RAINBOWRESEARCH Inc.

MINNESOTA'S ELIMINATING HEALTH DISPARITIES INITIATIVE (EHDI)

Report 4: Programmatic Results Achieved by EHDI Grantees

Prepared for

Minnesota Department of Health
Office of Minority and Multicultural Health

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Overview of Series of Reports

This report is the fourth in a series of seven documents detailing the work and accomplishments of the Eliminating Health Disparities Initiative (EHDI) of the Minnesota Department of Health's Office of Minority and Multicultural Health. This report describes the results achieved by EHDI grantees.

In 2001, Minnesota passed landmark legislation to address the persistent and growing problem of disparities in health status between the white population and populations of color and American Indians. Although Minnesota is one of the healthiest states in America, it has some of the greatest disparities in health between racial/ethnic groups. By competitively distributing funds to 52 community organizations, and tribes across the state, Minnesota charged its populations of color and American Indian communities to develop strategies and approaches for eliminating disparities in eight key health areas. A history of the Eliminating Health Disparities Initiative is detailed in the first report of the series (Report #1).

Minnesota's approach to eliminating health disparities, and the work of many of the EHDI grantees are consistent with model program practices identified by national researchers documenting other initiatives addressing health disparities (Report #2). How grantees developed exemplary and innovative program practices and outreach strategies grantees to overcome barriers to reach members of their communities with health promotion programs and messages building on the communities' inherent strengths, values, traditions, institutions and other assets is described with examples (Report #3). These strengths and culturally-based strategies can serve as a model for other states and communities to learn from as they work to address disparities. This report (Report #4) describes the health disparity context in Minnesota, and reviews results being achieved by Minnesota's 52 EHDI grantees. Additional outcomes related to capacity building and community impacts are described in Report #5. Report # 6 provides an in-depth description of a select group of these grantees, and the last document (Report #7) is a catalogue of all grantee programs.

	Report #1:	Minnesota's Eliminating Health Disparities Initiative: Overview and History
	Report #2:	Models and Methods for Identifying Exemplary Program Practices to Eliminate Health Disparities
	Report #3:	Exemplary Program Practices in Action
⇨	**Report #4:**	**Programmatic Results Achieved by Eliminating Health Disparities Initiative Grantees**
	Report #5:	Building Capacities among Individuals, Organizations, Communities and Systems
	Report #6:	Case Studies
	Report #7:	Catalogue of EHDI Programs

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Background of the Eliminating Health Disparities Initiative (EHDI)

Minnesota's Eliminating Health Disparities Initiative (EHDI) is a 10-year effort of the Minnesota Department of Health to address the deeply entrenched health disparities within Minnesota's communities of color. Since 2002, the Minnesota Department of Health's Office of Minority and Multicultural Health has provided funding and technical assistance to 52 community-based organizations and tribes. These grantees work to reduce health disparities in one or more of eight priority areas:

1. Breast and Cervical Cancer
2. Cardiovascular Disease
3. Diabetes
4. HIV/AIDS and Sexually Transmitted Infections
5. Healthy Youth Development
6. Immunization
7. Infant Mortality
8. Unintentional Injury and Violence

Minnesota's EHDI has intentionally chosen a community-based approach to address health disparities. This approach is grounded in the philosophy (substantiated with research) that community issues require community solutions. EHDI exclusively funds and supports organizations and programs working in communities of color and American Indian tribes to develop and implement strategies targeted to their communities. Their work is focused on providing health education, promoting healthy lifestyles and behaviors as well as facilitating access to health care and building community capacity.

Evaluation Overview

The EHDI Exemplary Practices Project is part of the evaluation of the Initiative being coordinated by Rainbow Research Inc. and the Minnesota Department of Health's Office of Minority and Multicultural Health and Center for Health Statistics. This evaluation is designed to:

- Identify effective program practices being used by communities to eliminate health disparities.
- Describe how those practices are being implemented in programs in Minnesota.

- Assess programmatic outcomes of the work of EHDI grantees, and systemic impacts of the EHDI on organizations and communities.

This report addresses the third objective: to document the 2006 outcomes achieved by grantees for each of the eight health priority areas. Background information and grantee strategies are presented for each health priority area as well a snapshot of the collective reach of the grantees and a sampling of outcomes.

Over the six year program history, grantees have also been building their internal capacity to evaluate their work. In this process, grantees first worked within their communities to identify the key outcomes for their programs. Once the outcomes were selected, they developed evaluation plans to measure progress towards the outcomes, identified or developed comparative data and documented their outcomes. This report also describes the evaluation capacities of the grantees.

DATA SOURCES

Three sources of data were used in this report.

1. Annual Evaluation Report

Grantees submit an annual report to the Minnesota Department of Health detailing their program outputs (numbers served), outcomes they selected to work towards, comparative data, challenges encountered, thoughts and recommendations. Forty-six grantees completed reports in 2006.

2. Evaluation Capacity Rating Process

In 2006 grantees were rated on their evaluation capacity. This process identified strengths and weaknesses in the grantees' program evaluations and factors that predicted success. This information was conveyed to grantees, and additional training and technical assistance was provided in 2006. Grantee's annual reports for 2006 were reviewed in 2007 and progress was noted.

3. In-depth Semi-structured Interviews

Hour-long, mostly qualitative interviews were conducted with program coordinators during the summer of 2007. These hour-long interviews allowed the grantees to "tell their story" from their perspective. They described evaluation challenges and successes and shared how they had used their evaluation findings to strengthen programs, leverage resources and communicate results.

LIMITATIONS

As described in the next section, grantees were supported to identify outcomes and indicators that made sense in terms of their community needs and issues. Given the diversity of outcomes addressed by grantees, the different ways outcomes were measured, and the different approaches of working with their target population, aggregating outcomes across grantees was not feasible. This report, therefore, highlights grantee findings that were strongest and most clearly documented.

This report primarily focused on the evaluation findings of the EHDI grantees as reported on their annual evaluation report for 2006. The results for six grantees were not included in this overall summary as they did not enter findings into the standardized reporting system--this primarily applies to some tribal grantees who reported to the State through other mechanisms.

Lastly, statewide data on the status of health disparities is presented as part of the discussion. This is intended to provide context on the nature, size and trends of the disparities in each health disparity area, and is not intended to document statewide impact of the initiative.

ORGANIZING FRAMEWORK

The organizing framework (see Table 1) was generated through a Delphi study of Minnesota experts working in the field of health disparities. (A Delphi study is an iterative poll of experts conducted to achieve consensus on a set of ideas.) In 2005, thirty experts responded to an online survey of what strategies were most important for programs to effectively address health disparities in their communities. The expert panel achieved consensus in two rounds on a list of program values, philosophies, organizing approaches, programmatic strategies, and qualities of effective health disparities programs. This list was validated through a review of the literature on model programs and practices.

EHDI grantees were then assessed to determine whether and how they incorporated these seventeen philosophies and practices. The responses of grantees were reviewed by multi-cultural panels of program managers, researchers, and community members to identify which activities and approaches stood out as exemplary programs practices to address health disparities in community-based program settings. The Delphi study and this programmatic review process are detailed in Report #2 of this series. This report (#4) describes and provides examples of how EHDI grantees achieved and documented programmatic outcomes (Exemplary program practice criterion #10 in Table 1, see next page).

Table 1. EHDI Organizing Framework of 17 Exemplary Program Practice Criteria

A. Exemplary Program Practices in Action	B. Programmatic Results Achieved	C. Capacities Built Among Individuals, Organizations, Communities and Systems
1. The community is involved in authentic ways 2. Programming is data-driven 3. A comprehensive approach is utilized in developing and implementing programming 4. Recruit participants or deliver services in community settings in which community members feel comfortable 5. Trust is established as the foundation for effective services 6. Programming builds upon cultural assets and strengths of community 7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants 8. Staff reflect community being served; and or cultural competence is ensured among those who are delivering services 9. Program model or components are innovative	**10. Program is able to document strong outcomes or results**	11. Leadership and commitment by staff are in evidence 12. Partnerships are essential to support effective programming 13. Funding and resources are available and leveraged to sustain the efforts 14. Staff issues are attended. Training and technical assistance are available for capacity building 15. Capacities are built in the organization and/or community (types other than evaluation) 16. Challenges are confronted 17. Systems change is undertaken

Building Evaluation Capacities in Grantee Organizations & Grantee Requirements

Consistent with its community empowerment philosophy, the Office of Minority and Multicultural Health (OMMH) requires EHDI grantees to identify their program outcomes and to conduct program evaluations based on the outcomes they selected. As specified in their contracts, community grantees are required to conduct an outcome evaluation and report on at least one short-term outcome each year in each health disparity area they are contracted to address. Since 2006, EHDI grantees have also been required to provide a basis of comparison to monitor their progress.

Rainbow Research Inc. (Rainbow) was contracted by the MDH to provide technical assistance, coaching and training to grantees as they develop and implement outcome evaluations of their programs. The majority of evaluation development was accomplished through the one-to-one coaching and technical assistance provided by a Rainbow staff consultant.

In the first phase of the evaluation training (2002-2003) grantees received 15 to 20 hours of technical assistance to develop and implement their evaluations. Since 2006, grantees have received about 5 hours of one-to-one technical assistance per year based on funding availability and need. In addition to the technical assistance, grantees were required to attend one to two full-day evaluation trainings and at least one roundtable or small group training session each year. Rainbow also produced a set of training materials for the grantees.

Two methods were used to assess the evaluation capacity and progress of EHDI grantees—a capacity review by a panel of researchers and a progress assessment by the Rainbow staff consultant assigned to the program.

Participatory and Empowerment Evaluation

In recent years there has been a growing emphasis and adoption of participatory and empowerment evaluation models. Under this approach, the professional evaluation consultant becomes a teacher, coach and advisor to the program and its stakeholders. Instead of the professional evaluator specifying the evaluation, decisions about what to evaluate and how to measure outcomes are shifted to the program staff. Staff and their stakeholders are responsible to develop an evaluation plan, collect and analyze the data and report the findings.

The participatory/empowerment model, by shifting the decision-making and power to program staff and stakeholders, enhances their understanding of why and how the information was produced and increases their confidence in the validity of the results. Ultimately, program staff and stakeholders have a greater commitment to utilizing the evaluation findings and improving their program based on what they learned.

Evaluation Capacity Review Process

In 2006, a panel of ten researchers and evaluators was assembled to conduct a review of the evaluation capacity built by EHDI grantees. Each grantee was rated independently by three members of the panel – two independent reviewers randomly assigned and the Rainbow staff consultant with whom the grantee had been working. The Rainbow staff consultant was included to speak to the grantee's history and organizational context, as well as their engagement in the evaluation capacity building process.

Teams rated each grantee's 2005 annual evaluation report using eight objective criteria. These criteria focused on the outcome results reported by the grantee, and examined their outcome statements, indicators, presentation and interpretation of results. The eight criteria were:

- outcomes state intended beneficiary of change,
- one type of change is documented per outcome,
- outcomes are stated in the present tense,
- outcomes are measurable,
- indicators reflect changes targeted in outcome statement,
- results are consistent with the identified indicators, and
- results are clearly stated in context of the outcomes.

Points were then assigned, and summed. The table below presents the results of that review—24 percent of grantees were rated as having "high" evaluation capacity, 61 percent were rated as "moderate" and 15 percent were rated as having "low" evaluation capacity based on their reports for that year.

Table 2. EHDI Grantee's Evaluation Capacity Scores*

Distribution	Percent of Possible Points --Evaluation Capacity Score (both scores combined) N=51
Low-- 50% or less of possible points	15%
Moderate --51% to 75% of possible points	61%
High --76% to 100% of possible points	24%
Total	100%

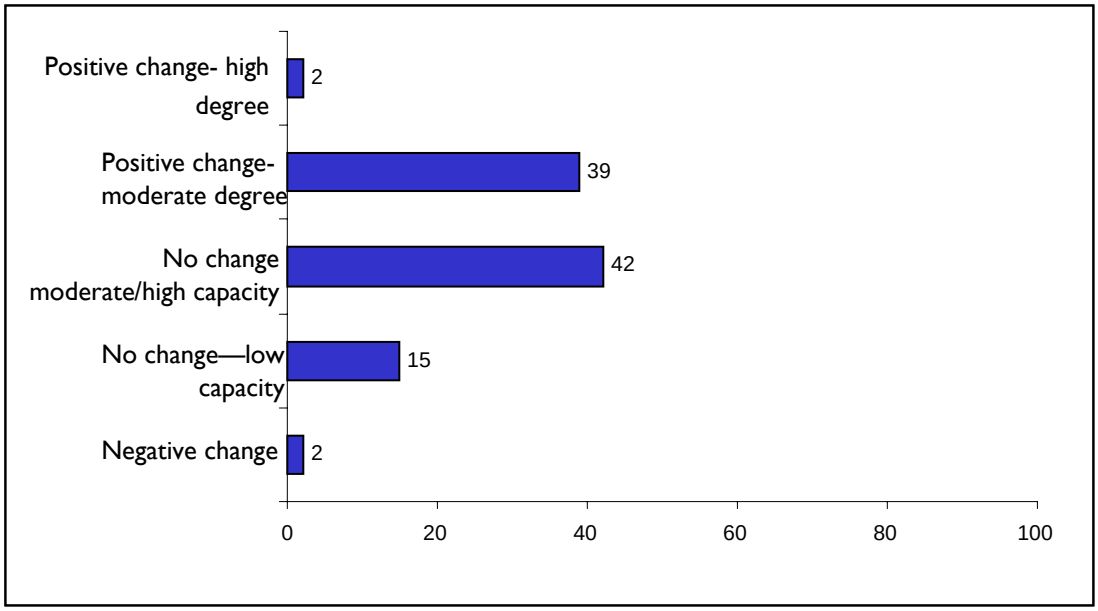
*based on the eight criteria and a review process involving a panel of researchers.

PROGRESS IN BUILDING EVALUATION CAPACITY

At the beginning of the third year of funding (2004), Rainbow staff consultants assessed the evaluation capacity level of their assigned grantees. The assessment was based on the perceived capacity of the grantee to conduct their evaluation—not necessarily what was demonstrated on their formal reports. This rating was repeated again at the beginning of the fifth year (2006). A progress indicator was then developed by comparing these two indicators, capacity at the beginning compared to capacity at the end of this time frame. (There was small group for which this change could not be assessed because their evaluation consultants had changed.)

The progress in evaluation capacity level among grantees across this two year period is shown in Figure 1. About 40 percent of grantees showed improvements in their evaluation capacities over this period of time. This chart shows the "ups and downs" of capacity building. For most the trajectory is upwards, but some factors such as staff turnover in the grantee organization, or problems with data collection in a given year impact the ability of organizations to conduct effective evaluations. Grantees that participated in more training sessions and worked more closely with their evaluation consultant may have been more interested in evaluation or had higher aptitudes in the first place. While Rainbow cannot claim responsibility for all of the grantees' progress in developing evaluation capacities, many grantees likely benefited from the training and technical assistance provided.

Figure 1. EHDI Grantees' Evaluation Capacity Level: Degree of Change from 2004-2006 – Percent of Grantees (Based on Rainbow Consultant Perception).



FACTORS PREDICTING EVALUATION SUCCESS

Through this process of assessing the grantees' evaluation capacity, Rainbow Research identified four factors that were associated with higher levels of evaluation capacity:

- **Engagement with evaluation technical assistance and coaching.** Grantees who engaged with their Rainbow staff consultant, and had several meetings across the period did better on their reporting, as rated by the three person panel. These grantees were motivated and worked hard on improving their evaluations.

- **Participation in evaluation training and workshops.** One of the main factors associated with strong evaluation results was high levels of participation in evaluation training and workshops. Grantees who attended the required trainings and participated in a number of optional workshops on specific topics had strong evaluations.

- **Retention in key grantee staff positions with evaluation responsibilities.** Grantees with high levels of staff turnover tended to perform less well on their evaluation reporting. In some cases this was a critical factor predicting poor performance, and in other cases, it merely meant the difference between a mediocre but acceptable outcome evaluation report and a high quality report.

- **Employment of outside evaluation consultants.** Grantees with paid evaluation consultants tended to engage less in learning and getting involved with evaluation, and therefore built fewer internal capacities. When the paid consultants participated in trainings/workshops or meetings with Rainbow, the reports were more likely to be rated as having met the criteria for acceptability. However, when an outside evaluator was no longer contracted with a project, they often took the grantees' evaluation information with them.

STATEWIDE PORTRAIT: EHDI WORKS TO ADDRESS ALL HEALTH DISPARITY AREAS

In the following pages, the reach and programmatic outcomes of the grantees of the Eliminating Health Disparities Initiative are described. This information is drawn from the annual evaluation reports submitted by each grantee for their work in 2006. This description is intended to provide a "snapshot" of the numbers and types of persons reached by the programs. For each disparity area, examples of grantee efforts and programmatic outcomes documented by grantees are described. These efforts and outcomes are provided as an illustration of the specific results they are achieving.

The information displayed in the Snapshots shows the number of grantees working in each health disparity area, the total number of people reached by their efforts, the general type of intervention, the racial/ethnic breakdown of the populations reached through direct services (defined as one-to-one or groups contact), and the counties of the state in which these services are delivered. The complexity of the initiative—with grantees often working in more than one health disparity area, through a combination of types of interventions—makes providing a simple summary of numbers served challenging.

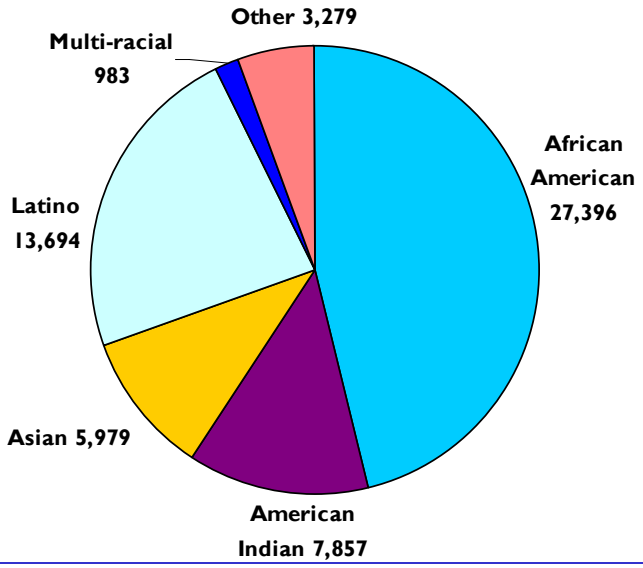
In some cases, numbers are **duplicated**, reflecting the reality that programs often address more than one type of health disparity, and involve participants in several types of interventions, aimed at several health issues. In some cases, the numbers reported are **unduplicated** and reflect aggregated numbers of individuals reached across programs. The unduplicated numbers presented in the following section reflect the most direct and intensive types of services provided—through individual (one-to-one) or group contact, and excludes encounters such as fleeting contacts at large events or through forms of media such as TV, radio, or printed material.

Some background information on the statewide disparities in health status and health outcomes that exist in each area is also presented.[1] It provides the best available data collected by the health monitoring systems in Minnesota. This information is provided as context to better understand the disparities that exist in health status between racial/cultural groups in Minnesota: these are the gaps that the initiative and the grantees are working to close. To document trends, baseline status of disparities from the late 1990's or early 2000's is presented along with more recent data, where available. Care should

[1] This information is drawn from Eliminating Health Disparities Initiative Report to the 2007 Minnesota Legislature, issued January 15, 2007 by the Minnesota Department of Health.

be taken in interpreting these trends, as changes reflect a number of factors, including but not limited to the Eliminating Health Disparities Initiative.

2006 EHDI Snapshot: All Health Priority Areas

Number of EHDI Grantees	**52**
Number of People Reached	**59,188 people reached through contact methods (unduplicated)**
Number of People Reached All Contact Methods (duplicated counts—people may participate in more than one type of intervention, addressing more than one health area)	**Breast and Cervical Cancer: 24,731** **Cardiovascular Disease: 64,782** **Diabetes: 62,261** **Healthy Youth Development: 88,337** **HIV/AIDS and STI's: 59,872** **Immunizations: 29,690** **Infant Mortality: 67,608** **Violence/Unintentional Injury: 40,370**
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Aitkin, Becker, Beltrami, Benton, Brown, Carlton, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Dodge, Goodhue, Hubbard, Isanti, Itasca, Kanabec, Kandiyohi, Koochiching, Lac Qui Parle, Lake, Le Sueur, Mahnomen, Mille Lacs, Mower, Nicollet, Norman, Olmsted, Pennington, Pine, Polk, Red Lake, Redwood, Renville, Rice, Saint Louis, Sherburne, Sibley, Stearns, Steele, Wadena, Waseca, Yellow Medicine

See page 9 for description of issues related to duplicated vs. unduplicated counts

Health Priority Area 1: Breast and Cervical Cancer

Ten EHDI grantees are working to eliminate health disparities in breast and cervical cancer rates in 19 counties throughout Minnesota.

Disparity Status

The portrait of disparities in breast and cervical cancers is complex. For instance, breast cancer incidence rates are higher among white women than among women of color and American Indian women. On the other hand, most groups of women of color and African American women in particular, are more likely to die of breast cancer than white women. These trends are summarized in Table 3, below. This data underscores the importance of screening and early detection--which greatly improves the chances of survival for women with breast cancer.

Table 3. Minnesota Breast and Cervical Cancer Incidence and Death Rates per 100,000 Females by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Breast Cancer Incidence					
1995-1999 Rate	109.7	55.5	70.3	*	137.2
1999-2003 Rate	105.5	89.2	59.4	83.4	136.1
Breast Cancer Deaths					
1995-1999 Rate	38.7	23.2	15.3	*	27.7
1999-2003 Rate	27.7	27.1	8.2	23.5	21.4
Cervical Cancer Incidence					
1995-1999 Rate	21.4	14.2	15.2	*	7.0
1999-2003 Rate	12.6	12.8	12.3	13.4	6.2
Cervical Cancer Deaths					
1995-1999 Rate	5.2	***	11.7	*	1.8
1999-2003 Rate	***	***	5.0	***	1.4

* Data not available *** Numbers too small to report. Source: 2007, MDH

Table 3 also shows the incidence and death rates for cervical cancer between 1999 and 2003. Women of color and American Indian women had nearly double the incidence of cervical cancer compared to white women. However, improvement was seen among all racial/cultural groups for whom data were available. Little data is available to examine for cervical cancer mortality rates, because the numbers of deaths are too few to report for most racial/cultural groups.

GRANTEE STRATEGIES TO ADDRESS BREAST AND CERVICAL CANCER

The EHDI grantees working to reduce the incidence and mortality of breast and cervical cancer have developed strategies that build on the strengths, cultural values, assets and social networks within their communities. Below are examples of strategies being employed by EHDI grantees to eliminate the disparities in breast and cervical cancer.

- Grantees are conducting large-scale and varied **health education campaigns** aimed at getting the word out to women about breast and cervical cancer; emphasizing the importance of early screening; and where applicable, promoting proven prevention strategies (e.g., vaccine for HPV). This health education and outreach is occurring at health fairs and other community events, in churches and other religious institutions, at powwows, through schools, beauty salons, at clinics and through health care providers.

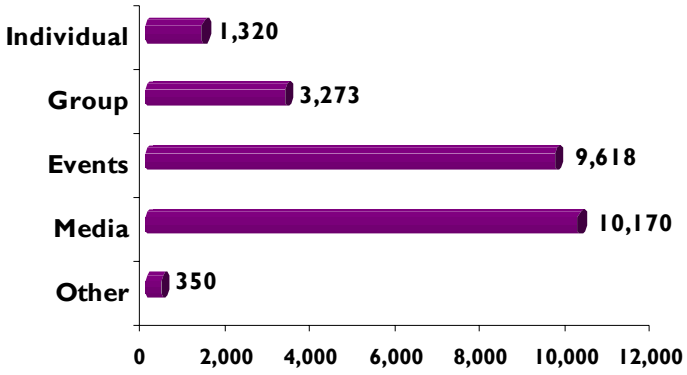
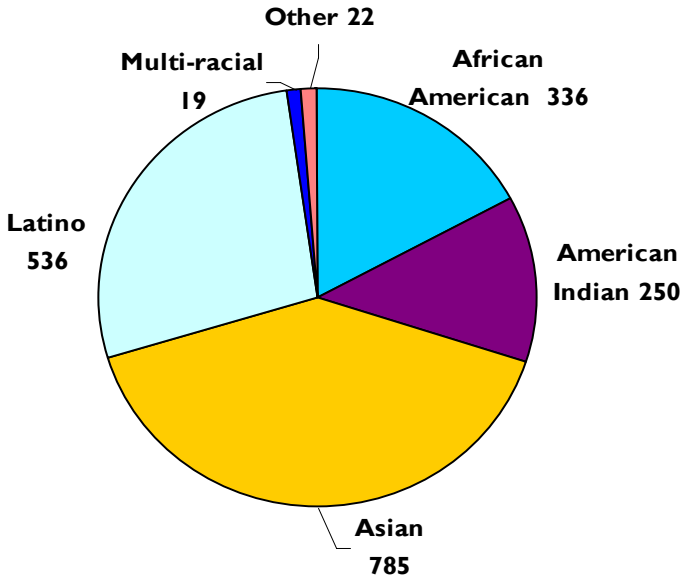
- Another strategy of the grantees is to make **screening referrals** to health care providers. Getting women in for mammograms and pap smears is a critical first step in the detection of cancer. Often times, grantees assist clients in their application for insurance/Medicaid coverage or help them to find low-cost or sliding fee scale screening services. The grantees also accompany women to screening, provide support as well as transportation, and then follow-up to ensure they receive and understand the screening results.

- If a woman is diagnosed with cancer, a number of grantees connect women and their families with sources **of informational, emotional, logistical and physical support**. They provide assistance to navigate the health care system, advocate on their behalf and help women make decisions about treatment options. In short, they support women to overcome a plethora of barriers and walk with them through their healing journey.

- Some grantees help community members access traditional healers and ceremonies or encourage women to seek **spiritual resources** and/or family support.

The statistics conveyed in the Snapshot on the next page summarize the efforts of the ten grantees working in this area in 2006. Their combined efforts reached nearly 25,000 people across 23 counties. Grantees used a variety of outreach strategies such as community events, launching media campaigns and disseminating messages through print media, TV, radio, CD's or DVD's or the internet. Over 4,500 people were reached through one-to-one contact and/or small group sessions.

2006 EHDI SNAPSHOT: BREAST & CERVICAL CANCER

Number of EHDI Grantees Working in Health Area	**10 (20 percent of total)**
Number of People Reached	**24,731 (duplicated)**
24,731 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Benton, Dodge, Koochiching, Le Sueur, Mower, Pine, Rice, Saint Louis, Sherburne, Stearns, Steele, Waseca

See page 9 for description of issues related to duplicated vs. unduplicated counts

SELECTED OUTCOMES: BREAST & CERVICAL CANCER

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge / Awareness	3	Increased knowledge of symptoms, risk factors and prevention methods
Health Care Access / Utilization	3	Increased numbers of women receiving pap smears and mammograms
Attitude, Feelings or Intentions	1	Changed feelings about cultural traditions

SPOTLIGHT ON RESULTS

- **Stairstep Foundation's** faith-based initiative works with congregations in North Minneapolis to raise awareness of health issues. According to their 2006 Church Health Survey of 553 women over age 35, 62 percent reported completing a mammogram—an increase of 9 percent over 2005.

- **St. Mary's Health Clinics** works with Latino parishes to provide culturally appropriate health care education and health screenings. From January 1 to November 15, 2006, 323 Latinas received a pap smear and 126 Latinas received a mammogram, a 75 percent and 73 percent respective increase in numbers served over the previous year.

- **Vietnamese Social Services of Minnesota** provides education and screening services to Vietnamese women in the Twin Cities area. In 2006, 300 women completed a breast cancer screen and 257 women were screened for cervical cancer—almost double the number of women screened in 2005. In addition, 96 percent of the participants (58) reported an understanding of why and how often to get pap, pelvic and breast examinations.

- **Indian Health Board of Minneapolis:** The Community Wellness Project of Indian Health Board works to educate American Indian Women. At the initial assessment, 12 of 21 American Indian women could define a mammogram and knew the recommended screening scheduling. After the project all 21 of the 21 participants could do so.

HEALTH PRIORITY AREA 2: Cardiovascular Disease in Minnesota

In 2006, eleven EHDI grantees worked in 29 Minnesota counties to improve rates of cardiovascular disease among communities of color.

DISPARITY STATUS

Cardiovascular disease is a leading cause of death in the American Indian community, and the second leading cause of death among African Americans, Asians and Latinos. The disparities in death rates are particularly pronounced for African Americans and for American Indians compared to whites, as shown in Table 4 below. Across the time frame, as the data in Table 4 show, there were major reductions in cardiovascular death rates for all groups. The disparities between the mortality rates for the populations of color and white groups narrowed, although death rates due to cardiovascular disease among American Indians remains a third higher than for whites. The reductions in death rates are likely due to earlier detection of heart disease through screening, widespread use of drugs to address risk factors such as cholesterol, high blood pressure, and co-occurrence of diabetes, as well as an increase in exercise and healthier eating among many groups.

Table 4. Minnesota Cardiovascular Disease Death* Rates per 100,000 Population by Race/Ethnicity.

	African American	American Indian	Asian	Latino	White
Cardiovascular Disease Deaths					
1995-1999 Rate	221.6	263.3	112.4	155.5	205.7
1999-2004 Rate	159.4	239.7	71.4	107.8	160.8

*Age-adjusted death rates

Source: 2007, MDH

GRANTEE STRATEGIES TO ADDRESS CARDIOVASCULAR DISEASE

These following examples reflect the types of strategies used by the twelve EHDI grantees working in their communities to reduce cardiovascular disease:

- Offering blood pressure, cholesterol and blood glucose **screening** at a wide range of community events and at community institutions such as beauty/barber shops, churches, mosques, coffee shops/cafes and through outreach to people in their homes.

- **Training of Community Health Workers and using parish nurses**, or other partners to reach out to the community, conduct screenings and provide education about risk factors and prevention of cardiovascular disease through diet and exercise.

- **Making exercise safer and more accessible** by opening community fitness centers in communities that hadn't had such resources such as at the Bois Forte Community and the Prairie Island community. Some grantees offer subsidies to help low-income community members join the YMCA or YWCA in their community.

- Developing fun, linguistically supportive and culturally relevant opportunities for community groups to engage in **fitness activities** such as: exercise classes for Southeast Asian elders, soccer leagues or dance classes for Latino families in rural Minnesota, organizing walking clubs for African Americans in Minneapolis and taking urban American Indian youth on canoe and camping trips.

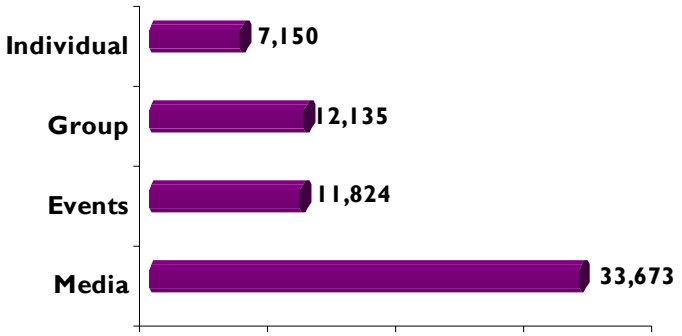
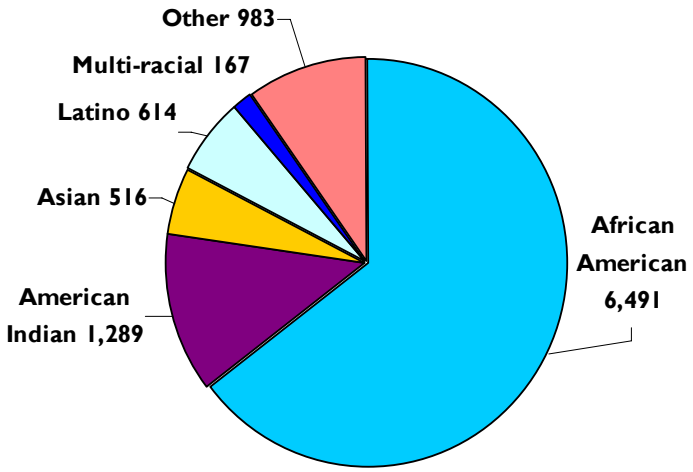
- **Teaching people how to handle stress** in healthy ways such as exercise, improving communication and relationship skills, asking for help when needed and getting involved in spiritual ceremonies and activities.

- **Educating communities about healthy diets** through nutrition education, cooking classes, and by offering healthy fare at feasts and community events.

Nearly 65,000 members of communities of color and American Indian communities were reached by one or more of these activities. Over 19,000 people were reached directly through one-to-one contact or small group sessions in 2006. More than 10,000 people were reached at large group events while media was used to reach an estimated 33,000 people.

The outcomes targeted by EHDI grantees reflect the priorities set by the programs and community members involved in planning and evaluation. Various grantees determined their priorities as: promoting knowledge and awareness of cardiovascular disease—its risk factors, prevention methods, symptoms and screening. One grantee specifically focused on lowering blood pressure levels among participants.

2006 EHDI SNAPSHOT: CARDIOVASCULAR DISEASE

Number of EHDI Grantees Working in Health Area	**11 (22 percent of total)**
Number of People Reached	**64,782 (duplicated)**
64,782 of People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Aitkin, Brown, Carlton, Chippewa, Chisago, Cook, Isanti, Itasca, Kanabec, Koochiching, Lac Qui Parle, Lake, Le Sueur, Mille Lacs, Nicollet, Olmsted, Pine, Redwood, Renville, Saint Louis, Sibley, Yellow Medicine

See page 9 for description of issues related to duplicated vs. unduplicated counts

SELECTED OUTCOMES: CARDIOVASCULAR DISEASE

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge / Awareness	7	Increased knowledge of symptoms, risk factors and prevention methods
Behavior	5	Increased physical activity and improved nutritional intake
Health Care Access/ Utilization	3	Increased numbers of blood pressure screenings
Health Status	2	Lowered blood pressure
Attitude, Feelings or Intentions	1	Changed feelings about cultural traditions

SPOTLIGHT ON RESULTS

- **Bois Forte Band of Chippewa** provides cardiovascular screenings and education to tribal members. In 2006, 42 teens received body composition screenings, a 47 percent increase over 2005.

- **Fremont Community Health Services** trained two peer educators to provide stroke prevention education to North Minneapolis African Americans. Both peer educators became proficient in understanding stroke risk factors, knowledge of healthy lifestyles, and in taking blood pressures. The fifty participants that received a "full screening" from a nurse and health education from the peer educators increased their knowledge of stroke risk factors by an average of 50 percent from pre to post-test.

- **Grand Portage Band of Ojibwe** screens tribal members for diabetes and cardiovascular disease. In 2006, 271 people received blood sugar and blood pressure screenings, a 64 percent increase over 2005. Thirty-five were referred for further testing, of which seven received treatment for either diabetes or cardiovascular disease

HEALTH PRIORITY AREA 3: Diabetes

Sixteen grantees are working in 34 Minnesota counties to eliminate disparities in diabetes.

DISPARITY STATUS

As Table 5 shows, in 1995-1999 (the baseline rates), American Indians had diabetes mortality rates that were five times higher than white Minnesotans. Likewise, African Americans were three times as likely to die from diabetes compared to whites. The data presented here from the Minnesota Department of Health's 2007 Legislative Report only reflects deaths due to diabetes. Diabetes morbidity and its complications and costs are also greatly overrepresented in communities of color. The data in Table 5 show that death rates have declined between the baseline period and the most recent period for which data were available (2000-2004), for African Americans and American Indians, but stayed essentially the same for Latinos, Asians and whites. The disparities between American Indians and African Americans and whites narrowed slightly but are still quite large.

Table 5. Diabetes Death Rates* per 100,000 Population by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Deaths					
1995-1999 Rate	59.7	108.8	21.1	37.7	22.3
2000-2004 Rate	54.6	86.5	22.5	37.5	23.3

** Age-adjusted death rates

Source: 2007, MDH

GRANTEE STRATEGIES TO ADDRESS DIABETES

Grantees developed multiple diabetes intervention strategies that build on the strengths and assets of their communities. Most of the EHDI grantees are working to prevent the onset of diabetes while a few grantees are working directly with diabetics to better manage their disease. Many grantees working in the area of diabetes are also addressing cardiovascular risk given the common risk factors and prevention strategies. Following are examples of strategies being employed by the 16 EHDI grantees working to eliminate health disparities in diabetes:

- Blood glucose screenings are offered by a number of grantees, on site in their offices and in convenient community locations.

- Some programs work with participants living with diabetes providing **one-to-one counseling and education for the self-monitoring** of the disease. The workers encourage the diabetic participant to see their health care provider, regularly monitor their blood glucose levels and review the logs of their readings with them.

- Many grantees are providing **nutrition education** to community members. The education teaches both the basics of healthy diets as well as how to prepare healthy foods.

- Several grantees are providing participants with opportunities for fun, healthy **exercise**. Grantees help participants get active by providing no-cost, low-cost memberships in fitness centers and/or providing personal trainers, classes, and fitness challenges.

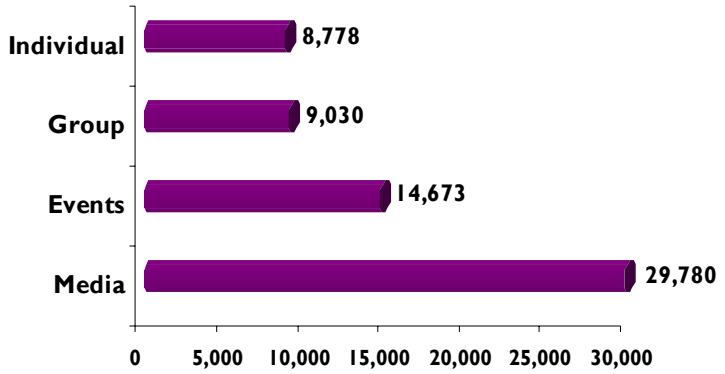
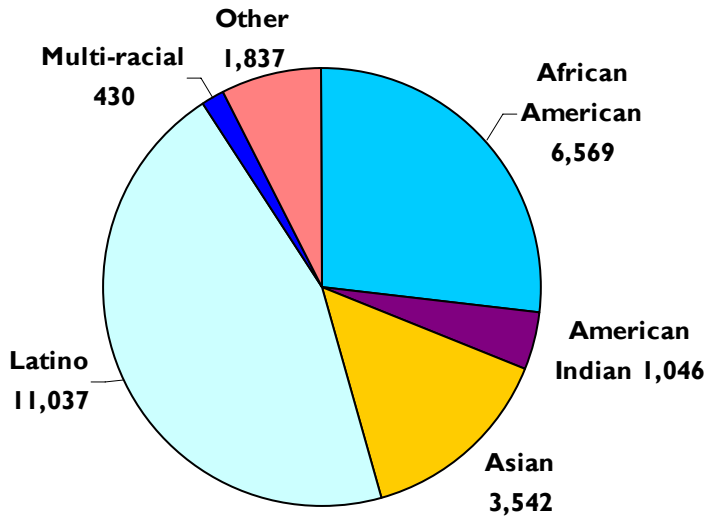
- Many grantees use community health workers or parish nurses to make **home visits** or set up visits in other comfortable settings. These visits typically involve blood sugar screenings, education and counseling on nutrition.

- Some grantees are using other types of **media** to reach their communities about diabetes prevention and control. Two grantees have produced CD's and DVD's on diabetes in the language of their participants—Hmong and Cambodian. These CD's/DVD's are given to participants to view at home and share with family members. One grantee has developed an interactive website aimed at Hmong youth to educate them about diabetes prevention, and through the youth, also reach the parents.

- One grantee is working with their community to promote **access to fresh local produce** and organic meats and vegetables. They are also teaching their youth about foods in the traditional diet and how these traditional diets are healthy and naturally prevent diabetes.

The statistics conveyed in the Snapshot on the next page summarize the efforts of the ten grantees working in this area in 2006. Cumulatively they reached over 60,000 people—by working one-to-one or in group settings, by holding and participating in large community events and by disseminating messages through print media, TV, radio, CD's, DVD's, or the internet. Approximately 18,000 persons were reached through direct methods of contact involving one-to-one contact or group sessions. The outcomes they were working to achieve included increase in knowledge about factors contributing to diabetes, how to prevent diabetes, change in nutritional habits and exercise behaviors, increase in health care utilization and compliance, attitude changes, and actual change in health status (lowered blood glucose levels).

2006 EHDI SNAPSHOT: DIABETES

Number of EHDI Grantees Working in Health Area	**16 (31 percent of total)**
Number of People Reached	**62,261 (duplicated)**
62,261 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington, **Outstate:** Aitkin, Becker, Brown, Carlton, Chippewa, Chisago, Cook, Dodge, Isanti, Kanabec, Lac Qui Parle, Lake, Le Sueur, Mahnomen, Mille Lacs, Mower, Nicollet, Olmsted, Pine, Redwood, Renville, Rice, Saint Louis, Sibley, Steele, Waseca, Yellow Medicine

See page 9 for description of issues related to duplicated vs. unduplicated counts

SELECTED OUTCOMES: DIABETES

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge / Awareness	7	Increased knowledge of symptoms, risk factors and prevention methods
Behavior	6	Increased physical activity and improved nutritional intake
Health Care Access/ Utilization	2	Increased numbers of diabetics who are continuing to receive follow-up care
Health Status	2	Decrease in HgbA1c levels
Attitude, Feelings or Intentions	2	Increased intentions to stop smoking

SPOTLIGHT ON RESULTS

- **Center for Asian and Pacific Islanders** helps new Asian immigrants navigate the health care system. In 2006, they enrolled 47 individuals in MinnesotaCare and connected 234 people to a primary care clinic--a 58 percent increase over previous years. In addition, 80 percent of their clients reported a better understanding of the medical system because of the program.

- **Dar Al-Hijrah** provides culturally and linguistically appropriate diabetes education and screenings to the Somali community. In 2006, each of their 81 participants reported receiving regular blood sugar level checks and 53 (65 percent) were aware that obesity can lead to diabetes.

- **Westside Community Health Services** provides diabetes education and health care to the Hmong and Latino communities in the Twin Cities. After receipt of clinical care, education and follow-up, 100 patients decreased their HgbA1c levels an average of 1.3 points.

- **Grand Portage Band of Ojibwe** offered a walking competition. Teams were formed in the community with each team logging the number of miles walked for a 6 week period of time. The team that logged the most miles won. All other teams received recognition for participating. A total of 11,643 miles were logged by 130 participants in the community.

HEALTH PRIORITY AREA 4: Healthy Youth Development

Nineteen grantees are working in 31 Minnesota counties to promote healthy youth development among youth of color and American Indian youth.

DISPARITY STATUS

As Table 6 shows, in 1997-1999 (the baseline rates), young African American, Latina and American Indian females ages 15 to 19 were four or more times as likely to experience a pregnancy as were young white females, while young females of Asian heritage were more than twice as likely to experience a pregnancy as young white females. The teen pregnancy rates in all groups declined between the baseline period (1997-1999) and the subsequent period (2002-2004), but the large disparities between racial/cultural groups remained.

Table 6. Minnesota Pregnancy Rates per 1,000 Females Ages 15-19 by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Pregnancy Rates of Females Ages 15-19					
1997-1999 Rate	174.4	120.6	87.8	151.8	32.2
2002-2004 Rate	121.0	114.4	64.2	130.1	25.0

Source: 2007, MDH

GRANTEE STRATEGIES TO ADDRESS HEALTHY YOUTH DEVELOPMENT

The grantees are promoting healthy youth development using a variety of approaches. While the outcome being monitored is teen pregnancies, grantees work to support youth and expose them to new skills, ideas, contexts and environments that help them think about and plan for their futures. Many of the EHDI programs working to promote healthy youth development also work in other disparity areas, such as prevention of HIV/AIDS and sexually transmitted infections or diabetes prevention. Following are some strategies illustrative of those used by the EHDI grantees:

- Youth are given **assistance to achieve in school**, through tutoring and homework help and encouraged to think about higher education by visiting college campuses and getting assistance with preparing for college tests.

- A number of programs provide youth with **camping and wilderness experiences**, many of whom had a few such opportunities.

- EHDI programs are helping youth **learn life skills** in, for example, the areas of budgeting and financial literacy, meal preparation and job hunting as well as many other areas of knowledge and experience that youth may not be exposed to elsewhere.

- Social relationships are emphasized in a number of programs, such as involving youth in **positive peer networks**, engaging them as peer educators and connecting youth to positive and caring adult role models.

- Many programs provide **fun "alternative" activities** for youth. These alternative activities keep youth occupied and out of substance use, sexual behavior and gang involvement. They take youth bowling, fishing, to sports events, dances and more. Several programs have strong arts components that expose youth to theater, music, dance, poetry and other creative writing activities.

- Several programs work to **build confidence and self-esteem** among youth and instill a sense of cultural pride and awareness of their heritage. These program elements are typically part of a comprehensive program designed to help youth make good decisions and build a productive future.

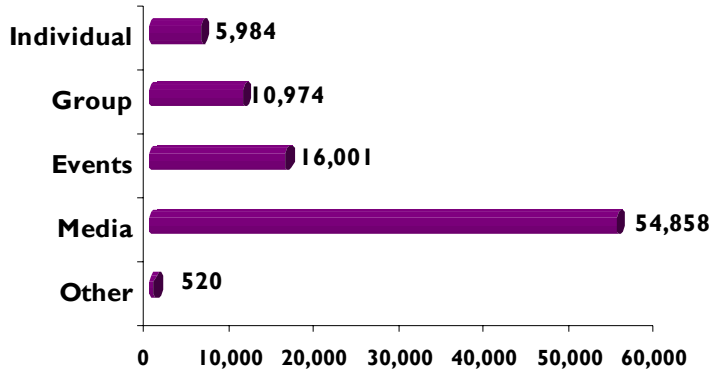
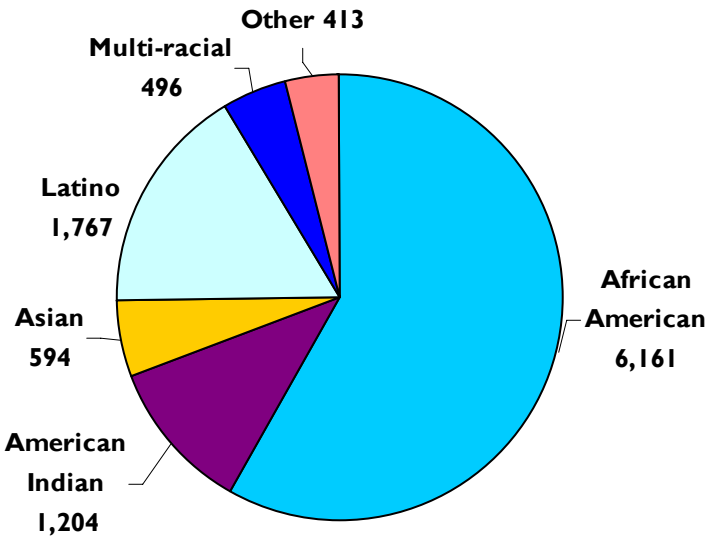
- Some programs involve **community service or service-learning projects** to get youth involved in community development work where they gain a sense of accomplishment and learn they can make a difference in their community.

- A number of EHDI programs are involving parents and other family members with the youth to develop and foster **communication between the generations**, and to provide support to parents to talk to their children about sexuality, alcohol, drugs and other risky behaviors.

The statistics conveyed in the Snapshot on the next page summarize the efforts of the grantees working in this area in 2006. Collectively they reached over 80,000 people across 30 counties. The grantees reached about 6,000 people through one-to-one contact and nearly 11,000 in group settings. Just fewer than 72,000 people were reached through large community events, and media (print media, TV, radio, CD's or DVD's or the internet).

Examples of programmatic outcomes of grantees working to promote healthy youth development are highlighted on the pages which follow:

2006 EHDI SNAPSHOT: HEALTHY YOUTH DEVELOPMENT

Number of EHDI Grantees Working in Health Area	**19 (37 percent of total)**
Number of People Reached	**88,337 (duplicated)**
88,337 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington, **Outstate:** Aitkin, Becker, Beltrami, Brown, Carlton, Cass, Chippewa, Chisago, Cook, Isanti, Kanabec, Kandiyohi, Lac Qui Parle, Lake, Le Sueur, Mille Lacs, Nicollet, Pine, Redwood, Renville, Saint Louis, Sibley, Yellow Medicine

See page 9 for description of issues related to duplicated vs. unduplicated counts

SELECTED OUTCOMES: HEALTHY YOUTH DEVELOPMENT

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge / Awareness	12	Increased knowledge and understanding of risks of tobacco, alcohol, drugs and unprotected sex
Behavior	7	Decreased teen sexual behaviors that may lead to pregnancy or STI's
Attitude, Feelings or Intentions	3	Increased self-esteem
Health Care Access/ Utilization	1	Increased use of school-based clinic

SPOTLIGHT ON RESULTS

- **Camphor Foundation's** UJIMA program is a faith-based community collaboration working to prevent teen pregnancy and foster healthy behaviors among African American youth. Ninety-four teens (80 percent) participating in the UJIMA program gained knowledge about the risks and consequences of sexual activity. Among the teens served, there were no reported unplanned pregnancies compared to 3 pregnancies among teens in the comparison group.

- **Lao Family Community of Minnesota** targets their teen pregnancy prevention program to Hmong teens, in particular Hmong teenagers who are already pregnant or parenting. As a result of their program, twenty young Hmong teens (100 percent) remained in school through their pregnancy and returned to school after giving birth. In addition, none of the 73 Hmong case-management and support-group participants experienced a second pregnancy.

- **Children's Hospitals and Clinics** provides a six-week class to English Language Learners (ELL) at Edison High School. The 64 student participants demonstrated increased knowledge about healthy relationships and access to health services.

HEALTH PRIORITY AREA 5: HIV/AIDS and Sexually Transmitted Infections

Nine grantees are working in 16 Minnesota counties to eliminate disparities in HIV/AIDS and sexually transmitted infections (STI's).

DISPARITY STATUS

As Table 7 shows, the rate of new HIV infections detected in year 2000 (the baseline) among African Americans was 54.2 per 100,000—almost 20 times as high as the comparable rate for the white population. The rate for new HIV infections was also disproportionately high for Latinos (21.6 per 100,000) and for American Indians (11.1 per 100,000), compared to whites. The rate for HIV infections worsened for African Americans and for whites across this five-year period but improved for American Indians and Latinos.

Table 7. New HIV, Chlamydia and Gonorrhea Infection* Rates per 100,000 Population by Race/Ethnicity in Minnesota

	African American	American Indian	Asian	Latino	White
New HIV Infections					
2000 Rate	54.2	11.1	3.0	21.6	2.8
2005 Rate	56.2	3.7	1.8	16.0	3.7
Chlamydia					
2000 Rate	1769	540	314	652	73
2005 Rate	1535	512	282	624	115
Gonorrhea					
2000 Rate	1149	123	34	135	18
2005 Rate	775	118	31	85	23

*HIV or AIDS at first diagnosis Source: 2007, MDH

Chlamydia and gonorrhea are two other types of sexually transmitted infections tracked by the Minnesota Department of Health. The rates per 100,000 persons are also shown in Table 7. Like HIV/AIDS, large disparities exist between populations of color and American Indians and the white population for these sexually transmitted infections. The rates of both are highest among African Americans--with rates 33 times higher than the white population. Although the rates of new chlamydia and gonorrhea infections declined for all populations except whites between 2000 and 2005, large disparities remain between racial groups.

GRANTEE STRATEGIES TO ADDRESS HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS

EHDI grantees are working within their communities to prevent the transmission of HIV/AIDS and other sexually transmitted infections. The following are examples of what they are doing:

- Most grantees are working in some fashion to **educate community members** about HIV/AIDS and other STI's, the modes of transmission, risk factors, strategies for effective prevention and the importance of getting tested. For some grantees this is done mostly on a one-to-one basis in an office or clinical setting. Others provide education to groups of youth participating in programs, or to community groups such as congregations, worksites for migrant workers and prison populations. Some grantees also have a street outreach component.

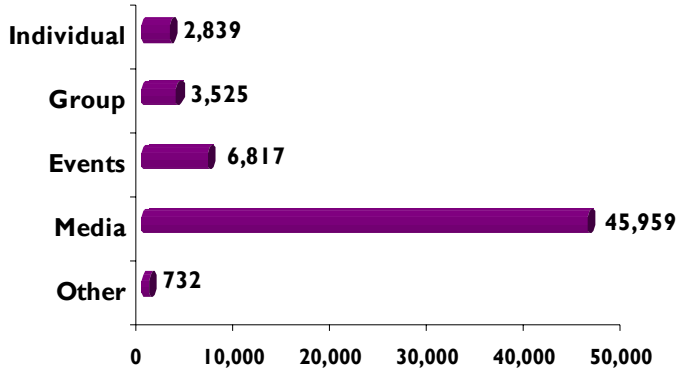
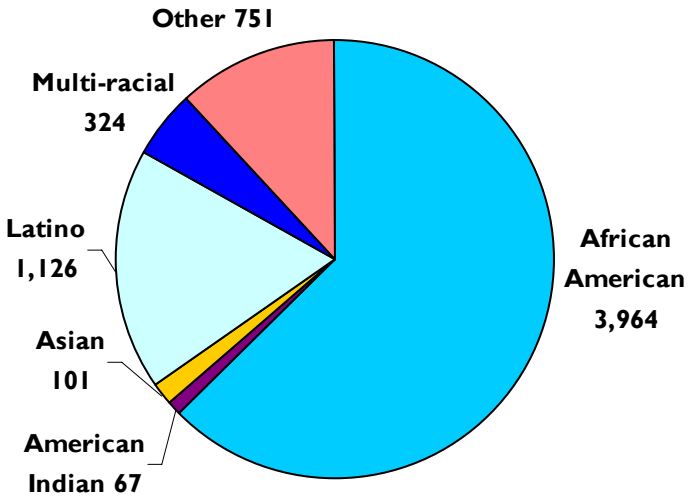
- Several EHDI grantees work with persons who test positive for HIV/AIDS, and help them to **connect to other resources** such as health care, housing, employment, health care insurance, and case management services. They also teach this population how to prevent transmission of the disease to others.

- **Community health workers and peer educators are trained** and supported by a number of EHDI grantees to spread the word about the risks related to HIV/AIDS and other STI's and to provide information about prevention strategies and testing.

- EHDI programs **employ staff members who understand the culture**, language and relationship dynamics of their target communities. This helps them overcome barriers of trust and deliver effective prevention messages.

The statistics conveyed in the Snapshot on the following page summarize the efforts of the nine grantees working in this area in 2006. Together their efforts reached almost 60,000 people in 16 counties. Over 6,000 people were reached directly through one-to-one contact or group sessions. Most grantees were focusing on promoting awareness and knowledge change, one documented outcomes in behavior change, and one documented intentions to change behavior.

2006 EHDI SNAPSHOT: HIV/AIDS AND STI'S

Number of EHDI Grantees Working in Health Area	**9 (18 percent of total)**
Number of People Reached	**59,872 (duplicated)**
59,872 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Chisago, Dodge, Le Sueur, Mower, Redwood, Renville, Rice, Steele, Waseca

See page 9 for description of issues related to duplicated vs. unduplicated counts.

SELECTED OUTCOMES: HIV/AIDS AND STI'S

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge / Awareness	7	Increased knowledge of symptoms, risk factors and prevention methods.
Behavior	1	Participants practice safe sex or abstain from sex.
Attitude, Feelings or Intentions	1	Participants intend to use safe sex practices or abstain from sex.

SPOTLIGHT ON RESULTS

- **African American AIDS Task Force** provides one-to-one counseling to high risk individuals. In 2006, 212 people (43 percent) reported learning something new about HIV/AIDS and intend to change their behavior based on what they learned.
- **Centro Campesino** provided workshops about HIV/AIDS and STI's to migrant Latino workers in southern Minnesota. After attending the workshop, 100% (18) of the participants reported an increased understanding about how to prevent HIV/AIDS and STI's.
- **Turning Point** provides HIV/STI education to African Americans and African born immigrants in the Twin Cities metro area. A random sample of pre and post tests verified that most of their participants (500 total) who scored 80 percent or below on the pretest, improved their scores to between 95 and 100 percent on the posttest.

HEALTH PRIORITY AREA 6: Immunizations

Seven grantees are working in 15 Minnesota counties to eliminate disparities in immunizations between their target communities and the majority (white) population.

DISPARITY STATUS

Table 8 presents the percent of each population group that was up-to-date on all required immunizations at 17 months of age. Eighty one percent of white children were up-to-date on their immunizations as compared to 71 percent of American Indian children, 66 percent of Latino children, 65 percent of Asian children and 61 percent of African American children. The disparity row in Table 8 shows differences between each respective racial/ethnic group and whites in the proportion of children with up to date immunizations, and the target row reflects for each respective ethnic/racial the percent set as the state's immunization targets for 2010 (2000-01 rate + half the rate of disparity).

Table 8. Percent Up-to-date for Primary Series Immunization Levels at 17 Months of Age by Race/Ethnicity in Minnesota

	African American	American Indian	Asian	Latino	White
2000-01 Percent	61	71	65	66	81
Disparity*	20	10	15	15	N/A
Target**	71	76	73	74	N/A

*Disparity= Population of color rate – white rate
**Target = (disparity x .50) + 2000-01 rate
N/A: not applicable-- index group

Source: 2007, MDH

GRANTEE STRATEGIES TO ADDRESS IMMUNIZATIONS

EHDI grantees are working to ensure both children and at-risk adults receive recommended immunizations. Most of the seven grantees working to promote immunizations are also working in other health priority areas such as infant mortality. Almost all have targeted their efforts towards immigrant groups. Grantees reported the following strategies:

- Many EHDI programs work with parents to ensure their **children and infants receive the required immunizations** on schedule or are immunized prior to starting school. They reach families through workshops, one-to-one support and outreach, case management and through broad-based education and media campaigns.

- Grantees **educate participants,** in their native languages, about the importance of immunizations. They educate their communities through community health workers, workshops, radio messages and events.

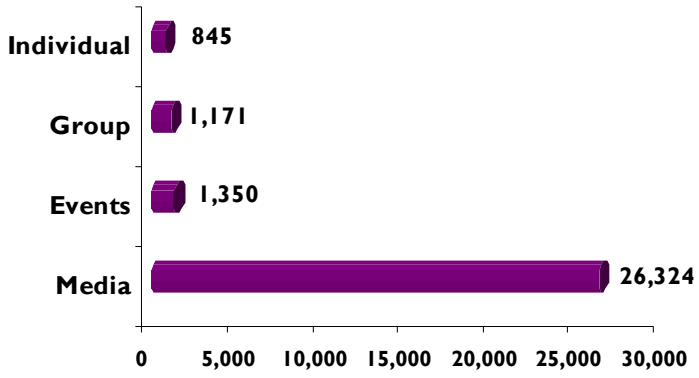
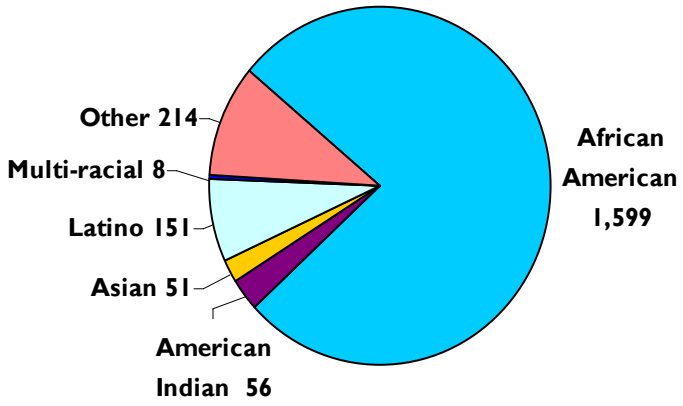
- One grantee provides an **incentive card** to participants who complete their series of immunizations.

- Several grantees offer **free vaccinations** through partnering clinics, referrals to clinics for vaccinations or offer vaccinations as part of other preventative health services (e.g. well-child visits).

The statistics conveyed in the Snapshot on the following page summarize the efforts of the seven grantees working in this area in 2006. In total, nearly 30,000 people in 13 counties were reached by their efforts with over 2,000 reached through one-to-one contact and/or small group sessions.

On the following pages are highlighted examples of programmatic outcomes of grantees working to promote immunizations. Three grantees were either able to document an increase in the number of immunizations administered, or by helping participants obtain insurance through which they are eligible for immunizations. Two grantees educated parents/families about the need for immunizations and for accurate record keeping about immunizations.

2006 EHDI SNAPSHOT: IMMUNIZATIONS

Number of EHDI Grantees Working in Health Area	**7 (14 percent of total)**
Number of People Reached	**29,690 (duplicated)**
29,690 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Chisago, Dodge, LeSueur, Mower, Olmsted, Rice, Steele, Waseca

SELECTED OUTCOMES: IMMUNIZATIONS

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Health Care Access/ Utilization	3	Increased number of people immunized and increased number of people with insurance
Knowledge / Awareness	2	Increased knowledge of the importance of immunizations and accurate recordkeeping

SPOTLIGHT ON RESULTS

- **Council on Crime and Justice** provides an educational program about immunizations to prison inmates. The 103 participants increased their post-test scores an average of 3.2 percent—demonstrating more understanding about the importance of immunizations.
- **Olmsted County Public Health Services** provided information to parents in the Rochester community about immunization schedules and how to access immunizations for their children. Between June and September 2006, 95 percent of the 1213 students behind on their immunizations, received the necessary immunizations that allowed them to attend school.
- **The Storefront Group** educated Somali families about the importance of immunizations. As a result of their program, 146 (91 percent) participants reported gaining a better understanding of the importance of keeping immunization records.

HEALTH PRIORITY AREA 7: Infant Mortality

Ten grantees are working in 12 Minnesota counties to eliminate disparities in infant mortality between their communities and the majority (white) population.

DISPARITY STATUS

Table 9 presents the infant mortality rates per 1,000 births for each racial/ethnic group in the years 1995-99 and 2000-2004. The infant mortality rate baseline measurement (years 1995-99) for whites was 5.5 per 100,000. American Indian and African American infants were more than twice as likely to die within the first year of birth as were white infants (respectively 13.5 and 13.2 vs. 5.5 infant deaths per 1,000 births).

Using these rates, targets were set to reduce the disparities by 50 percent of the difference between each group and the white baseline rate (1995-99). Between 1995-99 and 2000-04, infant mortality rates declined in every group. The targets were achieved for Asians and Latinos and the African American and American Indian rates came close to the targets.

Table 9. Minnesota infant mortality rates per 1,000 births by race/ethnicity

	African American	American Indian	Asian	Latino	White
Infant Mortality Rates					
1995-99	13.2	13.5	7.1	7.0	5.5
2000-04	9.5	10.2	5.0	5.3	4.8
Target**	9.4	9.5	6.3	6.3	N/A

**disparity= 1995-99 Population of color rate – white rate Source: 2007, MDH
Target = 1995-99 rate - (disparity x .50)
N/A: not applicable-index group

GRANTEE STRATEGIES TO ADDRESS INFANT MORTALITY

Of the ten grantees working to reduce infant mortality, six were working in American Indian communities--both urban and tribal. Two grantees worked in the urban Latino community, one worked in the urban African American community and one targeted the urban Hmong community. Their strategies were similar:

- Four programs offer **doula services**. Doulas are women with special training to provide peer-support and guidance to women through the

pregnancy, birthing process and up to a year afterwards. Three of these programs target American Indians while one program serves Latinas.

- Nearly all of the programs offer **pre and post-natal one-to-one care and home-visits**. At these visits, families are helped to prepare for the birth, learn what to expect at the delivery and also learn how to care for their infant postpartum. Many grantees also offer culturally-tailored childbirth classes for the women.

- A number of the programs have developed **automatic referral services** to ensure that newly pregnant women receive prenatal care in the first trimester. Many of these programs work to educate women about the dangers of smoking, alcohol and drug use during pregnancy.

- Most programs **encourage and promote breast-feeding** in their education sessions and provide support through one-on-one counseling and by providing pumps. One program developed a video about breast-feeding in Hmong and English to promote breast feeding among new Hmong arrivals and younger generations, which is now being used by WIC programs.

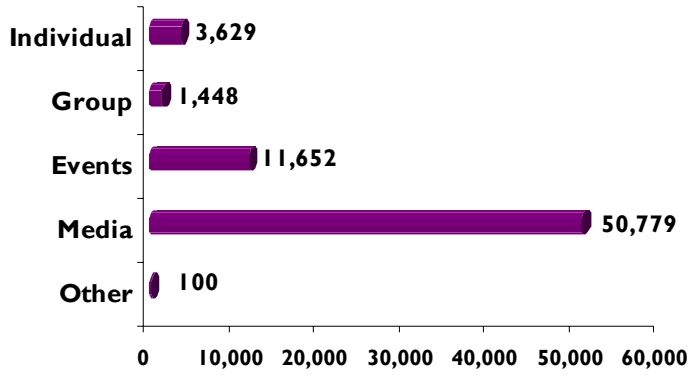
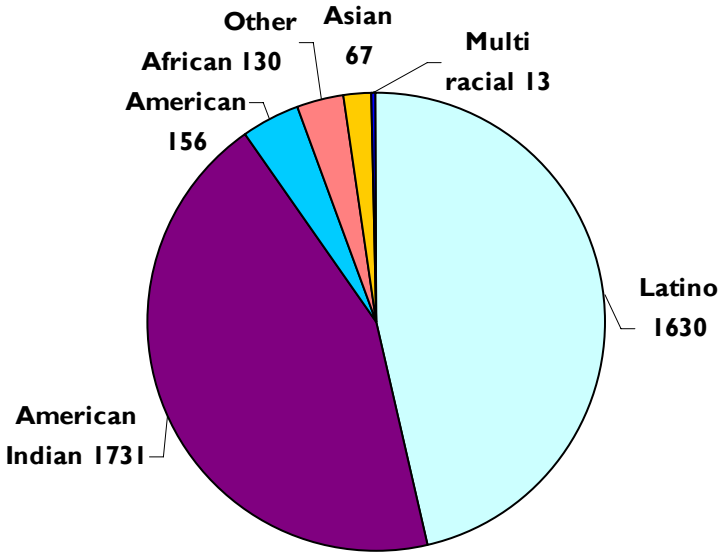
- One tribally-based program **provides safety and related supplies** for the new moms such as cribs, crib and sleep-safety kits, and car seats. They also conduct a Home Safety Assessment to help new parents identify and correct potential risks in their home.

- Two programs address infant mortality as part of their healthy youth development programs by **encouraging young women to defer childbearing,** as babies born to teen moms have higher rates of infant mortality.

These are several examples of the many ways EHDI grantees are working to reach their communities and prevent infant mortality. The statistics conveyed in the Snapshot on the next page summarize the efforts of the ten grantees working in this area in 2006. Together, the grantees reached over 67,000 people in 12 counties. Over 5,000 persons were reached through direct methods of contact involving one-to-one contact or small group sessions.

On the following pages are highlighted examples of programmatic outcomes of the grantees working to reduce infant mortality. Six grantees were targeting behaviors including utilization of prenatal care, breast feeding, and substance use among pregnant women. Two specifically worked to increase access to and utilization of doula services. Two grantees targeted higher birth weights as their outcomes, and one worked towards increased knowledge about the causes of or factors contributors to infant mortality.

2006 EHDI SNAPSHOT: INFANT MORTALITY

Number of EHDI Grantees Working in Health Area	**10 (20 percent of total)**
Number of People Reached	**67,608 (duplicated)**
67,608 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Hennepin, Ramsey **Outstate:** Aitkin, Beltrami, Carlton, Cass, Clearwater, Hubbard, Itasca, Mille Lacs, Pine, Saint Louis

See page 9 for description of issues related to duplicated vs. unduplicated counts.

SELECTED OUTCOMES: INFANT MORTALITY

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Behavior	6	Increased levels of prenatal care and breastfeeding as well as reducing/ eliminating smoking, alcohol and drug use during pregnancy
HC Access / Utilization	2	Increased access to prenatal care and Doulas
Health Status	2	Higher number of infants born at a healthy birthweight
Knowledge / Awareness	1	Increased understanding of causes of infant mortality

SPOTLIGHT ON RESULTS

- **American Indian Family Collaborative** trains women to be birth partners, or doulas, and pairs these doulas with pregnant women to provide culturally-specific labor support. Of the 124 deliveries to women participating in the Doula Program, only 3 (2 percent) were born at low birth weight—far better than the Minnesota low birth weight average of 6.3 percent. The doulas also successfully encouraged breastfeeding. Eighty-five percent (105 mothers) breastfed their babies compared to the CDC's national average of 73 percent.

- **Leech Lake Band of Ojibwe** connects with women who have a positive pregnancy test. The workers encourage the pregnant woman to get adequate prenatal care, reduce her use of alcohol and drugs and breastfeed her baby. In 2006, 200 pregnant women (73 percent) received prenatal care within their first trimester of pregnancy compared to the 50 percent rate in 2002. In 2006, 55 women (20 percent) reported reducing their use of substances during pregnancy and 73 percent initiated breastfeeding in the hospital.

HEALTH PRIORITY AREA 8: Unintentional Injury and Violence

Ten grantees are working in 32 Minnesota counties to eliminate disparities in unintentional injury and violence between their communities and the majority (white) population.

DISPARITY STATUS

Table 10 presents the rates of death due to unintentional injury per 100,000 for each population group for 1995-99 and 2000-2004. Unintentional injuries include deaths due to motor vehicle accidents, falls, drowning, poisoning and fire-related deaths. For the baseline period (1995-99), the rates of unintentional injury deaths were higher among all populations of color as compared to whites. American Indians had rates that were more than twice that of whites. Between 2000 and 2004, the unintentional injury death rates fell—and disparities narrowed or disappeared for all groups except American Indians.

Table 10. Unintentional Injury, Homicide and Suicide Death Rate per 100,000 people by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Unintentional Injury Death Rates					
1995-99	40.7	75.8	36.1	40.2	34.4
2000-04	35.7	95.4	24.0	31.0	34.7
Homicide Death Rates					
1995-99	33.5	21.0	4.4	7.3	1.8
2000-04	17.2	14.6	3.8	5.0	1.6
Suicide Death Rates					
1995-99	9.6	15.7	10.0	11.5	9.9
2000-04	6.3	20.1	8.7	6.8	9.5

Source: 2007, MDH

Table 10 above also presents the homicide rates per 100,000 for populations of color, American Indians, and the white population in Minnesota. Between 1995 and 1999, the homicide rate for African Americans was over eighteen times higher and for American Indians eleven times higher than the homicide rate for the white population. Asians and Latinos were two and four times as likely to die from homicide as whites respectively.

As this table shows, between 2000 and 2004, homicide rates declined in every racial/ethnic group. Although the gap between racial/ethnic groups and whites narrowed somewhat, the rates for all minority groups remain at least twice as high as that of whites. African American homicide rates remain more than ten times higher than whites and American Indians nine times higher than whites.

Suicide rates per 100,000 are also presented in Table 10. For the baseline period (1995-1999), the greatest disparities existed for American Indians (15.7 suicides per 100,000 people) and Latinos (11.5) compared to the suicide rate in Minnesota's population of whites (9.9). Across the subsequent period (2000-2004) rates declined for African Americans, Asians and Latinos--essentially eliminating the disparity gap. For American Indians, however, the suicide rate worsened, and rose to more than double the rate among whites.

GRANTEE STRATEGIES TO ADDRESS UNINTENTIONAL INJURY AND VIOLENCE

Of the ten grantees working to reduce unintentional injury and violence in their communities, three specifically targeted American Indian communities, two targeted Latinos, two African Americans, one Asians and three worked with diverse populations. Given the breadth of this area, the strategies and foci of the grantees are very different:

- Many of the grantees provide **education** to youth, ex-offenders and the community at-large on different types of violence, what violence is, how to identify violence, and address risks of violence and suicide. They do this through trainings, community education, and peer educators. Many of these educational programs reconnect participants to traditional cultural values and practices. One program involves churches and other community institutions to promote the belief that domestic violence is everyone's problem—not just a family matter best left hidden.

- Several grantees provide **one-to-one counseling**. Some counsel victims of domestic violence to help them recover. Other counsel ex-offenders to help them make positive changes in their lives to prevent future offenses, manage their anger, or treat their mental and emotional health issues.

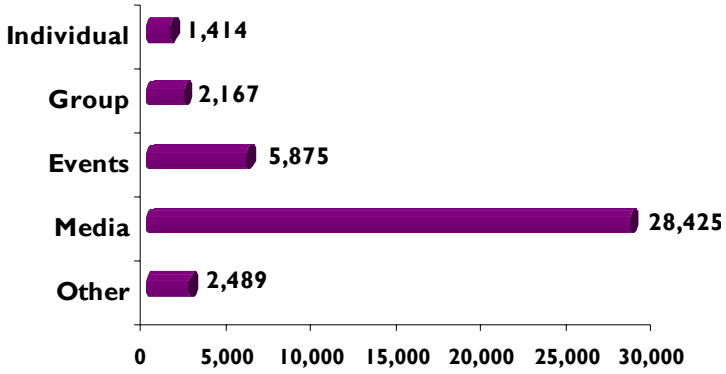
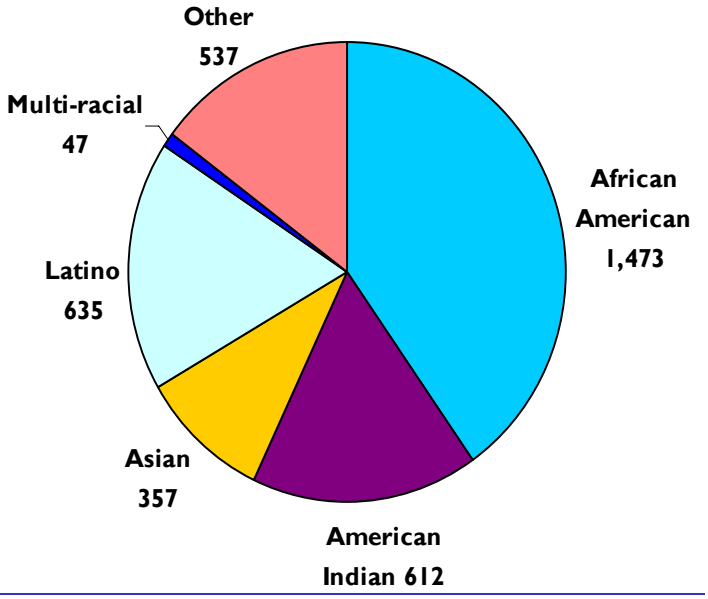
- Several programs **address violence risk factors** by working with participants to resolve root causes of violent behavior. Some provide positive experience to help youth feel connected to their community, valued and hopeful for their future, or identify youth with high truancy rates to determine why they are not attending school. Others provide case

management services to ex-offenders to connect them with sources of help, social support, jobs and housing to prevent future offenses. One program works with children who have witnessed violence in the home, which is a risk factor for later involvement in violence, either as victims or perpetrators. Two programs work with persons who are vulnerable to abuse and exploitation—including pregnant women who are often targets of domestic violence.

The statistics conveyed in the Snapshot on the next page summarize the 2006 efforts of the ten grantees working in 32 Minnesota counties. Together, these ten grantees reached over 40,000 people. Their efforts included working one-to-one, or in group settings, participating in large community events, and disseminating messages through print media, TV, radio, CD's or DVD's or the internet. Over 3,500 persons were reached through direct methods of contact involving one-to-one contact or small group sessions.

On the following pages are highlighted examples of programmatic outcomes of grantees working in the area of unintentional injury and violence. Five grantees worked to promote awareness and knowledge about domestic violence in the community. Four grantees worked to reduce behaviors associated with violence towards self or others, and two more grantees worked to change community norms around violence.

2006 EHDI SNAPSHOT: UNINTENTIONAL INJURY/ VIOLENCE

Number of EHDI Grantees Working in Health Area	**10 (20 percent of total)**
Number of People Reached	**40,370 (duplicated)**
40,370 People Reached All Contact Methods (duplicated)	
Ethnicity/Race of Population Groups Reached through Individual or Group Contact (unduplicated)	
Counties where Services are Delivered	**Twin Cities Metropolitan Area:** Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington **Outstate:** Becker, Beltrami, Cass, Chisago, Clay, Clearwater, Dodge, Hubbard, Itasca, Kandiyohi, Le Sueur, Mahnomen, Mille Lacs, Mower, Norman, Pennington, Polk, Red Lake, Redwood, Renville, Rice, Sherburne, Steele, Wadena, Waseca

See page 9 for description of issues related to duplicated vs. unduplicated counts.

SELECTED OUTCOMES: UNINTENTIONAL INJURY & VIOLENCE

Type of Outcome	# Grantees Reporting Outcome	Sample Outcomes
Knowledge/Awareness	5	Increased knowledge or understanding of violence, suicide or unintentional injury
Behavior	4	Changed behaviors associated with domestic or other forms of violence, suicide or unintentional injury
Attitude, Feelings or Intentions	2	Changed community norms about the acceptance of domestic violence

SPOTLIGHT ON RESULTS

- **United Hospital Foundation** conducts a Child Witness to Violence education class for health care providers and families. In 2006, 95 percent of the 235 participants increased their knowledge of domestic violence, and 90 percent (223) felt prepared to apply the information.
- **West Central Integration Collaborative** worked with youth to create videos about domestic violence. After the videos were created, 100 focus group participants (60 percent) said they learned about parental domestic violence.
- **White Earth Tribal Mental Health** holds a 27-week education class with men who batter. All of the 28 participants acknowledged components of the "equality wheel" in their relationships and identified changes they made by the end of the 27-week period. Only one participant from the groups re-offended. Finally, local school administrators observed that 38 (84 percent) of the students who participated in the group had fewer consequential behaviors during the 2006-2007 school year. Forty students (89 percent) identified two positive behavior techniques to use to manage their anger based on a pre/post test.

CONCLUSIONS

In 2006 alone, over 50,000 members of racial/ethnic communities were reached by EHDI grantees. As these highlights have shown, the grantees of the Eliminating Health Disparities Initiative have documented impacts on program participants in important ways:

- Changes in knowledge and increased awareness among program participants and community members in all eight health disparity areas.
- Increased numbers of community members without insurance were signed up for health coverage and can access primary health care.
- Many community members received preventative health screenings, such as mammograms, pap smears and other types of cancer screenings, blood pressure and cholesterol checks for heart disease, blood glucose levels for diabetes, testing for HIV/AIDS and other sexually transmitted diseases.
- Families kept up-to-date with immunizations for infants, and obtained necessary immunizations for children, allowing them to start school.
- Increased rates of early, consistent prenatal care among pregnant women.
- Community members with cancer and other chronic diseases such as diabetes were supported to navigate the health care system, understand and receive needed treatment, and comply with provider recommendations.
- Changed behaviors of program participants in the areas of improved diet, increased exercise, decreased tobacco and other substance use during pregnancy, increased breast feeding among new mothers, decreased high risk sexual behaviors and reduced violent behaviors among domestic abusers.
- Attitudinal changes such as improved self-image and confidence levels among youth participants, as well as intentions to change behavior, changed attitudes towards health care providers and traditional forms of healing and care and changed community norms about violence.
- Documented positive health outcomes such as healthy birth weight of infants, reduced recidivism among perpetrators of domestic violence and reduced rates of teen pregnancy among youth program participants.

The EHDI Grantees have accomplished what mainstream health organizations have had difficultly doing: effectively reaching out to and serving people of color and American Indians and making positive health changes in underserved communities. With continued effort and resources, these strategies can close Minnesota's gap in racial and ethnic health disparities.

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ELIMINATING HEALTH DISPARITIES INITIATIVE GRANTEES
2006 – 2008

Community Grantees

African American AIDS Task Force
Agape House for Mothers
American Indian Family Collaborative
Anishinaabe Center
Annex Teen Clinic
Bois Forte Band Community
Boys and Girls Club of the Twin Cities
Camphor Foundation
Center for Asian and Pacific Islanders
Centro (2 grants)
Centro Campesino
Children's Hospitals and Clinics
Council on Crime and Justice
Dar Al-Hijrah Cultural Center
Division of Indian Works (2 grants)
Family and Children's Services
Freeport West
Fremont Community Health Services
Hennepin Care East Clinic (formerly La Clinica en Lake)
Hmong American Partnership
Indian Health Board of Minneapolis
Lao Family Community of Minnesota
Leech Lake Band of Ojibwe
Minneapolis American Indian Center
Minneapolis Urban League
Minnesota International Health Volunteers
Olmsted County Public Health Services
Park Avenue Family Practice
Saint Mary's Health Clinics (formerly Carondelet LifeCare Ministries)
Sisters in Harmony Program
Southeast Asian Community Council
Southeast Asian Ministry
Stairstep Foundation
Summit University Teen Center
The Storefront Group
Turning Point
United Hospital Foundation
Vietnamese Social Services of Minnesota
West Central Integration Collaborative
Westside Community Health Services

Tribal Grantees

Bois Forte Band of Chippewa
Fond du Lac Band of Ojibwe
Grand Portage Band of Ojibwe
Leech Lake Band of Ojibwe
Lower Sioux Community
Mille Lacs Band of Ojibwe
Prairie Island Foundation
Red Lake Comprehensive Health Services
Upper Sioux Community
White Earth Tribal Mental Health