Health Departments Take Action:

A Compendium of State and Local Models Addressing Racial And Ethnic Disparities in Health

ASTHO
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U.S. Department of Health and Human Services
HRSA BPHC Bureau of Primary Health Care
Health Resources and Services Administration

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Maternal and Child Health Bureau

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Health Departments Take Action:

State and Local Model Programs Addressing Racial and Ethnic Disparities in Health

Eliminating racial and ethnic disparities in health represents a major challenge to our nation's public health system. In his radio address of February 21, 1998, former President Bill Clinton committed the nation to an ambitious goal by the year 2010: "to eliminate the disparities in six areas of health status experienced by racial and ethnic minority populations while continuing the progress we have made in improving the overall health of the American people." This goal parallels the focus on eliminating disparities in *Healthy People 2010* — the nation's health objectives for the 21st century — and the primary focus of the federal Health Resources and Services Administration's (HRSA) campaign to strive for **100% Access and 0 Health Disparities**.

State and local public health agencies — represented by the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) — are on the front lines of assuring the health of the population and addressing health disparities. Over the past few years, ASTHO and NACCHO have been working to strengthen our partnerships with federal health-related agencies and other partners to work collaboratively in this area. This compendium is a result of that collaboration. With the support of HRSA's Bureau of Primary Health Care (BPHC) and Maternal and Child Health Bureau (MCHB), ASTHO and NACCHO put out a call for model state and local programs addressing health disparities. The programs submitted as a response to that call form the basis of this compendium, supplemented by additional highlighted resources for state and local public health agencies and their partners.

We hope that this effort contributes to the flow of ideas and strategies for addressing disparities at the state and local level. Please note, however, that in the interest of space we requested only one model program from each state or locality. This compendium therefore should not be considered a complete inventory of state and local efforts addressing disparities, but rather an illustrative sampling of programs reflecting the diversity of strategies being used to meet the diversity of community needs. Both NACCHO and ASTHO will continue to work in partnership with others to achieve the goal of 100% access and 0 health disparities.

Table of Contents

Chronic Disease

General Chronic Disease Prevention

Program Title:	*Florida Chronic Disease Community Intervention Program*
Health Department:	Pasco County (FL) Health Department
Target Population:	Hispanic migrant and agricultural workers
Health Issue:	Chronic disease prevention
Funding Source:	Centers for Disease Control and Prevention (CDC)

Program Description: The *Florida Chronic Disease Community Intervention Program* (CIP) has been in existence for four years. CIP is administered by the Florida Department of Health and the Pasco County Health Department. Program goals include the reduction of cardiovascular disease, as well as diabetes and its complications through early detection and prevention. The program targets youth and adult members of the rural east Pasco County migrant farmworker and agricultural community, comprised in large part of people of Mexican and Mexican-American descent. Program goals and objectives were developed based on community health needs, as well as national and state data. National data indicate that this population is at higher risk for, and has a higher prevalence of, cardiovascular disease and diabetes.

This program seeks to address multiple determinants of health behaviors to improve quality of life in a number of ways:

- Program interventions include health assessments conducted door-to-door and at community events by bicultural outreach workers;
- The outreach workers offer blood pressure, blood cholesterol and blood glucose screenings;
- Individuals identified with urgent health problems are referred to a local free clinic, other local health agencies, or a community hospital;
- Those at-risk for developing the targeted chronic diseases are encouraged to participate in other programmatic activities available in the farmworker community;
- The program has offered opportunities to participate in leisure-time physical activities such as T'ai Chi and dance, as well as youth-oriented soccer and basketball games;
- An intergenerational dance program, called "Folklorico," encourages physical activity, social interaction, and cultural expression; and
- Chronic disease education is provided by bilingual health care workers using creative teaching strategies including healthy cooking classes, health advocacy training, culturally-appropriate videos, and written materials.

Program activities are tailored to meet the changing needs and interests of the farmworker community. Group activities are scheduled at times and in locations convenient to participants. Activities and programs provide participants with the flexibility to attend to personal, social, and economic needs yet still be involved in activities as their resources permit. Community interest is assessed and barriers are identified through routinely administered surveys. Lack of transportation and time constraints are addressed with flexible scheduling. The barrier most often identified by women, the need for child care and/or activities for children, has been overcome by incorporating intergenerational activities and partnering with a teen group to provide child care and homework help sessions. The fear of identification for undocumented workers has been lessened through staffing of activities with trusted community members.

Designed according to the tenets of public health community intervention models, this program could easily be reproduced in communities where partners are willing to collaborate. The longevity and success of CIP can, in part, be attributed to the ability to involve the target population in all phases of the program. Because members of the farmworker community have taken

ownership in the CIP, its continuance is likely. Beyond providing the initial organization and resources, the health department staff sought to impart the knowledge, skills, motivation and confidence to community members to develop this program and others for themselves. Process, impact, and outcome evaluation measures are incorporated into the CIP's five-year plan. Each activity has an evaluation component. Using national and some community baseline data, impact objectives are designed to measure changes such as the prevalence of undiagnosed diabetes, the amount of leisure-time physical activity for youth and adults, levels of blood cholesterol, and blood pressure. Preliminary impact data indicate that the prevalence of undiagnosed diabetes is lower for this community than the national average. Early data suggest a trend toward more hours spent watching television and less time engaging in physical activity for both youth and adults.

CIP has afforded the Pasco County Health Department an opportunity to partner with health and social service provider organizations in the farmworker community. Valuable lessons have been learned about trust, cultural sensitivity, and the power of community mobilization. It is hoped that CIP has built the foundation for a continuing relationship focused on enhancing the quality of life for the Pasco County migrant and agricultural community.

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Program Title:	*Generation Excellence*
Health Department:	Collier County (FL) Health Department
Target Population:	Diverse, under-served community of Immokalee
Health Issue:	Chronic disease prevention
Funding Source:	Centers for Disease Control and Prevention (CDC)

Program Description: *Generation Excellence* has been in existence since July 1997. The target audience is the ethnically diverse, under-served community of Immokalee. Special interest is given to screening and education services for the migrant farmworker population. The program's goals are to reduce the incidence of chronic disease in the community (heart disease, hypertension, and diabetes), as well as to increase the level of physical activity in children as a preventive measure.

The population of Immokalee is over 70 percent Hispanic, 20 percent African American and less than 10 percent is white. The higher percentage of Hispanics and African Americans in the community results in a disproportionately higher rate of Type II diabetes and hypertension, both underlying risk factors for heart disease. Language and cultural beliefs are seen as barriers to health care, with preventive health care being a new idea to many. In evaluating the results of this program, culturally-appropriate interventions were found necessary for reducing health disparities and the incidence of chronic disease.

Generation Excellence has utilized a wide variety of programs for both adults and children. All programs are offered free of cost to the community. These include:

- After-school physical activity programs for children;
- Community health screening with education, referral, and follow-up services;
- Health fairs;
- Bilingual smoking cessation classes;
- Spanish radio presentations;
- "Train-the-Trainer" nutrition seminars for outreach workers;
- Supermarket tours to provide nutrition education;
- Swim classes;
- S.W.A.T (Students Working Against Tobacco) interventions led by minority youth; and
- Employee health promotions.

A partnership was established with Florida Gulf Coast University (FGCU) for conducting the Immokalee *Generation Excellence* outreach health screenings. FGCU nursing students provide *Generation Excellence* with screening and health education support while gaining their required internship experience. In the last six-month period alone, weekly screening events have reached 545 people for diabetes and high blood pressure. Over 1400 children have been reached through after-school physical activity programs, and 600 additionally through anti-tobacco interventions.

A great variety of programs continue to be offered at Immokalee Middle School, and data has validated the direct relationship between the number of programs offered and youth school attendance. Lake Trafford Elementary School continues to maintain a "model" cardiovascular fitness program with the latest "Polar" heart rate technology implemented for tracking "target zones." An average of 35 minutes are spent each day in physical activity, three days per week, with 100 percent of Lake Trafford children achieving 50 percent or more of their exercising time inside their target heart rate zones. Along with increasing participation, testimonials have been received from numerous sources, ranging from parents of children in the after-school program to principals, teachers, agency directors, and participants of the free swim classes, all proclaiming the positive impact of this program on their lives and in the community.

The structure and design of the Immokalee *Generation Excellence* program validate some key concepts and practices of successful health promotion. The fundamentals of these practices are easily replicable in any community:

- Core partnerships for health promotion: The core partnerships for Collier County Health Department are the County Public Schools and County Parks and Recreation;
- Youth Empowering Youth, The S.W.A.T. (Students Working Against Tobacco) Movement: The Immokalee S.W.A.T. program uses youth to influence other youth, which has demonstrated success;
- Providing incentives and rewards: However, small and inexpensive, *Generation Excellence* believes in providing some form of incentive for rewarding healthy behaviors;
- Employing creative and motivated staff: The employees contribute to the development of new ideas that are invaluable to the success of the program;
- Promoting culture-specific awareness/strategies: *Generation Excellence* conducts bilingual, culture-

specific health education over Spanish Radio; and
- Tailoring programs to suit local needs: For a smaller, rural community such as Immokalee, the underlying theme of networking and coming together was effective for partnership-building.

The major obstacle, however, has been funding. *Generation Excellence* continues to search for additional funding to sustain the grant infrastructure after June 2002. The "buy-in" from the local schools and FGCU may, in some capacity, sustain the educational components to the program. However, the most critical components are seen to be outreach, health screening, referral, and follow-up services provided by the Collier County Health Department of the migrant population and senior residents. Additionally, after-school physical activity programs such as the Lake Trafford Elementary cardiovascular model are seen to be an invaluable preventive measure for hedging the rising incidence of obesity.

Process objectives are monitored quarterly for performance, while impact objectives are slated for review on or prior to June 30, 2002, and will require a repeat of the baseline Johnson's Institute Survey. Results for impact evaluation will include the number of Immokalee High School teens who: report exercising vigorously three days a week for a minimum of 20-30 minutes a day, smoking one to five cigarettes a day, have a BMI (Body Mass Index) of 27 or above, and have total serum cholesterol levels of 210 or above.

Program-specific outcomes include the number of migrants and residents found to be at-risk, referred to the local medical clinic, and identified to have disease. Quit rates for smoking cessation intervention, and the percentage of Lake Trafford Elementary school children found to have lowered resting heart rates (seen with a cardiovascular conditioning effect), will serve as outcome measures. Cardiovascular outcomes, such as improved resting heart rates, will be used to gauge the effectiveness of highly structured programs such as the Lake Trafford model as a preventive measure against the rising incidence of childhood obesity.

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Program Title: *Know Your Family Enemies Project*
Health Department: Delaware Health and Social Services
Target Population: African Americans and Latinos
Health Issue: Leading causes of mortality

Program Description: The six major causes of death for African Americans, Hispanics, and other racial and ethnic minorities in Delaware are cancer, heart disease, stroke, HIV/AIDS, diabetes, and unintentional injuries. These diseases are brought on, for the most part, by lifestyle but they also tend to run in families. This is not surprising because people from the same family tend to share lifestyles such as smoking, lack of physical activity, and nutritional habits.

Based on this reality, and on the interest of the minority communities in genealogy, the Delaware Office of Minority Health (OMH) focused attention on the particular diseases that run in an individual's family to educate the family on prevention strategies.

The project developed a set of materials that include a family health tree that has space for date of birth, date of death, cause of death, and diseases for each person named on the tree. The objective is to work with community partners such as churches, support groups and fraternal organizations to help people complete their own family trees. The visual impact of seeing these diseases as the major causes of death in their family is likely to drive home the point to an individual that, unless they take the necessary prevention measures, they are likely to become a victim to these family enemies just as sure as their forebears.

To accomplish this, the OMH is training members from partner organizations on how to complete the family health trees. The OMH will help them to organize events such as health-fairs, family reunions, homecoming days or family Sundays at which participants will have their family health trees completed. Their "family enemies" (the diseases that run in their family) will be identified for them, they will be advised on how to mitigate their personal risk and will be given directions for follow-up with a health provider. A companion brochure describes the risk factors for these diseases and the prevention steps to take to mitigate risk.

Although the material will be widely distributed, the project will follow two congregations to track any personal risk mitigation efforts that can be traced to this project.

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Program Title: *Praisercize*
Health Department: Virginia State Health Department
Target Population: African Americans
Health Issue: Chronic disease prevention

Program Description: Obesity is the leading risk factor for a number of chronic diseases that affect African Americans. An in-depth study done by Dr. Schorling, of the University of Virginia, identified African Americans in Central Virginia as having a health risk greater than the national average. Community–based health screening evaluations of African Americans in Central Virginia also revealed that the prevalence of diabetes, hypertension, and obesity were higher than in other regions of Virginia. Thus, the Buckingham Health Education Board (BHEB), under the direction of Central Virginia Community Health Center, through funding from the Virginia Office of Minority Health, decided to address the health problem of chronic obesity in Central Virginia.

BHEB utilizes its network within 35 African American churches in Buckingham County to address chronic obesity. BHEB addresses the problem of chronic obesity in three ways: weight reduction, increased physical activity, and lifestyle changes in a program they call *Praisercize*. *Praisercize* incorporates gospel music with low-impact exercise routines. *Praisercize* uses the Baptist General Convention of Virginia's "Reaching to Eat-N-Exercise Wisely (R.E.N.E.W.)" as a model. This 10 lesson nutrition and physical activity manual is specifically designed for church-based populations and includes appropriate scriptural references for participant encouragement. Monthly lifestyle challenges are also incorporated into the program. All participants are weighed in, have their height taken and are given their body mass index at the beginning of the program. Participants use four designated monitor sites with an electronic scale for weekly weight checks. Participants are recruited from 35 churches within the network. P*raisercize* sessions are rotated to churches throughout the network.

This program is in its third year of implementation. Data is collected though cardiovascular risk reduction tracking and risk reduction assessment forms. To date, the program has had over 1,400 contacts. Preliminary data show sustained weight loss, lower blood glucose levels, lower blood pressures, improved dietary habits, and increased awareness of personal health.

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Program Title:	*Vermont Minority Health Promotion Project*
Health Department:	Vermont Department of Health
Target Population:	American Indian and Laotian refugees
Health Issue:	Chronic disease prevention

Program Description: The *Vermont Minority Health Promotion Project* was a collaboration between four Vermont Health Department programs: Office of Minority Health, Diabetes Control Program, Alcohol and Drug Abuse Program, and the Tobacco Control Program. Two minority community-based organizations participated in the project as well: the Dawnland Center (for Inter-tribal American Indians), and the Green Mountain Lao Association (for Lao refugees and families).

The goal of the project was to increase each population's awareness and knowledge of behaviors that will lessen the risk for one or more of three preventable diseases: cancer, cardiovascular disease, and diabetes; through the development of a health promotion program designed for each cultural community.

The Dawnland Center program provided a "rites to adulthood" program called the "Three Fires Program" to address protective factors for youth at-risk. Within their "Longhouse for Life Program," they also provided multigenerational gatherings in which educational activities concerning nutrition, exercise, and the impact of second hand smoke on children were presented. Finally, the center developed an American Indian cookbook entitled *With Gratitude for Food*. This book used recipes from many different tribes throughout the U.S. and focused on creating heart healthy recipes using traditional foods.

The Green Mountain Lao Association program addressed all three disease areas. Activities included the implementation of an assessment to determine risks and barriers in accessing health care and health promotion information, and the delivery of educational workshops. Workshops addressed nutrition, the importance of tobacco and alcohol free lifestyles, and the impact of second hand smoke on children.

Four recommendations were made as a result of this project:

1. Create a partnership between several health department programs. This allowed each grantee to work with a variety of people with different knowledge levels and skills within the department. This helped build trust between the community organizations and the department.
2. "Cultural interpreters" were needed by all involved in the project. Each community had its own cultural experiences and history regarding prevention education and these "cultural interpreters" helped the health department staff to understand the cultural needs of the communities. In turn, the "cultural interpreters" were also able to help the communities understand what the health department was saying. It created an ideal avenue through which issues could be addressed in a helpful manner.
3. It was important to combine both the community's needs with the needs of the health department in order to increase participation in the project. The health department negotiated with both community organizations to develop a pre- and post-test which was culturally-appropriate for each population.
4. It was important for the project activities to include a jump-off point from which future activities could be planned. The Dawnland Center continues its Three Fires Program and the Green Mountain Lao Association is doing further prevention education through collaboration with health department programs.

Common themes from each program:

- Use of multi-generational programming;
- Increased cultural pride in both adults and youth;
- Importance of discussing both personal and group transitions to new life experiences; and
- Pushing beyond the historic mistrust of government.

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Cardiovascular Disease Prevention

Program Title: *Church Lay Health Promotion Program*
Health Department: Will County (IL) Health Department
Target Population: African American and Hispanic church communities
Health Issue: Cardiovascular disease prevention
Funding Source: Health department and local government

Program Description: *The Church Lay Health Promotion Program* has been in existence for four years. The target audience is African American and Hispanic churches and their congregations. The program seeks to address the high incidence of cardiovascular disease-related (CVD) deaths within Will County. The program focuses on behavioral change by addressing risk factors for CVD such as poor diet, lack of exercise, stress, high blood pressure, and tobacco use.

The strategy used for church lay health promotion is to "train-the-trainer." A local coalition headed by the Will County Health Department developed a training manual to address heart disease in Will County. Individuals within the coalition help with the training. Lay health educators from area churches are trained on a curriculum that covers what cardiovascular disease is, and the associated risk factors.

Information about the *Church Lay Health Promotion* program is presented to church groups and health units within area churches. The information describes the program, why the health department wants to train individuals within their congregation, and the length of the training, approximately eight hours. At the conclusion of the church lay health training, individuals are given monthly activities that they can bring to their congregation. Lay health workers are usually from the same community as the other members of the congregation and are thus more knowledgeable about their needs.

There have been language barriers within the Hispanic churches, which were addressed by hiring a part-time Spanish-speaking community health educator to work within the Hispanic community. This individual helps with implementing activities and is involved with community advisory boards.

Another barrier is maintaining the motivation for the church to continue to do educational activities. The churches are more willing to promote the program if the materials and activities are already available to them. In addressingthis barrier, the Will County Health Department has developed the *Church Lay Health Newsletter*. The newsletter is mailed out on a monthly basis to the churches that have been trained in the program, as well as other churches that have expressed interest in promoting positive healthy behaviors within their congregation. The newsletter gives suggestions on health topics to cover within their church, a healthy recipe, information on upcoming health events, as well as general health information. The newsletter can then be copied and put into the church bulletin.

The *Church Lay Health Promotion* program has been sustained for four years and can be replicated. The health department has continued to bring the program into area churches and local community sites and centers. Below are some outcomes of the program:

- Questionnaires have shown that the program's training has been well received;
- The program was piloted four years ago in two churches, one African American and the other Hispanic. Since that time, 19 congregations have participated in the program;
- Over the past three years, the program has implemented over 100 activities for church and community groups;
- Based on churches' increased requests for more information, new program areas have been added to address issues such as breast cancer, prostate cancer, diabetes, and Alzheimer's Disease, and future plans include bringing HIV/AIDS education into the churches; and
- The program has collaborated with other agencies to implement programs including two local park districts, University of Illinois Cooperative Extension, seven grocery stores, the housing authority, and area libraries.

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Program Title:	*Heart Health in Hamilton County*
Health Department:	Cincinnati (OH) Health Department
Target Population:	African Americans
Health Issue:	Cardiovascular disease prevention
Funding Source:	Federal Preventive Health Services Block Grant and general tax funds

Program Description: *Heart Health in Hamilton County* was established twelve years ago. The program targets African American adults and children. The program seeks to reduce the disparity in deaths and quality of life due to cardiovascular disease (CVD), by addressing the key risk factors for CVD, which are exercise and diet. Increased access to exercise facilities is facilitated through the use of a "Health Ministries" concept using volunteers as health advocates to conduct exercise sessions in local churches. Regular aerobic and ancillary exercise sessions are conducted to increase awareness and knowledge about proper diet and food preparation.

The health department has worked very hard to establish the concept of a risk factor approach for preventing multiple diseases. By having faith-based organizations as partners in their collaborative efforts, the health department has tried to increase access to facilities for physical activity. Using exercise classes as an attraction, health messages have been introduced into the programming.

Barriers to improving access to these facilities include the lack of motivation by participants to make the necessary transportation arrangements. In addition, it has been difficult to ensure the presence of a consistent peer leader at each location. Lessons learned include that consistent leadership and perseverance are necessary to ensure success and that incentives can encourage increased participation.

The evaluation of the program has been based on self-reports of satisfaction and participation records. There has also been anecdotal evidence of adoption of positive health behaviors by most program participants.

Participants have reported increased availability of places to exercise and improvement in health status as well as healthy behaviors in the following ways:

- Increased ability to sustain exercise regimen;
- Increased desire to exercise because of camaraderie experienced in groups;
- Decreased overall weight and less excess body fat; and
- Positive dietary changes with decreased fat and calories consumed.

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Program Title: *Louisiana Cardiovascular Health Program*
Health Department: Louisiana Department of Health
Target Population: Populations at-risk for cardiovascular disease and health planners
Health Issue: Cardiovascular disease prevention

Program Description: The *Louisiana (LA) Cardiovascular Health (CVH) Program* operates several activities that address racial and ethnic disparities. The mission of the *LA CVH Program* is to develop basic cardiovascular disease program functions and activities at the state level such as partnerships, program coordination, scientific capacity, and an inventory of policy and environmental strategies, and to develop a state plan for cardiovascular disease. The *LA CVH Program* will also provide training and technical assistance, and intervention strategies for both priority populations and for the general population.

To develop Louisiana's capacity to reduce the burden of cardiovascular disease and to eliminate the disproportionate disease burden in priority populations, the program will establish a core staff. The staff will be prepared through training opportunities from the Centers for Disease Control and Prevention (CDC), partners, programs in other states, and health experts. They will work from a science-base by establishing a surveillance system for cardiovascular health and disease, including the continuation and development of the Louisiana Hospital Inpatient Discharge Data (LAHIDD) Project. The LAHIDD Project is a registry of all inpatient hospital discharges in the state so that cardiovascular disease mortality can be tracked and analyzed. In addition, the demand for health care services for cardiovascular disease can be quantified and evaluated for health policies.

The state CVH plan will also use information from the expansion of the Behavioral Risk Factor Surveillance System (BRFSS) and take inventory of less traditional public health measures to:

- Support the orientation and work of the state-planning panel;
- Create and evaluate strategies for risk reduction; and
- Facilitate and participate in a network of knowledgeable, committed partners, jointly identifying the system and institutional opportunities for intervention.

The *LA CVH Program* planned an extensive and careful process for the creation, orientation, and sustenance of a state-planning panel. The attention to group process is designed to distribute vision and responsibility among a concerned group of leaders with the authority to institute policy and environmental change.

The Program has developed partnerships with many different organizations:

- To reach for cultural competence, the *LA CVH Program* will focus resources on health disparities by partnering with the Daughters of Charity Neighborhood Health Partnership to implement a one-year, information-gathering, pilot project. This project demonstrates a commitment to engage priority populations in the process of information gathering and presentation, intervention planning, delivery, and evaluation.
- The program is also partnering with the "Adolescent School Health Initiative," within the Office of Public Health, to pilot test the utility of the *School Health Index for Physical Activity and Healthy Eating: A Self-Assessment and Planning Guide*. The one-year evaluation will enable the program to determine the usefulness of implementing the tool within the Louisiana Department of Education.
- As part of a statewide improvement plan, the *LA CVH Program* recently signed a Memorandum of Agreement with the National Black Women's Health Project (NBWHP). The Louisiana State Department of Health and Hospitals, Office of Public Health and the NBWHP propose to enter into a collaborative relationship to conduct a "REACH 2010: At the Heart of New Orleans: A Black Women's Health Empowerment and Cardiovascular Risk Prevention Project" if funding is granted by the CDC for Phase II.
- The *LA CVH Program* also partnered with the LA SAFE KIDS coalition to pilot the "Walk Your Child to School Program" in three New Orleans Public Schools.

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Program Title: *Partners for Healthy Lifestyles*
Health Department: Piedmont (VA) Health District
Target Population: Adult African American women
Health Issue: Cardiovascular disease prevention
Funding Source: Federal Preventive Health Services Block Grant

Program Description: *Partners for Healthy Lifestyles* (PHL) has been in existence since 1998 targeting adult African American women. Cardiovascular disease is a significant public health concern in this rural seven-county region. Compared to the rest of Virginia, residents in the Piedmont Health District have higher rates of cardiovascular mortality, as well as wider racial disparities in mortality. PHL involves local African American churches throughout the district in education programs to reduce cardiovascular risk factors and to "Praisercize." "Praisercizing" engages participants in exercises set to gospel music.

The program attempts to overcome cultural dietary and exercise norms. Participants also have to buy into the idea that cardiovascular disease is a significant health issue to them and that its effects are modifiable. The low population density (32 residents per square mile) is a significant barrier to providing services to a large group of residents. Having the church pastors promote the program has been a major predictor of success.

Reducing mortality from heart disease requires participants to maintain their improvements in cardiovascular risk factors. An essential component of PHL is its sustainability. As part of this program, members of the participating churches are trained as volunteer lay health workers (LHWs). LHWs assume the responsibility for maintaining their church's program after the first year.

Success of *Partners for Healthy Lifestyles* is evaluated each year. Indicators of success include the church's level of participation and improvements in cardiovascular risk factors, as determined by baseline and six-month follow-up assessments. Of the five churches that completed the assessments last year, all showed improvements in cardiovascular risk factors overall. Specifically, 63 percent of participants decreased their Body Mass Index (BMI mean 0.77), 83 percent decreased waist circumference (mean 1.8 inches), 88 percent decreased the percentage of caloric intake from fat (mean 6.9 percent), and 99 percent increased their level of exercise.

Agencies interested in replicating this program are encouraged to contact the Piedmont Health District.

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Program Title: *Stratford Multicultural Health Program*
Health Department: Stratford (CT) Health Department
Target Population: African Americans and Latinos
Health Issue: Cardiovascular disease prevention and its associated risk factors
Funding Source: Connecticut Department of Public Health

Program Description: In December of 1999, Bridgeport's Park City Primary Care Center and the Stratford Health Department were awarded a collaborative grant from the Connecticut Department of Public Health to help reduce cardiovascular disease, particularly among African Americans and Latinos who reside in Stratford and Bridgeport. In Stratford, African Americans represent 8.2 percent and Latinos represent 4.9 percent of the population. *Stratford Multicultural Health Project* seeks to address cardiovascular disease and its associated modifiable risk factors (nutrition, diabetes, exercise, and tobacco) and to eliminate health disparities.

This project is unique in that it seeks to improve health through changes in agency policy and priorities, not through state funding of new programs. The *Stratford Multicultural Health Project's* task is to then advocate for programs or activities that can be launched and sustained using existing town or agency resources.

During the first six months of the project, the health department conducted interviews with African American and Latino leaders in the community, as well as focus groups comprised of various age groups from within the African American and Latino communities. They discussed their concerns about the following health problems:

- Cardiovascular disease risk factors such as smoking, diabetes, nutrition, and exercise/weight management; and
- Cultural sensitivity issues.

The health department gathered a group of 18 residents who participated in the interviews or focus groups, presented the findings, and developed a plan of action to reduce risk factors associated with cardiovascular disease. The residents decided upon the following actions:

- Start a farmer's market in the south end of Stratford (where the community is 50 percent minority) to improve access to fresh fruits and vegetables;
- Improve bus routes to large supermarkets from the south end to improve access to more nutritious foods, a greater variety of produce, and better prices. South end residents without cars must travel long distances to the large supermarkets. Research found that the small, local food markets have very little variety, poor quality produce, and much higher prices;
- Increase the number of diabetes screenings provided in the south end in order to identify African Americans and Latinos who have or are at-risk for diabetes;
- Launch a walking club in the south end to increase the number of African American and Latino residents participating in regular exercise and maintaining a healthy weight; and
- Continue Stratford Police Department "tobacco stings" in order to reduce youth access to tobacco and ultimately, reduce smoking prevalence among youth.

The project is currently in its second phase for implementing the above actions. By October 2001, the health department hopes to have launched all of the programs.

The recommendations to others who might be interested in replicating the program are:

1. Hire program coordinators who are minorities;
2. Send press releases to local newspapers that ask for minority participation in health councils, research, or other health department activities;
3. Launch a town-wide health council or task force and be sure to include minority members;
4. Conduct research that targets minority residents — interviews and focus groups are especially helpful in establishing new relationships with minority residents and community leaders;
5. Form a special multicultural health task force that includes minority residents and health department staff; and
6. Use the local media and any town newsletters to tell the community about your program.

A few small barriers to program implementation have been encountered related to misinterpretation of the health department's intentions. Overall, residents seem delighted that the Stratford Health Department is placing emphasis on minority communities.

While there is evidence of increasing relationships and minority participation in programs, the project has not been functioning long enough to show actual changes in health behavior or disease prevalence. Within the next two to three years, the Stratford Health Department will evaluate its efforts to determine the success of the programs that have been implemented.

While continued funding from the Connecticut Department of Public Health would ensure the sustainability of the project, it is very likely that the *Stratford Multicultural Health Project* will be supported through the volunteer efforts of residents and agencies that form the membership of the Healthy Stratford Council.

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Program Title: *UMOJA Project*
Health Department: Michigan Department of Community Health
Target Population: African Americans
Health Issue: Cardiovascular disease prevention

Program Description: The Program for Multicultural Health (PMCH), University of Michigan Health System conducted the *UMOJA Project* to focus on identifying African Americans' internal and environmental assets and strengths in the prevention of cardiovascular disease (CVD). The overall mission of the project is to identify factors (assets), which promote healthful lifestyle behaviors, and to develop and implement culturally competent interventions aimed at sustaining strengths and reducing risks. The assets identified were:

- The prominence of the church;
- The resilience of the African American family; and
- The support found in historically African American neighborhood institutions and community coalitions.

The *UMOJA Project* forged partnerships with ten local churches to develop church-based health ministries to promote healthy lifestyle behaviors among the parishioners. The culturally relevant approach resulted in empowering participants to identify assets, build upon those identified strengths, and further reduce the risks for cardiovascular disease among African Americans, with the following goals:

- Utilize indigenous professional community health workers to provide in-home exercises to reduce CVD risks;
- Develop church-based health plans to enable the church minister to deliver positive health style messages to parishioners;
- There were support group sessions for stress management which focused upon supporting and expanding participants' existing strengths through a variety of methods including the use of meditation, T'ai Chi, imagery, humor, and religious faith; and
- Advocate for the elimination of racial disparities in health status by addressing the health priorities identified in the Washtenaw County African American Health Improvement Plan (AAHIP).

Measurable changes occurred in the participants' behavior as a result of the major interventions with a noted increase in nutrition, stress management, and physical activity. Other results include:

- There was an increase from pre- to post-test scores for cholesterol and heart disease;
- The average blood pressure readings for both the systolic and diastolic improved;
- There was improvement in Body Mass Index (BMI) for those participants whose BMI was calculated; and
- Each participant received a year pass to the Washtenaw County Parks and Recreation Center where they met with their trainer.

By the end of the project, of the 43 percent of the participants still working with their trainer, and 88 percent were attending the recreation center independently.

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Cancer Prevention

Program Title: *Breast and Cervical Cancer Early Detection Program*
Health Department: Mississippi State Department of Health
Target Population: Minority women
Health Issue: Breast and cervical cancer prevention

Program Description: The central aim of the *Mississippi State Breast and Cervical Cancer Early Detection Program* (MBCCEDP) is to address the screening needs of women at highest risk. Typically, women at highest risk are uninsured, medically underserved, poor, African American (or other minority), and elderly. They are also more likely to have advanced disease at the time of presentation, reflecting differences in access to screening and care, and fear about cancer or being screened for cancer. Thus, the target population for the program is uninsured or underinsured, and/or minority women. Women 50 years of age and older are the target group for mammography screening, and women 18 years and older are the target for cervical cancer screening. The Mississippi Breast and Cervical Cancer Control Coalition acts as the advisory group for the program.

The *Breast and Cervical Cancer Early Detection Program*, with the Mississippi State Department of Health (MSDH) has implemented a plan, which makes early detection services available statewide. Pap test screening services are available to uninsured women 18 years of age and older at MSDH clinics, community health centers and through private providers, and mammography screening is available through contract providers to uninsured women 50 years of age and older. The program works to reduce the high morbidity and mortality caused by breast and cervical cancer in Mississippi. The program has seven objectives:

1. Establish a system for screening women for breast and cervical cancer as a preventive health measure.
2. Provide appropriate referrals for medical treatment for women screened in the program and to ensure the provision of appropriate diagnostic and treatment services.
3. Develop education and outreach programs and disseminate public information for the early detection and control of breast and cervical cancer.
4. Provide training to improve the education and skills of health professionals in the detection and control of breast and cervical cancer.
5. Establish mechanisms through which Mississippi can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures.
6. Establish mechanisms to enhance the state's cancer surveillance system to facilitate program planning and evaluation.
7. Ensure the coordination of services and program activities with other related programs.

As of August 2000, more than 2,000 women have been screened for breast and cervical cancer through the program. Of this number, 69 percent were minority women with nine diagnosed cases of breast cancer, and 30 percent white women with four cases of breast cancer. No cervical cancer has been found.

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Program Title: *Real Men Checkin' It Out*
Health Department: South Carolina Department of Health and Environmental Control
Target Population: African American men
Health Issue: Prostate cancer prevention

Program Description: *Real Men Checkin' It Out* is a prostate cancer health communication and education initiative promoting early detection in South Carolina's African American male population. With funding from the Department of Health and Human Services Office of Minority Health, the South Carolina Department of Health and Environmental Control, Office of Minority Health (OMH) developed this initiative in response to the prostate cancer disparity rates existing between African American men and white men in the state. African American males in South Carolina suffer and die from prostate cancer at an alarmingly greater rate than do their white counterparts. The risk of death due to prostate cancer among African American males is 2.5 times the same risk among white males.

A major objective of the demonstration project was to provide a culturally-appropriate public health-based education and outreach effort. Crafted as a community-based, community-driven project, OMH engaged the community in each stage of *Real Men Checkin' It Out*, from development of an education guide to implementation of education and outreach efforts. Even the title, *Real Men Checkin' It Out*, was derived from African American prostate cancer survivors in the community.

The program was initially implemented by African American community-based organizations, which included churches, fraternities, and other community groups. Through grassroots efforts and the use of the *Real Men Checkin' It Out* education guide, each organization successfully rallied their communities to become educated about the prostate screening process, and the importance of early detection, and obtaining appropriate follow-up.

Real Men Checkin' It Out, has most recently been adopted by "Palmetto Health Alliance-Cancer Initiative," a hospital-based community outreach program that provides cancer screening to indigent and working poor in four of South Carolina's counties. As a result of Palmetto Health Alliance linking up with 30 African American churches, *Real Men Checkin' It Out* has extended even further into the African American community. The program has been instrumental in educating and mobilizing the African American community of South Carolina to "get it checked."

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Diabetes Prevention

Program Title: *Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together)*
Health Department: North Carolina Department of Health and Human Services
Target Population: African American population age 18 and over living in the Southeast Raleigh community of Wake County
Health Issue: Diabetes Prevention
Funding Source: Centers for Disease Control and Prevention (CDC)

Project Description: *Project DIRECT* is the United States' largest and most comprehensive community demonstration project to address the growing burden of diabetes in African American communities. Specifically, the project targets the African American population age 18 and over living in the Southeast Raleigh community of Wake County. The project is a partnership between the federal government (Centers for Disease Control and Prevention), state government (NC Department of Health and Human Services), county government (Wake County Human Services) and the local community.

In North Carolina, the diagnosed cases of diabetes are about 60 percent higher among African American adults compared to non-Hispanic whites, and 100 percent higher for African American adults over 65 years of age as compared to non-Hispanic white adults in the same age group. Diabetes mortality in North Carolina is three to four times higher for African American men and women as compared to non-Hispanic white men and women.

Project DIRECT began in 1994 following a pilot study conducted in Wake County. The study showed that diabetes was diagnosed twice as frequently in African Americans than in non-Hispanic white residents in Wake County, and that undiagnosed diabetes was five times as frequent among this population. When diabetes and impaired glucose tolerance were pooled together, nearly one quarter of African Americans and one-tenth of non-Hispanic whites aged 20-74 years had evidence of abnormal glucose tolerance.

The overall purpose of *Project DIRECT* is to:

- Engage people in a walking program to increase physical activity;
- Reduce dietary fat by teaching people lower-fat cooking techniques;
- Increase awareness of African American adults about the risk factors for Type II diabetes;
- Increase the number of persons screened who are at-risk for diabetes;
- Refer persons who are screened for diabetes with a positive result to a health care provider and follow-up to assure they complete the referral;
- Improve the patterns of diabetes care through a targeted provider recruitment, retention and education process;
- Improve glycemic control for people with diabetes through improved patterns of diabetes care programs;
- Increase participation in appropriate control and risk reduction activity by involving persons outside the traditional networks and through networks of informal association; and
- Involve participation from the target community in planning and implementation of interventions to increase technical knowledge about diabetes and increase participation in risk reduction activities.

The project's activities are grouped under three main components: diabetes care, outreach, and health promotion. The diabetes care component seeks to improve the quality of life for people who have diabetes by initiating multiple strategies that empower individuals, their caregivers, and the community at large to effectively control diabetes and its complications. This includes classes on diabetes self-management, continuous quality improvement (CQI) efforts with local practitioners, and review of medical records in those practices to measure level of change. The outreach component also seeks to improve the community's capacity to screen and treat people with undetected diabetes, and to return to treatment those previously diagnosed, but lacking a regular source of health care. Outreach efforts use church interventions to reach participants, and also include the recruitment of patients from local health care facilities and community programs. The health promotion component includes a walking program, Ready Set Walk, a training program for lay exercise leaders to lead walking groups, Lay Exercise Leader Training, and nutrition education provided through the Church Nutrition Training intervention.

Project DIRECT uses community advocates, community ambassadors (members of a national nursing organization), and representatives of Strengthening the Black Family, Inc. a community-based program to promote quality of life for African American families to provide information to the public. *The Church Health Assessment Tool (CHAT*) and *Church Health Assessment Plan (CHAP)* are used to assess the needs of churches and prepare a plan of action to address these concerns.

Some of the barriers faced in implementing the project include the lengthy Institutional Review Board approval process, and the administration and management of the various project components such as coordinating interventions, arranging joint meetings, and receiving review and approvals from each partner. There has also been some difficulty with staff turnover, and as a result, training and orientation of new personnel is frequently required. Trust is also an important issue within the program, and *Project DIRECT* addresses this by involving community volunteers at all levels of planning.

An internal evaluation of the project is currently ongoing and the results of this evaluation will be presented at a National Forum on *Project DIRECT* in September 2001. The project includes continuous quality improvement including chart audits. Participants have requested continuation of the diabetes self-management classes and as a result a new protocol has been written to include this intervention. Since 1997, 20 churches have participated in this intervention. Between December 1996 and June 1999 over 3,000 people were screened for diabetes. People with abnormal blood glucose levels were referred to a health care provider. Follow-up was made to those referred to assure they received medical care. In 1997, a partnership was established with Wake Health Services, a federally-funded health center, to refer persons from their program into *Project DIRECT* activities. The number of persons referred by these providers has remained stable over time.

The greatest lesson learned from this project is the importance of having the community as a partner. This has assured the stability and success of the project. The governing board of the project consists of 13 members, nine of who are volunteer community representatives.

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Program Title: *REACH in Stockton*
Health Department: San Joaquin County (CA) Health Department
Target Population: African Americans and Latinos with Type II diabetes
Health Issue: Diabetes Type II Prevention
Funding Source: California Endowment

Program Description: *REACH in Stockton* program, targeting African Americans and Latinos with Type II diabetes residing in South Stockton, has been in existence since March 2000. This program addresses disparities in prevalence and complications of Type II diabetes. The program has two phases. Phase I is a one-year extensive planning process to design interventions based on identified local determinants of health outcomes. A Core Planning Group of local agencies serving African American and Latino diabetics in South Stockton, in partnership with a health research and education organization, is conducting local epidemiology, social, and assets assessments. The group's responsibility is to participate in the year one planning process and prioritize and select interventions for funding in years two and three. This includes conducting focus groups with diabetic patients, family and friends, physicians, and other health care professionals such as educators, nurses, and dieticians. The purpose of the focus groups was to learn about the needs, desires, and barriers of patients related to improving their health. Equally important was to hear what types of interventions they suggested and how interventions should be designed based on family and cultural needs and standards.

General community knowledge of the project, its planning activities, and the information learned was addressed in three forms. A two-day introduction and training of community agency leaders was held in April 2000. A second meeting was held in the summer of 2000 to identify existing services and other resources for diabetics in South Stockton. Representatives from these meetings were invited to participate in the review of the focus group findings and development of goals and objectives during the fall of 2000. A Town Hall Meeting was held in December 2000 to review project planning results and solicit resident response and ideas.

Phase II of the program centers on two years of interventions to improve health outcomes in the target population and area and an evaluation. The program interventions will focus on enhancing the diabetes self-management capacity of patients in the areas of diet, physical activity and blood glucose monitoring. These interventions are:

- Community-based support groups for weight management and physical activity;
- Community-based support groups for emotional support and education;
- Training and provision of current clinical practice guidelines for medical care providers;
- Training of provider office staff to develop a family-centered approach to diabetes management and referral to support services; and
- Development and distribution of a resource guide on community-based support services.

Developing supportive networks of patients and family members underlies the sustainability of the group interventions. The need for emotional support by other persons experiencing similar needs and by family members was identified as a key determinant in achieving and adhering to provider recommendations on weight, diet, and physical activity.

Innovations from Phase I of the project result from the exposure of health department and community agency participants to a new model of health program/intervention planning. This is based on identification of key determinants of both desired and undesired health behaviors and outcomes. At the start of the Planning Phase, most of the Core Planning Group members stated what services they wanted to fund in years two and three. As representatives of health care provider organizations, they had first-hand knowledge of the disproportionate impact of diabetes on the target population. The determinants-based planning moved the Core Planning Group beyond the classic patient-health care provider focus and it broadens the group's focus to include environmental and behavioral factors.

The length of the planning process has been frustrating for some planning group members. The practical application of the complex planning model has required more extensive staff resources than anticipated and has been difficult to translate effectively to community members. Even with a disease as prevalent as diabetes, and with a planning group composed primarily of health care providers, there was great disparity in knowledge regarding the disease, particularly in areas related to self-management.

Evaluation of the first year planning phase was designed as a process evaluation of the Core Planning Group and its utilization of the determinants-based Intervention-Mapping model. The process evaluation report will include members' descriptions of how using the model has been or could be applied to other projects.

For each key determinant identified, performance objectives at varying levels (system, institutional, community, family, individual) were developed. Performance objectives for each intervention were also developed. These will form the basis for formal design of the programmatic/intervention evaluation. The Project is developing plans to use hospital discharge and other service utilization data, as well as mortality data, to monitor changes in community health status for the target diabetic population and area.

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HIV Prevention

Program Title: *Champion Club Program*
Health Department: Orange County (FL) Health Department
Target Population: African American and Hispanic adolescent males
Health Issue: HIV, STD and teen pregnancy prevention
Funding Source: Title X Family Planning Special Initiative Project

Program Description: The *Champion Club Program* has been in existence since July 2000. The target population is African American and Hispanic adolescent males in four Orange County schools that are located in zip codes with the highest rates of HIV, sexually transmitted diseases (STD), and teen pregnancy. Rates of HIV, sexually transmitted diseases, and teen pregnancy among African American and Hispanic youth in Orange County, are very high in comparison to their white counterparts.

- For the years 1997-1999, Orange County's STD rates exceeded Florida's rates;
- In 1998, Orange County was ranked second in the state in the number of HIV cases reported for youth age 13 and younger;
- In 1998, 89 percent of the cases of HIV among adolescents were minority youth, 72 percent African American youth and 17 percent Hispanic youth, while white youth made up 11 only percent; and
- There are areas within Orange County where teen pregnancy rates are two to three times higher than the national, state, or county-wide rates.

The overall goal of the *Champion Club Program* is to decrease risk behaviors among high risk adolescent males. Since well-documented and effective HIV prevention programs for youth are based on Social Cognitive Theory, the *Champion Club Program* incorporated this theory and lessons from successful HIV prevention programs, while also adding content on preventing STDs and teen pregnancy.

The *Champion Club Program* works closely with the "Student Assistance and Family Empowerment Program (SAFE)," to recruit at-risk students to participate. This male responsibility program is implemented on four Orange County high school campuses located in the target area. Ten participants per campus participate in weekly group sessions to address underlying issues that result in high risk behaviors and to reinforce risk reduction messages.

The Orange County Health Department (OCHD) developed, implemented, and facilitates the services for this project. OCHD piloted this program in various community settings for two years prior to the implementation of this project in July 2000. The program was piloted among the following groups: adolescent males of farmworker and migrant parents, largely comprised of Latino/Hispanic youth; incarcerated youth in the local juvenile detention system; and local schools with a large percentage of students of African descent. The purpose of piloting the program was to gather information about norms and issues that impact a youth's decision to engage in high risk behaviors. This program is one of the only programs in the county that addresses HIV, STDs, and unintended pregnancy among African American and Hispanic adolescent males.

Important lessons have been learned from the program:

- It is important to involve parents, particularly fathers, in the program as they do have an impact on the behavior of the youth. The major issue that continues to surface is the lack of positive male role models who can provide guidance and instruction in the lives of the youth. To address family-related issues, this project offers parent/child communication sessions.
- Each school has unique issues, and thus issues specific to each school and community must be addressed.

Male-only health summits are conducted on each school campus and risk reduction information is disseminated to the large number in attendance. The concept of a male-only summit has been very successful. The uniqueness of the summits is that in addition to the dissemination of HIV, STD, and unintended pregnancy information via role plays, lecture, and videos, the summits also address issues that are important to the students and are unique to individual campuses. Prior to each summit, OCHD staff conduct informal focus groups with program and non-program participants to

gather information about issues to be addressed at the summit. Additionally, students involved in each school's drama program are recruited to help develop and act in role plays during the summit. Each summit participant receives a male responsibility business card with information regarding the names of the SAFE coordinators, and the telephone numbers and addresses of HIV and STD testing sites in Orange County.

The barriers that have been encountered are related to the guidelines within schools, which prohibit the discussion of many human sexuality-related issues. Before one can begin to address HIV, STD and teen pregnancy, one must first address the norms of the adolescent culture. Additionally, norms vary from school to school.

The project has received overwhelming support from school administrators of each participating school. Current participating schools have expressed interest in working with OCHD during the next school year, beginning Fall 2001. In addition, several non-participating schools have requested that OCHD implement the program on their campuses.

Two types of evaluation were implemented for this program: 1) formative evaluation, and 2) outcome monitoring evaluation, including a brief process evaluation. The formative evaluation included needs assessment data gathered through the previously mentioned focus groups. These group meetings with adolescents from the targeted communities assisted the program planners in identifying important content for group discussion that were relevant to the adolescent male participants. In addition, the program was piloted with adolescents in three different community settings (a correctional facility, schools, and a community center). Information obtained from the pilots also assisted planners in developing a stronger program.

The outcome monitoring evaluation was designed prior to current program implementation to measure changes in knowledge, attitudes, beliefs and reported behaviors among program participants. The evaluation consists of pre- and post-test surveys of all program participants. The evaluation includes process data, such as how the program was implemented, as well as opinions of participants and parents, and retention of participants. Data will be gathered via surveys and interviews. Results will be available soon; the program is still in operation for this school year.

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Program Title: *Planning Unit*
Health Department: Colorado Department of Public Health and Environment
Target Population: Health care providers
Health Issue: HIV prevention

Program Description: The *Planning Unit* of the Sexually Transmitted Disease (STD)/HIV Section, Disease Control and Environmental Epidemiology Division, Colorado Department of Public Health and Environment targets the disproportionate occurrence of HIV in Colorado's ethnic and racial minority populations. Additionally, the committee works to ensure the delivery of effective services to diverse communities as these communities vary along dimensions of age, gender, socioeconomic status, sexual orientation, disabilities, linguistics and geographic setting.

The *Planning Unit* exists to design and implement a comprehensive plan to ensure that HIV prevention providers are able to address the diverse needs of the populations they serve, as characterized by the adaptations of service models to better meet the needs of communities of color or other groups. The *Planning Unit* has developed and is in the process of implementing the plan.

The initial focus of the implementation is an objective (third-party) assessment of the direct-service providers, including programs within the Colorado Department of Public Health and Environment's STD/HIV Section. The tool for the assessment was developed by Coloradans Working Together, a stakeholder group, and was modified by the *Planning Unit*. The assessment will collect information regarding the providers' "cultural competence," including such information as whether individuals from the target populations have input into the development and implementation of provider policies, the composition of provider staff, and provider efforts at assessing and improving programs for targeted populations. This initial assessment phase is expected to be completed by May 31, 2001.

After the assessment period, the *Planning Unit*'s plan calls for provider-developed plans to ensure that services are culturally competent with regard to culture, disability, and other diversity. The *Planning Unit* and the larger STD/HIV Section will identify the necessary resources to implement agency plans to improve services for the targeted populations.

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Program Title: *Enhancing Involvement of the African American Faith Community in HIV Prevention*
Health Department: Washington State Department of Health
Target Population: African Americans
Health Issue: HIV prevention

Program Description: In 1999, the Washington State HIV Prevention Community Planning Group recognized the disparate impact of HIV infection in the African American population, where 16 percent of the state's reported AIDS cases were in African Americans - a group that makes up only about three percent of the state's population. The group acknowledged that national support through funding from efforts by the Congressional Black Caucus was unlikely to reach Washington State, and that programs that involved the African American faith community were likely to have an impact on the prevention of HIV infection.

As a result, the broad-based community planning group recommended that the Department of Health use a portion of existing federal grant funds to promote involvement of the African American faith community in HIV prevention.

Following a competitive request for proposals, Baker Street Ministries Counseling and Testing Center was selected as a contractor to carry out the following activities within the African American faith community:

- Increase the community's knowledge of HIV risk and promote their commitment to HIV prevention;
- Provide information on proven and effective HIV prevention interventions for the community;
- Identify members in the community who will provide leadership in taking these effective prevention strategies to the community;
- Strategize with community leaders on incorporating HIV prevention into their activities; and
- Encourage community leaders to become involved in regional and state planning of HIV-related intervention.

Funding for the contract with Baker Street Ministries is for the period May 2000 through May 2001.

Evaluation of the project will include:

- The number of ministers and other church leaders participating in HIV prevention trainings and workshops;
- The number of ministers and other church leaders becoming certified HIV prevention trainers; and
- An increase in the number of applications for membership on state or regional HIV prevention community planning groups from ministers and other church leaders.

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Program Title: *Help Education Living Program (HELP)*
Health Department: Maricopa County (AZ) Department of Public Health
Target Population: Incarcerated male and female adults
Health Issue: HIV prevention education
Funding Source: Arizona Department of Health/Maricopa County Department of Public Health

Program Description: The *Health Education Living Program (HELP)* workshops have been in existence since 1996. This HIV prevention education and risk reduction program targets incarcerated male and female adults, including monolingual Spanish-speaking inmates. U.S. prisons and jails have an incidence rate of HIV/AIDS that is six times greater than the general population. Traditionally, minorities are over-represented in the correctional system. This program functions primarily in three Maricopa County jails, but is expanding to include other correctional facilities and programs. The challenge for the Maricopa County Department of Public Health (DOPH) is to address the increasing number of minorities in jails at-risk for HIV, sexually transmitted diseases, and hepatitis infections.

This program demonstrates a variety of concepts that are creatively applied to the target community. HELP is the only program in Maricopa County providing skills-building services to the incarcerated population. The program combines multiple theories (Health Belief Model, Theory of Reasoned Action, and Transtheoretical Model) to cover all aspects of risk-taking behaviors demonstrated by the population. The workshops presented by the DOPH address cultural factors and are provided to inmates in Spanish. In 1996, the program was commended for decreasing the number of cases of hepatitis within the Estrella Jail, specifically hepatitis A. Hepatitis treatment and prevention protocols were established based on the program's involvement in the jails.

Linkages within the community have provided a myriad of opportunities to enhance the program. Capacity-building to educate correctional officers with similar information has been highly effective. Meetings with the Sheriff's office and correctional health staff have provided time to determine implementation and effectiveness of programs.

Community involvement has been an essential component to the program planning process. An advisory committee consisting of correctional staff, community members, and the program manager of HELP was established to ensure the quality of the program and to reduce duplication of services.
The program clearly demonstrates concepts and practices that could easily be replicated in other communities of the same population. Through the combination of theories, activities, and HIV/STD prevention skills-building instruction, the methods used during the workshop can be used universally in all types of correctional systems. There is also an established curriculum that can be used.

A pre- and post-test evaluates the knowledge, attitudes, beliefs, and behaviors of the inmates before and after program implementation. An informational survey, which collects personal risk-taking behavior data, is also completed on the first day of the workshop prior to the introduction of theories, activities, and skills-building. This information provides the basis for discussion of sexual and drug use risks taken by the inmates. The curriculum is adapted to focus on the specific risk-taking behaviors of the class. All materials are in Spanish and at a level specific to the population's abilities. The Statistical Package for the Social Services (SPSS) is used to analyze all data collected to verify reliability. The post-test shows an increase in knowledge among the inmates, along with helpful suggestions and comments about the effectiveness of the workshop.

The evaluation of the program shows that all inmates are learning the basics of HIV/STD transmission and prevention. From January to December 2000, 94 percent (N=529) stated their intention to practice safer sex and drug use behaviors. There is no contact with inmates after the workshop and especially after their release; therefore, long-term evaluation of the program is not possible at this time.

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Other Health Issues

General Health Issues

Program Title: *African American Health Initiative (AAHI)*
Health Department: Montgomery County (MD) Department of Health and Human Services
Target Population: African Americans
Health Issue: Infant mortality, diabetes, HIV/AIDS and oral health (oral cancer)
Funding Source: Montgomery County, CDC REACH Planning Grant

Program Description: The *African American Health Initiative (AAHI)* has been in existence for over two years. The target population is African American residents of Montgomery County. Due to the disparity in health status between African Americans and other county residents, the Montgomery County Department of Health and Human Services (DHHS) created a partnership with the community to target specific health problems among African American residents.

Four coalitions addressing infant mortality, diabetes, HIV/AIDS and oral health were formed to develop and implement strategies and recommendations for improving the health status of the county's African American residents. The coalitions include representatives from DHHS, physicians and other health providers, the faith community, hospital administrators, and other community stakeholders. Each coalition has outlined its top three priorities for FY 2001, and will use several methods, such as multi-media campaigns, health fairs and forums, and town hall meetings to increase public awareness about health disparities and to solicit more community partnerships to work with the AAHI.

Diabetes
The Diabetes Coalition targets both Montgomery and Prince George's Counties, and has been awarded a Phase I "Racial and Ethnic Approaches to Community Health (REACH)" grant from CDC to develop a community action plan that will be designed to address diabetes in the African American and Latino populations. This project has been renamed the "Bi-County Minority Diabetes Coalition Program." The focus of this program will be to develop a prevention strategy that addresses providers, the business community, and the community at large. The goals of the project are to:

- Educate the community about the risk, prevalence and prevention of diabetes;
- Ensure that providers are able to recognize the risk factors for diabetes and that persons at-risk for diabetes are screened and appropriately diagnosed;
- Target the business community for support and development of employer-sponsored educational and prevention activities that will reduce employee risk factors for diabetes; and
- Obtain from primary care providers a "commitment to excellence" in standards of care for patients with diabetes.

Successful completion of this community action plan and acceptance by the CDC will ensure funding of this program for four more years. The Bi-County Minority Diabetes Coalition Program is in the process of developing an evaluation plan that presents a process for monitoring and assessing progress of the coalition towards the development of the proposed Phase II of the community action plan. The progress of the project will be evaluated in September 2001.

Oral Health
The Oral Health (oral cancer) Coalition has received funding from Maryland's Tobacco Restitution Funds settlement to offer economically disadvantaged African Americans preventative and cessation education, screening, early diagnosis, and management of any oral and pharyngeal cancers that are detected. This funding will be provided until the end of FY 2001, with the goal of securing additional funding to continue the program for

FY 2002 and beyond. The success of the coalition's activities will be evaluated by performance measures, as follows:

- Number of persons reached with the educational messages on oral-pharyngeal cancer;
- Number of health care providers reached with the educational activities;
- Number of clients screened versus number of abnormalities detected;
- Number of clients found to have oral cancers; and
- Number of clients treated for oral-pharyngeal cancers.

A preliminary evaluation of the Oral Health Coalition will occur in August 2001. The long-term evaluative process will look at the reduction of the oral cancer death rate in the targeted population over time.

Infant Mortality

The Infant Mortality Coalition has been successful in creating a Web site entitled onehealthylife.org. This Web site targets African American women between the ages of 15 and 22 to increase awareness of the importance of being healthy before, during, and after pregnancy. In the future, the site will provide general information about identity, life goals, and decision-making for the future. The site is new and cannot yet be evaluated. The evaluative process will include:

- Number of hits to the site;
- Number of calls for a CD-ROM that supports the information on the site; and
- Number of participants in attendance at educational outreach activities.

It is anticipated that a preliminary report will be completed by the end of FY 2001. This site will be maintained for at least the next five years, and the information on themes appropriate to the targeted population will be updated quarterly.

HIV/AIDS

The HIV/AIDS Coalition, in collaboration with the Montgomery County African American Church Outreach Program, sponsored numerous activities during the African American Church Week of Prayer for the Healing of AIDS. These activities included a seminar entitled *HIV/AIDS and its Effects on Black Americans Today*. A theatre troop presented a dramatization of relationship issues faced by African American youth. Two hundred people attended a gospel concert entitled *Praises for Life,* where the messages were rendered through song. These outreach activities will be repeated yearly during the week of prayer activities.

The *African American Health Initiative* seeks to sustain all activities implemented by the coalitions through research and development, educational outreach to the community, and the evaluation of measurable outcomes.

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Access to Care

Program Title: *American Indian Health Program*
Health Department: Indiana State Department of Health
Target Population: American Indians and Alaskan Natives
Health Issue: Health promotion

Program Description: The *American Indian Health Program* was established in July 1999 and is funded by the Indiana Minority Health Coalition and the Indiana State Department of Health (ISDH). The project addresses the health needs of American Indians residing in Indiana, a population defined nationally as having the poorest health among all races. Indiana lacks health data on residents of this race although the 1990 Census reflected a total of 15,000 American Indians or Alaska Natives living in this state.

Prior to the advent of the *American Indian Health Program*, the American Indians in this area had no advocate for accessing health care, nor were they recognized collectively in health data statistics. In addition, American Indians cannot receive Indian Health Service (IHS) benefits in Indiana since Indiana does not qualify for reservation status. Those most at-risk in this indigent population are the people who come from the reservation seeking employment and those seeking to restore traditional health practices as they identify with their tribal affiliation.

The goals of the project are to:

- Increase health promotion services in a culturally effective manner;
- Increase access to health management through screening and referral strategies;
- Facilitate a network of providers who can offer services to meet the unique health needs of the identified indigent population; and
- Collect health data regarding targeted population and share that information with ISDH.

Most of the health screenings and health promotion takes place at Pow Wow's and at the American Indian Health Care Center in Indianapolis, where 1,200 Americans Indians reside. The project will expand its screening sites and health education topics during this coming fiscal year. A preliminary health survey has been done and the program's goal for this year will be to screen and educate 300 members of the target population.

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Program Title: *Mobile Health Clinic Services*
Health Department: Lincoln-Lancaster (NE) County Health Department
Target Population: Under-served racial and ethnic minorities and non-English speaking populations
Health Issues: Health care access
Funding Source: Health department and community-wide fundraising campaign

Program Description: The Lincoln-Lancaster County Health Department (LLCHD) has provided health and dental health services through a mobile health clinic since 1997. The target population for the mobile health clinic remains those with the most difficulty in accessing dental health and health care services. Clients typically have limited incomes and often are of racial and ethnic minority groups. Lincoln has a large refugee resettlement program and many clients have limited to no English speaking skills.

Highest need areas were identified subjectively through the use of focus groups and objectively by utilization of the Geographic Information System (GIS) using parameters of: 15 percent of population living in poverty; death rate and infant mortality rate more than 25 percent above county average; housing deterioration; non-white population distribution more than 10 percent; and schools with 50 percent or greater of children receiving free or reduced meals. In addition, the results of past school-based dental screenings were used as an indicator to determine placement of the mobile health clinic.

To further define individual needs in at-risk areas, LLCHD staff and student volunteers from the University of Nebraska College of Dentistry and the University of Nebraska have done door-to-door surveys to identify neighborhood needs and perceptions of dental and health services. The surveys have revealed significant barriers to health and dental care including transportation, language, and lack of insurance coverage. These assessment efforts provide added justification for use of the mobile health clinic in these neighborhoods.

The health department utilizes a local television station and local newspapers to advertise the location and services of the mobile health clinic. In addition, this information is disseminated through neighborhood churches, schools, businesses, cultural centers, outreach workers, and area agencies serving at-risk populations. With the purchase of the mobile health clinic, the Lincoln-Lancaster County Health Department facilitated a community advisory committee composed of community leaders, key providers, school representatives, citizens, and contributors. The community advisory committee was formed to assist with the marketing and outreach strategies for the delivery of services to at-risk populations.

A significant area of impact has been with the school-based dental screenings coordinated by LLCHD and the Lincoln Public Schools. These screenings are conducted in 37 elementary and 10 middle schools and target children that have not seen a dentist in the past twelve months. The school-based screenings utilize community dentists, dental students, and LLCHD dental staff to identify high risk children in need of priority dental care. As follow-up to the school screenings, LLCHD staff utilize the mobile health clinic and transportation services to provide school-based dental care services for children unable to access dental health care because of financial, cultural, psychological, social, and/or geographic barriers.

Difficulties have included:
- Bridging non-English speaking and cultural gaps to develop trusting relationships between clients and dental health and health care professionals;
- Convincing parents from multiple cultures that good oral health care must be a priority for their children;
- Finding a tremendous need for oral health services among adults but having very limited resources for adult dental care; and
- Ensuring that clients follow through with recommended referrals and treatments.

The program has been more effective in:
- Combining resources to more effectively provide services to under-served and at-risk populations;
- Identifying and addressing neighborhood issues and concerns;
- Having a consistent presence in high-need neighborhoods;
- Heightening community awareness of the need for services; and
- Facilitating a collaborative approach to addressing the needs of at-risk populations.

The most important lessons learned are as follows:

- Having a continued presence in high-need neighborhoods is essential to developing trusting relationships; and
- Clients seen on the mobile health clinic are most effectively served when advocacy and case management services are incorporated into their care.

Through the development of new partnerships, the enhancement of existing partnerships, reallocation of LLCHD resources, and the incorporation of mobile health clinic services into grant work plans has led to the sustainability of this program. The evaluation plan for this program includes the following data collection and analysis:

- Number of individuals with completed case management intervention plans with the outreach workers and care providers;
- Number of clients and the type of service provided by the mobile health clinic;
- Number of children receiving dental services;
- Number of schools and children screened;
- Findings of school children screened by level of care needed;
- Number of clients provided emergency and routine dental care; and
- Number of racial and ethnic minorities screened and receiving treatment.

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Program Title: *Northwest Ohio Migrant Health Services*
Health Department: Henry County (OH) Health Department
Target Population: Farmworkers and their families
Health Issue: Access to care
Funding Source: Ohio's General Revenue Fund

Program Description: *Northwest Ohio Migrant Health Services* has been in existence for two years. The Northwest Ohio area served by this program includes six counties covering over 2,565 square miles. The target population is migrant farmworkers and their families. Migrant workers are a vital component of the agricultural economy in Northwest Ohio. At least 1,482 migrants reside on a seasonal basis in this catchment area. Most work for several months each year (e.g., May through September) and as a result, have very limited access to health care providers in the area. Most migrants have no insurance. In addition, language is a barrier to accessing health care.

A local consortium was formed and has pioneered an approach to the provision of health care, social services, and advocacy support. The county health commissioner chairs this consortium. The Board of Health administers the funds and contracts with a number of public and private health agencies, clinics, and hospitals for many of the services that are provided.

A mobile health care unit is leased from one of the consortium members. The mobile unit takes services to the workers and their families. This overcomes the problem of rural isolation and the distance necessary to travel for health care. Through the use of the mobile unit, medical, preventive health, and social services are provided to migrant farmworkers and their families. The intention of this program is to increase access to health care to the level experienced by the general population in the region.

The most common ailments that migrants seek treatment for are aches and pains from job-related stooping and lifting. Treatment for hypertension and diabetes is also common. The family practice physician who provides services from the mobile health unit will see patients for any condition. Vouchers are provided to patients to pay for specialist referrals when needed. All vouchers that are issued are redeemed through the program. With bilingual Hispanic staff at each clinic, Hispanic migrants receive health information and community referrals in their primary language and in a culturally-appropriate manner. Health education efforts are often limited to emphasizing to the patient the importance of taking his/her medication. Providing health education and preventive services have been a challenge.

Another challenge has been assuring that the migrants receive necessary prescription drugs. This barrier is overcome by providing vouchers for migrants to pay for the drugs and negotiating with nearby drug stores to accept the vouchers and to stay open later in the evening during clinic days. A pharmacy located in one of the towns where the mobile unit is taken has agreed to write prescription label instructions in Spanish. The program's outreach worker (a public health nurse) visits the migrant camps to follow up on patients seen at the clinic to ensure both that they are taking their medications and that their medications are working.

Adequate preparation prior to the growing season when migrant farmworkers arrive is key to a successful program. The program's outreach worker spends considerable time meeting with farmers who are planning to bring migrant farmworkers to the area. Farmers are informed about the program's services and are queried about how many migrants they are contracting with and how long they estimate they will stay. This helps to determine how much staffing will be required, where clinics need to be located, and how many clinics should be scheduled. A pre-growing season training session with lunch is made available for all individuals involved in the program. Time is taken to explain how the process works and what the vouchers look like. Cultural differences are also explained to ensure that migrants receive the best possible care.

Early on, it was determined that prenatal care and delivery services needed to be provided by at least one obstetrics clinic or private obstetrician's office located in each of the six counties served by the program. These prenatal care and delivery services are now contracted out to both public and private clinics. A "promatora" (migrant health aide) is assigned to each prenatal patient to provide both transportation and translation services for

physician or clinic visits. The "promatoras" assure that prenatal patients make it to their medical appointments and understand the information that is conveyed during the medical visit.

A total of 611 migrant farmworkers were provided a medical service at these clinics during the past season. An additional 90 migrants were screened during three special dental clinics. Outreach workers made numerous visits to migrant camps. As a result of these clinic services being available, emergency room visits by migrants to the six hospitals in the area were limited to real emergencies.

An evaluation of the program is conducted annually. One component of the evaluation includes a meeting with all consortium members and other interested individuals, including workers and advocates. At this meeting, a review is conducted of the number of clients served, types of services they received, and client demographics. Program improvements are made from this evaluation. Patient medical chart audits are also conducted as a performance measure and quality assurance to determine that a high level of practice standards is maintained.

Northwest Ohio Migrant Health Services is being sustained primarily through funding from Ohio's General Revenue Fund. Ohio Senator Lynn Wachtmann's personal commitment to assuring the provision of basic health care services for migrant farmworker families has been instrumental in obtaining and maintaining this funding allocation. Some additional revenue is generated through Medicaid billings. Every effort is made to enroll eligible migrants in Medicaid and to bill for their services.

This program could be replicated in other parts of the country where similar population groups exist. The seasonal migrant workers population is unique and there are numerous barriers to overcome when providing services to them. Replication of the voucher system, nurse outreach worker, and "promatoras" would likely benefit similar populations in other regions of the country.

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Program Title: *Reduce Disparity in Access to Cardiac Services*
Health Department: New Jersey Department of Health and Senior Services
Target Population: Cardiac health patients
Health Issue: Access to cardiac health services

Program Description: New Jersey, a culturally diverse state, has launched a statewide effort to reduce disparities and improve access. Through regulatory changes, increases in the availability of cardiac surgery services have occurred. The New Jersey Department of Health and Senior Services has engaged in a collaborative, three-year project with the Department of Family Medicine Center for Healthy Families and Cultural Diversity at the Robert Wood Johnson Medical School to develop an assessment instrument to monitor these changes. This assessment tool will measure the availability and utilization of hospital-based cardiac care for medically under-served groups. This initiative will address:

- What quality measures of a hospital's organizational capacity are related to the provision of culturally competent cardiac services; and
- How these quality measures of cultural competence can be integrated with measures of availability and utilization to provide an overall assessment of access to cardiac care.

In addition, these measures will be pilot tested and implemented in a cross-sectional study of all 86 acute care hospitals in New Jersey to assess its feasibility and appropriateness for quality improvement efforts in cardiac care.

The results will not only serve as a baseline for a future statewide report to consumers profiling hospital-based access to cardiac care, but also as a model for application to other chronic illnesses and conditions, such as diabetes, cancer and HIV/AIDS.

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Domestic Violence Prevention

Program Title: *Latino Curriculum for Home Visitors*
Health Department: California Department of Health Services
Target Population: Latino families and home visitors
Health Issue: Domestic violence prevention

Program Description: The Family and Domestic Violence Prevention Program developed a Latino curriculum based on the Domestic Violence and the Home Visitor Training Project. This new curriculum includes the *Domestic Violence and Latino Families: A Guide for Home Visitors* and a training kit that is under development. The purpose of the curriculum is to give home visitors working with overburdened Latino families, an understanding of Latino culture in relationship to family violence prevention and culturally-specific practical guidance to assist families to live violence-free. The curriculum includes issues, such as:

- Specific factors linked to violence against Latinas;
- The rights of undocumented victims of domestic violence; and
- Accessing appropriate services for the Latino family.

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Environmental Health

Program Title: *Border-STEP (Small Town Environment Program)*
Health Department: Texas Department of Health
Target Population: Border residents
Health Issue: Environmental health

Program Description: *The Small Towns Environmental Program* (STEP) is a nationally recognized self-help program developed by The Rensselaerville Institute (TRI) that works directly with state health and environmental agencies to solve small community water and wastewater problems. In 1994, the Texas Department of Health (TDH), Office of Border Health (OBH) introduced *STEP* to Texas. Along the Texas-Mexico border, there are some 1,400 colonias (and over 360,000 colonia residents), which are small unincorporated communities lacking basic environmental infrastructure and public services. Over 24,000 colonia residents have benefited from *Border STEP*, and community projects have included drinking water supply, wastewater services, and flood control projects.

Border STEP's approach is unique from other service providers in organizational structure, program development, and training strategy. State employees are engaged to collaborate and lead community project development specific to their particular agency needs. When compared to traditional retail costs, the *Border STEP* community's self-help methodology increases the number of beneficiaries while significantly lowering the cost per beneficiary served.

The OBH has an essential role in identifying the readiness of candidate communities, providing ongoing training and technical assistance, and obtaining funding sources to complete projects. Colonia communities solve their water and wastewater problems by using local resources (expertise, donated equipment, volunteerism, labor, etc.). *Border STEP* also serves as a public health training resource for TDH involving actual demonstration projects with communities on topics such as sanitation and disease prevention. No other service provider can currently offer those innovative services.

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Program Title:	*Healthy Homes Program*
Health Department:	Boston (MA) Public Health Commission
Target Population:	Families of color from inner-city neighborhoods
Health Issue:	Asthma
Funding Source:	Centers for Disease Control and Prevention (CDC) and Department of Housing and Urban Development (HUD)

Program Description: Boston's *Healthy Homes Program* is designed to serve all families in the city who have one or more children with asthma. A particular focus and extra attention has been paid to enrolling and assisting low-income families of color living in Boston's crowded inner-city neighborhoods where resources are scarce and access to services can be limited.

Boston is currently experiencing an asthma epidemic. The average asthma hospitalization rate for the city of Boston is 11.1 per 1000, compared to four per 1000 for the state of Massachusetts. The problem is even worse for inner-city neighborhoods such as Dorchester and Roxbury where the rate is as high as 19 per 1000. These neighborhoods are predominantly low-income communities of color with industries such as auto shops and junkyards. Thus, families living in these neighborhoods are more likely to live in substandard housing and neighborhoods full of noxious industries exposing children to more asthma triggers. Many of the families most at-risk have the poorest access to resources and alternatives to dealing with poor housing conditions. This is not only a health disparity, but an issue of environmental injustice as well.

The *Healthy Homes Program* recruits participants through a number of methods, such as:

- Advertising in local neighborhood newspapers;
- Participating in health fairs;
- Advertising on the radio;
- Distributing flyers through neighborhood health centers;
- Enlisting the aid of physicians for direct referrals of clients;
- Direct mailing to homes; and
- Working closely with partnered community groups such as neighborhood associations, activist organizations, community development centers, and job training program

Once a participant is recruited into the program, he/she is provided with a complete home assessment and asthma evaluation. This includes air quality monitoring in the home; a visual inspection of asthma triggers, injury risks, and lead poisoning risks; and a comprehensive questionnaire to assess behavioral risk factors. Based on the result of this assessment, the team makes a number of recommendations for tasks that tenants and/or the owner of the building need to do to make the home safer for the asthmatic child. The program also provides participants with a number of free items to prevent injuries and asthma, such as cabinet locks, smoke detectors, hypoallergenic mattress covers, in-home education, and referrals.

The biggest barrier that the program has encountered has been recruiting participants. A second major barrier has been the jump from conducting the home assessment to connecting participants to home remediation resources. Many participants are either reluctant or unable to take out even low-interest loans, and grants are limited.

Boston's *Healthy Homes Program* includes a pilot program and an expanded citywide program. Valuable baseline data and experiential information have been collected and are being used in the development of a citywide program. Baseline housing data from 46 pilot homes show:

- Thirty-seven percent of residents reported having a regular smoker in the home;
- Mold was present in 50 percent of the homes;
- Eighty-seven percent of homes had a pest problem with either rodents, cockroaches, or both;
- Nine of the 46 residents reported using their stove for heat;
- Six of the 46 homes had no smoke detector present;
- Of 30 homes with clothes dryers, eight of the dryers were not vented to the outdoors; and
- Seventy percent of enrolled families are potentially eligible for a grant package of up to $9,750 to remediate their home.

As part of the pilot project evaluation, outcome data will include assessment of the number of families able to access the financial aid for remediation. Health and behavioral changes as reported by participants will also

be recorded and compared to baseline data to evaluate change.

The citywide program involves an expanded evaluation component, including post-intervention environmental assessments of the home. To assess changes in health, the participants will be interviewed by phone every other month for a year and a medical chart review will be conducted. A statistician will conduct a cost-benefit analysis.

Through these federally funded programs, the commission is developing a coordinated and integrated method of service delivery including outreach, inspection, environmental change, education, and advocacy for the leading environmental health concerns of children. This approach and these methods are being institutionalized in the Boston Public Health Commission and other agencies, beyond the scope of this project. Further, the Environmental Health Office is developing materials that address complicated health and environmental issues in an easy-to-read format for use in our programs and by other local, state, regional, and national agencies.

The *Healthy Homes Program* has provided an opportunity for collaboration among critical partners in the health and housing arena in Boston. Partners include the Department of Neighborhood Development, the city's housing agency, and nonprofit community development corporations that build and manage housing, as well as energy assistance/conservation organizations, community health centers, hospitals, and advocacy groups. The foundation laid through these programs has already led to other activities, including the development of Boston's First Affordable Health House, a two-family home that will receive a total rehabilitation based on healthy housing principals.

This model of environmental intervention, community education, and partnership-building, and the process through which it was developed, has demonstrated success in Boston. It can now be replicated by public health agencies and/or community-based organizations in other cities around the country that wish to address their own asthma problems with the benefit of learning from our experiences, successes, and barriers.

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Immunization

Program Title: *St. Louis Area African American Older Adult Immunization Project*
Health Department: Saint Louis County (MO) Health Department
Target Population: Elderly African Americans
Health Issue: Adult immunization
Funding Source: Health Care Financing Administration

Program Description: *The St. Louis Area African American Older Adult Immunization Project* has been in existence since July 2000. The target audience is African American older adults (60 years and older) in St. Louis County (and St. Louis City). The 1997 Behavioral Risk Factor Surveillance System (BRFSS) reported that for Missouri, the percentage of persons aged 65 and older receiving vaccination has increased from 66.6 percent in 1995 to 70.3 percent in 1997. However, little progress has been made in influenza vaccination rates in the African American population. In the St. Louis metro area, which accounts for 61 percent of the African American population of the state, there continues to be a large disparity in influenza vaccination rates. According to 1997 BRFSS data, only 36.8 percent of African Americans residing in St. Louis, compared to 80.1 percent for their white counterparts, received influenza vaccinations.

An advisory committee will be developed to assist with the design, implementation, and evaluation of this project, and to offer general support to the project. Key stakeholders from the health care community, senior organizations/programs, and the beneficiary population will be represented on this advisory committee. Specifically, the advisory committee will:

- Provide input into the environment assessment;
- Identify major events and partners;
- Provide expertise on the development of the direct and indirect interventions;
- Evaluate milestones regarding project activities; and
- Support project activities through promotion and education.

Year One of the project, which covers the period from February 2000 through March 2001, is the formative research stage. The following activities are currently underway:

- The target population will be selected using zip codes to identify areas in St. Louis City and County with the highest concentration of African American Medicare beneficiaries; and
- Six to eight focus groups will be held with the target population to identify key issues related to their knowledge, attitudes and beliefs, behaviors, and communication channels related to flu immunizations.

From January 2001 through October 2001, partnership development will be the emphasis, primarily through the following activities:

- Interviews will be completed with health care providers and community organizations serving the target population. The interviews will provide an opportunity for provider recruitment, as well as identification of provider barriers and knowledge of flu immunization rates in the targeted area.
- Potential partners will be identified; and
- Opportunities to partner, exhibit, and present at conferences will be sought in St. Louis City and County.

Development of direct and indirect interventions will occur during the period of April 2001 through August 2001. Interventions will:

- Be designed based on the results of the formative research with the target population, the partnerships developed, and the advisory committee;
- Include a message that encourages flu vaccinations among the target population and strategies for delivering that message; and
- Consider strategies for overcoming barriers identified from the formative research.

Some of the barriers encountered to date are:

- Scarcity of literature and resources specifically regarding African Americans;
- Misunderstanding of immunization safety and efficacy, preventing some seniors from getting flu shots; and
- Data accessibility limitations, which impact and restrict coordinated efforts to promote immunizations.

Lessons learned to date are:

- Time and patience are needed to develop relationships;
- Trust among grassroots stakeholders is absolutely critical to the program's success;
- Community partnerships require coordination, understanding of messages sent and received, and time spent in developing trust;
- It is critical to identify the informal and formal leaders within the African American population; and
- Time-intensive planning and understanding of a project and the targeted population is required for local grassroots efforts.

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Infant Mortality Prevention

Program Title: *Healthy Start—Northeastern Baby Love Plus*
Health Department: Northampton County (NC) Health Department
Target Population: Women of childbearing age (15-44)
Health Issue: Infant mortality prevention
Funding Source: Maternal and Child Health Bureau (MCHB)

Program Description: The five rural counties that make up the *Healthy Start—Northeastern Baby Love Plus* project area — Halifax, Hertford, Gate, Nash and Northampton — experience minority infant mortality rates that are among the highest in North Carolina, a state that itself has one of the highest rates of infant mortality in the nation.

Key facts about the project area are as follows:

- During 1995-1997, an average of 33 infant deaths occurred annually, of which 24 were African American infants and eight white. During the same period, the total infant mortality rate was 12.0 per 1,000 live births. Among African American births, the infant mortality rate was a remarkable 17.0 while the corresponding figure for white births was 6.0. The non-white infant mortality rate for this period was a striking 28:1, a much greater degree of disparity than that seen in the state as a whole.
- In 1998, the infant mortality rate increased to 17.0 per 1000 live births, with the African American rate increasing to 26.0, while the white rate remained unchanged.

The primary goals of *Healthy Start—Northeastern Baby Love Plus* are to reduce African American infant morbidity and mortality and to increase awareness of related issues in the American Indian community. The North Carolina Division of Public Health, Women's and Children's Health Section (WCHS), in collaboration with the Northeastern Baby Love Plus Regional Consortium, guides the process. Goals are achieved by 1) enhancing the effectiveness of existing activities; and 2) introducing new interventions that complement these existing strategies.

Healthy Start — Northeastern Baby Love Plus seeks to build on the strengths of the existing Baby Love Program (the state's Medicaid prenatal care program) and the Eastern and Triad North Carolina Baby Love Plus Initiative, as well as other existing community resources. Each component of the initiative is carefully designed to complement existing components of the local and state prenatal care systems.

As part of the program, community health advocates go door to door in the community to provide health education services and to recruit pregnant women into early prenatal care. They also help to ensure that clients receive needed prenatal and postpartum services. Linkages are created with other health and human service agencies to promote efficiency and to reduce duplication.

Child care and transportation continue to be barriers to accessing health and human services. In addition, an overall challenge for *Healthy Start – Northeastern Baby Love Plus* is not only to provide and coordinate these services, but also to continue to mobilize communities to take ownership of the infant mortality and morbidity problems and to provide leadership in the effort to implement programs in their communities.

WCHS has substantial experience with both data collection and evaluation, and also maintains close relationships with other agencies with extensive data collection and evaluation experience, such as the State Center for Health Statistics and the University of North Carolina School of Public Health (UNC-SPH). The program evaluation will utilize several data sources to test three main hypotheses:

- Community capacity/responsibility and ownership of infant mortality reduction efforts will increase;
- Enhanced Baby Love Plus services will result in more appropriate and more valued service provision; and
- Birth outcomes in the project area will improve more rapidly than in appropriately selected control areas.

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Program Title: *Infant Mortality Prevention Program*
Health Department: Nassau County (NY) Health Department
Target Population: African Americans in the target area
Health Issue: Infant mortality prevention
Funding Source: General health department fund

Program Description: African Americans who reside in the nine zip code areas within the county with the highest infant mortality rates (IMR) are the target audience for this program. Although the infant mortality rates have steadily declined in the county for the past 20 years, the disparity between racial groups is still substantial. In Nassau County, the infant mortality rate for African American infants is more than four times that of white infants. In 1998, the infant mortality rate was 15.1 (per 1000 live births) for African American infants, 3.9 (per 1000 live births) for white infants, and 6.7 (per 1000 live births) for Hispanic infants. The high infant mortality rate in African American women is primarily a result of preterm birth and low birth weight.

The goals of the program are to raise the awareness of members of the community to this disparity and mobilize community resources to prevent infant deaths. The education message is presented to audiences at businesses, community-based organizations, correctional institutions, churches, PTAs, shelters, hospitals, nursing homes, health centers, child care centers, physicians' offices, and other health care provider sites by five public health nurses and a public health educator.

The intervention's objectives are to:
- Design specific lessons for the targeted populations ate each site (i.e. juvenile detention center residents, homeless shelters inhabitants, high school students);
- Hold classes and one-on-one teaching;
- Network with organizations, churches, youth, etc., who can refer individuals and groups; and
- Establish a perinatal network.

The educational program covers preconceptual health, prenatal care, labor and delivery, postpartum care and parenting. These topics are tailored to the specific audience and can be a one-time presentation or a group of ongoing classes.

Barriers encountered include:
- Lack of community awareness of infant mortality;
- Belief that the community has no stake in the problem;
- Lack of collaborative efforts among agencies that deal with the same target audience while trying to decrease the feeling of competition among these agencies;
- Difficulty obtaining materials that are culturally sensitive that can be distributed to participants;
- Convincing young women of the need for education in the areas of disease prevention and health promotion;
- Identifying high risk women and direct them to the appropriate resources; and
- Selling the program to members of the faith community and help them to see the relevance of education in prevention.

The *Infant Mortality Prevention Program* has reached more than 8,000 persons through community-oriented educational programs. Evaluation results have revealed:
- Continued collaboration with community agencies enhances the ability for outreach into the community;
- A need exists to further tailor the educational curriculum to specific audiences;
- Evaluation of pre- and post-testing results indicates increased knowledge after the presentation; and
- Production of a community resource pamphlet targeting various populations is important.

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Prenatal and Early Childhood Care

Program Title: *Black Infant Health Program*
Health Department: County of Los Angeles Services (CA) Department of Health
Target Population: African Americans
Health Issue: Prenatal care
Funding Source: State Title V Maternal and Child Health Block Grant

Program Description: In 1988, in recognition of the social needs of the African American community with regard to perinatal outcomes, a Los Angeles County Initiative to "reduce perinatal mortality among Blacks" was created. A committee of experts in maternity care, health education, nursing, biostatistics, and community health was convened to investigate issues and submit recommendations to leaders of the Department of Health Services (DHS). This select group reviewed research, local data, and community factors affecting the outcome of pregnancies in Los Angeles County, and developed nine specific recommendations that were submitted to the DHS for consideration. These recommendations resulted in the "Great Beginnings for Black Babies Task Force," which began deliberations in February 1990 and ultimately became the community-based organization, Great Beginnings for Black Babies, Inc.

The agencies that were part of the task force chose to develop and implement programs based on both the Prenatal Care Outreach and Social Support and Empowerment models. DHS contracted with Great Beginnings for Black Babies, Inc. and Harbor-UCLA Research and Education Institute to implement the *Black Infant Health* (BIH) program. The Prenatal Care Outreach model utilizes community health outreach workers to identify potential families in the community in need of perinatal services. Outreach involves knowledge of the target area and community, networking with other agencies and providers, identifying outreach opportunities, canvassing, community-street outreach, enrollment, referrals, and follow-up. Workers conduct intensive outreach to locate high risk pregnant women, document their health needs, and link them with needed services. Workers also provide home health education visits, ongoing follow-up to assure continuity of health care, support and incentives to encourage women to obtain the needed services, and celebrations for families to promote awareness, self-empowerment, and self-esteem.

The Social Support and Empowerment model seeks to improve health outcomes of African American women and their children. The goal is achieved by providing high risk women with support, advocacy, and assistance that they and their children may need. This model helps women who feel powerless in their own lives to identify and uncover their inner strengths and utilize these strengths as a launching pad for empowerment. This goal is accomplished through group interaction that is curriculum-based.

The barriers encountered have been relatively few. The two contracted organizations have their roots deep in the community, and they both have the trust of the populace, so that finding appropriate clients has not been a problem.

The BIH program continues to be a high priority within both state and local public health agencies. Due to the initial support of the State Department of Health Services, Maternal and Child Health Branch for the belief that a coordinated, uniform approach across programs would most likely yield the maximum impact in improving the health and well-being of African American women and their families throughout the state, funding was provided for the California *BIH* Evaluation Project with San Diego State University (SDSU). The purpose of the project is to train model developers in the design, testing, and implementation of the various models who will facilitate training in other jurisdictions, and design and develop a data collection and evaluation system applicable to each model.

The SDSU Health Evaluation Project Team developed the BIH Management Information System (BIH-MIS) and its utilization is required for all BIH jurisdictions. The BIH-MIS provides storage and retrieval of client specific information. Data is collected daily and uploaded to SDSU on a monthly basis. Technical assistance is provided by SDSU for all users. Quarterly reports are generated for the State DHS.

According to SDSU data:

- Over the past four years (July 1, 1996-June 30, 2000), BIH client enrollment in California has steadily risen to 6,891, averaging 405 clients per BIH site. There have been 4,204 completed pregnancies and a 25 percent dropout rate during this time;
- In the period July 1, 1996-December 31, 1999, 85.4 percent of all clients had babies of normal birth weight. During the same period, there was a gradual reduction in low birth weight babies, evidence that the program is positively impacting outcomes; and
- In the period July 1, 1996-December 31, 1999, 17.7 percent of all clients entering BIH at less than 12 weeks gestation had premature births (<37 weeks gestation).

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Program Title: *Comenzando Bien—A Prenatal Education Program for Hispanic Women*
Health Department: Jefferson County (AL) Department of Health
Target Population: Hispanic pregnant women
Health Issue: Prenatal care
Funding Source: March of Dimes

Program Description: The Jefferson County Department of Health (DOH) provides comprehensive prenatal and child health services to eligible patients at eight health centers across the county.

The face of this community is changing quickly. In the last five years, the number of Hispanic patients seeking health department services has increased dramatically. In fact, the number has doubled each year. Most of these Hispanic patients are new to the area and speak only Spanish, are adjusting to a new culture, and may not know about the prenatal services available to them. Many only have an eighth grade level of education and bring with them many myths about how to have a healthy pregnancy. Therefore, the risk of infant mortality and morbidity are greater for these patients compared to other populations.

In the spring of 1999, a bilingual social work student intern piloted a prenatal education program for Hispanic women at an area church. She used a curriculum called *Comenzando Bien*, co-developed by the March of Dimes and the National Alliance for Hispanic Health. The health department supported her in the project, and the program was successful. The participants were encouraged by the program and have gone on to have healthy babies. The program was so successful that the local chapter of the March of Dimes agreed to fund future program implementation. In 2000, it was offered at three different churches. In 2001, it will be offered at even more locations.

The main goal of this program is to ensure that the newest Hispanic immigrants have access to prenatal care early in their pregnancies, resulting in healthy babies. The secondary goal of the program is to help these new moms build networks of friends in Alabama to whom they can turn when they have questions and problems both during and after their pregnancies.

The program is usually hosted by a local church (or churches) and consists of eight sessions conducted over an eight-week period. Each session focuses on a different aspect of pregnancy and is taught by a bilingual health professional specializing in that area. For example, the session discussing the importance of proper nutrition during pregnancy is taught by a bilingual dietician. If the health professional does not speak Spanish, the program coordinator/facilitator interprets for him/her. The eight sessions are as follows:

1. *Madre hay una sola*:
   The Importance of Having a Healthy Pregnancy
2. *Cuidarme es cuidarte*:
   Taking Advantage of Prenatal Care
3. *La cita*:
   My Prenatal Care Visit
4. *Comiendo para dos*:
   Nutrition During Pregnancy
5. *Tómelo con calma*:
   Physical Stress During Pregnancy
6. *Cada cabeza es un mundo*:
   Nurturing Relationships During Pregnancy
7. *Hábitos que dañan*:
   Drug, Alcohol and Tobacco Use
8. Graduation

In addition to these topics, others covered briefly are infant care, lead poisoning hazards, infant CPR, and childbirth preparation. Each session includes relationship-building activities, times for questions and answers, and open discussion about what is going on in their lives.

The soon to be implemented expanded project will:

- Be conducted in Spanish;
- Include money in the budget to allow for transporting patients to their classes and their appointments;
- Educate participants on the location for prenatal care and delivery, as well as their rights as patients in the U.S. health care system;
- Include a session on Lamaze techniques; and
- Have a more scientifically designed evaluation component.

Because the program focuses on building knowledge among participants, the first evaluation element of the program is a pre- and post-test of knowledge. It covers all the areas of the program. In addition, a discussion at the end of the program asks the participants what they

would like to see done differently and what they enjoyed the most. All comments are recorded and considered during program adjustments or enhancements. A more scientific evaluation with outcome measures is being designed for future use. In order to have continued success, acceptance, and effective duplication in other counties, it is the goal of the program planners to make the evaluation component stronger.

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Program Title: *Comenzando Bien*
Health Department: City of Meriden (CT) Department of Human Services, Health Division
Target Population: Hispanic women of childbearing age
Health Issue: Prenatal care
Funding Source: March of Dimes

Program Description: *Comenzando Bien,* has been in existence since 1999, targeting Hispanic women of childbearing age. This program is a prenatal educational program designed to ensure that Hispanic women receive adequate prenatal care. The program aspires to validate the participants' knowledge, tradition, culture and beliefs and integrate them with medically sound prenatal care practices. The program is based on the following premises:

- Hispanic women have informal networks through which they find support;
- Hispanic women find in the family major sources of concern, information, sharing, and consultation for decision-making; and
- Prenatal care recommendations are much more likely to be accepted and followed if they are integrated into the participants' life experiences.

The program strategy is to provide a facilitator-led group setting where the women look to each other and to experts in the community as sources of support and learning. The curriculum used was developed by the March of Dimes. The curriculum integrates linguistic and cultural factors, provides current medical information, promotes mutual interactions between facilitators and participants, and is knowledge-based and behavior-oriented. It consists of eight reasons, as previously outlined.

The biggest challenge encountered is getting women to sign up for the program. Recruitment is labor-intensive because one has to sell the program and get people interested enough to commit to the entire eight weeks. Follow-up phone calls and reminders are essential to maintain the commitment of the participants, especially during the first two weeks of the program. By the third week, participants are usually more comfortable with the program and require less follow-up. The health department provides babysitters, transportation, and lunch to the participants.

Pregnancy outcomes are used to evaluate the program. All the women who participate in the program are WIC participants, which allows the facilitator to follow the women at their monthly WIC visits. All program participants to date have delivered full-term, healthy babies and have breastfed at birth.

Preliminary groundwork is currently underway to replicate the program in a nearby community.

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Program Title:	*Esperanza Project: Prenatal and Early Childhood Nurse Home Visitation Program*
Health Department:	County of Los Angeles (CA) Department of Health Services
Target Population:	Hispanic low-income first-time mothers and their children
Health Issue:	Prenatal and early childhood care
Funding Source:	U.S. Department of Justice, State Title V Maternal and Child Health Block Grant, and the Proposition 10 Commission

Program Description: The *Esperanza Project: Prenatal and Early Childhood Nurse Home Visitation Program* (HVP) was piloted in Elmira, NY in 1997 and Memphis, TN in 1990. Los Angeles (LA) was chosen as one of six cities in the United States to attempt to replicate the earlier findings. This project utilizes the prenatal and early childhood home visitation model developed by Dr. David Olds to enable at-risk mothers and their children to get and stay on the path to a meaningful and productive life. This model uses nurses to provide home visitation services to single, first-time pregnant young women, and the nurses concentrate on making improvements in maternal health, social functioning, and parental behavior. Follow-up begins during the last trimester of the mother's pregnancy, and extends through the first two years of the child's life.

The Los Angeles County Department of Health Services (DHS) project targets 100 Hispanic, low-income, socially disadvantaged, first-time mothers and their children. A woman must be expecting her first baby, be under the age of 26, be less than 28 weeks pregnant at enrollment, and live within the project's catchment area (the Pico-Union, Westlake, and surrounding areas of downtown Los Angeles) to participate.

The project attempts to improve health and social functioning using a strengths-based, self-efficacy program. The objectives of the program are to:

- Improve clients' pregnancy outcomes by helping women practice sound health-related behaviors, including reduced use of cigarettes, alcohol, and illegal drugs, and eat healthier diets;
- Improve child health and development by helping parents provide more responsible and competent care for their children; and
- Improve families' economic self-sufficiency by helping parents develop a vision for their futures, plan future pregnancies, continue their education, and find employment.

Public health nurses provide home visits that are comprehensive (following prescribed protocols covering six domains of functioning), intensive (including weekly or biweekly visits, one to two hours in length); and extensive (visits beginning during pregnancy and continuing until the child's second birthday). Major activities during home visits include:

- Providing parent education, including prenatal and early childhood education;
- Enhancing informal support (i.e. assisting in building supportive relationships with family members and friends); and
- Providing and promoting linkages with formal services, such as other health and human services.

The nurse home visitors follow protocols that focus on the mother's personal health, quality of caregiving for the child, and the parents' own life-course development. Clients and their families receive a wide variety of comprehensive, coordinated services within six domains of functioning, as follows:

- Personal Health – improving health maintenance practices, nutrition, and exercise and encouraging positive behavioral change regarding substance use.
- Environmental Health – assessing home, school, work, and neighborhood environment and providing education and referrals as needed.
- Life Course Development – reducing unintended subsequent pregnancies and improving self-sufficiency and family stability.
- Maternal Role – encouraging maternal-child bonding and promoting early childhood development.
- Family and Friend Support – assisting with child care and development of a safe and reliable support system.
- Health and Human Services – assisting clients with service utilization.

The lessons learned by DHS relate to community collaboration and open, honest communication. Barriers were overcome by developing interpersonal relationships with those implementing similar home visitation programs. Sharing resources, staff expertise, and the stories of the home visitors helped link everyone into a common frame that supported the work of all the home visitation programs.

Although the HVP is still too early in its implementation phase to have proven outcomes, the community

has benefited by the establishment of linkages between the public health nurses and the home visitation network as a vital community resource. The evaluation component of this program is a collaborative effort between the DHS and Dr. David Olds' evaluation staff at the University of Colorado Health Sciences Center (UCHSC).

The planned evaluation of the project, which is partially underway, consists of a required UCHSC component specified in DHS' contract with UCHSC, and is complemented by a more area specific DHS evaluation. The evaluation involves collecting a wide variety of indicators that measure both outcomes and impact. Impact measures focus on the health, safety, and economic, social, and emotional well-being of the mother and child from the third trimester of pregnancy and at six-month intervals through the child's second birthday.

The goal of UCHSC's evaluation is to assess fidelity to the Olds model program, success at engaging families in the program, and program outcomes compared with other participating sites. DHS is collecting additional data and conducting an independent analysis to assess the impact of the program on Los Angeles County's highly diverse population.

This model program represents one of the most promising ways yet developed of enabling at-risk mothers and their children to get and stay on the path to a meaningful and productive life. Empirically evaluated for over 23 years, it has yielded significant and consistent outcomes in test sites throughout the nation, and is one of the most stringently applied home visitation programs in existence for this population of young mothers.

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Program Title:	*Health Link Program*
Health Department:	Rowan County (NC) Health Department
Target Population:	African American children from birth to age five living in the county
Health Issue:	Health and well-being of children birth to age five
Funding Source:	North Carolina Healthy Start Foundation, volunteers and local businesses, Robertson Foundation, Rowan County Partnership for Children, and Rowan County

Program Description: *Health Link* a partnership between the Rowan County Health Department and the Adolescent and Family Enrichment Council of Rowan County, was started in October 1998. The Program improves the health and well-being of children from birth to age five living in Rowan County. The majority of resources and time are directed toward children and families living in predominantly African American communities, especially those of low-income. The program seeks to impact health disparities between African American and white children. Mirroring the North Carolina and the country overall, African American infants in Rowan County experience death rates two times higher than white infants.

The program utilizes an ever-expanding network of volunteers who serve as lay health advisors. *Health Link* advisors receive 14 hours of training on community resources available to improve the health and well-being of children and education about health disparities. Many advisors live within the communities that the program serves. The advisors provide instrumental, social, and emotional support to families in need and link them with necessary resources. Some examples of *Health Link* advisor activities include the following:

- Advisors meet one-on-one and in small groups with low-income adult residents to link them with resources that improve the health and well-being of their children. Advisors recently established a new initiative to encourage and assist families in spacing the birth of their babies at least two years apart.
- Advisors formed the *Health Link* Teen Club and Choir. The club/choir markets *Health Link* throughout the community via singing engagements and participation in community events such as local parades. Most members of the club/choir are from low-income families with minimal parental involvement. Members receive life skills education and mentoring from the volunteers.
- Advisors organized an educational and support program for pregnant and parenting students at a local high school.
- Advisors support the activities of a local church youth group to distribute *Health Link* materials to low-income African American communities.
- Advisors participate in and recruit local residents to attend focus groups to identify community and individual needs, strengths, and interests.
- Advisors market free *Health Link* transportation services to residents in need. Through a contract with a local transportation company, free rides are provided for people experiencing barriers to accessing programs and services that help children thrive and succeed.

A *Health Link* Steering Team comprised of 13 volunteers who are informal leaders in the community was formed to:

- Identify and recruit new volunteers to serve as advisors;
- Provide support and advice to *Health Link* staff and advisors on the design, development, and implementation of activities that are culturally-appropriate and have the greatest likelihood of success;
- Market *Health Link* throughout the county;
- Establish collaborative relationships between *Health Link* and other local agencies and organizations; and
- Provide financial and in-kind donations to *Health Link*, as well to prepare grant proposals and provide grant writing assistance.

Lessons learned about important elements for success include:

- Identify the strengths and desires, as well as the needs, of the individuals and communities that are being served;
- Involve the people you are serving in identifying and solving their problems;
- Develop collaborative relationships with other individuals/organizations that share your vision, are willing to commit their resources and time, and accept mutual risk for potential program failure;
- Utilize already proven approaches;
- Listen to volunteers and act upon their advice and suggestions;
- Constantly market and sell your program to others because you never know from where support and allies may come;
- Apply a multi-intervention approach since no one

activity or endeavor will be effective in addressing complex societal problems such as racial and ethnic health disparities;
- Increase the racial and ethnic diversity of health department staff; and
- Implement health department customer satisfaction surveys to measure progress in continuously improving service delivery and quality.

Health Link activities have been replicated in many settings: a local municipality, city and county housing authorities, high schools, local youth groups, and neighborhoods. The program is evaluated based on several formative and process outcome measures, such as:
- Number of volunteers trained and participating in *Health Link;*
- Number of partnering agencies and organizations;
- Number of communities served;
- Number of community programs and activities delivered;
- Number of residents receiving services and support;
- Quality and quantity of information obtained from community residents through focus groups and door-to-door surveys;
- Breadth and depth of services available to local residents;
- Breadth and depth of funding streams;
- Level of volunteer commitment and involvement; and
- Creation and adoption of policies that strengthen program quality and sustainability.

Recently, specific risk factor measures have begun to be formulated to assess the success of some of the initiatives. However, there is a general lack of steady funding to support community-based prevention activities such as *Health Link*. Other difficulties include marketing health messages providing resources and support to low-income, disenfranchised communities, and advocating and achieving social and environmental change related to health with sufficient power to affect beneficial transformation in individual attitudes, values, and behaviors and environmental conditions conducive to a measurable improvement in individual and community health.

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Program Title:	*Hispanic Prenatal Project*
Health Department:	Marion County (OR) Health Department
Target Population:	Prenatal care for Hispanic women ineligible for Oregon Health Plan or other health insurance
Health Issue:	Prenatal care
Funding Source:	Northwest Health Foundation

Program Description: The 2000 census shows that Marion County's Hispanic community has increased 187 percent since 1990. Hispanics comprise 17 percent of the county's population. Over 93 percent of the clients seeking prenatal care at the health department are migrant, uninsured, and ineligible for the Oregon Health Plan. As a result of declining revenue from Medicaid and increasing numbers of Hispanic clients, the health department was forced to refer some clients to other providers for care. Unfortunately it became difficult to find providers willing and able to take these clients. As a result, the *Hispanic Prenatal Project* was initiated by the health department. It has just begun its second year. The major goal of the project is to provide culturally-appropriate prenatal care to Hispanic women.

The health department wrote a grant proposal to the private Northwest Health Foundation to fund the project. The project's primary purpose is to provide prenatal care to low-income uninsured monolingual Hispanic clients. Components of the project include:

- Care by Spanish-speaking providers;
- Client education related to nutrition, safety, adequate housing, childbirth, etc;
- Psychosocial and medical risk screening;
- Health department collaboration with obstetric staff at a local university to care for high risk clients; and
- Community planning meetings to bring together prenatal care providers from all parts of the county to provide an opportunity to meet and share information.

Some of the lessons learned include:

- It is critical, but difficult to begin bringing people together to talk about the issue.
- It is important to passionately believe in the health department's role in mobilizing the community for action, providing outreach, and forming partnerships for vulnerable populations.
- It is important to educate the Latina population about prenatal care.
- It takes time to develop trust within collaborations and partnerships.

As a result of the community collaboration, a reference guide was produced that lists all providers in the county willing and able to serve Hispanic clients. The project has increased awareness of the need for bilingual providers and improved access to care for Hispanic people. There is an urgent need for funding to assist the undocumented and uninsured in the rest of the county as well. Agencies previously not interested in partnering now seek to be part of the initiative.

Facilitating referrals to providers, arranging timely billing, providing a system for data collection, and facilitating quarterly planning meetings with county providers continue to be the most obvious challenges.

The program evaluation focuses on prenatal care and birth outcomes. Data show:

- The number of clients entering prenatal care in the first trimester has increased;
- Ninety-eight percent of the babies were born after full-term pregnancies and at the normal weight; and
- In 95 percent of the initial 110 births, mothers had more than eight prenatal visits.

The project had a positive impact on the community by creating an opportunity for providers to meet and share their concerns about this growing population. Strong working relationships will help ensure sustainability. The grantor has showcased this program to other prenatal providers in Oregon, suggesting an interest in replication in other regions in the state.

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Refugee Health

Program Title: *Refugee Health Assessment and Screening Program*
Health Department: Illinois Department of Public Health
Target Population: Refugees
Health Issue: Refugee health

Program Description: The Illinois Department of Public Health, *Refugee Health Assessment and Screening Program,* provides culturally competent and linguistically-appropriate refugee health assessment and screening services through nine local public health agencies to approximately 4,200 refugees every year. Since the wave of Southeast Asian refugees, which included Vietnamese, Cambodians, Hmongs and Laotians in 1975 and Russian Jews in 1980, refugees resettling in Illinois have come from very diverse backgrounds. These include the former Soviet Union (Bosnia, Yugoslavia, Czechoslovakia, Herzegovina), African nations such as Somalia, Ethiopia, Liberia, Sudan, and most recently Kosovo. Refugees also include parolees and asylees from Cuba and Haiti.

Despite tremendous racial and ethnic diversity, limited English proficiency, cultural differences, and financial problems, which are all compounded by an unfamiliar health care system, the program is very successful. One remaining barrier to the program is the number of isolated screening sites where it is difficult to hire bicultural staff or health care interpreters.

Program approaches used include:

- Refugee health screening sites with bicultural health aides who provide health care interpretation and health education;
- Mandatory health orientation and education with curricula that is culturally sensitive for all screening site staff;
- A health guide for refugees written at an educational level that is easy for refugees to understand. The healthguide has been translated into Vietnamese, Russian and Bosnian. Spanish, French, and Arabic translations are planned for FY 2001. The guide is available at all screening sites and community-based organizations that serve refugees;
- Mandatory training on health care interpreting skills and medical terminology for staff and health advocates at screening sites; and
- Cultural competency training for all screening site staff and medical provider referral agencies.

The Center for Minority Health Services has developed many resources, including a health care interpreting curriculum, a cultural competency curriculum and cultural competency assessment tool kit for health care organizations, a multicultural kit for health care organizations, and a patient's awareness rights for health care interpreting curriculum.

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Teen Pregnancy Prevention

Program Title:	*Baby Find*
Health Department:	Clark County (NV) Health District
Target Population:	First-time pregnant adolescents and high risk pregnant women living in North Las Vegas and old West Las Vegas neighborhoods
Health Issue:	Teen pregnancy prevention
Funding Source:	United Way and local businesses

Program Description: *Baby Find* has been in existence for seven years. The target audience is first-time pregnant adolescents and high risk pregnant women living in North Las Vegas and old West Las Vegas neighborhoods. The program seeks to reduce low birth weight rates among the adolescent African American population and reduce infant mortality rates. The program supports and educates pregnant adolescents and first-time pregnant women on prenatal care and their nutritional needs during pregnancy.

Baby Find has been using volunteers formally since 1993. These individuals have usually experienced, or have family members who have experienced, situations similar to the population being served. This helps to ease fears and makes clients feel more comfortable. *Baby Find* is very active in the African American community by attending neighborhood programs and functions such as health fairs, community programs hosted by other agencies, Urban Chamber of Commerce meetings, and meetings with various service providers. They also host a radio program once a month. Program staff go to hospitals, government agencies, and local businesses to do presentations to promote the program.

Since the program started in 1993, program data have been collected and analyzed. It was discovered that the pregnant adolescents in the target area were not eating properly during their pregnancies due to a lack of larger supermarket chains in the neighborhood. It was also noted that prenatal care was not being sought due to many factors, including the fact that many of the teens were hiding their pregnancies from family members. Once these issues were identified, volunteers started going door-to-door with information to help ease fears and to provide support to both the teen moms-to-be and their families. As a result of these findings, a program called Smart Shop began to address the nutritional needs of pregnant adolescents and to teach them how to prepare meals and learn to be self-sufficient once their babies are born.

Baby Find has access to vital statistics regarding all babies born in the area served. Staff compare statistics from year-to-year to monitor the program's progress. There has been a decrease in both the rates of low birth weight and infant mortality due to the close mentoring and support that the volunteers provide to their clients. The volunteers mentor their clients up until the baby's first birthday to assure that healthy babies are being born and thriving during the first-year of life.

Data is collected on a monthly basis by each "volunteer resource mother" on her client and entered into a database. Self-evaluation forms are sent to volunteers, and program evaluation forms to clients, on a quarterly basis. The program coordinator reviews the responses and makes necessary recommendations and changes to ensure quality of service.

The impact of *Baby Find* is felt throughout the community by reducing or eliminating the need for babies to remain for extended periods in the hospital due to illness or lack of proper weight gain during pregnancy.

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Program Title:	*Resource Mothers and Fathers Programs*
Health Department:	Macon-Bibb County (GA) Health Department
Target Population:	At-risk African American women, children, pregnant or parenting teens, and adolescent males ages 10-24 years
Health Issue:	Access to care and teen pregnancy prevention
Funding Source:	Georgia Department of Human Resources and health department

Program Description: *Resource Mothers Program* has been in existence for four years and *Resource Fathers' Program* has been operational for two years. *Resource Mothers and Fathers Programs* primarily target at-risk African American women, children, pregnant or parenting teens, and adolescent males ages 10-24 years old; however, anyone identified with a need for the program's services are welcome. The program is designed to:

- Address factors that affect teen pregnancy;
- Provide access to services and preventive care;
- Improve access to resources for families; and
- Develop skills that allow individuals to assume personal ownership for their health.

The program applies principles of community outreach and home visitation by lay health persons. Resource mothers and fathers are chosen from the areas in which they will be working and are of the same ethnicity as those to be served. Their training addresses communication skills, interviewing techniques, family/home assessments, documentation, community outreach, and referrals.

The services and activities provided by the resource mothers and fathers include:

- Family assessments;
- Coordination of referrals;
- Case management;
- Tutoring;
- Job placement;
- Health assessments and examinations;
- Counseling services; and
- Mentoring.

The barriers encountered included clients' fear of being reported to another agency and distrust of the government. In addition, cultural perceptions that health care is only needed for illness is also an issue.

Lessons learned include the fact that the existence of a support system is necessary for assuming personal responsibility. In addition, the neighbor-to-neighbor concept and having common language and circumstances help build a cohesive client-provider relationship. Trust is also vital to client acceptance and utilization of services. So far, outcomes have shown the program to be promising.

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Program Title: *African American Teen Pregnancy Initiative*
Health Department: Minnesota Department of Health
Target Population: African American adolescents
Health Issue: Teen pregnancy prevention

Program Description: The *African American Teen Pregnancy Initiative* began in 1997 due to an 18-year trend of high rates of teen pregnancy among African American teens. During this time Minnesota ranked the highest in the nation for African American teen pregnancy rates.

The goal of the initiative is to reduce teen pregnancy rates for African American teens by:

- Evaluating their risk factors;
- Providing information to teens;
- Establishing a collaborative of community-based organizations and school systems to better focus on risk factors; and
- Assisting access by African American teens to prevention and intervention services.

In order to identify the risk factors for African American teens in Minnesota, a risk assessment tool was administered to all 8th graders in the Minneapolis and St. Paul Public Schools. The risk assessment tool provided information specific to the needs of the African American teen population and policy, programmatic and community efforts needed to reduce teen pregnancy rates. The risk assessment tool also provides information on other populations of adolescents as well.

To date, the initiative has formed an African American Teen Pregnancy Prevention Collaborative (1999), which consists of 55 individuals representing social services, human services, school systems, public health, the faith community, health system, the private sector, community organizations, youth, and community members. The collaborative has four action groups that focus on achieving the following goals:

- Expand and deepen public awareness and mobilize the community on the issues of African American teen pregnancy;
- Promote pregnancy prevention efforts in institutions, organizations, and agencies which serve African American teens;
- Promote pregnancy programs and services that are culturally-specific to African American teens; and
- Monitor and advocate changes in policies that will increase resources for effective intervention/prevention programs for African American teens.

The Minnesota Office of Minority Health is working with the Minneapolis and St. Paul School Boards to develop a curriculum that addresses risk factors unique to African American teens. They are also developing a referral system to community-based organizations that have the capacity to work on risk factors for African American teens in a culturally-appropriate manner. There will also be a legislative proposal for the 2001 Minnesota Legislature to consider on this issue.

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Tobacco Use Prevention

Program Title: *American Indian Tobacco Use Prevention Program*
Health Department: Montana Department of Public Health and Human Services
Target Population: American Indians
Health Issue: Tobacco use prevention

Program Description: A 1999 survey of American Indians living on or near Montana's seven Indian reservations indicates that approximately 42 percent of adults 18 and older smoked cigarettes, as compared to 21 percent of Montanans in the general population. The Montana Legislature appropriated $7 million for the 2000-2001 biennium to the Montana Department of Public Health and Human Services (DPHHS) for tobacco use prevention programs. To provide guidance in their efforts to address the problem of commercial tobacco use among Montana's American Indians, the Montana Governor's Advisory Council on Tobacco Use Prevention created an American Indian Workgroup consisting of representatives from each of the eight Montana tribes and five Urban Indian Centers.

The Workgroup recommended the following three strategies to address this problem:

1. Provide funding to the tribes and Urban Indian Centers to develop community-based tobacco use prevention programs;
2. Assess tobacco use prevention needs in Indian communities; and
3. Develop culturally-specific tobacco use prevention training programs for American Indian contractors.

Following this direction, the DPHHS allocated seven percent of the settlement funds received for tobacco use prevention for American Indian programs. This percentage is based on the proportion of the Montana population that is American Indian. Each program is funded adequately to hire a tobacco prevention specialist. The prevention specialists are working within their communities on a variety of tobacco use prevention activities, including:

- Community-based tobacco use prevention coalitions;
- Community education and awareness;
- Creation of smoke-free work sites and public places;
- School programs;
- Tobacco cessation programs;
- Merchant education about sales of tobacco to minors;
- Youth projects;
- Community needs assessments; and
- Local media and public relations.

In addition, training is being provided through Montana's Tobacco Use Prevention Resource Center, specifically for this target population.

The American Indian Workgroup has raised awareness about the need to develop tobacco use prevention programs that acknowledge the sacred ceremonial use of tobacco as a positive piece of their Indian culture. These programs separate sacred ceremonial use from everyday commercial use. DPHHS has learned that this separation is a crucial step in reducing the prevalence of commercial tobacco use among this special population.

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Women's Health

Program Title: *Clinica de la Mujer Latina*
Health Department: Oklahoma State Department of Health
Target Population: Latina/Hispanic women
Health Issue: Women's health

Program Description: The *Clinica de la Mujer Latina* provides many services including breast and cervical cancer early detection, follow-up, and case management to Hispanic Women in the Oklahoma City area. The target population for the clinic is women 40 years of age and older. Special health education activities are conducted jointly for recruitment and education. The clinic/program began three years ago through a partnership between the Latino community, Women of the South, Komen Foundation of Oklahoma City, the state health department, Oklahoma City-County Health Department, two Latino radio stations, and Sprint, USA. When the program began the clinic was held only twice a year, but it has grown to serving women on a monthly basis. Evaluation is based on the national Centers for Disease Control and Prevention program standards.

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Program Title:	*Women's Way Health Screening Events*
Health Department:	Custer District (ND) Health Unit
Target Population:	Women age 40-64 who live on the Standing Rock Indian Reservation
Health Issue:	Screening services (mammograms and pap smears)
Funding Source:	Indian Health Service, Tribal support, and local business support

Program Description: *Women's Way Health Screening Events* (North Dakota's Breast and Cervical Cancer Early Detection Program) began on the Standing Rock Indian Reservation in Fort Yates, ND, in April of 1998. The target audience is primarily women ages 40 to 64 who live on the Standing Rock Indian Reservation and receive services from the Standing Rock Indian Health Service (IHS) located on the reservation. Some of the problems that the program seeks to address are:

- Lack of availability of mammography services;
- Women's lack of interest in annual screenings; and
- Transportation and child care barriers.

To reach the audience and overcome the barriers, the *Women's Way* Program partnered with the Standing Rock Indian Health Services, Standing Rock Tribal Health and Custer Health District as well as the local colleges of nursing and other local Standing Rock agencies to:

- Contract to provide on-site mammography three times per year;
- Hold women's health screening events at the IHS clinics two to four times per year for two consecutive days per event; and
- Offer transportation and child care to events.

At the women's health screening events, women eligible for *Women's Way* services can enroll in the program, where they receive a clinical breast exam, Pap test, pelvic exam, and mammogram. The providers at the Indian Health Service clinics who perform the exams address other medical needs as well and provide health education on various topics. Transportation, child care, food, and incentives are all part of the event. The following services are offered at the screening events:

- Breast self-exam education;
- Breast and cervical cancer screening guidelines;
- Diabetes education and testing;
- Nutritional counseling and education;
- Osteoporosis and cholesterol information;
- Menopause and hormone replacement therapy information;
- Mental health services;
- Family planning education; and
- Bone density screening.

Standing Rock Indian Health Services advertises each of the screening events through the local radio station, which is the primary mode of communication within the community. Staff ensure that local providers are available for the event, with a special effort to locate female providers.

The biggest draw of the screening events is the on-site mammography, since the IHS facility does not offer this service normally and women who want to receive mammography must travel 75 miles off of the reservation. IHS reported that, as a result of the distance, they had less than 50 percent compliance with women getting a mammogram before the screening events began on the reservation. After several years of visiting with the women of the Standing Rock Community, the providers have found that the women have an increased level of comfort when they have their mammogram done at a familiar location. Many women do not like the idea of going to a strange place and exposing their body to a stranger. They reported that if this service were done locally, they would be more compliant.

The Standing Rock Tribal Health staff work with the women before, during, and after each event to assist them in scheduling appointments, obtaining transportation, and receiving the necessary follow-up. If necessary, Tribal Health staff will accompany the woman during the follow-up appointment for support.

Replication of events in other areas is already in progress in North Dakota. Two other reservations have held successful screening events patterned after the Standing Rock model. Not only have events become popular on the North Dakota reservations, but the same model is being used successfully with other ethnic groups as well.

After each screening event, all participants and staff are asked to complete an evaluation to determine how they feel about their experience as a participant, provider, staff or volunteer. The evaluations have provided many useful insights and prompted changes in the program.

There are many positive outcomes of the Women's Health Screening Events, including:

- Women receiving screening services locally;
- Establishing a pattern of annual screening for the participants;
- Early diagnosis of breast cancer and treatment; and
- Multiple agencies working together for the common good of women.

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Health Professional Training

Program Title: *Minority Health Careers Academy*
Health Department: Maryland Department of Health and Mental Hygiene
Target Population: Baltimore City public school students
Health Issue: Allied health professional career planning

Program Description: The purpose of this program is to enhance health education awareness and motivate minority students and participants to pursue careers in the heath care field including the area of allied health professionals. It is a joint venture with the Maryland Department of Health and Mental Hygiene, the Baltimore City Public School System, the Department of Social Services, and Coppin State College.

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Program Title:	*Project CRISTAL* (*A Program for Collaborative Rural Interdisciplinary Service Training and Learning*)
Health Department:	North Dakota Department of Health
Target Population:	American Indians and health care provider trainees
Health Issue:	American Indian Health/Interdisciplinary training

Program Description: The purpose of the *Collaborative Rural Interdisciplinary Service Training and Learning Project (Project CRISTAL)* is to develop curricula designed to provide interdisciplinary training for students in occupational therapy, physical therapy, social work, clinical laboratory science, and medicine that will improve health care services to populations residing in a rural reservation area of North Dakota. The Turtle Mountain Indian Reservation in Belcourt is the rural site for this project. This location provides an excellent training ground for students and faculty due to the numerous and varied health conditions. The interdisciplinary training model fits into the traditional cultural belief of holistic medicine and community health.

Through *Project CRISTAL* there is hope for gaining an understanding and appreciation for the expertise each health discipline brings to solving health problems. *Project CRISTAL* will develop and sustain collaborative working relationships between the University of North Dakota (UND) and the Turtle Mountain Community College (TMCC). Through patient-centered, community-oriented learning, teams of health professional students will experience a learner-motivated approach to problem solving. The rural experience also provides an opportunity to recruit and retain health care practitioners to the reservation areas of North Dakota and make rural practice an attractive choice for health professionals. A major objective associated with the overall goal of *Project CRISTAL* includes the linkages with rural and under-served communities and centralized distance technology (i.e., computer-aided instruction, electronic mail networking, V-Tel connectivity, and electronic library resources). The experiences gained in the project will provide valuable insight into interdisciplinary health training as well as health issues of American Indian populations that may lead to future research specific to the Turtle Mountain community.

Project CRISTAL addresses the overall goal of promoting interdisciplinary health service learning in order to increase and retain the number of clinically competent health care providers practicing in rural reservation areas of the state. Objectives specific to this goal are:

- To develop the collaborative relationships between academic faculty, Indian Health Service, tribal representatives, and rural facilities at Turtle Mountain Reservation;
- To promote interdisciplinary health service learning as a core component of health professions curricula at UND by the end of the three years;
- To increase the numbers of students trained in the interdisciplinary health training curriculum from five to thirty by the end of the three years; and
- To examine potential areas of research at the Turtle Mountain Indian Reservation that may lead to better understanding of collaborative rural interdisciplinary service training and learning.

The project is a three-year pilot project based at the Turtle Mountain Indian Reservation. Initially, five students will be enrolled in a four-week summer didactic and clinical field experience at a health care center. In years two and three, additional students will be added to rotations at this site during the academic school year and by year three, 30 students will have participated in the project.

Project CRISTAL students will explore interdisciplinary team concepts, study cultural differences to integrate prevention, wellness, and disease management themes into the unique tribal culture, and participate in a four-week clinical experience. While on the rural rotation, the students will participate in curricular activities provided by the TMCC designed to promote cultural awareness and wellness, understand characteristics of health risk factors in American Indian populations, and help recruit future health care practitioners to the reservation setting. *Project CRISTAL* participants will invite persons from the community and state to visit the project site for a "Summer Health Profession Institute" to participate in team activities designed to familiarize them with rural and American Indian culture and associated health issues with the intent of recruiting others to the health service professions.

Students who participate in the project, upon completion, will be able to:

- Identify and describe opportunities for interdisciplinary collaboration in the rural reservation practice environment;
- Describe benefits and/or barriers associated with choosing a future health professions career in the rural reservation practice environment;
- Identify problem situations in the rural reservation practice environment which may be resolved or managed more effectively through collaborative action;
- Demonstrate the ability to use collaborative team-member skills as measured by interpersonal interactions and group cohesiveness; and
- Report increased competence in using collaborative interdisciplinary health service strategies for making decisions related to management of patient care.

This community-based experience will also provide the students and faculty an opportunity to explore the amount and types of potential research that may be conducted concerning issues in rural Indian health and/or interdisciplinary health service training in diverse populations. Additionally, this program will provide a mentoring opportunity for the community to promote the recruitment and retention of practitioners by encouraging students to practice in rural reservation areas throughout North Dakota where access to care is often not readily available.

This project just concluded year one and was an awesome experience for six disciplines of students. The sixth student was from the NHSC SEARCH program - a melding of two federal projects. *Project CRISTAL* is in the process of evaluation.

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Community Assessment and Development

Program Title:	*African American Health Matters*
Health Department:	Ingham County (MI) Health Department
Target Population:	African Americans
Health Issue:	Increase community awareness about health risks and prevention
Funding Source:	Kellogg Foundation and health department

Program Description: *African American Health Matters* is a collaborative effort of the Ingham County Health Department, the David Walker Research Institute at Michigan State University, and the Lansing African American Health Initiative. The purpose of *Health Matters* is to increase the awareness of African Americans about the most significant health disparities found in their community, factors that put them at-risk, and methods for health improvement. The Ingham County Health Department has a four-year agreement with the African American Health Institute that provides funding to support Institute planning and implementation activities.

Last November, more than 200 Lansing area residents gathered for the African American Health Summit, a community dialogue on the health status of this specific population in the county. Many participants expressed positive feedback about the importance of being well informed about one's health. They also expressed a willingness to work on strategies to decrease disparities, both individually and through community efforts. Focus areas included children's health, senior health, spirituality and mental health, income disparities, lifestyles and access to health care. The discussion resulted in a 10-page planning document covering a broad spectrum of ideas.

Evaluation will play an important role in the future of these efforts. The health department has contracted with a local firm to conduct an evaluation of Institute efforts over the next two and a half years. The evaluation will assist the Institute in identifying goals, objectives, and indicators of progress. The product should help the Institute improve the effectiveness of its initiatives and serve as a clear description of Institute efforts and outcomes for the community. The evaluation will describe best practices so people elsewhere in the state or country can implement them in their communities. It is also the hope that the evaluation will help to gain financial support to sustain Institute efforts. The evaluation effort is part of the health department's Kellogg Community Voices Foundation grant.

The African American Health Institute and *Health Matters* are in their second year and it is too early to measure health improvement outcomes in the community. An important process outcome, however, is the gatherings of African Americans in this community, including during the summit. African Americans gathered, perhaps for the first time for a health planning purpose, to better understand health and factors that influence health in their community, and to discuss strategies for improvement.

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Program Title: *Closing the Gap Grants*
Health Department: Florida Department of Health
Target Population: Minority communities
Health Issue: Health status and community development

Program Description: The Florida Office of Minority Health (OMH) has responsibility for coordination of grant application activities. The Florida Legislature provided $6 million to be utilized within communities to reduce racial and ethnic health disparities through *Closing the Gap* grants. The grant program is designed to stimulate the development of community-based and neighborhood-based projects, which will improve the health outcomes of racial and ethnic populations. Programs should foster the development of coordinated, collaborative, and broad-based participation by public and private entities and faith-based organizations. The grant program shall also function as a partnership between state and local governments, faith-based organizations, and private sector health care providers, including managed care, voluntary health care resources, social service providers, and nontraditional partners.

Closing the Gap proposals must address one or more of the following racial or ethnic disparities in:

- Maternal and infant mortality rates;
- Morbidity and mortality rates relating to cancer;
- Morbidity and mortality rates relating to HIV/AIDS;
- Morbidity and mortality rates relating to cardiovascular disease;
- Morbidity and mortality rates relating to diabetes; and
- Adult and child immunization rates.

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Program Title:	*Partners in Eliminating Health Disparities*
Health Department:	Mecklenburg County (NC) Health Department
Target Population:	Asians, African Americans, and Hispanics
Health Issue:	Enhance community partner's awareness and collaboration

Program Description: The development process for *Partners in Eliminating Health Disparities* began one year ago. In January 2000, the Mecklenburg County Health Department's (MCHD) health director began to lay the foundation for MCHD to make a stronger and more unified commitment to addressing critical health disparities in the county among Asian, African American and Hispanic populations. To emphasize the health department's commitment to the issue, a community health administrator was hired to lead these efforts.

In August 2000, the Community Health Administrator took the lead in conducting a series of "Community Think-Tank Dialogues." These dialogues brought together partners from various sectors of the community, including representatives from health groups, medicine, minority organizations, local universities, community-based organizations, faith institutions, and the private sector. The purpose of these meetings was to assess the community's ability and willingness to tackle the issues surrounding health disparities among the target populations.

Partners in Eliminating Health Disparities seeks to confront the issue of health disparities by creating a unified infrastructure through the development of a separate organization to implement a community-wide action plan. Through collaboration, education, and partnerships, this organization will encourage the coordination of city and countywide agencies to address the prevalence of health disparities among the diverse populations in the community.

Currently, the workgroup is defining the critical areas that will enable the development of a comprehensive Community Action Plan. The goal areas are to:

- Reduce the incidence/prevalence of diseases and morbidity/mortality in targeted clinical areas;
- Increase health care service utilization for underserved populations;
- Create coordinated linkages and outreach efforts to the community;
- Facilitate the cultivation of relationships with special populations in order to build trust and rapport;
- Expand and strengthen neighborhood actions and faith-based health initiatives in targeted areas of high morbidity and mortality;
- Increase the cultural competence and diversity of the health care workforce;
- Identify and recognize best practices in and review benchmarks of community-based health care delivery and services; and
- Enhance data collection.

One of the first steps will be to establish priorities for the top health issues. Initial activities will focus on a minimum of three to four priority health areas. These areas will be derived from baseline data and group consensus as to where the community needs significant improvement. Once these issues are identified, the health department will perform asset mapping, and utilize community mobilization strategies to address these issues as they relate to Asian, African American, and Hispanic populations.

The workgroup firmly believes that a culturally competent health care workforce is critical in order to eliminate health disparities. MCHD is incorporating cultural competence into its programs, practices, and policies. In addition, the workgroup recognizes that the patient-provider relationship is often enhanced by ethnic, cultural, and linguistic concordance.

Data collection and analysis are critical components. Without this information, Mecklenburg County cannot delineate the specific populations that suffer from health disparities and cannot appropriately target funding and resources. Key strategies must be developed for the collection of racial, ethnic, economic, and other demographic data, followed by the development of a communications plan for how the information will be distributed to the community.

Some of the barriers that have been encountered include:

- Lack of patience for creating a process that can have a long-term impact on the community;
- Difficulty in identifying resources to keep the process moving forward;
- Difficulty in developing group dynamics; and
- No unified vision for the county and, formerly, limited communication between the myriad of sys-

tems concerned with disparities. The establishment of a unified training system to address cultural competency, accountability, and leverage is needed.

The short-term plan is to evaluate progress against baseline data gathered through Mecklenburg County's Healthy Carolinians Community Health Assessment process. This includes examining data on community health status, contacting the North Carolina State Center for Health Statistics for secondary data, surveying various community groups, conducting community forums, and identifying and assessing community resources. At established intervals, the group will review milestones such as what strategies have been implemented toward narrowing disparities in specific areas. Finally, the group will re-examine existing data on community health status as compared to the 2001 baseline.

The preliminary outcomes include:

- Increased health care utilization for the underserved populations; and
- Recent application by several partners for a minority infant mortality grant with roles for each organization; this collaboration will help to maximize how service providers work together and utilize the planning grant to truly reach the population in need.

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Program Title:	*REACH 2010: The Genesee County Plan*
Health Department:	Genesee County (MI) Health Department
Target Population:	Health care providers and the business/economic community; various African American subgroups
Health Issue:	Community awareness
Funding Source:	Centers for Disease Control and Prevention

Program Description: The Genesee County Health Department is the central coordinating organization for a collaborative comprised of the Greater Flint Health Coalition, the University of Michigan, and community-based organizations. Genesee County's recently funded *REACH 2010* focuses on health care providers, and the business/economic community. Additionally, interventions will focus on subgroups of the African American population, including: pre-teens, teens, and adults, both female and male, in the three geographic zip codes with the highest African American infant mortality rate. The project also includes fundamental interventions aimed at healing racism in the community and offering a supportive and protective cultural framework for African Americans in targeted geographic zones. In addition, there is a strong community-based component including faith-based organizations and individuals.

The following are the proposed Community Action Plan activities:

Community Dialogue and Awareness

- Community dialogue groups: The community dialogue and awareness campaign will consist of discussion groups, workshops, and forums to raise community awareness about racism as a contributing factor to disparities in infant mortality and to keep the team informed as changes occur in the community.
- *Undoing Racism and Healing Racism Workshops*: These two and a half day intensive workshops will focus on racism as it relates to health and human care systems.
- Community media campaign: This campaign is to raise awareness about racial differences in infant mortality and to communicate culturally-relevant messages important to reducing infant mortality.

Education and Training

- University culture and racism curriculum: The University of Michigan-Flint will develop a curriculum for health care students that will highlight the importance of racial and cultural issues in disparity reduction.
- African Culture Education and Development Center: This center will be developed to increase African American awareness of their cultural and historical background.
- Healthy eating and Harambee dinners: This program is designed to support healthy eating habits among African Americans thereby reducing nutritional factors that influence birth outcomes.
- Coordinated perinatal system of care: A coordinated system of care will be developed to assure that all women are screened for potential problems during pregnancy for level of risk and receive appropriate care to address medical, psychosocial, economic, and other basic human needs.
- Male mobilization: This program seeks to reclaim and celebrate African culture and will translate historical and cultural education into personal and community tolerance in order to help African American males build their self-respect and dignity.

Outreach and Advocacy

- Maternal/infant health advocates and faith-based health teams: These will provide the outreach and advocacy components of the program by identifying early pregnant African American women in targeted zip codes.

Mentoring and Support

- "Birth Sisters and Birth Brothers" mentoring and support: This program will include partnering expectant African American women and men with mentors specifically trained to be confidants and supporters through pregnancy.
- "Go for Greatness" and "Young Men Destined for Success:" For preteen and teens, these programs have been designed for early intervention and prevention.

REACH 2010 is innovative in that it takes a socioeconomic, as well as a health care and cultural sensitivity approach, using geographic targeting, to address areas of the community most in need and at-risk. The program will continue to focus on implementing activities that will be sustainable beyond the current funding cycle.

The outcome evaluation will examine the effect of interventions on direct measures of infant health. The evalu-

ation team will track the incidence of infant mortality, low and very-low birth weight, and premature delivery using vital statistics data within targeted zip codes.

The impact evaluation will focus on knowledge, attitudes, behaviors and other mediating variables through which *REACH 2010* may influence infant health. Because infant mortality is a rare outcome that reflects diverse causes, and because *REACH 2010* seeks to address social, behavioral, and medical risks, impact analysis is an especially important part of the evaluation plan. The central component of the proposed impact evaluation is the Flint Health Infant Survey (FHIS), a telephone survey of new mothers. To provide data that are comparable with previous studies and surveys from other sites, the core FHIS survey builds upon the core survey of the Pregnancy Risk Assessment Monitoring System (PRAMS).

Process evaluation, unlike either outcome or impact evaluation, explicitly focuses on important aspects of how a policy or intervention was implemented in practice. The process evaluation is especially important in order to assess the impact of *REACH 2010* on community system change. A primary element of this analysis is the use of a structured instrument with key community decision-makers to explore the main obstacles to and resources for community-based interventions.

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Program Title: *Tennessee Minority Health and Community Development Coalition, Inc.*
Health Department: Tennessee Department of Health
Target Population: Minority communities
Health Issue: Health status

Program Description: Many Tennessee communities are comprised of populations that are adversely affected by a lack of resources. Needs are not being met, and the communities are experiencing disparities in access to resources between racial and ethnic populations related to numerous community issues. Data indicate a lack of equity in community benefits, such as health, information sharing, community development, and educational access. To facilitate empowering communities, appropriate statutes have been enacted through the following key entities: Black Caucus of State Legislators, Black Health Care Commission, Office of Minority Health, and the Regional Minority Health Coalition. The mission statement of the *Tennessee Minority Health and Community Development Coalition* (TMH and CDC), Inc. is to improve the health status and quality of life for disadvantaged communities. The TMH and CDC, Inc. is a non-profit corporation. The coalition focuses on health, community development, and educational issues, especially concerns in disadvantaged communities. The coalition with six regional components was established in 1997 by the Black Health Care Commission and the Tennessee Office of Minority Health based on recommendations from the Minority Health Summit in 1996.

The TMH and CDC, Inc. has several goals to address the needs of minority communities:

- Improve the health status and quality of life for African Americans and other minorities;
- Develop a process to eliminate disparities that exist in health, education and community development;
- Provide opportunities to promote a holistic approach to health care by working with the public, the private sector and community;
- Reduce morbidity and mortality from chronic diseases and other health issues arising from lifestyle and risk factors; and
- Serve as a premier clearinghouse for research and community-based training and technical assistance.

Each regional component has a coordinator. The coalition's regional components consist of counties that are grouped in contiguous geographical areas. These six regional components are autonomous and differ by spatial distribution, urban, rural and by economic factors. The components have worked for three years to coordinate community networks, serving to link resources of local public and private projects. The membership of each regional component is diverse and is comprised of both public and private organizations and agencies.

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General Health Promotion

Program Title: *Minority Health Promotion Program*
Health Department: Rhode Island Department of Health
Target Population: Minority populations
Health Issue: Community-based health promotion

Program Description: In 1992, the state legislature passed the *Minority Health Promotion Act*. The act called for the creation of a minority health promotion program "to provide health information, education, risk reduction activities in order to reduce the risk of premature death among minority populations from preventable conditions." Working with a Minority Health Advisory Committee, the Office of Minority Health awarded approximately 1.6 million dollars to community-based agencies from 1994-2000. In 1998, agencies awarded grant funding through the *Minority Health Promotion Program* were asked to institutionalize their programming through the creation of Minority Health Promotion Centers. Minority Health Promotion Centers are responsible for six activities as listed below:

1. Conducting individual and community health risk assessment activities;
2. Conducting community outreach;
3. Provision of health education regarding health conditions for which minorities are dying prematurely;
4. Provision of consumer empowerment activities which educate consumers regarding their rights and responsibilities with regard to the health care system;
5. Development of health information centers; and
6. Working with health care providers to provide health screenings and referrals for health care.

Minority Health Promotion Centers are operated by community-based agencies with an established record of service to the minority community. In providing minority health promotion services, the Centers have established collaborative relationships with the following organizations: RIte Care, Rhode Island Department of Health - Diabetes, Multicultural Coalition, Women's Cancer Screening Program, Lifespan, Traveler's Aid Society, Providence Family Van, American Heart Association, American Lung Association, National Marrow Donor Program, RI Project AIDS, Providence Ambulatory Health Clinics, Providence Smiles, Neighborhood Health Plan, Ocean State Action Fund, Immigration and Refugee Services, and Brown University.

Specific accomplishments for some of these Centers are recorded below:

- The *International Institute* provided health education to immigrants relating to cancer, diabetes, cardiovascular disease, and women's health. Approximately 500 immigrants from more than forty different countries are provided with these services. In addition to providing education on the aforementioned topics, the Institute has also provided monthly Spanish language immigration workshops to help immigrants understand the issue of public charge and its implications for accessing care. Immigrants participating in the program signed up for free mammograms, received flu shots, and free screenings for cholesterol.
- *The Socio-Economic Development Center for Southeast Asians (SEDC)* provides health education and diseases prevention programs for Rhode Island's Southeast Asian residents. Through the Center, SEDC has increased access to care for Southeast Asians, ensured access to health screenings and health information. On an annual basis more than 150 Southeast Asians receive services and information through this program relating to cancer, cardiovascular disease, and diabetes. Additionally, more than 200 health care providers receive training on Southeast Asian culture and health practices through the provision of an annual conference on cultural competency.
- *The Neighborhood Minority Health Promotion Center (NMHPC) at South Providence Neighborhood Ministries (SPNM)* has made a measurable contri-

bution to reducing health status disparities among minorities and the general population through empowering neighbors with the information and advocacy that they need to access appropriate health care services and physical fitness programs. Activities of SPNM have included maintaining a resource center for health information, revising and distributing consumer-friendly information on RIte Care and Medicaid programs and the difference between primary care and emergency room services, providing health education workshops, providing on-site diagnostic screening programs, providing referrals for health services, and providing staff advocacy and follow-up.

- The *Urban League of Rhode Island, Inc. (ULRI)*, a community-based organization with a 60-year history of service to the African American and other minority communities in Rhode Island, has developed and implemented programs and initiatives to improve the health of minority youth, teen mothers and adults living in the Providence area. The Center provides education and screening programs to address infant mortality, unintentional injuries, chemical dependency and teen pregnancy for which minorities experience a disproportionate burden. Through the Center's ongoing activities, the ULRI has improved access to health information, education resources and health screenings thereby increasing the comfort level of teen moms in communicating with their doctors and other health care professionals regarding their health care needs and concerns and to obtain appropriate health services when needed. Additionally, the ULRI has published a Minority Health Community Resource Guide.

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Program Title: *Minority Health Advisory Task Force*
Health Department: Iowa Department of Public Health
Target Population: Health care planners, policy-makers, and minority populations
Health Issue: Minority health

Program Description: The *Minority Health Advisory Task Force* was convened by the Iowa Department of Public Health (IDPH) to provide insight into Iowa's role within the United States Department of Health and Human Services' and President Clinton's initiatives focusing on eliminating racial and ethnic health disparities by 2010 in the areas of infant mortality, diabetes, cardiovascular diseases, HIV/AIDS, cancer, and childhood and adult immunization. The task force was also convened as part of a state representative's response to high African American infant mortality. This endeavor was an effort by the IDPH to dialogue with representatives from the minority population on issues related to strategies to address the diversity in health needs.

The responsibility of the *Minority Health Advisory Task Force* was to provide recommendations in various areas of concern pertaining to the health care access and service delivery of the diverse populations within the state. To ensure that input was provided by minorities regarding their perceived issues and health concerns, IDPH recruited members statewide for the task force from the African American, Latino, Asian Pacific Islander, American Indian, refugee and immigrant populations. Development of long and short-term recommendations and priorities ranging from one to five years was an additional directive to this task force. In June 2000, a final report was presented with inclusion of twelve recommendations pertaining to issues that were addressed.

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Program Title: *Promotoras Health Education/Risk Reduction Project*
Health Department: Arkansas Department of Health
Target Population: Hispanic/Latino community
Health Issue: Health promotion

Program Description: The Arkansas Human Development Corporation received a mini-grant to implement a health education/risk reduction project targeting the Hispanic community using "promotoras" (health promoters). The "promotoras" will:

- Determine the public health status of the Hispanic/Latino population living in Pulaski County (where the capital city, Little Rock is located) by conducting public health assessment surveys;
- Introduce the target population to the role of public health departments and offer referrals where needed to public and private health care resources; and
- Educate the population on the importance of pregnancy prevention, prenatal care, and other critical health issues affecting the community.

Five "promotoras" will educate this community via health fairs, migrant centers, churches, and through door-to door/one-on-one education.

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Program Title: *Racial and Ethnic Health Task Force*
Health Department: Oregon Department of Human Services
Target Population: Health planners, policy-makers, and minority populations
Health Issue: Health status

Program Description: The *Racial and Ethnic Health Task Force* was formed by a few dedicated people who recognized that persistent and significant health problems weaken Oregon's racial and ethnic communities much more than the same problems affect the population as a whole.

Following discussions in 1997, a small group began to meet in 1998 at the behest of the president of the African American Health Coalition. The group is co-chaired by Senator Avel Gordly and the governor's advisor on health, housing, and labor.

This group identified the following objectives for a standing committee on minority health:

- To build the capacity to study and report effectively on matters relating to health;
- To identify health issues of importance to Oregon's racial and ethnic minority communities, study those issues, and develop recommendations for addressing them effectively;
- To monitor the effectiveness of state agencies and community-based programs in improving the health of racial and ethnic minorities; and
- To report to the governor and the legislature on the results and findings of task force activities.

In 1999, the governor signed an executive order creating the task force. This executive order identified the composition of the task force as consisting of six legislators, eight representatives of state commissions on minority populations and of health care organizations, and seven community representatives. The target population includes African Americans, Asians, American Indians, Hispanic/Latinos and all other minority groups in Oregon. The executive order identifies the six issues selected by the working group that preceded the task force. These issues are:

- Access to medically appropriate treatment provided when necessary, by culturally competent providers in a suitable setting;
- HIV/AIDS;
- Diabetes;
- Asthma;
- Lead poisoning; and
- Alcohol and drug abuse.

Currently, the task force is hard at work identifying recommendations related to these issues that will be submitted to the governor. The recommendations are a result of several meetings and roundtable policy discussions consisting of policymakers, consumers, community-based organizations, providers, and community members. This is a work in progress that has resulted in increased credibility with minority populations in Oregon. The ultimate goal of the group is improved health outcomes for minority populations.

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Program Title: *Tribal Consultation Protocol*
Health Department: New Mexico Department of Health
Target Population: American Indians
Health Issue: Health status of American Indians

Program Description: The New Mexico Departments of Health, Human Services, and Children, Youth and Families (DHHS) *Tribal Consultation Protocol* is intended to serve as a guide to state employees for implementation of the New Mexico Government-to-Government Policy Agreement signed in 1996 by the governor and attorney general of the State of New Mexico and the governors or presidents of all 22 Indian Nations in the state. The Protocol was developed when the state engaged in a tribal consultation process to prepare its State Children's Health Insurance Program, Phase IIA Amendment.

The outcome of the process was the creation of an American Indian section in the Phase IIA Amendment and approval of the Phase IIA Amendment by the Tribal leaders, the Albuquerque Area and Navajo Area Indian Health Service offices, the Albuquerque Bureau of Indian Affairs office, and various Native American non-profit organizations serving reservation, rural and urban Native Americans. In addition, the process has been publicly supported at forums and legislative hearings by the Tribes, Pueblos and American Indian organizations and they have recommended replicating the process in the development of other health and social programs and policies.

The *Tribal Consultation Protocol* was developed by state agency personnel with involvement and assistance by members of Indian Nations and American Indian organizations, including the New Mexico Office of Indian Affairs. The governor and the secretaries of the DHHS formally signed the Protocol in May 2000. At this time, staff in these three agencies, in conjunction with the New Mexico Office of Indian Affairs, are proceeding with a plan to orient and train staff in the use of the Protocol.

The *Tribal Consultation Protocol* is a strategy to address health issues of a population, American Indians, that is disparately affected in such areas as diabetes and other chronic diseases, alcoholism and other substance abuse, and suicide, to name a few. In addition, it satisfies Federal regulations for states to consult with tribes in order for states to access federal funds, a devolution of the federal trust responsibility. Benefits of the tribal consultation process include:

- Shared responsibility and accountability for health and welfare of American Indians among federal, state and tribal governments;
- Improved relationships;
- Improved delivery and integration of health and social services for American Indians with other service delivery systems; and
- Reduced fragmentation and increased state agency staff ability to support tribes and Pueblos working to address local health problems.

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Program Title:	*Turning Points Initiative: Reducing Racial and Ethnic Disparities in Kansas*
Health Department:	Kansas Department of Health and Environment
Target Population:	Health care planners, policy-makers, and minority populations
Health Issue:	Health status

Program Description: A *Health Disparities Advisory Group* was established to provide guidance and input on project objectives. The group includes members of the African American, Asian American, Hispanic, and American Indian communities. Four minority communities will become sites for the creation of community coalitions and health forums to identify specific health disparities and to build community capacity for effective use of data in planning community interventions. To facilitate the work, a partnership has been formed with the Kansas Health Institute, which will implement the plan.

A Kansas Minority Health Data Book will be developed with comprehensive indicators such as behavioral, social and community factors that promote health and well-being. The four minority communities will be convened at a statewide conference to identify priorities for change. The data book and community training on effective interventions will become the tools for effecting change in health status as well as avenues for mobilization of other minority groups. The *Health Disparities Advisory Group* will assist in establishing mechanisms for incorporating minority health issues into the *Healthy Kansans 2010 Objectives*.

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Program Title: *Developing Reservation-based Efforts Addressing Mortality & Morbidity (DREAMM)*
Health Department: Utah Department of Health
Target Population: American Indians
Health Issue: General Health Promotion

Program Description: The Ute Indian Tribe of Utah through the concept of *Developing Reservation-based Efforts Addressing Mortality & Morbidity (DREAMM)*, is effectively addressing the health care needs of the reservation-based Indian populations in Utah. *DREAMM* focuses on developing collaborative partnerships among the eight Utah tribes, the Utah Department of Health (UDOH) and local health departments. The Ute Indian Tribe has an established health board and has worked well with the Indian Health Service (IHS) in the past. Recognizing that the Ute Indian Tribe has had more opportunities than most tribes in Utah to access health services, they requested the grant on behalf of all the tribes in Utah.

DREAMM is designed to:

1) Provide health promotion and disease prevention education and training to tribal community members and health staff;
2) Provide screening services to community members;
3) Develop collaborative working relationships between state, tribal and local health departments; and
4) Provide cross-cultural training for state and local health providers.

DREAMM activities center around a two day health fair held twice during the grant period on each of the eight Indian reservations in Utah. Educational and screening services are developed through consultation with each tribe prior to the fair, and provided by state, local or private agencies. The first day includes public presentations on health issues of primary importance to each reservation. More intensive workshops on the identified topics are given to tribal health staff and representatives on the second day. Topics are chosen with the assistance of tribal health boards based on UDOH and IHS data and community priorities. Health screenings are conducted for community members on both days. A cultural presentation by the host tribe is given to facilitate cross training and increase cultural sensitivity of state and local health department staff.

The change in the provision of health care services to American Indians residing on or near reservations is imminent. While the scope of the changes is not yet clear, there is little doubt that more involvement from state and local health departments will be necessary. There are many challenges to improving health care services to American Indians in Utah. Unfortunately, many state and local health programs have not been delivered on the reservations due to several issues including the perception that the IHS provides all needed services. Many state and local directors have little knowledge of the tribal health systems or have little personal contact with tribal health directors. This has resulted in poor communication and collaboration in services and health promotion activities. Partnerships must be built and understanding developed on how to maximize resources to effectively reach this population. In addition, the IHS has historically been limited in health education and disease prevention activities. Yet, the nature of many of the diseases that lead to high mortality and morbidity among American Indians would be responsive to educational and early detection interventions.

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Needs Assessment and Data Capacity

Program Title: *Healthy New Hampshire 2010*
Health Department: New Hampshire Department of Health and Human Services
Target Population: Health planners and policy-makers
Health Issue: Minority health status and data capacity

Program Description: New Hampshire shares the national Healthy People goal to eliminate racial and ethnic disparities in health. However, needs assessments and evaluation of progress are data driven initiatives modeled after *Healthy People 2010*, and New Hampshire is presented with challenges arising from data limitations. In response to such data limitations, the following objective was formulated for inclusion in *Healthy New Hampshire 2010*: Increase public health capacity to measure health care access, health status, and health-related behaviors in racial/ethnic minority populations.

To identify the needs of minority populations in New Hampshire, respond to those needs through culturally competent interventions, and measure progress in meeting identified needs, the New Hampshire Department of Health and Human Services (DHHS) commits to increasing capacity to collect, analyze, and disseminate data about racial/ethnic minority populations. This objective will be obtained through the cooperative efforts of many partners within and outside of DHHS. Within the DHHS, the Office of Planning and Research, the Office of Community Health, and the Bureau of Health Statistics and Data Management, are undertaking efforts to address this objective. Local public health agencies such as the Manchester Health Department are undertaking efforts to measure the health status of the diverse population within the Greater Manchester area. *Healthy New Hampshire 2010* will be released in March 2001. Evaluation of progress in meeting this objective will be reported in the five-year mid-course review for *Healthy New Hampshire 2010.*

To illustrate the point that data limitations exist, consider that in 1998 there were only 26 deaths among African Americans and 29 among Hispanics. It is difficult to use New Hampshire data when looking at specific causes of death, even when we combine multiple years of data. Any rate calculated is unstable due to these small numbers.

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Program Title: *Maternal and Child Health — Minority Services*
Health Department: Wyoming Department of Health
Target Population: Health care planners and policy-makers
Health Issue: Identifying minority health needs

Program Description: Although the population of Wyoming is predominantly Caucasian, there have been incremental increases in African American, Hispanic/Latino, American Indian, and Asian American/Pacific Islander populations since 1980. These five minority groups now comprise nine to ten percent of Wyoming's population. In 1999, all 23 counties in Wyoming completed a Maternal and Child Health (MCH) System Survey. According to the survey, 95 percent of the respondents replied that there were:

- Either "no available" or "some, but inadequate" training opportunities available in the community around cultural competency;
- Either "no available" or "some, but inadequate" number of culturally competent materials and activities available in their communities; and
- Either "no available" or "some, but inadequate" translation services for those seeking services.

Wyoming also identified gaps and needs that existed throughout the state:

- Access varies throughout the state;
- There is no leadership in the majority of the minority communities to channel information into health care services;
- There is a lack of systematic means of gathering valid minority statistics in Wyoming;
- There is a lack of outreach efforts in rural communities;
- There is a lack of resource coordination for effective use of available resources;
- Individuals with disabilities and individuals with age are under-represented; and
- Minorities are most likely to have lower economical and educational attainments.

To address these gaps, Minority Services adopted the following objectives:

- Social and economic development to facilitate family and consumer participants in holistic health care;
- Effective and efficient coordination of available health care services statewide;
- Outreach to families in rural communities;
- Increased awareness between families and health care providers of available services;
- Provide training in culturally competent and issues related to family support and health education;
- Promote shared translation services among agencies; and
- Advocate for employment and health insurance retention among minority populations.

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Program Title: *Minority Health Data Project*
Health Department: Hawaii Department of Health
Target Population: Health care planners, policy-makers, and minority populations
Health Issue: Health status

Program Description: The mission of the Hawaii Department of Health and Human Services, Office of Minority Health (OMH) is to improve the health of racial and ethnic minority populations in Hawaii and to close the gap in health status between minority and non-minority populations. The OMH has adapted as a key strategy, the empowerment of the minority community by building and strengthening viable partnerships across public and private sectors, and forming a minority health network.

In February 2000, the Director of the Hawaii State Department of Health established the Office of Health Parity (OHP). The mission of the OHP is to provide the leadership to:

- Address health disparities among populations with disproportionate health needs;
- Increase understanding of the relationship between health status, socioeconomic status, and ethnicity; and
- Develop recommendations for effective, culturally-appropriate interventions within selected populations.
- Assessment and policy development activities have served as the priority focus for this new office.

The current OHP *Minority Health Data Project* seeks to establish a community-based advisory group who will spearhead the research, analysis and publication of a report. The report will describe the characteristics of existing data sets related to the health of minority populations and extracted tables of the most current national and state data on the health status of minority populations in the State of Hawaii. The advisory group will coordinate analysis of and/or identify:

- The quality and utility of specific data sources;
- The data profile for the state's minority population which will be compiled and maintained;
- The resources that will be utilized in the assembly, analysis and maintenance of the health status data for the state's minority health population; and
- Produce a summary report for submittal to the OMH by June 30, 2001.

Successful completion of this project by June 2001 will ensure that the State of Hawaii is a full and contributing participant in the National Minority Health Network being established by the OMH. The report of the state's community-based advisory group will ensure that input is provided to the OMH about the issues and needs of the minority communities in the State of Hawaii.

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Program Title: *Multicultural Health: The Health Status of Minority Groups in Connecticut*
Health Department: Connecticut Department of Public Health
Target Population: Health care planners, policy-makers, and minority populations
Health Issue: Minority health status

Program Description: In 1999, the Office of Policy, Planning, and Evaluation released its' report, *Multicultural Health: The Health Status of Minority Groups in Connecticut* that compares the health status of Connecticut's racial and ethnic minority residents to that of white residents in the context of socioeconomic differences that affect health and access to health care. The report examines 34 areas of health disparities for Connecticut's minority residents, including all-cause mortality, chronic diseases, infectious diseases, injuries, behavioral risk factors, pregnancy and childbirth indicators, environmental hazards, hospitalizations, and access to health care. The findings are expressed as population-based rates, relative risks compared to whites, and excess events that would not have occurred if the minority group had the same rate or percentage as the white population. The report will be used to help target programs to specific groups.

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Program Title:	*Peace in Family: A Community Project for Amherst's Newcomer Populations*
Health Department:	Amherst (MA) Health Department
Target Population:	Newcomer Cambodian and Latino communities
Health Issue:	Preventive health care
Funding Source:	Health department and outside grants

Program Description: In 1995, the Amherst Health Department assessed the needs of the Cambodian and newcomer Latino populations in Amherst through needs assessments and focus groups. Some of the problems identified were isolation, a lack of culturally-appropriate health care, and inappropriate knowledge about preventive health care such as dentistry and mammograms, and issues such as alcoholism and domestic violence. In addition, post-traumatic stress syndrome and many resulting maladies were seen in the Cambodian population. *Peace in Family: A Community Project for Amherst's Newcomer Populations* has been in existence for about three years. Amherst's Cambodian residents were the initial target audience. The project has been extended to include the newcomer Latino population within the last year. Outreach workers are used as a way to build capacity within their communities while educating the governmental and social service agency workforces about the needs of these populations.

Health department outreach workers are members of the Cambodian and Latino communities. These workers assist community members in meeting their basic medical and social service needs. They have been able to establish support groups, but because of people's resistance to admit that they need help, these support groups may take the form of a travelers' club or cooking group. As trust develops, community members increasingly approach the outreach workers to help them in a variety of situations. The workers have also held special hepatitis B immunization clinics and have incorporated services to the target populations into regularly scheduled flu and immunization clinics. Another aspect of this project is to work with town and other agencies to increase their cultural sensitivity and understanding. Staff have worked to educate police, as well as other governmental and social service employees, about the needs of these populations. Outreach workers have served as interpreters and advocates to help clients interact with relevant agencies and have showcase aspects of the unique cultures.

The activities of the outreach workers are enhanced and supported by the Newcomer Health Task Force. Representatives from both the Cambodian and Latino populations, from organizations such as the police department, the school system, and human service agencies as well as outside agencies including WIC, Big Brother/Big Sister, Tapestry (the local family planning agency), and the Men's Resource Center, come together on a regular basis to talk about the needs and strengths of the target communities, to give support to the outreach workers, and to use the knowledge that they gain within their agencies.

The health department continues to be concerned about the sustainability of this program and has worked to ensure it. Town administration has expressed support for its continuation, and the outside funding agencies have also offered assurance that funds will continue to be available. Also, of great concern is the appropriateness of the compensation and support available for the outreach workers.

The outreach workers regularly attend monthly regional meetings of the Heath Access Network (HAN). This is an opportunity for them to meet others around the region who are doing similar work. Cases and problems are discussed with state agency staff. These meetings are an opportunity for both advocacy and support. The state has also recognized the need for outreach workers to enroll people who are eligible into some of their programs and has made additional funding available to facilitate this.

The health department has had great success in helping the program's target populations to use the services of the town and other agencies. Although there has not been a formal evaluation, the number of Cambodians using the clinics, sending their children to recreational programs, reporting violent situations in their homes, and seeking appropriate social services has dramatically increased. We are just beginning to see an increase in help sought by the newcomer Latino community, but we have every reason to believe that our experience with Amherst's Cambodian community will be replicated.

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Program Title: *West Virginia Minority Health Chart Book*
Health Department: West Virginia Bureau for Public Health
Target Population: Health care planners and policy-makers
Health Issue: Minority health data

Program Description: The *West Virginia Minority Health Chart Book* was released to the public in the spring of 2000. It was prepared as a reference to assist health care planners and policymakers in developing strategies to improve the health of West Virginia's minority populations. Until that point in time, minority health data was virtually non-existent. This data is being used as the basis to build programs and develop minority health initiatives statewide.

The six leading causes of premature death for minorities from 1985-1996 were: heart disease, homicide, cancer, non-motor vehicle accidents, motor vehicle accidents, and HIV infection.

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Preventive Health Care

Program Title:	*Jefferson County Health Department, Office of Minority Health*
Health Department:	Jefferson County (KY) Health Department
Target Population:	Minority populations
Health Issue:	Preventive health
Funding Source:	Preventive Health Services Block Grant

Program Description: The *Jefferson County Health Department (JCHD), Office of Minority Health* (OMH) was created in 1994. The primary function of OMH is to develop and provide culturally-appropriate programs to the community. The staff provide general information and referral assistance on health and social services information and consultation and coordinates the health department's speaker's bureau. The Minority Health Team consists of two health education specialists, a program coordinator, and a support staff person.

The OMH houses programs such as:

- An adult community health program providing health education to the general community, with a special focus on minority issues, through churches and civil and social organizations;
- A youth program providing minority youth and at-risk teens in both community-based and school-based settings with skills necessary to make healthy lifestyle choices;
- The "Christian Addiction Ministry Program," which takes place at Kentucky's largest African American church and provides a health component to help improve the quality of life for participants coping with various addictions;
- The "Taste of History," a work-site component to the JCHD employee activity observed during Black History Month, the purpose of which is to demonstrate how traditional ethnic dishes can be made healthier;
- The "Global Wellness" project, designed to bring various professionals together to learn about the similarities and differences in lifestyle choices among various cultures, which has developed into a professional training program for providers within the ethnic community; and
- Kentucky AIDS prevention education, a technical review committee that approves AIDS educational materials for the Kentucky Department of Education for all state schools and other youth services.

Overall, the OMH continues to provide support to the Greater Louisville/Jefferson County area. The OMH is dedicated to promoting involvement of under-served populations and minorities in the planning and improvement of community outreach and education. The OMH collaborates with individuals and groups to eliminate barriers to adequate health care and social services. These collaborative projects include:

- "Northwest Area Health Education Center, Kentucky Interdisciplinary Community Screening (KICS) clinic" providing free physicals to those who are unable to afford this service;
- "African Americans for Wellness," an annual community affair designed to empower and educate African Americans regarding health care, prevention, and access;
- "Kentucky Cardiovascular Health Coalition," funded to address racial disparities with regard to cardiovascular disease among African Americans;
- "Neighborhood Place Community Assessment Program Project (CAPP)," a network of one-stop health and human service centers located throughout Jefferson County; and
- "Louisville/Jefferson County Minority AIDS program," providing HIV/AIDS education and prevention skills to minorities.

The barriers encountered in reaching target populations include having a limited budget and a small staff. Despite these facts, there continues to be a large demand for programs at the local level. The lessons learned are that preventive health education is greatly needed in the

community and that collaboration is the key to improving the effectiveness of this education. Developing rapport and providing quality programming has resulted in a high number of requests for ongoing programs.

Some of the OMH's evaluation methods have included questionnaires and random post-event telephone contacts to participants. A pre- and post-test is administered to youth group participants. Random callbacks are used to document lifestyle changes as a result of the programs.

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Program Title: *Migrant Health Program*
Health Department: Barron County (WI) Health Department
Target Population: Migrant workers and their families
Health Issue: Safe housing
Funding Source: Health department funding

Program Description: The *Migrant Health Program,* started over a year ago, targets migrant workers and their families in Barron County. The program seeks to address the lack of affordable, adequate, and safe housing, which has a major impact on the health of seasonal workers, including an increased risk for the spread of communicable disease in this high risk population. General lack of health care resources and language barriers contribute to this problem.

Program interventions include:

- Providing bilingual educational sessions on communicable diseases;
- Providing on-site informational and referral services at the plant, which employs seasonal workers;
- Encouraging the employer to take a proactive role in employee health;
- Setting up bilingual immunization clinics;
- Building community coalitions; and
- Completing a needs assessment of seasonal workers.

Efforts are also being directed at educating legislators on current concerns and the lack of resources. The health department is advocating for local, private landlords to consider having their properties designated as migrant labor camps to facilitate a better inspection process, and as well as increased recognition of the number of migrant workers in the county. Problems encountered include language barriers, lack of community resources, and lack of diversity training for providers.

Partnerships and coalitions are necessary for program development and resource availability. Since financial resources are limited, partnering with other organizations that have designated resources is essential.

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Program Title: *Safe Healthcare Project*
Health Department: Orange County (CA) Health Care Agency
Target Population: Monolingual Spanish-speaking parents of young children
Health Issue: Preventive health
Funding Source: Orange County funds

Program Description: The *Safe Healthcare Project* was established in May 1999. The project's primary focus has been on monolingual Spanish-speaking parents of young children. The scope of the project is currently expanding to address Asians and Pacific Islanders and older adults and educational materials are being disseminated in Vietnamese, Cambodian, and Laotian/Hmong.

In 1999, two Orange County toddlers died after receiving injections of illegal imported drugs at an unlicensed back-room business. Reports later revealed that both children died of dehydration after receiving poor medical advice. In response to these deaths, the County Board of Supervisors directed the district attorney to increase enforcement of laws to prevent Orange County businesses from selling illegal prescription medications and providing fraudulent medical care. The Board also directed the health care agency to collaborate with the Safe Healthcare Coalition to develop community education strategies. The *Safe Healthcare Project* staff work closely with the coalition, comprised of representatives from community clinics, hospitals, health organizations, businesses, schools, community-based organizations, and local, state and federal government offices. The *Safe Healthcare Project* promotes awareness through a variety of community education strategies, including:

- Community presentations;
- "Train-the-trainer" program for community health workers;
- Distribution of flyers, posters, and promotional items to local businesses, community-based programs, and schools;
- Outreach with interactive activities at health fairs and community events;
- Media campaigns; and
- Partnerships with churches, community-based organizations, etc.

The *Safe Healthcare Project* provides both education about the dangers of illegal medication use and, more importantly, where low-income, uninsured populations can receive health information and resources. This is sustained through the project's "train-the-trainer" curriculum adapted for existing community-based outreach workers (promotoras). For example, at a local community-based organization, the "promotoras" combined the safe medicine message with their current diabetes curriculum section on "taking your diabetes medication." These educational efforts have enabled communities to become more empowered to make healthy decisions when accessing health care in their communities. The program also provides the community with the capacity to ask their providers for important health-related information.

The barriers that many program participants encounter are related to differences in the way health care is received in their countries of origin. In Latin America, a sick person may receive care by visiting a pharmacy and purchasing medications without prescription. Family members and ethnic neighborhood businesses are also alternative outlets for medications.

The universal need found among those who use illegal medications is for quality affordable health care, as is found nationwide. Awareness of low-cost state and federal health programs among the nation's growing multicultural populations can be easily enhanced by providing educational trainings about issues of self-medication combined with available local health care resources and services. Although there are several low-cost health insurance programs and low-cost community clinics available to Orange County residents, many have lengthy application processes, long waiting lists, or special eligibility requirements, which limit accessibility. Other barriers to utilization of these programs include public charge issues, immigration status, and language.

Several evaluation components were developed to demonstrate the program's impact. For example part of the "train-the-trainer" curriculum and community presentations, pre- and post-test surveys are used to assess the impact of the intervention. Evaluations are conducted during 95 percent of the presentations and trainings. Participants attain a mean pre-test score below 40 percent. The mean post-test evaluation scores increase dramatically after the intervention to 81 percent.

Evaluation results demonstrated an increase in phone calls to the health referral line promoted through the

campaigns. An educational web page was developed with a tracking system to determine total number of Web site visits. Additionally, 55,000 Hispanic consumers age 18-34 were reached via radio spots and 982,800 consumers were exposed to bus shelter ads. Since the project's inception there have not been any deaths in Orange County related to illegal prescription medications.

The project has been instrumental in helping establish a collaborative working relationship between community and governmental health agencies. The coalition has received a positive community response, and includes several representatives from school districts, public law and local community groups and volunteers. The coalition has applied for non-profit status that will make the group eligible to apply for future grant funding to promote health care access and medication education issues.

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Summary of State and Local Health Disparities Programs

State and local health agencies' commitment to eliminating racial and ethnic disparities in health is clearly demonstrated through their actions and efforts. Across the country, state and local health agencies are actively pursuing a variety of comprehensive and innovative strategies to raise awareness and address health disparities in their communities. As this compendium illustrates, these strategies target a range of health issues and population groups, and include an array of partner organizations. Sustaining these efforts will make a great contribution to achieving the national goal of "100% Access and 0 Health Disparities." Despite the different approaches and targets pursued, a number of shared lessons emerge from analysis of these programs. The following provides a general analysis of the common themes of state and local programs to reduce racial and ethnic disparities in health.

Health Issues

The 34 state and the 33 local public health agency (LPHA) programs highlighted in this compendium focus on the following issues:

- General minority health status
- General prevention and health promotion
- Chronic disease prevention and management
- Community awareness and development
- Cancer screening
- Prenatal care
- Infant mortality prevention
- HIV/AIDS prevention
- Communicable disease prevention
- Data capacity
- Access to services
- Teen pregnancy prevention
- Health professional training
- Tobacco use and prevention
- Domestic violence
- Environmental health

Target Population

While many of the state and local programs address health disparities among minority populations in general, several of the programs target subpopulations. African Americans and Latino/Hispanics are the populations most often targeted by the programs. Programs either focus on specific subgroups of these populations, such as low-income minority women, Latino adolescents, or African American men, or they include the broader category of people. There are also a number of programs that target non-English speaking, recent immigrant, and refugee populations, as well as programs focusing on American Indian/Alaskan Native populations and migrant farmworkers. Additionally, some of the programs target the community at-large, focusing on health planners, health professionals, policy-makers, employers, and others in the attempt to increase awareness about health disparities and other related health status issues. Often times, the programs' target populations have been selected as a result of needs assessments, surveys, and/or focus groups.

Interventions

State and local public health agencies submitted a diversity of programs and policies that utilize a wide range of interventions, all with the common goal of reducing racial and ethnic health disparities. Programs frequently center on health promotion and risk reduction associated with a wide variety of health issues and employ a range of program activities. Many programs use primary prevention strategies to target groups at high-risk for adolescent pregnancy, HIV, and tobacco use. State and local public health agencies also manage prevention programs that address chronic diseases and associated lifestyle factors, such as programs that target obesity and cardiovascular disease through promoting changes in diet and exercise. The health promotion and education programs are often held in local venues, such as community churches, schools, health fairs, and other social gatherings.

In order to communicate important health promotion messages that emphasize cultural-sensitivity and appropriateness, state and local public health agencies engage in activities such as:

- Media campaigns;
- Partnerships with churches and community-based organizations;
- Multi-lingual radio programs;
- Presentations at health fairs, forums, community dialogues, and town hall meetings;
- Mobile health care units; and
- Distribution of health education materials and community report cards.

Public health agencies also provide health assessment and cancer screening services to minority populations, which are often combined with support groups and health education workshops. A few programs also focus

on health professional training activities, including educating providers in cultural sensitivity and competency, and recruiting a diverse workforce.

The use of outreach workers, whether referred to as lay health advisors or community health workers, is a very popular and an effective intervention used by state and local programs. This strategy is often called "train-the-trainer." Outreach workers usually are from the communities in which the clients reside and are of the same race/ethnicity and socioeconomic status as the target population. Therefore, they are very well-versed in the needs and interests of the population and knowledgeable about the structure and function of the community. Outreach workers serve many different functions such as:

- Offering social and emotional support to clients;
- Making home visits;
- Building and enhancing life skills;
- Providing health education to clients and the general community; and
- Linking to or providing clients with case management services and culturally appropriate care.

Coalitions, task forces, partnerships, and collaborations are often the means through which a program/intervention is developed and implemented. Many agencies described the creation and ongoing activities of task forces and advisory committees that address racial and ethnic disparities in health. These task forces/advisory committees serve several functions, including:

- Providing leadership in the design and implementation of a community or statewide plan to address health disparities;
- Offering recommendations on a particular health issue; and
- Advocate to legislators and employers regarding the health needs of the target population.

A couple of agencies described legislation passed to create a minority health promotion program.

Several agencies administer programs that address minority health data capacity and collection. Included in this area are activities that assess current data capacity and new efforts to collect and analyze data on minority populations as a first step in addressing health disparities. Other examples include programs that develop a disease registry to document prevalence of the disease in a community.

Programs commonly focus on developing new publications and resources that examine minority health status in the state or community, or that organize available data into a minority health data book. Other examples of resource development include creating a curriculum for health professionals or home visitors.

Lastly, some programs addressing health disparities center on community development through community-based grants and initiatives that involve community members in improving health outcomes.

Obstacles

The major obstacles faced by programs were related to issues such as recruitment and retention — difficulty in attracting and retaining clients. The lack of community awareness, interest and commitment to the program and the targeted health issue were significant barriers. At times, program staff experienced difficulty in acquiring and retaining the community's interest and support in reducing health disparities. Ensuring that clients followed through with recommended referrals and treatments was also cited as a significant problem.

Cultural and language barriers reported include differences in cultural perceptions of health care, lack of focus and knowledge about prevention, fear about immigration status, and distrust or lack of interest in programs. The racial and ethnic diversity of a state's minority populations can also be a challenge to designing appropriate programs. This fact was particularly noted in some of the refugee health programs that serve individuals from a few different countries and ethnic backgrounds.

Geographic location can also present obstacles to implementing and sustaining programs. Some of the target populations reside in hard to reach rural areas and the lack of transportation and child care prevented their enrollment. Programs also noted shortages or difficulty finding adequate staffing in rural areas.

A few programs faced a lack of financial resources needed to sustain their activities, and the lack of reliable data on health disparities was a barrier to obtaining renewed funding. Access to services was decreased as a result of lengthy application processes, long waiting lists or special eligibility requirements for programs. Programs indicated a range in their data capacity and in the quality of available data, a significant barrier to effectively addressing health disparities.

What Works?

Although many of these programs are new and have not yet been evaluated, preliminary evidence shows some key components that have proven to be effective in the

successful design, implementation, and continuation of state programs addressing health disparities. They are:

- Developing partnerships;
- Involving the community;
- Performing needs assessment;
- Engaging in cultural competency; and
- Designing innovative practices.

Partnerships

It is remarkable that every program featured partnerships. Partnerships were established at a number of levels — between divisions within the Department of Health, with other state and local agencies, with community organizations, existing federal programs, foundations, private sector, and research and medical centers. Partnerships between different divisions within the Department of Health are a particularly common element of many programs. These partnerships include collaborations with the Offices of Minority Health, Community Health, Indian Affairs, and Border Health, and with the Bureau of Statistics. Many programs also showcase partnerships with other state agencies, such as the Departments of Education, Children, Youth and Families, Social Services, and Immigration and Refugee Services. Partnerships with faith-based institutions were frequently cited among the local programs. Partnering with other organizations is essential, especially when resources are scarce. Programs are often initiated by a governor's task force, created due to new state legislation, or involve members of political caucus groups.

Community Involvement

State and local public health agencies involve community members from the beginning stages of the program in a variety of roles such as members of task forces, program planners, and community health workers. In some cases, community members work together to identify local health priorities, community strengths, and local solutions. Including community members in each of these capacities helps to foster trust and acceptance of the program within the community.

Needs Assessment

Needs assessments, which help to identify the needs, interests and strengths of the target population, are essential to successful program development. Involving the population that is being served in the creation of the program helps to gain a greater level of support and buy-in for the interventions. Developing state and local data capacity on racial and ethnic populations is important to designing and implementing appropriate programs and policies.

Cultural Competence

Programs strive to be culturally-sensitive and competent. Programs developed curricula and resource materials that are language and level appropriate for program participants. Some programs try to understand health issues and beliefs from the community's perspective, and to incorporate shared cultural symbols. Cultural competence is also seen in staff training activities. As previously mentioned, several programs work with community members to identify their health needs and associated solutions. Educational messages must be tailored to specific audiences, and by increasing diversity and the cultural competency of staff, a greater level of trust can be developed.

Innovative Practices and Use of Resources

The innovative use of places, resources, and tools is a hallmark of programs targeting health disparities. Several programs hold interventions at sites accepted and frequented by community members, such as community centers, churches, and Pow Wows. State and local public health agencies' creativity is seen in their use of the Maternal and Child Health Block Grant and state tobacco settlement funds, and their engagement of corporate sponsors and foundations in supporting health programs. Exploring diverse funding sources can help expand program capacity. Building on existing federal programs can also be helpful in getting programs off the ground and extending the reach of programs. Also, providing child care and transportation can increase access to the program.

Using new and innovative ways to communicate messages and involve participants is a particularly noteworthy component of programs. It is important to continually market the program to the community through brochures, presentations, and public service announcements because you never know from where your support and allies will come. Lastly, maintaining a strong presence in the community and consistent communication is critical for developing trust with the target population, the most vital element for effective programs.

Other Lessons Learned

Other lessons learned from these programs include:

- The desire to reduce racial and ethnic disparities in health must be an established state and local priority;

- Facilitating opportunities for community groups and providers to come together to share concerns and strategies is helpful;
- In order not to duplicate existing programs, it is important to investigate and learn from other successful programs;
- Consistent leadership and perseverance are necessary to ensure success;
- Incentives can encourage increased participation;
- A multi-intervention approach is important since no one activity or endeavor can be effective in reducing health disparities;
- Developing supportive networks of patients and family members and involving parents in child and teen-related programs have proven to be effective;
- Collaborations and partnerships take time to develop trust; and
- Identifying the strengths of a community, as well as its needs, and involving the people you are serving throughout this process is critical to the program's success.

Funding Sources

The funding for these programs often comes from a combination of different sources, which include:

- State Department of Health (MCH Block Grant, Title X Family Planning Special Initiative projects and other block grants);
- Local health department general fund;
- Foundations (private, local or nonprofit);
- March of Dimes;
- Local government (city and county funds);
- Fund-raising campaigns;
- Federal sources — (Health Care Financing Administration, Centers for Disease Control and Prevention's REACH program, Department of Justice, United States Department of Housing and Urban Development, Indian Health Service);
- Volunteers and local businesses; and
- Local health system.

Conclusion

Overall, while it is clear that much remains to be done, the scale and scope of efforts included in this compendium represent much of the inspiring work underway across the nation. ASTHO and NACCHO offer our support and encouragement to all those involved in these efforts, and appreciate the willingness of public health professionals around the country to share good ideas across jurisdictions.

Index of Programs by Geographic Location

APPENDIX A:
Federal and National Programs Addressing Racial/Ethnic Health Disparities

Health Resources and Services Administration

Bureau of Primary Health Care (BPHC)
www.bphc.hrsa.gov
BPHC was the initiator of the "100% Access/0 Health Disparities" Campaign. They have a number of programs that address chronic disease prevention such as a "Native Hawaiian Health Care Program" to combat diabetes and a "Cardiovascular Health Initiative for Women of Color." They have several initiatives that provide cultural competency training for providers. Such initiatives include the "National Center for Cultural Competence," "Cultural Competence Training for the National Health Service Corps," and an "Interactive Media Training Program on Quality and Cultural Diversity." BPHC is committed to increasing diversity in the workforce with service-related educational scholarship and loan repayment programs for minority providers. Other initiatives include the "Congress of National Black Churches Partnership" and the "African American Women's Health Study." BPHC also has the "U.S.-Mexico Border Health Program" and they fund community/migrant health centers.

Maternal and Child Health Bureau (MCHB)
www.mchb.hrsa.gov
MCHB is committed to reducing the disparity in infant mortality rates between whites and people of color. In order to do so, MCHB has several initiatives, including the "Department of Health and Human Services Racial Disparity in Infant Mortality Workgroup" and the "Healthy Start" Project. The Maternal and Child Health Bureau Training Grants encourage diversity in the workforce.

HIV/AIDS Bureau (HAB)
www.hab.hrsa.gov
Through the Ryan White Care Act, HAB has been able to initiate programs related to reducing HIV/AIDS in minority communities, such as the "Communities of Color Children's Initiative." They also operate the "AIDS Education and Training Center Supplemental Grants Targeting Minority Providers" and health care providers serving tribal areas and communities and the "National Minority AIDS Education and Training Center." Another program is the "Faith-Based Initiative for the Prevention, Care, and Treatment of African Americans Living with HIV/AIDS."

Office of Minority Health (OMH)
www.hrsa.gov/omh/omh/omh.htm
OMH has many special initiatives targeting people of color including:

- "Project AHEAD: Approaches to Health Education and Diet" (cancer screening and management)
- "National Hispanic Religious Partnership for Community Health"
- "Asian American and Pacific Islander Implementation Plan"
- "National Minority Health Month"
- "Hispanic Agenda for Action Initiative"
- "Minority Health Knowledge Management Initiative"
- "Minority Management Development Program"

In terms of cultural competency training, OMH runs the "HRSA-Wide Cultural Competence Committee." OMH has several initiatives related to diversity in the workforce such as the "Historically Black Colleges and Universities Rural Health Faculty Fellowship Program" and the "Association of Hispanic-Serving Health Professions Schools."

Bureau of Health Professions (BPHr)
www.bhpr.hrsa.gov
BHPr is committed to increasing diversity in the workforce through programs such as:

- "Title VIII Nursing Workforce Development"
- "Diversifying in the Health Care Workforce Centers of Excellence"
- "Kids Into Health Careers"
- "Nursing, Medical, Dental, Allied Health, and Public Health Training Programs"
- "Title VIII Section 821 Workforce Diversity Grants"
- "Title VIII National Advisory Council on Nurse Education and Practice"
- "Recruitment of American Indians into Health Careers"

Other HRSA Programs

The **Center for Managed Care** (www.hrsa.gov/CMC/default.htm) is implementing *Cultural Competence Purchasing Specifications*.

The **Office of Rural Health Policy** (www.ruralhealth.hrsa.gov) targets minority populations living in rural areas through their "Rural Health Outreach Grant Program" and "Rural Health Research Centers."

Other Department of Health and Human Services Programs

Agency for Healthcare Research and Quality (AHRQ), Research Activities on Minority Health
www.ahrq.gov/research/minorix.htm

Centers for Disease Control and Prevention (CDC)
www.cdc.gov

National Center for Chronic Disease Prevention and Health Promotion, Diabetes Initiatives
www.cdc.gov/diabetes/projects/index.htm

Racial and Ethnic Approaches to Community Health (REACH 2010)
Office of the Associate Director of Minority Health
www.cdc.gov/od/admh

Directory of Minority Health and Human Services Data Resources
www.dhhs.gov/progorg/aspe/minority/mintoc.htm

Indian Health Service
www.ihs.gov

Initiative to Eliminate Racial and Ethnic Disparities in Health
www.raceandhealth.hhs.gov

National Institutes of Health (NIH), Office of Research on Minority Health
www1.od.nih.gov/ormh/main.html

Office of Minority Health
www.omhrc.gov

Office of Minority Health Resource Center
www.omhrc.gov/omhrc/index.htm

Office on Women's Health, Minority Health Information
www.4woman.gov/owh/prog/minority.htm

Substance Abuse and Mental Health Services Administration, National Clearinghouse for Alcohol and Drug Information (NCADI)
www.samhsa.gov/public/public.html

Non-profit Organizations

Association of State and Territorial Health Officials
www.astho.org

National Association of County and City Health Officials
www.naccho.org

American Diabetes Association African American Program
www.diabetes.org/africanamerican

American Medical Association, Minority Health
www.ama-asn.org/ama/pub/category/20.html

American Psychological Association, Minority Fellowship Program
www.apa.org/mfp/mfphp.html

Asian & Pacific Islander American Health Forum
www.apiahf.org

Asian Health Services Online
www.ahschc.org

Asian Pacific Islanders Women's Health
www.apanet.org/~fdala

Association of American Indian Physicians
www.aaip.com

Association of American Medical Colleges Community and Minority Programs
www.aamc.org/meded/minority

Association of Asian Pacific Community Health Organizations
www.aapcho.org

Black Health Net
www.blackhealthnetwork.com

Center for the Study of Race and Ethnicity in Medicine
wiscinfo.doit.wisc.edu/crem/

Center of Excellence in Minority Medical Education and Health
www.msu.edu/user/coemmeh

Center for American Indian Research and Education
www.caire.org/

The Cross Cultural Health Care Program (CCHCP)
www.xculture.org

Diversity Rx
www.diversityrx.org

Harvard Journal of Minority Public Health
www.harvardminorityhealth.com

Henry J. Kaiser Family Foundation, Minority Health Resources
www.kff.org/sections.cgi?section=minority

Institute for Minority Health Research
www.sph.emory.edu/bshe/imhr

Institute for Racial and Ethnic Health Studies
research.umbc.edu/chpdm/institute.htm

Latino Issues Forum
www.lif.org

Midwest Latino Health, Research, Training, and Policy Center
www.uic.edu/jaddams/mlhrc/mlhrc.html

Minority Health Network (MHNet)
www.pitt.edu/~ejb4/min

Minority Health Professions Foundation
www.minorityhealth.org

Minority Health Project
www.minority.unc.edu

National Asian Women's Health Organization
www.nawho.org

National Association for the Advancement of Colored People
www.naacp.org

National Black Child Development Institute
www.nbcdi.org

National Black Women's Health Project
www.nationalblackwomenshealthproject.org

National Center for Farmworker Health
www.ncfh.org

National Alliance for Hispanic Health
www.hispanichealth.org

National Council of La Raza
www.nclr.org

National Hispanic Medical Association
home.earthlink.net/~nhma

National Indian Health Board
www.nihb.org

National Native American AIDS Prevention Center
www.nnaapc.org

Native American Research and Training Center
www.ahsc.arizona.edu/nartc

Native American Women's Health Education Resource Center www.nativeshop.org/nawherc.html

National Minority AIDS Council
www.nmac.org

APPENDIX B: List of Selected Resources on Health Disparities

General/Historical:

Amick, B. et al. (1995). *Society and Health*. Oxford University Press: New York.

Bartley, M., Carpenter, L., Dunnell, K. and Fitzpatrick R. (1996). Measuring Inequalities in Health. *Social Health and Illness*. 18: 455-475.

Evans, R.G., Barer, M.L., and Marmot, L., Eds. (1994). *Why Are Some People Healthy and Others Are Not?: Determinants of Health of Populations*. Aldine de Gruyer: New York.

Feit, M.D. and Holosko, M.J. (1997). *Health and Poverty*. Haworth Press.

Fiscella, K., Franks, P., et al. (2000). Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care. *Journal of the American Medical Association (JAMA)*. (283): 2579-2584.

Harding, S. (1993). *The Racial Economy of Health*. Indiana University Press.

Kawachi, I., Kennedy, B.P. and Wilkinson, R.G. (1999). *The Society and Health Population Health Reader: Income Inequality and Health*. Volume I. The New Press: New York.

Keating, D. P. and Hetzman, C., Eds. (1999). *Developmental Health and the Wealth of Nations: Social, Biological, and Educational Dynamics*. The Guilford Press: New York.

Leavitt, J. (1999). *The Healthiest City*. University of Wisconsin Press.

Levins, R. (1999). Toward An Ecosocial View of Health. *International Journal of Health Services*. 29(2): 261.

The Kaiser Family Foundation (KFF)

- KFF released several documents at an October 1999 forum entitled *Race, Ethnicity and Medical Care: Improving Access in a Diverse Society*. The documents are available at www.kff.org/content/1999/19991014a and include a chart book, a report, a review, a survey, and a press release.
- UCLA Center for Health Policy Research and the Kaiser Family Foundation report, entitled *Racial and Ethnic Disparities in Access to Health Insurance and Health Care,* is the first of its kind to include information on health insurance coverage and access for subgroup populations of Latinos and Asian Americans/Pacific Islanders. The article is available online at www.healthpolicy.ucla.edu/publications/RacialandEthnicDisparitiesReport.pdf.

Health Resource and Services Administration (HRSA)

- HRSA's document, *Eliminating Health Disparities in the United States,* outlines the agency's strategy to end health disparities among U.S. population groups and describes agency activities toward meeting that goal. The report can be downloaded from the Web site at www.hrsa.dhhs.gov/OMH/disparities/default.htm.

The National Center for Education in Maternal and Child Health (NCEMCH)

- NCEMCH has produced a *Knowledge Path* on the topic of racial and ethnic disparities in health. It contains links to useful Web sites, publications, databases, newsletters and books geared toward the public health community. The document can be found at www.ncemch.org/RefDes/kprace.html.

Office of Minority Health, U.S. Department of Health and Human Services

- *Closing the Gap* newsletter can be ordered at www.omhrc.gov/OMH/WhatsNew/2pgwhatsnew/Closing.htm or by calling the Resource Center at 1-800-444-6472.
- *Eliminating Health Disparities*, a Web cast available at www.raceandhealth.hhs.gov/sidebars/sbhhs1.htm depicts the plenary session coordinated by the Office of Minority Health as part of the *Healthy 2010* launch at the *Partnerships for Health in the New Millennium Conference* that took place in Washington, DC, in January 2000. Panelists discussed ways to improve the health of racial and ethnic minority populations through the development of effective health policies and programs to eliminate health disparities.

The University of North Carolina (UNC) at Chapel Hill, School of Public Health

- For more information about the UNC School of Public Health's "Minority Health Project," its *Summer Public Health Research Institute and Videoconference on Minority Health*, and links to other national organizations of interest for researchers and students, visit www.minority.unc.edu.

Cultural/Language Competency:

American Public Health Association, Maternal and Child Health Community Leadership Institute

- The Institute released a new catalog focusing on the maternal health cultures of three main regions of the world from which immigrants to the U.S. frequently come — Latin America, Asia, and Africa. The publication includes information on the relevant predictors of maternal health, health status and risks of recent immigrant women associated with biological, cultural and lifestyle susceptibility, and effect on the utilization of

maternal health services in the U.S for each of the cultures. The catalog is available on the American Public Health Association's Web site at: www.apha.org/ppp/red.

Bureau of Primary Health Care (BPHC)

- *Cultural Competency: A Journey* offers examples of programs that were successful in working effectively with people of different cultures. Copies of this document are available through the Bureau of Primary Health Care Clearinghouse at (800) 400-2742 or at www.bphc.hrsa.gov/culturalcompetence

Department of Health and Human Services (HHS)

- HHS issued written policy guidance to assist health and social services providers in ensuring that persons with limited English skills can effectively access critical health and social services. This guidance will enhance the ability to reach the nation's goal of eliminating racial and ethnic disparities in health, and assist in increasing opportunities for persons with limited English proficiency to improve their socioeconomic status. To view the full press release, which details the written guidance, go to www.hhs.gov/news/press/2000pres/ 20000830.html.
- HHS, Office of Minority Health (OMH) released national standards for culturally and linguistically appropriate services (CLAS) to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. The 14 standards are organized by themes: culturally competent care, language access services, and organizational supports for cultural competence. The standards are available on the OMH Web site at www.omhrc.gov/CLAS/ finalcultural1a.htm.

Health Resources and Services Administration (HRSA)

- HRSA also released a new tool for states, *Optional Purchasing Specifications: Cultural Competence in the Delivery of Services Through Medicaid Managed Care*, which provides options for language on key contracting issues as states prepare their purchasing agreements with managed care organizations. The guidelines can be found at www.gwu.edu/~chsrp. Then click on "sample purchasing specifications."

National Center for Cultural Competence (NCC)

- NCC's Web site at gucdc.georgetown.edu/nccc/cultural.html includes information on current conferences and workshops, full-text versions of publications, and an extensive list of additional resources.
- *Getting Started: Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings* features a brief checklist of activities for programs and organizations to begin strategic development of policies, structures, procedures and practices that support cultural and linguistic competence. For more information, visit gucdc.georgetown.edu/nccc/ ncc9.html.

National Center for Education in Maternal and Child Health (NCEMCH)

- The bibliography, *Culturally Competent Services: Bibliography of Materials from the NCEMCH Library,* contains materials that focus on assessing current services for cultural sensitivity, developing culturally competent services, and providing services in a multicultural health care context. To download a copy of the bibliography, go to www.ncemch.org/databases/ PDFs/Bib%20PDFs/ CultCom.pdf.

Data:

Association of State and Territorial Health Officials (ASTHO)

- A core function of public health agencies is to promote a statewide assessment of current health status and access barriers to help prioritize interventions and set baselines upon which to measure progress. ASTHO's Resource Compendium, *Public Health Data Sources and Assessment Tools: Measuring Progress Towards 100% Access and 0 Health Disparities,* highlights a number of tools and data sources, which may be helpful in these efforts. The document can be accessed at www.astho.org/access/documents/PublicHealthDataSources.htm.

Commonwealth Fund. (1999). *U.S. Minority Health: A Chartbook*. New York.

Centers for Disease Control and Prevention (CDC)

- CDC's report, entitled *State-Specific Prevalence of Selected Health Behaviors, by Race and Ethnicity,* documents racial and ethnic disparities in several areas, including health status, access to health care and preventive services, and behavioral risk factors. To download a copy of the report, go to www.cdc.gov/mmwr/mmwr_ss.html.

Health Resources Services and Administration

- The Community Health Status Indicators Project provides a profile of each county's overall health status using a broad spectrum of health indicators. Counties can compare their health indicators to Healthy People 2010 targets, 1997 U.S. rates, and peer counties – counties which share characteristics of population size, density, age distribution, and poverty. Mortality data age-adjusted to the new year 2000 standard also are provided. Available at www.communityhealth.hrsa.gov.

National Center for Health Statistics

- NCHS provides state health statistics by sex, age, race/ethnicity, and year. Tables are available at: www.cdc.gov/nchs/datawh/statab/tables.htm.

The Urban Institute (UI)

- UI's report, entitled *Racial and Ethnic Disparities: Key Findings from the National Survey of America's Families,* concludes that racial or ethnic background is a better determinant of health and insurance coverage than income level. For more information, visit newfederalism.urban.org/html/series_b/b5/b5.html.

Maternal and Child Health and Women's Health:

Allan, A. (1999). Children, Asthma and Health Consequences of Class. *The Washington Post Magazine*.

Luz, C., et al. (1998). Environmental Health Sciences Education—A Tool for Achieving Environmental Equity and Protecting Children. *Environmental Health Perspectives*: 106(3).

Ronsaville, D.S. and Hakin, R.B. (2000). Well Child Care in the United States: Racial Differences in Compliance with Guidelines. *American Journal of Public Health*. 90(9):1436-1443.

Agency for Healthcare Research and Quality (AHRQ)

- The study, *Racial and Ethnic Differences in Children's Access to Care* is an analysis of data from AHRQ's Medical Expenditure Panel Survey (MEPS) and is published in the November 2000 issue of the *American Journal of Public Health*. For more information, go to www.ahrq.gov/news/press/pr2000/weinickpr.htm.

Centers for Disease Control and Prevention (CDC)

- *Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality* features more than 200 national and state maps as well as the first county-level maps showing differences in the U.S. women's heart disease death rates for the years 1991-1995. The Atlas is available at www.cdc.gov/nccdphp/cvd/womensatlas.

Maternal and Child Health Bureau (MCHB)

- *Racial and Income Disparities in Pediatric Oral Health* was published by MCHB in 1998. To order a free copy or for more information, call the National Maternal and Child Health Clearinghouse at (703) 356-1964, e-mail: nmchc@circsol.com, or visit www.nmchc.org/html/cf/fullrec.cfm?ID=3959.

The National Black Child Development Institute (NBCDI), the Health Resources and Services Administration (HRSA), and the National Institute of Child Health and Human Development (NICHD)

- These agencies have jointly developed a *Resource Kit for Reducing the Risk of Sudden Infant Death Syndrome (SIDS) in African American Communities*. The kit contains culturally-appropriate materials such as fact sheets, brochures, magnets and a leader's guide. To receive the kit, call the "Back to Sleep" toll-free number at (800) 505-CRIB. The resource kit may also be obtained on the NICHD Web site at www.nichd.nih.gov/sids/sidspubskey.cfm.

Medical Care:

The Agency for Healthcare Research and Quality (AHRQ)

- AHRQ published a fact sheet entitled *Addressing Racial and Ethnic Disparities in Health Care*. The fact sheet, which is available at www.ahrq.gov/research/disparit.htm, examines reasons for health disparities beyond issues of income and insurance.
- AHRQ's program brief, *Improving Health Care for Ethnic and Racial Minority Populations,* which is available at www.ahrq.gov/research/minorhlth.htm, summarizes the agency's activities to improve health and health care for minority populations.

Center for Studying Health System Change (CSHSC)

- CSHSC's Issue Brief, entitled *Race, Ethnicity and Preventive Services: No Gains for Hispanics,* shows that between 1997 and 1999 there was an increase in the percentage of White and African American persons receiving preventive care, such as mammography screening among women and physicians counseling cigarette smokers to quit, but there was no such increase in preventive measures for Hispanics. For more information, visit www.hschange.org.

Kaiser Family Foundation.

- Articles, entitled *The Key Facts: Race, Ethnicity & Medical Care*, *A Synthesis of the Literature: Racial and Ethnic Differences in Access to Medical Care*, and *Perceptions of How Race & Ethnic Background Affect Medical Care: Highlights from Focus Groups,* can be downloaded at www.kff.org/content/1999/19991014a .

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