Assessment of
State Minority Health Infrastructure and Capacity to Address Issues of Health Disparity

FINAL REPORT

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Preface

This deliverable presents the findings of the Assessment of State Minority Health Infrastructure and Capacity to Address Issues of Health Disparity conducted by COSMOS Corporation for the Office of Minority Health (OMH), Office of Public Health and Science, U.S. Department of Health and Human Services. The study was supported under a task order contract with the Department of Health and Human Services (Task Order No. 1, Contract No. 282-98-00127). Gerrie Maccannon, of OMH, was the task order officer and provided thoughtful leadership throughout the project.

The project could not have been conducted without the participation and support of the directors and coordinators of the minority health entities in the nine states and one territory participating in the study. The minority health entities in Delaware and Texas participated in a pilot test of the data collection procedures. The minority health entities in Arkansas, California, Delaware, Florida, Ohio, Puerto Rico, South Carolina, Utah and Wyoming not only provided valuable and insightful information on the minority health infrastructure in their jurisdictions, but also invested considerable time and effort in arranging interviews with relevant key informants in government agencies and community-based organizations.

The OMH Regional Minority Health Consultants offered a comprehensive overview of minority health initiatives in their regions.

The COSMOS project team, led by Thérèse van Houten, included Isaac Castillo, Darryl Crompton, Pamela Schaal, and Kemba Nobles. Their work was ably supported by COSMOS's production staff, particularly Pat Thibeaux.

An advisory panel composed of experts from both the public and private sectors provided important guidance in the design and report writing phases of the study. The final report reflects their extremely helpful comments as well as those of Tuei Doong, Deputy Director of OMH, and Valerie Ahn Welsh of the Division of Policy and Data in OMH. The commitment of Ms. Macannon, Ms. Welsh, and Captain Doong to this project has been invaluable.

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Introduction

I. INTRODUCTION

A. PURPOSE OF REPORT

In September 1998, the Office of Minority Health (OMH), Office of Public Health and Science, U.S. Department of Health and Human Services (DHHS), contracted with COSMOS Corporation to assess the minority health infrastructure in selected states and territories, and examine the capacity of these states and territories to address racial and ethnic health disparities in their jurisdictions. This report presents the findings of the study based on information collected through interviews with representatives from minority health entities and other key informants in eight states and Puerto Rico.

The goals of the study were to: 1) determine those factors that contribute to or detract from establishment and sustained support for minority health entities; 2) assess the viability of the state minority health entities; 3) examine the effects of the minority health entities on state capacity to address the needs of racial and ethnic minorities when carrying out the essential services of public health; and 4) assess state capacity to address issues of disparity in health status and risks to health.

B. THE OFFICE OF MINORITY HEALTH

In 1984, DHHS released a report on the health of the nation, entitled *Health, United States, 1983*.[1] The report documented that while the overall health of the nation showed significant progress, major disparities existed in "the burden of death and illness experienced by Blacks and other minority Americans as compared with [the] nation's population as a whole."

In response to the disparities identified in the report, the Secretary of DHHS established a Task Force on Black and Minority Health—the first time that the U.S. government formed a group of experts to conduct a comprehensive study of minority health problems. The Task Force identified six causes of death that together accounted for more than 80 percent of the excess mortality among Blacks and other minority groups: 1) cardiovascular and cerebrovascular disease; 2) cancer; 3) chemical dependency (measured by deaths due to cirrhosis); 4) diabetes; 5) violence (specifically, homicide, suicide, and unintentional injuries); and 6) infant mortality.[2]

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[1] *Health, United States,* 1983; and *Prevention Profile,* December 1983, 267 (PHS) 84-1232.
[2] Heckler, M.M., *Report of the Secretary's Task Force on Black and Minority Health,* Washington, DC: U.S. Department of Health and Human Services, 1985

Task Force findings were published in 1985, in an eight-volume document entitled *Report of the Secretary's Task Force on Black and Minority Health* (Heckler, 1985). To respond to recommendations made by the Task Force, DHHS Secretary Margaret Heckler established the Office of Minority Health (OMH) in 1985 to coordinate and advocate for minority health activities and issues within DHHS and throughout the nation.

One of the first activities of OMH was the formation of nine Health Issues Working Groups to research the minority health disparities and cross-cutting issues identified in the Task Force Report. Six working groups studied the six health conditions listed above that, according to the Task Force Report, collectively accounted for 80 percent of the excess deaths among minorities. Excess deaths were defined as the number of deaths among racial and ethnic minorities that would not have occurred had age- and sex-specific mortality rates for minorities equaled those of non-minorities. Three additional working groups addressed the cross-cutting issues identified in the Task Force Report: 1) access to and financial aspects of health care; 2) health care data; and 3) health professions development.

Over time, these six priority health areas and three cross-cutting issues were expanded. In 1988, because of increasing rates of HIV infection among minorities, OMH added HIV/AIDS as the seventh priority health area. Later, OMH added cultural competency as the fourth cross-cutting issue. Together, these health conditions and cross-cutting issues are often referred to as the "7+4" priority focus of OMH activities.

An ongoing thrust of OMH has been the fostering of a National Minority Health Network to address the health needs of racial and ethnic minorities. The Network includes but is not limited to:

- *Federal Offices of Minority Health and Minority Health Coordinators.* In addition to the Office of Minority Health, established by the Secretary in 1985 (and which serves the entirety of DHHS), other offices of minority health now exist in eight DHHS agencies: 1) the Agency for Health Care Research and Quality (formerly the Agency for Health Care Policy and Research); 2) the Centers for Disease Control and Prevention; 3) the National Institutes of Health; 4) the Substance Abuse and Mental Health Services Administration; 5) the Health Resources Services Administration[3]; 6) the Agency for Toxic Substance and Disease Registry; 7) the Food and Drug Administration; and 8) the Indian Health Service. In addition, minority health coordinators have been

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[3]Minority Health Liaison, Office of Minority Health Resource Center, March 2000.

designated in the Administration on Aging; the Administration for Children and Families; and the Health Care Financing Administration.

- *Regional Minority Health Consultants.* Also included in the federal component of the Network are ten regional minority health consultants who serve as an information and technical assistance resource on minority health at the regional, state, and local levels.

- *State and Territorial Offices of Minority Health and Minority Health Contacts.* The first five states to establish offices of minority health were Indiana, Michigan, Missouri, Ohio, and South Carolina. In 1990, OMH first met with these five state offices. Since that time, OMH has encouraged the establishment of state organizational units dedicated to minority health issues. As of January 2000, 33 states had established offices of minority health. Appendix A provides a list of the state offices of minority health. In addition to the states and territories with established offices of minority health, four states (i.e., Hawaii, Nevada, Wisconsin, and Wyoming) have designated minority health contact persons. The established offices of minority health and the minority health contacts are known collectively as "minority health entities."

Other major components of the Minority Health Network are community-based organizations, health advocacy groups, colleges and universities, and individuals.

The study reflects the mission of OMH, which is to improve the health of racial and ethnic minority populations, to close the gap in health status between minority and non-minority populations, and to coordinate the development and implementation of DHHS policies and programs affecting minority populations. OMH carries out its mission through the following activities:

- *Influencing Policy.* At the policy level, OMH influences, promotes, and informs policies that address the health of racial and ethnic minorities.

- *Forming Partnerships.* OMH establishes and strengthens partnerships to identify and solve problems that impact the health of racial and ethnic minorities.

- *Promoting the Collection of Data.* At both the national and local levels, data on health disparities are needed to guide activities. OMH promotes the collection of data necessary to identify the nature and extent of racial and ethnic health disparities. This data collection also enables effective monitoring of progress towards eliminating these disparities.

- *Developing and Implementing Strategic Communications.* Through the Office of Minority Health Resource Clearinghouse, periodic conferences, and other communication strategies, OMH informs and educates minority populations and those who serve them about policies, programs, and other efforts of relevance.

- *Conducting Service Demonstrations, Program Evaluations, and Policy Assessments.* OMH conducts and sponsors special studies and demonstrations to determine what works or does not work, promotes best practices, and obtains information needed to make informed decisions related to programs, policies, and funding. This study was part of the ongoing effort to inform decisionmaking related to the establishment, maintenance, and strengthening of state and territorial capacity to address the health needs of racial and ethnic minorities.

C. HEALTH DISPARITIES

Fifteen years following the publication of the *Report of the Secretary Task Force on Black and Minority Health,* and the establishment of OMH, disparities in health status and access to health care continue to affect the lives of racial and ethnic minorities in the United States and its territories.

In the *Report of the Secretary Task Force*, racial and ethnic health disparities were expressed as differences between racial and ethnic minorities and Whites. This same method is used in this report. At the national level, compelling data exist that document significant disparities in health status between Blacks and Whites. For instance, according to *Healthy People 2010*, AIDS was the 14th leading cause of death for the total population, but the leading cause of death for Blacks in 1997. Furthermore, even though overall the nation's infant mortality rate is declining, the infant mortality rate among Blacks continues to be double the rate among Whites.

As discussed later in this report, data on the health status of racial and ethnic groups other than Whites and Blacks are limited (Rosenberg,1999).[4] Nevertheless, at the time that this study was commissioned, the most recent data available from the National Center for Health Statistics (NCHS) on all major racial and ethnic groups provided a telling picture of disparities in health status by race and ethnicity.

Exhibit I-1 presents health disparities for the United States in 1996, expressed as ratios between the age-adjusted death rates (AADR)[5] of Whites and other major racial and ethnic groups, for OMH's priority health areas. Infant mortality is reported as a rate per 1,000 live births.

- *Disparities Between Blacks and Whites.* In 1996, at the national level, the AADR for Blacks exceeded that of Whites for every single OMH priority health condition area except suicide;

- *Disparities Between American Indians/Alaskan Natives and Whites.* The 1996 national data show disparities in AADR for the following health conditions: chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, suicide, homicide and legal intervention[6], and infant mortality;

- *Disparities Between Hispanics and Whites.* According to the 1996 NCHS data, the AADR of Hispanics exceeds that of Whites for the following health conditions: chronic liver disease and cirrhosis, diabetes mellitus, HIV infection, and homicide and legal intervention.

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[4]Rosenberg H.M., Maurer J.D., Sorlie P.D., Johnson N.J., et al., "Quality of Death Rates by Race and Hispanic Origin: A Summary of Current Research, 1999," National Center for Health Statistics, Vital Health Statistics 2(128), 1999.

[5]The age-adjusted death rate is the death rate used to make comparisons of relative mortality risks across different age groups. This rate should be viewed as an index rather than as a direct or actual measure of mortality risk. Statistically, it is a weighted average of the age-specific death rates, where the weights represent the fixed population proportions by age. In 1996, the direct method of computing the age-adjusted death rate applies the age-specific death rates for a given cause of death to the U.S. standard population (relative age distribution of 1940 enumerated population in the United States). It is important not to compare age-adjusted death rates with crude death rates. (Source: *Monthly Vital Statistics Reports*, National Center for Health Statistics, CDC, DHHS.)

[6]Legal Intervention includes: injuries inflicted by the police or other law-enforcing agents, including military on duty, in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order, and other legal intervention, (http://www.mcis.duke.edu/standards/termcode/Icd9/1tabular E970.html).

Exhibit I-1

THE RATIO BETWEEN THE AGE ADJUSTED DEATH RATE (AADR) AND THE INFANT MORTALITY RATE OF RACIAL AND ETHNIC MINORITIES AND WHITES, FOR THE UNITED STATES, BASED ON 1996 DATA FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Health Conditions	Black-White Ratio[a]	American Indian/Alaskan Native-White Ratio	Asian/Pacific Islander-White Ratio	Hispanic-White Ratio[b]
Diseases of the Heart	**1.48**	0.78	0.55	0.68
Cerebrovascular Disease	**1.80**	0.86	0.98	0.80
Malignant Neoplasms	**1.34**	0.68	0.61	0.62
Chronic Liver Disease and Cirrhosis	**1.26**	**2.84**	0.36	**1.73**
Diabetes Mellitus	**2.40**	**2.32**	0.73	**1.57**
HIV Infection	**5.75**	0.58	0.31	**2.26**
Unintentional Injuries	**1.23**	**1.93**	0.54	0.97
Suicide	0.57	**1.12**	0.52	0.58
Homicide and Legal Intervention[c]	**6.24**	**2.06**	0.94	**2.53**
Infant Mortality per 1,000 Live Births	**2.31**	**1.64**	0.85	1.00

[a]All disparity ratios greater than 1 are in bold type.
[b]The term Hispanic in the table includes Hispanics of all racial backgrounds.
[c]The National Center for Health Statistics (NCHS), CDC, combines into one category deaths resulting from homicides and from legal intervention.

- *Disparities Between Asian Americans/Pacific Islanders and Whites.* The national AADR data available from NCHS in 1996 do not show any health disparities. However, as discussed later in this report, available state-level data contradict the national 1996 AADR data. State-level data show health disparities for Asian Americans and Pacific Islanders.

As also shown in the exhibit, these are the three greatest health disparities at the national level:

- *Homicide*. Blacks are more than six times as likely to die from homicide (or legal intervention) as Whites;

- *HIV Infection*. Blacks are more than five times as likely to die from HIV infection as Whites and;

- *Chronic Liver Disease and Cirrhosis*. American Indians are almost three times as likely to die from chronic liver disease and cirrhosis as Whites.

D. A NATIONAL FOCUS ON ELIMINATING RACIAL AND ETHNIC HEALTH DISPARITIES

Although the most recent national data on the health status of racial and ethnic minorities are incomplete, they clearly indicate that health disparities remain a continuing national problem. Two recent federal programs directed at eliminating health disparities are: 1) President Clinton's *Initiative on Race* (including the focus of *Healthy People 2010* on eliminating racial and ethnic disparities); and 2) the work of the Congressional Black Caucus and the Congressional Hispanic Caucus, specifically the 1999 Minority HIV/AIDS Initiative.

In 1998, as part of his Initiative on Race, President Clinton announced a $400 million initiative to eliminate racial and ethnic disparities in six key health areas: infant mortality, diabetes, cancer screening and management, heart disease, HIV infection, and child and adult immunizations. These health areas were selected because they reflect areas of disparity known to affect multiple racial and ethnic populations, affect both adults and children, and are amenable to interventions. Activities by the DHHS complement *Healthy People 2010,* the nation's health promotion and disease prevention strategy for the next decade.

1. THE *HEALTHY PEOPLE 2010* INITIATIVE

Healthy People 2010: Understanding and Improving Health identifies objectives for the first decade of the 21st century. Its two central and overarching goals are to: 1) increase quality and years of healthy life; and 2) eliminate health disparities. *Healthy People 2010* targets disparities by race and ethnicity, as well as by gender, education or income, disability, living in rural communities, and sexual orientation. Race and ethnicity are associated with a number of these other factors such as education and income (e.g., proportionately fewer Whites than persons belonging to racial or ethnic minorities live at or below the poverty level).

The following examples of *Healthy People 2010* objectives address one of OMH's four cross-cutting issues—health professions development.

- Increase the proportion of individuals from underrepresented racial and ethnic minority groups enrolled in U.S. schools of nursing; and

- Increase the proportion of all degrees in the health professions and allied and associated health professions fields awarded to members of underrepresented racial and ethnic minority groups.

By setting specific objectives, *Healthy People 2010* provides benchmarks that can be used by OMH, other federal and state minority health entities, and their partners across the country, to measure progress towards reducing the gap and ultimately eliminating health disparities.

2. THE 1999 MINORITY AIDS INITIATIVE

Another example is the Minority HIV/AIDS Initiative developed by the Clinton administration and DHHS with the Congressional Black Caucus and the Congressional Hispanic Caucus in response to the disproportionate prevalence of HIV/AIDS among minorities. The "package" of minority HIV/AIDS projects designed to reduce the impact of HIV/AIDS on minority communities under this initiative started in FY 1999 with $156 million to provide grants for community-based minority organizations, research institutions, minority-serving colleges and universities, health care organizations, and state and local health departments. OMH is one of six DHHS agencies through which funding is awarded. The other DHHS agencies are: the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), the Indian Health Services (IHS), and the Health Services and Resources Administration (HSRA).[7]

E. PURPOSE OF THE STUDY

This study was commissioned at a time of increased national awareness of health disparities, increasing concern about the accuracy of available data on the health status of racial and ethnic minorities, and an increasing need to understand how state and local capacity to address issues of health disparity can be strengthened. For states with a minority health entity, OMH is interested in increasing its understanding of how these entities fit into, and interact with, their state or territorial public health infrastructure. More importantly, OMH

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[7]Source: http:/ww.omhrc.gov/omh/aids/aidshome.htr

wants to assess the impact that minority health entities may have on the capacity of a state or territory to address the health needs of racial and ethnic minorities.

Furthermore, in the Statement of Work, OMH also asks the contractor to focus on states' and territories' efforts to eliminate health disparities in OMH's 7+4 priority areas. These consist of seven health areas: 1) cancer; 2) diabetes; 3) cardiovascular disease; 4) infant mortality; 5) substance abuse; 6) HIV/AIDS; and 7) suicide, homicide, and unintentional injuries; and four cross-cutting issues: 1) access to health care; 2) cultural competence; 3) data collection and analysis; and 4) health professions development.

As the title indicates, this study is an assessment of state-level infrastructure and capacity to address the health needs of racial and ethnic minorities. Thus, even though efforts to address health disparities occur at the federal, state, and local levels, the focus of the study is on what is happening at the state level. The study also places a special emphasis on the activities of the minority health entities, and on their role in assisting states in their efforts to address the health needs of racial and ethnic minorities.

OMH intends to use the information generated by this study to assess its past efforts and to improve future initiatives aimed at expanding state capacity to address issues of racial and ethnic health disparities; determine what is being done regarding minority health issues, how, and by whom; and identify factors conducive or detrimental to effectively addressing the health needs of racial and ethnic minority populations. Furthermore, the Statement of Work states that other potential users of the study include states with minority health entities (who may find these findings useful in deciding how to best address health disparities in their jurisdictions), as well as states who are exploring mechanisms to establish state minority health entities.

F. REMAINING SECTIONS OF THIS REPORT

The report is divided into nine sections. This introduction is Section I. The remaining sections are as follows:

- *Section II: Study Questions and Methodology*. The section includes the key study questions and the corresponding study design. It distinguishes between the design phase of the study and the implementation phase during which certain adaptations to the design were made. The section concludes with a discussion of resulting study limitations.

- *Section III: Minority Health Entities in the Nine Study Sites*. The section begins with a description of the racial and ethnic

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distribution of each site's population and known health disparities. It then describes the following characteristics of the minority health entities: their history, resources, missions, functions, and placement in the organizational structure of the state or territory. It concludes with an overview of other components of the sites' minority health infrastructure.

- *Section IV: Cross-cutting Issues*. For each cross-cutting issue, the section discusses key approaches and strategies used by the states and the minority health entities, and discusses issues and factors affecting activities targeting the issue.

- *Section V: Efforts to Eliminate Disparities in the OMH Priority Health Areas*. For each priority health area, the section discusses key approaches used by the states and the minority health entities, and discusses issues and factors affecting activities targeting the health condition.

- *Section VI: Health Care to Native Americans*. Because of the sovereign status of federally recognized tribes and the health services provided by the Indian Health Service, the tribal infrastructure differs significantly from state health infrastructures. The report therefore devotes a separate section to Indian health.

- *Section VII: Responses to the Study Questions*.

- *Section VIII: Recommendations*.

SECTION II

Study Questions and Methodology

II. STUDY QUESTIONS AND METHODOLOGY

This section lists the key study questions and presents the corresponding study methodology. The section distinguishes between the design phase and implementation phase of the study. During the design phase, COSMOS developed and revised the design based on the results of two preliminary site visits arranged by the minority health entities in Delaware and Texas, and on feedback from a national advisory panel convened by OMH. During the design phase as well, COSMOS defined and operationalized key study terms. The design phase discussion presents the criteria for selecting study sites and key informants; the implementation phase discussion identifies which sites were selected, and the number and types of key informants who participated in the study. The section ends with a discussion of study limitations resulting from the design itself and from changes that occurred during the implementation phase.

A. KEY STUDY QUESTIONS

The Statement of Work specified the seven key study questions listed below:

- What are the nature and extent of efforts at the state level to eliminate health disparities, especially among racial and ethnic groups?

- What are the nature and extent of efforts at the state level to eliminate or close the gap between racial and ethnic groups in the priority health issue areas of particular concern to OMH? These priority health areas are cancer, cardiovascular disease, diabetes, HIV/AIDS, infant mortality, substance abuse, and homicide, suicide, and unintentional injuries.

- What efforts are in place or planned at the state level to address each of the four cross-cutting priority issue areas as they relate to improvements in the health of racial and ethnic minorities? The four crosscutting issues are: access to health care, cultural competence, data collection and analysis, and health professions development.

- To what extent are state efforts to eliminate health disparities and address health concerns of racial and ethnic minorities linked to national efforts such as *Healthy People 2010?*

- What, if any, features or characteristics of minority health entities hinder or contribute to their effectiveness? How is such effectiveness measured?

- What features, characteristics, or elements promote and hinder the establishment and effectiveness of minority health entities?

- Are efforts to "close the gap" in health disparities between racial and ethnic groups more likely to occur when dedicated minority health entities are established? Why or why not?

B. THE DESIGN PHASE

The Statement of Work specified the strategies to be used to answer the above questions: 1) site visits to nine sites; and 2) the gathering of information at each site from at least four key informants. These key informants were to include: directors of state health agencies, directors of state offices of minority health, legislators, governors, advisory councils, grassroots organizations, and other identified community groups. The design is therefore a descriptive cross-site assessment of the types of minority health initiatives that may exist within a state or territory, and the types and range of factors conducive or detrimental to effectively addressing the health needs of racial and ethnic minorities.

1. REFINING AND CLARIFYING THE RESEARCH QUESTIONS

OMH built into the contract the opportunity to convene a national panel of experts to review the design. The first meeting of the 20-member Advisory Panel occurred January 20-21, 1999.[1] Much of the Advisory Panel's discussion focused on the key research questions and the corresponding subtopics. Appendix C contains a copy of the subtopics associated with each research question.

A related issue concerned the fact that one of OMH's priority health areas consists of three different aspects of violence: homicide, suicide, and unintentional injuries. Addressing and preventing these three causes of death are often the focus of different state agencies. While unintentional injuries is the focus of health departments, suicide is usually

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[1]Appendix B lists the names of Advisory Panel members. Over the course of the study, three meetings were convened with the Panel. During the first meeting in January 1999, the Advisory Panel reviewed and revised the proposed research design. The methodology presented is based on work conducted during and immediately following the first Advisory Panel meeting. In September 1999, panel members reviewed the draft outline of the final report and preliminary findings; in February 2000, they reviewed the draft of this report.

addressed by departments of mental health, which in many states are separate and distinct from departments of health. Homicide, although defined by the Centers for Disease Control and Prevention (CDC) as a public health issue, is generally not addressed specifically by health departments. On the other hand, violence in general, and specifically youth violence, is often the focus of multiple state agencies (e.g., law enforcement, education, drug and alcohol abuse). In addition, as discussed in Section I, available data show that nationwide the greatest health disparity is in homicide. According to 1996 data from the National Center for Health Statistics, Blacks are six times more likely to die from homicide than Whites.

For these reasons, COSMOS and OMH decided to treat these three health conditions separately in requesting interviews with key informants, and in querying key informants about efforts to reduce health disparities in these areas. This report therefore addresses homicide, suicide, and unintentional injuries as separate health priority areas.

2. CRITERIA FOR SELECTING THE STUDY SITES

The Statement of Work recommended that in identifying criteria for selecting the nine sites, COSMOS review the profiles on state minority health entities prepared by OMH in 1997, and consult with OMH. Only one selection criterion was specified in the Statement of Work, namely the inclusion of states where minority health entities were abolished or had faced legislative sunset. In addition, implied in the Statement of Work was the need to include states with and states without established offices of minority health as this would help answer the question of whether efforts to close the gap are more likely to be effective in states with established offices of minority health.

Below are the three main site selection criteria reviewed and accepted by the Advisory Panel members:

- *States with an Established Office of Minority Health.* OMH recommended that this category include states with well-established offices that have a reputation of being effective, as these states were likely to produce the data needed to answer the study questions. OMH further recommended that at least one of the sites be a state with an independent commission on minority health, rather than an office of minority health located within the state department of health, in order to determine whether this structure makes a difference.

- *States That Formerly Had an Established Office of Minority Health.* These include states in which the minority health entity faced legislative sunset.

- *States That Never Had an Established Office of Minority Health but Do Have a Minority Health Contact Person.* OMH recommended selecting states with an active minority health contact person. It was felt that in states without an active minority health contact person, it would not be possible to identify or gain access to key informants in other components of the state's health infrastructure. Furthermore, following contract award, OMH recommended that at least one of these sites be an overseas territory.

The Advisory Panel agreed with two additional selection criteria proposed by COSMOS: 1) geographic representativeness, and 2) diversity in the racial/ethnic distributions of the state population.

3. CRITERIA FOR SELECTING KEY INFORMANTS

The research questions listed above are complex and multi-dimensional. For example, each of the four cross-cutting issues applies to all of OMH's priority health areas. Examining these issues within the context of a state infrastructure calls for collecting data from each of the relevant state public health divisions and branches, as well as from a number of private-sector and community-based institutions, and examining the formal and informal linkages and interactions among all of these entities. The challenge in designing and implementing this study was therefore to balance the desire to go to all possible data sources with the realistic limitations imposed by project resources.

The results of the first preliminary site visit to Texas confirmed that it would be very difficult to obtain the full range of information needed unless the number of key informants proposed in the Statement of Work was significantly increased. Furthermore, results of this first visit indicated that in order to increase the number of key informants interviewed during a two-to three-day site visit, it would be advisable to conduct as many interviews as possible in the same location to cut down on travel time between interviews. Results also suggested that it would be preferable to ask the representatives of the minority health entities to schedule the interviews rather than having COSMOS do the scheduling. This approach would permit the minority health entities to personally invite people to participate and brief them on the purpose of the study. Also, their knowledge of the key players in the state's minority health infrastructure permitted them to arrange for substitutes when certain individuals were not available, and to schedule group interviews when appropriate. This approach was successfully piloted during the preliminary site visit to Delaware.

The final plans specified that COSMOS would ask the representatives of the minority health entities to identify individuals from the list below who could be expected to provide

the greatest insight and information on the major components of the state's minority health infrastructure:

- Director of the state minority health entity/office or the minority health contact person;

- The Secretary, Commissioner, or Director of Public Health for the state;

- The directors, or senior staff, of the health agencies targeting the four cross-cutting issues and seven priority health areas;

- Legislators;

- Directors or representatives from community-based organizations (such as the American Diabetes Association and the March of Dimes), targeting OMH priority health areas;

- Representatives of minority health advisory committees, coalitions, or task forces;

- Representatives from community advocacy groups, including the faith community;

- Advocates for minority health;

- State epidemiologist and health data analysts; and

- Other key informants deemed relevant by the site.

In addition, the preliminary site visits showed that the site visits should be scheduled several months in advance to reduce the burden on the minority health representative scheduling the interviews, and increase the range of available key informants.

4. INTERVIEW PROTOCOLS

COSMOS developed interview guides for the four main types of key informants:
1) the director of the minority health entity or the minority health contact person;
2) representatives of other health department divisions, other state agencies, or community agencies; 3) health commissioners or individuals at cabinet-level position; and
4) legislators.

The first versions of the instruments were piloted and revised during the preliminary site visits to Delaware and Texas. COSMOS made additional changes following a review by the Advisory Panel. Specifically, questions were added to the interview guides to assess what is being done in the states and by whom (the minority health entity, other state entities, private sector organizations) for each of the OMH focus areas. The earlier versions of the interview guides focused more on the work of the minority health entities and less on other components of the state infrastructure.

COSMOS also developed modified versions of the interview guides for Puerto Rico to reflect Puerto Rico's territorial status. The guides can be found in Appendix D. A brief description of the content of each of the interview guides is presented below:

a.   Interview Guide for State Minority Health Director or Minority Health Contact Person

This interview guide covers seven main topic areas: 1) a description of the state or territorial minority health entity; 2) the capacity of the minority health entity to address issues of health disparities; 3) the capacity of the state to address minority health disparities; 4) minority health initiatives in the private sector; 5) the presence of minority health advisory committee, task force or coalitions; 6) the effectiveness of the minority health entity; and 7) challenges faced by the minority health entity. The guide is modular in format so that certain questions apply specifically to established offices of minority health while others are asked of minority health contact persons. A major focus of the questions is on the minority health entity's activities related to OMH's cross-cutting issues and priority health areas; and on linkages between the minority health entity and other components of the state infrastructure related to these issues.

b.   Interview Guide for Representatives of Health Department Divisions, Other State Agencies, and Private Sector Organizations

In these interviews each representative was asked about their agency or division's role in addressing one or more of the crosscutting issues or priority health areas in general, specifically related to reducing health disparities. In addition, the interview guide includes questions on other public and private sector components of the state or territory's minority health infrastructure, and the agency's linkages, if any, to these components.

c.   Interview Guide for the Secretary or Commissioner of Health

Questions for the Secretary or Commissioner of Health or other government official are broader in scope. They address policy and program history related to minority health, the state health strategic plans, the adoption of *Healthy People 2000* or *Healthy People*

2010 objectives, and specific minority health initiatives that are in effect or are being proposed.

d. Interview Guide for Legislators

The interview guide asked questions regarding the legislative history of minority health in the state or territory; specific racial and ethnic minority health laws enacted within the past five years as well as current legislation, barriers to minority health legislation, and the extent to which the legislature involves the grassroots community in the development of health-related laws (e.g., through hearings or citizen committees).

C. STUDY TERMINOLOGY

In reviewing the study questions, it became clear that they could not be answered without first defining several key study concepts, specifically minority health entity, racial and ethnic minority, health disparities, minority health, public health infrastructure, and capacity.

1. MINORITY HEALTH ENTITY

As defined in the Statement of Work, the term *minority health entity* refers to established offices of minority health as well as to persons designated as the minority health liaison or contact person in states that do not have an established office of minority health.

2. RACIAL AND ETHNIC MINORITY

The racial and ethnic minorities covered by this study are American Indians and Alaskan Natives, Asian American and Pacific Islanders, Hispanics, and Blacks.

OMH uses the following U.S. Office of Management and Budget (OMB) definitions of race and ethnicity: American Indian or Alaskan Native[2] is a term used for persons whose ancestors were any of the original peoples of North America and who identify, through tribal affiliations or community recognition, with these ancestral groups. Asian or Pacific Islander is the term used for persons whose ancestors were any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippines, and Samoa. Black is the term used by OMB for persons having origins in any of the Black racial groups of Africa. Hispanic is the term used for persons of Mexican, Puerto Rican,

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[2]Throughout this study, the terms American Indian and Native American are used interchangeably.

Cuban, Central or South American, or other Spanish culture or origin, regardless of race. White is the term used for persons whose ancestors were any of the original peoples of Europe, North Africa, or the Middle East.[3]

3.   HEALTH DISPARITIES

The study used age-adjusted death rates (AADRs) to define health disparities for all but one of the OMH priority health areas. The one exception to this method is the measurement and reporting of infant mortality, which is reported as a rate per 1,000 live births. AADRs were selected as the best indicator of health disparities because they provide a consistent pool of generally available data to compare disparities in the health status of major racial and ethnic groups at the national level. AADRs are used by the National Center for Health Statistics as an index for comparison of the mortality risk for causes of death. AADRs also were proposed as a means to identify health disparities by the *1985 Report of the Secretary's Task Force on Black and Minority Health*. The *Report* defines minority health disparity as "the statistical technique of 'excess deaths;' that is, the difference between the number of deaths observed in minority populations and the number of deaths which would have been expected if the minority population had the same age- and sex-specific death rate as the non-minority population."[4] Because of the difficulty of getting sex-adjusted as well as age-adjusted death rates for the OMH priority health conditions in all nine study sites, this study does not examine sex-adjusted death rates.

To facilitate comparisons across health conditions and across sites, the study uses *disparity ratios*. A disparity ratio can be defined as the AADR for a specific cause of death in a particular racial or ethnic group divided by the AADR for the same cause of death among the White population. A disparity ratio greater than 1.0 indicates that the minority group is at a higher risk of dying from a specific health condition than the White population. A disparity ratio less than 1.0 indicates that the minority group is at a lower risk of dying from the specific health condition than the White population. The disparity ratio also relates the level of the disparity; a disparity ratio of 2.0, for example, indicates that members of the minority group are twice as likely to die from a selected cause as Whites.[5]

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[3]Reference: http://www.whitehouse.gov/OMB/fedreg/notice_15htr.
[4]U.S. Department of Health and Human Services, Report of the Secretary's Task Force on Black and Minority Health, Volume I: Executive Summary (U.S. GPO: Washington, DC), August 1985, pp. 63-64.
[5]The concept referred to here as disparity ratio was presented in the *Report of the Secretary's Task Force on Black and Minority Health* as "relative risk." The *Report* provided further insight on the use of this measure by stating, "A high relative risk for a specific cause of death may be misleading if a disease is rare and affects a small number of people. The relative risk for a rare condition may appear to indicate a disproportionately high risk for a problem that may not be serious in terms of excess deaths because so few individuals are affected" (U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health, Volume I: Executive Summary* (U.S. GPO: Washington, DC), August 1985, p. (64).

As discussed in more detail in Section IV-B of this report, there are limitations to the above approach. However, it is an approach that allows a cross-site comparison of readily available data to the minority health entities and to the states at the time that the study was being conducted. Section IV-B discusses the limitations of these data, and why data collection and analysis is a key cross-cutting issue affecting federal and state decision-making regarding programs, policies, and funding related to health care for racial and ethnic minorities.

4.   MINORITY HEALTH

In this study, the term minority health refers to the health status, access to health care, treatment options, and other factors that affect the health and related quality of life of Blacks, Hispanics, Asian American and Pacific Islanders, and Native Americans. These other factors include differences in health status by race and ethnicity, the availability of culturally and linguistically appropriate health care, the training of health care providers from racial and ethnic minorities, and the inclusion of persons from racial and ethnic minorities in health care policy and decisionmaking.

5.   INFRASTRUCTURE

Advisory Panel members recommended the study use the definition of the term *infrastructure* in the *Healthy People 2010 Objectives*. This definition defines *infrastructure* as "the systems, competencies, relationships, and resources that enable performance of the essential *public health services* in every community." The resulting study framework determines whether a statewide system is in place to address health disparities, examine competencies and resources, and most importantly look at relationships or linkages between the various sectors (both public and private) providing *public health services* to respond to the health needs of racial and ethnic minorities.

As defined by *Public Health in America*[6], the ten essential *public health services* are to: 1) monitor health status to identify community health problems; 2) diagnose and investigate health problems and health hazards in the community; 3) inform, educate, and empower people about health issues; 4) mobilize community partnerships to identify and solve health problems; 5) develop policies and plans that support individual and community health efforts; 6) enforce laws and regulations that protect health and ensure safety; 7) link people to needed personal health services and ensure the provision of health care when it is otherwise unavailable; 8) ensure the availability of a competent public health and personal health care workforce; 9) evaluate effectiveness, accessibility, and

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[6]Public Health Function Steering Committee, Public Health in America, Fall 1994, www.health.gov/phfunctions/public.htm.

quality of personal and population-based health services; and 10) research new insights and innovative solutions to health problems.

6. CAPACITY

The Public Health Foundation, in a 1997 survey of state and local capacities to track health objectives, refers to states' *capacity* as the "ability to track their own health promotion and disease prevention objectives."[7] Within the context of this study, the term capacity therefore refers to state and territorial ability to reduce health disparities (and to document that these disparities are decreasing).

D. THE IMPLEMENTATION PHASE

1. SITE SELECTION

In deciding which states and territories best fit the various selection criteria, COSMOS consulted with OMH staff and with regional minority health consultants. The nine sites selected to participate in the study include one territory (Puerto Rico) and eight states: Arkansas, California, Delaware, Florida, Ohio, South Carolina, Utah, and Wyoming.[8] They constitute a purposive sample expected to provide access to the range of information needed to answer the research questions. Sites represent the range of minority health entities found in states and territories. Seven of the nine sites have an established office of minority health. Of these seven offices, six are located within a state health department and one is an independent commission. Two of the seven are newly re-established offices. One of the two sites without an established office of minority health is a U.S. territory. In addition, sites represent the racial and ethnic diversity found in U.S. states and territories. In four of the sites, the racial and ethnic minority population exceeds 25 percent; in two sites, the minority population is greater than 10 percent but less than 25 percent; and in two sites, the minority population is less than 10 percent. Exhibit II-1 presents a detailed view of the final selection criteria and how each site satisfied the criteria.

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[7]*Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*, Washington, DC: The Public Health Foundation, March 1998.

[8]New York was initially selected for the study; however, a number of conditions arose in the state that prevented its inclusion as one of the states visited. New York was selected for its cultural diversity and large population, both of which would have contributed significantly to OMH's knowledge of minority health programs. Unfortunately, New York was to be the last site visited, and became unavailable only two weeks before the site visit was scheduled to occur. Due to time constraints on the study itself, a suitable replacement for New York could not be found. Since considerable amounts of valuable data were collected during the preliminary site visit to Delaware, OMH asked that the state be considered one of the study sites.

Exhibit II-1

SELECTION OF THE STUDY SITES

Study Sites	Types of Minority Health Entities			New or Newly Re-established Offices of Minority Health	Inclusion of at Least One U.S. Territory	Diversity in Racial Ethnic Composition of the Population	
	Office of Minority Health	Minority Health Commissions	Minority Health Contact Person, but No Established Office of Minority Health			States with a Minority Population Greater than 25 Percent[a]	States with a Minority Population less than 10 Percent
Arkansas	✓						
California	✓					✓	
Delaware	✓			✓[b]			
Florida	✓			✓[c]		✓	
Ohio		✓					
Puerto Rico			✓		✓	✓	
South Carolina	✓					✓	
Utah	✓						✓
Wyoming			✓				✓

[a]For all sites but Puerto Rico, these percentages are based on data from the 1990 Census.

[b]The Delaware Office of Minority Health was established by executive order in 1991; however, the office was dormant and without staff from 1994 to 1998. In 1997, the office was re-established by the Secretary of the U.S. Department of Health and Human Services, and a new director was recruited.

[c]In 1993, Florida established a Commission of Minority Health Care Task Force. A sunset provision in its legislative authorization resulted in its termination in 1995. In 1998, the Secretary of Health created an Office of Equal Opportunity and Minority Affairs which addresses minority health disparities.

2. TIME FRAME OF THE DATA COLLECTION

All site visits were conducted between December 1998 and May 1999. This report includes some additional data provided by the sites following the site visits—in part as a result of feedback received from the minority health entities following their reading of site visit summaries submitted for review between June and December 1999. For the most part, however, the information in this report is based on information collected in the spring of 1999.

3. NUMBER AND TYPE OF KEY INFORMANTS

As described above, the design called for using the minority health entity as the entry point to each state and as the means of identifying other key informants. The extent to which this approach was successful varied by site. Exhibit II-2 shows how many and what type of interviews were conducted at each of the study sites. In all, 144 interviews and group meetings were conducted with 237 key informants.

As shown in Exhibit II-2, in all sites COSMOS interviewed the director of the state office of minority health or the minority health contact person. In all sites but California and Utah, COSMOS interviewed the secretary, commissioner, or director of public health (in California, the interview was canceled at the last minute as the Commissioner was called into a meeting with the Governor).

At no site was it possible to interview state or private sector staff from agencies targeting all of the OMH priority health areas. However, staff from the minority health entities scheduled helpful and instructive interviews regarding the following health disparity programs and issues:

- *Interviews Regarding Private Sector Initiatives.* In most sites, interviews were scheduled with representatives from minority advocacy groups, advocates for minority health, and task force representatives. In fact, overall, the largest number of interviews were with persons from community organizations. This was especially true in states where the minority health representatives had been in their positions for a long time and were well connected to the community. Conversely, in states where the minority health representatives were new to their position (e.g., California and Delaware) fewer interviews were scheduled with representatives from community-based organizations.

- *Interviews Regarding Disparities in HIV/AIDS.* In terms of the health condition covered by the interviews, the greatest number of interviews were conducted regarding disparities in HIV/AIDS. Most of these were conducted with health department staff.

- *Interviews Regarding Disparities in Chronic Diseases.* In a number of sites, health department staff from chronic disease divisions discussed cancer, cardiovascular disease, and diabetes. In Delaware, Ohio, and South Carolina, information

Exhibit II-2

KEY INFORMANTS PARTICIPATING IN INTERVIEWS, BY SITE

Type of Key Informants	Number of Key-Informant Interviews Per Site								
	AR	CA	DE	FL	OH	PR	SC	UT	WY
The director and the staff of the state office of minority health, or the minority health contact person	3	1	1	1	2	2	3	-	1
The secretary, commissioner, or director of health	1	-	2	1	1	1	1	1	1
The directors, or senior staff, of the state health agencies targeting OMH's priority health areas:									
• Chronic diseases	-	1	-	-	-	1	1	-	-
• Cancer	2	-	-	1	-	-	-	1	3
• Cardiovascular disease	-	-	-	1	-	1	-	1	1
• Diabetes	-	-	-	1	-	2	-	1	1
• Infant mortality	2	-	-	2	-	-	-	-	-
• Substance abuse	1	-	-	-	1	7	-	1	1
• HIV/AIDS	1	1	-	1	1	1	2	1	3
• Suicide, unintentional injuries, and homicide	-	-	-	-	-	2	1	1	1
Other state health officials	4	6	4	3	5	5	3	3	12
Directors or representatives from private sector community agencies targeting OMH priority health areas									
• All chronic diseases	-	-	-	-	-	-	-	-	-
• Cancer	-	-	-	-	-	-	-	-	-
• Cardiovascular disease	-	-	-	-	-	3	2	-	-
• Diabetes	-	-	-	-	-	-	-	-	1
• Infant mortality	-	-	1	-	-	2	-	-	1
• Substance abuse	-	-	-	-	-	-	1	-	1

(Continued on next page)

Type of Key Informants	Number of Key-Informant Interviews Per Site								
	AR	CA	DE	FL	OH	PR	SC	UT	WY
• HIV/AIDS	3	-	-	-	-	-	-	-	-
• Suicide, unintentional injuries, and homicide	-	-	-	-	1	-	-	-	-
Representatives from private sector community organizations and coalitions, including the faith community	3	3	1	3	5	5	3	12	8
Legislators	2	-	2	-	1	2	3	-	4
State epidemiologists and health data analysts	-	2	1	1	-	2	-	1	2
Representatives from the academic community	-	-	-	2	1	-	3	-	-
Representatives from the governor's office	-	-	-	-	-	1	1	-	-
Native Americans	-	1	-	1	1	-	-	14	4
Local/regional health care providers	5	-	2	-	-	2	-	1	3
Total number of key informants	25	16	14	18	19	39	21	38	47
Number of interviews per site	17	12	14	13	15	17	18	21	17
Average number of persons participating in each interview	1.5	1.3	1	1.4	1.3	2.3	1.2	1.8	2.8

on health disparity initiatives for these three chronic diseases was received in interviews with the minority health entity representative or senior health department staff.

- *Interviews Regarding Disparities in Infant Mortality.* In general, the topic of infant mortality disparities was addressed directly by the minority health representatives. Only in Arkansas, Florida, Puerto Rico, and Wyoming were interviews scheduled with representatives from the state Office of Maternal and Child Health.

- *Interviews Regarding the Collection of Data to Document Health Disparities.* The lack of readily available data on health disparities was a major concern to all minority health representatives. A number of interviews with minority health

representatives focused to a great extent on the frustrations that
they had experienced over the years in trying to get data to
document the need for health programs targeting racial and
ethnic minorities. In addition, in seven of the sites, interviews
were scheduled with state epidemiologists or health analysts
who were able to further explain data collection and analysis
difficulties.

- *Interviews Regarding Health Care to Native Americans.*
  Representatives from Native American tribes had not been
  specified as a specific category on the list submitted to the
  minority health entities. However, the minority health
  representatives in California, Utah, and Wyoming scheduled
  interviews with Native Americans to discuss unique concerns
  related to Native American health care.

- *Interviews Regarding State Legislation.* The minority health
  representatives arranged for interviews with state legislators in
  Arkansas, Delaware, Ohio, Puerto Rico, South Carolina, and
  Wyoming. In addition, the COSMOS interviewers discussed
  relevant legislative issues with representatives from the
  minority health entities and health department officials.

In a number of sites (especially in Puerto Rico), the minority health entities set up
interviews with groups of health department officials or other experts, as well as with
individual key informants.

E. LIMITATIONS OF THE DESIGN AND IMPLEMENTATION PHASES

Several limitations to the research design may have affected the findings of the study.

1. SELECTION OF STUDY SITES

The study could only focus on nine study sites, which limited the amount of data
collected on each site. In addition, site selection was not random. The sample is a
purposive one that meets criteria of interest to OMH, but does not claim to be
representative of all states.

Moreover, the sample consists primarily of states with well-established minority
health entities. Only a few sites were chosen that have no formal minority health office or
have a newly created office of minority health. As a result, it is difficult to determine

whether efforts to close the gap in health disparities are more likely to occur when dedicated minority health entities are established. The existing sample does not permit a comparison between sites with and without an established office of minority health. The unexpected exclusion of New York also means that the northeastern states are not included in the study.

2. SELECTION OF KEY INFORMANTS

While the study team provided each minority health entity with a list of the types of informants desired for the interviews, each selected and arranged for the interviewees. Therefore, the interviewees chosen were, for the most part, limited to individuals known to the minority health entities or with whom the minority health entities had a working relationship. Several key interviewees are likely to have been overlooked because the minority health contacts were unable to schedule interviews. In sites with new directors of minority health, lack of knowledge of other minority health initiatives in the state may have had an effect on the appropriateness of the selection of interviewees.

3. INCOMPLETENESS OF DATA COLLECTION

In the collection of data and information for this study, project resources limited the amount of time available to conduct interviews. This had an effect on the amount of information that realistically could be collected from each state. In addition, the study concentrated on collecting information related to OMH's identified 7+4 priority areas, which may have not been consistent with priorities set by the state or the minority health entity. Therefore, states may have limited information on their minority health infrastructure as it relates to the priority areas in this study. On the other hand, states may have had a greater focus on reducing disparities in areas that currently fall outside of the OMH 7+4 priorities (e.g., asthma).

This report therefore does not purport to be a comprehensive description of all components of each study site's minority health infrastructure as it relates to the 7+4 priority areas for the four major racial and ethnic minority groups. What it can do is present the type of components that may be present in a given state, identify a number of promising approaches, and discuss challenges related to eliminating health disparities.

4. PERCEPTIONS OF KEY INFORMANTS

The study also is limited by the emphasis on the perceptions of key informants. While each of the key informants was identified by the minority health contact, these individuals may not have complete knowledge of efforts related to minority health in their area or state. This limitation became very apparent in instances where key informants had recently come into their positions and had only limited knowledge of statewide efforts

surrounding minority health. Study resources allowed for the review of some documentation (such as mission statements and strategic health plans), and additional interviews with regional minority health consultants and national experts (including representatives from the Indian Health Service), but generally the information provided in this report is based on facts and opinions presented by key informants.

5.   LACK OF DATA ON HEALTH DISPARITIES

One of the subtopics listed in the Statement of Work had to do with identifying the health disparities in the study sites. The health disparity data presented in this report is based on data that are generally available to the sites. These data are often limited or even nonexistent, especially for Asian Americans, Pacific Islanders, and Native Americans. The incompleteness of the health data and its effect on states' efforts to eliminate disparities is a major finding of this report. It also is a cross-cutting issue that is addressed in detail in Section IV.

6.   LIMITED INFORMATION ON HEALTH CARE TO NATIVE AMERICANS

Because of the federal recognition of tribes as sovereign entities, and the federal government's obligation to provide health services under P.L. 83-568 in 1954, most health services to Native Americans are provided directly through the Indian Health Services rather than through state health departments.[9] Major differences exist between that agency and state health infrastructures. The impact that these differences have on efforts to close the gap in health disparities were revealed over the course of the study. The report therefore includes a separate section on health care to Native Americans.

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[9]Indian Health Service service areas consist of counties on or near federal Indian reservations. Indians residing in these service areas comprise about 60 percent of all Indians residing in the United States.

SECTION III

The Minority Health Entities in the Nine Study Sites

III. THE MINORITY HEALTH ENTITIES IN THE NINE STUDY SITES

This section describes the nine study sites in terms of the racial and ethnic composition of their population and known health disparities. Next, it provides information on the type of minority health entities, and their missions, functions, resources, history, organizational placement within the state infrastructure, and links to the minority community.

A. RACIAL AND ETHNIC CHARACTERISTICS OF THE POPULATION IN THE NINE STUDY SITES

The nine sites were selected in part so that they would reflect a range in the types and relative numbers of the minority populations within a state or territory. Exhibit III-1 presents the racial and ethnic distribution of the population in the eight states that participated in this study (based on 1998 population estimates by the Bureau of Census).[1] The exhibit does not include data breakouts for Puerto Rico by race or ethnicity because the majority of the island's population is Hispanic.

While percentages provide information on the relative number of minorities in a state, they do not provide a full picture. For instance, approximately the same percentage of Arkansas and Wyoming residents are Asian or Pacific Islanders (respectively, 0.7 and 0.8%). Yet an estimated 18,529 Asians live in Arkansas versus 4,023 in Wyoming. An estimated 6.8 percent of Utah residents and an estimated 6.0 percent of Wyoming residents are Hispanic. However, the Hispanic residents in Utah number 142,479 while the Hispanic residents in Wyoming number 28,870. The exhibit therefore presents both the numbers and the percentages of the estimated racial and ethnic distribution of the population in the eight states covered by the study.

Below is a brief overview of the differences in the population for each of the study states based on the data in Exhibit III-1:

- *Blacks*. Of the study states, South Carolina has the largest Black population relative to the population of the state (30%). However, California and Florida have two of the greatest

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[1]Hispanics who are not White are double-counted in this table. For example, an individual who is Black and Hispanic will be reported in both categories. This double-counting, along with rounding of percentages, results in percentages that do not equal 100 percent.

Exhibit III-1

POPULATION ESTIMATES FOR SELECTED STUDY SITES
BY RACE AND ETHNICITY, 1998[a]

	White (Not Hispanic)		Black		Asian/Pacific Islander		Native American		Hispanic (All Races)[b]		Total
	Est. Pop.	% of Total	Est. Pop	% of Total	Est. Pop.	% of Total	Est. Pop.	% of Total	Est. Pop.	% of Total	
Arkansas	2,054,564	80.9	407,618	16.1	18,529	0.7	13,712	0.5	49,473	1.9	2,538,303
California	16,511,020	50.5	2,455,570	7.5	3,937,722	12.1	308,571	0.9	10,112,986	31.0	32,666,550
Delaware	559,535	75.2	144,380	19.4	15,247	2.1	2,391	0.3	25,736	3.5	743,603
Florida	10,238,755	68.6	2,267,753	15.2	271,305	1.8	58,070	0.4	2,243,441	15.0	14,915,980
Ohio	9,609,951	85.7	1,289,760	11.5	128,639	1.1	22,939	0.2	179,054	1.6	11,209,493
South Carolina	2,603,304	67.9	1,147,239	29.9	34,355	0.9	9,291	0.2	49,817	1.3	3,835,962
Utah	1,866,289	88.9	18,677	0.9	53,479	2.5	29,544	1.4	142,479	6.8	2,099,758
Wyoming	435,427	90.5	4,082	0.8	4,023	0.8	10,608	2.2	28,870	6.0	480,907
United States	195,439,503	72.3	34,430,569	12.7	10,507,280	3.9	2,359,946	0.9	30,250,264	11.2	270,298,524

III-2

[a]Source: Population Estimates, Population Division, U.S. Bureau of the Census (ST-98-30), Population Estimates for States by Race and Hispanic Origin: July 1, 1998 Tables re-numbered effective October 6, 1999.
[b]Hispanics who are not White are double-counted in this table. For example, an individual who is Black and Hispanic will be reported in both the Black and the Hispanic categories. This double-counting, along with rounding of percentages, results in percentages that do not equal 100 percent.

Black populations in the nation. In Utah and Wyoming, Black residents make up less than one percent of the state's population.

- *Hispanics.* Excluding Puerto Rico, the study site with the highest percentage of Hispanics was California (31%). The percentage of Hispanics in Florida (15%) also is higher than the national average. Among the study states, Arkansas, Ohio, and South Carolina have Hispanic populations that make up less than 2 percent of the total state population. However, Ohio does have nearly 180,000 Hispanic residents.

- *Asian Americans and Pacific Islanders.* According to population estimates in 1998, of the nine sites participating in the study, California had the largest percentage (12%) and the largest numbers of Asian Americans and Pacific Islanders. In three states (Arkansas, South Carolina, and Wyoming), the percentage of the population that is Asian American or Pacific Islander is less than one percent.

- *Native Americans.* California had the largest population of Native Americans (308,571) among the study sites, even though only 0.9 percent of the state's population is Native American. Utah and Wyoming have Native American populations above the national average at 1.4 and 2.2 percent, respectively.

- *Whites.* Nationwide, the percentage of Whites (excluding those of Hispanic origin) in 1998 was 72 percent. Two of the states in the study had lower percentages of Whites than the nation as a whole (and therefore higher percentages of minorities): California, and South Carolina.

B. MAJOR HEALTH DISPARITIES IN THE STUDY SITES

States vary in the extent to which they report health data by race and ethnicity in state documents. Two of the states in this study (Arkansas and Florida) distinguish only between Whites and non-Whites. Aside from Puerto Rico, AADR breakouts for Hispanics are provided by only three study sites (California, Utah, and Wyoming). Two states (California and Utah) provide health data for Asian Americans/Pacific Islanders; two states (Utah and Wyoming) provide health data for Native Americans. Exhibit III-2

Exhibit III-2

THE AVAILABILITY OF MAJOR
AADR BREAKOUTS BY RACIAL AND ETHNIC GROUPS
IN EACH OF THE STUDY SITES

Study Sites	Year	White	Non-White	Black	Hispanic	Native American	Asian American and Pacific Islander
Arkansas	1997	✓	✓				
California	1997	✓		✓			✓
Delaware	1992-1996	✓		✓			
Florida	1997	✓	✓				
Ohio	1996	✓		✓			
Puerto Rico[a]	1997						
South Carolina	1996	✓		✓			
Utah	1993-1997	✓		✓	✓	✓	✓
Wyoming[b]	1993-1997	✓		✓	✓	✓	

[a]Puerto Rico does not report data by race or ethnicity since race is often difficult to determine. Most of the island is considered of Hispanic ethnicity.
[b]Data for Wyoming's racial and ethnic groups are limited to only a few priority areas (heart disease, suicide, and homicide); for the rest of the disease conditions, the state only provides data for the entire population.

shows which states routinely report AADRs for each of the major racial and ethnic groups. The exhibit also shows the most recent years for which these data are available. For those states that provide only Non-White data, it is possible to obtain data for Blacks,

Whites, and "others" from the national CDC WONDER database.[2] However, the WONDER database does not provide state-by-state breakouts for Asian Americans/Pacific Islanders, Native Americans, and Hispanics.

Exhibit III-3 presents data as ratios between Whites and Blacks in the eight study states for each of the OMH priority health areas. The exhibit clearly shows that at the state, as well as the national level, disparities exist between Whites and Blacks in all health conditions but suicide. (An exception is Wyoming, for which aggregate data from 1993 through 1997 show that the Black suicide rate is higher than that of Whites.) Very high disparity rates exist at the state level for homicide, HIV infection, infant mortality, and diabetes. Within these health conditions, currently available data show considerable ranges in the level of the disparity. Below are the highest disparities between Whites and Blacks in the nine study sites:

- *HIV Infection*. The greatest health disparity for any health condition is the Black-White disparity in HIV infection in Delaware. In 1997, Blacks in Delaware were 20 times more likely than Whites to die of HIV infection. Other states with high Black-White disparity ratios (greater than 5.0 indicating that Blacks are more than five times as likely to die of HIV infection) are: Florida, Ohio, South Carolina, and Utah.

- *Homicide*. The greatest disparities in the AADR ratio between Blacks and Whites for homicide and legal intervention are reported for Arkansas, Ohio, and Utah. The respective disparity ratios are 9.95, 6.23, and 5.57.

- *Diabetes*. The disparity ratios in Wyoming and Utah were 5.27 and 3.33. In all other states, Blacks were more than twice as likely to die from diabetes as Whites.

- *Infant Mortality*. In six of the eight states (Arkansas, California, Delaware, Florida, Ohio, and South Carolina), the mortality rate is at least twice as high for Black infants as for White infants.

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[2]CDC WONDER is a data system that provides access to a wide variety of CDC reports, guidelines, and numeric public health data. CDC WONDER furthers CDC's mission of health promotion and disease prevention by speeding and simplifying access to public health information for state and local health departments, the Public Health Service, the academic public health community, and the public at large. For this report, CDC WONDER was accessed through its web site at http://wonder.cdc.gov.

Exhibit III-3

DISPARITY RATIOS GREATER THAN 1.0
BETWEEN BLACKS AND WHITES IN THE EIGHT STUDY STATES
FOR THE OMH PRIORITY HEALTH AREAS

	Cancer	Diabetes	Cardio-vascular Disease	Infant Mortality	Chronic Liver Disease and Cirrhosis	HIV Infection	Homicide and Legal Intervention	Suicide	Accidents and Adverse Effects
Arkansas	1.41	2.9	1.41	[a]	1.46	4.88	5.57	–	1.17
California	1.33	2.38	1.59	2.53	–	3.34	4.01	–	1.13
Delaware	1.38	2.2	1.21	2.54	1.05	20.13	4.41	–	–
Florida	1.23	2.84	1.44	–	–	7.72	4.15	–	1.1
Ohio	1.28	2.22	1.36	2.57	1.62	5.67	9.95	–	1.04
South Carolina	1.39	3.33	1.43	2.01	1.49	9.59	2.92	–	1.36
Utah	1.7	2.18	1.29	1.81	1.77	6.94	6.23	–	–
Wyoming	1.03	5.27	–	–	–	4.58	2.41	1.42	–
United States	1.34	2.4	1.48	2.31	1.26	5.75	6.24	0.57	1.23

[a]The infant mortality data in Arkansas are available only for "non-Whites."

Note that the exhibit uses the International Classification of Disease (9th edition) category *homicide and legal intervention* to present data on homicide; the category *accidents and adverse effects* presents unintentional injuries.

Exhibit III-4 presents health disparity ratios for Hispanics, Asians, and Native Americans for those states that report for these minority groups. Puerto Rico, California, Utah and Wyoming present health data on Hispanics. However, for Utah and Wyoming, health data are not available for all conditions. Although no disparities were reported for Asian Americans at the national level, disparities are reported in two of the study sites—California and Utah. Only Utah and Wyoming report data, albeit limited, on the health status of Native Americans.

Efforts at comparisons between study sites are complicated by differences in the types of data reported by CDC, by study sites, and by the differences in reporting year. Four states report data for 1997; two states report data for 1996. Utah and Wyoming present aggregate data for 1993-1997, and Delaware presents aggregate data for 1992-1996.

The lack of state data on certain racial and ethnic minority populations has a number of infrastructure implications. First, if a state fails to collect data on its minority populations' health conditions, there is no accurate way to determine public health priorities for those populations. Second, without collection of health information on minority groups, states and territories have difficulty determining how successful their efforts to eliminate health disparities have been. The impact of these data limitations on states' efforts to eliminate health disparities is one of the crosscutting issues discussed in Section IV of this report.

C. DESCRIPTION OF THE MINORITY HEALTH ENTITIES IN THE STUDY SITES

The minority health entities in the nine study sites are described below. The description starts with an overview of the type of minority health entities (i.e., established office of minority health or minority health contact person), their establishment, and history. Next, it discusses resources (in terms of funding and staff), and the organizational placement of the minority health entity in the state. The section concludes with an examination of missions of the established offices of minority health, their key functions, and methods of measuring effectiveness.

Exhibit III-4

DISPARITY RATIOS GREATER THAN 1.0
AMONG HISPANICS, ASIANS AND NATIVE AMERICANS, AND WHITES
IN STUDY SITES FOR WHICH THESE DATA ARE AVAILABLE

Study Sites That Report Data on Hispanics	Disparity Ratios Greater than 1.0 between Hispanics and Whites								
	Cancer	Diabetes	Cardio-vascular Disease	Infant Mortality	Chronic Liver Disease and Cirrhosis	HIV Infection	Homicide and Legal Intervention	Suicide	Accidents and Adverse Effects
Puerto Rico[a]	–	3.31	–	1.7	2.71	–	4.8	–	1.21
California	–	2.02	–	–	1.25	–	3.17	–	–
Utah	–	1.26	–	1.14	–	–	4.35	–	–
Wyoming	NR	NR	NR	–	–	–	2.19	–	–

[a]Puerto Rico compares Island data with data on U.S. Whites.

Exhibit III-4 (Continued)

Study Sites That Report Data on Asian Amerians	Disparity Ratios Greater than 1.0 Between Asian Americans and Whites								
	Cancer	Diabetes	Cardio-vascular Disease	Infant Mortality	Chronic Liver Disease and Cirrhosis	HIV Infection	Homicide and Legal Intervention	Suicide	Accidents and Adverse Effects
California	–	1.11	–	NR	NR	NR	1.24	–	–
Utah	–	1.48	–	1.08	–	–	NR	–	–

Study Sites That Report Data on Native Americans	Disparity Ratios Greater than 1.0 Between Native Americans and Whites								
	Cancer	Diabetes	Cardio-vascular Disease	Infant Mortality	Chronic Liver Disease and Cirrhosis	HIV Infection	Homicide and Legal Intervention	Suicide	Accidents and Adverse Effects
Utah	1.03	–	–	1.47	6.08	–	–	–	–
Wyoming	NR	NR	1.62	NR	NR	NR	6.67	1.53	NR

1. **TYPE OF MINORITY HEALTH ENTITY**

Seven states covered by the study (Arkansas, California, Delaware, Florida, Ohio, South Carolina, and Utah) have an established state office of minority health. In addition to conducting in-state activities designed to reduce health disparities, these offices also serve as the main contact point between the state and the national OMH. In Puerto Rico and Wyoming, on the other hand, a minority health contact person (rather than a state organizational entity) serves as the liaison between the health department and the national OMH. Exhibit III-5 lists the nine minority health entities by site and by type.

The designation of the established offices of minority health varies. Arkansas, Delaware, and South Carolina have an Office of Minority Health. In Utah, there is an Office of Ethnic Health, while California has an Office of Multicultural Health. Ohio has a Commission on Minority Health. In Florida, the functions of the office of minority health are subsumed under the functions of the Health Department's Office of Equal Opportunity and Minority Affairs.

2. **AUTHORITY ESTABLISHING THE MINORITY HEALTH ENTITIES**

Of the minority health entities covered by the study, Ohio was the first to establish one (in 1987). The most recent one is the Florida minority health entity, established in 1998. Six of the nine minority health entities were established by administrative action of the state's health officer, and three were established by legislation.

- *Minority Health Entities Established by the State Health Department.* Six minority health entities were established by administrative action of the state health officer: Utah, 1989; South Carolina, 1990; Arkansas, 1991; Wyoming, 1996; Puerto Rico, 1997; and Florida, 1998.

- *Minority Health Entities Created by the State's Legislative Body.* The Ohio Commission of Minority Health was established by legislative statute in 1987; the Delaware Office of Minority Health and California's Office of Multicultural Health were established by Executive Orders of the Governor, in 1991 and 1993 respectively.

Exhibit III-5

MINORITY HEALTH ENTITIES IN THE NINE STUDY SITES

	Established Organizational Entities Responsible for Addressing Health Disparities in Minorities		
	Organizational Units Within the State Health Department	State Entities Outside the Health Department	Minority Health Contact Persons Within the Health Department
Arkansas	✓		
California	✓		
Delaware	✓		
Florida	✓		
Ohio		✓	
Puerto Rico			✓
South Carolina	✓		
Utah	✓		
Wyoming			✓

3. HISTORY OF THE MINORITY HEALTH ENTITIES

a. The Established Offices of Minority Health

The establishment of most of the minority offices of minority health followed a similar pattern: 1) recognition of health disparities by state officials; 2) the establishment of a task force to determine an appropriate response; and 3) the establishment of the minority health entity either by the legislature or by the health department. Exhibit III-6 provides an overview of the establishment of the offices of minority health. It identifies precursors (e.g., task forces) to the offices, and the legislative authority establishing the office. In addition, key informants reported that minority communities contributed to the establishment of the offices of minority health by advocating for minority health offices within their states. Often, the minority groups were motivated by observed minority health disparities in their neighborhoods and cities. Community organizations and residents from racial and ethnic minority groups contributed their personal stories, support, and voting power behind initiatives to create state programs to address minority

Exhibit III-6

HISTORY OF THE DEDICATED OFFICES OF MINORITY HEALTH

Minority Health Entity (Year Established)	Pre-cursors to the establishment of the Minority Health Entity	Establishment of the Minority Health Entity
The Ohio Commission on Minority Health (1987)	In 1985, a Governor's' Task Force on Minority Health was established by Executive Order to examine health disparities in Ohio. A major impetus was the 1985 federal *Report of the Secretary's Task Force on Black and Minority Health.*	In 1987, the Ohio Commission on Minority Health was created as a separate state agency by the legislature in July 1987. The bill was introduced by the chair of the Governor's Task Force. (Also, in 1987, the Ohio Department of Health established an Office on Minority Affairs; however, this office was abolished by the Director of Health in 1996.)
The Arkansas Minority Health Commission and the Arkansas Office of Minority Health (1991)	Dr. Jocelyn Elders, then director of the Arkansas Department of Health (later Surgeon General of the United States), identified health disparities between Blacks and Whites in Arkansas as a major health concern.	In 1991, the Minority Health Commission was established by the legislation as a separate state agency. That same year, Dr. Elders established the Office of Minority Health within the Health Department. The two minority health entities work collaboratively to address the health needs of minorities in Arkansas.
The California Office of Multicultural Health (1993)	In 1991, a Mulit-Ethnic Health Promotion Conference recommended that an office of minority affairs be created within the Health and Welfare Agency of the Department of Health.	In 1993, the Office of Multicultural Health was created by the Governor and placed in the Department of Health.
The South Carolina Office of Minority Health (1990)	In 1989, the Commissioner of the Department of Health and Environmental Control set up a task force to examine the need for a minority health entity. Increasingly, health department staff and leaders of the minority community were expressing concern about health disparities. In 1988, the Columbia Urban League in its annual assessment of the State of Black South Carolinians had urged the establishment of a state office of Black and minority health.	In 1990, the Office of Minority Health was established administratively by the Commissioner of the South Carolina Department of Health and Environmental Control. **(Continued on next page)**

Exhibit III-6 (Continued)

Minority Health Entity (Year Established)	Pre-cursors to the establishment of the Minority Health Entity	Establishment of the Minority Health Entity
The Delaware Office of Minority Health (first, 1991; re-established, 1997)	In the early 1990s the then governor was concerned about health disparities in Delaware, particularly as they related to infant mortality.	In 1991, the Office of Minority Health was created by Executive Order of the Governor. In 1994, the functions of the Office were delegated by a newly established Governor's Advisory Council on Minority Health. In 1997, the Office was re-established by administrative fiat of the Secretary of the Department of Health and Social Services.
The Utah Office of Ethnic Health (1994)	As early as 1983, a Utah policy document reported on health disparities in Utah's minority populations. In response, the state created an Ethnic Health Improvement Project. In 1987, its Steering Committee was renamed the Ethnic Health Committee. It became a permanent part of the Department of Health through an act of the Executive Director, and was renamed.	In 1994, the Office of Ethnic Health was created by the Health Department to oversee the Ethnic Health Improvement Project and the Ethnic Health Committee.
The Florida Office of Minority Health (1998)	In 1993, Florida's Minority Health Improvement Act authorized a two-year time-limited Minority Health Commission. The Commission was sunsetted in 1995. In the ensuing years, the Department of Health made several requests for an office of minority health.	In 1998, the Office of Minority Health was created in a newly established Office of Equal Opportunity and Minority Affairs.

health. For instance, in South Carolina, the Columbia Urban League was a strong supporter of the establishment of the Office of Minority Health.

The Ohio Commission on Minority Health. In 1985, in response to the national *Report of the Secretary's Task Force on Black and Minority Health,* Governor Richard Celeste issued Executive Order 85-69 on December 17, 1985, to form a Governor's Task Force on Minority Health. The task force was charged with examining the conditions that contributed to gaps in health care services among Ohio's minority communities and to recommend ways in which those gaps could be closed. To obtain more specific data, the task force formed the following six subcommittees: Health Promotion, Legislation, Health Care Finance, Hispanic Concerns, Native American Concerns, and Data. The Governor publicly released the Task Force report on April 4, 1987. Shortly afterwards, State Representative Ray Miller, who had chaired the task force, introduced a bill to create a separate state agency to focus on minority health issues. Ohio's minority communities lent a great deal of support to the legislation. In July 1987, Amended House Substitute Bill 171 created the Ohio Commission on Minority Health.[3]

At approximately the same time that the Commission on Minority Health was created, the Ohio Department of Health established an Office on Minority Affairs responsible for employment opportunity concerns as well as minority health. However, the Office was abolished in 1996 by the Director of Health.

The Ohio Commission on Minority Health is a free-standing commission that exists outside the Ohio Department of Health, and is funded directly from the Ohio state legislature. It consists of eighteen members. The Governor appoints nine of the members who have backgrounds as health researchers, health planners, and health professionals. The Speaker of the Ohio House of Representatives and the President of the Ohio Senate each appoint two Commission members, one from each political party. The remaining commissioners are the Directors of Health, Mental Health, Mental Retardation and Developmental Disabilities, and Human Services, along with the Superintendent of Public Instruction.[4] The Commission does not seek to duplicate the efforts of the Ohio Department of Health; rather, it complements it by providing information and grants to community agencies that can impact minority health.

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[3]Several individuals commented on the importance of having legislators involved in the entire process, from the Task Force formation through the passage of the bill. The involved legislators were able to anticipate problems with the creation of the commission and were able to take steps to overcome these barriers. Of particular importance was the bipartisan nature of the legislation, and the stipulation that two members of each political party would sit on the commission.
[4]Ohio House of Representatives, Amended Substitute House Bill 171, Language Creating Commission on Minority Health, 1987.

The Arkansas Office of Minority Health. The Arkansas Office of Minority Health was established in 1991 by Dr. Jocelyn Elders, then director of the Arkansas Department of Health, to serve as a link between the health department and an independent Minority Health Commission that had been established earlier that year by the Arkansas legislature. Until 1995, the current director of the Office of Minority Health worked part-time for the Office of Minority Health, and served as part-time staff to the Commission from 1993 to 1995.

Both the Arkansas Office of Minority Health and the Minority Health Commission are in existence today. The Office of Minority Health (located within the health department) serves as the official link with the federal OMH.

The California Office of Multicultural Health. In 1991, a Multi-Ethnic Health Promotion Conference played a central role in the development of a multi-ethnic health promotion agenda, by recommending a major policy change to create an office of minority health. The conference recommended that an Office of Minority Health Affairs be created within the state government, either within the Health and Welfare Agency or the Department of Health Services, to act as or coordinate the activities of an existing agency acting as a central clearinghouse for health-related information and interventions specific to California's multicultural communities; coordinate the activities of multiple state programs; provide technical assistance to communities on program planning, implementation, and evaluation; monitor the progress of state agencies and programs whose activities have an impact on the health of California's ethnic populations; and advocate for necessary resources to address emerging problems.

In August 1993, the Office of Multicultural Health was created by Executive Order W-58-93 by Governor Pete Wilson to serve as the focal point within the Department of Health Services for improved planning and coordination of activities and programs related to racial and ethnic populations in California. In June 1994, the Office was elevated and relocated to the Office of the Director, California Department of Health Services.

The Delaware Office of Minority Health. The Delaware Office of Minority Health was created in 1991 by executive order of the governor. It was re-established by administrative fiat by the Secretary of the Department of Health and Social Services in 1997. The first two directors of the Office of Minority Health faced a number of difficulties, including lack of clarity about the role of the Office within the public health infrastructure. When the second director left the position, the administration decided not to fill it, and the office became dormant. From 1994 to mid-1998, minority health concerns were the responsibility of a Governor's Advisory Council on Minority Health created on May 17, 1994, by Governor Thomas R. Carper through Executive Order 20.

In 1997, when the Office of Minority Health was re-established, the Division of Public Health recruited a new director. The director's role is to serve as a link between the Division of Public Health and the community, and implement recommendations made by the Task Force.

The South Carolina Office of Minority Health. The Office was established administratively in 1990 by then DHEC commissioner Michael Gareth. Prior to creating the office, in 1989, he set up a task force to study the need for such an entity. Among the community groups pushing for the establishment of the minority health entity was the Urban League. A September 12, 1990, article in *The State* newspaper describes the newly established OMH, and refers to the role of the Urban League: "Two years ago in its annual assessment of the state of black South Carolinians, the Columbia Urban League urged establishment of a state office of black and minority health."

The current director of the OMH staffed that initial task force, and was then appointed as the Director of the Office of Minority Health. A Minority Health Advisory Council established by the Commissioner was discontinued following his death a few years later.

The Utah Office of Ethnic Health. The origin of the current Office of Ethnic Health can be found in a policy document written in 1983 that demonstrated that health disparities between Utah's minority and non-minority populations were greater than previously thought. In response to these findings, the state created the Ethnic Health Improvement Project. Its steering committee was made a permanent part of the Utah Department of Health through an act of the Executive Director in 1987, and renamed the Ethnic Health Committee.

In 1994, the Utah Department of Health created the Office of Ethnic Health to oversee both the Ethnic Health Improvement Project and the Ethnic Health Committee. Later that year, an Ethnic Health Workforce Program was created to include ethnic and racial minorities in health care decisionmaking. This Workforce Program was placed under the supervision of the Office of Ethnic Health, as well.

The Florida Office of Equal Opportunity and Minority Affairs. In 1993, Florida's Minority Health Improvement Act authorized a two-year time-limited Minority Health Commission.[5] The charge of the Commission was to provide recommendations to the Governor and the legislature regarding the health status of Florida's minorities; increasing access to health care; increasing minority participation in the health professions industry; and establishing a center or an Office of Minority Health. The Commission faced legislative sunset in 1995.

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[5]Florida Commission on Minority Health, *Report to the Governor*, December 19, 1994.

In March 1998, the Department of Family Health Services, Florida Department of Health (DOH), prepared the *1999-00 Legislative Budget Request, Preliminary Issue Form* to establish a Minority Health Office. This request was turned down by the Florida legislature. On May 27, 1998, a group of ten senior persons from DOH met to propose the development of an Office of Minority Health to be located within DOH. Effective November 12, 1998, a new office was created in the Office of the Secretary called the Office of Equal Opportunity and Minority Affairs (the OEO component was formerly in the Bureau of Human Resource Management).

b. Sites with Minority Health Contact Persons

Puerto Rico. The functions of the minority health coordinator flow in part from a Memorandum of Agreement between the Puerto Rico Department of Health and its Office of Federal Affairs, the Puerto Rico Association of Primary Health Care Centers, the Puerto Rico Academy of Medical Directors, Inc., and the Health Resources and Services Administration. The emphasis of the cooperative agreement is on the implementation of community-based health care systems, and on the development of health care services, particularly in medically underserved areas. As a result of the site visit, Puerto Rico is considering the possibility of establishing an office of minority health.

Wyoming. A Minority Health Coordinator was appointed in January 1996 by the Department Director. A Minority Health Committee was organized by the coordinator in April 1996. This committee consists of 17 members from different ethnic backgrounds who work with public and private agencies dealing with minorities and underserved populations across the state. Prior to that date, the department did not have an organizational entity that focused on minority health.

4. FUNDING

There are major differences in funding sources and amounts of funding available to the seven established offices of minority health, and to the two minority health contact persons.

a. Funding for Established Offices of Minority Health

The seven established offices that participated in this study receive most of their funding from the state (six entities receive funding from the health department, while Ohio is funded directly by the state legislature). OMH is generally not a source of funding to state minority health entities. However, in 1998 six of the seven established offices of minority health applied for and received state partnership grants (for approximately $25,000 to $30,000), and four of the sites were awarded Minority HIV/AIDS

Demonstration Grants. In addition, several directors reported receiving funds from local businesses to assist with health promotion activities such as health fairs.

Below is a discussion of the major sources of funding for the seven established offices of minority health that participated in the study: funding from the state legislature, state health departments, and OMH:

Funding from the State Legislature. The Ohio Commission on Minority Health is funded by the state legislature. Funding (more than $1,888,000 in FY 1999) allows the Commission to award grants to community minority health programs.

Funding from State Health Departments. Arkansas, California, Delaware, Florida, South Carolina, and Utah are funded through the state health departments. As discussed below, in several states, some funding is discretionary, and not all directors have direct authority over their allocated budgets. In other states, funding is shared with other offices:

- In California, discretionary funds cover the equivalent of one full-time person plus fringe benefits and some travel. Other funding comes from a yearly grant from the Public Health Prevention Block Grant. The director of the California Office of Multicultural Health has no budgetary authority.

- In Utah, the Office of Ethnic Health shares its budget of approximately $105,000 per year with the Office of Human Resource Management.

- The Delaware Office of Minority Health has a yearly budget of $50,000. The director has no budgetary authority.

- In Florida, at the time of the spring 1999 site visit, there was as yet no budget for minority health programs or activities in the Office of Equal Opportunity and Minority Affairs. However, following the 1999 appropriation, the Office was allocated $1 million to develop and implement tobacco prevention programs in minority communities in Florida's 67 counties.

- The South Carolina Office of Minority Health receives its funding for minority health activities from the South Carolina Department of Health and Environmental Control. The budget

of the Office of Minority Health includes the Office of Migrant Health, which is funded by HRSA.

The OMH State Partnership Grant Program. In 1998, OMH awarded noncompetitive grants to state Offices of Minority Health to help them increase their capacity to address health disparities. All established offices of minority health were eligible to apply. Of the seven established offices of minority health covered by this study, only the Delaware Office of Minority Health did not apply. (Its newly appointed director was not aware of the grant.)

The OMH State and Territorial Minority HIV/AIDS Demonstration Grant Program. At the time of the site visits, sites were applying for funding from OMH's State and Territorial Minority HIV/AIDS Demonstration Grant Program—made possible through the minority HIV/AIDS program brought about through the aforementioned efforts of the Congressional Black Caucus, the Congressional Hispanic Caucus, the Clinton administration, and the DHHS. The purposes of these grants (in addition to the establishment of a project advisory committee) are: 1) assist in identifying needs for HIV/AIDS prevention and services among minority populations by collecting, analyzing, or tracking surveillance data as well as data on HIV services; 2) facilitate linking minority community-based organizations with other state and local recipients of federal funds for HIV/AIDS to thereby increase capacity to respond to identified needs; and 3) assist in coordinating federal resources, including sources of technical assistance to minority community-based organizations. The demonstration is expected to end in September 2002. Four of the nine sites participating in this study were awarded grants (averaging $150,000 for the first year): Delaware, Florida, Ohio, and South Carolina.

b.   Funding for the Minority Health Contact Person

In Wyoming, there is no official funding for the position of the minority health coordinator even though the coordinator has three additional titles: chronic disease section manager, state diabetes program coordinator, and women's health coordinator. She reports spending approximately 25 percent of her time on minority health issues. However, during the past two years, the minority health coordinator applied for and received two small grants from the Regional Office of Minority Health in Denver, Region VIII. (This was the only site that reported receiving funds from a regional office of minority health.) The Puerto Rico Coordinator for Primary Care and Minority Health is located in the Office of Federal Affairs in Puerto Rico, and funding is provided through HRSA.

5. STAFF

In the seven established offices of minority health studied, the number of staff range from one person in Delaware and Florida to eight in Ohio. However, these numbers do not tell the full picture, as some offices share staff, and others have access to support staff or are able to recruit interns. For instance, in Delaware, the director of the Office of Minority Health has no staff but has access to support staff from the Division Director.

Staff of the South Carolina Office of Minority Health includes five staff persons of the Office of Migrant Health. In California, the above-mentioned health department discretionary funds cover the equivalent of one full-time staff member (the director) plus fringe benefits and some travel. Monies from the Public Health Prevention Block Grant fund two additional staff and two clerical staff persons; technically, however, these positions are not within the Office of Multicultural Health. Arkansas extends its three-person staff by using $10,000 from its yearly allocation to provide stipends to two graduate social work student interns. A number of key informants indicated that insufficient staffing is a major problem for the minority health entities.

Staff turnover, particularly in the director's position, is a problem for a number of entities. Of the seven state offices of minority health, two experienced recent (within the last two years) turnover at the director's level (California and Utah). In two states, Delaware and Florida, the directors of the offices of minority health have been in their position for less than a year (in Delaware, because the office had been unstaffed for a number of years, and in Florida, because the office was newly established).

6. ORGANIZATIONAL PLACEMENT

As discussed below, most of the minority health entities in the nine study sites are located within the health department. Only the Ohio commission is an independent state agency. Closely related to the issue of the organizational placement of the minority health entity is the extent to which the minority health director or contact person has access to state policymakers and other key decisionmakers within and outside the state health department.

a. Location of the Minority Health Entity in the State Structure

The two minority health contact persons covered by this study are located within the Office of Federal Affairs of the Puerto Rico Department of Health and the Wyoming Division of Public Health. Six of the seven established state offices of minority health are located within their state health departments in various offices and divisions: 1) offices of the director or secretary of health—California, Delaware, and Florida; 2) divisions of

planning and policy development—Arkansas and South Carolina; and 3) the office of human resource development—Utah.

Key informants report that the Ohio Commission on Minority Health, which has been located outside the health department (as well as its budgetary independence) facilitates access to state agencies other than the department of health.

b.   Position of the Minority Health Directors and Contact Person in Relation to Key Decisionmakers

Key informants in other states report that it can be difficult for directors of offices of minority health to access state decisionmakers outside the health department. Moreover, the extent to which they have contact with health department decisionmakers varies. This appears to be a function of: 1) location of their office within the state structure; and 2) their state-assigned functions.

- *Established Offices of Minority Health*. Of the six offices of minority health located in health departments, three directors report directly to the executive director or secretary of health (California, Delaware, and Florida). The director of the Delaware Office of Minority Health attends meetings of the secretary's executive staff (participants include division directors and section chiefs). The directors of the remaining minority health entities report to an intermediary. The director of the Arkansas Office of Minority Health reports to the Deputy Director of Planning and Policy Development. Although the Utah Ethnic Health Coordinator does not report directly to the Executive Director of Health, she does serve as the liaison between Utah's Ethnic Health Committee and the Executive Director. The South Carolina Office of Minority Health Director reports to the Assistant Commissioner. However, she participates in executive meetings between departments, where she is the voice for minority health concerns.

- *The Minority Health Contact Persons*. In Puerto Rico, the director of the Office of Federal Affairs is the official minority health contact person and reports to the Undersecretary of Health. In Wyoming, the minority health contact person reports to the Administrator of the Division of Public Health.

7. MISSION STATEMENTS

Although the wording of the mission statements of the established offices of minority health differs, common goals include ensuring that minorities get needed health care, that this health care is provided in culturally appropriate ways, and that factors which lead to disparities are eliminated.

Exhibit III-7 presents the goals of six of the seven offices of minority health as stated in their mission statements. (The Delaware Office of Minority Health had not yet formulated its mission statement at the time of the site visit.) The California and Florida mission statements specifically refer to reducing gaps in health status and eliminating health disparities. The Utah statement specifies improving the health of racial and ethnic minorities. All mission statements identify one or more methods to reach their ultimate outcome—eliminating disparities. These methods are summarized below:

- *Increasing State Capacity to Address the Health Needs of Racial and Ethnic Minorities*. California specifies the goal of increasing the capacity of the health department, health care providers, and ethnic and racial communities through training, technical assistance, and strategic planning; and the development and dissemination of information strategies and resources. One of three goals of the Utah Office of Ethnic Health is to "affect the legislative process so that decisions are made and resources allocated with an awareness of Utah's ethnic populations." Florida specifies the development of new and existing partnerships. The mission of the South Carolina Office of Minority Health is to provide leadership by promoting, advocating, and assuring efforts to improve the health status of minority populations.

- *Ensuring That Health Services Are Accessible, and Linguistically and Culturally Appropriate*. The Arkansas mission statement states that the goal of the Office of Minority Health is to ensure that "health services are appropriate, accessible, and sensitive to the needs of the minority population." One of Utah's goals is to "stimulate the development of mechanisms for bridging cultural and linguistic language barriers" to health care. Florida aims to develop strategies to increase the participation of minorities in health care professions.

Exhibit III-7

GOALS OF THE STATE OFFICES OF MINORITY HEALTH, AS STATED IN THEIR MISSION STATEMENTS[a]

Office of Minority Health	Goals
Arkansas Office of Minority Health	To assist in assuring that health services are appropriate, accessible, and sensitive to the needs of the minority population.
California Office of Multicultural Health	To increase the capacity of the [Health] Department, health care providers, and ethnic and racial communities to reduce gaps in health status among, and improve the quality of life, of California's diverse populations.
Delaware Office of Minority Health	(No mission statement at the time of the site visit)
Florida Office of Equal Opportunity and Minority Affairs	To eliminate disparities in minority health and to address the unmet needs of specialized populations.
Ohio Commission of Minority Health	To ameliorate the diseases and conditions that cause excess deaths among economically disadvantaged Blacks, Asians, Hispanics, and Native Americans.
South Carolina Office of Minority Health	To ensure the development or modification of policies, programs, strategies, and initiatives to effectively target and provide services to minorities.
Utah Office of Ethnic Health	To eliminate all barriers for ethnic populations of Utah with respect to health care. The three goals are: 1) to promote the physical and mental health of ethnic groups in the state of Utah; 2) to stimulate the development of mechanisms for bridging cultural and language barriers; and 3) to affect the legislative process so that decisions are made and resources allocated with an awareness of Utah's ethnic populations.

[a]Excluded are Wyoming and Puerto Rico since they have a minority health liaison but no established office or commission on minority health.

- *Seeking Ways to Ameliorate Health Problems That Are Prevalent among Racial and Ethnic Minorities.* The mission of the Ohio Commission on Minority Heath is to "ameliorate the diseases and conditions that cause excess deaths among economically disadvantaged Blacks, Asians, Hispanics, and Native Americans." California's Office of Multicultural Health advocates "for policies and practices that increase the

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effectiveness by the Department of Health Services to diverse communities." The Florida mission is to "address the unmet needs of specialized populations." The mission of the Arkansas Minority Health Commission is to "seek ways to provide education, address, treat, and prevent diseases and conditions that are prevalent among minority populations."

8. FUNCTIONS OF THE MINORITY HEALTH ENTITIES

Sections V and VI of this report describe in detail how the nine minority health entities (and other components of the state minority health infrastructure) address each of the four cross-cutting issues affecting the health status of minorities, and the seven priority health areas. Below is an overview of the main functions of the minority health entities presented within the framework of the ten essential public health services identified earlier in this report.

a. Essential Public Health Services That Fall Within the Domain of the Minority Health Entities

Seven essential public health services implemented by the minority health entities focus on increasing state capacity to enhance health care to minorities:

- *Mobilizing Community Partnerships to Identify and Solve Problems.* Most minority health entities either take the lead or are active participants in government task forces and community coalitions concerned with minority health. Such partnerships and work groups ensure the mobilization of all levels of the community: state officials, tribal representatives, health department staff, health care providers, representatives of community agencies, and individuals and families who are members of racial and ethnic minorities.

- *Informing, Educating, and Empowering People about Issues.* This is a key function of all minority health entities that participated in the study. The state offices of minority health inform and educate through newsletters, conferences, public service announcements, media campaigns, and health fairs. As needed, they arrange to translate materials. In addition, they serve as a resource to state health divisions and community-based organizations engaged in health promotion activities.

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- *Developing Policies and Plans That Support Individual and Community Health Efforts.* Minority health entities advocate for policies that improve the effectiveness of their communities, and serve in an advisory capacity to health departments and other decisionmakers.

- *Monitoring Health Status to Identify Community Health Problems.* Minority health entities collect data from state offices of vital statistics to determine the health status of minority populations and to identify disparities. However, the lack of readily available data from these other state offices make this task difficult. For a more detailed discussion of data challenges, please see Section V of this report.

- *Ensuring the Availability of a Competent Public Health and Personal Health Care Workforce.* A major role of most minority health entities is the conduct of cultural competence and diversity training for the health department. Moreover, minority health entities engage in a number of outreach, educational, and cooperative relationships to bring about an increase in the number of health professionals who belong to racial and ethnic minorities, and to increase the cultural competency of all health providers. Section V of this report contains further details on health professions departments.

- *Evaluating Effectiveness, Accessibility, and Quality of Personal- and Population-Based Services.* Several minority health entities have assessed the health needs of the Hispanic, Asian, and Native American populations in order to determine the accessibility and cultural appropriateness of existing services. A more extensive discussion of this topic can be found in Section V of this report, which addresses cultural competence and access to health care.

b.   Essential Public Health Services That Are Beyond the Scope of the Missions of the Minority Health Entities

The following four essential public health services are not provided by minority health entities as they are beyond the scope of their mission statements:

- *Researching New Insights and Innovative Solutions to Health Problems.* The minority health entities do not generally have a research function. They do, however, as mentioned above, conduct needs assessments, and may fund demonstration programs.

- *Linking People to Needed Personal Health Services and Ensuring the Provision of Health Care When It is Otherwise Unavailable.* The minority health entities work to ensure access to health care by advising and training health providers on ways to remove existing linguistic and cultural barriers. However, none of the minority health entities in this study directly refer, or otherwise link, individuals to health services. Indirectly, referrals may occur when the minority health entity sponsors or participates in a health fair or community forum.

- *Diagnosis and Investigation of Health Problems and Health Hazards in the Community.* The minority health entities do not have administrative authority to conduct clinical or public health investigations.

- *Enforcement of Laws and Regulations That Protect Health and Ensure Safety.* The minority health entities do not have a regulatory function.

9. PERFORMANCE MEASUREMENT

To reach the end goal of eliminating health disparities, the minority health entities have a number of explicit or implicit intermediate objectives such as: increasing the number of linkages with community organizations, contributing towards greater awareness of health disparities throughout the health department, and increasing the cultural competence of health care providers. However, as discussed below, most minority health entities did not appear to have a formal system for determining whether these objectives were met. Also, because of the limitations of the available data, they had difficulties examining trends in racial and ethnic health disparities.

a. Documenting the Effectiveness of the Activities of the Minority Health Entities

The type of performance measurement used by the minority health entities appears to be a function of the performance measurement requirements of the organizational units where they were housed.

This is demonstrated by the following performance measures used in Arkansas and California. In Arkansas, the Department of Public Health's strategic plan is known as ASPIRE. The acronym stands for Arkansas Strategic Planning Initiative for Results and Excellence. For FY1999, the Department of Health required each work unit to set two strategic objectives, and to identify critical success factors. The two strategies of the Arkansas Office of Minority Health are: 1) to provide quarterly reports of the OMH activities of the Agency Director, Bureaus and community-based organizations; and 2) to develop a minority health calendar that targets preventive health initiatives. Performance measures for the Arkansas Office of Minority Health are therefore indicators of whether these two strategic objectives were met.

California requires state offices to develop specific objectives and performance measures for each strategic goal. The California Office of Multicultural Health aims to close the gap in health status and access to care for the state's minority populations. The office has identified specific objectives and performance measures associated with this effort.[6]

b.   Tracking Health Disparities

Systematically tracking health disparities over time requires reliable year-to-year data on health disparities. Most study sites reported that they had access to limited state-level health data on populations other than Blacks and Whites. Exceptions are California, which not only reports data for all major racial and ethnic groups, but also for subgroups; and Utah which is trying to separate out data for Polynesian and other Asian groups.

This is one reason why interviewees reported few strategies to systematically document and track changes over time. For instance, it took the Arkansas Office of Minority Health three years to obtain health data on categories other than Black and White. Similar concerns were expressed by key informants in Florida (where only limited data are available for Hispanics, Native Americans and Asians), Delaware, Ohio, South Carolina, Utah and Wyoming. Lack of statistical data for specific minority groups is a hindrance and prevents measurement of the extent of health problems and the determination of whether there has been an improvement.

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[6]Examples of objectives and performance measures developed by the California Office of Multicultural Health include the following: recruit for Director's appointment and orient 16 new members to the Task Force on Multicultural Health, by January 1999; convene four meetings of the Task Force on Multicultural Health, by July 1999; provide the director of the department and relevant programs with Task Force recommendations in the following areas: Medi-Cal Managed Care, Health Families, Welfare Reform, and Improving the Health Status of Blacks by July 1999; and work in partnership with department programs to identify strategies for closing the gap in health status and access to care among the state's racially and ethnically diverse communities.

c.   Linking State Objectives to Healthy People 2000 or 2010 Objectives

At the time of the site visits (Spring 1999) most of the states visited had yet to place a large emphasis on eliminating health disparities based on *Healthy People 2000* or *Healthy People 2010*. Many states have their own versions of these documents, such as *Utah's Healthy People 2000 Status Indicators*, or have strategic plans that spell out health goals based on those offered by *Healthy People 2000*. However, most of these goals do not relate directly to minorities or efforts to 'eliminate the gap.' Several interviewees indicated that while the *Healthy People 2000* and *Healthy People 2010* goals were important and served as benchmarks, the state had to adjust its own goals relative to what could be achieved with the state's population, health department, and political climate. Therefore, only a few programs existed that specified *Healthy People 2000* or *Healthy People 2010* as their guide for addressing minority health disparities. Delaware, for instance, has contracted with the Public Health Foundation, to develop a *Delaware 2010* plan and report. Presently, Puerto Rico uses the desired health data for residents of the continental United States as its benchmark.

D.   MINORITY HEALTH INFRASTRUCTURE IN THE STUDY SITES

The minority health entities constitute but one component of a state or territory's minority health infrastructure. In most sites, these entities served a coordinating function on issues related to minority health not only with health department agencies, but also with the minority community and other public and private sector agencies concerned with the health status of racial and ethnic minorities.

1.   LINKS BETWEEN THE MINORITY HEALTH ENTITIES AND THE MINORITY COMMUNITY

Historically, the minority health entities have strong links to the major minority populations in their state or territory. The extent and form of the linkages varied by site and by ethnic group. The most formal linkages were found in California between the Office of Multicultural Health and the California Pan Ethnic Network whose members include the following four organizations: the Latino Coalition for Healthy Californians, the California Rural Indian Health Board, the California Black Health Network, and the Asian American Pacific Islander Health Forum. In states with new minority health directors (i.e, Delaware and Florida), these linkages were the least well-established. Delaware state officials reported that communication and collaboration with minority communities was expected to be the main function of the new director of the Delaware Office of Minority Health.

Below is a brief overview of linkages between the minority health entities and the minority communities in Arkansas, Ohio, South Carolina, Utah, and Wyoming:

- *Links with the Black Community.* There appeared to be a direct association between the length of time that the director had been associated with the minority health entity and the strength of these relationships. The directors of the minority health entities in Arkansas, Ohio, and South Carolina, had long-lasting and deep roots in the Black community.

- *Links with the Hispanic Community.* At the time of the site visits, minority health entities in Arkansas, Ohio, and South Carolina, were developing increasing linkages with the Hispanic community. Key informants reported that in the past, the majority of Hispanics in these states had been migrant and seasonal farm workers. The key informants also reported that changes in labor patterns have resulted in large numbers of Hispanics settling in these states (attracted to some extent by employment opportunities in the poultry industry and construction).

- *Links with the Asian and Pacific Islander Communities.* Generally, links with Asian American communities were less well developed than with the Black and Hispanic communities. An exception is Utah where the Office of Ethnic Health works closely with two state government offices: the Utah Office of Asian Affairs which assists the Governor and other state agencies in addressing social problems (including a number of health issues) among Asian Americans in Utah, and the Utah Office of Polynesian Affairs which provides Polynesians and Pacific Islanders with access to state services and information.

- *Links with Native American Tribes and Other Indian Communities.* In states with small numbers of Native Americans (and few if any federally recognized tribes), the minority health entities appeared to have limited linkage to the Native American community. In Utah and Wyoming, most health department divisions have links to Indian tribes; the minority health entities work in a consulting role on many of these initiatives.

2. OTHER COMPONENTS OF THE MINORITY HEALTH INFRASTRUCTURE

Other components of the minority health infrastructure in the nine study sites include the following:

- *State-Level Plans to Eliminate Health Disparities*. The strategic plans of all sites but Arkansas and Wyoming specify goals addressing health disparities.

- *State-Level Task Forces and Coalitions*. All sites but Puerto Rico identified existing or proposed minority health task forces, advisory groups, or coalitions.

- *State Entities with a Specific Focus on Minority Health or Minority Affairs*. California, Florida, South Carolina and Utah have within their infrastructure other divisions or commissions with a specific minority focus. Some focus specifically on health issues, others have a broader focus on minority affairs, but include activities directed at reducing health disparities. These other organizational units generally work closely with the minority health entity.

- *Minority Health Initiatives Sponsored by Other Federal Agencies*. Other DHHS agencies that impact state programs for minorities include: the Centers for Disease Control and Prevention (e.g., HIV Prevention Community Planning Grants); Health Services and Resources Administration (e.g., programs under the Ryan White Comprehensive AIDS Resources Emergency Care Act, the Area Health Education Centers program, the Migrant Health Center Program); and the Substance Abuse and Mental Health Services Administration (e.g., the Substance Abuse Prevention/HIV Prevention Initiative for Youth and Women of Color).

- *Minority Health Initiatives by Other State Agencies*. In most states, the following four programs often have a specific focus on minorities because of their constituencies: offices on rural health, migrant health, refugee health, and women's health.

- *Multi-State Initiatives*. Examples include three projects with a minority health focus in which Arkansas is a participant: the

Mississippi Delta project, funded by CDC and the Agency for Toxic Substances and Disease Registry (ATSDR); and two consortia of programs serving migrant and seasonal farm workers.

- *Minority Health Initiatives by Private Sector Organizations.* These include initiatives by nonprofit community-based organizations, the business community, and the faith community.

- *Private Sector Minority Health Coalitions.* Two examples are: the Ohio Women of Color Network; and the California Pan Ethnic Network. Key member agencies of this latter network are: the California Black Health Network, the Asian Pacific Islander American Health Forum, the California Rural Indian Health Board, and the Latino Coalition for Healthy Californians.

- *The Academic Community.* The Historically Black Colleges and Universities in Arkansas, Florida, and South Carolina contributed significantly to the state's minority health infrastructure. Other initiatives in the academic community include the work on behalf of the Hispanic community by the Families in Society Institute at the University of South Carolina.

SECTION IV

Cross-Cutting Issues

IV. CROSS-CUTTING ISSUES

This section discusses four cross-cutting issues that contribute to the health disparities between the White population and racial and ethnic minorities: data collection and analysis, cultural competence, access to health care, and health professions development. The discussion of each cross-cutting issue starts with an overview of key approaches identified by key informants, and concludes with a discussion of challenges faced by the minority health entities and the states.

A. DATA COLLECTION, ANALYSIS, AND REPORTING

Data on racial and ethnic minorities for most health conditions remain limited in most of the states visited, and is of particular concern for Native Americans and subpopulations of other racial and ethnic minority groups. As described in earlier sections of this report, the study sites use different racial and ethnic breakouts to collect and report data on minority populations.

A lack of data on minority groups in a state creates many complications for a health department and the statewide health infrastructure. Limited minority health data make it difficult or impossible for health agencies to identify health disparities in the area, which could adversely affect the health of state residents. The lack of data also makes justification of special initiatives targeted towards minority populations difficult since the nature and extent of health problems in these populations are not known. Further, without data on the health conditions of minority groups in the state, it becomes difficult to measure the progress made by existing state initiatives directed towards addressing minority health disparities.

The process of delaying the collection of health data on minority populations is often circular and self-sustaining. Many key informants reported that it is not feasible to collect and report health data on minority populations because they believe that the minority populations are too small and rates would therefore be misleading. However, this attitude then prevents collection of detailed data to indeed show that there are limited minorities within a state. In every state visited, members of community organizations (and several health department employees) believe that official population counts are understated for racial and ethnic minorities, and in some cases severely so.

1. STRATEGIES

Despite these data collection challenges, most sites visited were attempting to improve the data that they collect and report on racial and ethnic minorities. The strategies used by the sites can be grouped into five categories: a) analyzing and distributing data on previously unreported populations; b) training data collection and analysis staff; c) examining health status of subpopulations; d) making new estimates or collecting new data on previously unreported populations; and e) responding to federal data collection requirements.

a.   Analysis and Distribution of Data on Previously Unreported Populations

Most of the sites collect some health data by racial and ethnic groups for federal reporting purposes. However, most do not provide racial and ethnic breakouts beyond Black and White (or non-White and White) populations in state documents. Several of the minority health entities visited have recently begun to work more closely with major data offices within their states to request data for minority populations and attempt to address some data collection and analysis barriers.

b.   Training of Data Collection and Analysis Staff

Two of the study sites have undertaken initiatives to standardize and emphasize data collection among minority populations. In California, the Executive Staff of the Department of Health Services developed a document entitled *Guidelines on Race/Ethnicity Data Collection, Coding, and Reporting* to standardize the department's collection and reporting of racial and ethnic data. To help physicians and health care providers carry out their reporting responsibilities, a number of Puerto Rican programs at the island level make training available on the importance of data and proper data reporting.

c.   Examination of Subpopulations

A few sites visited also have pursued efforts to collect information on subpopulations of minority groups, particularly among Asian Americans and Pacific Islanders. In California, efforts are made to examine age-adjusted death rates among Mexican Americans, Puerto Ricans, and Cuban Americans, along with nine separate Asian groups and three Pacific Islander groups. The state of Utah, through its Office of Polynesian Affairs, has made attempts to collect and report separate health information and data for Pacific Islanders since they often face very different health problems than other Asian populations.

d. New Estimations or Data Collection on Previously Unreported Populations

To address specific populations viewed as vital within their states, a few health departments collected new data on some racial and ethnic minority populations. For example, several states are facing growing numbers of Hispanics but have only limited data on the population. In South Carolina, the Institute for Family Studies at the University of South Carolina is using mapping software to document pockets of the state where Hispanics are settling. In Delaware, following repeated requests from the Hispanic community, the Division of Public Health was able to estimate the size of the increase in the Hispanic population in Sussex County by developing estimates based on the birth and death records filed with the Division of Public Health's Office of Vital Statistics.

e. Responses to Mandatory Data Collection

Many of the sites studied implemented specialized data collection systems to meet federal requirements to receive funding. The most frequently identified specialized data set was for CDC's HIV/AIDS Community Planning Group requirements. The program requires data on HIV/AIDS incidence among minority populations in the funded states and localities.

2. ISSUES

A number of limitations to both national- and state-level data prevent a truly accurate picture of minority health disparities from being created in the United States. Also, a number of pending changes with national-level data should be addressed when conducting comparisons between the health conditions of different population groups. Discussion of the most prominent of these issues is provided here.

a. Differences in Reporting by States

States vary in the extent to which they report health data in state documents by race and ethnicity. Each of the sites visited had limited amounts of health data relating to minorities. Of the sites visited, none provided complete breakouts for the four major racial and ethnic minority categories examined in this study across the health priority areas. Two of the states in this study (Arkansas and Florida) distinguish only between Whites and non-Whites. Aside from Puerto Rico, AADR breakouts for Hispanics are provided by only three study sites (California, Utah, and Wyoming). Two states (California and Utah) provide health data for Asian Americans/Pacific Islanders; and two states (Utah and Wyoming) provide health data for Native Americans. For those states that provide only non-White data, it is possible to obtain data for Blacks, Whites, and 'others' from the national CDC WONDER database. However, the WONDER database

does not provide state-by-state breakouts for Asian Americans/Pacific Islanders, Native Americans, or Hispanics.

Comparisons between study sites are made difficult by the differences in the types of data reported by CDC, by study sites, and by the differences in reporting year. Four states reported data for 1997, while two states reported data for 1996. Utah and Wyoming presented aggregate data for 1993-1997, and Delaware presented aggregate data for 1992-1996.

b. Lack of Requests for Race- and Ethnicity-specific Health Data

Several interviewees indicated that the number of requests or identified needs for data on minority populations by policymakers within their states was limited. Without these formal data requests by policymakers within their states, minority health entities often have to wait years to obtain health data from their appropriate state agencies, delaying timely response to public health problems that exist within minority groups.

c. Incomplete Data on Health Status of Native Americans

Native Americans are often improperly classified as belonging to another race or ethnic group at the time of their death. This is especially likely to occur in areas that are distant from Indian reservations. As described in more detail in Section VI, the Indian Health Service (IHS) conducted a study using the National Death Index (NDI) maintained by the National Center for Health Statistics to determine the degree of miscoding. Section VI also discusses why obtaining accurate state-level health data on Native Americans is difficult because the IHS collects and reports data by IHS region rather than by state.

d. Year 2000 Adjustments to Age-adjusted Statistics

As described earlier, disparities in this report are presented according to differences in the age-adjusted death rate. However, the common method used to calculate age-adjusted death rates nationally and at the state level can present a somewhat inaccurate picture of disparities. The age-adjusted death rate is a rate used to make comparisons of mortality risks across different age groups. Described as a statistical measure, the age-adjusted death rate is a weighted average of age-specific death rates, where the weights have traditionally represented fixed population proportions by age based on the 1940 U.S. standard population. Age-adjusted death rates are widely accepted as a means to compare health conditions across different population groups and geographic areas since age distribution among groups often varies substantially.

However, recent efforts have been undertaken to change the standard for age-adjustment calculation to the estimated 2000 U.S. standard population. This change,

which is first reflected in *Healthy People 2010* (Conference Edition), was made to provide a more contemporary standard which more closely approximates the average risk of death found in current crude death rates. The change to the Year 2000 standard will have an effect on age-adjusted rates in the United States since the 2000 population standard will be considerably larger than the 1940 standard, and the size of the standard population by age impacts the age-adjusted death rates (Anderson and Rosenberg, 1998).

When using the Year 2000 standard for age-adjusted death rates, disparities between the minority groups (particularly Blacks) and the White population tend to decrease slightly. This decrease occurs with the new standard, since it places a greater weight on older populations to reflect the longer lifespans of Americans over the past 60 years. Use of the new Year 2000 standard also will produce age-adjusted death rates that were much larger than those found under the old standard. However, the new standard will produce disparity ratios that provide a more accurate approximation of the 'real' population than those produced with the 1940 standard.[1] Due to the changes in age-adjusted death rates between the two standards, it is important to keep in mind that rates using different standards should not be compared to each other.[2]

In this report, all age-adjusted death rates use the 1940 standard population as that is how data are still being reported in national and state publications.

e.   The Proposed Reclassification of Racial Categories

As discussed earlier in this report, the Office of Management and Budget (OMB) defined the minority groups commonly used for data collection. However, a change occurred on October 30, 1997, with the publication of OMB's *Standards for Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity* (Federal Register, 62 FR 58781-58790). The new standards modified data collection techniques to be used by the federal government which will allow a more accurate picture of the nation's changing racial and ethnic populations. The two major changes to result from the new standards are: 1) the ability for individuals to "mark one or more" racial categories, and 2) the division of the "Asian" and "Native Hawaiian or Other Pacific Islander" categories during data collection and reporting.[3] These changes make data collection and analysis more complex but will likely lead to more accurate data of the nation and its various racial and ethnic groups. Once again, this study reports data and information based on the older

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[1]Anderson, R.N., and Rosenberg, H.M., "Age Standardization of Death Rates: Implementation of the Year 2000 Standard," *National Vital Statistics Reports*, vol. 47 no. 3, Hyattsville, MD: National Center for Health Statistics, 1998.
[2]U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition, in Two Volumes), Washington, DC, January 2000.
[3]*Healthy People 2010*, Op. cit.

OMB standard simply because most of the information gathered from the states had yet to be presented in this newer format.

f. The Need for Data on Racial and Ethnic Subgroups

Each of the four identified minority groups experience great differences among each of their subpopulations in regard to health. In the Asian and Pacific Islander category alone there are at least 24 distinct subgroups which range from Chinese to Tongan. Each of these subgroups, while collectively reported as Asian and Pacific Islanders in health data, often present a range of different characteristics. For example, the 1997 infant mortality rate for Asians/Pacific Islanders as a whole was 5.0 per 1,000 live births, as compared to 6.0 for Whites. However, Hawaiians had an infant mortality rate of 9.0, while Chinese Americans had a rate of 3.1—demonstrating the wide variation among the group. These variations are not seen only among the Asian/Pacific Islander population. During the same time, the overall infant mortality rate for Hispanics matched that of the White population at 6.0 per 1,000 live births. However, Puerto Ricans had a rate of 7.9 per 1,000 live births, while the rate for Cuban Americans was 5.5.[4]

g. Resistance to Data Collection by Minority Populations

Another key challenge facing those attempting to improve data collection among minority groups is the distrust many minorities have for government institutions. Many minority groups have deep-rooted fears of federal and state governments and might be reluctant to cooperate fully in data collection efforts. These fears are often the result of historical as well as recent incidents that degrade the confidence of minorities in public health institutions. For example, one interviewee described a state public health fair directed towards migrant farmworkers that was raided by the Immigration and Naturalization Service. The interviewee pointed out that since that time, the Hispanic community has been very unwilling to cooperate with public health efforts. This distrust, combined with the transitory nature and limited incomes of minority groups, often makes it difficult to obtain accurate health data.

h. Implications of Reporting Data on Small Populations

One of the most consistent findings among interviewees who dealt with minority health data was their reported difficulty in working with minority populations that were very small. Small population size was the most common response given to questions concerning the limited collection and reporting of minority health data. Many populations

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[4]MacDorman, M.F. and Atkinson, J.O., *Infant Mortality Statistics from the 1997 Period Linked Birth/Infant Death Data Set*, National Vital Statistics Reports. Centers for Disease Control and Prevention, Vol. 47, No. 23, July 30, 1999.

are too small even at the national level to provide reliable and accurate mortality rates, creating even greater difficulty for states or local areas to collect and report this data. This concern becomes particularly significant with efforts to examine subgroups among the larger racial and ethnic categories. Reporting small numbers of certain causes of death, particularly suicide and HIV in counties or areas with small populations, could produce unreliable rates along with jeopardizing confidentiality.[5]

To address these concerns, a number of study sites chose to report racial and ethnic health data as a sum over several years or as an average over a number of years. The state of Utah presented a very detailed explanation of their efforts to report minority health data by using confidence intervals and described it in *Health Status in Utah by Race and Ethnicity*:

> For a number of the indicators, it is difficult to obtain a precise measure of the indicator for individual racial and ethnic populations because their proportions in Utah are small. To improve precision, data from several years have been combined. In addition, to indicate the precision of the results, we have included bars on the graphs indicating confidence intervals, which can be interpreted as the range in which we are 95 percent confident that the true rate lies. A narrow confidence interval (a small range) indicates that the result is based on a larger amount of data than one with a wide confidence interval (a large range).[6]

i.   Underestimates of Minority Mortality Rates

In addition to the above-named difficulties with collecting, analyzing, and reporting health data for racial and ethnic minorities, there are problems obtaining accurate mortality rates with these same populations. According to the National Center for Health Statistics, the mortality rates usually given for the White and Black populations are fairly accurate, but are understated by the following amounts for other populations: American Indians, 21 percent; Asian or Pacific Islanders, 11 percent; and Hispanics, 2 percent.[7]

The reason for this undercount often lies in the way the data are collected. Mortality data in the United States are based on death certificates that are filed in state vital statistics

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[5]U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition, in Two Volumes), Washington, DC, January 2000.

[6]Utah Department of Health, Office of Public Health Data, *Health Status in Utah by Race and Ethnicity*, March 1999.

[7]Rosenberg, H.M., Maurer, J.D., Sorlie, P.D., Johnson, N.J., et al., "Quality of Death Rates by Race and Hispanic Origin: A Summary of Current Research, 1999," National Center for Health Statistics, *Vital Health Statistics* 2(128), 1999.

offices. The demographic information completed on the death certificates (including race and ethnicity) is filled out by the funeral director based on information provided by an informant (family member or friend of the deceased). However, when an informant is unavailable, the funeral director must complete this information based on observation alone, often resulting in misclassification. For example, many interviewees indicated that Native Americans are often reported as Hispanics in the absence of an informant at the time of death.

Knowledge of these underestimates of mortality rates is important since the formation of effective health policies and programs are often based on mortality rates. If these mortality rates do not reflect the true nature of a population, then resources may be distributed inappropriately, particularly when the incorrect belief is held that some minority groups have health conditions that match those of the White population.

To address this problem, tables and charts presenting mortality rates for racial and ethnic minorities should indicate the tendency toward undercounts in prominent locations. Another potential solution would be to adjust reported mortality rates for bias. However, this adjustment could be difficult as it requires very detailed levels of information, including bias estimates by age, race, and sex at the national, state, and possibly local levels.[8]

B.   CULTURAL COMPETENCE

California, the state with the greatest diversity, has a number of statutory provisions on cultural competence in its Welfare and Institutions Code and in the California Government Code. (See Appendix E.) California defines and describes cultural competency in a health care setting as follows:

> Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services.[9]

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[8] Ibid.
[9] April 2, 1999 memorandum to Medi-Cal Managed Health Care Plans by the acting chief of the Medi-Cal Managed Care Division.

1. STRATEGIES

Strategies to increase the cultural competence of health care providers in the sites visited consisted of: a) providing cultural competency and diversity training to health department staff and health care providers; b) conducting needs assessments to determine cultural barriers; c) integrating culture-specific health care strategies; and d) developing culturally appropriate health promotion messages.

a. Providing Training in Cultural Competence and Diversity

In most sites, cultural competence and diversity training are spearheaded by the minority health entities. Another major source of such training are Area Health Education Centers supported by HSRA. These efforts are described in further detail below:

- *Examples of Training Provided by Minority Health Entities.* In Ohio and South Carolina, staff in the minority health entity provide diversity training to health department staff. Utah's efforts to address cultural competency in the health infrastructure begin with the Office of Ethnic Health and the Office of Human Resource Management. These two offices provide cultural competency train-the-trainer training on topics such as cultural diversity, employment discrimination, and new employee orientation.

- *Examples of Training Provided by Other State Health Programs.* The Office of Migrant Health in South Carolina provides cultural competency training and Spanish-language materials to providers who serve Hispanic migrant and seasonal farmworkers. The Utah Diabetes Control Program also provides training to a number of health care providers concerning the proper care of people with diabetes. A Certification Program was initiated in 1997 that ensures that providers meet national standards for diabetes care. Part of the required curriculum centers around culturally appropriate methods to provide diabetes treatment. The Diabetes Control Program also provides professional updates on cultural sensitivity to those who have received certification, as well as to medical students.

- *Examples of Training Provided by Area Health Education Centers (AHEC).* In Florida, educational efforts by the AHEC Network include the provision of a medical course in Spanish to health care providers to increase cultural

competence in the workforce. Nova Southeastern University's Cultural Sensitivity Clearinghouse, in conjunction with the Florida Border Health Education Training Center (HETC) program, disseminates books, pamphlets, and other types of information on migrant and minority health care issues and cultural sensitivity education. In Arkansas, AHEC Southwest partners with CABUN Rural Health Services, Inc., to provide training to health professionals. The program includes a Cultural Medicine Rotation at the Migrant Health Center in Hope. In addition, AHEC Northwest residents are required to perform an obstetrical rotation at the Indian Health Service hospital in neighboring Tahlequah, Oklahoma.

b.   Identifying Cultural Barriers

Key informants reported a number of needs assessments that are being conducted, or that were recently completed, to identify barriers to health care for specific populations. Some examples may be found below:

- In Ohio, the Commission on Minority Health was instrumental in the development of a strategy to identify and recruit minority males for prostate examinations. This effort led to a number of examinations which identified abnormal findings, motivating many men to get treatment. The Commission was then provided with additional funding from the Ohio legislature to develop educational materials targeted at minority males informing them of the importance of regular prostate screenings.[10]

- In California, the Office of Women's Health conducts an annual California Women's Health population-based health survey of 4,000 women aged 18 and older. Topics include access to health care, health status, mental health, cancer, and family planning. To make sure that the health needs of Hispanic women are included, the survey is conducted in English and Spanish. Data are broken out by major racial and ethnic groups. There are plans to conduct further breakouts for Asian subpopulations to distinguish between the health

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[10]Office of Minority Health, *The Office of Minority Health's National Minority Health Network*, January 1997.

needs of the major Asian groups (e.g., Japanese, Chinese, Korean).

- In Arkansas, the Minority Health Commission recently met with Asian groups in Northwest Arkansas to discuss the specific health needs of the Asian community. The Commission plans to provide training and translators to help conduct a health needs assessment. Also in Arkansas, the Office of Minority Health assessed the health needs and health care seeking practices of Hispanics. The report found that staff need in-service training on cultural and behavioral differences between Hispanics and non-Hispanics.

The Utah Cardiovascular Program works to identify needs of underserved populations, including minority populations, and then collaborates with the Office of Ethnic Health to determine a culturally appropriate response.

In South Carolina, the Institute for Families in Society at the University of South Carolina conducted an analysis of the needs of the migrant program, and assisted in the translation of materials. In addition, the South Carolina OMH is planning focus groups with Hispanic residents to identify their health care needs.

c.   **Integrating Culture-specific Health Care Strategies**

Several state health departments engage in a variety of methods to integrate other health care approaches into the U.S. health care system. Below are some examples:

- Ohio and Puerto Rico use female "encouragers" to conduct interviews, collect data, and provide services with appropriate methods to encourage participation by women in health care.

- Local Utah health departments use cultural advisors, *promatoras*, and other culturally relevant health care providers to reach pregnant women in need of prenatal care.

- The Integrative Medicine Clinic in West Valley City, Utah provides drug and alcohol abuse and addiction treatment through the use of traditional Western medicine combined with acupuncture and other traditional Chinese methods. Also in Utah, the United Way provides an Indian Walk-In Clinic in

cooperation with the Division of Substance Abuse to provide culturally relevant substance abuse services for Native Americans in Salt Lake City.

- In Wyoming, the administrator of the Division of Behavioral Health, State Mental Health and Substance Abuse Authority, has integrated sweat lodges into the state mental health hospital in an effort to make mental health services more culturally relevant to Native Americans.

d. Developing Culturally Appropriate Health Promotion Messages

A major concern expressed by key informants is the lack of culturally appropriate health promotion materials. Below are examples of some of the approaches used by the participating sites to develop materials, and to use media that are likely to reach the targeted populations.

- In Utah, the Health Department developed a series of culturally appropriate videotapes for various Asian and Pacific Islander cultures that stress the importance of cancer screening. For the Hispanic community, the Health Department provides bilingual literature and informational flyers stressing the seriousness of diabetes and treatment options, and distributes these in community centers, churches, and Hispanic grocery stores.

- In Puerto Rico, the Diabetes Association provides (often with the cooperation of the health department) health clinics in grocery and drug stores where physicians provide diabetes education and screenings.

- In California, the state funds a tobacco prevention program targeting racial and ethnic minorities. The messages are on the Latino, Black, and Asian radio stations. Others are placed on billboards in minority communities. Some of the foreign-language spots have been so successful that they have been translated into English for use with English-speaking groups.

- Also in California, a nutrition campaign uses public service television spots that show Black and Latino models selecting healthy groceries.

- In South Carolina, the leading Black radio stations and the Palmetto Health Alliance broadcast health messages to the community.[11] The information also is disseminated through booklets and on the Internet.

2. ISSUES

Issues identified by key informants relate to the need for health care providers and planners to be aware of changing demographic patterns and the implications of health care delivery, understand barriers to health care, and engage the minority community in developing health promotional materials.

a. Unexpected Increases in the Hispanic and Asian Populations in Some States

Although all of the sites are making great strides in addressing the needs of their minority populations, they have encountered some problems. One issue identified by key informants is the unexpected increase in the Hispanic and Asian populations. As mentioned above, several minority health entities have conducted, or are planning to conduct assessments of the health needs of Hispanics and Asians. The Arkansas study of the health usage patterns of Hispanics identified the need for staff training. This issue also was identified in South Carolina, where the Office of Minority Health reports that it is often called on to provide culturally appropriate materials for nonmigrant Hispanic clients of health care providers. Interviewees report a general tendency in South Carolina to assume that anyone who is Hispanic must be a migrant farm worker.

b. Distrust of Government Programs

Another issue identified in Utah was the fact that some Hispanics are undocumented aliens and are afraid to get medical treatment unless absolutely necessary. This fear is not totally unjustified. In Utah, the Immigration and Naturalization Service conducted a raid searching for illegal immigrants during a Spanish-language clinic for migrant farm workers, causing loss in confidence in the Diabetes Control Program and the Department of Health.

c. Need to Involve the Community in Developing Health Promotion Materials

The Utah Diabetes Control Program partnered with Bayer, Inc. and several leaders of the Navajo Nation to produce a video in Navajo and English to address concerns

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[11]The Palmetto Health Alliance is an integrated health care system in Little Rock consisting of: 1) the Palmetto Richland Memorial Hospital; 2) the Palmetto Health Alliance; and 3) the Palmetto Baptist Medical Center serving Columbia and Easley.

surrounding diabetes and to explain how to obtain treatment. The video, entitled *Walking in Beauty,* uses several Navajo Nation members to describe the symptoms of the disease, its health effects, and how to treat it. However, the Diabetes Control Program failed to get final approval from the Navajo prior to final production. As a result, the video cannot be used in Utah.

C.   ACCESS TO HEALTH CARE

Members of racial and ethnic minority groups often have to contend with barriers that prevent access to adequate health care. These barriers may be geographic, financial, cultural, or linguistic. Interviewees were queried about these barriers and asked to identify state and local approaches to increase access to health care.

1.   STRATEGIES

a.   Geographic Access

The 1999 Ohio State Health Resources Plan defines geographic barriers as follows: limited availability of health care providers and institutions (particularly in rural areas and inner cities); lack of transportation to health care providers; and limited participation by local health care providers in Medicaid or Medicare programs. As a result, Medicaid and Medicare recipients must travel even greater distances to find a health care provider.

Most efforts targeted at reducing geographic barriers attempted to increase the number of health professionals in medically underserved areas. With the exception of Delaware, all states covered by the study include counties that have been defined as Health Practitioner Shortage Areas by the Health Services and Resources Administration[12]. Twenty-eight percent of the counties in the seven states covered by the study have a shortage of mental health or primary care professionals (see Exhibit IV-1). Moreover, on the average, in about 16 percent of the medical-shortage counties, the percentage of minorities in the county's population exceeded the state average (according to 1990 Census data).

The overall purpose of many of the programs described below is to increase access for persons who are medically underserved, regardless of race or ethnicity. However,

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[12]HRSA designates areas of the country as medical, mental health, or dental health practitioner shortage areas (HPSAs) according to the following criteria: 1) the geographic area is rational for the delivery of health services; 2) a specified population-to-clinician ratio representing shortage is exceeded within the area; and 3) resources in contiguous areas are overutilized, excessively distant, or otherwise inaccessible. Source: http://www.bphc.hrsa.dhhs.gov/nhsc/Pages/about_nhsc/3D2_eligible.htm

Exhibit IV-1

**ACCEPTED APPLICANTS TO U.S. MEDICAL SCHOOLS
BY RACE AND ETHNICITY[a]**

Race and Ethnicity of Applicants	1990		1999		1990-1999
	Number of Accepted Applicants	Percent of Total	Number of Accepted Applicants	Percent of Total	Percentage Increase in Number of Accepted Applicants
Black	1104	6.42	1199	6.87	8
American Indian and Alaskan Natives	72	0.42	117	0.67	38
Hispanic, non-Puerto Rican	590	3.43	794	4.55	26
Puerto Rican—Living on U.S. Mainland	105	0.61	119	0.68	12
Puerto Rican—Living in Puerto Rico	216	1.26	210	1.20	-3
Asian and Pacific Islanders	2614	15.19	3442	19.73	24
Whites	12215	70.99	11030	63.23	-11
Others (U.S. citizens)	36	0.21	342	1.96	89
Others (Non U.S. citizens)	254	1.48	192	1.10	-32
Total	17206	100.00	17445	100.00	

[a]Source: American Association for Medical Colleges, 1999. http://www.aamc.org/stuapps/facts/famg5.htm

many key informants report that these initiatives increasingly include specific projects targeting minorities. Key informants report linkages between the minority health entities and these programs (e.g., Area Health Education Centers, federally funded health care centers, farm worker programs).

- *The Area Health Education Centers (AHEC)*. AHECs in Florida and South Carolina support training sites in medically underserved areas for medical students and other health professional students. Sites include rural and urban hospitals

and clinics, community health centers, migrant health centers, and indigent health centers. West Florida AHEC's Minority

Outreach is implementing a new project designed to reach Black populations in two counties to educate and provide outreach efforts concerning AIDS/HIV.

- *HSRA Grants.* HRSA grants increase services in rural areas (e.g., CABUN Rural Health Services in Southwestern Arkansas, the Helena Regional Medical Center in the Delta region of Arkansas).[13]

- *Recruiting Health Care Providers to Medically Underserved Areas.* One example of an effort to recruit health care professionals is SEARCH (Student and Resident Experiences and Rotations in Community Health) in Ohio which places residents and medical students in medically underserved areas.

- *Assigning Foreign Medical Graduates to Underserved Areas Through the J-1 Visa Program of the Immigration and Naturalization Service, U.S. Department of Justice.* This program permits foreign medical graduates to stay in the United States if they work in a designated health shortage area for three years post-residency. Key informants in Delaware, Ohio, Utah, and Wyoming mentioned this program.

- *Loan Repayment Programs.* In Utah, the Rural Physicians and Physicians Assistants Medical Education Loan Repayment Program encourages physicians and physician assistants to practice medicine in rural parts of the state by providing grants to repay education loans. A related program offers scholarships to prospective medical students in exchange for a

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[13]The Rural Health Outreach Grant Program is authorized by Section 330A, Title III of the Public Health Service Act as amended by the Health Centers Consolidation Act of 1996, Public Law 104-299. The program is administered by the Office of Rural Health Policy (ORHP). The purpose of this program is to support projects that demonstrate new and innovative models of outreach and health care services delivery in rural areas that lack basic health services. Grants are awarded either for the direct provision of health services to rural populations. In order to qualify for the program, applicants are required to develop network arrangements among three or more health care and/or social service organizations. The program is designed to address urgent problems and needs in rural areas. Since 1991, over 365 projects have been funded that have provided services to more than 2.5 million rural citizens across the country. Rural populations that have been served by these projects include rural minority groups and migrant and seasonal farm workers. Source: http://www.nal.usda.gov/orhp/orgrante.htm#Arkansas.

commitment to practice in underserved areas of rural Utah. Also in Utah, the Special Population Health Care Provider Financial Assistance Program offers educational loan repayment funds to health professionals who work in organizations that serve agricultural workers (many of whom are Hispanic), Native Americans, and other underserved groups.

- *Assigning Health Department Staff to Indian Reservations.* In Wyoming, in response to the high infant mortality rate among Native Americans, the state's Maternal and Child Health Program has assigned health department staff to work on one of the Indian reservations.

Other initiatives include bringing health care directly to underserved populations through outreach workers or the use of a medical van. For instance, the Utah Farmworker Health Program sends outreach workers into the fields with farm workers and provides information about available health care in the region. In only a few years of existence, the Farmworker Health Program has enabled nearly 2,000 individuals to receive medical screenings and receive needed health care. A similar program was reported by key informants in Ohio. Key informants report that health department staff use mobile medical vans to reach residents in rural areas of Delaware and Wyoming.

b. Economic Access

Financial barriers to health care include: 1) the lack of health insurance coverage; 2) gaps in coverage; 3) restrictions in coverage or obtaining appropriate services; and 4) restrictions in usage of proper health care services. Some key informants indicate that the very poor do not view health care as a high priority and as a result individuals do not seek needed services. A major topic discussed during all site visits was the impact that the Children's Health Insurance Program will have on health care access to children.[14] Minority health advocates are working with state health officials and community leaders to promote outreach efforts to increase participation by minority children.

Puerto Rico's Health *Reformá* has brought about an island wide reform of health care coverage designed to increase access for all Puerto Ricans. The Reformá provides

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[14]Title XXI, State Children's Health Insurance Program (SCHIP)—often called CHIP by the states—of the Balanced Budget Act of 1997 (PL 105-33) provides states with the opportunity to design comprehensive and meaningful health insurance coverage for uninsured children. The program targets children below age 19, living in families at or below 200 percent of the federal poverty level. States may use the grant money to expand Medicaid, develop a new program, or expand an existing program that provides health insurance, or use a combination of the two approaches. Source: http://www.nga/CBP/Activities/SCHIPInfo.AS

health care coverage to most of Puerto Rico's medically indigent persons, allowing them access to primary care and other services once they have enrolled in the program. Several health department agencies have instituted outreach efforts to make sure that eligible persons participate in the program. The Division of Maternal and Child Health provides access to mothers and women of childbearing age. The Mental Health and Anti-Addiction Services Administration sponsors a health insurance information program. Offices for Orientation and Coordination assist individuals seeking mental health and substance abuse services in completing the necessary paperwork so that they can obtain a health insurance card.

c. Cultural Barriers

Individuals from minority groups may be unaware of important information and services available to assist them in their effort to obtain health care, may be unable to navigate the health care system, or may have cultural fears or objections to certain medical practices. Strategies designed to remove cultural barriers include efforts to increase the racial and ethnic diversity of state public health staff and of health care providers and their cultural competence, and efforts to promote the delivery of culturally competent health care. The first strategy was covered under health professions development (Section IV-B); the latter two strategies are covered in the section on cultural competence (Section IV-D).

d. Linguistic Access

Differences in language often create a number of barriers between those who are seeking medical care and health care providers. Clinic staff and health care providers may be unable to communicate with their patients. Even if both individuals are able to speak to each other in some common language, fluency differences may prevent the expression of key facts about a patient's condition or the type of treatment recommended.

A number of states (e.g., Arkansas, Delaware, and South Carolina) reported being unprepared for the unexpected increase in the Hispanic population and the corresponding need for educational materials, Spanish-speaking health care providers, or interpreters. Florida key informants report that Spanish language materials must be adapted for Cuban, Mexican, Central American, Guatemalan, and various South American populations. Florida also currently lacks health education materials in Haitian-Creole.

The Utah Office of Ethnic Health has created a Medical Interpreter's Directory as a resource guide for persons needing culturally appropriate translation and interpretation in health care settings. The Office of Ethnic Health maintains materials in the following languages: Cambodian, Chinese, Hmong, Korean, Loatian, Russian, Samoan, Spanish,

Tagalog, Thai, Tongan, and Vietnamese. Its directory provides contact points for medical interpreters in 34 different languages.

2. ISSUES

Challenges to increasing access to health care by minorities include the state's lack of preparation for changes in the racial and ethnic composition of the population, the consequent need for new materials, the distrust of government agencies (including health agencies) by some racial and ethnic groups, and the pervading effects of geographic isolation and poverty on health care access.

a. Lack of Preparation for Changes in the Population's Racial and Ethnic Composition

Linguistic access is a concern for states (such as California and Florida) that historically have had a relatively large number of non-English-speaking minorities as well as for states that only recently have seen an increase in non-English-speaking minorities (e.g., Arkansas, South Carolina). Methods for handling the need for interpreters was not fully addressed during most site visits. California, on the other hand, is now considering developing standards for medical interpreters. However, the state feels that if the standards are set too high, the cost of interpreters will increase and the service providers will not be able to absorb the costs.

b. Need for New Materials

Most sites reported translating materials ranging from health promotion and information brochures to health department intake forms. The interviewers found that, generally speaking, minority health entities and local health department staff are not always aware of resources available from federal clearinghouses (e.g., clearinghouses run by CDC on HIV/AIDS and chronic diseases by SAMHSA on substance abuse prevention and mental health). Moreover, there appeared to be little sharing across states. Each site appeared to be engaged in separate but parallel efforts.

c. Distrust of Government Agencies

For some minority groups, distrust of government agencies constitute yet another barrier to access. This fear is especially strong in minority populations that include large numbers of recent legal immigrants as well as undocumented persons. The Arkansas assessment of the health-seeking behaviors of Hispanics found that many are reluctant to provide documentation such as social security numbers. Public health clinics do not require documentation on a person's work or legal status, and services are not denied if a

person does not have a social security number. However, social security numbers are requested for record-keeping purposes.

d.   The Effect of Geographic Isolation and Poverty

Geographic isolation and poverty are issues that affect all residents living in medically underserved areas. Key informants report that these issues are exacerbated for racial and ethnic minorities. Concerns regarding the cultural competency of health care providers in these areas were raised by several key informants, along with the need to increase health professions development efforts in rural areas. The effect of poverty on health disparities is especially severe when the poverty defines entire communities or regions. A 1997 report by the Columbia Urban League, *The State of Black South Carolina: An Action Agenda for the Future*, documents that Blacks in South Carolina have the lowest per capital income of those in any state in the nation. To quote one of the state's Black legislators: "Poverty produces disorganization for families and communities." He explained that in some communities, the priority is in getting enough to eat, not on health care. Furthermore, how can people realize that good health care is missing if they have never had it.

D.   HEALTH PROFESSIONS DEVELOPMENT

Underrepresentation of minorities in the health professions is a major concern affecting the delivery of health care services to racial and ethic minorities. Studies have found that trust in the health care delivery system increases if patients see that at least some of the health care providers are members of the patients' racial or ethnic group. A study by the Association of American Medical Colleges (AAMC) found that:

> . . .the primary cause of minority underrepresentation in medicine,
> other health professions and health-related academic fields is
> essentially the same—the scarcity of minority applicants who are both
> interested in and academically prepared for the rigors of health
> professional and graduate schools. This scarcity does not stem from
> a lack of interest in health careers. Rather, it is based primarily in
> educational disadvantages that disproportionately affect the same
> minority communities that have borne the brunt of prejudicial
> treatment throughout most of American history.[15]

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[15]Source: The Association of American Medical Colleges, Division of Community and Minority Programs, *Project 3000 x 2000 Year Four Progress Report*, April 1996.
http://www.aamc.org/meded/minority/3x2/houryear.htm

Key informants identified a range of federal, state, and local approaches designed to increase minority representation in the health professions. These initiatives include efforts to prepare minority adolescents for health careers, efforts to recruit minorities into the health professions, and efforts to increase the training available to persons working in health professions.

A number of these programs have been in effect for at least a decade, in part because of the Disadvantaged Minority Health Improvement Act of 1990 which addresses the access of disadvantaged individuals, including minorities, to health care and health professions opportunities. Exhibit IV-2 shows the improvement in the number and percentages of minorities who applied and were accepted into medical school since 1990. Although there has been only a slight increase in the number of students accepted into medical school (17,206 in 1990; 17,445 in 1999), there has been an 11 percent decline in the percentage of "accepted applicants" who are White, and corresponding increases in the percentage of applicants from racial and ethnic minorities.

Another example of federal support in minority health professions development is the Program of Excellence in Health Professions Education for Minorities. The goal of this program is to assist certain health professions schools in supporting programs of excellence for minority individuals. The objectives are: to strengthen the national capacity to train students in the health professions, and to support health professions schools which train a significant number of minority health professionals.

The Association of American Medical Colleges (AAMC) launched *Project 3000 by 2000* in November 1991 to reverse what in the previous 15 years had been a worsening of minority underrepresentation in medical schools. The project's goal is to increase the number of underrepresented minority students in medical schools to 3,000 by the year 2000. AAMC defines the following racial and ethnic minority groups as underrepresented in the medical profession: Blacks, American Indians and Alaskan Natives, Mexican Americans, and Puerto Ricans residing in the continental United States. Other minorities (Asians and Pacific Islanders, Puerto Ricans residing in the Commonwealth of Puerto Rico, and other Hispanics) are not underrepresented.

Through *Project 2000 by 3000,* the AAMC has been trying to develop a national network of educational partners from the three main components of the health science education pipeline: 1) school systems with large minority enrollments; 2) colleges interested in revising the curriculum to better equip minority students for medical school and related graduate and professional programs; and 3) academic medical centers committed to increasing opportunities for minority students.

Exhibit IV-2

COUNTIES IN WHICH THERE IS A SHORTAGE OF MENTAL HEALTH OR PRIMARY CARE PROFESSIONALS

State	Total Number of Counties In the State	Counties with a Health Professionals Shortage		Percent of Counties in Which There is a Health Professional Shortage Areas and in Which the Percentage of Minorities Exceeds the State Average
		N	Percent	
Arkansas	75	28	37	13
California	58	7	12	7
Delaware	3	0	-	-
Florida	67	14	21	12
Ohio	88	12	14	0
South Carolina	46	17	37	28
Utah	29	14	48	17
Wyoming	23	16	70	22
Total	389	108	28	16

In 1999, AAMC, in collaboration with the Association of Schools for Public Health, the W. K. Kellogg Foundation, and the Robert Wood Johnson Foundation, initiated the Health Professions Partnership Initiative (HPPI). The initiative's goal is the development of partnerships between health professions schools and undergraduate colleges, community colleges, local high schools and middle schools, and community groups in order to improve student academic performance, academic skills, and interest in the health professions.

1. STRATEGIES

Below is a list of strategies designed to increase minority participation in the health professions—these are all strategies identified by key informants during the site visits. Not included in this list are efforts to enhance the cultural competence of health care providers or to increase the number of health professionals in medically underserved areas. These two topics are covered earlier under the discussion of cultural competence and access to

health care. The strategies to improve health professions development at the state level include:

a. Introducing Adolescents to the Health Professions Through Mentoring Programs and Summer Internships and College Preparatory Courses

One example is the Arkansas State Department of Health's partnership with a local junior high school to provide mentoring and summer internships.

b. Developing Strategies to Encourage Minorities to Enter and Remain in the Health Professions

For instance, the University of Wyoming has a summer program for minority students who want to study medicine. The university also has family practice residency programs that encourage minorities to apply. Key informants in Puerto Rico reported that the Island is finding it increasingly difficult to retain physicians because of the relatively low salaries. A number of initiatives provide continuing education and training to physicians who remain on the island. These include training by the Puerto Rican Heart Association, the Puerto Rican Diabetes Program, and the Island's Maternal and Child Health Division. In South Carolina, the Department of Health and Environmental Control has entered into a mentoring relationship with South Carolina's Historically Black Colleges and Universities in an attempt to develop future minority health professionals.

c. Promoting Advanced Professional Training for Minorities Working in the Health Professions

It is even more difficult for minorities to enter medical school or obtain a degree in public health if there are no medical or public health programs in the state. For instance, Arkansas does not have a school of public health. In response, the Arkansas legislature has approved scholarships for university and health department staff to obtain a Masters in Public Health from Tulane University in Louisiana. Also, the state pays for staff to travel to Atlanta to participate in the CDC Graduate Certificate Program. Twenty-one credits obtained through the CDC program can be transferred to the Tulane School of Public Health. In Arkansas, the Academy for Public Health Leadership is sponsoring training in public health at the University of Alabama in Birmingham, as well.

d. Offering Technical Assistance to Colleges and Universities on Minority Professional Development

Key informants in California indicated that the Health Careers Opportunity Program (HCOP) provides technical assistance to colleges and universities on minority health

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professional development, and conducts research on the status of minority participation in the health professions. In Florida, the Office of Equal Opportunity and Minority Affairs, as well as the minority health advisory committee, report plans to collaborate with the Institute of Public Health and Masters in Public Health program at Florida A&M University (a Historically Black University in Tallahassee) to provide quality graduate education and training to minority students.

2. ISSUES

Issues affecting health professions development include the fact that in order to attract qualified minority applicants recruitment (including, in many cases, mentoring and related support efforts) must start as early as middle school. Also, efforts will be most effective if there is state-level support—from professional schools as well as from policymakers.

a. The Need to Interest Middle and High School Students in the Health Professions

A major issue affecting health professions development is the need to provide interventions at all levels of the "pipeline," starting with youth in middle schools and high schools to provide academic remediation as needed and to spark interest in health professions. Strategies reported by key informants include mentoring projects, "shadowing" days, and summer internships. These projects, even when run by volunteers, are time- and labor-intensive. Similar efforts are needed at the college level.

b. Lack of Health Professions Schools in Some States

A second issue is the fact that in some states, there aren't any schools in some of the health disciplines. For instance, Arkansas, as mentioned above, has no school of public health, and Delaware has no medical school. A program exists for students to attend the Jefferson Medical School in Philadelphia; however, the program does not specifically target minority students. This creates a problem for any student regardless of race or ethnicity, and exacerbates the situation for minority applicants.

c. Recognition of Need for Minority Health Professions in State Strategic Plans

One of the factors that is likely to contribute to a state's success in increasing minority enrollment in a health professions program is statewide support as expressed in state strategic plans.

SECTION V

**Efforts to Eliminate Disparities
in the OMH Priority Health Areas**

V. EFFORTS TO ELIMINATE DISPARITIES
IN THE OMH PRIORITY HEALTH AREAS

This section presents approaches used by the minority health entities and other components of the sites' minority health infrastructure to eliminate disparities in the following health areas: cardiovascular disease, cancer, diabetes, infant mortality, substance abuse, HIV/AIDS, and suicide, homicide, and unintentional injuries.

Information is presented here on the major strategies used by the sites to eliminate disparities in these health priority areas. Generally speaking, these strategies consist of a combination of the following: task forces and consortia; community planning; needs assessments; social marketing campaigns; the development of disease prevention and health promotion materials; outreach; strategies to increase access to treatment; training health care providers and health department staff; technical assistance; and conferences for community members or health professionals. The text specifies whether the strategies were implemented by a minority health entity, a state organization, or the private sector (e.g., community-based organizations, the faith community). A discussion of issues and challenges follows the discussion of approaches and strategies that are currently in use to address each health priority area.

The activities presented in this section are those identified by the key informants during visits to the nine sites. The list is not exhaustive; rather, it is illustrative of the many and varied activities that may be implemented in a given state.

A. CARDIOVASCULAR DISEASE

Nationwide, and in the study sites, cardiovascular disease was the leading cause of death for all racial and ethnic groups. In every study site except Wyoming and Puerto Rico, Blacks faced cardiovascular disease AADRs higher than Whites. Native Americans in Wyoming also suffered disparities in cardiovascular disease. For Hispanics and Asian Americans, the AADR for cardiovascular disease is generally not as high as that of Whites. However, interviewees reported that the death rate in these populations is increasing, due in part to increasingly high levels of cholesterol in diets.

Blacks also suffered the highest disparities for strokes and heart disease at the national level and in the study sites, but a number of other disparities became apparent during the study. According to California data from 1990, certain Pacific Islander groups (Guamanians and Samoans) suffered disparity rates larger than those of Blacks. Ohio Asian Indian males were three times more likely to suffer strokes than White males in the state, while Asians/Pacific Islanders and Hispanics had higher associated risk factors for

cardiovascular disease (i.e., high cholesterol and blood pressure) than Whites, but had lower age-adjusted death rates.

1. STRATEGIES

Since the greatest disparities in cardiovascular disease are between Blacks and Whites, it is not surprising that the two study sites with the highest percentage of Blacks (Arkansas and South Carolina) provide the most examples of approaches aimed at addressing cardiovascular disease among minorities. Most of these activities, along with efforts in other study sites, focus on providing outreach services and culturally appropriate information. Approaches identified during the interviews to eliminate disparities in cardiovascular disease are described below.

a. Needs Assessments

Several states had already taken efforts to identify their at-risk groups for cardiovascular disease, but one site was planning a new initiative to get a better sense of the needs of their minority populations. The Southern Wyoming Regional Office of the American Heart Association will soon conduct a needs assessment and create a business plan that will focus on addressing heart disease and cardiovascular issues among the state's low-income Black and Hispanic communities.

b. Social Marketing Campaigns

Several social marketing campaigns were identified by key informants as being successful in reaching minority populations. One example is the California Nutrition Program which obtained funds from the private sector to implement a social marketing campaign aimed at improving the diets of minority individuals who use food stamps. The campaign featured public service announcements with Black and Latina models selecting healthy groceries. In addition, funding was provided to several grocery stores for the purchase of computers that could provide healthy recipes to shoppers.

In South Carolina, the health department received a three-year grant from the National Institutes of Health to implement the Strike Out Stroke initiative to provide information on behavior changes necessary for good cardiovascular health to the state's Black communities. The South Carolina Office of Minority Health cooperated by providing resources and information on the best techniques to reach the minority community, as well as participating on the initiative's advisory panel.

Taking a different focus, the Puerto Rico Heart Association is planning to begin a small campaign which stresses the importance of learning cardiopulmonary resuscitation (CPR) techniques. The organization will provide CPR training, discuss how it can be

used to save lives when used in a timely fashion, and translate available materials into Spanish for the island's population.

c. Educational Materials

Several sites report having to adapt Spanish-language materials to the colloquial Spanish spoken by Hispanic groups in their state. The Utah Cardiovascular Disease Program developed a special set of informational documents and screening procedures for the Navajo and Vietnamese residents of the state. The program also works with the Utah Office of Ethnic Health in translating relevant health literature into a variety of other languages to meet the needs of other minorities.

d. Outreach

Most of the study sites' activities focused on providing cardiovascular disease outreach services to minority populations. A number of the sites provided these activities by funding local organizations. For example, the Puerto Rico Cardiovascular Program works with a number of local programs to increase the level of education and prevention efforts in local populations. The programs focus on modifying risk factors and decreasing the prevalence of heart disease, all within the important context of culture and lifestyle. Two other study sites provide extensive grant programs to community organizations to provide cardiovascular services.

The Florida Cardiovascular Disease Program funds a number of community- and school-based projects which provide outreach services to minority populations. One program provides funds to a high school with large Hispanic and Black populations that conducts school-based wellness and fitness programs along with health fairs. Another program works with community groups within a county, including Black rural community groups, churches, work sites, middle and high schools, and daycare facilities to provide the following services: no-cost blood pressure and cholesterol screenings, tobacco education, smoking cessation programs, nutrition education, exercise and fitness education, and stress management.

In Ohio, the Cardiovascular Disease Risk Reduction Program provides Community Heart Health Grants for the coordination of community-based interventions and programs at the county level that seek to reduce cardiovascular risk. The program also funds a series of High-Risk Population grants to support primary prevention programs directed at high-risk populations with a predominant focus on Blacks. The grantees provide the following services: outreach to minority communities; detection and referral for diagnosis and treatment; follow-up on compliance with, and understanding of, prescribed treatment; and population-based interventions.

Some state health departments directly conducted activities aimed at reaching minority populations with cardiovascular information and screenings. For example, the Utah Cardiovascular Disease Program conducts health fairs that include blood pressure screenings, healthy diet and recipe demonstrations, and other cardiovascular information for the state's Japanese, Tongan, Samoan, and Black populations. In Wyoming, the health department was in the process of designing a statewide cardiovascular screening program for low-income minorities.

Perhaps the most impressive effort to provide cardiovascular services to minorities was found in South Carolina. In response to a 1994 study showing that a 13-county region in South Carolina had the largest heart disease and stroke disparities in the nation a free-standing nonprofit health organization called PeeDee Minority Health was formed. PeeDee Minority Health provides various cardiovascular outreach services to the Black population and the increasing Hispanic population, along with conducting three specialized workshops per year for the Native Americans who live in the state, and in particular for those in the PeeDee Region.

e. Increasing Access to Treatment

Several of the outreach programs identified above also worked to increase access to treatment services for minority groups. In addition to these, one example was found of a program directed at increasing access to clinical care for minority groups. The Arkansas Heartwatch program is a funded collaboration among that state's Office of Rural Health, a rural health community agency, the University of Arkansas Medical School, the AHEC program, and the Department of Health. The program provides clinical care and support groups in a five-county area in the southwestern part of the state which is primarily rural and has a population that is largely uninsured, unemployed, and Black.

f. Training

Two sites also were pursuing efforts to provide continuing education and training to health professionals across the state. The Puerto Rico Cardiovascular Program provides training to physicians and health care professionals to ensure that screenings for cholesterol and blood pressure are being provided according to government-established guidelines. Also in Puerto Rico, the Puerto Rico Heart Association cooperates with the Departments of Health and Education to provide training and materials to teachers regarding nutrition, exercise, and smoking intended to change the habits of their students. In Ohio, the Cardiovascular Disease Risk Reduction Program provides professional education efforts which include a regular blood pressure measurement standardization workshop for health care professionals along with an annual workshop on cardiovascular risk reduction strategies.

g. Conferences

Conferences also were identified as important venues to provide information for health professionals. The Puerto Rico Heart Association conducts a number of lectures along with an annual conference which provides physicians and health care providers with updates and additional information concerning cardiovascular disease. In South Carolina, the health department is in the planning stages for a tri-state (North Carolina, South Carolina, and Georgia) conference on strokes—the area is described as the 'stroke belt of the South.'

2. ISSUES

While the study sites are pursuing a number of successful activities to address cardiovascular disease in minority populations, several challenges still remain. Both at the national and state levels, a variety of issues continue to present difficulties in efforts to address disparities in cardiovascular disease among minority populations.

a. Need for Accurate and Complete Data

Several states still lack complete information on a number of their minority groups, particularly in relation to cardiovascular disease risk factors. The use of more complete data collection methods and reporting tools could provide improved information to agencies and organizations that provide cardiovascular services. With this new information, programs can more accurately determine what programs have been effective and concentrate on populations that still exhibit disparities. This same issue applies to the other health priority areas discussed later in this section.

b. Limited Knowledge Regarding Cardiovascular Disease

Despite extensive efforts to provide information to minorities regarding cardiovascular disease, greater efforts need to be pursued to provide information to minority groups. Key informants indicated that minorities are still not grasping the importance of health screenings and behavior changes to improve cardiovascular health.

c. The Importance of Community Involvement

Key informants repeatedly indicated that, based on their observations, those cardiovascular programs that had strong connections to their communities seemed to be the most effective. Most interviewees pointed out that a strong relationship with a local or community organization can provide valuable insight into the most effective ways to reach certain populations. However, state government agencies and organizations must often

spend a great deal of time identifying and then working with these local groups to realize the full effectiveness of their programs.

B.   CANCER

Throughout the United States, Blacks die from cancer (all sites) at a rate higher than the White population. This trend was mirrored in the sites visited for this study; all study sites except Puerto Rico reported cancer mortality disparities between their Black and White populations. While most of these disparities were fairly small when examining all cancers and cancer sites as causes of death, the disparities became much more pronounced with a more detailed examination of certain types of cancer. For breast cancer, several study sites reported significantly higher mortality rates for their Black populations than Whites. Similar trends were seen in lung and prostate cancer. In addition, Puerto Ricans had a far lower incidence of breast cancer than the U.S. population, but were more likely to die from breast cancer than mainland Whites.

Additional disparities were noted in cancer sites that are not commonly examined when looking at age-adjusted death rates. For example, Puerto Ricans have the third highest incidence and mortality rate for oral cancer in the world, far surpassing the rate for U.S. Whites. Further, Ohio Asians and Pacific Islanders have a far higher mortality rate from liver cancer than Whites.

1.   STRATEGIES

Most state cancer initiatives directed at minorities identified during the site visits focused on increasing cancer screenings. However, states also pursued a number of other methods to provide cancer information to racial and ethnic minorities. States implemented social marketing campaigns, provided information and materials in various languages, and used other methods described below to reach minorities.

a.   Task Forces and Consortia

To address the high incidence of breast and cervical cancer in Delaware among minorities, the Division of Public Health organized an advisory group that includes community members and representatives. The advisory panel provides direction and feedback regarding the division's outreach activities into the Black and Hispanic communities.

b. Social Marketing Campaigns

Two study sites implemented substantial social marketing campaigns to provide information regarding cancer risks and the importance of screenings to their minority populations. In South Carolina, the Department of Health and Environmental Control worked with two local radio stations and a local community organization to provide health messages to the community regarding the importance of cancer screenings for breast, cervical, and prostate cancer, in addition to other healthy living messages.

In California, two large social marketing campaigns for minorities were implemented with the goals of decreasing tobacco use and lung cancer. The first campaign used competitive grants to develop culturally appropriate public service messages for television and billboards. The public service announcements were broadcast on television stations with traditionally high viewership among Hispanic, Black, and Asian groups. The campaign was so successful that many of the spots were translated or reformatted to be used with the general public. In a separate campaign, the state implemented a campaign to counteract a series of tobacco advertisements directed at Native Americans and Alaska Natives.

c. Educational Materials

Study sites also were successful in developing educational materials focusing on cancer screenings and examinations for minority groups. The Ohio Commission on Minority Health was instrumental in developing of a strategy to identify and recruit minority males for prostate examinations. This effort led to a number of examinations which identified abnormal findings, motivating many men to get treatment. The commission was then provided with an additional set of funds from the Ohio legislature to develop educational materials targeted at minority males informing them of the importance of prostate screenings. In Utah, the Cancer Control Program developed culturally appropriate videotapes for various Asian/Pacific Islander communities that stress the importance of cancer screenings.

d. Outreach

Many study sites used some form of outreach activities to directly provide valuable information regarding cancer in minority communities. Often, these outreach activities included the provision of free screenings to individuals from racial and ethnic minorities. For example, the Florida Breast and Cervical Cancer Early Detection Program screens women in nine counties. Over half of the women screened during the program's five-year history were from racial and ethnic minorities.

In addition, several state programs provide funding to community organizations to conduct free cancer screenings. The Ohio Breast and Cervical Cancer Prevention Project funds twelve regional programs throughout the state which provide free breast and cervical cancer screenings. In Arkansas, the health department contracts with community-based organizations to provide mammograms to minority women.

Several other state organizations focus on providing information to minority groups encouraging them to seek out cancer screenings. For example, the Wyoming health department is making efforts to reach the Black community by providing cancer screening information through the community-based African American Wellness Project.[1] In Utah, the Cancer Control Program undertakes a number of steps to encourage women from racial and ethnic minorities to obtain screenings. For the Native American population, the program conducts screenings on reservations throughout the state, and a clinic is available at Fort Duchesne on the Uintah and Ourray Reservations. The Cancer Control Program also has an outreach worker specifically for the Hispanic population and provides screening support and information through a number of Spanish speakers.

Community and non-profit organizations also play a large role in providing outreach services. In eastern Arkansas, the church-based breast cancer Witness project is conducting an outreach program in the Black community aimed at increasing awareness of breast and cervical cancer. Delaware's Planned Approach to Community Health (PATCH) organization is working with the American Cancer Society to reach Black males who are not being screened for prostate cancer. Strategies include working with churches and fraternities, a buddy-to-buddy volunteer program, a media campaign, placards on buses, and special wellness days at local hospitals.

e.   Training

Another method used to provide valuable cancer services to minority populations was the training of individuals who have direct contact with various minority groups. An example of this was found in Wyoming, where the health department provided cancer screening training for staff on the Wind River Reservation and for local Indian Health Services staff. The training focused on methods to discuss the importance of cancer screenings with tribal populations and providing the screenings in culturally appropriate manners.

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[1] The African American Wellness Project is operated by the African American AIDS Project in Wyoming. Its original intent was to provide a mobile source of HIV/AIDS testing and information to the state's Blacks. However, additional funding was provided to expand the project to include a general wellness component, which addresses cancer screenings. The project also provides information to other minority groups in the state, including American Indians who live off reservations.

2. ISSUES

Key informants identified a number of critical challenges that impact the level of cancer services that are accessed by minority groups. These key challenges can be categorized into three groups: 1) lack of health insurance by racial and ethnic minorities; 2) incomplete information regarding cancer risks and screenings; and 3) cultural predispositions against screenings.

a. Lack of Health Insurance

A lack of health insurance by minority groups in the study sites prevents them from seeking preventative cancer care such as screenings or even early treatment. This condition often leads to the situations that were observed in most of the study sites where minorities have lower cancer incidence rates than Whites, but have higher mortality rates since their cancers are detected at far later stages. And while many sites are providing free or low-cost screenings, they often do not have the resources to reach all minorities who are unable to obtain screenings on their own.

b. Lack of Understanding of Benefits of Preventive Health Care

Another challenge is the lack of information that minorities have about the seriousness of cancer and the benefits of early detection. Many minorities are simply unaware that screenings can provide valuable information that can be life-saving. Others do not think that they are at risk for cancer or do not comprehend the dangers in delaying detection of the cancer. Continued education campaigns focusing on altering risky behaviors and stressing the importance of early detection could prove valuable in reducing disparities among a number of minority groups.

c. Effects of Culture-specific Health Seeking Behaviors

Cultural norms also have a large impact on efforts to provide cancer screenings and treatment to minority populations. Many minority groups will simply not visit a physician until they are very sick, believing that as long as they can go about their daily activities they are fine. However, this attitude often results in situations where conditions such as diabetes or cancer are allowed to progress to dangerous levels. Further, some individuals from racial and minority groups have a strong sense of fatalism; they believe that if their health is destined to deteriorate, there is nothing that physicians can do about it.

C. DIABETES

Each of the study sites reported health disparities between their minority populations and the White population in diabetes. Puerto Ricans are three times more likely to die from diabetes than U.S. Whites, while Blacks in every study site were at least twice as likely to die from diabetes than Whites. In the state of Utah, all minority groups had greater AADRs from diabetes than Whites. In California, Asian/Pacific Islanders and Hispanics in California also were more likely to die from diabetes than Whites.

1. STRATEGIES

Activities by minority health entities, state agencies, and the private sector consisted primarily of the provision of prevention messages and information on when, how, and where to get treatment, rather than providing treatment. The programs described below reflect the range of methods that states used to set priorities and include minorities in diabetes prevention activities.

a. Task Forces

Two of the study sites formed special statewide task forces to address many of the issues related to diabetes that minorities face. In South Carolina, a Diabetes Initiative was established in 1994 which includes the Office of Minority Health as an advocate for minority health needs. A similar statewide task force was formed recently in Delaware.

b. Social Marketing Campaigns

Many study sites have organized and implemented social marketing campaigns designed to provide culturally relevant information regarding diabetes to minority populations. The Utah Diabetes Control Program conducts a number of public awareness and screening campaigns to stress the seriousness of diabetes and associated risk factors. The Check Your Health campaign was developed with the assistance of the American Diabetes Association and uses radio stations and print media to provide diabetes risk factors, symptoms, and prevention strategies to various ethnic groups in culturally appropriate ways. In Ohio, the Diabetes Association of Greater Cleveland, through funding supplied by the Ohio Commission on Minority Health, operates a media campaign which provides diabetes information to minority groups in Cleveland. The South Carolina Department of Health and Environmental Control developed a Five-a-Day Campaign with the goal of changing the eating patterns of Blacks and encouraging them to eat five servings of fruits and vegetables a day.

c.   Educational Materials

A number of study sites either directly developed or supported the development or translation of diabetes information materials designed to reach minority populations more effectively. The state of California provides brochures in various languages informing persons with diabetes of the importance of getting the right kind of medical checkups. Targeted populations include Native Americans, Samoans, Blacks, and Hispanics. The Ohio Commission on Minority Health has provided grants and assistance to community organizations that published healthy diet cookbooks for Hispanics and other minorities with diabetes. In Utah, the Diabetes Control Program partnered with Bayer, Inc. and several leaders of the Navajo Nation to produce a video in Navajo and English to describe the symptoms of the disease, its health effects, and how to treat it.

As another way to reach minority communities, a few minority health entities studied provided grants to support the efforts of community organizations that provide diabetes-related information and materials to their constituencies. One example is the Delaware Office of Minority Health, which awarded $25,000 to the Wilmington Planned Approach to Community Health (PATCH) program to develop culturally and linguistically appropriate literature on diabetes. The materials are being developed in English and Spanish and are designed to be used by persons with low reading levels. The Ohio Commission on Minority Health and the Wyoming minority health contact also provided small grants to support materials dissemination by community agencies.

d.   Outreach

Study sites also are attempting outreach efforts in nontraditional venues to reach minority populations. As an example, the Wyoming Diabetes Control Program developed a Diabetes Minority Health exhibit in partnership with the Public Library System of Wyoming. The exhibit travels throughout the state's libraries in an effort to provide diabetes information and raise awareness of minority health and diabetes.

The Puerto Rico Diabetes Control Program cooperates with the Puerto Rico Diabetes Association to provide information and prevention services through nontraditional venues such as grocery stores, drug stores, and community health fairs. The health fairs often include health nutritionists from the Puerto Rico Sports and Recreation Department, who provide diet and exercise information in addition to important diabetes facts. A few key informants indicated that they were working with the faith community in their area to provide services to minority populations.

The South Carolina Department of Health and Environmental Control works closely with the Coalition of Black Church Leaders to help churches improve their knowledge of diabetes symptoms and available services for their communities. In Ohio, the YWCA of

Elyria conducts blood pressure and diabetes screenings with the Nurses Guild at two Black churches.

e. Increasing Access to Treatment

Study sites identified geographic areas and populations that presented high diabetes risks and developed programs to address those special needs. In Utah, the Diabetes Control Program conducts health fairs and screening visits for the Goshute tribe in the western part of the state, who have a high diabetes prevalence rate. In addition, specific clinics are conducted for Pacific Islanders and Hispanics throughout the state of Utah. The Arkansas Office of Rural Health Policy funds a comparable program called HeartWatch, which targets Blacks and migrant workers in the southwestern region of the state and provides them with cardiovascular disease and diabetes information and services.

f. Training

In Utah, the Diabetes Control Program provides training to a number of health care providers concerning the proper care of people with diabetes. In 1997, a Certification Program was initiated that ensures that providers meet national standards for diabetes care. Part of the required curriculum centers around culturally appropriate methods to provide diabetes treatment. Sessions are provided on cultural awareness that train providers how to approach individuals from different cultures using different methods. The Diabetes Control Program also holds professional updates on cultural sensitivity for those who have received certification, along with medical school students.

2. ISSUES

Each of the study sites identified a number of programs and activities related to minorities and diabetes. However, several larger themes emerged out of the interviews. Most sites indicated that they enjoyed having a federal model to use as a guide. Sites also indicated that collaboration with other agencies and community groups helped them reach more individuals from minority populations; however, they still needed to identify more effective ways to reach minority populations.

a. Impact of Federal Programs and Guidelines

Several key informants indicated that the presence of the CDC model to address diabetes provides a set of helpful guidelines that have increased the effect of state and private sector programs. The CDC model encourages strong community involvement in prevention and treatment activities and places a strong focus on the connection among diabetes, nutrition, and lifestyle. These guidelines and suggestions often provide a starting point for statewide programs and initiatives.

b.   The Importance of Health Department Collaboration with the Private Sector

Several sites also indicated that they had difficulty reaching minority populations until they teamed up with other government or non-profit agencies to provide information and services. As described earlier, cooperation with local affiliates with the National Diabetes Association, other state agencies, and community organizations all led to increased opportunity for state diabetes programs and the minority health entities to reach minority communities.

c.   Need for Effective Health Communication Strategies

Key informants in many sites indicated that although they are pursuing efforts to continue providing culturally appropriate information to minorities, they have often met with little success. Several interviewees expressed the belief that many individuals from minority groups still do not think of themselves as at risk for diabetes, nor do they know how to adequately recognize symptoms when they are present. This lack of information, despite continued education efforts, presents a new challenge for health professionals and health advocates working to decrease minority health disparities in diabetes. They must not only present information in culturally appropriate ways, but also in a manner that is believable and which can motivate people to change their behaviors.

D.   INFANT MORTALITY

Key informants from state agencies as well as from community-based organizations were very aware of the disparities in infant mortality, specifically the high mortality rate for Black infants, and were actively engaged in developing activities to reduce infant mortality rates. In California, Delaware, and Ohio, the infant mortality rate for Black infants is 2.5 times that of Whites. In Utah, the mortality rate for Native American infants is 1.5 times that of Whites.[2]

1.   STRATEGIES

In the eight states visited, and in Puerto Rico, the focal points for addressing infant mortality (both overall and among minorities) are divisions of maternal and child health in the state departments of health. Two federal initiatives that assist states and territories address infant mortality are: a) the Maternal and Child Health Bureau (MCHB) Block

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[2]*Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health.* March of Dimes, 1999.

Grant (Title V of the Social Security Act), which includes the Healthy Start initiative; and b) the Children's Health Insurance Program (CHIP).[3]

The main approaches identified during the site visits are listed below. The examples provided here include projects initiated by the maternal and child health divisions, minority health entities, and community-based organizations.

a.   Needs Assessments

The site visits identified several initiatives designed to better understand prenatal practices and needs of minority women. In Utah, the Office of Ethnic Health conducted focus groups with Black women regarding barriers to early prenatal care. In Wyoming, through a contract from the Maternal and Child Health Program, a community-based organization conducts needs assessments and planning focused on Native Americans. The South Carolina Office of Minority Health is working with the Hispanic community to address maternal and infant health issues, and has participated in a Native American pow-wow.

b.   Social Marketing Campaigns

Key informants described a number of social marketing campaigns designed to deliver messages on prenatal care to minority women. For example, the state-sponsored Arkansas Campaign for Healthier Babies delivers culturally appropriate prenatal health care messages on radio stations whose traditional listeners are from racial and ethnic minorities. In South Carolina, the Office of Minority Health is developing a social marketing campaign targeted at Black women.

The Puerto Rican Division of Maternal and Child Health identified the poor nutrition of the Island's residents as a factor contributing to the high infant mortality rate. Realizing that it did not have the resources to mount a social marketing campaign, the Division invited the March of Dimes to come to Puerto Rico to assist in this effort. The resultant Folic Acid Campaign provides information on the importance of folic acid prior to and during pregnancy.

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[3]Title XXI, State Children's Health Insurance Program (SCHIP)—often called CHIP by the states—of the Balanced Budget Act of 1997 (PL 105-33) provides states with the opportunity to design comprehensive and meaningful health insurance coverage for uninsured children. The program targets children below age 19, living in families at or below 200 percent of the federal poverty level. States may use the grant money to expand Medicaid, develop a new program or expand an existing program that provides health insurance, or use a combination of the two approaches. (Source: http://www.nga/CBP/Activities/SCHIPInfo.AS.)

c. Educational Materials

According to interviewees, most of the efforts to develop culturally and linguistically appropriate educational materials are targeted at Hispanic women. The Arkansas Office of Minority Health is working with the League of United Latin American Citizens (LULAC) to translate materials into Mexican Spanish to reach migrant and agricultural workers. In Wyoming, the Maternal and Child Health Program funds a community-based organization to develop Spanish language materials, and provides translators or interpreters for Spanish-speaking women. In Utah, the Office of Ethnic Health works closely with the Maternal and Child Health Branch to develop and translate materials for Hispanic women. The Branch also is establishing contacts within local health departments to provide culturally appropriate services to Hispanic, Black, and Native American women.

d. Outreach

The Ohio Infant Mortality Reduction Initiative (OIMRI) is an excellent example of a multi-pronged outreach effort. The OIMRI trains community outreach workers to provide culturally and linguistically appropriate services and messages in low-income and minority neighborhoods. OIMRI and the Ohio Commission on Minority Health fund a community organization, Rural Opportunities, to hire bilingual and bicultural outreach workers to reach farm worker women (most of whom are Hispanic) and their infants. Rural Opportunities also trains *promotoras*, traditional mother and child health care workers, who live among the farm worker population. In a similar program in Utah, local health departments use *promatoras* to promote culturally relevant health care practices.

e. Increasing Access to Services

Efforts directed at decreasing infant mortality include not only the above-mentioned prevention and outreach efforts, but also efforts to increase access to prenatal care. For instance, the Wyoming Maternal and Child Health Program provides funds to house a county public health nurse in an IHS clinic on a reservation and contracts with a nonprofit organization to increase services to racial and ethnic minorities. In California, the Black Infant Health Program in the Maternal and Child Health Branch provides services directed at decreasing infant deaths in the Black community. Also in California, community action teams develop and implement interventions based on recommendations from Fetal and Infant Mortality Case Review teams whose membership includes community leaders and health professionals.

The faith community also plays a large role in providing information and services to address infant mortality among minorities. An example of an initiative by the faith

community is a project by a Catholic church in Little Rock, Arkansas. The church provides midwives to deliver prenatal care to Hispanic women.

2. ISSUES

Three issues appear to impact state initiatives to eliminate disparities in infant mortality: a) the availability of federal funding; b) the relationship between infant mortality and other social indicators; and c) the need for data on infant mortality rates among racial and ethnic subgroups.

a. Availability of Federal Funding

The availability of block grant funding is a major factor that impacts the capacity of maternal and child health divisions to develop prevention and outreach efforts to reach women in population groups with excess infant mortality rates.

b. The Association Between Infant Mortality and Other Social Problems

Reducing infant mortality rates is not a controversial goal, and key informants report support for initiatives targeting the well-being of mothers and infants. However, key informants also report that infant mortality appears to be closely associated with other community indicators such as poverty, malnutrition, and adolescent parenthood. The issue is therefore seen as one that needs to be addressed not only through public health initiatives but through other venues as well (such as the abstinence program promoted by the Arkansas school system, and other school-based programs).

c. The Need for More Data

It is difficult for states to target resources at those most in need without having the data to justify allocation of resources. States report that data are inconclusive about the extent of infant mortality in different racial and ethnic subgroups. For instance, most data indicate that infant mortality among Asians and Pacific Islanders is lower than that of the other racial and ethnic groups. However, California data from 1990 show that the Hawaiian and Guamanian infant mortality rates (13.3 and 18.1 per 1,000, respectively) exceeds that of Whites, Hispanics, and Native Americans. Similar breakouts are needed for groups to assist in focusing prevention strategies.

E. SUBSTANCE ABUSE

As indicated earlier in this report, the study used AADRs for liver disease and cirrhosis as a proxy measure of substance abuse. Limited data are available at the state

level for mortality levels related to other substances and these data often differ greatly across states. In addition, substance abuse may be connected with other causes of death such as motor vehicle accidents or HIV infection. Therefore, obtaining a true measure of deaths related to substance use becomes extremely difficult, especially when attempts are made to identify deaths related to a particular substance (e.g., cocaine or heroin). However, using AADRs for liver disease and cirrhosis as a measure of disparities places a large focus on substance abuse deaths primarily related to alcohol use.

Disparities among chronic liver disease and cirrhosis AADRs were found in seven of the nine study sites. While Blacks were more likely than Whites to die from chronic liver disease and cirrhosis in Arkansas, Delaware, Ohio, South Carolina, and Utah, Hispanics and Native Americans faced far greater disparities in two study sites. Puerto Ricans were nearly three times as likely to die from these conditions than U.S. Whites, while Native Americans in Utah were over six times as likely to die from chronic liver disease and cirrhosis than Whites.

1. STRATEGIES

Strategies focusing on providing substance use prevention and treatment services to minorities varied widely among the study sites. At the federal level, within SAMHSA, the Centers for Substance Abuse Treatment and Substance Abuse Prevention have programs targeting racial and ethnic minorities. For instance, the Communities Coalitions Grant Program, funded by the Center for Substance Abuse Prevention, calls for inclusion of communities of color. However, only one site (Delaware) specifically identified this program during interviews. The following types of approaches were identified by the study sites.

a. Task Forces and Consortia

Several minority health entities indicated participating in some way in advisory boards which focus on substance use prevention or treatment. However, only one study site identified the existence of a special task force or consortium aimed at substance use among minorities. In Delaware, several task forces were formed to address substance use patterns in minorities throughout the state, including a highly visible task force on heroin use.

b. Social Marketing Campaigns

A number of social marketing programs focusing on substance use prevention originate at the federal level, creating very little need for states to pursue their own. One statewide example was found in South Carolina, where the Columbia Urban League is

implementing a youth drug prevention program called 'Drugs Destroy Dreams' for sixth through twelfth graders.

c. Outreach

Substance use prevention and treatment outreach programs were the most readily identified activities by key informants. Most of these outreach services are provided through local—or community-level programs funded by state agencies. For example, the Ohio Department of Alcohol and Drug Addiction Services has a number of programs that focus on violence prevention, along with a program directed at providing alcohol and drug outreach services to Black and Hispanic communities. In Arkansas, the Alcohol and Drug Abuse Program contracts with 200 community groups to provide prevention and treatment services. Twenty percent of the prevention contracts go to predominantly Black communities.

Several study sites also reported on the existence of local initiatives supervised by the state substance abuse agency. In Ohio, the Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOPs) serve prevention and intervention needs in Black and Hispanic communities. The programs have been in existence for 18 years and provide culturally appropriate and bilingual prevention services regarding alcohol and other drugs to youth groups, senior citizens, public housing communities, churches, schools, and grassroots organizations. Eleven separate UMADAOPs exist throughout the state.

Private sector initiatives also were identified by key informants as a vital source of outreach services. The largest example of such an effort was found in South Carolina, where the South Carolina Coalition of Black Church Leaders targets the congregations of black churches through four substance use prevention programs. The programs vary slightly in their audiences and services, but focus primarily on tobacco use prevention among youth, a parent training program providing parents with skills useful for developing anti-drug attitudes among their children, and teen leadership and self-esteem training.

d. Increasing Access to Treatment

In addition to outreach services, many states provide specialized treatment to minority groups. In Utah, the United Way provides an Indian Walk-In Clinic in cooperation with the Division of Substance Abuse to provide culturally relevant substance abuse services for Native Americans in Salt Lake City. In West Valley City, the Integrative Medicine Clinic provides drug and alcohol abuse and addiction treatment though the use of traditional Western medicine combined with acupuncture and other traditional Chinese methods.

In Puerto Rico, the Mental Health and Anti-Addiction Services Administration participates in the drug court system by cooperating with the Department of Justice, local police departments, the Department of Corrections, and the court system. The drug courts process non-violent offenders and the administration provides treatment and outpatient services to offenders referred by the drug courts. In addition, to increase access to services, the Puerto Rico Mental Health and Anti-Addiction Services Administration runs 78 Offices for Orientation and Coordination to assist individuals in their efforts to obtain mental health and substance use treatment services.

e.   Training

Two minority health entities reported providing training sessions for different groups focused on substance use issues related to minorities. In Ohio, the Commission on Minority Health funds substance abuse prevention training for community groups, schools and churches. The South Carolina Office of Minority Health provides an annual training to health department staff on substance abuse prevention efforts for minority groups.

2.   ISSUES

A number of challenges confront those organizations seeking to address substance abuse disparities among minority populations. These include difficulty in measuring the extent of substance abuse (by type of substances), the need for collaboration between the health department and offices of alcohol and other drug use, including tobacco use.

a.   Difficulty Obtaining Mortality Data Related to Substance Abuse

As described earlier in this section and elsewhere in this report, obtaining mortality data related to substance usage deaths can be very complicated. Many states classify deaths related to substance use differently, and substance use could be found to be responsible for deaths in other priority areas such as suicide, homicide, motor vehicle accidents, and HIV/AIDS, in addition to chronic liver disease and cirrhosis. Organizations need to carefully think about which rates they would like to use to represent disparities in their area, and then fully articulate the substances that are and are not covered with their data.

Disparities also can be measured with an examination of differences in substance use patterns between racial and ethnic groups. However, usage patterns differ greatly by race and ethnicity, age, sex, and the type of substance being examined. An examination of usage patterns is essential for effective prevention activities, but organizations need to remember that usage patterns might vary drastically from one substance to another, and from one age group to another. Similar programs may not work in preventing use of varied substances and the primary user populations will more than likely be different.

Further, substance use trends can change very quickly, and prevention and treatment agencies need to be prepared to respond to new and emerging substance use trends.

b.   Need for Interagency Collaboration

Another complication is the presence of substance use services in agencies outside the health department. In five of the sites visited (California, Florida, Ohio, South Carolina, and Utah), the alcohol and drug abuse departments were separate agencies, not part of state departments of public health. The fact that these agencies are outside the department of public health meant, in some states, that there was relatively little interaction between the minority health entities and these agencies, which limits the amount of collaborative services provided.

In addition, different areas of the state government may deal with different substances, and efforts directed at single substances may span several different programs and agencies. For example, tobacco prevention efforts for youth are often part of overall substance abuse prevention efforts; however, tobacco prevention programs for adults are often addressed by the chronic disease programs of the departments of public health. Confusion and difficulties could easily arise when organizations or individuals are trying to provide substance abuse services to minority populations but do not have a single identifiable location to obtain information on statewide programs.

c.   Sensitivity of Tobacco Prevention Efforts in Tobacco-producing States

Several study sites also indicated that tobacco prevention efforts in the state are limited due to political considerations and the level of influence that tobacco companies maintain in their respective areas. This was especially the case in states where tobacco is a traditional crop, a major source of revenue for the state, and a major source of employment for rural residents.

F.   HIV/AIDS

Of the OMH priority areas examined in this study, HIV/AIDS presented some of the largest disparities reported. In each of the study sites, a disparity in deaths from HIV/AIDS was reported between the Black and White populations (along with a disparity between Puerto Ricans and U.S. mainland Whites). Even in the state with the lowest disparity reported for HIV/AIDS (California), Blacks were more than three times as likely to die from the disease than their White counterparts. The state with the highest disparity was Delaware where Blacks are more than *twenty* times as likely to die from HIV/AIDS than Whites.

1. STRATEGIES

The study found that most states were undertaking specific initiatives directed at addressing the HIV/AIDS disparities in their states. A number of these were influenced by federal requirements or funding from agencies such as the CDC and the HRSA. All of the sites had contractual relationships between the HIV/AIDS offices and community organizations, and a high level of community involvement in AIDS programming.

As with many of the other priority areas, most of the HIV/AIDS public health efforts directed towards minority groups focus on prevention. However, HRSA provides funding for a number of treatment programs, most with a primary focus on minority groups. Reported efforts to eliminate HIV/AIDS disparities in minority communities in the study sites are described below.

a. Task Forces and Consortia

In a few of the study sites, specially created task forces or consortia provide critical feedback to public health officials regarding the HIV/AIDS prevention and treatment needs of minorities statewide. In Arkansas, the Office of Minority Health is an active participant in the health department's Minority AIDS Task Force. In an effort to address the increasing disparities in HIV/AIDS, the Delaware Division of Public Health developed an HIV/AIDS Consortium designed to include community input from minority groups most affected by HIV/AIDS in health planning and prevention activities. The Delaware HIV Consortium also manages several treatment grants.

b. Community Planning Groups

CDC provides funding to state and local health departments for the HIV Prevention Community Planning programs. In these programs, health departments develop prevention and intervention priorities through a local planning group composed of representatives of communities most at risk for HIV infection (which are often racial and ethnic minority groups).

In Arkansas, the community planning group works with a citizen advisory board to increase the involvement of minority organizations in HIV/AIDS prevention and treatment activities. Ohio's community planning group works closely with the state's AIDS Client Resource Program to develop more effective ways to reach minority populations.

In March 1999, the South Carolina Office of Minority Health and the Office of HIV/AIDS both participated in the state's community planning group where they were influential in presenting an update on the state's HIV/AIDS activities to the Congressional Black Caucus and in developing a response to the Presidential Initiative to Eliminate

Racial and Ethnic Disparities in Health. The community planning groups also are required to collect and analyze relevant data on HIV/AIDS among minorities such as the *Wyoming Epidemiologic Profile for HIV Community Planning*.

c. Educational Materials

Most state HIV/AIDS efforts include prevention programs tailored to minority groups through state health department programs. For example, the Utah HIV/AIDS Education Program provides culturally appropriate prevention information to racial and ethnic minorities on topics such as health education, risk reduction, other initiatives for HIV prevention among racial and ethnic minority populations, and HIV prevention among drug users.

d. Outreach

Often, the most successful approach in providing HIV/AIDS information to minority populations is through the use of culturally appropriate outreach programs. In Puerto Rico, the AIDS/STD Program uses 'community encouragers' (individuals trained to enter the community and provide health messages) to educate individuals who are susceptible to high-risk behaviors in culturally sensitive manners. In Arkansas, community organizations conduct HIV/AIDS education and outreach campaigns targeted at migrant workers directly in the communities where they are most likely to be found.

State agencies outside the health department often provide HIV/AIDS prevention services as well, such as the California Multicultural AIDS Resource Center, which provides HIV education and prevention for multicultural and minority communities. These prevention services include strong outreach components. Many community and non-profit organizations also provide culturally specific HIV/AIDS prevention programs (often with funding from state or federal agencies). In Wyoming, the minority health contact provided a supporting grant to the African American AIDS Project's Working with the Entire Community to Combat HIV/AIDS.

e. Increasing Access to Treatment

HRSA provides activities and services under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. HRSA provides supplemental funding under Title I of the Ryan White CARE Act to eligible metropolitan areas (where at least 30% of HIV/AIDS cases are among Blacks) to improve the quality of care and health outcomes. Under Title II of the Act, HRSA operates the AIDS Drug Assistance Program which provides medications to low-income persons with HIV/AIDS and who have limited or no private insurance or Medicaid coverage. HRSA's HIV/AIDS Bureau funds a number of activities directed at developing minority-related HIV/AIDS programs. HRSA also

provides Title III funding for targeted planning grants, with the goal of broadening the reach of community organizations serving Black and Hispanic areas affected by HIV/AIDS.

As with the CDC community planning grants, states are required to have planning bodies composed of populations that represent those affected by HIV/AIDS in the area. The Ohio AIDS Client Resources Program provides services through a network of case managers who assist individuals in enrolling in Ryan White programs. Services provided include transportation, child welfare services, medical and dental services, housing, nutrition, home health care, and rehabilitation. The AIDS Client Resources Program is also making an effort to improve its data collection among minorities and to ensure that minority populations are not discriminated against during service delivery. The California Office on AIDS contracts with a number of organizations and agencies to provide HIV/AIDS services. One of these organizations is the California Toll-Free AIDS Hotlines which provide HIV/AIDS information and referrals to individuals, private organizations, and government entities in a culturally appropriate manner using a variety of languages such as English, Spanish, and various Filipino dialects.

f.   Training

The South Carolina African American HIV/AIDS Council developed an AIDS prevention curriculum for Historically Black Colleges and Universities entitled "Nurturing the Tree of Life."

g.   Technical Assistance

Several study sites also provide technical assistance to community organizations, providing them with prevention messages or assisting them with efforts to develop and secure funding for HIV/AIDS programs for minorities. Another reportedly effective method to spread HIV/AIDS prevention messages is through the faith community. CDC provides technical assistance to grantees and works with the faith-based community to develop HIV and substance abuse prevention training grants at the schools of divinity on the campuses of Historically Black Colleges and Universities (HBCUs). In South Carolina, OMH staff have provided technical assistance to state organizations to inform them of the strong linkages in the Black community to address HIV/AIDS. The Ohio HIV and STD Prevention Program has recently hired a staff person to provide technical assistance on HIV/AIDS prevention issues to minority organizations.

The Florida Bureau of HIV/AIDS held a Black Leadership Conference on HIV/AIDS in 1997, and is currently conducting one-day workshops to involve Black clergy in HIV prevention as partners with the department of health. A community organization in Delaware called Planned Approach to Community Health (PATCH)

recently hosted a summit for area ministers and other faith community leaders to provide information on the state of HIV/AIDS in the Black community.

2. ISSUES

Federal programs, funding and guidelines, as well as federal data collection requirements have a major impact on state and local HIV/AIDS services for minorities. Another major challenge facing health planners is the difficulty in engaging members from minority communities in local planning efforts related to HIV/AIDS.

a. The Impact of Federal Funding and Guidelines

Many key informants indicated that the availability of federal funding for HIV/AIDS programs directed at minorities has contributed significantly to their statewide efforts. Key informants in at least two study sites also reported that their HIV/AIDS prevention funding comes entirely from federal sources.

b. Impact of Federal Data Requirements

Key informants also indicated that federal data requirements on HIV/AIDS in minority populations helped state agencies to change data collection and reporting methods. One key informant reported that without the federal data requirements, it would be very unlikely that the state would collect and report HIV/AIDS data on minority groups at the detailed level they do presently.

c. Importance of Community Involvement in Planning Efforts

One difficulty that many key informants identified was the lack of large numbers of individuals from racial and ethnic minorities available to participate in planning groups. As described earlier, some federal programs require community groups which include representatives from minority communities. However, key informants indicated only a limited number of individuals are willing to participate in these groups. What often results is the same individuals then serving on several different HIV/AIDS services planning groups.

G. SUICIDE, UNINTENTIONAL INJURIES, AND HOMICIDE

Homicide, suicide, and unintentional injuries are the three leading causes of death for young persons ages 15-24 in the United States.[4] The 1985 *Report of the Secretary's Task*

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[4]Source: http://www.cdc.gov/ncipc/factsheets/suifacts.htm

Force on Black and Minority Health found that violent deaths (as defined by deaths through homicide, suicide, and unintentional injuries) were one of six health conditions that accounted for 80 percent of excess deaths in minorities.[5] Together, suicide, homicide, and unintentional injuries represent OMH's seventh health priority area.

Limited information was obtained on efforts to eliminate disparities in suicide. Of all the sites visited, only Wyoming documented a suicide AADR for Blacks and Native Americans that exceeds that of Whites. For 1993-1997, available Wyoming health statistics show that the ratio between the suicide AADR of Whites and Blacks was 1.42; between Whites and Native Americans, it was 1.53.

Suicide is the third leading cause of death for young people ages 15-24 according to an analysis of 1979-1992 National Center for Health Statistics mortality data.[6] During this time frame, suicide rates for Native Americans were 1.5 times that of the national average. These data also show a disproportionate number of suicides among young male Native Americans. Male Native Americans, ages 15-24, accounted for 64 percent of all suicides by Native Americans.[7] Although the risk for suicide is greatest among young White males, suicide rates increased most rapidly among young Black males from 1980-1995.[8]

In the nine study sites, the ratio between the AADR for homicide and legal intervention for Whites and Blacks shows the following alarming disparities: Blacks in Ohio are almost 10 times more likely than Whites to die as a result of homicide; the White-Black AADR ratios for homicide exceed 5.5 in Arkansas and Utah; in California, Delaware, Florida, and Utah, the ratios exceed 4.0. Puerto Ricans living in Puerto Rico are four times more likely to die as a result of homicide than U.S. Whites living on the mainland. In Wyoming, Native Americans are nearly seven times as likely to die as a result of homicide than Whites.

Homicide is the second leading cause of death for persons ages 15-24 and is the leading cause of death for Black youth and the second leading cause of death for Hispanic

[5]Heckler, M.M., *Report of the Secretary's Task Force on Black and Minority Health*, Washington, DC: U.S. Department of Health and Human Services, 1985.
[6]CDC unpublished mortality data from the National Center for Health Statistics (NCHS) Mortality Data Tapes. Source: http://www.cdc.gov/ncipc/factsheets/suifacts.htm.
[7]CDC. Violence Surveillance Summary Series, No. 2, 1996. Source: http://www.cdc.gov/ncipc/factsheets/suifacts.htm.
[8]*Morbidity and Mortality Weekly Review*, 47(10)93-196, 1998.

youth.[9, 10] CDC reports that rates of homicide among youths ages 15-19 increased to record-level highs between 1985 and 1991 (from 13 to 33 per 100,000). Despite a decrease to 22.6 per 100,000 in 1997, the rate remains extremely high.[11]

Moreover, the Division of Unintentional Injury Prevention at CDC reports a strong correlation between substance abuse and unintentional injuries. The National Highway Traffic Safety Administration reports that alcohol is involved in 40 percent of all deaths due to motor vehicle crashes.[12]

In Arkansas, California, Florida, Ohio, and South Carolina, the AADR for accidents and adverse effects (which is how data on unintentional injuries are reported by the National Center for Health Statistics) exceeds that of Whites. Key informants in Utah and Wyoming expressed concern about the high rate of fatal motor vehicle accidents among Native Americans living in rural communities, and about the link between substance abuse and traffic fatalities. However, they point out that because of incomplete data collection systems, there are no reliable data to support these statements. In Arkansas, work-related injuries among migrants and seasonal farm workers (for instance, conveyor belt accidents) are said to be higher than actually reported. These injuries are reported through state department of labor work-related statistics.

1. STRATEGIES

a. Suicide

Other than programs run by the IHS in Utah and Wyoming, key informants identified only two suicide programs targeting minorities:

- *Task Forces*. Utah has a fairly new suicide prevention program that includes a Statewide Suicide Task Force. Key informants indicate that the Task Force will be examining factors associated with suicide by members of racial and ethnic minority groups.

[9]*National Summary of Injury Mortality Data*, 1981-1987. Atlanta, GA: Centers for Disease Control and Prevention, National Century for Injury Prevention and Control (Unpublished). Source: http://www.cdc.gov/ncipc/factsheets/yvfacts.htm.
[10]Anderson, R.N., Kochanek, K.D., and Murphy, S.L. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report* 45, 11 (2 Suppl.), 1997. Source: http://www.cdc.gov/ncipc/factsheets/yvfacts.htm.
[11]*National Summary of Injury Mortality Data*, 1981-1987. Atlanta, GA: Centers for Disease Control and Prevention, National Century for Injury Prevention and Control (Unpublished). Source: http://www.cdc.gov/ncipc/factsheets/yvfacts.htm.
[12]*Traffic Safety Facts 1995: Alcohol*. Washington, DC: National Highway Traffic Safety Administration, National Center for Statistics and Analysis, 1996. Source: http://www.cdc.gov/ncipc/duip/duip.htm.

- *Educational Materials.* In California, the Department of Mental Health (which has an Office of Multicultural Services) has developed culturally specific modules in suicide prevention. One of the prevention documents is a photo novella in Spanish.

b. Homicide

Although the disparity ratios for homicide and legal intervention are exceedingly high, only a few public health programs have a specific focus on reducing homicides, let alone reducing disparities. Nor did any key informant identify such a program in another state agency. Exceptions include a California program that aims to reduce the use of "Saturday Night Special" hand guns in urban areas. Most of the initiatives identified by the key informants were programs targeted at reducing youth or domestic violence.

- *Community Planning Regarding Youth Violence.* The city of Columbia, South Carolina, has a planning grant from the John S. and James L. Knight Foundation to plan a youth development and violence prevention program in three counties.

- *Outreach to Victims of Domestic Violence.* The Ohio Department of Health houses a Women of Color Network for victims of domestic violence. In addition, the Ohio Commission on Minority Health has implemented prevention programs for Hmong, Chinese, and Vietnamese women, and sponsors a rape prevention program for Black women at the Columbus Urban League. California is targeting immigrant communities where domestic violence may be viewed as an accepted way of solving family conflict.

- *Violence Programs and Curricula for Youth.* The Ohio Commission on Minority Health funds youth violence prevention programs including a Positive Adolescent Choices Training Program for Black Youth. Each summer in South Carolina, the departments of mental health, health, and criminal justice jointly sponsor an Institute for high school sophomores and juniors on anger, substance abuse, and sexual behaviors. The Office of Minority Health provides guidance to the sponsoring agencies regarding minority youth. Also, in South Carolina, the Columbia Urban League runs a *Stop the Violence* program for Black youth.

- *Conferences.* The Ohio Commission on Minority Health cosponsored a violence prevention conference with the Ohio Commission on Spanish Speaking Affairs.

c.   Unintentional Injuries

Despite widespread concern about disparities in unintentional injuries, few specific efforts were identified other than the work of the IHS in Utah and Wyoming. In Puerto Rico, concern about the high level of unintentional injuries led the Island to develop partnerships among the health department, local police departments, and the department of education. A conference which addresses unintentional injures also is being planned.

2.   ISSUES

Major issues facing the states in developing initiatives to reduce suicide, homicide, and unintentional injuries in minority populations are the lack of a state focal point, limited funding, and few coordinated efforts.

a.   Lack of a State Focal Point for Addressing Disparities in Homicide and Unintentional Injuries

In all sites, the primary responsibility for addressing suicide was the department of mental health. However, a major issue facing minority health advocates who are concerned about disparities in homicide and unintentional injuries is the plethora of state agencies that address one or more aspects of these two dimensions of violence. No one agency appears to have primary responsibility. Homicide as a domestic violence issue may be addressed through offices of women's health or a bureau of maternal and child health. Because of the relation of violence to substance abuse, prevention programs may exist within departments of alcohol and drug abuse. Furthermore, youth violence prevention programs also are often the purview of departments of education. As a legal issue, violence belongs to the domain of law enforcement agencies, and youth violence initiatives may be sponsored by a department of justice.

Unintentional injuries were generally the domain of special divisions within the health department. Preventing fatalities associated with substance abuse also was the concern of departments of alcohol and drug abuse, and departments of transportation. Fatalities (and nonfatal injuries) resulting from misuse of farm equipment (reportedly, a major source of injuries for migrant and seasonal farm workers) falls under the domain of agricultural safety and health. Data on farm accidents are collected by the Bureau of Labor Statistics.

b.   Lack of Funding for Prevention Efforts Designed to Reduce Unintentional Injuries

Key informants reported that lack of state or federal funding limits health departments' ability to develop prevention programs. For instance, in South Carolina, funding was available only for a program to promote the use of child safety seats.

c.   Lack of Coordinated Efforts to Address Disparities in Violence-related Deaths

The site visits identified several inter-agency initiatives, some with a minority health component: the Statewide Suicide Task Force in Utah; the proposed interagency partnerships in Puerto Rico; and the South Carolina interagency initiative to develop a summer program for youth targeting substance abuse, violence, and sexual behaviors. Overall, however, the site visits did not provide a clear picture of coordinated prevention efforts targeting these three health areas.

H.   SUMMARY OF APPROACHES TO ELIMINATE HEALTH DISPARITIES

Exhibit V-1 lists the main strategies used by the study sites to eliminate disparities in OMH's health priority areas An overview of strategies reported by the key informants indicates that outreach to the minority communities was the most frequently used approach to engage minorities in prevention or health care. Connected to outreach were efforts to provide health education through the development of culturally and linguistically appropriate health education and promotion materials and through social marketing campaigns. Social marketing campaigns targeting minority populations were identified for cardiovascular disease (California, Puerto Rico, and South Carolina); cancer (California and South Carolina); diabetes (Ohio, South Carolina, and Utah,); and infant mortality (Arkansas, Puerto Rico, and South Carolina).

Sites also were actively seeking ways to increase access to treatment for minorities suffering from chronic disease, substance abuse, and HIV/AIDS; and for ways to improve the health of minority women of childbearing age and to increase use of prenatal care by minority women. Approaches focused on removing cultural and related access barriers to getting treatment. To learn more about health behaviors related to cardiovascular disease and infant mortality, the Utah Office of Ethnic Health conducted focus groups with minority women, and the South Carolina Office of Minority Health is working with the Hispanic community. Wyoming is planning to assess ways to address cardiovascular health in Hispanic and Black communities.

Exhibit V-1

STRATEGIES REPORTED BY THE STUDY SITES TO ELIMINATE DISPARITIES
BY RACE AND ETHNICITY IN THE OMH PRIORITY HEALTH AREAS

Strategies Identified During the Site Visits	The OMH Priority Health Areas								
	Cardiovascular Disease	Cancer	Diabetes	Infant Mortality	Substance Abuse	HIV/AIDS	Suicide	Homicide[a]	Unintentional Injuries
Outreach	✓	✓	✓	✓	✓	✓	✓	✓	
Health prevention and promotion materials	✓	✓	✓	✓	✓	✓	✓		
Increasing access to treatment	✓		✓	✓	✓	✓			
Social marketing campaigns	✓	✓	✓	✓					
Task forces and consortia		✓	✓		✓	✓	✓		
Community planning groups						✓		✓	✓
Training	✓					✓		✓	
Conferences	✓								✓
Needs assessments	✓				✓				
Technical assistance						✓			

[a]Includes violence prevention activities

Task forces or consortia were reported for five of the health priority areas: cancer (Delaware); diabetes (Delaware and South Carolina); substance abuse (Delaware and South Carolina); HIV/AIDS (Arkansas and Delaware); and suicide (Utah).

Sites reported training health care providers and other professionals (including teachers) on chronic diseases and HIV/AIDS in minority populations. For instance, Wyoming provided training on diabetes to staff at an Indian reservation. Utah has a diabetes certification program for health educators—the curriculum includes sessions on culturally appropriate methods to provide diabetes treatment. The South Carolina African American HIV/AIDS Council has developed an AIDS prevention curriculum for Historically Black Colleges and Universities. A number of sites also report technical assistance efforts sponsored by CDC for minority HIV/AIDS programs.

Puerto Rico conducts a yearly conference on cardiovascular disease, and is planning a conference on unintentional injuries. South Carolina reports being in the planning phases for a tri-state conference on strokes. The Florida Bureau of HIV/AIDS held a Black Leadership Conference on HIV/AIDS and is currently conducting one-day workshops for Black clergy. In Delaware, a community-group hosted a summit on HIV/AIDS in the Black community for leaders of the faith community.

Ohio and South Carolina reported violence prevention curricula for minority youth. Undoubtedly, similar initiatives exist in all sites. As mentioned earlier, sites in general reported little information when queried about initiatives targeting disparities in homicide. The initiatives mentioned here were usually reported as a result of questions regarding specific minority health programs sponsored by community-based organizations.

I.   OVERVIEW OF ISSUES FACED BY STATES IN EFFORTS TO ELIMINATE HEALTH DISPARITIES

The approaches and strategies presented in this section were identified during three-day site visits to the nine study sites. It was not feasible to fully cover the 4+7 cross-cutting issues and health priority areas in this time frame. The information presented here is therefore not intended to be exhaustive, but rather to provide an overview of the type of strategies in use at the state and local levels to eliminate health disparities.

In their efforts to eliminate health disparities in the OMH priority health areas, the states faced a number of challenges. Key among these was difficulty in obtaining timely, accurate, and reliable morbidity data for minority populations. This problem was exacerbated for programs targeting disparities in substance abuse. Key informants reported that data collection on HIV/AIDS benefitted from federal data requirements.

They also reported positive impacts from federal funding and guidelines on state infant mortality and HIV/AIDS programs.

Lack of understanding by minorities of the importance of preventive health care was another major obstacle, especially as this related to cancer and cardiovascular disease. Closely related was lack of understanding by health care professionals of the health-seeking behaviors of minority populations. For all health conditions, key informants reported the need for increased collaboration among health departments, community-based organizations, and the minority community.

Considering the association of many health conditions (e.g., the association among HIV/AIDS, substance abuse, and violence), a major issue is the need for increased intra- and inter-agency collaboration. For homicide, suicide, and unintentional injuries, the lack of a state focal point (and lack of funding) severely hampers efforts to reduce disparities in these areas.

SECTION VI

Health Care to Native Americans

VI. HEALTH CARE TO NATIVE AMERICANS

Native Americans live in each of the eight states covered by the study. Because of the sovereign status of federally recognized Indian tribes, the infrastructure to address Native American health comprises federal and tribal governments as well as state governments. It is therefore appropriate to devote a section of this report to the efforts of these various government entities.

Five states (California, Florida, South Carolina, Utah, and Wyoming) have federally recognized tribes within state boundaries. Indians who are members of these tribes are eligible for health care through the Indian Health Service (IHS). Indians in the other states and Indians who are not members of federally recognized tribes receive health care from the same sources as other state residents.

A. THE INDIAN HEALTH SERVICE

Because of the status of federally recognized tribes as sovereign entities, and the federal government's obligation to provide health services under P.L. 83-568 (established in 1954), most health services to Native Americans on reservations are provided directly through IHS, rather than through state health departments. The IHS service areas consist of counties on or near federal Indian reservations. Indians living in these service areas comprise about 60 percent of all Indians residing in the United States.

IHS is organized into twelve regional areas. The area offices are the core of IHS administration and management.[1] Health care in these IHS regions are provided in three ways: 1) through clinics directly managed by IHS; 2) a contract or compact with tribes to provide services where IHS sets priorities for service provision; and 3) a compact with a tribe where latitude is given to the tribes to operate health programs as they deem appropriate. In addition, in a number of cities throughout the country, IHS runs clinics for urban Indians.

Indians from federally recognized tribes who live in California, Florida, South Carolina, Utah, and Wyoming, receive IHS health care supported by the following IHS area offices:

- *The Nashville Area IHS Office in Nashville, Tennessee,*
  oversees health care services for Indian people in the southern

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[1]*Regional Differences in Indian Health*, 1997, Rockville, MD: Indian Health Service, DHHS, 1997.

and eastern United States including Florida and South Carolina. It does not provide services in Delaware as there are no recognized federal tribes there. The IHS reports that for most Indians living within the Nashville Area, the IHS is the only available source of health care, although they are entitled to participate in the full range of programs available to them as residents of states, counties, and local communities.

- *The California Area IHS Office in Sacramento* oversees delivery of health care to Indians throughout the state of California.

- *The Billings Area IHS Office in Billings, Montana,* oversees the provision of health care services to Indian people on seven reservations in Montana and one in Wyoming (the Wind River Reservation).

- *The Phoenix Area IHS Office in Phoenix, Arizona,* oversees health care for Indians in Utah, Arizona, and Nevada. A number of health facilities throughout the Phoenix area are tribally operated, including a Service Unit in Fort Duchesne, Utah.

- *The Navajo Area of the IHS located in Window Rock, Arizona,* administers health care to members of the Navajo Nation (the largest Indian tribe in the United States). The Navajo reservation encompasses more than 25,000 square miles in northern Arizona, western New Mexico, and southern Utah.

- *The Albuquerque Area IHS Office in Albuquerque, New Mexico,* responsible for providing health services to Indians in a number of states, is the third IHS Area Office that provides services to Utah Indians. It oversees health care services to members of the Ute Mountain Ute Reservation a small portion of which extends from Colorado to southern Utah.

B. IHS PROGRAMS IN THE FIVE STUDY STATES WITH FEDERALLY RECOGNIZED TRIBES

Five of the eight states covered by this study have federally recognized tribes within state borders: California, Florida, South Carolina, Utah, and Wyoming. As shown below, reservation lands often cover land in more than one state. Thus, Native Americans living in one state may have to travel considerable distances to IHS clinics in neighboring states.

- *California.* All California Indian health programs are managed by the Indian people themselves. However, there are no tribal-run or IHS hospitals in California. A major player in managing contracts with Indian tribes is the non-profit California Rural Indian Health Board (CRIHB). CRIHB was founded in the 1970s to be an advocate for Indian health care, and over time became a mechanism for managing IHS health care contracts.[2] The tribes augment IHS funds with grants and contracts from other funding sources. The state of California is one such source.[3]

- *Florida.* IHS has contracts to provide medical services to the state's seven Indian reservations. Native Americans living in Escambia and Santa Rose Counties near the Alabama border are part of the designated IHS service area for the Poarch Band of Creek Indian reservation in southern Alabama.[4] Both Florida and Alabama are covered by the Nashville Area Office of the IHS.

- *South Carolina.* South Carolina is home to five Native American tribes, of which only one, the Catawba tribe, is federally recognized. There is no IHS clinic in the state. However, key informants report plans to establish a Native American health department clinic and to provide IHS contract

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[2] In the 1950s, through P.L. 280, the federal government divested itself of its trust responsibilities to Indians, and turned services to Indians over to the states. At that time, the federal government was proposing to mainstream Indians into the general population, and to terminate tribal rights. One result is that there are at present approximately 80,000 urban Indians living in California, particularly in the Los Angeles and San Francisco Bay areas.

[3] http://www.ihs.gov/FacilitiesServices/AreaOffices/California/Cal.asp.

[4] The Poarch Band of Creek Indians tribal reservation service area is legally defined as Escambia, and Baldwin, Mobile, and Monroe Counties in Alabama and Escambia County, Florida. Source: http://www.ihs.gov//FacilitiesServices/AreaOffices/Nashville/Nash.asp.

services. This will be the first time such a department has existed for the Catawba Nation.[5] At the time of the site visit, the South Carolina Office of Minority Health was developing a process for increasing communication with Native American tribes in order to identify and address health concerns.

- *Utah*. Utah contains several areas of reservation land, including land that is an extension of tribal lands in Arizona[6]. IHS divides the state into four service areas. The only IHS facility in Utah is an ambulatory outpatient facility located in Fort Duchesne (part of the Phoenix service area). The Utah Department of Health also has an Office of Indian Health. It sponsors an initiative known as Developing Efforts Addressing Mortality and Morbidity to establish collaborative partnerships among the eight largest Utah tribes, the Utah Department of Health, and local health departments.

- *Wyoming*. There are two federally recognized Native American tribes in Wyoming: the Arapaho and the Shoshone. Most of the state's 10,510 Native Americans reside on the Wind River Reservation which is served by IHS and by local health care providers. Other IHS clinics exist in Lander, Riverton, and Casper. Nevertheless, for some conditions, Wyoming's Native Americans may be referred to the IHS service center in Billings, Montana, Salt Lake City, Utah, or Denver, Colorado. The non-profit Urban Native American Program is conducting a needs assessment to develop better understanding of Wyoming's urban Indians and their needs. The program also sponsors traditional healing and spiritual healing clinics in settings that range from three-day seminars to one- to two-week outdoor camps.

IHS also provides health care to urban Indians who are members of recognized tribes. However, according to key informants, none of the 34 urban Indian clinics are located in one of the states covered by the study. A clinic in Los Angeles was shut down

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[5] http://www.ihs.gov//FacilitiesServices/AreaOffices/Nashville/catawba.asp.

[6] To the east, the Uintah and Ourray Reservation is home to the Utes. In the far west portion of the state, the Goshute tribe has reservation lands in both Ibapah and Skull Valley. In the southwest portion of the state, the Paiute tribe has reservation lands in four areas, including tribal land in Cedar City. In the southeastern part of Utah, the reservation lands of the Navajo Nation and the White Mesa Ute extend from Utah into other states. In fact, most of the Navajo reservation land is contained in Arizona, and only the northernmost part extends into Utah.

in part because of limited linkages with other health care referral sources such as hospitals. In California, the IHS area office contracts with urban Indian organizations in eight major urban centers to provide health care for Indians living in cities.[7]

C. HEALTH CARE TO INDIANS WHO ARE NOT MEMBERS OF FEDERALLY RECOGNIZED TRIBES

Native Americans who do not belong to federally recognized tribes, or who live in states that are not part of an IHS service area, face a number of barriers to receiving health care (e.g., lack of health insurance, cultural barriers). Key informants provided the following information on health care to Indians in Arkansas, Delaware, and Ohio.

- *Arkansas*. Arkansas key informants report that most Native Americans live in the Fort Smith area near the Oklahoma border, and receive medical treatment from IHS clinics in Oklahoma. The Arkansas Area Health Education Center program sponsors training for Arkansans health care providers in the IHS hospital in Oklahoma to increase their understanding of culturally competent health care to Native Americans.

- *Delaware*. Key informants report that about 200 Nanticoke Indians live near the Indian River Bay in southern Delaware. Representatives from the Southern Health Services (one of two public health regions in Delaware) report that despite some contact with leaders of the Native American community, they have not identified any specific health needs or developed any programs specifically targeting this community.

- *Ohio*. Over 40 different Native American tribes are represented in Ohio, although few are formally organized. There are no tribal lands within the state, and most Native Americans live in metropolitan areas, and consider their tribal homeland to be in other states. There are no IHS service areas within the state.

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[7] http://www.ihs.gov/FacilitiesServices/AreaOffices/California/Cal.aspResults of count for [california]: 15

D. DATA COLLECTION ON HEALTH STATUS OF NATIVE AMERICANS

Health statistics based on deaths of Native Americans are generally incomplete because of the miscoding of Indian race on death certificates. In other words, Native Americans are identified (or coded) as being members of other racial or ethnic groups. To address this problem, IHS conducted a study matching IHS patient deaths with data from the National Death Index (NDI) maintained by the National Center for Health Statistics for 1986-1988. The study revealed that "race" was miscoded on 10.9 percent of all matched patient death records. In California and Oklahoma, the percentage of miscoded records was 30.0 and 28.0 respectively.[8]

In 1997, IHS produced for the first time a report presenting health data adjusted for miscoding of Indian race on death certificates, for Indians living in IHS service areas. Below is an overview of the AADRs of Native Americans as presented in the report, *Regional Differences in Indian Health, 1997*. The data below present Indian death rates adjusted for the miscoding of Indian race on death certificates. Only for cancer and HIV infection are the Indian death rates lower than for the overall U.S. population.

- *Cardiovascular Disease.* In 1992-1994, the age-adjusted diseases of the heart death rate for the IHS service area population was 157.6. This rate is only slightly higher (8%) than the overall U.S. rate of 145.3 in 1993.

- *Cancer.* The malignant neoplasm AADR per 100,000 population for the IHS service area in 1992-1994 was 112.2. This rate is 15 percent lower than the overall U.S. rate of 132.6 in 1993.

- *Diabetes.* The diabetes AADR per 100,000 population for the IHS service area was 41.1 for 1992-1994. This rate is 3.31 times the overall U.S. rate of 12.4 in 1993.

- *Infant Mortality.* In the IHS report, a newborn is classified as American Indian or Alaskan Native if one or both parents are identified on the birth certificate as either American Indian or Alaskan Native. For the IHS Service Area population in 1992-1994, the infant mortality rate was 13.8 per 1,000 live births. This is 1.26 times the U.S. rate of 10.9 in 1993.

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[8]*Regional Differences in Indian Health*, 1997. Rockville, MD: Indian Health Service, DHHS, 1997.

- *HIV Infection*. In 1992-1994, the age-adjusted HIV infection death rate for the IHS service area population was 3.9. This rate is 72 percent less than the 1993 overall U.S. rate of 13.8.

- *Homicide*. The homicide AADR for the IHS Service area was 15.1 per 100,000 population for 1992-1994. This rate is 1.41 percent times the overall U.S. rate of 10.7 in 1993.

- *Unintentional Injuries*. In 1992-1994, the age-adjusted injury and poisoning death rates for the IHS service area population was 131.1 per 100,000 population for injury and poisoning death rates (versus an overall U.S. rate of 53.8 in 1993). For accident death rates, it was 94.5 (versus an overall U.S. rate of 30.3). The accident rate is 3.11 times the overall U.S. rate.

- *Substance Abuse*. The age-adjusted alcoholism death rate for the IHS service area population was 45.5. The Indian rate is 7 times the overall U.S. rate of 6.7 in 1993.

These data, adjusted for miscoding of race on death certificates, also are readily available by IHS region. However, they do not exist in published format by state.

E. EFFORTS OF MINORITY HEALTH ENTITIES TO IMPROVE THE HEALTH CONDITIONS OF NATIVE AMERICANS

Historically, minority health entities have worked primarily within or in conjunction with state departments of health towards eliminating the gaps in racial and ethnic minorities. Because of scarce resources, minority health entities with relatively low numbers of Native Americans have not been able to focus on developing relationships with Native American communities, regardless of whether they belonged to federally recognized tribes. As shown in the above examples, there is growing awareness that a statewide minority health infrastructure must extend beyond state agencies and take into account sovereign tribes whose lands may exist within a state's geographic boundaries, and with IHS representatives.

The unique nature of the Native American health care system creates several challenges for a state health infrastructure. The minority health entity and other state health programs may face difficulties providing services to Native Americans on reservations since many tribes prefer to work directly with the federal government. Tribal preferences and the presence of IHS may lead state officials to think that their state does not have an obligation to provide health services to Native Americans. Because of

the regional nature of the IHS health care system, and the fact that Indians may receive health care from IHS clinics located in other states, it is difficult to obtain state-specific data to document the health status and health needs of Indians. Often, state health departments do provide services to Native Americans who live in areas immediately surrounding reservations and to individuals who cannot access health care services through IHS. Thus, the unique health needs of Native Americans fall within the scope of the missions of state minority health entities. However, findings indicate that state efforts to document and address the health needs of Native Americans tend to lag behind efforts for other racial and ethnic groups.

SECTION VII

Responses to the Study Questions

VII. RESPONSES TO THE STUDY QUESTIONS

Responses to the key study questions listed in Section II of this report are presented here.

A. THE NATURE AND EXTENT OF STATE-LEVEL EFFORTS TO ADDRESS ISSUES OF HEALTH DISPARITY

The first three questions are:

- What are the nature and extent of the efforts at the state level to eliminate health disparities, especially among racial and ethnic groups?

- What are the nature and extent of efforts at the state level to close the gap between racial and ethnic groups in the priority health issue areas of particular concern to OMH?

- What efforts are in place or planned at the state level to address each of the four cross-cutting issue areas as they relate to improvements in the health of racial and ethnic minorities?

Findings indicate that the answers to these questions are a function of the activities and reach of the minority health entities, as well as of the breadth and strength of the statewide minority health infrastructure.

1. THE ACTIVITIES OF THE MINORITY HEALTH ENTITIES

The minority health entities engage in three broad categories of activities: a) activities designed to increase state capacity to enhance health care to minorities; b) activities designed to address issues that affect health care to minorities (e.g., the collection of reliable data on the health status of minorities, minority participation in the health professions, the cultural competence of health providers and other health professions, access to health care for racial and ethnic minorities); and c) activities designed to decrease disparities in specific health conditions.

a. Improving State Capacity to Respond to the Health Needs of Minorities

Taken together, the following three public health services influence a state's capacity to address the health needs of racial and ethnic minorities:

- *Mobilizing Community Partnerships to Identify and Solve Problems*. Minority health task forces either take the lead, or serve as active participants, in government task forces and community coalitions concerned with minority health.

- *Informing, Educating, and Empowering People About Issues*. This is a key function of the minority health entities that participated in the study. The state offices of minority health inform and educate through newsletters, conferences, public services announcements, media campaigns, and health fairs. As needed, they arrange to translate materials. In addition, they serve as a resource to state health divisions and community-based organizations engaged in health promotion activities targeted at minorities.

- *Developing Policies and Plans That Support Individual and Community Health Efforts*. Minority health entities often play a consulting role in the development of state strategic plans.

b. **Promoting Improved Data Collection, Increased Participation by Minorities in the Health Professions, and Improved Access to Culturally Competent Health Services**

Minority health entities promote and advocate for more accurate, detailed, and reliable data collection on the health status of minorities; engage in activities designed to increase the number of minority health professionals; and work with health departments and community-based organizations to improve access to culturally and linguistically appropriate health care for all minorities. These activities correspond to three of the essential public health services:

- *Monitoring Health Status to Identify Community Health Problems*. Minority health entities collect data from state offices of vital statistics to determine the health status of minority populations, identify disparities, and disseminate these data to community-based organizations, health department staff, and policymakers. However, the lack of readily available data make this task difficult.

- *Ensuring the Availability of a Competent Public Health and Personal Health Care Workforce*. Minority health entities collaborate with health professions schools, community

organizations, and other state programs (e.g., the Area Health Education Centers) to bring about an increase in the number of health professionals who belong to racial and ethnic minorities. Minority health entities also provide consultation to health departments to increase the cultural competency of all health providers. Several minority health entities conduct cultural competence and diversity training for the health department staff.

- *Evaluating Effectiveness, Accessibility, and Quality of Personal- and Population-Based Services.* Several minority health entities have assessed the health needs of the Hispanic, Asian, and Native American populations in order to determine the accessibility and cultural appropriateness of existing services.

c. Consulting with Health Departments and Community-based Organizations on How to Decrease Disparities in Specific Health Conditions

Findings show that outreach, the development of educational materials, and social marketing campaigns were the most frequently used strategies by state agencies and community-based organizations to address the health needs of minorities. Minority health entities participated in these efforts by serving as a resource, assisting with linkages between providers and the minority community, and serving on statewide task forces.

2. STATEWIDE MINORITY HEALTH INFRASTRUCTURES

Within all sites, multiple initiatives were identified that focused directly or indirectly on improving the health status of minorities. However, a review of infrastructure elements (systems, relationships, competencies, and resources) shows that in most states a coordinated overall infrastructure was still in the process of being developed. There also were indications that the study occurred at a critical point in time when national initiatives, such as *Healthy People 2010* and the *President's Initiative on Race,* were impacting national and state awareness of disparities in health.

The infrastructure appears strongest when it is supported at the core by a strong statewide minority health organization, statewide task forces, state strategic plans specifying minority health objectives, and legislation. In most of the sites visited, the minority health entity is at the center of the state minority health infrastructure. For instance, in Arkansas, the combination of an independent commission (which reports directly to the Governor's Office) and an Office of Minority Health (located within the health department) provides a strong force for further evolution of the state's minority

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health infrastructure. In California, the Pan Ethnic Health Network, comprised of organizations representing California's major minority populations, assures strong statewide linkages between the minority health entity and leaders of the state's minority communities.

Findings clearly indicate strong linkages between the minority health entity and minority communities, but less consistent linkages within and between state agencies, and between state agencies and the minority community. Interviewees often described their statewide minority health infrastructure as a 'patchwork quilt,' where the minority health entities provide the 'essential threads' to keep different pieces of the 'quilt' together. The minority health entities act as an important point of contact for state agencies and community-based agencies.

Within the context of this study, minority health competencies include the organizational capacity to produce strategic plans and other organizational resources. In general, states appear to be reactive rather than proactive in addressing health disparities. Initiatives are the strongest in areas where federal funding or guidelines require programs targeted at minorities with excess deaths in given health conditions. On the other hand, although one of the greatest disparities in most states was in homicide rates, no state appeared to have a public health response to this concern.

Throughout the system, minority health activities tended to be strongest in areas where funding was available, and where the minority communities were the most active. The advocacy and outreach functions of community-based organizations was identified as a major resource, not only in support of the activities of the minority health entities, but in support also of state and local efforts designed to identify and address the health needs of minority populations. Another major resource consists of legislative and political support. Key informants were unanimous in reporting that, historically, some state administrations have been less supportive of minority health activities than others.

B.   DOCUMENTING AND TRACKING HEALTH DISPARITIES

Question 4 asks: To what extent are state efforts to eliminate health disparities and address health concerns of racial and ethnic minorities linked to national efforts such as *Healthy People 2000* or *Healthy People 2010*? Subquestions address a) how state governments and minority health entities document the need for minority health initiatives and track outcomes; and b) whether documentation exists to show that the states or the minority health entities have been effective.

1. DOCUMENTING HEALTH DISPARITIES

OMH is interested in knowing whether states have the data needed to identify health disparities, document the need for activities targeted at minorities, and show whether efforts to demonstrate improvement are linked to *Healthy People 2000* or *Healthy People 2010* objectives. Findings show that data are extremely limited, and that (at the time of the site visit) not all of the sites visited have linked state objectives to *Healthy People 2000* or *Healthy People 2010* objectives.

The effect of the emphasis of *Healthy People 2010* on eliminating health disparities was not yet fully apparent at the time of the Spring 1999 site visits. Many states have their own versions of these documents, such as *Utah's Healthy People 2000 Status Indicators*, or have strategic plans that spell out health goals based on those offered by *Healthy People 2000*. Most of these goals did not relate directly to minorities or efforts to eliminate gaps in the health status of racial and ethnic groups.

Several interviewees indicated that while the *Healthy People 2000* and *Healthy People 2010* goals were important and served as benchmarks, the state had to adjust its own goals relative to what could be achieved with the state's population, health department, and political climate. Puerto Rico uses as its benchmarks the *Healthy People 2000* objectives for U.S. Whites.

2. TRACKING HEALTH DISPARITIES

Systematically tracking health disparities over time requires a stated goal of reducing health disparities and reliable year-to-year data on health disparities. In most of the states visited, the minority health entities were charged with the goal of eliminating disparities however, most had no access to state-level health data on populations other than Blacks and Whites. Exceptions are California (which not only reports data for all major racial and ethnic groups, but also for subgroups); and Utah (which is attempting to separate data for Polynesian and other Asian groups). However, the California data is not necessarily timely; the most recent breakouts are based on 1990 data. For Native Americans, data are generally not readily available at the state level (the Indian Health Service reports data by multi-state regions), moreover, data are often incomplete because of miscoding of race on death certificates of Indians.

C. FACTORS THAT HELP OR HINDER THE ESTABLISHMENT AND EFFECTIVENESS OF MINORITY HEALTH ENTITIES

This section presents information collected to answer research questions 5 and 6: What, if any, features or characteristics of minority health entities hinder or contribute to

their effectiveness? What features, characteristics, or elements promote and hinder the establishment and effectiveness of minority health entities?

1. FACTORS THAT CONTRIBUTE TO THE ESTABLISHMENT OF MINORITY HEALTH ENTITIES

The study found two factors that seemed to contribute significantly to the establishment of state offices of minority health in the study sites. The first factor was the creation of a task force, conference, or advisory group whose role was to examine racial and ethnic health issues within a state. These groups were formed by the state to provide a better assessment of minority health issues in their respective states, and were usually motivated by national studies[1] or changes in the population of a state. Recommendations for a dedicated minority health entity were then implemented by the Governor or the state health department.

The second factor identified as a significant contributor to the creation of state minority health offices is the influence and voice of the minority community. In most states visited, key informants reported that support from community organizations and residents from racial and ethnic minority groups were essential to the process of establishing minority health entities.

2. FACTORS THAT CONTRIBUTE TO THE EFFECTIVENESS OF MINORITY HEALTH ENTITIES

The information provided by key informants points to the following factors as contributors to the effectiveness and continuance of the seven established offices and commission of minority health:

- Support from the state government, including legislative initiatives and political endorsement of minority health activities;

- A state-level plan, statewide advisory groups, task forces, or commissions committed to eliminating health disparities;

- The presence of other state minority health programs, as well as private-sector minority health programs and coalitions;

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[1]Heckler, M.M., *Report of the Secretary's Task Force on Black and Minority Health*, Washington, DC: U.S. Department of Health and Human Services, 1985.

- Initiatives sponsored by the academic community and the faith community; and

- Strong links among the minority health entity, the minority community, and the state health department.

3. FACTORS THAT HINDER THE EFFECTIVENESS OF MINORITY HEALTH ENTITIES

The following factors detract from the effectiveness and continuance of minority health entities: lack of financial resources; staff turnover; isolation of the minority health entities from other state agencies (and from relevant divisions within the health department); lack of legislative or regulatory grounding of minority health initiatives; and lack of data (data on the health conditions of minorities as well as to performance indicators).

D. THE IMPACT OF MINORITY HEALTH ENTITIES ON EFFORTS TO ELIMINATE HEALTH DISPARITIES

Question 7 asks whether efforts to close the gap in health disparities between racial and ethnic groups are more likely to occur when dedicated minority health entities are established.

Visits to the nine study sites appear to indicate that dedicated minority health entities contribute to efforts to close the gap in a number of ways. First, many minority health entities serve in an advocacy role at the state and health department levels. The established minority health entities provide testimony to state legislatures, contribute feedback on health department decisions that affect minority groups, and provide feedback and support to their respective governors and directors of health regarding the health status of minority groups statewide. This organized and credible presence at the state policymaking level provides unique opportunities to shape and create initiatives that could have a large effect on minority health status.

Second, minority health entities provide information on issues surrounding minority health to policymakers, health professionals, and the general public. State minority health entities may be asked to inform legislators of potential impacts of specific policies on minority health. Many minority health entities also provide training and information to health professionals and health care providers concerning various issues surrounding minority health, including cultural competency, access to health care, and availability of resources. The minority health entities also provide a great deal of information to community groups and the public, and often serve as advisors on how to best reach minority groups with appropriate health messages.

Third, the minority health entities serve as important and visible points of contact in their states. The existence of a recognized minority health entity provides a key first step for community members from racial and ethnic minorities to express their concerns regarding health conditions in their areas. Minority health entities also provide health professionals with a recognized avenue within the state to pursue information on the appropriate counseling, diagnosis, and treatment of minority individuals.

Minority health disparities remain a major problem in the sites visited and throughout the nation. However, states are pursuing various efforts to try and "close the gap," and a recognized minority health entity often serves to improve the chance of success of efforts directed at improving the health of minorities.

SECTION VIII

Recommendations

VIII. RECOMMENDATIONS

Based on the findings in this study, the following recommendations are offered to the federal Office of Minority Health, state governments, state minority health entities, and state health departments. The purpose of these recommendations is to suggest strategies that, if addressed in their entirety, could lead to substantial improvements in efforts at the state level to address racial and ethnic health disparities. Since, by itself, no one particular entity, level, or sector of government will be able to address and eliminate health disparities, the recommendations do not specify who should implement them.

A. LAUNCH AN INITIATIVE TO ASSIST STATES IN THE COLLECTION, TRACKING, AND DISSEMINATION OF DATA ON HEALTH STATUS BY RACE AND ETHNICITY

Most of the study sites lack data on the health status of all racial and ethnic minorities living in their jurisdictions. Such data are essential for government agencies to identify health disparities, plan and justify the special initiatives targeted at minority populations, measure progress in eliminating disparities, and make cross-state comparisons.

A number of states routinely report data only for White and Black residents, or only for Whites and non-Whites. In states where there is no routine reporting on the health status of all minorities, minority health entities (and other organizations interested in identifying and eliminating health disparities) often experience significant delays when requesting special data runs to obtain health data on other racial and ethnic groups. Some state departments of vital statistics are reluctant to provide these data routinely because of concern that the data may be incomplete or misleading.

Efforts should be undertaken individually and collectively at the federal, state, and local levels, and in the public, private, and voluntary health sectors to stimulate and support data collection, reporting, and tracking by race and ethnicity. Consistent with *Healthy People 2010,* the minimum set of racial and ethnic categories used in such data efforts should be based on those recommended in the Office of Management and Budget standard for such data collection. In addition, states may want to decide to collect and report health data on racial and ethnic subgroups to reflect the composition of the racial and ethnic populations within their jurisdictions.

Strategies to identify data needs and to fund and support identified data gaps for small population groups need to be explored and pursued. For instance, it might be useful to provide training and technical assistance at the state and local level to address the following issues:

- *Inaccuracies in Health Data on Native Americans and on Asian and Pacific Islanders.* According to the National Center for Health Statistics, existing mortality rates for White and Black populations are fairly accurate but are understated for American Indians by 21 percent, for Asian and Pacific Islanders by 11 percent, and for Hispanics by 2 percent. Since most of these errors occur at the time that the death certificates are completed, training of funeral directors and coroners (who usually fill out the certificates) could help reduce the miscoding that results in these undercounts. Such an effort is probably best conducted at the local level and may involve collaborative efforts between state agencies, tribal governments, the funeral business, coroners' offices, and minority community-based organizations. Statistical adjustment is another possibility, and has been undertaken by the Indian Health Service in response to the large number of errors made on death certificates of Native Americans.

- *Difficulties Associated with Producing Meaningful Mortality Rates for Small Populations.* Even slight year-to-year variations in mortality rates in small populations can result in meaningless increases or decreases in death rates. Most states address this issue by aggregating data over multiple years. It is not the purpose of this report to discuss or recommend the various statistical techniques that can compensate for some of the data limitations. Rather, it is recommended that states and minority health entities recognize and acknowledge the limitations of existing data (for instance, by adding footnotes to any chart or table in which mortality rates represent undercounts).

To address the various and complex issues related to the timely collection and reporting of valid and reliable data on the health status of racial and ethnic minorities, it is also recommended that forums be sponsored to bring together representatives from state minority health entities; state, tribal, and local health administrations; state, tribal, and local health programs addressing issues (such as OMH's "7+4" issues) that impact the health of racial and ethnic minorities; and directors of vital statistics and related health data collection entities.

B. DEVELOP INITIATIVES TO ASSIST STATES IN IMPROVING INTER- AND INTRA-ORGANIZATIONAL COLLABORATIONS RELATED TO MINORITY HEALTH

Most of the effective approaches identified through the study and presented in this report are based on inter- and intra-organizational collaboration and communication: collaboration within and between state agencies; between health department divisions and relevant community organizations; and between the minority health entities and all of these groups. The following initiatives should make important contributions towards improving the health of racial and ethnic minorities:

- *Increased Collaboration Between State Agencies and Community-based Organizations*. Efforts directed at improving state-community relations of a state's minority health infrastructure could make important contributions towards improving the health of racial and ethnic minorities. Examples of mechanisms include task forces, coalitions, symposia, and contractual relationships (e.g., contracts or cooperative agreements between state agencies and community-based organizations).

- *Interdepartmental Responses to the Health Needs of Special Populations*. A number of state offices have responsibilities for addressing health problems of special populations that include large numbers of racial and ethnic minorities. For instance, offices of migrant health provide health care for migrant and seasonal farm workers of whom a large percentage are Hispanic or Black; offices of women's health often have specific programs for women of color; offices of rural health include services to isolated and underserved minority communities; and offices of refugee health focus on health care to newly arriving refugees (many of whom belong to racial and ethnic minorities). Interdepartmental programs and initiatives may allow for more concerted and effective attention to areas of mutual concern.

- *Coordinated Intra- and Interdepartmental Programs to Identify, Address, and Track Disparities in Unintentional Injuries and Homicide*. Because few programs were identified that specifically targeted disparities in unintentional injuries and homicide (even though these two causes of death are disproportionately high among minorities) it is recommended that special intra- and interdepartmental programs be developed to decrease the gap in unintentional injuries and homicide. Reasons cited by key

informants for the lack of targeted initiatives addressing homicide and unintentional injuries include the following:

- **Unintentional Injuries**. Key informants report that there is no funding to address disparities in unintentional injuries. Moreover, in terms of traffic fatalities, there is some overlap between prevention efforts of the traffic safety officials, departments of substance abuse, and health departments. As a rule, however, none of these efforts address disparities between racial and ethnic groups. In some states only anecdotal data exist to confirm that disparities exist between racial and ethnic groups.

- **Homicide**. Homicide prevention appears to be the purview of law enforcement agencies. Despite overwhelming evidence of large disparities between minorities and non-minorities in homicide AADRs, key informants did not identify any homicide prevention programs run by a health department.

Coordinated interdepartmental programs should therefore be developed to identify, address, and track disparities in unintentional injuries, and homicide. In states, with federally recognized tribes, tribal councils should be asked to participate in this initiative. Other suggested members of the initiative include the minority health entity, relevant divisions within the health department and the department of alcohol and drug abuse, law enforcement agencies, and the department of justice. Other health conditions that could benefit from similar approaches include HIV/AIDS and substance abuse.

C. PROVIDE TECHNICAL ASSISTANCE TO IMPROVE STATE HEALTH INFRASTRUCTURES PARTICULARLY RELATED TO POLICIES, PROGRAMS AND PRACTICES ON HEALTH DISPARITIES

Findings indicate that those minority health entities who have longstanding membership in OMH's national Minority Health Network, and participate regularly in OMH conferences, receive valuable information on how to develop and promote strategies designed to eliminate health disparities. A number of minority health entities conduct periodic training conferences that are of valuable assistance to community-based agencies serving minority populations. However, findings indicate that most if not all minority health entities (newly established as well as those that are older) and relevant state health agencies could benefit from technical assistance on effective or promising strategies for eliminating health disparities.

It is recommended that a process for securing and providing needed technical assistance be instituted. Specific technical assistance topics that could benefit the overall state infrastructure, not just minority health entities, include the following:

- Incorporating the goal of eliminating racial and ethnic disparities in health into short-term and long-term health plans consistent with the national *Healthy People 2010* plan.

- Examining local, regional, and national demographic trends and the implications for public health workers (for instance, if states are not prepared for increases in certain racial and ethnic groups, it will not be possible to be proactive in developing culturally appropriate and linguistically appropriate health care services for these groups).

- Conducting community health needs assessment, including the assessment of the needs of racial and ethnic minority populations in the studied jurisdiction– such assessments should examine demographic variables, including cultural and linguistic characteristics in order to inform policies, programs, and budgets, as well as workforce development and training.

- Identifying performance indicators to assess the effectiveness of programs addressing the health needs of racial and ethnic minority populations;

- Examining and assessing community health promotion strategies that promote healthy behaviors; and identifying effective communication strategies (e.g. announcements on ethnic minority radio and television stations, reports in newspapers read by the targeted minority groups, health fairs);

- Moving beyond individually-based determinants of health (e.g., to social, economic, political, environmental, cultural determinants), and promoting healthy communities conducive to healthy people;

- Recruiting, training, and retaining minorities in the health professions (e.g., mechanisms for introducing minority youth, as early as middle school, to the health professions; provision of mentoring, internships and other support programs; collaboration with community-based minority organizations, colleges and universities that have historically served minority students, and

state agencies such as Area Health Education Centers that focus on training and recruiting health professionals in medically underserved areas).

- Conducting periodic cultural competency training for public health employees in order to enhance the capacity of the public health system to effectively serve racial and ethnic minority populations, and to respond to changes in the racial and ethnic composition of the population.

D. SPONSOR A NATIONAL FORUM ON NATIVE AMERICAN HEALTH CARE

Findings indicate that the primary responsibility for providing health care to Native Americans who are members of federally recognized tribes belongs to the Indian Health Service, and that, in many instances, the services are administered by the tribes. However, state health departments and nonprofit groups provide some health care as well to Native Americans who are members of federally recognized tribes—to Native Americans living on or near tribal lands, as well as to those living elsewhere. In addition, all states provide health care to Native Americans who are not members of federally recognized tribes.

Confusion exists because the health care infrastructure for Native Americans includes three different government levels: 1) the federal government, 2) tribal governments, and 3) state governments. The issue is further compounded by differences in the geographic boundaries of state and tribal jurisdictions. States have distinct political boundaries; tribal lands, on the other hand, may spread across multi-state regions.

It is recommended that a national forum of Native American health care be sponsored. Such a forum would include state health department officials, tribal leaders, the directors and coordinators of minority health entities, and representatives from the IHS area offices that provide health care to Native Americans. The forum should identify strategies through which state and tribal governments can complement and supplement their respective health systems to improve the health of Native Americans, including Native Americans who are not part of federally recognized tribes.

E. ESTABLISH REGIONAL MULTI-STATE INITIATIVES ON AREAS OF COMMON CONCERN

Findings indicate that minority health concerns usually cross state boundaries and are often regional in nature (for instance, concern about the high incidence of stroke in South Carolina, North Carolina, and Georgia—an area known as the "stroke belt" of the South). It is therefore recommended that states consider the establishment of multi-state initiatives to address areas of common concern such as the collection of data on the health status of relatively small minority populations, health professions recruitment and training in minority populations; or tobacco use prevention efforts in tobacco-producing regions.

F. INCREASE FUNDING FOR MINORITY HEALTH INITIATIVES AT THE STATE AND LOCAL LEVELS

The availability of resources devoted to addressing minority health disparities plays a large role in the extent that a state's infrastructure can develop services for racial and ethnic minorities. It will be difficult for states to achieve the *Healthy People 2010* goal of eliminating health disparities along racial and ethnic lines if, at the federal, state and local levels, little or no attention is given to identifying, monitoring, and addressing these disparities.

It is recommended that states pursue efforts to obtain the necessary budgetary support to more adequately address the racial and ethnic health disparities that exist within their jurisdictions. It is also recommended that this funding support the work of the minority health entities, and their ability, where appropriate, to fund demonstration grants. However, the funding should not be limited to minority health entities. The leadership and vision for eliminating health disparities should come from the top. It is important that state leadership understand that without attention and resources dedicated to eliminating health disparities—whether or not through the minority health entities, the gaps between the most and least healthy population groups will continue to increase. Such gaps jeopardize the health of the whole population.

> *The entire Nation benefits when we protect the health of those most vulnerable.*
>
> —David Satcher, M.D., Ph.D.
> Assistant Secretary for Health and
> Surgeon General
> January 2000

STATES WITH AN ESTABLISHED OFFICE OF MINORITY HEALTH

December 1999
n=33

Alabama	Missouri
Arizona	Nebraska
Arkansas	New Jersey
California	New York
Connecticut	North Carolina
Delaware	Ohio
Florida	Oklahoma
Georgia	Oregon
Illinois	Rhode Island
Indiana	South Carolina
Iowa	Tennessee
Louisiana	Texas
Maryland	Utah
Massachusetts	Vermont
Michigan	Virginia
Minnesota	Washington
Mississippi	

APPENDIX B

List of Advisory Panel Members

ASSESSMENT OF STATE MINORITY HEALTH INFRASTRUCTURE AND CAPACITY TO ADDRESS ISSUES OF HEALTH DISPARITY

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APPENDIX C

Key Study Questions and Corresponding Subquestions

LIST OF KEY STUDY QUESTIONS AND
CORRESPONDING SUBQUESTIONS

1. **What are the nature and extent of efforts at the state level to eliminate health disparities, especially among racial and ethnic groups?**

   - What types of programs or policies is the state government implementing to eliminate health disparities? Do these programs include the work of a minority health entity?

   - What is the legislative or policy history of the minority health entity, if it exists?

   - What major health disparities among racial and ethnic minorities exist in the state?

   - How large are the state's minority health programs in terms of budgets, number of full-time equivalent staff, number of community-based organizations, and number of government agencies or number of people affected for current fiscal year?

   - What types of linkages and collaboration exist among state government offices, community-based organizations, consumers, and the minority health entity, if it exists?

2. **What are the nature and extent of efforts at the state level to eliminate or close the gap between racial and ethnic groups in the priority health issue areas of particular concern to OMH? These priority health areas are cancer, cardiovascular disease, diabetes, HIV/AIDS, infant mortality, substance abuse, homicide, suicide, and unintentional injuries.**

   - What state initiatives exist to eliminate health disparities in these priority health areas?

   - To what extent is the minority health entity involved in some or all of these initiatives?

3. **What efforts are in place or planned at the state level to address each of the four cross-cutting priority issue areas as they relate to improvements in the health of racial and ethnic minorities? The four crosscutting issues are: access to healthcare, cultural competence, data collection and analysis, and health professions development.**

   - What state initiatives exist that address the four cross-cutting issues as they relate to minority health?

   - To what extent is the minority health entity involved in some or all of these initiatives?

4. **To what extent are state efforts to eliminate health disparities and address health concerns of racial and ethnic minorities linked to national efforts such as Healthy People 2000 or 2010?**

   - How does the state government document the need for minority health initiatives and track outcomes?

   - How does the minority health entity document the need for minority health initiatives and track outcomes?

   - What documentation exists to show that the state government has been effective in identifying and addressing health disparities?

   - What documentation exists to show that the minority health entity, if it exists, has been effective in identifying and addressing health disparities?

   - Is any of this documentation linked to Healthy People 2000 or 2010 or other national objectives?

(Continued on next page)

5. **What, if any, features or characteristics of minority health entities hinder or contribute to their effectiveness? How is such effectiveness measured?**

   • What features or characteristics of minority health entities (e.g., mission statements, number of staff, presence of advisory board, level and stability of funding) contribute to their planning, operational, and political effectiveness?

   • What features or characteristics of minority health entities (e.g., absence of legislative support, staff and budget limits) hinder their planning, operational, and political effectiveness?

6. **What features, characteristics, or elements promote and hinder the establishment and effectiveness of minority health entities?**

   • What features, characteristics, individuals, or entities promote the establishment and/or continuance of minority health entities?

   • What features, characteristics, individuals, or entities hinder the establishment and/or continuance of minority health entities?

7. **Are efforts to "close the gap" in health disparities between racial and ethnic groups more likely to occur when dedicated minority health entities are established? Why or why not?**

APPENDIX D

1. Interview Guide for Directors of Established Offices of Minority
   Health and for rity Health Contact Persons
2. Interview Guide for Representatives from the State Health Department,
   Other State Agencies, and Community-based Organizations
3. Interview Guide for Health Commissioners and Persons at
   the Cabinet-level Position
4. Interview Guide for Legislators

APPENDIX D-1

Interview Guide for Directors of Established Offices of Minority Health and for Minority Health Contact Persons

INTERVIEW GUIDE FOR DIRECTORS OF ESTABLISHED OFFICES OF MINORITY HEALTH AND FOR MINORITY HEALTH CONTACT PERSONS

I. Description of State or Territorial Minority Health Entity

For States with a State Office of Minority Health:

1. What year was the State Office of Minority Health formed?

2. What was the mechanism for the formation of the State Office of Minority Health (e.g., legislation, executive order of governor or commissioner of health)?

3. What were some of the underlying factors (political, health-related, etc.) which contributed to the formation of the State Office of Minority Health?

4. How does the State Office of Minority Health fit into the government structure? Is it within the health department or outside of it? To whom does the State Office of Minority Health director report?

5. What is the mission of the State Office of Minority Health?

6. How large is the budget of the State Office of Minority Health? Where does the budget come from (federal, state or territorial, non-government/private funds)? Are these discretionary or mandated funds? What is covered by this budget?

7. If private funding does exist, how does its use differ from that of other funding sources?

8. Who has budgetary authority? How has the budget or budgetary authority evolved during the existence of the State Office of Minority Health?

9. How large is the State Office of Minority Health in terms of staff (FTEs)?

10. Are there satellite State Office of Minority Health offices?

For states and territories with a minority health contact person:

1. Since what year has there been a minority health contact person?

2. What factors contributed to the state or territory having a minority health contact? How was this person selected/recruited?

3. What is the position of the minority health contact in the government structure? Does he/she work within the health department or outside of it? To whom does he/she report?

4. What is the job description of the minority health contact person?

5. Does the minority health contact have a budget? Where does the budget come from (federal, state or territorial, non-government/private funds)? Are these discretionary or mandated funds? What is covered by this budget?

6. If private funding does exist, how does its use differ from that of other funding sources?

7. Who has budgetary authority?

II. Capacity to Address Minority Health Disparities Within the State Office of Minority Health

1. What programs/assistance/initiatives did the State Office of Minority Health or the minority health contact work on during the past year (FY98), and what are plans for the current year (FY99)?

2. Are these programs directed towards minorities (Blacks, Asian-Americans, Hispanics, and Native Americans) in general? Or, is the focus on specific racial/ethnic groups or on specific health areas?

3. What types of data or measurement are used: a) by the state or territory; and b) by the State Office of Minority Health or minority health contact to determine minority health disparities in the seven OMH priority health areas?

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-   Cancer
-   Cardiovascular disease
-   Diabetes
-   Infant mortality
-   HIV/AIDS
-   Substance abuse
-   Suicide, homicide and unintentional injuries
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4. Are there any health areas or racial/ethnic population groups for which it is difficult to obtain data?

5. Does the State Office of Minority Health or minority health contact have initiatives directed towards minority health in these seven priority health areas?

6. These are the four cross-cutting issues of primary concern to OMH. How does the State Office of Minority Health or minority health contact define these terms? Does the State Office of Minority Health or minority health contact have initiatives directed towards these four cross-cutting issues?

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-   Access to health care
-   Cultural competency
-   Data collection and analysis
-   Health professions development
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III. Statewide Capacity to Address Minority Health Disparities

1. Is there a statewide strategic plan/Health Improvement Plan that addresses minority health issues? Does this plan identify minority health objectives or goals?

2. What is the role of the State Office of Minority Health or minority health contact in formulating this plan and defining the objectives?

3. What other health department divisions or state or territorial agencies address minority health? Do they address minority health in general, or do they focus on specific racial/ethnic populations or health conditions?

4. To what extent do these other health department divisions or state or territorial agencies have initiatives in place to eliminate the gap in health disparities for minorities?

5. What other health department or state or territorial agencies address the four cross-cutting issues? What is the extent for their initiatives in terms of the four cross-cutting issues?

6. Does the State Office of Minority Health or minority health contact work or communicate with other agencies within or outside the health department concerning minority health? How formal is any collaboration or dialogue?

7. Do health coverage initiatives (such as Medicaid, Medicare, managed care, CHIPS) affect health care for minorities?

IV. Minority Health Initiatives in the Private Sector

1. What is the role of nongovernment organizations (NGO) in addressing and reducing minority health disparities in the priority health areas identified above?

2. Which, if any, mechanisms are used to facilitate collaboration between the NGOs and the State Office of Minority Health or minority health contact regarding issues of health disparity?

3. Does the State Office of Minority Health or minority health contact provide assistance to the private sector in addressing minority health issues (e.g., through training, technical assistance, funding)?

V. Minority Health Advisory Committee, Task Force, or Coalition

1. Is there an State Office of Minority Health Advisory Committee?

2. Is the State Office of Minority Health or minority health contact a part of a task force or coalition on minority health?

3. What is the role of the advisory committee/task force/coalition?

4. What are the demographic/geographic issues that influence the makeup of the advisory committee/task force/coalition?

5. Describe the size and composition of the advisory committee/task force/coalition.

6. Is the advisory committee/task force/coalition culturally and ethnically representative of minority communities? Which, if any segments of minority communities are not represented?

7. What specific types of support is the state or territorial department of health providing the advisory committee/task force/coalition?

8. How is the advisory committee/task force/coalition's work assessing the extent to which it is addressing health disparities in the minority community?

9. Does the advisory committee/task force/coalition serve in a policy-making, decision-making, or advisory capacity? If advisory, whom do they advise? If decision making, what decisions do they make? If policy-making, what policies do they set?

10. What is the level of coordination, communication and collaboration among the minority health advisory committee/task force/coalition and other agencies/departments/branches within the state or territorial government?

VI. Effectiveness of the State Office of Minority Health or Minority Health Contact

1. How does the state or territory evaluate its effectiveness in terms of addressing and responding to minority health concerns?

2. How does the State Office of Minority Health or minority health contact contribute to the overall effectiveness of the state or territory's minority health infrastructure?

3. Does a formal evaluation process exist to determine whether any of the State Office of Minority Health or minority health contact activities have been effective?

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4. Does a formal evaluation process exist to determine whether any other state or private sector minority health initiative has been effective?

VII. Challenges

1. What are the major barriers/challenges faced by the State Office of Minority Health or minority health contact in implementing its mission?

2. What are the major barriers/challenges faced by the State Office of Minority Health or minority health contact in developing linkages regarding minority health concerns; a) within the state or territorial health department; b) with other agencies in the state or territorial government; and c) with NGOs?

3. What factors have contributed to the continued operation of the State Office of Minority Health or the work of the minority health contact?

APPENDIX D-2

**Interview Guide for Representatives from the State Health Department,
Other State Agencies, and Community-Based Organizations**

**INTERVIEW GUIDE FOR REPRESENTATIVES FROM THE
STATE HEALTH DEPARTMENT, OTHER STATE AGENCIES, AND
COMMUNITY-BASED ORGANIZATIONS**

I.   Addressing Minority Health

1.   What is the mission of your agency/organization, and what are its primary functions?

2.   Does your agency/organization address any of the following Office of Minority Health (OMH) priority areas:

> - Cancer
> - Cardiovascular disease
> - Diabetes
> - Infant mortality
> - HIV/AIDS
> - Substance abuse
> - Suicide, homicide and unintentional injuries

3.   For each issue addressed by the agency:

- How does your agency/organization address this issue? What types of programs or initiatives are pursued?

- Do these initiatives or programs have minority health components?

- Do you receive funding from the state health department or other state agencies for your minority health programs?

4.   Does your agency/organization address any of the following four cross-cutting issues identified by OMH:

> - Access to health care
> - Cultural competency
> - Data collection and analysis
> - Health professions development

5.   For each cross-cutting issue addressed by your agency/organization:

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- How does your agency/organization address this issue? Are specific programs or initiatives identified by your agency/organization, or are these issues addressed at a more general level?

- Do these initiatives or programs have minority health components?

- Do you receive funding from the Puerto Rico government for your minority health programs?

6. Is your agency/organization working towards achieving Healthy People 2000/2010 objectives? How will the upcoming Healthy People 2010 objectives impact your agency organization?

7. Is your agency/organization working to achieve the objectives of the President's Initiative to Eliminate Racial and Ethnic Disparities in Health?

II. Commitment to Minority Health

1. Do you know whether there is a statewide strategic plan that addresses minority health issues? Does this plan identify minority health objectives?

2. What is the role, if any, of your agency/organization in formulating this plan and defining the objectives?

3. Are you familiar with the work of the State Office of Minority Health or the state minority health contact person?

4. What is the link between your agency/organization and minority health programs that exist at the state level? How was this linkage established?

5 Which, if any, mechanisms are used to facilitate collaboration between community-based organizations and the state department, State Office of Minority Health or [minority health contact person] in terms of minority health?

6. Does/would the presence of a dedicated state Office of Minority Health contribute to the operations, success, and influence of your agency/organization?

7. Do the individuals you serve feel that the state is making a dedicated effort to resolving the problems associated with minority health?

8. From your perspective, do health coverage initiatives (such as Medicaid, Medicare, managed care, CHIPS) affect health care for minorities?

9. Does your organization feel that the state has been effective in addressing minority health and decreasing minority health disparities? How does the state or your agency/organization determine if a program has been effective?

III. Challenges

1. What are the major barriers/challenges faced by your agency/organization in developing linkages regarding minority health concerns: a) within the state health department; b) with other agencies in the state government; and c) with NGOs? What has been done to address these barriers?

2. What factors facilitate the development of linkages regarding minority health concerns: a) within the state health department; b) with other agencies in the state government; and c) with nongovernment organizations?

3. In your opinion, what factors hinder or contribute to eliminating the disparity in health for minority populations in your state?

APPENDIX D-3

**Interview Guide for Health Commissioners and Persons at
the Cabinet-Level Position**

INTERVIEW GUIDE FOR HEALTH COMMISSIONERS
AND PERSONS AT THE CABINET-LEVEL POSITION

1. Please describe the policy and program history related to minority health.

2. Does the health department have a strategic plan related to minority health, i.e., Health Improvement Plan?

3. What policies have you put in place related to minority health since you took office?

4. What funding priorities in minority health have occurred in your administration?

5. Please describe the current minority health infrastructure. Do you see any changes in that infrastructure in the future?

6. For which racial/ethnic population group(s), and for which diseases are there the greatest disparities?

7   Is the health department working towards achieving Healthy People 2000/2010 objectives? How will the upcoming Healthy People 2010 objectives impact the health department?

8. Which Healthy People 2000/2010 objectives have been adopted based on the state's needs?

9. What specific minority health initiatives have your highest priority?

10. What are the challenges to eliminating minority health disparities in your state? What factors facilitate efforts to eliminate health disparities?

11. How is progress in minority health measured in the state?

12. What minority health programs or outcomes are you most proud of?

13. What minority health initiatives are currently being proposed/considered?

14. To what extent have you involved the grassroots and minority communities in the development or implementation of minority health initiatives?

15. What is the contribution of the minority health entity to the state's efforts to eliminate the gap in health disparities?

APPENDIX D-4

Interview Guide for Legislators

INTERVIEW GUIDE FOR LEGISLATORS

1. Please describe the legislative history related to minority health in your state?

2. For which population group(s) and which diseases is there the greatest disparity in the state?

3. What specific racial and ethnic minority health laws have been enacted within the past 5 years (e.g., HIV, infant mortality, diabetes)?

4. What are the current legislative bills related to minority health?

5. Are you familiar with the Healthy People 2000/2010 objectives? How will the upcoming Healthy People 2010 objectives impact the state?

6. How important is the development of minority health policy in the state?

7. What are the barriers to minority health legislation in the state? What factors facilitate minority health legislation?

8. To what extent does the legislature involve the grassroots community in the development or minority health laws, e.g., hearings and oversight?

APPENDIX E

**California Statutory Provisions Related to Cultural and
Linguistic Competence**

Appendix E

CALIFORNIA STATUTORY PROVISIONS RELATED
TO CULTURAL AND LINGUISTIC COMPETENCE

California State Statutes	Specific Legislative Language
Welfare and Institutions Code (WIC), Section 4341	Relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: "Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state."
WIC, Section 14684 (h)	Each plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competency needs of the program. The plan shall include, as part of the quality assurance program required by Section 40070, a process to accommodate data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.
WIC, Section 5600.2	Relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable, and which include the following factors:
WIC, Section 5600.2 (g)	"Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should: 1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting form cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs, 2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups, 3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities."
WIC, Section 5600.9 (a)	Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs."
WIC, Section 5802 (a)(4)	Relates to Adult and Older Adult Mental Health System of Care. "System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes.

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California State Statutes	Specific Legislative Language
WIC, Section 5855 (f)	Relates to Children's Mental Health System of Care. "Cultural Service effectiveness is dependent upon both culturally relevant and competent service delivery."
WIC. Section 5865 (b)	Relates to County System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. " A method to screen and identify children in the target population . . . including persons from ethnic minority cultures which may require outreach for identification. A defined mechanism to ensure that services are culturally competent."
WIC. Section 5880 (b)(6)	Relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. "To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation."
California Government Code (CGC) Section 7292	Relates to state agencies; bilingual employees. "Every state agency, as defined in Section 11000, except the State Compensation Insurance Fund, directly involved in the furnishing of information or the rendering of services to the public whereby contact is made with a substantial number of non-English-speaking people, shall employ a sufficient number of qualified bilingual persons in public contact positions to ensure provision of information and services to the public, in the language of the non-English-speaking person."
CGC, Section 7295	Relates to non-English translations. "Any materials explaining services available shall be translated into any non-English language spoken by a substantial number of the public served by the agency. Whenever notice of the availability of materials explaining services available is given, orally or in writing, it shall be given in English and in the non-English language into which any materials have been translated. The determination of when these materials are necessary when dealing with local agencies shall be left to the discretion of the local agency."
CGC Section 7296.2	Defines "substantial number" of non-English-speaking people. A "substantial number of non-English-speaking people are members of a group who either do not speak English, or who are unable to effectively communicate in English because it is not their native language, and who comprise 5 percent or more of the people served by any local office or facility of a state agency."