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Executive Summary

Eliminating Health Disparities Initiative

In 2001, the Minnesota Legislature created the Eliminating Health Disparities Initiative (EHDI). It is a 10-year statewide initiative to address and eliminate racial/ethnic health disparities in Minnesota through local and statewide activities and Community and Tribal Health Grants (see statute, Appendix A).

The mission of the EHDI is to support culturally appropriate public health programs designed and implemented by racial and ethnic communities. The success of these programs is built on community assets, and grounded in the cultural beliefs, practices, and traditions of communities.

Health Disparities in Minnesota

Health disparities are defined as the ***difference*** in health status between Populations of Color and American Indians and Whites.

Minnesota is known for being the ***healthiest state*** in the nation however it ***does not reflect*** the statistics for its Populations of Color and American Indians

Disparities are a result of a ***complex interplay*** of many factors including racism, access to health care, social conditions, and health behaviors.

The EHDI is administered through the Minnesota Department of Health Office of Minority and Multicultural Health (OMMH). This statewide initiative focuses on Africans/African Americans, American Indians, Asians, Latinos and Tribal Nations in eight health disparity areas: breast and cervical cancer, cardiovascular disease, diabetes, healthy youth development, immunization, infant mortality, HIV/AIDs and sexually transmitted infections, and unintentional injury and violence.

Legislative Report 2007

This is the third report to the Legislature and includes a description of EHDI activities through the fourth year of the Initiative*. Along with the Tuberculosis Grant Program (allocated to local public health agencies), this report provides an overview of Community and Tribal grant recipients, grantee activities, and program evaluation results. In addition, an update is provided on statewide outcome measures, capacity building, and technical assistance provided to grantees.

"The number of people from the community and the systems looking to us for connections, resources and partnerships continues to grow. This is perhaps the most hopeful indicator that what we are doing is having a positive impact."

– EHDI Grantee

Demographics and Disparities

While the EHDI was created because of disparities in health status between the White population and Populations of Color and American Indians, the continued growth in non White populations emphasizes the importance of sustaining these efforts.

* *a biennial report to the Legislature is required in statute and must be presented every other year beginning January 2003*

The non-White population in Minnesota has grown dramatically over the past several years. Between 2000 and 2005, the nonwhite population grew 21% – compared to the 2 % increase for the White (non Latino) population. Refugee arrivals in Minnesota in 2005 totaled 11.8% of all refugees coming to the U.S.

Even prior to this population growth, health disparities existed among Populations of Color and American Indians. In 1997, *Populations of Color in Minnesota: Health Status Report* documented health disparities in numerous areas.

- Infant Mortality rates among African American and American Indians were two to three times higher than the rates for Whites
- Women of color are less likely to receive sufficient prenatal care compared to Whites
- Death rates for African American and American Indians were two to three times that of Whites
- Higher rates of diabetes, hypertension and HIV/AIDs exist for most racial/ethnic minorities in Minnesota

Grant Program Budget

The 2001 legislation established three categories of EHDI grant programs: Community Health Grant Program, Tribal Health Grant Program and Tuberculosis Services for Foreign-born Persons. The Community and Tribal Health Grant Programs are administered by the Office of Minority and Multicultural Health in the Minnesota Department of Health. The Tuberculosis Program is administered through Community Health Services in the Minnesota Department of Health. Table 1 indicates the number of grantees and funding by grant program for the 2004-2005 and 2006-2007 cycles.

Table 1: EHDI Grants Distribution 2004-2005 and 2006-2007 State Biennium

	2004-2005 Cycle		2006-2007Cycle	
Funding Awarded To:	Number of Grantees	Budget	Number of Grantees	Budget
Community	42	$ 5,722,966	42	$ 5,722,966
Healthy Youth Development*	18	$ 4,000,000	20	$ 4,000,000
Tribal Nations**	10	$ 1,000,000	10	$ 1,000,000
TANF/Healthy Youth Dev. ***	10	$ 837,000	10	$ 837,000
Tuberculosis**	41	$ 700,000	34	$ 700,000
Biennial Funding Total	–	$12,259,966	–	$11,409,966

* Federal TANF funding distributed through the Community Grant process for healthy youth development

**Allocated on a formula basis

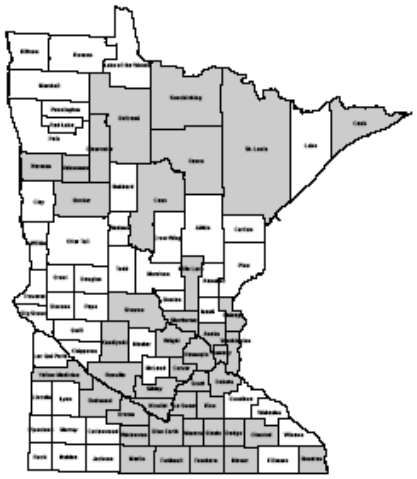
***Tribal TANF funds for both home visiting and healthy youth development

Grantee Outreach

Populations served: Community and Tribal grantees work with African/African Aerican, American Indian, Asian, Latino and Tribal Nations in Minnesota. Ten Tribal nations provide service to American Indians throughout the state.
Priority Health Areas: There are eight priority areas: breast and cervical cancer, cardiovascular disease, diabetes, healthy youth development, immunization, infant mortality, HIV/AIDs and sexually transmitted infections, and unintentional injury and violence. Grantees choose their priority health area based on the needs of their communities.

Geographic Regions : Grantees serve diverse geographic regions. Some grantees provide services in multiple counties while others concentrate on their neighborhoods. Together Community and Tribal grantees reach communities in 42 of Minnesota's 87 counties (Figure 1).

Figure 1: Counties Reached by Grantees



Source: December 2005 Grantee Reports

Program Impact and Outcomes

Two levels of outcome are being monitored to assess the impact of the EHDI – overall statewide outcome and grantee level outcomes.

Overall Statewide Outcomes

- The impact of EHDI programs reaching Minnesota's Populations of Color, American Indians and Tribal Nations in eight health priority areas.
- The efforts of the overall initiative to improve the health status and quality o life for Populations of Color, American Indians and Tribal Nations in Minnesota

Grantee Level Outcomes

- Culturally specific programming and objective that reduce health disparities in Populations of color , American Indians and Tribal Nations
- Increased capacity to evaluate and report program development and measurable outcomes

An overview of EHDI outreach, impact, and outcomes are shown in Table 2 by number of grantees per priority health area, counties served and disparity status by race/ethnicity.

Conclusion

The Eliminating Health Disparities Initiative is innovative, one of the first, and **currently the only existing statewide effort in the nation** to focus on the health and well being of Populations of Color and American Indians. The EHDI is a culmination of efforts that highlight the existence of health disparities in the state, and provides much needed resources to improve the health and well being of these communities. The EHDI Community and Tribal Grantees use multiple approaches to address disparities in the eight Priority Health Areas in communities throughout the state. Based on the statewide outcomes, EHDI has helped to decrease racial/ethnic health disparities. While grantees' activities have had a significant impact on the health and well being of Populations of Color and American Indians other factors can threaten the progress of this initiative. National, State, and Community efforts, in addition to EHDI, must work together to close the gap and eliminate racial /ethnic health disparities

EHDI Overview

Background

In 2001, the Minnesota Legislature passed the Eliminating Health Disparities Initiative (EHDI) MN Statute [145.928]. It was one of the first - and currently the only– statewide initiative to address and eliminate racial/ethnic health disparities in Minnesota through local and statewide activities and Community and Tribal Health Grants (see statute, Appendix A).

The 10-year mission of the EHDI is to support culturally appropriate public health programs designed and implemented by racial and ethnic communities. The success of these programs is built on community assets, and grounded in the cultural beliefs, practices, and traditions of communities.

The EHDI is administered through the Minnesota Department of Health Office of Minority and Multicultural Health (OMMH). The Office of Minority and Multicultural Health (OMMH) was established to strengthen the health and wellness of racial/ethnic, cultural and tribal populations in Minnesota by engaging diverse populations in health systems, mutual learning and actions essential for achieving health parity and optimal wellness.

Minnesotans have consistently ranked No.1 as the healthiest people in the nation, according to the United Health Foundation's annual ranking of states. Not everyone has shared in this legacy of good health due to health disparities. Health disparities are "...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[1] The health problems (disparities) that have been documented in the state's minority and tribal communities include shorter life spans, poorer general health, higher rates of infant mortality, and higher incidences of diabetes, heart diseases and cancer.

This statewide initiative focuses on Africans/African Americans, American Indians, Asians, Latinos and Tribal Nations in eight health disparity areas: breast and cervical cancer, cardiovascular disease, diabetes, healthy youth development, immunization, infant mortality, HIV/AIDs and sexually transmitted infections, and unintentional injury and violence.

The strategies of EHDI Community and Tribal Grant Programs are intended to promote active and full community involvement and build and strengthen relationships among community members, faith-based organizations, culturally based organizations, social service organizations, community non-profit organizations, tribal governments, community health boards, community clinics and other health care providers, and the Minnesota Department of Health. Through these partnerships, the EHDI Community and Tribal Grant Programs

> *"The number of people from the community and the systems looking to us for connections, resources and partnerships continues to grow. This is perhaps the most hopeful indicator that what we are doing is having a positive impact."*
>
> – EHDI Grantee

[1] National Institutes of Health. NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities; 2000. Available at: www.nig.gov/about/hd/strategicplan.pdf. Accessed September 5, 2006.

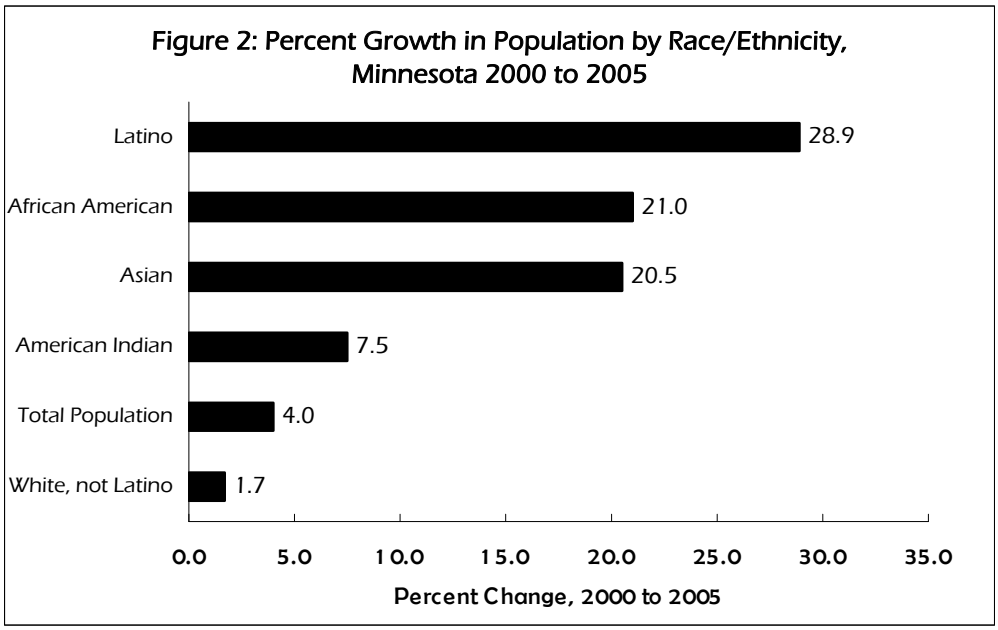
utilize racial/ethnic community strengths and assets to promote health and quality of life for populations of Color, American Indians and Tribal Nations throughout Minnesota. Each of these efforts contributes to the progress of the Initiative and to the realization of the EHDI goal – elimination of health disparities.

Legislative Report

The Legislature requires a biennial report that must be presented every other year at the beginning of budget session. The first report was due in 2003. The 2007 Legislative Report is the third EHDI report in compliance with this statute. This report provides an overview of Community and Tribal grantee activities along with the Tuberculosis Grant program (allocated through public health agencies). In addition, statewide outcome measures, program evaluation results, and capacity building/technical assistance are also documented.

Demographics and Disparities

The non-White population in Minnesota has grown dramatically over the past several years. Between 2000 and 2005, the nonwhite population (including Latinos), grew 21 percent – compared to the 2 percent increase for the White (non Latino) population (Figure 2). In 2005, 40% of all immigrants came from Africa and 28% came from Asia. Refugee arrivals in Minnesota in 2005 totaled 11.8% of all refugees coming to the U.S.



Source: *Nonwhite and Latino Populations in Minnesota Continue to Grow Rapidly*, Population Notes, August 2006, Minnesota State Demographic Center

Even prior to this population growth, health disparities existed among Populations of Color and American Indians. In 1997, *Populations of Color in Minnesota: Health Status Report* documented health disparities in numerous areas.

- Infant Mortality rates among African American and American Indians were two to three times higher than the rates for Whites
- Women of color are less likely to receive sufficient prenatal care compared to Whites
- Death rates for African American and American Indians were two to three times that of Whites
- Higher rates of diabetes, hypertension and HIV/AIDs exist for most racial/ethnic minorities in Minnesota

More recent data indicate that these long standing disparities continue and in a few cases are getting worse, not better (Appendix D).

While the EHDI was created because of disparities in health status between the White population and Populations of Color and American Indians, the continued growth in non White populations emphasizes the importance of sustaining these efforts.

Grant Programs

The 2001 legislation established three categories of EHDI grant programs: Community Health Grant Program, Tribal Health Grant Program and Tuberculosis Services for Foreign-born Persons. The Community and Tribal Health Grant Programs are administered by the Office of Minority and Multicultural Health in the Minnesota Department of Health. The Tuberculosis Program is administered through Community Health Services in the Minnesota Department of Health. Table 2 indicates the number of grantees and funding by grant program for the 2004-2005 and 2006-2007 cycles.

Table 2: EHDI Grants Distribution 2004-2005 and 2006-2007 State Biennium

	2004-2005 Cycle		2006-2007Cycle	
Funding Awarded To:	Number of Grantees	Budget	Number of Grantees	Budget
Community	42	$ 5,722,966	42	$ 5,722,966
Healthy Youth Development*	18	$ 4,000,000	20	$ 4,000,000
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**Allocated on a formula basis

***Tribal TANF funds for both home visiting and healthy youth development

Tuberculosis Services for Foreign-Born Persons

State General Funds in the amount of $350,000 per biennium are allocated to local public health agencies to specifically provide health screening and follow-up services for tuberculosis to foreign-born persons. Local public health staff contact each newly arrived refugee family, arrange for comprehensive screening, and report results back to MDH. Local public health agencies are also responsible for providing outreach services (e.g. directly observed therapy, interpreter services, incentives, etc.) to ensure that patients with tuberculosis adhere to and complete their prescribed treatment regimens. EHDI funding provides some of the financial support for this intensive outreach service to 34 Community Health Boards throughout Minnesota (See Appendix E for screening protocols).

> "The [EHDI] dollars have made a significant difference for us. If a foreign born individual comes in to be evaluated for tuberculosis and needs a chest x-ray, we know that lack of insurance will not deter offering the right care"
>
> *-Public Health Nurse in Greater MN*

Community and Tribal Grants Overview

This section provides an overall description of Populations of Color and American Indians served by the Community and Tribal Grantees. It also provides an overview of health disparity areas, and a description of the how these grantees are reaching communities throughout the state of Minnesota.

Community Grant Programs

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

At the start of the second biennium (2004-05), 42 EHDI Community grantees from the first cycle were funded for an additional two years. Grantees were recommended for awards based on their progress in the first cycle and the work proposed in the second cycle. For the 2006-07 cycle, $5,722,966 was awarded to 42 community grantees.

Tribal Grants Program

Tribal Governments were allocated $1 million from state general funds per biennium to reduce health disparities in the first seven priority areas listed above. In addition, $837,000 per biennium in federal TANF funds is allocated for home visiting and healthy youth development. These funds are included in the Local Public Health Block Grant for Tribal Governments instituted in 2003 with the Local Public Health Grant 145A.131.

A formula for resource allocation was developed with the assistance of Minnesota tribal health directors using Indian Health Service user population data for program year

2002-03 as the basis for the formula. The formula continues to be updated each cycle to ensure funding at the current level of need. Ten of the eleven tribal communities are participating in the tribal grants program.

Populations Served

The Community and Tribal grantees work with African/African American, American Indian, Asian, Latino, and Tribal Nations in Minnesota. Among the community grantees, 25 grantees serve African American communities throughout the state, 17 serve Latinos, 15 serve American Indians and 14 provide services to Asians. Additionally, ten tribal nations provide services to American Indians throughout the state (Table 4). Twenty-six grantees serve more than one racial/ethnic population. For example, one grantee is serving both Latino and African American teens while another grantee is working with all racial/ethnic populations in their community.

Table 2: Tribal Nations Receiving EHDI Tribal Grants

Tribal Nation	Region
Bois Forte	Northeast
Fond du Lac	Northeast
Grand Portage	Northeast
Leech Lake	North Central
Lower Sioux	Southwest
Mille Lacs	Central
Prairie Island	Southeast
Red Lake	Northwest
Upper Sioux	Southwest
White Earth	Northwest

Priority Health Area

Table 3 indicates the number of grantees by priority health area. Grantees choose their priority health areas based on their needs of their communities. Twenty-six grantees are working in more than one area.

Table 3: EHDI Funded Programs by Priority Health Area and People Served

Priority Health Area	Grantees*	Direct Contact**
Breast and cervical cancer	11	9,941
Cardiovascular disease	15	17,090
Diabetes	20	18,896
Healthy youth development	18	13,482
HIV/AIDS and STI's	10	7,775
Immunizations	13	6,232
Infant mortality	11	4.414
Violence and unintentional injuries	12	4,784

Source: December 2005 EHDI Grantee Reports

*26 grantees have selected more than one priority health area

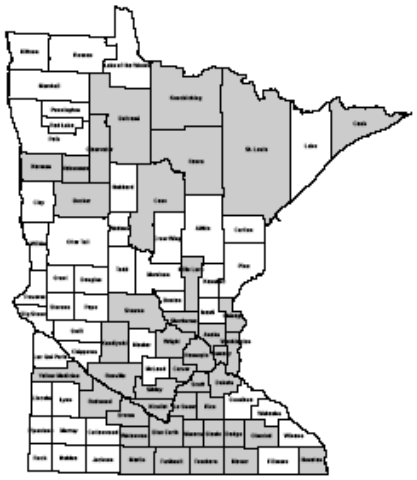
**People served through direct services: one-one individual contact such as counseling, screening and education in a private setting and group contact such as classes, workshops, and education sessions

. Numbers may overlap from health area to health area.

Geographic Regions Reached

Grantees serve diverse geographic regions. Some grantees provide services in multiple counties while others concentrate on their neighborhoods. Together, EHDI Community and Tribal Grantees reach communities in 42 of Minnesota's 87 counties (Figure 2).

Figure 1: Counties Reached by Grantees



Source: December 2005 Grantee Reports

Community and Tribal Grant Strategies and Outcomes

The Eliminating Health Disparities Initiative is innovative, one of the first, and **currently the only existing statewide effort in the nation** to focus on the health and well being of Populations of Color and American Indians. The EHDI is a culmination of efforts that highlight the existence of health disparities in the state, and provides much needed resources to improve the health and well being of these communities. The EHDI Community and Tribal Grantees use multiple approaches to address disparities in the eight Priority Health Areas in communities throughout the state. The EHDI encourages and supports innovation, partnerships, and cultural strengths of communities.

Innovation, Partnerships, and Cultural Strengths

The activities and strategies implemented by grantees are diverse; some are tested and proven, while others are innovative and evolving.

Innovation About half of the grantees that responded named more than one component or activity of their program that they considered innovative or unique. These included innovative approaches in curriculum and instruction; focusing on community strengths and assets; building partnerships; and using participatory approaches in programming. Innovation in curriculum and instruction includes the use of peer educators, culturally competent curriculum and using appropriate languages to communicate health information. Grantees focusing on community assets and strengths hire people reflective of the community as staff and incorporate the values and traditional practices into health education. Participatory approaches involve community in planning programs and activities.

Partnerships Building partnerships is an important aspect of the EHDI. Partnership refers to grantees building collaborative relationships with other community groups, cultural, groups, or health care delivery systems. A large majority of EHDI grantees (93%) have partnerships that are crucial to how they deliver services to the community. The types of grantee partnerships vary widely including community organizations, health care facilities, schools, tribes and government agencies.
Partners are also a source of funding and other monetary resources, although this is not a prominent role for them according to 24 % of grantees.

Cultural Strengths The EHDI grantees build on the cultural strengths of the community in many ways. The knowledge and experience of community members are important resources for grantees. For example, elders and traditional healers have provided guidance and counsel for grantees working with the American Indian community. In the African American community, a coalition of women with personal experience with breast and cervical cancer help to develop effective ways to improve screening for breast and cervical cancer.

The power of the Sisters in Harmony coalition is in the unique strengths and assets that each organization and individual member brings to the partnership. These women bring their courage, creativity, personal experience and tenacity to the table. Their stories, their lives and their spirit serve to motivate the cultural navigators.

Women's Cancer Resource Center

Program Outcome Measurement

Two levels of outcomes are being monitored to assess the impact of the EHDI – overall statewide outcomes and grantee level outcomes*.

Overall statewide outcomes

- The impact of EHDI programs reaching Minnesota's Populations of Color, American Indians and Tribal Nations in eight health priority areas.
- The efforts of the overall Initiative to improve the health status and quality of life for Populations of Color, American Indians and Tribal Nations in Minnesota.

Grantee Level Outcomes

- Culturally specific programming and objectives that reduce health disparities in Populations of Color, American Indians and Tribal Nations.
- Increased capacity to evaluate and report program development and measurable outcomes.

* Grantee strategies, activities, and outcomes by health priority area are included in the "Priority Health Section", as well as a report of statewide outcomes to assess the overall impact of the Initiative. A more complete description of grantee programs and selected program outcomes are available in Appendices B and C.

Priority Health Areas

Breast and Cervical Cancer

Cancer is one of the leading causes of death in Minnesota. Studies indicate that early detection of breast or cervical cancers saves lives. Increasing cancer screenings among women at risk can reduce many deaths from breast and cervical cancers.

According to 1995-1999 data, White women were diagnosed with breast cancer more often than Populations of Color and American Indians. African Americans, however, experienced the highest death rates in these groups. There was a disparity in cervical cancer mortality rates for African American compared to Whites, with cervical cancer death rates highest among Asians (Table 7).

Objective

Reduce disparities in the breast and cervical cancer incidence and death rates for racial/ethnic populations.

Grantee Impact

Grantees have developed an array of activities to address disparities in incidence and death of breast and cervical cancers. Several programs provide education and outreach for targeted communities to help community members' access care and become knowledgeable about resources for breast and cervical cancers. Several grantees also provide referral for screening and treatment for targeted communities.

Table 4: EHDI Grantee Outreach in Breast & Cervical Cancer

Breast & Cervical Cancer	Number
Grantees	11
Total Counties	27
Tribal	1
Direct Service Contacts	9,941

The programs sponsored through the EHDI are culturally appropriate and sensitive to the needs of the community. For example, Minnesota International Health Volunteers provides care to the Somali community; the American Indian Community Wellness Project who work to increase awareness and prevention of breast and cervical cancer through education, support and traditional healing; and the Vietnamese Social Services Breast and Cervical Cancer Education and Screening Project that uses

She knew little of the traditional way and the traditional ways of healing when she first attended the "We are all related" spiritual retreat held in October 2003 in Fond du Lac. She continues today to have that relationship with our healers. Today, she lives her life in a traditional way and is an awesome role model to many. We greatly appreciate her participation."

-- Indian Health Board of Minneapolis

culturally sensitive approaches to increase cervical and breast cancer screening in their community.

Statewide Outcomes

While the incidence rates for African Americans and Asians have declined, the incidence rate for American Indians has increased. Breast cancer death rates also show mixed results. Again, breast cancer death rates declined for African Americans and Asians, but increased for American Indians.

Cervical cancer incidence rates declined for all racial groups. Cervical cancer death rates were only available for Asians in the most recent period as rates are not reported for under 10 cases. It should be noted that an increase in breast and cervical cancer incidence rates may reflect an increase due to awareness and importance of screening for breast and cervical cancer.

Figure 3: 27 Counties Reached by Breast and Cervical Cancer Grantees

Source: December 2005 Grantee Reports

Table 5: Minnesota Breast Cancer Incidence and Death Rates per 100,000 females by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Incidence					
1995-99 Rate	109.7	55.5	70.3	*	137.2
1999-2003 Rate	105.5	89.2	59.4	83.4	136.1
Disparity Status	None	None	None	**	N/A
Deaths					
1995-99 Rate	38.7	23.2	15.3	*	27.7
1999-2003 Rate	27.7	27.1	8.2	23.5	24.4
Disparity Status	Better	None	None	**	N/A

* Data not available

**Cannot determine due to lack of data

By having a Native American female provider (nurse practitioner), the women are more culturally at ease with the provider. [Her patients] feel that they can relate to her, as she understands the culture and traditions. She was raised on the reservation and offers the patients the best quality care. She really cares about her people".

– Bois Forte Reservation

Table 6: Minnesota Cervical Cancer Incidence and Death Rates per 100,000 females by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
Incidence					
1995-99 Rate	21.4	14.2	15.2	*	7.0
1999-2003 Rate	12.6	12.8	12.3	13.4	6.2
Disparity Status	Better	Better	Better	**	N/A
Deaths					
1995-99 Rate	5.2	***	11.7	*	1.8
1999-2003 Rate	***	***	5.0	***	1.4
Disparity Status	**	**	–	**	N/A

* Data not available
**Cannot determine due to lack of data
***Less than 10 cases

Selected Grantee Outcomes

St. Mary's

Of the adult women who participated in the St. Mary's Health Clinic program, 27% of adult Latina women returned for follow-up pap smears and/or treatment. 22% of adult Latina women returned to SMHC for follow-up mammograms and/or treatment.

Vietnamese Social Services

Ninety-five percent of the participants said they will make screening appointments and about 75% actually received screening.

Bois Forte Reservation

There is a marked increase in females going to the two Bois Forte clinics to completing breast and cervical screenings and continues to improve their health by scheduling appointment for annual physicals and other female related health issues.

Cardiovascular Disease

Heart disease was the leading cause of death for American Indians in 2000-2004 and the second leading cause of death for African Americans, Asians, Latinos and Whites. American Indians and African Americans have higher death rates due to heart disease as compared to Whites in Minnesota. For 1995-99, the difference in heart disease death rates between American Indians and Whites was highest with 57.6 deaths per 100,000 population while the difference between African Americans and Whites was 15.9 deaths per 100,000 population. At the time of EHDI legislation, Asian and Latino rates were lower than the White rate for that time period (1995-99).

Objective

Reduction in disparities in the heart disease rates for African Americans and American Indians and maintain zero-disparities for Asians and Latinos.

Grantee Impact

EHDI grantees have implemented a variety of activities to improve cardiovascular health including screenings for stroke risk, peer education training, referral services, home visits, exercise programs, nutrition programs, patient advocacy, health care outreach, support groups, workshops and health information booths.

Table 7: EDHI Grantee Outreach in Cardiovascular Disease

Cardiovascular Disease	Number
Grantees	15
Total Counties	21
Tribal	2
Direct Service Contacts	17,090

The services provided by the grantees build on the cultural strengths of their communities. For example, the Prairie Island Community program provides education and training while honoring the culture and traditions of their people. Centro Campesino is training community members to become leaders in the promotion of physical, economic and social health. The grantee programs and activities are described in more detail in Appendix B.

Figure 4: 21 Counties Reached by Cardiovascular Disease Grantees

Source: December 2005 Grantee Reports

Statewide Outcomes

There have been improvements in heart disease death rates for all racial and ethnic groups. There were only two populations, African Americans and American Indians, in which disparities in heart disease existed in 1995-99.

The 2000-04 data indicate that currently, there is only a slight disparity in heart disease death rates between African Americans and Whites. The disparity that existed between American Indians and Whites decreased from 57.6 to 34.0 and while there were no disparities for Asians and Latinos in 1995-99, the rates for 2000-04 have improved from the 1995-99 period.

Table 8: EHDI Heart Disease Death**Rates per 100,000 Population by Race/Ethnicity

	Baseline Rate 1995-99	Current Rate 2000-04	Disparity* Status
African American	221.6	159.4	Better
American Indian	263.3	239.7	Better
Asian	112.4	71.4	Better
Latino	155.5	107.8	Better
White	205.7	160.8	N/A

*Disparity = Population of Color rate minus the White rate from 1995-99 (205.7)

**Age-adjusted death rates

Selected Grantee Outcomes

A wide range of services, activities, strategies, and approaches define the work of EHDI grantees working towards improving cardiovascular health. These grantees work within their communities to define the goals, objectives and project outcomes. Through these outcomes, grantees have documented an increase in the knowledge of risk factors that lead to cardiovascular disease, improvement in blood pressure and eating habits, and increased exercise. Some examples of these outcomes are included in this section with a more complete set of grantee outcomes included in Appendix B.

Bois Forte Band of Chippewa Cardiovascular Program

There has been improvement in weight, BMI and body fat of groups and individuals participating in exercise and education programs (as indicated by pre and post tests). The elementary students have physical education class at the Native Hearts Fitness Center under the direction of the physical fitness trainer.

Grand Portage Health Services

There has been a 50% increase in the patient/doctor visits in the past two years (2004-2005) (N=125).

Southeast Asian Ministry (SEAM): Parish Nurse Program

SEAM Elder Program participants have gained knowledge about the relationship between exercise and cardiovascular disease. In the post survey, 86% of the elders reported exercising 3 or more times a week.

In honor of our community elders who were traveling to Washington D.C., we promoted "Walk to Washington." Teams were formed in the community with each team logging the number of miles walked for a 6-week period of time. The team that logged the most miles won. All other teams received recognition for participating. 130 participants in the community logged a total of 11,643 miles. This was a great activity and enjoyed by many.

–Grand Portage Tribal Reservation

Diabetes

Diabetes and its complications are a significant cause of illness and death in Minnesota. It is an insidious chronic condition that is complex, serious, costly and increasingly common*. Diabetes disproportionately affects Populations of Color and American Indians. The 1995-99 diabetes death rates indicate that American Indians were five times more likely to die of diabetes than Whites and African Americans were almost three times as likely to die from diabetes compared to Whites.

Objectives

Reduction of disparities in the diabetes disease death rates for African Americans, American Indians and Latinos and maintain a zero disparity for Asians

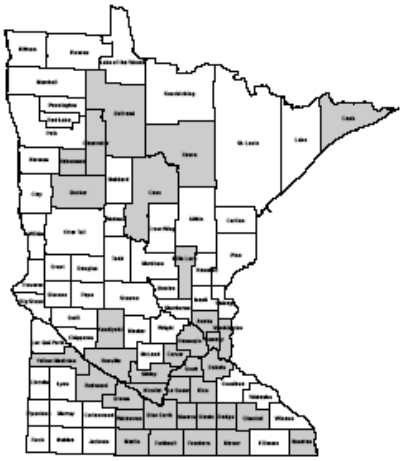
Grantee Impact

EHDI grantees have implemented a variety of activities to decrease risk factors for diabetes and improve the lives of diabetics including blood glucose screenings, nutrition education workshops, culturally appropriate diabetes support groups, one-one patient counseling, education classes on self-monitoring diabetes, and in-home health education to diabetic patients.

Table 9: EHDI Grantee Outreach in Diabetes

Diabetes	Number
Grantees	20
Total Counties	35
Tribal	5
Direct Service Contacts	18,896

Figure 5: 35 Counties Reached by Diabetes Grantees



Source: December 2005 Grantee Reports

The services provided by the grantees build on the cultural strengths of their communities. For example, the St. Mary's Health Clinics have established their program where their participants worship with the full support of the priests and parish staff. Westside Community Health Services invites family members to attend diabetes education classes, which builds on the close-knit family ties and societal influences in the Hmong and Latino communities. The grantee programs and activities are described in more detail in Appendix B.

* Diabetes in Minnesota, Minnesota Department of Health Diabetes Program www.health.state.mn.us/diabetes/diabetesinminnesota/ accessed November 2006

"...I want you all to know how thankful I am of the clinic and the diabetes health educators. To me they have been my angels that God put in my path to help me control my disease. I arrived with my blood glucose very high and had gained weight. Today, I have lost 44 pounds. My blood glucose level is controlled and the thing that makes me the happiest is that my medication dose has been reduced. Today I feel completely different and can't find the words to express how good I feel."
—Patient, Westside Community Clinic

Statewide Outcomes

There have been improvements in diabetes death rates and decreases in disparities for African Americans and American Indians. The death rate for Latinos remained virtually the same over the two time periods. The Asian diabetes death rate increased slightly but remains lower than the White rate of 22.3.

Table 10: Diabetes Death Rates* per 100,000 Population by Race/Ethnicity

	Baseline Rate 1995-99	Current Rate 2000-04	Disparity Status
African American	59.7	54.6	Better
American Indian	108.8	86.5	Better
Asian	21.1	22.5	Worse
Latino	37.7	37.5	Better
White	22.3	23.3	N/A

[1]Disparity = Population of Color rate – White rate
* Age-adjusted death rate

Selected Grantee Outcomes

A wide range of services, activities, strategies, and approaches define the EHDI grantees working on decreasing and preventing diabetes in their communities. These grantees work to define the goals, objectives and project outcomes. Through these outcomes, grantees document increases in the knowledge of risk factors that lead to diabetes, increased exercise, improvement in blood pressure and eating habits. Some examples of these outcomes are included in this section with a more complete set of grantee outcomes included in the Appendix B.

Dar Al-Hijrah: Somali Health Screening Center

The number of clients who come to the Dar Al Hijrah Health Screening Center to get their blood sugar level tested has increased from 550 during the first year the Center was open to over 1,600.

Anishinaabe Center: Defeat Diabetes

70% of the participants in the Defeat Diabetes Days have increased their knowledge about diabetes. 70% of the participants in the Defeat Diabetes Days indicated they have improved their eating habits to improve diabetes.

Upper Sioux

Tribal grantee worked on building an infrastructure to increase the consistency and continuity for delivery of healthcare for Upper Sioux community tribal members 40% (17) of USC members attended diabetes workshops, 100 % (5) of staff participated in workshops on diabetes and/or cardiovascular disease.

"We have been very encouraged about the improvement in the diabetes program. While program services have also improved, the EHDI-supported improvements in the diabetes monitoring systems are really exciting. Because diabetes is such an issue for our community, the improvements in this program are a hopeful sign for the community."

–Upper Sioux Community

Healthy Youth Development

Investment in health during adolescence has long-term benefits for Minnesota youth. Healthy youth development includes promoting healthy behaviors, positive attitudes and prevention of high-risk behaviors such as alcohol, drug use, and sexual activity among Minnesota youth. Healthy Youth Development projects focus on the physical, emotional, social, and spiritual health of youth; providing a foundation for adult life.

Objectives

Increase culturally specific programming for youth that will reduce the disparity of teen pregnancy for Populations of Color and American Indians compared to Whites in Minnesota.

Grantee Impact

Healthy youth development grantees provide services for all age groups, though more targeted services are provided to teens and their parents. The programs and services are provided through community-based organizations, clinics, tribal health organizations, and churches. These programs make a difference in the targeted communities by promoting abstinence, education, and helping youth avoid high-risk behaviors such as alcohol, drug use, and unprotected sex. Programs encourage healthy youth development through their work with youth and parents to increase positive cultural identity, increased self-esteem, and decision-making.

Table 11: EHDI Grantee Outreach in Healthy Youth Development

Healthy Youth Dev.	Number
Grantees	18
Total Counties	16
Tribal	5
Direct Service Contact	13,482

Figure 6: 16 Counties* Reached by Healthy Youth Development Grantees

Source: December 2005 Grantee Reports

*Carlton, Cook, Goodhue, Redwood, Renville, Yellow Medicine

Programs have implemented several curricula focused on healthy youth development. Grantees select culturally appropriate materials and activities and have adapted materials to meet the needs of their cultural communities.

Grantees focus on providing services to targeted groups including people of African, American Indian, Asian, Latino, and multi-racial descent. A larger number of grantees focused their activities on American Indians, African Americans, and Latinos.

Statewide Outcomes

Disparities for African Americans, American Indians, Asians and Latinos have declined, consistent with the goals of the EHDI. These data indicate that while EHDI programs may be having some impact on statewide outcomes, considerable disparities remain between Populations of Color/American Indians and Whites in Minnesota.

Table 12 ; Minnesota Pregnancy Rates per 1,000 Females Age 15-19 by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
1997-99 Rate	174.4	120.6	87.8	151.8	32.2
2002-04 Rate	121.0	114.4	64.2	130.1	25.0
Disparity Status	Better	Better	Better	Better	N/A

Selected Grantee Outcomes

Camphor Foundation: UJIMA Teen Pregnancy and Healthy Youth

89% of the females in the program have self-reported that they are NOT engaging in sexual activity* 81% of the males in the program have self-reported that they are NOT engaging in sexual activity* To date, there has been NO babies of the females who have participated in the program. N=389 Time period 01/01/2004 to 12/10/2005.

Freeport West: Project Solo

Results for 2004: Staff reported that 113 youth set behavior goals. Of those, 71 goals were reported as progressing, achieved, or maintaining their behavior goal for the quarter; therefore, of the goals set, 63% decreased high risk behaviors. Results for 2005: there were 25 youth with one or more behavior goals set (35 goals set in all). Of that, 20 of the 25 have made progress (80%). There are 12 youth that set a substance use goal; of those all 12 youth have made progress (100%).

West Central Integration Collaborative

60 % of the youth (N=260) reported that they now watch less than 5 hours of television per week. Parents have noticed not only an increase in activity for their youth but also an improvement in schoolwork and attendence to school.

"Our program builds on the strengths of the community … our curriculum was created after surveying our community, particularly our teen parents, and listening to what community members believe will help lower teen pregnancy rates. Based on community recommendations … incorporating American Indian culture with sexuality education was imperative. We hired American Indian consultants to work with our community to create such a curriculum, which has now been implemented at eleven schools, community based organizations and reservations in Minnesota. Also, our curriculum incorporates input from elders in the community and strongly recommends their involvement at each implementation site."

– Division of Indian Work

HIV/AIDS and Sexually Transmitted Infections

Data has documented widespread disparities between African American, American Indians, and Latinos as compared to Whites for new HIV infections, persons living with AIDS, and other sexually transmitted diseases. For example, 2000 data indicated that the new HIV infection rate for African Americans was 19 times the White rate ; the Latino rate was 6 times the White rate; and the American Indian rate was 3 times the White rate. Chlamydia, a sexually transitted infection, shows a similar disparity.

Objectives

Reduction in disparities in the new infection rates for HIV/AIDS and sexually transmitted infections i.e. Chlamydia and gonorrhea

Grantee Impact

EHDI grantees have implemented a variety of programs to reduce the spread of HIV/AIDS and STI in Minnesota including health education workshops, outreach services, screening, after-school and summer enrichment programs, pre and post test counseling, risk assessment, support groups and follow-up consultations.

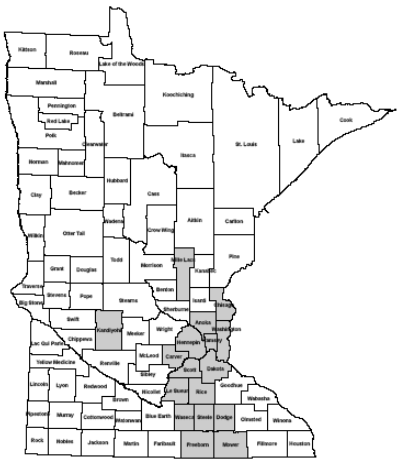
Table 13: EHDI Grantee Outreach In HIV/AIDs & STIs

HIV/AIDs & STIs	Number
Grantees	10
Total Counties	17
Tribal	-
Direct Service Contacts	7,575

Statewide Outcomes

The new HIV infection rates for Latinos, Americans Indians and Asians have decreased from 2000 to 2005. While the new HIV infection rate for African Americans increased slightly as did the disparity between African Americans and Whites.

Figure 7: Counties Reached by HIV/AIDS Grantees



Source: December 2005 Grantee Reports

Table 14: New HIV Infection* Rates per 100,000 Population by Race/Ethnicity in Minnesota

	African/African American	American Indian	Asian	Latino	White
2000 Rate	54.2	11.1	3.0	21.6	2.8
2005 Rate	56.2	3.7	1.8	16.0	3.7
Disparity Status	Worse	Better	–	Better	N/A

[1]Disparity = Population of Color rate minus the White rate from 1999 (2.8)
*HIV or AIDS at first diagnosis

The disparities for chlamydia and gonorrhea rate between Populations of Color/American Indians and Whites have decreased for all groups.

Table 15: Chlamydia and Gonorrhea Rates per 100,000 Population by Race/Ethnicity in Minnesota

	African American	American Indian	Asian	Latino	White
Chlamydia					
2000 Rate	1,769	540	314	652	73
2005 Rate	1,535	512	282	624	115
Disparity Status	Better	Better	Better	Better	N/A
Gonorrhea					
2000 Rate	1,149	123	34	135	18
2005 Rate	775	118	31	85	23.0
Disparity Status	Better	Better	Better	Better	N/A

[1]Disparity = Population of Color rate – White rate (chlamydia = 73 and gonorrhea = 18)

Selected Grantee Outcomes

African American AIDS Task Force
AAATF and the Hennepin County Medical Center staff collaborated to increase knowledge of HIV/AIDS and screening and assessment resources in communities of color. 2211 contacts were recorded and there was an increase in the number of people seeking both pre and post-test counseling

Centro Campesino
The number of local Latino participants in HIV/AIDs awareness and screening has increased by 200% (N=206) compared to the 2002 results.

Council on Crime and Justice: Health Educational Lifestyles Project
HELP has been successful in building many community partnerships that can support HELP participants once they are released.

Southside Community Clinic and Freemont Community Clinic have provided free physicals, STD testing, and assistance to participants as they apply for ongoing medical coverage. Program participants took a 10-week course about HIV/AIDS, STIs, and Hepatitis C. The participants took pre and post tests. In the pre-test the mean score was 7.24 answers correct out of 9 and the post-test was 7.18. (Pre and post tests need to be changed to more effectively show what knowledge about STDs is changing in the class).

Child and Adult Immunization

Vaccines prevent disease in people who receive them and protect those who come into contact with unvaccinated individuals (CDC National Immunization Program). The percent of 17 month old children who were up-to-date on their primary series immunizations in 2000-01 varied by race/ethnicity as do the disparities. The greatest disparity was for African American children. At the age of 17 months, 20% more White children were immunized than African American children. The percent of American Indian children who were immunized at 17 months was 71%, a 10% disparity. Asian and Latinos disparities were 15%.

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

Objectives

The EHDI Legislation specifically stated that by 2010, the disparities in adult and child immunizations rates between Populations of Color/American Indians and Whites be reduced by 50 percent.

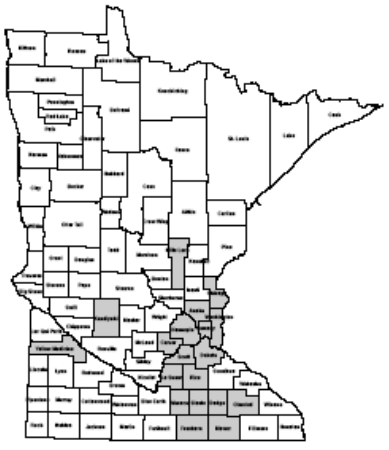
Grantee Impact

Programs and services are offered at community organizations, clinics, and tribal health organizations. EHDI grantees have provided a variety of services to increase immunization rates. Grantees have conducted immunization clinics, implemented immunization awareness campaigns and education workshops, and assisted individuals with accessing health care and referral services.

Table 16: EHDI Grantee Outreach in Immunizations

Immunization	Number
Grantees	13
Total Counties	19
Tribal	2
Direct Service Contacts	6,232

Figure 8: 19 Counties Reached by Immunization Grantees



Source: December 2005 Grantee Reports

[*] *Adult immunization data by race/ethnicity are not available at the state level.*

Table 17: Percent Up-to-Date for Primary Series Immunization Levels at 17 Months of Age by Race/Ethnicity: Minnesota, 2000-01

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

*Disparity = Population of Color rate – White rate
**Target = (Disparity*.50) + 2000-01 Percent

Statewide Outcomes

Since MDH no longer conducts the *Minnesota Retrospective Kindergarten Study*, a statewide outcomes update for childhood immunizations is not available. While national immunization data suggest that all immunization rates have improved, the data are not available by race/ethnicity. At this time, there are insufficient funds to evaluate immunization coverage levels by race/ethnicity.

Selected Grantee Outcomes

Olmsted County Public Health EHDI

In 2004, District 535 (Rochester) reported there were 93 students who were excluded from school because their immunizations were not current. In 2005 there was only one student who was excluded because of their incomplete immunization status.

Storefront Group: Bridge to Success

Bridge to Success conducted immunization awareness workshops provided one-on-one support, and information and resources for Somali families resulting in an increase in knowledge about the need for immunization. 87% of participants completed a survey with the results indicating that they have learned about immunization and the need to have children immunized.

"I have gained my health and a healthy body"
–Somali Elder

Infant Mortality

Infant mortality is one of the priority health areas specifically identified with a goal in the EHDI legislation. Infant mortality is the death of a baby before its first birthday. Disparities in infant mortality are greatest for American Indians and African Americans. While there are also disparities in rates for Asian and Latinos, these disparities are not as severe as African Americans or American Indians.

Objective

The legislation defines a specific outcome of reducing the gap in infant mortality rates among the African American, American Indian, Asian, Latino and the White populations in Minnesota by 50 percent.

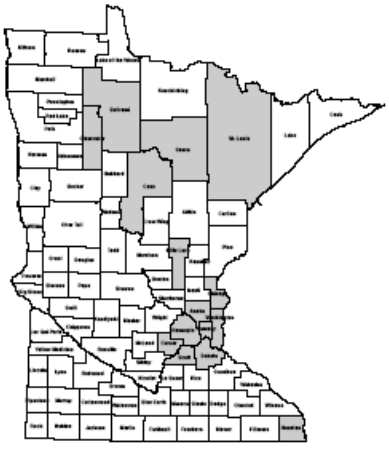
Grantee Impact

Programs and services provided by grantees are developed and implemented based on the specific needs and culture of each community. EHDI grantees have designed and administered a wide range of activities to address infant mortality and promote healthy birth outcomes in their communities.

Table 18: EHDI Grantee Outreach in Infant Mortality

Infant Mortality	Number
Grantees	11
Total Counties	15
Tribal	3
Direct Service Contacts	4,414

Figure 9: 15 Counties Reached by Infant Mortality Grantees



Source: December 2005 Grantee Reports

Grantees focus on providing services to targeted groups including people of African American, American Indian, Asian, Latino, and multi-racial descent. Grantees provide services to all of these populations, others specifically target one racial/ethnic group in their programming (e.g. Stairstep primarily focuses on African Americans).

Four tribes in Minnesota and two urban health organizations chose infant mortality as one of their priority health areas.

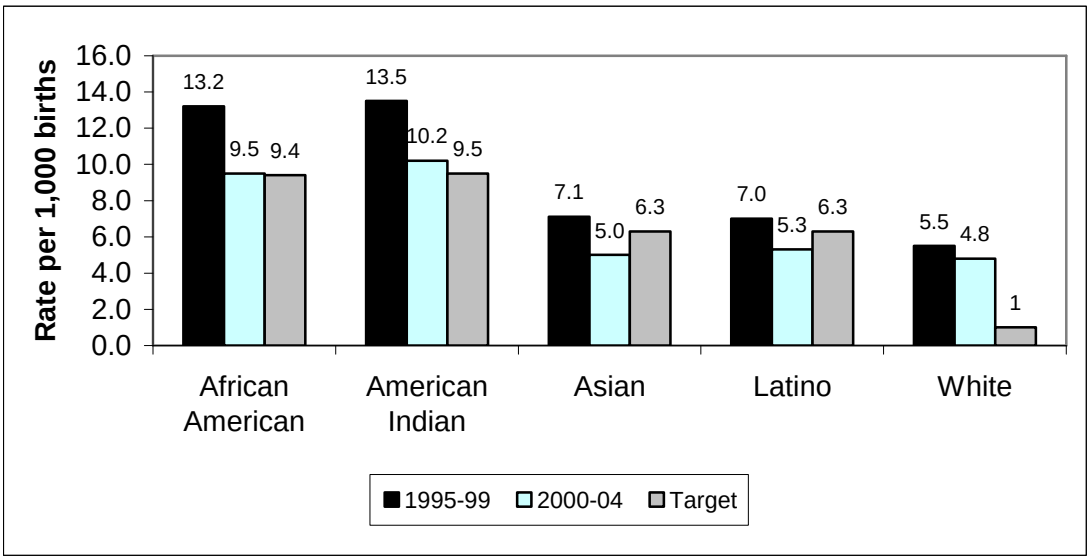
One effective strategy is the doula program that has been implemented in 3 organizations. Doula programs promote healthy pregnancy through education and support of mothers and infants during pregnancy, birth, and parenting. Assessment, screening, nutrition, exercise, mental health, prenatal care, and newborn care are educational opportunities provided as a part of these activities.

Other activities include workshops; classes; strategies to increase breastfeeding initiation and duration; safe sleep education; and cultural competency education for physicians and health providers.

Statewide Outcomes

Infant mortality rates have declined for all racial ethnic populations (Figure 9). This graph also indicates that with EHDI funds, target rates have been met for Latinos and Asians. Yet, while infant mortality rates have declined noticeably for African American and American Indians, disparities between these two groups and Whites continue to exist.

Figure 10: Infant Mortality rates compared to EHDI Target Rates



[1]The 50 percent reduction was computed by finding the difference between the rate for racial/ethnic groups and Whites and multiplying this difference by 50 percent. Reduction in disparity is then subtracted from the baseline rate. (Target = 1995-99 rate - (Disparity)*.50)

These outcomes indicate that while EHDI and other efforts have had an impact on the rates of infant mortality for Populations of Color and American Indians that disparities continue to exist. EHDI efforts, community, state, and national efforts directed toward reductions in infant mortality must continue.

Selected Grantee Outcomes

A wide range of services, target populations, activities, strategies, and approaches define the EHDI grantees focusing on infant mortality. The community-based grantees work within their communities to define the goals, objectives and project outcomes. Each of these projects is unique and each is required to submit an evaluation plan that includes objectives that are realistic and measurable within the framework of the Initiative.

Grantees are asked to report progress on their outcomes on an annual basis. Some examples of grantee outcomes are included in this section with a more complete set of grantee outcomes included in Appendix B.

Division of Indian Work: Doula – Women of Traditional Birthing

Of the 230 births born to American Indian women in Minneapolis in 2004, 12% (28) were doula assisted by our "Women of Traditional Birthing" program. Thirty-two pregnant Native women participated in the prenatal doula services with 90% (29) having a doula-assisted birth.

Fond du Lac Tribe: Human Services Division

The US National breastfeeding initiation rate for American Indian women in 2004 was 68%. (2004 N = 64, 2005 N = 62 women who delivered in that year). In 2004, 78% of mothers who were served by the Center for American Indian Resources initiated breastfeeding, the following year it increased to 81%.

"[At a home visit with a new mother], we reviewed indicators and interventions on the prevention [of SIDS]. I also stressed the importance of teaching this information to other friends and relatives with small children under one year old. This is important as clients listen to their friends and relatives on how to care for their children rather than the suggestions of a provider, it also gives community members leadership roles. At another home visit the following week, I was reviewing the same literature and this particular mother knew this information because I had seen her aunt the week prior. Her aunt relayed the information about SIDS and both mothers were astonished at the high numbers in American Indian infant deaths related to SIDS. It was great that these mothers care enough about each other to educate one another."

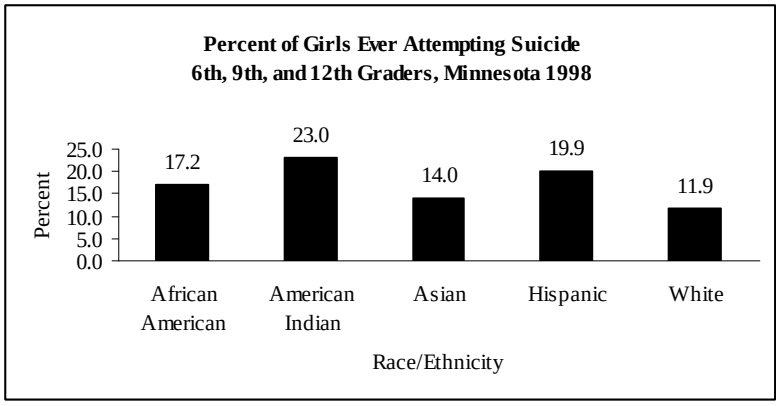
-Public Health Nurse, Red Lake Comprehensive Health Services

Unintentional Injury and Violence

Unintentional injury and violence, includes homicide, suicide, domestic violence, sexual assault, motor vehicle injuries/deaths, falls, drownings, poisonings and fire-related deaths. Because this health area is so broad, it is difficult to summarize the burden and impact unintentional injury and violence has on Populations of Color and American Indians.

Mortality data indicate that unintentional injuries, homicides and suicides disproportionately affect Populations of Color and American Indians. For example, the homicide rate for African Americans was 18.6 times higher than Whites in 1995-99. The Asian homicide rate was closest to the White rate for that time period but was still 2.4 times higher. The suicide rate and unintentional injury death rates for American Indians were twice as high as the White rate for 1995-99. Finally, the 1998 Minnesota Student Survey indicates that the percent of Latina and American Indian girls who have ever attempted suicide is considerably higher than White girls in the same grade.

Figure 11: Percent of Girls Attempting Suicide in Minnesota, 1998



Source: Minnesota Student Survey

Objective

Reduction in disparities in the death rates of unintentional injury, homicide and suicide for Populations of Color and American Indians

Grantee Impact

EHDI grantee program activities varied greatly. One grantee focused on violence prevention in the Hmong community specifically addressing "injuries resulting from violence". Another grantee provides family violence prevention and intervention services including victim sensitive support and resources to victims.

Another grantee targets its violence and unintentional injury services on suicide prevention and mental health. The program encourages community members to live in balance, addressing mental health through the physical, emotional, and spiritual aspects of the individual.

Among the many strategies utilized to reduce violence and unintentional injury in targeted communities, grantees provide education, counseling, group activities, assessment, home visiting, support and advocacy, and case management.

Figure 12: 24 Counties Reached by Violence and Unintentional Injury Grantees

Source: December 2005 Grantee Reports

Table 19: EHDI Grantee Outreach in Violence and Unintentional Injury

Violence & Injury	Number
Grantees	12
Total Counties	24
Tribal	4
Direct Service Contact	4,784

Statewide Outcomes

According to most recent figures, the disparity for Asian and Latinos has been eliminated! While death rates for unintentional injury have improved for African Americans, unfortunately they have gotten markedly worse for American Indians.

Table 20: Unintentional Injury Death Rates per 100,000 Population by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
1995-99 Rate	40.7	75.8	36.1	40.2	34.4
2000-04 Rate	35.7	95.4	24.0	31.0	34.7
Disparity Status	Better	Worse	Better	Better	N/A

[1]Disparity = Population of Color rate minus the White rate from 1995-99 (34.4)

The disparities in homicide rates have gotten better between the two time periods for all racial and ethnic groups. The suicide rate disparities also narrowed for all groups except American Indians.

Table 21: Homicide Rates per 100,000 Population by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
1995-99 Rate	33.5	21.0	4.4	7.3	1.8
2000-04 Rate	17.2	14.6	3.8	5.0	1.6
Disparity Status	Better	Better	Better	Better	N/A

[1]Disparity = Population of Color rate minus the White rate from 1995-99 (1.8)

Table 22: Suicide Rates per 100,000 Population by Race/Ethnicity

	African American	American Indian	Asian	Latino	White
1995-99 Rate	9.6	15.7	10.0	11.5	9.9
2000-04 Rate	6.3	20.1	8.7	6.8	9.5
Disparity Status	Better	Worse	-Better	Better	N/A

Examples of Grantee Outcomes

United Hospital Foundation

Partners for Violence Prevention provided education to health and social service professionals about family violence and screening, community and school related activities and animal assisted therapy groups to increase knowledge about family violence prevention and interventions. Post test indicated an increase in healthcare provider's knowledge about family violence prevention and interventions, screening, responding to patients in violent family situations, intervention and referral sources.

"... She never knew how he could so understanding and respectful ... she was treated with respect and their children are also being treated with respect. She told the group that she was proud of them [family members]."

– Spouse of anger management participant

Hmong American Partnership: We Are the Peace We Need, We Are Our Own Solutions

83 attended the community forum to identify and strengthen cultural protective factors and promote violence prevention awareness. The attendees included Hmong residents, Hmong professionals and system representatives. Below are comments from two attendees:

"[We have an] improved understanding of cultural differences and saw more clearly the concerns of Hmong Americans"

"I gained more insight into the issue of cultural protective factors. I realized that although the elders are not educated, how intellectually gifted they are. Their ability to conceptualize and play out the situational circumstances is amazing and oftentimes we young people too quickly missed the points and dismissed their perspectives"

White Earth Tribal Mental Health

100% (17) of individuals who completed the White Earth Anger Management Program understood what it meant to be accountable and that no one else could control their behavior. They understood that they were responsible for their negative and positive actions and consequences came from both types of actions. The group participants enjoyed the consequences that accompanied the positive actions.

Grant Management and Capacity Building

Grant Management

The mission of the Office of Minority and Multicultural Health (OMMH) is to strengthen the health and wellness of racial/ethnic, cultural and tribal populations in Minnesota by engaging diverse populations in health systems, mutual learning and actions essential for achieving health parity and optimal wellness.

Minnesotans have consistently ranked No.1 as the healthiest people in the nation, according to the United Health Foundation's annual ranking of states. Not everyone has shared in this legacy of good health due to health disparities. Health disparities are "...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[2]

The health problems (disparities) that have been documented in the state's minority and tribal communities include shorter life spans, poorer general health, higher rates of infant mortality, and higher incidences of diabetes, heart diseases and cancer.

Over this two-year funding period (2004-05), the Minnesota Department of Health funded 42 community-based organizations (grantees) and 10 Minnesota Indian Tribes funding to improve the health status of Minnesota's Populations of Color and American Indians served by the Community and Tribal Grantees. Staff has monitored the grantee's work and provided technical assistance to ensure that their programs are compliant with the EHDI contractual grant agreements. OMMH has nurtured community relations, created partnerships that strengthen the work of the Minnesota Department of Health, and incorporated a planning process that will support the impact of EHDI. The four distinct components include

Strategic clarity

- Develop a concrete description of EHDI's impact complete with accountability measures for OMMH and the communities it serves

Strategic priorities

- Determine the specific actions and activities needed to achieve the elimination of racial/ethnic health disparities;

Resource implications

- Understand the resources – financial, human, and organizational – needed to pursue priorities and map out the plan to secure them;

Performance measures

- Establishing the quantitative and qualitative milestones that make it possible to measure progress toward eliminating health disparities.

[2] National Institutes of Health. NIH Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities; 2000. Available at: www.nig.gov/about/hd/strategicplan.pdf. Accessed September 5, 2006.

The Office of Minority and Multicultural Health's activities cover a broad spectrum of areas. The following examples highlight only a sampling of its impact throughout Minnesota:

Education and Training

- Grantees attend semi-annual capacity building trainings
- Grantees attend MN Department of Health Community Health Conference
- OMMH office presents 'Eliminating Health Disparities' at the MN Department of Health Community Health Conference
- OMMH Staff and EHDI Grantees work together to increase education opportunities for cultural communities
- EHDI Grantees were key presenters for national evaluation conference
- Conference planning partnership with the Minnesota Department of Education.
- Macalester College Diversity in Science and Computers Participant Internship site
- Facilitate Tribal Emergency Preparedness Training

Collaborations

- State Maternal and Child Health Task force
- Hennepin County Latino Infant Mortality Advisory Symposiums
- Federal Office of Women's Health – Region V
- Partnerships to enhance collective capacity to address HIV/AIDS for Populations of Color and American Indians
- Minnesota State University at Mankato (MNSCU representative) Health Education Industry Partnership with healthcare system partners (Blue Cross Blue Shield, HealthPartners, Medica, Neighborhood Healthcare Network Portico, UCare Minnesota) and local community organizations to design and pilot the Community Health Worker Certificate Program
- Save 10 Community Task Force, Twin Cities HealthyStart and Periscope Advertising Agency created a public campaign to create awareness about infant mortality in the African American community

Evaluation Capacity Building

The goal is to increase the evaluation capacity of the grantees and to document the outcomes from a grantee perspective. The evaluation model implemented for the EHDI is not a traditional "evaluator-controlled evaluation" where the outside evaluator evaluates the program for the organization. In the EHDI evaluation model, the evaluators, Rainbow Research, provide one-on-one technical assistance and small group trainings to grantees and their stakeholders. The program staff and stakeholders are expected to develop evaluation logic models and plan and implement their evaluation.

At the end of the fourth year, EHDI grantees were assessed to determine if evaluation capacity had been built. The grantees that were most successful in their evaluations were the ones who attended the evaluation trainings, workshops and one-on-one evaluation sessions.

In addition, OMMH staff use conventional methods of site visits, budget reviews and reports to monitor EHDI grantees' progress while also providing technical assistance in the development, implementation and promotion of culturally effective strategies.

The organizational capacity built through this aspect of the EHDI has prepared grantees to become active and valued partners with external organizations engaged in disparities work including research. In addition to better documentation of EHDI and disparities work in general, the capacity built at the organizational level will yield better research, better evaluation, better programs and positive health outcomes.

APPENDICES

Appendix A: EHDI Statutes

Eliminating Health Disparities Initiative Legislation
Laws of Minnesota 2001 1st Special Session, Chapter 9, Article 1

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

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

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

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

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

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

Subd. 6. [PROCESS.] (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section.

In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.
(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:
(1) decreasing racial and ethnic disparities in infant mortality rates; or
(2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.
(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.
(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.
(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:
(1) is supported by the community the applicant will serve;
(2) is research-based or based on promising strategies;
(3) is designed to complement other related community activities;
(4) utilizes strategies that positively impact both priority areas;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:
(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;
(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;
(3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;
(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or
(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.
(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.
(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:
(1) is supported by the community the applicant will serve;
(2) is research-based or based on promising strategies;
(3) is designed to complement other related community activities;
(4) utilizes strategies that positively impact more than one priority area;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. [HEALTH OF FOREIGN-BORN PERSONS.] (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:
(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;
(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;
(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and
(4) $50 per foreign-born person in the community health board's service area.
(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

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

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

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

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

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

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

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

[INFANT MORTALITY REDUCTION.] Of the TANF appropriation, $2,000,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 7, to reduce infant mortality.
[REDUCING INFANT MORTALITY CARRYFORWARD.] Any unexpended balance of the TANF funds appropriated for reducing infant mortality in the first year of the biennium does not cancel but is available for the second year.

Chapter 220-H.F.No. 351
Article 17
Health And Human Services Appropriations

Sec. 3. COMMISSIONER OF HEALTH
Subd. 2 Family and Community Health

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

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

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

Appendix B: Grantee Program Descriptions

Grantee Index by Health Area

Grantee Program Descriptions

Grantee Index by Racial/Ethnic Group

Grantee Index by Region

Metropolitan - Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington
Northwestern - Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Marshall, Pennington, Polk, Red Lake, Roseau
Northeastern - Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis
Central - Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, Wright
West Central - Becker, Clay, Douglas, Grant, Mahnomen, Norman, Otter Tail, Pope, Stevens, Traverse, Wilkin
South Central - Blue Earth, Brown, Faribault, Le Sueur, McLeod, Martin, Meeker, Nicollet, Sibley, Waseca, Watonwan
Southeastern - Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona
Southwestern - Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Yellow Medicine

EHDI Grantees

African American AIDS Task Force
Project Name: Eliminating Health Disparities Initiative

Contact Person: Gwendolyn Velez
E-mail: gwen_velez@qwest.net
Phone: (612) 825 1137
Website:

Address: 310 East 38th Street Suite 304 E Minneapolis, MN 55409

EHDI Project Description

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/STD screening; Health Education/Risk Reduction; and HIV Counseling, Testing and Referrals. The HCMC medical staff conduct the screening and refer the clients who are considered to be at risk for HIV or STI's to AAATF for further risk assessment and health education. AAATF staff then conducted a more intensive risk assessment and provide clients with information on the services provided by the AAATF/HCMC EHDI program. 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 behavior change. Under the Out-Reach component of the Program, AAATF is continuously establishing relationships with community leaders in the African and African American communities.

Geographic Service Area: Primarily Twin Cities Metropolitan area and several outer/inner ring suburbs: Brooklyn Park, Bloomington, Brooklyn Center, Richfield, Maple Grove, Champlin, West St. Paul, Cedar Riverside, Elliot Park, etc.

Health Disparity Areas Being Addressed by Grantee

Infant Mortality		Immunizations	
Breast & Cervical Cancer		Violence & Unintentional Injuries	
Diabetes		Healthy Youth Development	
HIV/AIDS and STI's	X	Cardiovascular Disease	

Project's Target Population

Immigrant Status		Race		Age	
Primarily Immigrants		African American	X	Infants	
Immigrants and others	X	American Indian	X	Children	
Primarily non-immigrant		Asian	X	Teens	X
Not applicable		Hispanic/Latino	X	Adults	X
		Multi-racial	X	Seniors	X
		Other	X		

Specific cultural group: The greatest number served are: African American and African populations from Kenya, Somalia, Liberia, Ethiopia, Tanzania, Uganda, Cameroon, Sudan, Burundi, Zambia, and Rwanda.

Source: December 2005 EHDI Community and Tribal Grantee Reports

Agape House for Mothers
Project Name: Agape House for Mothers, Inc.

Contact Person: Roberta D. Barnes
E-mail: Roberta.Barnes@agapehouseinc.com
Phone: 651-221-9146
Website:

Address: 400 Selby Avenue, Suite T St. Paul, MN 55102

EHDI Project Description

The intentions of our Agape HYD/EHDI program is 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 the positive roles and contributions that family members, community, and church can contribute to a values-centered life. Think through the life-altering impact of early pregnancy. To know where to go for support and counseling regarding issues around sex, sexually transmitted infections and pregnancy. Know how to practice various techniques of refusal and abstinence. Be prepared to avoid situations that can potentially lead to pregnancy and sexually transmitted infections. Know facts regarding safe sex and the proper use of contraceptives as a "protection wall" against pregnancy and sexually transmitted infections. Develop and implement a post plan to assume the responsibility, to protect against pregnancy and sexually transmitted infections. Last but not least become more actively involved in positive activities through community services.

Geographic Service Area: St. Paul neighborhoods: Summit-University, Frogtown, East Side, West Side and West Seventh Street and Minneapolis neighborhoods: North Side, Phillips, South Central, and Powderhorn

Health Disparity Areas Being Addressed by Grantee

Infant Mortality		Immunizations	
Breast & Cervical Cancer		Violence & Unintentional Injuries	
Diabetes		Healthy Youth Development	X
HIV/AIDS and STI's	X	Cardiovascular Disease	

Project's Target Population

Immigrant Status		Race		Age	
Primarily Immigrants		African American	X	Infants	
Immigrants and others		American Indian	X	Children	
Primarily non-immigrant	X	Asian		Teens	X
Not applicable		Hispanic/Latino		Adults	X
		Multi-racial	X	Seniors	
		Other	X		

Specific cultural group: Within the African population the culture served is Somali, Nigerians and Liberians.

Source: December 2005 EHDI Community and Tribal Grantee Reports

American Indian Family Collaborative
Project Name: Family Center Community Doula Program

Contact Person: Janice LaFloe
E-mail: janice@aifc.net
Phone: 651-793-3803
Website: aifc.net
Address: 579 Wells Street St. Paul, MN 55101

EHDI Project Description

The Community Doula program was created to train women in communities of color to serve as doulas. Doula is a Greek word meaning "mothers taking care of mothers during pregnancy." 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.

Geographic Service Area: Ramsey County

Health Disparity Areas Being Addressed by Grantee

Infant Mortality	X	Immunizations	
Breast & Cervical Cancer		Violence & Unintentional Injuries	
Diabetes		Healthy Youth Development	
HIV/AIDS and STI's		Cardiovascular Disease	

Project's Target Population

Immigrant Status		Race		Age	
Primarily Immigrants		African American	X	Infants	X
Immigrants and others		American Indian	X	Children	
Primarily non-immigrant	X	Asian	X	Teens	X
Not applicable		Hispanic/Latino	X	Adults	X
		Multi-racial	X	Seniors	
		Other	X		

Specific cultural group:

Source: December 2005 EHDI Community and Tribal Grantee Report