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New England Regional Health Equity Profile & Call to Action

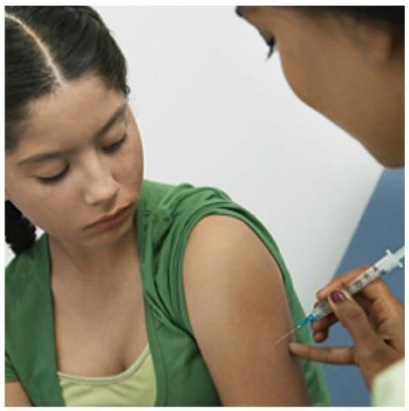
Charles E. Drum
University of New Hampshire, Durham, Charles.Drum@unh.edu

Kimberly G. Phillips
University of New Hampshire, Durham, Kimberly.Phillips@unh.edu

K. Chiu

Data, Research, and Evaluation Committee of the Region I Health Equity Council

NATIONAL PARTNERSHIP FOR ACTION to End Health Disparities



New England Regional Health Equity Profile & Call to Action

New England RHEC

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EXECUTIVE SUMMARY

Good health is a foundation that allows people to participate in the most important aspects of life. The purpose of the New England Regional Health Equity Profile and Call to Action is to identify where differences in good health exist among racial, ethnic, and disability populations in New England as well as foster policy, programmatic, and individual action to combat health disparities and achieve health equity for racial, ethnic, disability and underserved populations in New England. The report was written by the members of the New England Regional Health Equity Council (RHEC), one of ten regional health equity councils formed by the Office of Minority Health at the federal Department of Health and Human Services. The mission of the New England RHEC is to achieve health equity for all through collective action in the New England region. The New England RHEC's vision is to achieve health equity through cross-sector interaction and collaboration of activities and resources to optimize health for all where they live, learn, work, and play.

The New England Regional Health Equity Profile and Call to Action uses a "social determinants of health" approach. A social determinants of health approach focuses on understanding how the intersection of the social and physical environments; individual behaviors; and access to education, income, healthy foods and health care, impacts a wide range of health and quality-of-life outcomes. The report examines the following topics: Socio-Economic Status, Healthy Eating and Physical Activity, Risky Behaviors, Cultural Competency in Health Care, Health Care Access, Health Outcomes, and the Intersection of Race/Ethnicity & Disability. It also includes a description of State Health Equity Activities and a Regional Call to Action.

Key Findings

Demographics

- Although New England is predominantly white, racial and ethnic minorities are scattered throughout the region and each state has a substantial proportion of people with disabilities.
- Most people in the region live in urban settings, with the exception of people from Maine, New Hampshire, and Vermont.

Socioeconomic Status

- Many racial and ethnic minorities and people with disabilities have low incomes and less than a high school education. Many people, especially individuals with disabilities, are unemployed.

Healthy Eating & Physical Activity

- Fruits and vegetables are less likely to be a part of the diets of several racial and ethnic groups and people with disabilities in New England.
- African-Americans, American Indian/Alaska Natives, and Hispanics in several states are exercising less frequently than whites. People with disabilities in New England are much less likely to exercise than the non-disabled.

Adult Risk Factors

- Smoking is a significant problem for people with disabilities and many racial and ethnic groups in New England.
- Binge drinking is less of a problem in New England compared to the US as a whole.

Health Care Access

- Not having health insurance or a primary care physician, as well as having to delay needed medical care because of cost is an issue for many racial and ethnic minorities. People with disabilities also often delay medical care.

Preventive Health Services

- Many racial and ethnic minorities are not receiving flu shots in the region, but most people with disabilities are receiving flu shots.
- As a region, New England is not meeting the HP2020 goal for HIV testing.

Health Outcomes

- Coronary heart disease, stroke, and cancer are significant issues for people with disabilities in the New England region.
- Chronic conditions (high blood pressure, asthma, chronic obstructive pulmonary disease or COPD, diabetes, and obesity) are a significant problem for people with disabilities in our region and many of these same conditions are a problem for racial and ethnic minority populations in New England.
- In some New England states, racial and ethnic groups experience challenging health outcomes, as do people with disabilities throughout the region.

Intersection of Race & Disability

- The combination of a racial and ethnic minority status with the presence of a disability creates a challenging multiplier effect in several areas of health.

State-Based Health Equity Activities

- States within the New England region are engaging in activities that align with the NPA goals to address health disparities affecting racial and ethnic minority populations and people with disabilities. These goals include awareness; leadership; health system and life experience; cultural and linguistic competency; and data, research, and evaluation activities.

Regional Call to Action

- Collectively, New England can serve as a powerful example of how we can work together to address health equity in our region. Many examples of how to provide a regional basis to health equity are provided in the Regional Call to Action.

Introduction & Overview

Introduction

Good health is a foundation that allows people to participate in the most important aspects of life. The purpose of this report by the New England Regional Health Equity Council (NE RHEC) is to identify where differences in good health exist among racial, ethnic, and disability populations in New England. The NE RHEC is one of ten regional health equity councils in the United States formed in 2011 to implement the National Partnership for Action to End Health Disparities (NPA). The NPA is a public-private initiative that seeks to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity. Created by the Office of Minority Health at the federal Department of Health and Human Services, Regional Health Equity Councils (RHECs) are public/private partnerships comprised of community leaders; health insurers; state legislators; and leaders and stakeholders from universities, community-based organizations, faith-based organizations, foundations, state government organizations, hospitals and health systems, and many other groups.

The mission of the New England RHEC is to achieve health equity for all by working together in this region. The overall goal of the NE RHEC is to foster policy, programmatic, and individual action to combat health disparities and achieve health equity for racial, ethnic, and disability populations in New England. Accomplishing this goal will require focused and ongoing efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health-related disparities. The RHECs' primary role is to develop action steps to accomplish the goals of the NPA and address health disparities from a grassroots perspective.

New England Regional Report: First in a Series

This report examines a number of determinants of health to learn what adult racial and ethnic minorities and adults with disabilities in New England are experiencing in terms of health disparities. It provides a snap shot of the health of these vulnerable populations in this region. While the report provides a good description of health issues, more complex analysis is needed to explain all of the causes of health differences described in the report. We will address causality in greater detail in future publications. The purpose of this report is to bring attention to health disparities and foster a dialog on how our region should collaborate to take action to address the exposed disparities.

We also recognize how important it is to identify disparities affecting the health of children and youth in New England and intend to center attention on this population in a future report.

Report Contents

This report examines the following topics: Socio-Economic Status, Healthy Eating and Physical Activity, Risky Behaviors, Cultural Competency in Health Care, Health Care Access, and Health Outcomes. We also examine the intersection of race/ethnicity and disability. The report begins by looking at the demographics of the region; factors such as the number of people residing in each state and the region as a whole, their race, ethnicity, and disability status, and levels of education and income levels. Although this is a regional report, many states have already focused on health equity issues and we will provide short summaries of a

few of those state activities as well. The report concludes with a Regional Call to Action to ensure the health of racial and ethnic minorities and people with disabilities in New England. The report also includes a glossary of some of the more complex terms used in the report, but we begin with a description of the core concepts associated with health disparities.

What is "good health"?

Although "health" can be defined many different ways, this report uses the definition of health developed by the World Health Organization (WHO). The WHO defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] In this sense, health is not just avoiding illness but ensuring a balance in one's life physically, mentally, socially, and spiritually in order to be active, engaged, and feel good.

What are the "social determinants of health"?

Health can be impacted by risky individual behaviors like smoking or drinking too much or not exercising regularly. Other social, cultural, economic, and political factors can influence health outcomes as well. For example, not having a support network, limited access to nutritious foods, being unemployed, or living in an unsafe environment can negatively impact health and health outcomes. Collectively, these types of factors - displayed graphically in Figure 1 - are called *the social determinants of health*.[2,3]

What are "health disparities"?

The social determinants of health can cause differences between groups of people. When these health differences become clinically or statistically significant they are called a *health disparity*[4] and serve as a call to action!

What is "health equity"?

Healthy People 2020 defines "health equity" as the "attainment of the highest level of health for all people."[5] What are the *Healthy People* reports? Every ten years, a group of public health experts establish a comprehensive set of 10-year national health goals and objectives called the *Healthy People* reports. *Healthy People 2020* covers 42 topic areas with over 1,200 objectives to improve our country's health!

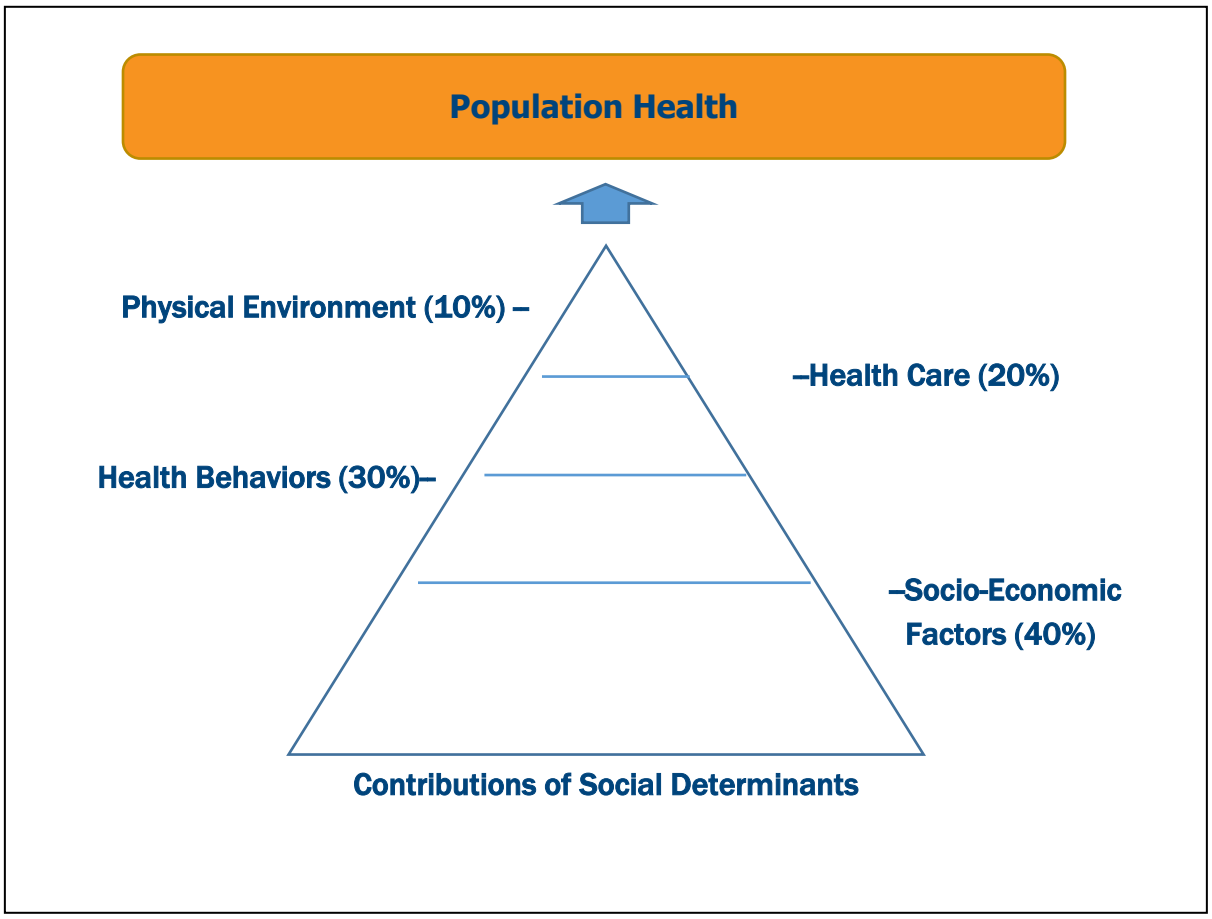


Figure 1. Social Determinants of Health

How Are We Doing? Comparing Health Disparities in New England

Often, but not always, people who are white experience better health compared to racial and ethnic minorities. Many people without disabilities also experience better health than people with disabilities, even though having a disability isn't the same thing as being ill.[6] To determine if health disparities exist in New England, we looked at a number of health outcomes among racial and ethnic minority populations compared to the white population. The white population is called a "referent group" to determine if any differences are statistically significant. We also examined these same health outcomes among people with disabilities compared to the non-disabled population as a "referent group."

Data are presented throughout this report in tables with colored highlighting to denote statistical significance. Green indicates where a group is faring better than the referent group, and red indicates where a group is faring worse. Lack of highlighting means there is no statistically significant difference between the group and the referent group.

We also analyzed how the entire New England population (not just racial and ethnic minorities and persons with disabilities) is doing compared to some of the objectives in HP 2020. For example, HP 2020 has an

objective that 70% of the United States (US) population receives an annual flu shot. We compared how New England was doing according to this target. Comparisons of the general population in New England to the HP 2020 objectives are also listed as: green (New England is statistically significantly *better than* the HP target), red (New England is statistically significantly *worse than* the HP target), and a lack of highlighting means there is no statistically significant difference between New England and the HP target. Although HP 2020 is comprehensive, not all of the determinants that we examined correspond to a Healthy People objective.

Where the Data Comes From

Public health reports often use many sources of information. The data from this report relied on information from the 2013 Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an annual telephone survey conducted in every state and territory. The BRFSS has a core set of demographic and health-related questions that are asked every year, in addition to a number of optional questions. With more than 500,000 interviews being conducted, the BRFSS is the largest telephone survey in the world! The actual (i.e., "unweighted") responses to the BRFSS are then weighted to create a representative sample based on US population demographics. To help readers understand the numbers that the results are based on, we've included weighted and unweighted sample sizes in Table 1 (Demographics).

How Were the Data Analyzed?

Statistics for this report were generated using Stata statistical software. Descriptive analyses were conducted with the seven mutually exclusive racial/ethnic groups, using United States Census labels including White, Black or African American (AA), Asian, Native Hawaiian or other Pacific Islander (NH/PI), American Indian or Alaska Native (AI/AN), multiple races (Multi), and Hispanic. "Mutually exclusive" means that survey participants picked a single answer to the race/ethnicity question and we analyzed responses within those seven race/ethnicity groups, but didn't combine them.

Descriptive analyses were also conducted among people with and without disabilities, however, the disability population includes individuals of all races/ethnicities. Disability in the BRFSS is defined by saying "yes" to any of the following: a self-report of limitations due to physical, mental, or emotional problems and/or a health problem that necessitates the use of special equipment such as a wheelchair, special bed, communication device, or other tools. In addition, definitions of disability found in the American Community Survey have also been added to the BRFSS. Individuals have a disability if they answer "yes" to any of the following:

1. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
2. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?
3. Do you have serious difficulty walking or climbing stairs?
4. Do you have difficulty dressing or bathing?
5. Because of a physical, mental, or emotional condition do you have difficulty doing errands alone, such as visiting a doctor's office or shopping?

Statistical significance between the referent groups (racial/ethnic groups or disability) was determined by examining the 95% confidence intervals for each estimated data point. Confidence intervals indicate that 95% of all samples drawn from the whole population will result in a point estimate somewhere within the given range. Statistical significance was determined at the commonly accepted alpha level .05.

Limitations - the Report's "Warning Label"

While the BRFSS is a frequently used survey, it has some key limitations that are important to keep in mind. The BRFSS is a random survey, meaning that any resident might be called. However, some groups of people are not included. People who are in an institution, such as a jail or nursing home, or those who have no telephone are not included. Starting in 2011, the survey was expanded to include cell phone subscribers. Since the survey is only offered in English or Spanish, it excluded people who do not speak these languages. Some people with disabilities may be excluded because the survey was not made available in alternative formats. Other individuals with disabilities may not be included if they couldn't get to the phone in time or they may use a special telephone that sounds to the caller like a fax machine. Notably, no questions were asked about deafness or hearing impairments.

Readers are also cautioned that the number of respondents in some racial or ethnic groups were very small. In an effort to present as much information as possible, we included results even when there were five or less characteristics observed. If the tables have a dash in the column, it means that the cell size, or characteristics observed, was too small to include in the results. While other reports would only include results with a minimum cell size of 50,[7] we are including results with small cell sizes (five or less), because there is less racial diversity in some states in the region. As a result, we urge caution to the reader in over-interpreting the responses.

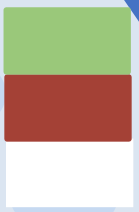
Readers may also question results that are not highlighted in color, but seem to indicate a statistically significant difference with the referent group. For example, in Table 3, 21% of Native Hawaiian/Pacific Islanders in Maine have less than a high school education which looks significantly different from the white referent group (7%). Because the sample size of Native Hawaiian/Pacific Islanders is small, these results are not statistically significant and result in a finding of "No difference."

A larger issue is that the report uses racial, ethnic, and disability categories as if everyone that fits into one of these categories has shared experiences. The lived experience of an individual from Brazil is significantly different from someone originating from Mexico, but both are "Hispanics." Similarly, there are many different cultures and tribal origins for American Indians and Alaska Natives, and Native Hawaiian/Pacific Islanders, cultures and countries of origin for "Asians" and "blacks," and sources of disability. For example, African Americans may include those of African, Caribbean, and West Indian descent and may exclude culture, language and comprehension abilities. The needs of vulnerable subgroups may be masked by not disentangling race, ethnicity, and disability categories. For example, overall low rates of poverty among Asian Americans may mask high poverty rates among Southeast Asians as an ethnic group.[8] Unfortunately, the BRFSS does not ask enough questions to address these issues. For this report, we use the BRFSS race, ethnicity, and disability categories.

Health Equity Report Card Summary

New England (NE) Region

Connecticut • Maine
Massachusetts • New Hampshire
Rhode Island • Vermont



Green indicates where a group is **faring better** than the referent group

Red indicates where a group is **faring worse** than the referent group

Lack of highlighting (white) means there is **no statistically significant difference** between the group and the referent group

	Subject/Activity Name		NE Ethnic/Racial Minority Population						NE People with Disabilities	NE vs. Healthy People 2020
			Bl/AA	Asian	NH/PI	AI/AN	Multi	Hisp		
1	Socioeconomic Status	Income								N/A
		Education								N/A
		Employment								N/A
2	Healthy Eating and Physical Activity	Eat Vegs. & Fruits								
		Exercise								
3	Adult Risk Factors	Tobacco								
		Alcohol								
4	Health Care Access	Health Insurance								
		Primary Care Provider								
		Delay Medical Care								
5	Preventive Health Services	Flu Shot								
		HIV Testing								
6	Health Outcomes	Cardiovascular								N/A
		Kidney Disease								N/A
		Cancer								N/A
		Chronic Conditions								N/A
		Quality of Life								N/A

New England Regional Health Equity Council

Demographics

Demographics are defined as information about a group or population at a specific point in time. Table 1 presents national, regional, and state information about race and ethnicity, disability status, age, gender, and urban and rural status. Some important findings include:

- While 65.5% of the nation's population is white, 80.4% of the population in the New England region is white.
- Hispanics were the largest minority population in each New England state except Maine; African-Americans were the second-largest minority population in three states (Connecticut, Massachusetts, and Rhode Island); and multiracial persons were the second-largest minority population in two states (New Hampshire, and Vermont), and the largest minority population in Maine.
- Around 27% of the regional population have a disability, ranging from a low of 26.6% in Connecticut to a high of 29.9% in Rhode Island.
- Eighty-seven percent of people in the region lived in urban settings (called Metropolitan Statistical Areas or MSAs), although New Hampshire (39.5%), Maine (43.4%), and Vermont (68.2%) have large rural populations.

Table 1. Demographics & Sample

	Nation	Region I	CT	ME	MA	NH	RI	VT
Total (Millions)	240.0	11.3	2.8	1.1	5.2	1.0	0.8	0.5
Race/Ethnicity								
White								
Total %	64.5	80.4	72.9	95.0	77.6	93.8	79.3	94.8
Weighted	150M	9.1M	2M	1M	4M	960,000	640,000	470,000
Unweighted	(376,451)	(42,787)	(5,998)	(7,674)	(11,744)	(6,031)	(5,367)	(5,973)
Black/African American								
Total %	11.7	5.4	9.2	1.0	5.8	0.9	4.6	0.5
Weighted	28M	610,000	250,000	11,000	300,000	9,330	37,000	2,310
Unweighted	(39,151)	(1,858)	(643)	(42)	(877)	(38)	(239)	(19)
Asian								
Total %	4.6	3.7	3.6	0.5	5.3	1.1	2.3	1.3
Weighted	11M	420,000	98,000	4,908	280,000	11,000	18,000	6,564
Unweighted	(9,510)	(720)	(148)	(26)	(384)	(45)	(83)	(34)
Native Hawaiian/Pacific Islander								
Total %	0.2	0.2	0.2	0.1	0.3	0.1	0.2	0.0
Weighted	520,000	23,000	4,423	828	15,000	684	1,725	82
Unweighted	(1,546)	(63)	(17)	(3)	(28)	(2)	(11)	(2)
American Indian/Alaska Native								
Total %	1.0	0.6	0.5	1.0	0.5	0.8	0.8	1.2
Weighted	2.5M	69,000	14,000	11,000	24,000	8,241	6,172	5,775

Unweighted	(7,683)	(323)	(43)	(70)	(58)	(43)	(47)	(62)
Multiple								
Total %	1.4	1.1	0.7	1.4	1.2	1.4	1.0	1.1
Weighted	3.3M	120,000	18,000	15,000	63,000	15,000	8,098	5,393
Unweighted	(9,130)	(545)	(69)	(95)	(185)	(65)	(51)	(80)
Hispanic								
Total %	16.6	8.6	13.1	1.0	9.2	1.9	11.9	1.1
Weighted	40M	970,000	360,000	11,000	480,000	19,000	96,000	5,405
Unweighted	(37,054)	(2,591)	(577)	(60)	(1,354)	(71)	(476)	(53)
Disability Status								
Disability								
Total %	29.6	27.2	26.6	29.8	26.7	27.0	29.9	27.1
Weighted	71M	3.1M	730,000	320,000	1.4M	280,000	250,000	130,000
Unweighted	(165,591)	(15,742)	(2,307)	(2,639)	(4,724)	(1,977)	(2,164)	(1,931)
No Disability								
Total %	70.4	72.8	73.4	70.2	73.3	73.0	70.1	72.9
Weighted	170M	8.2M	2M	740,000	3.7M	760,000	570,000	360,000
Unweighted	(316,479)	(33,492)	(5,284)	(5,402)	(9,747)	(4,406)	(4,266)	(4,387)
Gender (%)								
Male	48.6	48.1	48.1	48.4	47.8	48.9	47.7	48.8
Female	51.4	51.9	51.9	51.6	52.2	51.1	52.3	51.2
Age (%)								
18-64	81.3	80.3	80.2	78.0	80.9	80.6	80.2	79.7
65 & over	18.7	19.7	19.8	22.0	19.1	19.4	19.8	20.3
Urban/Rural Status (%)								
MSA	80.8	87.0	90.6	56.6	99.4	60.5	100.0	31.8
Non-MSA	19.2	13.0	9.4	43.4	0.6	39.5	0.0	68.2

Source: BRFSS, 2013

Socioeconomic Status

Living in poverty, having less education, and not being employed are significant social determinants of health. Poor socioeconomic status is often linked to reduced health and a lack of access to health care services and healthy foods. Tables 2-4 present information about socioeconomic status. Important findings are described below.

Income

- When compared to white households, large percentages of African-American, American Indian/Alaska Native, Hispanic, and multiracial households in our region have household incomes that are less than $25,000 per year.
- People with disabilities in our region are more likely to have low incomes compared to non-disabled populations.

Table 2. Percent with Household Income less than $25,000 per year

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	23	46	23	39	52	34	54	24	49
Region	20	38	19	25	48	30	59	17	44
CT	15	36	11	23	44	31	53	16	39
ME	29	60	42	-	44	43	41	21	49
MA	19	38	20	22	46	28	63	16	46
NH	20	39	16	-	62	28	50	14	40
RI	21	45	33	19	52	24	69	20	46
VT	24	44	28	-	43	38	17	18	42

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Education

- Large percentages of Hispanics, and a significant proportion of African-Americans and American Indian/Alaska Natives in our region have less than a high school education.
- In comparison to those without disabilities, people with disabilities are more likely to have less than a high school education.

Table 3. Percent with Education Less Than High School Diploma

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	9	18	6	9	23	14	38	12	23
Region	8	22	4	18	21	14	38	8	19
CT	7	22	5	10	17	11	33	9	20
ME	10	17	3	-	11	12	14	8	15
MA	7	23	3	21	30	15	42	8	20
NH	8	7	5	-	20	19	18	6	17
RI	10	25	10	4	20	14	43	11	27
VT	9	20	6	-	19	14	4	7	15

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Employment

- People with disabilities in our region are much less likely to be employed compared to non-disabled populations, but there are few differences between whites and racial and ethnic minorities in employment rates.

Table 4. Percent Employed for Wages or Self-Employed

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	56	52	63	64	47	53	57	65	33
Region	59	56	62	58	53	54	56	67	36
CT	59	54	61	63	52	60	57	66	38
ME	58	72	46	--	51	49	61	68	33
MA	60	56	61	49	60	51	54	67	35
NH	61	45	65	--	55	57	57	70	36
RI	56	60	73	96	35	66	58	66	34
VT	61	63	64	--	53	64	60	68	42

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy Eating and Physical Activity

Eating a nutritious diet and exercising or being physically active are building blocks to good health. Unfortunately, it can be hard to find healthy and affordable food in some communities! Even when fresh fruits and vegetables are available, economic and transportation barriers may limit access. Physical, environmental, and health barriers may also limit physical activity. Tables 5-7 present information about food consumption and physical activity. Important findings are described below.

Eating Vegetables & Fruits

- African-Americans and Hispanics in several New England states eat vegetables less frequently than whites, but there are fewer differences with fruit consumption.
- People with disabilities in our region are much less likely to eat fruits and vegetables than non-disabled people.

Table 5. Percent Who Consume Vegetables at Least Once Per Day

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	80	65	81	78	72	80	77	79	74
Region	81	65	87	79	80	84	73	82	75
CT	80	62	87	62	85	80	73	80	72
ME	82	81	72	-	88	90	84	84	78
MA	81	67	87	81	77	85	72	82	74
NH	83	69	89	-	71	91	78	85	79
RI	80	69	84	94	69	66	77	80	75
VT	84	51	74	-	84	78	83	86	77

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Table 6. Percent Who Consume Fruit at Least Once Per Day

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	61	58	63	61	57	62	63	63	58
Region	68	60	67	75	66	62	59	68	63
CT	70	59	66	81	67	52	53	68	62
ME	66	77	39	--	51	72	77	67	62
MA	68	61	68	69	85	58	61	68	64
NH	66	72	75	--	41	77	64	69	58
RI	65	57	70	89	47	64	62	66	62
VT	67	56	51	--	72	61	78	69	61

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Exercise

- African-Americans, American Indian/Alaska Natives, and Hispanics in several states are exercising less frequently than whites. People with disabilities in our region are much less likely exercise than non-disabled people.
- However, as a region, the New England general population has already exceeded the HP 2020 Objective on increasing physical activity.

to

Table 7. Percent Reporting No Exercise in Last 30 Days

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	24	31	23	26	28	23	33	21	39
Region	22	29	26	11	31	25	38	19	36
CT	22	31	23	11	25	23	40	20	38
ME	23	41	33	-	25	19	17	19	34
MA	21	28	26	2	31	27	38	19	36
NH	22	23	23	-	38	22	30	17	38
RI	25	30	31	43	44	20	35	21	40
VT	20	28	26	-	38	31	16	16	32

Source: BRFSS, 2013

Healthy People 2020 Objective: Reduce the proportion of adults who engage in no physical activity

Target	US	Region	CT	ME	MA	NH	RI	VT
32.6%	27	24	25	23	24	22	27	20

Adult Risk Factors

Engaging in risky individual behaviors such as smoking or drinking excessively can contribute to poor health and an early death. According to McGinnis and colleagues,[9] individual behaviors account for 40% of early deaths! Unfortunately, many communities do not implement culturally competent awareness campaigns about the negative health effects of smoking and drinking. Tables 8 and 9 present information about smoking and alcohol consumption. Important findings are described below.

Tobacco

- In many states in our region, multiracial persons, Hispanics, African-Americans, Asians, and American Indian/Alaska Natives are more likely to be smokers than whites.
- Throughout the region, more people with disabilities smoke than people without disabilities.
- As a region, the New England general population has significantly higher smoking rates (37%) than the HP 2020 Objective (12%).

Table 8. Percent Who Are Current Smokers

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	40	54	44	55	57	52	44	40	46
Region	34	61	48	17	57	58	50	33	44
CT	31	58	30	9	64	56	51	33	40
ME	39	62	43	-	56	44	47	37	44
MA	35	64	54	26	56	62	47	34	46
NH	33	62	79	-	58	57	56	29	44
RI	35	54	34	39	60	57	56	24	44
VT	35	57	73	-	47	66	9	32	43

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Reduce the proportion of cigarette smokers among adults

Target	US	Region	CT	ME	MA	NH	RI	VT
12%	42	37	35	39	38	34	38	36

Alcohol

- The BRFSS survey results showed that binge drinking doesn't seem to be a problem for racial and ethnic minorities and people with disabilities in this region, and the New England population as a whole has already met the HP 2020 Objective.

Table 9. Percent Who Report Binge Drinking in Last 30 Days

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	17	12	13	19	16	20	18	18	13
Region	19	14	11	8	18	20	17	19	16
CT	20	12	6	3	18	29	16	19	14
ME	17	5	16	-	11	17	22	19	12
MA	20	14	13	10	35	19	19	20	18
NH	17	28	3	-	17	18	9	17	16
RI	19	13	9	14	12	26	17	19	14
VT	17	30	20	-	15	13	17	18	14

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Reduce the proportion of persons engaging in binge drinking

Target	US	Region	CT	ME	MA	NH	RI	VT
24.4%	17	18	18	17	19	17	18	17

Health Care Access

Over time, everyone will experience some type of health need, whether it is immunizations that are overdue or acute conditions that need immediate attention. Access to health services and care has long been viewed as a powerful determinant of health. Tables 10-12 present information about having health insurance, a primary care provider, and delaying care because of cost. Although it is too soon to tell, the adoption of the Affordable Care Act, the federal law that is intended to increase the affordability of health insurance, may reduce some of these problems. Important findings are described below.

Health Insurance

- African-Americans, Hispanics, and some multiracial persons in our region are less likely to have health insurance compared to whites, but there are no differences between people with and without disabilities.
- As a region, the New England general population is lagging behind the HP 2020 targets on having medical insurance, a primary care provider, and delays in needed medical care.

Table 10. Percent with Health Insurance

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	88	78	87	79	81	82	64	83	83
Region	93	87	94	79	87	86	75	91	90
CT	94	87	95	82	84	84	69	90	89
ME	88	64	90	-	85	82	86	87	89
MA	96	89	96	74	91	92	82	94	93
NH	88	77	84	-	87	60	62	88	85
RI	90	75	76	-	76	90	58	86	82
VT	91	67	78	-	85	88	83	91	90

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Increase the proportion of persons with medical insurance

Target	US	Region	CT	ME	MA	NH	RI	VT
100%	83	91	90	88	94	87	85	91

Primary Care Providers

- Racial and ethnic minorities are less likely to have a primary care physician compared to whites.
- More people with disabilities in the region have a primary care physician compared to people without disabilities.

Table 11. Percent Who Identify a Primary Care Provider

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	82	74	72	72	68	71	59	74	82
Region	90	82	75	81	72	78	71	86	89
CT	89	81	80	91	75	68	68	84	88
ME	88	67	80	-	72	76	89	86	92
MA	91	85	74	76	68	81	75	87	91
NH	88	76	87	-	75	75	75	87	89
RI	89	78	61	84	67	84	64	84	85
VT	87	76	64	-	84	87	81	86	90

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Increase the proportion of persons with a usual primary care provider

Target	US	Region	CT	ME	MA	NH	RI	VT
83.9%	76	87	85	87	88	87	84	87

Delaying Medical Care Due To Cost

- African-Americans, American Indian/Alaska Natives, Hispanics, and multiracial persons in several states are more likely to delay medical care due to cost.
- People with disabilities in every state in our region are much more likely to delay health care because of cost.
- As a region and within each state, we're falling significantly short of the HP 2020 objective of reducing the number of people who delay medical care due to cost.

Table 12. Percent Who Delay Needed Medical Care Due to Cost

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	12	21	12	18	23	20	26	12	25
Region	8	15	7	20	22	18	24	8	18
CT	9	19	6	10	19	26	25	9	21
ME	10	18	0	-	20	16	16	8	15
MA	7	10	7	17	16	14	21	6	16
NH	11	33	5	-	37	29	32	8	22
RI	11	15	18	26	28	13	32	10	23
VT	9	35	1	-	29	11	8	7	15

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care

Target	US	Region	CT	ME	MA	NH	RI	VT
4.2%	16	10	12	11	9	12	14	9

Preventive Health Services

Receiving clinical preventive services such as screenings and tests contribute to improved health outcomes, reduction of health disparities, and improvement in quality of life. Tables 13-14 have information about receiving an annual flu vaccine and HIV testing. Important findings are described below.

Flu Vaccine

- African-Americans, Hispanics, and multiracial persons in Connecticut; Hispanics in New Hampshire; and African-Americans and Hispanics in Rhode Island are less likely to receive an annual flu shot compared whites.
- People with disabilities in the region are more likely to receive an annual flu shot.
- As a region, the New England general population is failing to meet the HP 2020 Objective on annual flu shots by a large margin (70% target versus 39% actual).

Table 13. Percent Who Received Flu Vaccine in Last Year

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	42	32	40	41	39	34	30	36	44
Region	47	38	45	37	44	37	42	44	49
CT	44	32	33	18	30	22	32	40	42
ME	44	32	48	-	44	37	30	42	50
MA	50	43	50	33	53	43	52	48	54
NH	42	44	45	-	42	33	22	41	44
RI	48	30	43	75	30	41	34	44	48
VT	45	37	40	-	49	31	48	43	47

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Increase the percentage of adults who are vaccinated annually against seasonal influenza

Target	US	Region	CT	ME	MA	NH	RI	VT
70%	39	39	40	44	50	42	45	44

HIV Testing

- The New England adult population appears to be short of the HP 2020 HIV objective.
- Almost all racial and ethnic minorities are as likely or more likely to have ever had an HIV test compared to whites.
- People with disabilities in two states (New Hampshire and Vermont) are more likely to have ever had an HIV test compared to non-disabled persons.

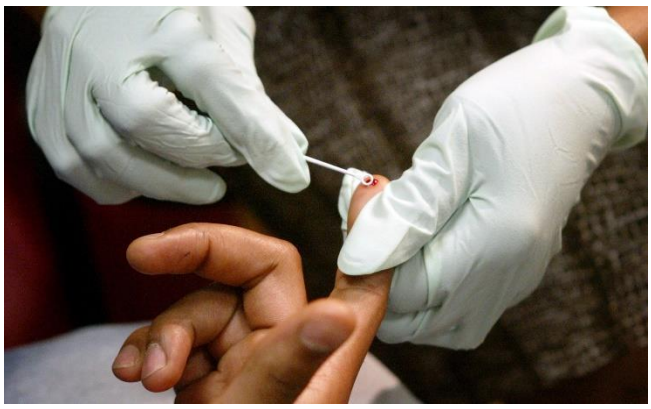


Table 14. Percent of Persons Ages 18 to 44 Who Have Ever Had HIV Test

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	46	73	34	45	54	58	51	48	58
Region	48	62	38	68	59	59	60	48	57
CT	47	70	37	23	30	61	63	51	62
ME	45	69	26	-	52	47	35	43	51
MA	50	55	40	87	72	64	60	50	56
NH	43	37	30	-	70	51	50	40	55
RI	46	72	27	58	100	54	55	47	58
VT	45	57	15	-	46	61	35	42	54

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

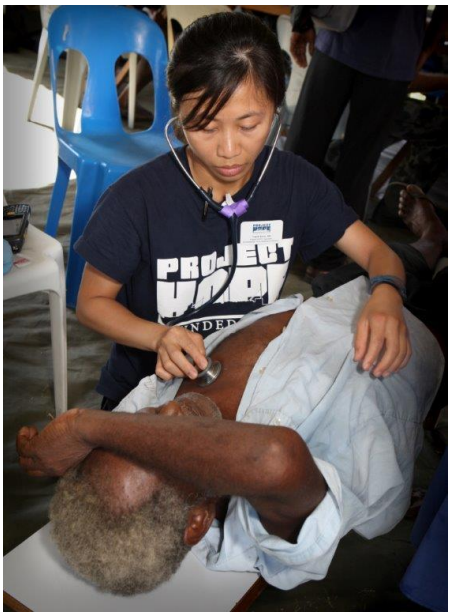
Healthy People 2020 Objective: Increase the proportion of adolescents and adults aged 15-44 who have been tested for HIV in the past year.**

Target	US	Region	CT	ME	MA	NH	RI	VT
76.3%	50	50	52	45	52	43	50	44

**Data shown are for population of adults aged 18 and over. Because of the difference in target population and population described in this report, statistical significance is not reported.

Selected Health Outcomes

Traditional health outcomes focus on physical health issues such as cardiovascular or other chronic diseases that might end your life early or if you experience chronic conditions during your life. Tables 15-24 focus on physical health issues such as chronic diseases and conditions. While physical health is critically important to a long life, good health also includes experiencing a quality of life and participating in society. Although quality of life is not measured directly in the BRFSS, it assesses other important areas like the number of healthy days you experience each month and whether you've been diagnosed with depression. Tables 25-29 focus on health status information. Important findings are described below.



Cardiovascular Diseases

- People with disabilities in New England experience much higher rates of coronary heart disease and strokes than people without disabilities.
- In most New England states, racial and ethnic minorities are doing well or slightly better than whites in rates of coronary heart disease, heart attacks, and strokes, with the exception of American Indian/Alaska Natives and multiracial persons in several states.

Table 15. Percent Ever Diagnosed With Coronary Heart Disease

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	5	4	2	2	4	4	3	2	10
Region	4	2	1	2	7	9	3	2	9
CT	4	3	1	0	4	1	3	2	9
ME	5	6	0	-	9	5	3	3	11
MA	4	2	1	3	7	14	3	2	8
NH	4	2	6	-	7	6	0	2	9
RI	4	2	2	0	6	1	2	2	9
VT	4	0	0	-	10	6	7	2	8

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Table 16. Percent Ever Diagnosed With Heart Attack

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	5	4	2	2	7	6	3	2	10
Region	4	3	2	1	10	8	3	2	9
CT	4	3	3	0	1	3	3	2	8
ME	5	5	0	-	13	10	1	3	11
MA	4	3	1	2	12	11	2	2	9
NH	4	0	6	-	15	2	0	2	9
RI	5	4	1	0	14	3	3	2	11
VT	4	0	0	-	7	7	2	2	10

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

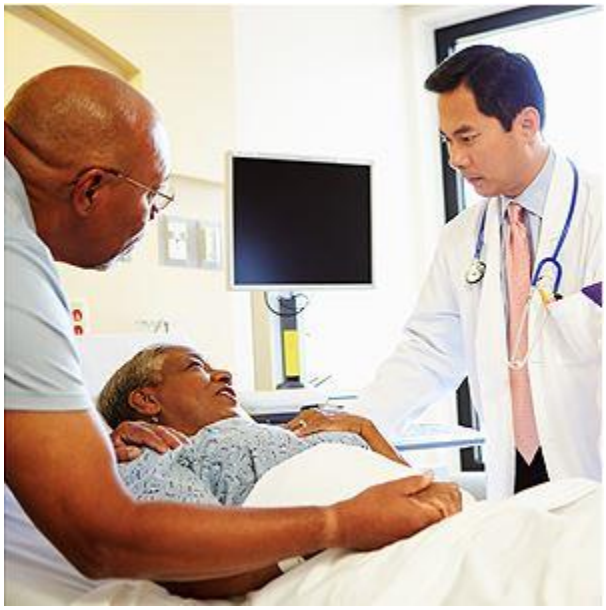


Table 17. Percent Ever Diagnosed With a Stroke

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	3	4	1	2	5	4	2	1	7
Region	2	2	1	1	13	7	2	1	6
CT	3	3	0	4	5	4	1	1	6
ME	2	0	0	-	7	5	3	1	6
MA	2	2	1	0	27	8	2	1	6
NH	2	0	1	-	3	4	2	1	5
RI	2	4	1	0	6	0	3	1	6
VT	3	2	0	-	8	8	1	1	7

Source: BRFSS, 2013

Kidney Disease

- People with disabilities in New England experience much higher rates of kidney disease than people without disabilities.
- Except for American Indians/Alaska Natives in Rhode Island, racial and ethnic minorities appear to be doing as well or better than whites in rates of kidney disease.

Table 18. Percent with Kidney Disease

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	3	3	2	3	2	3	3	1	6
Region	2	2	1	0	4	2	2	1	5
CT	3	2	0	2	2	0	2	1	5
ME	2	0	0	-	3	2	6	1	5
MA	2	2	1	0	3	2	2	1	5
NH	2	0	0	-	6	2	1	1	6
RI	1	4	0	0	10	1	3	1	5
VT	2	1	1	-	4	4	4	1	4

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Cancer

- People with disabilities in New England experience much higher rates of cancer than people without disabilities.
- Throughout the region, racial and ethnic minorities appear to be doing as well as or better than whites in cancer rates.

Table 19. Percent Ever Told By a Health Professional That They Have Cancer (Other than Skin)

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	8	5	2	2	6	6	3	5	11
Region	8	5	1	0	7	8	4	5	12
CT	9	6	2	0	1	5	4	5	13
ME	8	1	5	-	6	5	6	6	12
MA	8	5	1	0	9	10	3	5	11
NH	8	3	0	-	4	2	4	6	12
RI	8	8	0	0	10	6	2	6	11
VT	7	2	1	-	11	7	16	6	13

Source: BRFSS, 2013

Chronic Conditions

A chronic condition is a type of health problem that is long-lasting and persistent.[10] Chronic conditions such as heart disease, stroke, diabetes, and obesity are among the most common, costly, and preventable of all health problems.[11] Over time, chronic conditions can negatively impact a person's health and even impact how long they live! Important findings about chronic conditions are described below.

High Blood Pressure (Hypertension)

- Persons with disabilities in New England have much higher rates of high blood pressure than the non-disabled population.
- As a region, the New England general population has higher rates of hypertension (31%) than the HP 2020 Objective (26.9%).
- Racial and ethnic minorities in New England appear to be doing as well as or slightly better than whites in high blood pressure rates, except for African Americans and American Indian/Alaska Natives in Massachusetts.

Table 20. Percent Ever Told By a Health Professional They Have High Blood Pressure

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	34	42	22	24	34	32	25	26	50
Region	32	36	13	29	40	29	26	25	46
CT	33	36	15	55	16	25	26	25	49
ME	34	16	10	-	31	36	25	28	47
MA	30	37	12	21	56	32	26	24	44
NH	31	21	16	-	35	18	20	25	43
RI	36	36	10	33	49	23	23	28	47
VT	31	26	7	-	40	32	28	26	45

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Healthy People 2020 Objective: Reduce the proportion of adults with hypertension

Target	US	Region	CT	ME	MA	NH	RI	VT
26.9%	33	31	31	33	29	30	34	31

Asthma

- Hispanics in Maine and multiracial persons in Massachusetts have high rates of asthma.
- Persons with disabilities in New England have much higher rates of asthma than the non-disabled population.

Table 21. Percent who Currently Have Asthma

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	9	11	4	10	14	15	7	6	16
Region	11	10	8	8	14	21	12	8	19
CT	10	9	8	10	15	14	10	7	18
ME	12	13	29	-	9	15	25	9	20
MA	12	10	7	6	10	25	13	9	19
NH	11	18	2	-	20	18	11	8	20
RI	12	13	10	17	26	27	9	8	21
VT	11	4	1	-	15	21	10	8	19

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Chronic Obstructive Pulmonary Disease (COPD)

- COPD is a significant problem for American Indian/Alaska Natives in Rhode Island and Vermont and for multiracial persons in Massachusetts, Rhode Island, and Vermont.
- Persons with disabilities in New England have much higher rates of high blood pressure, asthma, COPD, diabetes, and obesity than the non-disabled population.

Table 22. Percent with Chronic Obstructive Pulmonary Disease (COPD)

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	7	7	2	6	11	10	4	3	15
Region	7	5	1	2	11	14	4	3	15
CT	7	5	1	0	7	8	4	3	15
ME	7	7	2	-	7	12	5	3	18
MA	6	4	0	0	9	15	4	3	13
NH	7	1	2	-	14	10	3	3	19
RI	7	7	0	0	27	22	6	3	17
VT	6	2	1	-	15	14	4	3	13

Source: BRFSS, 2013

Diabetes

- Diabetes is a significant problem for African Americans in three states (Connecticut, Massachusetts, and Rhode Island) and American Indian/Alaska Natives in three states (Maine, New Hampshire, and Rhode Island).
- Persons with disabilities in New England have much higher rates of diabetes than the non-disabled population.

Table 23. Percent with Diabetes (Not Including Gestational)

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	9	14	8	11	11	11	10	6	20
Region	8	13	7	7	16	9	9	6	17
CT	8	14	6	7	5	9	8	6	16
ME	10	1	3	-	21	10	2	6	18
MA	8	13	7	2	18	8	10	6	17
NH	9	5	5	-	21	5	5	6	17
RI	9	15	4	28	22	14	9	6	17
VT	8	23	1	-	13	12	8	5	15

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Obesity

- Obesity is a significant issue in two states for African Americans and Hispanics (Connecticut and Massachusetts) and for American Indians/Native Alaskans in Maine compared to whites.
- Persons with disabilities in New England have much higher rates of obesity than the non-disabled population.
- As a region, the New England general population has lower rates of obesity (25%) than the HP 2020 Objective (30.5%).

Table 24. Percent Who Are Obese (Body Mass Index > 30)

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	27	38	10	31	25	32	31	24	39
Region	25	33	10	8	36	27	32	21	36
CT	23	33	9	24	43	33	33	21	36
ME	29	27	9	-	45	26	27	24	40
MA	23	34	10	3	36	28	32	20	35
NH	27	28	10	-	20	18	25	23	37
RI	27	36	12	29	22	24	31	24	36
VT	25	54	10	-	40	31	24	21	36

Source: BRFSS, 2013

Healthy People 2020 Objective: Reduce the proportion of adults aged 20 and older who are obese

Target	US	Region	CT	ME	MA	NH	RI	VT
30.5%	28	25	25	29	24	27	27	25

Health Status and Quality of Life

Self-rated health questions have been shown to be powerful predictors of the use of physician services, how well you are, and even how long you'll live.[12] Tables 25-29 focus on physical and mental health, depression, and overall health. Important findings about health status are described below.

Physical and Mental Health

- African Americans in Maine, Native Hawaiians/Pacific Islanders in Rhode Island, and Hispanics in Massachusetts report more physically unhealthy days than whites.
- African Americans in Connecticut and Hispanics in Connecticut and Massachusetts report more mentally unhealthy days than whites.
- Only American Indians/Alaska Natives in New Hampshire and Rhode Island report more days when their physical or mental health has limited their activities compared to whites.
- People with disabilities in New England are much more likely to report poor physical health, poor mental health, and limitations in activities due to poor health.

Table 25. Average Days with Poor Physical Health in Last 30 Days

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	11	11	8	10	13	12	11	7	17
Region	10	12	7	7	14	13	12	6	15
CT	9	13	10	8	11	11	12	6	15
ME	11	13	11	-	12	11	9	6	16
MA	9	11	6	5	12	14	13	6	14
NH	10	11	14	-	20	13	12	6	15
RI	10	11	9	13	18	12	10	6	15
VT	10	13	11	-	17	14	5	5	15

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Table 26. Average Days with Poor Mental Health in Last 30 Days

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	11	13	8	11	14	13	11	9	17
Region	10	12	7	11	12	12	12	8	15
CT	9	12	4	19	4	11	12	7	14
ME	11	11	9	-	15	14	17	8	15
MA	10	13	8	10	10	13	12	8	15
NH	11	10	5	-	19	9	13	7	16
RI	10	11	13	6	17	13	11	7	15
VT	9	15	12	-	14	7	11	7	14

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Table 27. Average Days (in Last 30 Days) Poor Physical or Mental Health Interfered with Ability to Perform Usual Activities

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	11	13	8	11	14	13	11	6	16
Region	11	12	8	4	18	11	12	5	15
CT	11	13	7	-	17	9	13	6	15
ME	12	14	6	-	8	14	11	5	16
MA	10	11	8	3	20	11	12	5	15
NH	11	15	15	-	22	11	14	5	15
RI	12	10	11	-	25	12	11	5	15
VT	11	11	6	-	15	9	10	5	15

Source: BRFSS, 2013

Depression

- In most New England states (Connecticut, Massachusetts, New Hampshire, and Vermont), Asians are much less likely to have been told they have depression; but the rates for American Indians/Alaska Natives in Maine, multiracial persons in Massachusetts and New Hampshire, and Hispanics in Massachusetts are much higher than whites.
- People with disabilities in New England are much more likely to have been told they have depression compared to the non-disabled population.

Table 28. Percent Ever Told By a Health Professional That They Have a Depressive Disorder

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	20	15	7	12	24	27	15	10	37
Region	20	17	7	5	24	34	23	12	42
CT	18	16	6	7	14	25	19	11	37
ME	23	17	27	-	37	36	33	14	45
MA	20	18	6	2	17	31	25	11	43
NH	22	14	0	-	28	57	28	14	43
RI	22	20	13	29	39	28	21	13	43
VT	23	15	6	-	35	35	20	16	43

Source: BRFSS, 2013

Statistical significance compared to the *referent group:

No difference	Better	Worse

Overall Health Status

- African Americans, American Indian/Alaska Natives, multiracial persons, and Hispanics in a number of states are more likely to rate their health as “fair or poor” compared to whites.
- Asians in several states are less likely to rate their health as “fair or poor” compared to whites.
- People with disabilities in New England are much more likely to say that their health is “fair or poor” compared to the non-disabled population.

Table 29. Percent Who Self-Rated Health “Fair” or “Poor”

	White*	Black/AA	Asian	NH/PI	AI/AN	Multi	Hispanic	No Disability*	Disability
US	16	23	10	19	25	22	26	8	43
Region	12	17	6	4	27	22	27	5	38
CT	11	17	4	10	9	18	23	5	37
ME	15	6	3	-	20	16	16	5	39
MA	12	17	6	2	37	24	30	5	37
NH	12	11	7	-	30	21	18	4	36
RI	14	17	12	8	32	18	31	5	41
VT	12	2	3	-	27	31	6	3	36

Source: BRFSS, 2013

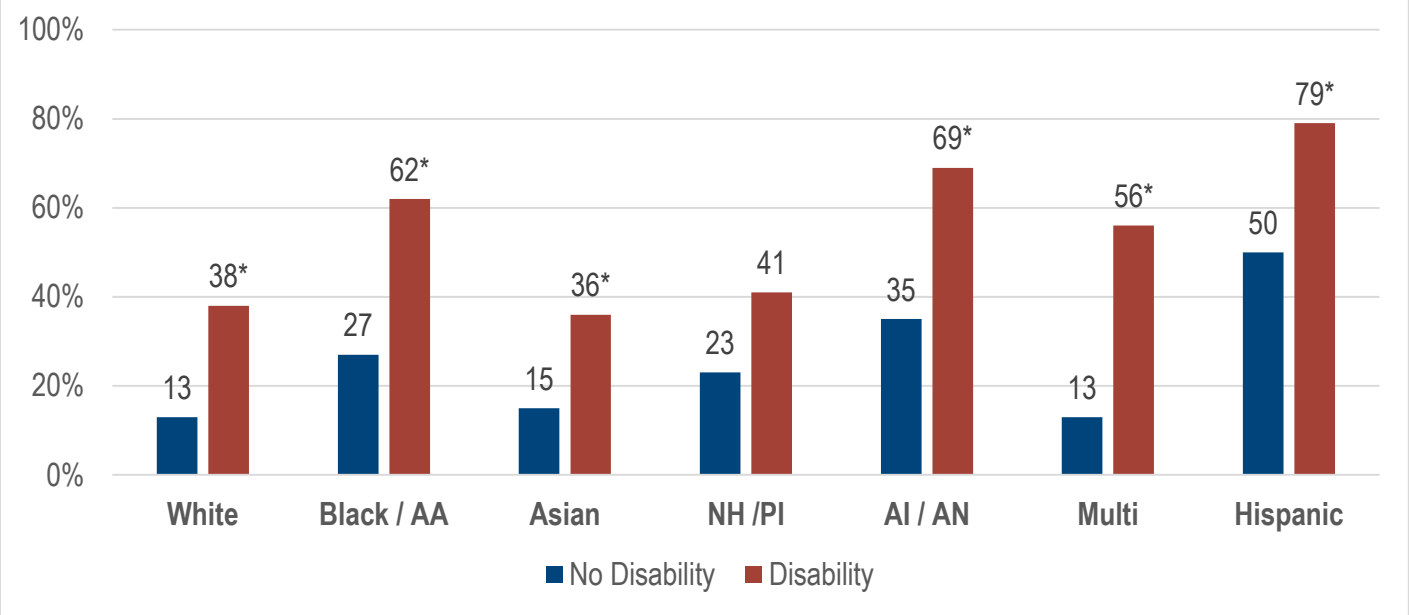
The Intersection of Race, Ethnicity, and Disability

While the analysis in the previous sections treated people with disabilities as a separate group and made comparisons to the non-disabled population, disability can be found in all of the race/ethnic categories. Previous research has shown that racial and ethnic minorities who also have disabilities experience a significant increase in health disparities as a result of minority status and disability.[13] For this reason, we compared racial and ethnic groups with and without disabilities on several determinants of health (income, delayed care, and health status) in this report. Because some of the state level race/ethnicity and disability data was small, we combined the data to provide a regional profile of race/ethnicity and disability. Important findings are described below.

Income

- In comparison to households without persons with disabilities, many racial and ethnic minority groups with disabilities in New England are more likely to live in households with an annual income that is less than $25,000.
- Statistically significant differences in income are experienced by blacks, Asians, American Indian/Alaska Natives, and Hispanics with disabilities in New England compared to households without persons with disabilities.
- The three largest income gaps between people with no disabilities and those with disabilities are for multiracial persons (43%), blacks (35%), and American Indians/Alaska Natives with disabilities (34%).

Figure 2. Percent of Region I Households with Income Less Than $25,000



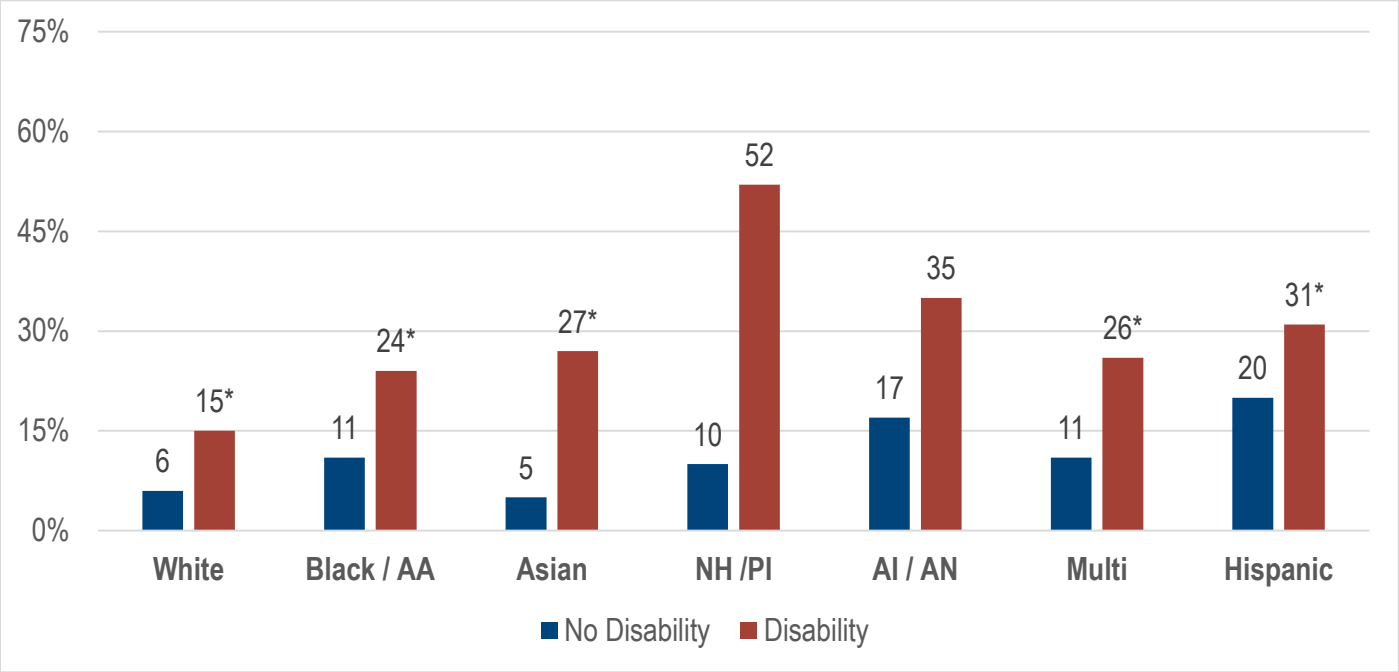
Source: BRFSS, 2013

*Statistical significance compared to the referent group (no disability)

Delaying Medical Care Due To Cost

- Many racial and ethnic minority groups with disabilities in New England delay needed medical care because of cost.
- Statistically significant differences occur for blacks, Asians, multiracial, and Hispanics with disabilities in New England compared to minorities without disabilities.
- These differences are largest for Asians (22%), multiracial persons (15%), and blacks (13%) with disabilities.

Figure 3. Percent of Persons in Region I Who Delay Needed Medical Care Due to Cost



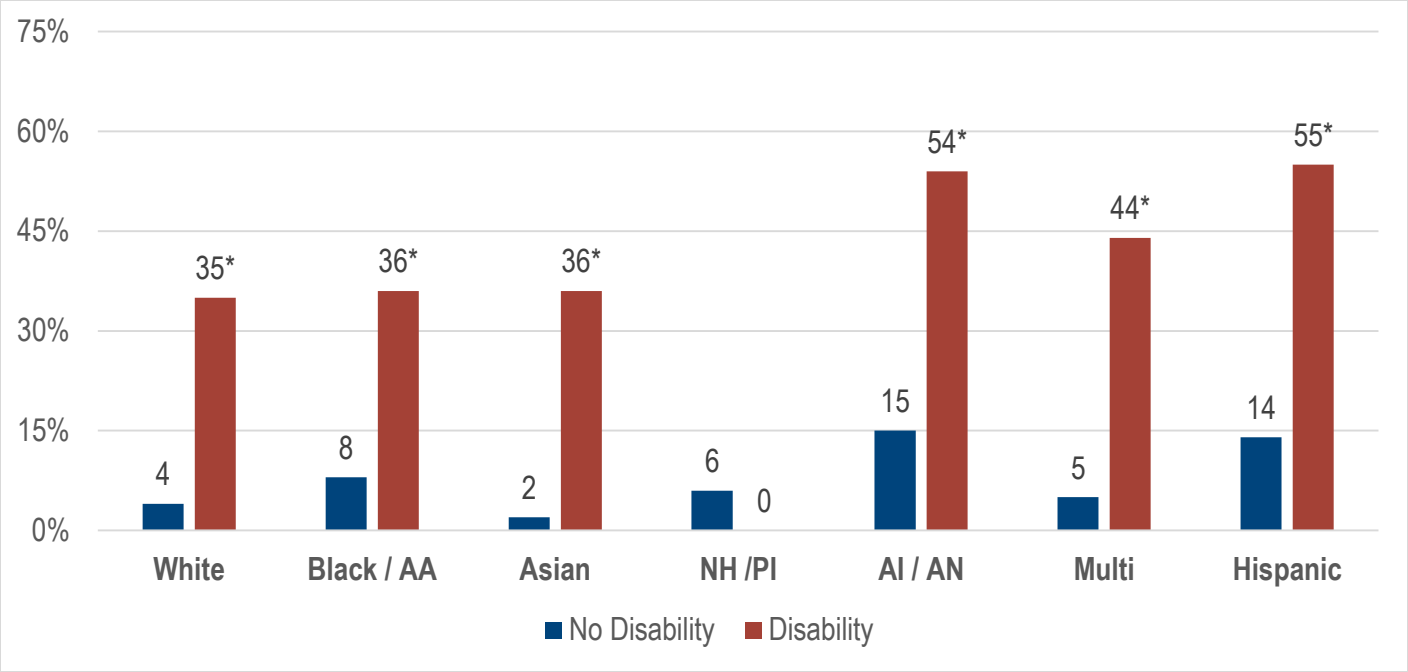
Source: BRFSS, 2013

*Statistical significance compared to the referent group (no disability)

Overall Health Status

- Many racial and ethnic minority groups with disabilities in New England report that their health is fair or poor.
- Statistically significant differences occur for blacks, Asians, American Indian/Alaskan Native, multiracial, and Hispanics with disabilities in New England compared to minorities without disabilities.
- These differences are largest for Hispanics (41%), American Indian/Alaskan Native (41%) and multiracial persons (39%) with disabilities.

Figure 4. Percent of Persons With and Without Disabilities in Region I Whose Self-Reported Health is "Fair" or "Poor"



Source: BRFSS, 2013

*Statistical significance compared to the referent group (no disability)

State Health Equity Activities

Many states are already taking steps to address health disparities affecting racial and ethnic minorities and people with disabilities! Table 30 identifies the states engaged in activities that contribute to achieving the goals of the National Partnership for Action to End Health Disparities (NPA). Examples of these important activities are provided below.

Table 30: States Addressing NPA Health Disparity Goals

NPA Goals	CT[14,15]	ME[16]	MA[17]	NH[18,19]	RI[20,21]	VT[22,23]	Total
Goal 1: Awareness — Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.	✓	✓	✓	✓	✓	✓	6
Goal 2: Leadership — Strengthen and broaden leadership for addressing health disparities at all levels.	✓		✓	✓		✓	4
Goal 3: Health System and Life Experience — Improve health and healthcare outcomes for racial, ethnic, and underserved populations.	✓		✓	✓	✓	✓	5
Goal 4: Cultural and Linguistic Competency — Improve cultural and linguistic competency and the diversity of the health related workforce.	✓	✓	✓	✓		✓	5
Goal 5: Data, Research, and Evaluation — Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.	✓	✓	✓	✓	✓	✓	6

Goal 1: Awareness

All six states in Region I are conducting activities related to NPA Goal 1. Examples include:

- The Massachusetts Department of Public Health is currently piloting a series of racial equity trainings within one of its bureaus. It plans to bring this experience to scale for other bureaus and programs.
- The New Hampshire Health & Equity Partnership's Awareness & Promotion Committee collaborates on activities to increase the knowledge and engagement of others in addressing health disparities and promoting equity.

Goal 2: Leadership

Three states in Region I are engaging in activities related to NPA Goal 2. Examples include:

- Through the Connecticut Multicultural Health Partnership, the Department of Public Health (DPH) widens the circle of involvement and leadership to diverse sectors of the state through this group's on-going meetings, projects, and special conferences, which most recently featured Dr. Adewale Troutman, a Professor and Associate Dean for Health Equity and Community Engagement at the University of San Francisco and international expert in Health Equity and Social Justice. DPH has also infused its organization with Leadership training opportunities for staff at all levels. This Leadership Development Program was facilitated by Leadership Greater Hartford and included a diverse staff representation in a series of trainings. A State Health Assessment and the subsequent Improvement Plan meetings, with a diverse group of stakeholders throughout the state, focused on one of six overarching goals: To Champion Health Equity in the State. This was in line with the department's Health Equity Policy Statement signed by the DPH Commissioner in 2012. Connecticut hospitals are working on goals to increase diversity on governance boards and senior management, improve cultural competence and linguistically appropriate services, and increase opportunities to contract with diverse suppliers.
- The Massachusetts Department of Public Health has identified a "firm commitment to eliminate health disparities" as a priority of its new vision. Health equity is listed in its mission statement. Data, disparities and determinants of health are identified as the core drivers to achieve that mission. The Commissioner also announced plans to start an Office of Population Health to look specifically at health disparities across all DPH services.
- The priorities of Vermont's Eliminating Health Disparities Statewide Initiative include building the organizational structure, capacity, and enhancing community development and leadership around health disparities.

Goal 3: Health System and Life Experience

Five states in Region I are addressing Goal 3 of the NPA. Examples include:

- The Massachusetts Department of Health Office of Health Equity is implementing an Oral Health Equity Project funded by OMH. Over the next five years, the Office of Health Equity expects to increase the number of children up to age 14 who visit the dentist/dental hygienist each year by 10% over baseline. The focus is on two low-income, racial and ethnic minority communities considered hotspots for oral health disparities.
- In Rhode Island, the Minority Health Promotion Program focuses on health system enhancements and provides funding to community-based organizations addressing the Department of Health's priorities of reducing disparities.

Goal 4: Cultural and Linguistic Competency

Four states in Region I are conducting activities regarding cultural and linguistic competency. Examples include:

- In Massachusetts, the Determination of Need Program aims to enhance the quality and availability of hospital interpreter services.
- The CLAS Initiative at the Massachusetts Department of Health conducts in-person trainings for staff and contracted vendors that address what CLAS is, what is expected of health providers and how DPH monitors and supports their efforts. A web-based training for DPH staff is being developed to extend the reach of this effort.
- Connecticut, as part of its licensing requirements for many health professionals, requires training in cultural competency. Originally just applicable to physicians, the State Legislature has favorably voted on expanding the list of providers included in this required training. Connecticut has been active in promoting the CLAS Standards and continues these efforts, which have included providing translation of information on the DPH web pages to the public in 80 languages. The Office of Health Equity has also had many program materials translated into different languages, as requested by the DPH program staff who know the varied populations they serve. A CLAS Coordinator was appointed by the Commissioner to offer instruction on the CLAS Standards to numerous internal staff members as well as external partners. DPH vendor contracts include language requiring compliance with cultural and linguistic federal guidelines.

Goal 5: Data, Research, and Evaluation

All six states in Region I are conducting activities related to Goal 5 of the NPA. Examples include:

- An objective of the Connecticut Department of Public Health's Strategic Plan (2013-2018) is to assess the impact of programs in addressing disparities within the state and adjust services as needed.
- As data collection is a priority area for Maine's Office of Health Equity, the Office is aiming to enhance data systems and improve the collection of racial and ethnic data in order to better understand and identify existing health disparities.
- The CLAS Initiative at Massachusetts Department of Health integrated the CLAS Self-Assessment into an electronic Procurement Tracking System within the department to identify CLAS priorities and goals established by MDPH contracted vendors. MDPH Contract Monitors overseeing direct service contracts have been trained to provide support to their vendors in how to use the standards as a framework for quality improvement.
- The Massachusetts Department of Health has an electronic CLAS Internal Assessment, which has been piloted within the department as part of a performance management quality improvement strategy. It is expected to be launched department-wide in the spring of 2016. This tool will allow Bureaus and programs within MDPH to monitor and report on their efforts to meet the CLAS Standards. Findings from these self-assessments will be compiled to produce reports on DPH-wide findings, as well as recommendations and strategies for improvement.

State Disability and Health Programs

The Centers for Disease Control and Prevention's (CDC) state-based disability and health programs inform policy and practice at the state level. These programs ensure that individuals with disabilities are included in ongoing state disease prevention, health promotion, and emergency response activities. The CDC

supports 18 state-based programs to promote equity in health, prevent chronic disease, and increase the quality of life for people with disabilities. Each program customizes its activities to meet its state's needs, which broadens expertise and information sharing among states. CDC-funded disability and health programs in New England are found in New Hampshire, Massachusetts, and Rhode Island.

Summary of Key Findings

Awareness of both state and regional health equity issues, including changing regional population dynamics, socioeconomic status, diet and exercise, risk factors, health care access and services, and health outcomes, are key to a broader, collective approach to addressing health equity.

- As a region, we must be aware that New England is becoming increasingly diverse, with significant increases in racial, ethnic, and disability populations, and that the population lives in both urban and rural settings.
- Efforts to address health equity in our region need to recognize the significant challenges that racial and ethnic minorities and people with disabilities face in socioeconomic status.
- Access to a healthy diet and opportunities for physical activity are challenging for many racial and ethnic groups and people with disabilities in New England.
- High smoking rates occur among people with disabilities and many racial and ethnic groups in New England.
- Lack of health insurance and a primary care physician as well as delaying medical care negatively impacts the health of many racial and ethnic minorities and people with disabilities in New England.
- One of the most basic of preventive health services – receiving flu shots – is a problem in the region for racial and ethnic minorities.
- Negative health outcomes such as coronary heart disease, stroke, cancer, and chronic conditions are a significant problem for many people with disabilities and racial and ethnic minority populations in New England.

A Regional Call to Action

Collectively, the New England region needs to commit to the following:

- Working together to address the health equity of racial and ethnic minorities and persons with disabilities. These activities should reflect our changing population dynamics and recognize that education, employment, and income are significant determinants of health.
- Sharing and adopting strategies that are already effective in improving health equity across New England.
- Prioritizing the implementation of the Affordable Care Act in order to address health equity, including access to preventive health services.
- Ensuring that region wide, health equity efforts include the under-served and vulnerable population of racial and ethnic minorities with disabilities.
- More fundamentally, we need to adopt the principle that ill health does not have to be part of the life experience for racial and ethnic groups and people with disabilities.

As the Jakarta Declaration on Leading Health Promotion into the 21st Century[24] argued, ''health promotion is carried out by and with people, not on or to people.'' Similarly, the New England region needs the involvement of people and diverse communities to address health disparities and increase health equity for all. The Region I Health Equity Council calls upon New England to develop specific and measureable action items to address the issues identified in this report. While there may be challenges in addressing this mandate, the difficulty should not turn us from where we need to go. In the words of Martin Luther King, "The time is always right for doing what's right."

Glossary of Terms

Alternative formats – materials provided in Braille, large print text, audio recordings, etc., in order to ensure effective communication for persons who may have difficulty reading the text.[26]

American Indian or Alaska Native – people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.[27]

Asian – people having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.[28]

Avoidable inequalities – differences in health status or in the distribution of health determinants between different population groups.[29]

Behavioral Risk Factor Surveillance System (BRFSS) - an annual telephone survey with more than 500,000 interviews conducted in every state and territory in the U.S with a core set of demographic and health-related questions that are asked every year, in addition to a number of optional questions.

Black or African American – people having origins in any of the Black racial groups of Africa which includes people who identify as "Black, African American, or Negro" or as having origins in Sub-Saharan Africa such as Kenyan and Nigerian; and Afro-Caribbean such as Haitian and Jamaican.[30]

Binge drinking – A pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 grams percent or above. This typically happens when men consume 5 or more drinks, and when women consume 4 or more drinks, in about 2 hours.[31]

Cardiovascular diseases – conditions of the heart that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina), or stroke.[32]

Chronic diseases – a long-lasting condition that can be controlled but not cured; the leading cause of death and disability in the United States.[33]

Chronic obstructive pulmonary disease (COPD) – a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.[34]

Clinical preventive services – recommendations by the U.S. Preventive Services Task Force on the use of screening, counseling, and other preventive services that are typically delivered in primary care settings.[35]

Community – a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.[36]

Culture – the blended patterns of human behavior that include "language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."[37]

Cultural competency – "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."[37]

Delay of medical care – a delay or foregoing of necessary treatment due to cost and medical cost burden, such as out-of-pocket expenses exceeding some threshold and rates of medical debt and medical bankruptcy.[38]

Health - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1]

Health care access – the timely use of personal health services to achieve the best health outcomes.[39]

Health disparities – when the social determinants of health cause clinically or statistically significant differences between groups of people.[4]

Health equity - the attainment of the highest level of health for all people.[25]

Health insurers – those who are required to pay some or all of your health care costs in exchange for a premium.[40]

Health outcomes – a change in a patient's current and future health status that can be attributed to antecedent health care.[41]

Healthy People Reports – A comprehensive set of 10-year national health goals and objectives established by public health experts covering 42 topic areas with over 1,200 objectives.

Hearing impairment – a hearing loss that prevents a person from totally receiving sounds through the ear.[42]

Hispanic – a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[43]

Hypertension – also referred to as high blood pressure, is a common condition in which the long-term force of the blood against the artery walls is high enough that it may eventually cause health problems such as heart disease.[44]

Quality of life – a broad multidimensional concept that usually includes subjective evaluations of both positive and negative aspects of life.[45]

Immunizations – a process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination or inoculation.[46]

Multiple Races – people who belong to two or more of the federally designated racial categories.[47]

Native Hawaiian or Pacific Islander – people having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.[48]

New England Region – a region located in the northeast corner of the USA made up of six diverse U.S. states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.[49]

Obesity – weight that is higher than what is considered as a healthy weight for a given height. A Body Mass Index (BMI) of 30.0 or higher is considered obese.[50]

Public-private – medium to long-term arrangements between the public and private sectors whereby some of the service obligations of the public sector are provided by the private sector, with clear agreement on shared objectives for delivery of public infrastructure and/or public services.[51]

Racial and ethnic – categories developed in 1997 by the Office of Management and Budget that are used to describe groups to which individuals belong, identify with, or belong in the eyes of the community.[52]

Risky behaviors – those that potentially expose people to harm or significant risk of harm, which will prevent them from reaching their potential.[53]

Rural – all population, housing, and territory not included within an urban area.[54]

Self-rated health questions – measures an individual's perception of his or her overall health.[55]

Self-report – a study in which respondents report their own behavior.[56]

Socio-Economic status – the social standing or class of an individual or group that is often measured as a combination of education, income, and occupation.[57]

Stakeholders – persons or groups that have a vested interest in a clinical decision and the evidence that supports that decision; they may be patients, caregivers, clinicians, researchers, advocacy groups, professional societies, businesses, policymakers, or others.[58]

Stata/STATA – a general-purpose statistical analysis package created and maintained by StateCorp LP. Its capabilities include a broad range of statistical analyses plus data management, graphics, simulations, and custom programming.[59]

Statistically significant – mathematical technique to measure whether the results of a study are likely to be true and calculated as the probability that an effect observed in a research study is occurring because of chance.[60]

Social determinants of health – the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[61]

Unsafe environment – all that is external to an individual that may create unsafe conditions or foster disease.[62]

Urban – an identified territory encompassing at least 2,500 people, at least 1,500 of which reside outside institutional group quarters.[63]

White (race) – people having origins in any of the original peoples of Europe, the Middle East, or North Africa.[64]

World Health Organization (WHO) – part of the United Nations system designated to "direct and coordinate" international public health efforts.[65]

References

[1] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. Retrieved June 2015 from http://www.who.int/about/definition/en/print.html

[2] Ansari et al, 2003 Ansari, Z., Carson, N. J., Ackland, M. J., Vaughan, L., & Serraglio, A. (2003). A public health model of the social determinants of health. *Sozial-und Präventivmedizin*, *48*(4), 242-251.

[3] Drum, C. E., Krahn, G. L., Peterson, J. J., Horner-Johnson, W., & Newton, K. (2009). Health of people with disabilities: determinants and disparities. In Drum, C.E, Krahn, G.L., & Bersani, H. (eds.), *Disability and Public Health,* Washington, American Public Health Association, 2009, 125-144.

[4] Kilbourne, A. M., Switzer, G., Hyman, K., Crowley-Matoka, M., & Fine, M. J. (2006). Advancing health disparities research within the health care system: a conceptual framework. *American Journal of Public Health*, *96*(12), 2113.

[5] US Department of Health and Human Services, & Office of Disease Prevention and Health Promotion. (2012). *Healthy People 2020.* Washington, DC.

[6] Office of the Surgeon General (2005).The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities. Office of the Surgeon General, Rockville (MD).

[7] Centers for Disease Control and Prevention (CDC). (2014, February 5). Retrieved June 2015 from http://www.cdc.gov/minorityhealth/populations/REMP/definitions.html

[8] Asian Americans Advancing Justice (2013). A community of contrasts: Asian Americans, Native Hawaiians and Pacific Islanders. Washington, DC.

[9] McGinnis, J. M., Williams-Russo, P., and Knickman, J. R. The case for more active policy attention to health promotion. Health Affairs 21: 78-93 (2002).

[10] World Health Organization (WHO). (2014, February 5). Retrieved June 2015, from http://www.cdc.gov/minorityhealth/populations/REMP/definitions.html

[11] Centers for Disease Control and Prevention (CDC). (2014, February 5). Retrieved June 2015 from http://www.cdc.gov/chronicdisease/overview/index.htm

[12] Drum, C. E., Horner-Johnson, W., & Krahn, G. L. (2008). Self-rated health and healthy days: examining the "disability paradox". *Disability and Health Journal*, *1*(2), 71-78.

[13] Drum, C., McClain, M. R., Horner-Johnson, W., & Taitano, G. (2011). Health disparities chart book on disability and racial and ethnic status in the United States. Institute on Disability, University of New Hampshire.

[14] Connecticut Department of Public Health. (February 1, 2013). Retrieved June 2015, from http://www.ct.gov/dph/lib/dph/admin/org/ctdph_strategic_plan.pdf

[15] Connecticut Department of Public Health: Health Education Management & Surveillance. (N.D.). Retrieved June 2015, from http://www.ct.gov/dph/cwp/view.asp?a=3137&pm=1&Q=552788

[16] Maine Office of Health Equity. (N.D.). Retrieved June 2015, from http://www.maine.gov/dhhs/mecdc/health-equity/services.shtml

[17] Massachusetts Health Equity. (N.D.). Retrieved June 2015, from http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/

[18] New Hampshire Health & Equity Partnership (March 2011). Retrieved June 2015, from http://www.dhhs.state.nh.us/omh/documents/disparities.pdf

[19] NH Health & Equity Partnership. (N.D.). Retrieved June 2015, from http://www.equitynh.org

[20] Rhode Island Department of Health (January 2014). Retrieved June 2015, from http://www.health.ri.gov/publications/healthassessments/RI2014.pdf

[21]Minority Health, Rhode Island Office of. (N.D.). Retrieved June 2015, from http://www.health.ri.gov/programs/minorityhealth/

[22] Vermont Public Health National Association of State Offices of Minority Health. (N.D.). Retrieved June 2015, from http://www.nasomh.org/page.asp?id=1&detail=6698

[23] Vermont Public Health (January 2013). Retrieved June 2015, from http://healthvermont.gov/hv2020/documents/ship_full.pdf

[24] World Health Organization. Jakarta Declaration on Leading Health Promotion into the 21st Century. Geneva, Switzerland: World Health Organization; 1997.

[25] US Department of Health and Human Services, & Office of Disease Prevention and Health Promotion. (2012). *Healthy People 2020.* Washington, DC.

[26]U.S. Department of Justice: Civil Rights Division. (2007). *Tool kit: Chapter 3, general effective communication requirements under title II of the ADA* No. 3) U.S. Department of Justice.

[27]Centers for Disease Control and Prevention. (2015). *American-Indian and Alaska native populations.* Retrieved 09/09, 2015, from http://www.cdc.gov.libproxy.unh.edu/minorityhealth/populations/REMP/aian.html

[28]Centers for Disease Control and Prevention. (2013). *Asian American populations.* Retrieved 09/09, 2015, from http://www.cdc.gov.libproxy.unh.edu/minorityhealth/populations/REMP/asian.html

[29]World Health Organization. (2015). *Health impact assessment (HIA): Glossary of terms used.* Retrieved 09/09, 2015, from http://www.who.int.libproxy.unh.edu/hia/about/glos/en/index1.html

[30]Centers for Disease Control and Prevention. (2015). *Black or African American populations.* Retrieved 09/09, 2015, from http://www.cdc.gov.libproxy.unh.edu/minorityhealth/populations/REMP/black.html

[31]National Institute on Alcohol Abuse and Alcoholism. (N.D.). *Drinking levels defined.* Retrieved 09/09, 2015, from http://www.niaaa.nih.gov.libproxy.unh.edu/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

[32]Mayo Clinic. (2014). *Heart disease: Definition.* Retrieved 09/09, 2015, from http://www.mayoclinic.org/diseases-conditions/heart-disease/basics/definition/con-20034056

[33]University of Michigan Center for Managing Chronic Disease. (2011). *What is Chronic Disease?* Retrieved 09/09, 2015, from http://cmcd.sph.umich.edu.libproxy.unh.edu/what-is-chronic-disease.html

[34]World Health Organization. (2015). *Chronic Respiratory Diseases: COPD: Definition.* Retrieved 09/09, 2015, from http://www.who.int.libproxy.unh.edu/respiratory/copd/definition/en/

[35]The Community Guide. (2015). *Guide to clinical preventive services.* Retrieved 09/09, 2015, from http://www.thecommunityguide.org/about/guide.html

[36]MacQueen, K., McLellan, E., Metzger, D., Kegeles, S., Strauss, R., Scotti, R., et al. (2001). What is Community? An Evidence-Based Definition for Participatory Public Health. *American Journal of Public Health, 91*(12), 1929--1938. doi:10.2105/AJPH.91.12.1929

[37]Centers for Disease Control and Prevention. (2014). *Social determinants of health.* Retrieved 09/09, 2015, from http://www.cdc.gov.libproxy.unh.edu/nchhstp/socialdeterminants/definitions.html

[38]Paradise, J., & Garfield, R. (2013). What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence (Issue Brief No. 8467). Menlo Park, CA: The Henry J. Kaiser Family Foundation.

[39]HealthyPeople. (2014). *2020 topics & objectives: Access to health services.* Retrieved 09/09, 2015, from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

[40]U.S. Centers for Medicare and Medicaid Services. (N.D.). *Glossary: Health insurance.* Retrieved 09/09, 2015, from https://www.healthcare.gov/glossary/health-insurance/

[41]Jee, M. and Z. Or (1999), "Health Outcomes in OECD Countries: A Framework of Health Indicators for Outcome- Oriented Policymaking", *OECD Labour Market and Social Policy Occasional Papers*, No. 36, OECD Publishing. http://dx.doi.org/10.1787/513803511413

[42]Kentucky's Office for the American's with Disabilities Act. *Hearing impairments.* Retrieved 09/14, 2015, from http://ada.ky.gov/hearing_imp_def.htm

[43]Centers for Disease Control and Prevention. (2015). *Hispanic and Latino populations.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/minorityhealth/populations/REMP/hispanic.html

[44]Mayo Clinic. (2015). *High blood pressure (hypertension).* Retrieved 09/14, 2015, from http://www.mayoclinic.org/diseases-conditions/high-blood-pressure/basics/definition/con-20019580

[45]Centers for Disease Control and Prevention. (2011). *Health-related quality of life (HRQOL).* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/hrqol/concept.htm

[46]Centers for Disease Control and Prevention. (2014). *Vaccines and immunizations.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/vaccines/vac-gen/imz-basics.htm

[47]Centers for Disease Control and Prevention. (2010). *Multiracial populations.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/omhd/Populations/Multiracial.htm

[48]Centers for Disease Control and Prevention. (2013). *Native Hawaiian & other Pacific Islander populations.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/minorityhealth/populations/REMP/nhopi.html

[49]Discover New England. (N.D.). *New England USA quick facts.* Retrieved 09/14, 2015, from http://discovernewengland.org/about-new-england/new-england-usa-quick-facts-0

[50]Centers for Disease Control and Prevention. (2012). *Defining adult overweight and obesity.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/obesity/adult/defining.html

[51]World Bank Group. (2015). *Public-private partnership in infrastructure resource center.* Retrieved 09/14, 2015, from http://ppp.worldbank.org.libproxy.unh.edu/public-private-partnership/overview/what-are-public-private-partnerships

[52]National Center for Education Statistics. (N.D.). *Definitions for new race and ethnicity categories.* Retrieved 09/14, 2015, from https://nces.ed.gov/ipeds/reic/definitions.asp

[53]London Borough of Richmond upon Thames. (2014). *Risky behavior training program.* Retrieved 09/14, 2015, from http://www.richmond.gov.uk/risky_behaviour_programme

[54]Health Resources and Services Administration. (N.D.). *Defining the rural population.* Retrieved 09/14, 2015, from http://www.hrsa.gov/ruralhealth/policy/definition_of_rural.html

[55]Employment and Social Development Canada. (2015). *Indicators of well-being in Canada.* Retrieved 09/14, 2015, from http://well-being.esdc.gc.ca.libproxy.unh.edu/misme-iowb/.3ndic.1t.4r@-eng.jsp?iid=10

[56]Fielding, N. (2006). SELF-REPORT STUDY. In V. Jupp (Ed.), *The SAGE Dictionary of Social Research Methods.* (pp. 276-278). London, England: SAGE Publications, Ltd. Retrieved from http://srmo.sagepub.com/view/the-sage-dictionary-of-social-research-methods/SAGE.xml

[57]American Psychological Association. (N.D.). *Socioeconomic status.* Retrieved 09/14, 2015, from http://www.apa.org.libproxy.unh.edu/topics/socioeconomic-status/

[58]Agency for Healthcare Research and Quality. (2014). *The effective health care program stakeholder guide chapter 3: Getting involved in the research process.* Retrieved 09/14, 2015, from http://www.ahrq.gov/research/findings/evidence-based-reports/stakeholderguide/chapter3.html

[59]Indiana University. (2015). *What is Stata, and How Do I Access it at IU?* Retrieved 09/14, 2015, from https://kb.iu.edu/d/afly

[60]Agency for Healthcare Research and Quality. (N.D.). *Effective health care program: Glossary of terms.* Retrieved 09/14, 2015, from http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/?termid=67&pageaction=showterm

[61]World Health Organization. (N.D.). *Social determinants of health.* Retrieved 09/14, 2015, from http://www.who.int.libproxy.unh.edu/social_determinants/en/

[62]Centers for Disease Control and Prevention. (2014). *Healthy places.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/healthyplaces/about.htm

[63]United States Census Bureau. (2015). *2010 census urban area FAQs.* Retrieved 09/14, 2015, from https://www-census-gov.libproxy.unh.edu/geo/reference/ua/uafaq.html

[64]Centers for Disease Control and Prevention. (2010). *White populations.* Retrieved 09/14, 2015, from http://www.cdc.gov.libproxy.unh.edu/omhd/Populations/White.htm

[65]Renwick, D., & Johnson, T. (2014). *The world health organization (WHO).* Retrieved 09/14, 2015, from http://www.cfr.org/public-health-threats-and-pandemics/world-health-organization-/p20003