low-income adults with children in the household, over two-thirds say a child has Medicaid or SCHIP coverage.

Portrait of Low-Income Adults in New Orleans in 2008

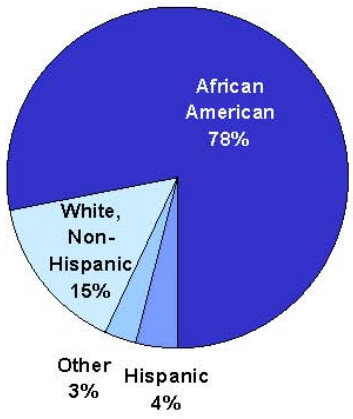
Before Hurricane Katrina, Louisiana and the New Orleans area had some of the highest rates of low-income residents in the nation. In 2004, Louisiana ranked third in the country, with 44% of non-elderly adults and children living in families with income below twice the federal poverty level (FPL) ($37,700 for a family of four in 2004), compared to 35% overall in the United States. Among New Orleans area residents, 42% percent of non-elderly adults and children were low-income.

The 2008 Kaiser Family Foundation survey finds that Orleans Parish (the city of New Orleans) continues to have a sizeable population of low-income adults. Among those reporting income, some 41% of adults report family income below 200% FPL ($42,400 for a family of four in 2008). Nearly eight in ten low-income adults are African American (78%)). Additionally, about two thirds of low-income adults are women (67%), and the bulk of low-income adults have education limited to a high school degree or less (62%).

These findings reflect the fact that African American adults are significantly more likely to be low-income than white adults (47% vs. 15 %,). Further, over four in ten women (42%) are low-income compared to only a quarter of men (25%). Adults with more limited education also are at increased risk of being low-income, stemming from the fact that they tend to be employed in lower-wage jobs. Likely a result of dual incomes in some married households, married adults are less likely to be low-income. However, adult parents are more likely to be low-income than adults without children in the household.

Figure 1

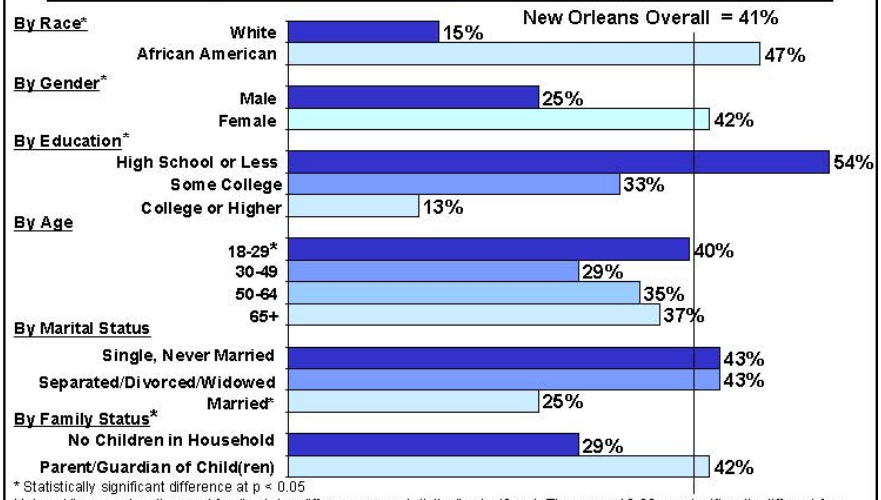
Low-Income Adults in New Orleans by Race/Ethnicity, 2008



Note: Low-Income defined as family income below 200% of the federal poverty level or $42,400 for a family of four in 2008.
Source: The Second Kaiser Post-Katrina Survey, 2008.

Figure 2

Low-Income Rate Among All Adults in New Orleans by Selected Characteristics, 2008



* Statistically significant difference at p < 0.05
Notes: All race, education, and family status differences are statistically significant. Those age 18-29 are significantly different from those age 30-49 but not from the other age groups. Married adults are significantly different from single and separated, divorced, or married adults. Low-Income defined as family income below 200% of the federal poverty level or $42,400 for a family of four in 2008.

KCMU and Urban Institute analysis of two-year pooled data from the March 2004 and March 2005 Current Population surveys. KCMU and Urban Institute analysis of the March 2005 Current Population survey for the New Orleans metropolitan area, including New Orleans, Metairie, and Kenner, LA. Analysis in this survey brief is limited to the 83% of respondents who reported income in the survey.

Personal Recovery from the Storm

The survey reveals that many low-income adults are facing significant challenges recovering from the aftermath of Katrina. About nine in ten (92%) low-income adults in New Orleans are Katrina survivors. Reflecting the flooding's disproportionate impact on low-income neighborhoods as well as the limited resources of the low-income population to deal with the flood damage; low-income adults are significantly more likely than other adults to say they suffered a lot of hardship as a result of the storm and that their life continues to be disrupted. Low-income adults also are more likely to describe their financial situation as worse than before Katrina (53% vs. 34%).

However, other adults in the city are equally as likely as low-income adults to be dealing with increased stress levels and to have low quality of life ratings. Over half of all adults report that their stress level is worse than before Katrina. Further, regardless of income, only about a quarter of adults say they are very satisfied with their quality of life. (In the 2006 Kaiser survey, 65% of adults said pre-Katrina they rated themselves as very satisfied with their quality of life.)

Worries, Daily Hassles, and Employment Challenges

Low-income adults in New Orleans have many worries and concerns about their current situation as well as their future and that of their children, especially around financial issues. For example, low-income adults are three times more likely than other adults to say they are very worried they won't be able to find or afford a decent place to live (53% vs. 17%). Further, they are more than two times as likely to say they are very worried they won't have enough income to meet their needs (60% vs. 25%) and that they will not be able to find or keep a good job (34% vs. 14%). Low-income adults also voiced greater concern than other adults about the quality of their children's education, their ability to obtain needed health care, their safety from violent crime, and the threat and potential impact of a future storm on their neighborhood.

In addition to increased worries, low-income adults face additional daily hassles related to the resources available in their neighborhood. Relative to other adults in New Orleans, low-income adults are more likely to report that their neighborhood does not have enough places where children can play outside, grocery stores, bus service, restaurants, and places of worship. The lack of bus service combined with the lack of resources such as grocery stores can make daily tasks very difficult, particularly because four in ten low-income adults (40%) say they rely on public transportation and over one in three (37%) do not have a car.

Although a quarter (24%) of low-income adults in New Orleans are full-time workers, the majority of low-income adults have limited or no attachment to the workforce. Those who are working are often in low-wage jobs that leave them facing financial challenges. While 20% of higher-income adults report some sort of employment-related challenge, the rate rises to nearly half (47%) among low-income adults, with nearly one in five (19%) unemployed, 12% on disability and unable to work, and 16% in a job that does not pay enough to cover basic expenses. Another one in five (22%) low-income adults in New Orleans is retired and likely surviving on a fixed income. Further, low-income adults are more than four times as likely as other adults to say they are struggling to make ends meet (38% vs. 9%). Given that the survey

was conducted prior to the most recent economic downturn, financial worries and challenges facing low-income adults have likely further increased in recent months.

Health Status, Coverage, and Access

The physical and mental health needs among low-income adults in New Orleans are substantial and may impede their ability to work. Low-income adults are more than twice as likely as other adults to say they are in fair or poor physical health and significantly more likely to rate their mental health as fair or poor. Further, nearly three-quarters of low-income adults (72%) report a chronic condition or disability versus 57% of other adults, and low-income adults are four times more likely than other adults to report they are receiving disability and cannot work. Despite their extensive health problems, low-income adults are at a disadvantage in being able to obtain needed health care as over one in four lack health coverage (27%). The high uninsured rate among low-income adults is primarily driven by a low rate of private coverage and limited Medicaid coverage in Louisiana where eligibility excludes adults without dependent children and only reaches working parents with income up to 20% FPL and non-working parents up to 13% FPL ($4,240 and $2,756 respectively per year for a family of four in 2008).

Among employed adults, low-income adults are less than half as likely as other adults to have an offer of health coverage from their employer (35% vs. 79%), reflecting the fact many are in part-time or low-wage jobs that often do not provide health coverage. Even when employer coverage is offered, the employee share of the premium may make coverage unaffordable given the limited budgets of low-income adults. Medicaid helps fill some of the gap in private coverage for the poorest and sickest, but most low-income adults are ineligible for public coverage.

While Medicaid's role in covering low-income adults is limited due to low eligibility levels for parents and the exclusion of childless adults, Medicaid plays a significant role in covering children in New Orleans, particularly those in low-income households. Over half (56%) of all adults with a child or children living in the household, report that a child in the household is covered by Medicaid or SCHIP. Among low-income adults with children living in the household, more than two-thirds (71%) say a child has Medicaid or SCHIP coverage.

Not only are low-income adults significantly less likely than other adults to have health insurance coverage, but they are also significantly less likely to be connected to a usual source of care other than the emergency room (61% vs. 87%). About one in four (28%) low-income adults report a neighborhood or hospital clinic as their usual source of care, which is not significantly different from the percent of other adults who rely on a clinic for care. However, low-income adults are about half as likely as other adults to say a private doctor's office is their primary source of care (31% vs. 62%). Among those who do have a usual source of care, low-income adults are more than twice as likely to say it is difficult to get to that place of care than other adults (27% vs. 13%). Given their more limited connection to sources of care, low-income adults are less likely than other adults to report receiving preventive care (43% vs. 53%). They also are more likely to report visiting an emergency room (28% vs. 16%), which may stem from both their lack of

connection to a usual source of care as well as their increased health needs relative to other adults. Further, low-income adults are more than twice as likely as other adults to say that their health needs are not being met well (20% vs. 8%).

Financial burdens of health care costs also negatively affect access to care for low-income adults. They are significantly more likely than other adults to report problems related to medical bills, with nearly four in ten (37%) saying they had difficulty paying for household medical bills in the past six months and about a quarter (23%) saying that medical bills had a major financial impact on their household. In comparison, paying medical bills was a problem for about one in five (19%) other adults and 9% of other adults said that medical bills had a major financial impact. However, similar to other adults, they struggle with cost containing behavior that leads one in four (23%) to say they have skipped or postponed care and one in five (18%) to skip or stretch doses of prescription drugs.

Health Care for Former Charity Hospital Users

The access problems faced by low-income adults, particularly their limited connection to sources of care have been greatly exacerbated by the loss of key health care resources for the city's low-income and uninsured population in the wake of Katrina. Before Katrina, many of these adults relied on the city's now-shuttered public hospital that was run by Louisiana State University (LSU)—Charity Hospital—or one of its clinics for care. Overall, 24% of adult Katrina survivors living in the city today say they usually went to Charity or one of its clinics for care. This group of former Charity users is predominately low-income (67%) and African American (83%). Many have physical and mental health problems, with half (50%) reporting fair or poor physical health and 29% reporting fair or poor mental health.

Usual Source of Care for Former a chronic condition or disability

Yet, Charity Hospital users in 2008 over one in three (35%) lack health coverage, making it difficult to obtain affordable health care. Since the closure of Charity, some have turned to other clinics and doctor's operating in the city as well as other area hospitals, including a growing network of neighborhood clinics and the limited LSU-operated services being provided through University Hospital, but many others still have not connected with a new source of care.

New Orleans in 2008, although smaller in size than pre-Katrina, continues to be a city with a substantial low-income population. Some four in ten adults in the city have family income below 200% of poverty. Given the areas in Orleans Parish that were affected by flooding post-Katrina, the low-income population faced both extensive devastation of their communities and incredible rebuilding challenges with limited personal resources. Yet, many low-income adults have found a way to return to the city, and almost all (92%) low-income adults living in the city today are Katrina survivors. However, low-income adults are more likely to still be struggling with recovery, have greater worries and concerns about their current situation and their future, and face increased daily hassles due to limited resources in their neighborhoods.

On top of these challenges, low-income adults continue to face substantial employment and financial difficulties along with a high rate of physical and mental health problems relative to the rest of the adult population. A high uninsured rate, limited financial resources, and other access barriers in addition to slow progress rebuilding health service capacity makes meeting the substantial health needs of these adults both difficult and complex. As recovery continues, focusing on the key areas of opportunity to lessen the challenges facing the low-income population, particularly in the area of health care, will be important for continuing to improve and rebuild New Orleans.

Why Health Disparities Exist

Health disparities refer to gaps in the quality of health and social services across racial and ethnic populations. Health Resources and Services Administration (HRSA) defines health disparities as population-specific differences in the presence of disease, health outcomes, or access to health care.

There are many factors that contribute to racial and ethnic health disparities in health care. In 2004-2006, the Bureau of Minority Health Access conducted door-to-door interviews and surveys in St. Tammany and Plaquemines parishes, along with forty-five community-based organizations that participated in the Minority and Multicultural Health Month statewide campaign to determine the root cause of health disparities in African Americans and Native Americans. Among the countless surveys and interviews performed by the Bureau and its stakeholders for these areas around the state, it was determined that minorities are less likely than whites to receive needed services, including clinically necessary procedures. Here are several reasons documented from community residents as to why most believe the health care system is partly the blame for the ever-present health disparity gap:

- Many people from minority groups live in areas where there are fewer doctors or other health providers.
- Many doctors are not skilled in communicating with people from different racial/ethnic backgrounds.
- Most doctors assume that people from minority groups do not have enough insurance or money to pay for the care they get.
- Most doctors do not think that people from minority groups do enough to take care of their own health.
- Most doctors are white, and many do not understand the health care needs and how to treat the illnesses of people from minority groups.

Health disparities can occur in populations that do not self-identify as a member of an ethnic and racial group. Health disparities can be identified also with regard to geographic location, economic status, access to insurance, poverty status and education level. (U.S. Health Department of Humans Services Office of Minority Health) Causes of health disparities are numerous and cannot be dealt with in a “one size fits all framework.” More reasons for health

disparities can include the following:

Lack of insurance coverage. Without health insurance, patients are more likely to postpone medical care, more likely to go without needed medical care, and more likely to go without prescription medicines. Minority groups in Louisiana lack insurance coverage at higher rates than non-minorities.

Lack of a regular source of health care. Without access to a regular source of health care, patients have a greater difficulty obtaining care, fewer doctor visits, and more difficulty obtaining prescription drugs. Compared to whites, minority groups in Louisiana are less likely to have a doctor they go to on a regular basis and are likely to use emergency rooms and clinics as their regular source of care.

Lack of financial resources. Although the lack of financial resources is a barrier to healthcare access for many Louisianans, the impact on access appears to be greater for minority populations.

Structural barriers. These barriers include poor transportation, an inability to schedule appointments quickly or during convenient hours, and excessive time spent in the waiting room, all of which affect a person's ability and willingness to obtain needed care.

Linguistic barriers. Language differences restrict access to medical care for minorities in the United States who are not English-proficient.

Health literacy. This is where patients have problems obtaining, processing and understanding basic health information. For example, patients with poor understanding of good health may not know when it is necessary to seek care for certain symptoms. While problems with health literacy are not limited to minority groups, the problem can be more pronounced in these groups than in whites due to socioeconomic factors.

Lack of diversity in the health care workforce. A major reason for disparities in accessing care is the cultural differences between predominately white healthcare providers and minority patients.

Gender and Healthcare

Whereas some differences in health between men and women are the result of biological differences, others are more complicated and require greater attention and scientific exploration. Some health differences are obviously gender specific, such as cervical and prostate cancers. Overall, men have a life expectancy that is six years less than that of women (Women 77.3 and Men 71.2) and have higher death rates for each leading causes of death. Although overall death rates for women currently may be lower than for men, women have shown increased death rates over the past decade in areas where men have experienced improvements, such as lung cancer. Women also are at greater risk of Alzheimer's disease than men and twice as likely as men to be affected by major depression.

Race and Ethnicity

Current information about the biologic and genetic characteristics of African Americans, Hispanics, American Indians, Alaskan Natives, Asians, Native Hawaiians and Pacific Islanders does not explain the health disparities experienced by these groups compared to white, non-Hispanic population in Louisiana. These disparities are believed to be the result of complex interaction among genetic variations, environmental factors and specific health behaviors.
Even though the state's infant mortality rate is slightly down, the infant mortality rate among African Americans is still more than double that of whites (13.6 per 1,000 live births compared to 5.7 for whites.). African Americans have higher rates of heart disease and cancer than whites. African American women have a higher death rate from breast cancer as a result of low mammography screenings. The death rate from HIV/AIDS is much higher than for whites; the rate of homicide among African Americans is considerably higher than whites.
Hispanics living in Louisiana and throughout the United States are almost twice as likely to die from diabetes as are non-Hispanic whites.

American Indians and Alaskan Natives have much higher infant deaths than whites. The rate of diabetes for this population group is more than twice that for whites. American Indians and Alaskan Natives also have disproportionately high deaths rates from unintentional injuries and suicide.

Asian and Pacific Islanders on average, have indicators of being one of the healthiest population groups in the United States and in Louisiana. However, there is great diversity within this population group, and health disparities between some specific segments are quite marked. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis also are higher in Asians and Pacific Islanders living in the United States than whites.

Income and Education

Inequalities in income and education underlie many health disparities in Louisiana. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status also are those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including but not limited to, heart disease, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.

Income inequality in Louisiana has increased over the past few decades. There are distinct demographic differences in poverty by race, ethnicity and household composition as well as geographical variations in poverty areas across the state. Recent health gains for the state as a whole appear to reflect achievements among the higher socioeconomic groups; lower socioeconomic groups continue to lag behind.

Fear and Myths Hinder Health Care

Louisiana's most lethal obstacles that obstruct access to health care that never seems to go away are the constant fears and myths that permeate entire towns and parishes. Once a traumatic event takes place, past or present, that involves a suspicious death of a member of particular race or community, or a nearby doctor or hospital makes a critical medical blunder and causes fatal injury, it becomes news throughout the community and remains in the psyche for years. Some myths have been known to persist and haunt residents in minority communities for decades and get larger and more fascinating with each generation. One example of these bothersome barriers that prevent quality health care is when the Bureau conducted door-to-door health assessments during Operation Safe Re-entry in the Bayous of Terrebonne Parish. Residents in this isolated coastal community of Dulac consist of Native Americans, African Americans, Vietnamese and

Hispanics. Most in this township told surveyors they did not want their children to sign up with the state's Children Health Insurance Program (LACHIP). Their reluctance came about when two Native American tribes were locked in a political tribal feud to win the hearts and minds of other Native American members throughout the area. During a number of interviews, it was recorded that the larger of the two tribes told residents not to register their children with LACHIP because the state would see the impoverished conditions in which they live, have their children taken away and placed in foster care. As a result, children and families that fully qualified for the program did not apply and were left struggling to choose between paying rent, keeping the lights on, buying groceries or purchase prescription medicines. According to locals, most in these isolated communities think that every state-run or private program is not affordable. So they go without until their conditions illness becomes catastrophic.

Another myth that hinders health care to people of color is their reluctance to disclose personal information to providers or hospital staff when they become ill and must utilize emergency rooms or a primary care physician. (Operation Safe Re-entry Surveys, 2005) Mistrust is the main issue here because someone may have told an anecdotal story that happened years ago about someone whose personal information fell into the wrong hands and suffered grave consequences. Still, myths like these remains persistent in minds of older residents in these communities who pass down stories to younger men and women that believe every word and will not trust "the system."

Overall, those with higher incomes tend to fare better than those with lower incomes. For example, among white men aged 65 years, those in the highest income families could expect to live more than three years longer than those in the lowest income families. The percentage of people in the lowest income families reporting limitation in activity caused by chronic disease is three times that of people in the highest income families. The average level of education in the U.S. population has increased steadily over the past several decades—an important achievement given that more years of education usually translate into more years of life. For women, the amount of education achieved is a key determinant of welfare and survival of their children. Higher levels of education also may increase the likelihood of obtaining or understanding health-related information needed to develop health-promoting behaviors and beliefs in prevention. Again, education attainment differs by race and ethnicity. The infant mortality rate is almost double for infant mothers with less than 12 years education compared with those with an educational level of 13 or more years.

Geographic Location

Twenty-five percent of Americans live in rural areas, that is, places fewer than 2,500 residents. Injury-related deaths rates are 40 percent higher in rural populations than in urban populations. Heart disease, cancer and diabetes rates exceed those in urban areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. Timely access to emergency services and the availability of specialty care are other issues for this population group.

Stress and Depression

Disparities exist in both access to and quality of mental health care for racial and ethnic minority groups in Louisiana. Examples of these disparities include the underutilization of psychiatric services by persons from ethnic minority groups, problems in treatment engagement and retention of persons from minority groups, the over-diagnosis of schizophrenia among African Americans and depression among Latinos, the inappropriate use of antipsychotic medications among African Americans (and the use of these medications at higher dosages among African Americans and lower dosages among Latinos), and very high rates of substance use disorders and completed suicide among Native Americans. But the one diagnosis that occurs more often than most based on door-to-doors surveys conducted by the Bureau of Minority Health Access (BMHA) shortly after Katrina and Gustav was depression. Depression is the gateway to other illnesses and is now a major contributor to the widening of health disparities among racial and ethnic populations.

Depression frequently co-occurs with a variety of other physical illnesses, including heart disease, stroke, cancer, and diabetes, and also can increase the risk for subsequent physical illness, disability and premature death. Depression in the context of physical illness, however, is often unrecognized and untreated. Furthermore, depression can impair the ability to seek and stay on treatment for other medical illnesses. Research suggests that early diagnosis and treatment of depression in patients with other physical illnesses may help improve overall health outcome. Now more than ever before, mental health is a major player to be considered when addressing health disparities and the overall health of Louisianans. BMHA is seeing more evidence statewide of the growing effects of depression and the need for mental health services in low-income and underserved areas.

Psychosocial and environmental stressors are known risk factors for depression. Research has shown that stress in the form of loss, especially death of close family members or friends, can trigger depression in vulnerable individuals. Genetics research indicates that environmental stressors interact with depression vulnerability genes to increase the risk of developing depressive illness. Stressful life events may contribute to recurrent episodes of depression in some individuals, while in others depression recurrences may develop without identifiable triggers. Research also indicates that stressors in the form of social isolation or early-life deprivation may lead to permanent changes in brain function that increase susceptibility to depressive symptoms.

In addition to access barriers, such as inadequate insurance coverage, other factors affect minority patients' utilization of mental health services. Inadequate detection of psychiatric conditions by primary care physicians and under referral of these patients to psychiatric care constitute fundamental deficits. Even for those who gain access to treatment, early dropout (often after just the first session) and high rates of missed appointments for psychiatric treatment are a persistent problem. Thus, effective communication with the patient, especially in first interactions, is essential to engage patients in treatment. Among patients for whom English is a second language, qualified interpreters to translate content are not always used in clinical practice. Far less often is cultural context translated, which may be done more effectively by a trusted bilingual family member or friend of the patient in addition to a professional interpreter. Before hurricanes Katrina/Rita, nearly one-quarter of state residents, including almost one-third of Louisiana’s children, lived in families with incomes below the federal poverty level. One-fifth of non-elderly residents had no health insurance. Twelve percent of the children were uninsured.

As a result, the state had the fourth highest emergency department use per capita among all states in 2004. The largely poor, uninsured and African-American residents of New Orleans were served by the Medical Center of Louisiana at New Orleans (MCLNO), which included Charity Hospital, University Hospital, and affiliated clinics. In the New Orleans area, the MCLNO provided 83% of inpatient and 88% of outpatient uncompensated care costs in 2003. Most of the region's psychiatric, substance abuse, and HIV/AIDS care was provided by the MCLNO. The MCLNO housed most of the region's inpatient mental health beds.

Two years after the storm, approximately half of New Orleans' physicians no longer practiced in the area. More than half of all hospitals that existed before the hurricanes were closed. Nineteen percent of the city's residents felt their physical health was worse than before the storm. Thirty-six percent indicated that their access to health care had been compromised. Almost one-quarter of individuals from the New Orleans area reported that post-Katrina stress affected their temper, alcohol consumption, and marital relations. Mental health clinics report higher rates of depression, post-traumatic stress disorder, substance abuse, acute psychosis, domestic violence and even suicide. At some facilities, it is estimated that 50 to 60 percent of adults and 20 percent of children are clinically diagnosed.

A study to rigorously assess the mental health fallout from Hurricane Katrina was conducted to confirm what many researchers and Gulf Coast residents predicted: that mood problems after the storm occurred about as often as in any natural disaster ever studied, and that the delayed government response almost certainly made the problem worse. The analysis, a continuing survey of more than 1,000 residents of New Orleans and surrounding areas, found that 17 percent of people in New Orleans reported signs of serious mental illness in the month after the disaster, compared with 10 percent in surrounding areas. The estimated prevalence of such problems in the general population is 1 to 3 percent in any month. Post-traumatic stress symptoms — which include flashbacks, nightmares, a hair-trigger temper — were by far the most common type of mental problem and were often associated with incidents that happened in the storm's wake, like property losses, robberies and assaults.

Nearly half of New Orleans residents in the survey reported some significant symptoms of anxiety in that first month after the storm, about as high as can be expected in a community hit by a natural disaster, according to the study, being published in the Archives of General Psychiatry. Women, young adults and lower-income residents were hardest hit, just as studies of previous disasters have found. In surrounding areas like Slidell where low-income pockets of poverty exist, residents experienced identical symptoms which brought about increased rates of alcohol and drug abuse just to get through day-by-day.

From January to March 2006, about six months after the hurricane, the surveyors asked participants 30 questions, including one open-ended query: "What would you say are currently your most serious practical problems caused by Katrina?" Based on the answers, the researchers focused on 10 common storm-related incidents, like risk of death in the storm or an assault on a loved one in the lawless limbo before some order was restored.

They found that property loss affected 70 percent of New Orleans (65 percent in Slidell and St. Bernard Parish) respondents and that 40 percent of the city dwellers reported other traumas, like robberies, compared with 17 percent living outside the city. Over all, New Orleans residents were nearly twice as likely as those living elsewhere to report mild or serious mental distress. Experts say they expected many of these post-traumatic effects to resolve with time; depending on how horrifying their experience, 3 to 10 percent of people will suffer symptoms for a year or longer. "The main message here is that the primary drivers of mental health risk were social and financial circumstances," said Dr. Sandro Galea, an associate professor at the University of Michigan and the study's lead author. "So if we're intent on minimizing psychopathology, it means mitigating those stressors quickly," by restoring order and helping people back on their feet financially.

What about Louisianans that were spared from the brunt of hurricanes Katrina, Rita and most recently Gustav? Why are stress and depression levels still very high in northern Louisiana with the coastline being several hundred miles away? Although residents throughout parts of Louisiana did not experience the hurricanes' destruction, minority populations suffer disproportionally from higher rates of stress and depression that lead to hypertension, high blood pressure and a host of other chronic illness and disease. Communities of color in the northern part of the state are routinely spared from hurricanes and they still suffer from stress and depression that is usually generated from low socioeconomic status, education attainment and poverty. Besides these contributing factors, which are all major causes of health disparities, one must not overlook how our health care system plays a pivotal role in the declining health status of racial and ethnic populations.

Obesity in Minority Populations

Obesity is a major epidemic in Louisiana. It is affecting minority groups at a disproportionate rate, with Hispanic teens having the highest rates of Body Mass Index (BMI) growth, and black women having the largest membership in the extreme BMI (>40) group. Native Americans with obesity have the highest incidence of diabetes, and health care outcomes for these groups fare poorly compared to whites. Most Americans consume more calories than we need, and are becoming more and more sedentary with the plethora of technology around us. Behavior modification ***is*** important.

We must modify the behavior of health care providers and third party payors so obesity can be treated. We must ***stop*** just talking about it, and move to ***do*** something about treatment of obesity, and prevention of further obesity. Address obesity at every visit and even involve office staff. According to the Operation Safe Re-entry Community Assessment Survey 2006, here are some recommendations for physicians that treat minority populations

Here are concise suggestions for providers:

- ✓ Reward positive behavior on the part of your patients
- ✓ Do ***not*** threaten (i.e. if you don't take care of your weight you'll get diabetes).
- ✓ Refer for dietician consultations.
- ✓ Do not ask your patients to diet and exercise -- rather: Do ask every one of your patients to improve their nutrition and be more active.
- ✓ Do provide culturally and linguistically appropriate care.
- ✓ Providers must convey in simple, understandable terms, that inactivity and overeating are **not** okay, and that proper nutrition and physical activity add quality and quantity of life.

Health Effects of Childhood Obesity on Minority and Low-Income Populations

In 2000, the Louisiana Governor's Council on Physical Fitness and Sports conducted a physical fitness study of elementary school children in 12 parishes throughout Louisiana. Early on in the study that obese children would become obese adults and suffer obesity-related health complications. The Council's concerns, however, are more immediate: obese children are already suffering from these complications. According to Shiriki Kumanyika, professor of biostatistics at the University of Pennsylvania School of Medicine, obesity-related diseases seen in children include precursors of cardiovascular disease, type 2 diabetes, and sleep-disordered breathing. Ethnic minority and low-income children appear more likely to experience some of the obesity-related health problems. Type 2 diabetes provides a useful example.

Among adults, Type 2 diabetes is more common in African Americans and Hispanics than among whites. The higher rates of diabetes among ethnic minorities and low-income children, when combined with adverse health effects of child obesity, are likely to produce continued racial and economic differences in health outcomes. Preventing obesity for all children may be a way to reduce socioeconomic and ethnic health disparities. These outcomes appear to be prevalent in the communities surveyed by the Bureau of Minority Health Access and the Office of Public Health that shows high rates of hypertension, high blood pressure, diabetes and stress in adults that started brewing in their childhood years.

Kumanyika states that effectively addressing ethnic and socioeconomic disparities in childhood obesity requires understanding which causes of obesity might be especially prevalent or intensified in ethnic minority and low-income populations; understanding how aspects of the social, cultural and economic environments of minority low-income children might magnify the effects of factors that cause obesity; and determining which changes in those environments would help most to reduce obesity.

In what follows, the Louisiana Governor's Council on Physical Fitness and Sports argued these issues in relation to media and marketing influences, community food access, built environments, noting each case factor that may promote obesity are particularly likely to affect low-income and minority youth.

Health Disparities Experienced by Black Children/Youth

- In 2002, 37% of non-Hispanic black children aged 2-17 years visited a dentist within the
- past year, compared with 58% of non-Hispanic white children in the same age group.[1]

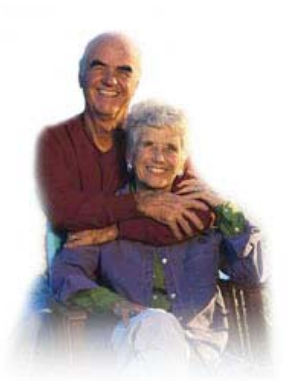
- In 2003, 73% of non-Hispanic black children aged 19-35 months received all recommended vaccines, compared with 83% of non-Hispanic white children in the same age group.[2]

- During 2003-2004, 24% of non-Hispanic black females aged 2-19 years were overweight, compared with 15% of non-Hispanic white females in the same age group.[3]

- During 2003-2004, 18% of black children aged 0-17 years had asthma, compared with 12% of white children and 11% of Hispanic children in the same age group.[4]

- In 2006, non-Hispanic black females aged 10-14 years were 18 times more likely to have gonorrhea than non-Hispanic white females aged 10-14 years.[5]

- In 2006, 8% of non-Hispanic black children younger than age 18 years were uninsured for health care, compared with 6% of non-Hispanic white children younger than age 18.[6]



Health Disparities: *From A Grass-roots Perspective*

In 2006, the Bureau of Minority Health Access fully engaged the core functions of public health to mobilize local communities toward eliminating health disparities among vulnerable populations in Louisiana. This section gives an accounting of the day-to-day tribulations and solutions regarding health disparities throughout the state, from north Louisiana by way of Shreveport to Lake Providence in East Carroll Parish and southwestward through Lafayette, on to Baton Rouge across I-10 to coastal Louisiana and south to Terrebonne and Plaquemines parishes. Minority community-based organizations, public health clinics and the faith-based communities from these areas rallied around issues of health disparities and subsequently participated in a community-driven systematic assessment of their needs through the Bureau's annual Minority and Multicultural Health Month campaign. This campaign provided for the development of coalitions and delivery of culturally appropriate health programs. Collaborative relationships between the public health workers, public policy makers and the community were developed over time, and their findings are now well-documented for the purpose of this report. In order to portray an accurate picture of how health disparities affect Louisiana's minority populations, a microscopic viewpoint from a *Grass Roots Perspective* with real-life accounts will help readers see Louisiana's declining health among racial and ethnic populations up close and personal in their own words.

EXCELth, INC Primary Health Care Network
New Orleans, Louisiana Commentary to Louisiana Minority Health Report

Health Disparities

Across this country, there are dramatic differences in health status closely linked with levels of social inequities. Most health inequities arise out of circumstances and conditions where people grow, live, work, age and are treated for illnesses. The conditions in which people live and die are consequently shaped by societal, political, economic and social structures. Social and economic public policy plays a tremendous role in determining the future health status of populations of the world, the United States and Louisiana. Health disparities that exist among Americans are an indicator of the inequality in health status found among the races in this country. In this context, health disparities refer to the disproportionate burden of disease, illness and preventable deaths that haunt African-Americans and other minorities in the United States.

Health disparities are referred to as health inequities when they result from systemic and unjust distribution of social determinants or conditions non-conducive to maintaining a positive state of health. Social determinants of health incorporate socioeconomic factors, such as housing, education, the neighborhoods where we live, access to health care, racism and discrimination. Any efforts to end health disparities in this country and in Louisiana must address the social determinants that impede progress to achieving and maintaining health equity for all (Commission on Social Determinants of Health, 2008).

Community Health Centers are at the forefront of the Health Access movement in this country and in the state of Louisiana. They provide an excellent source of cost effective primary and preventive health services to vulnerable populations, who are greatly affected by social and economic determinants of health. Community Health Centers serve as one of the spokes in the wheel to achieving health equity in the country and the state.

EXCELth, INC

Operating as a not-for-profit Federally Qualified Health Center (FQHC) grantee in New Orleans since 1992, EXCELth, Inc. Primary Care Network provides coordinated, system-wide community-based primary health care to improve the quality of life for residents of the New Orleans area. EXCELth provides direct care and support services for underserved and uninsured populations in New Orleans. EXCELth Primary Care Network presently includes EXCELth, Inc., Daughters of Charity Services of New Orleans and the New Orleans Health Department. Combined, these network members operate five primary care centers located in New Orleans, Baton Rouge and Metairie, as well as a dental clinic and three mobile health units based in New Orleans.

BARRIERS TO ACCESSING HEALTH CARE SERVICES

Challenges are an intrinsic part of living for individuals, families and communities served by EXCELth Primary Care Network Clinics. Ordinary challenges were propelled overnight into extraordinary, insurmountable life events for individuals and families with Hurricane Katrina in 2005. Disrupted lives, communities and health care infrastructure were the results that followed and continue to prevail today. The shaded areas of the map in Figure 1 show flooding to 80 percent of the city. The flooding destroyed over 180,000 homes, the health care delivery system, schools, businesses, jobs and a way of life for so many.

Figure 3

Orleans Parish Sept 11th flood extent with neighborhoods & major roads

Figure 1

African-Americans residents of New Orleans' poorest communities, renters and the unemployed were disproportionately impacted by Katrina's floodwaters. Quigley (2006) reported the damaged areas were populated by 46 percent African-Americans compared to 26 percent African-Americans in the rest of the city. Forty-six percent of the population in the most damaged areas were renters compared to 31 percent in the rest of the city. Twenty-one percent lived below poverty compared to 15 percent in the rest of the city. If you lived in New Orleans and were African-American, you were at increased risk for sustaining storm-related damages and losses. Pastor et al. (2006) suggests groups of individuals lacking access to resources, power and information are usually further disenfranchised before during and after a disaster. More than three years after Katrina, barriers that prevent access to health services for these individuals take on the shape and form of the uncertainties of the future for many of our clients. While there has been some improvement in the availability of primary health care services in New Orleans, many of our clients still struggle with the basic needs for food, shelter and jobs. Currently there are still 5,550 people living in FEMA trailers in the state (Associated Press, 2008).

With the demolition of public housing units, there is a shortage of affordable housing, as rent rates are 46 percent higher now than before the storm. Public transportation to community clinics presents yet another challenge to clients accessing health care services. Orleans Parish experienced a 45 percent increase in ridership from August 07 – 08 (GNODC, 2008). Providing health care services to a population lacking basic resources, including health insurance presents its own challenges.

HEALTH INSURANCE

Based upon the 2007 uninsured estimates of Louisiana's population, 30 percent of the population in the New Orleans region is uninsured and 33.5 percent of the adult population is at or below 200 percent of the federal poverty level (FPL). As a result of menial jobs, lack of social service resources, excessive loss and damage to neighborhoods, and severe homelessness, many adults are or have become uninsured. Consequently, the children of these families are uninsured. Because of greater awareness of the LaCHIP program and the expansion of health coverage to children in households between 200 percent – 250 percent FPL, more children have been afforded access to health care. Many of our clients, insured and uninsured, routinely experience difficulties in obtaining prescription drugs.

PHARMACEUTICALS

Access to prescription drugs is essential to the successful treatment of our clients. Individuals who have no insurance are ineligible for medications under most Prescription Assistance Programs. These programs are utilized and are of maximum benefit in treating clients. However these programs have limitations and are often used in conjunction with other programs and discount prescription services. In some instances an individual may be insured with or without limited drug benefits which often renders them ineligible for many Prescription Assistance Programs.

MENTAL HEALTH

Mental health needs were at the top of the chart in the aftermath of the disaster and continue as a major issue. The immediate stress and trauma experienced by many individuals are now manifesting in the form of depression and anxiety disorders. Individuals with chronic mental illness conditions are exacerbated in the absence of stability in their lives, treatment facilities and medical providers. In a survey conducted of evacuated families still in Louisiana in February 2006, mental health problems were significant. The survey documented nearly half of the parents reporting behavior of emotional problems observed in their children after the storm (Abramson and Garfield, 2006).

Based on results from a standardized mental health-screening tool, more than half of the mothers scored at a level consistent with a psychiatric diagnosis. The deputy coroner of Orleans Parish recorded almost a threefold increase in suicide rates, from 9 per 100,000 to 26 per 100,000 in the four months after Katrina hit. The following year there were 93 homicides in New Orleans, compared with 202 by the same time the previous year, according to police reports. Murders were running at about the same rate as before the storm considering the drastically reduced population. There are also reported increases in domestic violence cases. In a report from the Journal of the American Medical Association, in 2006 only 22 percent of the 196 psychiatrists were practicing in New Orleans, with drastic reductions in inpatient beds that still have not been restored. The poor, the uninsured, the elderly, homeless people and people of color are disproportionately impacted in the situations and circumstances they currently face in post-Katrina life.

HEALTH DISPARITIES

As in other states in the U.S., African-Americans and other minorities in Louisiana are disproportionately affected by illness and disease. Cardiovascular disease, cancer and diabetes are among the leading causes of death in the state. African-Americans are consistently at greater risk with higher morbidity and mortality rates. African-American women have a 40 percent higher chance of dying of cardiovascular disease than white women. In the case of breast cancer African-American women have lower rates of incidence of disease but higher mortality rates when compared to white women in the state. African Americans have the highest prevalence of diabetes, with a 10.9 percent diagnosis rate, compared to 7.9 percent of Hispanics and seven percent of the white population. Infant mortality rates per 1,000 live births for African-American infants were 14.1 in the state and 10.4 in New Orleans, just over two times the rate for white infants. Of the persons who are living with a diagnosis of HIV/AIDS in the state and parish, African-Americans comprise 66 and 60 percent respectively compared to a national rate of 42 percent (BRFSS, 2004) (Louisiana Office of Public Health, 2005, 2006).

The burden of inequality as previously discussed in relation to poverty, health status and health disparities begs the question, "*Do place and race matter*"? These health status data suggest if you lived in Louisiana you were at risk for living in poverty and having poor health outcomes. However, if you lived in Louisiana and were African-American, you were at risk for living in poverty and having poor health outcomes. On the other hand, if you lived in New Orleans, you were more than likely African-American and you were at a greater risk of having poorer health and living in poverty (Webb, 2007).

THE BURDEN OF INEQUALITY

The cumulative effects of poverty, inequality, social isolation and racism on a people have a mounting effect. These social determinants are closely linked to the poor health outcomes experienced by many African-Americans and other minority populations in the United States. Health disparities often results in decreases in the quality and years of healthy life for many Americans (Webb, 2007).

RECOMMENDATIONS

The problem of health inequities has been studied and documented extensively for the past several years. Therefore we agree and put forth the recommendations of the World Health Organization Commission on Social Determinants of Health, Closing the Gap in a Generation Report 2008. The overarching recommendations are:

- **Improve Daily Living Conditions**
  Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age.

- **Tackle the Inequitable Distribution of Power, Money and Resources**
  Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally.

- **Measure and Understand the Problem and Assess the Impact of Action**
  Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health and raise public awareness about the social determinants of health.

Tulane New Orleans Children's Health Project

This health disparity perspective comes of a case manager who is currently providing services to the community through the Tulane New Orleans Children's Health Project. This program provides free medical and mental health services to children and young adults up to 24 years old. Currently, about 40 percent of our patients are of Hispanic descent and do not have health coverage. Majority of parents and their children are without health insurance coverage. Although they are employed, most companies where they are employed do not provide health coverage to their employees or their families. Those who are self-employed are not able to afford health coverage. As a result, many go without health care. Many usually end up at our hospital emergency rooms when they become ill, using the ER as a clinic. There are a few resources in the community that can provide basic health care for a reasonable price. If more significant medical care is required, most go without it, until they are in crisis and seek their medical care at our local emergency rooms.

Some clinics in the community that once provided care without requirements are now requiring a Social Security number, which many do not have in order to access services. Others require a local identification card and without it, clients are charged a higher fee. Some of these practices are understandable, as most clinics are having a difficult time in providing medical services, as their budgets are limited.

Our program has been able to provide medical care to a large number of the current Latino population that lacks medical health coverage, but our capacity is limited. As our national economic crisis worsens, we will probably see an increasing need for our services across all ethnic groups in the Greater New Orleans area.

Oakdale, Louisiana

Allen Parish is a Health Professional Shortage Area designation which disproportionally exacerbates the poor health condition of minorities in this underprivileged, rural area. A Community Health Assessment (CHA) of Allen Parish's condition conducted by Professional Research Consultants Inc., commissioned by The Rapides Foundation, revealed staggering health statistics for minorities in Allen Parish.[1]

- More than one in three (37.6%) African American adults reported four or more days in the past month when poor physical or mental health prevented their usual activities compared to 15.3% among Whites.
- African Americans are more likely to be obese.
- The self-reported prevalence of chronic depression is considerably higher among Black/African American respondents.
- By race, the average annual infant death rate between 1993 and 2002 in Allen Parish was higher among African Americans than whites.
- A higher prevalence of diabetes in Allen Parish is reported among African Americans.
- The stroke death rate in Allen Parish is nearly twice as high (145.0) among African Americans than among whites (76.8).

Given the benefits of exercise in a number of chronic medical conditions, such as hypertension, diabetes, and osteoporosis, the center is playing a vital role in the health and well-being of many minority residents of Allen Parish. The Health Enrichment Network (THEN) created an innovative, alternative solution to the problem of service provision in a remote area. THEN took an abandoned city property and turned it into a Wellness and Aquatic Center that provides health and wellness services available at one fixed site. The Center also has a team of multi-skilled health and social care professionals working from a single location. The response to this resource has been phenomenal and it serves as the primary exercise and wellness resource for the parish.

Difficulties of access, isolation and lower levels of service provision in rural areas actively contribute to health and social care problems.

[1] 2005 PRC Allen Parish Community Health Assessment prepared for the Rapides Foundation. https://www.prceasyview.com/Reports/PDFs

The Health Enrichment Network is a model for creatively utilizing meager community resources to make wellness resources available to disadvantaged communities. However, THEN is continuously challenged by the precarious balancing act to maintain its services in an economic environment that calls for free and sliding scale fee structure without the assistance of state funding to assist in its proactive work.

Jefferson Community Health Care Centers, Inc.

Jefferson Community Health Care Centers, Inc. provides health care services to the medically underserved people living in Jefferson Parish, Louisiana. Jefferson Parish, located in the Southeast region of Louisiana, has a total population of 455,466 according to the 2000 U.S. Census. Jefferson is divided into east and west quadrants by the Mississippi River that runs completely through the middle of the parish.

According to the 2000 U.S. Census data, within Jefferson Parish there is a ratio of 1486 persons per mile with 61,608 below 100 percent of the federal poverty level (FPL). There are a total of 144,062 individuals who are below 200 percent FPL. Lack of access to affordable care is just one of many factors impacting access for the target population of the area. Specifically, there is a high rate of poverty and a high percent of uninsured (100 percent and percent of the racial and ethnic population, respectively). Those who live in poverty and are underinsured face significant barriers to health care since many local physicians' offices are not willing to accept the underinsured population without up-front cash payment for services.

The organization's current user population includes 2.3 percent who are of Hispanic origin, 65.3 percent who are African American, 1 percent who are American Indian or Native Alaskan, and 28.9 percent who are Caucasian. The target population exhibits several indicators of poor health. Indicators include: high rates of low birth weight babies, infant mortality, strokes, heart disease, diabetes, cancer, accidental deaths, tuberculosis, severe mental illness and high teen birth rates. The service area has the following designations that also indicate a high need for health care services: designations as Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA).

Needless to say, the severity of these conditions is worsened for residents because of a lack of insurance and personal fiscal stability resulting in a lack of access to affordable health care. Two additional disparities significantly relevant to our population are Socioeconomic status and unemployment.

Socioeconomic Status: Approximately 31.2 % of the households in Jefferson Parish have a total income of less than $25,000, compared to 28.7% in the U.S. This makes a total of 144,062 people are living below 200% poverty within the service area. This includes 13.7% of the general population (61,608 people) who are below 100% and 18.3% (82, 454 people) between 100-199% of the federal poverty level. According to 2003 data from the Louisiana Department of Education, 69.3% (35,190) of students within the district qualify for free or reduced school lunches. Consistent with high rates of poverty, certain non-violent crime rates in the area have a higher rate of occurrence as compared to the State. For instance, of all crimes reported in 2000, the percent of larceny/theft is 60.6% for the service area compared to 59.6% for the State and robbery is also higher at 3.4% compared to 3.1% for the State. In addition, another indicator of the presence of poverty is the percentage of motor vehicle thefts (11.5%) as compared to 8.8% for the state.

Unemployment: According to data the unemployment rate for Jefferson Parish is 4.1%. While significantly higher than the State or Nation, rates has risen from the 3.9% reported in the Census of 2000. Of significant concern are unemployment rates within census tract areas where the majority of the target population is located. For instance, census tract 275.02 (where the organization is located) had an unemployment rate of 7.4%. Adjoining census tracts 276.02 and 274 also had significantly higher unemployment rates (7.7% and 6.1% respectively) than the parish or the state (3.0% and 3.4% respectively).

Choctaw – Apache Community of Ebarb (Zwolle)

Health care is a serious issue among minorities in Sabine Parish. Two of the major diseases in the area are diabetes and heart disease. Because the area is so rural, many people must go to a facility in a larger city to receive care for very serious problems, usually LSU Medical Center in Shreveport. Shreveport is approximately seventy-five miles from Zwolle. This population is an aging one and health care has become a very big issue. Many of the diseases that disproportionately affect minorities, such as diabetes and heart disease, are made much worse by cultural habits and traditions. Obesity is very prevalent among minorities in Sabine parish. Obesity is the direct result of diets high in excess fat, carbohydrates and salt. Lack of exercise is a major contributor to obesity. Obesity-related illnesses such as diabetes, arthritis, cardiovascular disease, and cancer are all problems faced by minorities. Some studies have suggested that genetics play a role in minority health. What exact role it plays is not clear. Nor is it clear what can be done about this aspect of health care.

Culture, education (or lack of) and socio-economic status all seem to play a major role in the health care crisis among minorities.

There seems to be a problem with access to health care, utilization of healthcare and, to some extent, the quality of health care received. Of these factors, it would seem that education is the variable that can be most easily addressed. Small, one-day workshops that address these issues seem to work best in this community. In addition, constant re-education on aspects of a healthy lifestyle is necessary. Periodic health fairs help people, especially the elderly, keep an eye on their blood pressure, cholesterol and sugar levels. When these are held at a local convenient venue (a church hall or the tribal office) more people can be reached.

According to MSNBC.com, a new report released by the federal Centers for Disease Control and Prevention says that almost 12 percent of the deaths among Native Americans and Alaska Natives are alcohol-related—more than three times the percentage in the general population. The two leading causes of alcohol-related deaths among Indians were traffic accidents and alcoholic liver disease. The study recommends "culturally appropriate clinical interventions" to reduce excessive drinking and better integration between tribal health care centers. Sabine Parish also suffers from alcohol-related problems, though the exact statistics are not available. An effort has been made to work through the schools to educate all students as to the harmful effects of alcohol, drug abuse and smoking.

Louisiana Primary Care Association- Calcasieu Parish

According to results from the 2004 BRFSS (Louisiana Health Report Card), approximately 15% of adult women in Louisiana did not receive a Pap test within the last three years. Black women in the state are more likely not to receive adequate screening for cervical cancer (15.3%) than white women (14.0%). A high proportion of women who are 65 years of age and older (25%)

The five-year low birth weight rate for Calcasieu Parish (Lake Charles) was 9.6%, but the comparison rate for b**lacks was 14.6 and 7.6 for whites**. Similarly the Lafayette Parish (Lafayette) rate was 9.2%, and the rate for Blacks was 14.6 and 7.6 for whites. With low birth rates greater than twice that of whites at the parish level and 1.3 times the national rates, low birth weight rates among Blacks who comprise more than 80% of the Calcasieu target population and 71% of Lafayette, are challenging, to say the least, and they are telling indicators of the less than adequate health care delivery system in the Southwest Louisiana (SLWA) service areas. In 2002 the Calcasieu Parish low birth weight rate was 9.6%, and the Lafayette Parish rate was 8.8%. By comparison the state, national, and Healthy People 2010 rates were 10.5%, 7.7%, and 5.0% .

Black women in the state gave birth to infants of low birth weight about twice as frequently as white women did, at 15.0% compared to 7.7% of live births, respectively.

This discrepancy held true for almost all age groups, excluding women under 15 years of age where the racial disparity was almost threefold. Black teenagers under 15 were more likely to have low birth weight babies than white women under 15. Examination of births by age group found that mothers over age 40 years had the highest percentage of low birth weight babies (14.1% of live births), followed by mothers under age 20 (13.0%).

The National Survey of Children's Health estimated in 2004 that 10.7 percent, or 125,649 children in Louisiana have asthma. The prevalence of asthma among children varies by race, age, and income. By race, the prevalence is highest among blacks with 15.7 percent of black children reported to have asthma, compared to 7.5 percent of whites, and 10.1 percent of other races. By age the highest prevalence is found in the 6 to 11 age group at 12.1 percent. The prevalence of asthma also increases with decreasing levels of income, with the highest prevalence rate of 19.6 percent among persons below the federal poverty level.

David Raines Community Health Centers and Health Disparities
Caddo, Claiborne, Webster, and Bossier Parishes

David Raines Community Health Centers, is an independent non-profit, Joint Commission Accredited (JCAHO), Federally Qualified Health Center (FQHC), provides quality, affordable, primary and preventive services to all regardless of race, national origin or ability to pay. The health center's service area includes Caddo, Claiborne, Webster and Bossier parishes. Health and dental services are provided in five sites located in Shreveport, Gilliam, Haynesville, Minden and Bossier City. The total service population of the four parishes served by the health center is 141,016. The target populations are the uninsured and those in the service area who are under 200% and 100% of the federal poverty level (FPL). The number of people under 200% and 100% of the FPL are 55,049 (39.1%) and 25,584 (18.1%), respectively. The estimated numbers of uninsured residents are 39,206 (27.85%). The most significant barrier to addressing health disparities is lack of access to affordable health care. There are no other providers in the service area providing comprehensive, affordable and culturally appropriate primary health care services, or have a sliding fee program in place for the uninsured and underserved individuals below 200% of the FPL. The primary patient base is 99% under 200% FPL, 75% African American, 25% white**,** , 37% uninsured, 48% Medicaid and 7% Medicare.

All of DRCHC's service areas are designated as medically underserved areas (MUA) as well as Health Professional Shortage Areas (HPSA). The entire service area is generally economically underdeveloped and the population is largely low income. Core health disparities in the service area are high obesity rate, diabetes, high pneumonia death rate, uncontrolled hypertension, high infant mortality rate and high suicide rate.

Other disparities include the high rate of births to teenage mothers, low cancer screening rates, high unintentional injury death rate and high Chlamydia and gonorrhea rates.

The centers' most difficult challenge is empowering people to understand that early diagnosis and treatment is very important to improving outcomes and to living healthier. Individual barriers such as educational literacy and health literacy skills are problem areas that contribute to individuals forgoing or prolonging seeking medical attention. There is also a cultural barrier which is the reticence of the community to seek preventive care and to make appointments for medical care. DRCHC's patients primarily seek care on a walk-in basis for emergent conditions.

The aforementioned barriers and access to affordable health care are more prevalent in Claiborne and Webster parishes. A major reason for this anomaly is due to the very limited number of culturally competent providers in the parishes. Only one of the providers in Claiborne Parish is African American and she is one of DRCHC's providers. Almost half of the parish is comprised of African Americans. In Webster Parish, there are two African American physicians who accept a limited number of Medicaid patients but do not have a sliding fee schedule for those individuals at or below 200 percent of FPL. The service areas of Caddo and Bossier parishes also face major challenges of poverty, low educational levels, geography, inaccessible and inadequate primary health care services for the underserved and underserved residents. Children under the age of 18 make up a major portion of the target population. The majority of the elementary schools within the DRCHC's service area are designated as Title I schools. (Title I of the Elementary and Secondary Education Act provides funds to school systems across the country to improve education for children at risk of school failure who live in low-income communities.) Two-thirds of the elementary and secondary school children qualify for free or reduced-cost lunches. The population age 65 and older in the service area faces increased risk for developing multiple health problems. In addition, many lack the necessary finances and means of transportation that would allow them access to primary health care. The service area also has limited public transportation. Public transportation is not available in the rural areas of the parishes served.

Recommendations

In order to reduce health disparities, access to affordable culturally competent primary health care must increase. Programs and efforts to educate the public bring awareness and increase access to quality health services must also be available. By doing so the dependency on emergent care and adverse health outcomes would be reduced.

Iberia Comprehensive Community Health Center

ICCHC's service area's most prevalent minority population are African Americans (Iberia – 32.5%, St. Martin – 31.1%, Vermilion – 14.1%, U.S. – 12.4%). In Iberia and St. Martin parishes the percentage of African Americans is almost three times the national average. Minorities experience greater disparities in infant mortality, chronic and infectious disease on national and state levels. ICCHC's service area struggles with these same issues and has implemented effective interventions for over 23 years to improve the health status of the population we serve. Access to affordable, culturally competent, comprehensive health care services and non-traditional health education have been effective strategies in our efforts to reduce minority health disparities.

Pointe Coupee Better Access Community Health (BACH)

One of the most significant health care barriers residents of Pointe Coupee Parish face is non-emergency medical transportation. BACH is currently the sole provider of this service for residents into Baton Rouge. Pointe Coupee has very few healthcare specialists so most chronic diagnoses require treatment in Baton Rouge. Currently BACH has two – 12 passenger vans. They remain full, running a morning and afternoon route Monday through Thursday. The Friday route was recently discontinued due to lack of funding. This is an essential service for every person who needs transportation for services related to health issues like cancer. A major component that cripples BACH's ability to provide additional services is the cost of the insurance. Currently, non-emergency transporters like BACH are in the same category as ambulances. With the aging population and rural area BACH serves, demand is constantly increasing. Pointe Coupee also has a very low vehicle ownership and so many are dependent on neighbors or family members to get to their point of medical treatment. This could mean a three-hour round trip into Baton Rouge, depending on the location of the resident. BACH is an approved Medicaid provider, but this also is limited as to the nature of the medical visit and reimbursement certainly does not cover the cost of insurance, vehicles, fuel and staff. This is an access issue to health care that must be improved upon.

Another significant healthcare barrier for Pointe Coupee residents is the lack of funding for an urgent care clinic. BACH was recently forced to close its urgent care week-end clinic. The clinic saw patients on a sliding scale based on income and the expenses could not be met. This is detrimental to the quality of life because residents cannot afford a $500 - $800 emergency visit.

Action Steps to Address Health and Educational Disparities

The following action steps have been proposed by CDC's Division of Adolescent and School Health for consideration by state and local education and health agencies to address health and educational disparities among students.

Focus Programmatic Efforts

- Analyze data to identify which groups of youth are at high risk for targeted problems or risk behaviors.
- Target efforts and resources to support policy and programmatic efforts that address the needs of youth in high risk groups.
- Support the design and implementation of evidence-based, culturally- and linguistically-appropriate interventions and programs that focus on youth at high risk.

Raise Awareness

- Learn more about the causes of disparities and about evidence-based strategies for effectively addressing specific issues among specific groups of youth at high risk.
- Educate policy makers, the public, and other agencies and organizations about health and educational disparities, their causes, and evidence-based strategies for effectively addressing specific issues among specific groups of youth at high risk.

Build Partnerships

- Strengthen and sustain partnerships with agencies and organizations serving youth at high risk.
- Participate in broad coalitions that work to address the root causes of health and educational disparities (e.g. poverty, access to health care, discrimination).
- Actively involve youth at high risk in advisory boards or youth councils that plan programs to address health and educational disparities.

Document Impact

- Monitor health outcomes and behaviors among youth at high risk and, if possible, policies and programs that address these outcomes and behaviors among these youth.
- Evaluate activities and programs that focus on youth at high risk, and use findings to improve programs.
- Document and share broadly the successes, challenges, and lessons learned in reaching youth at high risk.

Other methods for ending health disparities or reducing health disparities have been suggested based on research that observes cultural differences within health care systems. In an effort to reduce health disparities between racial and ethnic groups, the health care system should consider the following cultural competency techniques:

[Interpreter Services] If agencies take an active approach in hiring professional interpreters, for both foreign languages and fro the speaking and hearing impaired.

[Recruitment and Retention] Healthcare systems need to become more conscious of the staff within their facilities. It is essential to the reduction of disparities that most minority groups be represented within the various health care facilities and clinics.

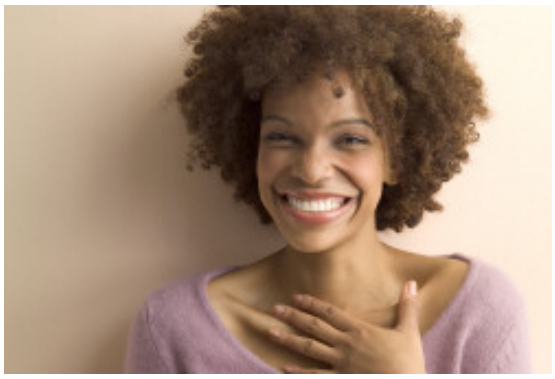
[Training] Emphasize the importance of health care professionals being trained to work with interpreters and minority groups.

[Use of Community Health Workers] These individuals could be responsible for bringing in the population of people who rarely seek out health care.

[Culturally Competent Health Promotion] This information can be available through community health workshops, or simply by health care workers taking the necessary measures to promote early detection and treatment and outlining the good and risky health behaviors to all patients.

[Including Family and/or Community Members] This particular cultural competency may be vital to obtaining consent and adherence to treatments.

[Immersion into Another Culture] Allowing yourself to step outside of your comfort zone will increase your tolerance for another culture as well as raise your awareness to new ideals and beliefs.



APPENDICES

Bureau of Minority Health Access Activities

Community Preparedness Response Network (CPRN)

Community Preparedness Response Network (CPRN) is designed to assist low-income communities with establishing their own emergency preparedness plan in the event of a natural disaster or pandemic flu outbreak. This plan provides hard-to-reach populations a point of contact during natural disasters or pan flu outbreak and make available resources to assist them with relief and recovery efforts specific for their communities.

This pilot project was funded by CDC Community Preparedness Program and Louisiana's Public Health Office of Community Preparedness. The Bureau of Minority Health Access (BMHA) contracted with the Chahta Native American tribe in St.Tammany Parish to help carry out the functions and responsibilities of the project. A CPRN Resource Center was established to host trainings, store equipment and coordinate the 24 hour phone bank in the event of a natural disaster.

When a natural disaster strikes, designated captains on each neighborhood block will receive instructions from the CPRN Resource Center and distribute emergency information to members of the network on their block. Each member of the Network will have an Emergency Preparedness Kit and a checklist of items inside. A pre-determined rendezvous point will be selected well in advance for evacuees to meet. When everyone is accounted for that belong to the Network, evacuees will enter their vehicles and proceed in a caravan-type fashion to designated shelters in Little Rock, Arkansas or state-run shelters. Special arrangements will be made for those who are without transportation. Upon arriving at the shelters, evacuees will be processed as a group by FEMA under the Community Preparedness Response Network that is pre-arranged by the Arkansas Office of the Governor and the Chahta Tribe. This arrangement was established so that relief aid can flow much faster. A database was created to better organize the communities and determine their immediate needs.

Establishing the CPRN

Objectives	Tasks
1.) The Bureau of Minority Health Access and the Chahta Native American Tribe hosted community meetings to inform the public about the pilot program	Chahta tribe and the Bureau will hosted meetings with the Ministerial Alliance, the city Council of Slidell and the parish office to introduce them to the CPRN program and solicit their support. Separate community meetings with residents were held in areas where the pilot program would be operating: Alton, North Slidell, Bayou Liberty, Lincoln Park, Lacombe, 190 West (Bonfouca).
2.) Conduct Community Health Assessment Surveys	Conducted surveys door-to-door in the CPRN network areas to determine the immediate needs of residents, special care for the handicap, those who are without transportation, identify those who do not have phone service, internet access and identify and track new-born and pregnant mothers.
3.) Identify and Train Block Captains	Captains must be well-known and respected in the community. They must have a computer, cell phone, home phone and reliable transportation. Each captain will be trained on how to use walkie-talkie radios. Captains that do not have a computer will be furnished one. The CPRN Resource Center assigned dates to train all Block Captains on conducting the Community Health Assessment Surveys.

Objectives	Tasks
4.) Sign up community residents in the Network for Training	The Chahta Tribe and the CPRN Resource Center trained the community on the overall plan one section at a time. Training community residents took approximately six weeks: **Week one: Alton Community** **Week two: North Slidell** **Week three: Bayou Liberty** **Week four: Lincoln Park** **Week five: Lacombe** **Week six: 190 West (Bonfouca)**
5.) Secure items for the Emergency Preparedness Kits and distribute to community residents in the Network	A list of necessary items were distributed to the members of the Network that must be placed in the kit in case of a natural disaster strikes. The kit should be put in a safe place where it can easily be found. All important papers will be scanned on a disc and secured in the CPRN resource center.
6.) Create a Community Preparedness Response Network Data Base	The Community Preparedness Assessment data was gathered, entered and analyzed to better organize the community and determine their immediate health care needs; compile a list of emergency kit items for hurricanes and pandemic flu; cost of prescription medicine; latest physical exam; updates on shots; and specialty care and those in need of transportation were tagged for "high importance." A list of members with low literacy levels, a total household count for the elderly, students and children, pregnant and new mothers were entered in the database.


OFFICE OF
EMERGENCY PREPAREDNESS
Bureau of Minority Health Access
Community Preparedness Response Network
Resource Center
Alton
North
Slidell
Lincoln
Park
Bayou
Liberty
Bonfouca
190 West
Bayou
Lacombe

Game Plan

Once a hurricane occurs:

Step 1. The Office of Emergency Preparedness (OEP) will alert the Bureau of Minority Health Access to execute the CPRN drill and forward other important emergency instructions.

Step 2. The Bureau of Minority Health Access will alert the CPRN Resource Center in Slidell under the direction of the Chahta Native American Tribe to execute CPRN Emergency drill with additional emergency instructions from the Bureau.

Step 3. The CPRN Resource Center will then make contact with Neighborhood Block Captains to execute the drill. Broad band radios and walkie-talkies will be used as a result of power outages.

Step 4. Captains will make contact with neighbors by phone, radios on their block or go door-to-door if necessary notifying residents to proceed with drill.

Step 5. Captains will execute a check list to ensure neighbors are accounted for, and make sure they have their emergency kits and are ready to move towards the Evacuation Rendezvous point.

Step 6. The Tribe will contact the Bureau of Minority Health and OEP to confirm that everyone is accounted for at the Evacuation Rendezvous point.

Step 7. CPRN residents will then ride in vehicles provided by local churches, community-based organizations, neighbors, relatives and proceed in a caravan-like manner on a prepared predetermined route to a reserved evacuation location in Little Rock, Arkansas or state shelters.

Step 8. CPRN evacuees will be greeted by the Watershed Development Center under the direction of Reverend Hezekiah Stewart in Little Rock for shelter. The Chahta Tribe has a written ordinance designating Little Rock as a tribal evacuation "high ground" for CPRN evacuees.

Step 9. The CPRN Resource Center (Chahta Tribe) will then set up a satellite office for evacuees linking them with hospitals, clinics, employment opportunities and housing with help from the Arkansas State Dept.

Step 10. CPRN will then make contact with Red Cross, Salvation Army, local media outlets, faith based communities for food and clothing, Dept. of Education for evacuee school children, Dept. of Health and Federal Agencies.

Step 11. CPRN will keep lines of communication open with the Bureau of Minority Health and OEP concerning recovery efforts back in Louisiana and when it is safe for re-entry.

Once a Pandemic Flu Outbreak Occurs:

Step 1. OEP alerts the Bureau of Minority Health Access to execute CPRN drill for pan flu outbreak and forward other important emergency instructions.

Step 2. The Bureau of Minority Health Access will alert the CPRN Resource Center in Slidell under the direction of the Chahta Native American Tribe to execute CPRN Emergency drill for Pandemic Flu with additional emergency instructions from the Bureau.

Step 3. CPRN will then make contact with Neighborhood Block Captains to execute the drill. Broad band radios and walkie-talkies will be used as a result of power outages.

Step 4. Captains will make contact with neighbors by phone, e-mail, fax, text message, walkie, radios or anything outside of personal contact to notify residents on their block to stay indoors and refer to Pandemic Flu Emergency Kits.

Step 5. CPRN will keep the lines of communications open for instructions from OEP and the Bureau of Minority Health Access.

Step 6. When supplies run low, CPRN Resource Center will contact the necessary agencies to replenish supplies. Supplies such as prescription medicine, water, food and gas will be distributed by CPRN Resource Center and block Captains.

Step 7. Coordinate with local law enforcement (St. Tammany Sheriff) to open routes to escort supplies into CPRN designated areas.

Step 8. If a CPRN resident comes down with the flu, Block Captains will make sure that infected person stay indoors and follow home quarantine procedures and contact the CPRN Resource Center immediately.

A list of necessary items will be distributed to the members of the Network that must be placed in the kit in case of a natural disaster strikes. The kit should be put in a safe place where it can easily be found. All important papers will be scanned on a disc and secured in the CPRN resource center.

Items for the Emergency Preparedness Kits

Below are items that are needed for obtaining assistance from federal and state agencies in a punctual manner. These items are necessary and must be scanned to a disc in case important papers are lost. Why these items are necessary:

- ✓ **Social Security and Birth Certificates:** Proof of who you are and birth place.
- ✓ **Picture State I.D or Passport:** Lessen the chances of fraud which could hinder federal and state assistance.
- ✓ **Medical Card-** Speeds up health care assistance if evacuating to another state.
  Proof of Address- Lessens chance of fraud and help agencies assist in a punctual manner.

- ✓ **Organizations and Affiliations-** Allows family and friends know where you are and gives the Red Cross one less person to look for, and could help locate missing persons much sooner.
- ✓ **Past FEMA Numbers-** Helps FEMA process applications much quicker by having records already on file.
- ✓ **Medical History-** Speeds up quality of health care in a timely manner and prevents misdiagnosis.
- ✓ **Property Records-** Proof of ownership if home is lost so that inspection assistance can be done in a timely manner.
- ✓ **Voter Registration-** Proof of residency, which district you live, and documentation to maintain voting status as an evacuee.
- ✓ **Land Tax Assessment-** Shows that your taxes have been paid and there are no liens on your property which could hinder your assistance with state and federal agencies.
- ✓ **IRS Documents-** Shows that your yearly taxes are paid, and your quality of assistance is based on your income level as a taxpayer.
- ✓ **Legal Disability Record-** Determines the quality of assistance you receive and fully describes the disability.
- ✓ **Power of Attorney**- Allowing said person to act on someone else's behalf in a legal business matter.
- ✓ **Interdiction-** Once a disabled person is over 21, one must have a court declare a person is not competent to take care of his own affairs and appoints a curator for that person.
- ✓ **Custody and Legal Guardianship-** Allowing guardians of minors to be legally responsible for their care.
- ✓ **Proper Storage for Medicines-** Medicine needing special handling and storage, i.e. refrigeration, packaging.
- ✓ **Copy of Rental Lease-** Proof of renting an apartment or home in order to obtain assistance from state and local agencies
- ✓ **Housing Voucher-** If you live in public housing, having housing vouchers help speed up voucher transfers when evacuating to another state.
- ✓ **Children's School Records-** If an evacuee child is out of school more than thirty days, they must enroll in the present school system. This allows the current school system in other states to know their proper grade level.

Community Residents will be trained in the following areas:

- How to assemble Emergency Kits
- How to prevent panic and stress in emergency situations through training with Mental Health and Behavioral Professionals (Louisiana Spirit).
- How to properly store medicine.
- How to interpret business-related documents for those with low literacy levels.
- How to work as a team in emergency situations.

- How to handle pregnant and newborn mothers during an emergency, via training with Maternal Child Health.
- Conduct Table-top pan flu exercises for the community residents.
- How to handle patients with HIV/AIDS and Hepatitis patients that evacuate with the rest of the population.
- How to properly care for pets in a disaster.

Other Emergency Kit items:

- Food- At least enough for 3 to 7 days, non-perishable packaged canned foods, juices, food for infants or the elderly, snack foods, non-electric can opener, cooking tools, fuel, paper plates, plastic utensils.
- Water- at least one gallon daily per person for 3-to 7 days
- Toiletries
- Disc with important information
- Medicines
- Non-perishable foods
- Small radio
- Batteries
- Hand Sanitizers
- Fully charged cell phones w/ charger
- Cash-in small bills, credit cards and a debit card
- Clothing- seasonal/rain gear/shoes
- First Aid Kits
- Keys
- Toys, books and games
- Tools
- Pet Care items- Proper I.D., immunization records, medications, supply of food, a carrier cage, muzzle or leash
- Maps
- Blankets and pillows

April Is Minority and Multicultural Health Month

'Eliminating Health Disparities through innovation, collaboration and evidence-based solutions'

The month of April is acknowledged by many states and organizations as National Minority Health Month, providing a high-visibility campaign for many year-round activities. In Louisiana, during this annual 30-day period, community groups, faith-based organizations regional and local health departments and other public and private entities may join in the promotion of activities which may include health screenings, educational events, health fairs or assessments.

Issues addressed by these activities may include: cancer, heart disease, diabetes, adolescent pregnancy, HIV/AIDS, mental health, cultural awareness, urban, rural health needs and gender issues Minority and Multi-Cultural Health Month is designed to be a 30-day, high visibility, health promotion and disease prevention campaign. Conducted with and by community-based agencies and organizations, this celebration reaches into urban, suburban and rural areas of the state. Minority and Multi-cultural Health Month is designed to: promote healthy lifestyles; provide crucial information to allow individuals to practice disease prevention; showcase the resources for and providers of grass roots health care and information; highlight the resolution of the disparate health conditions between Louisiana's minority and non-minority populations; and to gain additional support for the on-going efforts to improve minority health year round.

Health Disparities

According to the Minority Health and Health Disparities Research and Education Act of 2000, health disparities are differences in "the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates. Disparities result not only in a lower overall quality of life among those impacted, but their families and communities as well.

Health Priority Areas

Infant Mortality
HIV/AIDS
Obesity
Diabetes
Heart Disease and Stroke

Operation Safe Re-entry- 2005 - '06

Immediately following the devastation of Hurricane Katrina, the hardest hit communities were those inhabited by racial and ethnic minorities who lived below the poverty level, had little to no access to medical care and lacked transportation, Internet access and in some cases televisions. Areas such as Slidell, Chalmette, Lacombe and Port Sulphur never received the same national attention as New Orleans, but they did suffer tremendous damage when the eye of Katrina swept through their communities. The Bureau of Minority Health Access (BMHA) received numerous calls from lesser-known communities requesting immediate assistance with housing, transportation, debris removal, affordable prescription medicine, food, water, clothing, hygiene products and navigating FEMA Web sites and applications. In order to properly and precisely meet the needs of victims devastated by Hurricane Katrina, the Bureau was given the following tasks:

1) Identify and establish partnerships with health care providers, medical facilities, faith-based organizations and community-based minority-serving organizations.
2) Develop a work plan of action in the approach and process for implementing project tasks.
3) Coordinate efforts with city and health officials to address environmental toxins and diseases in hurricane-affected areas.) Collaborate with identified partners, coordinate medical/mental health/social services and counseling services as identified for remaining hurricanes victims.

Once the tasks were identified, BMHA developed a plan of action called ***Operation Safe Re-entry***, which was designed to determine the health status of minority communities and facilitate preventive and post care through support for victims devastated by Hurricane Katrina in designated parishes such as Orleans, St. Bernard, Plaquemines and St. Tammany. Operation Safe Re-entry called for the mobilization of health care stakeholders, community-based organizations (CBOs), Historically Black Colleges and Universities (HBCUs), faith-based organizations and local city and parish governments to assist minority communities with immediate hurricane recovery efforts.

Operation Safe Re-entry was implemented in four phases:

Phase One: Health screenings with presentations from city, state and federal officials like FEMA, U.S. Public Health Service and distribution of supplies.

Phase Two: Organize street teams to conduct door-to-door community health assessments.

Phase Three: Reorganize street teams in newly discovered hurricane ravaged areas with an emphasis on pregnant women and infants.

Phase Four: Establish a 24-7 satellite recovery office for evacuees in Arkansas and Louisiana.

Phase Five: Phase Five of Operation Safe Re-entry consisted of informing hurricane-ravaged communities about health and environmental concerns post-Katrina. Community environmental workshops were conducted with city and health officials to address concerns plaguing low socioeconomic areas. The Bureau collaborated with medical/mental and health/social services to implement other projects to alleviate the suffering of hurricane victims. Partners for Healthy Babies and the BMHA organized Baby Health Fairs to address the growing number of infant deaths post-Katrina, which became an issue overlooked after the storm. Other projects included:

A partnership with Care Unlimited Obesity Prevention Clinic in New Orleans addressed children who are dealing with obesity problems largely due to the impact of trauma experienced during and after Katrina. The Bureau arranged for the removal of debris that had been left for months. Access to medical care improved with the help of state and city officials pouring in resources to expand services in primary care clinics within minority communities. Children who wandered the streets of New Orleans and trailer sites shortly after the storm had places of refuge provided by community minority-based partners and faith-based communities.

Remaining Safe Re-entry essentials such as the 24-7 phone bank and satellite offices remained in operation months after the storm because so many evacuees continued to have trouble with FEMA assistance and access to medical care in other states. Louisianans were being dropped from Medicaid and Medicare rolls and they needed their eligibility re-established in order to receive medical services. After suffering through the worst natural disaster this country has ever witnessed, there is still work to be done.

With the success of Operation Safe Re-entry, several organizations have now implemented similar projects in other parts of the state that suffered from both hurricanes Katrina and Rita. Health Screenings shortly after Katrina included:

Yellow Room: Eye screening provided by the Office of Public Health's Healthy People 2010 program.

Blue Room: Tetanus, Hepatitis A, and flu shots were provided by the DHH Office of Public Health Immunization Division.

Green Room: High blood pressure and diabetes screenings were provided by the U.S. Public Health Service.
Orange Room: Mental health screenings and counseling were provided by the DHH Office of Mental Health.

Red Room: DHH's Maternal Child Health Program provided information referrals for pregnant and new mothers.
In order to reach residents that could not attend the Thanksgiving Dinner and health fair, the Bureau and its partners organized a door-to-door outreach campaign (Phase Two to assist the remaining victims who suffered from the storm.

Barriers
One of the most significant barriers to overcome was that people in the community had trouble with transportation even though the church where the screenings took place was centrally located. Most victims were still trapped in their homes, some with no phone or Internet services, and most were just too afraid to come out. Also, it was difficult to tell who and how many residents had actually evacuated. In an effort to overcome these barriers and to make sure victims received hurricane recovery assistance, the Bureau and its partners decided it was time to go door-to-door or implement Phase Two of Operation Safe Re-entry. Phase Two Health Assessment not only addressed their immediate needs, but also allowed the health department to evaluate their health status and make necessary referrals to health care providers.

The collected information was shared with health care professionals and community leaders in these areas to address their concerns and design the best course of action. Many interventions such as referrals to Medicaid, toll-free helpline information for women and children, information on local parish health clinics, as well as giveaways and information on infant and toddler car seat safety were provided during the survey process. BMHA arranged for the St. Tammany Sheriff's Department. to escort street teams throughout neighborhoods to avoid heavy traffic and provide protection from looters and criminals still at large.

During the door-to-door phase, a problem arose that no one anticipated. Volunteers were spending too much time at each home listening to grief stricken residents that were overwhelmed that someone came to see about them. Each surveyor was instructed to spend no more than five minutes at each home, but each survey at times took much longer because residents wanted to talk out their stress and frustrations from the aftermath of the storm. The Bureau and other organizers underestimated the level of trauma and grief the people of the Slidell community were still suffering.

After experiencing the level of trauma that blanketed this community, BMHA and organizers met immediately after the campaign to discuss a Phase Three plan that would include mental health grief counselors and additional emergency medical personnel. In addition, mental health counselors had to be prepared to make proper referrals on the spot for those with more severe problems. The need for mental health services in the Slidell and New Orleans area was so great that the Bureau and its partners put together Phase Three with twice the number of volunteers, medical personnel and much-needed grief counselors assigned to us by a new organization called Louisiana Spirit. Phase Two received so much publicity that it brought about more community-based organizations from surrounding parishes and more donations came from new sponsors that were sympathetic to the campaign.

Phase Three kicked-off on March 25, 2006 with 325 homes surveyed in the Slidell, Lacombe and Alton communities. Supplies poured in from everywhere and each component of Phase Three was executed as planned. Results from the surveys concerning the most critical needs are as follows:

- Lost loved ones or family members
- No primary physicians who accepted Medicaid clients in the areas
- Mental health problems such as severe depression and stress
- Food
- Debris removal
- Beds and other furniture
- Clean water to bathe
- FEMA trailers

Key medical problems:
Lung cancer, lupus, arthritis, asthma, heart complications, migraines, stroke, allergies and breast cancer.

Lessons Learned

Special concessions must be made for the elderly, handicapped and those who are not computer literate. It was imperative to keep information flowing from Louisiana to other states in order to keep evacuees apprised of any changes in policies, implementation of new programs, employment and access to medical care related to hurricane recovery efforts.

Baby Health Fairs

DHH's Maternal and Child Health, the Office of Public Health's Partners for Healthy Babies and BMHA sponsored Baby Health Fairs to address high infant mortality rates in Orleans and St. Tammany parishes. The first Baby Health Fair was held Saturday, March 18, 2006 at Clearview Mall in Metairie. The time of the fair was 10 a.m. to 1 p.m. Clearview Mall did not charge for use of the facility. Participants could register online or the day of the fair. According to door prize entries, 315 women were pregnant, 64 women had a baby younger than one year-old, and 12 women were both pregnant and had a baby younger than one year-old.

Purpose: To give educational information to pregnant women about the benefits of prenatal care and the importance of good oral health, nutrition, breastfeeding and smoking cessation to have a healthy baby. The event also rewarded women currently receiving or who recently received adequate prenatal care with a drawing of 100 car seats and encouraged the correct use of the seats. Community partners includes: March of Dimes, SIDS Prevention, TUXCOE, Tobacco Free Living, Office of Family Planning, Jefferson Parish Health Unit, Shots for Tots, DHH Office of Mental Health, OPH Nurse-Family Partnership, LaCHIP/LaMOMS, Charity School of Nursing, Healthy Start and the Safe Kids Coalition. Babies-R-Us also had a table promoting upcoming educational events, primarily the car seat inspection clinic. Aveda Institute, Mary Kay and Beauti-Control promoted pampering for the participants and Clowns For All Occasions entertained children in attendance with balloon animals and face painting.

Other Activities

Summer Enrichment Camp for Evacuee Children

After Katrina, thousands of evacuees migrated to Baton Rouge and set up residence in trailer sites. Approximately 70 percent of the children who evacuated from New Orleans and St. Bernard parishes were not enrolled in school. The 2006 summer Enrichment and Recreational Camp, sponsored by the Bureau and Louisiana Center Against Poverty, provided education, fitness and sports skills, drug and alcohol prevention, physical health and juvenile delinquency mediation. The camp lasted for nine weeks, five days a week, ten hours a day. More importantly, the Camp helped maintain and reinforce educational instruction that was offered the previous school year, while instructing and preparing for the upcoming school year.

Approximately 140 low-income at-risk evacuee children from Hurricane Katrina-affected areas attended the camp, which improved academic skill levels, presented them with healthy lifestyle choices and allowed them to define their role in society.

Back-to-School Activities

Throughout the month of August 2006, the Bureau of Minority Health and Parkview/Trishell Apartments in Monroe, which houses low-income families, hosted Back-to-School activities for resident children and evacuee children from New Orleans. School supplies, health information and early start textbooks were distributed to give kids a jump start on the upcoming school year. Each child engaged in physical activities and educational sessions that included substance abuse programs, conflict resolution, career opportunities and life choices. Onsite staff, counselors and volunteers placed the kids in groups according to age and rotated them to stations. Each station had a different learning experience that lasted the entire afternoon. Metro-Narcotics Unit gave presentations on the importance of saying "no" to drug use or any involvement with drugs. More than 600 kids received textbooks, backpacks, pens, pencils, notebooks, crayons, along with food and drinks.

Plaquemines Parish Relief Efforts

Port Sulphur of Plaquemines Parish was completely wiped out by the storm. With a population of 3,115, there were no doctors or nurses in the entire parish. Citizens in Port Sulphur who remained lived in tents or trailers, including the mayor. The Bureau teamed up with Pfizer Pharmaceuticals and the Office of Public Health to sponsor a comprehensive health fair that administered shots and offered relief supplies, mental health counseling and blood pressure and diabetes screenings. More than 530 people attended and took advantage of the health and wellness information that was available to them.

Accomplishments

Major accomplishments were made since the inception of Operation Safe Re-entry with the restoration of a new primary health care clinic in a medically underserved area. Hurricane victims with low literacy levels and limited English proficiency are now able to get special assistance through the Chahta Tribe with regards to their FEMA applications, prescription medicine and transportation to and from the doctors. More than 450 people in Slidell benefited from the project and 1,350 evacuees from New Orleans took advantage of the 24/7 services from the Tribe's satellite office in Arkansas.

Pregnant and new mothers received valuable information on prenatal care and referrals to health care providers through the Baby Health Fairs. Approximately 2,550 participants benefited from both Baby Health Fairs and will receive follow-up care if needed.

More than 300 car seats were distributed free of charge, along with other useful baby products. Kids probably had the hardest time adjusting to the trauma of Katrina and had little hope of getting back to a normal childhood. With the Kids Adventure Race (sponsored by the Governor's Council on Physical Fitness and Sports); Care Unlimited Obesity Clinic and Back-to-School activities in Monroe; and Summer Enrichment Camp kids had a summer of fun and went to school equipped with needed supplies. Plaquemines Parish now had satellite clinics with doctors and nurses rotating on Tuesdays and Thursdays of each week while their public health unit was being restored.

PROJECT RELIEF, RECOVERY & RE-ENTRY
2005-2006

The Bureau of Minority Health Access, partnered with the Chahta Native American Tribe of the Old Florida Parishes in Slidell, established two satellite offices for Phase III: Project Relief, Recovery and Re-entry that was sponsored financially by the HHS Office of Minority Health in Washington, D.C. and the DHH/Bureau of Minority Health Access to provide 24/7 service of relief, recovery and re-entry for residents in Slidell/LaCombe, Orleans Parish and residents that evacuated to Arkansas. Elder tribesman directed day-to-day operations in Slidell and additional tribal aides managed the office in Arkansas to oversee evacuees currently living there. Data gathered from Phase II of Operation Safe Re-entry was used for follow-up and referrals to provide and improve access to health and social services for hurricane victims with the most critical needs.

The satellite offices developed mechanisms that support increased dissemination of information, prevention and service delivery to hurricane victims in Slidell/LaCombe and Arkansas. Tribal aides collaborated with local parish government, coordinated medical/mental health/social services, counseling services and other services as identified for hurricane victims through the Arkansas Office of the Governor and Arkansas Commission on Minority Health. This project also helped reduce the deleterious health effects attributable to the displacement of families through partnerships with faith-based and community-based minority-serving organizations. As a result of high rates of depression, stress and suicides on the rise, the Chahta, in partnership with DHH Office of Mental Health and Louisiana Spirit, developed culturally competent services to provide outreach and supportive counseling needed throughout these communities. Door-to-door surveys from Phase II of Operation Safe Re-entry identifies the need for such services in conjunction with specially designed outreach and counseling services to identify those significantly impacted by the hurricane. In addition, BMHA and the Tribe worked with

DHH to assist with intervention and referral for any children and their families for more intensive services.

The Tribe provided housing assistance, helped seniors with prescription medicines, transportation, assist with FEMA applications, utilities, food, Spiritual Guidance if requested, assist with job placement, and helped evacuees develop individual recovery plans for re-entry back to Louisiana. A database was developed with updated information flowing to residents of Slidell/Lacombe and evacuees in Arkansas regarding changes with FEMA. Case Management includes entire families, disabled residents and children to make sure that all needs are met.

Operating Funds:

Funding for this project went toward the overall operation of both satellite offices. The Tribe organized another door-to-door campaign for those hurricane victims with critical needs from Phase II of Operation Safe Re-entry. Equipment and supplies were needed for the surveyors as they canvassed the community. Supplies for the day-to-day operations of both offices were needed for printing, software for the computer database to track evacuees and scheduling doctor's visits for the elderly and disabled.

Outcome:

To implement Phase III of Operation Safe Re-entry based on door-to-door surveys to help meet the immediate needs of hurricane victims in Slidell, LaCombe and evacuees in Arkansas.

Performance Indicators:

Housing - assisted residents with housing, especially residents with low literacy levels that have difficulty interpreting homeowner insurance documents, locating rental apartments and negotiating with FEMA.

Health Care – worked with DHH, local parish government to secure primary care physicians, assist elderly with prescription medicine.

Transportation – made sure those residents who are without reliable transportation get to their scheduled medical appointments by way of tribal members' carpooling.

FEMA – kept all lines of communication open regarding FEMA matters for residents with low literacy levels; provide mobile office that allows evacuees to obtain their FEMA numbers. Gather documents on residents and evacuees for services received.

Utilities – secured vouchers for utility assistance to evacuees and residents.

Mental health – specially designed outreach and counseling services was developed to identify those significantly impacted by the hurricane and offer residents intervention and referral for any children and their families for more intensive services.

Spiritual Guidance – partnered with faith-based organizations to help assist with neighborhood residents from all faiths.

Agency Networks – Watershed Development, Moody Chapel AME Church, Pulaski County, Arkansas, Caffee, Caffee, & Associates, La. Bureau of Minority Health Access, DHH/Office of Mental Health, Louisiana Spirit, Katrina Relief Network (New York), Arkansas State Agencies, Mayor of Sherwood/Police Department.
Individual Recovery Plan – coordinated and implemented a plan for returning home to Louisiana.
Job Placement – Network with local agencies to find employment for local residents and evacuees.

Monitoring of the Project:
Housing- continued to make sure that rent from FEMA for evacuees was paid on a monthly basis; made sure residents from low-socioeconomic backgrounds were getting a fair shake with rental apartments, building contractors.
Health Care– improved access to care by working with local primary care physicians to form a relationship to better serve clients; follow-up with DHH/Medicaid and Medicare and LaChip to monitor benefits.
Transportation – made sure carpools leave for doctor's appointments, FEMA Office and other appointments for the elderly.
FEMA – continued constant communication with FEMA on a weekly to monthly basis to ensure that housing needs are met.
Utilities – monitored utility bills for evacuees and for residents that have trouble making payments.
Mental Health– scheduled routine visits with citizens who in critical and help them understand their current situation and reactions, review their options, address their emotional support and link them with other individuals and agencies that may assist them. During individual services, crisis counseling is active listeners who provide emotional support.
Spiritual guidance – religious classes will be held in conjunction with the faith-based community in a group setting.
Agency Networks –continued to network with CBOs and other agencies as listed above to keep resources flowing into communities affected by the storm.
Individual Recovery Plan –continued one-on-one sessions with head-of-households' evacuees in Arkansas with a plan for returning home.
Job Placement – make sure those being assisted with job placement kept appointments and interviews; follow-up with job training organizations to secure training for unemployed residents.

Future Guidelines

Current state data provide a limited picture of the health status of various populations in Louisiana Health data (e.g., births, deaths, risk factor prevalence) collected on smaller population subgroups, specifically American Indians or Alaska Natives, Asians, and Native Hawaiians or Other Pacific Islanders are often limited due to low numbers of reported occurrences. More information about the health and health-related experiences of these groups is needed.

Compared with other population subgroups, there is relatively more health information available for Hispanics or Latinos in Louisiana. However, because the Louisiana Hispanic or Latino population is rapidly increasing in both size and diversity, more detailed information, particularly on issues related to access to quality health care and language barriers, is needed.

Mortality data show that compared with other racial and ethnic subgroups in Louisiana, Blacks or African Americans suffer disproportionately from the major chronic diseases (heart disease, stroke, diabetes) and other causes of death such as HIV/AIDS and homicide. Detailed information is lacking, however, on subgroups within the Black or African American population, as well as the influences of poverty, low-income neighborhood environments, and discrimination on health outcomes.

The amount of available health and social data are generally good for the White, non-Hispanic population in Louisiana relative to other subgroups; however, White residents are socioeconomically and ethnically diverse, and detailed information is lacking on the role of socioeconomic status, geographic area of residence, and living environments on health, as well as access to appropriate health care in this population.

Creation of a more detailed picture of the health status of Louisiana population subgroups is achievable through increased collaboration between local communities and public and private agencies who are committed to providing more in-depth descriptions (and understanding) of the health needs and health status of the residents of our state. Such an effort would entail use of both qualitative (ethnography, participant observation, focus groups) and quantitative (survey) methods as well increased use of GIS (Geographic Information Systems) technology so that accurate and vivid depictions of the health status and needs of smaller, diverse subgroups are captured

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CONCLUSION

This report has presented the contexts and descriptions of health disparities experienced by various populations in Louisiana. First, social context was provided by presenting the definition of "health disparities," and outlining selected socio-demographic characteristics of Louisiana residents. Social factors implicated in health disparities, such as socioeconomic position, behaviors, social support, stress, discrimination, and environmental exposures, were also discussed. Health outcomes for populations based on characteristics such as race, ethnicity, gender, educational attainment and income level were presented, as was the dearth of consistently-collected data on various vulnerable populations (i.e., older or younger persons, those living in rural areas, sexual and gender minorities, persons with disabilities, immigrants and refugees, limited English proficiency populations, and homeless persons).

Second, using available data from the state of Louisiana and the U.S. Census, this report has documented and described some disparities in the health status of Louisiana racial and ethnic minority groups relative to the White population. A few disparities by household income and education were also documented. The patterns of disparities documented here are generally consistent with previous analyses for Louisiana and with those observed nationally. With adequate resources and attention, a number of documented gaps in health status can be narrowed. Improvements in the quality of data collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities. Improvements in data quality involve several tasks including: consistent collection of race and ethnicity according to current federal standards; improved collection of other socio-demographic information, such as educational attainment, employment status, and preferred language, which are known to influence health outcomes; and enhanced use of geographic information system (GIS) management and routine performance of spatial analysis using residential address information, so that health outcomes can be reported for smaller geographic areas of the state.

A more detailed and clearer picture of the health status of Louisiana population subgroups is achievable through increased collaboration between local communities and public and private agencies who are committed to providing more in-depth descriptions (and understanding) of the health needs and health status of the residents of our state. Such an effort would entail use of both qualitative (ethnography, participant observation, focus groups) and quantitative (survey) methods as well as increased use of geographic information systems (GIS) technology so that accurate and vivid depictions of the health status and needs of small neighborhoods are captured.

In 2010, the U.S. decennial census will provide an updated picture of the Louisiana population, and the *Healthy People 2020* health objectives for the nation will be released. These enterprises, together with this report, will provide Louisiana with important new information. This knowledge will be invaluable to public health practitioners, state and local leaders, academic researchers, and others engaged in identifying health priorities and objectives for the next decade that can help assure the conditions in which all people can be healthy.

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Hurricane Katrina themed sessions at the APA Convention include:
Session 1100 - Paper Session: **Applications in Hypnosis—Children of the Katrina**

Disaster and DID, Presentation: *Therapy With Victims of Hurricane Katrina: Relaxation Therapy and Imagery*, 10:00 - 10:50 AM, Thursday, August 10, Morial Convention Center, Second Level, Meeting Room 272

Session 1128 - Symposium: **Hurricane Katrina—Effects on Drug Abuse, Risk Behaviors, and Coping,** Presentations**:** *Impact of Katrina on Drug Markets and Distribution Networks; Substance Use and Health Consequences Among Katrina Evacuees in Houston; Family-Based Drug Services for Young Disaster Victims*; and *Drug Use Among High-Risk Youth in New Orleans After Katrina;* 10:00 - 11:50 AM, Thursday, August 10, Morial Convention Center, Second Level, Meeting Room 243

Session 1164 - Symposium: **Promoting Resiliency in Children and Families in the Wake of Hurricane Katrina**, 11:00 AM - 12:50 PM, Thursday, August 10, Morial Convention Center, Third Level, Meeting Room 335

Session 1179 - Symposium: **Potentials of Psychologists and Their Networks in Katrina-Like Crises,** Presentations: *Having Futures: Putting Them on Hold;* and *Hurricane Katrina and Homelessness: What Can We Do to Help?;* 12:00 - 12:50 PM, Thursday, August 10, Morial Convention Center, Third Level, Meeting Room 349

Session 1237 - Symposium: **Tough Lessons From Katrina and Rita—Toward Better Disaster Preparedness,** Presentations: *Walk Toward Trauma: You'll Find Ways to Help; Response to Katrina: Lessons Learned From San Antonio and Houston; My Date With Katrina: Encouraging Social Responsibility in Counseling Psychology;* and *Strategic Responses to Disasters: Lessons From Katrina and Rita*; 1:00 - 2:50 PM, Thursday, August 10, Morial Convention Center, Third Level, Meeting Room 338

Session 1299 - Symposium: **Trauma and Resilience in Survivors of Hurricanes Katrina and Ivan**, Presentations: *Trauma, Coping, and Acute Stress Disorder in Hurricane Katrina's Evacuees; College Student Evacuees of Hurricane Katrina: Needs, Coping, and Intervention*

Strategies; and *Hurricane Coping Self-Efficacy and Written Disclosure Interventions Following Hurricane Ivan;* 3:00 - 3:50 PM, Thursday, August 10, Morial Convention Center, Second Level, Meeting Room 266

Session 2049 - Symposium: **Psychologists Respond to Katrina and Rita With Highest-Caliber Psychotherapy Strategies and Newly Earned Prescriptive Authority**, Presentations: *Risks and Rewards of Providing Comprehensive Services to Katrina Survivors; Prescribing Authority Is Essential in Mental Health Disaster Relief; Mental Health Organizational Response to Katrina; Louisiana Office of Mental Health: Operating in the Wake of Disaster*; and *Child and Caregiver Needs Following Katrina's Impact on Mississippi's Gulf Coast;* 8:00 - 9:50 AM, Friday, August 11, Morial Convention Center, Second Level, Meeting Rooms 235 and 236

Session 2070 - Discussion: **Aftermath of Hurricane Katrina Through the Eyes of Displaced and Affected Predoctoral Interns—Reflections of Maslow's Hierarchy of Needs**, 9:00 - 9:50 AM, Friday, August 11, Morial Convention Center, Third Level, Meeting Room 353

Session 2078 - Paper Session: **African American Church—Promoting Post-Katrina Resilience,** 9:00 - 9:50 AM, Friday, August 11, Morial Convention Center, Second Level, Meeting Room 261

Session 2169 - Symposium: **Plenary—Moving Forward After Katrina: Addressing Social Justice and Mental Health Needs**, Presentations: *Public Health Response to Katrina: Applying Lessons Learned-Mental Health; Blacks and Katrina: The Mental Health Aftermath;* Doctoral *Student Affected by Katrina: Thinking Back but Moving Forward;* and *Breaking Through Barriers: Delivering What Our People Need;* 12:00 - 1:50 PM, Friday, August 11, Morial Convention Center, Second Level, Meeting Room 243

Session 2251 - Symposium: **Mission to the Gulf—Meeting the Crisis of Hurricanes Katrina and Rita**, Presentations: *Responding to Mental Health and Substance Abuse Needs Post-Katrina: A Perspective From SAMHSA; Responding to Katrina: Intervening With the New Orleans First Responder Community*; *Responding to Katrina and Rita: Meeting the Mental Health Needs of Evacuees in Central Louisiana;* and *Central Louisiana Mental Health System Adapts to Hurricanes Katrina and Rita;* 2:00 - 3:50 PM, Friday, August 11, Morial Convention Center, Second Level, Meeting Room 245

Session 2373 - Workshop: **Group Intervention in the Aftermath of Hurricanes Katrina and Rita**, 5:00 – 5:50 PM, Friday, August 11, Morial Convention Center, Third Level, Meeting Room 339

Session 3012 - Symposium: **Collaboration in the Wake of Katrina,** Presentations**:** *Displaced Psychologists;* and *Mental Health Authority in Need of Assistance;* 8:00 - 8:50 AM, Saturday, August 12, Morial Convention Center, Second Level, Meeting Room 257

Session 3024 - Symposium: **Children of Hurricane Katrina and We Who Treat Them**, Presentations: *Stress and Coping in Adolescents Impacted by Hurricane Katrina; Assessment of Symptoms of Posttraumatic Stress Following Hurricane Katrina;* and *Old Dog, New Tricks: Post-Katrina Child and Family Psychotherapy and Parenting;* 8:00 - 9:50 AM, Saturday, August 12, Morial Convention Center, Second Level, Meeting Room 252

Session 3070 - Symposium: **State Psychological Association's Response to Hurricane Katrina**, Presentations: *Psychological Issues of Hurricane Katrina Victims in Kentucky;* Kentucky *Psychological Association's Response to Hurricane Katrina;* and *KPA Hurricane Katrina Project;* 9:00 - 9:50 AM, Saturday, August 12, Morial Convention Center, Second Level, Meeting Room 257

Session 3265 - Symposium: **Psychological Services to First Responders—Post-Katrina Guidelines**, Presentations: *Perspectives on Post-Katrina Disaster Response From a New Orleans Native; First Responders of Saint Bernard Parish;* and *Cultural Competency in the Aftermath of Katrina;* 1:00 - 1:50 PM, Saturday, August 12, Morial Convention Center, Second Level, Meeting Room 252

Session 4054 - Symposium: **Recreating Home After Disaster—Challenges for Katrina's Kids**, Presentations: *Baton Rouge Blues: Improvised Care for Katrina's Kids; Breaking Rules: How I Learned Disaster Response From Katrina's Kids; Cultural Sensitivity Issues: The Retraumatizing of Hurricane Survivors; Katrina Volunteer Leadership: Why Race and Community Mattered; After Katrina: Scarce Housing for Vulnerable Populations;* and *Banda Aceh to Baton Rouge: The International Rescue Committee;* 9:00 - 9:50 AM, Saturday, August 12, Morial Convention Center, Second Level, Meeting Room 252

This information was provided by J. Michael Gonzalez-Campoy, MD, PhD, FACE, MAC Governing Council member. Dr. Gonzalez-Campoy specializes in endocrinology and is the medical director and CEO for the Minnesota Center for Obesity, Metabolism and Endocrinology. The Minesota Medical Association has additional information on this issue. (This link takes you off of the AMA Web site. The AMA is not responsible for content on non-AMA Web sites).

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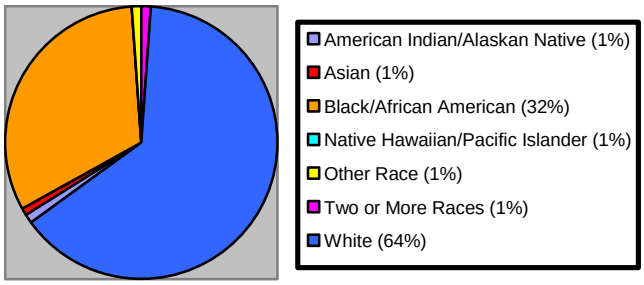
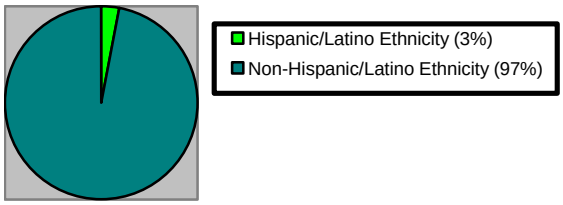
State Health Equity Report
LOUISIANA

Total State Population: 4,287,768

Racial Distribution



Hispanic/Latino Ethnic Distribution



Note: People can self-identify as members of any racial group in the Census, as well as report having Hispanic/Latino ethnicity.
Source: 2006 American Community Survey, US Census Bureau.

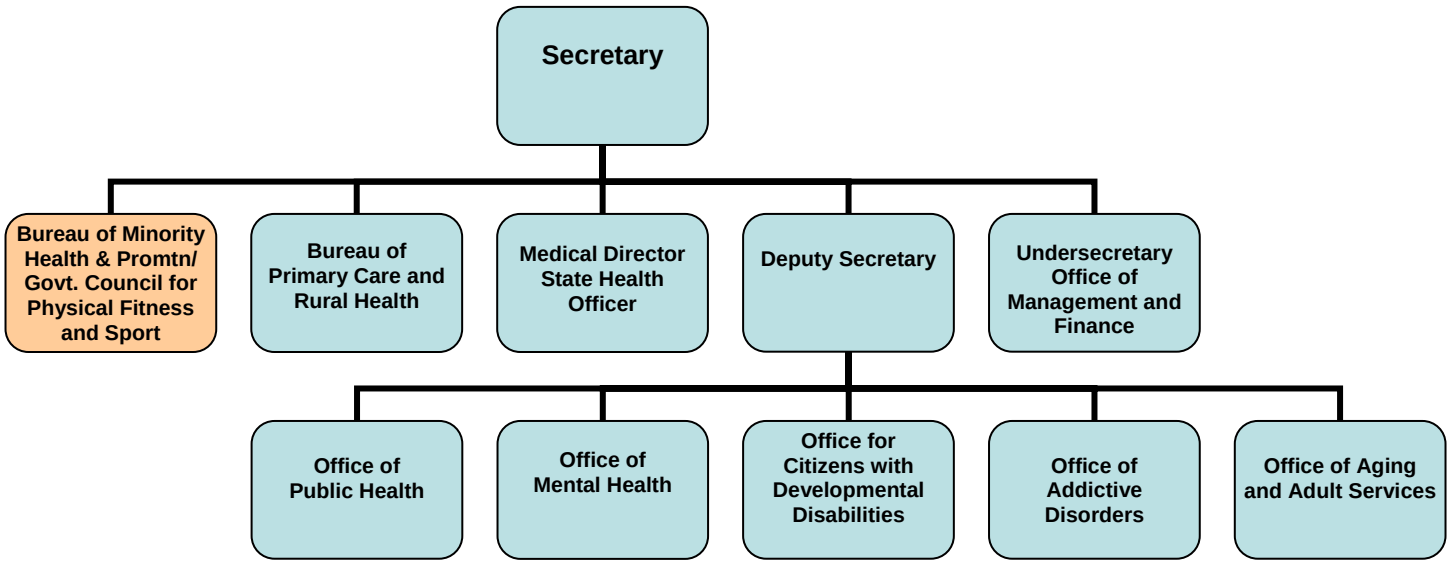
STATE HEALTH PRIORITIES

The Louisiana Department of Health and Hospitals (LDHH) has identified health priorities for the people of Louisiana, and additional priorities for racial/ethnic minority populations residing in the state.

Health Priorities for the General Population	Health Priorities Specifically for Racial/Ethnic Minority Populations
Cancer	Cancer
Cardiovascular Disease	Cardiovascular Disease
Obesity	Diabetes
Mental Health	HIV/AIDS
	Infant Mortality

ORGANIZATION, INFRASTRUCTURE AND RESOURCES

The following is a simplified organizational chart that demonstrates the location of the state's racial/ethnic minority health focal point in relation to the State/Territorial Health Official and/or other key public health leadership:



	Funding for MH/HD Activities	Personnel Dedicated to MH/HD	MH/HD Unit	MH/HD Advisory Body	State MH/HD Legislation or Mandate	MH/HD Strategic Plan	Evaluation of MH/HD Activities
Louisiana	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Total of 46 States/Territories responding YES	**30**	**38**	**36**	**36**	**27**	**36**	**TBD**

- The Louisiana Minority Health and Health Disparities Coalitions mandated that the Louisiana Department of Health and Hospitals (LDHH) establish a Bureau of Minority Health Access in 1996.
- The LDHH consults with an internal Minority Health Coalition that supports and guides leadership on racial/ethnic minority health and health disparities (MH/HD) issues in the state.
- MH/HD activities are conducted and coordinated across many LDHH program offices.
- LDHH maintains partnerships with an array of entities active in MH/HD, including: local health departments, tribal government, health departments in other states, federal government, health disparities advisory bodies, community-based, non-profit and faith-based organizations, schools, universities and the media.

STRATEGIC PLANNING

As part of its mission to protect and promote health, and ensure access to medical, preventive, and rehabilitative services for all citizens of Louisiana, the LDHH maintains a strategic plan designed specifically to eliminate racial and ethnic health disparities Bureau of Minority Health Access and Promotions.

Goal I: **Facilitate collection, analysis, dissemination and access of information concerning minority health issues, to reduce disparities in health status for underserved populations.**

Tracking Methods: Track the number of hits at the Bureau of Minority Health website, monitor state and federal legislation specific to minority health issues.

Goal II: **Use multicultural and culturally competent approaches to enhance ways in which health services are designed and delivered.**

Tracking Methods: Progress is tracked through the number of LDHH documents translated into languages other than English that reflect populations served, number of LDHH staff involved in community outreach projects in diverse communities, and the number of staff who complete cultural competency training.

Goal III: **Increase public awareness of minority health issues.**

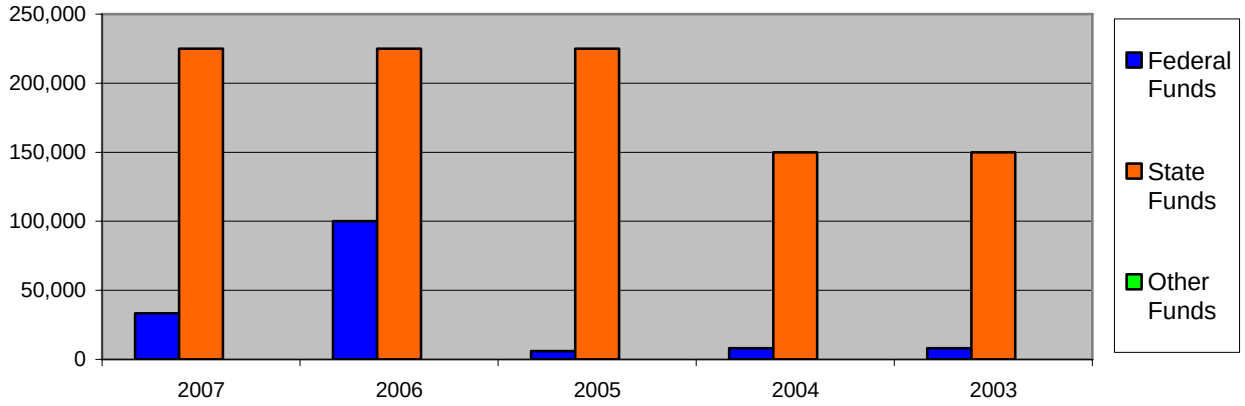
Tracking Methods: Track the number of health disparities awareness activities at community and faith based organizations and events, the number of newsletters distributed regarding minority health, results of community needs assessments and surveys, and the number of organized public hearings held regarding health disparities.

Goal IV: **Recruitment of minority health professionals.**

Tracking Methods: Track the number of minority recruitment partnerships and strategies established with academic institutions, local and state government, health and human service agencies.

FINANCIAL INVESTMENTS

LDHH investments in racial/ethnic minority health and health disparities (MH/HD) activities from 2003 to 2007:



HUMAN CAPITAL INVESTMENTS

The following staff dedicates all or part of their work hours to MH/HD issues and activities at the LDHH:

Job Category	Total Number Dedicated to MH/HD	% of Work Hours Spent on MH/HD Activities
Administrator or Director	**1**	**75%**
Bureau of Primary Care and Chronic Disease	6	50%
Louisiana Tobacco Control Program	6	50%

ACTIVITIES

Minority and Multicultural Health Month

The month of April is dedicated to high-visibility health promotion and disease prevention campaigns for the state's racial/ethnic minority populations. Its activities are conducted in cooperation with community based organizations that are located in and/or serve racial/ethnic minority communities. Campaigns target medically underserved areas of the State and addresses health issues related to infant mortality, diabetes, HIV/AIDS, high blood pressure, cardiovascular disease, and other health issues that disproportionately affect racial/ethnic minorities in Louisiana.

Partners and Funding

LDHH Office of Public Health and Maternal and Child Health program, State Medicaid Agency, LACHIP and the Louisiana Tobacco Control Program.

Activity Outcomes

Promoted health agencies located in medically underserved areas, and encouraged communities to use those local health services as their principal sources of primary health care. This has reduced the number of hospital emergency room visits made for primary care services across the state.

Evaluation Methods

Daily reports from every participating organization on the status of each health campaign activity, sign-in sheets that track the number of participants at each event, and monitoring the number of referrals for treatment following health screenings.

Operation Safe Re-Entry Hurricane Recovery Initiative

Operation Safe Re-Entry was designed to determine the health status of minority communities and facilitate preventive and post-care through support for victims devastated by hurricanes Katrina and Rita in Orleans, St. Bernard, St. Tammany, Calcasieu and Cameron parishes. The Louisiana Dept. of Health and Hospitals' Bureau of Minority Health Access (BMHA) led the charge by mobilizing health care stakeholders, community-based organizations (CBOs), Historically Black Colleges and Universities (HBCUs), faith-based organizations and local city and parish governments to assist minority communities with establishing mechanisms to improve access to health care, assist with hurricane relief efforts and community clean up. Phase two of the project consisted of a complete Community Health Assessment made of ***Street Teams*** which included health care advocates, community volunteers, local dignitaries and college students going door-to-door appealing for information on the following concerns: **General Health, Transportation, Prenatal Care, Prescription Medicines, Mental Health, Housing/Shelter, Supplies, Medicaid and Clothing.**

Partners and Funding

FEMA Department of Health and Hospitals, Office of Minority Health/US Department of Health and Human Services (OMH/DHHS) ($100,000), Louisiana Medicaid Agency ($150,000), LDHH Maternal and Child Health Program, LACHIP, North Carolina Office of Minority Health, Louisiana Primary Care Association, Chahta Tribe, St. Tammany Sherriff's Department, St. Tammany Ministerial Alliance; Pfizer Pharmaceuticals and ExCelth Health System.

Activity Outcomes

Minority residents who suffered disproportionately from the effects of the hurricanes have improved access to health and social services, particularly mental health care.

Evaluation Methods

Door-to-door surveys are conducted to assess the Initiative's impacts on health care access and health outcomes, and to identify unmet health and related needs of underserved populations. Survey results are used to revise Initiative priorities and methods, and address unmet needs.

Post-Hurricane Katrina Program

The Bureau of Minority Health Access partnered with the Chahta Native American tribe to develop mechanisms that supported the increase and dissemination of information, prevention and service delivery to hurricane victims in Slidell/LaCombe and Arkansas. Elder tribal members collaborated with local parish government, coordinated medical/mental health/social services, counseling services and other services as identified for hurricane victims. This project also served to reduce the deleterious health effects attributable to the displacement of families through partnerships with faith-based and community-based minority-serving organizations. Develop mechanisms that supported increased dissemination of information, prevention and service delivery to hurricane victims in Slidell/LaCombe and Arkansas.

Partners and Funding

OMH/DHHS), LDHH Maternal and Child Health Program, Healthy Start Program, Office of Family Planning and Nurse-Family Partnership, LACHIP, LAMOMS, Jefferson Parish Health Unit, March of Dimes, Safe Kids Coalition, Shots for Tots, Tobacco Free Living, Hispanic Apostolate and the Charity School of Nursing.

Activity Outcomes

Approximately 2,550 pregnant women and mothers of newborns received valuable information on prenatal, post-partum and well-baby care, as well as referrals to health care providers at two Baby Health Fairs. More than 300 car seats were also distributed to mothers free of charge, among other baby products.

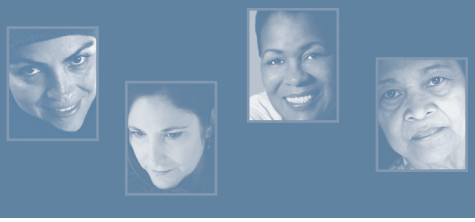
Evaluation Methods.

Assessment forms were distributed to all Operation Safe Re-entry and Health Fair participants.

Louisiana's primary contact for racial/ethnic minority health and health disparities is:

Rudy Macklin
Executive Director
Bureau of Minority Health Access and Promotion
Louisiana Department of Health and Hospitals
http://www.dhh.louisiana.gov/lamha
Phone: (225) 342-4886

PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP:
Examining Racial and Ethnic Disparities at the State Level

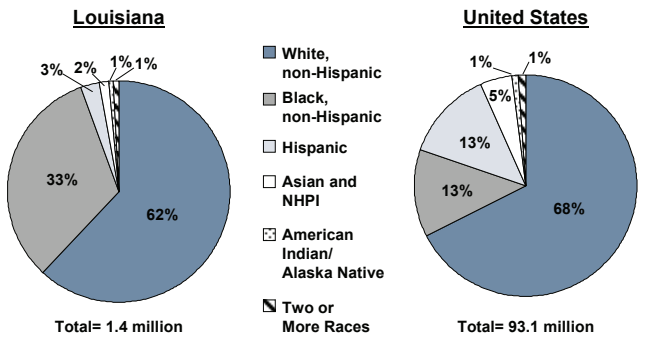


LOUISIANA

This fact sheet presents selected data and findings from the report *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level*. For more information or explanation of methodology, please refer to the full report, available at www.kff.org/womensdisparities/.[1]

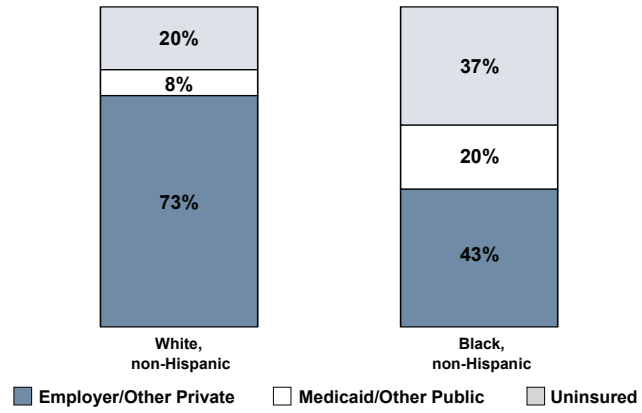
For more state-level data and comparisons, see www.statehealthfacts.org/womensdisparities.jsp.

Distribution of Women Ages 18-64 by Race/Ethnicity, 2003-2005



Note: Data may not total 100% due to rounding.
Source: Kaiser Family Foundation analysis of March 2004-2006 Current Population Surveys, U.S. Census Bureau.

Health Insurance Coverage for Women Ages 18-64 by Race/Ethnicity, 2003-2005
Louisiana



Note: Data may not total 100% due to rounding. Data are not presented for all racial/ethnic groups due to limitations in sample size.
Source: Kaiser Family Foundation analysis of March 2004-2006 Current Population Surveys, U.S. Census Bureau.

HEALTH STATUS									
		Louisiana Rates							
LA Dimension Score[2]: Worse than Average	U.S. All Women	All Women	White, non-Hispanic	All Minority[3]	Black, non-Hispanic	Hispanic	Asian and NHPI	American Indian/ Alaska Native	LA DISPARITY SCORE[4]
Fair or poor health status (%)	12.8	14.3	11.2	19.9	20.1	17.7	-	-	**1.78**
Mean number of days physical or mental health was "not good" (in past 30 days)	7.3	6.8	6.8	7.0	7.1	6.7	-	-	**1.03**
Mean number of limited activity days (in past 30 days)	3.5	4.0	3.8	4.4	4.5	5.1	-	-	**1.17**
Diabetes (%)	4.2	5.3	4.0	7.6	7.8	8.1	-	-	**1.90**
Cardiovascular disease (includes heart attack, angina, heart disease or stroke) (%)	3.2	4.5	3.5	6.4	6.6	6.1	-	-	**1.85**
Obesity (Body Mass Index ≥ 30) (%)	22.7	25.8	19.8	36.9	38.8	26.6	-	-	**1.87**
Current smoking (%)	21.9	24.1	28.4	16.2	15.5	18.1	-	-	**0.57**
Cancer mortality rate for women of all ages (per 100,000 women)	162.2	179.5	170.0	N/A	207.2	80.5	108.1	68.0	**1.14**
New AIDS cases for women ages 13+ (AIDS case rate per 100,000 women)	9.4	16.5	3.3	39.2	43.5	14.3	0.0	0.0	**12.05**
Live births that are low birthweight (%)	8.1	11.0	8.1	16.0	15.3	7.6	8.5	10.1	**1.97**
Serious psychological distress[5] (%)	15.7	18.6	21.6	13.7	14.3	-	-	-	**0.63**

THE HENRY J. KAISER FAMILY FOUNDATION

THE HENRY J. KAISER FAMILY FOUNDATION
Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274 **www.kff.org**

ACCESS & UTILIZATION									
		Louisiana Rates							
LA Dimension Score[2]: Worse than Average	U.S. All Women	All Women	White, non-Hispanic	All Minority[3]	Black, non-Hispanic	Hispanic	Asian and NHPI	American Indian/ Alaska Native	LA DISPARITY SCORE[4]
No health insurance (%)	17.7	25.9	19.7	36.3	36.9	-	-	-	**1.84**
No personal doctor/health care provider (%)	17.5	19.4	15.5	25.8	26.4	20.7	-	-	**1.66**
No routine checkup in the past two years (%)	15.9	11.8	14.2	7.7	7.3	12.7	-	-	**0.55**
No dental checkup in the past two years (%)	28.7	32.1	29.0	38.0	38.8	30.0	-	-	**1.31**
No doctor visit in the past year due to cost (%)	17.5	23.0	18.5	30.6	31.1	28.0	-	-	**1.66**
No mammogram in the past two years for women ages 40-64 (%)	25.5	25.4	25.7	24.8	24.4	28.8	-	-	**0.97**
No Pap test in the past three years (%)	13.2	13.6	12.7	14.1	12.9	21.4	-	-	**1.12**
Late initiation of or no prenatal care (%)	16.2	15.5	9.2	22.9	24.1	16.3	11.7	15.6	**2.48**

SOCIAL DETERMINANTS									
		Louisiana Rates							
LA Dimension Score[2]: Worse than Average	U.S. All Women	All Women	White, non-Hispanic	All Minority[3]	Black, non-Hispanic	Hispanic	Asian and NHPI	American Indian/ Alaska Native	LA DISPARITY SCORE[4]
Women living in poverty (%)	16.4	23.7	16.5	36.0	37.4	-	-	-	**2.18**
Median household income ($)	45,000	33,000	44,420	20,000	18,000	-	-	-	**2.22**
Gender wage gap (compared to White men working full-time, year round) (%)	69.2	63.0	70.2	51.4	51.4	-	-	-	**1.37**
Women without a high school diploma (%)	12.4	15.1	9.7	24.3	24.8	-	-	-	**2.50**
Women in female-headed households with children (%)	22.1	25.7	15.6	40.2	42.8	-	-	-	**2.57**

HEALTH CARE PAYMENTS AND WORKFORCE		
	U.S.	LA
Physician diversity ratio[6]	N/A	3.69
Women living in a primary care health professional shortage area (%)	43	51
Women living in a mental health professional shortage area (%)	42	18
Medicaid-to-Medicare fee index for all services[7] (1.00 = no difference)	0.69	0.73
Medicaid-to-Medicare fee index for primary care services[7] (1.00 = no difference)	0.62	0.70
Medicaid-to-Medicare fee index for obstetric care services[7] (1.00 = no difference)	0.84	0.89
Medicaid income eligibility for working parents (as a percent of the Federal Poverty Level[8])	63	20
Medicaid/SCHIP income eligibility for pregnant women (as a percent of the Federal Poverty Level[8])	133	200
State-directed family planning funding per woman in need ($)	149	95
Mandatory waiting period for abortion	N/A	Yes
Use of state-only funds to cover "medically necessary" abortions for Medicaid recipients	N/A	No
Women living in counties with no abortion provider (%)	N/A	62

Notes:

NHPI= Native Hawaiian and Pacific Islander
(-) Sample size insufficient for analysis
(N/A) Not applicable

1. Data for this analysis were primarily drawn from the Behavioral Risk Factor Surveillance Survey and the Current Population Survey and are reported for the years 2003-2005. Unless specified, data are from women ages 18-64. Specific information on each indicator is available in the full report.
2. States were categorized as better than average, average, or worse than average by comparing their dimension score to the national average. This categorization is calculated by averaging the disparity scores for all indicators in the dimension.
3. All Minority women includes non-Hispanic Black, Hispanic, Asian and NHPI, American Indian/Alaska Native women, and women of two or more races.
4. The disparity score is the factor by which minority women in a state would need to change in order to achieve parity with the average non-Hispanic White woman in the state. A disparity score of 1.00 indicates no disparity between minority and White women; a score greater than 1.00 indicates that minority women experience health problems, barriers or socioeconomic disadvantages at rates higher than White women; and a score less than 1.00 indicates that more White women than minority women experience health problems, barriers or socioeconomic disadvantages.
5. Data based on the K6 scale of non-specific psychological distress. Information about the K6 scale is available at http://www.hcp.med.harvard.edu/ncs/k6_scales.php.
6. Factor by which the physician workforce would need to be changed so that the ratio of minority physicians to the minority population would match the ratio of White physicians to the White population in the state. For example, a physician diversity ratio equal to 5.00 indicates that the minority physician workforce would need to increase 5-fold to match the state's ratio of White physicians to the White population.
7. The Medicaid-to-Medicare fee index measures each state's Medicaid fee-for-service physician fees relative to Medicare fees in each state. An index of 0.69 indicates that Medicaid fees averaged 69% of Medicare fees in the state.
8. The Federal Poverty Level for a family of four in 2005 was $19,350.