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CONSORTIUM CONNECTIONS

CYFC

BUILDING BRIDGES FOR THE WELL-BEING OF CHILDREN, YOUTH & FAMILIES

In this issue

Imagine for a minute the persistent cough and wheezing of six-year-old Joshua, his chronic asthma exacerbated by mold from unrepaired water damage in his family's crumbling apartment, not to mention secondhand smoke from tenants across the hall. With no cash to cover the co-pay on Josh's prescriptions, his mom has put off refilling them until she gets her next paycheck. Not only does Josh feel lousy much of the time, but due to repeated absences from school, he is falling rapidly behind his first-grade classmates in basic skills and is having trouble making friends.

Or picture Luis, who doesn't understand why his wife Maria has been so tired and sad in the months since the birth of their last child. Luis works all day, then comes home to a crying wife and crying children. Feeling a million miles away from the friends and family they left behind in Mexico, he doesn't know where to turn for help. He wishes Maria would talk to the doctor about her problems when she takes the baby in for her shots, but he knows she's too embarrassed and has trouble finding the right words in English.

Joshua, Luis, Maria and their families are just a few of the thousands of Minnesotans who feel the sting of gross disparities in basic health and access to appropriate health care. Despite the fact that Minnesota often is held up as a model of good health and cutting edge health care, too many children and families in our state still suffer the consequences of harsh environments, limited health knowledge, and care that is inaccessible, costly, and/or culturally insensitive. These disparities cut across both physical health and, as documented in a recently released report from the U.S. Surgeon General, mental health.

In this issue of Consortium Connections, leaders from within the University of Minnesota and from several of our community partner organizations explore the varied and complex factors that underlie major health disparities in Minnesota. And they point to promising new efforts to narrow those gaps and ensure good health and health care for all Minnesota residents. As the new academic year gets under way, the Consortium will continue to focus on health disparities as a major area of emphasis for linking research, practice and policy for the well-being of children, youth and families. While this fall issue primarily addresses physical health, the winter issue of Consortium Connections will focus on disparities in mental health and access to mental health treatment.

Marti Erickson, Director

Minnesota Health Through a National Lens

Nicole Lurie, M.D., MSPH, Professor of Medicine, University of Minnesota, and Medical Advisor to the Commissioner, MN Department of Health

Dr. Lurie recently returned to the University of Minnesota after serving as principal deputy under U.S. Surgeon General Dr. David Satcher at the Department of Health and Human Services. She helped design the new "Healthy People 2010" federal objectives and was instrumental in launching the national initiative on eliminating racial and ethnic health disparities.

The US Surgeon General has identified three broad priorities for his tenure: a healthy start for every child, the elimination of health disparities, and increased attention to global health issues. Each of these has particular relevance to Minnesota's children.

A healthy start for every child includes being born to parents prepared to love, nurture, and provide the best possible environment for growth and development; an in-utero environment free from toxins, such as tobacco, alcohol or other drugs; and access to health care, to name a few. The focus on global health is particularly relevant as the number of refugee and immigrant children in Minnesota has grown rapidly over the last decade. In some counties, the size of the minority population has tripled. While this creates new challenges for us, it also affords new opportunities to learn from other cultures about how to create a healthier state. Finally, the goal of eliminating health disparities, especially those associated with race and ethnicity, is key not only for the Surgeon General, but is one of the highest health priorities for Governor Ventura and Commissioner of Health Jan Malcolm.

Minnesota prides itself on having some of the best health statistics in the country, on

Minnesota Health Through a National Lens—*continued on page 9*

Mission Statement

The Children, Youth & Family Consortium was established in fall 1991 in an effort to bring together the varied competencies of the University of Minnesota and the vital resources of Minnesota's communities to enhance the ability of individuals and organizations to address critical health, education, and social policy concerns in ways that improve the well-being of Minnesota children, youth, and families.

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UNIVERSITY OF MINNESOTA

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Teens Speak Out on Health

Becky Johnson, Youth Project Leader, Teens Take Action on Health

I am 17 years old and have had chronic asthma since I was two. I have spent much time in hospitals, emergency rooms, and doctor's offices. I decided to take part in *Teens Take Action on Health* because I wanted to teach other kids about asthma. I wanted them to know they were not alone in their daily struggles to balance medications, fit in with other kids, and manage to keep themselves safe and happy all at the same time. I am proud to be doing this. It shows if you want to change something or make a difference you need to get up and do it.

Not many teens are involved in health issues. Most teens figure they are young, fit, and can worry about their health when they are older. They think they can take on the world, that they are immortal and will never be hurt or die. Most of all, teens tend to blow off adults telling them what to do. The moment an adult starts to talk at us, our eyes glaze over and we nod just to get through it. It's no different with health issues than with curfew, dating, or any other topic.

If we really want today's teenagers to live healthy, safe lives we need to get them *involved*.

What adults need to know about engaging youth

When getting teens involved in teaching or helping with health organizations, it is important to treat them as an adult. Don't talk down to them or make them feel unimportant. Give clear instructions on what is wanted and needed of them. Include teens in the planning stages of the project; it helps them feel part of the group. Give teens a chance to share their experiences and opinions on the subject. Connect them with people that can mentor and give information as well as encouragement.

What teens need to know about working with adults and community groups

Getting involved in health issues lets you voice your thoughts and experiences. But, it is important to know the audience you are teaching. Know what will draw their attention and what level of understanding they already have. Use hands on activities or things to look at while you teach. Involve your audience, ask them questions, and have them ask you questions. Be real and don't be afraid to show them the mistakes you've made.

Minnesota Extension Service

Latino youth work on a community health project at the Casa Guadalupe neighborhood in Cold Springs, MN

CONSORTIUM CONNECTIONS

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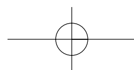


Adolescent Health Disparities

Nikki Sigler Andrews, Program Associate, Center for 4-H Youth Development

Adolescence holds great opportunity for the adolescent, the family and the community in which the adolescent lives. But it is also a time when health disparities become intensified. Adolescents—particularly adolescents of color— are often at a disadvantage when it comes to health-related risk behavior. According to a new Urban Coalition report, *Warning: Health Disparities Ahead: The Health and Well-Being of Youth in Minnesota*, adolescents of color are reporting that they are engaging in riskier behaviors at earlier ages than White adolescents. Using data from the 1998 Minnesota Student Survey (MSS), the report highlights these disparities:

Depression and suicide. Significantly more African American, American Indian, Chicano/Latino and Asian/Pacific islander than White students felt so discouraged or hopeless during the previous 30 days of the survey they wondered if anything was worthwhile. This held true for 6th, 9th, and 12th grade students. 6th and 9th grade White students were half as likely as American Indian and Chicano/Latino students to attempt suicide in the last year. By 12th grade, the reported rate of attempted suicide decreased among all students but remained higher for African American, American Indian, Chicano/Latino and Asian/Pacific Islander students.

Alcohol use. Almost one-third (28%) of 9th grade Chicano/Latino students reported having used alcohol 3 or more times in the past month, while 26% of American Indian, and 18% of both African American and White students reported the same. By 12th grade, American Indian youth report a 31% rate of alcohol use in the past month, which is significantly higher than Chicano/Latino (25%), African American (23%), White (20%) and Asian/Pacific islander (13%) students.

Smoking. 32% of 9th grade American Indian youth reported smoking daily in the past month, compared to 28% of Chicano/Latino, 17% of both African American and White youth and 14% of Asian Pacific Islander students. By 12th grade, however, reported rates of smoking increased for all ethnic groups, and the rate for American Indian youth increased the greatest, to 41%.

School violence. Students of color reported being threatened or injured with a weapon on school property in the previous year at a higher rate than White students at all grade levels —6th, 9th, and 12th.

Sexual health. White and Asian/Pacific Islander 9th and 12th grade students were less likely to have had sexual intercourse than their African American, American Indian and Chicano/Latino counterparts. Students of color, of any ethnicity, were also more likely to have been or gotten someone pregnant than White students by the time they reach 12th grade.

How can we positively influence young people's health behavior and develop their skills so they have the chance to thrive and be contributing members of society? A positive youth development approach, used in tandem with medical and prevention models, can be a powerful tool. When we provide young people with opportunities to develop their skills in relation to health beliefs and behavior, they are more invested in the experience and the outcome it produces, and they become more connected to their families and their communities.

Positive youth development is also a strong framework to address adolescent health disparities. By engaging in community-based experiences related to health, young people develop a sense of confidence and set of skills that is specific to their culture and the needs of their communities. A positive youth development approach allows us to see adolescents as resources and active participants in their own development, and to connect them more closely with their culture, families and communities.

One example of a positive youth development approach to addressing adolescent health issues is the *Teens Take Action on Health* project, a collaborative project of the University of Minnesota's Center for 4-H Youth Development and Division of General Pediatrics and Adolescent Health. Its goal is to support Minnesota youth in leading and producing original work in health research, advocacy or education that can be replicated by youth in other communities. Youth from around the state are paired with local and campus-based mentors to develop and carry out projects within their own communities. This model provides young people with the opportunity to become project directors and to discover their community by engaging in an issue they care about. To find out more about the project, contact *Teens Take Action on Health* coordinators Nikki Andrews (sigle003@umn.edu) and Mae Sylvester (sylve001@umn.edu)

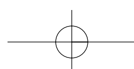
Information about *Warning: Disparities Begin Here: The Health and Well-Being of Minnesota's Youth*, June 2001, is available on line at www.urbancoaltion.org

New Report on Health Disparities in Minnesota Populations

Key Findings from the Minnesota Department of Health's *A Call to Action*:

- People with higher incomes generally enjoy better health and longer lives than people with lower incomes. However, the health of people of color and American Indians at every level of income is worse than that of their White peers.
- People with low income do not experience worse health simply because of high risk personal behavior. In one recent study, differences in health behaviors such as cigarette smoking, alcohol use, and physical inactivity explained less than 20 percent of the differences in death rates across income groups.
- Racism and discrimination play a crucial role in explaining health disparities through factors such as restricted socioeconomic opportunities, limited access to and bias in medical care, residential segregation, and chronic stress.
- The health of people in the middle income groups is worse in communities with a high degree of income inequality. The health of a population depends not just on the size of the economic pie, but on how the pie is shared.

The report can be read on line at www.health.state.mn.us, or call for a copy at 651-296-7012.



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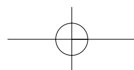


Community Circles of Caring

Interviews with Atum Azzahir, Director, Powderhorn/Phillips Cultural Wellness Center and Mary Nesvig, Director, West Side Community Health Center/La Clinica

Neighborhood-based care that is culturally sensitive and rooted in community values is getting plenty of attention in the current public debate about how to improve health of all Minnesotans. But you don't need to tell that to the dynamic directors of two such organizations in the Twin Cities. They see daily evidence of the progress that flows from thoughtful, steady community-defined health and well-being.

Nancy Conroy

Community birthing teams provide critical support to new moms and dads.

Atum Azzahir is the director of the Powderhorn/Phillips Cultural Wellness Center, a 5-year old organization with the mission of "unleashing the power of citizens to heal themselves." Many different cultural groups make their home in the Powderhorn and Phillips neighborhoods, and all of them are welcome at the Center. There are Hmong youth and parents education projects, coalitions of African women, councils of elders, and an array of other opportunities for self-reflection and community building.

Mary Nesvig, M.D. is the director of the West Side Community Health Center/La Clinica, which has been operating for 28 years to provide "comprehensive primary care, education and advocacy for those who are experiencing cultural, economic or other barriers to health care." This St. Paul neighborhood has been home to many different waves of immigrants and new arrivals, and currently is made up of predominantly Latino and Hmong families. La Clinica's bilingual staff serves individuals whose primary language is Spanish or Hmong, and about 80% of the families are uninsured.

What do you count as the most important successes of your centers?

Atum:
Our emphasis is on personal responsibility and taking personal action to eat well, resolve conflicts in the family, and help build kinship and community support systems. So, for us, success means a community that is acting in a way that reflects deeply understood values about health and wellness, like taking care of children, changing patterns of behavior that are destructive, and not holding on to disease.

I'm particularly proud of our work to provide community care and birthing teams for pregnant women in our neighborhoods. Teams provide transportation to check ups and the grocery store, encouragement with healthy eating, support from elders in their particular culture, and are present throughout every step of labor and delivery. Success would mean that no woman would be alone through her pregnancy and the birth and earliest care of her child. Anecdotally, I can tell you that with this method we are finding that labor is shorter, hospital stays are shorter, women report less pain, and there have been no C-sections so far.

Bruce Wilcox

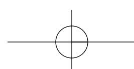
Exercise and good nutrition are the building blocks of lifelong health.

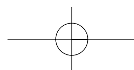
Mary:
People tell us they are much more comfortable coming here for care than going to an HMO or large medical facility. They feel welcomed, are greeted by friendly staff from the community, and receive care that is culturally sensitive and in their own language. We used to refer women off site for regular mammograms until we found out that only 40% kept those appointments. Now that mammography is available here at the clinic, 85% of the women follow through. We are also seeing more women coming in for prenatal care in their first trimester, rather than further along in their pregnancies, and this early care is leading to healthier births. The availability of community birthing coaches, massage therapy and chiropractic care, and herbal medicine all contribute to the comfortable environment of the clinic.

Clearly your centers are reaching and serving individual families in important ways. Are you also seeing broad, community-wide improvements in health?

Atum:
We've only been here 5 years, but I am very hopeful that our influence is spreading. We log about 2,000 visits a month and serve about 500 individuals. Our voluntary return visits and participation rates are high, which is very encouraging. We strive to fully engage people over time, and to hold and maintain their attention on individual and community health. That's the only way we're going to see long term changes. We have made this a place where people come to celebrate and communicate with each other, as well as come to work on health issues.

Community Circles of Caring—*continued on page 5*





Minnesota Takes Aim on Health Disparities

Jan Jernell, Director, Division of Family Health, MDH

The Minnesota Department of Health (MDH) was successful this past legislative session in securing funding to begin a concerted effort to eliminate health disparities in Minnesota. This effort, which has been evolving for several years, began in response to the staggering and unacceptable statistics that belie Minnesota's high standard of health and quality of life.

On average, Minnesota looks very good. Looking below the surface, however, there are racial, ethnic, and economic disparities throughout all health measures – ranging from pregnancy and birth outcomes, to chronic conditions and diseases, to mortality measures. Because of the involvement of many community-based organizations and individuals, we were able to secure legislative approval for new resources to address this issue. The initiative was structured to address disparities in the following seven areas: infant mortality, immunizations, breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and injury and violence.

One of the most exciting aspects of this activity was the passionate involvement of many community members and organizations. This was a relatively new and different way for the MDH, as a whole, to work with communities. We had much to learn and teach each other. Although communities live with and see the effects of these disparities daily, many people were unaware of the overall data that describes the breadth, depth, and specific trends of these disparities. Sharing this information was a first step in engaging community partners. MDH held a series of community-based forums to determine what needed to be done

Health Disparities—*continued on page 11*

Community Circles of Caring

—*continued from page 4*

Mary:
I used to be in private practice, and I can tell you that community-based health is a much better model of care—I can spend more time with each person and get to know them better, community members on the staff work together on many aspects of health, and there are more checks and balances. One measure of community care can be found in our East Metro Diabetes Project that involves 5 community clinics, including our own. The rise of diabetes in the Latino community is approaching the very high incidence rates that occur in the Native American communities, so we are providing intensive diabetes screening, education and follow through. Our latest metro wide audit shows strong improvements: we are screening more people, including immigrants who have had no previous medical care whatsoever, and people are coming to us much earlier than ever before. Our intensive community support for diet, exercise, and early detection is resulting in measurable improvements in hemoglobin A1c (long-term blood glucose levels) in our patients. But, it continues to be a challenge for the people we serve to have healthy diets when fresh fruits and vegetables cost more than pasta and other prepared food.

In your estimation, what would make a significant difference in bridging the gaps in health for Minnesota populations?

Atum:
I believe we are in a state of emergency. But, I'm less concerned with how we got there than how we are going to get out. Communities of color need to make promises to themselves. One promise must be that we will not let ourselves get this sick again before we act. Another promise is to stop comparing our community's health and well being against a standard of white, non-immigrant health. Instead, our measuring stick must be—are we healthier today than we were yesterday? The state of Minnesota and the Department of Health have an important role to play in this. They need to help us leverage resources so that communities can take responsibility for their own health and, ultimately, hold themselves accountable to a standard of well being.

Mary:
Access to affordable health care is the burning issue, and the real disparity that we should be addressing. How can we prevent diabetes when people in our community can't afford the $3 a day—$90 a month— for test strips to monitor their disease? Whenever our clinic receives a shipment of free samples from pharmaceutical companies, they are gone by the first day. On those days I feel like I work in a M.A.S.H. unit. As a physician, I can't simply write a prescription because I know so many of the people I serve can't afford to fill them. My basic, daily frustration is that most of the diseases that lead to early death in my community could have been prevented with early detection, community education, proper medication and diet, and a change in behavior. Physicians need to step up to the plate and join community leaders in speaking out about the specific health improvements we could bring about right now, if we had adequate health care for all.

New Report on Metro Minority Health

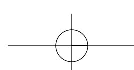
Key Findings from the *Metro Minority Health Assessment Project Report:*

- People of color in the seven-county metro area are more likely to die at younger ages that Whites. Over half of deaths among people of color occur before age 64, compared to about 20 percent for Whites.
- The infant mortality rates metro-wide for American Indian and African American infants are as much as four times greater than White infants.
- People of color under the age of 45 are more likely to die from violence than White people in the metro area.
- Adolescents of color have higher rates of sexually transmitted infections than White adolescents. For example, the gonorrhea rate among Black adolescents is about 70 times higher than that of Whites.

For a copy of the report, call 612-673-5438 or visit www.mncounties.org/metroplan/MinHealth.htm

Bruce Wilcox

Kinship and community supports pass on powerful messages about health and wellness to children.



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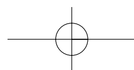

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TEACHING

Computer-based Course to Reach Health Professionals and Policy-makers

A dramatic influx of African, Asian, Latino and Eastern European immigrants to rural and urban communities has led to an urgent need for the training of policy makers and providers in immigrant and refugee health needs, including the characteristics, practices and belief systems of new residents. This need prompted Humphrey Institute Professor of Public Affairs Katherine Fennelly to develop a computer-based distance education course on Immigrant Health Issues that professionals, policy makers, and graduate students can take from their home or office computers.

Hennepin County Medical Center and Regions Hospital helped develop the course outline with three University units—Humphrey Institute of Public Affairs, School of Public Health, and the Medical School. In addition, administrators of international clinics at local hospitals, the Refugee Health Task Force, the Immigrant Task Force of the Urban Coalition, and the Minnesota Department of Health all confirmed that the course would be valuable for professionals in the field.

The web-based course incorporates videotaped segments with immigrants and refugees, and experts in cross-cultural health. On the class web site students respond to the videotaped segments, explore community resources, and access electronic reserve readings, searchable web sites and library data bases on immigration and health.

But the heart of the course revolves around community visits to local businesses, clinics and INS hearings. "The single best way to become culturally competent," says Professor Fennelly, " is to work in the community, talking to and learning from the residents whom you wish to serve."

For more information contact Professor Fennelly at kfennelly@hhh.umn.edu.

RESEARCH

Health Risks in Poor Neighborhoods

A study in the July 12 issue of the *New England Journal of Medicine* made headlines by stating that people living in poor neighborhoods are more likely to have heart attacks than those living in affluent areas, even when differences in income, profession and education are controlled. UM Professor of Epidemiology Donna Arnett was one of the co-authors of the study, which followed 13,000 residents from four regions of the country—including the northwest suburbs of Minneapolis—for nine years.

The study showed that white residents living in disadvantaged neighborhoods who were healthy at the start of the study were 70 – 90% more likely to develop coronary disease when compared to whites living in high income neighborhoods. African American residents living in disadvantaged areas were 30-40% more likely to develop the disease than African Americans living in high income areas.

What it shows, says Dr. Arnett, is that where you live has a strong influence on your behavior and your health risks. The chronic violence, poverty, noise and decaying infrastructures associated with disadvantaged neighborhoods may be contributing to chronic stress, which also can increase the likelihood of heart attacks.

So what are the policy implications of this kind of study? "I'm an epidemiologist," says Dr. Arnett, "not a policy analyst. But the results are telling us that the community level—the macro level—of people's lives matters a great deal when it comes to health and well being."

A 1999 study from the Institute of Medicine*, Toward Environmental Justice: Research, Education, and Health Policy Needs*, does put forward recommendations in four key areas – public health, research, education and health policy. It reports that residents of some communities may not be aware of environmental stressors that could be harmful to health and may be more vulnerable to health problems because of poor nutrition, inadequate health care and other factors.

There is still much to be determined about the cause of poor health typically experienced in disadvantaged communities. And great strides need to be taken toward understanding the interrelationship between research and education on environmental health disparities.

Miss

The University of Minnesota is dedicated to
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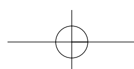
through education for a diverse community,



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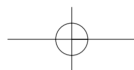

ULFILLS ITS LAND GRANT MISSION

us on health

OUTREACH & PUBLIC SERVICE

A New Generation of Health Care Professionals

The Center of American Indian and Minority Health (CAIMH) at the University of Minnesota-Duluth's School of Medicine is working to encourage and support Indian young people from Kindergarten all the way through Graduate School. Its goal is to improve the health and well being of American Indians by increasing the number of Indian students going into the health care professions—medicine, nursing and public health—and encouraging critical research on Indian health issues.

The Center works with American Indian kids of all ages. It runs summer camps for K-8th grade students that teach math and science skills in culturally sensitive and fun ways, mentors high school students by matching them with tribal health clinics, and provides intensive academic support for undergraduates considering the health professions. And, the American Indian students enrolled in the Medical School receive one-on-one support throughout their training.

CAIMH Director Johanna Clevenger, M.D., is particularly excited about several new developments. "Half of this year's class of American Indian students admitted to the Medical School have gone through our K-12 or undergraduate programs, so we are beginning to see a wonderful cumulative effect of our work."

Since 1990, CAIMH has successfully graduated 43 American Indian/Alaska Native physicians from the UM Medical School. But Dr. Clevenger is quick to add that the influence of the Center's work goes beyond the numbers. "I'm very hopeful about subtle changes in the overall teaching, administration and research in our Medical School," she reports, pointing proudly to the fact that the UM-D School of Medicine now has 3 faculty members who are American Indian.

Another hopeful sign is the emergence of a research base on American Indian health issues conducted by American Indian researchers. CAIMH Fellow, Dr. Jennifer Giroux, M.D., whose tribal affiliation is Rosebud Sioux, is working on ground-breaking research that investigates the link between tuberculosis and diabetes in American Indian populations.

But so much more needs to be done in both research and practice. Dr. Clevenger says she is alarmed by the soaring rates of tobacco use by American Indian populations in Minnesota, Oklahoma and the Dakotas. "We haven't seen the full impact of these trends yet," she cautioned, "but we will. And we must start paying attention to them right now."

For more information log on www.caimh.org

The Health Insurance Gap

At the peak of the presidential campaign last September, the Census Bureau released the results of a nationwide survey which found that 42.5 million Americans—15.5 percent of the population—have no health insurance. The report sparked renewed debate about how to expand health care coverage.

That same week, the Robert Wood Johnson Foundation awarded a three-year, $4 million grant to the University of Minnesota's School of Public Health to launch an ambitious project to help individual states assess their health insurance needs. The money is being used to establish the State Health Access Data Assistance Center (SHADAC) within the School's Division of Health Services Research and Policy. SHADAC will help states monitor rates of uninsurance through existing data and the development of new coordinated state surveys.

In order to figure out how to get kids and adults covered, states must know who needs insurance.

"There's a severe shortage of state-level data" that might help legislators improve existing programs and develop new ones, says Lynn Blewett, SHADAC principal investigator and an assistant professor in the School of Public Health.

Assistant Professor Kathleen Thiede Call, co-principal investigator for SHADAC, says "having detailed information about the characteristics of the uninsured helps policymakers target interventions more effectively, whether through outreach efforts to those without insurance, tinkering with public programs, or encouraging changes in the private market."

One reason this grant was awarded is that Minnesota has served as a model of innovative policy solutions to increase health insurance coverage, particularly for children through MinnesotaCare. SHADAC's goal is to help translate the numbers of uninsured into real people and effective public policy.

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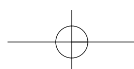

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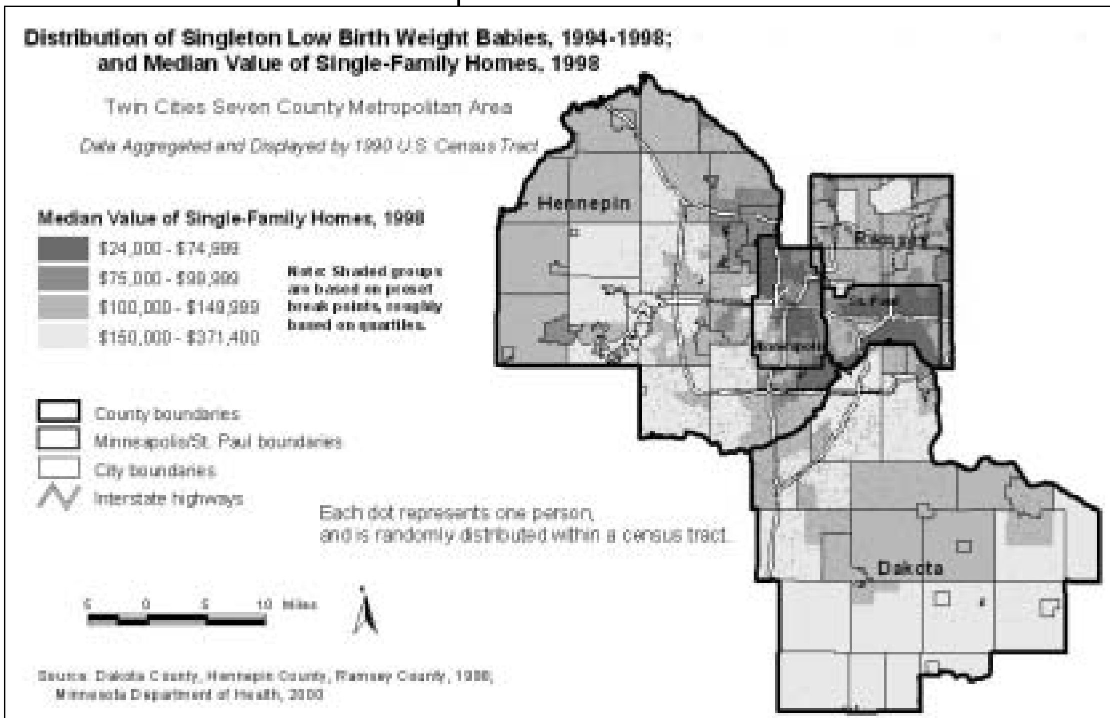
"Draw me a picture!" Using GIS to understand health disparities

Laurie L. Meschke, Ph.D., Maternal and Child Health Program, Division of Epidemiology, School of Public Health, University of Minnesota

Health disparities are obvious to many, yet invisible to others. Oftentimes the statistics appear to have clear application to certain communities, but not necessarily to our own. It is often said, "A picture paints a thousand words." GIS (Geographic Information Systems) provides a tool by which the combination of geographic locations (e.g., map boundaries) and health information can be used to display the severity of health disparities for any given location. The end result is a picture with a wealth of information.

For example, in Figure 1[1] two characteristics have been graphed: low infant birth weight (LBW) and median home value (a measure income). The map depicts that in the three counties, the greatest concentrations of LBW occur in the poorest neighborhoods. In other words, there is a disparity in infant birth weight by income. Programs to address LBW can be focused and tracked using this geographic information.



[1] *This map was created by Tim Zimmerman of the Hennepin County Community Health Department.*

GIS is created to collect, store, and analyze objects and phenomena when geographic location is important or critical to the analysis. GIS tools are available in a number of different software packages (e.g., ESRI [ArcView, ArcInfo] or MapInfo). Over time this software has become more sophisticated and powerful, yet easier to use. GIS packages have the unique ability to link two types of data (attribute and object data) in order to map characteristics of areas.

Attribute data are characteristics to be mapped. These characteristics might be teen births, immunizations, or low infant birth rates. In order to map characteristics, the attribute data must be attached to a geographic point or place. This could be an actual street address, zip code area, census block, or census tract. Any survey can be attribute data if a geographic area question is asked and participants respond.

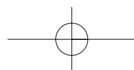
Object data are the actual boundary information to be mapped. These may include created borders (e.g., county lines or streets) or natural borders (e.g., coastline or rivers). The selected object data must include the geographic areas represented in the attribute data. If attribute data are collected based on counties then the object data must contain county boundaries. The geographic measure is the link between the attribute and object data. Object data are available from the U.S. Census Bureau as TIGER files (http://tiger.census.gov/).

The smaller the geographic location linked to the attribute data, the better. Building up or aggregating the data can always create larger geographic areas, but a large geographic area can never be "reduced." For example, if the attribute data are teen births by county, these data can never be examined by town, but if the data have a town identifier, the data can be aggregated to create county level data.

When collecting data, consider what might be the smallest geographic area that respondents might disclose. The collection of a geographic identifier is very helpful but if the question appears too personal, the result will be a lot of missing data, and this is never helpful. The GIS user also must consider privacy. Data should never be mapped if they identify the person behind the data. A general rule of thumb is to map data only if five or more cases of a particular event occur. However, if the five cases easily identify a person, then a GIS display should not be used.

GIS support resources available on the web:

Create your own maps at the CIESIN site (www.ciesin.org/interapps.html) with their interactive GIS program. Data to use with GIS software can be found at http://plue.sedac.ciesin.org/plue/ddcarto/ (attribute data) and http://tiger.census.gov/ (object data).



Minnesota Health Through a National Lens

—continued from cover

average. However, a closer look at the numbers reveals some of the worst discrepancies between whites and children of color, especially African-Americans, anywhere in the country. With regard to infant mortality, African-American and Native-American children have some of the highest rates in the country, and immunization rates for children of color lag substantially behind the white population in Minnesota. The epidemic of childhood obesity, a precursor of diabetes and heart disease, is also most pronounced in minority communities.

In recognition of this priority, the state legislature recently allocated $13.9 million for a statewide health disparities initiative (see article on page 5) The initiative will focus on infant mortality, immunization, reducing injury and violence, and diabetes, cardiovascular disease and HIV, with a particular emphasis on preventing these diseases. While focus of this initiative is on health disparities that are associated with race and ethnicity, it is important to remember that other important disparities exist. These include disparities associated with socioeconomic position, urban vs. rural residence, and sexual orientation.

Success in addressing these disparities will require efforts not only within the health and public health system, but also efforts focused on social conditions in communities, as well as formal and informal community systems. Indeed, a recently released study by the Minnesota Department of Health, points to social conditions as a key factor in improving health. Among the most important factors to address are reducing poverty, improving educational attainment, and increasing access to affordable, non-segregated housing. In Minnesota, the burdens of these factors fall disproportionately on children of color.

The health and public health systems play an important role in these disparities. Minnesota has made significant progress toward providing health insurance for all children, and our rates of uninsurance, including those for children of color, are among the lowest in the country. Yet, we should not rest until all children have health insurance, and we still have a long way to go in insuring adults—including the parents of our children. Insurance, though, is only one part of the picture. Data repeatedly show that simply having insurance does not guarantee access to high quality care, and that even with insurance, minority populations have less access to care and receive less care as well as poorer quality care, than whites. This is the case for both children and adults. Minnesota's health plans have led the way in developing systems to assure the receipt of high quality care. Now it's time to assure that we have systems that work for everyone, and that people of color are not left behind.

Another area in which changes in the health care system are likely to help in addressing disparities is in the health care workforce. Nationally, only 11% of recent medical school graduates were underrepresented minorities. The situation is similar (or worse) for nurses and dentists. In Minnesota, it is critical that we strive to make our health care workforce reflect the changing nature of our communities. This will assure access to providers who understand the culture and often speak the language of people they serve, and will most likely increase both the access to care and the quality of care that minority individuals receive. There is ample evidence that increasing the diversity of the student body increases the appreciation for cultural differences among *all* students, thereby increasing the cultural capacity of a large number of providers.

Public health efforts also play an important role. The health choices many individuals make, including whether to smoke or exercise, or when to become sexually active, are conditioned by the norms and messages in the communities in which they live. Community-led efforts, such as those that will receive funding through the statewide disparities initiative, will be critical to creating environments in which people can make healthy choices. Those choices made in childhood often have lifelong effects.

But, as noted earlier, we will not succeed in eliminating disparities simply by making changes in the health and public health systems. Education has been identified as a key determinant of health. Unfortunately, disparities in educational attainment, including high school graduation rates, are well documented, with the lowest graduation rates for Native Americans and Hispanics. Such low educational attainment will not only have consequences for future earning potential, but will have lifelong consequences for health.

The Consortium has already noted the role that housing stability plays in educational achievement (see www.cyfc.umn.edu/policy/issues/housing.html). The lack of decent, affordable housing, and particularly segregated housing, also has implications for the health of individuals and of communities. In fact, the Centers for Disease Control has identified housing vouchers as a highly effective socio-cultural intervention to improve health. These facts suggest that addressing the crisis in affordable housing will have multiple effects—on education *and* health—and probably on other factors that impact on health such as exposure to violence and environmental toxins.

While eliminating disparities is a particular health goal for Minnesota, the fact is, it's not simply about medical care. It's about the very nature of our social fabric. We're all in it together.

Consortium Calendar

OCTOBER

October 2
Conference on Community-based Transportation, hosted by the UM's Center for Transportation Studies. Earle Brown Center, St Paul Campus. Contact Josh Barney 612-624-0768 or jbarney@cce.umn.edu

October 3
Changes and Challenges: Policy Analysis in the 21st Century will focus on census data, population trends and ways to access and analyze data. Sponsored by the State Demographic Center, MN Planning, and the University of Minnesota, held at Earle Brown Center, St. Paul. See: www.minnstats.org/pac.htm

October 3-5
The Communities of Health Conference will be held at Madden's Gull Lake in Brainerd, MN. Contact the Minnesota Association of Community Mental Health Programs at 651/642-1903.

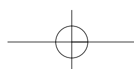
October 6
Picnic for teens and parents at Rio Vista Recreation Center, 179 S Robert St, St Paul, to introduce MOAPPP's Latino Youth Outreach Project. Noon to 4:30 pm. Contact Marlenis Millan at 651-644-1447.

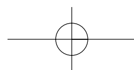
October 10
Sponsored by the League of Women Voters of Minneapolis and the Minneapolis Center for Neighborhoods, the Neighborhood Leadership Breakfast series is free and open to the public. All take place at the Gallery 8 Restaurant, Walker Art Center, Minneapolis. This session will feature Dr. Carol Johnson, Superintendent Minneapolis Public Schools. For questions, call 612/333-6319 or 612/339-3480.

October 11
Turn off the Violence Day, visit www.turnofftheviolence.org for more information.

October 11
"Through the Eyes of a Child: Establishing Permanency and Addressing Mental Health Needs of Children" is a conference co-hosted by the Minnesota Supreme Court along with the MN Department of Human Services. Contact Mary Sontag at DHS, 651/296-5420.

October 11-12
15th Upper Midwest Conference on Adolescents & Children In Need will be held at the Holiday Inn-St. Paul North, Arden Hills, MN. Intended for all people who work with adolescents and children. Contact Mary at 320-629-1307 or: cedinc@ecenet.com.





October 14-20
Teen Read Week 2001 – Make Reading A Hobbit is October 14-20. Browse the Young Adult Library Services Association's website at www.ala.org/yalsa/. Follow the link to Teen Read Week for more information.

October 16-17
It's Time for Action:Closing the Racial and Ethnic Health Gap in Minnesota is a conference hosted by the Minnesota Department of Health addressing their new health disparities initiative. Featuring Dr. David Satcher, U.S. Surgeon General. Held at the Earle Brown Heritage Center, Brooklyn Center. Visit the website www.health.state.mn.us, call 651/296-7012 or email Deb Burns at debra.burns@health.state.mn.us

October 19
What Do Suburbs or PHAs Spell for Low Income Kids and Parents? The Center for Law and Social Policy (Washington DC) lunchtime talk show, 12:30-1:30pm EST. Visit www.claps.org/audioconference/brochure.html or contact Janellen Duffy at jduffy@clasp.org for more details and registration information.

October 20
The Twin Cities Men's Center is coordinating and co-sponsoring a one-day symposium dedicated to men's health, *Twin Cities Men's Health & Well-Being Symposium.* For more information, contact the Men's Center at 612/822-5892.

October 23
The 10th Annual Kids Plus Conference *Connecting Kids and Community* will be held in Duluth, MN. For more information, call 218/723-4040.

October 24 - 25
The Family: Building Character, Strengthening Connections is the 10th Annual Symposium sponsored by St. David's Child Development and Family Services and the Children, Youth and Family Consortium. Drs. Ron Taffel, Pedro Noguera and David Walsh will be the featured speakers. For more information call 952/939-0396.

October 25-26
Welfare Reform as We Know It, Humphrey Institute policy forum at Cowles auditorium, Humphrey Center. Call 612-625-8330 or visit http://www.hhh.umn.edu/centers/policy-forum. The University of Minnesota fulfills its land grant mission…with a focus on health disparities

October 27
A Citizen's Call to Action: Democracy: Mend It, Don't End It. This conference is sponsored by the U of MN's Institute on Race and Poverty. Visit www1.umn.edu/irp/whatnew.html for more information and registration details.

Consortium Update

Tools for Parents in Difficult Times

This year's St. David's Symposium, October 24-25, focuses on the pressures that surround today's families and how those pressures affect children. And, it will also provide parents and parent educators with tools and strategies to effectively parent through those difficulties. Featured speakers include Dr. Ron Taffel, noted child and family therapist and author of *Parenting by Heart* and *Why Parents Disagree*; David Walsh, founder of the National Institute on Media and the Family and one of the leading authorities on the impact of media on children and families; and Pedro Noguera, Professor of Communities and Schools at Harvard Graduate School of Education, who researches ways to build supportive relationships between parents and schools. To register and to find out about scholarships for families, call 952-939-0396.

Family Re-Union reflects on 10 years of policy efforts

This year's Family Re-Union conference is a retrospective on the past 10 years of national policy efforts to strengthen families. On November 19 at Vanderbilt University, former Vice-President Al Gore will again moderate the discussion of best practices in policy making and program development, along with national experts and community-based leaders. This is the 8th year that CYFC has been a co-sponsor of Family Re-Union. If you would like to receive an invitation, please contact Rebecca at 612-625-7865 or rreib@umn.edu.

The Power of Promises

The Center for 4-H Youth Development's Summer issue of *The Center* highlights local accomplishments that have grown out of America's Promise, the four-year-old national effort to promote community supports for young people. The issue includes articles by national and local researchers, educators, practitioners, and young people, and it is being distributed nationally by the Washington D.C. based America's Promise. To receive a copy of the publication and find our more about community-wide youth development, contact co-editors Stephan Carlson (carls009@umn.edu) and Joyce Walker (walke007@umn.edu). Have questions about the U M's University of Promise initiative? Call (612-625-7865) the Consortium office.

Healthy Kids Learn Better

Minneapolis 8th graders are more than twice as likely to pass the Minnesota Basic Standards Reading Test if their attendance is ranked as "good" (attending 95% of school days) versus "fair" (80-85%). The Healthy Learners Board is a 3-year old partnership of community leaders working together to foster healthy students who can attend school every day, ready to learn. All their programs specifically address the special issues of economically disadvantaged, culturally diverse, and non-English speaking students and their families.

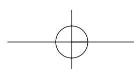
Immunizations. In 1997, just 69% of Minneapolis Public School students were up to date on their immunizations. The "No Shots, No School" project was implemented, and now over 98% of new and current students are properly immunized. This means fewer students miss critical days in the classroom due to vaccine-preventable illness or incomplete immunization records. Eighteen other Minnesota communities now replicate this project in their school districts.

New Families Center. Immigrant and refugee families now comprise over 20% of the Minneapolis Public Schools student body. This Center leverages school registration to integrate immigrant and refugee families to our community's health systems. Interpreters build trusting relationships, nurses do health assessments and administer immunizations, and social workers enroll students in public insurance programs and assist families in accessing health resources.

Asthma. Asthma is a leading cause of school absenteeism and the most common chronic health problem among Minneapolis students. The Healthy Learners Board is striving to cut in half school absenteeism, emergency room visits and hospitalizations related to asthma over 3 years.

Health Care Access. Access to health care coverage and a medical home impacts children's health. Reducing the number of uninsured students — at the time they register for school, or when a health problem arises — is one focus of program activities. Insured kids who are connected to a source of care are better learners.

For more information, contact:
Minneapolis Public Schools Health Related Services 612-588-3111



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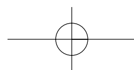


Connection Corner

Improving Children's Access to Health Care

On June 28, the University of Minnesota's Center for Spirituality and Healing recognized individuals and organizations working to improve health care for children. Martha Farrell Erickson of the Children, Youth & Family Consortium was one of the 10 honorees; the others were David Brant and Karen Lehman of Youth Farm and Market; Ellis Bullock of Youth Trust; Angela Carter of Hennepin County; Kathy Cerra of Reach Out and Read; Beverly Dusso of the Harriet Tubman Center; Louis J. King II of Summit Academy OIC; Mark Ritchie of the Institute for Agriculture and Trade Policy; and State Representative Jean Wagenius. Housed within the School of Nursing, the Center is working to integrate biomedical, complementary, and cross-cultural care into clinical, research and educational practices.

Turn Off the Violence

In 1991, a small group of hopeful police officers, doctors, teachers, parents and others began a campaign called Turn Off the Violence. Within the first two years the campaign began spreading to other states and eventually to other countries. Now in its tenth year, the campaign is back with its original founders. October 11th has been proclaimed Turn Off the Violence Day. It's a day when people are encouraged to turn off all the violence in their lives -- on their radios, TVs, video games, and in their behavior -- so that we can show children what it would be like to live in a world where everyone feels safe and respected. More information is available at www.turnofftheviolence.org.

A Winning Proposal for Early Literacy

Minnesota has received a federal grant award of $24.5 million under the Reading Excellence Act. The funds, aimed at improving literacy for K-3 students, will be re-granted to the state's neediest schools to support tutoring, family literacy, professional development of teachers, and the transition to first grade for kindergarten students. The University of Minnesota's College of Education and Human Development assisted in the proposal planning and will be involved in delivering professional development training and on-going support for teachers and leadership teams. Congratulations to the MN Department of Children, Families and Learning for securing the grant, and to the many community organizations dedicated to early literacy, school success, and child and family well being that provided assistance.

Health Disparities

—continued from page 5

and how we could work together to make progress. Community members called and visited legislators and held meetings and rallies, all of which was invaluable in educating policy makers and generating broad public support for the initiative.

Now we are in the process of planning the implementation, and we must carry forward our new relationships and partnerships into the important work ahead. Although MDH received $13.9 million per year for the initiative, this was less than originally requested and considerably less than it will take to fully address Minnesota's health disparities. Expectations will need to be shifted for these decreased resources, and priorities will need to be established.

Many challenges lie ahead. Eliminating racial and ethnic health disparities is a statewide issue, so we will need statewide goals and objectives. However, for maximum success and emphasis, this work must be implemented locally. How will we support that local flexibility while at the same time maintain adequate focus and effort to assure some statewide progress? How will we measure progress? How can we facilitate and build capacity at the local level – for the actual work and for needed coordination and cooperation? What information will we need in the future to convince policy makers and citizens that this work should not only be continued, but expanded? These are the kinds of questions we are currently exploring with our community partners.

Minnesota is only the second state to have such a focused health disparity initiative – the first was Florida. For the first time we have significant targeted resources, solid committed partnerships, and are establishing clear priorities. It's an exciting time to be involved in public health. I hope you'll join in this effort wherever you are and whatever role you can play in helping eliminate health disparities.

More detail is available on the MDH website at www.health.state.mn.us .

NOVEMBER

November 2
Meeting the Challenge of Aging: Uniting Public Health Research, Practice and Policy is the theme of this year's University of Minnesota's School of Public Health Roundtable. For more information email cpheo@umn.edu or call 612-626-4515.

November 2
Life at Low Wages: What Work and Child Rearing Choices Do Parents Face? The Center for Law and Social Policy (Washington DC) lunchtime talk show, 12:30-1:30pm EST. Visit www.claps.org/audio-conference/brochure.html or contact Janellen Duffy at jduffy@clasp.org for more details and registration information.

November 8-10
The Minnesota Association for the Education of Young Children's 43rd Annual Conference will be held at the Minneapolis Convention Center. Contact Maggie Vyskocil at secretary@aeyc-mn.org or 651/646-8689.

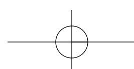
November 16
Australian writer and scholar Mem Fox, author of *Reading Magic* will be at the Hennepin County Library, Ridgedale location. For more information call 952-847-8800.

November19
Family Re-Union 10: Back to the Future, Accomplishments and Next Steps held at Vanderbilt University, co-sponsored by the University of Minnesota's Children, Youth and Family Consortium and Vanderbilt University's Child and Family Policy Center. Visit the website www.familyreunion.org.

DECEMBER

December 3-5
Our Future is… Talking and Working Together, the Association of Minnesota Counties will hold its annual conference at the Touchstone Energy Place in the RiverCentre, St Paul, MN. Email Laurie Klupacs at lklupacs@mncounties.org.

December 7
Reauthorization: What Looms for 2002? The Center for Law and Social Policy (Washington DC) lunchtime talk show, 12:30-1:30pm EST. Visit www.claps.org/audio-conference/brochure.html or contact Janellen Duffy at jduffy@clasp.org for more details and registration information.



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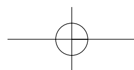

On Line at — www.cyfc.umn.edu

Michael Brott, CYFC Community Partnership and Communication Coordinator

Addressing Health Disparities
http://healthdisparities.nih.gov

The National Institutes of Health's plan of action is a good place to start to understand what are health disparities. NIH has developed a multi-faceted plan in order to address the varying components of this growing concern for children and families throughout our nation.

Health Disparities and Environmental Health
http://www.niehs.nih.gov/oc/factsheets/disparity

A large subset of health disparities focuses on environmental health. This is magnified by the health disparities between its advantaged and disadvantaged populations. "The National Institute of Environmental Health Sciences (NIEHS) has been a leader in the area of understanding how poverty, environmental pollution, and health interrelate. The NIEHS has developed a number of projects and grant programs designed to define the health disparities issue and to arm policy makers with the necessary information to reduce these disparities. Additionally the NIEHS has developed innovative grants programs aimed at empowering local communities to deal with the environmental health problems in their regions."

Indian Health Service's Health and Heritage Brochure
http://info.ihs.gov/Health/Health_INDEX.asp

The Indian Health Service has produced a brochure on health and heritage that outlines health disparities trends from diabetes to heart attacks, and mental to oral health.

Understanding Health Disparities Across Education Groups
http://papers.nber.org/papers/W8328

Authors Dana Goldman, Darius Lakdawalla issued a working paper for the National Bureau of Economic Research, a private, nonprofit, nonpartisan research organization dedicated to promoting a greater understanding of how the economy works. Their research is conducted by more than 600 university professors around the country.

"Better-educated people are healthier, but the magnitude of the relationship between health and education varies substantially across groups and over time." The authors "undertake a theoretical and empirical study of how health disparities by education vary over time and across the population, according to underlying health characteristics and market forces."

Who's the Consortium?

Amanda Blount, CYFC's terrific summer intern, has been hired as a research assistant with the National Center for Educational Outcomes, housed within the UM's Institute on Community Integration. A graduate student in the School Psychology program, Amanda spent the summer gathering data on youth research and programs for CYFC.

Gloria Lewis, the new director of the MN Department of Health's Office of Minority Health, has been busy meeting with community groups that are working to reduce health disparities affecting Minnesota's ethnic and racial communities. She recently spoke to CYFC's Advisory Council, and is helping us find ways to assist with the state's new Health Disparities legislative initiative.

Marlenis Millan, Outreach and Training Coordinator for the MN Organization on Adolescent Pregnancy Prevention and Parenting, is coordinating a new Latino youth outreach project. This summer, Marlenis generously assisted CYFC in producing a Spanish language version of parenting resources for Latino families.

Elizabeth Sifuentes is an undergraduate student who has been helping CYFC translate and prepare Spanish language materials to post on our web site. This summer, Elizabeth has worked closely with staff from Unidos para los Niños, a coalition of community organizations that serve Latino families, to create a searchable database of parenting resources. Elizabeth also serves as a tutor with the UM's El Puente mentoring program.

And the Consortium is YOU!

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