



ELIMINATE HEALTH DISPARITIES

Minnesota has been noted as one of the healthiest states in the nation; however, racial/ethnic minority populations in Minnesota experience poorer health in several areas. Overall, populations of color and American Indians experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, and cancer, as well as other diseases and conditions. These disparities also affect Minnesota's newly arrived immigrants and refugees. In some cases, the health disparities among these populations are the highest in the nation. Populations of color and American Indians have joined with MDH and its Office of Minority and Multicultural Health for increased attention to these issues.

Data on Health Disparities. Improved data collection now is more accurately uncovering the breadth of these health disparities in Minnesota. Highlights of those data are summarized on fact sheets covering Minnesota's four major racial/ethnic minority groups - African American, American Indian, Asian American and Hispanic/Latino. To locate these fact sheets see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “African American” for *Eliminating Disparities in the Health Status of African Americans*; on “American Indian” for *Eliminating Disparities in the Health Status of American Indians*; on “Asian American” for *Eliminating Disparities in the Health Status of Asian Americans*; and on “Hispanic/Latino” for *Eliminating Disparities in the Health Status of Hispanics/Latinos*.

Data on “subgroups” within several of these racial/ethnic groups, for example Somalis from Africa and the Asian Hmong community in Minnesota (one of the largest Hmong communities in the United States) are not specifically identified among the data for the respective larger racial/ethnic group. Without this identification of subgroups, accurate analysis and assessment of health status and specific health issues is very difficult, and is a disservice to the population subgroups.

More specifically, some examples of these racial/ethnic and American Indian health disparities include:

- < Among the racial/ethnic groups in Minnesota, African American women have a breast cancer mortality rate that is 50 percent higher than that of white or Hispanic/Latina women, despite similar incidence rates. A greater proportion of African American women with breast cancer are diagnosed at a later, less treatable stage.
- < African American, American Indian, and Asian American women have cervical cancer incidence rates that are three to four times higher than the rate for white women. Deaths due to cervical cancer also occur at significantly higher rates among Asian Americans and African Americans compared with whites.
- < Mortality rates for Minnesotans overall are lower than for the nation as a whole; however, for some segments of the population, including American Indians, Asian Americans, and African American females, mortality rates for heart disease or stroke are higher than these rates for the overall state population. American Indian death rates from 1990 through



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1998 were 33 percent higher than the state's population rates and 44 percent higher than the total U.S. American Indian rates. Age-adjusted death rates also indicate considerable disparities in heart disease for African American females living in Minnesota. Asian Americans living in Minnesota are more likely than other population groups to suffer from stroke.

- < In Minnesota, glaring racial and ethnic disparities in diabetes exist. These are reflected in the prevalence, complications, death rates, and preventive care received by those who have diabetes. Compared to whites, diabetes, as an underlying cause of death in Minnesota, was between 1.5 and five times more common among African Americans, Hispanics/Latinos, and American Indians. The diabetes death rate among Asian Americans is increasing faster than among any other racial or ethnic group. Among people with diabetes: kidney failure is two to six times greater in populations of color; lower limb amputations are four times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos, and 40-50 percent greater in African Americans.
- < In 2000, the number of newly reported cases of HIV among persons of color was greater than among whites for the first time in Minnesota, even though communities of color make up approximately 10 percent of Minnesota's population. African American men have the highest annual rate of newly reported HIV/AIDS infections, 21 times greater than white males in Minnesota. The disparity is even greater for African

American women with an HIV/AIDS rate 91 times greater than that among white women.

- < Infant mortality is a summary statistic reflecting multiple conditions and causes. Although Minnesota has one of the lowest state infant mortality rates in the nation, the overall state rate masks severe and longstanding disparities in infant mortality experienced by some of Minnesota's populations. American Indian infant deaths have been rising over time. In fact, the National Center for Health Statistics and the Bemidji Indian Health Service have reported that Minnesota's Indian infant death rate is the highest in the U.S. African American infant deaths, although improving over time, remain significantly higher than those of white infants. Asian infant deaths are also rising in the most recent time period measured.
- < Minnesota has wide and unacceptable disparities in the rates of teen pregnancy across its population. While Minnesota's teen pregnancy rate among whites is one of the lowest in the nation, the rates among African American and Hispanic/Latina teens are first and second respectively. While teen pregnancy rates among many Minnesota populations are decreasing, there is an alarming increase in pregnancy rates for Asian and Hispanic/Latina teens. Preventing teen pregnancy reduces infant mortality, child poverty, and out-of-wedlock childbearing and is an effective way to improve overall child and family well-being.

Social and Economic Determinants of Health Disparities. According to the report



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A Call to Action: Advancing Health for all through Social and Economic Change (July 2001), “health is the product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with the collective conditions (factors in the physical, social, and economic environment).”

(For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Social Determinants”.)

In addition, factors and barriers to better health status have been identified as: lack of health care insurance and access to affordable health services; language differences and lack of interpreters; negative cultural history with western medicine and systems; lack of transportation to health services; lack of child care available to attend health-related appointments; and lack of health providers from and familiar with the varying cultural groups in Minnesota.

A Call to Action further identifies the key aspects of the social and economic environments that affect health as education, income, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation, and nutritious foods; racism and discrimination; employment and working conditions; and culture, religion, and ethnicity. In addition:

- < The effect of income inequality on health is not limited to people in poor or low income groups. The health of people in middle (and, in some studies, upper) income groups is worse in communities with a high degree of income inequality (a large income gap) when compared to

communities with less income inequality (a smaller income gap).

- < Poverty is not the overarching factor for poor health. Regardless of income or health care coverage, people of color receive poorer services. (Institute of Medicine, 2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington D.C. Contact: National Academy Press, at (800) 624-6242, <http://www.nap.edu/books/030908265X/html/>).
- < Culture, religion, and ethnicity have an overarching influence on beliefs and practices related to health, illness, and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about type of provider or healer that should be sought.

Underlying social and economic conditions affect health status as much as do individual health behaviors, access to health care, and genetics. Studies conducted to date point to conclusions, such as:

- < Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), environmental hazards and chronic stress.
- < People of color and American Indians do not experience poorer health simply because they are more likely to have lower income; at every level of income



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the health of people of color and American Indians is poorer than that of their white peers.

- < People of low income do not experience worse health simply because of high-risk personal behavior. In one recent study, (detrimental) health behaviors explained less than 20 percent of the difference in death rates across income groups.

It is clear that successfully addressing disparities cannot be done without also addressing the realm of social and economic conditions that influence health status. It is also clear that interventions to improve access to medical care and reduce behavioral risks must be combined with broader efforts to increase socioeconomic status and reduce racial/ethnic discrimination in eliminating health disparities.

While public health in Minnesota has the responsibility to address all populations and identify and address all health disparities, the Office of Minority and Multicultural Health (OMMH) exists within MDH to focus attention on the disparities in health status among Minnesota's American Indians and racial/ethnic populations.

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 of the State of Minnesota by engaging diverse populations in health systems, mutual learning, and actions essential for achieving health parity and optimal wellness". (OMMH Mission Statement, 2002)

The OMMH provides leadership within MDH to:

- < Ensure that all health policies, initiatives, and strategies - throughout all levels of the Minnesota Department of Health - are inclusive of populations of color and American Indians.
- < Collaborate on all levels regarding community health activities addressing racial/ethnic and American Indian health.
- < Assist communities in assessing public health needs of populations of color and American Indians.
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- < Build state and community capacity to meet the needs of populations of color and American Indians in disease prevention, health promotion, and health care systems, and to close the gap on health disparities.
- < Identify resources available to community-based organizations regarding racial/ethnic and American Indian health.
- < Work in partnership with communities throughout the state to ensure the health issues of racial/ethnic and American Indian populations are addressed.

In addition, all of MDH is responsible for working with racial/ethnic communities and American Indians in Minnesota, with local public health, and with other organizations and groups to:

- < Identify research issues on the health status of racial/ethnic populations and collaborate with internal and external partners to conduct research.



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- < Identify and develop policies to improve the health status of populations of color and American Indians.
- < Promote collaboration and increased communication among local public health departments, state and local government officials, non-government agencies and organizations (such as voluntary agencies, community-based organizations and philanthropic groups), and populations of color and American Indians, in order to identify and address public health issues.
- < Work to ensure that valid, available, and reliable health data are available on each population of color and on American Indians in Minnesota.

OMMH’s work is based in public health principles* in the following ways :

Implicit in this work is the philosophy that racial/ethnic community members must be able to design strategies and activities relevant to their cultures, traditions, customs, and beliefs.

General Public Health Principles:	Public Health Principles Specific to Addressing Racial and Ethnic Health Disparities:
<p>Aggregate: Public Health’s focus is population-based, rather than individual-based as in medical practice. The whole population as well as population groups within the whole are identified and addressed as groups.</p>	<p>Identify and Address Populations of Color: Racial/ethnic groups are addressed from a population-based, whole group aggregate perspective to determine health status, spotlighting specific groups when indicators of health disparities are noted.</p>
<p>Prevention: Public Health’s priority is to promote health and prevent health problems before risks are apparent and problems occur.</p>	<p>Support Culturally-relevant Health Promotion and Prevention: Community-determined, culturally-relevant strategies that enhance, promote, and improve the health status of communities and populations of color and American Indians are essential.</p>



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<p>Community Organization: Public Health practice means identifying and bringing together community resources to meet needs.</p>	<p>Support Communities' Coming Together for Strength: Racial/ethnic and American Indian community groups develop their own cohesiveness, identify their strengths and assets, and develop their own strategies based in cultural beliefs and practices to enhance health and overall well-being of their people.</p>
<p>Greater Good: Public Health's first consideration is interventions that provide the greater good for the greatest number of people.</p>	<p>Greatest Good: The health of vulnerable populations affects us all and is all our responsibility. With improved quality of life, people have energy and resources to create stronger families and communities.</p>
<p>Leadership: Public Health does what others cannot or will not do.</p>	<p>Support Leadership: Work with, connect, and support local communities and their leaders to identify, take responsibility for, and address racial/ethnic health disparities, and to identify and publicize health disparities among their members, together developing strategies to address the disparities.</p>
<p>Epidemiology: Public Health describes the health status of populations, explains the causes of disease, predicts the occurrence of disease, and controls the distribution of disease. Public health relies on epidemiology as its method of inquiry.</p>	<p>Epidemiology of Racial/Ethnic Health Disparities: Reliable data on the health status of Minnesota's populations of color are almost non-existent, and data collection methods are not culturally-sensitive. Actions can be developed to prevent poor health outcomes by: appropriately identifying, collecting, and reporting racial/ethnic group-specific data; identifying where data are lacking and developing appropriate tools to collect those data; and linking poor health status indicators to social conditions and influences, as well as personal behaviors and genetics.</p>

* For more information on public health principles, see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "CHS Planning Guidelines".



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The Minnesota Eliminating Health Disparities Initiative (EHDI). The populations experiencing these disparities have many strengths and traditions to draw upon for solutions. For example, in the African American and Latino communities, churches provide connections and leadership on community issues. For American Indians, restoring cultural traditions such as native foods, cradleboards, and sacred use of tobacco can improve infant health. Hispanic/Latino and Asian communities have similar traditions around family, nutrition, and healing practices that are strong already and need support from mainstream providers to promote healthy pregnancy, birth, and infancy.

Recognizing these assets, along with the need to provide funding to the communities experiencing disparities, the Minnesota Legislature created in statute (MN. Stat. 145.928) a statewide initiative and funding to close the gap on health disparities in Minnesota. The resulting legislation has two main goals:

- < 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 in Minnesota as compared with the rates for whites; and
- < Close the gap in health disparities of American Indians and populations of color as compared with the rates for 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 (Temporary Assistance to Needy Families) funds are distributed through this program for infant mortality prevention. These funds focus on preventing out-of-wedlock teen births through programs that support healthy youth development.

The Eliminating Health Disparities Initiative (EHDI) legislation focuses on African Americans/Africans, Latino/Hispanics, Asian/Pacific Islanders, and American Indians living in Minnesota. Eligible Community Grant applicants include, but are not limited to faith-based organizations, social service organizations, community non-profit organizations, community health boards, tribal governments, and community clinics.

The following are the major components of the EHDI:

- < A partnership steering committee to address health disparities in a comprehensive way.
- < A set of measurable outcomes to track Minnesota's progress in reducing health disparities.
- < Improved statewide assessment of risk behaviors among African Americans/Africans, Asian/Pacific Islanders, Latinos/Hispanics, and American Indians in Minnesota.
- < Competitive community grants directed at reducing health disparities in immunizations for adults and children and infant mortality; breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and violence and unintentional injuries; and teen pregnancy prevention through healthy youth development.



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- < Formula grants to Community Health Boards for health screening and follow-up services for tuberculosis in foreign-born persons.
- < Formula grants to American Indian tribal governments for community interventions to reduce health disparities.
- < Evaluation of the initiative.
- < A biennial report to the legislature.

All aspects of the EHDI, from creation of the legislation to the Request for Community Grant Proposals to review and evaluation of the proposals received, have been developed with the input from and involvement of members of Minnesota's racial/ethnic and American Indian communities. The use of community engagement principles is encouraged throughout any state and local processes addressing eliminating health disparities, whether funded by this initiative or not. These community engagement principles include:

- < Fostering openness and participation in the planning process.
- < Ensuring that those representing a specific community truly represent that community's values, norms, and behaviors.
- < Using strategies that insure inclusion, representation, and equality in the planning process. For example, ensuring that those representatives who are included in the process participate in a meaningful way and share fully in the decision making process; and offering orientation and skill building opportunities so that everyone will have an equal voice in voting and other decision making activities.
- < Developing cultural competence in the organization's staff.

- < Communicating with and involving the community in the planning process.

For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Community Engagement".

The 2002-2003 EHDI Community Grants Request for Proposals (RFP) provides information on the initiative, the legislation (Appendix A of the proposal), the grants, social conditions, asset-based community development, community engagement, the eight EHDI priority health areas (Appendix B of the proposal) and strategies shown effective in addressing these eight areas to-date. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "EHDI".

Some specific strategies suggested in Appendix E of the EHDI RFP (*Social Conditions*) and promoted and supported by Office of Minority and Multicultural Health, include:

- < Addressing issues of unequal access to affordable, nutritious food.
- < Working to improve community environments that promote physical activity and wider mental well-being and quality of life.
- < Advocating for good quality, affordable housing.
- < Promoting education, literacy, and employment.

The EHDI is unique in that it provides support for communities to determine their assets, as well as needs, and to develop and implement the strategies they create to employ those assets to address the needs.



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Evaluation plans include steps to assess overall changes in health systems as well as lessons learned by the community-based strategies. Grantees are encouraged to try practical, common sense approaches; and new, culturally relevant health promotion, prevention, and improvement approaches including those proven effective in the mainstream science-based research. The lessons and specific effective strategies will be shared with other communities so that successful approaches can be promoted and additional new approaches tried.

Racial/Ethnic and American Indian Health Committees are being organized in partnership with Minnesota's four statutory Councils, to further identify, support, coordinate, and share lessons learned in the EHDI and related communities.

The MDH Office of Minority and Multicultural Health has on staff Minority Health Coordinators for each of the racial/ethnic and American Indian groups designated in statute. These staff work closely with community grantees to assure members of communities are intricately involved in assessing the strengths, resources, and needs of the community, and in planning for and overseeing activities toward improved health status. Program staff of MDH working with the eight priority health (and related) areas in the statute meet with OMMH staff on a monthly basis to coordinate technical assistance, resources, and training opportunities for the EHDI grantees. For more information contact the Office of Minority and Multicultural Health, at (651) 297-5813. For additional information see the website for strategies resources at:

www.health.state.mn.us/strategies. Click on "Minority Health".

In addition, staff of OMMH address the broader scope of minority and multicultural health and encourage local (geographic) communities to take on this important work. First steps include those identified in the *Service Delivery Systems* category of this strategies document. In addition, local (geographic) communities are encouraged to take the following first steps:

- < Recognize that racial/ethnic and American Indian community members may not participate in offered programs and services because the programs do not fit for them.
- < Actively involve community members in designing and implementing strategies will likely lead to more effective approaches.
- < Build relationships that lead to increased mutual knowledge, comfort, familiarity and trust, before launching into major new efforts.

Prevention is the best investment. It has long been documented that money spent on prevention of sickness, chronic conditions, and injuries is an investment in preventing or reducing more serious and expensive health crises later. This philosophy extends to other arenas as well. For example:

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



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Improved quality of life allows people to have energy and resources to create stronger families, and can become more involved with their communities. With the *Service Delivery System* category of this document there is a segment on *Eliminating Health Disparities*. Within this are the universal systemic strategies that every community in Minnesota should be doing, to assure that the health of all Minnesotans of racial/ethnic heritage is assessed, addressed, and assured.