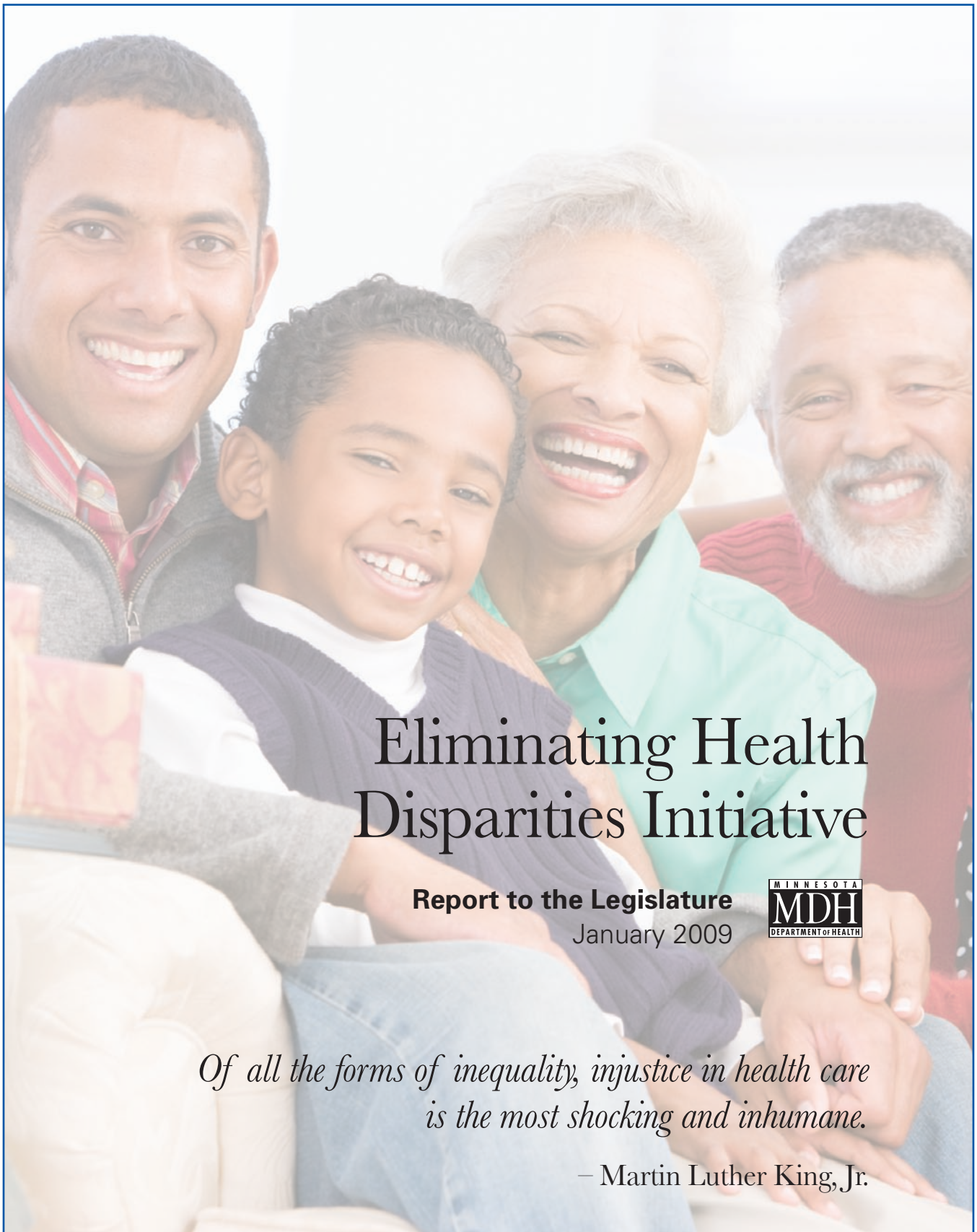


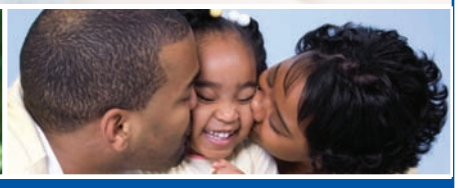
Eliminating Health Disparities Initiative

Report to the Legislature
January 2009

MINNESOTA MDH DEPARTMENT OF HEALTH

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

– Martin Luther King, Jr.



Eliminating Health Disparities Initiative

Report to the Legislature

January 2009

Office of Minority and Multicultural Health
P.O. Box 64975
St. Paul, MN 55164-0975
Phone: (651) 201-5813
Fax: (651) 201-4986
TDD: (651) 201-5797

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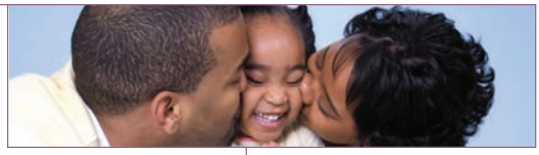

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Due to their length, the appendices referenced in this report appear in a separate volume titled "Eliminating Health Disparities Initiative 2009 Legislative Report: Appendices." This companion report is available at www.health.state.mn.us/ommh/publications/index.html.

EXECUTIVE SUMMARY

Minnesota is one of the healthiest states in the nation. On a variety of indicators, from insurance status to life expectancy to the overall quality of care available from healthcare providers, Minnesota ranks near the top among all states. But Minnesota also has some of the greatest disparities in health status and incidence of chronic disease between Populations of Color / American Indians and Whites.

In 2001, the Minnesota Legislature passed landmark legislation to address these persistent disparities, the Eliminating Health Disparities Initiative (EHDI). In the most recent biennium, the EHDI program awarded a total of $10.4 million in competitive grants to local programs and projects statewide, challenging them to develop effective strategies and solutions for eliminating disparities in seven health priority areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STI's, immunization, infant mortality and violence and unintentional injuries. In addition, $500,000 went to support tuberculosis programs for foreign-born persons through local public health agencies. Federal TANF funds were also directed to address disparities in the area of healthy youth development through the EHDI. Healthy youth development is included as one of the eight health priority areas discussed in this report.

For two priority areas, infant mortality and immunization, the EHDI statute provides a target of a 50 percent reduction in the magnitude of the disparity by 2010. A goal to reduce disparities in five other health priority areas is also included in the statute. Since the inception of the program, measurable and substantial progress has been achieved in many of these areas. Specifically:

- Infant mortality rates have declined for all population groups with decreases in disparities in infant mortality rates ranging from 26.3 percent to 75.0 percent for Populations of Color and American Indians.
- Disparities in gonorrheal incidence have decreased for American Indians (25.7 percent), African Americans/Africans (26.7 percent), and Hispanics (32.5 percent); although gonorrheal incidence remains an issue, disparities for Asians have been eliminated.
- Heart disease mortality has decreased for African Americans/Africans by 94.3 percent and while heart disease remains an issue for Asians and Hispanics, no disparities exist.
- New HIV infections have decreased for American Indians by 51.8 percent.
- Disparities in homicide mortality have decreased for racial/ethnic groups ranging from 6.8 percent for American Indians to 48.3 percent for African Americans/Africans.
- Disparities in cervical cancer incidence have decreased for Asians (32.9 percent) and African Americans/Africans (54.2 percent).

However, we have not yet met all of the goals that were set out under the law. Specifically, while infant mortality disparities were substantially reduced for all Populations of Color and

American Indians, the goal of a 50 percent reduction was only met for Asians and Hispanics. In the area of immunization, the discontinuation of the Minnesota Kindergarten Retrospective Survey means that data are not available to assess progress in eliminating disparities, and Minnesota-specific data on adult immunization is also limited. In the other priority areas, of the 45 indicators that were measurable, 23 indicators have shown improvement, five of the indicators show that disparities have been eliminated, one indicator shows no change, six have gotten worse and 10 had no disparity in either the baseline or current period.

The mission of the EHDI program is to achieve sustainable statewide reductions in disparity levels in each priority area by allowing communities to build on their strengths and values and develop effective solutions to pressing health problems. Beyond the direct service provided by grantees, the EHDI grant program is a tool to support capacity-building in organizations and communities by fostering partnerships, supporting organizational development and leveraging resources. At the individual and community level, the EHDI program and its grantees have realized a number of successes that lay the groundwork for additional improvements in statewide rates:

- Directly serving over 37,000 members of racial/ethnic communities in 2007, with an additional 140,000 reached through community events such as health fairs.
- Increasing rates of early and prenatal care, increasing the number of community members who receive preventive health screenings such as cancer screenings, blood pressure, cholesterol and blood glucose checks, decreasing high-risk sexual behaviors and teen pregnancy, and reducing recidivism rates among perpetrators of domestic violence.
- Changing educational programming in local school districts, including the development of new curricula based on community needs and knowledge of effective strategies.
- 28 grantees have used EHDI grants to leverage three million dollars in additional funding from foundations, corporations, and government entities. Forty grantees have leveraged in-kind or non-monetary resources such as supplies, staff, and office space.

The EHDI program has been successful in accomplishing what many health organizations and providers have long had difficulty doing; effectively reaching out to and serving People of Color and American Indians and making positive health status changes in underserved communities. It has also helped to nurture promising approaches that can be used as models for other organizations or communities, and has improved our understanding of the dynamics of this complex issue. However, the initiative's focus on individual and small-community level change has, by necessity, limited its ability to impact broader systems changes, and the work of individual grantees is unable to reach all populations at risk. Additionally, a lack of reliable statewide data on Populations of Color and American Indians has made it difficult to comprehensively measure progress towards certain goals.

Despite the substantial improvements in health status and disparities that have been achieved since EHDI began, stark differences remain between health status, life expectancy, and quality of life for Populations of Color and American Indians compared with Whites. As Minnesota's population continues to become more diverse, our sense of urgency around this issue must also increase.

In order to meet the goal of eliminating health disparities statewide in each of the health priority areas, MDH will need to take several important steps to ensure that the EHDI program is as effective as possible in addressing this complex issue, and that we improve our ability to measure our progress. We are proud of the work accomplished to date and will move the Initiative from Version 1.0 to Version 2.0 by:

- *Maximizing the investment in EHDI by integrating strategies for eliminating health disparities into MDH programs, as well as coordinating and collaborating with other health promotion efforts and a range of state agencies, local public health, and other institutions.*
- *Developing policies and programs to address the environmental factors that contribute to poor health and health disparities.*
- *Improving data collection efforts toward common goals so that high-quality, reliable statewide data is available for the evaluation of EHDI outcomes and to hold the initiative accountable.*
- *Expanding and replicating innovative programs that systematically and sustainably reach as many people as possible and that work for Populations of Color and American Indians.*
- *Expanding the focus of the EHDI to explore and address policies and systems that impact health disparities to create sustainable change.*
- *Exploring how to increase social capital as part of the work in eliminating health disparities as the demographics of Minnesota diversify, so we embrace our rich cultural and ethnic heritage now and into the future.*

The next phase of the EHDI will focus on building on the gains that have been made in eliminating disparities while expanding our work at the system and policy level. In this way, we can move more rapidly towards the goal of eliminating health disparities for all Minnesotans.

INTRODUCTION

Life expectancy and overall health have shown substantial improvements in recent years as a result of a number of factors including a focus on prevention and advancements in medical technology. However, not all populations have benefitted from these changes.

For example, Minnesota is one of the healthiest states in the nation, yet it has some of the greatest disparities in health[1] between racial/ethnic groups. This means that racial/ethnic populations in Minnesota experience greater rates of disease, illness, premature death and poorer quality of life as compared to Whites. These inequities in health for some populations in Minnesota pose a threat to the health of all Minnesotans. In addition to the moral and ethical obligation to ensure that all populations in Minnesota have good health, disparities are costly. For example, poorly managed chronic illness or inadequate treatment of chronic illness can result in significantly more expensive interventions.

In 2001, Minnesota passed landmark legislation to address these persistent health disparities. The Eliminating Health Disparities Initiative legislation (MN Statute 145.928) specified that the commissioner of health establish a program to focus on two broad goals aimed at reducing disparities:

- By 2010, decrease by 50 percent the disparities in infant mortality rates and adult and child immunizations rates for American Indians and Populations of Color (Asians, African Americans/Africans, and Hispanics) 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 Whites in the following priority health areas:
    - Breast and cervical cancer
    - Cardiovascular disease
    - Diabetes
    - HIV/AIDS and sexually transmitted infections
    - Violence and unintentional injuries

In addition, federal TANF funds were directed to healthy youth development through this initiative.

This legislation provided critical support and funding to begin work on the complex, long-standing issue of health disparities in Minnesota by providing a tribal and community grant program to address the two broad goals outlined in statute. To address the legislative goals, MDH partnered with Populations of Color and American Indian communities, awarding grants to 52 community organizations to develop and implement evidence-based and promising strategies to eliminate disparities in these health priority areas.

[1] Under the direction of then-director Dr. Harold Varmus, an NIH-wide working group developed the first NIH definition of "health disparities:" as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations (NIH, 1999).

MDH has been tracking the progress towards achieving these goals using statewide outcomes data, and by measuring the results achieved by individual grantees. While substantial progress toward a reduction in statewide disparities has occurred in the health priority areas for Populations of Color and American Indians, Minnesota has yet to meet all of the EHDI goals as established in legislation.

The EHDI has changed the landscape of public health efforts in Minnesota and increased understanding of the contributing factors for health disparities

EHDI Disparity Reduction Progress – Selected Areas

- **Infant mortality**

  A reduction in the disparity for Asians (75.0%) and Hispanics (66.7%) exceeds the 50 percent reduction in disparity goal of the EHDI. For African Americans/Africans (36.4%) and American Indians (26.3%), the disparity is also significantly reduced but has not yet met the EHDI goal.

- **Diabetes mortality**

  The goal to reduce disparities in diabetes mortality has been met for African Americans/Africans (17.1%), American Indians (18.7%) and Hispanics (25.3%). For Asians, there are no disparities in either the baseline or current time period.

- **New HIV infections**

  The goal to reduce disparities in new HIV infection rate has been met for American Indians (51.8%), while the disparities for African Americans/Africans and Latinos has widened by 7.4 percent and 30.3 percent respectively. No disparity exists for Asians.

- **Cardiovascular mortality**

  The goal to reduce disparities in cardiovascular mortality rate has been met for African Americans/Africans (94.2%) and Hispanics (42.6%). However, the disparity for American Indians increased by 37.5 percent. No disparity exists for Asians.

The EHDI has also changed the landscape of public health efforts in Minnesota and increased understanding of the contributing factors for health disparities among MDH and local public health agency staff, policy makers and other stakeholders. Health promotion and prevention efforts in Minnesota are now more apt to recognize the multiple and complex factors that contribute to disparities in health status among Populations of Color and American Indians, are aware of the differing causes and approaches for addressing health disparities in diverse communities, and are recognizing the need for community established priorities and initiatives. For example, Minnesota's State Health Improvement Plan is using many of the lessons learned through the EHDI to plan and implement this important initiative and the Diabetes Plan includes efforts to address racial/ethnic disparities in diabetes prevalence and mortality.

As we move into the next decade and beyond, ongoing efforts to eliminate health disparities will become even more important as Populations of Color and American Indians continue to

comprise a greater share of Minnesota's population. Table 1 illustrates the significant changes in the composition of the population as evidenced by substantial increases in the 19 and under age group for African American/African, Asian, and Hispanic populations from 2000 to 2010; 2020 projections for these groups indicate even greater growth.

Table 1:
Minnesota Population, Ages 19 and under, Actual and Projection

Race and Ethnicity	2000	2010 Projected	Percent Change 2000 - 2010	2020 Projected
African American/African	69,036	95,000	37.6	104,200
American Indian	22,073	23,600	6.9	25,200
Asian	58,168	73,800	26.9	85,000
Hispanic*	60,621	93,500	54.2	110,200
White	1,205,993	1,198,900	-0.6	1,217,100

*Hispanic is an ethnicity which is a separate category from race, and includes persons from any race group.
Source: Minnesota Department of Administration, State Demographic Center, January 2005
http://www.demography.state.mn.us/resource.html?Id=10959

In the current phase of the Initiative, we have learned:

- The importance of community involvement in embracing the Initiative and understanding the direction;
- The importance of connecting programming efforts and successful modeling of programs with the goals established in the EHDI statute;
- The importance of capacity-building, partnerships and leadership in creating the environment for sustainable change.

But we have also identified several areas for improvement, particularly in how we monitor progress towards statewide goals and ensure that grantees' work is consistent with those goals, the degree to which we have integrated EHDI efforts into all of MDH's work, and the need to focus on policy and social determinant interventions that impact the multiple factors that contribute to health disparities.

In order to achieve health equity in Minnesota, much more needs to be done. The following sections of this report will describe the current efforts of the Eliminating Health Disparities Initiative, including a description of grantee programs, goals, and outcomes (statewide and grantee level) and a description of grantee capacities built. The report concludes with a set of recommendations for strengthening the EHDI to ensure that the gains we have made to date are sustained and expanded and that we are able to more accurately measure progress towards statewide goals.

EHDI grantee programs serve as a testbed of models for effective strategies that can be adopted or adapted by other programs

The Eliminating Health Disparities Initiative (EHDI) serves as a cornerstone effort of the state of Minnesota, the Minnesota Department of Health, and local communities to eliminate racial and ethnic disparities in the health of Populations of Color and American Indians.

The core of the EHDI is a statewide grant program which provides funding to community-based organizations and Minnesota tribal communities to implement proven strategies and innovative practices that will contribute to statewide improvements in health status for Populations of Color and American Indians. The EHDI grantee programs serve as a testbed of models for effective strategies that can be adopted or adapted by other organizations or state programs addressing disparities. Another aspect of the EHDI is capacity building by strengthening organizations, building partnerships and leveraging resources.

Through the efforts of the EHDI, 52 community partners are supported in their work to establish community-based and culturally-appropriate programs to eliminate health disparities in the health priority areas[2] among African Americans/Africans, American Indians, Hispanics, and Asians. The underlying philosophy of the EHDI is that health improvement and elimination of health disparities emanate from the social, cultural, and human assets that are already present in these communities. The principles of the EHDI are based on respect for the healthy values, beliefs, and traditions of Minnesota's diverse populations, and engaging communities to reclaim their health.

EHDI Framework

The approach of the EHDI is reflective of the complexity of the factors that create and sustain health disparities among Populations of Color and American Indians as compared to Whites. In recent years, we have improved our understanding of the connections between the environment, community, and health status. For instance, we have learned that health disparities are often the result of a number of contributing factors with varying levels of influence. These individual, social determinants/environmental factors and systems factors interact with varying effects to contribute to the health of individuals.

Individual factors are the characteristics or behaviors of individuals and populations including age, weight, smoking, genetic characteristics, and history of chronic illness.

Social Determinants and environmental factors are related to the physical environment (e.g. living and working conditions); the social environment (e.g. cultural and social cohesion); and the economic environment (e.g. income, insurance and affordable health care).

Systems factors relate to the health care delivery system, the social services system, and the state and local public health system.

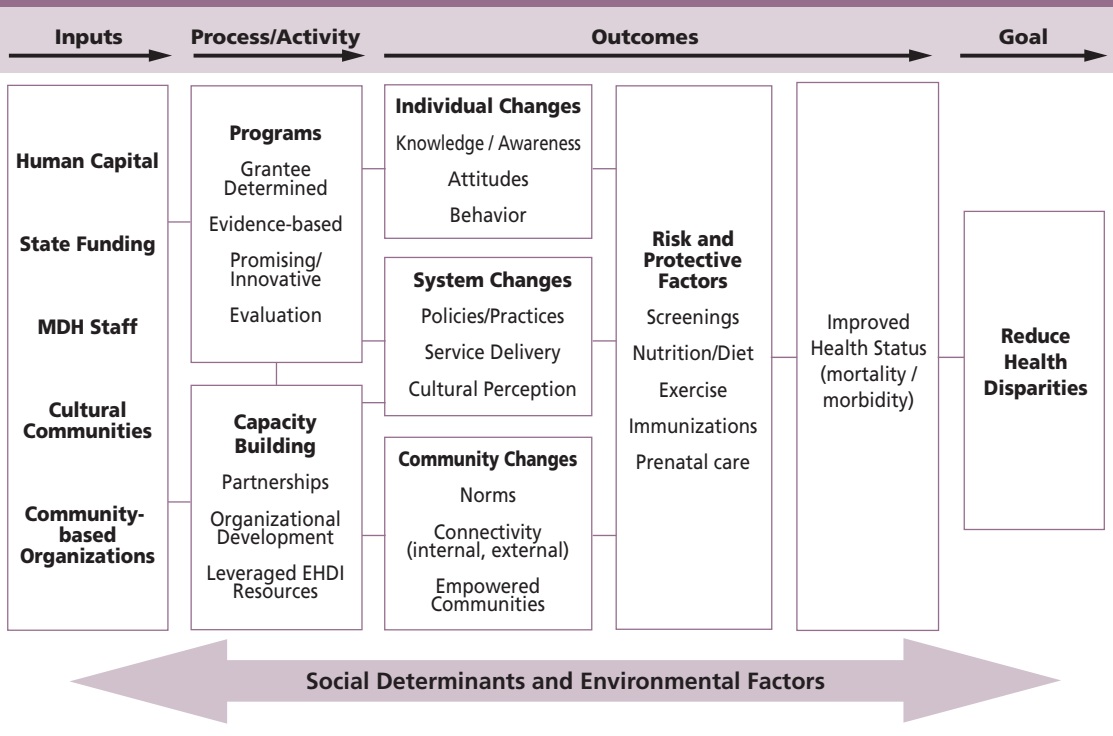
[2] breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, immunization, infant mortality, and violence and unintentional injury. In addition, federal TANF funds were directed to healthy youth development through this initiative.

Because of the far-reaching and complex nature of these factors, they also present challenges in identifying and implementing successful approaches to reducing health disparities. The EHDI has been a mechanism to learn about and address the multiple factors that contribute to health disparities and successful approaches to address these disparities among Populations of Color and American Indian communities.

Figure 1 displays the EHDI framework, within which the Initiative operates. The framework provides the rationale as to how the initiative contributes to the overall goal – *the reduction of health disparities in health priority areas among racial/ethnic groups in Minnesota.* The EHDI stakeholders (Populations of Color, American Indians, advisory groups, MDH staff, local public health staff, and community organizations) developed the framework based on their perceptions about what works to address the factors that contribute to health disparities among Populations of Color and American Indian communities. Data was used to define the problem, to develop a plan of action, and to monitor the progress of the EHDI. The basic elements of the framework are the inputs, process/activities, outcomes, external influences and overall goal.

This model illustrates the complexity of eliminating health disparities by showing outcomes relating to the multiple factors that contribute to disparities (individual, systems, and community) and the complex interrelationships between the outcomes and the goal of reducing health disparities. Complex interactions differ by community, by health priority area, and by the extent of the disparity. For example, to reduce infant morality in the American Indian community, there may be a need to educate women about the importance of early prenatal care, hold evening clinic hours, provide transportation, increase the societal norm around smoke-free environments and train medical staff to address the cultural needs of this community. All of this might then lead to

FIGURE 1:
EHDI Framework



reduced risk behaviors (e.g. smoking during pregnancy) and increased protective behaviors (e.g. early and consistent prenatal care) – leading to a reduction in infant mortality and reduced health disparities. However, how the American Indian community is engaged in this initiative might look different than how the African American/African community is engaged in reducing infant mortality. In order to reach the overall goal of the Initiative, there is a complex combination of changes at many levels (e.g. individual, system and policy) that must occur – all of which contribute to the goal of reducing health disparities.

Framework Components

The Inputs column shows the resources that are drawn upon in implementing EHDI. Inputs include human capital, state funding, MDH staff, cultural communities (i.e. African Americans/Africans, American Indians, Asians and Hispanics), and community-based organizations. Human capital includes the workforce (e.g. public health, health care organizations, community organizations); state funding are the funds received through EHDI legislation; MDH staff is the technical assistance and support provided to grantees; cultural communities and community-based organizations are the many organizations adept in working in culturally appropriate ways to address the unique needs of targeted communities. Together, these inputs support the work of EHDI grantees to identify priority health areas and plan and implement programs and activities to address disparities in their communities.

The Process/Activity column highlights the existing activities of the EHDI. Two broad areas of activity – programs and capacity building – represent the primary work of the EHDI. Programs include a variety of community and culturally-based interventions designed and implemented by grantees (e.g. doula programs, nutrition classes using traditional foods to prevent diabetes, health screenings in churches). These grantee-designed programs are either evidence-based or promising strategies. Evidence-based programs include those that are based on published studies, demonstration projects, or best practices with theoretical backing. Many of the efforts are considered promising/innovative strategies because there is limited information on how these strategies work in racial/ethnic communities and because the grantees have the expertise to develop innovative strategies that are likely to be effective in their communities.

Each of the grantees have been encouraged to develop programs that focus on known risk and protective factors of the disparity area, involve the targeted group in development and implementation of the project, and are linked to other community efforts that enhance or expand project strategies. Grantees are required to evaluate their own programs, and use these evaluations to improve and modify their interventions.

The EHDI has also focused on capacity building in the areas of partnerships, organizational development, and leveraging of resources. Focusing on these areas results in a strong network of efforts aimed at improving health and eliminating disparities in racial/ethnic communities. The EHDI encourages grantees to strengthen current partnerships and establish new ones. Grantees use their partners for referrals, sharing resources and in-kind support, provision of services, coordination of programming, joint programming, replication of services, and co-sponsorship of activities and events.

The EHDI has also focused on building capacity in organizations. EHDI conducts trainings and provides individual consultations on many topics including asset building, grant writing, evaluation and programming. By strengthening skills of staff and organizations, grantees are able to expand services, improve credibility, stabilize funding and increase awareness of health disparities. Grantees leverage their funds (including non-monetary resources) in order to create long-term funding, an essential element required to sustain the effort needed to address disparities.

The Outcomes columns describe the results of the EHDI activities. Outcomes resulting from EHDI activities impact individuals, systems and communities, though the primary focus of grantees has been on individual-level outcomes related to knowledge, awareness, attitudes and behaviors. Examples of individual changes include increased understanding of the importance of immunizations, diet and exercise (knowledge) and increased immunizations and improved diets (behaviors). These changes are important precursors to improved health status; however, a focus on individual-level changes alone will not be as likely to lead to improved statewide outcomes as a more comprehensive approach that includes changes in the broader systems and communities in which individuals exist.

Together, individual, systems and community changes lead to improvements in health status

System and community changes refer to outcomes that alter the environment within which individuals and groups function. System changes occur within the grantee organization and in the broader health system (e.g. public health, health care delivery system, and social services). System changes include modifications of policies, programs and cultural practices while examples of community changes include increased leadership, strengthening connectivity and modification of community norms. Again, much of the focus of EHDI grantees to date has focused on changing "micro systems," rather than changing systems at the statewide and national level. These smaller-level modifications are an important first step toward statewide change, one that will need to be expanded as EHDI moves forward.

Together, individual, systems and community changes lead to improvements in health status. For example, improved awareness of the importance of prenatal care during pregnancy (knowledge/awareness) can lead to women seeking earlier and consistent prenatal care (behavior) which may lead to decreased infant mortality (improved health status). Implementing systems and community changes to increase smoke-free environments (e.g., sudden infant death syndrome is associated with second hand smoke) and to increase educational status of pregnant women will contribute to a decrease in infant mortality.

The final column of the EHDI framework represents the goal to reduce health disparities statewide. The framework illustrates how the Initiative inputs lead to process/activities and outcomes which in turn contribute to meeting the Initiative goal.

EHDI Grantee Programs

As described in the framework, the grantee programs are grantee-designed. It is the philosophy of EHDI that communities have a critical role in identifying approaches and implementing programs to address disparities. Thus the programs that the grantees have implemented are evidence-based programs adapted to work in their communities or innovative, promising strate-

gies created by the grantees and their communities. These programs are replicable, and merit consideration for expansion to other communities throughout the state.

Grantees often target services to more than one racial/cultural population: 49 percent of the grantees serve African Americans/Africans, 46 percent serve American Indian tribes or communities, 33 percent serve Hispanics, and 31 percent serve Asians. EHDI grantees provide services in 44 counties in Minnesota. Sixty-nine percent of the grantees serve the Twin Cities metropolitan area (36 grantees), and 31 percent provide services in outstate Minnesota (16 grantees).

Though the populations served and health priority areas targeted vary greatly, grantees share some common characteristics including the following:

- Prevention is the primary emphasis - nearly two-thirds of grantees (65 percent) stated that their programs place a greater emphasis on prevention.
- Communities are involved in planning and implementing programming - 68 percent of the grantees report involving the community in program development and 50 percent report continued community involvement.
- Grantees provide a comprehensive approach to addressing health disparities - 70 percent of the grantees report involving family members in program services, 48 percent work with clients on an ongoing basis and 39 percent provide follow up services.
- Cultural values and traditional practices are incorporated into programs - their programs reinforce strong positive cultural identities by incorporating the cultural history and traditional healing of their communities into program curricula and activities.

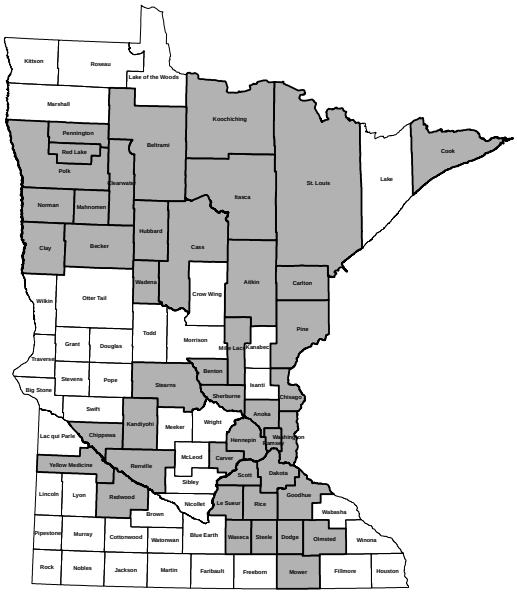
White Earth Tribal Mental Health uses a 27-week program for men who batter, adapted from another model to fit their community. They use sweat lodge ceremonies, traditional healers, speakers, and smudging ceremonies to help men change their behavior, and also change unhealthy community norms. Several measures document the success of this approach including reduced rates of recidivism for violence and decreased truancy rates among participants.

Table 2 provides a general description of the EHDI Grants Programs including numbers served by health area and population.

TABLE 2:
Overview of EHDI Grants Programs, 2007

	Community	Tribal
Number of Grantees:	42	10
Populations Served:	African American/African, Asian, American Indian and Hispanic	American Indian

Counties Served (44):

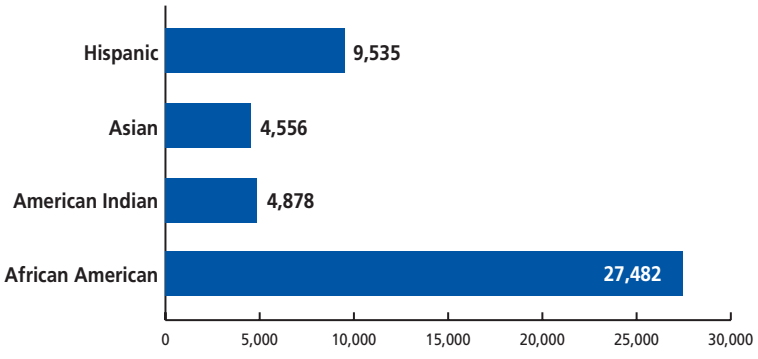


See Appendix E for full size map

Funded Programs by Health Area and Population Reached:

Health Area	Grantees	Population Reached[1]
Breast and cervical cancer	9	4,380
Cardiovascular disease	12	9,465
Diabetes	17	11,950
HIV/AIDS	8	8,314
Immunizations	8	3,147
Infant mortality	10	2,804
Healthy youth development	19	12,092
Violence/unintentional violence	9	3,669

Population Reached[1] by Race/Ethnicity:



[1]through direct or group contact

Grantee Activities by Health Priority Area

By health priority, grantees have implemented a variety of programs aimed at reducing health disparities. The following section summarizes these activities by health area. For a more detailed description of the EHDI grant program by health priority area, go to Appendix A.

Breast and Cervical Cancer — Grantees help women apply for insurance, accompany them to screenings, provide transportation and help women navigate the health system.

Cardiovascular Disease — Grantees offer blood pressure, cholesterol and blood glucose screenings at barber shops, churches, mosques and coffee shops and use parish nurses, community health workers and other partners to conduct screenings. They also offer culturally appropriate exercise and nutrition classes.

Diabetes — Grantees use community health workers or parish nurses to make home visits for screenings, education and counseling. They provide educational classes for self-monitoring of diabetes and teach their youth about traditional diets to prevent diabetes.

Healthy Youth Development — Grantees provide peer networks that connect youth with positive role models; offer tutoring and after-school activities; involve youth community service and provide one-one and group services such as counseling and educational classes.

HIV/AIDS and Sexually Transmitted Infections — These grantees have trained community health workers and peer educators to raise awareness and provide prevention strategies. Grantees also test clients for HIV/AIDS and STIs. Finally, they work with people who have HIV/AIDS, and help them connect with resources such as health care and housing.

Adult and Childhood Immunizations — The services include education on the importance of immunizations and immunization clinics. Grantees help participants obtain insurance through which they are eligible for immunizations.

Infant mortality — Grantees target behaviors including utilization of prenatal care, breast feeding, and substance use among pregnant women. Grantees work to increase access to and utilization of doula services, prenatal care and substance abuse programs. Grantees also provide educational session in topics such as breast feeding and causes of infant mortality.

Violence and Unintentional Injury — Grantees have been promoting awareness and knowledge about domestic violence in the community through group and individual counseling, marches, pledges and media campaigns.

The characteristics of EHDI-funded programs are consistent with current "best practice" principles: their programs are comprehensive and prevention-focused, and involve communities in program planning and implementation. In fact, many EHDI programs surpass best practice criteria by incorporating cultural values and traditional practices into programming. The programs with improved outcomes and greatest impact can serve as best-practice models for eliminating health disparities in Minnesota. A next step is a greater integration of these promising strategies into existing public health programs at the state and local level.

For more information on EHDI best practices, see the 2007 EHDI Reports "Exemplary Program Practices in Action," "Building Capacities among Individuals, Organizations, Communities and Systems" and "Grantee Case Studies" which can be found on the OMMH website: http://www.health.state.mn.us/ommh/grants/ehdi/index.html.

III. OUTCOMES

This section describes outcomes at the statewide and grantee level. The statewide outcomes document the progress made to reach the overarching EHDI goal of reducing health disparities, while the grantee-level outcomes document results including individual change, system change, and community change.

To date, the primary focus of EHDI grantees has been on individual-level changes, including changes in knowledge, awareness, attitudes, behaviors and health status, and on changes to systems within their communities. This focus has been necessary for testing the most effective strategies to reduce health disparities in grantee communities. But change will not be realized on a statewide level through a focus on individual change alone. In order to achieve these broader changes and achieve statewide goals, systems and community changes, the outcomes that alter the environment within which individuals and groups function will need to be a stronger focus of the initiative. The next sections, on EHDI goals I and II, report on the statewide outcomes.

Disparity is defined as the difference between the Population of Color Rate and the White Rate.

Disparity reduction measures the percentage change in disparity between the baseline and current years.

EHDI Goal 1: **Reduce disparities in infant mortality and immunization rates between Populations of Color and American Indians by 50 percent**

Current data indicate that the goal for infant mortality has been met for Asians and Hispanics since the inception of the EHDI. Also, the disparities in infant mortality rates have decreased for African Americans/Africans and American Indians but not yet by the 50 percent established in the statute. For immunizations, it is not possible to assess whether the immunization goal has been met due to a lack of reliable statewide data on adult and child immunization rates.

Infant Mortality

Table 3 provides a summary of infant mortality rates and disparities between Populations of Color/American Indians and Whites. The 50 percent reduction in disparities for infant mortality has been met for Asians and Hispanics, with the disparities reduced by 75.0 and 66.7 percent respectively. While significant progress has been made for African Americans/Africans and American Indians, with a 36.4 percent reduction for African Americans/Africans and a 26.3 percent reduction for American Indians, the 50 percent reduction in disparities has not yet been achieved for these populations.

Baseline data (1995-1999) indicate that African American/African and American Indian rates were over twice as high as White rates; these rates were prior to the establishment of the EHDI. Current rates and percent mortality reduction indicate that while rates have declined considerably for all racial/ethnic groups, African American/African and American Indian rates remain twice as high as Whites, indicating that much more progress needs to be made before these groups see the same outcomes as Whites.

TABLE 3:

EHDI Infant Mortality Rates and Disparities

	African American^	American Indian	Asian	Hispanic	White
Baseline Rate (1995-1999)	13.2	13.5	7.1	7.0	5.5
Current Rate (2001-2005)	9.3	10.3	4.8	4.9	4.4
Rate Reduction	29.6%	23.7%	32.3%	30.0%	20.0%
Disparity Reduction with Whites	36.4%	26.3%	75.0%	66.7%	
EHDI Disparity Goal Met*	**no**	**no**	**yes**	**yes**	

Disparity Reduction with Whites = the percentage change in disparity between the baseline and current years
^Includes African born
*EHDI Disparity Reduction Goal - 50 %

Immunization

MDH used the 2001 Minnesota Kindergarten Retrospective Survey to set the 2001 EHDI baseline, from which progress towards the goal of a 50 percent reduction in childhood immunization disparities would be measured. Based on the survey, the overall immunization rate for the 4:3:1 vaccine series for White children at 24 months of age in Minnesota was 85 percent in 2001 compared to 65 percent for non-White children, a gap of 20 percentage points. After Whites, American Indians had the highest immunization rates at 73 percent and African Americans/Africans had the lowest at 62 percent (Table 4).

TABLE 4:

2001-2002 Immunization Levels for the 4:3:1 Series by Race/Ethnicity at 24 Months in Minnesota

Race (Number of Children)	Percent Up to Date at 24 Months
White, non-Hispanic (48,317)	85%
American Indian (1,072)	73%
Asian/Pacific Islander (3,331)	66%
Hispanic/Latino (3,079)	65%
African American, non-Hispanic/ Latino (4,599)	62%

Source: 2001 Minnesota Retrospective Kindergarten Survey

The Minnesota Retrospective Kindergarten Survey was discontinued after 2001, in part, because the survey was unsustainable for local public health and schools, requiring high cost and staff time. In addition, MDH had planned on using data from the Minnesota Immunization Information Connection (MIIC) as a replacement measure for the purposes of assessing progress towards

EHDI goals. However, MIIC has not been able to fill this role as quickly as hoped, meaning that no adequate comparative data are yet available to assess whether the gaps are increasing or decreasing.

The two main sources for the adult immunization data are the National Health Interview Survey (NHIS) and Medicare. Each dataset has its limitations: NHIS is not state specific and can only report on Whites and African Americans/Africans, and available Medicare data is only for adults 65 and over, and does not include those in managed care plans.

For the EHDI goal to reduce disparities in adult immunization rates by 50 percent by 2010, MDH used information from the 2000-2001 National Health Interview Survey for the Midwest region to establish a baseline (Table 5). While the NHIS shows a gap of nearly 20 percentage points between White and African American/African adults, the same data from 2007 show an increase of approximately 10 percentage points for influenza vaccine and approximately 13 percentage points for pneumococcal vaccine among African American/African adults. There was a small increase for White adults for both vaccines.

TABLE 5:

Percentage of Adults Vaccinated Against Influenza and Pneumococcal in the Midwest during the 2000-2001 and 2006-2007 Influenza Season

	Percent Vaccinated Against Influenza		Percent Vaccinated Against Pneumococcal	
	2000-2001	2006-2007	2000-2001	2006-2007
African American/African	49.5	59.1	35.3	48.0
White	67.3	69.3	58.8	62.0

Source: 2000-2001 and 2006-2007 National Health Interview Surveys

Among adults 65 and older, Minnesota-specific data indicate narrowing of the disparities among some racial and ethnic groups in flu shot coverage among Medicare recipients. Between 2001 and 2007, the gap between the White and African American rates shrank by roughly five percentage points, while the gap between Whites and Asians was reduced by roughly 14 points. However, it is not clear whether these changes are significant because of the limitations of the Medicare data.

While multiple sources of data on adult and child immunization rates exist, none of the available data sources are currently complete enough to allow an assessment of immunization rates for Populations of Color and American Indians, particularly for children. Going forward, it will be important to strengthen the available immunization data where possible, and to identify alternative strategies for measuring progress towards the reduction of health disparities in child and adult immunizations.

The Minnesota Department of Health has recently written two reports that detail disparities in immunization and infant mortality. The documents are available on the MDH website, www.health.state.mn.us/divs/chs/.

EHDI Goal 2: **Reduce health disparities in other health priority areas**

Table 6 summarizes progress made in reducing disparities in breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, violence and unintentional injury and healthy youth development,. The table lists the health indicators by population, along with the percent decrease or increase in the disparity from the baseline to current reporting periods (data used to calculate these disparities are included in Appendix C). The sources for these indicators are morbidity and mortality data from Minnesota Department of Health's surveillance systems and vital statistics. The indicators for diabetes, cardiovascular disease, and violence and unintentional injuries are measured by mortality data. Using these data alone limits our ability to measure the progress made in reducing health disparities because many years of intervention are often needed to change mortality rates

The data indicate that, although the goals have not yet been met for all populations, substantial progress has been made in reducing the disparities between Whites and Populations of Color and American Indians. Most evident is the success in reducing disparities in gonorrheal incidence, teen pregnancy, diabetes mortality and homicide for all racial/ethnic groups.

Though these reductions point toward progress, large disparities continue to exist in Populations of Color and American Indians. For example in Minnesota, teen pregnancy rates are still 2.3 to 4.8 times higher for Populations of Color and American Indians than the White rate; the Chlamydia incidence rates are 2.4 to 14.4 times higher, and the cervical cancer incidence rates are 1.9 to 2.8 times higher for Populations of Color and American Indians than for Whites.

A lack of data at the statewide level on Populations of Color and American Indians limits the ways in which progress towards statewide outcomes can be measured. For health priority areas such as diabetes and cardiovascular disease, for example, incidence data is not available for racial/ethnic groups, which means that the analysis of progress in these areas is limited solely to mortality data. Evaluating the success of programs using only mortality data provides a narrow perspective on progress. As a lagging indicator, mortality data will not detail improvements in health risk and protective behaviors until long after the changes have been made, and offer no ability to estimate differences in quality of life, use of preventive screenings or other tools, or ongoing management of a chronic condition. To more comprehensively measure progress, and target areas of greater need, incidence or behavioral risk data by race/ethnicity is needed.

In order to hold the initiative accountable for its success in meeting statewide goals, additional reliable data sources for Populations of Color and American Indians will need to be developed. Conversations with groups such as Minnesota Community Measurement, health plans and others are occurring to determine how other data sources might enhance and complement our efforts.

Table 6:

Disparity Reduction/Increase by Health Area and Population, 1995-1999 to 2002-2006*, Minnesota

Health Priority Area and Indicators	African American^	American Indian	Asian	Hispanic
Breast and Cervical Cancer				
Cervical Cancer Incidence	54.2%	15.3%	32.9%	#
Breast Cancer Incidence	- - -	- - -	- - -	#
Breast Cancer Mortality	55.5%	- - -	- - -	#
Cardiovascular Disease				
Heart Disease Mortality	94.3%	(37.5%)	- - -	- - -
Diabetes				
Diabetes Mortality	17.1%	18.7%	- - -	25.3%
Healthy Youth Development**				
Teen Pregnancy	39.1%	4.2%	36.6%	15.8%
HIV/AIDS and Sexually Transmitted Infections*				
New HIV Infection	(7.4%)	51.8%	0.0%	(30.3%)
Chlamydia Incidence	(2.7%)	19.9%	24.9%	10.9%
Gonorrheal Incidence	26.7%	25.7%	- - -	32.5%
Violence and Unintentional Injuries				
Unintentional Injury Mortality	- - -	(29.7%)	- - -	- - -
Homicide	48.3%	6.8%	23.1%	52.7%
Suicide	- - -	(65.5%)	- - -	- - -

The data in this table represent the percentage change in disparity between the baseline and current years.
^ Includes African born
-- - No current disparity
( ) Disparity increase
Baseline data not available, cannot measure disparity
*HIV and STI - Baseline Year = 2000, Current Year = 2007
**Though not specified in statute, federal TANF funds were directed to healthy youth development through this initiative.
All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19
See Appendix C for rates and disparities

Grantee Outcomes

As indicated in the EHDI framework, before overall health status is improved and disparities reduced, changes need to occur in outcomes at the individual, system and community levels. Much of the focus of the EHDI to date has been on individual-level changes in knowledge and behavior within grantee communities, and grantees have achieved many positive outcomes at that level. At the systems level, grantees have also seen some success, particularly in changing internal systems and improving cultural competence among organizations within their communities. This work has helped to improve health status within grantee communities, and has served as a proving ground for innovative approaches to working effectively with communities of color.

But while individual and micro-system level change is a crucial precursor to statewide improvements, those changes alone will not be sufficient to meet the statewide goals established as part of the EHDI. To expand the impact of the initiative, the focus on broader system changes will need to increase. MDH and communities will need to take what has been learned from grantee organizations and communities and integrate those successes across larger populations and into the larger public health, social service, and healthcare delivery systems.

EHDI grantees have been provided with the resources to create culturally-specific innovative programs that improve these outcomes in their communities. This section briefly describes grantee level outcomes that have changed individuals, systems and communities.

In 2007 alone, over 37,000 members of racial/ethnic communities were directly served by EHDI grantees

Knowledge, Awareness, Behavioral and Health Status

In 2007 alone, over 37,000 members of racial/ethnic communities were directly served by EHDI grantees. Another 140,000 were reached through community events such as health fairs. The grantees of the Eliminating Health Disparities Initiative have documented impacts on program participants in important ways:

- Changes in knowledge and increased awareness among program participants and community members in all health disparity areas.
- Increased numbers of community members without insurance signed up for health coverage and access to primary health care including prenatal care.
- Increased preventive health screenings (e.g. mammograms, pap smears

Selected Grantee Outcomes

92.5% of the participants believe that their knowledge about diabetes has increased through Centro Campesinos diabetes workshops (N=900).

208 clients served by Center for Asian and Pacific Islanders did not have a medical home and by the end of the program 169 were connected to a medical home.

In 2006, Turning Point tested an average of 20 men a month for HIV/AIDS, the average is now 30 to 40 men a month.

Olmsted County Public Health Services - 23 people with abnormal blood pressure test results who were not under a doctor's care were referred to a clinic.

and other types of cancer screenings, blood pressure and cholesterol checks for heart disease, blood glucose levels for diabetes, testing for HIV/AIDS and other sexually transmitted diseases).

- Obtained necessary immunizations for children, allowing them to start school.
- Supported community members to navigate the health care system, understand and receive needed treatment, and comply with provider recommendations.
- Changed behaviors of program participants in the areas of improved diet, increased exercise, decreased tobacco and other substance use during pregnancy, increased breast feeding among new mothers, decreased high risk sexual behaviors and reduced violent behaviors among domestic abusers.

Selected Grantee Outcomes

At Park Avenue Family Practice, 69.2% of Hmong mothers breastfed for at least 2 months compared to approximately <1% in 2005.

73% of West Central Intergration Collaborative's youth participants agreed that the after-school program helped them do better in school and increased their knowledge about exercise (N=22).

Based on Minnesota Department of Corrections and White Earth Tribal Court data, 14% of White Earth Tribal Mental Health's group partcipants re-offended compared to 37% of State and Tribal Court average.

- Changed attitudes such as improved self-image and confidence levels among youth participants, as well as intentions to change behavior, changed attitudes towards health care providers and traditional forms of healing and care and changed community norms about violence.
- Documented positive health outcomes such as healthy birth weight of infants, reduced recidivism among perpetrators of domestic violence and reduced rates of teen pregnancy among youth program participants.

This information is drawn from the annual evaluation reports submitted by each grantee for their work in 2007. Grantee outcomes by health area can be found in Appendix B.

Grantee Outcomes - System and Community Changes

Undertaking system changes recognizes that for the health status of communities of color and American Indian communities to improve, the larger systems of care, service and governance must be engaged. Systems change often occurs in stages – internal, external and community-wide.

Grantees have changed internal systems by modifying their own policies and programs. Grantees have also influenced changes in external systems (e.g. health care organizations, educational systems, governmental agencies). These changes include improving the cultural competency of providers, modifying programming and service delivery, and altering perceptions of communities. Finally, norms and behaviors have begun to change in grantee communities as the result of EHDI programs. These systems changes promote and facilitate behavior changes that lead to improvements in health status.

While some grantees have documented significant successes in achieving internal and external systems change, only a relatively small number of grantees have done work at this level, and their impact to date has, of necessity, largely been limited to the communities in which they work and the organizations with which they partner. Again, these changes at the micro-level are crucial, as they lay the groundwork for achieving community norms and behavior. But going forward, the initiative will need to do what it can to broaden this work to other communities and achieve a greater statewide impact.

Internal System Changes

Twenty-three grantees reported that they have changed their internal systems by providing alternative services, and culturally-competent services that were not previously available. Twelve grantees reported changes in systems through improved policies and procedures. Examples of internal policy changes include changing check-in and charting procedures, modifying medical forms and adding work-time exercise hours.

External System Changes

Increasing cultural competence of partnering agencies: As leaders in their area, nine organizations reported having an impact on their partners' work. Several educated healthcare providers on the cultural aspects of health within their community. As a result, these providers recruited medical professionals the reflected the culture of the community being served and addressed specific health disparity issues.

Modifying programming and services: Ten grantees have had on impact on modifying programs in the education system and government services. They developed new curricula in physical activity, health and violence prevention education in schools. Grantees have also had an impact on public health programming at the county level and have become service providers for county health and human service agencies.

Minneapolis American Indian Center. As part of their EHDI program, they developed a physical education curriculum for a local school that lacked a physical education program. Now a program staff member goes to the school twice a week to implement the curriculum with students. The school system is changing to allow for this culturally competent organization to work with students on important health and physical activity issues.

Agape House for Mothers. Through their program, they're having an impact on how schools and juvenile probation work with students who have behavioral issues. In the past, the emphasis was on discipline, but through Agape's work, administrators now work to address the root causes. They are also working with parents to address truancy issues. As a result, fewer students are being suspended.

Community-wide System Changes

Five grantees reported their work is beginning to change community norms. Grantee organizations reported an increased willingness of communities to discuss sensitive health issues with each other, particularly sexual health and violence. Grantees can have a greater impact when people are more open to talking about these issues.

Changes in community norms are necessary in order to impact disparities statewide. As people become more comfortable talking about sensitive issues, as well as about the steps they are taking to protect their own health, that openness can help others to make changes in their own lives. While relatively few grantees have yet been able to achieve this level of change in their communities on a large scale, their experiences, when shared, can serve as a model for other grantees on how to broaden their impact.

Annex Teen Clinic. By addressing sexual health issues openly, in a caring way, the community is beginning to change what is considered acceptable conversation. An "increasing number of community members agree that we need to be able to speak openly and honestly about sexual health."

EHDI grantees have improved individual health outcomes (e.g. increased awareness of risk factors, increased exercise and improved birth outcomes); and influenced change in internal and external systems (e.g. modified education programs; facilitated the cultural competence of health care providers, and changed community norms). There is a need for continued work in these areas to maintain and improve on the gains that have been made and to reach an even greater number of community members.

In addition to health outcomes, grantees have also documented changes in some environmental factors that influence health. They have increased access to health care for their clients, and helped clients complete their education and find employment. There need to be more efforts aimed at addressing these factors at both the EHDI and statewide levels. Health disparities will not be eliminated until these and broader environmental factors as well as social determinants of health are addressed.

VI. CAPACITY BUILDING

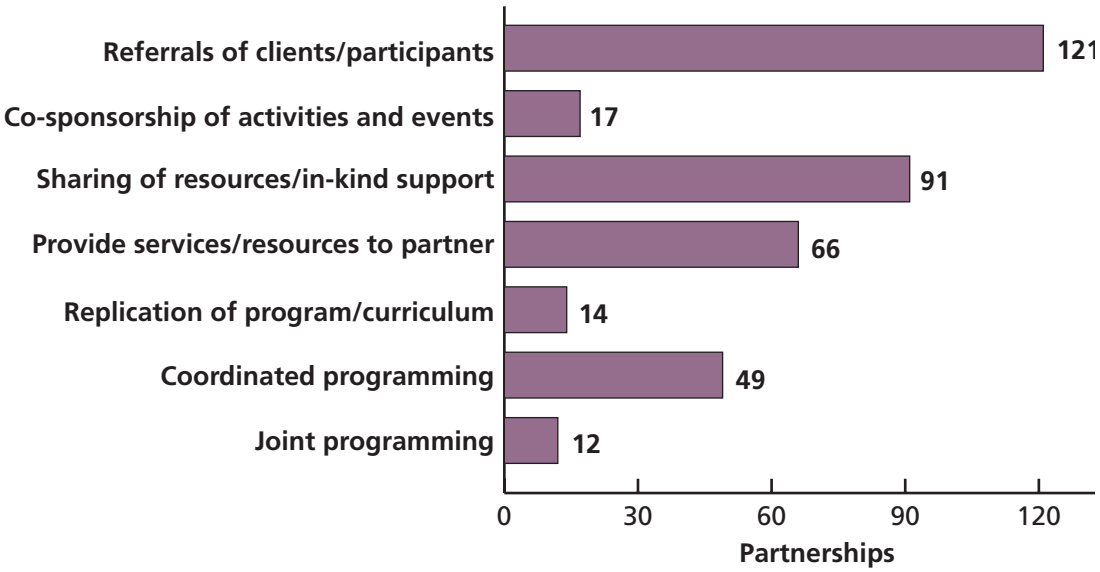
Grantees expanded their influence in their communities and in health systems through the cultivation of partnerships

Capacity building is a key process/activity of the EHDI. The focus of the EHDI capacity building work has been on partnerships, organizational development and leveraging. By building capacities, grantees have been able to expand services, improve credibility, stabilize funding, and increase awareness of health disparities. In turn, grantees are able to improve health outcomes of the people they serve.

Partnerships to Support Effective Programming

Grantees expanded their influence in their communities and in health systems through the cultivation of partnerships. Partnerships allow programs to leverage support, thereby making it possible to address the other individual needs (e.g. education and other social services) that lead to better health. Grantees reported 296 partners, with many of these partners being cross-sectional (e.g. health care providers, education, government, business). Grantees used their partners for referrals, sharing resources and in-kind support, provision of services, coordination of programming, joint programming, replication of services, and co-sponsorship of activities and events. The most common types of partnerships were referrals, sharing resources and provision of services (Figure 2).

FIGURE 2:
Number and Type of Partnerships, EHDI Grantees



Sixty-six partnerships involved the provision of services. Grantees provided education materials and services to their partners and vice versa. For example, KMOJ radio supports the Family and Children Services' 100 Men Take a Stand program through the developing and producing of public service announcements, providing air time, and sponsoring programming.

Ninety-one partnerships involved sharing resources including space, volunteers or staff time, and transportation services. For example, Midwest Mountaineering and REI provide equipment and training to the Minneapolis American Indian Center.

Grantees reported 121 partnerships in which referrals were the main reason for partnering. This meant either the partner referred participants to the EHDI program, or the EHDI program referred their participants to partners for services such as screenings, medical services, financial assistance, traditional healing, employment services. For example, the Agape House for Mothers refers their graduates to Bridges of Hope for leadership programming.

The benefits of partnerships are many. By using partners, grantees saved money, expanded their service network, created more comprehensive services, improved cross-sectional relationships and formalized relationships with health care providers.

EHDI funding has helped organizations expand services, improve credibility, stabilize funding, increase awareness within the organization, and become leaders in their communities

Organizational Development

Organizational development has been a major focus of the EHDI. The EHDI has conducted training on various topics including evaluation, asset building, and grant writing. At these trainings, grantees have the opportunity to meet with MDH content experts and fellow grantees to discuss program challenges and successes. Grantees have also had individual consultations with evaluation experts and grant managers who have consulted with the grantees on the development and implementation of their program evaluations and provided technical assistance in the development, implementation and promotion of programs.

EHDI funding has helped improve the skills of grantee organization staff and increased staffing levels. It has also helped organizations expand services, improve credibility, stabilize funding, increase awareness within the organization and become leaders in their communities.

Capacities Built Among Staff

Increased staff: Seventeen grantees reported that their EHDI grant enabled them to increase staffing levels. They have hired for new positions, increased staff hours, hired staff members with new skills, and sent existing staff members to trainings. One organization grew from eight staff members to 25; another hired an outreach worker who speaks Spanish; and a third increased their physical therapist's hours from four to 16.

Improved staff skills: Several grantees reported that their EHDI grant enabled them to improve staff skills. In addition to the EHDI sponsored trainings, workshops and individual consultations, grantees have sent staff to local, regional and national conferences and workshops. Some staff

members completed degrees, certifications, or licensing programs (e.g. Masters in Public Health, Doula certification, etc).

EHDI grantee staff are also increasing their evaluation skill set. Forty-one percent of the grantees showed improvements in their evaluation capacities over a two-year period (2004 and 2005) with seventy-five percent of the grantees having high to moderate evaluation capacity.

Grantees have become leaders in their communities and have gained reputations as experts in their health disparity areas. Twenty-nine (63%) of grantees reported they have been recognized by one or more external groups or organizations for the EHDI work. Eleven grantees have received a formal award (one international, four national, four state and two local). Grantees are also being asked by other organizations for advice and technical assistance on programming and their programs and materials are being replicated in Minnesota and nationally. Other examples of leadership include:

- Collaboration and involvement in other health promotion efforts
- Increased referrals from new sources
- Providing assistance to health organizations to access community
- Serving as community representatives for media or mainstream organizations on health topics

Capacities Built in Grantee Organizations

Organization is more aware of and focused on health issues: Eleven grantees reported that their EHDI work has increased the knowledge and awareness of their larger parent organization. As a result, several grantees reported an expansion in the focus of their programming. One tribal grantee explained that their EHDI program has "made the higher administration aware that there are issues in the community."

Expanding services: Thirteen grantees have expanded their programming by adding education components, fitness programs, health services and referral networks to their service structures. As one grantee explained, the goal of their organization is to "provide a continuum of services," which EHDI has helped them do.

Leveraged Funds and Resources to Sustain Efforts

A consistent, long-term funding commitment is essential to addressing health disparities, given the entrenched nature of the determinants of these health issues. A variety of revenue streams provide stability, flexibility and allow for expansion and unforeseen problems. Of the 36 grantees who sought outside funding, 28 successfully leveraged other funds for their EHDI programs (Table 7). These grantees received a total of $3,000,000 in additional funding from various entities including foundations, corporations, and government agencies. And forty grantees reported receiving in-kind, non monetary resources such as office space, supplies and staff from other organizations.

TABLE 7:
Profile of Successful Leveraging by 28 Grantees

Number of Grantees	28
Total Raised	$3,000,000
Range of Dollars Raised	$150 to $500,000
Source	**Percent successful**
Foundations/corporations	57%
Government grants/contracts	43%
Fee for service/insurance payments	18%
Other sources of funds	18%

EHDI grantees have become leaders and key resources in their communities

Four factors contribute to the success of leveraging EHDI funds: the grant served as a solid foundation for funding; grantees were able to demonstrate positive outcomes; funders were interested in their issue, population or approach; and they had adequate infrastructure and support for fund-raising. While not all grantees were able to successfully leverage funds, those that did will now have a more stable base for their work in the future, beyond the life of their EHDI grant, and will be better positioned to build on their successes.

In the area of capacity building, the EHDI grantees are able to document many clear and positive outcomes. The EHDI grantees have become leaders and key resources in their communities, and will continue to improve health status for their clients and partners in the coming years. But statewide success in eliminating disparities will take much more than that. Going forward, there will be a need to ensure that the initiative is able to use the successes of these grantees as models for additional partnerships on multiple levels. Successful grantees and organizations need to be paired with other grantees to share strategies for partnering and leveraging funds. On a broader level, MDH will need to work to further strengthen relationships between the EHDI program and other potential partners in the provider, payer, education, social service and public health communities in order to ensure that the successes of EHDI are shared and can be implemented in new communities and new settings.

V. CONCLUSION AND RECOMMENDATIONS

As racial/ethnic populations continue to increase in Minnesota, the moral and financial costs of health disparities will also grow unless the gains made to date are sustained and expanded

In 2001, the Minnesota Department of Health was charged with reducing health disparities through the landmark Eliminating Health Disparities Initiative (EHDI). This law was passed in recognition of the fact that health disparities among Populations of Color and American Indians lead to a lower life expectancy, higher rates of illness and disease, poorer quality of life, and increased costs of health care. The passage of EHDI legislation was a critical factor in starting Minnesota on the road to addressing these long-standing disparities in health status by helping to raise awareness of this crucial issue and serving as a catalyst for learning about why disparities exist, as well as for developing effective approaches to eliminating them.

The Eliminating Health Disparities Initiative set out clear goals for the Minnesota Department of Health – reduction in disparities in infant mortality and adult and childhood immunizations by 50 percent and closing the gap in five additional health priority areas by 2010. The Initiative also established goals for Healthy Youth Development. To meet these goals the EHDI has supported community-based organizations to develop and implement innovative culturally based programs that address the complex factors that contribute to health disparities and provides organizational capacity-building in key areas.

Since the inception of the EHDI, MDH and its partners have made progress in improving health status and reducing disparities across all health priority areas, and grantees have expanded their capacity to serve their communities by developing new partnerships and leveraging additional funds. Unfortunately, MDH and its partners have yet to fully meet the goals set out in statute. Specifically:

- While the goal of a 50 percent reduction in disparities in infant mortality rates has been met for Asians and Hispanics, this goal has not been achieved for African Americans/Africans and American Indians.
- For immunization, a lack of reliable state-level data means that MDH is unable to assess its progress towards the goal of a 50 percent disparity reduction.
- Progress for each of the other priority areas has been largely positive and significant, although stark differences remain between Populations of Color, American Indians, and Whites, particularly in the areas of sexually transmitted infections and teen pregnancy.

MDH continues its commitment to address the significant health disparities that exist. As racial/ethnic populations continue to increase in Minnesota, the moral and financial costs of health disparities will also grow unless the gains made to date are sustained and expanded. While the EHDI program has achieved significant successes in working with individuals and communities to increase knowledge and change behavior, that work alone will not be sufficient to achieve statewide goals. The lack of available data for more comprehensively measuring progress in certain priority areas also means that the program is not being fully held accountable for meeting those goals.

MDH is committed to ensuring that the elimination of health disparities is a high priority agency-wide and in the community, that EHDI is as effective as possible in meeting its goals, and that progress towards those goals is adequately measured. Looking forward to 2010 and beyond, MDH plans to take several steps to strengthen the EHDI and in essence move the initiative from Version 1.0 to Version 2.0. Specifically the MDH plan includes:

1. *Maximizing the investment in EHDI by integrating strategies for eliminating health disparities into MDH programs, as well as coordinating and collaborating with other health promotion efforts and a range of state agencies, local public health, and other institutions.*

   The elimination of health disparities is a priority for all of MDH. The Office of Minority and Multicultural Health has played a crucial role in building bridges with communities of color, and, through EHDI, fostering learning about how to successfully impact health status in these communities. These successes need to be shared with, and more fully incorporated into, MDH programs working in each of the health priority areas (e.g. diabetes, cardiovascular disease). MDH also needs to assume a larger role in sharing what has been learned with other stakeholders including healthcare providers, local public health, and other community organizations.

2. *Developing policies and programs to address the environmental factors that contribute to poor health and health disparities.*

   While the EHDI has been very successful in achieving change on the individual level, the initiative must also be working to achieve change on a broader level. Health disparities will not be eliminated until environmental factors including the physical environment, social and economic issues are addressed. MDH needs to reach out to other organizations that work on issues such as economic development, poverty, racism, and affordable high quality healthcare, to ensure that we are addressing those issues through our own programs to the extent possible. We also need to ensure that our health reform efforts are addressing quality, affordable, accessible health care for Populations of Color and American Indians.

3. *Improving data collection efforts toward common goals so that high-quality, reliable statewide data is available for the evaluation of EHDI outcomes.* In order to assure accountability for the EHDI, new and enhanced data collection mechanisms need to be developed to assess the health of Populations of Color and American Indians. Progress made on increasing immunization rates for adults and children could not be assessed due to a lack of reliable data. Measuring and reporting on progress was also limited for some priority areas because incidence data is not available by race (e.g. diabetes, cardiovascular disease), resulting in a need to rely on mortality data alone. In addition, Minnesota does not have statewide measures of behavioral risk factors (e.g. smoking, exercise, nutrition) for Populations of Color and American Indians. These data, along with data from healthcare providers, are needed to better understand where and why disparities exist, to confirm the progress being made in reducing disparities, and to ensure that the initiative is held accountable for the work that it is doing.

4. ***Expanding and replicating innovative programs that systematically and sustainably reach as many people as possible, and that work for Populations of Color and American Indians, to other communities.*** The grantee programs have been successful in reaching traditionally hard-to-reach populations, providing programming that incorporates cultural values and traditional practices, and are consistent with current "best practice" principles. The programs are prevention-focused and involve communities in program planning and implementation. However, the grantees are only able to work in selected communities, and are unable to reach all populations at risk. While important as a proving ground for innovative approaches, the grantee programs alone will not be enough to achieve sustainable statewide change. These programs with the greatest system approach must be expanded and replicated in a sustainable way to reach Populations of Color and American Indians in other counties and to serve as best-practice models for eliminating health disparities in Minnesota and in other states.

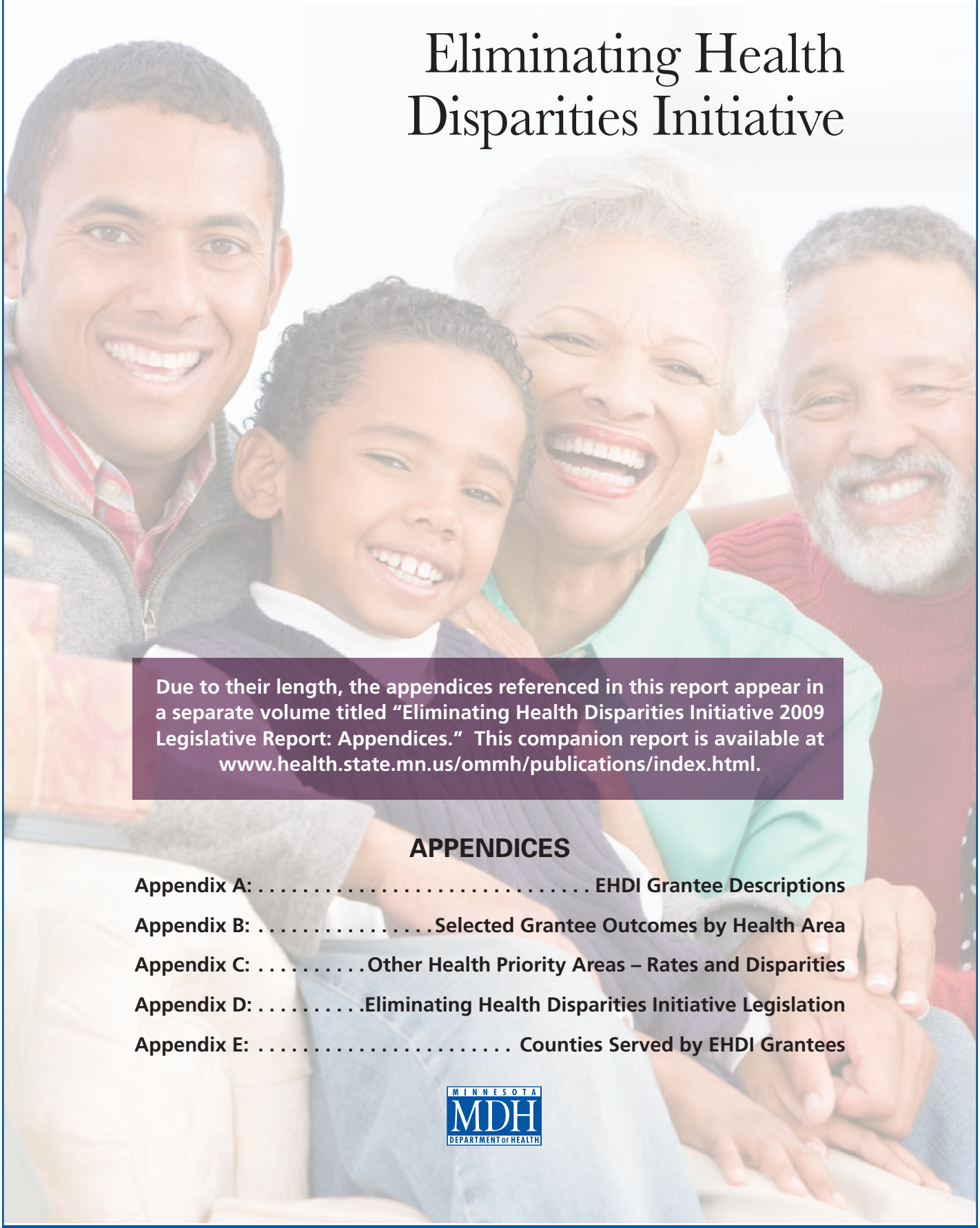
5. ***Expanding the focus of the EHDI to explore and address policies and systems that impact health disparities to create sustainable change.*** Current policies and systems need to be reviewed to address health disparities. For example, to create change that is sustainable, the capacity of the public health system to work with Populations of Color and American Indians must be assessed and improved, as well as addressing the capacity of the healthcare delivery. Policies and systems in many areas must also be reviewed, assessed, and improvements made including education, housing, and labor.

6. ***Exploring how to increase social capital as part of the work in eliminating health disparities as the demographics of Minnesota diversify, so we embrace our rich cultural and ethnic heritage now and into the future.*** Social capital is the inter-connectedness among individuals and communities. As our society evolves, building social capital is an important element in any foundational work such as EHDI, and helps us to explore how to increase citizens' connections with each other, their understanding of each others perspectives and their collective solutions to common problems and goals. Therefore, we will work to increase social bonding within populations as well as increase social bridging across populations to build a Minnesota of the future which benefits from our rich ethnic and racial heritage

The Eliminating Health Disparities Initiative was one of the first statewide efforts to focus on the health and well being of Populations of Color and American Indians. Its ground-breaking philosophy and innovative approaches have served as a model for other states as well as the national Office of Minority Health to address the long-standing and complex issue of disparities.

The Initiative has been successful in many respects, yet there is much more to be accomplished. Successes at the individual and small community level need to be broadened to impact new communities and to begin changing community norms statewide. We need to improve our ability to measure our success and hold the Initiative accountable for its work. MDH is now poised to enter into the next phase of this Initiative in order to continue and build on the progress that has been made in eliminating disparities, learn from our experiences, and move forward.

Eliminating Health Disparities Initiative



Due to their length, the appendices referenced in this report appear in a separate volume titled "Eliminating Health Disparities Initiative 2009 Legislative Report: Appendices." This companion report is available at www.health.state.mn.us/ommh/publications/index.html.

APPENDICES

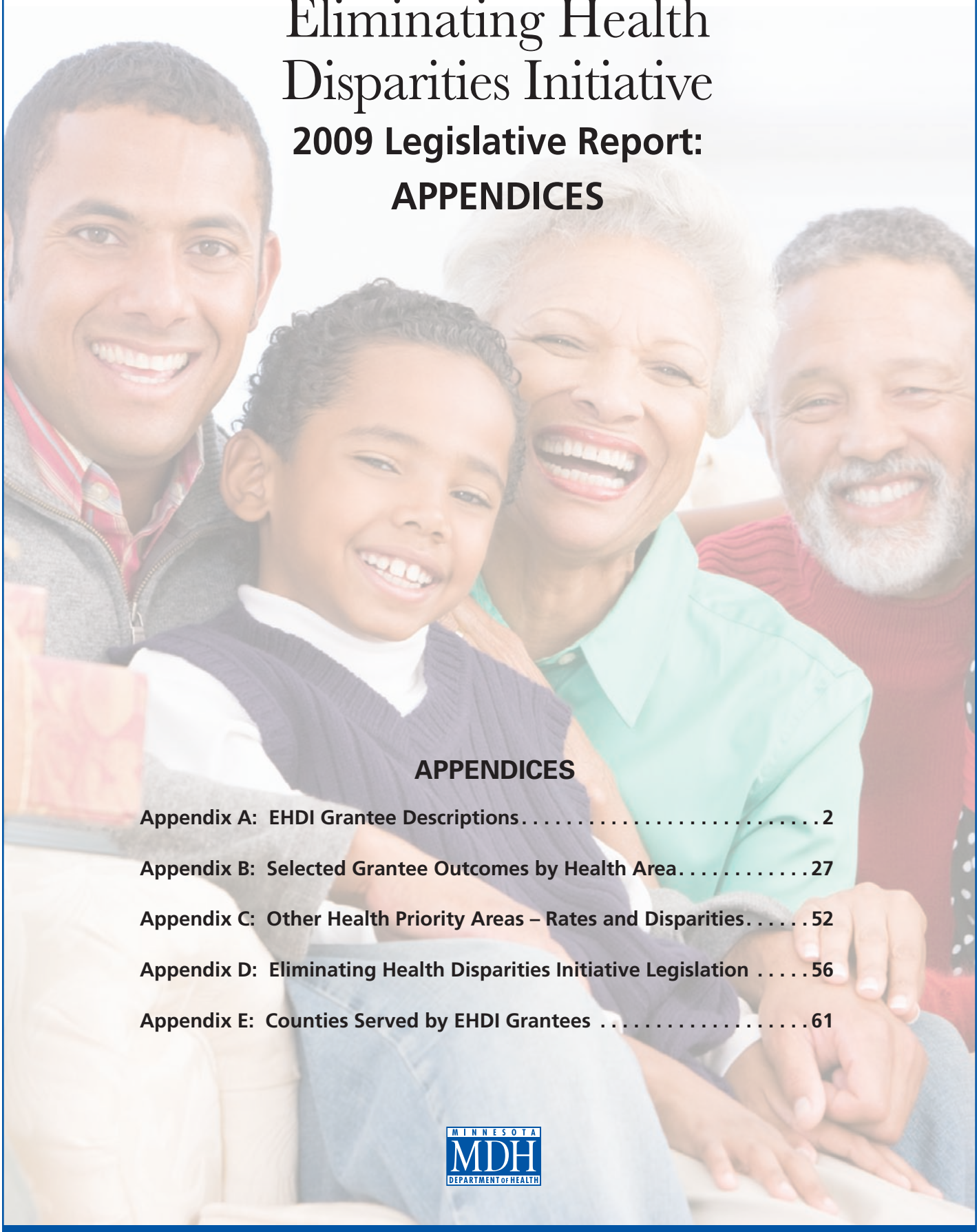
MINNESOTA MDH DEPARTMENT of HEALTH

Office of Minority and Multicultural Health
P.O. Box 64975
St. Paul, MN 55164-0975
Phone: (651) 201-5813
Fax: (651) 201-4986
TDD: (651) 201-5797

Eliminating Health Disparities Initiative

2009 Legislative Report:

APPENDICES



APPENDICES

MINNESOTA MDH DEPARTMENT OF HEALTH

Appendix A: EHDI Grantee Descriptions

EHDI Grantees by Health Area and Target Population, 2007

	Health Areas								Targeted Populations			
Grantee	BCC	CVD	DM	HYD	HIV	IMM	INF	VUI	AA	AI	As	Hi
African American AIDS Task Force					•				•	•	•	•
Agape House for Mothers				•	•				•		•	•
American Indian Family Collaborative							•		•	•	•	•
Anishinaabe Center			•							•		
Bois Forte – Tribal	•									•		
Bois Forte – Community		•								•		
Boys and Girls Club of the Twin Cities				•					•	•	•	•
Camphor Foundation				•					•	•	•	•
Carondelet LifeCare Ministries	•		•									•
Cass County /Leech Lake Reservation							•			•		
Center for Asian and Pacific Islanders						•			•		•	
Centro (2 grants)				•			•					•
Centro Campesino	•		•		•	•		•				•
Children's Hospitals and Clinics		•	•	•					•	•	•	•
Council on Crime and Justice					•	•		•	•	•		•
Dar Al-Hijrah Cultural Center		•	•			•			•			
Division of Indian Work (2 grants)				•			•			•		
Family and Children's Service								•	•			
Fond du Lac Tribe							•			•		
Freeport West				•					•			
Fremont Community Health Services		•	•						•			
Grand Portage Health Service		•	•							•		
Hmong American Partnership								•			•	
Indian Health Board of Minneapolis	•									•		
La Clinica en Lake				•								•
Lao Family Community of Minnesota				•							•	
Leech Lake Band of Ojibwe								•		•		
Lower Sioux Community			•	•	•			•		•		
Mille Lacs Reservation				•		•	•			•		
Minneapolis American Indian Center		•	•	•						•		
Minneapolis Urban League				•	•				•	•		•
Minnesota International Health Volunteers	•	•	•	•	•				•			
North Suburban Youth Health Clinic				•					•			
Olmsted County Public Health Services		•	•			•			•			•
Park Avenue Family Practice		•	•				•				•	
Prairie Island Foundation		•	•							•		
Red Lake Comprehensive Health Svcs							•			•		
Southeast Asian Community Council				•							•	
Southeast Asian Ministry		•	•								•	
Stairstep Foundation	•	•	•	•		•	•		•			
Summit University Teen Center				•					•		•	•
The Storefront Group						•			•			
Turning Point					•				•			
United Hospital Foundation								•	•	•	•	•
Upper Sioux Community	•		•							•		
Vietnamese Social Services of Minnesota	•										•	
West Central Integration Collaborative				•				•	•			•
Westside Community Health Services			•						•	•	•	•
White Earth Tribal Mental Health								•		•		
Women's Cancer Resource Center	•								•			
Total Number of Grantees	9	12	17	19	8	8	10	9	24	25	16	17

* BCC=breast and cervical cancer; CVD= cardiovascular disease, DM=diabetes; HYD=healthy youth development; HIV=HIV/AIDS and sexually transmitted infections; IMM=immunizations; INF=infant mortality; VUI=violence and unintentional injury; AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic; Infant mortality – Centro has two grants: INF and INF & HYD

Grantee Summary by Health Priority Area

2007 EHDI Snapshot: Breast and Cervical Cancer

Number of Grantees: 9 **Number of Counties Served:** 22

Number Reached: 4,380	African American^:	1,975	American Indian:	420
	Asian:	1,330	Hispanic:	582

Summary

In 2007, the grantees' combined efforts reached 4,380 people through direct contact (e.g. counseling, screenings, and classes) across 17 counties. Grantees also reached another 26,600 people through educational campaigns held in various locations including churches, powwows and beauty salons. The grantees have implemented various programs to raise awareness and increase screenings all of which build on the strengths, cultural values, assets and social networks within their communities. Grantees help women apply for insurance accompany women to screenings, provide transportation and help women navigate through the health system. Grantees also help women access traditional healers and ceremonies and encourage women to seek spiritual resources and/or family support.

Outcomes*

Through the EHDI programs, grantees were able to:

- increase the awareness of the importance of cancer screenings,
- increase the number of women receiving mammograms and pap smears in their communities and
- Provide referrals and support services to women with positive screenings.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Bois Forte		•			Bois Forte Reservation (Itasca, Koochiching and St. Louis)
Carondelet LifeCare Ministries				•	Anoka, Dakota, Hennepin, Ramsey, Scott
Centro Campesino				•	Dodge, LeSueur, Mower, Rice, Steele, Waseca
Indian Health Board of Mpls		•			Hennepin and Ramsey
MN Internat'l Health Volunteers	•				Hennepin and Ramsey
Stairstep Foundation	•				Hennepin and Ramsey
Upper Sioux Community		•			Upper Sioux Community (Chippewa and Yellow Medicine)
Vietnamese Social Services of MN			•		Anoka, Benton, Carver, Dakota, Hennepin, Ramsey, Rice, Scott, Sherburne, Stearns, Washington
Women's Cancer Resource Ctr	•				Hennepin and Ramsey

Number reached includes other and multi-racial
^includes African born
Grantees in **bold** are working only on breast and cervical cancer
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Cardiovascular Disease

Number of Grantees: 12 **Number of Counties Served:** 10

Number Reached: 9,465 African American^: 6,691 American Indian: 738
Asian: 1,123 Hispanic: 339

Summary

In 2007, the CVD grantees' combined efforts reached 9,465 people through direct contact (e.g. blood glucose screenings, and exercise classes) and almost 23,300 through large events such as health fairs. These grantees offer blood pressure, cholesterol and blood glucose screenings at a wide range of locations such as barber shops, churches, mosques and coffee shops. They use parish nurses, community health workers and other partners to conduct these screenings. They also offer culturally appropriate exercise and nutrition classes.

Outcomes*

These grantees have:

- increased the number of people screened for risk factors for cardiovascular disease,
- trained peer educators, and
- increased awareness of the risk factors of cardiovascular disease.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Bois Forte		•			Itasca, Koochiching, and St. Louis
Dar Al-Hijrah Cultural Center	•				Anoka, Hennepin and Ramsey
Fremont Community Health Services	•				Hennepin
Grand Portage Health Service		•			Cook
Minneapolis American Indian Center		•			Dakota, Hennepin and Ramsey
Minnesota International Health Volunteers	•				Hennepin and Ramsey
Olmsted County Public Health Service	•		•		Olmsted
Prairie Island Foundation		•			Goodhue
Park Avenue Family Practices			•		Hennepin
Southeast Asian Ministry			•		Ramsey
Stairstep Foundation	•				Hennepin and Ramsey
TAMS/Children's Hospitals and Clinics	•	•	•	•	Hennepin and Ramsey

Number reached includes other and multi-racial

^includes African born
Grantees in **bold** are working only on cardiovascular disease
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Diabetes

Number of Grantees: 17 **Number of Counties Served:** 20

Number Reached: 11,950 African American^: 6,247 American Indian: 1,348
Asian: 836 Hispanic: 2,574

Summary

Diabetes grantees developed multiple intervention strategies that build on the strengths and assets of their communities. Most of the EHDI grantees are working to prevent the onset of diabetes while a few grantees are working directly with diabetics to better manage their disease. Many grantees use community health workers or parish nurses to make home visits for screenings, education and counseling. One grantee is working with their community promote access to fresh local produce and organic meats and vegetable. They also teach their youth about foods in the traditional diet and how these traditional diets are healthy and naturally prevent diabetes. Cumulatively they reached almost 12,000 people through direct methods of contact including blood glucose screenings, educational classes for self-monitoring of the disease and home visits. In addition, nearly 24,000 people were reached through large events such as health fairs.

Outcomes*

Through these programs grantees have:

- increased the number of community members who were insured and connected to a primary care clinic,
- increased the number of people screened for diabetes, and
- decreased HbA1c levels among those with diabetes.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Anishinaabe Center		•			Becker and Mahnomen
Carondelet LifeCare Ministries				•	Anoka, Dakota, Hennepin, Ramsey, Scott
Centro Campesino				•	Dodge, LeSueur, Mower, Rice, Steele, Waseca
Dar Al-Hijrah Cultural Center	•				Anoka, Hennepin and Ramsey
Fremont Community Health Services	•				Hennepin
Grand Portage Health Service		•			Cook
Lower Sioux Community		•			Lower Sioux Community (Redwood and Renville)
Minneapolis American Indian Center		•			Dakota, Hennepin and Ramsey
Minnesota International Health Volunteers	•				Hennepin and Ramsey
Olmsted County Public Health Service	•		•		Olmsted
Park Avenue Family Practices			•		Hennepin
Prairie Island Foundation		•			Goodhue
Southeast Asian Ministry			•		Ramsey
Stairstep Foundation	•				Hennepin and Ramsey
TAMS/Children's Hospitals and Clinics	•	•	•	•	Hennepin and Ramsey
Upper Sioux Community		•			Upper Sioux Community (Chippewa and Yellow Medicine)
Westside Community Health Services	•	•	•	•	Ramsey

Number reached includes other and multi-racial
^includes African born Grantees in **bold** are working only on diabetes
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Healthy Youth Development

Number of Grantees: 19 **Number of Counties Served:** 15

Number Reached: 12,092 African American^: 8,500 American Indian: 857
Asian: 563 Hispanic: 1,304

Summary

The healthy youth development grantees expose youth to new skills, ideas, contexts and environments that help them plan their futures. They provide peer networks that connect youth with positive role models; offer tutoring and after-school activities; and involve youth community service. Grantees also work with youth to instill a sense of cultural pride and awareness of their heritage. Collectively they served almost 12,000 youth and families through one-one and group services such as counseling and educational classes. The grantees also reached nearly 32,000 Minnesotans through large scale events such as community events. Grantees have increased the number of youth who are abstinent, gotten teen parents to continue their education, and improved knowledge regarding healthy relationships and access to health services.

Outcomes*

Grantees have

- increased the number of youth who are abstinent,
- gotten teen parents to continue their education, and
- improved knowledge regarding healthy relationships and access to health services.

	Target Populations				
Grantee	**AA**	**AI**	**As**	**Hi**	**Counties/Geographical Region**
Agape House for Mothers	•		•	•	Hennepin, Ramsey and Washington
Annex Teen Clinic	•				Hennepin
Boys and Girls Club of the Twin Cities	•	•	•	•	Dakota, Hennepin and Ramsey
Camphor Foundation	•	•	•	•	Hennepin and Ramsey
Centro				•	Hennepin
Division of Indian Work - HYD		•			Becker, Beltrami, Carlton, Cass, Hennepin and Ramsey
Freeport West	•				Hennepin
La Clinica en Lake				•	Anoka, Dakota, Hennepin and Ramsey
Lao Family Community of Minnesota			•		Ramsey
Lower Sioux Community		•			Lower Sioux Community (Redwood and Renville)
Mille Lacs Reservation		•			Aitkin, Mille Lacs, and Pine
Minneapolis American Indian Center		•			Dakota, Hennepin and Ramsey
Minneapolis Urban League	•	•		•	Hennepin
MN International Health Volunteers	•				Hennepin and Ramsey
Southeast Asian Community Council			•		Hennepin and Ramsey
Stairstep Foundation	•				Hennepin and Ramsey
Summit University Teen Center	•		•	•	Dakota, Hennepin, Ramsey and Washington
TAMS/Children's Hospitals and Clinics	•	•	•	•	Hennepin and Ramsey
West Central Integration Collaborative	•			•	Kandiyohi

Number reached includes other and multi-racial
^includes African born Grantees in **bold** are working only on healthy youth development
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: HIV/AIDS and Sexually Transmitted Infections

Number of Grantees: 8 **Number of Counties Served:** 16

Number Reached: 8,314 African American^: 5,948 American Indian: 330
Asian: 34 Hispanic: 1,140

Summary

Most HIV/AIDS and STI grantees are working to educate community members about HIV/AIDS and STIs. These grantees have trained community health workers and peer educators to raise awareness, provide prevention strategies and testing for HIV/AIDS and STIs. Grantees also work with people who test positive for HIV/AIDS, and help them connect with other resources such as health care, housing and employment. Together grantees have served 8,300 people through various direct contact activities such as group education, individual counseling and service referral. In addition to direct service contact, EHDI grantees have reached 6,800 people through large events such as health fairs. Grantees have documented increased awareness of the HIV/AIDS transmission and prevention.

Outcomes*

Grantees have documented increases in:

- awareness of HIV/AIDS transmission and prevention,
- the number who intend to practice safe sex and
- numbers tested for HIV/AIDS.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Agape House for Mothers	•		•	•	Hennepin, Ramsey and Washington
African American AIDS Task Force	•	•	•	•	Anoka, Hennepin, Ramsey and Washington
Centro Campesino				•	Dodge, LeSueur, Mower, Rice, Steele and Waseca
Council on Crime and Justice	•	•		•	Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott and Washington
Lower Sioux Community	•				Lower Sioux Community (Redwood and Renville)
Minneapolis Urban League	•	•		•	Hennepin
Minnesota International Health Volunteers	•				Hennepin and Ramsey
Turning Point	•				Hennepin and Ramsey

Number reached includes other and multi-racial
^includes African born
Grantees in **bold** are working only on HIV/AIDS and STIs
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Adult and Childhood Immunizations

Number of Grantees: 8 **Number of Counties Served:** 18

Number Reached: 3,147 African American^: 2,111 American Indian: 277
Asian: 203 Hispanic: 478

Summary

3,100 people were provided immunization services by EHDI grantees in 2007. The services included education on the importance of childhood and adult immunizations and immunization clinics. Another 36,000 people were reached through broad-based education and media campaigns. EHDI grantees are working to ensure both children and at-risk adults receive recommended immunizations. In some cases, this meant helping participants obtain insurance through which they are eligible for immunizations. Most immunization grantees are also working in other health priority areas such as infant mortality. Almost all have targeted their efforts towards immigrant groups.

Outcomes*

Grantees were able to document increases in:

- the number of immunizations administered, and
- the importance of immunizations and for accurate record keeping about immunizations.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Center for Asian and Pacific Islanders	•		•		Hennepin and Ramsey
Centro Campesino				•	Dodge, LeSueur, Mower, Rice, Steele and Waseca
Council on Crime and Justice	•	•		•	Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott and Washington
Dar Al-Hijrah Cultural Center	•				Anoka, Hennepin and Ramsey
Mille Lacs Reservation		•			Aitkin, Mille Lacs, and Pine
Olmsted County Public Health Service	•		•		Olmsted
Stairstep Foundation	•				Hennepin and Ramsey
The Storefront Group	•				Dakota and Hennepin

Number reached includes other and multi-racial
^includes African born
Grantees in **bold** are working only on immunization
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Infant Mortality

Number of Grantees: 10 **Number of Counties Served:** 12

Number Reached: 2,804 African American^: 392 American Indian: 1,165
Asian: 522 Hispanic: 695

Summary

Of the 10 grants focused on reducing infant mortality, six were working in American Indian communities--both urban and tribal. Three grantees work in the urban Latino community, two work in the urban African American community and one targets the urban Hmong community. Grantees target behaviors including utilization of prenatal care, breast feeding, and substance use among pregnant women. Two specifically worked to increase access to and utilization of doula services. These grantees provided direct services to 2,800 women, infants and families that were geared toward reducing infant mortality. They also reached nearly 18,000 community members through large scale events such as health fairs. Grantees documented a decrease in the percentage of infants born low birth weight, increased the percent who receive early prenatal care and increased the percent who breastfed their infants.

Outcomes*

Grantees documented:

- a decrease in the percentage of infants born low birth weight,
- an increase the percent who receive early prenatal care and
- an increase the percent who breastfed their infants.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
American Indian Family Collaborative	•	•	•	•	Ramsey
Cass County /Leech Lake Reservation		•			Beltrami, Cass, Hubbard, and Itasca
Centro – Healthy Youth Development				•	Hennepin
Centro – Infant Mortality				•	Hennepin
Division of Indian Work - Doula		•			Hennepin
Fond du Lac Tribe		•			Carlton and St. Louis
Mille Lacs Reservation		•			Aitkin, Mille Lacs, and Pine
Park Avenue Family Practice			•		Hennepin
Red Lake Comprehensive Health Svcs		•			Beltrami and Clearwater
Stairstep Foundation	•				Hennepin and Ramsey

Number reached includes other and multi-racial
^includes African born
Grantees in **bold** are working only on healthy youth development
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

2007 EHDI Snapshot: Violence and Unintentional Injury

Number of Grantees: 9

Number of Counties Served: 32

Number Reached: 3,669

African American^:	1,254	American Indian:	873
Asian:	482	Hispanic:	439

Summary

Of the nine grantees working to reduce unintentional injury and violence in their communities, four work in the metro area, two in greater Minnesota and three on tribal reservations. These nine grantees served almost 3,700 people through one-to-one counseling or in peer groups. In addition, grantees reached another 6,700 people through large events such as health fairs. Five grantees promote awareness and knowledge about domestic violence in the community. Four grantees work to reduce behaviors associated with violence towards self or others, and two more grantees are working on changing community norms around violence. Given the breadth of this area, the strategies and foci of the grantees are very different.

Outcomes*

Grantees have:

- increased the awareness of domestic violence,
- reduced the number youth engaging in consequential behaviors at school, and
- decreased the recidivism rate of domestic abuse charges.

Grantee	Target Populations AA	AI	As	Hi	Counties/Geographical Region
Centro Campesino				•	Dodge, LeSueur, Mower, Rice, Steele, Waseca
Council on Crime and Justice	•	•		•	Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott and Washington
Family and Children's Service	•				Hennepin and Ramsey
Hmong American Partnership			•		Ramsey
Leech Lake Band of Ojibwe		•			Beltrami, Cass, Hubbard, and Itasca
Lower Sioux Community		•			Lower Sioux Community (Redwood and Renville)
United Hospital Foundation	•	•	•	•	Ramsey
West Central Integration Collaborative	•			•	Kandiyohi
White Earth Tribal Mental Health		•			Becker, Beltrami, Cass, Clay, Clearwater, Hennepin, Hubbard, Itasca, Mahnomen, Mille Lacs, Norman, Pennington, Polk, Red Lake, Sherburne, and Wadena

Number reached includes other and multi-racial
^includes African born
Grantees in **bold** are working only on violence and unintentional injury
AA=African American/African; AI=American Indian; As=Asian; Hi=Hispanic
*For examples of grantee specific outcomes, go to Appendix B

Grantee Project Descriptions

African American AIDS Task Force

EHDI Program: Eliminating Health Disparities Initiative

Contact Person: Gwendolyn Velez
Phone: 612-825-1137

Address: 310 East 38th Street, Suite 209
Minneapolis, MN 55409

The EHDI Program is a collaboration between AAATF and the HCMC medical staff at the Medicine Walk-In and Orientation Clinics for purposes of conducting HIV/STI screening; Health Education/Risk Reduction; and HIV Counseling, Testing and Referrals. The HCMC medical staff performs the HIV tests and STI tests, generally after a screening of patients from AAATF staff. AAATF staff refer patients who are considered to be at risk for HIV or STIs to HCMC medical staff for tests. AAATF staff conducts a risk assessment, HIV pre & post test counseling, STI and HIV education including referrals. In addition, the clients are informed about other services that are provided by AAATF and/or within HCMC. The seropositive clients are connected to appropriate support networks, services and medical care, and the sero negative clients have follow-up sessions in order to encourage risk reduction and high risk behavior change. Under the Outreach component of the Program, AAATF is continuously establishing relationships with community leaders in the African American and African born communities. In addition, community health education programs are undertaken through cultural and community group functions in the Metro Area, both within the African American and African immigrant communities. In 2008 the goals is to further these community building/mobilizing efforts and estabilish a POL program within the African Born communities.

Agape House for Mothers

EHDI Program: Agape House for Mothers, Inc.

Contact Person: Roberta D. Barnes
Phone: 651-221-9146

Address: 1002 Blair Avenue
St. Paul, MN 55104

The intentions of our Agape HYD/EHDI program are that teens and families have a greater awareness, knowledge and appreciation of self-worth and a greater belief in their life potential that will help with making self-directed positive decisions. To understand and utilize the rich and powerful contributions that members of their families, communities, and churches can contribute to the reinforcement and support in living a values-centered life. The impact of the program: • Understands and has the ability to quantify and measure the risk factors that contributes to teen pregnancy and the spread of sexually transmitted infections including HIV/AIDS. • Understands and know the life-altering impact of early and unintended pregnancy, sexually transmitted infections such as Herpes, Genital Warts, or a diagnosis of HIV or AIDS. • Know where to go to receive guidance, support and counseling regarding issues around sex, pregnancy, and sexually transmitted infections including HIV/AIDS, seek help as needed. • Know how to employ and practices various techniques of refusal and abstinence. • Prepared and know how to avoid situations and circumstances that can lead to early sexual involvement, unintended pregnancy and sexually transmitted infections including HIV/AIDS. • Sexually active teens, know the facts, techniques and their limitations, and where to access resources regarding the proper use of contraceptives as a "protective wall" against pregnancy and sexually transmitted infections including HIV/AIDS. • Develop and implementation of a post-training plan to assume the ongoing accountability, responsibility, and sustainability of practices and protection against pregnancy and sexually transmitted infections including HIV/AIDS. • Determined and diligently work toward obtaining a high quality education, primary and post-secondary. • Utilization of programs and services of community organizations as a means of becoming better acquainted with and more actively involved in positive activities. • Living a wholesome-productive life and valuable contributors within their perspective communities. • Leaders within their perspective communities that influence and shape the norm.

American Indian Family Collaborative

EHDI Program: Community Doula Program

Contact Person: Nicole Wocelka
Phone: 651.793.3803

Address: 579 Wells Street
St. Paul, MN 55130

The Community Doula program was created to train women in communities of color to serve as doulas. Doula is a Greek word meaning "woman who serves." The Community Doula Program provides culturally specific labor support to women at greatest risk for poor birth outcomes throughout their pregnancy, labor, and birth in an effort to reduce infant mortality in the American Indian, African American, African Immigrant, Hispanic/Latino, and Asian communities of Ramsey County. The Program has four desired outcomes: healthy birth outcomes, healthy prenatal care, increase awareness of parenting role and health education, and improved service integration.

Anishinaabe Center

EHDI Program: Defeat Diabetes

Contact Person: Leslie Fain
Phone: 218-935-2550

Address: 322 Main St.
Callaway, MN 56521

To make native people and others in our area aware of diabetes, what it is, what it does, how we can prevent it and how to deal with it for those who have it. To make aware that there are traditional and conventional ways of preventing and treating this disease. It is intended to reach all age groups by using elders to teach the younger.

Annex Teen Clinic

EHDI Program: REACH

Contact Person: Brian Russ
Phone: 763-533-1316

Address: 4915 42nd Avenue North
Robbinsdale, MN 55422

The primary, long-term goal of the REACH collaborative is to reduce unintended adolescent pregnancies among African American adolescents in North Minneapolis. As a collaborative we have approached the prevention of unintended adolescent pregnancies with a comprehensive and research-based strategy. One of the most significant accomplishments of our collaborative is bringing together the individual efforts of each of our partners and integrating them for more effective programming. The most current research into best practices for teen pregnancy prevention is making clear that our best hope lies in the integration of youth development programming, comprehensive sexuality education and improved access to clinical services. Our collaborative is doing just that.

Bois Forte Band of Chippewa

EHDI Program: Bois Forte Cardiovascular Program

Contact Person: Kristen Strong
Phone: 218-757-0087

Address: 13071 Nett Lake Road
Nett Lake, MN 55771

The Bois Forte Cardiovascular program focuses on offering activities to the Bois Forte Band members and reservation community members who have or are at risk for cardiovascular disease. The activities are carefully designed to increase the Bois Forte community's awareness of cardiovascular disease and its risk factors and to aide in behavioral change. The Cardiovascular program currently provides cardiovascular health education, with an emphasis on prevention. The program also provides screenings that include blood pressure, blood sugar, and body composition analysis. Weight loss/management exercise programs have been a recent addition to the program. The Cardiovascular program works with four specific age groups: 1) youth (kindergarten – sixth grades); 2) secondary youth; 3) adults; 4) elders. The long term outcome of the Bois Forte Cardiovascular Program is that the Bois Forte community will have a reduced risk of cardiovascular disease.

Bois Forte Reservation

EHDI Program:

Bois Forte Breast & Cervical Cancer program contracted with a female Family Nurse Practitioner who is Native American to provide Women's Health Clinics 2-4 days per month at Nett Lake and Vermilion. The FNP was to do paps and referrals for mammograms for

Boys and Girls Club of the Twin Cities

EHDI Program: SMART Moves

Contact Person: Eric Bonley
Phone: 612-435-1914

Address: 6500 Nicollet Avenue South, Suite 201
Minneapolis, MN 55423-1674

SMART Moves is a series of prevention programs for members ages 6-15. There are several programs that make up the SMART Moves Curriculum: SMART Start, SMART Kids, SMART Girls, Street SMART, and SMART Teens. All of these programs are run throughout the year at different intervals. SMART Moves is part of the Boys & Girls Club SMART Moves Prevention Program. SMART Moves is age-appropriate prevention education, designed to help young people avoid alcohol, drug and tobacco use as well as sexual activity. For example, during one week, members study facts about drug use and then follow up the next week with a Jeopardy game to test mastery of the facts. Members are evaluated with pre and posttests.

Camphor Foundation

EHDI Program: Camphor Foundation

Contact Person: Gloria Roach Thomas
Phone: 651 224 0341

Address: 585 Fuller Avenue
St. Paul, MN 55103

The UJIMA Healthy Youth Development Project is a five-year old faith-based community collaboration that works to prevent teen pregnancy and foster healthy behaviors and lifestyles among at-risk inner-city African American youth. We have found that our teens are bombarded with sexuality and sexual issues on a regular daily basis. Many times they have no one to talk with and express and validate their feelings and concerns about sexuality and other normal adolescent concerns. We are able to provide, not only education and information, but also a safe, nurturing protective environment where teens can come and experience healthy interactions with other teens and adults. The intentionality of creating such a support system helps teens to build positive and supportive friendships with their peers as well as adults. Increasingly, we find that both adults and teens in our area lack consistency and structure. It is very gratifying to be able to fulfill that need, even in small measure, and know that we are helping strengthen families while removing teens from environments that foster inappropriate behavior and destructive life outcomes. We offer an opportunity for program participants to talk about these very sensitive issues in a safe and protective environment. We support and reinforce our teens as they deal with the problem of peer pressure. We provide them with appropriate language and information to understand the consequences of reckless and risky behavior, including pregnancy, sexually transmitted disease, and dating violence and sexual violence. To date, there have been no unplanned pregnancies among UJIMA program teens.

Carondelet LifeCare Ministries

EHDI Program: Carondelet LifeCare Ministries / St. Mary's Health Clinics

Contact Person: Barbara L. Dickie
Phone: 651-690-7021

Address: 1884 Randolph Avenue
St. Paul, MN 55105

St. Mary's Health Clinics have established our Eliminating Health Disparities Initiative (EHDI) program to help reduce diabetes and breast and cervical cancer disparities in the adult Latino population by collaborating with Latino parishes to provide culturally appropriate health care information, health screening, and education. In addition, St. Mary's Health Clinics have increased access to health care services for Latinos through advocacy, referrals, and actual scheduling of health care services. By partnering with Latino congregations, St. Mary's Health Clinics has reached Latinos who currently do not have access to health care and information about cancer screening and diabetes. St. Mary's Health Clinics has used EHDI grant funds to accomplish the following: 1)Promote early diagnosis of diabetes through education and screening activities. 2)Promote breast and cervical cancer screenings. 3)Provide access to Pap smears and mammograms. 4)Provide access to necessary follow-up treatment and services for positive Pap smear and mammogram results. 5)Provide culturally and linguistically appropriate basic health care information. 6)Provide culturally and linguistically appropriate one-to-one diabetes education and assistance with self-management of the disease. 7)Provide access to ongoing treatment, medicines and supplies for uninsured diabetic patients.

Cass County /Leech Lake Reservation

EHDI Program: EHDI/MCH Program Or Cass County/Leech Lake Reservation

Contact Person: Emily Bakken
Phone: 218-335-4500

Address: 6530 Highway 2 NW
Cass Lake, MN 56633

Decrease the infant mortality rate on the Leech Lake Reservation.

Center for Asian and Pacific Islanders (CAPI)

EHDI Program: Immunizations

Contact Person: Robinson Cook
Phone: 612-721-0122

Address: 3702 East Lake Street, # 200
Minneapolis, MN 55406

Our EHDI Program is intended to educate the targeted communities populations to better understand their health and preventions; to help them navigate the health care system in this country; and to help them understand the importance of immunizations. Often times our clients think that immunizations are for children only and that prevention is not that important.

Centro

EHDI Program: Healthy Youth Development & Teen Pregnancy/Infant Mortality Prevention

Contact Person: Tyrone Guzman
Phone: 612-874-1412

Address: 1915 Chicago Ave S
Minneapolis, MN 55404

Increase healthy communication between parents and teens. Educate parents and teens about sex and sexuality. Assist youth in developing personal goals that: a)promote healthy lifestyle choices, b)increase future educational/career opportunities, c)empower teens to delay becoming sexually active and/or prevent pregnancy and STDs, d)increase knowledge on infant mortality prevention methods; e) increase family communications and f) improve Latino teen self-esteem / cultural pride.

Centro Campesino

EHDI Program: Centro Campesino

Contact Person: Gloria M. Contreras
Phone: 507-446-9599

Address: 216 Oak North Ave
Owatonna, MN 55060

The focus of Centro Campesino's Promotores de Salud Project is on empowering migrant agricultural workers and rural Latinos in south central Minnesota to become leaders in the promotion of community physical, economic and social health and towards eliminating health disparities between Latinos and whites in Minnesota. This includes building health-based leadership within migrant agricultural worker and rural Latino communities in south central Minnesota and on decreasing the health disparities faced by these communities. Specific areas of focus are improved access to health services and health information; increased adult farmworker and rural Latino access to tetanus vaccine; increased early detection and treatment of breast and cervical cancer; diabetes prevention and improved diet and lifestyle of Latinos with type 2 diabetes; and HIV/AIDS/STD prevention within the migrant agricultural worker and rural Latino communities of this region.

Centro-Infant Mortality

EHDI Program: Maternal Health & Infant Mortality Prevention

Contact Person: Tyrone Guzman
Phone: 612-874-1412

Address: 1915 Chicago Avenue
Minneapolis, MN 55404

The EHDI Program at Centro works to improve birth and health outcomes of pregnant and post-partum Latino women and their newborns. Centro's Maternal and Child Health Program will serve 1,000 low-income pregnant Latina women, ages 14-30, in Minneapolis annually to promote healthy live births.

Council on Crime and Justice

EHDI Program: Council on Crime and Justice - Healthy Educational Lifestyles Project (HELP)

Contact Person: Pamela G. Alexander
Phone: 612-353-3036

Address: 822 South 3rd Street Suite 100
Minneapolis, MN 55415

The focus of HELP is reducing the rate of HIV, Hepatitis C, and other STDs among offenders and ex-offenders of color in Minnesota. The project also seeks to increase the capacity of this population to advocate for their own health care, and increase pro-activeness in seeking health resources. In this general health education, the project emphasizes immunizations and activities that prevent infant mortality, and violence prevention.

Dar Al-Hijrah Cultural Center

EHDI Program: Dar Al-Hijrah Cultural Center

Contact Person: Abdulahi Warsame
Phone: 612-227-3933

Address: 504 Cedar Ave South
Minneapolis, MN 55454

Dar Al-Hijrah EHDI Program is intended to provide culturally and linguistically appropriate health education through community outreach programs to the Somali community. Dar Al-Hijrah has established a health-screening center which is staffed by Somali professionals. The main focus of Dar Al-Hijrah services is on these health disparities issues: Immunization, Cardiovascular Diseases, and Diabetes.

Division of Indian Work

EHDI Program: Strengthening Family Circles- Doula - Women of Traditional Birthing

Contact Person: Noya Woodrich
Phone: 612-722-8722

Address: 1001 East Lake St.
Minneapolis, MN 55407-0509

DIW started the Doula program in 2002 as an approach to addressing the problem of the high infant mortality rate in the American Indian community. Through education, training, and outreach, the Doula program is assisting American Indian pregnant women on understanding the role of a Doula, the birth process, receiving services such as developing a birth plan, having a doula attend the birth, and offer intensive support before, during, and after. The Doula program recruits and trains women interested in becoming a Doula and matches pregnant clients and their families with a trained Doula. The Doula project strengthens the emotional health and self-care empowerment for the women in this especially critical time of parent and infant relationship and bonding, direct indicators of positive future health and development of the child and families.

Division of Indian Work

EHDI Program: Youth Leadership Development Program-Live It!

Contact Person: Noya Woodrich
Phone: 612-722-8722

Address: 1001 East Lake Street
Minneapolis, MN 55407

Our EHDI program's long-term goal is to decrease the teen pregnancy rates among American Indian youth. Our program does this using two versions of a culturally based curriculum that we developed. The versions are designed for American Indian adolescents and adults such as parents, grandparents or professionals who work with them. Our short-term goals are to increase the knowledge of program participants as to what contributes to teen pregnancy and to increase their knowledge of how to prevent pregnancy. Program participants will also have an increased understanding of the issue of teen pregnancy from both a cultural/ traditional and a contemporary point of view. Intermediate goals of our program include increasing healthy youth behaviors such as increased cultural identity, increased self-esteem, and improved ability to set goals. For youth participants, we aim to increase their knowledge of what it means to have a child, increase their decision making skills re: whether or not to be sexually active, increase their decision making skills re: whether or not to use birth control pills. For adult participants, our goals include increasing their knowledge about how to talk to their children about sexuality, decision making, and birth control. We also want to increase their knowledge of methods available to them about how to talk to their kids.

Family and Children's Service

EHDI Program: 100 Men Take a Stand

Contact Person: Jeannette Raymond
Phone: 612.728.2093

Address: 4123 East Lake Street
Minneapolis, MN 55407

Family & Children's Service (FCS) will engage African American men in the prevention of domestic violence in Minneapolis and other metro African American communities. Ultimately, we are working to reduce deaths and injuries due to family violence in the African American community. But the intermediate changes we will create are as follows: Men increase the number of actions they take to prevent family violence; Men increase their knowledge of domestic violence services in the community; Men adopt norms that discourage domestic violence and promote domestic peace; and men increase their understanding of the personal impact of experience with family violence.

Family Medical Center/La Clinica en Lake
EHDI Program: Aqui Para Ti/ Here For You

Contact Person: Bibiana Garzon
Phone: 612-545-9242

Address: 2700 East Lake Street
Minneapolis, MN 55406

Aquí Para Ti / Here For You (APT) is a multidisciplinary, bicultural/bilingual youth program housed at Hennepin East Lake Clinic, one of Hennepin County Medical Center community-based outpatient clinics.
APT serves as a patient-centered medical home for Latino families going through the transition of adolescence. The program targets Latino youth ages 11 to 24 and their families. Through an intake questionnaire, APT team identifies protective and risk factors to determine the need level of youth and define a plan for prevention and intervention. APT offers medical services, health education, mental health assessments, counseling, education for parents, coordination of services and referrals to community resources as needed. The program team includes a family practice physician, health educator, social worker, and a program coordinator. All staff understands the language, needs and culture of their clients, which helps to create a comfortable and welcoming environment for youth and families.

Fond du Lac Tribe
EHDI Program: Fond du Lac Public Health Nursing

Contact Person: Deb Smith RN PHN MSN
Phone: 218-878-2104

Address: 927 Trettel Lane
Cloquet, MN 55720

Fond du Lac's EHDI Program intends to reduce infant mortality through the application of various strategies. Focuses of the EHDI Program include strategies to increase breastfeeding initiation and duration.

Freeport West
EHDI Program: Project SOLO

Contact Person: Mark McNamer
Phone: 612-252-2768

Address: 2222 Park Ave
Minneapolis, MN 55404

Freeport's program is intended for the development of a culturally-specific and culturally-based circle of care for African-American adolescents who are at risk of pregnancy, pregnant or parenting. Freeport provides both concrete skill development around issues vital to these young people, such as securing basic needs around shelter, education and /or employment, and cultural support and teachings to help them take responsibility for their own decision-making, choices, and quality of life. The work with youth is based upon our natural recognition of the interplay of health, culture and community. Freeport draws from the strengths of cultural heritage as a way to teach, guide and inform behaviors, attitudes, and lifestyles. Our intent is to reduce significantly the incidence of too-early pregnancy by providing young women/men of African descent the cultural support and skill, knowledge and attitudes—particularly around self-perception—for them to make positive lifestyle choices.

Fremont Community Health Services

EHDI Program: Fremont Community Health Services, Inc.

Contact Person: Sandra Levine
Phone: 612-287-2425

Address: 3300 Fremont Avenue North
Minneapolis, MN 55412

The Stroke Prevention Project's goal is to increase education, understanding and awareness of cardiovascular disease (including cardiac, stroke, peripheral vascular disease) and diabetes in the African American adult community on the Northside of Minneapolis and into the NW suburbs. The project offers free stroke risk screenings with the intention of diagnosing high blood pressure, hyperlipidemia, and diabetes in participants who are not aware they have the conditions or the risk factors. Full screenings are performed by a licensed nurse and one-on-one education and referrals are made if the participant does not have a provider. If the participant does have a provider, we encourage them to make an appointment or at the very least call that provider. The Nurse Coordinator and peer educators have community resource information and other clinic information to which they refer participants.

Grand Portage Health Service

EHDI Program: Grand Portage Health Service

Contact Person: Wayne Raske
Phone: 218.475.2235

Address: 62 Upper Road
Grand Portage, MN 55605

The long term goal for the Grand Portage EHDI is framed in a wellness model. Through proactive outreach and increased education , the people of Grand Portage would learn about health care resources and self-care resulting in better health. The long term outcome specifically states, "Community members live longer, healthier lives with decreased incidence of cardiovascular disease." We hope to achieve this goal by building relationships with community members and programs on the reservation so that a consistent message is presented to people regarding health and wellness.

Hmong American Partnership

EHDI Program: We Are The Peace We Need

Contact Person: Pa, Chia Vue
Phone: 651/495-9160

Address: 1075 Arcade Street
St. Paul, MN 55106

The partners in the We Are the Peace We Need, We Are Our Own Solutions are committed to continuing a multi-strategy, collaborative effort in the Hmong community to address health disparities in the area of "Injuries and Death Resulting from Violence". This initiative focus' on both violence against self and others. We are committed to a three pronged approach working to create a comprehensive response to this public health crisis. Our activities work to directly affect individuals in the Hmong community through public education and engagement; to affect providers in a way that builds their capacity to effectively serve the community; and to become active in coalitions and systems coordination so as to change policies that affect outcomes for the community. We employ a public health strategy using public radio, the Hmoob Teen Magazine and community dialogues to identify and strengthen cultural protective factors; promote awareness that violence is a preventable public health problem; increase the number of Hmong who seek out and receive appropriate mental health services; and work to foster more effective clinical and mental health practices.

Indian Health Board of Minneapolis
EHDI Program: American Indian Community Wellness Project

Contact Person: Cheryl Secola
Phone: 612 722 8722

Address: 1001 East Lake Street
Minneapolis, MN 55407

The American Indian Community Wellness Project(AIWCP)is committed to increasing awareness & prevention of breast, cervical and colon cancer through education, support and tradtional Native health and healing. AICWP has two components: 1) Home visits cancer prevention educational sessions with participating families & community groups. 2) Increase Native traditional healing and awareness in the American Indian community of Minneapolis and St. Paul.

Lao Family Community of Minnesota
EHDI Program: Kev Xaiv (Making Choices)

Contact Person: Vern Xiong
Phone: 651-209-6808

Address: 320 West University Avenue
St Paul, MN 55103

Kev Xaiv (Making Choices) is a teen pregnancy prevention program, based in and specific to the Twin Cities Hmong community. Kev Xaiv has two components that address two areas of primary concern in the Hmong community. The Healthy Hmong Teens Program provides abstinence-based pregnancy prevention education for Hmong teens 12-15 years old who may or may not be sexually active but have not become pregnant nor fathered a child. The Young Parents Program provides services designed to prevent repeat pregnancies with young Hmong parents.

Leech Lake Band of Ojibwe
EHDI Program: Anishinaabeg Minosewag

Contact Person: Luanne Koch
Phone: 218.335.4587

Address: 115 Sixth St. NW - Suite E
Cass Lake, MN 56633

Our EHDI program is intended to provide services to residents of the Leech Lake Reservation that support living in balance -- physically, mentally, emotionally, and spiritually. Through one-to-one services, community gatherings and presentations, and collaboration with other agencies, our program seeks to provide education about the problem of suicide and other violence. This includes supporting behavioral change intended to reduce violence.

Lower Sioux Community
EHDI Program:

Provide information to the members about various health concerns. Teaching a positive traditional lifestyle.

Mille Lacs Reservation

EHDI Program: Mille Lacs Band of Ojibwe Public Health Maternal Child Health Program

Contact Person: Lisa Blahosky RN- MCH Coordinator
Phone: 320-532-7459

Address: 17230 Noopiming Drive
Onamia, MN 56359

Our EHDI program is designed to reduce infant mortality. This is accomplished by providing education. We provide client's with packages designed to initiate prenatal care, sleep safety, car seat safety, and safe food handling and preparation. We encourage initiation of breastfeeding through providing education and supplies to get started.Along with assisting client's in ordering breast pumps. The Home Visting Program is centered on prenatal, postpartum education, and well child visits with a focus on age appropriate milestones, feeding, and regular check ups for immunizations. Safety packages are specific to providing supplies for home safety. We are in the process of implementing the Doula Program. We currently have ten trained community members who will be providing prenatal and postparum education along with support to mom through labor and delivery.

Minneapolis American Indian Center

EHDI Program: Minneapolis American Indian Center

Contact Person: LeMoine LaPointe
Phone: 612.879.1744

Address: 1530 East Franklin Avenue
Minneapolis, MN 55404

Healthy Options Program provides and promotes physical fitness opportunities, health education, and youth leadership opportunities for American Indians in the Twin Cities. The EHDI Program is intended to increase the knowledge of youth and adults who particpate in our diverse activities about how to avoid cardivascular disease, diabetes, and teen pregnancies, while infusing Native American perspectives, practices, and culture into contemporary health and youth leadership development.

Minneapolis Urban League

EHDI Program: OOPS - Other Options Program Services

Contact Person: Makeda Norris
Phone: (612) 302-3164

Address: 2100 Plymouth Avenue N
Minneapolis, MN 55411

OOPS provides healthy youth development activities and comprehensive sexuality education services and activities to youth (grades 6-8) who are enrolled in or have recently completed a pregancy prevention curriculum (an 8 module abstinence based program). The objective of the program is to offer youth opportunities to practice the skills and use the tools they learned in the prevention curriculum to avoid risky behaviors (e.g., unprotected sex). By providing these youth with services including educational enrichment, tutoring and homework help; computer instruction and training; theater/drama classes, music classes; visual arts classes; chess; crafts; games field trips to cultural events and amusement parks; and other youth centered recreational and social activities, the program hopes to inculcate a greater sense of self-confidence to make beneficial decisions and engage in healthy relationships with peers and adults.

Minnesota International Health Volunteers

EHDI Program: Somali Health Care Initiative

Contact Person: Andrea Leinberger-Jabari
Phone: (612) 230-3253

Address: 122 West Franklin Avenue, Suite 510
Minneapolis, MN 55404

The goal of our project is to reduce health disparities between the Somali community and the general population of Minnesota in the areas of breast and cervical cancer, cardiovascular disease, diabetes, immunizations, infant mortality, and HIV/AIDS and STDs. For this grant period (06-07) the SHCI has shifted its focus to working more with the Somali youth. We are therefore actively working in the areas of cardiovascular disease, diabetes, breast and cervical cancer, HIV/AIDS, and Healthy Youth Development. Our objectives for 2006-2007 are:
To improve knowledge/attitudes among Somali adults about good nutrition and the importance of daily physical activity.
To increase Somali adults' skills to maintain an active lifestyle and to be able to make health choices about food and nutrition.
To increase the health capacity of the Somali community by identifying and training more Lay Health Workers.
To identify opportunities and barriers to maintaining a healthy lifestyle for Somali people living in the Twin Cities through a Walkability and community inventory project.
To increase utilization of preventative health care services among people in the Somali community.
To engage Somali youth in activities that encourage them to learn more about healthy living (i.e. - nutrition, physical activity, and reproductive health).

Olmsted County Public Health Services

EHDI Program: Olmsted County Eliminating Health Disparities Initiative

Contact Person: Marty Aleman or Miguel Valdez
Phone: 507-328-7500

Address: 2100 Campus Drive SE
Rochester, MN 55904

The primary areas of focus for the 2006-2007 grant activities will be diabetes and cardiovascular disease prevention through community based health promotion activities. We do limited health promotion activities focusing on childhood immunizations with our community partners. Examples include: Health Education classes and presentations to School age youth,Health Fairs, Group Health Promotion Activities, Media Campaigns, and Screening Events.

Park Avenue Family Practice

EHDI Program: Park Avenue Family Practice

Contact Person: Paul Lee
Phone: 612-874-8811

Address: 2707 Nicollet Ave S
Minneapolis, MN 55408

Park Avenue is in the fourth cycle of the Eliminating Health Disparities Initiative Grant and is working on 3 different health areas: diabetes, infant mortality, and cardiovascular disease. Our grant is intended to improve the health of the local Hmong community by promoting health behaviors through culturally-sensitive educational materials such as DVD's and a multimedia website on diabetes prevention, and individual counseling sessions in the clinic focusing in different health topics.

The goal of these programs is to increase abstinent behavior among youth and promote breastfeeding, thereby decreasing the rate of infant mortality; improve medication compliance and lifestyle changes among diabetics and those with CVD risk factors; and to encourage young people at risk for diabetes and CVD to become more educated about the disease process and take preventative measure through multimedia website materials.

Red Lake Comprehensive Health Services

EHDI Program: Red Lake Comprehensive Health Services

Contact Person: Connie Jorgensen, PHN
Phone: 218-679-3316

Address: P. O. Box 249
Red Lake, MN 56671

Identify pre-teens, teenagers and first time mothers early in their pregnancy, and other high risk prenatals. Increase clients' knowledge as it pertains to our high risk program and goal of healthy pregnancies and delivering healthy babies. To help guide families to become their own advocate for themselves and their children for a healthy life. We want to empower, challenge and be a helpful resource to these families and not enable them to be dependent upon us, so they can too become a teacher and mentor to others in the community.

Sisters in Harmony Program

EHDI Program: Sisters in Harmony Program

Contact Person: Judine Pattinson
Phone: 612-543-2567

Address: 1315 Penn Ave North
Minneapolis, MN 55411

The purpose of Sisters in Harmony(SIH)is to provide culturally sensitive support and advocacy for African American/African Women who have breast and cervical cancer. This initiative is overseen by a coalition of 13 health and human service organizations serving women in the community. This coalition helps set directions for SIH, provides oversight, coordinates activities and services, and helps plan to meet the needs of African American women with cancer, and leverage resources available. Through its coordinator, SIH provides culturally appropriate navigation support to African and African American women seeking breast/cervical cancer education and screening and to women with a diagnosis of breast or cervical cancer. A SIH patient navigator helps women with
1.education and support about cancer and its treatments
2.guideing patients through the complex health systems and patient care services.
3.breast and cervical cancer education, screening, diagnosis information, and treatments.
4.follow-up care efforts and clinic appointments.
locating community resources and support services to satisfy needs such as insurance or transportation referrals.
5.encourage women to become an active partner in their overall health and well-being.

Southeast Asian Community Council

EHDI Program: Teen Pregnancy Prevention

Contact Person: Yia Lee
Phone: 612-521-4859

Address: 1827 44th Avenue North
Minneapolis, MN 55412

Our program intends to decrease the teenage pregnancy rates and increase awareness of STD, STI, and HIV/AIDS issues within the Southeast Asian community. Through programming that will engage youths in productive activities as well as teach them the consequences of unprotected sexual activities; which include early pregnancy as well as STD, STI, and HIV/AIDS. In turn these youths go out into the community to teach other youths about early teen pregnancy, STD, STI, and HIV/AIDS.

Southeast Asian Ministry
EHDI Program: Parish Nurse Program

Contact Person: Jennifer Krueger
Phone: 651-293-1261

Address: 105 W. University Ave.
St. Paul, MN 55103

The purpose of the Parish Nurse Program is to educate members of the Cambodian, Hmong and Burmese communities about health care - prevention, management of disease and how to access the health care system. Most Southeast Asians came to the United States with a very different understanding of health care from what they experience here. The parish nurses work with them so that they can understand health issues, manage their health and access appropriate care. In particular SeAM is addressing cardiovascular disease and diabetes. For Cambodians, Hmong and Burmese/KaRen in their homelands, exercise was not an option - it was part of everyday life. Healthy food was a way of life. Now there is a need for education about diet and the necessity for physical exercise and what constitutes a healthy lifestyle, especially in relationship to cardiovascular disease and diabetes. Also, we believe that children, who attend with parents and grandparents, are also learning the importance of exercise and nutrition.

Stairstep Foundation
EHDI Program: Stairstep Foundation

Contact Person: Helen Jackson Lockett-El
Phone: 612 521-3110

Address: 1404 - 14th Avenue North
Minneapolis, MN 55411

The Stairstep Foundation Health Initiative "There Is A Balm" is a unique model that uses the community of faith to raise awareness, increase collaboration, and build capacity while empowering congregations and individuals to take charge of their health.

Summit University Teen Center
EHDI Program: Teens Choosing Healthy Options Programs and Services

Contact Person: Jim Robinson
Phone: 651-644-3311

Address: 1063 Iglehart Ave. West
St. Paul, MN 55104

TC-HOPS is a culturally specific parenting and pregnancy prevention program, offering teen parents developmental support designed to help build their competency and confidence as new parents. The program provides age-appropriate parenting education and opportunities in the following areas: Comprehensive adolescent pregnancy prevention education to avoid subsequent teen births or pregnancies; adequate programming and services to prepare and assist young parents in developing parenting skills; encourage family activities that enhance parent/child social development; and increase knowledge and understanding regarding sexual and preventative health. TC-HOPS reinforces to teens that as parents, they are responsible for the health, safety, and well-being of their children. Participants are taught that as the primary protector and provider for their children they must adequately be prepared to meet the challenges of parenthood.

TAMS / Children's Hospitals and Clinics
EHDI Program: TAMS - Teenage Medical Service

Contact Person: Emily Scribner-O'Pray
Phone: 612-813-6844

Address: 2425 Chicago Avenue South
Minneapolis, MN 55404

Our program is multi-faceted: Soulful living (CVD and Diabetes) is intended to promote healthy nutrition and physical activity for African American women and girls in a supportive culturally responsive framework. Latino youth development (Healthy Youth Development) is intended to help Latino youth develop to their fullest potential by promoting healthy relationships, communication skills, developing Latino youth role models and ambassadors and supporting only responsible sexual activity.

The Storefront Group
EHDI Program: Bridge to Success

Contact Person: Amin Mohamed
Phone: 612-798-8164

Address: 6425 Nicollet Ave South
Richfield, MN 55423

Bridges to Success is specially designed to educate Somali parents about the importance of immunization and record keeping. The program also bridge between schools and Somali families through collaboration with school nurses to insure school age children are fully immunized. In addition, Bridge to Success program provides assistance and information to families to be able to navigate in the complicated health care system.

Turning Point
EHDI Program: Tuning Point's EHDI-HIV Awareness Program

Contact Person: Woodrow Jefferson
Phone: 612-520-9190

Address: 1500 Golden Valley Rd
Minneapolis, MN 55411

Our program is intended to increase the awareness of HIV/AIDS in the African American community, to change the attitudes toward safer sex and condom usage and to encourage the community to "know their status" through HIV/AIDS testing. In promoting awareness about HIV/AIDS, we are hoping to see individuals change risky behaviors and live a safer, healthier lifestyle, therefore lowering the transmission risks within this population.

United Hospital Foundation

EHDI Program: Partners for Violence Prevention/United Hospital Foundation

Contact Person: Anita Berg
Phone: 651-241-8532

Address: 340 Walnut Street
St. Paul, MN 55102

Partners for Violence Prevention's (PVP's) EHDI program is intended to reduce the impact and incidence of violence within the community (with an emphasis on the cultures affected by health disparities) by working in two main areas: Family Violence Prevention with a focus on health care - Working within the health care and social service areas, PVP seeks to educate professionals about family violence and establish mechanisms for these workers to intervene and provide culturally and victim sensitive support and resources to victims of violence. PVP also provides an educational component offered to childcare providers, early childhood educators, school and social service staff called "Understanding Domestic Violence and Its Impact on Children". Community Violence Prevention with a focus on children - Through community education and awareness, collaboration and the provision of resources to schools and community agencies, PVP addresses the public health strategy of primary prevention, addressing violence before it occurs, which is best accomplished by working with children. This program area includes the West 7th Family Center, which focuses on early childhood education. Family center staff provide an animal assisted therapy program to three area battered women's shelters. Also in the Community Violence Prevention area is the EastSide Peacemakers, a network of agencies dedicated to violence prevention on the EastSide of St. Paul.

Upper Sioux Community

EHDI Program: Upper Sioux Community EHDI Program

Contact Person: Audrey Fuller
Phone: 612-309-5708

Address: P.O. Box 147
Granite Falls, MN 56241

The Upper Sioux Community (USC) utilizes most of the Eliminating Health Disparities Initiative (EHDI) funds to develop and improve health infrastructure and systems within the USC health services department. Funds have also been used to support coalition-building between the health services department and local and tribal health organizations and individuals. Finally, EHDI funds have been used to support health-related events for Upper Sioux Community members.

Vietnamese Social Services of Minnesota

EHDI Program: Breast and Cervical Cancer Education Project

Contact Person: Marie Tran
Phone: 651-917-2945

Address: 1159 University Ave, Suite100
St. Paul, MN 55104

Vietnamese Social Services Breast and Cervical Cancer Education and Screening Project addresses the Breast and Cervical Cancer priority health area. The rate of cervical cancer among Vietnamese women is many times higher than the rate in the general population. We are committed to reducing the incidence of cervical and breast cancer among Vietnamese women by increasing the participation of Vietnamese women in cervical and breast cancer screening.

West Central Integration Collaborative

EHDI Program: Healthy Youth Tour

Contact Person: Idalia Leuze
Phone: 320-231-8571

Address: 611 SW 5th St. Room# 354
Willmar, MN 56201

The project's long term goal is to prevent unwanted health issues such as pregnancy, obesity, and other health problems directed towards those who participate in the program. Participants are members of racial/cultural groups with disparately high levels of pregnancy rates, obesity, and other health disorders. To do this, the project seeks to build knowledge, promote positive attitudes and behaviors related to healthy living (diet and lifestyle) as well as to build other factors and assets among youth that will contribute to positive development and prevent a range of risk behaviors. Lastly, we seek to make changes about violence within the communities our youth live in and promote anti-violence behavior and coping mechanisms to deal with escalated situations. We also want to have a youth led awareness program that informs the community about the issue of parental domestic violence.

Westside Community Health Services

EHDI Program: West Side Community Health Services

Contact Person: Gail Kelly
Phone: 651-602-7542

Address: 153 Cesar Chavez Street
Saint Paul, MN 55107

The proposed project is designed to reduce health disparities for Diabetes Mellitus between Latinos and Hmong and whites in the Minneapolis/St. Paul metropolitan area. Activities will include the following: • Provide 1:1 visits at WSCHS clinics that offer comprehensive health care. • Provide diabetes classes and group visits at WSCHS' main clinic, La Clinica en Lake, and East Side Family Clinic. • Develop and disseminate culturally- and linguistically-appropriate peer education and community health education materials. • Provide in-home health education to diabetic patients and family members at risk of becoming diabetic. • Conduct community health interventions in Hmong and Latino organizations to educate specific groups about diabetes and the program. • Conduct a media campaign to increase awareness in the Hmong and Latino communities. • Collect and analyze data about rates, diabetes complications, and effectiveness of project interventions. • Provide fitness activities for diabetic patients and WSCHS staff.

White Earth Tribal Mental Health

EHDI Program: White Earth Tribal Mental Health

Contact Person: Jim Schmitt and JoAnne Riegert
Phone: 218-983-3285

Address: P.O. Box 300
Whte Earth, MN 56591

In short term, there would be an increase in community awareness of the program and the problems exsisting on the Reservation. A decrease in acceptance of dysfunctional behavior as the norm would also be realized. More program inter-connectedness would also become a reality in the short-term as programs work together to decrease violence and unintentional injuries on the White Earth Reservation and surrounding communities. Long term, a change in families becoming healthier and staying together would be realized with a successful program. This will be accomplished by a decrease in domestic violence among other behaviors.

Appendix B: Selected Grantee Outcomes by Health Area

Breast and Cervical Cancer

Carondelet LifeCare Ministries

Outcome: Latina women receiving information regarding breast and cervical cancer prevention from outreach activities and information about SMHC free services will make appointments for preventive screening.

Result: 390 Latina Women made appointments at SMHC for Pap Smears and 120 made appointment SMHC for mammograms. Our data supports that increasing numbers of participants are changing their knowledge and behavior as it related to breast and cervical cancer.

Outcome: Latino women in the SMHC BCC program demonstrate a sustained focus on the value of ongoing breast & cervical cancer screening and treatment.

Result: From 1/1/07 to 12/31/07: 31% of adult Latina women returned to SMHC for follow-up pap smears and/or treatment, 12% returned for follow-up pap smears and/or treatment for multiple years (three or more), 58% to SMHC for follow-up mammograms and/or treatment., 11% returned follow-up mammograms and/or treatment for multiple years (three or more).We believe SMHC participants are sustaining their increased knowledge and behavior in regard to breast and cervical cancer prevention through screening and/or treatment at SMHC. This is demonstrated by the increasing percentages of returning participants for next year's testing and continuing for three years and more.

Indian Health Board of Minneapolis

Outcome: Program participants show an increase of knowledge in early detection of breast and cervical cancer. Early detection is key to prevention.

Result: 21 familes that have completed the program, show increased knowledge of early detection / cancer prevention. 21 families does not mean 21 individuals. The families participate in the program together. The total number of program participants is reflected in direct contact/one on one.

Sisters in Harmony Program

Outcome: For 2007 (planning year), the perceived needs of African/African American women with breast and cervical cancer are identified from key stake holders.

Result: This needs assessment reinforces the data and findings that were collected as part of the Sisters in Harmony evaluation over the past six years. This suggests that the needs have not changed very much, and that the set of services that were being provided to women remain the key services that need to be provided as services resume in 2008.Cultural navigation services provide the most significant impact on SIH participants. The most significant cultural navigation services: the support group; advocacy and accompaniment at appointments and treatments; open access to cultural navigators; access and referrals to cultural specific resources; and guidance on how to self-advocate.

Vietnamese Social Services of Minnesota

Outcome: Participants know where to go for a low cost or free breast and cervical cancer screening.

Result: 100% of 41 women who were provided educated and access assistance about where to go for a free breast and cervical screening when joining the program know where to go and went back for repeat screening after one year. These women are happy to know where and how to get services that are available.

Outcome: Participants who planned to make a screening appointment will actually make the appointment and get screen.

Result: 100% of the 272 program participants said yes to the survey question 'Do you intend to get a Mammogram with in the next 12 months? Our data shows 397 women received mammogram for breast cancer sceening in 2007. This is a change in behavior, women are actually getting cancer screening, not just saying "yes" to be nice.

Cardiovascular Disease and Diabetes

Centro Campesino

Outcome: Migrant agricultural workers and rural Latinos in south central Minnesota have increased knowledge about diabetes prevention, symptoms, treatment, management and healthy lifestyle choices.

Result: The vast majority of participants (92.5%) believe that their knowledge about diabetes has increased as a direct result of having participated in Promotores de Salud diabetes workshops. In combination with the high level of community member participation in the workshops (n=900), this is an indicator that we are moving toward accomplishing the desired outcome that migrant agricultural workers and rural Latinos in our geographical region have increased knowledge about diabetes prevention, symptoms, treatment, management and healthy lifestyle choices.

Dar Al-Hijrah Cultural Center

Outcome: Somali adults and adolescents increase their awareness and knowledge about type 2 diabetes risk factors.

Result: 96% said "strongly agree" to checking their blood sugar level regularly at the health screening center. 60% of participants said they were aware that obesity leads to diabetes (N=167).

Fremont Community Health Services

Outcome: Provide access to blood pressure screenings.

Result: 1,971 participants received a B/P screening. Of these, 9.58% or 189 participants had no MD/provider. All participants with no provider were referred to resources for insurance enrollment and to community-based clinics offering affordable (sliding fee scale), accessible health care services in the community. All participants who received a full stroke risk screening who were in stage 2 hypertension and who did not have a medical provider increased access to health insurance.

Grand Portage Health Service

Outcome: Grand Portage community members will have an increased awareness of their own risks for cardiovascular disease and diabetes.

Result: During 2007 screenings were done and physician referrals were made (N=470). Compared to baseline data, the project has significantly increased the number of screenings for diabetes and hypertension. This has resulted in significantly more referrals for further care.

Outcome: There is an increase in the number of people with diabetes who would like to change their smoking behavior.

Result: All identified with diabetes who smoke have been encouraged to participate in our smoking cessation programs. An estimated 25% of smokers with diabetes attended the Quit Smart program for one or more sessions. However, there are an additional five diabetic smokers who have quit using other strategies.

Indian Health Board of Minneapolis

Outcome: Program participants show an increase of knowledge in proper nutrition and exercise.

Result: 21 familes that have completed the program, show increased knowledge of what is proper nutrition and exercise. 21 families does not mean 21 individuals. The families participate in the program together. The total number of program participants is reflected in direct contact/one on one.

Minneapolis American Indian Center

Outcome: Change in participant attitude about cardiovascular disease will be assessed some time after activities are concluded.

Result: 90% of participants randomly sampled agreed they experienced a considerable change in attitude about cardio vascular disease N=100).

Outcome: Participants knowledge of diabetes will increase.

Result: **:** 90% of participants agreed their knowledge of diabetes increased considerably

Minnesota International Health Volunteers

Outcome: Somali adults learn new fitness skills to increase their daily physical activity levels through participation in free exercise classes.

Result: In 2006, program participants were surveyed at two intervals and asked to report how often they were physically active during the week. The first survey showed that 40% of participants were active on at least 3 days per week and the second survey showed a decrease in this number to 29%. In 2007, when asked how many days per week they were active, 60% of participants reported they were active on at least 3 days in the week. These results suggest that this exercise class continues to be a valuable resource for Somali elders in the community. They continue to learn new skills as well as practice their skills in order to be able to do the exercises on their own. The increase in self-reported daily physical activity suggests that their participation in the exercise class is encouraging them to be active outside of the class and on more days of the week.

Outcome: Somali adults have increased access to affordable, fresh foods such as fruits and vegetables, in the neighborhoods where they live.

Result: In 2006, 39% of the stores (N=29) we surveyed were interested in learning more about what their store could do to accommodate a healthy diet for their Somali clients. In 2007, we concluded our research with a total of 41 stores in the Metro area. The majority of these stores were interested in learning about the results of the research. The results of the Somali community food assessment show that there are limited numbers of grocery stores or supermarkets in neighborhoods with a higher concentration of Somali residents. There are, however, a number of smaller Somali-owned grocery stores or halal markets in these areas. These markets do not carry a wide selection of fresh fruits or vegetables, and those they do carry tend to be more expensive. Somali residents must then travel to multiple stores for one grocery trip and must have reliable transportation between these stores.

Olmsted County Public Health Services

Outcome: Latino and African American adults who participate in a walking club or sports team increase their physical activity from prior to attending group activity to end of group activity.

Result: 70% of program participants increased their activity level, 30% maintained their level which was at 4-6 hours of exercise per week. By the end of the program all participants were exercising at least 4-6 hours a week.

Outcome: Increase number of participants getting blood pressure screens and follow-up care (when necessary).

Result: Target of 100% was achieved. 133 blood pressure screens. Of the 23 people with abnormal test results and who were not under a doctor's care, 100% were referred to a clinic (23/133).

Southeast Asian Ministry

Outcome: Elders who attend SeAM Elder Programs increase their understanding of the dangers of heart disease and diabetes.

Result: 97% of the focus group participants (N=32) self-reported that their knowledge about heart disease and diabetes had increased. We believe the health of the Southeast Asians we serve will be improved as they take responsibility for maintaining and improving their own health. Knowledge about the dangers of heart disease and diabetes is critical for people to begin the process of knowing what they must do to prevent and control heart disease and diabetes.

Outcome: Elders who attend SeAM Elder Programs increase their understanding of the importance of exercise in relationship to diabetes and cardiovascular disease.

Result: 94% of the focus group participants (N=32) self-reported that they increased how often and how long they exercise. We believe the health of the Southeast Asians we serve will be improved as they take responsibility for maintaining and improving their own health. Exercise is a critical element in maintaining and improving health especially in relationship to cardiovascular disease and diabetes.

Stairstep Foundation

Outcome: There is a decrease in blood pressure from baseline in individuals in five churches.

Result: In 2007 the AHA survey indicated that 23 individuals from five congregations (5%) had a decrease in blood pressure from five congregations. However, the monthly program records indicated that 121 individuals had experienced lower readings during 2007 after intervention. The monthly reporting from coordinators also noted several were diagnosed with hypertension after a follow up with a healthcare provider.

TAMS / Children's Hospitals and Clinics

Outcome: Participants in the Soulful Living Program have improved nutrition and activity levels. Participants include mothers, adolescent daughters and other women in the community who are enrolled in the Soulful Living Program.

Result: 97% of participants reported consuming less fried and fast foods; 98% reported consuming less sugared drinks and fruit juice; 92% reported increasing their intake of fruits, salads and vegetables; and 83% reported eating a healthy breakfast daily (N=60).

Westside Community Health Services

Outcome: Selected patients follow the basic diabetes health care guidelines and practices using a multi-disciplinary care coordination model.

Of 111 participants, 51% met with the nutritionist at least one time in a 12-month period either in a group setting or individual setting. 99% set a self-management goal. 99% of the patients established self-management goals with the diabetes team members at clinic visits. Included in the self-management goals were: 23% who had dental exams; 32% who attended smoking cessation class; 26% who had a retinal exam; and 98% who had a depression

Outcome: Selected adult patients with diabetes demonstrate a decrease in their HbA1c levels, thus helping to prevent serious long-term complications.

Result: By end of 2007, we had 86 (or 66%)of this select group of 100 patients have 2+ A1c 90 days apart. The average A1c baseline was 9.2 and from this we had 44% show a decrease from the baseline.

Healthy Youth Development

Agape House for Mothers

Outcome: Teen program participants enrolled in the program are engaged and find it valuable.

Result: We experienced significant increases in enrollment, graduation, and program participants who made referrals; the baseline data and comparison made from April 2002 through December 2003 compared to January through December 2007. The enrollment of program participants for the period ending December 2003, 1222 to 3150 for the period ending December 2007, a 158% increase. A graduation rate of 85% was experienced period ending December 2003 to a 91% for the period ending December 2007, a 6% increase, indicating that teens attended regularly as documented in attendance records and met the minimum requirements to graduate. Program participants referred family members or friends to the program for the period ending December 2003, 177 to 1607 and for the period ending December 2007, an increase of 167%, captured through the intake process. Teen participants were engaged and found the Agape House EHDI/HYD Program valuable.

Outcome: Program graduates gain the knowledge that will help them to make better choices when it comes to decisions that could adversely affect their health.

A 39% decrease in sexually activity among program graduates, only 28% or 412 are reporting that they are sexually active post training, and are practicing safe sex 100% of the time and one sexually partner, a 46% increase in graduates choosing abstinence, and 72% or 1058.

Employment increase by 31%, from 294 or 8% to 426 or 29%, and 54% or 196 of the 100% or 426 hold degrees. A 43% or 112 have 4-year degrees, and a 4% or 4 are seeking their masters.

A 100% or 1470 are reporting no drug use, a 100% decrease, a decrease of 96% in alcohol consumption 100% or 1279 to 4% or 55 reported they consume alcohol occasionally and responsibly. A 99% decrease in tobacco use, 5 or 1% of the 100% or 382 continued to smoke and all reported smoking under a pack per day. A 100% or 221 have had no repeat offenses.

Anishinaabe Center

Outcome: Anishinaabe youth who participated in Berry Camp developed skills in foraging,processing and preserving foods.

Result: Sixty pint jars of jelly were porduced by participating youth with assistance and distributed to the community and 112 pints of deer meat were produced by the youth with assistance and distributed to the community.

Outcome: Access to healthy, locally produced food has increased in the White Earth community and surrounding area.

Result: We compiled a list of 238 farmers within a 250 mile radius, later in the year we downsized the list to 118 in a 60 mile radius, because elders were unable to travel to sites futher away.

Annex Teen Clinic

Outcome: Increase the number of positive inter-generational interactions of African-American adolescents living in North Minneapolis.

Result: 85% of targeted participants showed a 55% increase in involvement with a positive community adult. When asked in formal group settings, and displayed through demonstrated involvement in several intergenerational service projects, participants showed an increase in desire to connect with positive adult community mentors.

Outcome: Increase African American mothers' knowledge and comfort about talking to their children about sexuality and puberty issues

Result: 100% of the 65 targeted adults surveyed reported that they feel Celebration of Change has made it easier for them to communicate with their child about sexuality issues

Bois Forte Band of Chippewa

Outcome: Secondary youth are more aware of a healthy lifestyle and body compostion.

Result: There was a 8% decrease in the amount of body composition screenings conducted on teens/youth that participated in the 2007 Healthy Teen Conference compared to that in 2006 (N=123).

Boys and Girls Club of the Twin Cities

Outcome: Youth members of all ages are more aware of the risks of alcohol.

Result: 672 SMART Moves participants gained a better understanding of the risks associated with alcohol use and gateway drugs (852).

Outcome: Youth members of all ages are more aware of the risks of tobacco.

Result: 649 SMART Moves participants gained an understanding of the risks associated with tobacco use (854).

Camphor Foundation

Outcome: African, Black and bi-racial youth, males and females, ages 11 to 18 participating in the UJIMA program during 2007, have less than 1% unplanned pregnancies.

Result: UJIMA Program participants (227) includes a population of teens ages 11-18 years. Among this population, the pregnancy rate is 0%, e.g. no incidences of pregnancy. Compared to the two major counties in which our participants reside (Ramsey and Hennepin Counties), the rate of the general population is 5.5 and 4.7 times higher. If the range included teens ages 11-14 years, these rates could possibly be even greater.

Outcome: Parents, caregivers. and other caring adults of youth participating in the UJIMA program,a) learn techniques and b)obtain strategies and tools to improve their knowledge of adolescent development and sexuality.

Result: Of the 74 parents, caregivers and other caring adults who participated in parent/adult sessions, 100% name at least 3 techniques to prevent unwanted and/or unplanned pregnancies.

Centro

Outcome: Parents increase their knowledge about how to communicate more effectively with youth.

Result: 27% of parents reported having good communication with their son/daughter. 27% of parents answered yes to the question your son/daughter tells you everything that has been happening at school. 80% of parents answered yes to the question do you talk with your son/daughter about sexual issues.There is an increase of knowledge about communication techniques in the parent -teen relationship; an increase of parents' confidence towards their siblings; and an increase of knowledge of how parents and teens can communicate about sexual matters.

Outcome: Youth in Raices have an increased confidence in being successful academically.

Result: 63% of participants answered they were going to graduate from high school.Youth in Raices have an increased confidence in being successful academically. They state they will graduate from high school; plan to attend university and that education is the most important thing for their future.

Division of Indian Work

Outcome: American Indian youth and adults increase knowledge of contributors to and methods of preventing teen pregnancy.

Result: Only 43% of participants were able to answer this correctly on the pre-test (N=327). The number of correct answers increased to 80% on the post-test. Comparing the pre tests and post tests of program participants demonstrates a change in knowledge or awareness of the target population. Participants consistently increase the number of correct answers given on the post test as compared to the pre test.

Outcome: American Indian youth and adults increase understanding of the issue of teen pregnancy from both a cultural/traditional and contemporary point of view.

Result: Only 28% of participants were able to answer this correctly on the pre-test. The number of correct answers increased to 78% on the post-test. (N=327). Comparing the pre tests and post tests of program participants demonstrates a change in knowledge or awareness of the target population. Participants consistently increase the number of correct answers given on the post test as compared to the pre test.

Family Medical Center/La Clinica en Lake

Outcome: Increase access to mental health services for Latino youth who experience depression

Result: The percentage of Latino youth diagnosed with depression/ depressive symptoms (65%) stayed the same from 2006 to 2007. The percentage of patients referred to therapy in their first visit was smaller (67%) than the one from last year (90%). However, the percentage of patients who attended therapy was slightly higher (42%) compared to 2006 (32%).

Outcome: Increase follow up visit rates of Latino teens and young adults who are at risk

Result: The rate of high follow up for high risk patients went up by 11%. 2004 & 2005 follow up rates were analyzed using a random sample. The average rate of high follow up at that time was 39%. In 2006 and 2007 we looked at follow up rates of new patients only instead of choosing a random sample. We found that in 2006 the rate of high follow up stayed at 39%, and in 2007 this rate went up to 50%.

Freeport West

Outcome: Youth will gain knowledge of self and culture through Rite of Passage group

Result: 100% of the youth that accepted their Rite of Passage and completed the Life Skills post test increased their score (N=5). The data indicates youth are increasing their knowledge of self and culture by participating in the Rite of Passage group.

Outcome: Youth decrease high-risk behavior through stabilizing their lives because of the Life Skills curriculum.

Result: 62 of the 80 youth that completed the employment section of the Life Skills curriculum have gained employment (78%). The data shows that youth are gaining employment and stable housing at a higher rate than anticipated. Data would indicate that youth are gaining knowledge and skills in the area of employment and obtaining stable housing.

Hmong American Partnership

Outcome: Increase knowledge within participating families regarding the impact of change, improving communication and the need for a common vision (goal setting).

Result: Consensus of the group was that after hearing others share their goals they were inspired to set their own goals higher (N=10).

Lao Family Community of Minnesota

Outcome: Hmong adolescents will increase their knowledge about delaying sexual activity and pregnancy.

Result: Adolescents who completed the 10-week session and both a pre-test and a post-test demonstrate increased knowledge of the benefits of remaining abstinent, have learned and can use new assertiveness and problem-solving skills, and have increased knowledge of human sexuality (N=112).

Outcome: Young Hmong parents will appreciate the benefits of postponing having additional children while they are in high school.

Result: 100% (91) of participants did not become pregnant during the year.

Leech Lake Band of Ojibwe

Outcome: Youth and families increase their utilization of behavioral health and/or mental health services.

Result: Out of 80 community members served, 33 were given referrals to services not previously used that they took advantage of.

Outcome: Native youth attending Gatekeeper Training on Youth Suicide Prevention learn what to do when someone they know is at risk for suicide and depression.

Result: By the end of the training, a majority of youth were able to verbally walk through and state the steps for suicide prevention as (1) recognition of risk and name one or more signs; (2) ask the person if they are suicidal; (3) ascertain whether the at-risk person is willing to talk to an adult about their issues; (4) remain with that person to ensure their safety until an adult arrives; and (5) transfer the responsibility to the adult (N=50).

Minneapolis Urban League

Outcome: Increase number of minority youth who are able to identify the definition of abstinence.

Result: 63% of students (41) answered this question correctly both at the pre and posttest. 17% of students answered the question incorrectly on the pretest but correctly on the posttest. There was a significant difference between change in knowledge from pretest to posttest ($p=0.033$).

Outcome: Increase the number of youth who are able to identify risk factors for contracting HIV/AIDS.

44% of students answered this question correctly both at the pre and posttest. 44% of students answered the question incorrectly on the pretest but correctly on the posttest. There was a significant difference between change in knowledge from pretest to posttest ($p<0.0001$).

Southeast Asian Community Council

Outcome: Youths participating in our program show increased proficiency in using multi-media to express ideas and teach about TPP issues.

Result: This year, a total of 36 youths have participated in designing and updating the SEAYEP website. We were able to expose all 36 youths to website design and maintenance by dividing them into two groups: 18 youth for the first six months and 18 youths for the last six months. As a result, it was clear that giving youths the responsibility as well as the authority to make decisions about their work gave them a better understanding of how and why the use of mulit-media tools are important.

Outcome: Youth participants have shown a great increase in their comfort and abilities in communicating about teen pregnancy prevention issues as well as public speaking.

Result: Youths are now comfortable with partaking in conversations about teen pregnancies and sexually transmitted infections among their peers, with adults, and professionals. As a result of giving presentations in front of large groups, youths are now capable and effective public speakers. Based on the focus groups that SEAYEP conducts at the beginning and end of each year, we have seen that there is a large increase in the comfort and confidence of youth presenters.

Summit University Teen Center

Outcome: Participants increase their knowledge and awareness of sexual health topics.

Result: 73% of TC-HOPS program participants that successfully completed the program improved their knowledge and awareness and were able to correctly identify and describe a minimum of (3) contraceptive methods and their proper usage (N=126).

Outcome: Participants are educated of the different ways on how to budget their money, importance of establish good credit and purchasing the appropriate necessities for their child.

Result: Based on our findings over 80% of the participants had a better understanding and knowledge on how to budget their money and the importances of establish good credit (N=50) .

West Central Integration Collaborative

Outcome: 50% of the participants in our Healthy Youth Tour program wil increase their involvement in healthy behaviors related to walking and other forms of exercise.

Result: The results were as follows: 49% of participants noticed a physical change in themselves, 60% of participants say their parents noticed a physical change in them, 99% of participants increased exercise habits and limited their use of television, 49% of participants are making healthier food choices, 73% of participants agreed that the after school program helped them do better in school and increased their knowledge about exercise and healthy eating choices. The results of this survey suggest that this program has been successful in helping participants succeed in school and also make healthier lifestyle choices (N=22)

Outcome: Participants in the Healthy Youth Tour involved in a media project, increased their awareness of parental domestic violence.

Result: After viewing the media project and providing a discussion that was open and respectful many students (30%) started to ask about specific scenarios with parental abuse. There was a 100% increase in awareness through viewing the videos which was indicated by a question or comment related to parental domestic violence (N=22).

HIV/AIDS and Sexually Transmitted Infections

African American AIDS Task Force

Outcome: Increased knowledge about HIV/AIDS & STI's among African Americans and African born populations. Reduce the number of people testing positive for HIV and STI's though education.

Result: More than 90% indicated that they learned something new about HIV and STI as a direct result of the EHDI Program. Of that group at least 85% said they intended to practice safer sex.

Centro Campesino

Outcome: Migrant farmworkers and rural Latinos in south central Minnesota have increased knowledge about HIV/AIDS and STI causes, prevention and treatment.

Result: More than half of participants (60%) believe their knowledge about HIV/AIDS and STI prevention has increased as a direct result of having participated in the workshops. Although there was a relatively large percentage of participants who answered that their knowledge had not increased as a result of the workshops (40%), when asked anecdotally as a group, why this was, some participants reported that they had participated in prior HIV/AIDS workshops offered by Promotores de Salud.

Council on Crime and Justice

Outcome: Increase in knowledge about HIV/AIDS, Hepatitis C, and other STIs for prison inmates participating in HELP.

Result: There was a slight increase in the percentages of correct answers in the post-surveys, over the pre-surveys (as stated in E1-c1a. Compared with 2006 results, the percentage of correct answers in the pre-surveys was much higher in 2007. This suggests that participating inmates have a high level of knowledge about STD issues (N=66).

Turning Point

Outcome: Community members/target population increase their knowledge and understanding about how HIV/AIDS is contracted and spread by attending groups or workshops.

Result: Based on the results from the pre/post test, the men in the inpatient trearment program are increasing their knowledge and understanding about HIV/AIDS is contracted and spread. On average the men increased their scores 20-30% from pretest to post test (N=480).

Outcome: Through Street Outreach and PSA's Community members show an interest in knowing their status and they will actually have an HIV test done.

Result: We have showed a dramactic increase in testing of our clients who are in the treatment programs. When we first started on site testing in 2006 we were averaging 20 men a month being tested. We are now averaging 30 to 40 men a month being tested and that's for both programs.

Child and Adult Immunizations

Center for Asian and Pacific Islanders (CAPI)

Outcome: Increased their access to medical home/clinic/doctor/primary clinic for S.E Asian and East African who are newly arrived refugees and immigrants.

Result: Out of 260 we served 208 did not have medical home and by the end of the program we connected 169 to medical home. Our results show that helping our clients with teaching sessions, immunization clinics and medical paperwork has empowered them in their dealings with the Western medical system. By the end of the program year.

Outcome: Immunization coverage increases for non and under-immunized clients.

Result: 80% of 260 was under and non-immunized and after going through our program 113 got fully immunized.

Outcome: Increased access to MN care or other health care insurance for S.E. Asians and East Africans who are newly arrived and/or have no medical insurance.

Result: We helped 75 participants secure health insurance and after six months all of them still have their health insurance. Clients are becoming more confident and familiar in navigating the Western health care system. They are inititating visits on their own and contacting our health navigation specialist if they need assistance.

Dar Al-Hijrah Cultural Center

Outcome: Somali parents are aware of the importance of immunizing their children to protect them from diseases.

Result: In 2003, 98% of respondents showed they aware of their children's immunization records. Then there was a sharp fall to 65% in 2006. In 2007, our data shows that 80% of parents know the immunization record of their children. This fluctuation might be due to an increased number of new immigrants resettling in the Twin Cities who may not be as particular about record keeping as those who are used to the system in Minnesota.

Stairstep Foundation

Outcome: Increase in the number of older adults receiving flu shots.

Result: The nine church flu vaccine clinics in 2007 reported - 83 adults 50 and older received flu vaccine compared with 74 older from previous year. Only 19% (16) were 65 and older. Although the senior population was low, further investigation concluded that after five years of raising awareness for senior flu vaccine many are seeking and receiving their shots earlier than we have them available.Although we have seen an increase, then a slight decrease, in older adults in church clinics it is because we have increased awareness and knowledge of vaccination, therefore lowering mistrust that is changing the cultural norm and seniors are seeking and receiving their shots earlier than we have them available. What we have found that coincides with the study mentioned is that participants show a willingness to participate in FBO education as well as activity or promotion.

The Storefront Group

Outcome: Somali parents improve their record keeping of their children immunization records.

Result: Significant number of program participants(45%) have indicated that they learned how to keep immunization records accurately (289).

Outcome: Improved knowledge of immunization resources and centers

Result: 83%of the participants have reported a better accesses to immunization centers (N=289).

Infant Mortality

American Indian Family Collaborative

Outcome: Women served by Community Doulas will have healthy birth outcomes.

Result: Only 2% of babies born to mothers in the program were considered low birth weight. In Minnesota, this statistic was 6.1% in 2000.

Outcome: Women served by Community Doulas have an increase in Healthy Prenatal Care.

Result: We have surpassed our indicator. 98% of mothers supported by Community Doulas received early prenatal care with 90% of American Indian mothers, 89% of African American mothers, 80% of Asian mothers and 100% of mothers from all other groups indicating receipt of prenatal care before 15 weeks gestation.

Outcome: Participants supported by Community Doulas have an increased awareness of the parenting role and health education.

Result: Our program focus on the benefits of breastfeeding has exceeded national averages with 65% of African American mothers, 93% of Hispanic mothers, and 100% of American Indian, African Immigrant, and other mothers choosing to breastfeed their babies.

Outcome: Participants in the Community Doula Program will experience greater service integration.

Result: Only 1% of program participants reported being uninsured compared to 15.7% of the United States population being uninsured.

Cass County /Leech Lake Reservation

Outcome: Increase the number of women who attend their first prenatal appointment in the 1st trimester.

Result: We have had an increase in the number of women who have presented for their first prenatal visit in the 1st trimester from 50% to 80%.

Outcome: Decrease high risk substance use behaviors. i.e. commercial tobacco use, smoking, drug use, and alcohol use among pregnant women who are seen for prenatal care .

Result: Reported substance use during participants' pregnancy at their first prenatal appointment has decreased from 63% to 44%. Reported substance use during the duration of participants' pregnancy at the time of birth has decreased from 40% to 34%.

Outcome: Increase breastfeeding rates among Native American women.

Result: Teh number of participants that initiated breast feeding in the hospital at the time of birth, has increased from 50% to 65%

Centro

Outcome: Participants will learn pre-natal care has a positive influence in the development of the baby.

Result: 73% of participants surveyed stated good nutrition increases the probability of a baby being healthy. 80% of participants answered during pregnancy it is not advisable to consume drugs like cocaine, marijuana;to drink a lot of caffeine or to smoke (N=15).

Outcome: Participants will learn about post-partum depression.

Result: 87% of participants learned talking about post-partum depression symptoms with family members can help them recognize it.

Division of Indian Work

Outcome: An increased number of pregnant American Indian women had a certified birth partner, called the Ondaadiziike Kwe-"She was there at birth".

Result: All twenty-six American Indian women utilized Doula services provided by the Division of Indian Work. There are more women in the Strengthening Family Circles program using Doula services now than prior to the inception of the program.

Outcome: American Indian mothers are giving birth to healthier babies.

Result: 92% (24 of 26) mothers gave birth to an infant that weighed 5.5 pounds or greater The use of a doula is having a positive impact on the birth weight of the child.

Fond du Lac Tribe

Outcome: More mothers continue breastfeeding for 6 months.

Result: 85% of mothers who initiate breastfeeding continued to do so at one month. 55% of mothers who initiated breastfeeding continued to do so at 3 months (N=116).

Mille Lacs Reservation

Outcome: Mille Lac's families are more aware of issues that impact the safety of their infants.

Result: Signature sheets recorded and filed for sleep safety education and SIDS education. Home visiting with education provided. Home safety checks. Breastfeeding educational packets. Prenatal education. Postpartum education. All of these factors pertain to healthy safe children environment, physical and emotional education (N=1,071).

Park Avenue Family Practice

Outcome: Pregnant Hmong women and mothers of newly born infants will be more likely to breastfeed their infants after being exposed to our culturally tailored video, "Breastfeeding for Healthy Babies and Healthy Moms." They are also more likely to learn new factua

Result: The percentage of Hmong mothers who have breastfed at least 2 months) is very high (69.2%) compared to the baseline of approx <1% seen in 2005 at Park Avenue and compared to low precentages reported among Hmong mothers in other states found in the literature of <12% (http://nutrition.ucdavis.edu/briefs/Issues/NovDec96.htm). This is also higher than our previous report for 2006 of 45.8% of breastfeeding Hmong mothers.

Red Lake Comprehensive Health Services

Outcome: American Indian women on the Red Lake Reservation who attended child birthing classes have increased knowledge of dealing with high risk pregnancies.

Result: 41 percent of women enrolling in child birth classes (N=202) attended two or more classes during 2007. Staff were able to contact and survey 137 women who participated in child birth classes during 2007. 115 of these women were able to answer "yes" to the survey question or 84 per cent found the class information helpful during their labor and delivery experiance

Violence and Unintentional Injury

Council on Crime and Justice

Outcome: Recidivism of HELP Case Advocacy participants will be reduced

Result: Of 108 clients that participated in Case Advocacy, we are aware that 22 clients returned to prison. The majority returned on a parole violation, not a new crime. Often times the parole violation is a result of not reporting to their parole officer at the right time or for failing a urine analysis. They then return to prison to complete their original prison sentence. In summary, 80% of participants did not return to prison. Our analysis appears to indicate that HELP participants returned to prison at a lower rate than the average of all people released from Minnesota prisons.

Family and Children's Service

Outcome: Institutions that serve the African American Community adopt policies and practices that support a norm of violence-free relationships.

Result: We believe there are significant changes in the actions of institutions - family, media, health care and faith communities that are supporting the adoption of a nonviolent norm for African American Families.

For the first time focus group participants identified family as a place where are getting the message that violence is not okay. In the focus groups held in 2003, clinics were not identified as a contributor to family violence prevention. In our 2005 focus groups, clinics were identified as doing screening for domestic violence but participants questioned the legitimacy of clinics to get into family business . The 2007 focus group results, participants did not question the legitimacy of clinics inquiries and were able to identify specific actions that clinics are taking.

One other interesting change between the 2003 focus group report and the 2007 results were the focus group participants reflections on the causes of domestic violence in the African American Community. There were common themes that bridged the two reports: Frustration and stress, denial, drug abuse, lack of resources, and family dysfunction. However the 2007 focus groups reflected a belief that violence is a learned behavior. This change in understanding also led to a change in perceptions about what could work to prevent family violence. 2007 focus group participants suggested talking with youth about violence and proper relationships at an early age, men getting counseling and being held accountable, education, community members acknowledging that problems exist and getting help can prevent family violence.

United Hospital Foundation

Outcome: Child Witness to Violence education attendees have increased knowledge about family violence, its impact on children and how they can better identify and respond to these children.

Result: Our results show that the child witness to violence education is having the intended results stated in our desired outcome. For the participants completing both tests, 88% reported an increased knowledge about the topic, 79% reported an increased ability to identify and respond to the needs of the children in their care (n=89).

Outcome: Participants in the Hmong Girls Empowerment groups will have improved their connection to their school and peers and progress toward setting individual goals.

Result: From referring teacher/counselor documented observations: more than 90% of the participating girls had improved connection to their school, improved peer relationships, and in most cases, improved school attendance (N=65).

White Earth Tribal Mental Health

Outcome: Recidivism rates for domestic abuse charges, based on data from tribal, county, and state agencies, have decreased as a result of participation and completion of the program.

Result: Based on Minnesota Department of Corrections and White Earth Tribal Court 14% of group partcipants re-offended compared to 37% of State and Tribal Court average. 100 % of family members gave testimonials to the fact that a noted positive change in the relationship had taken place based on pre

Outcome: Native American adolescents living on or near the White Earth Reservation will use anger management techniques when dealing with conflict.

Result: 43% of the students who participated in anger management groups spent less time in "in school suspension" due to fighting and or being disrespectfull. There grades had increased and truancy rates decreased. 100 % of the students served were able to descibe techniques and tools used to decrease or minimize the negative consequences due to their anger.

Appendix C: Other Health Priority Areas – Rates and Disparities

Baseline / Current Rates and Disparity Status, 1995-1999 to 2002-2006*, Minnesota

Cervical Cancer Incidence	African American^	American Indian	Asian	Hispanic	White
Baseline Rate	21.4	14.2	15.2	#	7.0
Current Rate	12.6	12.1	11.5	16.9	6.0
Baseline Disparity	14.4	7.2	8.2	#	
Current Disparity	6.6	6.1	5.5	10.9	
Disparity Reduction	54.2%	15.3%	32.9%	#	
Breast Cancer Incidence					
Baseline Rate	109.7	55.5	70.3	#	137.2
Current Rate	100.0	94.8	54.1	82.6	129.8
Baseline Disparity	---	---	---	#	
Current Disparity	---	---	---	---	
Disparity Reduction	---	---	---	#	
Breast Cancer Mortality					
Baseline Rate	38.7	23.2	15.3	#	27.7
Current Rate	27.1	13.5	7.9	22.5	22.2
Baseline Disparity	11.0	---	---	#	
Current Disparity	4.9	---	---	0.3	
Disparity Reduction	55.5%	---	---	#	

Disparity = Population of Color / American Indian Rate – White Rate
Disparity reduction = the percentage change in disparity between the baseline and current years.
^ Includes African born
--- No disparity
( ) Disparity reduction increase
Baseline data not available, cannot measure disparity
*HIV and STI - Baseline Year = 2000, Current Year = 2007
All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19

Heart Disease Mortality	African American^	American Indian	Asian	Hispanic	White
Baseline Rate	221.6	263.3	112.4	155.5	205.7
Current Rate	147.0	225.3	72.5	74.5	146.1
Baseline Disparity	15.9	57.6	---	---	
Current Disparity	0.9	79.2	---	---	
Disparity Reduction	94.3%	(37.5%)	---	---	
Diabetes Mortality					
Baseline Rate	59.7	108.8	21.1	37.7	22.3
Current Rate	53.4	92.7	20.7	33.9	22.4
Baseline Disparity	37.4	86.5	---	15.4	
Current Disparity	31.0	70.3	---	11.5	
Disparity Reduction	17.1%	18.7%	---	25.3%	
Teen Pregnancy					
Baseline Rate	174.4	120.6	87.8	151.8	32.2
Current Rate	113.0	111.1	61.7	127.2	26.4
Baseline Disparity	142.2	88.4	55.6	119.6	
Current Disparity	86.6	84.7	35.3	100.8	
Disparity Reduction	39.1%	4.2%	36.6%	15.8%	

Disparity = Population of Color / American Indian Rate – White Rate
Disparity reduction = the percentage change in disparity between the baseline and current years.
^ Includes African born
--- No disparity
( ) Disparity reduction increase
*HIV and STI - Baseline Year = 2000, Current Year = 2007
All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19

New HIV Infection*	African American^	American Indian	Asian	Hispanic	White
Baseline Rate	54.2	11.1	3.0	21.6	2.8
Current Rate	58.6	7.4	3.6	27.9	3.4
Baseline Disparity	51.4	8.3	0.2	18.8	
Current Disparity	55.2	4.0	0.2	24.5	
Disparity Reduction	(7.4%)	51.8%	0.0%	(30.3%)	
Chlamydia Incidence*					
Baseline Rate	1,769	540	314	652	73
Current Rate	1,871	504	311	646	130
Baseline Disparity	1,696	467	241	579	
Current Disparity	1,741	374	181	516	
Disparity Reduction	(2.7%)	19.9%	24.9%	10.9%	
Gonorrhea Incidence*					
Baseline Rate	1,149	123	34	135	18
Current Rate	851	100	20	101	22
Baseline Disparity	1131.0	105.0	16.0	117.0	
Current Disparity	829.0	78.0	---	79.0	
Disparity Reduction	26.7%	25.7%	---	32.5%	

Disparity = Population of Color / American Indian Rate – White Rate
Disparity reduction = the percentage change in disparity between the baseline and current years.
^ Includes African born
--- No disparity
( ) Disparity reduction increase
*HIV and STI - Baseline Year = 2000, Current Year = 2007
All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19

Unintentional Injury Mortality	African American^	American Indian	Asian	Hispanic	White
Baseline Rate	40.7	75.8	36.1	40.2	34.4
Current Rate	32.4	88.5	23.4	27.9	34.8
Baseline Disparity	6.3	41.4	1.7	5.8	
Current Disparity	---	53.7	---	---	
Disparity Reduction	---	(29.7%)	---	---	
Homicide					
Baseline Rate	33.5	21.0	4.4	7.3	1.8
Current Rate	17.7	19.2	3.3	3.9	1.3
Baseline Disparity	31.7	19.2	2.6	5.5	
Current Disparity	16.4	17.9	2.0	2.6	
Disparity Reduction	48.3%	6.8%	23.1%	52.7%	
Suicide					
Baseline Rate	9.6	15.7	10.0	11.5	9.9
Current Rate	5.3	19.7	6.9	7.0	10.1
Baseline Disparity	---	5.8	0.1	1.6	
Current Disparity	---	9.6	---	---	
Disparity Reduction	---	(65.5%)	---	---	

Disparity = Population of Color / American Indian Rate – White Rate
Disparity reduction = the percentage change in disparity between the baseline and current years.
^ Includes African born
--- No disparity
( ) Disparity reduction increase
*HIV and STI - Baseline Year = 2000, Current Year = 2007
All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19

Appendix D: 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

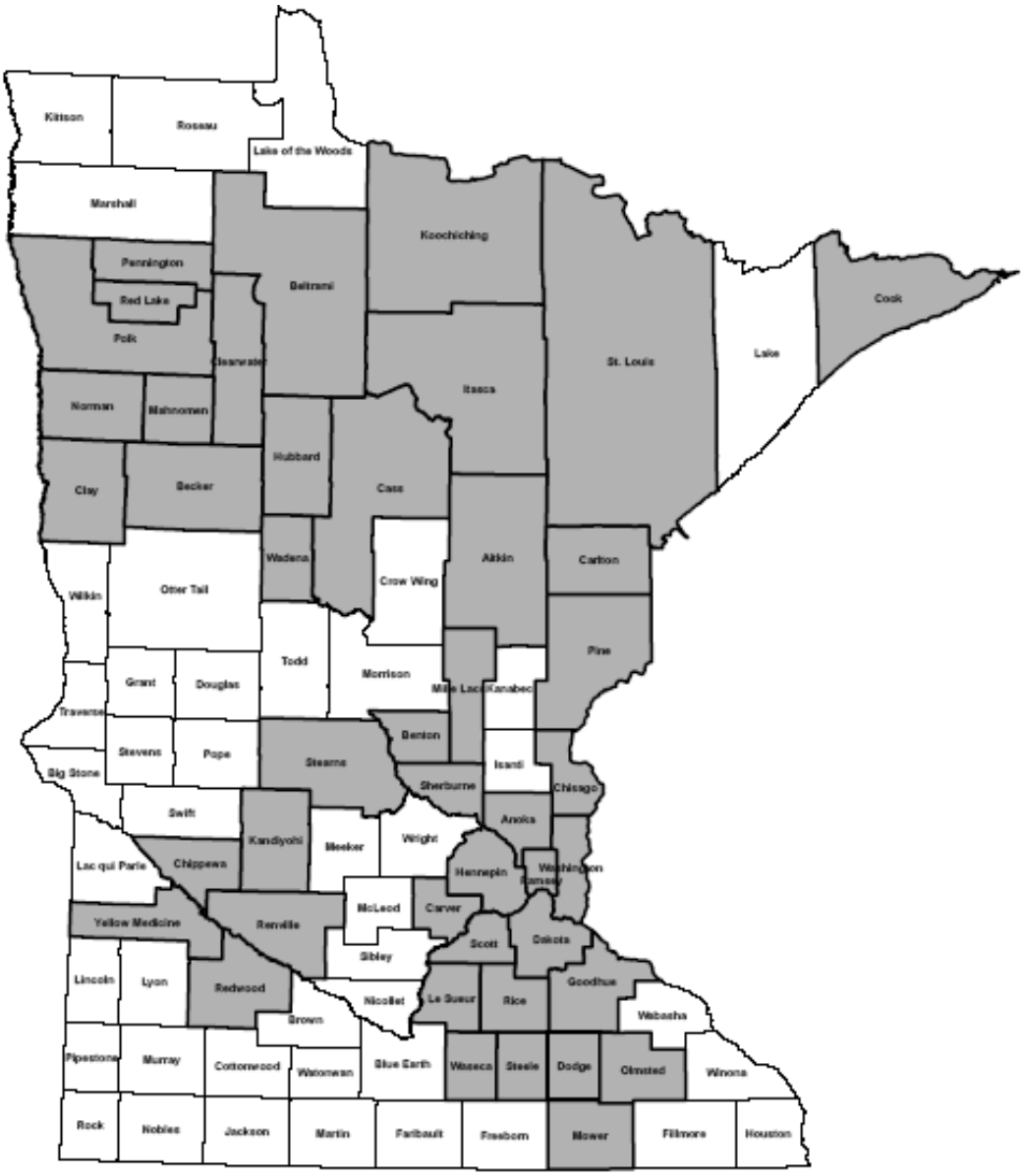
Subd. 2 Family and Community Health

[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
Health disparities data.

Appendix E: Counties Served by EHDI Grantees



Office of Minority and Multicultural Health
P.O. Box 64975
St. Paul, MN 55164-0975
Phone: (651) 201-5813
Fax: (651) 201-4986
TDD: (651) 201-5797