

Tennessee Health Equity Commission



Health Disparities Elimination Report 2009

Tennessee General Assembly
Health Equity Commission
Rachel Jackson Bldg, 8th Flr.
320 – Sixth Avenue North
Nashville, TN 37243
(615) 741-3553

I. Health Equity Commission History and Mission

U.S. History on Improving Health Status for Minorities

In 1985, the United States Secretary of Health and Human Services empanelled a Task Force on Minority Health to review the available data and assess the health status of minority Americans. The task force identified six causes of death as collectively accounting for more than 80 percent of the excess death and mortality of minority groups:

- Cancer
- Asthma
- Heart disease and stroke
- Chemical dependency
- Diabetes
- Intentional and unintentional injuries and infant mortality

The task force also discerned that minorities experience significantly poorer health outcomes when compared to their white counterparts. While the health status for Americans overall is improving, the health status for minorities is declining. Because of these disparities, the U.S. Secretary created the federal Office of Minority Health to continually monitor minority health issues and to recommend ways to improve the health status and outcomes for minorities.

Tennessee's Health Equity Commission Background

The Commission was established in 1990 as the Black Health Care Commission. In 2008, the name was changed to the Health Equity Commission to encompass all minorities and underserved citizens of Tennessee (Tennessee Code Annotated, Section 3-15-401). The commission was formed to advocate the elimination of health inequities among all racial and ethnic minorities and underserved communities in Tennessee. The Commission is committed to educating policy makers and the general public about the social determinants of health. Continued growth in the State's minority population, shorter life spans, poorer health status in these populations and gaps in access to care, emphasize the importance of sustaining the Commission's efforts.

Our Membership

The Commission is comprised of six members of the Legislature, three Senators and three Representatives, and six health equity stakeholders from across the state. All appointments are made by the Speakers of both houses of the State Legislature.

Mission:

Ensuring accessible, quality, culturally competent and affordable health care for all and making communities healthier places to live, work, learn and play.

Objectives:

- Increasing awareness of and reduce health disparities
- Identify limitations associated with existing laws, regulations, programs and services.
- Identify and review health promotion and disease prevention strategies to improve health outcomes for racial and ethnic minorities and underserved populations.
- Promote workforce diversity and cultural competency and tolerance of every culture's perspective across all health delivery systems.

How does the work of the Commission benefit all Tennesseans?

Health is a powerful determinant of self-sufficiency, a goal that unites all communities. If we neglect basic prevention measures today, we guarantee ourselves even greater health care cost tomorrow. Improved health and prevention of serious health problems is good for the state's economy. Healthy families and a healthy workforce elevate the fortunes of the entire state.

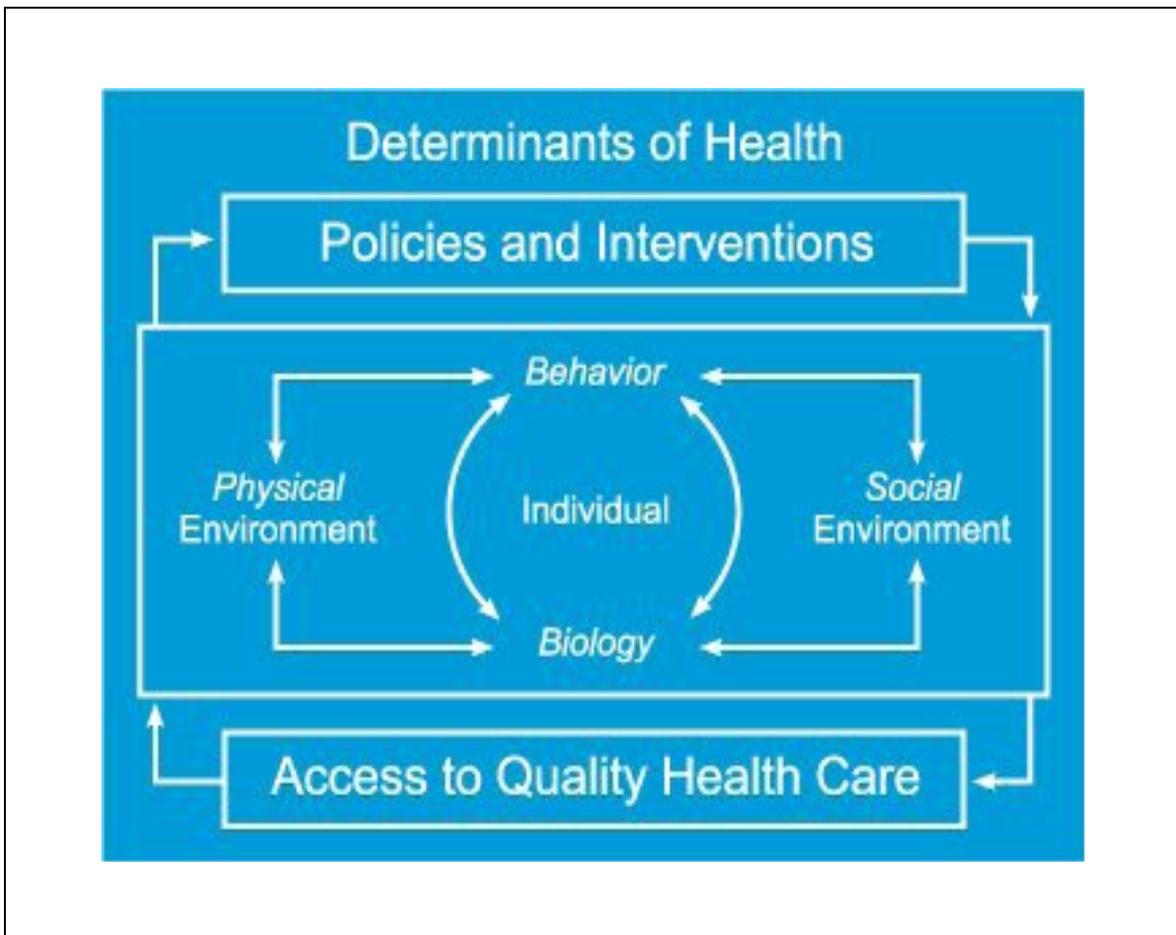
II. Health Definitions

Several terms are required to understand the concept of health equity.

- Health disparities are the differences in the incidence, prevalence, morbidity, mortality, burden of disease, access to prevention, screening & treatment services and other health indicators that exist between specific, different populations. These disparities are further influenced by socio-economic status and biases, including race, religion, sexual identity and immigrant status.
- Health Equity is the desired goal or outcome of efforts to eliminate health disparities. The concept of health equity is based on valuing all persons equally and viewing health as essential to the well-being of society. Achieving health equity allows everyone to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society.
- Health inequities disparities in health that are systematic and avoidable and considered unfair or unjust.
- Health itself must be distinguished from health care. While health care can prolong survival and improve prognosis after some serious diseases. Health is defined as a “state of complete physical, mental and social well-being”. Health is a state where people are performing at their best in both mind and body. Health is influenced by social determinants. The smaller the inequality gap, the better the health status of the overall population.
- Social determinants of health (SDOH) are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across a state’s population effectively determines length and quality of life. SDOH have a direct impact on the health of individuals and are the best predictors of the health status of the overall population. Health is a multidimensional entity. Likewise, there are multiple factors that either maintain or disrupt its balance, including: the social and economic environment, the physical environment, health practices and coping skills, health care services, genetics, health literacy, and early child development (ECD).

III. How Social Determinants influence Health

An Individual's biology and behavior combined with the individual's social and physical environments influence health. In addition, policies and interventions can improve health by targeting the fundamental causes of disease (or the SDOH), including access to quality health care. Equitable distribution of these social determinants contributes to health equity.



IV. Tennessee Demographics

Tennessee's population is comprised of 77.8% Caucasian, 16.8% African American, 3.7% Hispanic/Latino, 1.4% Asian/Pacific Islander, and .03% Native American Indian (2008 American Community Surveys, U.S. Census).

Poverty and lack of Health Insurance

According to the 2008 American Community Surveys an estimated 15.5 percent of Tennesseans had income below the poverty threshold in the past 12 months. 36.3% of Tennesseans have a high school diploma or the equivalent and 17% have less than a high school diploma.

Most uninsured Tennesseans (74.7 percent) are members of working families. Twenty-two percent of Tennessee's children live in poverty.

Nearly one out of three people (32.4 percent) in Tennessee under the age of 65 went without health insurance for all or part of the two year period 2007-2008 (see chart). Of the 1.7 million uninsured Tennesseans, nearly three-quarters (72.9 percent) went without health coverage for six months or longer during this period.

People of racial and ethnic minorities are more likely to go without health insurance than Caucasians. In Tennessee, 63.0 percent of Hispanics/Latinos and 35.7 percent of African Americans were uninsured, compared to 29.6 percent of Caucasians.

Percent Uninsured during 2007-2008, by Race and Hispanic Origin

RACE	TOTAL NUMBER	NUMBER UNINSURED	PERCENT OF SUBGROUP INSURED
Caucasian	4,034,000	1,193,000	29.6%
African American	915,000	326,000	35.7%
Hispanic, all	219,000	138,000	63.0%
Other	*	*	*

*Due to small sample size, data not reportable

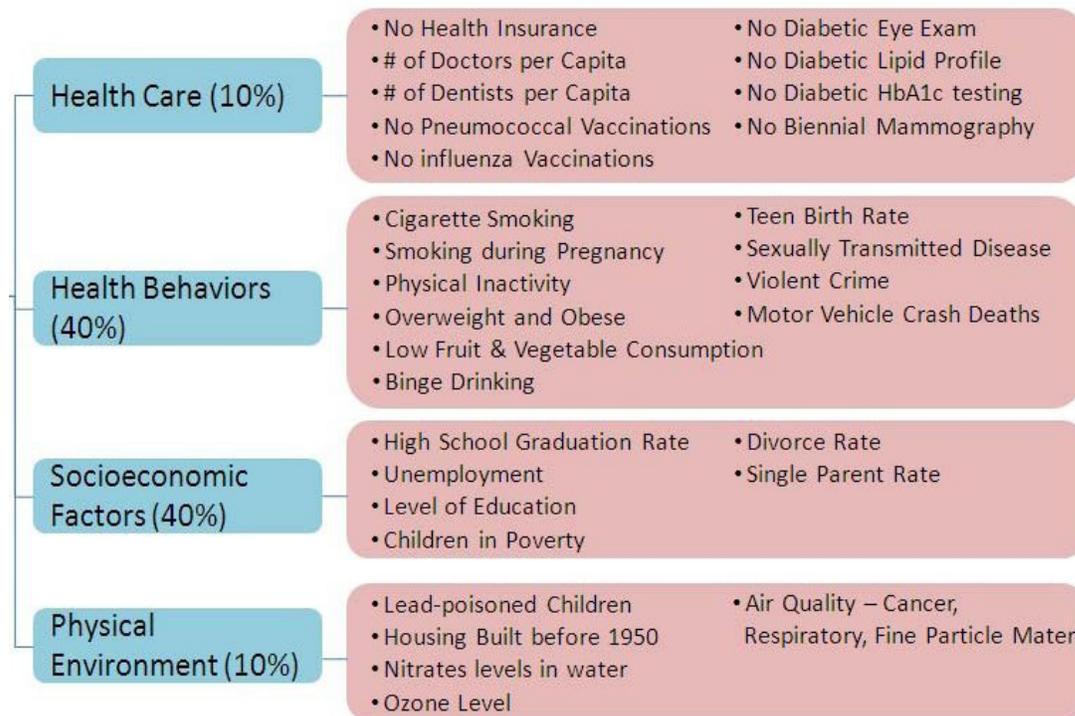
According to a 2009 report from Families USA, a national consumer health organization, between 2008 and 2010:

- 810 Tennesseans will lose their health coverage, on average, every week;
- 3,520 Tennesseans will lose their health coverage, on average, every month; and
- 42,290 Tennesseans will lose their health coverage every year.

V. Measuring Health Disparities

Assessing health equity requires measuring population-based data on health status, health care, and the social determinants of health that can be disaggregated by race or ethnic group, socioeconomic status, and gender, and how they change over time in relation to policies.

A report by the Tennessee Institute of Public Health, "Tennessee County Health Rankings 2009", divides health determinant measures into four major components: health care, health behaviors, socioeconomic factors related to health, and the physical environment. Each of these four major components consists of multiple health determinants.



Tennessee Counties with the BEST health determinant outcomes:

2009 INDEX RANKING	COUNTY	2007 RANKING
1	Williamson	1
2	Rutherford	2
3	Moore	9
4	Montgomery	10
5	Sumner	6
6	Wilson	3
7	Cheatham	4
8	Weakley	11
9	Davidson	30*
10	Knox	6

* Davidson County improved by lowering the percentage of cigarette smokers, mothers who smoked during pregnancy, and the percentage of the population that was overweight or obese.

Tennessee Counties with the WORST health determinant outcomes

2009 INDEX RANKING	COUNTY	2007 RANKING
86	McNairy	61*
87	Fentress	91
88	Clay	47*
89	Decatur	63*
90	Hancock	95
91	Lake	94
92	Carroll	90
93	Unicoi	19*
94	Jackson	70*
95	Benton	92

*McNairy, Clay, Decatur, Unicoi and Jackson fell down in the rankings because of high mortality rates, inadequate access to health care (fewer doctors in these counties), poor disease management, higher unemployment and more children living in poverty.

VI. Specific Health Disparities afflicting Tennessee

This report will focus on six priority health areas for Tennessee: Infant Mortality, Diabetes, Asthma, Obesity, HIV/AIDS and Cancer.

1. Infant Mortality is defined as the number of deaths of infants (one year of age or younger) per 1000 live births.

Infant Mortality Rate (IMR) is the number of newborns dying under a year of age divided by the number of live births during the year. Overall, Tennessee's infant mortality rate is ranked 45th compared to other states, based on data from 2007, the overall state infant mortality rate was 8.7.

Nationally the mortality rate of minority infants is more than twice that of Caucasian infants, but in Tennessee, the magnitude is even greater. Memphis, Shelby County has among the highest infant death rates of any American city -- a baby dies there every 43 hours.

Infant Mortality Rate (Deaths per 1000 live births) by Race/Ethnicity

Caucasian, non Hispanic	6.7
African American	16.0
Hispanic, Latino	6.4
Asian, Pacific Islander	*
American Indian	*
Overall All for Tennessee	8.7

Infant mortality seems to be more prevalent in poverty stricken areas. The physical and emotional strain of living in an inner city community with higher crime rates, failing schools, falling property values, and often higher tax rates can lead to health complications, especially during pregnancy, all of which can lead to infant death.

This trend is evidence of the social injustices faced by many minorities and underserved communities. These parents are often younger, low income mothers who have little or no access to health services. Since many are without health insurance, or even a car, getting to a health clinic or picking up medicine is often not an option.

The combination of youth and poverty in these parents make them the group at highest risk for premature birth, which is the primary medical cause of infant mortality.

Commission efforts:

The Health Equity Commission addresses the issue of Infant Mortality by researching national efforts and initiatives, educating policy makers and the public on the issue and new initiatives, working with community coalitions on outreach efforts, and monitoring state policies and programs that address the issue of infant mortality. Currently the Health Equity Commission is assisting the Study Committee on Infant Mortality/teen Pregnancy (HR 0082) in their efforts to identify methods and practices for reducing infant mortality and the incidence of teen pregnancy.

2. Diabetes (medically known as diabetes mellitus) is a group of serious, lifelong disease affecting 17 million Americans. All forms of the disease are caused by higher than normal levels of blood sugar, which is a result of the body not producing or properly using insulin. Insulin is a hormone that converts sugar, starches and other food into energy needed by the body.

Diabetes can lead to serious complications and premature death if blood sugar, blood pressure and cholesterol are not kept under good control. There are three different classifications of Diabetes: Type 1, Type 2, and Gestational Diabetes.

Average Annual Incidence Rates of Diagnosed Diabetes Among Adults, 2005-2007		
	TN	US
Age-adjusted rate	11.0	9.1

African Americans are 1.8 times more likely to have diabetes than Caucasians of similar age. One in four, or 25 percent of African Americans between the ages of 65 and 74 has diabetes. African Americans experience nearly three times as many complications and deaths from diabetes as do Caucasians. African Americans are 50 percent as likely to develop diabetic retinopathy, a type of eye disease which can lead to blindness; 5.6 times as likely to suffer from kidney disease with more than 4000 new cases of end stage renal disease

(ESRD) each year; and 1.6 times more likely to suffer from lower limb amputations.

Racial and ethnic disparities in diabetes complications and diabetes related deaths are made worse by a variety of factors, including poor access to diabetic medicines and supplies, and culturally and linguistically appropriate preventative care.

Self-management education or training is a key step in improving health outcomes and quality of life. It focuses on self-care behaviors, such as healthy eating, being active, and monitoring blood sugar. It is a collaborative process in which diabetes educators help people with or at risk for diabetes gain the knowledge and problem-solving and coping skills needed to successfully self-manage the disease and its related conditions.

Commission Efforts:

The Health Equity Commission participates in PROJECT DIABETES, a program designed to develop, implement, and promote a statewide effort to combat the proliferation of Type 2 diabetes. The Commission supported legislation that made all schools, not just high schools, eligible for grants from the TN Center for Diabetes Prevention and Health Improvement (Public Chapter 187).

Considering Diabetes is the leading cause of kidney failure, accounting for 40% of new cases each year. And the fact that approximately 7,000 Tennesseans suffer from chronic kidney failure and need dialysis or a kidney transplant to live, and the possibility of an additional 200,000 (about 1 in 26) Tennesseans contracting kidney disease. The Health Equity Commission has created the TN Chronic Kidney Disease Taskforce (Public Chapter 576), composed of Nephrologists, Clinicians, Renal Care providers, and others to develop a plan of action to educate the public and health care professionals about CKD and its complications. The action plan will be submitted to the TN General Assembly by Spring of 2011.

3. Asthma is an inflammatory disorder of the airways, which causes attacks of wheezing, shortness of breath, chest tightness, and coughing. Asthma is caused by inflammation in the airways. When an asthma attack occurs, the muscles surrounding the airways become tight and the lining of the air passages swell. This reduces the amount of air that can pass by, and can lead to wheezing sounds.

Asthma symptoms can be triggered by breathing in allergy-causing substances (called allergens or triggers). Triggers include pet dander, dust mites, cockroach allergens, molds, or pollens. Asthma symptoms can also be triggered by respiratory infections, exercise, cold air, tobacco smoke and other pollutants, stress, food, or drug allergies. Aspirin and other non-steroidal anti-inflammatory medications (NSAIDs) provoke asthma in some patients.

Current prevalence of asthma in Tennessee is 8.5% in children and 8.4% in adults. That's roughly 286,000 asthma patients in the state.

- Among adults, asthma was more common among women than men. However, among children asthma prevalence rates were higher among boys.
- Asthma was more common among black children than white children. However, there were no racial differences in asthma prevalence among adults.
- Asthma prevalence increased with decreasing income and education
- Hospitalizations, emergency department visits and deaths due to asthma are all indicative of severe and/or poorly managed disease and are costly both monetarily and in terms of personal suffering. However, such severe consequences are largely preventable with appropriate treatment and disease management. A recent report conducted by Asthma in America, revealed Tennessee is missing the mark in terms of asthma care. Some key findings are highlighted below.

Many Patients in Tennessee Are Uninformed

There is a widespread misunderstanding about the causes and treatment of asthma. In Tennessee, 77% of asthma patients believe there is a "strong need" for patient education.

Only 7% of those surveyed could name inflammation as the underlying cause of asthma symptoms.

More than half (54%) thought it was possible to treat only asthma attacks and symptoms, not their underlying cause.

Many Patients in Tennessee Treat the Symptoms of Asthma, Not the Disease Itself

The National Heart, Lung, and Blood Institute (NHLBI) guidelines recommend anti-inflammatory medication for patients with mild, moderate or severe persistent asthma. However, many patients in

Tennessee appear to be treating only the symptoms of asthma and not the underlying inflammation:

62% of those surveyed who use a quick-relief inhaler use it three times a week or more -- indicating a need for long-term control medication, according to the NHLBI guidelines.

About 1 in 11 people (9%) with persistent asthma take inhaled corticosteroids, the anti-inflammatory drugs the guidelines call "the most effective long-term control medication for asthma, and the preferred initial therapy for patients with persistent asthma" for patients five years of age and older.

Closing the Patient-Provider Communications Gap May Help
The national survey reveals real disparities between what doctors say and what patients say -- and suggests a communications gap exists between asthma patients and their healthcare providers.

70% of doctors surveyed say they use spirometry to measure patient airflow on an ongoing basis, but only 35% of patients report having a lung function test in the past year.

92% of doctors surveyed say anti-inflammatory drugs are either "essential" or "very important" in the long-term management of persistent asthma, but only 19% of asthma patients report using anti-inflammatory medication in the past four weeks.

70% of doctors say they prepare a written action plan for their patients, but only 27% of patients say their doctor has developed one for them.

Commission Efforts:

The Commission supports asthma awareness and encourages coaches throughout the state to participate in "Winning with Asthma" training program through SJR 0056.

The Commission continues to monitor the progress of the TVA ash spill clean up efforts and monitor the possible health impact.

The Commission also urges the Department of health to design a comprehensive plan to reduce the burden of asthma on students.

4. Obesity

A condition in which excess body fat has accumulated to such an extent that health may be negatively affected. It is commonly defined as a body mass index (BMI = weight divided by height squared) of 30 kg/m² or higher. Excessive caloric intake and a lack of physical activity in genetically susceptible individuals is thought to explain most cases of obesity, with purely genetic, medical, or psychiatric illness contributing to only a limited number of cases.

Obesity is a public health and policy problem because of its prevalence, costs, and health effects. Obesity increases the risk of many diseases and health conditions, including (but not limited to) hypertension, high cholesterol, coronary heart disease, stroke, Type 2 Diabetes, sleep apnea, and some cancers.

The prevalence of being overweight/obese for the total population of Tennessee was estimated to be 67.4 percent, according to the Tennessee Behavioral Risk Factor Surveillance System 2007.

Commission efforts:

Nutritious food is a basic need to start and support an active, healthy and productive life. Maintaining a nutritious diet is impossible if healthy foods are not available; many inner city and rural families have no access to healthful foods. In 2010 the Health Equity Commission will urge Government to support public-private partnerships to open and sustain full-service grocery stores in communities without access to healthful foods.

5. HIV/AIDS

AIDS is a chronic, life-threatening condition caused by the human immunodeficiency virus (HIV). By damaging your immune system, HIV interferes with your body's ability to fight off viruses, bacteria and fungi that cause disease. HIV makes you more susceptible to certain types of cancers and to infections your body would normally resist, such as pneumonia and meningitis. The virus and the infection itself are known as HIV. "Acquired immunodeficiency syndrome (AIDS)" is the name given to the later stages of an HIV infection.

Causes

Normally, white blood cells and antibodies attack and destroy foreign organisms that enter your body. This response is coordinated by white blood cells known as CD4 lymphocytes. These lymphocytes are also the main targets of HIV, which attaches to the cells and then enters

them. Once inside, the virus inserts its own genetic material into the lymphocytes and makes copies of itself.

When the new copies of the virus break out of the host cells and enter the bloodstream, they search for other cells to attack. In the meantime, the old host cells and some uninfected CD4 cells die from the effects of the virus. The cycle repeats itself again and again. In the process, billions of new HIV particles are produced every day. Eventually, the number of CD4 cells in the body decreases, leading to severe immune deficiency, which means your body can no longer effectively fight off viruses and bacteria that cause disease.

How HIV is transmitted

You can become infected with HIV in several ways, including: Sexual transmission, Transmission through infected blood, Transmission through needle sharing, Transmission through accidental needle sticks, transmission from mother to child, Other methods of transmission (in rare cases, the virus may be transmitted through organ or tissue transplants or un-sterilized dental or surgical equipment). You cannot become infected through ordinary contact — hugging, kissing, dancing or shaking hands — with someone who has HIV or AIDS.

Estimated numbers of persons living with HIV infection (not AIDS) or with AIDS at the end of 2007, by area of residence—United States

	Living with HIV (not AIDS)	Living with AIDS	AIDS cases per 100,000 population
United States	256,363	455,636	12.4%
Tennessee	7,154	6,834	10.7%

CDC HIV/AIDS Surveillance Report 2007

- There are approximately 350 new diagnosed cases of HIV and AIDS annually.
- Reported annual new infections have increased 35% over the past 5 years, though this is probably due as much to expanded HIV testing as it is to any increase in risky behaviors.
- African Americans and Hispanics represent 54 % of new HIV infections in recent years (AA 47%, H 7%)
- Women represent 22% of new HIV infections, 65% of whom are African American women.

- Men who have Sex with men (MSM) account for 52% of new HIV infections of whom white and black men are represented in roughly equal numbers.
- 15% of new HIV infections are among teenagers or youth under age 25.

Commission Efforts:

Public Chapter 467 urges the Health Equity Commission to study the disproportionate impact that HIV/AIDS has on the African American community. And examine the need to develop, implement and maintain a comprehensive, culturally sensitive HIV Prevention plan targeting communities identified as high risk. The Commission has begun to investigate current State wide efforts and has identified partners to assist in the gathering of data and report development.

The Commission is also active on the Meharry Center for AIDS Health Disparity Research Board of Directors. The Center works to identify factors responsible for the profoundly disproportionate burden of HIV/AIDS among minority populations.

6. Cancer (medical term: malignant neoplasm) is a class of diseases in which a group of cells display uncontrolled growth (division beyond the normal limits), invasion (intrusion on and destruction of adjacent tissues), and sometimes metastasis (spread to other locations in the body via lymph or blood). Nearly all cancers are caused by abnormalities in the genetic material of the transformed cells. These abnormalities may be due to the effects of carcinogens, such as tobacco smoke, radiation, chemicals, or infectious agents. Other cancer-promoting genetic abnormalities may be randomly acquired through errors in DNA replication, or are inherited, and thus present in all cells from birth.

Compared to other states, Tennessee has a cancer mortality rate that is one of the highest, ranked 46th for all cancers and races aggregated. The overall age-adjusted cancer mortality rate is 215.4 per 100,000 Tennessean compared to 197.8 per 100,000 U.S. residents. There are racial disparities in cancer mortality both nationwide and in Tennessee. For example, African-Americans in Tennessee exhibited a mortality rate of 274.4 per 100,000 from cancer, while the mortality rate among whites was 208.4 per 100,000 during the 1998-2002 periods. Although there is a racial disparity in

cancer mortality rates on the national level, the disparity is even greater in Tennessee.

Nationally, the mortality rate is 27 percent higher among African-Americans than whites, whereas in Tennessee it is 32 percent higher. Males of both races have a higher cancer mortality rate than females.

Specific cancers with the highest disparity

Specific cancers exhibit varying degrees of racial disparity.

Colorectal cancer mortalities occurred at a rate of 33.6 per 100,000 African-Americans compared to 19.5 per 100,000 whites. This is contrasted to the national rates of 27.9/100,000 and 20/100,000 respectively.

Breast cancer occurs at a 12 percent higher incidence among white women; however the mortality rate from breast cancer is 48 percent higher for African-American women. In other words, proportionally many more African-American women die from breast cancer than do white women, even though white women actually have a higher risk of developing the cancer.

Lung cancer mortality rates are higher among males than females. African-American and white women in Tennessee have nearly the same mortality rate from lung cancer: 44.4 per 100,000 African-American women versus 44 per 100,000 white women. African-American males have higher lung cancer mortality rates: 121.9 per 100,000. This is higher than both the national average for African-American male lung cancer mortality (101.3 per 100,000 nationally) and the lung cancer rate for white males in Tennessee (102.3 per 100,000 white males). In turn, white males in Tennessee have a lung cancer mortality rate that is higher than the national average for white males (75.2 per 100,000). Tennessee ranks as nearly the worst state in lung cancer mortality rates - 48th in 2002.

Prostate cancer is one of the greatest causes of mortality among African-American males and is more than two and a half times as frequent among white males: 72.6 prostate cancer deaths per 100,000 African-American males versus 28.6 deaths per 100,000 white males.

African-Americans have much higher mortality rates among the cancers that are the biggest killers: colorectal, lung, prostate and breast. The cancers which are responsible for the majority of cancer

deaths occur with startling disparity among minority and underserved communities.

Commission Efforts:

Support the importance of early detection of colorectal cancer and supports regular screening for the disease by health practitioners (HJR 281).

Participated in the American Cancer Society & REACH US Mid-South Regional Meeting (January 2010) to gather information on current initiatives to combat the cancer epidemic.

Publicize information on Breast health and mammograms and the possible need for guidelines specific to African American women.

Other efforts of the Health Equity Commission:

In April of 2009, the Commission hosted Minority Health month events at the Legislative Plaza. There was a viewing of the award winning documentary, "Unnatural Causes, Place Matters" and a health fair where a variety community based organizations conducted health screenings and educated Legislators on their organization's efforts to eliminate health disparities in Tennessee.

The Commission is assisting in the development of the state health plan spearheaded by the State Health Planning Division of the Department of Finance and Administration (Public Chapter 574).

The Health Equity Commission circulates a monthly newsletter on current health issues to members of the General Assembly.

The Health Equity Commission continues to support the Meharry HBCU Wellness Project and the student ambassadors from Tennessee's Private Historically Black Colleges and Universities: Lemoyne-Owen, Lane, Knoxville College, and Meharry in their efforts to educate campus students/faculty and the surrounding community on Health disparities.

The Commission Director is currently participating in a nine month Diversity RX - Peer Learning Network, designed to unearth practice innovations and challenges faced by health professionals. The focus of this network is to educate, support and advance cultural competence in health care. The Director is also part of the Center for Disease and

Control and Prevention's Racial and Ethnic health Disparities Action Institute (REDHAI) Tennessee Team, the institute provides local state teams with tools, resources, and strategies for developing evidence-based approaches to build healthier communities.

VII. LOOKING FORWARD

Because racial and ethnic minority groups are expected to comprise an increasingly larger portion of Tennessee's overall population, the future health of Tennessee will be greatly influenced by our success in improving the health of these groups. Eliminating disparities will require a collaborative effort (encompassing policy makers, the public and private sectors, individuals, and communities) to raise awareness and increased knowledge of social determinants of health inequities and their influence on health, building skills and capacities to change a social determinant and altering social, economic, or environmental conditions through policies changes. Utilizing a combination of approaches increases the likelihood of reaching the desired goal - better health for all Tennesseans.

The Health Equity Commission will support community capacity building efforts, coalition building and outreach activities, advocate for a more representative health care work force and the need for qualified translators within health care organizations, support cultural competency training as part of state medical licensure requirements, support funding of public health education, address provider and facility shortages in minority communities, and support legislation to make health care more accessible and affordable, and promote preventive screenings.

Contact Information:

LaTonya Ellis
Office Director
Tennessee Health Equity Commission
(615) 741-3553
Latonya.ellis@capitol.tn.gov

Legislative Members:

Rep. Joe Armstrong, Chair
Sen. Reginald Tate, Vice-Chair
Rep. Larry Miller

Rep. Joey Hensley
Sen. Tim Burchett
Sen. Ophelia Ford

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