Appendix K.
Eliminating Health Disparities in Unintentional Injury and Violence

1. Background Information

a. Motor Vehicle Crashes

More people have died in motor vehicle crashes in the United States than have died in all this nation's wars. According to *Injury Prevention and Public Health*, motor vehicle crashes account for 29 percent of all injury deaths in the U.S. and 47 percent of all unintentional injury deaths. More than 80 percent of crash deaths involve drivers or other occupations, and the remaining 20 percent are bicyclists, pedestrians, and motorcyclists.

In Minnesota, motor vehicle-related injuries are the leading cause of injury-related death overall and in nearly every age group. About half the serious traumatic brain injuries and 60 percent of spinal cord injuries are the result of motor vehicle crashes. Those at greatest risk are young (15-24 year old) drivers, elderly drivers, male drivers, unbelted occupants, and unrestrained children. Pedestrian injuries are among the most expensive in terms of hospital charges, and elderly people are particularly vulnerable.

There has been a steady decline in motor vehicle crash fatalities, due to increased seat belt use, declining rates of drinking and driving, safer road and vehicle designs, improvements in emergency medical services, and new acute care technologies. Continued improvements are needed in all these areas.

b. Falls

In Minnesota, falls are the leading cause of injury for children, and for all adults 35 and older. They account for almost half the hospitalized injuries and are the leading cause of injuries treated in emergency departments.

Minnesotans of all ages have fall death rates 1.5 times higher than the U.S. rates. Among the elderly, Minnesota fall death rates are more than three times greater than the national rate. One of every three Americans 65 years old or older falls each year, and falls are the leading cause of injury deaths among this age group. Falls account for 87 percent of all fractures for people 65 years and older, and they are the second leading cause of spinal cord and brain injury among older adults.

Most fatal falls occur in the home, especially for children and the elderly. Fall-related death rates are higher among men than women and differ by race: white men have the highest death rate, followed by white women, African American/African men, and African American/African women.

Falls are the most expensive injury to society, based on hospital charges for all people who were injured in falls.

c. Home Fires

According to the CDC, the U.S. currently has the fourth highest overall fire death rate of all industrialized countries. In 2000, 85 percent of all U.S. civilian fire deaths occurred in homes. On average, a civilian died in a fire nearly every two hours, and someone was injured every 23 minutes.

Residential fires disproportionately affect young children, older adults, African Americans, American Indians, and the poorest Americans. When working and properly installed, smoke alarms decrease the chances of dying in a house fire by 40 to 50 percent.

However, about one-quarter of U.S. households lack working smoke alarms. In a typical home fire, people have only about two minutes to get outside safely once the alarm sounds.

Alcohol impairment contributed to 40 percent of the residential fire deaths, and cigarettes caused about a fourth of fire deaths.

d. Poisonings

Poisonings, both self-inflicted and unintentional, are leading causes of hospitalized injuries in Minnesota. Self-inflicted poisoning is the first leading cause for females ages 10-44 and the second leading cause for those aged 45-54.

When all age groups are combined, unintentional poisoning is the fourth leading cause of hospitalized injury. The youngest children are most affected: for infants under age one, poisoning is the leading cause of injury, and for those ages one to four, the second leading cause of injury.

According to the CDC, U.S. poison control centers handle an average of one poison exposure every 15 seconds. More than 90 percent of poison exposures occur in the home and 53 percent occur among children younger than age six. The most common poison exposures for children were ingestion of household products such as cosmetics and personal care products, cleaning substances, pain relievers, foreign bodies, and plants. For adults, the most common poison exposures were pain relievers, sedatives, cleaning substances, antidepressants, and bites and stings.

Childhood lead poisoning is considered one of the most preventable environmental diseases of young children, yet about one million children have elevated blood levels of lead. Carbon monoxide results in more fatal unintentional poisonings in the United States than any other agent, with the highest number occurring during the winter months.

U.S. medical spending for poisoning treatment totaled $3 billion in 1992. Spending averaged $925 (in 1992 dollars) per case.

e. Suicide and Self-Inflicted Harm

Suicide and other self-inflicted harm is a public health problem in Minnesota. Minnesotans are five times more likely to die from suicide than from homicide. The national average is one suicide for every homicide.

In the 1990s, Minnesota became the first state to dedicate money to suicide prevention. The suicide rate declined steadily for 15 years, to a low of 8.9 per 100,000 people in 2000. Minnesota's rate declined faster than the national average. However, since 2000, the suicide rate in Minnesota has risen steadily every year, with rates much higher than the national average. By the end of 2005, Minnesota's rate had increased nearly 16 percent compared to four percent nationally. In 2008, our rate reached an all-time high of 590 suicide deaths, or 11 per 100,000 population. Not since 1986 has Minnesota experienced such a high rate of suicides, which then topped 13 per 100,000 people. The current trend does not appear to be showing any signs of reversal.

In Minnesota:

- Males comprise more than four-fifths of all suicide deaths.
- Suicide is the sixth leading cause of death for Asian Americans, seventh for American Indians and Hispanics/Latinos, and tenth for whites. Suicide is not in the top ten causes of death for African Americans.
- The suicide rate for American Indians is higher than for any other racial/ethnic group, the white rate is the second highest, followed by Hispanic/Latino, African American, and Asian American. [1]

More than 90 percent of suicides are associated with mental illness and/or alcohol and substance abuse, but more than 95 percent of those with mental health problems, such as depression or post-traumatic stress disorder, do not complete suicide.

Reducing depressive symptoms by medicine or counseling alone does not necessarily reduce suicidal behavior; the greatest success in dealing with depression is a combination of exercise, counseling therapy, and medication.

f. Sexual Violence

Nationally, according to the Centers for Disease Control and Prevention (CDC):

- One in six women and one in 33 men reported experiencing an attempted or completed rape at some time in their lives.
- The rates are much higher for persons with disabilities.
- Other sources report as many as one in four women. Note that it is important to consider each data source, because victims differentially seek medical care, report to law enforcement, and/or respond to surveys. Viewing different data sources may also offer further insight in understanding sexual violence.

[1] MDH Injury and Violence Prevention Unit. *Injury-Related Mortality in Minnesota, 1990-1999.* Published May 2002. http://www.health.state.mn.us/injury/pub/mort/index.cfm.

In Minnesota, according to *The Costs of Sexual Violence*:

- In 2005 alone, 61,000 Minnesota children and adults were sexually assaulted, some of them more than once, for a total of 77,000 assaults.
- Of the 61,000, 80 percent were female and 29 percent were under age 18.
- One in 70 Minnesota children was sexually assaulted, with the highest rate among girls aged 13-17.
- In 2005, the cost of sexual violence in Minnesota was $8 billion, including direct health care costs, work losses, law enforcement and prison-related charges, and indirect costs.

Almost two-thirds of all rapes are committed by someone who is known to the victim. Seventy-three percent of sexual assaults reported in a 2005 survey were perpetrated by a non-stranger. Of those, 38 percent were friends or acquaintances of the victim, 28 percent were intimates and seven percent were other relatives. [2]

2. Menu of Activities

Goal: To close the gap in the health status of populations of color and American Indians as compared to whites in unintentional injury and violence.

♦♦♦♦♦♦ Indicates an activity that will lead to a policy, systems, or environmental change.

Objective A. Prevent unintentional injuries and violence	
Strategy A.1. Improve road and trail safety	
UIV Activity A.1.1.	Determine patterns of seatbelt usage in the target population and frame, develop, and provide culturally-appropriate messages about the importance of wearing a seatbelt.
UIV Activity A.1.2.	Promote the use of car safety seats and booster seats in community settings through education and giveaways. Addresses more than one PHA. See: Infant Mortality Activity C.4.2.
UIV Activity A.1.3.	Establish policies and procedures in worksites and other community settings that will reduce driving while impaired, sleep-deprived, using a cell phone, or texting. ♦♦♦♦♦♦
UIV Activity A.1.4.	Provide an intervention training program for servers of alcoholic beverages, such as the *Alcohol Server Intervention Program,* the *Training for Intervention Procedures Program,* the *Responsible Beverage Server Training Program,* or the *Techniques of Alcohol Management Program.*

[2] National Crime Victimization Survey, 2005

UIV Activity A.1.5.	Promote the use of bicycle helmets in community settings through education and giveaways.
Strategy A.2. Improve home safety	
UIV Activity A.2.1.	Provide education on home safety and injury prevention in health care and other community settings.
UIV Activity A.2.2.	Conduct home visits to reduce hazards and promote safety in homes, using such tools as the *Home Safety Checklist, Safety: A Home Fall Prevention Checklist for Older Adults*, or the *Fall Prevention Home Safety Checklist*. Addresses more than one PHA. See: Infant Mortality Activity C.4.3.
UIV Activity A.2.3.	Provide the *Matter of Balance Program* for older adults in clinical or community settings, and encourage older adults to manage medications, get regular vision checks, and maintain lower body strength and balance through regular physical activity.
Strategy A.3. Prevent suicide and self-inflicted harm	
UIV Activity A.3.1.	Conduct suicide prevention training, such as *Gatekeeper Training,* the *American Indian Life Skills Development Curriculum,* or the *Columbia University TeenScreen Program* in schools and other community settings.
UIV Activity A.3.2.	Establish policies and procedures that will identify people who are at high risk for suicide or self-inflicted harm in worksites and other community settings and link them to culturally and linguistically appropriate prevention resources. ♦♦♦♦♦♦
UIV Activity A.3.3.	Encourage people who are at high risk for suicide or self-inflicted harm to exercise regularly, participate in culturally and linguistically appropriate counseling or therapy programs, and comply with prescribed medications.
Strategy A.4. Prevent traumatic brain injuries	
UIV Activity A.4.1.	Provide messages about the dangers of shaking infants and young children to parents, family members, and informal child care providers, such as shaken baby prevention videos, parent education protocols, “no shaking” pledges, and *Babies Cry* tip cards through hospitals, prenatal classes, and other organizations. Addresses more than one PHA. See: Infant Mortality Activity C.4.1.
Strategy A.5. Prevent injuries from assaults	
UIV Activity A.5.1.	Provide public health nurse home visiting to prevent child maltreatment and to teach effective parenting and behavior management strategies and techniques.
UIV Activity A.5.2.	Provide youth afterschool and weekend mentoring activities and programs that address life, communication, and conflict resolution skills.

UIV Activity A.5.3.	Provide fatherhood training and accountability.
Strategy A.6. Decrease sexual violence	
UIV Activity A.6.1.	Implement modules from *A Place to Start: A Resource Kit for Preventing Sexual Violence* in the community.
UIV Activity A.6.2.	Implement intimate partner violence prevention interventions, such as public health nurse home visiting and effective partnering training and modeling. Addresses more than one PHA. See: Infant Mortality Activity B.1.8.

Objective B. Reduce the risk factors that can lead to unintentional injuries and violence	
Strategy B.1. Increase physical activity	
UIV Activity B.1.1.	Promote opportunities in the community for culturally-appropriate physical activity, such as implementing worksite wellness programs or increasing access to neighborhood parks, health clubs, and fitness centers. ♦♦♦♦♦♦ Addresses more than one PHA. See: Diabetes Activity B.2.1. and Heart Disease and Stroke Activity B.2.1.
UIV Activity B.1.2.	Establish policies that will ensure daily quality physical education in schools ♦♦♦♦♦♦ or implement school-based physical activity programs, such as *Walking for Health* and *WOLF* (Work Out Low Fat). Addresses more than one PHA. See: Diabetes Activity B.2.1. and Heart Disease and Stroke Activity B.2.1.
UIV Activity B.1.3.	Provide fitness and healthy life-style programs, such as the *Enhance Fitness Program,* the *Healthy Eating for Successful Living Program,* and the *Healthy Moves for Living Well Program*, in clinical or community settings. Addresses more than one PHA. See: Diabetes Activity B.2.6. and Heart Disease and Stroke Activity B.2.6.
Strategy B.2. Decrease alcohol misuse	
UIV Activity B.2.1.	Establish policies and procedures that will hold individuals criminally responsible for allowing an event where people under 21 possess or consume alcohol, such as a social host ordinance. ♦♦♦♦♦♦

UIV Activity B.2.2.	Establish policies and procedures that will ensure the implementation of *SBIRT (Screening, Brief Intervention, and Referral to Treatment)* in primary care centers, hospital emergency rooms, trauma centers, and other community settings. ♦♦♦♦♦♦ Addresses more than one PHA. See: Infant Mortality Activity B.3.1.

3. Resources

UIV Activity A.1.1.	Seatbelt promotion in communities: Click It or Ticket is the most successful seat belt enforcement campaign ever, helping create the highest national seat belt usage rate of 82 percent (90% in Minnesota). Coast to coast, day or night, the message is simple - Click It or Ticket. Also, use the Zodiac Wheel in appropriate communities. See www.nhtsa.gov for detailed intervention information.
UIV Activity A.1.2.	Car seats and booster seats: The *4 Steps for Kids* campaign will help parents and guardians properly choose and install the correct safety seat for your child. The LATCH program consists of installing lower attachments on child seats and a set of tether anchors in the vehicle to hold the child seat in place without the use of the vehicle's seat belts. See www.nhtsa.gov for detailed intervention information.
UIV Activity A.1.3.	Worksite and community policies dealing with impaired, distracted and sleep-deprived driving: See www.nhtsa.gov for detailed intervention information at a variety of levels – individual, community, organizational, employer, courts and enforcement (ignition interlock, for example), etc. The Impaired Driving Division develops partnerships to cooperatively save lives, prevent injuries, and reduce traffic-related health care and economic costs resulting from impaired driving (alcohol and other drugs). Also, see http://www.cdc.gov/MotorVehicleSafety/ Impaired_Driving/impaired-drv_factsheet.html for a list of proven interventions.
UIV Activity A.1.4.	Server intervention training: A systematic review conducted by CDC researchers on behalf of the Task Force on Community Preventive Services concluded that well-executed multi-component interventions with community mobilization are effective in reducing alcohol-related crashes. The interventions included most or all of following: responsible beverage service training, other efforts to limit alcohol access, sobriety checkpoints, and a strong local media component. Based on these findings, the Task Force recommended that multi-component interventions with community mobilization be widely implemented. See http://www.cdc.gov/MotorVehicleSafety/Impaired_Driving/impaired-drv_factsheet.html for additional details and references.
UIV Activity A.1.5.	Bike helmet promotion and distribution: Through education, enforcement, outreach and legislation, the National Highway Traffic Safety Administration’s (NHTSA) bicycle safety program goals are directed toward reducing bicycle injuries and fatalities. Bicycling is encouraged as an alternate mode of transportation to motor vehicle travel. See www.nhtsa.gov for detailed

	intervention information, with further links to Safe Routes to Schools. The Minnesota Department of Transportation (www.dot.state.mn.us) and the Bicycle Helmet Safety Institute (http://www.helmets.org) provide additional information on bicycle facilities and helmet resources. The Brain Injury Association of Minnesota (www.braininjurymn.org) along with the Brain Injury Association of the U.S. (www.biausa.org) both advocate strongly for helmet use and can assist with helmet procurement, distribution and fitting.
UIV Activity A.2.1.	Home safety education in health care and community settings: refer to an array of resources to assist with incorporating home safety education in existing health care and community settings, including: www.cdc.gov/NCIPC; www.cpsc.org; www.stipda.org; www.usfa.fema.gov; www.safekids.org; and www.nfpa.org.
UIV Activity A.2.2.	The nurse-family partnerships, tribal, state and local health departments all are able to provide levels of involvement and support in nurse or health educator home visiting to both educate on injury prevention and make home modifications.
UIV Activity A.2.3.	Matter of Balance and other fall prevention strategies: An overview of fall prevention strategies from the National Injury Prevention Center at the CDC can be accessed at www.cdc.gov/ncipc/factsheets/falls.htm. Information about the Matter of Balance program and how this program is being implemented in Minnesota can be found at www.mnhealthyaging.org . Additional resources and information about falls prevention in Minnesota can be found at www.mnfallsprevention.org. For questions about falls prevention programs, including leader training and program implementation, send an e-mail to health.aging@state.mn.us
UIV Activity A.3.1.	Suicide prevention training: Refer to the MDH Suicide Prevention Program (www.health.state.mn.us/divs/cfh and look for suicide prevention in the listings), the National Suicide Prevention Resource Center (www.sprc.org), to the National Injury Center at the CDC (www.cdc.gov/ncipc/) and to Suicide Awareness Voices of Education (SAVE) at www.save.org. A number of states offer support for Gatekeeper Training (WI, OH, OR, WA) and several Tribal Leaders support American Indian Life Skills Training.
UIV Activity A.3.2.	Policies and procedures to identify those at high risk for suicide and attempts: Refer to the resources indicated above.
UIV Activity A.3.3.	Prevention and intervention: exercise, counseling therapy, medication: Refer to the resources indicated above.
UIV Activity A.4.1.	The website of the Brain Injury Association of the U.S. (www.biausa.org) includes a prevention section for different age groups that are particularly at risk for brain injury and includes information on motor vehicle safety, falls, firearm injury and alcohol. Several state, national and international entities are

	supporting communities, hospital / trauma centers and local / state health departments in implementing the Abusive Head Trauma (formerly Shaken Baby Syndrome) Prevention Program. Resources are being compiled at www.dontshake.org. Parents are encouraged to watch an educational DVD and then sign a pledge to never shake a baby.
UIV Activity A.5.1.	PHN home visiting to prevent child maltreatment: Training and support for this intervention can be found through Tribal and local health departments across Minnesota, as well as from the MDH (Division of Community and Family Health, www.health.state.mn.us/divs/cfh). In addition, resources include www.cyfd.org/content/home-visiting and www.nursefamilypartnership.org.
UIV Activity A.5.2.	Afterschool and weekend mentoring for youth: Several cities and counties have summer employment and afternoon / evening job skills training programs designed to both impart useful job skills and offer real earned income and, at the same time, provide a viable alternative to gang activity and unemployment. The Mentoring Partnership of Minnesota (www.mpmn.org) seeks to link young people with a quality mentor and mentoring program; in addition, Minnesota has an array of corporate partners involved with mentoring youth (www.management-mentors.com) and www.mentoring.org.
UIV Activity A.5.3.	Fatherhood training and accountability: Refer to www.fatherhood.org, www.fatherhood.gov and www.fatherhood.hhs.gov for a variety of intervention ideas. In Minnesota, MAD DADS (www.maddads.com and www.minneapolismaddads.org) and the Minnesota Fathers and Families Network (www.mnfathers.org) serve to strengthen healthy fathering.
UIV Activity A.6.1.	Resources and strategies to prevent sexual violence are varied. Contact the MDH at www.health.state.mn.us/injury/topic/svp/index.cfm and speak with the prevention program director to tailor specific interventions; implement components of "A Place to Start" (http://www.health.state.mn.us/injury/topic/svp/addinfo/index.cfm#resourcekit), a resource kit for professionals and community members; and contact the Minnesota Coalition Against Sexual Assault (MNCASA at www.mncasa.org).
UIV Activity A.6.2.	PHN home visiting to prevent IPV: As described above, PHN home visiting to prevent child maltreatment: Training and support for this intervention can be found through Tribal and local health departments across Minnesota, as well as from the MDH (Division of Community and Family Health, www.health.state.mn.us/divs/cfh). In addition, resources include www.cyfd.org/content/home-visiting and www.nursefamilypartnership.org.

UIV Activity B.1.1.	Physical activity helps to prevent falls in senior adults by building strong muscles, balance and endurance (www.fallpreventiontaskforce.org/ falls_physicalactivity.htm). An overview of fall prevention strategies from the National Center for Injury Prevention and Control at the CDC may be accessed at www.cdc.gov/ncipc/factsheets/falls.htm.

	Information about program implementation in Minnesota for Matter of Balance, EnhanceFitness, and Healthy Eating for Successful Living can be found at www.mnhealthyaging.org. This website includes information, links and resources about the program as well as information and contacts for leader training in Minnesota. For information about Healthy Moves for Successful Living, go to Partners in Care Foundation http://www.picf.org/landing_pages/22,3.html. For questions or information about falls prevention programs, exercise programs and other healthy living programs in Minnesota including leader training and program implementation, send an e-mail to health.aging@state.mn.us.
UIV Activity B.1.2.	Schools that promote physical activity may have a significant impact on reducing childhood obesity, chronic disease, and, ultimately, adult mortality (www.kidsource.com).
UIV Activity B.1.3.	For resources supporting fitness and lifestyle training in community and health care settings, see www.cdc.gov/healthyyouth/physicalactivity/index.htm, www.fallpreventiontaskforce.org/News.htm, and www.cdc.gov/ncipc/duip/FallsPreventionActivity.htm.
UIV Activity B.2.1.	Develop and adopt social host ordinances: (Also see the supporting resource information in A.1.4, above.) An array of local, state and national organizations have crafted (and many have adopted) model policies aimed at holding adults accountable for youth access to alcohol. See www.madd.org/Professionals/Social-Host/Enacting-a-Social-Host-Ordinance.aspx, socialhost.org, www.chaskamn.com/Social%20Host%20Ordinance.pdf (Chaska, MN), www.co.carver.mn.us/docs/SocialHost_QA.pdf (Carver County, MN), and docs.sumn.org/SocialHostOrdinancesFAQ.pdf for a useful reference guide that compiles the questions and issues most often confronted.
UIV Activity B.2.2.	Policies and procedures to promote, adopt and implement SBIRT (Screening, Brief Intervention and Referral to Treatment) in our trauma centers, with other health care providers, and on college and university campuses: supporting resources are available at www.nhtsa.dot.gov and at www.cdc.gov/ncipc.

4. MDH Contact Person

For more information about unintentional injuries and violence, contact:

Mark Kinde
651/201-5447
mark.kinde@state.mn.us

Appendix L.
Standard MDH Grant Agreement

Minnesota Department of Health
Grant Agreement

THIS GRANT AGREEMENT, and amendments and supplements thereto, is between the State of Minnesota, acting through its Commissioner of Minnesota Department of Health (hereinafter "STATE") and [INSERT GRANTEE'S FULL LEGAL NAME], an independent organization, not an employee of the State of Minnesota, address [INSERT GRANTEE'S ADDRESS], (hereinafter "GRANTEE"), witnesseth that:

WHEREAS, the STATE, pursuant to Minnesota Statute §[INSERT THE AUTHORIZING STATUTE OR LEGISLATION] is empowered to [GIVE A BRIEF DESCRIPTION OF THE PURPOSE OF THIS GRANT PROGRAM]; 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 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. The total obligation of the STATE for all compensation and reimbursement to GRANTEE shall not exceed [AMOUNT IN WORDS] dollars [$(AMOUNT IN NUMERALS)].

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 [ONLY APPLICABLE FOR TANF (TEEN PREGNANCY PREVENTION) GRANTS] 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 Minnesota Statute §16C.05, Subdivision 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

A. If the GRANTEE fails to comply with the provisions of this grant agreement, the STATE may terminate this grant agreement without prejudice to the right of the STATE to recover any money previously paid. The termination shall be effective five business days after the STATE mails, by certified mail, return receipt requested, written notice of termination to the GRANTEE at its last known address.

B. The STATE or GRANTEE may cancel this grant agreement at any time, with or without cause, upon thirty (30) days written notice to the other party.

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 will not be effective until it has been fully 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 attorneys' 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 Chapter 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 (6) 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

[OPTION #1]: [ONLY APPLICABLE FOR TANF (TEEN PREGNANCY PREVENTION) GRANTS]

Disposition of all equipment purchased under this grant shall be in accordance with Code of Federal Regulations, Title 45, 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 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.

[**** OR ****]

[OPTION #2]:

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 parts 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 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 of 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 without prior written approval by the STATE’S Authorized Representative, unless such release is a specific part of an approved work plan included in this grant agreement.

XV. ENDORSEMENT The Grantee must not claim that the STATE endorses its products or services.

XVI. WORKERS' COMPENSATION The GRANTEE certifies that it is in compliance with Minnesota Statute §176.181, Subdivision 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. 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.

XVIII. OTHER PROVISIONS [ONLY APPLICABLE FOR TANF (TEEN PREGNANCY PREVENTION) GRANTS]

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 Minnesota Statute §16C.03, Subdivision 2, provides the Commissioner of 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 contact, GRANTEE certifies that it and its principals:

1. Are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded form 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 of 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 $500,000 or more per year, the grantee agrees to: a) 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, b) to comply with the Single Audit Act of 1984, as amended (31 U.S. Code Chapter 75) and OMB Circular A-133.

   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 expends total direct and indirect federal assistance of $500,000 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 Organization" 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.

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 (4) 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 nine (9) months of the GRANTEE'S fiscal year end.

   OMB Circular A-133 requires recipients of more than $500,000 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 10th 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 Untied 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.

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 [**** PLEASE SELECT ONE OF THE FOLLOWING PROVISIONS BASED ON UPON THE GRANTEE'S ORGANIZATION. DELETE THE OTHERS ****]

[OPTION #1]:

The GRANTEE agrees to comply with the provision 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).

IN WITNESS WHEREOF, the parties have caused this grant agreement to be duly executed intending to be bound thereby.

APPROVED:

1. GRANTEE
The Grantee certifies that the appropriate persons(s) have executed the grant agreement on behalf of the Grantee as required by applicable articles, bylaws, resolutions, or ordinances.

By: ______________________________

Title: ______________________________

Date: ______________________________

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: ______________________________
(with delegated authority)

Title: ______________________________

Date: ______________________________

Distribution:

Agency – Original (fully executed) Grant Agreement
Grantee
State Authorized Representative

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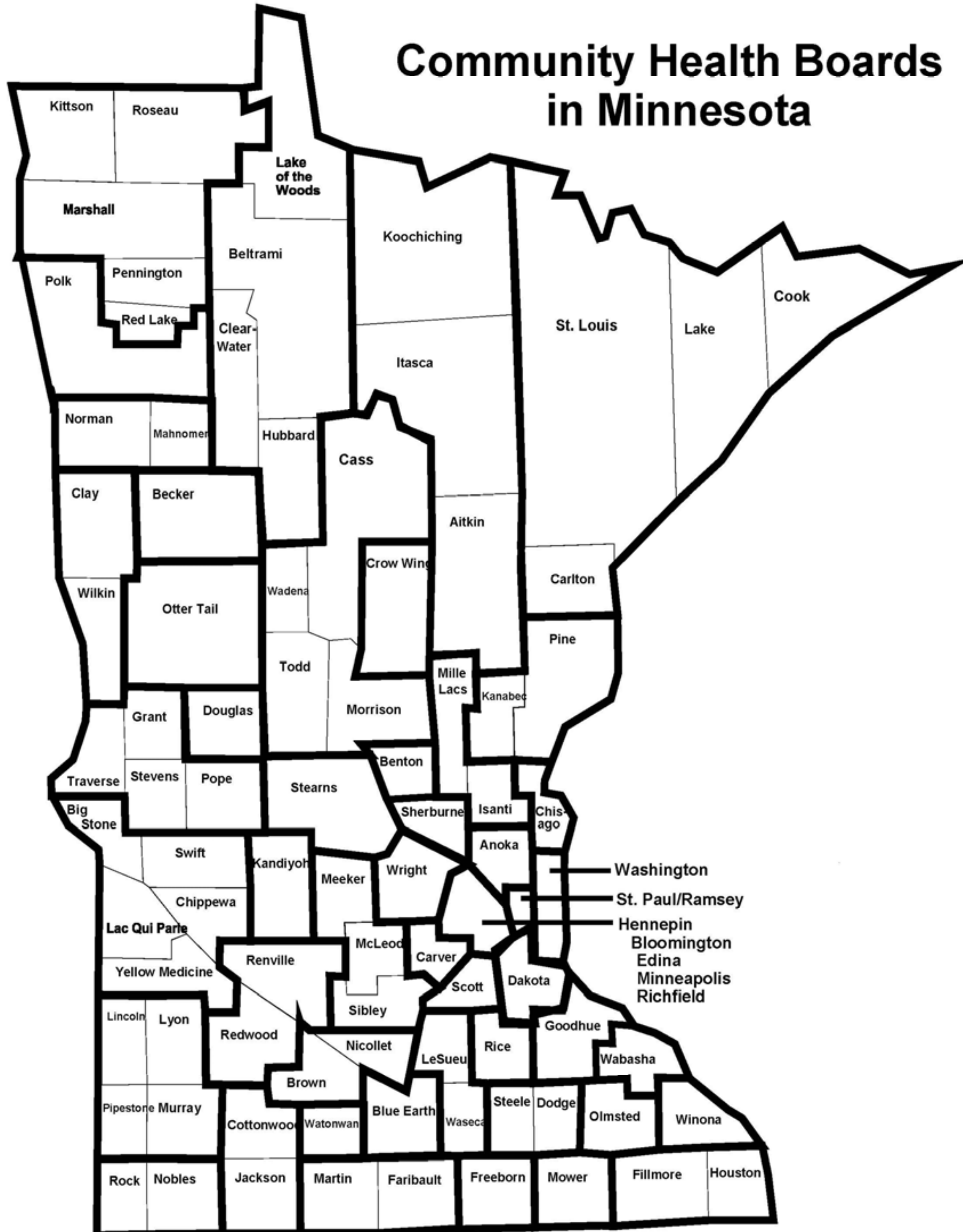
Appendix M.
Community Health Board
Map and Administrators List



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Email: rina.mcmanus@co.anoka.mn.us

BECKER
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Phone: 5399
Email: rmstock@co.becker.mn.us

BENTON
Benton County Human Services
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Cottonwood-Jackson County CHB
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COUNTRYSIDE (BIG STONE-CHIPPEWA-LAC QUI PARLE-SWIFT-YELLOW MEDICINE)
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FARIBAULT-MARTIN
Human Services of Faribault & Martin Counties
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Freeborn County CHB
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Goodhue County CHB
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Isanti County Public Health
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AITKIN-ITASCA-KOOCHICHING
Itasca County Health & Human Services
Sue Erzar
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KANABEC-PINE
Kanabec-Pine County CHB
Wendy Thompson
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Kandiyohi County CHB
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Le Sueur-Waseca CHB
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LLMP Public Health Services Community Health Board
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Meeker-McLeod-Sibley County CHB
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MIDSTATE (GRANT-POPE-STEVENS-TRAVERSE)
Mid-State CHB
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MINNEAPOLIS
Minneapolis Department of Health & Family Support
Gretchen Musicant
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MN, MN 55415
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MORRISON-TODD-WADENA
Morrison County Public Health
Bonnie Paulsen
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Mower County Community Health Services
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Nobles-Rock County CHB
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NORMAN-MAHNOMEN
Norman-Mahnomen Public Health
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NORTH COUNTRY (BELTRAMI-CLEARWATER-HUBBARD-LAKE OF THE WOODS)
Clearwater County Nursing Service
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Quin County CHB
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Winona County CHB
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