

Appendices



Oklahoma Task Force to Eliminate Health Disparities

DATA REPORT · SEPTEMBER 2004

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Summary and Key Findings

This report represents the work completed by the Data Committee of the Oklahoma Task Force to Eliminate Health Disparities for year one of the Task Force mandate. Participating agencies and groups in the Data Committee included:

- Absentee Shawnee Tribe
- Cherokee Nation
- Integris Mental Health
- Northeast Oklahoma Community Health Center
- Oklahoma City Area Indian Health Service
- Oklahoma City Area Inter-Tribal Health Board
- Oklahoma Department of Commerce
- Oklahoma Department of Human Services
- Oklahoma Department of Mental Health and Substance Abuse Services
- Oklahoma Foundation for Medical Quality
- Oklahoma Health Care Authority
- Oklahoma Primary Care Association
- Oklahoma State Department of Health
- Oklahoma State House of Representatives
- Oklahoma State Senate
- Paradox A. I. Research
- University of Oklahoma

To begin the process of identifying health disparities through available data, committee members agreed on several principles dealing with what data to review, how the data would be combined from the different participating agencies and groups, and what key benchmarks to look at (i.e., years 1997 through most current available data and standard age categories). The end result was a comprehensive database of indicators representing the combined data of the participating agencies and groups. Just having produced this very preliminary database was a significant outcome, since data from these different agencies and groups had never been combined in this way before.

In addition to the basic principles on what data to collect and how it would be combined into a single database, the group decided that the primary way to report analyses would be through regional planning districts, graphically displayed on maps of Oklahoma. Each data map also includes a brief narrative of bullet points, providing additional information on the particular health indicator. Copies of the data charts for each of these maps and bullet points may be downloaded at <http://www.health.state.ok.us/commish/disparities.html>. Technical notes about these charts also may be found at this location.

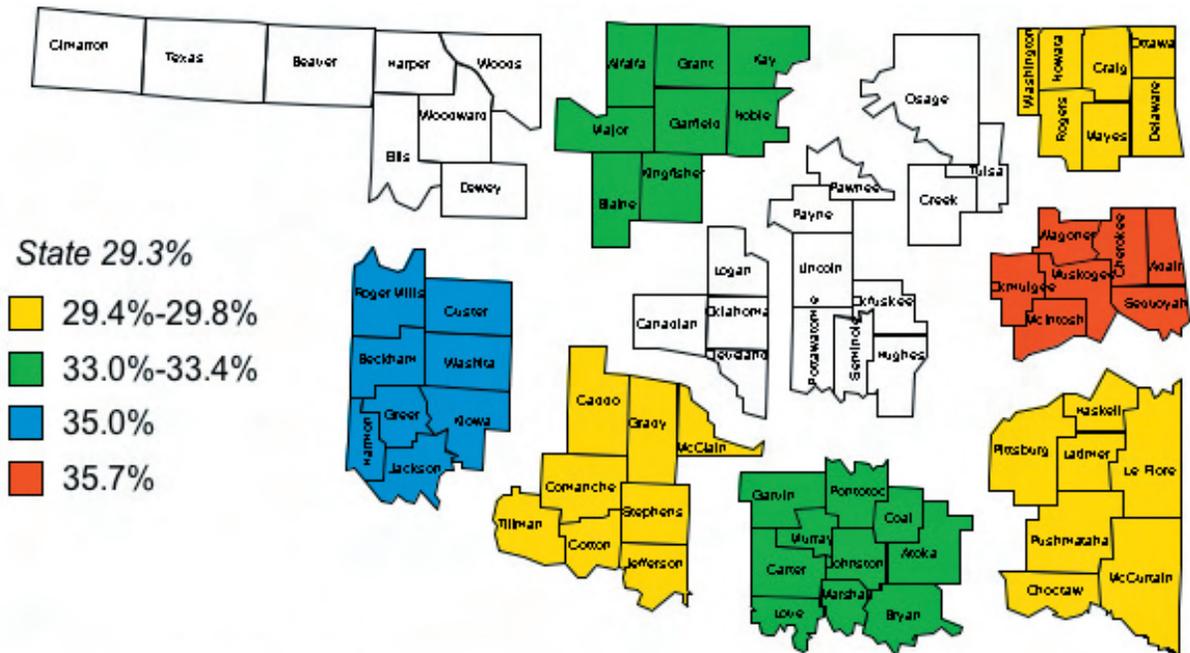
Although this is the initial, year one report of the Data Committee, some key findings have already been identified, which will lead the committee to further investigations.

These findings include:

- High rates of elevated blood pressure among African Americans.
- High rates of diabetes among Native Americans.
- High rates of obesity among African Americans, Hispanics, and Native Americans.
- Disparities in affordable medical care for African Americans and Native Americans.
- Possible treatment disparities among African Americans, resulting in higher death rates for cardiovascular disease and certain cancers.

As the Data Committee of the Oklahoma Task Force to Eliminate Health Disparities continues its work, these key findings and other areas of concern identified through this report will be further analyzed. Rather than focusing on regional differences as this report did, the year 2 report will identify disparities within ethnicity, gender, and socio-economic groups.

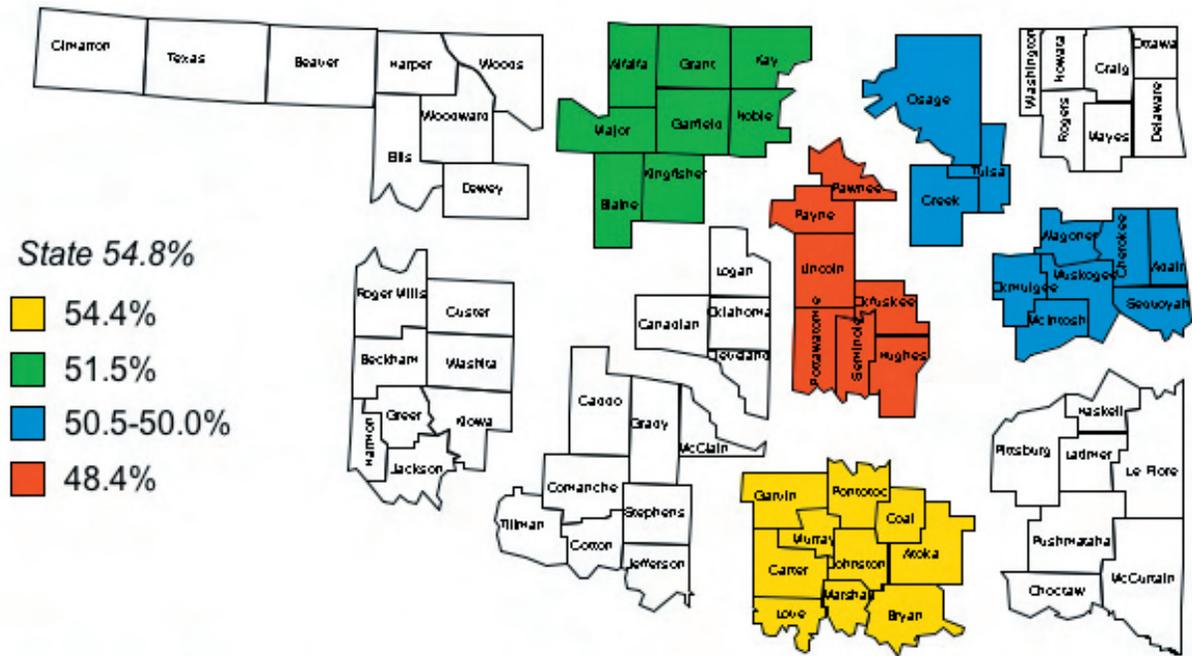
Percent of Adult Respondents Reporting Having Been Told by a Doctor, Nurse, or Other Health Professional that You have High Blood Pressure by



Source: Oklahoma Behavioral Risk Factor Surveillance System

- Lower rates of high blood pressure as education and income increases.
- Rates of high blood pressure increasing overall (possibly due to increases in obesity).
- Rates of high blood pressure are higher among females than males.
- Higher rates of high blood pressure are found in the east-central part of the state.
- Highest rates of high blood pressure among African Americans.

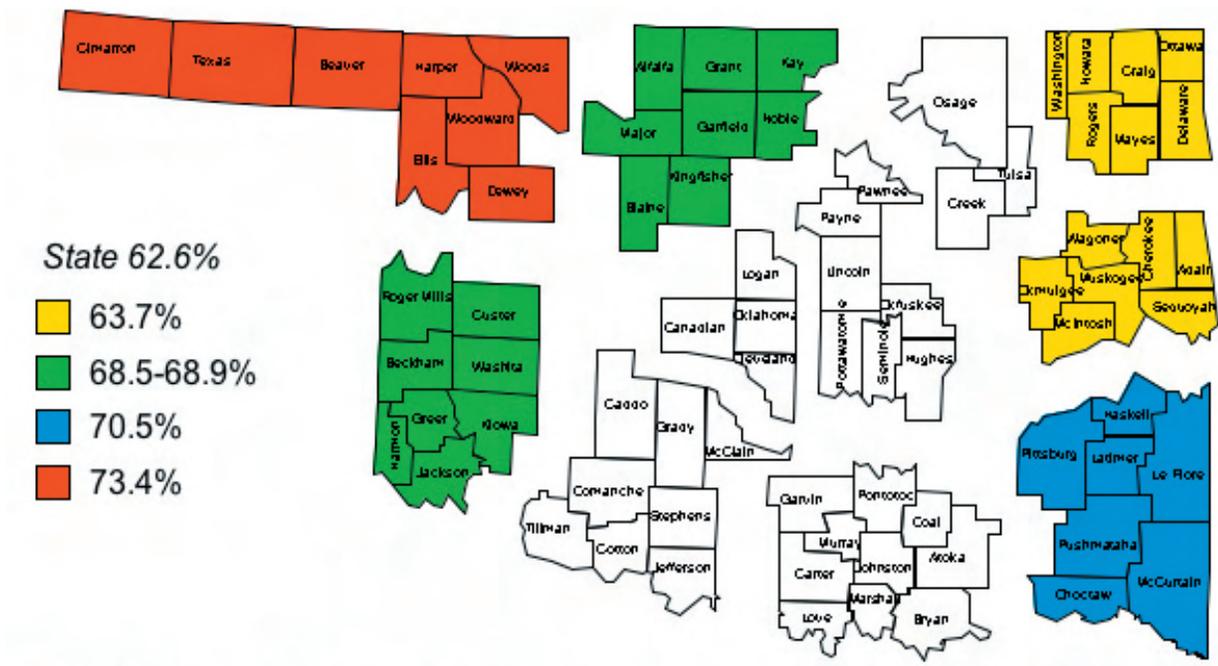
Percent of Adult Respondents Having Pneumonia Vaccination among People with Diabetes by



Source: Oklahoma Behavioral Risk Factor Surveillance System

- Rates for pneumonia shots among those with diabetes increasing over time.
- Rates for pneumonia shots among those with diabetes are significantly lower for those without health insurance coverage.
- Rates for pneumonia shots among those with diabetes tend to increase as age increases.

Percent of Adult Respondents Not Tested for HIV by

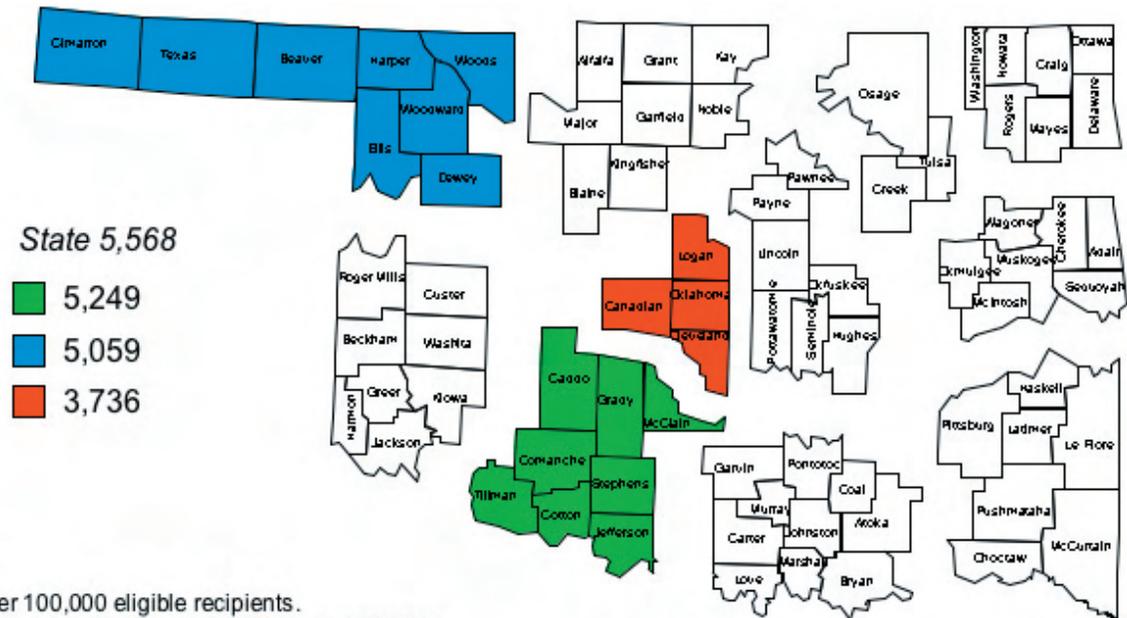


White areas are less than or equal to state rate.

Source: Oklahoma Behavioral Risk Factor Surveillance System

- African Americans are being tested more for HIV than other groups.
- Fewer people getting tested for HIV in southeast and northwest Oklahoma.

Rate of Paid Claim Data for Immunization Among Medicaid Patients by Sub-State Planning Districts:



Rates per 100,000 eligible recipients.

White areas are greater than or equal to state rate.

Rates obtained were from administrative data which included paid claims/encounters only and for recipients eligible at any time during the defined year.

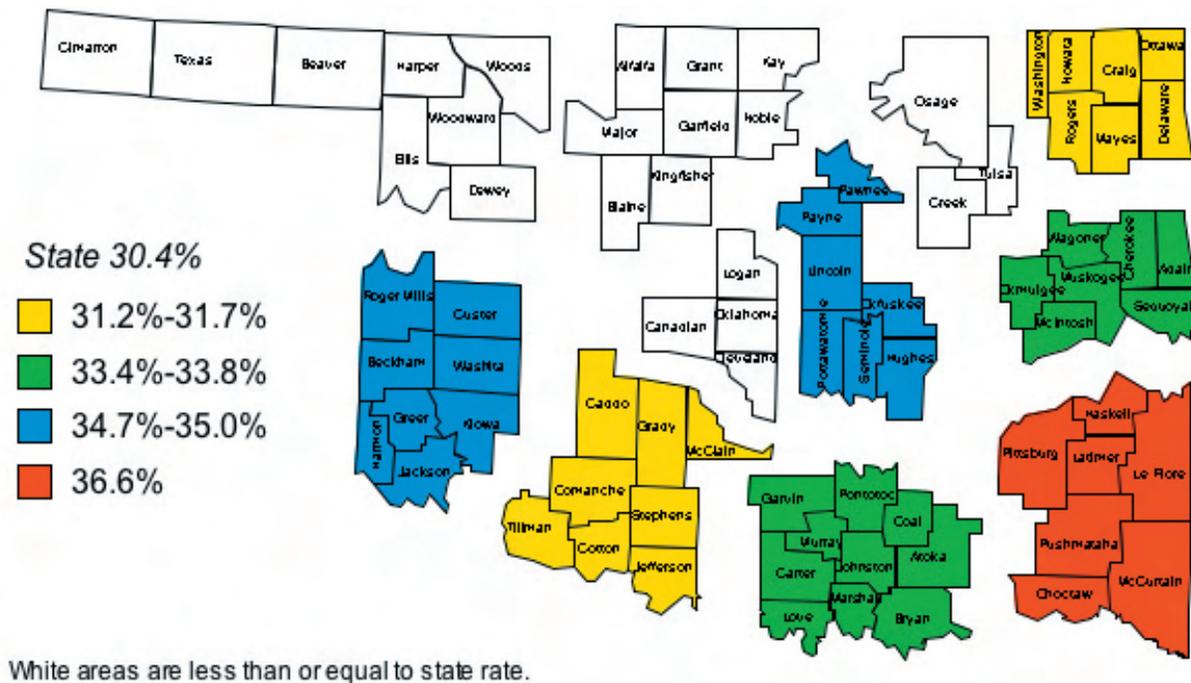
Numerator = eligible Medicaid recipients with defined diagnosis code

Denominator = total number of people that were Medicaid eligible at any point during the given year

Source: Oklahoma Health Care Authority

- Significant African American disparity for Medicaid immunization coverage.
- Significant Hispanic disparity for Medicaid immunization coverage.
- Central Oklahoma rates are worse than any other region in the state for Medicaid immunization coverage.

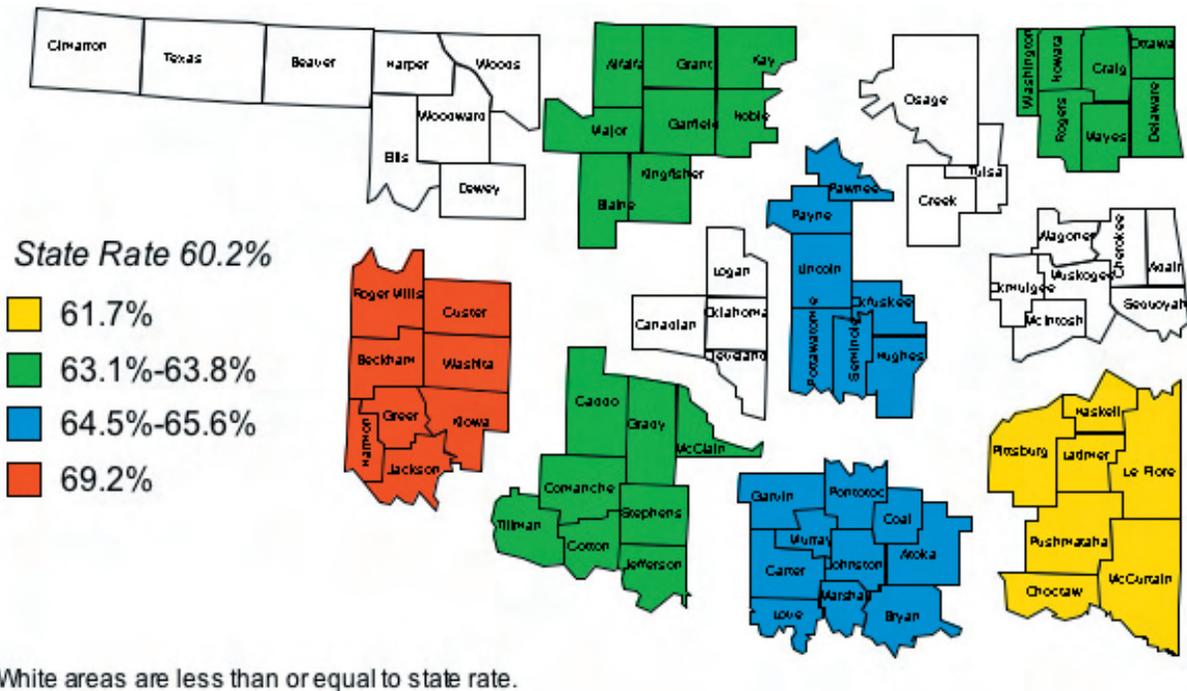
Percent of Adult Respondents Reporting Not Participating in a Leisure Time Physical Activity During the Past Month by Sub-State Planning



Source: Oklahoma Behavioral Risk Factor Surveillance System

- Lack of physical activity increases with age.
- Physical activity increases with increased income.
- Physical activity increases with increased education.
- Disparity among the Hispanic population (less physical activity than any other group).
- Females participate in physical activity less than males.

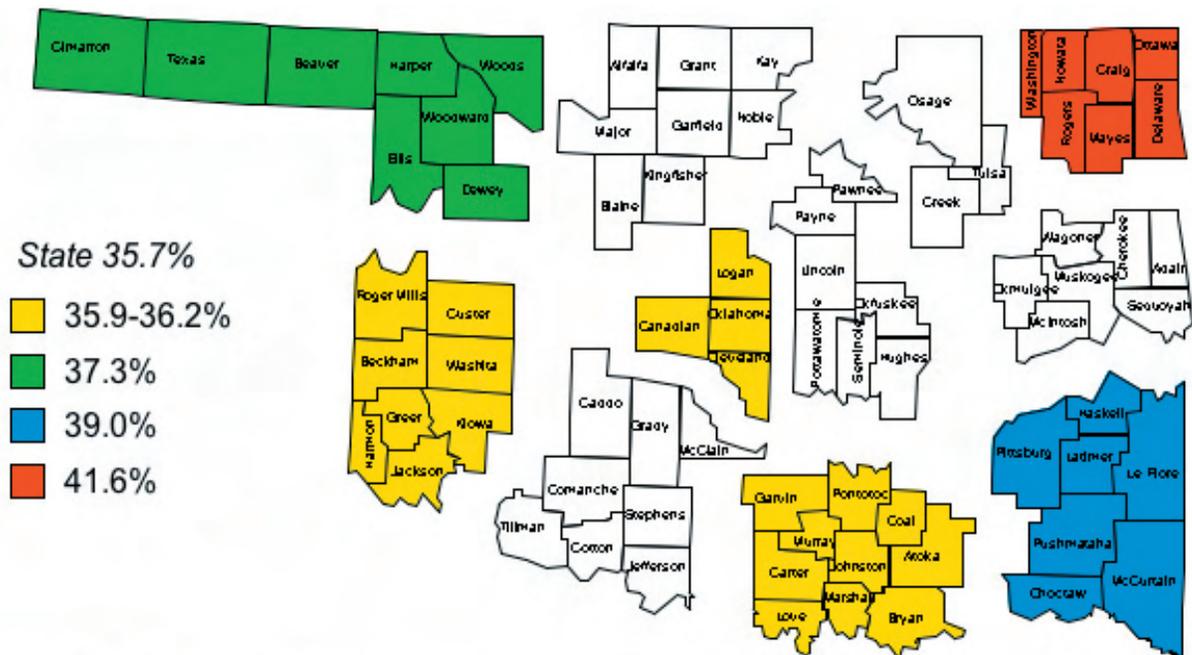
Percent of Adult Respondents Reporting an Overweight BMI (≥ 25.0) by Sub-State Planning



Source: Oklahoma Behavioral Risk Factor Surveillance System

- The percent of those who are overweight steadily increased from 1997-2003.
- African Americans and Native Americans have higher rates of being overweight than Hispanics.
- Higher rates of being overweight in males than females.
- Those reporting being overweight increasing more rapidly in the 20-29 age group.
- Higher rates of being overweight correspond with increase in type 2 diabetes, especially in younger age groups.
- High rate of increase of being overweight in 80+ age group.
- Slightly lower rates of being overweight in urban areas.

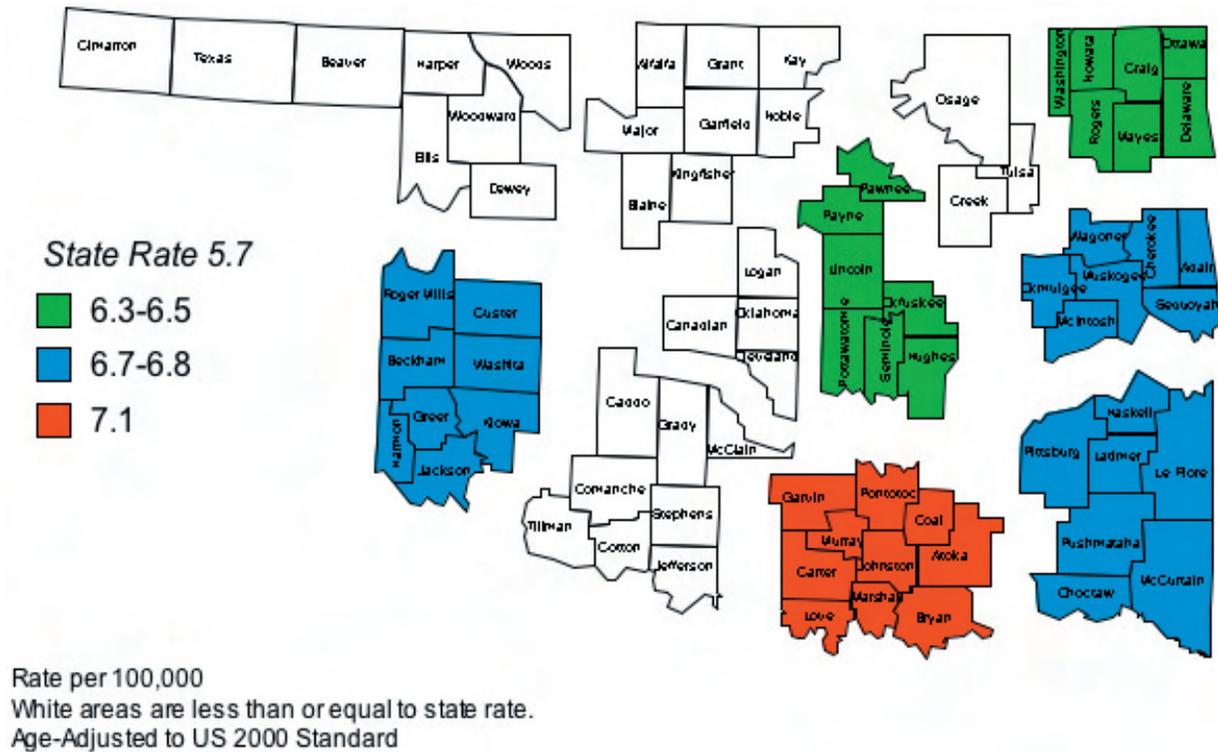
Percent of Cancer Diagnosed at Regional or Distant Stage by Sub-State Planning Districts:



Source: Oklahoma Central Cancer Registry

- Rates of cancer increase with age.
- Rates of cancer have stayed steady over time.
- Higher rates of cancer among African Americans.
- Higher rates of cancer among males.
- Higher rates of cancer among the very young.

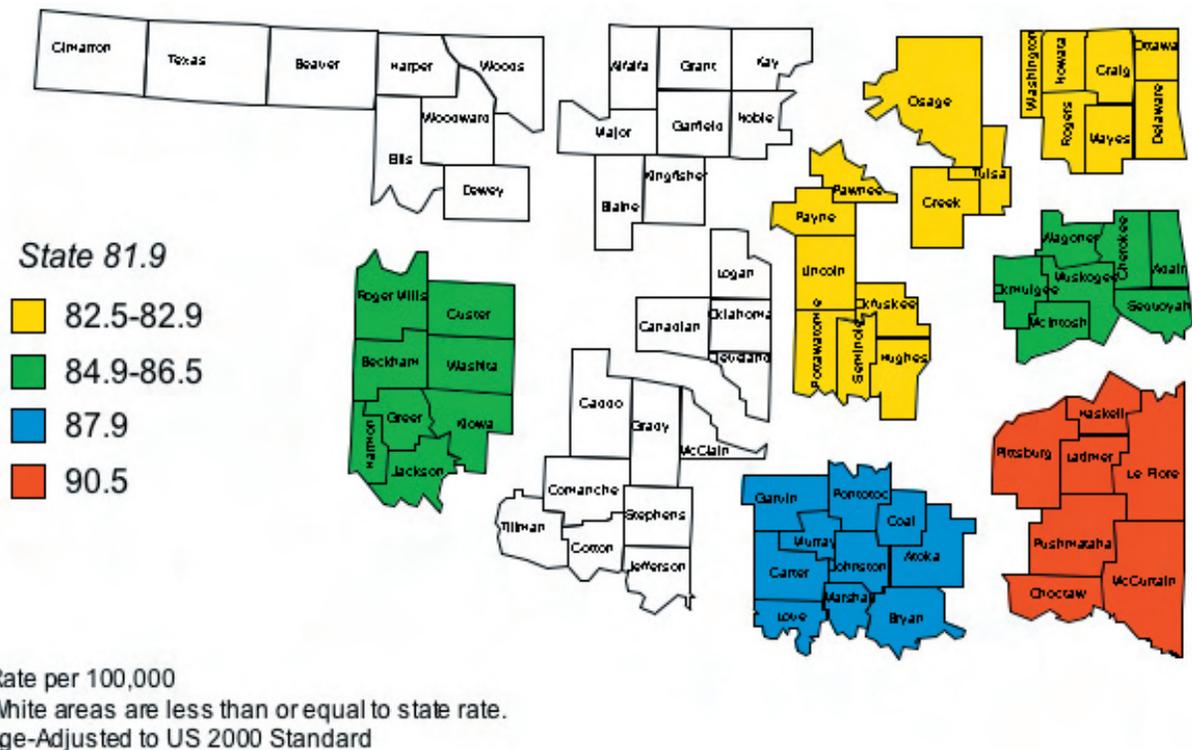
Age-Adjusted Incidence Rate Colon and Rectum Cancer by Sub-State Planning Districts:



Source: Oklahoma Central Cancer Registry

- Highest rates of colon cancer among African Americans.
- Higher rates of colon cancer among males.
- Rates of colon cancer increase with age.

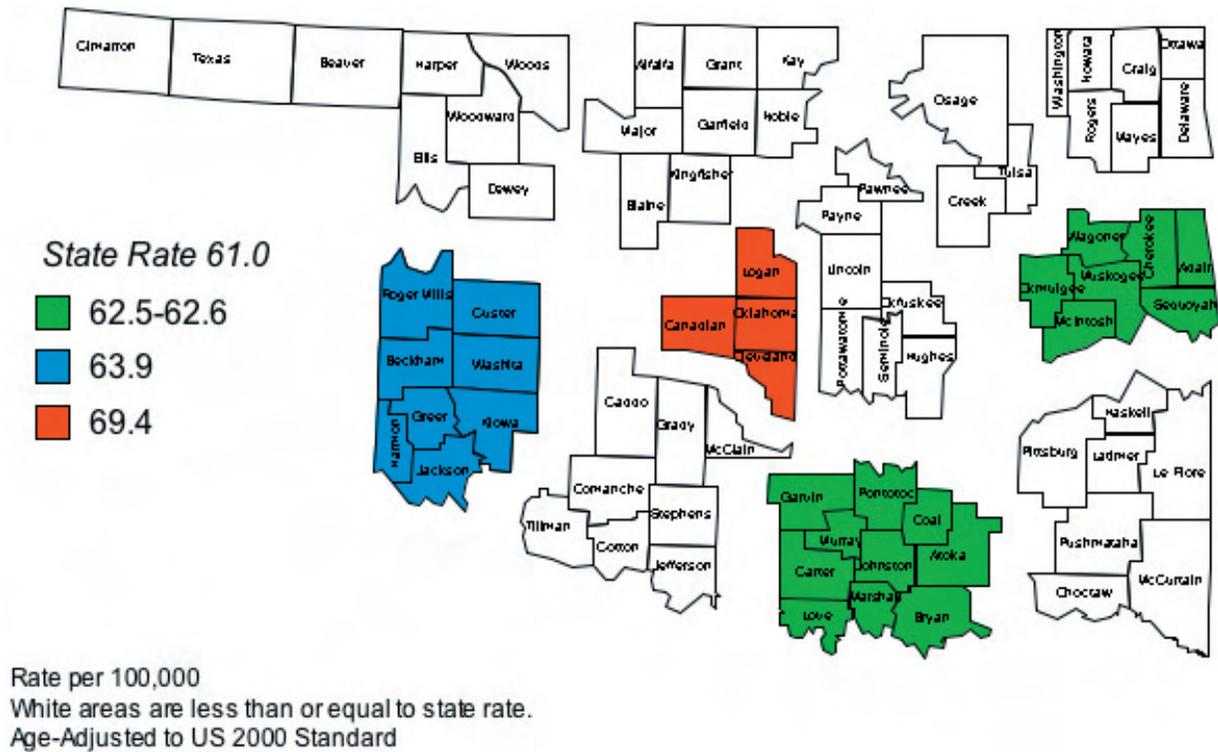
Age-Adjusted Incidence Rate Lung and Bronchus Cancer by Sub-State Planning Districts:



Source: Oklahoma Central Cancer Registry

- Rates for lung cancer among males are almost twice as high as females.
- Although there are improvements in smoking rates, lung cancer deaths have not caught up.
- Lowest rates for lung cancer are in northwest Oklahoma and highest in southeast.
- Lung cancer rates for Hispanics are beginning to decrease.

Age-Adjusted Incidence Rate Prostate Cancer by

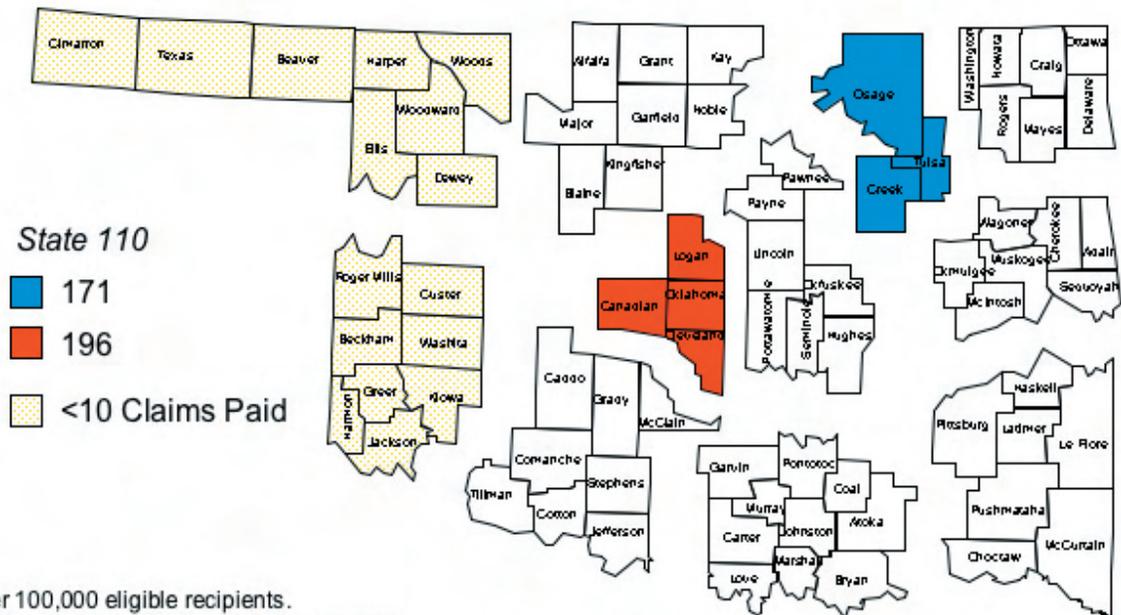


Source: Oklahoma Central Cancer Registry

- Significant disparity for prostate cancer among Native Americans.
- Prostate cancer rates are worse for 60-69 and 70-79 age groups.

Rate of Paid Claim Data with a Diagnosis of HIV Among Medicaid Patients by Sub-State Planning Districts: Oklahoma 2003

Rate of Paid Claim Data with a Diagnosis of HIV Among Medicaid Patients by Sub-State Planning Districts: Oklahoma 2003



Rates per 100,000 eligible recipients.

White areas are less than or equal to state rate.

Rates obtained were from administrative data which included paid claims/encounters only and for recipients eligible at any time during the defined year.

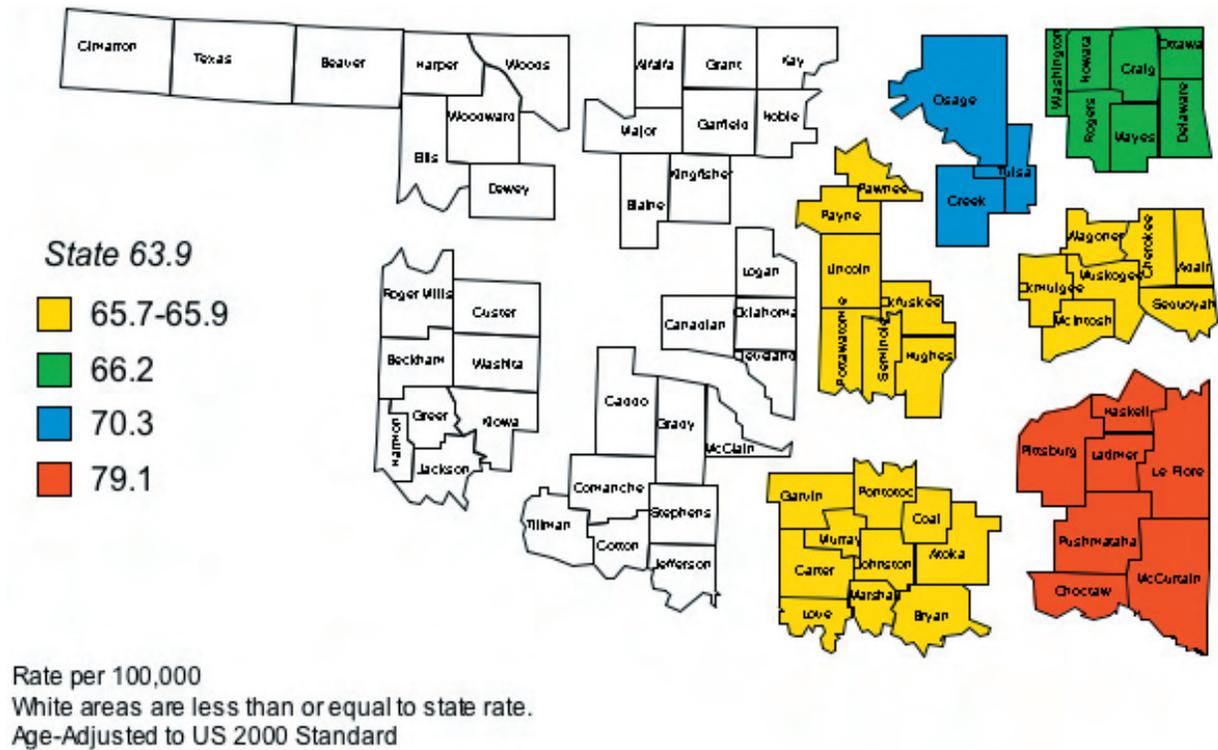
Numerator = eligible Medicaid recipients with defined diagnosis code

Denominator = total number of people that were Medicaid eligible at any point during the given year

Source: Oklahoma Health Care Authority

- HIV infection rates are highest among African Americans and increasing over time.
- HIV infection rates are highest in the 30-49 age group.
- HIV infection rates are higher in males.

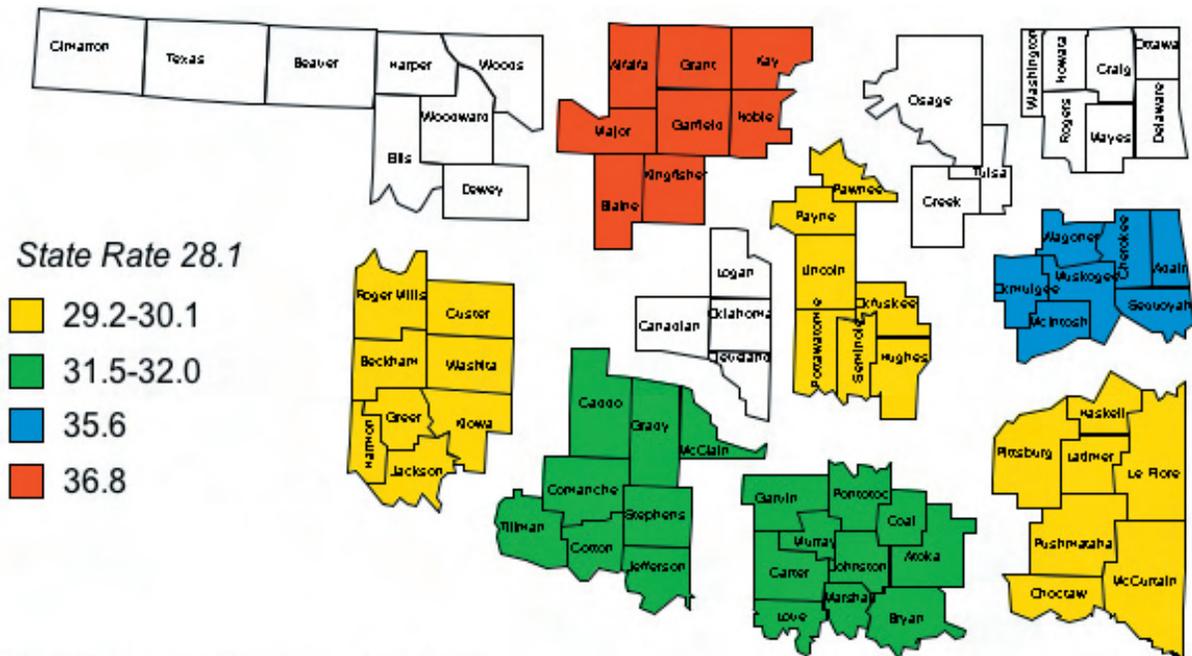
Age-Adjusted Mortality Rate Cancer of the Lung and Bronchus by Sub-State Planning Districts:



Source: Oklahoma Vital Records

- Higher death rates of lung cancer in African Americans and Native Americans.
- Higher death rates of lung cancer in males.
- Lowest death rates of lung cancer in northwest Oklahoma, and highest rates in southeast Oklahoma.
- African Americans have lower incidence rates of lung cancer but higher death rates, indicating possible health access or treatment disparities.

Age-Adjusted Mortality Rate for Diabetes by

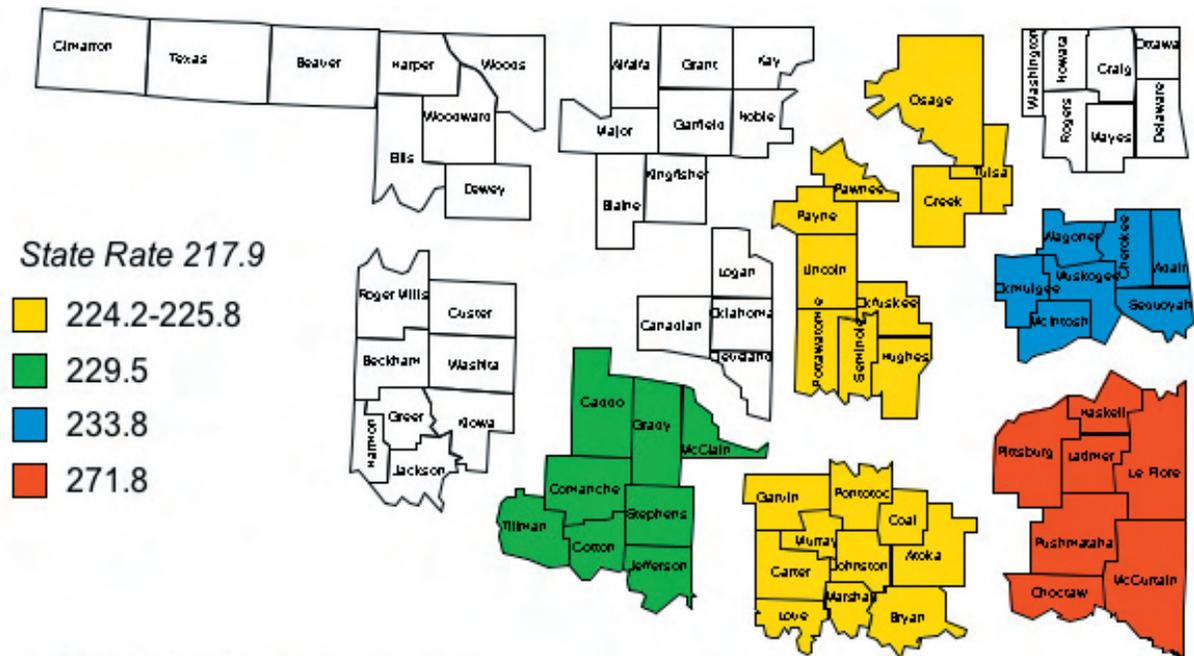


White areas are less than or equal to state rate.
 Rate per 100,000
 Age-Adjusted to US 2000 Standard

Source: Oklahoma Vital Records

- Much higher rates of diabetes deaths among Native Americans and African Americans.
- Increasing rates of diabetes deaths over time.
- Highest rates of diabetes deaths in north central Oklahoma and lowest in north-west Oklahoma.

Age-Adjusted Mortality Rate Ischemic Heart Disease

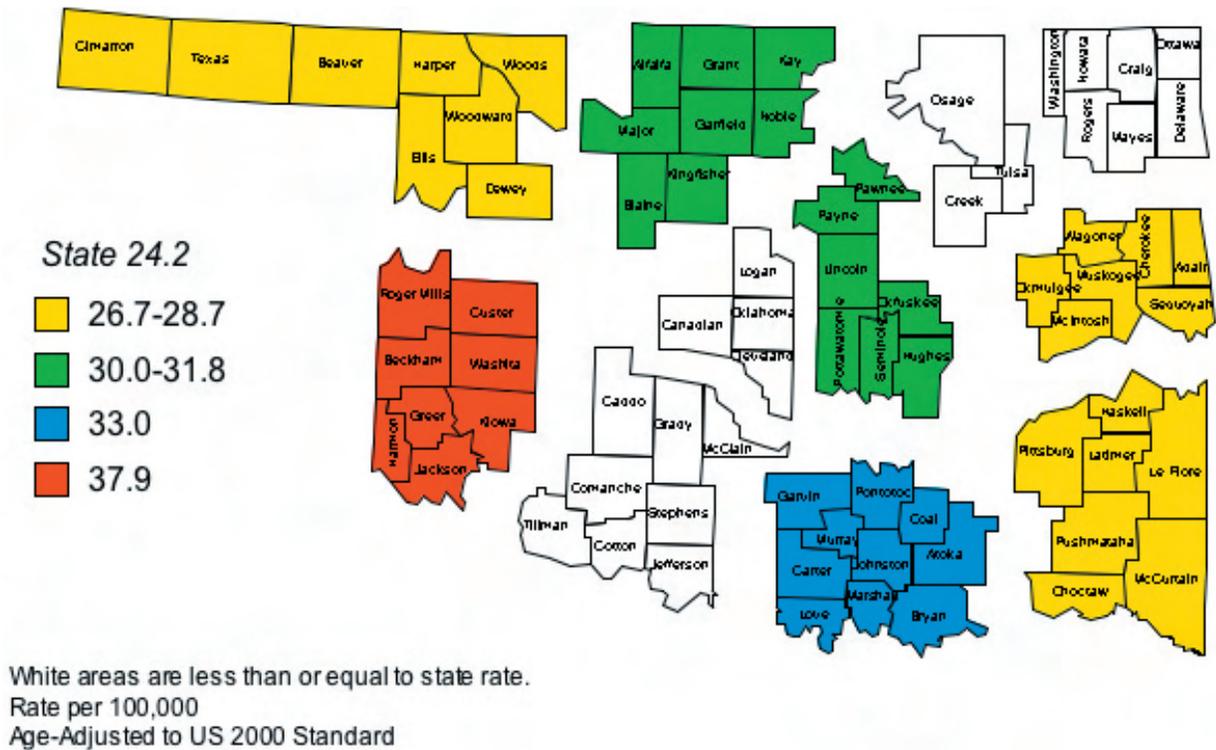


White areas are less than or equal to state rate.
 Rate per 100,000
 Age-Adjusted to US 2000 Standard

Source: Oklahoma Vital Records

- High ischemic heart disease deaths among African Americans and Native Americans.
- High ischemic heart disease deaths among men.
- Ischemic heart disease death rates are highest in southeast Oklahoma and lowest rates in northwest Oklahoma.
- Lower ischemic heart death rates among Hispanics.
- Ischemic heart disease deaths going down in all categories.
- Ischemic heart disease deaths decreasing further in men than women.
- Higher rates of ischemic heart disease deaths in rural areas, possibly due to lack of access to emergency care.

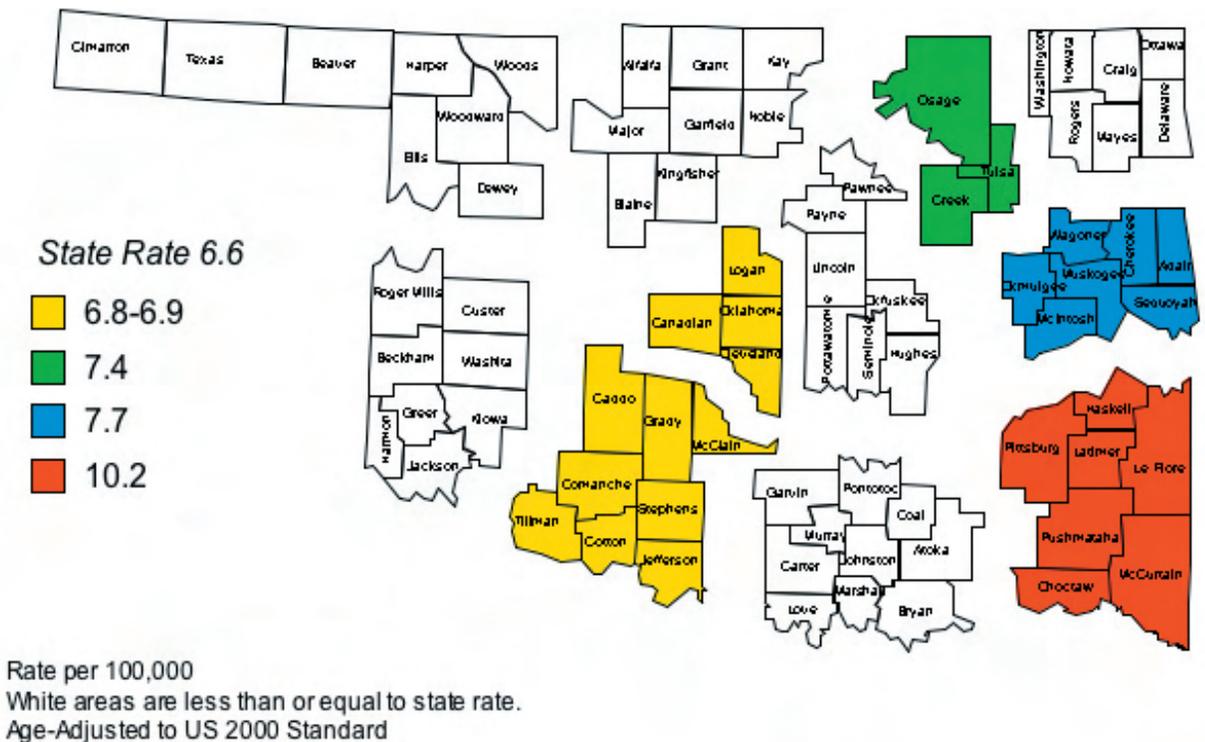
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Source: Oklahoma Vital Records

- Higher death rates from influenza and pneumonia in rural vs. urban areas, probably due to health access.
- Higher death rates from influenza and pneumonia among males vs. females.
- Highest rates of death from influenza and pneumonia in southwest Oklahoma.

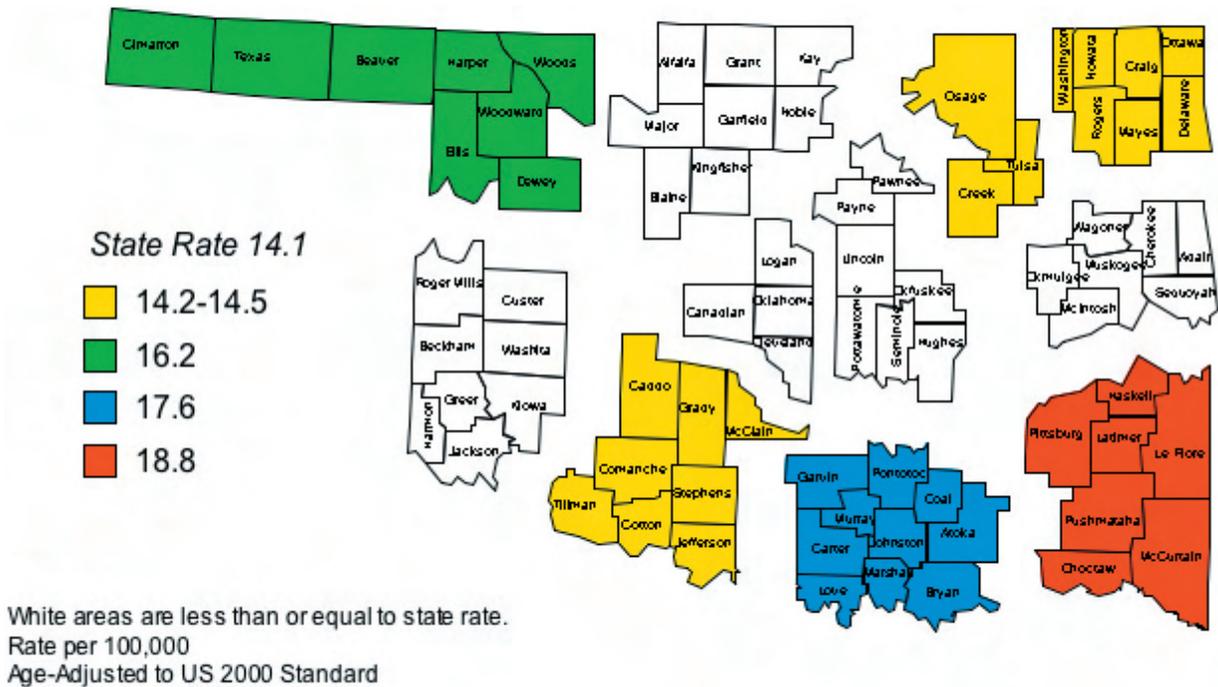
Mortality Rate Homicide by Sub-State Planning



Source: Oklahoma Vital Records

- Clear disparity for deaths due to homicide among African Americans.
- Clear disparity for deaths due to homicide among males.
- Highest rates for deaths due to homicide in southeast Oklahoma, but decreasing.
- Disparity for deaths due to homicide among the 20-29 and 30-39 age groups.

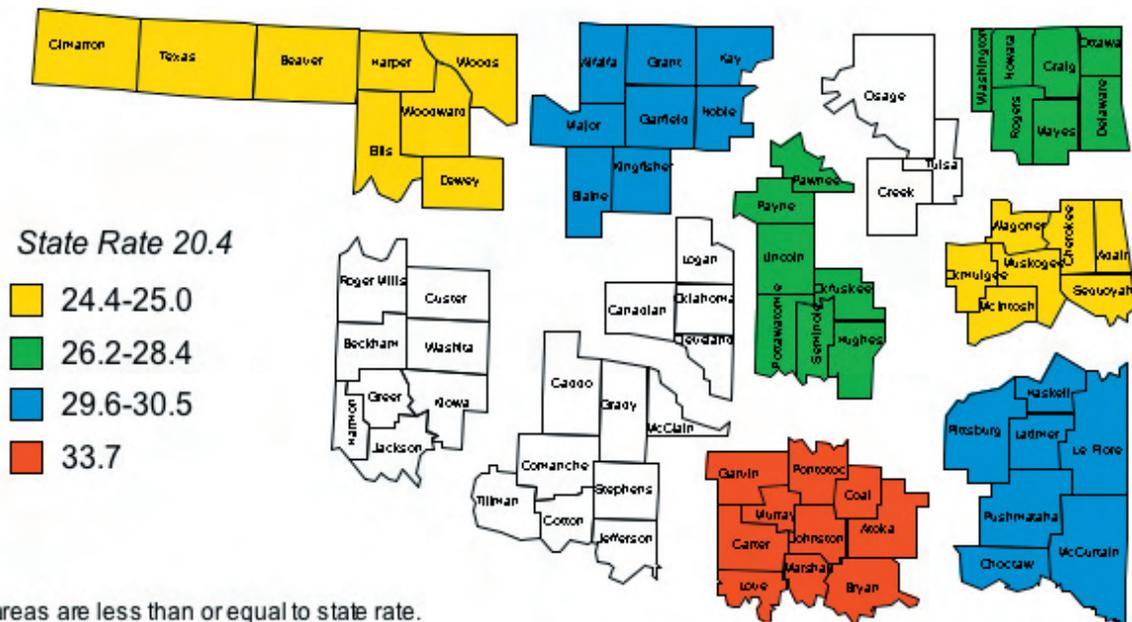
Mortality Rate Suicides by Sub-State Planning



Source: Oklahoma Vital Records

- High suicide death rates among whites.
- Highest suicide death rates among Native Americans.
- Male disparity for deaths due to suicide.
- Highest rates for deaths due to suicide in southeast Oklahoma.

Age-Adjusted Mortality Rate Motor Vehicle Crash Deaths by Sub-State Planning Districts:



White areas are less than or equal to state rate.
 Rate per 100,000
 Age-Adjusted to US 2000 Standard

Source: Oklahoma Vital Records

- Highest rates of deaths due to motor vehicle crashes among Native Americans.
- Male disparity for deaths due to motor vehicle crashes.
- Highest rates for deaths due to motor vehicle crashes in south central Oklahoma.

Acknowledgment

This report was made possible by the collaborative efforts of the Data Committee of the Oklahoma Task Force to Eliminate Health Disparities. The Committee members' willingness to share data and look at trends in a different way has been an important first step toward identifying health disparities in Oklahoma, which will lead to healthful solutions.

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Breast Cancer Disparities

Breast Cancer Facts



Most common cancer diagnosed in women in the US and Oklahoma.

2nd most common cause of cancer death among women in US and Oklahoma.

Less than 1% of all breast cancers are diagnosed in men.

1 in 8 women will develop breast cancer during her lifetime.

Among Oklahoma women alive in 2000, 250,680 will develop breast cancer sometime in their lifetime.

Each year in OK:

- 2,500 women will be diagnosed, and
- 475 will die of breast cancer.

Each year in the US:

- 184,200 women will be diagnosed, and
- 41,200 will die of breast cancer.

White women were slightly (1.1 times) more likely to be diagnosed with breast cancer in Oklahoma.

African American women were 1.7 times more likely to die from breast cancer compared to White women.

Over 40% of African-American and American Indian women were diagnosed with breast cancer at a regional or distant stage compared to 29% of White and 33% of Hispanic women.

In 2002, Oklahoma ranked as the 6th worst in the U.S. for the highest percentage of women who haven't had a mammogram in 5 or more years.

From 1997-2001, Oklahoma's rate of breast cancer incidence was better than the U.S. (70.3 vs. 72.5/100,000).

In 1999-2001, Oklahoma ranked 24th worst in breast cancer mortality in the U.S.



Early Detection



BREAST CANCER SCREENING

- Perform monthly breast self examinations.
- Have a clinical breast exam every year after the age of 21.
- Get your first screening mammogram at 40 years of age.

Note: If you have risk factors for breast cancer, you may need to have your mammogram at an earlier age.

Continued on page 3



future, however, the percent of obesity or overweight women in

Continued on page 2

Risk Factors

Risk factors for breast cancer include overweight or obesity, heavy alcohol use, limited physical activity and poor nutrition.

Currently, the percent of women who are obese or overweight are similar between the US and Oklahoma. In the near

Provided by: Data Subcommittee to the Oklahoma Task Force to Eliminate Health Disparities

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For More Information

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www.cancer.gov
1-800-4-CANCER*

*Centers for Disease
Control and Prevention
www.cdc.gov*

Inside this issue:

<i>Breast Cancer Facts</i>	<i>1</i>
<i>Early Detection</i>	<i>1,3</i>
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<i>Mortality</i>	<i>4</i>
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Risk Factors— continued

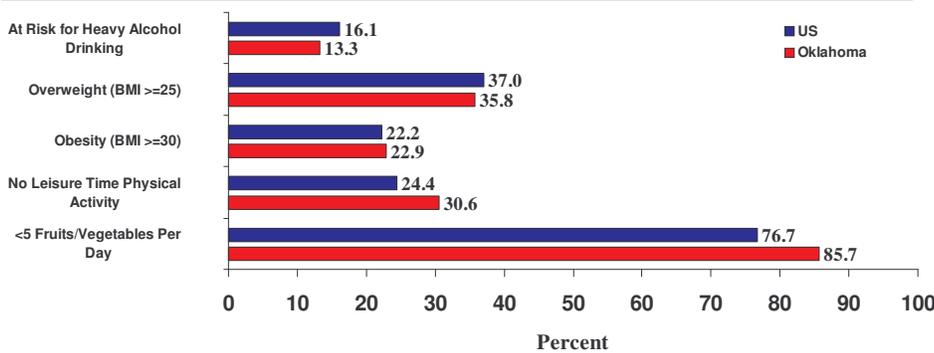


Oklahoma will likely exceed that of U.S. women. Oklahoma women are more likely to report they do not participate in leisure-time physical activity and more likely to report they do not eat the recommended levels of fruits and

vegetables. If this trend continues, increasing rates of obesity and overweight will not be far behind.

Oklahoma women are less likely to report heavy alcohol use.

Prevalence of Cancer Risk Factors
BRFSS 2002



Incidence



Breast cancer incidence increases with age. As women get older, their chance of being diagnosed with breast cancer increases.

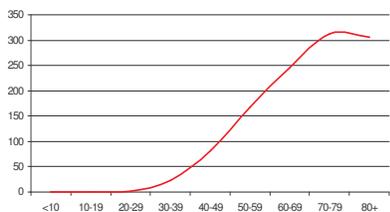
The risk of being diagnosed with breast cancer also varies by race and ethnicity.

White women are more likely than women of other races to

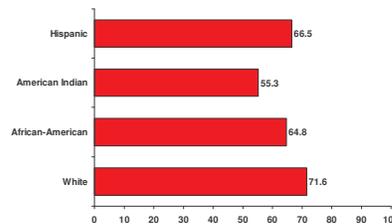
be diagnosed with breast cancer. American Indian women are least likely to be diagnosed.

This may finding, however, be less reflective of a difference in the actual disease process and more indicative of decreased or limited access to screening opportunities.

Breast Cancer Incidence
by Age Oklahoma 1997-2001



Breast Cancer Incidence
by Race/Ethnicity Oklahoma 1997-2001



Task Force Committee

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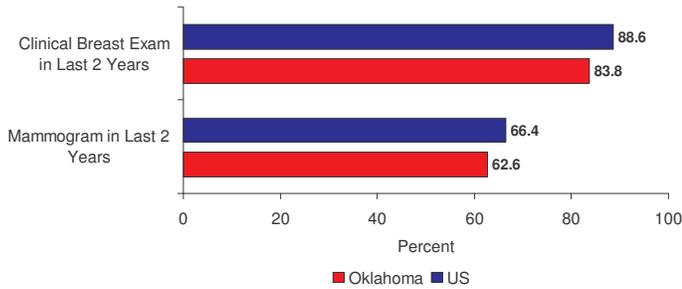
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First Annual Data Report— Sept 2004
<http://www.health.state.ok.us/commish/HDReport2004lowres.pdf>

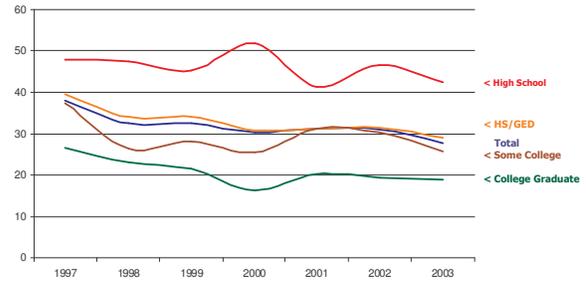
Early Detection: continued



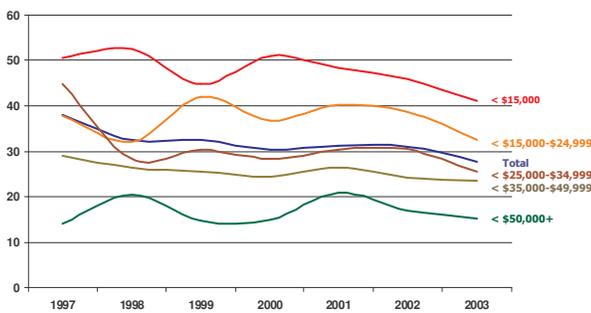
Breast Cancer Screening BRFSS 2002



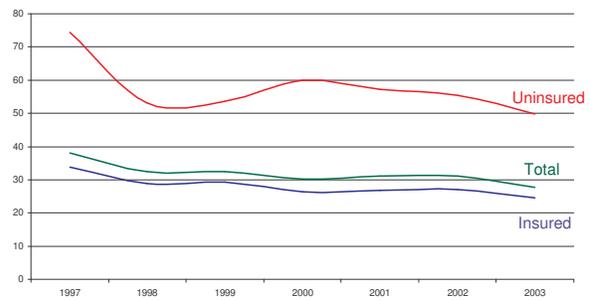
Women 40+ yrs without a Mammogram in 2 years by Education Oklahoma



Women 40+ yrs without a Mammogram in 2 years by Income Oklahoma



Women 40+ yrs without a Mammography in 2 years by Insurance Status Oklahoma



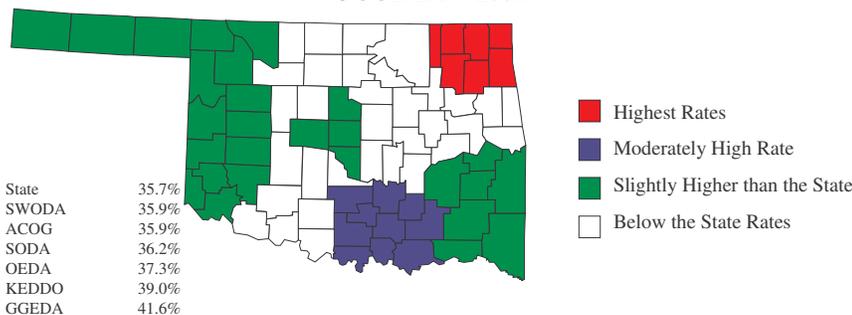
Staging



One in eight female breast cancers are diagnosed *In situ* and half (49.5%) are diagnosed *Localized*. Women with either an *In situ* or *Localized* diagnosis have excellent chances of survival with proper treatment.

Approximately 1 in 4 women (23.1%) are diagnosed at a *Regional* stage and 1 in 20 are diagnosed at a *Distant* stage. Women who are diagnosed at an advanced stage are less likely to survive more than 5 years.

Percentage Breast Cancers Diagnosed at Regional or Distant Stage: OCCR 1997-2001



Percent Survival by Stage

Stage	5-yr relative survival rate
0-In Situ	100%
I - Localized	98%
IIA—Regional	88%
IIB—Regional	76%
IIIA—Regional	56%
IIIB—Regional	49%
IV—Distant	16%

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*Newsletter prepared by
Health Care Information
Division, Oklahoma State
Department of Health*

Good News!

Breast and Cervical Cancer Treatment Medicaid Plan Amendment

Effective January 1, 2005, the State of Oklahoma began providing Medicaid benefits to uninsured women under 65, who are identified through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and are in need of diagnosis and treatment for breast or cervical cancer (including pre-cancerous conditions and early stage cancer).

- **SB 741**— Amended May 2001 Directs the Health Care Authority to develop a program for Medicaid eligibility and services for individuals in need of breast or cervical cancer treatment.
- **SB 978**—April 2004 Appropriation of \$2 Million to Oklahoma Health Care Authority
- **HB 2552** – May 2004 “Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund”



Oklahoma Cares program

Client Eligibility

- Income at or below 185% FPL
- No creditable insurance coverage
- US Citizen or qualified alien
- Oklahoma citizen
- Abnormal finding on screening
- Not otherwise eligible for Medicaid

For more information, call this toll-free number: 866-550-5585 (V/TDD)

Mortality

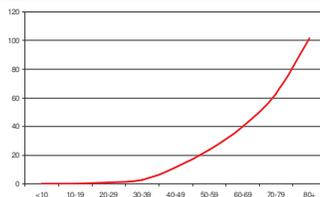


African American women are more likely to die from breast cancer than are White, American Indian or Hispanic women.

This is most likely related to delayed diagnosis which results in both later stage disease and delays in treatment.

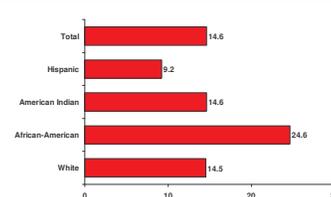
Breast Cancer Mortality Rate

by Age Oklahoma 2002



Breast Cancer Mortality Rate

by Race/Ethnicity Oklahoma 2002



Breast Cancer

Who gets it and who dies from it?

Race	Age Adjusted Incidence Rate 1997 2001	Percent Regional or Distant Stage 1997 2001	Adjusted Death Rate 1999 2001
White	71.6	28.8%	13.9
African -American	64.8	40.4%	23.3
American Indian	56.3	40.0%	14.2



Available Services

- Breast and cervical cancer and pre-cancer diagnosis and treatment
- Medicaid coverage that includes the full range of services (not only cancer treatment)
- Medicaid eligibility continues until the woman is no longer need breast or cervical cancer treatment.

Once a woman has an abnormal screening (clinical breast exam, mammogram, or pap smear) and has been found to be in need of further diagnosis and treatment, you or your healthcare provider can call 1-866-550-5585 to see if you qualify and how to apply for Oklahoma Cares.

If you have been previously diagnosed with breast or cervical cancer and are still undergoing treatment and meet all of the other eligibility criteria, you may be eligible for this program. Call the Oklahoma State Department of Health to find out how.

Oklahoma Disparities in Cardiovascular Disease

What is Cardiovascular Disease?

Cardiovascular Disease is a group of diseases that affects the heart and the circulatory system. This includes the muscles and nerves that support the heart, arteries, and veins. There are more than 60 different types of cardiovascular disease.

Heart Diseases

- **Congenital Heart Defects** – structural problems with the development of the heart.
- **Acute Myocardial Infarction** – heart attack.
- **Infections of the Heart**, endocarditis.
- **Congestive Heart Failure** – chambers of the heart fail to function.
- **Angina** – chest pain caused by plaque in the vessels that feed the heart muscle.

- **Arrhythmia** – irregularities of the heart beat such as Atrial Fibrillation.

Circulatory System Diseases

- **High Blood Pressure or Hypertension** – restriction of blood flow through the arteries of the body.
- **High LDL (or Total) Cholesterol** – the build up of plaque on the arteries leading to the heart and brain.
- **Peripheral Vascular Disease** – diseases of blood vessels outside the heart and brain, most commonly found in the lower extremities.
- **Stroke** – blockage of the blood vessels that supply oxygen and food to the brain.
- **Phlebitis** – blockages in the veins.



Provided by: Data Subcommittees of the Oklahoma Task Force to Eliminate Health Disparities and the Oklahoma Turning Point Council

Volume 1, Issue 2

February, 2005

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American Heart Association
www.americanheart.org
1-800-AHA-USA-1

National Stroke Association
www.stroke.org
1-800-787-6537
1-800-STR-OKES

National Heart, Lung and Blood Institute
www.nhlbi.nih.gov

Oklahoma CVD Facts

• Heart disease and stroke remain the **1st and 3rd leading causes of death** in Oklahoma.

• In 2003, heart disease and stroke accounted for over **one-third of the total deaths** in Oklahoma.

• In 2003, heart disease caused **11,039 deaths** in OK, 5,403 were male and 5,636 were female, representing 31% of total deaths.

• **Oklahoma ranks 50th** in age-adjusted mortality due

to cardiovascular disease deaths. (1999-01).

• Oklahoma's (Age-Adjusted) **CVD mortality rate is 411.6 per 100,000** compared to the U.S. rate of 336.6 per 100,000.

Continued on Page 4

Risk Factors

Non-Modifiable

- **Increasing Age**
 - Men ≥ 45 years
 - Women ≥ 55 years
- **Gender: Male**
- **Heredity**
 - Race/ethnicity
 - Family history

Life Habit (Modifiable)

- **Cigarette Smoking**
- **Obesity (BMI ≥ 30)**
- **Overweight (BMI ≥ 25)**
- **Other contributors**
 - Physical inactivity
 - Poor nutrition
 - Stress

Other Diseases

- **High Blood Cholesterol**
 - Low HDL cholesterol: <40 mg/dL
 - Total blood chol: > 200 mg/dL
- **Hypertension or HBP**
 - Pre-hypertension: >120-139/>80-89 mmHg
 - Hypertension: ≥140/90 mmHg
 - On anti-hypertensive medication
- **Diabetes**

Inside this issue:

<i>What is CVD?</i>	1
<i>CVD facts</i>	1,4
<i>Risk Factors</i>	1,2
<i>Heart Disease Deaths</i>	2
<i>Red Dress Info</i>	2
<i>Prevalence of Risk</i>	3
<i>Cholesterol Screening</i>	3
<i>Signs & Symptoms</i>	3
<i>What Now?</i>	4
<i>Nat'l Performance Measures (Medicare)</i>	4

Deaths Due to Heart Disease

An individual's risk of dying from heart disease increases with age. Nearly 1 in 5 heart disease deaths occurs before age 65. Fully 1/3 of heart disease deaths occur after age 85.

Heart Disease Deaths by Selected Demographics: Oklahoma, 1999-2003

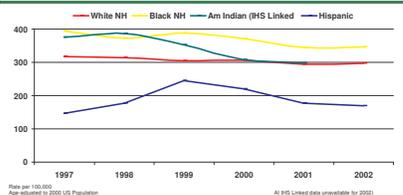
Age	Deaths	Population	Death Rate
Under 1	41	244,840	16.7
1-4 years	12	948,993	1.3
5-14 years	18	2,449,559	0.7
15-24 years	82	2,622,539	3.1
25-34 years	186	2,274,199	8.2
35-44 years	1,043	2,559,365	40.8
45-54 years	2,958	2,328,619	127.0
55-64 years	5,600	1,642,658	340.9
65-74 years	9,483	1,209,378	784.1
75-84 years	16,392	791,433	2,071.2
85+ years	19,254	287,975	6,686.0

All rates are deaths per 100,000 population.
Age-adjusted rates based on 2000 U.S. population standard.
ICD10: Diseases of Heart: I11, I13, I20-I25, I00-I09, I26-I51

More than half of deaths due to heart disease occur among women, however, men die at an earlier age than women do. When mortality rates are adjusted for these age differences, the heart disease mortality rate for men (371.5/100,000) is nearly 50% higher than that of women (250.5/100,000) [1999-2003].

African Americans have the highest rates of death due to heart disease in Oklahoma (345.3/100,000), followed by Whites (293.1) and American Indians (191.1) [2001].

Deaths due to Heart Disease by Race and Ethnicity Oklahoma 1997-2002



There is concern that rates among American Indians may be artificially low due to errors in racial misclassification. A preliminary study based on death certificates linked with the race data collected by the Indian Health Service (IHS) suggests the American Indian rates may actually be up to 50% higher. The linked rate for heart disease deaths to Oklahoma American Indians in 2001 was 298.0. Rates of death due to heart disease among Hispanics was lower at 194.0.

Go Red For Women

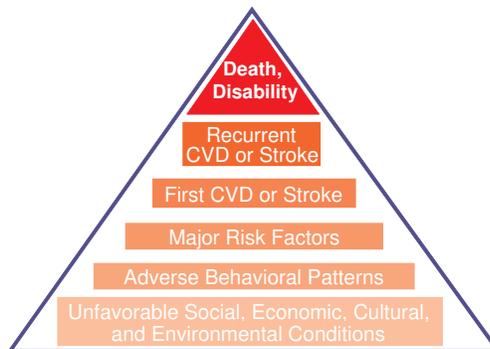
Join women across America by supporting the Go Red For Women movement. Don't forget to call 1-888-MY-HEART to receive your free red dress pin and wear it with pride. Get one. Give one. And Go Red For Women.



Risk Factors (continued)

Emerging Risk Factors

- Lipoprotein(a)
- Homocysteine
- Prothrombotic factors
- Proinflammatory factors
- Impaired fasting glucose
- Subclinical atherosclerosis
- Gum disease



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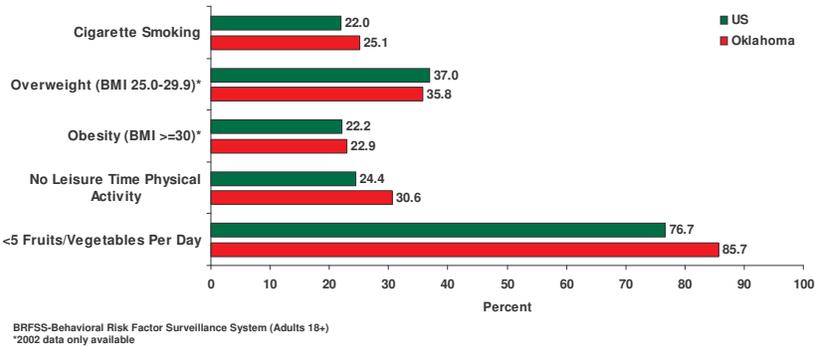
First Annual Data Report— Sept 2004
<http://www.health.state.ok.us/commish/HDRReport2004lowres.pdf>

Prevalence of Risk Factors

More of Oklahoma's residents smoke compared to the nation, and it would appear that Oklahomans are relatively average as to overweight or obesity compared to the nation. This, however, may be of short-lived comfort.

Oklahoma residents are significantly more likely not to participate in physical activity and six of seven Oklahomans do not eat 5 or more servings of fruits and vegetables each day. Given this, it is quite likely that in the near future, the state rates of obesity and overweight will surpass that of the nation.

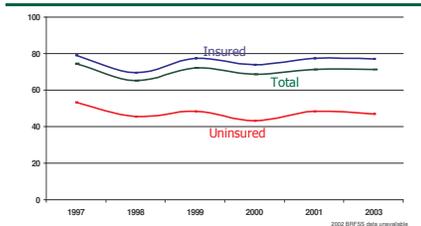
Prevalence of CVD Risk Factors BRFSS 2003



Cholesterol Screening

Sixty-six percent of Oklahoma adults have had their cholesterol checked in the past 5 years compared to 71% of the nation.

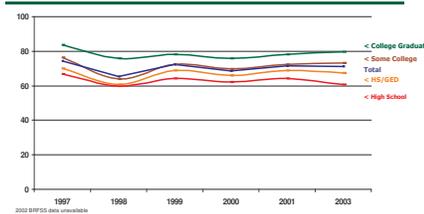
Cholesterol Check in Past 5 Years by Insurance Oklahoma



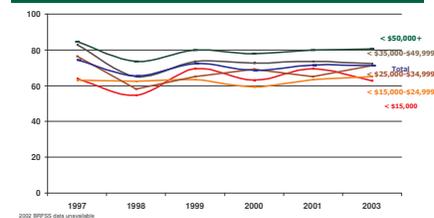
Those with insurance (2003: 77%) are significantly more likely to have had theirs checked when compared to those without insurance (2003: 47%).

Education is also associated with obtaining cholesterol checks. Those with a college degree (2003: 80%) are most likely, followed by those with some college (2003: 73%), those with a high school diploma or GED (2003: 67%), and finally, those with less than a high school education (2003: 61%).

Cholesterol Check in Past 5 Years by Education Oklahoma



Cholesterol Check in Past 5 Years by Household Income Oklahoma



The likelihood of an adult reporting he or she had their cholesterol checked in the past 5 years is also correlated with household income. Those adults with a household income of \$50,000 or more were most likely (81%) to report a recent cholesterol check compared to those who made \$15,000-\$24,999 (65%).

Signs and Symptoms

Time is critical to increase survival and decrease disabilities.

Heart Attack

Treatment < 5 minutes of onset

Stroke

Treatment < 3 hours of onset

Survey results demonstrated that 94% of Oklahoma adults recognized chest pain as a sign or symptom of a heart attack; 88% shortness of breath; 86% pain or discomfort in the arms or shoulders; 70% feeling weak, faint, or lightheaded, and 53% pain in jaw, neck or back.

Regarding the signs and symptoms of stroke, 90% recognized sudden numbness or weakness; 88% sudden confusion or trouble speaking; 86% sudden trouble walking, dizziness or loss of balance; 65% trouble seeing in one or both eyes; and 60% severe headache with no know cause.

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*Newsletter prepared by:
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Oklahoma CVD Facts (continued)

- Oklahoma has **experienced the least improvement** in the cardiovascular mortality disease rate, declining by only 12.7/100,000 population compared to 15.0/100,000 for the overall U.S. population.
- More than 25% of Oklahoma's adult population had either **high blood pressure** or **high blood cholesterol**.
- Oklahomans with **lower income** are more likely to have been diagnosed with high blood pressure.
- African-Americans and American Indians** are more likely to die from heart disease in Oklahoma.

What Now?

Given the high cost we are paying with our citizens lives, what is being done to address cardiovascular disease in Oklahoma? Currently, only \$300,000 is being made available by the Federal Government to fund the Oklahoma Heart Disease and Stroke Health Program. There are no state dollars allocated at this time.

In 2004, a strategic plan was written for use as a framework to improve the quality of care for persons and families with heart disease and stroke, to reduce the risk factors among all Oklahomans to prevent heart disease and stroke, to reduce the disparities in health status among persons with heart disease and stroke, and to improve on the early recognition, action, and healthcare response needed to reduce death and disability related to heart attack and stroke. The strategic plan provides a framework through 2010 with recommended action steps. Strategies have been developed that focus on seven over-arching goals.

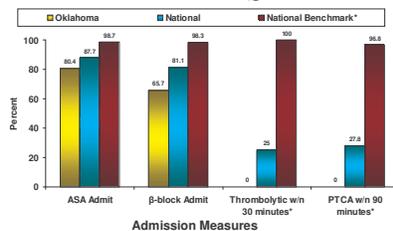
If you would like to receive more information on the strategic plan and the specific goals, please contact Misty D. Worley at (405) 271-4072.

Quality Improvement in Medicare: National Performance Measures

Acute myocardial infarction (MI) is responsible for the death of 1.1 million Americans each year. There are 400,000 Medicare hospital admissions annually and it is the most common cause of death. Heart failure affects 1-2 million Americans. It is responsible for 713,000 Medicare hospital admissions annually and is the most common reason for hospitalization.

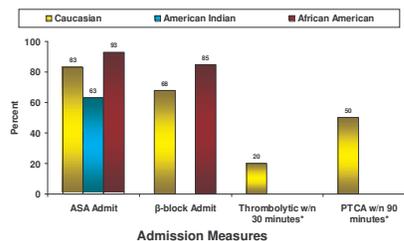
National performance measures have now been implemented to ascertain how often *Best Practices* are utilized. For acute MIs, this includes upon admission, an early administration of aspirin and beta blockers and measuring the time until reperfusion therapy.

Acute Myocardial Infarction Current Surveillance, 1st Quarter 2004



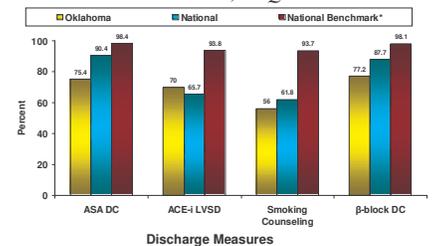
For the first quarter of 2004, Oklahoma was below the national rate in all four measures. Rates varied, however, based on the race of the individual. Whites were more likely than either American Indians or African Americans to receive any of the recommended practices.

Acute Myocardial Infarction Current Surveillance, 1st Quarter 2004



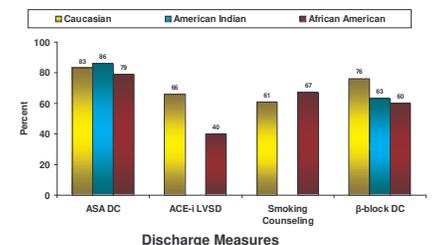
At discharge, measures include the administration of aspirin, ACE-I/ARB for patients with systolic dysfunction, beta blockers and smoking cessation counseling. For the first quarter of 2004, Oklahoma was lower than the national rate for all measures except the administration of ACE-I/ARB.

Acute Myocardial Infarction Current Surveillance, 1st Quarter 2004



Administration of aspirin upon discharge was slightly higher among American Indians than Whites. African Americans were most likely to receive smoking counseling and Whites were most likely to receive beta blockers.

Acute Myocardial Infarction Current Surveillance, 1st Quarter 2004



Assessing Health Disparities: The Oklahoma Minority Health Survey

What is the Oklahoma Minority Health Survey?

The Oklahoma Minority Behavioral Risk Factor Survey (OMBRFS) is a survey that was done in Oklahoma and focused specifically on minority populations. Information was collected using a questionnaire similar to the one used in the OK Behavioral Risk Factor Health Surveillance System (BRFSS). *See page 2 for details.*

The OMBRFS was conducted over the telephone and includes several initial questions to identify whether or not there is anyone in the household who may be any racial group other than non-Hispanic White. While all Hispanic and non-White members of a given household were

eligible, only one member was selected at random to be interviewed.

In addition to the routine questions regarding health status, access to care, and various health behaviors, other important questions were also asked to determine if minority populations acted or were treated differently from White populations. The added questions asked about discrimination, trust, language and ethnicity, and alternative medicine. Other questions addressed sexual assault, osteoporosis and deterrents to obtaining mammograms and pap smears.

The OMBRFS was conducted from April



2003 through December 2004. The survey took approximately 20 to 30 minutes to complete and required the help of 8 part-time interviewers, 4 of which were Spanish-speaking.



Provided by: Data Subcommittees of the Oklahoma Task Force to Eliminate Health Disparities and the Oklahoma Turning Point Council

Volume 1, Issue 3
April, 2005

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BRFSS Website
www.edc.gov/brfss

Discrimination in Oklahoma

Determining whether or not patients felt they were discriminated against by health care providers, as well as estimating to how this perception varied by race, was of high concern to researchers.

OMBRFS interviewers asked non-White

residents whether or not they felt like they were treated unfairly or with disrespect due to a variety of issues such as race, appearance, ability to pay, English fluency, and weight. *[For the exact wording of the question, see page 3].*

Of those who believed

they had been discriminated against, the most often cited reasons were related to their health insurance status (7.1%) and their ability to pay (5.3%). Four of the top six categories were related to money and included

Continued page 3

Inside this issue:

Discrimination in Oklahoma 1,3

BRFSS 2

OMBRFS Response Rates 2

What Now? 4

Special Thanks 4

Health Outcomes: OMBRFS vs. BRFSS 4

Behavioral Risk Factor Surveillance System

The Okla. Minority Behavioral Risk Factor Health Survey is modeled after a larger project, the Behavioral Risk Factor Surveillance System (BRFSS).

According to the Centers for Disease Control and Prevention (CDC), scientific research clearly shows that personal health behaviors play a major role in premature death and illness. In order for Oklahoma policy makers and health experts to evaluate the risk our state residents have for poor health, it is very important that they have data on actual behaviors, rather than on attitudes or knowledge. This type of information is especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

The Oklahoma BRFSS is an ongoing, state-based survey that has been conducted since 1988. This survey is currently being conducted in all 50 states, the District of Columbia, Puerto Rico, Guam and many other countries.

Adults age 18 and older across the state are called at random and asked various questions related to their health status, their access to health care and a range of associated risk behaviors. Some of these behaviors include physical activity, nutrition, tobacco use, health care access, and immunization. Other questions revolve around potential diagnoses that may have been made by a health care provider such as cancer, diabetes, arthritis and heart disease.

OMBRFS Response Rates

Normally, it is very difficult to develop estimates of health related risk for races other than African American or American Indian using BRFSS due to the small number of individuals from other races who are called at random and who then respond to the survey.

The OMBRFS was specifically designed to call areas that were more likely to have non-White households. OMBRFS was particularly successful at accomplishing this.

In the 2003 BRFSS, 79% of the respondents were White, which is similar to the proportion of White in

the state population. In the OMBRFS, however, less than 5 percent of the respondents were White.

In 2003, the BRFSS surveyed a total of 71 Asian individuals. With few exceptions, this was much too small for evaluation. OMBRFS, however interviewed 335.

There were 3.5 times more interviews completed by African American Oklahomans with the OMBRFS than the BRFSS, 2.5 times more by American Indians and 5.5 times more surveys completed by Hispanics.

Completed Survey Comparison (Number and Percent)

	OMBRFS 2003-2004		OK BRFSS 2003	
African American NH	1,582	29.0%	468	6.1%
Native American NH	1,381	25.3%	528	6.9%
Asian NH	335	6.1%	71	0.9%
Pacific Islander NH	27	0.5%	13	0.2%
Other NH	53	1.0%	38	0.5%
White NH	240	4.4%	6,061	79.4%
Multi-racial	356	6.5%	169	2.2%
Hispanic	1,476	27.1%	266	3.5%
Unknown	2	0.0%	19	0.2%
Total	5,452	100.0%	7,633	100.0%

NH=Non-Hispanic

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First Annual Data Report- 9/04

<http://www.health.state.ok.us/commish/HDRReport2004lowres.pdf>

Other Newsletters: <http://www.health.state.ok.us/commish/hd/newsletters.html>

Discrimination in Oklahoma (continued)

income (4.1%) as the 4th most often cited reason and Medicaid (2.1%) coverage as the 6th. Race or ethnic background was 3rd at 4.4%. Discrimination due to sexual orientation was cited least often (0.3%).

Perceived Reason	Percent
Health Insurance	7.1
Pay	5.3
Race	4.4
Money	4.1
Treatment	3.2
Medicaid	2.1
Gender	1.9
Language	1.9
Disabled	1.9
Education	1.7
Dressed	1.8
Overweight	1.7
Medical History	1.6
Medicare	0.9
Gay/Lesbian	0.3

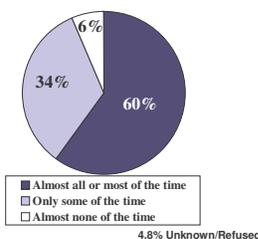
One in twelve Asian residents (8.2%) felt like they had been discriminated against because of their race. This is higher compared to 6.3% of African-Americans, 3.9% of Hispanics, 2.6% of American Indians and 2.4% of multiracial residents. Overall 4.4% reported they had been discriminated against because of race.

Survey Question

How much of the time do you think you can trust [Doctors or other health care providers, Hospitals, Clinics or Health Centers, County or City/County Health Departments, Medicare, Medicaid, Health Insurance Companies] to do what is best for patients or customers?

Sixty percent of non-White residents trusted their doctors to do what was

Doctors and Other HCPs: OkMBRFS 2003-04



Survey Question

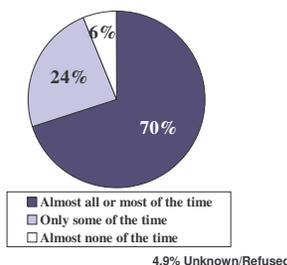
“Thinking about all of the experience you have had with health care visits in the last 2 years, have you ever felt that the doctor or health provider you saw or any other staff members judged you unfairly or treated you with disrespect because of...

- ✓ What your **race or ethnic** background is.
- ✓ Whether or not you have **health insurance**.
- ✓ Whether you are **male or female**.
- ✓ How well you speak **English**.
- ✓ Whether or not you were physically **disabled**.
- ✓ How you were **dressed or groomed**.
- ✓ How much **education** you have.
- ✓ Whether or not you were **overweight**.
- ✓ How much **money** you had.
- ✓ Your **sexual orientation** – that is, if you are gay, lesbian or have a same sex partner.
- ✓ Your **ability to pay** for the care.
- ✓ Something in your **medical history**.
- ✓ The **treatment** you needed that day.
- ✓ Your **Medicaid** coverage.
- ✓ Your **Medicare** coverage.

best for them almost all or most of the time. Only 4% reported trusting their doctors almost none of the time.

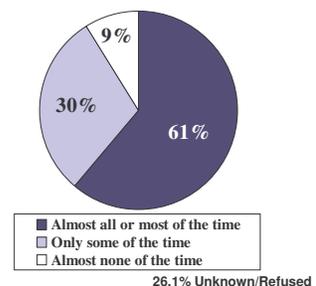
Seventy percent trusted hospitals to do the right thing most or almost all of the time, one in four trusted hospitals only some of the time and six percent trusted hospitals almost none of the time. This was similarly true for clinics/health centers, health departments and Medicare.

Hospitals: OkMBRFS 2003-04



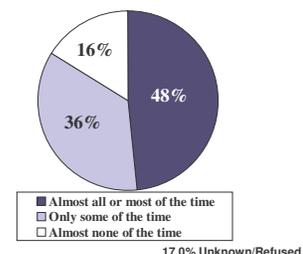
Sixty-one percent of non-White residents trusted Medicaid to do what was best most or almost all of the time. Thirty percent trusted Medicaid only some of the time and nine percent reported they trusted Medicaid to do what was right almost none of the time.

Medicaid: OkMBRFS 2003-04



Fewer than half (48%) trusted health insurance companies to do what was best for patients or customers. Thirty-six percent trusted them only some of the time and one in six reported they almost never trusted health insurance companies to do what was best for patients or customers.

Health Insurance Companies: OkMBRFS 2003-04



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*Newsletter prepared by:
Health Care Information
Division, Oklahoma State
Department of Health*

Health Outcomes: OMBRFS vs. BRFSS

The estimates provided by the OMBRFS were very similar to those provided by the BRFSS. This is important because it provides evidence for the accuracy of the estimates. Not only will OMBRFS provide new estimates for non-White groups that were not previously available due to small numbers but it will also allow researchers to estimate health disparities among those groups with greater precision than before which is reflected in lower standard errors (SE).

What has been learned so far?

- Rates of diabetes and high cholesterol can now be calculated for Oklahoma’s Asian population.
- American Indians rate of high blood pressure was significantly higher than that of Whites.
- African-American and Hispanic rates of high cholesterol was significantly lower than that of Whites.

What Now?

A data CD is currently being prepared and a work group is being organized to develop an analysis and publication plan.

Participants will consider how to best merge the OMBRFS with the 2003 Oklahoma BRFSS, as well as to how to interpret the information collected from the Trust and Discrimination modules.

It is hoped that culturally appropriate interventions can be developed using the OMBRFS data and that recommendation related to provider education can be made to the Health Disparities Task Force to lessen provider discrimination in the treatment of ethnic minorities.

If you have questions or would like to participate in the workgroup, please contact Janis Campbell, PhD [janisc@health.ok.gov] for more information.

Special Thank You

Eight part-time staff worked 6 days a week for 21 months interviewing state residents in order to collect the OMBRFS information. Our thanks go out to them! (OMBRFS Bilingual interviewers—Left to Right: Gloria Martinez, Daniela Cavazo, Yvonne Gonzales, Adriana Alfonsin)



	OMBRFS 2003-2004		OK BRFSS 2003	
	Percent	S.E.	Percent	S.E.
DIABETES				
African American NH	9.2	1.1	9.5	1.4
Native American NH	12.3	1.1	11.3	1.4
Asian NH	5.6	2.2	**	**
Other NH	*	*	6.3	2.9
White NH	*	*	6.6	0.3
Multi-racial	9.2	2.7	12.8	3.1
Hispanic	6.8	1.2	6.5	1.5
HIGH BLOOD PRESSURE				
African American NH	30.6	1.9	34.9	2.6
Native American NH	31.1	1.7	29.4	2.2
Asian NH	13.3	2.9	14.3	4.3
Other NH	*	*	**	**
White NH	*	*	29.4	0.7
Multi-racial	34.8	4.5	46.0	4.4
Hispanic	14.3	1.4	14.6	2.4
HIGH CHOLESTEROL				
African American NH	25.0	2.0	28.8	2.7
Native American NH	36.2	2.1	26.1	2.4
Asian NH	31.0	5.3	**	**
Other NH	*	*	**	**
White NH	*	*	33.5	0.8
Multi-racial	39.8	5.3	41.4	4.9
Hispanic	26.6	2.5	24.6	4.1

NH: Non-Hispanic

* Excluded from analysis

** Small numbers in cell

Tobacco-Related Disparities in Oklahoma

Why is Tobacco Important?

When thinking about the impact smoking is having on Oklahoma, it is important to consider not only the number of deaths attributed to smoking and when people die, but also the economic impact smoking has associated with the treatment of smoking-related illnesses.

To accomplish this, SAMMEC (Smoking Attributable Mortality and Morbidity Economic Costs) was developed by the Office of Smoking and Health at the U.S. Centers for Disease Control and Prevention.

It has been estimated that each year in Oklahoma, there is an

average of 5,827 deaths due to smoking (1997-2001). This includes 2,231 cancer deaths, 2,078 cardiovascular deaths, and 1,518 respiratory disease deaths. (Deaths due to secondhand smoke and cigarette-caused fires were not included.)

There were 83,738 years of life lost for each of those deaths that occurred before the age of 65. This included 34,156 years of potential life lost to cancer, 31,587 years to cardiovascular disease, and 17,995 years to respiratory disease.

Economically, nearly \$1.5 billion (\$1,462,187,000) in productivity are lost



annually due to smoking. Approximately \$1 billion (\$908,000,000) are spent annually on adult health care expenditures, including ambulatory care, hospitals, prescription drugs, nursing homes and other expenditures (1998).

Among newborns, it was estimated in 1997 that there was nearly six million additional dollars (\$5,764,723) spent in neonatal costs due to

Provided by: Data Subcommittee of the Oklahoma Task Force to Eliminate Health Disparities and the Oklahoma Turning Point Council

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Oklahoma Tobacco Helpline
1-866-PITCH-EM
1-866-748-2436

Who Smokes?

Among pregnant women, one in three (31.2%) smoked during the three months prior to their pregnancies. Of those, two-thirds were still smoking during the last trimester of their pregnancies. One in four (27%) mothers reported smoking after delivery. (2002 PRAMS)

Men (28.1%) are moderately more likely

than women (24.2%) to report smoking. (2004 BRFSS)

Native Americans are most likely to report smoking (34.9%), followed by African Americans (31.8%), Whites (23.4%) and Hispanics (17.3%). (2004 BRFSS)

Smoking is highly associated with income. The less income an

individual reports, the more likely he or she is to report smoking. More than one-third (36.5%) of those who made less than \$15,000 reported smoking compared to 15.9% of those who made \$75,000 or more [see graph on page 2]. (2004 BRFSS)

Education is also associated with smoking.

Continued page 2

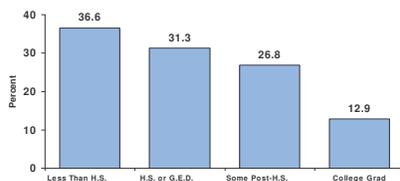
Inside this issue:

<i>Why is Tobacco Important?</i>	1
<i>For More Information</i>	1
<i>Who Smokes?</i>	1-2
<i>Health Care Provider Advice</i>	2
<i>Who is Quitting?</i>	3
<i>Data Sources</i>	4
<i>Secondhand Smoke</i>	4

Who Smokes? *continued*

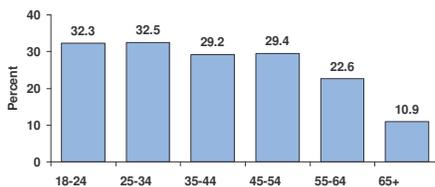
More than one-third (36.6%) of adults (age 18+) with less than a high school diploma report smoking compared to 12.9% of college graduates. (2004 BRFSS)

Smoking Status by Education



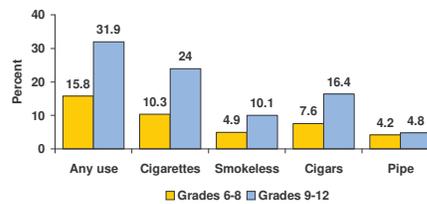
Older adults are less likely to report smoking than younger adults.

Smoking Status by Age



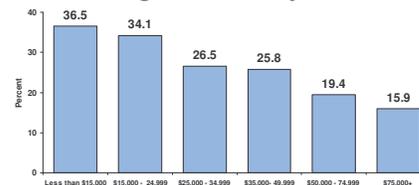
Approximately one in three adults age 18-54 report smoking compared to one in four (22.6%) adults age 55-64 (22.6%) and one in 10 (10.9%). (2004 BRFSS)

Youth Tobacco Use



High school students (grades 9-12) are more likely than middle school students (grades 6-8) to report using tobacco, be it cigarettes, cigars, pipe or any tobacco. (2002 OYTS)

Smoking Status by Income



Health Care Provider Advice

Three of four (73.1%) new mothers reported that a health professional talked to them about smoking while they were pregnant. Health care professionals were more likely to talk to smokers than non-smokers. Those women whose doctors were less likely to talk to them were older (age 35+), were better educated (more than a high school education), or did not use Medicaid to pay for their delivery. (2002 PRAMS)

Among adult smokers who received medical care in the past 12 months, health care providers were more likely to provide advice about smoking to women (72.9%) than men (66.3%). Native Americans were more likely to report receiving advice (76.0%) than Whites (68.9%), African Americans (68.5%) or Hispanics (64.3%). (2003

BRFSS)

Providers were most likely to talk to smokers with mid-level incomes of \$24,000-\$49,999 and less likely to talk to individuals with higher incomes. (2003 BRFSS)

Three of four smokers with a high school diploma reported receiving advice about smoking compared to 70.0% of those with less than a H.S. diploma, 67.6% of those with some post-H.S. courses, and 65.7% of college graduates. (2003 BRFSS)

Providers were more likely to offer advice as smokers got older. Fifty-seven percent of smokers between 18 and 24 years of age reported receiving advice compared to 77% of those age 55 to 64. This decreased to 69% among those age 65 or older. (2003 BRFSS)

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First Annual Data Report- 9/04

<http://www.health.state.ok.us/commish/HDRReport2004lowres.pdf>

Other Newsletters: <http://www.health.state.ok.us/commish/hd/newsletters.html>

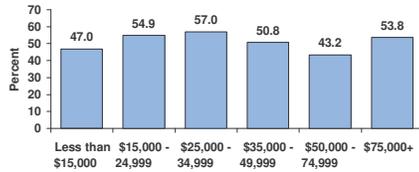
Who is Quitting?

Male smokers (59.4%) were more likely than female smokers (55.0%) to report that they had quit smoking for at least one day during the last year. (2004 BRFSS)

Three of five Hispanic (63.5%) and African American (61.3%) smokers report they tried to quit for at least one day last year compared to 52.6% of Native Americans. White smokers were least likely to have attempted to quit (49.1%). (2004 BRFSS)

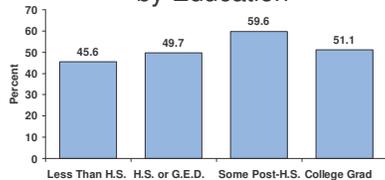
There was no clear association between attempting to quit and income. Reported attempts to quit ranged from 43% among those with an income of less than \$15,000 to 67% among those with an income between \$25,000 and \$34,999. (2004 BRFSS)

Smokers Who Quit Smoking 1+ Days Last Year by Income



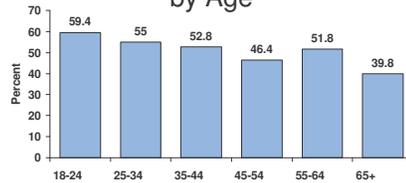
Smokers with less than a high school education were less likely to try to stop than those with more education. Smokers with some post H.S. education (59.6%) were most likely to report they had tried to quit during the past year. (2004 BRFSS)

Smokers Who Quit Smoking 1+ Days Last Year by Education



Younger smokers were most likely to have attempted to quit in the past year. Three in five (59.4%) of smokers age 18-24 tried compared to 39.8% of those age 65 or older. (2004 BRFSS)

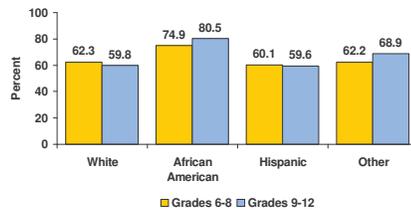
Smokers Who Quit Smoking 1+ Days Last Year by Age



Among middle and high school students, African American youth were more likely to have attempted cessation compared to White, Hispanic or other youth. (2002 OYTS)

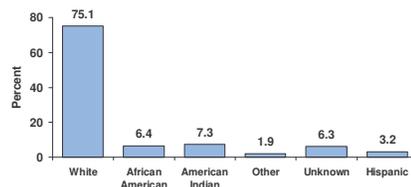
With the exception of the White youth, high school students were more likely to have tried to quit. Rates were very similar between high school and middle school Hispanic youth. (2002 OYTS)

Youth Tried to Quit Past Year



A tobacco helpline was established in August 2003 and the University of Oklahoma Health Sciences Center College of Public Health was contracted to conduct a survey of the callers.

Registered Tobacco Helpline Callers by Race/Ethnicity

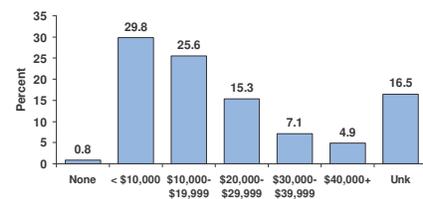


Two-thirds of callers to the registered tobacco helpline were women (65.2%). These individuals spoke to a tobacco specialist and/or received a self-help kit. Three of four callers were White. (8/03-3/05 OUHSC)

Thirty percent of the callers reported less than \$10,000 income. More than

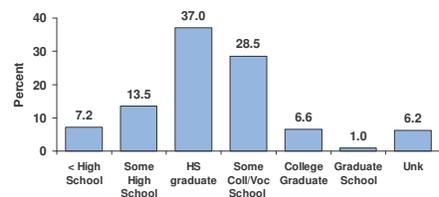
half of the callers reported income less than \$20,000. Five percent of callers reported having incomes of more than \$40,000. A significant number (1 in 6) did not disclose their income to the helpline. (8/03-3/05 OUHSC)

Registered Tobacco Helpline Callers by Income



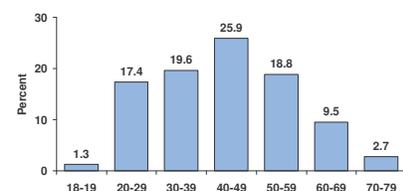
Two-thirds of callers were either H.S. graduates or had additionally attended some college or vocational school. Twenty percent of callers had less than a high school education and less than 8% were college graduates or higher. (8/03-3/05 OUHSC)

Registered Tobacco Helpline Callers by Education



The age of callers to the helpline spanned all groups. The fewest calls came from the youngest (18-19) and the oldest (70-79) and peaked among callers age of 40 to 49. Approximately 40% of callers were less than 40 years of age and just over 30% were age 50 or older. (8/03-3/05 OUHSC)

Registered Tobacco Helpline Callers by Age



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Data Sources

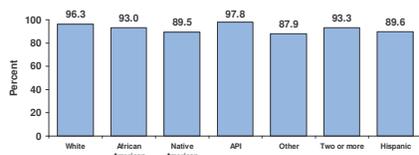
Data for this report was compiled from a variety of sources that collect the information in very different ways.

- Behavioral Risk Factor Surveillance System (BRFSS) - telephone
- Pregnancy Risk Assessment Monitoring System (PRAMS) - mail
- Oklahoma Tobacco Helpline - telephone
- Oklahoma Youth Tobacco Survey (OYTS) - school based

Concerns were expressed at an earlier task force meeting about the efficacy of telephone surveys and whether all racial groups were equally represented given not all households have a phone.

The 2000 Census estimated more than 90% of all households had a telephone available. This figure ranged from 87.9% among those of the "Other" race to 97.8% of the Asian/Pacific Islander race.

Household Telephone Available by Race/Ethnicity of Householder

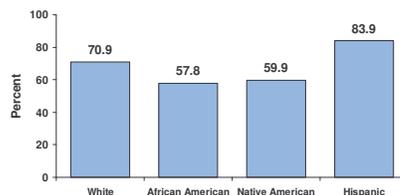


Secondhand Smoke Exposure

In 2004, 70% of adults reported that no smoking was allowed inside their home (69.2% males, 71.4% females). (2004 BRFSS)

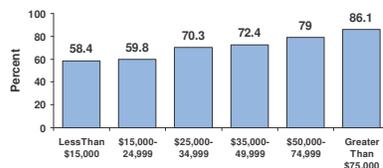
Hispanic adults were most likely to report home smoking bans (83.9%) followed by 70.9% of Whites, 59.9% of Native Americans and 57.8% of African Americans.

No Smoking Inside the Home by Respondent Race/Ethnicity



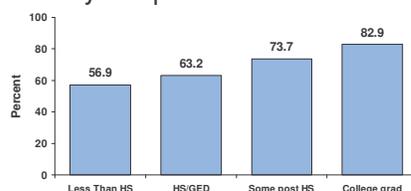
Home smoking bans were more likely to occur among individuals with higher household incomes. Adults with less than \$15,000 were least likely to report there was no smoking allowed in their homes (58.4%) compared to 86.1% of adults with household incomes of \$75,000 or more.

No Smoking Inside the Home by Household Income



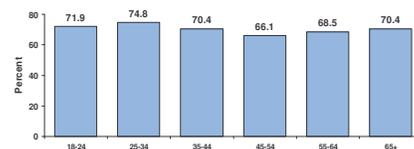
Smoking bans in the home were more likely to be reported by those with higher educations. College graduates were most likely to report banning smoking (82.9%) compared to 56.9% of those with less than a high school education.

No Smoking Inside the Home by Respondent Education



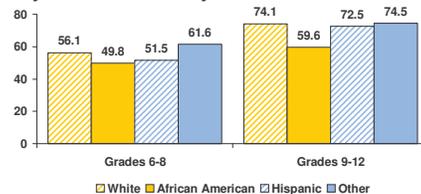
Home smoking bans were relatively consistent across all age groups. Rates ranged from 66.1% among adults age 45-54 to 74.8% among those aged 25 to 34. (2004 BRFSS)

No Smoking Inside the Home by Respondent Age



High school students were more likely to report they had been in a room with someone who was smoking during the past week than middle school students. This was most common among students who were either White or "Other" race. African American students were least likely to report recently being in the room with a smoker. (2002 OYTS)

Youth in Room with Smoker During the Past Week by Race/Ethnicity and School Level



Eighty-three percent of women report their worksites have a no-smoking policy compared to 73% of men. This is most common among White adults (80.5%) compared to 76.5% of Native Americans, 70.3% of African Americans and 69.5% of Hispanics.

No-smoking policies were reported more often by adults with higher household incomes and ranged from 70.6% among those with incomes of less than \$15,000 up to 86.2% among those with incomes of \$75,000 or more. Smoking bans at work increased with age and adults with less than a high school education (64.3%) were least likely to report working somewhere with a smoking ban compared to 88.3% of college graduates. (2004 BRFSS)

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