



# Racial and Ethnic Health Disparities in Colorado 2009

## EXECUTIVE SUMMARY

Office of Health Disparities  
Colorado Department of Public Health and Environment



All Coloradans will have an equal opportunity to be healthy regardless of race and ethnicity.

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Office of Health Disparities, Colorado Department of Public Health and Environment

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# Executive Summary

This document represents a summary of the *Racial and Ethnic Health Disparities in Colorado 2009* report. The complete report is available at [www.cdphe.state.co.us/ohd/](http://www.cdphe.state.co.us/ohd/) and on the CD supplied in the back cover of this summary.



*The Office of Health Disparities is a state program of multi-cultural health professionals dedicated to eliminating racial and ethnic health disparities in Colorado by fostering systems change and capacity building through multi-sectoral collaborations.*

Additional copies of the complete report may be obtained at [www.cdphe.state.co.us/ohd/](http://www.cdphe.state.co.us/ohd/) or contact the Office of Health Disparities, 4300 Cherry Creek Drive South, Denver, Colorado 80246, phone: 303-692-2087, email: [cdphe.edohd@state.co.us](mailto:cdphe.edohd@state.co.us)



# Executive Summary

OVER THE PAST 50 YEARS, the United States has benefited greatly from advances in medicine, environmental protection, disease-control and health-promotion strategies. Improved technologies within the medical, public health and environmental fields have resulted in increased life expectancy and a better quality of life. However, all racial and ethnic groups have not benefited equally from these advances. Communities of color are disproportionately affected by disease, disability and death. These differences in health status among groups are known as health disparities and are present at the national, state and local levels.

This is the third report prepared by the Colorado Department of Public Health and Environment to examine racial and ethnic health disparities in Colorado. The first health disparities report was published in 2001 by the Colorado Turning Point Initiative in cooperation with the Colorado Minority Health Forum. The Turning Point Initiative coordinated the development and implementation of a public health improvement plan, which identified the elimination of health disparities as a high priority for the Turning Point Initiative. The 2001 report was a profile of health disparities among communities of color in Colorado and included an executive summary and overview of the state's population, health indicators by race and ethnicity, factors that contribute to health disparities and recommendations for the elimination of health disparities in Colorado.<sup>1</sup> A second, more comprehensive report was published in 2005.<sup>2</sup> The bulk of the 2005 report focused on 29 indicators of health status for four Colorado communities of color. It also included discussions of mental health, determinants of health and the cost of health disparities and recommended measures for reducing health disparities. The most recent data included in the 2005 report are for 2002.

The 2009 report updates and expands on the findings of the 2005 report while retaining a focus on Colorado's four major communities of color: Hispanics/Latinos, African-Americans/Blacks, American Indians and Asians/Pacific Islanders.\* New features include

- more information on the characteristics of each group, including demographic and social differences within each broader community of color;

\* Some sections of this report, especially the section on mental health, include material published in the 2005 report

- an updated discussion of the relationship of social and environmental determinants of health to health disparities;
- new material on immigrants and health disparities and the importance of culturally competent care and services to improving the health of Colorado's diverse population;
- a summary of promising initiatives undertaken by public and private organizations in Colorado to reduce documented health disparities; and
- a detailed discussion of the strengths and weaknesses of the data sources used in this report.

Most important, this report expands the number of Colorado indicators from an average of 14 per group/community in the 2005 report to an average of 40 in this report.

National data show a discouraging pattern that is evident in this report as well. Despite increased attention to health disparities at the national, state and community levels, relatively little progress has been made in achieving the vision of the Healthy People 2010<sup>3</sup> initiative of eliminating racial and ethnic health disparities by 2010. Each of the four communities of color has deep historical roots in Colorado, and the state has become increasingly diverse in recent years.

Today, Hispanics/Latinos account for nearly 20 percent of the state's population. African-Americans/Blacks make up 4 percent, Asians/Pacific Islanders 3 percent and American Indians 1 percent. Today roughly 15 percent of Coloradans speak a language other than English at home, and members of the four communities of color reside throughout rural and urban Colorado.

As mentioned above, this report consists of an average of 40 health indicators based on recent Colorado data for each of the four communities of color. Each section begins with a brief demographic overview of the group. Health indicators then are presented in a sequence based on life cycle stage (maternal and infant health, child and adolescent health, and adult health), risk factors (smoking, nutrition, etc.) and leading causes of death (heart disease, cancer, etc.). Each section includes a discussion of data limitations, one or more summaries of initiatives in Colorado to address disparities and recommendations for reducing disparities for each group.

The introduction is followed by five more general sections that precede the sections presenting indicators for each community of color. The general sections are as follows:

- **Determinants of health.** This section explores how the social conditions in which people live and work contribute to the health disparities documented later in the report. Data are presented on socioeconomic status for each group, variations in access to health care due to differing levels of insurance coverage, differences in quality of health care and environmental justice.
- **Immigration.** Each community of color includes native-born Americans whose roots in Colorado go back generations as well as recent immigrants. While many recent immigrants are healthy young adults, immigrants who are undocumented have limited ability to speak English or lack health insurance and are at risk for poor health. This section calls attention to ways that immigration status can contribute to health disparities, especially for Colorado’s Asian/Pacific Islander and Hispanic/Latino communities.
- **Cultural Competence.** Providing culturally competent health services to a culturally diverse population is a challenge for Colorado’s public health and health-care systems. This section points to steps that can be taken to address this problem.
- **Mental Health.** This section reminds us that health is more than the absence of physical diseases and that mental health issues may present themselves differently in communities of color.
- **Cost of Health Disparities.** Health disparities are costly in several senses of the term. They generate costs to the health-care system that could be reduced by the elimination of disparities. More importantly, poor health extracts a cost to individuals, families and communities by limiting the ability of people to realize their full potential.

## Summary of Findings

The indicators presented in each group section provide a fairly comprehensive picture of disparities: areas where the burden of disease is greater or lesser for a particular community than for the Colorado population as a whole. The term “health disparities” carries the connotation of greater disease burden, health risk, access to quality health care, etc. for communities of color. However, as demonstrated in this report, there are indicators for each group where its “performance”



is disparate but “better” than that of the state population overall. To distinguish between the two types of disparities we have labeled the former “disparities of concern” and the latter “positive indicators.” Except for the Asian/Pacific Islander population, where we found many more positive indicators than disparities of concern, and American Indians, where the available indicators provide very limited information on either type of disparity, we have found in Colorado what has been reported elsewhere for the nation as a whole: disparities of concern substantially outnumber (and outweigh in terms of seriousness of health concern) positive indicators.

Below we present selected disparities of concern and positive health indicators for each community of color. Each is given a brief title with the relevant figure number within that group section in parentheses. There are fewer indicators presented for American Indians and Asian/Pacific Islanders due to data limitations. Readers are encouraged to consult the individual sections to get a clearer picture of the extent to which a group’s performance differs from that of the total population. Additional information on data sources and accuracy may be found in the Appendix.

## Hispanic/Latino

The rapidly growing Hispanic/Latino community is burdened by disparities of concern affecting children, youth and adults, yet there are areas where Hispanics/Latinos exhibit better health behaviors, lower disease prevalence and lower mortality rates.

Disparities of concern (Figure No.)	Positive indicators (Figure No.)
Child obesity (13)	Smoking and drinking in last three months of pregnancy (11,12)
Child oral health (14–16)	Hypertension (27)
Teen fertility (18)	Lung cancer incidence and mortality (38,39)
Adult obesity (26)	Heart disease mortality (40)
Diabetes mortality (43)	
Chronic liver disease and cirrhosis mortality (50)	
Motor vehicle injury mortality (52)	
Homicide and legal intervention mortality (53)	

## African-American/Black

The African-American/Black population experiences the greatest magnitude of health disparities by race and ethnicity, both nationally and in Colorado. However, there are areas where African-Americans/Blacks exhibit better health behaviors, lower disease prevalence and lower mortality rates.

Disparities of concern (Figure No.)	Positive indicators (Figure No.)
Infant and perinatal mortality (5, 6)	Drinking during last three months of pregnancy (11)
Low-weight births (7)	Teen fertility (16)
Three+ stressors during pregnancy (9)	Binge drinking (23)
Childhood obesity (12)	Chronic lower respiratory disease mortality (44)
Adult obesity (24)	Suicide (49)
Hypertension (25)	Motor vehicle injury mortality (50)
Heart disease mortality (26)	
Cancer mortality (all cancers) (28)	
Prostate cancer mortality (36)	
Diabetes mortality (47)	
Homicide and legal intervention mortality (48)	
HIV mortality (52)	

## American Indian

As described in the American Indian section, there are fewer health indicators for Colorado's American Indian population, and those indicators that do exist are less reliable for American Indians than for other groups. Data limitations represent a major challenge for identifying health disparities for Colorado's American Indian population. These limitations are primarily a function of the inadequacies of the current data systems and misclassification of American Indians as some other race/ethnicity group in standard health data systems such as vital records. There also are limitations on data sharing from the Indian reservations. National data suggest that the burden of disease for Colorado's American Indian population is greater than suggested by the indicators included in this report.

Disparities of concern (Figure No.)	Positive indicators (Figure No.)
Smoking (6)	Heart disease mortality (11)
Binge drinking (10)	Cancer mortality (12)
Diabetes Mortality (16)	

## Asian/Pacific Islander

In contrast to the other three communities of color covered in this report, Colorado Asians/Pacific Islanders, like Asians/Pacific Islanders nationally, exhibit far more positive indicators than disparities of concern. By the indicators covered in this report, the Asian/Pacific Islander community appears healthier than other groups. Small population numbers and the diversity of Colorado's Asian/Pacific Islander population create special challenges to compiling data appropriate for assessing the health of this diverse community and for accurately estimating the extent of health disparities between the Asian population and the total population, as well as within the Asian population.

Disparities of concern (Figure No.)	Positive indicators (Figure No.)
Cervical cancer mortality (31)	Three+ stressors during pregnancy (9)
Tuberculosis incidence (36)	Smoking and drinking in last three months of pregnancy (10, 11)
Chronic Hepatitis B (43)	Children's oral health (13–15)
	Life expectancy (16)
	Smoking and drinking (20, 21)
	Adult obesity (22)
	All cancer mortality (25)
	Lung cancer mortality (33)
	Heart disease mortality (34)
	Chronic lower respiratory disease mortality (38)

## Addressing Disparities

At the national, state and community level, various groups, both public and private, have done much to heighten public awareness of the extent and persistence of health disparities. Researchers have extended our knowledge of the pervasiveness of this problem, and public health officials have devised a number of strategies for reducing health disparities. In Colorado, the Office of Health Disparities was established in the Colorado Department of Public Health and Environment in 2004. Local foundations have generously funded numerous initiatives to reduce disparities, often for specific health conditions afflicting specific communities of color in Colorado. No magic bullet has emerged from these efforts, but small victories are being won across the state. Each group session opens with a discussion of community strengths that can be drawn upon to address disparities. Each session concludes with summaries of specific initiatives in Colorado communities and recommendations to redouble efforts to reduce and, ultimately eliminate, disparities.

## Recommendations

This report illustrates the facts that racial and ethnic health disparities are complex, and suggests that solutions to close the gap must be equally complex and will need to operate on many levels.

### Recommendation for Improving the Social Determinants of Health

Plan and develop socioeconomic interventions that improve community's access to better housing conditions, improved nutritional choices, health care, goods and services.

### Recommendation for Improving the Practice of Epidemiology

Researchers and public officials need to work together to evaluate the effectiveness of disparities interventions and to document and publicize those programs and policies that yield positive results.<sup>4</sup>

### Recommendations for Improving Cultural and Linguistic Competence

With numerous cultural competence resources available (e.g., books, videos, training), all people can pursue professional development to improve their cultural competence skills to work more collaboratively with the communities they serve. Recommendations to

expand cultural competence capacity include the following:

- Develop standards tailored to community needs, collect data to identify service needs, finance interpreter services and increase the supply of minority health providers.<sup>5</sup>
- Incorporate funding for professional interpretation and translation services into grant applications.
- Develop minimum standards for culturally and linguistically competent health services; undertake data collection and research on successful practices; support education, training and development of a more competent workforce; and monitor and enforce the effectiveness of implemented programs.<sup>6</sup>
- Provide equitable and effective treatment in an appropriate manner to all people who enter the health-care system.<sup>7</sup>
- Allocate time and resources for cultural competence training.

### Recommendations for Improving Work Force Diversity and Leadership Development in the Health Professions

A means to achieving the aforementioned cultural and linguistic competence in an organization is the strategic recruiting, hiring and retaining of a diverse work force. The supply, composition and competence of the health work force are important ingredients in maintaining and improving the health status of individual patients and broader populations.<sup>8</sup> Recommendations include the following:

- Provide financial incentives for minority students and institutions committed to increasing the graduation rates of those students to increase public health work force diversity. Provide substantial support for scholarships and loan repayment grants to minority and low-income health professions students willing to practice in underserved areas.
- Support people of color in the health professions through strategic partnerships, leadership development, continuing education and networking activities, as well as organizations that educate policymakers about public and institutional policies that promote health work force diversity.<sup>9</sup>
- Create leadership development programs that intentionally recruit people of color and that incorporate individual leadership training, organizational capacity building and constituency development.<sup>10</sup>

- Diversify health professions through such efforts as mentoring, developing a critical mass of under-represented minority health professions students and faculty, providing focused and consistent support from leadership, and providing social and psychological support.<sup>11</sup>

### Recommendations for Health Promotion and Preventive Care

- Expand the number and capacity of community health centers, reduce financial barriers to obtaining primary care, and increase research efforts to address disparities in primary care for minority populations.
- Encourage provider-community prevention partnerships, target resources to populations disproportionately affected by disease, and implement screening and prevention programs targeted toward minority communities.<sup>12</sup>
- Implement and evaluate culturally appropriate patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions.<sup>13</sup>
- Implement patient navigator and/or outreach worker models to effectively address the needs of disparate populations with chronic diseases.



### Recommendations for Improving Mental Health Disparities

The presence of mental illness predicts adverse physical health outcomes. Addressing disparities in mental health care also can address general health outcomes for those suffering mental illness. The tables below outline corrective measures to address these needs:

**Table 1.1: Corrective Measures for Mental Health Disparities<sup>14</sup>**

- Reduce stigmatization of mental illness through education.
- Enhance communication-based social skills training for those with mental illness.
- Improve access to and availability of mental health services in underserved communities.
- Enhance numbers of providers to the underserved through targeted recruitment.
- Increase education to improve treatment compliance.

**Table 1.2: Corrective Measures for Physical Health Disparities in Patients with Mental Illness<sup>15</sup>**

- Correct educational deficits on the part of health-care deliverers.
- Improve cultural competence of health-care providers.
- Provide “health-care extenders” to address shortages of providers in underserved communities.
- Provide “one-stop shopping” for medical and psychiatric interventions.
- Emphasize evidence-based prevention and effective interventions.

### Recommendations for Strengthening the Safety Net System

- Support safety net hospitals and providers in the community (e.g., provide funding for community-recommended services, volunteer to help transport patients to and from clinics).
- Health services programs should ensure that underserved clients (including racial and ethnic minorities) receive all services for which they are eligible.
- Health services programs should collect and analyze patient data to improve services for the racial and ethnic minorities.

### Research and Promising Practices

- Improve research, surveillance, monitoring and evaluation to provide better data and tools to address health disparities. Major inadequacies in data collection hamper efforts within individual states and hinder efforts to understand differences among states.<sup>16</sup>

- Enhance surveillance systems and supply necessary resources to enable the generation of reliable estimates for minority populations.
- Seize the opportunities and fulfill the critical role that public and private agencies have in fostering collection, analysis and use of minority health data for the identification and amelioration of disparities.<sup>17</sup> The accepted national standard for data collection is the race and ethnicity categories in the Office of Management and Budget's Directive 15.
- Researchers must talk with people in the community to get their personal stories and opinions to fully understand how stress, racism and health are related. Such descriptions (qualitative studies) provide a context to help researchers understand how social interactions create health outcomes.<sup>18</sup>
- Infuse practice with evidence-based interventions and share results of community-based research and promising program strategies with others in the field and in the community.



## Overarching Recommendations

Social and behavioral factors have a broad and profound impact on health across a wide range of conditions and disabilities. A better balance is needed between the clinical approach to disease (presently the dominant public health model for most risk factors) and research and intervention efforts that address generic social and behavioral determinants of disease, injury and disability.<sup>19</sup>

Rather than focusing interventions on a single or limited number of health determinants, interventions on social and behavioral factors should link multiple levels of influence, (i.e., individual, interpersonal, institutional, community and policy levels).<sup>20</sup>

- Organizations should adopt the goals and strategies from the Colorado Interagency Health Disparities Leadership Council's strategic plan *Working Together to Address Racial and Ethnic Health Disparities in Colorado*. (<http://www.cdph.state.co.us/ohd/08HealthDisparitiesStrategicPlan.pdf>)
- The Office of Health Disparities invites organizations to report on their successfully implemented best practices, challenges and ideas for private and public partnerships.
- The Office of Health Disparities reminds organizations to keep the overarching issues of health disparities in mind when developing and implementing programs and providing equitable services to the community.

## Suggested Uses of this Report

- Cite report data in grant applications.
- Cite report data in presentations to educate people about health disparities and their root causes.
- Use the data for planning and setting priorities.
- Use the data to set measurable objectives to develop a program.
- Use the recommendations in the report to advance your organizations' programs, policies and/or priorities.
- Use data and recommendations to advocate for the needs of communities of color.





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Colorado Department  
of Public Health  
and Environment

“To protect and improve  
the health and environment  
of the people of Colorado.”

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