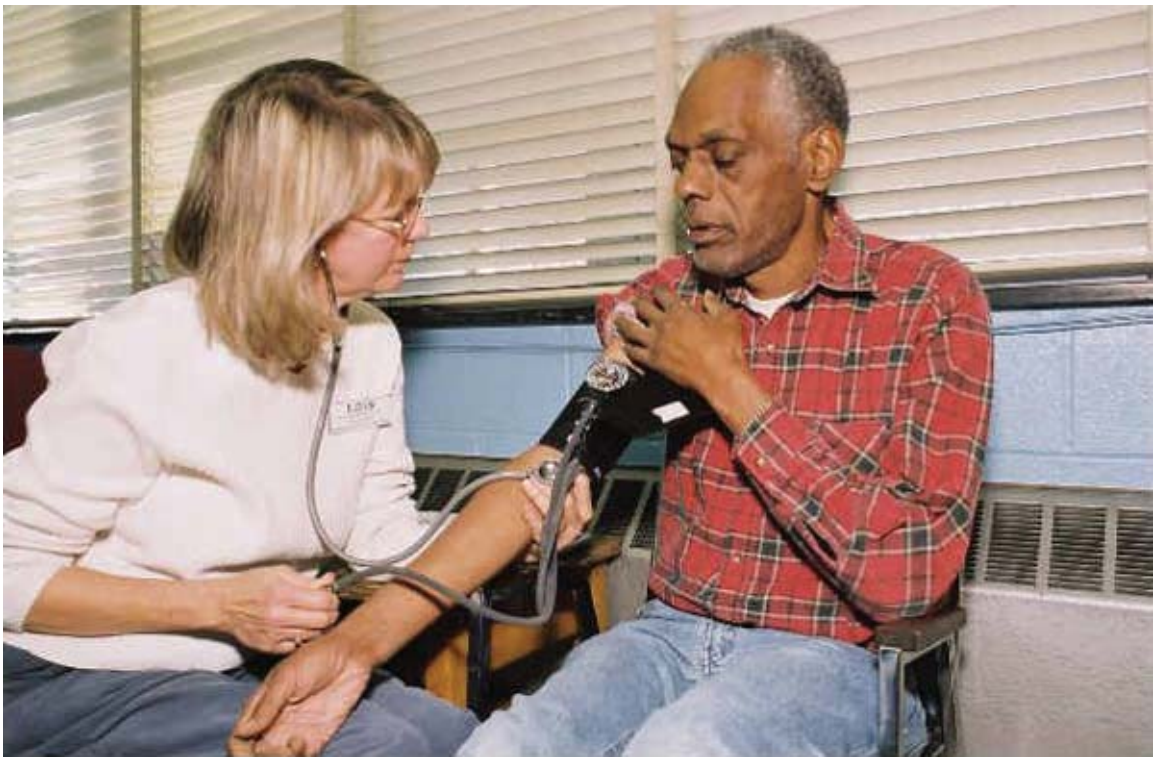
Summary of
Promising Programs* to Eliminate Racial and Ethnic Health Disparities

*in states other than Delaware



researched and compiled by
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Healthcare Policy

December 2004

Institute for Public Administration
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www.ipa.udel.edu

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Promising Programs to Eliminate Racial and Ethnic Health Disparities

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This report provides Delaware policymakers with a series of approaches, or best practices, **used in other states** to address minority health disparities. Since narrowing health disparities has gained greater attention at the national, state, and local levels, this collection of policy options should be considered a work-in-process. In developing this compendium, the research team had the benefit of input and feedback from State of Delaware officials and representatives of the Metropolitan Wilmington Urban League. Shortly after IPA began researching promising practices, The Commonwealth Fund published a tremendously valuable 87-page report: *A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities* (June 2004). www.cmwf.org/programs/minority/mcdonough_statepolicyagenda_746.pdf

Many of the approaches described below are included in the aforementioned report from The Commonwealth Fund. Not surprisingly, there are similar kinds of information in both resources. However, IPA did not simply "cut and paste" from The Commonwealth Fund report. The material presented has been modified (and hopefully improved) in a few important ways: 1) rather than long narratives, it is presented in a tabular (more user-friendly) form and will be accessible online; 2) to ensure that the information is complete and up-to-date, IPA researched state/program websites and contacted program officials when necessary; and 3) included is additional information obtained through IPA's own, independent search (to continue through fall of 2004) to identify promising programs.

Other important sources of information have been evaluated and included in this summary. Specifically, this summary includes programs and approaches from five other major disparities resources, including the American Public Health Association (APHA), Centers for Disease Control and Prevention (CDC), Association of State and Territorial Health Officials (ASTHO), National Association of County & City Health Officials (NACCHO), U.S. Department of Health and Human Services: Health Resources and Services Administration (HRSA), Robert Wood Johnson Foundation (RWJF), and the American Medical Association (AMA). IPA also examined a variety of resources from key states, including state departments of health and offices of minority or multicultural health.

- **APHA**: IPA studied at length a database of programs provided by the American Public Health Association (APHA) entitled Community Solutions to Health Disparities Database: www.apha.org/NPHW/solutions/. The database features a search engine where users can sort disparity programs by specific age groups, racial/ethnic groups, gender, and state.

  In addition to the searchable database, APHA publishes facts sheets on eliminating health disparities entitled Communities Moving from Statistics to Solutions. Fact sheets can be found at www.apha.org/NPHW/pressroom/.

- **RWJF**: The Robert Wood Johnson Foundation is working with health plans, providers, and patients to design programs and approaches to eliminate disparities. They also conduct research on data-collection methods, allocate grants, and present a program to eliminate cultural and language barriers (www.rwjf.org/programs/programArea.jsp).

- **CDC**: IPA examined the national initiative *Racial and Ethnic Approaches to Community Health* (REACH). A list of the 2004 REACH project sites can be found on the CDC website at www.cdc.gov/nccdphp/aag/aag_reach.htm.

  The CDC also highlights several Exemplary State Programs specifically aimed at chronic disease prevention for racial and ethic minorities. To be selected, these programs must be based on strong research, incorporate innovative approaches, and yield positive, measurable outcomes (www.cdc.gov/nccdphp/exemplary/).

- **ASTHO, NAACHO, HRSA**: IPA researched the collaborative publication *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health*. This resource presents dozens of model state and local programs that reflect diverse strategies being used to address health disparities. The report can be purchased at www.naccho.org/prod107.cfm.

- **AMA**: The American Medical Association's Minority Affairs Consortium examines minority health issues and professional concerns of minority physicians and medical students, and seeks to inspire minority children to pursue careers in the medical profession (www.ama-assn.org/ama/pub/category/20.html).

IPA has developed, organized, and presented programmatic information in a way that will help leaders think systematically about actions that work together to narrow racial and ethnic disparities. Policies and approaches can address both structural causes (e.g., data collection) and interpersonal factors (e.g., physician interaction and language competency). IPA presents two types of policy interventions: specific health conditions and system-wide (state-level) infrastructure and capacity options. To date, IPA presents information for 15 categories of best practices (nine health conditions and six system-wide interventions):

Health Conditions
- Asthma
- Cancer
- Cardiovascular Disease
- Diabetes
- HIV/AIDS
- Immunizations
- Infant Mortality
- Obesity
- Oral Health

System-wide Interventions
- Cultural and Linguistic Competency
- Data
- Regional Networking and Collaboration
- Purchasing
- State Infrastructure
- Workforce Development

Health Conditions	**No. of Programs**
Asthma	7
Cancer	5
Cardiovascular Disease	7
Diabetes	6
HIV/AIDS	6
Immunizations	6
Infant Mortality	7
Obesity	6
Oral Health	6
TOTAL	**56**
State-wide Interventions	**No. of Programs**
Cultural and Linguistic Competency	9
Data	5
Regional Networking and Collaboration	4
Purchasing	5
State Infrastructure	5
Workforce Development	6
TOTAL	**34**

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Asthma**
Background:	In 1996, there were 14.6 million people with asthma in the United States, a 74 percent increase from 1980. Evidence shows that asthma is more prevalent among those with lower socioeconomic standing or minority status, possibly due to poor healthcare quality and access, environmental conditions, financial restrictions, and lingual/cultural barriers. Among minorities, there are significantly higher rates of diagnosis, hospitalization, and death from asthma. Nationally, African Americans have 40 percent higher rates of asthma induced office visits than whites, 125 percent higher asthma-related emergency room visits, and 220 percent higher asthma-related hospitalization rates. African-American children are four times as likely to die from asthma as white children.
State Programs:	Current state programs most frequently focus on distributing information to high-risk populations; allowing students to carry their medications in school; housing environment assessments; enhanced education, outreach and disease management; and other proactive measures that focus on prevention, rather than reaction to the condition (e.g., limiting exposure to environmental and housing stimulants like dust and animal fur.)
Illinois	***Asthma Information Program*** – This program targets high-risk groups for distribution of information regarding asthma causes, prevention techniques, and treatment. Target groups include African Americans, Hispanics, the elderly, children, people with a family history of asthma, and those exposed to environmental factors associated with high risk of asthma. (20 ILCS 2310/2310-337) www.legis.state.il.us/legislation/ilcs/ilcs.asp
	Self-administration of Asthma Medication – State legislation that allows students to possess and use their asthma mediations at their own discretion. (105 ILCS 5/ 22-30) www.legis.state.il.us/legislation/ilcs/ilcs.asp
New York	***Action Against Asthma: Healthy Neighborhoods Program*** – Asthma education and management is promoted in households where a member has asthma. Seeks to cut asthma hospitalizations through proactive interventions such as dust control, pillow and mattress covers, and mold/mildew removal in the home. www.health.state.ny.us/nysdoh/asthma/ny_action.htm
California	***California Asthma Public Health Initiative (CAPHI)*** – State, local, and community efforts are coordinated to promote consistent and equal asthma management, education and trainings, treatment, and prevention. CAPHI provides funding for community interventions, treatment services, and provider education. California law focuses greater attention on data surveillance, data analysis, and evidence-based care. www.dhs.ca.gov/ps/cdic/cdcb/Medicine/Asthma/
Mississippi	***Caffee, Caffee, and Associates PHF Inc. Hattiesburg, Miss.*** – The group developed partnerships with faith-based groups, NGOs, and tribes in order to address the issue of secondhand smoke. The program designs events to encourage the community to reduce exposure to secondhand smoke. Events

	motivate people to declare their homes and cars "tobacco-free" environments. This is an APHA *Statistics to Solutions* program example. For more information, contact Brenda Caffee at (601) 583-0599.
Pennsylvania	***Health Promotion Council: Smokeless Homes in Philadelphia, Pa.*** – This program is geared toward educating African Americans and Latinos about the link between asthma and smoking. Program administrators attend community health fairs and distribute information about smoking to teachers, parents, and healthcare providers. This is an APHA *Statistics to Solutions* program example. For more information, contact Tawanda Hayes at (215) 731-6106. www.hpcpa.org/smokeless.htm
Seven Major U.S. Cities: Results published in Sept. 9, 2004 issue of NEJM.	***Results of a Home-Based Environmental Intervention Among Urban Children with Asthma*** – This study was used to determine if an environmental intervention specific to a child's allergies would improve asthma-related health conditions over the course of one year. 937 children with asthma were randomly chosen from seven major U.S. cities. Their households received education and remediation for exposure to allergens and tobacco smoke. Each household was evaluated every six months, and the child's asthma-related health complications were evaluated every two months. The study concluded that, after each two-week interval, the intervention group had fewer days with symptoms and significant declines in the levels of allergens in the home. As a result, morbidity caused by asthma related illness was reduced.[1]

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Cancer**
Background:	In 2003, approximately 556,500 people died in the United States of cancer, and the largest portion of them were African Americans, who have the highest rate of cancer incidence and death of all ethic or racial groups. According to the NIH, socioeconomic levels are the biggest factor in the incidence of cancer. While African Americans have the highest incidence of all cancers combined, Hispanics have the highest incidence of cervical cancer. Asian/Pacific Islanders have the lowest incidence of all cancers combined, but they have the highest death and incidence rates of stomach and liver cancers. Disparities for minority cancer patients can be seen in the forms of less radiation care after surgery, less aggressive treatment, and fewer uses of new or more expensive treatment. In Delaware in 2001, cancer mortality rates were 216 per 100,000 for whites and 249 per 100,000 for African Americans. Both rates are higher than national averages of 194 per 100,000 for whites and 243 per 100,000 for African Americans.[2]
State programs:	State programs tend to focus on prevention and awareness. Many programs offer screenings to high-risk minorities at low or no cost. Some provide mobile screening/testing centers, while others partner with health clinics and other community organizations.
New Jersey	***Bergen County Education and Early Detection Program, Paramus, N.J.***

	The program's purpose is to increase awareness of and screenings for prostate cancer among African-American men. This is done through the use of African-American celebrities and prominent pastors and community events where local hospitals give free screenings. This is an APHA *Statistics to Solutions* program example. bergenhealth.org
Maryland	***Baltimore City Cancer Plan Prostate Cancer Screening*** – African-American men in Baltimore City experience three times the age-adjusted prostate cancer mortality of Caucasian men. This program partners with seven community-based organizations to help encourage age-appropriate prostate cancer screening for minority populations. The goal of this project is to identify and treat prostate cancer for high-risk underinsured Baltimore residents. The program also educates the community about prostate cancer screening, provides opportunities to participate in no-cost screening, and provide diagnosis and treatment to eligible individuals. Source: APHA insidehopkinsmedicine.org/oncology/.
California	***Increase Cervical Cancer Screening Among Vietnamese American Women*** – The Vietnamese Community Health Promotion Project organized a coalition to prevent cervical cancer among Vietnamese American women in Santa Clara County. Coalition members held community forums, meetings, and retreats to identify barriers to Pap testing, and designed ways to address each concern. Six strategies were implemented, including a media education campaign; outreach efforts using lay health workers; patient navigation; a low-cost Vietnamese-language clinic (staffed by a female Vietnamese physician); mailed screening reminders; and advocacy to re-establish a breast- and cervical-cancer-control program in the county. Results show that, after meeting with lay workers, 46.8 percent of women who had never received a Pap test obtained one, and more than 1,214 Vietnamese American women called to receive more information and assistance. CDC Exemplary Program: **REACH** www.healthisgold.org
Mississippi	***Mississippi Breast and Cervical Cancer Program*** – The program targets women, specifically African Americans and the elderly, who are uninsured, medically underserved, and poor. Participants work to reduce differences in screening and access to care and eliminate fear about cancer or being screened for cancer. The Mississippi Department of Health and Early Detection Services provides this service through funding from state, federal, and CDC funds. Pap smear tests are available for uninsured women 18 years and older, and mammogram screenings are available for uninsured women 50 years and older. www.msdh.state.ms.us/msdhsite/index.cfm/41,0,103,html
Ohio	***Breast and Cervical Cancer*** – The local health departments in Ohio have teamed up with the Breast and Cervical Cancer Early-Detection Program to help screen underserved populations. This program uses a mobile mammogram unit as well as a team of volunteer translators to target Amish, Asian, Hispanic, and African-American communities. Source: APHA www.odh.state.oh.us

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Cardiovascular disease**
Background:	Cardiovascular disease (CVD) is the leading cause of death for all minority and ethnic groups in the United States. Multiple conditions, including hypertension, heart disease, and stroke, contribute to 62 million cases of CVD annually. Over $350 billion dollars are spent on CVD-related health care each year. Racial minorities develop the conditions that lead to CVD more frequently, at a younger age, and they are less likely to seek treatment. For instance, 35 percent of African-American men develop hypertension, compared to 25 percent of all men. Similar statistics exist among ethnic groups for women. Mortality from CVD also varies by ethnic group, with mortality rates 40 percent higher for African Americans compared to those for whites. In 2001, Delaware's CVD mortality rates per 100,000 people were 251 for whites, compared to 302 for African Americans.[3]
State programs:	Most states have some CVD-related programs, ranging from general education and awareness programs to those specifically aimed at reducing disparities in CVD development and treatment. Due to the nature of CVD and its importance as a healthcare issue, many programs collaborate with employers, academic, and community organizations.
Maine	***Worksite High-Blood-Pressure Programs*** – The Maine Board of Health helps to fund and establish new programs at worksites that do not provide blood-pressure screening. The screenings detect high blood pressure and make referrals to physicians so employees can control blood pressure. The Board of Health will also periodically evaluate the effectiveness of the program. janus.state.me.us/legis/statutes/22/title22sec1697.html
	Community-Based Heart Attack– and Stroke-Prevention Programs – These programs provide education in schools, the community, and the workplace on how to prevent heart attacks and strokes. Programs that promote healthy behaviors, such as smoking cessation programs and blood-pressure and cholesterol screenings, are also offered to the public. janus.state.me.us/legis/statutes/22/title22sec1699.html
Illinois	***Stroke Task Force*** – Stroke prevention education is presented to high-risk populations and areas with high incidence of stroke. Educational efforts concentrate mostly on the prevention, identification, and treatment of strokes. (20 ILCS 2310-372) www.legis.state.il.us/legislation/ilcs/ilcs.asp
	Atherosclerosis Prevention Act – Illinois enacted this legislation to increase efforts to prevent and reduce the incidence of, disability from, and death from atherosclerosis (a deadly heart condition). (410 ILCS 3/) www.legis.state.il.us/legislation/ilcs/ilcs.asp

	Employee Wellness Program Grant – Grants are given to employers for health-promotion programs. These can reduce the risk factors associated with CVD, and programs can include aerobic exercise, blood-pressure or cholesterol screenings, smoking cessation, weight-loss programs, and blood-pressure or nutrition education. Benefits from these programs include an increase in the overall health of the population and, consequently, lower healthcare costs. (30 ILCS 770/) www.legis.state.il.us/legislation/ilcs/ilcs.asp
Massachusetts	***Cherishing Our Hearts and Souls Coalition*** – Created by the Harvard School of Public Health to reduce CVD among the African-American community, the coalition develops strategies to reduce risk factors, address racism, and enhance stress coping skills. It provides instruction through after school programs and trainings for healthcare providers. This program has been evaluated and extremely successful in educating not only the public but also community healthcare providers, about the issues of racism and heart disease. This is an APHA *Statistics to Solutions* program example. For more information, contact Autumn Allen at (617) 496-8073. www.hsph.harvard.edu/php/pri/pehd/cohs_summary.htm
Oregon	***Changing Community Norms to Address Cardiovascular Disease in African Americans*** – The African American Health Coalition Inc., was created to address alarming differences in CVD rates between blacks and whites in Oregon. The state launched multiple programs to target the root cause of this gap. One program promotes physical activity and other heart-healthy behaviors among African Americans. Entitled "Lookin' Tight, Livin' Right," it uses the relationships between beauty shop and barbershop operators and their clients to assess readiness to change and promote health behaviors. Another program, "HOLLA," trains high school students to educate their peers about cardiovascular disease and the risk factors associated with it. Finally a program called "Wellness Within REACH" offers free physical activity classes to African Americans in order to help reduce some barriers to an active lifestyle. CDC Exemplary Program: **REACH** www.aahc-portland.org

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Diabetes**
Background:	Although diabetes is the sixth leading cause of death in the U.S., many people are unaware that they have the disease until they develop the potentially life-threatening complications it can cause. These can include kidney damage or failure, blindness, nerve damage leading to amputations, or cardiovascular disease, which is the leading cause of death among diabetes patients. Annually, diabetes care totals $132 billion, or 11 percent of national healthcare expenditures. Among adults, 17 million are diabetic; additionally 40 percent of adults are diagnosed as pre-diabetes, or at high risk for developing the disease. All minority groups are at greater risk of developing diabetes. African

	Americans and Hispanics are twice as likely to develop diabetes as whites, with the disease affecting 25 percent and 10.2 percent of each group, respectively. Native Americans are 2.6 times more likely to develop diabetes, and 15.1 percent of that population is diabetic. Among ethnic and racial minorities, children are also at high risk for developing diabetes. In 2001, diabetes mortality rates in Delaware for whites were 24 per 100,000 compared to 49 per 100,000 for African Americans.[4]
State programs:	On the national and state level, efforts have been made to educate people about diabetes and diabetes prevention. Many programs exist to ensure that diabetes patients receive proper care, treatment, and medication. As of 2002, 46 states had laws requiring some insurance coverage for diabetes patients.
California	***Viva la Vida! (Live Your Life!) San Francisco, Calif.*** – A local program developed by a non-profit organization, Lumetra, *Vida la Vida!* increases awareness of diabetes among Hispanic Medicare beneficiaries through coordination with community groups and local healthcare providers. The program includes distribution of bi-lingual educational materials, fact sheets, and media campaigns that reach an estimated 10,000 people annually. This is an APHA *Statistics to Solutions* program example. For more information, contact Ana Perez at (415) 677-2142. www.lumetra.com/diabetesandlatinos/
New York	***New York Diabetes Prevention and Control Program (DPCP)*** – Currently, 18 communities and three universities participate to improve access to diabetes care for African-American and Hispanic patients. The program aims to overcome socioeconomic, cultural, and linguistic barriers to care and emphasizes monitoring diabetes through controlling glucose levels. DPCP also assists schools and daycares with diabetic pupils, advises the Department of Motor Vehicles about issues for diabetic drivers, and establishes relationships with insurance companies regarding insurance coverage for diabetes. www.cdc.gov/diabetes/states/ny.htm
North Carolina	***Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together)*** – The program targets the African-American community of southeast Raleigh through community-based interventions focused on decreasing disparities in diabetes prevention and care. Collaboration occurs among the CDC, North Carolina Department of Health, and county and community organizations. The project focuses on improving the quality of care and self-management, diagnosing diabetes, and maintaining access to care for diabetics. Prevention is promoted through reducing risk factors, specifically through encouraging more physical activity and better nutrition. www.ncdiabetes.org/ProjectDirect/

	Bringing Together Community Partners to Improve Diabetes Care and Control for African Americans – The Charleston and Georgetown Diabetes Coalition goal is to improve diabetes care and control for more than 12,000 African Americans. More than 40 organizations reach out to African-American communities where they live, worship, work, play, and seek health care. The plan links people to necessary services and medical supplies, creates learning environments where health professionals and people with diabetes can talk about the disease, and establishes walk-and-talk groups. This program has been evaluated and has already shown that disparities in diagnostic and annual testing have decreased. More African Americans are undergoing annual A1c tests, annual kidney tests, referral for dilated eye examinations, and blood pressure control. www.musc.edu/diabetes/reach/
Wisconsin	***The Wisconsin Collaborative Diabetes Quality Improvement Project*** – In cooperation with Wisconsin's Diabetes Prevention and Control Program, this project coordinates efforts among public health departments, minority groups, insurance organizations, and academic centers to share resources, strategies, and best practices in diabetes education, treatment, and prevention. Through emphasizing lifestyle changes, the project implements population-based interventions to target groups that are at high risk for developing diabetes. Efforts are also made to evaluate the implementation of Wisconsin's *Essential Diabetes Mellitus Care Guidelines* and collect data on the effectiveness of diabetes control and prevention programs. dhfs.wisconsin.gov/health/diabetes/Diabetes_Collaborative_Improvement_Project.htm
Tennessee	***Working Together to Reduce the Burden of Cardiovascular Disease and Diabetes*** – The Nashville project created four action teams that concentrate on specific risk factors, along with a Community Action Plan that stresses the connection between community leaders, residents, and health professionals. Programs include nutrition and exercise classes, walking clubs, Tai Chi classes, healthy cook-offs, and smoking cessation classes. All of the activities promote healthy eating, regular exercise, no smoking, getting regular check-ups, and getting screened for cardiovascular disease and diabetes. CDC Exemplary Program: **REACH** www.mwchc.org

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**HIV/ AIDS**
Background:	In 2002, Delaware's AIDS case rate per 100,000 people was 8.4 for whites, 113 for African Americans, and 36 for Hispanics.[5] Since 1981 the CDC has been tracking the AIDS epidemic, which has infected about 830,000 people in the United States to date. Of these 830,000 people, 61 percent of them are either African-American or Hispanic. However African Americans only make up about 12 percent of the overall population, and Hispanics make up 13 percent. In cases of women, 78 percent of them are African American or

	Hispanic. AIDS is currently the leading killer of African-American men ages 25-44. Even though there have been significant gains in medicine and education about AIDS, it still dominates minority communities.[6]
State programs:	State programs usually focus on HIV/AIDS awareness, education, testing, and prevention. Some operate through local churches and religious organizations, while others partner with community organizations to target at-risk populations.
California	***Los Angeles Centers for Alcohol and Drug Abuse: Latino HIV/AIDS Awareness Task Force*** – The goal is to reduce the number of Latinos who contract the HIV/AIDS virus by providing education and awareness classes through the local churches. The task force provides churches with educational flyers, training sessions to educate pastors, and health fairs to recognize church involvement. This is an APHA *Statistics to Solutions* program example. For more information, contact Ruben Acosta at (562) 906-2676 ext. 120.
New Hampshire	***New Hampshire AIDS Prevention Program*** – This program provides culturally competent prevention services with the goal of decreasing the spread of HIV, especially in minority populations. www.nhhealthequity.org/pro_hivaids.html
Pennsylvania	***Rapid HIV Teen Testing Program, Philadelphia, Pa.*** – This program is sponsored by St. Christopher's Hospital's Pediatric and Adolescence HIV/AIDS organization, which targets African-American and Hispanic adolescents. Teens are provided with screenings, sexual-health education, and risk counseling from other positive teens in the community. The program encourages teens, especially in urban areas, to get tested and to learn about HIV/AIDS and how it affects the body. The program has been evaluated, and, though less than a year old, it has been successful in increasing teen awareness. www.apha.org/nphw/solutions/index.cfm?fuseaction=view&inventionID=43
Virginia	***Minority AIDS Projects*** – The program provides funds to minority community–based organizations that will conduct HIV/AIDS prevention programs and education to minorities at risk for infection. Money is allocated to nine areas in which morbidity among African Americans, Latinos, and Asian/Pacific Islanders are the highest. www.vdh.state.va.us/std/PreventionProgram.asp
Mississippi	***Building Bridges*** – The program targets African-American women, in order to educate and increase the knowledge about HIV and STDs. The main goal is to prevent or reduce the behaviors and practices that place individuals in risky situations. The program also works to increase the knowledge about HIV/AIDS support programs throughout the community.

South Carolina	***The South Carolina Minority HIV/AIDS Demonstration Project*** – This is a three-year project to address the impact of HIV on African-American communities. The project identifies and then works with organizations that are community-based and serve the African-American population. These organizations will be provided with training, workshops, funding opportunities, and grant-writing seminars to help generate more resources for HIV/AIDS prevention and treatment. This initiative also helps in researching and collecting data from local communities in order to plan specific programs to meet the population's needs. www.scdhec.net/hs/omh/mcbo.html

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Immunizations**
Background:	According to the American Lung Association, minorities are particularly prone to influenza and pneumonia infections. About 36,000 people die from flu complications each year. African Americans and Hispanics are one-third less likely to receive vaccinations compared to whites. One out of four African-American children ages 19-35 months do not receive standard vaccinations.
State Programs:	Existing programs focus on at risk populations, specifically infants and the elderly. Many provide vaccinations free of charge in local churches and health clinics. An important aspect of immunization programs is the provision of information in many languages with the help of interpreters.
National Program:	***CDC National Immunization Program: Racial and Ethnic Adult Disparities Immunization Initiative*** – The program's goal is to increase immunization of Hispanic and African-American seniors by supplying vaccines, promoting immunization registry to Medicaid beneficiaries, and placing vaccine orders for providers and nursing homes. Focuses on immunization for the influenza and pneumococcal viruses. www.cdc.gov/nip/
Pennsylvania	***Hazelton Immunization Clinic in Hazelton, Pa.*** – The program is designed to help immunize children from Hispanic and migrant-worker families. The clinic holds regular immunization opportunities in local churches, provides interpreters, and calls to remind families in their native language. This program has been evaluated and has been effective for the past five years. www.health.state.pa.us
Florida	***Florida Department of Health and the Bureau of Immunization*** – These organizations work together to reduce racial and ethnic disparities among citizens receiving vaccinations. They provide grants to local counties and private organizations with the intent to increase community-based health-promotion and disease-prevention activities. The programs focus on both child and adult immunization, reaching more than 10,000 people per year. This program has been evaluated and found successful for the past five years. www.doh.state.fl.us/equopp/ctg/indexCTG.html

Missouri	***St. Louis Area African American Older Adult Immunization Project –*** Coordinated by the St. Louis County Health Department since July 2000, the project focuses on improving influenza-vaccination rates among elderly African Americans (60 years and older.) Focus groups are held with the target population to identify key issues regarding attitudes, behaviors, beliefs, and knowledge regarding flu immunizations. The program recognizes the importance of time, trust, and community partnerships to achieve success. Source: NACCHO/ASTHO. For more information, contact Jocelyn Tobnick at (314) 615-1674.
California	***Immunizes LA Kids, Inglewood, Calif.*** – This coalition links public and private agencies to the community in order to implement strategies to improve immunization among Latino and African-American children. Immunization practices in physician offices are supported through ongoing technical assistance and resources. The program also reaches out to the community through culturally appropriate materials and media messages. Source: APHA.
New York	***Migrant Health Immunization Initiative, Albany N.Y.*** – The program works to increase the immunization rates in adult migrant farm workers and their children. It also educates the population on the purpose and benefits of up-to-date vaccinations. The initiative facilitates the distribution of vaccines to migrant programs and then tracks the systems to determine their efficiency. Source: APHA. For more info, contact Kathie Fazekas, Immunization Program, Albany, N.Y. www.health.state.ny.us/nysdoh/immun/immunization.htm

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Infant Mortality**
Background:	In 2001, Delaware's infant-mortality rate was 107 deaths per 10,000 births. The rate for African Americans was 200 per 10,000, compared to 80 per 10,000 for whites in the same year. Nationally, the rate was 68 deaths for every 10,0000 births[7]. The U.S. had the 28th highest infant-mortality rate among industrialized nations in 1998. Nationally, the infant-mortality rate is 14.1 among African Americans and 9.3 for Native Americans, compared to 5.8 for non-Hispanic whites. Conditions contributing to an infant's well-being include prenatal care, maternal health, access to health care, and socioeconomic conditions. Furthermore, the leading cause of infant mortality is Sudden Infant Death Syndrome (SIDS). Deaths from SIDS are 2-3 times higher for African Americans and Native Americans than for whites.
State Programs:	Current state programs focus on behaviors that affect infant health. These include distributing information and encouraging healthy behaviors among mothers. Of particular emphasis are prenatal care, smoking, substance abuse, and nutrition.

California	***Fetal and Infant Mortality Review (FIMR) Program of Alameda County*** – Areas of the county with high infant-mortality rates were found to have high incidence of high-risk behaviors such as prone sleeping, not using cribs, co-sleeping, and maternal smoking and substance abuse. Information about SIDS and infant mortality was reworked so that it is consistent throughout the community and is available in the eight major languages spoken in the county. www.acog.org/from_home/departments/dept_notice.cfm?recno=10&bulletin=145
	Seven Principles Project – Created by the San Francisco Department of Public Health to address high infant-mortality rates for African Americans, the program provides social support and education to men and women of reproductive age. It includes a community-awareness campaign to educate healthcare providers and improve cultural awareness. This is an APHA *Statistics to Solutions* program example. For more information, contact Virginia Smyly at (415) 581-2400.
	Black Infant Health Program in Los Angeles – This program provides services to pregnant and parenting African-American women ages 18 and older who are at high risk of low-birth rates. These services include health education, doctor referrals, self-esteem classes, and networking with community outreach services. After a formative and summative evaluation of the program, it was shown to heighten community awareness, increase self-esteem, and reduce the rate of infant mortality. ASTHO/NACCHO program: www.lapublichealth.org/mch/BIH/bih.htm
Florida	***Northeast Florida Healthy Start*** – *The Magnolia Project* – The federal Healthy Start initiative addresses infant mortality through increasing awareness of risks, and improving maternal and infant health. In Northeast Florida, Healthy Start aims to assess the health of clients and increase awareness of available prenatal/infant-care services. Healthy Start provides risk screenings for women/infants and prenatal/infant care, paying special attention to the needs of at-risk clients. Another project, the Infant Mortality Work Group, identifies risk factors leading to high rates of infant mortality among African Americans in Duval County. The results of this study led to the creation of the Magnolia Project, which targets preconception and prenatal care for African Americans to reduce risk factors leading to infant deaths. www.healthystartflorida.com/directory/coalition.asp?CoalitionID=HSNEF
Missouri	***Nurses for Newborns Foundation, St. Louis*** – This project was implemented in all hospitals with neonatal units in Missouri and Tennessee, to help reduce infant mortality rates, specifically among black infants. The program provides home visits to families with limited access to health care from experienced RNs at no charge. The nurses provide intensive parent education, access to community resources, safe-home assessment, medical assessments, diapers, formula, and 24-hour on-call availability for a two-year period. Source: APHA. www.nursesfornewborns.org/index2.html

South Carolina	***Supporting Kids and Infants into the Next Generation, Columbia –*** This program is aimed at reducing the prevalence of premature births and infant mortality among African Americans. The goals of the intervention are to reduce the racial disparity through education and implement strategies in the local congregations to support pregnant women and parents of infants. Another aspect of the program is called "Vitamins for Brides," which gives new brides a kit with prenatal vitamins as part of their pre-marital counseling session. Source: APHA. www.scdhec.net
New Hampshire	***Healthy Families: Minority Health Coalition*** – The Healthy Families program targets pregnant women and teens, educating them about the prenatal period and providing follow-up programs after the baby is born. These educational sessions are held in the participants' homes so they feel comfortable and supported. Culturally sensitive and native-language-speaking nurses provide bimonthly visits during the prenatal period. Participants are also provided handouts with information on each stage of their baby's development. www.nhhealthequity.org/pro_healthfam.html

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Obesity**
Background:	According to the American Obesity Association, there is a higher prevalence of obesity in African Americans and Hispanics, especially women; this trend has continued to grow over the past decade. Asian/Pacific Islanders have the lowest incidence of obesity compared with other minorities and whites. Statistics show that 40 percent of African Americans and 34 percent of Hispanics are obese, with a BMI > 30. The incidence of obesity in minorities has lead to an increase in cancer, heart disease, hypertension, and diabetes.
State Programs:	The majority of current state programs focus on promoting nutrition, physical activity, and weight reduction. Most programs combine a physical fitness component to increase activity with nutrition education to improve diet and facilitate weight loss.
Illinois	***Illinois WISEWOMAN Program*** – Sponsored by the State Department of Public Health, participants engage in a 12-week nutrition and physical-activity curriculum. Women receive informational newsletters and telephone support throughout the program. Goals are to improve diet and cardiovascular-risk profiles while reducing the amount of sedentary behavior. This is an APHA *Statistics to Solutions* program example. www.idph.state.il.us/about/womenshealth/wise.htm

Virginia	***Piedmont Health District: Partners for Healthy Lifestyles*** – Local African-American churches are involved in activities that address chronic obesity in three ways: weight reduction, increased physical activity, and lifestyle changes. The program is implemented in areas of Virginia with populations greater than 40 percent African-American, low socioeconomic status, multiple health disparities, and a lack of healthcare providers and services. Of the fives churches picked for the program, all showed improvements in patrons' overall cardiovascular health and significant decrease in BMI. Source: ASTHO/NACCHO. For more information, contact the Piedmont Health District at (434) 392-3984.
	Praisercize – The Virginia State Health Department and Central Virginia Community Health Center coordinate this program to address chronic obesity among African Americans. A network of 35 churches incorporates gospel music with low-impact exercise routines. Participants focus on weight reduction, increased physical activity, and lifestyle changes (including nutrition education). To date, more than 1,400 people have participated and health improvement results are positive. Source: ASTHO/NACCHO. For more information, contact Henry Murdaugh at (804) 786-3561.
New York	***Physical Activity and Nutrition Steering Committee (PAN) –*** The committee focuses on five elements of a healthy lifestyle, including prenatal weight gain and breastfeeding, physical activity and TV viewing, fruits and vegetables, other dietary determinants, and obesity awareness and healthcare practices. Children are specifically being targeted especially those at high risk of obesity. The committee began a Child Health and Fitness Study, an intervention to improve nutrition and physical activity in childcare settings. www.cdc.gov/nccdphp/dnpa/obesity/state_programs/new_york.htm
Maryland	***The Nutrition and Physical Activity Program*** – This very successful program, funded by the CDC, established the Maryland's Nutrition and Physical Activity Coalition, which includes more than 12 community partners. The organization hosts a regional meeting to expand and strengthen partnerships and to scan communities for current nutrition and physical activity programs and initiatives. It also identifies surveillance systems that monitor the risks and prevalence of overweight and obese populations in the state. www.fha.state.md.us/fha/cphs/npa/
* Great obesity program database	***Shaping America's Youth (SAY)*** – Contains comprehensive information on programs and community efforts across the United States directed at increasing physical activity and improving nutrition for children. Partners include the American Obesity Association, American Academy of Pediatrics, and the American Diabetes Association. www.shapingamericasyouth.com

Racial and Ethnic Health Disparities
Current and Existing Programs Targeting Specific Health Conditions

Health Condition:	**Oral Health**
Background:	Tooth decay is one of the most prevalent and preventable chronic diseases in the United States. Incidence of tooth decay is five times more common than asthma. By the time children reach 18 years of age, 80 percent have had some form of dental decay. Conditions leading to tooth decay can develop during early childhood, especially in minorities, as 60 percent of minority elementary school children do not receive proper dental care. Among African-American and Hispanic adults, 47 percent have untreated tooth decay, compared to 28 percent of whites. Similarly, 20 percent of African Americans and 11 percent of whites have untreated root decay. In Delaware, 74 percent of whites adults visited the dentist or a dental clinic within the past year, compared to only 58 percent of African Americans and 54 percent of Hispanics.[8]
Stage Programs:	Many state programs promote proper dental care to prevent and treat conditions detrimental to oral health. A variety of programs exist on the state, local, and community level, mostly concentrating efforts on increasing access to dental care for low-income and other high-risk groups.
Ohio	***School-Age Sealant Program*** – In accordance with Healthy People 2010's goal of having half of all eight-year-olds with sealants on their teeth, Ohio has implemented a sealant program in its schools. Sealants are plastic coatings applied to the chewing surfaces of teeth that help prevent tooth decay. Only 11 percent of African-American children and 10 percent of Mexican-American children have sealants, but in schools with sealant programs, 57 percent of minority students have sealants. School programs coordinate with dental health providers and allow states to reach high-risk populations. www.healthinschools.org/ohiosealant.asp
Washington	***ABCD "E" Program*** – The Access to Baby and Child Dentistry "Expanded" Program provides dental care for high-risk children from when they grow their first tooth until the age of 19. The primary goal of the program is to reduce dental decay and oral health diseases through preventative care. Partnerships among the Department of Health, doctors, and universities, allow dentists to identify high-risk children and go to them to provide preventative dental care. Primary-care physicians and Head Start programs are also educated on basic oral health, oral-assessment techniques, and fluoride application. www.smileabcd.org/abcde.html
Missouri	***Health Access Incentive Fund*** – The fund is used for loan repayment, liability insurance, start-up grants, and practice subsidies. Doctors who agree to practice in areas where there is a need for care, regardless of the patients' ability to pay, receive the grants or subsidies for Medicaid payments as an incentive to provide care. In addition, Missouri law states that the Department of Health will recruit minorities for healthcare careers when implementing the program. www.ncsl.org/programs/health/oral.htm
Oregon	***Oregon Department of Human Services*** – Oregon is working on expanding its preventative programs for low-income pregnant women and children to

	include oral health. This expansion comes from a million-dollar grant from the Robert Wood Johnson Foundation to improve oral health. This program offers risk assessment and fluoride varnish to children who are brought to a WIC appointment. The project has partnered with a wide range of public, volunteer, and professional members who are serving low-income families. They are working together to coordinate free and low-cost oral health services with the support of the Oregon Dental Association. Another component of the project is 24-hour "Baby Days" clinics for children 9–24 months of age. In its first five months, parents and their children made 725 visits, 701 children received fluoride varnish applications, and 29 received dental referrals. www.chcs.org
South Carolina	***State Action for Oral Health Access*** **–** The South Carolina Department of Health and Environmental Control collaborates with the Seventh Episcopal District of the AME Church to provide oral-health education to African-American patrons. At various church events, more than 600 children have been screened and referred to dentists for further service. The church has integrated oral health into its overall Strategic Health Plan for minority communities. The church designated February 8, 2004, as "More Smiling Faces Sunday" and sponsored a large Dental Fair at three churches following Sunday services. Many parishioners received information about oral health services and the resources available to receive them. The state has also developed a curriculum for pediatric and special-needs oral-health training for general dentists, as well as curricula for pre-school-age children. The funding for this program was provided by the Robert Wood Johnson Foundation as a part of the State Action for Oral Health Grant program. www.chcs.org/grants_info3963/grants_info_show.htm?doc_id=206685
Colorado	***Children's Oral Health Outcomes Partnership, Colorado Community Health Network*** **–** This program helps to improve the health care and dental health of poor and underserved communities by fighting a disease-specific disparity. Through a partnership among the local health departments, the Colorado Oral Health Network, the clinician's advisory network, and the Caring Foundation, a health-services team educates and supplies kids with the needed prevention tools, including access to regular medical check-ups, screenings, and dental-care supplies. www.cchn.org/activities/COHOP_Fact_Sheet.pdf

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**Cultural and Linguistic Competency**
Background	Cultural competence combines awareness of patients' diverse values, behaviors, language, and needs, with the ability to provide responsive and effective health care. A successful culturally competent healthcare system and workforce is able to provide high-quality care to all patients, regardless of background. Barriers include a lack of diversity in the healthcare workforce

	and poor communication between patients and providers. Providers have difficulty understanding and working with lingual barriers and sociocultural factors, which results in patient dissatisfaction and poor health outcomes. However, when appropriate languages and approaches are used, diagnosis is accelerated and the likelihood of patient compliance increases.
State Programs	Existing programs address components of cultural competence, specifically language. Through translator programs, states hope to limit error in diagnosis and decrease healthcare costs. To date, many of the cultural competence programs have focused on services at the provider and insurer level.
Washington	***Certification of Interpreters or Translators*** – The Washington Department of Social and Health Services provides and pays for certified interpreters for all health services patients, including Medicaid patients, receive. DSHS ensures the quality of interpreters through standardized written and oral examinations. Certifications are offered in eight languages: Spanish, Vietnamese, Russian, Cambodian, Laotian, Mandarin, Cantonese, and Korean. www1.dshs.wa.gov/msa/ltc/itsvcs.html
Massachusetts	***Competent Interpreter Services in the Delivery of Certain Acute Health Care Services*** – Acute-care hospitals must have an interpreter in the emergency room for any non-English speaking patients. The decision to hire interpreters or to keep one on-call is left to the discretion of the hospital. However, hospitals must provide interpreter services and cannot deny care to non-English speaking patients. (Acts of 2000) www.mass.gov/legis/laws/seslaw00/sl000066.htm
	Department of Public Health: Hospital Translation Services Poster – A sign is displayed throughout hospitals conveying in over 30 languages: "You have the right to a medical interpreter at no cost to you." Patients and visitors can point to their language, and hospital officials will contact the appropriate interpreter. www.mass.gov/dph/omh/interp/interpreter.htm
New Hampshire	***New Hampshire Minority Health Coalition*** – A Cultural-Competency Group works to develop leadership among minorities, train private- and public-sector educators, work with healthcare agencies to increase their awareness, policies, images, and resources, and assist in eliminating barriers. Counselors will come to an organization, specifically those in healthcare, human services, and outreach programs, to provide cultural education. Other programs include cultural forums, the Mental Health of Greater Manchester Cultural Competency Initiative, and the Weed and Seed Cultural Competency Priority. www.nhhealthequity.org/pro_cultcomp.html
California	***Los Angeles County Office of Diversity Programs*** – Cultural and linguistic standards have been set for the Los Angeles County healthcare system by the L.A. Department of Health Services (DHS). Half of the households in the county speak a language other than English, with 83 different nationalities represented. DHS trains staff with cultural and linguistic competency and skills and tries to recruit bilingual and bicultural workers. Furthermore, services are available to document patients' language of preference and records are kept of patients' use of services. ladhs.org/odp/docs/dhsexecsumm.pdf
Oklahoma	***Cultural Competency and Diversity Training*** – This program provides training that addresses cultural differences and barriers between minority patients and

	healthcare providers. The program works to help underserved populations, especially those who speak limited English. Employees of the Oklahoma Department of State Health are required to complete cultural-competency and diversity training as a part of their annual performance evaluations. www.health.state.ok.us/program/omh/
Texas	***Hablenos de su Salud, Fort Worth, Tex.*** **–** This program seeks to eliminate language barriers that lead to health disparities. The project focuses on patient-provider communication and promotion of science-based standards for linguistic competence in the healthcare setting. Source: APHA. For more information, contact Dr. Holly Jacobson at 817-735-2365.
Managed Care	***Kaiser Permanente*** – On the state and national level, Kaiser Permanente makes efforts to increase cultural and linguistic competence. Nationally, six Institutes for Culturally Competent Care focus on the areas of African-American Populations, Latino Populations, Linguistic and Cultural Services, Women's Health, Disabilities, and Eastern-European Populations. On the state level, programs in linguistic and cultural services have been especially effective. The California Endowment granted funds to Kaiser Permanente to assess outcomes and programs for linguistic and cultural services. Specifically, the San Francisco facility focuses on providing services to Chinese and Latino patients. An extensive translation unit offers 14 dialects and languages and ensures that clients are aware of and understand healthcare services. Additionally, all staff members, from clinical nurses to health educators, have undergone cultural understanding training and many are bilingual. *Note: Currently, Kaiser Permanente does not provide an external website for its Permanente National and Linguistics & Cultural Programs.
Robert Wood Johnson Foundation	***Hablamos Juntos*** (Let's Talk Together) – This national program strives to improve access to quality health care for Latinos with limited English proficiency. It focuses on improving the availability and quality of interpreter and language services, allowing people to communicate orally. Another aspect is the promotion of multi-lingual medical-facility signage. www.rwjf.org/news/special/languageBarrier_1.jhtml

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**Data Collection**
Background	Data collection is crucial in order to understand and eliminate healthcare disparities. National and state efforts should include the standardization of data-collection methods to facilitate sharing of information. Accurate and up-to-date data collection allows researchers and health plans to "monitor performance, ensure accountability to enrolled members and payers, improve patient choice, allow for evaluation of intervention programs, and help identify discriminatory practices.[9]" The Institute of Medicine recommends the collection of data on "healthcare access and utilization by patients' race, ethnicity, socioeconomic status, and primary language.[10]"

State Programs	States utilize a variety of methods to collect and interpret health-disparities data. A particularly useful source of information is the CDC's Behavioral Risk Factor Surveillance System (BRFSS). States often coordinate with health-insurance companies and state Departments of Health Statistics to collect demographic and vital-statistics data.
Massachusetts	***Massachusetts Health Status Indicators by Race and Hispanic Ethnicity*** – This compilation of state data provides information on the health status of residents by race and ethnicity. The purpose of the report is to provide data from a variety of sources in one place for convenient use by policy makers, public-health officials, advocates, and program planners. Each chapter of the report contains information on the agency or program responsible for collecting and reporting the health data and how the data were collected. Health status areas included are demographic data, maternal and infant health, mortality patterns, health status and risk behaviors, indicators of healthcare access, hospital discharge data, and AIDS-incidence data. The link below also contains information in a PowerPoint format regarding Mass. state data-collection and monitoring programs. www.mass.gov/dph/bhsre/resep/resep.htm#raceethnicity
Virginia	***The Health of Minorities in Virginia, 1999*** – In the early 1990s, the State Minority Health Advisory Committee recommended that Virginia collect and evaluate health statistics data by racial and ethnic group. The fifth edition of this report covers calendar year 1999. It provides vital statistics information by race and ethnicity for each health district (city/county) in the state. Some data are collected from population estimates (birth, fetal deaths, pregnancy, and death). All vital events (births, deaths, induced terminations of pregnancy) are reported to the Center for Health Statistics at the Va. Department of Health. www.vdh.state.va.us/HealthStats/stats.asp
Rhode Island	***Policy for Maintaining, Collecting, and Presenting Data on Race & Ethnicity*** Created by the R.I. Department of Health, Office of Minority Health, and Office of Health Statistics in July 2000, this report emphasizes the importance of collecting data by race and ethnicity for the purposes of research, public-health monitoring, program administration, and civil rights. These data are intended to help monitor trends of existing/emerging diseases, track health status among population groups, assess progress in improving health, and assure non-discriminatory healthcare access and treatment. www.health.ri.gov/chic/statistics/data%20policy%20guide.pdf
Kaiser Family Foundation	***50 State Comparisons on Minority Health*** – The Kaiser Family Foundation (KFF) provides racial and ethnic data in a comprehensive, user-friendly website. The site includes information on demographics, health statistics (birth rates, death rates, immunization rates, smoking, obesity, and mental health), health insurance coverage, women's health, and HIV/AIDS. Data can be displayed as bar graphs, tables, and color-coded maps, or presented in individual state profiles. Data sources include the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), and the U.S. Department of Health and Human Services (DHHS). www.statehealthfacts.org/cgi-bin/healthfacts.cgi

America's Health Insurance Plans (AHIP) & The Robert Wood Johnson Foundation (RWJF)	In July 2004, America's Health Insurance Plans (AHIP) collaborated with the Robert Wood Johnson Foundation (RWJF) to assess the collection and use of racial and ethnic data by health insurance plans. Their findings indicated that plans that collect such data do so to identify enrollees with risk factors for certain conditions, develop disease-management programs, and facilitate communication among the plan, providers, and enrollees with translation services and multi-lingual websites. Plans that do not collect data do not because of barriers such as enrollees' reactions to collecting these data, enrollee misperception of the intended use of this information, and lack of standardization in data-collection techniques. www.rwjf.org/research/files/080504AHIPFinalSummary.pdf
Data Collection Limitations	No federal law exists prohibiting the collection of data on race and ethnicity. Only four states have laws or regulations that prohibit the collection of these data: California, Maryland, New Hampshire, and New Jersey.[11]

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**Partnering Opportunities with Regional Organizations**
Background	Regional coalitions and conferences provide opportunities to share health information and data-collection techniques between state/local policy makers, community organizations, researchers, and healthcare providers. Through these forums, leaders can also share best practices for programming and unique strategies or models for eliminating racial and ethnic disparities.
New England	***New England Regional Minority Health Committee*** – The committee hosts a bi-annual conference on tools, skills, and networks for action to eliminate health disparities. Partnering states include Conn., Mass., N.H., R.I., Vt., and Maine. Next Conference: April 10-12, 2005. Portland, Maine. www.une.edu/chp/transcultural/conference.html
Various Conferences	***11th Annual Rural Minority and Multicultural Health Conference*** – **"State of the States' Rural Racial and Ethnic Health Disparities: Yesterday, Today and Tomorrow"** May 18, 2005**.** New Orleans, La. The conference will address innovative rural healthcare programs, service delivery models, policy issues, educational programs, clinical concerns, leadership development and skills training as they relate to rural racial and ethnic health disparities. www.nrharural.org/pagefile/NRHAconf.htm
	Everyone Counts: State Infrastructure and Capacity to Eliminate Racial & Ethnic Disparities in New England. December 6, 2004. Tufts University School of Medicine. Boston, Mass. Hosted by the New England Coalition for Health Equity. www.omhrc.gov/omhrc/ and www.neche.org/about/about.htm
	Southeast Regional Civil Rights Training Conference – May 3-5, 2005. Representatives from eight states (Ala., Ga., Fla., Ky., Tenn., Miss., N.C., S.C.) will meet in Nashville, Tenn., to discuss health disparities, mental health, immigrant access, community/faith-based initiatives, and social programming. www2.state.tn.us/health/minorityhealth/Civil_Rights050305.pdf

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**Purchasing**
Background	The purchasing of healthcare contracts through the states should ensure that providers are culturally competent and sensitive. In order to do this, states must encourage competitive bidding so that managed-care facilities address health disparities. Along with financial incentives, these requirements can greatly improve the quality of health care to minority patients.
State Programs	The following states have obtained healthcare contracts that address disparity issues and cultural differences in their populations. These contracts require that medical services, such as Medicaid, HMOs, and other providers, offer linguistically competent services. These healthcare programs must also be sensitive to the attitudes, beliefs, and practices of its patients and have caregivers that can appropriately address these issues.
California	In California, an anti-discrimination clause was added to the Medicaid managed-care contract prohibiting discrimination of minority patients. This clause also organized state agency reviews of discrimination complaints in order to better address health-disparity issues. This contract specifically prohibits discrimination in health services among Medicaid recipients on the basis of race, color, ancestry, national origin, or gender. The contract also forces Medicaid to copy all grievances concerning discrimination to the Department of Health Services in order for appropriate action to be taken. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa196.html
New Jersey	Contracts in N.J. require healthcare facilities to provide linguistically appropriate services for non-English speaking patients. Health providers also must have a diverse group of employees who reflect the ethnic/racial composition of patients, as well as be able to accommodate another language if 10% or more of the patients speak that particular language. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa162.html
Wisconsin	In Wisconsin the Medicaid contract is required to provide an interpreter service for patients who speak limited English. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html
Iowa	Iowa HMOs are required to provide information to patients about linguistically competent providers. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa165.html
Colorado	Contractors in Colorado are required to determine if culturally sensitive services are being delivered to its members. They must also train their providers to understand and recognize healthcare attitudes, beliefs, and practices that affect the access and benefit of health services. Contractors also must try to employ a diverse faculty to address culturally sensitive situations. Finally Colorado healthcare contractors must respect the healthcare attitudes and practices of its members, regardless of their cultural affiliation. www.gwn.edu/~chsrp/Fourth_Edition/GSA/Subheads/gsa167.html

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**State Infrastructure**
Background	Recently, states have been more forward in addressing disparities in health care among their minority populations. In order to combat these disparities, states have come up with various state infrastructures such as councils, commissions, and advisory panels. States that do not have the resources to develop a formal Office of Minority or Multicultural Health can implement the help of analysts, special project officers, and specific activities to close the gap in disparities. These offices and analysts team up with state policymakers and community organizations to develop solutions, programs, and strategies for their state.
State Programs	State programs vary from Offices of Minority and Multicultural Health to individuals working for the Governor's Office or the State Department of Public Health, with a concentration in Minority Health. These initiatives all have the same overall goals, which are to have a formal group that addresses the issues concerning the minority populations in their state. Specifically, these offices work to reduce health disparities through community-based outreach programs that target various health conditions and diseases.
Arkansas	The state minority-health infrastructure is made up of the Office of Minority Health located within the Department of Health, as well as an independent commission that reports directly to the Governor's Office. Together this group has a statewide plan, advisory groups, task forces, and committees specifically targeted towards reducing health disparities. This initiative also works to include other state and private-sector minority-health programs and coalitions. www.achi.net/current_initiatives/health.asp
California	In order to help address health disparities for ethnic communities California has created the Office of Multicultural Health. The purpose of this office is to build a bond between the state health department and minority communities, in order to help the state health offices more effectively handle cultural-competency issues. Having an Office of Multicultural Health also encourages data collection and performance measurements of state healthcare providers. www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=00001-01000&file=150-152
Connecticut	Connecticut has created an Office of Multicultural Health (OMH) in hopes of eliminating differences in disease, disability, and death rates among minority populations. Federal, state, and private funds are used to carry out the objectives of the office such as providing education, activities, and health resources to minority groups. These funds can be used to create new programs or to help support existing ones that focus on minority health. The Office also created an advisory committee to represent diverse multicultural and multiethnic backgrounds. This committee meets quarterly to go over the preparation and implementation of reports and strategic plans. It also coordinates and discusses issues and policies related to the functions of OMH. www.cga.state.ct.us/2001/pub/Chap368a.htm
Florida	The state of Florida has a Commission on African American Affairs that is part of

	the executive Office of the Governor. This office is in charge of ensuring that African Americans in Florida receive adequate education, healthcare and welfare attention, as well as address economic and social issues. www.flsenate.gov/sstatutes/index.cfm?App_mode=Display_Statute&URL=Ch0014/ch0014.htm
Texas	The Texas Department of Public Health dedicated two million dollars toward the creation of a Minority Health Office. The office is designed to effectively address minority health and disparities issues. The structure of this office consists of a Minority Health Coordinator in the TDPH central office, staff support from the Office of Public Health Practice, and local/regional support within each office. The new office will work with communities at the local level to increase their capacity to implement strategies that improve the health status of minority and underserved populations. Additionally, it will provide and link community-based coalitions and networks with technical assistance and training for use in the development of community health plans. There is hope that links can be made with external partners to help support and finance minority programs. There will also be translator services available. The main goal of this organization is to create a link between the Department of Public Health and underserved communities. www.tdh.state.tx.us/minority/aboutus.htm#Background

Racial and Ethnic Health Disparities
Existing Programs Regarding System-wide Interventions

Program Area	**Workforce Development**
Background	Minorities make up 25 percent of the US population; however, they only account for 6 percent of physicians. Similarly, minority nurses only make up 14 percent of the workforce. Minority physicians tend to reside in federally designated shortage areas and are three times more likely to see minority patients and accept Medicaid. This promotes higher satisfaction, greater adherence to treatment, and better care outcomes for minority patients. The workforce should be representative of the population, which means creating more diversity in such fields as dentistry, nursing, medicine, and physical therapy. One of the ways to ensure this happens is to encourage minority students to pursue careers in the sciences and increase the number of minority students enrolled in medical schools.
State Programs	State programs focus on increasing diversity in the workplace, especially in the fields of science and medicine. States have come to realize that a diverse workforce leads to decreased racial and ethnic differences in health care, not only with diverse physicians, but also nurses, dentists, pharmacists, and physician assistants. Programs targeting minority students have been developed to encourage them to pursue careers in allied health fields. This includes increasing medical school admissions for minority students, specialized training in various languages for employees, and high school programs geared at encouraging students to pursue careers in the sciences.
Minnesota	The state of Minnesota has passed legislation in order to recruit professionals in

	underserved communities, specifically those that lack sufficient medical coverage. The Duluth School of Medicine has a federal grant to help recruit minority students and increase their awareness of careers in medicine. This program also operates an area health-education center designed to show the importance of supporting underserved areas.[12]
Maryland	***Minority Health Careers Academy*** **–** This program was created by the Maryland Department of Health and Mental Hygiene, and is supported by Coppin State College and the Department of Social Services. It targets Baltimore City public-school students. The goal of the project is to get inner-city minority students interested in allied-health-profession careers. Students are introduced to various health-related fields to increase their motivation and awareness in pursuing these avenues. Source: ASTHO, NACCHO, and HRSA.
North Dakota	***Project CRISTAL - A Program for Collaborative Rural Interdisciplinary Service Training and Learning*** **–** This collaborative project joins the University of North Dakota, Turtle Mountain Community College, and the CRISTAL group to provide interdisciplinary training for minority students in physical therapy, occupational therapy, social work, clinical laboratory science, and medicine. The program encourages minority healthcare workers to practice in underserved areas. Source: ASTHO, NACCHO, and HRSA.
California	***Increasing Culturally Competent Workforce Capacity*** **–** California instituted a law allowing Mexican- and Caribbean-licensed physicians and dentists to practice without additional licensing in communities that are medically underserved. The law has helped create the Licensed Physicians and Dentists from Mexico pilot program, which authorizes a three-year, non-renewable license to those doctors.
Washington	***Health Workforce Diversity*** **–** The Health Systems Quality Assurance Division is designed to develop a program that creates a diverse and culturally competent workforce within the Washington state healthcare field. This includes looking at a workforce-development continuum starting with the academic aspect of grade school and moving forward to a career in health care and policy. It will include a focus on recruiting minority employees to the healthcare workforce. Also, there will be new licensing rules, including the elimination of unnecessary barriers, clarification of licensing rules, and incorporation of multiple ways to show competency. www.doh.wa.gov/SBOH/Priorities/Disparities/HWDNActivities.htm
	Health Occupations Preparatory Experience (HOPE) **–** The State of Washington created HOPE to allow minority and rural students the opportunity to experience working in a healthcare field. The State Department of Health funds a student internship program to create a greater interest among a diverse group of high school and community college students. The program is designed to introduce these students to the variety of healthcare positions they may be unaware of, through first-hand shadowing, mentoring, and clinical rotations. www.doh.wa.gov/hsqa/ocrh/R&R/HOPE1.htm

[1] *New England Journal of Medicine* 9/9/04
[2] Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
[3] Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
[4] Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
[5] Data provided by the Kaiser Family Foundation State Health Facts Online. www.statehealthfacts.org
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