

**Minnesota Department of Health**  
**Office of Minority and Multicultural Health**



**Eliminating Health Disparities**  
**Initiative**  
**Community Grants Program**

**Request for Proposals**

**November 5, 2001**

**Eliminating Health Disparities Initiative Community Grants Program  
Request for Proposals**

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**Glossary**

# Summary

**Eliminating Health Disparities Initiative Community Grants Program  
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**Summary**

Timeline	
Application period begins.....	November 5, 2001
Application workshops.....	November 7-20, 2001
Applications due.....	December 17, 2001
Notice to applicants .....	January 15, 2002
Work begins.....	March 1, 2002

**A. Purpose**

We are soliciting proposals to close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota as compared with whites in the following priority health areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations for adults and children, infant mortality, teen pregnancy prevention, and violence and unintentional injuries.

**B. Eligible Organizations**

Eligible applicants include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics.

**C. Available Funding**

**Priority Health Areas: Immunizations for Adults and Children  
and Infant Mortality**

	<b>Planning Grants</b>	<b>Implementation Grants</b>
Funds Available	\$280,000	\$2,100,000
Grant Size Range	\$25,000-\$75,000	\$135,000-\$450,000
Estimated # of Grants	4-14	5-15
Contract Period	3/1/02 - 3/31/03 (up to 13 months)	3/1/02-12/31/03 (22 months)

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**Priority Health Areas: Breast & Cervical Cancer; HIV/AIDS & Sexually Transmitted Infections; Cardiovascular Disease; Diabetes; and Unintentional Injuries & Violence**

	<b>Planning Grants</b>	<b>Implementation Grants</b>
Funds Available	\$440,000	\$3,250,000
Grant Size Range	\$25,000-\$75,000	\$135,000-\$450,000
Estimated # of Grants	6-22	7-24
Contract Period	3/1/02 - 3/31/03 (up to 13 months)	3/1/02-12/31/03 (22 months)

### Priority Health Area: Teen Pregnancy Prevention

	<b>Planning Grants</b>	<b>Implementation Grants</b>
Funds Available	\$200,000	\$3,300,000
Grant Size Range	\$25,000-\$75,000	\$135,000-\$450,000
Estimated # of Grants	3-10	7-24
Contract Period	3/1/02 - 3/31/03 (up to 13 months)	3/1/02-12/31/03 (22 months)

## D. Questions

Direct your questions regarding this Request for Proposals to:

<b>Topic Area</b>	<b>Contact Name</b>	<b>Phone</b>	<b>E-Mail</b>
Breast & cervical cancer	Nim Ha	612/676-5659	nim.ha@health.state.mn.us
Cardiovascular disease	Wanda Hilton	651/281-9847	wanda.hilton@health.state.mn.us
Diabetes	Martha Roberts	651/281-9842	martha.roberts@health.state.mn.us
HIV/AIDS & STIs	Julia Ashley	612/676-5665	julia.ashley@health.state.mn.us
Immunizations	Margo Roddy	612/676-5237	margo.rodny@health.state.mn.us
Infant mortality	Cheryl Fogarty	651/281-9947	cheryl.fogarty@health.state.mn.us
Teen pregnancy prevention	Jill Briggs	651/281-9781	jill.briggs@health.state.mn.us
Violence and unintentional injuries	Mark Kinde	651/281-9832	mark.kinde@health.state.mn.us
Copy of application forms on disk	Fran DesRosier	651/297-5813	fran.desrosier@health.state.mn.us
Financial/budget	Pati Maier	651/281-9882	pati.maier@health.state.mn.us
Other	Answer Line	651/215-0701	answer.line@health.state.mn.us

## E. Grant Workshops

We, along with the Local Public Health Association, will be holding workshops on how to prepare grant applications, what our expectations are for your application, and how your local public health agency may be able to help you develop your application. We encourage you to attend a workshop but you are not required to; you can submit an application if you do

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not attend a workshop. To find the dates and locations of the workshops, go to <http://www.health.state.mn.us/> Scroll to “Announcements” and then to “RFPs/Rule Proposals” and click on “Request for Proposals: Eliminating Health Disparities Initiative Community Grants Program” or call Fran DesRosier at 651/297-5813.

### **F. Application Due Date**

In order to be considered for funding, you must submit one unbound signed original and seven copies of your application and meet the application deadline of Monday, December 17, 2001. We will not accept FAXed or e-mailed applications. We will not accept or consider late applications. Send your application to:

#### Delivery Address

Attention: Fran DesRosier  
Minnesota Department of Health  
Office of Minority and Multicultural Health  
85 East Seventh Place  
Suite 400  
St. Paul, MN 55101

#### Mailing Address

Minnesota Department of Health  
Office of Minority and Multicultural Health  
P.O. Box 64882  
St. Paul, MN 55164-0882

# Background

**Eliminating Health Disparities Initiative Community Grants Program  
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**Background**

**A. What Is The Eliminating Health Disparities Initiative?**

The Eliminating Health Disparities Initiative (EHDI) was created by the 2001 Minnesota Legislature (M.S. 145.928) and has two main goals (see Appendix A, “Eliminating Health Disparities Initiative Legislation”):

by 2010, decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color in Minnesota, as compared with the rates for whites; and

close the gap in health disparities of American Indians and populations of color as compared with whites in the following priority health areas:

- breast and cervical cancer
- cardiovascular disease
- diabetes
- HIV/AIDS and sexually transmitted infections
- teen pregnancy prevention
- violence and unintentional injuries

The components of the EHDI are:

A partnership steering committee that will address health disparities in a comprehensive and coordinated way.

A set of measurable objectives to track Minnesota’s progress in reducing health disparities.

Improved statewide assessment of risk behaviors among African Americans/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota.

Technical assistance for grant applicants and recipients.

Community grants directed at reducing health disparities in:

- immunizations for adults and children, and infant mortality;
- breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and violence and unintentional injuries; and
- teen pregnancy.

Health screening and follow-up services for tuberculosis for foreign-born persons.

Grants to American Indian tribal governments for community interventions to reduce health disparities.

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Evaluation of the initiative.

A biennial report to the Legislature.

### **B. What Is Included In This Request For Proposals?**

This Request for Proposals makes available state general funds and federal TANF (Temporary Assistance to Needy Families) funds for community grants to reduce racial/ethnic health disparities for African Americans/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota as compared with whites in the following eight priority health areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations for adults and children, infant mortality, teen pregnancy prevention, and violence and unintentional injuries.

The goals of this initiative are consistent with those of *Healthy People 2010* (the national public health goals) and *Healthy Minnesotans – Public Health Improvement Goals for 2004* (Minnesota's public health goals). Each of these documents contains goals and objectives in the eight priority health areas as well as special emphasis on eliminating disparities in health status. (See the Application Content section for the website location of these documents.)

These grants provide an opportunity for you to mobilize and organize your community's resources in new and creative ways to:

- work toward eliminating the health disparities of racial and ethnic populations;
- promote the health and quality of life of individuals and communities;
- build on your community's strengths and assets to address health issues;
- develop effective working relationships among community members and the organizations and leaders who serve them;
- involve the people who will be reached in decision-making, planning, developing, and guiding activities; and
- focus on prevention and early detection.

### **C. What Funds Are Available, And What Are They For?**

We have funding available for planning and implementation grants for local or regional projects and initiatives. An organization can only submit one application, for either planning or implementation, but an organization can be included as a partner in more than one application.

This grant program is intended to:

- foster broad and active community participation;
- build on strengths in individuals, organizations, and communities;
- build and strengthen partnerships and working relationships among community members, faith-based organizations, culturally-based organizations, social service organizations, community non-profit organizations, tribal governments, community health boards,

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community clinics and other health care providers, and the Minnesota Department of Health; and identify and/or create new and innovative strategies that are more effective than past efforts have been to address racial/ethnic disparities.

### **1. Planning Grants**

Planning grants must be used to address such areas as:

- community assessment,
- coordination activities, and
- development of community supported strategies.

Additional funds not included in this Request for Proposals have been set aside for planning grantees to implement their plans during the second year of the grant cycle (approximately March through December, 2003). If you receive a planning grant, in the fall of 2002 you will be able to request funds to implement the activities that come out of your planning process. If we have more requests than we can fund, we will choose recipients based on successful completion of the planning process, readiness for implementation, and likelihood of success.

### **2. Implementation Grants**

Implementation grants are for applicants that are ready to provide services and activities that will reduce the gap in health status. We encourage you to propose activities or projects that:

- address underlying contributing factors and protective factors;
- address social and/or economic conditions that affect one or more of the eight priority health areas;
- help to coordinate and integrate services delivered;
- give community residents more of a voice in program planning and implementation;
- encourage timely and appropriate use of health care services;
- strengthen working relationships and partnerships in the community;
- are more likely than past efforts have been to be effective in addressing health disparities; and/or
- address multiple priority health areas.

See Appendices B, C, D, E, and F for some examples of strategies, concepts, and approaches you might want to consider.

If you are not sure whether to apply for a planning grant or an implementation grant, consider the following:

- If all or most of the following statements are true for you, or will be within four to six months after funding begins, you should apply for an implementation grant.

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You know what priority health area(s) you want to address.  
 You know whom you want to reach and what their strengths and assets are.  
 You know what activities you want to do and what other related activities are happening in your community.  
 Your partnerships and cooperative relationships are already in place.  
 You are ready to start delivering services or activities.

If you apply for an implementation grant, and we think you should have applied for a planning grant, we will contact you to see if you are interested in being considered for a planning grant instead.

### 3. Available Funds

Specific funding availability is as follows:

#### Priority Health Areas: Immunizations for Adults and Children and Infant Mortality

	Planning Grants	Implementation Grants
Funds Available	\$280,000	\$2,100,000
Grant Size Range	\$25,000-\$75,000	\$135,000-\$450,000
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#### Priority Health Areas: Breast & Cervical Cancer; HIV/AIDS & Sexually Transmitted Infections; Cardiovascular Disease; Diabetes; and Unintentional Injuries & Violence

	Planning Grants	Implementation Grants
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#### Priority Health Area: Teen Pregnancy Prevention

	Planning Grants	Implementation Grants
Funds Available	\$200,000	\$3,300,000
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Contract Period	3/1/02 - 3/31/03 (up to 13 months)	3/1/02-12/31/03 (22 months)

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If you are receiving implementation funds as of July 1, 2003, you will be eligible to extend your contract for the period January 1, 2004 through December 31, 2005, depending on successful progress and the continued availability of funds.

Funds from this grant program must be used to develop new programs or expand current programs that reduce health disparities. These funds cannot be used to take the place of funding you currently have for existing organization and community activities.

### **D. Who Can Apply?**

Eligible applicants include, but are not limited to, faith-based organizations, social service organizations, community non-profit organizations, community health boards, tribal governments, and community clinics throughout Minnesota.

Non-profit organizations must submit proof of tax-exempt status with the application.

### **E. What Are The Application Requirements?**

You must write your application in a 12-point font with one-inch margins. You must submit one signed unbound original and seven copies.

In order to be considered for funding, you must meet the application deadline below. We will not accept FAXed or e-mailed applications. We will not accept or consider late applications. Send your application to:

Delivery Address

Attention: Fran DesRosier  
Minnesota Department of Health  
Office of Minority and Multicultural Health  
85 East Seventh Place  
Suite 400  
St. Paul, MN 55101

Mailing Address

Minnesota Department of Health  
Office of Minority and Multicultural Health  
P.O. Box 64882  
St. Paul, MN 55164-0882

To meet the deadline, your application must:

be hand delivered to the address listed above and date-stamped upon delivery before 4:30 p.m. on Monday, December 17, 2001, or

have a legible postmark from the U.S. Post Office or a private carrier dated on or before December 17, 2001. We will not accept a postmark from a private, in-office metering machine as proof that you mailed your application on time.

If you send your application via the U.S. Postal Service, you are encouraged to send your application by registered mail and secure a receipt from the U.S. Postal Service.

**WARNING:** we will not be responsible for an application lost in transit by a carrier.

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### F. What Will Be Required Of You?

If you apply for one of these grants, you must agree to the requirements described below.

#### 1. During The Application Process

Involve members of the community that are affected by the priority health area in developing the grant activities to strengthen the overall commitment of the community and to appropriately design activities and reflect community expectations. See Appendix G for more information about community engagement.

Designate a lead organization for your project. The lead organization will:

- assure that your proposed activities occur,
- be responsible for reporting required evaluation data,
- report progress on activities, and
- communicate regularly with other partners.

The lead organization may not have the capacity or expertise to effectively implement the proposed strategies or program activities. If so, you must designate another partner organization to take the lead in program implementation.

The lead organization may not have the capacity or expertise to effectively provide fiscal oversight or be a legal entity that can sign a contract with us. If so, you must designate another partner organization to be the fiscal agent for the grant.

Set aside at least ten percent of your proposed grant funds to work in conjunction with the state-contracted evaluation consultant.

#### 2. After Receiving A Grant

Comply with the requirements of our standard grant agreement, a copy of which can be found in Appendix H.

Ensure that community representatives who are included in your process participate fully in decision-making and the development, implementation, and evaluation of your activities. For example, you may want to provide orientation, skill-building, and funding for translators/interpreters, transportation, child care, and stipends.

Participate in two annual MDH-sponsored statewide or regional workshops for technical assistance, planning, evaluation, and other essential programmatic issues.

Participate in the evaluation of the Eliminating Health Disparities Initiative Community Grants Program. Your evaluation responsibilities are likely to include:

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for all grants, providing information to us twice a year using a reporting system for all grantees that will be developed with grantee input; for implementation grants, with assistance from our evaluation consultant, developing a “logic model” that documents the connections between your activities and your intended outcomes; and for implementation grants, with assistance from our evaluation consultant, identifying at least one short-term result you intend to achieve during this contract; designing an evaluation plan to collect information, evidence, or data to assess that result; and taking follow-up actions based on that evidence.

Send us a financial report (invoice) every three months. If you need it, you will be able to request a funding advance equal to about three month’s worth of the grant; however, advances are not available for teen pregnancy prevention grants because of restrictions by the federal funding source.

Participate in conferences and workshops to inform and educate others regarding the experiences and lessons learned from your project, and work with appropriate partners to make the results of your project available to the public health community and policy makers.

Let us and others use any products produced by activities supported with these funds.

Establish relationships with other public and private groups to maintain funding for your program when our funds end.

### **G. What Will We Do For You?**

To help you succeed, we will be responsible for the following activities:

#### **1. During The Application Process**

In consultation with community partners, develop measurable outcomes to achieve the overall goal of the initiative.

Provide technical assistance and training to potential applicants on the preparation of successful grant applications, especially regarding responses to this Request for Proposals.

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### a. Questions

Direct your questions regarding this Request for Proposals to:

Topic Area	Contact Name	Phone	E-Mail
Breast & cervical cancer	Nim Ha	612/676-5659	nim.ha@health.state.mn.us
Cardiovascular disease	Wanda Hilton	651/281-9847	wanda.hilton@health.state.mn.us
Diabetes	Martha Roberts	651/281-9842	martha.roberts@health.state.mn.us
HIV/AIDS & STIs	Julia Ashley	612/676-5665	julia.ashley@health.state.mn.us
Immunizations	Margo Roddy	612/676-5237	margo.rodny@health.state.mn.us
Infant mortality	Cheryl Fogarty	651/281-9947	cheryl.fogarty@health.state.mn.us
Teen pregnancy prevention	Jill Briggs	651/281-9781	jill.briggs@health.state.mn.us
Violence and unintentional injuries	Mark Kinde	651/281-9832	mark.kinde@health.state.mn.us
Copy of application forms on disk	Fran DesRosier	651/297-5813	fran.desrosier@health.state.mn.us
Financial/budget	Pati Maier	651/281-9882	pati.maier@health.state.mn.us
Other	Answer Line	651/215-0701	answer.line@health.state.mn.us

Other members of our staff may have helpful information for you but will not be able to give official answers to your questions about this Request for Proposals. Staff at your local public health agency may also be able to help you; a list of Minnesota's Community Health Service Administrators can be found in Appendix I.

### b. Grant Workshops

We, along with the Local Public Health Association, will be holding workshops on how to prepare grant applications, what our expectations are for your application, and how your local public health agency may be able to help you develop your application. We encourage you to attend a workshop but you are not required to; you can submit an application if you do not attend a workshop. To find the dates and locations of the workshops, go to <http://www.health.state.mn.us/> Scroll to "Announcements" and then to "RFPs/Rule Proposals" and click on "Request for Proposals: Eliminating Health Disparities Initiative Community Grants Program" or call Fran DesRosier at 651/297-5813.

## 2. After Grants Are Awarded

Assist grant recipients in working with local health departments, community planning groups, foundations and other funding institutions, and other potential partners.

Provide technical assistance and training for grant recipients, including two annual statewide or regional meetings that will address such topics as best or promising practices, planning, evaluation, and other essential programmatic issues.

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Develop reporting requirements for all grantees in conjunction with grantees and the state-contracted evaluation consultant to measure the performance of the grant recipients and demonstrate improved health outcomes.

Participate in and/or sponsor conferences and workshops to inform and educate others regarding the experiences and lessons learned from the initiative, and collaborate with appropriate partners to share the results of the initiative with the public health community and policy makers.

### **3. On-Going**

Work in partnership with culturally-based community organizations, Minnesota's councils for American Indians and each of the populations of color, community health boards, and tribal governments to develop an overall coordinated and comprehensive plan to reduce health disparities in the eight priority health areas.

Provide data and information about the priority health areas and recommendations on promising program strategies and health promotion, prevention, and intervention measures.

Coordinate the activities of this initiative with other efforts at the local, state, and national levels to avoid duplication of effort and to promote consistency.

Attempt to establish relationships with foundations and other public and private groups to maintain financial support for grantees at the conclusion of state support.

### **H. What Should Be Included In Your Application?**

Your application must be complete and signed where noted. All of the required forms are located in Appendix J and on the MDH website. Go to <http://www.health.state.mn.us/> Scroll to "Announcements" and then to "RFPs/Rule Proposals" and click on "Request for Proposals: Eliminating Health Disparities Initiative Community Grants Program" or call Fran DesRosier at 651/297-5813 for an electronic copy on disk.

Use the checklist below to assure that you have completed all the parts of this application:

- MDH Grant Application Face Sheet
- MDH Project Information Sheet for EHDI Applications
- Project Description (Narrative)
- Partners Chart
- Budget form

### **I. How Will Your Application Be Reviewed?**

Applications will be reviewed by teams that include content experts in the priority health

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areas and volunteers who reflect the diversity of Minnesota's communities, including youth. To avoid obvious conflicts of interest, reviewers will review applications from geographic areas other than their own and will not review applications if they have a direct relationship with the applicants.

Each application will be evaluated individually against the criteria described below. We plan to balance the grants we award across geographic areas, populations of color, and priority health areas. Therefore, we may not award grants solely on the scores assigned by the review teams. Also, if you and someone else propose to do similar projects with the same target population in the same area, you may be asked to combine into one grant in order to be funded.

Reviewers will use the following criteria when scoring applications:

### **1. Criteria For Planning Grants**

#### **a. Who you are (30 points)**

A description of the applicant is provided.

The applicant has appropriate experience working with the intended racial/ethnic group(s).

The applicant has appropriate experience working with the intended priority health area(s), if a selection has been made.

Group and/or board members and people in key program positions are appropriate for working with the intended racial/ethnic group(s).

The applicant is well-suited for addressing the intended priority health area(s) with the intended racial/ethnic group(s).

#### **b. What and whom you will focus on (20 points)**

The priority health area(s) to be addressed is described, if known.

The racial/ethnic group(s) chosen is identified and described. A description of the population with appropriate demographic information is provided.

There is a health disparity between the racial/ethnic group(s) chosen and the white or general population; the extent of the disparity is described; and the extent of the disparity justifies the need for an intervention.

#### **c. What you will do (40 points)**

Requested information is provided and is adequate to understand the proposed planning activities.

The plan provides information as to how the priority health area(s) were or will be selected.

The plan describes the steps that will be taken to identify potential strategies.

The plan describes the steps that will be taken to assess the resources available in the community to address the priority health area(s).

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People who reflect the race and/or ethnicity of the community will be meaningfully involved in all aspects of the planning process.  
Appropriate cooperative relationships with other community organizations are in place.  
The planning process will utilize the identified strengths and assets in the people and in the community.  
The proposed planning process is likely to result in a plan that can be implemented.  
The proposed planning process can be completed within the available 13 months.

### **d. Budget (10 points)**

The budget form is complete and correct.  
The information in the budget description is consistent with the proposed activities.  
The costs projected for the planning process are reasonable.

## **2. Criteria For Implementation Grants**

### **a. Who you are (20 points)**

A description of the applicant is provided.  
The applicant has appropriate experience working with the intended racial/ethnic group(s).  
The applicant has appropriate experience working on the intended priority health area(s).  
Group and/or board members and people in key program positions are appropriate for working with the intended racial/ethnic group(s).  
The applicant is well-suited for addressing the intended priority health area(s) with the intended racial/ethnic group(s) and for implementing the proposed activities.

### **b. What and whom you will focus on (30 points)**

The priority health area(s) to be addressed is described.  
The reason for choosing the priority health area(s) is described and supporting information is provided. The people who will be affected support the choice.  
The racial/ethnic group(s) chosen is identified and described. A description of the population and appropriate demographic information are provided.  
There is a health disparity between the racial/ethnic group(s) chosen and the white or general population; the extent of the disparity is described; and the extent of the disparity justifies the need for an intervention.  
There is a logical connection between the chosen priority health area(s) and racial/ethnic group(s).  
Strengths and assets upon which to build a successful intervention are identified.

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c. What you will do (45 points)

Requested information is provided and is adequate to understand and assess the appropriateness of the proposed activities.

The proposed strategies are racially, ethnically, and culturally appropriate.

The proposed strategies are appropriate for the priority health area(s).

The timeline and resources needed are reasonable.

The steps that will be needed to implement the proposed strategies are appropriately identified.

People who reflect the race and/or ethnicity of the community have been and will be meaningfully involved in the proposed activities.

Community strengths and assets will be used appropriately.

Appropriate cooperative relationships with other community organizations are in place.

The proposed activities will be appropriately connected with related community activities.

Needed resources not likely to be provided by this grant and a reasonable plan to get them are identified.

The explanation of how the proposed activities will improve health status in the priority health area(s) is clear and convincing.

The effectiveness of the proposed strategies can be measured.

The proposal is likely to contribute to a reduction in health disparities.

Funding this proposal would be a good use of these grant funds.

d. Budget (5 points)

The budget form is complete and correct.

The information in the budget description is consistent with the proposed activities.

The costs projected for the proposed activities are reasonable.

You will be notified by January 15, 2002 by letter whether or not the Commissioner of Health has accepted your proposal; her decision is final. We reserve the right to negotiate changes to the budget you submit.

# **Application Content**

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Application Content

### A. Forms Required For All Applications

The following forms, which can be found in Appendix J and on the MDH website, must be completed and included in your application:

MDH Grant Application Face Sheet  
MDH Project Information Sheet For EHDI Applications  
Partners Chart  
Budget Form

To find the forms on the MDH website, go to <http://www.health.state.mn.us/> Scroll to “Announcements” and then to “RFPs/Rule Proposals” and click on “Request for Proposals: Eliminating Health Disparities Initiative Community Grants Program” or call Fran DesRosier at 651/297-5813 for an electronic copy on disk.

### B. Project Description For Planning Grant Applications

This section contains specific instructions on describing in narrative form the activities you propose to accomplish with a planning grant. See the Background section for guidance on whether you should apply for a planning grant or an implementation grant. You are encouraged to develop this application with your community partners.

#### 1. Who Are You?

In one or two pages, briefly describe who you are and identify what legal entity will serve as the fiscal agent.

To the extent possible and applicable, include the following kinds of information:

Identify your group or organization.

Describe your group’s experiences working with the intended racial and/or ethnic group(s).

If you have selected a priority health area, describe your group’s experience working in that area. (You do not have to know for certain which priority health area(s) you will be addressing to apply for a planning grant.)

If your work is or will be guided by a group of advisors and/or a board of directors, describe the make-up of that group, their charge, how the members are or will be chosen, and how they make or will make their decisions. Describe the racial/ethnic identity of the people who serve on the group and/or board.

If you are a formal organization, such as a private non-profit organization, community clinic, or faith-based organization, describe what you do, how you do it, how you are organized and funded, and how this proposal fits with your current work and resources.

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If you are an informal group or unincorporated organization, describe the makeup of your group or organization and your past and present work together. Identify what organization will take the lead in program implementation and what legal entity will serve as your fiscal agent.

Describe the racial/ethnic identity of the people in the key program positions who will be involved in your activities, including management, administration, and service provision. Describe their ability and experience to carry out your proposed activities.

### **2. What Do You Plan To Do With The Grant Money?**

In five pages or less, describe what you will do. Remember that planning grants must be used for such activities as community assessment, coordination activities, and development of community-supported strategies. Examples of activities that could be considered for planning grants include:

- assessing the gap between the community's assets and its needs;
- convening the community to choose priority health area(s) to address or strategies to implement;
- pulling services together to explore new ways of coordinating activities;
- developing new partnerships between community organizations and institutions and the people they serve;
- engaging people from the community in data collection, analysis, and program planning;
- finding and using community "wisdom" to adapt strategies;
- trying out new ways to engage community members in organizational decision-making processes; and
- developing networking and information sharing systems among community-based organizations and governmental entities.

#### **a. What and whom will you focus on?**

*Which priority health area(s) do you think you might address in the planning process?* (You do not have to know for certain which priority health area(s) you will be addressing to apply for a planning grant.) Explain why you have chosen that priority health area, or why you think you are likely to choose it. The eight priority health areas are:

- breast and cervical cancer,
- cardiovascular disease,
- diabetes,
- HIV/AIDS and sexually transmitted infections,
- immunizations for adults and children,
- infant mortality,
- teen pregnancy prevention, and
- violence and unintentional injuries.

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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*Whom are you trying to reach?* State the race or ethnicity of, and briefly describe, the people you propose working with to improve their health status. Include: where they live in Minnesota, what their lives are like, and any other information that will help reviewers understand who you will work with and how what you propose doing relates to the people. Identify the age group(s) you propose to work with. Include in this section data/numbers on the total people in the community, their ages and gender, and, if available, data/numbers about their health status in the priority health areas above. See Appendix B for state-wide information on disparities in each priority health area by racial/ethnic group. The racial/ethnic groups that can be served with these funds are listed below; you may choose more than one.

African Americans and African immigrants and refugees,  
American Indians,  
Asian Americans, including immigrants and refugees from Southeast Asia, and  
Hispanics/Latinos, including immigrants and refugees.

Describe the strengths and assets of the people and the community that you propose to work with.

### b. What will you do?

*How will you do the planning?* Describe the steps you will take in the planning process. If you don't already know which priority health area(s) you will be addressing, describe how you will make that decision. Describe how you will identify the strategy or strategies you would like to implement and how you will identify what resources are available to support those strategies. Describe how you will use the strengths and assets of the people and community in your planning process.

*How will the people you intend to reach be involved in the proposed planning process?* Describe their support for your proposal. Explain how you will ensure and enhance the community's involvement in your planning process. Describe the steps you will take to ensure that community representatives can participate fully in your planning process, such as orientation, skills-building, and funding for transportation, child care, translators/interpreters, and stipends. If you intend to improve the health status of youth, especially if you plan to address teen pregnancy prevention, describe how you will meaningfully include youth in your planning and decision-making. However, teen pregnancy prevention grant funds cannot be used to provide cash benefits to individuals being served, including reimbursement for out-of-pocket expenses such as child care or transportation, because of restrictions by the federal funding source.

We encourage you to consider the principles of community engagement:

Foster openness and participation in your planning process.  
Ensure that those who are representing a specific community in your planning process truly reflect that community's values, norms, and behaviors.

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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Use strategies that ensure inclusion, representation, and equality in your planning process. For example, ensure that those representatives who are included in the process participate in a meaningful way and share fully in the decision-making process. Offer orientation and skill building opportunities so that everyone will have an equal voice in voting and other decision-making activities. Develop cultural competence within your organization's staff. Communicate with the community about your planning process.

See Appendix G for more information about community engagement.

*Who are or will be the partners working to develop and implement your planning process?* State whether there is, or will be, a coalition, collaborative, or group of community members, and partners working together on this planning process. See Appendix F for ideas on the types of partners you may want to include. Briefly describe the partners you already have. Describe how they reflect the race or ethnicity of the people you intend to reach and how new partners or members will be recruited. Explain how you expect the coalition or group to operate. Include the partners you already have on the Partners Chart from Appendix J.

*What will your final product be?* Describe what your resulting plan to move toward implementation funding will look like. You can use the information requested below for implementation grant funds as an outline for your proposed final plan.

### **C. Project Description For Implementation Grant Applications**

This section contains specific instructions on describing in narrative form the activities you propose to accomplish with an implementation grant. See the Background section for guidance on whether you should apply for a planning grant or an implementation grant. You are encouraged to develop this application with your community partners.

#### **1. Who Are You?**

In one or two pages, briefly describe who you are and identify what legal entity will serve as the fiscal agent.

To the extent possible and applicable, include the following kinds of information:

Identify your group or organization.

Describe your experiences working with the intended priority health area(s).

Describe your experiences working with the intended racial and/or ethnic group(s). If your work is or will be guided by a group of advisors and/or a board of directors, describe the make-up of that group, their charge, how the members are or will be chosen, and how they make or will make their decisions. Describe the racial/ethnic identity of the people who serve on the group and/or board.

If you are a formal organization, such as a private non-profit organization, community clinic, or faith-based organization, describe what you do, how you do it, how you are

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organized and funded, and how this proposal fits with your current work and resources.

If you are an informal group or unincorporated organization, describe the makeup of your group or organization and your past and present work together. Identify what organization will take the lead in program implementation and what legal entity will serve as your fiscal agent.

Describe the racial/ethnic identity of the people in the key program positions who will be involved in your activities, including management, administration, and service provision. Describe their ability and experience to carry out your proposed activities.

### 2. What Do You Plan To Do With The Grant Money?

In 20 pages or less, describe what you will do. Remember that implementation grants must be used to fund activities that will close the gap in the health status of American Indians and populations of color as compared to whites in eight priority health areas.

#### a. What and whom will you focus on?

*What are you trying to change?* State which priority health area(s) you propose to address. We encourage you to address more than one priority health area. Explain why you have chosen those priority health area(s). The eight priority health areas are:

breast and cervical cancer,  
cardiovascular disease,  
diabetes,  
HIV/AIDS and sexually transmitted infections,  
immunizations for adults and children,  
infant mortality,  
teen pregnancy prevention, and  
violence and unintentional injuries.

Describe the problems, situations, and issues you want to address with this proposal. See Appendix B for information about causes and conditions that contribute to each of the priority health area(s).

*Whom are you trying to reach?* State the race or ethnicity of, and briefly describe, the people you propose working with to improve their health status. Include: where they live in Minnesota, what their lives are like, and any other information that will help reviewers understand who you will work with and how what you propose doing relates to the people. Identify the age group(s) you propose to work with. Include in this section data/numbers on the total people in the community, their ages and gender, and, if available, data/numbers about their health status in the priority health areas above. See Appendix B for state-wide information on disparities in each priority health area by racial/ethnic group. The racial/ethnic groups that can be served with these funds are listed below. You may choose more than one.

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African Americans and African immigrants and refugees,  
American Indians,  
Asian Americans, including immigrants and refugees from Southeast Asia, and  
Hispanics/Latinos, including immigrants and refugees.

Describe the strengths and assets of the people and the community that you propose to work with.

### b. What will you do?

*What are your proposed activities?* Describe the strategies you are proposing to implement. If they are based on strategies proven with other groups, explain what will need to be done so they fit the people and community you work with. Consider strategies that:

- affect more than one priority health area, particularly those that have similar contributing factors (see Appendix D).
- address the social and economic environment that affects the eight priority health areas, including: income; education; distribution of resources; social norms; social support and community relationships; safe housing; access to transportation, health care, and nutritious foods; employment; working conditions; and culture, religion, and ethnicity.
- prevent disease or disability before it happens, promote positive attitudes, skills, and behaviors, or increase the presence of protective factors.
- detect or reduce risk factors, screen people at risk, or intervene early in a disease or disability.
- limit further negative effects by treating disease or disability, or minimize health problems.
- are more likely than past efforts have been in addressing health problems in American Indians and populations of color.

Examples of such strategies are included in Appendices B, C, D, E, and F.

Describe how you will use the strengths and assets of the people and community in your proposed activities.

Describe the “products” you will develop or produce. These could include: policies or practices changed; events, workshops, or gatherings held; materials purchased or developed; curricula developed or implemented; and people screened at clinics.

Provide a timeline for your proposed activities. Explain who will do them; describe the types and numbers of staff and partners needed. Include the roles of people already involved as well as the roles of new people who will be hired or become involved.

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*How will the people you intend to reach be involved in developing and guiding your proposed activities?* Describe their support for your proposal. If they have been involved in developing your proposal, explain who was involved and how they were involved. If they are not currently involved, describe how you will identify, recruit, and include them. Explain how community representatives will be involved in implementing your proposed activities. Describe the steps you will take to ensure that community representatives can participate fully in your proposed activities, including orientation, skills-building, and funding for transportation, child care, translators/interpreters, and stipends. However, teen pregnancy prevention grant funds cannot be used to provide cash benefits to individuals being served, including reimbursement for out-of-pocket expenses such as child care or transportation, because of restrictions by the federal funding source.

If you intend to serve youth in your proposed activities, especially if you plan to address teen pregnancy prevention, describe how you will meaningfully include youth in your planning and decision-making.

We encourage you to consider the principles of community engagement:

- Foster openness and participation in your proposed activities.
- Ensure that those who are representing a specific community in your proposed activities truly reflect that community's values, norms, and behaviors.
- Use strategies that ensure inclusion, representation, and equality in your proposed activities. For example, ensure that those representatives who are included participate in a meaningful way and share fully in the decision-making process.
- Offer orientation and skill building opportunities so that everyone will have an equal voice in voting and other decision-making activities.
- Develop cultural competence within your organization's staff.
- Communicate with the community about your proposed activities.

See Appendix G for more information about community engagement.

*Who are the partners working to develop and implement your proposed activities?* State whether there is, or will be, a coalition, collaborative, or group of community members and partners working together on your proposed activities. See Appendix F for ideas on the types of partners you may want to include. Briefly describe the partners you already have. Describe how they reflect the race and/or ethnicity of the people you intend to reach and how new partners or members will be recruited. Explain how the coalition or group does or will operate. Describe the commitment of the partners to this project and/or how you will go about seeking their commitment. Include the partners you already have on the Partners Chart from Appendix J.

*How do your proposed activities relate to current activities?* Describe any activities in the community that your proposed activities will build on, move ahead, relate to, coordinate with, or complement. If you are proposing to address

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teen pregnancy prevention, describe the connection between your proposed activities and the teen pregnancy prevention activities of your local Community Health Board; a list of Community Health Administrators is included as Appendix I.

*What other organizational resources will you need?* Describe the resources such as funds, staff, facilities, and equipment that you will need to implement your proposed activities that you are not applying for in this proposal. Indicate whether they are currently in place in your organization or through your partners, and if not, explain your plans to get them.

*What makes you believe that your proposed activities will improve the health status of the people you will be serving?* Indicate whether your proposed activities will build on or expand something you know is already working, develop activities or services that people have said they need or want, or use cultural traditions and practices to adapt strategies known to work in other communities. Explain the thinking behind your proposal, and describe the connection you see between the activities you are proposing and the health disparity(ies) you are trying to reduce. Explain why you think your proposed activities will be more effective than past efforts have been.

*What would progress look like if your proposed activities are effective?* Describe the changes you expect to see in the short-term and those you expect to see in the long-term. If you can, use numbers or measurements to indicate how much you think your proposed activities will change the problems, situations, issues, strengths, and assets you are hoping to address. See Appendix B for outcomes to consider for each priority health area.

In addition to the resources provided in Appendix B, you may find the following additional resources and information useful in developing your proposal:

Populations of Color in Minnesota Health Status Report, Spring 1997. Call the Office of Minority and Multicultural Health, MDH at 651/297-5813 for a copy.

Minnesota Census Data (<http://factfinder.census.gov>) or Minnesota Center for Health Statistics 651/297-1232

Minnesota Health Profiles (<http://www.mnplan.state.mn.us/datanetweb/health.html>)

Federal Office of Minority Health (<http://www.omhrc.gov/omhhome.htm>)

Healthy People 2010 (<http://web.health.gov/healthpeople>)

Healthy Minnesotans – Public Health Improvement Goals for 2004 (<http://www.health.state.mn.us/divs/chs/phg/intro.html>) or 651/296-9661

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Strategies for Public Health (<http://www.health.state.mn.us/divs/chs/phs/phs.html>)

Youth Risk Behavior Resource Directory  
(<http://www.health.state.mn.us/divs/fh/chp/yrbdirectory.htm>)

Community Engagement Website: (<http://www.health.state.mn.us/communityeng/>)

A Call to Action: Advancing Health for All Through Social and Economic Change:  
(<http://www.health.state.mn.us/divs/chs/hsd/schools.htm>)

### **D. Budget Materials Required For All Applications**

This grant money must be used to develop new programs or activities or expand current programs or activities that reduce health disparities. This money cannot be used to take the place of funding you currently have for existing organization and community activities.

#### **1. Budget Form**

Use the budget form from Appendix J to show your proposed budget. Include only the total amount for each line item; you do not need to include any detail on the budget form. If you are applying for a planning grant, your budget should cover up to 13 months. If you are applying for an implementation grant, your budget should cover 22 months.

#### **2. Budget Description**

Also include a narrative description explaining the details of your budget that is three pages or less. Below are specific instructions on what to include in your budget description for each line item, as well as information about what you can and cannot spend this grant money on. Remember that the total of your evaluation expenses must be at least ten percent of your total proposed budget.

##### **a. Salary and fringe benefits**

In your budget description, indicate for each position the name (if known) and title, the full time equivalent (see below for a definition), the expected rate of pay, and the total amount you expect to pay the position for the entire grant period. Grant funds can be used for salary and fringe benefits for staff members directly involved in your proposed activities. Costs for other staff, such as supervisors or bookkeepers, should be reported on the Administrative Costs line item. Indicate how much of the money you plan to spend on salary and fringe benefits will be used for evaluation-related activities.

“Full time equivalent” (or FTE) is defined as the percentage of time a person will work. To calculate the FTE, divide the hours the person will work by the standard number of work hours, which is 40 hours per week, 174 hours per month, or 2,088

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hours per year. For example, a person who works 20 hours per week is a 0.5 FTE ( $20 / 40 = 0.5$ ).

### b. Contractual services

In your budget description, list the services you expect to contract out, the likely contractor's name if you know it, whether the contractor is non-profit or for-profit if you know, and the total amount you expect to pay the contractor for the entire grant period. Grant funds can be used for small contracts such as facilitators, speakers, or trainers, and for large contracts if other organizations are planning to provide different parts of your proposed activities. Indicate how much of the money you plan to spend on contractual services will be used for evaluation-related activities.

### c. Travel

In your budget description, explain your expected travel costs, including mileage, hotel, and meals. At a minimum, you must include the cost for at least one staff member to attend two MDH-sponsored statewide or regional meetings each year. Grant funds cannot be used for out-of-state travel without prior written approval from us. Indicate how much of the money you plan to spend on travel will be used for evaluation-related activities.

Travel paid for from these grant funds cannot be paid at a rate higher than:

Mileage	The current IRS rate, which now is 34.5 cents per mile
Parking fees	actual cost
Breakfast	\$7.00
Lunch	\$9.00
Dinner	\$15.00
Hotel	actual cost within reason

### d. Supplies and expenses

In your budget description, briefly explain your expected costs for such items as telephone equipment and service, postage, printing, photocopying, office supplies, materials, food at gatherings, and equipment. Include the costs you expect to have to ensure that community representatives who are included in your process can participate fully in the decision-making process. Examples include translators/interpreters, transportation, child care, and stipends. Grant funds may be used to purchase computers. We expect to rely on electronic means to communicate with our grantees, so if you do not already have internet access, include that cost. Grant funds may not be used to purchase any individual piece of equipment that costs more than \$5,000 and teen pregnancy prevention grant funds cannot be used to provide reimbursement such as child care or transportation. Indicate how much of the money you plan to spend on supplies and expenses will be used for evaluation-related activities.

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e. Other costs

In your budget description, explain very clearly any expenses you expect to have that do not fit on any other line item. Grant funds cannot be used for direct patient medical services/care, treatment of disease or disability, capital improvements or alterations, cash assistance paid directly to individuals to meet their personal/family needs outside your proposed activities, conference sponsorships, or any cost not directly related to the grant. Indicate how much of the money you plan to spend on other costs will be used for evaluation-related activities.

f. Administrative costs

“Administrative costs” are defined as costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity, but are necessary for the general operation of the organization and the conduct of activities it performs. Examples of such expenses include accounting, human resources, general agency administration, and costs to operate and maintain facilities. Administrative costs can be calculated as an indirect cost rate or through a cost allocation plan.

In your budget description, explain what kinds of administrative costs you expect to have. If you are awarded a grant, we will work with you to record how your administrative costs are calculated and how you charge them to this grant. Your administrative costs cannot be more than 15 percent of your total proposed budget.

# Appendices

## **Appendix A**

# **Eliminating Health Disparities Initiative Legislation**

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**Eliminating Health Disparities Initiative Legislation  
*Laws of Minnesota 2001 1<sup>st</sup> Special Session, Chapter 9, Article 1***

**Sec. 48. [145.928] [ELIMINATING HEALTH DISPARITIES.]**

**Subdivision 1. [GOAL; ESTABLISHMENT.]** It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

**Subd. 2. [STATE-COMMUNITY PARTNERSHIPS; PLAN.]** The commissioner, in partnership with culturally-based community organizations; the Indian affairs council under section 3.922; the council on affairs of Chicano/Latino people under section 3.9223; the council on Black Minnesotans under section 3.9225; the council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

**Subd. 3. [MEASURABLE OUTCOMES.]** The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

**Subd. 4. [STATEWIDE ASSESSMENT.]** The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

**Subd. 5. [TECHNICAL ASSISTANCE.]** The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

**Subd. 6. [PROCESS.]** (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

**Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.]** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

- (1) decreasing racial and ethnic disparities in infant mortality rates; or
- (2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

- (1) is supported by the community the applicant will serve;
- (2) is research-based or based on promising strategies;
- (3) is designed to complement other related community activities;
- (4) utilizes strategies that positively impact both priority areas;
- (5) reflects racially and ethnically appropriate approaches; and
- (6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

**Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.]** (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

- (1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;
- (2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;
- (3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;
- (4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or
- (5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

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(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

- (1) is supported by the community the applicant will serve;
- (2) is research-based or based on promising strategies;
- (3) is designed to complement other related community activities;
- (4) utilizes strategies that positively impact more than one priority area;
- (5) reflects racially and ethnically appropriate approaches; and
- (6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

**Subd. 9. [HEALTH OF FOREIGN-BORN PERSONS.]** (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

- (1) \$1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;
- (2) \$500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;
- (3) \$500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and
- (4) \$50 per foreign-born person in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

**Subd. 10. [TRIBAL GOVERNMENTS.]** The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

**Subd. 11. [COORDINATION.]** The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

**Subd. 12. [EVALUATION.]** Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the

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commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

**Subd. 13. [REPORT.]** The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

**Subd. 14. [SUPPLANTATION OF EXISTING FUNDS.]** Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

***Laws of Minnesota 2001 1<sup>st</sup> Special Session, Chapter 9, Article 17, Subd. 2***

**[HEALTH DISPARITIES.]** Of the general fund appropriation, \$4,950,000 each year is for reducing health disparities. Of the amounts available:

(1) \$1,400,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 7, to eligible applicants to reduce health disparities in infant mortality rates and adult and child immunization rates.

(2) \$2,200,000 each year is for competitive grants under Minnesota Statutes, section 145.928, subdivision 8, to eligible applicants to reduce health disparities in breast and cervical cancer screening rates, HIV/AIDS and sexually transmitted infection rates, cardiovascular disease rates, diabetes rates, and rates of accidental injuries and violence.

(3) \$500,000 each year is for grants to tribal governments under Minnesota Statutes, section 145.928, subdivision 10, to implement cultural interventions to reduce health disparities.

(4) \$500,000 each year is for state administrative costs associated with implementation of Minnesota Statutes, section 145.928, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, and 13.

(5) \$100,000 each year is for state operations associated with implementation of Minnesota Statutes, section 145.928, subdivision 9.

(6) \$250,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 9, to community health boards to improve access to health screening and follow-up services for foreign-born populations.

**[INFANT MORTALITY REDUCTION.]** Of the TANF appropriation, \$2,000,000 each year is for grants under Minnesota Statutes, section 145.928, subdivision 7, to reduce infant mortality.

**[REDUCING INFANT MORTALITY CARRYFORWARD.]** Any unexpended balance of the TANF funds appropriated for reducing infant mortality in the first year of the biennium does not cancel but is available for the second year.

## **Appendix B**

### **Priority Health Areas**

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

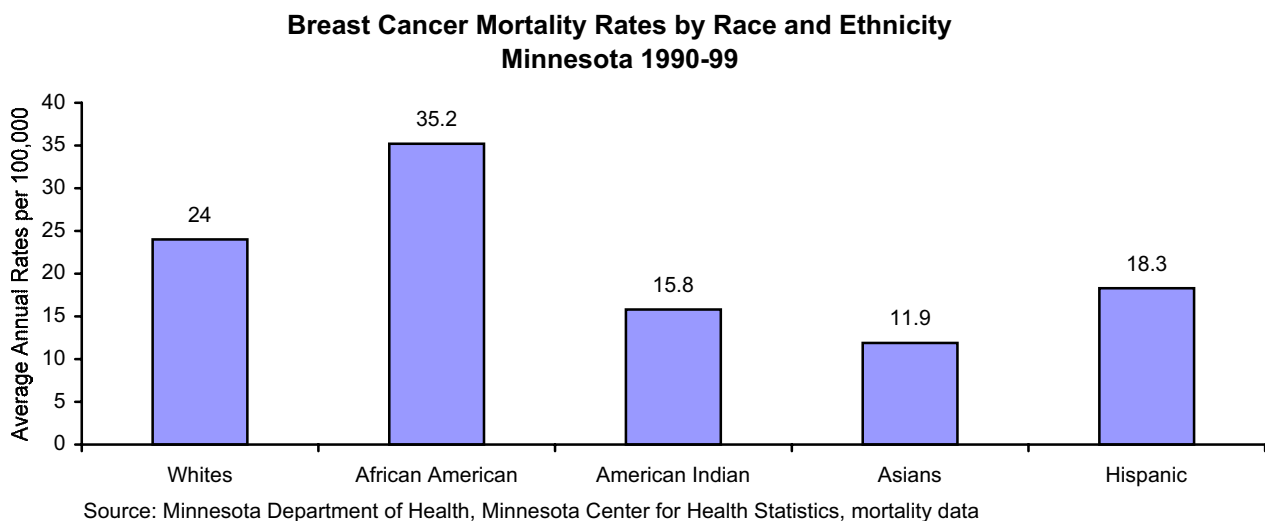
## Eliminating Health Disparities In Breast And Cervical Cancer

### Background

**Breast cancer.** Breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer deaths. Each year approximately 3,200 women in the state are diagnosed with breast cancer and 700 die from it. Survival from breast cancer is directly related to the stage of the disease at the time of diagnosis. Approximately 97 percent of women who have their breast cancer detected in its earliest stages survive. The proportion of survivors drops to 21 percent for women whose breast cancer is diagnosed at a late stage.

The key to reducing deaths from breast cancer is routine screening with mammography and clinical breast examination so that the disease can be detected and treated in its earliest stages. Mammography is an especially effective early detection tool because it can identify a breast abnormality long before it can be felt by a woman or health care provider. Scientific trials have shown that widespread screening for breast cancer reduces mortality by 30 percent, which would translate into 210 fewer deaths per year in Minnesota.

Among the racial/ethnic groups in Minnesota, African American women have a breast cancer mortality rate that is 50 percent higher than that of white non-Hispanic/Latina women, despite similar incidence rates. A greater proportion of African American women have their breast cancers diagnosed at a later, less treatable stage. The other racial and ethnic minority groups have breast cancer mortality rates that are similar or significantly lower than that of white non-Hispanics.

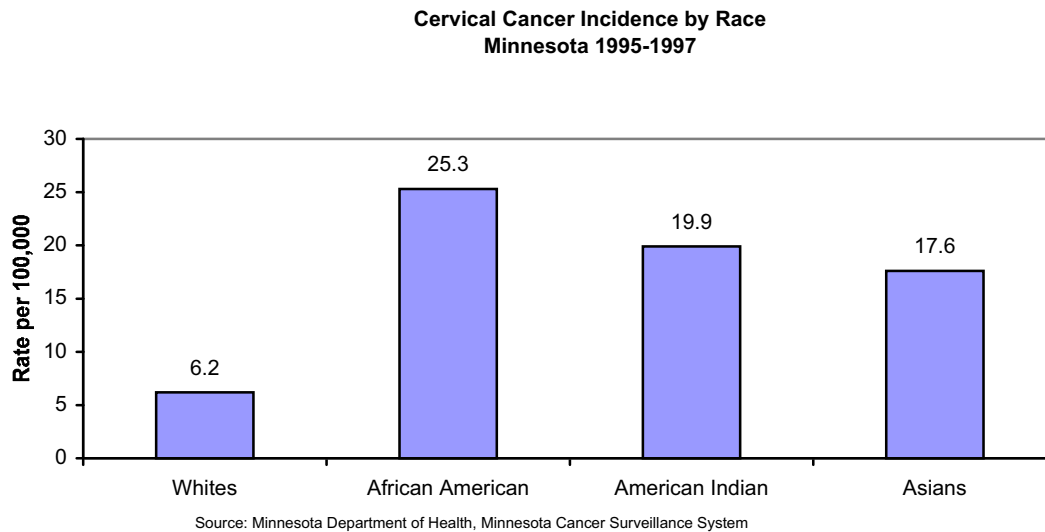


## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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**Cervical cancer.** Approximately 200 women develop invasive cervical cancer and 50 die from it every year in Minnesota. Thousands more develop pre-cancerous changes of the cervix that can progress to cancer if left untreated. Detected early, these pre-cancerous changes generally require less extensive treatment. Virtually all cervical cancer occurrence and death are preventable through regular screening with Pap smears and prompt treatment of pre-cancerous cervical changes.

Major health disparities exist among the state's racial and ethnic minority populations for cervical cancer. African American, American Indian, and Asian American women have cervical cancer incidence rates that are three to four times as high as the rate for white women. Deaths due to cervical cancer also occur at significantly higher rates among Asian Americans and African Americans compared with white non-Hispanics.



### Contributing Factors

**Breast cancer.** All women are at risk for developing breast cancer. Most women have no identifiable risk factor other than age; the risk for developing the disease increases as women get older. The vast majority of women diagnosed with breast cancer have no family history of the disease.

In order to reduce deaths from breast cancer, all women age 40 and older should get regular mammograms and clinical breast examinations. Women with abnormal screening test results require prompt referral for diagnostic tests and treatment, if needed. Statewide survey data (2000 BRFSS) indicate that less than two thirds (61 percent) of women age 40 and over have had a mammogram in the past year. Minnesota's public health goal for 2004 targets a 90 percent screening rate for all women age 40 and over. Women cite economic, social, and cultural barriers to screening, referral, and treatment, such as cost, lack of or inadequate health insurance, poor access to health care, lack of physician recommendation, language, cultural beliefs and practices, fear, and knowledge gaps as reasons for not getting screened. Only 27 percent of

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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Minnesota women reported knowing that yearly mammograms were recommended for women starting at age 40. Lack of time and inconvenience have also been reported as barriers.

**Cervical cancer.** Invasive cervical cancer occurrence and death are entirely preventable. All women who are age 18 and older or sexually active should undergo regular screening with Pap tests and prompt treatment of significant pre-cancerous lesions. Statewide survey data indicate that 83 percent of women age 18 and over have had a Pap test within the past three years. Deaths from cervical cancer increase with age, yet screening rates drop among older women: 90 percent for women age 18-39 versus 64 percent for women age 65 and over. Minnesota's public health goal for 2004 targets a 99 percent screening rate for all women age 18 and over.

Barriers to screening for and treatment of cervical lesions include lack of health insurance, cultural beliefs and practices, and lack of knowledge about the need for on-going screening after childbearing years. African American women with significant cervical abnormalities may be less likely to get follow-up treatment.

### **Strategies For Intervention**

The following strategies may be included in proposals to eliminate health disparities in breast and cervical cancer, but other strategies not listed here may also be included. Many of the strategies have been used successfully by the Minnesota Department of Health to recruit lower income, uninsured, and underinsured women to the Minnesota Breast and Cervical Cancer Control Program (MBCCCP). This program provides free breast and cervical cancer screening services at over 300 clinics statewide to women who meet certain age, income, and insurance eligibility guidelines.

Hold "special screening days" that offer clinical breast exam, mammography, and Pap smear at convenient locations in the community (particularly lower income and rural communities), and use local outreach workers to promote the event and assist with patient navigation and follow-up. This strategy has been effective at recruiting different racial and ethnic minority groups, especially African American and Hispanic/Latina women, to MBCCCP.

Develop and disseminate culturally specific materials (brochures, pamphlets, videos, posters, flip charts) that have been peer-reviewed and tested with target audiences for cultural sensitivity, reading/comprehension level, and content accuracy. Use these materials in conjunction with other outreach strategies to educate and recruit women for screening.

Hire and train a local lay recruiter or outreach worker to conduct "one-on-one" recruitment for screening to a community hospital or clinic, or to MBCCCP. Lay recruiters who know their community can effectively identify and approach local businesses and organizations to directly recruit women for screening.

Implement an "inreach" system at a local health care setting (clinic, hospital, or private practice). Use nurses, lay health advisors, or senior aides to identify unscreened women in hospital specialty clinics and recruit them for screening. Conduct patient chart audits and develop a tickler system to identify women due for screening and prompt physicians to refer

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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patients for screening. This strategy has been scientifically tested and shown to increase breast and cervical cancer screening at a local clinic, particularly among American Indian women.

Implement a peer-based program in a community setting to increase mammography use. This strategy uses social networks (e.g. churches, public housing, community groups) to influence women's screening behavior in groups by providing them with an opportunity learn about the benefits of screening, share experiences and opinions about screening with peers, and commit to screening by making an appointment. This strategy has been scientifically tested and shown to increase breast cancer screening among low-income women in public housing.

Develop a comprehensive appointment scheduling system that is convenient for women to use and assures that women complete their screening. Establish a toll-free phone line that women can call to locate free or low-cost screening services, obtain barriers counseling, and receive on-the-spot assistance with making an appointment, and that follows up with women to assure that they completed their appointments. This type of phone and follow-up system has been shown to greatly increase screening rates and reduce appointment no-shows for the MBCCCP.

Conduct local media campaigns using radio, television, or print combined with a toll-free number that women can call to learn about and access screening services. Offer to help women schedule appointments when they call.

Improve access to free and low-cost screening services by targeting lower-income minority populations for the MBCCCP using any of the strategies described above.

Provide case management services for at-risk women. Case management is a collaborative process that involves individually focused assessment, planning, and coordination of services to meet an individual's health needs. It relies on good communication, knowledge of available community resources, and an ability to monitor the quality and outcomes of care for the individual.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in breast and cervical cancer in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

More women are routinely screened for breast and cervical cancer according to guidelines.

More women are knowledgeable about breast and cervical cancer screening guidelines.

More women complete their screening appointments.

More African American, Asian American, American Indian, and Hispanic/Latina women are screened through the MBCCCP.

More culturally specific cancer screening education materials are developed and disseminated.

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Fewer women are lost to follow-up, more women complete treatment, and time intervals from screening abnormality to diagnosis and then from diagnosis to treatment are reduced.

### **Resources**

Minnesota Breast and Cervical Cancer Control Program (MBCCCP) website ([www.health.state.mn.us/divs/dpc/cc/mbcccp.htm](http://www.health.state.mn.us/divs/dpc/cc/mbcccp.htm)) or via the MDH website ([www.health.state.mn.us](http://www.health.state.mn.us))

National Asian Women's Health Organization (NAWHO) ([www.nawho.org](http://www.nawho.org)) or 415/989-9747.

Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program ([www.cdc.gov/cancer/nbccedp/index.htm](http://www.cdc.gov/cancer/nbccedp/index.htm))

American Cancer Society at ([www.cancer.org](http://www.cancer.org)) or 800/ACS-2345.

Slater, J. et al. A Randomized Community Trial to Increase Mammography Utilization among Low-Income Women Living in Public Housing. *Prev Med.* 1998;27:862-870.

Margolis, K. et al. Increasing Breast and Cervical Cancer Screening in Low-Income Women. *J Gen Intern Med.* 1998;13:515-521.

Benard, V. et al. Race-Specific Results of Papanicolaou Testing and the Rate of Cervical Neoplasia in the National Breast and Cervical Cancer Early Detection Program, 1991-1998 (United States). *Cancer Causes and Control.* 2001;12:61-68.

SHAPE 1998: Overall Comparison Report, Survey of the Health of Adults, the Population, and the Environment. Minneapolis, MN, December 1998. Hennepin County Community Health Department and Minneapolis Department of Health and Family Support. Call Hennepin County Community Health Department at (612) 348-3925 for a copy or visit the HCCHD website ([www.co.hennepin.mn.us/commhlth/reports/shape.htm](http://www.co.hennepin.mn.us/commhlth/reports/shape.htm))

Cancer in Minnesota: Racial and Ethnic Disparities. Minnesota Department of Health, Division of Chronic Disease Prevention and Control, October 2001.

### **MDH Contact**

For more information about breast and cervical cancer, contact:

Nim Ha  
612/676-5659  
[nim.ha@health.state.mn.us](mailto:nim.ha@health.state.mn.us)

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Eliminating Health Disparities In Cardiovascular Disease

### Background

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease, stroke, high blood pressure, high blood cholesterol, and rheumatic heart disease. Heart disease is the first and stroke is the third leading cause of death in Minnesota. Mortality rates for Minnesotans overall are lower than the nation as a whole; however, for certain segments of the population, including American Indians, African American females, and Asians, mortality rates for heart disease or stroke are higher than the overall state population rates. American Indian death rates from 1990 through 1998 were 33 percent higher than the state's population rates and 44 percent higher than the total U.S. American Indian rates. Age-adjusted death rates also indicate considerable disparities in heart disease for African American females living in Minnesota. Asians living in Minnesota are more likely than other population groups to suffer from stroke.

### Contributing Factors

Arteriosclerosis (hardening of the arteries), the underlying disease process of the major forms of CVD, begins in childhood and slowly progresses throughout a person's lifespan. Arteriosclerosis is associated with several modifiable risk factors, including high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, obesity, and poor diet. Control of modifiable risk factors at the population and individual level is key to preventing CVD and its complications.

CVD incidence and mortality rates are higher among people of lower socioeconomic (SES) status. The greatest declines in CVD mortality over time have been among those at the highest income and educational levels. These differences have been attributed to the greater prevalence of risk factors (e.g., obesity, lack of exercise, high blood pressure, smoking) within lower SES populations and to the effects of neighborhood socioeconomic status.

### Strategies For Intervention

There are many different strategies aimed at reducing risk factors for cardiovascular disease and thus improving the health of communities and individuals. Below are several strategies that can be used to lower people's risk of cardiovascular disease. Any of these strategies or other effective strategies can be used in proposals to eliminate health disparities in cardiovascular disease.

Creating supportive environments that encourage physical activity and healthy food choices in communities

Neighborhoods and communities can work with community leaders to identify barriers and supporters of healthy diet and physical activity. Some ideas of how partnerships can work toward developing a heart healthy community are: passing policies that require new commercial buildings and site plans to address options for physical activity; enacting policies and zoning

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laws that use highway funds for increasing bicycle trails and sidewalks; promoting access to affordable fresh fruits and vegetables by increasing farmers' markets, co-ops, green grocers, community gardens, and produce vendors; improving safety of public recreational spaces such as parks, neighborhood streets, sidewalks, and/or community centers; increasing time available for safe public use of recreations facilities, such as ice rinks, ball fields, schools, and parks; providing transportation alternatives to and from work and shopping areas; and providing "point-of-purchase" information and labeling in grocery stores promoting USDA/DHHS dietary guidelines. Some examples are:

ON THE MOVE! is a program developed by the California Department of Health that includes nine community-based projects to promote moderate physical activity among ethnically diverse adults. One intervention strategy, Walk for Health, is designed to meet the needs of an Asian/Pacific Islander community in Oakland, CA. Walk for Health provides walking clubs for young women, community walkathons for families, and a worksite exercise program. Another ON THE MOVE! Project involves the United Indian Health Services' Cultural Health and Mobilization Project (CHAMP), a group of seven tribal coalitions promoting traditional sports and physical activities that focus on diabetes prevention. The project sponsored a tournament of the traditional "stick game" (similar to lacrosse) that gave area youth the chance to learn from elders about the old ways of training physically and spiritually for the game. For more information about ON THE MOVE! or any of its local programs, visit the website at ([www.dhs.ca.gov/otm/](http://www.dhs.ca.gov/otm/)).

Incorporating bikeways, sidewalks, and recreational facilities into community plans can provide supportive environments that increase physical activity levels. In addition, bicycle use can help relieve pollution and congestion. In 1999, the Berkeley, CA City Council adopted the Berkeley Bicycle Plan. The goal of the Berkeley Bicycle Plan is "to create a model bicycle-friendly city where bicycling is an attractive, easy, safe, and convenient form of transportation and recreation for people of all ages and bicycling abilities." The plan calls for the implementation of a broad network of bike boulevards, extensive bicycle education, safety promotion, and increasing the enforcement of traffic laws for autos and bikes. For more information about the Berkeley Bicycle Plan, visit ([www.bfbc.org](http://www.bfbc.org)) or call 510/549-7433. Similar projects can be done in local communities in Minnesota. In 1992, Minnesota drafted its own bicycle plan, PLAN B, the Comprehensive State Bicycle Plan: Realizing the Bicycle Dividend, to support and guide the development of bicycling in Minnesota. For more information on Plan B contact: Minnesota Department of Transportation, 807 Transportation Building, 395 John Ireland Blvd., St. Paul, MN 55155.

### **Creating supportive environments and conducting educational programs that encourage physical activity and healthy food choices in schools**

Schools provide an important opportunity to learn, practice, and enjoy physical activity and healthy eating behaviors. In recent years, schools have reduced time for physical education. Communities can work with the schools to implement policies that increase time for physical activity, including time for unstructured physical activity. Schools provide a setting where food and beverage choices are available not only for school meals, but also for social events and other snacks during and after school. Schools need to consider the impact of these choices and

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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identify ways they can maximize them as learning opportunities. Schools should develop and implement a nutrition policy that supports the development of healthy nutritional practices including healthier snacks and juices in vending machines.

Research demonstrating the effectiveness of school-based programs in influencing children's eating patterns has taken place at the elementary school level, including the Child and Adolescent Trial for Cardiovascular Health (CATCH), the Minnesota Heart Health Program, and the Power Plus Program. The most successful programs are behaviorally focused, devote adequate time and intensity, incorporate self-evaluation or self-assessment and feedback, and intervene in the school environment to support behavioral change. Some examples are:

Food on the Run is an example of a school-based program for high school age youth. It trains teens in physical activity, nutrition, policy and the media using the "Jump Start Teens" and "Playing the Policy Game" resource kits developed by the California Project Lean. Through this program, teens serve as advocates for increased physical activity opportunities and healthy eating in the community. In addition, high school students participate in advancing policy and environmental changes that promote healthy eating and physical activity at school and in the community. At the same time, students are motivated to make healthier choices themselves. For a detailed list of materials, background reports and order information visit ([www.dhs.ca.gov/lean](http://www.dhs.ca.gov/lean)) or contact the California Project Lean with the California Department of Health at 916/323-4742.

The WOLF (Work Out Low Fat) program curriculum, developed by the Diabetes Unit in the MDH Center for Health Promotion, promotes regular physical activity for Native American elementary school-aged children. The school meals program offers an opportunity to provide the proper nutritional balance in the meals served. It also offers an opportunity for students to try new fruits and vegetables and other low fat foods.

Extracurricular programs for students, including extended-day programs, offer another opportunity for students to learn about fun physical activity and healthy foods. Materials about extracurricular activities are available from the Fitness Fever Program, the 5 a Day Program, and the MDH Nutrition and Physical Activity Unit (see resources section below for more information).

### **Creating supportive environments and conducting educational programs that encourage physical activity and healthy food choices in work sites**

Work sites offer important opportunities for providing healthy choices for adults; demonstrating ways to incorporate physical activity and healthy eating choices into their day-to-day lives; providing information and education to help workers and their families to live healthier lives; and creating environments that support workers' healthy choices. Environmental supports include providing opportunities for physical activity at the work site and facilitating their use, providing healthy choices within on-site food service through vending machines and/or cafeteria food service, and developing work site nutrition policies that offer guidelines and suggestions for healthy food choices offered at meetings and events. Some work sites may be able to negotiate options for employee use of area recreation facilities at dedicated hours or for reduced fees.

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Opening stairwells so that employees can use stairs instead of elevators is an inexpensive way to increase the availability of physical activity opportunities at the work site. Flexibility in the use of lunch and other breaks will facilitate employees' use of some of this time for physical activity. Employee walking clubs or sports teams can also encourage regular physical activity. Work sites can provide education about healthy living through newsletters, displays, presentations, and other materials.

Work site interventions are moving in the direction of a public health approach, designed to include all employees at the work site, rather than directed only at high-risk individuals. More detailed data is available demonstrating the success of highly targeted and individualized programs, including coordination with health care providers and risk-appropriate counseling and education. Intervention strategies involving a broader employee population with demonstrated success have included the tailoring of interventions to people's needs, experiences, and stages of change; timing of intervention strategies to reinforce new behaviors and prevent relapse; peer involvement and support; and community support at all levels.

The most successful work site programs are integrated with employee health care providers. These programs are able to assess individual risk and tailor work site programs to meet individual needs. The work site, in many ways, becomes an extension of the health care system and provides the education and skill-building opportunities to support needed behavioral change. An example is:

A variety of ready-to-use programs and materials are available for use in work sites. The MDH has developed several work site modules through its own employee health promotion program that are available for use in other settings, including the work site version of Fitness Fever.

**Healthcare organizations working to create supportive environments that encourage physical activity and healthy food choices and conducting screening and follow-up activities**

In addition to providing information, education, and referral to clients, health care providers and health care organizations can provide needed support and partnership with communities to improve physical activity levels and dietary change. Numerous studies have shown that physicians and other health care providers consider preventive health services to be important and believe they have a central role in providing preventive services. Consumers also consistently identify physicians and nurses as primary sources of health information and consider their advice on health promotion activities to be a primary motivator for behavior change.

Health counseling is currently underutilized, as studies also show that many primary care practitioners overestimate the amount of preventive care they provide. Decreasing time provided for health care visits and lack of reimbursement for preventive care services and patient education are significant barriers to providing education and referral. Health care providers and health care organizations can play a key role in communicating to the public the amount and types of physical activity and food that are needed to prevent disease and promote health. Health care providers and organizations are seen as important sources of health information by

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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consumers and with this credibility are in an important position to communicate the importance of adopting healthy lifestyles for chronic disease prevention. Health care providers are in a unique position to provide individualized information appropriate to lifestyle, risk, and health status. They can encourage behavioral change, support individuals in overcoming barriers, and make referrals to other providers or organizations when appropriate. Special attention should be focused on populations who are disproportionately at risk for conditions that respond positively to physical activity and eating-pattern change. These populations include those with low incomes, those with less education, American Indians and populations of color, those with disabilities, and those with other risk factors such as physical inactivity, smoking and obesity. An example is:

Healthcare organizations can implement policies and guidelines to routinely reimburse for assessment and counseling for physical activity as part of their standard care package. Health Partners 10,000 Steps® Program is an example of a program that encourages active lifestyles with an innovative approach to thinking about daily physical activity goals. Walking 10,000 steps a day is equivalent to 30 minutes of physical activity a day. The program includes state-of-the-art pedometers, a personal action planner, a walking log to keep track of steps, and motivational cards sent through the mail biweekly for eight weeks and then bimonthly for six months. If you are interested in learning more about Health Partners 10,000 Steps® Program, visit ([www.healthpartners.com](http://www.healthpartners.com)) or call 952/883-7800 or 800/311-1052.

Research has demonstrated that lowering blood cholesterol reduces the risk of heart disease and evidence strongly indicates the importance of blood pressure control in the prevention of stroke. Studies conducted in a variety of settings have demonstrated that targeted screening is effective in identifying those individuals needing intervention and provides a basis for tailored referral of services necessary for appropriate care. An example is:

Methods to identify individuals with high cholesterol include standardized blood cholesterol measurement services offered to groups such as work site populations. Methods to identify hypertensive individuals include standardized blood pressure measurement clinics or services offered to community groups such as work site populations (particularly those employing lower-educational-status employees, such as blue-collar or pink-collar industries), community groups representing lower-income-level populations, populations of color (particularly African American populations), and older adults. Follow-up activities include assisting individuals in seeking appropriate care to treat high blood cholesterol/hypertension. Follow-up activities supportive of behavioral change to treat high blood cholesterol include programs promoting diets low in fat (especially saturated fat) and high in fruits and vegetables, weight management, and aerobic physical activity. Follow-up activities supportive of behavioral change to treat hypertension include programs promoting reduced alcohol consumption, smoking cessation, weight management, aerobic physical activity, and dietary measures to reduce sodium intake, increase fruit and vegetable intake, reduce fat intake, and maintain appropriate potassium, calcium, and magnesium intake.

Healthcare organizations can encourage health behavior by implementing policies or guidelines to routinely reimburse for assessments and counseling for physical activity, medical nutrition therapy, and tobacco cessation as part of their standard care package. Seventy percent of smokers

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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report a desire to quit smoking, and the vast majority visit a health care provider each year. As highly credible sources of information and support, health care providers systems are uniquely positioned to prevent tobacco use, help patients reduce or quit using tobacco, and influence public policy. Screening for tobacco use and treatment for nicotine addiction is not uniformly integrated into medical practice. Coverage of cessation services is generally fragmented and incomplete. Community groups could work with health care organizations to develop policies that address these issues.

### **Creating supportive environments that encourage physical activity and healthy food choices through the media**

Effective public information campaigns can provide consumers with the information they need to incorporate healthy eating habits and physical activity in their daily lives. Public information campaigns support efforts to promote environments and community norms that lead to healthy eating and physical activity. Media coverage of campaigns or events can add additional reach and impact a message. Research on community-wide health promotion and disease prevention strategies that promote regular physical activity and/or nutrition has shown that public information is a critical component in changing a community's behavior and improving community health status. The presence of public information campaigns used in conjunction with active community coalitions, widespread community involvement, and well-organized community efforts are important in increasing physical activity levels and increase the level of readiness among community members to change their eating habits.

The primary goal of a public information strategy is to change perceived norms that are favorable to healthy behavior, such as tobacco cessation. Tobacco use norms can be changed by increasing people's exposure to negative messages about using tobacco or to positive messages about not using tobacco and by increasing people's ability to identify hidden messages (e.g., "smoking is glamorous and sophisticated") in tobacco advertising and tobacco-industry marketing tactics. This strategy has been most widely used with specific groups that are often targeted by tobacco industry advertising, including children, women, and populations of color. The research evidence strongly suggests that counter advertising is effective in changing the attitudes of adolescents about tobacco use. An example is:

Local media are often interested in stories and information that describe community activities or provide useful information to their audiences. Plan a community event that offers community members the opportunity to build skills or confidence in healthy eating patterns and promotes fun in physical activity. Nutrition events might focus on choosing or preparing new or unfamiliar foods, promoting the good taste of healthy foods, promoting healthy eating as a family or community activity, or informing community members about a new opportunity for healthy eating (e.g., a new restaurant with healthy menu items or the annual opening of a farmers' market or other facility). Physical activity events could focus on promoting physical activity as a family or community activity, or informing community members about a new opportunity for recreation (e.g., a new walking or biking trail or a new ice rink or other facility) and is a newsworthy event that will gain coverage from local media.

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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### **Creating supportive environments that encourage physical activity and healthy food choices in faith-based organizations**

Faith-based organizations can play a big role in changing behavior. Some examples include the North Carolina Black Churches United for Better Health (BCUBH) Project. The target audience for this project was 2,519 African American members of 24 black churches in rural North Carolina. Activities targeted predisposing factors (e.g. personalized bulletins to each church member; brochures posters, banners etc.), enabling factors (e.g. planting gardens for fruit trees, conducting educational sessions, cooking classes etc.), and reinforcing factors (e.g. training Lay Health Advisors in each church, forming coalitions, encouraging pastors to support the project, promoting farmers' markets, etc.). Serving more fruits and vegetables at church functions was the activity that had the highest overall impact. Other activities with high impact included the personalized, tailored bulletins, pastor sermons, and printed materials. Project Joy and "Eat for Life Trail" are some other examples (for more information see the resources section at the end of this document).

### **Creating supportive environments that reduce tobacco use**

For background information and recommended strategies to reduce tobacco use, please refer to the following resources:

Minnesota Department of Health. Tobacco Use Prevention and Reduction in Minnesota. Elements, Roles and Costs of a Comprehensive Approach. January 1999.

Minnesota Department of Health. Minnesota Youth Tobacco Prevention Initiative Strategic Plan. September 1999.

Minnesota Department of Health. A Compendium of Ideas, Experience, and Research from Minnesota's Public Health Professionals. October 1998.

Randy Kirkendall may also be contacted at 651/281-9780 for additional information and questions regarding the reduction of tobacco use.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in cardiovascular disease in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

- increased physical activity,
- better diet,
- less obesity, and
- a reduction in the need for medical interventions, such as treatment for high blood pressure or high cholesterol.

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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### Resources

#### Articles

- Demark-Wahnefried, W. et al., (2000), Partnering with African American Churches to Achieve Better Health: Lessons Learned during the Black Churches United for Better Health 5 a Day Project. *Journal of Cancer Education*. Vol.15 (3): 164-167.
- Pargee D, Lara-Albers E, Puckett K. (1999) Building on Tradition: Promoting Physical Activity with American Indian Community Coalitions. *Journal of Health Education*, 30 (supplement 2): s37-s43.
- Resnicow, K., et al., (2000). Dietary Change through African American Churches: Baseline Results and Program Description of the Eat for Life Trial. *Journal of Cancer Education*, Vol.15 (3): 156-16.
- Schmid, T.L. and Howze, E. (1995) Policy as Intervention: Environmental and Policy Approaches to the Prevention of Cardiovascular Disease. *American Journal of Public Health*. Vol 85. No 9, pp 1207-1211.
- Yanek. L.R., et al., (2001), “Project Joy”: Faith Based Cardiovascular Health Promotion for African American Women. *Public Health Reports*, Vol. 116: 68-82.

#### Reports

- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (1997). *Unrealized Prevention Opportunities: Reducing the Health and Economic Burden of Chronic Disease*, A Report of the National Center for Chronic Disease Prevention and Health Promotion Centers for Disease Control and Prevention. Health Partners, Center for Health Promotion. (Unpublished internal report, 1996). *Adult Weight Management Philosophy and Recommended Approaches*. Minneapolis, MN: Center for Health Promotion, Health Partners. Contact: 612/883-7453.
- U.S. Department of Health and Human Services. (1993). *Promoting Healthy Diets and Active Lifestyles to Lower-SES Adults*, Market Research for Public Education.
- National Institutes of Health, National Heart, Lung and Blood Institute. (1997). *The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure*.
- National Institutes of Health, National Heart, Lung and Blood Institute. (1993). *Working Group Report on Primary Prevention of Hypertension*.
- Satter, E. (1987). *How to Get Your Kid to Eat But Not Too Much*. Palo Alto, CA: Bull Publishing Company.

#### Other resources and websites

- Fit, Healthy and Ready to Learn – a resource tool that focuses on helping states, schools districts and schools adopt and implement effective policies. National Association of State Boards of Education 800/220-5183 ([www.nasbe.org/healthyschools/fithealthy.html](http://www.nasbe.org/healthyschools/fithealthy.html)).
- A First Step Toward Healthy Eating: The 1% or Less Handbook. Contact: CSPI, 1875 Connecticut Ave., NW, Suite 300, Washington, D.C. 20009-5728, 202/332-9110.
- Fitness Fever website (<http://www.fitnessfever.com>).

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5-A-Day program materials. A variety of ready-to-use promotional materials from the 5 A Day program are available, including CD-Rom public service announcements (PSAs) for radio featuring Graham Kerr, videotape PSAs, scripts for radio PSAs and press releases, and camera-ready art in hard copy or on disk. Contact: Fran Doring, MDH Nutrition and Physical Activity Unit, at 651/215-8954.

School Health Index: A Self-Assessment and Planning Guide. For more information visit ([www.cdc.gov/nccdphp/dash/SHI/index.html](http://www.cdc.gov/nccdphp/dash/SHI/index.html)) or contact the Centers for Disease and Prevention 888/231-6405.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Ready. Set. It's Everywhere You Go. This physical activity promotion kit from the Centers for Disease Control and Prevention includes video and audio public service announcements, camera-ready art, and a guidebook with information about marketing strategies, working with the media, and developing programs and events. Contact: Chris Kimber, MDH Health Education Unit, at 651/215-8954.

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Cardiovascular Health (<http://www.cdc.gov/nccdphp/cvd/>).

### **MDH Contact**

For more information about cardiovascular health, contact:

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Elizabeth Gardner  
651/281-9840  
[Elizabeth.Gardner@health.state.mn.us](mailto:Elizabeth.Gardner@health.state.mn.us)

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Eliminating Health Disparities In Diabetes

### Background

Diabetes mellitus is a collection of serious diseases affecting nearly 16 million Americans. All forms of the disease are caused by the body not producing or not responding correctly to insulin. Insulin is a hormone that converts carbohydrates (sugars and starches) from food into the energy needed by the body. If insulin does not function properly, sugars accumulate in the blood, which can result in many disabling or deadly complications. The situation is much worse if the diabetes is accompanied by high blood pressure or elevated cholesterol.

Diabetes is the seventh leading cause of death in Minnesota, and the leading cause of blindness, kidney failure, and lower-limb amputations. It increases the risk of heart disease two to four times. Between 1995 and 1999, the number of people in Minnesota with diabetes increased more than 50 percent. The disease costs Minnesotans an estimated \$2 billion annually.

In Minnesota, glaring racial and ethnic disparities in diabetes exist that are reflected in the disease's prevalence, complications, death rates, and preventive care received by those who have diabetes. As Figure 1, on the following page, illustrates, compared to non-Hispanic whites, diabetes as an underlying cause of death (diabetes-related death) in Minnesota was between 1.5 and five times more common among African Americans, Hispanics/Latinos and American Indians. The diabetes death rate among Asian Americans is increasing faster than among any other racial or ethnic group.

Non-white racial and ethnic populations have higher rates of diabetes complications. Among people with diabetes: kidney failure is two to six times greater in populations of color; lower-limb amputations are four times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos, and 40-50 percent greater in African Americans.

In Minnesota, diabetes during pregnancy increases the risk of birth defects by over 70 percent and doubles the rate of perinatal death. Compared with the state's white population, diabetes-complicated birth is 1.7 times greater in African Americans and 5.2 times greater in American Indians. Pregnancy complicated by diabetes is increasing faster among Hispanics/Latinas, American Indians, and Asian Americans than among whites. These groups are also at greater risk of receiving less than adequate prenatal care.

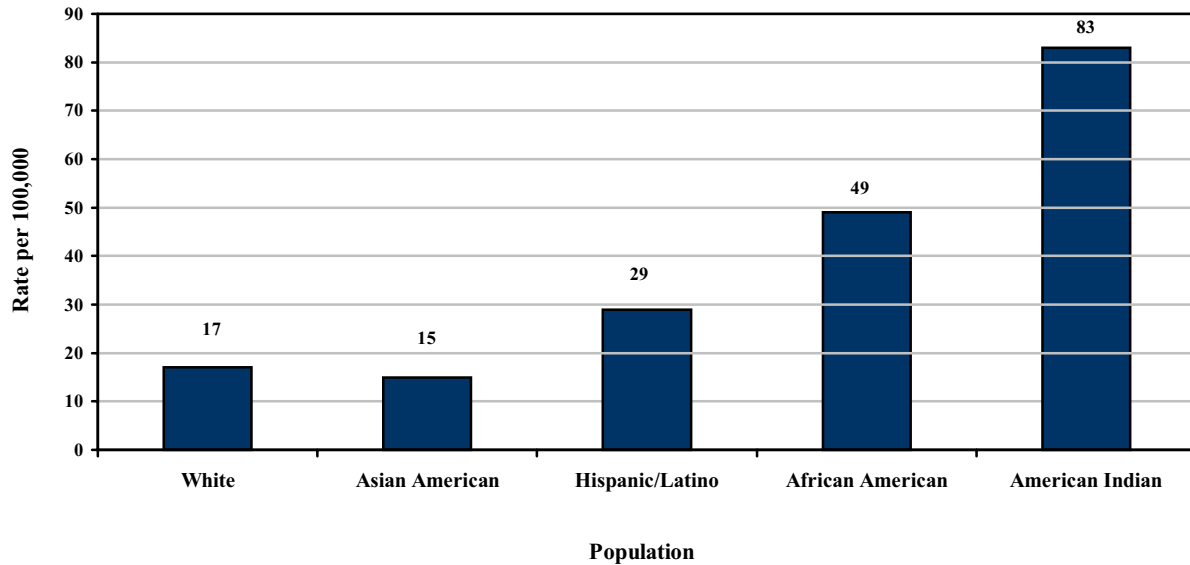
Trends indicate that the disease's disproportionate impact is increasing at alarming rates in racial and ethnic minority populations in Minnesota. This is evidenced by increases in the overall prevalence of diabetes, its prevalence during pregnancy, and in diabetes-related deaths in these populations. Furthermore, it is likely that this trend will continue to worsen before it improves, because rates of obesity (a major contributing risk factor for diabetes) are also increasing at a dramatic rate.

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Figure 1. Diabetes as an Underlying Cause of Death in Minnesota per 100,000, 1989-1998.

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\*Sources: Minnesota death certificates and the Minnesota Health Profiles (1998)

### Contributing Factors

Disparities in the prevalence of diabetes and its complications are associated with a number of social, behavioral, and physiological factors. The rapid increase in the most common form of diabetes, type 2, is related to changes in lifestyle associated with the increased urbanization of our culture. American Indian and other racial and ethnic minority populations have been especially vulnerable to these societal changes.

Obesity is a major risk factor for developing type 2 diabetes. Approximately 80 percent of people with type 2 diabetes are obese at the time they are first diagnosed. Other risk factors include a high-fat diet, and physical inactivity. For people with diabetes, potentially modifiable factors such as high blood sugar, smoking, and hypertension greatly increase the risk of complications such as vision loss, amputations, heart disease, kidney failure, stroke and heart disease.

Racial and ethnic disparities in diabetes complications and diabetes-related deaths are made worse by a variety of factors, including poor access among non- white populations to diabetes medicines, supplies, and culturally and linguistically appropriate preventive care. Lack of culturally and linguistically appropriate diabetes education materials and support systems further impede effective diabetes management in these populations.

### Strategies For Intervention

Diabetes is a complex disease that potentially affects all areas of an individual's life. Effective management of the disease requires significant lifestyle changes, on-going health care, and constant vigilance. As a result, the most effective diabetes interventions are those that are built

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on diverse partnerships that support people with diabetes in all aspects of their lives, and that involve people with diabetes. For your interventions, consider collaborating with groups in your community, such as:

- Public health agencies
- Faith-based organizations
- Neighborhood and community centers
- Advocates for public housing residents, the elderly, and distinct ethnic groups
- Clinic outreach workers and healthcare professionals
- Diabetes educators
- Community fitness centers
- Employers and schools
- Grocery stores

The following list of strategies provides samples of what may be included in proposals to eliminate health disparities in diabetes. Other strategies not listed here may also be included; however, it should be noted that in most cases, community-wide screening for diabetes has not been found to be cost-effective. To enhance your capacity to carry out interventions, consider seeking additional funding from foundations, diabetes supply companies, and other sources. For more information about the programs described below, see the Resources section below.

**Peer education.** A number of programs throughout the country train and utilize lay educators who are bilingual, bicultural members of the community for whom the intervention is designed. The educators provide diabetes education and lead support groups in the participants' native language in a manner that is culturally appropriate. Examples of groups that have utilized this model include Migrant Health Services, Inc. and the Chicago Department of Health.

**Culturally and linguistically appropriate diabetes educational materials.** Minnesota and other states lack adequate diabetes education materials in Asian, African, and other languages, including Spanish. Because many of the populations disproportionately affected by diabetes have strong oral traditions and learn best through visual and oral methods, videos are often more effective than print materials. Videos also remove barriers related to literacy, poor vision, and formal learning styles. Development of videos and print materials in various languages would meet a significant educational gap and facilitate diabetes self-management in disproportionately impacted populations.

**Diabetes awareness media campaigns for specific populations.** Media campaigns can be an efficient way to provide information to a large portion of a given population. The National Diabetes Education Program has a series of ready-to-use television, radio, and print public service announcements that are designed for different ethnic populations to convey the message that diabetes can be controlled to prevent complications.

**Health radio and television talk shows.** A number of communities have developed health education radio and television shows in their native languages. These shows are often hosted by a bilingual, bicultural health care provider and provide an interactive segment so that

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callers can ask questions anonymously. One example of this is Saludando Salud's La Hora de la Salud (Health Hour) weekly radio show in Spanish.

**Diabetes care delivery improvements.** By bringing community and clinic representatives together, the Diabetes Community Collaboration Project provides a model to improve diabetes care and education, and to bridge gaps between clinics and the community that may hinder diabetes self-management. This model enables communities to develop strategies according to their specific resources and needs. The model has been implemented in two Minnesota communities. Results show dramatic improvements in blood sugar control and the provision of diabetes preventive services.

**Free or low cost medicines, supplies and equipment to benefit low income people with diabetes.** Many diabetes medical product companies sponsor programs that offer medicines, supplies and equipment to clinics or other health organizations for their patients who cannot afford these products or testing. For example, companies have worked with clinics to provide free glucose meters, use of a specific drug, or a machine to test blood glucose levels.

**Programs with faith-based organizations.** Involving faith-based institutions in diabetes awareness efforts expands social support for people with diabetes and provides information in a trusted setting. Diabetes Sunday is a project developed by the American Diabetes Association that has been implemented in many African American communities across the nation. At a Diabetes Sunday, the spiritual leader shares information with the congregation about risk factors, the importance of screening, and for those with the disease, the importance of blood sugar management.

**School-based programs to prevent type 2 diabetes.** Work Out Low Fat – WOLF is a Minnesota school-based program promoting physical activity and low-fat eating to reduce risk factors of type 2 diabetes in American Indian youth. This highly regarded program is being implemented in many Minnesota tribal schools under the guidance of the American Indian Diabetes Prevention Advisory Task Force representing the 11 Minnesota tribes.

**Community diabetes forums.** These events bring together people from the community to meet and learn from diabetes experts. The experts may speak individually or as a panel about various aspects of diabetes management. A question and answer format allows for interaction between the audience and the presenters.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in diabetes in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

More quality culturally and linguistically appropriate diabetes educational resources are available.

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Greater access to culturally appropriate social support networks that can facilitate diabetes self-management.

The health care workforce has a greater number of bilingual, bicultural diabetes educators. A greater variety of translated, culturally appropriate diabetes educational tools are available for health care providers and people with diabetes.

More culturally appropriate diabetes messages are received through the media.

People with diabetes have more knowledge, positive attitudes, and self-confidence about diabetes so that they are better able to self-advocate for culturally appropriate diabetes care. Clinics and organizations work closely together and have integrated their systems to better serve people with diabetes.

Diabetes medicines and supplies are available to uninsured and under-insured people with diabetes to help them effectively manage their disease.

More children are learning about healthy lifestyles (good nutrition, promoting physical activity, tobacco abstinence, etc.)

### Resources

#### Report website

Voices from the Community: Focus Groups with African American, American Indian, Hmong and Latino People with Diabetes, Minnesota Diabetes Program, 1998  
(<http://www.health.state.mn.us/divs/fh/chp/voices/>)

#### Data source websites

Diabetes in Minnesota fact sheet  
(<http://www.health.state.mn.us/divs/fh/chp/FACTSHEET.html>)  
Office of Minority Health's Data and Statistics links  
(<http://www.omhrc.gov/OMH/sidebar/datastats.htm>)

#### Other websites

Minnesota Diabetes Program, Minnesota Department of Health  
(<http://www.health.state.mn.us/divs/fh/chp/diabmiss.htm>)  
National Diabetes Education Program (<http://ndep.nih.gov/>)  
National Diabetes Information Clearinghouse  
(<http://www.niddk.nih.gov/health/diabetes/ndic.htm>)  
The American Diabetes Association (<http://www.diabetes.org>)  
Migrant Health Services, Inc. (<http://www.fargoweb.com/hcwb/migranthealth.html>)  
The Community Tool Chest (<http://ctb.lsi.ukans.edu/>)  
Saludando Salud (<http://www.rndc.org>)  
Centers for Disease Control and Prevention Diabetes Public Health Resource (<http://www.cdc.gov/diabetes/index.htm>)

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### Research websites

For summaries of important diabetes clinical trials, go to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) (<http://www.niddk.nih.gov/health/diabetes/diabetes.htm>). Look for the following studies: the Diabetes Control and Complications Trial (DCCT); the United Kingdom Prospective Diabetes Study (UKPDS); the Diabetes Prevention Program (DPP); and the Finnish Diabetes Prevention Study (DPS).

Diabetes in Control (for a collection of current research summaries) (<http://www.diabetesincontrol.com/>)

Juvenile Diabetes Research Foundation (<http://www.jdrf.org/>)

Reach 2010 Community Programs to Eliminate Health Disparities (<http://www.rand.org/health/reach/>)

### Clinical practice guidelines websites

American Diabetes Association Clinical Practice Recommendations (<http://www.diabetes.org/clinicalrecommendations/CareSup1Jan01.htm>)

Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: Management of Type 2 Diabetes Mellitus (<http://www.icsi.org>)

ICSI Health Care Guideline Translation for Patients (<http://www.icsi.org>)

American Academy of Family Physicians: Benefits and Risks of Controlling Blood Glucose Levels in Patients with Type 2 Diabetes Mellitus (<http://www.aafp.org/clinical/diabetes/allofit.html>)

National Guideline Clearinghouse (<http://www.guidelines.gov/>)

### **MDH Contact**

For more information about diabetes, contact:

Martha Roberts

651/281-9842

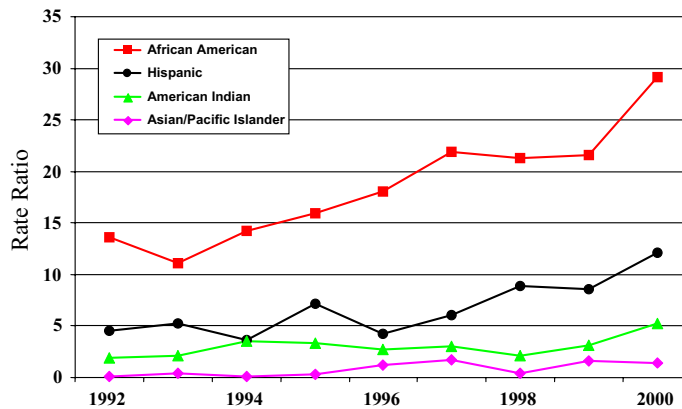
[martha.roberts@health.state.mn.us](mailto:martha.roberts@health.state.mn.us)

## **Eliminating Health Disparities In HIV/AIDS And Sexually Transmitted Infections**

### **Background**

HIV/AIDS. The number of newly reported HIV/AIDS cases has remained relatively stable in Minnesota over the past five years with an average of just over 350 cases reported per year. Advances in HIV treatment have resulted in lower numbers of both AIDS cases and AIDS deaths. However, populations of color continue to be disproportionately affected by HIV/AIDS. In 2000, the number of newly reported cases of HIV among persons of color was greater than among whites for the first time in Minnesota, even though communities of color make up approximately 10 percent of Minnesota's population. African American men have the highest annual rate of newly reported HIV/AIDS infections, 21 times greater than white males in Minnesota. The disparity is even greater for African American women with an HIV/AIDS rate 91 times greater than that among white women. Overall comparisons of the annual rate of newly reported HIV/AIDS infections among populations of color, compared to the rate among whites are illustrated in Figure 1 below. Since 1992, the disparity in HIV/AIDS rates between African Americans and whites has been steadily increasing.

Figure 1. HIV/AIDS Rate Ratios by Race/Ethnicity and Year of Report, Minnesota 1990-2000



Data source: Minnesota HIV/AIDS Surveillance System

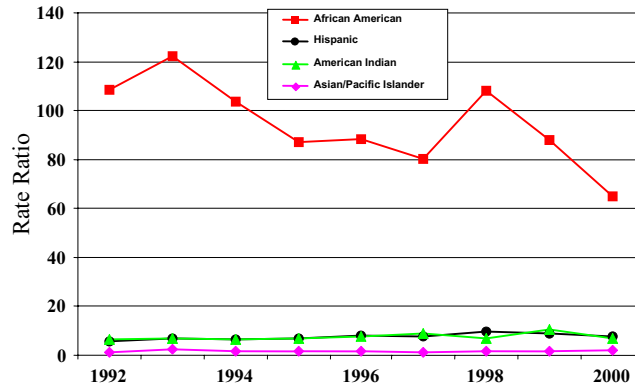
Sexually transmitted infections. Gonorrhea and chlamydia infections are the most common reportable diseases in Minnesota with over 11,000 cases reported in 2000. Infection with these STIs can cause infertility in women and increase the chances of spreading HIV. Communities of color are also disproportionately affected by STIs. Among Minnesotans in 2000, African Americans had the highest rates of gonorrhea and chlamydia. As shown in Figure 2, the African American gonorrhea rate disparity has decreased in size over the past eight years. However, the African American rate was still 64 times greater than that for whites in 2000. The level of disparity has remained fairly stable for other communities of color during that time. Figure 3 illustrates the same comparisons for chlamydia. Overall, the disparities in chlamydia rates have increased over the past eight years among all communities of color. However, there has been a

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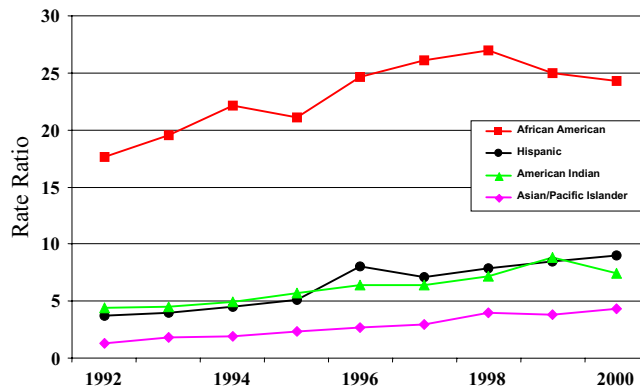
slight decrease in the past two years for African Americans with a chlamydia infection rate 24 times greater than whites in 2000.

Figure 2. Gonorrhea Rate Ratios by Race/Ethnicity and Year of Report, Minnesota 1990-2000



Data source: Minnesota STD Surveillance System

Figure 3. Chlamydia Rate Ratios by Race/Ethnicity and Year of Report, Minnesota 1990-2000



Data source: Minnesota STD Surveillance System

### Contributing Factors

Factors that directly increase the risk of HIV and STI transmission include the following:

- Susceptibility of the uninfected individual
- Infectiousness of the infected individual
- Sex behaviors
- Drug behaviors
- Health care behaviors
- Prevalence

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Through the process of community planning, a great deal of work has been done to identify cultural and other factors/issues that help to determine the nature of these risk factors within communities of color.

### **Racism**

External racism may promote low socio-economic status (see below)

Internalized racism may induce feelings of hopelessness, despair, and self-destruction, which may prompt risky behaviors, including drug use.

Lack of bilingual and bicultural health professionals and health education materials impact on ability to access effective health care.

Non-western medical models make HIV disease hard to comprehend.

Some immigrants do not seek medical care for fear of deportation or denial of citizenship.

Some cultures believe that HIV is perpetrated by the government to rid society of people of color, resulting in a lack of motivation to internalize HIV prevention messages.

### **Socio-economic status (SES) factors (e.g., poverty, homelessness, joblessness, low education)**

Low SES level may induce feelings of lack of control, despair, and hopelessness, which may prompt risky behaviors.

Low SES level may directly promote risky behaviors related to survival (sex for money, drug use to escape despair).

Low SES level directly impacts on ability to access health care, including HIV and STI tests, treatment, and prevention messages.

Low SES results in many personal survival issues that take precedence over personal investment in changing risk behaviors.

Many school-aged, high-risk youth are not in school and do not receive HIV and STI prevention messages.

### **Homophobia/heterosexism**

In some cultures, men who have sex with men do not identify themselves as homosexual and therefore do not consider themselves at risk.

Internalized homophobia may induce feelings of hopelessness, despair, and self-destruction, which may prompt risky behaviors.

Externalized homophobia may create environmental and legal barriers to engaging in safe behaviors (e.g., criminalization of sodomy, lack of access to condoms in prisons, lack of safe environments for sex, lack of information and support for gay/bisexual youth).

### **Non-injecting substance use/abuse**

The culture that surrounds drug use may promote risky drug/sex behavior, as well as contribute to factors that support risky behaviors (e.g., alienation from family/friends/society, loss of job, low self-esteem, depression).

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Women drug users may be at particular risk since 1) there are fewer drug treatment options open to them; 2) their reliance on drug-using sex partners for financial/emotional support may reinforce their drug use; 3) they are likely to exchange sex for drugs to support drug addiction rather than, or in addition to, engaging in other criminal activities.

### **Societal, cultural, and peer norms**

Societal norms promoted through entertainment and media may increase risky behaviors. In some communities of color, cultural prejudices against homosexuality, and against the discussion of sexuality, particularly between parents and children, may contribute to high rates of STI and HIV.

In some communities of color, condom use is embarrassing and threatening.

HIV is associated with a fear of discrimination and stigma, which keeps homosexual and HIV-infected individuals silent about their orientation and/or their disease.

Male privilege bestowed by society may increase feelings of invincibility, a need to procreate, or promote a view of promiscuity as masculine.

Female oppression decreases ability of women to be assertive in sexual relationships, particularly regarding initiation of safer sexual practices and discussion with their partners of their sexual behaviors.

### **Strategies For Intervention**

The following strategies may be included in proposals to eliminate health disparities in HIV/AIDS and STI, but other strategies not listed here may also be included. Based on several needs assessments, the following have been identified as important elements of interventions:

Church and other community leaders must be included if HIV and STI prevention is to be effective.

Comprehensive, culturally-appropriate HIV and STI prevention programming, including transportation and child care, needs to be available.

Health care providers need to consistently provide HIV/STI prevention information, and work to be perceived as trustworthy and able to maintain confidentiality.

Culturally-appropriate chemical dependency services need to be available.

Attitudes and beliefs of youth regarding violence, sexual promiscuity, and chemical use need to be addressed.

Parents need to have the skills and motivation to discuss HIV/STI prevention issues with their children.

Addressing cultural taboos around sexuality and homosexuality is critical. Consistent condom use needs to become a cultural norm for men and women.

Prevention messages do help people to change their behavior.

Individuals need to hear prevention messages face-to-face and more than once.

Individuals injecting drugs must know where to obtain new needles.

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### Some ideas for specific interventions

Identify common risk factors for teen pregnancy and for teen STI acquisition. Target prevention information to individuals with those common risks.

Perform universal STI screening programs in selected high schools, in alternative schools or in other community settings where youth congregate. Provide on-going programming, educational planning and intervention to encourage youth to be tested, and provide treatment.

Implement a basic public health media campaign to increase general public awareness. Messages about testing need to include the notion that it is cool and/or normal. Develop billboards featuring youth, rappers, entertainers, etc.

Advertise statistics. Target general population to ask their providers about STIs. Send information packets and offer training to professionals to be ready for the consumer campaign.

Give information out to those sitting in waiting areas of clinics, hospitals and service organizations via video and/or posters.

Work with pre-sentencing for incarceration to develop routine HIV and STI screening, ensuring confidentiality of results and treatment.

Provide training to health care providers regarding culturally sensitive and appropriate services, and on taking sexual histories. Work with teen or specialty clinics to provide services such as sexual health and life skills.

Train adults in existing mentorship programs, e.g., college sororities and fraternities, and 100 Men to talk about HIV and STI prevention and testing.

Provide training to pharmacists, barbers, etc. to talk about HIV and STI prevention and testing. Training should raise awareness, provide information designed for a specific environment (such as church, street, or sports) with quick, concise information that is culturally and age appropriate .

Use existing youth theater organizations to provide presentations at group homes, etc.

Provide community-based peer education among parents, teachers, block clubs, and churchgoers. Support for parent education is especially needed. Link the notion of safety for children with a health message. Provide information where parents gather -- school parent involvement days, parent conferences, etc. Provide parenting classes with food and support.

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### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in HIV/AIDS and STIs in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

- Increase in the percentage of people using condoms.
- Decrease in the number of sexual partners within the last year.
- Decrease in the number of times needles are shared.
- Increase in the number of people getting tested for HIV and STI.

### **Resources**

Much of the information listed above was taken from a variety of resources developed by the STD and HIV Section of MDH. Available reports include Minnesota Comprehensive HIV Prevention Plan and Statewide Plan to Address STDs in Minnesota. In addition to these reports there are a number of needs assessment reports available from the STD and HIV Section at MDH for specific populations.

### **Websites**

- CDC Division of HIV/AIDS Prevention (<http://www.cdc.gov/hiv/pubs/facts.htm>)
- CDC Division of HIV/AIDS Prevention Tools (<http://www.cdc.gov/hiv/prevtools.htm>)
- CDC Division of Sexually Transmitted Diseases  
(<http://www.cdc.gov/nchstp/std/dstdp.html>)
- American Social Health Association (<http://www.ashastd.org>)
- Hidden Epidemic (<http://www.nap.edu/books/0309062322/html>)

### **MDH Contact**

For more information about HIV/AIDS and sexually transmitted infections, contact:

Julia Ashley  
612/676-5665  
[julia.ashley@health.state.mn.us](mailto:julia.ashley@health.state.mn.us)

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**Eliminating Health Disparities In Immunizations  
For Adults And Children**

**Background**

A person's need for immunizations is life long. Children need protection against at least 11 serious vaccine-preventable diseases. To be fully protected, children should receive up to 20 doses of vaccine throughout the first two years of life, additional immunizations before kindergarten, and still more as adolescents. Adults also need shots: tetanus-diphtheria boosters, influenza, and pneumococcal vaccine. Medical conditions, environmental conditions, and work situations are other reasons for additional vaccines for many children and adults.

The use of vaccines has resulted in the lowest levels of vaccine-preventable disease ever reported, but the immunization rates of children and adults in certain socioeconomic and racial/ethnic groups remain low. These low immunization rates can lead to disease outbreaks at any time.

The most recent statewide retrospective kindergarten survey of immunization levels identified disparities in coverage levels between different racial/ethnic populations (Table 1). On average children from the American Indian community and communities of color had immunization levels that were 27 percentage points lower than their white counterparts.

**Table 1 Percentage Up-To-Date By Age and Race/Ethnicity, Retrospective Kindergarten Survey, 1996-97**

<b>Population Group</b>	<b>4 Months of Age</b>	<b>6 Months of Age</b>	<b>8 Months of Age</b>	<b>17 Months of Age</b>	<b>20 Months of Age</b>
All Students	90%	80%	71%	65%	55%
American Indian	81%	61%	49%	45%	41%
Asian and Pacific Islander	67%	50%	39%	38%	30%
African American	75%	61%	48%	46%	38%
Hispanic/Latino	72%	56%	44%	43%	33%
All non-white	72%	55%	43%	42%	34%
White	93%	85%	76%	69%	58%

Race/ethnicity information was available for 90 percent of kindergarteners statewide.

A similar trend is seen with adult immunization. The 1999 Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS) identified that African Americans had rates for influenza and

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pneumococcal vaccines that were significantly lower than white adults. Although the Minnesota BRFSS sample is small, the data reflect national trends showing populations of color have lower levels of immunization for influenza and pneumococcal vaccine (Table 2).

**Table 2 1999 BRFSS Data for Influenza and Pneumococcal Vaccine Coverage for persons 18 years and older**

<b>Population Group</b>	<b>Influenza MN Rates</b>	<b>Influenza National Rates</b>	<b>Pneumococcal MN Rates</b>	<b>Pneumococcal National Rates</b>
Black	14.0 %	27.0 %	6.2 %	15.8%
Hispanic/Latinos	18.5 %	24.0 %	10.5 %	11.8%
Other	24.4 %	27.8%	11.3%	15.0%
White	29.7%	33.1%	17.0%	19.3%

Overall in both pediatric and adult populations immunization levels have shown recent improvements, but American Indians and populations of color consistently have immunization levels significantly below that of the white population.

### **Contributing Factors**

There are a number of factors that contribute to low immunization rates in people of color and American Indians in Minnesota. These factors include, but are not limited to the following:

**Income.** Children who live in low-income areas are under-immunized. Childhood immunization levels are as low as 45 percent in some low-income zip code areas of Minnesota. Also, children on Prepaid Medical Assistance (PMAP) have lower immunization rates than children who have other health insurance plans.

**Lack of provider and community awareness of special vaccine recommendations.** Persons with diabetes, cardiovascular disease, sexually transmitted diseases, breast and cervical cancer, and other medical conditions are at high risk of complications from certain vaccine-preventable diseases. Unfortunately, persons of color and American Indians are more likely to have these diseases and less likely to have received the recommended vaccines for these diseases than white Minnesotans.

In addition, adults at high risk for hepatitis B are disproportionately from communities of color. Despite the fact they have sought out medical care, they are not receiving hepatitis B vaccination.

American Indian children are at increased risk of hepatitis A. The last statewide hepatitis A outbreak in Minnesota spanned the years 1989 through 1993 and resulted in more than 2,500 cases. In 1992 alone there were 884 cases, 339 (38.3 percent) of which occurred among

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American Indians. The majority of these cases were in children 5-14 years of age. Hepatitis A outbreaks usually occur every five to 10 years.

Southeast Asian children, and children from areas of the world where hepatitis B is endemic, are at increased risk of hepatitis B. Studies show that older Southeast Asian children are less likely than other children to have received three doses of the hepatitis B vaccine.

**Common barriers to immunization.** Common barriers include, but are not limited to, lack of transportation, lack of health insurance, lack of a medical home, need for interpreters, lack of knowledge of the importance and safety of immunization, and lack of clinic reminders when shots are due.

**Misperceptions regarding influenza and pneumococcal vaccines.** Studies indicate that many individuals do not receive flu shots for the very reason they are considered high priority--they had a health condition or chronic illness. In spite of the fact that flu and pneumococcal vaccines are safe and have minimal side effects, fear of potential side effects limit acceptance of these vaccines.

In African American and Hispanic/Latino communities studies of knowledge, attitudes and behavior indicate that lack of transportation and accessibility were barriers to vaccine. Individuals in these communities expressed mistrust of government. Additionally, people felt that influenza vaccine was for the “frail elderly” and they did not view themselves as such.

### **Strategies For Intervention**

The following strategies may be included in proposals to eliminate disparities in immunization, but other strategies not listed here may also be included.

Utilize community members to provide outreach and education.

Develop volunteer programs to identify and follow-up with children and adults who are not properly immunized. Services may include transportation and child care.

Encourage religious leaders to include education programs on health issues, including immunizations, so that all infants, children, and adults receive needed immunizations on schedule. Utilize and/or enhance the parish nurse role to promote immunizations if available.

Utilize religious-based gatherings (centers) as a forum for offering adult vaccination.

Utilize block nurse programs.

Provide transportation so that adults can receive influenza vaccination, as well as offering such clinics at neighborhood community centers and senior high rise and retirement facilities.

Educate providers about the importance of offering all recommended vaccines at every clinic.

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Access ECFE programs in neighborhood schools to include information about immunization and offering resources to assist parents in vaccinating their children.

Conduct media campaigns (neighborhood newspapers, Hmong, Hispanic/Latino radio and television programs, etc) about the serious complications of vaccine-preventable diseases and the benefits of vaccination.

Place visual messages at day care centers, neighborhood community centers, social service agencies, WIC, and health care provider clinics and develop programs to remind parents and prospective parents to immunize their children.

Create programs with private industry to help maintain high rates of childhood immunizations. These programs may include posting immunization information on bulletin boards in employee break rooms, including immunization schedules and clinic information on paycheck stubs, and donating or offering to pay for billboard space, bus signs, and immunization brochures and posters. Programs should be executed in collaboration with members of the targeted communities.

Develop culturally-appropriate materials in collaboration with members of the community.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in immunization rates of American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

Providers will not miss as many opportunities to vaccinate African American/African, Asian American, American Indian, and Hispanic/Latino children and adults.

More African American/African, Asian American, American Indian, and Hispanic/Latino children and adults will receive the vaccines they need to be protected against vaccine-preventable diseases.

### **Resources**

Schneider EC, Cleary PD, Zaslavsky AM, Epstein AM. Racial Disparity in Influenza Vaccination: Does Managed Care Narrow the Gap Between African Americans and Whites? JAMA. 2001; 286:1455-1460.

Minnesota Department of Health immunization ([www.health.state.mn.us/immunize](http://www.health.state.mn.us/immunize))

Immunization Action Coalition ([www.immunize.org](http://www.immunize.org))

American Lung Association of Minnesota 651/223-9564

Minnesota Coalition for Adult Immunization 651/725-2085

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National Coalition for Adult Immunization, 301/656-0003, email [adulthood@aol.com](mailto:adulthood@aol.com) , or  
([www.medscape.com/NCAI](http://www.medscape.com/NCAI) )

National Immunization Program ([www.cdc.gov/nip](http://www.cdc.gov/nip))

CDC Spanish Immunization Hotline 1-800-232-0233.

Vaccine information statements, which provide basic information about various vaccinations,  
are available in multiple translations ([www.health.state.mn.us/immunize](http://www.health.state.mn.us/immunize))

National Medical Association, a professional association of African American physicians,  
has a packet of information available on working with communities ([www.nmanet.org](http://www.nmanet.org))

### **MDH Contact**

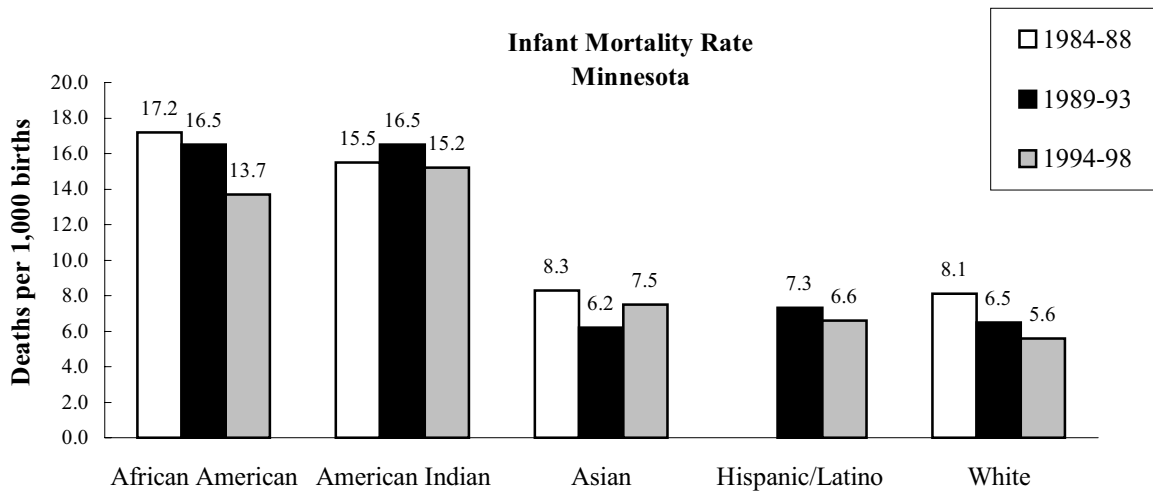
For more information about immunizations for adults and children, contact:

Margo Roddy  
612/676-5237  
[margaret.rodny@health.state.mn.us](mailto:margaret.rodny@health.state.mn.us)

## **Eliminating Health Disparities In Infant Mortality**

### **Background**

Infant mortality is defined as the death of a live-born infant from any cause before the infant's first birthday. Infant deaths are usually expressed as rates that represent the number of infant deaths per 1000 live births. Infant mortality rates (IMRs) are an important indicator of the health and well-being of families and communities. Minnesota's IMR in 1999 was 6.2 infant deaths per 1000 live births, representing an increase of 5.1 percent from the 1998 rate of 5.9 deaths. Although Minnesota has one of the lowest state rates in the nation, this overall state rate masks severe and longstanding disparities in infant mortality experienced by some of Minnesota's populations.



Some disturbing trends are revealed in the above graph. American Indian infant deaths have been rising over time. In fact, the National Center for Health Statistics and the Bemidji Indian Health Service have reported that Minnesota's Indian infant death rate is the highest in the U.S.

African American infant deaths, although improving over time, remain significantly higher than those of white infants.

Asian infant deaths are also rising in the most recent time period measured.

The populations experiencing this and other health disparities have many strengths and traditions to draw upon for solutions. In the African American community, churches provide connections and leadership on community issues. For American Indians, restoring cultural traditions such as native foods, cradle boards, and sacred use of tobacco could improve infant health. Hispanic/Latino and Asian communities have similar traditions around family, nutrition, and healing practices that could be strengthened to promote healthy pregnancy, birth, and infancy. All four populations have media connections and community advocacy groups to mobilize their respective communities on important issues.

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### Contributing Factors

Infant mortality is a summary statistic reflecting multiple conditions and causes. Poverty, poor housing, less education, no health care insurance coverage prior to pregnancy, racism and chronic race-related stress, and the absence of social support networks including a caring partner all are associated with increased rates of infant mortality.

**Access to health care.** Preconception care, access to primary preventive health care including family planning services, and medical care for acute and chronic disease conditions are essential health care components needed to promote women's health and healthy infants. Populations of color and American Indians suffer from higher rates of poverty than whites. With less economic security, they are less likely to have continuous health insurance, and, consequently, have less access to essential preventive, acute, and chronic health care services.

**Primary causes.** The primary causes of infant mortality in Minnesota vary by race. Pre-term births and low-birth-weight babies (weighing less than 5½ pounds at birth) are the number one cause of infant mortality among African Americans; Sudden Infant Death Syndrome (SIDS) is the number one cause of infant death in the American Indian population; among Asian, Hispanic/Latino, and white populations in Minnesota, birth defects (congenital anomalies) are the number one cause of infant death.

**Babies born too soon or too small.** With regard to pre-term delivery (PTD) and low-birth-weight (LBW) infants, the question remains as to what is the best approach to reducing their incidence. We can say that neither PTD nor LBW are only a function of medical problems occurring prior to or during pregnancy; they are also a function of social and environmental factors that impact a woman's health, her behaviors, and her access to preventive services and health care.

**Stress.** Recent research has documented the contribution that stress has on low birth weight and pre-term birth. African American babies' deaths occur in the first few weeks or months of life because they are born too early and too small. There are multiple sources of stress for women of color and American Indian women that differ from stress experienced by white women. "These sources of stress include ways in which gender inequity, racial discrimination, and class inequality impose limitations on access to health care and, perhaps more important, on secure jobs, adequate housing, good nutrition, adequate child care, a safe and healthy environment, and necessary social services --- all of which are necessary for good health." (Mullings, 2001)

**Smoking.** Smoking is the most powerful known determinant of low birth weight. Smoking during pregnancy triples the risk that an infant will die of SIDS. Infants exposed to environmental tobacco smoke are also more likely to die of SIDS and are more likely to suffer from respiratory illnesses such as ear infections, bronchitis and pneumonia. American Indian infants tend to die later than the first month of life from causes such as SIDS, birth defects, and infections. Minnesota's American Indian mothers have higher rates of smoking during pregnancy than whites. While fewer African American women who are pregnant

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smoke, those that do smoke experience a greater negative impact on their babies (higher rates of low birth weight and pre-term birth). African American babies also have higher rates of SIDS than do white infants.

**Prenatal care.** High quality prenatal care begun early in pregnancy is essential to promote and maintain the health of both mother and infant and prepare for a healthy birth. Populations of color and American Indian women in Minnesota have lower rates of obtaining prenatal care early and receiving an adequate number of prenatal care visits than white women.

**Birth defects.** Congenital anomalies or birth defects account for the greatest number of infant deaths for Asian, Hispanic/Latino, and white babies. Undiagnosed and/or uncontrolled diabetes will contribute to birth defects such as cardiac abnormalities that can lead to infant deaths. American Indians, Hispanic/Latinas, Asians, and African Americans all have higher rates of diabetes than whites.

**Folic acid.** Taking a supplement known as folic acid or folate before pregnancy and continued through the early weeks of pregnancy, can reduce neural tube defects (NTDs) by up to 70 percent. Annually in the U.S., 2500 babies are born with NTDs and many additional pregnancies are miscarried or result in stillbirths because of NTDs. If defects are severe, many of these babies will die. Again, women who do not have access to preconception care and family planning services are unlikely to begin folic acid therapy on their own before pregnancy occurs and will not benefit from this simple, safe, and economical preventive measure.

**Births to teens.** In Minnesota, a disproportionate number of infants born to teens die before their first birthday. Many of these deaths occur because of social conditions faced by these very young parents, especially when they find themselves trying to raise two or more children before the age of twenty.

### **Strategies For Intervention**

Infant mortality is a summary statistic reflecting multiple conditions and causes. Strategies must address the range of specific causes as well as the many social conditions that give rise to them. The following strategies may be included in proposals to eliminate health disparities in infant mortality, but other strategies not listed here may also be included. Strategies that promote, restore, or strengthen cultural or traditional health practices to promote women and infants' health, safety, and well-being are encouraged.

**Back to sleep.** Infants who sleep prone—on their tummies—are at much higher risk for SIDS. Since this risk factor was identified, the Back To Sleep campaign was implemented nationwide to teach parents this important risk reduction technique. The campaign has been credited for a greater than 40 percent decline in SIDS both nationally and in Minnesota. However, Back To Sleep has not been widely accepted in the African American population primarily because of the way it was implemented. New materials that explain Back To Sleep and address the concerns of the whole African American community—rather than just new

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parents—are now available. Strategies to deliver this message as well as messages about other safe infant sleep practices to the community should be considered by applicants.

**Smoking cessation and reduction.** Quitting or reducing smoking during pregnancy has been shown to increase infant birth weight and sustaining cessation after delivery would improve the health of women, infants, and other family members. Smoking during pregnancy also triples the risk that an infant will die of SIDS. Smoking cessation initiatives for pregnant women would save \$2 to \$3 for each dollar spent on smoking cessation intervention. Effective interventions have been implemented in other communities across the nation and could be implemented in Minnesota. Examples are the *Five A's* program (Ask, Assess, Advise, Assist, Arrange) and/or *Make Yours a Fresh Start Family* from the American Cancer Society.

**Social support through home visiting programs.** Social support provided through home visits to pregnant women by trained, racially/ethnically-matched paraprofessionals has been found to improve birth outcomes, including infant mortality, low birth weight and pre-term labor. In addition, these programs have been successful in assisting African American pregnant teens and other ethnic/minority groups to access and participate in early and on-going prenatal services by reducing personal and system/structural barriers and other factors that hinder access to needed prenatal services. The strength of paraprofessional home visiting programs is their impact on enhancing young women's ability to improve their own health. The paraprofessional provides needed social support to women whose lives are compounded by multiple and complex problems.

Home visiting programs using public health nurses and trained community health workers have also demonstrated a positive impact on birth outcomes. Barnes-Boyd, et al in their 1996 publication, reported that repeated home visits by a trained nurse-community worker team with on-going infant health monitoring plus individualized and culturally-sensitive teaching, helped mothers maintain good health practices, identify illnesses early, and decrease post neonatal mortality rates in the study group.

Although not traditionally thought of as a home visitor, doula, as women of the community, provide a similar service to young women and their new babies. Doula program evaluation has documented significant reduction in the use of pitocin, epidurals, forceps, and cesarean sections during labor and birth as well as increases in the confidence, sense of control, and self-esteem of the mother. Doulas also significantly reduced the stress level of the mother and the neonatal problems for the infant. Augmenting the role of the doula as a home visitor and health educator enhances potential to affect the health behaviors of young women and the health of their babies.

**Avoiding drugs and alcohol.** Drug and alcohol abuse impact pregnancy and the infant by increasing rates of pre-term birth and low birth weight, intrauterine growth retardation, and fetal alcohol syndrome, and may contribute to overlay deaths and other infant injuries, including injuries as a result of abuse and neglect. Screening by asking women sensitive questions at regular intervals and referral for needed services are effective techniques to address these issues.

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**Breastfeeding is best.** It is well established that breastfeeding is the healthiest way for a newborn child to get the best nutrition possible, and breastfed babies have fewer infections and colds, higher I.Q.s, and less incidence of diabetes and childhood obesity than babies that are not breastfed. In addition, breastfeeding can enhance maternal-infant attachment. A recent study (Forste, 2001) documented the impact of not breastfeeding on infant mortality rates among African American women. The results of this study indicate that breastfeeding accounts for the difference in infant mortality in the U.S. between African Americans and whites at least as well as low birth weight. Thus, increasing breastfeeding rates could have a measurable effect on infant mortality, especially in the African American population.

**Health education to reduce infant mortality.** Targeted and community-wide education addressing nutrition, breastfeeding, sexually transmitted disease, parenting, and family planning can work to reduce infant mortality.

**Folic acid.** Folic acid taken before conception and during pregnancy could reduce the rate of babies born with neural tube defects by 70 percent. These birth defects of the brain and spinal cord occur in about 2,500 babies annually in the U.S. resulting in infant deaths and paralysis. Insufficient maternal folic acid has also been associated with other birth defects, stillbirths, and miscarriages. A March of Dimes education campaign to promote the use of folic acid has been implemented nationally and in Minnesota. The key to success with this intervention is to get the message to women before they become pregnant.

**Prenatal care.** Early and continuous prenatal care that includes assessment, education, and intervention for medical, social, and behavioral risks is an important component of a healthy pregnancy. Necessary components of good prenatal care include : monitoring and treating infections that can cause pre-term delivery, monitoring weight gain and blood pressure; and counseling about nutrition, stress, and reducing behavioral risks such as alcohol, tobacco, and drug use. Prenatal care with case management to assure needed services (medical and psycho-social) are identified, intervention planned, services delivered, and follow-up accomplished will better meet the needs of pregnant women, their newborns, and families.

**Family planning, preconception counseling and primary health care.** Community interventions that have a positive effect on planned pregnancies, preconception counseling, and continuous health care coverage are all associated with better health and lower infant mortality rates. Especially important are programs that help teens delay additional pregnancies until they have achieved their own educational and vocational goals and are well prepared to raise and support healthy children.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in infant mortality rates of American Indians and populations of color as compared to whites. Examples of possible local project outcomes include:

More planned pregnancies.

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More adult/teen women initiating care early in pregnancy and continuing care throughout pregnancy.

More adult/teen women with adequate social support during pregnancy, labor and birth, and during infancy.

More adult/teen women/infants enrolled in WIC.

More adult/teen women receiving appropriate case management during pregnancy and the first year of their child's life.

More health education materials distributed in communities of color and among American Indians.

Greater awareness of the community's role in reducing infant mortality.

More new mothers breastfeeding and continuing to breastfeed during the first year of life.

Fewer adult/teen women and fewer pregnant women who smoke.

Fewer pregnant women using alcohol and/or other drugs during pregnancy.

More adult/teen women screened and treated before pregnancy for acute or chronic disease, including STDs/HIV, hypertension, diabetes, etc.

More adult/teen women enrolled in early intervention programs prior to or early in pregnancy.

More babies sleeping on their backs.

More adult/teen women taking folic acid prior to and during early months of pregnancy.

Fewer uninsured women and children.

### **Resources**

#### **Local resources**

REACH Planning Reports from the African American and American Indian Work Groups, Hennepin and Ramsey Counties, addressing infant mortality issues in their populations. Available from MDH contacts or ([www.health.state.mn.us/communityeng/multicultural/resources](http://www.health.state.mn.us/communityeng/multicultural/resources))

SIDS information, Minnesota SID Center, Kathleen Fernbach, Director 612/813-6285.

Doula information and resources. Available from MDH contacts.

Qualitative Reports on pregnancy and infancy from African American and American Indian women in the Twin Cities Healthy Start Program. Available from MDH contacts.

A Community Review Project To Decrease Fetal/Infant Deaths, Veronica Sterling, St. Louis County Public Health Division, Duluth, MN, (218) 725-5277

Lowering Infant Deaths: Promoting Change to Save Lives, Minneapolis Dept. of Health & Family Support & St. Paul – Ramsey Co. Public Health. Available from MDH contacts.

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### Websites

Centers for Disease Control and Prevention, Infant Mortality  
([www.cdc.gov/nccdphp/drh/ih\\_idmort.htm](http://www.cdc.gov/nccdphp/drh/ih_idmort.htm))

National SIDS Resource Center ([www.sidscenter.org](http://www.sidscenter.org))

National Healthy Start Association ([www.healthystartassoc.org](http://www.healthystartassoc.org))

March of Dimes Resource Center ([www.modimes.org](http://www.modimes.org))

Annie E. Casey Foundation ([www.aecf.org](http://www.aecf.org))

### References

American Academy of Pediatrics Task Force on Infant Sleep Position and Sudden Infant Death Syndrome. Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position. March, 2000. *Pediatrics* 105 (3) pp. 650-656.

Centers for Disease Control and Prevention. Recommendations for the Use of Folic Acid to Reduce the Number of Cases of Spina Bifida and Other Neural Tube Defects. *Morbidity and Mortality Weekly Report*. 41(RR-14). September 11, 1992.

Lightwood, JM et al. Short-term Health and Economic Benefits of Smoking Cessation: Low Birth Weight. December, 1999. *Pediatrics* 104(6) pp. 1312-1320.

Wisborg, K et al. A Prospective Study of Smoking During Pregnancy and SIDS. *Archives of Diseases in Childhood* 2000. 83. pp. 203-206.

Windsor, RA et al. Effectiveness of Agency for Health Care Policy and Research Clinical Practice Guideline and Patient Education Methods for Pregnant Smokers in Medicaid Maternity Care. 2000. *Am J OB/GYN*. 182(1) pp. 68-75.

Moore, LL et al. A Prospective Study of the Risk of Congenital Defects Associated with Maternal Obesity and Diabetes Mellitus. November, 2000. *Epidemiology* 11(6) pp. 689-694.

Rogers, M et al. Impact of a Social Support Program on Teenage Prenatal Care Use and Pregnancy Outcomes. *Journal of Adolescent Health*, 1996. 19: 132-140.

Mullings, L et al. Qualitative Methodologies and Community Participation in Examining Reproductive Experiences: The Harlem Birthright Project. *Mat. & Child Health Journal* 2001. Vol. 5 #2: 85-94.

Forste, R et al. The Decision to Breastfeed in the United States: Does Race Matter? *Pediatrics* 2001. Vol. 108 #1:291-296.

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Barnes-Boyd, C et al. Promoting Infant Health Through Home Visiting by a Nurse-Managed Community Worker Team. Public Health Nursing 2001. Vol. 18 #4: 225-235.

**MDH Contacts**

For more information about infant mortality, contact:

Cheryl Fogarty  
651/281-9947  
cheryl.fogarty@health.state.mn.us

For more information about perinatal and women's health, contact:

Mary Rossi  
651/281-9941  
mary.rossi@health.state.mn.us

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**Eliminating Health Disparities In Teen Pregnancy Prevention**

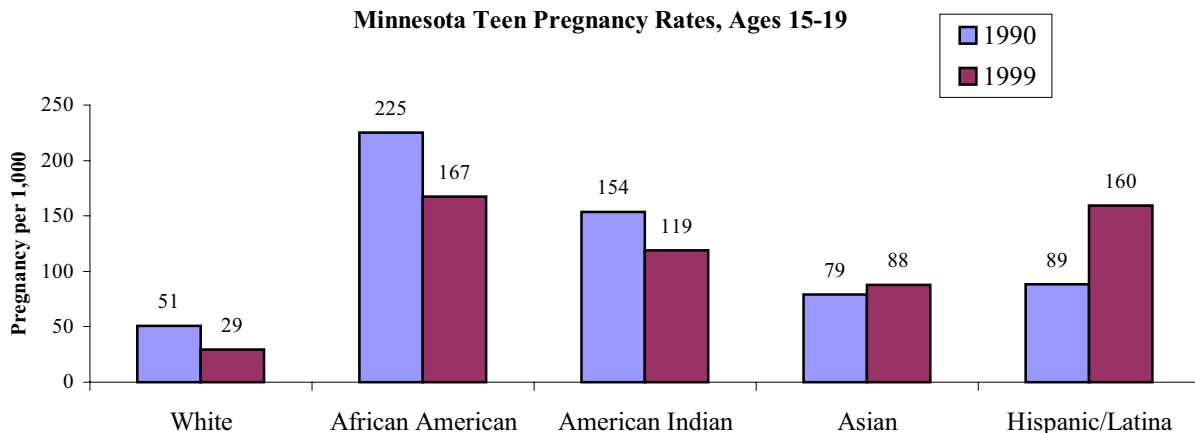
**Background**

Every day in Minnesota, more than 20 teens become pregnant and the vast majority of these pregnancies are unintended. Teen girls who become parents are less likely to graduate from high school and more likely to be single parents, live in poverty, have experienced sexual abuse, and depend on welfare programs, than women who wait to give birth beyond their teen years. Their infants are more likely to die before their first birthday than infants of adult women. Children of adolescent parents have poorer health outcomes, lower cognitive development, worse educational outcomes, higher rates of behavioral problems, and higher rates of teen childbearing themselves.

Nationally, half of all initial adolescent pregnancies occur within the first six months following the initiation of intercourse, and 20 percent occur within the first month. Thirty-nine percent of adolescents who never practice contraception become pregnant within six months. A sexually active teenager who does not use a contraceptive has, over the course of a year, an 89 percent chance of becoming pregnant.

It is estimated that 80 percent of all adolescent mothers will at sometime receive government assistance during the 10 years following the birth of their first child. Data from the Minnesota Department of Human Services indicates that approximately 48 percent of Minnesota families who received MFIP (Minnesota Family Investment Program) in December 1999 began with a teen birth. Decreasing teen pregnancy is one of the most significant steps we can take to increase self-sufficiency.

Minnesota has wide and unacceptable disparities in the rates of teen pregnancy across its population (see below). While Minnesota’s teen pregnancy rate among whites is one of the lowest in the nation, the rates among African American and Hispanic/Latina teens are first and second respectively. While teen pregnancy rates among many Minnesota populations are decreasing, there is an alarming increase in pregnancy rates for Asian and Hispanic/Latina teens.



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Funds for the teen pregnancy prevention grants included in this Request for Proposals come from the federal Temporary Assistance for Needy Families (TANF) program. TANF provides significant flexibility to states in designing and funding strategies to support TANF purposes and allows funding to serve not only families on welfare but also families who may be at risk for needing welfare assistance in the future. The four federal TANF purposes are:

- to provide assistance to needy families so that children may be cared for in their homes or in the homes of relatives;
- to end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
- to prevent and reduce the incidence of out-of-wedlock pregnancies; and
- to encourage the formation of two-parent families.

The focus of these grants is on the third federal purpose of TANF: the prevention and reduction in the incidence of out-of-wedlock pregnancies. In Minnesota, over 85 percent of teen pregnancies are to unwed mothers. Preventing teen pregnancy reduces infant mortality, child poverty, and out-of-wedlock childbearing and is an effective way to improve overall child and family well-being.

### Contributing Factors

The reasons teens become pregnant are complex and varied. While all teens are at risk, some teens are at increased risk for early sexual activity, poor contraceptive use, and pregnancy. Knowing what factors put some youth at increased risk for teen pregnancy and what factors appear to be protective allows communities to target activities that can guide the development of effective programs. While no program can address all contributing factors, effective programs focus efforts on more than one factor. The following table identifies some of the risk and protective factors related to the family, the individual and the community. The recently published document *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* has a more comprehensive list of contributing factors to adolescent sexual behavior, use of contraception, pregnancy and childbearing and is an excellent resource for planning teen pregnancy prevention efforts. (See resource section).

Contributing Factors	Risk Factors	Protective Factors
Family Factors	Living with a single parent Having an older sibling who became pregnant Disconnected from family with little parental monitoring of activities and poor child/parent communication Mother who had sex and first birth early	Living with biological parents Close, warm parent-child relationship High parental income High parental educational attainment Appropriate parental supervision and monitoring Positive parental attitudes about contraception

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<b>Contributing Factors</b>	<b>Risk Factors</b>	<b>Protective Factors</b>
	Intergenerational dependency on welfare	Conservative parental attitudes about premarital or teen sex
Individual Factors	Tobacco, alcohol or drug use Problem behavior or delinquency Depression Early and frequent dating Experienced sexual abuse Having a partner three or more years older Running away from home School dropout	Good school performance Plans for the future Perceived susceptibility to pregnancy, STDs/HIV Greater knowledge about contraception Greater participation in sports Positive self-concept Greater perceived negative consequences of pregnancy
Community Factors	High unemployment rate High crime rate High rate of residential turn over High percent of full-time working females Higher teen non-marital birth rate	High level of education High income level Higher percent foreign born individuals Higher percent religious adherents Greater community monitoring by adults in the community

**Strategies For Intervention**

There is no simple solution or single approach to the complex issue of teen pregnancies. Ultimately we would like to enhance the factors that protect youth from an unplanned pregnancy while decreasing the risk factors that make it more likely that they will become pregnant. Teen pregnancy prevention projects: 1) can be evidence based, replicating an existing program that has been shown to be effective with similar populations of teens; 2) can choose to select or design programs with similar strategies of promising programs that have been effective with similar populations of teens; or 3) can design new innovative approaches to the problem that can be expected to affect particular behaviors by teens.

To enhance the chances of success, teen pregnancy prevention efforts should:

- Address the risk and/or protective factors contributing to teen pregnancy;
- Involve youth and their parents/caregivers in the development and implementation of the project;
- Be linked to other community efforts (e.g., school, local public health, non-profit activities, etc.) that can enhance or expand project strategies;

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Coordinate with other community efforts/activities that target the same population to prevent duplicative efforts or mixed messages; and  
Build partnerships to mobilize the community to come together to address the issue of teen pregnancy prevention.

Examples of evidence-based and promising strategies:

<b>Focus Area</b>	<b>Evidence-Based and Promising Strategies</b>
<p><b>Reproductive Health</b> Effective programs share ten necessary characteristics (from <i>Emerging Answers</i>): Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD. Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. Provide information about the risks of teen sexual activity and ways to avoid intercourse or use methods of protection. Include activities that address social pressures. Provide examples and practice with refusal skills, communication, and negotiation. Employ teaching methods designed to involve participants. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of student. Last a sufficient length of time. Select teachers or peer leaders who believe in the program and provide them adequate training.</p>	<p>Implement evidence-based curricula identified by CDC as programs that work. These include: <i>Reducing the Risk</i> <i>Safer Choices</i> <i>Becoming a Responsible Teen</i> <i>Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention; and</i> <i>Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention.</i></p> <p>Abstinence focused curriculum such as: <i>Postponing Sexual Involvement;</i> <i>Managing Pressures</i> (formerly known as <i>PSI Corollary</i>); <i>Abstinence Curriculum;</i> <i>Worth the Wait Program;</i> and <i>Removing the Risk</i></p> <p>As an adjunct to teacher-led instruction, train and support peer educators/leaders who can role model social skills and lead role-plays.</p> <p>Implement educational programs to improve parent/child communication about healthy sexuality such as <i>Can We Talk?</i> or the Spanish version <i>Conversamos</i>.</p> <p>Implement programs designed to improve access and/or correct use of condoms or other contraceptives for sexually active adolescents.</p> <p>Implement programs to address emotional, legal, financial etc. responsibilities of paternity. Programs to promote abstinence or sexual responsibility or to increase involvement of young fathers in their children’s lives. An example would be <i>Dads Make a Difference</i>.</p> <p>Provide training to health care workers and others who work with adolescents on how to talk to youth about reproductive health issues.</p> <p>Implement a multi-faceted program such as <i>MN ENABL Program</i>, which uses a focused curriculum; has community-organizing activities; and is supported by media efforts.</p>

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<b>Focus Area</b>	<b>Evidence-Based and Promising Strategies</b>
<p><b>Youth Development Programs for Adolescents</b></p> <p>Effectiveness of youth development programs can be enhanced if sexuality education is included or programs are linked to community/school reproductive health education.</p> <p>Essential elements of an effective youth development program include (from the National Youth Development Information Center):</p> <ul style="list-style-type: none"> <li>A comprehensive strategy with clear mission and goals.</li> <li>Committed, caring, professional leadership.</li> <li>Youth-centered activities in youth accessible facilities.</li> <li>Culturally competent and diverse programs.</li> <li>Youth ownership and involvement.</li> <li>A positive focus including all youth.</li> </ul>	<p>Implement effective Service Learning Programs such as <i>I Have A Future</i>, <i>Reach for Health Community Youth Service Learning</i>, and <i>Learn and Serve</i>.</p> <p><i>Teen Outreach Program</i> (TOP) and the Spanish version <i>Cambios</i> are youth development programs combining life skills and sexuality education with involvement in community service.</p> <p>Provide assistance with academic subjects/homework beyond regular classes that will lead to school success.</p> <p>Provide mentoring opportunities – one-on-one regular contact for an extended period of time with trained adult for recreation and skill/relationship building.</p> <p>Implement programs that provide meaningful activities that enhance parent/youth communication and promote connectedness.</p> <p>Implement programs that focus on parent/caregiver education skill building and involvement with their children. Classes on sexuality, positive parenting techniques, rules, behavior management, etc. to provide parents with age-appropriate information, resources, and skills to support, nurture, and affirm their children.</p> <p>Implement after-school activities that are linked with community resources (schools, churches, synagogues, etc.) to engage youth in physical activity, technology, leadership, etc.</p> <p>Implement life skills education/training for adolescents that include skills such as communications, decision-making, and goal setting.</p> <p>Provide employment opportunities and skill development through apprenticeships with business/other employers to assist youth in learning marketable skills while experiencing work.</p> <p>Provide supervised volunteer community service opportunities/activities for youth.</p>
<p><b>Programs That Include Both Reproductive Health and Youth Development Components</b></p>	<p><i>California’s Adolescent Sibling Pregnancy Prevention Program</i> targets sisters of teen girls who became pregnant; and offers individual case management and group activities and services.</p> <p><i>Children’s Aid Society Carrera Teen Pregnancy Prevention Program</i>. This is an intensive program lasting through high school. It includes: family life and sex education; education component; a work-related intervention; self-expression through the arts; and individual sports.</p> <p><i>Girls Incorporated Preventing Adolescent Pregnancy</i> provides information and fosters skills in communication, assertiveness and refusal, contraception and STD prevention, and academic and career planning.</p>

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Focus Area	Evidence-Based and Promising Strategies
Programs That Prevent or Delay Second Teen Pregnancies	<p>Implement a program that provides opportunities to meet with other pregnant or parenting teens to develop problem-solving skills, sense of uniqueness, personal power, etc.</p> <p>Provide case management services to coordinate the variety of services that pregnant or parenting teens need and to work with teen mothers to prevent subsequent pregnancies, encourage school completion, and strengthen parenting skills.</p> <p><i>A Health Care Program for First-Time Adolescent Mothers</i> uses a medical and counseling approach.</p>

\* Information on ordering curricula can be found at ([www.health.state.mn.us/divs/fh/chp/yrbplan.htm](http://www.health.state.mn.us/divs/fh/chp/yrbplan.htm))

**Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in teen pregnancy rates of American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

**Outcomes related to decreasing risk factors:**

- Decrease the percentage of youth who drop out of school.
- Decrease the percentage of youth who skip school.
- Decrease the percentage of youth who cannot talk to their parents/caregivers about their problems.
- Decrease the percentage of youth who run away from home.
- Decrease the percentage of youth who use tobacco, alcohol, or other drugs.

**Outcomes related to promoting or strengthening protective factors:**

- Increase the percentage of youth that have goals/plans after high school graduation.
- Increase the percentage of youth who feel they can talk about problems with their parents/caregivers.
- Improved school performance.
- Increase the percentage of students who report feeling good about themselves.
- Increase the percentage of parents/caregivers who appropriately monitor their children's activities.

**Outcomes related to sexual behaviors:**

- Increase the percentage of youth who are abstinent.
- Increase the percentage of sexually active youth who report that they always use birth control.
- Increase the percentage of sexually active youth who correctly use contraception methods.
- Reduce the percent of subsequent births to teens.
- Increase birth spacing to 24 months.

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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### **Resources**

The following resources provide excellent information on contributing factors and on effective strategies to reduce teen pregnancies:

- Centers for Disease Prevention and Control, Programs That Work  
([www.cdc.gov/nccdphp/dash/rtc](http://www.cdc.gov/nccdphp/dash/rtc))
- Centers for Disease Prevention and Control, Unintended Pregnancy  
([www.cdc.gov/nccdphp/drh/up.htm](http://www.cdc.gov/nccdphp/drh/up.htm))
- The U.S. Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior, June 2001 ([www.surgeongeneral.gov/library/sexualhealth/call/htm](http://www.surgeongeneral.gov/library/sexualhealth/call/htm))
- Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, Douglas Kirby, Ph.D., May 2001 ([www.teenpregnancy.org](http://www.teenpregnancy.org))
- Teen Pregnancy and Childbearing In Minnesota Fact Sheet  
([www.teenpregnancy.org/usa/mn.htm](http://www.teenpregnancy.org/usa/mn.htm))
- Communities Responding to the Challenge of Adolescent Pregnancy Prevention: "Linking Pregnancy Prevention to Youth Development." Volume V. Advocates for Youth, Washington, D.C. 1998. ([www.advocatesforyouth.org](http://www.advocatesforyouth.org))
- Adolescent Health Status. Population Health Assessment Quarterly, Volume 1, Issue 4, Special Issue 2000, Center for Health Statistics, Minnesota Department of Health.  
([www.health.state.mn.us/divs/chs/data/popassess.htm](http://www.health.state.mn.us/divs/chs/data/popassess.htm))
- Kirby, D. (2000) Logic models: A useful tool for designing, strengthening, and evaluating programs to reduce teen pregnancy. Santa Cruz, AA: ETR Associates.
- Get Organized: A Guide to Preventing Teen Pregnancy, National Campaign To Prevent Teen Pregnancy. ([www.teenpregnancy.org](http://www.teenpregnancy.org))
- Blum, R.W., Beuhring, T., Rinehart, P.M., (2000) Protecting Teens: Beyond Race, Income and Family Structure, University of Minnesota, 200 Oak Street SE, Suite 260, Minneapolis, MN.
- Minnesota Department of Health, Youth Risk Behaviors,  
([www.health.state.mn.us/divs/fh/chp/yrbplan.htm](http://www.health.state.mn.us/divs/fh/chp/yrbplan.htm))

### **MDH Contact**

For more information about teen pregnancy prevention, contact:

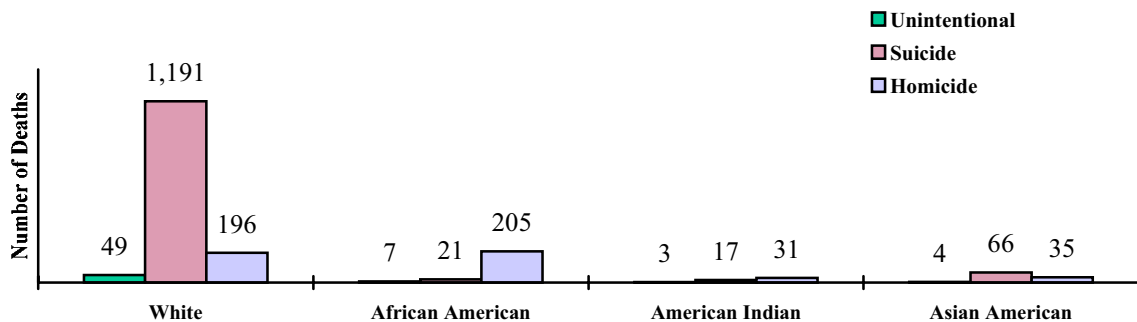
Jill Briggs  
651/281-9781  
[jill.briggs@health.state.mn.us](mailto:jill.briggs@health.state.mn.us)

## Eliminating Health Disparities In Violence and Unintentional Injuries

### Background

Injuries are a substantial burden on our communities, resulting in lost time from work and school and in long-term disability. The burden of injury and violence in Minnesota is not shared equally. American Indian males aged 18 and 19 have suicide rates six times higher than in any other age or population group. African American youth aged 15 - 24 have firearm injury (FRI) mortality rates eight times greater than for all males 15 - 24 in Minnesota, and 15 times greater than the rates for all ages, races and genders combined. African Americans and American Indians in Minnesota have rates of Traumatic Brain Injury (TBI) more than four times higher than among the rest of the population. African American, American Indian, and Hispanic/Latino children have rates of child maltreatment five, three and two times greater, respectively, than Asian/Pacific Islander and white children in Minnesota. African American, American Indian and Hispanic/Latino sixth to twelfth grade students report sexual abuse more often than white or Asian youth. All minority groups in Minnesota report higher rates of intra-familial abuse compared to white Minnesotans.

### Number of Firearm Related Deaths 1992-1996

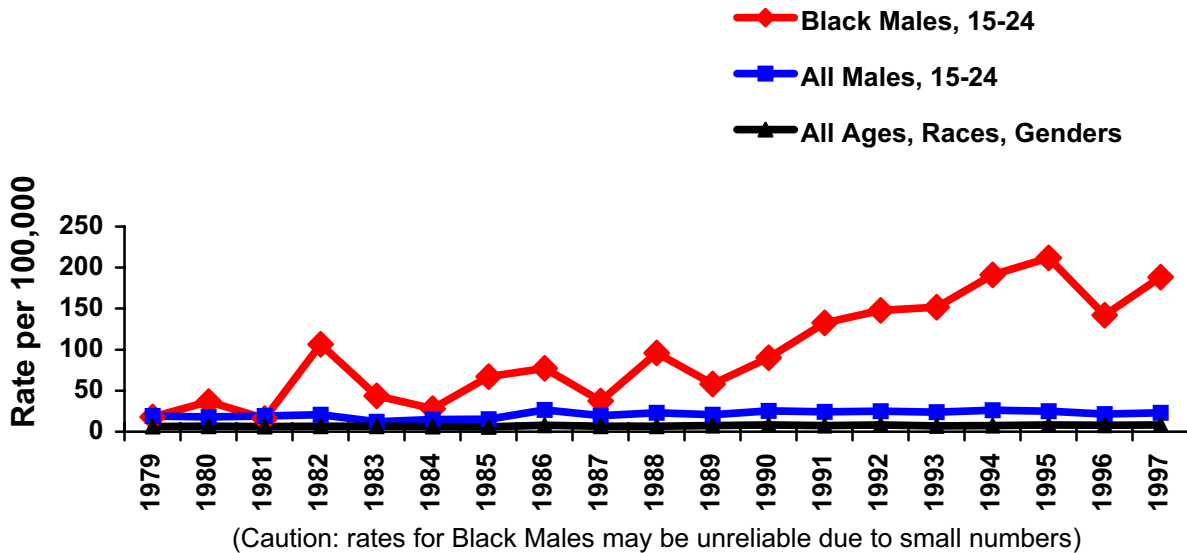


Other important disparities also exist in Minnesota. Women experience more non-fatal injuries than men. Self-inflicted poisonings are the leading cause of hospitalization for women aged 10 - 39. Men sustain more fatal injuries than women. All Minnesotans have fall death rates one and one-half times higher than the U.S. fall death rates. Among the elderly, fall death rates are more than three times greater. Childhood TBI mortality rates are twice as high in non-metro Minnesota than in metropolitan Minnesota. Minnesota's poor (median household income less than \$20,000 per year) are injured at twice the rate of all others. And this group sustains assault-related injuries at more than five times the rate of all others.

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**Minnesota Firearm Related Mortality**



**Contributing Factors**

Known contributing modifiable factors for injury and violence include:

- Poverty,
- Unsupervised access to firearms and inadequately stored firearms,
- High rates of depression and hopelessness,
- Alcohol,
- Home hazards,
- Inadequate fall-prevention education, and
- Policies and programs that do not adequately support parents and families.

**Strategies For Intervention**

The following strategies may be included in proposals to eliminate health disparities in unintentional injury and violence, but other strategies not listed here may also be included. Community-driven and directed prevention programs and policies are the most effective way to address the disparity between those enjoying good health and those most affected by injury and violence.

Based upon the evidence to date, effective or promising strategies include:

- Strengthen asset-based parenting training and family support systems. This should occur when community and faith-based initiatives partner to support community and culturally specific appropriate interventions and activities at the family and community level.

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Provide parenting education and youth mentorship programs.

Provide for the safe storage of and limited access to firearms and ammunition.

Provide broader availability of mental health services.

Provide fall prevention programs for people of all ages including home safety, exercise, and medication management.

Implement home safety programs using the Home Safety Checklist, which includes smoke alarm distribution and installation, fire safety training, and home hazard amelioration.

Promote regular exercise (walk for 30 minutes each day) and support appropriate nutrition.

Modify the environment to support community walking and other exercise programs (for example, install street or parking lot lighting; this will reduce risk of falls and will enhance safety).

Encourage bicycling.

Implement school-based and workplace non-violent conflict resolution and bullying prevention policies and training.

Promote increased use of seat belts.

Support legislation to lower the blood alcohol content level for legal driving to 0.08 or 0.06.

Reduce community acceptance of alcohol use in general, alcohol use by women of childbearing age, and access to and use of alcohol by minors.

Support and promote smoking cessation programs at the community level. This will reduce the risk of house fires, burn injuries, and deaths.

Ensure access to information about sexual abuse for children, youth, parents, and other adults.

### **Anticipated Outcomes**

The overall goal of this initiative is to reduce the disparities in violence and unintentional injuries in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

- An increase in community and family assets.
- Fewer cases of suspected and confirmed child neglect and maltreatment.
- Fewer cases of sexual violence.
- Fewer firearm-related injuries (unintentional, self-inflicted, and assaultive).
- Fewer suicides and suicide attempts.
- An increase in seatbelt use and a decrease in injuries associated with motor vehicle crashes.
- Fewer alcohol-related motor vehicle crashes.
- Fewer house fires and a decrease in injuries and deaths associated with such fires.
- A decrease in fall injuries, especially those occurring in the home.

### **Resources**

Youth Violence: A Report of the Surgeon General  
(<http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec3.html>)

Thornton TN, Craft CA, Dahlberg LL, Lynch BS, Baer K. Best Practices of Youth Violence Prevention: A Sourcebook for Community Action. Atlanta: Centers for Disease Control and

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Prevention, National Center for Injury Prevention and Control, 2000.

Risks and Realities of Violence in Bloomington, Bloomington Advisory Board of Health, 1996.

Violence-free Minnesota. 1994 Report to the Minnesota Legislature, Office of Drug Policy and Violence Prevention, Minnesota Department of Public Safety.

The Future of Children: Unintentional Injuries in Childhood. The David and Lucille Packard Foundation, Volume 10 (1): spring/summer 2000.

Thompson NJ, McClintock HO. Demonstrating Your Program's Worth: A Primer on Evaluation for Programs to Prevent Unintentional Injury. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1998.

For youth violence prevention: ([www.colorado.edu/cspv/blueprints](http://www.colorado.edu/cspv/blueprints))

For violence against women: (<http://www.ojp.usdoj.gov/vawo/>)

A Community Checklist: Important Steps to End Violence Against Women. Call the US Department of Justice at 202/616-8894.

For sexual violence prevention: ([www.health.state.mn.us/svprevent](http://www.health.state.mn.us/svprevent))

Preventing Sexual Assault in Colorado: Multidisciplinary Strategies. Colorado Department of Public Health and Environment, Sexual Assault Prevention Advisory Committee; 303/782-0095.

For Injury and Violence data (<http://www.health.state.mn.us/divs/fh/chp/injury.htm>) or 651/281-9857

Raising Responsible and Resourceful Youth, Strengthening Families, Empowering Parents. Juvenile Justice, Volume VII, Number 3. Journal of the Office of Juvenile Justice and Delinquency Prevention. 202/307-5911.

Guard A. Violence and Teen Pregnancy: A Resource Guide for MCH Practitioners. Newton, MA: Children's Safety Network, Education Development Center, Inc., 1997.

### **MDH Contact**

For more information about violence and unintentional injury, contact:

Mark Kinde  
651/281-9832  
[mark.kinde@health.state.mn.us](mailto:mark.kinde@health.state.mn.us)

## **Appendix C**

# **Asset-Based Community Development**

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Asset-Based Community Development

*Be Creative, Involve Others  
Plan, Plan, Plan*

### What Is Asset-Based Community Development?

Asset-based community development (ABCD) is a strategy used to discover a community's capacities and assets and to mobilize those assets for community improvement. The information presented here is based on the work of John McKnight and John Kretzmann, co-directors of the Asset-Based Community Development Institute, Institute for Policy Research, Northwestern University. To learn more about their work you can go to their website at <http://www.northwestern.edu/IPR/abcd.html>.

The process of ABCD differs from the more traditional strategy of community needs assessment. Needs assessments typically focus attention on problems and deficiencies and negative images. The ABCD process focuses on the strengths of a community and how to bring those strengths to bear in community improvement activities. For example, a typical needs assessment starts with the questions, "What is wrong? What is the problem?" And leads to the question, "How can we fix it?" In ABCD work, we start with the question, "Where are the gifts of the individuals, local associations, and local businesses in the community?" And leads to the question, "How can our community assemble its strengths into new combinations, new structures of opportunity, new sources of income and control, and new possibilities?"

Each community boasts a unique combination of assets upon which to build its future. One can discover in every community a vast and often surprising array of individual talents and productive skills, few of which are being mobilized for community-building purposes. In many communities across the country, community builders are refocusing their attention on capacities and assets and are inventing new methods for mobilizing neighborhood residents.

### Five Steps Toward Whole Community Mobilization

The following steps do not presume to add up to a complete blueprint for broad, asset-based community development. Rather, they identify some of the major challenges and point to a potential process. They could become part of your disparities grant proposal and could be adapted to the various priority areas for this community grants program. They include:

**Step 1.** Mapping the capacities and assets of individuals, citizens' associations, and local institutions that exist and that can be marshaled in the community. This mapping can be done at the individual, organizational, or the community level. It can be used to identify who to involve, which issue(s) to work on, or after the issue is prioritized to further plan and implement activities. Mapping tools are located on the web site mentioned above.

**Step 2.** Building and strengthening partnerships among local assets for mutually beneficial problem-solving within the community. The mapping mentioned above can be used to identify and recruit potential partners in ways that are different than how we tend to

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recruit (e.g., recruit the “usual suspects” by going to the professional organizations in the community and asking for a representative). Again, this can be done at multiple levels and in the context of the different priority health areas. For example, groups have found and mobilized the capacities of individuals; the gifts of “strangers” (marginalized individuals who can be involved not as “clients” but as contributors); the existing associations and clubs; the local private, public and nonprofit institutions; the community’s physical assets (land, buildings, streets, transportation systems) and the community’s collaborative leaders who are interested in constantly expanding the numbers and kinds of people involved.

**Step 3. Mobilizing the community’s assets for economic development and information sharing purposes.** Beyond locating assets and beginning to build relationships, ABCD involves mobilizing all of the community’s assets. Each local association and institution can be urged to begin making its own set of contributions. For example, organizations can provide support (e.g., encouragement, direction, mentoring, guidance, linkages, transportation, etc.) to those who have contributions to make as part of the solutions/activities that are being implemented. The capacity to exchange information is central to the success of any community building project. So it is important to learn about all those places in the community where communication of a “public” nature takes place: churches, clubs, beauty and barber shops, even street corners. How can these be validated, strengthened and expanded?

**Step 4. Convening as broadly representative a group as possible for the purposes of building a community vision and plan.** Who are we in this community and what do we value most? Where would we like our community to go in the next five, ten, twenty years? These are simple but compelling questions that can be adapted to the work of eliminating health disparities. There are many community planning models and approaches. What works in one community will not necessarily work in another. The main ideas here are begin with assets, expand the table, and combine planning with problem-solving. Beginning with assets means starting with a thorough inventory of the capacities of individuals, associations, and institutions in the community. Expanding the table refers to making the planning process as open and participatory as possible, including participants not normally thought of as community leaders. Finally, combining planning with problem-solving means choosing practical activities that the group can start working on now, while at the same time planning longer term efforts.

**Step 5. Leveraging activities, investments and resources from outside the community.** Leveraging activities, investments, and resources from outside the community to support asset-based, locally-defined development, according to McKnight and Kretzmann, is only done when all of the steps above have begun. A community that has mobilized its internal assets offers opportunities for real partnerships, for investors who are interested in effective action and in a return on their investment.

For more information on these and other ideas see (<http://www.northwestern.edu/IPR/abcd.html>)

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### **What Are Some Practical Ideas For Implementing Asset-Based Community Development Activities In A Community?**

Listed below are examples of practical asset-based community development activities that emerged from an asset mapping project in the city of Savannah. Neighborhoods identified priority issues of crime prevention and youth development and developed projects through a small grants program. This list of activities is not exhaustive or even necessarily appropriate to the elimination of health disparities. It is offered to help jump start your own creative ideas. The Savannah activities included:

- Sponsoring community conversations on neighborhood safety issues.
- Supporting a parental-involvement workshop.
- Supporting local oral history projects.
- Holding workshops on health-related special needs.
- Finding ways to build partnerships between associations and churches.
- Using the local association mapping process to find associations that are willing to do similar projects and convening a meeting to determine how they can work together.
- Asking local business owners to become members of the neighborhood associations, valuing their unique perspective on the neighborhood, and making sure they feel that they have a role to play in community building efforts.
- Installing motion detector lights for yards and public areas.
- Holding a neighborhood anti-drug march.
- Participating in the National Night Out Festival.
- Providing after-school tutoring programs for young people.
- Offering mentoring programs for youth.
- Cleaning a vacant lot for the Soccer in the Streets Program.
- Taking young people on special interest field trips.
- Sponsoring membership in Boys and Girls Clubs.
- Promoting an Adopt-a-Grandparent Program.
- Organizing a Youth Working Together project.

## **Appendix D**

### **Contributing Factors That Cut Across Priority Health Areas**

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**Contributing Factors That Cut Across  
Priority Health Areas**

The priority health areas that are the focus of the Eliminating Health Disparities Initiative are multifactorial in nature. In other words, there are many factors that contribute to them and in some cases these factors “cut across” or contribute to more than one of the priority health areas.

As an applicant for these grant funds, you are encouraged to consider focusing your activities on one or more cross-cutting, contributing factors as a way to address your chosen priority health area(s). The table below illustrates some of those factors and indicates which priority health areas they affect (sources are cited under the title of the table).

Many of the social conditions and the asset-based activities mentioned throughout this Request for Proposals also cut across the priority health areas. Appendices C, E, F and G provide information and examples that may help you choose activities on which to focus your grant application. Those appendices are:

- Appendix C - Asset-Based Community Development Strategies
- Appendix E - Social Conditions
- Appendix F - Potential Strategies And Community Partners
- Appendix G - Community Engagement

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**Contributing Factors That Cut Across Priority Health Areas**

*[Sources: (1) Appendix B, “Priority Health Areas”, of this Request for Proposals; (2) McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993; 270:2207-12; (3) Breastfeeding: A Guide for the Medical Profession, 5th edition 1998. Ruth Lawrence, Mosby, pages 388-389, 520-521; and (4) Singhal, A, Cole, T and Lucas, A. Early nutrition in pre-term infants and later blood pressure: two cohorts after randomized trials. Lancet; 357:413-419. Feb 2001.]*

<b>Cross-Cutting Contributing Factors</b>	<b>Breast &amp; Cervical Cancer</b>	<b>Cardiovascular Disease</b>	<b>Diabetes</b>	<b>HIV/AIDS and Sexually Transmitted Infections</b>	<b>Immunizations for Adults and Children</b>	<b>Infant Mortality</b>	<b>Teenage Pregnancy Prevention</b>	<b>Unintentional Injuries and Violence</b>
Alcohol Use								
Breastfeeding		1			2			
Illegal Drug Use								
Infectious Agents								
Motor Vehicles								
Overweight and Obesity								
Physical Inactivity								
Poor Diet/Nutrition								
Sexual Behavior								
Tobacco Use								

<sup>1</sup> Breastfeeding is a factor in preventing obesity and hypertension later in life, both of which are strong contributing factors in cardiovascular disease.

<sup>2</sup> Breastfeeding does not replace immunizations. Breastfeeding does offer some additional protection for the infant or child who is breastfed and may also result in higher antibody titers after some types of immunizations.



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## Social Conditions

This appendix contains a portion of the Executive Summary of the report, *A Call To Action: Advancing Health For All Through Social and Economic Change*. The full report can be found on the internet at (<http://www.health.state.mn.us/divs/chs/hsd/schools.htm>). The findings in this report challenge us to change the way we implement health improvement efforts, examine the health impact of social and economic forces at play outside the traditional health sector, and renew attention to the roles we play as individuals and organizations in creating and perpetuating health disparities.

As you work on your application for the funds from The Eliminating Health Disparities Initiative Community Grants Program, consider focusing activity on the social conditions that affect your chosen priority health area(s) and/or the people with whom you will work on this project. The examples and ideas in this appendix are meant to stimulate your thinking and to encourage you to be creative about how you might implement them. This community grants program provides both an opportunity and a challenge to you to make a difference by developing “best practices” appropriate to the populations in your communities.

**A CALL TO ACTION:  
Advancing Health For All Through  
Social and Economic Change**

This report is a multi-disciplinary, inter-sector Call to Action produced by the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership (MHIP).

The purpose of this report is to deepen understanding of the impact that social and economic conditions have on health, and identify recommendations with potential to help create more health-enhancing social and economic environments in Minnesota.

A unique contribution of this report is its focus on social and economic change as a strategy for health improvement and as a remedy to health disparity. This report examines the importance of social interactions and policies within settings (e.g., places where we live, work, learn, worship and play) and systems (e.g., education, criminal justice, human services) outside of the health sector that have a profound impact on health.

**VISION:** All people in Minnesota have an equal opportunity to enjoy good health.

Minnesota ranks as one of the healthiest states in the nation, but mounting evidence shows that this great state of health is not shared by all – particularly American Indians, populations of color, foreign-born populations, and people with low income.

We are one Minnesota. Health disparities affect us all. Minnesota should commit to leading the nation in the health of all of its citizens, not only because this is the right thing to do, but because this will contribute to the overall health and prosperity of Minnesota.

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Health is more than not being sick. Health is a resource for everyday life – the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. Health has physical, mental, social and spiritual dimensions.

Achieving this vision is bigger than our systems of public health and health care. All individuals, systems and institutions in the community share responsibility for – and reap the rewards of – improved health.

*America's strength is rooted in its diversity. Our history bears witness to that statement. E Pluribus Unum was a good motto in the early days of our country and it is a good motto today. From the many, one. It still identifies us – because we are Americans.—Barbara Jordan, former U.S. Senator*

### **Summary Of Key Findings**

Health is a product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with collective conditions (factors in the physical, social and economic environment).

The social and economic environment is a major determinant of population health that has not been a focus of most health improvement efforts in Minnesota.

Key aspects of the social and economic environment that affect health include income, education, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation and nutritious foods; employment and working conditions; and culture, religion and ethnicity. For example:

People with a higher income generally enjoy better health and longer lives than people with a lower income. The rich are healthier than the middle class, who are in turn healthier than the poor. This is true for people of all racial and ethnic backgrounds.

Disease and death rates are higher in populations that have a greater gap in income between the rich and poor. The effect of income inequality on health is not limited to people in poor and low income groups. The health of people in middle (and in some studies upper) income groups is worse in communities with a high degree of inequality when compared to communities with less inequality. The health of a population depends not just on the size of the economic pie, but on how the pie is shared.

People are healthiest when they feel safe, supported and connected to others in their families, neighborhoods, workplaces and communities. More cohesive communities (those characterized by greater civic participation, volunteerism, trust, respect and concern for others) have lower rates of violence and death.

Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe and there are ample opportunities for control, decision-making, advancement and personal growth.

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Culture, religion and ethnicity have an overarching influence on beliefs and practices related to health, illness and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about the type of provider or healer that should be sought.

More research is needed to understand precisely how these factors affect health and health disparities, and how to translate these findings into the most promising policies and programs. Studies conducted to date point to conclusions such as:

Social and economic factors influence a broad array of opportunities, exposures, decisions and behaviors that promote or threaten health (e.g., availability of safe and convenient parks and trails encourage recreation and neighborhood connections; oppression and marginalization contribute to violence and apathy; high housing costs leave fewer resources for other necessities; transportation eases isolation; farmer's markets encourage eating fresh produce; family leave and quality child care promote attachment and positive development; cultural insensitivity alienates community members; the concentration of liquor outlets in low income neighborhoods encourages alcohol use and abuse).

Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), and chronic stress.

People of color and American Indians do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). At every level of income, their health is worse than that of their white peers.

People with low income do not experience worse health simply because of high risk personal behavior (although this is an important factor). In one recent study, health behaviors such as cigarette smoking, alcohol use, and physical inactivity explained less than 20 percent of the difference in death rates across income groups.

### **Conclusions**

Good health enables Minnesotans to lead productive and fulfilling lives, and contributes to the competitiveness, prosperity and social stability of the state.

Good health results from good systems of public health and medical care, from sound public policies that create social and economic conditions that support health, and from individual decisions and behaviors that value health. A comprehensive health improvement agenda addresses each of these determinants and recognizes the inter-relationships between them.

More supportive social and economic conditions are needed to eliminate disparities and achieve Minnesota's overall health improvement goals.

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The links between health and factors such as income, education, living and working conditions, culture, social support and community connectedness are clear. But more research is needed to understand more precisely how these factors affect health, and how to translate these findings into the most promising policies and programs.

The eight priority areas are indicators of greater disparities experienced by racial and ethnic minority groups in Minnesota. The social determinants of health play an essential role in the priority health areas targeted in this initiative. Strategies that address these underlying social and economic factors can have positive and lasting effects on the health of those groups experiencing the greatest health disparities.

### **Some Suggested Strategies**

For example, strategies could focus on:

#### **Addressing issues of unequal access to affordable, nutritious food**

Unequal access to food is a well-documented issue. Over the years, commercial pressures have led to fresh food outlets in many low-income areas being closed down. The alternative way of obtaining fresh food is to make a journey to a supermarket – often not possible by public transportation. The spread of out-of-town supermarkets aimed at car users have caused big problems for many inner city communities, who are left with corner shops that do not carry a large or varied supply of nutritious foods.

People who cannot easily get to the supermarkets are thus surviving on corner shop food, usually canned or processed, or fast food. Their diet suffers, and consequently their health also. The overall effect is to increase the inequalities in health already suffered by disadvantaged communities.\*

Examples of activities that have addressed this issue include:

Develop community centers that grow or that buy and bring in fresh fruit and vegetables, then sell the produce at cost to community members and consumers.

Provide shuttles that transport community members to shopping centers and supermarkets at convenient times.

Source: Linda Sheridan (unpublished), from The Report of HIA on the Greater London Authority draft economic development strategy; 2001.

#### **Working to improve community environments that promote physical activity and wider mental well-being and quality of life**

Unsafe, dirty environments present many barriers for community members attempting to increase their activity levels. Fear of crime keeps many people indoors, as does the lack of safe and pleasant parks and green spaces, or even usable sidewalks. Many residents from a low-income neighborhood would find it difficult, if not impossible, to afford fitness center memberships or undesirable to travel to cleaner, safer neighborhood with good facilities.

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Examples of activities that have addressed this issue include:

Increase feelings of community safety by developing working partnerships with local law enforcement, community planners, and residents to address packets of crime.

Offer free or low-cost fitness facilities, exercise classes, or outdoor recreation areas at community centers. Classes on diabetes management or parenting skills could be offered in conjunction with other health opportunities. Including young people could help them to develop healthy habits that may prevent the onset of many chronic conditions, such as diabetes, and promote self-esteem.

### **Advocate for good quality, affordable housing**

The impact of housing on health cannot be overemphasized. Enabling people to obtain a safe, secure place to live can have far reaching health implications, from the environmental effects contributing to the control of asthma to mental health and well-being. Some strategies may include:

Offer housing benefit workshops to link people with resources or programs that can help them afford housing. This can empower them to navigate the application processes. Many processes needed to receive benefits are complex and require a high level of literacy, and are barriers to access.

Foster relationships between community members and housing developers to ensure that housing meets the needs of the community, as well as future residents.

### **Promoting education, literacy, and employment**

Promoting education, literacy, and employment policy are major factors contributing to employment status. Addressing barriers to employment such as illiteracy or lack of education can open avenues of access to better housing, improved nutrition, leisure, and health care.

Examples of strategies include:

Connect elderly residents in the community with literacy programs. This has a two-pronged approach of addressing social isolation issues for the elderly, as well as offering the opportunity to learn to read to community members, which in turn can increase their ability to apply and qualify for jobs.

Develop partnerships with local employers to develop innovative recruitment practices that are culturally sensitive or accessible to marginalized populations. This could also involve strategies to improve working conditions for current employees, such as assisting in the development of workplace safety or stress management programs, or to alter workplace policies to make jobs more accessible. Policy development could include, for instance, job share opportunities for people with child care issues, assistance with child care facilities, or culturally sensitive leave and vacation policies.

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These are just a few examples of a broad approach to thinking about how we can tackle health disparities in Minnesota. Recognizing that health extends beyond indicators such as death, disease and disability is essential. Addressing factors such as mental and social well-being, quality of life, income, employment and working conditions, education and others factors known to influence health can have important, sustainable effects on health.

## **Appendix F**

### **Potential Strategies And Community Partners**

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### Potential Strategies And Community Partners

The strategy grids in this appendix provide a “menu” of strategies for the priority health areas and for the contributing factors that cut across the priority health areas (See Appendix D, “Contributing Factors That Cut Across Priority Health areas”). The strategies are listed down the left-hand side of each grid and potential community partners are listed across the top of each grid. Checkmarks appear in the intersections of the two and indicate the community partner(s) that could be involved in collaboratively implementing the strategy. Each community is unique and will need to adapt the list to its specific situation.

Because these strategy grids are taken directly from a 1999 MDH document called *Strategies for Public Health: A Compendium of Ideas, Experience and Research from Minnesota’s Public Health Professionals*, some of the strategies are different than those described in Appendix B, “Priority Health Areas” of this Request For Proposals. They represent a broader range of strategies than may be fundable for this community grants program. To see if they are eligible to be funded through this community grants program, call the contact person for your chosen priority health area(s).

The grids in this appendix include strategies on the following topics:

- Alcohol and other drug use
- Early detection of cancer (breast and cervical cancer)
- Heart disease, heart attack and stroke (cardiovascular disease)
- Diabetes
- STD/HIV/AIDS
- Vaccine preventable diseases (immunization for adults and children)
- Infant mortality
- Nutrition
- Physical activity/inactivity
- Tobacco use
- Teenage pregnancy prevention (unintended pregnancies, parenting and youth development)
- Unintentional injuries (home hazard injury, residential fire-related injury)
- Violence (bias-motivated assaults; child maltreatment, including children with special health needs; domestic and intimate partner violence; maltreatment of vulnerable adults and the elderly; sexual violence; youth violence; suicide)

Detailed descriptions of the strategies on these grids, and information about additional strategies can be obtained from the original document, which can be found at (<http://www.health.state.mn.us/divs/chs/hsd/strategies.htm>)

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: **ALCOHOL, TOBACCO AND OTHER DRUGS**

**Problem: Alcohol and other drug use**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Reduce alcohol and other drug-related problems by examining the community norms and practices of their use, as well as their accessibility to youth	8			8	8	8	
Reduce preconception, prenatal and post-natal exposure to alcohol, tobacco and other drugs	8	8	8				Restaurants, bars, and other establish-ments that sell liquor
Decrease the appeal of alcohol products by examining, publicizing and reducing advertising and marketing that may influence their use as well as by conducting counter advertising	8			8	8		
Promote alternatives to alcohol use for those who choose not to or should not drink	8			8	8	8	
Encourage work sites, schools, communities and others to examine their policies about alcohol, tobacco and other drugs	8	8	8	8	8	8	
Reduce alcohol-related problems by increasing the price of beverage alcohol products	8						

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Encourage health care providers to screen and, if necessary, counsel and/or refer patients for alcohol and other drug abuse problems	8	8	8				Allied Health Care and Social Service Providers

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: CHRONIC/NONINFECTIOUS DISEASE**

**Problem: Early Detection of Cancer**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Create "one-stop services" in the community for breast and cervical cancer screening		8	8				
Develop quality improvement systems to increase rates of preventive service delivery in the health care setting		8	8				
Conduct "in-reach" in the health care setting to promote breast and cervical cancer screening		8	8				
Implement a peer-based program to increase mammography use among low-income, under-serviced women	8			8	8	8	
Create "special events" for breast and cervical cancer screening.	8	8	8		8	8	

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### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: CHRONIC/NONINFECTIOUS DISEASE**

**Problem: Heart Disease, Heart Attack and Stroke**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Conduct targeted cholesterol screening and follow-up activities	8	8	8		8	8	
Conduct targeted hypertension detection and follow-up activities	8	8	8		8	8	

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: **CHRONIC/NONINFECTIOUS DISEASE**

**Problem: Diabetes**

#### Organizations with Potential Collaborative Roles

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community-based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Implement diabetes-focused consumer education and support programs	State, and Local, Centers for Disease Control and Prevention (CDC)	8	Pharmacies, Eye Care Providers, Diabetes Patient Education Programs, Mental Health Providers	K-12, Technical Schools, Universities, Community Colleges, Adult Education Services	Local Advocacy and Professional Groups, Community Health Coalitions, and Organizations Representing At-risk Populations (i.e., Communities of Color, Senior Citizens)	8	Consumers, Medical Societies and Provider Trade Associations, Pharmaceutical Companies, Fitness Clubs, Community Social Services, Libraries
Promote healthy behaviors to prevent type 2 diabetes and other chronic diseases	Same	8	Same	Same	Same	8	Same
Convene a diabetes coalition to address the issues of diabetes in the community	Same	8	Same	Same, plus School Health Services	Same	8	Same, plus Nursing Home and Long-term Care Facilities
Build a diabetes registry or database	State and Local	8	Pharmacies, Eye Care Providers, Diabetes Patient Education Programs		Same		Same, plus Local Communication Media (e.g., Radio, TV, Newsprint)

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Create a profile of the impact of diabetes in the community	State and Local, CDC	8	8				Quality Monitoring Groups, Nursing Home and Long-term Care Facilities
Provide diabetes education and training for health professionals	State and Local, CDC National Institutes of Health (NIDDK)	8	Pharmacies, Eye Care Providers, Diabetes Patient Education Programs, Mental Health Providers	Universities, Medical Schools, Nursing Schools, Community Colleges	Local Advocacy And Professional Groups		Medical Societies and Provider Trade Associations, Pharmaceutical Companies, Guideline Development Groups, Nursing Home and Long-term Care Facilities
Facilitate improvement of diabetes care in clinical settings	State and Local, CDC	8	Same		Same		Same

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### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: INFECTIOUS DISEASE**  
**Problem: STD/HIV/AIDS**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Develop and implement standardized protocols for: sexual health risk assessment, testing and referral, partner notification, and care of infected individuals	8	8	8				
Provide HIV/STD testing, counseling, treatment, or all three at multiple sites	8	8	8	School Clinics	8		Jails
Conduct HIV/STD data surveillance, community assessments, and community planning	8	8	8				
Identify, and advocate the use of, effective HIV/STD prevention curricula in schools	8			8	8		Concerned Individuals and Parents
Provide one-to-one, group and community HIV/STD prevention education, including education in institutional settings	8	8	8	8	8	8	Jails, Chemical Dependency Treatment Programs
Build community capacity through: community organizing, agency development, agency collaborations, and social support	8	8	8	8	8	8	Concerned Individuals

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Establish street outreach services	8				8		
Reduce environmental and other risk factors that increase the risk of HIV/STD transmission	8	8	8	8	8	8	Concerned Individuals
Provide public information via mass media, hotlines, and clearinghouses	8	8	8		8	8	Concerned Individuals
Improve health care providers' skills and knowledge of adolescent sexuality issues, including STDs	8	8	8	8			

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: INFECTIOUS DISEASE**  
**Problem: Vaccine-Preventable Diseases**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Plan and implement school-based programs to vaccinate adolescents against hepatitis B	8	8	8	middle, junior and high schools			
Implement strategies to increase rates of immunization against influenza among high-risk adults and others wishing to obtain immunity	8	8	8		8	8	
Implement and maintain a quality control system to insure that vaccines are viable	8	8	8				
Ensure that patients receive all needed vaccines at every visit	8	8	8				
Begin the incremental steps a medical clinic can take to prepare for full participation in a community immunization registry	8	8	8				
Ensure that all newly arrived refugees receive a domestic refugee health assessment	8	8	8		8	8	

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: PREGNANCY AND BIRTH**

**Problem: Infant Mortality**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Promote educational messages to reduce the risk of infant death	8	8	8	8	8		
Create and disseminate educational messages to promote the concept of no primary or secondary tobacco exposure, and no alcohol and other drug use during pregnancy or while parenting or caretaking	8	8	8	8	8		

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: **CHRONIC/NONINFECTIOUS DISEASE**

**Problem: Nutrition**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Conduct public information campaigns and events to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	8	8	8	8	8	8	
Conduct school-based programs to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	8	8		8	8		
Implement Fitness Fever in communities, schools, and work sites	8	8	8	8	8	8	
Conduct work-site programs to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	8	8	8	8	8	8	

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Provide counseling and education by health care providers and organizations to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables, adequate calcium intake, and healthy weight management	8	8	8				

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: CHRONIC/NONINFECTIOUS DISEASE**

**Problem: Physical Activity/Inactivity**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Conduct public information campaigns and events to promote regular physical activity	8	8	8	8	8	8	
Conduct school-based programs to promote regular physical activity	8	8		8	8		
Implement Fitness Fever in communities, schools, and work sites	8	8	8	8	8	8	
Increase the availability of recreational facilities in the community	8	8	8	8	8	8	
Conduct work site programs to promote regular physical activity	8	8	8	8	8	8	
Provide counseling and education by health care providers and organizations to promote physical activity, healthy weight management, and osteoporosis prevention and treatment	8	8	8				

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: UNINTENDED PREGNANCY**

**Problem: Unintended Pregnancy**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Provide or assure low-cost, comprehensive family planning services specifically designed to meet the cultural, age, and gender needs of clients in a variety of settings	8	8	8	8	8		Government Social Services
Develop and implement a social marketing plan to raise awareness of family planning services in the community	8				8		Media
Develop community-based comprehensive adolescent pregnancy prevention programs	8	8	8	8	8		
Train health care providers to communicate effectively with clients about sexual health issues and family planning	8	8	8		8		
Train school staff and social service professionals to communicate effectively with clients about sexual health issues and family planning	8			8	8		Government Social Services

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Provide assessment, policy development and planning, and assurance activities to support the provision of comprehensive family planning services	8						
Change community norms about the acceptability of adolescent contraceptive use and access to confidential family planning services	8			8	8		
Increase the proportion of all health insurance policies that cover contraceptive services and supplies with no co-payments or other cost-sharing requirements	8	8	8				
Promote healthy sexual behaviors	8	8	8	8	8		
Conduct information sessions in the community on family planning and how to access services	8			8	8		

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### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: HEALTH, GROWTH AND DEVELOPMENT OF CHILDREN AND ADOLESCENTS**  
**Problem: Adolescent Health - Parenting and Youth Development**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Develop focus on the role of parents in adolescent health	8			8	8		
Increase awareness of parents about the importance of parenting in the healthy development of teens	8	8	8	8	8		
Improve the parenting skills of parents of adolescents	8	8		8	8		
Develop youth service and youth leadership opportunities	8	8		8	8	8	
Provide youth with career opportunities				8	8	8	
Develop an increased focus on healthy youth development in health care systems	8	8	8				
Expand data collection on adolescent health issues	8			8			
Teach youth social skills		8	8	8	8	8	
Provide youth enrichment opportunities	8			8	8	8	

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Help youth feel comfortable with and connected to schools	8			8	8		

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: ALCOHOL, TOBACCO AND OTHER DRUGS**

**Problem: Tobacco use**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Reduce youth access to tobacco products	7	7	7		7	7	
Restrict advertising and promotion of tobacco products	7				7	7	
Screen for tobacco use and treat nicotine addiction		7	7				
Create and integrate school, community and media programs	7			7	7		Media, Advertising Agencies
Increase the price of tobacco products	7				7		
Reduce exposure to environmental tobacco smoke	7				7	7	
Conduct counter advertising	7	7			7		Media, Advertising Agencies

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: UNINTENTIONAL INJURY**

**Problem: Home Hazard Injury**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Conduct home visits to assess the home environment	8	8	8	8	8		Insurance Companies, MN Department of Human Services (DHS)
Distribute home safety supplies	8	8	8		8	8	Insurance Companies, Day Care, Head Start, Social Services
Offer home safety and injury prevention education to the public through day care providers, and community organizations and agencies	8	8	8		8		Insurance Companies, DHS
Provide academic instruction on injury prevention and control	8			8			Insurance Companies, DHS
Provide age-appropriate and culturally sensitive counseling by primary care providers	8	8	8				Insurance Companies
Collect and analyze data, and support new prevention efforts	8	8	8	8	8		Insurance Companies, DHS

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: UNINTENTIONAL INJURY**  
**Problem: Residential Fire-related Injury**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Conduct home visits to assess presence, maintenance and functionality of smoke alarms	8	8	8				Insurance Companies, State Fire Marshal, Local Fire Department
Distribute (or offer at low cost) smoke alarms through community-based smoke alarm installation programs	8	8	8		8	8	Insurance Companies, State Fire Marshal, Local Fire Department
Offer fire safety education following a burn or visit to an emergency department	8	8	8	8			
Support legislation requiring smoke alarms on every floor of a dwelling	8	8	8		8		Insurance Companies, State Agencies
Provide age-appropriate and culturally sensitive counseling by primary care providers on fire safety and burn injury prevention	8	8	8				Insurance Companies
Provide academic instruction and public education on fire safety and burn injury care	8			K-12, Professional Education	8	8	Insurance Companies, State Fire Marshal, Local Fire Department

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Enforce current smoke alarm legislation							State Fire Marshal, Local Fire Department
Collect and analyze data, and support new prevention efforts	8	8	8	8	8		State Fire Marshal, Local Fire Department

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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Interpersonal Violence - Bias-motivated Assaults**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Collect and analyze data to inform interventions, policies, and the community	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Educate the community to recognize the need for support and to refer victims, including self-reported victims, of bias-motivated assaults to law enforcement and necessary supports	8	8	8	8	8	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

**Eliminating Health Disparities Initiative Community Grants Program  
Request for Proposals**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Promote culturally specific relational models of attachment, self-efficacy, community connectedness, coping, and conflict resolution skills	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problems: Interpersonal Violence - Child Maltreatment, Including Children with Special Health Needs**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Promote culturally- specific relational models of attachment, self-efficacy, community connectedness, and coping skills	8	8	8	8	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Promote healthy child development through early intervention	8	8	8	8	8		Policy Makers, Social Services
Facilitate access to universal and targeted home visiting	8	8	8	8			Policy Makers, Social Services
Facilitate access to child development and disability information	8	8	8	8	Community Coalitions		Policy Makers, Social Services, Mental Health Services

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Facilitate access to culturally- and disability-specific parenting information and support	8	8	8	8	Community Coalitions	8	Policy Makers, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Facilitate referrals to mental and chemical health programs	8	8	8	8	Community Coalitions, Counseling Centers	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Collect and analyze data to inform interventions, policies, and the community	8	8	8	8	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for child maltreatment	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts Media and Entertainment
Educate the community to recognize and refer victims of child maltreatment to child protection, law enforcement, and supportive services	8	8	8	8	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services
Conduct child mortality reviews	8	8	8				Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Incorporate information on the maltreatment of children with special needs into mainstream child abuse prevention programs	8	8	8	8	Family & Children's Services Collaboratives, Children's Mental Health Collaboratives		Faith Communities, Social Services, Advocacy Organizations

**Eliminating Health Disparities Initiative Community Grants Program  
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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Interpersonal Violence - Domestic and Intimate Partner Violence**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Educate the community to recognize and refer victims and their children who witness battering to safety and treatment	8	8	8	8	Community Coalitions	8	Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Collect and analyze data to inform interventions, policies, and the community	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Facilitate access to victim services and perpetrator programs	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Promote relational models specific to culture and sexual preference that focus on community connectedness, intimacy, and coping skills	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for domestic and partner violence	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

**Eliminating Health Disparities Initiative Community Grants Program  
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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Interpersonal Violence - Maltreatment of Vulnerable Adults and the Elderly**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Collect and analyze data to inform interventions, policies, and the community	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, law Enforcement, Courts
Promote relational models of attachment, self-efficacy, community connectedness, and social skills	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

**Eliminating Health Disparities Initiative Community Grants Program  
Request for Proposals**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon these strengths to address risks for maltreatment of vulnerable adults and the elderly	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Educate the community to recognize and refer victims to safety, treatment, and related services	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Interpersonal Violence - Sexual Violence**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Increase the availability, accessibility, and utilization of services for victims and perpetrators of sexual violence	8	8	8	8	Civic, Cultural, Service, Political, Neighborhood, Educational, Social and Faith-based Groups	8	Policy Makers, Criminal Justice, Social Service Providers
Educate the community about prevalence, forms and effects of sexual violence	8	8	8	8	Same	8	Same
Identify and promote healthy community norms that discourage sexual abuse, including norms from a diversity of cultures	8	8	8	8	Same	8	Same

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Interpersonal Violence - Youth Violence**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Provide training and education on youth violence and violence prevention	8	8	8	8	8	8	
Promote culturally specific relational models of attachment, self-efficacy, community connectedness, coping, school success and conflict resolution	8	8	8	8	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Collect and analyze data to inform interventions, policies, and the community	8	8	8	8	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Promote healthy development through early intervention	8	8	8	8			Policy Makers, Social Services

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Facilitate access to culturally and disability-specific parenting information and support	8	8	8	8	Community Coalitions		Policy Makers, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Facilitate referrals to mental and chemical health programs	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Assess (including self-assessments) the strengths of youth, families, communities, and systems and build upon these strengths to address risks for youth violence	8	8	8	8	Community Coalitions	8	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

**Eliminating Health Disparities Initiative Community Grants Program  
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**Examples of Strategies & Organizational Roles**

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: VIOLENCE**

**Problem: Suicide**

**Organizations with Potential Collaborative Roles**

	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Educate professionals and the community to recognize suicidal ideation and behaviors in adolescents and adults, to respond appropriately, and to make referrals for treatment and necessary supports	8	8	8	8	Counseling Centers, Social Services, Faith Communities	8	
Facilitate access to crisis and mental and chemical health programs and support services	8	8	8	8	8	8	
Collect and analyze data to inform interventions, policies, and the community	8	8	8				
Promote relational models, specific to culture and sexual preference, of attachment, self-efficacy, community connectedness, and healthy coping	8	8	8	8	8	8	
Promote and enforce means restrictions, including limiting access to firearms, promoting safe storage of firearms, and encouraging use of trigger locks	8	8	8	8	8	8	Law Enforcement

**Eliminating Health Disparities Initiative Community Grants Program  
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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Assess (including self assessments) families, communities, and systems and build upon those strengths to address risks for suicide and suicide attempts	8	8	8	8	8	8	

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

### Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem.  
Organizations that may play a role in the implementation of a particular strategy are indicated.

**Category: PREGNANCY AND BIRTH**

**Problem: Breastfeeding**

#### Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Promote and support breastfeeding and the use of human milk for infant feeding	State and Local	8	8	8	8	8	
Support baby-friendly facilities	State and Local	8	8	8	8	8	
Develop systems to support women who are breastfeeding and returning to work or school	8	8	8	8	8	8	
Ensure training on breastfeeding for health professionals and paraprofessionals	8	8	8	8			
Initiate peer- counseling breastfeeding programs	Local	8	8	8	8		
Offer breastfeeding materials in prenatal and pediatric clinics, offices, and hospitals	8	8	8		8		
Assess barriers to breastfeeding for the individual client, then address the barriers and discuss breastfeeding as the optimal infant feeding choice during prenatal care	Local	8	8	8			
Develop methods to track breastfeeding initiation and duration rates	8	8	8				

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	<b>Governmental Public Health Agencies</b>	<b>Health Plans</b>	<b>Hospitals &amp; Clinics</b>	<b>Educational Systems</b>	<b>Community- based Organizations</b>	<b>Businesses/ Work Sites</b>	<b>Other</b>
Provide post-hospital support for breastfeeding	State and Local	8	8		8	8	
Acquire a sustainable funding source for statewide promotion of breastfeeding	State	8	8		8		

## **Appendix G**

# **Community Engagement**

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Community Engagement

*“Go in search of people.  
Begin with what they know.  
Build on what they have.”*

*Chinese proverb*

Community engagement is a key ingredient in Minnesota’s Eliminating Health Disparities Initiative Community Grants Program. Promoting a statewide community of informed, inspired, committed people who are actively engaged in confronting the challenges of eliminating health disparities will be critical to our success. Grantees will be expected to serve as catalysts, engaging people in ways that set the stage for a new level of communication and cooperation among community members, organizations, and government entities.

### What Is Community Engagement?

Community engagement is the process of involving community residents in thinking, debating, talking about and together addressing issues that affect the quality of their lives. Effective community engagement brings people to the table—both community members and professionals—and nurtures their active participation in all aspects of planning and implementation processes. Community members are valued as equal partners. Cultural strengths are identified and valued as the process seeks to meld community “wisdom” with scientific and institutional expertise. Effective community engagement results in activities and programs that reflect the strengths, needs, and resources of the community, and outcomes that are understandable to community members and that reflect community expectations.

### The Cycle Of Engagement

The cycle of engagement has three parts:

Coming together—starting the conversation and dialogue; building trust and safe spaces for people to think, debate, reflect and make decisions.

Moving forward—converting dialogue into activity; reaching out beyond the original planning group; creating dynamic partnerships to implement programs and provide services.

Sustaining momentum—building structures; developing and sustaining leadership; assessing and improving programs; measuring change and communicating results.

### The Move From Communication To Engagement

In the past, good communication meant informing community members about issues and publicizing information about programs. This grant program has strong expectations that people will move beyond these traditional communication efforts to truly engaging community members in all aspects of planning and implementation processes. The chart below shows the

## Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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differences between the old way of thinking about communication and this new way of thinking about community engagement.

### Communication

communicate to

public hearing

talk to, tell

seeking to establish/protect turf

authority

influencing the like-minded

top down

building a hierarchy for  
decision-making

goals/strategic plan

products

public relations

### Engagement

deliberate with

community conversation

talk with, share

seeking/finding common ground

responsibility

understanding those not like-minded

bottom up

establishing a stakeholder network

values/vision

process

public or community engagement

For more information on community engagement see  
(<http://www.health.state.mn.us/communityeng/>)

## **Appendix H**

# **Standard MDH Grant Agreement**

**Eliminating Health Disparities Initiative Community Grants Program  
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**STATE OF MINNESOTA  
GRANT AGREEMENT**

Grant Agreement Number \_\_\_\_\_ between the Minnesota Department of Health and \_\_\_\_\_

THIS GRANT AGREEMENT, and amendments and supplements thereto, is between the State of Minnesota, acting through its Minnesota Department of Health (hereinafter "STATE") and \_\_\_\_\_, an independent organization, not an employee of the State of Minnesota, address \_\_\_\_\_ (hereinafter "GRANTEE"), witnesseth that:

WHEREAS, the STATE, pursuant to Minn. Stat. § \_\_\_\_\_ is empowered to \_\_\_\_\_, and

WHEREAS, \_\_\_\_\_, and

WHEREAS, GRANTEE represents that it is duly qualified and willing to perform the services set forth herein.

NOW, THEREFORE, it is agreed:

I. GRANTEE'S DUTIES (Attach additional page if necessary which is incorporated by reference and made a part of this agreement.) GRANTEE, shall:

II. CONSIDERATION AND TERMS OF PAYMENT

A. Consideration for all services performed by GRANTEE pursuant to this grant agreement shall be paid by the STATE as follows:

1. Compensation \$ \_\_\_\_\_
2. Matching Requirements. (If Applicable) GRANTEE certifies that the following matching requirement, for the grant, will be met by GRANTEE:
3. Reimbursement for travel and subsistence expenses actually and necessarily incurred by GRANTEE in performance of this grant agreement in an amount not to exceed \_\_\_\_\_ dollars (\$\_\_\_\_\_); provided, that GRANTEE shall be reimbursed for travel and subsistence expenses in the same manner and in no greater amount than provided in the current "Commissioner's Plan" promulgated by the Commissioner of Employee Relations. GRANTEE shall not be reimbursed for travel and subsistence expense incurred outside the State of Minnesota unless it has received prior written approval for such out of state travel from the STATE.

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4. The total obligation of the STATE for all compensation and reimbursements to GRANTEE shall not exceed \_\_\_\_\_ dollars (\$\_\_\_\_\_).

**B. Terms of Payment**

1. Payments shall be made by the STATE promptly after GRANTEE'S presentation of invoices for services performed and acceptance of such services by the STATE'S Authorized Representative pursuant to Clause VI. Invoices shall be submitted in a form prescribed by the STATE and according to the following schedule:
2. FEDERAL FUNDS (When applicable) Payments are to be made from federal funds obtained by the STATE through Title \_\_\_\_\_ of the \_\_\_\_\_ Act of \_\_\_\_\_ (Public law \_\_\_\_\_ and amendments thereto). If at any time such funds become unavailable, this grant agreement shall be terminated immediately upon written notice of such fact by the STATE to the GRANTEE. In the event of such termination, GRANTEE shall be entitled to payment, determined on a pro rata basis, for services satisfactorily performed.

III. CONDITIONS OF PAYMENT All services provided by GRANTEE pursuant to this grant agreement shall be performed to the satisfaction of the STATE, as determined at the sole discretion of its Authorized Representative, and in accord with all applicable federal, state, and local laws, ordinances, rules and regulations. GRANTEE shall not receive payment for work found by the STATE to be unsatisfactory, or performed in violation of federal, state or local law, ordinance, rule or regulation.

IV. TERMS OF AGREEMENT This grant agreement shall be effective on \_\_\_\_\_, 20\_\_\_\_, or upon the date that the final required signature is obtained by the STATE, pursuant to Minn. Stat. § 16C.05, Subd. 2, whichever occurs later, and shall remain in effect until \_\_\_\_\_, 20\_\_\_\_, or until all obligations set forth in this grant agreement have been satisfactorily fulfilled, whichever occurs first. GRANTEE understands that NO work should begin under this grant agreement until ALL required signatures have been obtained, and GRANTEE is notified to begin work by the STATE'S Authorized Representative.

V. CANCELLATION This grant agreement may be cancelled by the STATE or GRANTEE at any time, with or without cause, upon thirty (30) days' written notice to the other party. In the event of such a cancellation, GRANTEE shall be entitled to payment, determined on a pro rata basis, for work or services satisfactorily performed.

STATE may cancel this grant agreement immediately if the STATE finds that there has been a failure to comply with the provisions of this grant agreement that reasonable progress has not been made, or that the purposes for which the funds were granted have not been or will not be fulfilled, the STATE may take action to protect the interests of the

**Eliminating Health Disparities Initiative Community Grants Program  
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State of Minnesota, including the refusal to disburse additional funds and requiring the return of all or part of the funds already disbursed.

- VI. STATE'S AUTHORIZED REPRESENTATIVE The STATE'S Authorized Representative for the purposes of administration of this grant agreement is \_\_\_\_\_. Such representative shall have final authority for acceptance of GRANTEE'S services and if such services are accepted as satisfactory, shall so certify on each invoice submitted pursuant to Clause II, paragraph B. The GRANTEE'S Authorized Representative for purposes of administration of this grant agreement is \_\_\_\_\_. The GRANTEE'S Authorized Representative shall have full authority to represent GRANTEE in its fulfillment of the terms, conditions and requirements of this grant agreement.
- VII. ASSIGNMENT GRANTEE shall neither assign nor transfer any rights or obligations under this grant agreement without the prior written consent of the STATE.
- VIII. AMENDMENTS Any amendments to this grant agreement shall be in writing, and shall be executed by the same parties who executed the original grant agreement, or their successors in office.
- IX. LIABILITY GRANTEE shall indemnify, save, and hold the STATE, its representatives and employees harmless from any and all claims or causes of action, including all attorney's fees incurred by the STATE, arising from the performance of this grant agreement by GRANTEE or GRANTEE'S agents or employees. This clause shall not be construed to bar any legal remedies GRANTEE may have for the STATE'S failure to fulfill its obligations pursuant to this grant agreement. Nothing herein shall be construed as a waiver by grantee of any of the immunities or limitations of liability to which grantee may be entitled to pursuant to Minnesota Statute 466 or pursuant to any other statute or law.
- X. STATE AUDITS The books, records, documents, and accounting procedures and practices of the GRANTEE relevant to this grant agreement shall be made available and subject to examination by the STATE, including the contracting Agency/Division, Legislative Auditor, and State Auditor for a minimum period of six years from the end of this grant term.
- XI. DATA PRACTICES ACT The GRANTEE and the STATE shall comply with the Minnesota Data Practices Act and other applicable laws as it applies to all data provided by the STATE in accordance with this grant agreement and as it applies to all data created, gathered, generated or acquired in accordance with this grant agreement.
- XII. OWNERSHIP OF EQUIPMENT

*Teen Pregnancy Prevention Grants:*

Disposition of all equipment purchased under this grant shall be in accordance with title 45, code of federal regulations, part 74, subpart C for all equipment having a current per unit fair market value of \$5,000 or more, the STATE shall have the right to require

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transfer of the equipment (including title) to the Federal Government or to an eligible non-Federal party named by the STATE. This right will normally be exercised by the STATE only if the project or program for which the equipment was acquired is transferred from one grantee to another.

*All other grants:*

The STATE shall have the right to require transfer of all equipment purchased with grant funds (including title) to the STATE or to an eligible non-STATE party named by the STATE. This right will normally be exercised by the STATE only if the project or program for which the equipment was acquired is transferred from one grantee to another.

### **XIII. OWNERSHIP OF MATERIALS AND INTELLECTUAL PROPERTY RIGHTS**

A. The STATE shall own all rights, title and interest in all of the materials conceived or created by the GRANTEE, or its employees or subgrantees, either individually or jointly with others and which arise out of the performance of this grant agreement, including any inventions, reports, studies, designs, drawings, specifications, notes, documents, software and documentation, computer based training modules, electronically, magnetically or digitally recorded material, and other work in whatever form ("MATERIALS").

The GRANTEE hereby assigns to the STATE all rights, title and interest to the MATERIALS. GRANTEE shall, upon request of the STATE, execute all papers and perform all other acts necessary to assist the STATE to obtain and register copyrights, patents or other forms of protection provided by law for the MATERIALS. The MATERIALS created under this grant agreement by the GRANTEE, its employees or subgrantees, individually or jointly with others, shall be considered "works made for hire" as defined by the United States Copyright Act. All of the MATERIALS, whether in paper, electronic, or other form, shall be remitted to the STATE by the GRANTEE, its employees and any subgrantees, shall not copy, reproduce, allow or cause to have the MATERIALS copied, reproduced or used for any purpose other than performance of the GRANTEE'S obligations under this grant agreement without the prior written consent of the STATE'S Authorized Representative.

B. GRANTEE represents and warrants that MATERIALS produced or used under this grant agreement do not and will not infringe upon any intellectual property rights of another, including but not limited to patents, copyrights, trade secrets, trade names, and service marks and names. GRANTEE shall indemnify and defend the STATE, at GRANTEE'S expense, from any action or claim brought against the STATE to the extent that it is based on a claim that all or part of the MATERIALS infringe upon the intellectual property rights of another. GRANTEE shall be responsible for payment of any and all such claims, demands, obligations, liabilities, costs, and damages including, but not limited to, reasonable attorney fees arising out of this grant agreement, amendments and supplements thereto, which are attributable to such claims or actions. If such a claim or action arises, or in GRANTEE'S or the STATE'S opinion is likely to arise, GRANTEE shall at the STATE'S discretion either procure for the STATE the right

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or license to continue using the MATERIALS at issue or replace or modify the allegedly infringing MATERIALS. This remedy shall be in addition to and shall not be exclusive to other remedies provided by law.

- XIV. PUBLICITY Any publicity given to the program, publications, or services provided resulting from this grant agreement, including, but not limited to, notices, informational pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the GRANTEE or its employees individually or jointly with others, or any subgrantees shall identify the STATE as the sponsoring agency and shall not be released, unless such release is a specific part of an approved work plan included in this grant agreement prior to its approval by the STATE'S Authorized Representative.
- XV. AFFIRMATIVE ACTION GRANTEE certifies pursuant to Minn. Stat. § 363.073 that: (A) GRANTEE has not had more than 40 full-time employees at any time during the twelve months preceding the date it submitted its response to the STATE; OR (B) if GRANTEE has more than 40 full-time employees within the State of Minnesota on a single working day during the previous twelve months preceding the date GRANTEE submitted its response to the STATE, that it has an affirmative action plan pursuant to the requirements of Minn. Stat. § 363 for the employment of minority persons, women and qualified disabled individuals approved by the State of Minnesota, Commissioner of Human Rights; OR (C) if GRANTEE does not have 40 full-time employees within the State of Minnesota on a single working day during the previous twelve months preceding the date it submitted its response to the STATE, but has had more than 40 full-time employees on a single working day during the previous twelve months in the state in which it has its primary place of business, then (1) GRANTEE has current Minnesota certificate of compliance issued by the Minnesota Commissioner of Human Rights, OR (2) GRANTEE certifies that it is in compliance with federal Affirmative Action requirements.

If GRANTEE has more than 40 full-time employees within the State of Minnesota on a single working day during the previous twelve months. GRANTEE shall comply with the following Affirmative Action requirements for disabled workers:

Minnesota Rule 5000.3550 DISABLED INDIVIDUALS AFFIRMATIVE  
ACTION CLAUSE.

1. The GRANTEE shall not discriminate against any employees or applicants for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified. The GRANTEE agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified disabled individuals without discrimination based upon their physical or mental disability in all employment practices such as the recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.
2. The GRANTEE agrees to comply with the rules and relevant orders of the Minnesota

**Eliminating Health Disparities Initiative Community Grants Program  
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Department of Human Rights issued pursuant to the Minnesota Human Rights Act.

3. In the event of the GRANTEE noncompliance with the requirements of this clause, actions for noncompliance may be taken in accordance with Minn. Stat. § 363.073 and the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.
  4. The GRANTEE agrees to post in conspicuous places, available to employees and applicants for employment, notices in a form to be prescribed by the commissioner of the Minnesota Department of Human Rights. Such notices shall state the GRANTEE's obligation under the law to take affirmative action to employ and advance in employment qualified disabled employees and applicants for employment, and the rights of applicants and employee.
  5. GRANTEE shall notify each labor union or representative of workers with which it has a collective bargaining agreement or other contract understanding, that the GRANTEE is bound by the terms of Minn. Stat. § 363.073 of the Minnesota Human Rights Act and is committed to take affirmative action to employ and advance in employment physically and mentally disabled individuals.
- XVI. WORKERS' COMPENSATION The GRANTEE certifies that it is in compliance with Minn. Stat. § 176.181, subd. 2, pertaining to workers' compensation insurance coverage. The GRANTEE's employees and agents will not be considered STATE employees. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees and any claims made by any third party as a consequence of any act or omission on the part of these employees are in no way the STATE's obligation or responsibility.
- XVII. ANTITRUST GRANTEE hereby assigns to the State of Minnesota any and all claims for overcharges as to goods and/or services provided in connection with this agreement resulting from antitrust violations which arise under the antitrust laws of the United States and the antitrust laws of the State of Minnesota.
- XVIII. JURISDICTION AND VENUE This grant agreement, and amendments and supplements thereto, shall be governed by the laws of the State of Minnesota. Venue for all legal proceedings arising out of this grant agreement, or breach thereof, shall be in the state or federal court with competent jurisdiction in Ramsey County, Minnesota.
- XIX. OTHER PROVISIONS: *(For Teen Pregnancy Prevention Grants only)*
- A. Contractor Debarment, Suspension and Responsibility Certification
- Federal Regulation 45 CFR 92.35 prohibits the State from purchasing goods or services with federal money from vendors who have been suspended or debarred by the federal government. Similarly, Minn. Stat. 16C.03, Subd.2 provides the Commissioner of

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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Administration with the authority to debar and suspend vendors who seek to contract with the State.

Vendors may be suspended or debarred when it is determined, through a duly authorized hearing process, that they have abused the public trust in a serious manner. In particular, the federal government expects the State to have a process in place for determining whether a vendor has been suspended or debarred, and to prevent such vendors from receiving federal funds.

By signing this contract, GRANTEE certifies that it and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from transacting business by or with any federal, state or local governmental department or agency; and
2. Have not within a three-year period preceding this contract: a) been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract; b) violated any federal or state antitrust statutes; or c) committed embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and
3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity for: a) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction; b) violating any federal or state antitrust statutes; or c) committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement or receiving stolen property; and
4. Are not aware of any information and possess no knowledge that any subcontractor(s) that will perform work pursuant to this grant/contract are in violation of any of the certifications set forth above.

### **B. Audit Requirements to be included in grant agreements with subrecipients**

1. For subrecipients (GRANTEES) that are state or local governments, non-profit organizations, or Indian Tribes:

If the GRANTEE expends total federal assistance of \$300,000 or more per year, the grantee agrees to (1) obtain either a single audit or a program-specific audit made for the fiscal year in accordance with the terms of the Single Audit Act of 1984, as amended (31 U.S. Code chapter 75) and OMB Circular A-133; and (2) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code chapter 75) and OMB Circular A-133.

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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Audits shall be made annually unless the grantee is a state or local government that has, by January 1, 1987, a constitutional or statutory requirement for less frequent audits. For those governments, the federal cognizant agency shall permit biennial audits, covering both years, if the government so requests. It shall also honor requests for biennial audits by state or local governments that have an administrative policy calling for audits less frequent than annual, but only audits prior to 1987 or administrative policies in place prior to January 1, 1987.

For subrecipients (GRANTEES) that are institutions of higher education or hospitals:

If the GRANTEE receives total direct and indirect federal assistance of \$300,000 or more per year, the GRANTEE agrees to obtain a financial and compliance audit made in accordance with OMB Circular A-110 "Requirements for Grants and Agreements with Universities, Hospitals and Other Nonprofit Organizations" as applicable. The audit shall cover either the entire organization or all federal funds of the organization.

The audit must determine whether the GRANTEE spent federal assistance funds in accordance with applicable laws and regulations.

2. The audit shall be made by an independent auditor. An independent auditor is a state or local government auditor or a public accountant who meets the independence standards specified in the General Accounting Office's "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions."
3. The audit report shall state that the audit was performed in accordance with the provisions of OMB Circular A-133 (or A-110 as applicable).

The reporting requirements for audit reports shall be in accordance with the American Institute of Certified Public Accountants' (AICPA) audit guide, "Audits of State and Local Governmental Units," issued in 1986. The federal government has approved the use of the audit guide.

In addition to the audit report, the GRANTEE shall provide comments on the findings and recommendations in the report, including a plan for corrective action taken or planned and comments on the status of corrective action taken on prior findings. If corrective action is not necessary, a statement describing the reason it is not should accompany the audit report.

4. The GRANTEE agrees that the grantor, the Legislative Auditor, the State Auditor, and any independent auditor designated by the grantor shall have such access to GRANTEE's records and financial statements as may be necessary for the grantor to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code chapter 75) and OMB Circular A-133.

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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5. GRANTEES of federal financial assistance from subrecipients are also required to comply with the Single Audit Act Amendments of 1984, as amended (31 U.S. Code chapter 75) and OMB Circular A-133.
6. The Statement of Expenditures form can be used for the schedule of federal assistance.
7. The GRANTEE agrees to retain documentation to support the schedule of federal assistance for at least four years.
8. The GRANTEE agrees to file required audit reports with the State Auditor's Office, Single Audit Division, and with federal and state agencies providing federal assistance, within six months of the grantee's fiscal year end.

OMB Circular A-133 requires recipients of more than \$300,000 in federal funds to submit one copy of the audit report within 30 days after issuance to the central clearinghouse at the following address:

Bureau of the Census, Data Preparation Division  
1201 East 10<sup>th</sup> Street  
Jeffersonville, Indiana 47132  
Attn: Single Audit Clearinghouse

### C. Drug-free Workplace

GRANTEE agrees to comply with the Drug-Free Workplace Act of 1988, and implemented at 34 CFR Part 85, Subpart F.

### D. Lobbying

The GRANTEE agrees to comply with the provisions of United States Code, title 31, section 1352. The GRANTEE must not use any federal funds from the STATE to pay any person for influencing or attempting to influence an officer or employee of a federal agency, a member of Congress, an officer or employee of Congress, or any employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. If the GRANTEE uses any funds other than the federal funds from the STATE to conduct any of the aforementioned activities, the GRANTEE must complete and submit to the STATE the disclosure form specified by the STATE. Further, the GRANTEE must include the language of this provision in all contracts and subcontracts and all contractors and subcontractors must comply accordingly.

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E. Equal Employment Opportunity

GRANTEE agrees to comply with the Executive Order 11246 “Equal Employment Opportunity” as amended by Executive Order 11375 and supplemented by regulations at 41 CFR part 60.

F. Cost Principles

Option #1:

The GRANTEE agrees to comply with the provisions of OMB Circular A-21 regarding cost principles for administration of this grant award for educational institutions.

Option #2:

The GRANTEE agrees to comply with the provisions of OMB Circular A-87 regarding cost principles for administration of this grant award for state and local governments and Indian tribal governments.

Option #3:

The GRANTEE agrees to comply with the provisions of OMB Circular A-122 regarding cost principles for administration of this grant award for non-profit organizations.

G. Rights to Inventions --Experimental, Developmental or Research Work:

The GRANTEE agrees to comply with 37 CFR part 401, “Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements” and any implementing regulations issued by the awarding agency.

H. Clean Air Act

The GRANTEE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act as amended (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251 et seq.). Violations shall be reported to the Federal awarding agency Regional Office of the Environmental Protection Agency (EPA).

**Eliminating Health Disparities Initiative Community Grants Program  
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IN WITNESS WHEREOF, the parties have caused this grant agreement to be duly executed intending to be bound thereby.

APPROVED:

**1. GRANTEE:**

GRANTEE certifies that the appropriate person(s) have executed the agreement on behalf of the GRANTEE as required by applicable articles, by-laws, resolutions, or ordinances.

By:
Title:
Date:

**2. STATE AGENCY:**

Grant Agreement approval and certification that STATE funds have been encumbered as required by Minn. Stat. §§ 16A.15 and 16C.05.

By (authorized signature):
Title:
Date:

By:
Title:
Date:

Distribution:

Agency - Original (fully executed) agreement  
Grantee  
State Authorized Representative



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**AITKIN-ITASCA-KOOCHICHING**

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Aitkin-Itasca-Koochiching CHS Bd.  
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**ANOKA**

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**BECKER-MAHNOMEN-NORMAN**

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Multi County Nursing Service  
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**BELTRAMI-CLEARWATER-HUBBARD-LAKE OF THE WOODS**

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**BENTON-SHERBURNE**

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**BIG STONE-CHIPPEWA-LAC QUI PARLE-SWIFT-YELLOW MEDICINE**

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**BLUE EARTH**

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**BROWN-NICOLLET**

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**CARLTON-COOK-LAKE-ST. LOUIS**

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**CARVER**

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**CASS-TODD-WADENA-MORRISON**

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**CHISAGO**

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Chisago County CHS/PHN Service  
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**CLAY-WILKIN**

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**COTTONWOOD-JACKSON**

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**CROW WING**

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**DAKOTA**

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Dakota County Public Health Depart.  
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**DODGE-STEELE**

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**DOUGLAS**

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**FARIBAULT-MARTIN**

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**FILLMORE-HOUSTON**

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**FREEBORN**

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**GOODHUE**

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Goodhue Co. Public Health Services  
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**GRANT-POPE-STEVENS-TRAVERSE**

PHN Director - CHS Administrator  
Mid-State CHS/Stevens-Traverse PH  
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(320)324-2689

**HENNEPIN**

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**HENNEPIN (BLOOMINGTON)**

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**Eliminating Health Disparities Initiative Community Grants Program  
Request for Proposals**

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**HENNEPIN (EDINA)**

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**HENNEPIN (MINNEAPOLIS)**

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**HENNEPIN (RICHFIELD)**

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**ISANTI-MILLE LACS**

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**KANABEC-PINE**

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**KANDIYOHI**

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**KITTSOON-MARSHALL-PENNINGTON-RED LAKE-ROSEAU**

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**LE SUEUR-WASECA**

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**LINCOLN-LYON-MURRAY-PIPESTONE**

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**MEEKER-MC LEOD-SIBLEY**

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**MOWER**

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**RAMSEY & ST.PAUL**

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**REDWOOD-RENVILLE**

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**SCOTT**

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**STEARNS**

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**Eliminating Health Disparities Initiative Community Grants Program  
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**WATONWAN**

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**WRIGHT**

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## **Appendix J**

### **Required Application Forms**

**Eliminating Health Disparities Initiative Community Grants Program  
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**Required Application Forms**

An electronic version of these forms is available. Go to <http://www.health.state.mn.us/> Scroll to “Announcements” and then to “RFPs/Rule Proposals” and click on “Request for Proposals: Eliminating Health Disparities Initiative Community Grants Program” or call Fran DesRosier at 651/297-5813. You may also type or handwrite on the copy of the forms included in this Request for Proposals.

## Minnesota Department of Health Grant Application Face Sheet

**Grant Application for:**

Eliminating Health Disparities Initiative Community Grants Program

**1. Applicant Agency With Which Grant Contract is to be Executed**

Legal Name:	Street Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**2. Director of Applicant Agency**

Name and Title:	Street Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**3. Fiscal Management Officer of Applicant Agency**

Name and Title:	Street Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**4. Operating Agency (if different from number 1 above)**

Name and Title:	Street Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**5. Contact Person for Operating Agency (if different from number 2 above)**

Name and Title:	Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**6. Contact Person for Further Information on Application (if different from number 5 above)**

Name and Title:	Street Address:	Telephone Number: (    )
	E-Mail Address:	FAX Number: (    )

**7. Certification**

I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.

\_\_\_\_\_  
Signature of Director of Applicant Agency

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## Instructions for Completing Face Sheet

Please type or print all items on the Grant Application Form Face Sheet.

**Applicants please note:** The application form has been designed to be used on all Special Project grants administered by the Minnesota Department of Health. If you have questions, or need assistance in completing the application form, please contact the program Manager or Consultant identified as responsible for the grant.

### 1. Applicant Agency

Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health, e.g., \_\_\_\_\_ Community Health Board, \_\_\_\_\_ Community Clinic, First \_\_\_\_\_ Church.

### 2. Director of the Applicant Agency

Person responsible for directing the applicant agency.

### 3. Fiscal Management Officer of Applicant Agency

The chief fiscal officer for the recipient of funds who has primary responsibility for grant and subsidy funds expenditure and reporting.

### 4. Operating Agency

Complete only if other than the applicant agency listed in number 1 above.

### 5. Contact Person for Operating Agency

Person who may be contacted concerning questions about implementation of this project.

### 6. Contact Person for Further Information

Person who may be contacted for detailed information concerning the application or the project if different from number 5 above.

### 7. Signature of Director of Applicant Agency

Provide original signature and date.



## **Instructions for Completing Project Information Sheet for Eliminating Health Disparities Proposals**

Please type or print all items on the Project Information Sheet for Eliminating Health Disparities Proposals.

### **1. Applicant Information**

Provide name of applicant agency, Minnesota Tax I.D. Number (if applicable), Federal I.D. Number (if applicable), and/or Social Security Number (if applicable). Check the appropriate answer for 501.C3 status. Nonprofit agencies are required to provide a copy of their 501.C3 form with this form as evidence the agency is a non-profit institution, corporation or organization.

### **2. Proposal Information**

Indicate the total amount requested, the proposed geographic service area, the proposed type of grant, the proposed target population(s), and the proposed priority health area(s).



**Minnesota Department of Health**

**Budget  
for  
Eliminating Health Disparities Applications**

<b>Name of Applicant Agency:</b>	
<b>Name of Contact Person for Budget:</b>	
<b>Phone:</b>	<b>Fax:</b>
<b>E-mail:</b>	
<b>Proposed Type of Grant</b>	
___ Planning grant proposal (budget is for up to 13 months)	
___ Implementation grant (budget is for 22 months)	
<b>Line Item</b>	
<b>Total Proposed Amount</b>	
<b>Salary and Fringe Benefits</b>	\$
<b>Contractual Services</b>	\$
<b>Travel</b>	\$
<b>Supplies and Expenses</b>	\$
<b>Other</b>	\$
<b>Administrative Costs</b>	\$
<b>Total</b>	\$

Attach a narrative description of your budget.

## **Appendix K**

### **Grant Writing Tips**

**Eliminating Health Disparities Initiative Community Grants Program  
Request for Proposals**

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**Grant Writing Tips**

*(These tips were adapted from Florida's "Closing the Gap" Grant Program Application Packet)*

1. One size never fits all. Don't send us the same application you have sent to several other funding sources. Write your proposal to match our requirements.
2. Your application must arrive on time. If you are even an hour late, we won't fund you, no matter how wonderful your application is.
3. Your application should be clear, to the point, and understandable. Don't use jargon or catch phrases in your application. We may not know the phrases, or may have a different meaning for them than you do. State your case simply and directly.
4. Stay within the page limits specified: five pages means 5 pages! Don't use more pages than you need, either. If you can say everything you need to say in four pages, please do.
5. Don't ask for more money than you need.
6. Look for other resources you can use for the project. We probably won't be able to give you all the money you need.
7. Think about how you can continue the project when our grant funds are gone.
8. Follow all of our instructions exactly. We really don't want to try to read a proposal with a font smaller than 12 point or with margins smaller than an inch.
9. Use our forms and submit all of our forms.
10. Include everything in the application that is asked for in the order in which it is asked for. That will help us find the information without hunting for it and lessens the chance that things may be missed.
11. Don't submit things we didn't ask for. Note that we are not asking for resumes or letters of support.
12. Partner, partner, partner. The more community support you have, the better.
13. When you're finished, don't just look at it and pat yourself on the back, go through and score your own application using the scoring criteria we have given. Have someone else score it as well.

# **Glossary**

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## Glossary

### Assets

Things of value or any personal qualities or traits of practical value, including the skills of local residents; the power of local associations; the resources of public, private, and non-profit institutions; and the physical and economic resources of local places. See Appendix C, Asset-Based Community Development.

### Coalition

An organization of individuals representing diverse organizations, interests, or constituencies who agree to work together in order to achieve a common goal. A coalition mobilizes individuals and groups to influence outcomes, is an example of cooperative and coordinating action, and is not as strong a relationship as a collaborative.

### Collaborative

A commitment on the part of two or more people or organizations to enhance their capacity by: voluntarily exchanging information; altering activities; and sharing risks, resources, responsibilities, and rewards for mutual benefit and to achieve a common goal or purpose. A collaborative is stronger and more substantive than a coalition, but is much more challenging to develop.

### Community

A group of people having interests in common. For the purposes of this Request for Proposal, applicants can define the community they will be working with however they wish; the community can be based on geography, racial/ethnic identity, or some other common interest.

### Community Assessment

A process by which a community examines its needs, assets, and strengths to determine how to mobilize for community improvement activities, such as reducing a health disparity.

### Community Engagement

The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people; involving individuals, groups, organizations, and businesses in their community or their government. See Appendix G, Community Engagement.

# Eliminating Health Disparities Initiative Community Grants Program Request for Proposals

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## **Contributing Factor**

An underlying social, behavioral, or physiological factor that puts an individual at risk for a disease or disability.

## **Coordination**

Exchanging information for mutual benefit, and altering activities and sharing resources to achieve a common purpose. Coordination is working together harmoniously toward the same end or goal.

## **Cooperation**

Exchanging information for mutual benefit, and altering activities and sharing resources to achieve a common purpose. Cooperation is the act of working together to produce an effect or to reach a common goal.

## **Health Disparity**

A negative difference in health status between a racial/ethnic group and the white or general population.

## **Implementation Grants**

Grants available through this Request for Proposals that will fund services and activities that will close the gap in health status.

## **Incidence**

The number of new cases identified and/or reported during a given time period. For example, the number of breast cancer cases diagnosed in Minnesota in 1999.

## **Outcome**

A result, consequence, or effect of an action.

## **Planning Grants**

Grants available through this Request for Proposals that will fund such activities as: community assessment, coordination activities, and development of community-supported strategies.

## **Populations Of Color**

Groups, in addition to American Indians, who can be served with grants under this Request for Proposals. Populations of color are African Americans and African immigrants and

## **Eliminating Health Disparities Initiative Community Grants Program Request for Proposals**

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refugees, Asian Americans including Southeast Asian immigrants and refugees, and Hispanics/Latinos including immigrants and refugees.

### **Prevalence**

The number of persons in a population who have ever experienced the event of interest. For example, the number of women living in Hennepin County who have been diagnosed with breast cancer.

### **Priority Health Areas**

The health conditions that can be addressed with grants under this Request for Proposals. The eight priority health areas are: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations for adults and children, infant mortality, teen pregnancy prevention, and violence and unintentional injuries.

### **Protective Factors**

Those factors or elements that buffer against or moderate the effects of individual, family, and community vulnerabilities, stressors, and environmental hazards. Protective factors do not eliminate risks, but moderate them and protect against harm.

### **Racial/Ethnic Groups**

Groups who can be served with grants under this Request for Proposals. Racial/ethnic groups are African Americans and African immigrants and refugees, American Indians including those who live on reservations as well as those who do not, Asian Americans including Southeast Asian immigrants and refugees, and Hispanics/Latinos, including immigrants and refugees.

### **Strategies**

An approach, activity, or set of activities to reach an objective.

### **Strengths**

The ability or capacity to act effectively or be strong. Research indicates that community strengths are key building blocks in sustainable community revitalization efforts. See Appendix C, Asset-Based Community Development.