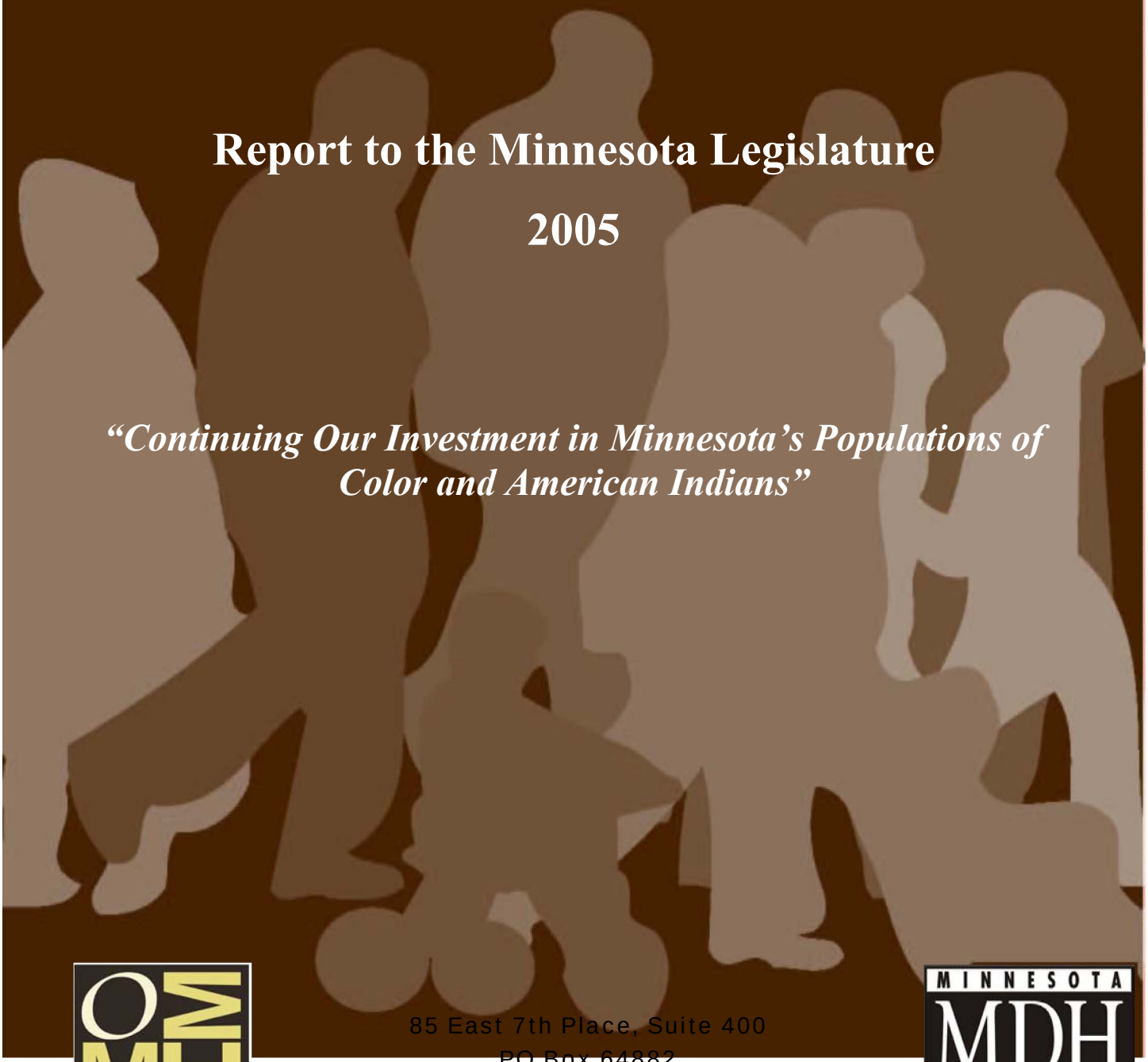
Eliminating Racial and Ethnic Health Disparities Initiative

Report to the Minnesota Legislature

2005

"Continuing Our Investment in Minnesota's Populations of Color and American Indians"



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MINNESOTA MDH DEPARTMENT OF HEALTH

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"Continuing Our Investment in Minnesota's Populations of Color and American Indians"

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Minnesota Eliminating Health Disparities Initiative Report to the 2005 Minnesota Legislature

The Eliminating Health Disparities Initiative, a comprehensive, statewide initiative, focuses on strengthening and improving health of Minnesota's American Indians, African Americans, Asian Americans and Latinos/Hispanics in eight Priority Health Areas: immunizations; infant mortality; HIV/AIDS and sexually transmitted diseases; cardiovascular disease; diabetes; breast and cervical cancer; violence and unintentional injuries; and healthy youth development.

In 2001, the Eliminating Health Disparities Initiative (EHDI) was funded by the Minnesota Legislature with the goal of strengthening and improving the health status of American Indians, African Americans, Asian Americans, and Latinos/Hispanics in Minnesota. The legislature directed the Minnesota Department of Health to design and implement a comprehensive plan to eliminate these health disparities with the support and involvement of communities of color and tribal representatives.

Community is critical to the stability and continuation of the EHDI. Since its inception, representatives of Populations of Color have had a key leadership role in the initiative. There are several other key elements to the initiative including building the capacity of local grassroots organizations and developing partnerships to create greater access to health care and prevention services in local communities.

This initiative is made up of several components including three grant programs, Tuberculosis Services for Foreign-born Persons, Community Health Grants and Tribal Health Grants. The Office of Minority and Multicultural Health (OMMH) administers the Community and Tribal Health Grants while the Tuberculosis Program is administered through the Infectious Disease Epidemiology, Prevention, and Control Division at the Minnesota Department of Health.

The **Tuberculosis Services for Foreign-born Persons Grant Program** provides funding to local public health agencies for tuberculosis screening and follow-up services for foreign-born persons. Forty-one local public health agencies are participating in this program.

Fifty-two **Community and Tribal grantees** are serving communities in 31 counties throughout the state in the eight Priority Health Areas (Figure 1). Identifying and/or creating new and innovative strategies to address racial/ethnic disparities is a key part of the EHDI program, as is a focus on prevention and early detection. The grant programs are intended to promote active and full community involvement and build and strengthen relationships among community members, faith-based organizations, culturally based organizations, social service organizations, community non-profit organizations, tribal governments, community health boards, community clinics and other health care providers, and the Minnesota Department of Health.

The Community and Tribal grantees have been working hard in the first four years of the EHDI to achieve the short-term results (e.g. increased awareness of the importance of immunization) that will in turn encourage improvement in long-term results (e.g. increased immunization levels) to eliminate health disparities. Grantees have been using innovative, culturally-specific strategies to achieve their goals. Their efforts have been a combination of innovative thinking, strong partnerships, and capacity building, all led by their communities.

Eliminating Health Disparities Initiative Legislative Goals

By 2010, decrease by 50% disparities in infant mortality and adult and child immunization rates.

By 2010 close the gap in health disparities in breast and cervical cancer; HIV/AIDS and sexually transmitted infections; cardiovascular disease; diabetes; and accidental injury and violence.

Examples of Community and Tribal grantee strategies include:

The EHDI has provided support for doula training programs. In EHDI programs, doulas provide support during pregnancy and birth, to reduce the risk of poor birth outcomes and decrease **infant mortality** rates in targeted communities.

Grantees have carried out many activities to improve **healthy youth development** including health-oriented youth leadership trainings, educational and career planning and spiritual retreats to promote positive attitudes and prevent risk behaviors such as alcohol and drug use and sexual activity among Minnesota youth.

In **unintentional injury and violence,** grantees have developed programs focusing on numerous topics ranging from domestic violence prevention in a tribal community to the reduction of work-related injuries among migrant farm workers. Another grant program taps the wisdom of tribal leaders and spiritual elders to reduce the incidence of domestic violence.

Cardiovascular disease grantees use a wide range of methods to reduce the incidence of the disease. These include nutrition classes, providing health care information through radio and television programs, hosting walk/run events, organizing walking clubs, blood pressure screening, and assisting with interpretation.

Community and Tribal Grantee Outcome Examples

Ninety-five percent of high risk mothers participating in the American Indian Family Center Doula Program gave birth to normal birth weight babies.

Youth in the Bois Forte Band of Chippewa Summer Youth program lost an average of 3.4 pounds and 1.33 body mass index points.

Seventy-five percent of the men participating in White Earth Tribe anger management program were able to identify their triggers for anger after completing the group sessions.

Grantees have taken several approaches to increase the number of women screened for **breast and cervical cancer**. Through EHDI, grant programs have increased their clients' understanding of the importance of early screening for detection of breast and cervical cancer through community workshops and classes; church festivals; and powwows.

Through EHDI, Community and Tribal Grantees have reached Minnesotans throughout the state. EHDI grantees report that through their EHDI programs over 100,000 people have been reached through diabetes programs, over 97,000 people through cardiovascular disease programs, and over 22,000 through healthy youth development programs (Table 1).

Number of People* Served through Eliminating Health Disparity Initiative Grantees, by Priority Health Area and Population

	African American^	American Indian	Asian	Hispanic	Total**
Infant Mortality	34,594	1,351	401	4,523	73,687
Immunization	37,503	259	591	7203	79,600
Breast and Cervical Cancer	33,201	3,483	230	4,152	72,950
Diabetes	53,915	799	823	9,896	100,442
Cardiovascular Disease	53,455	1,567	1,660	5,574	97,136
Unintentional Injury and Violence	3,873	781	1,590	6,761	15,101
HIV/AIDS and STIs	31,054	488	2	2,094	68,879
Healthy Youth Development	13,771	608	1,761	4,748	22,004

*Numbers are reported by individual grantees and include people reached through mass media campaigns, workshops, health fairs etc. Numbers may be duplicative across health areas.
^Includes African-born
**Total includes multi-racial and White individuals

Evaluation and Measurable Outcomes

Results are vital to the success and continuation of the EHDI.

The identification, measurement, and reporting of measurable outcomes (long term, intermediate, and program level) for community, tribal, and local public health programs has been a priority for the EHDI since its inception. Long-term measurable outcomes have been identified through the technical expertise of state and national consultants and are monitored through existing surveillance systems. EHDI is working with community and University of Minnesota researchers to identify and design data collection tools for intermediate outcomes. Since 2002, MDH has contracted with Rainbow Research, Inc., a local evaluation firm, to provide technical assistance and evaluation capacity building to EHDI grantees in order to establish and monitor short term outcomes relevant to their communities and tribes.

Appendix H addresses measurable outcomes, Appendix I short-term grantee outcomes, and Appendix J provide outcomes by Priority Health Area.

Other EHDI Components

Community leadership, technical assistance, capacity building and coordination, and establishing partnerships are key elements of the EHDI. Most recently, because of the significance of the EHDI and the illumination of racial and ethnic health disparities in Minnesota, the Office of Minority and Multicultural Health (OMMH) has been directed to work more extensively throughout the Minnesota Department of Health. The OMMH works across divisions so that program elements essential to eliminating racial and ethnic health disparities can be addressed and incorporated throughout the agency. The EHDI has also provided the impetus for OMMH, racial and ethnic communities, and Local Public Health (LPH) agencies to partner in powerful and constructive ways. EHDI grantees have worked along with LPH agencies to provide much needed health promotion and prevention services to their communities.

Other EHDI partners include community- and faith-based organizations, local public health, and the four state councils: the Indian Affairs Council, the Council on Chicano/Latino Affairs, the Council on Black Minnesotans, the Council on Asian-Pacific Minnesotans, health care systems and institutions who have come together as the *Health Care Disparities Task Force,* the Minnesota Department of Human Services, and the University of Minnesota Academic Health Center.

Conclusion

The EHDI has had significant impact in communities throughout the state. It is clear that the legislation, resources, and people committed to this work are changing the way Minnesota's communities and systems address health among Populations of Color and American Indians around the state. Their efforts have been a combination of innovative thinking, strong partnerships, and capacity building, all led by their communities.

In 2001, in response to growing disparities in health between Minnesota's American Indians and Populations of Color, and the White population, the Minnesota Legislature created the *Eliminating Health Disparities Initiative* (EHDI). A biennial Report to the Legislature is required in statute (see Appendix A) and must be presented every other year beginning January 2003. This report includes information on who receives the EHDI grants, the ways in which the grant funds are being used, evaluation data, and outcome measures. Additional components of the statute are addressed as well, as they are part of the road to successful achievement of the EHDI goals.

The Minnesota EHDI is one of several projects and activities administered through the Office of Minority and Multicultural Health (OMMH) at the Minnesota Department of Health. OMMH's mission is consistent with the mission of the Minnesota Department of Health, which is to promote the health of all Minnesotans. The OMMH focus is promoting the health of Populations of Color and American Indians in Minnesota. The EHDI focuses on eliminating racial and ethnic health disparities in Minnesota through local and statewide activities and Community and Tribal Health Grants. OMMH is part of the Office of the Commissioner of Health, and, as such, influences all areas of the agency (see Appendix B). OMMH staff work with communities, tribes, MDH program staff, and other sectors to coordinate local, regional, and statewide efforts and provide grantees and racial and ethnic communities with capacity-building skills, resources, and technical assistance.

> ***"I don't have words to thank God to have placed in my path, practically at my doorstep, people that work in health prevention."***
>
> **EHDI Grantee Client**

EHDI is a comprehensive statewide effort focusing on strengthening and improving the health of American Indians, African Americans, Asian Americans, and Latinos/Hispanics. Minnesota is only the second state in the country to develop a statewide effort to address racial and ethnic health disparities, and the first to do so in a comprehensive manner. The comprehensiveness of EHDI means it has become a catalyst and player in changing Minnesota's public and private health systems. The Minnesota EHDI also serves as a model for eliminating racial and ethnic health disparities nationwide. As a result, information and presentations on EHDI are requested by many state and national organizations in order for others to learn from this landmark initiative.

The heart of EHDI's purpose, mission, and success is its commitment to supporting health promotion activities that are driven by racial and ethnic communities, based in their cultural beliefs, practices, and traditions, and grounded in the assets of the community.

The EHDI was created to address health disparities among Minnesota's Populations of Color, Americans Indians, and Whites. Data indicate racial/ethnic populations in Minnesota have grown dramatically including Asian, Hispanic/Latino, and African American communities. Census data reflects this increasing diversity (Table 1).

Table 1: Minnesota Population Change: 1980-2000

Racial/Ethnic Group	1980 Census	1990 Census	2000 Census[1]	1980-2000 Percent Change
African American	53,344	94,944	171,731	221.9
American Indian	35,016	49,909	54,967	57.0
Asian	32,226	77,886	143,947	346.7
Hispanic/Latino	32,123	53,884	143,382	346.4
White	3,935,770	4,130,395	4,400,282	11.8
Total Population[2]	4,075,970	4,375,099	4,919,479	20.7

Source: U.S. Bureau of Census

[1] The population base for 2000 Census data is from Census 2000 Summary File 1 (SF 1) 100-Percent Data using the "race alone."

[2] The population count for each racial/ethnic group does not add up to "Total Population" because Hispanic/Latino, who can be of any race, are counted in the racial groups and because "Some other race alone" and "Two or more races" categories are excluded from the table.

Minnesota's increasing diversity is a result of many factors including immigration. In 2000, population figures indicated that 5.3 percent of the state's population was born outside the United States and Puerto Rico. These figures also indicate that 69.0 percent of Asians and 40.6 percent of Hispanics living in Minnesota were foreign-born.

Table 2: Immigrants Living in Minnesota, 2000

Racial/Ethnic Group:	Population[1]	Number Foreign-born	Percent Foreign-born
African American	167,857	29,457	17.5 %
American Indian	54,568	1,529	2.8 %
Asian	140,969	97,279	69.0 %
Hispanic/Latino	141,786	57,573	40.6 %
White	4,402,124	84,883	1.9 %
Total Population[2]	4,919,479	260,463	5.3 %

Source: U.S. Bureau of Census, Census 2000

[1] The population base is extrapolated from sample data (Census 2000 SF-3) and therefore differs from the real count.

[2] The added value of each population group does not add up to "Total Population" because Hispanics, who can be of any race, are not counted in the total and because "Other Race" is excluded from the table.

Health disparities are evident among both U.S. born and immigrants and refugee populations in Minnesota.

Health disparities are defined as the difference in health status between Populations of Color and American Indians and Whites in Minnesota. Health disparities means Populations of Color and American Indians experience shorter life spans; higher rates of infant mortality; higher incidences of diabetes, heart disease, cancer, and other diseases and conditions; and poorer general health than the White population (Appendices C and D).

Disparities in health status between the White population and Populations of Color and American Indians in Minnesota have existed for some time, and have, in some cases, been getting worse, not better. These disparities are a result of a complex interplay of many factors including racism, access to health care, social conditions, and health behaviors. Populations of Color and American Indians experience worse health outcomes and poorer health status than the White population. For example:

"We know that African Americans, Hispanics and Native Americans die younger and suffer from heart disease, diabetes and HIV/AIDS at higher rates than everyone else. These numbers are unacceptable".

Wm. Frist, Majority Leader
U.S. Senate

African Americans: Individuals are less likely to be insured; infants are much more likely to be born early or too small or to die during infancy; children are less likely to be immunized; youth are more likely to die as a result of firearms; and as a population experience higher rates of HIV/AIDS.

American Indians: Individuals are less likely to be insured; infants are much more likely to die during infancy; as a population experience higher rates of suicide; and more likely to die from diabetes and cardiovascular disease.

Asian Americans: Asians are less likely to be covered by health insurance plans; children are less likely to be immunized; and individuals are more likely to die from a stroke than other populations.

Latinos/Hispanics: Individuals are less likely to have health insurance; children are less likely to be immunized; youth are more likely to be victims of violence; as a population experience higher rates of AIDS/HIV; and individuals are more likely to die from diabetes and cardiovascular disease.

The EHDI was created to reduce disparities and improve the health of Populations of Color and American Indians in the state. EHDI provides capacity building and support for EHDI grantees and other local service organizations; plans and supports health fairs, conferences, and trainings; works to build partnerships within/between communities, health providers, and state and local public health agencies; and promotes a system-wide approach to address health disparities in Minnesota.

The purpose of the Eliminating Health Disparities Initiative is to close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanic/Latinos in Minnesota compared with Whites in the following priority health areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, healthy youth development, and violence and unintentional injuries, and by 2010, decrease by 50 percent the disparities in infant mortality and adult and child immunization rates.

"I wish to extend my sincere gratitude to your organization for your active participation in saving my life. The blood pressure reading you discovered prompted me to take immediate action. Had it not been for your organization, I might have waited too late to address this issue."

EHDI Grantee Client

The statute addresses these components of the EHDI:

- A partnership steering committee that will address health disparities in a comprehensive and coordinated way and develop a state plan for EHDI (Appendix A).
- A set of measurable outcomes to track Minnesota's progress in reducing health disparities. (Appendix H).
- Improved statewide assessment of risk behaviors among African American/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota. (See page 20).
- Technical assistance for grant applicants and recipients. (See page 22).
- Community and tribal grants directed at reducing health disparities in:
    - Immunizations for adults and children, and infant mortality;
    - Breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and violence and unintentional injuries; and
    - Healthy youth development.
- Health screening and follow-up services for tuberculosis for foreign-born persons (See page 5 and Appendices E and F).
- Evaluation of the initiative. (See page 20).
- A biannual report to the legislature (Appendix A).

Identifying and/or creating new and innovative strategies to address racial/ethnic disparities is a key part of the EHDI, as is a focus on prevention and early detection. This initiative is intended to promote active and full community involvement and build and strengthen relationships among community members, faith-based organizations, culturally-based organizations, social service organizations, community non-profit organizations, tribal governments, community health boards, community clinics and other health care providers, and the Minnesota Department of Health. The EHDI provides an opportunity for the grantees, community members, and the Minnesota Department of Health to build on the strengths and assets of a community as they promote the health and quality of life of individuals and communities, and work toward reducing the health disparities of racial and ethnic populations.

The 2001 legislation established three categories of EHDI grant programs: Tuberculosis Services for Foreign-born Persons, Community Grants, and Tribal Health Grants. OMMH administers the Community and Tribal Health Grants while the Tuberculosis Services Program is administered through the Infectious Disease Epidemiology, Prevention, and Control Division at the Minnesota Department of Health.

Tuberculosis Grants Program - Local Public Health

$700,000 per biennium from State General Funds is allocated to local public health agencies to specifically provide health screening and follow-up tuberculosis services for foreign-born persons. Local public health staff contact each newly arrived refugee family, arrange for comprehensive screening, and report results back to MDH. Local public health agencies are also responsible for providing outreach services (e.g., directly observed therapy, interpreter services, incentives, enablers, etc.) to ensure that patients with tuberculosis adhere to and complete their prescribed treatment regimens. EHDI funding provides some of the financial support for this intensive and costly outreach service to 41 Community Health Boards throughout Minnesota (See Appendix E for current screening rates, and Appendix F for 2004 protocols).

Community Grants Program

This Legislation directs State General Funds each biennium for the Community Grants Program to eliminate racial and ethnic health disparities in the following priority health areas: infant mortality; adult and child immunizations; breast and cervical cancer; cardiovascular disease; HIV/AIDS and STIs; diabetes; and violence and unintentional injury. $4 million per biennium in federal TANF (Temporary Assistance to Needy Families) funds was allocated to EHDI for healthy youth development.

"I cannot THANK YOU enough for the printed Somali info you have sent. Our clients also thank you. Thanks again for coming to my rescue. I feel like I am better prepared to care for these women and want to be sensitive to their cultural desires/needs."

Nurse Midwife, Chicago, Ill

For the second Community Grant biennium (2004-05), the 49 EHDI Community grantees from the 2002-03 cycle could re-apply for an additional two years of funding. Grantees were recommended for awards based on their progress in the first cycle and the work proposed in the second cycle. For the 2004-05 cycle, $5,722,966 was awarded to 42 community grantees.

Tribal Health Grants Program

Tribal governments were allocated $1 million from State General Funds per biennium to reduce health disparities in the first seven priority health areas listed above. Formulas for resource allocation were developed with the guidance of Minnesota tribal governments and tribal health directors. Ten tribal communities are participating in the Tribal Health Grants Program.

Table 3: EHDI Grants Distribution 2002-2003 and 2004-2005 State Biennia

Grant	Eligibility	2002-2003 Cycle	2004-2005 Cycle	Number of Grantees 2002-2003 Cycle	Number of Grantees 2004-2005 Cycle
Community	Faith based, social service & community non profit organizations, Community Health Boards & Others	$ 6,700,000	$ 5,722,966	49	42
TANF*	Same as Community	$ 4,000,000	$ 3,974,860	20	18
Tribal	Tribal Governments	$ 1,000,000	$ 1,000,000	10	10
Tuberculosis**	Community Health Boards	$ 700,000	$ 700,000	46	41
Biennial Grants Total		**$12,400,000**	**$11,397,826**		

* Federal TANF funds were distributed through the Community Grants process for healthy youth development.
**Allocated on a formula basis

Populations Served

The 2004-05 Community and Tribal Health Grantees work with each of the four major racial/ethnic communities in Minnesota and address each of the eight Priority Health Areas. A total of 20 grantees are serving African American/African Born communities throughout the state, 18 are serving Latinos, 19 are serving American Indians, and 15 are providing services to Asians (Table 4). Many grantees serve more than one racial/ethnic population. For example, one grantee serves Latino and Somali teens while another grantee serves Asian, African American, Latino, and American Indian pregnant women to improve their birth outcomes.

Table 4: Number of 2004-5 Tribal Health and Community Grantees by Racial and Ethnic Communities Served

EHDI Grantees*	Racial/Ethnic Communities
20	African American/African Born
19	American Indian
18	Latino
15	Asian/SE Asian
15	Multi-racial & other

* Many grantees serve more than one racial/ethnic community.

Priority Health Area

The Community and Tribal Health Grantees address each of the eight Priority Health Areas. Twenty grantees are working on reducing disparities in diabetes, 11 are addressing HIV/AIDS and STIs, 12 are implementing programs on improving immunizations, and 18 are working with youth to encourage healthy development (Table 5). Many grantees are working in more than one area. Sixteen EHDI grantees have implemented programs that address the risk factors associated with cardiovascular disease and diabetes.

Table 5: Number of 2004-5 Tribal Health and Community Grantees by Priority Health Area

EHDI Grantees*	Priority Health Area
9	Breast and cervical cancer
16	Cardiovascular disease
20	Diabetes
11	HIV/AIDS and STIs
11	Infant mortality
12	Immunizations
18	Healthy youth development
11	Violence and unintentional injuries

*Many grantees have selected more than one priority health area.

People Served

According to the EHDI grantees, Table 6 shows the number of people reached through EHDI grants programs as of December 2004. Diabetes programs have reached approximately 100,442 people, cardiovascular disease 97,136 people, and healthy youth development 22,004 people.

Table 6: Number of People* Served through Eliminating Health Disparity Initiative Grantees, by Priority Health Area and Population

	African American^	American Indian	Asian	Hispanic	Total**
Infant Mortality	34,594	1,351	401	4,523	73,687
Immunization	37,503	259	591	7,203	79,600
Breast and Cervical Cancer	33,201	3,483	230	4,152	72,950
Diabetes	53,915	799	823	9,896	100,442
Cardiovascular Disease	53,455	1,567	1,660	5,574	97,136
Unintentional Injury and Violence	3,873	781	1,590	6,761	15,101
HIV/AIDS and STIs	31,054	488	2	2,094	68,879
Healthy Youth Development	13,771	608	1,761	4,748	22,004

*Numbers are reported by individual grantees includes people reached through mass media campaigns, workshops, health fairs etc. Numbers are not non duplicative across health areas.
^Includes African-born
**Total includes multi-racial and White individuals

Geographic Regions Reached

Grantees serve diverse geographic regions. Some grantees provide services in multiple counties while others may concentrate on small neighborhoods in Minneapolis and St. Paul. Together, EHDI Community and Tribal Grantees reach communities in 43 counties in Minnesota (Figure 1).

Figure 1: Counties Reached by 2004-5 Community and Tribal Grants

The EHDI Community and Tribal Grantees serve many communities throughout the state using innovative strategies in the eight Priority Health Areas. The strategies selected and implemented by grantees, therefore, are very diverse; some are tested and proven, others innovative and evolving. Because of the innovative nature of the strategies, a crucial aspect of the EHDI Grants Program is the grantee-implemented evaluations. Rainbow Research, Inc. worked with the grantees to build their evaluation capacity. Each grantee developed a program outcome model, an evaluation plan, and at least one measurable outcome. Because the strategies are diverse and the types of measurable outcomes are numerous, this section will provide a summary of grantee programs and measurable outcomes. Descriptions of grantees programs and selected program outcomes are available in Appendices G, H, and I.

Immunization

Disease prevention is the key to public health. It is always better to prevent a disease than to treat it. Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals (CDC National Immunization Program). In 2001, the legislature identified immunization of Populations of Color and American Indians as a priority for the Eliminating Health Disparities Initiative. The EHDI Legislation specifically stated that by 2010, the disparities in adult and child immunization rates between Populations of Color/American Indians and Whites be reduced by 50 percent.

In 2001, the percent of children immunized varied by race and ethnic group (Table 7). Eighty-five percent of White children were up to date on their immunizations at 24 months of age, compared to 62% for African American children, 65% for Hispanic/Latino, 66% for Asian children, and 73% for American Indian children of the same age.

Table 7: 2001-02 Immunization Levels for Primary Series (Percent Up to Date) by Race/Ethnicity and Age in Months

Race (Number of children)	4 Mo	6 Mo	8 Mo	17 Mo	20 Mo	24 Mo
White, non-Hispanic (48,371)	95%	91%	86%	81%	80%	85%
American Indian (1,072)	91%	80%	67%	71%	65%	73%
Asian/Pacific Islander (3,331)	82%	69%	59%	65%	58%	66%
Hispanic/Latino (3,079)	87%	79%	70%	66%	58%	65%
African American, non-Hispanic/Latino (4,599)	78%	68%	58%	61%	55%	62%

Source: Minnesota Retrospective Kindergarten Survey

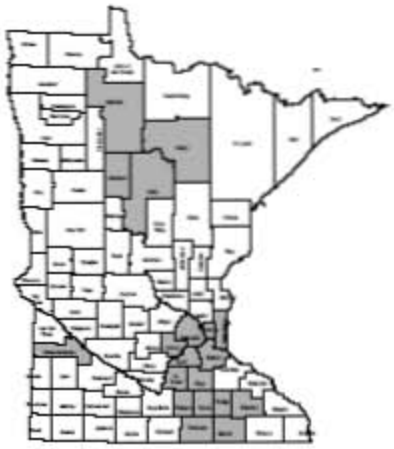
In accordance with the legislation's mandate, a 50% reduction in disparities would mean that 79% of American Indian, 76% of Asian, 75% of Hispanic and 74% of African American children 24 months old would be up to date on their immunizations by 2010 (Table 8).

Table 8: 2010 Target Immunization Levels based on a 50% Reduction in Disparities for Minnesota Children by Race and Ethnicity

Race	4 Mo	6 Mo	8 Mo	17 Mo	20 Mo	24 Mo
White, non-Hispanic	--	--	--	--	--	--
American Indian	93%	86%	77%	76%	73%	79%
Asian/Pacific Islander	89%	80%	73%	73%	69%	76%
Hispanic/Latino	91%	85%	78%	74%	69%	75%
African American, non-Hispanic	87%	80%	72%	71%	68%	74%

Nationally, disparities in immunizations for influenza and pneumococcal vaccinations between Whites and Populations of Color/American Indians have been documented. The Centers for Disease Control and Prevention's 2000-2001 National Health Interview Survey indicated that in the Midwest, 50.2% and 49.4% of African Americans and Hispanics, respectively, over age 65 were immunized for influenza compared to 66.4% of Whites. From the same survey, 33.9% and 27.8% African Americans and Hispanics/Latinos, respectively, over age 65 were immunized for pneumococcal compared to 56.5% of Whites.

Figure 2: Counties Reached by Immunization Grantees



Twelve EHDI grantees have implemented programs throughout Minnesota to meet the targeted levels of immunization (Figure 2). Since these programs began, EHDI grantees have reached a total of 79,600 adults and children through immunization-related activities with many positive results. Their efforts have increased the understanding of the importance of immunizations among their communities. For example the **Center for Asian Pacific Islanders** held hour-long information sessions in Hmong and Somali on the importance of immunizations. Before taking the sessions, only 25% of the participants were knowledgeable about immunizations, after the test 79% were knowledgeable.

79,600
People reached through immunization-related activities.

Their efforts have also increased awareness of clinic locations and the need for immunizations that in turn increases vaccination levels. In Southern Minnesota, **Centro Campesino**, a migrant farm worker organization, held eight immunization clinics in three southern counties. A total of 464 adults were immunized for Hepatitis B and tetanus. In Eagan, **The Storefront Group** worked, through workshops and targeted outreach, with Somali families to make sure their children had up-to-date school immunization records. As a result, 95% of Somali students in the three schools in which Storefront worked had up-to-date records.

Immunization Activities

- Educational Workshops
- Interpretation Services
- Cultural Competency Courses
- Immunization Clinics
- Media Campaigns

Infant Mortality

As with immunization, the goal of the EHDI is to reduce disparities in infant mortality by 50 percent. In 1995-99, the infant mortality rates for African Americans and American Indians were more than twice the White infant mortality rate. The 2010 goal for infant mortality is 9.4 and 9.5 infant deaths per 1,000 births for African Americans and American Indians respectively and 6.3 for Asians and Hispanics.

IMR* Baseline^	*Race/Ethnicity*	IMR* Target
5.5	White	-- --
13.2	African American	9.4
13.5	American Indian	9.5
7.1	Asian	6.3
7.0	Hispanic	6.3

*Infant Mortality Rate
^1995-1999
Vital Statistics, MDH

Eleven grantees in the Minneapolis/St. Paul Metro Area and the tribal communities of Leech Lake, Red Lake, Fond du Lac, and Mille Lacs have implemented programs to reduce disparities in infant mortality rates. An estimated 73,687 people have been reached by EHDI grantee efforts to reduce infant mortality including 7,500 children.

Grantees have been holding workshops on breastfeeding, SIDS, and prenatal health care, providing education outreach through home visits and role modeling, and offering holistic curricula that incorporate diet, exercise, and drug/alcohol education. Grantees have also conducted media campaigns through radio and television.

73,687
People reached through infant mortality-related activities.

Through their programs, EHDI grantees have been working to increase the knowledge of women with high risk pregnancies, provide women with a better understanding of fetal development and changes that occur throughout pregnancy, increase the knowledge of effective parenting techniques, and increase the use of doulas during pregnancy and delivery.

From their efforts, EHDI grantees have seen an increase in the number of clients receiving prenatal care and a decrease in the percent of high risk pregnancies that result in low birth weight babies. For example, 100% of the Fond du Lac Center for American Indian Resource's obstetric clients received prenatal care information over an 18-month period, a 22 percentage-point increase, 54% of Red Lake Comprehensive Health Services clients seeking other services attended child birth classes, and 95% of high risk mothers participating in the American Indian Family Center Doula Program gave birth to normal birth weight babies.

What is a Doula?

"A woman experienced in childbirth who provides continuous physical, emotional, and informational support to the mother before, during and just after childbirth."

At the **American Indian Family Center** in St. Paul, doulas give clients support and guidance before and after the baby is born, attend clinic appointments, offer breastfeeding support, and provide at least two post-partum visits.

Doulas at the **Division of Indian Work** in Minneapolis help teen mothers-to-be with labor and child birth.

Leech Lake Reservation /Cass County Children's Initiative has included the services of doulas to improve birth outcomes and increase breastfeeding.

Healthy Youth Development

Good health (physical, emotional, social, and spiritual) provides youth with a strong foundation for adult life. Lifestyle behaviors developed during childhood and adolescence continue into adulthood and influence long-term prospects for health and risk of chronic disease. Investment in health during adolescence has long-term benefits and is an important part of the Eliminating Health Disparities Initiative.

Eighteen EHDI grantees have implemented programs aimed at improving the health of youth of color and American Indian youth in the Twin Cities metro area and Kandiyohi County. Grantees have carried out many activities to improve the health of Minnesota youth including health-oriented block parties, youth leadership trainings, educational and career planning, and spiritual retreats to promote positive attitudes.

11,227
Youth reached through Healthy Youth Development-related activities.

Since these programs began, EHDI grantees have reached a total of 11,227 youth and 10,627 adults in their efforts to promote healthy youth development. Their programs have improved the parenting skills of young parents, decreased high risk behaviors such as alcohol and drug use and having unprotected sex, promoted the use of health clinics, and encouraged positive behaviors.

Community and Tribal Grantees

Agape House provides African and African American teens in the Twin Cities with behavioral health skills and decision making tools.

- ✓ Ninety-five percent (1,315) of youth who participated in the Agape House's pledge to remain abstinent, did so.

Freeport West's Project Solo Pregnancy Prevention Program in Minneapolis is a culturally-specific, community-based circle of care for adolescent African American females.

- ✓ Fifty percent of the 66 teens who were in Project Solo were not engaging in high risk behaviors such as using alcohol and drugs and having unprotected sex.

The **Lao Family Community of Minnesota** offers a young parents' program, which provides case management services and group sessions to young Hmong mothers and fathers, serving mainly high school students in the St. Paul area.

- ✓ Fifty percent of the 34 young parents participating in the program achieved their self-set goals for parenting improvement.

Unintentional Injury and Violence

The burden of injury and violence in Minnesota is not shared equally. The homicide rate for American Indians is eight times the White rate and the rate for African Americans is almost 12 times the White rate. The percent of 6th, 9th, and 12th grade Latino and American Indian girls who have ever attempted suicide is almost double that of White girls in the same grades. Finally, three times as many American Indians are dying from unintentional injury than any other racial/ethnic group.

Figure 3: Counties Reached by Violence and Unintentional Injury Grantees

Eleven grantees have implemented programs to reduce the disparities in unintentional injury and violence throughout the state (Figure 3). Because the areas of unintentional injury and violence are broad, these grantees are focusing on many different topics ranging from reducing domestic violence in a tribal community to preventing work-related injuries among migrant farm workers.

A group participant while discussing the past with his significant other asked; "Why have you waited so long to talk to me about this"? Her reply; "I am not afraid of you anymore"

EHDI Grantee Client

Grantees have reached a total of 15,101 people through their EHDI funded programs on unintentional injury and violence. A total of 8,814 children participated in program activities as well as 6,287 adults. Their efforts have included reducing the amount of domestic violence by re-offenders through anger management programs, increasing awareness of services to prevent family violence, and connecting clients to appropriate services for work-related injuries.

Community and Tribal Grantees

In Northern Minnesota, **White Earth Reservation Tribal Council** conducts anger management sessions for men convicted of domestic violence. Tribal Elders and Spiritual Leaders present traditional values and beliefs in these sessions. Seventy-five percent of the men participating in this program were able to identify their triggers for anger after completing the group sessions.

Family and Children's Service works with African American Men in North Minneapolis to end domestic violence and promote peace through their **Domestic Peace Pledge Ceremonies**. Of the men who participated in these ceremonies, 95% have spoken out against family violence and 85% have promoted healthy relationships.

United Hospital's **Partners for Violence Prevention (PVP)** provides culturally competent family violence education and training to health and social services, schools, and community organizations. PVP conducted several violence prevention and awareness programs in St. Paul schools. To date, an estimated 98% of school participants completed PVP violence prevention programs.

Cardiovascular Disease

Cardiovascular disease is the number one killer of Minnesotans and the leading cause of disability in the nation. Heart disease is the leading cause of death for American Indians and the second leading cause of death for Asians, African Americans and Hispanics in Minnesota. Sixteen Community and Tribal Grantees have chosen to work on reducing the burden of cardiovascular disease among Populations of Color and American Indians throughout Minnesota (Figure 4).

Figure 4: Counties Reached by Cardiovascular Disease Grantees

Grantees have focused on a variety of methods to improve the heart health of their populations. Methods include encouraging behavior change through healthy eating classes, providing health care information through radio and television programs, hosting walk/run events, organizing walking clubs, providing blood pressure screening, and assisting with interpretation.

97,136
People reached through cardiovascular disease-related activities.

The goals of the grantees ranged from increasing healthy eating behaviors and physical activity to increasing the understanding the risks of cardiovascular disease. Through the grantee efforts, an estimated 78,693 adults participated in activities related to reducing cardiovascular disease. Because good cardiovascular health starts young, grantees did not focus on adults alone. 10,944 children and youth were also reached through these programs.

Community and Tribal Grantees

Through a peer educator program **Fremont Community Health Services** is working to reduce the risk of stroke among African Americans living in North Minneapolis and its northern suburbs.

*17,362 people received information about cardiovascular disease.

The **Bois Forte Band of Chippewa** developed a six-week Summer Youth Work Program to improve physical fitness.

*Youth in this program lost an average of 3.4 pounds and 1.33 body mass index points.

Region 9 Developmental Commission's Saludando Salud program to improve heart health includes heart health workshops, physical fitness events, and a weekly radio show, "Su Salud" to Latinos living in Southwest Minnesota.

* Saludando Salud has screened 1,362 people for cardiovascular disease over 27-months.

Diabetes

Diabetes and its complications are a significant cause of morbidity and mortality in Minnesota. It is an insidious chronic condition that is complex, serious, costly and increasingly common.[1] Diabetes disproportionately affects Populations of Color and American Indians. For the time period 1997-2001, the age adjusted diabetes mortality rate for Whites was 23 per 100,000 people compared to 94.4 for American Indians, 57.7 for African Americans and 39.9 for Hispanics. The Asian rate was just below the White rate at 20.1 per 100,000.

Figure 5: Counties Reached by Diabetes Grantees

Twenty EHDI grantees implemented programs to reduce the incidence of diabetes and its complications. Grantees have carried out many activities to combat diabetes in their communities including media campaigns, community health forums, on-site health education classes, screenings and referrals, and cultural competency classes for health care providers.

100,442
People reached through Diabetes-related activities.

Since these programs began, EHDI grantees have reached a total of 100,442 people through diabetes-related activities. Their efforts have increased the understanding of diabetes and its complications, improved diabetes self-care, increased physical activity, and improved eating habits.

[1] Diabetes in Minnesota, Minnesota Department of Health Diabetes Program http://www.health.state.mn.us/diabetes/diabetesinminnesota/ accessed December 15, 2004

Community and Tribal Grantees

Carondelet LifeCare Ministries collaborates with Latino parishes in the St. Paul area to provide culturally appropriate diabetes education classes, and health screenings. Carondelet offers the Diabetes Education Enhancement Program (DEEP) where participants have to attend at least four meetings with a diabetes coach and two diabetes education classes.

- Carondelet screened 846 people for diabetes over a 27-month period

Southeast Asian Ministry conducts the Elders Program that provides Cambodian and Hmong elders with information on the dangers of diabetes and cardiovascular disease. In addition this program provides tips on nutrition and offers exercise opportunities.

- The percentage of participants who had some knowledge about the symptoms and management of diabetes increased from 29% in the pre-test to 74% at post-test

Westside Community Health Services provides diabetes education to Spanish and Hmong patients through a variety of methods including one-on-one consultations and peer education.

- Glucose levels of participants dropped from 9.2 to 8.2 over 15 months.
- Westside increased the percent of participants testing glucose levels:
    - 61% to 68% for Latinos
    - 64% to 100% for Hmong

HIV/AIDS and Sexually Transmitted Infections

There are great disparities in the incidence of HIV/AIDS and sexually transmitted infections between Populations of Color/American Indians and the White population in Minnesota. In 2002, the new HIV infection rate for African Americans was 17 times the White rate and the Hispanic rate was six times the White rate. Similarly, the chlamydia case rate in 2002 ranged from 2.5 to 15 times the White rate for Populations of Color and American Indians.

Eleven grantees have implemented programs to reduce the disparities in HIV/AIDS and sexually transmitted infections throughout Minnesota. Grantees provide services to adults and youth in detecting, managing, and preventing these communicable diseases. Examples of services provided by grantees include counseling and education on available services, workshops on leadership skills and self-awareness, and media campaigns. Grantees have reached 68,879 people through their EHDI funded programs on HIV/AIDS and sexually transmitted infections. The majority of people reached were African, African American, and Latino.

68,879

People reached through HIV/AIDS- and sexually transmitted infections-related activities.

Grantees are working closely with their communities to improve knowledge, attitudes, and behaviors that will decrease the incidence of HIV/AIDS and sexually transmitted infections among Populations of Color and American Indians. Grantees have been empowering teens to improve self-respect, increase personal aspirations, and make positive decisions. Grantees have also been working with their communities to improve access to health care services and counseling.

Community and Tribal Grantees

Council on Crime and Justice provides a 10-week health education course on HIV/AIDS, Hepatitis C, and other STIs to offenders of color as well as pre and post release advocacy for men and women of color. The advocacy program engages the inmate and family in positive health-related decision-making upon release.

Agape House for Mothers provides services and education to African American teens in Minneapolis and St. Paul. The Agape Healthy Youth Development program is tailored to address the unique needs of each program participant. Each participant receives a minimum of 40 hours of tailored training using the "Sex Can Wait Curriculum" to help clarify personal values, gain self awareness, grow in confidence, and develop life-long leadership and relationship skills.

- 1,315 completed the healthy life choices program
- 95% are honoring their commitment to remain abstinent

In Southern Minnesota **Centro Campesino's Promotores de Salud Project** conducts small group workshops on HIV/AIDS prevention and detection. The Promotores de Salud Project focuses on cultural change by changing the way that parents talk with their children about sex and preventing pregnancy and sexually transmitted infections. This requires an open discussion of sexual activity while respecting and incorporating cultural norms and values.

- 24 migrant workers have been tested so far for HIV.

Breast and Cervical Cancer

Many deaths from breast and cervical cancers could be avoided by increasing cancer screening rates among women at risk. Studies show that early detection of breast and cervical cancers saves lives.

Table 9: Cancer Incidence among Women Minnesota 1996-2000

	Rate per 100,000	
Race	**Breast**	**Cervical**
African American	104.5	18.0
American Indian	49.9	9.6
Asian	67.1	16.5
White	137.3	6.6

*Hispanic/Latino data not available
Source: Minnesota Cancer Surveillance System

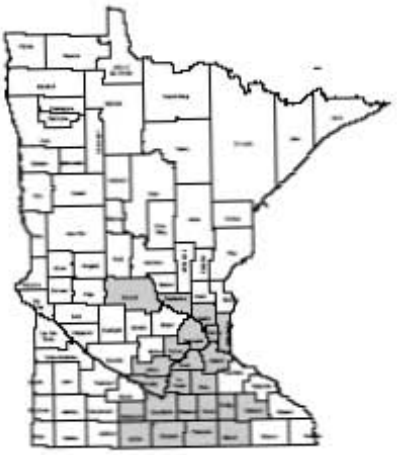
The 1996-2000 cervical cancer incidence rates for Asian and African American women were twice as high as White women living in Minnesota. The breast cancer incidence rate for the same time period was highest among White women with African American women having the second highest rate. Though the breast cancer incidence rate for African American women is lower than White women, the breast cancer mortality rate is higher. 1990-1999 Minnesota breast cancer mortality rates were 24.0 per 100,000 for White women and 35.2 for African American women.

Nine Community and Tribal grantees are working to improve breast and cervical cancer screening rates throughout Minnesota. Five grantees are working with African Americans and African-born people, 2 with American Indians, and 3 with Latinos.

Grantees have taken several approaches to increase the number of women screened for these cancers. Their programs have increased their clients' understanding of the importance of early screening and detection of breast and cervical cancer through:

- community workshops and classes providing health care education,
- media campaigns,
- church festivals,
- powwows, and
- personalized health plans.

Figure 6: Counties Reached by Breast and Cervical Cancer Grantees



The grantees have also been working to make the health care system more accessible to their clients by:

- working with employers to offer worksite education, health promotion, and screenings;
- arranging for transportation and child care services; and
- providing cultural navigators who help clients with referrals and screenings.

72,950

People reached through breast and cervical cancer -related activities.

Through the efforts of these nine grantees an estimated 72,950 people have been reached including 7,989 African Americans, 3,483 American Indians, and 4,152 Latinos. .

Community and Tribal Grantees

The Indian Health Board, Nurturing Families/Native Ways, an American Indian Community Wellness Project, addresses social ills and risk factors that contribute to breast and cervical cancer health disparities for American Indian women under the age of 40 in Minneapolis.

- Families participating in the program were provided with educational home visits after which 90% were aware of the risk factors for breast and cervical cancer.

The Sisters in Harmony South Minneapolis Cancer Control Coalition out of the **Women's Cancer Resource Center** developed the cultural navigators program which aids clients in getting referrals for mammograms and pap smears and performs one-on-one and group prevention education. Through this navigator program:

- 75 one-on-one education sessions were held;
- 69 referrals for mammograms were given; and
- 69 referrals for pap smears were conducted.

Results are vital to the success and continuation of the EHDI. It is essential that EHDI grantees have the capability to evaluate their own work. The recipients of EHDI grants were expected to be able to produce and explain their program logic (why and how the strategies would logically lead to the anticipated results), credibly document results, analyze data to enable grantees to draw conclusions about contextual challenges and program effectiveness, and share their findings with interested audiences. Since 2001, MDH has contracted with Rainbow Research, Inc. (Rainbow), a local evaluation firm, to provide technical assistance and evaluation capacity building to EHDI grantees in order to carry out these requirements. Rainbow staff assist Community and Tribal Health Grantees in developing individual program level evaluations to ensure grantee accountability and build grantee evaluation capacity. Rainbow's activities have focused on (1) the creation and implementation of a uniform reporting system (2) building grantees' evaluation capacity through a threefold strategy of statewide training conferences, individual consultation, and coaching grantees to design and implement a program evaluation and (3) producing periodic progress updates and reports for MDH.

Long Term Outcomes

The identification, measurement, and reporting of measurable outcomes (long term, intermediate, and program level) for community, tribal, and local public health programs has been a priority for the EHDI since its inception. Initially, long term measurable outcomes were identified through the technical expertise of state and national consultants (See Appendix H). Most often these measures are traditional public health measures related to the eight Priority Health Areas for the EHDI. Baseline rates and figures were determined by legislation for infant mortality and adult and child immunizations. Baseline rates for other health disparity areas were identified as the rates that were available at the inception of the program (2002-03)). Long-term measurable objectives describe the impact on the overall health priority area and, as such, tend to indicate change in the health status of a population frequently described in terms of morbidity or mortality (e.g. infant mortality rates).

Intermediate Outcomes

Identifying and meeting intermediate outcomes can have an impact on the desired long-term outcomes. Intermediate outcomes include health behaviors of community members including smoking, alcohol use, or physical activity. Intermediate outcomes could also include system factors (i.e. health insurance coverage) and environmental factors (i.e. racism, poverty) that research indicates have an impact on health status. To improve or maintain good health and eliminate disparities in health status, the overall initiative is looking at approaches to identify and enhance or develop new data tools to assess the health of Populations of Color and American Indians in Minnesota.

Subd. 4. Statewide Assessment.

The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas … The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section.

EHDI Legislation

At the June 2002 EHDI Steering Committee meeting, the **Participatory Research Partnership** (PRP) was designated as EHDI subcommittee. The PRP brought together community researchers and representatives of the MDH Center for Health Statistics and OMMH, the EHDI Steering Committee, and the University of Minnesota School of Public Health. The charge of the PRP included the identification of measurable intermediate objectives and other factors that impact the health of communities including health status, health system, environmental, community assets, historical factors, and cultural factors.

Why "participatory" research?

"Community-based participatory research is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community, has the aim of combining knowledge with action, and achieving social change to improve health outcomes and eliminate health disparities."

WK Kellogg Foundation Community Health Scholars Program

In October 2003, five racial/ethnic community groups successfully responded to an RFP receiving short term funding from the University of Minnesota. Because there have been no EHDI or other long term funds allocated toward this effort, the PRP has struggled to keep the partners engaged and to complete the process of identifying these community specific intermediate outcomes. The PRP continues to meet and is currently seeking funding to support the continuation of this important work.

See Appendix G for measurable outcomes, Appendix I for short-term grantee outcomes, and Appendix J for Priority Health Area outcomes.

Conclusion

The EHDI Community and Tribal Grantees have been working hard in the first four years of the EHDI to achieve the short-term results (e.g. increased awareness of the importance of immunization) that will in turn encourage improvement in long-term results (e.g. increased immunization levels) to eliminate health disparities. Grantees have been using innovative, culturally-specific strategies to achieve their goals. Their efforts have been a combination of innovative thinking, strong partnerships, and capacity building, all led by their communities. The next section describes how partnerships, technical assistance, capacity building, coordination, and community involvement have made the Eliminating Health Disparities Initiative successful in its first four years.

Community Leadership

Community leadership, technical assistance, capacity building, and coordination, and establishing partnerships are key elements of the Eliminating Health Disparities Initiative. Community is critical to the stability and continuation of the EHDI. Distinct to a state initiative of this scope, the EHDI has fostered the development of leadership and created a unique partnership with grass roots communities to address health disparities. From conception to implementation, communities of color and tribal communities continue to be vital players in the EHDI. Communities have been involved in the passage of the landmark EHDI legislation, development of the request for grant proposals, and review of grant proposals, and have taken part in the initiative at each step of the way. At the inception of the program, MDH, led by the Office of Minority and Multicultural Health, sponsored the first statewide conference on racial and ethnic health disparities in Minnesota. With over 600 attendees; grass roots communities, legislators, local public health, health providers, and government workers learned about health disparities.

Grassroots community involvement remains critical to the EHDI. In 2004, MDH and the EHDI Grantees organized the EHDI Results Conference: *Looking Back, Moving Forward: Continuing Our Investment in the Health of Minnesota's Populations of Color and American Indians.* Grassroots communities were again well represented among the more than 400 people who attended this conference. Grantees presented results of their work projects to date. The conference also included an update on health disparities at the national and local level. In the coming months, materials from the conference will continue to be shared statewide through community forums and the OMMH web site.

Technical Assistance, Capacity Building, and Coordination

Office of Minority and Multicultural Health

The EHDI has had significant impact on the work of the Minnesota Department of Health. Most recently, because of the significance of the EHDI and the illumination of racial and ethnic health disparities in Minnesota, the role of the Office of Minority and Multicultural Health has broadened in scope. The OMMH works across divisions so that program elements essential to eliminating racial and ethnic health disparities can be addressed and incorporated throughout the agency.

The structure of OMMH includes racial/ethnic Community-Specific Health Coordinators (CSHCs). The four primary responsibilities for EHDI CSHCs include: management of the EHDI Community and Tribal Health Grants programs; serving as liaison and contributing to the health-related efforts of Africans/African Americans, American Indians, Asian Americans, and Hispanic/Latinos living in Minnesota communities; serving as liaison and contributing to the work of other MDH programs to address health disparities and identify approaches to improving the health status of Populations of Color and American Indians; and working toward the goals of the Office of Minority and Multicultural Health.

In addition to the management of EHDI grants, a primary role of EHDI CSHCs and the MDH Tribal Health Liaison is to enhance community/tribal/state relations. CSHCs coordinate state health advisory groups comprised of community members, health professionals, and providers to assess and monitor the public health needs of each racial/ethnic community. CSHCs identify community and cultural strengths and community needs, discuss and develop strategies, and act on plans to enhance the health status of their member populations. Through these roles and activities, relationships between MDH and cultural communities have developed and improved.

MDH EHDI Technical Assistance Group

MDH health program staff working in areas related to the eight Priority Health Areas (PHAs) work with OMMH staff and EHDI grantees to develop culturally-appropriate health promotion strategies. This Technical Assistance Group (TAG) meets regularly and has not only provided support for EHDI grantees to come together and learn from each other how to design, implement, and evaluate culturally-relevant initiatives, but have learned from the grantees about the appropriateness and sensitivity of public health approaches in working with Populations of Color and American Indians in Minnesota. It has been a unique learning experience for everyone involved.

Establishing Partnerships

The EHDI has provided the impetus for OMMH, racial and ethnic community, and Local Public Health (LPH) groups to partner in powerful and constructive ways. The MDH local public health partnership, initiated by the Community Health Services Act and fundamental to the success of Minnesota's public health system, recognizes the role of local public health agencies to identify and meet the health needs of local communities. Since its inception, EHDI grantees have worked along with LPH agencies to provide much needed health promotion and prevention services to their communities. In addition, OMMH staff have worked closely with LPH staff to identify the elimination of racial and ethnic health disparities as a priority throughout the state, including the inclusion of strategies that work in racial/ethnic communities for the current Minnesota *Strategies for Public Health*.

> ***"Partnerships have helped us reach larger numbers of people, improving the health of community members that are often not reached…They have opened doors into other towns and regions to create new health partnerships in new regions.***
>
> EHDI Grantee

In addition to this work and with the support and cooperation of the OMMH and EHDI grantees, MDH has recently been awarded funds from the new federal "*Steps to a Healthier US*" (*Steps)* program. *Steps* focuses on physical inactivity, poor nutrition, and tobacco use in order to help Americans live longer, better, and healthier lives by reducing the burden of diabetes, overweight, obesity, and asthma. *Steps* activities will occur in four cities (Minneapolis, Rochester, St. Paul, and Willmar) and will focus on populations with disproportionate burden of chronic diseases/ conditions who also tend to experience disparities in access to and use of preventive and health care services.

Partnerships Occur Within/Among Communities, Government, and Other Supporters

As EHDI was passed and became an immediate reality at MDH, members of the racial and ethnic communities who worked on its passage, as well as many majority community members, both inside and outside of MDH, stepped up to volunteer to help with implementation. Over the following months and years, those same folks and many others have joined with us in this work.

The following is a brief description of some of these supporters and the roles they play:

1. The EHDI Steering Committee guides the work of EHDI and is comprised of community members representing community- and faith-based organizations, local public health, and the four state councils: the Indian Affairs Council, the Council on Chicano/Latino Affairs, the Council on Black Minnesotans, and the Council on Asian-Pacific Minnesotans.

2. Community-based institutions (faith-based and others) and community-based organizations who have taken a lead in getting the word to their community members about health disparities and the EHDI opportunities, often acting as forum conveners and community organizers.

3. Health care systems and institutions who have come together as the *Health Care Disparities Task Force* to evaluate and change their own systems, and who have participated in and financially supported many EHDI activities and events.

4. Minnesota Department of Human Services whose staff are involved in many EHDI-related health care coverage and access activities.

Partnerships have proven to be essential to the work of the EHDI.

Comprehensive and Coordinated State Plan (CCSP)

As mandated by legislation, MDH led by OMMH is developing a comprehensive and coordinated state plan to eliminate racial and ethnic health disparities. The plan will include recommendations for policy, interventions, and program components, and provide recommendations on the work and proposed work to achieve the elimination of health disparities. The Minnesota Legislature, recognizing the complexity of components and players to be involved in eliminating racial and ethnic health disparities, mandated that the Commissioner of Health, in partnership with culturally-based community organizations; the Indian Affairs Council; the Council on Chicano/Latino Affairs; the Council on Black Minnesotans: the Council on Asian-Pacific Minnesotans; and community health develop and implement a comprehensive, coordinated plan to reduce disparities in the Priority Health Areas.

During 2004, working with the EHDI Steering Committee, OMMH developed a survey tool to use in gathering community members' input on priorities for a Comprehensive and Coordinated State Plan. In 2005, regional and community forums and town hall meetings will be held to gather additional input to refine and focus the plan's elements and content. In addition, other state and local agency leaders, public health leaders, and health providers will be contacted to provide input into this plan.

Summary and Conclusion

It is also clear that the legislation, the resources, the communities, and all the people committed to this work are changing the way Minnesota's communities and systems address health among populations of color and American Indians around the state. This work must continue if Minnesota is going to eliminate racial and ethnic health disparities.

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APPENDIX A

EHDI STATUTES

"The mission of the South Minneapolis Cancer Control Coalition is to gather, engage, and leverage strengths of south Minneapolis organizations and individuals to create a culturally based, coordinated continuum of health care support for African American/African women who are at risk for or diagnosed with breast and/or cervical cancer."

-Women's Cancer Resource Center

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Eliminating Health Disparities Initiative Legislation

Laws of Minnesota 2001 1st Special Session, Chapter 9, Article 1

Sec. 48. [145.928] [ELIMINATING HEALTH DISPARITIES.]

Subdivision 1. [GOAL; ESTABLISHMENT.] It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.] The commissioner, in partnership with culturally-based community organizations; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. [MEASURABLE OUTCOMES.] The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. [STATEWIDE ASSESSMENT.] The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. [TECHNICAL ASSISTANCE.] The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. [PROCESS.] (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates; or

(2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact both priority areas;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

(1) is supported by the community the applicant will serve;

(2) is research-based or based on promising strategies;

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact more than one priority area;

(5) reflects racially and ethnically appropriate approaches; and

(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. [HEALTH OF FOREIGN-BORN PERSONS.] (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;

(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;

(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and
(4) $50 per foreign-born person in the community health board's service area.
(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. [TRIBAL GOVERNMENTS.] The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11. [COORDINATION.] The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 12. [EVALUATION.] Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 13. [REPORT.] The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

Subd. 14. [SUPPLANTATION OF EXISTING FUNDS.] Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

Laws of Minnesota 2001 1st Special Session, Chapter 9, Article 17, Subd. 2

[HEALTH DISPARITIES.] Of the general fund appropriation, $4,950,000 each year is for reducing health disparities. Of the amounts available:
(1) $1,400,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 7, to eligible applicants to reduce health disparities in infant mortality rates and adult and child immunization rates.
(2) $2,200,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 8, to eligible applicants to reduce health disparities in breast and cervical cancer screening rates, HIV/AIDS and sexually transmitted infection rates, cardiovascular disease rates, diabetes rates, and rates of accidental injuries and violence.
(3) $500,000 each year is for grants to tribal governments under Minnesota Statutes, section 145.928, subdivision 10, to implement cultural interventions to reduce health disparities.
(4) $500,000 each year is for state administrative costs associated with implementation of Minnesota Statutes, section 145.928, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, and 13.
(5) $100,000 each year is for state operations associated with implementation of Minnesota Statutes, section 145.928, subdivision 9.
(6) $250,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 9, to community health boards to improve access to health screening and follow-up services for foreign-born populations.

[INFANT MORTALITY REDUCTION.] Of the TANF appropriation, $2,000,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 7, to reduce infant mortality.

[REDUCING INFANT MORTALITY CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for reducing infant mortality in the first year of the biennium does not cancel but is available for the second year.

Chapter 220-H.F.No. 351

Article 17
Health And Human Services Appropriations

Sec. 3. COMMISSIONER OF HEALTH

Subd. 2. Family and Community Health [ONETIME GRANT REDUCTIONS.] $200,000 of the appropriation reduction the first year is from competitive grants to reduce health disparities in infant mortality rates and adult and child immunization rates authorized in Laws 2001, First Special Session chapter 9, article 17, section 3, subdivision 2. $300,000 of the appropriation reduction the first year is from competitive grants to reduce health disparities in breast and cervical cancer screening rates, HIV/AIDS and sexually transmitted infection rates, cardiovascular disease rates, diabetes rates, and rates of accidental injuries and violence authorized in Laws 2001,

First Special Session chapter 9, article 17, section 3, subdivision 2. $150,000 of the appropriation reduction the first year is from community-based programs for suicide prevention authorized in Laws 2001, First Special Session chapter 9, article 17, section 3, subdivision 2.

Presented to the governor February 21, 2002
Vetoed by the governor February 25, 2002, 3:48 p.m.
Reconsidered and approved by the legislature after the governor's veto February 28, 2002

APPENDIX B

Minnesota Department of Health Organization Chart

We will use the findings to seek additional funding for 2005 and going forward to enhance and expand our services, and to reach a greater number of teens. We will also work towards achieving more long-term objectives with past, present and current program participants/graduates.

- Agape House for Mothers

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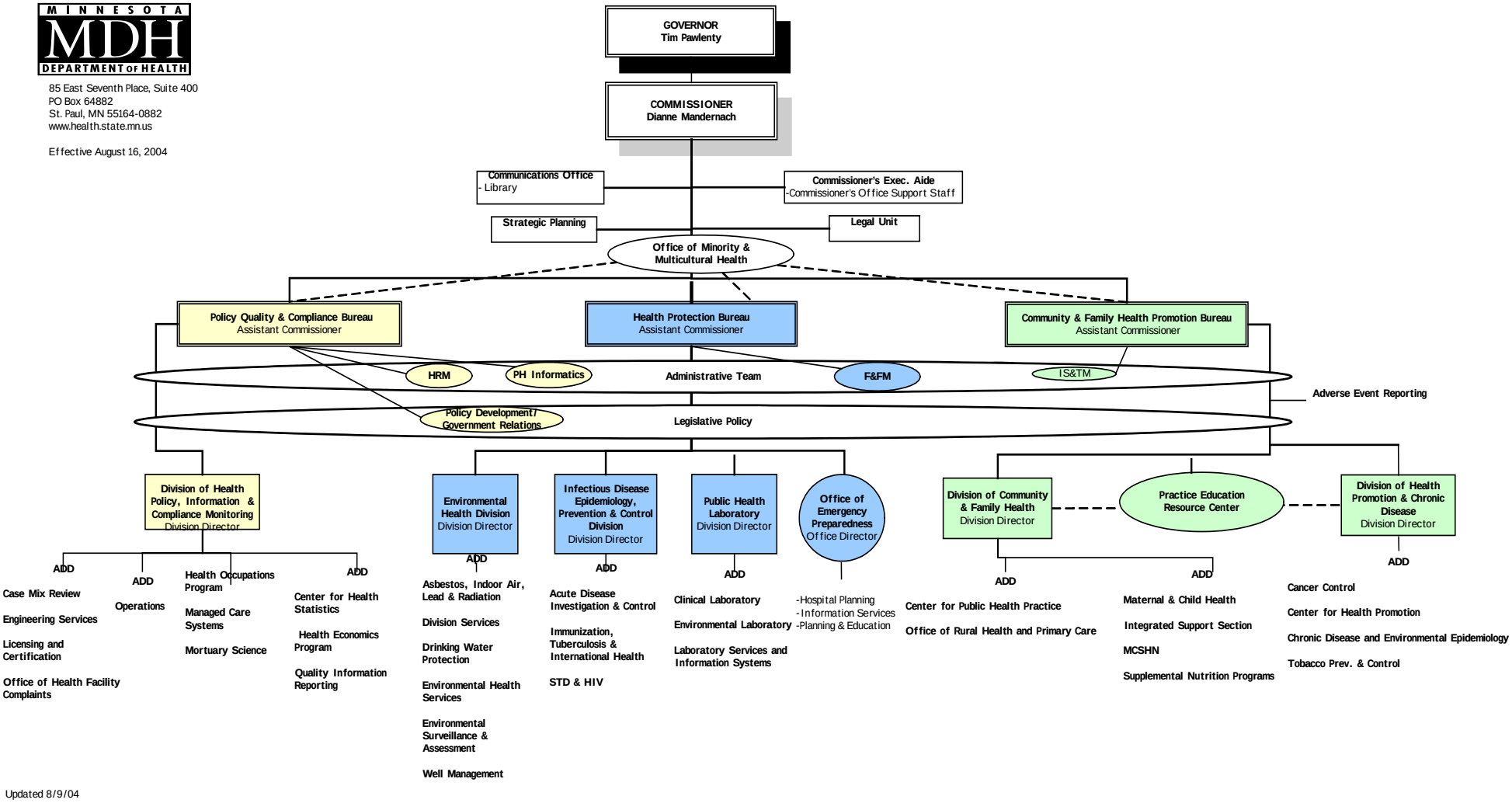
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Assistant Commissioner
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Assistant Commissioner
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PH Informatics
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Office of Health Facility Complaints
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Managed Care Systems
Mortuary Science
ADD
Center for Health Statistics
Health Economics Program
Quality Information Reporting
Environmental Health Division
Division Director
ADD
Asbestos, Indoor Air, Lead & Radiation
Division Services
Drinking Water Protection
Environmental Health Services
Environmental Surveillance & Assessment
Well Management
Infectious Disease Epidemiology, Prevention & Control Division
Division Director
ADD
Acute Disease Investigation & Control
Immunization, Tuberculosis & International Health
STD & HIV
Public Health Laboratory
Division Director
ADD
Clinical Laboratory
Environmental Laboratory
Laboratory Services and Information Systems
Office of Emergency Preparedness
Office Director
-Hospital Planning
- Information Services
-Planning & Education
Division of Community & Family Health
Division Director
ADD
Center for Public Health Practice
Office of Rural Health and Primary Care
Practice Education Resource Center
ADD
Maternal & Child Health
Integrated Support Section
MCSHN
Supplemental Nutrition Programs
Division of Health Promotion & Chronic Disease
Division Director
ADD
Cancer Control
Center for Health Promotion
Chronic Disease and Environmental Epidemiology
Tobacco Prev. & Control
Updated 8/9/04

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APPENDIX C

Populations of Color Fact Sheets

Prior to our services being implemented, around 78% of obstetric clients in our clinic were seen by a Public Health Nurse. After initiating our Prenatal Waiting Area Program, 100% of the obstetric clients were seen by a public health nurse in some capacity.

-Fond du Lac Center for American Indian Resources

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Minnesota Department of Health Fact Sheet 5/04

Eliminating Disparities in the Health Status of African Americans in Minnesota

Latest U.S. Census figures indicate that African Americans are the largest racial or ethnic group in Minnesota, comprising 3.5 percent of the total population. African Americans comprise nine percent (total 99,943) of the population in Hennepin County alone, the greatest combined population of African Americans in the state.

Vital statistics indicate the continued growth of this population. In 2000, births to African Americans comprised over six percent (6.5 percent), of the total births in Minnesota. Also, fertility rates (births per 1,000 for women ages 15-44) indicate that African Americans had the highest fertility rates of all groups, currently 92.2 per 1,000 (1995 figures—94 per 1,000).

Even with an increasing presence in Minnesota, African Americans are among the least insured populations, and among those most affected by the trends toward increasing segregation and concentrated poverty among other social factors within the Twin Cities area. These factors have significant influence on the health status of African Americans in Minnesota.

Infant Mortality

Minnesota's African American infant mortality rates have been two to three times higher than the White rate for 20 years. Most recent data indicates that for every thousand live births, almost 12 African American babies died before their first birthday, compared to five White babies (1996-2000 figures). These excess deaths are primarily a result of higher rates of low birth weight (LBW) and pre-term births (PTB). The reasons for LBW/PTB may include hypertension, infections, poor weight gain, and closely spaced pregnancies. Recent research indicates that stress and adverse social and environmental conditions combined with an individual's vulnerability to these conditions undeniably contribute to LBW/PTB. LBW/PTB are major determinants of infant mortality. Access to culturally acceptable primary preventive health care, family planning services, preconception care, and early prenatal care is essential to manage these conditions. Yet, over 12 percent of African American women receive late or no prenatal care, and nearly 16 percent of the Black population in Minnesota is uninsured.

Injury and Violence

Among African American youth aged 15-24, firearm injury mortality rates are eight times greater than for all males 15-24 year olds in Minnesota, and 15 times greater than the rates of all ages, races, and genders combined. Compared to Whites in Minnesota, African American males in this age group are 25 times more likely to die as a result of firearms.

Unintentional injury is one of the major causes of both death and disability among African American males and females in this age group. According to Minnesota injury-related mortality data for 1990-1999, the overall injury-related mortality rate was approximately 75 percent higher for African Americans as compared to Whites. Homicide rates from stabbing injuries was nearly sixteen times higher, combined (intentional and unintentional) poisoning death rates were two times higher, suffocation rates were more than two times higher, drowning death rates two times higher and fire-related death rates were nearly two times higher between 1990-1999.

The rate (per 100,000 people) of traumatic brain injury was nearly twice as common among African Americans compared to Whites during 1999. In 1999, spinal cord injury rates (per 100,000 people) were also more than three times higher in African Americans as compared to Whites.

Diabetes

Recent self-report estimates from Hennepin County, Minn. (2002) indicate that the prevalence of diabetes among African Americans is 11.4 percent

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compared to 4.8 percent among Whites. National estimates that include persons with undiagnosed diabetes found the prevalence of diabetes among African Americans is 14.9 percent compared to 7.6 percent among Whites. If impaired fasting glucose (i.e., prediabetes) is included, these numbers increase to 21.1 percent and 13.1 percent respectively. Furthermore, for African Americans born in 2000, the lifetime risk of developing diabet4es is 40 percent for men and 49 percent for women. This compares to 27 percent and 31 percent respectively, in their White counterparts.

The increased diabetes prevalence among African Americans is also reflected in a Minnesota diabetes-related death rate that is 2.4 times greater than Whites.

Cardiovascular Disease

On a national level, African American women are at particular risk, with coronary heart disease (CHD) and mortality rates 35.3 percent higher and stroke rates 71.4 percent higher than that for White women. In Minnesota, the Women and Heart Disease Atlas indicates that the annual age-adjusted death rate per 100,000 for African American women (339) exceeds that for White women (284).

Deaths resulting from CVD are 16 percent higher among African Americans than Whites in Minnesota. Cardiovascular disease was also one of the leading causes of death among both males and females ages 45-64 and 65 and older in African American communities.

Immunization

A smaller percent of African Americans of all ages in Minnesota are less up-to-date with immunizations than Whites. At each target age group, the immunization levels for African Americans youth were lower than that of Whites. Only 62 percent of African American children were up-to-date with immunizations at 24 months of age (MDH Retrospective Survey of Kindergartners, 2001). Only 22.5 percent of African American elders in Minnesota are immunized against pneumococcal disease, one of the leading causes of death in elderly people (Medicare claims data).

Breast and Cervical Cancer

Breast cancer is the most commonly diagnosed cancer among Minnesotan women (32.3 percent of all cancers) and the second leading cause of cancer death. Each year in Minnesota, approximately 3,200 women develop breast cancer and 700 die from the disease. The breast cancer mortality rate is 50 percent higher in African American women (35.2 per 100,000) than in White non-Hispanic women (24 per 100,000), even though the incidence rates are similar. A greater proportion of African American women have their cancers diagnosed at a late stage.

Approximately 200 women in Minnesota develop cervical cancer and 50 die from the disease annually. Virtually all cervical cancer deaths are preventable through regular screening with Pap smears and early detection and treatment of pre-cancerous cervical abnormalities. African American women have significantly higher incidence (25.3 vs. 6.2 per 100,000) and mortality rates (4.2 vs. 1.5 per 100,000) of cervical cancer than White non-Hispanic women.

Teen Pregnancy

While Minnesota's teen pregnancy rate among Whites is one of the lowest in the nation, the rate among African American teens is one of the highest. In the U.S., for every 1,000 births to African Americans, 73.5 are births to teen mothers (Whites 30.5 per 1,000). Disparities in teen births in Minnesota are even greater. For every 1,000 births to African Americans, 75.4 are births to teen mothers, as compared to Whites (21.7 per 1,000).

HIV/AIDS and STDs

MDH Surveillance reports in 2002 indicate that the HIV infection rate (AIDS or HIV at first diagnosis) is 37 per 100,000 for African American and between 130-185 per 100,000 for African-born persons, several times greater than the White rate (3.0 per 100,000). In 2002, African Americans accounted for 20 percent of new HIV infections and African –born persons accounted for 21 percent of new HIV infections, compared to 3 and less than 1 percent of the state's population. Over the past three years, the infection rate for African-Americans has decreased from 45 in 21000 to 37 per 100,000 in 2002, while the rate for African-born persons has increased from 107 in 2000 to 185 per 100,000 in 2002.

Disparities for bacterial STDs are equally great. The gonorrhea rate among Blacks in 2002 was 745 per

100,000, 40 times greater than the White rate. For chlamydia, the rate among Blacks was 1,444 per 100,000, almost 15 times higher than the White rate.

Eliminating Health Disparities Status

Minnesota is committed to eliminating health disparities among populations of color (including African Americans) and Whites in Minnesota. Included in these efforts is the *Eliminating Health Disparities Initiative*, Minnesota Statute 148.928, created by the 2001 Minnesota Legislature.

We hope that you share the concern about the importance of these initiatives with the Minnesota Department of Health and the African American communities in Minnesota.

If you would like more information about the *Eliminating Health Disparities Initiative,* the health status of Minnesota's populations of color, health disparity areas, information resources, or the OMMH, visit our Web page at www.health.state.mn.us/ommh or contact:

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Minnesota Department of Health Fact Sheet 5/04

Eliminating Disparities in the Health Status of American Indians in Minnesota

Minnesota is one of the healthiest states in the country, yet American Indians experience rates of disease and premature death that are significantly greater than Whites and other racial or ethnic groups.

American Indians in Minnesota experience higher rates of poverty, discrimination and race-related stress. Because of higher rates of poverty and economic insecurity, American Indians are less likely to have continuous health insurance, and as a result, less access to health care resources. Most disturbing is the impact of all of these factors on the health status of American Indian communities. A recent study indicates that American Indians are uninsured at over three times the rate of Whites (4.6/Whites, 15.9/American Indians).

Infant Mortality and Related Factors
In their first year of life, Minnesota's American Indian babies die (12.0/1000) at a rate more than two times higher than the White rate (5.2/1,000). American Indian women's pregnancies are affected by rates of diabetes, tobacco and alcohol use, and teen births that are higher than those of the White population.

Birth weight affects American Indian babies at both extremes. Low birth weight rates have risen slightly which contributes to infant mortality and morbidity. High birth weight, possibly related to high rates of gestational and pre-existing diabetes among American Indian women of reproductive age, can complicate labor and delivery, cause birth defects, and result in poor infant health.

Their access to primary preventive health care, preconception care and early prenatal care is impacted by higher rates of being uninsured – more than three times the White rate. Their rate of inadequate or no prenatal care is almost six times higher than the White rate.

American Indian babies continue to die from Sudden Infant Death Syndrome (SIDS) at higher rates than the population overall.

Injury and Violence
Injury and violence appears to disproportionately affect American Indians more than any other racial/ethnic group in Minnesota. American Indian males ages 18 and 19 have suicide rates six times higher than in any other age or population group. The rate (per 100,000 people) of fatal and not-fatal firearm related injury was three times higher among American Indians as compared to Whites between 1998-2001. During 1999, traumatic brain injury (TBI) rates were nearly four times higher among American Indians as compared to Whites in Minnesota.

Minnesota injury-related mortality data for 1990-1999 revealed higher rates (per 100,000 people) for American Indians as compared to Whites in numerous categories; the overall injury-related mortality rate was nearly three times higher than that of Whites. Motor vehicle, pedestrian related death rates were six times higher and motor vehicle, occupant related death rates were nearly twice as common. Additionally, for American Indian, homicide rates from stabbing injuries were 19 times higher, suffocation death rates were nearly three times higher, combined (intentional and unintentional) poisoning death rates were 2.5 times higher, fire related death rates were four times higher and drowning death rates 1.5 times higher between 1990-1999. Contributing factors to injury and violence consistent with the lives of American Indians in Minnesota include poverty, depression and feelings of hopelessness, motor vehicle crashes. Non-use of seat belts, helmets and other protective devices also contribute to death and injury among this population.

Diabetes
Diabetes mellitus is a serious disease that significantly impacts the health of American Indian

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populations. In 1997, the Indian Health Services reported that the age-adjusted prevalence of diagnosed diabetes among American Indians age 20 and older among tribes in Michigan, Minnesota and Wisconsin was 15.2 percent. A similar rate, 17.6 percent was found among American Indians living in Hennepin County, Minn. These rates are over three times higher than non-Hispanic Whites living in the same areas.

Type 2 diabetes, while usually developing in older adults, has doubled from 1990-1998 among Bemidji Areas American Indian ages 35 years and younger.

In Minnesota, complications and death rates are also substantially higher in American Indians. Births complicated by pre-existing diabetes were more than eight times greater compared to non-Hispanic Whites (1998-2001). Diabetes-related kidney failure is almost six times greater (1999) and diabetes related morality is over three times greater (1989-2000)

Cardiovascular Disease

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease, stroke, high blood pressure and high blood cholesterol. While mortality rates resulting from CVD are generally lower in Minnesota than the nation as a whole, American Indian death rates were 33 percent higher than the state population figures, and 44 percent higher than the total U.S. American Indian population.

Premature Death Related to Various Factors

Overall mortality rates indicate that American Indians in the 15-24, 25-44 and 45-64 year old age ranges had death rates that were up to 3.5 times higher than the death rate of Whites in those same age groups. That means that even in younger age groups, American Indians were over three times more likely to die from various causes as compared to Whites. These disparities in rates are due to a number of factors, including unintentional injury (21.43 percent), homicides (11.66 percent), heart disease (9.04 percent) and cirrhosis (7.21 percent).

Immunization

American Indians of all ages in Minnesota are less up-to-date with immunizations than Whites. Only 73 percent of American Indian children were up-to-date with immunizations at 24 months. American Indians, like all other non-White populations, have lower rates of immunization at all target ages (MDH Retrospective Survey of Kindergartners, 2001). Less than 50 percent of American Indian elders are vaccinated against pneumococcal disease, one of the leading causes of death in American Indian communities. American Indians are also at higher risk of hepatitis A than other Minnesotans. In 1992, over 38 percent of the 884 cases of hepatitis A in Minnesota were in American Indians. Hepatitis A vaccine can protect American Indian children against hepatitis A virus infection.

Breast and Cervical Cancer

Breast cancer is the most commonly diagnosed cancer among Minnesotan women (relative frequency 32.3 percent) and the second leading cause of cancer death. Each year in Minnesota, approximately 3,200 women develop breast cancer and 700 die from the disease. Compared to White non-Hispanic women, American Indian women have a significantly lower breast cancer incidence rate (112.7 vs. 50.9 per 100,000, respectively), but not a significantly lower mortality rate.

Approximately 200 women in Minnesota develop cervical cancer and 50 die from the disease annually. Virtually all cervical cancer deaths are preventable through regular screening with Pap smears and early detection and treatment of pre-cancerous cervical abnormalities. American Indian women have a cervical cancer incidence rate three times higher than White women (19.9 vs. 6.2 per 100,000) and a similarly higher mortality rate (4 vs. 1.5 per 100,000).

Teen Pregnancy

Minnesota's teen pregnancy rate among White teens is one of the lowest in the nation. Births and pregnancy rates of populations of color are of increasing concern. While the teen birth rate for American Indians is lower than Hispanics, these rates are almost five times higher than Whites (2001 figures). Teen pregnancy rates for American Indians 15-19 years old are also nearly four times that of Whites in Minnesota.

HIV/AIDS and STDs

MDH surveillance reports indicate that the HIV infection rate (HIV or AIDS at first diagnosis) in 2002 for American Indians is 8.6 per 100,000,

almost three times as high as the rate for Whites (3.0 per 100,000). The number of new AIDS cases diagnosed has declined from 8 cases in 1998 to five cases in 2002.

The situation is similar for bacterial STDs. The gonorrhea rate among American Indians in 2002 was 88 per 100,000, over four times greater than the White rate. For chlamydia, the rate among American Indians was 375 per 100,000, almost four times higher than the White rate.

Eliminating Disparities in Health Status

Minnesota is committed to eliminating health disparities among populations of color and American Indians and Whites in Minnesota. Included in these efforts is the *Eliminating Health Disparities Initiative*, Minnesota Statute 148.928, created by the 2001 Minnesota Legislature.

We hope that you share the concern about the importance of these initiatives with the Minnesota Department of Health and the American Indian communities in Minnesota.

If you would like more information about the *Eliminating Health Disparities Initiative,* the health status of Minnesota's American Indians and populations of color, health disparity areas, information resources, or the OMMH, visit our Web page at www.health.state.mn.us/ommh or contact:

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Minnesota Department of Health Fact Sheet 5/04

Eliminating Disparities in the Health Status of Asian Americans in Minnesota

Latest Census figures indicate that there are 141,083 Asians living in Minnesota, representing 2.9 percent of the total population. In Hennepin and Ramsey counties, Asians represent 4.8 and 8.8 percent of the total population, respectively. The Asian population is substantial and diverse. Health status indicators are carefully monitored to identify trends among several groups that make up the Asian population. Some studies indicate that migration, colonization or globalization can cause massive changes within cultures that adversely influence health. Minnesota is home to several refugee and immigrant populations, including those from Laos, Vietnam, Korea, China and Cambodia. In terms of numbers, Minnesota has one of the largest Hmong populations in the country.

Fertility rates (births per 1,000 women ages 15-44) have declined slightly for Asians on the national level (66.4 per 1,000 in 1995 and 64.1 per 1,000 in 1998). In Minnesota, most recent fertility rates (81.1/1,000 in 2000)) is lower than that of previous years (96.3 per 1,000 in 1995 and 96.4 per 1,000 in 1998), though these rates have remained consistently higher than the national rates.

Even with an increasing presence in Minnesota, a recent Minnesota Department of Health (MDH) study indicates that compared to Whites (4.6 percent uninsured), all other racial groups, including Asians (7.2 percent uninsured), were less likely to be covered by health insurance plans. This may have a significant impact on both access to health care and the resulting health status of Asians and other racial or ethnic groups in Minnesota.

Infant Mortality

Minnesota's most recent birth outcome data indicate that low birth weight rates and infant mortality rates among Asians have increased. This is a disturbing trend that bears close monitoring. It had been believed that previous low rates of infant mortality – especially in the Hmong community – reflected protective cultural traditions and strong social support which compensated for high rates of closely spaced pregnancies, late or no prenatal care, language barriers and high rates of poverty. Rising infant mortality rates may be the early warning that these protective factors are unraveling.

Injury and Violence

A report released by the Urban Coalition of St. Paul in 2002 notes that "physical and sexual abuses are reaching epidemic proportions, particularly among some young people of color in Minnesota." The report notes that nine percent of ninth grade Asians reported being threatened or injured with a weapon on school property in the year before the study. This report also indicates that a greater number of Asian students (as compared to White students) skipped school in the past month because they felt unsafe. The report notes a growing concern over school safety and the prevalence of weapons and violence on school property. This concern is reflective of recent firearm-related injury data that indicate the rate (per 100,000 people) of fatal and non-fatal firearm related injury between 1998-2001 was nearly one-and-a-half times greater in Asians (13.1) versus Whites (8.9).

Diabetes

Diabetes is the seventh leading cause of death in Minnesota and increased in Minnesota by more than 50 percent between 1995 and 1999. Most recent figures indicate that Asians experience fewer deaths related to diabetes than all other groups. Figures also indicate that the diabetes death rate among Asian Americans in Minnesota is increasing at a greater rate than among any other racial or ethnic group. Further studies confirm that diabetes during pregnancy for this population is also increasing, creating concern because of the increased risk of perinatal conditions.

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Cardiovascular Disease

Cardiovascular disease was the leading cause of death in Minnesota in 1996, accounting for 14,320 deaths or 38 percent of all deaths. Mortality data indicates that Asian women in Minnesota actually have one of the lowest rates of death due to cardiovascular disease (58 per 100,000) as compared to all other racial or ethnic groups, including Whites (99.2 per 100,000). Yet other figures indicate that Asians in Minnesota are more likely than other population groups to suffer from stroke. Even while the death rate due to CVD is low among Asians, the implications for premature death, disability, and health care costs make it necessary to continue to monitor not only incidence and death rates but also those behaviors that contribute to heart disease and stroke. For example, the Minnesota Urban Coalition Student Survey Report indicates that nearly 20 percent of Asian 12th graders reported smoking on a daily basis in the past month. Smoking, nutrition and physical activity are major behavioral risk factors that can lead to heart disease.

Immunization

Asian American Minnesotans of all ages are less up-to-date with immunizations than Whites. Only 66 percent of Asian American children were up-to-date with immunizations at 24 months of age (MDH Retrospective Survey of Kindergartners, 2001). Less than 50 percent of Asian American elders are vaccinated against pneumococcal disease, one of the leading causes of death in elderly people. Asian Americans are also at increased risk of hepatitis B virus infection due to high HBV infection levels in their communities, but Asian American children 4-14 years old are likely not to be protected against hepatitis B virus infection (MDH survey data, 1999).

Breast and Cervical Cancer

Breast cancer is the most commonly diagnosed cancer among Minnesotan women (relative frequency 32.3 percent) and the second leading cause of cancer death. Each year in Minnesota, approximately 3,200 women develop breast cancer and 700 die from the disease. Compared to White non-Hispanic women, Asian American women have a significantly lower breast cancer mortality rate (24 vs. 11.9 per 100,000, respectively).

Approximately 200 women in Minnesota develop cervical cancer and 50 die from the disease annually. Virtually all cervical cancer deaths are preventable through regular screening with Pap smears and early detection and treatment of pre-cancerous cervical abnormalities. Asian American women have significantly higher incidence (17.6 vs. 6.2 per 100,000) and mortality rates (7.7 vs. 1.5 per 100,000) of cervical cancer than White non-Hispanic women. Nationally, Asians have lower biennial mammography screening rates than Whites (67 percent vs. 79 percent).

Teen Pregnancy

Minnesota's teen pregnancy rate among White teens is one of the lowest in the nation. Births and pregnancy rates for populations of color are of increasing concern. While the teen birth rate for Asians (52.4/1,000) is lower than other non-White groups in Minnesota, these rates are more than two times higher than Whites (21.7/1,000 in 2001). Teen pregnancy rates for Asians (15-19 years old) are also nearly three times that of Whites in Minnesota.

HIV/AIDS and STDs

MDH surveillance reports in 2002 indicate that the HIV infection rate (HIV or AIDS at first diagnosis) for Asians is 5.3 per 100,000, the lowest of all racial or ethnic groups, except Whites (3.0 per 100,000).

For bacterial STDs, MDH surveillance reports indicate that gonorrhea rates among Asian Americans in 2000 were 29.0 per 100,000, 1.5 times higher than the White rate. For chlamydia, the rate among Asian Americans was 245 per 100,000, over two times higher than the White rate.

Eliminating Disparities in Health Status

Minnesota is committed to eliminating health disparities among populations of color (including Asian Americans) and Whites in Minnesota. Included in these efforts is the *Eliminating Health Disparities Initiative*, Minnesota Statute 148.928, created by the 2001 Minnesota Legislature.

We hope that you share the concern about the importance of these initiatives with the Minnesota Department of Health and the Asian American communities in Minnesota.

If you would like more information about the *Eliminating Health Disparities Initiative,* the health status of Minnesota's populations of color, health disparity areas, information resources, or the OMMH, visit our Web page at www.health.state.mn.us/ommh or contact:

Emily Williamson
Asian American Health Coordinator
Emily.Williamson@health.state.mn.us
651-281-9798

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Minnesota Department of Health Fact Sheet 5/04

Eliminating Disparities in the Health Status of Latinos in Minnesota

Latest Census figures indicate that there are 143,382 Latinos in Minnesota, representing 2.9 percent of the total population. In Hennepin County, Latinos represent 4.1 percent of the total population.

While fertility rates (births per 1,000 among women ages 15-44) have declined for Latinos on the national level (105/1,000 in 1995 and 101.1/1,000 in 1998. In 2000, fertility rates among Latinos (114.6/1,000) in Minnesota are the highest among all racial groups and are more than double that of Whites (58.8/1,000).

Even with an increasing presence in Minnesota, a recent Minnesota Department of Health (MDH) study indicates that Latinos were the group that were most likely to be uninsured as compared to all other racial groups. Latinos in Minnesota are also one of the groups most affected by the trends toward increasing segregation and concentrated poverty among other social factors. These factors have significant influence on the health status of Latinos in Minnesota.

Injury and Violence
A report released by the Urban Coalition of St. Paul noted that "physical and sexual abuse are reaching epidemic proportions, particularly among some young people of color in Minnesota." The report notes that 19 percent of ninth grade Latinos reported being threatened or injured with a weapon on school property in the year before the study. This report also indicates that among sixth and ninth grade Latinos, 10 percent skipped school in the past month because they felt unsafe.

Between 1990-1999, the homicide rate for Latinos was nearly four times higher for Latinos compared to Whites. Homicides from stabbing injuries were over eight times higher and firearm-related homicides were three times higher among Latinos during this same time period.

AIDS/HIV
MDH Surveillance Reports indicate that in 2002, the HIV infection rate (HIV or AIDS at first diagnosis) for Latinos is 21.6/100,000, seven times higher than the rate among Whites (3.0 per 100,000). The number of new AIDS cases among Latinos has stayed constant over the past five years, with 18 cases diagnosed in 1998 compared to 17 cases diagnosed in 2002.

The situation is similar for bacterial STDs. In 2002, the chlamydia rate among Hispanics is 584 per 100,000, six times greater than the rate among Whites. The gonorrhea rate is 91 per 100,000, almost five times greater than the rate among Whites.

Cardiovascular Disease
Cardiovascular disease was the leading cause of death in Minnesota in 1996, accounting for 14,320 deaths or 38 percent of all deaths. Cardiovascular disease disproportionately affects all groups of populations of color. Rates of death from cardiovascular disease were 13 percent higher among American Indians, 16 percent higher among African Americans, and 12 percent among Latinos than Whites in Minnesota.

Diabetes
In Hennepin County (2002), self-reported diabetes among Hispanics was similar to that of Whites (4.4% vs. 4.8%) However, national estimates that also include undiagnosed diabetes found 12% of Mexican Americans had diabetes, compared to 7.4% of Whites. When impaired fasting glucose (i.e., prediabetes) is included these numbers increase to 18.8% and 13.1%, respectively. Furthermore, a recent study indicates that the lifetime risk of developing diabetes for a Hispanic born today is 45% for men and 52% for women. This compares to 27% and 31% for Whites, respectively.

MINNESOTA MDH DEPARTMENT OF HEALTH

Minority and Multicultural Health
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
651-297-5813
www.health.state.mn.us/ommh

In Minnesota, Latinos are almost twice as likely to die from diabetes as Whites (1.7 times as likely). They are also twice as likely to experience serious complications such as eye disease. Also, recent figures confirm that diabetes during pregnancy is becoming more common among Latinos in Minnesota.

Infant Mortality

While Latino infant mortality rates appear just slightly higher than the White rate, members of the community have raised concerns that they may undercounted. Significant risk factors for infant morality are documented in the population: 11.2 percent of Latino women received inadequate or no prenatal care, four times greater than the White rate; Latino teen birth rates are more than five times the White rate and among the highest in the country; and over 17 percent of the Latino population is uninsured, nearly four times the White rate.

Being uninsured before pregnancy may reduce access to family planning and preconception care. For a population experiencing high rates of diabetes, preconception care is essential for a healthy birth outcome. Uninsured women are not likely to receive this type of care. As a consequence, their infants may suffer from preventable birth defects such as neural tube defects. The risk for these conditions can be reduced by as much as 70% by preconception care and taking folic acid before pregnancy.

In 2002, the Centers for Disease Control reported that the City of Minneapolis had the second highest Latino infant mortality rate among the US' 60 larg4est cities. For the years 1995-1998, Minneapolis' rate was 10.2 Latino infant deaths per 1,000 live births.

Immunization

American Latinos and other non-White students as a group had lower immunization levels than White students at every age point assessed. Immunization data indicates that only 65 percent of Latino children were up-to-date with immunizations at 24 months, indicating the need to develop and implement strategies that more effectively met the needs of this population (MDH Retrospective Survey of Kindergartners, 2001).

Breast and Cervical Cancer

The MDH Center for Health Statistics notes cancer is one of the leading causes of death for Latinos. Breast cancer is the most commonly diagnosed cancer among Minnesotan women (relative frequency 32.3 percent – 1992-96 figures). National data indicates that Latinos have one of the highest rates (14.4/100,000) of cervical cancer in the U.S. (8.7/100,000 – all races).

Teen Pregnancy

Minnesota's teen pregnancy rate among White teens is one of the lowest in the nation. Between 1990-99, teen pregnancy among Latino teens aged 15-19 increased by 39 percent. In 1989, the birth rate for Latinos was 78.9/1,000. In 1999, that rate had risen to 137.5, making teen birth among Minnesota's population the second highest in the nation.

In 2000, the rate of births to teens in Minnesota was higher than any other racial group (1110.21/1,000 as compared to White rate of 21.7/1,000)

Eliminating Disparities in Health Status

Minnesota is committed to eliminating health disparities among populations of color (including Latinos) and Whites in Minnesota. Included in these efforts is the Eliminating Health Disparities Initiative established in 2002. We hope that you share the concern about the importance of this initiative to the Minnesota Department of Health and the Latino community in Minnesota.

If you would like more information about health disparity, please contact:

Rosemarie Rodriguez-Hager
Latino Health Coordinator
Rosemarie.Rodriguez-Hager@health.state.mn.us
651-215-5802

APPENDIX D

2004 Populations of Color Health Status Report

"Because of the EHDI project Save Our Sons has been able to enhance its programming to focus on its clients from short, intermediate, and long term outcomes. Save Our Sons focuses on African American youth of all ages."

-Save Our Sons

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2004 POPULATIONS OF COLOR: HEALTH STATUS REPORT

DATA HIGHLIGHTS

Birth-related Health Indicators

In 1997-2001 **teen birth rates** for Populations of Color (African American, American Indian, Asian and Hispanic) decreased from 1989-1993 figures, but are still two to four times higher than Whites.

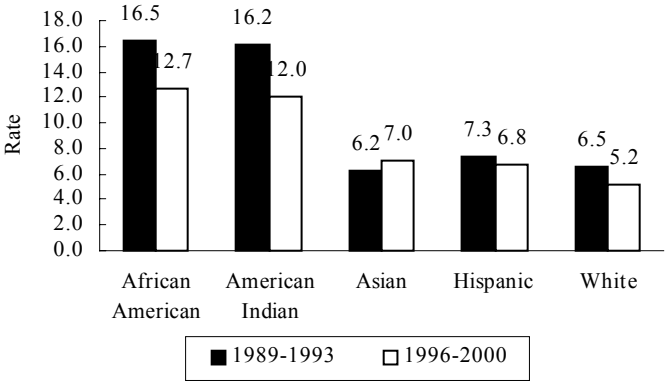
In 1997-2001, a greater percent of African American, American Indian, Asian and Hispanic women received **prenatal care** in their first trimester as compared to 1989-1993 figures. However, approximately 23% more White women received prenatal care in the first trimester as compared to Women of Color.

Recent figures indicate that **low birth weight births** decreased in the African American population, with little change in other populations. Overall, the disparities in low birth weight compared to Whites have remained small for all the racial/ethnic groups except for African Americans. Similar to national statistics, African American babies born in Minnesota are more than two times as likely to be born low birth weight than White babies.

Mortality Rates and Causes of Death

In Minnesota, **infant mortality rates** for African Americans, American Indians and Hispanics have decreased while the Asian infant mortality rate increased slightly from 1989-1993 to 1996-2000. Despite the decreases in the disparities in infant mortality rates, American Indian and African American infant mortality rates are still two times higher than the White rate.

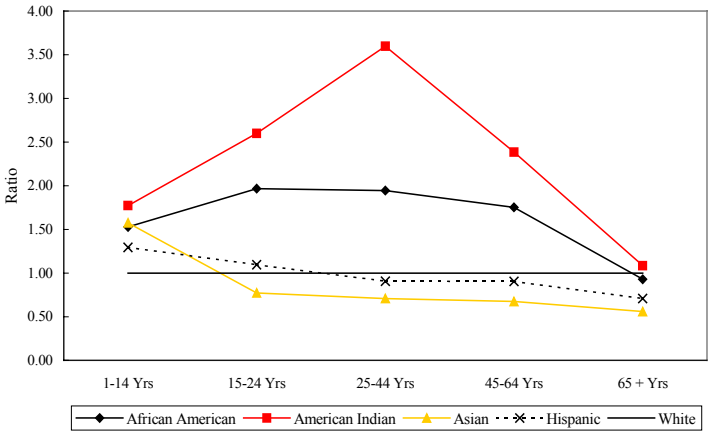
Infant Death per 1,000 births in Minnesota
by Race and Ethnicity: 1989-1993 and 1996-2000



In 1997-2001, the **age at death** was on average younger for Populations of Color than Whites. Almost 15 percent of Hispanic deaths and 10.5 percent of African American deaths were to those under 15 years of age compared to 1.2 percent for Whites. The percent of total deaths for Populations of Color under age 65 is 2-3 times higher than Whites.

Premature death, measured by YPLL (years of potential life lost) rates, robs individuals of their most productive years. YPLL takes into account the age at which people die, drawing attention to deaths, and to the causes of death, that occur early in life and which may therefore be more preventable. YPLL rates have decreased for each of the racial/ethnic groups from 1989-1993 to 1997-2001, yet disparities continue to exist. For example, even after adjusting for age, American Indians and African Americans are twice as likely to die prematurely than Whites. Asians and Hispanics had YPLL rates that were fairly close to those of the White population. Disparities in **death rates** exist for African

Age-Specific Disparity Ratio of Non White to White
Mortality Rates in Minnesota, 1997-2001



Americans and American Indians compared to Whites in all age groups except in the 65+ age group in 1997-2001. The death rate for American Indians ages 25-44 is 3.6 times higher than Whites. For African Americans, ages 15-24 and 25-44 years old, the death rate is 2.6 and 1.9 times higher than Whites for each respective age group.

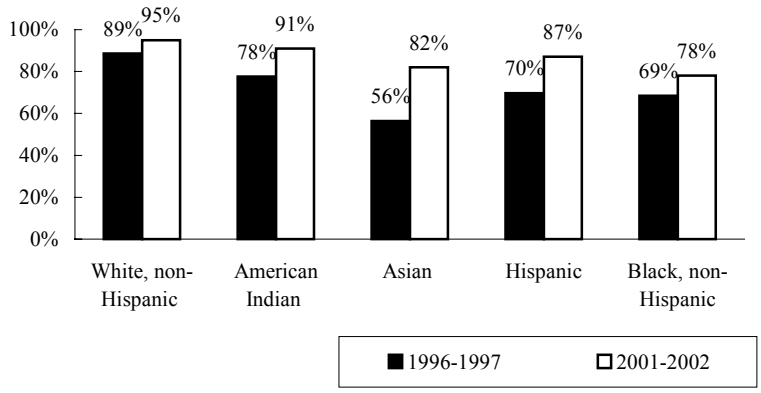
Illness and Injury

The **overall cancer incidence rate** in 1996-2000 was similar between African American and White women while Asian/Pacific Islander women had the lowest overall cancer incidence rate. Other data indicates that African American women were at the greatest risk of dying of this disease. In 1996-2000, the breast cancer mortality rate among African American women was 30 percent higher than among White women, despite the fact that their incidence rate was 25 percent lower.

Minnesota **HIV infections and rates** include all new cases of HIV (both HIV, non-AIDS) and AIDS at first diagnosis. In 2002, Whites accounted for 42 percent of new HIV infections and African Americans (including both U.S. and foreign born) accounted for 41 percent of new infections, even though African Americans account for only 4 percent of the general population. These factors are indicated in the elevated rates among these groups. New AIDS cases have declined or remained stable for most ethnic groups. However, cases have increased among African born persons, from 8 cases in 1996 to 29 cases in 2002, over a 200 percent increase.

Immunization Levels By Race/Ethnicity at 4 Months
Retrospective Kindergarten Survey, 1996-97 and 2001-

Overall **immunization rates** for children (ages 4, 6, 8, 17, 20 and 24 months) have increased from 1996 to 2001. The percent of children up-to-date with immunizations increased a minimum of three percent (at 4 months) to twenty percent (at 20 months). However, at each target age group, the immunization levels for Populations of Color and American Indians were lower than that of Whites.



APPENDIX E

Tuberculosis Screening and Treatment Rates for Foreign-Born Persons

"The Council on Crime and Justice Project focuses on African-American Male ex-offenders, based on prevention and intervention strategies in north Minneapolis and the east side of St. Paul."

-Council on Crime and Justice

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Tuberculosis Screening and Treatment Rates for Foreign Born Persons

Table 3: Tuberculosis Screening Rates for Primary Refugees Minnesota 1999-2003						
	1999	**2000**	**2001**	**2002**	**2003**	**2004 Target**
Arrivals	2,148	1,454	2795	1,033	2401	na
Total refugee screenings	2,705	3,154	2,294	890	2115	
% Screened for TB**	93%	96%	96%	94%	97%	90%

*na: not available
**Some refugees received a health assessment without the TB screening component

Table 4: Completion of Therapy for Tuberculosis Disease among Foreign Born Populations, Minnesota, 1998-2002*						
Objective: Completion of Case Therapy	**1998 No. (%)**	**1999 No. (%)**	**2000 No. (%)**	**2001**	**2002**	**Target Percent**
Number of TB cases	112	150	145	188	174	-
Within 12 months	80 (71)	117 (78)	108 (74)	152 (81	141 (81)	90
Overall	102 (91)	142 (95)	137 (94)	178 (95)	162 (93)	n/a

*Due to the potential for 12 months of therapy, completion of therapy data for cases counted in 2003 cannot be reported until 2005.

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APPENDIX F

Tuberculosis Screening Protocol

"We organized two vaccination clinics in coordination with local public health agencies. The outcome was a tremendous success, with 100 adults vaccinated for Hepatitis B and 116 adults receiving the T/D vaccine. We sincerely thank the Minnesota Department of Health for your support in creating a healthier migrant farmworker community in Minnesota."

-EHDI Grantee

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Tuberculosis Services Grants Through Community Health Boards

State General Funds allocated to local public health agencies specifically provide tuberculosis health screening and follow-up services for foreign-born persons.

In 2004, $250,000 of these funds was allocated to 41CHS agencies throughout Minnesota on a formula basis. The remaining $100,000 was used to coordinate and educate the local public health response to refugee resettlement in communities throughout Minnesota. As of October 30, 2004, Minnesota has resettled 5,885 new refugees. 2,272 of these arrivals were Hmong from WatTham Krabok in Thailand. This unprecedented influx of refugees strained the current health screening system, so assistance was sought and provided by the private health care community. Each new Hmong arrival has been called by a bi-lingual MDH staff person who helps arrange for their health screening exam.

Tuberculosis Screening Protocol *(2004)*

For each refugee whose initial U.S. resettlement is in the CHS service area after ***January 1, 2002*** *and for whom no previous health screening services have been provided in this state, the following duties shall be undertaken:*

A. Contact any new refugee (or the refugee's sponsor) resettling in the CHS service area to initiate a referral for a general health assessment.
B. Work with the refugee, sponsor or Volag (voluntary agency) to ensure that all refugees are referred for a general health assessment, evaluation, and treatment with a licensed health care provider within the first 90 days after the refugee's initial date of entry into Minnesota.
C. Work with the refugee, sponsor or Volag to ensure that transportation, interpretation, and financial barriers to the assessment are successfully resolved.
D. Provide follow-up within 30 days to all refugees who were referred for a general health assessment to ascertain if the assessment was completed and if acute disease problems necessitating follow-up were identified.
E. Ensure that all refugees identified with Class A conditions are screened within seven days of U.S. arrival. Those with Class B conditions must be screened within 30 days of U.S. arrival. Collect, report, and record information as requested by the Minnesota Department of Health regarding the initiation and adherence to prescribed treatment.

For persons in the CHS service area with active tuberculosis (TB) disease or latent TB infection (LTBI), responsibilities include but are not limited to:

A. Provide Directly Observed Therapy (DOT), as needed, for TB patients being treated for TB disease in the public or private sector. DOT will be provided in various appropriate settings, including the CHS's clinic, patients' homes, or elsewhere in the field.
B. Conduct contact investigations surrounding infectious TB cases. Investigations include interviewing the source case, locating exposed individuals residing in the CHS's jurisdiction, and referring contacts to health care providers for screening and medical evaluation and treatment; notifying other jurisdictions of contacts residing outside of the CHB's jurisdiction; and collecting and reporting data to MDH regarding findings of the investigation and completion of therapy rates for infected contacts.
C. Ensure the availability and appropriate use of professional interpreters, as needed, for non-English-speaking TB patients during the provision of TB-related services.
D. Provide or arrange for enablers (e.g., transportation to clinic visits and DOT appointments) and assist eligible patients in applying for financial assistance programs to cover the cost of TB-related services.
E. Provide appropriate incentives to ensure patients' adherence to therapy and follow-up care. Funds will not be used to provide monetary incentives directly to patients.
F. Provide individualized, linguistically and culturally appropriate patient education regarding TB treatment and follow-up.
G. Act as an advocate for TB patients, as needed, with private medical providers and health care systems to ensure that culturally appropriate medical follow-up is obtained.

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APPENDIX G

Community and Tribal Grantee Descriptions

One of the ways we will use the outcome findings is to develop better systems of collecting and recording information. Through this, we will be better able to evaluate where we need to improve the content of our curriculum.

- Freeport West

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Community Grantees

African American AIDS Task Force
310 East 38th St., Suite 304
Minneapolis, Minnesota 55409

Goal:	Expand health education and community outreach to people of African descent in the Hennepin County Medical Center Clinics.
Target population:	Africans/African Americans through places of worship and community events for African and African Americans
Priority health area(s) to be addressed:	HIV/AIDS and Sexually Transmitted Infections
Service area(s):	Hennepin County
Partners:	Hennepin County Medical Center

Agape House for Mothers
400 Selby Ave., Suite T
St. Paul, Minnesota 55102

Goal:	Promote Healthy Youth Development through hosting regular trainings, career workshops, seminars, community focus groups, and teen and parent meetings.
Target population:	African American
Priority health area(s) to be addressed:	Healthy Youth Development, HIV/AIDS and Sexually Transmitted Infections
Service area(s):	Twin Cities

American Indian Family Center
579 Wells Ave.
St. Paul, Minnesota 55101

Goal:	Expand the doula network by the following activities: training at least 20 new doulas; providing 200 women with doula services; updating current doula manual, creating a Spanish doula manual, creating Hmong and Somali doula information brochures, provide continuing education for current doula, partner with Division of Indian Works in Minneapolis to address the postpartum gap for families.
Target population:	African/African American, American Indians, Asian Americans, and Latino
Priority health area(s) to be addressed:	Infant Mortality
Service area(s):	Twin Cities
Partners:	Division of Indian Works

Anishinaabe Center
921 8th St. SE
Detroit Lakes, Minnesota 56501

Goal:	Reduce the onset of diabetes and effects of the disease on the long-term health of American Indians living in service area. Production of animated video series to be used as a teaching tool by Young Warriors Society peer educators. Youth will be trained to use the video as a discussion tool to share lifestyle changes such as healthy diet and exercise to prevent diabetes from defeating American Indian people.
Target population:	American Indian
Priority health area(s) to be addressed:	Diabetes
Service area(s):	Detroit Lakes area including White Earth Reservation in Becker, Mahnomen and Clearwater counties
Partners:	Indian Health Service, St. Mary's Hospital, Traditional Healers

Bois Forte Reservation
13071 Nett Lake Road
Nett Lake, Minnesota 55771

Goal:	Reduce the incidence of cardiovascular disease and diabetes for band members of all ages by promoting physical activity and healthy nutrition. Tribal members have been assessed for cardiovascular disease risk factors and individualized physical activity plans have been designed for each person with identified risk. Staff provides education and physical activity for all ages in schools and work sites tailored to the needs and fitness level of individuals.
Target population:	American Indian
Priority health area(s) to be addressed:	Cardiovascular Disease
Service area(s):	Nett Lake, Vermillion, Bois Forte Reservation, St. Louis County
Partners:	Bois Forte Community Health, Bois Forte Elderly Assistance, Bois Forte Fitness Center, Bois Forte Medical Clinic, Indian Health Service, Honoring the Gift of Heart Health

Boys and Girls Club
2575 University Ave. West, #100
St. Paul, Minnesota 55114

Goal:	Utilize "Smart Moves" program, a program with various components for different age groups and parents, in additional sites to increase healthy youth development.
Target population:	African/African American, American Indian, Asian American, and Latino

Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	Minneapolis and St. Paul

Camphor Foundation
585 Fuller Ave.
St. Paul, Minnesota 55103

Goal:	Use a faith-based approach to Contribute to Healthy Youth Development.
Target population:	African/African American
Priority health area(s) to be addressed:	Healthy Youth Development (Teen Pregnancy Prevention)
Service area(s):	St. Paul
Partners:	Aurora/ St. Anthony Neighborhood Development Agency Morning Star Baptist Church, Mount Olivet Baptist Church, River of Life Church, St. James A.M.E. Church, St. Peter Claver Parish, Twin Cities Healthy Start, United Church of God in Christ

Carondolet Life Care Ministries
1884 Randolph Ave.
St. Paul, Minnesota 55105

Goal:	Coordinate activities between parishes to increase education and outreach around diabetes and breast and cervical cancer.
Target population:	Latino
Priority health area(s) to be addressed:	Breast and Cervical Cancer, Diabetes
Service area(s):	Minneapolis and St. Paul
Partners:	Holy Rosary Parish, Assumption Parish, Our Lady of Guadalupe

Cass County-Leech Lake Reservation Family Services Collaborative
Leech Lake/Cass County Family Services Collaborative
6530 Hwy 2 NW
Cass Lake, Minnesota 56633

Goal:	Reduce infant mortality on the Leech Lake Reservation by recruiting and training band members as doulas to assist families throughout their pregnancy, delivery and post delivery.
Target population:	American Indian
Priority health area(s) to be addressed:	Infant Mortality

Service area(s):	Leech Lake Reservation including counties of Cass, Beltrami, Hubbard and Itasca
Partners:	Cass Lake Indian Health Service MCH committee, North Country Hospital, Beltrami County Public Health, Itasca County Public Health, Merit Care Clinic, Public Health Nurses, Deer River Health Care Center, Leech Lake Baby Tracks, Leech Lake Health Division, Walker Family Resource Center, Cass County Public Health, Leech Lake Family Services, Cass Lake Family Services, University of Minnesota Little Ears Project, Leech Lake Domestic Violence Program, Leech Lake Public Health Traditional Healer, Anishinaabeg Minosewag

Center for Asians and Pacific Islanders
3702 E. Lake St.
Minneapolis, Minnesota 55406

Goal:	Project will provide culturally competent, language-specific, preventive health care education and assistance in accessing care.
Target population:	Hmong, Vietnamese, Somali, and Oromo
Priority health area(s) to be addressed:	Immunizations
Service area(s):	Twin cities seven county metro area

Centro
1915 Chicago Ave. South
Minneapolis, Minnesota 55404

Goal:	Utilize family networks to increase communication between children and parents in order to increase healthy youth development. Provide education in a culturally specific manner to decrease infant mortality.
Target population:	Latino
Priority health area(s) to be addressed:	Healthy Youth Development, Infant Mortality
Service area(s):	Minneapolis
Partners:	Planned Parenthood of Minnesota & South Dakota, MOAPPP, University of Minnesota Physicians-Midwife Program, Children's Hospital

Centro Campesino
104½ Broadway St. West, #206
Owatonna, Minnesota 55060

Goal:	Expand culturally specific project to additional geographic areas to address breast and cervical cancer, diabetes, HIV/AIDS and Sexually Transmitted Infections, immunizations for adults and children, and violence and unintentional injuries.

Target population:	Latino
Priority health area(s) to be addressed:	Immunizations for adults and/or children, Breast and Cervical Cancer, Diabetes, HIV/AIDS and Sexually Transmitted Infections, Violence and Unintentional Injuries
Service area(s):	Steele and LeSueur Counties
Partners:	Migrant Health Services, Inc., Steele County Public Health Nursing Service, American Red Cross, Owatonna Hospital, Shannon Pergament, University of Minnesota Center for Urban and Regional Affairs

Children's Health Care
2425 Chicago Ave. South
Minneapolis, Minnesota 55404

Goal:	Increase outreach and education to address healthy youth development, HIV/AIDS and Sexually Transmitted Infections prevention, and immunization rates in the Latino community. Also, increase education and services to prevent cardiovascular disease and diabetes in the African American community.
Target population:	African American and Latino
Priority health area(s) to be addressed:	Immunizations for adults and/or children, Cardiovascular Disease, Diabetes, HIV/AIDS and Sexually Transmitted Infections, Healthy Youth Development
Service area(s):	Hennepin County
Partners:	TAMS, Centro de Salud, YWCA of Minneapolis, Macedonia Baptist Church, The City, Inc, Edison High School, The Bridge for Runaway Youth, Centro Cultural Chicano, Phillips TLC, Camden's Future, Powderhorn Family Network

Dar Al-Hajrah Cultural Center
504 Cedar St.
Minneapolis, Minnesota 55454

Goal:	Use a faith-base approach to increase the awareness and access to immunizations; to decrease incidences of undiagnosed and untreated cardiovascular disease and diabetes; and to create culturally and linguistically appropriate health education materials.
Target population:	African/African American (Somali)
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes, Immunizations
Service area(s):	Cedar-Riverside Neighborhood, Minneapolis
Partners:	Metropolitan Health Plan

Family and Children's Service
4123 East Lake St.
Minneapolis, Minnesota 55406-2028

Goal:	Increase the number of African American males committed to domestic peace.
Target population:	African/African American
Priority health area(s) to be addressed:	Violence and Unintentional Injury
Service area(s):	North Minneapolis-Hennepin County
Partners:	African American Men's Project, CCP/SAFE 4th Precinct, The City, Inc. Holding Forth the Word of Life Church/ Oasis of Love, Jordan New Life Community Fellowship Church, Kwanzaa Church, MAD DADS

Freeport West
2219 Oakland Ave. South
Minneapolis, Minnesota 55404

Goal:	Contribute to Healthy Youth Development by providing life skills training, leadership opportunities and rite of passage program for high-risk youth of African descent.
Target population:	African/African American
Priority health area(s) to be addressed:	Healthy Youth Development (Teen Pregnancy Prevention)
Service area(s):	Minneapolis, St. Paul

Fremont Community Health Services
3300 Fremont Ave. North
Minneapolis, Minnesota 55412

Goal:	Focus on cardiovascular health and diabetes in the African, African American, Asian American and Latino communities in Northeast and North Minneapolis.
Target population:	African/African American
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes
Service area(s):	North Minneapolis- Near North, Camden, NW Hennepin County- Brooklyn Center, Brooklyn Park
Partners:	North Memorial Stroke Center. North Point Health Center, University Family Physicians, Ageless Possibilities, Insight News, Stairstep Foundation, Turning Point

Greater Minneapolis Council of Churches: Division of Indian Work
1001 East Lake St.
Minneapolis, Minnesota 55407-0509

Goal:	Promote health as a means to reduce infant mortality in the urban American Indian community. Recruit and train American Indian women to serve as doulas to pregnant mothers and their families.
Target population:	American Indian
Priority health area(s) to be addressed:	Infant Mortality
Service area(s):	Hennepin County
Partners:	Minnesota Indian Women's Resource Center, Indian Health Board, Little Earth Community Partnership, American Indian Family Center

Greater Minneapolis Council of Churches: Division of Indian Work
1001 East Lake St.
Minneapolis, Minnesota 55407-0509

Goal:	Field test culturally appropriate teen pregnancy prevention curriculum in 4-6 sites. Analyze data and outcome results from first field test sites. Review and evaluate results. Revise and reprint curriculum as well as recruit additional sites for second year of curriculum testing. Advisory committee will continue to meet throughout project.
Target population:	American Indian
Priority health area(s) to be addressed:	Healthy Youth Development (TANF)
Service area(s):	Minneapolis metro area - Hennepin County
Partners:	Minnesota Indian Women's Resource Center, Little Earth Community Partnership, Indian Health Board, Ginew/Golden Eagles, DIW Teen Pregnancy Project

Hmong American Partnership
1000 Payne Ave.
St. Paul, Minnesota 55106

Goal:	Project will create supportive environments that directly encourage physical activity, healthy food choices, and decrease the use of violence as a response to family conflict. Project will increase availability and effectiveness of mental health services for the Hmong community in order to reduce domestic violence.
Target population:	Hmong
Priority health area(s) to be addressed:	Cardiovascular Disease, Violence and Unintentional Injuries

Service area(s):	St. Paul
Partners:	May's Health and Fitness Studio, True Thao, LICSW

Metropolitan Urban Indian Directors/Indian Health Board
1001 East Lake St.
Minneapolis, Minnesota 55407-0509

Goal:	Raise awareness in the American Indian community about breast and cervical cancer. Target American Indian women under age 40 and their families to establish a medical home, get regular checkups and follow up with health provider if needed. Provides outreach, case management, follow-up, and access to traditional healers and community educational events around breast and cervical cancer. Facilitates support groups and family groups for support and healing.
Target population:	American Indian
Priority health area(s) to be addressed:	Breast and Cervical Cancer
Service area(s):	Twin Cities metro area including Hennepin and Ramsey counties
Partners:	Leech Lake Twin Cities Office, Mille Lacs Band Urban Office, Minneapolis Department of Health and Family Support, Minnesota Indian Women's Resource Center, Healthy Nations, American Indian OIC, Native Path to Wellness, Indian Health Board, Hennepin County Medical Center, Little Earth Community Partnership, Office of Indian Ministries

La Clinica, La Oportunidad, CLUES
2700 East Lake St., Suite 100
Minneapolis, Minnesota

Goal:	Provide comprehensive services, including referrals for health care, academics, after school activities, employment, to increase healthy youth development.
Target population:	Latino
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	Minneapolis - Hennepin County
Partners:	MOAPPP, National Teen Pregnancy Research Center

Lao Family Community
1299 Arcade St.
St. Paul, Minnesota 55106

Goal:	Project will provide culturally-specific abstinence-based education, case management, and support group services for youth in schools and parents of parenting teens, in order to prevent teen pregnancy and repeat pregnancies.
Target population:	Hmong
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	Ramsey and Hennepin counties
Partners:	St. Paul Public Schools: Cleveland Quality Middle School, Washington Junior High, Battle Creek Middle School, Hazel Park Middle School, Arlington High School, AGAPE and St. Paul Public Schools Alternative Learning Center. Minneapolis Public Schools: Anwatin Middle School and Franklin Middle School

Minneapolis American Indian Center Healthy Nations
1530 East Franklin Ave.
Minneapolis, Minnesota 55404

Goal:	Provide opportunities for individual and team physical activities for youth and young adults as well as education about healthy lifestyle choices.
Target population:	American Indian
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes, Unintentional Injury and Violence, Healthy Youth Development
Service area(s):	Twin Cities metro area
Partners:	Indigenous People's Task Force, Community University Health Care Center, Children's Hospitals and Clinics

Minneapolis Urban League
2100 Plymouth Ave. North
Minneapolis, Minnesota 55411

Goal:	Provide healthy after school programming from a variety of disciplines for middle school age youth.
Target population:	African/African American
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	City of Minneapolis near north neighborhoods

Partners:	Janelle Ranek and associates, Legacy Village, Hospitality House, Track Minnesota Elite

Minnesota International Health Volunteers:
Somali Health Care Project Initiative
122 W. Franklin Ave., Suite 522
Minneapolis, Minnesota 55404-2480

Goal:	Project will strengthen the cultural responsiveness of health care and social service providers through education. Project will also further assess and strengthen the community's knowledge and awareness of priority health areas through language and cultural-specific means in order to support the adaptation of healthy lifestyle behaviors.
Target population:	Somali
Priority health area(s) to be addressed:	Breast and Cervical Cancer, Cardiovascular Disease, Diabetes, HIV/AIDS and Sexually Transmitted Infections, Immunizations, Infant Mortality
Service area(s):	Twin Cities
Partners:	Confederation of Somali Community in Minnesota (CSCM) and Leadership, Empowerment and Development Group (LEAD)

North Suburban Youth Clinic (Annex Teen Clinic)/
Restore and Empower African American Adolescents to Create and Hope (REACH)
4915 42nd Ave. North
Robbinsdale, Minnesota 55422

Goal:	Project will provide an intergenerational program that gives youth positive experiences that enhance their assets, support their reproductive health and reduce risk behaviors to prevent teen pregnancy.
Target population:	African American
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	North Minneapolis
Partners:	Minneapolis Beacons Project and Network (through the YMCA of Minneapolis and the YWCA of Minneapolis), the North Community YMCA, Nia-Imani Youth Development Center of Kwanzaa Presbyterian Church and the Annex Teen Clinic/North Suburban Youth Health Clinic

Olmsted Community Health Board
2100 Campus Drive SE
Rochester, Minnesota 55904-4722

Goal:	Educate and promote prevention health services to address cardiovascular disease, diabetes, and immunizations for adults and children.

Target population:	African American and Latino
Priority health area(s) to be addressed:	Immunizations for adults and/or children, Cardiovascular Disease, Diabetes
Service area(s):	Olmsted County
Partners:	Salvation Army Free Clinic, Migrant Health Services, Olmsted Medical Center, Mayo Clinic-Rochester, NAACP, Emmanuel Baptist, Iglesia Cristo del Rey, St. Francis Catholic, St. Charles Catholic, Jehovah Witness, World of Life Church of God in Christ, Rochester Community Baptist Church, Somali Community Resettlement Services, Alliance of Chicano Hispanic and Latino American, Intercultural Mutual Assistance Association, Multicultural Healthcare Alliance, Workforce Development Center, Adult ESOL, Hand in Hand Program, Rochester Public Schools, Boys and Girls Club, Post Bulletin, KNXR Radio, KTTC TV, Somali TV, Charter Cable TV, American Heart Association, American Diabetic Association, Midwest Dairy Council, American Cancer Society

Park Ave Family Practice
2707 Nicollet Ave. South
Minneapolis, Minnesota 55408

Goal:	Project will enhance patient understanding in order to change behavior in priority health areas through the creation and use of culturally-specific multimedia educational tools during patient visits and in youth groups.
Target population:	Hmong
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes, Infant Mortality, Healthy Youth Development
Service area(s):	Twin Cities
Partners:	St. Vincent Hmong Catholic Church

Region 9 Development Council
410 Jackson East St.
Mankato, Minnesota 56002-3367

Goal:	Provide health care services through culturally appropriate programming to address cardiovascular disease, breast and cervical cancer, and diabetes.
Target population:	Latino
Priority health area(s) to be addressed:	Breast and Cervical Cancer, Cardiovascular Disease, Diabetes
Service area(s):	Blue Earth, Brown, Faribault, LeSueur, Martin, Nicollet, Sibley, Waseca, Watonwan Counties
Partners:	Saludando Salud, Open Door Health Center, Blue Earth County Public Health

Southeast Asian Community Council-Southeast Asian Youth Empowerment Council
555 Girard Terrace, Suite 110
Minneapolis, Minnesota 55405

Goal:	Project will build youth's leadership skills, academic/career goals, interpersonal communication skills, and self-esteem, while enhancing parent/youth communication and connectedness, in order to prevent teen pregnancy.
Target population:	Hmong
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	Hennepin County, Ramsey County
Partners:	Association for the Advancement of Hmong Women in Minnesota, Lauj Youth Society, and Asian Media Access

Southeast Asian Ministry
105 W. University Ave.
St. Paul, Minnesota 55103

Goal:	Project will utilize a culturally-specific parish nurse/elder program to provide health education and promote health-related changes/activities through home visits, follow-up phone calls and group sessions.
Target population:	Cambodian and Hmong
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes
Service area(s):	St. Paul area
Partners:	United Cambodian Association of Minnesota, Hmong Baptist National Association, Hmong American Partnership, and Lyngblomsten Services

Stairstep Foundation
1404 14th Ave. North
Minneapolis, Minnesota 55411

Goal:	Project will utilize the Foundation's Community Reclamation Project's Health Initiative entitled, *There is A Balm*: A network of eleven health coordinators working with sixteen African American churches to strengthen the role of the church pastor as a health leader. The health coordinators provide targeted health education to the lay community and create opportunities for the community to practice healthy behaviors.
Target population:	African American
Priority health area(s) to be addressed:	Breast and Cervical Cancer, Cardiovascular Disease, Diabetes, Healthy Youth Development, Immunization, Infant Mortality
Service area(s):	Hennepin, Ramsey

Partners:	Christ Temple, Faith Tabernacle, Fellowship Baptist Church, Grace Temple, Greater Friendship Baptist, He Is Risen Church of God In Christ, Holding Forth the Word of Life Church, Kwanzaa Community Church, Living Word Church, Mt. Olivet Baptist, New Salem Baptist Church, Progressive Baptist Church, Resurrection Temple, The Sanctuary Covenant, Shiloh International Ministries, and Wayman A.M.E. Church

St. Paul Urban League
401 Selby Ave.
St. Paul, Minnesota 55102

Goal:	Provide programming to increase the success of youth through education and youth development activities.
Target population:	African American
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	St. Paul
Partners:	Indianhead Council of St. Croix Valley, Weed & Seed, St. Paul Public Schools

Storefront Group
6425 Nicollet Ave. South
Richfield, Minnesota 55423

Goal:	Project will build cultural/spiritual/familial understanding of the importance of immunizations and preventative health care. Provide opportunities for the community to practice healthy behaviors.
Target population:	Somali
Priority health area(s) to be addressed:	Immunizations
Service area(s):	Eagan and Burnsville area within Dakota
Partners:	Eagan High School, Dakota Hills Middle School, Glacier Hills Elementary School, Park Nicollet Clinic, Fairview Ridges Hospital, Burnsville Family Service Collaborative, and Dakota County Public Health

Summit University Teen Center
1063 Iglehart Ave.
St. Paul, Minnesota 55104

Goal:	Conduct gender specific after school classes that teach life skills needed by youth to become healthy community contributing adults. Job skills, socialization and community service, cultural awareness, community activism and a Black College Fair are part of the curriculum for this agency.
Target population:	African/African American and Asian American
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	St. Paul neighborhoods of West Central and Frogtown
Partners:	Minnesota AIDS Project, M.E.L.D., St. Paul Public Schools, Working Family Resource Center, City of St. Paul Center for Employment and Training, Ramsey County Department of Health

Turning Point
1500 Golden Valley Road
Minneapolis, Minnesota 55411

Goal:	Increase education and awareness about HIV/AIDS and Sexually Transmitted Infections transmission through culturally specific efforts.
Target population:	African/African American
Priority health area(s) to be addressed:	HIV/AIDS and Sexually Transmitted Infections
Service area(s):	Minneapolis
Partners:	Minneapolis Urban League, The City, Inc., Minnesota AIDS Project, Aliveness Project, Hennepin County Medical Center Infectious Disease Clinic, African American AIDS Task Force, Community Fitness Today, National Black Alcoholics Addiction Committee, Stair Step Foundation

United Hospital Foundation
333 North Smith Ave.
St. Paul, Minnesota 55102

Goal:	Expand current strategies in unintentional injury and violence prevention to include culturally specific issues in the following settings: health care, schools, and community.
Target population:	African/African American, American Indian, Asian American, and Latino
Priority health area(s) to be addressed:	Violence and Unintentional Injuries

Service area(s):	St. Paul- W. 7th Twin Cities expansion
Partners:	West 7th Community Center; St. Paul Domestic Abuse Intervention Project; Women of Nations Eagles Nest Battered Women's Shelter; Casa de Esperanza; Monroe Community School; Adams Spanish Immersion School; St. Francis/St. James United School; Four Seasons Elementary School; Twin Cities Academy; St. Paul Open School; Bridgewies School; Asian Women United; CLUES; St. Francis Medical Center; La Clinica; Centro de Salud

Vietnamese Social Services of Minnesota
1159 University Ave. West, Suite. 100
St. Paul, Minnesota 55104

Goal:	Project will provide education to promote screening through: conducting a culturally-specific media campaign, training lay health workers, supporting a language-specific cancer screening clinic and incorporating a Pap smear registry.
Target population:	Vietnamese
Priority health area(s) to be addressed:	Breast and Cervical Cancer
Service area(s):	Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington
Partners:	American Cancer Society Friend-to-Friend Project, Church of St. Joseph Hien International Health CARE Alliance, Medica, Minneapolis Children's Hospital, Regions Hospital, National Cancer Institute-Mayo Clinic, Susan G. Komen Breast Cancer Foundation, University of California -Department of Medicine-San Francisco, University of Minnesota Cancer Center, Vietnamese Buddhist Association of Minnesota

West Central Integration Collaborative (was Kandiyohi Public Health in the first grant cycle)
611 5th St. SW
Willmar, Minnesota

Goal:	Increase education and outreach efforts to support healthy youth development.
Target population:	African/African American and Latino
Priority health area(s) to be addressed:	Healthy Youth Development
Service area(s):	Kandiyohi County
Partners:	Kandiyohi County Public Health, The Center for Cross-Cultural Health, PACT 4 Families, Rice Memorial Hospital, Pioneer Public TV, Jennie-O Foods, Inc., Paz Y Esperanza Church, MBCCCP, Coalition for African Communities Kandiyohi County, Ridgewater College, HACER

West Side Community Health Service
153 Concord St.
St. Paul, Minnesota 55107

Goal:	Increase education and outreach efforts to support healthy lifestyles for Latino and Hmong with diabetes.
Target population:	Asian American and Latino
Priority health area(s) to be addressed:	Diabetes
Service area(s):	Minneapolis/St. Paul metro area
Partners:	St. Paul Ramsey County Department of Public Health, CLUES, Neighborhood House, HealthPartners for Health Promotion, West Side Family Center, East Metro Diabetes Initiative, St. Mary's Clinics, Lens Crafters Woodbury, Indian Health Board of Minneapolis, St. Paul Family Medical Clinic, Lo Medical Clinic, Hmong Health Care Professionals, Regions Hospital Health mobile, Hmong American Partnership, Women's Association of Hmong and Lao, UCare, Hmong Alliance Church

Women's Cancer Resource Center
4604 Chicago Ave. South
Minneapolis, Minnesota 55407

Goal:	Project will utilize a cultural navigation program to provide prevention education to women at risk of breast and cervical cancer. Project will also provide culturally-specific support to women diagnosed with breast and cervical cancer.
Target population:	African/African American
Priority health area(s) to be addressed:	Breast and Cervical Cancer
Service area(s):	Minneapolis
Partners:	Africa Solutions, African American Breast Cancer Alliance, African American Family Services, Moore Board and Lodge, North Point Health Center, and Southside Community Health Center

Tribal Health Grants

The Tribal Health Grants are now included in the Local Public Health Block Grant for Tribal Governments.

Bois Forte Reservation Tribal Council
P.O. Box 25
Nett Lake, Minnesota 55772

Goal:	Develop materials to encourage women to receive screenings for breast and cervical cancer and to collaborate with Bois Forte Health Services Community Health program to provide case management for the women using health services and provide transportation as necessary.
Priority health area(s) to be addressed:	Breast, Cervical Cancer
Service area(s):	Bois Forte Reservation including St. Louis, Koochiching, Itasca counties

Fond du Lac Band of Lake Superior Chippewa
927 Trettel Lane
Cloquet, Minnesota 55720

Goal:	Reduce infant mortality and encourage healthy youth development by providing education-appropriate referral services.
Priority health area(s) to be addressed:	Infant Mortality, Healthy Youth Development
Service area(s):	Fond du Lac Reservation including Carlton and southern Cook County

Grand Portage Reservation Tribal Council
62 Upper Road, P.O. Box 428
Grand Portage, Minnesota 55605

Goal:	Implement a combined approach to reducing risk factors, contributors and diagnosis of cardiovascular disease and diabetes as well as providing youth related activities for healthy development among Grand Portage enrollees and other American Indians residing in the service area.
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes, Healthy Youth Development
Service area(s):	Grand Portage Reservation including Cook County

Leech Lake Band of Ojibwe
6530 Hwy 2 NW
Cass Lake, Minnesota 56633

Goal:	Promote healthy lifestyle change for American Indians to reduce incidences of cardiovascular disease, diabetes, and unintentional injuries and violence. Reducing infant mortality and increasing awareness of adult immunization protocol is also a health focus. Additionally, creating supportive environments and conducting educational programs will encourage physical activity and healthy food choices for all ages of patients.
Priority health area(s) to be addressed:	Immunizations, Infant Mortality, Cardiovascular Disease, Diabetes, Violence and Unintentional Injuries
Service area(s):	Leech Lake Reservation including Beltrami, Cass, Hubbard, Itasca counties

Lower Sioux Community
39527 Reservation Hwy 1, P.O. Box 308
Morton, Minnesota 56270

Goal:	Provide education from a cultural perspective with a focus on improving the health and wellness of tribal members.
Priority health area(s) to be addressed:	Diabetes, Violence and Unintentional Injuries
Service area(s):	Lower Sioux service area including Redwood County

Mille Lacs Band of Ojibwe
43500 Migizi Drive
Onamia, Minnesota 56359

Goal:	Provide education and awareness to increase adult and child immunizations, reduce incidence of infant mortality and unintentional injuries and violence.
Priority health area(s) to be addressed:	Immunizations, Infant Mortality, Unintentional Injuries and Violence
Service area(s):	Mille Lacs Reservation including Mille Lacs, Aitken, Kanebec and Pine Counties

Prairie Island Sioux Community
1158 Island Boulevard
Welch, Minnesota 55089

Goal:	Improve the health and well being of tribal members.
Priority health area(s) to be addressed:	Diabetes, Cardiovascular Disease

Service area(s):	Prairie Island Reservation (includes Goodhue County)

Red Lake Comprehensive Health Services
P.O Box 249
Red Lake, Minnesota 56671

Goal:	Assess family and prenatal strengths and risks and develop an individualized prenatal care plan to reduce infant mortality for all community members.
Priority health area(s) to be addressed:	Infant Mortality
Service area(s):	Red lake Indian Reservation including counties of Beltrami, Clearwater, Lake of the Woods, Pennington, & Polk

Upper Sioux Community
P.O. Box 147
Granite Falls, Minnesota 56241

Goal:	Build collaborations with counties and health centers, to strengthen and improve health care system for community.
Priority health area(s) to be addressed:	Cardiovascular Disease, Diabetes, Immunizations, Infant Mortality
Service area(s):	Upper Sioux Community includes Yellow Medicine County

White Earth Reservation Tribal Council
P.O. Box 300
White Earth, Minnesota 56591

Goal:	Provide community-based violence prevention activities to reduce unintentional injuries and violence.
Priority health area(s) to be addressed:	Unintentional Injuries and Violence
Service area(s):	White Earth Reservation includes Mahnomen, Becker and Clearwater counties

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APPENDIX H

Measurable Outcomes

Our youth are currently doing a play entitled "Inside Out" and producing a cable show called "Ask The Question." The young people in our program are innovative, creative, energetic, and willing to do something new that speaks to and about young people.

-St Paul Urban League
African American Teen
Pregnancy Prevention
Collaborative

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Long-Term, Intermediate and Program Level Outcomes

Eliminating Health Disparities Initiative
Measurable Outcomes

Long Term Measurable Outcomes[1]	
Decrease by 50%, the disparity in infant mortality rates among targeted populations.	
Decrease by 50%, disparities in the immunization rates of children from targeted groups (% up-to-date for 4 doses of DTP, 3 doses polio, 1 dose MMR vaccine at 24 months)	
Decrease by 50%, disparities in immunization rates of adults from targeted groups (influenza and pneumococcal disease.)	
Decrease breast and cervical cancer mortality rates among targeted populations.	
Decrease the incidence and prevalence rates for gonorrhea, chlamydia, syphilis, and HIV infections between targeted groups and the white population	
Decrease the age adjusted CVD, heart disease, and cerebrovascular death rates among targeted groups.	
Increase the proportion of persons with diabetes who have an Annual lipid and HbA1c measurement	
Decrease the disparities in teen pregnancy rates and subsequent births to women in targeted groups.	
Decrease the rates of deaths due to unintentional injury, suicide, homicide, and motor vehicle accidents in targeted populations	
Intermediate (e.g.) [2]	
Health Behaviors	Health System
Tobacco Use	Health Care Coverage
Alcohol Use	Cultural Competency
Physical Activity	Clinic Hours
Community Assets	Environmental Factors
Social Support	Childhood Poverty
Accessible clinics	Affordable Housing
Program Level (e.g.)[3]	
Schools in the district who use WOLF diabetes curriculum Home visiting assessment and referrals of women and infants	

[1] These measures identify long-term outcomes for the initiative. They have been identified primarily through the technical expertise of state and national consultants and are the traditional measures related to the eight health priority areas for the EHDI. With the exception of the measure for diabetes, data is available from MDH vital records and public health surveillance systems. These outcomes measure the impact on the overall health priority area and, as such, tend to be long-term indicating change in the health status of a population (frequently described in terms of morbidity or mortality, e.g. infant mortality rates).

[2] Intermediate outcomes can have an effect on the desired long-term outcome. These outcomes are monitored in shorter time frames and are clearly focused on measures which have a high probability of reducing a health problem or increasing individual and/or community resiliency/capacity (e.g. Prenatal Quality of Care Index.)

[3] Short term, process or program-level outcomes are measures of the effect of an intervention. They detail the specific tasks that will be carried out by the EHDI grantees. Process outcomes measure the effectiveness of the EHDI grantee intervention or strategy (e.g. number of women who attend prenatal care classes.)

EHDI Baseline and Target Rates for Infant Mortality and Immunizations

Infant Mortality Rates per 1,000 Births by Race and Hispanic Origin of Mother, 1995-99

	White	African American	American Indian	Asian	Hispanic
EHDI Baseline	5.5	13.2	13.5	7.1	7.0
EHDI Target	---	9.4	9.5	6.3	6.3

Source: Infant Mortality statistics for Minnesota from the 1995-99 linked birth/infant death data set, Minnesota Department of Health, Center for Health Statistics.

Immunization Rates at Age 17 months by Race and Hispanic Origin

	White	African American	American Indian	Asian	Hispanic
EHDI Baseline 2001-02	81.0	61.0	71.0	65.0	66.0
EHDI Target	---	71.0	76.0	73.0	74.0

Source: Retrospective Kindergarten Survey, Minnesota Department of Health

APPENDIX I

Community and Tribal Health Outcomes

"The Grant activities of Olmsted County Public Health Services involve partnering with the Adult Literacy Program (ESOL) to provide health teaching, referral and follow up for these students who lack knowledge and/or access to local health care resources. We can reach our target populations at a teachable moment as well as enhance the health teaching component of their curriculum."

-Olmsted County Public Health Services

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COMMUNITY AND TRIBAL HEALTH GRANTEES
SELECTED SHORT-TERM OUTCOMES
December 2004

Breast and Cervical Cancer

INDIAN HEALTH BOARD

- Families were provided with educational home visits after which more than 90% were aware of the risk factors for breast and cervical cancer

CENTRO CAMPESINO

- Held educational talks and workshops which were attended by 293 people
- 102 of the people who attended received pap smears and cervical exams as a result of attending these talks/workshops

WOMEN'S CANCER RESOURCE CENTER

- Provided cultural navigators who aided clients in getting referrals for mammograms and pap smears and performed one-on-one and group prevention education

Cardiovascular Disease

FREMONT COMMUNITY HEALTH SERVICES

- Trained peer educators to teach others about the dangers of cardiovascular disease
- Provided information about cardiovascular disease to 17,362 people

BOIS FORTE RESERVATION

- Youth in the 6-week Summer Youth Work Program lost an average of 3.4 pounds and 1.33 BMI points

MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS

- 7 out of 10 Somali elders in a physical fitness pilot program were completing at least 20 minutes of moderate physical activity, at least 5 times a week

REGION NINE DEVELOPMENT COMMISSION

- Screened 1,362 people for cardiovascular disease over a 27-month period

MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS

- Screened 30 of 39 Somali Cardiovascular Forum participants for heart health

Violence and Unintentional Injuries

WHITE EARTH RESERVATION TRIBAL COUNCIL

- 75% of men participating in an anger management group were able to identify their triggers for anger after completing all of the group sessions

UNITED HOSPITAL FOUNDATION

- The bullying curriculum "Steps to Respect" was introduced to 4 new schools, at which 600 students received the curriculum

FAMILY AND CHILDREN'S SERVICES

- Of men who pledged to take action on the issue of domestic violence:
  - 95% had spoken out against family violence
  - 85% promoted healthy relationships
  - 85% talked to others about their pledge ceremony

LEECH LAKE HEALTH DIVISION

- 440 clients were seen for integrated health visits over a one-year period including behavioral health services
- 66% of the 167 behavioral health clients had more than one visit

Diabetes

SOUTHEAST ASIAN MINISTRY

- Held sessions to teach Cambodian and Hmong elders about the dangers of diabetes
- At pre-test 71% of elders had little information about diabetes, at post-test only 26% had little information about diabetes

WESTSIDE COMMUNITY HEALTH SERVICE

- Conducted programs about diabetes for Latino and Hmong participants
- Monitored blood glucose levels, which dropped for participants from 9.2 to 8.2 over a span of 15 months
- Increased the number of participants testing their glucose levels:
  - 61% to 68% for Latinos
  - 64% to 100% for Hmong

THE PARK AVENUE FAMILY PRACTICE

- By August 2004, 60 of the 274 diabetic patients at the clinic had an ophthalmology screening

CARONDELET LIFECARE MINISTRIES

- Screened 846 people for diabetes over a 27-month period

HIV/AIDS and Sexually Transmitted Infections

AGAPE HOUSE

- Enrolled and taught 1547 teens about making healthier life choices
- Of the 1315 teens who completed their healthy life choices program, 95% are honoring their commitment to remain abstinent

CENTRO CAMPESINO

- Tested 24 migrant workers for HIV with plans to test many more in the April to November agricultural season

Healthy Youth Development

SUMMIT UNIVERSITY TEEN CENTER

- Youth knowledge of life skills and community resources increased from 46% at pre-test to 78% at post-test

PARK AVENUE FAMILY PRACTICE

- Youth participating in the program were more likely (22.5%) to believe that abstinence is the best way for them to achieve future goals following completion of the program

AGAPE HOUSE

- 95% of the 1315 youth who took a pledge to remain abstinent did so

FREEPORT WEST-PROJECT SOLO

- 50% of the 66 teens who were in the program were engaging in less high-risk behavior such as using alcohol and drugs and having unprotected sex

LAO FAMILY COMMUNITY OF MINNESOTA

- 34 young parents were provided case management services previously unavailable to them
- 50% of these parents achieved their self-set goals for parenting improvement

Immunizations

CENTER FOR ASIAN AND PACIFIC ISLANDERS

- Held hour-long information sessions in Hmong and Somali communities on the importance of immunizations
- 79% of participants were knowledgeable at post-test, an increase from 25% at pre-test

THE STOREFRONT GROUP

- Worked with Somali families to make sure their children had up-to-date school immunization records
- 95% of Somali students in the 3 schools in which Storefront worked had up-to-date records

CENTRO CAMPESINO

- Established 8 immunization clinics for migrant workers in 3 southern Minnesota counties
- 464 adults were immunized for both Hepatitis B and tetanus

Infant Mortality

FOND DU LAC CENTER FOR AMERICAN INDIAN RESOURCES

- Obstetric clients receiving prenatal information increased from 78% to 100% over and 18-month period

CASS COUNTY/LEECH LAKE TRIBE

- 63% of women attended a prenatal appointment in the first trimester

AMERICAN INDIAN FAMILY CENTER

- After high-risk women participated in child birthing classes that taught the benefits of breastfeeding, 66% percent chose to breastfeed

RED LAKE COMPREHENSIVE HEALTH SERVICES

- 95% of clients' prenatal records had a completed assessment form for referral to child birthing classes
- 54% of women using the clinic for other health services chose to attend a child birthing class

AMERICAN INDIAN FAMILY CENTER

- Through the use of doulas for high-risk pregnancies:
  - 95% of births were at a birth weight above 5 lbs 8 oz
  - 85% of births were vaginal births

APPENDIX J

Interim Summaries: Progress and Outcomes by Priority Health Area

Hmong youth participating in the program were more likely (22.5%) to believe that abstinence is the best way for them to achieve future goals following completion of the program.

-Park Avenue Clinic

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Eliminating Health Disparities Initiative

An Interim Summary of
Grantee Progress and Outcomes
Addressing ***Breast and Cervical Cancer***

Prepared for the
Minnesota Department of Health

Prepared by
Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

These are quotes that have been translated from Spanish to English for the purposes of this report:

"I am not going to share my name, but I live in the area of Montgomery. In August 2003, I was at mass when a person announced that they were doing a small campaign against breast and cervical cancer. They explained how the program worked and they invited me to do my studies. Because of my economic conditions, the tests were free. My chest came out fine. But how difficult it was when they gave me the news that my Pap exam was abnormal. I cried, I could not contain myself. There with me was a Promotora de Salud that came up to me and provided me with supportive words, told me about the next steps and although the nurse had already explained things, the hug and the support that the Promotora provided made me feel like I wasn't alone. Now, I am in the process of follow up. Every now and then, the Promotora calls me to ask me about my health. Here I am struggling because I don't have health insurance and am asking God that they allow me to pay my treatment with a payment plan. My depression is passing. I am conscious that I am the only economic support for my son, but I don't have words to thank God to have placed in my path, practically at my doorstep, people that work in health prevention."

Another community member said, "My name is Lupita Davila. More than one year ago, Ofelia (Promotora de Salud) was constantly pushing me and many other women – please go and do the physical exam [for breast and cervical cancer] – Ay! poor Ofelia, there was not a day that passed that she didn't bother us saying, go to the clinic and conduct your exam. Finally, one day, I paid attention to her and I went to several exams that didn't seem normal. Several years earlier, I had done the mammogram test and it was only one exam and then they let me go. Everything came out fine. But now, when the Doctor told me that I had breast cancer and that they were going to remove the breast, I was left without words and I became depressed. Thanks to God I had and still have to this day the support of my family. I continue to be depressed and undergoing treatment but above all I am happy and content that I paid attention to Ofelia. I am content that they have removed my breast – no, I'm not crazy. I am only thankful to God that God gave me a warning and gave me the opportunity to continue living. Well, they took away my breast on time so that the cancer did not invade my body. Now, I am another Ofelia. I go throughout my life saying that we should love ourselves and love our family. I tell my story and invite everyone to do their cancer exams."

- Centro Campesino

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing Breast and Cervical Cancer

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address breast and cervical cancer. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were asked to share a 'success story' from their program.

Based on these reports, we know that over 72,000 people across Minnesota were reached by the eight grantees working to reduce or eliminate disparities in breast and cervical cancer. They documented increases in knowledge and awareness about breast and cervical cancer among program participants, changes in behaviors, including more women conducting breast self-examinations, increased used of health care, particularly screenings for breast and cervical cancer, and some changes in the systems of care for breast and cervical cancer. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way, including staff turnover, funding issues, and difficulty recruiting qualified staff and volunteers to work in these demanding evening and weekend programs. Some programs noted it was essential to provide transportation or childcare to enable the women to participate in program activities. Another grantee noted a critical issue that remains in the health care system that poses serious challenges to their clientele, who are mostly undocumented, uninsured Latinas living in rural communities; they may detect cancer, but they cannot afford to treat it.

For the most part, grantees used creative and innovative approaches to their missions involving breast and cervical cancer. One such approach involved empowering community members in leadership roles in the program. Another involved offering programming through trusted institutions in the community like the church.

Grantees reported they are using their evaluation results to improve their programs to better serve the needs of their communities, to market their programs to increase referrals into the program, and to make key decisions regarding future programming.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

Disparities persist between different population groups in incidences of breast and cervical cancer, as well as the death rates due to breast and cervical cancer. For instance:

- For African American and Asian women, cervical cancer incidence rates were more than two times the White rate in 1996-2000.
- Though the breast cancer incidence rate for African American women was lower than White women, the mortality rate was almost 30 percent higher than White women in 1996-2000.[1]

[1] Minnesota Cancer Surveillance System

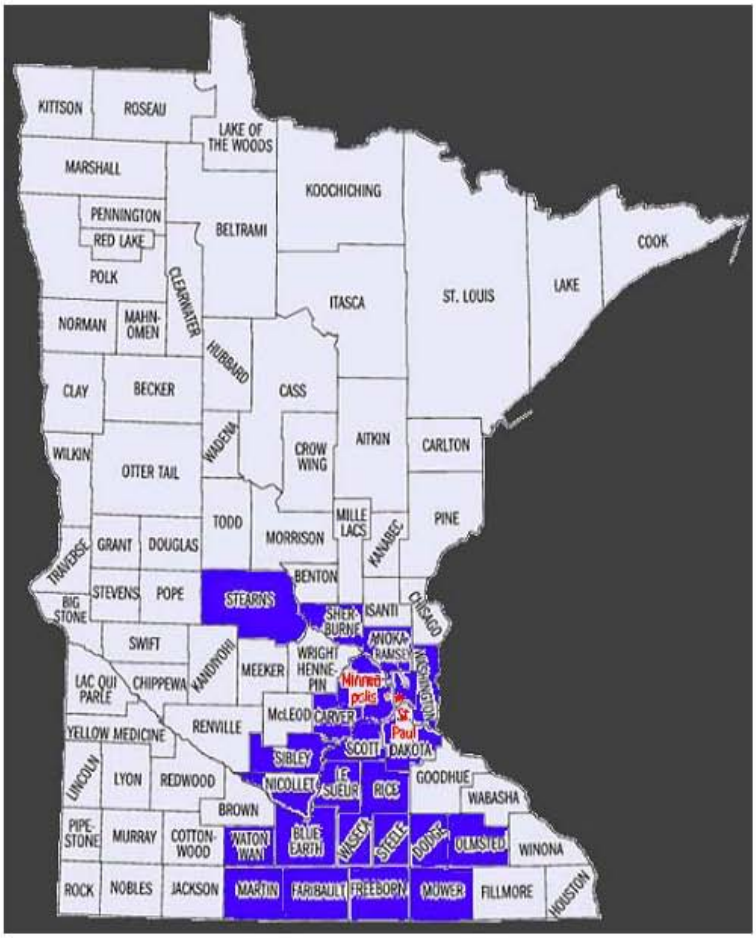
NUMBERS AND POPULATION GROUPS REACHED

Nine EHDI Grantees are working to reduce breast and cervical cancer disparities across the state:

- 2 are working with African Americans
- 3 with African-born people
- 2 with American Indians
- 3 with Latinos
- 1 with Asian/Southeast Asians
- 1 with Multi-racial and other individuals

72,950 Minnesotans were reached through the efforts of the 8 grantees working on breast and cervical cancer.

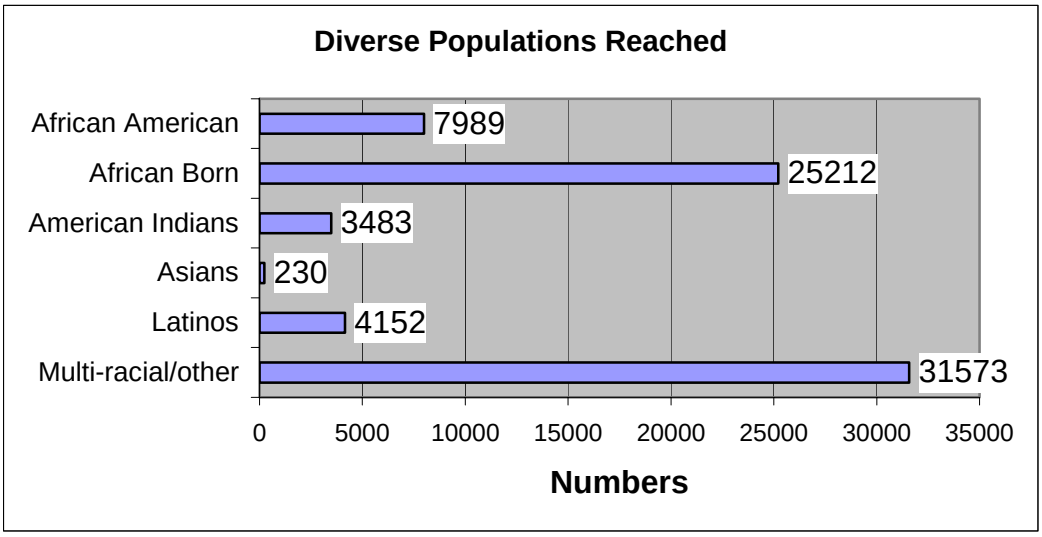
The counties in which the grantee organizations and tribes were working to address breast and cervical cancer are shown in the figure below.



Grantees working in the breast and cervical cancer health disparity area reached:

- 60,280 adults,
- 4,352 children, and
- 10,193 people of unknown ages (primarily attendees at large events).

The racial/cultural groups reached is shown in the figure below.



> *"[There is a] cultural divide between Minnesota health institutions and the cultures, languages, schedules, health practices of Minnesota's migrant agricultural worker and rural Latino/a communities. The lack of relationships between communities requires significant work to build trust, respect and a positive working relationship."*
>
> -Centro Campesino

GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address breast and cervical cancer in their communities. They worked to

1. Increase awareness of breast and cervical cancer and increase knowledge about detection, treatment of breast and cervical cancer, and to change attitudes about regular screenings for breast and cervical cancer;
2. Change behaviors related to breast and cervical cancer, such as how to conduct breast self-exams to promote early detection of cancer;
3. Increase access to and utilization of health care, such as screenings for breast and cervical cancer and improving compliance with treatment regimens;
4. Create systems-level changes that prevent breast and cervical cancer, or improve care.

> *[From our evaluation] we found out that the educational piece has a big impact on clients' knowledge about breast and cervical cancer and on their decisions to go in for a screening. Therefore, we would like to provide more educational workshops to our clients.*
>
> -Vietnamese Social Services

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about breast and cervical cancer and changing peoples' attitudes were important outcomes that many of the grantees targeted. In particular, most grantees were working to help women understand the importance of early screening when it comes to breast and cervical cancer.

Examples of approaches used by grantees to increase awareness and knowledge:

- Distributing written information and fact sheets
- Soliciting information through pre/post tests to measure and track levels of knowledge, and educating participants in areas of knowledge deficiencies
- Creating personalized health plans for cancer patients to monitor progress
- Establishing a culturally-competent website
- Educating participants through group events such as church festivals, community forums, and powwows

Changing Behaviors

Grantees worked to change behaviors among program participants, primarily to promote early detection through annual screening and breast self-exams. Grantees were working to ensure that women would have the skills to perform breast self-exams and detect breast cancer at an early stage.

Examples of approaches used by grantees to change behaviors related to breast and cervical cancer include:

- Distribution of materials teaching women how to conduct breast self-exams.
- Educational workshops

> *[We] conducted 76 cultural interviews, 69 women screened for breast and cervical cancer, [and we] made 45 referrals to other organizations.*
>
> - Women's Cancer Resource Center

Increasing Access to and Utilization of Health Care

To increase access to breast and cervical cancer screening and improve breast and cervical cancer coverage, grantees used a variety of approaches including:

> - Held educational talks and workshops attended by 293 Latinas and Latinos
> - 102 of the Latinas who attended received pap smears and cervical exams
>
> *Lack of health insurance for Latinas who are migrant/farmworkers makes follow-up extremely difficult; for example, when breast and cervical cancer is detected, the necessary medical procedures are extremely costly and require extensive follow-up and payments. Providing preventative education is extremely difficult when the resources to support community members in health care and follow-up are virtually non-existent.*
>
> – Centro Campesino

- Health care education through community workshops and classes
- One-on-one outreach in local communities
- Facilitating access to health care by arranging for transportation and/or child care services
- Initiating partnerships with other grantees to provide service availability information to patients

Significant barriers remain to increasing access to and utilization of health care for some populations as some of the grantee statements suggest.

Promoting Systems Change

To create systems changes related to breast and cervical cancer grantees used these approaches:

- Networking with related organizations to promote cultural competency and understanding
- Providing women with information about traditional healing practices, and how to access these resources
- Providing health information through worksite newsletters
- Compiling stories regarding patient experiences and reporting relevant trends

- American Indian families were provided with educational home visits
- After which more than 90% were aware of the risk factors for breast and cervical cancer, based on a post-visit survey

Based on what we learned from our evaluation, we will continue to asssess American Indian needs in terms of culturally appropriate health care. We will focus more on traditional healing to meet the needs of American Indian families, cancer survivors and communities.

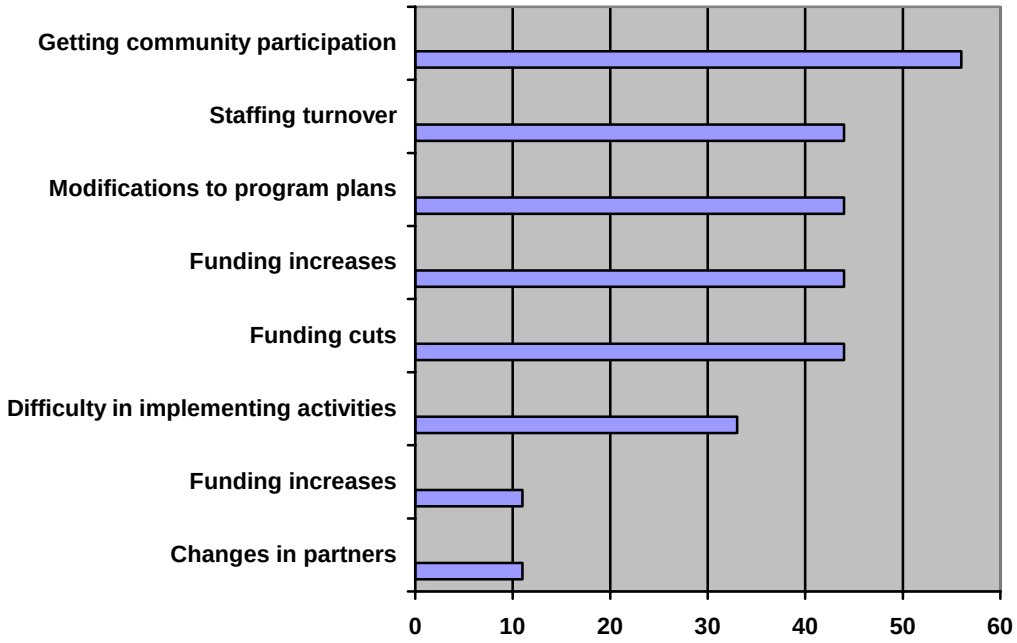
- American Indian Community Wellness Project/ Indian Health Board

CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Grantee stressed the problems around staffing—staff turnover and recruiting was quite difficult for many grantees, particularly because the positions usually require work on weekends and evenings. Other commonly cited challenges included transportation and the need to provide childcare. Lastly, several program staff noted that the most fundamental challenge lies in the cultural chasm between health institutions and the day-to-day realities of the targeted community.

> *Generally speaking, our target population comes from countries with very few preventive services available to the poor. Prevention and proactive behavior are foreign concepts to them. Also, health and health prevention is not perceived as important when individuals and families have more immediate priorities such as employment, housing, family needs and food.*
>
> - Carondolet

Percent of Grantees Citing These Challenges to Effective Programming



CREATIVE AND INNOVATIVE ASPECTS OF PROGRAMS

Grantees working on breast and cervical cancer listed a number of creative or innovative aspects of their programs. One grantee pointed out that their program was the only one of its kind addressing breast and cervical cancer among American Indian women in the Twin Cities.

Another grantee felt that by delivering the services out in the community through one of the most trusted institutions—the church—was the most innovative and effective aspects of their programs, allowing them to reach so many community members.

> *"We have come to where our participants live, worship and come for services. We have placed our program in indentified Latino parishes, and we work with the full support of the priest and parish staff. Latinos see us as an extension of the church and they have trust and confidence in our intentions. We collaborate with multiple agencies that meet the social and economic needs of the target population, we provide information, services, moral support, referral and outreach by considering all aspects of health and wellness."*
>
> - Carondolet

Two programs specifically noted that involvement and leadership of community members in their program was one of the most innovative aspects of their program.

> *The Promotores de Salud project is most proud of its community leadership from the migrant farmworker communities and new immigrant rural Latino/Latinas. They are actively engaged in taking charge of the health of their communities.*
>
> -Centro Campesino

The data from the Somali Health Survey-- one of the first attempts to gather health information specific to that population in the United States (and perhaps the world)-- will provide information on knowledge, practices and coverage of the Somali community to health providers, community organizations, and researchers in order to create better informed programming and add to the body of knowledge on Somalis

The and health. The participatory approach was also unique in that it utilized the assets and input of the Somali community throughout the survey process. The program staff intends to document the participatory approach in the hopes that it can be replicated and used as an example of successful community partnerships in reasearch.

- Minnesota International Health Volunteers

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs, or to upgrade or expand existing programs. Several grantees were going to use their evaluation findings to market the program to other organizations and increase referrals into the program. One program was using its evaluation results to plan a subsequent conference for health providers.

We will use the information to improve the marketing/outreach strategies, getting more women to use the program and more organizations to recognize the values and benefits for women, thereby generating more referrals to the program.

-Women's Cancer Resource Center

We will be holding the next health provider conference series in the spring of 2005. The response to the series has always been very positive, and the participants have found the topics to be very relevant and useful to their daily work.. We are planning to invite speakers back who were given a very positive response, and have them discuss the same topics and provide updated information, and we will explore the idea of providing new seminars on topics that have not been previously covered (i.e. - Islam and Health).

- Minnesota International Health Volunteers

Eliminating Health Disparities Initiative

An Interim Summary of
Grantee Progress and Outcomes
Addressing ***Cardiovascular Disease***

Prepared for the
Minnesota Department of Health

Prepared by
Rainbow Research, Inc.
621 West Lake Street, Suite 300
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Stories of Success

A systems change came about early this summer that was directly related to the Cardiovascular Program and the Fitness Center. The acting Executive Director at the time approached the Cardiovascular Program regarding an estimated amount of time per week an individual should spend on physical activity. It was suggested by the Program at the very minimum, one hour per week. The acting Executive Director then explained why she was asking. She wanted to request an amount of paid time per week for employees to engage in physical activity. The acting Executive Director purposed 2 hours per week to the Reservaiton Tribal Council. The Reservation Tribal Council approved the 2 hours per week for physical activity each employee. So as a direct result of the Tribe obtaining a Fitness Center all RTC employees are granted 2 hours of paid time per week to exercise.

- Bois Forte Reservation

We do not have one story but many insights and comments from a variety of individuals who the SHCI has impacted over the years. The following are some comments on the SHCI from program participants:

- *"I never attended exercie class before, so this class was very important to me and to others who attended because we want to get healthier and live longer."*
- *"I have gained a lot of helpful tools about doing exercise. I also got healthier and my community needs this kind of class. Please continue doing it. Thanks."*
- *"By attending this exercise class, I have become an acticve person."*

- Minnesota International Health Volunteers

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing Cardiovascular Disease

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address cardiovascular disease. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were also asked to share a 'success story' from their program.

Based on these reports, we know that approximately 97,000 people across Minnesota were reached by the sixteen grantees working to reduce or eliminate disparities in cardiovascular disease. They documented increases in knowledge and awareness among program participants, changes in behaviors, increased used of health care, particularly health screening, and how systems can change by bringing together diverse partners to work together to deal with cardiovascular disease. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way—in fact some of the most creative and innovative aspects of the cardiovascular work being done by EHDI grantees were responses to the biggest challenges they faced. Interestingly, partnerships and relationship building turned out to be key supports and key challenges in addressing cardiovascular risk in many communities. EHDI grantees are bringing together non-profits, health care agencies, and other partners, such as faith-based institutions, employers, and schools in this effort. Other more typical challenges were also present, of course, such as staff turnover, and funding cuts.

> *Because of the success of holding events with an informational session and a practical exercise or opportunity for screening, we will continue to enlist the help of other EHDI grantees who have the clinical expertise and materials to provide opportunities for forum participants to have access to health screenings (i.e. - Heart health screening) and practice in adopting healthy behaviors (i.e. - healthy food cooking seminar).*
>
> - MN International Helath Volunteers

Grantees are using their evaluation results to improve or expand their programs to better serve the needs of their communities. Some grantees were moving into the second stage of their evaluations by exploring issues that emerged in their evaluations in more in-depth qualitative ways.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

In 1997-2001, heart disease was the leading cause of death for American Indians and the second leading cause of death for Asians, African Americans and Hispanics.[1]

[1] MN Vital Statistics.

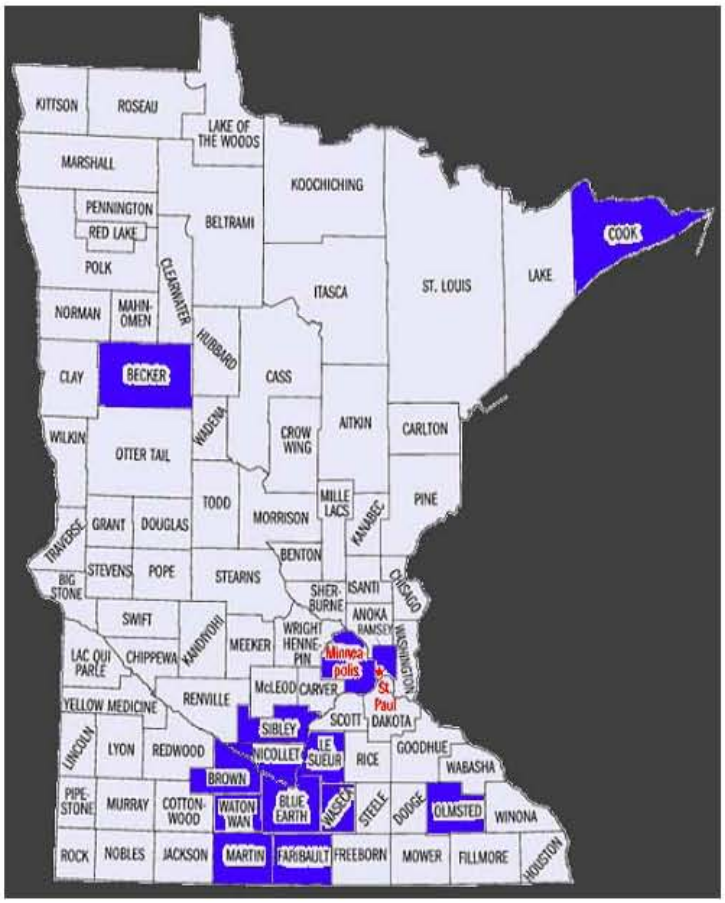
NUMBERS AND POPULATION GROUPS REACHED

16 EHDI Grantees are working to eliminate Cardiovascular Disease disparities across the state:

- 5 are working with African Americans
- 4 with African-born people
- 7 with American Indians
- 5 with Latinos
- 5 with Asian/Southeast Asians
- 6 with Multi-racial groups and other individuals

96,944 Minnesotans were reached through the efforts of 16 grantees working on cardiovascular disease.

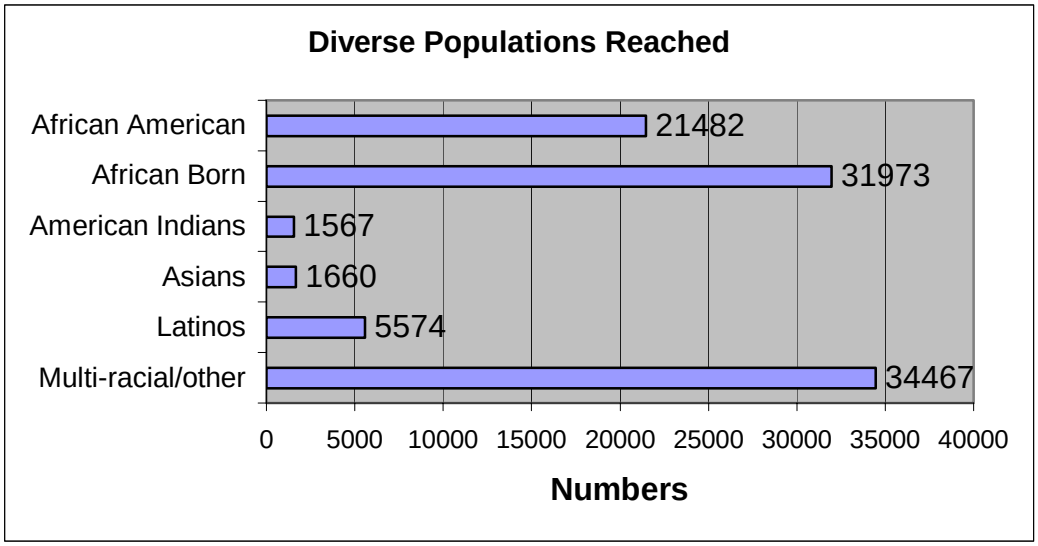
The counties in which they are working are highlighted in the figure below.



Grantees working in the cardiovascular disease disparity area reached:

- 10,944 children
- 78,693 adults
- 7,500 persons of unknown age (primarily reached through events or media)

The racial/cultural groups reached through grantee efforts directed at reducing cardiovascular disease are shown in the figure below.



GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address cardiovascular disease in their communities:

1. To increase awareness and knowledge of cardiovascular disease—its risk factors, and prevention methods, and to change attitudes and norms related to exercise and healthy diets.
2. To change behaviors that lead to cardiovascular disease, in particular to increase exercise levels, and change unhealthy eating patterns;
3. To increase access to and utilization of health care, such as the availability of cholesterol and blood pressure screenings; and
4. To create systems-level changes that address cardiovascular disease, such as forming partnerships between organizations of different sectors to reach underserved populations.

Increasing Awareness, Knowledge and Changing Attitudes

Healthy opportunities provide an arena for staff and youth interaction. During these interactions, youth and staff begin to formulate trust and respect. These relationships are extremely important when trying to approach or introduce issues of health awareness.

- Healthy Nations Program, Minneapolis American Indian Center

Increasing awareness and knowledge about cardiovascular disease and stroke as well as changing peoples' attitudes about the importance and feasibility of diet and exercise were important outcomes targeted by many grantees.

Examples of approaches used by grantees to increase awareness and knowledge:

- Providing health care information on radio programs

Going to where the people are does guarantee that someone will hear or receive information that may help improve the health of themselves or someone else they know. By training peer educators to teach others about the dangers of cardiovascular disease, 17,362 people were reached with information.

– Fremont Community Health Services

- Gathering information on participant attitudes through a statewide health survey and reporting it back to the community
- Establishing a health screening center to increase participants' knowledge of their health status and progress

Changing Behaviors

Grantees worked to change behaviors among program participants to prevent cardiovascular disease, and for those who had already had health problems in this area, to reduce recurrences.

Examples of approaches used by grantees to change behaviors related to cardiovascular disease include:

- Encouraging behavior change through Healthy Eating classes
- Hosting Walk/Run events and organizing walking clubs

7 out of 10 Somali elders in a physical fitness pilot program were completing at least 20 minutes of moderate physical activity, at least 5 times a week.

- Minnesota International Health Volunteers

"Youth in the 6-week Summer Youth Work Program lost an average of 3.4 pounds and 1.33 BMI points. I have been working with these kids for two summers now. To see the results that we have seen with the kids who participate in the walking workouts is just amazing. Walking is what each and everyone of us is capable of doing. The community and kids who participated know that it doesn't take much effort to become more physically active."

- Bois Forte Community

Increase Access to and Utilization of Health Care

We screened 30 of 39 Somali Cardiovascular Forum participants for heart health.

- Minnesota International Health Volunteers

To increase access to cardiovascular screening, treatment and care, grantees used a variety of approaches, including:

We screened 1,362 Latinos for cardiovascular disease over a 27-month period.

- Region Nine Development Commission

- Helping participants gain access to services by providing information on affordable health care clinics within area,
- Providing free blood pressure screenings at community events, and
- Assisting with the interpretation and processing of insurance applications.

Systems Change

To create systems changes related to cardiovascular disease, the grantees reported using these approaches:

- Educating health care providers on proper use of medications
- Hosting annual conference series to publicize cardiovascular issues
- Increasing the number of languages accommodated in educational materials about cardiovascular disease
- Developing partnerships across agencies, sectors and communities to promote cardiovascular health

For community health projects, it is important to select the right partners to work with. We were able to bring together three organizations that worked in synergy to address health disparities in the Somali community. …..In practice, partnerships also come with constraints: it is more challenging to get things done when staff are spread over different organizations because coordinating schedules is challenging, as are supervision and communication.

- Minnesota International Health Volunteers

Our greatest challenges have involved finding key indiviudals in healthcare and employment settings that will champion project activities and services. Where we have found these champions, we have had great successes!

- Region Nine Development Commission

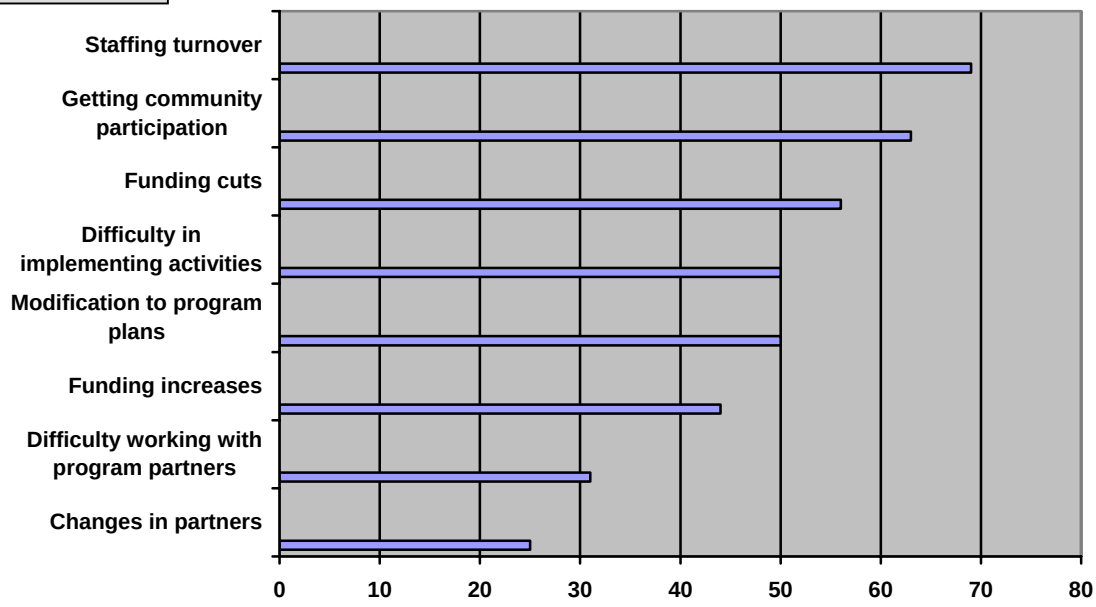
CHALLENGES

We have had cuts in infrastructure funding that funds basic clinic services along with increased funding for outreach - this unfortunately means we are generating more demand with less capacity to provide care.

– TAMS

Grantees noted that they experienced a number of implementation challenges. Quite common were problems around staffing—staff turnover and recruiting volunteers were quite difficult for many grantees. Funding cuts were experienced by a number of grantees, and this caused some challenges to their programming. These cross-cutting challenges are shown in the figure below. Partnerships emerged as key processes and outcomes for addressing cardiovascular risks—but were also seen as major challenges to cultivate and maintain.

Percent of Grantees Citing These Challenges to Effective Programming



We have experienced difficulty in coordinating the schedules of program partners with program activities. For example, during the most recent volleyball league we invited program partners to provide health related information to participants but a majority were unable to attend, and instead, sent information (i.e. brochures). In addition to this, partners who had conducted health screenings in the past are no longer able to do this for free or at low cost. The challenging aspect is developing new partnerships with other agencies in spite of staff turnover.

- Healthy Nations Program, Minneapolis American Indian Center

CREATIVE OR INNOVATIVE ASPECTS OF PROGRAMMING

Grantees working on cardiovascular disease listed a number of creative aspects of their programming. One of the most common elements cited was the partnerships that were built across the sectors and communities to provide the comprehensive education, screening services, and prevention activities needed to impact cardiovascular health, and the commitment of the staff and partners to work through the issues.

> *I am most proud of how staff pulled together to focus on patient needs…while not particularly innovative, the ability to care deeply about patient needs and work together on specific goals is a key aspect to success.*
>
> - Grand Portage

> *The innovative aspect is restoring and reinforcing that church is and can be relevant to the communities they serve by addressing the whole person. Lives are being saved and are impacted by hosting regular Blood Pressure monitoring in a familiar and nonthreathening environment.*
>
> – Stairstep Foundation

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs. Some said they would use the information to upgrade existent programs while others said they would develop new services or approaches based on the findings, as the following quotes show.

> *Some of the outcome findings have been used to modify or improve repeated activities such as the Walking program for the Summer Youth. Most of the other outcome findings have been or will be used to educate the community.*
>
> - Bois Forte Band of Chippewa

> *We are always looking to reach more Latinos in our area. The outcomes will guide and challenge us to increase the number of Latinos we reach in our area.*
>
> - Region Nine Development Commision

> *Currently, our partners are using some of the findings from the survey to develop a series of nine focus groups designed to delve deeper into some of the issues raised by the survey findings. According to the survey data, 10 percent of women and 20 percent of men report not participating in any form of exercise during the week. Somali aduts in the survey are also falling short of the recommended daily servings of fruits and vegetables with less than 10 percent of men and women reporting three or more servings of fruits and vegetable per day. As a result, six of the focus groups will be on the topic of diet and physicial activity; discussing some of the changes in daily exercise and dietary habits that may have occurred since moving to the United States, finding out what are some of the messages about diet and exercise, and trying to find new ways to promote good eating and physical activity behaviors in the Somali community.*
>
> - Minnesota International Health Volunteers

Eliminating Health Disparities Initiative

An Interim Summary of Grantee Progress and Outcomes Addressing ***Diabetes***

Prepared for the

Minnesota Department of Health

Prepared by

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Rainbow Research Inc

Stories of Success

"JF" was a pastor at one of the Latino congregations in our community and after several months of meetings, hesitantly agreed to have one of our "Get Active" walking programs start with his Wednesday Bible study group. This 5 week program promotes physical activity and healthy nutrition by encouraging members to start walking more, learning about the long-term benefits of activity and how to eat more healthy. We give the participants a pedometer at the first meeting and do a short survey of what they are currently doing and what they would like to learn about. They keep track of their "steps" and report back each week. We offer short presentations based on their interests, and give different small incentives for keeping track of their activity and coming to the sessions. At the end there is a celebration recognizing the participants and a healthy meal is served, demonstrating optimal portion sizes. Most of the group stayed with the program, including JF, although he did not think it could make much of a difference.

Miguel, our Outreach worker didn't see JF again for almost 4 months until one day he ran into him in the grocery store. He didn't recognize him because he had lost almost 40 pounds! JF told Miguel that after the walking group stopped their meetings, he started to realize his clothes didn't fit, in particular one of his favorite suits. He remembered the healthy foods presentations and pulled out his pedometer and decided he would try some of the things that Miguel had suggested and found out they actually worked. The pastor's wife was very supportive and members of the congregation noticed his weight loss and have joined him in his efforts. He has continued to encourage other members to make positive changes in their lives like he did. Before Miguel left him in the grocery store, JF proudly showed him all the fruits and vegetables in his grocery cart.

-- Olmsted County

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing Diabetes

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address diabetes. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were also asked to share a 'success story' from their program.

Based on these reports, we know that over 100,000 people across Minnesota were reached by grantees working to reduce or eliminate disparities in diabetes. They documented increases in knowledge and awareness among program participants, changes in behaviors, increased used of health care, particularly screenings for diabetes, and some changes in the systems of care for diabetes. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way—staff turnover was the most common, along with difficulty recruiting qualified staff and volunteers to work in the programs. Figuring out how to reach these traditionally underserved populations was challenging for some programs. Transportation issues were also noted by some grantees as problematic.

Grantees used their intimate knowledge of their communities to solve these challenges. They used creative and innovative approaches, such as using peers to reach out and educate other members of the community. They formed partnerships with institutions and organizations that were well trusted within the communities such as churches and other spiritual or faith-based organizations. They created videos and used other forms of media to get the word out to their communities about diabetes.

Grantees are using their evaluation results to improve their programs to better serve the needs of their communities and comprehensively address the threats posed by diabetes to the health of Minnesotans disparately affected by this disease.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

Disparities persist between different population groups in incidence of diabetes, and death rates due to diabetes. For example, according to Minnesota Vital Statistics in 1997-2001:

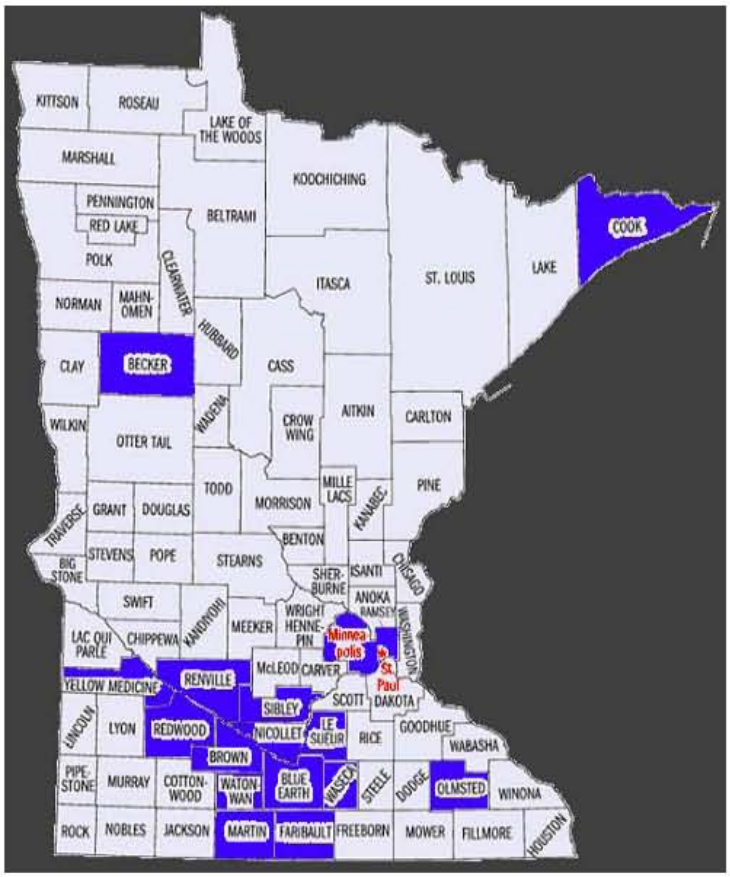
- The Hispanic diabetes mortality rate was ***twice*** as high as the White and Asian rate.
- The African American death rate due to diabetes was almost ***four*** times higher than the White and Asian rates.
- The American Indian diabetes death rate was almost ***five*** times higher than the White and Asian rates.

NUMBERS AND POPULATION GROUPS REACHED

Twenty EHDI grantees were working to eliminate diabetes disparities across the state. The counties in which the grantee organizations and tribes were working to address diabetes are shown in the figure below.

- 5 are working with African Americans
- 5 with African-born people
- 8 with American Indians
- 8 with Latinos
- 5 with Asian/Southeast Asians
- 6 with Multi-racial and other individuals.

100,442 Minnesotans were reached through the efforts of the 20 grantees working on diabetes.

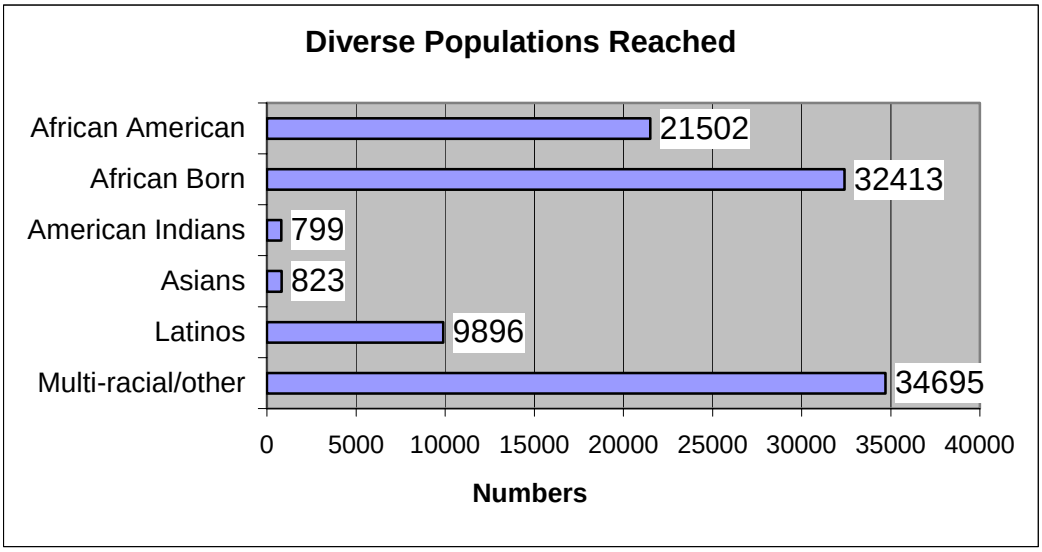


Many of the EHDI grantees working in the diabetes health disparity area are targeting several different racial and cultural groups.

Grantees working in the diabetes health disparity area reached:

- 18, 610 children
- 79, 970 adults, and
- 1961 people of unknown ages (primarily attendees at large events).

The racial/cultural groups reached are shown in Figure 2 below.



GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address diabetes in their communities: They worked to:

1. Increase awareness of diabetes and increase knowledge about prevention and control of diabetes, and to change attitudes about diabetes;
2. Change behaviors related to diabetes, such as lifestyle changes to prevent diabetes, and better self-care for diabetics;
3. Increase access to and utilization of health care, such as screenings for diabetes and improving compliance; and
4. Create systems-level changes that prevent diabetes, or improve care.

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about diabetes and changing peoples' attitudes about diabetes in the racial and ethnic populations were important outcomes that many of the grantees targeted.

Examples of approaches used by grantees to increase awareness and knowledge:

- Public education through radio shows, newsletters and TV campaigns
- Group activities including community health forums, support groups

Education sessions were held to teach Cambodian and Hmong elders about the dangers of diabetes. Based on a pre-test, 71% of the elders had little information about diabetes before the program, which dropped to 26% at the time of the post-test.

- Southeast Asian Ministry

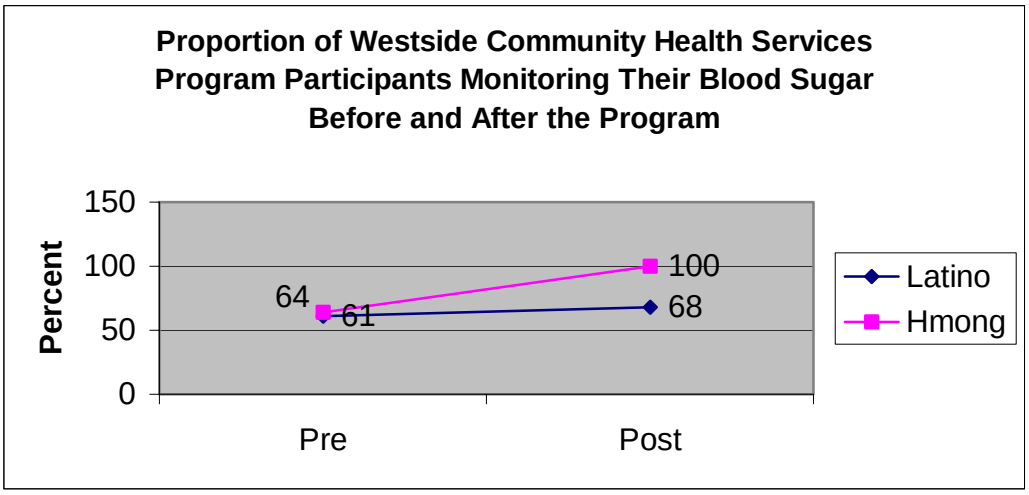
Changing Behaviors

Grantees worked to change behaviors among program participants to prevent the onset of diabetes, or for diabetics, to help them better manage their disease.

Examples of approaches used by grantees to change behaviors related to diabetes include:

- Fitness classes, and
- Providing exercise tools like pedometers and giving incentives or rewards for success.

The Westside Community Health Service conducted programs about diabetes for Latino and Hmong participants. Two key indicators were monitored to determine whether the program was effective in helping participants to better control and manage their diabetes:



- Across a 15-month period, the proportion of program participants who were testing their glucose levels improved as the chart above shows.
- Participants' blood glucose levels were also monitored over this period, and showed a drop on average form 9.2 to 8.2.

Increase Access to and Utilization of Health Care

To increase access to diabetes screening and improve diabetes coverage, grantees used a variety of approaches, including:

- Making information available through health resource libraries and community workshops
- Offering free-of-charge services, such as screenings and clinic referrals

> *We were able to screen 846 Latinos for diabetes over a 27-month period.*
>
> - Carondelet LifeCare Ministries

- Educational outreach through health fairs and school presentations
- Soliciting partnerships with related health organizations, and networking with community leaders

Systems Change

To create systems changes related to diabetes, grantees used the following approaches:

- Developing health registries to better understand diabetes in minority populations and to track patients' progress
- Holding an annual conference series on culturally competent care
- Partnering with employers to offer onsite health education classes
- Educating health care providers to increase cultural proficiency
- Removing barriers to care

One clinic changed how they provided specialty services to Hmong clients. Instead of sending Hmong diabetics to another clinic for eye exams, they brought the ophthalmologist to the patients. This dramatically increased screenings for retinal problems among Hmong diabetics, and by August 2004, 60 of the 274 Hmong diabetic patients at the clinic had received ophthalmologic screening.

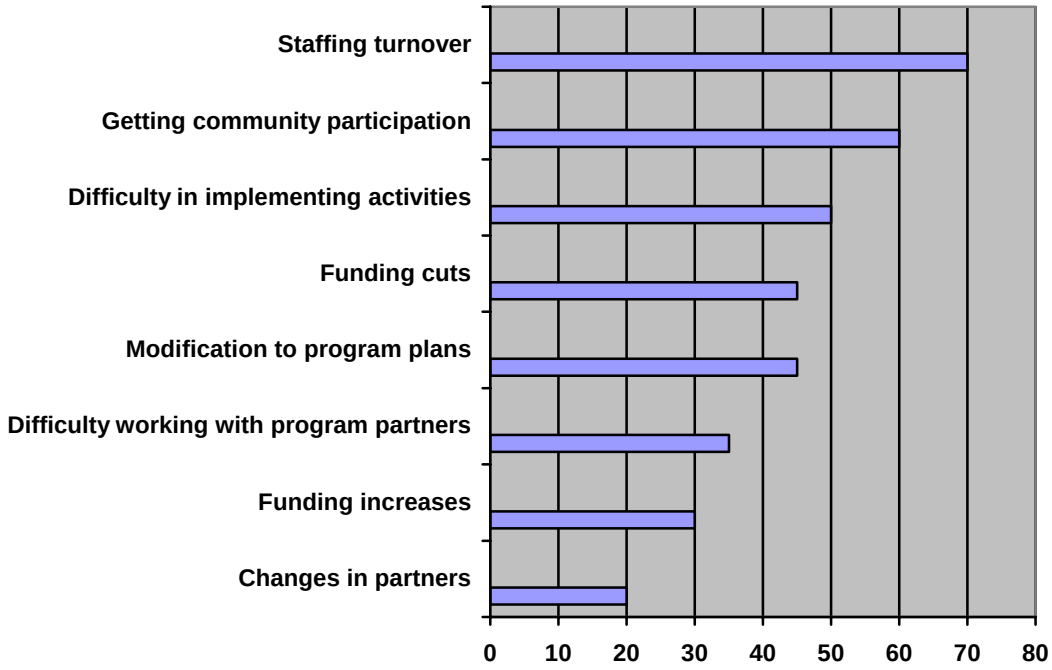
-The Park Avenue Family Practice Clinic

CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Grantee stressed the problems around staffing—staff turnover and recruiting volunteers was quite difficult for many grantees. Another commonly cited challenge listed by grantees was transportation.

> *Many people in our target population do not drive or own cars and they walk to the churches or rely on public transportation and rides from friends and relatives. Bad weather is always a problem and the bus strike was especially challenging.*
>
> - Carondolet Lifecare Ministries

Percent of Grantees Citing These Challenges to Effective Programming



CREATIVE OR INNOVATIVE ASPECTS OF PROGRAMMING

Grantees working on diabetes listed a number of creative aspects that improved their programs' effectiveness in serving communities while targeting an issue. One commonly cited creative aspect was peer education, where people within the community educated each other. In some cases this was adult to adult, and in some cases adult to youth.

Other grantees felt that offering services that are convenient for community members is the most creative aspect of their programs. The value of this goes beyond convenience, and entails partnering with existing institutions that are well trusted within the community.

> *Diabetics were utilized as educators for youth. Youth are able to hear and see what devastation occurs with diabetes. An unexpected outcome has been that the diabetics have improved their own monitoring of their disease due to this project.*
>
> - Anishinaabe Center

The development and use of media was another creative aspect noted by grantees. One grantee developed a Latino media in their community (Southeast Minnesota) while another developed an educational DVD about diabetes for Hmong clients at their health clinic. One program developed an animated video to educate American Indian youth about the dangers and consequences of diabetes.

> *We have come to where our participants live, worship and come for services. We have placed our program in indentified Latino parishes and we work with the full support of the priest and parish staff. Latinos see us as an extension of the church and they have trust and confidence in our intensions.*
>
> - Carondolet LifeCare Ministries

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs. Some said they would use the information to upgrade existent programs while some would develop new services based off of the findings. Another grantee summed up the intentions of many by noting what her organization would do with their evaluation findings.

> *Our findings/results will be used to help improve existing and producing new programs. For example, that we learned about the prevalence of depression in patients with diabetes has already allowed us to provide one more service that wasn't provided before; offering a depression screening to all patients with diabetes at least once a year.*
>
> -Westside Community Health Services

Eliminating Health Disparities Initiative

An Interim Summary of
Grantee Progress and Outcomes
Addressing ***Healthy Youth Development***

Prepared for the
Minnesota Department of Health

Prepared by
Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

"Mary Lee is a 16 year old African American female that joined the Teens Choosing Healthy Options Program in October 2003. She was 6 months pregnant. When she arrived in the program, she was living with her father and stepmother, due to personality conflicts with her mother. At that time, Mary was very angry and upset about her pregnancy. She had a very negative viewpoint about what being an African American was and about her future. Mary believed that once she had her baby, she would be forced to drop out of school to support her child. While attending the program, Mary had her son and spent 6 weeks in home school. With our assistance, she is now at AGAPE House for Pregnant and Parenting teens. We also assisted her in getting enrolled back in school at the Area Learning Center, which allows her to work quickly to receive the credits she needs to graduate. Mary is also employed at a fast food restaurant, so that she can save her money to one day have her own home. Staff members have noticed a significant change in Mary's attitude. She is now very enthusiastic about the program and often volunteers to read our daily affirmations at the beginning of each session. We believe that Mary is on her way to a self-sufficient future where she will be an asset to our community."

-Summit University Teen Center

"We met Marco through his mother. She was coming to the clinic for prenatal care for her fourth baby, when she mentioned to her provider that she was having problems with her teenager, a 13-year-old. As we got to know Marco, we discovered the different faces of his problems. Because Marco was the oldest of four siblings, he was expected to fulfill the male role in the family. Marco admitted he was using marijuana, and sometimes skipping school to hang out with friends. Marco agreed to initiate outpatient chemical dependency treatment at CLUES. He gradually realized that most of his behaviors were a reaction to his environment and fragile family situation. We discussed several times that he was facing lots of barriers, but that he could overcome them. He understood that there were ways that he could use his boredom to benefit him in a constructive way. Marco became very engaged with a youth program at his church. He graduated proudly from the outpatient chemical dependency program. His attitude with his mother changed radically, always letting her know where he was, coming back on time, and helping out. We continuously discussed some innovative techniques he could use to resist peer pressure and maintain healthy relationships. Marco's aggressive and defiant behavior in school changed, and he was enjoying his classes more. Soon we found out that he was awarded a special scholarship for gifted students in mathematics. Now, his sister Rosa has joined our program, and she has recently started psychotherapy with our behavior specialist. They are currently working on issues related to self-esteem and anger management. His mother is actively seeking job opportunities, and the are working on strengthening their relationship in psychotherapy."

-La Clinica en Lake

EHDI: An Interim Summary of Grantee Progress and Outcomes Addressing Healthy Youth Development

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address healthy youth development. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were asked to share a 'success story' from their program.

Based on these reports, we know that over 22,000 people across Minnesota were reached by the eighteen grantees working to reduce or eliminate disparities in healthy youth development. They documented increases in knowledge and awareness about youth development-related issues among program participants, reductions in youth risk behaviors, an increase in youth seen at health care clinics and for related services, and some changes in the larger systems to support healthy youth in our communities. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way, including difficulties in involving some groups of targeted program participants (e.g. parents), needs to modify program plans, staff turnover, and funding cuts. Transportation was difficult for some programs, particularly with rapidly escalating fuel costs. Another grantee noted that providing consistent health care for Latino/a youth--a number of whom are undocumented—remains difficult given the many challenges facing these youth.

For the most part, grantees used creative and innovative approaches to their missions involving healthy youth development. One such approach involved empowering youth community members in leadership roles in the program, running cable TV shows, theater performances, and informally teaching their peers. Working to change cultural norms by involving dads in the lives of their sons and particularly daughters was another innovative strategy used by one program. Another program provided one-stop-shopping to a comprehensive set of health care services especially designed for teens.

Grantees reported they are using their evaluation results to improve their programs to better meet the needs of youth and families in their communities, to help overcome barriers to services, and to advocate for larger systems changes to promote healthy youth development in our communities.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

Disparities persist between different population groups in the problems encountered by teenagers as they grow up, such as substance abuse and teen pregnancy. For instance:

- In 2001, the percent of 9th graders who reported drinking alcohol in the last 30 days ranged from 41 percent for American Indians to 21 percent for Asians
- During this same year, 28 percent of Hispanic and 36 percent of American Indian 9th graders reported smoking anytime during the past 30 days
- In 1997-2001, the Asian teen birth rate was more than ***twice*** the White rate
- During these same years, African American, American Indian and Hispanic teen birth rates was more than ***three*** times the White rate[1]

[1] 2001 Minnesota Student Survey and MN Vital Statistics

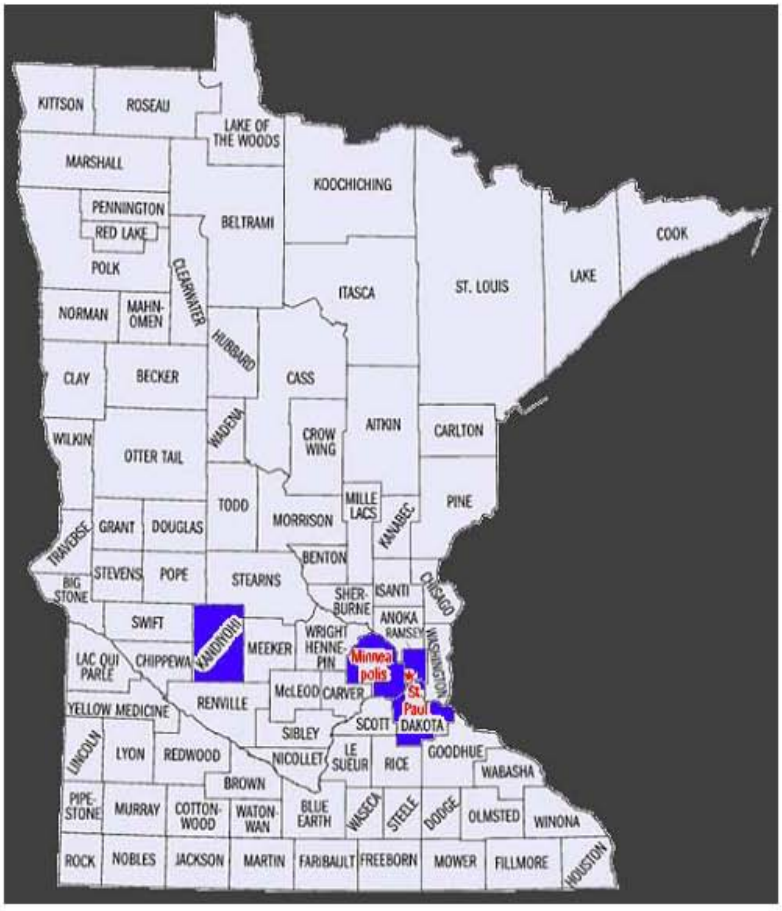
NUMBERS AND POPULATION GROUPS REACHED

Eighteen EHDI Grantees are working to promote healthy youth development across the state:

- 9 are working with African Americans
- 6 with African-born people
- 3 with American Indians
- 7 with Latinos
- 5 with Asian/Southeast Asians
- 7 with Multi-racial and other individuals

22,004 Minnesotans were reached through the efforts of the 18 grantees working on healthy youth development.

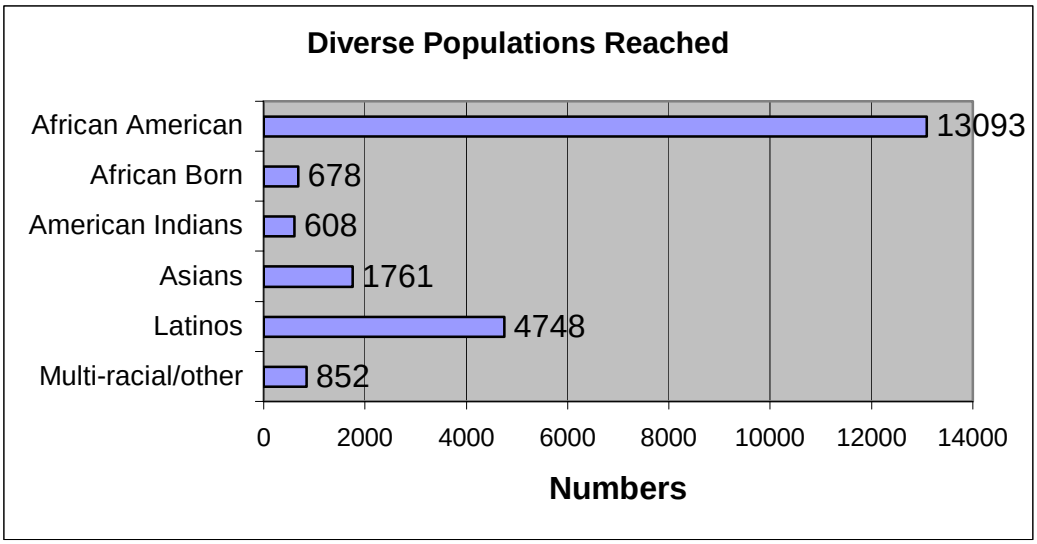
Some grantees worked with more than one racial/ethnic group. The counties in which the grantee organizations and tribes were working to address healthy youth development are shown in the figure below.



Grantees working in the healthy youth development health disparity area reached:

- 11,227 children and teenagers,
- 10,627 adults, and
- 150 people of unknown ages (primarily attendees at large events).

The racial/cultural groups reached is shown in the figure below.



GRANTEE APPROACHES AND OUTCOMES

The research on healthy youth development tell us that many of the risk behaviors that youth engage in tend to occur together—those young people who abuse substances also tend to engage at earlier ages in sexual behaviors, which can lead to pregnancy and sexually transmitted diseases. The same holds true for youth violence and anti-social behavior. These behaviors form a "cluster." A prevention program must be comprehensive and address all of these risky youth behaviors if any are to be prevented or reduced. Comprehensiveness also means addressing and strengthening all of the potential protective factors in the lives of youth—family, school, peers, neighborhoods or environment. EHDI grantees took this comprehensive approach to promoting healthy youth development. There were four types of changes or outcomes that EHDI grantees were working towards to address healthy youth development in their communities. They worked to:

1. Increase awareness of healthy youth development and increase knowledge around the problems youth might become involved in, such as alcohol and drugs, risky sexual behaviors and mental health issues, as well as changing attitudes among youth and sometimes adults about these issues;
2. Change behaviors among youth, such as reducing substance abuse, early/risky or unsafe sexual behaviors, and promoting engagement in more positive activities such as school, after-school activities, and in other organizations such as faith-based organizations, clinics, among others,
3. Increase access to and utilization of health care, such as screenings for problems among youth such as sexually transmitted diseases, mental health and other issues, and improving youths' engagement with treatment regimens for these issues;
4. Create systems-level changes that promote healthy youth development.

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about healthy youth development and changing peoples' attitudes were important outcomes that many of the grantees targeted. In particular, most grantees were working to provide youth with the information and skills to make positive decisions in their lives.

> *Entering the AATPCC program, only 77 of 116 youths (66.4%) surveyed in a pre-test knew the true facts about teen pregnancy and healthy intimate relationships. Within a month, 90% of these youth or 104 out of 116 knew 100% of the same facts in a post survey.*
>
> - St Paul Urban League

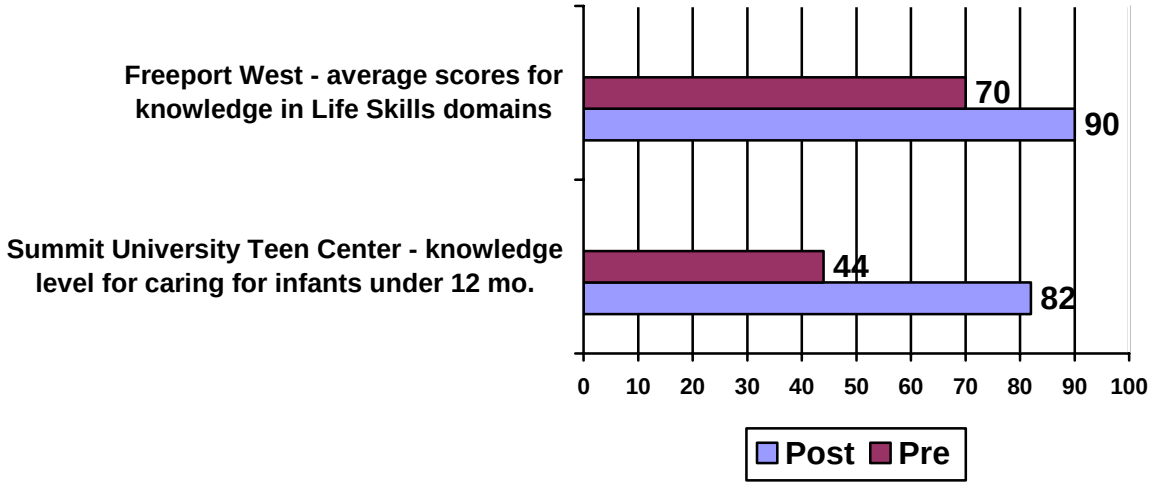
Examples of approaches used by grantees to increase awareness and knowledge:

- Engaging participants in community service projects
- Promoting positive attitudes through spiritual awareness retreats and activities
- Providing guidance on education/career planning
- Changing attitudes by introducing youth to leadership opportunities within community
- Offering clinic tours to familiarize youth with services

Hmong youth participating in the program were more likely (22.5%) to believe that abstinence is the best way for them to achieve future goals following completion of the program.

-Park Avenue Clinic

Pre- and Post-Test Survey Results for Knowledge Gained



According to pre-test scores, youth participants' knowledge level of community resources and life skills had an average score of 46%. The post-test scores showed an increase to the average score of 78%.

-Summit University Teen Center

Changing Behaviors

Grantees worked to change behaviors among program participants, primarily to reduce engagement in health-risk behaviors and promote involvement in positive behaviors and activities. In many cases this involved building skills—skills to resist peer pressure, and skills to be better parents for teen parents as well as adult parents of teens. Examples of approaches used by grantees to change behaviors related to healthy youth development include:

50% of the 66 teens living in unstable situations who were in the program reported engaging in less high-risk behaviors such as using alcohol and drugs and having unprotected sex.

- Freeport West

95% of the 1315 youth who took a pledge to remain abstinent did so.

- Agape House

- Promoting healthy parent-adolescent relationships
- Helping teens develop resistance skills
- Producing an educational DVD on teen pregnancy
- Group talks with a staff psychologist on health and behavior issues

In the case management program, 28 young women and six young men received services. Of the 28 cases, over half set educational goals (64.3%), another half set goals to enhance parenting skills (54.2%), and over a quarter increased their use of social services (29.2%).

- Lao Family Community

Increasing Access to and Utilization of Health Care

Grantees used a variety of approaches to increase access to health care and other services that help support healthy youth development, including:

45% of Latino youth at high levels of risk returned to the program for services after a comprehensive assessment of their needs. Having staff who understand the language, needs and culture of their clients creates a comfortable and welcoming environment.

- La Clinica en Lake

- Distributing information packets in various languages
- Hosting an annual block party with health educators to familiarize residents with available options
- Advocacy through health education presentations
- Providing confidential comprehensive care to teens

Promoting Systems Change

To create systems changes related to healthy youth development, grantees used the following approaches:

- Implementing community-wide cultural competency assessment to update local programs
- Participation in state committees
- Leadership training to increase advocacy skills of youth and parents
- Providing best-practices training to mainstream health systems to improve services to youth of color and American Indian youth

Aqui Para Ti (APT) is the only program in Minnesota that brings together Latino professionals from different fields to serve the needs of Latino youth and their families. In addition, APT is able to bridge the cultural values of American medical culture with the values of the Latin American medical culture. For example, confidential care for teenagers in an established practice in the US, but can be misinterpreted and thus not accepted by some Latino parents.

- La Clinica en Lake

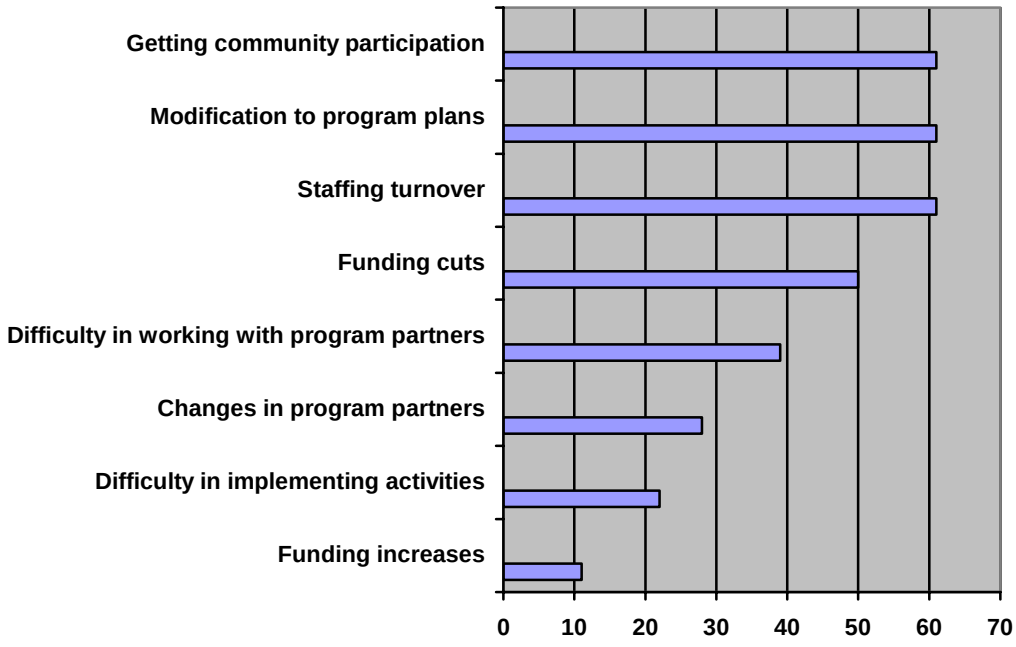
CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Getting targeted community members involved and participating in the programs was a challenge for some of these new programs—getting dads involved in the Latino community was difficult for one program as described below. Some grantees described the need to change program plans mid-stream, and the challenges this posed for carrying on their programming and conducting the evaluation. A number of grantees stressed the problems around staff turnover, the increasing costs of transportation. Other commonly cited challenges included problems working with program partners, and dealing with funding cuts.

We found that there was a need to address the parents' lack of interest. We are working on a project that will motivate parents, especially fathers, to participate more with their sons. Mothers tend to work well with their girls, but boys and fathers are mostly disconnected regarding these topics. This may be partially why teen pregnancy among Hispanics is growing in the US; now we will work hard to tackle these issues.

- Centro Inc

Percent of Grantees Citing These Challenges to Effective Programming



CREATIVE AND INNOVATIVE ASPECTS OF PROGRAMS

We are proud of many aspects of our program, but are especially pleased with Community Mapping, used in our Leadership Development sessions with teens aged 14-16. Teens discuss a problem (such as finding a resource) and map out a solution to the problem. Community Mapping can be converted into a process where youth and adults can use it to solve problems in everyday life, and several of the teens have mentioned that they use it as a tool to help with homework problems.

-The Camphor Foundation

Grantees working on healthy youth development listed a number of creative or innovative aspects of their programs. Many of the grantees worked to promote youth leadership development. They did this through a variety of innovative ways--youth were taught skills on how to solve problems in their lives, as well as how to help others solve problems. Some programs taught youth theatrical production and acting skills to spread the word to others, and some used video/DVD, or cable TV to educate their peers and community about healthy youth-related issues. One program developed a "rites of passage" ceremony to help youth and their families celebrate, understand and deal with youths' changing lives. Many programs worked with youth to form connections to positive supportive systems in the community.

Our youth are currently doing a play entitled "Inside Out" and producing a cable show called "Ask The Question." The young people in our program are innovative, creative, energetic, and willing to do something new that speaks to and about young people.

-St Paul Urban League
African American Teen Pregnancy Prevention Collaborative

Our Celebration of Change curriculum was reviewed and revised by a community curriculum review committee to ensure it was respectful of community values. The program provides sexuality education for pre-adolescents by empowering their parents to be involved in the education. The program also provides a "rite of passage" into adolescence. Finally, the program is delivered with the help of trained community volunteer facilitators.

- North Suburban Youth Health Clinic

USES OF EVALUATION INFORMATION

> *One of the ways we will use the outcome findings is to develop better systems of collecting and recording information. Through this, we will be better able to evaluate where we need to improve the content of our curriculum.*
>
> - Freeport West

Grantees used evaluation information to improve their programs to better meet the needs of their participants—such as by providing mental health services that the evaluation process found was needed by many youth. Some grantees were going to upgrade or expand their programs based on evaluation findings. Others talked about showing the effectiveness of their programs and the role this would play in leveraging funding in the future. Most grantees learned enough about evaluation to continue strengthening and expanding their evaluation process.

> *We will use the findings to seek additional funding for 2005 and going forward to enhance and expand our services, and to reach a greater number of teens. We will also work towards achieving more long-term objectives with past, present and current program participants/graduates.*
>
> - Agape House for Mothers

> *The findings helped us to understand the follow up rates of our high and medium risk patients. Based on the findings we will work on strategies to increase the follow up rates among specific groups of clients for whom additional clinic visits would be most beneficial. For example, we will conduct individual phone interviews with those patients who did not follow up to learn the reasons why they did not come back. We also learned that emotional needs were one of the main reasons why our youth sought services in our program, reconfirming the need for mental health professionals who can offer support and psychotherapy to our clients when needed.*
>
> - La Clinica en Lake

Eliminating Health Disparities Initiative

An Interim Summary of Grantee Progress and Outcomes Addressing ***HIV/AIDS and STIs***

Prepared for the

Minnesota Department of Health

Prepared by

Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

Irene is an HIV positive African immigrant woman and the mother of two young children. She came to the program emotionally devastated. Her partner had fallen ill and been admitted to the hospital with complications related to meningitis. She became suspicious about some of the medications prescribed to her partner and decided to ask his doctor what the problem was. She was told that her partner was HIV positive. The woman was then pre-tested to assess how much she knew about HIV and AIDS and a risk assessment of her behaviors was conducted. She was provided with information about HIV/AIDS and encouraged to be tested for HIV. The woman consented. Her test results came back positive.

When she received her results, the woman broke down hysterically and was comforted by staff until she was calm enough to resume the post-test counseling process. By the time she left the office, the woman was calm and armed with a number of resources regarding her newly diagnosed HIV status and had a return follow-up appointment with her doctor and the infectious disease clinic.

Irene later confided in EHDI staff that she had contemplated suicide. She stated that meeting with staff made her think otherwise, saying "you made me feel like a human being again." It was easy for Irene to connect with the staff immediately, mainly because both staff and client are African born immigrants and there were no language barriers. The woman said that "she immediately felt she had found a sister, a shoulder to cry on and someone who could share her burden."

Irene is one of the many clients who have been led into care and have stayed in care. She has developed a strong bond and trust with EHDI staff who have learned how to work through systems. The woman quickly learned how to connect and maneuver HIV care and social service systems on her own.

Today, Irene regularly attends the AAATF HIV positive women's emotional support group and was an active participant and facilitator in the last HIV positive women's retreat for African-born immigrants and refugees living with HIV and AIDS. She gained personal confidence and strength and became a leader, encouraging other newly diagnosed African-born women in the program.

- African American AIDS Task Force

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing HIV/AIDS and STIs

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address HIV/AIDS and STIs. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were also asked to share program 'success stories.'

Based on these reports, we know that over 68,000 people across Minnesota were reached by the 11 grantees working to reduce or eliminate disparities in HIV/AIDS and STIs. They documented increases in knowledge and awareness among program participants, changes in preventative behaviors, increased used of health care, particularly testing for HIV/AIDS and STIs, and some changes in the systems that provide care for HIV/AIDS. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way—staff turnover was the most common, along with difficulty recruiting qualified staff and volunteers to work in the programs. Literacy issues posed problems in education and evaluation. Transportation issues were noted by some grantees as problematic. Additional challenges included establishing trust, the stigma of HIV/AIDS, and the difficulties of dealing with sexual issues with cultures not used to openly discussing these topics.

Grantees used their intimate knowledge of their communities to solve these challenges. They used creative and innovative approaches such as locating services in convenient locations with other related services. They also formed partnerships with institutions and organizations that were well trusted within the communities, such as churches, hospitals, employers and other community organizations.

They are using their evaluation results to improve their programs to better serve the needs of their communities and comprehensively address the threats posed by HIV/AIDS and STIs to the health of Minnesotans of color disparately affected by this disease.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

Disparities persist between different population groups in incidences of HIV/AIDS and STIs. For instance, in 2002,

- Rates of Chlamydia and Gonorrhea were higher for all Populations of Color, including American Indians) as compared to Whites;
- The rate of newly diagnosed HIV infection for African Americans was over ***17*** times higher than the White and Asian rates; and,
- The rate of newly diagnosed HIV infection for Hispanics was over ***six*** times the White and Asian rates.[1]

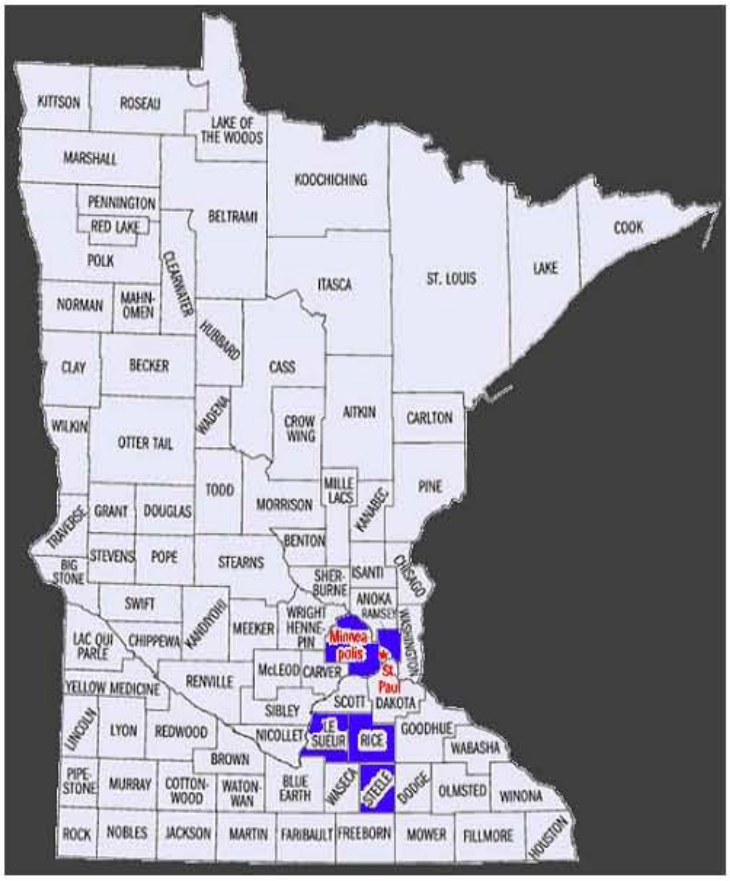
[1] Minnesota Department of Health HIV/AIDS Surveillance System

NUMBERS AND POPULATION GROUPS REACHED

11 EHDI Grantees are working to eliminate HIV/AIDS and STI disparities across the state:

- 5 are working with African Americans
- 4 are working with African-born people
- 3 are working with American Indians
- 6 are working with Latinos
- 4 are working with Multi-Racial individuals

68,879 Minnesotans were reached through the efforts of the 11 grantees working on HIV/AIDS and STIs.

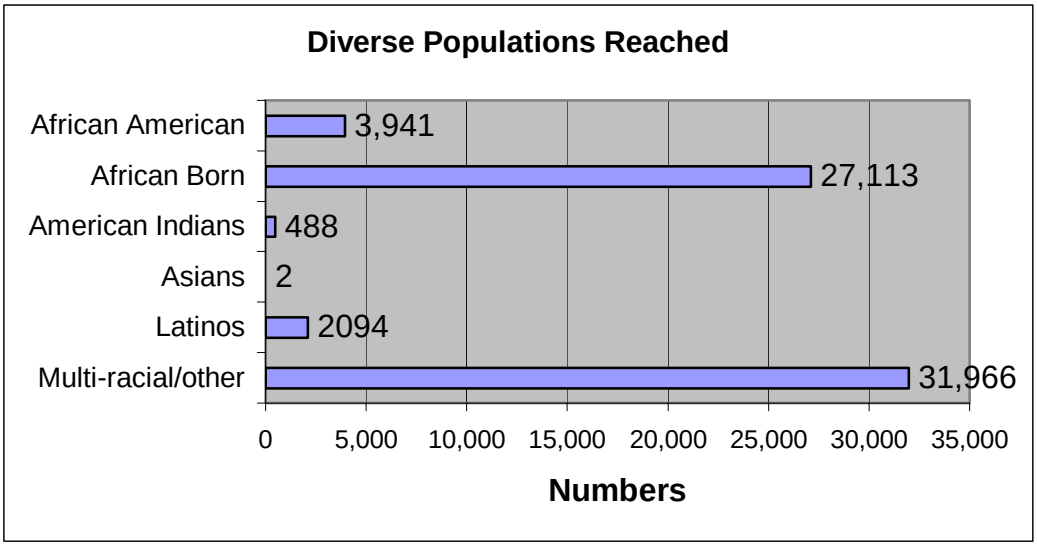


Many of the EHDI grantees working in the HIV/AIDS and STI health disparity area are targeting several different racial and cultural groups. The counties in which the grantee organizations and tribes were working to address HIV/AIDS are shown on the left.

Grantees working in the HIV/AIDS and STIs health disparity area reached:

- 56,510 adults,
- 3,360 children, and
- 9,003 people of unknown ages (primarily attendees at large events).

The racial/cultural groups reached by grantee programs addressing HIV/AIDS and STIs are shown in the figure below.



GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address HIV/AIDS and STIs in their communities. They worked to:

1. Increase awareness of HIV/AIDS and STIS and increase knowledge about prevention of HIV/AIDS and STIS, and to change attitudes about HIV/AIDS and STIS;
2. Change behaviors related to HIV/AIDS and STIS, such as lifestyle changes to prevent HIV/AIDS and STIS, and to promote better care for people living with HIV.
3. Increase access to and utilization of health care, such as testing for HIV/AIDS and STIS, and making sure participants have access to medical and other types of social support; and
4. Create systems-level changes that improve care related to HIV/AIDS and STIS, or more effective, comprehensive prevention for HIV/AIDS and STIS.

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about HIV/AIDS and STIs and changing peoples' attitudes about HIV/AIDS and STIs in the racial and ethnic populations were important outcomes that many of the grantees targeted.

Examples of approaches used by grantees to increase awareness and knowledge included:

- Providing services, such as tutoring, employment referrals, and individual counseling
- Training and education on leadership skills and self-awareness
- Education through motivational speakers
- Organizing educational events, such as movie nights and Parent/Kids Day

> *We enrolled and taught 1547 teens about making healthier life choices Evaluation results show that of the 1315 teens who completed their healthy life choices program, 95% are honoring their commitment to remain abstinent, 5% indicated they had made the choice to not abstain, but they were practicing safe sex 100% of the time*
>
> - Agape House

Changing Behaviors

Grantees worked to change behaviors among program participants to prevent HIV/AIDS and STIs and to help them better manage their disease and stay healthy.

> *There are still many misperceptions about HIV in the community that we worked to correct: 40% of clients were surprised to learn that mother to child transmission could be prevented; 20% still felt that HIV was mainly in the gay community. Thirty percent did not think transmission was possible through tattoos not done professionally. After educating them, 70% of clients said they had learned something new and would share information they had learned with friends or family.*
>
> -African American AIDS Task Force

Examples of approaches used by grantees to change behaviors related to HIV/AIDS and STIs included:

- Education through motivational speakers and risk-behavior prevention curriculum
- Promoting goal-setting to achieve individual health objectives

Increase Access to and Utilization of Health Care

To increase access to HIV/AIDS testing, and link HIV positive people with health care and other services, grantees used a variety of approaches, including:

- Providing counseling to help identify and address barriers to health care
- Offering biweekly visits from guest speakers to educate participants on access points
- Displaying clinic information on billboards and in bus shelters
- Providing health care services on a sliding-fee scale

> *We tested 24 migrant workers for HIV in the last year, and will test many more in the April to November agricultural season.*
>
> – Centro Campesino

Systems Change

To create systems changes related to HIV/AIDS and STIs, grantees used these approaches:

- Networking with educational institutions and county offices to better address target populations
- Participating in poster presentations
- Holding a community summit: "Returning Home: Offenders and HIV/AIDS"
- Educating youth on their health care rights and options

> *Minnesota Correctional facilities have become increasingly aware of the gaps in resources both for offenders dealing with issues related to HIV/AIDS and for the communities receiving them upon release because of this project.*
>
> - Council on Crime and Justice

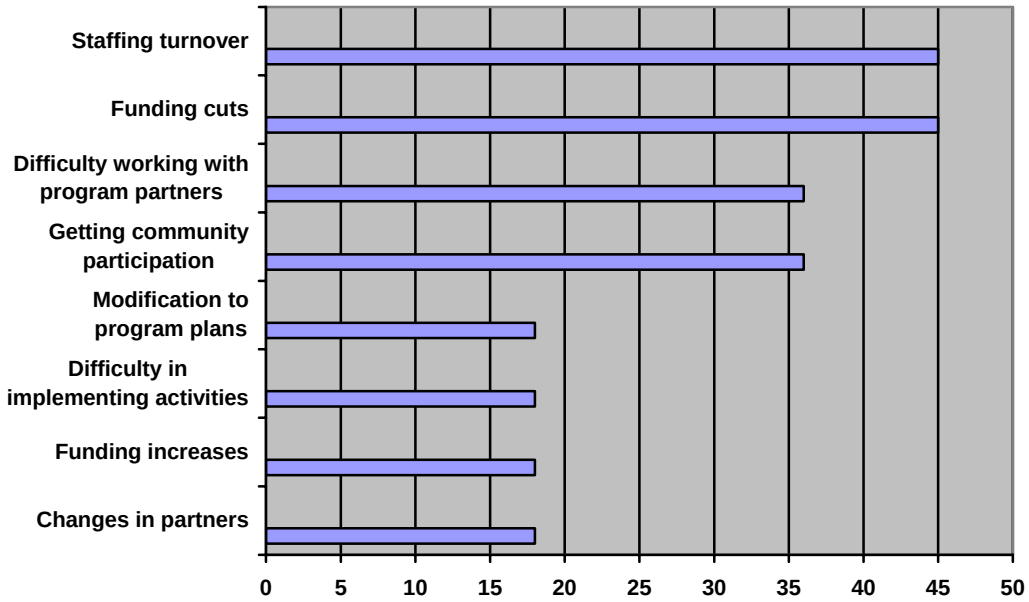
CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Grantees stressed the problems around staffing—staff turnover and recruiting volunteers was quite difficult for many grantees. Other commonly cited challenges listed by grantees were transportation, space for youth programming, parent involvement, literacy issues, and trust.

> *My desire is to reach as many teens as are in need; and to have my financial resources and manpower equal this desire.*
>
> - Agape House

> *We have discovered that the target population still has a great degree of mistrust even when the prevention messages are delivered from members of the population.*
>
> - Turning Point

Percent of Grantees Citing These Challenges to Effective Programming



> *One challenge in the Latino community is fear and discomfort around HIV/AIDS discussion and discussions about preventative sexual behaviors.*
>
> – Centro Campesino

CREATIVE OR INNOVATIVE ASPECTS OF PROGRAMMING

Grantee working on HIV/AIDS listed a number of creative aspects that improved their programs' effectiveness in serving communities while targeting and issue. One commonly cited creative aspect was a holistic approach. This was discussed in two ways-- reaching not only the program participants, but also the partners/spouses and family members. Also not only dealing with the person's disease or risk of disease but the whole person. Related to this, being co-located with a variety of services was an innovative feature of several programs.

> *The part of our program that is most creative is advertising prevention messages. Here, we have created cost-effective messages that may be delivered to the community with very little resources. We have discovered that presentation of prevention messages is highly important when it comes to reaching the target population. If you're going to get their attention, it will most likely be from something with which they can identify—the style of clothing, or a jingle associated with rap music, for example.*
>
> -Turning Point

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> *The program being within the hospital set up is able to provide 'one stop shopping' for patients who want to be tested but also have other health issues. It also provides patients with referral opportunities both within and outside to community resources that are of help to them. The program staff ,being part of the target community, are able to provide culturally appropriate care.*
>
> - African American AIDS Task Force

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs. Some said they would use the information to upgrade existent programs while some would develop new services based on the findings. Another grantee summed up the intentions of many by noting what their organization would do with their evaluation findings.

> *In order to improve our program based on the outcome findings, we are in the process of updating the curriculum to add a behavior component and we also want to start focusing more on improving our case advocacy services, as well as referrals.*
>
> - Council on Crime and Justice

> *The outcomes reported in section E will be used to improve the program by helping the target population use the knowledge gained to develop norms that involve safer sex.*
>
> - Turning Point

Eliminating Health Disparities Initiative

An Interim Summary of Grantee Progress and Outcomes Addressing ***Immunizations***

Prepared for the

Minnesota Department of Health

Prepared by

Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

Halimo is a single mother of seven children, ranging in age from 3 to 11, one of whom is developmentally disabled. Halimo arrived in Minnesota one year ago from Africa. She did not have anyone that could assist her in resettlement, but eventually found a home in a housing complex in Eagan. By the time she arrived, it was the middle of the school year, and because of the multiple barriers Halimo was faced with, it was difficult to do anything on her own.

I was informed about her arrival by my colleagues, who run a Somali Success Program in Eagan. We made a house visit to Halimo and went through all her paperwork to find out her immigration status and health concerns. We contacted the schools and found out what immunizations were required before her children could be enrolled. I transported the family to the Dakota Public Health Office so they could meet the immigration requirements. Because of our existing relationship with the schools, within one week we were able to enroll her children. We continue to provide all kinds of support to Halimo so she can live independently. Halimo recently obtained her drivers license and goes to ESL school part time and works in the evening. Her children are doing well in school and she is working hard to adjust.

- The Storefront Group

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing Immunizations

Table of Contents

EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address immunizations. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were also asked to share program 'success stories'.

Based on these reports, we know that nearly 79,600 people across Minnesota were reached by grantees working to reduce or eliminate disparities in immunizations. They primarily documented increases in immunization rates for participants, but also documented increased knowledge of the importance of immunizations, who should get them and when, and how to maintain records of immunizations that will meet the requirements of schools, and assist health care providers. Some systems changes were documented, such as having employers allow immunization clinics at worksites for migrant workers. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way—staff turnover was common, along with difficulty recruiting qualified staff and volunteers to work in the programs. They talked about the importance of having community members serve in leadership roles in projects, to help establish trust, and to get the word out into communities through their own networks. Cultural issues were challenging—many people come from parts of the world where preventative health care is unknown, so there were many myths and misconceptions about immunizations to dispel.

Grantees used their intimate knowledge of their communities to solve these challenges. They used creative and innovative approaches, such as using community peers to reach out and educate other members of the community. They formed partnerships with employers and community-based organizations to increase access to immunizations.

Grantees are using their evaluation results to improve programs to better serve the needs of their communities and share their successes with others.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

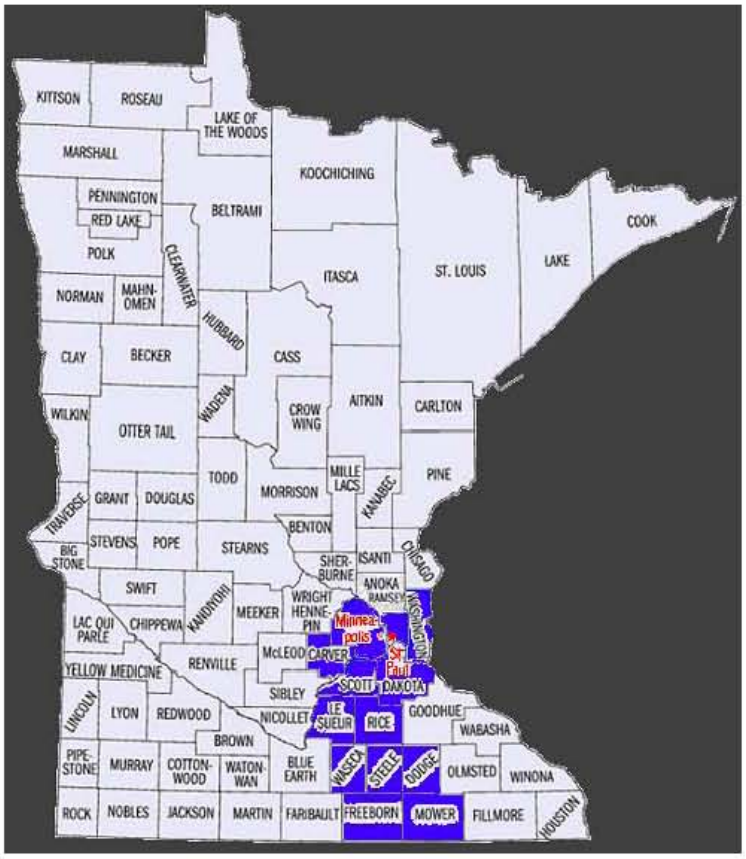
Disparities persist between different population groups in rates of immunizations for various diseases, and in the incidences of various vaccine-preventable diseases. For instance:

- African American and Asian infants (at four months of age) were least likely to be immunized compared to other infants in Minnesota
- Hispanic and African American elders (over age 65) in the Midwest were less likely than other racial/ethnic groups to receive either influenza or pneumococcal vaccinations.[1]

NUMBERS AND POPULATION GROUPS REACHED

12 EHDI grantees were working to eliminate immunizations disparities across the state. The counties in which the grantee organizations and tribes were working to address immunizations are shown in the figure below.

- 4 are working with African Americans
- 5 are working with African-born people
- 4 are working with American Indians
- 5 are working with Latinos
- 4 is working with Asian/Southeast Asians
- 5 are working with multi-racial/other individuals



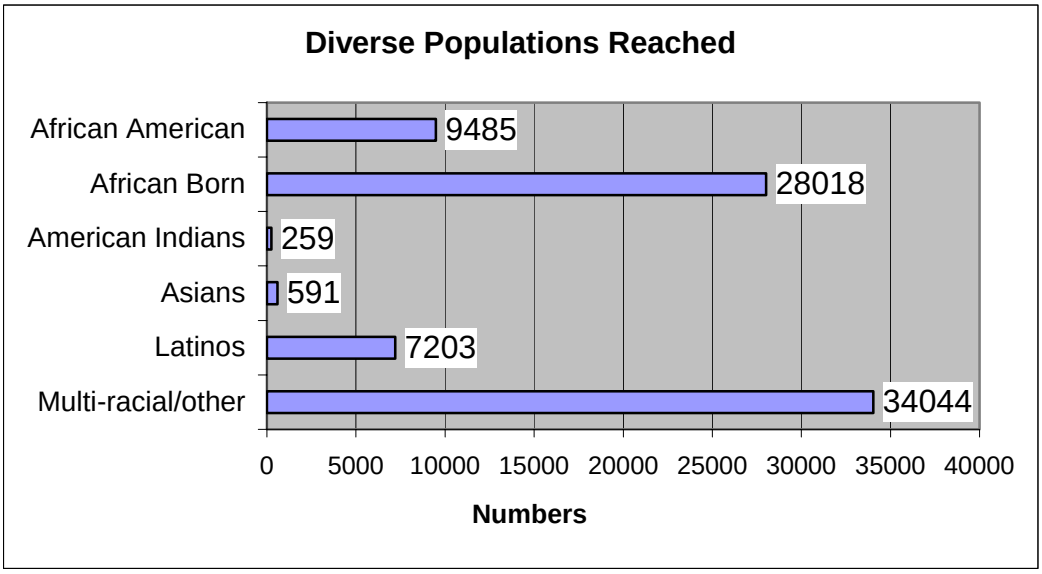
[1] Minnesota Retrospective Kindergarten Survey for school year 2001-2002 and 2000-2001 National Health Interview Survey

Grantees working in the immunizations health disparity area reached:

- 10,447 children
- 61,133 adults, and
- 8,020 people of unknown ages.

The racial/cultural groups reached are shown in the figure.

79,600 Minnesotans were reached through the efforts of the 6 grantees working on immunizations.



Immunization is new to most of the minority communities. These communities only go to see doctors when they are in need due to lack of health care knowledge, health care insurance and language barriers.

- Center for Asian and Pacific Islanders

GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to increase the rate of immunizations in their communities: They worked to:

1. Increase awareness of immunizations and increase knowledge about immunizations—what they are, why they are needed and by whom, and where to go to get immunized;
2. Change some behaviors related to immunizations, such as developing and maintaining record keeping systems to monitor when immunizations have been given, and when they are due; and being able to interface with school systems regarding the required immunizations;
3. Increase access to and utilization of immunizations and other health care; and
4. Create systems-level changes that promote access to immunizations such as working with employers to offer vaccination clinics at worksites.

Increasing Awareness, Knowledge and Changing Attitudes

CAPI held hour-long information sessions in Hmong and Somali communities on the importance of immunizations. Evaluation data for the 389 who completed the training show a significant increase in knowledge about immunizations, from 25% at the pretest to 79% at the post-test.

-Center for Asian and Pacific Islanders

Increasing awareness and knowledge about immunizations and changing peoples' attitudes about immunizations in the racial and ethnic populations were important outcomes that many of the grantees targeted. This educational process focused on increasing community members' understanding of what immunizations are, teaching that people of all ages need to be immunized, and improving participants' knowledge of the location and purpose of immunization centers.

65% of the families that attended the workshops stated that they gained new information about immunization.

-Storefront Group

Examples of approaches used by grantees to increase awareness and knowledge include:

- Educational workshops/discussions to help clients apply for low-income insurance
- Health care education such as home visits to educate clients/participants
- Promotion of community dialogue to create a chain of leadership within the community
- Provision of immunization information and resources

Changing Behaviors

Grantees worked to change behaviors among program participants in areas that promoted immunizations, and met immunization-related requirements for various institutions.

Examples of approaches used by grantees to change behaviors related to immunizations include:

- Helping families develop record keeping systems to keep track of when their children have had immunizations as well as when they are scheduled to have immunizations, and
- Ensuring that children start school with complete and up-to-date immunization records.

We worked with Somali families to make sure their children were properly vaccinated and had up-to-date school immunization records. In the three schools in which we worked in the Burnsville area, 95% of Somali students had up-to-date records.

-The Storefront Group

Increasing Access to/Utilization of Health care

To increase the immunization rate, grantees used a variety of approaches, including:

- Encouragement or facilitation of behavioral change by transporting or accompanying clients to and from the clinic
- Facilitating access by holding free shot clinics once a month

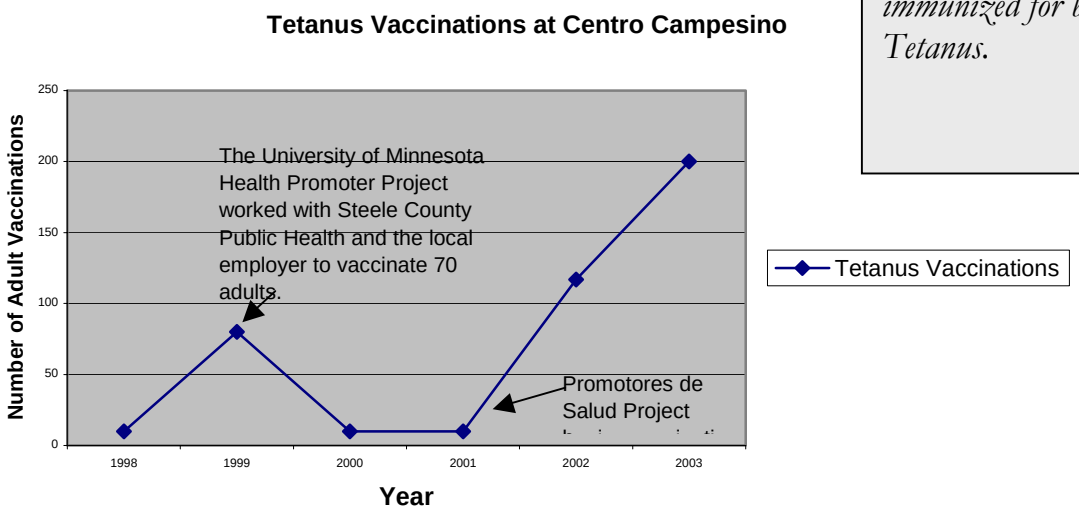
- Educational workshops/ discussions to help clients apply for low-income insurance to pay for services
- Assistance with interpretation

The part that we are so proud of is that clients slowly understand that immunizations are important for everyone and not just for children. Clients started to come in for their own prevention shots.

- Center for Asian and Pacific Islanders

We established 8 immunization clinics for migrant workers in 3 southern Minnesota counties, and through these clinics, 464 adults were immunized for both Hepatitis B and Tetanus.

- Centro Campesino



46% of the Somali families we worked with reported they were more comfortable using local clinics, after having been introduced to them in the workshop. Park Nicollet Clinics have also reported to us that they have more Somali people accessing their clinics now.

- The Storefront Group

Systems Change

To create systems changes related to immunizations, grantees used the following approaches:

- Collaboration/networking with related institutions to encourage cultural competency
- Networking by holding discussion forums among different health organizations
- Health care being organized and supported by the community
- Advocacy by supporting union development
- Visits to the legislature

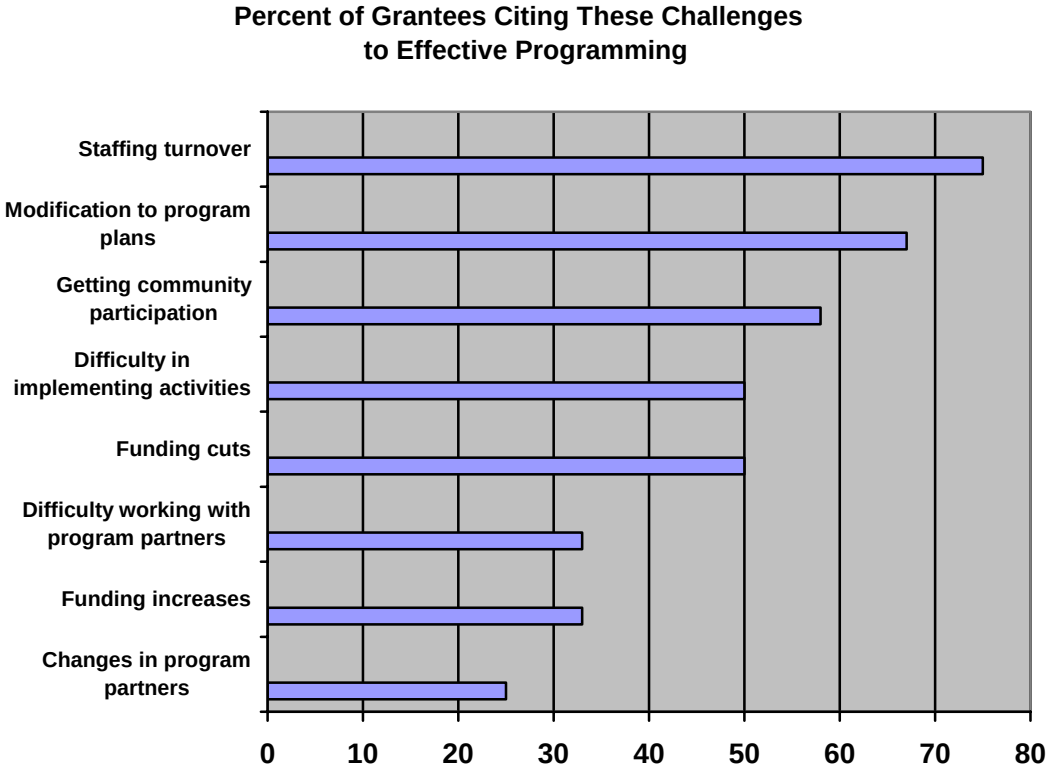
In order to affect systems change to reduce health disparities, the Promotores de Salud Project is involved in: providing information and advocacy about workers compensation issues and supporting injured individuals with their claims and medical needs; supporting the formation of a seasonal agricultural worker union in order to negotiate higher salaries, improved housing conditions and health insurance; and conducting educational visits with legislators about the need for rural health care options for migrant worker and new immigrant communities.

-Centro Campesino

CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Grantee stressed the problems around staffing—staff turnover and recruiting volunteers was quite difficult for many grantees. Another commonly cited challenge listed by grantees was transportation.

> *Language barriers are still a problem and will continue to be a problem as 90% of our clients are not educated, even in their own mother tongue, so we will continue to need the support of interpreters.*
>
> - Center for Asian and Pacific Islanders



CREATIVE OR INNOVATIVE ASPECTS OF PROGRAMMING

Grantees working on immunizations listed a number of creative aspects that improved their programs' effectiveness in serving communities. One commonly cited creative aspect was involving community members in developing strategies to get the word out about immunizations. This fostered trust, and the community members took the leadership role to talk to others and share critical pieces of information.

> *The Promotores de Salud project is most proud of its community leadership from the migrant farmworker communities and new immigrant rural Latino/as that are actively engaged in taking charge of the health of the communities.*
>
> - Centro Campesino

> *I think involving the community from the starting point and including community members in the decision making process did help us to gain the trust of the Somali families.*
>
> - Storefront Group

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs. Some said they would use the information to upgrade existent programs while some would develop new services based on the findings. Another grantee summed up the intentions of many by noting what her organization would do with their evaluation findings.

> *The outcome findings will be reported back to community members to energize people that change in health status is happening and that the change is because of the leadership and involvement of migrant workers and rural Latino/Latina residents, along with effective allies in mainstream health organizations. Promotores de Salud will utilize the findings to support perspectives that encourage initiatives that are truly community-led.*
>
> - Centro Campesino

Eliminating Health Disparities Initiative

An Interim Summary of Grantee Progress and Outcomes Addressing ***Infant Mortality***

Prepared for the

Minnesota Department of Health

Prepared by

Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

"A single mother enrolled in the program after becoming pregnant for the first time. Her father was deceased, and her mother suffered from alcoholism and remained unsupportive of her daughter. The nurse followed her situation throughout her pregnancy, providing education and support. Ultimately, the client delivered a healthy baby and was followed through Well Baby Visits. With support of the nurse, the mother has breastfed through the entire first year. Additionally, she has become a Peer Breastfeeder helper, and has completed her first semester at a local technical college, getting A's and B's."

-Fond du Lac Tribe, Center for American Indian Resources

"Ana was in a very chaotic living situation and was unsure of her relationship with the father. Although they lived together, he was unfaithful and had problems with drugs. She spoke only Spanish and all of her family is still in Mexico. Although Ana's home was safe, she did not feel comfortable there because she had never used drugs and did not like that environment. The doula found that it was easier to connect with this mother at the clinic, where they had a great deal of time to sit and talk about labor and birth. Ana continued to take prenatal classes at the clinic, and also sought information from the doula about nutrition, comfort measures, and relaxation exercises. She spoke with or saw the doula every few days in the weeks leading up to the birth. When in the hospital, she relied on the physical and emotional support of her aunt and her doula, and gave birth to a very healthy 8lb baby boy. Ana started breastfeeding immediately. The doula continued to visit often, providing emotional support, breastfeeding knowledge, and help with community resources. The doula helped Ana assemble and use a breast pump a few weeks after delivery. Ana needed dental and medical care after the birth of her baby, so the doula helped her to make those appointments in clinics where Spanish is spoken. Ana's medical assistance will end soon due to her immigration status, so the doula helped Ana apply for MinnesotaCare to continue her health coverage. She is now living in an apartment with her partner and one other family member. There are no drugs in this home, which is a great relief for her. Ana is deeply attached to her baby and feels confident in her parenting abilities. The doula is now encouraging her to attend an Early Childhood Family Education class so that she can meet other parents in the area."

-American Indian Family Center

“Laurie is a young mother who was referred to the community doula program during her second trimester of pregnancy. The Social worker making the referral indicated that Laurie had a history of traumatic sexual assault, and drug use, and that she wanted the support of a doula. The doula's role is to help the mother prepare for birth by providing individual prenatal education and preparation for childbirth, breastfeeding and parenting. Laurie's doula met with her many times before her birth and also attended prenatal health care appointments with her. The doula expressed that she was glad to have had the information about Laurie's sexual assault as it helped her to tailor the education sessions for Laurie's special concerns that would inevitably arise during her clinical care and birth. During their meetings they made a birth plan which allowed Laurie to have as much control and assertion as possible. When her day of birth approached Laurie was feeling well informed and ready for the journey. The doula got the call one morning that Laurie's contractions had begun, she counseled her over the phone and offered words of advice and comfort. The doula spoke with Laurie's partner and joined them both at Laurie's apartment soon after. When the doula arrived she assisted Laurie with finding comfort measures that they had practiced earlier in her pregnancy. They went to the hospital when Laurie was ready. Laurie had planned a water-birth. Generally water-birth can help a woman with inhibitions feel more discreet and less discomfort. Laurie's labor progressed rapidly in the water and soon it was time to push. Laurie panicked but the doula was able to give her words of encouragement and reassure her fears of becoming a mother to a baby on the outside and pushing a baby out of her body. It is typical to have these fears after a traumatic experience. Laurie reported later that her doulas words of encouragement during that fearful time were what carried her through and made her aware that she could do it. Laurie was very pleased with her natural birth experience. She breastfed her baby immediately. She felt empowered and ready to mother her baby. She even felt better about her relationship with her partner. Laurie was receiving ongoing support from her social worker who followed up with her after the birth. Laurie also maintained a drug free lifestyle while working with the doula. The doula felt that her reassurance and support effected Laurie's ability to stay clean. Her baby was very healthy and mother and baby are bonding well. Laurie decided to move to her mother's house shortly after she left the hospital, for the added sense of support. This was a positive experience for this new family because of Laurie's sense of empowerment and control over her birth process. Laurie also felt very supported by her clinical staff. The support of the doula was essential to her positive experience because of the individualized concentration, the support for staying off of drugs, encouragement to attend prenatal clinic appointments, and assistance with her birth.

-American Indian Family Center

EHDI: An Interim Summary of Grantee Progress and Outcomes Addressing Infant mortality

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EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address infant mortality. These progress reports were submitted in September of 2004, and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were asked to share a 'success story' from their program.

Based on these reports, we know that over 73,687 people across Minnesota were reached by the eleven grantees working to reduce or eliminate disparities in infant mortality. They documented increases in knowledge and awareness about infant mortality among program participants, changes in behaviors, such as breast feeding their babies, increased used of health care, particularly prenatal care, and some changes in the systems of care for prenatal care, birthing, and assistance postpartum. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way, including demand outstripping service capabilities—or contrarily, problems getting clients to sign up, funding issues, and difficulty recruiting qualified staff and volunteers to work in these demanding evening and weekend programs.

For the most part, grantees used creative and innovative approaches to their missions involving infant mortality. The doula programs were innovative in that they used women of color to support and educate other women of color. Some grantees structured their setting, or interaction with other organizational units to promote effective programming in the infant mortality area.

Grantees reported they are using their evaluation results to improve their programs to better serve the needs of their communities, to market their programs to increase referrals into the program, and to make key decisions regarding future programming.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

Disparities persist between different population groups in incidences of infant mortality, as well as the death rates due to infant mortality. For instance, in 1996-2000,

- Infant mortality rates for all Populations of Color and American Indians were higher than the rate for Whites.
- For every one White infant death, there are two African American and two American Indian Infant deaths.[1]

[1] MN Vital Statistics

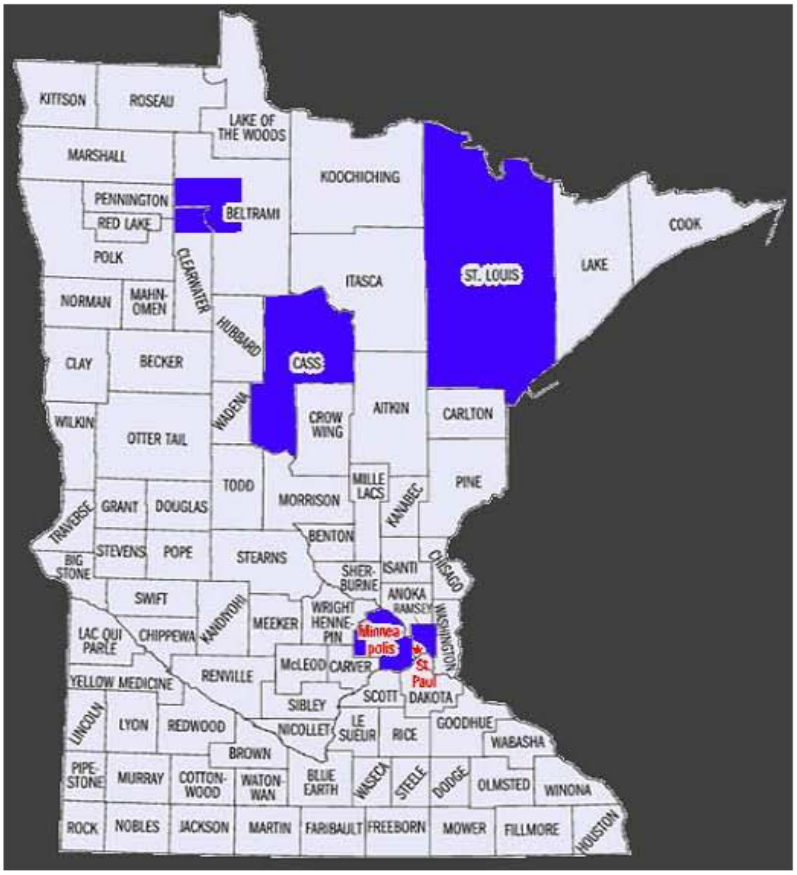
NUMBERS AND POPULATION GROUPS REACHED

Eleven EHDI Grantees are working to reduce infant mortality disparities across the state:

- 4 are working with African Americans
- 4 with African-born people
- 4 with American Indians
- 4 with Latinos
- 6 with Asian/Southeast Asians
- 7 with Multi-racial and other individuals

73,687 Minnesotans were reached through the efforts of the 11 grantees working on infant mortality.

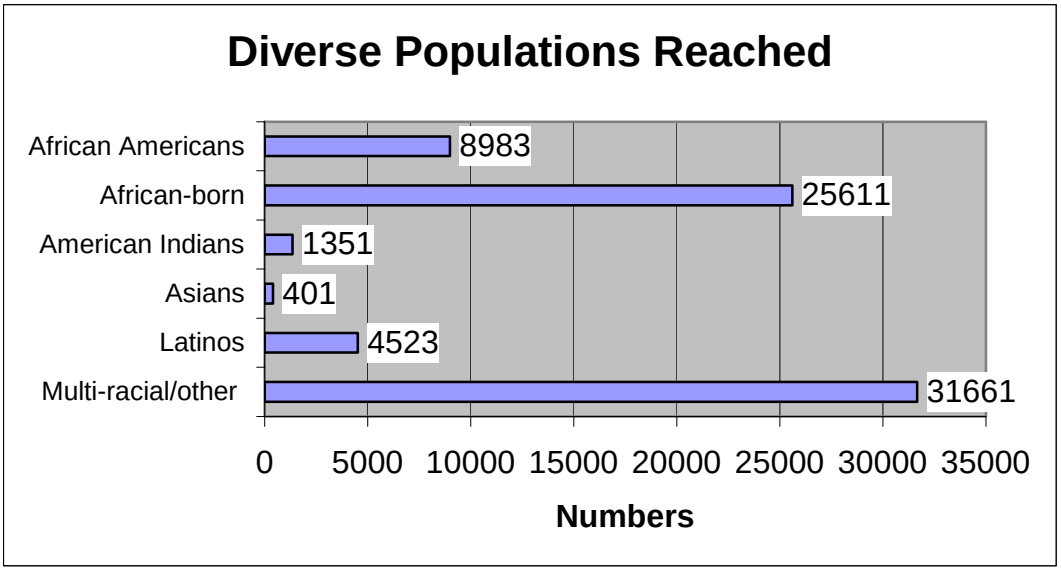
Some grantees are working with more than one population. The counties in which the grantee organizations and tribes were working to address infant mortality are shown in the figure below.



Grantees working in the infant mortality health disparity area reached:

- 57,138 adults,
- 7,500 children, and
- 9,049 people of unknown ages (primarily attendees at large events).

The racial/cultural groups reached is shown in the figure below.



We …continue to believe that a community based program that using women of color to work with women of color to empower and teach each other is an innovative practice.

- American Indian Family Center.

From the evaluations we see that all of the clients felt they had gained new and useful knowledge in the Parenting education sessions. Some commented on learning new ways to discipline, and not to lose your cool. I had one young parent say they didn't know there were other things to do than beat your kid when they do wrong. Many parents state that nowadays you really can't spank kids like in the past, but they don't know any other way to discipline. Nobody teaches that. Several clients mentioned they really like meeting other native parents and hearing their stories. Many come from dysfunctional, abusive and alcoholic families, and are struggling themselves not to follow the same pattern.

-Fond du Lac CAIR

GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address infant mortality in their communities. They worked to:

1. Increase awareness, knowledge and attitudes related to infant mortality, such as increasing knowledge about the preventative importance of prenatal care, nutrition and healthy lifestyles, about birthing options and supports available, breastfeeding, infant care, and parenting;
2. Change behaviors for expectant and new mothers, such as adopting healthier lifestyles and good nutrition, seeking prenatal health care, and breastfeeding;
3. Increase access to and utilization of health care, particularly prenatal care and well-baby care;
4. Create health status changes—positive birth outcomes, and promote systems-level changes around care and support systems for expectant mothers and newborns.

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about infant mortality and changing peoples' attitudes were important outcomes that many of the grantees targeted. For example, through child birthing classes, grantees worked to increase the knowledge of women with potential high-risk pregnancies, and to help women better understand fetal development and the changes that occur in pregnancy. Some grantees held parenting groups to increase participants' knowledge of effective parenting techniques and tools. Others coordinated and promoted the services of doulas. Most grantees were working to help women understand the importance of prenatal care and breastfeeding.

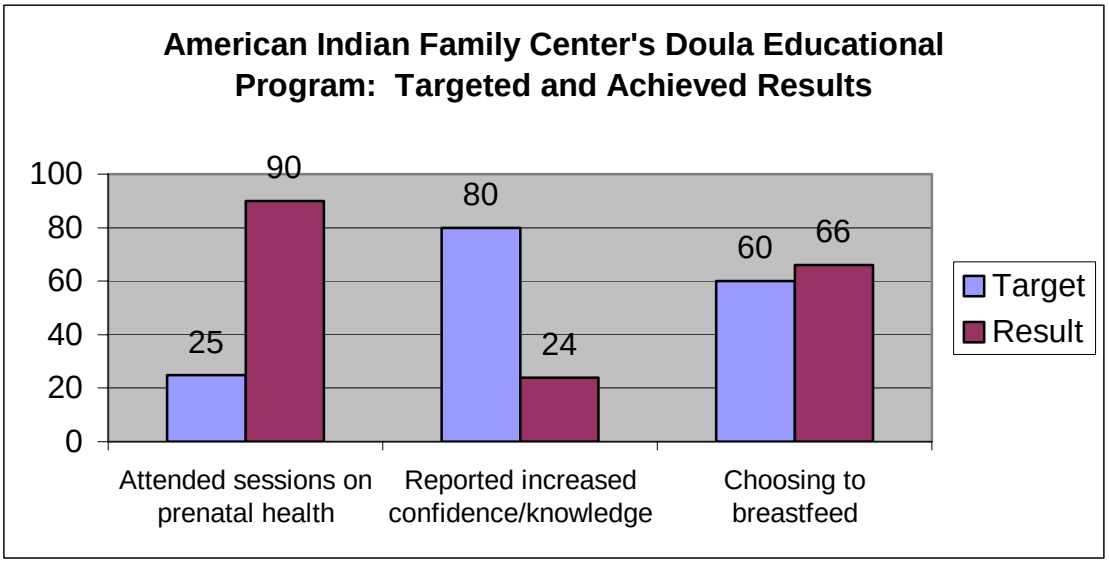
Examples of approaches used by grantees to increase awareness and knowledge include:

- Conducting group educational sessions with spiritual/cultural leaders
- Holding workshops on topics such as breastfeeding, SIDS, and prenatal health care

> *Prior to our services being implemented, around 78% of obstetric clients in our clinic were seen by a Public Health Nurse. After initiating our Prenatal Waiting Area Program, 100% of the obstetric clients were seen by a public health nurse in some capacity.*
>
> - Fond du Lac Center for American Indian Resources

- Providing educational outreach through home visits and role modeling
- One-on-one education through doula programs
- Providing access to resources through a lending library

The American Indian Family Center's Doula Program documented changes in knowledge, attitudes, and intentions to behave among participants, as the figure below shows. The projected attendance rate far outstripped the targeted levels, and although women did not come away with the increased feelings of confidence and knowledge anticipated by program staff, two-thirds of the women chose to breastfeed after the educational sessions



There is a clear association between holding the "Prenatal Waiting Area", which allows for face to face contact with clients and some education, and an increase in the number of clients accepting PHN services. Clients do recall some things they have learned and state they have applied it to their daily lives. Referrals are up, our WIC program is at it's highest number of clients it's ever had.

- Fond du Lac CAIR

Changing Behaviors

Grantees worked to change behaviors among program participants. Examples of behaviors they worked to change included urging more women to begin prenatal appointments in their first trimester, urging women to decrease high-risk behaviors such as smoking, alcohol and drug use, and to work to increase breastfeeding rates.

Examples of approaches used by grantees to change behaviors related to infant mortality include:

- Offering a holistic curriculum approach incorporating diet, exercise, and drug/alcohol education
- Creating individualized health plans to promote healthy behaviors
- Referring participants to other community resources (housing, child care) when needed

Our emphasis on breastfeeding during all meetings with prenatal clients, our breastfeeding client picture board, and support from our lactation consultant have helped Fond du Lac retain one of the highest breastfeeding initiation rates in Minnesota.

- Fond du Lac CAIR

After high-risk women participated in child birthing classes that taught the benefits of breastfeeding, 66% percent chose to breastfeed.

-American Indian Family Center

Red Lake has worked on integrating its health services so that pregnant women coming into contact with the system are automatically assessed and referred to prenatal care and related services. There is some support to show that this integration process is working-- 95% of clients' prenatal records had a completed assessment form for referral to child birthing classes, and 54% of women using the clinic for other health services chose to attend a child birthing class.

- Red Lake Comprehensive Health Services

Increasing Access to and Utilization of Health Care

Increasing access to and utilization of health care is important to ensure healthy birth outcomes. A number of the grantees worked hard to make sure their participants had access to care, got in for prenatal care early in their pregnancies, were referred for comprehensive services associated with prenatal care and childbirth. Examples of approaches used for this included:

- Creating individualized health plans to promote healthy behaviors
- Facilitating access by accompanying patients to appointments
- Referring participants to other community resources (housing, child care) when needed
- Maintaining early or late clinic times to better serve target populations

Significant barriers remain to increasing access to and utilization of health care for some populations as some of the grantee statements suggest.

The number of women getting in for their first prenatal appointment increased from March 2002 to August 2004. Currently, 275 of 443 (62.8%) patients completed their first PN checkup in their first trimester.

- Cass County; Leech Lake Band of Ojibwe

77% of 127 evaluations completed reported that participants obtained prenatal care in their 1st trimester, 14% stated that prenatal care began in the 2nd trimester and 7% stated that prenatal care began in the 3rd trimester. 83% reported they had regular prenatal during their pregnancy—exceeding the target set at 60%.

- American Indian Family Center

(See Success Stories) Another outcome related to this birth is "Laurie's" health insurance provided reimbursement for part of the doulas' services. We have been able to establish a relationship with UCare to provide its members with doula perinatal education. This systems change is symbolic of the greater health industry's realization of the positive impact doulas can have in the pregnancies and births of high-risk women.

- American Indian Family Center

Promoting Changes in Health Status and Systems

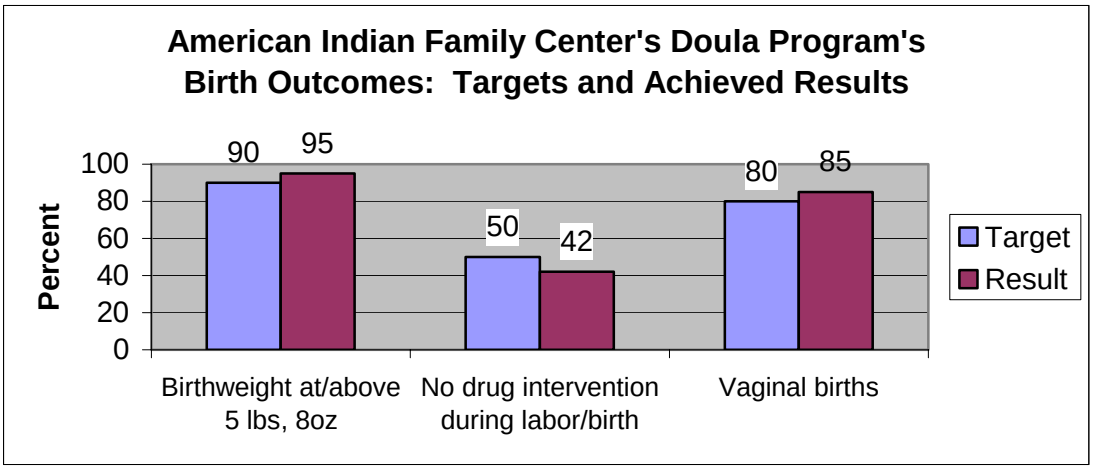
Infant mortality is the one area where we can see increases in health status among program participants—positive birth outcomes, such as acceptable infant birth weight. Other aspects suggest a positive birthing experience for both mother and infant, such as vaginal births and no drugs being used during delivery. Another outcome was adoption of breastfeeding, which has been shown to have many positive health benefits for the infants, and for the woman, long-term. Systems changes were also evident in this disparity area. To create systems changes related to infant mortality, grantees used these approaches:

95% (21 of 22) participants had a normal labor and delivery. 100% (22 of 22) participants had a baby weighing at least 5.5 pounds.

- Division of Indian Works

- Networking/improving relationships with state and local organizations
- Advocacy aimed at increasing the number of bicultural providers within local communities
- Incorporating mental health care into traditional treatment services
- Integration of infant mortality interventions

The American Indian Family Center's Doula Program set performance targets for birth outcomes and exceeded the targets for two out of three indicators, as the figure below shows:



"We are attempting to change health care systems by actively pursuing contracts with health insurance providers so that we may be reimbursed for doula services and women with health care will have better access to doula support services. Cost savings to health care systems are tremendous."

- American Indian Family Center

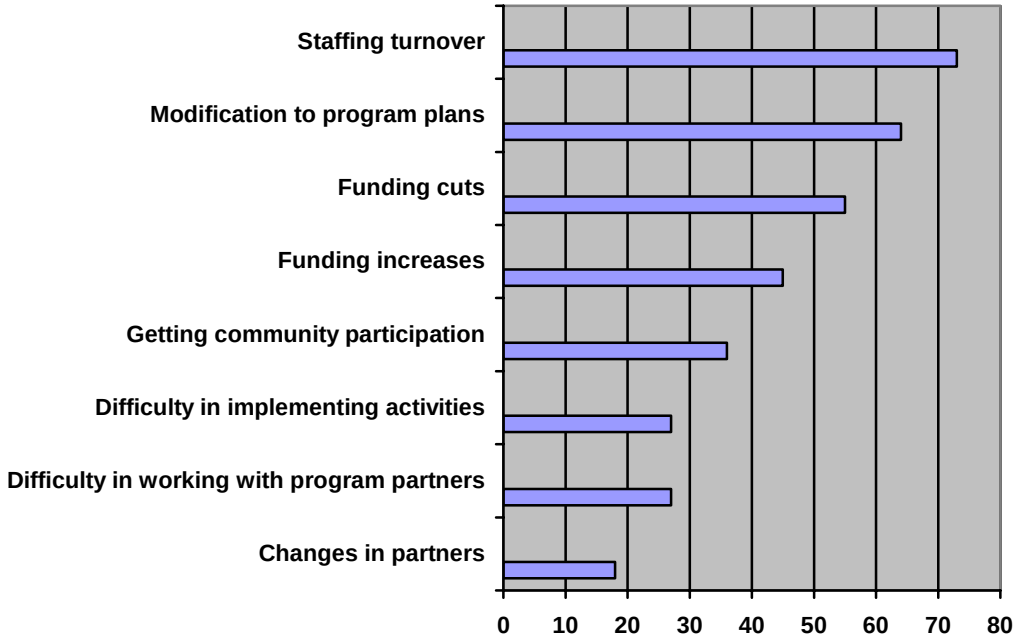
CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Some programs described being overwhelmed by demand for services, and others had more difficulty getting started. Some had a difficult time recruiting and retaining volunteers and staff, because the work usually requires being on call weekends and nights. Funding cuts or changes in fund allocation impacted a number of programs.

> *The need far outweighs the resources. The demand from the communites is great. This demand is testimony that community based programming such as this is not only essential but strongly desired by communities of color.*
>
> - American Indian Family Center

Other challenges noted by program staff included the high rate of poverty and intergenerational dysfunction in some communities, and the difficulty this presents to women who want to have healthy babies and be good parents but have never been exposed to positive role models.

Percent of Grantees Citing These Challeneges to Effective Programming



CREATIVE AND INNOVATIVE ASPECTS OF PROGRAMS

Grantees working on infant mortality listed a number of creative or innovative aspects of their programs. Several grantees pointed out how the doula programs were creative and culturally appropriate infant mortality reduction strategies for their communities. Another grantee pointed out that having women come back and tell their birth story to expectant families was an innovative method used by one program. Integrating prenatal services across programs and clinics was another innovation that resulted in referring all pregnant women to appropriate services.

> *The return visit that many new parents make to tell their birth story and introduce their new child is an innovative part of the program for both staff and parents. Being able to share these experiences with other clients has helped other clients who are anticipating the birth of their babies.*
>
> - Red Lake Comprehensive Health Services

> *"Doulas reinforce regular health care, accompany pregnant women to appoinments, make referrals when there hasn't been any prenatal care yet, and communicate with health care providers. Doulas also educate and infom so that women can make informed decisions and ask informed questions. This empowerment ususally enables a better prenatal health care experience."*
>
> - American Indian Family Center

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs, or to upgrade or expand existing programs. In recruiting participants, some learned who they were successful at conducting outreach with, as well as with whom they were less successful. Several grantees were going to use their evaluation findings to market the program to other organizations and increase referrals into the program, or find additional partners to refer to.

> *We will try and increase the number of pregnant women participating in our program. We will also begin to focus more on the first time pregnancies, although classes are open to all. In the next year we will try to increase the number of significant others/husbands in the program.*
>
> - Red Lake Comprehensive Health Services

Eliminating Health Disparities Initiative

An Interim Summary of
Grantee Progress and Outcomes Addressing
Violence and Unintentional Injuries

Prepared for the
Minnesota Department of Health

Prepared by
Rainbow Research, Inc.
621 West Lake Street, Suite 300
Minneapolis, MN 55408

Stories of Success

On September 13th, a domestic peace pledge ceremony was held at Shiloh Temple International Ministries Church. There was an overwhelming response by the women and children in the audience. More than two hundred and fifty men took the domestic peace pledge and apologized to every woman and child who was present. When the men passed out the roses to the women you could see the emotional healing that was taking place in the sanctuary.

State Representative Keith Ellison and Police Chief William McManus both praised the efforts of MADDADS and 100 Men Take A Stand for the outstanding work that they have done to help the community work towards healing. Bishop Howell led the men in the apology to all women and children. His delivery of the apology was felt throughout the room, not only were the women and children weeping, some of the men were as well.

After the ceremony was completed, our project organizer had the opportunity to speak with many of the men who had taken the pledge. One gentleman in particular really experienced the essence of the pledge and the apology. He had been in a failed relationship fifteen years ago and since then he had made some significant changes in his behaviors. He explained that until this day he could never find the words to apologize to his ex-partner for the ways he had mistreated her and abused her fifteen years ago. It wasn't until the day that he had taken the pledge that he could find the words and the courage to address the issue and apologize to this sister who was seated in the audience. He went on to say that he experienced a sense of responsibility and freedom once he had taken the pledge and that he was now motivated to get involved with other men who are attempting to bring positive change to their families and communities.

-- Family and Children Services

Group participant, while discussing the past with his significant other, asked; "Why have you waited so long to talk to me about this"? Her reply; "I am not afraid of you anymore."

During group one evening we were discussing the topic "Using the Children". Group particpant who was to graduate that evening made the comment; "It is really neat to have my children step on my feet, legs, and jump on my stomach. They used to try and walk around me."

Group participant; "I really like the fact that we can communicate now. It adds intimacy to our relationship, if you know what I mean." The smile on his face after that comment said it all.

--White Earth Tribal Mental Health Services

EHID: An Interim Summary of Grantee Progress and Outcomes Addressing Violence and Unintentional Injuries

Table of Contents

EXECUTIVE SUMMARY

The report summarizes the progress reports submitted by Eliminating Health Disparities Initiative (EHDI) grantee organizations and American Indian tribes that were funded to address unintentional injuries and violence. These progress reports were submitted in September of 2004 and were inclusive of grantee efforts since their program startup in 2002, (or in 2003 for those initially funded for planning), into the summer of 2004. Standardized reports were filed by 51 of the 53 grantee organizations and American Indian tribes.

Grantees were asked to report on activities implemented, numbers served, and outcomes achieved to date. They were asked to report on challenges they had encountered in their work, innovative or creative strategies they had employed, and partnerships formed. They were also asked to share a 'success story' from their program.

Based on these reports, we know that approximately 15,000 people across Minnesota were reached by the eleven grantees working to reduce or eliminate disparities in unintentional injuries and violence. They documented increases in knowledge and awareness among program participants, changes in behaviors, increased use of health care, particularly mental health services, and how systems can change the ways they work together to deal with unintentional injuries and violence. Examples of these outcomes are highlighted herein.

A number of challenges were encountered along the way—staff turnover was the most common, along with difficulty finding qualified staff and volunteers to work in the programs. Getting acceptance for their programs by other providers in the community, or other institutions involved was a challenge at first for some. Maintaining the focus on the issue of domestic violence in the face of other community challenges was also pointed out.

Grantees used their intimate knowledge of their communities to solve these challenges. They used creative and innovative approaches such as using churches as a way to reach out and educate members of the community, and change the norms around violence. One grantee developed a partnership with the courts and correctional agencies to reinforce participant responsibilities to change their behaviors.

Grantees are using their evaluation results to improve or expand their programs to better serve the needs of their communities. In some cases, other communities are interested in adopting these programs based on the promising results.

EXAMPLES OF STATISTICS DOCUMENTING HEALTH DISPARITIES IN MINNESOTA

During 1997-2001,

- American Indian and African American homicide rates were eight and 12 times higher than the White rate
- The suicide rate for American Indian was twice the rate of all other populations
- The mortality rate for unintentional injury for American Indians was double the White rate
- Populations of Color and American Indian 6th, 9th, and 12th graders attempted suicide more often than their White counterparts [1]

[1] MN Vital Statistics and 2001 Minnesota Student Survey

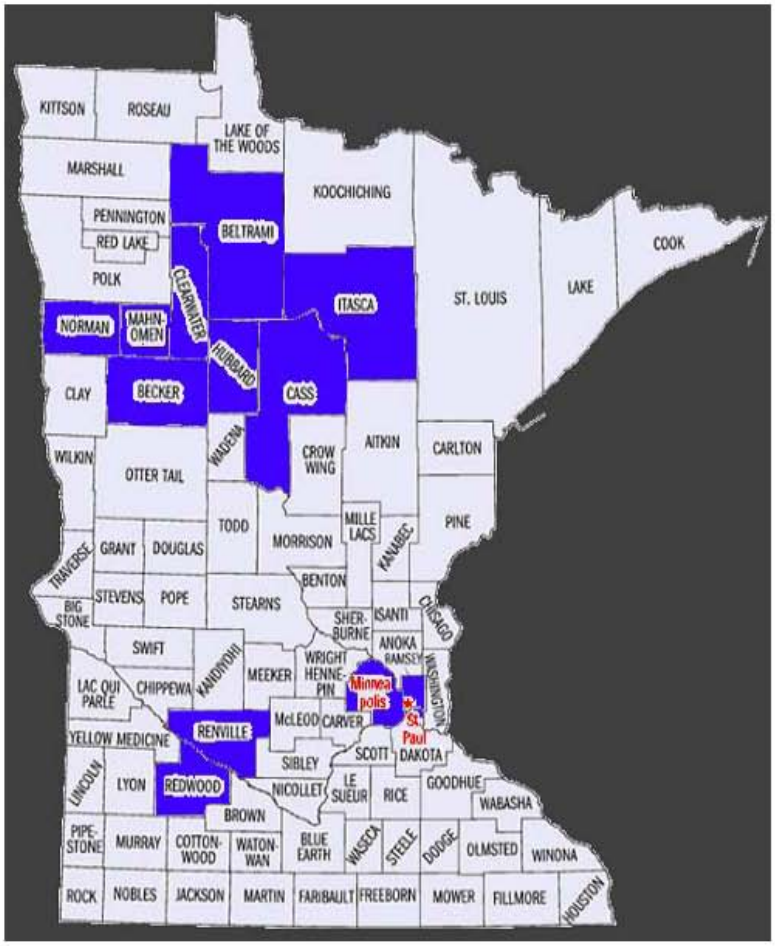
NUMBERS AND POPULATION GROUPS REACHED

15,101 Minnesotans were reached through the efforts of the 11 grantees working on unintentional injuries and violence.

Eleven EHDI Grantees worked to eliminate disparities in violence/unintentional injuries disparities across the state:

- 4 are working with African Americans
- 2 with African-born people
- 6 with American Indians
- 6 with Latinos
- 3 with Asian/Southeast Asians
- 3 are working with Multi-Racial/Other individuals

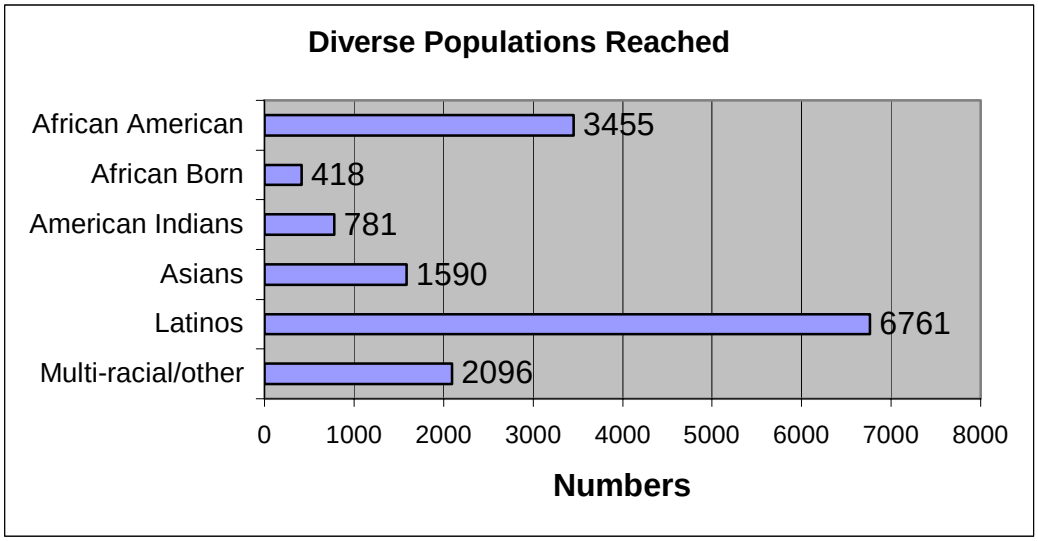
The counties in which they are working are highlighted in the figure to the right.



Grantees working in the unintentional injuries/violence disparity area reached:

- 8,814 children, and
- 6,287 adults.

The racial/cultural groups reached through grantee efforts directed at reducing unintentional injuries/violence is shown in the figure below.



We have utilized a wide range of media opportunities. We are in the middle of a five-month bus shelter campaign. The bus shelter poster shows a positive image of an African American man with his children and the message, "Violence Hurts - Show Ya Love." Tens of thousands of people will be exposed to this image.

- 100 Men Take a Stand/Family and Children Services

GRANTEE APPROACHES AND OUTCOMES

There were four types of changes that grantees were working towards to address unintentional injuries/violence in their communities. Grantees worked to:

1. Increase awareness of unintentional injuries and violence and to increase knowledge about these issues, where to receive help, as well as to change attitudes and norms in the community that violence is not acceptable;
2. Change violent behaviors, or behaviors that lead to unintentional injuries;
3. Increase access to and utilization of health care, such as availability of mental health screenings, anger management classes;
4. Create systems-level changes that address violence/unintentional injuries, such as enlisting health care professionals in routinely screening for violence and offering resources for assistance.

Increasing Awareness, Knowledge and Changing Attitudes

Increasing awareness and knowledge about unintentional injuries and violence and changing peoples' attitudes and community norms about violence in the racial and ethnic populations were important outcomes that many of the grantees targeted.

75% of American Indian men participating in an anger management group were able to identify their triggers for anger after completing all of the group sessions

-White Earth Tribal Mental Health Services

Examples of approaches used by grantees to increase awareness and knowledge include:

- Using spiritual leaders to educate participants by linking actions to consequences
- Increasing public knowledge through targeted media campaigns on billboards and in bus shelters
- Introducing violence-prevention curriculum in schools
- Educating foster parents on the relationship between grief and violence

The bullying curriculum "Steps to Respect" was introduced to four new schools, and 600 students received the curriculum.

- United Hospital Foundation

Changing Behaviors

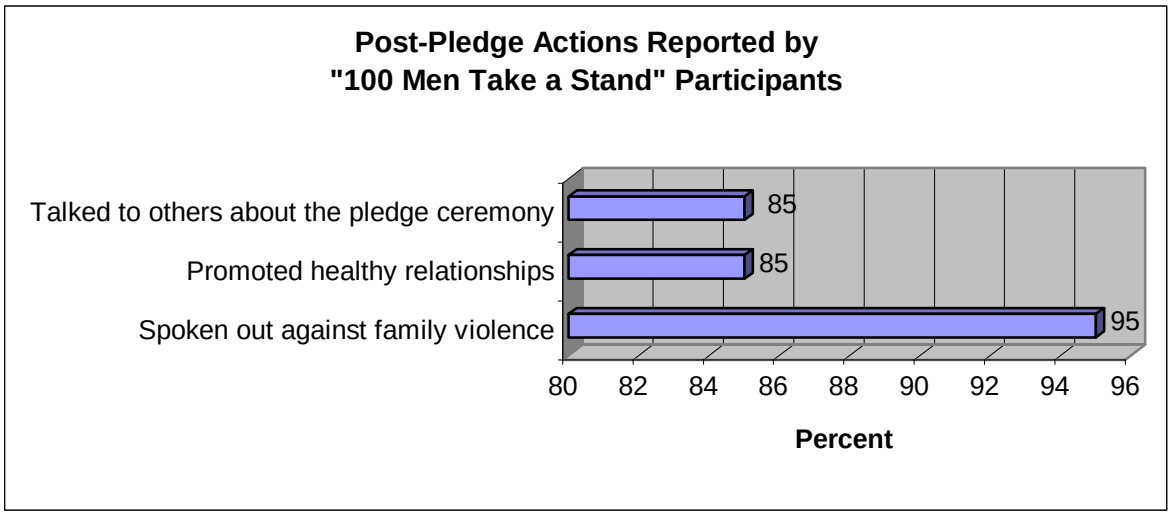
Grantees worked to change behaviors among program participants to prevent domestic violence, and for those who had already been in the criminal justice system for domestic violence offenses, to reduce recidivism.

Examples of approaches used by grantees to change behaviors related to violence:

- Encouraging behavioral change through talking circles and anger management groups, and
- Having men publicly commit to domestic peace in a ceremony in a community or church-based setting.

> *The part of the program I am most proud of is the "Domestic Abuse/Creating a Process of Change For Men Who Batter". I was overwhelmed by the amount of men attending group that had such a willingness to change and make life for themselves and their families healthier.*
>
> - White Earth Tribal Mental Health Services.

The "100 Men Take a Stand" project coordinated by Family and Children Services takes a comprehensive environmental approach to changing community norms around domestic violence in the African American community of North Minneapolis. Over 500 men have taken a pledge for domestic peace, and based on a follow-up survey of pledge-takers, many had taken subsequent action in support of their pledge to changed the attitudes of others in their community:



Increase Access to and Utilization of Health Care

To increase access to mental health screening, treatment and care to help address violence/unintentional injury issues, grantees used a variety of approaches, including:

- Promoting services within the community through a Health and Wellness Fair
- Providing individual counseling to identify and address barriers to health care utilization
- Facilitating/encouraging use of health care services through street outreach

Leech Lake Behavioral Health Services developed a program to integrate behavioral health services, provide outreach and home-based counseling services to reduce domestic and other forms of violence on the reservation. 440 clients were seen over a one-year period. One measure of success for this new program is that two-thirds of the participants (66%) engaged in the program, and had more than one home visit.

- Leech Lake Tribal Health

Systems Change

To create systems changes related to violence/unintentional injuries, the grantees reported using these approaches:

- Encouraging health care providers to screen for domestic violence
- Emphasizing accountability in relationships with program participants, the Department of Corrections, and the local community

Examples of New Partnerships Formed to Address Violence:

- ✓ *Churches, grassroots community groups and Non-profits*
- ✓ *Schools, Health care providers and Foundations*
- ✓ *Tribal government, local courts, and State Department of Correction*

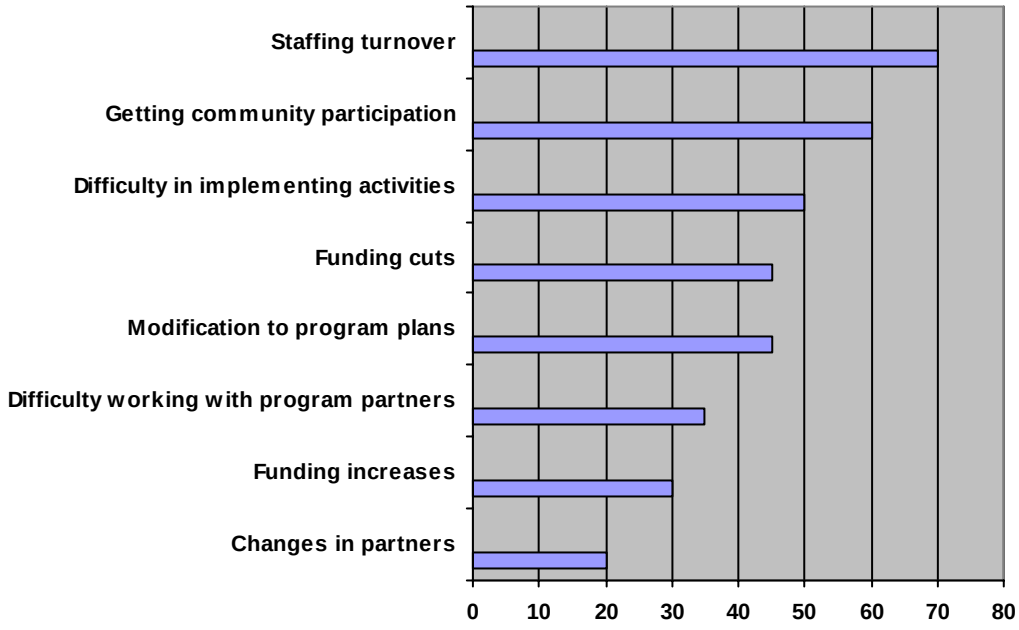
CHALLENGES

Grantees noted that they experienced a number of implementation challenges. Quite common were problems around staffing—staff turnover and recruiting volunteers was difficult for many grantees. These cross-cutting challenges are shown in the figure below.

One of our main challenges is getting primary care providers to recognize that our services are equal in importance to theirs. For instance, we have met resistance in procuring space in the clinics to meet with our clients.

- Leech Lake

Percent of Grantees Citing These Challenges to Effective Programming



Another challenge is that while domestic deaths are lower than when we began the project, gang and youth violence-related dealths on the North Side have increased. This creates a challenge to keeping the focus on domestic violence issues.

-100 Men Take a Stand/Family and Children Services

CREATIVE OR INNOVATIVE ASPECTS OF PROGRAMMING

Grantee working on violence/unintentional injuries listed a number of creative aspects of their programming. One of the common elements cited was that these approaches are generated by community members and utilize community members' own strengths, energy and resources.

> *The most innovative, creative aspect of our program is being able to help people find their OWN strengths and resources; being able to incorporate cultural resources; the ability to provide services to people where it is most convenient for them (including in their homes on a limited basis); and the informal manner in which we are able to work in assisting people on their healing journey in a holistic manner.*
>
> – Leech Lake Behavioral Health

From the use of animal therapy with children who have been impacted by domestic violence and are living in shelters, to an innovative norm campaign being adopted by other communities around the country, EHDI grantees are developing and testing new culturally-based approaches to reducing violence and unintentional injuries in their communities that are becoming models for other communities to adopt.

> *We are getting information requests from other parts of the United States, regarding the Men's Domestic Peace Pledge, the domestic peace action postcard messages, and the Healing Curriculum. All of these items underscore the strength of our work - we translate the idea of engaging men in the prevention of family violence into concrete action steps that can be taken by many people. We know that the pledge has been used in San Francisco and that men from other cultural groups are using it to develop their own domestic peace pledge.*
>
> - Family and Children's Service

USES OF EVALUATION INFORMATION

Grantees used evaluation information to improve their programs to better meet community needs. Some said they would use the information to upgrade existent programs while others said they would develop new services based on the findings. One grantee noted that the findings of the evaluation encouraged them to work to sustain the program developed with EHDI funds as an ongoing program in their community.

> *We will use it to increase the ability of our services to meet the needs of participants AS IDENTIFIED BY THE PARTICIPANTS THEMSELVES.*
>
> *We continue to use information collected in key informant interviews and in the focus groups to evaluate what activities we should maintain, eliminate, or revise.*
>
> *These findings have encouraged me to do the best I can to keep this program ongoing on the White Earth Indian Reservation.*
>
> - White Earth Indian Reservation