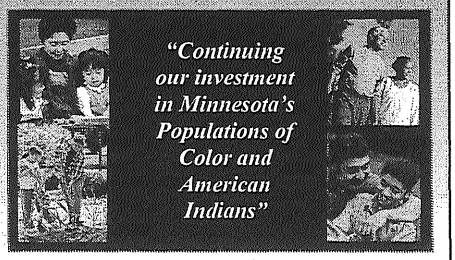
Eliminating Health Disparities Initiative 2004 - 2005



Legislative Hearing
Office of Minority and Multicultural Health
January 25, 2005

Eliminating Health Disparities Initiative (EHDI)

The EHDI focuses on two main goals:

- By 2010, decrease by 50% the disparities in infant mortality rates and adult and child immunization rates for American Indians and Populations of Color in Minnesota as compared with the rates for Whites.
- Close the gap in health disparities of American Indians and Populations of Color as compared with the rates for Whites in six additional priority health areas.

EHDI Primarily Serves:

- Africans/African Americans
- Latino/Hispanic Americans
- Asian Americans/Pacific Islanders
- American Indians

Eliminating Health Disparities Initiative

- Community, Tribal Health, and Tuberculosis Services Grant Programs
- Partnerships
- Capacity Building

EHDI Community and Tribal Health Grant Programs

These grants provide communities and tribes with an opportunity to:

- Work toward eliminating the health disparities of racial and ethnic populations;
- Promote the health and quality of life of individuals and communities;

EHDI Community and Tribal Health Grant Programs

These grants provide communities and tribes with an opportunity to:

- Build on community strengths and assets to address health issues;
- Develop effective working relationships among community members and the organizations and leaders who serve them;
- Focus on prevention and early detection.

Gloria Lewis
MDH

EHDI Tuberculosis Grants Program

- Tuberculosis Screening
  - Serves foreign-born persons
  - Outreach provided by 41 community health boards throughout Minnesota
  - Provides screening and follow up services

EHDI Grants Programs

- 42 Community Grantees
  - Serve African Americans, American Indians, Asians and Latinos in 31 counties
  - Provide public health prevention and health promotion programs throughout Minnesota
  - Address 8 Priority Health Areas: breast and cervical cancer, cardiovascular disease, diabetes, immunization, infant mortality, HIV/AIDS and STI's, healthy youth development, and unintentional injury and violence

EHDI Grants Programs

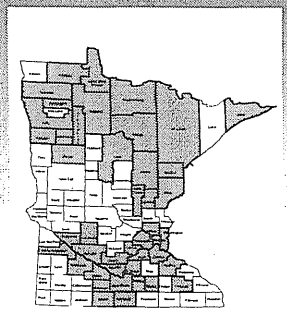
- 10 Tribal Health Grantees
  - Serve American Indians residing on tribal lands
  - Address 7 Priority Health Areas: breast and cervical cancer, cardiovascular disease, diabetes, immunization, infant mortality, HIV/AIDS and STI's, and unintentional injury and violence

Number of Community and Tribal Grantees by Priority Health Area

9	Breast & Cervical Cancer
16	Cardiovascular Disease
20	Diabetes
11	HIV/AIDS
18	Healthy Youth Development
12	Immunizations
11	Infant Mortality
11	Unintentional Injury & Violence

*Some grantees have chosen more than one priority health area

Counties Reached by 2004-05 Community and Tribal Grantees



People Served by 2004-05 Community and Tribal Grantees

Priority Health Area	African American
Infant Mortality	34,594
Immunization	37,503
Breast and Cervical Cancer	33,201
Diabetes	53,915
Cardiovascular Disease	53,455
Unintentional Injury and Violence	3,873
HIV/AIDS and STI's	31,054
Healthy Youth Development	13,771

People Served by 2004-05 Community and Tribal Grantees

Priority Health Area	American Indian
Infant Mortality	1,351
Immunization	259
Breast and Cervical Cancer	3,483
Diabetes	799
Cardiovascular Disease	1,567
Unintentional Injury and Violence	781
HIV/AIDS and STI's	488
Healthy Youth Development	608

People Served by 2004-05 Community and Tribal Grantees

Priority Health Area	Asian American
Infant Mortality	401
Immunization	591
Breast and Cervical Cancer	230
Diabetes	823
Cardiovascular Disease	1,660
Unintentional Injury and Violence	1,590
HIV/AIDS and STI's	2
Healthy Youth Development	1,761

People Served by 2004-05 Community and Tribal Grantees

Priority Health Area	Latino/ Hispanic
Infant Mortality	4,523
Immunization	7,203
Breast and Cervical Cancer	4,152
Diabetes	9,896
Cardiovascular Disease	5,574
Unintentional Injury and Violence	6,761
HIV/AIDS and STI's	2,094
Healthy Youth Development	4,748

Capacity Building

OMMH, MDH program staff, and Rainbow Research, Inc. work together to provide grantees with technical assistance, support, information, resources, and training on culture, communities, and best practices to eliminate these health disparities.

Minnesota Department of Health program staff provide technical assistance to EHDI grantees and have learned from their experience with communities

Partnerships

Partnerships are crucial to the success of EHDI. Partnerships have occurred within/among communities, government and other supporters.

EHDI grantees have partnered with local public health agencies providing health promotion and prevention services.

Health care systems and institutions have come together as the Health Care Disparities Task Force.

Eliminating Health Disparities is of Benefit to all Minnesotans

Improved health, and the prevention of serious health problems, is good for the state's economy

Health is a powerful determinant of self-sufficiency.

The health of all Minnesotans is a crucial resource. If we neglect basic prevention measures today, we guarantee ourselves even greater health care costs tomorrow.

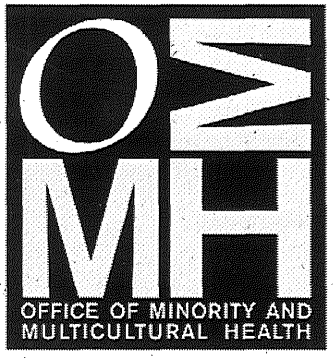
Outcomes

Contact Information

Office of Minority and Multicultural Health
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Phone: 651-297-5813
Web site:
Email: OMMH@health.state.mn.us

Gloria
Lewis
MDH



Minnesota's
Eliminating Health Disparities Initiative
Community and Tribal Grantees

Grantees' Health Outcomes Profiles and Contact Information

Prepared by Rainbow Research, Inc. and
The Office of Minority and Multicultural Health
Minnesota Department of Health and
Presented to the 2004 EHDI Results Conference:

Looking Back, Moving Forward:
Continuing our
Investment in Minnesota's
Populations of Color and American Indians

December 6 & 7, 2004

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EHDI GRANTEE PROFILES

Part 1: 2004-05 Community Grantees Unless Otherwise Noted:

African American AIDS Task Force
AAATF, working in partnership with HCMC, has been able to provide STI and HIV/AIDS education and counseling to patients who utilize medical services at the facility. The program addresses HIV/AIDS and STI health disparities experienced by Africans and African Americans in the Twin Cities with the objective of improving access to a broader range of medical and social services. The two organizations have combined resources to test individuals for HIV, offer preventive health screening, provide education and counseling services, and connect patients with community health and social service resources.
Minneapolis, MN 612-825-1137

Agape House for Mothers
www.agapehouseinc.com
Focusing on health disparities related to teen pregnancy, HIV/ AIDS and sexually transmitted infections, Agape House provides African and African-American teens in Minneapolis and St. Paul with necessary behavioral health skills and decision making tools to assist them in improving their self-awareness, make positive life choices, set goals and fulfill their dreams. This is accomplished through training and education, leadership conferences, social retreat camps, health services, case management, community action programs and teen conferences.
St. Paul, MN 651-222-2770

American Indian Family Center Collaborative
The goal of the Family Center Community Doula Program is to provide culturally and linguistically appropriate prenatal, labor, delivery and postpartum services to women in Ramsey County. By prioritizing services to minority women, the program strives to reduce health disparities, including infant mortality and premature births, as well as improve access to and use of appropriate prenatal health and community resources for pregnant and parenting families.
St. Paul, MN 651-793-3803

Anishinaabe Center
The Defeat Diabetes Project strives to provide diabetes education to youth, ages eight to 19, to reduce diabetes in the Anishinaabe (Ojibwe, Chippewa) community and to develop awareness of available traditional healing methods. Activities to promote awareness involved the creation of an animated film directed towards youth that contains educational information about diabetes as well as a monthly Defeat Diabetes Day, in which adult diabetics provide youth with information and describe their personal experiences with the disease.
Detroit Lakes, MN 218-846-9463

2002-03
Battered Women's Legal Advocate Project
www.bwlap.org
The BWLAP works with American Indian battered women to reduce health disparities in unintentional injuries and violence. The program's activities include working with reservation-based advocates to increase American Indian women's access to information and resources related to finding safety from domestic violence,

establishing relationships between advocates and local healthcare providers, helping advocates conduct needs assessments, facilitating planning meetings, creating a model for culturally appropriate health-care based intervention for American Indian women, facilitating trainings, and assisting in the creation of resources and printed materials.
Minneapolis, MN 612-343-9844

2002-03
Black Storytellers Alliance
www.blackstorytellers.com
The Healthy Youth Development program of the Black Storytellers' Alliance addressed teen pregnancy health disparities by serving African American youth ages 10 to 14 in North Minneapolis through focus groups discussions and Toys U Can't Return workshops.
Minneapolis, MN 612-529-5864

Bois Forte Band of Chippewa
The Cardiovascular Program focuses on reducing cardiovascular disease and its modifiable risk factors in members of the Bois Forte Band of Chippewa. Program activities include the collection of data from the cardiovascular community assessment, collaborating to design a community fitness center, fitness programs, and planning for and presenting at community events. Youth are a main target of the program, which is shown through activities offered during student's gym times at school as well as summer youth work programs for adolescents ages 14 to 19. Other services include fitness screenings as well as blood pressure and glucose screenings.
Nett Lake, MN 218-757-3650

Boys and Girls Club of the Twin Cities
www.boysandgirls.org/health.htm
The SMART Moves program of the Boys and Girls Club works to improve healthy youth development in Minneapolis and St. Paul by providing a community-based preventive program designed to help youth, ages six to 18, identify and resist peer, social and media pressures that promote high-risk behaviors. This is accomplished through educating youth and teaching them the resistance skills needed to avoid alcohol and other drugs, as well as sexual involvement.
St. Paul, MN 651-967-1105

Camphor Foundation
www.camphorumc.org
The UJIMA Teen Pregnancy Prevention and Healthy Youth Development Program targets African American teens and families who live in the Thomas/Dale, Summit/University and Eastside communities of St. Paul. The goals of the program are to prevent teen pregnancy among African American youth and foster healthy and appropriate behaviors through leadership development, culturally based education, spiritual awareness, building self-esteem and positive self-identity, community advocacy, peer training and adult educational trainings.
St. Paul, MN 651-224-0341 or 651-641-0181

Carondelet LifeCare Ministries
www.csjstpaul.org/content.asp?id=182
The Carondolet LifeCare program of St. Mary's Clinics seeks to reduce diabetes, breast and cervical cancer health disparities in the adult Latino population by collaborating with three Latino parishes to provide outreach through culturally

appropriate health care information, health screening, and education. The clinics also increase access to necessary health care services for Latinos through advocacy, referrals, and scheduling of health care services.
St. Paul, MN 651-690-7021

Cass County Children's Initiative/Leech Lake Reservation
www.co.cass.mn.us/hhvs/human_services/human_partnerships.html
The goal of the Cass County Children's Initiative is to reduce infant mortality rates among American Indian women of the Leech Lake reservation by encouraging pregnant women who are at highest risk for poor pregnancy outcomes to participate in medical care and social programs. The initiative offers prenatal and postpartum services to outlying tribal clinics, home visits by a public health nurse, doula services, and advocacy to pregnant and postpartum women and their families through transportation, childcare and other support.
Cass Lake, MN 218-335-4509

Center for Asian and Pacific Islanders (CAPI)
www.capiusa.org
CAPI provides culturally grounded services to communities in transition and endeavors to reduce disparities in immunization rates among Asians through education, referrals, paperwork, advocacy assistance and on-site immunization clinics. The target population includes low-income Asian residents of Hennepin County, specifically Hmong, Vietnamese and Cambodian families who are or become clients of the CAPI Food Shelf, Family Strengthening Program or Elder Services.
Minneapolis, MN 612-721-0122

Centro
Centro's Healthy Youth Development Program uses culturally appropriate approaches to provide education and increase healthy communication between Latino parents and teens. With the goal of reducing health disparities in teen pregnancy rates, the program also assists youth in developing personal goals that promote healthy lifestyle choices, increase future educational/career opportunities and empower them to delay becoming sexually active and/or prevent pregnancy and STDs.
Minneapolis, MN 612-874-1412

Centro Campesino
The Promotores de Salud Project of Centro Campesino works with Latino migrant agricultural worker communities in south-central Minnesota to reduce disparities in the areas of breast and cervical cancer, HIV/AIDS and STIs, immunization, diabetes, unintentional injuries and violence. To reach these goals, the project selects, trains, empowers and supports members of the communities to become community health workers who provide a link between the communities and local health care organizations. Other program activities include the development of immunization clinics, as well as workshops, focus groups and support groups related to these health disparities.
Owatonna, MN 507-446-9599

Children's Health Care
Teen Age Medical Services (TAMS)
http://xpedio02.childrenshc.org/stellent/groups/public/@xcp/@web/@clinicsanddepts/documents/policyreferenceprocedure/web027520.asp
Teen Age Medical Services (TAMS) at Children's Hospital and Clinics strives to reduce health disparities in cardiovascular disease and diabetes by working with African American females and their mothers to remove barriers that prevent them from improving their diet and increasing physical activity. Through partnering with the Women's Wellness Program at the YWCA, TAMS offers a 12-session nutrition and fitness program called "Healthier Ways" to mother-daughter pairs who were recruited when the daughters were identified as being at high risk of cardiovascular disease and diabetes.
Minneapolis, MN 612-813-8970

Council on Crime and Justice
www.crimeandjustice.org
The Health Educational Lifestyle Project (HELP) endeavors to reduce health disparities among multicultural offenders of color. HELP primarily addresses issues of HIV/AIDS/ Hepatitis C and other STDs by providing a 10-week health educational course as well as pre and post release advocacy for men and women of color, with priority given to HIV and Hepatitis C positive inmates. Advocacy includes transportation and a birth/disease control packet, health planning management, employment and housing, as well as a concentrated effort to engage the inmate's family in positive health-related decision-making upon release.
Minneapolis, MN 612-348-7874

Dar Al-Hijrah Cultural Center
The Dar Al-Hijrah Cultural Center aims to provide the Somali community with preventive health services, including community health education, outreach, and health screening services in order to eliminate health disparities, specifically in the areas of cardiovascular disease, diabetes and immunizations.
Minneapolis, MN 763-438-0744

Division of Indian Work
www.gmcc.org/diw
The Doula (Women of Traditional Birthing) Project of DIW works to reduce the number of infant deaths in the American Indian community in Hennepin County. Progress towards this goal is achieved through recruiting and training women who are interested in becoming doulas, recruiting pregnant American Indian women who are interested in utilizing a doula, matching the two, and monitoring the progress of the pregnancy and outcome of the birth.

The Teen Pregnancy Prevention Project of DIW strives to reduce teen pregnancy rates in the American Indian community of Minneapolis and St. Paul. To reach the goals of the planning phase of the project, a consultant was hired to conduct interviews and focus groups with teen mothers in order to develop an implementation plan and write a curriculum for youth and parents that will be implemented at five sites.
Minneapolis, MN 612-722-8722

Family and Children's Service
www.famchildserv.org
100 Men Take a Stand, an initiative for Violence Free Families of the Family and Children's Service, engaged African American men residing in North Minneapolis in making a commitment to end domestic violence and promote domestic peace in an effort to reduce health disparities related to violence in the African American community. To further the goals, a Project Action Team supports the men to act on their commitment.
Minneapolis, MN 612-728-2093

Freeport West
Freeport West collaborated to design the Project SOLO Pregnancy Prevention Program to create a culturally-specific and culturally-based circle of care for 13-to-18-year-old young people of African descent who are at risk of pregnancy, or are already pregnant or parenting. Freeport offers case management, family reunification and preservation services, as well as connections to community resources and support networks. The Cultural Wellness Center helps participants design a "Map of Wellness" and offers support groups aligned to meet the needs and goals of those maps. The program endeavors to reduce the incidence of too-early pregnancies by providing young people of African descent the skills, knowledge and attitudes to make positive life choices.
Minneapolis, MN 612-824-3040

Fremont Community Health Services
www.fremonthealth.org/clinic.html
The goal of the Stroke Prevention Project is to increase understanding of cardiovascular disease and diabetes and to lower the risk of stroke in African American adult communities of North & Northeast Minneapolis and the northern suburbs. Through education, outreach and screening, the program strives to increase awareness of risk factors for these diseases in order to increase referrals to the clinics, leading participants to receive needed medical care and manage their conditions.
Minneapolis, MN 612-287-2423

Hmong American Partnership
www.hmong.org
Hmong American Partnership focuses on reducing health disparities in the Hmong community in the areas of cardiovascular disease and violence. The project creates a supportive environment that directly encourages physical activity and healthy food choices, and decreases the use of violence as a response to family conflict. HAP utilizes a "talking circle" process to: 1) build new ways for Hmong people to connect to each other and 2) build capacity within the professional community to respond to issues related to violence. Other activities include community trainings on mental health, health fair events, walking clubs and radio shows to promote physical, emotional and social well-being through fitness and healthy diets.
St. Paul, MN 651-495-1505

2002-03
Hmong National Organization
www.hmongnat.org
Targeting Asian American youth and children, the Hmong National Organization strives to reduce disparities in immunizations rates by offering services that will improve the health of Hmong children, teach families enrolled in the program to use preventive health care services on their own, and promote

immunizations through educational campaigns in the Hmong media.
St. Paul, MN 651-290-2343

2002-03

Hope International Health and Social Services

Hope International Health and Social Services serves African immigrants and refugees, including many with chronic health conditions such as cardiovascular disease and diabetes. They may be unaware of their conditions or are neglecting treatment because they are unfamiliar with, could not, or would not access healthcare systems in their new country or could not afford health care services. African nurses, hired by Hope International, go into the homes of these families to assist them in meeting their health care needs.
St. Paul, MN 651-721-8821

Metropolitan Urban Indian Directors Group

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. Activities included a Welcome Feast to recruit families and discuss the project's intentions, a Family Retreat that involved health education sessions, talking circles and healing ceremonies, and a Gathering of Families Powwow that described available programs. The project also offers home visits for family education and shares its vision, mission and progress through health fairs, schools, cancer support groups and cultural events.
Minneapolis, MN 612-722-8722

La Clinica en Lake, CLUES, La Opportunidad

www.moappp.org

The Aquí Para Tí (Here For You) Latino healthy youth development program creates access to comprehensive healthcare, social and educational services through a coordinated assessment and referral system that includes West Side Community Health Services/La Clinica en Lake, CLUES (Chicanos Latinos Unidos en Servicio), La Oportunidad, and MOAPPP. Targeting youth and young adults ages 11 to 24, the program addresses teen pregnancy health disparities in the Latino community.
Minneapolis, MN 612-728-7689

Lao Family Community of Minnesota

www.laofamily.org

Kev Xaiv is a healthy youth development program of the Lao Family Community of Minnesota that offers culturally specific, abstinence-only sexual health curriculum to 6th to 8th grade Hmong students in middle schools across Minneapolis and St. Paul. A second component is the young parents program, which offers case management services and group sessions to young Hmong mothers and fathers, serving mainly high school students in the St. Paul area.
St. Paul, MN 651-209-6808

Minneapolis American Indian Center

www.maicnet.org

The Twin Cities Healthy Nations Healthy Options Program aims to reduce health disparities related to violence and unintentional injuries, cardiovascular disease and diabetes in the urban American Indian community. Opportunities have been created that encourage physical activity and healthy lifestyle choices, such

as fitness-related activities and sports leagues. In addition, a multi-media public awareness campaign, promoting healthy pursuits and lifestyles aimed at American Indian youth, will create three posters and one brochure for all Healthy Nations activities, which will be distributed to the community.
Minneapolis, MN 612-879-1719

Minneapolis Urban League
www.mul.org
The Other Options Program Services (OOPS) of the Minneapolis Urban League is a collaboration of healthy youth development programs that address teen pregnancy and educate youth about HIV/AIDS and STIs. The programs are targeted towards African American teens in grades six through eight who live in Near North Minneapolis and are considered at-risk for HIV/STDs or pregnancy.
Minneapolis, MN 612-302-3164

Minnesota International Health Volunteers (MIHV)
www.mihv.org
The Somali Health Care Initiative, a partnership between MIHV and two Somali-led organizations (The Confederation of Somali Community in Minnesota [CSCM] and Leadership Empowerment, and Development [LEAD]Group), works to reduce health disparities in the Somali community of Minnesota, specifically in the areas of immunizations, infant mortality, breast and cervical cancer, diabetes and cardiovascular disease. Activities include workshops intended to increase the cultural competence of health care providers working with Somali patients, community forums to increase awareness and knowledge about disease prevention, and an asset-building mapping exercise conducted to identify community strengths. A participatory process was used to establish baseline Somali health data. In addition, two Somali Community Health Workers were hired to raise awareness around disease prevention, mobilize the community and conduct outreach.
Minneapolis, MN 651-230-3250

North Suburban Youth Health Clinic (REACH)/Annex Teen Clinic
www.teenhealth411.org
REACH (Restore & Empower African American Adolescents to Create and Hope) is a collaborative of successful youth development programs, community organizations, a faith community, and a teen reproductive health clinic. REACH provides an intergenerational program that gives youth positive experiences that enhance their assets, support their reproductive health , and reduce risk behaviors to prevent teen pregnancy through strengthened peer education programs, enhanced arts-based programming, and effective health education involving parents and committed adults.
Robbinsdale, MN 763-533-1316

Olmsted County Public Health Services
www.olmstedcounty.com/publichealth
The Olmsted County Public Health Department strives to reduce health disparities related to immunizations, diabetes and cardiovascular disease in African American and Latino residents in Olmsted County. The health department provides outreach regarding the benefits and recommended schedule for immunizations and creates educational materials related to diabetes, cardiovascular disease prevention, nutrition, and physical

activity. Also available are peer education programs for adults and school classes for elementary students that provide information on diabetes and cardiovascular disease.
Rochester, MN 507-285-8391

2002-03
Parents in Community Action Head Start (PICA)
www.picaheadstart.org
The Cardiovascular Program of Parents In Community Action, Inc. (PICA) addresses health disparities related to cardiovascular disease by conducting health information forums, health fairs, aerobic classes and on-site health screenings. Services are provided to families living at or below poverty level in Hennepin County, specifically African, African American, Asian American, American Indian, and Hispanic/Latino communities.
Brooklyn Park, MN 763-391-5018

Park Avenue Family Practice
Park Avenue Family Practice works with Hmong residents in the Twin Cities to reduce health disparities in the areas of diabetes, youth development, cardiovascular disease, and infant mortality. The clinic provides education about diabetes and pregnancy through DVDs, videos, brochures and individual counseling. Brochures have been created that provide information on cardiovascular disease, violence and infant mortality.
Minneapolis, MN 612-874-8811

Region Nine Development Commission/ Saludando Salud /
www.rndc.org/programs/salud
Saludando Salud strives to improve the health of Latinos in southern Minnesota by expanding the cultural competence of health care professionals. Saludando also offers one-on-one outreach services, health-related workshops and produces *Su Salud*, a weekly Spanish language radio program that addresses health topics. Goals of the program are to reduce disparities in the Latino community related to cardiovascular disease, breast and cervical cancer and diabetes.
Mankato, MN 507-389-8873

2002-03
Save Our Sons
www.saveoursons.org
Save Our Sons addresses the health disparity area of unintentional injuries and violence by mentoring and providing prevention and intervention services to African American males ages 10 to 18 who live in Ramsey County and are likely to become or are already involved in violent or criminal activity.
St. Paul, MN 651-222-6906

Southeast Asian Community Council
www.seacc-mn.org
The Southeast Asian Youth Empowerment Project is a collaboration of four community-based organizations that work to reduce teen pregnancy by utilizing youth leadership activities and community engagement to build resiliency in Southeast Asian youth so they'll delay pregnancy. Youth and parent advisory councils plan community events and activities. SEAYEP also provides media training and education to youth, host's yearly community celebrations to share accomplishments and develops articles that address teenage pregnancy.
Minneapolis, MN 612-342-1530

Southeast Asian Ministry
Southeast Asian Ministry is a faith-based ministry that services refugees from Southeast Asia as they strive to achieve

self-reliance. Targeting Cambodian elders and Hmong families, SeAM addresses cardiovascular disease, diabetes and immunization disparities. In addition to providing information about the dangers of diabetes and cardiovascular disease, the Elders Program provides education about nutrition and offers exercise opportunities.
St. Paul, MN 651-293-1261

St. Paul Urban League
The African American Teen Pregnancy Prevention Collaborative (AATPPC) of the St. Paul Urban League addresses the high prevalence of African American teen pregnancies in Minnesota. Through programs that serve youth ages 11 to 21 in St. Paul, AATPPC offers programs that are culturally responsive, preventative and promote youth's whole development – socially, mentally, physically, and emotionally.
St. Paul, MN 651-224-5771

Stairstep Foundation
www.stairstep.org
The Stairstep Foundation Health Initiative's "There is a Balm" project involves a partnership between 16 metro area churches. Church health coordinators convene monthly health sessions in their congregations around health disparities that include breast and cervical cancer, cardiovascular disease, diabetes, healthy youth development, immunizations, and infant mortality. The health sessions are opportunities to provide information and educational presentations, distribute materials and resources, conduct health screenings, and host health fairs.
Minneapolis, MN 612-521-3110

The Storefront Group
www.storefrontgroup.org
As part of the planning phase of the development of programs to reduce immunizations disparities in the Somali community, the Bridge to Success Project of the Mosaic Group conducted a community cultural assessment. The goal was to discern community assets and needs relative to immunizations as well as access to existing interceptive and preventative systems available to the Somali community. The project included interviews with key players in stakeholder groups as well as focus groups with Somali adults and health care providers to establish community needs and indicate strengths and gaps related to immunization.
Richfield, MN 612-798-8174

Summit University Teen Center
Sponsored by SUTC, Teens Choosing Healthy Options Programming and Services (TC-HOPS) is an after school program for African American adolescent mothers and fathers, which addresses the issues of teen pregnancy prevention, HIV/AIDS and other STIs. Targeting adolescents in the Summit/University neighborhood of St. Paul, TC-HOPS provides culturally specific parenting and pregnancy prevention educational activities designed to increase parenting and life skills development. The program's goals are to provide support and address the realities of parenthood, family planning, sexual health and self-efficiency.
St. Paul, MN 651-644-3311

Turning Point
Turning Point endeavors to increase the community's awareness of HIV/AIDS risks through educational classes, trainings, workshops, website development, health

fairs and street outreach. The target population includes African American men and women in the Twin Cities metro area, ages 13 to 55 who have incomes at or below the federal poverty level, less than 12 years of education, and are either at-risk or participate in behaviors that put them at-risk for HIV/AIDS transmission. Some may have a history of chemical and substance use or abuse and may be involved in the criminal justice system.
Minneapolis, MN 612-520-9183

United Hospital Foundation
http://www.allina.com/ahs/united.nsf/page/partnerships#violence
Partners for Violence Prevention works to reduce the incidence and impact of violence, as well as the injuries and health problems resulting from violence. Using a community-based approach, PVP works with schools and community organizations in the West 7th neighborhood of St. Paul to promote peace and also provides culturally competent family violence education training to health and social service providers.
St. Paul, MN 651-241-8532

2002-03
Vietnamese Social Services of Minnesota
www.vssmn.org
The Vietnamese Social Services Breast and Cervical Cancer Educational Project strives to improve the screening rates of Vietnamese women for both cancers. The project aims to accomplish these goals through educating Vietnamese women about preventive care and knowledge about breast and cervical cancer, including special outreach to women who may have recently arrived to the U.S., have low educational levels or low incomes, have limited English abilities or have difficulties becoming acculturated to western medical systems.
St. Paul, MN 651-917-2945

West Central Integration Collaborative
The Community Health Outreach Workers Project focuses on healthy youth development by providing services to Latino and Somali/East African youth in Kandiyohi County. The goals are to reduce the adolescent pregnancy rate in Latina girls and educate Latino and Somali youth and their families about health care services available to them. Current activities include the Healthy Youth Tour, a bi-monthly six-hour program that provides education on nutrition, sexual activity, etc., offers nutritional meals and encourages participation in physical activities.
Willmar, MN 320-231-8546

Westside Community Health Services
WCHS addresses diabetes in the Hmong and Latino communities of the Minneapolis/St. Paul metropolitan area in an attempt to reduce health disparities. Programs and strategies include one-on-one patient visits with Spanish and Hmong-speaking nutritionists and health educators, group visits, the creation of culturally- and linguistically-appropriate peer education and community health education materials, identification and training of Latinos with diabetes to become peer educators, a media campaign to increase awareness, and the collection and analysis of data about rates and complications of diabetes and effectiveness in project interventions. Also provided are in-home health education as well as venues and classes for physical education and exercise in community centers, organizations, and churches.

St. Paul, MN 651-389-2450

Women's Cancer Resource Center
www.givingvoice.org
The Sisters in Harmony South Minneapolis Cancer Control Coalition worked with health programs and organizations serving African and African American women in south Minneapolis who are at risk for or have been diagnosed with breast and/or cervical cancer to develop a model of culturally-based coordinated continuum of health care support for these women. The WCRC then implemented the program by training cultural navigators who provide support to diagnosed women, developing a marketing/outreach framework to promote the program, and creating and distributing a brochure that describes Coalition services.
Minneapolis, MN 612-825-7646

2002-03
Youthlink
www.youthlinkmn.org
Project OffStreets, a program of Youthlink, offers support and services to homeless youth ages 15 to 19 who come primarily from the Twin Cities area. Youthlink is committed to increasing immunization rates of youth by utilizing a client database and conducting street outreach. The project also strives to reduce HIV/STD rates in youth by screening new clients and providing health education. To reduce disparities in teen pregnancy and infant mortality rates, case management is offered to pregnant and parenting youth along with pregnancy testing, education and counseling. In order to reduce disparities related to violence and unintentional injuries, the Mental Health Program serves youth who are highly impaired in daily functioning due to their mental health status and are homeless or precariously housed.
Minneapolis, MN 612-252-1273

Part 2: Tribal Health Grants:

Bois Forte Reservation
Under the Minnesota Breast and Cervical Cancer Program, the Bois Forte Medical Clinic aims to reduce health disparities in breast and cervical cancer by increasing the number of American Indian women who receive pap smears and physical exams through contracting with a female Family Nurse Practitioner who is American Indian and enrolled in the White Earth Tribe. Previously, only male providers were available and many women were avoiding their annual exams because they did not want to see a male provider. Additional activities to boost exam rates include advertising and promoting the program through flyers, Bois Forte News publications, home visits by Community Health staff and word of mouth.
Nett Lake, MN 1-800-223-1041

Fond du Lac Tribe – Center for American Indian Resources (CAIR Clinic)
www.fdlrez.com
The Fond du Lac Band of Lake Superior Chippewa works to reduce infant mortality rates by serving pregnant Indian women, their infants, as well as girls and women of child-bearing age living in the Fond du Lac Service area. Services include a Prenatal Waiting Area, designed to encourage prenatal clients to use the clinic, home-visiting, education about car safety, SIDS and home safety, parenting classes, and presentations on women's health issues, birth control and STDs.
Duluth, MN 218-726-1370

Grand Portage Health Service
Grand Portage Health Services provides education and proactive outreach concerning healthcare resources and self-care to residents and employees of the Grand Portage Indian Reservation in order to decrease incidences of cardiovascular disease in the community. Services and activities offered include on-site employee health screening, educational/informational sessions as well as flyers/information sheets on topics related to wellness and reducing cardiovascular disease in general.
Grand Portage, MN 218-475-2235

Leech Lake Band of Ojibwe Health Division
The Leech Lake Band of Ojibwe Health Division seeks to reduce health disparities in the Leech Lake Reservation population through supportive clinics offering educational programs that encourage physical activity and healthy food choices, diabetes care, a diabetes curriculum offered to grade school students, as well as identifying patients at risk for Hepatitis C and encouraging vaccinations. In addition, behavioral health specialists support pregnant women/new mothers in their spiritual and cultural traditions. Classes are offered on parenting, childhood safety, car seats, conflict resolution services, smoking cessation, and alcohol use.
Cass Lake, MN 218-335-4542

Mille Lacs Reservation
www.millelacsojibwe.org
Through public health intervention, the Mille Lacs Band of Ojibwe hopes to decrease infant mortality and childhood injuries. A public health nurse visits the homes of families with high-risk pregnancies, before and after the birth, to assist them in maintaining health care by offering health education. The Sleep Safe Program provides cribs to families who have cribs that are unsafe, or none at all. It has also served as a social marketing tool leading to an increase in requests for home visits as word of the program spread.
Onamia, MN 320-532-4163

Prairie Island Foundation
Prairie Island addresses Diabetes through a structured educational and physical fitness approach. Each community member will participate in an individualized fitness plan that includes education about diabetes and physical fitness activities monitored by an activities coordinator within the health system.
Welch MN. 651-385-4113

Upper Sioux Community
The Upper Sioux Community Health Services Department works to improve the health of the Upper Sioux community of Minnesota by establishing an ambulatory care clinic within reservation boundaries with the goal of reducing health disparities related to diabetes, maternal child health, and immunizations. To prepare for the establishment of the clinic, UPCHS is engaging in needs assessment and planning, developing clinic policies and procedures, securing funding, and collecting and compiling health data for community members.
Granite Falls, MN 763-712-0541

Lower Sioux Community
The Yuwipi Wicasta, Oka Wicasta and the Ikce Wicasta provide and facilitate opportunities in the Lower Sioux Indian community for individuals and families to experience and participate in traditional ceremonies, language and song, women's circles and gatherings that address specific health disparities.

Morton, MN 507-697-6185

Red Lake Comprehensive Health Services
RLCHS works to reduce infant mortality rates on the Red Lake Indian Reservation through interventions that aim to increase the knowledge base of high-risk pregnant women and their partners in order to promote healthy pregnancies and deliveries. Activities included the development of a standardized form to identify high-risk pregnancies, as well as the creation of a childbirth class curriculum designed to meet the needs of the clients. A home visiting program was also established that provides clients with information and encouragement regarding childbirth classes, prenatal appointments and well child care after the baby is born.
Red Lake, MN 218-679-3316

White Earth Tribal Mental Health
The Mental Health Anger Management Program works specifically with American Indian adults and youth living on or near the White Earth Indian Reservation to reduce the incidence of domestic violence. The program facilitates educational groups that encourage adults and youth to recognize unhealthy responses to anger and learn alternatives to violence and dominating behavior and to be accountable for their actions. Brochures have been distributed throughout the reservation promoting the program and a Clinical Social Worker facilitates weekly sessions for men and women as well as male and female student groups.
White Earth, MN 218-983-3285 or 1-800-950-3248

Minnesota Department of Health January 20, 2005

Eliminating Health Disparities

The Public Health Need

Culturally and linguistically responsive health education and access to health care is critical to the productivity and well-being of all Minnesotans. Although Minnesota is ranked as the healthiest state in the nation in 2005, we continue to experience some of the greatest racial and ethnic health disparities in the nation. *Unequal Treatment* (Institute of Medicine 2002) reaffirms the influence that race can have on the inequities of health care quality a person receives. Regardless of race, culture, religion, class and English proficiency, the elimination of health disparities is paramount to Minnesota and MDH.

Recent Accomplishments

Harvard University's John F. Kennedy School of Government invited the Office of Minority and Multicultural Health (OMMH) to apply for the prestigious 2005 Innovations in American Government Award for their eliminating health disparities efforts. This national honor is awarded to only fifteen applicants of distinction.

OMMH has created venues for on-going dialogue between MDH and minority communities around health.

OMMH, along with other stakeholders, partnered with Minnesota State Colleges and Universities (MNSCU) for the Robert Wood Johnson Foundation funding for a Community Health Worker (CHW) Project. This partnership has produced Minnesota's first CHW training and certification program, which will be piloted Spring 2005 at two MNSCU campuses, with statewide expansion planned for Fall 2005.

The Participatory Research Partnership (PRP) is a partnership between minority community-based groups and health-related institutions such as MDH-OMMH & Center for Health Statistics and University of Minnesota-School of Public Health. This collaborative effort is charged with determining meaningful outcomes for Minnesota to measure the progress it makes towards eliminating health disparities.

The Minnesota Asian Health Data Summit Series has received national and local attention in convening national and local health-related professionals and community to address the dearth of Asian Pacific Islander data necessary for effective health action. The first Summit took place on June 28th, 2004. The second Summit will take place on February 11th, 2005.

A collaborative effort among OMMH, community-based organizations and community-clinics has successfully integrated health-related activities into the Mercado Central in Minneapolis, a commercial and gathering place for the Latino community. A monthly clinic provides: blood pressure checks, glucose testing, HIV testing, and assistance with applying for health insurance.

Eliminating Health Disparities Initiative (EHDI)

The Eliminating Health Disparities Initiative was established in the 2001 legislative session. The purpose of the 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

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Gloria Lewis MDH

unintentional injuries. By 2010, the initiative is also charged with decreasing disparities rates in infant mortality and immunizations by fifty percent. The majority of funding is provided to community through community grants and tribal health grants.

Examples of EHDI successes

American Indian Tribal: Anger management activities have positively impacted the health of families, schools, and the community as a whole on the White Earth reservation. These efforts have decreased the number of incarcerations and out-of-home placements, improved behaviors of school age children, and influenced positive family relationships in the tribal communities. Activities have expanded to other areas in the community to address violence and anger management.

American Indian Urban: EHDI grantees use a doula model to improve infant mortality for American Indians statewide. Doulas act as a supportive coach to the mother throughout her pregnancy, during delivery and postpartum. A successful model developed by the American Indian Family Center in St. Paul has been duplicated and implemented on the Leech Lake Indian Reservation by the Cass County/Leech Lake Family Collaborative as well as by the Division of Indian Work in Minneapolis.

Asian: Health plans and cancer institutions are investing in the work of EHDI. Medica, American Cancer Society and the Susan G. Komen Foundation are three examples of institutions who are partnering with the culturally and linguistically responsive cancer prevention efforts of Vietnamese Social Services of Minnesota (VSS). The work of VSS has helped these institutions communicate more effectively with their Vietnamese patients and communities at both national and local levels.

Latino: Centro Campesino in collaboration with local public health and community-based agencies established eight immunization clinics in Southern Minnesota (LeSueur, Waseca, Rice and Stelle Counties). Utilizing culturally and linguistically responsive outreach methods, Promotoras (lay health promoters), elected by their fellow migrant community members, successfully promoted the clinics and immunized 464 migrant workers in Hepatitis B and Tetanus.

African Descent: African American AIDS Taskforce and Hennepin County Medical Center have forged a successful partnership to provide in-house HIV health education for its walk-in clinic patients of African descent.

Future Challenges

- Optimal culturally and linguistically responsive support to local partners in health

- Social determinants that impact public health (i.e. housing, education, employment, new immigrant/refugee status, etc.)

- Optimal culturally and linguistically responsive data collection, health education, and health service delivery systems

- Alignment of efforts around the elimination "health care disparities" with efforts around the elimination of "health disparities."

Proposed Initiatives

- Policy alignment of emerging/promising practices for populations of color and American Indians across tribal, state, local levels of government (county, city) and community-based agencies to strengthen the health and well-being of these communities.

- Policy alignment of emerging/promising practices for populations of color and American Indians across State Departments to strengthen the health and well-being of these communities. This action will begin to address social conditions which impact health.

- Population of Color Health Status Reports

Eliminating Health Disparities – page 3

•Creation of one interpreter standard for Minnesota. By following the guidelines of the National Council on Interpreting in Health Care, Minnesota can meet the Limited English Proficiency (LEP) and Culturally and Linguistically Appropriate Services (CLAS) requirements for bilingual/bicultural health care interpretation across the U.S.

•Build upon the work of the Health Care Disparities Task Force, a partnership with the Minnesota Department of Human Services. The charge of this group is to produce a more culturally and linguistically responsive Minnesota by creating mechanisms to diversify the workforce, with the goal of eliminating racial and ethnic health care disparities.

OMMH Reports

Assessment of the Minnesota Department of Health's Office of Minority and Multicultural Health's Infrastructure and Capacity to Address Issues of Health Disparity

Comprehensive Coordinated State Plan-Summary of Survey Responses

Populations of Color Health Status Reports

EHDI 2005 Legislative Report

Rainbow Research Summary Report on EDHI Grantees

Minnesota Department of Health January 21, 2005

Eliminating Racial and Ethnic Health Disparities Initiative

What is the Eliminating Health Disparities Initiative?

The Eliminating Health Disparities Initiative, established by the 2001 Minnesota Legislature, allocated $10,697,826 in Community and Tribal Health Grants to communities and tribes for the 2004-05 biennium. The grants are aimed at improving the health status of Minnesota's communities of color and American Indians, and are distributed through the Minnesota Department of Health's Office of Minority and Multicultural Health.

What are health disparities?

Although Minnesota has long been noted as one of the healthiest states in the nation, minority populations in Minnesota experience much worse health in several areas: Overall, 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. These disparities also affect Minnesota's newly arrived immigrants and refugees. Highlights of those data are summarized on fact sheets covering Minnesota's four major racial/ethnic groups - African American, American Indian, Asian and Hispanic/Latino.

In some cases, the Minnesota's racial and ethnic health disparities are the highest in the nation. This is a distinction that the state of Minnesota simply should not have.

Funding

Community-based nonprofit organizations are funded to serve all four of the racial/ethnic groups below:

Table 1: 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.

They serve communities in 31 counties across the state, urban, suburban, and rural. Grantees focus on one or more of eight priority health areas:

Table 2: 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.

Key elements of the initiative include building the capacity of local grassroots organizations, and developing partnerships to create greater access to health care and prevention services in local communities. The heart of EHDI's purpose, mission, and success is its commitment to supporting health promotion activities that are

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Eliminating Racial and Ethnic Health Disparities Initiative – page 2

driven by racial and ethnic communities, based in their cultural beliefs, practices, and traditions, and grounded in the assets of the community.

People Served:

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

How does this initiative benefit all Minnesotans?

Health is a powerful determinant of self-sufficiency, a goal that unites all communities and political viewpoints.

Improved health, and the prevention of serious health problems, is good for the state's economy and its ability to bounce back in tough times. Healthy families and children, and a healthy work force, elevate the fortunes of the entire state.

A healthy population is Minnesota's greatest resource Even in tight budgetary times, the health of all Minnesotans is a crucial resource. If we neglect basic prevention measures today, we guarantee ourselves even greater health care costs tomorrow.

Prevention is the best investment. It has long been documented that money spent on prevention of sickness, chronic conditions, and injuries is an investment in preventing or reducing more serious and expensive health crises later.

Prevention affects other arenas as well:

* Healthy pregnancies reduce infant mortality and promote healthier infants.
* Healthy children learn better.
* Youth who are learning healthy attitudes and behaviors remain in school longer and can set better long-term goals for themselves.
* Healthy workers are more productive and take less medical leave.
* Healthy elders live longer and need fewer health resources.

With improved quality of life, people have energy and resources to create stronger families, and can become more involved with their communities.

For more information on the grants to eliminate health disparities or other health disparities issues, contact:

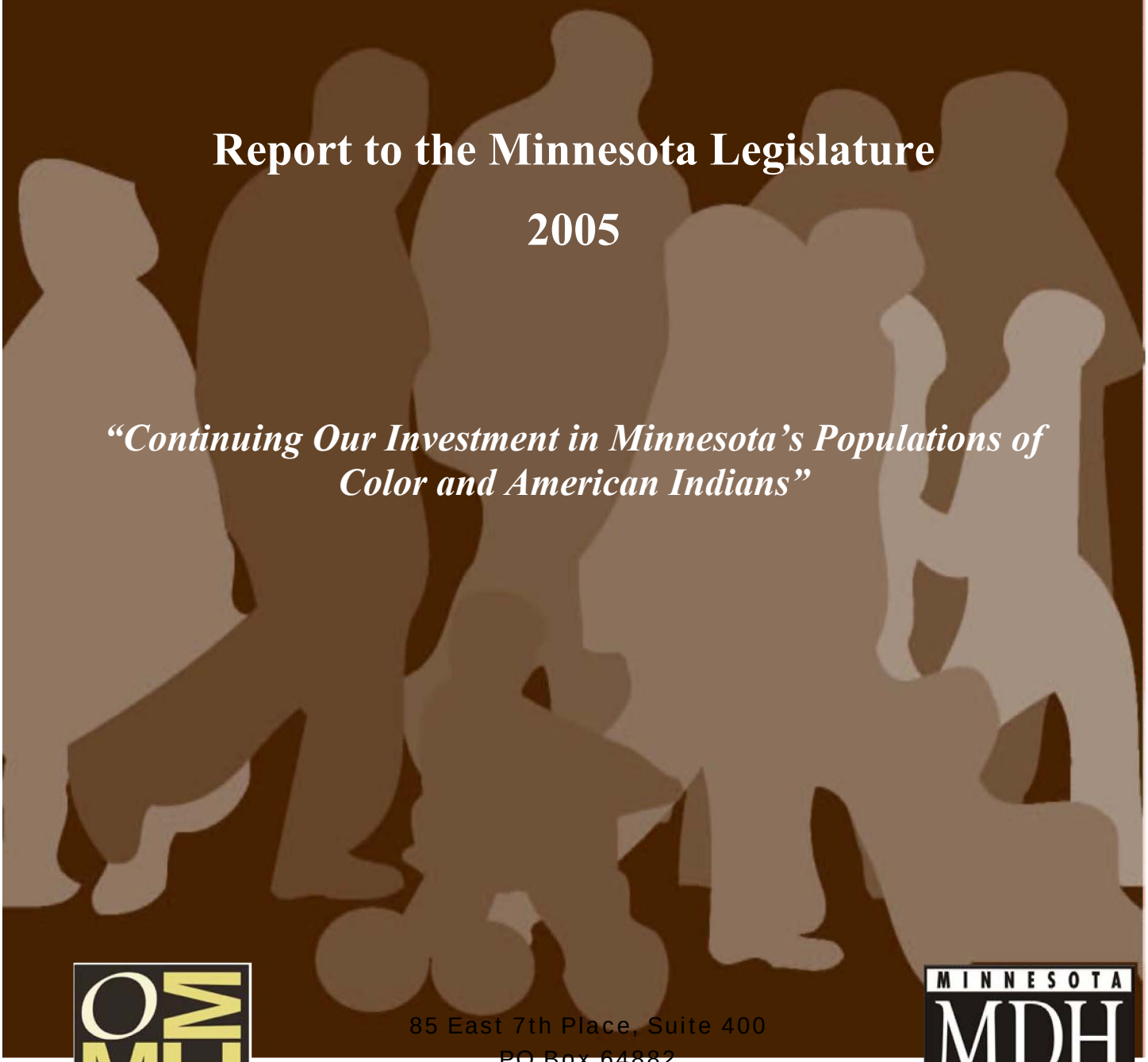
Gloria Lewis, Director
Gloria.Lewis@health.state.mn.us

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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January 15 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

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Eliminating Health Disparities Initiative
Report to the 2005 Minnesota Legislature

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

January 15, 2005

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As requested by Minnesota Statute 3.197, this report cost approximately $3000 to prepare, including staff time, printing and mailing expenses.

Upon request this material will be made available in an alternative format such as large print, Braille or cassette tape.

Printed on recycled paper.

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Tables

Figures

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
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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

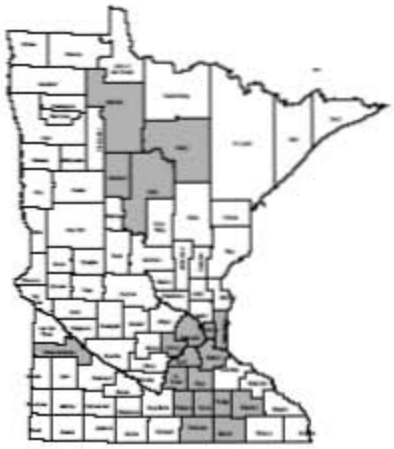
In accordance with the legislation's mandate, a 50% reduction in disparities would mean that 79% of American Indian, 76% of Asian, 75% of Hispanic and 74% of African American children 24 months old would be up to date on their immunizations by 2010 (Table 8).

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

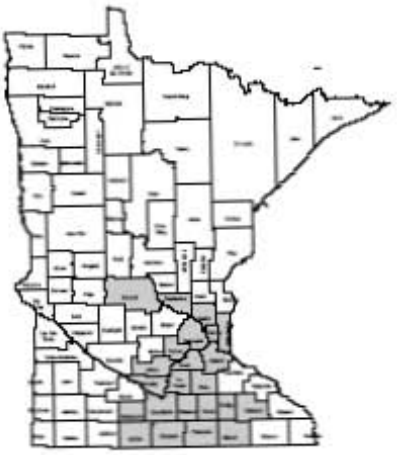
The 1996-2000 cervical cancer incidence rates for Asian and African American women were twice as high as White women living in Minnesota. The breast cancer incidence rate for the same time period was highest among White women with African American women having the second highest rate. Though the breast 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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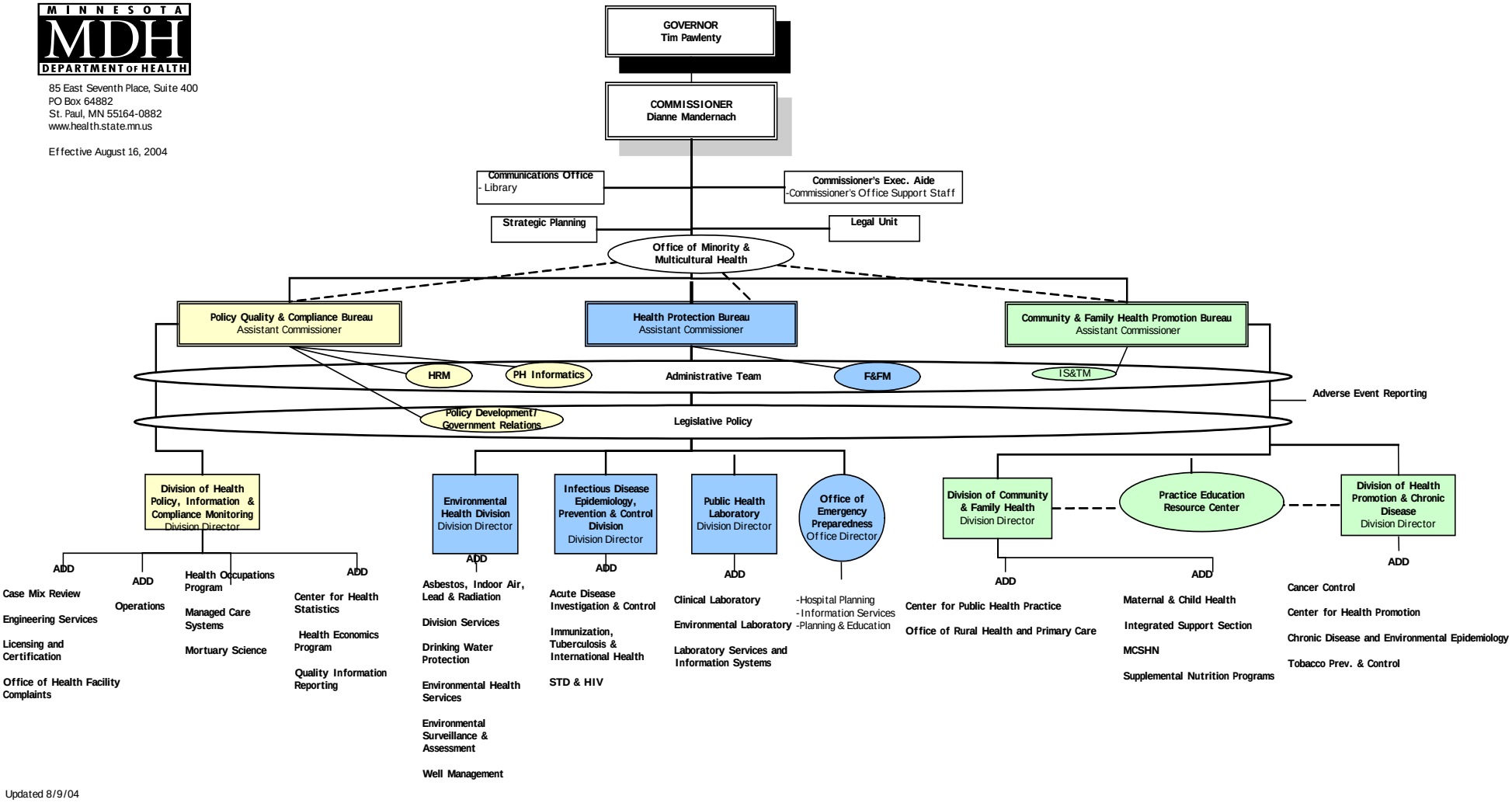
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Office of Minority & Multicultural Health
Policy Quality & Compliance Bureau
Assistant Commissioner
Health Protection Bureau
Assistant Commissioner
Community & Family Health Promotion Bureau
Assistant Commissioner
HRM
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Division of Health Policy, Information & Compliance Monitoring
Division Director
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Licensing and Certification
Office of Health Facility Complaints
ADD
Operations
Health Occupations Program
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:

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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.

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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:

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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.

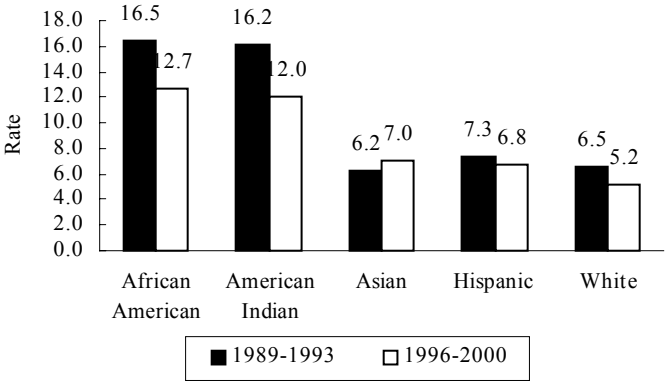
In 1997-2001, a greater percent of African American, American Indian, Asian and Hispanic women received **prenatal care** in their first trimester as compared to 1989-1993 figures. However, approximately 23% more White women received prenatal care in the first trimester as compared to Women of Color.

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.

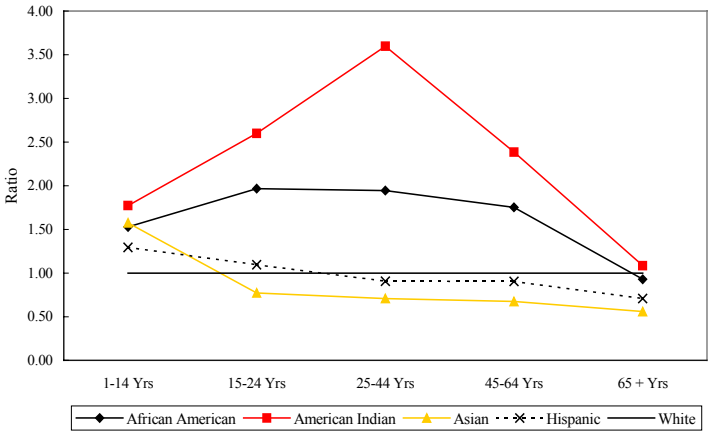
Infant Death per 1,000 births in Minnesota
by Race and Ethnicity: 1989-1993 and 1996-2000



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.

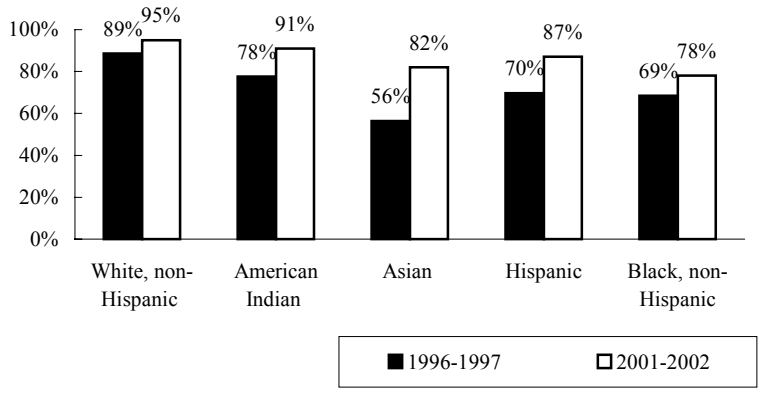
Illness and Injury

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

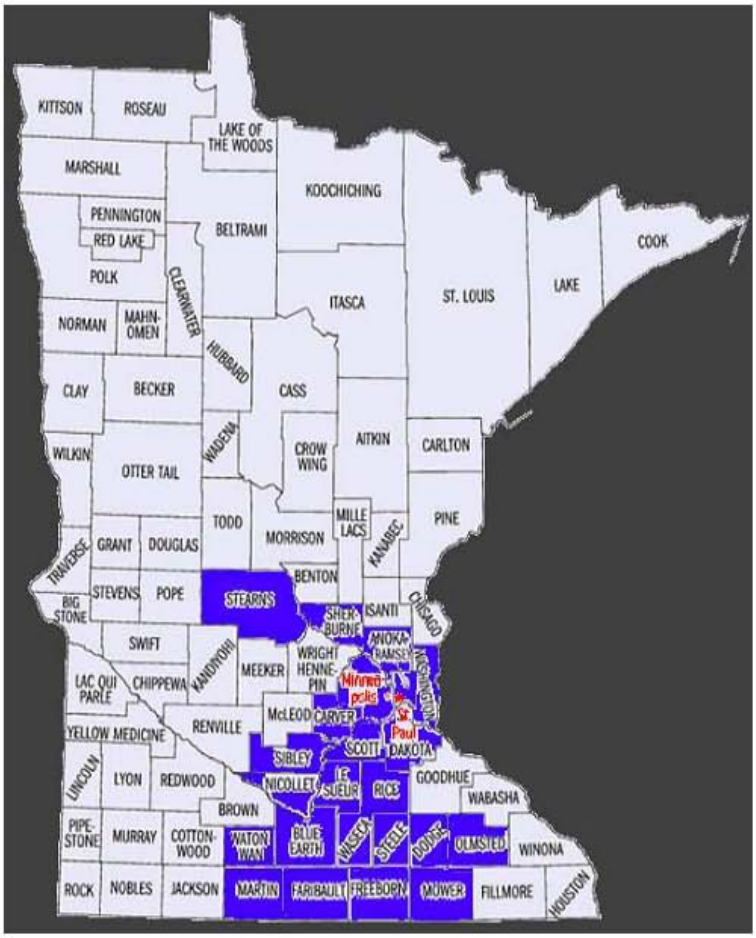
NUMBERS AND POPULATION GROUPS REACHED

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.

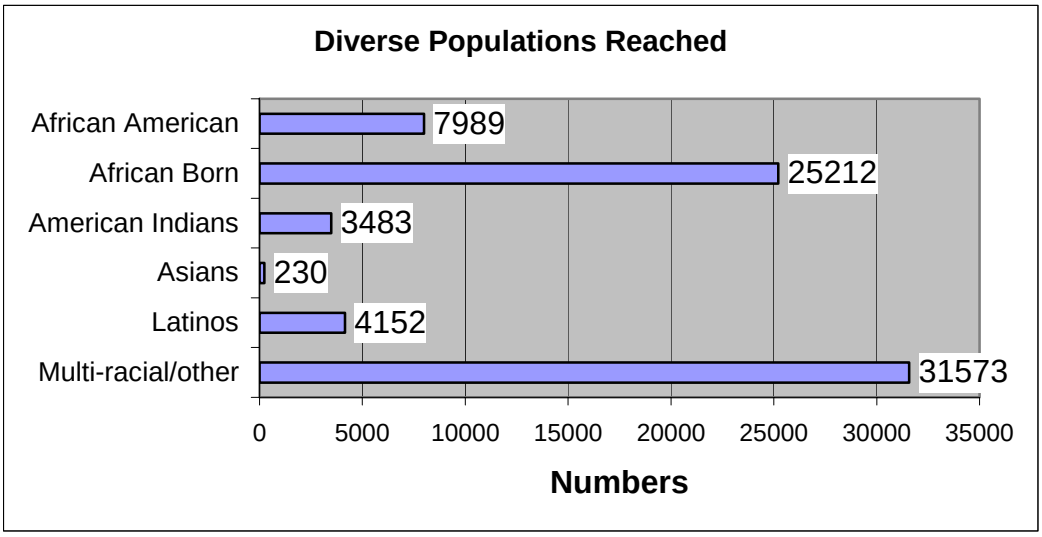
The counties in which the grantee organizations and tribes were working to address breast and cervical cancer are shown in the figure below.



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.

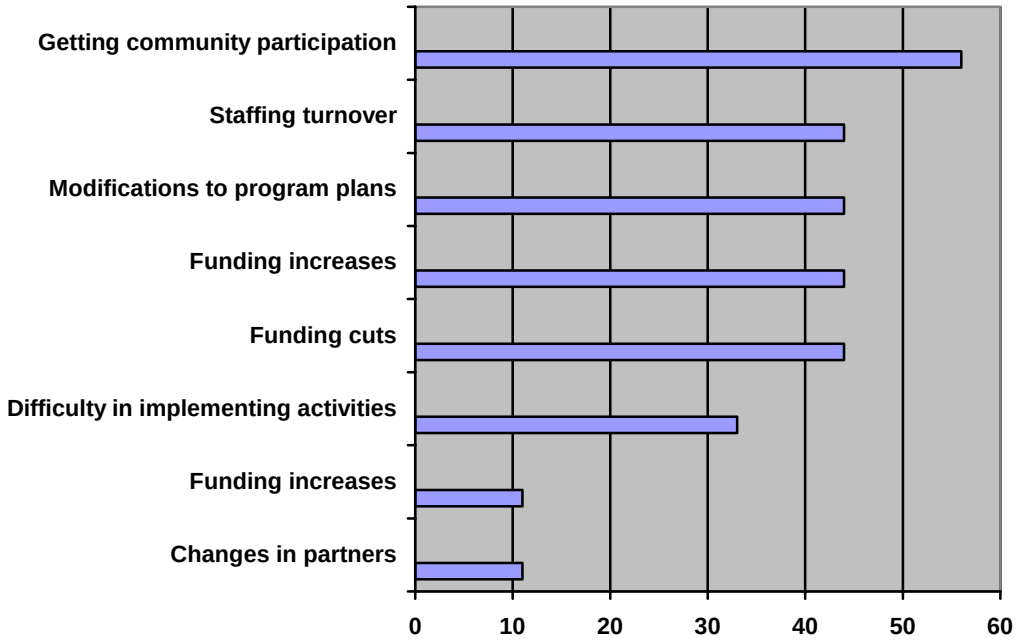
- American Indian Community Wellness Project/ Indian Health Board

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
Minneapolis, MN 55408

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.

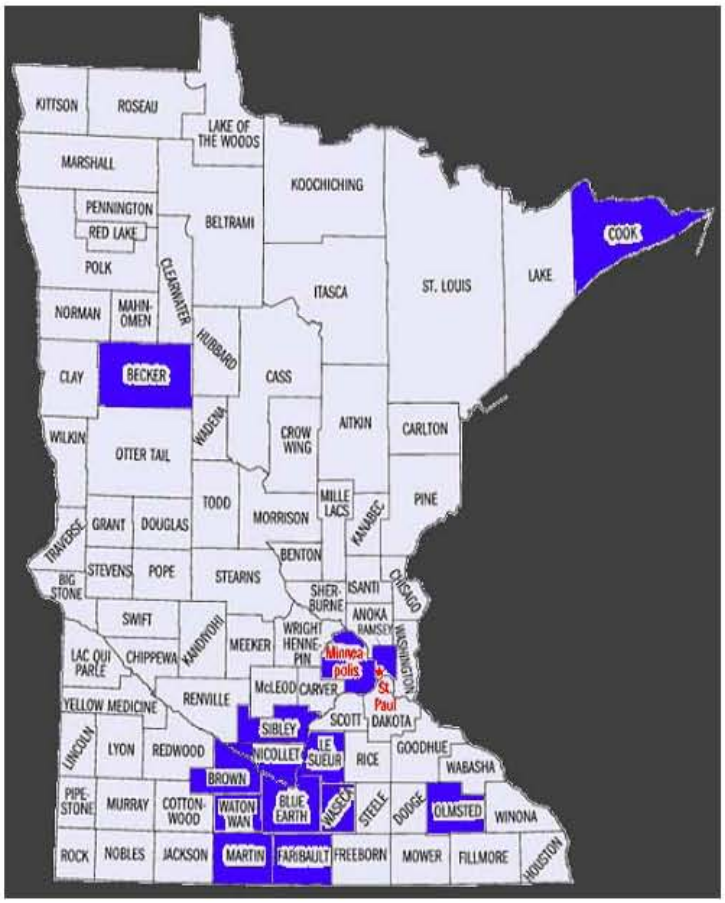
NUMBERS AND POPULATION GROUPS REACHED

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.

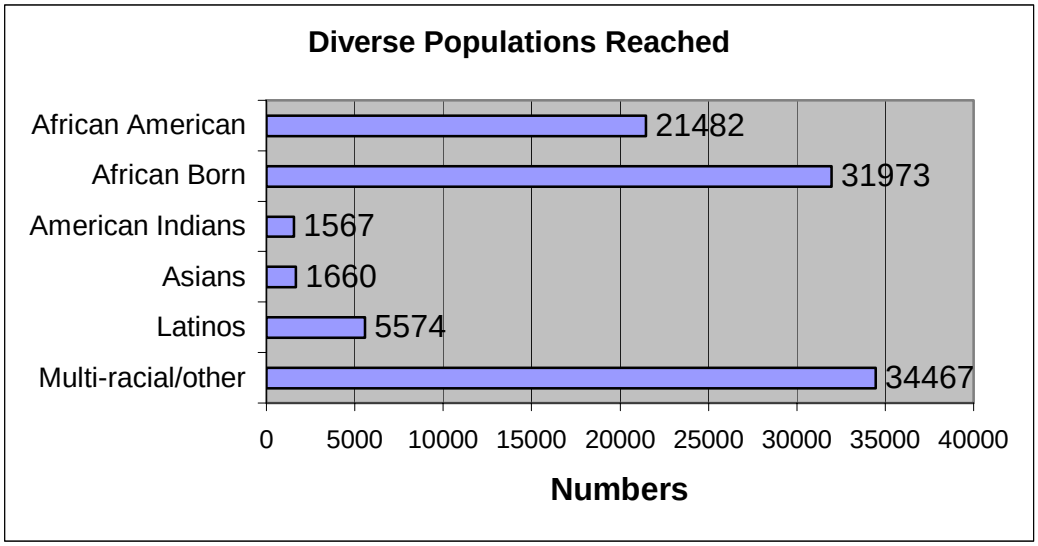
The counties in which they are working are highlighted in the figure below.



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

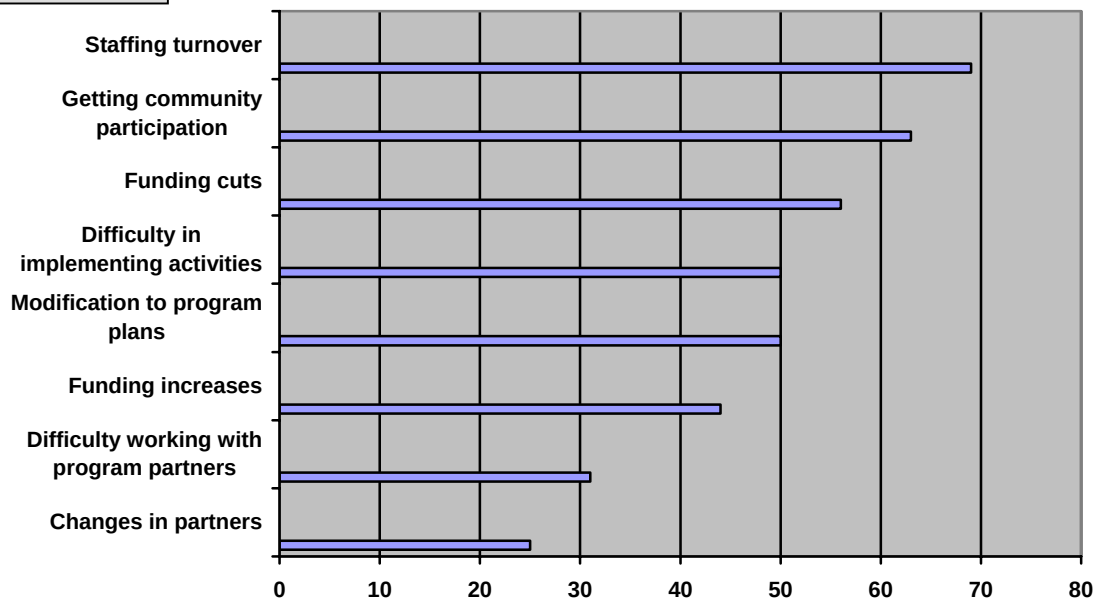
CHALLENGES

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:

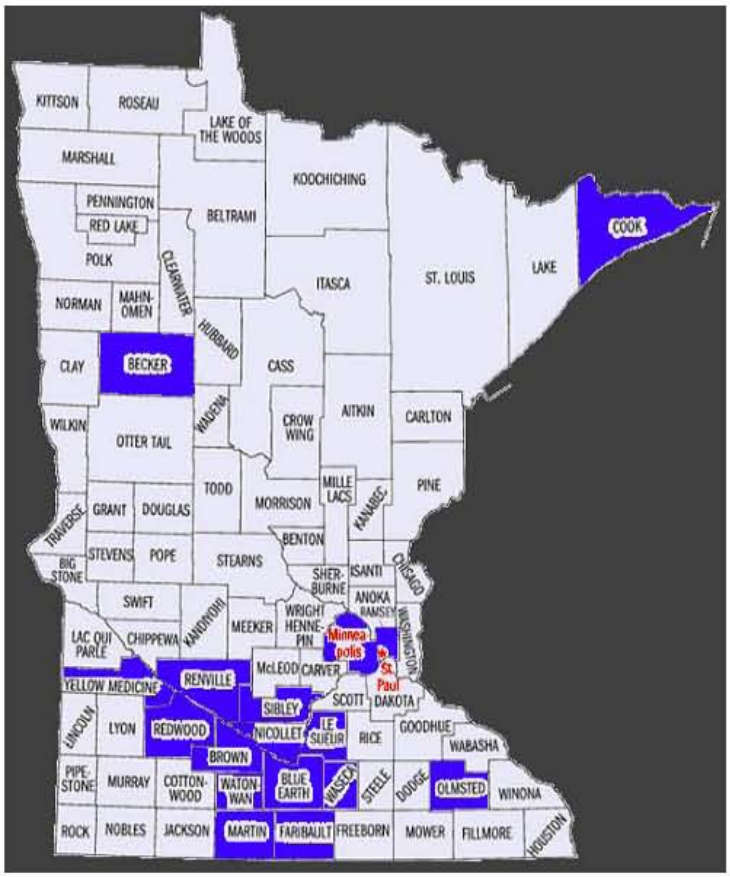
- The Hispanic diabetes mortality rate was ***twice*** as high as the White and Asian rate.
- The African American death rate due to diabetes was almost ***four*** times higher than the White and Asian rates.
- The American Indian diabetes death rate was almost ***five*** times higher than the White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

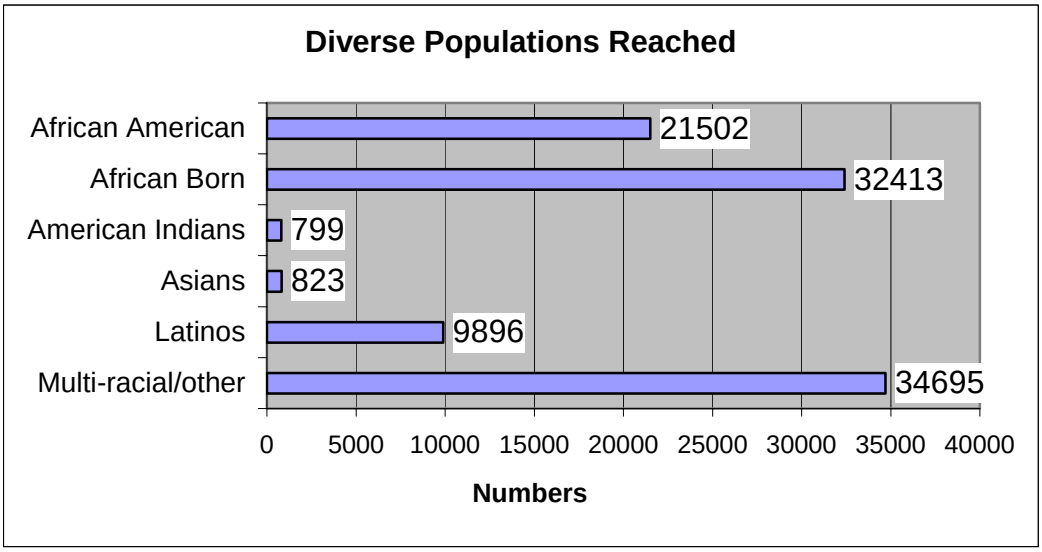


Many of the EHDI grantees working in the diabetes health disparity area are targeting several different racial and cultural groups.

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

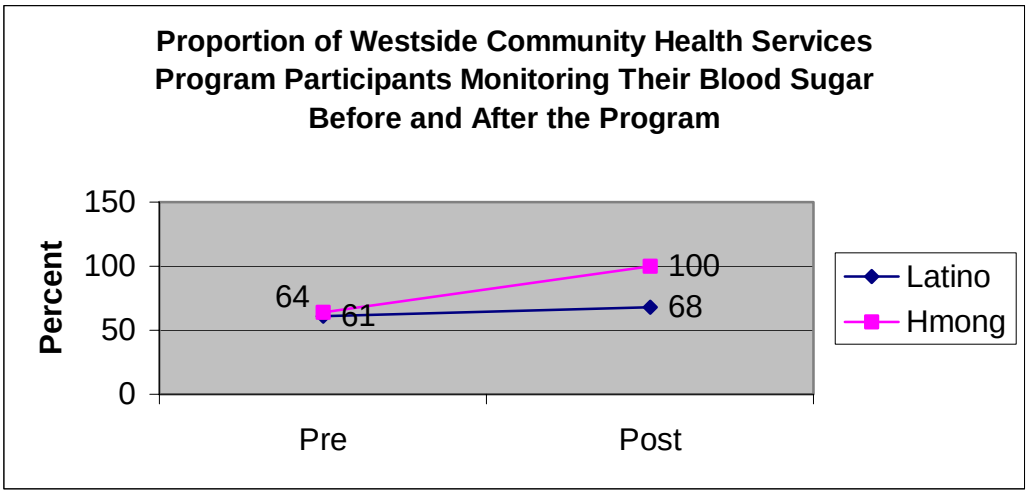
Changing Behaviors

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.

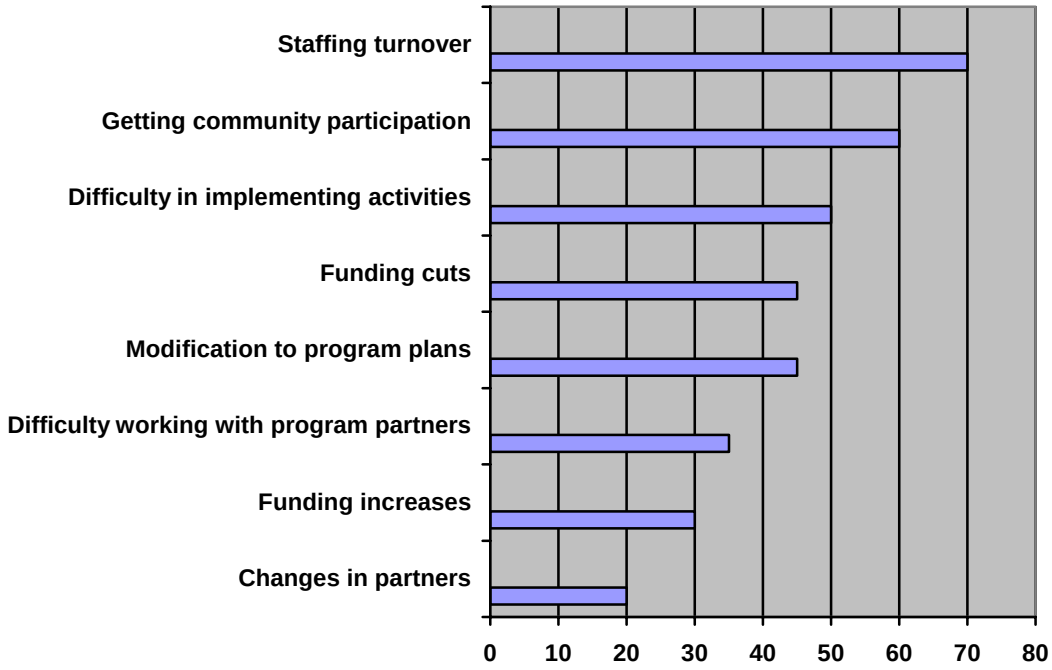
-The Park Avenue Family Practice Clinic

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
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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

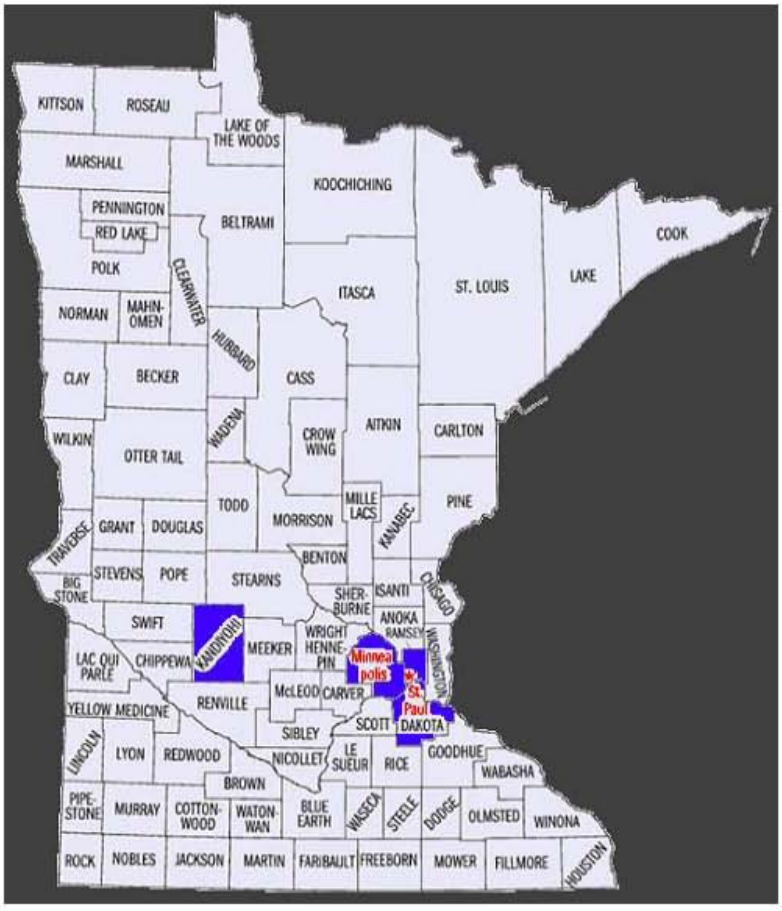
NUMBERS AND POPULATION GROUPS REACHED

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.

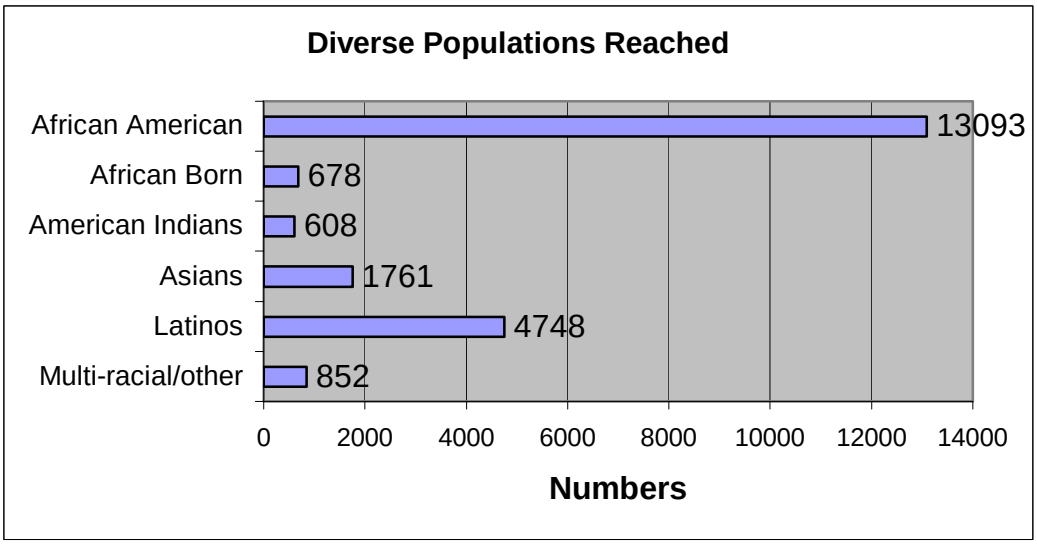
Some grantees worked with more than one racial/ethnic group. The counties in which the grantee organizations and tribes were working to address healthy youth development are shown in the figure below.



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

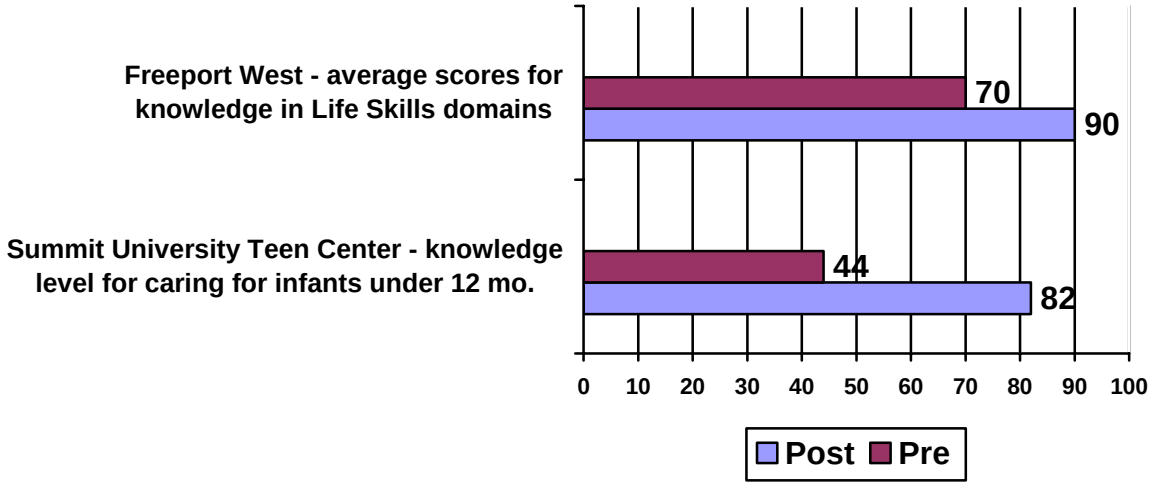
Examples of approaches used by grantees to increase awareness and knowledge:

- 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

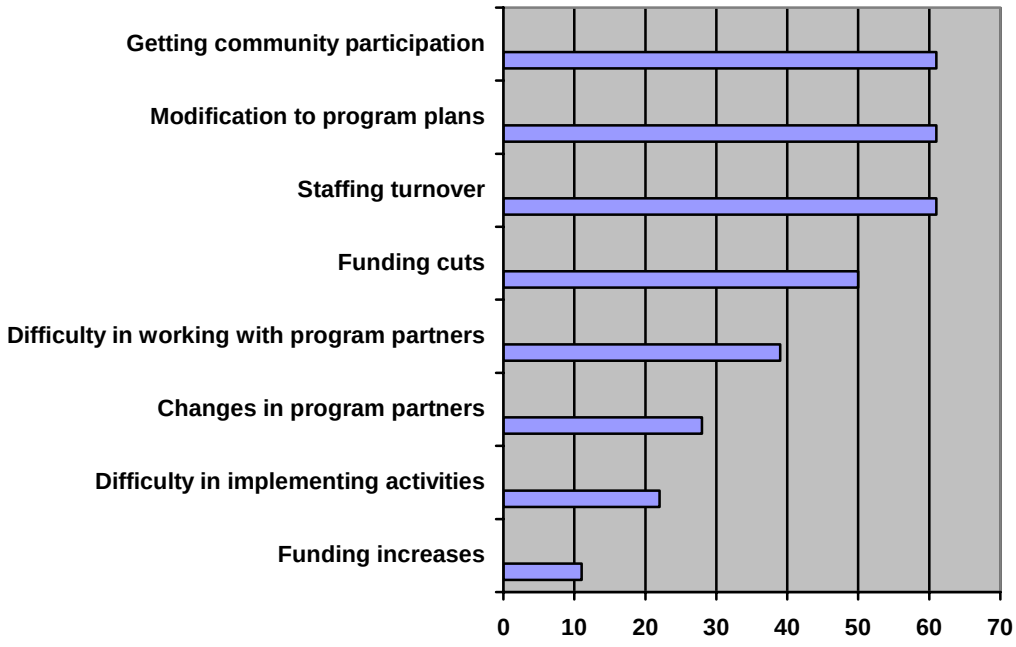
CHALLENGES

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

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 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]

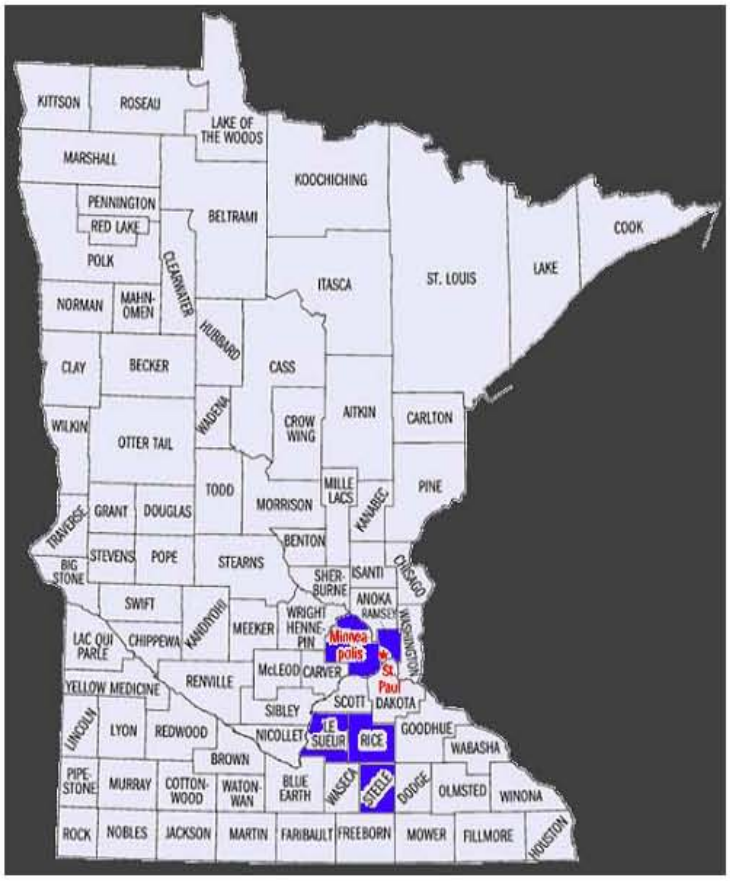
[1] Minnesota Department of Health HIV/AIDS Surveillance System

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.

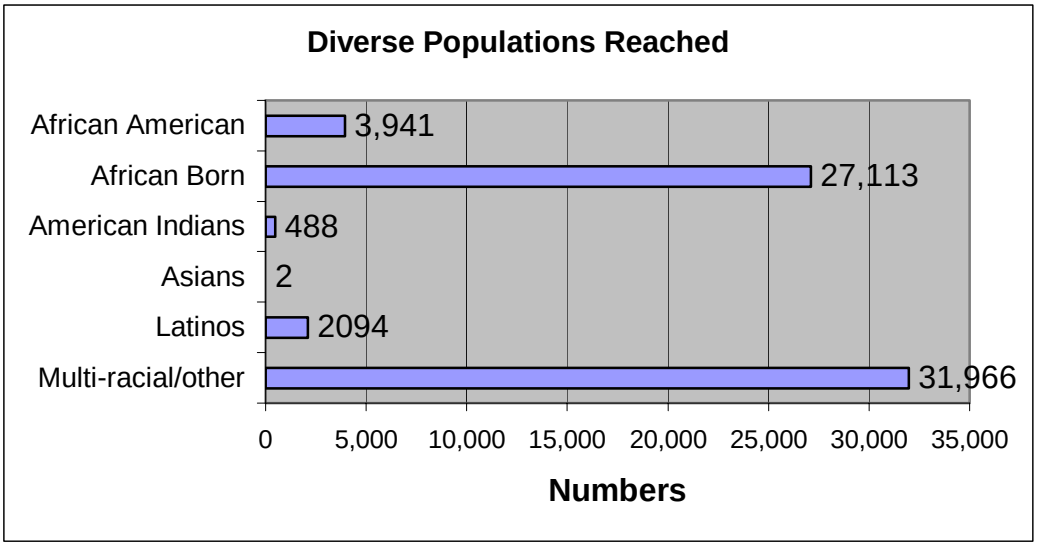


Many of the EHDI grantees working in the HIV/AIDS and STI health disparity area are targeting several different racial and cultural groups. The counties in which the grantee organizations and tribes were working to address HIV/AIDS are shown on the left.

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

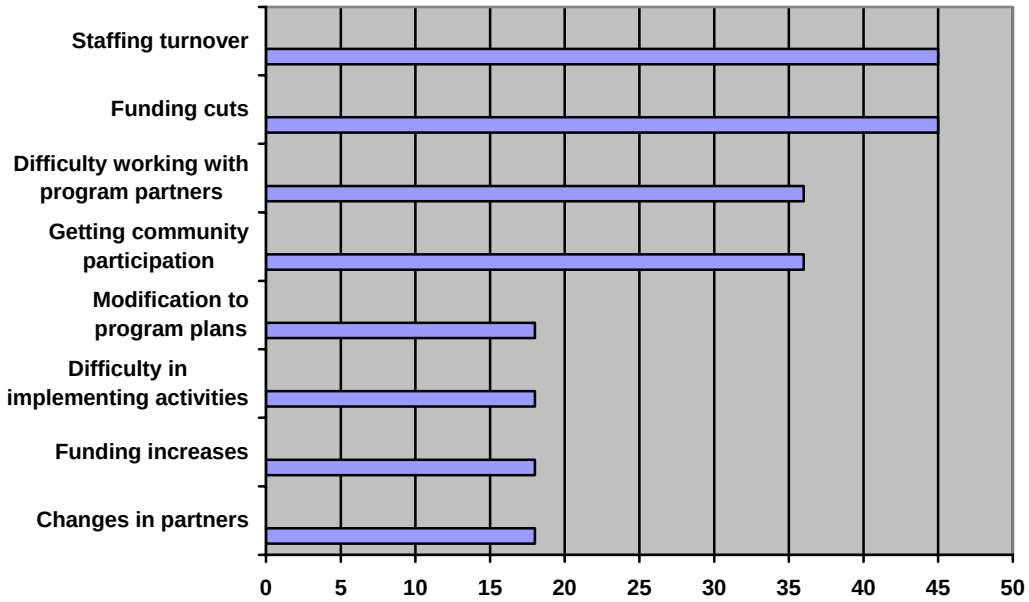
CHALLENGES

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

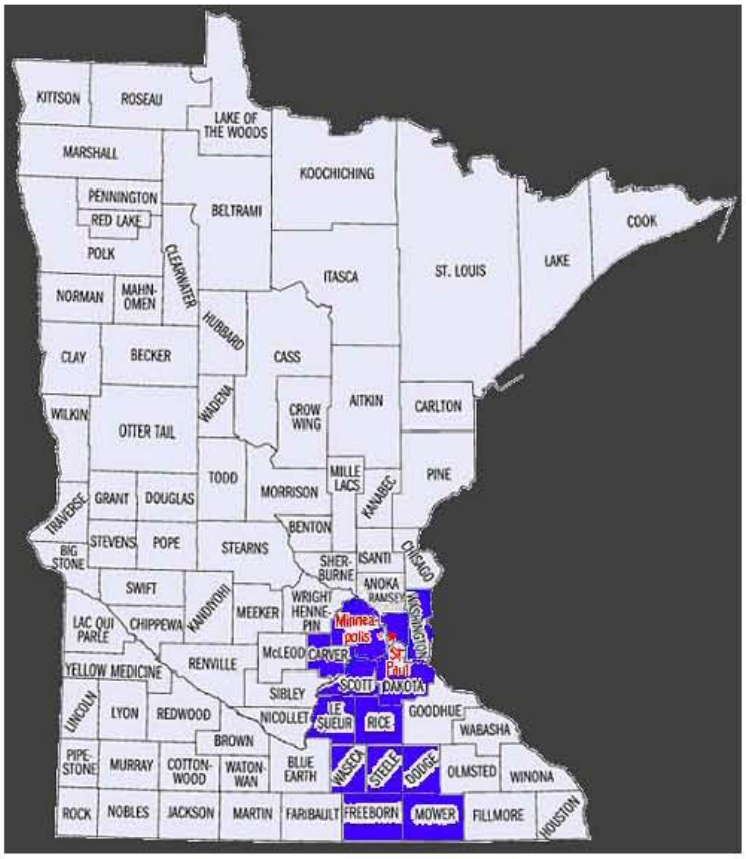
Disparities persist between different population groups in rates of immunizations for various diseases, and in the incidences of various vaccine-preventable diseases. For instance:

- 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



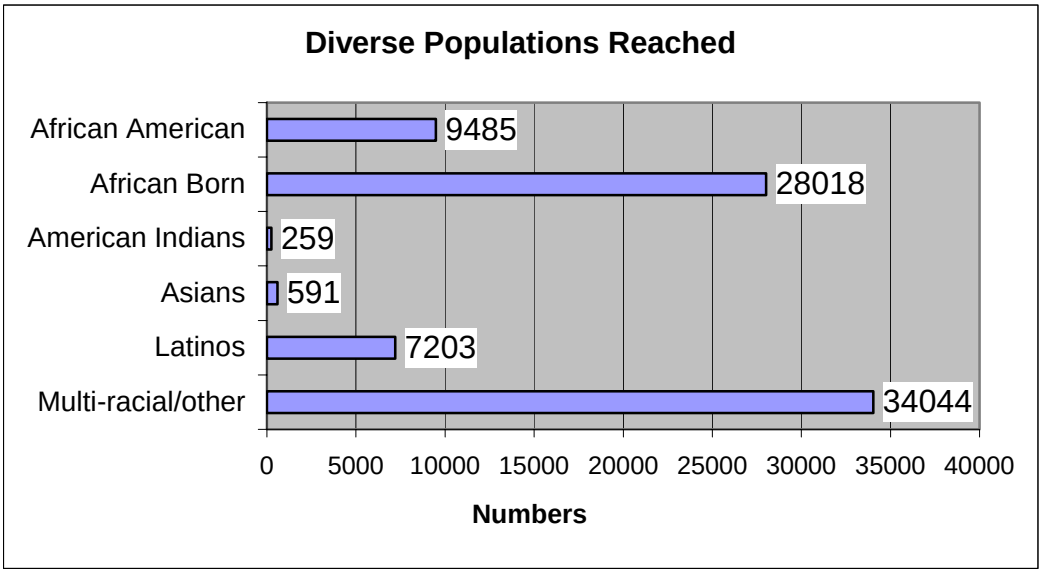
[1] Minnesota Retrospective Kindergarten Survey for school year 2001-2002 and 2000-2001 National Health Interview Survey

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

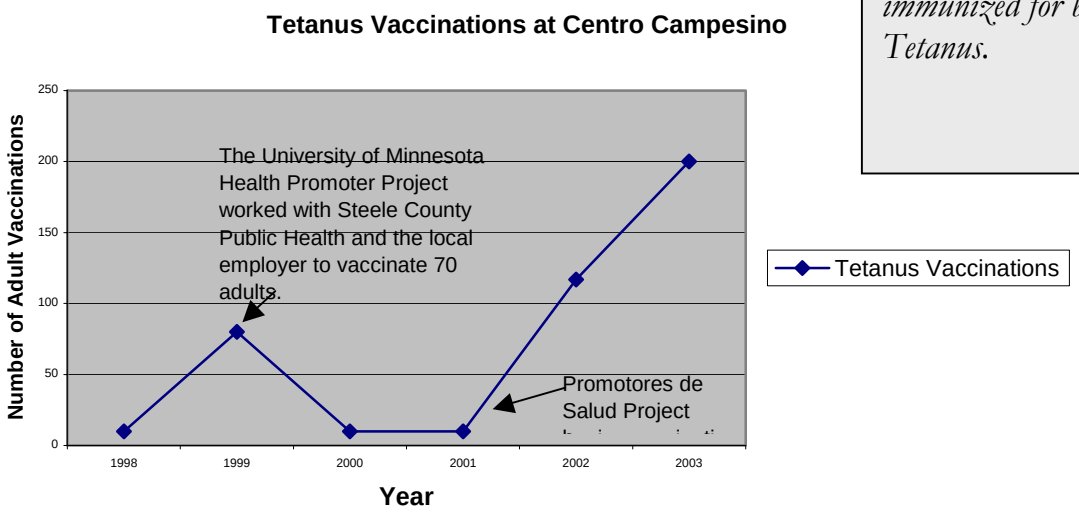
- Educational workshops/ discussions to help clients apply for low-income insurance to pay for services
- Assistance with interpretation

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

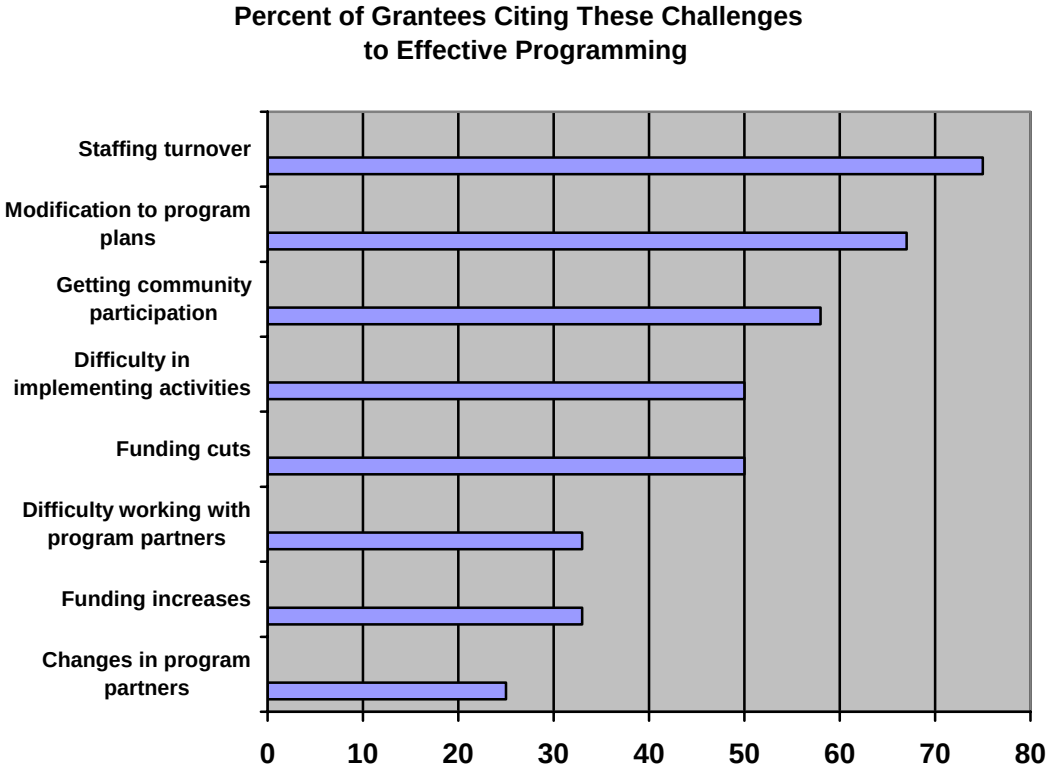
In order to affect systems change to reduce health disparities, the Promotores de Salud Project is involved in: providing information and advocacy about workers compensation issues and supporting injured individuals with their claims and medical needs; supporting the formation of a seasonal agricultural 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

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 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

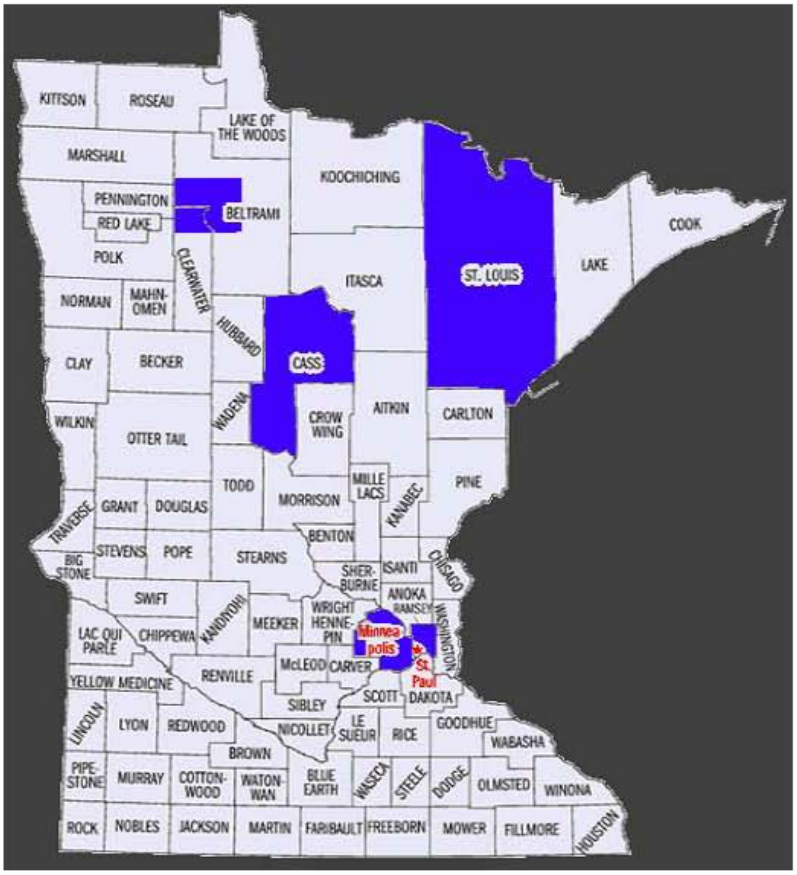
NUMBERS AND POPULATION GROUPS REACHED

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.

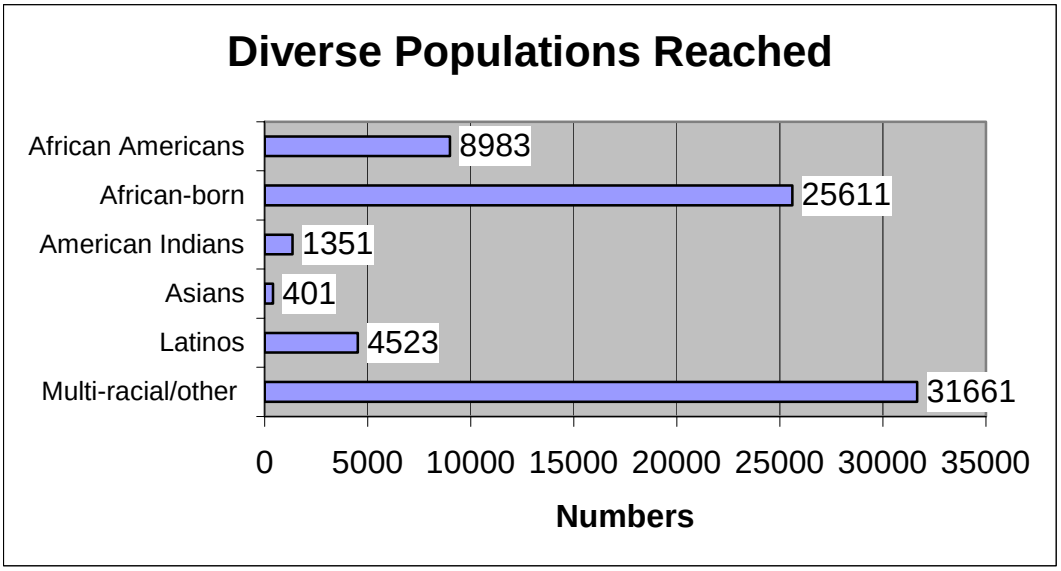
Some grantees are working with more than one population. The counties in which the grantee organizations and tribes were working to address infant mortality are shown in the figure below.



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.

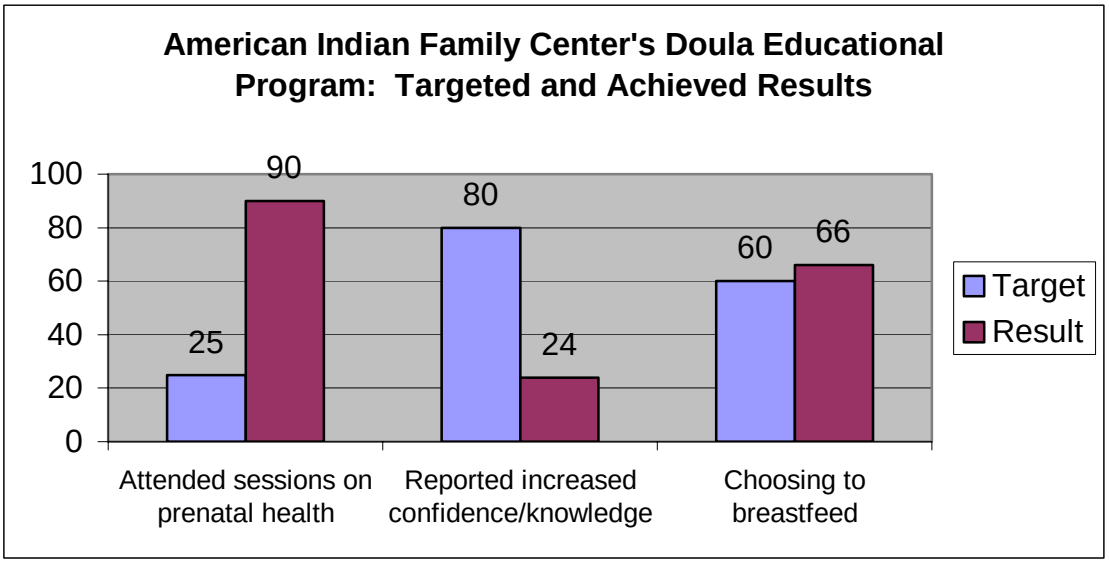
Examples of approaches used by grantees to increase awareness and knowledge include:

- 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

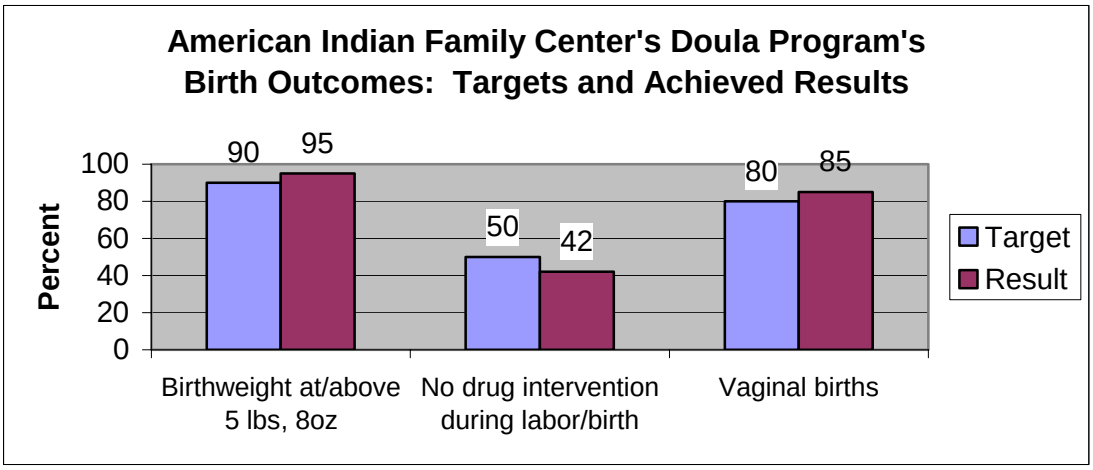
Infant mortality is the one area where we can see increases in health status among program participants—positive birth outcomes, such as acceptable infant birth weight. Other aspects suggest a positive birthing experience for both mother and infant, such as vaginal births and no drugs being used during 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

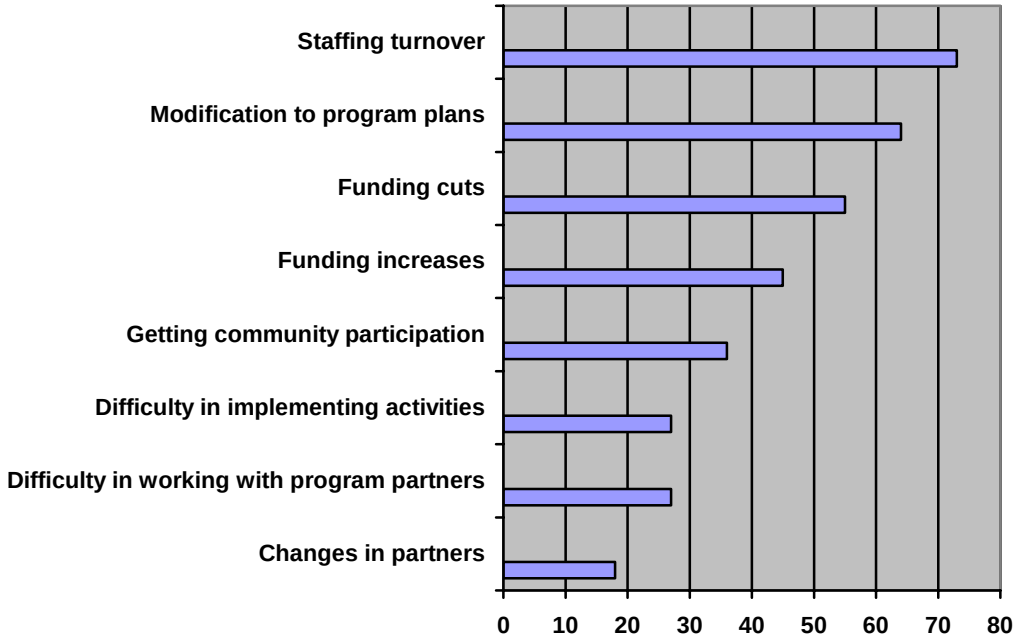
CHALLENGES

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

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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 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

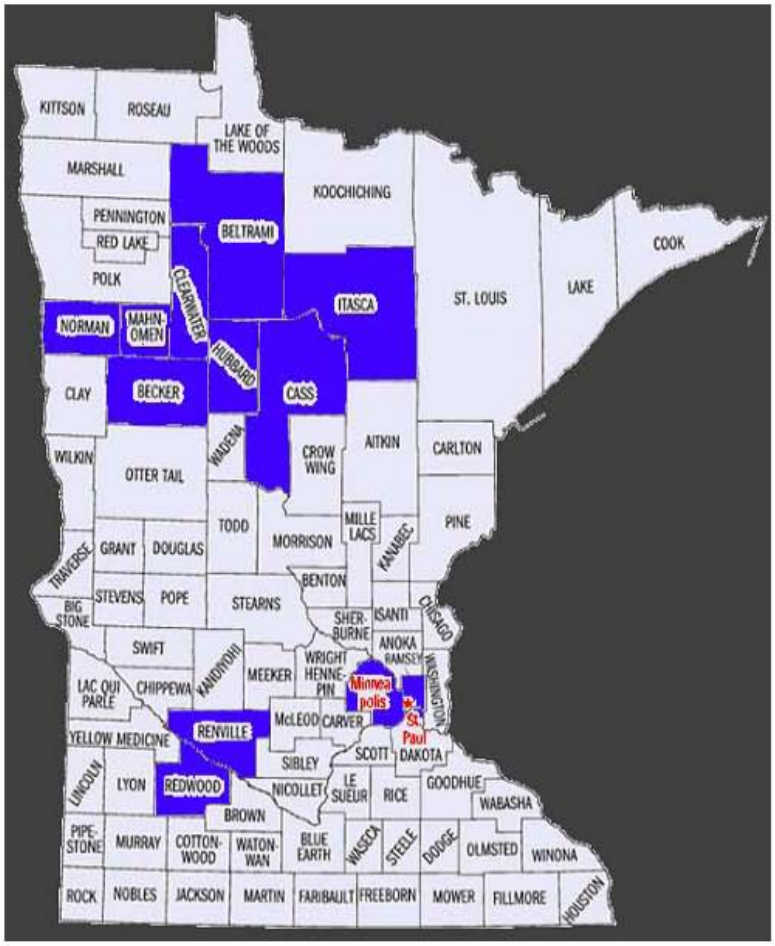
NUMBERS AND POPULATION GROUPS REACHED

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

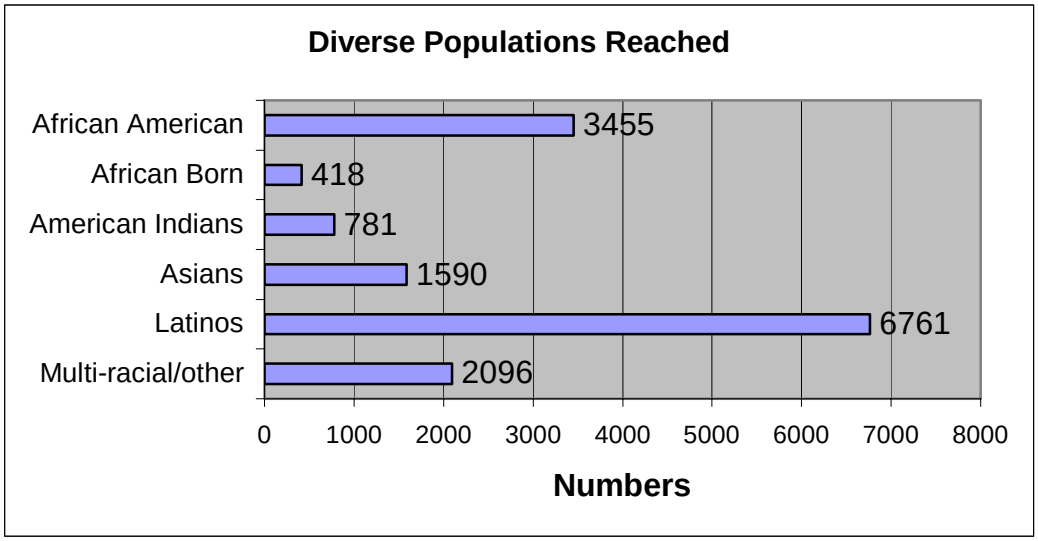
The counties in which they are working are highlighted in the figure to the right.



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

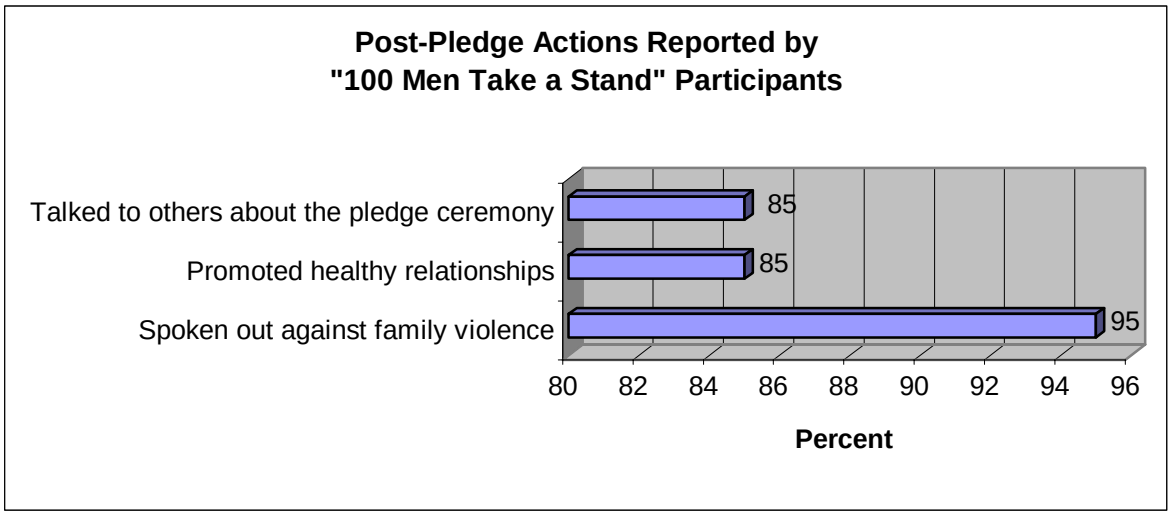
Grantees worked to change behaviors among program participants to prevent domestic violence, and for those who had already been in the criminal justice system for domestic violence offenses, to reduce recidivism.

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*

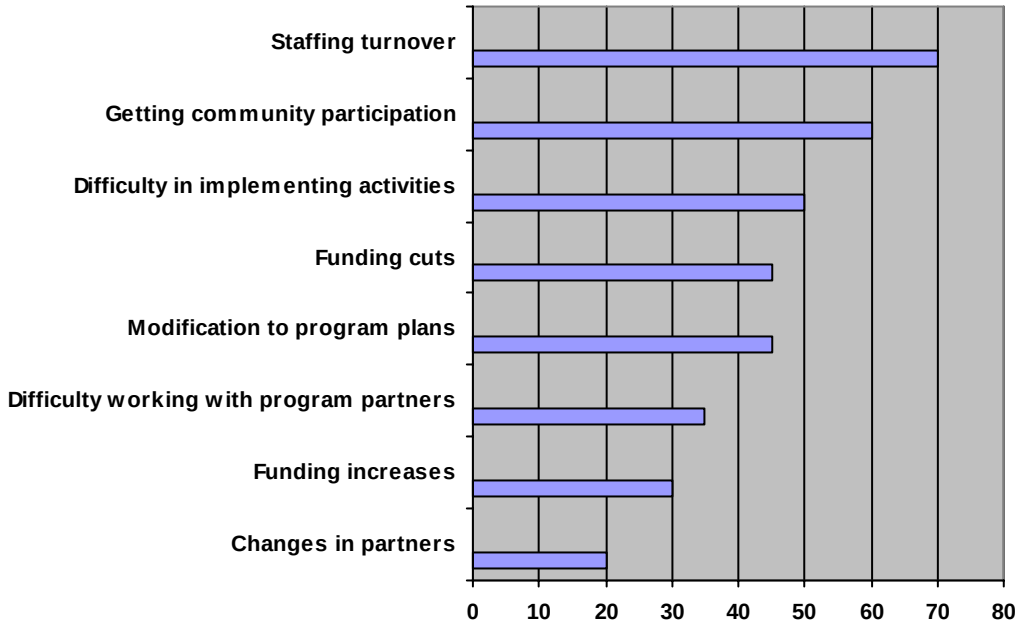
CHALLENGES

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

Hmoob Teen

The place where Hmong teens can speak and be heard.

hmoobtn@hmong.

Next Issue:
March 2005
Theme:
Lessons & Regrets

Embarrassing Moments

MOTIVATION

COMIC:
SHE'S SO HOT

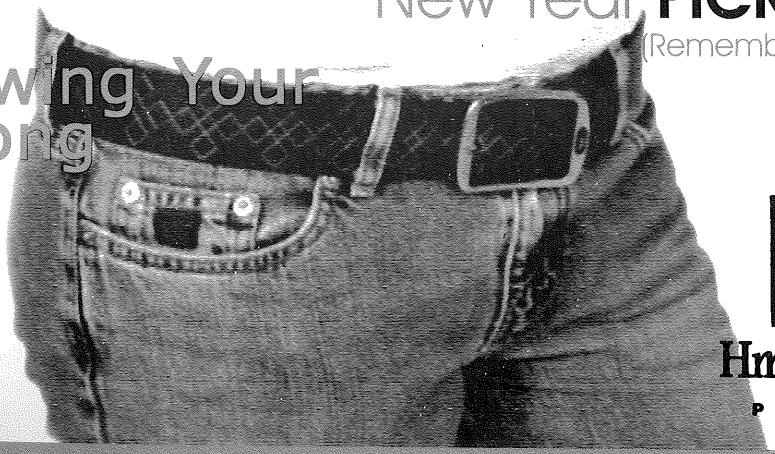
Words from the **Newcomers**

MY INSPIRATION

Hmong Clothes?

GUYS:
New Year **PICK UP** Lines
(Remember no means no.)

Knowing Your Hmong



November 2004

Hmong American PARTNERSHIP

This publication is made possible through Hmong American Partnership (HAP). HAP provides culturally appropriate social services to Hmong families in Minnesota, such as: employment services and English language classes for adults, After school programs for children and youth, and counseling and support programs for families. For more information please visit www.hmong.org.

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November 2004

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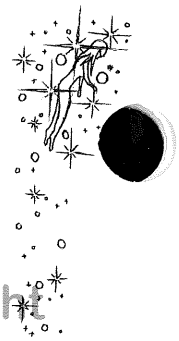

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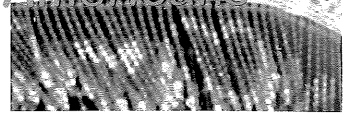


HmoobTeen

EDITORS' NOTE:

Welcome to **HmoobTeen**! This issue's theme is motivation. We received an overwhelming response from our readers on this theme. Many people talked about their family and how meaninful family is in their lives.

This issue of HmoobTeen is being distributed primarily at the St. Paul Hmong New Year. Come to our booth and vote on the **ElimiFACE CONTEST**. The winners of the contest will be in our next issue. They also get a Hmong dressed teddy bear.

HmoobTeen has a paid, part-time position open for an Editor-In-Chief. The position is open to all qualified candidates, including teens. A full job description and deadline will be on the Hmong American Partnership website soon. www.hmong.org.

The next issue of **HmoobTeen** comes out in March 2005. Until then, enjoy the new year celebrations and your Christmas vacation and don't forget to submit your articles, poems, crazy holiday photo's, comics and thoughts before our next deadline: January 31, 2005. Be good!

March 2005 Theme is Lessons & Regrets!
Deadline: January 31, 2005
Send your work in!
We put a lot of information on our webpage.
Go to www.hmong.org and click on HmoobTeen.

SCHOLARSHIP

The Hmong Chamber of Commerce is giving away a $1,000 college scholarship.
Deadline: December 8, 2004.
For all the details call 651-645-6777.

JOB OPENING

HmoobTeen is seeking a Editor-In-Chief. This is a paid, part time position. We are looking for a mature person with the following skills: graphic design, leadership, fluent in Hmong, administrative (filing, email, typing, meets deadlines,) extremely organized, creative.
For full details check www.hmong.org.
All qualified candidates are encouraged to apply, including teens.

Letters To The Editors

Hey **HmoobTeen**! I just received the September issue, I would like to post a response to those young girls going through depression; whether it is "love" or "family issues".

I've read your articles in the last issue and you all remind me of someone I know – myself! Whether the situations that you're faced with are "love" or "family problems" – I can relate to them all. Anonymous, your article, "Loved the Least", really touched me. What you're going through is part of growing up. I always thought my parents loved me the least too.

I can relate to the statement in your article, I would always cry and ask myself why I was born into this family. Thoughts like this are serious and it's thoughts like these that lead young teenagers into temptation that leads to suicide. My advice to you is to go out and hear stories of the many others who have it worse than you do. That's when you start to see things clearly and appreciate the great things that God has blessed you with.

Lastly, yes Leng Thao – author of "Comments on Love" – I have to agree with all that you said about love. "LOVE" is a strong word. Don't use the words "I LOVE YOU" or just the word "LOVE" so loosely. The word "love" has many great and powerful meanings. If you use it too freely, then the words "I LOVE YOU" won't have meaning anymore. If a guy kisses you, IT'S NOT LOVE. IF a guy holds your hand, IT'S NOT LOVE. If a guy tells you he loves you after knowing you for 3 days, leave him. He's no good and it SURE ISN'T LOVE! My theory on love is that, you never know what love is until marriage "For better, for worse – till death do you part." - Heartless Dying Soul Yang

Dear **HmoobTeen**, Hey there! My name is Pakou Vang and I am 16 years old. I read every issue of **HmoobTeen** magazines and I think that they are cool. There are many things in these magazines that have inspired me as a student in school and as a daughter to my parents. I feel that you guys should continue to produce these magazines because it gives teens all around the world the chance to see other teen's work and hear about their ideas. It's kind of like a way for Hmong teens to communicate with each other. Not only is this magazine a place for Hmong teens to speak their minds, it is also pulling us a little closer to each other. Keep up the great work and I am hoping to be able to read more of these magazines in the future. Much love and peace out! - Pakou Vang, 16, Mpls, MN

Dear **HmoobTeen**, Your magazine is fascinating! I am really happy to know and find out that I'm not the only one with a wayout stressful life. Your magazine tells me that I'm not alone. There must be at least on other person out there with the same problem as me. Thanks for showing me that. – Mai Maycee Yang,13, St. Paul, MN

Hey **HmoobTeen**, my name is Linda Yang. I really enjoy reading your **HmoobTeen** magazine. The things I really enjoy and look forward to reading about is friends, people, ideas, artwork, articles, poems, and things about our culture. I can hardly wait to read the next issue. I hope to see you at the Hmong New Year Celebration. I want to tell all the **HmoobTeen** editors that they are doing a really good job with the magazine! - Linda Yang, 12, Brooklyn Center, MN

HmoobTeen Editors
Autumn Vang, Features Editor
Choua Her, Editor-In-Chief
Kau Chee Vang, Features Editor
Lashere Lee, Features Editor
Leng Thao, Features Editor
Patsy Lee, Features Editor
Phai Vang, Features Editor
Stacy Bellward, **HmoobTeen** Advisor

SEND IT IN!

We pay for work we publish.
Articles/Photo Essays/Comics: up to $25
Drawings: up to $20
Poems: up to $15

You must include your name, age, city, state, telephone number and email where we can reach you. Art must be on unlined paper, please donot fold your art. **HmoobTeen** holds all the rights of works once we publish them. Please email your work if you can.

HmoobTeen publishes 5 times per year: March, May, July, September and November. Currently we reach over 18,000 readers per issue. Our next issue, coming to you in March 2005, has the theme Lessons & Regrets. Get started...send us your work! We can't wait to read it. We really want to hear from our bro's and sista's in far off states. **HmoobTeen** is made possible, in part, by funds provided by the Metropolitian Regional Arts Council through an appropriation by the MN Legislature, and the Mall of America Foundation for Youth. Thank you for your sponsorship of **HmoobTeen**.

Letters to AN Editor: Comments On Love

Dear Leng Thao, I must admit it was rather amusing to read what you said on "Comments About Love." Instead of love letters from these preteens, you'll have to prepare yourself for the coming wrath. I was not upset. I was too preoccupied laughing after reading each paragraph.

Don't be so harsh towards these growing minds Mr. Thao. Once we were at their age and you known personally for yourself love is an unsolved mystery. Allow them to keep asking more questions, even more so let them send in their love stories. Those kids won't stay 12 or 15 years old forever.

Print their stuff no matter how tired you are after reading all their letters. I think it's great if teenagers listen to the love stories of us older folks and we should pay respected attention to their young loving hearts.

I'm quite glad you have set up some ideal standards for that special someone, hopefully not too impossible for anyone to fulfill. Have a great day and lots of fun with **HmoobTeen**! Thank you. – Rosemary Lee, St. Paul, MN

Rude-ness must not be spoken! Okay, here I am finishing reading the very last page of the September issue and I never realized how un-supportive some of these editors are, male in particular. I mean **HmoobTeen** is the place where teens can express themselves, right? Then why would you criticize people, telling them to cut down on the romance and the lovey dovey stuff, as you say, when you, yourself have no idea of what the feeling is.

As Leng Thao says, the ages range from 12 to 15, but think about how these pre-teens will feel if **HmoobTeen** was the only place where they can express themselves? I mean, you chose to become an editor, why not support their thoughts and help them out by giving them some advice on how they might handle it? Maybe, they want to be heard just like you. I find it offensive that this Leng guy made "LOVE" seem like it was a game to play and in the end, you win an AWARD of some sort. How can you publish such an offensive piece that admits you are a jerk?

My exact comments to Leng are to take a second look at what you have written before preaching your thoughts and views to people. – Miss Anonymous, 18, St. Paul, MN

Dear Rosemary and Miss Anonymous, Thanks for your response. I was looking forward to some negative responses. I'm prepared for all the wrath that's going to come my way, I look forward to it. Not that I'm trying to start anything, I just like hearing people's thoughts. Sorry if the article seemed a little harsh, I intended it to be a more comical and relaxed type of reading. If you find it offensive, sorry (and that goes to everyone), if you find it true and comical, look forward to my other writings. I'm not saying that we won't print any love articles; (I am only one person out of a whole group who decides what goes in each issue) it is a place where teens can speak their mind; I'm just saying to calm down on it. Like I said, if you think you're in love, that's good for you, but please DON'T PREACH ABOUT IT. Also, there are more things out there to write about besides love, especially when they're in the ages of 12-15. They write about it as if their whole life revolves around and depends on it, living just to experience love. THERE ARE MORE THINGS IN LIFE TO EXPERIENCE OTHER THAN LOVE, AND I KNOW THAT FOR A FACT. If you're dealing with a break up then go ahead and write, we'll help you out. Anyway, thank you again for your responses. - Leng Thao, **HmoobTeen** Editor

P.S. I did not say I was a jerk, I said if you thought I was one then go ahead and think so.

RESPECT

By Jerry Xiong, 13, St. Paul, MN

I see a lot of Asian girls and Asian guys acting all cool and drinking, smoking, and doing drugs. If you think about it, it's not cool at all. It's not good for your health; in fact it can kill you. I'm not trying to be a hater saying this and that about kids who smoke or drink. The only reason you get a lecture is because you go out for so long and never tell anybody where you're going, they get worried about you. They just want you to be home where you are safe.

Your parents are the ones who gave birth to you and took care of you. Your parents are at a much higher level than you are and they have the right to tell you what's right for your life. I know that at times your parents can be a little strict and can make you angry at them, but they're just telling you what's right and what's wrong. Respect them, learn what's right and what's wrong from them, and love them for who they are.

They join gangs, get into fights, and so on. It's okay to be in between but NEVER disgrace yourself, your parents, and especially your culture, Go to school, focus on your education, and learn from your mistakes.

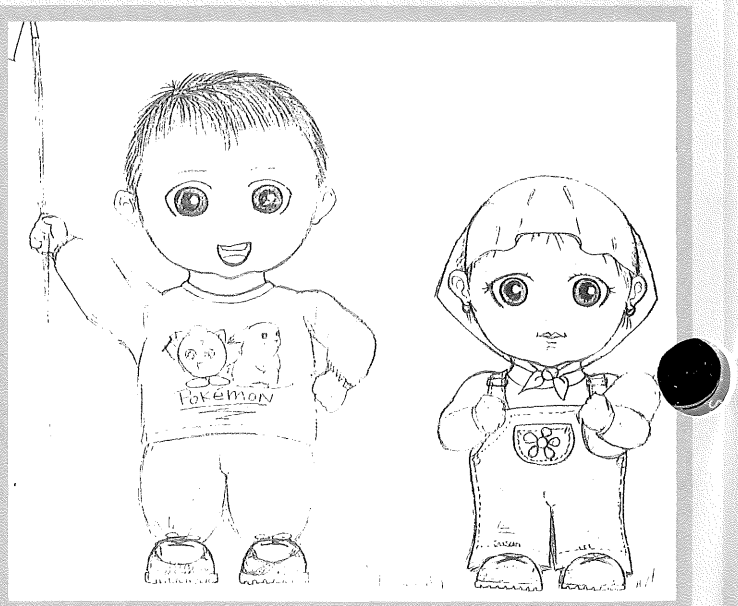
I Listen To My Heart

By Pheng Lor, 13, St. Paul, MN

My greatest motivation is myself. I listen to myself. I also listen to my heart and what it says to me. My heart tells me to do the right things like not running away from home or stealing things. I have a brain which helps me to think before doing wrong things.

I go to school so I can get my education, which helps me in the future. Education helps you enter college, and get better jobs, so you get paid more to help your family. Many things motivate me but the greatest is that I motivate myself.

Artwork by Pa Houa Lee, St. Paul, MN



Saved by the Stalker

By Anonymous, St. Paul, MN

One time during the Hmong New Year celebration an OG (old geezer) was following me around and I could not get rid of him. It's rude in the Hmong culture to tell him to go away so I tried to come up with every excuse in the world for him to leave me alone. I even told him that I was going to go home but he insisted on walking with me to the car. Out of luck, I tried to walk as fast as I could so I could lose him but he kept up the pace. I started to walk really fast, almost running. I looked behind and saw that he was at least 6 or 7 feet away. Happy and overjoyed that he was a distance away, there was only one more step before I could be free. I quickly turned into the nearest restroom to hide when all of a sudden he grabbed my shoulders from behind sending shockwaves through my body. I was disappointed at the failed attempt to escape. Then I realized that he stopped me from entering the men's restroom. I was totally embarrassed!

Over and Over

By phai vang, 18, Minneapolis, MN

Ladies and gentlemen, boys and girls, cats, dogs, zebras, ducks, goose, geese, prepare to take out your pepper spray and start spraying. We are about to venture into one of the world's most dangerous places, men at the new year who do not understand the word NO.

Comon bro, man to man, **if she's not digging you, leave her alone.** Don't follow her around the whole river center. There's a lot of other girls to talk to, she's not the only one. When you ask for her number and she replies with a NO. I'm pretty sure she's not interested. Leave her alone, many girls attend the new year to have fun, not to be bothered by some guy. Think to yourself, maybe the new year is not the best place to hollar at girls.

How Embarrassing

Booty Call?... Mommy Call

By Jennifer Vang, 15, St. Paul, MN

One summer day my cousins and I went swimming at Phalen Lake and after that we went walking. We were at the picnic area and I stood by the side of the road. Every time a car would go by I would pretend to hitchhike or say something stupid or funny. After a while, I told my cousins that this was going to be the last car. The last car passed by and I yelled, "Hold on sexy... (I said it in Hmong). The car had black windows so obviously I didn't know who the driver was. The next thing I knew, the windows were rolling down and it was my mother looking at me... I was embarrassed.

Strutting My Stuff

By Ling-Moua Thao,

I was at camp for church and there were a lot of Hmong people from everywhere. I was wearing my friend's very high-heeled shoes. I was walking with my cousin and my sister to the evening program in front of these 3 cute guys. It was just the 6 of us out there! I was trying to do a sexy walk, so I could get noticed. All of a sudden I tripped over my own feet! I grabbed my sister's arm to keep my balance, but missed and fell right in front of them. The guys laughed and asked, "Are you okay lady?" I was so embarrassed, that I got up quickly and walked away. If that wasn't embarrassing enough, when more people came, my cousin told everyone how I tripped in front of the guys and their reaction! Everyone laughed at me, I was embarrassed that whole week!

Flying Ball

By Choua Her, St. Paul, MN

My cousin and I had waited all year for the Hmong New Year Celebration. It was finally here and we were more than excited to go. We woke up at 6 am to get dressed in our beautiful Hmong clothes and found our neon green tennis balls for ball tossing. We got to the Hmong New Year and started ball tossing with a few friends. After a while we decided to pov pob swb, a ball tossing game where if you drop the ball then you have to give up an item that belongs to you or sing kwv txhiaj (traditional song). The object of the game was to throw the ball really fast and hard or throw it in such a way that the ball would curve and spin so the person you're throwing it to would drop it. It was my turn to throw and I knew that I had to come up with a strategy. I swung my hand and threw it as fast as I could. Ooppss... I had thrown it too high and too fast. Instead of trying to catch the ball, my friend ducked and it flew directly past him hitting an elderly woman in the head making her phuam (hat) fall off. My cousins and friends started laughing. I didn't have the guts to go retrieve the ball because I was totally embarrassed!

Sushi

By Gaoweed Vang, 15, St. Paul, MN

My most embarrassing moment is eating stinky fishy sushi. Me and a couple of friends are at the buffet, just eating and then my friend bet me and my other friend Lee $5.00 to eat the sushi. I never ate sushi before, it stunk like crap! I took a bite and Oh My Gosh, I ran to the bathroom fast, not caring who was staring at me. As I pushed the stall door open, someone was taking a dump! When I smelled that awful aroma it was all I could take. I puked. I went back to the table and told my friends, we all had a good laugh about it and that was the last time I will try eating sushi.

Send It In!!! We Want to Know!

Do you have an embarrassing moment to tell? Send it in! Let us know what happened, what you did, or what you will never do again. Send your embarrassing moment to us and we'll send you a **HmoobTeen** bubble clock. Make sure to include you name, age, address, email address, and phone number.

Hmoob Thaib Teb? NO! HMONG AMERICANS!

By Choua Her, HmoobTeen Editor, St. Paul, MN

They're no longer Hmoob Thaib Teb (Hmong Thailand), they're Hmong Americans!

I had the wonderful opportunity of sitting down with a few teenage Hmong refugees from the Wat in Thailand and a young lady from Argentina, South America to get their thoughts on life in America. Meeting new Hmong immigrants for the first time was exciting. Just seeing them put me in a state of awe. It felt unexplainably happy to be in the presence of these new faces. I started by asking "kawm ntawv li cas lawm xwb? Puas nyuaj thiab? (How is school? Is it hard?) Sai Xiong, 16, who've been in Minnesota for 4 months said "tsis nyuaj heev thiab, tsuas yog tsis paub lus amiliskas xwb. Kuv nyiam kawn lej vim nws yooj yim rau qhov peb twb tau kawm lej tim Thaib Teb lawm thiab. Thaum twg nai khu hais dab tsi yus tsis tau taub ces kuv hais I don't know xwb." (Translation: Not that hard but it's just that we don't know how to speak English. I like math because it's easier. We've taken math classes before in Thailand. When the teacher says something that I don't understand, I say I don't know.)

Although new to Minnesota, all of them have agreed that the educational system here is much better than in their hometown. Cha Vang, 14, who's been here 4 months shared with me that schools in the camp were dreadful because teachers could beat you with a stick if he or she thought that you were bothering other students (especially Thai students); or if you weren't singing the pledge of allegiance. There was nothing your parents could do about it and many students ditched school because of this. The teens concur that the teachers favored the Thai students over the Hmong students in the Wat. There were no laws in Thailand and especially inside the Wat to protect Hmong from abuse. "Schools in Argentina were much more pleasant because we attended Christian schools" recalled Marcela Thor, 20, whose family immigrated here 6 months ago.

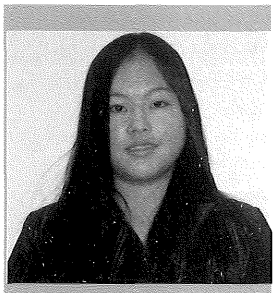
America is a much better place for them they nodded. "Everything from living conditions to education is significantly better because the American government helps and there are more opportunities." Yee Lee, 12, who's been here only 2 months said that there's no more worrying about how to feed her family and knows that she will have a better future here. Marcela explained, "Nothing is impossible here because if you have a dream, you just have to work hard and it will come true."

They dream big dreams! "I want to go to the moon," said Zoua Lor, 12, who has been here for also 2 months. "A future of becoming someone great in Thailand or Argentina was a blur where as in America they seemed more promising." Becoming doctors, mechanics, singers, and astronauts were on their list of dreams and aspirations for the future.

Even though life in America is rather comfortable, they still miss their homeland. Most of them have left behind family, friends, and burial sites of loved ones. Most important of all, they have come to terms that they will miss the house in which they were born and raised the most. Though most of them have not been out of the city limits of the Wat and have not had the opportunity to experience the beautiful wonders of Thailand, they miss the land dearly.

Stories about America from relatives and people who have visited America have flood them but to no comparison can the actual thing compare to their imagination, they all said. America has exceeded their wildest dream because America is better and more than a dream come true!

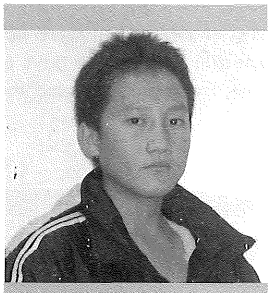
Advice from the newcomers: Don't take life for granted. Value the things that you have. Take advantage of all the opportunities America offers. Lend a helping hand because we want to be your friends.



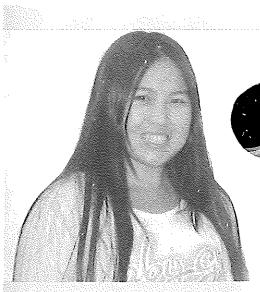
Yee Lee, 12

Cha Vang, 14

Zoua Lor, 12



Sai Xiong, 16



Knowing Your Hmong

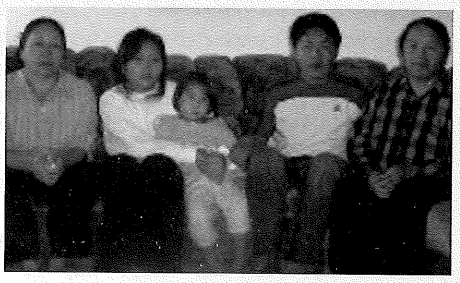
By Choua Her, **HmoobTeen** Editor, St. Paul, MN

Hey teens, can you name the countries that Hmong immigrated to after leaving the refugee camps of Thailand after the Vietnam War?

Yes, it's the United States, France, Australia, Canada, Germany, Argentina, and rumors of South Africa!

The biggest populas of Hmong live in the United States and France compared to Germany which has only 6 families and Argentina with only 7 families. Can you imagine what life would be like having only a few families in your entire country!? I can not even begin to imagine how I would go through life. I also heard a rumor that there are 12 Hmong families living in South Africa. I think this would be a very interesting research topic. Maybe one of you can find out and let me know.

Welcome Home



KauChee Vang, 16, **HmoobTeen** Editor, St. Paul, MN

In 1963 the Vietnam War began. The Hmong people weren't visibly affected by this war until 1975, when the Hmong people became refugees and had to move to Thailand. There were families running for their lives just to cross to the other side of Laos. One year later, in 1976, Hmong families began emigrating to the United States, France, Australia, and Canada. In 2000, the Hmong population in the United States grew to approximately 70,000 to 85,000 in California, 50,000 to 70,000 in Minnesota, and 45,000 to 50,000 in Wisconsin.

In December 2003, 15,000 resettled Hmong refugees from the Wat Tham Krabok refugee camp, a Buddhist temple north of Bangkok, Thailand, were scheduled to come to the United States. June 2004 the first refugee family arrived in California.

Leng Xiong, 34, was interviewed in June of 2004 by **HmoobTeen Magazine** , because was sponsoring family his mother's sister, ee Yang, and her family. Hlee and her family members are just a few of the 15,000 Hmong refugees who are resettling in the United States.

Leng Xiong's household will be different once Hlee arrives. Not only does Leng have to prepare physically, he also has to emotionally get ready for this arrival.

"Everyone has arrived here in the United States as planned, except my mother's sister, and daughter," explained Leng.

Hlee's son, Chang Xiong, 24, and his family arrived in September of 2004 in St. Paul. Hlee has not arrived yet, but will in December 2004.

"The minute Chang knew that he was arriving, he called us," said Leng.

Hmong refugees who signs up to come to the United States, are required to get a medical check up, and complete papers. Because of the requirements, Chang and his mother were grouped differently when they registered to come as a family to the United States.

"My mother was a little quiet when she had heard her sister wasn't coming together with her son," said Leng.

Tria Yang, 59, Leng's mother, anxiously awaits the arrival of her sister, and Chang.

"Zoo siab heej," said Tria, of Chang's arrival.

Chang Xiong, his wife Youa Yang, and their four-year-old daughter, Chutima Xiong, settle in a whole new environment where they wake up to English being spoken inside a 36 inch box called the television. Shyly lifting his tan face, and answering in fluent Hmong, Chang spoke of how he feels arriving here in the United States, "I am very happy to be here."

Their arrival in St. Paul was welcomed by a large crowd of family members.

"When we arried, everyone in the family was at the airport to greet my family and I. If they weren't here, they were at home preparing lunch. It was one of my happiest moments," said Chang.

Hlee Yang and her daughter just like Leng and his family will soon begin to navigate the American lifestyle, and the English language. They have family to support them through the journey.

Homework: A Motivator?

By Mai Moua, M.A.M

Movies. Dancing. Friends. Family. Chat rooms. Parties. Sleep. All these motivate me in different ways. There is *one* thing that doesn't come easy though. Homework.

I've been doing homework for over twenty three years. Yep. That means longer than most of you have been alive. When I have homework, I have to motivate myself to do it. But to be honest, it's not so bad. To me homework has the following values:

1. Doing homework makes you think. Your homework is a better tool for education than any media source you see or play with. It's your *education* that will get you a job, not a T.V. show or a video game.

2. When you put effort into doing your homework, you're telling others that you care about yourself and your future. When you stop learning, you stop caring.

3. When you do your homework you're telling your teacher, parents, and peers that you're a responsible, diligent student. An employer once called my high school teacher for a reference and my teacher told them I was a hard-working person. I got the job.

4. The times I didn't do homework, I was the one that suffered because I didn't learn anything.

The best things for us in life are the most difficult. So don't underestimate doing your homework. Place it up there as one of the key motivators to getting ahead in life. Do it not because you have to, do it because you need to.

What are your thoughts on this article? You can contact Mai at m_moua@comcast.net to talk about this article or about how to develop your leadership skills.

Mai Moua is a doctoral student in leadership studies at Gonzaga University in Spokane, Washington. She is currently studying how Hmong youth can be effective leaders in their communities.

BIG CHANGE

I just hope to make it through high school.

By Mai Vang, 15, St. Paul, MN

School is here! Can you believe it? The summer was just here and now it's time to go back to school, with all those tests and quizzes, projects and look at those stacks of homework.

Entering high school is a big change in my life. I never have had so many friends before. When I went to Jr. High and grade school, I went to small schools and didn't have many friends. Most of my friends were Caucasian. I love them a lot but no matter how close we are it was hard for me to communicate with them because we have such different backgrounds.

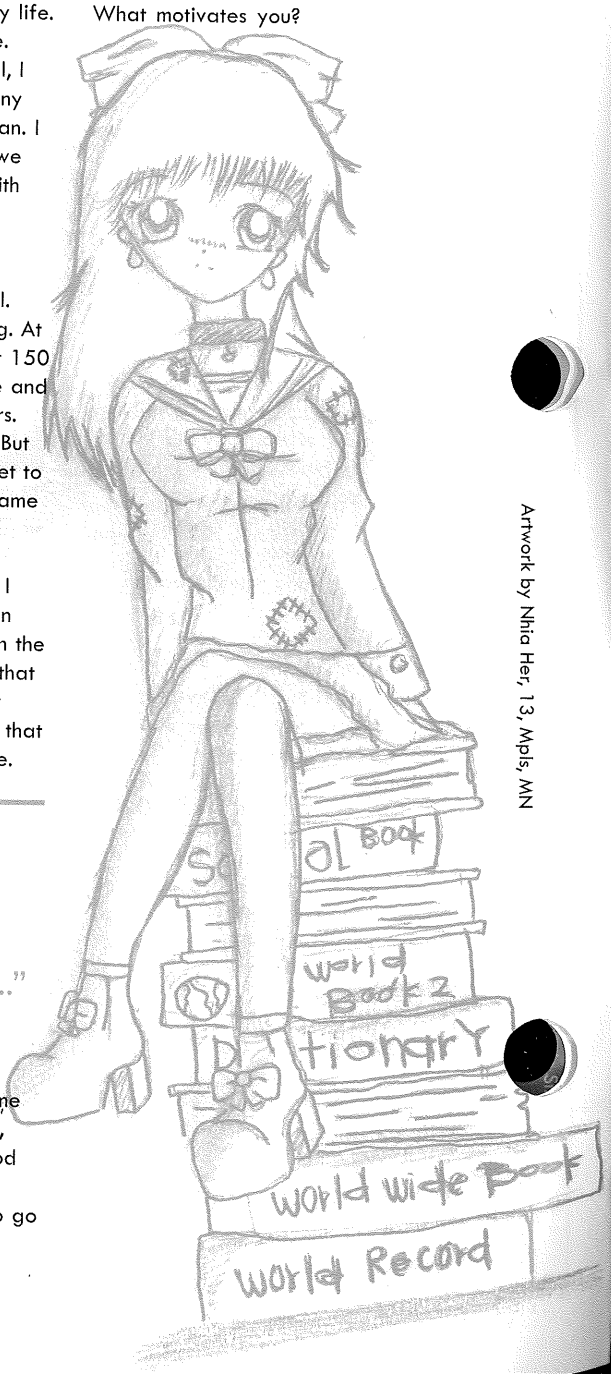
Right now, I'm attending a very big school. There are about 2,200 kids in this building. At my Jr. High school, there were only about 150 kids. It was easy to get to know everyone and have a close relationship with the teachers. They were always there to help you out. But here it so big and huge that it's hard to get to know everyone, even the people in the same grade as you.

I just hope to make it through high school. I just have to remember that I'm not alone in this world and that someone out there is in the same situation as me. To all those people that have a similar situation like me, you're not alone. There is always someone out there that is going through the same thing as you are.

There are other things that motivate me (and a lot of other people) to do well and never give up in school. Once a teacher said "if you try hard and don't get the answer it's better than not trying at all because you never know, the answer might be closer that you think." Teachers care about kids and want us to have good futures, that's why they teach.

Even though my friends don't know it, they are the ones that motivate me to learn in class and to have fun. Friends are an important part of school and of life. It's good knowing that you have friends and family to support you when you're in need. These are the people that motivate me to do well in school, and in life.

What motivates you?



Artwork by Nhia Her, 13, Mpls, MN

school

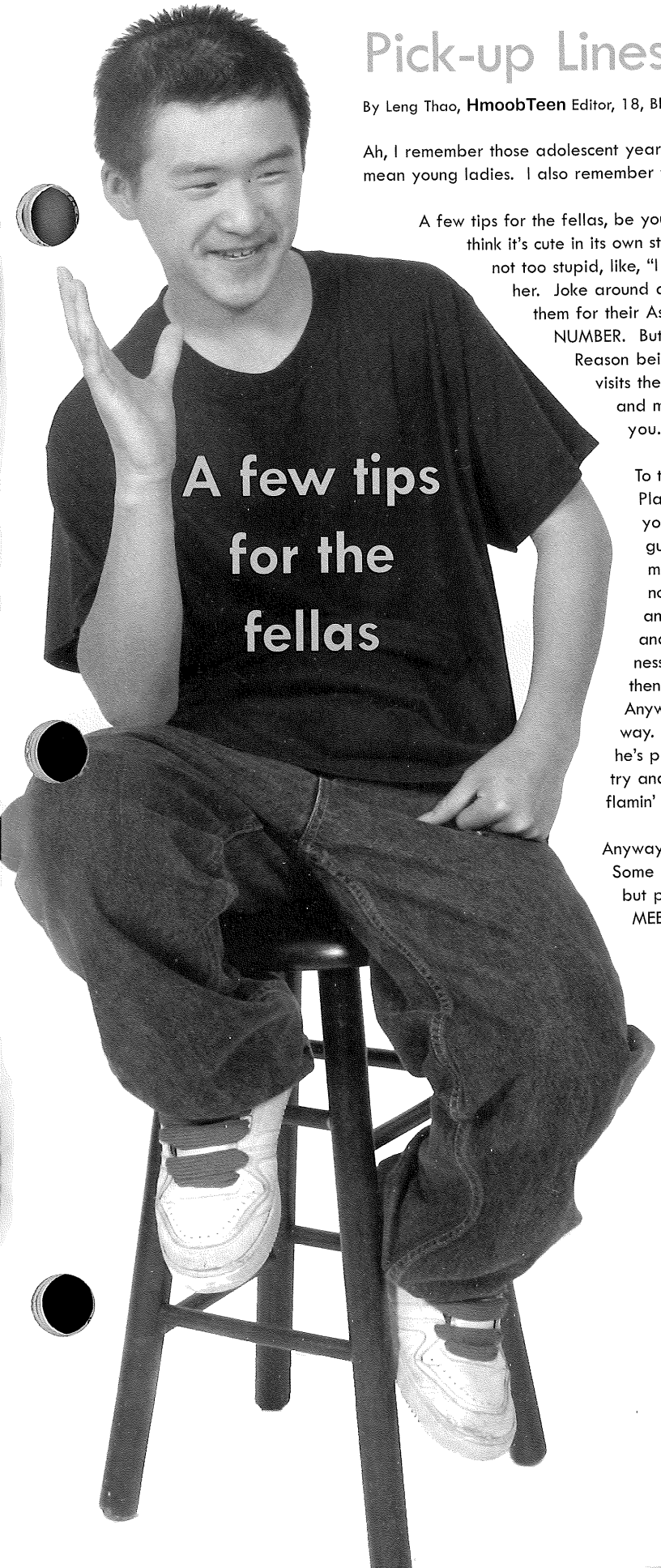
"...teachers care about kids..."

By Ma Yang, 13, Minneapolis, MN

My motivation for going to school are my parents. They are the ones that motivate me to wake up every morning to go to school, they are ones that motivate me to get good grades and stay in school. Without my parents, I would not have the motivation to go school, and to live.

Pick-up Lines for Hmong New Year

By Leng Thao, **HmoobTeen** Editor, 18, Blaine, MN



Ah, I remember those adolescent years in my life, going to the New Year just to pick up chicks. Sorry, I mean young ladies. I also remember the ladies hitting on me (which was most of the time, lol j/k).

A few tips for the fellas, be you. Go ahead and act like a dork, girls may think it's weird, but they think it's cute in its own strange way. And don't be afraid to say something stupid, as long as it's not too stupid, like, "I didn't know buffalos had wings" kind of stupid unless you're mocking her. Joke around and show them a sense of humor, they love that. And if you want, ask them for their Asian Avenue page, Xanga, find-a-pic, fax, or e-mail INSTEAD OF THEIR NUMBER. But of course later on you will say just kidding and get their number. Reason being, if you ask them for any one of those choices, every time that girl visits their page or see a fax machine or e-mails someone, they'll think of you, and maybe that's stupid, but hey, the goal here is to have them think about you.

To the ladies, please don't act stuck up, nor even look it. It's a big turn off. Playing hard to get is cool, just don't do it to the point where the guy thinks you're stuck up. If an OG follows you around, just pull over one of your guy cousins and say he's your husband. Now if the guy cousin were like me, they'd say something like "Oh you like her? Go ahead and talk, I'm not her husband." If that happens, move to plan B. That would be anything else you can think of. Also, if you think a guy is cute, go ahead and approach him. It's the 21st century now, I mean there is an attractiveness to a chivalrous man, but women can take the initiative every now and then. Heck, I'd love it if a lady opens the door for me every so often. Anyway, lastly, be yourself. Don't try to impress a guy by acting a certain way. If he is attracted to you for being someone else than who you really are, he's probably not the right kind of guy to talk to. Oh yeah, one more, don't try and act like you're all-a-that and a bag of potato chips, unless you're the flamin' hot cheetos, then go ahead.

Anyway, here are a few pick up lines for you youngin's trying to hook up. Some work, and some are jokes. Remember, it's fine getting to know people, but please don't get serious, and DO NOT SAY I LOVE YOU AFTER ONLY MEETING THEM FOR 2 HOURS!

Lines or techniques you can use:

- Hi. How's it going? Crowded isn't it? Oh, I'm _____, you are?
- Basic point of this, just go up and strike up a conversation.
- Dang girl/boy, you so fine I wish I could plant a whole field of y'all.
- Are your feet tired? (Most likely they will say yeah, but if they say no, then say) Well they should be 'cause you been running through my mind all day!
- Yo baby yo baby yo!
- Hi, I'm Hazoo Kwj, and in English, they call me Forest Gump.
- Leej muas
- You got the time? (and maybe add in) Oh, just wondering 'cause when I saw you it seemed like time froze (if your watch is really broken, it adds to the situation.)
- Can you take a picture of us? I'll send you one.

This issue will be passed out during the New Year, so if you want to know more pick up lines, come and visit me at our **HmoobTeen** table.

*The photo is for graphic purposes and is not the author of this article.

Surrounded By Two Angels

By Chue Her, 17, St. Paul, MN

Every where I go, the stores, walking around, and even from my gang buddies I've heard a lot of good things about myself since the last article. Thanks to HmoobTeen because other's words of praise motivated me more to change.

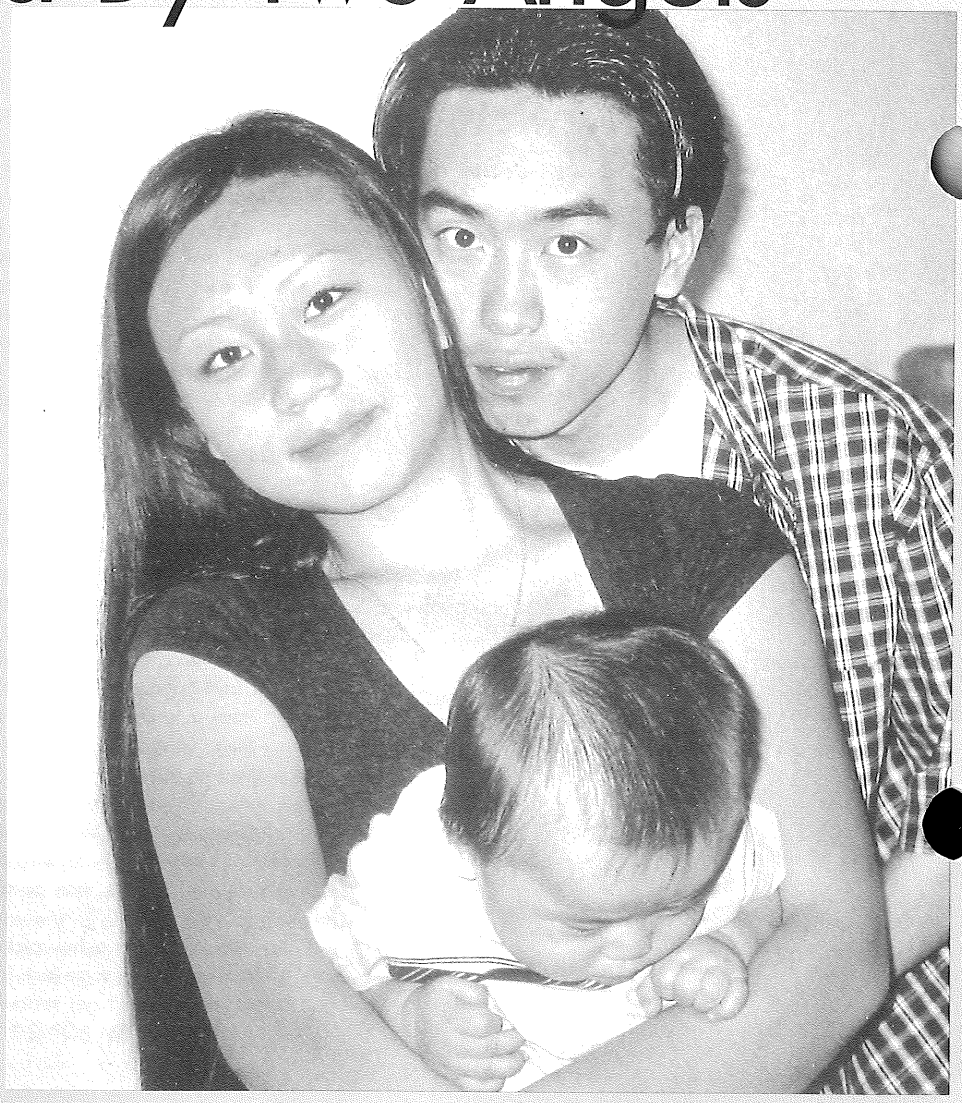
I have come a long way and worked really hard to get here (change). I used to be really negative. I was involved in gangs, was abusive, stole, cheated, lied, and even used drugs. I used to believe that I could never make it to where I am in life now. But I did, thanks to all the Correctional Facilities I've been in. In spite of all the uncles and family members that gave up on me when my dad died back when I was 8 years old and all my negative peers that hate to see me change, I am a changed man today.

Now I am about to realize how important my son and wife are, how important my life is, and how important my mom's words of wisdom are.

I have been able to go back to school and pass all BST (basic standard tests) after two years of dropping out of school. I'm getting close to finishing high school. Maybe someone reading this might think that the BST is nothing and it is easy but for me it took a lot of time to pass.

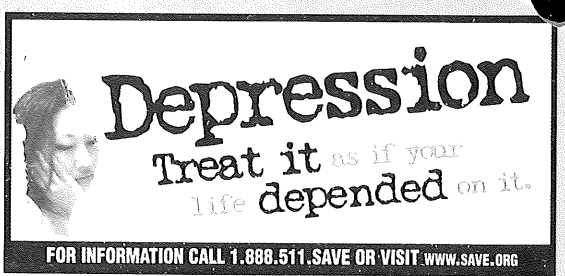
I can't wait until the day I stand on that stage with my cap and gown and say I've finished high school and show all the people that didn't believe in me that I've made it. I want to show them that I'm a human being too and I do feel pain. Pain is something that motivates me to change. Pain makes me change because I can't stand the pain anymore. The pain of having nothing, the pain of going nowhere in life, the pain of being less, the pain of counting days and months, and the pain of missing my family because I'm in a correctional facility.

I was able to say no to my gang buddies. I realized that they're not my real friends because they keep on telling me to do things that will send me to jail. I was able to tell them that I needed real friends and one day if they would be positive friends then we could be friends again. Each time I say no to my friends, I am proud of myself. The feeling that I get is like a high that helps me grow inside and motivates me. I can't get that high from any street corner or drug dealer.

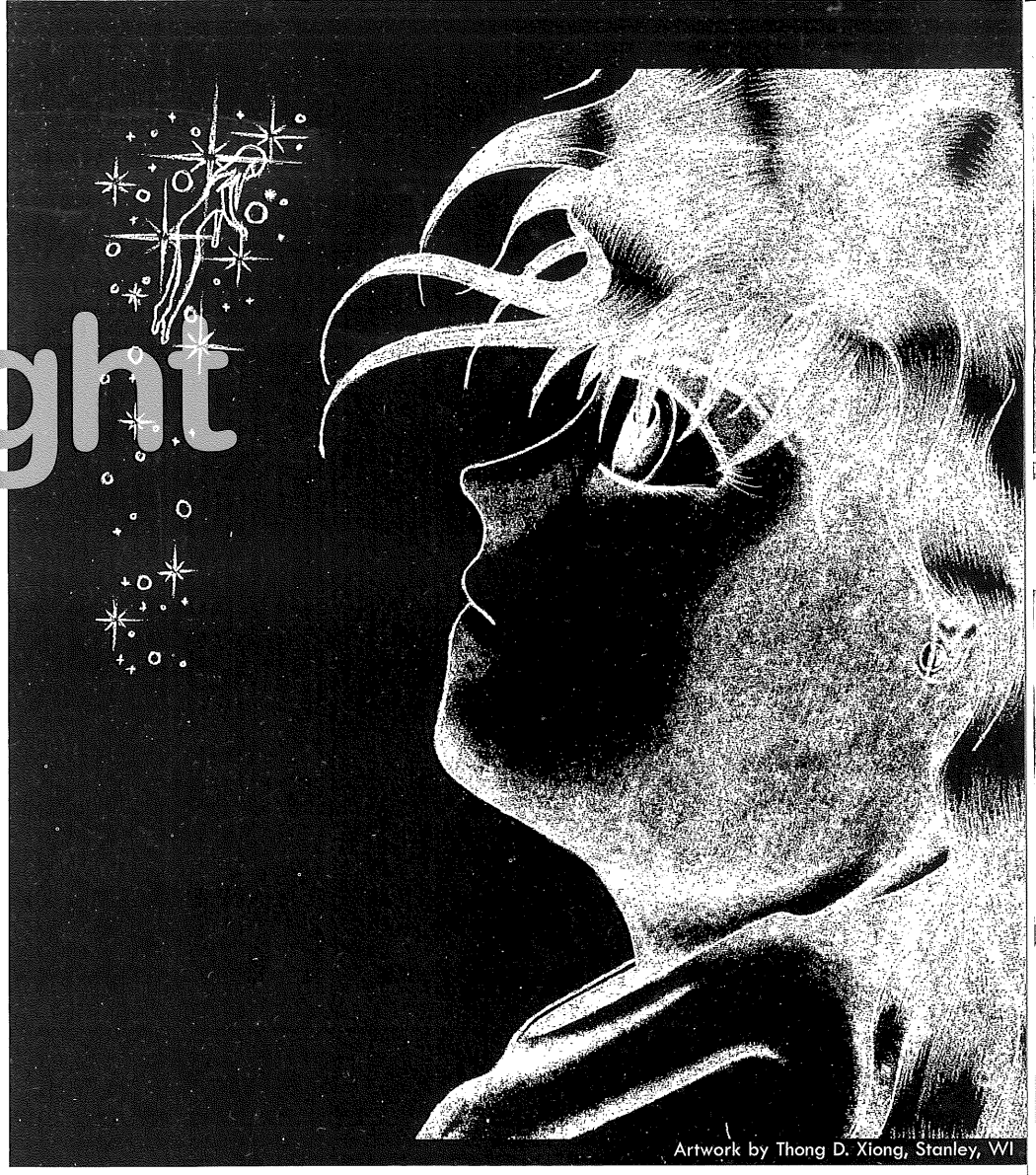


"I am a changed man today."

Every time I see my wife and son's face, it takes away all my worries, pain, and stress. There is nothing in this world I want more than my family. Those are the two people I want to wake up next to every morning and go to sleep with every night. That's what motivated me to change my life and to do all these things. Not a day goes by that I don't thank God for sending me these two angels. To me they are the definition of love, life, determination, and my motivation.



My Light



Artwork by Thong D. Xiong, Stanley, WI

By Lashere Lee, 18, **HmoobTeen** Editor, St. Paul, MN

It's amazing how I'm here writing an article about self-motivation when I'm in need of it now. What is self-motivation? I guess the definition of this word is different for each person. For me, self-motivation means strength. The strength that comes from self-motivation doesn't come anywhere except within. I call this "my light." We, as individuals, have a light to guide us through our lives. We shine our light when we are lost in the dark and can't see where to go. We shine our light when we can't seem to find hope in anything. Our strength is the power that shines our lights for us. Without our inner strength, our lights won't work.

ght now, I'm shining my light. I'm shining my t because I am lost in life and I don't know y way back. I'm draining every drop of strength to help push me forward. Being 18, and faced with so many obstacles is so hard. I can't juggle all this. I do the usual: go to school, work, study, involved in other things, run errands, etc. It may not sound hard to others, but it's killing me inside! I've always been really good with this whole idea of "shining my light" and keeping my self-esteem up. However, this year seems like no matter how much I try I can only get a dim, lifeless, spark from my light.

I've thought about my problems and I've cried over it several times. I go to sleep hoping to wake up a new person with new skills but that never happens. I've learned that life will NEVER give you what you want. Only your self-motivation can earn you your happiness. Sound stupid and confusing? Yeah, I know. That's what I got out of it.

e technique that seems to be very helpful me is this: whenever I feel like I'm surrounded by negativity and that I'm sliding downhill at a fast rate, I take all that negativity and turn it into "motivation." Don't ask how I do it, I just do. Anyone can do it. All you really have to do is block everything and everyone out. My attitude about this is that it's MY life, MY decisions, MY happiness.

Self-motivation comes with love and appreciation. Loving yourself and appreciating your own efforts make such a huge difference in your life. Who cares what people think! Another thing I've learned is to stop competing! Sure, life is competitive because you want to be the best and have the best G.P.A or highest class rank, but stop pushing yourself to be someone you're not! Stop trying to impress others! Love yourself for who you are. Award yourself for your abilities and for what you know. You might not be the best in Calculus, so what? There's more to life than Calulus!

When we are lost we can't find a good reason to keep striving for our dreams. It is up to us to evaluate our priorities and determine if our "dreams" are really what we want. If it is, we'll pursue them regardless of what's in our way. So take a minute to evaluate your priorities and see if it's worth striving for. Always remember that it won't get any easier and that the harder you strive the closer you'll get. Someone once said, "Reach for the moon, and if you fall short you're still amongst the stars." That's my motivation. What's yours?

Inspiration From My Parents

By Pakou Vang, 16, Mpls, MN

Have you ever had a time where you felt that it couldn't get any worse in life and nothing was ever going to make your life normal again? If you have, you're not alone. I sometimes have feelings like that too. Sometimes you may feel that there are no motivations in your life.

In my life my parents are my greatest motivation. They encourage me in almost everything that I do, except for the bad things. They are not there for me 24/7 but they are there when I need them. I remember when I went on a two nights and three day camping trip with my fifth grade class. Before I left, I thought I would not be able to stay at the camp for all three days because I'll miss my parents. When I came home, I gave my parents the biggest hug ever because those three days felt like three months.

My parents are the inspiration that gets me up in the morning and prepares me for what's ahead. Nothing can replace my parents.

Self Motivation

By Leng Thao, **Hmoob Teen** Editor, 18, Blaine, MN

Where does motivation come from? Some say from other people like friends, family, other relatives, and so on. And yes, some parts of motivation do come from each and every single person you come in contact with, even if it's negative motivation. So, you're probably wondering where the other part of motivation comes from.

People may argue that it starts when someone else motivates a person to be something or do something. Not true. From what I see, when a person motivates another, it's because that motivator sees the potential of the non-motivated. But how did that non-motivated person become non-motivated? I believe that every person has an interest or a purpose they want to pursue. That interest or purpose is the motivation. At least, it's the motivation to begin a particular task. But later down the road, that task gets harder and the person gives up. Deep down inside there is still a small burning fire of motivation that just needs some gasoline thrown on it. Take for example cleaning the house (bad example of something to be motivated about.) Who wants to have a dirty house? So you start cleaning, but you slack off because it's no fun and very tiring (example of little burning fire). All of a sudden you get a phone call from your mom saying she's going to come over, and of course, you always have to clean things up and make things look the best it can before mom comes over (mom being an example of the gasoline). So you take five shots of espresso and start cleaning like crazy. At the end of it you'll be tired, but everything will be perfect.

Maybe that was a bad example of motivation, but a great example of the fire and gas metaphor? Anyway, what I'm really trying to say is, when things aren't going the way you want them to, look inside you and encourage yourself to do or be something before looking elsewhere. You are your strongest motivator.

Artwork by Meng Yang, 16, St. Paul, MN

My Big Sister

By Tou Vang, 14, St. Paul, MN

The person that I most admire is my big sis, Mai Phai Xiong. I admire her for many reasons. I admire her because even though she's not my blood sister, she still cares, loves, and respects me like I am her blood brother. She is always there for me and always cheers me up when I get stressed out. Sister, you inspire me. Even though we don't live in the same town or same city, we still care about each other like we live next door. I believe that we were destined to know, meet, and care for each other. I want to thank God for bringing us together.

Motivation

By Tou Nhia Khang, 13, St. Paul, MN

I motivate myself because it's my life. I have to work hard if I want a good life in the future. I don't want to be dumb so I go to school and do what I'm supposed to do. I motivate myself because I'm the only one to control my life and future. If you die you can never get a second chance.

Pretty Girls

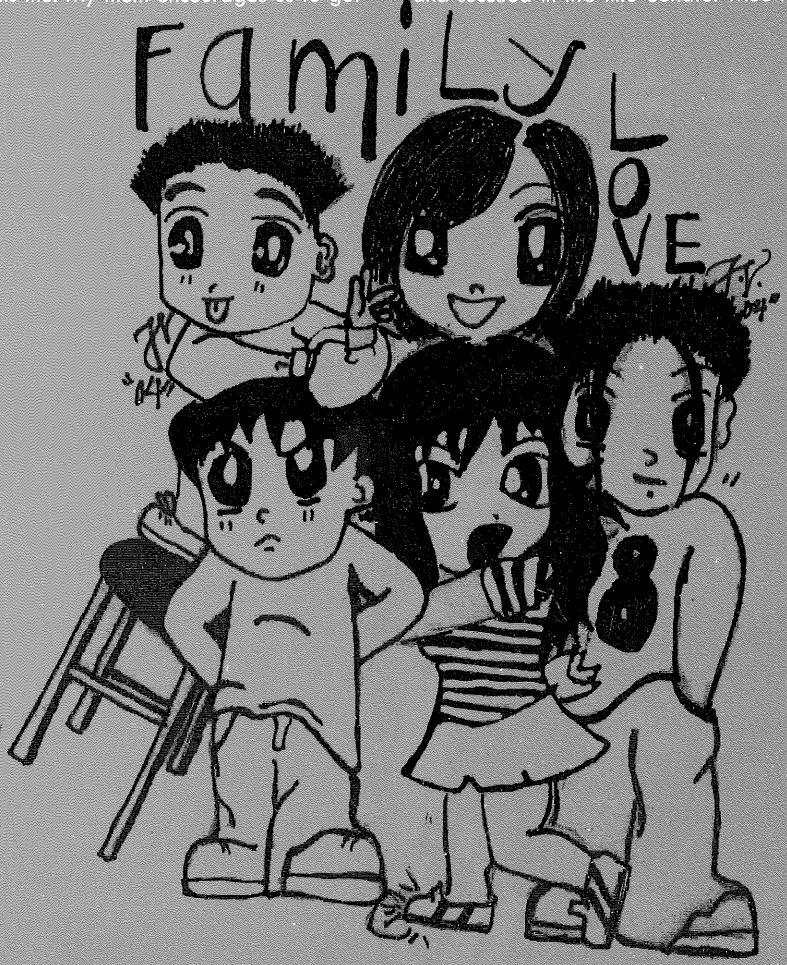
By Taeng Yang, 13, St. Paul, MN

What makes me wake up every morning are thepretty girls in school! I thought that if I keep going to school, then one day I will go out with them. I try to pass all my class and do good in school so that girls will like me more. The more I study the more girls I will have. I hope one day they will call me to come to their birthday party.

Nothing Can Break The Love

By Mai Nhia Thao, 14, St. Paul, MN

NOTHING CAN BREAK ME AWAY FROM THE LOVE I HAVE FOR MY FAMILY. My parents, Ger Thao and Mai Yia Chang, are the ones who brought me to life. My dad always told me that if I do something good then it represents my whole family (I'm the oldest). I will lead my brother and sisters into a good place and be a good role model for them, that's what my dad always tells me. My mom encourages us to get educated and study hard. Everything counts in the future is what my mom always says. Don't be like me, not being able to speak American, not being able to have a good job to support you all, not being able to be the mom you've always wanted, not being able to give you what you want. It hurts me a lot to see my mom so down. I try my best to do what my parents tell me and show them that I can be like any other Hmong fellows who graduated and succeed in life like Senator Mee Moua, Doctor Phoua Xiong, and many others. My parents are my inspiration; they are the ones who bring me to my feet every morning.



I have two brothers, Phillip and Andy Thao, and three sisters, Julie, Lisa, and Nina Thao. We may fight everyday and argue every second, but all you five are the only people that can understand my feelings inside and out. We share everything ever since each of our births, its all family. I love you all. You five are the reasons why I want to be well educated, live, and love. Especially to Julie, we fight everyday, there is never a day that goes by that we don't get mad at each other. I'm sorry for not being a good sister for you. I love you with all my heart even though I may say I hate you sometimes when you get me mad, I do love you a lot! And to the rest of my family dad, mom, Phillip, Andy, Lisa and Nina including Julie, you're all the best, my motivation for living, my everything, I can't afford to lose any of you and remember I may not be a good role model, daughter, sister, friend for you all, I'm sorry and I'll try my best. I love you all! Mai Nhia Thao 3 You All!!

Editor's Note: Family means so much to us. Tell them you love- don't wait.

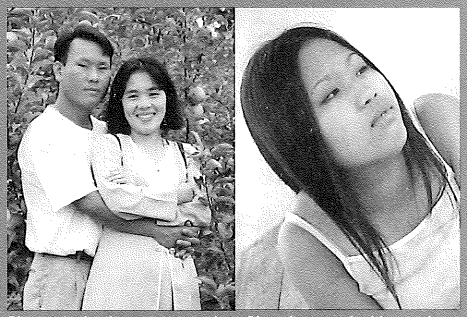


Photo: Author's parents, Author. Photo's provided by author.

Artwork by Jennifer Vang, St. Paul, MN

Where is the Support?

By Lashere Lee, 18, **HmoobTeen** Editor, St. Paul, MN

Ever wondered what happened to the support parents are supposed to give us? I do. I'm going to speak the truth here. In my 18 years of living I have never ever heard anything nice from my parents. Don't get me wrong because my parents are loving parents; it's just that they don't seem to support anything I do!

I'm not a bad person. I go to school, get good grades, pay my own way through life, and do whatever it is that they want me to do. Yet, I still don't get a compliment from them. Why are Hmong parents like this? I'm sure I'm not the only one feeling this way. Why do good when you don't get recognition or encouragement for it, right? If all they see is the bad that I do, why not do more bad so that they have something to yap about?

I hate to say this, but I think our parents are stuck in the past. They are so stubborn that they think everything they say is true and right. Most of the time they don't even care what you have to say. What kind of relationship is that? I guess because I grew up in America I have a different view of my "ideal family." We see different types of families portrayed on television and we wish our family were like that.

Picture this: you are being recognized in a school assembly for your good academic performance. Your name is called and you proudly walk across the stage to receive this dumb piece of paper that is supposed to mean something. You turn to the audience and quickly scan the faces to see your parents cheering you on and clapping for you. Oooops! Let's snap back to reality because your parents aren't there.

It's ridiculous! I don't know about the rest of you Hmong teens out there but it sure does hurt deep when I can't get any support or motivation from my very own parents. I know they love me and all but sometimes I just feel the need to see it. It's almost like I crave for their attention. I just want someone to tell me, "Hey nice job! I'm very proud of you! Keep it up!" Is that too much to ask for?

But you know what? When I stop to look at this from a different perspective this is what I see: I see myself as a stronger individual. I am more powerful and more willing to do what I want. I've tried to impress my parents so much that my efforts haven't really gone to waste; instead, my efforts brought me here! I've learned (all my life) that the only person who really benefits from my efforts and my accomplishments is me. Who am I doing this for anyway? Myself. So if you ask me if I think what our parents is doing is wrong, I'll have to give you 2 answers, yes and no. Yes, because by doing what they're doing it's really giving a lot of us the impression that they don't care. No, because I see it as another life lesson. You want something, you get it yourself.

Looking at my fellow Hmong teens and what they're currently going through, I think I see two different groups. One group doesn't care whether or not their parents give them support because they do it for themselves. They strive for the better and they don't let anything stupid stand in their ways or pull them down. The other group lets people take things away from them. They run away from home, drop out of school, or lose their direction in life because of what others say.

I've thought about doing bad things just to get my parents attention. But I have way too much to lose. I did not work this hard to lose it all in a blink of an eye. You have that choice too, my peers. You can either risk it all for nothing, or hang on to it regardless of what happens because I know you did not work so hard for nothing either.

Just keep your heads up and walk proud 'cause one day, we will look back on this and be thankful.

Artwork by Maya Xiong, 13, St. Paul, MN

"I just want someone to tell me, Hey, nice job!"

Discovering a Hero

By Leng Thao, **HmoobTeen** Editor, 18, Blaine, MN

I didn't know much about my father's past, whether it was in Laos or Thailand or here in the states. I never questioned him about things that happened either. I guess I just never really cared.

Before coming to America, my dad served in the Vietnam War, like most other fathers who immigrated to the states. I can't remember specifically what he did, but I know it was a lot. I used to hear stories about it, but never really knew the details of it until I stumbled upon his resume. Boy, his resume is surely impressive. Before coming to America, he had already received a degree in...something, I have to look at the resume again, which made me think to myself "If my father was able to do all of that in the past in a war torn country, why is it so hard for us to even want to go to school in this country?" After reaching America, he received another degree from La Salle University, which astonished me even more. I'm in awe when I look at his resume and all of his accomplishments. Struggling through the war and still able to accomplish what he has, then coming to the states and struggling to provide his family with food, shelter, and clothing and still able to accomplish many feats can put even the President in awe.

I started thinking. I never really knew my father. I mean I knew him, but I didn't at the same time. To me, he was just dad, someone to go fishing with, go hunting with, and go out to relatives with. But now I see that he is much more than that, he's a perfect example of a hero.

Your Poems

Crushing On You

By Mai Maycee Yang, 13,
St. Paul, MN

Have a crush on you ever since we met,
But in our culture last names matter,
Always loving you ever since we've talked,
But can only stare and day dream,
My heart aches just can't tell it outloud,
Can't stop staring at you just don't know why,
[illegible] last thought...
[illegible]mpossible to date
So I'll keep everything personal,
Just for our culture and boundaries,
But still wonders silently...
Why were we born to have the same last name?

Best Friends

By Mai Thao, 16, St. Paul, MN

We've known each other since little girls
We've kept in touch in far away places
We've been through things that were never there
But we'll always be best friends
We were able to help each other when we need
Even though we are far apart and don't talk
We'll always keep in touch
And remember each other in our hearts
We both hope that one day
We will be able to continue those times we had
We had fun, played, and work through hard times
There is always time for us to hang and talk but
[illegible] time between us has been crashing
[illegible]ing to see and talk to one another some day
In our hearts, we'll always be best friends
To the end of time.

Ordinary But Inspired

By Pa Kou Vang

I am an ordinary Asian girl who is inspired by many things in life.
I wonder everyday how my future will turn out.
I hear my mom's voice that lectures me everyday.
She lectures me because she cares.
That is a motivation.
I see good opportunities waiting for me ahead.
I want to be able to reach them.
I am an ordinary Asian girl who is inspired by many things in life.
I am inspired by all my older cousins,
Because they have been there and knows how things are.
My friends and teachers inspire me,
Because they are the group that I turn to when my family is not around.
I understand that like is short.
I say make the best out of it.
Have a goal and a dream to look forward to in the future.
My dream for the future is to become a leader for my people.
My education inspires me to run towards that dream everyday.
I believe that life depends on destiny.
But an individual can do things in life to change their course.
Many people have hopes and dreams.
I am one of them.
Someday I will be who I want to be,
Because I am an ordinary Asian girl who is inspired by many things in life.

Never

By Wendy Lee, 14, St. Paul, MN

Never say I love you,
If you really don't care
Never talk about feelings,
If they really aren't there
Never hold my hand,
If you're going to break my heart
Never say you are going to,
If all you do is lie
Never say hello,
If you really mean good bye
Then say you will,
Never say forever
Because forever makes me cry

Artwork by Sheng Vue, St. Paul, MN

TEACHER: "Mrs. Her"

By KauChee Vang, 16, **HmoobTeen** Editor, St. Paul, MN

Imagine being a teacher who gets to witness generations of Hmong students excel in high school. Kita Vang Her is in her late 20s, and is passionate about teaching adolescents. **HmoobTeen** interviewed her:

HTM: When you were in high school, what did you want to be?
KVH: I wanted to become a journalist. I went to Como Senior High School in St. Paul, Minnesota. I had prepared myself to become a reporter, but as I entered college, and discover my values, I decided to major in anthropology, minor in history, and master in teaching.

HTM: What motivated you to enter this career?
KVH: I participated in teaching programs while I was in school, such as at Hmong American Partnership. I worked with youth and found how interesting they are at the age where changes revolve around them. Another motivation was my mother. She had always told me to keep trying my best and not to give up.

HTM: What are the advantages of having this career?
KVH: You get the chance to become creative at what you do and learn new ideas. You help encourage the mental development of young adults by guiding them through a very difficult part of their life.

HTM: What are the disadvantages of this career?
KVH: There are long hours. This career is more of an idea that you don't always see the end product. It isn't like journalism. I hope that students understand what is taught.

HTM: In what career do you see the Hmong teens in the future?
KVH: I can see Hmong teens in the science field and business. Diversity is a call to the occupations, rather if it is nursing, medicine, or sales, I can see Hmong teens there.

HTM: So what would you say to a high school student who wants to become a teacher?
KVH: This is a career that is wonderful, enriching, and definitely need strong individual to work with young adults.

LOAN OFFICER

Patsy Lee, 17, **HmoobTeen** Editor, St. Paul, MN

HTM: What Company do you work for? For how long have you worked there?
A: I have worked for New World Finance Group, for one year.

HTM: What is your job title?
A: My Job title is Loan Officer.

HTM: Did you go to college for this career?
A: No, I went to college for Accounting.

HTM: What motivated you to enter this career?
A: I like to be my own boss, have independence and be self-employed.

HTM: What do you enjoy most about your career?
A: Helping customers, I love to help people get their dream home.

HTM: What are the advantages of this career?
A: Making my own decisions and the independence.

HTM: What are the disadvantages of this career?
A: The work can be hard and demand long hours, the income can fluctuate so you don't know how much you will be making.

HTM: What advice would you give a high school student who wants to enter this career?
A: Start with a company that pays a base salary and commission.

HTM: What is your message to Hmong teens?
A: You need to have a good personality, leadership skills and be independenct to enjoy this career.

SOCIAL WORKER

HTM: What Company do you work for?
A: I work for Hmong American Partnership as an Employment Services Manager.

HTM: When you were in high school what did you want to be?
A: A police officer, but my parents did not like that career.

HTM: What motivated you to enter the social work field?
A: I want to help families in our community. Recently I became a manager and know I can do more to assist the community in finding jobs and social services.

HTM: What are the advantages of being a social worker?
A: I get a very good feeling after I help someone to find a job or get the help they need. I am working to support our community.

HTM: What are the disadvantages of being a social worker?
A: There is always more work to do. We have so many families to take care of that we need more hours in the day to get it done. Also, compared to working in a business, the pay is not great.

HTM: What is your advice to Hmong teens who want to enter this career?
A: You need to like working with people, have a lot of patience and want to give back to the community.

HTM: Do you have any final words for the teens?
A: If you don't mind the lower pay - the world will need many social workers in the future.

FAMILY

The Important People

By Boua Mee Her, 17, St. Paul, MN

My brother-in-law, sister, and mom motivate me the most.

My brother-in-law always tells me to be good in school. He tells me not to smoke or drink. He also tells me to not put myself down.

My sister is the one who tells me to go to school everyday. She tells me to clean the house and don't go play. She reminds me to do my homework.

My mom tells me to work really hard, so I can be successful in life in the future. She always tells me what is right and what is wrong. She tells me to be nice to others and talk nice to them. Those are the people who motivate me the most and make a difference in my life.

My New Parents

By Yee Vang, Mpls, MN

"I'm thankful for my sister-in-law and brothers because to me they are like my parents now."

I hate waking up early at 7 in the morning and going to school all the way in the Southside; but it's what I do everyday from Monday through Friday. I'm glad that I get up and go to school because then I get to see all my friends and the secret crush I think about almost every second. What really motivates me is love. There's love everywhere. Love in education, love in money, love in friends, love in family and even love in food. If I didn't feel loved at all, I wouldn't want to be in this world anymore. I would hate myself because of the very little self-confidence that I have.
Since I lost my parents that doesn't mean that I have less love, my life is just more challenging.

I'm thankful for my sister-in-law and brothers because to me they are like my parents now. When I need money for a fieldtrip, they give me the money. When I need a new pair of shoes, they take me shopping. When I need a big hug, they give me one. They love me very much and are always there for me and that's why I love my family and friends.

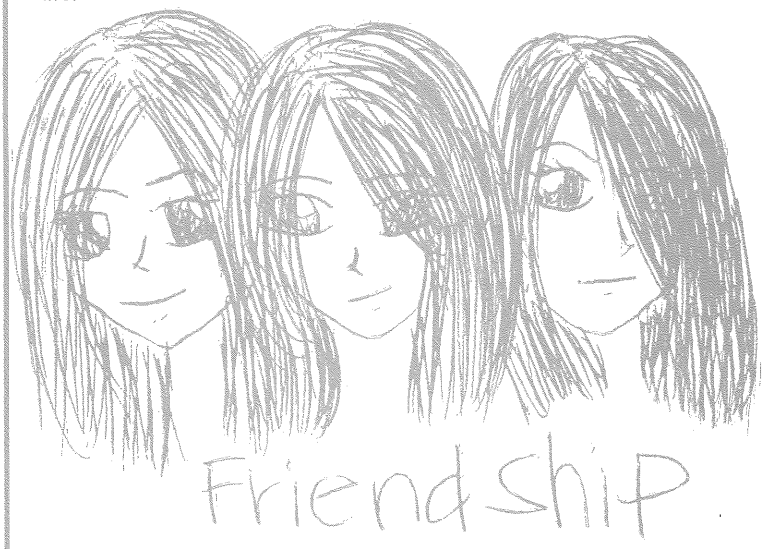
Artwork by Sheree Yang, 13, St. Paul, MN

I CAN LIVE

By Gaoweed Vang, 15, St. Paul, MN

"I can't always run to my family, that's why I have my friends."

What motivates me to get through life is my friends and family. Without them, there would be no me. With them being around to care and heal my pains, I live. I can't always run to my family, that's why I have my friends. I know that they'll be there through thick and thin. If I have family problems then I call my friends or write to them. If my friends are troubling me, I run to another friend. It' so frustrating in high school right now and all I want to do is give up but my friends make me look at the good side like when I graduate. They want me to grow up with a good job so that we can finally live together and sleep whenever. What more would you ask? Therefore I pick my friends and family as my motivation to get through life.



Motivators

By Xee Yang , 14, Minneapolis, MN

"you really need to surround yourself with positive friends that will motivate you to do the right things."

In life there are many motivators. As teenagers most of these motivators are our friends. Through life they motivate us to do many things, good and bad. Good friends encourage us to go for our dreams. They even try to help us reach our dreams. These good friends inspire us and make us want to succeed. Friends are such great motivators because they are similar to you and they can relate. Even for young children, if their friends didn't try bad things then they wouldn't. People may not see it but friends influence you in so many ways.

I personally have friends that motivate me in different ways. Some friends are funny and energetic. Some are intelligent and sincere. There are so many types of motivators based on how they act and their characteristics. You hear people talk all the time about people hanging with the wrong crowd. If you hang with the wrong crowd, they influence you and they motivate you to do things. Through middle school a few of my friends got into the wrong crowd and they changed so much. Some started smoking and others started experimenting with other drugs. Good motivators are important to have.

We especially need good motivators during our teen years. These are the years when you really need to surround yourself with positive friends that will motivate you to do the right things. Our teen years are very hard. They're full of stress, pain, and uncertainty. Positive friends motivate us to look on the bright side. I think that good motivation is the secret to a successful future.

Good friends who motivate us to do better and succeed in life are important. Choose your friends wisely.

Artwork by Maya Xiong, 13, St. Paul, MN

Waking Up to a Brand New Day

By Mai Vang Vue, 14, St. Paul, MN

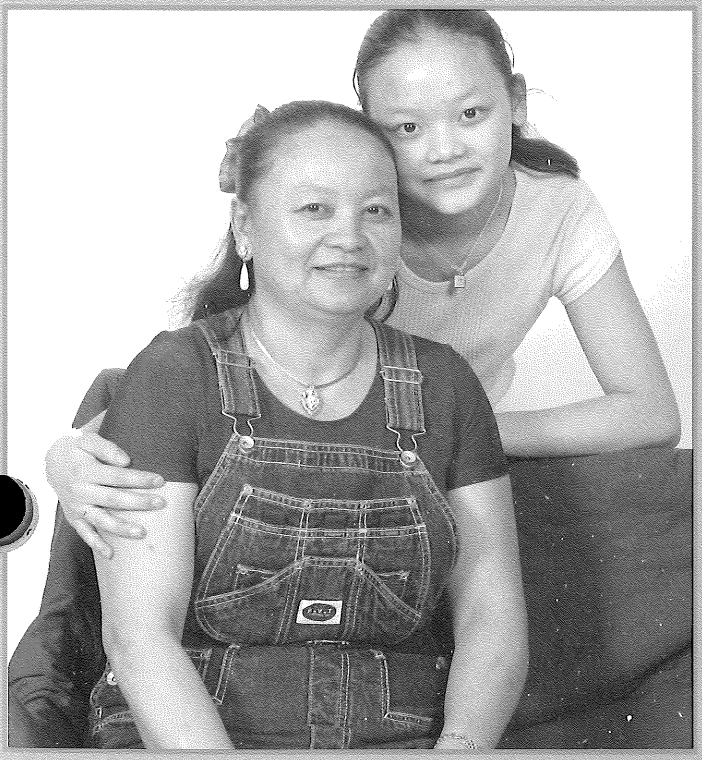
What makes me wake up to the morning dawn is waking up knowing that today will be a brand new day for me. It will be a new day for me to step forward and reach my goals and plans for the future. Every morning I tell myself, "Mai, today will be your day to shine and reach for your goals."

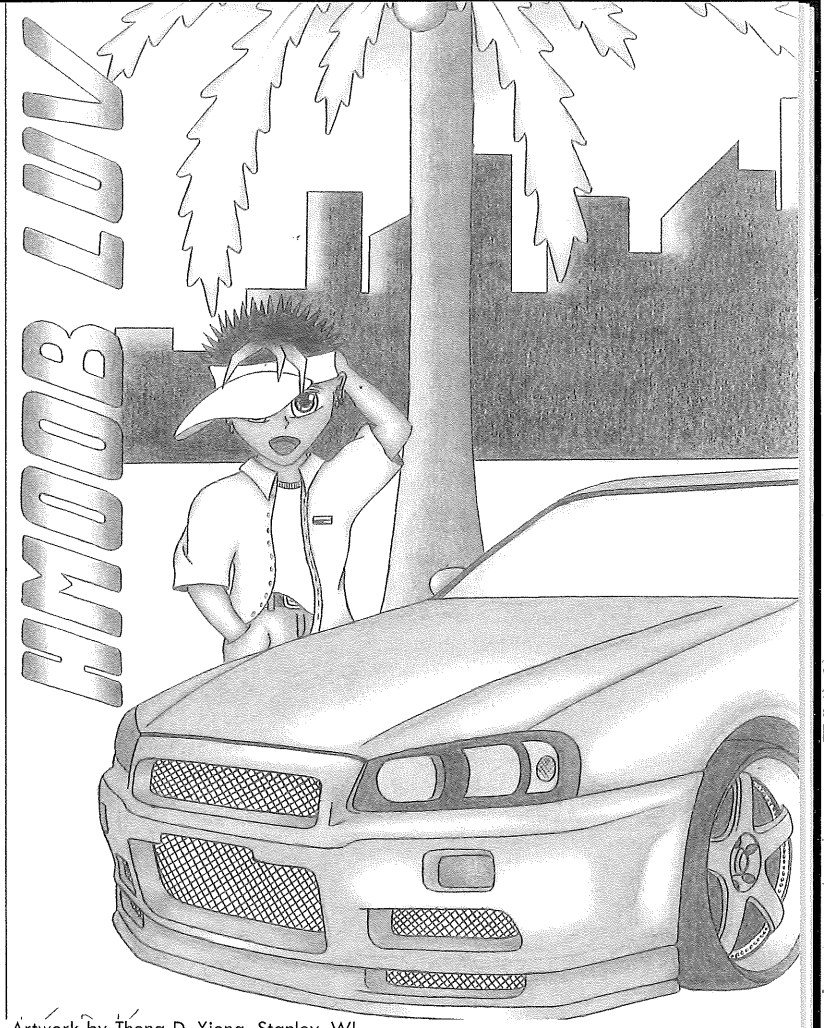
Waking up early every morning teaches me to not be a lazy person. Going to school every day will help me reach my goals. When I reach my goals, my family will be proud and know who was the number one super star for her siblings.

School is the most important part of my life because it will help me to be successful in everything. My mom tells me the same because she didn't get an education so she couldn't get a good job that pays well. She wants me to have a good life and a good career so that I won't end up like her. I know that I will reach my goals if I work hard enough and believe in my hopes and dreams. I take my mom's words of wisdom to school everyday. She tells me, "go to school and learn, don't think about what people say or do to put you down, and come home proud." Forever those words will stay with me until I reach my goals.

Living life to the fullest isn't always easy. Sometimes life can be really stressful especially when people put you down and say that you can't do something. I move on with my life and don't let those things get in my way. I want to try my best even if I'm not good.

To those who haven't got a plan for the future yet, you should start thinking about it because it will help guide you through life. Don't let what other people say to you get you down. Just do what is right and you will be successful. Even if you're young like me, believe in your hopes and deams and you won't regret it.





Artwork by Thong D. Xiong, Stanley, WI

I Never Give Up

By Mai Her, 13, St. Paul, MN

I only have one life to live so I live it well.

What keeps me motivated to go to school is my parents' determination. They didn't finish high school but they tried so hard and now, they have to support a family. I want to finish high school and go to college so they can be proud. I want to get a good education and a great career that I like with a good wage. My parents' will be very proud of me for not giving up. This is the motivation I get to go to school.

Another motivation for school to me is all of the friends and new people I get to meet. When I'm sad or having a bad day, my friends will always be there to cheer me up. That makes me really happy because it shows that they care. I also like meeting new people. I met a couple of new people and now, they're my friends. The more friends to cheer you up on a bad day, the merrier! That is why I always make an effort to go to school!

My motivation for life is everything! I live it for the entertainment, the fun, the love, and etc. I only have one life to live so I live it well. I'm so determined to do my best every time because I only have a short period of time. Life is everything! That's why I never give up! If I make my dreams come true, my life can be the best that I can be.

I OVERCAME

By Pangnhia Thao, 16, Watertown, WIS

It is amazing how one little thing can change your life in so many ways. As I sit here and reminisce about the past few years and where my life is now, I just can't believe it. Just a few years ago I was a cocaine addict and an alcoholic. I did not care about anything; and today, I have that something that motivates me to go for my dreams.

I had been doing drugs since I was about 9 or 10 years old, but I never told my family. I was in so much mental and physical pain and anguish that I didn't want to think about my problems. I was never motivated and I would argue with my friends when they would tell me that I needed help. I didn't want to hear them say that because it was hurting so much already. It was bad enough that I was not living with my family. I hadn't been with my family since I was 10n years old. I would stay up at night and just drink everything away hoping that one of these times I would overdose. I was to the point where nothing else mattered but drugs and alcohol. I was sleeping around and getting into abusive relationships because I wanted to be loved. I felt so alone and confuse about everything. I wanted to know what my mission on earth was.

I was also against Hmong culture because my step-dad and my uncle abused me. I felt like Hmong people didn't understand who I was and that they hated me. Every time I saw a Hmong person I would make rude comments to them not ever giving them a chance to introduce themselves. I have never dated a Hmong guy in my life. My current boyfriend is white and Japanese. I love him but I don't feel happiness with him. I wish I could find a Hmong guy who would understand me and accept me for who I am. Deep down inside I long for that special Hmong guy. It is hard because I feel like he would look down on me because of the things that have happened to me in the past.

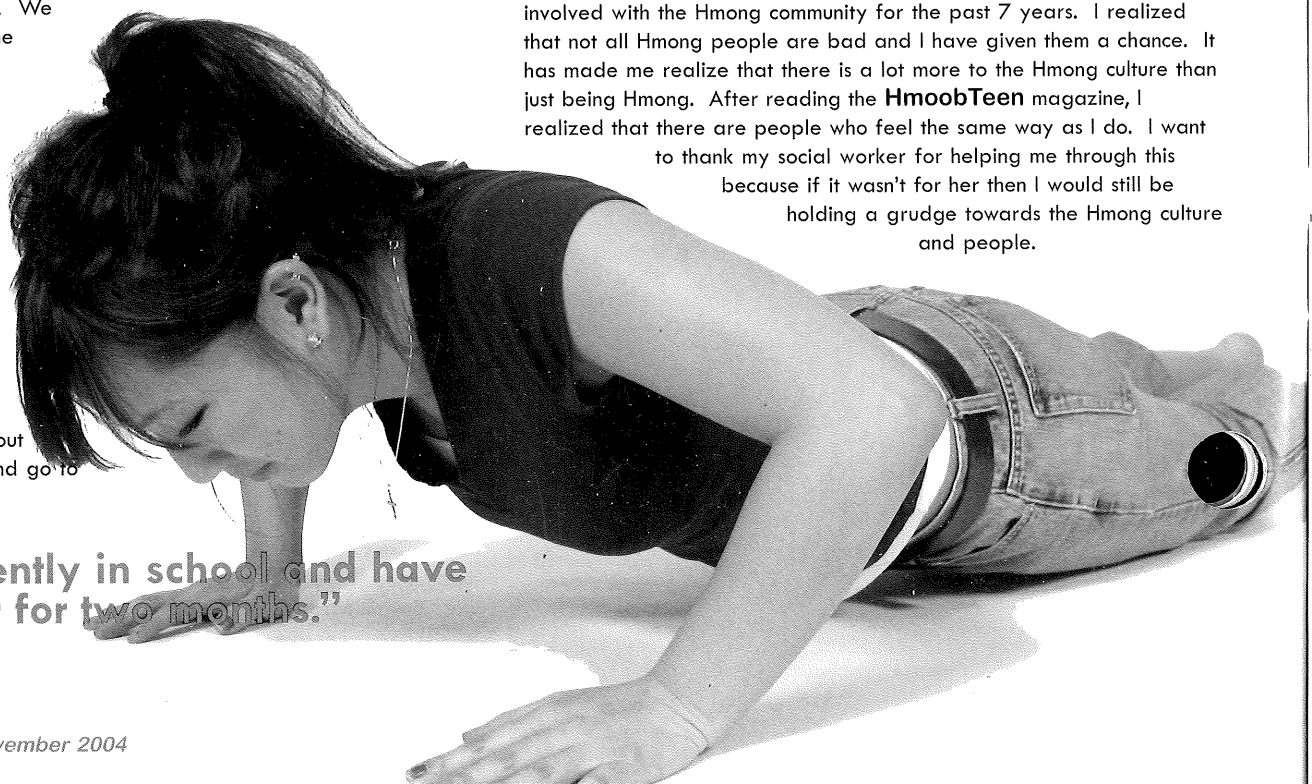
It was after my mother had my baby sister, Aailliyah, that I realized I wanted to change. My baby sister's birth changed me in so many ways and every time that I think about it, it brings tears to my eyes. She is the most precious thing in my life. I love her with all my heart and I want her to know that. We may not have the same dad, but we have the same mother and that makes us blood. Every time I see her, it makes me want to succeed more. I want to be a role model for her. I want to know that she can do anything that she wants to when she gets older. She is the reason why I get my butt of out bed every morning and go to school. I want to make her proud of me because I have screwed up so many times in my life. Now, I feel like this is my chance to show her that I can do it. Aailliyah is my true motivation for getting my life together and that is why I am here today doing the things I am doing. Some day when she is older, I want her to look back at this article and just know that she was my inspiration.

"Every time I saw a Hmong person I would make rude comments to them.."

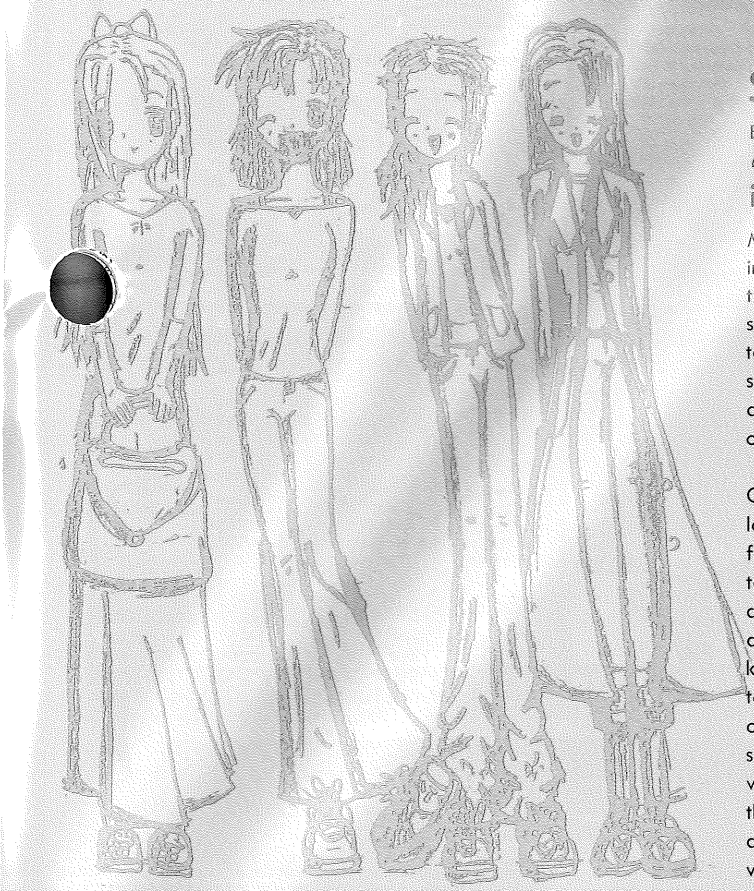
The author and her sister.

This past year has been so emotional and painful because a lot of the things have changed for me. I am currently in school and have been sober for two months. I also attend Alcoholics Anonomous meetings at least once a week. It has also taught me how to live my life being sober and still enjoy myself. I will graduate in 2006 and although I don't like school I know that I want a better life for myself. I am currently living at an Independence Living Skills Program where I have a lot of support. They have made me realize that in order for me to get to where I want to be, I have to work hard. I'm working to save money for my own place some day. All the people at this program have made me feel so comfortable. I feel it in my heart that the staff are here not just to work but they are truly here because they want to help us succeed in life.

Before I came here I talked to my social worker who is also Hmong. She got me involved in the Hmong community because I have not been involved with the Hmong community for the past 7 years. I realized that not all Hmong people are bad and I have given them a chance. It has made me realize that there is a lot more to the Hmong culture than just being Hmong. After reading the **HmoobTeen** magazine, I realized that there are people who feel the same way as I do. I want to thank my social worker for helping me through this because if it wasn't for her then I would still be holding a grudge towards the Hmong culture and people.



"I am currently in school and have been sober for two months."



SISTERS

By Pang Xiong,

"there are many times that our "sisterly-love" turns into a "sisterly-hatred."

My greatest motivators in life are my sisters. They build my motivation when I am in a struggle and build my confidence. Living life as a roller coaster, with many twists and turns; my sisters are always there to support me and eventually their supports eases the pain of personal affliction. Being raise in America, compared to Thailand, thaught me never to take things for granted especially the relationship that I share with my siblings. My sisters and I learned at a very early stage to depend on one and another as well as cooperate with each other to cope with our common problems.

Our relationships are not always perfect, there are many times that our "sisterly-love" turns into a "sisterly-hatred". I won't deny it; we have our shares of cat fights and criticizing and even taking advantage of each other's flaws. No matter how furious we are our sisterly kinship still exists. There will always be those days where we will want to hit a crushing blow to destroy one another for losing a favorite necklace or ruining a favorite shirt but no matter what happens we know we're still sisters regardless. At the end of the day it's still them who I want to share my struggles and triumphs with, it's only with my sisters that I reveal parts of myself that at times I'm reluctant to share with anyone else. The bond that I share between my sisters is quite unique—some people say the bond u have with your sister is perhaps the longest lasting relationship most people have, longer than the parent/child or husband/wife relationship. While the bonds may wax and wane, a person's lifetime quest for personal identity is undeniably interwoven with your siblings. All in all I consider myself very fortunate to have these incredible girls as sisters and best friends.

Artwork by Jennifer Her, 11, St. Paul, MN

They Keep Me Going and Going

By Linda Lee, 14, Brooklyn Center, MN

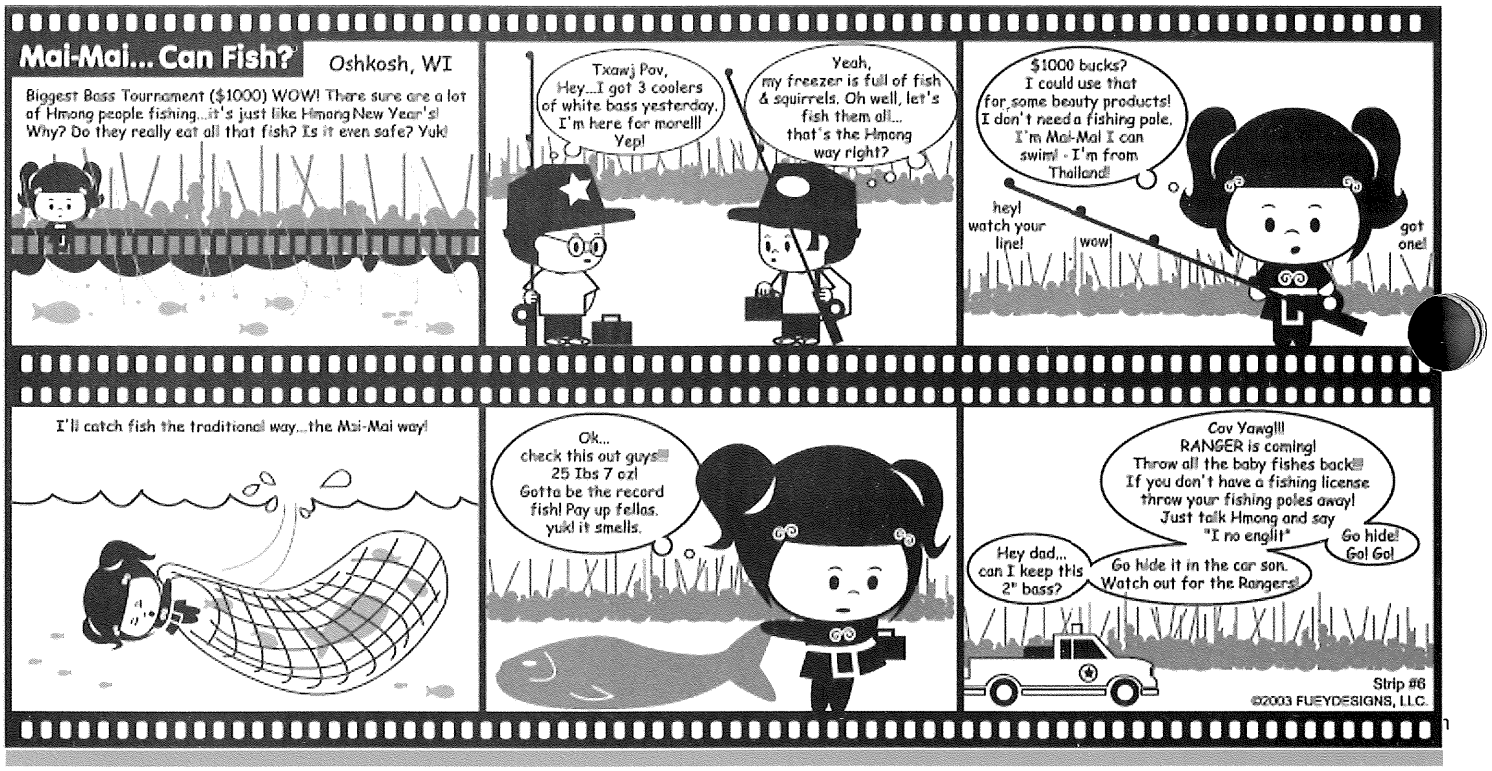
"We keep secrets for each other and love each other a lot."

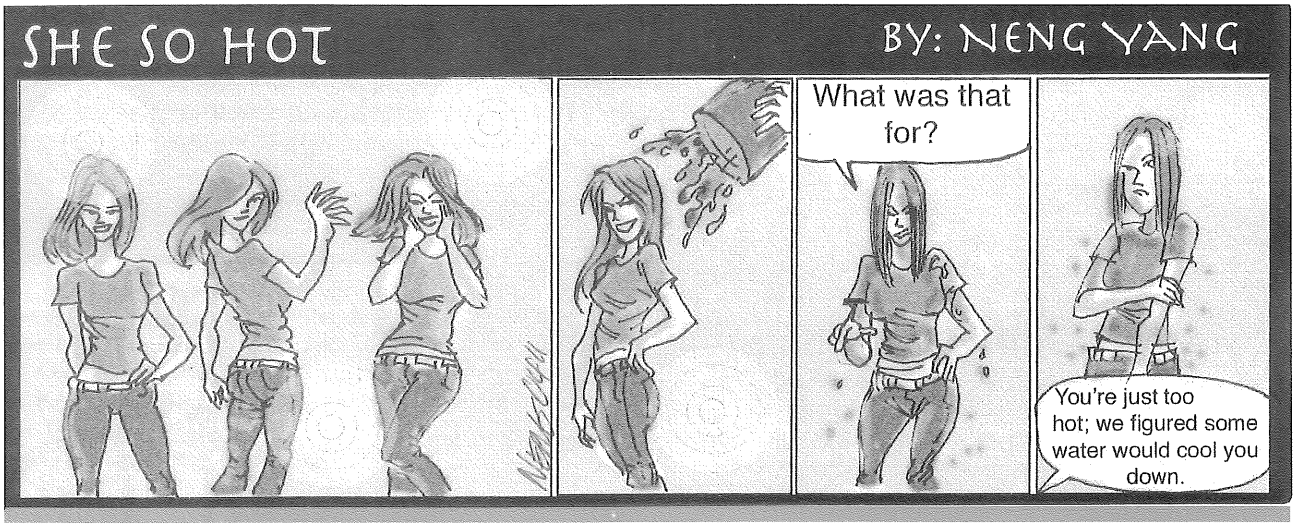
Like a normal teenager, I have stress. Every single day I face something new no matter if it's good or bad. Sometimes I feel like quitting and giving up on everything but what keeps me going and living are my friends and loved ones. When I'm feeling down, they make me smile and laugh. They make me happy and they cheer me up. They're there for me through thick and thin and teach me right from wrong. I know that I've made many mistakes in the past but I'm learning from them. They make my life worth living. If it weren't for them I wouldn't be where I am right now, living and breathing. They're always there to listen to my problems and are always very supportive.

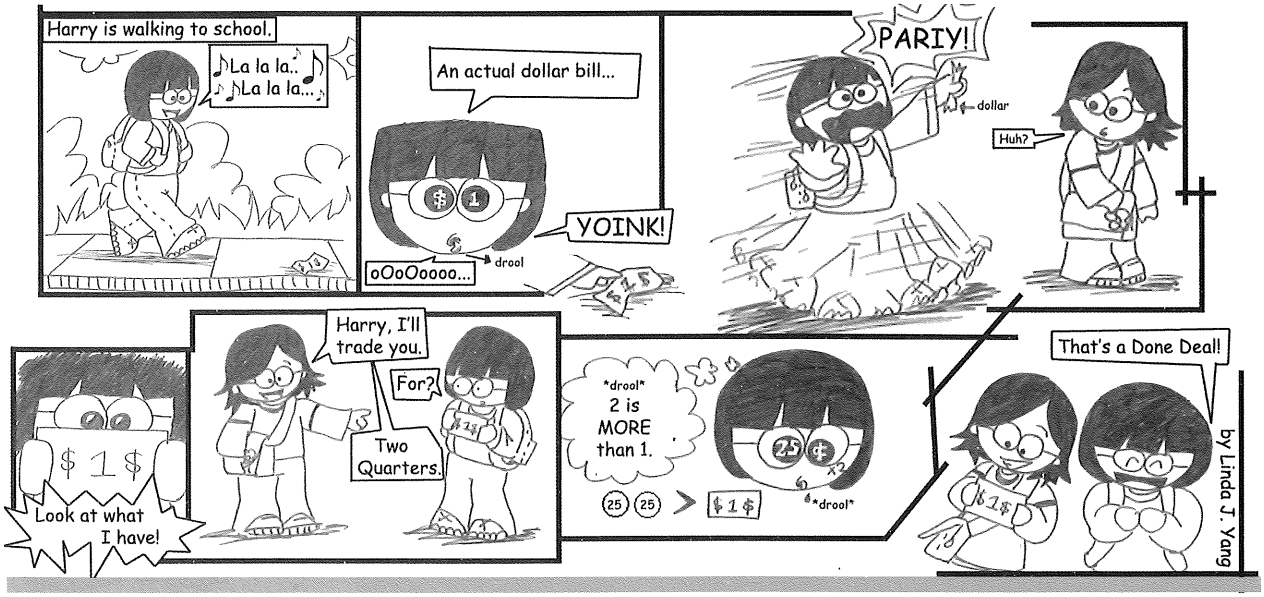
I am very lucky to have my family. My parents keep me on task. Like all parents, they lecture me not because they hate me but because they want me to learn from my mistakes. They just want us to know what we did wrong. I get lectured for many things and many different reasons. They lecture me about things that I didn't do, did do, and things that I need to be lectured about. No matter what my parents are there for me and I'm very thankful for that. I know they want us to do best that is why they encourage us to do very hard in school. My parents supply the roof over head, the food that I eat, and the clothes that I wear.

My siblings also motivate me. I they teach me and I learn from them. I even learn from my younger sister. My siblings help on things that I don't know. From helping me with my homework to teaching me what's right and what's wrong, they keep me on task. We keep secrets for each other and love each other a lot. I'm very lucky to have all of them in my life and they are the people that keep me going and going!

Artwork by Pa Houa Lee, St. Paul, MN


Mai-Mai... Can Fish?
Oshkosh, WI
Biggest Bass Tournament ($1000) WOW! There sure are a lot of Hmong people fishing...it's just like Hmong New Year's! Why? Do they really eat all that fish? Is it even safe? Yuk!
Txawj Pov, Hey...I got 3 coolers of white bass yesterday. I'm here for more!!! Yep!
Yeah, my freezer is full of fish & squirrels. Oh well, let's fish them all... that's the Hmong way right?
$1000 bucks? I could use that for some beauty products! I don't need a fishing pole. I'm Mai-Mai I can swim! - I'm from Thailand!
hey! watch your line!
wow!
got one!
I'll catch fish the traditional way...the Mai-Mai way!
Ok... check this out guys 25 lbs 7 oz! Gotta be the record fish! Pay up fellas. yuk! it smells.
Cov Yawg!!! RANGER is coming! Throw all the baby fishes back! If you don't have a fishing license throw your fishing poles away! Just talk Hmong and say "I no englit"
Go hide! Go! Go!
Hey dad... can I keep this 2" bass?
Go hide it in the car son. Watch out for the Rangers!
Strip #6
©2003 FUEYDESIGNS, LLC.


SHE SO HOT
BY: NENG YANG
What was that for?
You're just too hot; we figured some water would cool you down.

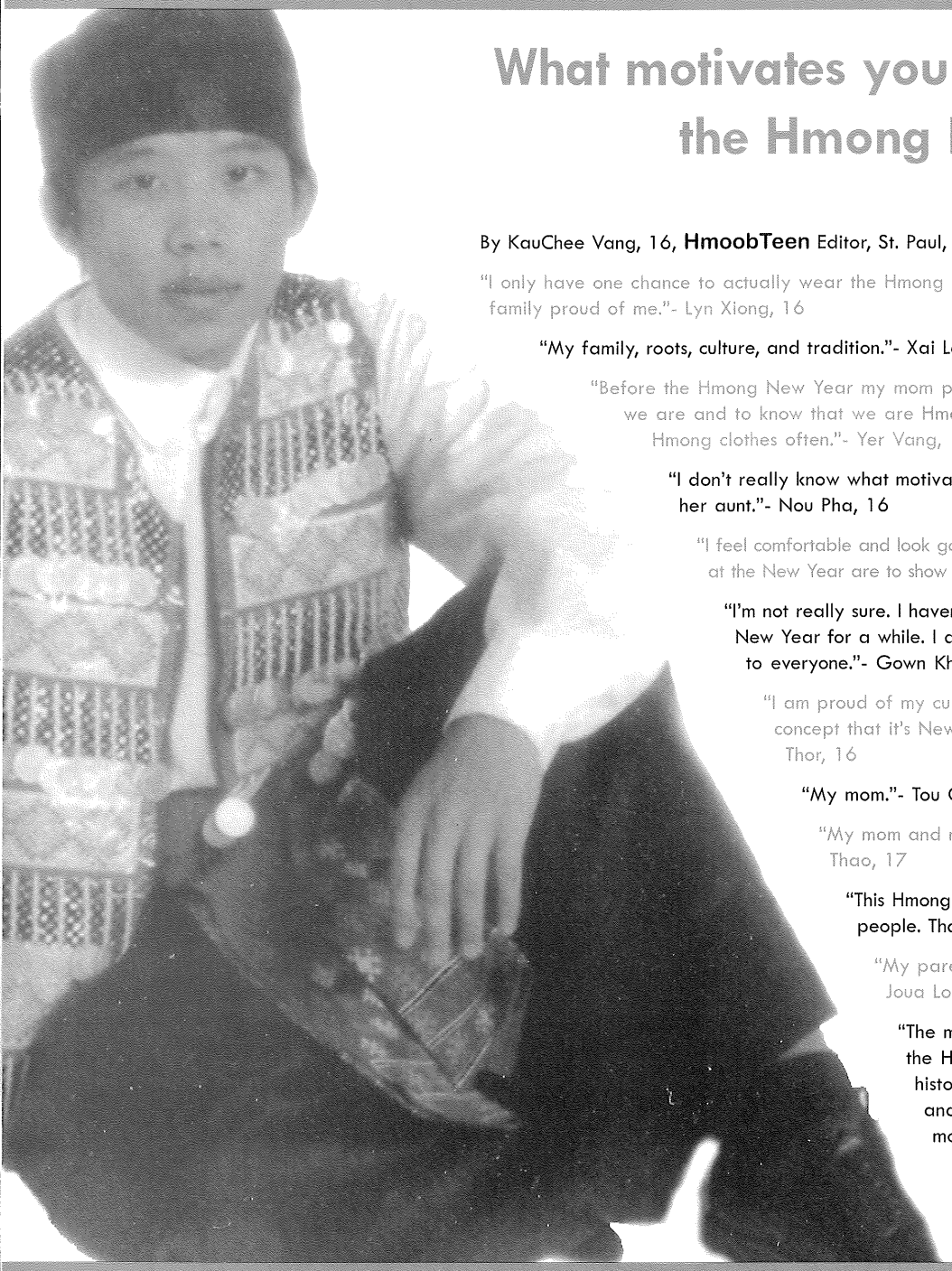

Harry is walking to school.
♪La la la..♪ ♪La la la...♪
An actual dollar bill...
YOINK!
oOoOoooo...
drool
PARIY!
dollar
Huh?
Harry, I'll trade you.
For?
Two Quarters.
Look at what I have!
drool 2 is MORE than 1.
drool
That's a Done Deal!
by Linda J. Yang


The Life of Paj...
work by Xee Yang, 14, Mplsl, MN
?
oh bleep this test is hard
I didn't study
Did I feed the cat?
Focus Paj Focus
HW: Page 136 #s 6-13
Homework due tommorrow
Test is over class! I pass the tests forward
I hope my grade isn't tha bad.
-ring
2 second later...
so boring
oh he's so cute!
Ga Ga Ga Ga Ga...
Boom Clang
ouch
Thanks for helping!
no problem
What's your name?
I'm Sean
uh...uh Paj.
yeah really
okay
looks like you have a bad grade
Don't worry I can tutor you
Well I'll tutor you saturday at 7:00. Don't worry you'll do great just stud I know you can do it!
-oka well ummm.. Thanks Bye!
To be continued.


Beginner's Luck
-Hi
BY: PA HOUA LEE
ENG DO YOU HAVE A MINUTE?
UH SURE.
AN INTERVIEW.....
Question: If you weren't an actor, what will you be?
WOW! WHAT I WANTED TO BE ALL MY LIFE WAS... "A COMEDIEN!"
EH?
HA HA HA HA HA HA
THAT SOUNDS REALLY COOL ENG! I ADMIRE YOU A LOT!
AH THANKS!
HOLD ON! HERE'S A JOKE!
NICE! THANK YOU I....
YOU GOTTA HEAR IT! UM... WHY.. 'NO. It's... HOW CAN YOU TELL IF A PLANT IS SICK?... BECAUSE IT'S ALWAYS GREEN?!
TEE HEE
HEY DUDE WHY'S YOUR FLY OPEN.
..aHAhah.... AH HA HA... Ha HE HE HE Ha hA HA... hehe.....
MUST HIDE IN CAVE FOREVER!
"WHAT!" ...NOT AGAIN!!!
?!&@#@?!!

HmoobTeen Magazine

The place where Hmong teens can speak and be heard.



What motivates you to go traditional to the Hmong New Year?

By KauChee Vang, 16, **HmoobTeen** Editor, St. Paul, MN

"I only have one chance to actually wear the Hmong clothing during the year, and also it makes my family proud of me."- Lyn Xiong, 16

"My family, roots, culture, and tradition."- Xai Lee, 16

"Before the Hmong New Year my mom prepares for this event. She says, it's to show who we are and to know that we are Hmong because we don't have the chance to wear Hmong clothes often."- Yer Vang, 16

"I don't really know what motivates me to wear it, but I think it is my mom, and her aunt."- Nou Pha, 16

"I feel comfortable and look good in the Hmong outfit. The traditional Hmong outfits at the New Year are to show pride in our Hmong people." –Anonymous, 15

"I'm not really sure. I haven't worn my traditional Hmong outfit to the Hmong New Year for a while. I don't know, I think that it means something different to everyone."- Gown Khang, 16

"I am proud of my culture and I want to represent it. The whole concept that it's New Year and time to show what you have."- Violet Thor, 16

"My mom."- Tou Ger Pha, 17

"My mom and my girlfriend, wants me to wear the outfit."- Chai Thao, 17

"This Hmong outfit represents the Hmong culture, history, and people. That is what motivates me."- Pa Houa Vang, 17

"My parents, first of all, then my pride for being Hmong."- Joua Lor, 16

"The main thing that motivates me is the clothing that the Hmong people still have which represents our history, people, and tradition. My mom's hard work and hope for me to wear the outfit each year motivates me also." – KauChee Vang, 16

HmoobTeen

March's Theme is Lessons & Regrets.

WHAT HAVE YOU LEARNED? HOW DID YOU LEARN IT? Tell us stories about how you learned your life lessons. Tell us about those things you regret: saying, doing, acting, spending money on, getting involve in. What advice would you give others? Send it all in.

Deadline is January 31, 2005.

Yes! **HmoobTeen** is awesome! Here is my $8.00 to cover the cost of mailing me the next five issues (one year.)

Name

Address

City State Zip

Email Your Age

Cut this box out & mail your check to HAP:1075 [illegible] St, St. Paul, MN 55106

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S.F. No. 210 - Living-At-Home/Block Nurse Programs (The Delete-Everything Amendment)

Author: Senator Mee Moua

Prepared by: David Giel, Senate Research (651/296-7178)

Date: January 20, 2005

S.F. No. 210 (the delete-everything amendment) expands the maximum number of local Living-At-Home/Block Nurse (LAH/BN) programs to 47 from the current 33; requires local programs and their umbrella agency to receive annual cost-of-living adjustments beginning in 2006; and provides money for these purposes and to fund the contract with the umbrella agency for the upcoming biennium.

Section 1 (256B.0917, subdivision 7) increases base funding awarded to Living-at-Home/Block Nurse Program, Inc., (LAH/BN, Inc.) as part of the contract to administer the LAH/BN program by four percent effective July 1, 2006, and requires a cost-of-living adjustment in the contract in each subsequent fiscal year. This section also deletes outdated language.

Section 2 (256B.0917, subdivision 8) increases to 47 from the current 33 the maximum number of local LAH/BN programs. This section requires a four percent increase in base level funding for each local program effective July 1, 2006, and requires a cost-of-living adjustment for each program in each subsequent fiscal year.

Section 3 includes blank appropriations for the following:

(a) to fund 14 additional local LAH/BN programs;

(b) to provide a four percent funding increase for each local program on July 1, 2006; and

(c) to fund the contract with LAH/BN, Inc., for the upcoming biennium, and the cost-of-living increase required on July 1, 2006.

DG:rdr

Senators Moua, Lourey and Anderson introduced--
S.F. No. 210: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; increasing the number of living-at-home/block nurse programs; increasing annual program funding; appropriating money; amending Minnesota Statutes 2004, section 256B.0917, subdivision 8.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.0917, subdivision 8, is amended to read:

Subd. 8. [LIVING-AT-HOME/BLOCK NURSE PROGRAM GRANT.] (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to ~~33~~ 38 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed ~~$80,000~~ $100,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under

this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Sec. 2. [APPROPRIATION.]

$560,000 is appropriated from the general fund to the commissioner of human services, for the biennium ending June 30, 2007, to increase base funding by $5,000 per year for living-at-home/block nurse programs and to establish five new living-at-home/block nurse programs, as provided under section 1.

Senator Moua moves to amend S.F. No. 210 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 256B.0917, subdivision 7, is amended to read:

Subd. 7. [CONTRACT.] (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) ~~The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.~~ Base funding awarded to LAH/BN, Inc. as part of the contract shall be increased by four percent for the fiscal year beginning July 1, 2006, and shall be increased by the change in the Consumer Price Index-All Items (United States city average) (CPI-U) for fiscal years beginning on or after July 1, 2007.

Sec. 2. Minnesota Statutes 2004, section 256B.0917, subdivision 8, is amended to read:

Subd. 8. [LIVING-AT-HOME/BLOCK NURSE PROGRAM GRANT.] (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to ~~33~~ 47 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county

metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed $80,000 per applicant for the grant period. The organization under contract may increase the grant

amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services. The base amount awarded to each applicant for a grant period shall be increased by four percent for the fiscal year beginning July 1, 2006, and shall be increased by the change in the Consumer Price Index-All Items (United States city average) (CPI-U) for fiscal years beginning on or after July 1, 2007.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Sec. 3. [APPROPRIATION; LIVING AT HOME/BLOCK NURSE PROGRAMS.]

(a) $..... is appropriated from the general fund to the commissioner of human services, for the biennium beginning July 1, 2005, to fund 14 additional living-at-home/block nurse programs.

(b) $..... is appropriated from the general fund to the commissioner of human services, for the fiscal year beginning July 1, 2006, to increase base funding for living-at-home/block nurse programs as required by Minnesota Statutes, section 256B.0917, subdivision 8, paragraph (c).

(c) $..... is appropriated from the general fund to the commissioner of human services, for the biennium beginning July 1, 2005, to fund the contract awarded under Minnesota Statutes, section 256B.0917, subdivision 7, and an additional $..... is appropriated to the commissioner for the fiscal year beginning July 1, 2006, to increase base funding for the organization under contract as required by Minnesota Statutes, section 256B.0917, subdivision 7, paragraph (b)."

Amend the title as follows:

Page 1, line 6, delete "subdivision" and insert "subdivisions 7,"

Eric Eloff

Minnesota Board on Aging

STATEMENT OF BUDGET PRIORITIES AND RECOMMENDATIONS

January 25, 2005

Home and Community-Based Services
The Board strongly supports the long-term care system reforms that were instituted by the Legislature in 2001. The state funded grant programs that promote this system change are highly leveraged, bringing in other public, private and volunteer resources. Because the state is able to use these resources as effective incentives to change the system, state funds for these programs should be sustained at a level sufficient to continue the momentum for long-term care reform. Ultimately, community-based services—that maximize family and volunteer assistance—are less costly than institutional models of care.

The Board supports increasing efficiency and eliminating redundancy—where it exists—in all home and community-based services. From its work with competitive contracts to its current efforts to fill community-identified gaps, the Board has fostered both collaboration and accountability and will continue to do so. Given the state budget shortfall, we will continue to look for opportunities to provide efficient local service delivery with fewer resources.

State Senior Nutrition Grants
Senior nutrition programs (congregate dining and home delivered meals) are cost-effective and target the most frail elderly in both rural and urban communities. Nutrition is a basic human need and Minnesota has built a network of programs that now serve the frailest, most vulnerable elderly. State dollars leverage federal funds and client contributions. To ensure that state nutrition dollars further the state's policy of rebalancing Minnesota's long-term care system, the state funds that are appropriated will be targeted to minimize site closures in both rural and inner-city communities that have no other nutrition resources, and to low-income, frail elderly who are at risk for costly nursing home placement.

State Volunteer Program Grants
Workforce shortages coupled with fiscal constraints make it critical that the state continue supporting the use of volunteers to supplement and expand vital long-term care services. The state's role should focus on volunteer resources that are targeted to fill the community-identified "gaps" in long-term care resources—such as volunteer transportation, companion services, caregiver respite and support, and delivering meals.

Jeanette Metz, Chair

Call for Critical Action: 2005 Legislative Session

MOVE THE LONG-TERM CARE REBALANCING AGENDA FORWARD

With a rapidly aging population, it is imperative that policy makers aggressively build upon the Legislature's 2001 mandate to rebalance the long-term care system of Minnesota. Minnesota must undertake a long-term care agenda that moves resources from a dependence on institutional care to one **focused on community care**.

Minnesota must have an adequately funded, well-leveraged, cost-effective, community care system that ensures quality of care and quality of life. The percentage of public funding allocated to community-based, long-term care of seniors must be increased at an accelerated rate to fulfill the promise of the 2001 mandate.

Minnesota must:

1. **Sustain and expand community-based, long-term care. Maintain the current level of total funding for long-term care while rebalancing resources. Increase the share of State spending for home and community-based services to 30% of the long-term care budget during this biennium.**
   - Most long-term care happens at home. In addition to formal services, elders retain the support of families, friends and neighbors. Homemaking services, home health care, meals, transportation and respite for family caregivers are essential services for maintaining independence and quality of life.
   - Shift existing funding from institutional support to community care through incentives to close additional nursing home beds. Move the savings to support waiver programs, nutrition services, volunteer support, neighborhood and faith-community services, companion programs, caregiver support, transportation, technology advances, information and assistance and care coordination.

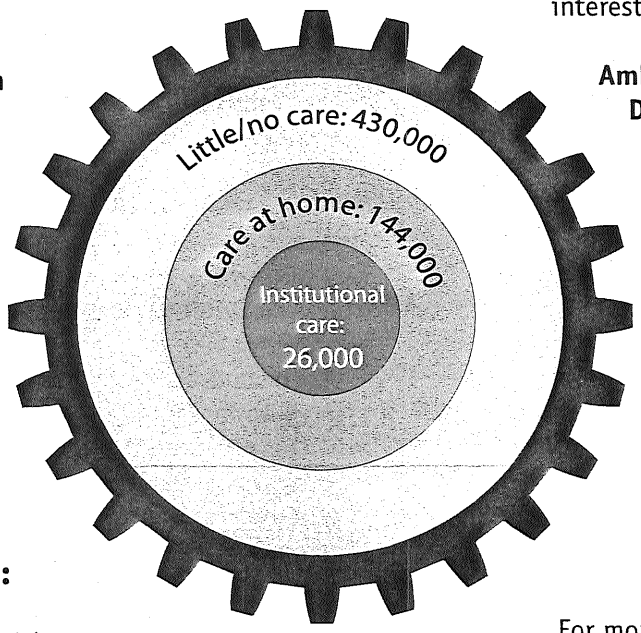
2. **Maintain and expand state-funded programs that support community-based long-term care. Assure that savings gained from rebalancing the system support community care.**
   - Maximize use of the Elderly Waiver program for eligible persons and maintain a strong Alternative Care program recognizing its importance in supporting seniors in danger of falling into the expensive, institutional safety net.
   - Ensure that older Minnesotans have choice and access to the services they need in their communities. Increase rates for community-based service providers to assure the survival of quality providers able to hire and retain a trained work force.
   - Assure equal access for older Minnesotans without the income to pay for the services they need by maintaining benefits for Elderly Waiver and Alternative Care enrollees.

(Continued...)

Malcolm Mitchell

Current Environment:

The Legislature is facing difficult decisions during a biennium in which resources are limited. The Department of Human Services estimates that, of the total 65+ population of 584,266 persons, almost one third receive support from the home health care and nonprofit social service sectors to help them remain at home. It is imperative that these seniors remain above the safety net now and that community-based support is available for the growing older population of the next two years and to serve the baby boom generation of 2030.



Background:

In 2001, the Legislature approved the bi-partisan Long Term Care Task Force's successful reform agenda to rebalance long-term care from an unnecessarily high reliance on nursing homes and assisted living facilities to greater reliance on home and community-based services. Through implementation of funding for community service development, nursing home bed closures and systems changes, a growing number of functionally and economically needy seniors have been able to remain in their own homes and dependence on institutional nursing home care has been reduced. Currently, 78% of all public funding to support senior care goes to nursing homes; down from 84% in 2001.

Eleven leading nonprofit organizations that help older adults live independently at home in communities across Minnesota have come together to ensure that seniors have community care to meet their basic needs and to assure them quality of life. Together, the organizations of the Leadership Council on Aging serve over 240,000 seniors and family caregivers and represent more than 120,000 older persons interested in aging issues.

Amherst H. Wilder Foundation
DARTS
Elderberry Institute/ Living at Home
Block Nurse Programs
Hospice Minnesota
Lutheran Social Service of Minnesota
Metropolitan Senior Federation
Minnesota Association of Area Agencies on Aging
Minnesota Home Care Association
Minnesota Senior Federation
Senior Community Services
Volunteers of America of Minnesota

For more information about the Minnesota Leadership Council on Aging and its legislative positions, please contact:

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Minnesota Leadership Council On Aging

Malcolm Mitchell

The Living at Home/Block Nurse Program[sm]

Neighbors Helping Elders Stay at Home

Across Minnesota, 42 non-profit, community-owned Living at Home/Block Nurse Programs (LAH/BNPs) are helping elders stay healthy while living in their own homes, avoiding early or unnecessary nursing home placement. The Programs organize volunteer assistance and nursing care for elders, providing or arranging "whatever help is needed" for elders to stay at home, safely and independently, for as long as possible. Elderberry Institute and Living at Home/Block Nurse Programs are:

- Neighbors helping neighbors as volunteers and paid professionals within the Programs' neighborhood or small community boundaries,
- Enhancing quality of life for elders and caregivers,
- Preventing "spend down" to welfare programs,
- Building more elder friendly communities,
- Delaying or averting admission to nursing homes,
- Adept at working alongside existing health care services,
- Promoting a sustainable, long-term model of elder care,
- Successful, cost-effective and caring community Programs,
- Successfully growing the model in Minnesota, and
- A part of the solution for the growing population of elderly, particularly for single elder women living alone.

Rebalancing long-term care

The Living at Home/Block Nurse Program is needed by Minnesota to provide more services for elders in the community rather than institutional care. Currently, 78% of all MN public dollars to support elder care go to nursing homes, and 22% to home & community based services. While the percentage of MN elders using community based services has increased from 38.8% in 1998 to 50% in 2004, more is needed. One of the MN Board on Aging's strategies in 2005 is to "accelerate the rebalancing of Minnesota's long-term care system" because "four persons can be supported in the community for every one person in an institutional setting." Data for 2003-04 show that:

- 39 MN LAH/BNPs helped an est. 928 elders avoid nursing home placement for over 7,500 months.
- This resulted in a care-related cost savings to the people of Minnesota of just over $18,000,000.
- LAH/BNP volunteers provided nearly 90,000 hours of direct service to elders.
- For every $1.00 spent on LAH/BNPs, the people of MN realized a savings of $3.60.
- For every $1.00 provided by the State of MN for LAH/BNPs, local communities raised $1.38 (through fundraisers, grants & local government).

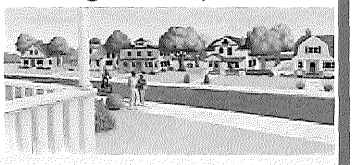
Making an Impact for Elders

"I just had my first hug in 15 years!" says a 95 year-old woman being supported by a local LAH/BNP.

[She's] "a gem, professional, has boundaries, caring, an excellent caregiver. She should be negotiating world peace."- from a caregiver receiving assistance from a LAH/BNP nurse.

"I was afraid I would never be able to go home again."- from an elder helped by a LAH/BNP to return home after a stay in a nursing home to recover from an injury.

For more information about the Living at Home/Block Nurse Program contact:



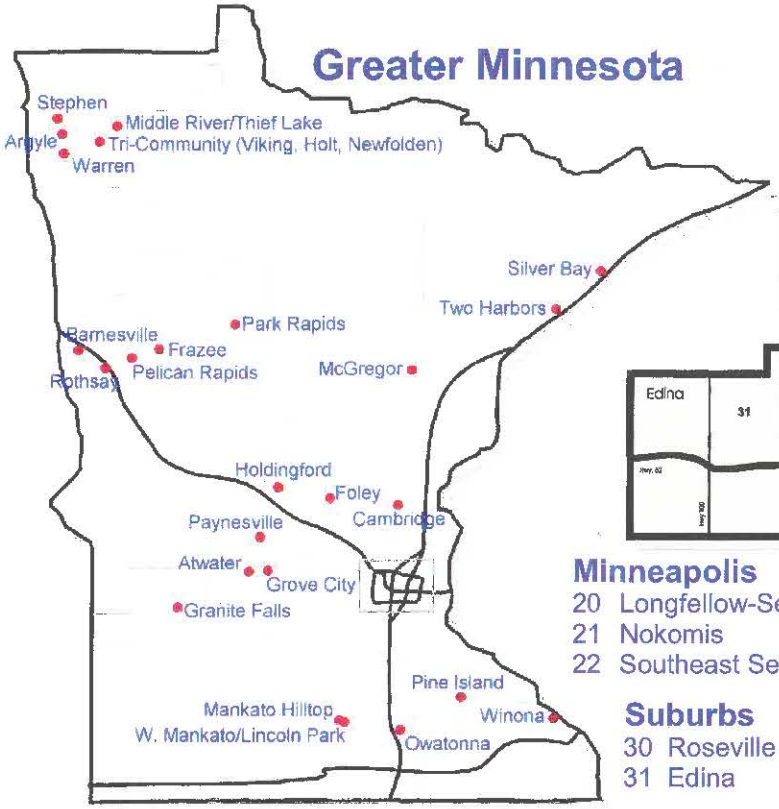
Elderberry Institute[SM]

475 Cleveland Ave. North,
Suite 322
St. Paul, MN 55104

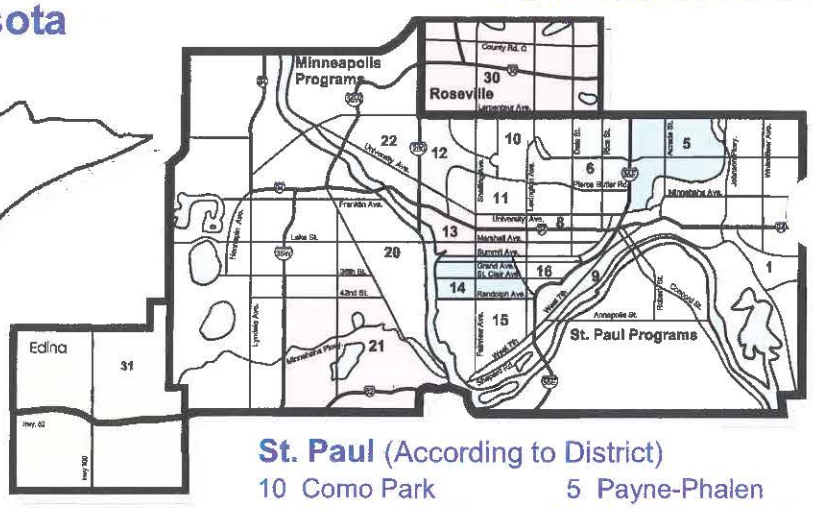
Phone: 651-649-0315
Email: elderb@elderberry.org
www.elderberry.org

Minnesota Living at Home/Block Nurse Program Locations:

Greater Minnesota



Twin Cities Area



Minneapolis
- 20 Longfellow-Seward
- 21 Nokomis
- 22 Southeast Seniors

Suburbs
- 30 Roseville
- 31 Edina

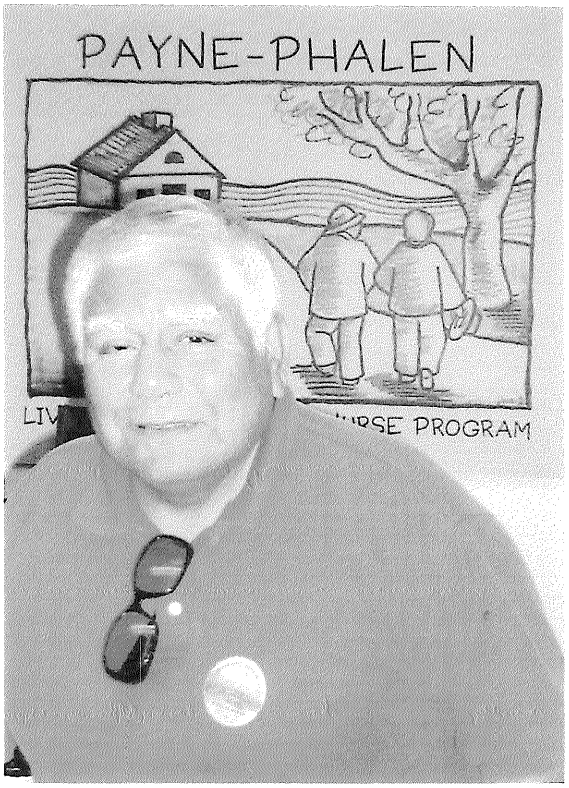
St. Paul (According to District)
- 10 Como Park
- 1 Conway-Battle Creek
- 11 Hamline-Midway
- 15 Highland
- 14 Macalester-Groveland
- 13 Merriam Park
- 6 North End-South Como
- 5 Payne-Phalen
- 12 St. Anthony Park
- 16 Summit Hill
- 8 Summit University
- 9 West 7th

Living at Home/Block Nurse Program Contact People:

Program	*Board Chair*
Argyle 218-437-8431	V Tulibaski 218-437-8103
Atwater 320-974-8737	B Moll 320-974-8972
Barnesville 218-354-7090	L Froslie 218-493-4589
Cambridge 763-689-1881	C Joslin 763-689-4101
Como Park 651-642-1127	C Leach 651-490-1715
Conway-BC 651-793-8190	J Narveson 651-731-1167
Edina 952-922-1110	D Nordenson 612-827-8284
Foley 320-968-7848	A Jergenson 320-968-7928
Frazee 218-334-3559	J Lamont 218-334-3611
Granite Falls 320-564-3235	A Gisalson 320-564-2442
Grove City 320-857-2274	G Cumings 320-857-2002
Hamline-Mid 651-209-6542	C Sheehan 651-644-9916
Highland 651-696-8425	S Kiernat 651-690-2287
Holdingford 320-746-9960	J Christensen 320-746-2619
Longfell.-Swd. 612-729-5799	E Cutting 612-728-3999
Mac.-Grove. 651-696-6882	S Rose 651-779-7202
Mankato Ht. 507-345-2985	T Knapp 507-345-6352
McGregor 218-768-2762	S Conzet 218-426-3420
Merriam Pk. 651-646-2301	J Wilebski 651-690-4210
Middle River 218-222-4466	W Lunsetter 218-459-3379
Nokomis 612-729-5499	J Bargman (call Program)
NEnd-SComo 651-487-5135	L Reilly 651-489-3116

Program	*Board Chair*
Owatonna 507-455-7648	J WrayRaabolle 507-451-1120
Park Rapids 218-732-3137	D Bessler (call Program)
Payne Phalen 651-774-7078	K Stone 651-778-9352
Paynesville 320-243-5144	L Hull (call Program)
Pelican Rapids 218-863-1515	L Suter 218-863-1621
Pine Island 507-356-2999	P Shelton 507-356-4387
Roseville 651-604-3720	N Johnson 651-645-2354
Rothsay 218-867-1234	B Westfall 218-867-2621
St. Anthony Pk. 651-642-9052	J Osgood 651-644-0745
Silver Bay 218-353-7318	C Johnson 218-353-7720
S.E. Seniors 612-331-2302	B Distad (call Program)
Stephen 218-478-3834	N Carl 218-478-3562
Summit Hill 651-222-7884	N Hakanson 651-224-7859
Summit U. 651-227-1367	P Kane 651-293-9026
Tri-Comm. 218-874-2256	S Bring 218-874-3713
Two Harbors 218-834-8024	S Nelson (call Program)
Warren 218-745-4005	R Tureson 218-745-4647
West 7th 651-298-5493	C Akale 651-459-8685
W. Mankato 507-345-2985	K Purscell 507-625-3309
Winona 507-457-6400	L Theurer 507-457-6400
Inquiring Communities: Willmar, Minneapolis, Duluth, St. Michael, Cold Spring, Finland, Medford, Brooklyn Park, Grand Forks, others	

Hello, my name is Charles "Chuck" Aguirre.....



Let me tell you a bit about myself. I am 71 years old, a life long residence of the East Side of St. Paul. I come from a family of 15 brothers and sisters. Ten of us are veterans. I'm legally blind and the past president of the Minnesota Blinded Veteran's Association. Six years ago my wife of 43 years died. The next year I went blind and a year later, I lost my left leg. Then two years ago, the other leg due to diabetes. I am on dialysis three times a week. I have had open-heart surgery and three heart attacks. I qualify to live in a nursing home. And, thanks to the Living at Home/Block Nurse Program, I am living on my own in an apartment at the Edgerton High Rise. A few years ago, someone told me the Block Nurse Program could help me. Boy, were they right! At that time I lived in the Conway Battle Creek LAH/BNP area. They helped me in many ways. They interviewed me to learn my needs. They lined me up with a wonderful volunteer who took me shopping, she helped me get my prescriptions, and drove me to the doctor. About a year ago, I moved to my present location, which is served by the Payne-Phalen Living at Home/Block Nurse Program. They have continued to help me with many things. They check up on me regularly to see that I'm okay. Last year following a heart attack, they visited me in the hospital. They help me maintain my independence by driving me to the supermarket to do my grocery shopping. This is a wonderful program that allows me, despite my limitations, to remain in my own home where I want to be. I really couldn't exist without them. I am so proud of the program I love telling others about it. In fact, last year the Payne-Phalen program invited me to be on their board, so I am now also one of their many volunteers.

<u>Please, please vote to fully fund the</u>
<u>Living at Home/Block Nurse Program Bill 210 thank you</u>.

Chuck Aguirre, 01.25.05

Senate Counsel & Research

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MAJA WEIDMANN

Senate
State of Minnesota

S.F. No. 211 - Senior Nutrition Programs Funding

Author: Senator Mee Moua

Prepared by: David Giel, Senate Research (651/296-7178)

Date: January 20, 2005

S.F. No. 211 increases funding for senior nutrition programs by $822,000 per biennium and provides $200,000 per biennium for grants to support innovative methods by these programs to reach hard-to-serve populations.

Subdivision 1 increases base level funding for senior nutrition programs by $822,000 per biennium.

Subdivision 2 appropriates $200,000 for two-year grants to senior nutrition programs to support innovative ways to deliver services to (1) persons with language or cultural barriers, (2) persons with special diets, (3) persons living in isolated rural areas, and (4) other hard-to-serve populations. These grants may be renewed for additional two-year periods if the Commissioner of Human Services determines that a grantee has significantly increased access for hard-to-serve populations. The appropriation becomes part of the senior nutrition programs' base level funding.

DG:rdr

Senators Moua, Lourey and Anderson introduced--

S.F. No. 211: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; restoring senior nutrition funding; providing senior nutrition grants to serve certain populations; appropriating money.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [SENIOR NUTRITION FUNDING.]

Subdivision 1. [INCREASE IN BASE FUNDING.] $822,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2007, to restore funding for senior nutrition programs under Minnesota Statutes, section 256.9752. This funding shall become part of the base funding for senior nutrition programs for the biennium beginning July 1, 2007.

Subd. 2. [TARGETED GRANTS.] $200,000 is appropriated from the general fund to the commissioner of human services for the biennium ending June 30, 2007, to be used to provide two-year grants to senior nutrition programs to fund innovative methods of delivering services to: (1) persons facing language or cultural barriers in accessing services; (2) persons with special diets; (3) persons living in isolated rural areas; and (4) other hard-to-serve populations. Grants may be renewed for additional two-year periods, if the commissioner of human services determines that a grant recipient has significantly increased access to services for a hard-to-serve population. This funding shall become part of the base funding for senior

nutrition programs for the biennium beginning July 1, 2007.

Senator Howe moves to amend S.F. No. 211 as follows:

Page 1, lines 9 and 15, after "for" insert "the Minnesota Board on Aging for"

Senators Lourey, Solon, Higgins and Fischbach introduced--
S.F. No. 371: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; appropriating money for senior citizen programs.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [APPROPRIATION.]

Subdivision 1. [SENIOR COMPANION PROGRAM.] $593,000 is appropriated from the general fund to the commissioner of human services for purposes of the senior companion program under Minnesota Statutes, section 256.977, for the biennium beginning July 1, 2005.

Subd. 2. [VOLUNTEER PROGRAMS FOR RETIRED SENIOR CITIZENS.] $572,000 is appropriated from the general fund to the commissioner of human services for purposes of the volunteer programs for retired senior citizens under Minnesota Statutes, section 256.9753, for the biennium beginning July 1, 2005.

Subd. 3. [FOSTER GRANDPARENT PROGRAM.] $928,000 is appropriated from the general fund to the commissioner of human services to fund the foster grandparent program under Minnesota Statutes, section 256.976, for the biennium beginning July 1, 2005.

Senator Lourey moves to amend S.F. No. 371 as follows:

Delete everything after the enacting clause and insert:

"Section 1. [APPROPRIATION.]

Subdivision 1. [SENIOR COMPANION PROGRAM.] $1,186,000 is appropriated from the general fund to the commissioner of human services for purposes of the senior companion program under Minnesota Statutes, section 256.977, for the biennium beginning July 1, 2005.

Subd. 2. [VOLUNTEER PROGRAMS FOR RETIRED SENIOR CITIZENS.] $1,144,000 is appropriated from the general fund to the commissioner of human services for purposes of the volunteer programs for retired senior citizens under Minnesota Statutes, section 256.9753, for the biennium beginning July 1, 2005.

Subd. 3. [FOSTER GRANDPARENT PROGRAM.] $1,856,000 is appropriated from the general fund to the commissioner of human services to fund the foster grandparent program under Minnesota Statutes, section 256.976, for the biennium beginning July 1, 2005."

CATHOLIC
DIOCESE OF SUPERIOR
OFFICE OF THE BISHOP

January 24, 2005

Lourey
Hogg

Chairperson Becky Lourey
Health and Family Security Policy Committee
State Capitol
Saint Paul, Minnesota 55405

Dear Chairperson Lourey and
Members of the Health and Family Security Policy Committee:

It is a privilege to submit my testimony to the Health and Family Security Policy Committee in support of the Foster Grandparent Program. I have asked Margaret Hogg, the Director of the Foster Grandparent Program of Northwest Wisconsin and Northeast Minnesota, to express my support for the compassionate work of over 100 senior volunteers who serve as Foster Grandparents in five counties of northern Minnesota through the sponsorship of Catholic Charities Bureau of the Diocese of Superior. Catholic Charities Bureau has sponsored this Foster Grandparent Program since 1975. Since that time, it has been our experience that the Foster Grandparent Program has provided services to children in an effective, efficient manner by mobilizing the resources of the faith based nonprofit sector with public agencies and private enterprise to meet the critical needs and issues of our society.

Each year the Foster Grandparent Program reports on the accomplishments of over 100 volunteers who serve at risk children, adolescents in crises, and families in poverty in twenty-three communities of northeastern Minnesota. These senior citizens share their love and their wisdom with children who may not have another nurturing adult in their lives. This concern and caring is certain to have a positive impact on the lives of children. In addition to the benefits of this compassionate person-to-person, generation-to-generation contact, are the quantifiable gains in academic achievement young children demonstrate when they experience a caring relationship with a Foster Grandparent. Academic scores, school attendance, and social skills all improve when at risk children are mentored and tutored by Foster Grandparents.

The Foster Grandparent Program provides an opportunity for active, creative senior citizens to commit their time and their talents to advance the common good of their communities, to pass along the wisdom of our diverse cultural heritage from one generation to another, and to assist the poor and the vulnerable to succeed in our society. Foster Grandparents come from all walks of life, from diverse ethnic, religious, economic, and educational backgrounds. Through their faithful citizenship, they embody the selfless sharing found in the story of the Good Samaritan in the Scriptures.

1201 HUGHITT AVENUE, P.O. BOX 969, SUPERIOR, WISCONSIN 54880
715-392-2937 FAX 715-395-3149

Catholic Charities Bureau has found that the coordination, encouragement and professionalism of the Minnesota Office of the Corporation for National Service has consistently expanded and extended the capacity of the Foster Grandparent Program to respond to requests for senior volunteers in schools, child care centers, and treatment programs. The Minnesota Bureau on Aging has administered this program in a manner that has been sensitive to the needs of our volunteers and the vulnerable children they serve. The Foster Grandparent Program is a product of many people of good will working efficiently to alleviate the effects of poverty through education, mentoring, and human compassion.

After nearly three decades of sponsorship, Catholic Charities Bureau has found that the Foster Grandparent Program puts into action the spirit of our Mission Statement, which reads, in part, "...to collaborate with all people of good will ...to create an environment of human dignity built on mutual respect, understanding and trust."

Thank you for allowing me this opportunity to express my support for the work of Foster Grandparents serving vulnerable children and youth in northern Minnesota.

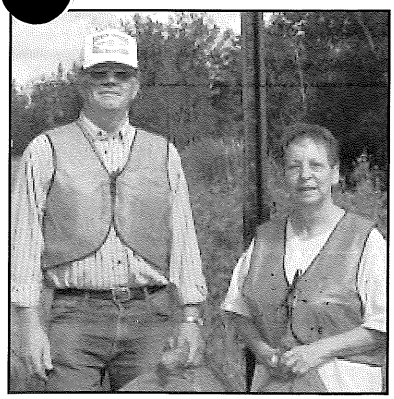
Sincerely yours in the Lord,

+ Raphael M. Fliss

Most Rev. Raphael M. Fliss
Bishop of Superior

Minnesota Senior Corps

A joint publication of the Minnesota Foster Grandparent, Senior Companion, and Retired and Senior Volunteer Programs



RSVP

Foster Grandparents

Senior Companions

2005

Volunteers Thrive in 2005!

Senior Corps is good for Minnesota. The 20,000 older citizens who volunteer through Senior Corps, a network of three programs — the Foster Grandparent Program, Retired and Senior Volunteer Program (RSVP), and the Senior Companion Program — work in every corner of the state to ensure that our friends and neighbors thrive.

Thousands of Minnesota youth with special needs do well in school because Foster Grandparent Program volunteers make a commitment to helping them learn basic academic skills. Perhaps more importantly, they nurture, guide, and comfort each child in their care, setting the stage for life-long success.

Thousands of grassroots organizations, government agencies, and health care facilities depend on RSVP volunteers to provide services that keep neighborhoods vital. RSVs train for disaster preparedness, build homes, prepare taxes, tutor children, operate tourist attractions, provide transportation, deliver meals, and play a role in nearly every aspect of a region's struggles and triumphs.

Thousands of frail, older Minnesotans are provided the opportunity to maintain independence because Senior Companion Program volunteers dedicate service not only to assisting them with daily living tasks, but to being a friend, an advocate, and a connection to the greater community.

Senior Corps is good for volunteers. A growing body of research points to the benefits of volunteering, particularly for older volunteers. Not only are they happier, they are healthier. Their generosity of service is what makes each truly thrive as a human being reaching beyond oneself.

For 40 years, Senior Corps volunteers have improved themselves by improving life for others. Senior Corps will continue to lead for generations to come in ensuring that Minnesota and every Minnesota citizen not only thrives, but surpasses his or her hopes and dreams.

Bonnie Ebnet

Bonnie Ebnet
President, Minnesota Senior Corps Assoc.

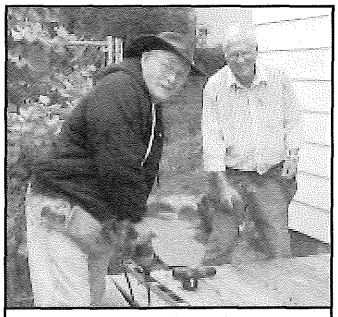
Lonny Hogg

RSVP

Serving in organizations ranging from hospitals and youth recreational centers to local police stations a[illegible] education facilities, RSVP participants put their skills, talents, and life experiences to work in their commun[illegible] RSVP engages people 55 and over in a diverse range of volunteer activities. Last year, 18,850 RSVP volunteers delivered more than 3 million hours of service.

RSVP of the Red River Valley volunteer drivers are making a difference in the Red River Valley where lack of transportation for the elderly and others who aren't able to drive is a big issue. From January through September 2004, these volunteers contributed 5,384 hours and 32,146 miles to transport people to necessary appointments and destinations.

North Central RSVP's Handy Hands volunteers perform small home repairs and maintenance to keep senior clients safe and independent in their homes. Other independent living programs include Groceries To Go, Meals On Wheels, and Senior Wheels.



Helping Hands volunteers Jack Kaspari and Rick Twaddle build a new porch for a senior client.

At least 103 clients in Douglas County were served by 58 peer counselors from **West Central Minnesota RSVP**, who focused on issues of loss, change, and loneliness. If all of the peer counseling clients had sought more expensive professional services, the cost to Medicare or Medicaid may have reached more than $290,000.

South Central Minnesota RSVP volunteers serve in schools, food shelves, thrift stores, hospitals, care centers, and as Meals on Wheels drivers in many of the area's communities. Other RSVs are making snow pants, sewing quilts, and volunteering to help with Red Cross Blood Drives.

Two volunteers with **Augustana RSVP**, Gene Bahr and Larry Baker, received awards from the Region #6 Minnesota Social Service Association for their willingness to transport emotionally disturbed children. Consistency in the lives of these children is very important and a familiar face is much easier on the child. Gene and Larry drive many miles out of the county and make themselves available on weekends and even near holidays.

Jerilyn Bernie, a volunteer with Greater Twin Cities RSVP

Jerilyn Bernie, a 2004 winner of the Mpls./St.Paul Magazine Twin Citian Volunteer Hall of Fame and volunteer with the **Greater Twin Cities RSVP**, volunteers at 18 RSVP sites. Whether acting as a Washington County Guardian ad Litem, answering telephones for the Minnesota Department of Health's Flu Hotline, or knitting more than 3,365 items for disadvantaged St. Paul school children with the Marvelous Mitten Makers, Jerilyn truly makes an impact in her community.

Members of **RSVP Volunteers United** are helping families and soldiers of the National Guard Charlie Company 1-151 adjust to an 18-month deployment. As members of the "Charlie's Angels Family Readiness Group," volunteers helped with a dinner for the soldiers and their families, the deployment ceremony at the school and a dance that allowed family, friends, and the community to wish soldiers well.

> "A volunteer is a person who believes that people can make a difference and is willing to prove it."

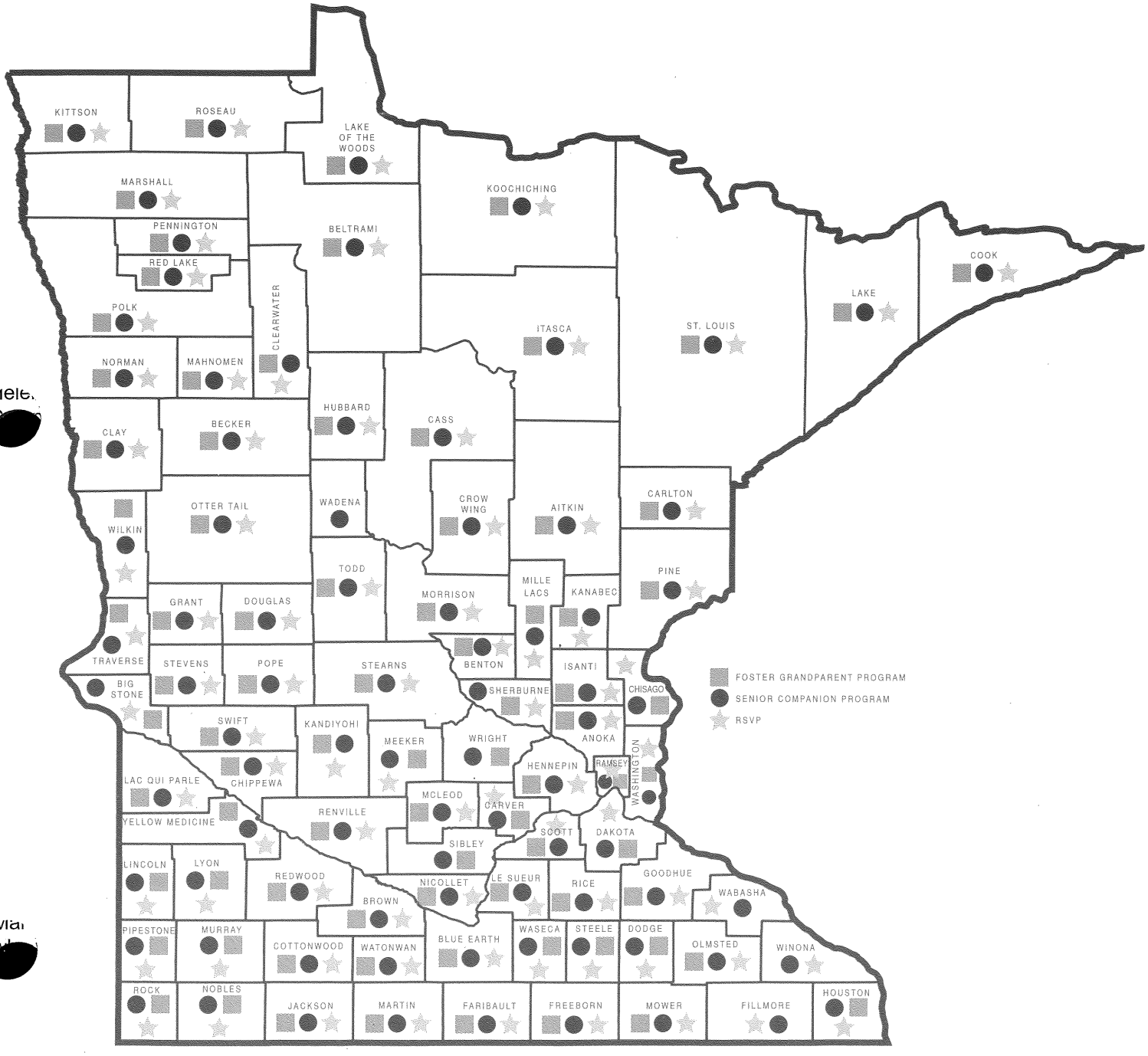
Last year, 16 RSVP Tax Aide volunteers with **Mahube RSVP** donated 2,194 hours and served 1,977 clients in Mahnomen, Becker, and Hubbard counties in west central Minnesota. The volunteers filed 1,272 income tax returns and 774 property tax/rental refunds. The volunteers' service resulted in their clients receiving $812,846 in refund[illegible] $437,04 in Earned Income Tax Credits (EITC).

Nearly 70% of residents in Lake and St. Louis Counties living in poverty received monthly nutritious food allocations with the help of 100 **Arrowhead RSVP** volunteers who served 11,159 hours with area food shelves.

Volunteers from **Horizon Health RSVP** are helping elementary students in Bemidji increase their reading and listening skills, and the kids don't even realize it — they think they're just having fun! The newly formed RSVP Readers Theater group is sharing their love of reading and performing with elementary students in the Bemidji area. It's a fun and engaging way to enc[illegible]e students to read and it[illegible]t fun for the volunteers as well. In 2005, the program will expand into Morrison, Cass, and Lake of the Woods counties.

Minnesota Senior Corps

County-by-County Coverage



RSVP

Aitkin-Carlton County RSVP
Serving Aitkin and Carlton counties
Deb Lindamood
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Toll Free: 888.419.1235
E-mail: jhatfield@vscci.com

Anoka County RSVP
Serving Anoka County
Diane Pokorney
Phone: 763.422.7090
E-mail: diane.pokorney@co.anoka.mn.us

Arrowhead RSVP
Serving Cook, Lake, and St. Louis counties
Bonnie Ebnet
Phone: 218.748.7328
E-mail: bebnet@aeoa.org

Augustana RSVP
Serving Kandiyohi, McLeod, Meeker, and Renville counties
Judy Barka
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E-mail: jbarka1@bsm1.org

Common Good RSVP
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East Central Minnesota RSVP
Serving Chisago, Isanti, Kanabec, Mille Lacs, and Pine counties
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Greater St. Cloud RSVP
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Horizon Health RSVP
Serving Beltrami, Cass, Lake of the Woods, and Morrison counties
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Mahube RSVP
Serving Becker, Clearwater, Hubbard, and Mahnomen counties
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E-mail: jhaack@mahube.org

North Central Minnesota RSVP
Serving Itasca and Koochiching counties
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E-mail: valeriej@kootasca.org

RSVP Greater Twin Cities
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Terry Straub
Phone: 612.617.7830
E-mail: tstraub@voamn.org

RSVP of Red River Valley
Serving Kittson, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau counties
Deanne Patenaude
Phone: 218.281.8288
E-mail: dpatenau@crk.umn.edu

RSVP of Southwest Minnesota
Serving Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, and Rock counties
Mary McLaughlin
Phone: 507.372.7374
E-mail: mmclaugh@rconnect.com

RSVP of Todd/Wadena/OtterTail/Wilkin
Serving Otter Tail, Todd, Wadena, and Wilkin counties
Kathryn Baril-Quittschreiber
Phone: 218.385.2900
E-mail: katieq@otwcac.org

RSVP Volunteer Services
Serving Crow Wing County
Mike Koecheler
Phone: 218.824.1345
E-mail: rsvp@co.crow-wing.mn.us

RSVP Volunteers United
Serving Big Stone, Chippewa, Lac qui Parle, Swift, and Yellow Medicine counties
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Senior Companion Program

Senior Companions serve as friends and companions to frail, older persons who need help to maintain their independence. This past year, Minnesota's 400 Senior Companions provided more than 285,000 hours of service. The Senior Companion Program offers seniors age 60 and older the opportunity to serve individuals who have difficulty with daily living tasks.

Irma Castle, a Senior Companion in **Thief River Falls**, helps keep Agnes, who struggles with depression, busy with crafts. Irma was able to encourage and help Agnes enter some of the items at the local county fair where Agnes earned several blue ribbons. The long winter will now go much faster for Agnes as she is busy getting ready for next summer's fair.

Senior Companion Irma Castle with a client

Helene, a Senior Companion in **[redacted]ington**, noticed that her 91-year-old client, Jenny, was constantly tired. Helene was concerned and asked Jenny what medications she was taking. Her client listed a number of prescription medications and then one that she called Tylenol Special Formula. Helene did not remember this kind so she asked to see the bottle. Her client had been taking Tylenol PM every six hours, which explained why she was so tired and had no energy. The client is no longer tired. This is a terrific example of a Senior Companion who noticed that something was not quite right and looked into the problem.

The Senior Companion Program in **Winona** received a referral about Martha, a 90-year-old woman who was not only wheelchair [redacted] but had not been out of her home for more than a year. Although her 95-year-old husband remained active and involved, he was not able to help with Martha's mobility. Assigned to a SC, Martha found a new friend and a resource person who helped develop a growing sense of independence. Thanks to her SC and these resources, Martha has a new wheelchair, a wheelchair ramp, additional home health assistance, and chore services. She no longer needs a SC but says, "because of her visits, I decided that it was time to get out into the world."

From Gina Sommerhauser, site coordinator at Children's Home Society and Family Services in **St. Paul**: "*We would not be able to provide the level of care to our clients that we have become known for without our Senior Companion volunteers. They are the eyes and ears of our social workers for many of our clients with higher level needs. They take on the more-difficult clients, make special weekend trips to visit, and advocate for our clients at every turn. A number of our clients would be in residential facilities were it not for SCs.*"

"Volunteering satisfies that urge to continue to be useful," says Pat Ryan, who has been a Senior Companion in **Dakota County** for seven years. Pat believes that her generation, born during the depression, has a strong work ethic. She decided to help give family caregivers a break by becoming a respite volunteer, which is a good fit because Pat had been a home health aide. Pat emphasizes that volunteering combines usefulness with freedom. "You can choose what work you would like to do and remain useful to humanity," she explains.

> "You cannot define success in America without including service to others."
>
> — George H.W. Bush

Kathleen is a 68-year-old widow who has Multiple Sclerosis. She lives alone in **Duluth**, receives no public assistance, and has become increasingly frustrated not only with her lack of mobility but also the extreme effort it takes to do the simplest tasks and her dependence on others. She had become somewhat reclusive and initially only wanted monthly grocery shopping trips with her assigned Senior Companion. But the relationship has evolved into weekly visits with opportunities to get out, see the town, and slowly learn once again to enjoy a bit more freedom.

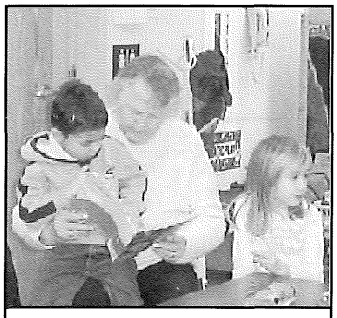
Senior Companion Betty Lou Olson with a client

Betty Lou Olson, an SC in **Thief River Falls**, visits Gertrude Christianson each week. During each visit, Betty Lou helps Gertrude call her daughter, Arlene. During the call, Betty Lou gives Arlene an update of her mom's activities during the previous week. "Because I live 1,800 miles from Mom, knowing that Betty Lou checks on and visits with my mother weekly is a great comfort to me. I visit Mom several times a year, but I can't attend to her weekly needs from this distance. I feel very fortunate to be connected to this program and Betty Lou." Gertrude turned 100 this past October.

Foster Grandparent Program

The Foster Grandparent Program offers seniors 60 and older opportunities to establish relationships with children and youth who have special needs by serving as mentors, tutors, and role models. They volunteer in schools, shelters, Head Starts, and day care centers. During this past year, more than 870 Minnesota Foster Grandparents provided a total of 575,000 hours of service helping others.

From Becky Hanson, an ECFE coordinator in **Ada/Borup**: "*Grandma Marge. Wow! What an asset to our room. She reads to the children, helps with table activities, lots of one-on-one time, and is such a positive influence with the children. I can't say enough great things about her. I am lucky to have her as a part of our staff.*"

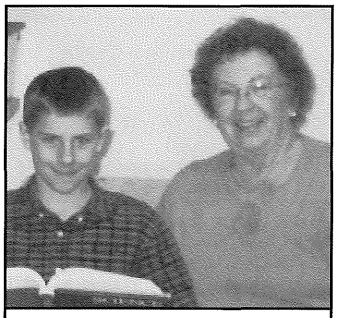


Grandma Marge with two ECFE students

FG Nancy McParlan volunteers in a Head Start room at Grant Elementary School in **Duluth** and says, "I love it!" Volunteering four days each week, Nancy is "Grandma" to 31 children and is a special help for children with special needs. Grandma Nancy is concerned that the children's basic needs are met and is the "watchdog" for children who may need breakfast or may not have the proper cold weather or adequate school clothes.

Susan, a single mother, needed to temporarily split up her four children while she received chemotherapy. As a result, her son, Dylan, was having difficulty concentrating and his grades were suffering. Grandma Winnie in **Breckenridge** became his "in school support." With Grandma Winnie's guidance, Dylan's teachers soon noticed a marked improvement in his behavior and grades. Susan also reported a happier child at home.

At the Harriet Tubman Center in **Minneapolis**, two FGs support the infants, toddlers, and preschoolers of moms escaping abuse and putting their lives back together. The FGs interact with the children *and* moms by offering encouragement, reminding them that they have made a step toward a better life, and sharing stories from their own lives that show that obstacles can be overcome.



Grandma Winnie with Dylan

In **Worthington**, the Foster Grandparents at the Alternative Learning Center work primarily with students who are learning English. The school's primary population does not speak English as their home language and there are no interpreters available. Foster Grandparents volunteer one-on-one with students from Sudan, Ethiopia, and Somalia to assist them with their English homework as well as a special program in science and humanities subjects.

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Senior Nutrition

Claire Thoen

- Supports senior health
- Contributes to the vitality of rural communities and
- Saves money - Seniors stay in their homes and out of nursing homes

Senior Nutrition is an essential part of a network of community services that contribute to preserving the vitality of rural Minnesota. Lutheran Social Service (LSS) serves seniors, 57% of whom are 80 years or older and 73 % of whom live alone.

In all the counties LSS serves in the northwest quadrant of the state, senior nutrition sites are struggling but in some counties, where economies are stressed and incomes are particularly low, both the wider community and individual seniors are hard-pressed to come up with the extra contributions to make up for the cuts in state funding.

In Crow wing, Todd, Morrison and Wadena Counties, in particular, the budget cuts from 2003 are threatening to close senior nutrition sites.

State funding for Senior Nutrition was established 30 years ago with no built-in funding increases for inflation with the net result that year-in and year-out Senior Nutrition providers have done more with less. At some point one must ask – when does meager state funding create a meal too meager?

The increased cost of fuel (diesel and gas) has driven Meals on Wheels (MoW) delivery charges up to around $8.00 each.

What other '03-'04 Session choices affected Seniors?

State funding for Senior Companions was cut by 15% resulting 37,500 fewer hours of companion activity to frail elderly Seniors. (Minnesota Board on Aging- MBA Survey)

Statewide, there are 210 vulnerable Seniors missing out on visits, the individual attention and help of a member of their peer group as well as the loss of monitoring their status. (MBA Survey) Many of these Senior Companions helped with meal delivery as well as helped in getting seniors to congregate dining sites.

Claire Thoen-Levin, Director, Office of Public Policy and Advocacy www.lssmn.org/advocate

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Who is our government serving when it chooses to cut **Foster Grandparents ?**

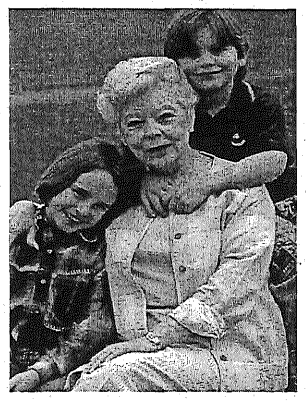
695 fewer people will be served by Senior Volunteer Foster Grandparent & Senior Companion programs in the first 6 months of (fiscal year) 2004 than in the first 6 months of (FY) 2003. - Minnesota Board on Aging (MBA) survey

Foster Grandparents, as part of Senior Volunteers, were cut 15% in the 2003 Session.

What Do Foster Grandparents Do?

Foster Grandparents serve in schools helping children who are struggling with school work or with behavioral issues. They make special, and personal, connections with youngsters and allow teachers to teach.

Foster Grandparents (who have average incomes of $11,000 a year) are given a stipend of $2.65 per hour for their service. The Foster Grandparents serve, on the average, 5 children each and contribute 15 hours a week.



What happened in the 2003-04 Legislative Sessions?

Foster Grandparent funding was cut by 15% resulting in children at-risk missing out on benefits of Foster Grandparents, who provide additional individual attention, reduce disruptions and increase the opportunities for success in the classroom.

Who has been affected?

485 children and youth who would have been served (MBA survey) and approximately **100 Foster Grandparents** who won't experience cross-generational successes.

Who was served by these other choices in '03-'04 ?

- **Grants for after-school activities for high-risk kids were cut 100%**
- **Crisis Nurseries were cut between 30-50%**
- Grants for **children at risk, including youth intervention programs, were reduced by 27%**
- **Early Childhood** and **School Readiness were cut** by $9.3 million
- **Head Start was cut** by $3.1 million
- There are **200 fewer AmeriCorps volunteers to help children** with school & housing needs
- State funding for **essential nutrition to infants and pregnant women (WIC) was eliminated**
- **1,200 working families lost child care support** and, in addition,
- Funding for **families fleeing domestic abuse has decreased by 46%** since 2001.

Thoen -

LSS facilitates the work of 60% of the Foster Grandparents in Minnesota. Foster Grandparents serve with LSS, and other nonprofits, across all of Minnesota.

Below is a sample of inter-generational success stories statewide.

Metro area:

"In the greater St. Paul *service area, 26 Foster Grandparents (FG) work on reading and tutoring at 14 schools, with 360 students with the lowest grades. The sites report that, on average,* ***90% of those receiving tutoring showed a marked improvement on their test scores.****"*

Northern Minnesota:

"In Koochiching *and* Itasca *counties, 16 FG volunteers provide tutoring/mentoring services to 85 children in grades K-5. The sites report that* ***98% of the children, with FG-help in reading, math and spelling, were working at grade level and would advance to the next grade level.****"*

In Bemidji*'s Gilfillan residential treatment center for youth ages 6-18 with emotional and behavior disturbances Foster Grandparents play an important role, providing "the unconditional love that a lot of our kids have not experienced." They give these kids hugs, hold their hands and tell them it's going to be OK. "Foster grandparents...mentor and tutor youth, as well as serve as a caring influence in their lives."*
Bemidji Pioneer 5-20-04

Southern Minnesota:

La Crescent / Hokah District*: "As a direct result of four eager Foster Grandparents, there was a* ***70% reduction in behavioral disruptions and 80% of the children served showed reading and math skills improvements****. Children also expressed greater happiness with school and feeling more a part of the classroom. All of the students benefit since the teachers are able to spend more time teaching to all of the students and less time with behavior issues."*

Central Minnesota:

Annandale: Bendix Elementary School provides just a few examples of many positive experiences:

"My fourth graders fight to get a chance to read with "Grandma" when she comes to our class two mornings a week. ***She is so enthusiastic about reading that even my most reluctant readers will beg to read with her. She is so positive with the kids. Their self-esteem is bolstered****. She makes a big statement about being a life-long reader when she ... takes home the books ... so she can finish them and ... talk about them with my class.* ***I'd like a Foster Grandparent all day every day if that were possible."***

*"****I found the Foster Grandmother that I worked with was absolutely one of the best uses of government funding****. [C]hildren lacking parental guidance at home... don't have anyone to show their work to...or that kind ear to listen to their first attempts at reading. The Foster Grandmother in my room filled a huge void for these children. She would go over their homework with them, listen to them read, read to them, and give them the 'oooos' and 'ahhhhhs' they needed to hear about their work. I could go right on teaching with the rest of the class while Grandma Alida provided those one-to-ones.* ***This program has made it clear to me that our oldest generation can have a gigantic impact on our youngest generation!****"*

"They are there for our high risk kids. ***They provide comfort, security, hugs, help with academics, encouragement, understanding, empathy, and consistency in daily routine****. They are there for kids who have no grandma, broken families, and all other losses."*

Who is our government serving, when, as the **St. Cloud Times** reported, "Early estimates show **programs that serve Minnesota's poor, elderly and those with disabilities absorbed roughly half of the cuts** needed to balance the budget without raising taxes. **Yet these programs account for about a fifth of state spending.**" 6-2-03

Research by Britta Reitan, LSS Public Policy Research Intern, 2003-2004
Research edited by Claire Thoen-Levin, LSS Office of Public Policy and Advocacy, May 2004
For more information, please visit our website: www.lssmn.org/advocate

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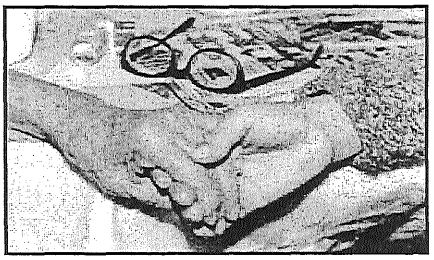
Consequences to Senior Companions from Choices Made in the 2003-04 Legislative Sessions



695 fewer people will be served by Senior Volunteer Foster Grandparent & Senior Companions in the first 6 months of 2004 than in the first 6 months of 2003.

- Minnesota Board on Aging (MBA) survey

What Do Senior Companions Do?

Senior Companions are active Seniors who help frail and elderly Seniors stay in their own homes and communities. Senior Companions (with average incomes of $11,000 a year) are given a stipend of $2.64 per hour for their services and, on average, contribute 750 hours of service a year.

Their visits and services include helping with appointments, with errands and minor household chores. Senior Companions monitor the status of vulnerable seniors enabling them to identify when seniors can no longer stay at home and alternate plans are necessary.

In addition to the benefits that individuals receive, local communities benefit when seniors are able to remain part of their hometowns, members of their home churches and patrons of local their banks and businesses.

What happened in the 2003-04 Legislative Sessions?

State funding for Senior Companions was cut by 15% resulting 37,500 fewer hours of companion activity to frail elderly Seniors. (MBA Survey)

Who has been affected?

Statewide, there are 210 vulnerable Seniors missing out on visits, the individual attention and help of a member of their peer group as well as the loss of monitoring their status. (MBA Survey)

How did Seniors fare in other ways at the Capitol?

In addition to reductions in these state supports, state funding Senior Nutrition was also cut by 15%. Senior Nutrition services not only provide healthy meals to Seniors, they are also an important part of encouraging activity, socializing and engagement with others at a time of life when isolation can lead to poor physical and mental health. The Governor's 2004 Supplemental budget proposed further cuts to home delivered meals for seniors.

Thoen

Senior Companions serve all over the state of Minnesota Below is a sampling of success stories:

Metro:

St. Paul Area

"At Family Service, seven Senior Companions served 75 clients. ***75% reported an increase in their quality of life as a result of weekly visits from the volunteers.***

Another eight SCs serve as respite volunteers, giving caregivers an opportunity to take some much needed time away. ***Ninety percent of these caregivers returned more relaxed and able to continue to provide the primary care for the family member with renewed spirit."***

Hennepin, Anoka and Sherburne

"In Hennepin, Anoka and Sherburne counties, 77 Senior Companion volunteers serve 390 homebound elderly – many of them low income with no family living close by. ***100% of these seniors were able to remain living in their homes in 2003."***

Northern Minnesota:

"Senior Companion Charles visits a client who continues to live in his home despite a stroke that paralyzed his left side and left to speak very few words. At the request of his daughter who lives out of town, a Senior Companion was assigned. Much to the amazement and appreciation of the daughter, her father is able to go shopping with the help of the Companion, pushing a cart around at his own pace. ***Both the daughter and volunteer coordinator believe that the Senior Companion is keeping this client going and independent."***

Becker County

Becker County Senior Coordinator, Judy Peterson, sees that programs, such as Senior Companions, are especially important in outstate/rural Minnesota. Many of the seniors she works with are facing increased isolation due to the high number of young people leaving rural communities for regional centers and the metro area. As a result, the rural population is aging without an adequate support system.

She also noted that the current economic situation means younger seniors who could have provided support to the older seniors now either have to continue working longer than planned or must go back to work due to financial needs. In her view, this is a particularly bad time to be cutting programs that offer assistance to vulnerable senior populations.

Judy explained that, ***"The state feels it is more cost effective to keep people in their homes, but then you need a support system."*** She observed that the seniors she serves are *"really in tough times ... and I see tougher times ahead."*

Who is our government serving when, as the St. Cloud Times reported, "Early estimates show **programs that serve Minnesota's poor, elderly and those with disabilities absorbed roughly half of the cuts** needed to balance the budget without raising taxes. **Yet these programs account for about a fifth of state spending**." 6-2-03

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