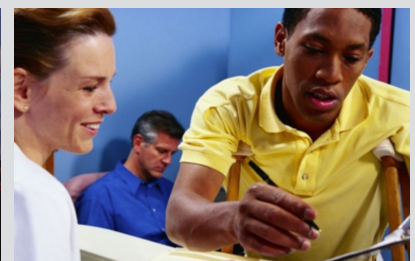




# NATIONAL PARTNERSHIP FOR ACTION

to End Health Disparities

## Southwest Regional Health Equity Council Blueprint for Action



Southwest RHEC

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## **Disclaimer & Limitations:**

The Southwest Regional Health Equity Council (SWRHEC) acknowledges the limitations of the research and the interpretation of data contained within this document.

### **No warranties:**

This Blueprint is provided “as is” without any representations or warranties, express or implied. The SWRHEC makes no representations or warranties in relation to the information and materials contained in this Blueprint.

Without prejudice to the generality of the foregoing paragraph, the SWRHEC does not warrant that:

- The information contained herein is complete, current, or non-misleading for the topic areas nor the states referenced.
- Nothing in this Blueprint constitutes, or is meant to constitute, advice of any kind.

### **Limitations**

Please note that data elements originate from different sources. Be aware that racial and ethnic populations could be categorized differently.

## Executive Summary

In 2010, representatives from Arkansas, Louisiana, New Mexico, Oklahoma, and Texas convened at Langston University in Oklahoma City, to discuss the launch of Regional Health Equity Boards. It was at this meeting that individuals discussed opportunities to 1) end health disparities addressing social determinants that impact health; 2) draft the National Plan for Action; 3) strategize actions to effectively meet the Board's charge and responsibilities; and 4) propose considerations for Board formation.

Today, representatives from these states form the SWRHEC. They, along with nine other Regional Health Equity Councils in the United States, are aligned under the National Stakeholder Strategy (NSS) for Achieving Health Equity. The NSS is an overarching roadmap for eliminating health disparities through cooperative and strategic actions. Regional Health Equity Councils use a "bottom up" approach by bringing front-line representatives to identify and help shape core actions for a coordinated national response to ending health disparities.

This past year, the SWRHEC has compiled regional data addressing health outcomes and burdens along with data from select social, behavioral and environmental determinants of health that also effect health equity. The data has been captured within the SWRHEC's "Blueprint for Action" and depicts current and emerging trends in our region.

Our regional populations are growing, especially our communities of color. Two of our five states, Texas and New Mexico, have minority populations that outnumber non-Hispanic Whites and are known as "majority-minority" states.

The least populated state is New Mexico and the most populated state is Texas. The landscape in the region can be flat, mountainous, desert, green, swampy and sometimes below sea level. The people represent the picture of the next millennium. Based on 2014 Census data estimates, women represent a little over 50% of the population. Ethnic/racial minorities represent approximately 44% of the population with Hispanics/ Latinos representing the largest and fastest growing group. Blacks/African Americans are the second largest group. American Indians/Alaska Natives are solidly represented and account for almost 10% of New Mexico's population and 9% of Oklahoma's population. Asian and Pacific Islanders have the smallest representation at 5.4% in the region. As in national projections, minority populations are considerably younger than the majority population. Health issues affecting the region are adult obesity, diabetes, heart disease, infant mortality and a limited supply of influenza vaccine.

"HEALTH EQUITY is defined as valuing all people, recognizing and rectifying social injustices and providing resources based on need."

Camara Jones, MD, PhD, MPH

2015 APHA Annual Conference, Chicago



## Regional Health Challenges

Youth Obesity – All states in the region experienced an overall increase in the percentages of overweight or obese children between 2003 and 2012. In all states except for New Mexico, African Americans had the highest percentages of overweight or obese children. (National Survey of Children's Health, 2012)

### According to CDC Sortable Stats:

- Adult Obesity – Louisiana, followed by Arkansas, had the highest percentages of overweight or obese adults in 2012. African Americans had the highest percentage in all states except for New Mexico.
- Adult Diabetes – Louisiana, followed by Oklahoma, had the highest percentage of adults diagnosed with diabetes. African Americans had the highest percentage in Louisiana and Texas. Hispanics/Latinos had the second highest percentage in diagnosed diabetes in New Mexico and Texas.
- Heart Disease Death Rates – Rates in all five states decreased steadily between 2000 and 2011. Within this time frame, Oklahoma consistently had the highest rate of heart disease-related deaths and New Mexico had the lowest. In all states except for New Mexico, African Americans had the highest rates of heart disease-related deaths among all race categories in 2011.
- Infant Mortality – Between 2000 and 2011, Louisiana consistently had the highest infant mortality rates (IMR) in the region. New Mexico had the greatest decrease in IMR rates in this time period, dropping by 1.3 infant deaths per 1,000 live births. Texas was the only state to show an IMR increase from 5.6 in 2000 to 5.7 in 2011. Across all five states, African Americans had the highest IMRs.
- Influenza Vaccinations – All states except for Arkansas experienced an overall increase in vaccinations between 2009 and 2013. The 18–64 age category and African American population consistently had the lowest influenza vaccination rates for all states in the region and the U.S.

The importance of preventing disease and promoting health – rather than treating the disease once it appears – has tremendous potential for reducing health disparities and improving our nation's health (HealthReform.Gov, 2011) (Prevention Institute on Behalf of Trust for America's Health, 2011).

In order to do this, we must look at the conditions of places where people live, learn, work, and play that affect a wide range of health risks and outcomes according to the World Health Organization. These conditions are known as social determinants of health (SDOH). Further defined, they are life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education, and health care, whose distribution across populations effectively determines the length and quality of life. (James, 2002)

Poverty limits access to healthy foods and safe neighborhoods. More education is a predictor of better health (Adler NE, 2002) (Walker RE, 2010) (Saegert S, 2003). We also know that differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education (Braveman, 2006) (Norman D, 1999).

## This Blueprint Reveals:

- Arkansas and Louisiana will have the greatest percentage of jobs requiring at least a high school diploma in 2020. New Mexico, Oklahoma and Texas will have above 60% of jobs that require at least some college (National Equity Atlas, 2015).
- No state has a minimum wage that meets the calculated living wage for any of the categories of working adults and children provided (Living Wage Calculator, 2015).
- African Americans have a high overall frequency for living in high-poverty neighborhoods across the five states and the US. The greatest percentage of African Americans living in high-poverty neighborhoods was found in Louisiana in 2000. The greatest number of American Indians live in high-poverty neighborhoods in New Mexico. Considering all races, Louisiana has the highest percentage of people living in high-poverty neighborhoods in both 2000 and 2012 (HUD, Comprehensive Housing Affordability Strategy, 2008-2012).
- According to the National Equity Atlas, home ownership in all states has declined. Nearly 50% of the housing stock in Arkansas and New Mexico was built prior to 1980; more than 50% of the housing stock in Louisiana and Oklahoma was built prior to 1980. Oklahoma has the highest percentage of houses built before 1940.
- Arkansas had the highest rate (per 100,000 population) of Housing and Urban Development and Fair Housing Assistance Program Complaints from 2010 to 2013. In 2013, Louisiana, New Mexico and Oklahoma all had a relatively low rate compared to those of Arkansas and Texas. This gap clearly marks a separation between the top two and bottom three states in terms of complaints registered.
- In all five states, renters had housing costs above 30% of household income with a much greater frequency than did homeowners. For housing costs exceeding 50% of household income, New Mexico had the greatest percentage of burdened homeowners (10%) while Louisiana had the greatest percentage of burdened renters (24%). (HUD, Comprehensive Housing Affordability Strategy, 2008-2012)
- The worst food insecurity in the United States is in our region. Arkansas, New Mexico, Oklahoma and Texas display the highest tier of percentages of households with food insecurity. Louisiana does not have a percentage in this upper tier. (USDA Economic Research Service, 2015)
- Carbon monoxide and volatile organic compounds (VOCs) were the two most emitted pollutants across all five states in 2011. Texas produced nearly 3 times more carbon monoxide and VOCs than the second highest producer in the region, Louisiana. Arkansas, Louisiana, New Mexico and Oklahoma produced comparable amounts of all five pollutants reported (CO, NOs, VOCs, PM and SO<sub>2</sub>). (Environmental Protection Agency, Air Emission Sources, 2015)

## Call to Action

The *Southwest Regional Health Equity Council's Blueprint* is a roadmap to new opportunities that address common concerns of committed individuals wanting to work together to improve health outcomes. This *Blueprint for Action* reveals ongoing and emerging challenges as well as signs of promise for improved health status and health equity. The population in our region is growing in diversity and in number. To



achieve health equity, how we communicate is fundamental. The SWRHEC recognizes that more interventions to strengthen the cultural and linguistic competencies of our health (care) workforce is essential. Both health/ medical organizations and the populations we serve must become more health literate. In doing so, they will optimize their time together that will result in improved comfort levels, improved communication and improved health outcomes. But, we must go beyond the healthcare setting and our personal behaviors.

We must seek to understand the communities where we live, work, learn and play. We must better understand and engage with our municipalities and other sectors of the community. Addressing the health of our communities must not be an afterthought but we literally must live and breathe by the decisions we make in our communities. Our built environment, schools, housing, public transportation and stores that provide healthy foods must be available, accessible and affordable for our communities to sustain themselves. We must invest in our schools, improve housing, integrate neighborhoods, create living wage jobs with career ladders and assure more equitable fiscal policies. We must pull together to address the root causes of our health inequities so we may persevere to see the health potential of all people maximized. Our future generations depend on us. The SWRHEC is primed to advocate for better policies that support positive health outcomes. The SWRHEC Blueprint identifies the growing racial and ethnic diversity of our people and the issue of health literacy in our region. We must take action! The SWRHEC must work in collaboration with other groups, coalitions, councils and others to implement strategies that support positive health outcomes. In so doing, we strongly recommend the following actions:

**Goal:** Enhancing Individual and Community Well-Being\*

**Objective:** The SWRHEC will launch a Health Literacy Campaign. The SWRHEC believes that health literacy levels can impact the quality of care by acting as a barrier to accessing health information, and ultimately functioning as a social determinant of health.

**Strategy:** The SWRHEC will promote evidence-based or best practice health literacy interventions: one targeting the patient, the other targeting the health provider.

Join us! Let's live healthier so all people can prosper to enjoy life.

*\*This goal is intentionally worded to align with the RWFJ "Culture of Health" Framework and the National Action Plan to Improve Health Literacy.*

## Introduction

The United States is among the richest countries in the world, yet disparities in health and healthcare continue to exist for many of its vulnerable populations. A health disparity refers to differences in access to or availability of facilities and services, and is a particular type of health difference that is closely linked to social or economic disadvantages. Health disparities adversely affect groups of people who have systematically experienced greater social, economic, and environmental obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health, cognitive, sensory, or physical disability; sexual orientation; gender identity, geographic location, historical trauma; or other characteristics historically linked to discrimination or exclusion. (U.S. Department of Health and Human Services, Office of Minority Health, 2011)

These persistent and pervasive health disparities carry a high societal burden in terms of the loss of valuable resources, such as financial capital, healthy children and families, and workforce capacity. If the nation addresses healthcare disparities, **health equity** can be achieved. **Health equity** is the attainment of the highest level of health for all people. (U.S. Department of Health and Human Services, Office of Minority Health, 2011) According to the U.S. Department of Health and Human Services, achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. In order to achieve health equity, we must be relentless in addressing health disparities.

Acknowledging that persistent health disparities are the manifestation and interplay of complex factors is critical to solving these problems. It is only as we develop a fuller understanding of the scope and magnitude of factors affecting health outcomes and evidence for what works to reduce disparities that the most effective advancement of appropriate policy and intervention strategies can occur. This will require the combined efforts of governments, academia, institutions, businesses, humanitarian/faith-based organizations, and individuals working across the entire spectrum of public, private, community, and individual enterprise.

**Social determinants of health** are the circumstances in which people are born, grow up, live, work and age, as well as the systems put in place to deal with illness (World Health Organization, 2015). Understanding social determinants of health is critical for devising strong public policy and action that promote health equity and the elimination of health disparities. A person's health is shaped by these circumstances, "including the health system," and "distribution of resources at global, national and local levels" (World Health Organization, 2015).

Access to health care, education, employment, the environment, food security and housing are examples of social determinants of health. There are powerful linkages between societal factors, health and health care. Much attention is being paid to the linkages between social and economic policies and their direct impact on the health and well-being of those who live, work, learn, and play under these policies. These linkages are further evidenced in the impact that social determinants have on health. Achieving health equity will require addressing the health of all groups and the impacts of all relevant policies on health care.

## Background

The mission of the National Partnership for Action to End Health Disparities (NPA) is to improve the effectiveness of programs that target the elimination of health disparities through coordination of partners, leaders, and stakeholders committed to action.

The NPA was launched to close the health gap for the nation’s racial, ethnic, and underserved communities. The vision for the NPA has been shaped by the voices of more than 5,000 individuals who shared their experiences and expertise through a series of regional conversations and meetings held by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH).

The driving force of the NPA is the conviction that a nationally based strategy is needed – one that relies on multiple layers of partnerships across sectors in order to leverage resources and talent. The NPA is the first national, multi-sector, community- and partnership-driven effort on behalf of health equity. The mission of the NPA is to increase the effectiveness of programs that target the elimination of health disparities through coordination of partners, leaders, and stakeholders committed to action.

## The National Stakeholder Strategy for Achieving Health Equity (NSS)

The National Stakeholder Strategy was developed through activities involving collaboration of stakeholders from across the country. Following the regional divisions established by the U.S. Department of Health and Human Services, each region is responsible for selecting strategies aligned with the NPA. To this end, the SWRHEC developed specific strategies and based its action plans on the NSS and five NPA goals (U.S. Department of Health and Human Services, Office of Population Affairs):

**Table 1: NPA Goals**

<b>Awareness</b>	Increase awareness of the significance of health disparities; their impact on the nation; and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations
<b>Leadership</b>	Strengthen and broaden leadership for addressing health disparities at all levels
<b>Health System and Life Expectancy</b>	Improve health and healthcare outcomes for racial, ethnic, and underserved populations
<b>Cultural and Linguistic Competency</b>	Improve cultural and linguistic competency and the diversity of the health-related workforce
<b>Data, Research, and Evaluation</b>	Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes

## Regional Movements

Region VI is comprised of the following states: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. With the intent to create sustainable growth and structure, the NSS is implemented through Regional Health Equity Councils (RHECs). The council members serve as leaders and catalysts to address health disparities in each region. The intent is for the RHECs to promote cross-sector collaboration, as each council comprises a diverse group of leaders and stakeholders from non-federal public and private sectors

from within that region. Examples of sectors represented on the RHEC include academia, community-based organizations, health systems, health insurers, state legislators, faith-based organizations, foundations, and state government organizations.

With one council for each of the 10 HHS regions, the RHECs play a critical role in coordinating and enhancing state and local efforts to address health disparities and social determinants of health. They also play a critical role in driving collective action at the regional level.

Upon its inception on September 9, 2011, the Region VI RHEC changed its name to the SWRHEC to reflect its location and the area in which members reside and serve. The SWRHEC is a voluntary multi-sector group that provides leadership for addressing health equity, ensures continuous dissemination of information, and galvanizes action to strengthen programs, policies, practices and services to achieve better health. The SWRHEC has paid particular attention to addressing cultural competence and social determinants of health to eliminate health disparities.

The SWRHEC is committed to coordinating action, enhancing collaboration, and strengthening partnerships to ensure that state, regional, and local community efforts are assessed, enhanced, and implemented to create health equity in this region. The purpose of the SWRHEC is to provide a forum for various sectors represented to do the following:

- Promote collaboration between states on health issues that impact minority populations and disparate groups.
- Utilize resources from various organizations that promote the elimination of health disparities.
- Convene regional stakeholders and partners to address regional health disparity issues and advance responsive action.

## **Regional Blueprint for Action**

In alignment with the National Stakeholder Strategy, RHECs have utilized stakeholder input to develop Regional Blueprints. While the Blueprints embody the goals and priorities of the NSS, they are tailored to reflect regional priorities, build on existing strengths, and address existing gaps. Concrete and actionable, the Blueprints guide the Councils' work to implement and monitor collaborative strategies to address the NPA's goal to end health disparities in their region. The intention of the Blueprint is to encourage stakeholders to identify and implement strategies and actions most important for their communities. The Blueprints will be living documents that are updated periodically as the SWRHEC evolves.

The SWRHEC has developed this Blueprint for Action to highlight regional challenges and opportunities. This Blueprint will demonstrate why the RHEC is pursuing particular priorities and show the extent of health disparities throughout the region.

## **Regional Context**

### **Regional Strengths, Opportunities, and Challenges**

Region VI faces key regional challenges and opportunities in relation to demographics and geographic distribution, health and healthcare disparities, and the impact of specific social determinants of health. However, existing strengths within Region VI can help us drive strong public policy and action that promote health equity and the elimination of health disparities.

## **Regional Strengths**

- Council members have broad and deep expertise in program development, community partnerships, and program evaluation as well as knowledge in health-related policy.
- Region VI has diverse and excellent leadership and representation from various state and community levels.
- A diversity of colleagues are interested in working toward the elimination of ethnic and racial health disparities.
- Rural, border and frontier communities have a strong sense of self-reliance and cooperation. Tapping into these natural community resources will help mobilize individuals and communities to support one another, reduce health disparities and improve health status.

## **Overarching Strengths**

- The region's overarching strengths lie in the Council's content expertise, engaged leadership, diversity of colleagues committed to reducing disparities and the region's unique rural, border and frontier attributes of self-reliance and cooperativeness.

## **Regional Opportunities**

While the overall intent of this Blueprint is to identify areas of challenge and health disparities, it has also created a host of opportunities for thinking about how to address these issues and their associated disparities. The Blueprint provides an opportunity to:

- Set benchmarks and measurable outcomes to show outcomes (versus outputs) and influence policy change through policy briefs, information and advocacy to advance health equity.
- Fund and conduct research that could give us a better understanding of the immigrant population needs, particularly in the areas of health literacy, preventive health education, family influence on health, family planning and more.
- Continue to work in the area of health equity and the disparities most prevalent in communities.
- Recruit new and additional expertise to the Council.
- Utilize, train, expand and pay paraprofessionals, clients and other community members to help one another as peers and reduce reliance on professionals due to shortages, high caseloads, limited patient time, and lack of bilingual and bicultural staff.
- Tap into community assets who speak diverse languages, speak in layperson language, are knowledgeable of the local cultures and help to seek patterns.
- Bring the community's expertise to bear on health planning and community leadership and optimize their skills, assets and strengths by training them as health navigators, interpreters and community health coaches.

## **Regional Challenges**

Recognizing and understanding the role and impact that social determinants of health have on health outcomes, SWRHEC has critically examined the factors that influence health behaviors and outcomes. It is

imperative that we identify underlying and cross-cutting issues that greatly influence our populations to effectively address health equity and social determinants of health. Such challenges have been addressed with a variety of methods and by a plethora of organizations, but it will take a collective effort to make the great gains needed for sustainable improvements. This Blueprint has outlined the issues and health disparities that make this region unique. These challenges are summarized below:

- LGBTQIA<sup>1</sup> voices are often absent or excluded when communities talk about health disparities even within their own respective communities. While it includes race and ethnicity, it often leaves out people experiencing intersecting oppressions or multiple instances of oppression.
- Diversity and priorities for each state: Medicaid expansion did not take place in all states to create greater access to health care. Rural and border geographical areas lack finances and other resources, including workforce shortages.
- No unified strategy has been developed to address health disparities and health equity issues that are common to all SWRHEC states. This gap makes it difficult to attain collective impact across the region.
- The large influx of immigrants from Mexico is challenging the region. States are responding differently to the demands on services and capacity.
- The increasing complexity of health systems has made it more difficult for individuals to use health care, understand insurance plans, find help when needed, and navigate more simply.

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<sup>1</sup> LGBTQIA is an acronym for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual



## Demographics and Geographic Distribution

Below is information about projected population size by race and ethnicity for states in the Southwest Region. These tables examine the expected growth of each racial and ethnic group over the next 25 years (e.g., White, Black/African American (AA), Asian, Hispanic/Latino and other).

### Demographics

#### Indicator: Population projections, minority to majority status by 2040

##### Race Projections

Today, the populations of both Texas and New Mexico can be classified as the majority-minority. Over the next 25 years, Region VI is projected to be majority-minority in which people of color will exceed 50% (see Table 2). It is projected that all Region VI states will experience a significant increase in Native Americans and Hispanic/Latinos.

**Table 2: Population Projections by Race, 2020-2040**

Location	Year	White	Black/African American	Asian	Other
Arkansas	2020	2,333,545	503,685	49,062	234,432
	2030	2,399,902	555,475	60,908	295,736
	2040	2,429,918	597,492	70,208	368,041
Louisiana	2020	2,817,040	1,526,318	88,129	203,585
	2030	2,779,881	1,596,606	102,277	239,372
	2040	2,709,000	1,649,657	111,542	281,317
New Mexico	2020	1,510,877	48,510	37,610	710,563
	2030	1,581,436	53,973	45,826	864,035
	2040	1,606,713	57,860	51,805	1,035,760
Oklahoma	2020	2,752,581	304,392	85,305	844,678
	2030	2,758,337	327,144	102,367	1,017,639
	2040	2,705,256	341,705	113,951	1,215,795
Texas	2020	19,443,865	3,428,502	1,304,773	4,560,973
	2030	20,928,311	3,830,782	1,613,517	5,821,595
	2040	21,952,076	4,153,701	1,853,595	7,291,459

Source: University of Virginia, Weldon Cooper Center for Public Service,

<http://www.coopercenter.org/demographics/national-population-projections>,

[http://www.coopercenter.org/sites/default/files/node/13/National ProjectedRaceDistribution 2020-2040 FINAL v.2.0.xls](http://www.coopercenter.org/sites/default/files/node/13/National%20ProjectedRaceDistribution%202020-2040%20FINAL%20v.2.0.xls)

### Ethnicity (Hispanic/Latino) Projections

Hispanics/Latinos are the largest ethnic group in New Mexico. This trend will continue through 2040 when more than 60% of the state’s population will identify as Hispanic. By 2040, Texas is projected to be predominantly Hispanic in ethnicity as well, while Arkansas, Louisiana and Oklahoma are projected to remain predominately non-Hispanic by 2040. Hispanic ethnicity in these states will comprise between 5% and 20% of the overall population (see table 3).

**Table 3: Population Projections by Ethnicity, 2020-2040**

Location	Year	Non-Hispanic	Hispanic/Latino
Arkansas	2020	2,857,120	263,605
	2030	2,958,492	353,530
	2040	3,013,170	452,488
Louisiana	2020	4,389,341	245,731
	2030	4,418,340	299,797
	2040	4,396,252	355,263
New Mexico	2020	1,112,937	1,194,624
	2030	1,096,633	1,448,637
	2040	1,049,768	1,702,372
Oklahoma	2020	3,526,584	460,372
	2030	3,597,706	607,781
	2040	3,611,004	765,703
Texas	2020	16,182,786	12,555,326
	2030	16,318,999	15,875,206
	2040	16,024,060	19,226,772

Source: University of Virginia, Weldon Cooper Center for Public Service,  
<http://www.coopercenter.org/demographics/national-population-projections>,  
[http://www.coopercenter.org/sites/default/files/node/13/National\\_ProjectedEthnicityDistribution\\_2020-2040\\_FINAL\\_v.2.0.xls](http://www.coopercenter.org/sites/default/files/node/13/National_ProjectedEthnicityDistribution_2020-2040_FINAL_v.2.0.xls)

## American Indian/Native American Population

Based on the 2013 American Community Survey, 9.2% of New Mexico's population in 2013 and 8.7% of the population in 2014 identified as American Indian or Native American. This population represents 23 Federally Recognized Tribes, nations, urban off-reservation populations, and 19 pueblos throughout the state: Acoma, Cochiti, Isleta, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo/ Kewa, Taos, Tesuque, Jemez, Zia, Zuni, Navajo Nation, Mescalero Apache Tribe, Jicarilla Apache Nation, and Fort Sill Apache Tribe of Oklahoma. (American Fact Finder, 2015)

In 2014, 8.7% of New Mexico's population identified as American Indian or Native American representing 23 federally recognized tribes, pueblos, and nations including: 19 pueblos—Acoma, Cochiti, Isleta, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo/Kewa, Taos, Tesuque, Jemez, Zia, Zuni; The Navajo Nation; The Mescalero Apache Tribe; The Jicarilla Apache Nation; The Fort Sill Apache Tribe of Oklahoma, as well as urban off-reservation populations, throughout the state. (American Fact Finder, 2015)

Oklahoma's American Indian/Alaska Native population represents 9.0% of the state population. The state is home to 38 Federally Recognized Tribes: Absentee-Shawnee Tribe of Indians, Alabama-Quassarte Tribal Town, Apache Tribe, Caddo Nation of Oklahoma, Cherokee Nation, Cheyenne-Arapaho Tribes, Chickasaw Nation, Choctaw Nation of Oklahoma, Citizen Potawatomi Nation, Comanche Nation, Delaware Nation, Delaware Tribe of Indians, Eastern Shawnee Tribe of Oklahoma, Fort Sill Apache Tribe of Oklahoma, Iowa Tribe of Oklahoma, Kaw Nation, Kialegee Tribal Town, Kickapoo Tribe of Oklahoma, Kiowa Indian Tribe of Oklahoma, Miami Tribe of Oklahoma, Modoc Tribe of Oklahoma, Muscogee (Creek) Nation, Osage Tribe, Ottawa Tribe of Oklahoma, Otoe-Missouria Tribe of Indians, Pawnee Nation of Oklahoma, Peoria Tribe of Indians of Oklahoma, Ponca Tribe of Indians of Oklahoma, Quapaw Tribe of Indians, Sac & Fox Nation, Seminole Nation of Oklahoma, Seneca-Cayuga Tribe of Oklahoma, Shawnee Tribe, Thlopthlocco Tribal Town, Tonkawa Tribe of Indians of Oklahoma, United Keetoowah Band of Cherokee Indians in Oklahoma, Wichita and Affiliated Tribes (Wichita, Keechi, Waco and Tawakonie), and Wyandotte Nation.

Texas has 1.0% of its population that identified as American Indian or Alaska Native. The three Federally Recognized Tribes in the state are the Alabama-Coushatta Tribes, Kickapoo Traditional Tribe of Texas, and Ysleta Del Sur Pueblo of Texas.

In Louisiana, 0.8% of the population is American Indian/Alaska Native. The four Federally Recognized Tribes in the state are the Chitimacha Tribe of Louisiana, Coushatta Tribe of Louisiana, Jena Band of Choctaw Indians, and Tunica-Biloxi Indian Tribe of Louisiana.

## Disparities in Health Outcomes

While medical care in the United States is among the best in the world, access to quality, affordable health care and preventive care is not consistent across the country. Individuals and families in Region VI may live in an area with a shortage of doctors, not have health insurance, or receive a lower quality of care because of stereotyping, language barriers, or poor health literacy. Disparities in health care further exacerbate disparities in health. It is hard to manage a chronic disease, such as asthma or diabetes, without a doctor nearby or health insurance coverage.

Some of the most **critical health and healthcare disparities** faced in Region VI include<sup>2</sup>:

- Adult obesity
- Diabetes
- Level of physical activity
- Infant mortality
- Influenza vaccination

## Health Burdens

**Indicator: Adult Obesity** (mapped with Adult Physical Activity and Diabetes; see below)

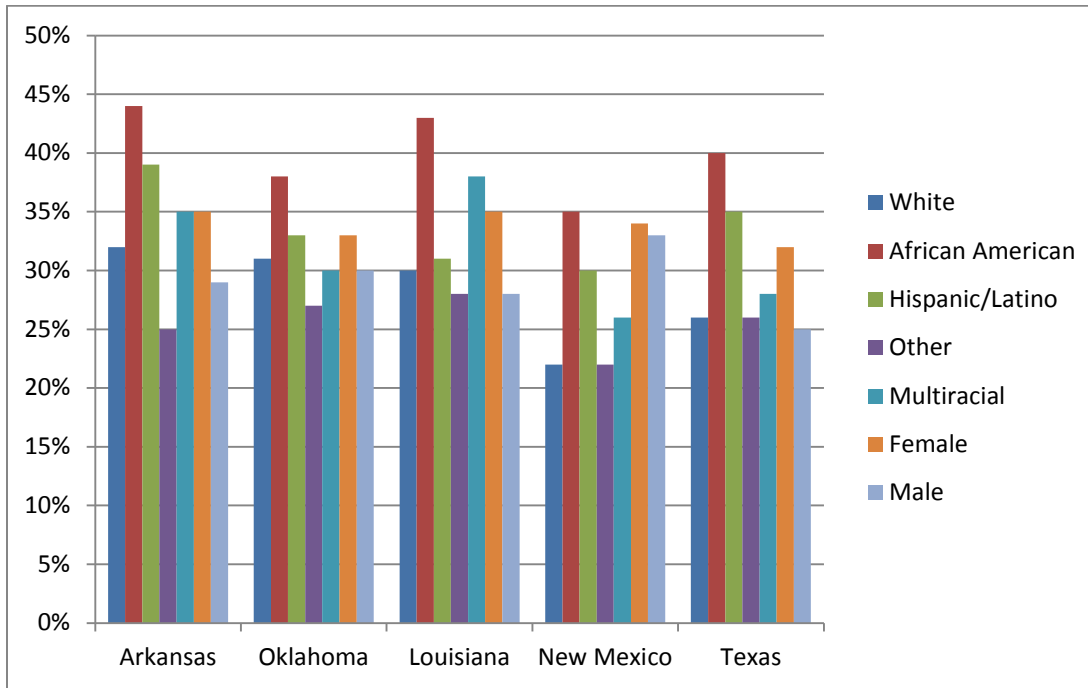
Adult obesity is defined as having a higher weight than what is considered healthy for a given height. Physicians examine an individual's body mass index (BMI) to determine whether an individual is obese. Obese individuals are those with a BMI of 30 or higher (Centers for Disease Control and Prevention, 2012). Obesity rates are influenced by various factors, including level of physical activity and access to adequate nutrition. Obesity impacts the quality of life of an individual because it increases the risk of conditions such as heart disease and strokes.

The following data show that all states in the region experienced obesity rates higher than the national benchmark of 28.1%. Louisiana had the highest percentage of adults who were overweight or obese in 2012. Arkansas had the second highest percentage of adult obesity in the region, followed by Oklahoma and Texas. We are also able to see that racial disparities exist in the region, especially when it comes to obesity rates among African Americans and Hispanics/Latinos.

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<sup>2</sup> Note that a previous review identified the following health outcomes as the poorest in Region VI (CDC Sortable Stats) relative to other HHS regions (ranked 9 or 10 of 10).

**Figure 1: Adult Obesity Rates By Race and Gender for States in Region VI**



Source: CDC Sortable Facts

**Indicator: Diagnosed Diabetes**

(Mapped with Adult Physical Activity and Adult Obesity; see below)

Diabetes is a disease in which blood glucose levels are above normal (CDC). Diabetes can cause serious health complications such as heart disease, blindness and kidney failure. Figure 1 above shows that the region experienced variations in rates of diabetes diagnosis. Louisiana had the highest percentage of people diagnosed with diabetes in 2012, which coincides with its historically low physical activity rates and high incidence of obesity. Oklahoma had the second highest percentage of people diagnosed with diabetes, followed by Arkansas and Texas. New Mexico had the lowest percentage of people diagnosed with diabetes in 2012, which coincides with its historically high rates of rates of physical activity and low incidence of obesity. Currently, the CDC notes that 29.1 million people (or 9.3% of the U.S. population) have diabetes (Centers for Disease Control and Prevention, 2014).

Table 4 below shows that African Americans experienced consistently high rates of diagnosed diabetes in the region. Hispanics/Latinos had the second highest percentage of diagnosed diabetes in New Mexico (11.6%) and Texas (11.6%), and relatively low percentages in Louisiana and Oklahoma. No rate was reported for Hispanics/Latinos in Arkansas. Whites (11.2%) had the second highest percentage of diagnosed diabetes in Louisiana, the third highest percentage in Oklahoma and Texas, and the third highest rate in Arkansas and New Mexico.

**Table 4: Diagnosed Diabetes rates in region VI according to race and gender, 2012**

Location	Total	White	African American	Hispanic/Latino	Native American	Asian/Pacific Islander	Female	Male
Arkansas	11.3	10.6	14	N/A	N/A	N/A	11.7	10.9
Louisiana	12.3	11.2	14.8	8.6	N/A	N/A	12.7	11.8
New Mexico	10.3	7.9	N/A	11.6	N/A	N/A	9.9	10.7
Oklahoma	11.5	11.6	12.3	7.6	N/A	N/A	10.6	12.3
Texas	10.6	9.5	14.4	11.6	N/A	N/A	10.3	11

Source: CDC Sortable Stats

## Indicator: Infant Mortality

The infant mortality rate (IMR) is a measure of the number of infant deaths for every 1,000 live births<sup>3</sup>. Infant mortality is often caused by preterm births, birth defects, maternal health conditions and the lack of health care access to address high risk pregnancies (CDC, 2011). By examining the IMR, we can also gain a glimpse into the health and well-being of communities because the same conditions that factor into how people live, learn, work, and play can also impact the mortality rate of infants.

### 2000-2011 State Trends

Louisiana consistently had the highest IMR in the region over the period from 2000 to 2011 (see table 5 below). New Mexico and Texas have traded off having the lowest rates in the region over the period of time observed. New Mexico's rate has shown the greatest decrease over the period of time observed, dropping by 1.3 infant deaths per 1,000 live births. Texas was the only state to show an overall increase in the IMR over the period observed, rising from 5.6 in 2000 to 5.7 in 2011. Arkansas and Oklahoma displayed comparable rates over the period observed with both states fluctuating between 7 and 9 infant deaths per 1,000 live births.

Between 2011 and 2013, some of these trends began to shift (see table 6 below). For this period, Oklahoma had the highest IMR, while New Mexico and Texas continued to have lower rates than other states in the region.

### 2011 State Rates

<sup>3</sup> Centers for Disease Control and Prevention, CDC Health Disparities and Inequalities Report – United States, 2011, <http://www.cdc.gov/minorityhealth/CHDIR/2011/FactSheets/InfantDeath.pdf> Accessed March 1st, 2016.



Louisiana had the highest IMR in 2011, followed by Arkansas and Oklahoma. New Mexico had the lowest IMR in 2011, followed closely by Texas. A gap between the rates for Texas and Oklahoma clearly separated the top three from the bottom two.

### 2011 Ethnicity Rates

Rates for Native Americans and Asians were the least reported due to raw numbers of infant deaths being too low for these racial categories. African Americans had the highest IMR across all 5 states in 2011. Whites and Hispanics/Latinos had comparable rates across all 5 states, but the IMRs never rose above 7.4 infant deaths per 1,000 live births. The IMR for Native Americans was the second highest in New Mexico and Oklahoma.

**Table 5: Infant Mortality Rates, 2011 by Race/Ethnicity**

Location	Total	White	African American	Hispanic/Latino	Native American	Asian/Pacific Islander
Arkansas	7.4	6.9	11.5	4.7	N/A	N/A
Louisiana	8.2	6.2	9.5	N/A	N/A	N/A
New Mexico	5.4	3.8	12.1	5.1	7.8	N/A
Oklahoma	7.2	6.2	15.4	7.4	7.5	N/A
Texas	5.7	5.2	12	4.6	N/A	3.2

Source: CDC Sortable Stats

**Table 6: Infant Mortality Rates 2011-2013**

Location	Total	White	African American	Hispanic/Latino	Native American	Asian/Pacific Islander
Arkansas	7.9	6.7	10.9	6.2	N/A	N/A
Louisiana	8.7	6.2	12.0	4.8	N/A	6.4
New Mexico	5.3	5.2	N/A	6.1	5.9	N/A
Oklahoma	6.7	6.5	12.5	6.5	7.0	7.6
Texas	5.8	5.1	10.7	5.3	N/A	3.8

Source: <http://kff.org/other/state-indicator/infant-mortality-rate-by-race-ethnicity/>

### Key Findings:

- Following a plateau from 2000 through 2005, the U.S. infant mortality rate declined 12% from 2005 through 2011. Declines for neonatal and post-neonatal mortality were similar<sup>4</sup>.
- From 2005 through 2011, infant mortality declined 16% for non-Hispanic black women and 12% for non-Hispanic white women<sup>5</sup>.
- Infant mortality declined for four of the five leading causes of death during the 2005–2011 period: congenital malformations, short gestation/LBW, SIDS, and maternal complications<sup>6</sup>.
- Infant mortality rates declined most rapidly among some, but not all, Southern states from 2005 through 2010. Despite these declines, states in the South still had the highest rates in 2010. Rates were also high in 2010 in some states in the Midwest.

## Healthcare service and public health indicators

### Indicator: Influenza Vaccination

The CDC Advisory Committee on Immunization Practices (ACIP) recommends an annual flu shot for everyone over the age of 6 months to prevent the spread of the flu through communities, especially to those who are vulnerable to contracting the flu. The most at-risk populations include older individuals over the age of 65 and persons whose immunity could be compromised. Racial and ethnic disparities exist in flu vaccination rates in Region VI. Some explanations for this include ‘barriers to access such as cost, insurance status, and language differences’<sup>7</sup>.

#### State Trends

No state in Region VI was consistently the highest in terms of flu vaccination rates for the four flu seasons observed. Texas was the only state to have a vaccination rate lower than that of the U.S. All other states had rates above that of the U.S. Arkansas was the only state to experience an overall decrease in its flu vaccination rate over the period observed with a decrease of 5.1% over the four flu seasons. All other states experienced an overall increase to some degree over the period observed (see figure 3).

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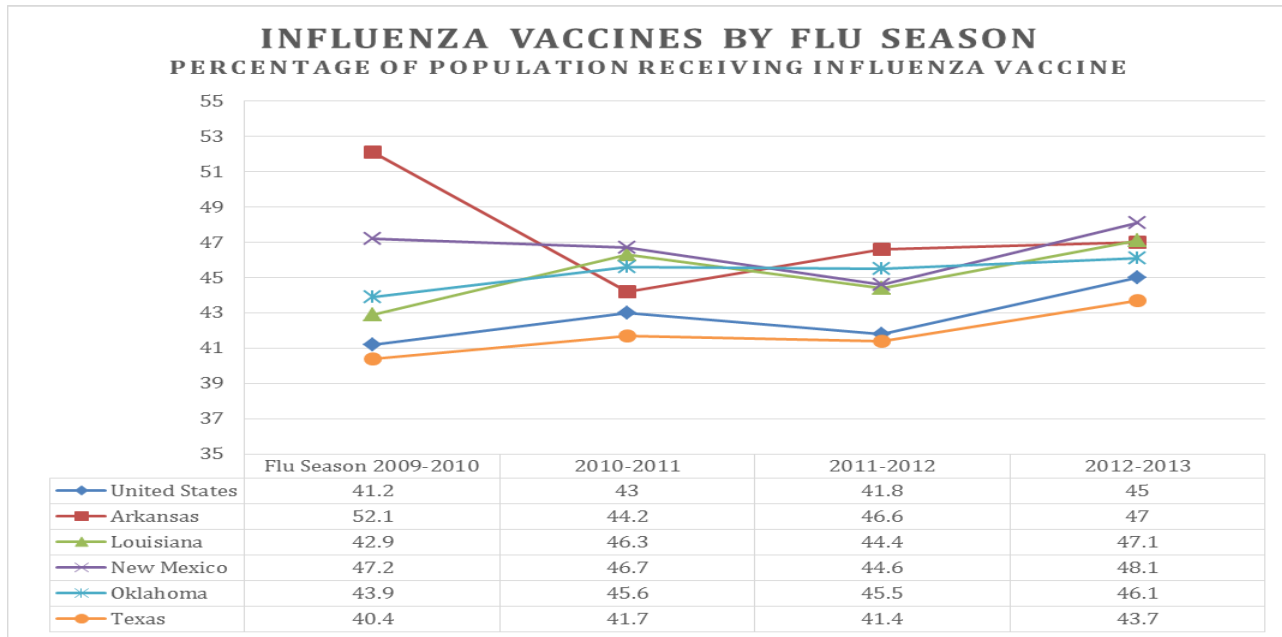
<sup>4</sup> [Recent Declines in Infant Mortality in the United States](http://www.cdc.gov/nchs/data/databriefs/db120.pdf), 2005-2011. NCHS Data Brief, No. 120. April 2013.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Logan JL. Disparities in influenza immunization among US adults. *J Natl Med Assoc.* 2009 Feb; 101(2):161-6.

**Figure 3: Influenza Vaccines by Flu Season**

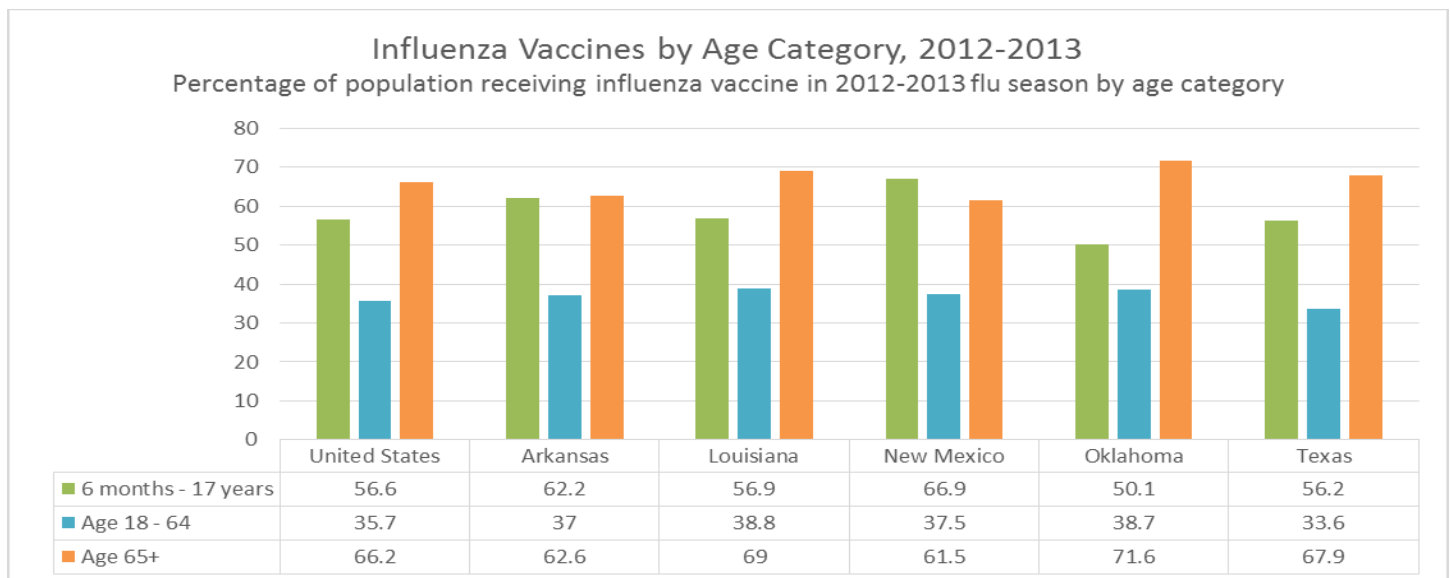


Source: CDC Sortable Stats

**Age trends for 2012-13 Flu season**

The 18-64 age category consistently had the lowest flu vaccination rates for all five states and the U.S. In Arkansas, Louisiana, Oklahoma, Texas and the U.S., the 65+ age category had the highest flu vaccination rates. In New Mexico, the 6 month-17 age category had the highest flu vaccination rates. (See figure 4)

**Figure 4: Influenza Vaccination by Age Category, 2012-2013**

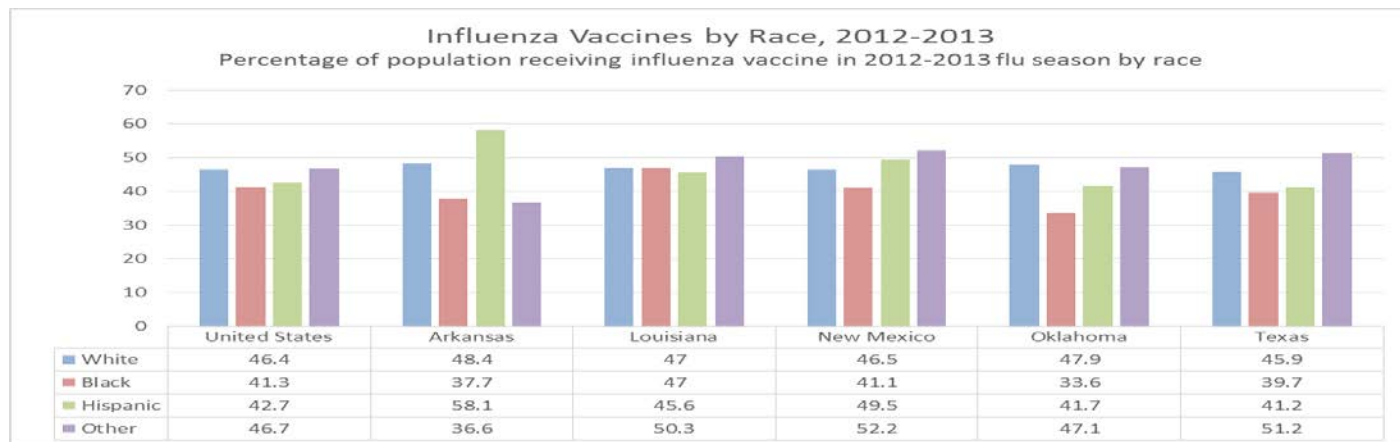


Source: CDC Sortable Stats

**Race/Ethnicity Trends for 2012-13 Flu Season**

Figure 5 shows that African Americans had the lowest flu vaccination rates in Region VI states and the U.S. The **exception**: African Americans in Arkansas had the second lowest flu vaccination rates, while the “other” racial category had the lowest. In Louisiana, New Mexico, Texas and the U.S., the “other” racial category had the highest flu vaccination rates. Whites consistently had the highest flu vaccination rates in the region and the U.S. The **exception**: Whites had the second lowest rates in New Mexico. Hispanics/Latinos had the highest flu vaccination rates in Arkansas, but the rates were comparable to other racial categories in other states. With the exception of Arkansas, rates for all racial categories were fairly comparable across Region VI states and the U.S.

**Figure 5: Influenza Vaccination by Race, 2012-2013**



Source: CDC Sortable Stats, <http://sortablestats.cdc.gov/#/indicator>

## Health Behaviors

**Indicators: Adult Physical Activity** (mapped with Adult Obesity and Diabetes; see below)

According to the CDC, regular physical activity helps to improve overall health and reduce the risk for many chronic diseases<sup>8</sup>. People who are physically active “live longer and have lower risks for heart disease, stroke, type 2 diabetes, depression, and some cancers”<sup>9</sup>.

<sup>8</sup> Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Physical Activity Basics, <http://www.cdc.gov/physicalactivity/basics/index.htm> . Accessed March 1st, 2016

<sup>9</sup> Ibid.

### 2001-2011 State Trends

New Mexico consistently had the highest percentage of physically active adults in the region from 2001 to 2011. Louisiana frequently had the lowest percentage of physically active adults in the region. All states experienced an overall increase in percentages of physically active adults from 2001 to 2011. Louisiana experienced the greatest overall increase in this time, rising by 6.6%. Arkansas experienced the smallest overall increase in this time, rising by only 0.5%.

### Indicator: Youth Physical Activity

Similar to physical activity in adults, youth physical activity is linked to overall well-being and health, and can lower the risk of diseases such as obesity and diabetes<sup>10</sup>.

### 2003-2012 State Trends

All states experienced an overall increase in their percentages of children engaging in at least 20 minutes of daily physical activity from 2003 to 2012. Oklahoma experienced the greatest overall increase during this time, with its rate rising by 5.2%. Texas experienced the smallest overall increase during this time, with its rate rising by only 1.1%.

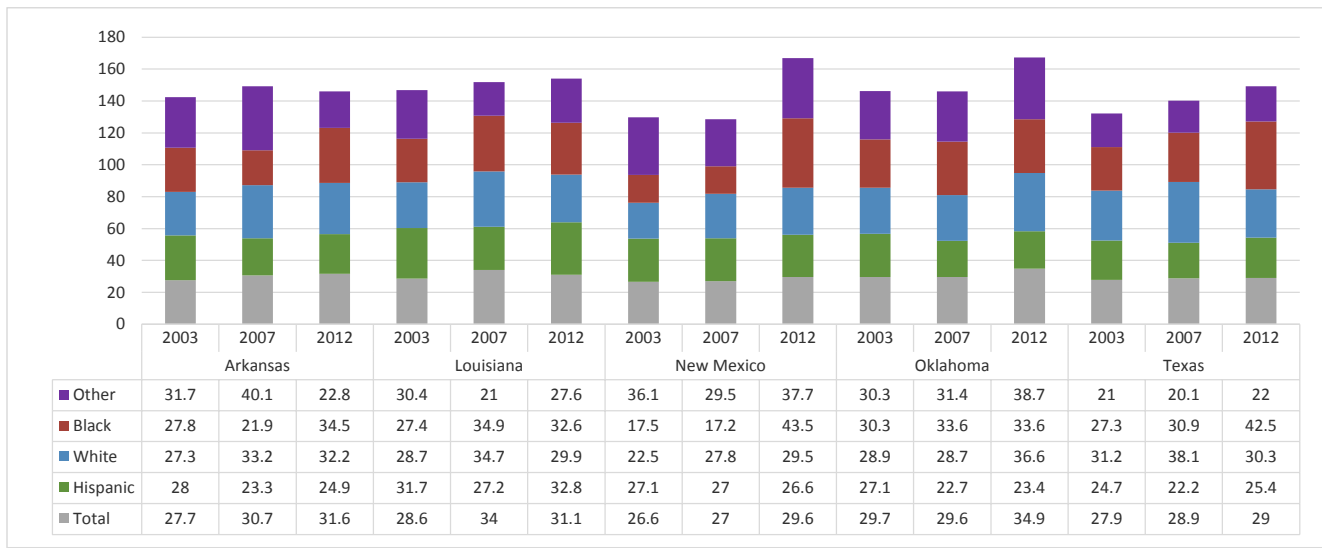
### 2003-2012 State/Ethnicity Rates

Figure 6 below shows that Hispanics/Latinos consistently had rates of childhood activity that were below 30%, whereas both Whites and African Americans frequently had rates above 30%. Hispanics/Latinos have had overall lower rates than those of the other racial categories reported. African Americans and Whites often traded their relative position temporally and spatially. Whites had the highest percentage of youth physical activity at some times in states, while African Americans had the highest percentage at other times. The racial category labeled "Other" experienced wide variation in its percentage of youth physical activity and its position relative to the other racial categories reported. For this reason, it is difficult to establish an overall trend for this undifferentiated group.

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<sup>10</sup> Ibid.

**Figure 6: Percent of Children Engaging in at Least 20 Minutes of Daily Physical Activity by Race/Ethnicity**

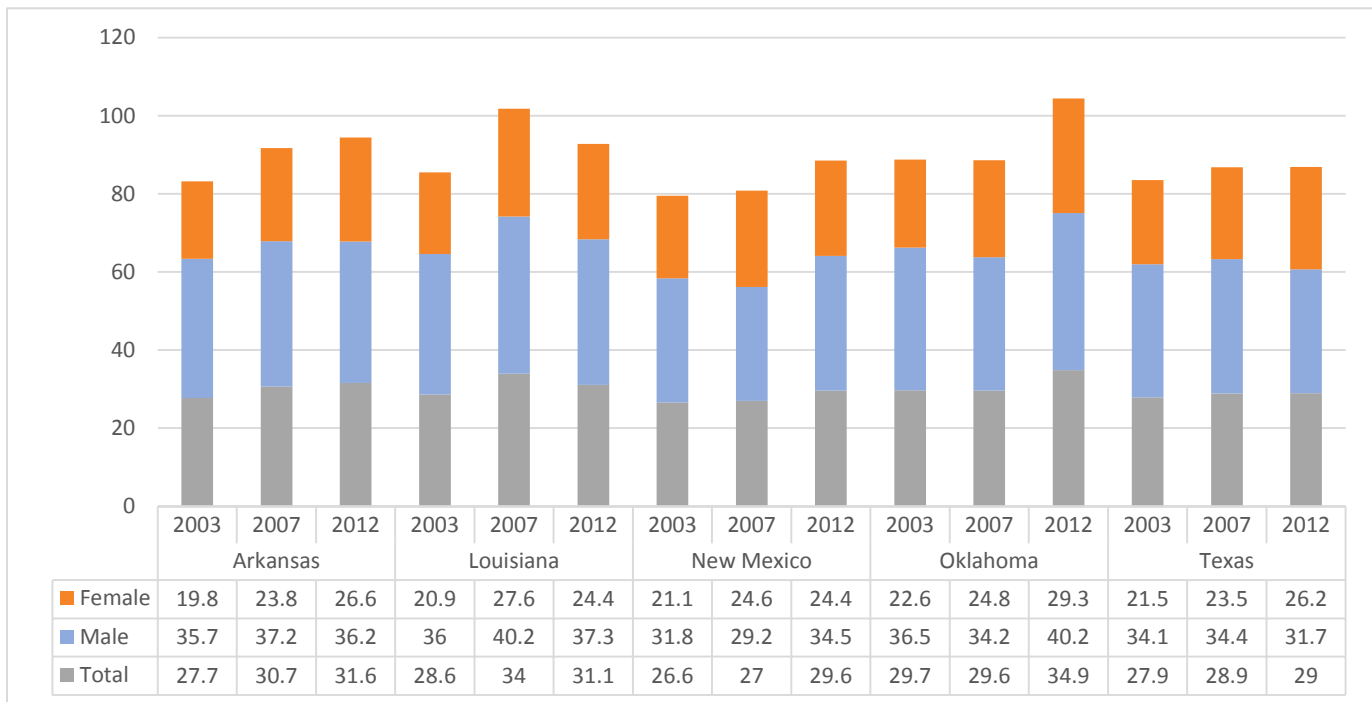


Source: National Survey of Children's Health, Data Resource Center for Child & Adolescent Health, <https://childhealthdata.org/>

### 2003-2012 Gender Rates

Figure 7 shows that for years 2003 -2011, females had lower rates of youth physical activity compared to males. The data also show a steady decrease in the percent difference between males and females since 2003.

**Figure 7: Percent of Children Engaging in at Least 20 Minutes of Daily Physical Activity by Gender**



Source: National Survey of Children's Health, Data Resource Center for Child & Adolescent Health, <https://childhealthdata.org/>



The importance of daily physical activity among children cannot be understated. Physical activity in childhood has been linked to healthy growth, maintenance of energy balance, a healthy weight and mental well-being (Tanha, 2011). However, data from figure 7 above indicate that across all five states in Region VI, male children are engaging more in physical activity than female children.

## Death Rates

### Indicator: Heart Disease Death Rates

According to the CDC, heart disease is the leading cause of death for men and women. Although rates for all five states decreased steadily over the period from 2000 to 2011, table 7 below indicates that Oklahoma consistently has had the highest rates of heart disease-related death over the time period observed. New Mexico consistently has had the lowest rates of heart disease-related deaths over the time period observed.

In Arkansas, Louisiana, Oklahoma and Texas, African Americans had the highest rates of heart disease-related deaths among all racial categories in 2011. Native Americans experienced the greatest variability in the rates across the 5 states in 2011: the second highest rate in Oklahoma and the lowest rate in Texas. Asians consistently had the lowest comparative rates across all five states. Heart disease-related death rates for Whites were consistently among the highest in all five states.

**Table 7: Heart Disease Death Rates, 2011-2013 by Race/Ethnicity and Gender<sup>11, 12</sup>**

Location	Total	White	African American	Hispanic/Latino	Native American	Asian/Pacific Islander	Female	Male
Arkansas	215.4	213.6	262.1	77.4	71.3	117.5	169.80	274
Louisiana	213.1	208.6	241.7	75.7	102.8	78.6	171.6	273.3
New Mexico	148.3	156.5	170.3	137.7	116.3	81.5	109.9	182.4
Oklahoma	225.8	227	259.2	113.4	244.2	99.3	184.4	280.3
Texas	171.4	179.2	222	137.8	59.7	89.5	134.4	213.9

Source: CDC Sortable Stats

<sup>11</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention. Heart Disease Fact Sheet, released 2015.  
[http://www.cdc.gov/dhdsp/data\\_statistics/fact\\_sheets/fs\\_heart\\_disease.htm](http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm) Accessed on Feb 20th, 2016.

<sup>12</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention. Heart Disease Fact Sheet, released 2015.  
[http://www.cdc.gov/dhdsp/data\\_statistics/fact\\_sheets/fs\\_heart\\_disease.htm](http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm) Accessed on Feb 20th, 2016.

Table 7 above shows that three of the five Region VI states (Arkansas, Louisiana and Oklahoma) have heart disease death rates that are higher than the national death rate of 173.7 deaths per 100,000 individuals. Native Americans in Oklahoma have a heart disease death rate that is 48% higher than the national death rate in the U.S. Similarly, Asians in Arkansas have a heart disease death rate that is 39% higher than the national death rate for Asians. With the exception of New Mexico, African Americans in Region VI have heart diseases death rates above the national death rate of 219.3 per 100,000 African Americans in the U.S.

In terms of gender, Oklahoma has the highest heart disease death rates for both males and females (33% and 32%, respectively, above national death rates).

## Social Determinants of Health

The World Health Organization (WHO) defines social determinants of health as conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. Social determinants of health are primarily responsible for health inequities defined as “unfair and avoidable differences in health status seen within and between countries” (World Health Organization, 2015). Figure 8 highlights the nine social determinants of health within Region VI.

**Figure 8: Social Determinants of Health in Region VI**



In an effort to achieve health equity, it is important that we take a closer look at social determinants of health and their impact on health and health outcomes of individuals in Region VI. The following is a discussion on nine social determinants of health in Region VI.

## Economic

Economic conditions in which individuals live, work and play not only contribute to health disparities, but also have negative impacts on achieving health equity. According to Healthy People 2020, individuals with greater income and social status experience better health and health outcomes. There are five indicators that provide information on the economic well-being of individuals in Region VI: income inequality, median hourly wage, unemployment, neighborhood poverty, job growth and loss and the minimum wage. The Gini Coefficient measures “the amount of the extent to which the distribution of income (or, in some cases, consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution” (World Bank). In the last two decades, the Gini Coefficient has increased from 0.4 in 1980 to 0.47 in 2012. These data show that income inequality has increased.

### Indicator: Median Hourly Wage

Tables 8, 9 and 10 below show that while there has not been any significant change in median hourly wages across all races since 1990, data from 1990, 2000 and 2012 consistently shows that whites continue to have a higher median hourly wage compared to other races. For example, the median hourly wage in Louisiana has not increased for Black/African American workers since 1990 and decreased by \$2 for Native American workers in 2012. The most recent data from 2012 (Table 10) show that in 2012, the median wage for Black workers was \$7 less than that of white workers. This trend is similar in Arkansas, New Mexico, Oklahoma and Texas where Blacks/African American workers earn \$3-\$5 less than white workers. Data from 2012 (Table 10) also show that Hispanic/Latino workers have the lowest median hourly wages in Region VI and earn \$5-\$9 less than white workers in all Region VI states.

**Table 8: Median Hourly Wage (USD) by Race 1990**

Location	All	White	People of Color <sup>13</sup>	Black/African American	Hispanic/Latino	Native American	Asian
Arkansas	16	16	13	13	12	15	N/A
Louisiana	18	19	13	13	16	14	16
New Mexico	18	21	15	16	14	17	19
Oklahoma	18	18	16	16	14	15	18
Texas	19	21	15	16	14	17	19

<sup>13</sup> People of color - The share of the population that does not identify as non-Hispanic white, [http://nationalequityatlas.org/indicators/People\\_of\\_color](http://nationalequityatlas.org/indicators/People_of_color)

Table 9: Median Hourly Wage (USD) by Race 2000

Location	All	White	People of Color	Black/AA	Hispanic/Latino	Native American	Asian
Arkansas	16	17	13	14	12	16	15
Louisiana	18	20	14	13	16	18	18
New Mexico	18	20	16	17	15	15	20
Oklahoma	17	18	15	15	13	15	17
Texas	19	22	16	17	14	19	22

Source: <http://nationalequityatlas.org/indicators>

Table 10: Median Hourly Wage (USD) by Race 2012

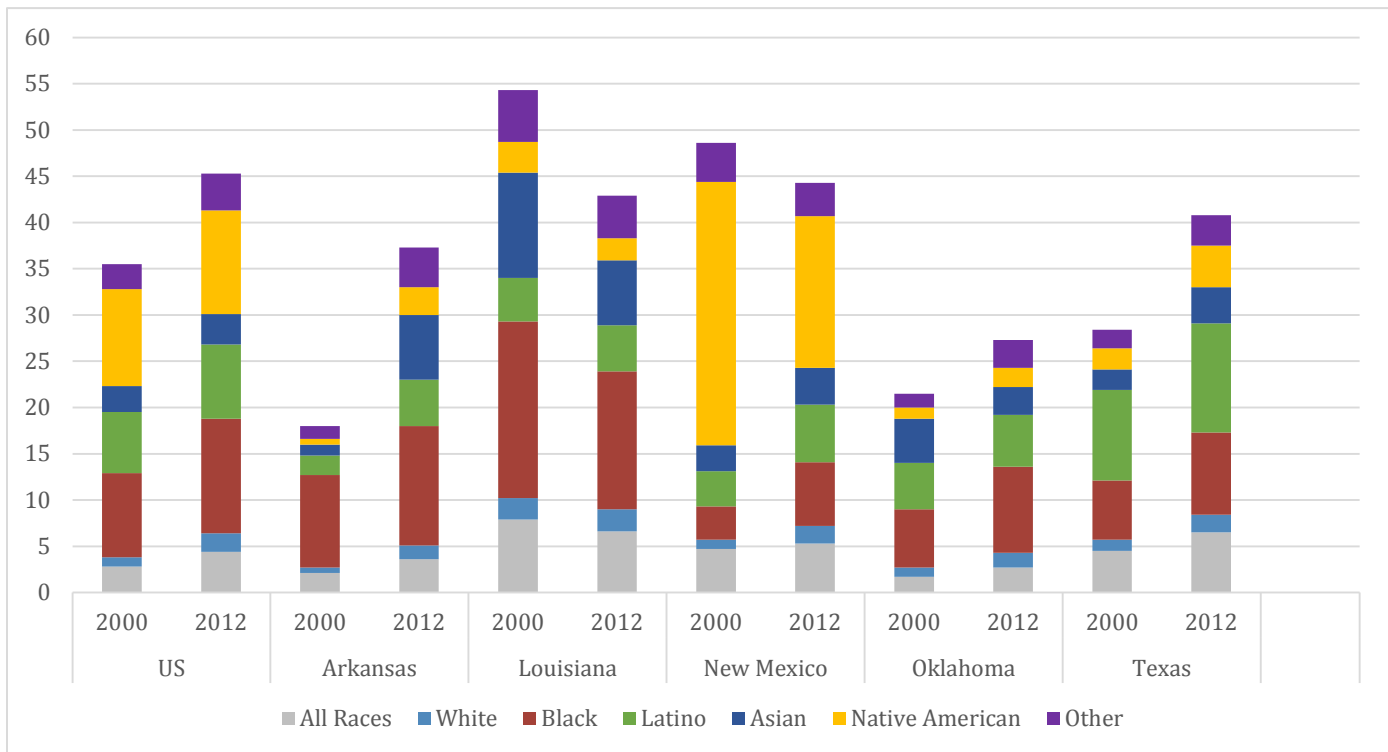
Location	All	White	People of Color	Black/AA	Hispanic/Latino	Native American	Asian
Arkansas	16	17	13	14	11	15	16
Louisiana	17	20	14	13	15	16	17
New Mexico	17	21	15	17	15	15	19
Oklahoma	16	17	14	14	12	15	15
Texas	18	22	15	17	13	19	23

Source: <http://nationalequityatlas.org/indicators>

### Indicator: Percentage of Persons Living in High-Poverty Neighborhoods

African Americans generally have had a high overall frequency for living in high-poverty neighborhoods across the five Region VI states and the U.S. Louisiana had the highest percentage of people of all races who lived in high-poverty neighborhoods in 2000 and 2012. Neighborhoods with higher percentages of individuals living in poverty experience higher levels of health disparities (CDC). Figure 9 below shows that Whites, followed by Asians, consistently exhibited the lowest rates of people living in high-poverty neighborhoods. The **exception**: African Americans, followed by Asians, have the highest rates of living in high-poverty neighborhoods in Arkansas and Louisiana. Hispanics/Latinos also have relatively low percentages of people living in high-poverty neighborhoods within the region with the **exception** of in Texas and nationwide.

Figure 9: Percent of Persons Living in High-Poverty Neighborhoods by Race/Ethnicity, 2000 and 2012

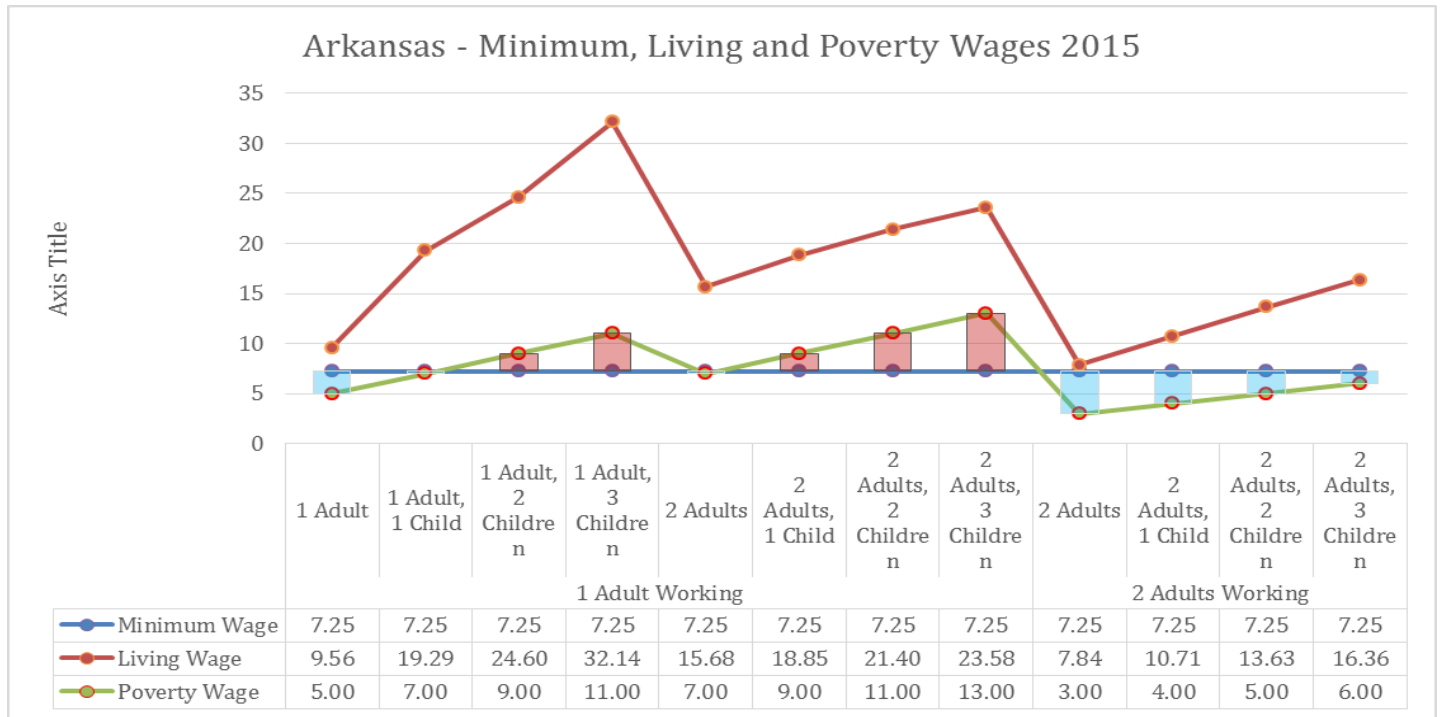


Source: National Equity Atlas, 2015

### Indicator: Minimum, Living and Poverty Wage

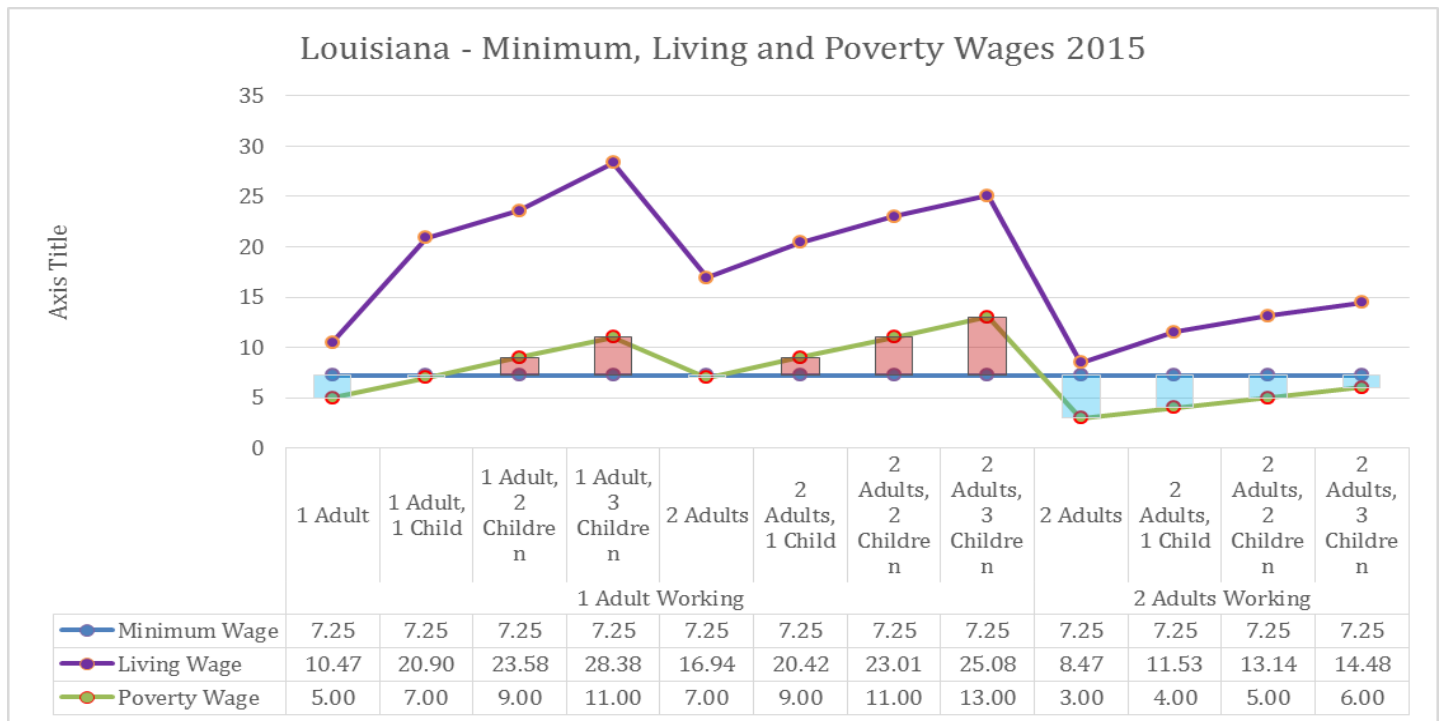
Minimum, living and poverty wages affect better health and health outcomes because of their impact on income and social status. Data from Figures 10-14 below indicate that none of the Region VI states provides a minimum wage that meets the calculated living wage for any of the categories of working adults and their children. The calculated poverty wage exceeds state minimum wages for the following categories: one working adult with two children; one working adult with three children; two adults (one working) with one child; two adults (one working) with two children; and two adults (one working) with three children. While New Mexico has the highest minimum wage at \$7.50, it falls below the calculated living wage for the state.

Figure 10: Arkansas - Minimum, Living and Poverty Wages



Source: Living Wage Calculator, Massachusetts Institute of Technology, <http://livingwage.mit.edu/>

Figure 11: Louisiana - Minimum, Living and Poverty Wages



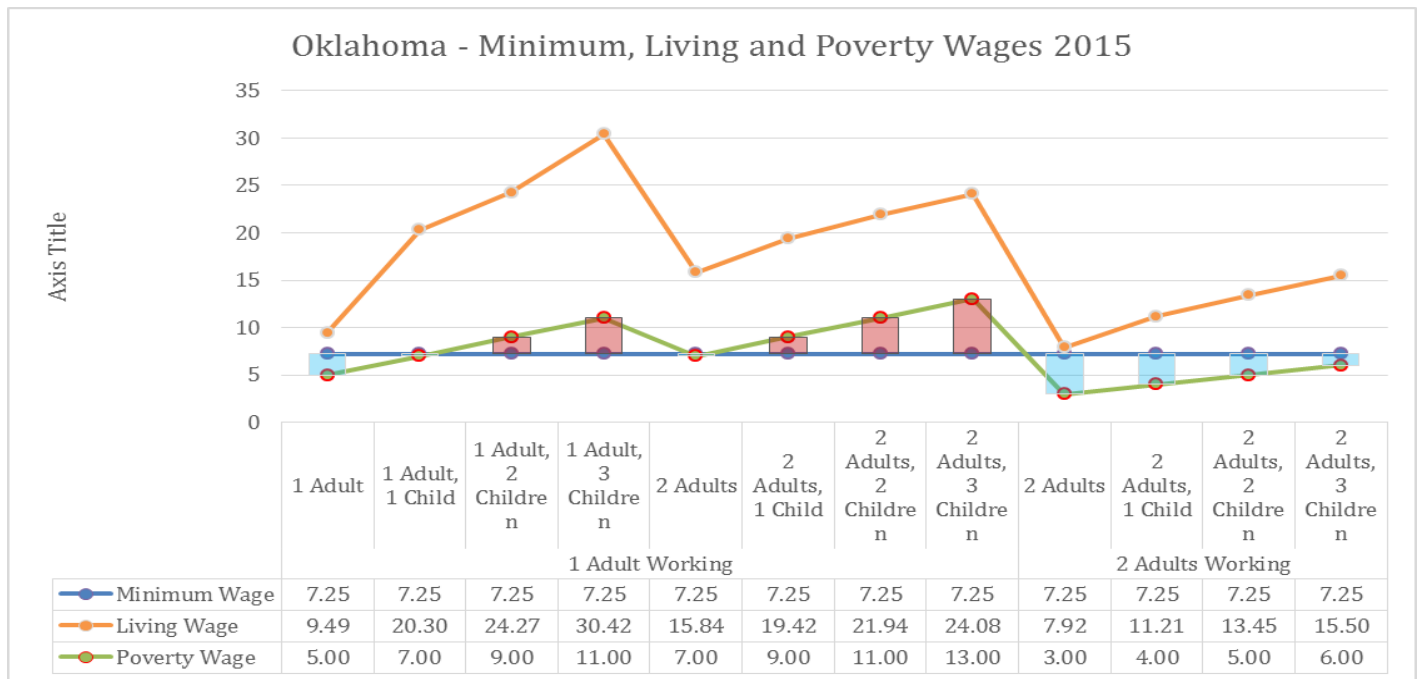
Source: Living Wage Calculator, Massachusetts Institute of Technology, <http://livingwage.mit.edu/>

Figure 12: New Mexico - Minimum, Living and Poverty Wages



Source: Living Wage Calculator, Massachusetts Institute of Technology, <http://livingwage.mit.edu/>

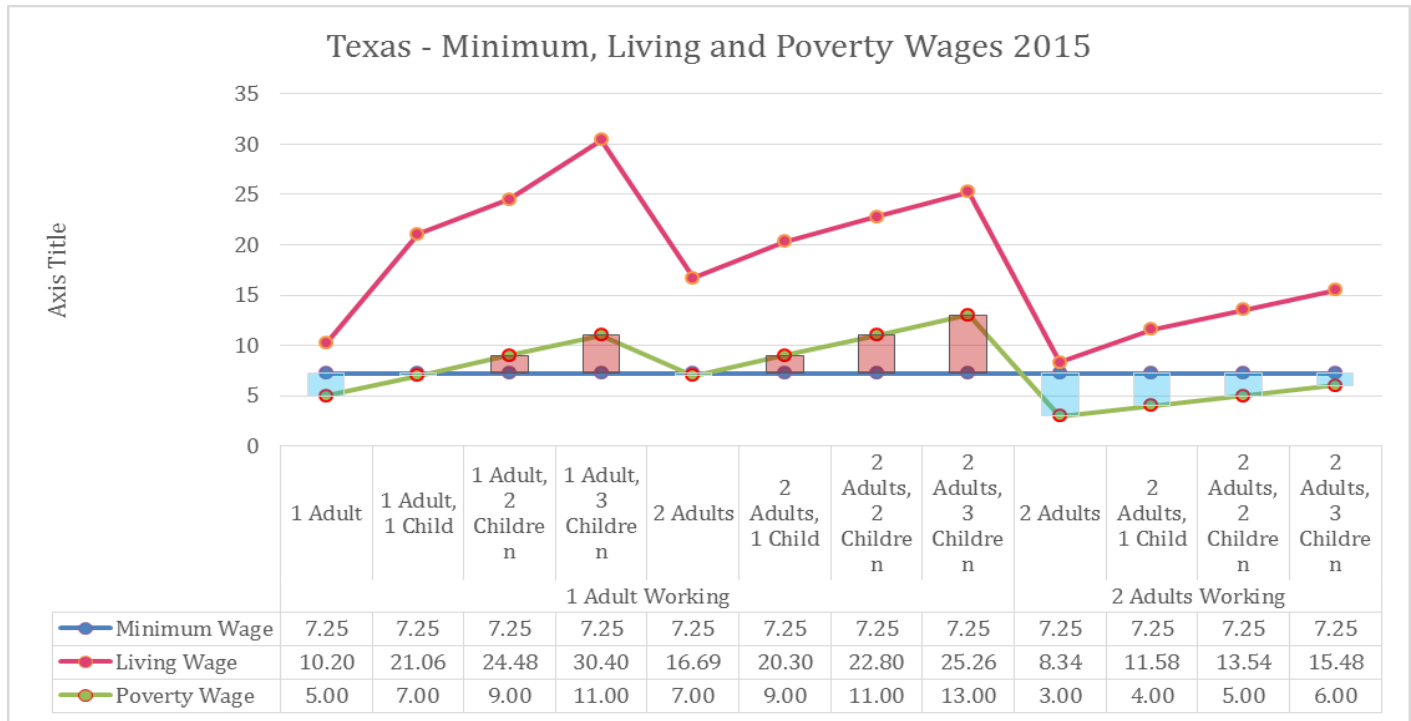
Figure 13: Oklahoma - Minimum, Living and Poverty Wages



Source: Living Wage Calculator, Massachusetts Institute of Technology, <http://livingwage.mit.edu/>



Figure 14: Texas - Minimum, Living and Poverty Wages



Source: Living Wage Calculator, Massachusetts Institute of Technology, <http://livingwage.mit.edu/>

## Employment

Employment is a determinant of health due to its impact on both physical and mental health. Individuals who are unemployed, underemployed or experience job insecurities tend to have higher self-reports of an increased risk of physical illness, cardiovascular disease, anxiety and depression, suicide, accident-related injuries and premature death (Wilkinson, 1998).

### Indicator: Unemployment

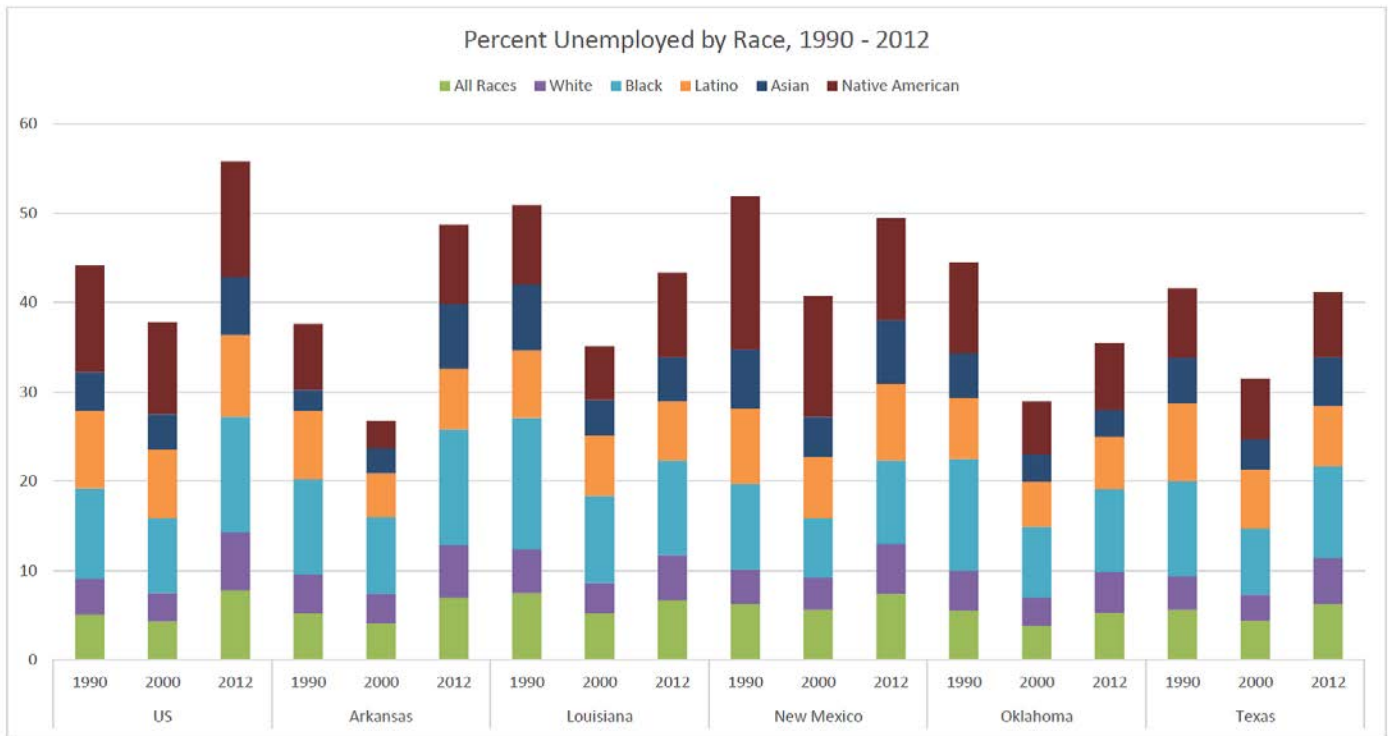
Unemployment rates have declined overall in Region VI, but are significantly higher for Blacks/African Americans compared to other races. African American and Native American populations consistently have had the highest percentages of unemployment reported across time.

Figure 15 below also indicates:

1. Native Americans have the highest rates of unemployment with New Mexico recording the highest percentage in 1990.
2. Unemployment rates among Native Americans in Arkansas tremendously decreased in 2000, but had again increased by 2012. This trend applied to all races and might be a result of the 2008 recession, but Native Americans and African Americans appeared to have the most significant impact.

- The unemployment rate among Latinos/Hispanics appears to be constant for the most part across all Region VI states.

Figure 15: Unemployment by Race Ethnicity and State



Source: National Equity Atlas, 2015 [www.nationalequityatlas.org](http://www.nationalequityatlas.org)

## Housing

Where we live and the conditions to which we are exposed impact our health. Access to quality, affordable and accessible housing helps to foster a healthy and sustainable community where we can work, play, learn and live (RWJF, Commission to Build a Healthier American, 2011).

Adequate housing refers to housing that protects individuals and families from harmful exposures and provides a sense of privacy, security, stability and control. It can be an important contributor to health. In contrast, poor quality and inadequate housing contributes to health problems such as infectious and chronic diseases (e.g. asthma), injuries and poor childhood development (e.g. lead poisoning).

In 2011, the Centers for Disease Control and Prevention (CDC) issued the *CDC Health Disparities and Inequalities Report* that provided evidence of the link between housing and health. The report analyzed health disparities that exist in certain indicators, including housing. Although there was an overall decrease in unhealthy housing, the findings indicated that “the disparity by race/ethnicity, socioeconomic status, disability status and education level, however, is still substantial” (Centers for Disease Control and Prevention, 2011). The following section will discuss several indicators related to housing.

## Indicator: Owner-Occupied Housing

Home ownership has “been associated with reduced morbidity and mortality risk” (Filakti H, 1995)” and it is also viewed as a good marker for the well-being of individuals and communities (Filakti H, 1995). From 2000 to 2012, all Region VI states experienced a decrease in the percentage of owner-occupied housing. In Region VI states in both 2000 and 2012, Texas had the lowest percentage of owner-occupied housing, while New Mexico had the highest percentage.

By race/ethnicity in all Region VI states in both 2000 and 2012, Whites had the highest percentage of owner-occupied housing; African Americans had the lowest percentage; and Hispanics/Latinos experienced tremendous variability in comparing their percentages to those of other racial categories. In all Region VI states in both 2000 and 2012, Native Americans consistently had comparatively high percentages of owner-occupied housing, while Asians tended to have comparatively low percentages. However, Asians also experienced percentage increases over the period of time observed.

**Table 11: Percentage of Owner-Occupied Housing by Race/Ethnicity**

Location	Year	%Total	%White	%Black/ African American	%Latino	%Asian	%Native American	%Other	%People of Color
Arkansas	2000	69.6	74	50.3	38.9	54.5	59.6	59.6	50
	2012	66.8	72.1	45.8	47.8	49.3	62	60.1	47.6
Louisiana	2000	68.3	76.1	52.3	51.9	52.2	68.4	59.3	52.7
	2012	67.2	76.2	50.7	46.2	61.2	68.7	63.5	51.3
New Mexico	2000	70.3	72.2	47.1	69.8	53.4	69.2	58.9	68.2
	2012	68.8	72.2	45	66.7	62.9	64.5	58.5	65.4
Oklahoma	2000	68.8	72.7	43.7	46.2	48.7	65	64.8	54.2
	2012	67.3	71.9	42.9	50.5	57	64.1	60.5	54
Texas	2000	64.3	71.3	46.8	56.7	53.2	57.4	51.9	53.5
	2012	63.5	71.6	44.4	57.4	61.3	61.1	53.3	54.3

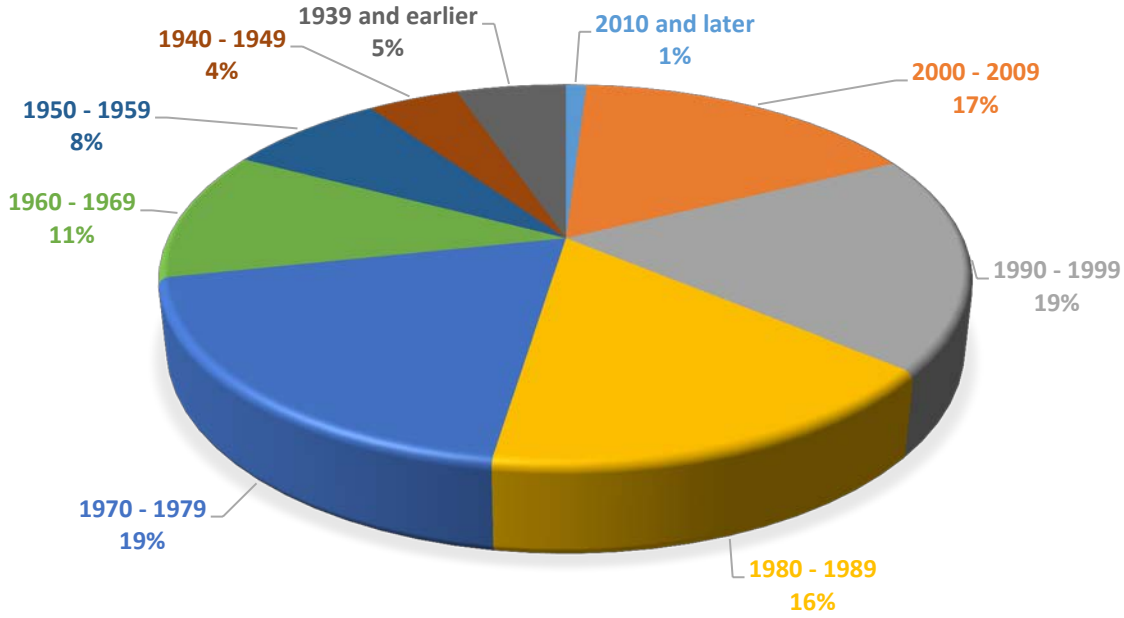
Source: National Equity Atlas, 2015, [www.nationalequityatlas.org](http://www.nationalequityatlas.org)

## Indicator: Housing age (Housing stock by decade built and median year housing built)

With the exception of Texas, more than 50% of the housing stock in Region VI states was built prior to 1980. This increases the chance that lead-based products were used in their construction. Homes that are in substandard condition are prone to suffer the elements of our regional weather. The consequences could dramatically lead to expensive repairs and ongoing maintenance to address contaminants, water leaks, poor ventilation, dirty carpets and pest infestation that increase the potential for mold, mites and other allergens associated with poor health.

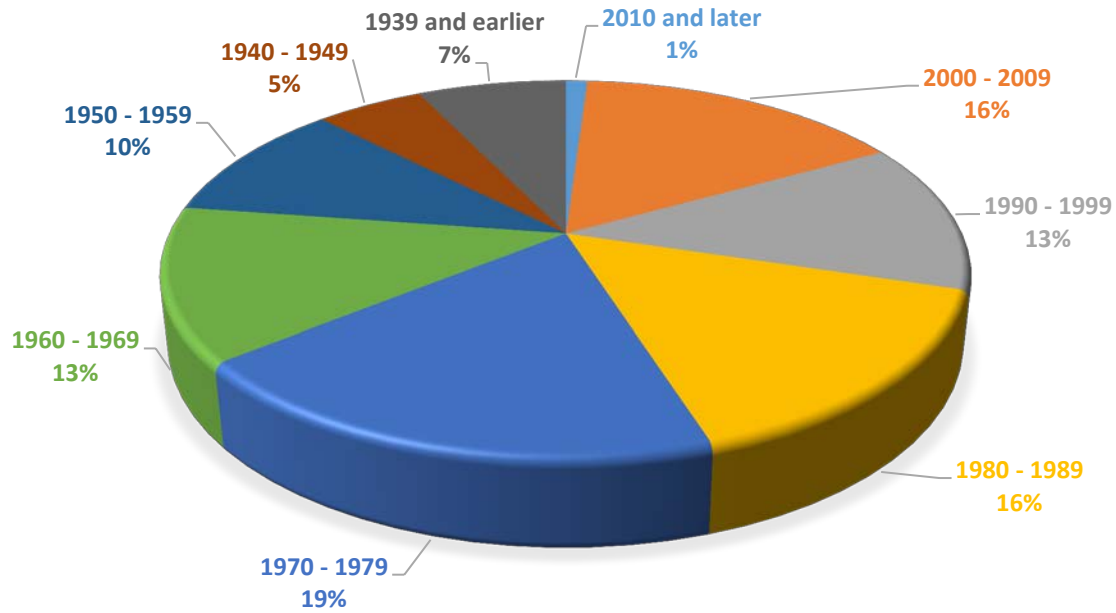
### ARKANSAS - HOUSING STOCK BY DECADE BUILT

(EST. TOTAL = 1,320,772)



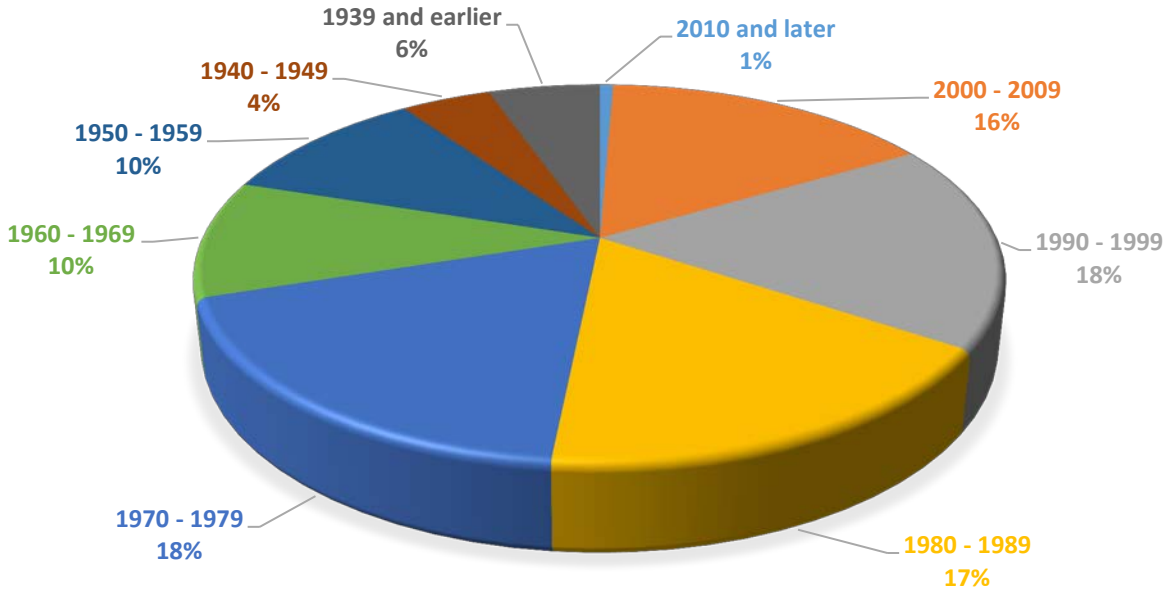
### LOUISIANA - HOUSING STOCK BY DECADE BUILT

(EST. TOTAL = 1,974,313)



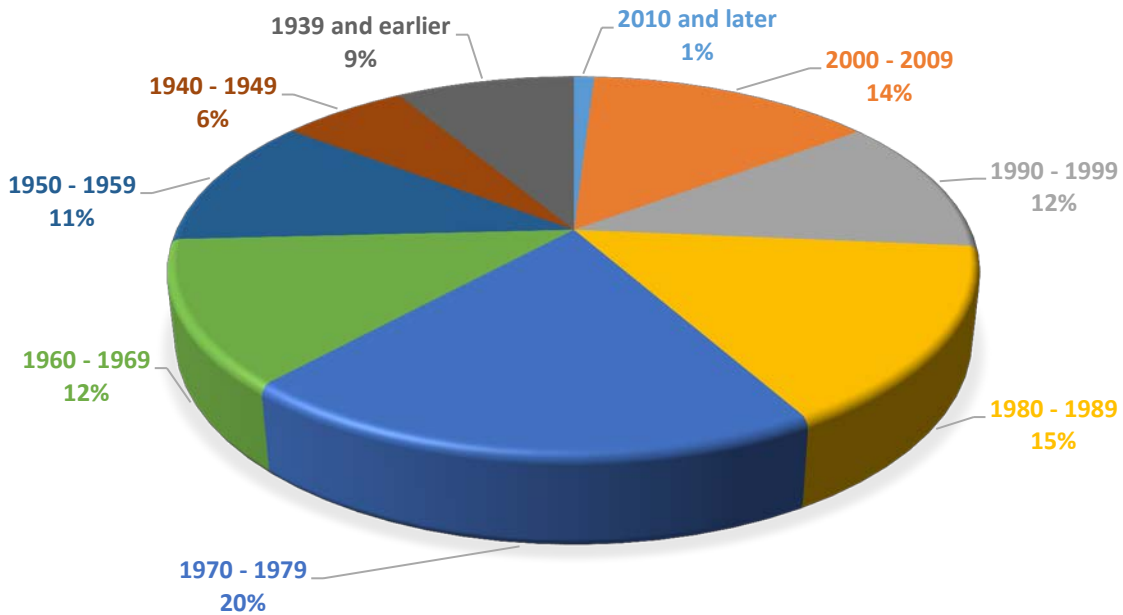
## NEW MEXICO - HOUSING STOCK BY DECADE BUILT

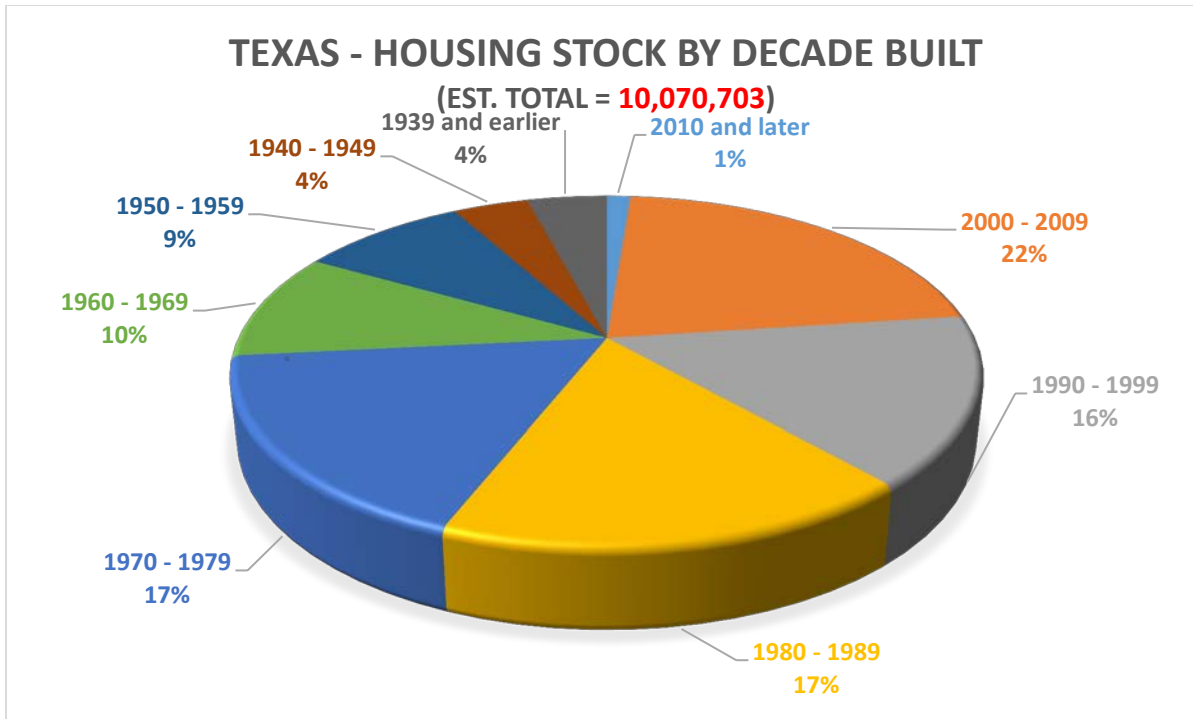
(EST. TOTAL = 902,302)



## OKLAHOMA - HOUSING STOCK BY DECADE BUILT

(EST. TOTAL = 1,669,828)





#### Median year housing built

- The earliest median years for the housing stock in RHEC VI states are 1976 (Oklahoma) and 1977 (Louisiana). Texas has the latest median year at 1983. All other Region VI states have median years after 1980.

#### Housing stock by decade built

- More than 50% of the housing stocks in Louisiana and Oklahoma were built prior to 1980.
- Nearly 50% of the housing stocks in Arkansas and New Mexico were built prior to 1980.
- Oklahoma has the greatest percent of houses built before 1940. Nearly 1 in 10 houses in the state was built in 1939 or earlier.
- Only Texas has more than 20% of its housing stock built after 2000.
- Houses built after 2010 account for only 1% of the housing stock in each state.

#### Indicator: HUD and FHAP Complaints

The mission of the U.S. Department of Housing and Urban Development (HUD) is to build communities that are inclusive and free of discriminatory housing practices. HUD envisions housing as a platform to improve the quality of life for individuals because where we live can provide access to greater opportunities in education, healthcare and employment. The Fair Housing Assistance Program (FHAP) provides agencies with funding to enforce fair housing laws that were enacted to prevent housing discrimination. The rate of complaints per 100,000 is an indicator of the existence of discriminatory practices that may result in lost opportunities for those who are impacted by unfair housing practices.

## 2010-2013 Trends

- Arkansas consistently had the highest rate (per 100,000 population) of HUD and FHAP complaints from 2010 to 2013.
- New Mexico consistently had the lowest rate of HUD and FHAP complaints from 2010 to 2013.
- New Mexico was the only state to experience an overall increase in the rate of HUD and FHAP complaints over the four-year period, rising by 0.37 complaints per 100,000 population. All other states experienced an overall decline.
- Louisiana, New Mexico and Oklahoma all had a relatively low rates of HUD and FHAP complaints in 2013 compared to those in Arkansas and Texas. This gap clearly marks a separation between the top two and bottom three states in terms of the number of complaints registered.
- Louisiana experienced the greatest decrease in the rate of HUD and FHAP complaints registered from 2010 to 2013, falling by 2.2 complaints per 100,000 population.
- Texas experienced the smallest decrease in the rate of registered complaints from 2010 to 2013, falling by 0.46 complaints per 100,000 population.

Figure 16: HUD and FHAP Complaints



## Indicator: Housing Cost Burden

HUD defines affordable housing as an occupant paying no more than 30% of a family's household income for gross housing costs, including utilities. "Many low-income families have been forced to live outside city centers where housing is more affordable and access to public transportation is limited." These families often spend more on driving than health care, education or food. Mixed income and mixed development housing help to bring resources closer to home to benefit persons with more limited resources.

Infrastructure and access are connected to housing choices. Food access, job access, transportation costs, increased exposure and disaster resiliency are all connected to the location of affordable housing. Inequities in health outcomes that are location-based are directly connected to where affordable housing is available.

### State trends

- In all five Region VI states, renters had housing costs above 30% of their household incomes at a much greater frequency than homeowners (see Table 12):
  - 41% of renters compared to 19% of owners in Arkansas
  - 44% of renters compared to 20% of owners in Louisiana
  - 42% of renters compared to 24% of owners in New Mexico
  - 40% of renters compared to 19% of owners in Oklahoma
  - 44% of renters compared to 23% of owners in Texas
- Texas and Louisiana had the greatest percentages of renters whose housing costs were above 30% of their household income (44%). Oklahoma had the lowest percentage (40%).
- New Mexico had the greatest percentage of owners whose housing costs were above 30% of their household income (24%). Arkansas and Oklahoma had the lowest percentages (19%).
- For housing costs exceeding 50% of household income, New Mexico had the greatest percentage of burdened homeowners (10%), while Louisiana had the greatest percentage of burdened renters (24%).
- Oklahoma and Arkansas had the greatest percentages of owners whose housing cost was less than 30% of household income (80%). Oklahoma had the greatest percentage of renters whose housing cost was less than 30% of household income (58%).

**Table 12: Housing Cost Burden**

Location	Cost Burden	Owners	Renters	Total
Arkansas	<=30% Household Income	608500	206895	815395
	>30% to <=50% Household Income	88185	75125	163310
	>50% Household Income	56190	78020	134210
	Not available	5950	9945	15895
	Total	758815	369985	1128795
Louisiana	<=30% Household Income	902910	291450	1194360
	>30% to <=50% Household Income	134790	111395	246185
	>50% Household Income	94675	133245	227920
	Not available	10600	17445	28045
	Total	1142965	553535	1696500



Location	Cost Burden	Owners	Renters	Total
New Mexico	<=30% Household Income	396185	129805	525990
	>30% to <=50% Household Income	72880	48330	121210
	>50% Household Income	52245	51860	104105
	Not available	5190	7355	12545
	Total	526495	237350	763845
Oklahoma	<=30% Household Income	778175	269285	1047460
	>30% to <=50% Household Income	116670	93310	209980
	>50% Household Income	68980	94025	163005
	Not available	7200	11660	18860
	Total	971015	468275	1439290
Texas	<=30% Household Income	4267320	1719350	5986670
	>30% to <=50% Household Income	788845	696350	1485195
	>50% Household Income	508970	682430	1191400
	Not available	43860	75455	119315
	Total	5609005	3173590	8782600

Source: HUD, Comprehensive Housing Affordability Strategy, 2008-2012 ACS,  
<http://www.huduser.gov/portal/datasets/cp.html>

## Walkability, Built Environment and Transportation

### Complete Streets Policies

#### Planning and Designing Streets for Active/Healthier Living

People living in Arkansas, Louisiana, New Mexico, Oklahoma and Texas live with a high prevalence of chronic health problems such as obesity, heart disease and diabetes. Stress and lack of exercise contribute to our poor health. Obesity has reached epidemic proportions (Healthy People 2010, 2nd edition, 2000).

In Region VI, Louisiana had the highest prevalence of overweight or obese adults, followed by Arkansas, Oklahoma and Texas. New Mexico had the lowest prevalence of overweight or obese adults. Health experts agree that inactivity is a major factor: 55% of the adult U.S. population falls short of recommended activity guidelines and approximately 25% report being completely inactive.<sup>1</sup> Inactivity also plays a key role in many other diseases, including diabetes, heart disease and stroke. Incomplete streets do not provide people with opportunities to be active in their daily lives (Sallis, 2009).

Streets that are designed only for cars deny opportunities for people to choose more active modes of transportation, such as walking and biking. Even in areas with sidewalks, large intersections and speeding traffic may make walking unpleasant or unsafe and discourage any non-motorized travel. Walkability has a direct and specific relation to the health of residents.

A comprehensive walkability study found that people in walkable neighborhoods who engaged in 35-45 more minutes of moderate intensity physical activity per week were substantially less likely to be overweight or obese than similar people who lived in low-walkable neighborhoods.<sup>2</sup> Easy access to transit can also contribute to healthy physical activity. Nearly 33% of transit users meet the Surgeon General's recommendations for minimum daily exercise through their daily travels.<sup>3</sup> A community with a Complete Streets policy ensures streets are designed and operated to make it easy for people with abilities at all levels to engage in physical activity as part of their daily routine, maintain a healthy weight, avoid heart disease, and achieve other benefits of physical activity. (Besser, 2005)

The SWRHEC is a member of the National Complete Streets Coalition ([www.smartgrowthamerica.org/completestreets](http://www.smartgrowthamerica.org/completestreets)). The Complete Streets Coalition is a national movement that was launched in 2004 to integrate people and place in the planning, design, construction, operation and maintenance of transportation networks. There has been progressive movement to develop and implement policies and professional practices that ensure streets are safe for people of all ages and abilities, balance the needs of different modes, and support local land uses, economies, cultures and natural environments.

Complete Streets are designed and operated to enable safe access to all users. People of all ages and abilities are able to safely move along and across streets in communities regardless of their modes of transportation. We acknowledge that public transportation must be addressed simultaneously with the planning and design of streets and municipalities for healthier living. The SWRHEC will address public transportation next year as it remains prominent in how we transport people and goods on a daily basis that are essential to enhancing good health outcomes.

Of over 700 Complete Streets policies that have been adopted by towns and municipalities throughout the country, the Region VI states have adopted 25: 3 by Arkansas, 9 by New Mexico, 3 by Louisiana, 7 by Oklahoma and 3 by Texas.

## Food Security

### Indicator: Food Insecurity and Food Deserts

The U.S. Department of Agriculture (USDA) defines food security as having access to enough food for all household members at all times to lead an active, healthy life. Health and food security are dependent on fair access, fair use and fair expectations. A healthy, integrated and self-aware community must share resources. A community is defined as "food secure" based on the following indicators:

- There are adequate resources (such as grocery stores or farmers markets) from which people can purchase foods.
- Available resources are accessible to all community members.
- Available food in the community is sufficient in quality, quantity and variety.

- There are adequate food assistance programs to help low-income people purchase and prepare nutritious foods.
- Locally produced food is available to community members.
- There is support for local food production.
- Every household is food secure within the community.

According to the USDA, food security is defined as “access by all people at all times to enough food for an active, healthy life.” The following statistics reveal the following about Region VI (USDA, 2006).

### **Food Deserts, 2012**

“Food deserts” are defined by the USDA as parts of the country that are vapid of fresh fruit, vegetables and other healthy whole foods. The higher number of food deserts in impoverished areas is largely due to a lack of grocery stores, farmers markets and healthy food providers.

- Much of New Mexico and west Texas are affected by massive food desert patches that could be due to large census tracts being mapped.
- The Eastern states, Texas and Oklahoma have many more food deserts, but these are smaller and scattered.
- Many small food deserts appear in and around urban areas, especially throughout the Eastern part of the region.

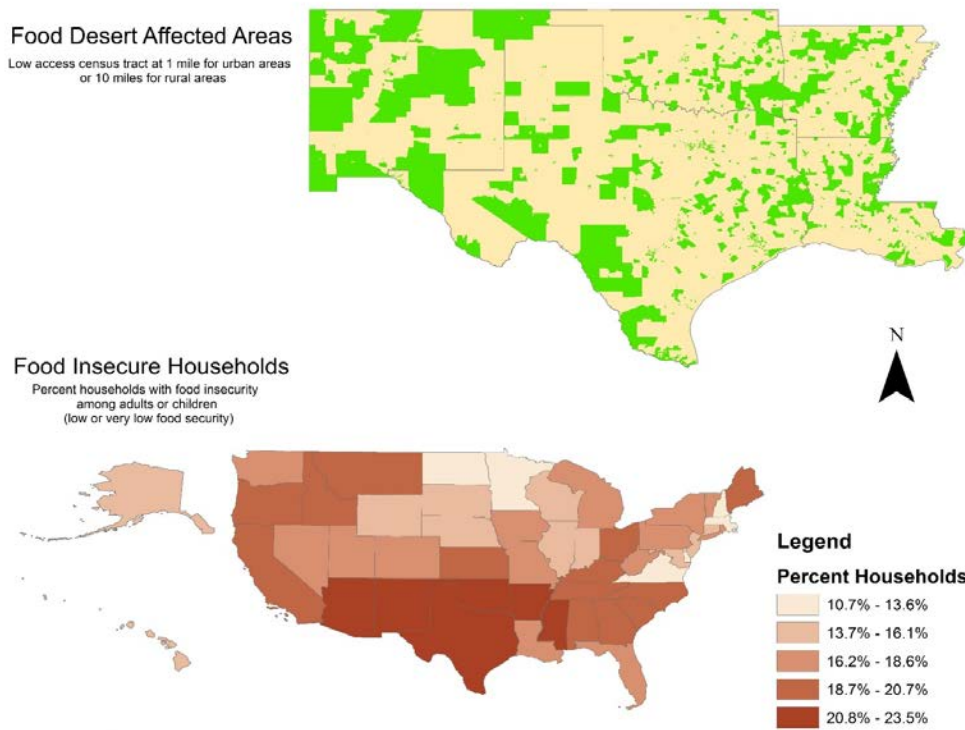
### **Food Insecure Households, 2003-11**

- Region VI states account for the worst food insecurity in the U.S.
- Arkansas, New Mexico, Oklahoma and Texas display the highest tier of percentages of households with food insecurity (>20.8%).
- Only Louisiana does not have a percentage in the upper tier.
- Only two states outside of Region VI, Arizona and Mississippi, have food insecurity percentages in the highest tier.

All Region VI states are food insecure. Food insecurity is a major factor that contributes to the high rates of obesity and diet-related diseases across the region.

In 2009, the USDA reported that nearly 24 million people do not have access to a supermarket within one mile of their homes (Treuhaft & Karpyn, 2010). A study of over 3,000 U.S. metropolitan counties across all 50 states found lower obesity rates in areas with higher supermarket density (Jilcott et al., 2011). A nationwide study of middle-aged and elder adults found that living in a census tract with at least one supermarket is associated with adherence to recommended guidelines for fruit and vegetable consumption and lower obesity prevalence (Morland, Wing, & Roux, 2002; Morland et al., 2006). Consequently, the relationship between supermarket access, healthy dietary intake and lower obesity rates appears to be mediated by indicators of socioeconomic status such as race, ethnicity, income and access to a personal vehicle (Larson et al., 2009; Morland & Evenson, 2008).

**Figure 17: Region VI Food Desert Affected Areas and U.S. Insecure Households**



**Table 13: United States Food Insecurity Prevalence, 2003-11 Averages**

State	Number of households with children (in thousands)	Percent of household with food insecurity among adults or children
Arkansas	378	21.8
Louisiana	609	17.1
New Mexico	261	21.9
Oklahoma	487	21.0
Texas	3,371	23.5

Source: USDA, Economic Research Service, <http://www.ers.usda.gov/data-products.aspx>

# Literacy

## State and County Adult Literacy Estimates

Communication refers to the transfer of information between people and can occur in various methods. It is considered an essential component of health care. Despite the known linkages between literacy and health and the prevalence of written words throughout the industrialized U.S. society, problems with literacy persist. With nearly one in five American adults reading at a 5th grade level or below, addressing health literacy is critical to achieving improved health outcomes.

**Table 14: Adult Literacy Levels by Racial/Ethnic Group**

Ethnic Group	Below Basic	Basic	Intermediate	Proficient
White	9%	19%	58%	14%
Black/AA	24%	33%	41%	2%
Hispanic/Latino	41%	24%	31%	4%
Other	13%	21%	54%	12%

Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy

Equitable care is defined as “care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.” Equitable care is an important factor to achieve health equity and eliminate health disparities (IOM, 2001). Health literacy levels can impact the quality of care by acting as a barrier to accessing health information and ultimately functioning as a social determinant of health.

Health literacy is an individual’s capacity to obtain, process and understand health information and services. Health literacy moves beyond reading and writing and involves higher order skills. These higher order skills are taught, learned and reinforced in many systems that impact an individual’s life with the outcome being its impact on health. Health literacy is also a method for assessing and addressing social determinants of health. Healthy literacy has been a major barrier to accessing health care, especially among African Americans, Hispanic/Latinos and immigrants. Recognition of the important role of culture in communication helps us to better understand health literacy.

### General Stats:

- Populations most likely to experience low health literacy are older adults, racial/ethnic minorities, people with less than a high school degree or GED certificate, people with low-income levels, non-native English speakers and people with compromised health status. Education, language, culture, access to resources and age are all factors that affect a person's health literacy skills. (Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy)

- The U.S. population with basic or below basic health literacy includes 77 million adults. (Source: U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy)
- Only 12% of U.S. adults had proficient health literacy. More than 33% of adults were in the basic (47 million) and below basic (30 million) health literacy groups. The majority of adults (53%) had intermediate health literacy skills.
- The proportion of adults aged 18 and over who reported that their healthcare providers always explained issues in an understandable manner increased by only 1.0% from 60.0% in 2007 to 60.6% in 2010. This change was not statistically significant. The proportion varied by race and ethnicity. In 2010, for example, 66.5% of non-Hispanic Black adults aged 18 and over reported that their healthcare providers always explained issues in an understandable manner compared to 60.9% of non-Hispanic white adults, 58.6% of Asian adults, 55.4% of Hispanic/Latinos adults, and 50.6% of American Indian/ Alaska Native adults. (Source: Healthy People 2020)
- The National Assessment of Adult Literacy (NAAL) was the only tool used to collect baseline data on health literacy. The only study conducted addressing health literacy was completed in 2003 in Oklahoma.
- The Centers for Disease Control and Prevention (CDC) will begin collecting health literacy data in early 2016 for states to include in their Behavioral Risk Factor Surveillance Survey (BRFSS). Arkansas, Louisiana, Oklahoma, New Mexico and Texas will include additional questions in their BRFSS modules in the future:
  - How difficult is it for you to obtain advice or information about health or medical topics if you need it? Would you say it is?
  - How difficult is it for you to understand information that doctors, nurses and other health professionals tell you? Would you say it is?
  - You can find written information about health on the Internet, in newspapers/magazines and brochures in the doctor's office and clinic. In general, how difficult is it for you to understand the materials?

#### Oklahoma Stats:

- The Oklahoma population with below basic health literacy includes 14% of the adult population. Below basic literacy includes individuals who are unable to read and understand any written information or only able to locate easily identifiable information in short, commonplace prose text in English, but nothing more advanced (U.S. Department of Education, Institute of Education Sciences, 2003)
- Texas County accounts for the highest below basic health literacy level in the state (24% of the adult population).

## Public Policy/Safety Indicators

### Indicator: Incarcerated Youth

Studies have shown that detention has a significant effect on the mental and physical health of incarcerated youth. Many young people in detention centers experience mental disorders, some of which begin or worsen during incarceration. Others experience mental disorders that affect behaviors for which youth are incarcerated. One analysis suggests that mental health, in combination with the environment existing in the detention centers, generates higher rates of depression and a tendency for suicide or self-harm. The long-term effects of youth incarceration include diminished wages or economic hardship and are associated with lower levels of mental well-being, physical health, social attachments and a lower life expectancy (Holman).

Arkansas was the only state to have an overall increase in its rate (per 100,000 population) of incarcerated youth in the region from 1997 to 2011. All other states and the U.S. had an overall decrease over the period observed (Holman). No state consistently had the highest rate of incarcerated youth over the period observed. Louisiana experienced the greatest overall decrease in its incarcerated youth rate from 1997 to 2011, falling by 327 youth per 100,000 population. Oklahoma experienced the smallest overall decrease in its incarcerated youth rate from 1997 to 2011, falling by 52 youths per 100,000 population (Holman).

As seen in Figure 18, 711 Arkansas youth were incarcerated in a juvenile detention, correctional facility and/or residential facility in 2011. This equates to 224 youth incarcerated for every 100,000 youth under the age of 21 years. In the past 15 years (1997-2011), the youth incarceration rate increased by 16.7% in Arkansas, peaking in 2006. At the same time, the national rate decreased by 44.9% from 356 per 100,000 in 1997 to 196 per 100,000 in 2011. Black/African American youth consistently have had the highest incarceration rate, which is 75.1% greater than the group with the second highest rate in 2011. However the greatest increase during this time occurred among white youth (34.6%), followed by Hispanic/Latino youth (21.3%) and Black/ African American youth (7.2%) (Kids Count Data Center, 2001, 2003, 2006, 2010, 2011).

African Americans had the highest rates of incarcerated youth across all five Region VI states and the U.S. in 2011. In most states, their rates were considerably higher than those of other racial categories. Asians had the lowest rates of incarcerated youth in all states except for Arkansas. Their rates were the third highest among all racial categories in the state. Native Americans had the second highest rates of incarcerated youth in Oklahoma, Arkansas and the U.S. Their rates were the third highest in Louisiana and New Mexico and the fourth highest in Texas. Hispanics/Latinos had the second highest rates of incarcerated youth in New Mexico and Texas. In all other states, their rates were relatively low compared to other racial categories reported. (Young Adults in Jail or in Prison, 2012)



**Figure 18: Incarcerated Youth by Race/Ethnicity**



Source: The Annie E. Casey Foundation, Kids Count Data Center

## Disconnected Youth<sup>14</sup>

### Indicator: Disconnected Youth

According to Table 15 below, Louisiana had the highest percentage of disconnected youth in Region VI for the three years reported (1990, 2000 and 2012). Oklahoma had the lowest percentage of disconnected youth in the region for the three years reported. Only the rate in Arkansas consistently increased from 1990 to 2012.

Whites and Asians consistently had comparatively low rates of disconnected youth across all states for the three years reported. “People of color” are defined as all populations, excluding non-Hispanic Whites. This racial category consistently had higher rates of disconnected youth than both White and Asians across all five Region VI states for the three years reported. Native Americans were commonly highest or among the highest in the other states for the three years reported. Blacks/African Americans and Hispanic/Latinos had comparable rates of disconnected youth, but the rates of both groups were commonly among the highest.

<sup>14</sup> Disconnected youth are young adults aged 16-24 year olds, who are not working or in school



**Table 15: Disconnected Youth by Race/Ethnicity 1990-2012**

Location	Year	White	People of Color	Black/African American	Latino	Asian	Native American
Arkansas	1990	14.5	22.3	22.7	17.3	N/A	N/A
	2000	14.8	23.8	24.4	26.6	9.5	24.6
	2012	16.1	20.5	22.7	17.6	11.9	19.3
Louisiana	1990	15.9	27.9	29.2	17.4	10.9	26.9
	2000	13.6	25.3	26.5	21.9	13.6	20.9
	2012	13.8	22.1	23.9	16.1	9.4	15.2
New Mexico	1990	11.5	22.1	17.4	20.6	N/A	30.4
	2000	11.6	21.6	16.8	20.8	10.1	28.8
	2012	12.8	18.8	15.9	18.1	6.4	24.8
Oklahoma	1990	13.9	19.5	19.8	19.8	4.6	21.3
	2000	12.4	20.4	20.2	24	8.5	21.7
	2012	12.9	17.6	18.7	18.3	5.1	19.4
Texas	1990	11.6	21.1	22.2	21.4	9.1	18.5
	2000	11.2	22.7	22	24.2	9	20.6
	2012	11.3	17.4	20	17.7	7.4	14.6

Source: National Equity Atlas, 2015 <http://nationalequityatlas.org/indicators>

## Education

### Indicator: 2020 Job Requirements vs. Current Education Attainment

In health terms, economic conditions and educational achievement combined with demographic characteristics, such as age and race/ethnicity, work interactively to determine the life chances of children. Gaps in educational achievement are also key determinants of racial, ethnic and socioeconomic disparities in adult health. For example, the literature reports that education is associated with earlier onset of chronic diseases, disabilities and declining functional status. (Cutler, 2006)

#### State job requirements 2020

- Arkansas and Louisiana will have the greatest percentage of jobs requiring at least a high school diploma in 2020.
- New Mexico, Oklahoma and Texas will have above 60% of jobs that require at least some college.
- An associate's degree will be required for more than 33% of all jobs in Oklahoma and Texas.
- About 30% of all jobs in Texas will require a bachelor's degree. This is the highest percentage of the highest requirement forecasted for the region.

### Current (minimum) education attainment by race/ethnicity

- Asians have the highest percentage of educational attainment in the category of “at least some college and above.”
- The highest comparative percentages of minimal education attainment for Hispanic/Latinos and Native Americans is observed in the category of “at least a high school diploma.”
- The highest comparative percentages for Whites is observed in the categories of “at least some college” and “at least an associate’s degree.” Their percentages begin to taper off slightly in the category of “at least a bachelor’s degree.”
- African Americans have among the lowest percentages observed in the categories “at least an associate’s degree” and “at least a bachelor’s degree.” Their strongest percentages are in the categories of “at least a high school diploma” followed by “at least some college.”

The “other” racial category tends to have average comparative percentages of education attainment. However, their percentages in the category of “at least some college” and the college degree categories are strong in some states, particularly New Mexico and Texas.

**Table 16: 2020 Job Requirements vs. Current Education Attainment**

% population currently meeting minimum education requirements

Location	Education Level	% jobs requiring certificate 2020	White	African American	Hispanic/Latino	Asian	Native American	Other
Arkansas	High School	41	45	55	55	30	46	45
	Some	59	55	45	45	70	54	55
	Associate's	33	30	21	24	36	26	30
	Bachelor's	24	23	14	17	28	16	22
Louisiana	High School	44	45	58	44	26	64	46
	Some	56	55	42	56	74	36	54
	Associate's	33	33	18	31	54	16	30
	Bachelor's	25	27	13	25	47	11	24
New Mexico	High School	37	25	33	49	16	53	23
	Some	63	75	67	51	84	47	77
	Associate's	36	48	34	24	53	21	42
	Bachelor's	27	39	25	16	47	10	34
Oklahoma	High School	36	40	45	50	23	47	42
	Some	64	60	55	50	72	53	58
	Associate's	37	35	26	24	46	26	29
	Bachelor's	27	26	17	16	34	17	20
Texas	High School	38	30	42	51	16	50	29
	Some	62	70	58	49	84	60	71
	Associate's	37	44	27	23	64	32	42
	Bachelor's	30	36	19	16	57	23	33

Source: National Equity Atlas, 2015 <http://nationalequityatlas.org/indicators>

## Access to Healthcare

### Indicator: Uninsured Population

Access to health care plays a vital role in helping people achieve optimal health (Healthy People 2020). Health outcomes are affected by the ability to seek treatment for ongoing health conditions and access to preventative care. Healthy people 2020 includes limited availability, high cost and the lack of insurance coverage as obstacles to healthcare.

Figure 19 below shows that:

- All five Region VI states have an uninsured rate above the national rate for the period from 2006 to 2012.
- Texas consistently had the highest rate of uninsured persons in the region for the period observed.
- Louisiana, New Mexico and Oklahoma were the only states to see an overall reduction in the number of uninsured persons by 2012. Arkansas, Texas and the U.S. all experienced increases.
- Oklahoma had the lowest uninsured rate and Texas had the highest rate in the region in 2012.

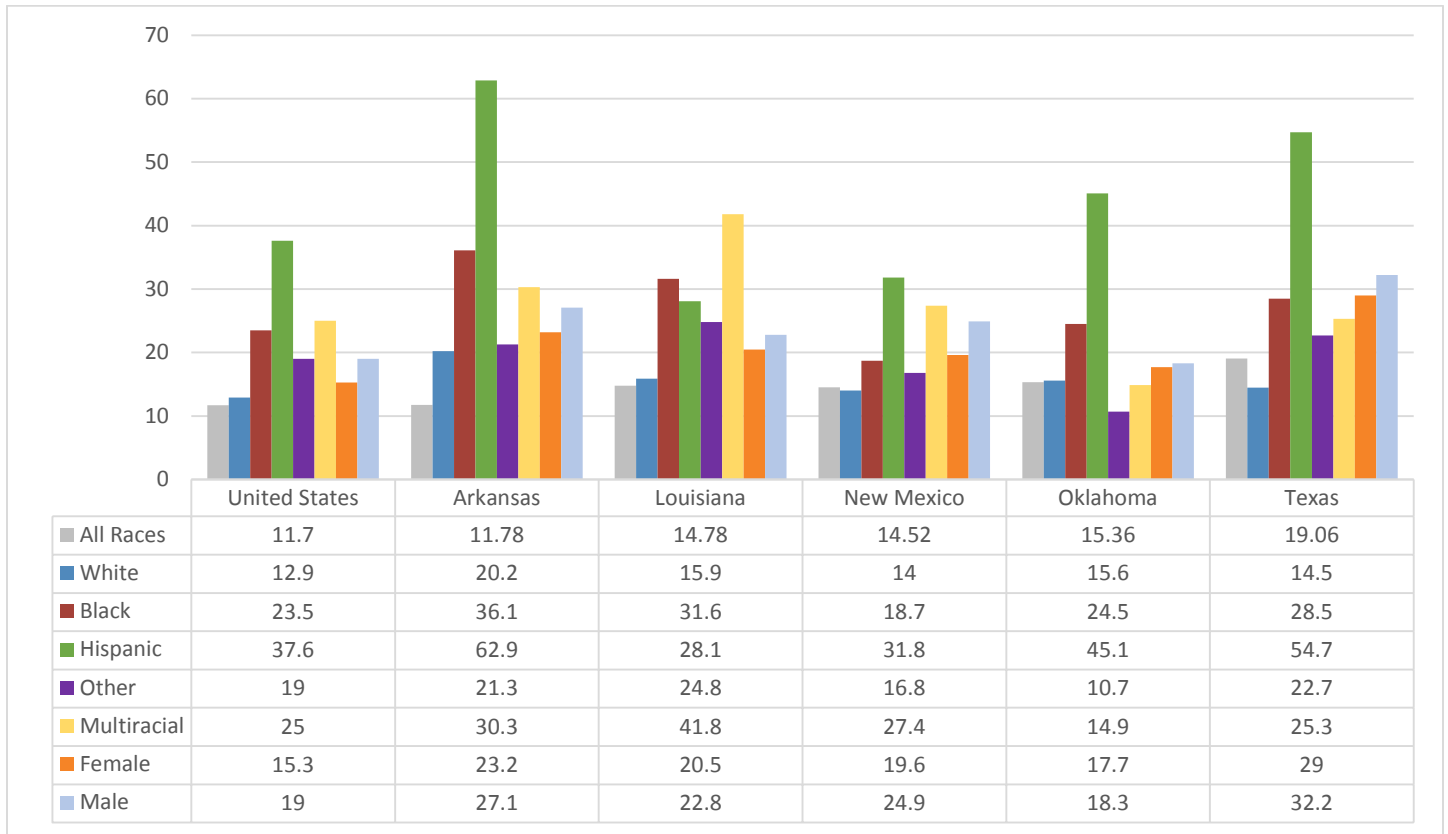
### 2012 Race/Ethnicity Rates

- In the U.S., Arkansas, New Mexico, Oklahoma and Texas, Hispanics/Latinos were the racial category with the greatest percentage of being uninsured.
  - In Arkansas, Oklahoma and Texas, Hispanics/Latinos were considerably more uninsured than other racial categories.
  - Louisiana was the only state in which Hispanics/Latinos did not have the greatest uninsured rate. Multiracial populations had the greatest uninsured rate in Louisiana.
- In Arkansas, Louisiana and Oklahoma, Blacks/African Americans had the second greatest uninsured rates.
- Whites consistently had among the lowest rates of being uninsured.
- The “other” racial category was rather variable in its position compared to other racial categories, but its uninsured rates were usually in the lower to middle range.

### 2012 Gender Rates

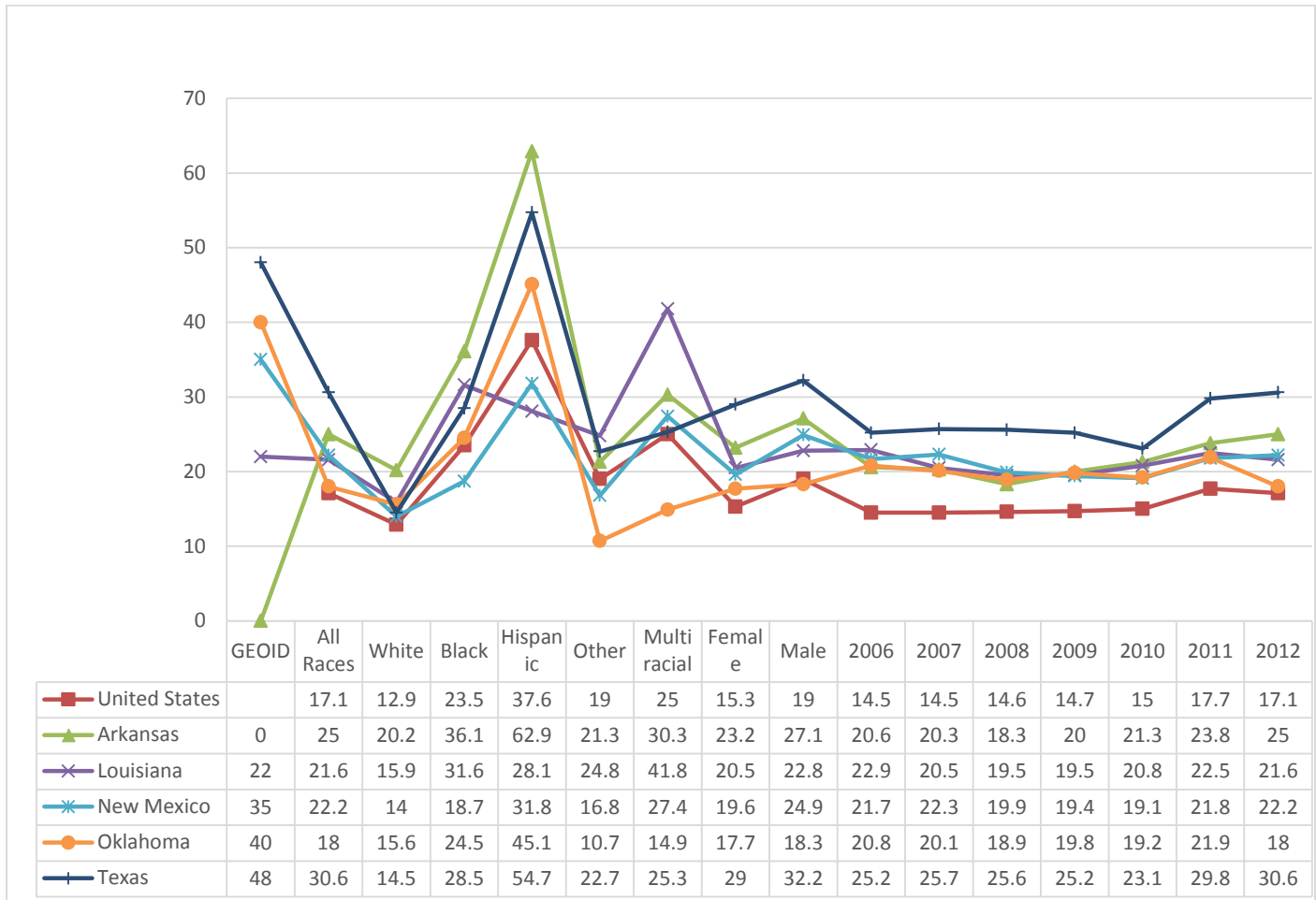
In all Region VI states and the U.S., males had only slightly higher uninsured rates than females.

**Figure 19: Percentage of Population Without Health Care Coverage by Race/Ethnicity**



Source: CDC Sortable Stats, <http://sortablestats.cdc.gov/#/indicator>

**Figure 20: Percentage of Population Without Healthcare Coverage**



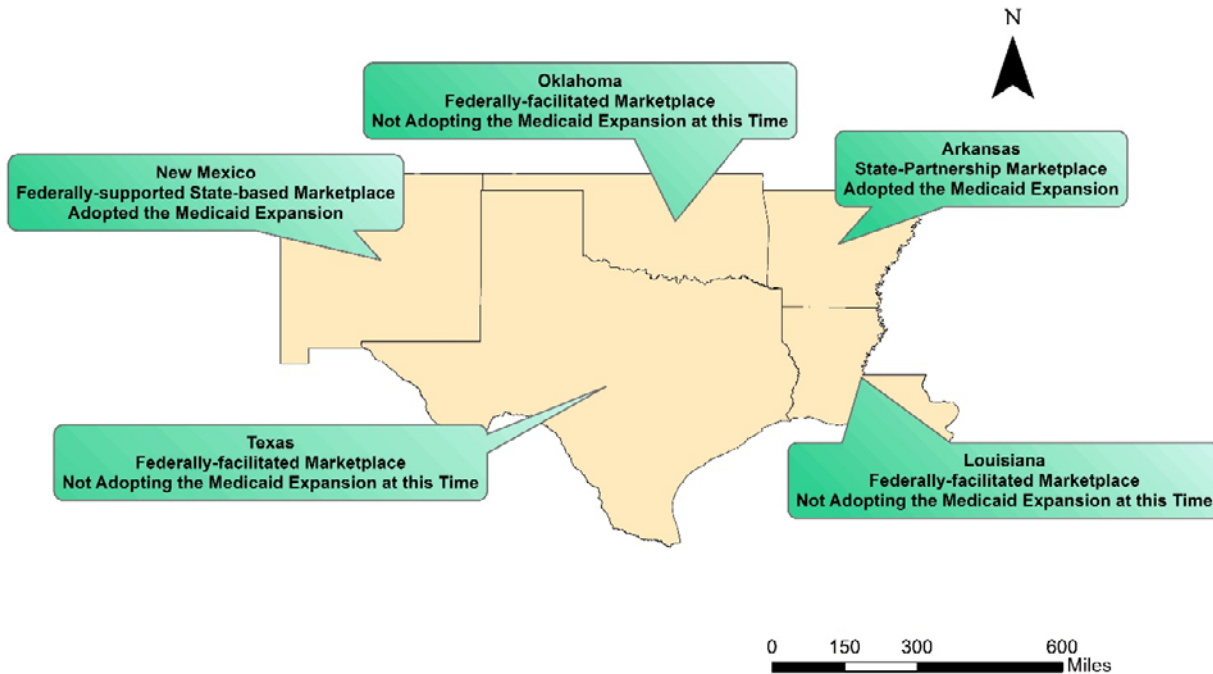
Source: CDC Sortable Stats, <http://sortablestats.cdc.gov/#/indicator>

**Indicator: Marketplace and Medicaid Expansion Status**

The Affordable Care Act (ACA) Medicaid expansion was created to provide adults with incomes at or below the federal poverty level with access to healthcare services that play a role in achieving optimal health and health equity<sup>15</sup>. The poverty level is defined as having an income that is 138% below and is used to determine eligibility for programs that assist the poor. Medicaid expansion was not implemented across all states resulting in lack of coverage for many poor adults.

**Figure 22: Marketplace and Medicaid Expansion Status**

## Marketplace and Medicaid Expansion Status



Source: Kaiser Family Foundation

### Marketplace and Expansion Status

#### Medicaid Expansion in Region VI States

- Louisiana, Oklahoma and Texas have federally-facilitated Marketplaces, but did not expand Medicaid.
- Louisiana's governor-elect has pledged to support Medicaid expansion; legislation is underway.
- New Mexico did expand Medicaid, but its state-based Marketplace is supported by the federal government.
- Arkansas has a state-partnership marketplace.<sup>16</sup>
- Only Arkansas and New Mexico have adopted the Medicaid expansion.

Arkansas offered the Private Option in which Medicaid dollars could be spent to purchase insurance in the Marketplace. The new governor appointed a commission to make recommendations. Revisions to the plan are underway. Arkansas ranked number one in the nation in open enrollment periods 1 and 2 for the percentage of the population insured.

<sup>16</sup> Source: HHS Region VI Office

## Environmental Health

### Indicator: Air Pollutant Emissions 2011/Unhealthy Air Days 2014

Air quality plays a prominent role in addressing social determinants of health. A disproportionate number of people in the U.S. suffer from air-related illnesses such as asthma, bronchitis and other illnesses related to breathing poor-quality air. In low-income people of color communities, thousands of homes are located on the fence line of oil refining, chemical processing and chemical incineration industries. Many of these industries dump thousands of tons of legal and illegal chemicals, gases and known carcinogens into the air. State and federal agencies often do not regulate these chemical emission levels. (Air Pollution for Coal-Fired Power Plants, 2011)

To help eliminate health deterrents from the air, more actions need to be taken to reduce harmful emissions from coal-fired power plants, chemical processing plants, incineration facilities and oil refining facilities. Close collaboration among local governments, state regulatory agencies, federal agencies and political leaders can greatly contribute to reducing toxins in the air. Fostering and enforcing new policies in communities where large polluting industries exist will force many polluting industries to clean their sites and become better neighbors. (More than Half of the U.S Population Live in Counties with Unfair Air, 2015)

**Table 17: Number of Unhealthy Air Days 2014**

(measured in short tons)

Location	Number of bad air days 2014	Carbon Monoxide (CO)	Lead (Pb)	Nitrogen Oxides (NOx)	Volatile Organic Compounds (VOCs)	Particulate Matter (PM)	Sulfur Dioxide (SO <sub>2</sub> )
Arkansas	1	1575665	17	257601	1805006	469045	93233
Louisiana	23	2507843	17	547899	1978278	432023	236912
New Mexico	22	1775073	4	249026	2049448	916406	29451
Oklahoma	12	2151614	11	468105	1842306	776494	133250
Texas	43	6839207	50	1420740	8112737	2707236	559804

Source: Environmental Protection Agency, AirCompare, Air Emission Sources

### Air Pollutant Trends

- Carbon monoxide and volatile organic compounds (VOCs) were the two most emitted pollutants across all Region VI states in 2011.
- Texas produced nearly three times more carbon monoxide and VOCs than Louisiana, the second highest producer in the region.

- Arkansas, Louisiana, New Mexico and Oklahoma produced comparable amounts of all five pollutants reported: CO, NOs, VOCs, PM and SO<sub>2</sub>.

### Unhealthy Air Day Trends

- Across all Texas counties, 43 unhealthy air days (those affecting people with asthma and other lung diseases) were reported in 2014. This was the highest reported number in the region.
- Arkansas had the fewest number of reported unhealthy air days. Only one unhealthy air day was reported in one county.
- Louisiana and New Mexico had a similar number of unhealthy air days at 23 and 22, respectively. Oklahoma had the second lowest at 12.



# Regional Health Equity Council: Structure, Priorities, and Next Steps

## Mission:

To increase the effectiveness of programs that target the elimination of health disparities and address the determinants of health through the coordination of partners, leaders and stakeholders committed to action within Region VI.

## Vision:

A nation free of disparities in health and health care.

**Table 18: SWRHEC Priorities**

NPA Goals	Priorities
Awareness	<ul style="list-style-type: none"> <li>• Support sharing of information among community stakeholders to address health disparities and enable health equity via social media, namely Facebook</li> </ul>
Health System and Life Experience	<ul style="list-style-type: none"> <li>• Increase enrollment in health insurance through education and outreach to persons from diverse cultural and linguistic backgrounds in Region VI               <ul style="list-style-type: none"> <li>○ Support local events and activities through collaboration on venues, resource sharing, etc. to conduct outreach and education on insurance enrollment</li> <li>○ Use existing resources to reinforce or realign members' existing activities to encourage enrollment in health insurance</li> <li>○ Communicate with public officials to obtain support and commitment for bilingual navigators and outreach for enrollment</li> </ul> </li> <li>• Increase the number of bilingually-proficient navigators in Region VI               <ul style="list-style-type: none"> <li>○ Research the current status of the bilingual navigator workforce</li> <li>○ Develop issue brief for policymakers on the importance of bilingually-proficient navigators for Affordable Care Act enrollment</li> </ul> </li> <li>• Identify social and economic determinants of health in region via the Blueprint</li> </ul>
Cultural and Linguistic Competency	<ul style="list-style-type: none"> <li>• Advocate for policies to require health professionals to receive cultural competency training in order to renew their license</li> <li>• Advocate for health professional training programs to incorporate cultural competency throughout the curriculum rather than as a standalone module</li> </ul>
Data, Research and Evaluation	<ul style="list-style-type: none"> <li>• Share information with policymakers that will inform the development of initiatives to address health disparities and enhance health equity               <ul style="list-style-type: none"> <li>○ Collect data on activities by each state to address health equity in the region in the format of a Blueprint: Call to Action</li> <li>○ Develop dissemination strategies for the Blueprint</li> </ul> </li> </ul>

## Membership and Structure

Members of the SWRHEC are individuals from the public and private sectors who serve in a volunteer capacity and are willing to engage in actions to advance health equity and/or improve healthy living standards for the nation’s most vulnerable populations. SWRHEC members are committed to engagement in relevant work, policies or programs that seek to eliminate health disparities and/or promote healthy living standards. Membership includes individuals from the public and private sectors who represent state government, higher education, healthcare delivery, private foundations, community organizations, advocacy groups, volunteer organizations and more.

The Chair of the Council guides efforts to identify best practices and leverage support and resources for the SWRHEC’s activities.

The SWRHEC has established a committee structure to advance the mission and align its current and future priority areas to the NPA goals. Committees are charged with prioritizing the goal area strategies that are most relevant to the stakeholder communities represented by the members; ensuring a focus on and the inclusion of one or more social determinants of health in the committee’s activities; and developing an annual action plan. The committees are described in the following chart.

**Table 19: The SWRHEC Committee Structure**

Subcommittee	Description
Social Determinants of Health Committee	<p>The focus is to educate and increase awareness of social determinants of health and initiatives to address health inequities.</p> <p><b>Members:</b> Marisa New (Committee Chair), Lovell Allan Jones, Marshan Marick, Javier Rios, Frederick Sandoval, Thankam Sunil</p>
Policy Committee	<p>The focus is to convene local/regional groups and legislators to address policy issues related to health equity, health disparities, social determinants of health and the Affordable Care Act.</p> <p><b>Members:</b> Janice Ford Griffin (Committee Chair), Christine Patterson, Akeisha Singleton</p>
Communication	<p>The focus is to foster communication among RHEC members using the telephone, email and social media. This includes sharing the activities of SWRHEC and its partners, policies, data, reports and other communication requests that pertain to the SWRHEC’s health disparities work.</p> <p><b>Lead:</b> Javier Rios</p>
Governance	<p>The focus is to attract, recommend and promote membership and leadership within the SWRHEC.</p> <p><b>Lead:</b> Rick Ybarra</p>

## The Work of the RHEC

The Southwest Regional Health Equity Council (SWRHEC) recognized the need for collective action across its five states: Arkansas, Louisiana, New Mexico, Oklahoma and Texas. The initial focus of the SWRHEC was to examine collective action around the following issues. Health inequities are inconsistent with American values. Public and private sector investments in health are substantial. The contribution of health disparities to rising healthcare costs is often unrecognized. Increasing communication across our networks with data-driven messages have been key to our work. As our nation embraces the Affordable Care Act, the SWRHEC is continuing to address cultural competency and other issues that have impacted our health systems. A special focus was placed on Federally Qualified Health Centers and a policy statement was developed and distributed to all RHECs for their support and use.

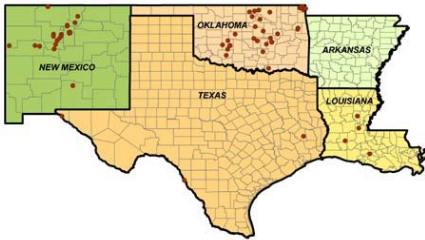
## Roles in Creating Health Equity

The SWRHEC continues to serve as a policy advisor for Region VI to the Office of Minority Health (OMH) NPA to ensure that Culturally and Linguistically Appropriate Services (CLAS) Standards are applied throughout the region through the use of data implementation. The SWRHEC also serves as experts on CLAS Standards content, implementation and best practices. In addition, the SWRHEC serves as a catalyst in health equity to:

- Maintain an integrated, three-pronged role in health equity by:
  - Promoting health disparities research to advance sustainable examples of community-driven health equity.
  - Advancing policies that promote health equity through evidence-based analyses and identifying gains, barriers and gaps in policies.
  - Strengthening front-line public health practice by connecting communities in Region VI with existing, but underutilized assets that promote health in its broadest sense.
- Provide insight into the healthcare landscape for Region VI states and their unique challenges and opportunities.
- Serve as a conduit to convene more groups or individuals to discuss and address health equity challenges.
- Promote and support model policies or programs that can help advance the SWRHEC's mission and vision.

The SWRHEC's primary role is to develop a shared understanding of the National Stakeholder Strategy for Achieving Health Equity; the impact of health disparities and social determinants that affect the health in the region; and existing projects and initiatives at community, state, tribal and regional levels. The SWRHEC continues to identify leaders and innovators and leverage activities conducted at state and local levels by identifying and highlighting successful models and initiatives. The SWRHEC's role in supporting tribal activities is aligned with the unique government-to-government relationship between tribes and the federal government. A focused collaboration with tribal and Indian urban organizations will be established to ensure American Indian/Alaska Native participation.

**Figure 21: The states served by the SWRHEC**



Source: <http://www.epa.gov/region6/6dra/oejta/tribalaffairs/mapspages/index.html>

## Existing and Potential Partners

- Día de la Mujer Latina (DML) and the Harold Freeman Patient Navigation Institute
- BlueCross Blue Shield of Texas
- Association for State and Territorial Health Officers (ASTHO)
- Hogg Foundation for Mental Health

## Wins and Successes

The SWRHEC has achieved many process and outcome milestones to date:

- Partnered with BlueCross Blue Shield of Texas and ASTHO to host a “Cultural Perspectives in Behavioral Health” Workshop for health service providers, community members and RHEC representatives (April 29, 2013).
- Hosted a one-day workshop during the “Addressing Stereotyping American Indian/Alaska Natives: Promoting Health Equity through Cultural Sharing Cultural Perspectives on Behavioral Health” Conference in Austin, TX (April 29, 2013).
- Organized a Health Day Summit to connect with supporters and funders and leverage resources (2013).
- Partnered with DML and the Harold Freeman Patient Navigation Institute to develop a three-day “Community Navigator” training session (July 2013).
- Developed an issue brief regarding Federally Qualified Health Centers and patients affected by the Affordable Care Act (September 2014).
- Developed a Social Media and Communications Policy (January 2015).
- Partnered with the Hogg Foundation for Mental Health to present the “It’s the Engine, Not the Caboose!” Webinar using logic models to develop SMART outcomes (May 7, 2015).
- Collected data on activities and events in Region VI related to Affordable Care Act enrollment (March-April 2015).

- Increased the number of “likes” on the RHEC VI Facebook page to 207.

## Call to Action

The *Southwest Regional Health Equity Council’s Blueprint* serves as a roadmap to new opportunities that address common concerns of committed individuals with an interest in collaborating to improve health outcomes. The *Blueprint for Action* reveals ongoing and emerging challenges as well as signs of promise for improved health status and health equity. The population in Region VI is growing in both size and diversity. Communication strategies are fundamental to achieving health equity. The SWRHEC recognizes that more interventions to strengthen the cultural and linguistic competencies of the healthcare workforce are essential. Both health/medical organizations and the target populations must become more health to improve communication and health outcomes. However, efforts must extend beyond the healthcare setting and personal behaviors.

We must seek to understand the communities where we live, work, learn and play. We must better understand and engage with our municipalities and other sectors of the community. Addressing the health of our communities must not be an afterthought. Instead, we must live and breathe by the decisions we make in our communities. A built environment, schools, housing, public transportation and stores that provide healthy foods must be available, accessible and affordable for long-term sustainability of our communities. We must invest in our schools, improve housing, integrate neighborhoods, create living wage jobs with career opportunities and assure more equitable fiscal policies. We must coordinate efforts to address the root causes of health inequities to maximize the health potential of all people. Our future generations depend on us.

The SWRHEC is positioned to advocate for better policies that support positive health outcomes. The SWRHEC Blueprint identifies the growing racial and ethnic diversity of our people and the issue of health literacy in our region. We must take action! The SWRHEC must collaborate with coalitions, councils and other groups to implement strategies that support positive health outcomes. The SWRHEC strongly recommends the following actions to achieve this goal.

**Goal:** Enhancing Individual and Community Well-Being\*

**Objective:** The SWRHEC will launch a Health Literacy Campaign. The SWRHEC believes that health literacy levels can impact the quality of care by acting as a barrier to accessing information that is needed to achieve optimal health and ultimately functioning as a social determinant of health.

**Strategy:** The SWRHEC will promote evidence-based or best practice health literacy interventions: one targeting the patient and the other targeting the health provider.

Join us! Let’s live healthier so all people can prosper to enjoy life.

*\*This goal is intentionally worded to align with the RWFJ “Culture of Health” Framework and the National Action Plan to Improve Health Literacy.*

## Appendices

*Note: Below is an inventory of Complete Streets policies in Region VI as of 2/27/2015, which could be incorporated into a table such as the example given above. Additional context on the meaning and implications of the policies would be helpful here.*

Agency	Policy	Level	Type	Year
Conway, AR	Ordinance No. 0-09-56	City	Legislation	2009
Hot Springs, AR	Complete Streets Policy	City	Policy adopted by elected board	2015
North Little Rock, AR	Resolution No. 7425	City	Policy adopted by elected board	2009
Baton Rouge, LA	Resolution 51196	City	Policy adopted by elected board	2014
Louisiana DOTD	Complete Streets Policy	State	Internal Policy	2010
New Orleans, LA	Ordinance No. 24706	City	Legislation	2011
Albuquerque, NM	0-14-27	City	Legislation	2015
Bernalillo County, NM	Pedestrian and Bicyclist Safety Action Plan	County	Plan	2012
Dona Ana County, NM	Resolution 09-114	County	Resolution	2009
Las Cruces MPO	Resolution No. 08-10	MPO	Resolution	2008
Las Cruces, NM	Resolution No. 09-301, Adopting Complete Streets Guiding Principles	City	Policy adopted by elected board	2009
Mesilla, NM	Resolution 2008-25	City	Resolution	2008
Metropolitan Transportation Board of the Mid-Region Council of Governments (Albuquerque, NM region)	R-11-09	MPO	Resolution	2011
Santa Fe Metropolitan Planning Organization (Santa Fe, NM area)	Resolution No. 2007-1	MPO	Resolution	2007
Santa Fe, NM MPO	Resolution 2007-1	MPO	Resolution	2007
Collinsville, OK	Resolution No. 2012-02	City	Resolution	2012
Edmond, OK	Resolution No. 11-10	City	Resolution	2010
Guthrie, OK	Resolution No. 2011-02	City	Resolution	2011
Lawton, OK	Resolution	City	Resolution	2011
Owasso, OK	Resolution No. 2015-03	City	Resolution	2015
Sand Springs, OK	Resolution 13-28	City	Resolution	2013

Tulsa, OK	Resolution	City	Resolution	2012
Alamo Area Metropolitan Planning Organization (San Antonio, TX area)	Resolution Supporting a Complete Streets Policy	MPO	Resolution	2009
Austin, TX	Resolution No. 020418-40	City	Resolution	2002
Austin, TX*	Complete Streets Ordinance	City	Legislation	2014
Brownsville Metropolitan Planning Organization (Brownsville, TX area)	MPO Resolution Supporting a "Complete Streets" Policy	MPO	Resolution	2013
Brownsville, TX	Resolution No. 2012-056	City	Resolution	2012
Capital Area Metropolitan Planning Organization (Austin, TX Area)	Texas Mobility Plan 2030	MPO	Plan	2005
El Paso, TX	Plan El Paso	City	Plan	2012
Houston, TX	Executive Order 1-15	City	Executive Order	2013
San Antonio, TX	Complete Streets Policy	City	Policy adopted by elected board	2011
Texas Department of Transportation	Guidelines Emphasizing Bicycle and Pedestrian Accommodations	State	Internal Policy	2011

**AI/AN Data:**

Race reporting for the American Indian/Alaska Native population through the 2009-2013 American Community Survey five-year estimates (American Fact Finder, 2015)

**Oklahoma:**

2013: 7% AI/AN only, 5.4% AI/AN and White

**Arkansas:**

2013: 0.6% AI/AN only, 0.9% AI/AN and White

**Louisiana:**

2013: 0.6% AI/AN only, 0.4% AI/AN and White

**Texas:**

2013: 0.5% AI/AN only, 0.5% AI/AN and White

**NOTE**

Native American is defined as a person who has origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicate their race as "American Indian/Alaska Native" or report entries such as Navajo, Blackfeet, Inupiat, Yup'ik, Central American Indian groups or South American Indian groups.

Respondents who identified themselves as "American Indian/Alaska Native" were asked to report their enrolled or principal tribe. Therefore, tribal data in tabulations reflect the written entries reported on the questionnaires. Some of the entries (for example, Metlakatla Indian Community and Umatilla) represent reservations or a confederation of tribes on a reservation. The information on tribes is based on self-identification, and therefore, does not reflect any designation of federally or state-recognized tribes. The information for the 2010 Census was derived from the American Indian/Alaska Native Tribal Classification List for the 2000 Census and updated from 2002 to 2009 based on the annual *Federal Register* notice, "Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs" (U.S. Department of the Interior, Bureau of Indian Affairs, Office of Management and Budget, and consultation with American Indian/Alaska Native communities and leaders).



Oklahoma:

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
<b>AMERICAN INDIAN [4]</b>			
Apache	2,125	2,316	3,576
Arapaho	669	753	961
Blackfeet	225	325	1,325
Canadian and French American Indian	29	37	99
Central American Indian	69	71	116
Cherokee	114,533	117,684	185,850
Cheyenne	2,152	2,374	3,157
Chickasaw	16,826	18,253	27,538
Chippewa	541	609	984
Choctaw	51,431	54,148	79,006
Colville	48	68	89
Comanche	6,413	6,708	8,741
Cree	51	66	132
Creek	28,364	31,003	44,170
Crow	118	132	210
Delaware	1,938	2,057	3,100
Hopi	64	86	137
Houma	25	25	44
Iroquois	2,398	2,580	3,548
Kiowa	5,724	6,218	7,711
Lumbee	79	89	137
Menominee	30	38	51
Mexican American Indian	913	953	1,470
Navajo	1,310	1,548	1,954
Osage	4,746	5,405	7,586
Ottawa	411	455	637

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
Paiute	35	54	94
Pima	85	90	122
Potawatomi	5,428	5,518	8,078
Pueblo	300	336	436
Puget Sound Salish	35	38	52
Seminole	7,429	8,834	11,493
Shoshone	109	137	198
Sioux	1,280	1,480	2,352
South American Indian	69	72	167
Spanish American Indian	72	76	109
Tohono O'Odham	55	62	86
Ute	30	34	66
Yakama	36	38	46
Yaqui	47	57	108
Yuman	94	98	112
<b>ALASKA NATIVE [5]</b>			
Alaskan Athabascan	72	77	103
Aleut	102	109	168
Inupiat [6]	90	104	196
Tlingit-Haida	70	76	122
Tsimshian	13	18	20
Yup'ik	32	36	63

Arkansas:

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
<b>AMERICAN INDIAN [4]</b>			
Apache	224	265	627
Arapaho	7	9	27
Blackfeet	136	211	799
Canadian and French American Indian	17	17	49
Central American Indian	46	46	67
Cherokee	8,659	9,090	20,330
Cheyenne	45	54	121
Chickasaw	318	345	613
Chippewa	190	219	374
Choctaw	2,702	2,902	4,840
Colville	10	10	15
Comanche	98	106	203
Cree	13	16	44
Creek	579	635	1,059
Crow	6	12	68
Delaware	71	71	140
Hopi	12	12	29
Houma	37	39	49
Iroquois	153	161	310
Kiowa	67	73	106
Lumbee	68	74	100
Menominee	7	9	13
Mexican American Indian	484	491	727
Navajo	171	190	331
Osage	169	198	379
Ottawa	46	57	77

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
Paiute	17	19	30
Pima	9	12	18
Potawatomi	228	230	325
Pueblo	53	59	96
Puget Sound Salish	7	8	20
Seminole	81	102	216
Shoshone	28	28	47
Sioux	265	299	609
South American Indian	28	29	61
Spanish American Indian	33	34	62
Tohono O'Odham	18	18	25
Ute	7	10	31
Yakama	5	6	16
Yaqui	36	42	73
Yuman	5	6	8
<b>ALASKA NATIVE [5]</b>			
Alaskan Athabascan	42	48	67
Aleut	28	33	41
Inupiat [6]	33	35	64
Tlingit-Haida	30	34	47
Tsimshian	2	2	2
Yup'ik	30	30	69

Louisiana:

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
<b>AMERICAN INDIAN [4]</b>			
Apache	158	209	486
Arapaho	11	13	23
Blackfeet	124	162	650
Canadian and French American Indian	75	80	187
Central American Indian	135	135	296
Cherokee	2,712	2,924	7,631
Cheyenne	17	25	65
Chickasaw	155	163	335
Chippewa	144	152	232
Choctaw	1,644	1,818	3,736
Colville	2	2	5
Comanche	61	73	143
Cree	11	12	41
Creek	323	346	598
Crow	10	13	45
Delaware	27	32	69
Hopi	3	6	18
Houma	6,846	6,889	8,666
Iroquois	94	99	202
Kiowa	21	27	49
Lumbee	71	74	88
Menominee	7	7	10
Mexican American Indian	402	416	675
Navajo	139	148	277
Osage	41	44	103
Ottawa	35	36	56

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
Paiute	17	17	34
Pima	8	8	13
Potawatomi	78	79	115
Pueblo	36	39	73
Puget Sound Salish	3	3	9
Seminole	48	54	150
Shoshone	21	23	42
Sioux	223	230	469
South American Indian	40	41	122
Spanish American Indian	69	80	131
Tohono O'Odham	4	4	8
Ute	3	3	12
Yakama	4	4	6
Yaqui	8	9	23
Yuman	6	7	10
<b>ALASKA NATIVE [5]</b>			
Alaskan Athabascan	39	43	66
Aleut	16	17	32
Inupiat [6]	15	18	35
Tlingit-Haida	17	17	33
Tsimshian	0	0	0
Yup'ik	3	3	6

**Texas:**

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
<b>AMERICAN INDIAN [4]</b>			
Apache	4,729	5,264	9,529
Arapaho	112	125	283
Blackfeet	738	926	3,744
Canadian and French American Indian	302	323	658
Central American Indian	1,266	1,295	2,072
Cherokee	17,084	18,281	50,954
Cheyenne	263	303	628
Chickasaw	3,861	4,080	6,836
Chippewa	1,164	1,205	2,098
Choctaw	12,722	13,395	24,024
Colville	43	47	76
Comanche	1,647	1,863	3,989
Cree	104	123	303
Creek	2,302	2,545	4,823
Crow	119	127	312
Delaware	478	500	849
Hopi	154	198	359
Houma	213	218	377
Iroquois	751	810	1,764
Kiowa	540	579	895
Lumbee	403	425	642
Menominee	53	60	109
Mexican American Indian	14,435	14,641	20,349
Navajo	2,759	2,927	4,269
Osage	739	805	1,535
Ottawa	282	295	415

Subject	Tribe alone [1]	Tribe alone or in combination with one or more other tribes [2]	Tribe alone or in any combination [3]
Paiute	130	138	216
Pima	150	161	250
Potawatomi	1,373	1,383	2,099
Pueblo	1,904	2,001	2,599
Puget Sound Salish	77	78	121
Seminole	585	717	1,496
Shoshone	148	160	267
Sioux	1,936	2,095	3,951
South American Indian	707	728	1,644
Spanish American Indian	1,214	1,235	1,845
Tohono O'Odham	164	174	252
Ute	113	129	216
Yakama	45	46	83
Yaqui	374	431	736
Yuman	94	98	160
<b>ALASKA NATIVE [5]</b>			
Alaskan Athabascan	183	190	296
Aleut	159	162	259
Inupiat [6]	173	185	317
Tlingit-Haida	182	188	290
Tsimshian	13	19	35
Yup'ik	84	84	120

1. One tribe alone (e.g., Cherokee, or Navajo, or Alaskan Athabascan).
2. One tribe alone (as in footnote 1), or in combination with one or more other tribes (e.g., Apache and Navajo, or Yakama and Aleut). Individuals are included in each category.
3. One tribe alone (as in footnote 1), or in combination with one other tribe (as in footnote 2), or in combination with any other race group in addition to American Indian and Alaska Native (e.g.,



Cherokee and White; or Apache, Navajo, and White; or Inupiat, White, and Black or African American).

4. The American Indian categories shown represent tribal groupings, which refer to the combining of individual American Indian tribes, such as Fort Sill Apache, Mescalero Apache, and San Carlos Apache into the general Apache tribal grouping.
5. The Alaska Native categories shown represent tribal groupings, which refer to the combining of individual Alaska Native tribes such as King Salmon Tribe, Native Village of Kanatak, and Sun'aq Tribe of Kodiak into the general Aleut tribal grouping.
6. The term "Inupiat" is used in the 2010 Census to classify responses that were classified in previous censuses as "Eskimo." (US Census Bureau, 2010 Census).

Summary File 1, Tables PCT1, PCT2, and PCT3.