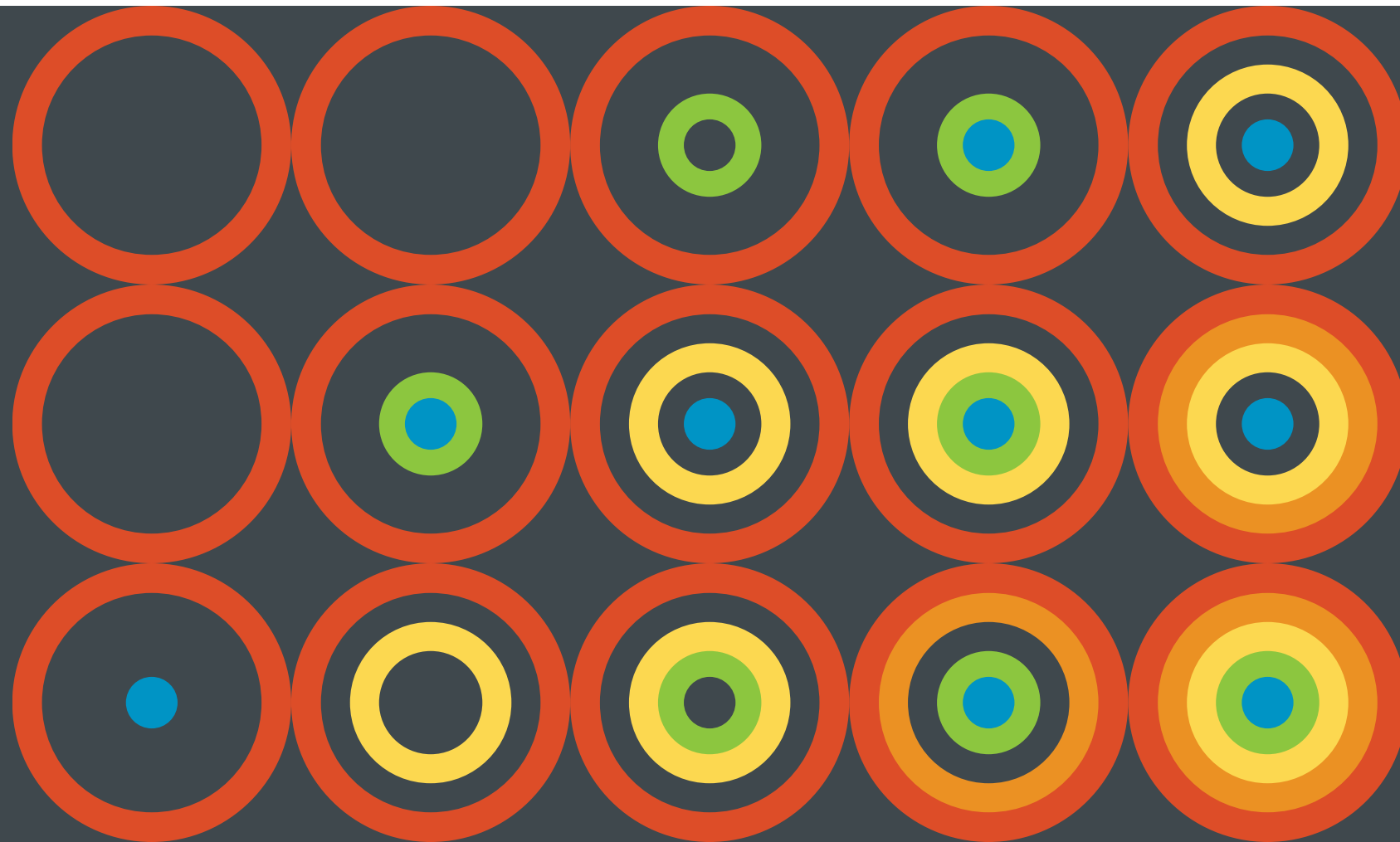


Partnering Toward a Healthier Future

2007 PROGRESS REPORT

Eliminating Health Disparities in Frederick, Montgomery and Prince George's Counties in Maryland



Center on Health Disparities



Compilation, analytics, and graphic design
by Avalere Health LLC

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Dear Community Partners,

The diversity that makes our region so unique brings both great opportunity as well as challenges. It is our mission at Adventist HealthCare to *demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing*. In order to achieve this goal we need to understand the wealth of diversity that exists in our communities, how care is "demonstrated," the different health beliefs and health-seeking behaviors practiced, and how trust is built.

Adventist HealthCare's Center on Health Disparities was created from a deep desire to provide quality care to everyone by bridging the healthcare access gap that some of our communities are experiencing. Whether the gap comes from lack of access to care, limited adoption of healthy behaviors, lack of access to maternal and infant health care, limited English proficiency, complexity of patient-provider relationships, or the prevalence of disease such as diabetes, heart disease, HIV/AIDS, and cancer, we strive to develop programs and services that will aid in the elimination of health disparities in our communities.

The Center on Health Disparities will focus on innovative, practical strategies that will assist in reducing and eliminating health disparities among the most vulnerable populations within our communities. These approaches include:

1. Community outreach through health and wellness messages that will resonate with target populations that are most affected by disease and illness.
2. Provider and staff training that will provide the tools necessary to remain objective when facing cultural conflicts. We will also provide educational interventions that will help our healthcare providers connect at a deeper level with their patients.
3. Enhancing the linguistic skills of our staff and community partners in order to provide high quality interpreting services.
4. Conducting evidence-based research and analysis, developing initiatives, and partnering with community organizations to improve the health of our communities.
5. Development of a health disparities progress report. This report will highlight areas of disparities as it relates to Healthy People 2010 and will be updated periodically.

The Center is committed to playing a supportive role to the dozens of local community groups that already provide vital services to many underserved communities. As a result of a series of meetings with these groups, as well as representatives from other governmental and non-governmental agencies, the Adventist HealthCare Center on Health Disparities has prepared the attached report to provide all interested members of our communities an overview of health issues impacting the underserved.

This is the first progress report that we have developed for Frederick, Montgomery and Prince George's Counties. The need for solid data at a county level is imperative if we are to effect change and focus our efforts in areas that are relevant to our local community. The findings that you will review in this report will serve as a catalyst for all of us to target interventions in the areas of greatest need. This report will bring to focus our efforts and further refine our agenda as we positively affect health and minimize healthcare disparities in our tri-county area.

I invite you to review our findings and join us in our journey. Though this may be the road less traveled, the destination is worth every step.

Marcos Pesquera

*Executive Director, Center on Health Disparities
Adventist HealthCare, Inc.*

Acknowledgements

ADVENTIST HEALTHCARE AND THE CENTER ON HEALTH DISPARITIES WOULD LIKE TO THANK the members of the Center's Advisory Board, who were instrumental in shaping the mission and vision of the Center and this report. The panel is comprised of the following members, listed along with their organization affiliation:

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The Center would also like to thank the other community organizations that were interviewed as part of this report and that provided valuable insights into the issues facing their communities. Profiles of these groups can be found beginning on page 99. The Center hopes that the future will provide opportunities to partner with these organizations to reduce and eliminate the disparities described in this report.

Finally, the Center thanks Avalere Health for its analytic support of this report, and would especially like to recognize Kristal Vardaman, Rita Deng, Madeline Taskier, Scott Woods, and Jon Glaudemans for their contributions to this effort.

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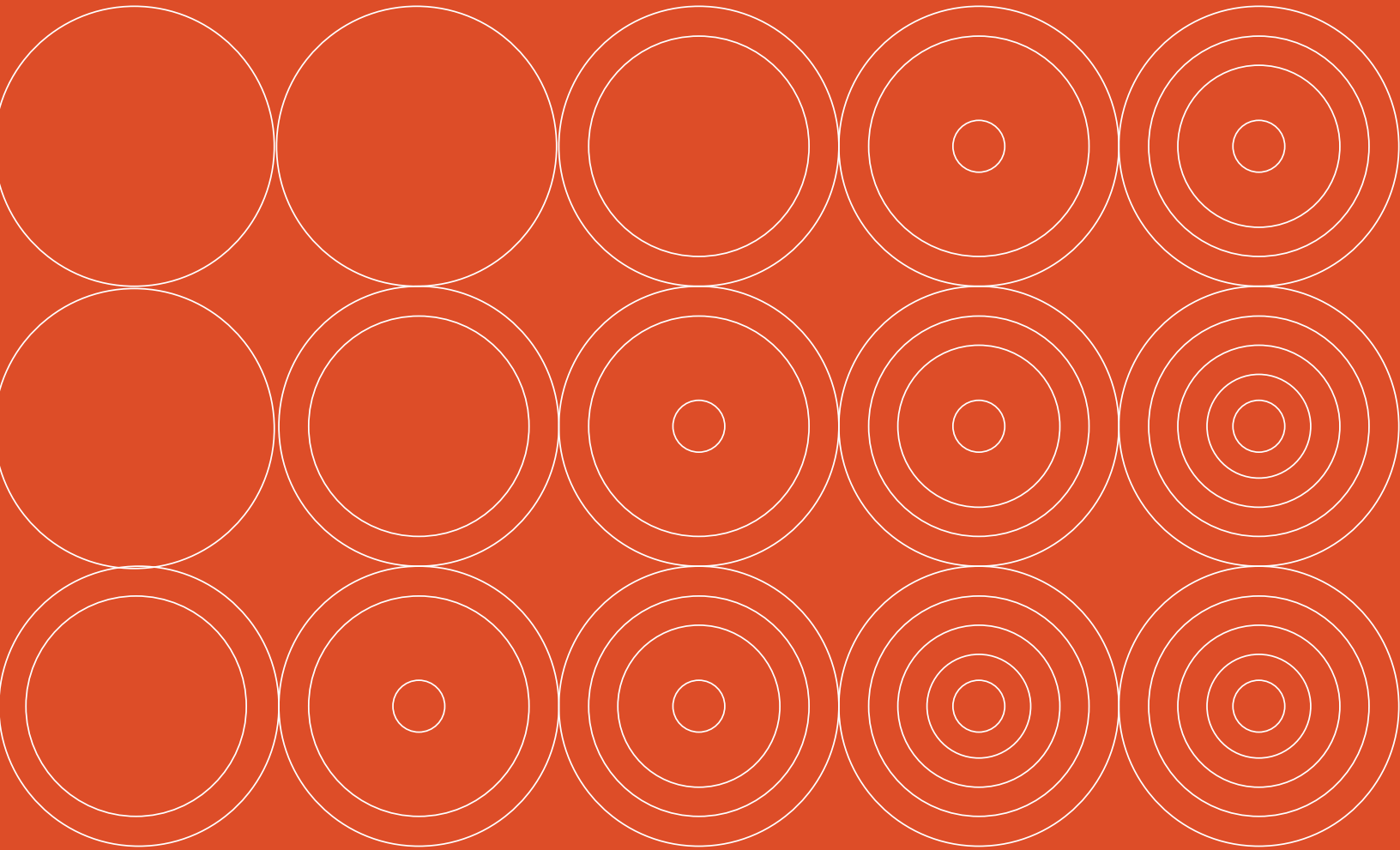
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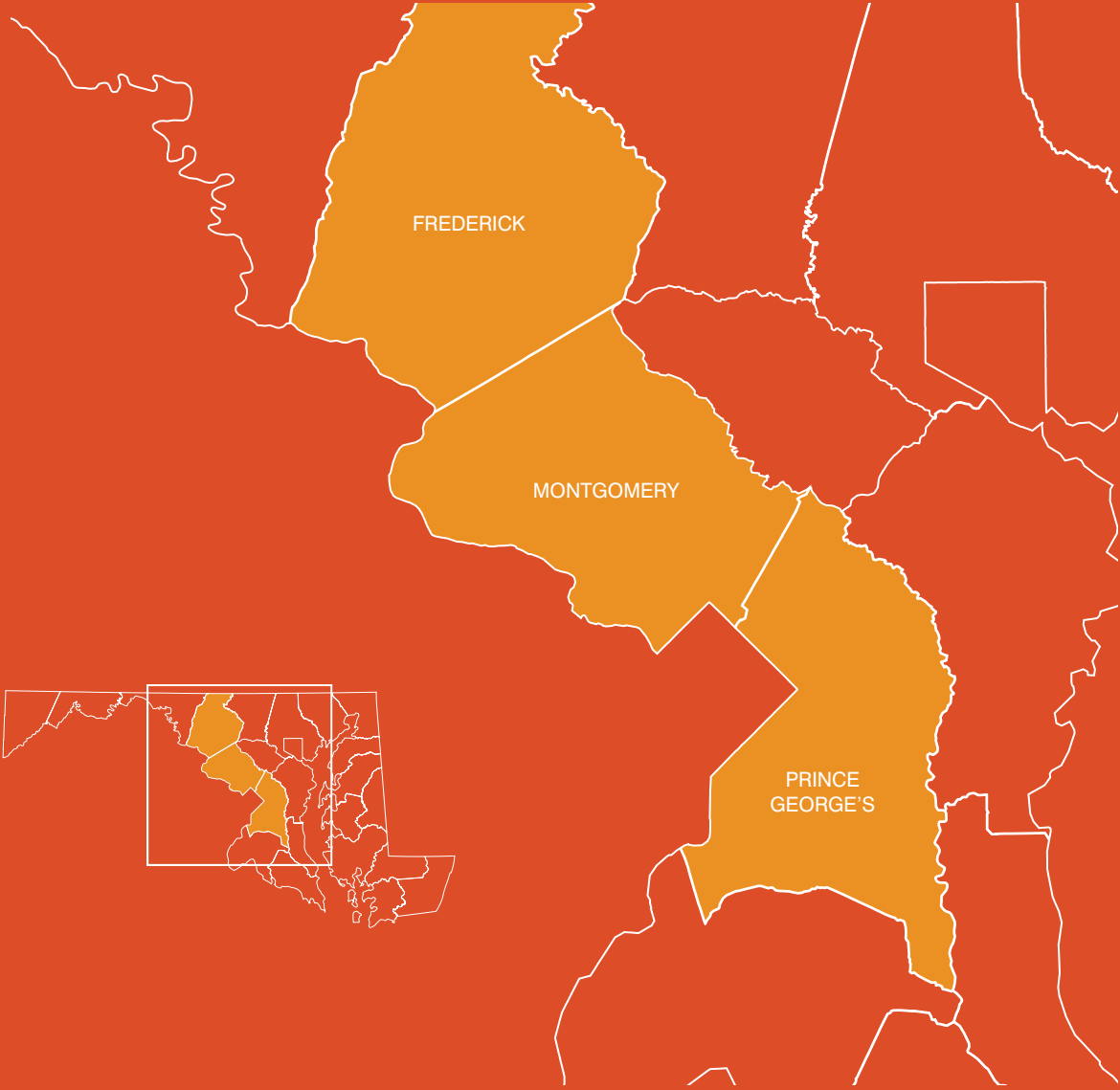
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Executive Summary



Maryland: Tri-County Area



Executive Summary

THE PURPOSE OF THIS INAUGURAL CENTER ON HEALTHCARE DISPARITIES REPORT IS TO PROVIDE local health providers, community stakeholders, and policy makers with an overview of health disparities affecting communities in the tri-county Maryland region surrounding Washington, DC (Frederick, Montgomery, and Prince George's Counties). This report details demographic trends, cultural influences on health, analyses of health disparities across a range of health issues, and provides brief descriptions of local community groups working to reduce health disparities.

Demographics

The proportion of residents in the tri-county area and Maryland as a whole identified as African American, Latino, or Asian American is growing, with implications on the health of the community. These data mirror national trends.¹

- From 2000 to 2005, the proportion of whites in the tri-county region decreased by 4.4 percentage points, while the African American, Latino, and Asian American populations increased.²
- An influx of Latino immigrants from Mexico and Central America and black immigrants from the Caribbean and Africa brings new challenges to local leaders. Immigrant communities face challenges adjusting to the U.S. health care system, and those who lack English proficiency face additional difficulty in navigating the health care system.
- Without action, the existing health disparities affecting these communities will only grow more pronounced. This population shift demonstrates a need for more activity aimed at understanding the health concerns of these groups and for determining how the local health system can better serve these needs.

Understanding Cultural Influences on Health Status and Health-Seeking Behavior

Understanding a population's cultural beliefs about health helps providers and policy makers understand that community's interactions with the healthcare system. This report summarizes some studies that demonstrate how cultural beliefs and practices, and obstacles such as insurance status and language barriers, guide communities' interactions with healthcare providers and institutions. For example:

- A number of research studies have highlighted that some African Americans, especially the elderly, use home herbal and natural remedies that are often misunderstood by healthcare providers.³ These misunderstandings also affect other communities that use traditional treatments.
- Fear and mistrust of the American health system is common among undocumented and documented African immigrants. Some individuals may only visit the emergency room as a last resort for treatment.
- Latino patients are at risk of lower quality care than non-Latino whites when a language barrier exists between the patient and the provider. Research shows that access to bilingual physicians reduces the risk of miscomprehension and limits use of an interpreter.⁵
- In a research study, many Chinese Americans said Western medical care is best for acute care, but Chinese medicine is best for health promotion, disease prevention, and recovery.⁶

Identification of Health Disparities in the Tri-County Area

The health indicators covered in this report include: healthful behaviors, access to health care, maternal and infant health, children's health, elder care, cancer, diabetes, heart disease, mental health, HIV/AIDS, and accidents and injuries.

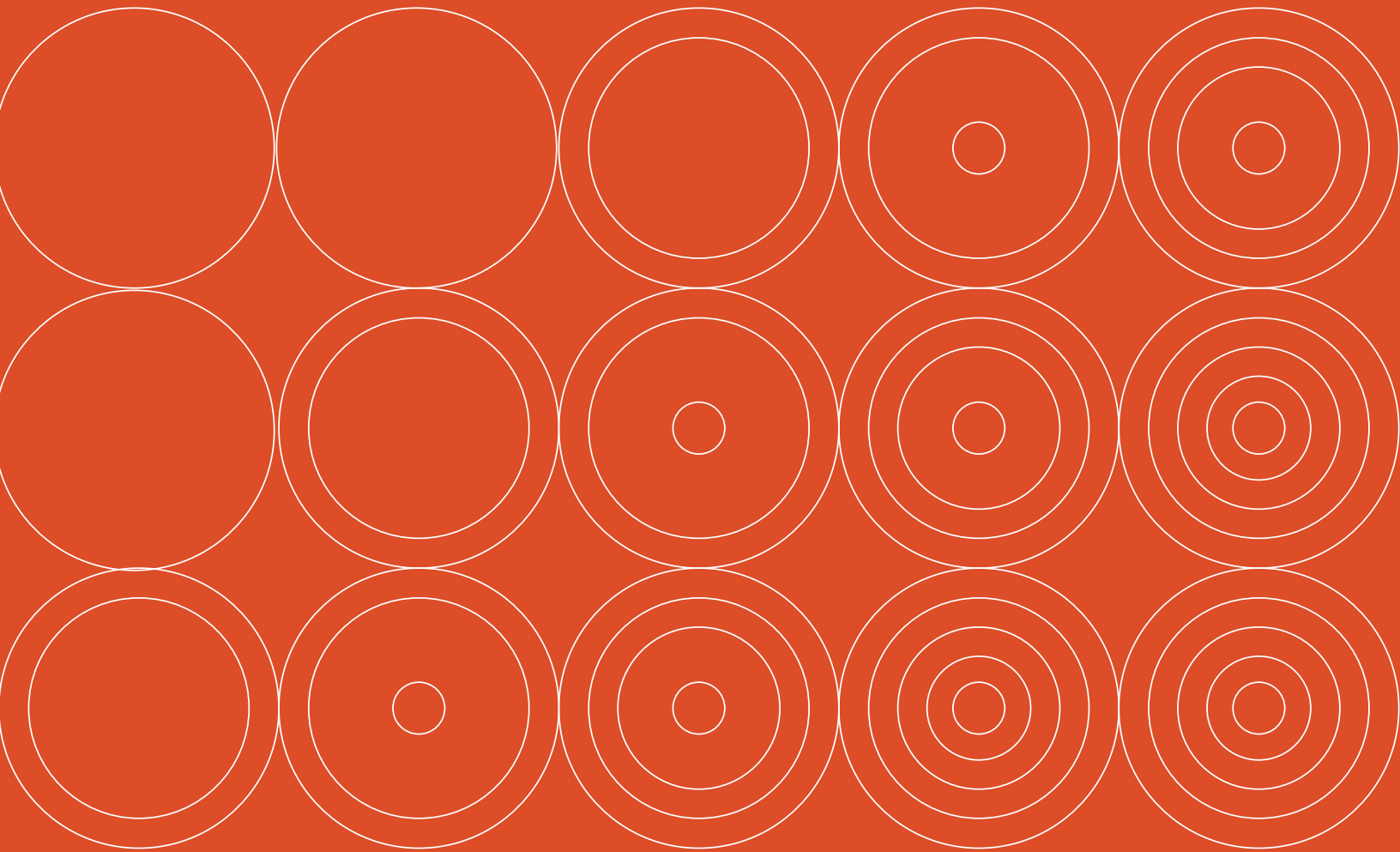
- Using information from state and national data sets, the report provides an overview of health status across a variety of key indicators, broken down by racial and ethnic identification.
- Where possible, this data is displayed for the three counties of interest, but where this was not possible state and national estimates were used to make inferences on the likely health status of local minority communities.
- Racial and ethnic disparities were identified across a variety of measures, including insurance status for Latinos, birth outcomes for African Americans, and cervical cancer mortality rates among Asian American women.
- Mortality and hospital data suggest disparities in the management of chronic diseases such as diabetes and heart disease, leading to notable excess morbidity, mortality and hospitalizations for African Americans.
- Data limitations prevent meaningful analyses of immigrant health (and for select measures Latinos and/or Asian Americans). Data for Native Americans were virtually nonexistent, therefore that group is regrettably omitted from this report.

Conclusions and Recommendations

This report describes the health status of racial and ethnic minority communities in the tri-county area across 11 health topics. In order to respond to these disparities, providers and policy makers may wish to develop strategies to track health disparities across important sub-populations, and to promote initiatives to equip caregivers, patients, and their families with the tools necessary to make full use of our existing healthcare system. Finally, an ongoing program of research into best practices across these initiatives – working in close collaboration with local, regional, state, and national groups – would equip all stakeholders with the information necessary to develop effective prevention, treatment, and care programs for all individuals, regardless of their economic, cultural, linguistic, or demographic characteristics.

- **Expand outreach and services for needs of racial and ethnic minorities.** As noted across this report, healthcare providers, county health departments, state agencies, and community organizations are all implementing initiatives to reduce health disparities. As the region moves forward in addressing these issues, more resources should be devoted to these efforts, with special emphasis placed on taking advantage of other programs' successes, and understanding how to successfully replicate some of these programs.
- **Pursue programs of coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers.** As different stakeholders explore the causes of disparities and the efficacy of interventions aimed at reducing these disparities, a coordinated research agenda is needed. There is a need for the more systematic collection of racial and ethnic data, as well as language preference. In particular, it is difficult to evaluate health status among many immigrant populations as virtually no publicly available datasets disaggregate data by nativity. In order to better address the needs of the immigrant community, researchers will need to understand the health status and health needs of these populations in order to inform effective policy and interventions.
- **Promote culturally and linguistically competent care and provide funding mechanisms to foster the exchange of best practices.** Current grant programs and initiatives often concentrate on the development of innovative means of addressing health disparities. Educational efforts to disseminate these best practices is a vital next step. State and county funding streams could be created to promote increased collaboration and the formation of teams and working groups that would share experiences in different settings.

Methodology



Methodology

Definitions

This report incorporates race and ethnicity classifications based on standards established by the U.S. Office of Management and Budget (OMB) in 1997 and used in the 2000 Census. The report categorizes demographic and health information by white, African American, Latino, and Asian American:

- White refers to a person having origins in any of the original people so Europe, the Middle East, or North Africa;
- African American refers to a person having origins in any of the black racial groups of Africa;
- Latino refers to a person having origins of Cuban, Mexican, Puerto Rican, South or Central American or of other Spanish culture or origin, regardless of race;
- Asian American refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam, or a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

The health status of the Native American community is not explored in this report due to lack of data to evaluate the health of this community. Census data demonstrates that in 2000, fewer than one percent of tri-county residents were classified as Native American or American Indian alone.

Literature Review

A comprehensive literature review encompassed a range of academic, institutional and community resources. Main sections of the report cited information from:

- Academic journal articles retrieved from PubMed within the last 10 years related to health disparities in care access, as well as disease incidence and prevalence, treatment, and prevention across race and ethnicity;
- National and state governments and institutions that include the Center for Disease Control (CDC), the Agency for Healthcare Research and Quality (AHRQ), the Maryland Department of Health and Mental Hygiene (MD/DMMH), and the Maryland Health Care Commission (MHCC); and
- Correspondence with tri-county and Maryland community group leaders and Center on Health Disparities' Advisory Board members.

Interviews

The community profiles and community group highlights feature formative research at the tri-county level. Specifically, we incorporated information from:

- Phone-based interviews conducted by Avalere Health with the Center on Health Disparities' Advisory Board members and other community groups;
- Current health, social, and research initiatives from websites of various community groups.

Data Sources

This report incorporates descriptive findings from national and state datasets.

National Datasets

Nationally, we analyzed the 2000 5 Percent Maryland Public Use Microdata Sample (PUMS) files from the U.S. Census to produce cross tabulations on socio-demographic characteristics such as income and education by county, race, and ethnicity. The PUMS provide flexibility in data tabulation in small geographic locations and by minority groups. Sample weights are provided to produce nationally representative estimates.

We used the 2005 release of the Area Resource File (ARF) from the Health Resources and Service Administration (HRSA), Bureau of Health Professions to compute the number of health professionals by county. The ARF contains 2000 physician data from the American Medical Association Physician Master Files, 1998 dentist data from the American Dental Association Distribution of Dentists in the United States by Region and State, and 2001 nurse practitioner data from the 2001 American Academy of Nurse Practitioners Survey.

Descriptive statistics on access to health and disease conditions from the Quick Health Data Online System from the Office on Women's Health were tabulated. The database develops indicators across time and geographic areas at the county, state, and national level from information provided by Center for Disease Control's Wide-ranging Online Data for Epidemiologic Research (CDC Wonder), national surveys including the CDC Behavioral Risk Factor Surveillance System (BRFSS), Census data, ARF, and state health and surveillance departments.

State Datasets

In Maryland, we produced descriptive tabulations based on data from the Maryland Behavioral Risk Factor Surveillance System (MD BRFSS), the Maryland Cancer Registry, the Maryland Vital Statistics Administration, and the Maryland Hospital Discharge Database.

The MD BRFSS collects population-based behavioral health data on chronic diseases, injuries, and preventive health services associated with premature morbidity and mortality. The survey is conducted annually through 4,400 telephone calls to Maryland-dwelling, English-speaking adults aged 18 and over with stratified sampling by urban/rural status and other socio-demographic variables. We examined data from 2003 to 2006 at the county and state levels. In cases of insufficient sample size, data from multiple years were pooled to generate descriptive statistics.

The Maryland Cancer Registry shared registered cancer incidence and mortality rates across counties for all Maryland residents by age, race/ethnicity, and date of diagnosis. The organization also produced a population based statewide survey on cancer screening and behavior risk factors in 2004.

The Maryland Vital Statistics Administration provided 2005 population estimates from the tri-county area and all of Maryland by race and ethnicity, number of births, and death rates by the top 10 causes of mortality per county.

The Maryland Health Care Commission's Health Service and Cost Review Commission (HSCRC) releases annual inpatient discharge rate information with disease coded by International Classification of Diseases (ICD-9). The data include patients served by Maryland's 66 general hospitals.

In addition to these data sources, we have also summarized findings from various national and state level reports on insurance coverage, affordability of care, disease conditions, and healthy behaviors released by the CDC, the Agency for Healthcare Research and Quality (AHRQ), the Maryland Department of Health and Mental Hygiene, and county health departments.

Data Limitations

Despite extensive efforts to prepare comprehensive sets of health access and health status indicators across race and ethnicities at the county level, the following limitations should be considered when interpreting the statistics cited in this report:

- Much of the data, especially population-adjusted rates across race and ethnicity per county, were not available;
- Often, databases do not differentiate races for Latinos;
- Much of the data were obtained from different sources with various data collection and publication protocols;
- Large amounts of county data collected, processed, and checked could not be utilized due to privacy concerns related to small number of observations;
- Self-reporting in surveys can generate underreporting or overreporting, yielding unreliable estimates;
- No tests were performed to determine the statistical significance of data;
- Estimates based on sample sizes less than 50 should be interpreted with caution.

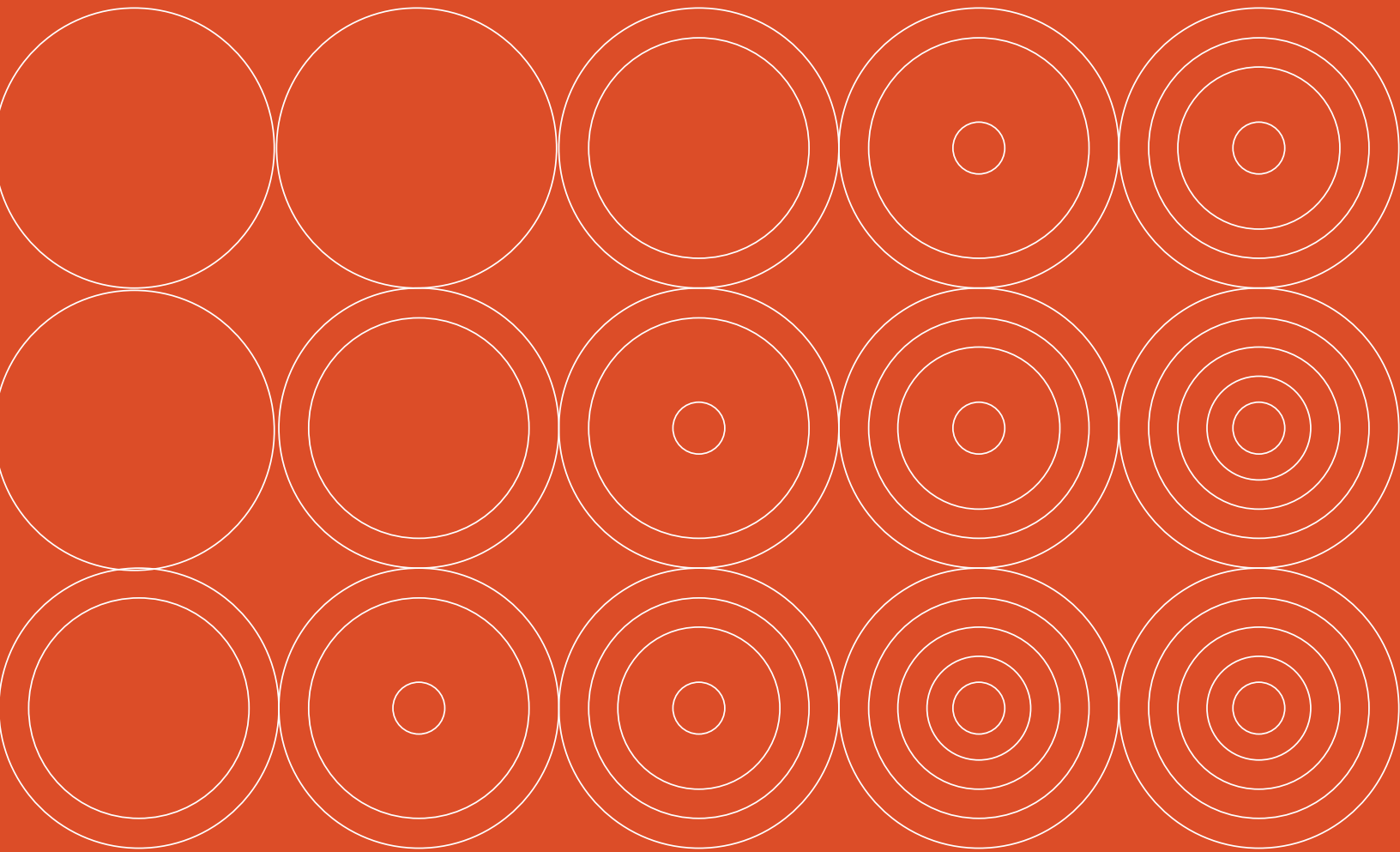
Tables and Figures in this Report

Across tables and figures presented in the report, missing categories of race and ethnic groups at the county, state, or national levels may exist due to lack of classification or data availability. For example, data for Latinos may not be available due to the lack of collection of ethnic category in addition to racial identification; disease and mortality rates from Asian Americans may not be reported due to small sample sizes that prevented reporting due to privacy concerns.

Across populations and disease conditions, calculated percentage sums may not equate 100 percent due to rounding.

As of 2005, residents of Frederick, Montgomery, and Prince George's Counties make up a third of the Maryland population. Sample sizes tabulated at the tri-county level may be insufficient to generate conclusions for all of Maryland.

Community Characteristics



Demographics of the Tri-County Area

FREDERICK, MONTGOMERY, AND PRINCE GEORGE'S COUNTIES ARE NEIGHBORING COUNTIES in Maryland, which comprise the tri-county area under study in this report. These counties, similar to many other metropolitan areas of the United States, are currently experiencing dramatic growth in the proportion of residents belonging to racial and ethnic minority groups (including African Americans, Latinos, Asian Americans, and other minority communities). Given the racial and ethnic transformation, there are increasing challenges in addressing the health disparities that tend to affect these rapidly growing populations. Success in eliminating these disparities is dependent on an understanding of the unique needs of each racial and ethnic community. Factors such as poverty status, citizenship, linguistic isolation, and educational attainment are all known to impact health status. Data on racial and ethnic minorities in these Maryland counties highlights disparities in income, education, and English proficiency when compared to whites. As the proportion of racial and ethnic minority residents continues to grow, these factors will become even more important for counties to understand in order to meet the health needs of the community.

Size and Growth of the Racial and Ethnic Minority Population in the Tri-County Area

Like the rest of the country, Maryland is experiencing an influx of immigrants, and the unique health issues for those immigrant groups will become more acute if action is not taken now.

- Of the counties comprising the tri-county region, Montgomery County is the most populous, followed by Prince George's and Frederick Counties (Figure 1).
- The proportion of residents belonging to a racial or ethnic minority in Prince George's County grew by nearly 6 percent from 2000 to 2005, the largest increase across the tri-county area (Figure 2).
- The Latino population in the tri-county area grew by nearly 3 percent over five years, representing the largest growth of all racial/ethnic groups (Figure 2).

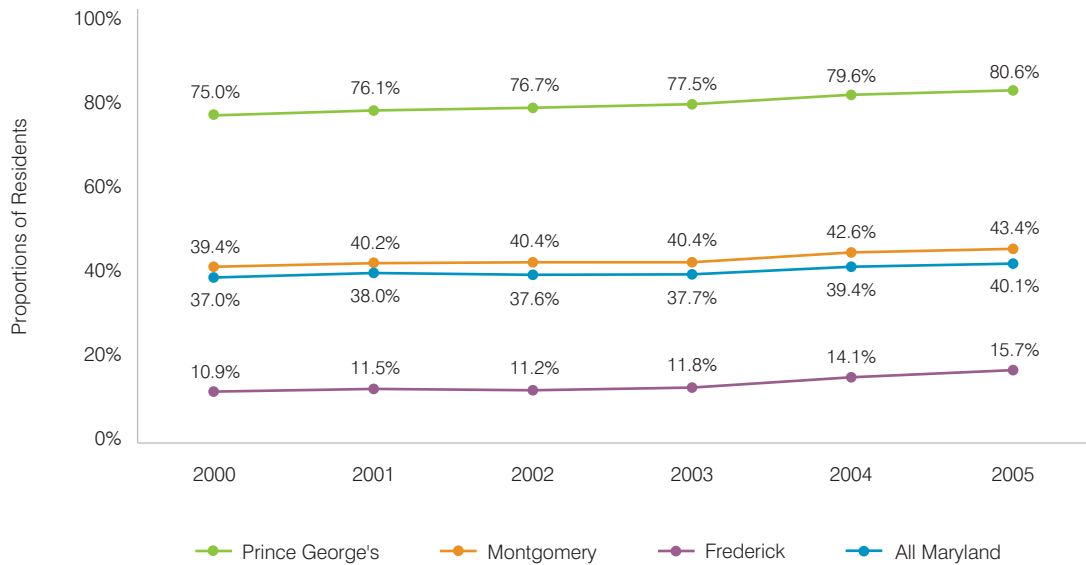
FIGURE 1. Population, Tri-County, 2005

Population, Tri-County, Maryland 2005

	FREDERICK	MONTGOMERY	PRINCE GEORGE'S	ALL MARYLAND
White	184,095	563,263	178,889	3,356,489
African American	14,928	144,976	542,583	1,564,914
Latino	9,883	125,354	90,365	316,257
Asian American	6,796	119,923	31,849	261,083
Total Population	215,877	918,046	828,834	5,461,318

Source: Maryland Vital Statistics Administration, 2007.

FIGURE 2. Proportion of Residents Belonging to Racial or Ethnic Minority, 2000-2005



Source: Maryland Vital Statistics Administration, 2007.

Racial Subgroups and Countries of Origin

The United States is one of the most culturally and ethnically diverse nations in the world. This region of Maryland reflects that diversity. In the tri-county area, Latino, Asian American, and African American residents come from varied backgrounds, leaving great challenges for health providers to understand and meet the needs of these communities.

- Most Latino residents in the tri-county region are from Mexico or Central America.
- Residents from Guatemala, Mexico, Puerto Rico, and El Salvador are in the top five most populous Latino groups in each of the tri-counties and in Maryland as a whole (Figure 3).

- Chinese residents represent the most populous Asian group in each county and in all of Maryland, with Korean, Asian Indians, and Vietnamese residents following (Figure 4).
- African American residents in the tri-counties and Maryland who were not born in the United States are mostly from Caribbean and African countries (Figure 5).

FIGURE 3. Top Five Countries of Ancestry, Latinos, Tri-County, Maryland, 2000

Latino Residents Reporting Country of Ancestry – Highest Values

FREDERICK	MONTGOMERY	PRINCE GEORGE'S	ALL MARYLAND
Mexico – 1,244	El Salvador – 20,605	Mexico – 14,386	Mexico – 43,515
Puerto Rico – 873	Mexico – 8,818	El Salvador – 13,651	El Salvador – 38,376
El Salvador – 452	Puerto Rico – 4,977	Puerto Rico – 4,559	Puerto Rico – 26,156
Guatemala – 276	Peru – 4,973	Guatemala – 2,825	Guatemala – 8,694
Cuba – 243	Guatemala – 3,862	Dominican Republic – 1,522	Peru – 7,374

Source: Census, 2000.

FIGURE 4. Top Five Countries of Ancestry, Asian Americans, Tri-County, Maryland, 2000

Asian American Residents Reporting Country of Ancestry – Highest Values

FREDERICK	MONTGOMERY	PRINCE GEORGE'S	ALL MARYLAND
China – 978	China – 27,018	Philippines – 9,109	India – 49,822
Korea – 637	India – 24,288	India – 6,932	China – 46,892
India – 544	Korea – 15,344	China – 4,513	Korea – 38,997
Vietnam – 405	Vietnam – 9,350	Korea – 3,412	Philippines – 27,601
Japan – 297	Philippines – 7,105	Vietnam – 2,471	Vietnam – 16,434

Note: "China" does not include Taiwanese respondents.
Source: Census, 2000.

FIGURE 5. Top Five Countries of Ancestry, African Americans, Tri-County, Maryland, 2000

Places of Birth for African Americans Not Born in U.S. – Highest Values

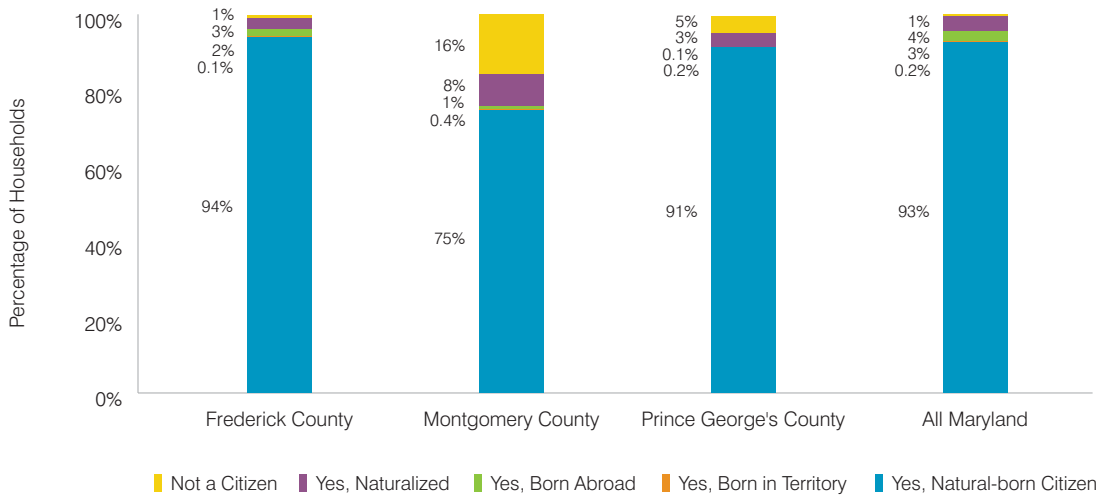
FREDERICK	MONTGOMERY	PRINCE GEORGE'S	ALL MARYLAND
Germany – 190	Jamaica – 4,730	Nigeria – 7,194	Jamaica – 17,376
Barbados – 143	Africa – 3,771	Jamaica – 6,844	Nigeria – 13,829
Liberia – 97	Ethiopia – 3,326	Trinidad & Tobago – 3,646	Trinidad & Tobago – 8,559
Jamaica – 49	Nigeria – 2,644	Sierra Leone – 3,374	Africa – 6,939
Haiti – 37	Haiti – 2,268	Ghana – 2,886	Ghana – 6,505

Note: "Africa" was non-specified by respondents
Source: Census, 2000.

Citizenship

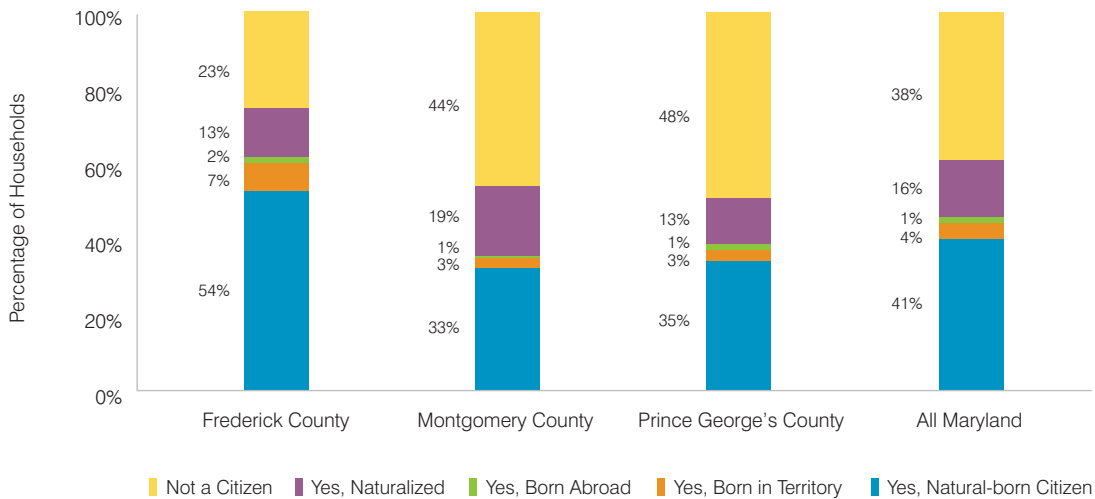
- The greatest percent of non-U.S. citizen African Americans reside in Montgomery County (Figure 6).
- Across counties and the state as a whole, Latinos represent the racial group with the greatest percentage of non-citizens; nearly half of Latinos in Montgomery and Prince George’s Counties are non-citizens (Figure 7).
- Across counties, roughly two-fifths of Asian Americans are naturalized citizens, whereas only one-fifth to one-fourth are natural-born citizens—the lowest percentage among all racial and ethnic groups (Figure 8).

FIGURE 6. Citizenship Status, African Americans, Tri-County, Maryland, 2000



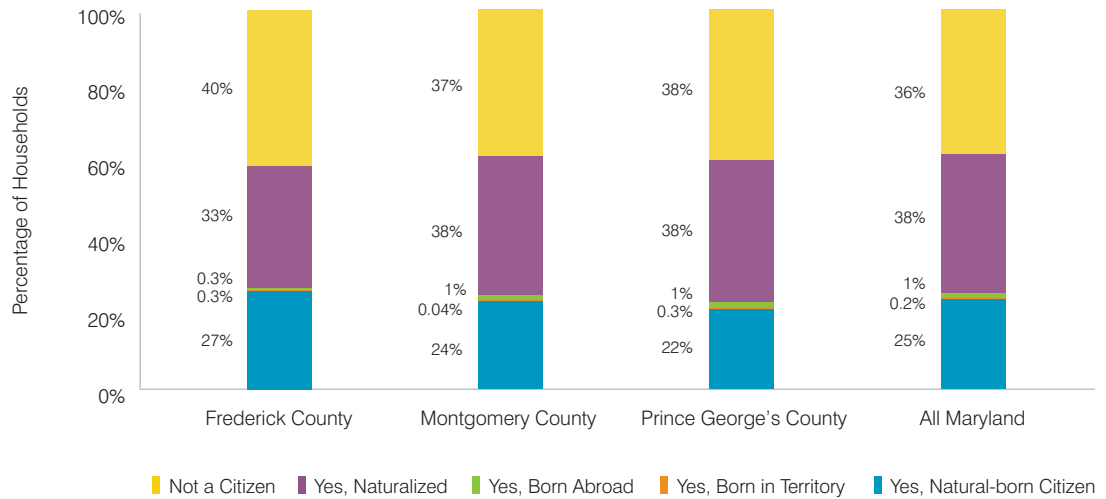
Source: Census, 2000.

FIGURE 7. Citizenship Status, Latinos, Tri-County, Maryland, 2000



Source: Census, 2000.

FIGURE 8. Citizenship Status, Asian Americans, Tri-County, Maryland, 2000



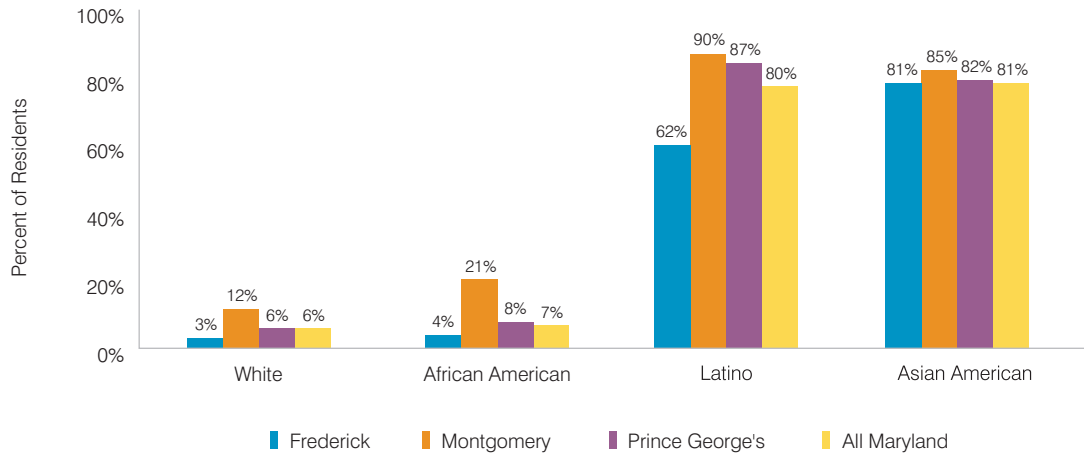
Source: Census, 2000.

Language

Fluency in English is a key factor in one’s ability to navigate the healthcare system. Linguistic isolation is defined by the U.S. Census Bureau as living in a household in which all members aged 14 years and older speak a non-English language and also speak English less than “very well” (i.e., have difficulty with English). Those who are linguistically isolated face significant challenges in attaining employment and receiving quality healthcare.

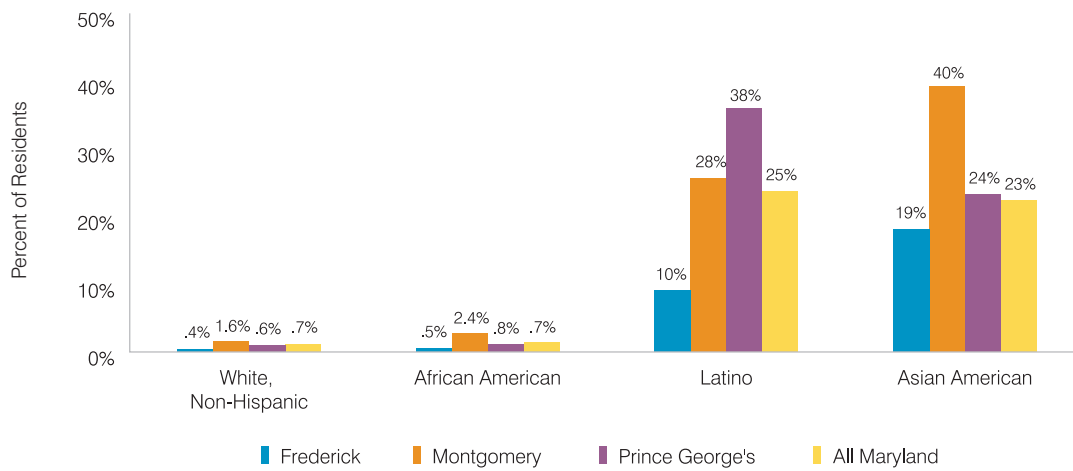
- Of the various racial and ethnic groups, Latinos and Asian Americans represent the highest number of persons who speak a non-English language (Figure 9).
- These high rates of linguistic isolation among Latino and Asian American residents speak to the strong need for interpreter and translator services within the healthcare system (Figure 10).

FIGURE 9. Percentage of Residents Speaking a Non-English Language, Tri-County, Maryland, 2000



Source: Census, 2000.

FIGURE 10. Linguistic Isolation, Tri-County, Maryland, 2000



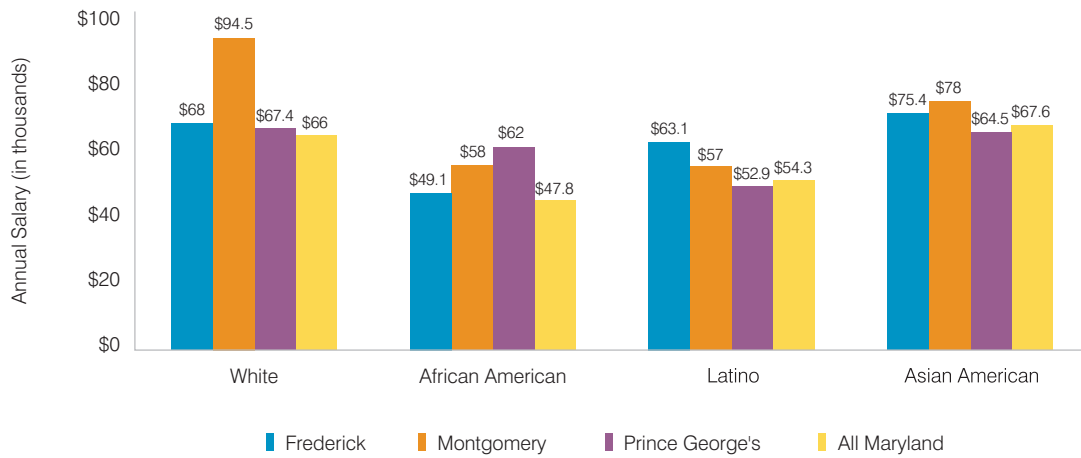
Source: Census, 2000.

Income and Poverty

Household income has a direct influence on a family’s ability to purchase food and other necessities including health insurance. Research on healthcare disparities demonstrates that low-income individuals tend to experience worse health outcomes than wealthier individuals.⁷ Thus, income disparities are suggestive of health disparities. Across most racial and ethnic groups and counties, whites have the highest median household income (Figure 11). Furthermore, disparities in wealth, particularly between African Americans and whites, have been captured in a number of studies.⁸

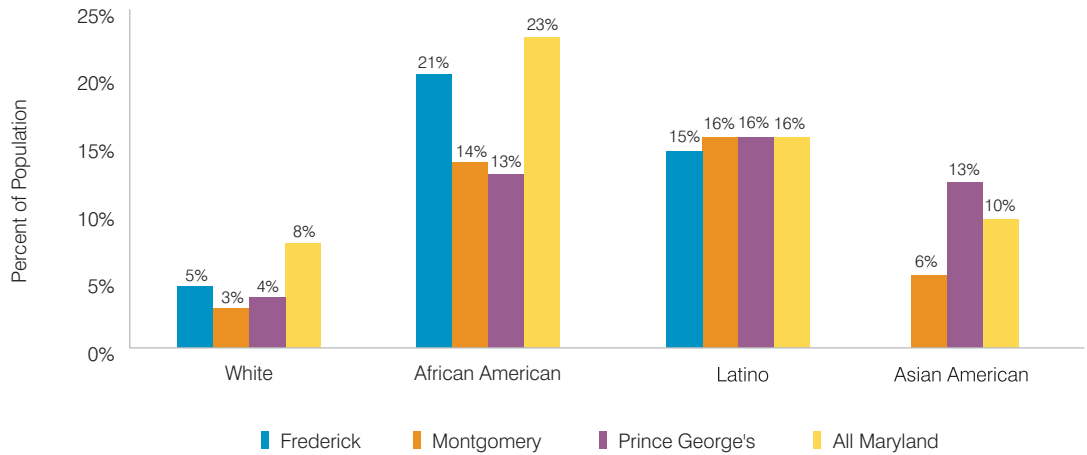
- Among minorities, Asian Americans have the next highest salaries across the tri-county region and Maryland, with the exception of Frederick County and Maryland as a whole, where Asian Americans have higher salaries than whites (Figure 11).
- The percentage of children in poverty was highest among African Americans in Frederick County, followed by Latino children in Montgomery and Prince George’s Counties (Figure 12).
- Among adults, the poverty levels were highest for African Americans and Latinos across counties, with the exception of Asian Americans in Prince George’s County (Figure 13).

FIGURE 11. Median Household Income, Tri-County, Maryland, 1999



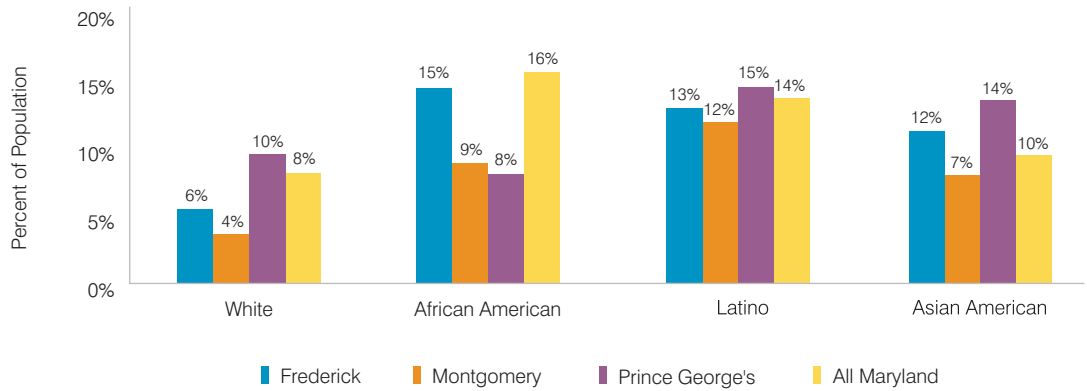
Source: Census, 2000.

FIGURE 12. Persons in Poverty, Children Under Age 18, Tri-County, Maryland, 2000



Notes: The federal poverty level was \$17,050 for a family of four in 2000. The number of Asian Americans in poverty in Frederick County was not available. Source: Census, 2000.

FIGURE 13. Persons in Poverty, Adults Over Age 18, Tri-County, Maryland, 2000



Note: The federal poverty level was \$17,050 for a family of four in 2000. Source: Census, 2000.

Employment Status

Employment status has a direct influence on household income and insurance status as 54 percent of the U.S. population is insured through their employer.⁹

- The greatest rates of unemployment across racial and ethnic groups and across counties are among African Americans.
- Asian Americans and whites have the lowest unemployment rates across counties (Figure 14).
- Across all racial and ethnic groups, Montgomery County has the lowest unemployment rates (Figure 14).

FIGURE 14. Employment Status, Tri-County, Maryland, 2000

Employment Status

PERCENT UNEMPLOYED	WHITE	AFRICAN AMERICAN	ASIAN AMERICAN	LATINO
Frederick	1.7	3.5	1.7	2.0
Montgomery	1.1	3.1	1.8	2.5
Prince George's	2.3	3.5	1.6	4.0
All Maryland	1.7	4.1	1.7	2.9

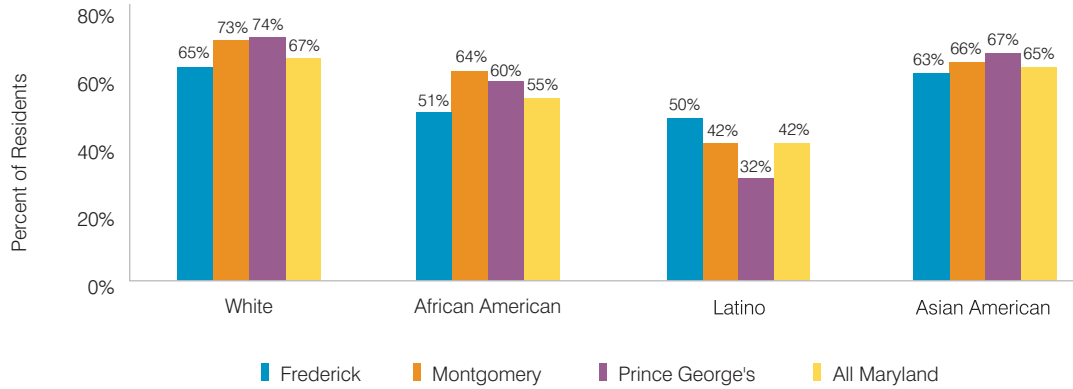
Source: Census, 2000.

Education

The relationship between education and health status is widely documented. Research on health disparities has mostly focused on the relationship between socioeconomic status and health or demographics and health; however, educational attainment appears to be as significant a determinant of future health status as demographics or socioeconomic status.¹⁰

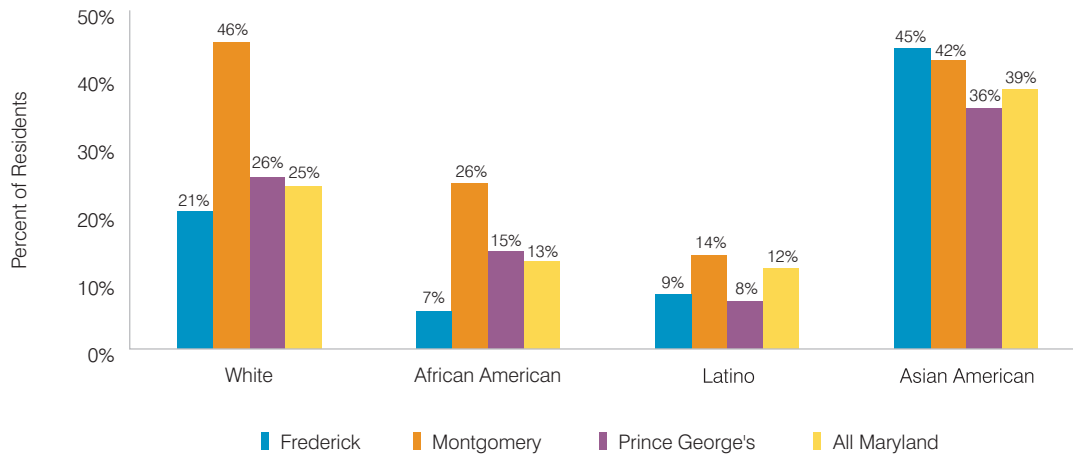
- Frederick County has the lowest rates of high school graduation among all racial and ethnic groups compared with Montgomery and Prince George's Counties. The county also reports a lower percentage of educated adults as compared to all of Maryland (Figure 15).
- Montgomery County is the most highly educated county, with more than 25 percent of African American residents and more than 40 percent of white and Asian American residents having received a bachelor's degree (Figure 16).
- Across the three counties, Latinos have the lowest rates high school completion as well as low rates of bachelor's degree recipients.

FIGURE 15. Highest Level of Education Attained, High School Diploma, Tri-County, Maryland, 2000



Source: Census, 2000.

FIGURE 16. Highest Level of Education Attained, Bachelor's Degree or Above, Tri-County, Maryland, 2000



Source: Census, 2000.

African American Community Health Profile

THE AFRICAN AMERICAN COMMUNITY IS THE LARGEST MINORITY GROUP IN MARYLAND AND the tri-county area. The community not only includes U.S.-born African Americans, but also an increasing number of immigrants from Caribbean and African countries. Heart disease, cancer, diabetes, infant mortality, and HIV/AIDS are some of the major health issues affecting African Americans. The overall mortality rate for African Americans is the highest of all minority populations in the United States. Lack of culturally competent providers, diminished access to care, and reduced rates of health insurance appear to be among the chief contributors to poor health status in this community. Health illiteracy and lingering discrimination in the healthcare system also contribute to the health challenges faced by African Americans.

Cultural Beliefs About Healthcare

Like many other communities, cultural beliefs and practices strongly influence African Americans' health behaviors and healthcare utilization.

- Religion is an important factor in African American health perceptions, and religious practices may be used as a support system or as alternative treatment.¹¹
- Several studies have noted that some African Americans, especially the elderly, use home herbal and natural remedies that are often misunderstood by healthcare providers.¹²
- Cultural stigmas associated with mental health, HIV/AIDS, and other infectious diseases can lead to further misinformation and ineffective prevention.¹³

Provider and Patient Interaction

Poor patient-provider interaction within the healthcare system is a significant contributor to poor health status in the African American community.

- Historical episodes of medical mistreatment of African Americans, including medical experimentation, poor quality, and segregated treatment during the "Jim Crow" era and the Tuskegee syphilis study, have contributed to a lingering mistrust of medical providers among some African Americans, particularly the U.S.-born.¹⁴

- Studies have shown that African Americans are at risk of lower quality healthcare when there is a cultural barrier between the patient and the physician.¹⁵
- Racial discrimination and stereotyping is unfortunately common in provider and patient interactions. One research study found that providers were more likely to discuss community violence and alcohol or drug abuse with African American pediatric patients than with other non-African American patients from the same communities.¹⁶
- Research has shown that some African immigrants with little prior experience in the U.S. healthcare system mistrust American physicians.¹⁷

Access to Healthcare and Insurance

Facilitators of access to healthcare such as health insurance and reliable transportation to providers often present problems for many African Americans. Disparities in treatment recommendations may also result in reduced access to care.

- Like many other minority populations, lack of transportation is a large barrier to healthcare for the African American community. Health centers in rural or suburban areas may be significant distances away from accessible public transportation.¹⁸
- African Americans are more likely to be seen by a physician in emergency rooms and hospital clinics than in provider offices as compared with non-Latino whites.¹⁹
- African Americans are less likely to receive a combination of therapies for prostate, breast, and colorectal cancer treatments as opposed to whites who receive multiple treatments.²⁰
- Many physicians under Medicaid and Medicare give African American patients fewer referrals to specialists than white patients.²¹

Insurance

African Americans comprise approximately 16 percent of the uninsured population in the United States.²² Socioeconomic status can be correlated with insurance status.

- African Americans are disproportionately enrolled in Medicaid.²³
- For Medicare, whites and African Americans show very few differences in access.²⁴

Caribbean and African Immigrant Health

The proportion of recent immigrants in the tri-county African American community is increasing. The majority of these immigrants arrive from the West Indies and several African countries.²⁵

- Children and women are among the most vulnerable members of this population. Some have come from violent circumstances in their native countries, and suffer from mental health conditions as a result.²⁶
- African immigrants from non-English speaking countries often have more difficulty adapting to the United States linguistically than those from the former British colonies.²⁷
- African immigrants, despite high employment rates, have low rates of insurance, indicating low occurrences of employment-based insurance.²⁸
- Fear and mistrust in the American health system is common among undocumented and documented African immigrants. Some individuals may only visit the emergency room as a last resort for treatment in fear of deportation.²⁹
- Caribbean immigrants regularly experience issues with patient satisfaction, cultural sensitivity to alternative treatment and home remedies, and language barriers.³⁰

Latino Community Health Profile

THE LATINO POPULATION IS THE SECOND LARGEST MINORITY POPULATION IN THE TRI-COUNTY area.³¹ Latinos are often misrepresented as a homogenous ethnic group with a distinct pattern of healthcare needs and practices, but these assumptions tend to ignore significant differences between Latino subpopulations. The Latino community actually contains a heterogeneous mixture of subgroups – usually aligned by country or region of origin – each with diverse experiences and health needs.³² Nonetheless, many Latino sub-populations face similar healthcare challenges, including language barriers, immigration status, insurance access, lack of cultural competency among healthcare providers, and the rising health risks in the workplace.

Language Barriers

Language barriers are a significant contributor to health disparities in the Latino community. Most Latinos in the United States indicate Spanish as their first language.³³

- After an initial visit with limited language comprehension, Latino patients with difficulty understanding English may cease seeking treatment.
- Latino patients are at risk of lower quality care than non-Latino whites when a language barrier exists between the patient and the provider. Research shows that access to bilingual physicians reduces the risk of miscomprehension and limits use of an interpreter.³⁴
- Relatives or friends of the patients often fill the interpreter role, sometimes resulting in miscommunication of critical medical information.³⁵

Workplace Health Risks and Barriers

More Latinos than whites (25 percent versus 13 percent) pursue high-risk occupations such as agriculture, construction, and service industries.³⁶ These environments tend to present employers with a high-risk environment for injury, and tend to be associated with below-average health status.³⁷

- Approximately 80 percent of Latinos in Maryland have emigrated within the last two decades from Central America. Their most common sources of employment are construction, restaurant or hotel service, house cleaning services, and janitorial work.³⁸
- More than 23 percent of fatal injuries among foreign-born workers occur in construction.³⁹

- Several research studies show that essential safety training for hazardous occupations is often not provided in Spanish for Latino Limited English Proficiency (LEP) workers.⁴⁰
- Immigrant workers often provide financial support to family members in their native countries. If an occupational injury occurs, workers may face additional stresses trying to pay for treatment while maintaining financial support.⁴¹
- Alcoholism is an issue of concern for some working-class Latino immigrants. Researchers attribute the behavior to possible stressful work environments and lack of social support systems.⁴²
- Employers in the agricultural, construction, and service industries that employ many Latino workers may not offer employer-based insurance, or premiums may not be affordable.⁴³
- The work schedule of those working in construction, agriculture, or the service industries often make it difficult to reach a provider during regular medical or dental office hours.⁴⁴

Familiarity with U.S. Health System

Among Latinos who are recent immigrants to the United States, past experiences with the health system in the immigrants' home countries can shape expectations of healthcare in this country.

- A majority of Latin American countries have an inclusive social healthcare system. Unemployed citizens of these countries have public sector healthcare with access to clinics and hospitals.⁴⁵
- The appointment system is uncommon in Latin American countries, and many clinics are operated on a first-come, first-serve basis. In the United States, some Latino immigrants are unfamiliar with the scheduling system and may become frustrated, decreasing continuity of care.⁴⁶
- In Latin America, pharmacists often prescribe medication based on symptoms and at a local pharmacy. In the United States, providers find that some Latinos may obtain medication or antibiotics from local Latin American supermarkets, which can result in the misuse of medication.⁴⁷

Use of Traditional or Alternative Medicine

Some Latino patients choose traditional home remedies over conventional medical care.

- Research shows that alternative medicine users are more likely than nonusers to be female, have lower incomes, lower English proficiency, and less education.⁴⁸
- U.S. healthcare providers are often hesitant to integrate alternative medicine with standard medical treatment. Patients may also be reluctant to share their use of home remedies with their clinicians, and clinicians may not be trained to ask the right questions.⁴⁹

Health Insurance and Access to Care

Immigration and insurance are intertwined issues that affect the health status of Latinos.

- According to a study conducted in Northern Virginia, 56 percent of Latino workers did not have employer-based health insurance and 21 percent had no idea how to pay for healthcare.⁵⁰
- Research shows that Central Americans and Mexicans are less likely than Puerto Ricans and Cubans to receive private employer-based coverage.⁵¹
- Transient employment significantly decreases healthcare benefits for Latinos.⁵²
- Some individuals may be offered health insurance from their employers, but may decline coverage due to unaffordable premiums and copayments.⁵³
- Research shows that a U.S. citizen child of undocumented parents is less likely to enroll in Medicaid due to the parents' fear of deportation.⁵⁴
- Latinos may use community clinics and hospital outpatient departments for healthcare because out-of-pocket costs tend to be lower compared to managed care or private health insurance.⁵⁵

Asian American Community Health Profile

THE UNITED STATES IS HOME TO MORE THAN 10 SUBPOPULATIONS OF ASIAN AMERICANS.⁵⁶

The Asian American community in the tri-county area is extremely diverse in language, and socioeconomic and health status. Tuberculosis, hepatitis, malaria, a variety of cancers, and diabetes are significant health issues affecting the Asian American community. Mental health is also an emerging and relatively unexplored health issue in this group. Language and cultural barriers along with a lack of access to health insurance are the key causes of health disparities for the Asian American population. Mistrust of providers, lack of experience with U.S. primary care, and providers' unfamiliarity with traditional Asian American health practices all combine to create barriers to care.

Language Barriers

One of the most significant barriers to care for Asian Americans is the language barrier.

- East and South Asian languages are grouped into multiple language families spreading over more than 20 Asian countries, with regional dialects creating even more diversity.⁵⁷ This is a challenge to healthcare providers, who may not be able to offer interpretation services that span all the potential languages and dialects of their Asian patients.⁵⁸
- Asian American patients often cite increased time in examinations caused by inefficient interpreter services or waiting times as a problem.⁵⁹
- English proficient family members of a patient often become involved in the consultation and examination when adequate interpreter services are unavailable.⁶⁰
- LEP may also correlate with poor health literacy, which can be a great barrier to care.⁶¹

Cultural Beliefs About Healthcare

With the diversity of the Asian American sub-populations come a wide variety of cultural practices and approaches to illness.

- Cultural values of politeness, respect for authority, and the avoidance of shame can change the dynamics of a visit with a provider. During examinations, some Asian American patients may avoid asking questions or interrupting the provider in order to maintain a level of respect, which can hinder communication with the provider and decrease the effectiveness of care.⁶²
- Some Asian Americans view suffering and illness as an inevitable part of life, and therefore may not seek healthcare services.⁶³
- For Southeast Asian immigrants, cultural beliefs about illness such as spiritual imbalances and illness as penalties for immoral behavior may affect how they view their conditions. Providers often do not appreciate or are insensitive to perceptions of causation of illness made by Asian Americans.⁶⁴
- In some Asian countries, healthcare is provided in a community setting that offers additional social supports as a complement to medical treatment, equivalent to the United States version of social services and consultations.⁶⁵

Generational Issues of Healthcare

Research has shown that Asian immigrant health tends to be better than the health of other recent immigrants and minority groups, which may be due to healthy behaviors such as good nutrition as well as strong family support systems. Asian immigrants tend to have a lower mortality rate that increases steadily with extended acculturation in the United States.⁶⁶

- Asian subgroups that already have a large community within the United States, such as Chinese, Filipinos, Japanese, Koreans, and South Asians, are more likely to get regular healthcare and experience fewer generational disparities.⁶⁷
- Members of the elder generation of Asian Americans often find themselves isolated in their homes due to language and culture barriers. This can lead to mental health issues such as depression and anxiety.⁶⁸
- Second-generation Asian Americans may be more adjusted to mainstream American culture and have health behaviors and attitudes that differ from their families.⁶⁹

Use of Traditional or Alternative Medicine

Traditional medicine plays a significant role in Asian culture, continues to be practiced by many Asian Americans, and may cause individuals to seek acute emergency care when their illnesses are in late stage for treatment.⁷⁰

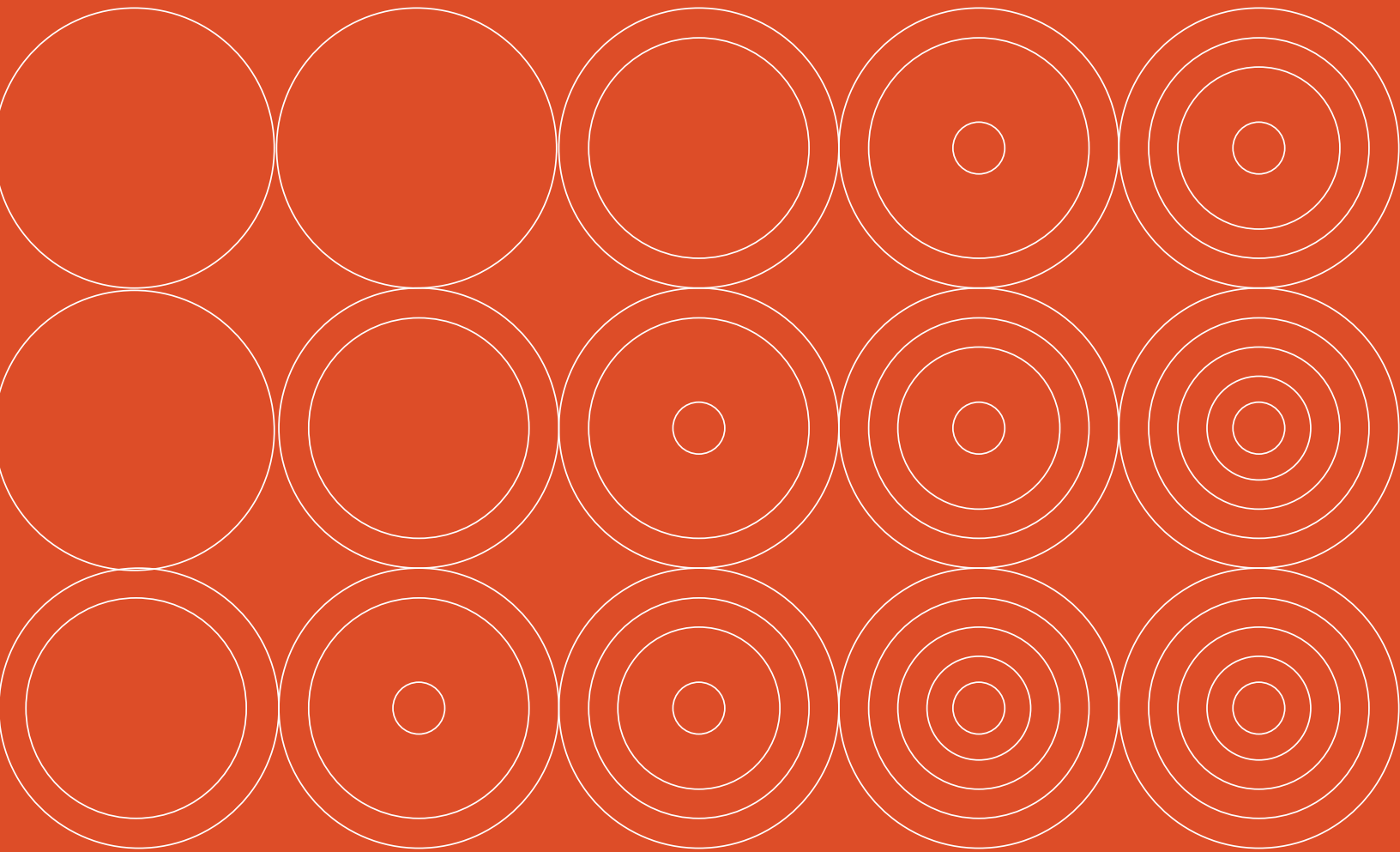
- Asian Americans may mistrust the Western medical system due to cultural discrepancies, language barriers, and provider dissatisfaction.⁷¹
- The high cost of healthcare, particularly for the uninsured, may also prompt some Asian Americans to use traditional remedies before seeking healthcare services.⁷²
- Some providers lack knowledge of traditional treatments among Asian cultures and therefore do not incorporate them into practice or consultation.⁷³
- Some Asian countries do not have family providers and thus the practice of primary care or the desired continuity of care is a new concept.⁷⁴
- In a research study, many Chinese Americans said that Western medical care is best for acute care, but Chinese medicine is best for health promotion, disease prevention, and recovery.⁷⁵

Health Insurance and Access to Care

Along with many other minority immigrants, immigration and insurance are intertwined issues that affect the health status of Asian Americans.

- Immigrants new to the country often have reduced access to insurance. Immigration status affects access to insurance with respect to public programs, but is not necessarily an issue when purchasing private insurance.⁷⁶
- Studies show that recent immigrants from Asia are less likely to visit physicians than other groups.⁷⁷
- For uninsured immigrants, preventative care is very difficult to access. Some Asian Americans, specifically Chinese Americans, have a pattern of family self-care, which decreases annual primary care examinations or preventative treatments.⁷⁸

Overview of Health Disparities



Overview of Health Disparities

IN TERMS OF HEALTHFUL BEHAVIORS, MARYLAND STRUGGLES TO REACH THE CDC'S GOAL of reducing the adult smoking rate to 12 percent. Seventeen percent of the Maryland population over age 40 are smokers and 33 percent are past smokers. African American men in Maryland are more likely to be tobacco users as compared to white and Latino men, but tobacco use for Latina women is higher than white and African American women. Obesity is also a great concern. In 2003, approximately \$1.5 billion in medical care spending was attributable to obesity-related illness in Maryland. Across the tri-county area, nearly two thirds of adults fall short of consuming the recommended five servings of fruit and vegetables daily and African American adults were more likely than others to be obese.

With respect to **access to healthcare**, national figures show that Latinos were three times more likely to be uninsured than whites, 2.5 times more likely to be uninsured than Asian Americans, and twice as likely to be uninsured as African Americans. In keeping with national trends, Maryland's non-elderly Latinos were much more likely to be uninsured relative to whites, African Americans, and Asian Americans. In addition to insurance coverage, access to physicians is a critical concern, and uneven access to care is seen in the tri-county region.

Ensuring **maternal and infant health** is a major public health goal, and yet there are significant disparities that exist at the beginning of life. In 2005, there were 74,880 live births in Maryland. In the tri-county area, the infant mortality rate for African Americans is more than two times as high as whites in Montgomery and Prince George's Counties. African American and Latina expectant mothers are more likely to be receiving Women, Infant, and Children benefits during their pregnancy than other groups, and to have had their delivery paid for by Medicaid. Across racial and ethnic groups, Latina expectant mothers are least likely to receive prenatal care in the first trimester; yet despite their decreased access to prenatal care, the infant mortality rate among Latinos was similar to whites.

Disparities in **children's health** are apparent across a variety of measures. In Maryland, the highest percentage of low-income, uninsured children under the age of 19 are African Americans, followed by Latinos, and whites. With the exception of whites, these percentages of uninsurance among Maryland children are higher than national percentages for the same racial and ethnic groups. In Maryland, the highest prevalence of childhood asthma exists among African Americans, where 17 percent of children have been diagnosed with asthma by a physician, compared to 15 percent of Latino children and 11 percent of white children.

Cancer is the second leading cause of death in Maryland. Lung cancer is the leading cause of cancer-related death for both men and women in Maryland—in the tri-county region African Americans have the highest rates of mortality from lung cancer. From 1997 to 2001, Maryland ranked fifth among states in its colorectal cancer mortality rate. Locally and statewide, the incidence of colorectal cancer in African

Americans is slightly higher than for whites. In the tri-county region, African American women have higher mortality rates for breast cancer despite lower rates of incidence when compared to white women. In Maryland, Asian American women have the highest rates of mortality from cervical cancer.

In 2006, an estimated 334,000 (7.9 percent) of Maryland adults had been diagnosed with **diabetes**, with another 143,000 estimated to have undiagnosed diabetes. Based on local survey data, African Americans have a higher prevalence of diabetes than whites. Diabetes patients are at risk of hospitalization for complications arising from the disease, such as low blood sugar or kidney failure, and the data show that African Americans had the highest rates of diabetes hospitalizations across all geographic areas.

Many Marylanders are affected by **heart disease and stroke**. In 2006, Prince George's County had the highest rate of hospitalized ischemic heart disease cases in the tri-county region. Asian Americans are nearly twice as likely to suffer from ischemic heart disease in Montgomery and Prince George's Counties as compared to Latinos. At the state level, African Americans of both genders report the highest prevalence rate of age-adjusted hypertension from 1997 to 2005 compared with whites, Latinos, and Asians. Across the tri-county area, Prince George's County had the highest rate of hospitalized stroke cases in 2006. Comparable to national trends, African Americans have higher mortality rates due to stroke in Frederick County, Prince George's County, and across Maryland.

In 2005, over 10 percent of all Marylanders reported being in poor **mental health**, and rates varied only slightly by race. In the tri-county region, rates of hospitalizations for certain mental conditions are highest among African Americans and whites. Research has also shown that African Americans are more likely to suffer from physical symptoms of depression than whites. Community advocates note particular concern about the lack of culturally competent mental health services available to the regions' minority populations.

African Americans comprised the majority of new **HIV and AIDS** cases from July 1, 2004 to June 30, 2005 in Montgomery and Prince George's Counties. In Maryland, African Americans are more likely to have been tested at confidential counseling, testing, and referral sites, comprising 68 percent of clients to such sites. The high rates of testing suggest that outreach efforts to African Americans and Latinos have been successful in facilitating testing.

Unintentional injuries can occur in the home, workplace, recreational settings, and elsewhere. White and African American residents of Prince George's County are twice as likely to die from unintentional injury compared to the same groups in Montgomery and Frederick Counties. Asian Americans had the lowest mortality rates across all three counties.

1. Healthful Behaviors

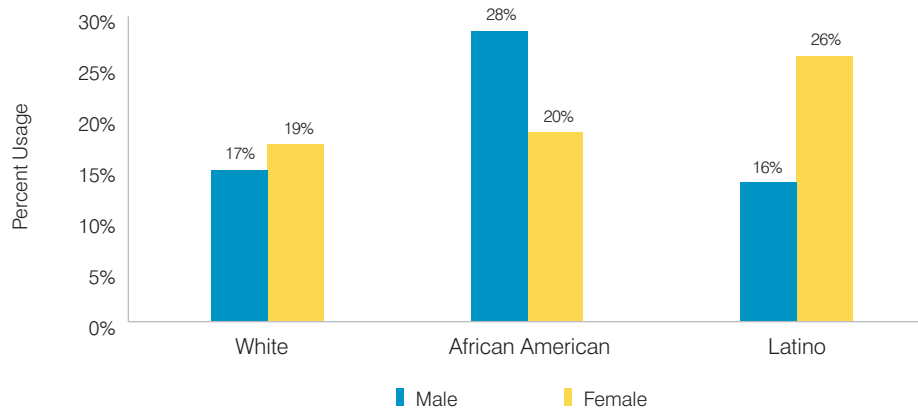
IN ITS DECENNIAL PUBLICATION, HEALTHY PEOPLE 2010, THE CDC DEVELOPED HEALTHY LIFESTYLE goals for all states, which included reducing the number of tobacco users, improving nutritional habits, and increasing physical activity. These healthful behaviors are known to reduce the risk of developing many acute and chronic conditions. For example, maintaining healthy eating habits significantly reduces the risk of developing obesity-related diseases such as heart disease, cancer, stroke, and diabetes.⁷⁹ These conditions not only decrease quality of life, but they also increase healthcare costs for individuals and society.

Smoking

Maryland struggles to reach the CDC's goal of reducing the adult smoking rate to 12 percent. Currently, 17 percent of the Maryland population over age 40 are smokers. Cigarette smoking and other tobacco use contributes to a variety of acute and chronic conditions including heart disease, stroke, cancer, and chronic obstructive pulmonary disease (COPD).⁸⁰

- African American men in Maryland are more likely to be tobacco users as compared to white and Latino men, but tobacco use for Latina women is higher than white and African American women (Figure 1.1).^a
 - » Several national studies suggest that smoking rates among Latino and Asian American immigrants increase with increased time in the United States.⁸¹ This implies a need for targeted interventions that counteract environmental factors that encourage increased tobacco use.

FIGURE 1.1. Adult Tobacco Use by Gender and Race, Maryland, 2003



Source: Behavioral Risk Factor Surveillance System (BRFSS), Center for Disease Control, 2003.

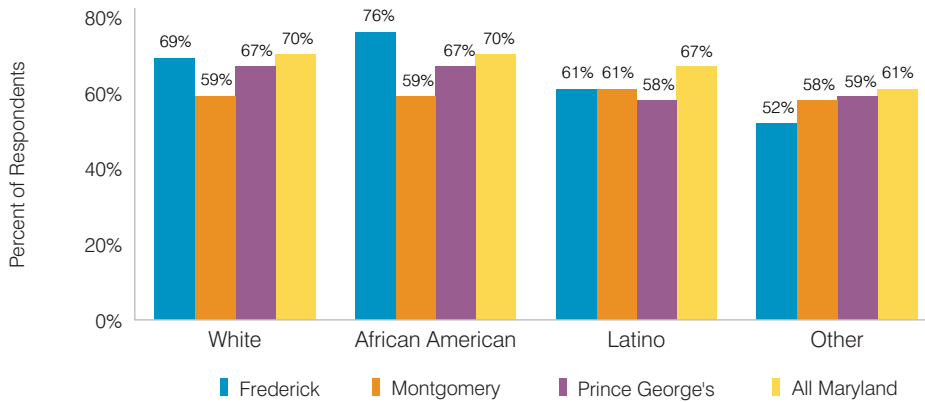
^aTobacco use includes cigarettes, cigars, pipe tobacco, and other forms.

Nutrition

In Maryland, obesity-related illness attributed approximately \$1.5 billion to 2003 medical care spending.⁸² According to recent data, nearly a quarter of Maryland’s adults are considered obese, and an additional 35 percent are considered overweight.^{b, 83}

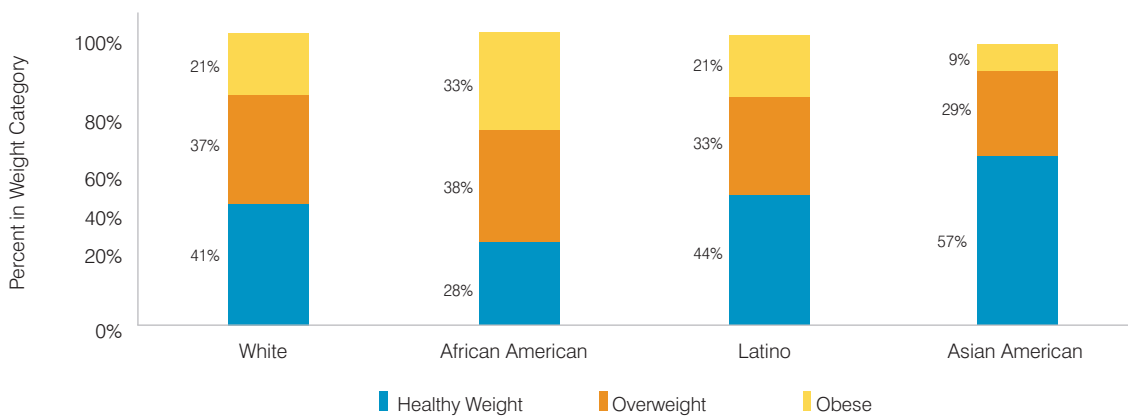
- Across the tri-county area, nearly two-thirds of adults fall short of consuming the recommended five servings of fruit and vegetables daily (Figure 1.2).
- African American adults are more likely than others to be obese (Figure 1.3).
 - » Asian Americans are most likely to be at a healthy weight compared to all other racial and ethnic groups.

FIGURE 1.2. Percent of Respondents Who Consume Less Than 5 Servings of Vegetables per Day, Tri-County, Maryland, 2003–2005



Source: Maryland Behavior Risk Factor Surveillance System, 2003–2005; Health Data for All Ages, Center for Disease Control Wonder Database, 2004–2006.

FIGURE 1.3. Percent of Obese Adults Aged 20+, by Body Mass Index, Maryland, 2003–2005



Note: Percentages may not add to 100 due to rounding.

Source: Maryland Behavior Risk Factor Surveillance System, 2003–2005; Health Data for All Ages, Center for Disease Control Wonder Database.

^b Obesity is defined as an excessively high amount of body fat or adipose tissue in relation to lean body mass. Overweight refers to increased body weight in relation to height, which is then compared to a standard of acceptable weight. Body mass index (BMI) is a common measure expressing the relationship (or ratio) of weight-to-height. Adults with a BMI of 25 to 29.9 are considered overweight, while individuals with a BMI of 30 or more are considered obese (definition from the Fund for America’s Health).

Physical Activity

Regular physical activity decreases the risk of hypertension, heart disease, obesity, diabetes, and other chronic conditions.

- The CDC's *Healthy People 2010* benchmarks include a goal that at least 30 percent of all adults over the age of 18 should engage in moderate physical activity five times per week or vigorous physical activity three times per week. According to the Maryland BRFSS, Maryland adults have met this goal as 40 percent of respondents from all races reported this level of physical activity; however, over 20 percent of adults are not active at all during their leisure time.⁸⁴
 - » In Maryland, the proportion of women who were physically inactive was higher among African American (32 percent) and Hispanic (31 percent) women compared to white women (21 percent).
 - » Physical inactivity is more prevalent among those individuals with less education and lower household income.⁸⁵

PROGRAM SPOTLIGHT: CASA DE MARYLAND

CASA DE MARYLAND IS A COMMUNITY BASED ORGANIZATION SERVING IMMIGRANT communities in the state of Maryland that advocates and practices the health promoter model. Originating in Latin America, the health promoter model addresses health disparities and prevention using a community-based approach, and has gained popularity in the United States as a means of reaching out to diverse communities. CASA's program includes 15 volunteers who receive an initial training of 25 to 30 hours on health promotion, health prevention, and the basic skills of a health promoter. The initial instruction is complemented by ongoing training on specific health topics of priority for the target population. These health promoters educate members of the community on nutrition, cardiovascular disease, diabetes, HIV/AIDS, cancer prevention, tobacco use prevention, and other health issues. The model is an effective approach to health prevention because it reaches individuals on a personal level in a way that is culturally and linguistically appropriate for the community.

2. Access to Care

AHRQ'S 2006 NATIONAL HEALTHCARE DISPARITIES REPORT DEFINES ACCESS TO HEALTHCARE AS the efficient and timely use of personal health services to obtain the best health outcomes.⁸⁶ This definition includes gaining access to sites of care delivery and the availability of treatment from providers who meet the needs of the individual patient in the context of a professional relationship based on mutual communication and trust. A wide and growing body of data suggests that minorities are more likely to face barriers in accessing care that meets this definition, and are less likely to find culturally competent care that acknowledges the relationship between individuals' cultural values and beliefs and their experience with the healthcare system.

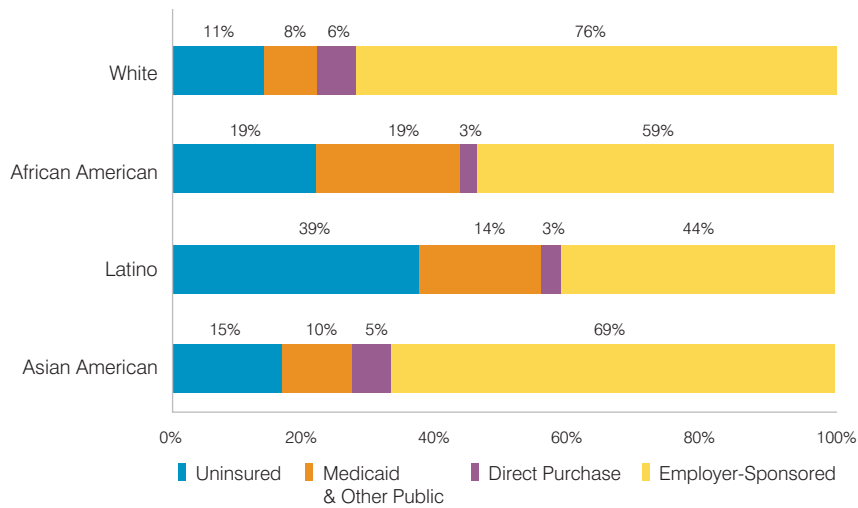
Health Insurance Coverage

Health insurance is an important predictor of access to care. Nationally, Latinos are three times more likely to be uninsured than whites, 2.5 times more likely to be uninsured than Asian Americans, and twice as likely to be uninsured as African Americans.⁸⁷

- Similar to national trends, Maryland's non-elderly Latinos are much more likely to be uninsured relative to whites, African Americans, and Asian Americans (Figure 2.1).^c
 - » Among the non-elderly, Latinos are the least likely to receive employer-sponsored insurance.
 - » In addition, African Americans and Latinos are more frequently covered by Medicaid than whites and Asian Americans.

^c Access to Medicare helps most elderly citizens access health insurance, however, there are immigrants and non-citizen elderly who are left out of this system.

FIGURE 2.1. Health Insurance Coverage of Non-Elderly, Maryland, 2004-2005



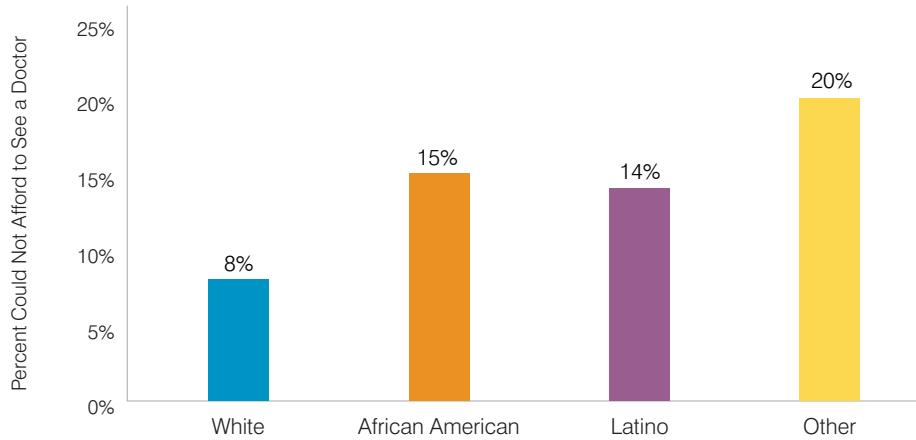
Note: Percentages may not add to 100 due to rounding.
 Source: Maryland Healthcare Commission. Health Insurance Coverage in Maryland through 2005.

Obtaining Care

Insurance status, cost-sharing, and lack of transportation may limit some individuals' ability to maintain continuity of care. In 2002, Latinos (33 percent), Asian Americans (27 percent) and African Americans (21 percent) were more likely than whites (15 percent) to lack a usual source of care.⁸⁸

- One factor that influences access to a consistent source of care is affordability. In Maryland, African Americans and Latinos are most likely to report that they were unable to afford to see a doctor in the past 12 months (Figure 2.2).

FIGURE 2.2. Percent of Maryland Residents Who Could Not Afford to See a Doctor in the Past 12 Months, Maryland, 2006



Source: Maryland Behavior Risk Factor Surveillance System, 2006.

Diversity and Supply of Health Professionals

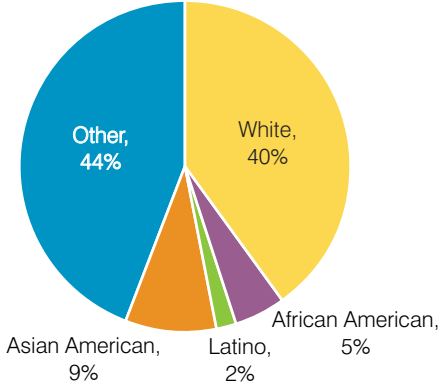
The Institute of Medicine report *Unequal Treatment* found racial and ethnic minority patients are generally more involved in their care and satisfied while seeking care from minority physicians and other providers. In Maryland, as elsewhere in the United States, the racial and ethnic makeup of the physician supply does not mirror the diversity in the population.

- As of 2006, whites comprised 40 percent of non-federal physicians in Maryland.^d The percentages of physicians in an American Medical Association (AMA) survey reporting their racial or ethnic background as Asian American, African American, or Latinos combined fall below 20 percent (Figure 2.3).^{e, 89}
 - » Furthermore, in 2005, 68 percent of Maryland medical school graduates were white. Asian Americans comprised 23 percent of graduates, while African Americans and Latinos made up only 5 and 3 percent respectively.⁹⁰ This suggests that the composition of the physician supply is not likely to dramatically shift in the near future.
- Montgomery County's physician to patient ratio is four times as high as Frederick County's or Prince George's County's, twice as high as Maryland, and three times the national average according to U.S. Census data. Furthermore, the dentist to patient ratio in Montgomery County is twice as high as its neighboring counties (Figure 2.4).
 - » This maldistribution has implications for access to care, particularly specialty care, in Frederick and Prince George's Counties.
 - » The supply of physicians is only one aspect of access as certain patients, such as those with Medicaid, may find that providers do not accept their health insurance.

^dNon-federal physicians are physicians working in the private sector.

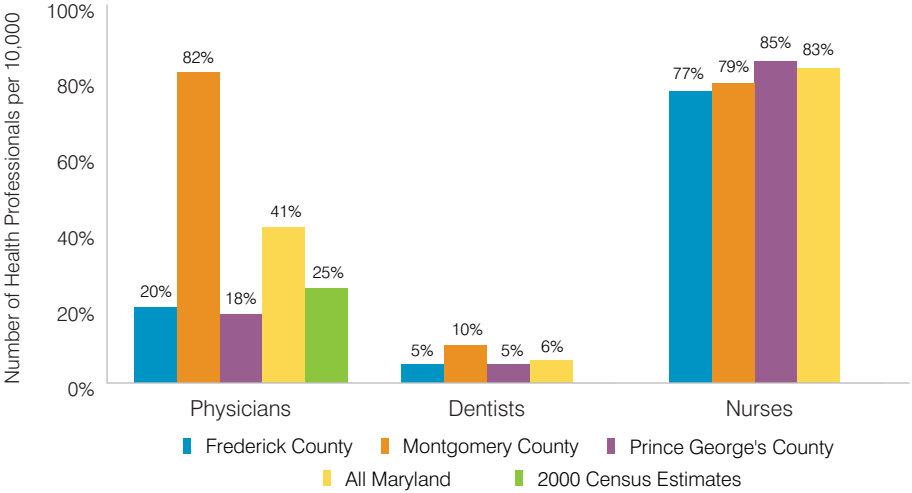
^eThe AMA survey may underreport the presence of minority physicians if those physicians were classified as "other" in this survey, which does not provide detail on the composition of that descriptor.

FIGURE 2.3. Non-Federal Physicians, Maryland, 2006



Note: "Other" includes non-reported.
Source: American Medical Association, Physicians Professional Data, 2006.

FIGURE 2.4. Health Professionals per 10,000, Tri-County, Maryland, 2005



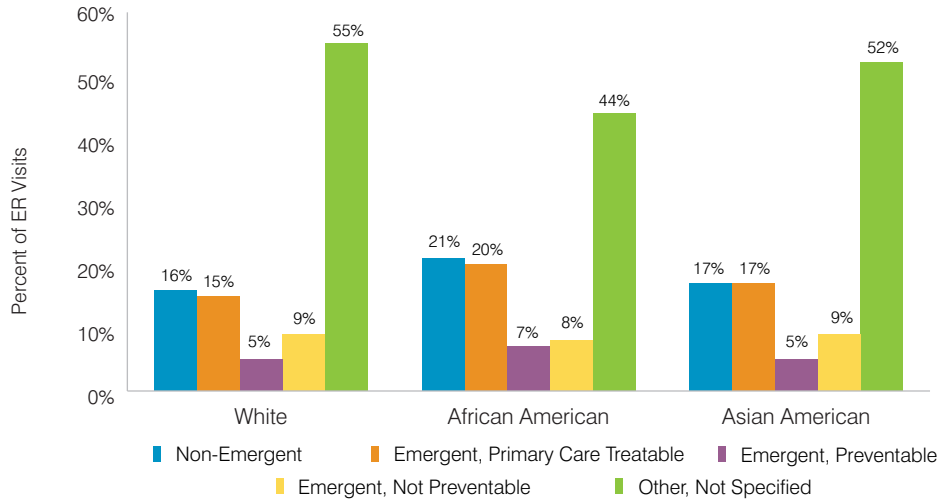
Note: Figures represent non-federal health professionals practicing in Maryland.
Source: Area Resource Files, 2005.

Healthcare Utilization Patterns

Poor health outcomes and increased healthcare costs are often the result of delays in the receipt of care. A high rate of emergency room (ER) visits suggests gaps in access to preventive care, routine care, and other avenues of regular treatment. Nationally, African Americans have a lower use of outpatient mental healthcare and outpatient HIV care but a higher use of ERs, hospitals inpatient mental health care, and inpatient HIV care.^{91, 92}

- A 2005 analysis of ER visits by race in Maryland demonstrate that many ER visits, particularly among African Americans, are for non-emergences or causes that can be treated in the primary care setting (Figure 2.5). This suggests that reduced access to primary care among African Americans may result in higher utilization of the ER.

FIGURE 2.5. Emergency Room Visits by Race, Maryland, 2005



Note: Emergency room utilization has been classified by Billings et al using four main categories: "Non-Emergent" indicates immediate medical care not required within 12 hours; "Emergent/Primary Care Treatable" indicates care was required within 12 hours but could have been safely provided in primary care setting; "Emergent/Preventable" indicates emergency department care was required but the emergent nature of the condition was potentially preventable with receipt of adequate ambulatory care; "Emergent/Not Preventable" indicates requirement of emergency department care and ambulatory care could not prevent the condition.

Source: Maryland Health Services Cost Review Commission, Hospital Discharge Abstract Data Base and Hospital Ambulatory Care Data Set.

PROGRAM SPOTLIGHT: MONTGOMERY CARES

MONTGOMERY CARES IS A PUBLIC/PRIVATE COLLABORATION THAT PROVIDES PRIMARY CARE TO low-income, uninsured, and ethnically diverse residents through non-profit community clinics. In fiscal year 2008, Montgomery County provided \$11.4 million to support Montgomery Cares. The Primary Care Coalition serves as the Montgomery Cares integrator and implementer, and 10 non-profit community clinics provide direct patient care. The 10 clinics are Community Clinic, Mobile Medical Care, Proyecto Salud, Mercy Health Center, People’s Community Wellness Center, Muslim Community Center, Community Ministries of Rockville, Holy Cross Clinic, Mary’s Center, and Under One Roof. The Primary Care Coalition also administers Care for Kids (CFK) that provides primary care to low-income, uninsured children who are not eligible for the Maryland Children’s Health Insurance Program (MCHIP). CFK providers include Kaiser Permanente, Community Clinic, Spanish Catholic Center, school-based health centers (3), and three private pediatric practices. Montgomery Cares and Care for Kids served 13,000 and 3,000 clients in fiscal year 2007.

3. Maternal and Infant Health

POOR ACCESS TO PRENATAL CARE AND POOR BIRTH OUTCOMES IN MARYLAND’S minority communities remain central issues of concern to health professionals, given persistent disparities and the effect of poor access and outcomes on subsequent health status. Nationally, the infant mortality rate is 13.6 deaths per 1,000 live births for African Americans, compared to 5.7 per 1,000 live births for whites.⁹³ Latina expectant mothers often receive prenatal care later than recommended, which may be a consequence of lower rates of insurance and other access barriers.⁹⁴ These varied issues across minority communities require multifaceted approaches by providers seeking to improve care for all.

Birth Rates

In 2005, there were 74,880 live births in Maryland. In the tri-county area, there were nearly 20,000 live births among African Americans, Latinas and Asian Americans. The birth rate for Latina mothers was the highest of the three groups across all three counties and for all of Maryland (Figure 3.1).

FIGURE 3.1. Number of Births and Birth Rate per 1,000 Population, Tri-County, Maryland, 2005

COUNTY	WHITE		AFRICAN AMERICAN		LATINO		ASIAN AMERICAN	
	#	BIRTH RATE	#	BIRTH RATE	#	BIRTH RATE	#	BIRTH RATE
Frederick	2,260	13.2	282	15.6	321	31.9	161	22.6
Montgomery	5,642	13.7	2,691	17.1	3,212	25.5	1,878	14.7
Prince George's	1,396	17.0	7,917	13.9	2,700	29.7	515	14.5
All Maryland	36,903	12.5	173	14.6	8,690	27.2	4,573	16.1

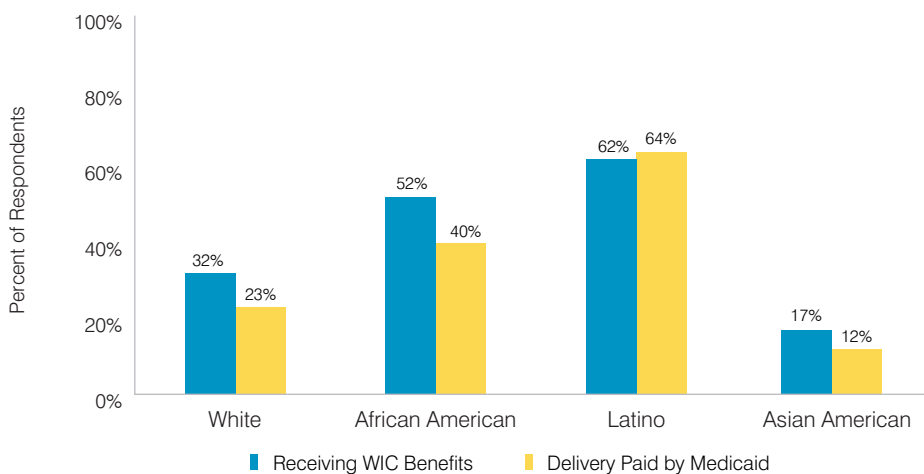
Source: Maryland Vital Statistics Administration, 2005.

Healthful Behavior and Challenges During Pregnancy

Not smoking, maintaining good nutritional habits, and adhering to other pregnancy guidelines are behaviors encouraged before and during pregnancy.⁹⁵ Data at the tri-county level is not available to examine some of these items, but statewide findings can help to illuminate some of the issues likely present in the tri-county area.

- According to the Maryland Pregnancy Risk Assessment Monitoring System (PRAMS), African American and Latina expectant mothers are less likely than non-Hispanic whites and Asian mothers to take a multivitamin during pregnancy.⁹⁶
- Also according to PRAMS, more Latina and African American mothers report abuse by a partner during pregnancy than other groups (11 and 7 percent respectively).
- African American and Latina expectant mothers are more likely to be receiving Women, Infant, and Children (WIC) benefits during their pregnancy than other groups (Figure 3.2).
 - » These mothers were also more likely to have had their delivery paid for by Medicaid.
- Minority PRAMS respondents did not report disparities in satisfaction with respect shown by staff during prenatal care, or smoking during pregnancy.
- Studies suggest that African American, Latina, and Asian American expectant mothers are at increased risk for developing gestational diabetes during their pregnancy.⁹⁷

FIGURE 3.2. Percent of Expectant Mothers Receiving WIC Benefits, Maryland, 2003



Note: Latinos may be double counted as PRAMS reporting system does not allow combined tabulations of race and ethnicity.

Source: Maryland Pregnancy Risk Assessment Monitoring System, 2003.

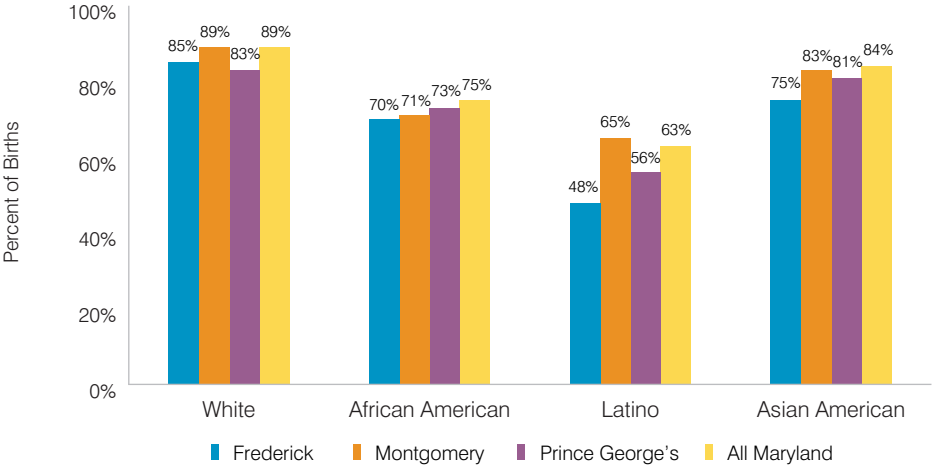
Receipt of Prenatal Care

Receipt of proper prenatal care is an important factor in birth outcomes. Ideally, prenatal care should begin in the first trimester of pregnancy, or better yet, discussed prior to conception.⁹⁸

- Across racial and ethnic groups, Latina expectant mothers are least likely to receive prenatal care in the first trimester. For example, Latina expectant mothers in Frederick County receive prenatal care in the first trimester less than half the time, while their white counterparts in the county receive prenatal care in the first trimester 85 percent of the time (Figure 3.3).
 - » In most geographic areas, Asian American expectant mothers received prenatal care early care at higher rates than their African American and Latina counterparts.

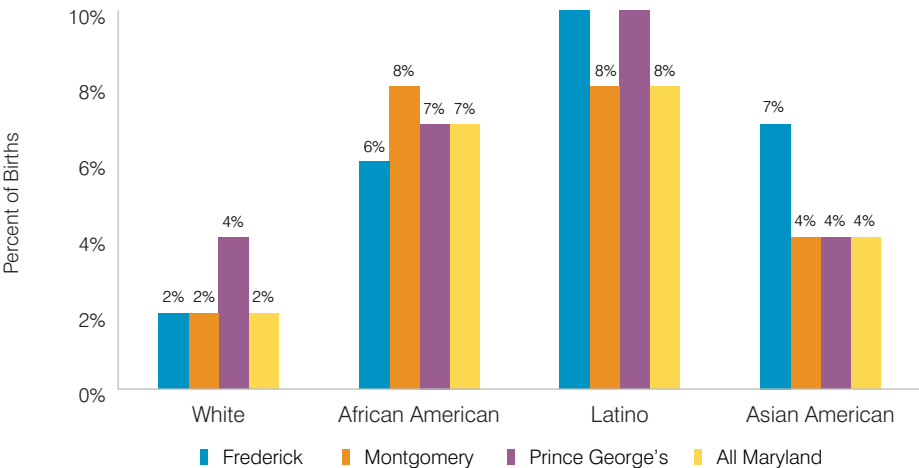
- Latina mothers in Maryland are also most likely to receive late or no prenatal care (Figure 3.4). This is possibly linked to a larger proportion of uninsured in the Latino community.

FIGURE 3.3. Percent of Births to Women Receiving Prenatal Care in the First Trimester, Tri-County, Maryland, 2005



Source: Maryland Vital Statistics Administration, 2005.

FIGURE 3.4. Percent of Births to Women Receiving Late or No Prenatal Care, Tri-County, Maryland, 2005



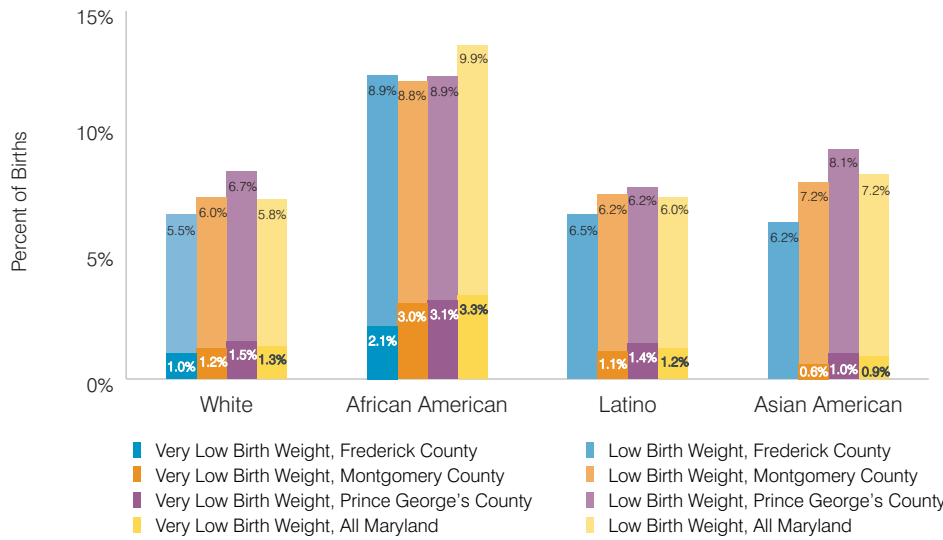
Source: Maryland Vital Statistics Administration, 2005.

Low Birth Weight

Low birth weight is an important measure of birth outcomes and is a key predictor of infant mortality.

- In Maryland, African American babies have the highest rates of low and very low birth weight (Figure 3.5).
 - » Rates of low and very low birth weight for Latinos and Asian Americans are close to rates for whites.

FIGURE 3.5. Percent of Low Birth Weight Births, Tri-County, Maryland, 2005



Notes: Low birth weight = Less than 2,499 grams but greater than 1,499 grams; Very low birth weight = 1,499 grams or less.
 Source: Maryland Department of Vital Statistics, 2005.

Infant Mortality

Infant mortality is an issue of major concern for African American community health advocates, as the infant mortality rate among African Americans is significantly higher than for any other racial or ethnic group.

- In the tri-county area, the infant mortality rate for African Americans is more than two times as high as whites in Montgomery and Prince George's Counties (Figure 3.6).
 - » Despite decreased access to prenatal care, the infant mortality rate among Latinos was similar to whites.

FIGURE 3.6. Infant Mortality Rate per 1,000 Live Births, Tri-County, Maryland, 2005

COUNTY	WHITE	AFRICAN AMERICAN	LATINO	ASIAN AMERICAN
Frederick	6.2	—	—	—
Montgomery	3.6	14.9	3.7	5.3
Prince George's	6.5	10.4	5.6	—
All Maryland	4.5	12.7	4.6	3.9

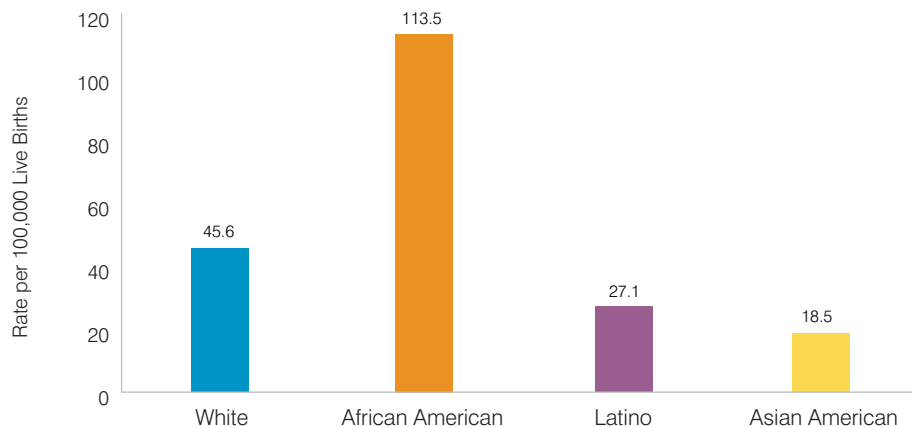
Note: Rates based on fewer than five events are not presented as they are likely to be unstable estimates.
 Source: Maryland Vital Statistics Administration, 2005.

Sudden Infant Death Syndrome (SIDS)

SIDS is a leading cause of infant mortality. Improper sleeping position has been linked to SIDS and local and national campaigns encourage caregivers to place infants on their backs when sleeping in order to lessen the risk of SIDS.⁹⁹

- In 2005, SIDS was the third largest cause of infant deaths for both African Americans and whites in Maryland; however, the rate of SIDS for African American infants is higher than the rate for whites. In 2005, the SIDS rate was 131 per 100,000 live births for African Americans, and 48.5 per 100,000 live births for whites.¹⁰⁰
 - » Nationally, SIDS rates for Latino and Asian infants are lower than for whites (Figure 3.7). It is important to note that disparities within the Latino population exist; for example, Puerto Ricans have higher rates of SIDS than Mexicans.¹⁰¹

FIGURE 3.7. SIDS Rate per 1,000,000 Live Births, United States, 2001



Source: National SIDS/Infant Death Resource Center, 2001.

PROGRAM SPOTLIGHT: AFRICAN AMERICAN HEALTH PROGRAM

IN 1999, MONTGOMERY COUNTY OFFICIALS RECOGNIZED THAT THE INFANT MORTALITY RATE FOR blacks in the county was much higher than that of whites. This health outcome was the major impetus for the establishment of the African American Health Program (AAHP). One of AAHP's major initiatives is the Black Babies SMILE (Start More Infants Living Equally Healthy) program. The major component of this program is a home visiting case management program for high-risk mothers, which is open to all African American/black mothers and is not restricted by socioeconomic or insurance status. The mothers are seen from the time they enter the program (typically during pregnancy) until their baby is one-year-old. The numbers of visits are based on the needs of the clients, but at minimum mothers are provided one visit per month. The program is staffed by two nurses. In addition to the Black Babies SMILE program, AAHP provides child birth classes, breastfeeding education, crib and car seat education, and instructions on safe infant sleeping positions.

4. Children’s Health

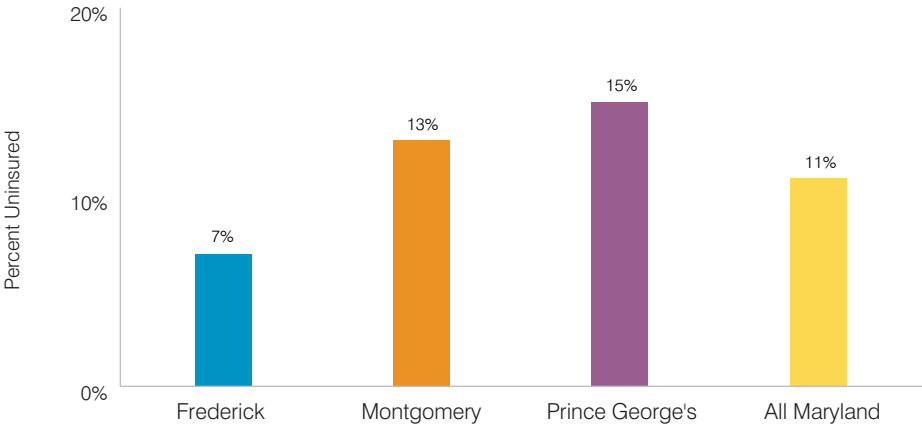
STATE AND LOCAL POLICY MAKERS CAN MAKE A SIGNIFICANT LONG-TERM IMPACT IN improving the health and well-being of communities by focusing on the health needs of children. Keeping children healthy sets them on track to lead healthy lives and can prevent the development of chronic diseases, whose rates are increasing as childhood obesity becomes more widespread.

Health Insurance Coverage

A review of the literature on racial and ethnic disparities in the primary care experiences of children found African American and Latino adolescents made fewer doctor visits in the last year compared to whites and lacked continuity between sources of care, after controlling for health insurance, family income, need, and other socio-demographic factors.¹⁰² Non-English speaking families were less likely than English-speaking families to report a regular source of care for their children.

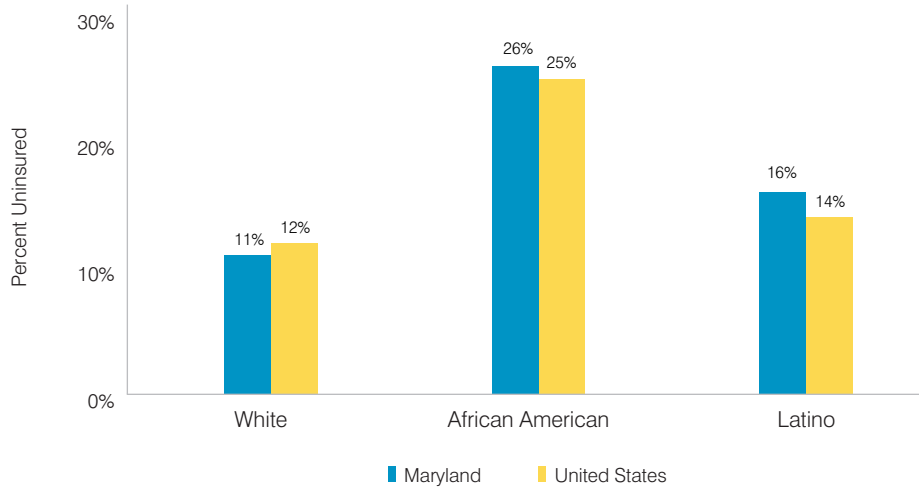
- The AHRQ Consumer Assessment of Health Plans Survey (CAHPS) showed that Asian American, African American and Latino parents had more negative views of primary care features including timeliness of care, provider communication, staff helpfulness, and rating of providers.¹⁰³
- Across Maryland, the highest percentage of low-income, uninsured children under the age of 19 are African Americans, followed by Latinos and whites. With the exception of whites, these percentages among Maryland children are higher than national percentages for the same racial and ethnic groups (Figure 4.2).

FIGURE 4.1. Uninsured Children Under Age 18, Tri-County, Maryland, 2000



Source: Census 2000, Small Area Health Insurance Estimates.

FIGURE 4.2. Uninsured Children Under Age 19 and Under 300 Percent of Poverty, Maryland, United States, 2004–2005



Note: 300 percent of the poverty level was \$59,913 for a family of four in 2005. Data not available for Asian Americans.

Source: Kaiser Commission on Medicaid and the Uninsured, Insurance Coverage of Children by Race/Ethnicity and Poverty Level, 2005: National and State Level Estimates.

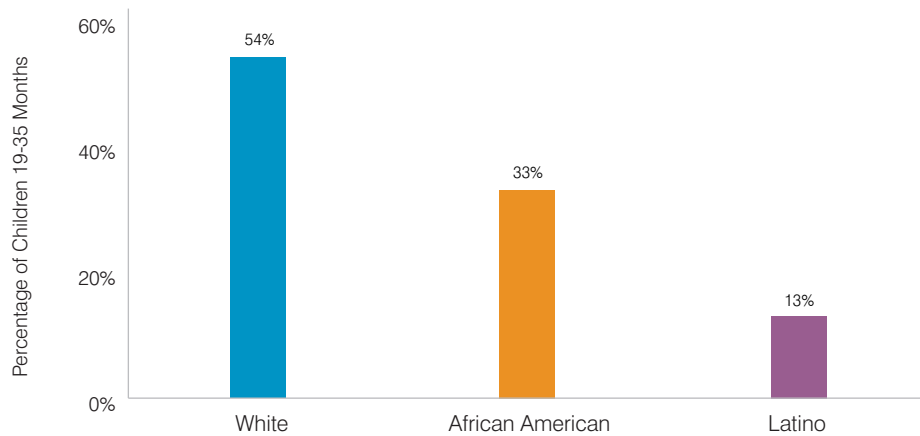
Immunizations

Keeping immunizations up-to-date is essential to prevent children from contracting many infectious diseases, such as polio and measles. Potential explanations for the vaccination coverage disparity are access barriers such as lack of insurance. Other factors may include competing priorities and incomplete understanding of the importance of immunizations.

- The 2005 National Immunization Survey found that only one-third of African American children ages 19 to 35 months had adequate vaccination coverage and only 13 percent of Latino children had adequate vaccination, while over half of white children were adequately covered.^f
 - » African American children in Maryland have far higher levels of coverage than the national average for African American children (33 percent compared to 14 percent respectively).
 - » Latino children in Maryland have far less coverage than the national average for Latino children (13 percent compared to 29 percent respectively).

^f Adequate vaccine coverage is defined as being up-to-date on all of the vaccinations recommended for a particular age group.

FIGURE 4.3. Percent of Vaccination Coverage Among Maryland Children 19–35 Months, 2005



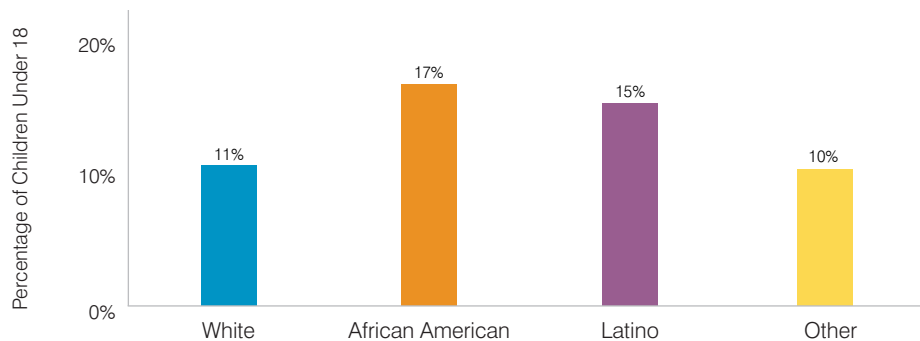
Note: Data not available for Asian Americans.
 Source: National Immunization Survey, 2005.

Asthma

Asthma is the most common chronic disease in childhood and one of the most common reasons for children’s hospital admissions. In 2002, 12 percent of all children in the United States had been diagnosed with asthma during their lifetime. Families who live in low-income neighborhoods are more likely to be exposed to high levels of pollutants, which can cause asthma or exacerbate a pre-existing condition.¹⁰⁴ Given higher rates of childhood poverty in some minority communities, minority children are at greater risk for exposure to these asthma-causing pollutants.

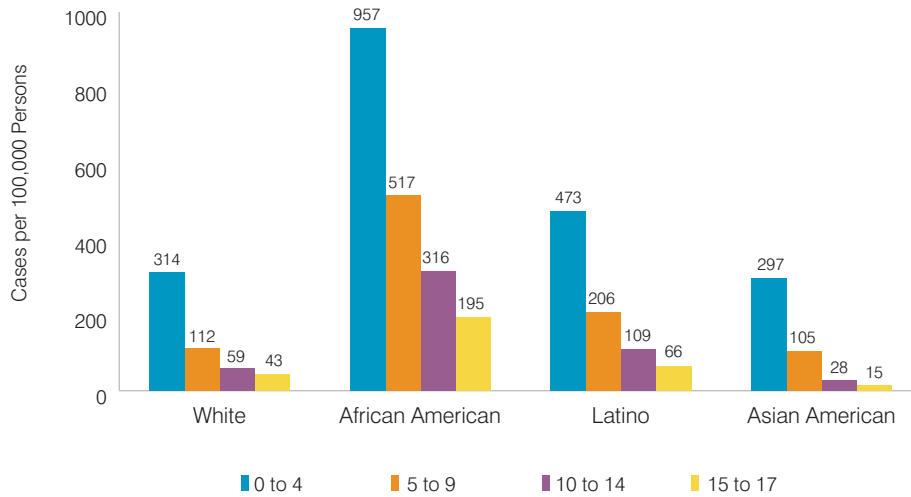
- In Maryland, the highest prevalence of childhood asthma exists among African Americans, where 17 percent of children have been diagnosed with asthma by a physician, compared to 15 percent of Latino children and 11 percent of white children (Figure 4.4).
- Nationally, African American children have the highest levels of hospital admissions for asthma. Asian American children have the lowest levels of asthma admissions (Figure 4.5).

FIGURE 4.4. Pediatric Asthma Prevalence in Maryland, 2006



Note: Data not available for Asian Americans, may be included in “Other”.
 Source: Maryland Behavior Risk Factor Surveillance System, 2006.

FIGURE 4.5. Pediatric Asthma Admissions per 100,000, by Age Group, 2003



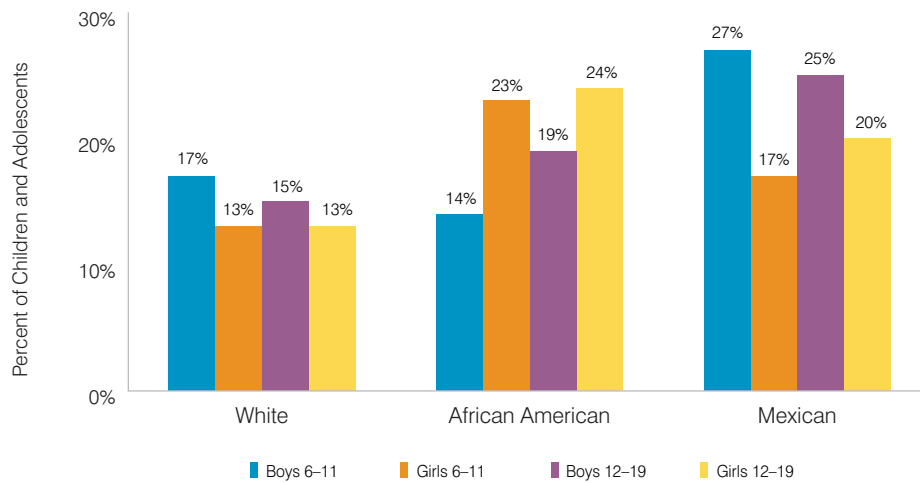
Source: Agency for Healthcare Research and Quality, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, State Inpatient Databases, Disparities Analysis File, 2003.

Childhood Obesity

According to the CDC, overweight children are more at risk than children of normal weight to be overweight or obese as adults. Overweight children are also at a higher risk of developing a number of related health problems, such as heart disease, type 2 diabetes, stroke, some cancers, and osteoarthritis.¹⁰⁵ Research indicates that for both adults and children, type 2 diabetes is more common among African Americans and Latinos than among whites.¹⁰⁶

- National data show that the number of children who are overweight is increasing across genders, age groups, and racial and ethnic groups (Figure 4.6).
- Research indicates that socioeconomic status (SES) may be a contributing factor to childhood obesity. For example, children whose only meals are the free or reduced breakfast and lunch they receive at school may not be getting all the nutrients they need. Low-income families may not be able to afford healthy alternatives to fast food and other unhealthy foods, or may simply live in neighborhoods where the grocery stores are not stocked with healthful foods.¹⁰⁷

FIGURE 4.6. Overweight Children and Adolescents in the United States, 1999-2002⁹



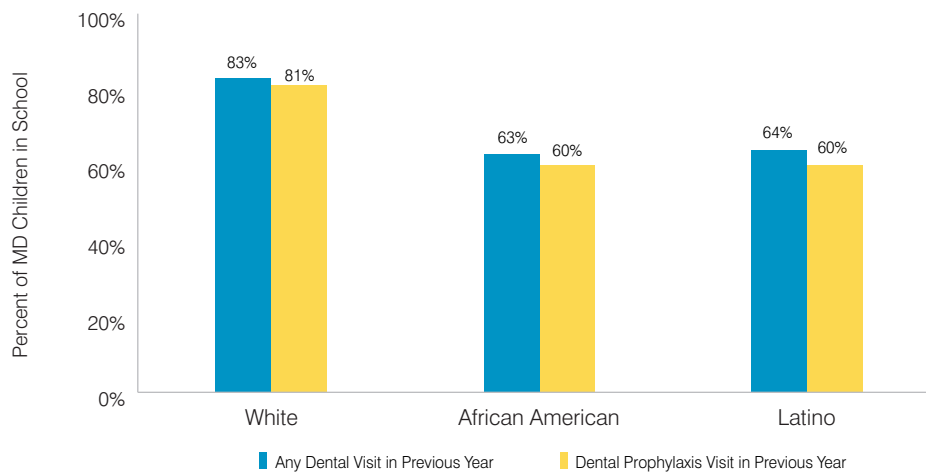
Note: Data not available for Asian American.
 Source: National Health and Nutrition Examination Survey.

Dental Care

In *Healthy People 2010*, the CDC called for reducing the disparity among low-income children receiving preventative dental services. The disparity in children’s dental care can be partially attributed to a lack of access to dentists and dental hygienists; many low-income communities do not have enough of these professionals, or they may not accept certain insurance carriers such as Medicaid.

- Across the state of Maryland, white schoolchildren receive dental care, including preventive visits, at higher rates than African American or Latino schoolchildren (Figure 4.7).

FIGURE 4.7. Dental Visits Among Maryland Schoolchildren, 2005



Source: Macek, M.D., et al. "Dental Visits and Access to Dental Care Among Maryland Schoolchildren." *JAMA*. April 2005.

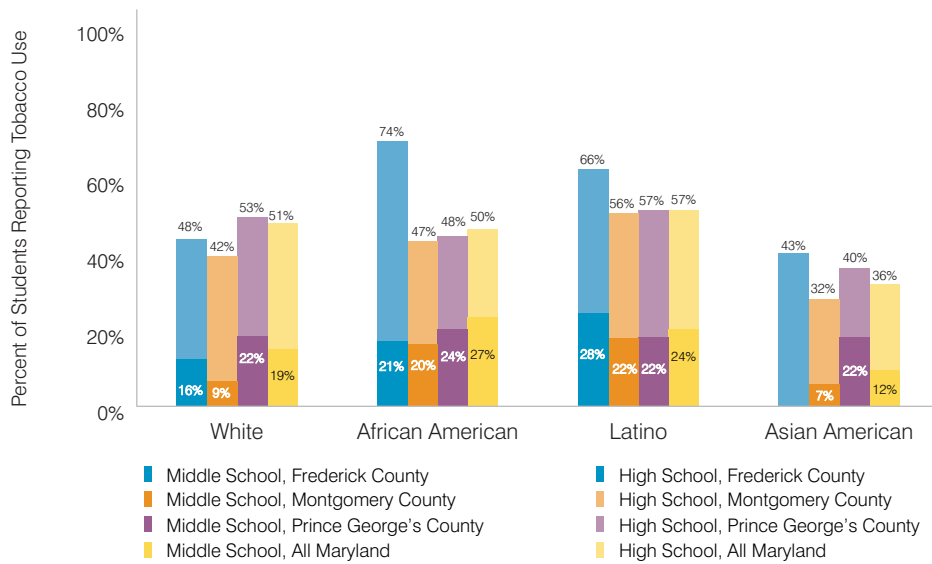
⁹ Overweight is defined as body mass index (BMI) at or above the sex-and age-specific 95th percentile BMI cutoff points from the 2000 CDC Growth Charts: United States.

Drug and Alcohol Abuse

National, state, and local policy makers grapple with the problem of substance abuse among teenagers. Health professionals view tobacco as a “gateway” drug for other addictions; in other words, teens who start using tobacco may be more inclined to start abusing other drugs and/or alcohol.¹⁰⁸

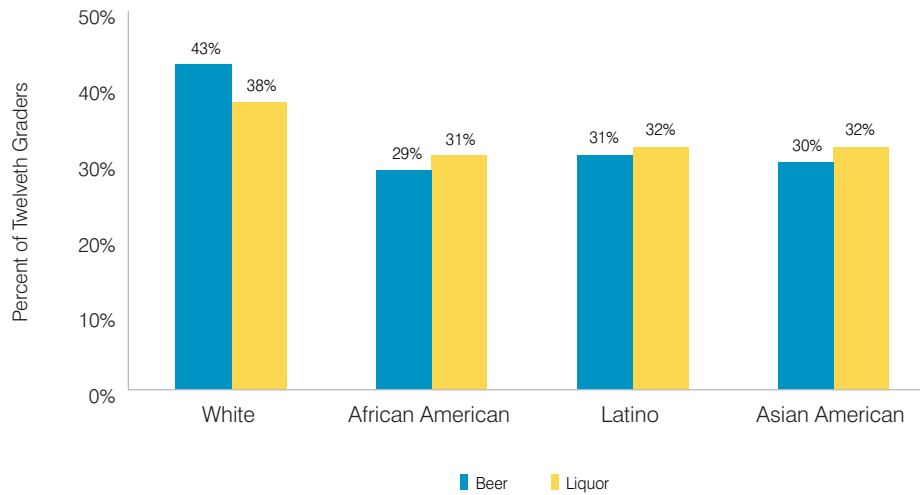
- Tobacco use is very common among high school students, but there are significant numbers of middle school students who have tried various forms of tobacco (Figure 4.8).
 - » Latino high school students are more likely to have used tobacco than their counterparts, while Asian American students are least likely to have ever used tobacco.
 - » In Frederick County, 21 percent of African American middle school students reported ever having used tobacco, while 74 percent of African American high school students in the same county reported ever having used tobacco.
- According to the 2004 Maryland Adolescent Survey, white high school seniors report higher frequent use of both beer and liquor than their African American, Latino, and Asian American peers. (Figure 4.9).

FIGURE 4.8. Youth Reporting Ever Having Used Tobacco, Tri-County, Maryland, 2002



Source: Maryland Youth Tobacco Survey, 2002.

FIGURE 4.9. Alcohol Abuse Among Maryland Twelfth Graders, 2004



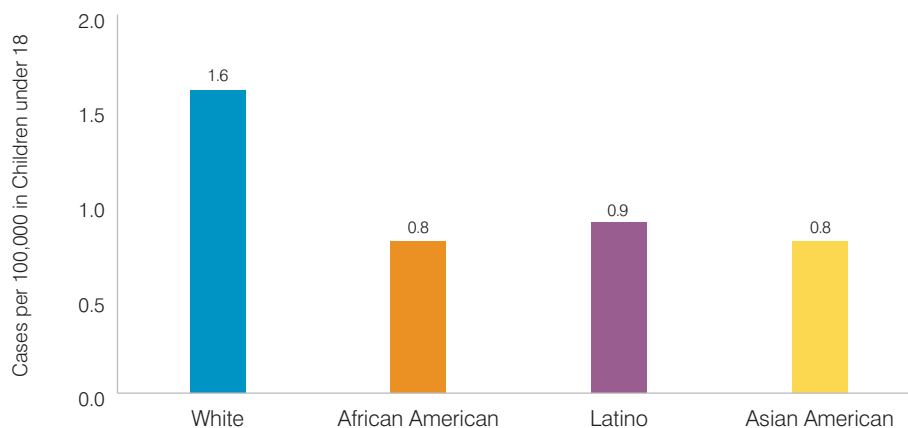
Source: Maryland Adolescent Survey, 2004.

Childhood Injury: Suicide and Homicide

Suicide rates often illustrate underlying mental health issues facing young people, while homicide rates suggest violent environments.

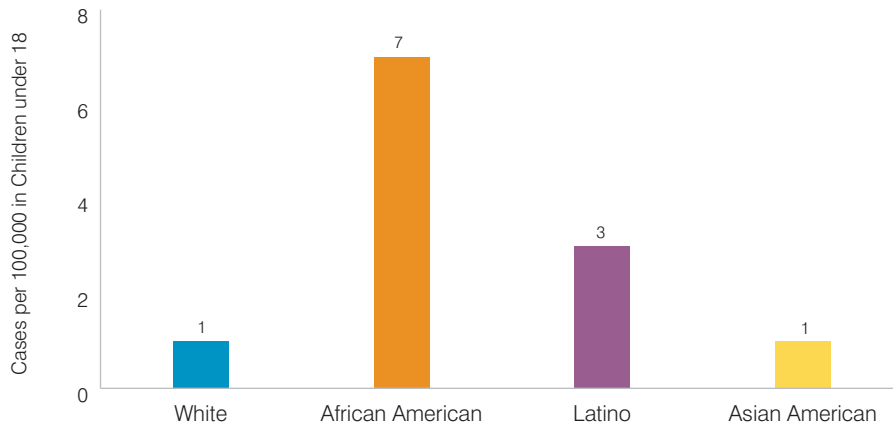
- Suicide among young people is a serious problem. National data show that across racial and ethnic groups, the rate of suicide among whites ages 0 to 17 is nearly twice that as for racial and ethnic minorities (Figure 4.10).
 - » Mental health professionals should pay close attention to the special needs of young people of all backgrounds.
- In contrast, the greatest rate of child and adolescent homicides occur among African Americans ages 0 to 17, a rate that is markedly higher than for other groups (Figure 4.11).

FIGURE 4.10. Child and Adolescent Suicide, United States, 2002–2004



Source: CDC National Center for Health Statistics, Health Data for All Ages.

FIGURE 4.11. Child and Adolescent Homicide, United States, 2002-2004



Source: CDC National Center for Health Statistics, Health Data for All Ages.

PROGRAM SPOTLIGHT: PRINCE GEORGE'S CHILD RESOURCE CENTER

THE PRINCE GEORGE'S CHILD RESOURCE CENTER'S (PGCRC) HEALTHY FAMILIES PROGRAM AIMS to prevent child abuse and neglect in families. This home visit program serves first-time expecting mothers under age 25 with the upcoming birth and up to the fifth year. Eight trained home visiting staff supported more than 65 families in the past year. The program creates a long-term support system for the family through education, connection to community resources including medical assistance, and performing regular child development assessments.

5. Elder Care

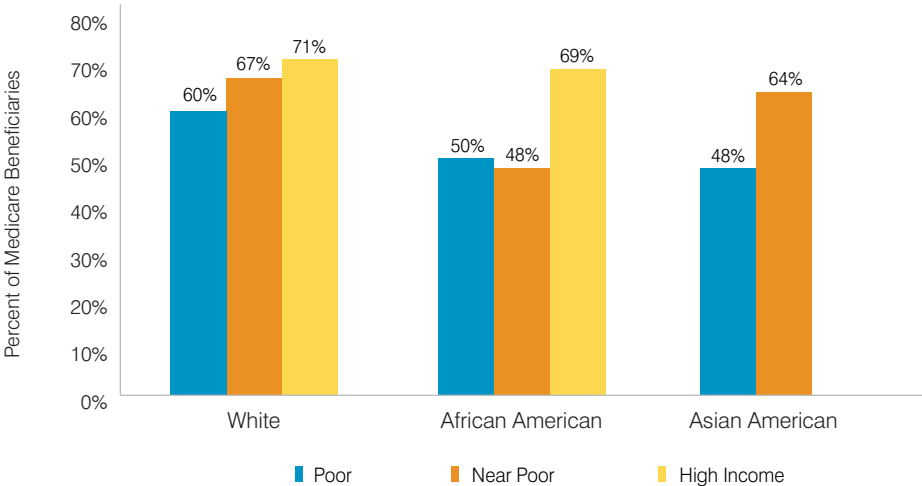
THE POPULATION OF THE UNITED STATES IS AGING RAPIDLY. AHRQ ESTIMATES THAT BY THE year 2030, the elderly population (those over age 65) will account for one in four Americans. Disparities tend to persist as subpopulations age, and with the overall aging of our population, we can expect to see increased numbers of aged citizens experiencing significant disparities in health status and access.

Diseases Affecting the Elderly

As people age, they become more susceptible to disease, so ensuring the health of the elderly requires special attention to both sub-acute and acute conditions, such as respiratory disorders and certain types of cancer.

- Across all income groups, African Americans and Asian Americans lag behind whites in the numbers of Medicare beneficiaries who are vaccinated against pneumonia, a serious disease afflicting the elderly (Figure 5.1).

FIGURE 5.1. Medicare Beneficiaries Who Ever Had Pneumonia Vaccination by Race and Ethnicity and Income, 2000



Note: The MCBS definition of poverty is based on the income of the individual and spouse and excludes income from others in the household. This results in a larger population being defined as poor than what is reported by the US Census. The poor include people with income less than 100% of the poverty line, including negative income. The near poor include people with income from 100% to less than 125% of the poverty line.

Source: Medicare Current Beneficiary Survey, 2000.

Institutional Care

As of June 2007, there are 1.4 million nursing home residents across the country, with more than 25,000 residents in Maryland.¹⁰⁹ As the aged population grows and lives longer, the number of persons needing nursing home care is expected to grow. Research indicates that disparities exist in long-term care facilities; nursing facilities that serve primarily low-income persons on Medicaid may not have as many resources as other long-term care facilities, may be disproportionately located in low-income communities, and are more likely to serve African American residents.¹¹⁰ These national trends may serve to inform policymakers in the tri-county area.

PROGRAM SPOTLIGHT: CHINESE CULTURE AND COMMUNITY SERVICE CENTER

THE CHINESE CULTURE AND COMMUNITY SERVICE CENTER (CCACC) OFFERS SOCIAL and cultural activities for the area's Chinese elders. In the 1990s CCACC started offering senior services after recognizing that many seniors were socially isolated due to lack of transportation and limited English proficiency. CCACC plans to expand its senior services to include an adult day healthcare center. This center, expected to be launched in November 2007, will be located in northern Rockville and will provide primary care services in addition to social components. The program will be qualified for Medicaid reimbursement. CCACC hopes to have the participation of 30 clients in the first year of operation.

6. Cancer

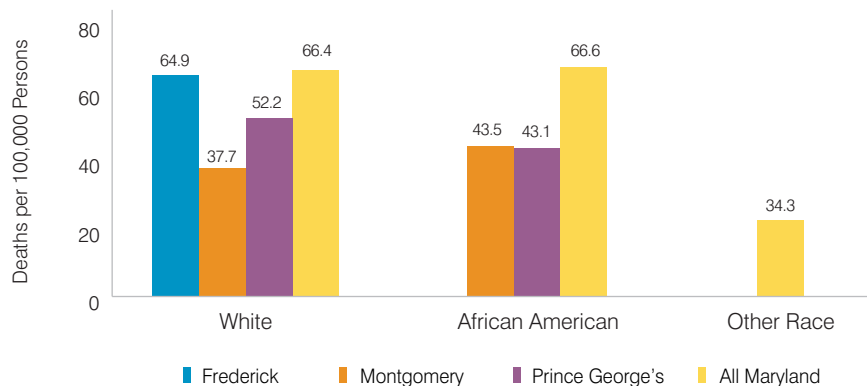
ACCORDING TO THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, cancer is the second leading cause of death, accounting for a quarter of all deaths among all Marylanders.¹¹¹ Cancer is the leading cause of death between the ages of 35 and 74. African Americans are most likely to die from lung, prostate, breast, and colorectal cancers compared to other race groups. Amongst minority women across the Maryland tri-county area, African Americans have the highest breast cancer incidence and mortality rates. In addition, Asian American women are most likely to die from cervical cancer. Screening and maintenance of other healthy behaviors can prevent many cancers, or identify them at an early stage, when treatment is most successful.

Lung Cancer

Lung cancer is the leading cause of cancer-related death for both men and women in Maryland. Data indicates that Maryland residents do not meet the *Healthy People 2010* objectives for lung cancer risk factors such as smoking, fruit and vegetable consumption, or healthy body mass index.

- In Maryland, lung cancer incidence is comparable between whites and African Americans; however, lung cancer among residents classified as “other” is much lower (Figure 6.1).^h
- In the tri-county area, African Americans have the highest rates of mortality from lung cancer (Figure 6.2).

FIGURE 6.1. Lung Cancer Incidence Rate per 100,000 Residents, Tri-County, Maryland, 1998–2002ⁱ

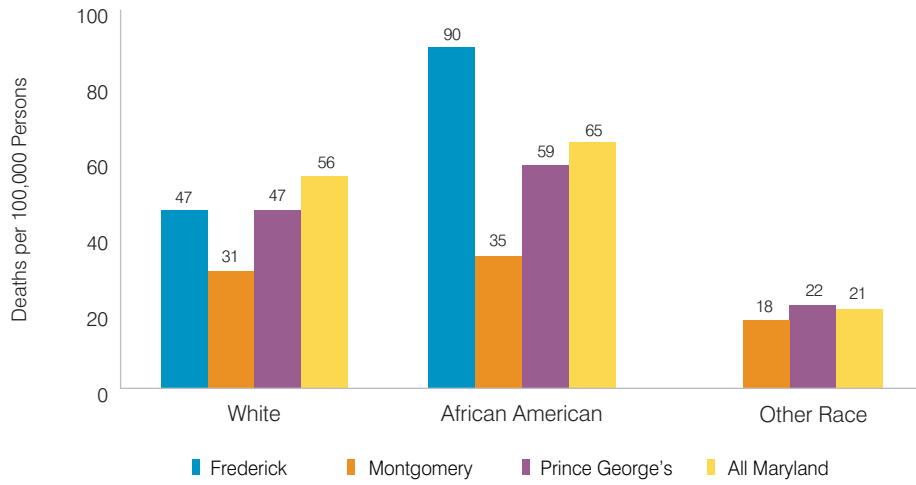


Source: Maryland Cancer Registry, 2006.

^h Definition of other includes Latinos of all races, Asian Americans, bi-racial/multi-racial, and other racial and ethnic categories. Data for these groups are not available disaggregated by specific group.

ⁱ For most cancer data, disaggregated incidence and mortality was unavailable for Latinos and Asian Americans.

FIGURE 6.2. Lung Cancer Mortality Rate per 100,000, Tri-County, Maryland, 2002



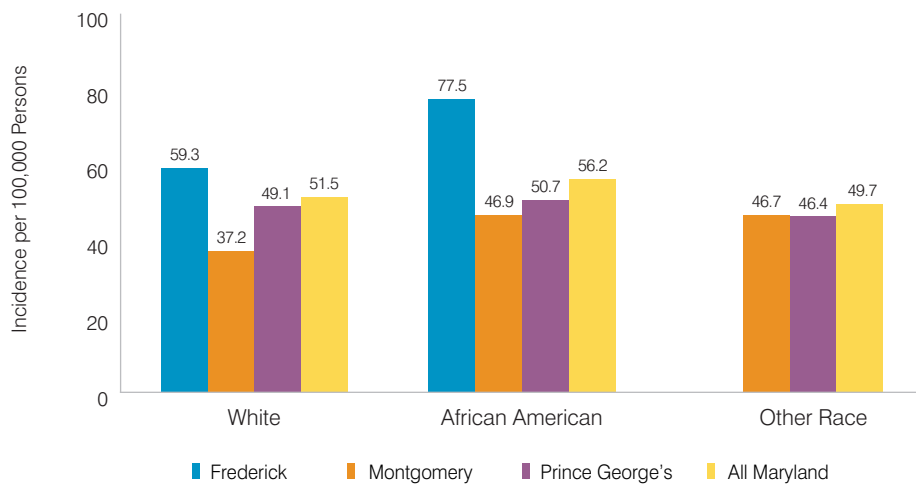
Source: Maryland Cancer Registry, 2006.

Colorectal Cancer

From 1997 to 2001, Maryland’s colorectal cancer mortality rate ranked fifth among states. Colorectal cancer is largely preventable with screening tests which find precancerous growths early enough to either cure or prevent further growth with surgery.¹¹²

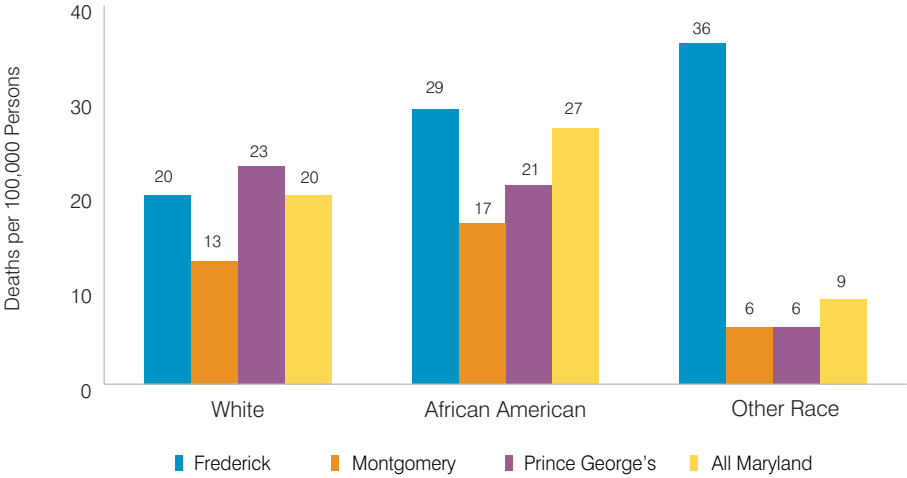
- In the tri-county area and in Maryland, the incidence of colorectal cancer in African Americans is higher than for whites (Figure 6.3).
- African Americans in the state generally have the highest rate of mortality for colon cancer compared to others (Figure 6.4).

FIGURE 6.3. Colorectal Cancer Incidence Rate per 100,000, Tri-County, Maryland, 1998-2002



Source: Maryland Cancer Registry, 2006.

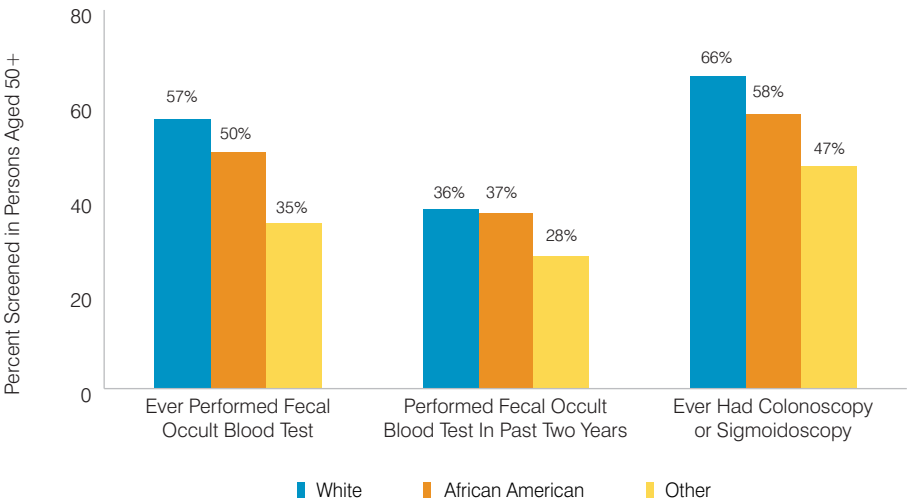
FIGURE 6.4. Colorectal Cancer Mortality per 100,000, Tri-County, Maryland, 2002



Source: Maryland Cancer Registry, 2006.

- Women are more likely to have ever had a screening fetal occult blood test (FOBT) for colorectal cancer than men. Whites are more likely to ever have had an FOBT as compared with African Americans and members of other racial groups (Figure 6.5).

FIGURE 6.5. Percent Aged 50+ Participating in Colorectal Cancer Screening, Maryland, 2004



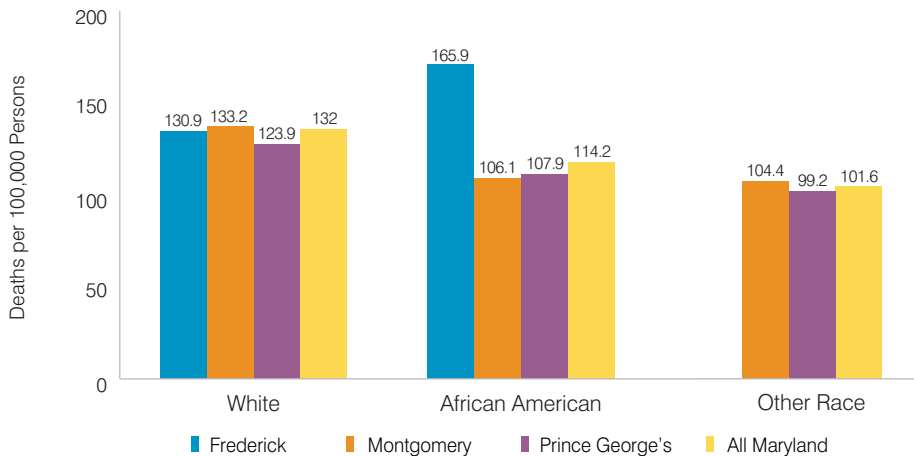
Source: Maryland Cancer Survey, 2004.

Cancers Affecting Women

Breast cancer is the second leading cause of cancer mortality in women, with mortality rates for African American women being disproportionate to incidence in that population. Cervical cancer disproportionately affects Asian American women, who have the lowest rates of cervical cancer screening and experience the highest mortality rates.¹¹³ Researchers have also documented racial and ethnic disparities in cancer treatment. Several studies report that white women were more likely to have a combination of chemotherapies and surgical interventions for a variety of female cancers.¹¹⁴

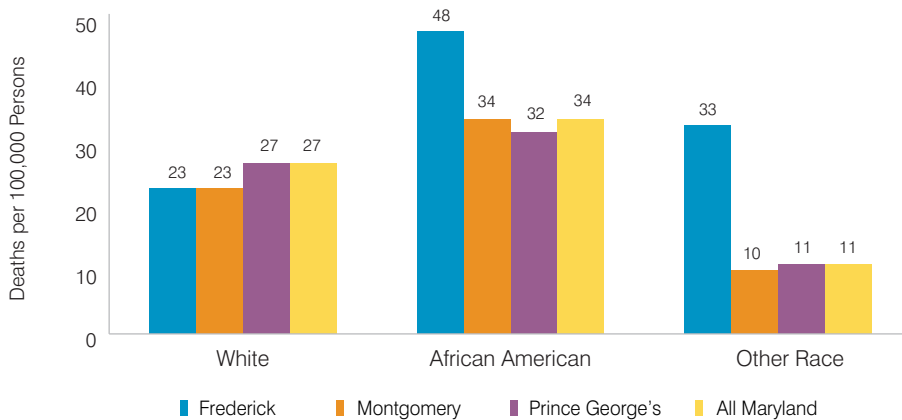
- In the tri-county area, white women have higher incidence rates for breast cancer than women of other races. The rate of mortality from breast cancer however is highest for African American women (Figures 6.6 and 6.7). Factors such as lack of screening, delay of entry into treatment, and encountering more aggressive forms of cancer contribute to this disparity.
- In Maryland, the mortality rate for cervical cancer is higher in African Americans, Latinos, and Asian Americans than in whites (Figure 6.8). Data on incidence of cervical cancer by jurisdiction is not available.

FIGURE 6.6. Breast Cancer Incidence Rate per 100,000, Tri-County, Maryland, 1998–2002



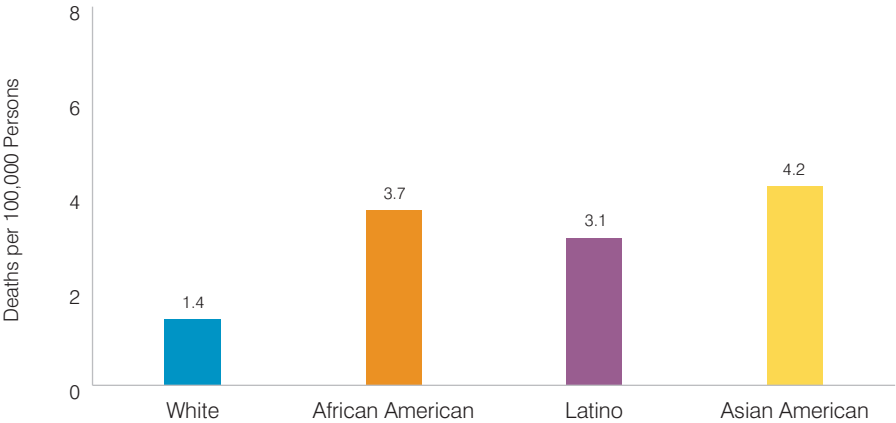
Source: Maryland Cancer Registry, 2006.

FIGURE 6.7. Breast Cancer Mortality per 100,000, Tri-County, Maryland, 2002



Source: Maryland Cancer Registry, 2006.

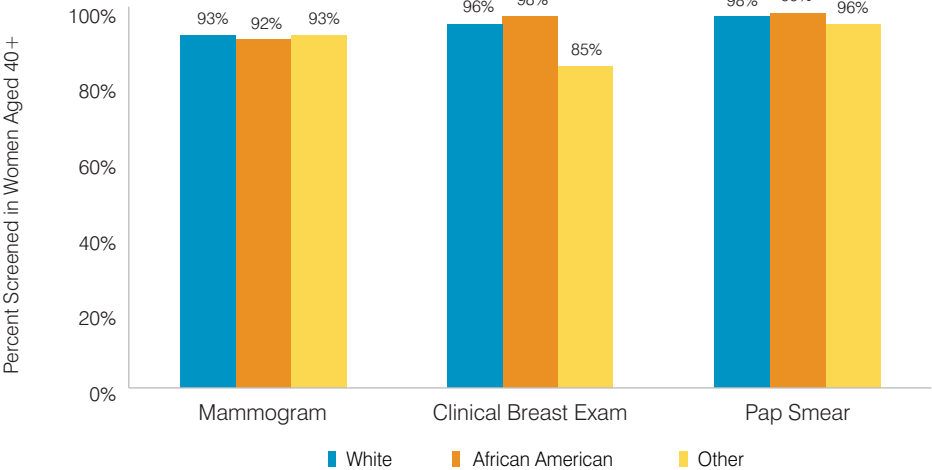
FIGURE 6.8. Cervical Cancer Mortality per 100,000, Maryland, 1998–2002



Source: Maryland Cancer Registry, 2006.

- Rates of screening for breast cancer in the state are quite high across all racial and ethnic groups (Figure 6.9).
 - » State and county screening initiatives appear to have been successful in providing access to breast cancer screening in the tri-county area.
 - » Having a usual source of healthcare and being insured are the strongest predictors for breast and cervical cancer screenings.

FIGURE 6.9. Women Aged 40+ Participating in Breast and Cervical Cancer Screening, Maryland, 2004



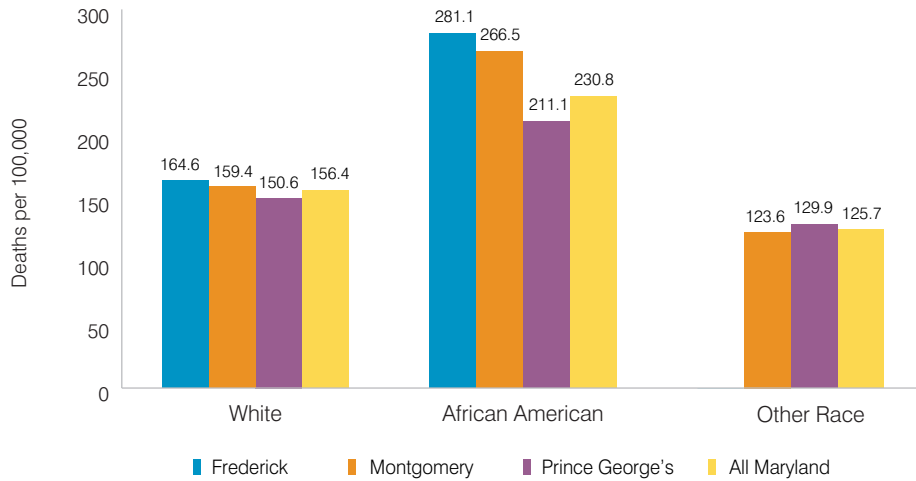
Source: Maryland Cancer Survey, 2004.

Prostate Cancer

In Maryland, African American men are disproportionately affected by prostate cancer. African American men have slightly higher rates of prostate cancer incidence (Figure 6.10), but significantly higher rates of mortality from the disease (Figure 6.11).

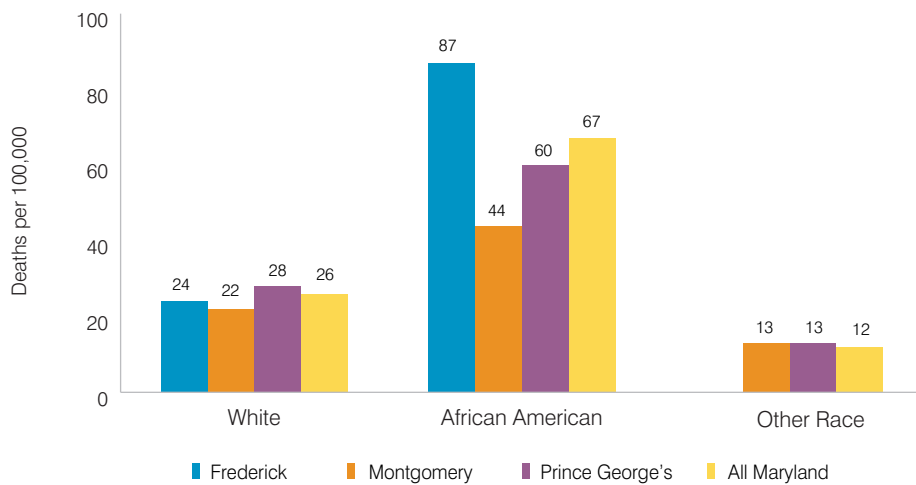
- Studies have concluded that African American men are more likely to be diagnosed with advanced stage prostate cancer than white men. They are also less likely to be aware of regular screening procedures.¹¹⁵
- Maryland data indicates that African American men are less likely than whites to have had a prostate-specific antigen test ever or in the past year (Figure 6.12).

FIGURE 6.10. Prostate Cancer Incidence per 100,000, Tri-County, Maryland 1998–2002



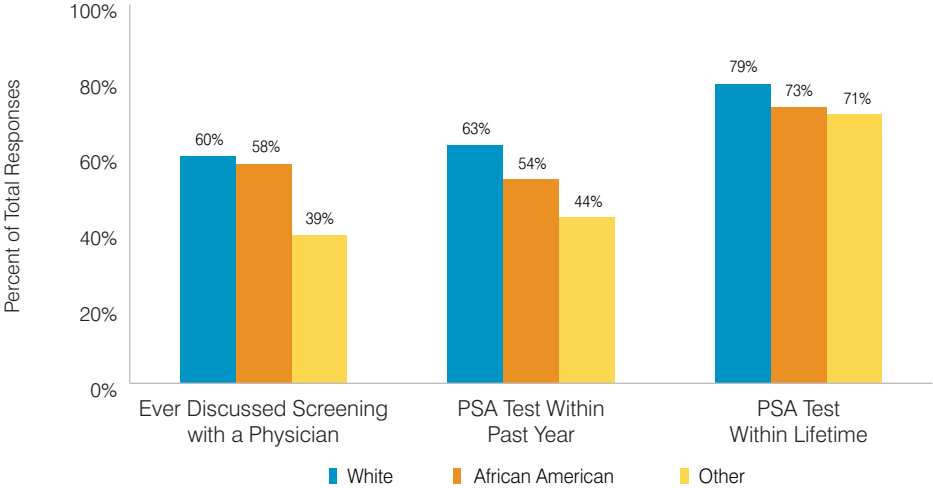
Source: Maryland Cancer Registry, 2006.

FIGURE 6.11. Prostate Cancer Mortality per 100,000, Tri-County, Maryland 1998–2002



Source: Maryland Cancer Registry, 2006.

FIGURE 6.12. Percent of Men Aged 50+ Participating in Prostate Cancer Screening, Maryland, 2004



Source: Maryland Cancer Registry, 2006.

PROGRAM SPOTLIGHT: CAREFIRST, INC.

CAREFIRST, INC., THE LARGEST HEALTH INSURER IN THE MID-ATLANTIC REGION, SERVES MORE than 3.2 million people in Washington, DC, and Maryland. In 2005, CareFirst launched the CareFirst Commitment, a program that aims to reduce racial disparities in the health system. One initiative is the “Health Awareness Program for Immigrant Cervical Cancer.” For this program, CareFirst partners with Boat People SOS, an organization serving the local Vietnamese community, to develop media and outreach materials targeting Vietnamese women. In the past year, they have screened more than 400 Vietnamese women and plan to reach a total of 4,000 women in the next several years. In the future, CareFirst plans to expand this program to colon and liver cancer.

7. Diabetes

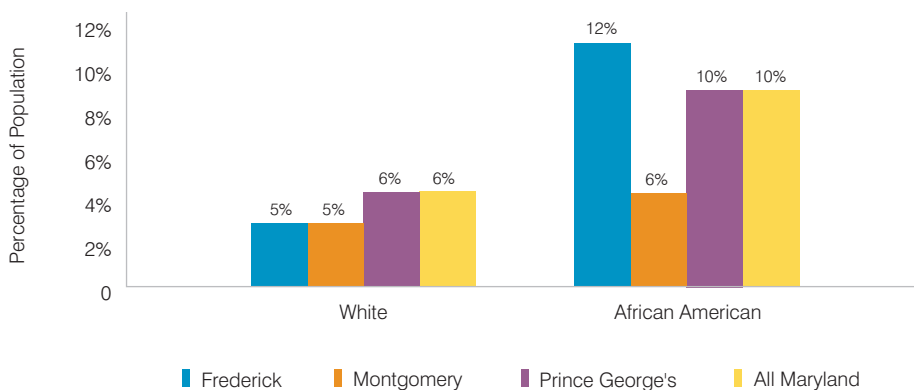
DIABETES IS DEFINED AS A GROUP OF DISEASES CHARACTERIZED BY HIGH BLOOD GLUCOSE levels caused by deficiencies in insulin production and/or insulin action. According to the American Diabetes Association, there are two forms of diabetes, type 1 and type 2. Type 1 diabetes is usually diagnosed in children and young adults, and was previously known as juvenile diabetes. Type 2 diabetes is the most common form of the disease and can be prevented or delayed with a healthy lifestyle, including maintaining a proper weight, eating sensibly, and exercising regularly.¹¹⁶ The rising prevalence of type 2 diabetes is of growing concern. Without treatment, diabetes can lead to serious health problems and even death, but with treatment, people with diabetes can learn to manage the disease and lower their risk of complications arising from the disease.

Prevalence and Mortality

In 2006, an estimated 334,000 (7.9 percent) of Maryland adults had been diagnosed with diabetes, with another 143,000 estimated to have undiagnosed diabetes.¹¹⁷ State data reveals a disparity between whites and African Americans, with a higher prevalence of diabetes in the African American community.

- In the tri-county area, survey data indicates that African Americans have a higher prevalence of diabetes than whites (Figure 7.1).
- In 2003, the prevalence of diabetes among Latinos was 3.5 percent across Maryland, significantly lower than the national prevalence rate of 6.4 percent among Latinos.¹¹⁸
- Diabetes mortality rates for African Americans in Prince George’s County are much higher than in other areas (Figure 7.2).

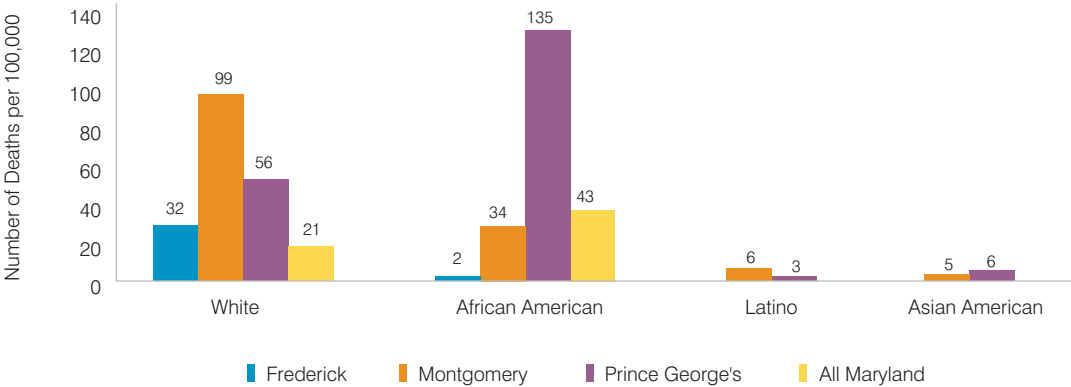
FIGURE 7.1. Prevalence of Diagnosed Diabetes, Tri-County, Maryland, 2000–2004 Five-Year Average



Note: Figures for Latinos and Asian Americans were not available.

Source: Maryland Behavior Risk Factor Surveillance System, 2000-2004.

FIGURE 7.2. Diabetes Mortality per 100,000, Tri-County, Maryland, 2005



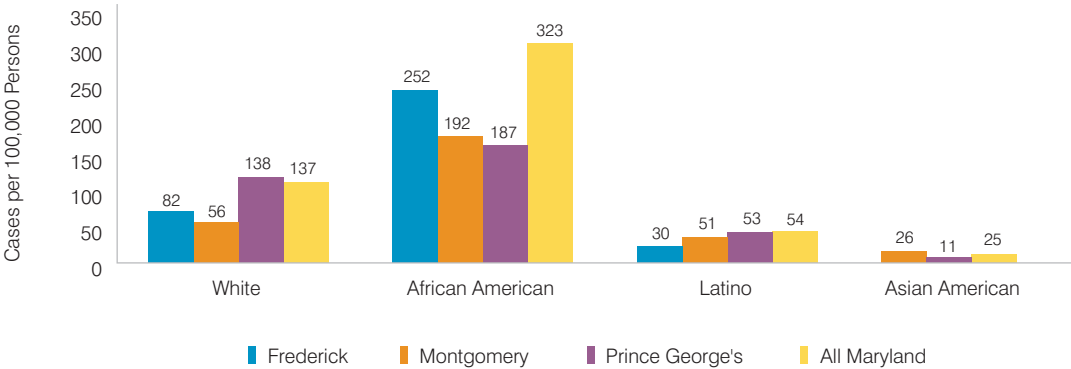
Source: Maryland Vital Statistics Administration, 2005.

Hospitalizations

Diabetes patients are likely to be hospitalized for complications arising from the disease, such as low blood sugar or kidney failure. Many of these hospitalizations are preventable with proper medical management of the condition.

- African Americans had the highest rates of diabetes hospitalizations across all geographic areas (Figure 7.3).

FIGURE 7.3. Diabetes Hospitalizations per 100,000, Tri-County, Maryland, 2006



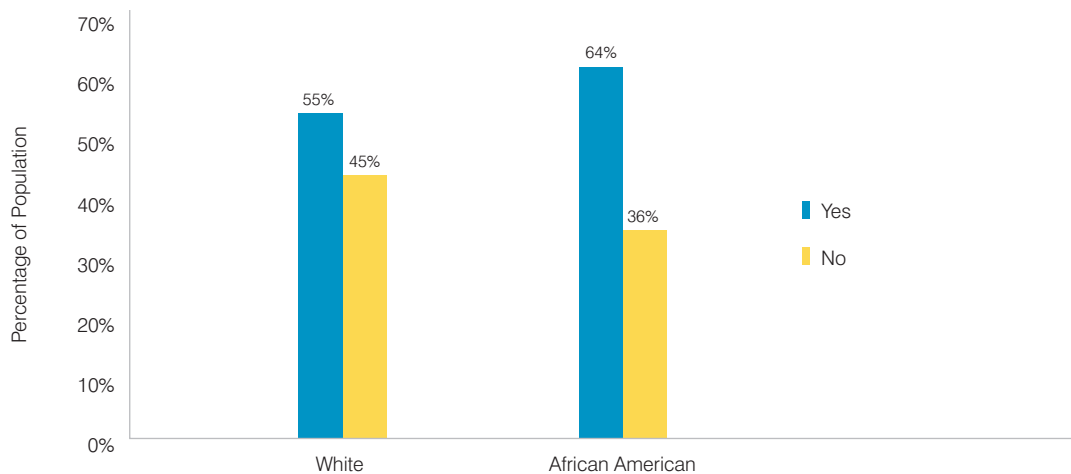
Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission; Maryland Vital Statistics Administration.

Self-Management

In addition to eating well and taking medication, the CDC lists diabetes self-management education as an integral part of controlling diabetes. Additionally, patients with different cultural backgrounds need information on how to adjust traditional meals in order to help manage their diabetes.

- In Maryland, African Americans diabetics have a higher rate of taking a diabetes self-management course (Figure 7.4). This indicates that outreach efforts to African American diabetics have been successful.
- Keeping blood sugar levels under control can help diabetics stay healthy and prevent potentially life-threatening side effects of the disease. The American Diabetes Association recommends that people with diabetes consume a diet with foods low in fat and high in fiber.¹¹⁹
 - » A barrier to adhering to these recommendations may be the availability of such foods in neighborhood grocery stores. Research has shown that in low-income, predominantly minority neighborhoods, residents may not have the same access to healthy foods that residents in more affluent neighborhoods may have.¹²⁰

FIGURE 7.4. Percentage of Diabetics in Maryland Who Have Taken a Diabetes Self-Management Course, 2006



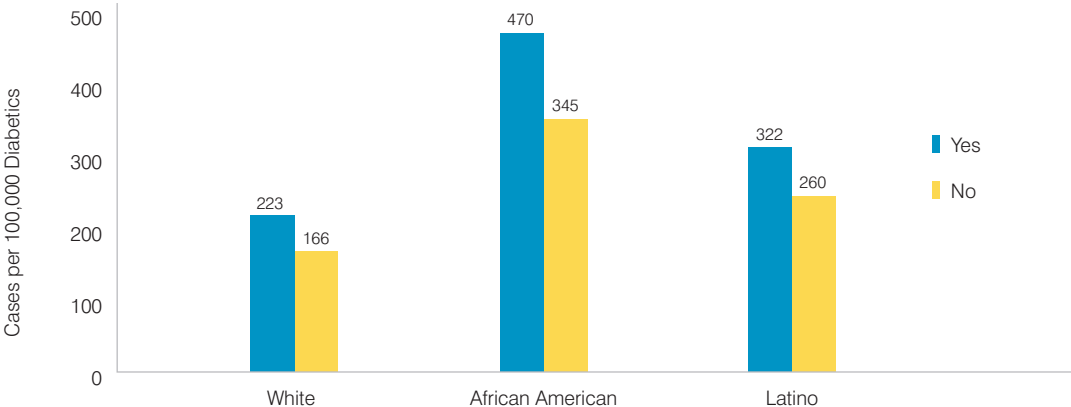
Source: Maryland Behavior Risk Factor Surveillance System, 2006.

Comorbidities Associated with Diabetes

Diabetics have a high risk of developing other co-morbidities, like heart disease and stroke due to other increased risk factors like high blood pressure and elevated cholesterol levels. Additionally, diabetes is the leading cause of foot and lower leg amputation, new cases of blindness among adults 20-74, and end-stage renal disease (ESRD) in America.¹²¹

- Nationally, the rate of diabetes related ESRD is more than two times greater among African Americans than among whites (Figure 7.5).
 - » The rate of ESRD among Latinos is higher than that of whites, but less than African Americans.

FIGURE 7.5. Rate of Diabetes Related ESRD per 100,000 Diabetics, 2002



Source: CDC National Diabetes Surveillance System.

PROGRAM SPOTLIGHT: MOBILE MEDICAL CARE, INC.

WITH THREE MOBILE VANS AND 20 CLINICS THROUGHOUT MONTGOMERY COUNTY, Maryland, MobileMed serves people in Bethesda, Gaithersburg, Potomac, Rockville, and Silver Spring. MobileMed is also a large provider of healthcare services for the homeless in Montgomery County. As a provider of primary care, MobileMed treats patients with common health problems such as hypertension, diabetes, asthma and other respiratory disorders, and chronic obstructive pulmonary disease (COPD).

8. Heart Disease and Stroke

HEART DISEASE TENDS TO AFFECT RACIAL AND ETHNIC MINORITIES DISPROPORTIONATELY, compared to whites, with minorities experiencing greater disease severity levels and, ultimately, worse health outcomes. While African Americans have a greater risk of stroke-related mortality, Latinos with acute heart attack or stroke experience longer delays in reaching the hospital compared with whites and other populations.¹²²

Prevalence and Mortality

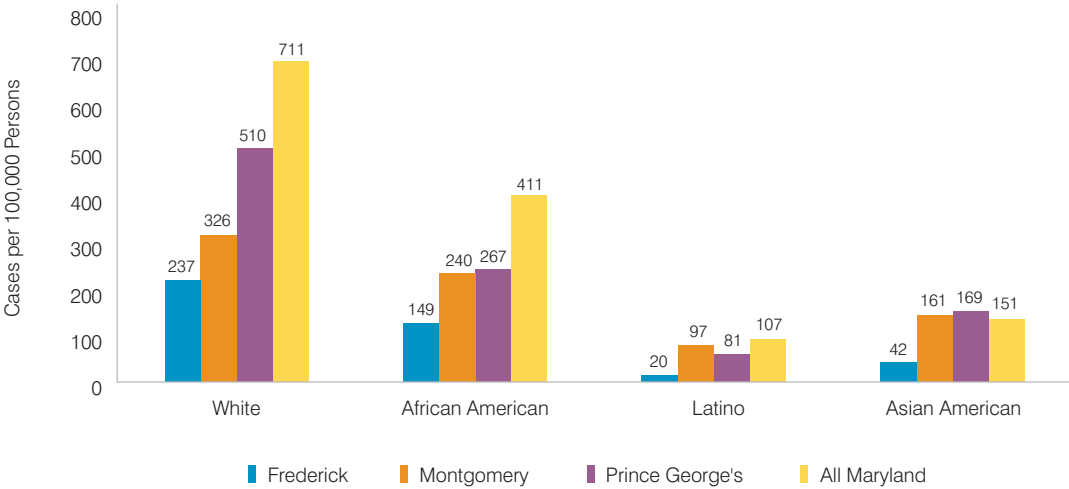
The CDC estimates that approximately 6 percent of adult residents in Maryland have a history of myocardial infarction (MI)^j or angina/coronary heart disease^k in 2005.

- In 2006, Prince George's County had the highest rate of hospitalized ischemic heart disease cases in the tri-county region (Figure 8.1).
 - » Asian Americans are nearly twice as likely to suffer from ischemic heart disease in Montgomery and Prince George's County compared to Latinos.
- Variation in cardiovascular mortality exists at the tri-county level. Compared to Frederick and Montgomery Counties, Prince George's County had the highest population-adjusted death rate due to heart disease as of 2005 (Figure 8.2).
 - » Across the tri-county area, African Americans are two to three times more likely to die from heart disease compared to their Latino and Asian American counterparts.

^j Myocardial infarction, commonly known as heart attack, is caused by a critical imbalance between the oxygen supply and demand of the myocardium. This usually results from plaque rupture in a coronary vessel, resulting in an acute reduction of blood supply to a portion of the myocardium.

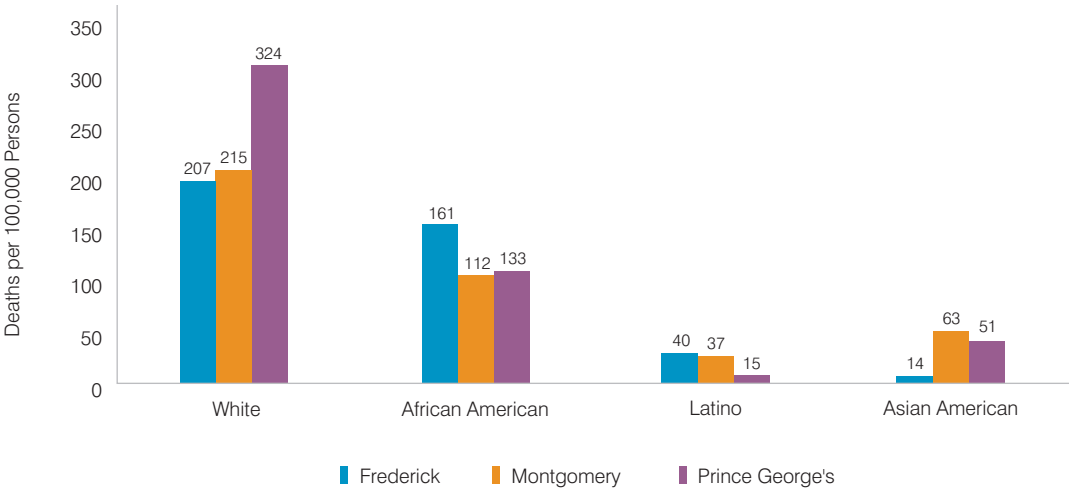
^k Coronary artery disease generally refers to the presence of atherosclerotic changes within the walls of the coronary arteries, which causes impairment or obstruction of normal blood flow with resultant myocardial ischemia.

FIGURE 8.1. Ischemic Heart Disease Hospital Cases per 100,000, Tri-County, Maryland, 2006



Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission; Maryland Vital Statistics Administration.

FIGURE 8.2. Heart Disease Death Rate per 100,000, Tri-County, Maryland, 2005



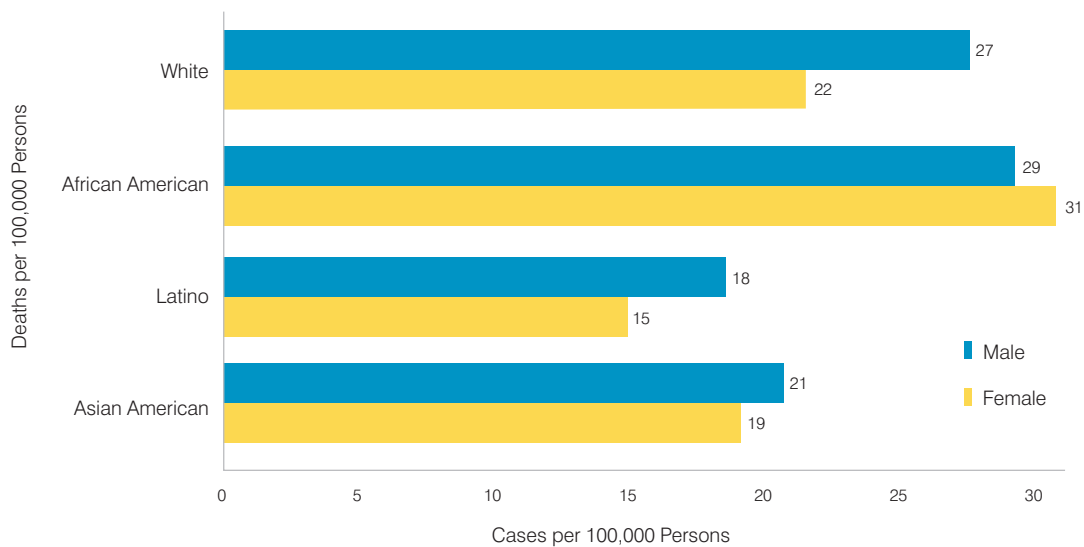
Source: Maryland Vital Statistics Administration, 2005.

Hypertension

Hypertension is the major risk factor for stroke and most other cardiovascular diseases. Historical and current studies demonstrate that incidence and prevalence of hypertension is greater in African Americans than in whites regardless of sex or education status.¹²³ While African Americans are more aware than whites of hypertension presence and treatment protocols, they were less likely to adequately control their blood pressure across age groups.¹²⁴

- In Maryland, African Americans of both genders report the highest prevalence rate of age-adjusted hypertension from 1997 to 2005 compared with whites, Latinos, and Asian Americans (Figure 8.3).

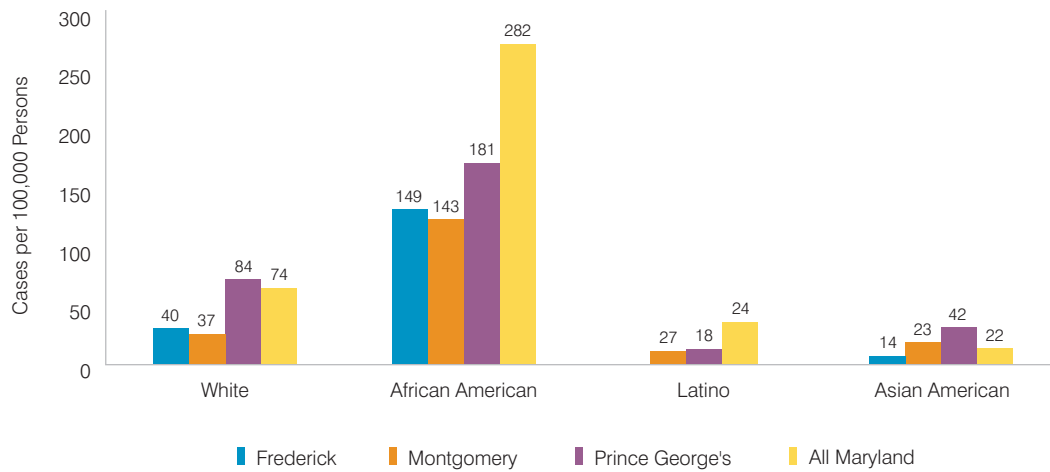
FIGURE 8.3. Self-reported Hypertension Prevalence in Adults per 100,000, Maryland, 1997-2005



Source: Behavior Risk Factor Surveillance System, Health Data for All Ages (HDAA), Center for Disease Control.

- Locally, African Americans are 3 to 10 times more likely to be hospitalized for hypertension compared to their white, Latino, and Asian American counterparts (Figure 8.4).
 - » Across all racial and ethnic groups, Prince George’s County has the highest hypertension hospitalization rate in the tri-county area.

FIGURE 8.4. Hypertension Hospital Cases per 100,000, Tri-County, Maryland, 2006



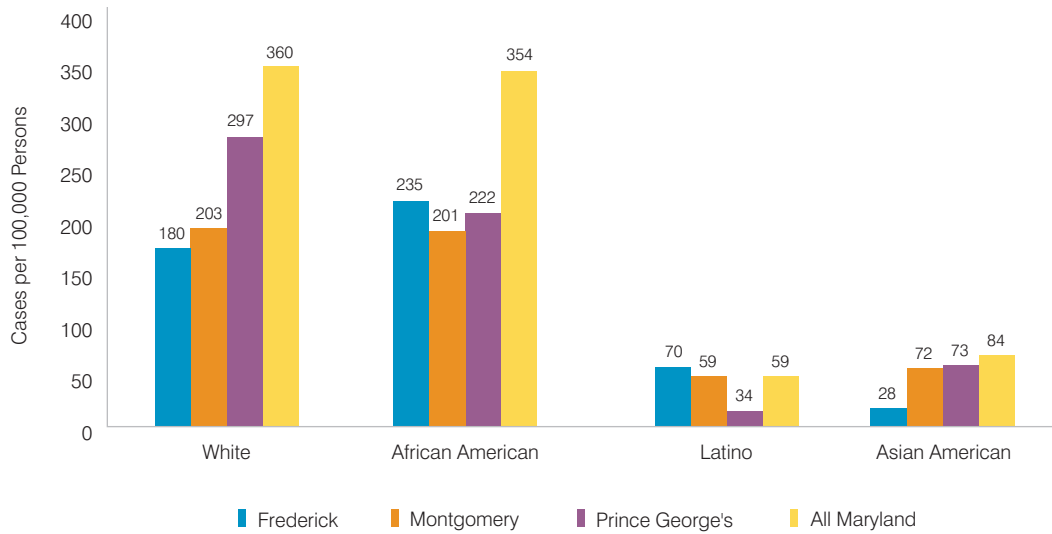
Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission; Maryland Vital Statistics Administration.

Stroke

Stroke was the third leading cause of death for people of all ages in the United States from 1950 to 2002. Nationally, African Americans, Asian Americans, and Latinos die from stroke at younger ages than whites.¹²⁵ At 45 years of age, the risk of death from stroke is four times greater for African Americans than for whites. Notable disparities also exist in the treatment of stroke. Medical record reviews and community hospital studies demonstrate that compared to whites, African Americans are 20 to 50 percent less likely to be administered with Tissue-Type Plasminogen Activator (TPA), a recommended therapy that must be started within three hours of symptoms onset.¹²⁶

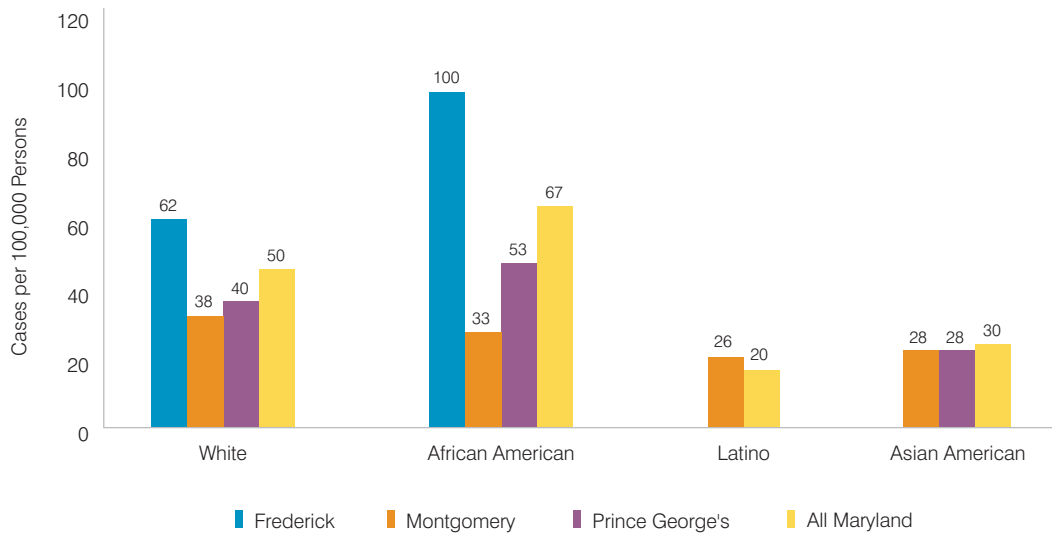
- Across the tri-county area, Prince George’s had the highest rate of hospitalized stroke cases in 2006 (Figure 8.5).
- Comparable to national trends, African Americans have higher mortality rates due to stroke in Frederick County, Prince George’s County, and across Maryland (Figure 8.6).
 - » Frederick County has the highest rates of mortality related to stroke across race and ethnicity compared to the tri-county area and all of Maryland. In Frederick County, African Americans are nearly twice as likely to die from stroke compared to whites.

FIGURE 8.5. Stroke Hospital Cases per 100,000, Tri-County, Maryland, 2006



Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission; Maryland Vital Statistics Administration.

FIGURE 8.6. Stroke Death Rate per 100,000, Tri-County, Maryland, 2003



Note: Data for Frederick County's Latino and Asian American population, and Prince George's Latino population not reported due to small sample sizes on which to base estimates.

Source: CDC Wonder and Healthy People 2010, Center for Disease Control.

PROGRAM SPOTLIGHT: ADVENTIST HEALTHCARE HEART CENTERS

ADVENTIST HEALTHCARE IS A LEADER IN THE DIAGNOSIS AND TREATMENT OF HEART disease that is committed to improving the heart health of the community's we serve. The heart centers at both the Washington Adventist Hospital and Shady Grove Adventist Hospital partner with several community groups and national organizations in providing a wide array of community education and health screening to help identify individuals risk level of heart and vascular disease and stroke and direct them to the best way to reduce that risk. Some spotlights of these programs are the annual "Legs for Life" screening program at both Washington Adventist Hospital and Shady Grove Adventist Hospital campuses as part of the national effort promoted by "The Society for Vascular & Interventional Radiologists," and as the main sponsor of the "Sister to Sister" annual event, in addition to numerous programs with the American Heart Association. All these events provide free screening and testing and are open to the public.

9. Mental Health

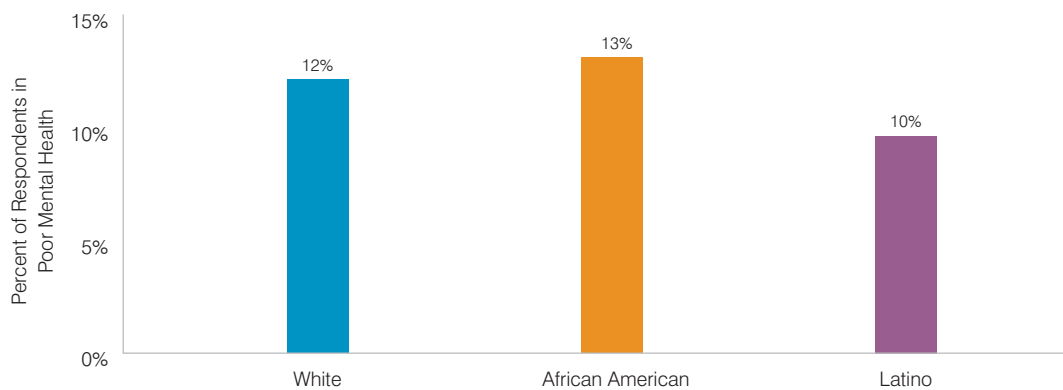
MENTAL HEALTH ISSUES AFFECT MANY MARYLANDERS OF ALL RACIAL AND ETHNIC BACKGROUNDS. Researchers have documented disparities in rates of seeking treatment from mental health providers between racial and ethnic minorities and whites.¹²⁷ These disparities in accessing care are subsequently reflected in statistics showing higher rates of hospitalization for mental illnesses among minorities, many of which are preventable. Community advocates note that a lack of culturally competent mental health providers and continuing social stigma towards the mentally ill may be factors in disparate treatment rates.

Mental Health Status

The Substance Abuse and Mental Health Services Administration (SAMHSA) states that African Americans may be less likely to suffer from depression and more likely to suffer from phobias than whites. Research has also shown that African Americans are more likely to suffer from physical symptoms of depression than whites. SAMHSA also notes that there is a lack of availability of mental health professionals belonging to racial and ethnic minorities, with African American and Latino mental health professionals making up only a few percent of the nation's psychologists, psychiatrists, and social workers.¹²⁸

- In 2005, more than 10 percent of all Marylanders reported being in poor mental health (Figure 9.1). These rates varied only slightly by race.

FIGURE 9.1. Survey Respondents Self-Reporting Poor Mental Health Status, Maryland, 2005



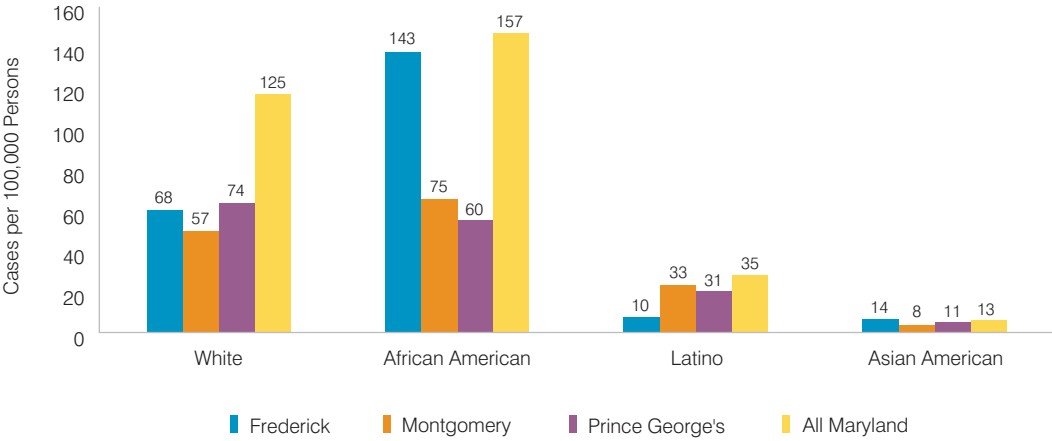
Source: Maryland Behavioral Risk Factor Surveillance System, 2005.

Hospitalizations

Many mental health hospitalizations are preventable. Lack of access to providers in the community may play a role in hospitalizations for mental illnesses.

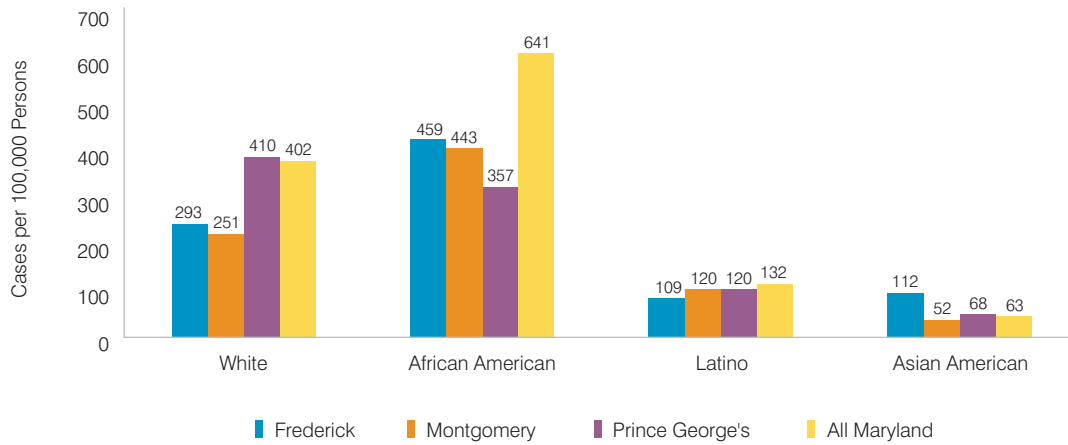
- Locally, rates of hospitalizations for mental conditions are highest among African Americans and whites (Figures 9.2 and 9.3).
 - » SAMHSA notes that 60 percent of older African Americans adults with mental conditions may not receive the care they need.

FIGURE 9.2. Hospitalizations for Neurotic Conditions per 100,000, Tri-County, Maryland, 2006



Note: Neurotic disorders include personality disorders, depressive disorder, alcohol and drug dependence, and emotional disturbance.
Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission.

FIGURE 9.3. Hospitalizations for Psychotic Conditions per 100,000, Tri-County, Maryland, 2006



Note: Psychoses include schizophrenia and paranoia.

Source: Maryland Patient Care Analyst Database; Maryland Health Services Cost Review Commission.

PROGRAM SPOTLIGHT: AFRICAN IMMIGRANT REFUGEE FOUNDATION

THE AFRICAN IMMIGRANT REFUGEE FOUNDATION (AIRF) AIDS AFRICAN IMMIGRANTS IN the Washington, DC, metropolitan area. This population contains a number of individuals who have survived genocide, refugee camps, and other hardships in their native countries. As a result, they may suffer from a variety of mental health issues such as post-traumatic stress disorder and depression. The organization also conducts group counseling and focus groups for adults and elders in order to empower them and assist them in adjusting to life in the United States. For clients who need more individualized mental health counseling, AIRF maintains a referral network of mental health professionals who are also from the African community.

10. HIV/AIDS

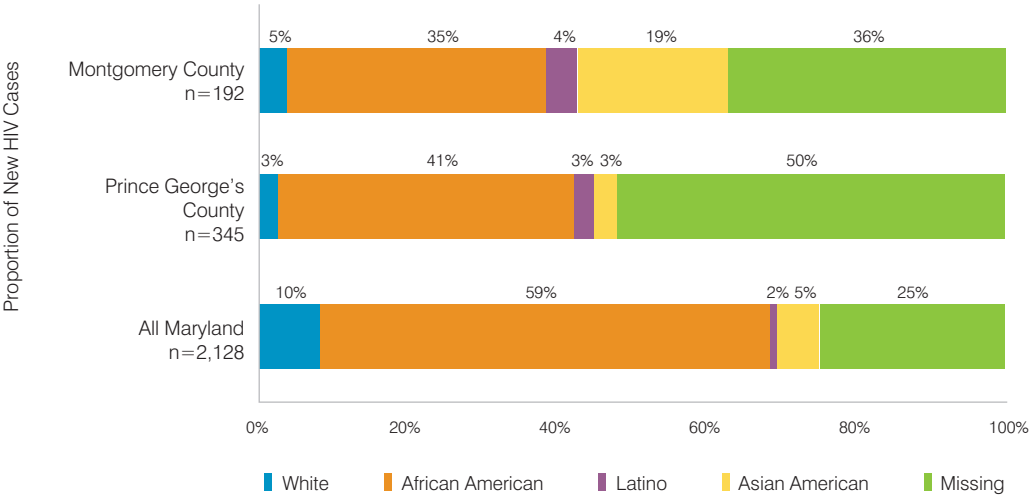
NATIONALLY, THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), THE VIRUS THAT CAUSES THE Acquired Immune Deficiency Syndrome (AIDS), is found disproportionately in African American and, to a lesser extent, Latino populations. In 2005, African Americans made up 49 percent of HIV/AIDS cases diagnosed in the country, while comprising only 13 percent of the population. Latinos accounted for 18 percent of newly diagnosed cases while also comprising approximately 13 percent of the population. In Maryland, statistics show a similar story for African Americans, with 79 percent of newly diagnosed HIV cases and 83 percent of newly diagnosed AIDS cases. AIDS is the leading cause of death of Maryland African American men and women age 25 to 44.¹²⁹

Incidence

African Americans comprised the majority of new AIDS cases from July 2004 to June 2005 (Figures 10.1 and 10.2).

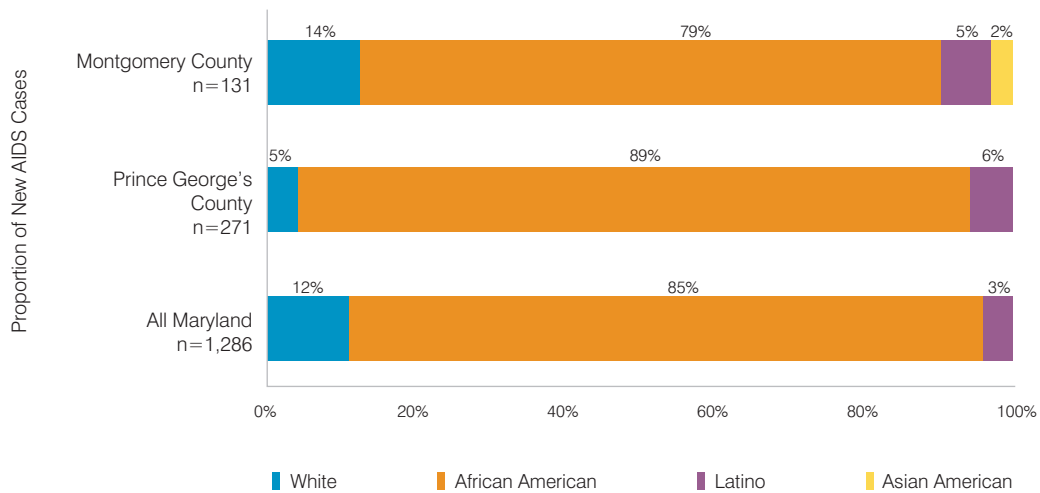
- Racial and ethnic data for many new HIV cases is missing, but African Americans comprise the majority of new cases in Maryland.

FIGURE 10.1. Incidence of HIV, Maryland, July 2004 to June 2005



Source: Maryland AIDS Administration, 2007.

FIGURE 10.2. Incidence of AIDS, Maryland, July 2004 to June 2005



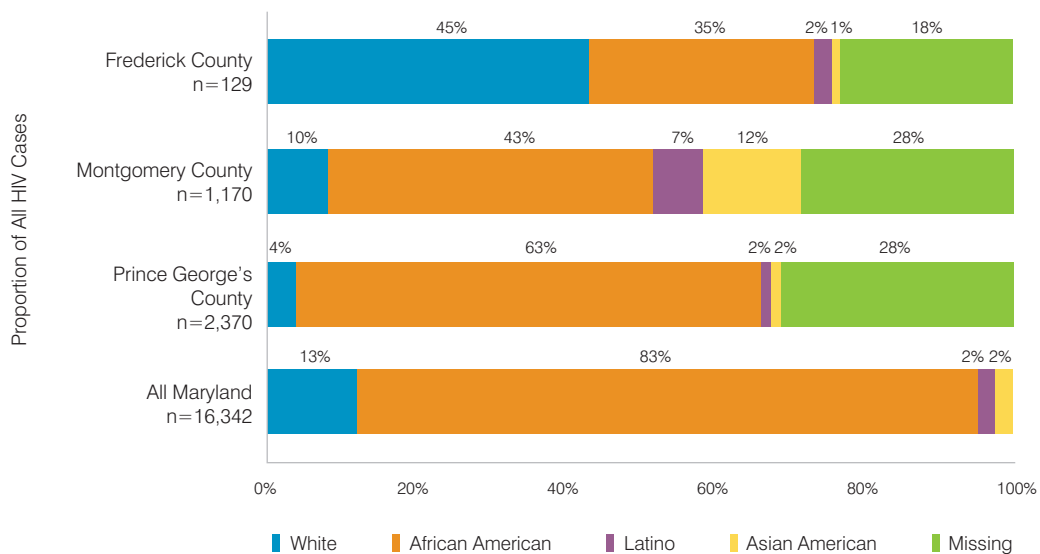
Source: Maryland AIDS Administration, 2007.

Prevalence

According to the most recent figures from the Maryland AIDS Administration, in 2004 there were 16,342 Marylanders with HIV, and 12,781 whose conditions have progressed to AIDS.¹³⁰

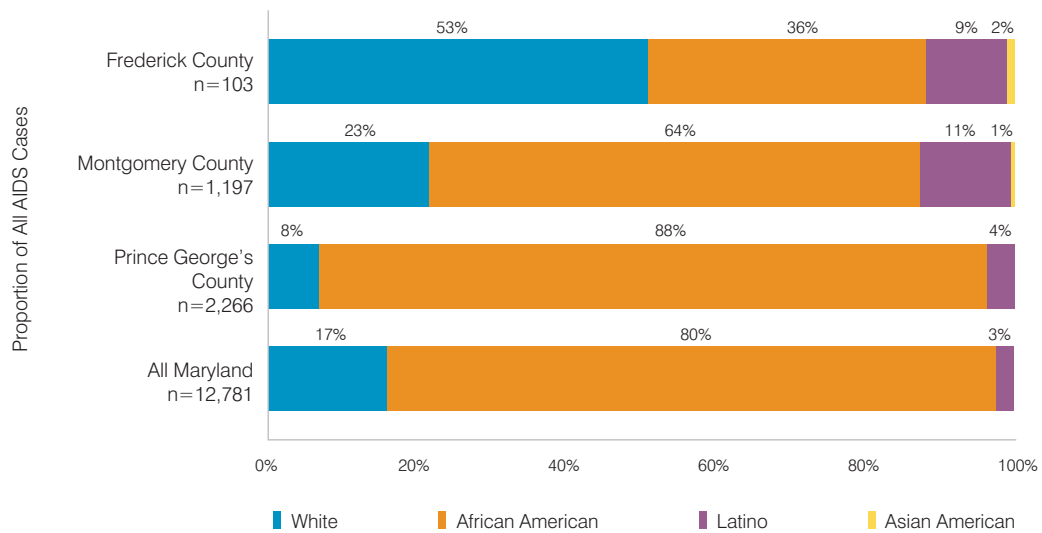
- African Americans in Maryland are disproportionately impacted by HIV and AIDS (Figures 10.3 and 10.4).

FIGURE 10.3. Prevalence of HIV, Tri-County, Maryland, July 2004 to June 2005



Source: Maryland AIDS Administration, 2007.

FIGURE 10.4. Prevalence of AIDS, Tri-County, Maryland, July 2004 to June 2005



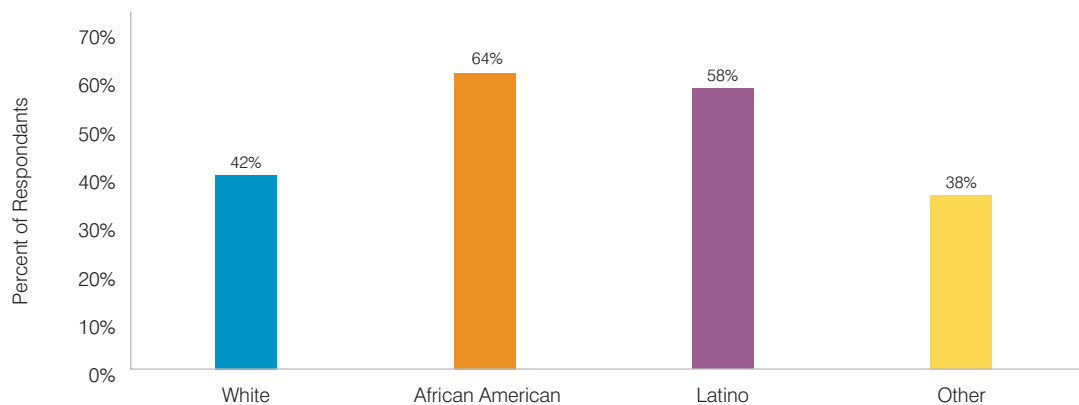
Source: Maryland AIDS Administration, 2007.

Testing

Making individuals aware of their HIV status is a major goal of HIV/AIDS advocates. In Maryland, African Americans are more likely to have been tested at confidential counseling, testing, and referral sites, comprising 68 percent of clients to such sites.¹³¹

- In the tri-county area, African Americans are most likely to report having been tested for HIV (excluding blood donations), followed by Latinos, whites, and others (Figure 10.5).
- These figures suggest that outreach efforts to African Americans and Latinos have been successful in facilitating testing.

FIGURE 10.5. Survey Respondents Who Have Been Tested for HIV, Maryland, 2004-2006



Source: Maryland Behavior Risk Factor Surveillance System, 2004-2006.

Access to Medications

Treatment for HIV can prolong life during the course of the disease. Given that African Americans and Latinos in Maryland are more likely to be uninsured, access to antiretrovirals and other needed medications to prevent and manage opportunistic infections may be diminished in these populations.

- African Americans comprised 66 percent of Maryland AIDS Drug Assistance Program (ADAP) clients. Maryland's ADAP helps provide medications to HIV/AIDS patients who are uninsured. Of other participants, 5 percent are Latino, 1 percent Asian American, 18 percent white, and the remaining 10 percent are multiracial or other.¹³²

PROGRAM SPOTLIGHT: AFRICAN AMERICAN COALITION AGAINST AIDS

THE AFRICAN AMERICAN COALITION AGAINST AIDS WAS FOUNDED IN 2001 TO IMPROVE grassroots HIV/AIDS education for residents of metropolitan Washington, DC, by dealing with myths and misconceptions about AIDS in the African American community. Through street outreach, more than 500 volunteers engage some 10,000 people a year in the African American community and distribute educational material and condoms. Volunteers also participate in educational workshops addressing the African American community, such as the Black Family Reunion, and partner with local universities to promote education among African American students.

11. Unintentional Injuries

AN ADDITIONAL CONCERN FOR THE PUBLIC HEALTH COMMUNITY IS THE SAFETY OF WORKERS, drivers, and pedestrians. In Maryland in 2003, there were 709 motor vehicle mortalities and 1,432 deaths from other unintentional injuries.¹³³ Many of these accidents are preventable through increased workplace safety conditions and stricter driving and machine operating laws.

Mortality Caused by Unintentional Injuries, Including Motor Vehicle Crashes

Unintentional injuries can occur in the home, workplace, recreational settings, and elsewhere. Common accidents include residential fires, falls among older adults, fireworks, and water-related accidents.

- White and African American residents of Prince George’s County are twice as likely to die from unintentional injury compared to the same groups in Montgomery and Frederick Counties (Figure 11.1).
 - » Asian Americans had the lowest mortality rates from unintentional injuries at the state level.
 - » Latinos had the highest rate of deaths due to unintentional injuries in Montgomery County.

FIGURE 11.1. Unintentional Injuries and Accidents Mortality per 100,000, Tri-County, Maryland, 2003

MORTALITY RATE	WHITE	AFRICAN AMERICAN	LATINO	ASIAN AMERICAN
Frederick County	29.5	—	—	—
Montgomery County	16.0	15.0	26.1	18.1
Prince George’s County	36.9	27.4	18.4	22.2
All Maryland	26.4	27.3	22.5	15.6

Note: Data for Frederick County were too small to produce accurate estimates.

Source: Behavioral Risk Factor Surveillance System (BRFSS), Center for Disease Control, 2003.

- In 2003, the highest mortality rate of motor vehicle accidents was in Prince George’s County for whites compared to Montgomery County and Frederick County (Figure 11.2).

FIGURE 11.2. Motor Vehicle Accident Mortality per 100,000, Tri-County, Maryland, 2003.

MORTALITY RATE	WHITE	AFRICAN AMERICAN	LATINO	ASIAN AMERICAN
Frederick County	14.8	—	—	—
Montgomery County	7.4	9.1	10.7	9.1
Prince George's County	18.6	14.1	8.5	16.6
All Maryland	13.1	13.1	9.1	9.0

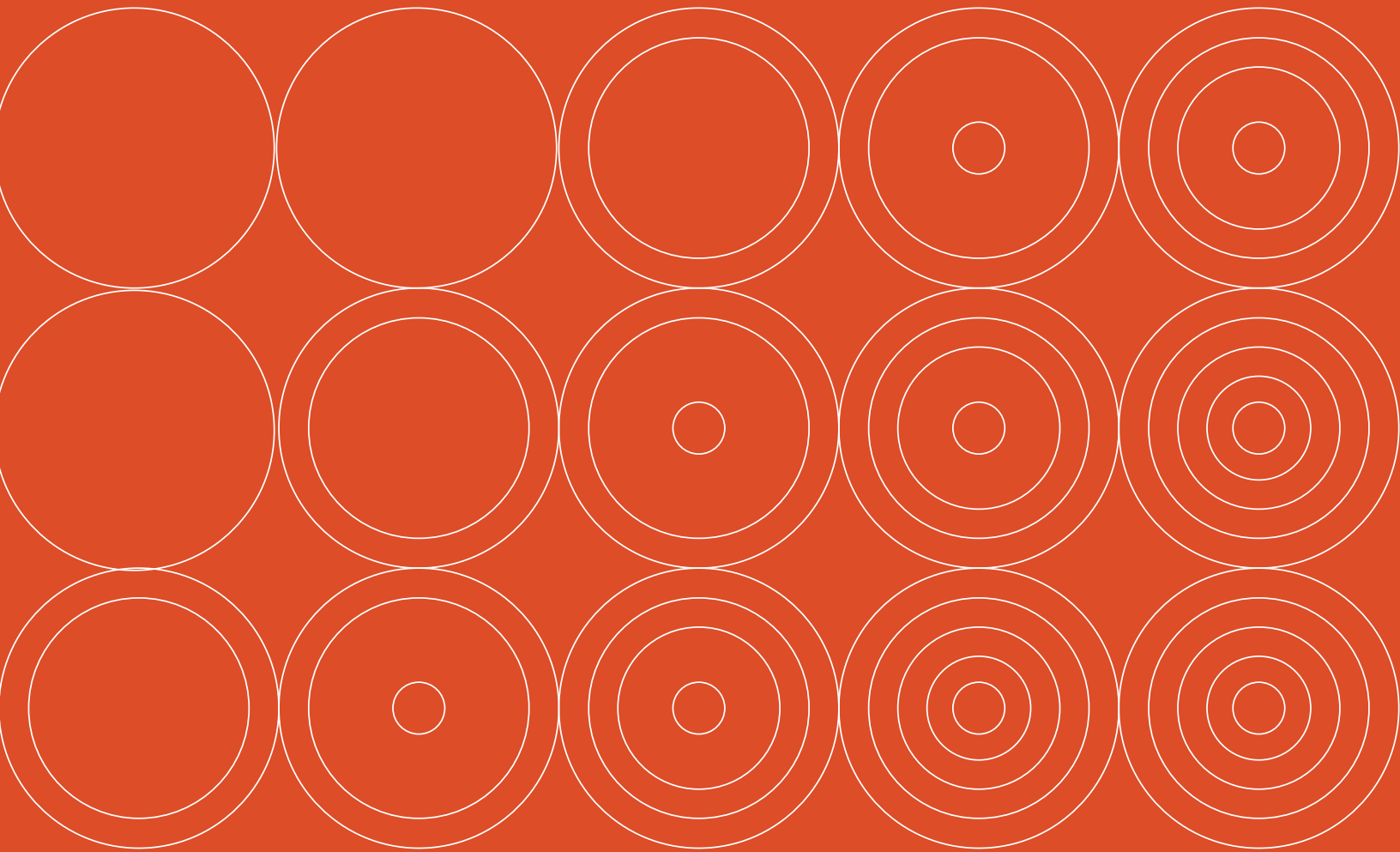
Note: Data for Frederick County were too small to produce accurate estimates.
 Source: Behavioral Risk Factor Surveillance System (BRFSS), Center for Disease Control, 2003.

PROGRAM SPOTLIGHT: ADVENTIST HEALTHCARE

ADVENTIST HEALTHCARE (AHC) HAS IMPLEMENTED A TRAINING PROGRAM FOR BILINGUAL support staff. The training covers the ethics of interpreting, medical terminology, cultural competency, modes of interpretation, and serving as a cultural broker, among other topics. The purpose of the training is to provide staff members that serve in an interpreting role with the necessary skills to provide a therapeutic environment in which free flow of information is encouraged, clear and accurate. The Qualified Bilingual Staff program provides participants with the skills necessary to provide proper interpreting in a medical encounter.

The Center on Health Disparities also provides comprehensive cultural competency training to providers at AHC. The training is aimed at providing tools to healthcare practitioners to improve their communication with diverse patient populations. The Center on Health Disparities also offers this training to community partners.

Conclusions and Recommendations



Conclusions and Recommendations

THIS REPORT DESCRIBES THE HEALTH STATUS OF RACIAL AND ETHNIC MINORITY COMMUNITIES in the tri-county area across 11 health topics. In order to respond effectively, providers and policy makers should develop strategies to track disparities and to promote higher standards for culturally and linguistically competent care. The following pages describe three specific sets of initiatives that, if implemented, would bring us closer to the elimination of health disparities across all communities.

Expand outreach and services for needs of racial and ethnic minorities.

As noted across this report, healthcare providers, county health departments, state agencies, and community organizations are each implementing initiatives aimed at raising awareness of certain health issues specific to racial and ethnic minority communities. Additionally, these groups devote time and resources to screening programs, support services, and other interventions that counteract some of the underlying factors leading to health disparities. As the region moves forward in addressing these issues, more resources should be devoted to these efforts, with special emphasis placed on understanding how to successfully replicate some of these programs.

Pursue coordinated research into the underlying causes of health disparities, the efficacy of various health initiatives, and the appropriate knowledge diffusion strategies into local communities and caregivers.

In order to address disparities effectively, more information is needed for healthcare providers, researchers, policy makers, and community organizations to interpret. As different stakeholders explore the causes of disparities and the efficacy of interventions aimed at reducing these disparities, a coordinated research agenda at the state or county level could be implemented. This research agenda would also promote better collaboration between stakeholders, and would direct the state and counties' strategic planning efforts around reducing disparities. Much of this work has already begun through the Maryland Department of Minority Health and county health departments, and the broad support of this work should be further leveraged.

The success of this research agenda is dependent on improvements in the collection of racial and ethnic data across the healthcare system. As noted in this report, publicly available data sets at the state and national levels are often insufficient to evaluate health disparities for certain racial and ethnic minorities, particularly at the local level. Without this data it is difficult for healthcare providers, advocates, and policy makers to identify health disparities, and therefore impossible to evaluate methods to address them. Furthermore, no datasets analyzed for this report disaggregated data by country of origin. Without this

data the authors were not able to make distinctions within communities regarding the health of immigrant populations versus the native born. Given the recent influx of immigrants into the tri-county area, it is important to understand how healthcare providers should respond to the unique health needs of those who have recently arrived in the country. The following are the items that should be a part of data collection efforts.

- Racial identification – to allow providers and researchers to begin analyzing data at the community level.
- Ethnic group identification – to allow measurement of disparities among Latinos of all racial backgrounds.
- Language preference – to note the need for additional interpretation and translation services for populations with limited English proficiency.
- Country of origin – to assist in identifying issues unique to immigrant populations, and to disaggregate data among broad racial and ethnic categories that loses focus on the experiences of smaller subcommunities.

Promote culturally and linguistically competent care and funding mechanisms to foster the exchange of best practices.

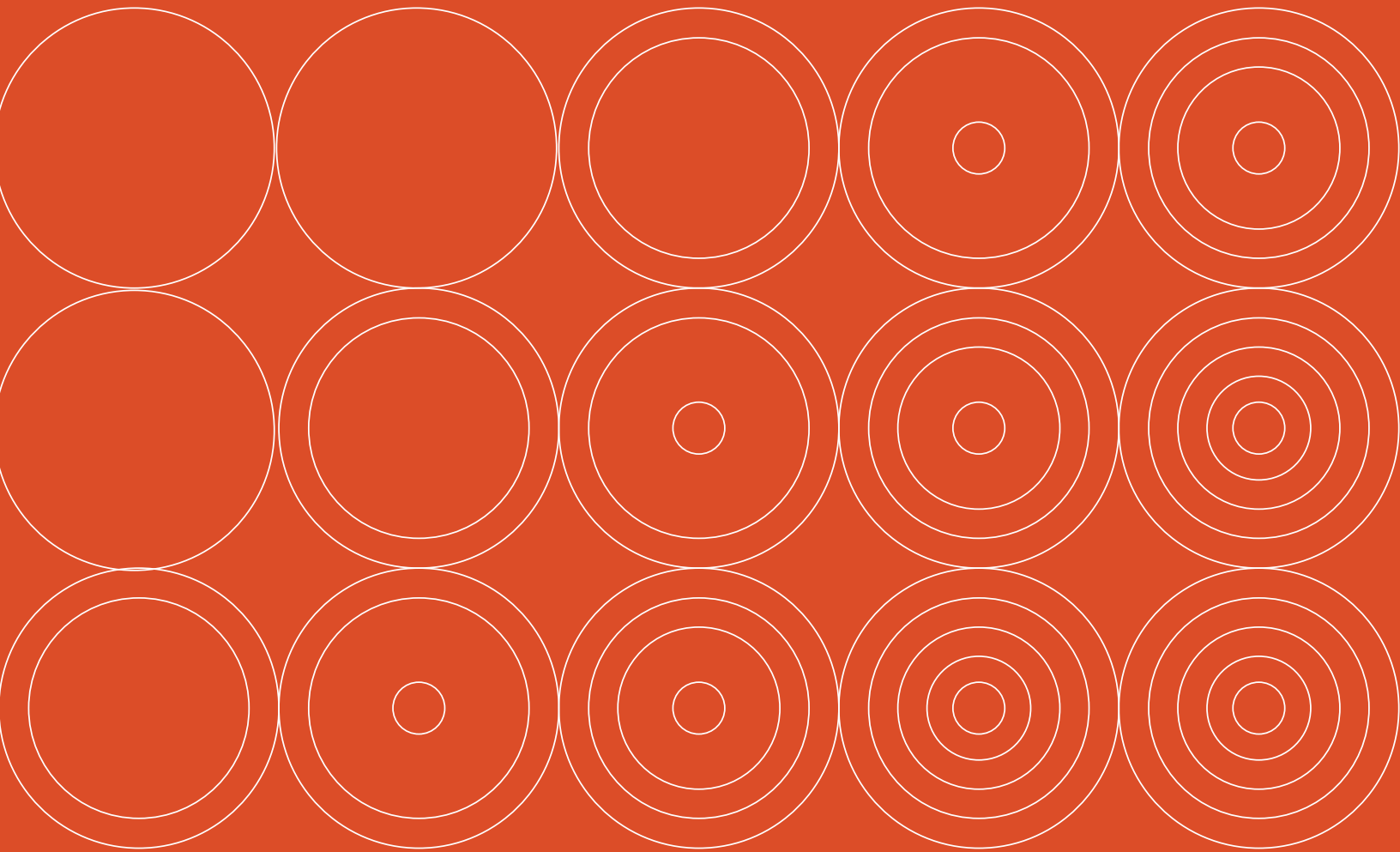
Current grant programs and initiatives often concentrate on the development of innovative approaches to addressing health disparities. The next step for these programs is to distribute best practices to healthcare providers. State and county funding streams could be created to promote increased collaboration and the formation of teams and working groups that would share experiences in different settings. For example, counties could institute workgroups that would bring together providers for a specific purpose such as addressing the relative underrepresentation of minority health professionals. Providers, educators, and other stakeholders could discuss strategies for promoting entry into training programs, recruitment, and other pertinent issues. Healthcare providers and researchers could also be encouraged to increase their partnerships with community organizations to create interventions and conduct formal analyses of health at the community level.

Counties could also promote collaboration by recognizing facilities or providers that strive to deliver culturally competent care. Incentives for providers that receive this designation could be helpful in promoting this program. By highlighting providers that are doing well in reducing health disparities, or educating minority communities about health, local municipalities would be sharing these strategies with a broader audience.

In addition to placing more emphasis on cultural and linguistic competency at the facility level, cultural competency also needs to be part of healthcare professionals' training. Utilization of trained interpreters improves patient-provider communication, which can in turn decrease errors and improve outcomes. Standards for proper training of healthcare interpreters and bilingual staff need to be agreed upon and enforced in order to ensure proper interpreting in all medical encounters. This will allow linguistically isolated and LEP individuals to access care without fear of not being able to communicate with their provider.

Ultimately, our ability to address persistent, and in some cases deepening, healthcare disparities across all of our communities will depend on the ability of community leaders, healthcare professionals, health plans, employers, and government policy officials to collaborate on a multi-pronged set of interventions, educational programs, and research initiatives. The Center on Health Disparities looks forward to working with its community partners toward our common goal of eliminating health disparities in our region.

Community Organization Profiles



Many local organizations have begun the work of narrowing health disparities in our community.

Community Organization Profiles

African American Coalition Against AIDS

The African American Coalition Against AIDS (AACAA) was founded in 2001 due to its founder's perception that the metropolitan Washington, DC, area lacked a group conducting grassroots HIV/AIDS education. Most local organizations were focused on fundraising for medical research or legislative advocacy, but very few were on the streets providing the community with educational materials.

AACAA's mission is to promote prevention, education, and testing among communities of color in areas that have been highly impacted by HIV/AIDS. The group is based in Largo, and is staffed completely by volunteers. The program aims to serve the African American community in the DC metropolitan area. The majority of the work is centered on the distribution of educational materials and condoms, and communicating directly with community members to gauge their understanding of HIV/AIDS and to counteract myths with knowledge. Volunteers are trained to engage community members in conversation about HIV/AIDS while distributing materials. Volunteers are also asked to not only share knowledge about how individuals can protect themselves, but also to provide statistics on how HIV/AIDS affects the African American community, in the hope that people will both change their behavior and increase their consciousness of the growing challenge of HIV/AIDS. AACAA serves at least 10,000 people annually.

In addition to street outreach, AACAA conducts educational workshops for audiences at health fairs and festivals such as the Black Family Reunion held annually on the National Mall. It also partners with local colleges and universities such as Prince George's Community College, where it has held several events on campus.

The program reports that the majority of people it encounters are receptive to the information, but a segment of the community remains reluctant to discuss the disease. Some persistent myths continue to exist, and stigmatization is an issue. The program notes that increased collaboration and leadership is needed in order to get the message out and have a greater effect in addressing the epidemic.

For more information, visit the AACAA website at <http://www.stophivaids.org> or call 301.499.7178; Kristen Clarke – Director.

African Immigrant Refugee Foundation

In 2000, the African Immigrant Refugee Foundation (AIRF) was founded with the mission to aid African immigrants and refugees in the metropolitan DC area during their transition and adaptation to life in the United States. AIRF addresses issues of mental health, language barriers, health issues, and domestic and youth gang violence. The organization reaches individuals from more than 35 African countries represented in this area, such as Sierra Leone, Sudan, Zaire, Cameroon, Nigeria, Ethiopia, Ghana, and Somalia via:

- Schools as the door to low-income African immigrant and refugee families to further its mission to facilitate the effective transition of African immigrants to American society and to support their productive, sustainable integration into their new homeland. The organization does this through a series of programs.
- Group counseling and focus groups as a source of empowerment for students through an after-school mentoring/tutoring program titled Catching Up. The program is established in three high schools, one middle school, and an elementary school.
- Tutoring programs as an aid to elementary and middle school children in catching up with academics. Often, immigrant children will be confused about their identity. In their home countries they had a specific nationality, but upon immigration to the United States, they are labeled as an “African.” This program aims to help children define and address issues of identity and cultural immersion which in turn transforms them into a resource to their schools.
- Mentoring programs, which primarily serve some 150 high school students in the DC metropolitan area. More than 55 cross-age tutor/mentors from African Student Associations (ASA) from University of Maryland and Howard University (ASA and The Knights Fraternity), Georgetown University department of African Studies, develop close relationships with the adolescents and discuss social, personal, or academic issues.
- Cultural competency training for health providers, employees in places of work, and school counselors, staff and teachers. This program educates these professionals to understand African culture so that a certain amount of sensitivity can be applied in the workplace or school.

AIRF is a member of a coalition of 12 nonprofit groups working with Silver Spring youth, and a partner with Bethel Church and secular grassroots African organizations. In the future, it hopes to partner with the Adventist Church, apply for grants from the Robert Wood Johnson Foundation, and work with students from local universities. The group would also like to open an office in Maryland that would serve as a home for the organization and act as an additional resource for the community.

For more information, visit the AIRF website at <http://www.airfound.org> or call 202.234.2473 / 301.593.0241; Wanjiru Kamau, Ed. D. – Founder.

CareFirst BlueCross BlueShield

CareFirst, Inc., the largest health insurer in the Mid-Atlantic region, serves nearly 3.1 million members in Maryland, Washington, DC, and Northern Virginia. It works to:

- Ensure healthcare affordability to reduce care costs,
- Raise the bar to improve healthcare quality and safety for members and non-members, and
- Close the gaps to the healthcare needs of the diverse communities it serves.

The *Closing the Gaps* component of *CareFirst Commitment* is built around partnerships with organizations that understand the specific health needs of their communities. CareFirst researched best medical practices, and approached key community leaders and organizations in order to learn how best to support the communities it serves in the Mid-Atlantic region. Several community-based programs with outreach and clinical components were developed to target high disease prevalence among minority populations with significant health disparities. These programs include:

- **Diabetes Treatment and Education Initiative:** Launched in partnership with La Clinica del Pueblo, to implement a chronic disease or disease-specific chronic care model, peer health promotion, and diabetes education aimed at reducing diabetes health disparities among Latinos. La Clinica del Pueblo is one of the only free non-profit health clinics in Washington, DC, serving over 5000 mostly uninsured clients.
- **Health Awareness Program for Immigrants - Cervical Cancer (HAPI-CC):** Launched in partnership with the Boat People SOS, a Vietnamese advocacy organization, to implement a media and outreach cervical cancer campaign targeting Vietnamese women who have an extremely high risk of cervical cancer.
- **Hair, Heart and Health:** Launched in partnership with University of Maryland School of Medicine and the Church/Community Health Awareness Program to address cardiovascular health risks among African Americans in barbershops and hair salons.
- **Cultural Competency Training:** Launched online cultural competency training for external network physicians.
- **MiDieta:** Hispanic Diet and Weight Loss Study compared the impact on disease prevention (diet and physical activity) by examining the difference in effective program methodology when education and resources are delivered in different modalities (online, paper, or a combination of both versions).

Beyond *Closing the Gaps*, CareFirst seeks to invest in partnerships that are consistent with its three-pronged CareFirst *Commitment* initiative such as: the Governor's Wellmobile program to provide mobile primary medical care for the uninsured; the Whitman-Walker clinic to provide HIV/AIDS testing; Health care for the Homeless (serving 197,000 in primary care) to provide a broad range of medical and social services to the less fortunate; and school health programs for nutrition education.

For more information, visit the CareFirst website at <http://www.carefirst.com> or call 410.528.7133; Doris Addo-Glover – Senior Clinical Quality Specialist.

CASA de Maryland

In 1985, in response to the human needs of the growing number of refugees that were fleeing civil strife in Central America, a group of such refugees and concerned United States citizens living in Maryland created CASA de Maryland to address the need for job access, health and human services, and advocates for immigrants in the community. CASA's primary mission is to work with the community to improve the quality of life and fight for equal treatment and full access to resources and opportunities for low-income Latinos as well as other low-income immigrant communities. The organization advocates for social, political, and economic justice for all low-income communities.

CASA programming and services target issues of limited English proficiency, health education with links to primary care and screening programs, and socioeconomic development through job placement, vocational training, and education on legal rights. CASA's programming around these areas include:

- More than 15 volunteer health promoters in different leadership roles that provide outreach and education on cardiovascular health, diabetes, HIV/AIDS, cancer, and tobacco use prevention to the community in a manner that is both culturally and linguistically competent.
- Primary healthcare provided by Mobile Medical Care, Inc. once a week at the Silver Spring worker center. Free HIV/AIDS counseling and testing takes place once a week rotating around the different day labor centers. CASA tested approximately 600 individuals last year.

- Medical interpreter services provide culturally competent interpreters to clients at community clinics around Montgomery County. Interpreters do not only translate during a patient consultation or examination, but also serve as patient advocates. CASA provides safety net clinics with approximately 300 interpretations every month.
- Health Information Hotline serves more than 3,000 clients per year by providing information and referral to health and human services and by providing system navigation assistance.
- Social services such as document translation, notarization, legal counseling, English classes, and computer training. These classes and services help community members integrate into the workforce and achieve citizenship. CASA also has several day labor centers dispersed through Montgomery County that connect individuals with local businesses for employment.

CASA de Maryland continues to use social networking and support services to improve access and quality of life for immigrants in Montgomery County. A five-year strategic plan is in process, examining the needs of the community and the potential expansion and improvement of the programs. Nutrition has become a rising issue in the community which CASA wishes to address in the future. The organization also wishes to partner with area hospitals in order to provide an educational piece to the hospital system.

For more information, visit the CASA website at <http://www.casademaryland.org> or call 301.431.4185; Gustavo Torres – Executive Director.

Chinese Cultural and Community Service Center

The Chinese Culture and Community Service Center (CCACC) began in 1982 primarily as a social vehicle for the local Chinese community, but has since grown to offer a variety of programming divisions: Health, Senior Services, Community Services, Teens and Youth, Sports and Fitness, Education, and Culture and Arts.

In the 1990s, CCACC started offering senior services after recognizing that many seniors in the community faced isolation; required transportation; had limited English proficiency; and lacked opportunities to socialize. CCACC has since created four locations where seniors can gather to socialize and participate in cultural activities.

CCACC plans to expand its senior services to include an adult day healthcare center. This center, expected to be launched in November 2007, will be located in northern Rockville, and will provide medical care services in addition to social components. The program will be qualified for Medicaid reimbursement. CCACC hopes to have the participation of 30 clients in the first year of operation.

In addition to senior services, CCACC runs the Pan-Asian Health Clinic. CCACC found that many people in the community did not have health insurance, and some were forced to go back to China for services. To respond to the needs of low-income, uninsured patients in the community, CCACC started its own clinic and ensured that Chinese-speaking providers were available. All physicians at the clinic are bilingual and first-generation immigrants, thus delivering culturally competent care. Diabetes, asthma, and hypertension make up the most common conditions addressed at the clinic. The clinic serves approximately 700 patients a year. While the majority of the clinic's patients are Chinese, CCACC also serves other members of the local Asian community.

For more information, visit the CCACC website at <http://www.ccacc-dc.org> or call 301.984.1618; Meng Lee – Community Services Director.

Identity

Based in Montgomery County, Identity is a community organization with programs that focus on Latino youth. Identity was founded in 1998 and ensures that all of its programming is culturally and linguistically competent. The organization is led by two boards: a youth advisory board made up of Montgomery County Latino high school students and a board of directors composed of local business and community leaders. With a vision of empowering the future Latino community leaders, Identity operates the following programs:

- An after-school program designed to teach leadership, community building, and communication skills is conducted over the course of 30 sessions. This program also discusses several health issues, including substance abuse, HIV/AIDS, and sexual health. Through this program, youth are trained to become peer educators in order to pass along the lessons they learn to other youth in their schools and neighborhoods.
- Personal fitness and recreational activities are conducted in Montgomery County public schools when funding is available.
- Parental education and support is given for parents of students in the after-school program. Parents are taught parenting and communication skills, and Identity staff work to help parents better support their children in school.
- Case management and referral services for students and their families are coordinated by Identity staff.

Identity's after-school programs are conducted in Spanish and the staff utilizes the Positive Youth Development (PYD) approach—viewing youth as assets to be nurtured rather than as problems that need fixing—in order to build Latino families and communities.

For more information, visit the Identity website at <http://www.identity.ws> or call 301.963.5900; Diego Uriburu – Deputy Executive Director.

Maryland Asian American Health Solutions

In 2004, Maryland Asian American Health Solutions (MAAHS) began as a center located at the University of Maryland's School of Public Health in partnership with Montgomery County's Asian American Health Initiative (AAHI). As the AAHI research arm, MAAHS carries out county and state assessments of the health needs of the local Asian American community. MAAHS' goal is to reduce health disparities in Asian Americans living in Maryland through research that identifies their health needs and to develop and evaluate interventions that address those needs.

Montgomery County contains 85 percent of Maryland's Asian population. Focusing on Montgomery County, MAAHS has hosted focus groups with the Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, and Vietnamese communities. Health needs and barriers to access were identified from these focus groups through a series of seven reports. Additionally, MAAHS has initiated focus groups with smaller Asian communities (Burmese, Khmer, Nepalese, Taiwanese, Thai, Indonesian, Pakistan, Muslim Asian Americans of various countries of origins) and a group of young adult Asian Americans. The findings on these communities are yet to be released.

In addition to community needs assessments, MAAHS has received funding from the county to implement and evaluate an intervention to screen and treat Hepatitis B, a risk factor for liver cancer that disproportionately affects the Asian community. This work was recently published in the August 2007 issue of the *Journal of the National Medical Association*.

In the future, MAAHS hopes to expand its work in these areas:

- Infectious diseases, such as tuberculosis and Hepatitis B
- Cancer, particularly stomach, liver, and cervical cancer
- Diabetes
- Mental health

MAAHS highlights mental health as a predominant health issue facing Asian Americans. The issue spans across generations, although concerns in each generation may vary. Younger populations may be more acculturated to the mainstream American lifestyle and may face problems communicating with parents. Older respondents in focus groups report difficulty adjusting to a new country, work and financial stress, and loss of the social status from their home country. Elderly immigrants often find being in the United States isolating due to the language barrier and/or the lack of transportation. Stigma within the community around mental health problems was highlighted as a barrier to care, and more culturally competent mental health professionals and resources are needed to address this issue.

For more information, visit the Maryland Asian American Health Solutions website at <http://www.maahs.umd.edu>, or call Sunmin Lee – Director at 301.405.7251 or Ed Hsu – Co-Director at 301.405.8161.

Mobile Medical Care, Inc.

For 40 years, Mobile Medical Care, Inc. (MobileMed) has been providing healthcare to a range of racial and ethnic groups and the homeless population with three mobile vans and 20 clinics throughout Montgomery County. The organization serves people in Bethesda, Gaithersburg, Potomac, Rockville, and Silver Spring. MobileMed partners with various community groups such as the Chinese Culture and Community Service Center (CCACC), Our Lady of Vietnam Church's L'Ami group, Adventist HealthCare, and CASA of Maryland. These organizations provide volunteers, space, and community outreach to support the work of MobileMed. MobileMed does not bill any of its services to Medicaid, and only receives funding through the county, foundations, and individual and organizational donations. Montgomery County provides funding to MobileMed to provide primary care for the uninsured population and for a number of other safety net clinics.

- As a provider of primary care, MobileMed treats patients with common health problems such as hypertension, diabetes, asthma and other respiratory disorders, and chronic obstructive pulmonary disease.
- MobileMed integrates prevention programs in its service offerings by ensuring whenever possible that patients receive any necessary preventive services. MobileMed also offers flu and tetanus vaccinations, and refers mammography, colonoscopy, and prostate screenings to other county programs. MobileMed also provides counseling for tobacco, alcohol, and drug abuse as well as for high-risk sex behavior.
- MobileMed is a large provider of healthcare to Montgomery County's homeless population.

- The Healthy Bodies program at MobileMed promotes healthy living through obesity improvement. Patients are given nutritional information, and MobileMed pays for a three-month membership to a community recreation center to get people exercising. Patients who use their membership are allowed to renew it at no cost.

The shortage of specialty care is a serious issue for the uninsured. MobileMed has a small cadre of volunteer specialists who provide orthopedic, cardiology, pulmonary, and podiatry services. It also has a volunteer psychiatrist on staff, but the organization does not have any psychiatric drugs. MobileMed hopes to begin urology services in October 2007.

For more information, visit the MobileMed website at <http://www.mobilemedicalcare.org> or call 301.841.0835; Barbara Clark – Clinical Director.

Montgomery County African American Health Program

In 1999, Montgomery County officials recognized that the infant mortality rate for blacks in the county was four times that of whites. To respond to this challenge and other health disparities, the African American Health Initiative, now the African American Health Program (AAHP), was born. The mission of the AAHP is to eliminate health disparities for African Americans in Montgomery County, to ensure quality of care, and to ensure quality of life.

Since 1999, the AAHP has grown to provide a variety of programming for Montgomery County's black community, including U.S.-born African Americans and African or Caribbean immigrants. The program began with a focus on four health areas (infant mortality, HIV/AIDS, diabetes, and oral cancer) but has since expanded its reach to include cardiovascular disease and breast, colorectal, and prostate cancers. AAHP's programming around these areas is broad and includes:

- Management of high-risk births via the Black Baby SMILE program. The program provides home visit case management to high-risk mothers, and aims to reduce preterm delivery and low-birth weight, which have been proven to be factors that lead to infant mortality. The program has also recently begun offering monthly childbirth classes and lactation assistance.
- Diabetes education through a four-week course offered 9 to 12 times a year, with an average of 10 to 12 students per class. AAHP also sponsors 3 diabetes dining clubs that assist 50 to 75 participants in learning how to make healthy food selections, participate in physical activities that can be replicated in other settings, and additional information pertaining to topics of interest for diabetics.
- Promotion of physical fitness through the cosponsoring the Health Freedom walk with CHAMP, a Baltimore health awareness and prevention program. Participants form groups several weeks prior to the walk in order to help make walking a part of their lifestyle.
- HIV testing, counseling, and referral services in line with state guidelines.
- Hypertension education through the HEAAL (Hypertension Education and Awareness Link) outreach program staffed by volunteers who visit beauty salons, barbershops, and churches to educate the community on hypertension prevention and management.
- Support of The Peoples Community Wellness Clinic, a safety net clinic started by The Peoples Community Baptist Church that primarily serves the black community in the eastern portion of the county.

The AAHP continues to examine additional opportunities to improve the health of the African American community. Recognizing the growth in the African immigrant population in the county, AAHP recently conducted a community needs assessment to understand the needs of the local African community. In the future, program staff would like to mobilize more resources to address asthma and mental health. The organization plans to collaborate with Montgomery County's other minority health initiatives and other local organizations in the future to address these issues.

For more information, visit the AAHIP website at <http://onehealthylife.org> or call 240.777.1833; Brenda Lockley – Program Manager, 301.421.5447.

Montgomery County Asian American Health Initiative

The Asian American Health Initiative (AAHI) is a part of Montgomery County Department of Health and Human Services, established and funded in Fiscal Year 2005. AAHI is the first health-related program that has directly addressed the needs of the Asian American community in Montgomery County. The mission of AAHI is to identify the healthcare needs of a diverse group of Asian American communities, to develop culturally competent healthcare services, and to implement health education programs that are accessible and available to all Asian Americans.

The Asian American Health Initiative strives to:

- Conduct an in-depth data collection, analysis and reporting of health status for the different ethnic groups in the Asian American community.
- Expand and improve the existing health services available to Asian Americans.
- Ensure the availability of quality healthcare directed to the specific needs of the different ethnic groups in the community.
- Provide outreach programs to inform and educate the different ethnic groups about the accessibility and the availability of healthcare services.
- Ensure that all ethnic groups in the Asian American community have their fair share of health care by eliminating barriers.

In addition, AAHI seeks to improve access to health services and reduce health disparities through education and outreach activities in a culturally and linguistically appropriate manner. In doing so, several programs are in place to address the various health disparities affecting Asian Americans in Montgomery County. With the assist of bilingual and bicultural health promoters, AAHI actively works to educate the community about cancer, osteoporosis, diabetes, Hepatitis B, and mental health among other topics in order to improve access to health services. Education sessions and health fairs are delivered in many diverse Asian American populations in collaboration with various organizations and partners. With these services, AAHI continues to decrease barriers in accessing healthcare in an effort to improve the quality of life for Asian Americans.

For more information, visit the AAHI website at <http://www.aahiinfo.org> or call 240.777.4510; Julie Bawa – Program Manager.

Montgomery County Latino Health Initiative

The Latino Health Initiative (LHI) of the Montgomery County Department of Health and Human Services was established in July 2000, with the support of the County Executive and County Council.

The mission of the LHI is to improve the quality of life of Latinos living in Montgomery County by contributing to the development and implementation of an integrated, coordinated, culturally and linguistically competent health wellness system that supports, values, and respects Latino families and communities.

The overall functions of the LHI are to:

- Enhance coordination between existing programs and provide technical assistance to programs and services targeting Latinos.
- Develop and support models of programs and services to adequately reach Latinos.
- Advise individuals in decision-making positions regarding policies and practices needed to effectively reach and serve Latinos.

The Latino Health Steering Committee (LHSC) was formed in August of 2000 to advocate for Latino Health and provide expert guidance and technical assistance. The LHSC is a group of volunteer professionals representing local and national organizations. These individuals work as a team to inform the Latino community about the LHI and to collect feedback from them regarding their health concerns. In addition, this group acts as the planning body for the LHI.

For more information, visit the LHI website at <http://www.lhiinfo.org> or call 240.777.1779; Sonia Mora – Program Manager.

The People's Community Wellness Center

The mission of The People's Community Wellness Center (TPCWC) is to provide primary, ambulatory health care to adults in Montgomery County – especially eastern Montgomery County – who are unable to afford private healthcare and have no health insurance. TPCWC is co-sponsored by Montgomery County Government and The People's Community Baptist Church of Silver Spring, Maryland.

Clinical services are available for uninsured adults who are ineligible for government-assisted healthcare and can demonstrate that they do not have personal assets, financial reserves, or sufficient family resources to support their own medical care. Many of these residents may be foreign-born and/or not have access to traditional healthcare resources. Maximum efforts are made to accommodate bilingual adults.

The services of TPCWC include the following:

- Care for acute illness
- Care for chronic medical conditions such as diabetes, hypertension, and asthma
- Routine physical examinations
- Preventive care/wellness examinations

- Laboratory tests including HIV screening
- Medications, when available
- Nutrition and diabetes management counseling
- Lifestyle management counseling
- Mental health counseling

A mandatory \$10 co-pay is assessed for each office visit and voluntary financial contributions from patients will also help the center continue to operate and provide free services. TPCWC is open for health care services Monday thru Friday by appointment only. Afternoon and evening clinics are available on Wednesday and Thursday (2 p.m. to 10 p.m.).

For more information, contact TPCWC at 301.847.1172; Wilbur Malloy – Director.

Primary Care Coalition, Montgomery Cares, Care for Kids

In 1993, the Primary Care Coalition (PCC) was formed in the midst of growing interest in public-private partnerships to reduce health disparities for the uninsured in Montgomery County. Under the guidance of 50 staff members, PCC aims to provide access to high quality, culturally sensitive primary care to uninsured children and adults in Montgomery County.

PCC programs serve individuals below 250 percent of the federal poverty level who do not have access to other forms of insurance. The coalition conducts its work through five Centers.

- The Center for Healthcare Access administers Montgomery Cares and Care for Kids, county-funded programs that provide primary care to adults and children. Montgomery Cares, founded in 2005, sub-contracts with nine clinics for adult care. This voluntary network of service providers reaches approximately 15,000 uninsured people per year. Care for Kids contracts with eight providers and serves 3,000 uninsured children under the age 19 with 2,900 annually. The Center additionally managed Project Access, a pro-bono specialty care referral network, a healthcare for the homeless initiative, and pilot programs that provide oral and behavioral health services in the primary care setting.
- The Center for Medicine Access administers the Community Pharmacy that provides 30 generic point-of-care medicines to clinic patients and free brand name drugs through Maryland Medbank. The Center additionally administers a pharmacy benefit plan for children who participate in Care for Kids and adults who receive specialty care from Project Access volunteer physicians.
- The Center for Health Improvement seeks to improve the health status of children and adults participating in PCC programs with an emphasis on care quality, community outreach and education, evidence-based medicine, and research.
- The Center for Community-Based Health Informatics develops and deploys an Open Source, web-based, and shared electronic medical record in collaborating community clinics. It additionally is implementing an Agency for Healthcare Research and Quality grant that will facilitate the exchange of electronic health information between Montgomery County community clinics and mainstream healthcare.

- The Center for Children’s Health administers the Tree House, a one-stop center for children victims of physical and sexual abuse.

The PCC was recently one of twelve national organizations selected by the Institute for Health Improvement to participate in their Triple Aim initiative that seeks to optimize population health, cost per patient, and patient experience.

For more information, visit the PPCC website at <http://www.primarycarecoalition.org> or call 301.628.3405; Steve Galen – Executive Director; Sharon Zalewski – Center for Health Care Access.

Prince George’s Child Resource Center

The Prince George’s Child Resource Center (PGCRC) was founded to address increasing cases of child abuse, teen pregnancy, and substance abuse. PGCRC creates healthy and nurturing environments for children by supporting families and educating caregivers. The organization focuses on child safety, connecting families with community resources, and educating child care providers. PGCRC programs include:

- Child care referral services, which aid families in receiving contact information for licensed child care providers. These services include summer camps, nursery schools, part-day programs, or child care centers.
- A family support center located at the satellite office in Adelphi, providing adult education, employment assistance, basic computer training, and health education for parents of children under age four.
- A car seat loan program, which allows families to use a child car seat for an extended time period and exchange it as their child grows. The program helps promote child car safety.
- Training for child care providers includes classes such as school age training, infant and toddler training, literacy enhancement training, CPR and first aid training, or children’s discipline training.
- Healthy Families program to prevent child abuse and neglect in families. This home visit program serves first-time expecting mothers under age 25 with the upcoming birth and up to the fifth year. Eight trained home visiting staff supported more than 65 families in the past year. The program creates a long-term support system for the family by education, connection to community resources including medical assistance, and performing regular child development assessments.

The organization conducts a participant satisfaction survey for Healthy Families annually and reported a 100 percent satisfaction rate from families last year. Recognizing the instability of the health environment surrounding many families, PGCRC would like to expand the capacity of the Healthy Families Program and extend services to more families in Prince George’s County.

For more information, visit the PGCRC website at <http://www.childresource.org> or call 301.431.6210; Liliana Janssen-Checa – Family Support Center.

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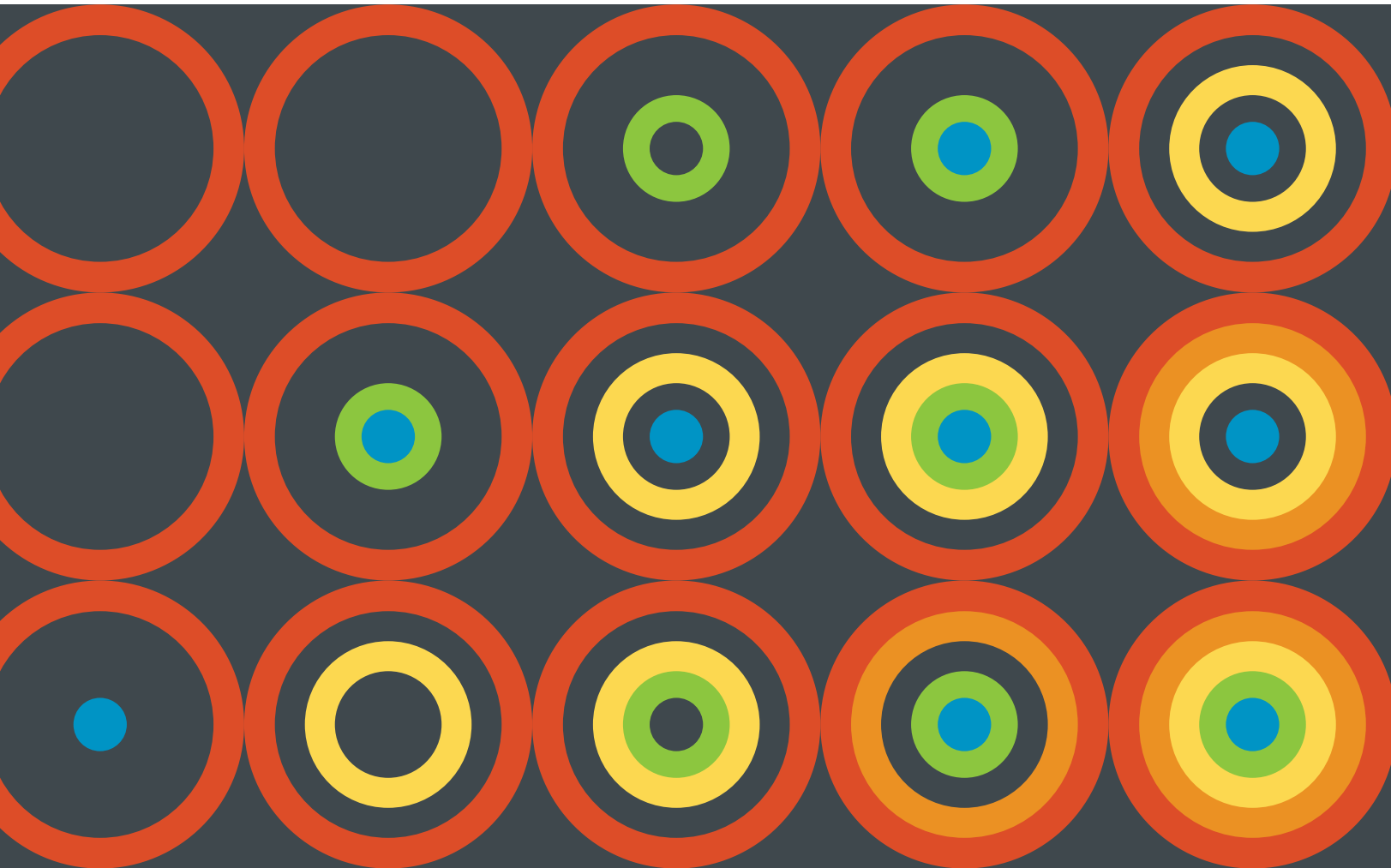
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