



Minority Health Data Pages 2013

Introduction

The Office of Minority Health, located within the Vermont Department of Health, received a grant in 2010 to help address persistent gaps in health status and access to health services among racial and ethnic populations in Vermont.

One of the specific goals in the Minority Health Grant is to improve data quality, collection, and reporting among Vermont data sources. This report is a first step towards accomplishing this goal as it provides a look at currently available minority health data in Vermont.

Notes about this report.

- Data in this report are mostly presented as comparisons between racial and ethnic minorities (abbreviated REM) and white non-Hispanics (abbreviated WNH).
- Throughout this report, data comparisons presented as more or less, or significantly different, are all considered statistically significant differences.

Racial and Ethnic Minority Profile

- ❑ State and U.S. Comparisons
- ❑ Youth
- ❑ Age
- ❑ County
- ❑ Federal Poverty Level
- ❑ Education
- ❑ Language

Racial and Ethnic Minority Profile

Vermont Population

Vermont's racial and ethnic minority population is growing at a fast pace. In 2000, racial and ethnic minorities made up 3.8% (23,396 people) of Vermont's population. In 2010, they were 5.7% (35,518 people) of Vermont's population, which is a change of 52% in 10 years.

- As of 2010, the largest racial and ethnic minority population in Vermont was those who identified as two or more races (1.6%), followed by Hispanic or Latinos (1.5%), Asians (1.3%), and Black or African Americans (1.0%).
- Between 2000 and 2010, the Black or African American population in Vermont doubled, from 0.5% to 1.0%, and the Hispanic or Latino population nearly doubled, from 0.9% to 1.5% of Vermont's population.
- Asians have also been a fast growing racial group in Vermont, going from 0.9% of the population in 2000 to 1.3% of the population in 2010.

Racial and Ethnic Populations in Vermont

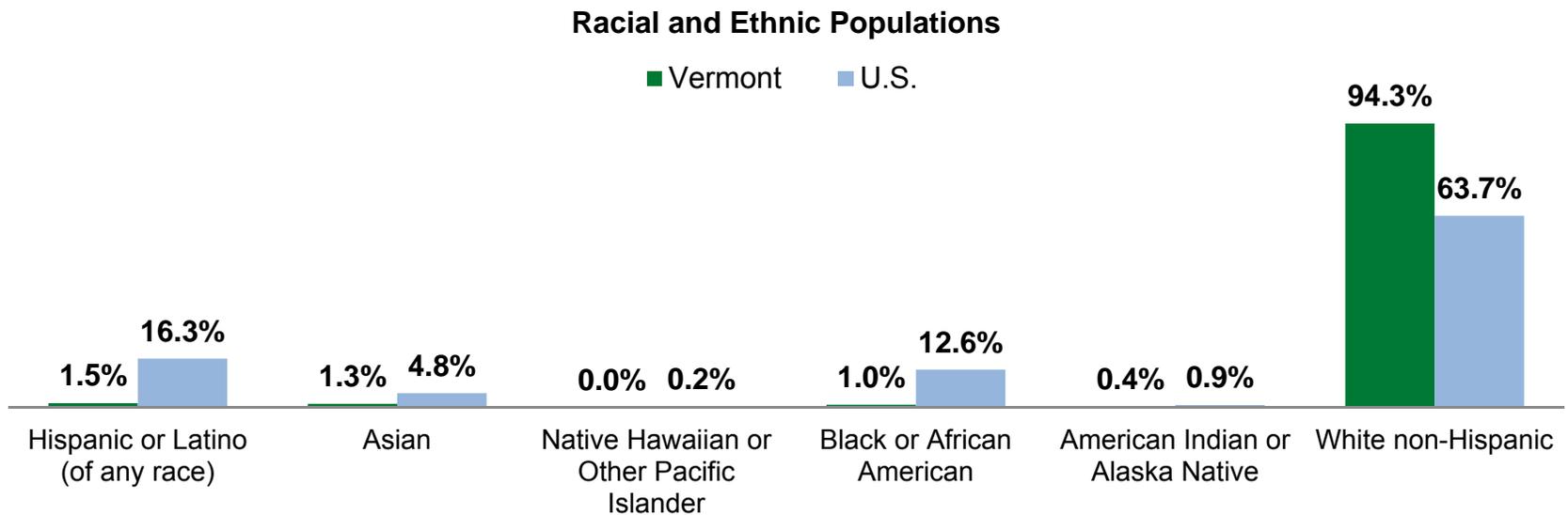
	<u>2000</u>		<u>2010</u>	
	(Number)	(%)	(Number)	(%)
White non-Hispanic	585,431	96.2	590,223	94.3
Hispanic or Latino (of any race)	5,504	0.9	9,208	1.5
Asian	5,217	0.9	7,947	1.3
Black or African American	3,063	0.5	6,277	1.0
American Indian or Alaska Native	2,420	0.4	2,207	0.4
Native Hawaiian or Other Pacific Islander	141	0.0	160	0.0
Other Races	1,443	0.3	2,105	0.3
Two or More Races	7,335	1.2	10,753	1.6
Total Vermont Population	608,827	--	625,741	--

Note: Percentages will not equal 100%. Races include people who identify as both Hispanic/Latino or not Hispanic/Latino.

Vermont Compared to the U.S.

According to 2010 U.S. Census counts, compared to the U.S., Vermont has a much lower racial and ethnic minority population. In fact, compared to other states in the nation, only Maine had a lower racial and ethnic minority population (5.6% in Maine compared to 5.7% in Vermont).

Four states in the U.S. had racial and ethnic minority populations comprising less than 10% of the States total population, including Vermont (5.7%), Maine (5.6%), West Virginia (6.8%), and New Hampshire (7.7%).



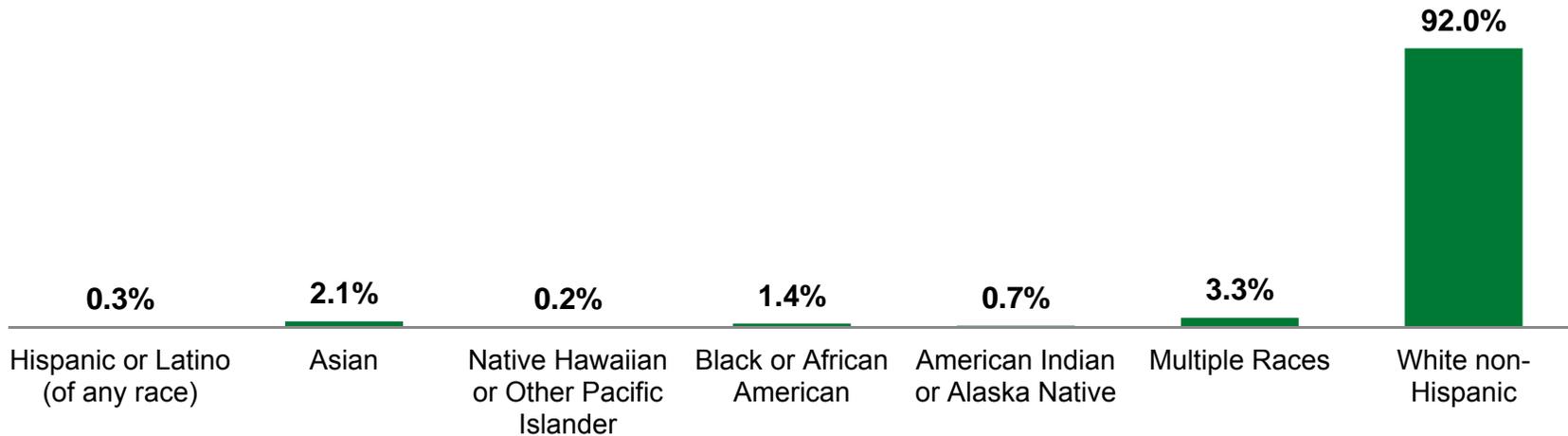
Note: Percentages will not equal 100%, within Vermont and within the U.S., as races include people who identify as both Hispanic/Latino or not Hispanic/Latino.

Racial and Ethnic Minority Profile

Youth

Among high school students in Vermont, 8% identified as being part of a racial or ethnic minority group according to the 2011 Youth Risk Behavior Survey (YRBS). A majority of racial and ethnic minority students identified themselves as being of multiple races (3.3%), followed by Asian (2.1%) and Black or African American (1.4%).

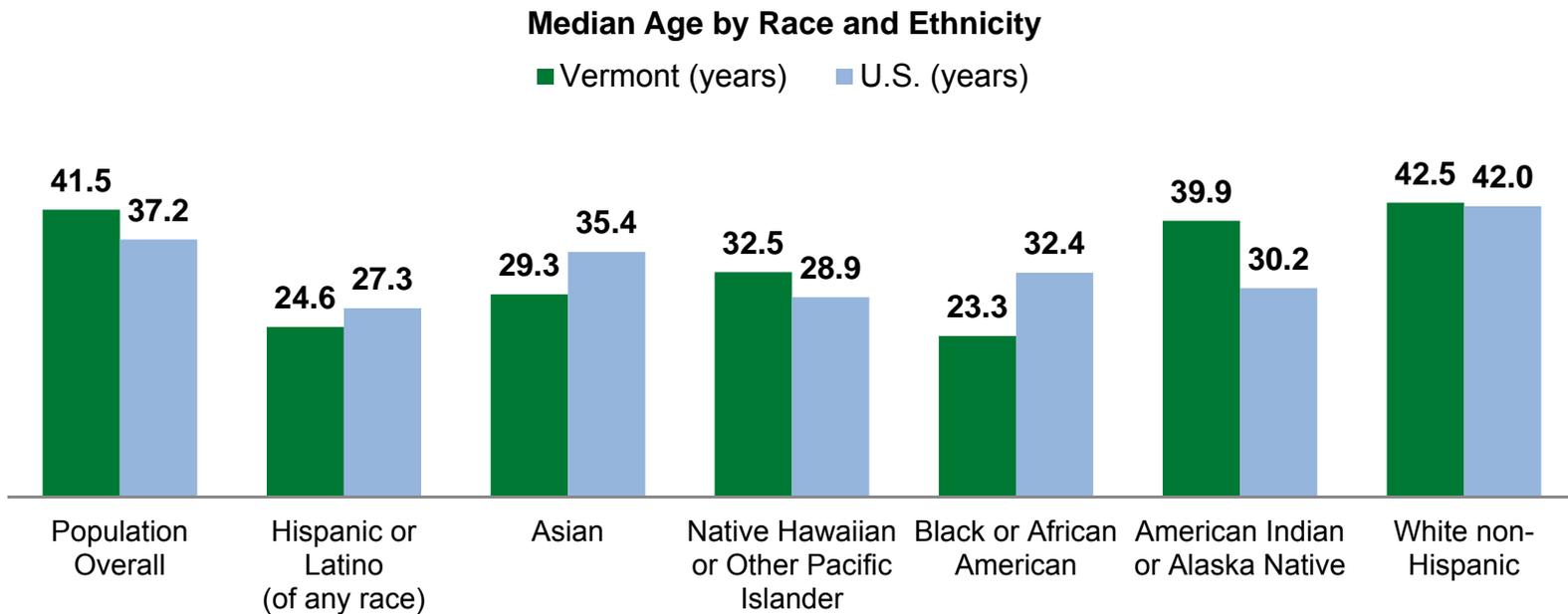
Racial and Ethnic Populations Among Vermont High School Students



Age

Racial and ethnic minorities tend to be younger than white non-Hispanics in Vermont. Among Hispanics or Latinos, Asians, and Black or African Americans in 2010, each only had about 30% of their population over the age of 40, whereas 52% of white non-Hispanics were aged 40 or older (data not shown).

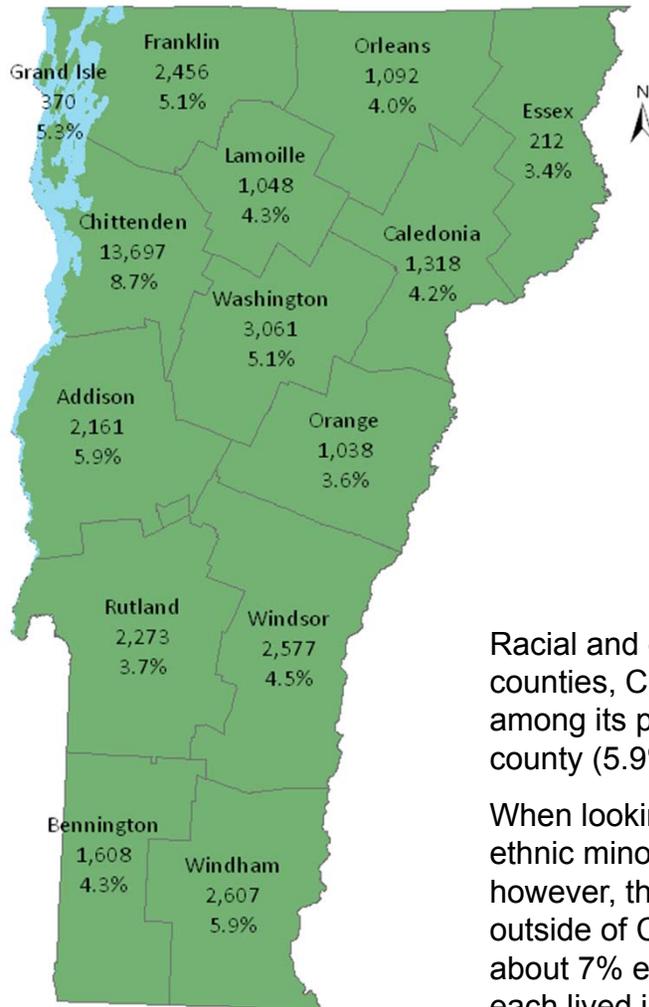
In addition, compared to the U.S., the median age was less for Hispanics or Latinos, Asians, and Black or African Americans living in Vermont.



Racial and Ethnic Minority Profile

County Level Data

**Racial and Ethnic Minority Population
and % of County Population**



**Racial and Ethnic Minority Population
and % of Total Vermont Population**

Chittenden	13,697	38.6%
Washington	3,061	8.6%
Windham	2,607	7.3%
Windsor	2,577	7.3%
Franklin	2,456	6.9%
Rutland	2,273	6.4%
Addison	2,161	6.1%
Bennington	1,608	4.5%
Caledonia	1,318	3.7%
Orleans	1,092	3.1%
Lamoille	1,048	3.0%
Orange	1,038	2.9%
Grand Isle	370	1.0%
Essex	212	0.6%

Racial and ethnic minorities live in all counties throughout Vermont. Among Vermont counties, Chittenden county had the largest proportion of racial and ethnic minorities among its population (8.7%), followed by Windham county (5.9%) and Addison county (5.9%).

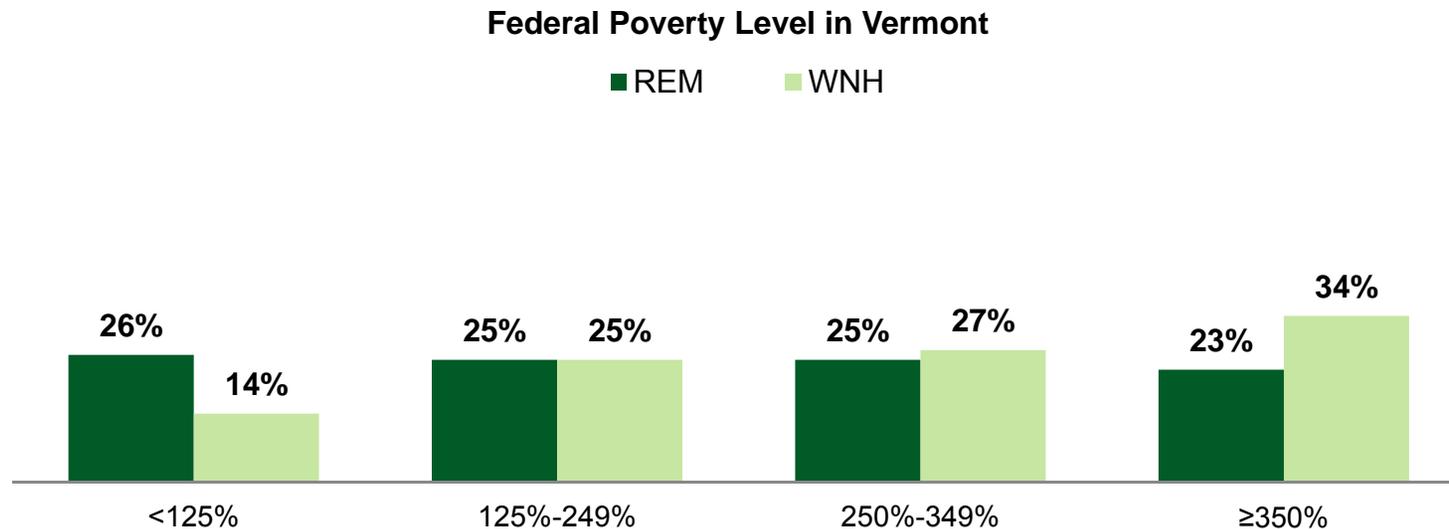
When looking across Vermont (see table above), the largest proportion of racial and ethnic minorities lived in Chittenden county (39%). It is important to keep in mind, however, that a majority of Vermont's racial and ethnic minority population lived outside of Chittenden county (61%). Nearly one in ten lived in Washington county, about 7% each lived in Windham, Windsor, and Windham counties, and about 6% each lived in Rutland and Addison counties.

Federal Poverty Level

Federal poverty level (FPL) is a federal measure calculated from both annual household income and family size. FPL is presented as a percentage, where 100% is considered at poverty level. FPL is used to determine eligibility for government assistance programs. People living below 250% FPL, for example, are still considered low income, often lacking sufficient income to meet basic needs.

In Vermont, nearly twice as many racial and ethnic minorities were at <125% FPL, compared to white non-Hispanics, and fewer racial and ethnic minorities were at ≥350% FPL (23%), compared to white non-Hispanics (34%).

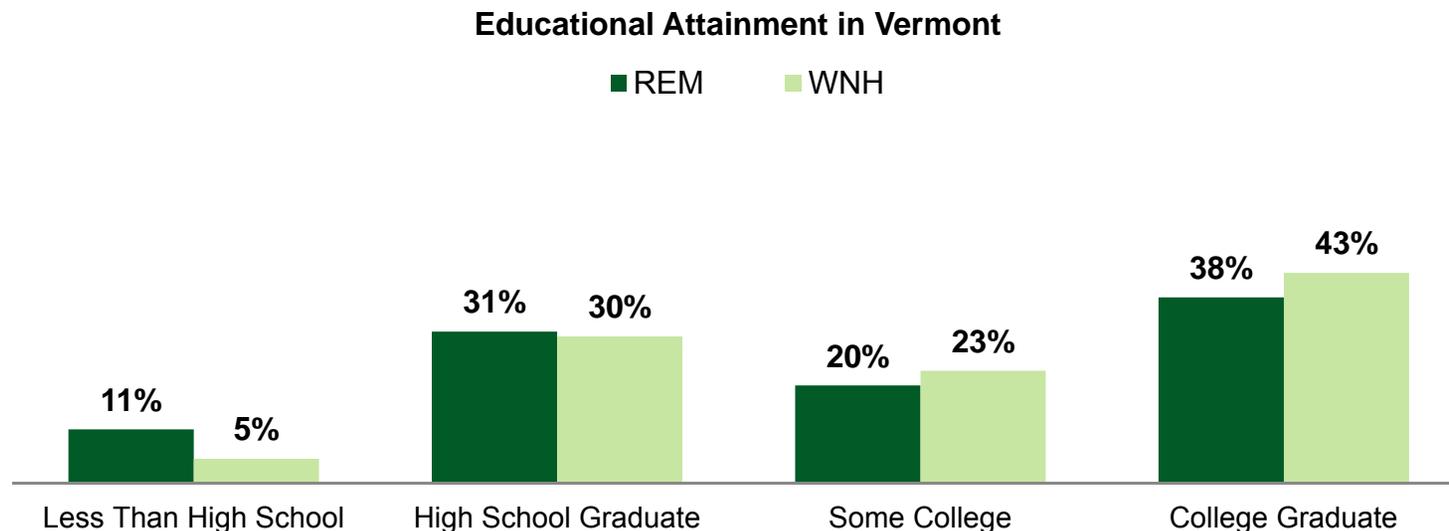
Interestingly, Vermont had fewer racial and ethnic minorities at <125% FPL (26%), compared to the U.S. where 41% of racial and ethnic minorities were living at <125% FPL (data not shown).



Educational Attainment

In Vermont, significantly more racial and ethnic minorities had less than a high school diploma (11%), compared to white non-Hispanics (5%). A similar number of racial and ethnic minorities had graduated high school, attained some college, or had graduated college, compared to white non-Hispanics.

When specifically comparing racial and ethnic minorities who live in Vermont to those in the U.S. overall, there are some differences. More racial and ethnic minorities in Vermont had a college degree (38%) compared to the U.S. (28%), whereas fewer racial and ethnic minorities in Vermont had less than a high school diploma (11%), compared to the U.S. overall (19%) (data not shown).



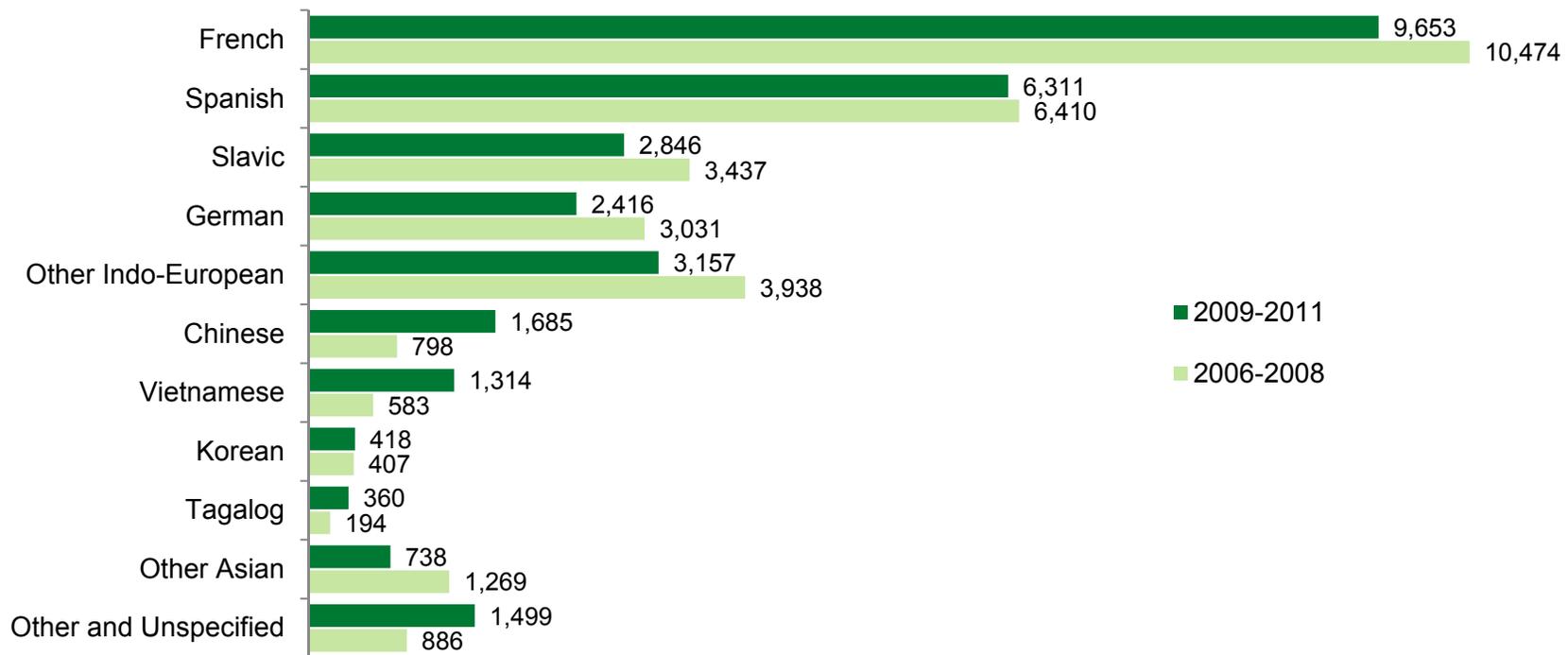
Note: Adults aged 25 and over were included in educational attainment analyses.

Languages Spoken in Vermont

Between 2008 and 2011, the number of Vermonters speaking Indo-European languages spoken at home has decreased, while Vermonters speaking an Asian language at home, specifically Chinese, Vietnamese, Korean, and Tagalog, has increased.

- It is important to note that this data is not the primary language spoken per household. Language spoken at home is collected by asking what language each person in the household speaks the most, and as such, more than one language can be included per household.

Languages Spoken in Vermont



Note: These numbers include Vermont residents aged 5 years or more, who spoke a language other than English at home.

Health Care Access

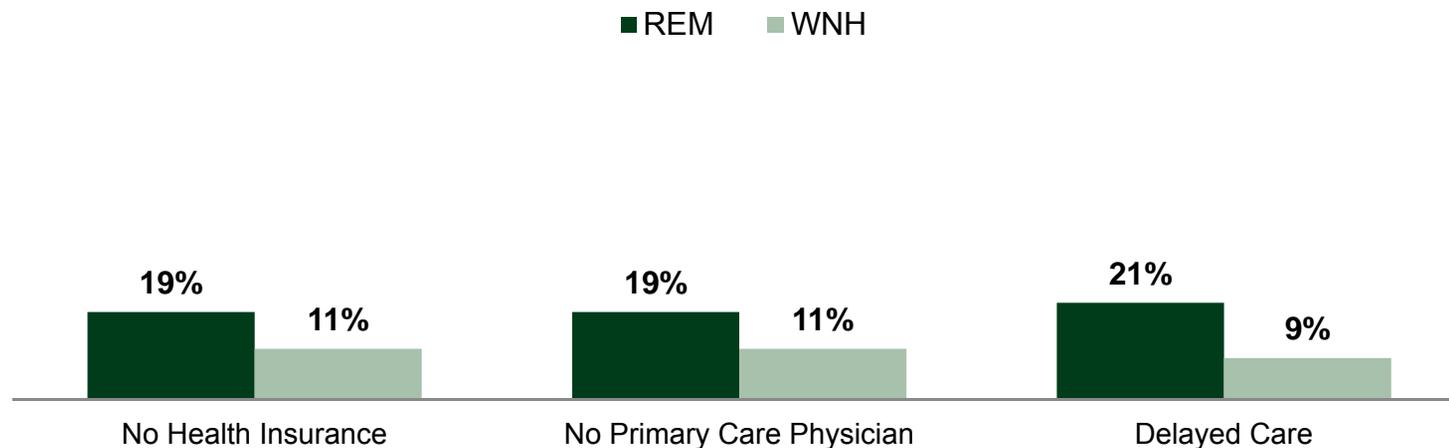
- Health Insurance
- Primary Care Physician
- Delay in Health Care

Health Insurance, Primary Care Physician, and Delayed Care

A person's health insurance status is a major determinant of his or her access to health care services in the United States. According to the Department of Health and Human Services, a lack of health insurance for racial and ethnic minorities primarily affects the quality of health care they receive in a negative way.*

In Vermont, racial and ethnic minorities had a higher proportion of their population without health insurance (19%), compared to white non-Hispanics (11%). This lack of health insurance for racial and ethnic minorities was true for the U.S. as well.

Additionally, racial and ethnic minorities were more likely to report that they do not have a primary care physician and more than twice as likely to report having had to delay care, compared to white non-Hispanics.



Note: Health insurance includes adults aged 18-64 years.

*U.S. Department of Health and Human Services. **HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care.** Washington, D.C.: U.S. Department of Health and Human Services, [April 2011].

Chronic Conditions

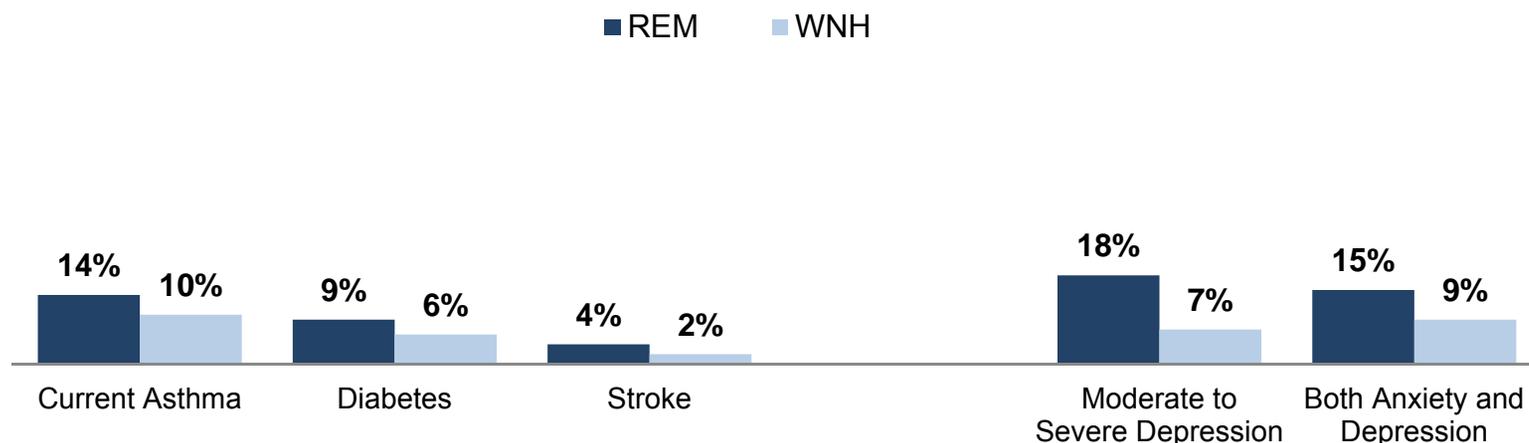
- Asthma, Diabetes, Stroke, Depression, and Anxiety
- Arthritis, Cancer, COPD, Heart Disease, Osteoporosis, and Obesity
- U.S. Comparisons

Asthma, Diabetes, Stroke, Depression, and Anxiety

Asthma, diabetes, stroke, depression and anxiety are chronic conditions where higher prevalence rates were seen among Vermonters who were a racial or ethnic minority, compared to those who were white non-Hispanic.

Specifically in Vermont, 14% of racial and ethnic minorities reported having current asthma, 9% reported ever having been diagnosed with diabetes, and 5% reported having ever had a stroke. These are all significantly higher prevalence rates compared to white non-Hispanics.

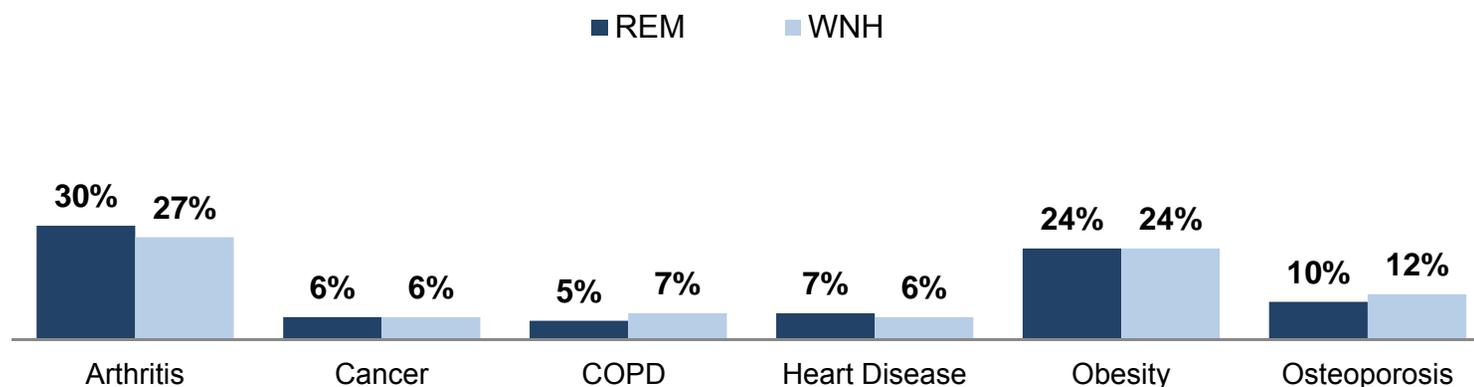
In addition, racial and ethnic minorities in Vermont were two and a half times more likely to report that they had moderate to severe depression and nearly twice as likely to have been diagnosed with both an anxiety and a depression disorder, when compared to white non-Hispanics.



Arthritis, Cancer, COPD, Heart Disease, Obesity, and Osteoporosis

The percentage of Vermonters ever diagnosed with arthritis, cancer, heart disease, chronic obstructive pulmonary disease (COPD), osteoporosis, and obesity was similar for both racial and ethnic minorities and white non-Hispanics.

- It is particularly important to keep in mind that cancer prevalence and race/ethnicity is a complex topic. Different types of cancer can be more or less prevalent among people of various race and ethnicities. Unfortunately, Vermont can not examine prevalence for specific cancers at this time.

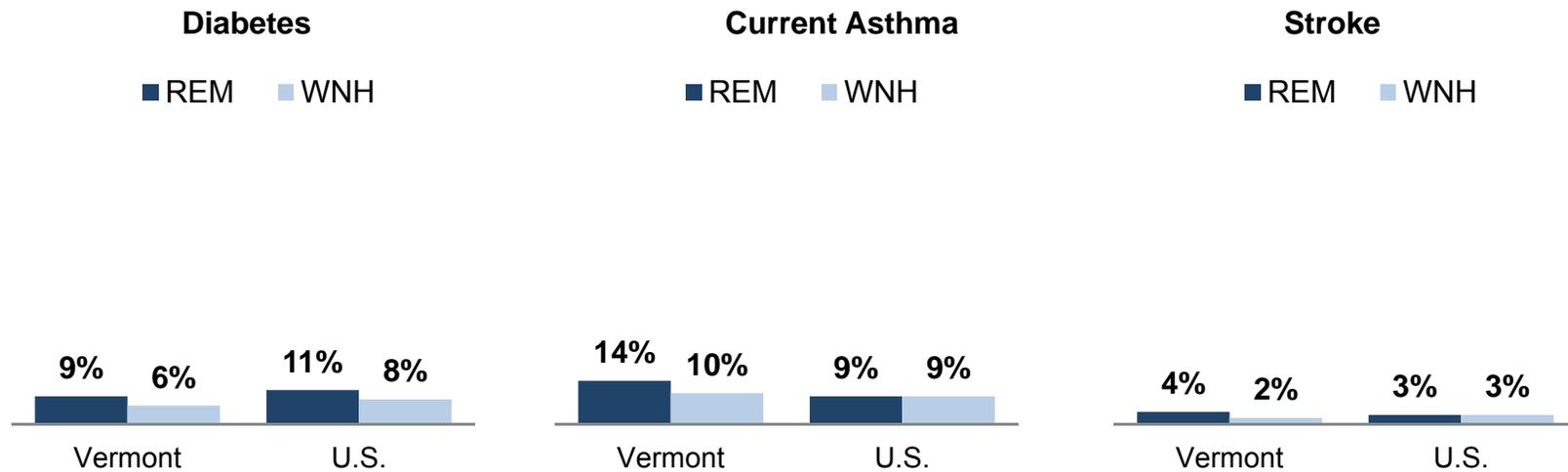


Notes: Obese is defined as a body mass index of 30 kg/m² or greater. Cancer prevalence does not include those ever diagnosed with non-melanoma skin cancer. COPD includes those aged 45 or more. Osteoporosis includes those aged 50 or more. Obesity includes those aged 20 or more. Obesity and osteoporosis prevalence is age adjusted to the U.S. 2000 population.

Vermont and U.S. Comparisons

A higher percentage of racial and ethnic minorities in Vermont reported currently having asthma (14%) or ever having a stroke (4%), compared to racial and ethnic minorities in the U.S. overall. In contrast, a similar percentage of racial and ethnic minorities in Vermont and the U.S. reported ever having been diagnosed with diabetes.

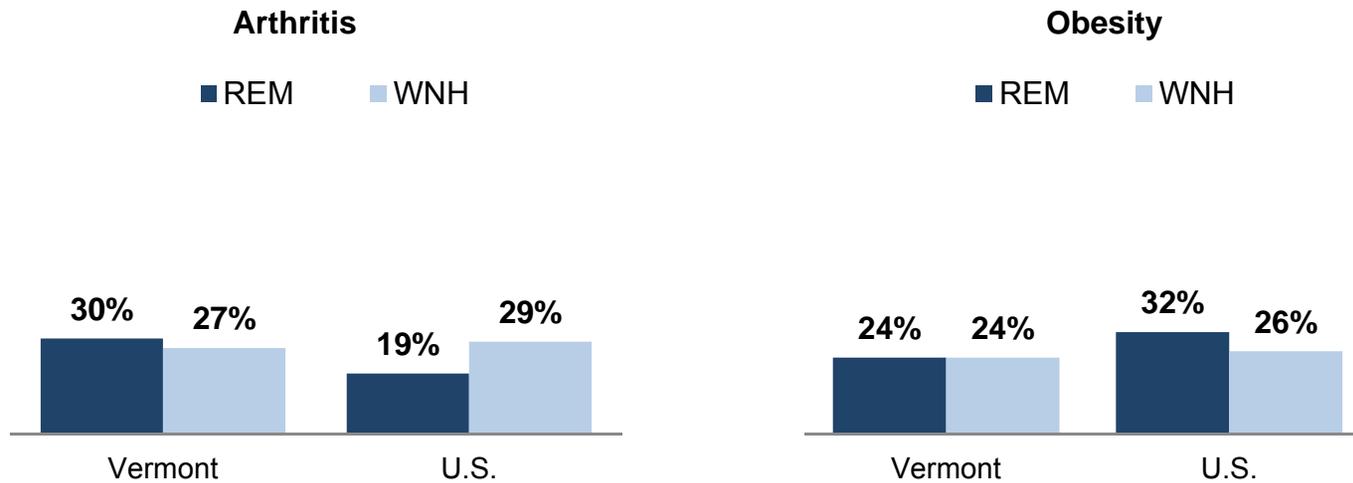
Interestingly, racial and ethnic minorities reported a higher burden of asthma and stroke compared to white non-Hispanics in Vermont, but in the U.S. overall, the burden for asthma and stroke was similar among the two groups.



Vermont and U.S. Comparisons

Racial and ethnic minorities in Vermont, compared to those in the U.S. overall, reported a higher prevalence of arthritis. However, the opposite is seen with obesity prevalence, where a smaller percentage of racial and ethnic minorities in Vermont were considered obese.

It is interesting to note that where racial and ethnic minorities and white non-Hispanics in Vermont had similar prevalence rates for arthritis and obesity, these two groups had significantly different prevalence rates for both of these chronic conditions nationally.



Notes: Obesity prevalence is age adjusted to the U.S. 2000 population and includes adults aged 20 or more.

Adult Risk Factors

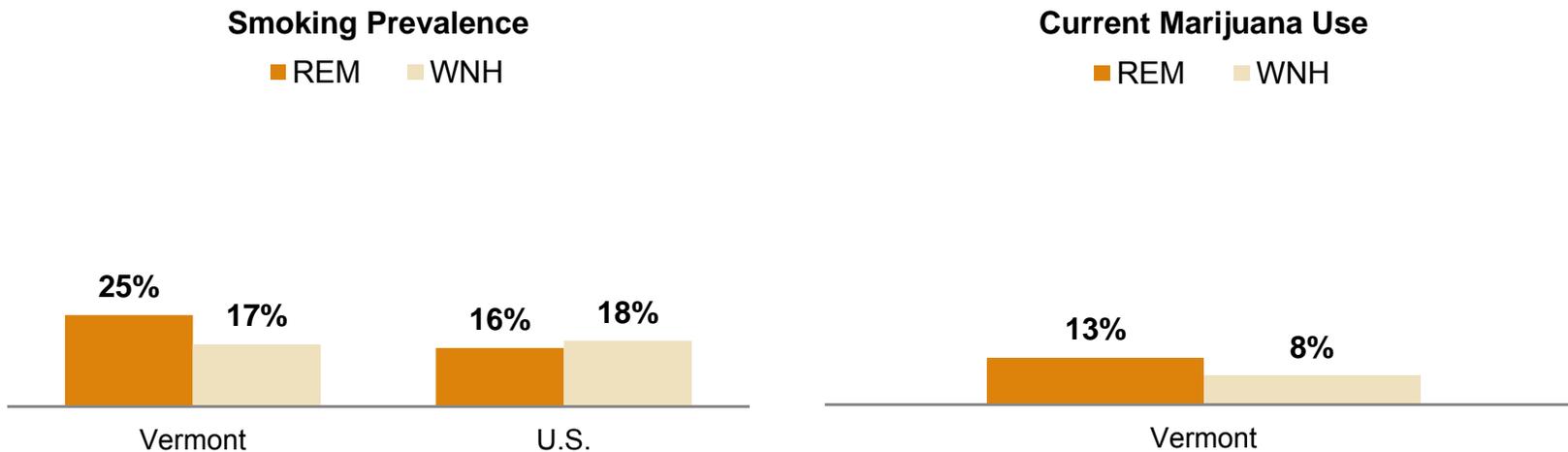
- Tobacco, Drug, and Alcohol Use
- Physical Activity and Nutrition
- Unhealthy Days and Support

Tobacco, Drug, and Alcohol Use

In Vermont, 25% of racial and ethnic minorities reported that they currently smoke, a significantly higher percentage than white non-Hispanics (17%). Interestingly, the opposite is seen when looking at the U.S. overall, where racial and ethnic minorities were less likely to currently smoke.

In addition, racial and ethnic minorities were nearly twice as likely to report current marijuana use, compared to white non-Hispanics, in Vermont. When looking at people who had ever used marijuana, however, no differences were seen (data not shown).

Binge drinking rates were similar between racial and ethnic minorities in Vermont (20%), compared to white non-Hispanics (17%) (data not shown).

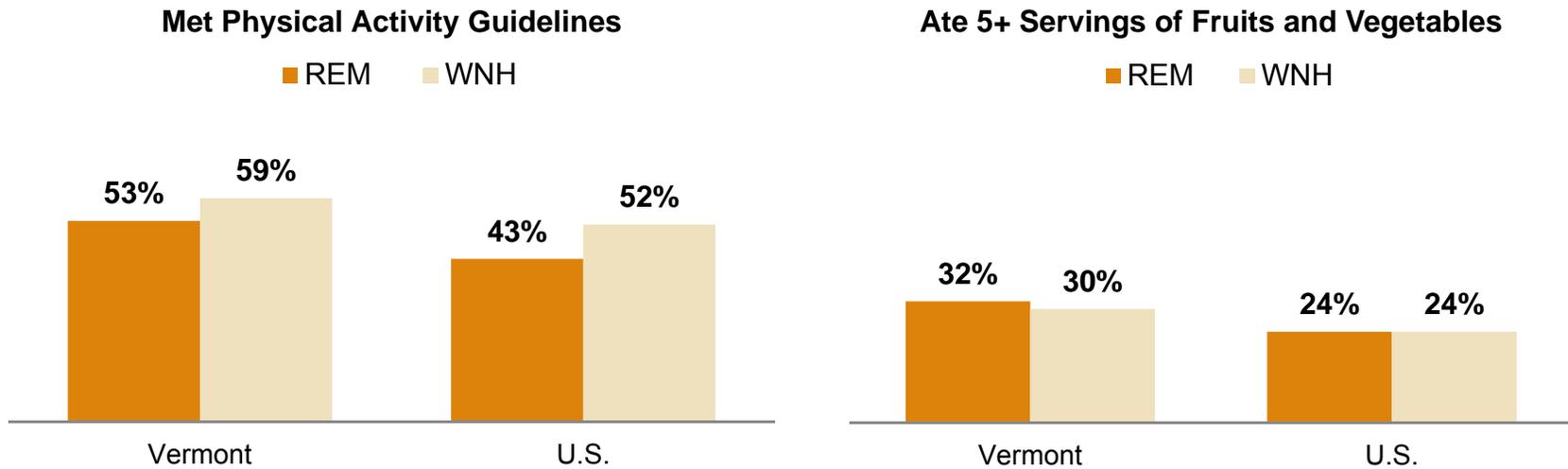


Notes: Smoking prevalence is age adjusted to the U.S. 2000 population. Current marijuana use is defined as use in the last 30 days.

Physical Activity and Nutrition

In Vermont, fewer racial and ethnic minorities met the Centers for Disease Control and Prevention recommended physical activity guidelines (53%), compared to white non-Hispanics (59%). Of note, however, Vermont racial and ethnic minorities were more likely to have met the physical activity guidelines than those nationally.

Both in Vermont and nationally, there were no differences in the proportion who eat the recommended daily serving of fruits and vegetables when comparing racial and ethnic minorities to white non-Hispanics. However, 32% of racial and ethnic minorities met the fruit and vegetable recommendation in Vermont, while only 24% met the recommendation nationally.

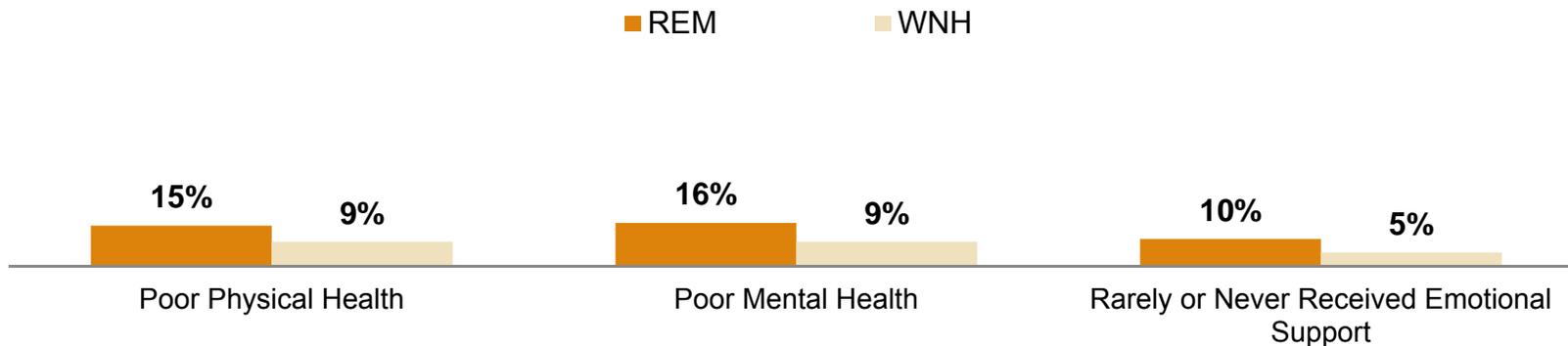


Note: Physical activity guidelines include either: at least 150 minutes of moderate activity per week or 75 minutes of vigorous activity per week. All rates are age adjusted to the U.S. 2000 population.

Unhealthy Days and Emotional Support

When asked about physical and emotional well being, racial and ethnic minorities were more likely to report poor physical health (15%) and poor mental health (16%), compared to white non-Hispanics (9% for both measures).

They were also more likely to report not receiving the emotional support they needed (10%), compared to white non-Hispanics (5%).



Prevention Behaviors

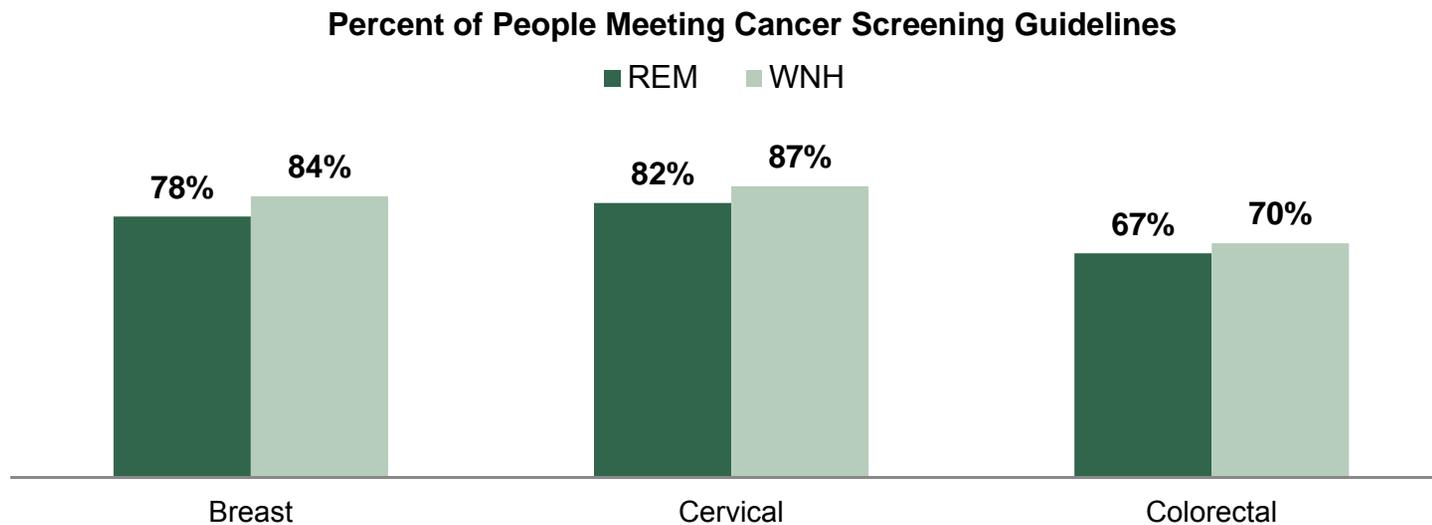
- Cancer Screening
- Cholesterol Testing
- Immunizations
- HIV Testing

Prevention Behaviors

Cancer Screening

In Vermont, racial and ethnic minorities and white non-Hispanics had similar cancer screening rates.

Nationally, however, cancer screening rates were significantly lower for racial and ethnic minorities compared to white non-Hispanics: breast cancer (78% for REMs and 79% for WNHs), cervical cancer (82% for REMs and 84% for WNHs), and colorectal cancer (56% for REMs and 65% for WNHs) (data not shown).

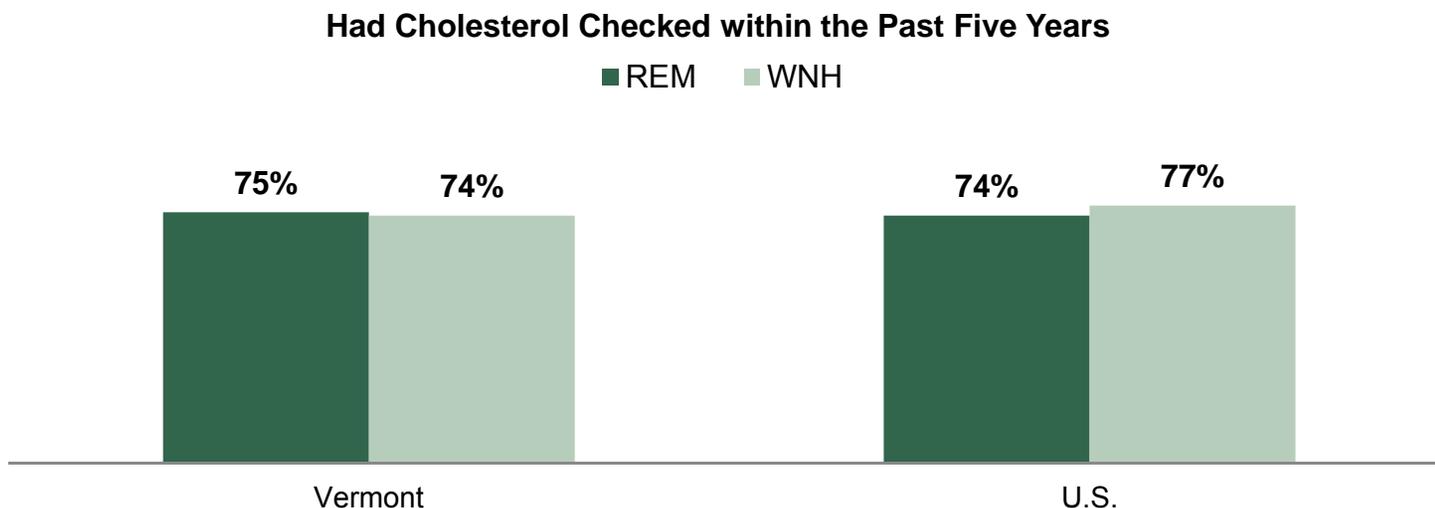


Note: Cancer screening guidelines include women aged 50-74 who had a mammogram in the past 2 years (breast), women aged 21+ who had a Pap test in the past 3 years (cervical), and men and women aged 50-75 who met current guidelines (colorectal). All based on current USPSTF cancer screening guidelines. All rates are age adjusted to the 2000 U.S. standard population.

Cholesterol Testing

About three-quarters of both racial and ethnic minorities and white non-Hispanics, in Vermont, had their cholesterol tested within the past five years.

In the U.S. overall, racial and ethnic minorities were less likely to have had their cholesterol tested in the past five years (74%), compared to white non-Hispanics (77%). Interestingly, racial and ethnic minorities in Vermont had similar rates of cholesterol testing as those in the U.S., whereas white non-Hispanics in Vermont were less likely than those in the U.S. to have had their cholesterol tested.



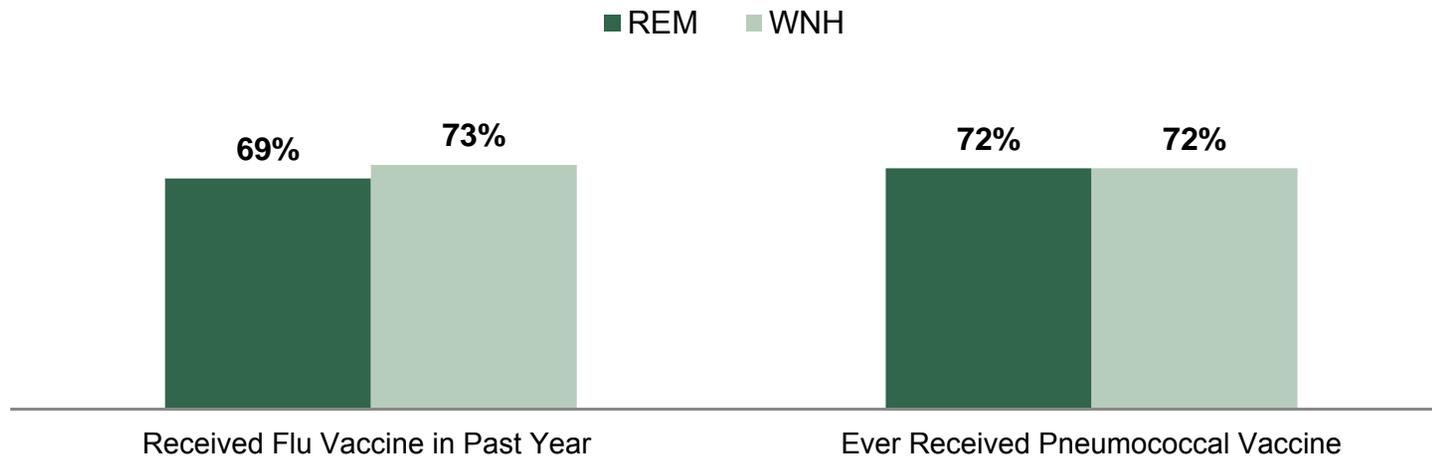
Note: All rates are age adjusted to the 2000 U.S. standard population.

Prevention Behaviors

Immunizations

Approximately seven out of every ten Vermonters had received a flu vaccination in the previous year or had ever received the pneumococcal vaccine. In Vermont, the vaccination rates among racial and ethnic minorities and white non-Hispanics were not different.

In the U.S., however, only 55% of racial and ethnic minorities had received a pneumococcal vaccination ever and 55% had received a flu vaccination in the past year, which are significantly lower rates than for white non-Hispanics (71% and 69% respectively) (data not shown).



Note: Flu and pneumococcal vaccination rates are among men and women aged 65+.

HIV Testing

Among Vermonters, significantly more racial and ethnic minorities had been tested in the past year for HIV (15%), compared to white non-Hispanics (6%). Comparing racial and ethnic minorities in Vermont to those nationally, a similar percentage had been tested.

Tested for HIV within the Past 12 Months

■ REM ■ WNH



Note: HIV testing includes only those aged 18-64 years.

Youth Risk Factors

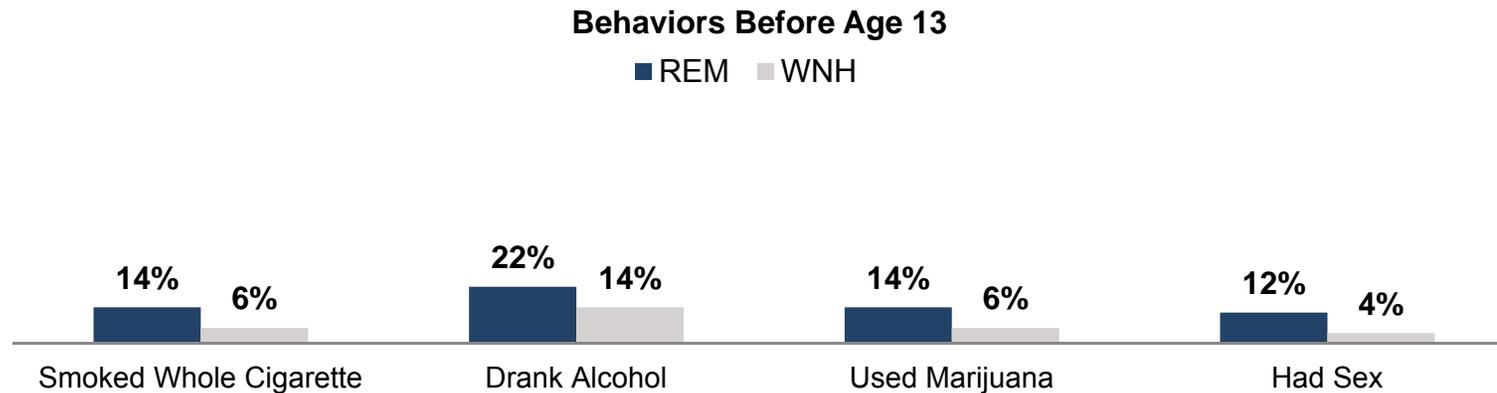
- ❑ Behavior Before Age 13
- ❑ Tobacco Perceptions and Use
- ❑ Personal Safety and Harm
- ❑ Exercise, Nutrition, and Weight
- ❑ Assets

Note: Youth data from the Youth Risk Behavior Survey (YRBS) 2011 are for high school students only.

Behavior Before Age 13

Early adoption of risk behaviors often puts a child at risk for substance abuse later in life.

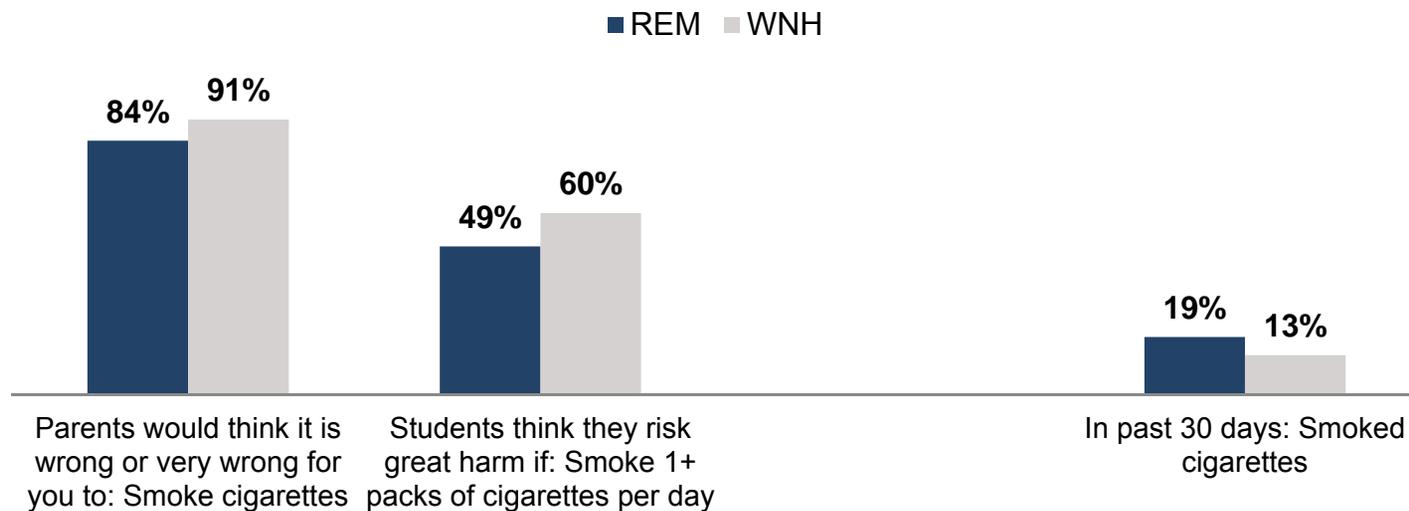
Among Vermont students, racial and ethnic minorities were more likely than white non-Hispanics to report that they smoked a whole cigarette (14% compared to 6%), drank alcohol (22% compared to 14%), used marijuana (14% compared to 6%), and had sex (12% compared to 4%), all before the age of 13.



Tobacco Perceptions and Use

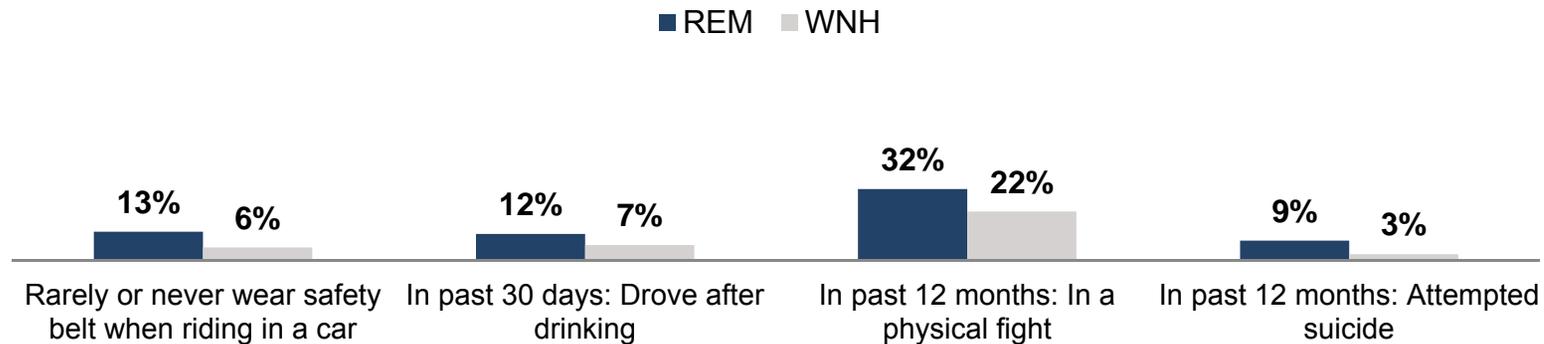
Racial and ethnic minority students were less likely to report that their parents would disapprove of them using tobacco (84%), or that they personally risk great harm from smoking (49%), compared to white non-Hispanic students (91% and 60% respectively).

Additionally, they were more likely to report being current smokers (19%), than white non-Hispanic students (13%).



Personal Safety and Harm

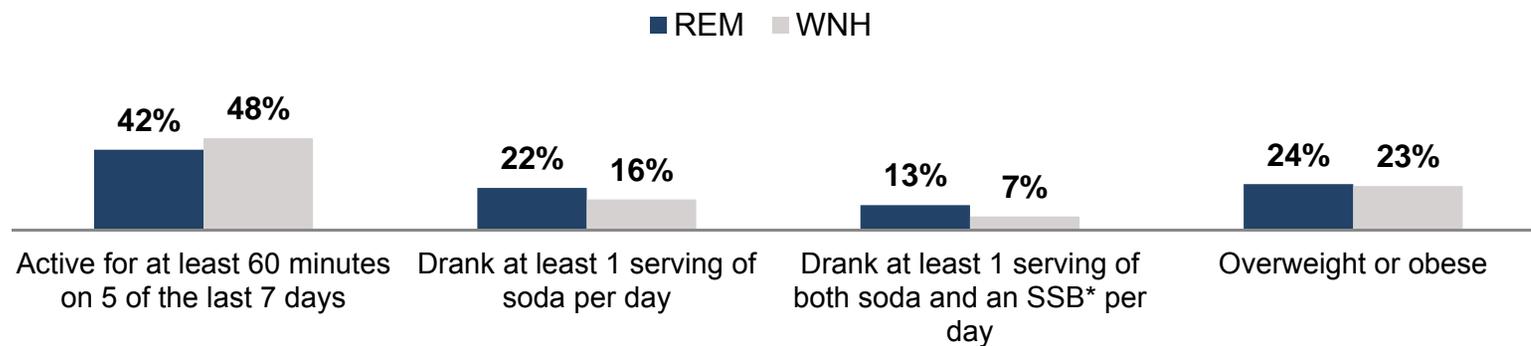
Racial and ethnic minority students were significantly more likely to risk their personal safety than white non-Hispanic students. In 2011, approximately twice as many reported that they rarely or never wear a safety belt or that they drove after drinking, and three times as many reported attempting suicide in the past year.



Exercise, Nutrition, and Weight

Racial and ethnic minority students were significantly more likely to drink soda and sugar sweetened beverages, and were less likely to have met physical activity recommendations, compared to white non-Hispanic students.

Despite this, overweight and obesity rates were similar.



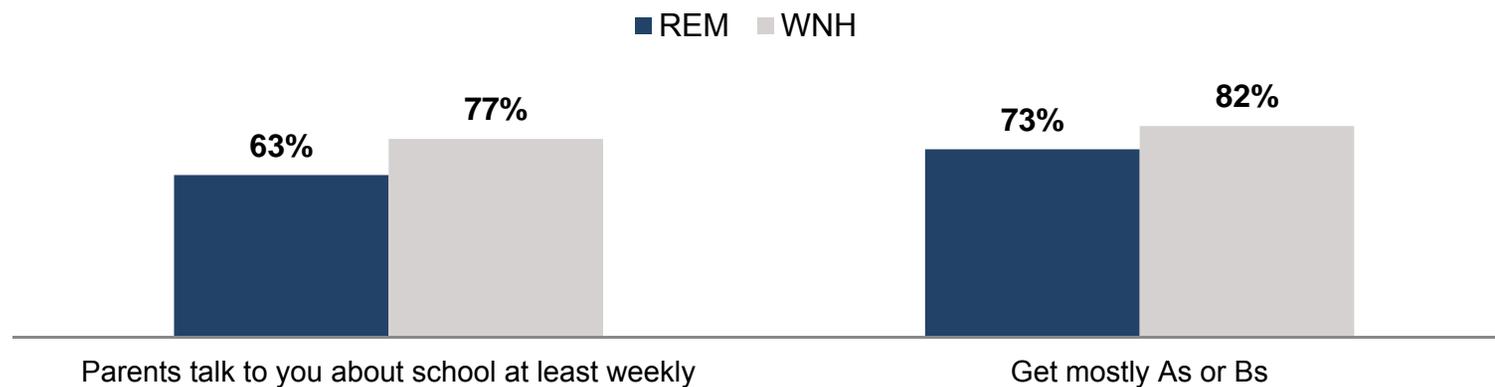
*SSB stands for sugar sweetened beverage, including drinks such as lemonade, sweetened tea or coffee drinks, sports or energy drinks, or juice drinks that are not 100% fruit juice.

Note: Overweight and obesity rates calculated based on self-reported height and weight.

Prevention Behaviors

Assets

Racial and ethnic minority students were less likely to report that they talk to their parents about school (63%), or that they get mostly As or Bs (73%), compared to white non-Hispanic students (77% and 82% respectively).



Data Notes

- Definitions for race and ethnicity
- Data challenges
- Data sources in Vermont

Definitions for race and ethnicity

The Office of Management and Budget (OMB) publishes standards for collecting race and ethnicity data. These standards are required in all national population health surveys and apply to self-reported information. Race and ethnicity are considered separate concepts, and as such, the OMB suggests that race and ethnicity be asked as separate questions.

Presented here are the OMB standard minimum five race categories and ethnicity, which is asked as a yes or no question. Keep in mind, these categories can be expanded to include more detail within each category. For example, a survey could ask if a person identifies as Asian, or this question could be expanded to ask if they identify as Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or Other Asian.

RACE CATEGORIES

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

ETHNICITY

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino”.

Data challenges in Vermont

Vermont is a small state. A majority of the population is white non-Hispanic (94%), with racial and ethnic minorities making up only 6% of the population (U.S. Census, 2010). Because of this, surveillance data are often comprised of very few racial and ethnic minority cases, which often makes reliable statistical analysis tenuous. As such, it can be difficult to view any true differences in health status across racial and ethnic populations. There are some ways, however, to look at the data that can begin to overcome the problem of small numbers.

- When available, multiple years of data can be combined for more statistical power. When using this method, however, trends can become distorted.
- Racial and ethnic minority categories can be combined and compared to white non-Hispanic populations. This can give us an idea about what racial and ethnic minorities are experiencing in Vermont, although it is important to keep in mind that various groups of racial or ethnic minorities experience health disparities differently.
- Population data based on the U.S. Census can be provided by individual racial and ethnic groups, as these data are actual population counts. Only a population profile (e.g. age and gender) can be viewed using this data set, however, as opposed to other demographic health status measures (e.g. income and education).

Currently in Vermont, we can not look at risk factors, morbidity, or mortality for racial or ethnic minorities by county. Unfortunately, the numbers become too small to report, even when using combined racial and ethnic minority categories and multiple years of data. Analyses by county may be achievable in the future as racial and ethnic populations grow in Vermont.

In addition to the above data challenges, some Vermont data sets do not collect data based on current OMB race and ethnicity categories. Others do not actively collect race and ethnicity, resulting in a number of missing values, while others have data collection methods that lead to potentially inaccurate data. It is a goal of the Minority Health Program at the Vermont Department of Health to improve data collection for race and ethnicity.

Data Sources in Vermont

The Office of Management and Budget (OMB) federal regulations has five race categories and two ethnicity categories that they consider standard for data collection. Many data sources in Vermont collect race and ethnicity using either the minimum or more than the minimum five race categories (“American Indian or Alaska Native”, “Asian”, “Black or African American”, “Native Hawaiian or Other Pacific Islander”, and “white”) and two ethnicities (“Hispanic or Latino” and “Not Hispanic or Latino”).

Vermont data sources that meet or exceed the OMB standard categories for race and ethnicity:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavior Survey (YRBS)
- Vermont Vital Statistics System (Births and Deaths)
- Adult Tobacco Survey
- Oral Health Survey
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Student Assistance Program
- Vermont Cancer Registry
- Ladies First
- Immunization Registry
- HIV/AIDS and STD data (not including Hepatitis C)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Vermont data sources that do not meet the OMB standard categories for race and ethnicity:

- Vermont Uniform Hospital Discharge Data Set
- Substance Abuse Treatment Information System (SATIS)
- Treatment Episode Data Set (TEDS)

Vermont data sources that do not collect race and ethnicity data:

- Vermont Prescription Monitoring System (VPMS)
- Adverse Events (Patient Safety) System
- Vermont Vital Statistics System (Marriage and Dissolution Certificates)
- Blood Lead Surveillance System
- Food and Lodging
- Hepatitis C Data