I have some important news to share with you. The first is that our Medical School was recently awarded $6.24 million by the National Institutes of Health to establish a Center for Excellence in Health Disparities Research, Engagement, and Training (CeHDRET) focusing on minority health and health disparities. Among other things, the center will be partnering with minority-serving Colleges and Universities for their students to attend workshops and seminars at the University of Minnesota. The center will also be supporting research and community engagement projects addressing minority health and health disparities in collaboration with the local community.

I would like to take this opportunity to thank everyone that was involved and participated in this entire process beginning last year when so many decided to exchange a bit of summer relaxation to meet an approaching deadline.

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Improving Treatment Adherence and Outcomes in Homeless Smokers

Smoking rates have decreased over the last few decades among adults in the United States, but rates remain high among certain populations. One population is the 4 million homeless persons in the United States, where the cigarette smoking rate is approximately 70% - three times the national average. Heart disease and cancer, two of the three leading causes of death, are smoking-related.

Despite the high smoking rate and its relationship to cancer and heart disease, little research on smoking cessation has been conducted for the homeless. Recent studies indicate that homeless smokers have the same desire and readiness to quit as the non-homeless, and that nicotine replacement therapy plus counseling shows promise as a treatment for smoking cessation with homeless persons. However, homeless persons face many challenges, and one barrier for them is adhering to the treatments that have proven effective in the general population. Smoking cessation interventions for the homeless must include ways to improve treatment adherence in the homeless populations.

Power to Quit is a four-year research study recently initiated in Saint Paul, Minnesota and led by Program in Health Disparities Research Director, Dr. Kola Okuyemi. This study seeks to provide a model to help overcome barriers to cancer prevention services among homeless persons and inform policy changes that will increase homeless persons’ access to smoking cessation medication and treatment. Funded by the National Institutes of Health, Power to Quit will recruit 428 participants from homeless shelters and facilities in the greater Minneapolis/St. Paul metro area.

In Power to Quit, each participant will be randomly assigned to one of two treatment groups. In one group, the participants will receive six motivational interviewing sessions, and the other participants will receive a one-time brief advice session to quit smoking. Both groups will receive a nicotine patch for 8 weeks. The primary outcome of this study is the participant’s smoking status at 6 months after beginning the program. Another expected outcome of the study is the influence of substance abuse and psychiatric disorders on treatment adherence with homeless smokers. 

What’s Going On?

Meet the Board

The Program in Health Disparities Research Advisory Board plays a key role in the direction and focus of our Program. In this issue, we talk to Beverly Propes, P.H.N., R.N., a public health nurse consultant at North High School in Minneapolis, and a Program in Health Disparities Research Advisory Board member.

Q: What are the three greatest community health challenges that you see during your work?

A: The first health challenge that I see is how do we better inform, inspire and empower the community in choosing risk reduction practices that improve family health and wellness as primary practices of living. Second I would say, being bolder, more creative, and more aggressive in attempts to raise awareness of the critical value of culture and wellness as a priority when addressing health care for all populations. Finally, I believe there is need for additional training in building partnerships across the physical, intellectual, social, emotional, economical, spiritual and occupational wellness dimensions.

Q: Thinking of the health needs of the communities that you work with, are there any areas that current research or local initiatives are not adequately addressing?

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Heart Failure is a chronic condition in which the heart is unable to pump enough blood throughout the body to meet the body’s need for blood and oxygen. It is the leading cause of hospitalization among older American adults, and according to the National Institutes of Health, approximately 5 million people in the U.S. have heart failure, contributing to 300,000 deaths each year.

Heart failure also presents in specific populations at rates significantly higher than others. For example, heart failure among young and middle-age blacks was found to be approximately 20 times more common than for whites in the United States, and it strikes this population overall at a younger age, according to a 20-year study published in the March 2009 New England Journal of Medicine. Following 5,115 black and white study participants age 18 to 30, over two decades, 26 of the 27 people who got heart failure were black. High blood pressure, obesity, kidney problems, and a diminished ability of the heart to contract (all seen earlier in blacks) were reported key indicators of the problem.

Certain predictors of heart failure can be influenced by modifiable lifestyle actions. A July 2009 Journal of American Medical Association article details findings of research examining the association between six modifiable lifestyle factors and the lifetime risk (risk of ever developing a disease during one’s remaining lifetime before dying from another cause) of heart failure in a large group of men. Participants in this research are members of the Physicians’ Health Study, which followed over 20,000 male physicians for more than 20 years.

Normal body weight, regular exercise, moderate alcohol intake, consumption of breakfast cereals, consumption of fruits and vegetables, and never smoking were individually and jointly associated with a lower lifetime risk of heart failure compared to the respective alternative behaviors. The highest heart failure risk (21%) was in men adhering to none of the six lifestyle factors, and the lowest risk (10.1%) in participants adhering to four or more of the factors. Further, lifetime risk of heart failure was higher in men with hypertension compared to men without hypertension. Given the similar education and socioeconomic status of this study group, these findings support the position that education alone without adherence to healthy behaviors is not enough to lower heart failure risk.

A: An area that needs more attention is mental health. There is a Ghanaian proverb that I recall that speaks to the unseen health of the family, such as hopelessness and depression – “The ruins of the nation rests in the homes of its people”. There are many families within the community that are experiencing mental health issues that impact the whole family. Support is vital in reducing the stigma and the fear of seeking care and treatment.

Q: What is the greatest opportunity for improvement that you see in the local fight against obesity?

A: More obesity prevention programs with incentives for group activities like weigh-ins, weight management, menu planning, jazz aerobics and healthy cooking classes for youth/children. Access to information on related specifics; like body image, metabolism, strength training, and stress management is also necessary. Seek funding for school health educators, and offer train-the-trainer certificates for teaching young children the importance of healthy eating and physical activity. Connect more programs that are supported by organizations like insurance companies, with civic groups and encourage working in partnership with local schools and faith-based organizations. We’re also always seeking additional support of the University of Minnesota North-Side Partnership efforts and adopt a neighborhood and survey awareness on the issue.
The second news is about a federal stimulus grant that we received in collaboration with University Of Minnesota Masonic Cancer Center. The purpose of this grant is to provide paid summer job opportunities in cancer research and education to undergraduates from minority and underserved communities in Minnesota. After a competitive review process from a pool of 54 applicants, 10 undergraduates from the state of Minnesota were selected for the 2009 eight week internship program. We expect to offer this internship program again next summer. Additional information about the interns, the mentors and their projects is available on our website under the Media link.

Enjoy the September 2009 Connection and we look forward to receiving any feedback or suggestions that you may have. Feel free to visit us on the Web or contact us at: healthdisparities@umn.edu.

Fairly Healthy
Reform We Can Believe In
by Eduardo Miguel Medina, Medical School, School of Public Health

The current struggle over reforming our health care system has demonstrated that it is no small order to challenge the special interests that own major media, have the resources to pressure and influence policy makers, and ultimately dictate public discourse.

This does not bode well for eliminating health disparities. Lost among the misrepresentations and unrighteous indignation is a real issue. Our health care system not only fails to offer real access to 47 million individuals, but also reinforces a legacy of economic, political, and cultural discrimination that has marred the history of this country.

Not only is this dysfunctional it is unjust.

It should be no surprise that the forces who have so vociferously opposed reform are the same individuals who have showed little interest in eliminating health disparities, and have no compunction using an individual’s wealth to determine their health and survival.

This is precisely why a fundamental principle to health care reform must be equal and open access.

Relying on the benevolence of the health care industry to provide us with the high-quality, equitable care we expect for our neighbors and ourselves is folly - for we have been ‘told’ the uninsured would be cared for in some manner far too long. Left to their own devices the powerful and entrenched status quo will continue to sacrifice the health of the many for the benefit of a very small number of extremely wealthy individuals.

The slogan ‘Health care for people-not profit’ is driving a group of doctors from Oregon as they make a cross-country plea for real health care reform. The group, Mad As Hell Doctors, will be in the Twin Cities in September and they are encouraging Americans to support a system that controls cost and cares for all people.

Health care reform that does not address access to care is no reform at all. We must reclaim control of our health care system away from those who profit from perpetuating health disparities.