New York State

Minority Health Surveillance Report

2012

Public Health Information Group

Office of Minority Health and Health Disparities Prevention

Center for Community Health

New York State Department of Health

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Executive Summary

The population in New York State is made up of many diverse racial and ethnic groups. Each faces unique strengths and challenges. In fact, New York State's population is becoming more diverse with large increases in both the Asian non-Hispanic and Hispanic populations over the past decade. In order to improve the health of all New Yorkers and to address health disparities in the population, it is critical that there is a base of knowledge and understanding of the variations in factors that influence health outcomes. The 2012 Minority Health Surveillance Report (MHSR) presents data on a wide variety of health indicators in New York State and serves as an important resource for identifying and addressing health disparities.

Among the challenges identified in the Surveillance Report are:

- Hispanic/Latino residents reported the highest percentages of fair or poor health and poor mental health compared to other racial/ethnic groups, occupational lead poisoning, and prevalence of asthma. Also, HIV/AIDS mortality among Hispanics/Latinos was 10 times the rate of White non-Hispanics, and approximately 60 percent of deaths among Hispanics/Latinos were premature (before the age of 75).

- African American/Black, non-Hispanics have the highest rate of diabetes hospitalization and morality; the highest rates of female breast cancer mortality, prostate cancer incidence and mortality; and the highest colorectal cancer incidence and mortality. In addition, individuals in this population also had above average rates among all groups for maternal mortality, infant death and low-birth weight, as well as new HIV cases, heart disease hospitalizations and mortality, and teen and unwanted pregnancies.

- Asian non-Hispanic New Yorkers represents the fastest growing population in the State between 2000 and 2010. While this population generally fared well in comparison to the White non-Hispanic population, the suicide rate was second highest of all racial/ethnic groups and smoking among Asian non-Hispanic high school students was also the second highest. Also, the premature death rate was 44 percent higher than among White non-Hispanic residents in the State, and maternal mortality has risen in recent years after fluctuating for most of the past decade.

- American Indians/Alaska Natives account for less than 1 percent of the New York population and it is more difficult to obtain reliable data to assess health-related risk factors and outcomes. However, high school students in this population had the highest rate of obesity, binge drinking and reported sexual intercourse. Additional concerns were identified regarding prenatal care among women giving birth and lack of physical activity among high school students.

These findings will be used to develop, inform and evaluate evidence-based and community-level interventions to improve health outcomes, while building on actions already undertaken by Governor Andrew M. Cuomo to address health disparities in New York through three high-level initiatives. The first is part of a larger effort to redesign the Medicaid program, through the New York State Medicaid Redesign Team (MRT), to achieve improved health outcomes and reduce costs. The second is by issuing an Executive Order to establish a statewide Health Exchange,

which will lower the cost of insurance and help more than one million uninsured New Yorkers afford coverage – thereby, reducing health disparities in New York communities. The third is through the creation of an Office of Health Disparities Prevention within the New York State Health Department to serve as a statewide resource focused solely on this important public health concern.

In addition, the findings of this report will also inform the State Health Department's ongoing work through its Prevention Agenda for the Healthiest State, the forthcoming State Health Improvement Plan, as well as build on the recommendations offered by the MRT's Health Disparities and Brooklyn work groups.

The MHSR examines more than 100 indicators, including socio-demographic information, health related behavior and disease prevalence statistics, birth-related indicators, rates of emergency department visits, hospitalizations and mortality for an array of diseases and conditions for New York State residents. The following sections highlight, for each racial/ethnic group, health-related indicators that remain a challenge and point to persistent disparities, as well as areas that indicate strengths and improvements.

Hispanic New York Residents

Socio-demographic

- The New York State Hispanic population increased by 19 percent from 2000 to 2010, the second largest percentage increase among all racial/ethnic groups (Asians increased the most at 35.7 percent). There were 3,416,922 Hispanics living in New York in 2010, approximately 18 percent of the total state population. More than 25 percent of all New York State Hispanics and one-third of Hispanic children were living below the federal poverty level in 2010, compared with only 9 percent of White non-Hispanics and 11 percent of White non-Hispanic children, respectively.

- Median household income in 2010 for Hispanic households was $37,781, well below the New York State average of $54,659. Over 58 percent of Hispanic households used at least 30 percent of their income for housing costs. Almost 30 percent of Hispanic adults were not covered by health insurance, which was higher than any other racial/ethnic group in New York State. Twenty-two percent did not see a doctor when they needed to because of the cost.

Challenges

- Hispanic New Yorkers reported the highest percentages of fair or poor health and poor mental health when compared to all other racial/ethnic groups. Hispanics also experienced the highest incidence of occupational related lead poisoning which can lead to permanent damage to major organ systems. About 60 percent of deaths among Hispanics are premature (before the age of 75), compared to only 34 percent among White non-Hispanics.

- Obesity among Hispanics increased steadily over the past decade to 29 percent of the adult population in 2010. Among children aged 2-4 participating in the Women, Infant and Children (WIC) program, Hispanics had the highest rate of obesity. Hispanic high school students also experienced higher rates of obesity as compared to White non-Hispanic students. Lack of exercise is a risk factor for obesity and its related consequences. Almost 35 percent of Hispanic adults reported they do not participate in any leisure-time physical activity. This was the highest percentage among all racial/ethnic groups. Hispanic high school students were twice as likely to report not participating in 60 minutes of physical activity daily, as compared to White non-Hispanic students.

- The prevalence of diabetes among adult Hispanics has remained at about 10 percent over the past decade, but hospitalizations related to diabetes have risen 15 percent during the same time period. Diabetes prevalence, hospitalization and mortality rates among Hispanics were considerably higher than rates among the White non-Hispanic population.

- Hispanics adults had the highest prevalence of current asthma among all racial/ethnic groups. Hispanic children and adults were three times more likely to be hospitalized and four times more likely to die due to asthma than their White non-Hispanic counterparts. Asthma-related emergency department visit rates were also three times higher among Hispanics as compared to rates among White non-Hispanics.

- The HIV/AIDS mortality rate among Hispanics was 10 times higher than the rate among White non-Hispanics and new cases of HIV/AIDS among Hispanics occurred at a rate six times greater than among White non-Hispanics. Early sexual activity is a risk factor for contracting HIV/AIDS. Almost half of Hispanic high school students reported ever having sex compared to about 40 percent of White non-Hispanic students. Among sexually active students, Hispanics were the least likely to report using a condom. More than 12 percent of Hispanic female high school students reported being forced to have sexual intercourse compared to about five percent of White non-Hispanics students. The teen pregnancy rate among Hispanics between the ages of 15 and 17 was five times higher than the rate among their White non-Hispanic counterparts.

Strengths and Improvement

- Hispanic women were the most likely of all racial/ethnic groups to initiate breastfeeding and second most likely to continue breastfeeding their newborns during the first eight weeks of life. They also had the second lowest rate of drinking alcohol and smoking during the last three months of pregnancy.

- Mortality rates for heart disease, cerebrovascular disease, chronic lower respiratory disease, and suicide have all declined and were lower among Hispanics as compared to White non-Hispanics and Black non-Hispanics. Although deaths from non-motor vehicle unintentional injury have increased over the past decade, Hispanics continued to have lower rates than White non-Hispanics and Black non-Hispanics.

- Breast cancer mortality rates among Hispanic women were markedly lower than among White non-Hispanic and Black non-Hispanic women. Colorectal cancer mortality was also lower among Hispanic men and women as compared to White non-Hispanics and Black non-Hispanics.

Black Non-Hispanic New York Residents

Socio-demographic

- The Black non-Hispanic population decreased approximately one percent from 2000 to 2010 and was 14 percent (2,783,857) of the total New York State population in 2010. Poverty has disproportionately affected this group. Almost 21 percent of all Black non-Hispanic New Yorkers and 29 percent of Black non-Hispanic children lived below the federal poverty level in 2010, compared to only 9 percent of White non-Hispanics and 11 percent of White non-Hispanic children.

- Median household income among Black non-Hispanic households was relatively low ($40,245), as compared with the statewide average of $54,659. More than half of Black non-Hispanic households spent at least 30 percent of their household income on housing costs. About 17 percent of Black non-Hispanic adults were uninsured and 16 percent indicated they did not see a doctor when they needed to because of cost, as compared to 10 percent and nine percent among White non-Hispanics, respectively.

Challenges

- Black non-Hispanics had the highest rates of diabetes hospitalization and mortality as well as the highest adult prevalence of diabetes and obesity.

- While adult asthma prevalence rates were similar for White non-Hispanics, Black non-Hispanics and Hispanics, the death rate due to asthma was more than four times higher among Black non-Hispanics than it was among White non-Hispanics. Black non-Hispanics had an emergency department visit rate due to asthma that was six times the rate for White non-Hispanics and more than four times the hospitalization rate due to asthma. Among youth ages 0-17, Black non-Hispanics were hospitalized due to asthma at a rate more than five times that of White non-Hispanics.

- Black non-Hispanics experienced the highest rates of female breast cancer mortality, prostate cancer incidence and mortality, and female and male colorectal cancer incidence and mortality. They also had the lowest rates of early stage diagnosis for breast, cervical and colorectal cancers.

- Disparities were especially evident for breast cancer. The incidence was more than 40 percent higher among White non-Hispanic women compared to Black non-Hispanic women, however, a higher rate of Black non-Hispanic women died from the disease.

- The time before and after a birth is when the health of women and infants is particularly vulnerable. Black non-Hispanics experienced maternal mortality, infant death and low birth weight rates above the rates for all other groups. Black non-Hispanic women were the most likely to have an unintended pregnancy, or a teen pregnancy and to be obese before pregnancy. They also had the lowest breastfeeding initiation rate and were less likely to place their babies to sleep on their backs, which is an important factor for reducing the risk of sudden infant death.

- Injury and violence are significant issues that contribute to poor health outcomes and disability. Emergency department visits due to an unintentional injury have increased over the past five years for all racial/ethnic groups and were highest among Black non-Hispanics. Additionally, the assault-related emergency department visit rate was four times higher and the homicide rate, 10 times higher among Black non-Hispanics as compared to White non-Hispanics.

- Black non-Hispanics had a high rate of hospitalizations that were potentially preventable (as defined by the U.S. Agency for Healthcare Research and Quality). This can be an indication of delayed or poor primary care for acute conditions. The rate among Black non-Hispanics was about 65 percent higher than the rate for White non-Hispanics. Black non-Hispanics aged 50 and older were also the least likely to receive a flu vaccination.

- Other measures that indicate that Black non-Hispanics fared the worst as compared to other racial/ethnic groups include the HIV new case rate and mortality, cerebrovascular and heart disease hospitalizations and mortality, emergency department visit rate due to unintentional poisoning and the drug-related hospitalization rate.

Strengths and Improvements

- Deaths due to HIV/AIDS, asthma, cerebrovascular disease, and deaths that were drug induced have been reduced markedly (between 37 and 66 percent) with corresponding reductions in the disparity between Black non-Hispanics and other racial/ethnic groups.

- Suicide mortality has continued to be lower among Black non-Hispanics, as compared to other racial/ethnic groups, and was half the rate of suicide among White non-Hispanics.

- Early stage diagnosis of colorectal cancer has been improving for both male and female Black non-Hispanics.

- Black non-Hispanic high school students had low rates of smoking and binge drinking as compared to White non-Hispanic students.

- While teen pregnancy was highest among Black non-Hispanics, their rate went down by 30 percent during the past ten-year period.

- Black non-Hispanic women were the least likely to drink during the last three months of pregnancy.

Asian Non-Hispanic New York Residents

Socio-demographic

- Asian non-Hispanic New Yorkers were the fastest growing population group in the state between 2000 and 2010, and made up about seven percent of the New York State population in 2010.

- About 16 percent of all Asian non-Hispanics and almost 19 percent of children were living below the federal poverty level in 2009. At the same time, this group ranked the second highest for both median household income ($59,244) and the percentage (60%) of population (ages 25 years and older) with at least some college education compared to all other racial/ethnic groups. More than 50 percent of Asian non-Hispanic households spent 30 percent or more of their income on monthly housing costs.

- Over time, the proportion of Asian non-Hispanic adults without health insurance has declined with the lowest percentage (14%) during 2007-2009. A similar trend occurred for the percentage of Asian non-Hispanic adults who indicated that they did not see a doctor, when needed, due to cost (8.9% during 2007-2009).

Challenges

- Although Asian non-Hispanics had the second-lowest percentage of premature death (before age 75 years), the rate was still 44 percent higher than among White non-Hispanics.

- Maternal mortality among Asian non-Hispanic women has fluctuated over the past decade with increases in recent years.

- The percentage of Asian non-Hispanic women consuming alcohol during the last trimester of pregnancy was lower than the percentage among White non-Hispanics, but higher than among Black non-Hispanics and Hispanics.

- While smoking prevalence for Asian non-Hispanic adults was the lowest among all racial/ethnic groups, the smoking prevalence among Asian non-Hispanic high school students was the second highest.

- The suicide rate among Asian non-Hispanics was the second highest of all racial/ethnic groups.

Strengths and Improvements

- Asian non-Hispanic New Yorkers had the lowest rates of adult smoking, high school student binge drinking, adult physical inactivity, and child and adult obesity. This group also had the lowest number of years of potential life lost.

- Asian non-Hispanics fared best, as compared to other racial/ethnic groups for chronic disease prevalence, emergency department visits, hospitalizations, and deaths related to asthma, chronic obstructive pulmonary disease, and cardiovascular diseases.

- Asian non-Hispanics had the lowest rates of breast, prostate, and colorectal cancer incidences and mortality compared to all racial/ethnic groups.

- Asian non-Hispanics had the lowest rates of injury-related emergency department visits, hospitalizations and deaths. In addition, Asian non-Hispanics also ranked best for potentially preventable hospitalizations and incidence of elevated blood lead level among employees.

- Asian non-Hispanic New Yorkers also had the lowest rates of teen pregnancy, pre-pregnancy obesity, and infant mortality. They were the second most likely racial/ethnic group to initiate breastfeeding and the most likely to continue for at least eight weeks.

American Indian/Alaska Native New York Residents

This section focuses on the challenges and strengths for this group that can be described from the available data presented in this report. Because of the lack of information regarding hospitalization and death rates, as well as adult health risk behavior and disease prevalence statistics, this summary does not fully describe the health status of American Indian/Alaska Natives.

Although data are limited for this group, information is available from the Youth Risk Behavior Survey, a survey of high school students. Caution should be used when interpreting these statistics because of large confidence intervals around the results due to the small number of American/Indian Alaska Natives participating in the survey.

Birth and death related statistics are also included in this report. The quality of self-reporting and coding of race information for American Indian/Alaska Natives in New York State is known to be challenging for birth and death records. Therefore, caution when interpreting the results is advised. Other data included in this report are from the WIC Program and the HIV/AIDS Surveillance System.

Socio-demographics

- The American Indian/Alaska Native non-Hispanic population increased by about 2 percent from 2000 to 2010 and accounted for less than 1 percent (53,908) of the total New York State population. American Indian/Alaska Native New Yorkers had the highest rates of poverty among both children and adults compared to all other racial/ethnic groups in New York State. Specifically, almost 28 percent of all American Indian/Alaska Natives and 38 percent of American Indian/Alaska Native children lived below the federal poverty level in 2010. These rates were three times higher as compared to White non-Hispanics.

- American Indian/Alaska Native households had the lowest median household income ($36,772) compared to the four other racial/ethnic groups analyzed in this report. More than half of American Indian/Alaska Native householders who were renters, and 47 percent who owned their own homes, spent at least 30 percent of their household income on housing costs.

- Among American Indian/Alaska Natives aged 25 or older, 44 percent attended at least some college. This was considerably lower than the proportion of all New York State adults (57 percent) and the proportion among White non-Hispanics (63 percent).

Challenges

- One of the challenges in assessing health-related risk factors and outcomes for American Indian/Alaska Natives is the lack of reliable New York State specific health statistics. Under reporting of American Indian/Alaska Native population counts in Census data, as well as miscoding, and the absence of race information on the birth and death records for this group contribute to the limited statistics available.

- The leading causes of death among American Indian/Alaska Native non-Hispanics in 2009 were heart disease, cancer, diabetes, chronic lower respiratory diseases and unintentional injury.

- American Indian/Alaska Native high school students had the highest rates of binge drinking as compared to White non-Hispanic, Black non-Hispanic, Asian non-Hispanic and Hispanic students.

- American Indian/Alaska Native high school students were also the most likely to report they have had sexual intercourse. Among female students, more than half reported being forced to have sexual intercourse. Early sexual activity is a risk factor for teen pregnancy, HIV/AIDS and other sexually transmitted diseases.

- Obesity, which is a risk factor for diabetes, heart disease and certain types of cancer, was highest among American Indian/Alaska Native high school students and second highest among American Indian/Alaska Native children aged 2-4 participating in the WIC program. Additionally, these high school students also had the highest rates of reported lack of physical activity (for at least 60 minutes per day) and daily television watching for three or more hours.

- About 65 percent of American Indian/Alaska Native non-Hispanic women giving birth received early prenatal care and 60 percent received adequate care. These rates are higher than rates among Black non-Hispanics, but below the rates among White non-Hispanics and Asian Pacific Islander non-Hispanics.

Strengths and Improvements

- American Indian/Alaska Natives have the lowest HIV new case rate among all racial/ethnic groups included in this report.

- Among American Indian/Alaska Native non-Hispanics, there were no maternal deaths between 2000 and 2009. This group also had a low rate of infants born at a low birth weight. Only White non-Hispanics had a lower rate.

Introduction

As part of its overall effort to improve minority health in New York State, The New York State Department of Health analyzes the health status of minority residents and the factors that affect health care access, quality and outcomes; and creates and disseminates a biennial minority health surveillance report.[1]

This Minority Health Surveillance Report (MHSR) provides a picture of the health status of New York State's racial and ethnic populations. This report is an important step in New York's commitment to numerous efforts nationally and within the state to eliminate differences in health status and improve the health of its residents. This report is based on data available as of calendar year 2009, assessing more than 100 health-related and socio-demographic indicators for New Yorkers, by race and ethnicity and, where available, by income. These indicators are presented in the following sections of this report:

- Population and Socio-demographic Characteristics,
- General Health,
- Maternal and Child Health,
- Risk Factors,
- Disease Prevalence,
- Emergency Department Visits and Hospitalizations, and
- Mortality.

All indicators in this report are presented for the following groups: Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic, and White non-Hispanic. Information for the American Indian/Alaska Native group is presented for a smaller number of indicators, where data are available.

The report also highlights areas of improvement, areas of continuing disparity, and areas where significant problems exist for Hispanics, Black non-Hispanics, Asian/Pacific Islander non-Hispanics, and American Indian/Alaska Natives.

The MHSR serves as a tool for raising awareness about minority health in New York State, including differences in health outcomes among racial and ethnic minorities. The challenges associated with collecting and analyzing race and ethnicity data have been well documented.[2,3,4] Two in particular are worth mentioning:

- There are disparities by race, as well as by socioeconomic status. These factors, while inter-related, are likely to play distinct, independent roles.[5] Therefore, the MHSR provides selected indicators that were analyzed by both race/ethnicity and income where data were available.

- There are three types of data showing promise as effective tools to monitor health status of populations: patient or population-based assessments, medical and administrative record data audits, and health outcome data.[6] This report uses New York State Department of Health's Behavioral Risk Factor Surveillance System as a population-based behavioral assessment data source. State vital records, hospital encounter data and

Cancer Registry data are used in this report and illustrate objective health outcomes. Medical and administrative record data audits are currently not available but could be pursued in future editions, if data are available and resources permit.

In addition, this report acknowledges that gaps exist in data reporting on other underserved populations such as persons with disabilities and persons with limited English proficiencies. It is anticipated that future Minority Health Surveillance Reports will incorporate improved measures and expanded analyses, where data are available, to provide more detailed information on race, ethnicity, gender identity, disabilities, and characteristics of other underserved populations--including characteristics historically linked to exclusion or discrimination or known to influence health status[7].

New York is an increasingly diverse state. To improve the health of all New Yorkers, it is critical that we continue to build knowledge and understanding of the variations in health outcomes that span across racial and ethnic groups, underserved populations and socio-economic boundaries. The MHSR reflects the growing recognition that despite progress in clinical and applied research, and diagnosis and treatment, minority and other underserved populations continue to bear a disproportionate burden of illness in the United States and New York State. The disproportionate burden of illness is evidenced in minority communities as shorter life expectancies and higher rates of cardiovascular disease, infant mortality, asthma, diabetes, stroke, and HIV infection and AIDS.

When compared to the health and well-being of the general population, racial and ethnic minorities demonstrate significant differences in rates of disease and the rates at which people die from diseases.[8] Disparities in health outcomes reflect the diseases, disorders, and conditions that unequally affect persons who are members of racial and ethnic minority groups. A disparity "acts as a signpost—indicating that something is wrong; if a disparity is identified and described, then the health community, public and policy makers can become more aware of it".[9] The causes of disparities are complex, but they are believed to be the result of intricate interactions among factors such as social and physical environments; education; healthcare systems and policies; socioeconomic status; biology; genetics; health behavior; and lifestyle choices and practices.[10]

What Is a Health Disparity?

Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

U.S. Department of Health and Human Services.

Among the numerous reports that have documented racial and ethnic differences in the status, access, and quality of health, two major factors[11] are seen as contributing to the challenge:

- ***Care that is not accessible***
  Geographic, linguistic, cultural, and health care financing factors may impede access to care.

- ***Care that is of substandard quality***
  Quality of care is typically measured by examining its effectiveness, safety, timeliness, and ability to meet individual patient needs. Even when minorities have similar levels of access to care, health insurance, and education, the quality and intensity of health care they receive is often substandard. A substandard quality of care may result from a number of factors including patient-provider miscommunication, provider discrimination, stereotyping, or prejudice.

The federal government has acknowledged the need to examine health disparities and address their underlying causes, most recently through the January 2011 release of the "Health Disparities & Inequalities Report"[12] by the U.S. Centers for Disease Control and Prevention, followed by the April 2011 unveiling of the "HHS Action Plan to Reduce Racial and Ethnic Health Disparities,"[13] and its companion document "*The National Stakeholder Strategy for Achieving Health Equity*".[14]

New York State Initiatives Responding to Health Disparities

In New York, Governor Andrew M. Cuomo is addressing health disparities through three high-level initiatives. The first is part of a larger effort to redesign the Medicaid program to achieve improved health outcomes and reduce costs. The second is by issuing an Executive Order to establish a statewide Health Exchange, which will lower the cost of insurance and help more than one million uninsured New Yorkers afford coverage. The third is through creation of an Office of Health Disparities Prevention within the State Health Department to serve as a statewide resource focused solely on this important public health concern.

Governor Cuomo's unique approach to Medicaid reform relies upon convening key Medicaid stakeholders to collectively develop recommendations to change course and rein in Medicaid spending, while at the same time improving quality. Governor Cuomo's vision for collaboration was effectuated through Executive Order #5 which created the New York Medicaid Redesign Team (MRT) in January 2011. The MRT, made up of 27 stakeholders, represented virtually every sector of the health care delivery system and developed a series of recommendations that not only lowered immediate spending, but also proposed important reforms to improve health outcomes. To address priority policy issues the MRT broke into a series of workgroups during 2011. Two of these workgroups specifically addressed health disparities; a Health Disparities Workgroup and a workgroup convened to address health care access in Brooklyn, a region recognized as experiencing significant disparities in access to care.

The Medicaid Redesign Team (MRT) Health Disparities Workgroup was comprised of experts speaking on behalf of persons who experience disparities from multiple perspectives including: race and ethnicity; persons with disabilities; persons with limited English proficiency (LEP); immigrants; lesbian, gay, bisexual and transgender persons; persons with mental illness; persons with substance abuse disorders and persons at risk of suicide. Specific actions recommended by this workgroup and endorsed by the full MRT include:

- Expand data collection standards and metrics to measure disparities with detailed reporting on race and ethnicity, gender identity, and disability status;
- Provide funding to support data analysis and research to facilitate the department's disparities reduction work;
- Improve language access through enhanced reimbursement for interpretation services for patients with limited English proficiency, as well as communication services for people who are deaf or hard of hearing;
- Promote language accessible and comprehensible prescriptions for limited English proficiency patients;
- Improve access to care, early diagnosis and management of chronic conditions through expanded Medicaid coverage;
- Strengthen the provision of culturally competent care through mandated training of the New York State health care workforce; and
- Enhance services to youth in transition with psychiatric disabilities, and promote maternal and child health, harm reduction and Hepatitis C care coordination.

These recommendations will be implemented over the coming years.

A second MRT workgroup focused on health disparities in Brooklyn where sub-optimal inpatient, emergency department and primary care access was found to vary by neighborhood and to correlate with health professional shortage area (HPSA) designations and poverty. High rates of preventable emergency department visits and preventable hospitalizations suggest that patients are not accessing appropriate or effective primary care necessary to keep them healthy and out of the hospital. The Brooklyn MRT work group developed the following recommendations to address these disparities:

- Appoint a Brooklyn Healthcare Improvement Board;
- Provide financial support for restructuring through an application process;
- Support involvement of private physician practices in integrated health systems;
- Develop new alternatives for capital support of primary care providers; and
- Provide funding for a multi-stakeholder planning collaborative in Brooklyn.

While facing unprecedented challenges, Brooklyn's healthcare community is also engaged in a variety of innovative activities intended to improve the health of its communities. One such effort is The Brooklyn Health Improvement Project (BHIP), a HEAL-funded project created in 2009 and led by SUNY Downstate. This multi-stakeholder collaborative is engaged in developing a comprehensive community health planning process with the goal of developing community engagement and primary care access strategies to improve community health. The BHIP is governed by a broad-based coalition that includes representatives of community-based organizations, hospitals, Federally Qualified Health Centers (FQHCs), health plans, business, and civic leaders.

On April 12, 2012, Governor Cuomo issued an Executive Order to establish a statewide Health Exchange in New York, a move that will significantly reduce the cost of coverage for individuals, small businesses and local governments, while making it easier for all New Yorkers to compare health insurance prices, benefits, and health plan performance. The Exchange is a

requirement of the federal Affordable Care Act, which was created to give families and businesses more control over their health care by providing greater benefits and protections for family members and employees.

New York's Health Exchange will be instrumental in establishing the first-ever comparative marketplace to bring down the cost of health insurance. By lowering the cost of health insurance, the Exchange will also help more than one million uninsured New Yorkers afford coverage. Through the Exchange more New York families, including minorities, will gain access to quality health care coverage. According to a recent study conducted by the United Hospital Fund, racial and ethnic minorities are far more likely to be uninsured than Whites in New York State. More specifically, Hispanics have a 25 percent uninsured rate and African Americans have a 21 percent uninsured rate, compared to Whites at 11 percent.[15] The establishment of the Exchange will be integral to helping reduce health disparities in New York State.

The newly created Office of Health Disparities Prevention will serve as a statewide resource for effecting change to eliminate health disparities. This new Office will collaborate with government systems, public and private partners, communities and individuals to strengthen the health care delivery system so that high quality, affordable and accessible health care is available to all New Yorkers. The Office will continue to build upon proven effective initiatives to reduce disparities and will continue a collaborative relationship with the U.S. Health and Human Services, Office of Minority Health.

Finally, New York's state health improvement plan, the Prevention Agenda toward the Healthiest State,[16] is being updated this year for the next five years. The new Prevention Agenda 2013-2017 will identify the state's public health priorities and describe strategies that can be implemented to improve health status and to address important disparities in those priority areas.[17]

The literature on health disparities highlights three important themes related to the use of race and ethnicity data for the provision of high quality, evidence-based health care services.

- Disparities cannot be addressed if they are not identified[18] and failure to collect, record and use race and ethnicity data translates into missed opportunities to ensure the best possible care and measurement of progress toward desired goals.[19]
- Culturally and linguistically competent health care systems that reduce communication barriers must be data-driven.[20, 21]
- Race and ethnicity data help to quantify the impact of interventions to reduce or eliminate racial and ethnic health disparities.[22]

It is clear that achieving our state's public health and health care goals cannot be realized without addressing health disparities. The State Health Department remains committed to collecting accurate, quality data on the health status of populations as important prisms through which public health interventions, quality of care, utilization of health services, health outcomes and satisfaction with health care services can be assessed and compared over time.[23] The State Health Department will continue to develop and support initiatives that help reduce health

disparities, with the goal of ensuring that all New Yorkers have access to the resources and services they need to be healthy.

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Racial and Ethnic Groups

Hispanics/Latinos

Background and Demographics

Hispanic ethnicity refers to people of Mexican, Puerto Rican, Cuban, Central and South American cultures of origin, regardless of race.[1] Hispanics (also called Latinos) make up the largest ethnic group in New York State. The health of Hispanics, including children, is significant given that this population comprises approximately 17 percent of New York State's populations with approximately 29 percent younger than 18 years old compared with approximately 23 percent for the total State's population.[2] Although the population remains numerically concentrated in New York City, smaller cities across the state have been experiencing significant increases in subgroups of Hispanic populations. This is due in part to greater Hispanic migration and immigration. In New York and nationally, the need for culturally and linguistically appropriate health care is magnified by growth of the Hispanic population and by the severity of its health problems.

Hispanic/Latino Health Concerns and Challenges

Of all racial-ethnic groups, Hispanics have the lowest health insurance rate. Disparities in access to care between Hispanics and other racial-ethnic groups are striking, and studies suggest that immigration status, language and community environment play important roles in access among New York's Hispanics. The "Latina paradox" is a recurring theme in discussions on women's health. Epidemiological research has shown that despite their parents' socioeconomic disadvantages, Latino infants are less likely than other U.S. infants to experience low birth weight and mortality. [3] The paradox can be explained partly by the functioning of informal prenatal systems of care (consisting of family, friends, community members, and lay health workers) that confer culturally and socially mediated benefits responsible for the better-than-expected birth outcomes.

Building Relationships with Hispanic/Latino Communities

In order to build trust and relationships with Hispanic/Latino communities, we must be aware of and understand the variances in Hispanics'/Latinos' history, dialects, cultural beliefs, traditions, and values.

African Americans

Background and Demographics

When viewed within a broad historical and social context, the African American experience in the United States has been and continues to be marked by race matters. While other racial-ethnic groups are much more likely to be foreign-born, immigrant history and status are also important dimensions of variation within African American populations. According to 2010 U.S. Census data, African Americans make up 12.6% of the U.S. population and 15.9% of the New York State population[4]. In New York City, African-Americans make up 22.8% of the population. This percentage includes African-American immigrants from the Caribbean.[5] In recent years, the number of immigrants from Africa has grown significantly.

African American Health Concerns and Challenges

African Americans continue to be disproportionately affected by health problems. Considerable research has provided evidence of complex health care disparities between African American and non-Hispanic white Americans, including socioeconomic differences, structural characteristics (such as lack of access to care) and racial bias in the health care system.[6] Over the years, there has not been a significant reduction in African Americans' mortality and morbidity rate. African Americans' historic experience with the health care system has been marked by health inequities and a shortage of preventive interventions that fully address the population's social, economic and environmental situations. Efforts to engage African Americans may be hindered by lingering mistrust of the medical system and dissatisfaction with provider treatment.

Building Relationships with African American Communities

Efforts to build and sustain relationships with African Americans must be grounded in trust, a sustained presence in the community, and a recognition and appreciation for the resilience of African American populations. Health providers without this knowledge or experience may be unaware of the African American heterogeneity, or the efforts needed to develop and maintain trust with the subgroups.

Asian and Pacific Islander Americans

Background and Demographics

The Asian and Pacific Islander Americans (APIAs) population is made up of racial-ethnic groups originating from at least 28 Asian countries and 25 Pacific Island cultures.[7] This is not a monolithic group; subgroups differ considerably in socioeconomic status, English language proficiency, citizenship status, religion, immigration history, health care utilization, beliefs, status and outcomes. The four largest Asian groups in New York State are Chinese (39 percent), Asian Indian (27 percent), Korean (10 percent) and Filipino (8 percent).[8] These subgroups differ in socioeconomic position, language, citizenship status, cultural norms, religion, immigration history, generation and other characteristics.

Asian and Pacific Islander Americans Health Concerns and Challenges

Although research on the health of Asian Americans is relatively scarce, data show that specific subgroups of Asian Americans have higher rates of morbidity and mortality across certain health indicators. Like other minority populations, they often lack health insurance and have language barriers that affect access to and utilization of health care. Thirty-six percent of Asian and Pacific Islander women under age 65 have no health insurance.[9] When studied as an aggregate group, Asian Americans appear to have better outcomes than other groups. However, such data classification practices can mask important differences within the population, with important consequences for program planning. For example, very little is known about the Indo-Caribbean subgroups, many of which live in Queens and Schenectady counties. Further, despite an absence of empirical evidence, many Asian Americans are labeled as a "model minority" assuming that they have good health, receive adequate care, and are not in need of social programs.[10] Over the next two decades, APIAs are expected to be one of the fastest-growing minority groups in the nation. The lack of empirical attention to and consequent inability to design effective health interventions for this population are important public and social policy issues.

Building Relationships with Asian and Pacific Islander American Communities

Understanding the considerable variances among APIA populations, the importance of culture and family, and identifying specific population-based messages is fundamental in building relationships with APIA communities. To design a framework of health interventions for this population, planners must involve community members and representatives of community-based organizations serving APIA populations.[11]

American Indians and Alaska Natives

Background and Demographics

As a racial group[12] federally recognized American Indians and Alaska Natives (AIANs) have a distinctive history, with a unique government-to-government relationship with the United States codified in numerous U.S. Supreme Court decisions, treaties, legislation, and Executive Orders.[13] Before the 1950s, most AIANs lived on reservations, in nearby rural towns, or in tribal jurisdictional areas. The 2010 U.S. Census indicated that more than 5 million Americans were of American Indian and Alaska Native heritage. According to the Indian Health Service (IHS), 57 percent of the AIAN population lives in urban areas; the remainder lives in rural areas.[14]

The provision of health services to AIANs grew out of the government-to-government relationship. The principal federal health care provider and health advocate is the IHS, which provides health care for approximately 1.9 million AIANs belonging to 562 federally recognized tribes in 35 states. The Snyder Act of 1921 authorized funds "for the relief of distress and conservation of health . . . [and] . . . for the employment of . . . physicians . . . for Indian Tribes throughout the United States."[15] Building on the Snyder Act, the Indian Health Care Improvement Act (IHCIA), Public Law 94-437, declared that it was federal policy to elevate the health status of American Indians to a level at parity with the general U.S. population. Since its passage in 1976, the Act has been reauthorized four times.[16]

New York State is home to eight federally recognized tribes: Cayuga, Oneida, Onondaga, Seneca, St. Regis Mohawk (also known as Akwesasne), Shinnecock, Tonawanda and Tuscarora (see Figure 1*).* Six of the tribes (Cayuga, Oneida, Onondaga, Seneca, St. Regis Mohawk and Tuscarora) comprise the Haudenosaunee, also known as the Iroquois confederacy. New York also recognizes the Unkechaug (Poospatuck) on Long Island, which is not part of the federal government's recognition system. The Ramapough Lenape Indians, a bi-state Nation (New York/New Jersey), reside on traditional lands in Rockland and Orange counties, and the Matinecock, on Long Island, are petitioning New York for state recognition. New York is one of 10 states with the largest American Indian populations; and, of the cities with a population of 100,000 or more, New York City has the largest American Indian population.[17]

American Indians and Alaska Natives Health Concerns and Challenges

The health status of American Indian and Alaska Native people is lower than other Americans, caused perhaps by inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. AIANs born today have a life expectancy 5.2 years less than the combined number of all U.S. populations (72.6 years and 77.8 years respectively, according to 2003-2005 rates). American Indians and Alaska Natives die at higher rates than other Americans from tuberculosis (500 percent higher), alcoholism (514 percent higher), diabetes (177 percent higher), unintentional injuries (140 percent higher), homicide (92 percent higher) and suicide (82 percent higher).[18] AIANs also experience high rates of chronic conditions

compared to other racial-ethnic groups. Scarcity of local data masks the health care needs of American Indians.

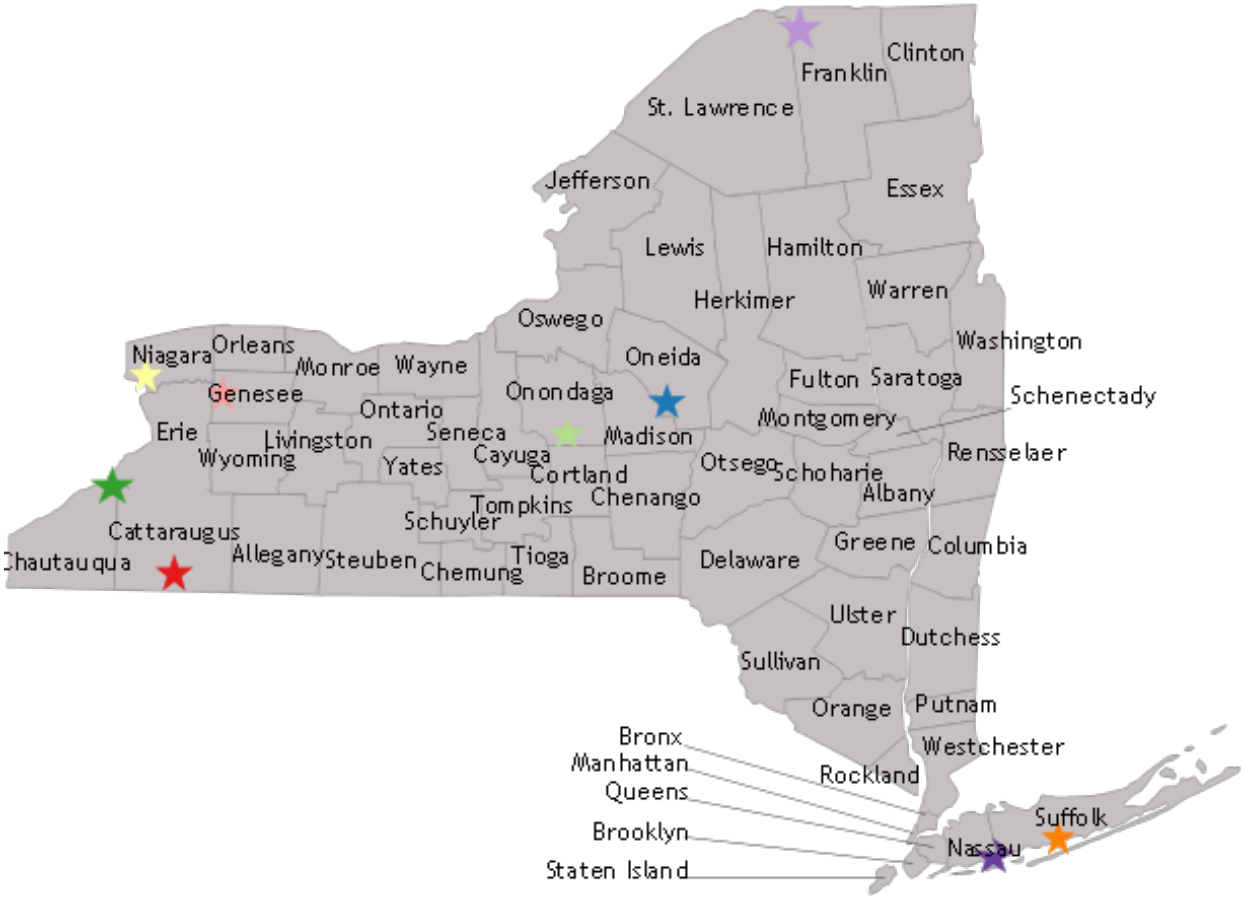
The federal government acts to meet its health care commitment to AIANs through hospitals and clinics located on or near reservations, managed by the IHS and, more recently, by tribal nations. While the IHS provides a valuable source of basic health care for some AIANs who lack coverage, there are gaps in preventive care.[19] In *A Profile of American Indians and Alaska Natives and Their Health Coverage*, the Henry J. Kaiser Family Foundation reported that AIANs under age 65 have the lowest private health insurance coverage of any racial/ethnic group, which makes public coverage crucial for low income AIANs. Uninsured AIANs fare worse on key access measures than those with private insurance or Medicaid.[20] According to IHS Director Yvette Roubideaux, M.D., M.P.H., American Indians living in rural areas can have limited local access to appropriate care. Additionally, the broad range of clinical conditions challenges even the most seasoned providers caring for AIAN populations.[21]

The New York State Department of Health has established clinics for American Indians on or near reservations in the following counties: Chautauqua and Cattaraugus (serving the Cayuga nation), Oneida (serving the Oneidas), Onondaga (Onondagas), Chautauqua and Cattaraugus (Senecas), Franklin and Genesee (St. Regis Mohawk and Tonowanda nations), Niagara (Tuscarora), Suffolk (Shinnecock), and Nassau (Unkechaug, Poospatuck). These clinics provide primary and specialty medical care, dental and podiatry care, diabetes education, mental health counseling, and laboratory services. They also facilitate enrollment of American Indians into public health insurance and social service programs, including Medicaid, Child Health Plus, Family Health Plus, the Prenatal Care Assistance Program (PCAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and others. There are several American Indian organizations that serve the unique needs of American Indian sub-populations in the State.

Building Relationships with American Indians and Alaska Natives Communities

In AIAN communities, important traditions and history are handed down through indigenous languages. The identities of American Indians have been shaped by attachment to family, culture, community, and the multi-generational trauma that has affected American Indians for centuries.[22] Thus, trust and respect for tribal values, customs and norms are crucial for gaining entry and building successful relationships with AIAN communities. Health providers without experience in American Indian communities may be unaware of the critical role of, or efforts required in, developing and maintaining trust.

Figure 1: Geographic Distribution of New York State-Recognized Tribal Nations



Legend	Tribal Nation
	Oneida
	Onondaga
	Seneca
	Seneca
	Tonawanda
	Tuscarora
	Unkechaug
	St. Regis Mohawk/Akwesasne
	Shinnecock

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Population and Socio-demographic Characteristics

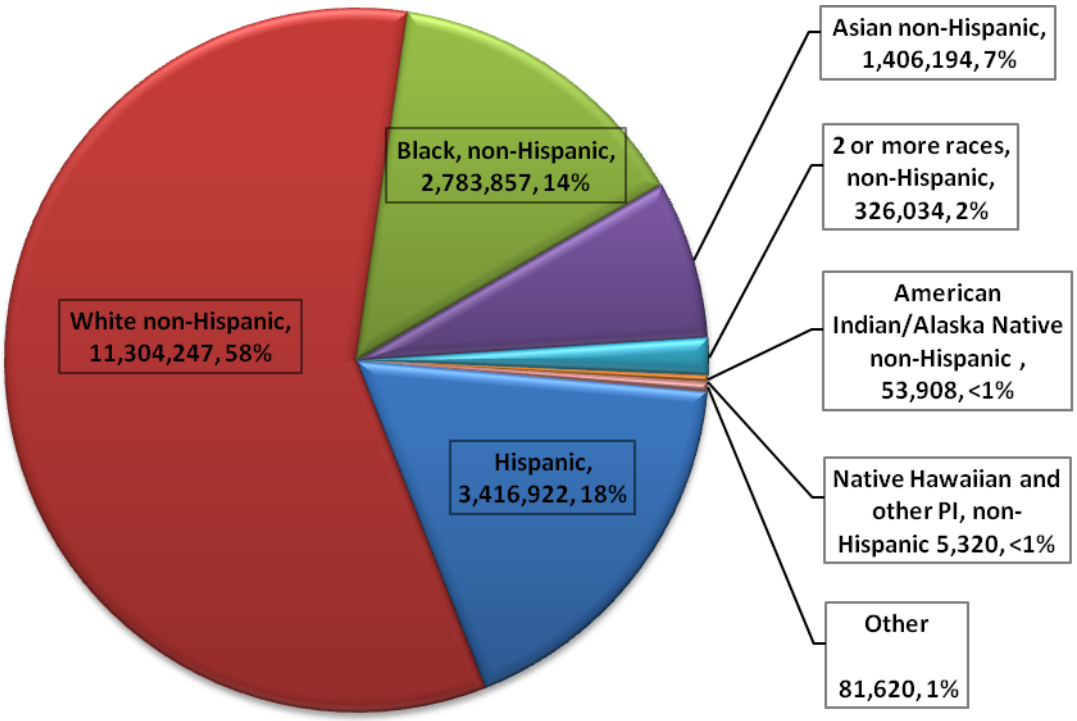
In 2010, New York's population was estimated at 19,378,102 residents. The racial and ethnic groups that make up the highest percentage of New York's population are White non-Hispanics (58 percent), Hispanics (18 percent), Black non-Hispanics (14 percent), and Asian non-Hispanics (7 percent).

People who are not Hispanic and reported being of two or more races make up nearly 2 percent of the population.

American Indian and Alaska Natives constitute less than 1 percent of New York State's population.

Compared to the U.S. population, New York has a greater proportion of Black non-Hispanics (14 percent vs. 12 percent), Hispanics (18 percent vs. 16 percent) and Asians (7 percent vs. 5 percent). Accordingly, the proportion of the population that is White non-Hispanic is lower in New York State than among all Americans (58 percent vs. 64 percent).

Figure 2. Population by Race and Hispanic Origin, New York State, 2010



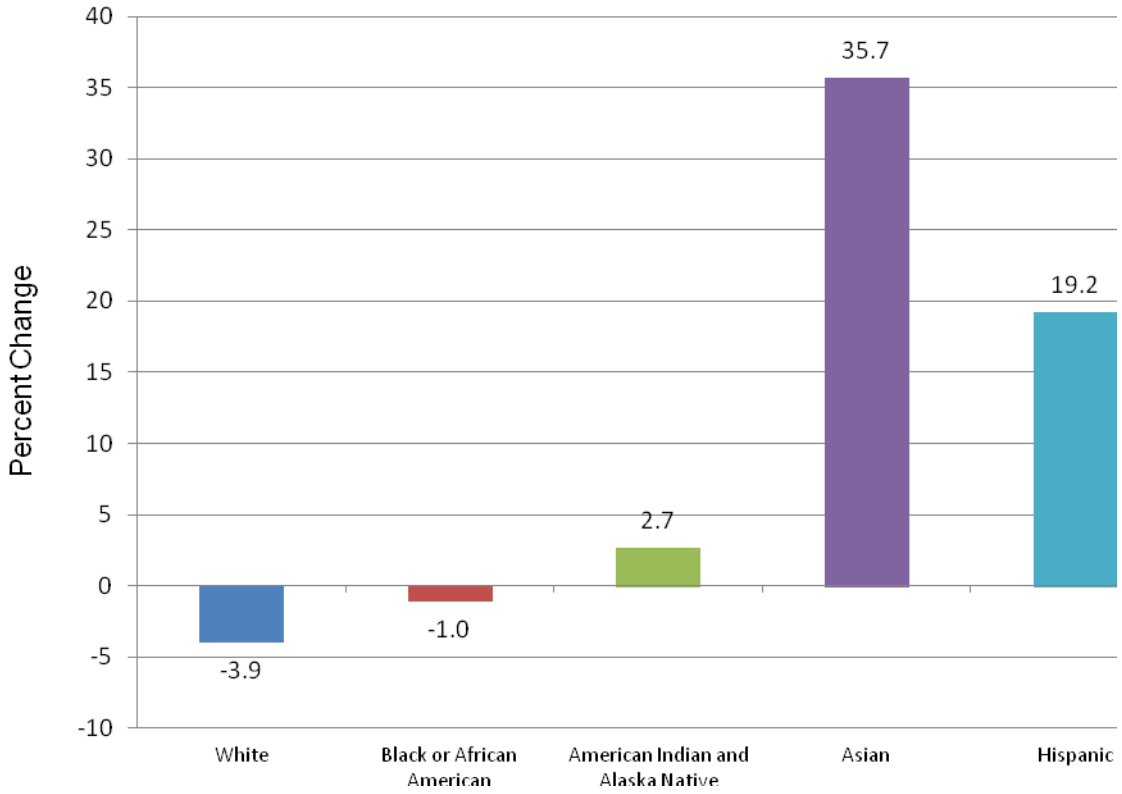
Source: U.S Census Bureau

New York's minority populations continued to increase as a percentage of the total population of New Yorkers. In 2000, 38 percent of New Yorkers were minorities. By 2010, the percentage of minorities had increased to 42 percent.

As shown in Figure 2, Asian non-Hispanics experienced the largest percentage increase between 2000 and 2010 (35.7 percent), followed by Hispanics (19.2 percent). The number of American Indian/Alaskan Native non-Hispanics in New York State increased by 2.7 percent between 2000 and 2010.

The Black non-Hispanic population declined by 1.0 percent, and White non-Hispanics dropped by 3.9 percent in the decade since the 2000 Census.

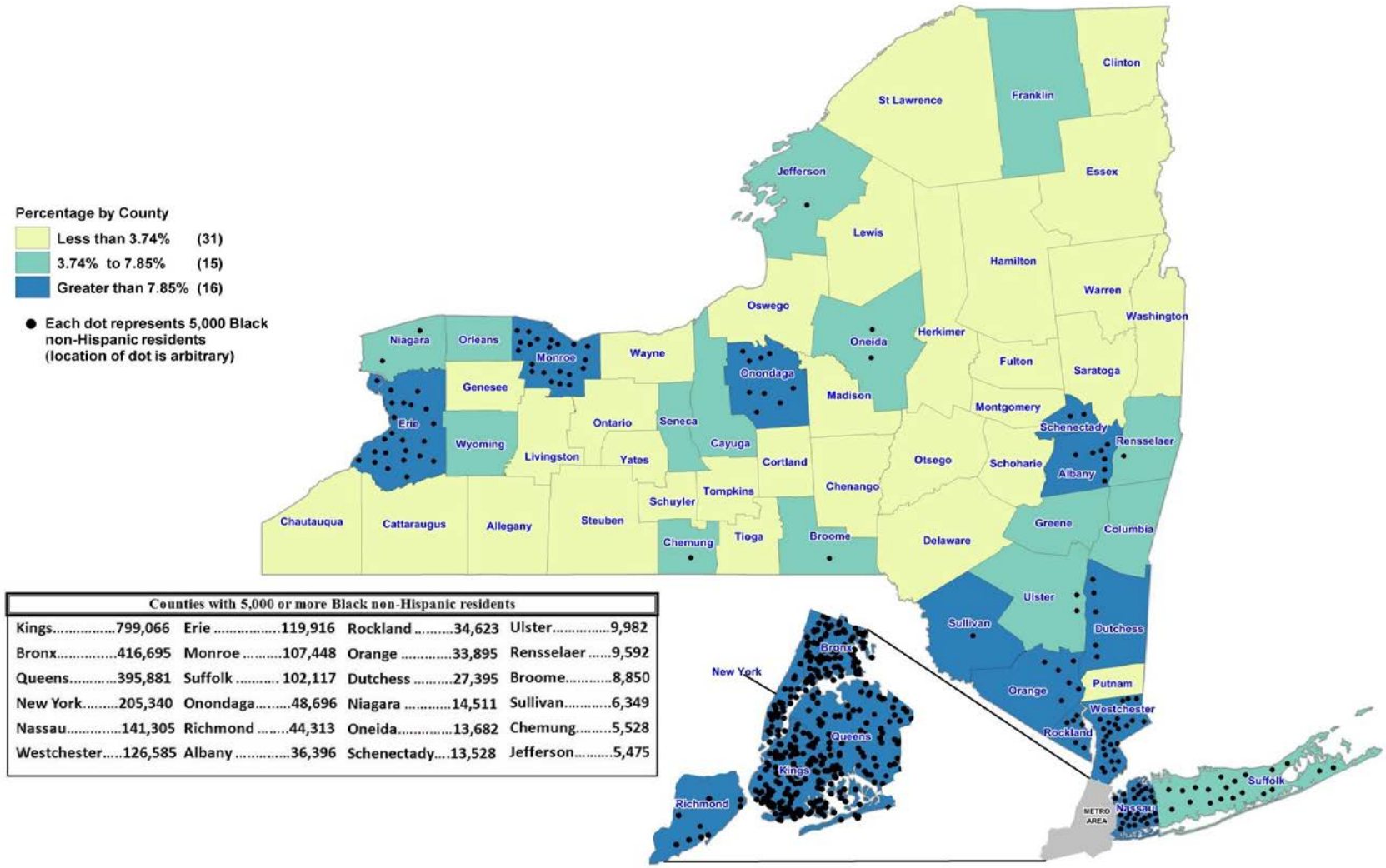
Figure 3. Percentage Change in Population by Race/Ethnicity, New York State, 2000 and 2010



Source: U.S. Census Bureau

Figure 4. Percentage of Population That is Black Non-Hispanic by County, New York State, 2010

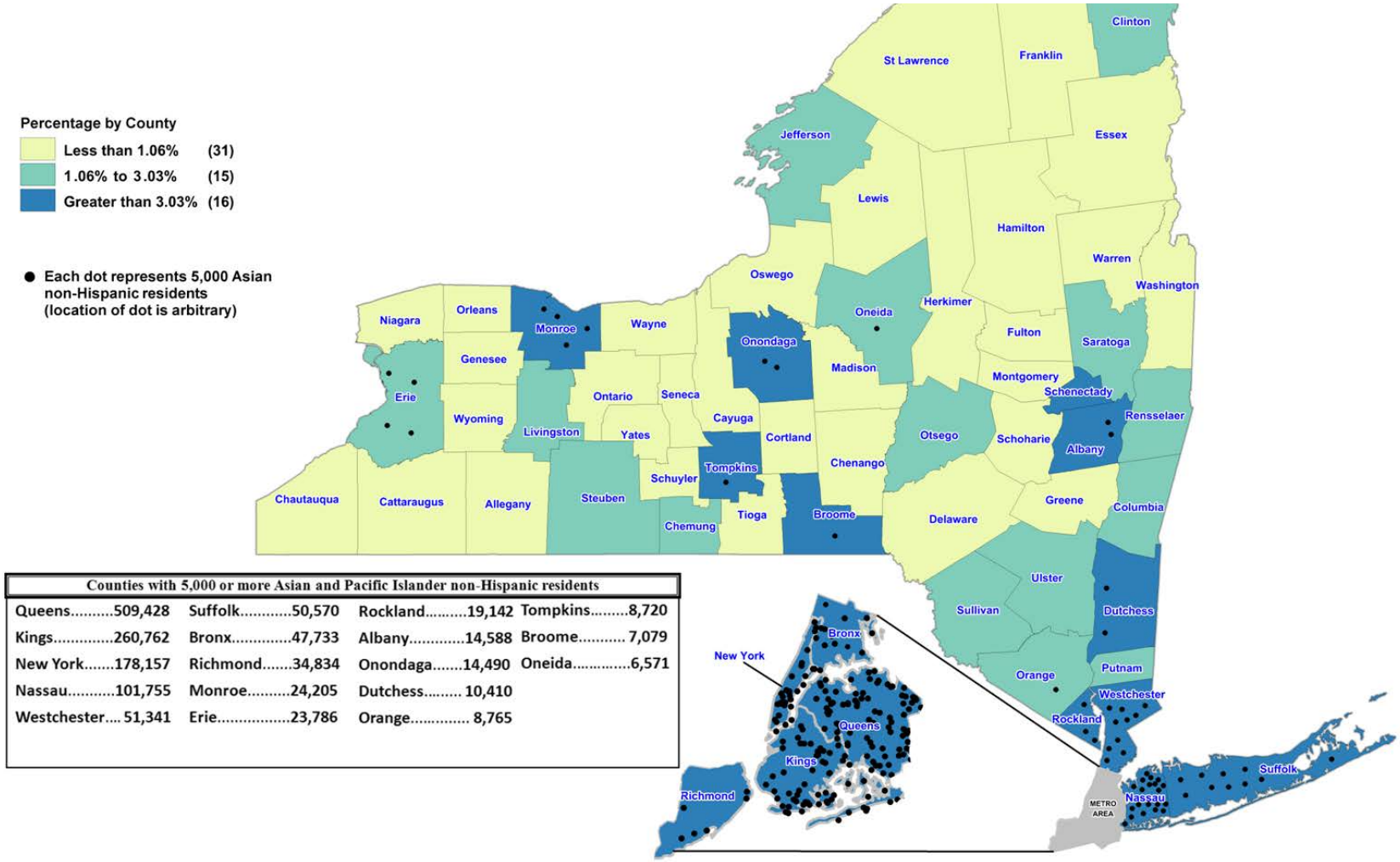
Counties with the largest percentage (i.e., top quartile) of residents who identify themselves as Black non-Hispanics include the five boroughs in New York City, Nassau County, five counties in the Lower Hudson Valley (Dutchess, Orange, Rockland, Sullivan and Westchester) and the five urban upstate counties of Albany, Erie, Monroe, Onondaga, and Schenectady.



Counties with 5,000 or more Black non-Hispanic residents							
Kings	799,066	Erie	119,916	Rockland	34,623	Ulster	9,982
Bronx	416,695	Monroe	107,448	Orange	33,895	Rensselaer	9,592
Queens	395,881	Suffolk	102,117	Dutchess	27,395	Broome	8,850
New York	205,340	Onondaga	48,696	Niagara	14,511	Sullivan	6,349
Nassau	141,305	Richmond	44,313	Oneida	13,682	Chemung	5,528
Westchester	126,585	Albany	36,396	Schenectady	13,528	Jefferson	5,475

Figure 5. Percentage of Population That is Asian/Pacific Islander Non-Hispanic by County, New York State, 2010

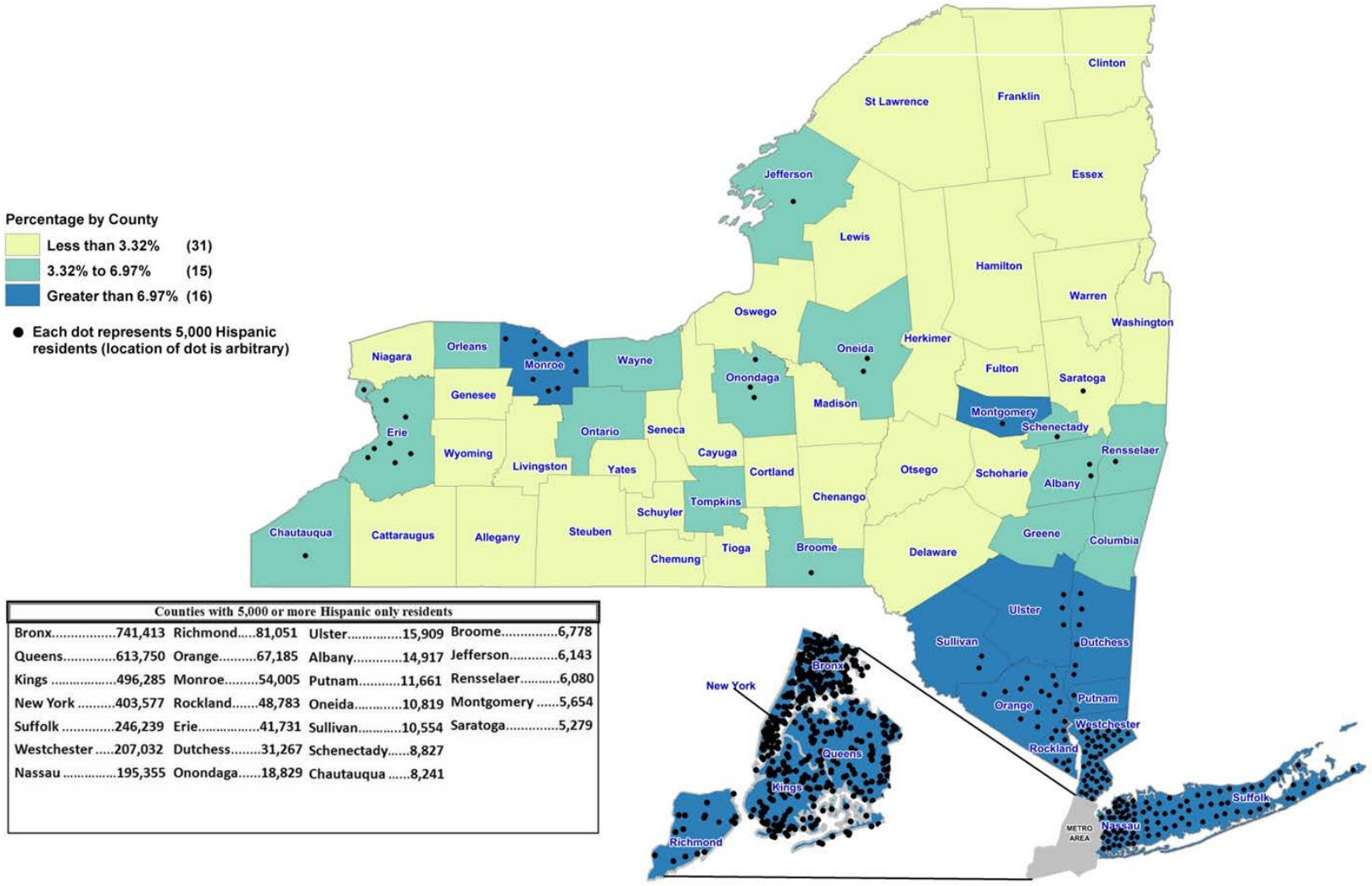
Counties with the largest percentage of residents who identify themselves as Asian/Pacific Islander non-Hispanics include the five boroughs in New York City, Nassau and Suffolk counties, some lower Hudson Valley counties (Dutchess, Rockland, Westchester), and the urban upstate counties of Albany, Broome, Monroe, Onondaga, Schenectady and Tompkins.



Counties with 5,000 or more Asian and Pacific Islander non-Hispanic residents			
Queens.....509,428	Suffolk.....50,570	Rockland.....19,142	Tompkins.....8,720
Kings.....260,762	Bronx.....47,733	Albany.....14,588	Broome..... 7,079
New York.....178,157	Richmond.....34,834	Onondaga.....14,490	Oneida.....6,571
Nassau.....101,755	Monroe.....24,205	Dutchess..... 10,410	
Westchester.... 51,341	Erie.....23,786	Orange..... 8,765	

Figure 6. Percentage of Population That is Hispanic by County, New York State, 2010

Counties with the largest percentage of Hispanic populations include the five boroughs of New York City and all seven counties in the Hudson Valley area (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester). Montgomery, Monroe, Nassau and Suffolk counties also have a large proportion of Hispanic residents.



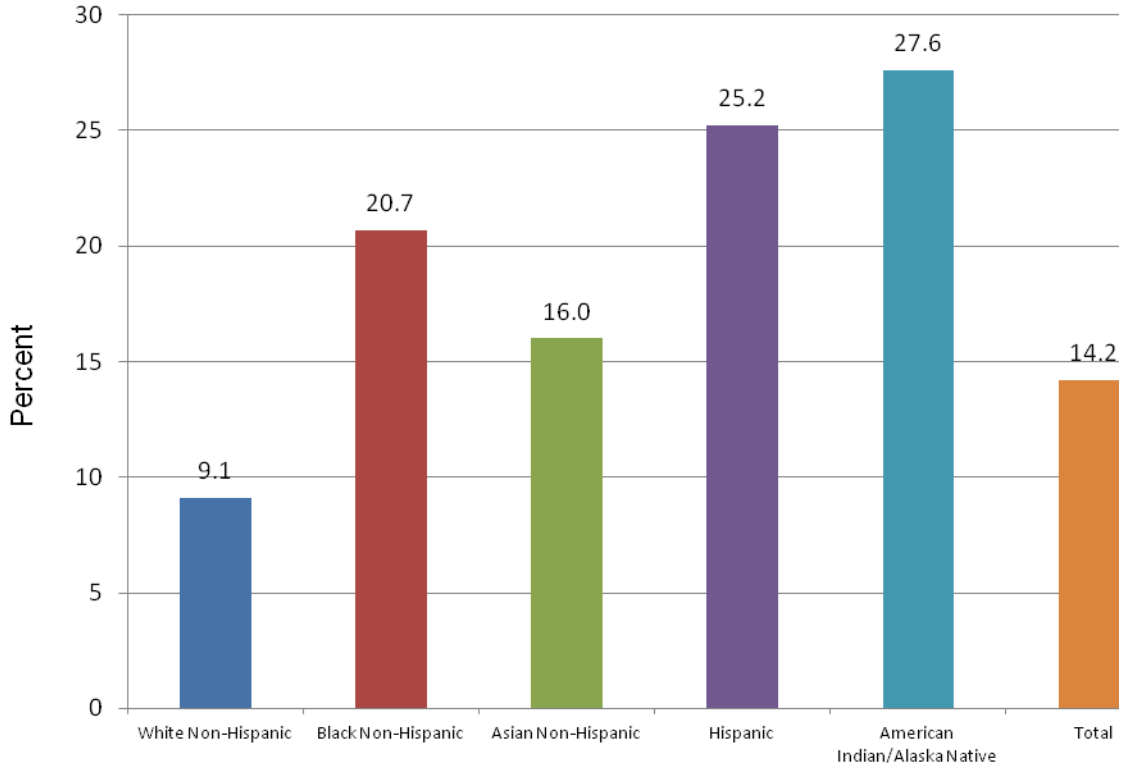
Counties with 5,000 or more Hispanic only residents							
Bronx	741,413	Richmond	81,051	Ulster	15,909	Broome	6,778
Queens	613,750	Orange	67,185	Albany	14,917	Jefferson	6,143
Kings	496,285	Monroe	54,005	Putnam	11,661	Rensselaer	6,080
New York	403,577	Rockland	48,783	Oneida	10,819	Montgomery	5,654
Suffolk	246,239	Erie	41,731	Sullivan	10,554	Saratoga	5,279
Westchester	207,032	Dutchess	31,267	Schenectady	8,827		
Nassau	195,355	Onondaga	18,829	Chautauqua	8,241		

Individuals benefit from receiving good education and having meaningful employment that provides a living wage. Disparities in education and income are very much a product of unequal opportunities. These disparities are strongly related to health outcomes.[1]

The U.S. Census Bureau determines poverty based on income, family size and the number of children living in the household. For example, in 2010, individuals living in a four-person household with two children and earning less than $22,113 would be considered living below the federal poverty level. If a family's total income is less than the family's threshold, that family and every individual in it is considered in poverty. The poverty thresholds do not vary geographically, but new poverty thresholds are developed each year.

Overall, 14.2 percent of New Yorkers were living below the federally designated poverty level in 2009. While only 9.1 percent of New York's White non-Hispanic population was living below the poverty level, 20.7 percent of the Black non-Hispanic population, 16.0 percent of Asians and 27.6 percent of American Indian/Alaskan Natives were living below the poverty level. Poverty also affects Hispanics disproportionately – 25.2 percent of New Yorkers of Hispanic origin lived below the poverty level in 2009.

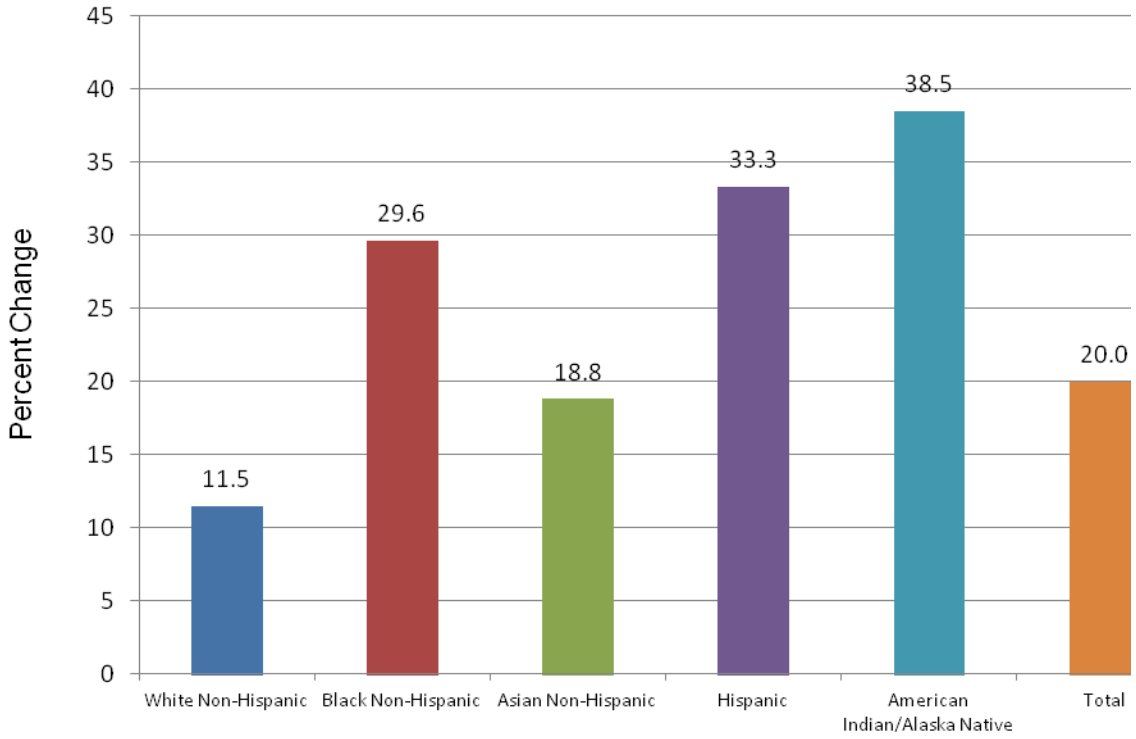
Figure 7. Percentage of Population Living Below Poverty by Race/Ethnicity and County, New York State, 2009



Sources: American Community Survey, U.S. Census Bureau.

Overall, 20.0 percent of New York State children under 18 were living in poverty in 2009. The percentage varied by race and ethnicity, from 11.5 percent of White non-Hispanics to 38.5 percent of American Indian/Alaska Natives. Among other non-Hispanic populations, the percentages in poverty were 18.8 percent in Asians and 29.6 percent in Blacks. One-third of Hispanic children were living in poverty.

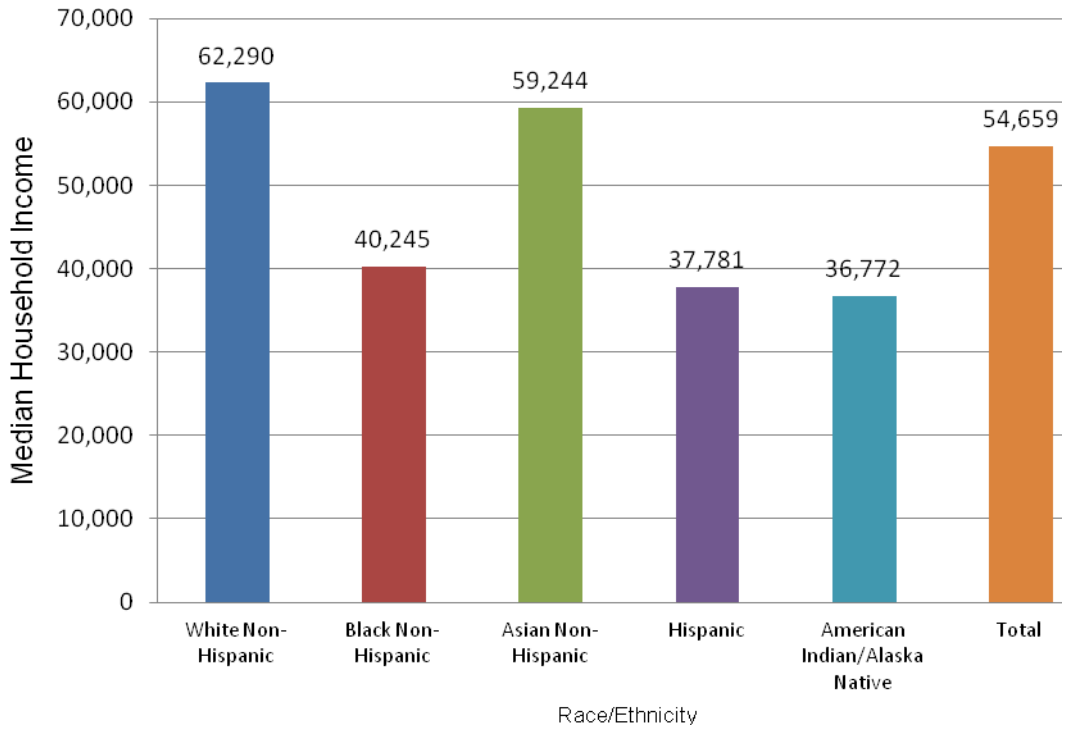
Figure 8. Percentage of Children Aged Less Than 18 Years Living Below Poverty by Race/Ethnicity, New York State, 2009



Source: American Community Survey, U.S. Census Bureau

The median household income among all New York residents was $54,659 in 2009, ranging from $36,772 in American Indian/Alaskan Native households to $62,290 in White non-Hispanic households. Among other racial/ethnic groups, the median household income was $37,781 in Hispanic households, $40,245 in Black non-Hispanics households, and $59,244 in Asian non-Hispanics households.

Figure 9. Median Household Income by Race/Ethnicity, New York State, 2009

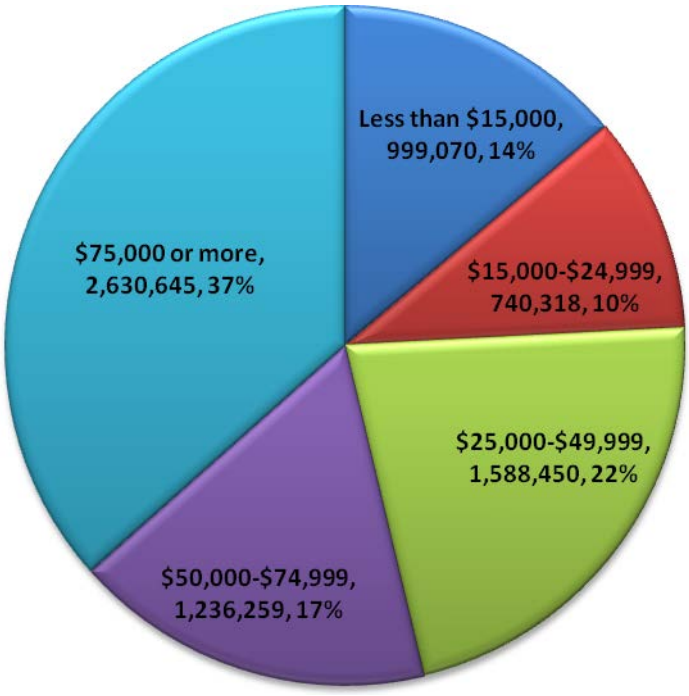


Source: American Community Survey, U.S. Census Bureau

People with higher education and income levels live longer, according to calculations from the National Longitudinal Mortality Survey. People whose family income put them in the top 5 percent had a life expectancy at all ages that was about 25 percent longer than those in the bottom 5 percent.[2]

In 2009, 24 percent of New Yorkers lived in households earning less than $25,000 per year, 39 percent had annual household incomes between $25,000 and $74,999, and 37 percent lived in households with $75,000 or more in annual income.

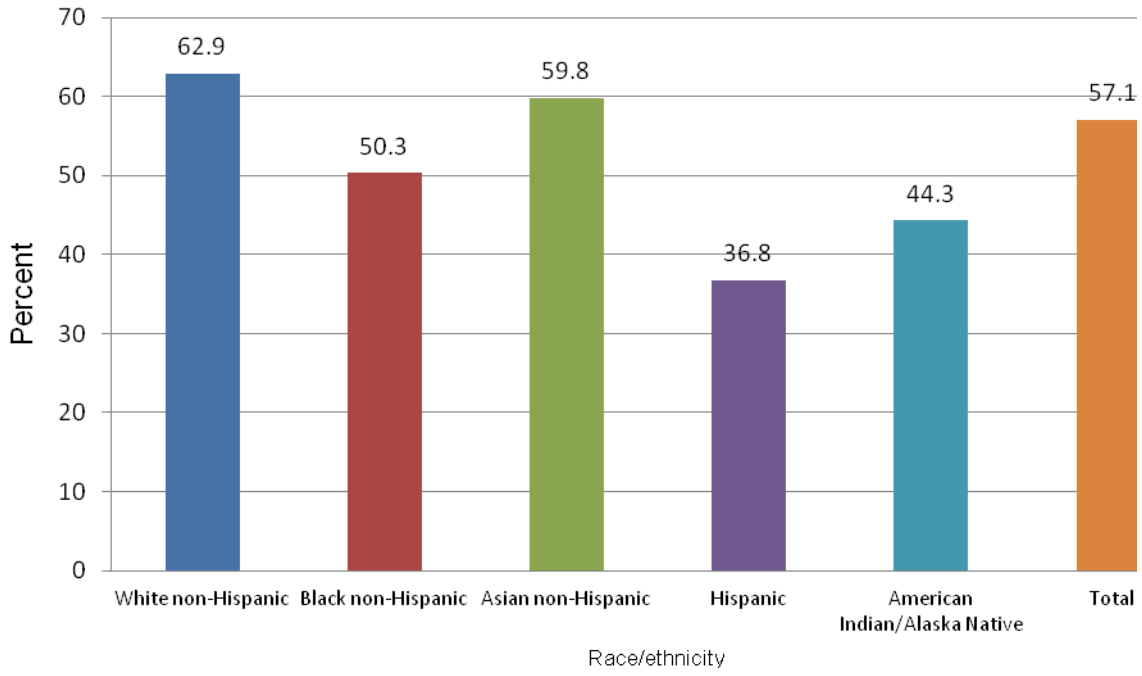
Figure 10. Number and Percentage of Households by Income Category, New York State, 2009



Source: American Community Survey, U.S. Census Bureau.

In 2009, 57.1 percent of New York State adults 25 years and older had at least some college education. The percentage varied among racial and ethnic groups, with a low of 36.8 percent of Hispanic adults with some college education. The percentage of adults with at least some college education was highest among White non-Hispanics (62.9 percent), followed by Asian non-Hispanics (59.8 percent), American Indian/Alaskan Natives (44.3 percent) and Black non-Hispanics (50.3 percent).

Figure 11. Percentage of Population Aged 25 Years or over with at Least Some College by Race/Ethnicity, New York State, 2009



Source: American Community Survey, U.S. Census Bureau

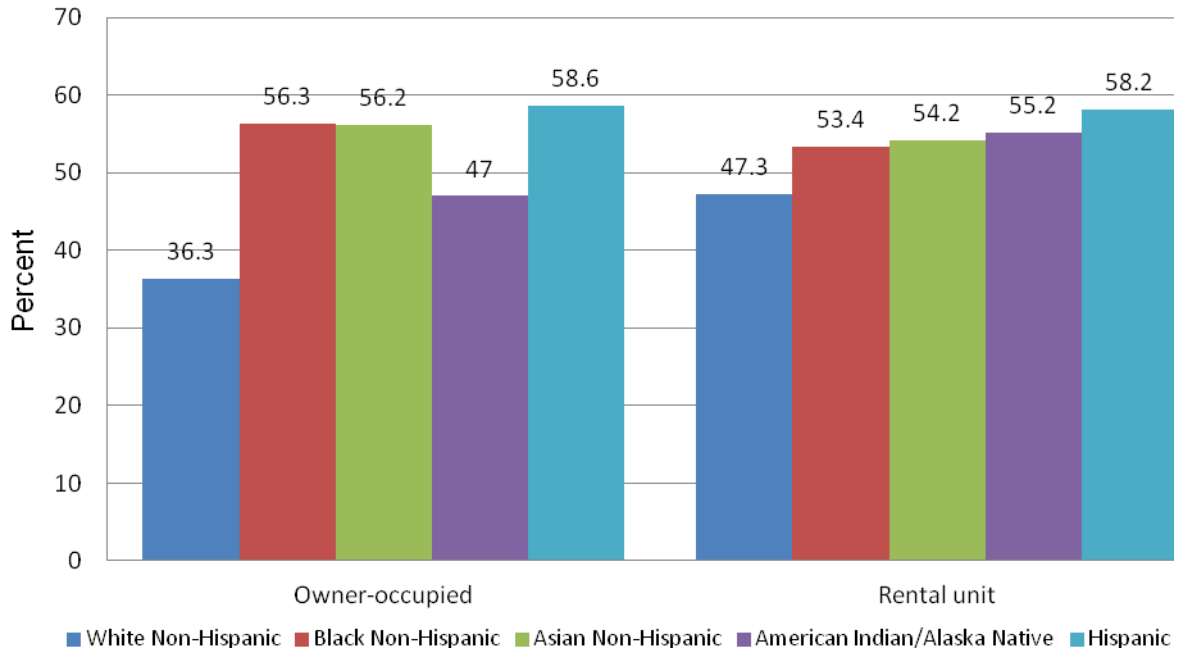
Families that spend a larger percentage of their household income on housing tend to spend less on food and health care than families that pay less on housing, affecting the health of family members.[3]

The percentage of income used to pay monthly housing costs provides a crude measure of economic stress for a household. In 2009, the percentage of New York State households whose monthly housing costs were at least 30 percent of total household income was determined separately for families occupying their own home or living in a rental unit.

The percentage of households with monthly housing costs that were at least 30 percent of their total income was highest among Hispanics (exceeding 58 percent), regardless of the type of occupancy. Among non-Hispanics in their own home, the percentages whose monthly housing costs were at least 30 percent of the total income were 36.3 percent in Whites; 56.2 percent in Asians; and 56.3 percent in Blacks. Forty-seven percent of American Indian/Alaskan Natives in their own home had monthly housing costs of at least 30 percent of total income.

Among non-Hispanic residents who lived in a rental unit, the percentages were 47.3 percent in Whites; 53.4 percent in Blacks; and 54.2 percent in Asians. Among American Indian/Alaskan Natives living in rental units, the percentage was 55.2 percent.

Figure 12. Percentage of Households Whose Monthly Housing Costs Were at Least 30% of Total Household Income by Race/Ethnicity, New York State, 2009



Source: American Community Survey, U.S. Census Bureau.

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[2] National Bureau of Economic Research. (Spring, 2003). *Health, Income and Inequality. Research Summary*. Retrieved November 9, 2011 from http://www.nber.org/reporter/spring03/health.html.

[3] Lubell J., Crain J., & Cohen R. (July, 2007). *Framing the Issues – the Positive Impacts of Affordable Housing on Health*. Retrieved November 9, 2011 from http://www.nhc.org/media/documents/FramingIssues_Heath.pdf.

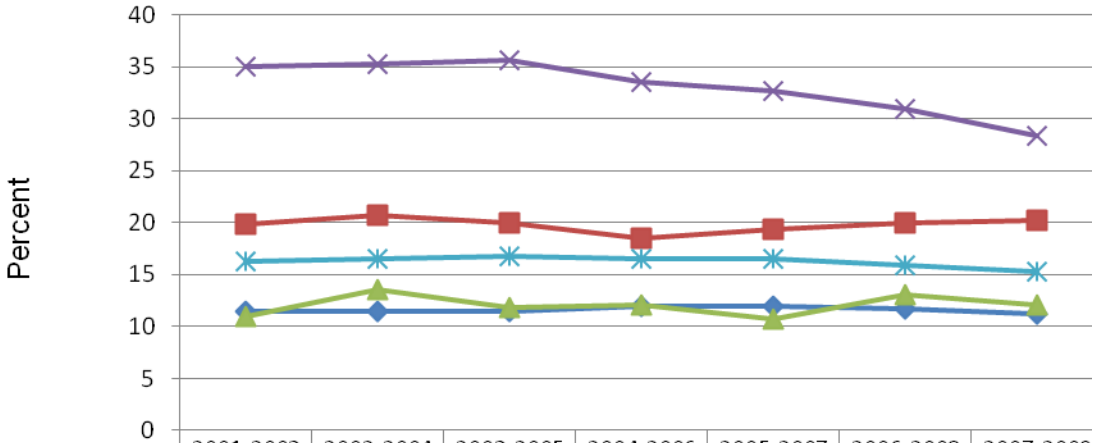
General Health

Self-reported health is an indicator used to assess the health and well-being of New Yorkers. Because it is based on an individual's perception of their health rather than a physical assessment, it is often combined with other measures.

For the 2007-2009 period, 28.3 percent of Hispanics reported their health as fair or poor during the past month – an improvement over 2001-2005, when the rates exceeded 35 percent.

Among Black non-Hispanic, White non-Hispanic and Asian non-Hispanic New Yorkers, the percentages reporting fair or poor health during 2007-2009 were 20.2 percent, 11.2 percent and 12.0 percent, respectively – similar to their rates in 2001-2003

Figure 13. Age-Adjusted Percentage* of Adults Aged 18 Years and Older Reporting Fair or Poor Health by Race/Ethnicity, New York State, 2001-2009



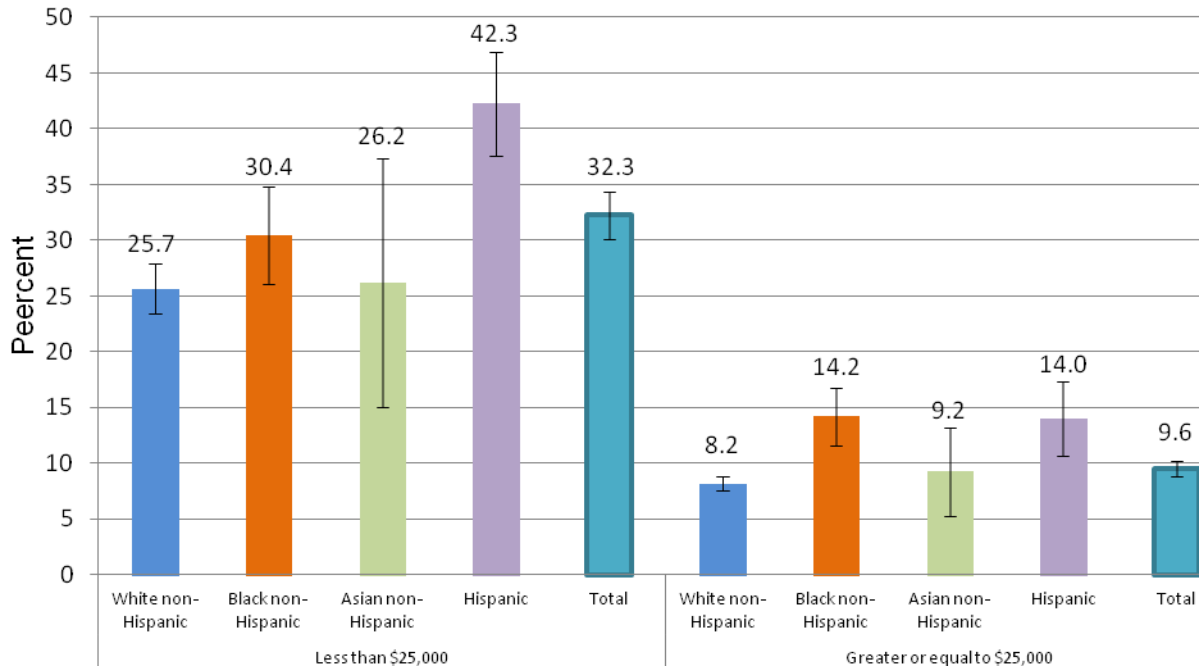
	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	11.5	11.4	11.5	11.9	12.0	11.8	11.2
Black non-Hispanic	19.9	20.7	20.0	18.6	19.4	20.0	20.2
Asian non-Hispanic	11.0	13.6	11.8	12.1	10.8	13.1	12.0
Hispanic	35.1	35.3	35.7	33.6	32.7	31.0	28.3
Total	16.3	16.6	16.8	16.5	16.5	15.9	15.2

*Three-year moving average adjusted to the 2000 U.S. population.
Source: Behavioral Risk Factor Surveillance System

Individuals with annual household incomes of less than $25,000 were more likely to report their health as fair or poor compared to those with household earnings of $25,000 or more annually, for all racial/ethnic groups.
More than 40 percent of Hispanic New Yorkers with the lower income level reported their health to be fair or poor – a significantly higher percentage than other race/ethnic groups.

About 14 percent of Hispanics and Black non-Hispanics with the higher income level reported fair or poor health, significantly higher than 8.2 percent of White non-Hispanics in this category.

Figure 14. Age-Adjusted Percentage of Adults Aged 18 Years and Older Reporting Fair or Poor Health by Race/Ethnicity and Income Categories, New York State, 2007-2009

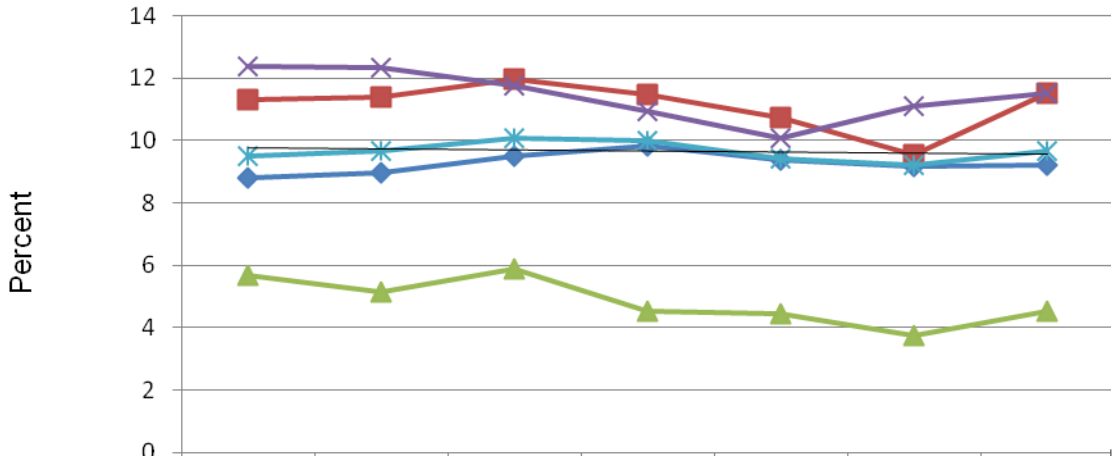


Rate adjusted to the 2000 U.S. population.

Source: Behavioral Risk Factor Surveillance System

Poor mental health is a major source of distress, disability, and social burden. In any given year, as many as one in five adults in the United States has a mental disorder.[1]
During 2007-2009, Black non-Hispanic and Hispanic New Yorkers reported the highest percentage of poor mental health for at least 14 days during the past month – both at 11.5 percent. Asian non-Hispanics were the least likely (4.5 percent) to report poor mental health. Between 2001 and 2009, the rates fluctuated for all groups, but the disparities among these race/ethnic groups persisted.

Figure 15. Age-Adjusted Percentage* of Adults Aged 18 Years and Older Reporting Poor Mental Health by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	8.8	9.0	9.5	9.8	9.4	9.2	9.2
Black non-Hispanic	11.3	11.4	12.0	11.5	10.8	9.5	11.5
Asian non-Hispanic	5.7	5.1	5.9	4.5	4.5	3.8	4.5
Hispanic	12.4	12.3	11.8	11.0	10.1	11.1	11.5
Total	9.5	9.7	10.1	10.0	9.4	9.2	9.7

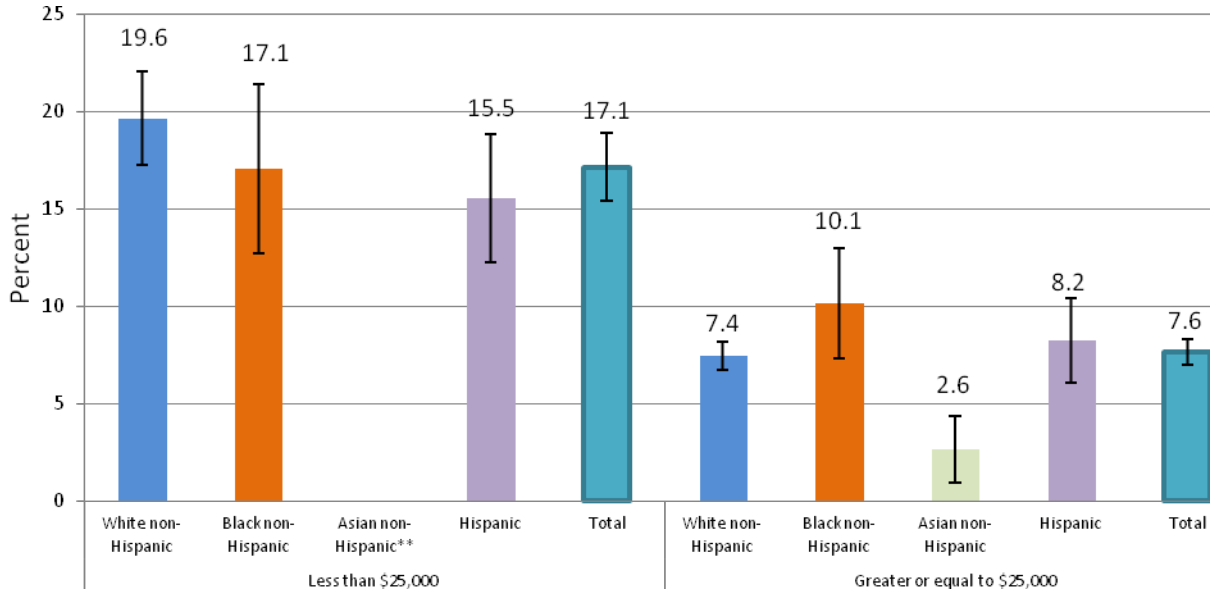
* Three-year moving average adjusted to the 2000 U.S. population.

** Fourteen or more days during the past month
Source: Behavioral Risk Factor Surveillance System

Nearly one-fifth (19.6 percent) of White non-Hispanic New York adults with household incomes less than $25,000 per year reported poor mental health on 14 or more days in the past month. Black non-Hispanics and Hispanics in this income group reported 17.1 percent and 15.5 percent, respectively. The sample size for Asian non-Hispanics in this income category was insufficient to report on this indicator.

For those with annual household incomes of $25,000 or more, Asian non-Hispanic New Yorkers were less likely to report poor mental health compared to the other race/ethnic groups. Among both White non-Hispanic and Hispanic New Yorkers, the prevalence of poor mental health was significantly less than in their lower-income counterparts.

Figure 16. Age-Adjusted Percentage of Adults Aged 18 Years and Older Reporting Poor Mental Health* by Race/Ethnicity and Income Categories, New York State, 2007-2009



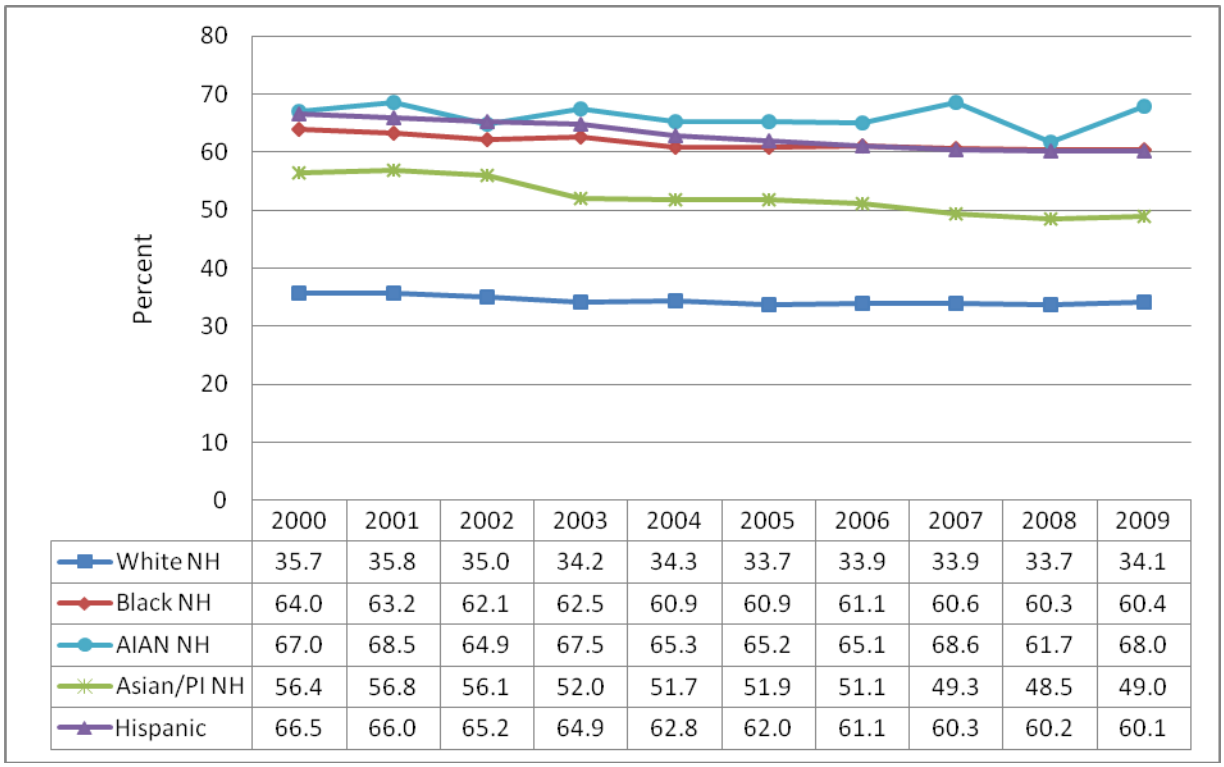
Rate adjusted to the 2000 U.S. population.

* Fourteen or more days during the past month
** Data do not meet reporting criteria
Source: Behavioral Risk Factor Surveillance System

Premature deaths are those occurring at less than 75 years of age. Groups with higher rates of premature mortality are more likely to be affected by causes of death that are more common in younger populations, such as unintentional injury, homicide and infant mortality.

Premature death rates for American Indian/Alaska Native non-Hispanic, Black non-Hispanic and Hispanic New Yorkers were nearly twice the rate for White non-Hispanics. For Asian/Pacific Islander non-Hispanics, the rate was more than 1.5 times the rate for White non-Hispanics.

Figure 17. Percentage of Deaths that Were Premature (Deaths of Persons <75 Years Old) by Race/Ethnicity, New York State, 2000-2009



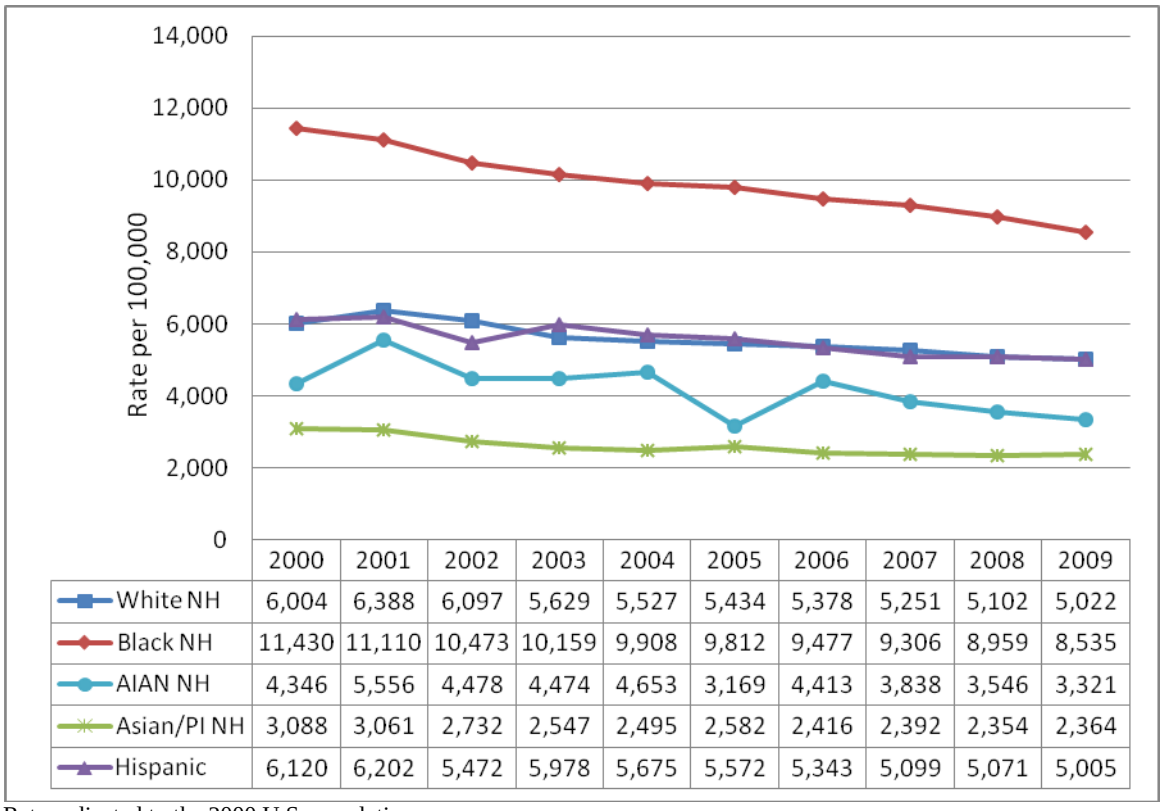
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	35.7	35.8	35.0	34.2	34.3	33.7	33.9	33.9	33.7	34.1
Black NH	64.0	63.2	62.1	62.5	60.9	60.9	61.1	60.6	60.3	60.4
AIAN NH	67.0	68.5	64.9	67.5	65.3	65.2	65.1	68.6	61.7	68.0
Asian/PI NH	56.4	56.8	56.1	52.0	51.7	51.9	51.1	49.3	48.5	49.0
Hispanic	66.5	66.0	65.2	64.9	62.8	62.0	61.1	60.3	60.2	60.1

Abbreviations: NH – non-Hispanic; AIAN – American Indian/Alaska Native, PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Years of Potential Life Lost (YPLL) draws attention to the loss of expected years of life due to deaths in childhood, adolescence and early adulthood. Injury-related deaths that affect predominantly young males cause as many lost years of potential life expectancy as cancer, which is mainly a disease of older people, even though cancer may cause more deaths.[2]

For the past decade, the years of potential life lost have been declining for all racial/ethnic groups. In 2009, Asian/Pacific Islander non-Hispanics and American Indian/Alaska Native non-Hispanics had the lowest YPLL (2,364 and 3,321 per 100,000, respectively), White non-Hispanics and Hispanics were in the middle (5,022 and 5,005 per 100,000, respectively) and Black non-Hispanics had the highest YPLL (8,535 per 100,000 population).

Figure 18. Age-Adjusted Years of Potential Life Lost per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	6,004	6,388	6,097	5,629	5,527	5,434	5,378	5,251	5,102	5,022
Black NH	11,430	11,110	10,473	10,159	9,908	9,812	9,477	9,306	8,959	8,535
AIAN NH	4,346	5,556	4,478	4,474	4,653	3,169	4,413	3,838	3,546	3,321
Asian/PI NH	3,088	3,061	2,732	2,547	2,495	2,582	2,416	2,392	2,354	2,364
Hispanic	6,120	6,202	5,472	5,978	5,675	5,572	5,343	5,099	5,071	5,005

Rates adjusted to the 2000 U.S. population
Abbreviations: NH – non-Hispanic; AIAN – American Indian/Alaska Native, PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

References

[1] Center for Disease Control and Prevention. (October 22, 2004). Self-reported frequent mental distress among adults – United States, 1993—2001. *Morbidity and Mortality Weekly Report*. *53*(41), 963-966.

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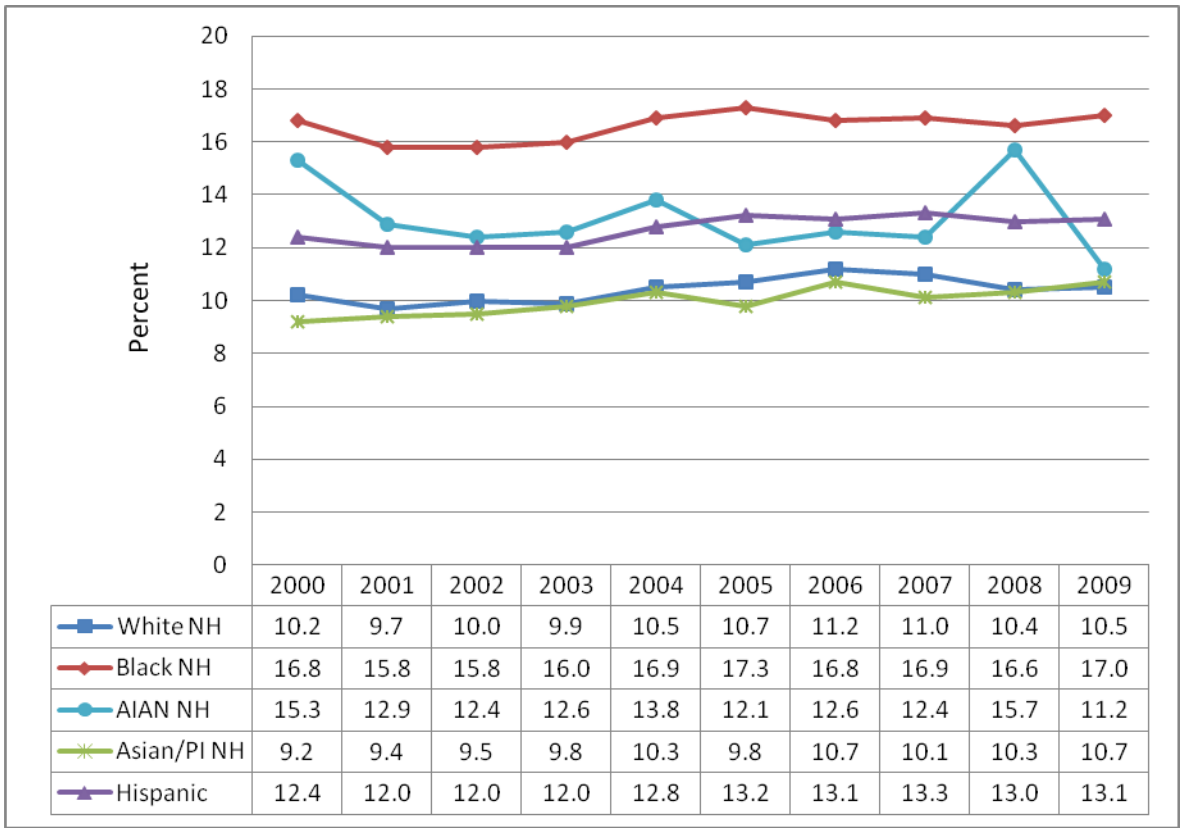
Maternal and Child Health

A preterm birth is any birth that occurs before the 37th week of pregnancy. It is the cause of many infant deaths and lingering infant illnesses in the United States. Premature babies also face an increased risk of lasting disabilities, such as mental retardation, learning and behavioral problems, cerebral palsy, lung problems and vision and hearing loss.[1]

Between 2000 and 2009, the percentage of births that were preterm has been relatively unchanged for all groups except American Indian/Alaska Natives who experienced a decrease of about 27 percent since 2000.

Among Black non-Hispanic women, 17 percent of births were born before 37 weeks gestation in 2009. This percentage was more than 50 percent higher than the rate for White non-Hispanics, American Indian/Alaska Native non-Hispanics and Asian/Pacific Islander non-Hispanics and 30 percent higher than the rate for Hispanic women.

Figure 19. Percentage of Preterm Births (Less than 37 Weeks) by Race/Ethnicity, New York State, 2000-2009



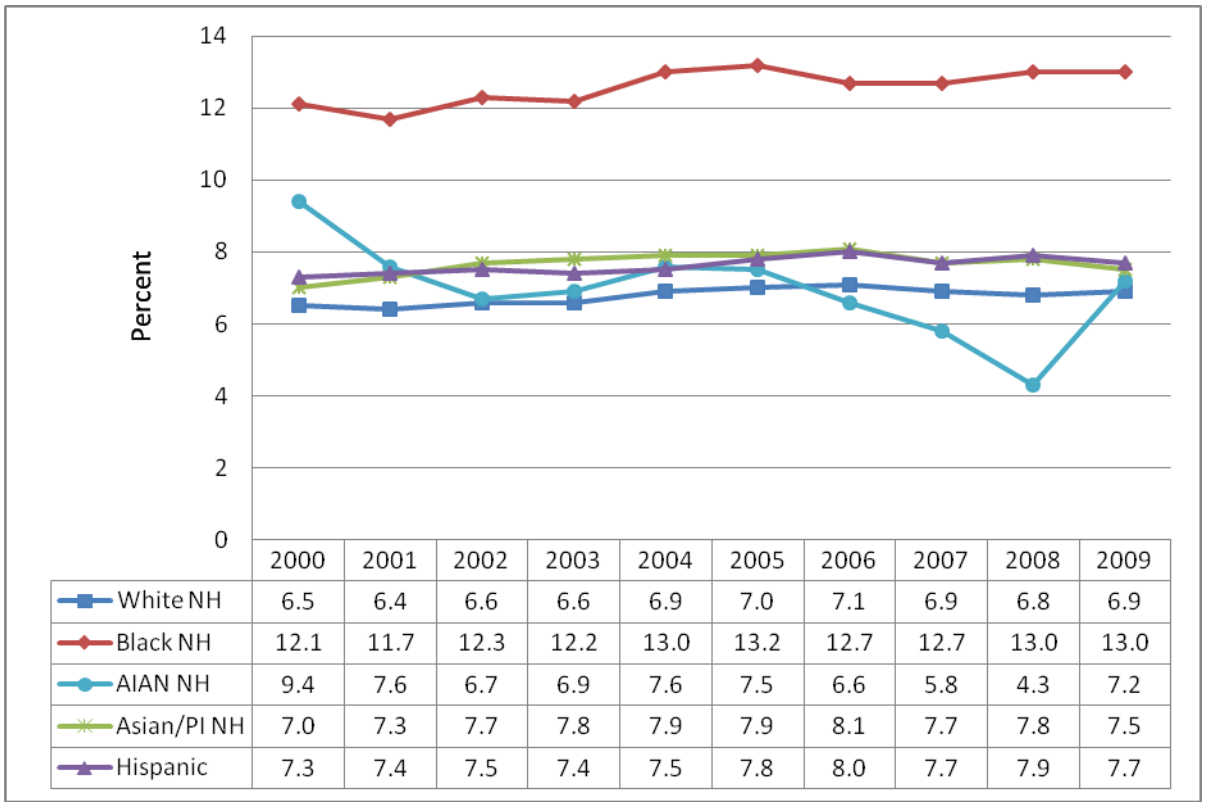
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	10.2	9.7	10.0	9.9	10.5	10.7	11.2	11.0	10.4	10.5
Black NH	16.8	15.8	15.8	16.0	16.9	17.3	16.8	16.9	16.6	17.0
AIAN NH	15.3	12.9	12.4	12.6	13.8	12.1	12.6	12.4	15.7	11.2
Asian/PI NH	9.2	9.4	9.5	9.8	10.3	9.8	10.7	10.1	10.3	10.7
Hispanic	12.4	12.0	12.0	12.0	12.8	13.2	13.1	13.3	13.0	13.1

Abbreviations: NH – non-Hispanics; AIAN – American Indian Alaska Native; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Infants weighing less than 2,500 grams at birth are at greater risk of death within their first month, as well as at increased risk for developmental disabilities and illness throughout their lives.

Over the past decade, the percentage of low birth weight infants among Black non-Hispanic mothers was the highest of all racial/ethnic groups, and rose from 12.1 percent in 2000 to13.0 percent in 2009. In 2009, these mothers (13.0 percent) had nearly twice the percentage of low birth weight births than White non-Hispanics, Asian/Pacific Islander non-Hispanics, American Indian/Alaskan Native non-Hispanics and Hispanics (6.9 percent, 7.5 percent, 7.2 percent and 7.7 percent, respectively).

Figure 20. Percentage of Births Under 2,500 Grams by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	6.5	6.4	6.6	6.6	6.9	7.0	7.1	6.9	6.8	6.9
Black NH	12.1	11.7	12.3	12.2	13.0	13.2	12.7	12.7	13.0	13.0
AIAN NH	9.4	7.6	6.7	6.9	7.6	7.5	6.6	5.8	4.3	7.2
Asian/PI NH	7.0	7.3	7.7	7.8	7.9	7.9	8.1	7.7	7.8	7.5
Hispanic	7.3	7.4	7.5	7.4	7.5	7.8	8.0	7.7	7.9	7.7

Abbreviations: NH – non-Hispanics; AIAN – American Indian Alaska Native; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics.

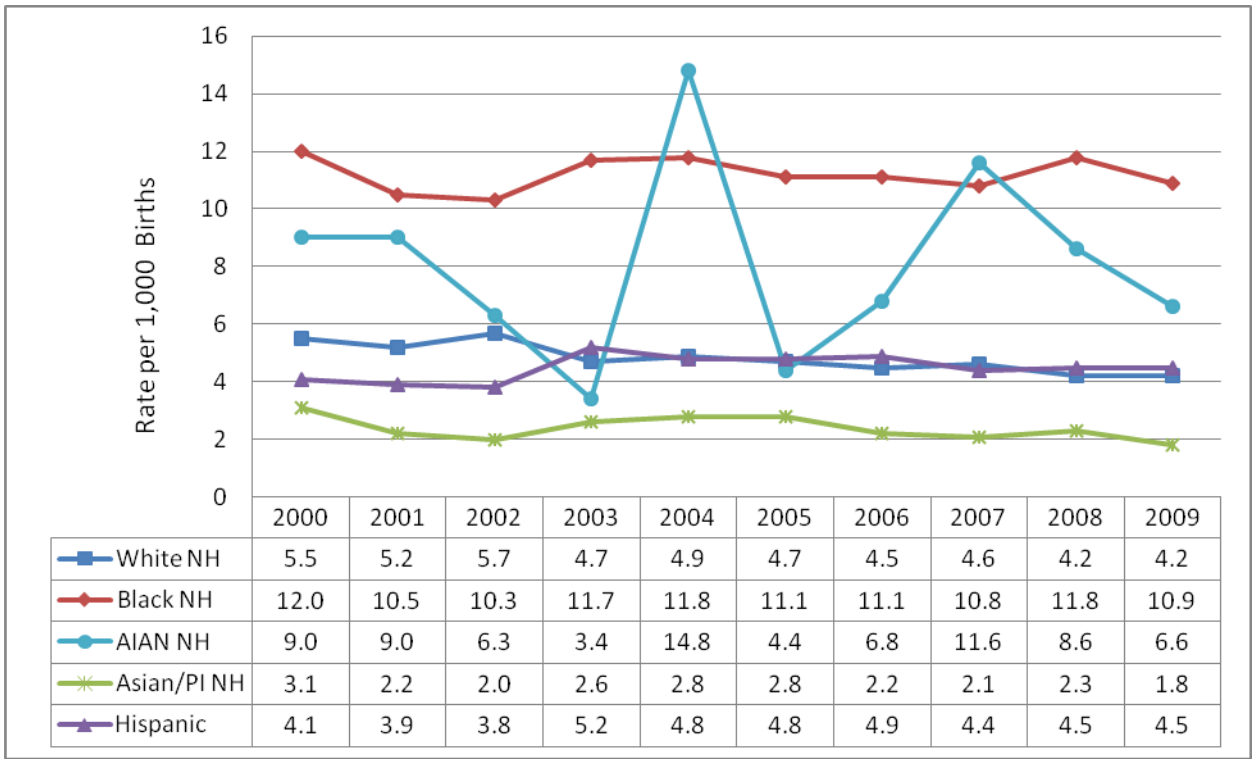
Infant mortality is one of the most widely used indicators of the health and welfare of a population because it reflects the general state of maternal health and effectiveness of primary health care. Infant mortality is related to a mother's health, prenatal care, quality of health services, socioeconomic status and other factors.

For the past decade, disparities in mortality remained significant between Black non-Hispanic infants and those born to White non-Hispanics and Asian/Pacific Islander non-Hispanics. While the infant mortality rate among the White non-Hispanic population declined steadily, the rate among Black non-Hispanic infants fluctuated.

In 2009, Black non-Hispanic infant mortality (10.9 per 1,000) was more than double the rate among White non-Hispanic (4.2 per 1,000) and Hispanic (4.5 per 1,000) infants and six times the rate among Asian/Pacific Islander non-Hispanics (1.8 per 1,000).

The infant mortality rate among American Indian/Alaskan Native non-Hispanics fluctuated during this time period, reaching a high of 14.8 per 1,000 in 2004, but then declining to 6.6 per 1,000 in 2009.

Figure 21. Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	5.5	5.2	5.7	4.7	4.9	4.7	4.5	4.6	4.2	4.2
Black NH	12.0	10.5	10.3	11.7	11.8	11.1	11.1	10.8	11.8	10.9
AIAN NH	9.0	9.0	6.3	3.4	14.8	4.4	6.8	11.6	8.6	6.6
Asian/PI NH	3.1	2.2	2.0	2.6	2.8	2.8	2.2	2.1	2.3	1.8
Hispanic	4.1	3.9	3.8	5.2	4.8	4.8	4.9	4.4	4.5	4.5

Abbreviations: NH – non-Hispanics; AIAN – American Indian Alaska Native; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Maternal deaths are reported on death certificates and defined as deaths to women related to or aggravated by pregnancy or pregnancy management and occurring during pregnancy or within 42 days after the end of the pregnancy. Racial disparity in maternal death is significant and exceeds any disparity noted in infant mortality and low birth weight.

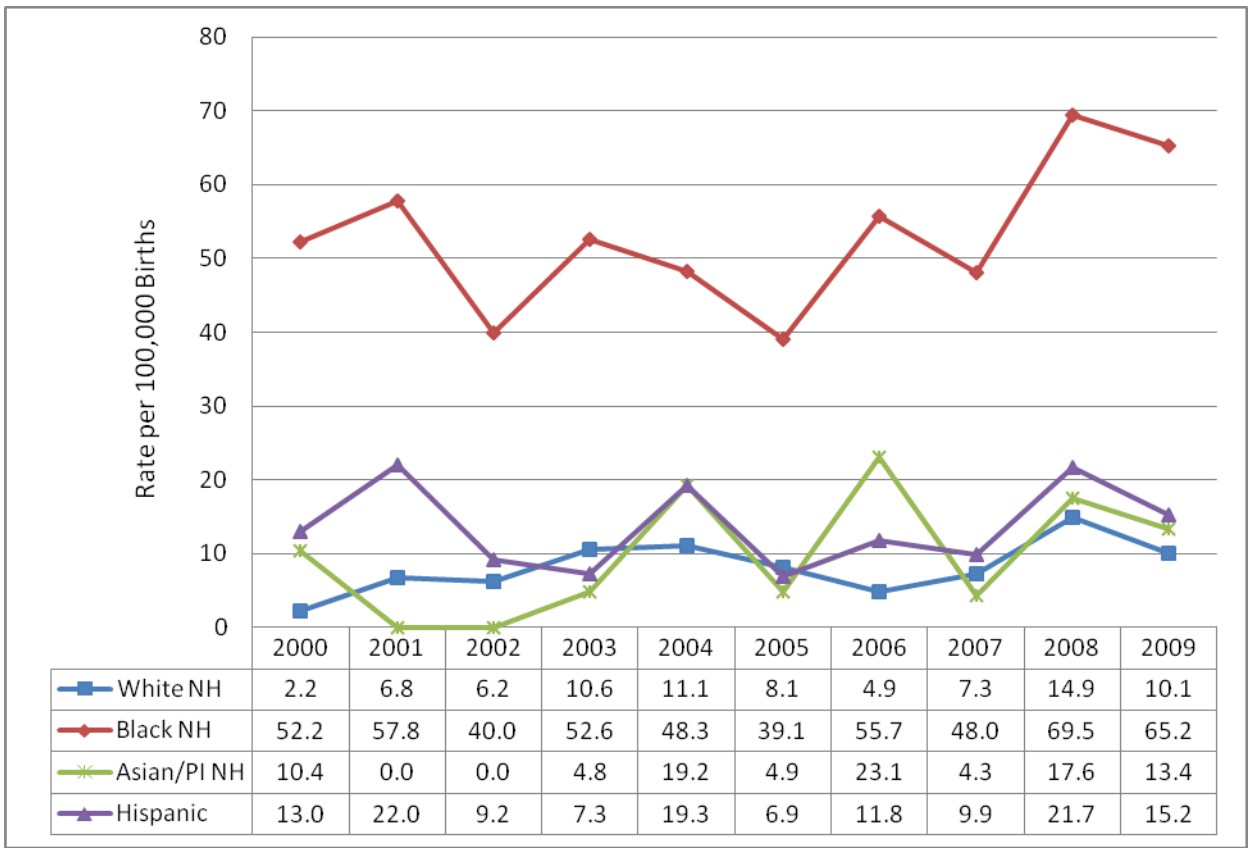
For the past decade, maternal mortality among Black non-Hispanics has been consistently higher than other racial/ethnic groups. Furthermore, maternal mortality rates have increased for all groups. The rate among White non-Hispanics was more than four times higher in 2009 (10.1 per 100,000 live births) than in 2000 (2.2 per 100,000 live births). Among Black non-Hispanics, the rate increased by about 25 percent from 52.2 per 100,000 live births in 2000 to 65.2 per 100,000 live births in 2009.

No maternal deaths were recorded among American Indian/Alaska Native non-Hispanic New Yorkers from 2000 to 2009.

In New York during 2009, the maternal mortality rate for Black non-Hispanics (65.2 per 100,000 births) was more than four times the rate for Asian/Pacific Islander non-Hispanics (13.4 per 100,000 births) and Hispanics (15.2 per 100,000 births) and more than six times the rate for White non-Hispanics (10.1 per 100,000 births).

Because maternal deaths are rare, rates are based on very small numbers. Small changes in numbers cause large fluctuations in rates. In 2009, there were 12 White non-Hispanic, 26 Black non-Hispanic, zero American Indian Alaska Natives non-Hispanic, three Asian/Pacific Islander non-Hispanic and nine Hispanic maternal deaths in New York. There are also many reporting issues related to maternal mortality that contribute to inconsistent rates. For example, if investigators rely solely on the death certificates to identify maternal deaths, the relationship of certain conditions to a previous pregnancy may not be clear, and the death may never be classified as a maternal death. Efforts to improve case ascertainment, such as the Department's Maternal Mortality Review, may result in what appears to be a significant increase in maternal deaths.

Figure 22. Maternal Mortality Rate per 100,000 Live Births by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	2.2	6.8	6.2	10.6	11.1	8.1	4.9	7.3	14.9	10.1
Black NH	52.2	57.8	40.0	52.6	48.3	39.1	55.7	48.0	69.5	65.2
Asian/PI NH	10.4	0.0	0.0	4.8	19.2	4.9	23.1	4.3	17.6	13.4
Hispanic	13.0	22.0	9.2	7.3	19.3	6.9	11.8	9.9	21.7	15.2

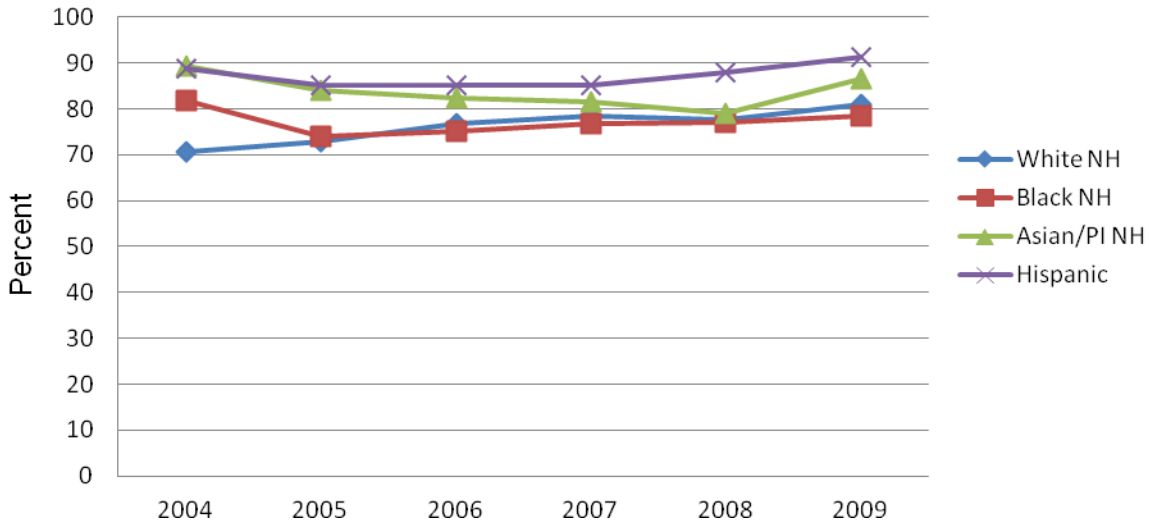
Maternal mortality rates are based on ICD-10 codes O00-95, O98-O99, and A34
Abbreviations: NH – non-Hispanic; AIAN – American Indian Alaska Native; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

For most infants and mothers, breastfeeding offers health benefits that cannot be found in formula feeding. Breast-fed infants are less likely to suffer from severe diarrhea, respiratory infections and ear infections. Their mothers tend to return to their pre-pregnancy weight earlier and are at a reduced risk of postpartum bleeding, pre-menopausal breast cancer and osteoporosis.[2]

Initiation of breastfeeding increased from 2004-2009 for White non-Hispanic and Hispanic women, and decreased for Asian/Pacific Islanders non-Hispanic and Black non-Hispanic women.

During 2009, the percentages of breastfeeding initiation ranged from a high of 91.3 percent among Hispanic women to a low of 78.4 percent among Black non-Hispanic women. New York State reports breastfeeding initiation rates for New York State Hospitals on the Department of Health website: http://hospitals.nyhealth.gov/

Figure 23. Percentage of Women Who Initiated Breastfeeding by Race/Ethnicity, New York State, 2004-2009

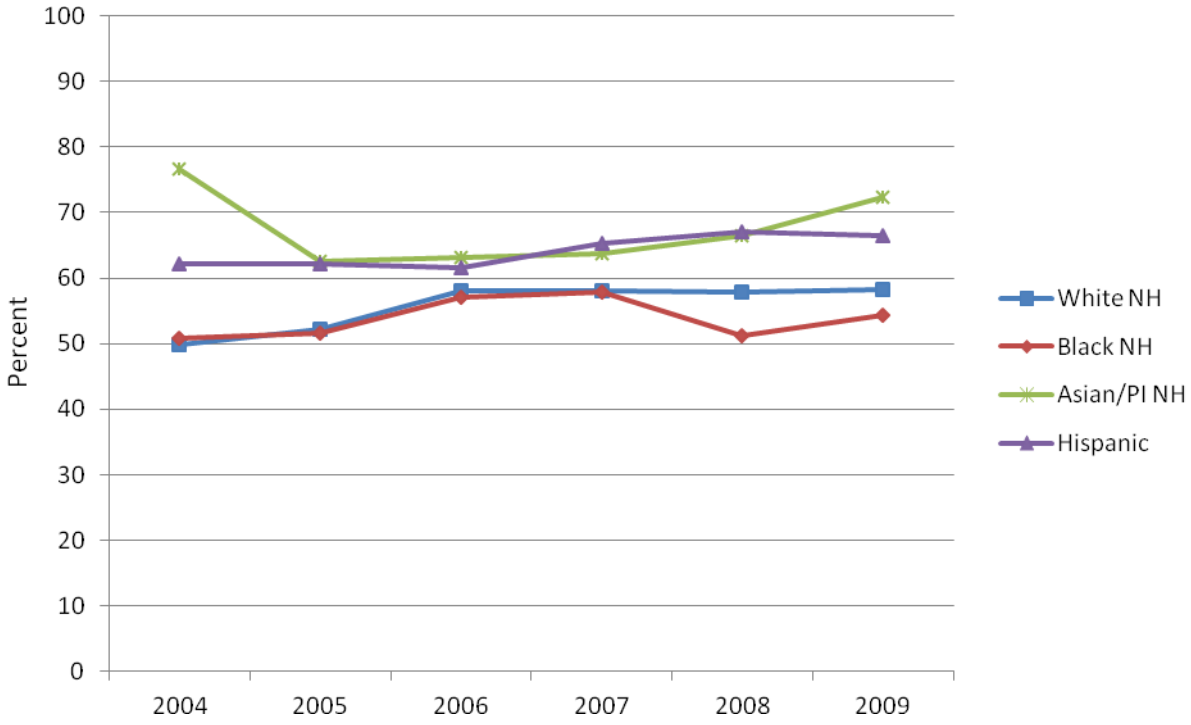


Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**70.6**	**72.9**	**76.9**	**78.5**	**77.6**	**81.0**
	CI	67.0 - 74.1	69.6 - 76.2	73.9 - 79.9	75.5 - 81.6	74.5 - 80.7	77.8 - 84.1
Black NH	Percent	**81.8**	**74.0**	**75.2**	**76.9**	**77.1**	**78.4**
	CI	75.9 - 87.7	67.5 - 80.5	69.6 - 80.9	71.3 - 82.5	70.5 - 83.8	72.5 - 84.2
Asian/PI NH	Percent	**89.4**	**84.1**	**82.4**	**81.6**	**79.0**	**86.5**
	CI	82.0 - 96.8	75.8 - 92.4	75.4 - 89.4	74.5 - 88.6	71.4 - 86.6	80.7 - 92.3
Hispanic	Percent	**88.7**	**85.2**	**85.2**	**85.2**	**88.1**	**91.3**
	CI	84.6 - 92.8	81.3 - 89.2	81.7 - 88.8	81.5 - 88.9	84.4 - 91.9	88.4 - 94.2

Abbreviations: NH – non-Hispanic; PI – Pacific Islander
CI: 95% Confidence Interval
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

From 2004 to 2007, the percentage of women, who breastfed for eight weeks or more, increased steadily among White and Black non-Hispanic women. After 2007, the percentage for White non-Hispanic women remained constant, while Black non-Hispanics decreased from 57.9 percent in 2007 to 51.3 percent in 2008. Percentages among Asian/Pacific Islander non-Hispanic and Hispanic women fluctuated from 2004-2009.

Figure 24. Percentage of Women Who Breastfed for Eight Weeks or More by Race/Ethnicity, New York State, 2004-2009



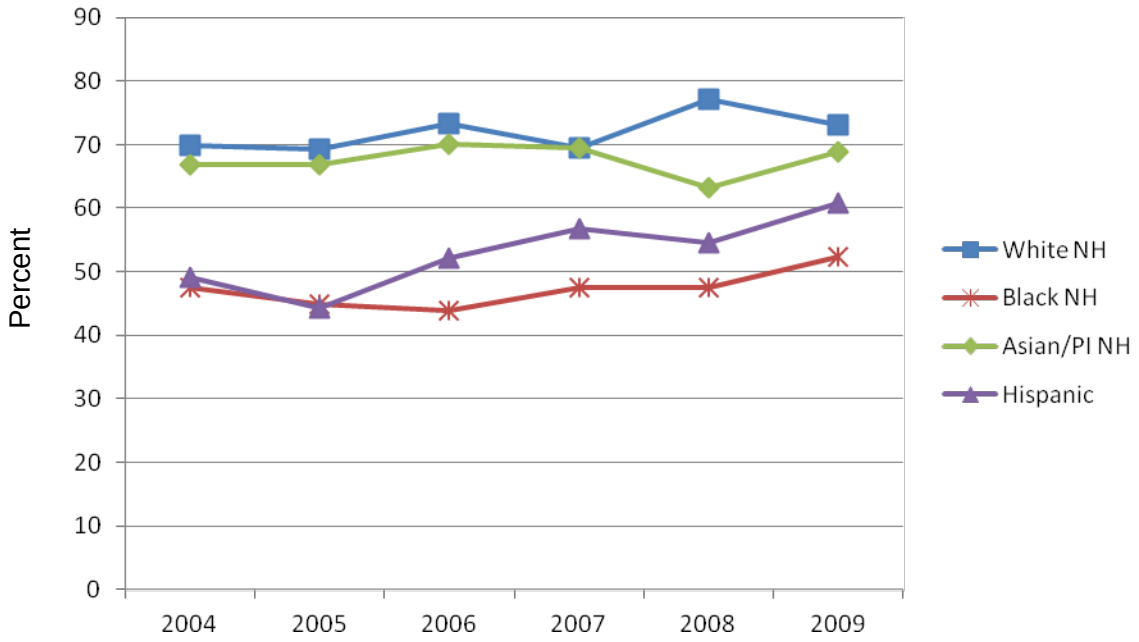
Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**49.9**	**52.1**	**58.0**	**58.1**	**57.9**	**58.3**
	CI	46.0 - 53.7	48.4 - 55.8	54.6 - 61.5	54.5 - 61.7	54.2 - 61.6	54.5 - 62.1
Black NH	Percent	**50.9**	**51.6**	**57.0**	**57.9**	**51.3**	**54.3**
	CI	43.1 - 58.8	44.3 - 58.9	50.8 - 63.3	51.4 - 64.3	43.6 - 58.9	47.6 - 61.0
Asian/PI NH	Percent	**76.7**	**62.5**	**63.2**	**63.7**	**66.5**	**72.4**
	CI	66.6 - 86.8	51.9 - 73.1	54.5 - 71.8	55.2 - 72.3	57.8 - 75.3	64.9 - 79.9
Hispanic	Percent	**62.2**	**62.2**	**61.6**	**65.2**	**67.0**	**66.4**
	CI	55.5 - 68.9	56.9 - 67.4	56.7 - 66.4	60.3 - 70.0	61.7 - 72.3	61.6 - 71.2

Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
CI: 95% Confidence Interval
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

Infants who are placed on their backs for sleeping are at a reduced risk for Sudden Infant Death Syndrome (SIDS). Infants under the age of one year who die suddenly are given the diagnosis of SIDS when the cause of death remains unknown after a complete investigation.

During 2004-2009, the percentage of babies who slept on their backs increased for all racial/ethnic groups. However, the percentage for Black non-Hispanic infants put to sleep on their backs has continued to be markedly lower than the percentage of infants from other racial/ethnic groups.

Figure 25. Percentage of Babies Put to Sleep on Their Backs by Race/Ethnicity, New York State, 2004-2009



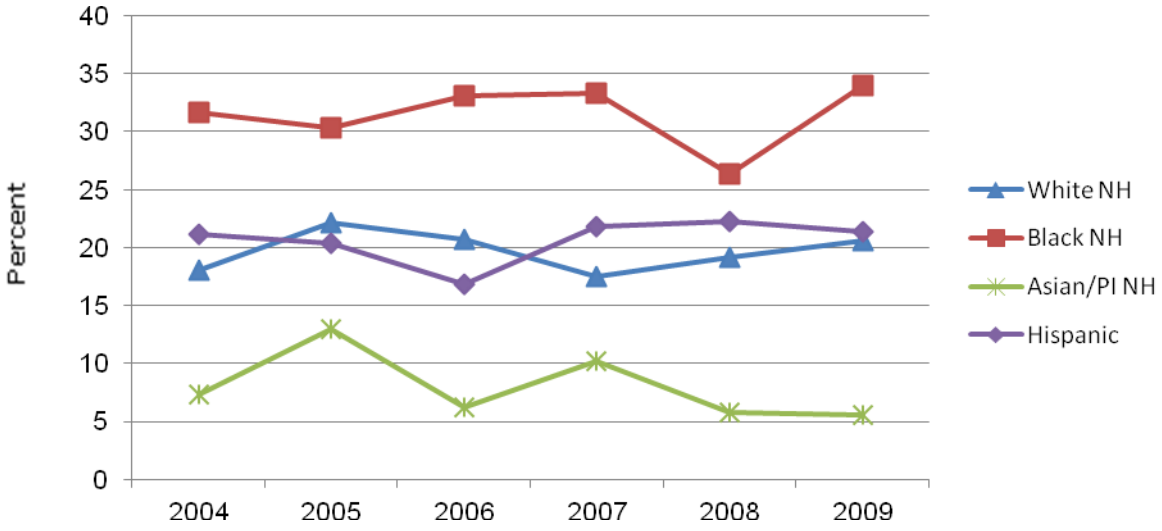
Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**69.9**	**69.2**	**73.3**	**69.4**	**77.1**	**73.1**
	CI	66.4 - 73.4	65.7 - 72.7	70.2 - 76.5	66.0 - 72.8	74.0 - 80.3	69.6 - 76.5
Black NH	Percent	**47.4**	**44.8**	**43.9**	**47.6**	**47.5**	**52.3**
	CI	39.7 - 55.2	37.5 - 52.0	37.7 - 50.1	41.2 - 54.1	39.8 - 55.1	45.7 - 59.0
Asian/PI NH	Percent	**66.9**	**66.8**	**70.1**	**69.5**	**63.2**	**68.8**
	CI	55.0 - 78.8	56.2 - 77.4	61.9 - 78.2	61.4 - 77.6	54.2 - 72.2	61.1 - 76.5
Hispanic	Percent	**49.1**	**44.2**	**52.1**	**56.8**	**54.5**	**60.9**
	CI	42.3 - 56.0	38.9 - 49.5	47.1 - 57.0	51.9 - 61.7	49.0 - 60.1	56.0 - 65.8

Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
CI: 95% Confidence Interval
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

Obesity has reached epidemic proportion in New York State as well as nationally. Maternal obesity is associated with many complications of pregnancy such as cesarean delivery, macrosomia, gestational hypertension, preeclampsia, gestational diabetes mellitus, fetal death, and certain birth defects. Children born to obese mothers are twice as likely to become obese and to develop diabetes later in life.[3]

The percentage of births to obese New York women fluctuated during 2004-2009 for all racial/ethnic groups. In 2004, 18.1 percent of White non-Hispanic women were obese before pregnancy. In 2009, the rate increased to 20.1 percent. Almost 32 percent of Black non-Hispanic women were obese before pregnancy in 2004; rising to 34.0 percent in 2009. Among Asian/Pacific Islander non-Hispanics, the pre-pregnancy obesity rate decreased from 7.3 percent in 2004 to 5.6 percent in 2009. Among Hispanic women, the percentage was relatively unchanged.

Figure 26. Percentage of Births to Women Who Were Obese* Before Pregnancy by Race/Ethnicity, New York State, 2004-2009



Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**18.1**	**22.1**	**20.7**	**17.5**	**19.2**	**20.6**
	CI	15.1 - 21.1	18.9 - 25.2	17.8 - 23.6	14.7 - 20.3	16.2 - 22.1	17.4 - 23.7
Black NH	Percent	**31.6**	**30.3**	**33.1**	**33.3**	**26.3**	**34.0**
	CI	24.4 - 38.8	23.4 - 37.1	27.3 - 39.0	27.1 - 39.6	19.8 - 32.9	27.6 - 40.5
Asian/PI NH	Percent	**7.3**	**13.0**	**6.2**	**10.2**	**5.8**	**5.6**
	CI	0.0 - 14.7	5.4 - 20.5	2.2 - 10.3	4.5 - 15.9	1.5 - 10.0	1.8 - 9.4
Hispanic	Percent	**21.1**	**20.4**	**16.8**	**21.8**	**22.3**	**21.4**
	CI	14.8 - 27.4	15.5 - 25.2	12.6 - 21.0	17.4 - 26.2	17.0 - 27.6	16.7 - 26.0

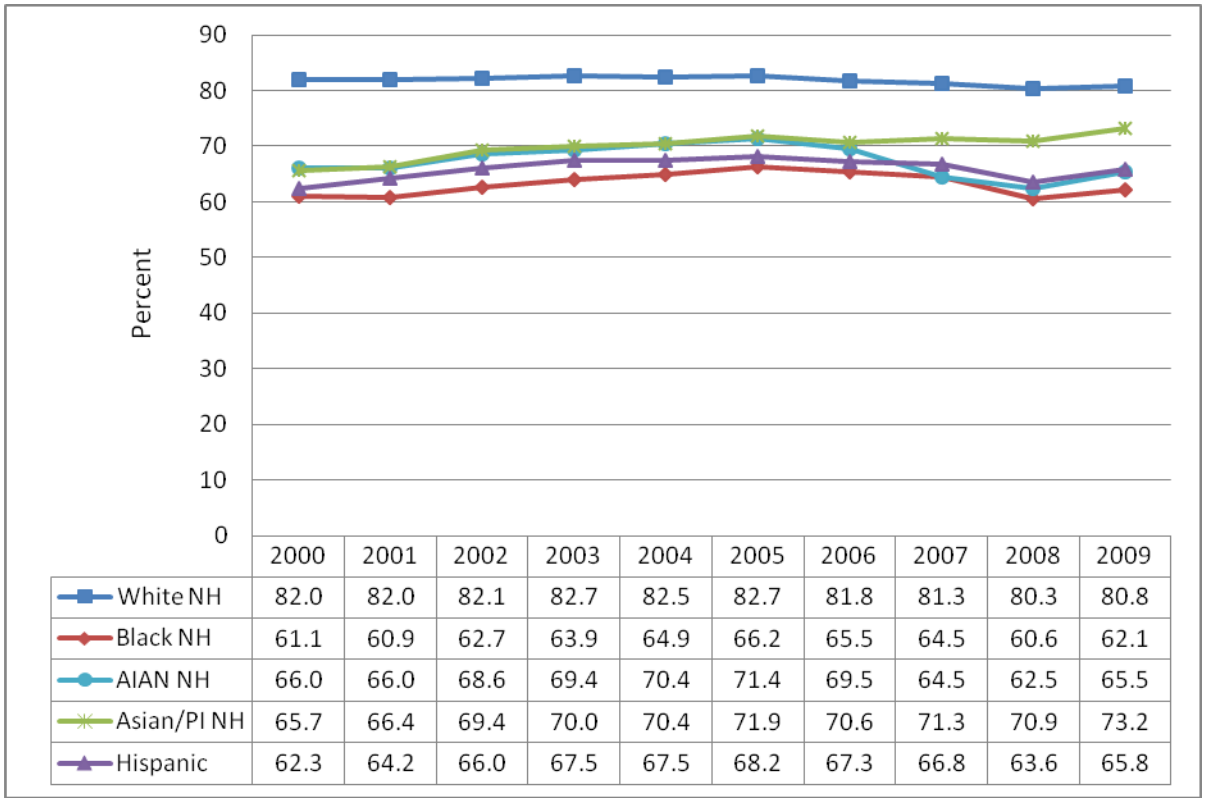
Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
CI: 95% Confidence Interval
* Body mass index was calculated based on mothers' self-reported pre-pregnancy weight and height. A BMI of 30 or higher was considered obese.
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

Early prenatal care is pregnancy-related care beginning in the first trimester (first-third months of pregnancy). Early prenatal care can significantly improve pregnancy outcomes for the infant and mother. Babies born to mothers who receive no prenatal care are three times more likely to be born at low birth weight and five times more likely to die than those whose mothers receive prenatal care.[4]

During the past decade, early prenatal care for White non-Hispanic New York women has slightly decreased from 82.0 percent in 2000 to 80.8 percent in 2009. Early prenatal care among Black non-Hispanic, American Indian/Alaska Native non-Hispanic and Hispanic women peaked in 2005, and decreased thereafter. The percentage of early prenatal care for Asian/Pacific Islander non-Hispanic women has increased overall during this time period.

Although racial/ethnic differences still existed in 2009, they were lower than in the previous nine years. A decade ago the rate for White non-Hispanics was 31-32 percent higher than the rate for Black non-Hispanic or Hispanic women. More White non-Hispanic women received early prenatal care (80.8 percent), followed by Asian/Pacific Islander non-Hispanics (73.2 percent), Hispanics (65.8 percent) American Indian/Alaska Native non-Hispanics (65.5 percent), and Black non-Hispanics (62.1 percent).

Figure 27. Percentage of Births Receiving Early* Prenatal Care by Race/Ethnicity, New York State, 2000-2009



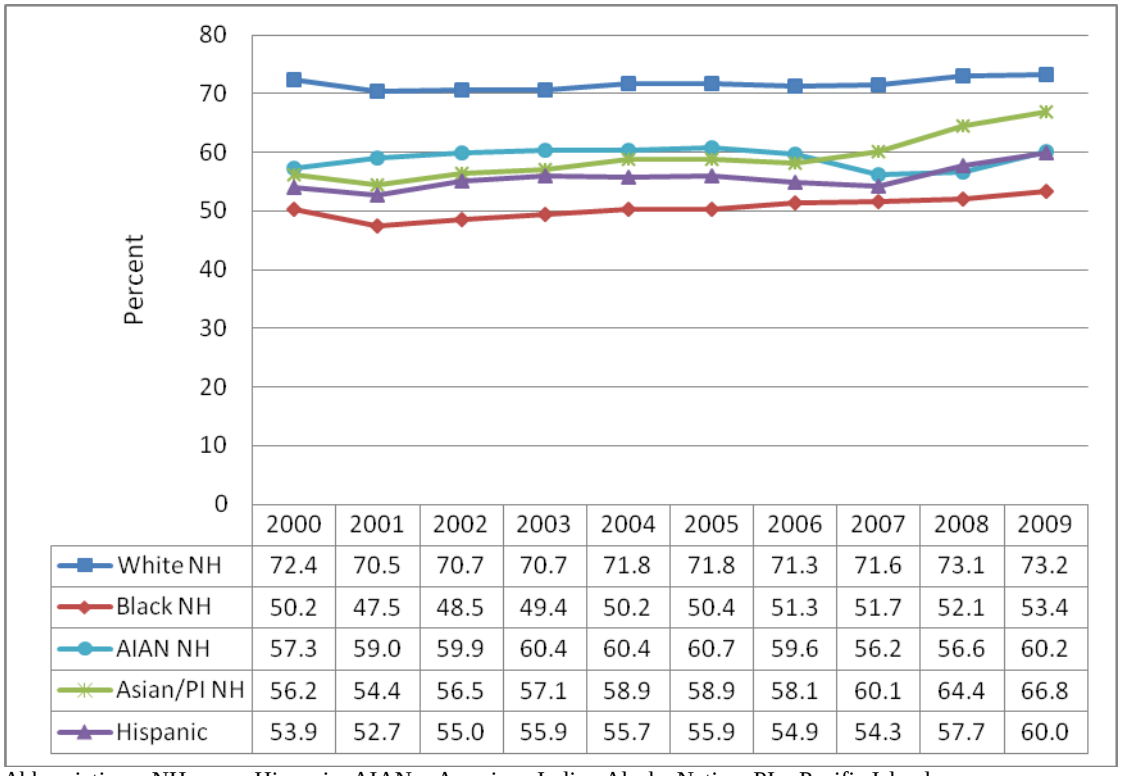
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	82.0	82.0	82.1	82.7	82.5	82.7	81.8	81.3	80.3	80.8
Black NH	61.1	60.9	62.7	63.9	64.9	66.2	65.5	64.5	60.6	62.1
AIAN NH	66.0	66.0	68.6	69.4	70.4	71.4	69.5	64.5	62.5	65.5
Asian/PI NH	65.7	66.4	69.4	70.0	70.4	71.9	70.6	71.3	70.9	73.2
Hispanic	62.3	64.2	66.0	67.5	67.5	68.2	67.3	66.8	63.6	65.8

Abbreviations: NH – non-Hispanics; PI – Pacific Islander
* During the first trimester; women with unknown entry into prenatal care were excluded.
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

The Kotelchuck Index is a calculation of the number of prenatal care visits by pregnant women ages 15-44 who had a live birth during the reporting year, expressed as a percentage of the observed-to-expected number of prenatal visits. For each mother, adequate prenatal care is defined as completion of greater than 80 percent of expected visits, based on when she begins prenatal care.[5]

The percentage of births to women with adequate prenatal care increased over the past decade for all racial/ethnic groups. White non-Hispanics consistently had the highest percentage of adequate prenatal care, followed by Asian/Pacific Islander non-Hispanics and American Indian/Alaska Native non-Hispanics. Black non-Hispanic women were the least likely to receive adequate prenatal during their pregnancy in the time period 2000-2009.

Figure 28. Percentage of Births with Adequate Prenatal Care (Kotelchuck Index) by Race/Ethnicity, New York State, 2000-2009



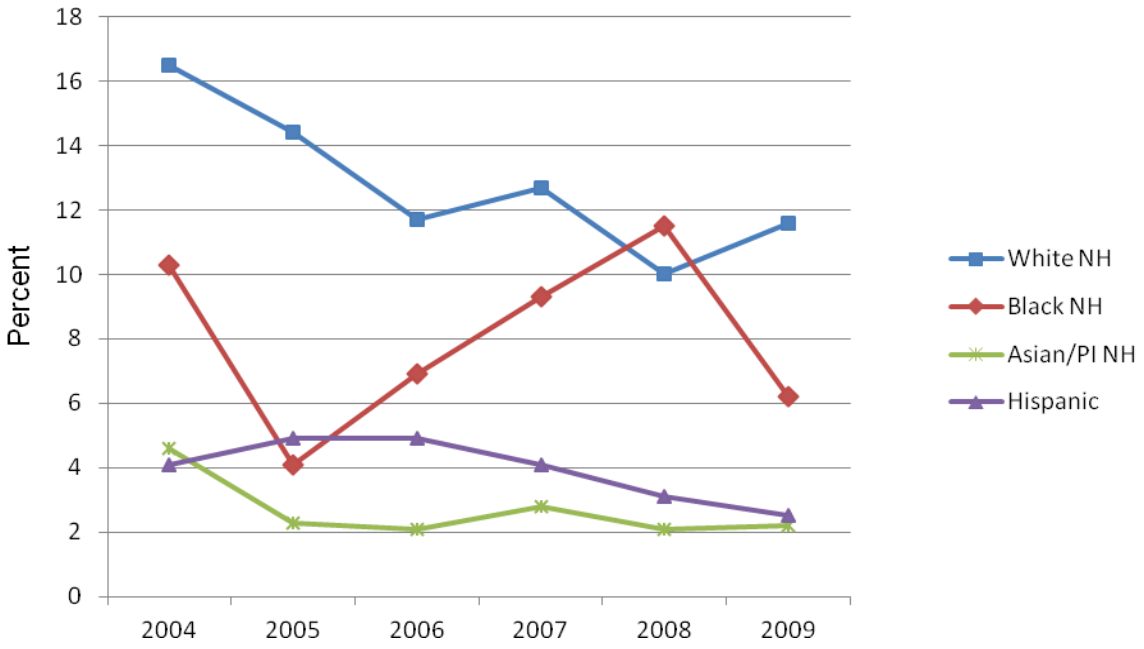
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	72.4	70.5	70.7	70.7	71.8	71.8	71.3	71.6	73.1	73.2
Black NH	50.2	47.5	48.5	49.4	50.2	50.4	51.3	51.7	52.1	53.4
AIAN NH	57.3	59.0	59.9	60.4	60.4	60.7	59.6	56.2	56.6	60.2
Asian/PI NH	56.2	54.4	56.5	57.1	58.9	58.9	58.1	60.1	64.4	66.8
Hispanic	53.9	52.7	55.0	55.9	55.7	55.9	54.9	54.3	57.7	60.0

Abbreviations: NH – non-Hispanic; AIAN – American Indian Alaska Native; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Cigarette smoking has been associated with numerous health problems for both mother and child. Cigarette smoking during pregnancy is linked to stillbirths, preterm deliveries, smaller babies for their gestational age, and low birth weight births. Children exposed to secondhand smoke are at increased risk of lower respiratory infections, ear infections, asthma and sudden infant death syndrome.[6]

The percentages of New York women who smoked during the last trimester of pregnancy decreased from 2004-2009 for all racial/ethnic groups. However, in 2009, White non-Hispanic pregnant women were at nearly twice the rate of Black non-Hispanics and five times the rate of Asian/Pacific Islanders and Hispanics.

Figure 29. Percentage of Women Smoking During the Last Three Months of Pregnancy by Race/Ethnicity, New York State, 2004-2009



Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**16.5**	**14.4**	**11.7**	**12.7**	**10.0**	**11.6**
	CI	13.5 - 19.5	11.7 - 17.1	9.3 - 14.1	10.2 - 15.2	7.8 - 12.3	9.0 - 14.2
Black NH	Percent	**10.3**	**4.1**	**6.9**	**9.3**	**11.5**	**6.2**
	CI	5.7 - 14.8	1.6 - 6.7	3.5 - 10.3	5.5 - 13.0	6.4 - 16.6	2.9 - 9.4
Asian/PI NH	Percent	**4.6**	**2.3**	**2.1**	**2.8**	**2.1**	**2.2**
	CI	0.0 - 10.7	0.0 - 5.1	0.0 - 4.8	0.0 - 5.8	0.0 - 5.0	0.0 - 4.6
Hispanic	Percent	**4.1**	**4.9**	**4.9**	**4.1**	**3.1**	**2.5**
	CI	1.7 - 6.5	2.5 - 7.3	2.8 - 7.0	2.1 - 6.0	1.3 - 4.9	1.0 - 4.0

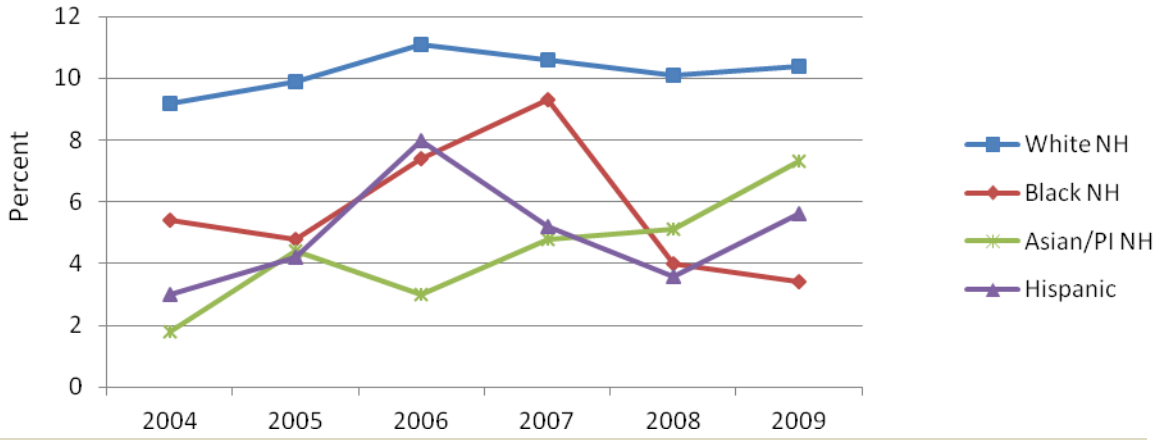
Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
CI: 95% Confidence Interval
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

During the third trimester of pregnancy a developing fetus grows and gains weight rapidly. The brain and central nervous system are in an important stage of development. Harmful substances, such as alcohol, can affect development. Drinking alcohol during pregnancy is associated with fetal alcohol syndrome, a birth defect that is 100 percent preventable by not drinking alcohol during pregnancy. Other possible side effects from maternal alcoholic consumption are higher risk of miscarriage, lower birth weight and/or delayed growth, learning disabilities, mental retardation and attention deficit/hyperactivity disorder.[7]

During 2004-2009, the percentage of women consuming alcohol during the last three months of pregnancy remained stable for all racial/ethnic groups with the exception of Asian/Pacific Islander non-Hispanic women. This group's percentage has gradually increased from 1.8 percent in 2004 to 7.3 percent in 2009.

In 2009, there were higher percentages of alcohol consumption during the last trimester among White non-Hispanic (10.4 percent) and Asian/Pacific Islanders non-Hispanic (7.3 percent) women. Percentages were somewhat lower among Hispanic and Black non-Hispanic women (5.6 percent and 3.4 percent, respectively).

Figure 30. Percentage of Women Drinking During the Last Three Months of Pregnancy by Race/Ethnicity, New York State, 2004-2009



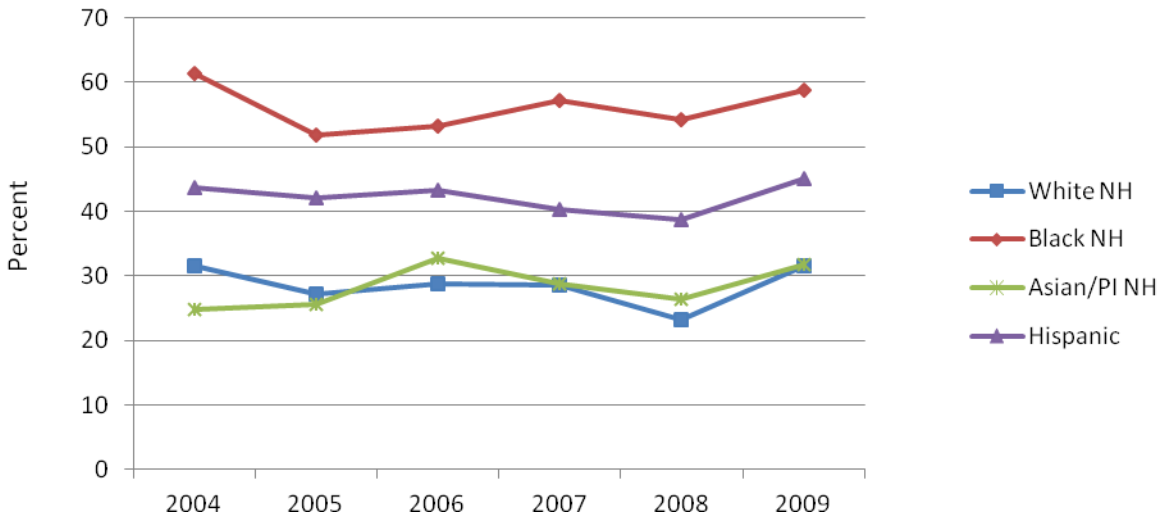
Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**9.2**	**9.9**	**11.1**	**10.6**	**10.1**	**10.4**
	CI	7.1 - 11.2	7.8 - 12.1	9.1 - 13.2	8.5 - 12.6	7.9 - 12.3	8.2 - 12.6
Black NH	Percent	**5.4**	**4.8**	**7.4**	**9.3**	**4.0**	**3.4**
	CI	2.1 - 8.7	1.9 - 7.6	3.8 - 11.0	5.6 - 13.1	1.0 - 7.0	1.1 - 5.8
Asian/PI NH	Percent	**1.8**	**4.4**	**3.0**	**4.8**	**5.1**	**7.3**
	CI	0.0 - 4.5	0.5 - 8.3	0.4 - 5.7	1.7 - 8.0	1.1 - 9.1	3.2 - 11.4
Hispanic	Percent	**3.0**	**4.2**	**8.0**	**5.2**	**3.6**	**5.6**
	CI	1.0 - 5.1	2.2 - 6.1	5.3 - 10.7	2.9 - 7.4	1.6 - 5.6	3.3 - 7.8

Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
CI: 95% Confidence Interval
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

An unintended pregnancy is a pregnancy that is either mistimed or unwanted at the time of conception. It is a core concept in understanding the fertility of populations and the unmet need for contraception. Unintended pregnancy is associated with an increased risk of morbidity for women, and with health behaviors during pregnancy that are associated with adverse effects. Black non-Hispanic women had the highest percentage of unintended pregnancy from 2004-2009, 61.3 percent and 58.8 percent, respectively, followed by Hispanic, Asian/Pacific Islander non-Hispanic and White non-Hispanic women. Over the past six years, the unintended pregnancy percentages remained relatively unchanged for all racial/ethnic groups.

Black non-Hispanic women had the highest percentage of unintended pregnancy from 2004-2009, 61.3 percent and 58.8 percent, respectively, followed by Hispanic, Asian/Pacific Islander non-Hispanic and White non-Hispanic women. Over the past six years, the unintended pregnancy percentages remained relatively unchanged for all racial/ethnic groups.

Figure 31. Percentage of Births Resulting From an Unintended* Pregnancy by Race/Ethnicity, New York State, 2004-2009



Race/Ethnicity		2004	2005	2006	2007	2008	2009
White NH	Percent	**31.6**	**27.1**	**28.7**	**28.6**	**23.2**	**31.5**
	CI	27.9 - 35.2	23.8 - 30.5	25.4 - 32.0	25.3 - 32.0	20.1 - 26.4	27.9 - 35.2
Black NH	Percent	**61.3**	**51.9**	**53.2**	**57.2**	**54.3**	**58.8**
	CI	54.0 - 68.6	44.8 - 59.0	47.1 - 59.4	50.9 - 63.4	47.0 - 61.7	52.4 - 65.3
Asian/PI NH	Percent	**24.7**	**25.5**	**32.7**	**28.7**	**26.4**	**31.7**
	CI	13.9 - 35.5	16.4 - 34.7	24.2 - 41.1	20.8 - 36.7	18.4 - 34.4	24.1 - 39.3
Hispanic	Percent	**43.7**	**42.0**	**43.3**	**40.2**	**38.7**	**45.0**
	CI	37.0 - 50.4	36.8 - 47.3	38.5 - 48.1	35.4 - 45.0	33.4 - 44.1	40.0 - 50.0

Abbreviations: NH – non-Hispanic; PI – Pacific Islander
CI: 95% Confidence Interval
* Unintended pregnancies are those that, at the time of conception, are either mistimed (the woman did not want to be pregnant until later) or unwanted (the woman did not want to be pregnant at any time).
Source: New York State Department of Health, Pregnancy Risk Assessment Monitoring System

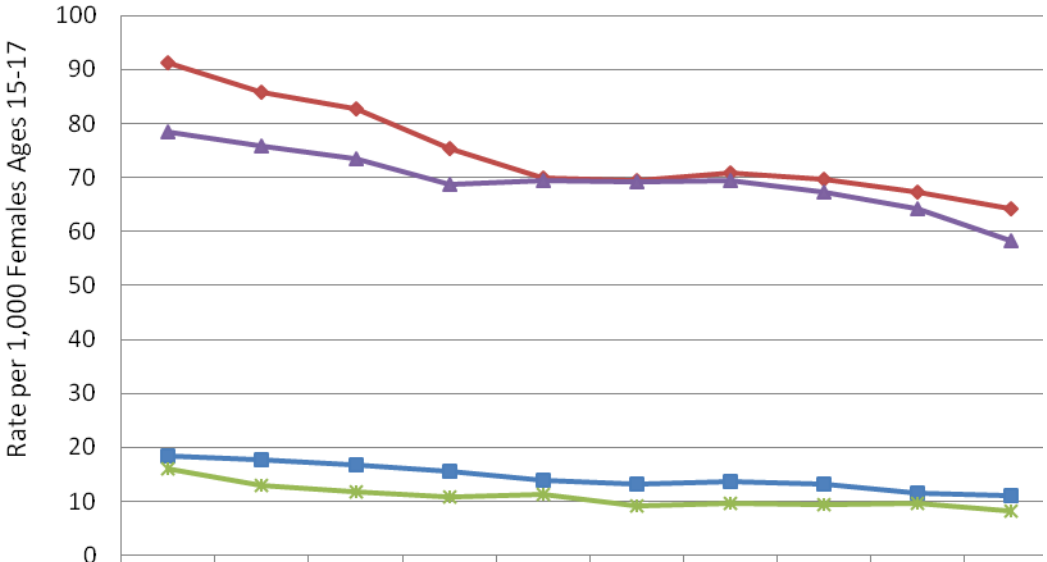
The incidence of teenage pregnancy is significantly higher in the United States than in other developed countries, despite similar ages of onset of sexual activity. Teen pregnancy costs American taxpayers an estimated $9 billion annually. Teen pregnancy is highly correlated with lack of educational attainment and a disadvantage in earning power and economic potential. Thirty-one percent of women in the United States become pregnant at least once before age 20.[8]

New York's teen pregnancy rate remains lower than the national average, however racial and ethnic disparities continue. In New York State, 46 percent of births in 2009 were to women enrolled in or eligible for? Medicaid or Family Health Plus. 6.7 percent of all New York State Births were to women less than 20 years of age.

For the past decade, teenage pregnancy rates have decreased for all racial/ethnic groups. Teenage pregnancy rates were the highest among Black non-Hispanics and Hispanics (64.1 and 58.3 per 1,000, respectively), compared to White non-Hispanics and Asian/Pacific Islander non-Hispanics (11.0 and 8.2 per 1,000, respectively).

Though Black non-Hispanics and Hispanics have shown large declines in their teenage pregnancy rates, considerable disparities remain between these groups and Asian/Pacific Islanders and White non-Hispanics.

Figure 32. Teenage Pregnancy Rate per 1,000 Females Ages 15-17 by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	18.4	17.7	16.8	15.6	13.9	13.1	13.7	13.1	11.4	11.0
Black NH	91.2	85.8	82.6	75.3	70.0	69.4	70.9	69.7	67.3	64.1
Asian/PI NH	15.9	12.8	11.7	10.7	11.2	9.1	9.7	9.5	9.7	8.2
Hispanic	78.5	75.9	73.5	68.7	69.5	69.2	69.4	67.2	64.3	58.3

Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

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[6] Center for Disease Control and Prevention. (2011). *Reproductive Health: Tobacco Use and Pregnancy*, Retrieved December 15, 2011 from http://www.cdc.gov/reproductivehealth/tobaccousepregnancy/.

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Risk Factors

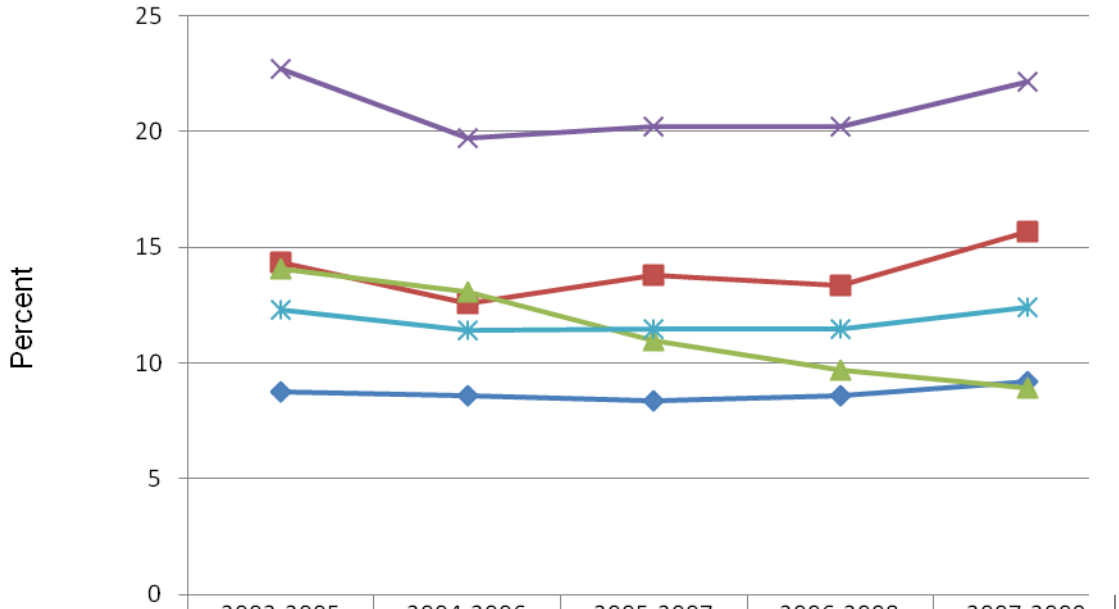
Risk factors include financial barriers that decrease or delay access to healthcare including lack of health insurance, smoking, obesity (often as a consequence of a poor diet and lack of physical activity), alcohol use and early initiation of sexual activity.

Financial barriers to medical care often result in care that is neither coordinated nor as effective as it should be. Delays in screening tests or in seeking treatment may result in more complicated treatments and other long-term health consequences.

During 2007-2009, 22.2 percent of Hispanic New York adults said cost was a barrier to doctor visits – more than twice the rate for White non-Hispanics (9.2 percent) and Asian/non-Hispanics (8.9 percent). Among Black non-Hispanics, 15.7 percent reported not seeing a doctor because of the cost.

From 2003-2008, cost as a factor declined during the three-year average between 2004-2006 and 2006-2008 and then increased during 2007-2009 among White non-Hispanics, Black non-Hispanics and Hispanics. Among Asian non-Hispanics, however, the percentage of adults reporting that cost prevented doctor visits steadily declined.

Figure 33. Age-Adjusted Percentage* of Adults 18 Years and Older for Whom Cost Prevented Doctor Visits by Race/Ethnicity, New York State, 2003-2009



	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	8.8	8.6	8.4	8.6	9.2
Black non-Hispanic	14.4	12.6	13.8	13.4	15.7
Asian non-Hispanic	14.1	13.1	11.0	9.7	8.9
Hispanic	22.7	19.7	20.2	20.2	22.2
Total	12.3	11.4	11.5	11.5	12.4

* Three-year moving average adjusted to the 2000 U.S. population.

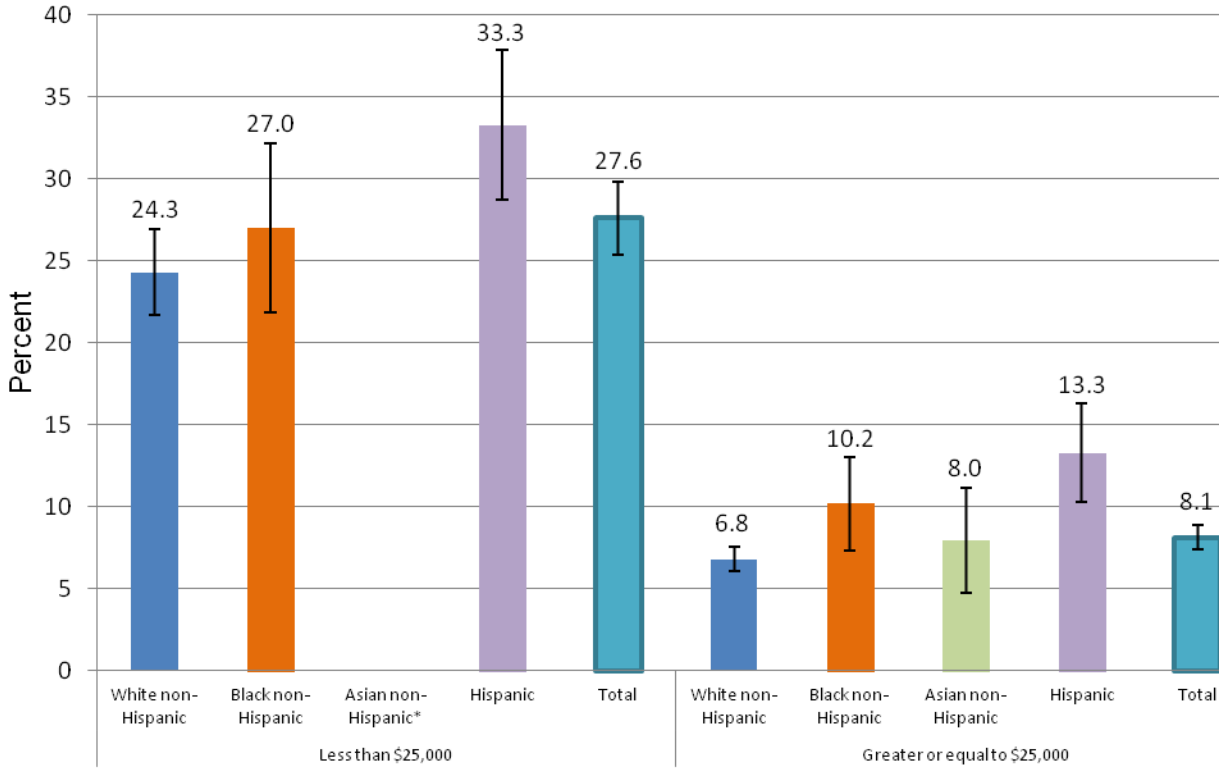
Source: Behavioral Risk Factor Surveillance System

New Yorkers in all racial/ethnic groups with annual household incomes under $25,000 were more likely to report that cost prevented doctor visits than those with higher incomes.

In the lower income category, a significantly greater proportion of Hispanics (33.3 percent) reported not visiting a doctor due to cost than White non-Hispanics (24.3 percent). The sample size for Asian non-Hispanics was insufficient to report on this indicator.

At higher incomes, 13.3 percent of Hispanics reported that cost prevented doctor visits – significantly higher than the 6.8 percent reported by White non-Hispanics.

Figure 34. Age-Adjusted Percentage of Adults 18 Years and Older for Whom Cost Prevented Doctor Visits by Race/Ethnicity and Income Categories, New York State, 2007-2009



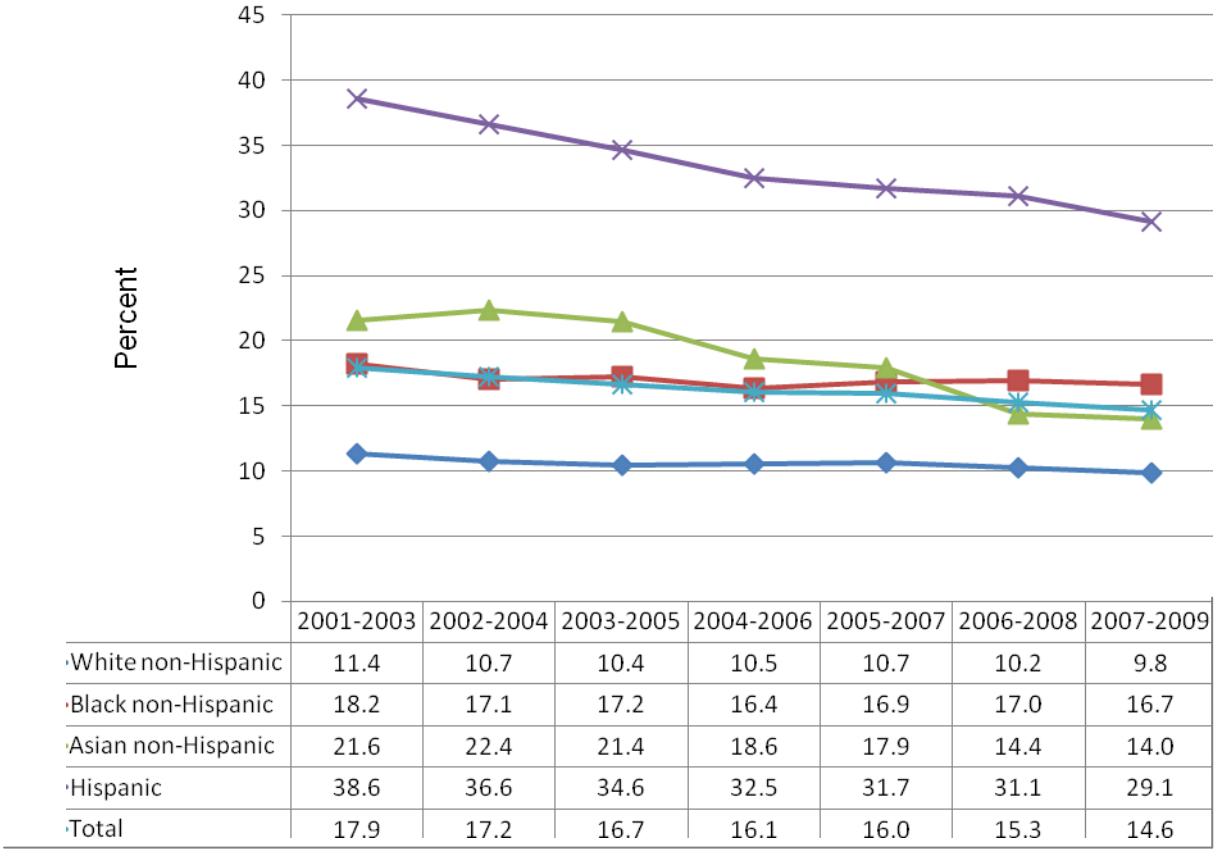
Rate adjusted to the 2000 U.S. population.

* Data do not meet reporting criteria
Source: Behavioral Risk Factor Surveillance System

Health insurance coverage improves access and quality of medical care and can contribute to the overall health of Americans, according to the U.S. Centers for Disease Control and Prevention.[1]

Between 2001-2009, the number of adults without health insurance declined in all race/ethnic groups. However, large disparities exist between groups and have persisted. During 2007-2009, 29 percent of Hispanic adults had no health insurance – three times higher than White non-Hispanics and almost double the rate for Black non-Hispanics and Asian non-Hispanics.

Figure 35. Percentage* of Adults Aged 18-64 Years with No Health Insurance by Race/Ethnicity, New York State, 2001-2009



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	11.4	10.7	10.4	10.5	10.7	10.2	9.8
Black non-Hispanic	18.2	17.1	17.2	16.4	16.9	17.0	16.7
Asian non-Hispanic	21.6	22.4	21.4	18.6	17.9	14.4	14.0
Hispanic	38.6	36.6	34.6	32.5	31.7	31.1	29.1
Total	17.9	17.2	16.7	16.1	16.0	15.3	14.6

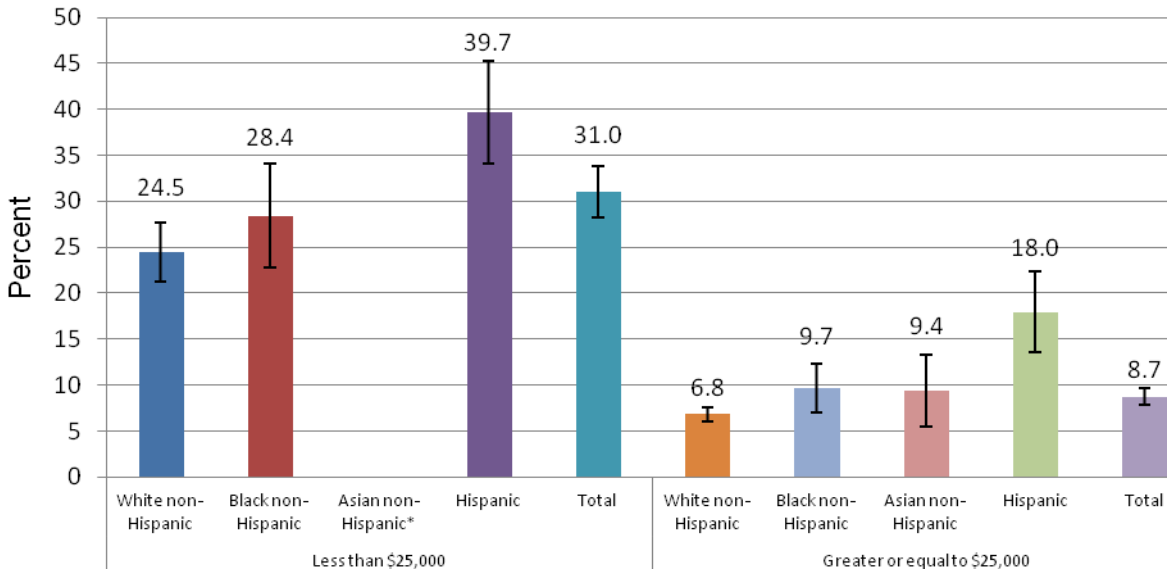
* Three-year moving average
Source: Behavioral Risk Factor Surveillance System.

White non-Hispanic, Black non-Hispanic and Hispanic New Yorkers in households with incomes less than $25,000 per year were more likely to report they did not have health insurance as compared to their counterparts with higher incomes.

In the lower income bracket, 39.7 percent of Hispanics reported having no health insurance – significantly higher than both White (24.5 percent) and Black non-Hispanics (28.4 percent). The sample size for Asian non-Hispanics was insufficient to report on this indicator.

Among New Yorkers in households earning $25,000 or more per year, 18 percent of Hispanics reported they had no health insurance, significantly higher than the percentages for non-Hispanic Whites (6.8 percent), Blacks (9.7 percent) and Asians (9.4 percent).

Figure 36. Percentage of Adults Aged 18-64 Years with No Health Insurance by Race/Ethnicity and Income Categories, New York State, 2007-2009



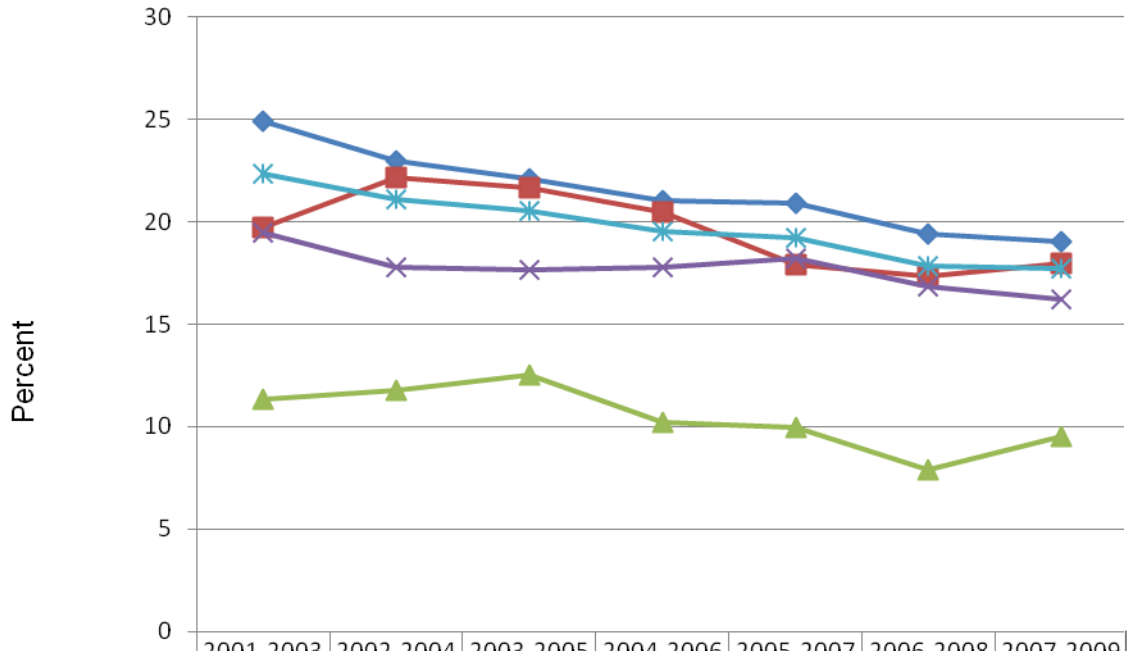
* Data do not meet reporting criteria.
Source: Behavioral Risk Factor Surveillance System

Cigarette smoking is directly responsible for approximately 30 percent of all cancer deaths and about 87 percent of all lung cancer deaths. It is the single largest contributor to preventable death.[2]

Between 2001-2003 and 2007-2009, smoking rates declined among all racial/ethnic groups. Throughout the nine-year period, White non-Hispanics reported the highest smoking rate but also experienced a large decline – from 24.9 percent to 19.0 percent. Among Hispanic New Yorkers, smoking declined from 19.5 percent to 16.2 percent during 2007-2009.

Current smoking percentages among Black non-Hispanics and Asian non-Hispanics fluctuated over the reporting period but were lower during 2007-2009 (18.0 percent and 9.5 percent, respectively) than in 2001-2003 (19.7 percent and 11.3 percent, respectively).

Figure 37. Age-Adjusted Percentage* of Adults 18 Years and Older who Were Current Smokers by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	24.9	22.9	22.1	21.0	20.9	19.4	19.0
Black non-Hispanic	19.7	22.1	21.7	20.4	17.9	17.3	18.0
Asian non-Hispanic	11.3	11.7	12.5	10.2	10.0	7.9	9.5
Hispanic	19.5	17.8	17.6	17.8	18.2	16.8	16.2
Total	22.3	21.1	20.5	19.5	19.2	17.9	17.7

* Three-year moving average adjusted to the 2000 U.S. population.

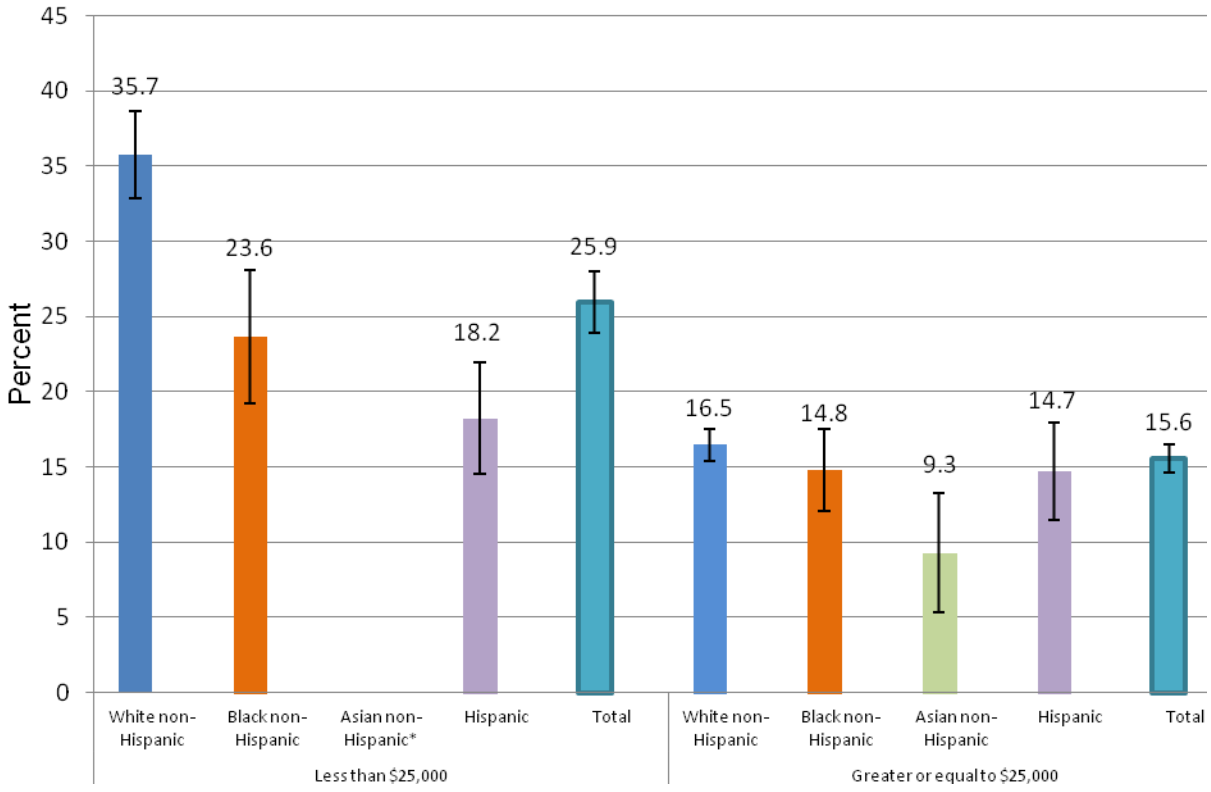
**** A current smoker has smoked at least 100 cigarettes in their lifetime and currently smokes every day or some days.
Source: Behavioral Risk Factor Surveillance System

White non-Hispanic New York adults with annual household incomes of less than $25,000 reported the highest smoking rate at 35.7 percent, significantly higher than the rates for Black non-Hispanics (23.6 percent) and Hispanics (18.2 percent). The sample size for Asian non-Hispanics was insufficient to report on this indicator.

The smoking rate among New Yorkers with annual household incomes of $25,000 or more was significantly lower for White non-Hispanics (16.5 percent) and Black non-Hispanics (14.8 percent) than their lower-income counterparts.

In the higher income category, the Asian non-Hispanics smoking rate (9.3 percent) was significantly lower than the rate among White non-Hispanics (16.5 percent). There were no other statistically significant differences in smoking rates in this income category.

Figure 38. Age-adjusted Percentage of Adults Aged 18 Years and Older who Were Current Smokers* by Race/Ethnicity and Income Categories, New York State, 2007-2009



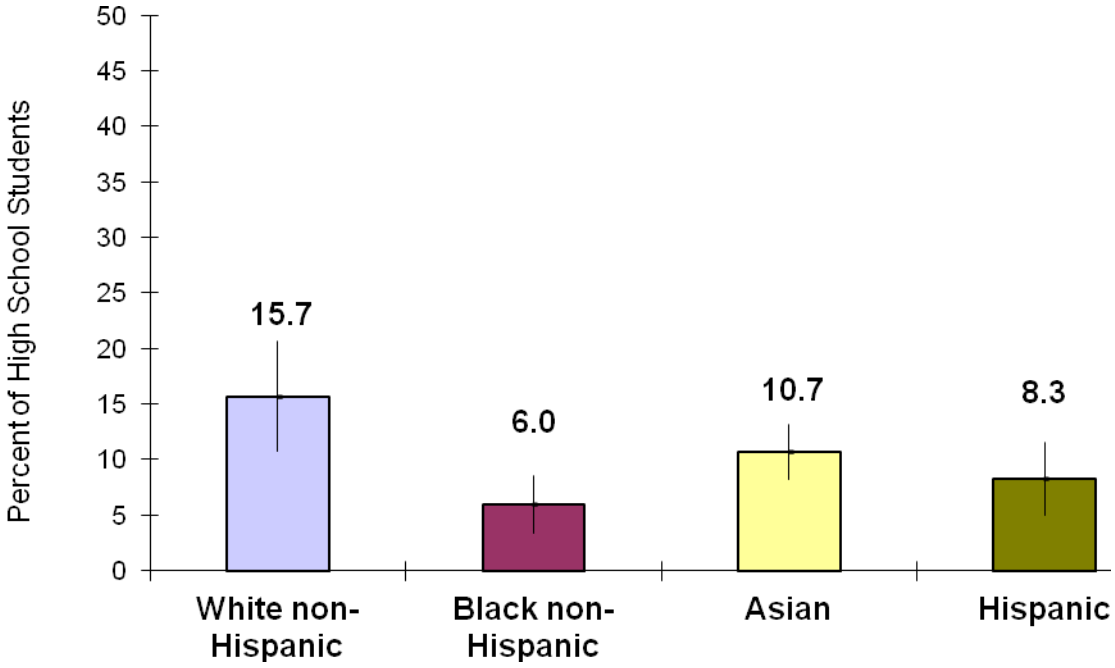
Rate adjusted to the 2000 U.S. population.

***** A current smoker has smoked at least 100 cigarettes in their lifetime and currently smokes every day or some days
Source: Behavioral Risk Factor Surveillance System

Nearly all first use of tobacco occurs before high school graduation. So if adolescents do not smoke by age 18, odds are they never will.[3]

In 2010, more than 15 percent of New York White non-Hispanic high school students had smoked cigarettes during the past 30 days, significantly higher than Black non-Hispanics (6.0 percent). Asian and Hispanic students reported smoking rates of 10.7 percent and 8.3 percent, respectively.

Figure 39. Percentage of High School Students who Smoked Cigarettes on One or More of the Past 30 Days by Race/Ethnicity, New York State, 2010

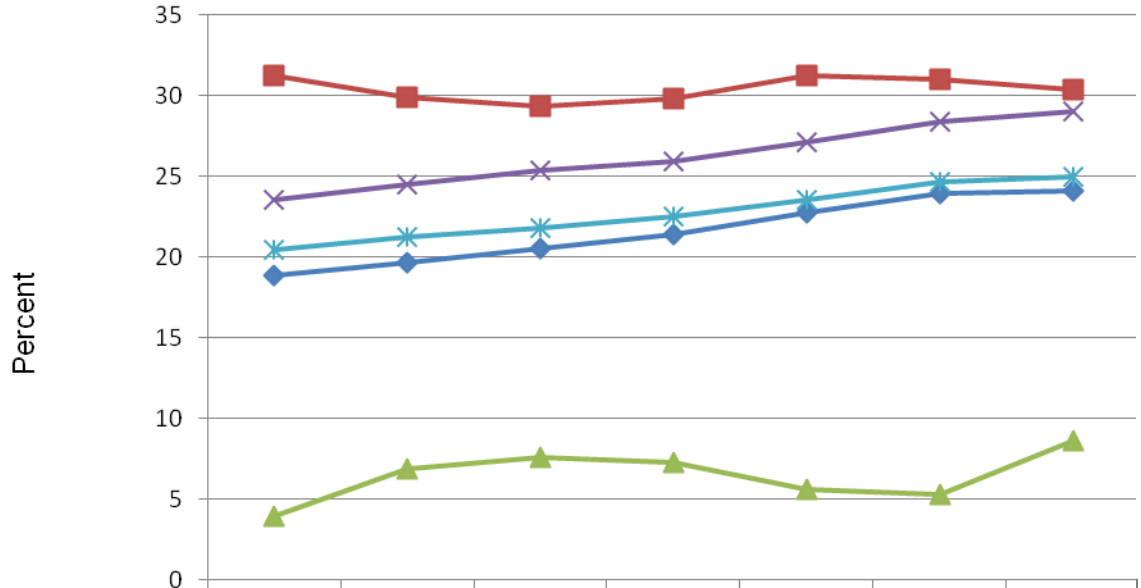


Source: New York Youth Tobacco Survey

During the past 20 years, obesity among adults has risen significantly in the United States. Being overweight or obese increases the risk of many diseases and health conditions.[4]

From 2001-2009, obesity rates increased for all groups except Black non-Hispanics, who consistently reported the highest rate. That rate changed very little from year to year and was slightly lower in 2007-2009 than in 2001-2003. All other racial/ethnic groups reported steady increases in obesity.

Figure 40. Age-Adjusted Percentage* of Adults 18 Years and Older who Were Obese by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	18.9	19.7	20.5	21.4	22.7	23.9	24.1
Black non-Hispanic	31.2	29.9	29.3	29.8	31.3	31.0	30.4
Asian non-Hispanic	4.0	6.9	7.6	7.3	5.6	5.3	8.6
Hispanic	23.5	24.5	25.4	25.9	27.1	28.4	29.0
Total	20.5	21.2	21.8	22.5	23.5	24.7	24.9

* Three-year moving average adjusted to the 2000 U.S. population.

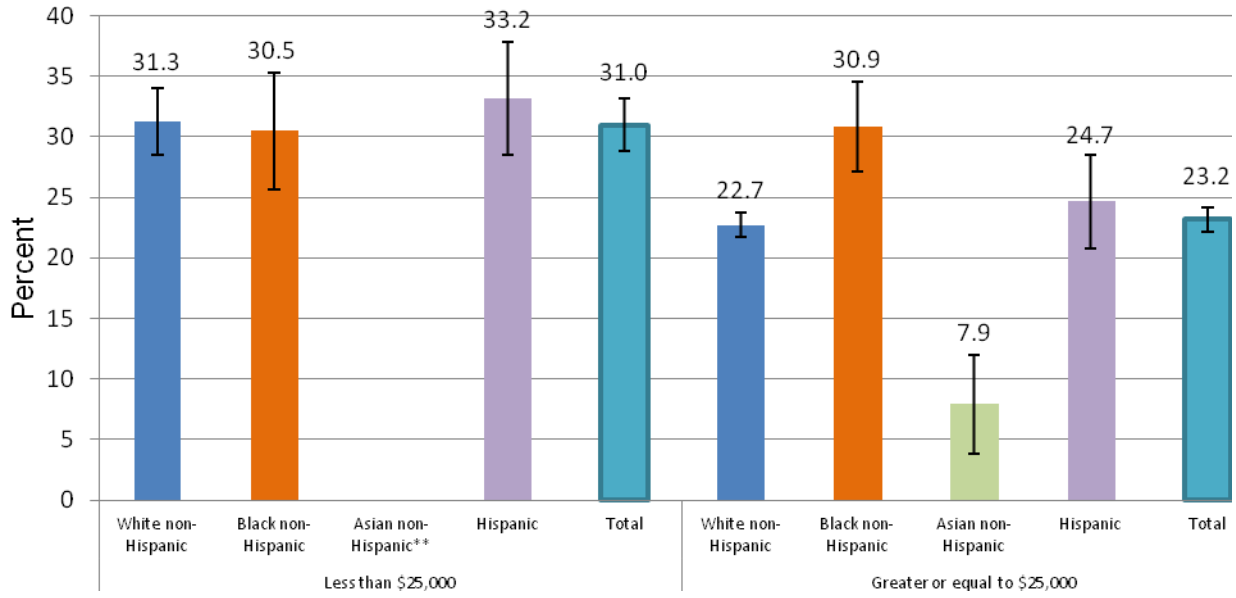
** Obesity among adults is defined as having a body mass index (BMI) of 30 or greater. (BMI is calculated by dividing weight in pounds by height in inches squared and multiplying by a conversion factor of 703.)
Source: Behavioral Risk Factor Surveillance System

The adult obesity rates in households with less than $25,000 in annual income were 33.2 percent among Hispanics, 31.3 percent among White non-Hispanics and 30.5 percent among Black non-Hispanics. Differences between these three groups were not statistically significant. The sample size for Asian non-Hispanics in this income category was insufficient to report on this indicator.

Among New York adults with higher income levels, the obesity rates were significantly higher for White non-Hispanics (22.7 percent), Black non-Hispanics (30.9 percent) and Hispanics (24.7 percent) than Asian non-Hispanics (7.9 percent).

The percentage of White non-Hispanic New Yorkers reporting obesity was significantly higher in the lower income group (31.3 percent) than the higher one (22.7 percent).

Figure 41. Age-Adjusted Percentage of Adults Aged 18 Years and Older who Were Obese* by Race/Ethnicity and Income Categories, 2007-2009



Rate adjusted to the 2000 U.S. population.

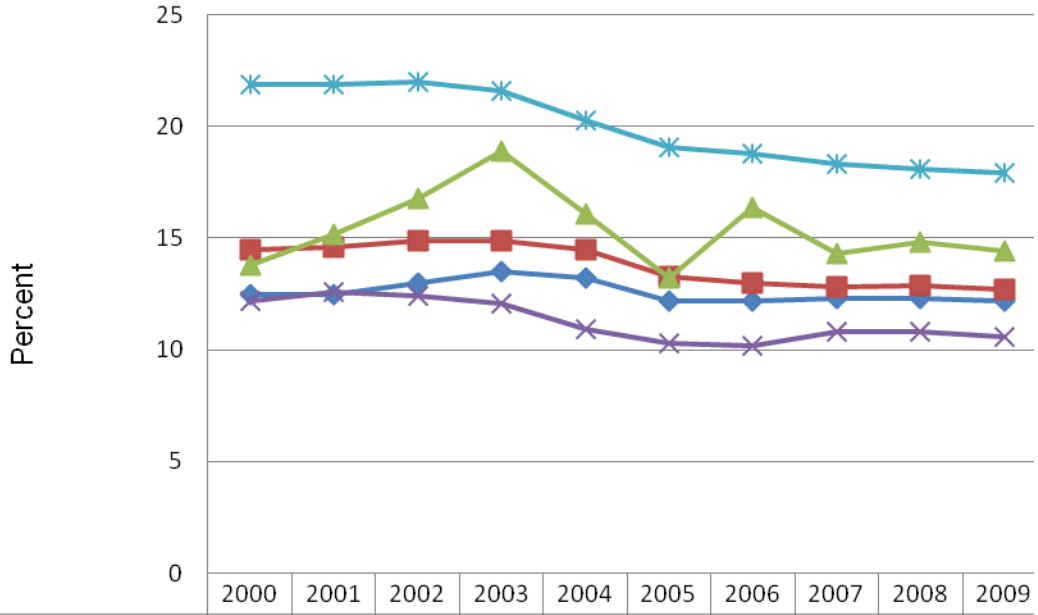
* Obesity among adults is defined as a body mass index (BMI) greater than or equal to 30. (BMI is calculated by dividing weight in pounds by height in inches squared and multiplying by a conversion factor of 703.)
** Data do not meet reporting requirements
Source: Behavioral Risk Factor Surveillance System

There is growing concern about the national epidemic in childhood and adult obesity.

The only BMI data available for pre-school children are for those from low-income families enrolled in the Special Nutrition Program for Women, Infants and Children (WIC). Among children ages 2 to 4 in New York State's WIC program, the percentage of obese children fluctuated between 2000 and 2009 and was lower in 2009 as compared to 2000 for all racial/ethnic groups except American Indian/Alaskan Natives. Among American Indian/Alaskan Native the percentage in 2009 was about 4 percent higher than in 2000.[5]

Among WIC children in 2009, Hispanics and American Indian/Alaskan Natives experienced the highest rates of obesity (17.9 percent and 14.4 percent, respectively). White non-Hispanic (12.2 percent) and Black non-Hispanic (12.7 percent) children had similar rates, while Asian/Pacific Islander non-Hispanics had the lowest obesity rate (10.6 percent).

Figure 42. Percentage of Obesity* Among Children Ages 2-4 Years in the WIC Program by Race/Ethnicity, New York State, 2000-2009



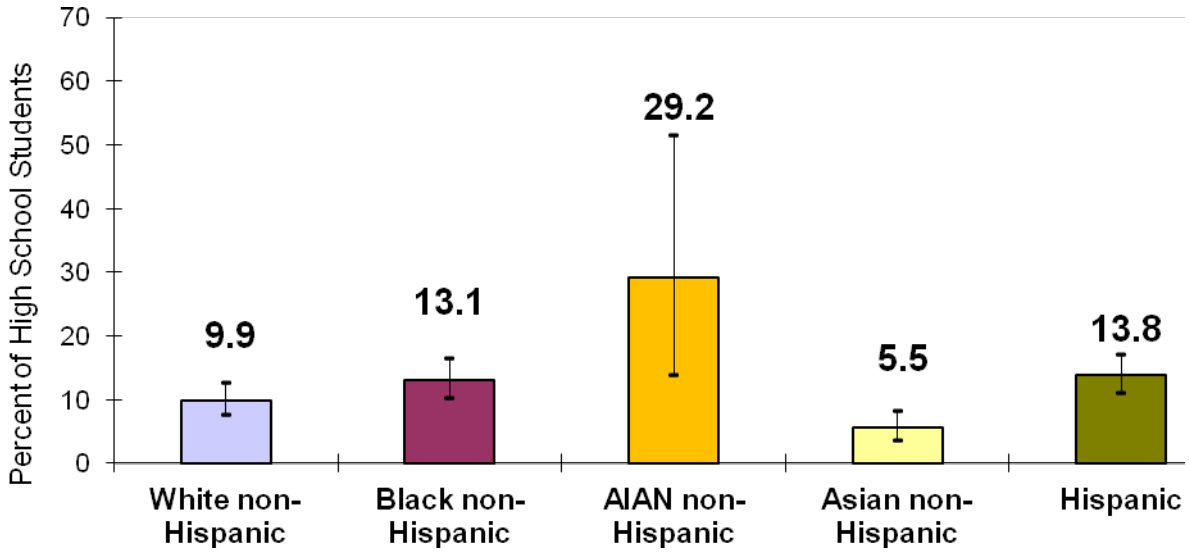
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White non-Hispanic	12.5	12.5	13	13.5	13.2	12.2	12.2	12.3	12.3	12.2
Black non-Hispanic	14.5	14.6	14.9	14.9	14.5	13.3	13	12.8	12.9	12.7
AIAN non-Hispanic	13.8	15.2	16.8	18.9	16.1	13.2	16.4	14.3	14.8	14.4
Asian/PI non-Hispanic	12.2	12.6	12.4	12.1	10.9	10.3	10.2	10.8	10.8	10.6
Hispanic	21.9	21.9	22	21.6	20.3	19.1	18.8	18.3	18.1	17.9

* Obesity among children is defined as having a body mass index (BMI) at or above the 95th percentile of sex-specific BMI for age based on 2000 National Center for Health Statistics, U.S. Center for Disease Control and Prevention growth charts.
Source: New York State Division of Nutrition WIC program, Pediatric Nutrition Surveillance System

Overweight and obesity in children and adolescents is generally caused by a lack of physical activity, unhealthy eating patterns, or a combination of the two, with genetics and lifestyle playing important roles in determining a child's weight, according to the U.S. Surgeon General.[6]

During 2009, the obesity rates among Hispanic (13.8 percent), Black non-Hispanic (13.1 percent) and American Indian/Alaskan Native non-Hispanic (29.2 percent) students were significantly higher than for Asian non-Hispanic (5.5 percent) students. American Indian/Alaskan Native students were more likely to be obese compared to White non-Hispanics (9.9 percent).

Figure 43. Percentage of High School Students who Were Obese* by Race/Ethnicity, New York State, 2009



Abbreviation: AIAN – American Indian Alaska Native
* Obesity among children is defined as having a body mass index (BMI) at or above the 95th percentile of sex-specific BMI for age based on 2000 National Center for Health Statistics, U.S. Center for Disease Control and Prevention growth charts.
Source: Youth Risk Behavior Survey

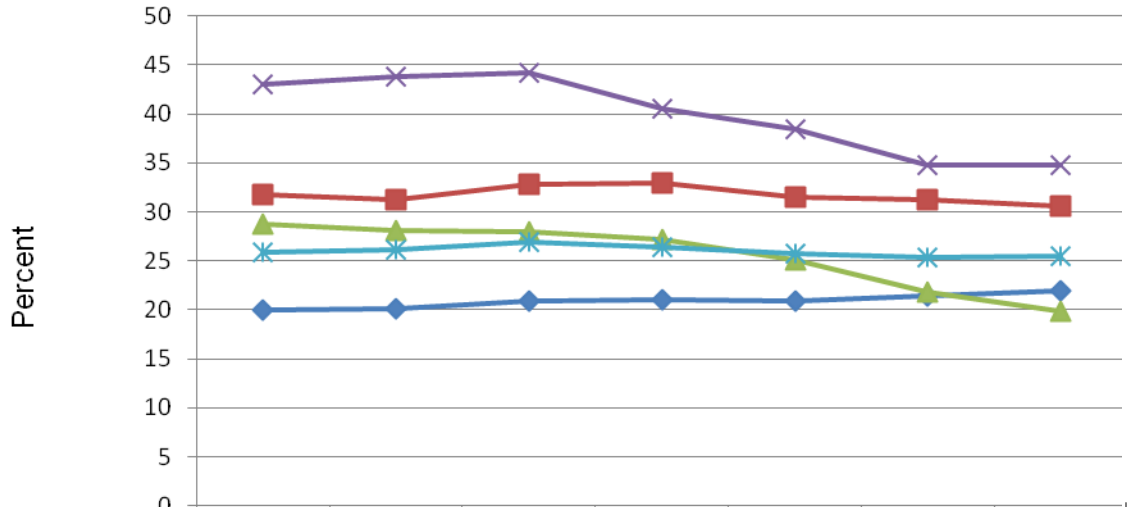
Poor diet and physical inactivity are the second leading causes of preventable death in the United States. Regular physical activity provides significant benefits for people with chronic diseases and disabilities.

During 2007-2009, the percentage of adult Hispanic New Yorkers who did not engage in any regular leisure-time physical activity was nearly 35 percent. Although the percentage declined from the 43.0 percent reported in 2001-2003, Hispanics remain the group with the highest absence of leisure time physical activity.

Asian non-Hispanic (19.8 percent) adults had the lowest percentage of non-participation in leisure time physical activity during 2007-2009, lower than that reported by White non-Hispanics (22.0 percent) and Black non-Hispanics (30.6 percent).

Between 2001-2003 and 2007-2009, the percentage of adults reporting no participation in leisure-time physical activity rate declined among Asian non-Hispanics and Black non-Hispanics and increased slightly among White non-Hispanics.

Figure 44. Age-Adjusted Percentage* of Adults Aged 18 Years and Older Reporting No Leisure-Time Physical Activity by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	19.9	20.1	21.0	21.1	20.9	21.5	22.0
Black non-Hispanic	31.8	31.3	32.8	33.0	31.5	31.3	30.6
Asian non-Hispanic	28.8	28.2	28.0	27.2	25.1	21.8	19.8
Hispanic	43.0	43.8	44.2	40.6	38.4	34.8	34.8
Total	25.9	26.1	26.9	26.4	25.7	25.3	25.4

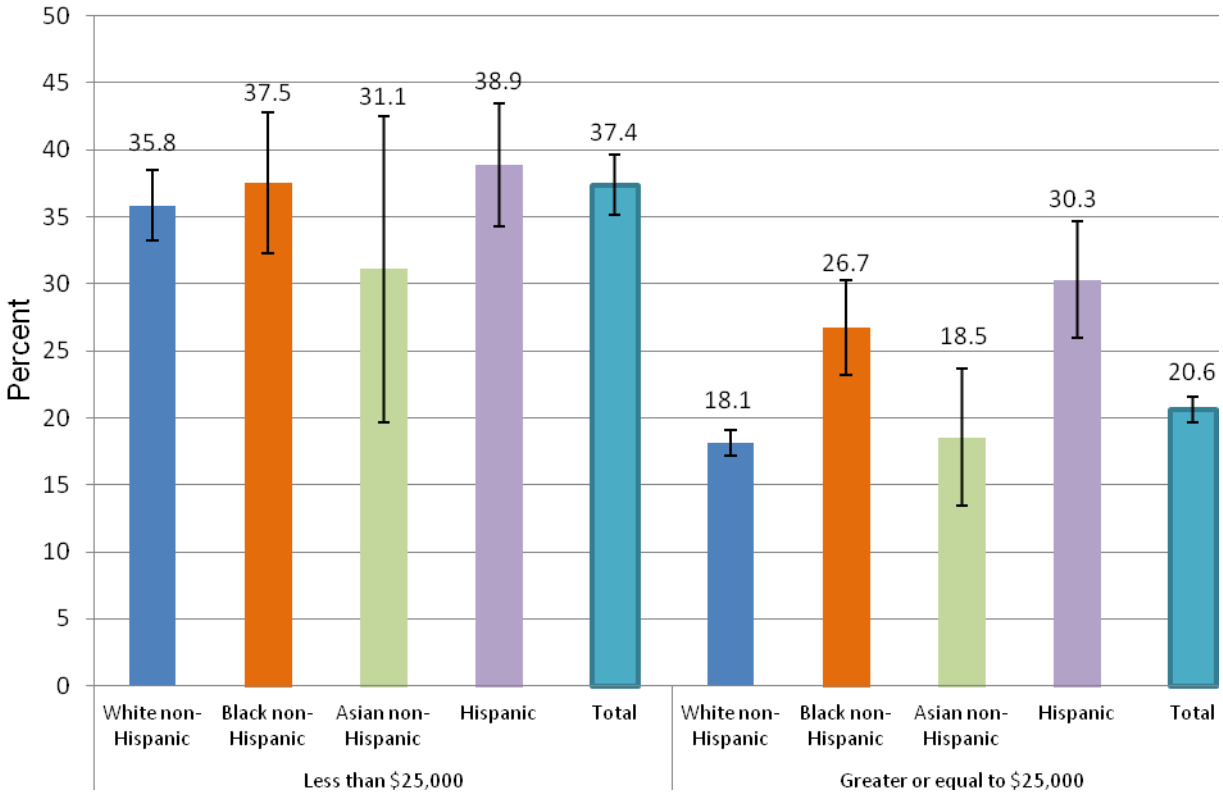
* Three-year moving average adjusted to the 2000 U.S. population.
** Leisure-time physical activity is defined as participating in physical activities or exercises (such as running, calisthenics, golf, gardening or walking for exercise) during the past month, excluding activities that are part of a regular job
Source: Behavioral Risk Factor Surveillance System

Among New Yorkers with annual household incomes less than $25,000, Hispanics were most likely to report no leisure-time physical activity (38.9 percent), followed by 37.5 percent among Black non-Hispanics, 35.8 percent among White non-Hispanics and 31.1 percent among Asian non-Hispanics. The rates among these racial/ethnic groups were not statistically different in this income category.

At higher income levels, White non-Hispanic and Black non-Hispanic adults reported significantly lower percentages of no leisure-time physical activity than their lower-income counterparts.

At higher income levels, the proportion of Black non-Hispanics and Hispanics reporting no leisure-time physical activity (26.7 percent and 30.3 percent, respectively) was significantly higher than White non-Hispanics (18.1 percent). The rate was significantly lower for Asian non-Hispanics (18.5 percent) as compared to Hispanics in the higher income category.

Figure 45. Age-Adjusted Percentage* of Adults Aged 18 Years and Older Reporting No Leisure-Time Physical Activity by Race/Ethnicity and Income Categories, New York State, 2007-2009**



* Rates adjusted to the 2000 U.S. population.
** Leisure-time physical activity is defined as participating in physical activities or exercises (such as running, calisthenics, golf, gardening or walking for exercise) during the past month, excluding activities that are part of a regular job.

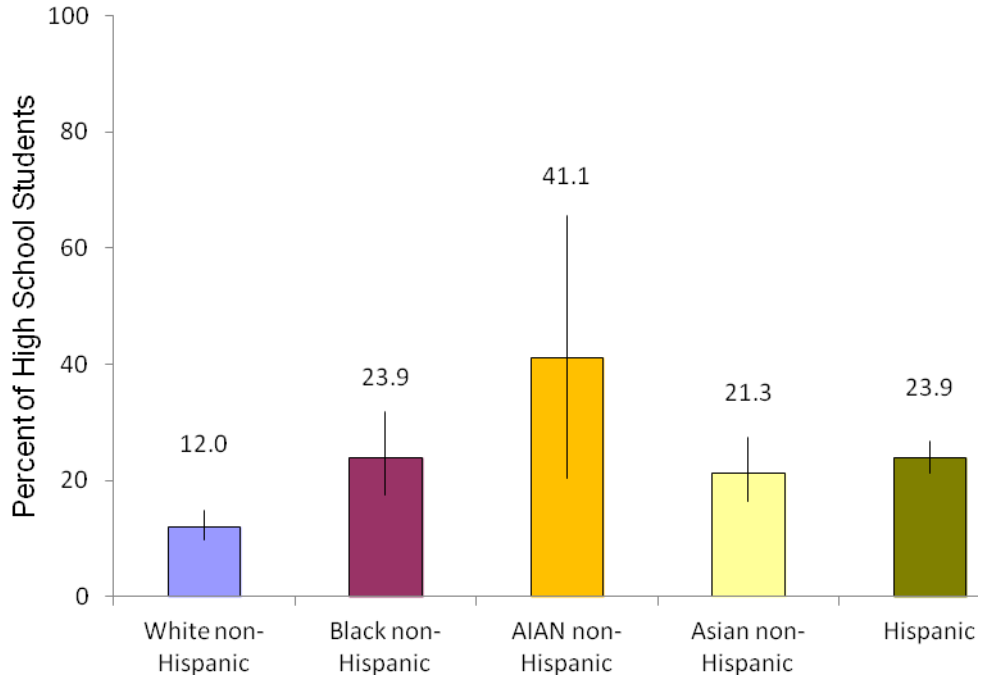
Source: Behavioral Risk Factor Surveillance System

The 2005 U.S. Dietary Guidelines recommend that teens get at least one hour of physical activity on most, and preferably, all days of the week.

Only 12.0 percent of White non-Hispanic high school students reported they did not participate in at least 60 minutes of physical activity during the past week, significantly lower than the rates for students from other racial/ethnic groups.

There were no significant differences in the proportion of students who exercised during the past week among Black non-Hispanic (23.9 percent), Asian non-Hispanic (21.3 percent), American Indian/Alaskan Native non-Hispanic (41.1 percent) and Hispanic (23.9 percent) students.

Figure 46. Percentage of High School Students Who Did Not Participate in at Least 60 Minutes of Physical Activity* on Any Day by Race/Ethnicity, New York State, 2009

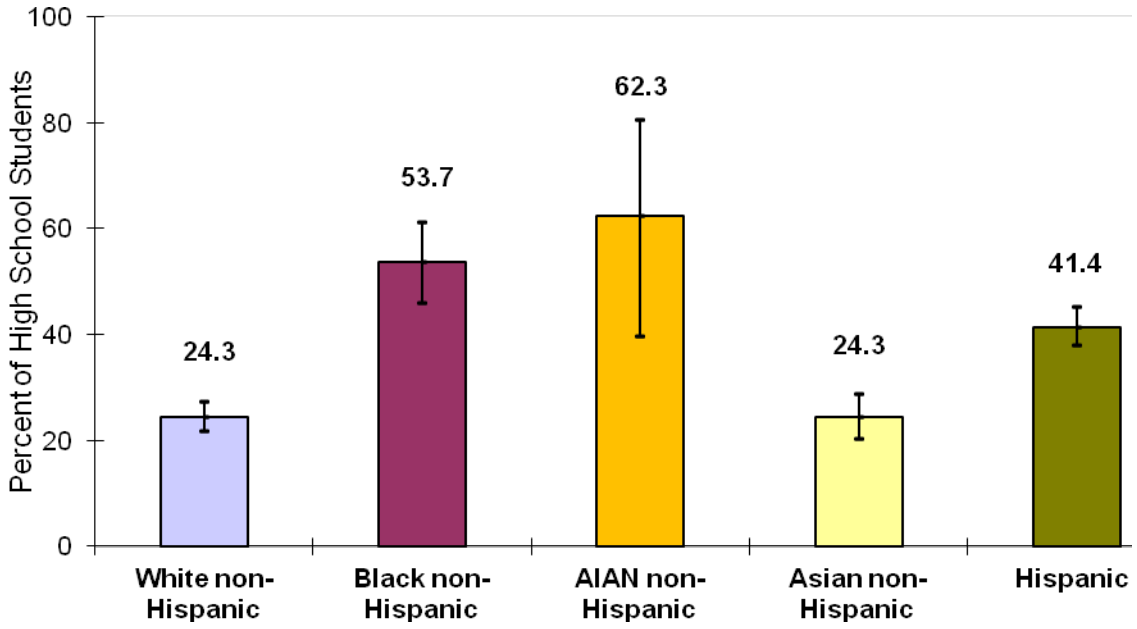


Abbreviation: AIAN – American Indian Alaska Native.
* Engaging in any physical activities that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey.
Source: Youth Risk Behavior Survey

Watching television for more than three hours per day is associated with an increased risk of becoming overweight or obese.

More than half of American Indian/Alaskan Native non-Hispanic and Black non-Hispanic high school students reported watching more than three hours of television daily. These rates were significantly higher than the rates for White non-Hispanic and Asian non-Hispanic students. The rate for Black non-Hispanic students was also significantly higher than the rate of Hispanic students.

Figure 47. Percentage of High School Students Who Watched Three or More Hours of Television per Day on an Average School Day by Race/Ethnicity, New York State, 2009

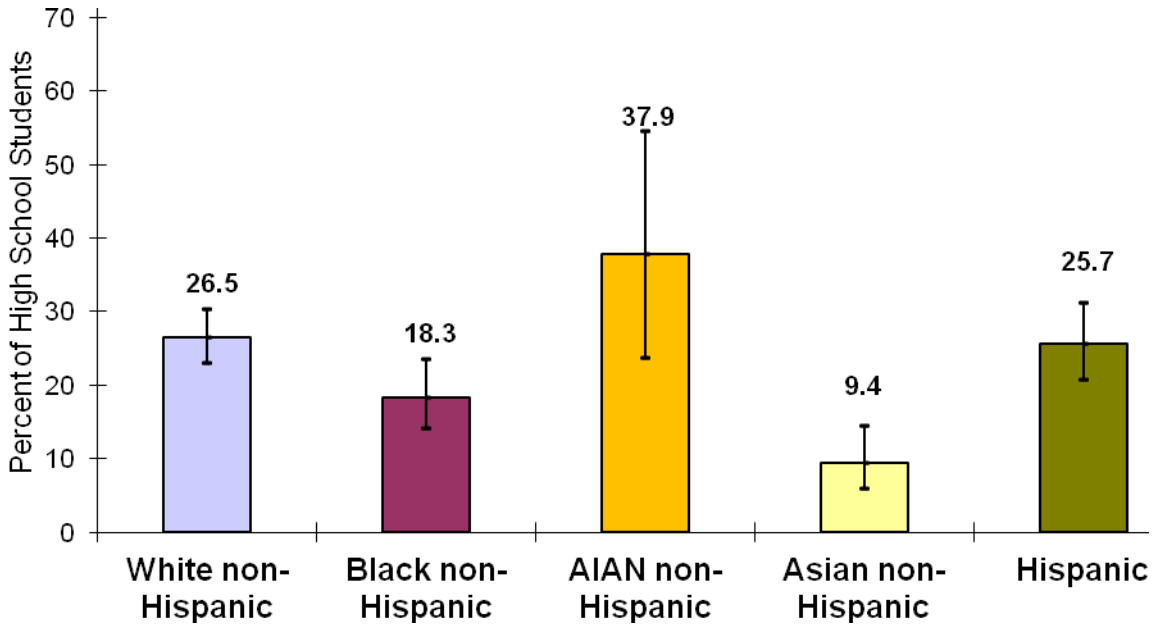


Abbreviation: AIAN – American Indian Alaska Native
Source: Youth Risk Behavior Survey

Alcohol use among youth is associated with risky behaviors and poor outcomes, including unprotected sexual intercourse, vulnerability to coerced sexual activity, the use of marijuana and poor academic performance. In 2008, nearly one-third of all traffic deaths among youth ages 15-20 were alcohol-related.[7]

White non-Hispanic (26.5 percent), American Indian/Alaskan Native non-Hispanic (37.9 percent) and Hispanic (25.7 percent) high school students have significantly higher rates of binge drinking than Asian non-Hispanics (9.4 percent). Among Black non-Hispanic students, 18.3 percent reported binge drinking.

Figure 48. Binge Drinking Among High School Students During the Past 30 Days by Race/Ethnicity, New York State, 2009



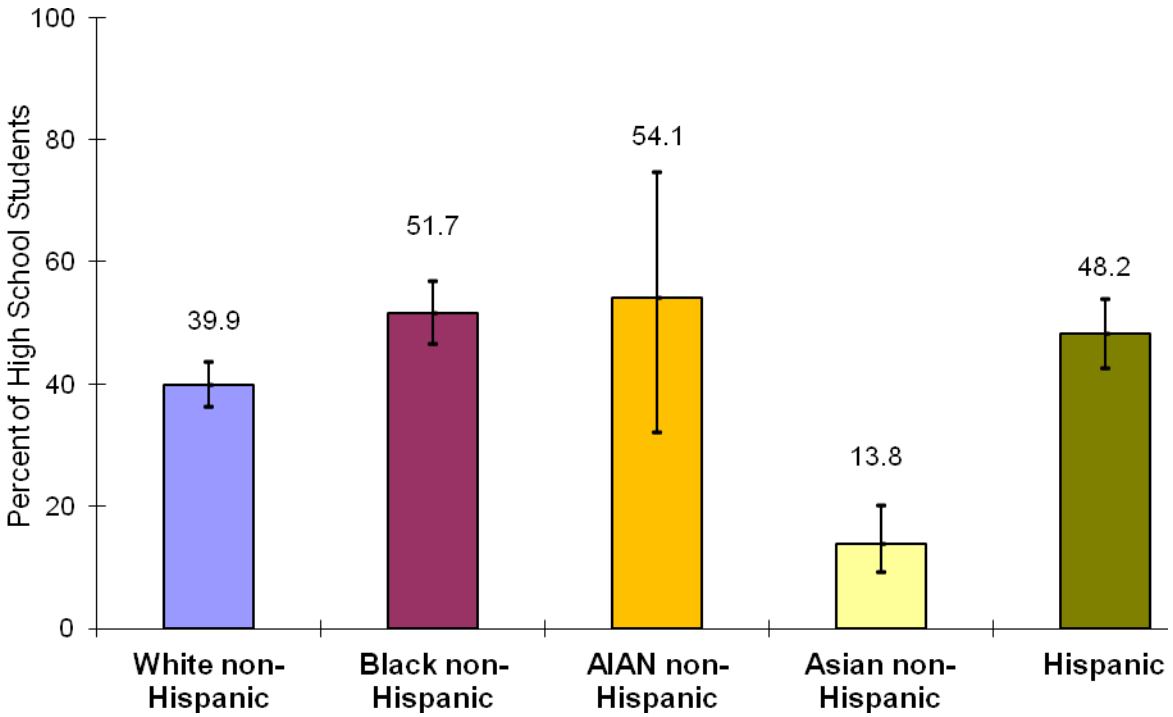
Abbreviation: AIAN – American Indian Alaska Native
* Binge drinking is defined as five or more drinks of alcohol in a row at least once during the past month.
Source: Youth Risk Behavior Survey

Most teenagers received formal sex education before they were 18 (96 percent of females and 97 percent of males). Nearly two-thirds of female teenagers talked to their parents about "how to say no to sex," compared with about two-fifths of male teenagers.[8]

More than half the Black non-Hispanic and American Indian/Alaskan Native non-Hispanic high school students in New York have had sexual intercourse – the highest rates. Both groups had rates that were significantly higher than Asian non-Hispanic (13.8 percent) students. The Black non-Hispanic rate was also significantly higher than that for White non-Hispanic (39.9 percent) students.

Among Hispanic high school students, 48.2 percent reported having sexual intercourse at least once. This was significantly higher than the rate among Asian non-Hispanics.

Figure 49. High School Students who Ever Had Sexual Intercourse During Their Lifetime by Race/Ethnicity, New York State, 2009



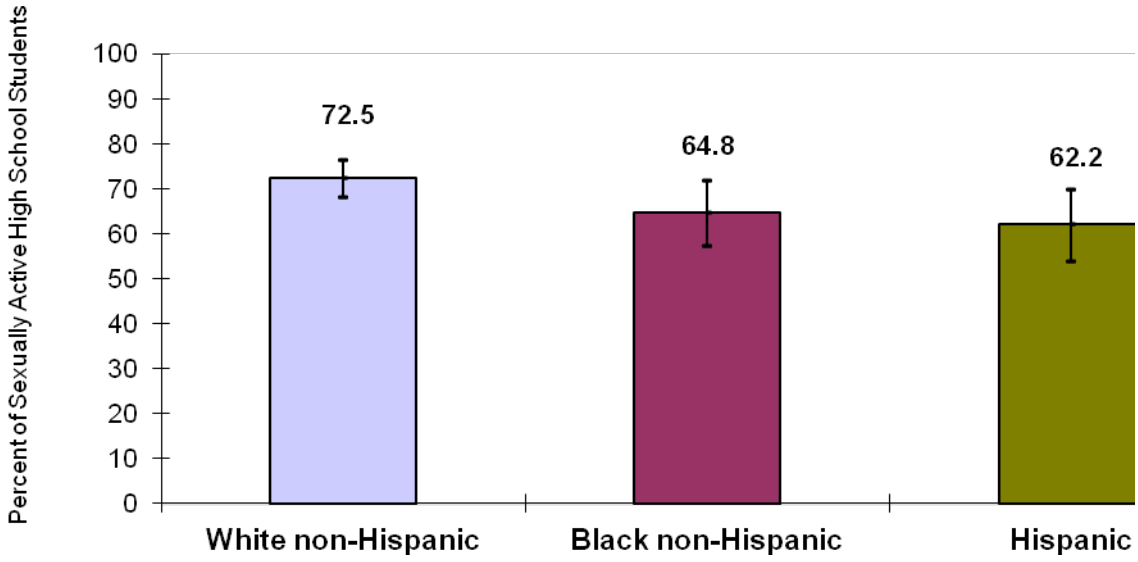
Abbreviation: AIAN – American Indian Alaska Native
Source: Youth Risk Behavior Survey

Condom use has been proven effective in reducing unwanted pregnancy and the transmission of sexually transmitted diseases, including HIV.

Seventy-two percent of White non-Hispanic New York high school students that were sexually active reported using a condom during their last intercourse. Black non-Hispanic (64.8 percent) and Hispanic (62.2 percent) sexually active high school students reported using a condom at their last sexual intercourse. The differences in condom use among the three racial/ethnic groups were not statistically significant.

Sample sizes for Asian non-Hispanic and American Indian/Alaskan Native non-Hispanic students were too small for data analysis.

Figure 50. Percentage of Sexually Active High School Students Who Used a Condom During Last Sexual Intercourse by Race/Ethnicity, New York State, 2009



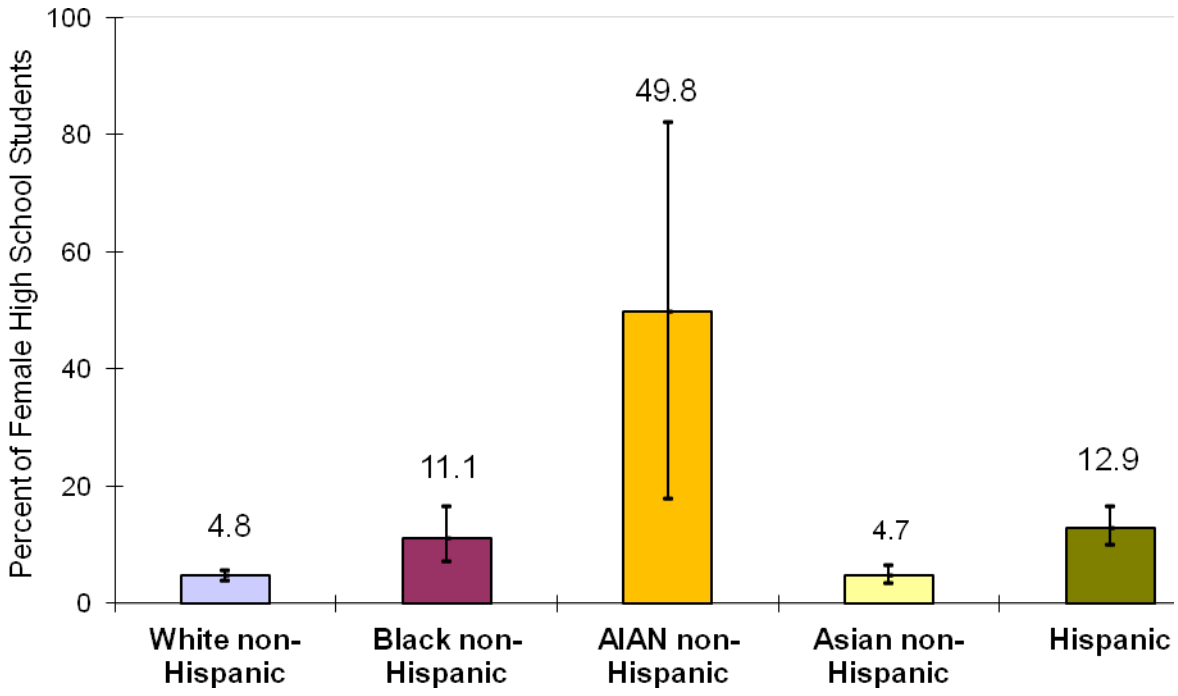
Source: Youth Risk Behavior Survey

Sexual coercion in childhood and adolescence has multiple consequences with links to adverse reproductive health and HIV-related outcomes, subsequent experience of violence at the hands of intimate partners and mental health problems.[9]

Nearly half of American Indian/Alaskan Native non-Hispanic high school girls in New York reported being forced to have unwanted sex, a much higher rate than all other racial/ethnic groups. Among both Black non-Hispanic and Hispanic female students, more than 10 percent reported being forced to have sex during her high school years. The lowest rates were reported for female White non-Hispanic (4.8 percent) and Asian non-Hispanic students (4.7 percent).

Forced sex also occurred among male high school students, but at a lower rate (6.9 percent).

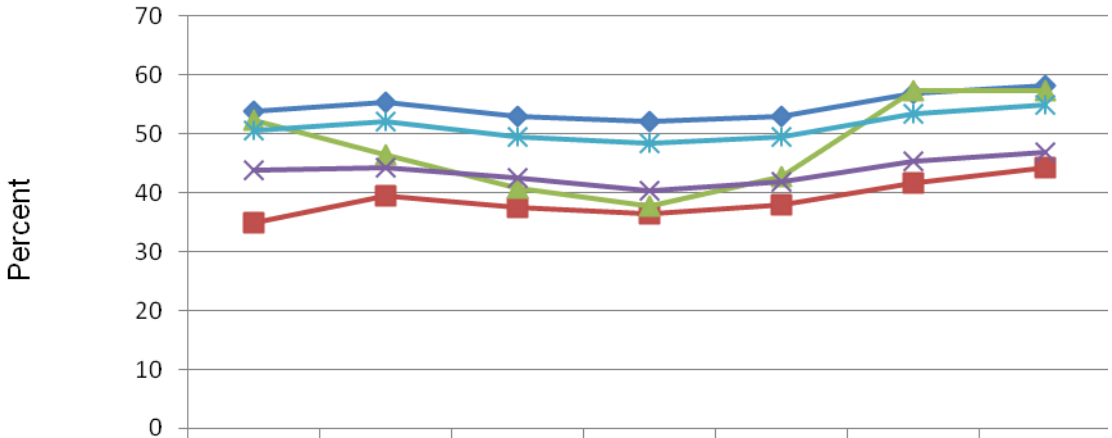
Figure 51. Female High School Students who Have Ever Been Forced to Have Sexual Intercourse* During their Lifetime by Race/Ethnicity, New York State, 2009



Abbreviation: AIAN – American Indian Alaska Native
* Forced sexual intercourse occurred when a girl reported that she was forced to have sex when she did not want to.
Source: Youth Risk Behavior Survey

Vaccination is an effective strategy to reduce illness and deaths due to pneumococcal disease and influenza. Elderly people are at higher risk for complications and deaths from these illnesses.[10] Influenza immunization among adults 50 and older has been increasing since 2001-2003 among all racial/ethnic groups. During 2007-2009, Asian non-Hispanic and White non-Hispanic New Yorkers reported the highest influenza immunization rates, 57.3 percent and 58.2 percent, respectively. Black non-Hispanic and Hispanic New Yorkers reported lower rates (44.3 percent and 46.8 percent, respectively).

Figure 52. Percentage* of Adults 50 Years and Older Reporting They Had Received an Influenza Vaccine within the Past 12 Months by Race/Ethnicity, 2001-2009



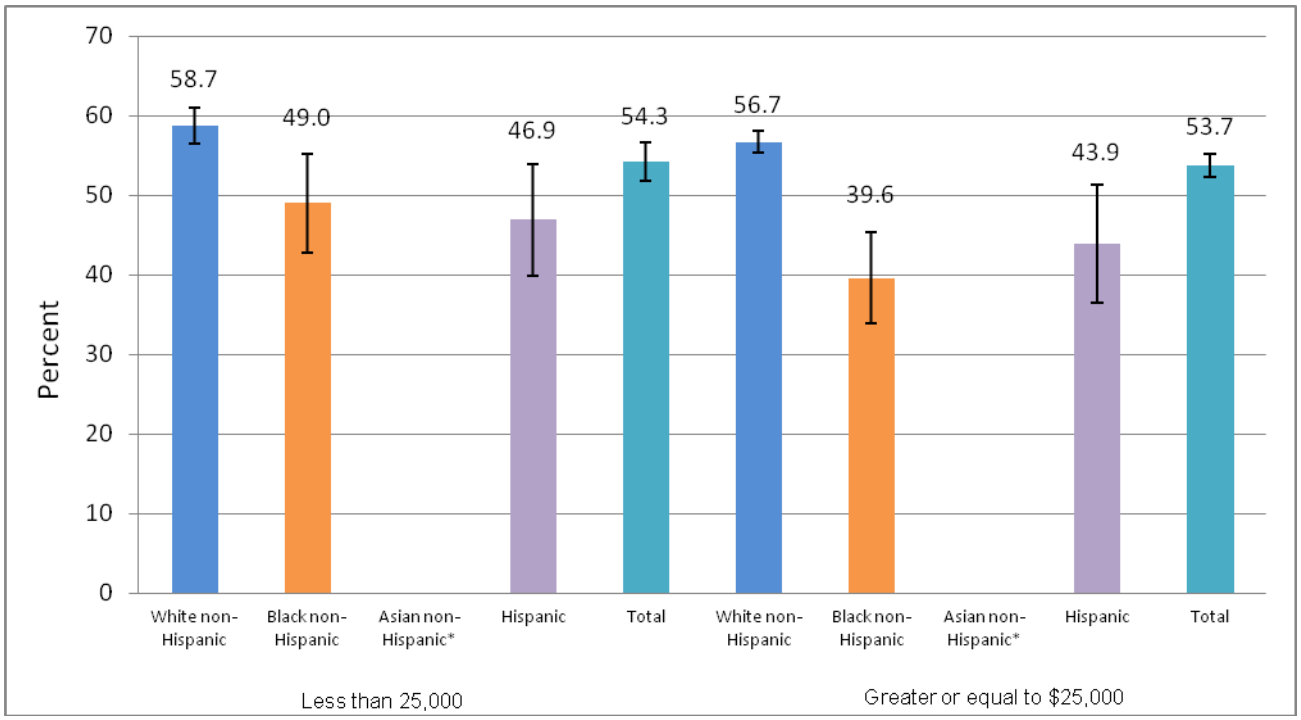
	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	53.7	55.4	53.0	52.1	52.9	56.8	58.2
Black non-Hispanic	34.9	39.5	37.4	36.4	37.9	41.7	44.3
Asian non-Hispanic	52.4	46.5	40.7	37.8	42.7	57.4	57.3
Hispanic	43.7	44.3	42.6	40.4	41.9	45.3	46.8
Total	50.5	52.0	49.6	48.4	49.4	53.5	54.9

* Three-year moving average
Source: Behavioral Risk Factor Surveillance System

During 2007-2009, White non-Hispanic New Yorkers 50 and older with annual household incomes of less than $25,000 had the highest influenza immunization rate (58.7 percent) among all racial/ethnic groups. Black non-Hispanics had a 49.0 percent flu immunization rate and Hispanics reported a 46.9 percent rate. The sample size for Asian non-Hispanics was insufficient to report on income indicators.

Among older New Yorkers with higher household incomes, White non-Hispanics (56.7 percent) were more likely than Black non-Hispanics (39.6 percent) and Hispanics (43.9 percent) to receive an influenza immunization.

Figure 53. Percentage of Adults 50 Years and Older Reporting They Had Received an Influenza Vaccine within the Past 12 Months by Race/Ethnicity and Income Categories, New York State, 2007-2009



* Data do not meet reporting requirements
Source: Behavioral Risk Factor Surveillance System

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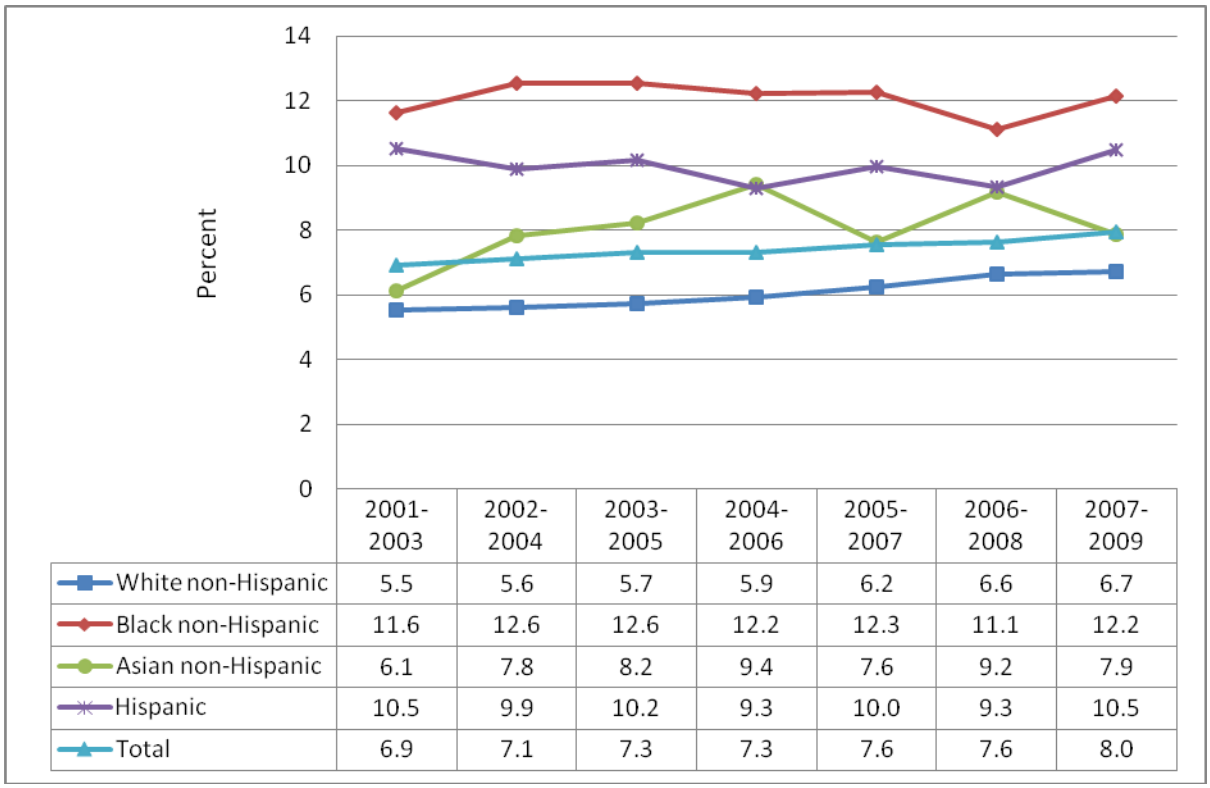
Disease Prevalence

Diabetes is the leading cause of kidney failure, non-traumatic lower-limb amputations, and new cases of blindness among adults in the United States.[1]

Diabetes prevalence has been increasing in New York over the past decade and reached 8 percent during 2007-2009. Over the past six years, all racial/ethnic groups have reported increases in diabetes prevalence with the exception of Hispanics, whose rate stayed the same.

In the 2007-2009 survey results, diabetes prevalence among adults by ethnic group shows Black non-Hispanics continue to report the highest rate, 12.2 percent. Prevalence among Hispanics was 10.5 percent, among Asian non-Hispanics, 7.9 percent and among White non-Hispanics, 6.7 percent.

Figure 54. Age-Adjusted Percentage* of Adults aged 18 Years and Older Ever Diagnosed with Diabetes by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	5.5	5.6	5.7	5.9	6.2	6.6	6.7
Black non-Hispanic	11.6	12.6	12.6	12.2	12.3	11.1	12.2
Asian non-Hispanic	6.1	7.8	8.2	9.4	7.6	9.2	7.9
Hispanic	10.5	9.9	10.2	9.3	10.0	9.3	10.5
Total	6.9	7.1	7.3	7.3	7.6	7.6	8.0

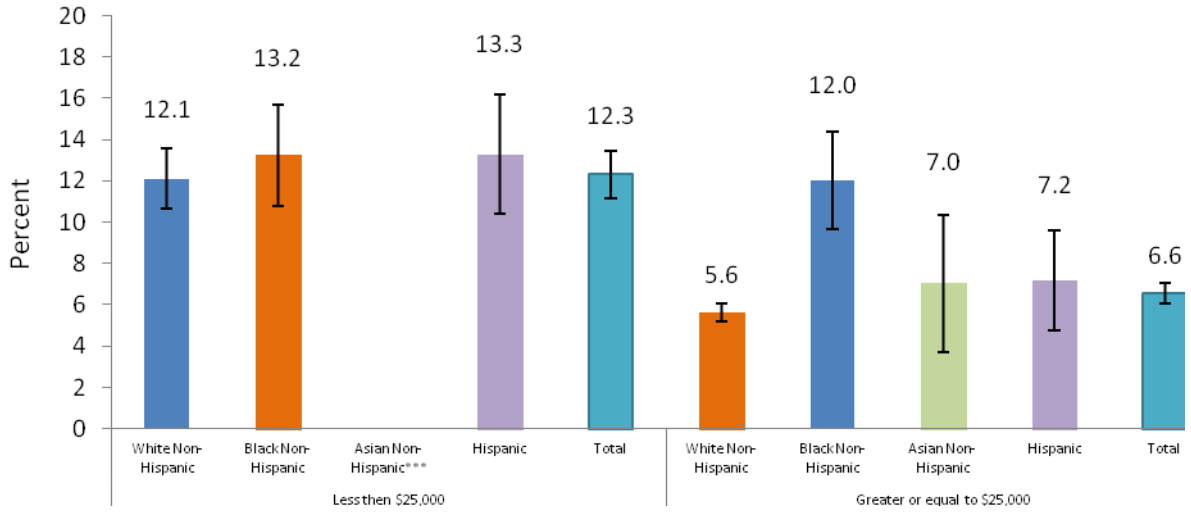
***** Three-year moving average adjusted to the 2000 U.S. population.
****** Diagnosed diabetes is defined as the respondent having ever been told by a doctor, nurse or other health professional that he or she has diabetes (excluding gestational diabetes).
Source: Behavioral Risk Factor Surveillance System

Diabetes disproportionally affects people in lower income brackets. White non-Hispanic and Hispanic New Yorkers with an annual household income of $25,000 or more had significantly lower rates of diagnosed diabetes than their lower-income counterparts.

Among New York adults with annual household earnings of less than $25,000 during 2007-2009, the age-adjusted diabetes prevalence ranged from 13.3 percent for Hispanics, 13.2 percent for Black non-Hispanics and 12.1 percent for White non-Hispanics, with no statistical differences between racial/ethnic groups. The sample size for Asian non-Hispanics in this income category was insufficient to report on this indicator.

At the $25,000 household earnings level, Black non-Hispanic New Yorkers reported significantly higher rates of diabetes (12.0 percent) than White non-Hispanics (5.6 percent) and Hispanics (7.2 percent). About 7 percent of Asian non-Hispanics reported having been diagnosed with diabetes.

Figure 55. Age-Adjusted* Percentage of Adults aged 18 Years and Older Ever Diagnosed with Diabetes by Race/Ethnicity and Income Categories, New York State, 2007-2009**

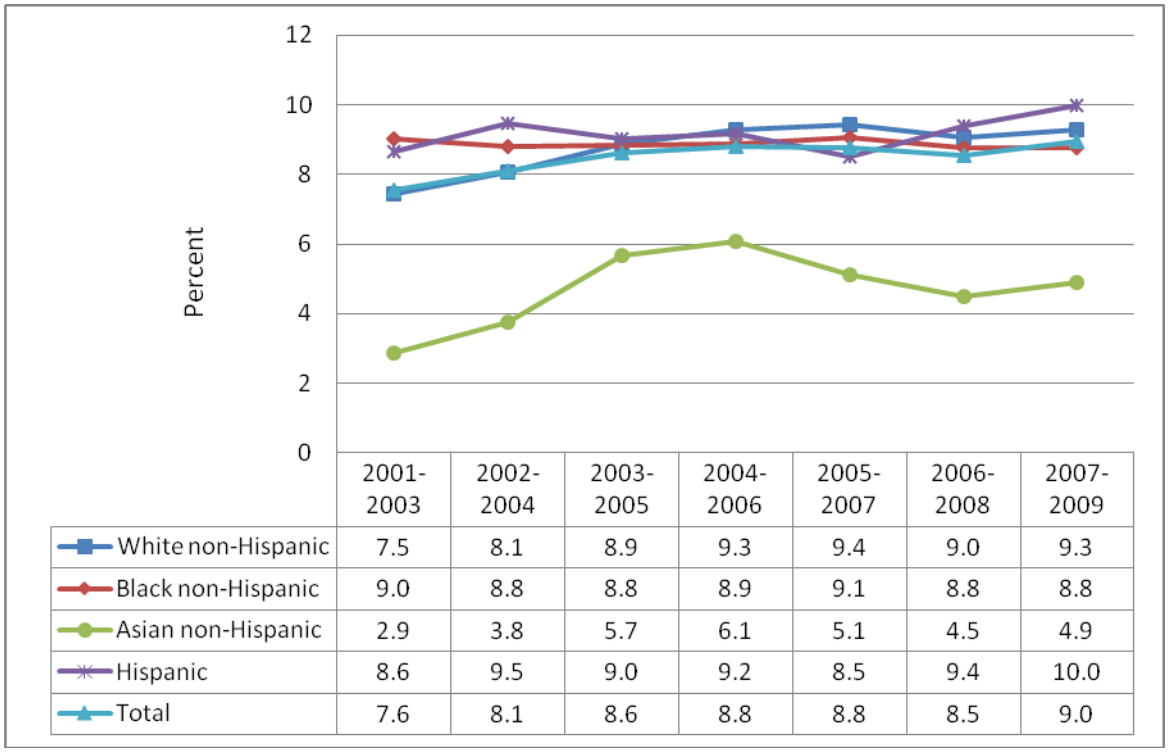


*Rates adjusted to the 2000 U.S. population
****** Diagnosed diabetes is defined as the respondent having ever been told by a doctor, nurse or other health professional that he or she has diabetes (excluding gestational diabetes).
***Data do not meet reporting requirements
Source: Behavioral Risk Factor Surveillance System

Ethnic differences in asthma prevalence, morbidity and mortality are highly correlated with poverty, urban air quality, indoor allergens, lack of patient education and inadequate medical care.[2]

Asthma prevalence among adult New Yorkers increased from 7.6 percent in 2001-2003 to 9.0 percent in 2007-2009. Similar increases occurred among all racial/ethnic groups except Black non-Hispanics. The rate for 2007-2009 among Hispanics was 10.0 percent, among White non-Hispanics, 9.3 percent, among Black non-Hispanics, 8.8 percent and among Asian non-Hispanics, 4.9 percent.

Figure 56. Age-Adjusted Percentage* of Adults aged 18 Years and Older Diagnosed with Current Asthma by Race/Ethnicity, New York State, 2001-2009**



	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009
White non-Hispanic	7.5	8.1	8.9	9.3	9.4	9.0	9.3
Black non-Hispanic	9.0	8.8	8.8	8.9	9.1	8.8	8.8
Asian non-Hispanic	2.9	3.8	5.7	6.1	5.1	4.5	4.9
Hispanic	8.6	9.5	9.0	9.2	8.5	9.4	10.0
Total	7.6	8.1	8.6	8.8	8.8	8.5	9.0

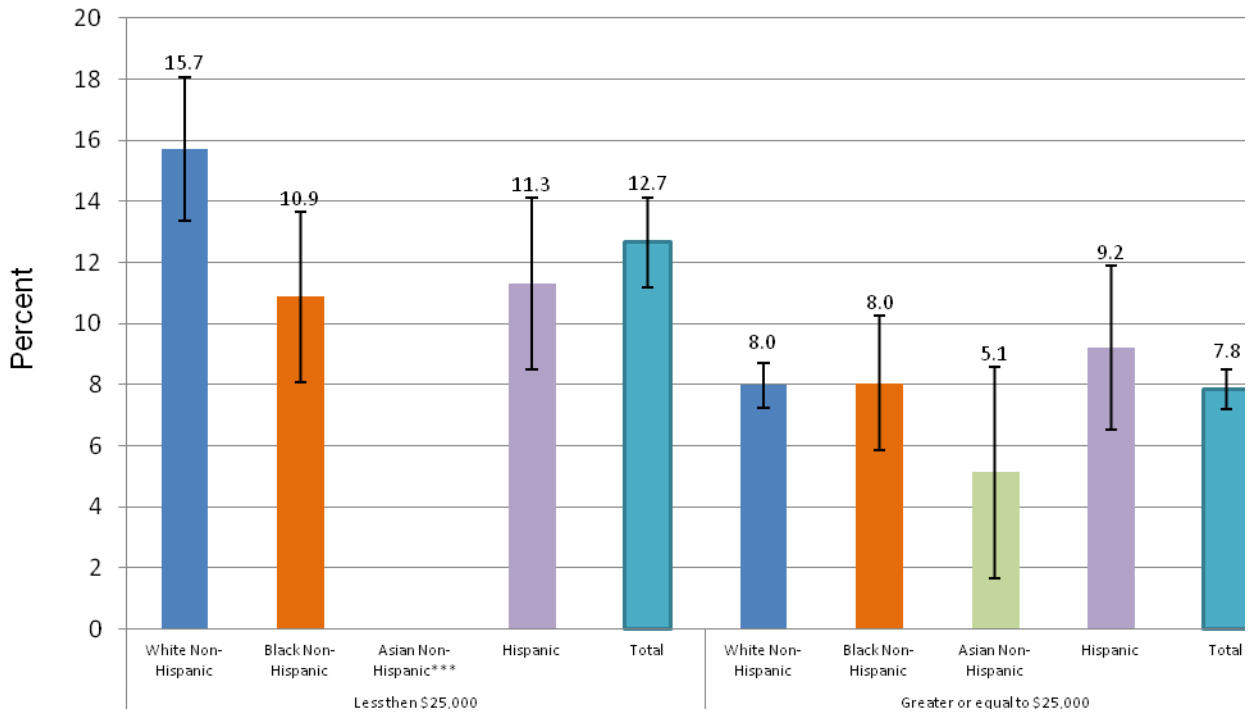
* Three-year moving average adjusted to the 2000 U.S. population.
** Current asthma is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she had asthma and still has asthma.
Source: Behavioral Risk Factor Surveillance System

There are no statistically significant differences in adult asthma prevalence among New York's ethnic groups by income.

Among White non-Hispanic, Black non-Hispanic and Hispanic New Yorkers with incomes under $25,000, the age-adjusted current asthma prevalence rates during 2007-2009 were 15.7 percent, 10.9 percent and 11.3 percent, respectively, with the sample size for Asian non-Hispanics insufficient to report on this indicator.

Among New Yorkers with household incomes of $25,000 or more per year, the rates of current asthma averaged 7.8 percent. However, White non-Hispanic New Yorkers with the higher income level had a significantly lower prevalence of current asthma compared to their counterparts in the lower income bracket.

Figure 57. Age-Adjusted* Percentage of Adults Aged 18 Years and Older with Current Asthma by Race/Ethnicity and Income Categories, New York State, 2007-2009**



*Rates adjusted to the 2000 U.S. population
** Current asthma is defined as the respondent having ever been told by a doctor, nurse or health professional that he or she had asthma and still has asthma.
***Data do not meet reporting requirements.
Source: Behavioral Risk Factor Surveillance System

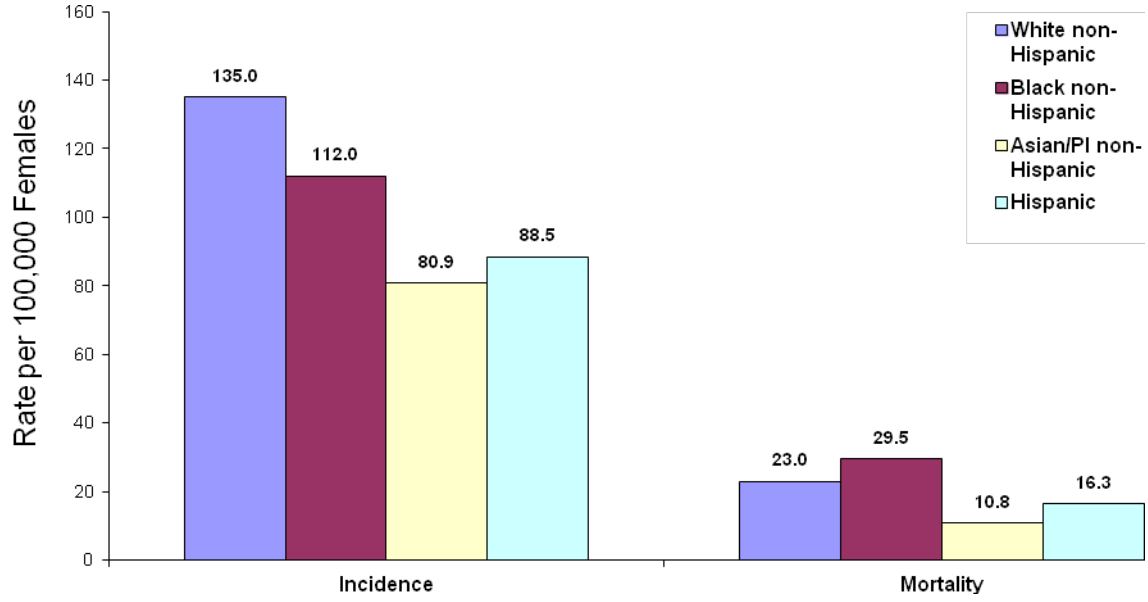
Among women in the United States, breast cancer is the most frequently diagnosed cancer and second most common cause of a cancer-related death after lung cancer.[3]

In New York State, White non-Hispanic women had the highest age-adjusted incidence rate of breast cancer compared to women of other racial/ethnic groups. During 2004-2008, the incidence of breast cancer among White non-Hispanic women (135.0 per 100,000) was 21 percent higher than Black non-Hispanic women (112.0 per 100,000), 67 percent higher than Asian/Pacific Islander non-Hispanic women (80.9 per 100,000) and 53 percent higher than Hispanic women (88.5 per 100,000).

Breast cancer mortality rates during this same time period did not follow the same pattern. Even though Black non-Hispanic women had an incidence rate 21 percent lower than White non-Hispanic women, their breast cancer mortality rate (29.5 per 100,000) was 28 percent higher than the mortality rate for White women (23.0 per 100,000).

Mortality rates among Asian/Pacific Islander non-Hispanic (10.8 per 100,000) and Hispanic (16.3 per 100,000) women were markedly lower than the rates among White non-Hispanic and Black non-Hispanic women.

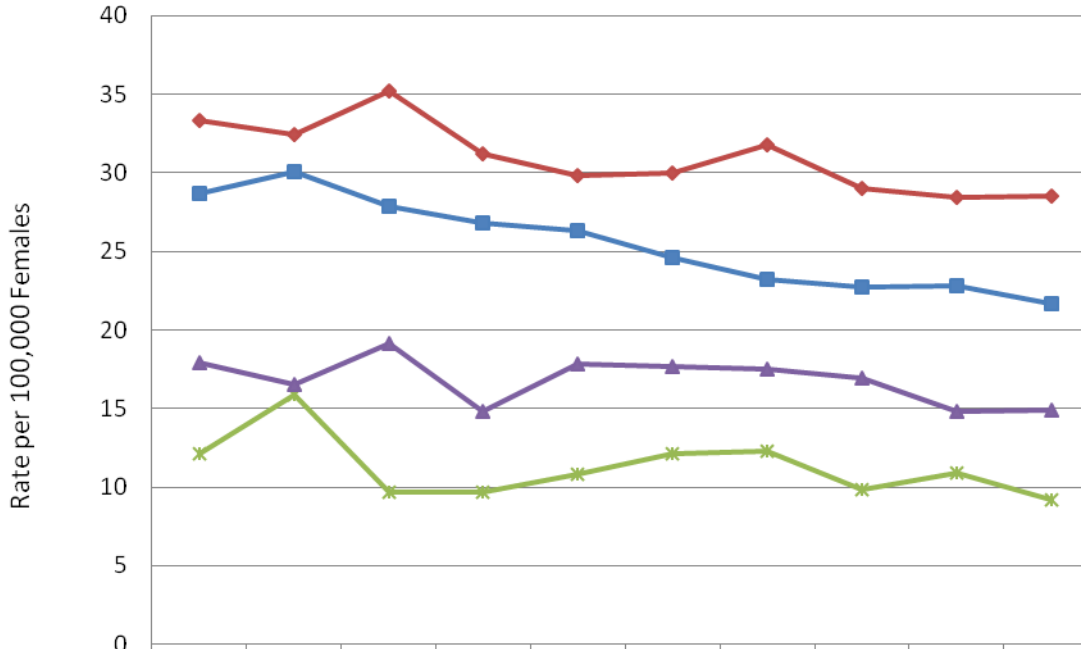
Figure 58. Age-Adjusted* Female Breast Cancer Incidence and Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 2004-2008



* Rates adjusted to the 2000 U.S. population
Abbreviation: PI – Pacific Islander
Source: New York State Cancer Registry

Rates among White non-Hispanic and Black non-Hispanic New York women were disproportionately high compared to Hispanic and Asian/Pacific Islander non-Hispanic women.

Figure 59. Age-Adjusted* Female Breast Cancer Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 1999-2008



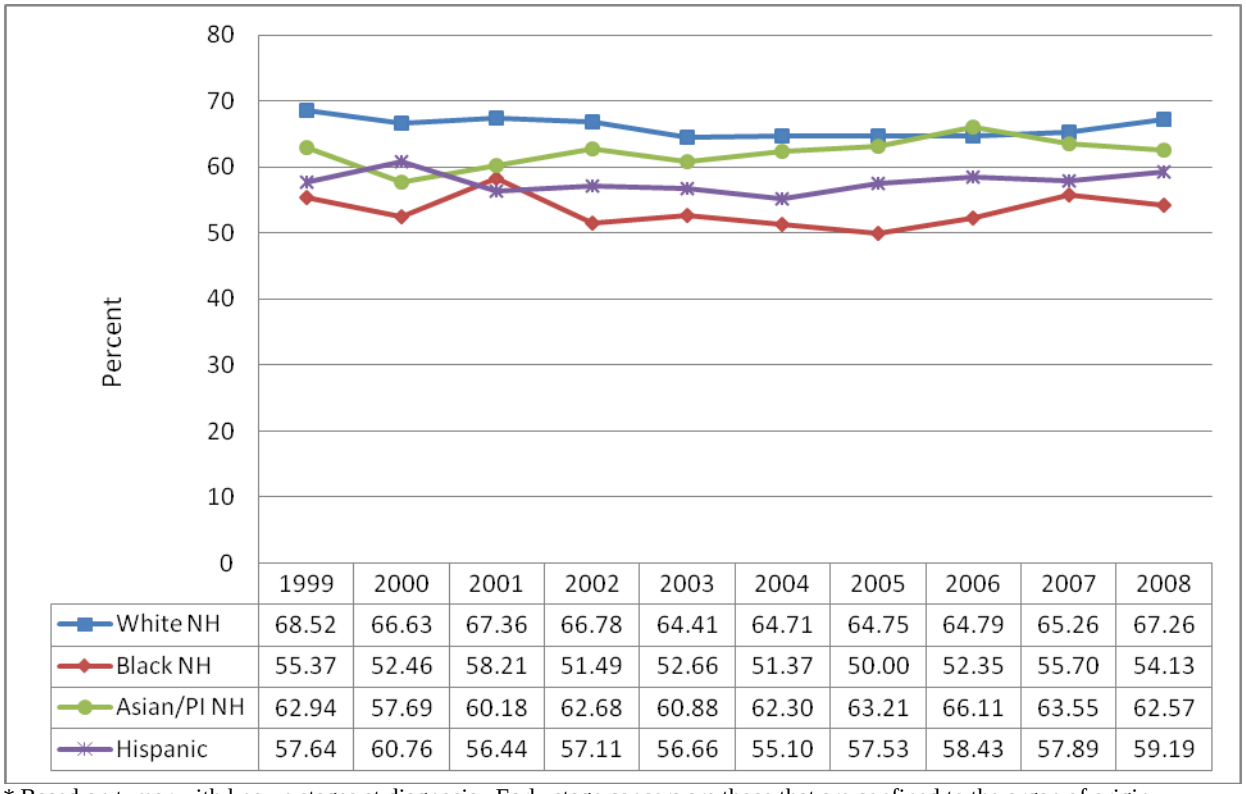
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	28.7	30.1	27.9	26.8	26.3	24.6	23.2	22.7	22.8	21.7
Black NH	33.3	32.4	35.2	31.2	29.8	30.0	31.8	29.0	28.4	28.5
Asian/PI NH	12.1	15.9	9.7	9.7	10.8	12.1	12.3	9.8	10.9	9.2
Hispanic	17.9	16.5	19.1	14.8	17.8	17.7	17.5	16.9	14.8	14.9

* Rates adjusted to the 2000 U.S. population
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

For several types of cancer, detection at an early stage greatly increases the likelihood that treatment will be successful and improves the treatment options available. The five-year survival rate for breast cancer that is in its earliest stages is 97.0 percent, while at late stage it is only 23.3 percent, according to the New York State Comprehensive Cancer Control Plan.[4]

The proportion of women whose breast cancer was diagnosed at an early stage has changed very little for all racial/ethnic groups during the past decade. That proportion remained at less than 70 percent from 1999-2008. Among Black non-Hispanic females, the proportion was only 54.1 percent.

Figure 60. Percentage of Female Breast Cancer Cases Diagnosed in Early Stages* by Race/Ethnicity, New York State, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	68.52	66.63	67.36	66.78	64.41	64.71	64.75	64.79	65.26	67.26
Black NH	55.37	52.46	58.21	51.49	52.66	51.37	50.00	52.35	55.70	54.13
Asian/PI NH	62.94	57.69	60.18	62.68	60.88	62.30	63.21	66.11	63.55	62.57
Hispanic	57.64	60.76	56.44	57.11	56.66	55.10	57.53	58.43	57.89	59.19

* Based on tumor with known stages at diagnosis. Early stage cancers are those that are confined to the organ of origin.
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

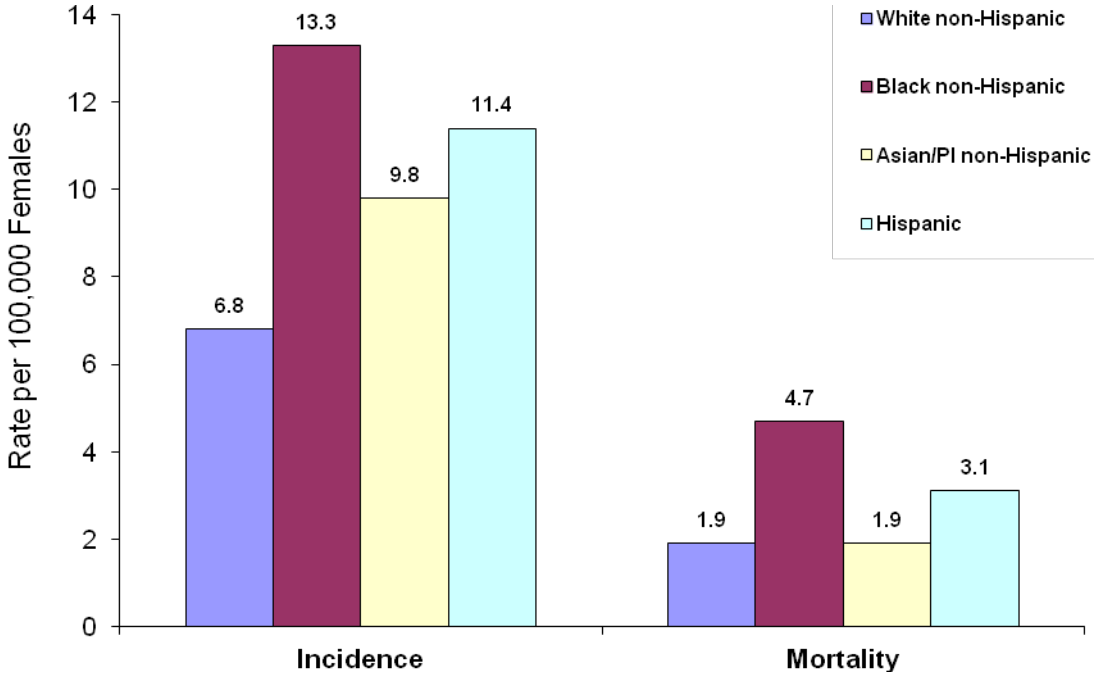
Although cervical cancer incidence and mortality rates declined by half in the United States over the past three decades, the disease remains a serious health threat.[5] In New York, the incidence rates for Black non-Hispanics and Hispanics were twice the level for White non-Hispanic women. Similarly, the death rate for Black non-Hispanic women was more than double that for White non-Hispanic and Asian/Pacific Islander non-Hispanic women.

The cervical cancer incidence rates during 2004-2008 were 13.3 per 100,000 for Black non-Hispanic women, 11.4 per 100,000 for Hispanic women, 9.8 per 100,000 for Asian/Pacific Islander women and 6.8 per 100,000 for White non-Hispanic women.

Black non-Hispanic women in New York State had cervical cancer mortality rates of 4.7 per 100,000 during 2004-2008 – more than double the rates for White non-Hispanic (1.9 per 100,000) and Asian/Pacific Islander non-Hispanic (1.9 per 100,000) women.

The cervical cancer mortality rate among Hispanic New York women during the same period was 3.1 per 100,000 – 63 percent higher than White non-Hispanic and Asian/Pacific Islander non-Hispanic women, yet 34 percent lower than the rate for Black non-Hispanic women.

Figure 61. Age-Adjusted* Cervical Cancer Incidence and Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 2004-2008



* Rates adjusted to the 2000 U.S. population
Abbreviation: PI – Pacific Islander
Source: New York State Cancer Registry

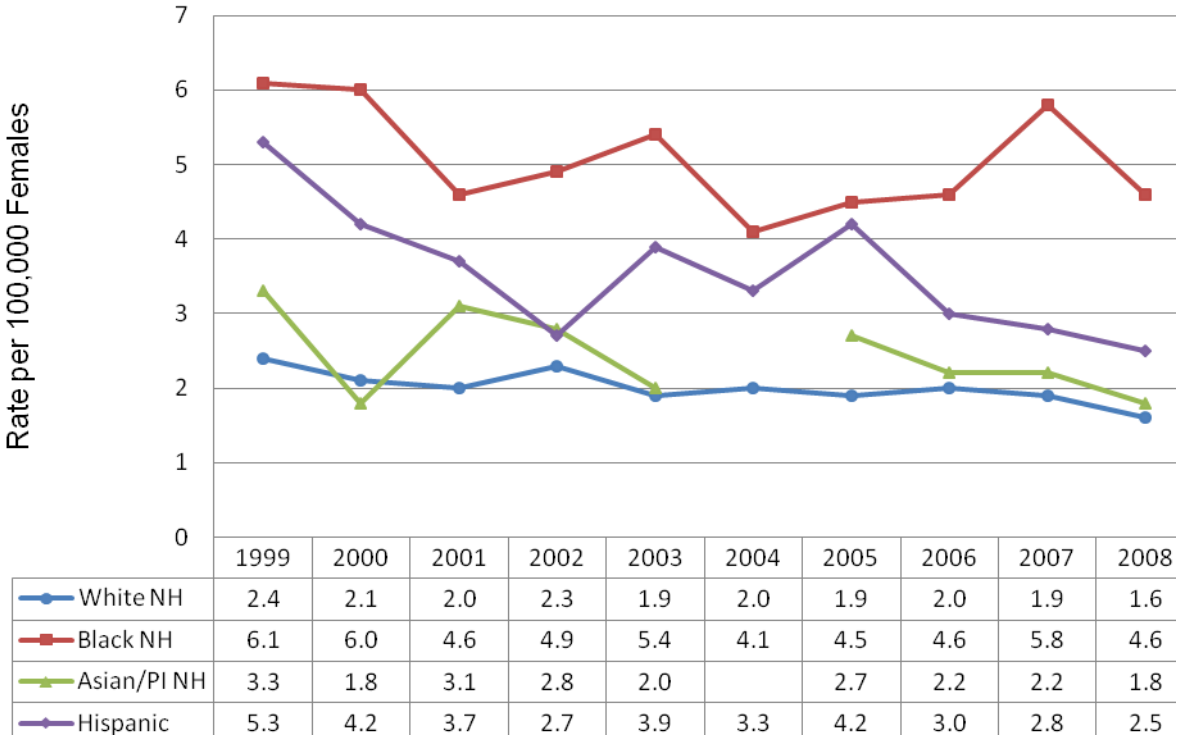
During the 50 years that screening programs have been using the Papanicolaou test (Pap test) widely, cervical cancer deaths have declined 75 percent nationwide. Yet cervical cancer still kills

approximately 4,000 American women each year – even though virtually all cervical cancers are preventable and curable if detected early.[6]

Between 1999-2008, the cervical cancer mortality rates fluctuated among White non-Hispanic (2.4 to 1.6 per 100,000), Black non-Hispanic (6.1 to 4.6 per 100,000), Hispanic (5.3 to 2.5 per 100,000) and Asian/Pacific Islander non-Hispanic (3.3 to 1.8 per 100,000) women in New York.

Black non-Hispanic women throughout this time period died from cervical cancer at more than double the rate for White non-Hispanic women and consistently higher than the rates for Hispanic and Asian/Pacific Islander non-Hispanic New York women.

Figure 62. Age-Adjusted* Cervical Cancer Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 1999-2008

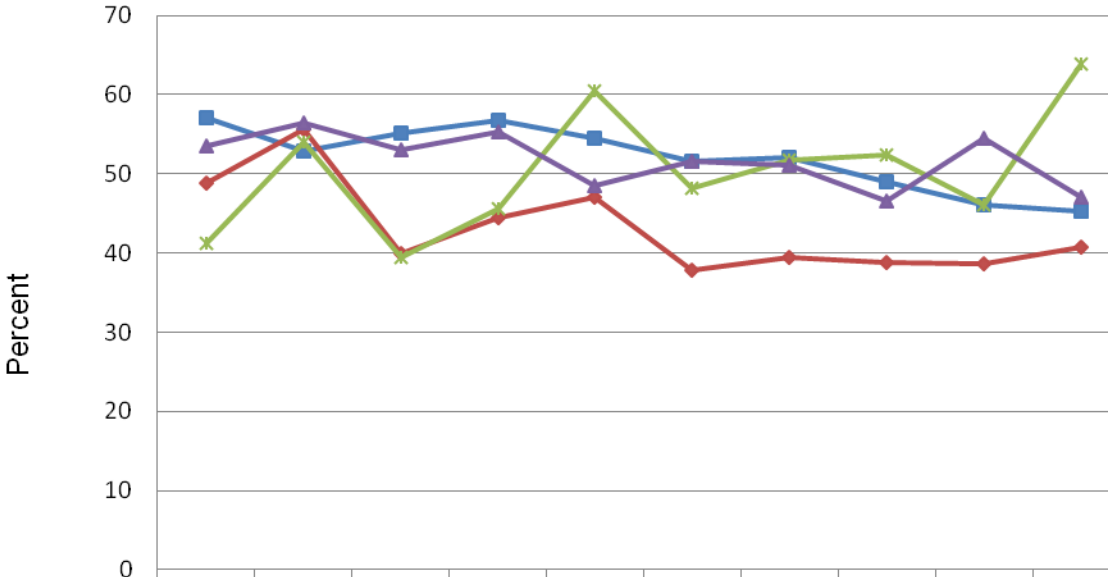


	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	2.4	2.1	2.0	2.3	1.9	2.0	1.9	2.0	1.9	1.6
Black NH	6.1	6.0	4.6	4.9	5.4	4.1	4.5	4.6	5.8	4.6
Asian/PI NH	3.3	1.8	3.1	2.8	2.0		2.7	2.2	2.2	1.8
Hispanic	5.3	4.2	3.7	2.7	3.9	3.3	4.2	3.0	2.8	2.5

* Rates adjusted to the 2000 U.S. population
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Note: 2004 Asian/PI NH data do not meet reporting criteria.
Source: New York State Cancer Registry

During 2008, the proportion of early-stage diagnosis cervical cancer cases was similar among White non-Hispanic and Hispanic women (45.3 percent and 47.1 percent, respectively). The percentages were the lowest among Black non-Hispanic women (40.8 percent) and highest among Asian/Pacific Islander non-Hispanic (63.9 percent) women.

Figure 63. Percentage of Cervical Cancer Cases Diagnosed in Early Stages* by Race/Ethnicity, New York State, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	57.0	52.9	55.2	56.7	54.5	51.5	52.1	48.9	46.2	45.3
Black NH	48.9	55.7	39.9	44.4	47.0	37.8	39.5	38.8	38.6	40.8
Asian/PI NH	41.2	54.1	39.4	45.7	60.5	48.2	51.7	52.3	46.2	63.9
Hispanic	53.5	56.5	53.1	55.3	48.6	51.6	51.0	46.6	54.5	47.1

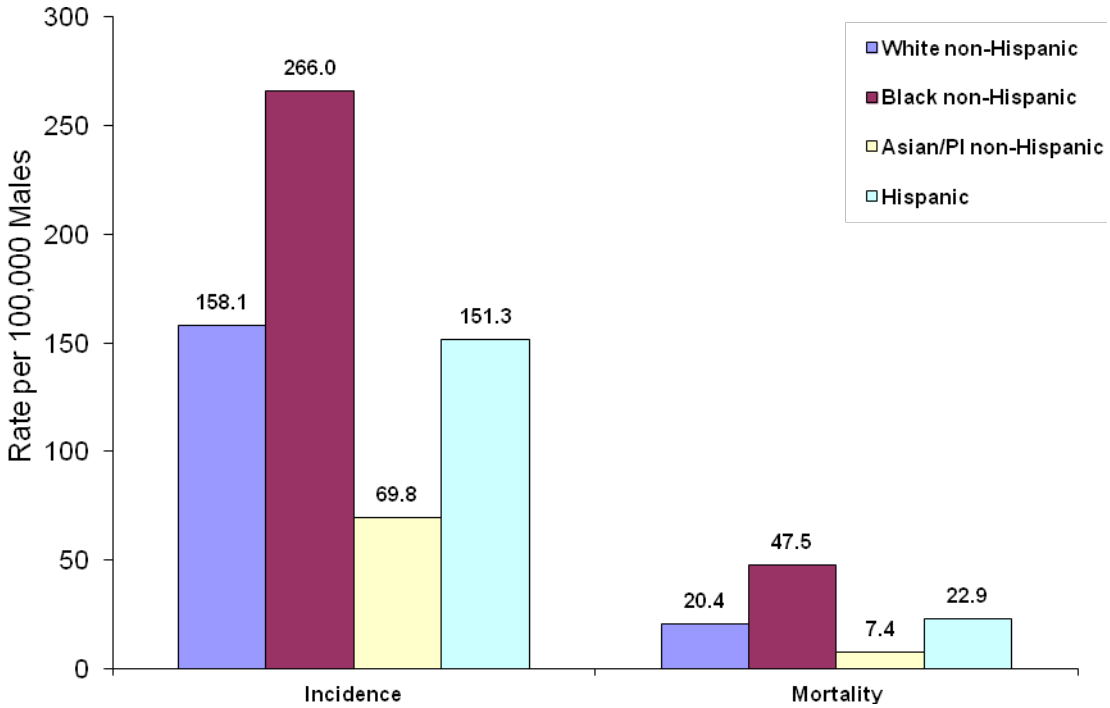
* Based on tumor with known stages at diagnosis. Early stage cancers are those that are confined to the organ of origin.
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

Nationwide, prostate cancer is the most frequently diagnosed cancer in men, with more than 240,000 new cases diagnosed each year – and is a leading cause of cancer death among men of all races and Hispanic origin. Nationally, incidence rates are significantly higher in Black men, compared to other groups.[7]

In New York State during 2004-2008, the age-adjusted incidence of prostate cancer among Black non-Hispanic men (266.0 per 100,000) was about 70 percent higher than rates among White non-Hispanic (158.1 per 100,000) and Hispanic (151.3 per 100,000) men and more than 3.5 times the rate among Asian/Pacific Islander non-Hispanic (69.8 per 100,000) men. These differences were similar to national patterns.

Black non-Hispanic New York men had the highest mortality rates from prostate cancer. Their rate (47.5 per 100,000) was twice that of White non-Hispanic (20.4 per 100,000) and Hispanic (22.9 per 100,000) men and more than six times the rate of Asian/Pacific Islander non-Hispanic (7.4 per 100,000) men.

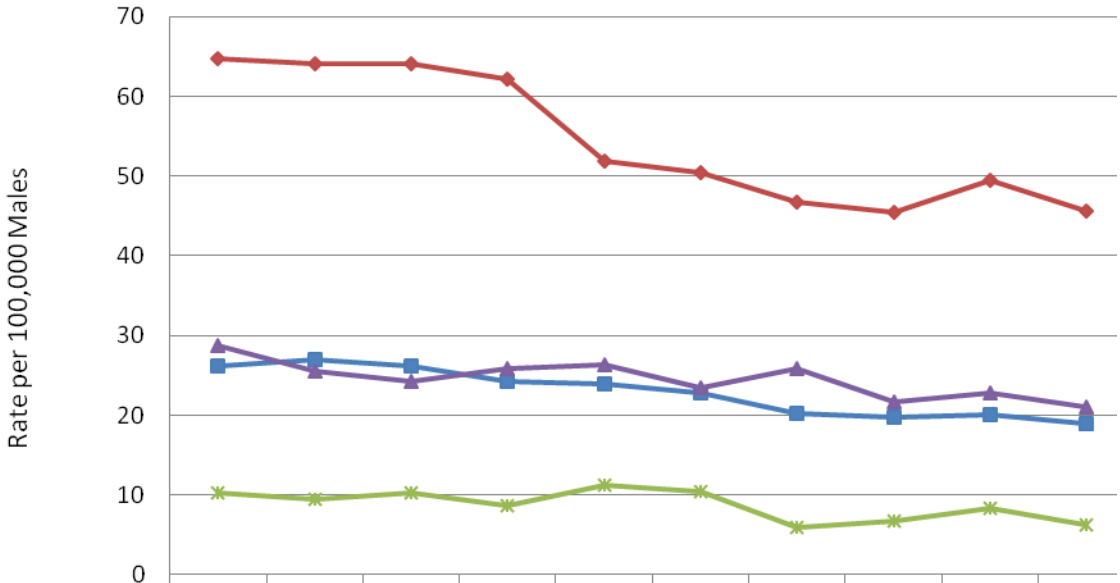
Figure 64. Age-Adjusted* Prostate Cancer Incidence and Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 2004-2008



* Rates adjusted to the 2000 U.S. population
Abbreviation: PI – Pacific Islander
Source: New York State Cancer Registry

The death rate for Black non-Hispanic men (45.6 per 100,000) continued to be more than twice the rate of White non-Hispanic (19.0 per 100,000) and Hispanic men (21.1 per 100,000) and seven times the rate of Asian/Pacific Islander men (6.3 per 100,000).

Figure 65. Age-Adjusted* Prostate Cancer Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 1999-2008

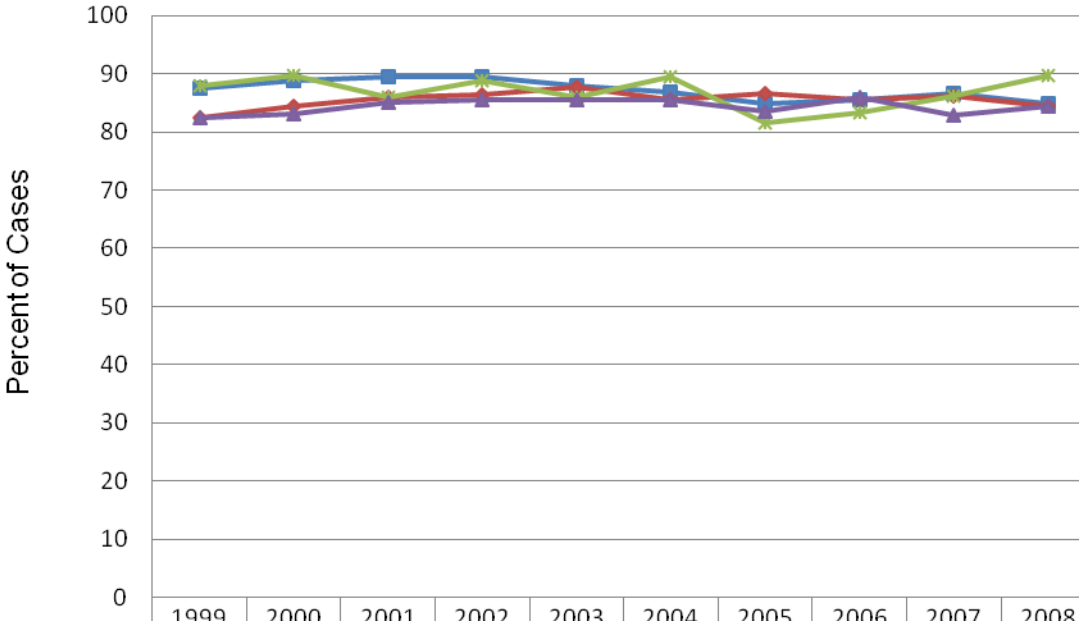


	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	26.1	26.9	26.1	24.3	23.9	22.8	20.3	19.8	20.1	19.0
Black NH	64.7	64.0	64.0	62.1	51.8	50.5	46.8	45.4	49.4	45.6
Asian/PI NH	10.3	9.5	10.2	8.7	11.3	10.4	5.9	6.8	8.3	6.3
Hispanic	28.7	25.6	24.2	25.8	26.3	23.4	25.9	21.7	22.8	21.1

* Rates adjusted to the 2000 U.S. population
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

In New York State, from 1999-2008, prostate cancer was detected early more than 80 percent of the time, across all racial and ethnic groups. By 2008, new cases of prostate cancer, regardless of race, were diagnosed early almost 85 percent of the time.

Figure 66. Percentage of Prostate Cancer Diagnosed in Early Stages* by Race/Ethnicity, New York State, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	87.6	88.8	89.5	89.6	88.0	86.8	84.9	85.6	86.7	84.8
Black NH	82.5	84.5	85.9	86.4	87.7	85.5	86.6	85.6	86.1	84.4
Asian/PI NH	87.8	89.7	85.9	88.8	85.9	89.4	81.5	83.4	86.1	89.6
Hispanic	82.4	83.2	85.1	85.6	85.6	85.4	83.4	85.9	83.0	84.4

* Based on tumor with known stages at diagnosis. Early stage cancers are those that are confined to the organ of origin.
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

Colorectal cancer is the third most common cancer in adults in the U.S. Incidence rates have been declining since 1985, in part due to increased screening and polyp removal, which prevents the progression of polyps to cancer.[8]

Among males, colorectal cancer incidence rates were highest for Black non-Hispanics (61.6 per 100,000) and White non-Hispanics (56.6 per 100,000). Hispanic (53.2 per 100,000) and Asian/Pacific Islander (42.9 per 100,000) men had the lowest incidence rates.

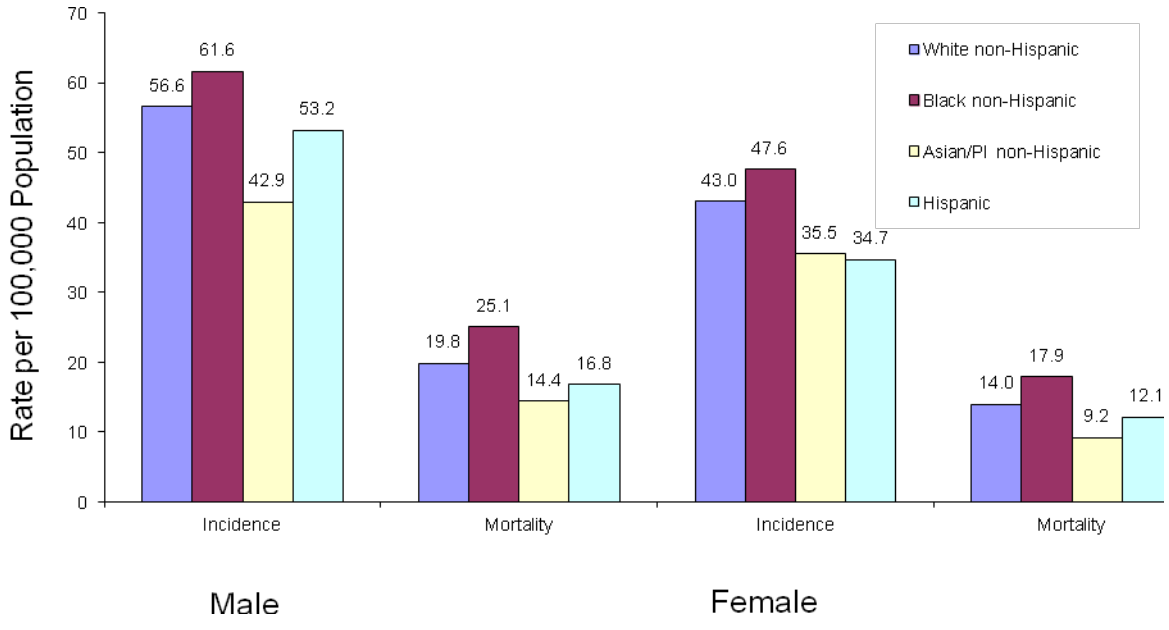
Colorectal cancer incidence among women was lower compared to men, but followed a similar racial and ethnic pattern. Black non-Hispanic (47.6 per 100,000) and White non-Hispanic (43.0 per 100,000) women had the highest incidence.

Colorectal cancer mortality rates were highest among Black and White non-Hispanic men, with the rate for Blacks (25.1 per 100,000) slightly higher than for Whites (19.8 per 100,000).

Similar to men, Black and White non-Hispanic women also had the highest colorectal cancer mortality rates among ethnic groups, with the rate for Black women (17.9 per 100,000) slightly higher compared to White women (14.0 per 100,000).

Mortality rates for Hispanic and Asian/Pacific Islander non-Hispanic men and women were markedly lower than rates for White non-Hispanics and Black non-Hispanics.

Figure 67. Age-Adjusted* Colorectal Cancer Incidence and Mortality Rates per 100,000 Population by Gender and Race/Ethnicity, New York State, 2004-2008

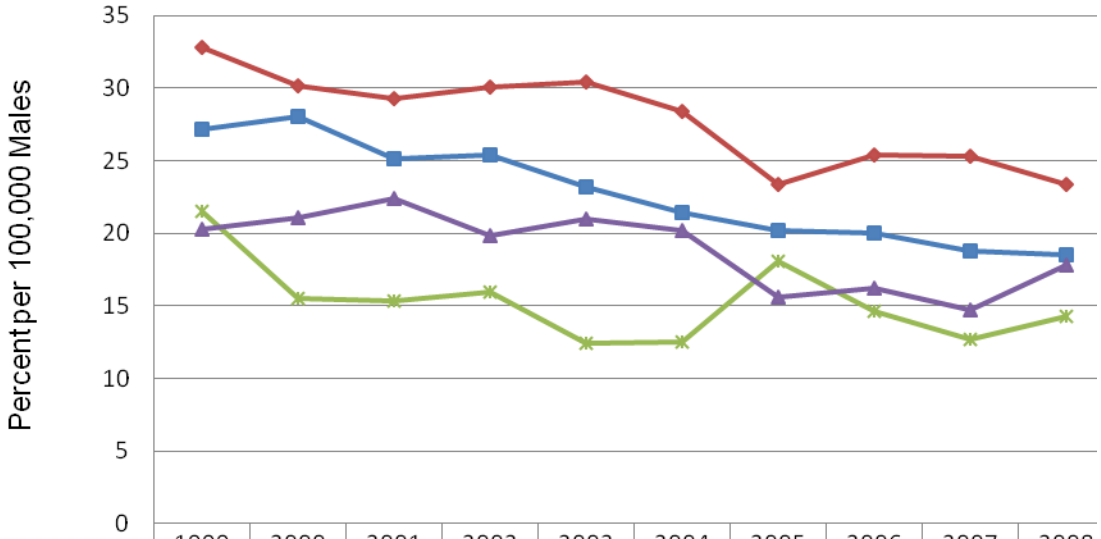


* Rates adjusted to the 2000 U.S. population
Abbreviation: PI – Pacific Islander
Source: New York State Cancer Registry

From 1999-2008, the colorectal cancer mortality rate among Black non-Hispanic New York men decreased from 32.8 to 23.4 per 100,000 men – the largest decrease of any racial/ethnic group. The reductions were also large among White non-Hispanic and Asian/Pacific Islander non-Hispanic men, while Hispanic men experienced a smaller decrease in their rate.

In 2008, colorectal cancer mortality rates were highest among Black non-Hispanic men (23.4 per 100,000) followed by White non-Hispanic (18.5 per 100,000) and Hispanic men (17.8 per 100,000). Asian/Pacific Islander non-Hispanic men (14.3 per 100,000) had the lowest rate.

Figure 68. Age-Adjusted* Male Colorectal Cancer Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 1999-2008



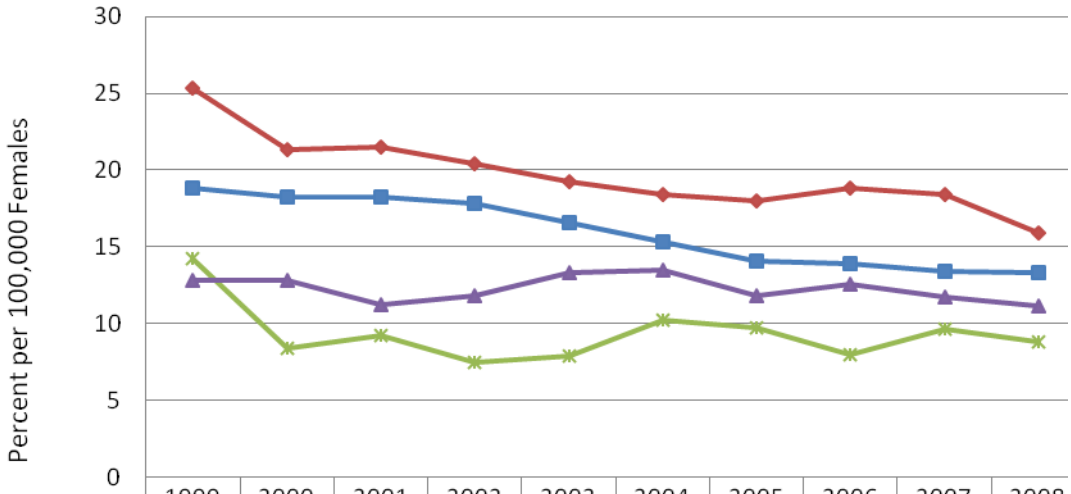
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	27.2	28.0	25.1	25.4	23.2	21.4	20.2	20.0	18.8	18.5
Black NH	32.8	30.2	29.3	30.1	30.4	28.4	23.4	25.4	25.3	23.4
Asian/PI NH	21.5	15.5	15.3	16.0	12.4	12.5	18.1	14.6	12.7	14.3
Hispanic	20.3	21.1	22.4	19.8	21.0	20.2	15.6	16.2	14.7	17.8

* Rates adjusted to the 2000 U.S. population
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

Colorectal cancer death rates in New York State decreased between 1999 and 2008 for women of all racial/ethnic groups.

In 2008, Black non-Hispanic and White non-Hispanic women experienced the highest rates (15.9 per 100,000 and 13.3 per 100,000, respectively), followed by Hispanic (11.1 per 100,000) and Asian/Pacific Islander non-Hispanic (8.8 per 100,000) women.

Figure 69. Age-Adjusted* Female Colorectal Cancer Mortality Rates per 100,000 Population by Race/Ethnicity, New York State, 1999-2008

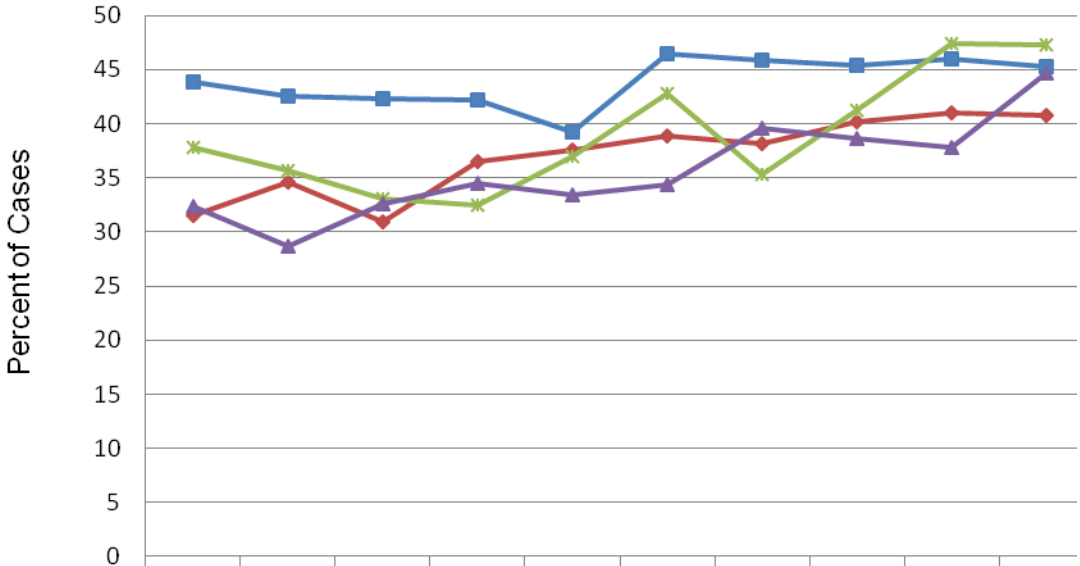


	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	18.8	18.2	18.2	17.8	16.6	15.3	14.1	13.9	13.4	13.3
Black NH	25.3	21.3	21.5	20.4	19.2	18.4	18.0	18.8	18.4	15.9
Asian/PI NH	14.2	8.4	9.2	7.5	7.9	10.2	9.7	8.0	9.6	8.8
Hispanic	12.8	12.8	11.2	11.8	13.3	13.5	11.8	12.6	11.7	11.1

* Rates adjusted to the 2000 U.S. population
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York Cancer Registry

Early stage diagnosis of colorectal cancer remains a serious challenge. Although it has improved for all racial/ethnic groups over the last ten years, no group of men had even half their colorectal cancers detected at an early stage. Asian/Pacific Islander non-Hispanic males (47.3 percent) had the highest percentage of early diagnosis, followed by White non-Hispanic (45.2 percent) and Hispanic (44.6 percent) men. Black non-Hispanic (40.8 percent) men had the lowest percentage.

Figure 70. Percentage of Male Colorectal Cancer Cases Diagnosed in Early Stages* by Race/Ethnicity, New York State, 1999-2008



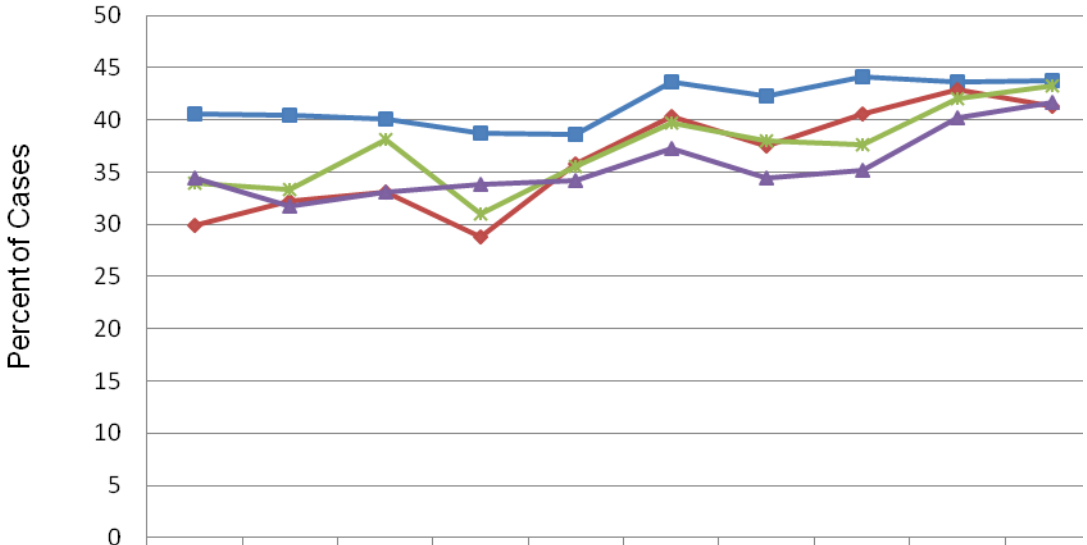
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	43.8	42.6	42.3	42.2	39.3	46.4	45.9	45.3	46.0	45.2
Black NH	31.5	34.6	31.0	36.6	37.6	38.9	38.2	40.2	41.0	40.8
Asian/PI NH	37.8	35.7	33.1	32.5	37.0	42.8	35.3	41.2	47.4	47.3
Hispanic	32.3	28.7	32.6	34.5	33.4	34.3	39.6	38.6	37.8	44.6

* Based on tumor with known stages at diagnosis. Early stage cancers are those that are confined to the organ of origin.
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

Even though disparities in early stage diagnosis of colorectal cancer have narrowed among female racial/ethnic groups, by 2008, all rates still remained lower than 45 percent.

In 2008, the percentage of colorectal cancer cases diagnosed at early stage was similar among all racial/ethnic groups. White non-Hispanic women were diagnosed early 43.7 percent of the time. Black non-Hispanic women were diagnosed early 41.3 percent of the time; Asian/Pacific Islander non-Hispanic women were diagnosed early in 43.3 percent of cases, and Hispanics, 41.7 percent.

Figure 71. Percentage of Female Colorectal Cancer Cases Diagnosed in Early Stages* by Race/Ethnicity, New York State, 1999-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
White NH	40.6	40.5	40.1	38.7	38.6	43.6	42.3	44.1	43.7	43.7
Black NH	29.9	32.2	33.1	28.8	35.7	40.3	37.5	40.6	42.9	41.3
Asian/PI NH	33.9	33.3	38.2	31.0	35.5	39.8	38.0	37.6	42.0	43.3
Hispanic	34.4	31.7	33.1	33.9	34.2	37.3	34.4	35.2	40.2	41.7

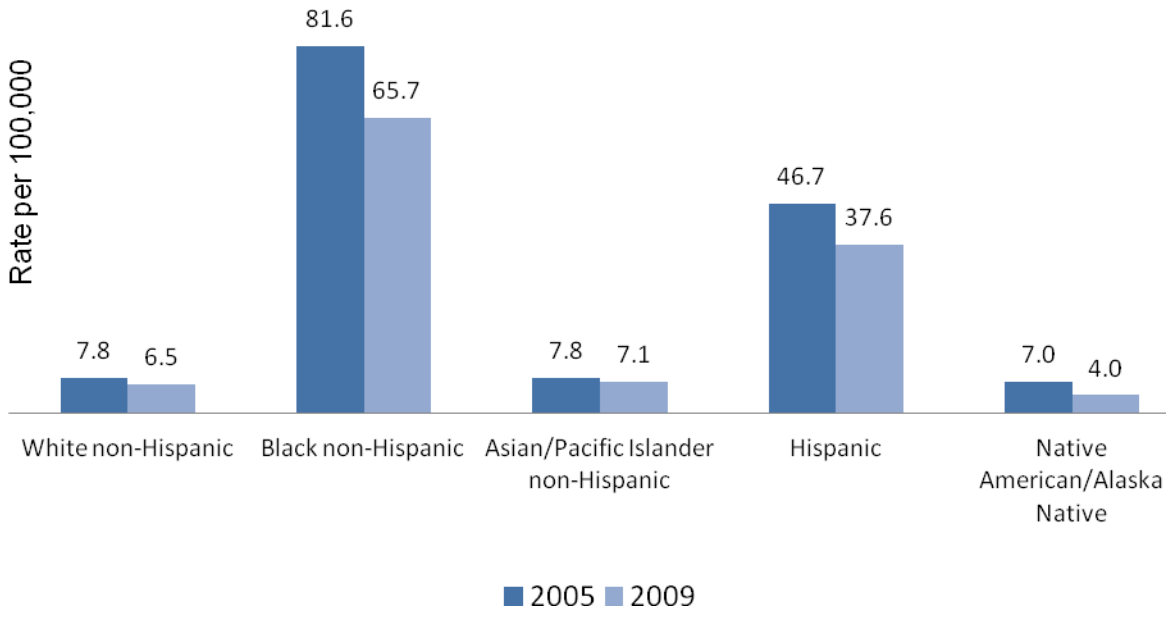
* Based on tumor with known stages at diagnosis. Early stage cancers are those that are confined to the organ of origin.
Abbreviations: NH- non-Hispanic, PI – Pacific Islander
Source: New York State Cancer Registry

Approximately 1.1 million adults and adolescents are living with human immunodeficiency virus (HIV) infection in the United States, with 48,200 - 64,500 persons newly infected each year.[9]

HIV new case rates declined for all New York racial/ethnic groups between 2005 and 2009. Black non-Hispanics and Hispanics had case rates many times higher than rates among other racial/ethnic groups. The new case rate decreased by 19 percent in both groups, with a drop from 81.6 to 65.7 per 100,000 for Black non-Hispanics and from 46.7 to 37.6 per 100,000 for Hispanics.

The HIV new case rates among White non-Hispanic, Asian/Pacific Islander non-Hispanic and Native American/Alaska Native New Yorkers were all below 10 per 100,000 in 2005 and 2009.

Figure 72. HIV New Case Rate per 100,000 Population by Race/Ethnicity, New York State, 2005 and 2009

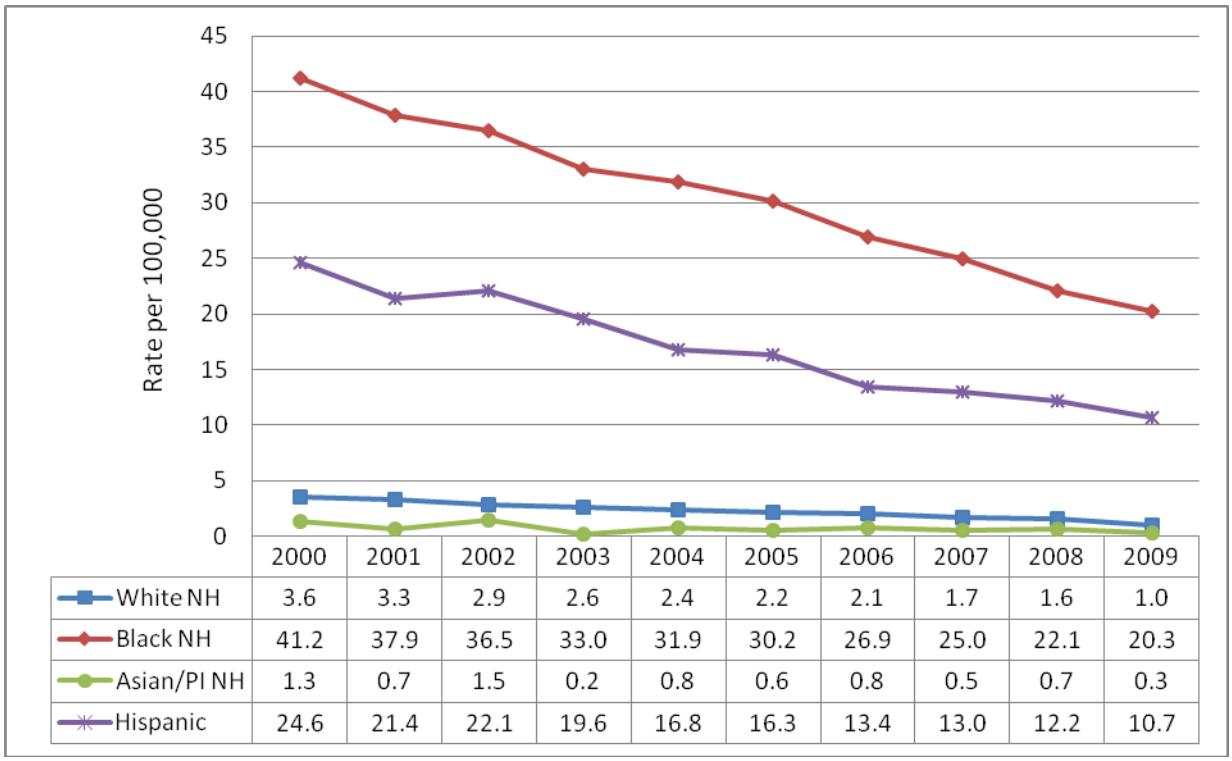


Source: Bureau of HIV/AIDS Epidemiology, New York State Department of Health

The HIV/AIDS epidemic has had a great impact on New Yorkers. A tribute to scientific advancements and the work of public health professionals and communities, the HIV/AIDS death rate has declined considerably and disparities have been reduced, although marked gaps between groups still exist. As of 2009, AIDS remains a leading cause of death for Black New Yorkers.[10]

The most striking decreases in HIV/AIDS mortality rates from 2000-2009 were among Black non-Hispanics (41.2 to 20.3 per 100,000) and Hispanics (24.6 to 10.7 per 100,000). Asian/Pacific Islander non-Hispanics and White non-Hispanic New Yorkers also experienced marked declines in HIV/AIDS death rates (1.3 to 0.3 per 100,000 and 3.6 to 1.0 per 100,000 respectively).

Figure 73. Age-Adjusted* HIV/AIDS Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	3.6	3.3	2.9	2.6	2.4	2.2	2.1	1.7	1.6	1.0
Black NH	41.2	37.9	36.5	33.0	31.9	30.2	26.9	25.0	22.1	20.3
Asian/PI NH	1.3	0.7	1.5	0.2	0.8	0.6	0.8	0.5	0.7	0.3
Hispanic	24.6	21.4	22.1	19.6	16.8	16.3	13.4	13.0	12.2	10.7

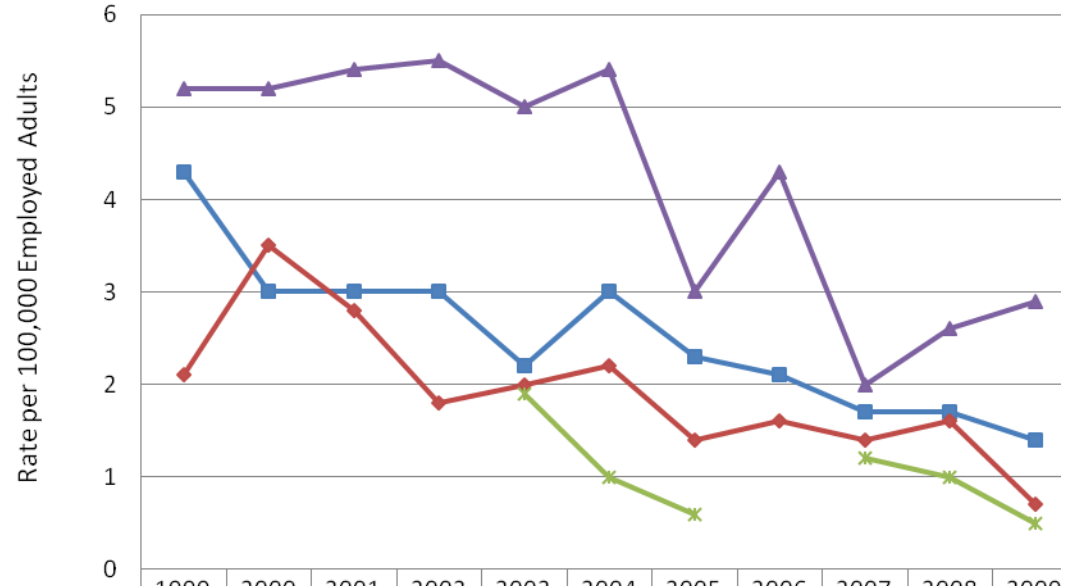
* Rates adjusted to the 2000 U.S. population
AIDS/HIV mortality rate based on ICD10 codes B20-B24.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Lead poisoning affects multiple organ systems and can cause permanent damage. Among adults, lead poisoning remains a persistent, mainly occupational, public health issue. Workers bringing lead dust home on their clothing can expose their children to lead. Blood lead level (BLL) is the best biological indicator of lead exposure.

New York State participates in the National Institute for Occupational Safety and Health's Adult Blood Lead Epidemiology and Surveillance (ABLES), which is a state-based surveillance program of laboratory-reported adult BLLs. For ABLES, adults are defined as persons 16 years or older. For adults with more than one BLL record in a given year, only the highest BLL is included. The incidence rate is calculated by determining the number of elevated (25 mcg/dL or higher) cases reported during a calendar year, but not reported in the immediately preceding year, divided by the state's annual employed population. The rate is expressed per 100,000 employed adults.

There has been a sharp decrease in the incidence rate of elevated BLLS among adults in New York State for all racial/ethnic groups from 1999-2009. However, Hispanics still had almost double the rate of elevated BLLs than all other groups.

Figure 74. Incidence Rate of Elevated* Blood Lead Level per 100,000 Employed Adults by Race/Ethnicity, New York State, 1999-2009



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	4.3	3.0	3.0	3.0	2.2	3.0	2.3	2.1	1.7	1.7	1.4
Black NH	2.1	3.5	2.8	1.8	2.0	2.2	1.4	1.6	1.4	1.6	0.7
Asian/PI NH					1.9	1.0	0.6		1.2	1.0	0.5
Hispanic	5.2	5.2	5.4	5.5	5.0	5.4	3.0	4.3	2.0	2.6	2.9

* Elevated Blood Lead Level defined as blood lead level of 25 mcg/dL or higher
Abbreviations: NH – non-Hispanic, PI- Pacific Islander
Note: 1999 – 2002 and 2006 data are not available for Asian/PI NH.

Source: Adult Blood Lead Epidemiology and Surveillance System

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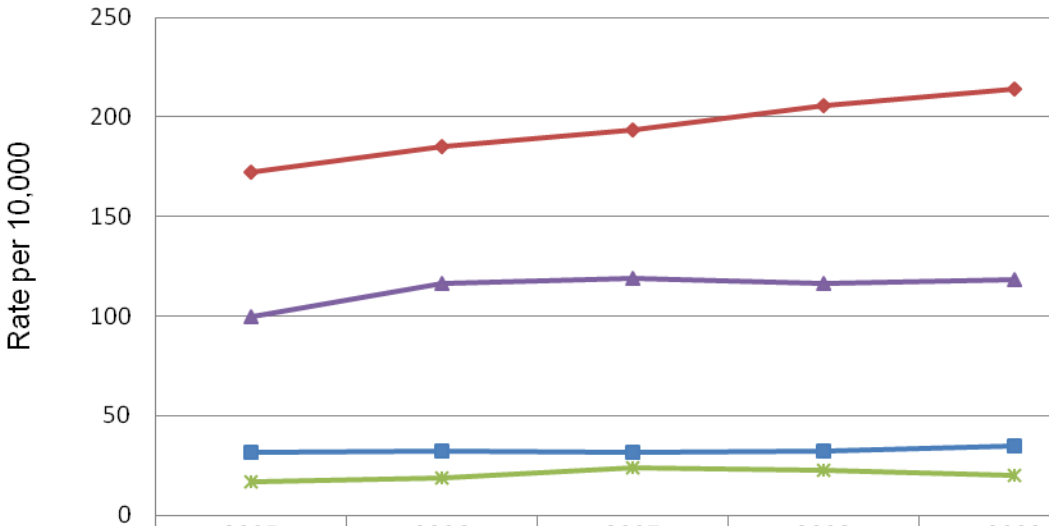
Emergency Department Visits and Hospitalizations

More than half (53 percent) of people in the United States with asthma had an asthma attack in 2008.[1] More children (57 percent) than adults (51 percent) had an attack – and 185 children and 3,262 adults died from asthma in 2007.[2]

A larger proportion Black non-Hispanic New Yorkers visited emergency departments for asthma care than all other groups. Specifically, the Black non-Hispanic rate (214.3 per 10,000) was almost double the rate among Hispanics (118.2 per 10,000), six times the rate among White non-Hispanics (34.5 per 10,000) and more than ten times the rate among Asian/Pacific Islander non-Hispanics (20.1 per 10,000). Between 2005-2009, the rate of emergency department visits for asthma increased among all racial/ethnic groups.

Figure 75. Age-Adjusted* Asthma-Related Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, New York State, 2005-2009



	2005	2006	2007	2008	2009
White NH	31.7	32.1	31.8	32.5	34.5
Black NH	172.1	185.1	193.4	205.5	214.3
Asian/PI NH	16.5	18.8	23.8	22.6	20.1
Hispanic	99.9	116.2	119.2	116.1	118.2

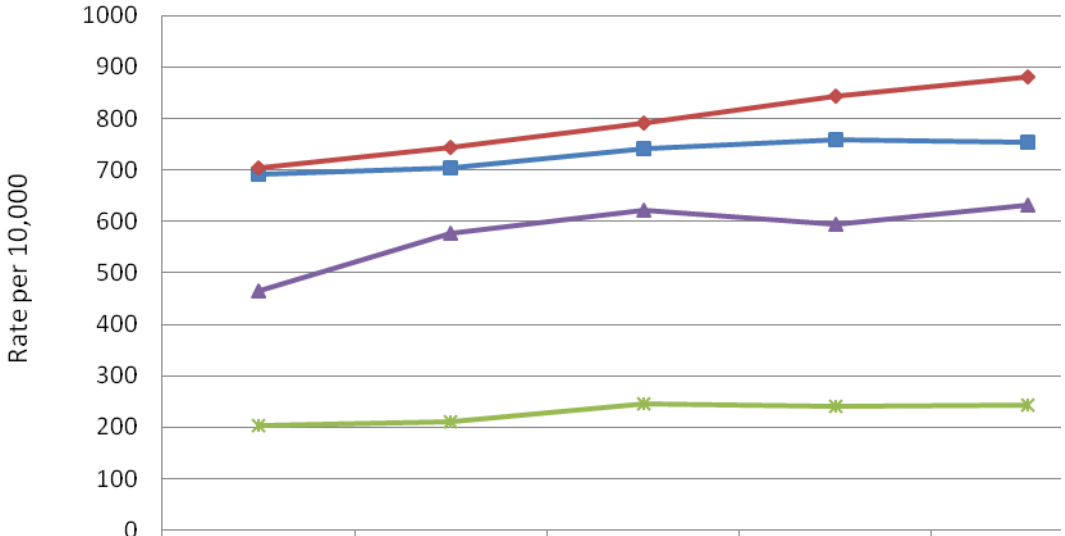
* Rates adjusted to the 2000 U.S. population
Asthma emergency department visit rate is based on ICD-9 code 493
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

More than 29 million people in the United States are treated annually in emergency departments for injury.[3]

Emergency department visits due to an unintentional injury have increased over the past five years for all racial/ethnic groups. The rate among Black non-Hispanics (881.2 per 10,000) was higher than all other racial/ethnic groups and had increased by 25 percent from 2005 to 2009. White non-Hispanics had the next highest rate (753.9 per 10,000), but its increase was more modest (9 percent).

The visit rate among Hispanics in 2009 (631.7 per 10,000) increased 36 percent since 2005. Asian/Pacific Islander non-Hispanics experienced the lowest rate of unintentional injury emergency department visits (244.2 per 10,000), an increase of 19.5 percent since 2005.

Figure 76. Age-Adjusted* Unintentional Injury-Related Emergency Room Visit Rate per 10,000 Population by Race/Ethnicity, New York State, 2005-2009



	2005	2006	2007	2008	2009
White NH	692.1	704.3	740.1	757.8	753.9
Black NH	704.1	743.7	791.2	844.1	881.2
Asian/PI NH	204.3	210.6	246.1	240.8	244.2
Hispanic	465.3	575.9	620.9	594.2	631.7

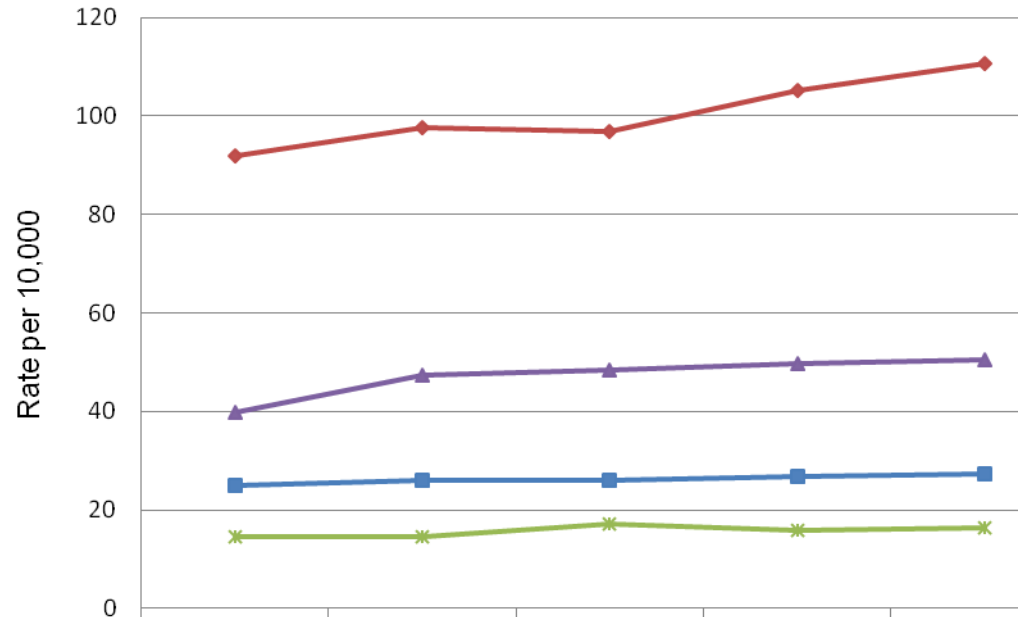
* Rates adjusted to the 2000 U.S. population
Unintentional injury emergency department visit rate is based on ICD9 codes E800-E928 (excluding E870-E879)
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

The health consequences of injury and violence, coupled with the enormous cost of these problems to society, make them a pressing public health concern.[4]

Assault-related emergency department visits were most prevalent among Black non-Hispanic New Yorkers. Their rate of 110.7 per 10,000 in 2009 was more than double the next highest rate (50.6 per 10,000 among Hispanic New Yorkers). Such emergency department visits were considerably lower among White non-Hispanics (27.3 per 10,000) and Asian/Pacific Islander non-Hispanics (16.4 per 10,000).

Emergency department visits for assault injuries increased for all racial/ethnic groups between 2005 and 2009.

Figure 77. Age-Adjusted* Assault-Related Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, New York State, 2005-2009



	2005	2006	2007	2008	2009
White NH	24.9	26.1	26.0	26.9	27.3
Black NH	92.0	97.5	96.9	105.2	110.7
Asian/PI NH	14.7	14.5	17.1	15.8	16.4
Hispanic	39.8	47.5	48.4	49.8	50.6

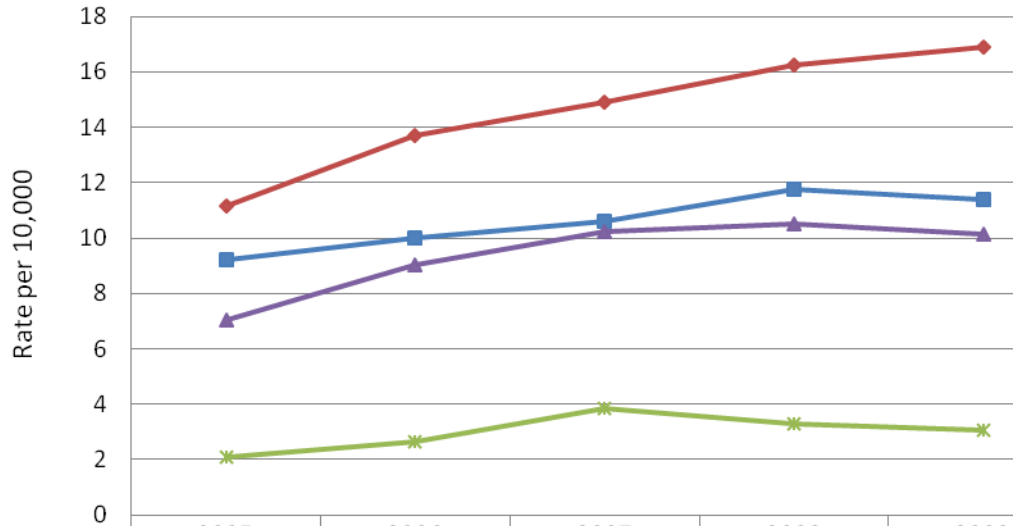
*Rates adjusted to the 2000 U.S. population
Assault-related Emergency Department Visit Rate is based on ICD9 codes E960-E968
Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
Source: Statewide Planning and Research Cooperative System (SPARCS)

Unintentional poisoning is an emerging public health threat. The national unintentional poisoning death rate increased two-fold from 2000 to 2006. Partly as a result of the growing abuse of prescription drugs, unintentional poisoning is now the leading cause of injury death in the nation, surpassing unintentional motor vehicle traffic deaths, for persons ages 35-54.[5]

Emergency department visit rates to treat unintentional poisoning were highest among Black non-Hispanic New Yorkers (16.9 per 10,000) and lowest among Asian/Pacific Islander non-Hispanics (3.1 per 10,000). Rates among White non-Hispanics and Hispanics were lower, at 11.4 and 10.1 per 10,000, respectively.

Rates of unintentional poisoning emergency room visits increased between 2005 and 2008 among all racial/ethnic groups but then leveled off between 2008 and 2009 for all groups except Black non-Hispanics.

Figure 78. Age-Adjusted* Unintentional Poisoning-Related Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, New York State, 2005-2009



	2005	2006	2007	2008	2009
White NH	9.2	10.0	10.6	11.7	11.4
Black NH	11.1	13.7	14.9	16.2	16.9
Asian/PI NH	2.1	2.6	3.9	3.3	3.1
Hispanic	7.0	9.0	10.3	10.5	10.1

* Rates adjusted to the 2000 U.S. population
Unintentional poisoning emergency department visit rate is based on ICD9 code E850.0-E869.9
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

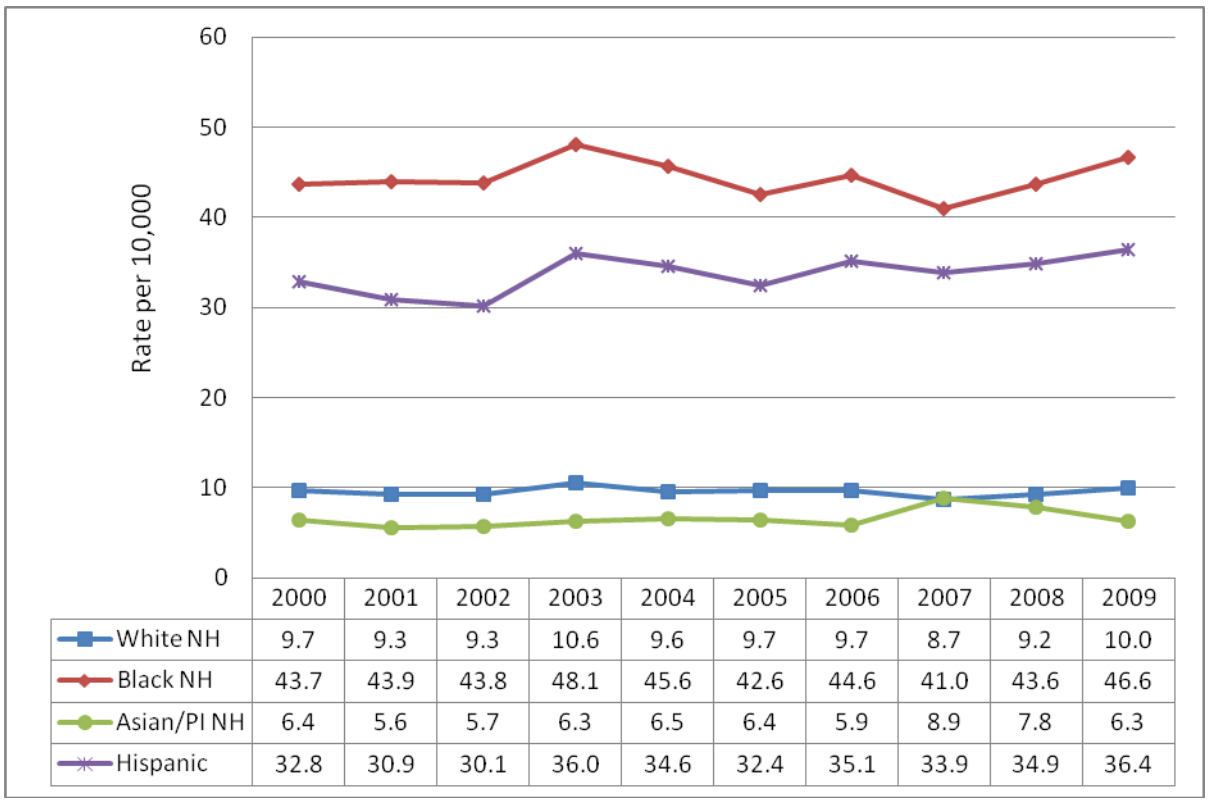
Asthma is a serious public health concern nationally and in New York. More than 1.5 million New York State residents live with asthma.

Black non-Hispanic and Hispanic New Yorkers had consistently higher asthma hospitalization rates than Asian/Pacific Islander non-Hispanics and White non-Hispanics. In 2009, Black non-Hispanics' asthma hospitalization rate (46.6 per 10,000) was more than four times higher than that for Whites (10.0 per 10,000) and six times higher than for Asian/Pacific Islanders (6.3 per 10,000).

Among Hispanics, the asthma hospitalization rate (36.4 per 10,000) in 2009 was triple the rate of White non-Hispanics (10.0 per 10,000) and more than five times greater than the rate among Asian/Pacific Islander non-Hispanics (6.3 per 10,000).

From 2000-2009, when asthma prevalence increased among New Yorkers, asthma hospitalization rates for all racial/ethnic groups fluctuated.

Figure 79. Age-Adjusted* Asthma Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	9.7	9.3	9.3	10.6	9.6	9.7	9.7	8.7	9.2	10.0
Black NH	43.7	43.9	43.8	48.1	45.6	42.6	44.6	41.0	43.6	46.6
Asian/PI NH	6.4	5.6	5.7	6.3	6.5	6.4	5.9	8.9	7.8	6.3
Hispanic	32.8	30.9	30.1	36.0	34.6	32.4	35.1	33.9	34.9	36.4

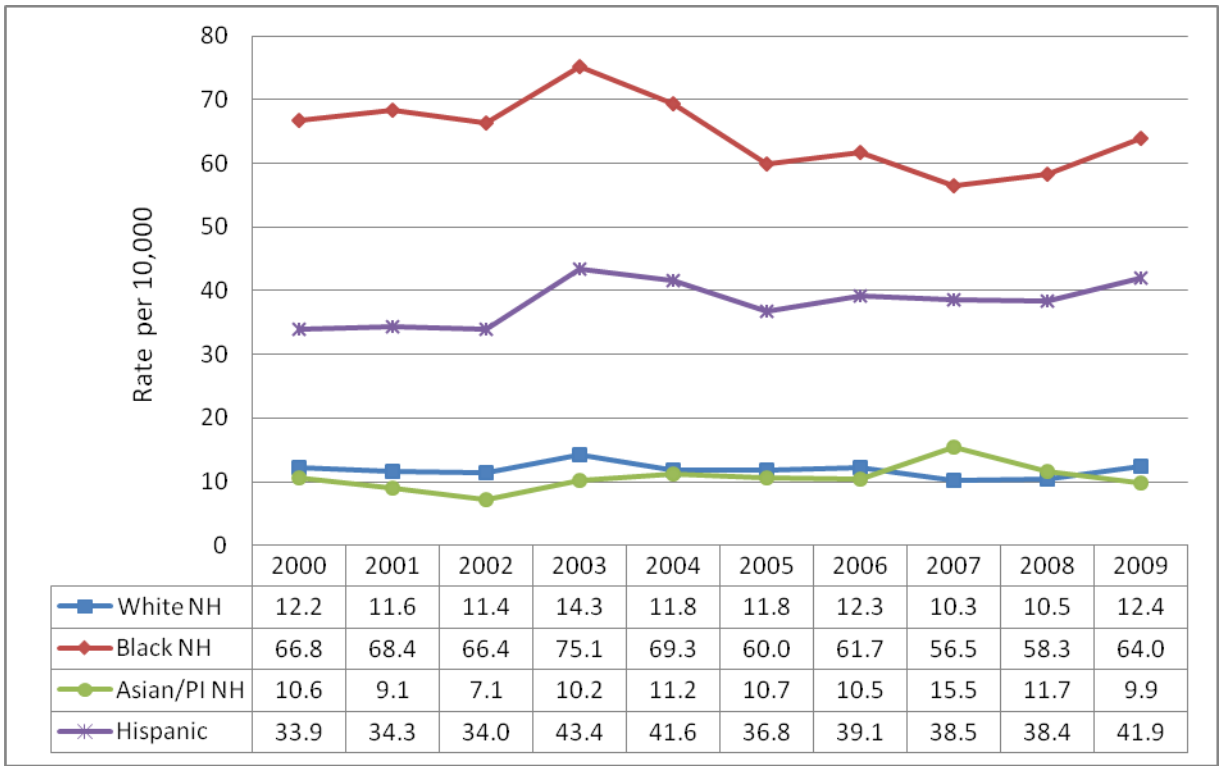
* Rates adjusted to the 2000 U.S. population
Asthma hospitalization rate is based on ICD9 code 493.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Asthma is the most common chronic illness among school-age children nationwide and in New York.[6] When the disease is properly controlled, children with asthma can lead full and active lives. The asthma hospitalization rate for children ages 2-17 years is used as a measure of the quality of outpatient and health care quality. Because most asthma cases can be managed in an outpatient setting, low hospitalization rates for asthma indicate better outpatient and health care.[7]

The past 10 years of data show large racial and ethnic disparities in children's asthma hospitalization rates in New York. In 2009, rates among Black non-Hispanic (64.0 per 10,000) youth were more than five times higher than for White non-Hispanic (12.4 per 10,000) and Asian/Pacific Islander non-Hispanic (9.9 per 10,000) youth.

Hispanic New York children had the second highest rate (41.9 per 10,000), which, while 35 percent lower than the Black non-Hispanic rate, is more than three times the rates among White non-Hispanic and Asian/Pacific Islander non-Hispanic children.

Figure 80. Asthma Hospitalization Rate among Children Ages 0-17 per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	12.2	11.6	11.4	14.3	11.8	11.8	12.3	10.3	10.5	12.4
Black NH	66.8	68.4	66.4	75.1	69.3	60.0	61.7	56.5	58.3	64.0
Asian/PI NH	10.6	9.1	7.1	10.2	11.2	10.7	10.5	15.5	11.7	9.9
Hispanic	33.9	34.3	34.0	43.4	41.6	36.8	39.1	38.5	38.4	41.9

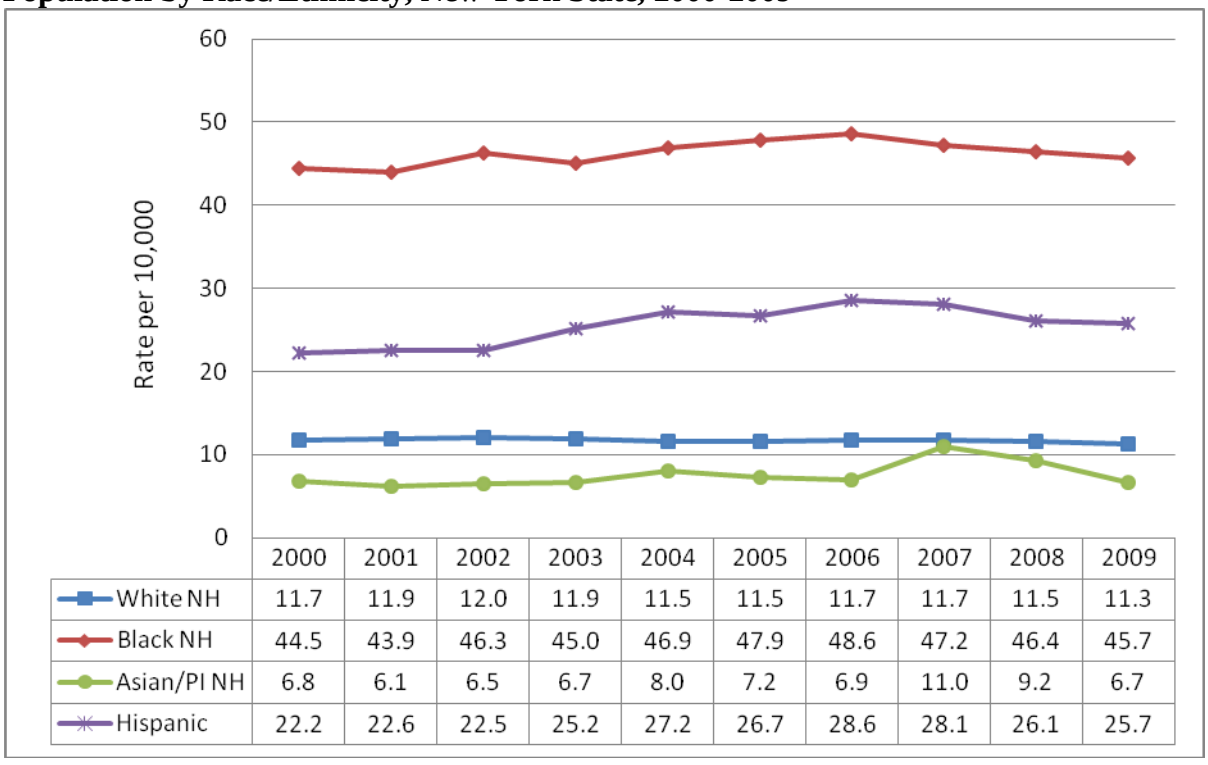
Asthma hospitalization rate is based on ICD9 code 493.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System

People with diabetes are more susceptible to other illnesses. Once they acquire these illnesses, they often have worse prognoses. For example, they are more likely to die from pneumonia or influenza than people who do not have diabetes.

From 2000-2009, Black non-Hispanic New Yorkers with diabetes had the highest hospitalization rates at 45.7 per 10,000 in 2009, followed by Hispanics (25.7 per 10,000), White non-Hispanics (11.3 per 10,000) and Asian/Pacific Islander non-Hispanics (6.7 per 10,000).

Between 2000 and 2009, the rate increased 15.6 percent among Hispanics and remained relatively unchanged among Black, White and Asian/ Pacific Islander New Yorkers.

Figure 81. Age-Adjusted* Diabetes (Primary Diagnosis) Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



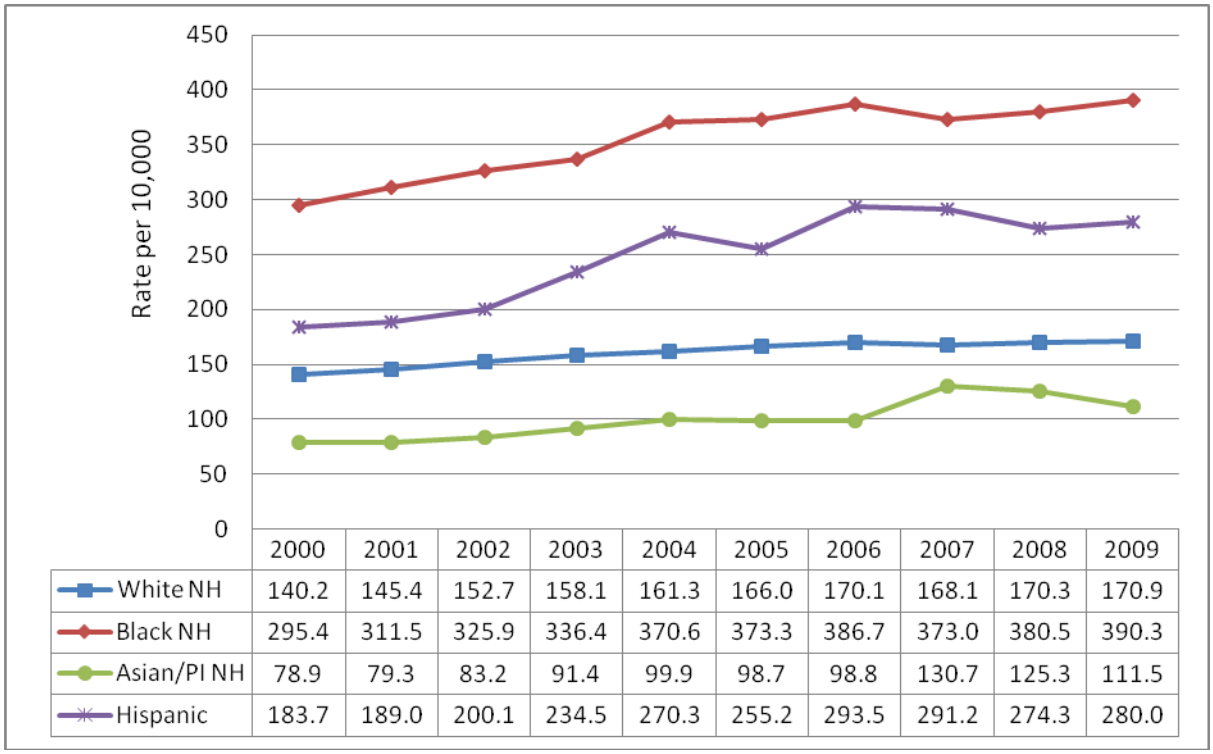
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	11.7	11.9	12.0	11.9	11.5	11.5	11.7	11.7	11.5	11.3
Black NH	44.5	43.9	46.3	45.0	46.9	47.9	48.6	47.2	46.4	45.7
Asian/PI NH	6.8	6.1	6.5	6.7	8.0	7.2	6.9	11.0	9.2	6.7
Hispanic	22.2	22.6	22.5	25.2	27.2	26.7	28.6	28.1	26.1	25.7

* Age-adjusted to U.S. 2000 population
Diabetes hospitalization rate is based on primary diagnosis of diabetes (ICD9 code 250).
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Hospitalizations with any diagnosis of diabetes are an important health indicator because diabetes is an underlying cause of many serious medical conditions and may complicate others. This figure shows hospitalizations among people with diabetes when diabetes was listed as a primary diagnosis or as any of up to 14 secondary diagnoses at hospital admission. Most disease-specific hospitalization rates include only information on the primary diagnosis.[8]

Hospitalization rates for all conditions among patients with diabetes have increased more than 30 percent over the decade for all racial/ethnic groups except White non-Hispanics, whose rate increased by 21 percent. In 2009, Black non-Hispanic and Hispanic New Yorkers had the highest rates of hospitalization (390.3 and 280.0 per 10,000, respectively). Rates among White non-Hispanics (170.9 per 10,000) and Asian/Pacific Islander non-Hispanics (111.5 per 10,000) were less than half the rates for Blacks and markedly lower than rates for Hispanics.

Figure 82. Age-Adjusted* Diabetes (Any Diagnosis) Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



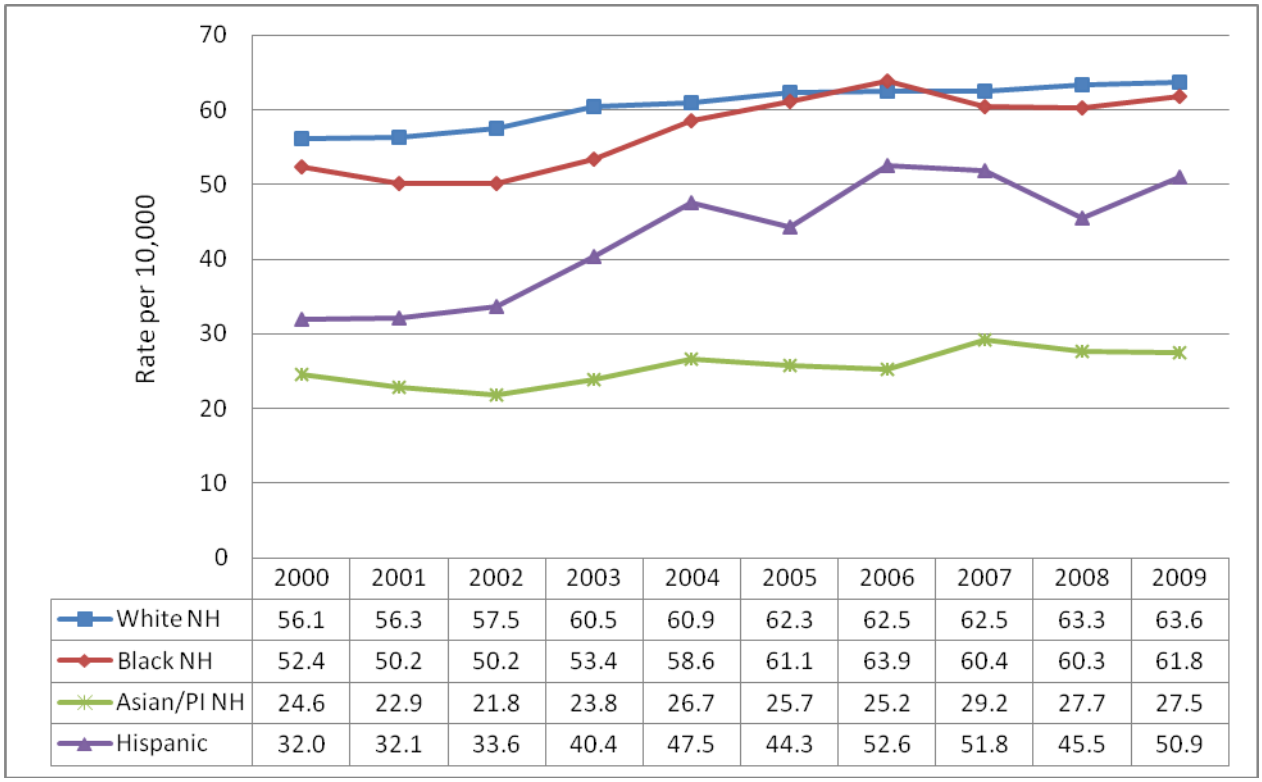
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	140.2	145.4	152.7	158.1	161.3	166.0	170.1	168.1	170.3	170.9
Black NH	295.4	311.5	325.9	336.4	370.6	373.3	386.7	373.0	380.5	390.3
Asian/PI NH	78.9	79.3	83.2	91.4	99.9	98.7	98.8	130.7	125.3	111.5
Hispanic	183.7	189.0	200.1	234.5	270.3	255.2	293.5	291.2	274.3	280.0

* Rates adjusted to the 2000 U.S. population
Any diabetes hospitalization rate is based on ICD9 code 250 and includes all diagnoses.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Although injuries and violence are widespread in society, most events resulting in injury, death or disability are predictable – and, therefore, preventable.[9]

Hospitalization rates for unintentional injury have increased for all racial/ethnic groups in New York over the past decade. In 2009, White non-Hispanics (63.6 per 10,000), Black non-Hispanics (61.8 per 10,000) and Hispanics (50.9 per 10,000) had similar hospitalization rates for unintentional injury, while the rate for Asian/Pacific Islander non-Hispanics (27.5 per 10,000) was much lower.

Figure 83. Age-Adjusted* Unintentional Injury Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



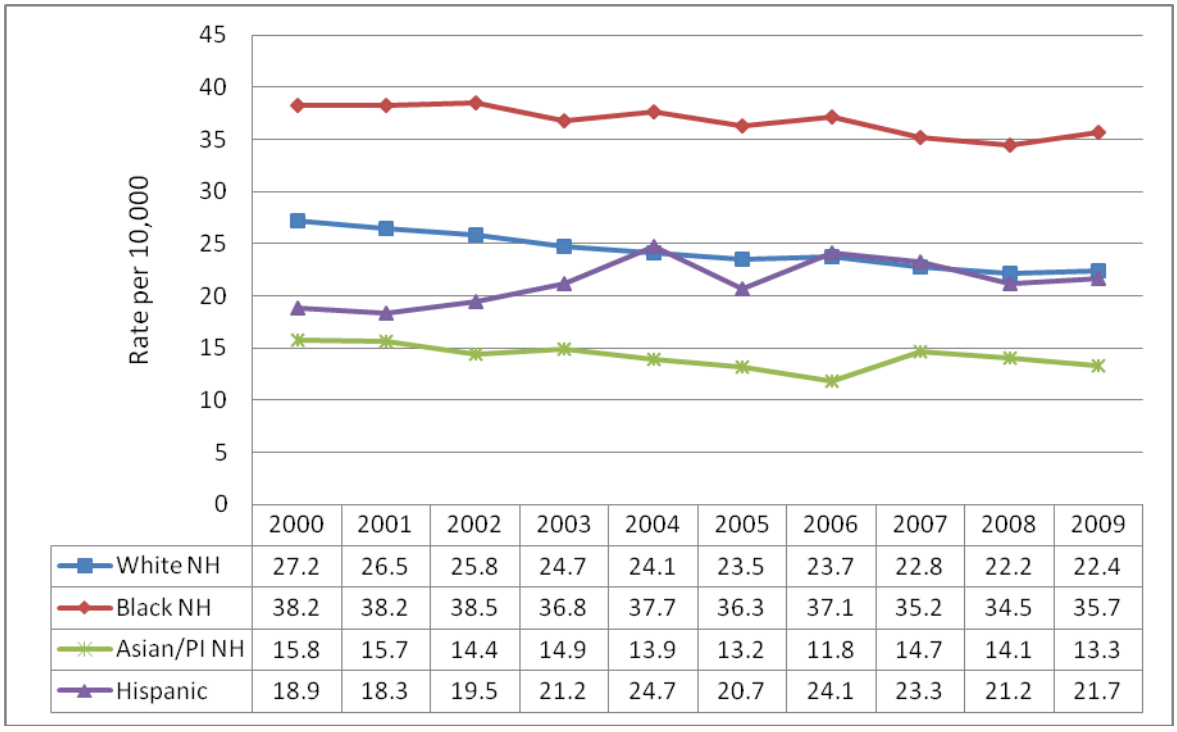
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	56.1	56.3	57.5	60.5	60.9	62.3	62.5	62.5	63.3	63.6
Black NH	52.4	50.2	50.2	53.4	58.6	61.1	63.9	60.4	60.3	61.8
Asian/PI NH	24.6	22.9	21.8	23.8	26.7	25.7	25.2	29.2	27.7	27.5
Hispanic	32.0	32.1	33.6	40.4	47.5	44.3	52.6	51.8	45.5	50.9

* Rates adjusted to the 2000 U.S. population
Unintentional injury hospitalization rate is based on ICD9 codes E800-E928, (excluding E870-E879).
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Cerebrovascular disease is the leading cause of long-term disability and the third leading cause of death in the nation. Each year, 795,000 new or recurrent strokes occur in the United States.[10] The cerebrovascular disease hospitalization rate among Asian/Pacific Islander non-Hispanics declined between 2000 and 2009, from 15.8 to 13.3 per 10,000, and was consistently the lowest rate among all racial/ethnic groups. The next lowest rate was for Hispanics; however, that rate increased from 18.9 in 2000 to 21.7 per 10,000 in 2009.

Rates among White and Black non-Hispanics decreased during the decade. The White non-Hispanic rate declined from 27.2 to 22.4 per 10,000 and the Black non-Hispanic rate – the highest among all groups – declined from 38.2 to 35.7 per 10,000.

Figure 84. Age-Adjusted* Cerebrovascular Disease (Stroke) Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



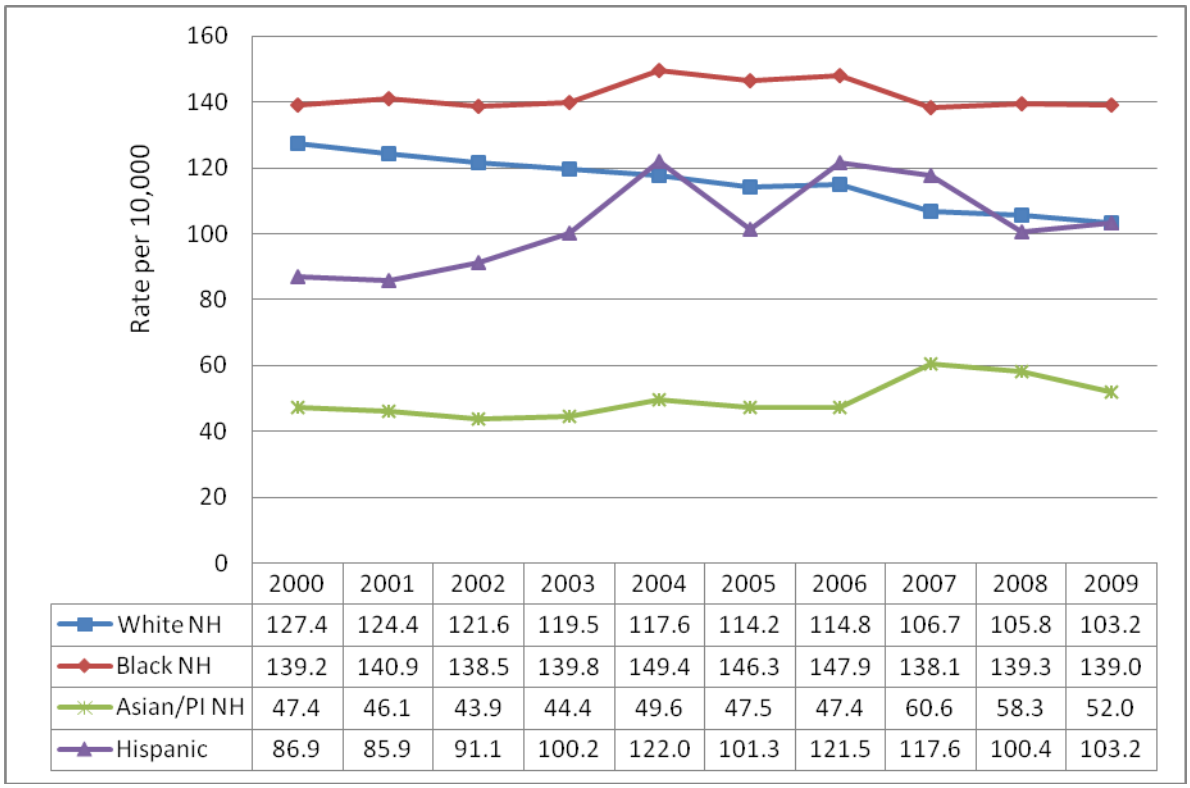
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	27.2	26.5	25.8	24.7	24.1	23.5	23.7	22.8	22.2	22.4
Black NH	38.2	38.2	38.5	36.8	37.7	36.3	37.1	35.2	34.5	35.7
Asian/PI NH	15.8	15.7	14.4	14.9	13.9	13.2	11.8	14.7	14.1	13.3
Hispanic	18.9	18.3	19.5	21.2	24.7	20.7	24.1	23.3	21.2	21.7

* Rates adjusted to the 2000 U.S. population
Cerebrovascular disease hospitalization rate is based on ICD9 codes 430-438.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Heart disease is the leading cause of death in the United States. In 2006, 26 percent of all U.S. deaths were from heart disease. It is projected that heart disease will cost the United States $304.6 billion annually in health care, medications and lost productivity.[11]

Hospitalization for heart disease increased during the decade for Hispanic and Asian/Pacific Islander non-Hispanic New Yorkers, and decreased for White non-Hispanics. The hospitalization rate among Black non-Hispanics fluctuated, but remained the highest among racial/ethnic groups. In 2009, the rate among Black non-Hispanics (139.0 per 10,000) was more than double the rate for Asian/Pacific Islander non-Hispanics (52.0 per 10,000) and 35 percent higher than rates among White non-Hispanics (103.2 per 10,000) and Hispanics (103.2 per 10,000).

Figure 85. Age-Adjusted* Heart Disease Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



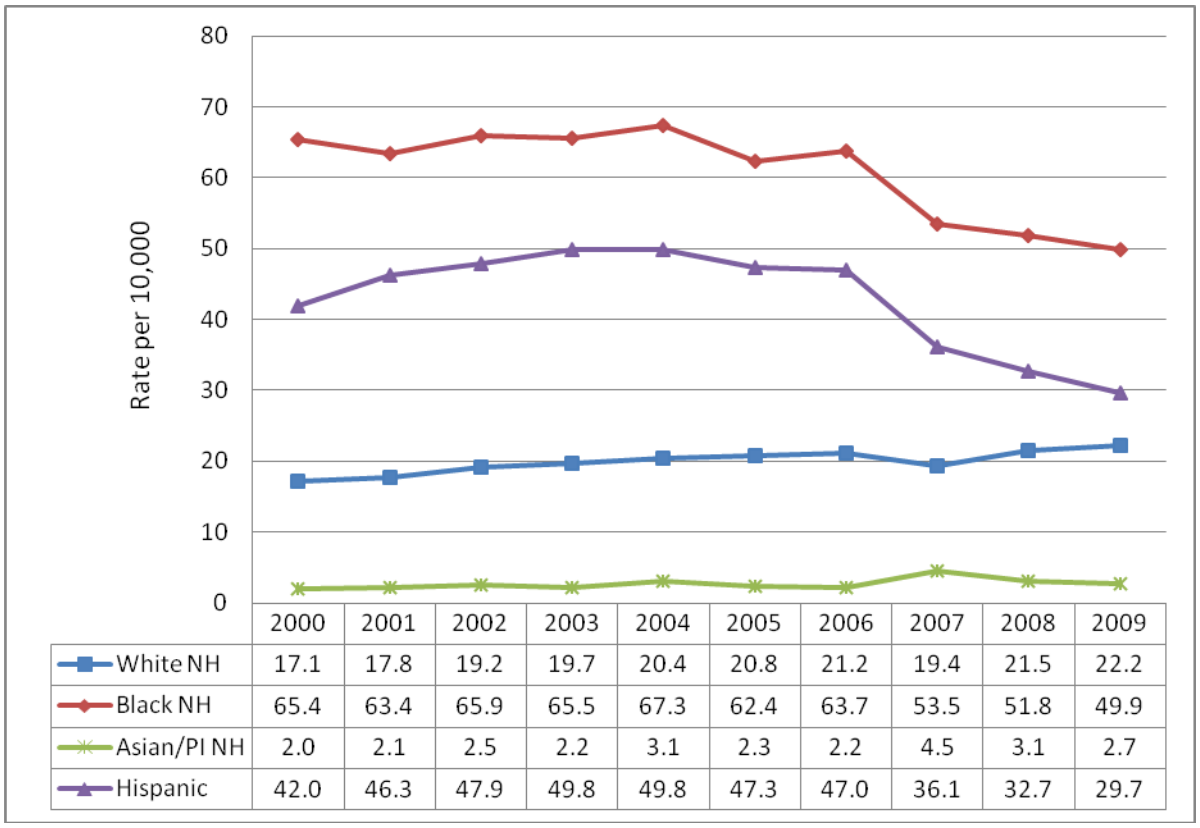
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	127.4	124.4	121.6	119.5	117.6	114.2	114.8	106.7	105.8	103.2
Black NH	139.2	140.9	138.5	139.8	149.4	146.3	147.9	138.1	139.3	139.0
Asian/PI NH	47.4	46.1	43.9	44.4	49.6	47.5	47.4	60.6	58.3	52.0
Hispanic	86.9	85.9	91.1	100.2	122.0	101.3	121.5	117.6	100.4	103.2

* Rates adjusted to the 2000 U.S. population
Heart disease hospitalization rate is based on ICD9 codes 390-398,402, 404-429
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Emergency department visits for the nonmedical use of prescription and over-the-counter drugs are now comparable to those for the use of illegal drugs like heroin and cocaine.[12]
In 2009, Black non-Hispanic New Yorkers' drug-related hospitalization rate (49.9 per 10,000) was 18 times higher than for Asian/Pacific Islander non-Hispanics (2.7 per 10,000), more than twice the rate for White non-Hispanics (22.2 per 10,000) and 68 percent higher than Hispanics (29.7 per 10,000).

Between 2000 and 2009, drug-related hospitalization rates declined among Black non-Hispanics and Hispanics, the two racial/ethnic groups with the highest rates, and increased among White non-Hispanics and Asian/Pacific Islander non-Hispanics.

Figure 86. Age Adjusted* Drug-Related Hospitalization Rate per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



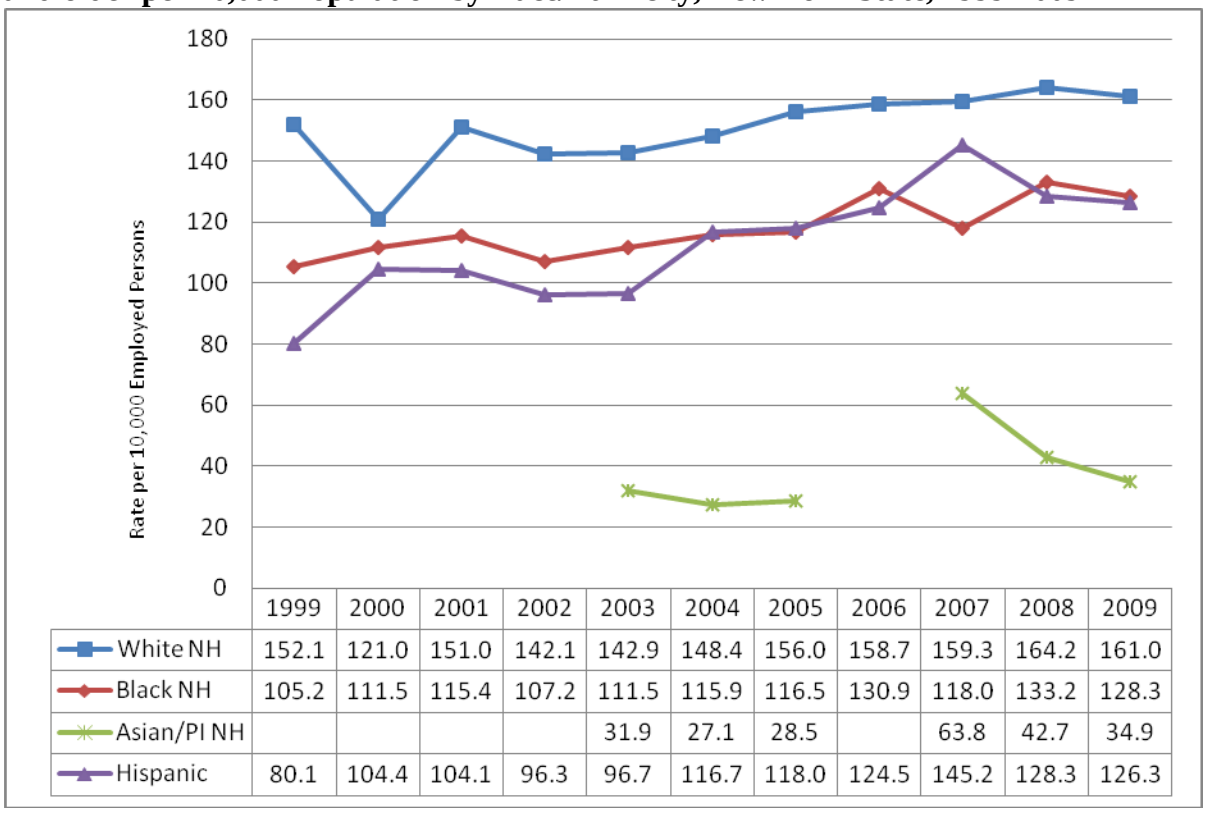
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	17.1	17.8	19.2	19.7	20.4	20.8	21.2	19.4	21.5	22.2
Black NH	65.4	63.4	65.9	65.5	67.3	62.4	63.7	53.5	51.8	49.9
Asian/PI NH	2.0	2.1	2.5	2.2	3.1	2.3	2.2	4.5	3.1	2.7
Hispanic	42.0	46.3	47.9	49.8	49.8	47.3	47.0	36.1	32.7	29.7

* Rates adjusted to the 2000 U.S. population
Drug-related hospitalization rate is based on ICD9 codes 292, 304, 305.1-305.9, 648.3, 655.5, 763.5, 779.4, 779.5, 965.0, 967.0, 968.5, 969.6, 969.7, 760.70, 760.72, 760.73, 760.75, 760.79, E850-E858, E950.0-E950.2, E962.0, E980.0-E980.2.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: Statewide Planning and Research Cooperative System (SPARCS)

Individuals hospitalized for work-related injuries and illnesses have some of the most serious and costly adverse work-related health conditions. Hospital discharge data are useful for surveillance of serious health conditions. While these data sets do not include explicit information about "work-relatedness" of the health conditions for which a patient is hospitalized, they do include information about the payer for the hospital stay. The designation of workers' compensation as primary payer is a good proxy for the work-relatedness of hospitalized injuries, but the true burden of work-related hospitalizations may be under-represented if workers utilize other payer sources.

There has been a gradual increase in the number of work-related hospitalizations among all racial/ethnic groups during the time period 1999-2009. White non-Hispanics had a higher rate of hospitalizations than other groups, although the greatest increase in work-related hospitalization rates has been among the Hispanic workers, whose rate has almost doubled in the past ten years.

Figure 87. Work-Related* Hospitalization Rate Among Employed Persons aged 16 years and older per 10,000 Population by Race/Ethnicity, New York State, 1999-2009



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	152.1	121.0	151.0	142.1	142.9	148.4	156.0	158.7	159.3	164.2	161.0
Black NH	105.2	111.5	115.4	107.2	111.5	115.9	116.5	130.9	118.0	133.2	128.3
Asian/PI NH					31.9	27.1	28.5		63.8	42.7	34.9
Hispanic	80.1	104.4	104.1	96.3	96.7	116.7	118.0	124.5	145.2	128.3	126.3

* A hospitalization with workers' compensation reported as the primary payor is defined as a work-related hospitalization.
Source: Statewide Planning and Research Cooperative System (SPARCS)

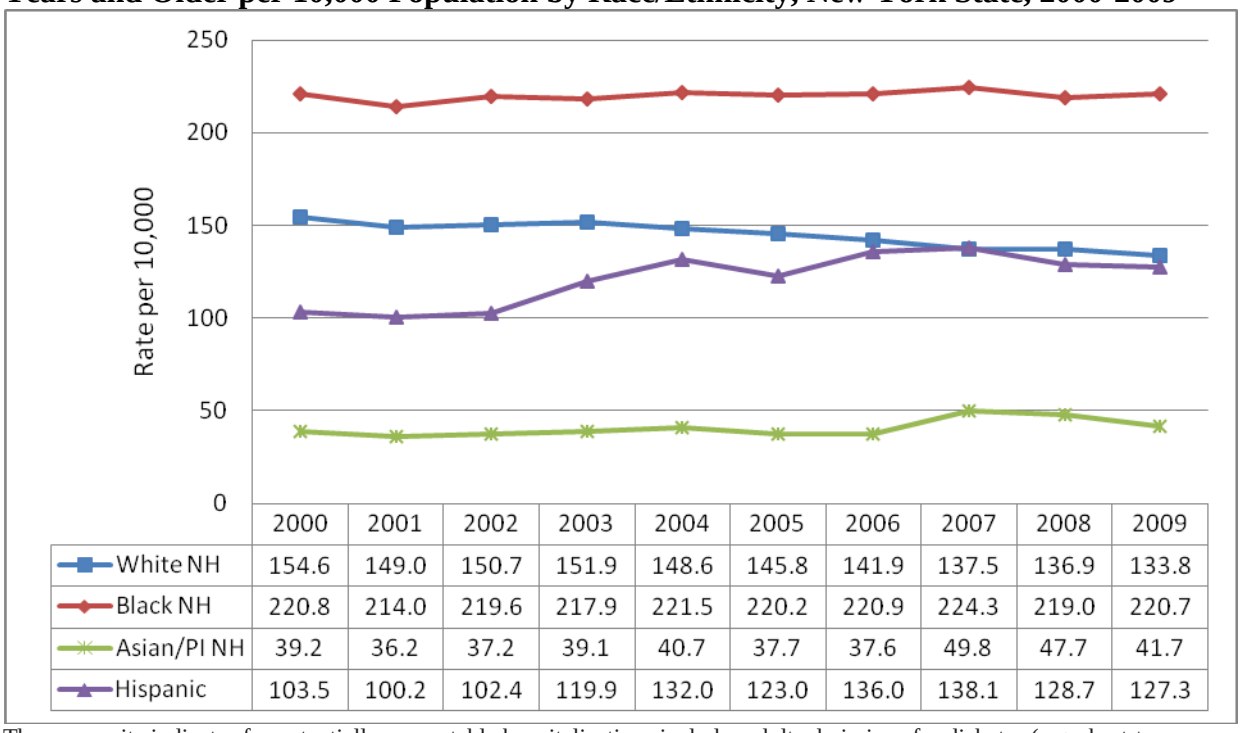
Hospitalization can be prevented if patients seek prompt attention from primary care providers for acute illnesses (e.g., pneumonia) or worsening chronic conditions (e.g., diabetes). Although not all hospitalizations can be avoided, communities with poorer access to coordinated primary care tend to have higher rates of potentially preventable hospitalizations.[13]

The Agency for Healthcare Research and Quality has developed 16 prevention quality indicators (PQI) using hospitalization data among adults.[14] New York State Department of Health produced a composite indicator, potentially preventable hospitalization, that include all PQIs with the exclusion of chronic obstructive pulmonary disease because of changes in International Classification of Diseases (Ninth Revision, Clinical Modification) coding that result in incompatibility across data years.

During 2000-2009, the potentially preventable hospitalization rate declined only for White non-Hispanic New York adults. For the other groups, the rate either stayed the same or increased.

The potentially preventable hospitalization rate was highest among Black non-Hispanic adults, with very little change over the decade. During 2009, that rate was 220.7 per 10,000, which was about 65 percent higher than rates for White non-Hispanics (133.8 per 10,000) and Hispanics (127.3 per 10,000). Asian/Pacific Islander non-Hispanics had the lowest rate at 41.7 per 10,000.

Figure 88. Potentially Preventable Hospitalizations Composite Rate Among Adults Ages 18 Years and Older per 10,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	154.6	149.0	150.7	151.9	148.6	145.8	141.9	137.5	136.9	133.8
Black NH	220.8	214.0	219.6	217.9	221.5	220.2	220.9	224.3	219.0	220.7
Asian/PI NH	39.2	36.2	37.2	39.1	40.7	37.7	37.6	49.8	47.7	41.7
Hispanic	103.5	100.2	102.4	119.9	132.0	123.0	136.0	138.1	128.7	127.3

The composite indicator for potentially preventable hospitalizations includes adult admissions for diabetes (e.g. short-term complications, long-term complications, uncontrolled diabetes, and lower-extremity amputations), hypertension, congestive heart failure, angina without procedure, asthma, dehydration, bacterial pneumonia, and urinary infections. Admissions for chronic obstructive pulmonary disease were excluded because of changes in *International Classification of Diseases* (Ninth Revision, Clinical Modification) coding that result in incompatibility across data years.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander.
Source: Statewide Planning and Research Cooperative System (SPARCS)

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Mortality

Heart disease and cancer remained the first and second leading causes of death among White non-Hispanics in New York State between 2000 and 2009. Stroke death rates have decreased by 33 percent since 2000. Chronic lower respiratory disease death rates have also decreased, with an 8 percent reduction since 2000.

Figure 89. Leading* Causes of Death Among White Non-Hispanics by Year, New York State, 2000-2009

Year # of Deaths	#1 Cause of Death # of Deaths Age-adjusted Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
2009 **Total: 109,176**	Heart Disease 35,503 207 per 100,000	Cancer 26,173 166 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,712 35 per 100,000	Stroke 4,536 27 per 100,000	Pneumonia and Influenza 3,177 18 per 100,000
2008 **Total: 111,470**	Heart Disease 37,903 219 per 100,000	Cancer 26,797 170 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,821 35 per 100,000	Stroke 4,546 26 per 100,000	Unintentional Injury 3,619 27 per 100,000
2007 **Total: 110,637**	Heart Disease 38,243 225 per 100,000	Cancer 26,732 173 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,606 35 per 100,000	Stroke 4,484 27 per 100,000	Unintentional Injury 3,547 26 per 100,000
2006 **Total: 112,383**	Heart Disease 39,116 232 per 100,000	Cancer 27,118 176 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,396 34 per 100,000	Stroke 4,917 29 per 100,000	Pneumonia and Influenza 3,578 21 per 100,000
2005 **Total: 114,975**	Heart Disease 40,839 242 per 100,000	Cancer 27,064 175 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,858 36 per 100,000	Stroke 5,190 31 per 100,000	Pneumonia and Influenza 4,177 24 per 100,000
2004 **Total: 114,995**	Heart Disease 40,773 245 per 100,000	Cancer 27,642 181 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,772 36 per 100,000	Stroke 5,335 32 per 100,000	Pneumonia and Influenza 4,116 24 per 100,000
2003 **Total: 117,653**	Heart Disease 43,353 265 per 100,000	Cancer 27,787 183 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,697 36 per 100,000	Stroke 5,686 35 per 100,000	Pneumonia and Influenza 4,074 25 per 100,000
2002 **Total: 119,207**	Heart Disease 44,133 277 per 100,000	Cancer 28,222 189 per 100,000	Stroke 5,985 37 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,983 38 per 100,000	Pneumonia and Influenza 4,113 25 per 100,000
2001 **Total: 119,692**	Heart Disease 44,316 278 per 100,000	Cancer 28,405 190 per 100,000	Stroke 6,084 38 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,909 38 per 100,000	Pneumonia and Influenza 3,836 24 per 100,000
2000 **Total: 119,867**	Heart Disease 45,597 287 per 100,000	Cancer 28,933 194 per 100,000	Stroke 6,347 40 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,903 38 per 100,000	Pneumonia and Influenza 4,035 25 per 100,000

* Ranks based on number of deaths
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Heart disease and cancer were the first and second leading causes of death among Black non-Hispanic New Yorkers between 2000 and 2009. Death rates from AIDS were cut by half during the decade, from the third leading cause of death between 2000-2004, dropping to fifth between 2007-2009. Although the number of Black non-Hispanics dying of diabetes decreased 20 percent during the decade, diabetes moved from the fifth leading cause of death in 2000 to the third of all causes of death among this population by 2005.

Figure 90. Leading* Causes of Death Among Black Non-Hispanics by Year, New York State, 2000-2009

Year and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
2009 **Total: 19,176**	Heart Disease 5,924 245 per 100,000	Cancer 4,554 174 per 100,000	Diabetes 822 33 per 100,000	Stroke 680 27 per 100,000	AIDS 609 20 per 100,000
2008 **Total: 19,732**	Heart Disease 6,366 260 per 100,000	Cancer 4,530 175 per 100,000	Diabetes 851 34 per 100,000	Stroke 768 31 per 100,000	AIDS 654 22 per 100,000
2007 **Total: 20,118**	Heart Disease 6,414 268 per 100,000	Cancer 4,655 184 per 100,000	Diabetes 853 35 per 100,000	Stroke 795 33 per 100,000	AIDS 725 25 per 100,000
2006 **Total: 19,947**	Heart Disease 6,426 274 per 100,000	Cancer 4,480 180 per 100,000	Diabetes 870 36 per 100,000	AIDS 780 27 per 100,000	Stroke 755 31 per 100,000
2005 **Total: 20,653**	Heart Disease 6,618 281 per 100,000	Cancer 4,642 186 per 100,000	Diabetes 966 40 per 100,000	AIDS 872 30 per 100,000	Stroke 779 33 per 100,000
2004 **Total: 20,601**	Heart Disease 6,554 288 per 100,000	Cancer 4,611 190 per 100,000	AIDS 917 32 per 100,000	Diabetes 894 38 per 100,000	Stroke 807 35 per 100,000
2003 **Total: 20,540**	Heart Disease 6,613 291 per 100,000	Cancer 4,562 186 per 100,000	AIDS 961 33 per 100,000	Diabetes 874 38 per 100,000	Stroke 855 37 per 100,000
2002 **Total: 20,804**	Heart Disease 6,795 333 per 100,000	Cancer 4,722 211 per 100,000	AIDS 981 35 per 100,000	Diabetes 853 40 per 100,000	Stroke 833 39 per 100,000
2001 **Total: 21,024**	Heart Disease 6,577 322 per 100,000	Cancer 4,791 215 per 100,000	AIDS 1,029 37 per 100,000	Stroke 857 41 per 100,000	Diabetes 838 39 per 100,000
2000 **Total: 21,042**	Heart Disease 6,791 330 per 100,000	Cancer 4,751 211 per 100,000	AIDS 1,125 40 per 100,000	Stroke 903 43 per 100,000	Diabetes 888 41 per 100,000

* Ranks are based on number of deaths
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Although death rates for heart disease and cancer decreased from 2000-2009 among Asian/Pacific Islander non-Hispanic New Yorkers, these diseases have remained the first and second leading causes of death. The death rate from unintentional injury has remained stable over time and was the fifth leading cause of death among this population. The pneumonia and influenza death rate decreased by 23 percent since 2000, but still moved from the fourth leading cause of death to the third-ranked cause in 2008 and 2009.

Figure 91. Leading* Causes of Death Among Asian/Pacific Islander Non-Hispanics by Year, New York State, 2000-2009

Year and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
2009 **Total: 3,448**	Heart Disease 1,066 109 per 100,000	Cancer 1,046 93 per 100,000	Pneumonia and Influenza 160 17 per 100,000	Stroke 146 15 per 100,000	Unintentional Injury 119 10 per 100,000
2008 **Total: 3,360**	Heart Disease 1,104 118 per 100,000	Cancer 912 82 per 100,000	Pneumonia and Influenza 156 17 per 100,000	Stroke 144 15 per 100,000	Unintentional Injury 132 11 per 100,000
2007 **Total: 3,254**	Cancer 1,042 100 per 100,000	Heart Disease 1,011 114 per 100,000	Stroke 155 17 per 100,000	Pneumonia and Influenza 142 17 per 100,000	Unintentional Injury 119 10 per 100,000
2006 **Total: 3,089**	Heart Disease 979 118 per 100,000	Cancer 876 87 per 100,000	Stroke 169 19 per 100,000	Pneumonia and Influenza 153 19 per 100,000	Unintentional Injury 114 11 per 100,000
2005 **Total: 3,108**	Heart Disease 981 125 per 100,000	Cancer 898 93 per 100,000	Pneumonia and Influenza 155 21 per 100,000	Stroke 150 18 per 100,000	Unintentional Injury 125 13 per 100,000
2004 **Total: 2,922**	Heart Disease 939 130 per 100,000	Cancer 818 92 per 100,000	Stroke 170 22 per 100,000	Pneumonia and Influenza 161 24 per 100,000	Unintentional Injury 95 10 per 100,000
2003 **Total: 2,882**	Heart Disease 912 133 per 100,000	Cancer 786 91 per 100,000	Stroke 182 24 per 100,000	Pneumonia and Influenza 133 21 per 100,000	Unintentional Injury 108 11 per 100,000
2002 **Total: 2,795**	Heart Disease 925 167 per 100,000	Cancer 793 111 per 100,000	Stroke 181 28 per 100,000	Pneumonia and Influenza 122 25 per 100,000	Unintentional Injury 107 13 per 100,000
2001 **Total: 2,782**	Heart Disease 880 155 per 100,000	Cancer 770 104 per 100,000	Stroke 162 27 per 100,000	Pneumonia and Influenza 120 24 per 100,000	Unintentional Injury 82 9 per 100,000
2000 **Total: 2,661**	Heart Disease 854 152 per 100,000	Cancer 774 108 per 100,000	Stroke 152 25 per 100,000	Pneumonia and Influenza 110 22 per 100,000	Unintentional Injury 95 11 per 100,000

* Ranks are based on numbers of death
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Among Hispanic New Yorkers, heart disease and cancer remained the leading causes of death from 2000-2009. Death rates from AIDS have declined; the disease is no longer a leading cause of death for Hispanic New Yorkers. The diabetes death rate decreased by 31 percent between 2000-2009, but has been the fourth-ranked cause of death since 2006.

Figure 92. Leading* Causes of Death Among Hispanics by Year, New York State, 2000-2009

Year and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
2009 **Total: 11,267**	Heart Disease 3,200 160 per 100,000	Cancer 2,682 120 per 100,000	Unintentional Injury 487 16 per 100,000	Diabetes 428 20 per 100,000	Pneumonia and Influenza 419 21 per 100,000
2008 **Total: 11,351**	Heart Disease 3,268 166 per 100,000	Cancer 2,518 115 per 100,000	Unintentional Injury 612 21 per 100,000	Diabetes 462 23 per 100,000	Pneumonia and Influenza 450 24 per 100,000
2007 **Total: 10,799**	Heart Disease 3,195 173 per 100,000	Cancer 2,410 116 per 100,000	Unintentional Injury 544 19 per 100,000	Diabetes 439 23 per 100,000	Pneumonia and Influenza 436 24 per 100,000
2006 **Total: 10,844**	Heart Disease 3,235 185 per 100,000	Cancer 2,243 111 per 100,000	Pneumonia and Influenza 468 27 per 100,000	Diabetes 446 23 per 100,000	Unintentional Injury 431 16 per 100,000
2005 **Total: 10,752**	Heart Disease 3,127 181 per 100,000	Cancer 2,352 118 per 100,000	Pneumonia and Influenza 494 29 per 100,000	AIDS 452 16 per 100,000	Diabetes 433 24 per 100,000
2004 **Total: 10,610**	Heart Disease 3,051 186 per 100,000	Cancer 2,280 119 per 100,000	Pneumonia and Influenza 483 30 per 100,000	AIDS 449 17 per 100,000	Stroke 433 24 per 100,000
2003 **Total: 10,885**	Heart Disease 3,241 206 per 100,000	Cancer 2,251 121 per 100,000	AIDS 543 20 per 100,000	Diabetes 464 27 per 100,000	Pneumonia and Influenza 439 29 per 100,000
2002 **Total: 9,928**	Heart Disease 2,956 227 per 100,000	Cancer 2,053 132 per 100,000	AIDS 549 22 per 100,000	Stroke 413 30 per 100,000	Diabetes 408 29 per 100,000
2001 **Total: 10,312**	Heart Disease 2,907 227 per 100,000	Cancer 2,078 132 per 100,000	Unintentional Injury 539 23 per 100,000	AIDS 537 21 per 100,000	Pneumonia and Influenza 407 34 per 100,000
2000 **Total: 9,704**	Heart Disease 2,868 220 per 100,000	Cancer 2,002 128 per 100,000	AIDS 630 25 per 100,000	Diabetes 408 29 per 100,000 Stroke 408 29 per 100,000	

* Ranks based on numbers of death
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Among American Indian/Alaska Native New Yorkers, heart disease and cancer remained the leading causes of death from 2000-2009. Death rates are not calculated for this group due to incomplete reporting. Liver disease remained a leading cause of death among American Indian/Alaska Natives, and was the third leading cause of death in 2008. In 2009, chronic lower respiratory diseases and unintentional injury were the fourth and fifth leading causes of death, respectively.

Figure 93. Leading* Causes of Death Among Native American/Alaska Natives by Year, New York State, 2000-2009

Year and # of Deaths	#1 Cause of Death and # of Deaths	#2 Cause of Death and # of Deaths	#3 Cause of Death and # of Deaths	#4 Cause of Death and # of Deaths	#5 Cause of Death and # of Deaths
2009 **Total: 183**	Heart Disease 40	Cancer 31	Diabetes 17	Chronic Lower Respiratory Diseases (CLRD) 9	
				Unintentional Injury 9	
2008 **Total: 197**	Heart Disease 55	Cancer 45	Liver Disease 11		Chronic Lower Respiratory Diseases (CLRD) 10
			Unintentional Injury 11		
2007 **Total: 192**	Heart Disease 52	Cancer 45	Liver Disease 15	Unintentional Injury 11	Chronic Lower Respiratory Diseases (CLRD) 10
2006 **Total: 201**	Cancer 47	Heart Disease 39	Unintentional Injury 20	Chronic Lower Respiratory Diseases (CLRD) 14	Diabetes 13
2005 **Total: 167**	Heart Disease 37	Cancer 36	Liver Disease 15	Unintentional Injury 13	Chronic Lower Respiratory Diseases (CLRD) 10
2004 **Total: 195**	Heart Disease 59	Cancer 46	Unintentional Injury 11	Chronic Lower Respiratory Diseases (CLRD) 10	
				Diabetes 10	
				Stroke 10	
2003 **Total: 198**	Cancer 51	Heart Disease 47	Chronic Lower Respiratory Diseases (CLRD) 12		Liver Disease 11
			Unintentional Injury 12		Stroke 11
2002 **Total: 196**	Heart Disease 47	Cancer 43	Liver Disease 16	Diabetes 11	Stroke 9
2001 **Total: 181**	Heart Disease 50	Cancer 36	Unintentional Injury 17	Diabetes 13	Stroke 11
2000 **Total: 184**	Heart Disease 51	Cancer 32	Diabetes 15		Liver Disease 11
			Stroke 15		

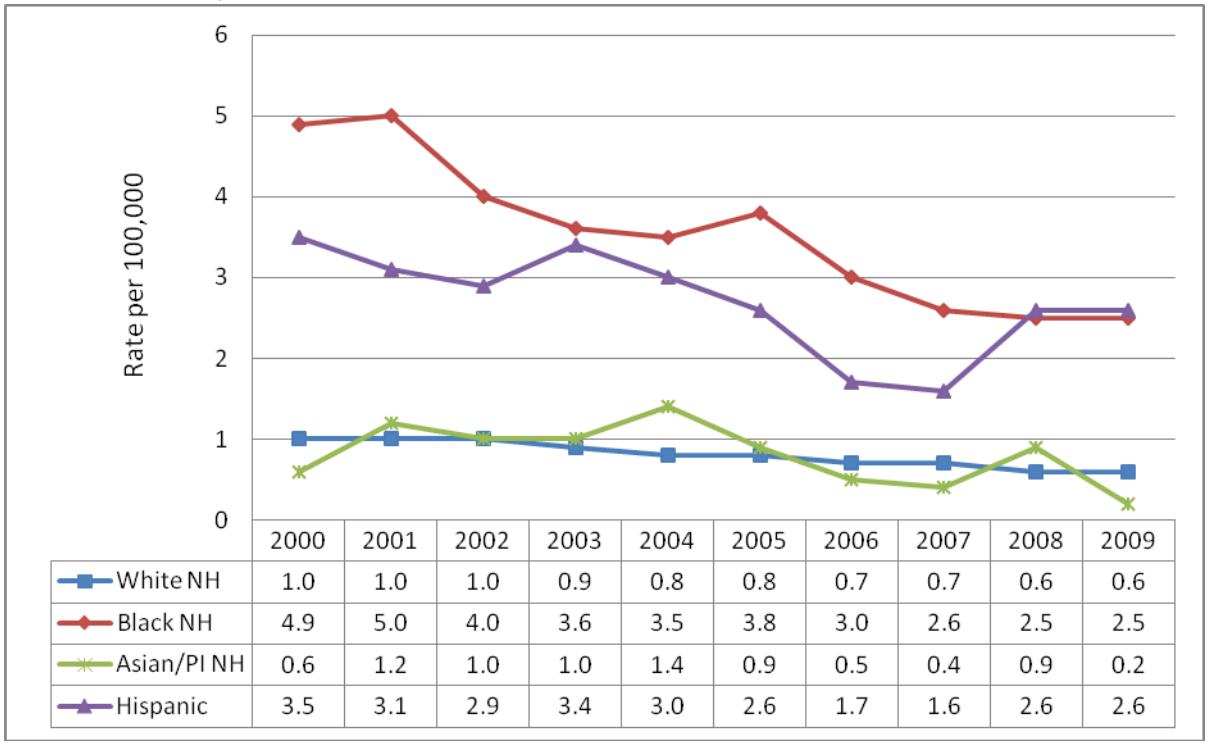
* Ranks based on numbers of deaths.
Note: Rates were not calculated due to small numbers and the poor quality of population counts for the Native American/Alaska Native racial/ethnic group.
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Over the past decade, the number of people with asthma in the United States has grown to about 25 million, or one out of 12 people. Every day, nine Americans die from causes related to asthma, a disease that costs the nation more than $50 billion every year.[1]

In New York from 2000-2009, asthma death rates fell in general, but there were fluctuations for some populations. Steady declines were noted among Black non-Hispanics (4.9 to 2.5 per 100,000) and White non-Hispanics (1.0 to 0.6 per 100,000). Overall, the asthma death rate among Hispanics declined by 26 percent from 3.5 to 2.6 per 100,000, but 2008 and 2009 showed modest increases.

In 2009, the asthma death rate among Black non-Hispanics and Hispanics was approximately 13 times greater than the rate among Asian/Pacific Islander non-Hispanic (0.2 per 100,000) and four times greater than White non-Hispanic (0.6 per 100,000) New Yorkers.

Figure 94. Age-Adjusted* Asthma Mortality per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



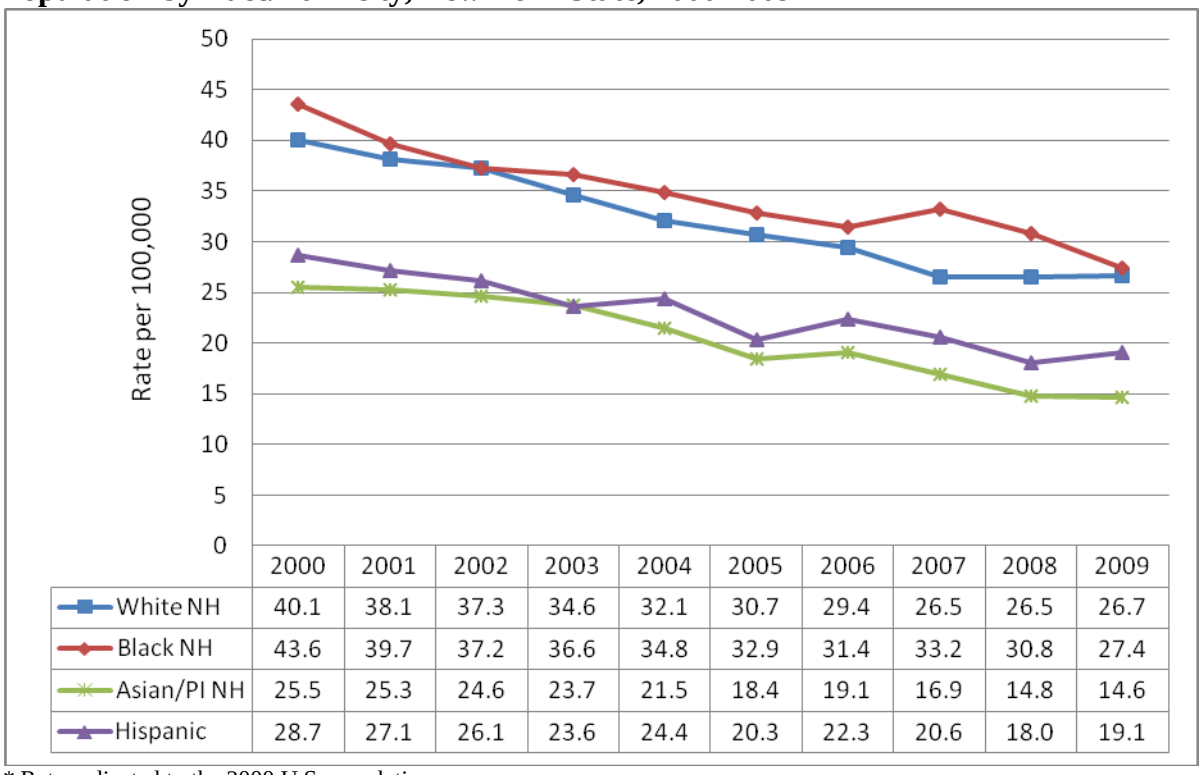
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	1.0	1.0	1.0	0.9	0.8	0.8	0.7	0.7	0.6	0.6
Black NH	4.9	5.0	4.0	3.6	3.5	3.8	3.0	2.6	2.5	2.5
Asian/PI NH	0.6	1.2	1.0	1.0	1.4	0.9	0.5	0.4	0.9	0.2
Hispanic	3.5	3.1	2.9	3.4	3.0	2.6	1.7	1.6	2.6	2.6

* Rates adjusted to the 2000 U.S. population.
Asthma mortality rates are based on ICD-10 codes J45-J46.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Although stroke risk increases with age, strokes can—and do—occur at any age. Nearly one quarter of strokes occur in people under age 65. In the United States, someone has a stroke every 40 seconds. Every three to four minutes, someone dies of stroke.[2]

During the past decade, stroke death rates have declined among all racial/ethnic groups, but disparities between groups continued. The rates among Black non-Hispanics and White non-Hispanics declined more than 30 percent, but remained 40 percent higher than rates among Asian/Pacific Islander non-Hispanics and Hispanics.

Figure 95. Age-Adjusted* Cerebrovascular Disease (Stroke) Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



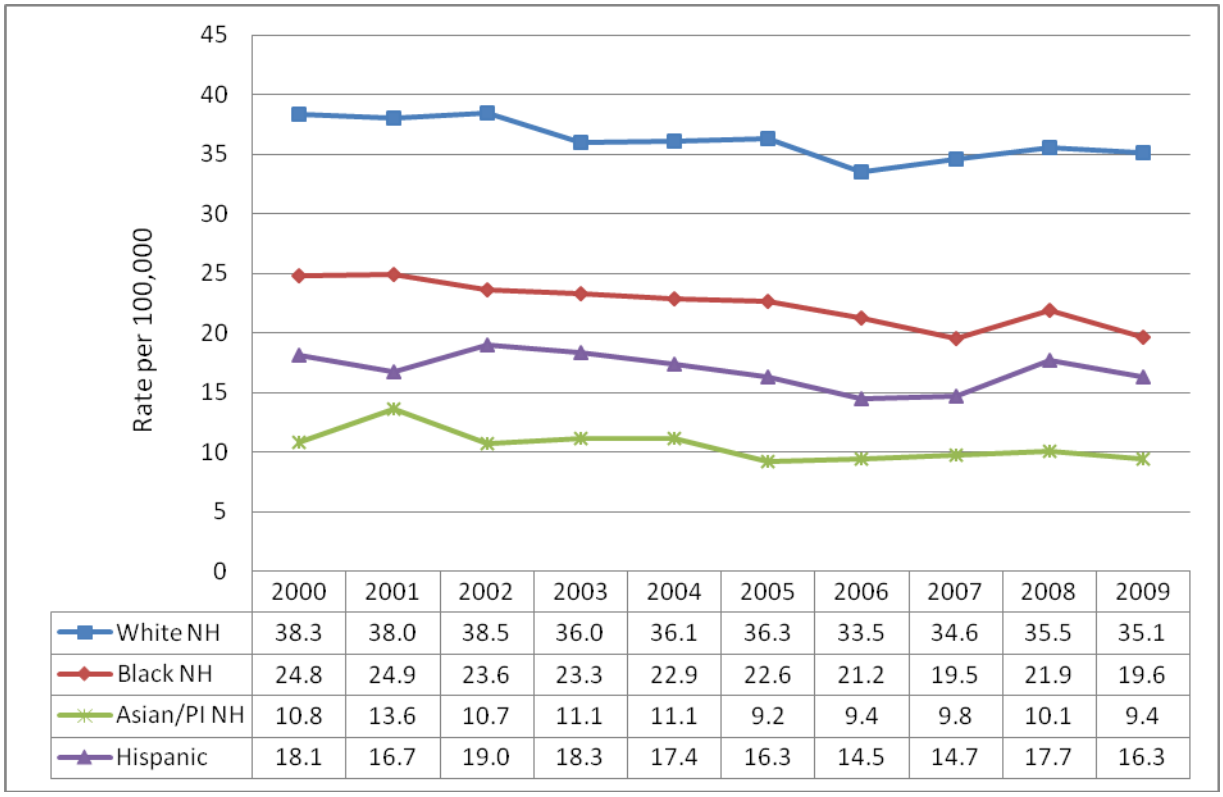
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	40.1	38.1	37.3	34.6	32.1	30.7	29.4	26.5	26.5	26.7
Black NH	43.6	39.7	37.2	36.6	34.8	32.9	31.4	33.2	30.8	27.4
Asian/PI NH	25.5	25.3	24.6	23.7	21.5	18.4	19.1	16.9	14.8	14.6
Hispanic	28.7	27.1	26.1	23.6	24.4	20.3	22.3	20.6	18.0	19.1

* Rates adjusted to the 2000 U.S. population.
Cerebrovascular disease mortality rates are based on ICD-10 codes I60-I69.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Before 1999, chronic lower respiratory disease (CLRD) was known as chronic obstructive pulmonary disease (COPD) and is still sometimes referred to as COPD. The disease is the third leading cause of death in America, claiming the lives of 124,477 Americans in 2007. Approximately 85 percent to 90 percent of these deaths are caused by smoking.[3]

Over the past 10 years in New York, the CLRD death rate has declined 8.4 percent among White non-Hispanics, 21.0 percent among Black non-Hispanics, 13.0 percent among Asian/Pacific Islander non-Hispanics and 9.9 percent among Hispanics. During the decade, the CLRD death rate among White non-Hispanics has stayed two to three times higher than the other groups.

Figure 96. Age-Adjusted* Chronic Lower Respiratory Disease Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	38.3	38.0	38.5	36.0	36.1	36.3	33.5	34.6	35.5	35.1
Black NH	24.8	24.9	23.6	23.3	22.9	22.6	21.2	19.5	21.9	19.6
Asian/PI NH	10.8	13.6	10.7	11.1	11.1	9.2	9.4	9.8	10.1	9.4
Hispanic	18.1	16.7	19.0	18.3	17.4	16.3	14.5	14.7	17.7	16.3

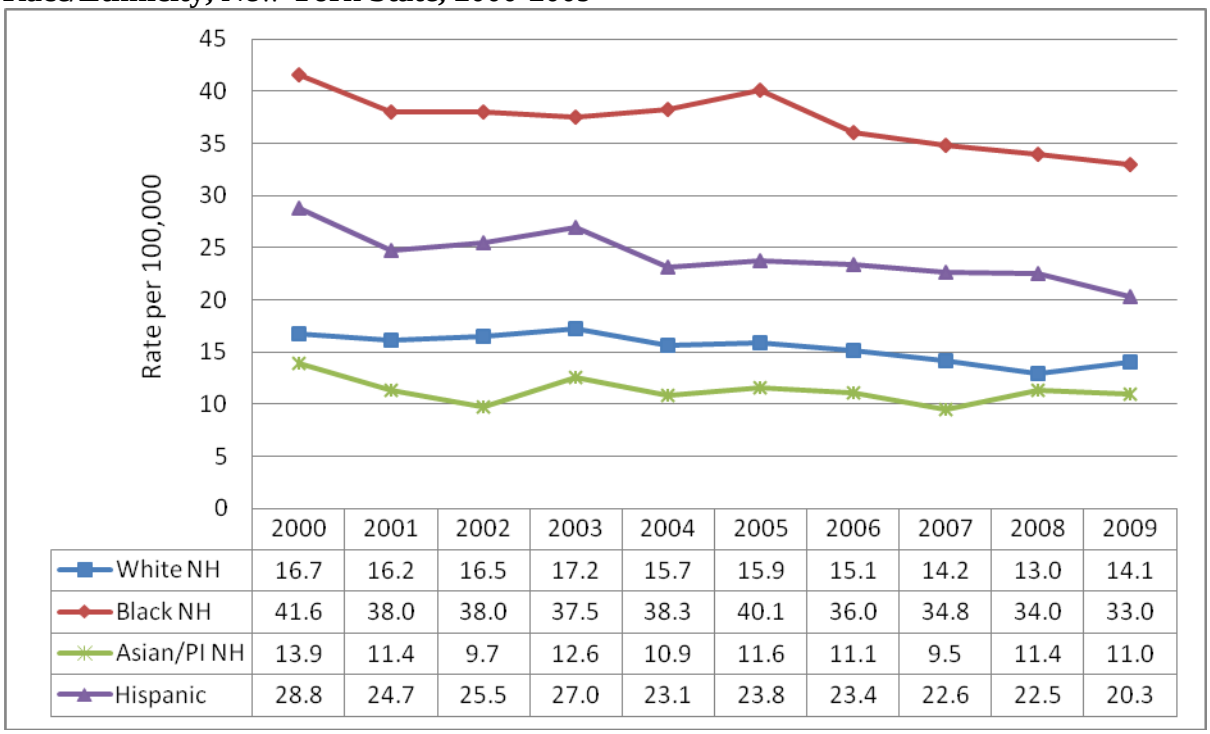
* Rates adjusted to the 2000 U.S. population.
CLRD mortality rates are based on ICD10 codes J40-J47.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

The risk of death among people with diabetes is about twice that of people of similar age without diabetes. In 2007, diabetes was the seventh leading cause of death and contributed to more than 231,404 deaths in the United States.[4]

In spite of the increases in prevalence, diabetes death rates slowly declined over the past decade, with some reduction in the disparities between racial/ethnic groups in New York.

In 2009, Black non-Hispanics (33.0 per 100,000) experienced diabetes death rates 62 percent greater than Hispanics (20.3 per 100,000), two times more than White non-Hispanics (14.1 per 100,000) and almost three times higher than Asian/Pacific Islander non-Hispanics (11.0 per 100,000).

Figure 97. Age-Adjusted* Diabetes Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	16.7	16.2	16.5	17.2	15.7	15.9	15.1	14.2	13.0	14.1
Black NH	41.6	38.0	38.0	37.5	38.3	40.1	36.0	34.8	34.0	33.0
Asian/PI NH	13.9	11.4	9.7	12.6	10.9	11.6	11.1	9.5	11.4	11.0
Hispanic	28.8	24.7	25.5	27.0	23.1	23.8	23.4	22.6	22.5	20.3

* Rates adjusted to the 2000 U.S. population.
Diabetes mortality rate is based on ICD-10 codes E10-E14.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

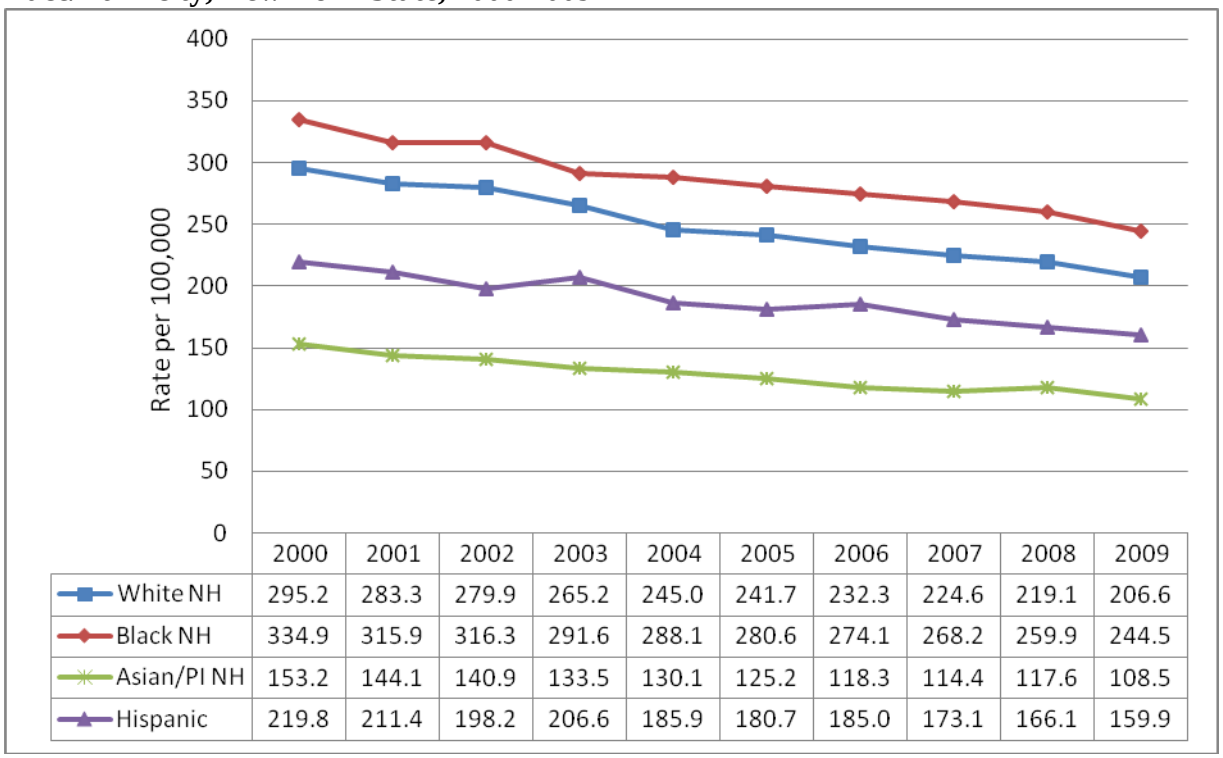
Heart disease is the leading cause of death in the United States for African Americans, American Indians or Alaska Natives, Hispanics and Whites. For Asian Americans, heart disease is second only to cancer.[5]

In New York during the past decade, the heart disease mortality rates for all four racial/ethnic groups declined by 27 percent to 30 percent. Disparities between groups remained constant.

In 2009, Black non-Hispanics (244.5 per 100,000) experienced the highest mortality rate, which was more than two times the rate for Asian/Pacific Islander non-Hispanics (108.5 per 100,000). White non-Hispanics had a rate of 206.6 per 100,000 and Hispanics, a rate of 159.9 per 100,000.

The largest declines in heart disease mortality between 2000 and 2009 were among Asian/Pacific Islander non-Hispanic (34 percent) and White non-Hispanic (29 percent) New Yorkers.

Figure 98. Age-Adjusted* Heart Disease Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	295.2	283.3	279.9	265.2	245.0	241.7	232.3	224.6	219.1	206.6
Black NH	334.9	315.9	316.3	291.6	288.1	280.6	274.1	268.2	259.9	244.5
Asian/PI NH	153.2	144.1	140.9	133.5	130.1	125.2	118.3	114.4	117.6	108.5
Hispanic	219.8	211.4	198.2	206.6	185.9	180.7	185.0	173.1	166.1	159.9

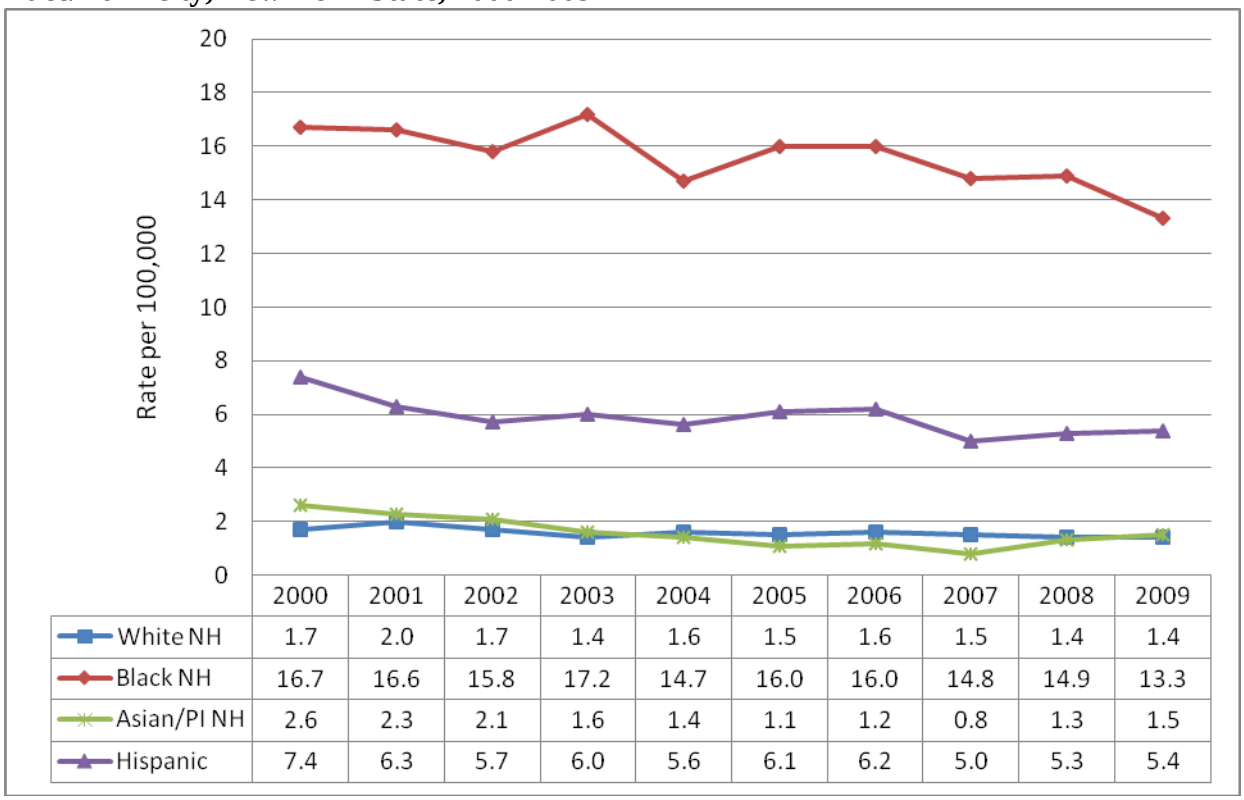
* Rates adjusted to the 2000 U.S. population.
Heart disease mortality rates are based on ICD-10 codes I00-I09, I11, I13, I20-I51.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Homicide remains a major cause of intentional injury among some populations. National statistics indicate Blacks, males and persons under 25 are the most likely to be murdered. Victimization rates for Blacks were six times higher than for Whites, and 78 percent of homicide victims are men. Approximately one-third of murder victims are under age 25.[6]

Although homicide rates for all groups declined during the past decade, in 2009, Black non-Hispanic New Yorkers died from homicide more than twice as often as Hispanics, who had the next highest rate (13.3 per 100,000 compared to 5.4 per 100,000).

Death rates for Black non-Hispanic and Hispanic New Yorkers remained stubbornly higher than rates for White non-Hispanics and Asian/Pacific Islander non-Hispanics. In 2009, the rate among Black non-Hispanics was nearly ten times the rate for White non-Hispanics and Asian/Pacific Islander non-Hispanics.

Figure 99. Age-Adjusted* Homicide Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	1.7	2.0	1.7	1.4	1.6	1.5	1.6	1.5	1.4	1.4
Black NH	16.7	16.6	15.8	17.2	14.7	16.0	16.0	14.8	14.9	13.3
Asian/PI NH	2.6	2.3	2.1	1.6	1.4	1.1	1.2	0.8	1.3	1.5
Hispanic	7.4	6.3	5.7	6.0	5.6	6.1	6.2	5.0	5.3	5.4

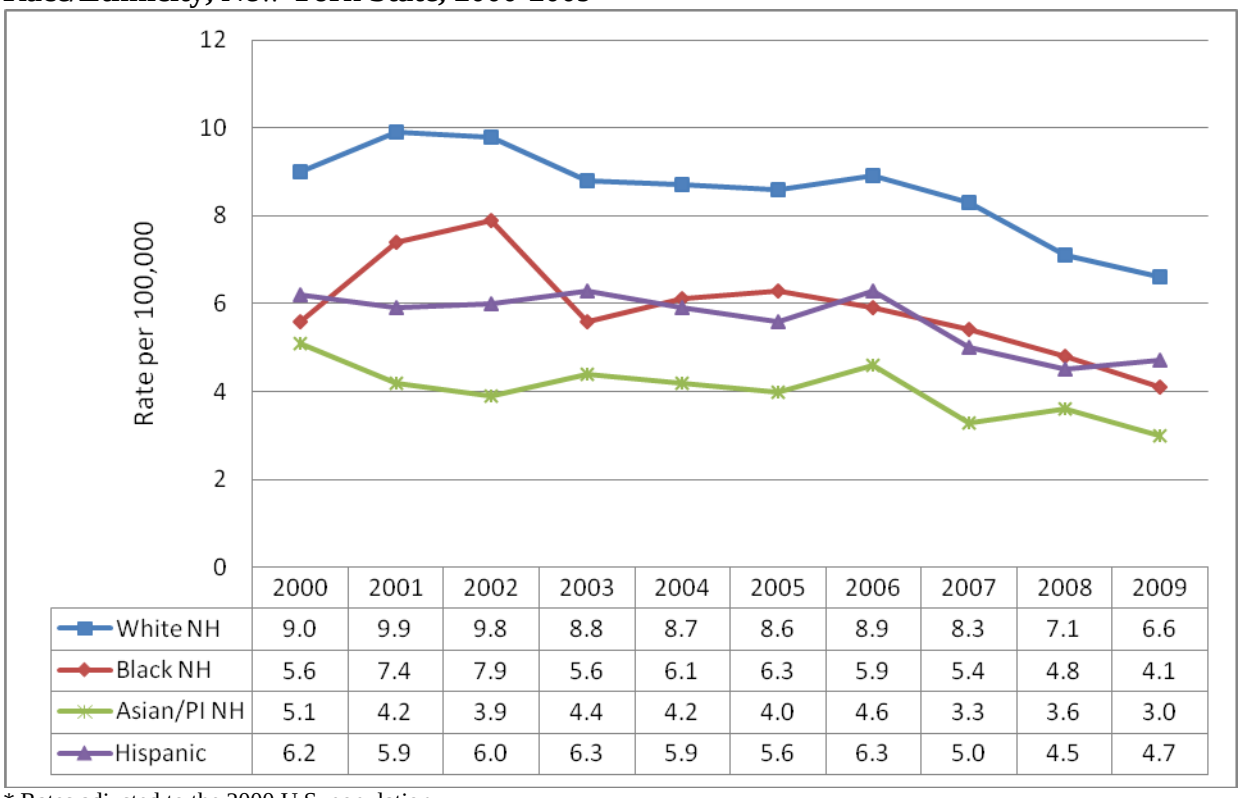
* Rates adjusted to the 2000 U.S. population.
Homicide mortality rate is based on ICD-10 codes X85-Y09, Y87.1. World Trade Center deaths in 2001 are excluded.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Motor vehicle crashes are the nation's leading cause of death among those aged 5-34. More than 2.3 million adult drivers and passengers were treated in emergency departments for motor vehicle crash injuries in 2009. Based on the magnitude of the health problem, and the ability to make significant progress in improving outcomes, the U.S. Centers for Disease Control and Prevention have designated motor vehicle injury prevention as a "Winnable Battle".[7]

From 2000-2009, motor vehicle-related death rates declined among all racial/ethnic groups – about 41 percent among Asian/Pacific Islander non-Hispanics, 27 percent among Black non-Hispanics and White non-Hispanics, and 24 percent among Hispanics.

In contrast to other mortality statistics, the death rate from motor vehicle injuries was highest among White non-Hispanics (6.6 per 100,000 in 2009) throughout the decade, never falling below the rates observed in other groups.

Figure 100. Age-Adjusted* Motor Vehicle Injury Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	9.0	9.9	9.8	8.8	8.7	8.6	8.9	8.3	7.1	6.6
Black NH	5.6	7.4	7.9	5.6	6.1	6.3	5.9	5.4	4.8	4.1
Asian/PI NH	5.1	4.2	3.9	4.4	4.2	4.0	4.6	3.3	3.6	3.0
Hispanic	6.2	5.9	6.0	6.3	5.9	5.6	6.3	5.0	4.5	4.7

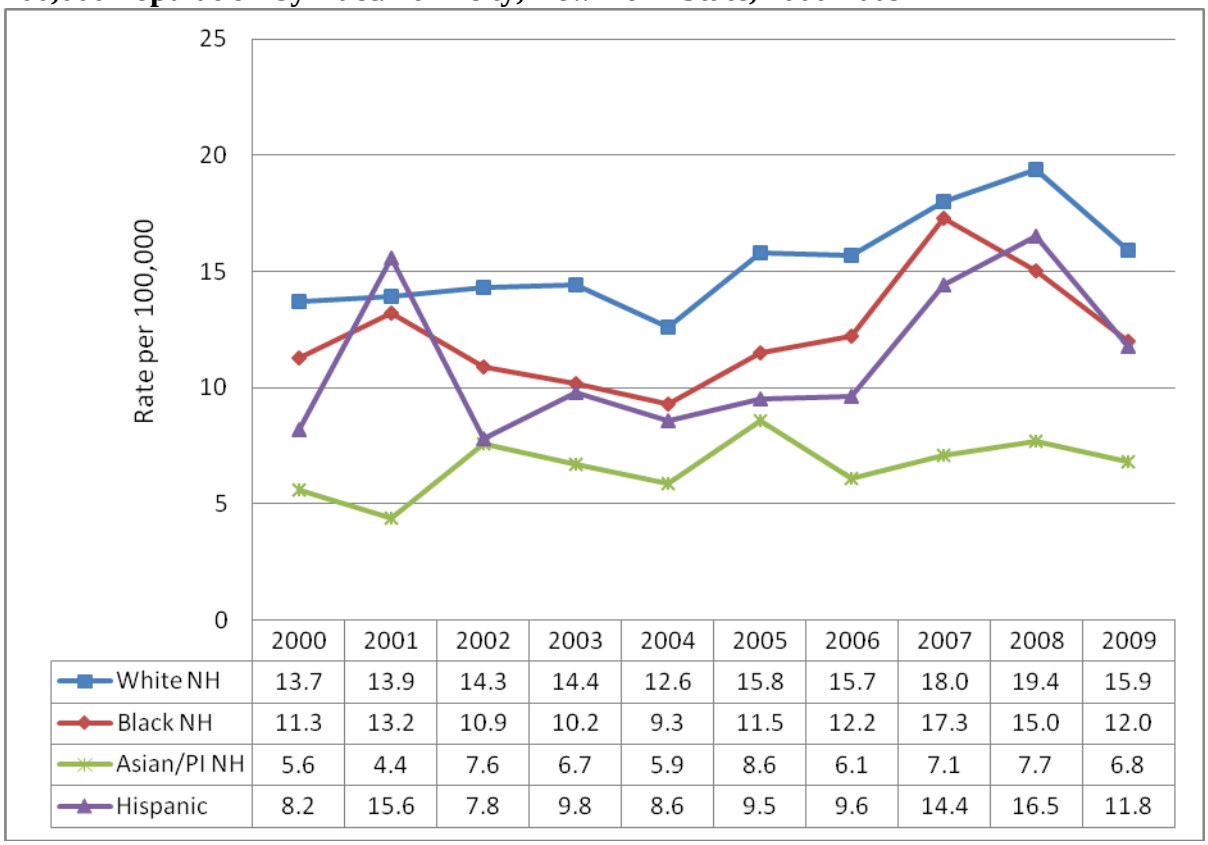
* Rates adjusted to the 2000 U.S. population
Motor vehicle injury mortality rates are based on ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Injuries have a substantial impact on individuals, their families, communities and society. Older adults and children are most vulnerable to sustaining injury requiring medical attention, but for Americans ages 1-44, injuries are the leading cause of death in the United States.[8]

From 2000-2009, non-motor vehicle unintentional injury death rates increased for all groups. Hispanics experienced the largest increase (44 percent), followed by Asian/Pacific Islander non-Hispanics (21 percent), White non-Hispanics (16 percent) and Black non-Hispanics (6 percent).

In 2009, White non-Hispanic New Yorkers had the highest non-motor vehicle unintentional injury death rates (15.9 per 100,000), followed by Black non-Hispanics (12.0 per 100,000) and Hispanics (11.8 per 100,000). Asian/Pacific Islander non-Hispanic New Yorkers had the lowest non-motor vehicle unintentional injury death rate (6.8 per 100,000).

Figure 101. Age-Adjusted* Unintentional Injury Non-Motor Vehicle Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	13.7	13.9	14.3	14.4	12.6	15.8	15.7	18.0	19.4	15.9
Black NH	11.3	13.2	10.9	10.2	9.3	11.5	12.2	17.3	15.0	12.0
Asian/PI NH	5.6	4.4	7.6	6.7	5.9	8.6	6.1	7.1	7.7	6.8
Hispanic	8.2	15.6	7.8	9.8	8.6	9.5	9.6	14.4	16.5	11.8

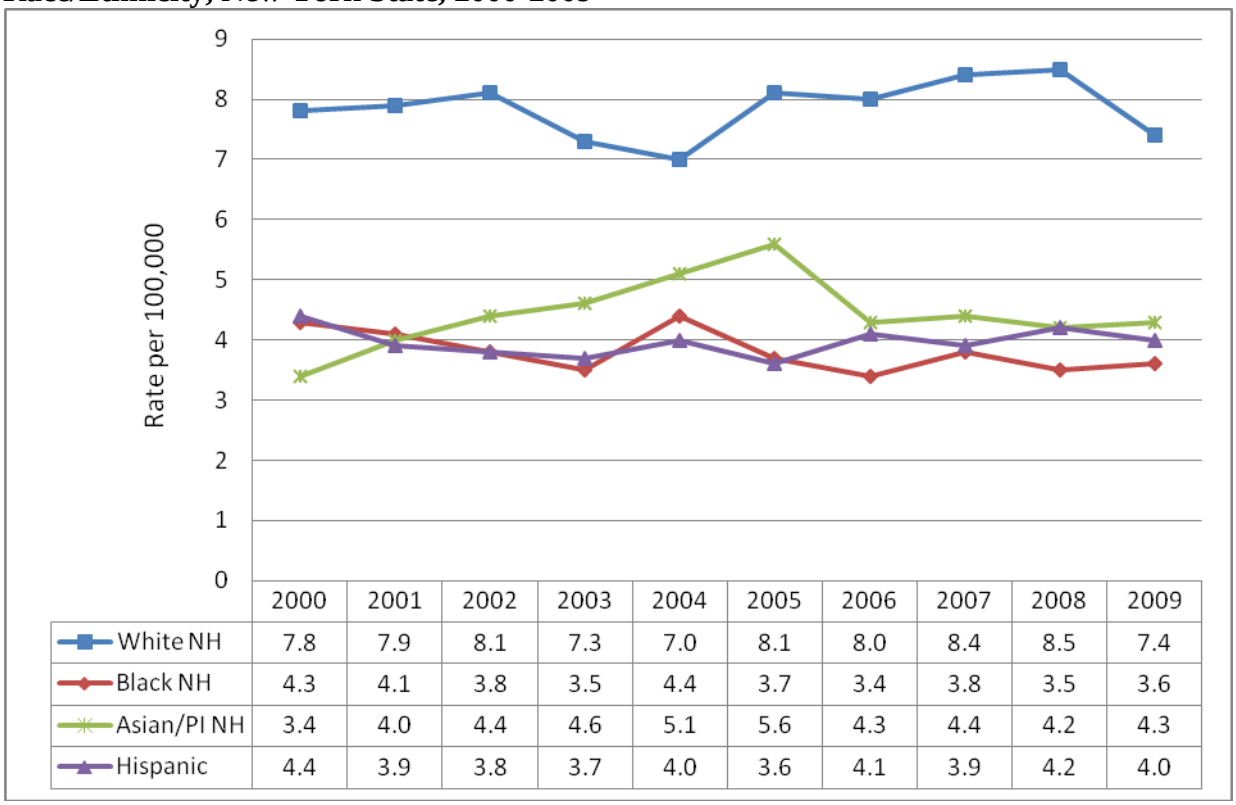
* Rates adjusted to the 2000 U.S. population
Unintentional injury non-motor vehicle mortality rates are based on ICD-10 codes V01, V05-V08, V09.1, V09.3-V09.9, V10, V11, V15-V18, V19.3, V19.7-V19.9, V80.0-V80.2, V80.6-V80.9, V81.2-V81.9, V82.2-V82.9, V87.9, V88.9, V89.1, V89.3-V89.9, V90-X59, Y85-Y86.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

More than 34,000 suicides occurred in the nation in 2007. Men are about four times more likely than women to die from suicide. However, three times more women than men report attempting suicide. In addition, suicide rates are high among middle-aged and older adults.[9]

During 2000-2009, suicide in New York continued to be much more prevalent among White non-Hispanics than other racial/ethnic groups, with a rate of 7.8 per 100,000 in 2000 and 7.4 per 100,000 in 2009. Asian/Pacific Islander non-Hispanics had the second highest suicide mortality rate and were the only group whose rate increased (3.4 per 100,000 to 4.3 per 100,000). All other groups experienced a decline in suicide death rates.

In 2009, death from suicide among White non-Hispanics was twice as high as the rate among Black non-Hispanics and Hispanics and 1.5 times the rate among Asian/Pacific Islander non-Hispanics.

Figure 102. Age-Adjusted* Suicide Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	7.8	7.9	8.1	7.3	7.0	8.1	8.0	8.4	8.5	7.4
Black NH	4.3	4.1	3.8	3.5	4.4	3.7	3.4	3.8	3.5	3.6
Asian/PI NH	3.4	4.0	4.4	4.6	5.1	5.6	4.3	4.4	4.2	4.3
Hispanic	4.4	3.9	3.8	3.7	4.0	3.6	4.1	3.9	4.2	4.0

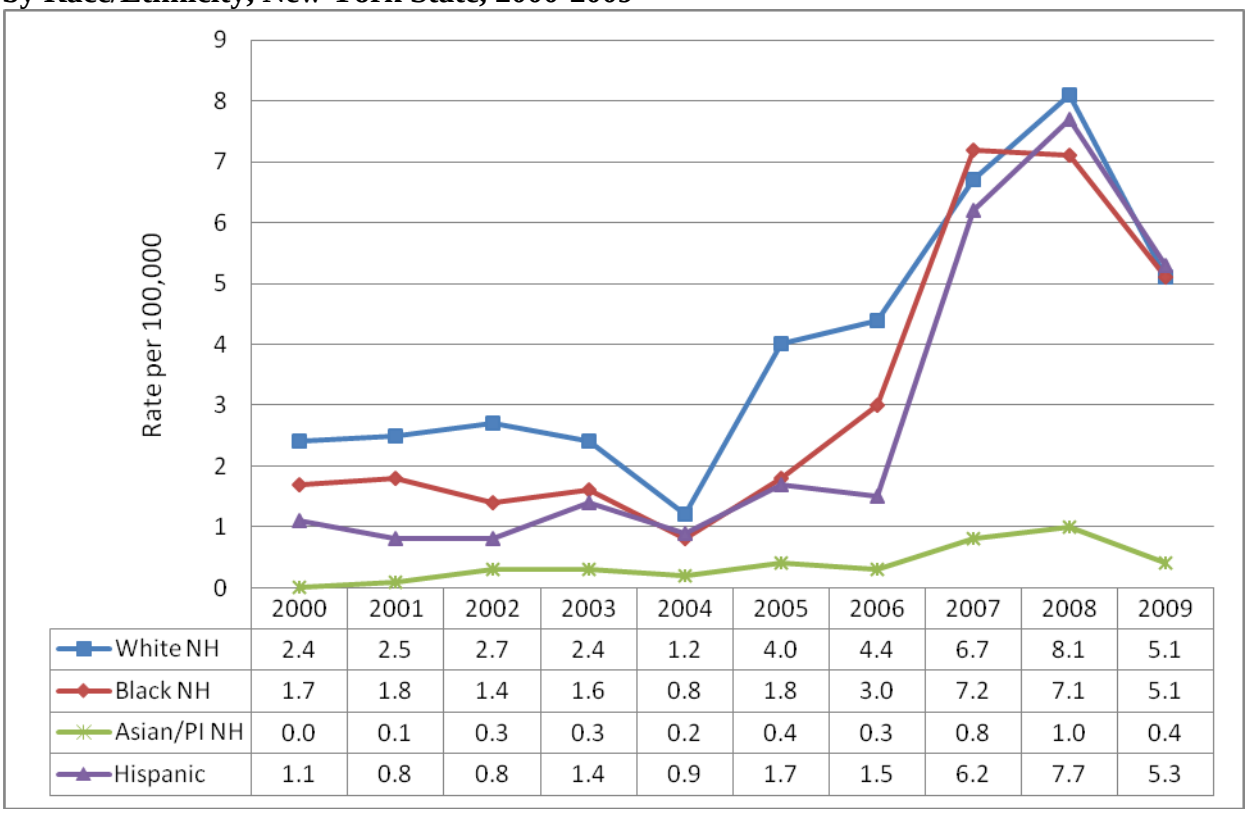
* Rates adjusted to the 2000 U.S. population
Suicide mortality rate is based on ICD10 codes X60-X84, Y87.0.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

Every day in the United States, nearly 82 people die from unintentional poisoning, and another 1,941 are treated in emergency departments. A poison is any substance, including medications, that harms the body if too much is eaten, inhaled, injected, or absorbed through the skin.[10]

The unintentional poisoning death rates in 2009 were similar for New York Hispanics (5.3 per 100,000), White non-Hispanics (5.1 per 100,000) and Black non-Hispanics (5.1 per 100,000). Asian/Pacific Islander non-Hispanics had a substantially lower rate at 0.4 per 100,000.

Between 2004 and 2008, death rates from unintentional poisoning increased dramatically among White non-Hispanics, Black non-Hispanics and Hispanics. In 2004, those rates ranged from 0.8 and 1.2 per 100,000. By 2008, the rates were all above 7.0 per 100,000. Between 2008 and 2009, the rates fell by 37 percent among White non-Hispanics, 28 percent among Black non-Hispanics and 30 percent among Hispanics. Death rates did not decline among Asian/Pacific Islander non-Hispanics, but instead fluctuated between 0.0 and 1.0 per 100,000 population.

Figure 103. Age-Adjusted* Unintentional Poisoning Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	2.4	2.5	2.7	2.4	1.2	4.0	4.4	6.7	8.1	5.1
Black NH	1.7	1.8	1.4	1.6	0.8	1.8	3.0	7.2	7.1	5.1
Asian/PI NH	0.0	0.1	0.3	0.3	0.2	0.4	0.3	0.8	1.0	0.4
Hispanic	1.1	0.8	0.8	1.4	0.9	1.7	1.5	6.2	7.7	5.3

* Rates adjusted to the 2000 U.S. population
Poisoning-related mortality rate is based on ICD10 codes.
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

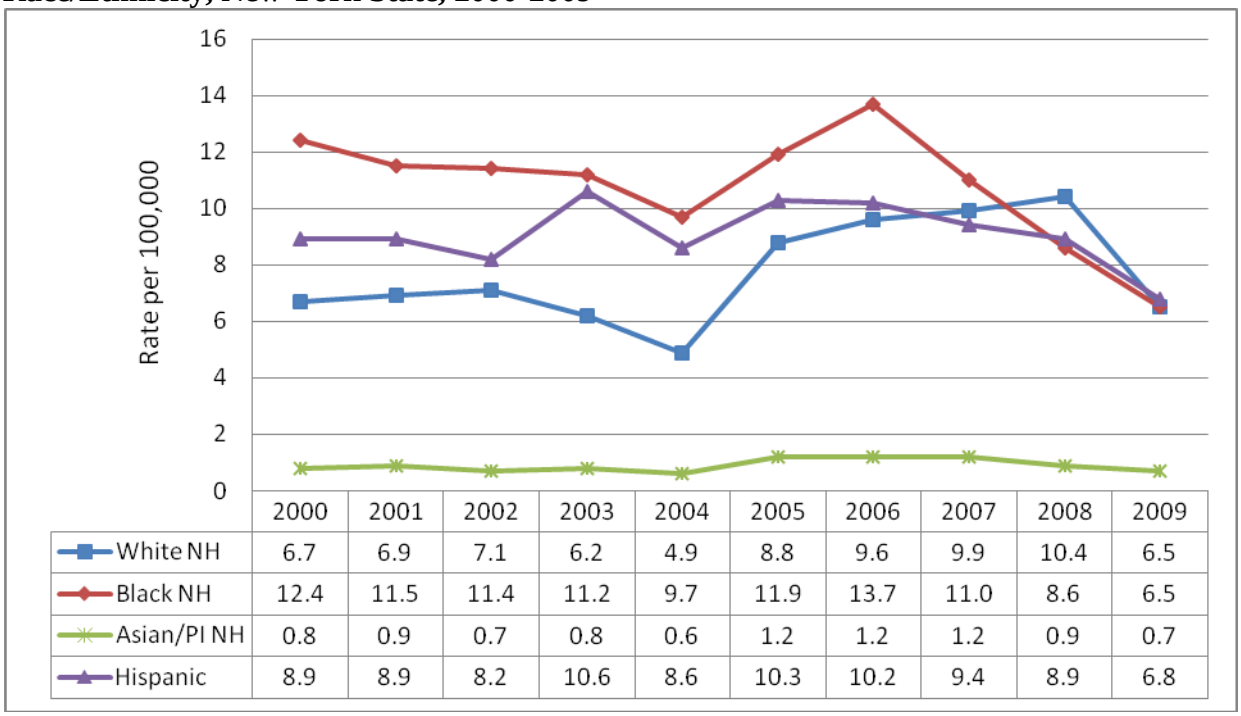
Drug-induced deaths include all deaths for which drugs are the underlying cause, including deaths attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. A drug includes illicit drugs, legal prescription drugs and over-the-counter drugs; alcohol is excluded.[11]

Drug-induced death rates have declined for all racial/ethnic groups over the past decade. The rate for each group was at its lowest point during 2004 and highest in either 2005 or 2006.

In 2000, large disparities were documented in New York, with Black non-Hispanics and Hispanics experiencing rates that were 85 percent and 33 percent higher, respectively than White non-Hispanics. In 2009, however, the rates were less than a percentage point apart for the three groups (6.5, 6.5 and 6.8 per 100,000, respectively).

During 2000-2009, Asian/Pacific Islander non-Hispanics had the lowest drug-induced death rate, ranging between 0.6 and 1.2 per 100,000 population.

Figure 104. Age-Adjusted* Drug-Induced Mortality Rate per 100,000 Population by Race/Ethnicity, New York State, 2000-2009



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White NH	6.7	6.9	7.1	6.2	4.9	8.8	9.6	9.9	10.4	6.5
Black NH	12.4	11.5	11.4	11.2	9.7	11.9	13.7	11.0	8.6	6.5
Asian/PI NH	0.8	0.9	0.7	0.8	0.6	1.2	1.2	1.2	0.9	0.7
Hispanic	8.9	8.9	8.2	10.6	8.6	10.3	10.2	9.4	8.9	6.8

* Rates adjusted to the 2000 U.S. population
Drug-induced mortality rate is based on ICD10 codes
D52.1,D59.0,D59.2,D61.1,D64.2,E06.4,E16.0,E23.1,E24.2,E27.3,E66.1,F11.0-F11.5,F11.7-F11.9,F12.0-F12.5,F12.7-F12.9,F13.0-F13.5,F13.7-F13.9,F14.0-F14.5,F14.7-F14.9,F15.0-F15.5,F15.7-F15.9,F16.0-F16.5,F16.7-F16.9,F17.0,F17.3-F17.5,F17.7-F17.9,F18.0-F18.5,F18.7-18.9,F19.0-F19.5,F19.7-F19.9, G21.1,G24.0,G25.1,G25.4,G25.6,G44.4,G62.0,G72.0,I95.2,J70.2-J70.4, K85.3,L10.5,L27.0-L27.1,M10.2,M32.0,M80.4,M81.4,M83.5,M87.1,R50.2,R78.1-R78.5,X40-X44,X60-X64,X85,Y10-14
Abbreviations: NH – non-Hispanic; PI – Pacific Islander
Source: New York State Department of Health, Bureau of Biometrics and Health Statistics

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Appendix A--New York State Population by County and Race/Ethnicity, 2010

County*	Non-Hispanic			Hispanic
	White	Black	Asian/Pacific Islander	
Albany	231,152	36,396	14,588	14,917
Allegany	46,701	494	458	670
Broome	173,074	8,850	7,079	6,778
Cattaraugus	73,849	966	538	1,345
Cayuga	73,098	3,009	413	1,896
Chautauqua	120,463	2,763	707	8,241
Chemung	77,643	5,528	1,055	2,240
Chenango	48,265	323	204	929
Clinton	74,832	2,953	905	2,054
Columbia	55,672	2,691	1,013	2,454
Cortland	46,252	705	415	1,094
Delaware	44,706	691	369	1,560
Dutchess	221,812	27,395	10,410	31,267
Erie	714,156	119,916	23,786	41,731
Essex	36,588	982	268	993
Franklin	42,640	2,834	223	1,506
Fulton	52,110	981	331	1,263
Genesee	54,990	1,491	357	1,616
Greene	42,857	2,606	397	2,419
Hamilton	4,664	33	28	51
Herkimer	61,690	640	333	1,040
Jefferson	99,682	5,475	1,737	6,143
Lewis	26,225	170	88	357
Livingston	60,296	1,491	791	1,802
Madison	68,916	1,260	587	1,316
Monroe	542,034	107,448	24,205	54,005
Montgomery	42,732	712	367	5,654
Nassau	877,309	141,305	101,755	195,355
Niagara	188,907	14,511	1,862	4,694
Oneida	199,254	13,682	6,571	10,819
Onondaga	370,040	48,696	14,490	18,829
Ontario	99,119	2,226	1,127	3,679
Orange	254,259	33,895	8,765	67,185
Orleans	37,658	2,368	180	1,757
Oswego	116,091	862	723	2,552
Otsego	57,734	958	676	1,921
Putnam	82,709	2,047	1,846	11,661
Rensselaer	136,555	9,592	3,494	6,080
Rockland	203,670	34,623	19,142	48,783
Saratoga	203,647	3,053	3,915	5,279
Schenectady	119,409	13,528	4,998	8,827
Schoharie	30,742	394	220	924
Schuyler	17,646	143	55	234
Seneca	31,999	1,513	240	952
St. Lawrence	103,943	2,259	1,100	2,146
Steuben	93,476	1,487	1,165	1,371
Suffolk	1,068,728	102,117	50,570	246,239
Sullivan	57,780	6,349	1,047	10,554
Tioga	49,105	349	383	694
Tompkins	81,490	3,773	8,720	4,264
Ulster	149,099	9,982	3,089	15,909
Warren	62,585	556	454	1,178
Washington	58,996	1,734	271	1,446
Wayne	85,318	2,743	489	3,476
Westchester	544,563	126,585	51,341	207,032
Wyoming	38,042	2,233	163	1,244
Yates	24,371	196	97	421
Bronx	151,209	416,695	47,733	741,413
Kings	893,306	799,066	260,762	496,285
Queens	616,727	395,881	509,428	613,750
Richmond	300,169	44,313	34,834	81,051
New York	761,493	205,340	178,157	403,577
New York City	2,722,904	1,861,295	1,030,914	2,336,076
NYS (Excluding NYC)	8,581,343	922,562	380,600	1,080,846
New York State	11,304,247	2,783,857	1,411,514	3,416,922

Source: U.S. Census 2010

Appendix B--New York State Percentage of Population by County and Race/Ethnicity, 2010

County*	Non-Hispanic			% Hispanic
	% White	% Black	% Asian/Pacific Islander	
Albany	75.99	11.96	4.80	4.90
Allegany	95.41	1.01	0.94	1.37
Bronx	10.92	30.08	3.45	53.53
Broome	86.28	4.41	3.53	3.38
Cattaraugus	91.95	1.20	0.67	1.67
Cayuga	91.34	3.76	0.52	2.37
Chautauqua	89.29	2.05	0.52	6.11
Chemung	87.41	6.22	1.19	2.52
Chenango	95.62	0.64	0.40	1.84
Clinton	91.12	3.60	1.10	2.50
Columbia	88.23	4.26	1.61	3.89
Cortland	93.75	1.43	0.84	2.22
Delaware	93.18	1.44	0.77	3.25
Dutchess	74.56	9.21	3.50	10.51
Erie	77.71	13.05	2.59	4.54
Essex	92.93	2.49	0.68	2.52
Franklin	82.64	5.49	0.43	2.92
Fulton	93.84	1.77	0.60	2.27
Genesee	91.53	2.48	0.59	2.69
Greene	87.07	5.29	0.81	4.91
Hamilton	96.44	0.68	0.58	1.05
Herkimer	95.62	0.99	0.52	1.61
Jefferson	85.76	4.71	1.49	5.29
Kings	35.67	31.90	10.41	19.81
Lewis	96.82	0.63	0.32	1.32
Livingston	92.21	2.28	1.21	2.76
Madison	93.84	1.72	0.80	1.79
Monroe	72.82	14.44	3.25	7.26
Montgomery	85.09	1.42	0.73	11.26
Nassau	65.49	10.55	7.60	14.58
New York	48.02	12.95	11.23	25.45
Niagara	87.27	6.70	0.86	2.17
Oneida	84.83	5.83	2.80	4.61
Onondaga	79.23	10.43	3.10	4.03
Ontario	91.84	2.06	1.04	3.41
Orange	68.20	9.09	2.35	18.02
Orleans	87.82	5.52	0.42	4.10
Oswego	95.07	0.71	0.59	2.09
Otsego	92.73	1.54	1.09	3.09
Putnam	82.95	2.05	1.85	11.69
Queens	27.65	17.75	22.84	27.51
Rensselaer	85.65	6.02	2.19	3.81
Richmond	64.04	9.45	7.43	17.29
Rockland	65.34	11.11	6.14	15.65
Saratoga	92.73	1.39	1.78	2.40
Schenectady	77.17	8.74	3.23	5.70
Schoharie	93.87	1.20	0.67	2.82
Schuyler	96.20	0.78	0.30	1.28
Seneca	90.77	4.29	0.68	2.70
St. Lawrence	92.85	2.02	0.98	1.92
Steuben	94.43	1.50	1.18	1.38
Suffolk	71.57	6.84	3.39	16.49
Sullivan	74.51	8.19	1.35	13.61
Tioga	96.05	0.68	0.75	1.36
Tompkins	80.24	3.71	8.59	4.20
Ulster	81.70	5.47	1.69	8.72
Warren	95.25	0.85	0.69	1.79
Washington	93.32	2.74	0.43	2.29
Wayne	90.98	2.93	0.52	3.71
Westchester	57.38	13.34	5.41	21.81
Wyoming	90.24	5.30	0.39	2.95
Yates	96.15	0.77	0.38	1.66
New York City	33.31	22.77	12.61	28.58
NYS (Excluding NYC)	76.60	8.23	3.40	9.65
New York State	58.34	14.37	7.28	17.63

Note: The percentages for racial/ethnic subgroups may not add up to 100% in the county because some groups are not included (e.g., 2 or more races).
Source: U.S. Census 2010

Appendix C--Prevention Agenda Tracking Indicators by Race/Ethnicity, New York State

Indicator	Prevention Agenda 2013 Objective	Total	Race/Ethnicity				Year
			White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic	
ACCESS TO QUALITY HEALTH CARE							
Adults with health care coverage	100%†	88.6%	92.2%	83.2%	86.1%	77.0%	2010
Adults with regular health care providers	96%†	86.6%	89.3%	86.7%	85.5%	74.5%	2010
Adults who have seen a dentist in the past year	83%†	72.5%	74.9%	68.5%	66.4%	67.3%	2010
Early stage cancer diagnosis:							
Breast	80%	64.6%	67.3%	54.1%	62.6%	59.2%	2008
Cervical	65%	46.1%	45.3%	40.8%	63.9%	47.1%	2008
Colorectal	50%	45.1%	44.5%	41.1%	45.2%	43.2%	2008
TOBACCO USE							
Cigarette smoking in adolescents (past month)	10%	12.6%	15.7%	6.0%	10.7%	8.3%	2010
Cigarette smoking in adults	12%†	15.5%	15.9%	14.2%	9.2%	16.0%	2010
COPD hospitalizations among adults 18 + years (per 10,000)	31.0	43.4	39.9	59.5	8.9	40.7	2009
Lung cancer incidence (per 100,000)							
Male	62.0*	75.2*	80.0*	74.6*	50.8*	48.3*	2008
Female	41.0*	55.4*	63.8*	43.6*	29.5*	25.5*	2008
HEALTHY MOTHERS/ HEALTHY BABIES/HEALTHY CHILDREN							
Early prenatal care (1st trimester)	90%†	73.3%	80.2%	62.1%	73.5%	65.8%	2009
Low birthweight births (<2500 grams)	5%†	8.2%	6.9%	13.0%	6.3%	7.7%	2009
Infant mortality (per 1,000 live births)	4.5 †	5.3	4.2	10.9	2.4	4.5	2009
Two year old children who receive recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 HepB)	90%	72.2%	68.9%	NA	NA	74.7%	2009
Children with at least one lead screening by age 36 months	96%	85.3%	NA	NA	NA	NA	2005 Cohort
Prevalence of tooth decay in 3rd grade children	42%†	54.1%	NA	NA	NA	NA	2002-04
Pregnancy rate among females aged 15-17 years (per 1,000)	28.0	31.4	11.0	64.1	8.2	58.3	2009

Indicator	Prevention Agenda 2013 Objective	Total	Race/Ethnicity				Year
			White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic	
PHYSICAL ACTIVITY/NUTRITION							
Obese (BMI for age>95th percentile) children age 2−4 years (WIC, pre-school)	11.6%	14.4%	12.2%	12.7%	10.6%	17.9%	2009
Adults who are obese (BMI>30)	15%†	24.5%	23.9%	35.4%	4.8%	25.6%	2010
Adults engaged in some type of leisure time physical activity	80%†	76.2%	77.7%	72.6%	79.6%	72.5%	2010
Adults eating 5 or more fruits or vegetables per day	33%	26.8%	26.9%	25.5%	NA	21.9%	2009
WIC mothers breastfeeding at 6 months	50%†	38.8%	34.7%	35.9%	36.3%	45.0%	2009
UNINTENTIONAL INJURY							
Unintentional Injury mortality (per 100,000)	17.1†*	20.5*	22.5*	16.1*	9.9*	16.6*	2009
Unintentional Injury hospitalizations (per 10,000)	44.5*	65.0*	63.6*	61.8*	27.5*	50.9*	2009
Motor vehicle related mortality (per 100,000)	5.8*	5.8*	6.6*	4.1*	3.0*	4.7*	2009
Pedestrian injury hospitalizations (per 10,000)	1.5*	1.7*	1.1*	2.7*	1.6*	1.9*	2009
Fall related hospitalizations age 65+ years (per 10,000)	155.0	204.7	226.1	105.9	85.6	128.4	2009
HEALTHY ENVIRONMENT							
Incidence of children <72 months with confirmed blood lead level >= 10 µg/dl (per 100 children tested)	0.0†	6.7	NA	NA	NA	NA	2006-08
Asthma related hospitalizations (per 10,000)							
Total	16.7*	21.5*	10.0*	46.6*	6.3*	36.4*	2009
Ages 0-17 years	17.3†	31.3	12.4	64	9.9	41.9	2009
Work related hospitalizations (per 10,000 employed persons aged 16+ years)	11.5	15.7	NA	NA	NA	NA	2007-09
Elevated blood lead levels (>25 µg/dl) per 100,000 employed persons age 16+ years	0.0†	3.3	NA	NA	NA	NA	2007-09

Indicator	Prevention Agenda 2013 Objective	Total	Race/Ethnicity				Year
			White non-Hispanic	Black non-Hispanic	Asian non-Hispanic	Hispanic	
CHRONIC DISEASE							
Diabetes prevalence in adults	5.7%	8.9%	7.9%	13.8%	8.1%	8.4%	2010
Diabetes short-term complication hospitalization rate (per 10,000)							
Age 6-17 years	3.1	3.3	2.6	5.3	0.3	3.1	2009
Age 18+ years	5.2	5.6	3.5	13.6	1.1	5.9	2009
Coronary heart disease hospitalizations (per 10,000)	48.0	46.8*	42.0*	46.7*	28.1*	44.5*	2009
Congestive heart failure hospitalization rate per 10,000 (ages 18+ years)	33.0	43.0	41.9	60.4	9.5	27.4	2009
Cerebrovascular (Stroke) disease mortality (per 100,000)	24.0*	26.2*	26.7*	27.4*	14.6*	19.1*	2009
Cancer mortality (per 100,000)							
Breast (female)	21.3* †	21.4*	21.7*	28.5*	9.2*	14.3	2008
Cervical	2.0* †	2.1*	1.6*	4.6*	1.8*	2.5	2008
Colorectal	13.7* †	15.6*	15.5*	18.7*	11.1*	13.6	2008
INFECTIOUS DISEASE							
Newly diagnosed HIV case rate (per 100,000)	23.0	21.3	6.5	65.7	7.1	37.6	2009
Gonorrhea case rate (per 100,000)	19.0†	87.0	NA	NA	NA	NA	2009
Tuberculosis case rate (per 100,000)	1.0†	5.2	NA	NA	NA	NA	2009
Adults 65+ years with immunizations							
Adults with flu shot in the past year	90%†	68.3%	71.4%	53.3%	NA	58.6%	2010
Adults with pneumonia vaccination in the past year	90%†	66.1%	68.4%	61.8%	NA	NA	2010
COMMUNITY PREPAREDNESS							
Population living within jurisdiction with state-approved emergency preparedness plans	100%	100%	100%	100%	100%	100%	2009
MENTAL HEALTH/SUBSTANCE ABUSE							
Suicide mortality rate (per 100,000)	4.8†*	6.2*	7.4*	3.6*	4.3*	4.0*	2009
Adults reporting 14 or more days with poor mental health in last month	7.8%	10.4%	10.1%	11.8%	3.3%	13.8%	2010
Binge drinking past 30 days (5 + drinks in a row) in adults	13.4%†	15.5%	16.5%	11.9%	8.6%	16.6%	2010
Drug-related hospitalizations (per 10,000)	26.0	27.7*	22.2*	49.9*	2.7*	29.7*	2009

† Healthy People 2010 Goal utilized

* Rate age-adjusted to the 2000 US population

Appendix D--Indicators in the Report with Comparable Healthy People 2020 Objectives

Indicator	HP 2020 Target
Infant Mortality Rate	6.0 per 1,000 live births
Maternal Mortality Rate	11.4 per 100,000 live births
Women Who Initiated Breastfeeding	81.9 percent (live births)
Babies Put to Sleep on Their Backs	75.9 percent (live births)
Births Receiving Early Prenatal Care	77.9 percent (live births)
Teenage Pregnancy Rate	36.2 per 1,000 females aged 15-17
Adults 18 Years and Older who Were Current Smokers	12 percent (adults aged 18 and older)
High School Students who Smoked Cigarettes	16.0 percent (HS students)
Adults 20 Years and Older who Were Obese	30.6 percent (adults aged 20 and older)
Prevalence of Obesity Among WIC Children Ages 2-4 Years	9.6 percent (children aged 2-5)
High School Students who Were Obese	16.1 percent (HS students)
Adults Aged 18 Years and Older Reporting No Leisure-Time Physical Activity	32.6 percent (adults aged 18-older)
Unintentional Injury-Related Emergency Room Visit Rate	829.7 per 10,000 population
Female Breast Cancer Mortality Rate	20.6 per 100,000 females
Cervical Cancer Mortality Rate	2.2 per 100,000 females
Prostate Cancer Mortality Rate	21.2 per 100,000 males
Colorectal Cancer Mortality Rate	14.5 per 100,000 population
HIV/AIDS Mortality Rate	3.3 per 100,000 population
Incidence Rate of Elevated Blood Lead Level	20.2 per 100,000 employed adults
Cerebrovascular Disease (Stroke) Mortality Rate	33.8 per 100,000 population
Homicide Mortality Rate	5.5 per 100,000 population
Motor Vehicle Injury Mortality Rate	12.4 per 100,000 population
Suicide Mortality Rate	10.2 per 100,000 population
Unintentional Poisoning Mortality Rate	13.1 per 100,000 population
Drug-Induced Mortality Rate	11.3 per 100,000 population

Source: Healthy People 2020 - http://www.healthypeople.gov/2020/default.aspx

Appendix E--Sources of Data

U.S. Census Bureau

The U.S. Census Bureau serves as the leading source of quality data about the nation's population and economy. Since 1790, data on gender, age, race, ethnicity and marital status are collected every ten years. Information on income, education, housing, occupation and industry is also collected from a representative sample of the population.

New York population figures, by race and ethnicity, used for presenting population counts and changes in population over time are generated from the Census Bureau's decennial census data for the years 2000 and 2010.

Data are presented for the following race/ethnic groups: White non-Hispanic, Black non-Hispanic, Asian non-Hispanic, American Indian/Alaska Native non-Hispanic, Native Hawaiian and Other Pacific Islander non-Hispanic, Hispanic and 2 or more races.

National Center for Health Statistics Bridged Race Population Estimates

National Center for Health Statistics (NCHS), bridged-race postcensal population estimates are used in the calculation of all population-based rates. These estimates are prepared under a collaborative arrangement with the U.S. Census Bureau. They are generated using the NCHS methodology that redistributes multiple race populations into single race categories.

All rates for indicators presented in this report for the 10-year period, 2000-2009, use the corresponding population estimate from the 2000-2009 NCHS bridged race population estimates files.

American Community Survey

The American Community Survey is part of the Census Bureau's re-engineered census process. It is designed to provide a fresh look at how communities are changing. The survey collects housing, demographic, social and economic information annually from a representative sample of not only the nation, but also of states and large urban counties.

American Community Survey-based indicators contained in this report are from the 2009 American Community Survey one year estimates and use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian non-Hispanic, Hispanic and American Indian/Alaska Native.

Vital Records

Information on mortality and natality are generated from birth, death and fetal death files that are managed by the NYSDOH Bureau of Biometrics and Health Statistics (BBHS). These files also include records from New York City, a separate vital registration district.

Mortality rates (excluding cancer mortality) contained in this report are from the BBHS death files from 2000 to 2009. The cause of death is the underlying cause classified according to the International Classification of Diseases (ICD-10). All mortality rates that are not age-specific are age-adjusted using the standard 2000 U.S. population.

Infant mortality rates are presented for the time period 2000-2009, and are based on all live births regardless of birth weight or gestation.

Natality rates are generated from the BBHS birth files from 2000 to 2009. Pregnancy rates also include the 2000 to 2009 fetal death (spontaneous and induced) files.

Mortality and natality indicators contained in this report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic, American Indian/Alaska Native non-Hispanic and Hispanic that are not age-specific. Any rate that is based on one or two events has been suppressed.

Statewide Planning and Research Cooperative System (SPARCS)

Hospitalization Inpatient data: Data on hospitalizations are collected through the hospital inpatient discharge data system. Each hospitalization is assigned an ICD-9 code at discharge which indicates the primary reason for the hospitalization and up to 14 other related discharge diagnoses. Data are not available on events that did not result in a hospitalization, such as cases that were only treated in a hospital emergency department.

Hospitalization rates contained in this report are from 2000 – 2009 SPARCS files. All hospitalization rates that are not age-specific are age-adjusted using the standard 2000 U.S. population.

Hospitalization-based indicators contained in this report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic and Hispanic. Any rate that is based on one or two events has been suppressed.

Emergency Department (ED) Visit Data: ED data was added as a SPARCS data collection responsibility in 2001. The data reporting began on a voluntary basis in September 2003, and was mandated in January 2005.

This report includes ED data from 2005 through 2009. Patients visiting the ED and admitted to a hospital inpatient service are also included in the calculation of the ED visit rates presented in this report. As with hospitalizations, each ED visit receives an ICD-9 code at discharge which indicates the primary reason for the hospitalization and up to 14 other related discharge diagnoses.

All ED visit rates presented in this report are age-adjusted using the standard 2000 U.S. population.

ED visit-related indicators contained in this report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic and Hispanic. Any rate that is based on one or two events has been suppressed.

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual statewide telephone survey system designed by the Centers for Disease Control and Prevention (CDC). New York State has participated annually since 1985. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality. The BRFSS sample represents the non-institutionalized adult household population, aged 18 years and older.

BRFSS race and ethnicity information is collected using two questions:

- Are you Hispanic or Latino? (Yes, No, Don't know/Not Sure, Refused); and
- Which one or more of the following would you say is your race? (White, Black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, Other, Don't know/Not sure, Refused).

BRFSS-based charts contained in this report use the following race/ethnicity groupings: White non-Hispanic; Black non-Hispanic; Asian non-Hispanic and Hispanic. The "Other" category, which includes multiple races, is excluded from the report because the mix of racial/ethnic groups does not lend itself to interpretation.

BRFSS income information is collected using the following question:

- Is your annual household income from all sources: less than $10,000; $10,000 to less than $15,000; $15,000 to less than $20,000; $20,000 to less than $25,000; $25,000 to less than $35,000; $35,000 to less than $50,000; $50,000 to less than $75,000; $75,000 or more; Don't know/Not sure; and Refused.

Each BRFSS indicator in this report is presented in two charts; a trend chart using 3-year moving averages from 2001-2003 through 2007-2009, and in a bar chart presenting race/ethnicity by income for the time period 2007-2009. All BRFSS-based rates are age-adjusted using the standard 2000 U.S. population.

When charts present race/ethnicity by income, this report uses the income break of less than $25,000 and $25,000 or more. The groupings were chosen to have a comparison with the low socio-economic population and to ensure sufficient numbers in the race/ethnicity categories for reasonable precision.

Results are suppressed if they do not meet reporting criteria: the confidence intervals have a half-width greater than 10, the cell size (denominator) is less than 50, or the numerator is less than 10.

New York State Cancer Registry

The NYS Cancer Registry collects, processes, and reports cancer statistics on incidence, mortality and stages of diagnoses by site. In addition to collecting information on the anatomic site of the tumor and stage of diagnosis, the registry also collects socio-demographic information, such as age, gender, ethnicity, race and residence for each individual diagnosed with cancer.

This report presents incidence, mortality and stage of diagnosis information from the NYS Cancer Registry. Incidence and mortality rates are age-adjusted using the standard 2000 U.S. population. Five year (2004-2008) incidence and mortality rates for selected sites are presented, with mortality rates also being presented annually from 1999-2008.

This report also contains early stage diagnoses for the selected cancer sites. Early stage cancers are those which are confined to the organ of origin. These percentages are presented annually from 1999 to 2008.

Cancer Registry-based indicators contained in this report use the same race/ethnicity groupings used for the natality and mortality data: White non-Hispanic, Black non-Hispanic, Asian Pacific Islander non-Hispanic and Hispanic.

Youth Risk Behavior Survey (YRBS)

The YRBS is a survey of public high school students using a methodology and questionnaire designed by the federal Centers for Disease Control and Prevention (CDC). The YRBS collects information on risk factors and behaviors for this adolescent population using an anonymous self-administered questionnaire. It is conducted every two years in New York State and is administered by the NYS Department of Education.

YRBS race and ethnicity information is collected using two questions:

- Are you Hispanic or Latino? (Yes, No); and
- What is your race? Select one or more responses (American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White).

YRBS-based graphs contained in the report use the following race/ethnicity groupings: White non-Hispanic, Black non-Hispanic, Asian non-Hispanic, American Indian non-Hispanic and Hispanic. Because of small numbers, the "Other" category, which includes multiple races, is excluded from the analysis. All YRBS-based prevalence rates are presented with their 95% confidence intervals. (Since the YRBS information is based on a sample, the confidence interval is the range where the true prevalence is likely to fall with a 95% degree of assurance). YRBS data contained in this report are from the 2009 survey.

Pediatric Nutrition Surveillance System

The Pediatric Nutrition Surveillance System provides nutrition-related information on low-income infants and children served by the New York State Nutrition Program for Women, Infants and Children (WIC). The Pediatric Nutrition Surveillance System is maintained by the New York State Department of Health's Division of Nutrition.

This Report contains a graph of the annual percentage of obese children aged two to four years among WIC participants from 2000–2009. Obesity is defined as at or above the 95th percentile sex-specified body mass index (BMI) for age based on the 2000 NCHS/CDC growth charts. The racial/ethnic groupings used are: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic, American Indian non-Hispanic and Hispanic.

New York State Youth Tobacco Survey

The Youth Tobacco Survey (YTS) was developed by CDC in collaboration with U.S. states to provide information on trends in youth tobacco use. Starting in 2000, NYSDOH has conducted the YTS biennially to produce separate estimates for New York City, the rest of the state, and the state as a whole. This report contains data from the 2010 survey for New York State high school students (including public, parochial, and private schools) for the following racial/ethnic groupings: White non-Hispanic, Black non-Hispanic, Asian and Hispanic.

Adult Blood Lead Epidemiology and Surveillance (ABLES)

New York State (NYS) participates in a National Institute for Occupational Safety and Health (NIOSH) surveillance program, Adult Blood Lead Epidemiology and Surveillance (ABLES), which is a state-based surveillance program of laboratory-reported adult BLLs.

For the ABLES program, adults are defined as persons 16 years or older. For adults with more than one (1) BLL record in a given year, only the highest BLL is included. The incidence rate is calculated by determining the number of elevated (25 mcg/dL or higher) cases reported during a calendar year, but not reported in the immediately preceding year, divided by NYS's annual employed population ages 16 or older (source: Bureau of Labor Statistics – Current Population Survey).

The racial/ethnic groupings available from the ABLES are: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic, and Hispanic.

The rate is expressed per 100,000 employed adults. Data are presented for 1999-2009 for all groups except for Asian/Pacific Islander non-Hispanics. This is due to the lack of employment data for this group for the years 1999-2002 and 2006.

HIV/AIDS Surveillance

Information on new cases of HIV presented in this report was generated from data collected and maintained by the NYS Department of Health, Bureau of HIV/AIDS Epidemiology and the HIV Epidemiology and Field Services (HEFS) Program of the NYC Department of Health and Mental Hygiene. All HIV cases newly diagnosed during the reporting period are counted, regardless of concurrent or subsequent AIDS diagnosis or vital status. Data are presented for the years 2005 and 2009.

The racial/ethnic groupings available from the HIV/AIDS Surveillance System are: White non-Hispanic, Black non-Hispanic Asian/Pacific Islander non-Hispanic, Hispanic and American Indian/Alaska Native.

Pregnancy Risk Assessment and Monitoring System (PRAMS)

New York State PRAMS is an ongoing mail/telephone survey of randomly selected mothers who have recently given birth to a live born infant. PRAMS collects information from mothers about behaviors and experiences before, during and after pregnancy to learn more about how to reduce infant deaths and low birth weight births. The PRAMS project was developed by the Centers for Disease Control and Prevention (CDC) in 1987.

The New York State Department of Health and the New York City Department of Health and Mental Hygiene collect PRAMS survey data. The information provided in this report is from a combined NYC/New York State (excluding NYC) file and is representative of the entire state. Data are presented for the years 2004-2009.

The racial/ethnic groupings available from the PRAMS are: White non-Hispanic, Black non-Hispanic, Asian/Pacific Islander non-Hispanic, and Hispanic.

Results are suppressed if they do not meet reporting criteria: the confidence intervals have a half-width greater than 10, the cell size (denominator) is less than 50, or the numerator is less than 10.

Appendix F--Glossary / Technical Notes

Age-adjustment – Age-adjustment is a statistical process applied to rates of death, hospitalization, disease or other health outcomes, which allows areas with different age structures to be compared. Age confounding occurs when the two populations being compared have different age distributions, and the risk of the outcome varies across age groups. The process of age adjustment (Direct Method) used for this report changes the amount that each age group contributes to the average rate in each area, so that the overall rates are based on the same age structure. Rates based on the same age distribution can be compared to each other without the presence of confounding by age. Adjustment was accomplished by first multiplying the age-specific rates of death or hospitalization by age-specific weights. The weights used in the age adjustment of asthma data are the proportion of the Standard Population (the U.S. population as enumerated by the Bureau of the Census, 2000) within each age group. The weighted rates are then summed across the age groups to give the age-adjusted rate.

Aggregating BRFSS data – BRFSS charts combine three years of data to have a sufficient sample to report the results by race and ethnicity and to improve precision. Each BRFSS indicator is presented in two charts: a trend charts with a 3-year moving average for the time period 2001-2009 and a chart with results that are stratified by income for the three year period 2007-2009. Sample weights were adjusted using standard procedures for analysis of the combined data.

Confidence Intervals (BRFSS) – Confidence intervals are useful to assess precision of probability surveys according to the sample size of the survey design. A 95% confidence interval refers to the range where the true prevalence is likely to fall with a 95% degree of assurance.

ICD-9CM – The International Classification of Diseases, 9th revision Clinical Modification.

ICD-10 – The International Classification of Diseases, 10th revision.

Incidence – The number of new cases of the disease or condition within a specified period of time.

Incidence rate – Cases of disease or condition in the given year(s) divided by the population at risk in given year(s).

Moving Average – A moving average is commonly statistical technique to smooth out short-term fluctuations and highlight longer-term trends.

Mortality – Death due to the disease or condition in question.

Mortality rate – Total number of deaths from the disease or condition in given year(s) divided by the population at risk in given year(s).

Percent Change – By accessing baseline and current period data, the user is able to determine the percent of change between two periods of time. To calculate a percent change, find the

difference between the current year and base year rate (subtract the base rate from the current rate), then divide the difference by the base year and multiply by a standardized multiplier (100 is used as the multiplier to present the change as a percent). The difference between the rates can show an increase (positive number) or decrease (negative number) and depending on the indicator, can depict a negative or positive change.

Prevalence – The number of existing cases with disease or condition in given year(s) divided by the population at risk in given year(s).

Race Code Bridging – The Census 2000 permitted respondents to fill out as many categories of race as they wanted. Prior to that, it was required to fill only one category of race. As a result, the data from 2000 Census are not comparable from any past data on race. To bridge this gap (i.e., to make the 2000 and post 2000 populations by race comparable with the past populations) the National Center for Health Statistics (NCHS) devised a method to redistribute the multiple race populations into single race categories. Some other categories were also collapsed. The bridged estimates are produced by the Census Bureau according to the race algorithm provided by the NCHS. The data set is derived from the Census Bureau estimates available at the time. The dataset is updated annually on the NCHS website (http://wonder.cdc.gov/wonder/help/bridged-race/estimates2000-03.html).

Race Coding – Birth File – Beginning in January 1, 2004, a web-based birth registration system was implemented in New York State, excluding New York City (New York City is its own vital registration district). New York City continues to use an older version of the live birth certificate. One major change associated with adoption of the revised birth certificate is the way the variable race is reported. Prior to 2004, a mother was allowed to select only one race category (1990 Census scheme), even when she identified herself with more than one race due to her multiple race heritage. Beginning in 2004, the Census 2000 coding scheme for race was used for New York State, excluding New York City, recorded births. With the Census 2000 scheme, the mother is allowed to report more than one race from among 15 race categories. For reporting purposes, only respondents selecting a single race are included in tabulations by specific race categories (White alone, Black alone, Asian/PI alone). Respondents selecting more than one race category are reported as "Other" race. Under both data systems, Hispanic origin is a separate tabulation equal to the total of Hispanic White, Hispanic Black, Hispanic Asian and Hispanic Other. The selection of race for statistical reporting of live births is based upon the race of the mother only.

Significance Testing – Confidence intervals are presented at the 95% level. When comparing two rates, if the confidence intervals overlap, the difference is not statistically significant at the 95% level. If they do not overlap the difference is statistically significant.

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Guthrie Birkhead, MD, MPH
Deputy Commissioner of Health

Ellen Anderson, MS
Deputy Director

Office of Public Health Practice

Sylvia Pirani, MS, MPH, *Director*

Trang Nguyen, MD, Dr.PH, *Deputy Director*

Pamela Sheehan

David Wikoff

Fangtao He, MPH

Daniella Thorne, MPH

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Anne Radigan

Aaron Mair

Yan Xu, MS

Xiaoke Yang, MA

Michelle Barnes, MPH

Linda Coney

Kimberly Felano

Center for Environmental Health

Alicia Fletcher, MPH

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Carla Boutin-Foster, MD, MS, *Chair*

Susan Scrimshaw, PhD

Office of Minority Health and Health Disparity Prevention

Yvonne Graham, MPH, RN
Associate Commissioner, NYSDOH
Director, Office of Minority Health and Health Disparities Prevention

Wilma Waithe, PhD, *Retired Director*

Dina M. Addario

Rodolfo Santos, LMSW

Kristen M. Pergolino

Center for Community Health

Bradley Hutton, MPH, *Director*

Claudia Hutton

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