

ELIMINATING HEALTH DISPARITIES INITIATIVE

2003 Report to the Legislature
January 15, 2003

“Mobilizing Community Assets for Action”

**“Building and strengthening
community partnerships to
reduce health disparities”**

**“Identifying and creating
innovative strategies to
address racial/ethnic
disparities”**

**“Promoting active and full
community involvement”**



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Report to the 2003 Minnesota Legislature on the Eliminating Health Disparities Initiative



January 15, 2003

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Executive Summary

Minnesota Eliminating Health Disparities Initiative

Report to the 2003 Minnesota Legislature

Overview:

- Disparities in health status between the majority population and populations of color and American Indians in Minnesota have existed for some time, and are, in some cases, getting worse, not better.
- These disparities are a result of a complex interplay of many factors including access to health care, genetics, racism, social conditions, and health behaviors.
- Effectively addressing these disparities requires a comprehensive, community-driven, sustained approach. Communities of color, American Indians, MDH, and the Legislature have worked tirelessly to ensure that the EHDI is comprehensive and community-driven.
- By creating the EHDI, a ten-year initiative, a powerful investment has been made in the current and future health of Minnesota's populations of color and American Indians and the state as a whole.
- In the first year of the EHDI, alone, great strides have been made to reduce these health disparities.
- The EHDI Report to the 2003 Minnesota Legislature describes the work underway through the grantees.

What is the EHDI?

The EHDI is comprehensive & statewide & focuses on strengthening and improving health of Minnesota's four major racial/ethnic groups:

- | | |
|--------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> American Indians | <input type="checkbox"/> African Americans |
| <input type="checkbox"/> Asian Americans | <input type="checkbox"/> Latinos/Hispanics |

Where did it come from and why?

- The EHDI was created by the 2001 Minnesota Legislature to reduce disparities and improve the health of populations of color and American Indians in the state.
- Health disparities mean that populations of color and American Indians in Minnesota experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, cancer and other diseases and conditions, and poorer general health.
- In some cases, Minnesota's health disparities are the worst in the nation. These health disparities have an impact on all Minnesotans.
- Improved health and prevention of serious health problems in communities of color are good for all of Minnesota. A healthy citizenry is good for the state's economy and its ability to bounce back in tough times. Healthy families and children, and a healthy work force, elevate the fortunes of the entire state.

What are the goals?

- **By 2010, decrease by 50% disparities in infant mortality and adult and child immunization rates.**
- **By 2010 close the gap in health disparities in breast and cervical cancer; HIV/AIDS and sexually transmitted infections; cardiovascular disease; diabetes; and accidental injury and violence.**

What is the EHDI 2003 Report to the Legislature?

A Report to the Legislature is required by statute and is to report on local community projects, tribal government, and community health board prevention activities funded under this initiative. This is the first of the biennial reports and was submitted as required January 2003.

What are the grants? What do they do? How are they funded?

- The EHDI grants are hard at work in communities across the state to improve the health of populations of color and American Indians through three grant programs:
 - **Community Grants Program**
 - **Tribal Grants Program**
 - **Tuberculosis Health Screening and Follow-up Services to Foreign-born Persons Grants Program**
- State General Funds support the **Community and Tribal Grants** to eliminate health disparities in the following priority health areas:
 - **Infant mortality**
 - **Adult and child immunizations**
 - **Breast and cervical cancer**
 - **HIV/AIDS and sexually transmitted infections**
 - **Cardiovascular disease**
 - **Diabetes**
 - **Accidental injury and violence**
- Federal TANF funds for **healthy youth development** work through the **Community Grants** program.
- Tribal Governments receive **Tribal Grants** through a distribution formula to reduce health disparities in the seven priority health areas.
- The 60 **Community and Tribal Grant Programs** grantees receive either **Planning** or **Implementation** grants.
 - **Planning** grants are short term and are being used by communities for assessing community needs and assets, coordinating activities, and developing community-supported strategies. Planning grantees are able to request funds for implementation of activities that come out of their planning process.

- **Implementation** grants are longer in duration and provide communities with the resources to deliver to their communities services and activities that will reduce the gap in health status.
- State General Funds were also allocated for local public health agencies through a statutory distribution formula to specifically provide **Tuberculosis Health Screening and Follow-up Services to Foreign-born Persons**.

Who receives the funds and what do they do with them?

- **Community and Tribal Grantees** work on one or more of the **priority health area**. Within each of the four racial/ethnic communities addressed by the Initiative, all priority health areas are being addressed by the EHDI grantees.
The selection of the targeted population and range of priority health areas make the EHDI unique and extremely complex and other factors contribute to this complexity. Each racial/ethnic group experiences the same health disparities, they do not experience these disparities to the same degree.
- Grantees' selections of diverse and culturally relevant strategies are based on the ideas, experience, and research of both local communities and state and national public health professionals.
 - ± MDH provides grantees with the most recent research on scientifically proven strategies.
 - ± Grantees bring their perspective on how these strategies can transfer to their own communities.**The strategies selected and implemented by grantees, therefore, are very diverse; some are tested and proven, others innovative and evolving.**
- EHDI grantees serve diverse geographic regions: some grantees provide services in multiple counties while others concentrate on small neighborhoods in Minneapolis and St. Paul.
- Together, EHDI **Community and Tribal Grant** recipients reach communities in a total of 43 counties in Minnesota.
- Grants to Community Health Boards (CHB's) to provide **Tuberculosis Health Screening and Follow-up Services** reach communities in 77 counties through 46 CHB's and provide services according to specified outreach, contact, referral, and medical protocols.

How is EHDI evaluated; outcomes determined and measured, and accountability assured?

- MDH, along with its community partners, is establishing a comprehensive plan to evaluate each component of the EHDI.
- Directed by the EHDI Steering Committee, the state and community partnership mandated in statute, MDH brought together local partners in the development of this plan, including community research experts and the University of Minnesota as the **Participatory Research Partnership (PRP)**. PRP's primary charge is identifying intermediate outcomes that impact the health of individuals and communities including health status, health systems, environmental (external) factors, community assets, historical factors, and cultural factors.

EXECUTIVE SUMMARY

- MDH has contracted with Rainbow Research to assist **Community and Tribal Grantees** in developing individual program level evaluation to ensure grantee accountability and build grantee evaluation capacity.

With increased emphasis on accountability and quality of services, it is essential that MDH continue to focus on program level evaluation activities and improved measurement of health outcomes for populations of color and American Indians.

- Evaluation efforts will lead to improved outcomes, greater quality of services, and cost-efficient approaches to eliminating health disparities.
- Improved outcome measurement includes the identification and monitoring of all of those factors that impact the health of communities.



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Eliminating Health Disparities Initiative *Mobilizing Community Assets for Action*

By 2010, decrease by 50% disparities in infant mortality and adult and child immunization rates.

By 2010 close the gap in health disparities in breast and cervical cancer; HIV/AIDS and sexually transmitted infections; cardiovascular disease; diabetes; and accidental injury and violence.

2001 Legislative Goals

INTRODUCTION

In 2001, in response to growing disparities in health between Minnesota American Indians and populations of color and the White population, the Minnesota Legislature created the Eliminating Health Disparities Initiative (EHDI). This 2003 Report to the Legislature is required by statute (see Appendix A).

The EHDI is a comprehensive statewide effort focusing on strengthening and improving the health of American Indians, African Americans, Asian Americans and Latinos/Hispanics. Minnesota is only the second state in the country to develop a comprehensive statewide effort to address racial and ethnic health disparities. The Minnesota EHDI could serve as a model for eliminating health disparities nationwide.

Health disparities mean that populations of color and American Indians in Minnesota experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, cancer and other diseases and conditions, and poorer general health (See Appendix B). These disparities also affect Minnesota's newly arrived immigrants and refugees. In some cases, the disparities are the worst in the nation. These health disparities have an impact on all Minnesotans. The EHDI has been created to reduce disparities and improve the health of populations of color and American Indians in the state. Improved health and prevention of serious health problems in communities of color is good for all of Minnesota. A healthy citizenry is good for the state's economy and its ability to bounce back in tough times. Healthy families and children, and a healthy work force, elevate the fortunes of the entire state.

The resources from the EHDI are hard at work in communities across the state to improve the health of populations of color and American Indians. According to 2001 legislation, in the first biennium MDH was allocated a total of \$12.7 million biennial funding for EHDI grant programs. (In 2002 this funding was reduced \$500,000 for this biennium. See Appendix A) The EHDI supports three grant programs: the

"Health disparities mean that populations of color and American Indians in Minnesota experience shorter life spans, higher rates of infant mortality, and poorer general health."

Community Grants Program, the Tribal Grants Program and the Tuberculosis Services to Foreign-born Person Grants Program (see Table 1).

The Minnesota Legislature directed State General Funds each biennium for the Community Grants Program to eliminate health disparities in the following priority health areas: infant mortality; adult and child immunizations; breast and cervical cancer; HIV/AIDS and sexually transmitted infections; cardiovascular disease; diabetes; and accidental injury and violence. An additional \$4 million per biennium in federal TANF funds were allocated to EHDI for healthy youth development.

Tribal Governments were allocated \$1 million from State General Funds per biennium to reduce health disparities in the seven priority health areas.

Participants in the Community and Tribal Grant Program participants receive either planning or implementation grants. *Planning* grants are short term and are being used by communities for assessing community needs and assets, coordinating activities and developing community-supported strategies. *Implementation* grants are longer in duration and provide communities with the resources to deliver services and activities to their communities.

<u>EHDI Priority Health Areas</u>
▪ Infant mortality
▪ Adult and child immunizations
▪ Breast and Cervical Cancer
▪ HIV/AIDS and sexually transmitted infections
▪ Cardiovascular disease
▪ Diabetes
▪ Accidental injury and violence
▪ Healthy youth development

Finally, \$500,000 per biennium from State General Funds were allocated to local public health agencies to specifically provide health screening and follow-up services for tuberculosis for foreign-born persons. MDH notifies local public health departments of the arrival of each new refugee who initially locates within their service area. Local public health staff contact each newly arrived refugee family, arrange for comprehensive screening and report results back to MDH. Local public health agencies are also responsible for providing outreach services (e.g. directly observed therapy, interpreter services, incentives, enablers, etc.) to ensure that patients with tuberculosis adhere to and complete their prescribed treatment regimens. EHDI funding provides some of the financial support for this intensive and costly outreach service (See Appendix C for tuberculosis screening and treatment rates).

Table 1: EHDI Grant Program Descriptions

Grant	Eligible Organizations/Communities	Distribution System	Biennial Funding	Number of Grantees
Community	Faith based, social service & community non profit organizations, Community Health Boards & Others	Competitive	\$ 6,700,000	11 Planning 25 Implementation
TANF*	Same as Community Grants	Competitive	\$ 4,000,000	4 Planning 16 Implementation
Tribal	Tribal Governments	Formula	\$ 1,000,000	4 Planning 6 Implementation
Tuberculosis	Community Health Boards	Formula	\$ 500,000	46 Implementation
Biennial Grants Total			\$12,200,000	

* Federal TANF funds were distributed through the Community Grants process for healthy youth development.

Each of these grant programs is helping communities organize and mobilize their resources in support of effective and sustainable programs to eliminate disparities. The EHDI grantees are community-based and supported by the communities they serve. The programs they are implementing are research-based or based on promising strategies that are designed to complement other related community activities and resources, and employ strategies with a positive impact on priority health areas.

PUBLIC HEALTH AND COMMUNITY PARTNERSHIP

The EHDI grew out of a grassroots effort by populations of color and American Indians to demonstrate the devastating impact of health disparities on their communities. For many years, these communities prompted MDH and the legislature to recognize the health disparities that exist in their communities. As support grew at the state level, community members, MDH and legislators shaped the legislation to create the EHDI. These efforts resulted in a community and strengths-based initiative that would empower communities to improve the health of their members.

Community involvement is crucial to the success of an initiative of this magnitude. From conception to implementation, communities of color and tribal communities have been vital players in the EHDI. Following the passage of the landmark EHDI legislation, people from all over the state came together for a one-day meeting to help MDH shape the way in which the grant funding requests would be solicited and funded. Approximately, 160 persons representing many communities from across the state attended the meeting to develop the Community Grants Request for Proposal (RFP) and discuss the needs of local communities to reduce health disparities.

In addition, MDH led by the Office of Minority and Multicultural Health (OMMH) sponsored the first statewide conference on racial and ethnic health disparities in Minnesota. The conference introduced the Initiative to communities and the general public as well as serving as an opportunity for communities of color and American Indians to develop partnerships and networks. Over 600 persons from all over the state attended to learn about the EHDI, the extent of health disparities in their communities and strategies to reduce health disparities. The conference also provided opportunities for communities to develop coalitions among their communities.

As the Community Grants RFP was released five Community and Tribal Grants Program workshops were held around the state to review the RFP and application process, encourage collaboration among organizations and tribes and increase awareness of health disparities. Community organizations co-hosted these sessions with local public health agencies. In attendance were local public health officials, community agencies, faith-based organizations as well as many potential new partners.

"Each community a 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..."

from Asset-based Community Development Institute

As a result of the workshops, the conference, and community involvement, the Community Grants Program received 167 applications totaling \$39.6 million from community based organizations across the state, some of which had never before submitted an application for grant funds to MDH.

MDH continued to reach out to the communities in the Community Grants review process. Approximately 100 community members representing all of the major racial and ethnic groups in Minnesota responded to a call for participation in the Community Grants proposal review process. Nineteen teams of five community members were assembled to review the proposals and make recommendations to MDH for funding. A total of 50 organizations and tribal governments were awarded grant funds through the competitive Community Grants process. Ten tribal governments were awarded grant funds through the Tribal Grants Program (See Appendix D for grantee descriptions).

The partnership that developed among public health and communities in Minnesota resulted in a geographically balanced initiative whose grantees are providing services to each of the four racial and ethnic communities in Minnesota. This innovative partnership could serve as a model for other states.

EHDI GRANTS

Community and Tribal Grantees work on one or more of the priority health areas (See Table 2). Within each of the four communities, all health priority areas are being addressed by the EHDI grantees. By documenting the need and identifying the significant priority health area, Community and Tribal Grantees are effectively able to establish the priorities for their targeted communities. This is especially important for the communities to feel ownership of the Initiative.

Table 2: Ranking of Health Priority Areas by Populations of Color and American Indians for Community, Tribal and TANF Grantees

African American		American Indian	
Healthy Youth Development*	1	Infant Mortality	1
Diabetes	2	Unintentional Injuries and Violence	2
Cardiovascular Disease	3	Cardiovascular Disease	3
HIV/AIDS and STDs	3	Diabetes	4
Immunization for Children and Adults	5	Immunization for Children and Adults	4
Unintentional Injuries and Violence	6	HIV/AIDS and STDs	6
Infant Mortality	7	Breast and Cervical Cancer	7
Breast and Cervical Cancer	8	Healthy Youth Development*	7
Asian American		Hispanic Latino	
Immunization for Children and Adults	1	Diabetes	1
Cardiovascular Disease	2	Healthy Youth Development*	2
Healthy Youth Development*	2	HIV/AIDS and STDs	3
Diabetes	4	Immunization for Children and Adults	3
Unintentional Injuries and Violence	4	Breast and Cervical Cancer	5
Breast and Cervical Cancer	6	Cardiovascular Disease	5
HIV/AIDS and STDs	7	Unintentional Injuries and Violence	5
Infant Mortality	7	Infant Mortality	8

*TANF dollars, which represent almost a third of total grant funding, can only be directed to Healthy Youth Development programs and, therefore, may influence the priorities selected by communities.

EVALUATION

MDH, along with its community partners, is establishing a comprehensive plan to evaluate each component of the EHDI. The final evaluation plan for the EHDI will include several data gathering instruments and procedures to measure outcomes at multiple levels. In developing this plan, MDH has partnered with a number of organizations and individuals with a wide range of expertise in measuring health disparities. MDH has been guided by the efforts of the Centers for Disease Control and Prevention and the National Office of Minority Health. Directed by the EHDI Steering Committee, the state and community partnership mandated in statute, MDH has also brought together local partners in the development of this plan including community research experts and the University of Minnesota.

"The concept of health is complex and must be approached as a multi-dimensional construct, comprising 'quantity of life' (mortality), 'quality of life' (morbidity or disability), social and environmental dimensions"

- New Zealand Ministry of Health

Within the initial months of the EHDI, extensive effort has been put forth to identify measurable outcomes (long term, intermediate and program level) for community, tribal and local public health grant programs. While MDH vital records and surveillance systems are available to monitor the progress of meeting long-term outcomes, additional data sources are under review to determine their effectiveness in documenting intermediate outcomes. The Participatory Research Partnership (PRP) was established with the primary charge of identifying intermediate outcomes that impact the health of individuals and communities including health status, health systems, environmental (external) factors, community assets, and historical and cultural factors. The PRP, a subcommittee of the EHDI Steering Committee, proposes to engage citizens from all of Minnesota's communities in the identification and monitoring of factors that support healthy communities or place communities at risk for poor health.

MDH has contracted with Rainbow Research to assist Community and Tribal Grantees in developing individual program level evaluations to ensure grantee accountability and build grantee evaluation capacity. Rainbow Research has provided individual consultation with each grantee and has held two statewide evaluation training sessions. Rainbow Research has also submitted *The First Interim Evaluation Report* to MDH in December 2002 (report is available upon request). Results included in this report provide a description of the Community and Tribal Grants Programs including the number of grants that focus on each priority health area, the grantee communities (e.g. African American), the type of activities (e.g. breast and cervical cancer screening, immunization clinics, etc.) conducted and the goals of each program. (See Appendix F for a list of long-term measurable outcomes along with examples of intermediate, and program level outcomes).

"Having more than fifteen minutes with both a trustworthy health provider and a qualified medical interpreter is key to receiving quality health care for most Somalis, some of our newest Minnesotans."

- EHDI Grantee

Future Evaluation Strategies

With increased emphasis on accountability and quality of services, it is essential that MDH continue to focus on program level evaluation activities and improved measurement of health outcomes for populations of color and American Indians. Evaluation efforts will lead to improved outcomes, greater quality of services, and cost-efficient approaches to eliminating health disparities. Improved outcome measurement includes the identification and monitoring of all of those factors that impact the health of communities.

Among the activities that MDH will initiate to improve outcomes measurement will be the:

- involvement of a partnership of stakeholders including citizens from throughout the state;
- review and prioritization of those outcomes that are to be measured and monitored as part of the EHDI;
- review and development of data sources and measurement tools to document the impact of the Initiative;
- further development of health system measures and community measures affecting disparities;
- reporting of more extensive qualitative results of program outcomes based on focus groups and other qualitative approaches; and
- greater use of cost-effectiveness analysis in evaluating priorities and programs.

Identification of these factors is especially important for accountability purposes and to emphasize the broad array of factors that create and sustain health disparities in our communities. In pursuing these enhanced accountability and performance measures, it needs to be acknowledged that it is not feasible to apply these across all the programs initially due to funding constraints. One potential option is to identify one or two program areas, such as infant mortality and immunizations, which would be feasible to serve as pilot programs for more extensive evaluation activities.

CONCLUSION

Disparities in health status between the majority population and populations of color and American Indians in Minnesota have existed for some time, and are, in some cases, getting worse, not better.

These disparities are a result of a complex interplay of many factors including, access to health care, genetics, racism, social conditions, and health behaviors. Effectively addressing these disparities requires a comprehensive, community-driven, sustained approach. Communities of color, American Indians, MDH and the Legislature have worked tirelessly to ensure that the EHDI is comprehensive and community-driven. By creating the EHDI, a ten-year initiative, a powerful investment has been made in the current and future health of Minnesota's populations of color and American Indians and the state as a whole. In the first year of the EHDI, alone, great strides have been made to reduce these health disparities.

"We organized two vaccination clinics in coordination with local public health agencies. The outcome was a tremendous success, with 110 adults vaccinated for Hepatitis B and 116 adults receiving the T/D vaccine. We sincerely thank the Minnesota Department of Health for your support in creating a healthier migrant farmworker community in Minnesota."

-EHDI Grantee

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APPENDIX A

EHDI STATUTE

"The mission of the South Minneapolis Cancer Control Coalition is to gather, engage, and leverage strengths of south Minneapolis organizations and individuals to create a culturally based, coordinated continuum of health care support for African American/African women who are at risk for or diagnosed with breast and/or cervical cancer."

Women's Cancer Resource Center

Eliminating Health Disparities Initiative Legislation
Laws of Minnesota 2001 1st 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 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.

(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 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 1st 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.

Chapter 220-H.F.No. 351

Article 17

Health And Human Services Appropriations

Sec. 3. COMMISSIONER OF HEALTH

Subd. 2. Family and Community
Health

[ONETIME GRANT REDUCTIONS.] \$200,000 of the appropriation reduction the first year is from competitive grants to reduce health disparities in infant mortality rates and adult and child immunization rates authorized in Laws 2001, First Special Session chapter 9,

article 17, section 3, subdivision 2. \$300,000 of the appropriation reduction the first year is from competitive grants 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 authorized in Laws 2001,

First Special Session chapter 9, article 17, section 3, subdivision 2. \$150,000 of the appropriation reduction the first year is from community-based programs for suicide prevention authorized in Laws 2001, First Special Session chapter 9, article 17, section 3, subdivision 2.

Presented to the governor February 21, 2002

Vetoed by the governor February 25, 2002, 3:48 p.m.

Reconsidered and approved by the legislature after the governor's veto February 28, 2002

APPENDIX B

Populations of Color in Minnesota Update Summary

*"The Council on Crime and Justice
Project focuses on African-American
Male ex-offenders, based on
prevention and intervention strategies
in north Minneapolis and the east side
of St. Paul."*

Council on Crime and Justice

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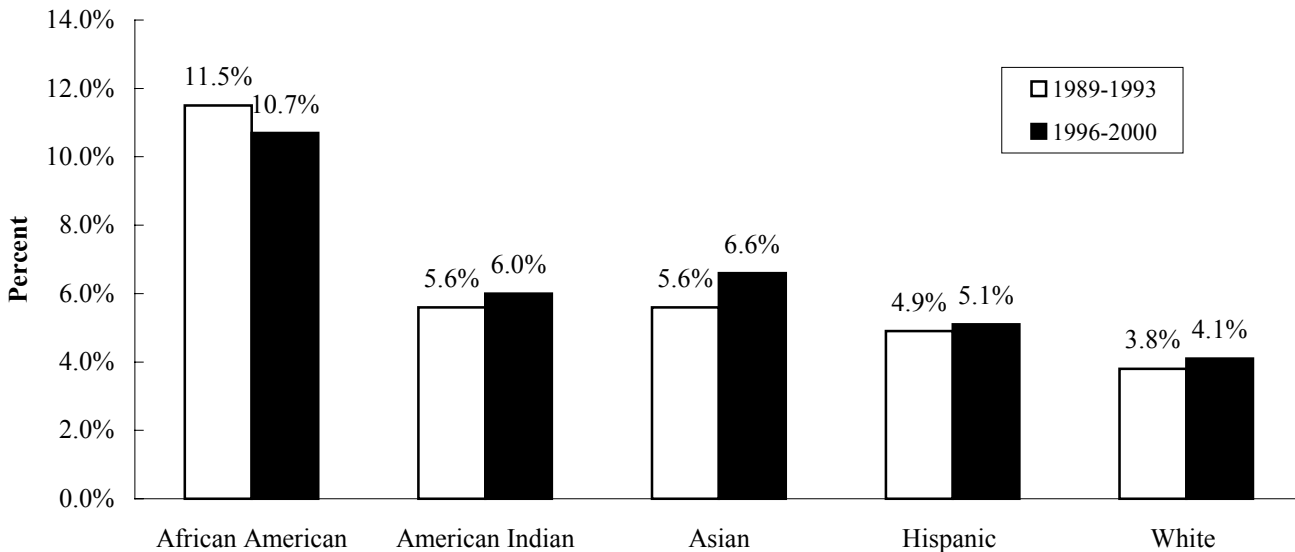
Part I: Birth-Related Health Indicators

Low Birthweight Births

Infants that weigh less than 2,500 grams at birth are considered low birthweight. Low birthweight can occur as a result of premature births or growth restriction prior to birth. Infant mortality or serious health and developmental complications are closely associated with low birthweight. The rates of low birthweight births among some populations of color, especially those to African American women, are substantially higher than those of White women.

Although overall rates of infant mortality have improved greatly in the past decade, recent Minnesota data indicates that the percentage of low birthweight births has increased in all groups, except African Americans. While the percentage of low birthweight births for African Americans has decreased in the most current 5-year period, low birthweight births among African Americans in Minnesota (10.7%), are greater than 2 ½ times that of Whites (4.1%) and higher than any other major racial/ethnic group.

Low Birthweight Births-Minnesota
(Percent of Singleton Births Under 2,500 grams)



Source: Center for Health Statistics, Minnesota Department of Health

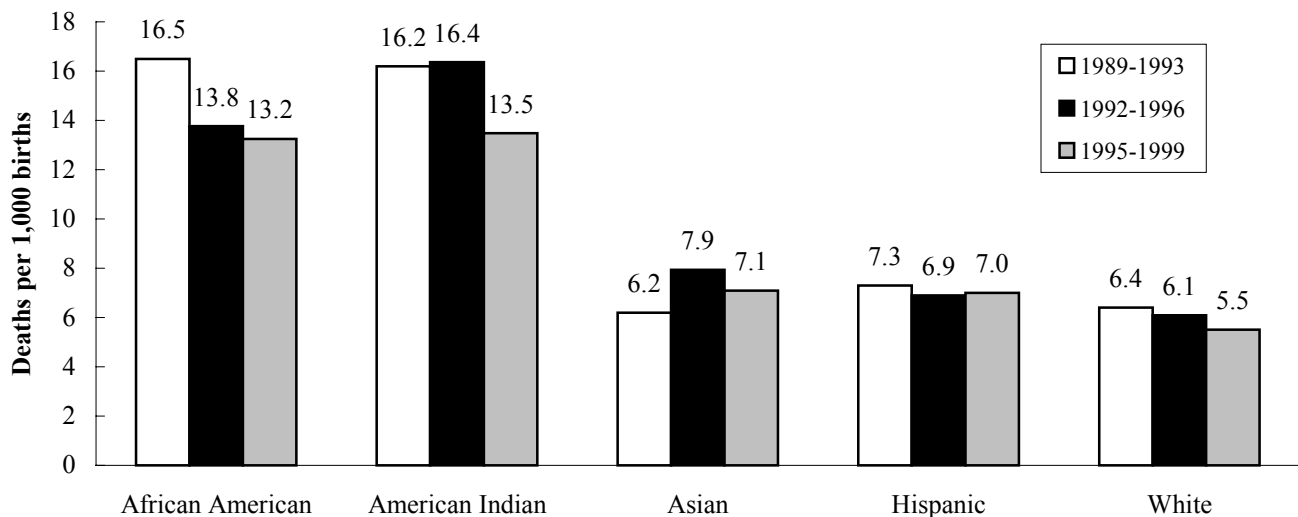
Discussion on the multiple etiologies, prevention interventions, and research and literature on this topic are presented in “Low Birthweight in Minority and High-Risk Women,” a Report by the Patient Outcomes Research Team (1998).

Infant Mortality

A review of the latest data indicates that disparities in infant mortality rates for populations of color and Whites are evident on the national as well as the state levels. While 1995-99 infant mortality rate for Whites in Minnesota (5.4/1,000) was lower than the national rate in 1999 (7.1/1,000), the rates for African American and American Indians in Minnesota are more than two times that of Whites. In the 1995-99 period, nearly 2000 infants died prior to their first birthday, almost 25 percent of those infants were of African American, American Indian, Hispanic, or Asian descent (Minnesota figures). In 1999, these populations of color comprised only 8.8 percent of the total population.

National Vital Statistics System (NVSS) reports indicate that for the 3-year period of 1997-99 linked files, African Americans had the highest rate of infant mortality (13.8/1,000). This rate was higher than any other racial ethnic group at the national level including American Indians (9.1/1,000), Asian/Pacific Islander (5.1/1,000), or Hispanic (5.8/1,000). A comparison of Minnesota to other states indicates that of the 16 states reporting, Minnesota had the 5th highest infant mortality rate for American Indians (10.9/1,000). In addition, while the rate for African Americans in Minnesota (12.7/1,000), was lower than the national average for African Americans (13.8/1,000), this rate was more than twice the rate reported overall for Minnesota (6.0/1,000).

**Infant Mortality Rate
Minnesota**



Source: Center for Health Statistics, Minnesota Department of Health

Using 5-year periods to examine trends in infant mortality rates among Minnesota’s populations of color, White rates are at their lowest rate at 5.5/1,000, decreasing in consecutive 5-year periods. African American (13.2/1,000) and American Indian (13.5/1,000) rates have also decreased in the last 5-year time period but both rates remain more than 2 ½ times that of Whites. The rates for Asian and Hispanic (7.1 and 7.0/1,000 respectively) also remain higher than that of Whites.

Prenatal Care

Current data indicates increases in the percent of Minnesota women that receive intensive and adequate prenatal care. This holds true for women from all racial/ethnic groups. Yet even with these increases, White women are still more likely to receive adequate and intense prenatal care than women of any other racial/ethnic group. The latest data also indicates that although there have been improvements in the percent of women from all groups for receiving intensive and adequate prenatal care, greater percentages of women from populations of color are receiving inadequate or no care during their pregnancies.

**Adequacy of Prenatal Care: Minnesota
(Singleton Births Only)**

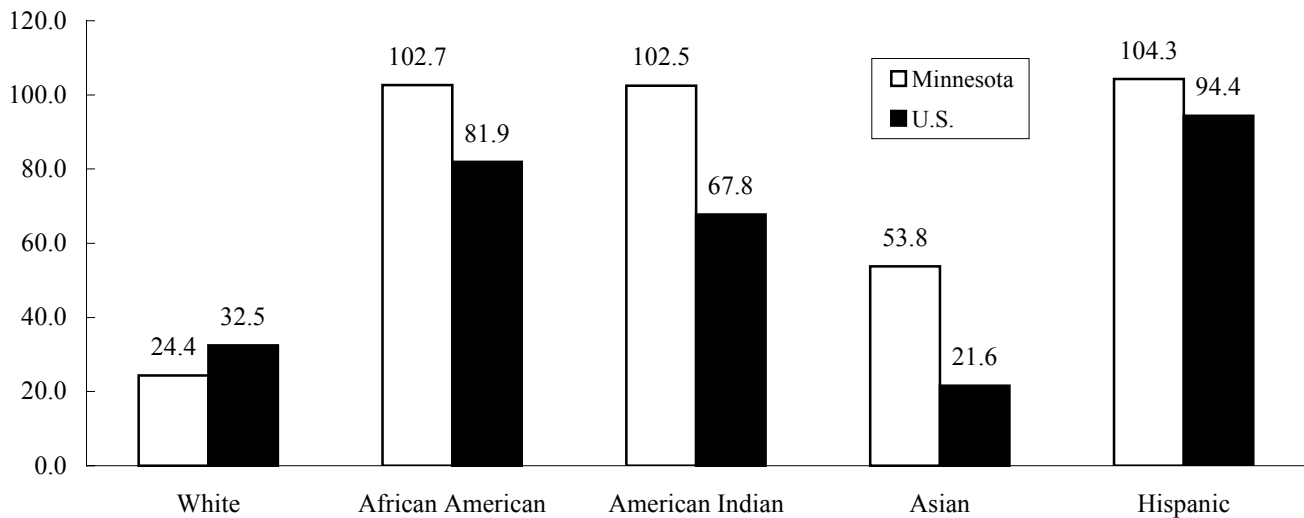
Race/Ethnicity	Intensive/Adequate		Inadequate or No Care	
	1989-1993	1996-2000	1989-1993	1996-2000
African American	46.7%	58.0%	20.4%	12.5%
American Indian	36.9%	48.5%	27.5%	17.8%
Asian	43.0%	54.5%	20.8%	10.7%
Hispanic	51.8%	54.6%	14.8%	11.4%
White	78.4%	79.9%	3.3%	3.2%

These figures indicate that American Indian women suffer the greatest disparity from White women. While this latest data indicates that greater disparities existed at the beginning of the decade, American Indian women are still six times more likely to receive inadequate or no care during their pregnancies. All other racial ethnic groups were over three times more likely to receive inadequate or no prenatal care during their pregnancies.

Teen Births

The most recent data on teen births in the U.S. shows an overall decline in the percent of births to teens (15-19 years) for all racial/ethnic groups, the greatest decrease occurring among African Americans. However, as the following chart indicates, the birth rate for African Americans in the U. S. (81.9/1,000) was still 2 ½ times greater than that of Whites (32.5/1,000). The rate for Hispanics (94.4/1,000) was almost three times, and American Indians (67.8/1,000) twice as high as the White rate. This chart also indicates that while Minnesota teen birth rates for Whites is lower than the national rate, rates for all populations of color and Hispanics are higher than the White rate and are higher than their respective groups at the national level.

Teen Births Rates
Minnesota and U.S 2000

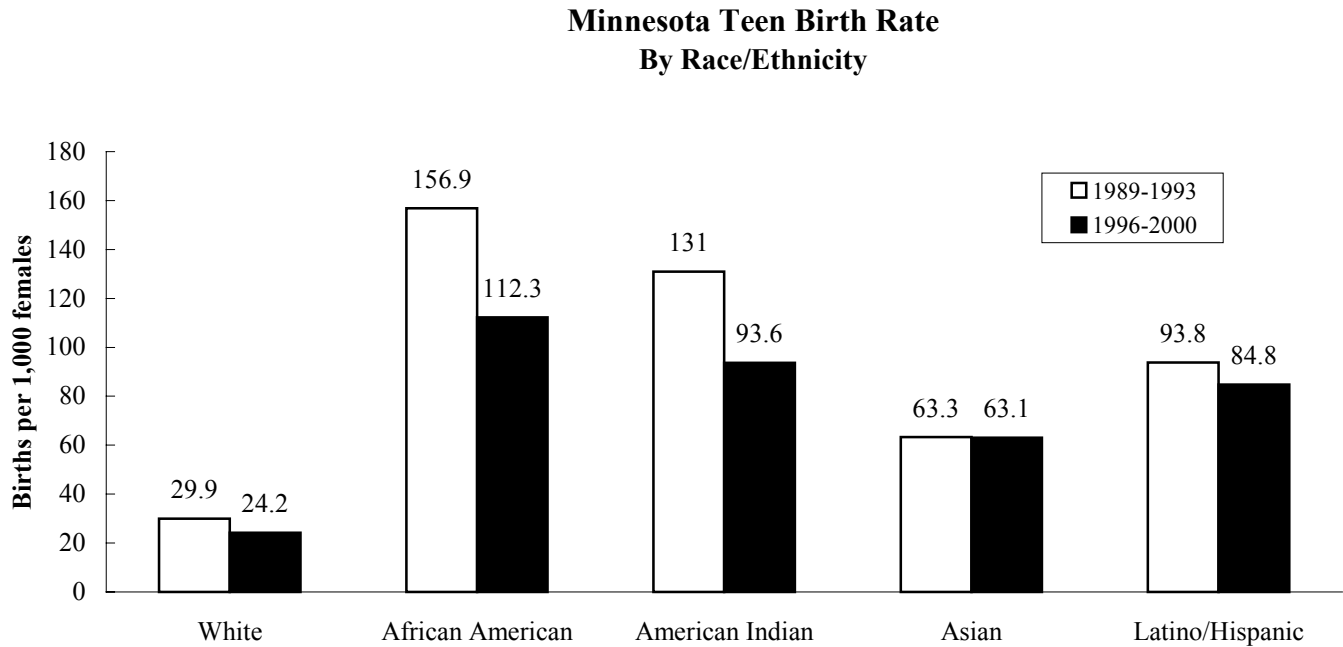


Source: Center for Health Statistics, Minnesota Department of Health. “Hispanic” is an ethnicity and may include individuals of any race.

APPENDIX B: POPULATIONS OF COLOR IN MINNESOTA: UPDATE SUMMARY

Recent data trends for Minnesota, as at the national level, indicate a decline in teen pregnancy rates among all populations. Minnesota figures indicate that although there has been a general decline in teen birth rates among all race/ethnic groups, African Americans teens are having babies at a rate that is over four times that of Whites. American Indian and Hispanics are three times as likely and Asians over twice as likely as Whites to have children during their teen years.

Minnesota Birth Rates are as follows:



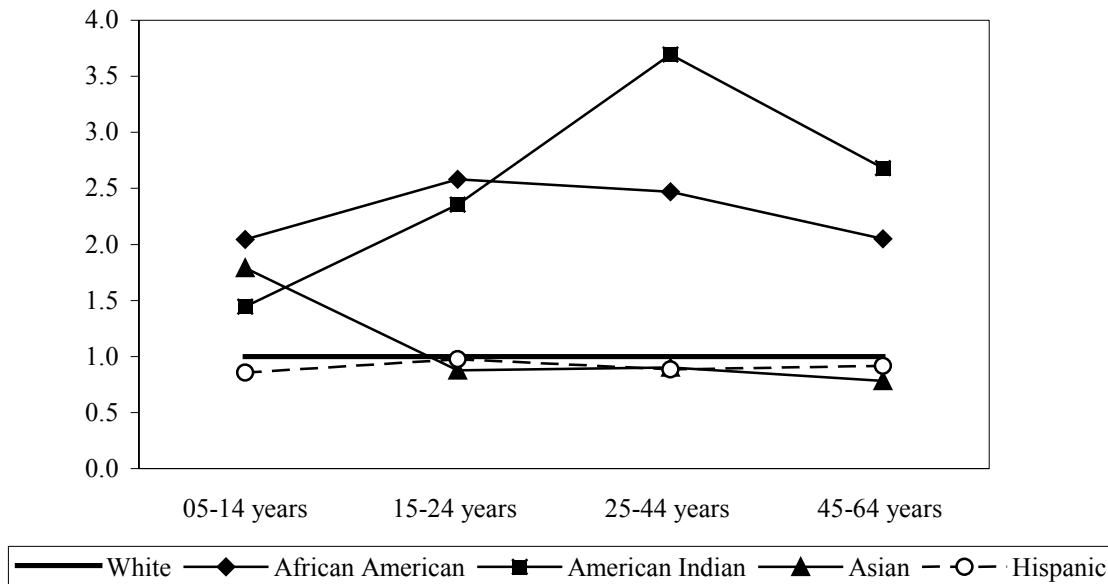
Part II: Death Rates and Causes of Death

Death Rate Ratio

Mortality rates were obtained by analyzing data on all deaths to Minnesota residents occurring between 1996 and 2000 and where appropriate as compared with 1995 and 1999 data.

The graph shows the ratio of death rates of racial/ethnic groups as compared to Whites. This graph indicates that the greatest disparities in death rates occur in the age range of 25-44 years old, though disparities exist in most all age groups for several groups of populations of color.

**Ratio of Non-White to White Minnesota Death Rates
Five Year Average (1996-2000)**



Death rates for African Americans and American Indians in the 15-24, 25-44, and 45-64 year age ranges were two to three and a half times higher than death rates for Whites. Hispanic and Asian death rates were most often lower than Whites among all age groups.

Cause of Death

Crude mortality rates are the number of deaths per 1,000 population. While these rates provide an estimate of the causes of death in a population, it may not be the best indicator of mortality in a population because of differing compositions of various populations. Populations with large numbers of older people may have higher crude mortality rates as compared to populations with larger numbers of young people. Age-adjusting is used to adjust for these differences most commonly used in comparative mortality analyses since age is a prime factor in mortality. This is particularly true with mortality due to chronic diseases such as heart disease and diabetes. Age-adjusted death rates provide a reliable basis for comparison between populations and are used to eliminate the bias of age in the make-up of a population.

**Age Adjusted Mortality Rates By Race
Minnesota 1996-2000**

Cause	White	African American	American Indian	Asian	Hispanic
	1996-00	1996-00	1996-00	1996-00	1996-00
HIV/AIDS	1.3	14.3	7.2	0.8	6.5
Alzheimers Disease	4.4	3.9	4.1	2.1	3.7
Cancer	113.3	177.8	163.6	95.7	111.8
Cirrhosis	4.8	7.3	35.8	2.1	9.3
Congenital Anomalies	4.2	7.1	6.7	4.7	4.3
COPD	18.2	18.6	32.1	10.5	9.2
Diabetes	11.8	36.8	65.7	11.1	21.3
Heart Disease	90.5	125.5	148.1	56.4	77.3
Homicide	1.9	30.6	19.5	4.7	4.7
Nephritis	4.2	10.0	15.2	8.7	7.0
Perinatal Conditions	3.0	12.9	7.6	3.1	4.3
Influenza-Pneumonia	7.8	11.2	15.6	5.6	8.2
Septicemia Total	2.1	4.6	6.4	1.9	2.6
Stroke	22.5	38.3	26.2	35.2	23.8
Suicide	9.0	8.8	18.4	9.3	7.4
Unintentional Injury	25.7	38.3	76.0	24.5	25.2

Rates presented are per 100,000 population (i.e. AIDS/HIV mortality rate for Whites is 1.3 per 100,000.)

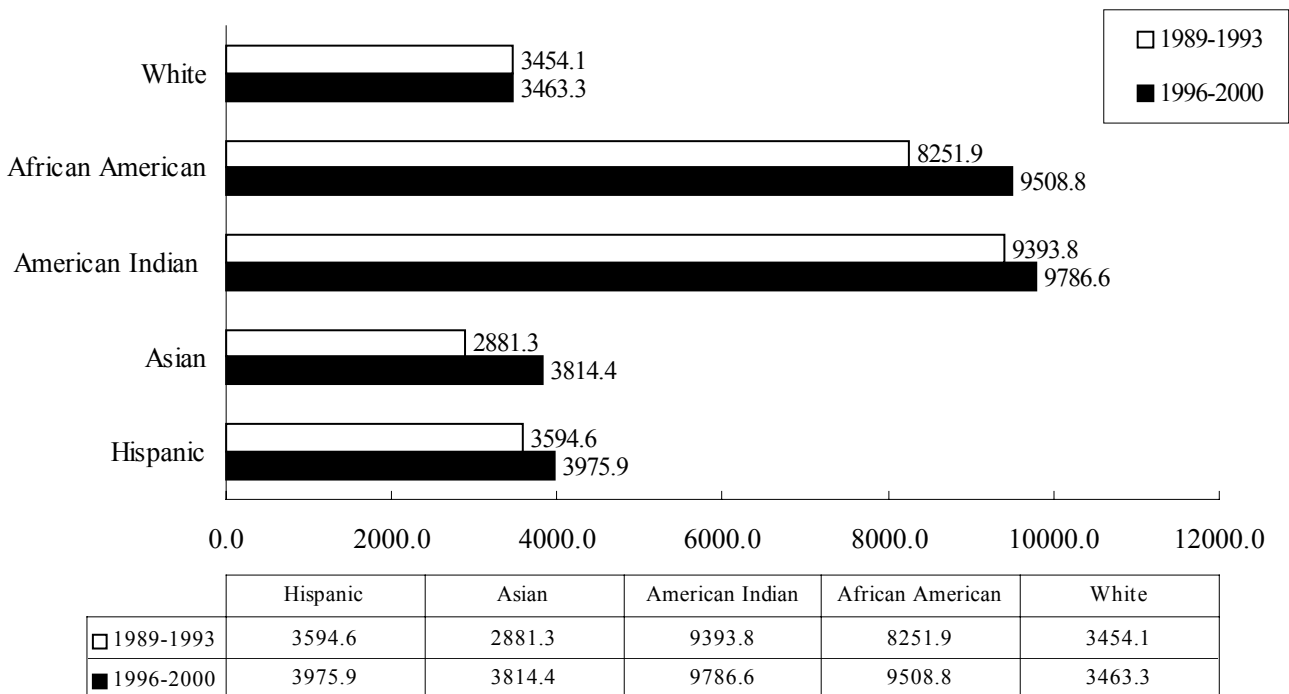
African Americans age-adjusted mortality rates due to HIV/AIDS, homicide and perinatal conditions are several times greater than those for Whites in Minnesota. Among American Indians death rates for homicide, cirrhosis, and diabetes are higher than those of Whites. Hispanic and Asian figures are more consistent with those of the White population though these rates do not reflect rates for specific groups within these categories (e.g. Hmong, Vietnamese, Mexican, Puerto Rican).

Years of Potential Life Lost

Years of Potential Life Lost (YPLL), measures premature mortality or the total sum of years of life lost annually to a person who dies prematurely or prior to the age of 65 years. The YPLL rate Type your question here and then click Search is the number of years of life lost before age 65 per 1,000 population ages 0-64.

The following illustration calculates the most recent YPLL rates by race and ethnic groups for 1996-2000 and for comparison purposes, rates for the beginning of the decade are included. This chart indicates that in the most recent 5-year period, while the YPLL rates for all populations of color (African American, American Indian, Asian, and those of Hispanic ethnicity), has increased while White rates have remained the same. Additionally, rates of African Americans and American Indians are over twice as high as that of Whites.

Years of Potential Life Lost Rate by Race/Ethnicity*
Minnesota 1989-93 & 1996-2000



*An example of the YPLL calculation is included in Section VI Notes provided at the end of this document.

Part III: Injury and Violence

A recent report by the Injury and Violence Prevention Unit at MDH indicates that the existence and extent of disparities among populations of color and Whites. While most injury-related deaths are preventable, extensive review of the data can provide some insight into the causes and preventative strategies of injury related deaths. Among findings from this recent study are the following:

- **American Indians and African Americans** are over-represented in injury-related mortality from all causes. The injury mortality rate per 100,000 people is 2.5 times greater for American Indians than for Whites and 1.5 times greater from African Americans than for Whites.
- For **American Indians**, motor vehicle crashes were the leading cause of injury death for all age groups from 10-44. Homicide appears among the first four leading causes of death in all age groups up to age 54. For teens and young adults, firearm homicide was among the three leading causes.
- For **African Americans**, firearm homicide was the first or second leading cause in all age groups from 10-54, and was the first leading cause when all age groups were combined.
- For **Asians**, suicide was the first, second, or third leading cause in most age groups. Firearm homicide was also a leading cause for Asian children and young adults and was the second leading cause of injury death overall among Asians.
- For **Hispanics (all races)**, the second leading cause of injury death of all ages was firearm homicides and the third leading cause was firearm suicides. Homicidal cut/pierce injuries (most often knifing) appeared frequently as a leading cause for all Hispanic adult age groups. Unintentional fires were the leading cause of injury death for Hispanics under the age of 9.

This information is part of a summary of data in *Injury-Related Mortality in Minnesota, 1990-00*, which is available on the MDH Injury and Violence Prevention website at:

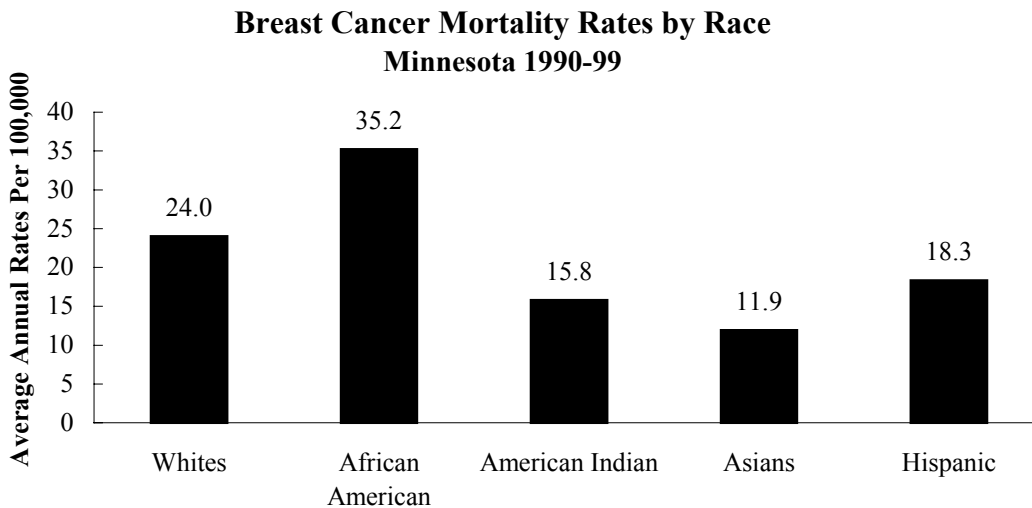
<http://www.health.state.mn.us/divs/fh/chp/injury.htm>

You may print portions of the databook or obtain a copy of the report by calling 651-281-9857.

Part IV: Breast Cancer Mortality and Cervical Cancer Incidence*

Breast Cancer Mortality

A recent MDH report indicates that breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer death. The breast cancer mortality rate of African Americans in Minnesota is 50% higher than for White non-Hispanic women. A greater proportion of African American women have cancers diagnosed at a later, less treatable stage. One-third of breast cancer deaths can be prevented through routine screening using mammography and clinical breast examination. These figures indicate the need for increased screening efforts, and appropriate follow-up and treatment. (For further information on breast, cervical, and other cancer information, see, “Cancer in Minnesota, Racial and Ethnic Disparities,” MDH Division of Chronic Disease Prevention and Control, 2001.)



Note: Hispanic includes Hispanic White Only.
Source: Minnesota Cancer Surveillance, MDH

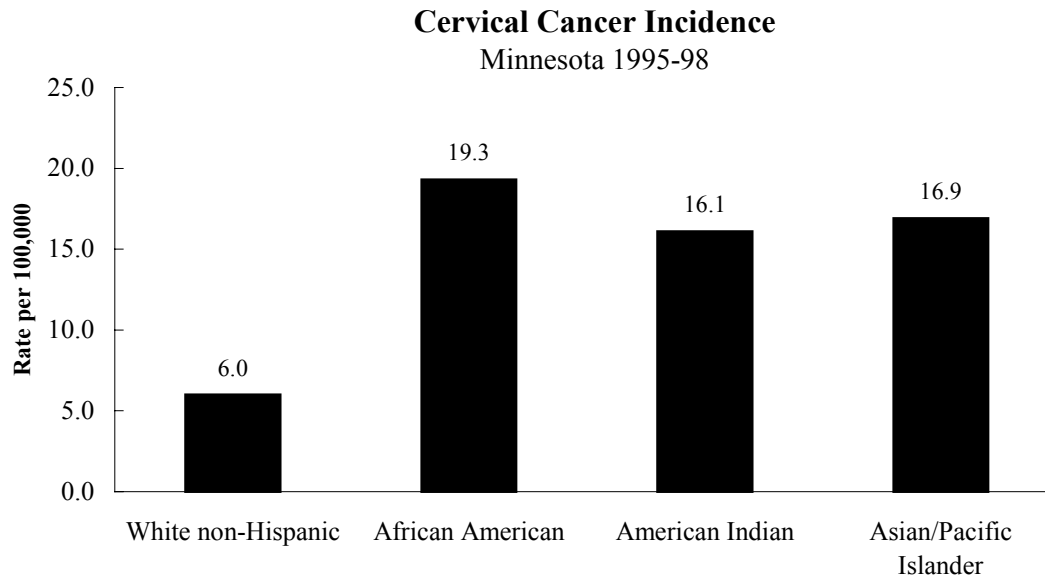
Cervical Cancer Incidence

Each year, approximately 200 women in Minnesota develop invasive cervical cancer and 50 die from it. Virtually all invasive cervical cancer occurrence and death is preventable through regular screening with Pap smears followed by treatment of precancerous cervical abnormalities.

* “Cancer in Minnesota, Racial and Ethnic Disparities,” MDH Division of Chronic Disease Prevention and Control, 2001. Minnesota Department of Health, Minnesota Center for Health Statistics, mortality data. Data by race and ethnicity are reported here for the years 1990-99.

APPENDIX B: POPULATIONS OF COLOR IN MINNESOTA: UPDATE SUMMARY

African American, American Indian, and Asian/Pacific Islander women have three to four times higher cervical cancer incidence rates than White women in Minnesota. Deaths due to cervical cancer are three to five times higher among African Americans and Asian/Pacific Islanders as compared with White (non-Hispanic) women. Regular screening, outreach to non-White women for screening, and referral when necessary, should be emphasized.



Note: Hispanic Rates were not available

Source: Minnesota Cancer Surveillance System,

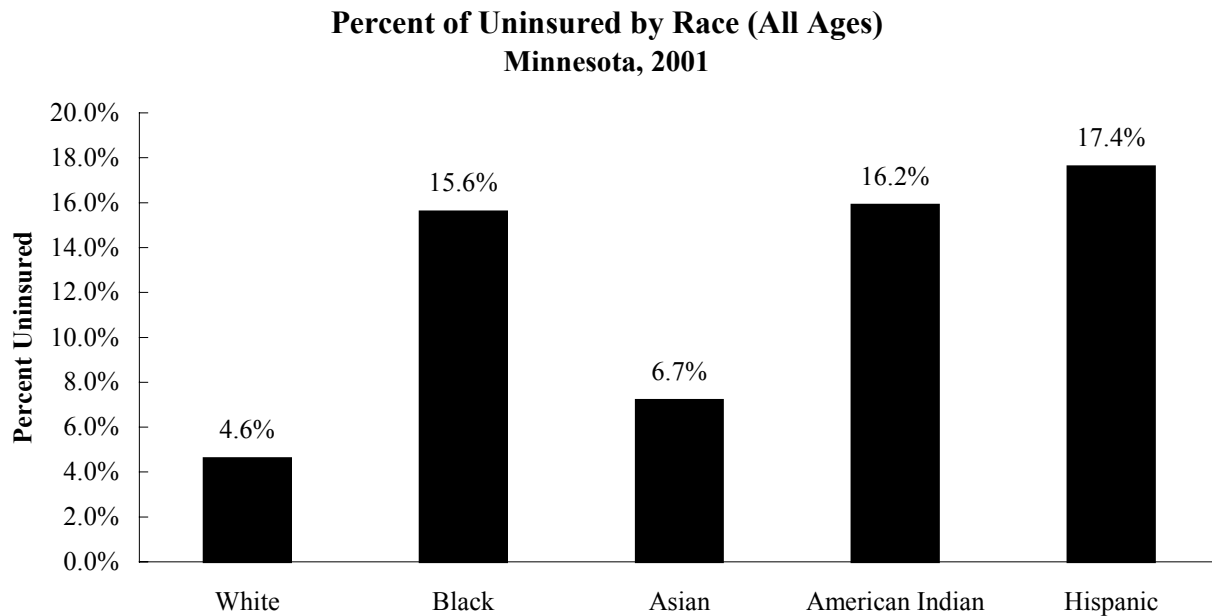
Other Cancers

Incidence and mortality rates for lung, prostate, colon, rectal, and skin cancers are available in a recent report by the Minnesota Department of Health Division of Chronic Disease Prevention and Control, in "Cancer in Minnesota: Racial and Ethnic Disparities." For more information contact the following:

Minnesota Department of Health
Division of Chronic Disease Prevention and Control
PO Box 9441, Minneapolis, Minnesota 55440
612-676-5500 (phone), 612-676-5520 (fax), 651-215-8980 (TDD)

Part V: Health Insurance**Rates of Uninsured**

The Health Economics Program of the Minnesota Department of Health is currently conducting an in-depth study of Minnesota's uninsured population.* According to these study findings, 5.4 percent of Minnesotans (approximately 266,000 people) were uninsured at the time of the survey in 2001. However, rates of uninsured vary widely across racial and ethnic groups. Because this study allowed the selection of multiple races, the race/ethnicity definitions include anyone who reported a single race or a single race and any other race/ethnicity (e.g., those included in "White", include those who reported White only and those who reported White and any other race/ethnicity.) As the following graph indicates, the results of the study indicate that African American, American Indian, and Hispanic/Latinos were up to four times less likely to be insured as compared to Whites.



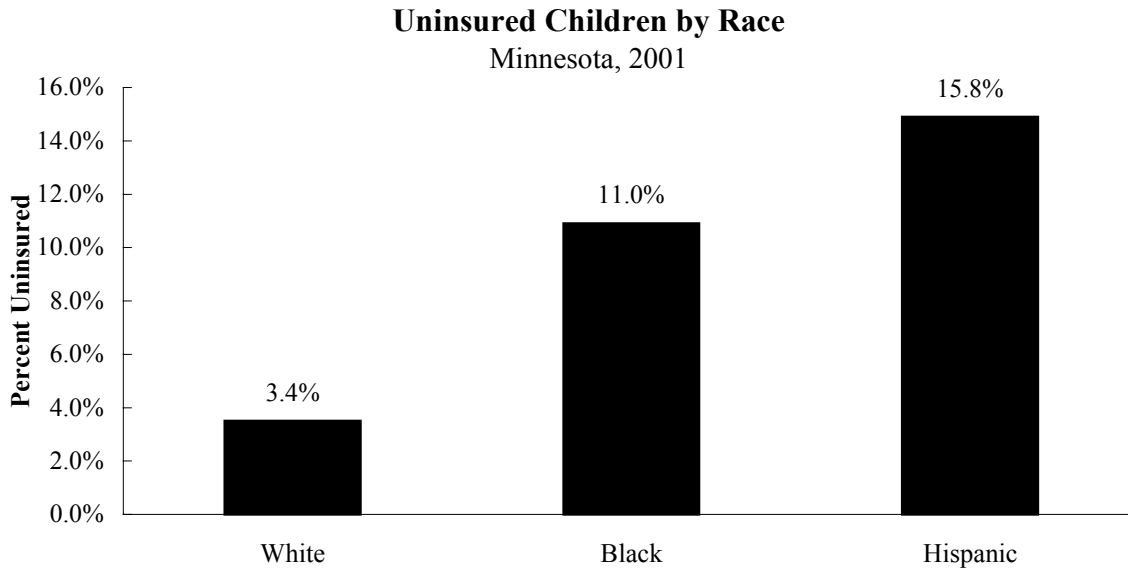
Source: 2001 MN Health Access Survey, MDH Health Economics Program

* Data Source: 2001 MN Health Access Survey, MDH Health Economics Program. Please contact the Health Economics Program at 651-282-6367 for more information on the results of the study.

Uninsured Children

Another significant finding of the study is that the number of uninsured children is larger overall, than had previously been thought. About 4.4 percent of all Minnesota children, or 57,000 children under the age of 18, lack health insurance.

Among those populations of color that the study was able to report, African American children were over three times and Hispanic children were over four times less likely to be covered by health insurance.

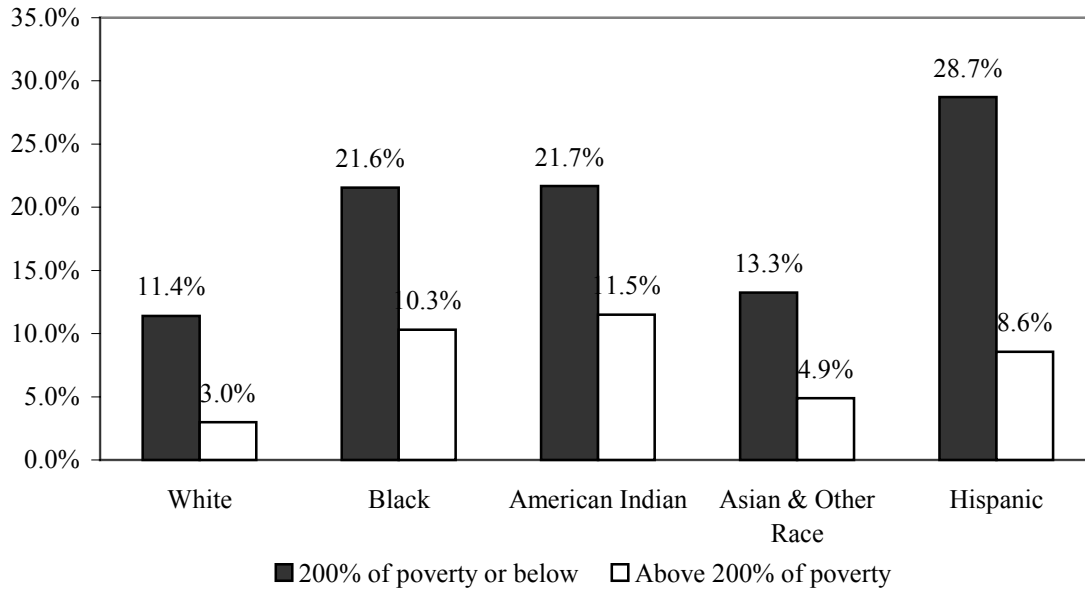


Source: 2001 MN Health Access Survey, MDH Health Economics Program.

Uninsured by Race and Income

One possible reason why uninsured rates are disproportionately high for populations of color and American Indians is that people in these groups have lower incomes on average than the White population. Uninsured rates for people with incomes less than 200% of the poverty level are higher than the uninsured rates for people with higher incomes, regardless of race. However, within the population that has income above 200% of the poverty level, non-White Minnesotans are more likely to be uninsured than White Minnesotans.

**Uninsurance Rates by Race/Ethnicity and Income
Minnesota, 2001**

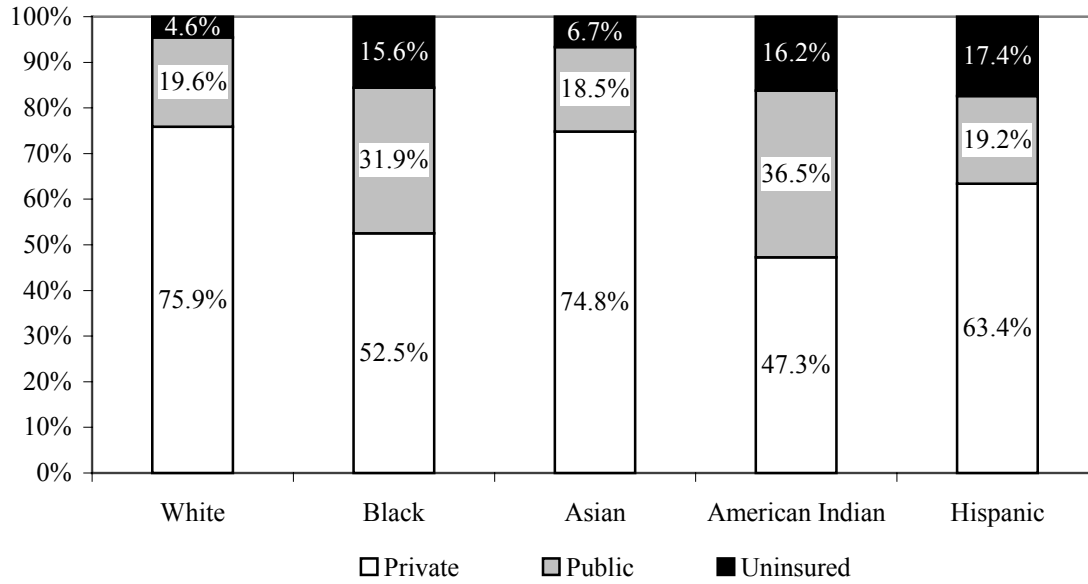


Source: 2001 MN Health Access Survey, MDH Health Economics Program

Uninsured by Type of Insurance Coverage

Additional study results indicate disparities in the type of insurance coverage identified by study participants. Whites were more often covered by group insurance, generally through their own or a family member’s employer. More African American and American Indians than Whites reported coverage through public health insurance, which included Medicaid, MinnesotaCare, GAMC, MCHA, CHIP, CHAMPUS, Veterans Affairs or Military Health Care, Railroad Retirement Plan, or Medicare.

**Sources of Insurance Coverage by Race/Ethnicity
Minnesota, 2001**



Source: 2001 MN Health Access Survey, MDH Health Economics Program

Part VI: Notes

Example of Calculation of YPLL for Heart Disease

A	B	C	D
Age Group	Number of Deaths	Factor (total population in age group)	YPLL by Age (B*C)
0-4	9	62.5	562.5
5-14	7	55	385
15-24	15	45	675
25-34	98	35	3430
35-44	100	25	2500
45-54	426	15	6390
55-64	700	5	3500
<u>Total YPLL for Heart Disease</u>			17442.5

APPENDIX C

Tuberculosis Screening and Treatment Rates for Foreign Born Persons

"One of the major ways this initiative is different is allowing communities to fund 'cross-cutting' measures to address disparities—this allows for more creative ways to create parity in various health areas"

Upper Sioux Community

Tuberculosis Screening and Treatment Rates for Foreign Born Persons

Table 3: Tuberculosis Screening Rates for Foreign Born Person Minnesota 1996-2001*							
	1996	1997	1998	1999	2000	2001	2004 Target
Arrivals	2,148	1,454	1,863	3,927	4,008	2,791	na
% Screened	67.1%	74.1%	84.3%	73.4%	82.7%	89.8%	90%

*na: not applicable

Table 4: Completion of Tuberculosis Therapy for Foreign Born Populations 1996-2000*						
Objective: Completion of Case Therapy	1996 No. (%)	1997 No. (%)	1998 No. (%)	1999 No. (%)	2000 No. (%)	Target Percent
Within 12 months	78 (63)	121 (83)	107 (72)	146 (79)	136 (79)	90
Overall	106 (86)	140 (96)	137 (93)	177 (96)	161 (94)	

*Due to the potential for 12 months of therapy, completion of therapy data for cases counted in 2001 cannot be reported until 2003.

APPENDIX D

EHDl Grantee Descriptions

"Because of the EHDl project Save Our Sons has been able to enhance its programming to focus on its clients from short, intermediate, and long term outcomes. Save Our Sons focuses on African American youth of all ages."

Save Our Sons

APPENDIX D: EHD GRANTEE DESCRIPTIONS

African American AIDS Taskforce
310 E. 38th St., Ste 304
Minneapolis, MN 55409

Anishinaabe Center
921 8th St. SE
Detroit Lakes, MN 56501

Grant Type: Community, Implementation
Health Priority Areas: HIV/AIDS and Sexually Transmitted Diseases
Geographic Service Area: Hennepin County Medical Center, Medicine Walk-in Clinic
Target Population: African American, African, American Indian, Hispanic/Latino, Asian American

Grant Type: Community, Planning
Health Priority Areas: Not Yet Determined
Geographic Service Area: Greater Detroit Lakes Area
Target Population: American Indian

Detroit Lakes Anishinaabe Center Diabetes Project Story

EHDI Planning Grant funds are being used by the Detroit Lakes area Anishinaabe Center to begin the health restoration process. Planning activities include coordinating and convening a group of traditional healers, White Earth Public Health Clinic's western medical professionals, youth, Anishinaabe Center constituents who are diabetic, and Anishinaabe Center staff to meet at least four times a year. Their goal is to find and incorporate community "wisdom" to culturally adapt proven strategies to reduce the onset of diabetes and to improve the effects of diabetes among the Anishinaabe people, and to develop networks among community based organizations and government entities in the Anishinaabe population to strengthen the incorporation of health promotion into the community.

The results of the planning activities will be a specific plan of activities which includes: A system in which diabetics are among the teachers for each other, youth, and medical professionals; a holistic (physical, medical, spiritual, and emotional) system that teaches early awareness of the disease, as well as prevention among youth; a system that provides a platform for experimentation, evaluation, and continual change; an arena where diabetics feel comfortable sharing knowledge with each other, learning modern diabetes management techniques, as well as, traditional wellness techniques; and a system which incorporates and combines diabetics' experiential knowledge, modern professional and medical expertise, and Anishinaabe traditional medical expertise to prevent and manage, and reduce levels of diabetes in Anishinaabe people. EHDI Conversion Grant funding will support next steps in implementing this plan.

Agape House for Mothers
400 Selby Ave
St. Paul, MN 55102

American Indian Family Center Collaborative
579 Wells Ave
St. Paul, MN 55101

Grant Type: Community, Implementation
Health Priority Areas: HIV/AIDS, Sexually Transmitted Infections and Healthy Youth Development
Geographic Service Area: Hennepin County – Minneapolis and Ramsey County – St. Paul
Target Population: African American

Grant Type: Community, Implementation
Health Priority Areas: Infant Mortality
Geographic Service Area: City of St. Paul, emphasis in North End and Highland-Mac-Groveland
Target Population: African American, African: Immigrants, American Indian, Hispanic/ Latino, Asian American

APPENDIX D: EHD GRANTEE DESCRIPTIONS

American Indian Family Center Collaborative
579 Wells Ave
St. Paul, MN 55101

Grant Type: Community, Implementation
Health Priority Areas: Infant Mortality
Geographic Service Area: City of St. Paul, emphasis in North End and Highland-Mac-Groveland
Target Population: African American, African Immigrants, American Indian, Hispanic/ Latino, Asian American

Black Storytellers Alliance
1112 Newton Ave N
Minneapolis, MN 55411

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: North Minneapolis
Target Population: African American

Boys and Girls Clubs of the Twin Cities
2575 University Avenue West, Ste 100
St. Paul, MN 55114

Grant Type: Community, Implementation
Health Priority Area: Healthy Youth Development
Geographic Service Area: St. Paul (East Side, West Side, and Mt. Airy neighborhoods) and Minneapolis (Phillips, Phelps, West Penn Ave and North Mpls. Neighborhoods)
Target Population: African American, Hispanic/Latino, Asian American

Cass County-Leech Lake Reservation Family Services Collaborative
6530 Hwy 2 NW,
Cass Lake, MN 56633

Grant Type: Community, Implementation; Tribal Implementation
Health Priority Areas: Infant Mortality, Immunizations, Diabetes, Cardiovascular Disease, Violence
Geographic Service Area: Leech Lake Reservation including counties of Cass, Beltrami, Hubbard and Itasca
Target Population: American Indian – Leech Lake members

Battered Women's Legal Advocacy Project
1611 Park Ave. So. 2nd Floor
Minneapolis, MN 55404

Grant Type: Community, Planning
Health Priority Areas: Violence and Accidental Injuries
Geographic Service Area: Upper Sioux Community, Lower Sioux Community, Mille Lacs Band of Ojibwe, White Earth Reservation
Target Population: American Indian

Bois Forte Reservation
13071 Nett Lake Road
Nett Lake, MN 55771

Grant Type: Community, Implementation; Tribal Planning
Health Priority Areas: Cardiovascular Disease
Geographic Service Area: Bois Forte Reservation located in Nett Lake and Vermilion (Tower, MN)
Target Population: American Indian – Chippewa

Camphor
585 Fuller Ave
St. Paul, MN 55103

Grant Type: Community, Planning
Health Priority Areas: Healthy Youth Development
Geographic Service Area: St. Paul's Summit-University and Frogtown neighborhoods
Target Population: African Americans/Africans

Carondelet LifeCare Ministries
1884 Randolph Avenue
St. Paul, MN 55105

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer and Diabetes
Geographic Service Area: Twin Cities Metro Area near St. Mary's Health Clinics and in the parishes of Holy Rosary in Minneapolis, Our Lady Guadalupe in St. Paul, Assumption Catholic Church in Richfield and Sacred Heart Parish in St. Paul
Target Population: Hispanic/Latino – Varied

APPENDIX D: EHDl GRANTEE DESCRIPTIONS

Center for Asians and Pacific Islanders
3702 E. Lake St.
Minneapolis, MN 55406

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer, Diabetes, Cardiovascular Disease, Immunizations
Geographic Service Area: Hennepin, Ramsey and Scott Counties
Target Population: Hmong Vietnamese, Somali and Ethiopian

Centro Campesino, Inc.
104 ½ Broadway St. W #208
Owatonna, MN 55060

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer, Diabetes, HIV/AIDS and Sexually Transmitted Diseases, Immunizations, Unintentional Injuries and Violence
Geographic Service Area: Owatonna and Grass Migrant Camp in Steele County, Waseca in Waseca County and Montgomery in Le Sueur County
Target Population: Migrant Agricultural Workers

Council on Crime and Justice
822 South 3rd St., Suite 100
Minneapolis, MN 55415

Grant Type: Community, Planning
Health Priority Areas: HIV/AIDS and Sexually Transmitted Diseases
Geographic Service Area: North Minneapolis in Hennepin County and The East Side of St. Paul in Ramsey County
Target Population: African American

Family and Children's Service
4123 E. Lake St.
Minneapolis., MN 55406-2028

Grant Type: Community, Planning
Health Priority Areas: Unintentional Injuries and Violence
Geographic Service Area: Minneapolis North Side Neighborhoods
Target Population: African American

Centro, Inc.
1915 Chicago Avenue South
Minneapolis, MN 55404

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Minneapolis
Target Population: Latinos

Children's Health Care
2425 Chicago Avenue South
Minneapolis, MN 55404

Grant Type: Community, Implementation
Health Priority Areas: Diabetes, Cardiovascular Disease, Healthy Youth Development
Geographic Service Area: Core City Neighborhoods of Minneapolis (Phillips, Powderhorn, Whittier, Longfellow, Near North)
Target Population: African American

Dar Al-Hijrah Cultural Center
1614 68th Ave NE
Fridley, MN 55432

Grant Type: Community, Planning
Health Priority Areas: Diabetes, Immunizations and Infant Mortality
Geographic Service Area: Cedar-Riverside neighborhood of Somali Community in Minneapolis
Target Population: African American – Somali

Fremont Community Health Services
3300 Fremont Ave N.
Minneapolis, MN 55412

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease and Diabetes
Geographic Service Area: North Minneapolis and Northwest Suburbs
Target Population: African Immigrants –primarily Liberian

APPENDIX D: EHD GRANTEE DESCRIPTIONS

Freeport West and Powderhorn / Phillips Cultural Wellness Center
2219 Oakland Ave S.
Minneapolis, MN 55404

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Phillips Powderhorn planning district of Minneapolis
Target Population: African American, African: Jamaican, Somali, Liberian, Nigerian

Fond du Lac Tribe
Center for American Indian Resources Clinic
927 Trettel Lane
Cloquet, MN 55720

Grant Type: Tribal, Implementation
Health Priority Areas: Infant Mortality
Geographic Service Area: Southern St. Louis including Duluth, MN and Fond du Lac Reservation (Carlton County)
Target Population: American Indian – FDL and Federally Recognized Tribes

Vietnamese Social Services of Minnesota

Although Minnesota lacks Vietnamese-specific data on cervical cancer rates, data from the National Cancer Institute shows that Vietnamese women have some of the highest incidence rates for cervical cancer among Asians as well as among the general population. In fact, the cervical cancer rate for Vietnamese women is 7.4 times higher than for Japanese women, who have the lowest incidence rate among Asians. Furthermore, the incidence of cervical cancer among Vietnamese women is nearly five times higher than for America's general population.

Research has shown that Vietnamese women have some of the lowest screening rates for cervical cancer. Many believe that language gaps, unfamiliarity with preventive care, a belief that cancer is a death sentence, and modesty issues contribute to the low screening rates in this community. Through the Eliminating Health Disparities Initiative, the Vietnamese Social Services of Minnesota (VSS) is leading a comprehensive effort to prevent breast and cervical cancer for this community. This effort involves: conducting a culturally-specific media/education campaign, creating a lay health worker program, scheduling appointments, and accompanying women as needed to medical appointments involving clinical breast examinations, mammograms, pelvic exams and pap smears. Despite the newness of the program, over 90% of Vietnamese women who attend presentations given by VSS staff, have shown a willingness to make a screening appointment after the presentation. Already, the Susan G. Komen Breast Cancer Foundation at the national level has recognized the new work of VSS in preventing breast and cervical cancer and has involved them in creating the Foundation's first breast self-exam education product in Vietnamese.

Grand Portage Health Service
62 Upper Road, P.O. Box 428
Grand Portage, MN 55605

Grant Type: Community, Planning
Health Priority Areas: Cardiovascular Disease, Diabetes and Immunizations
Geographic Service Area: Grand Portage Indian Reservation
Target Population: American Indian Grand Portage Population

Division of Indian Work
(Greater Minneapolis Council of Churches)
1001 East Lake St., P.O. Box 7509
Minneapolis, MN 55407-0509

Grant Type: Community, Implementation
Health Priority Areas: Infant Mortality
Geographic Service Area: City of Minneapolis and Hennepin County primarily
Target Population: American Indian

APPENDIX D: EHD GRANTEE DESCRIPTIONS

Hmong American Partnership
1075 Arcade St.
St. Paul, MN 55106

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease and
Violence and Unintentional Injuries
Geographic Service Area: Ramsey and Hennepin Counties
Target Population: Asian American – Hmong

Hope International Health and Social Services
1526 East 6th Street
St. Paul, MN 55106

Grant Type: Community, Planning
Health Priority Areas: Cardiovascular Disease, Diabetes,
Breast and Cervical Cancer, Immunizations, and
HIV/AIDS and Sexually Transmitted Diseases
Geographic Service Area: Metro – Twin Cities
Target Population: West African

Kandiyohi County Public Health
2200 23rd Street NE, Ste 1080
Willmar, MN 56201

Grant Type: Community, Planning
Health Priority Areas: Not Yet Determined
Geographic Service Area: Kandiyohi County Latino and
Somali Communities
Target Population: Latino and Somali Communities

Lao Family Community of Minnesota
320 University Ave. W.
St. Paul, MN 55103

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Health Hmong Teens Program
(Minneapolis and St. Paul area middle schools); Young
parents program (St. Paul area high schools)
Target Population: Asian American – Hmong

Hmong National Organization, Inc.
501 Dale Street N., Ste 106
St. Paul, MN 55103

Grant Type: Community, Implementation
Health Priority Areas: Immunizations
Geographic Service Area: Minneapolis and
St. Paul Metropolitan Area
Target Population:
Asian American – Hmong

Indian Health Board
1315 E. 24th St.
Minneapolis, MN 55404

Grant Type: Community, Planning
Health Priority Areas: Cardiovascular Disease, Diabetes,
Breast and Cervical Cancer, Immunizations, Infant
Mortality, Healthy Youth Development, Violence and
Unintentional Injuries, and HIV/AIDS and Sexually
Transmitted Diseases
Geographic Service Area: Twin Cities Metro Area
Target Population: American Indian

La Clinica
2700 E. Lake St., Suite 1100
Minneapolis, MN 55406

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Minneapolis, Hennepin County
Target Population: Latinos

Leech Lake Reservation
6530 Hwy 2 NW
Cass Lake, MN 56633

Grant Type: Tribal, Implementation
Health Priority Areas: Infant Mortality, Immunizations,
Diabetes, Cardiovascular Disease, Violence
Geographic Service Area: Leech Lake Reservation
including counties of Cass, Beltrami, Hubbard and Itasca
Target Population: American Indian – Leech Lake
members

APPENDIX D: EHDl GRANTEE DESCRIPTIONS

Lower Sioux Community
RR 1, Box 308
Morton, MN 56270

Grant Type: Tribal, Planning
Health Priority Areas: Not Yet Determined
Geographic Service Area: Lower Sioux service area including Redwood County
Target Population: American Indian

Minneapolis Urban League
2100 Plymouth Avenue North
Minneapolis, MN 55411

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Minneapolis Near North Neighborhoods
Target Population: African/African American

North Suburban Youth Health Clinic
4915 42nd Avenue N.
Robbinsdale, MN 55422

Grant Type: Community, Planning
Health Priority Areas: Healthy Youth Development
Geographic Service Area: North Minneapolis
Target Population: African American

Parents In Community Action Head Start
700 Humboldt Ave N
Minneapolis, MN 55411

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease, Diabetes, Immunizations, HIV/AIDS and Sexually Transmitted Diseases, Violence and Unintentional Injuries
Geographic Service Area: Hennepin County
Target Population: African American, African: Somali and Oromo, Urban American Indian, Hispanic/Latino, Asian American: Hmong

Mille Lacs Reservation
43500 Migizi Drive
Onamia, MN 56359

Grant Type: Tribal, Implementation
Health Priority Areas: Infant Mortality, Immunizations and Violence and Unintentional Injuries
Geographic Service Area: Mille Lacs Band of Ojibwe tribal lands
Target Population: American Indian – Ojibwe

Minnesota International Health Volunteers
122 W. Franklin Ave, Ste 210
Minneapolis, MN 55404-2480

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer, Cardiovascular Disease, Diabetes, Immunizations, Infant Mortality
Geographic Service Area: Twin Cities Metropolitan Area
Target Population: African – Somalis

Olmsted County Public Health Services
2100 Campus Drive SE
Rochester, MN 55904

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease, Diabetes and Immunizations
Geographic Service Area: Olmsted County
Target Population: African American and Hispanic/Latino

Park Avenue Family Practice
2707 Nicollet Ave. S.
Minneapolis, MN 55408

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer, Cardiovascular Disease, Diabetes, Immunizations, Infant Mortality, HIV/AIDS and Sexually Transmitted Diseases, Healthy Youth Development and Violence and Unintentional Injuries
Geographic Service Area: Twin Cities –Hennepin and Ramsey Counties
Target Population: Asian American

APPENDIX D: EHD GRANTEE DESCRIPTIONS

Partners for Violence Prevention / United Hospital Foundation
557 West 7th St. #1
St. Paul, MN 55102

Grant Type: Community, Implementation
Health Priority Areas: Violence and Unintentional Injuries
Geographic Service Area: Minneapolis/St. Paul Metro area, some focus in the West 7th Neighborhood of St. Paul
Target Population: African American, African, American Indian, Hispanic/Latino, Asian American – Hmong

Red Lake Comprehensive Health Services
P.O. Box 249
Red Lake, MN 56671

Grant Type: Tribal, Implementation
Health Priority Areas: Infant Mortality
Geographic Service Area: Red Lake Indian Reservation
Target Population: American Indian – Red Lake Reservation

Minnesota International Health Volunteers

In partnership with Confederation of Somali Community in Minnesota (CSCM) and the Leadership, Empowerment and Development Group (LEAD), Minnesota International Health Volunteers (MIHV) has successfully launched a Somali Health Care Initiative to reduce health disparities in key priority areas: breast and cervical cancer, immunizations, infant mortality, diabetes and cardiovascular disease. The project objectives include training Community Health Workers, conducting forums for both the provider and the Somali community as well as completing a comprehensive survey of Somali health issues.

The transition from Somalia to the United States has inevitably resulted in a dramatic shift in lifestyle for many Somalis. With these changes in diet and levels of physical activity, new health problems are emerging in the Somali community that were under-recognized or occurred infrequently in Somalia. Coming from a country where community members have little incidence of cardiovascular disease and diabetes makes it difficult for this community to understand how these conditions develop and more importantly, how to prevent and/or manage them when they do. Having more than fifteen minutes with both a trustworthy health provider and a qualified medical interpreter is key to receiving quality health care for most Somalis, some of our newest Minnesotans. MIHV has successfully facilitated a series of health education forums for the Somali community at the Brian Coyle Community Center in Minneapolis, complete with medical interpreters and key spiritual leaders. For the first time, many Somalis now understand what blood pressure and cholesterol levels measure in terms of preventing cardiovascular disease. Being able to spend more time with both the physician and the interpreter in a setting that is comfortable for the community also facilitated a true understanding of the importance of taking regular medications to manage their diabetes.

Prairie Island Sioux Community
1158 Island Boulevard
Welch, MN 55089

Grant Type: Tribal, Planning
Health Priority Areas: Not Yet Determined
Geographic Service Area: Prairie Island Reservation includes Goodhue County
Target Population: American Indian

Region Nine Development Commission
P.O. Box 3367
Mankato, MN 56002-3367

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer, Cardiovascular Disease and Diabetes
Geographic Service Area: Counties of: Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca and Watonwan
Target Population: Hispanic/Latino

APPENDIX D: EHDl GRANTEE DESCRIPTIONS

Save Our Sons
917 Selby Ave.
St. Paul, MN 55104

Grant Type: Community, Planning
Health Priority Areas: Violence and Unintentional Injuries
Geographic Service Area: St. Paul, Ramsey County
Target Population: African American

Southeast Asian Ministry (SeAM)
105 W. University Ave.
St. Paul, MN 55103

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease, Diabetes,
Immunizations and Breast and Cervical Cancer
Geographic Service Area: St. Paul
Target Population: Asian American – Hmong and
Cambodian

The Storefront Group
6425 Nicollet Ave. S.
Richfield, MN 55423

Grant Type: Community, Planning
Health Priority Areas: Immunizations and Not Yet
Determined
Geographic Service Area: Dakota County
(Eagan, Apple Valley, Burnsville)
Target Population: African – Somali

Summit University Teen Center
1063 Iglehart Ave.
St. Paul, MN 55104

Grant Type: Community, Planning
Health Priority Areas: Healthy Youth Development
Geographic Service Area: St. Paul neighborhoods of West
Central and Frogtown
Target Population: African American/African, Asian
American

Southeast Asian Community Council
430 Bryant Ave. N.
Minneapolis, MN 55405

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: Hennepin
Target Population: Southeast Asians

Stairstep Foundation
1404 14th Ave. N.
Minneapolis, MN 55411

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer,
Cardiovascular Disease, Diabetes, Immunizations, Infant
Mortality, Healthy Youth Development, Violence and
Unintentional Injuries
Geographic Service Area: Metro Area – Hennepin and
Ramsey County
Target Population: African American

St. Paul Urban League
401 Selby Avenue
St. Paul, MN 55102

Grant Type: Community, Implementation
Health Priority Areas: Healthy Youth Development
Geographic Service Area: St. Paul, Ramsey County,
Summit University
Target Population: African American

Turning Point, Inc.
1500 Golden Valley Road
Minneapolis, MN 55411

Grant Type: Community, Implementation
Health Priority Areas: HIV/AIDS and Sexually
Transmitted Diseases
Geographic Service Area: Hennepin County
Target Population: African American

APPENDIX D: EHD GRANTEE DESCRIPTIONS

Twin Cities Healthy Nations Program
1520 East Franklin Ave
Minneapolis, MN 55404

Grant Type: Community, Implementation
Health Priority Areas: Cardiovascular Disease and Diabetes
Geographic Service Area: South Minneapolis
Target Population: American Indian population

Upper Sioux Community
1158 Island Boulevard
Welch, MN 55089

Grant Type: Tribal, Planning
Health Priority Areas: Not Yet Determined
Geographic Service Area: Upper Sioux Community
Service Delivery Area (within 15 mile radius)
Target Population: American Indian

Centro Campesino

Centro Campesino's Health Promoter (Promotores de Salud) Project organized during September 2002 to vaccinate more than 140 migrant agricultural worker adults living near Owatonna and Montgomery in southern Minnesota. Promotores de Salud Co-Coordinator Gloria Contreras and José Rodriguez became aware of the need for vaccinations during community discussions in the evenings with residents of migrant camps and one-on-one house visits developed in order to ensure community input into the project. Migrant workers consistently expressed concern over the need for Tetanus/Diphtheria and Hepatitis B vaccine. Migrant agricultural workers face disproportionately high rates of workplace accidents and were worried about the consequences of cuts and other injuries without the T/D vaccine. Migrant workers also expressed concerns about Hepatitis B and the prohibitive cost of the vaccination. To address these needs and health concerns, Centro Campesino organized two vaccination clinics in coordination with Steele and Le Sueur County Public Health. Centro Campesino relied upon the 14 lay health promoters elected by migrant communities in southern Minnesota to help organize and promote the vaccination clinics and to discuss culturally-appropriate educational information in Spanish to fellow community members. The outcome was a tremendous success, with 110 adults vaccinated with Hepatitis B and 116 adults receiving the T/D vaccine. We sincerely thank the Minnesota Department of Health for your support in creating a healthier migrant farmworker community in Minnesota.

Vietnamese Social Services of Minnesota
1159 University Ave. W., Ste 100
St. Paul, MN 55104

Grant Type: Community, Implementation
Health Priority Areas: Breast and Cervical Cancer
Geographic Service Area: Hennepin, Ramsey, Anoka, and Dakota counties
Target Population: Asian American –Vietnamese

Westside Community Health Services
153 Concord Street
St. Paul, MN 55107

Grant Type: Community, Implementation
Health Priority Areas: Diabetes
Geographic Service Area: Metropolitan Area
Target Population: Latino and Hmong

APPENDIX D: EHD GRANTEE DESCRIPTIONS

White Earth Tribal Mental Health
P.O. Box 300
White Earth, MN 56591

Grant Type: Tribal, Implementation
Health Priority Areas: Violence and Unintentional Injuries
Geographic Service Area: White Earth Indian
Reservation, White Earth Minnesota, Becker County
Target Population: American Indian – Ojibwe

YouthLink
41 North 12th St.
Minneapolis, MN 55403

Grant Type: Community, Implementation
Health Priority Areas: Immunizations, HIV/AIDS and
Sexually Transmitted Diseases, Healthy Youth
Development and Violence and Unintentional Injuries
Geographic Service Area: Twin Cities Metropolitan area,
particularly inner-city Minneapolis, although homeless
youth from all over the state before ending up here
Target Population: African American, African

Women's Cancer Resource Center
4604 Chicago Ave. S.
Minneapolis, MN 55407

Grant Type: Community, Planning
Health Priority Areas: Breast and Cervical Cancer
Geographic Service Area: South Minneapolis
Target Population: African American, African – Somali

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APPENDIX E

Tuberculosis Screening Protocol

"The Grant activities of Olmsted County Public Health Services involve partnering with the Adult Literacy Program (ESOL) to provide health teaching, referral and follow up for these students who lack knowledge and/or access to local health care resources. We can reach our target populations at a teachable moment as well as enhance the health teaching component of their curriculum."

Olmsted County Public Health Services

Tuberculosis Screening Protocol

For each refugee whose initial U.S. resettlement is in the CHS service area after **January 1, 2002** and for whom no previous health screening services have been provided in this state, the following duties shall be undertaken:

- A. Contact any new refugee (or the refugee's sponsor) resettling in the CHS service area to initiate a referral for a general health assessment.
- B. Work with the refugee, sponsor or Volag (voluntary agency) to ensure that all refugees are referred for a general health assessment, evaluation, and treatment with a licensed health care provider within the first 90 days after the refugee's initial date of entry into Minnesota.
- C. Work with the refugee, sponsor or Volag to ensure that transportation, interpretation, and financial barriers to the assessment are successfully resolved.
- D. Provide follow-up within 30 days to all refugees who were referred for a general health assessment to ascertain if the assessment was completed and if acute disease problems necessitating follow-up were identified.
- E. Ensure that all refugees identified with Class A conditions are screened within seven days of U.S. arrival. Those with Class B conditions must be screened within 30 days of U.S. arrival. Collect, report, and record information as requested by the Minnesota Department of Health regarding the initiation and adherence to prescribed treatment.

For persons in the CHS service area with active tuberculosis (TB) disease or latent TB infection (LTBI), responsibilities include but are not limited to:

- A. Provide Directly Observed Therapy (DOT), as needed, for TB patients being treated for TB disease in the public or private sector. DOT will be provided in various appropriate settings, including the CHS's clinic, patients' homes, or elsewhere in the field.
- B. Conduct contact investigations surrounding infectious TB cases. Investigations include interviewing the source case, locating exposed individuals residing in the CHS's jurisdiction, and referring contacts to health care providers for screening and medical evaluation.
- C. Ensure the availability and appropriate use of professional interpreters, as needed, for non-English-speaking TB patients during the provision of TB-related services.
- D. Provide or arrange for enablers (e.g., transportation to clinic visits and DOT appointments) and assist eligible patients in applying for financial assistance programs to cover the cost of TB-related services.
- E. Provide appropriate incentives to ensure patients' adherence to therapy and follow-up care. Funds will not be used to provide monetary incentives directly to patients.
- F. Provide individualized, linguistically and culturally appropriate patient education regarding TB treatment and follow-up.
- G. Act as an advocate for TB patients, as needed, with private medical providers and health care systems to ensure that culturally appropriate medical follow-up is obtained.

APPENDIX F

Measurable Outcomes

“YouthLink focuses on street-based healthcare for homeless youth, its focus on the integration of wellness and cultural competency across the entire agency, its inclusion of homeless youth as part of the process, and it’s approach to organize staff to take leadership on implementation”

YouthLink

Long-Term, Intermediate and Program Level Outcomes

**Table 5: Eliminating Health Disparities Initiative
Measurable Outcomes**

Long Term Measurable Outcomes¹	
Decrease by 50%, the disparity in Infant mortality rates among targeted populations.	
Decrease by 50%, disparities in the immunization rates of children from targeted groups (% up-to-date for 4 doses of DTP, 3 doses polio, 1 dose MMR vaccine at 24 months)	
Decrease by 50%, disparities in immunization rates of adults from targeted groups (influenza and pneumococcal disease.)	
Decrease breast and cervical cancer mortality rates among targeted populations.	
Decrease the incidence and prevalence rates for gonorrhea, chlamydia, syphilis, and HIV infections between targeted groups and the white population	
Decrease the age adjusted CVD, heart disease, and cerebrovascular death rates among targeted groups.	
Increase the proportion of persons with diabetes who have an Annual lipid and HbA1c measurement	
Decrease the disparities in teen pregnancy rates and subsequent births to women in targeted groups.	
Decrease the rates of deaths due to unintentional injury, suicide, homicide, and motor vehicle accidents in targeted populations	
Intermediate (e.g.)²	
Health Behaviors	Health System
Tobacco Use	Health Care Coverage
Alcohol Use	Cultural Competency
Physical Activity	Clinic Hours
Community Assets	Environmental Factors
Social Support	Childhood Poverty
Accessible clinics	Affordable Housing
Program Level (e.g.)³	
Schools in the district who use WOLF diabetes curriculum	
Home visiting assessment and referrals of women and infants	

¹ These measures identify long-term outcomes for the initiative. They have been identified primarily through the technical expertise of state and national consultants and are the traditional measures related to the eight health priority areas for the EHDI. With the exception of the measure for diabetes, data is available from MDH vital records and public health surveillance systems. These outcomes measure the impact on the overall health priority area and, as such, tend to be long-term indicating change in the health status of a population (frequently described in terms of morbidity or mortality, e.g. infant mortality rates).

² Intermediate outcomes can have an effect on the desired long-term outcome. These outcomes are monitored in shorter time frames and are clearly focused on measures which have a high probability of reducing a health problem or increasing individual and/or community resiliency/capacity (e.g. Prenatal Quality of Care Index.)

³ Short term, process or program-level outcomes are measures of the effect of an intervention. They detail the specific tasks that will be carried out by the EHDI grantees. Process outcomes measure the effectiveness of the EHDI grantee intervention or strategy (e.g. number of women who attend prenatal care classes.)

EHDI Baseline and Target Rates for Infant Mortality and Immunizations

Table 6: Infant Mortality Rates per 1,000 Births by Race and Hispanic Origin of Mother, 1995-99					
	White	African American	American Indian	Asian	Hispanic
EHDI Baseline	5.5	13.2	13.5	7.1	7.0
EHDI Target	---	9.4	9.5	6.3	6.3

Source: Infant Mortality statistics for Minnesota from the 1995-99 linked birth/infant death data set, Minnesota Department of Health, Center for Health Statistics.

Table 7: Child Immunization Rates by Race and Hispanic Origin, 2000-01					
	White	African American	American Indian	Asian	Hispanic
EHDI Baseline	82.0	62.0	73.0	66.0	65.0
EHDI Target	---	78.0	79.0	76.0	75.0

Source: Minnesota Department of Health

Selected Program Level Outcomes

Grantee	Program Level Outcomes
African American AIDS Taskforce	<ul style="list-style-type: none"> • An increase in the number of people knowledgeable about HIV
Agape House for Mothers	<ul style="list-style-type: none"> • African American teens will have better knowledge, awareness, and prevention practice to develop effective behavioral skills and techniques that will greatly reduce the probability of getting pregnant and contracting a sexually transmitted diseases. • Teens will begin to tell and share the prevention knowledge and skills with their peer friends, while maintaining constructive involvement in progressive programs and activities that directly contribute to the prevention of teen pregnancy and HIV/STI.
American Indian Family Center Collaborative	<ul style="list-style-type: none"> • 30 new women will be trained as doulas • 400 expectant women will have a doula over the 2 year grant period • 75% reduction of trauma and medical interventions during labor and delivery • Increased healthy birth weight: 90% of births will be of 5.5 lbs. or more • Increased rate of mothers who are breastfeeding: 80% of mothers will breast feed at birth. 75% will continue through six weeks
Black Storytellers Alliance	<ul style="list-style-type: none"> • Hold two meeting with representatives from North-side youth serving agencies to discuss ‘best practices’ related to teen pregnancy prevention. • Hold two meetings with community stakeholders (political, spiritual, activist) to discuss best practices • Meet twice with groups of at least 10 boys and girls from each grade (4-9) to get feedback/discussion on stories, provide stipend, refreshments, and transportation for participation • Hold 4 “Toys U Can’t Return” workshops serving at least 50 young African-American girls and boys at each, supply refreshments, handouts, feature guest speakers

Selected Program Level Outcomes

Grantee	Program Level Outcomes
Boys and Girls Clubs of the Twin Cities	<ul style="list-style-type: none"> • Two Smart Moves Programs will be conducted at each site (7) quarterly. • 560 members will complete the program and show an increase in knowledge, refusal skills and changes in attitude. • Graduates will attend at least 70% of the session. • BGCTC will identify and train parents to facilitate Smart Moves along with Teens and Staff. • BGCTC Staff will provide and disseminate information as well accept referral from the Parents Advisory Groups. Cass County-Leech Lake Reservation Family Services Collaborative*
Carondelet LifeCare Ministries	<ul style="list-style-type: none"> • Promote breast and cervical cancer screenings, provide pap smears and mammograms with follow up treatments. • Promote early diagnosis of diabetes, provide improved services for those diagnosed with diabetes. • Increased knowledge about breast cancer and cervical cancer and their prevention • Increased knowledge about risk and prevention of diabetes
Centro Campesino, Inc.	<ul style="list-style-type: none"> • The migrant and rural Latino/a communities would have more information about tobacco, breast and cervical cancer, diabetes and sexually transmitted diseases • The migrant and rural Latino/a communities would have more information about worker’s compensation • The community would have increased access to health care • More migrant adults would have access to Tetanus and Hepatitis B vaccinations
Fremont Community Health Services	<ul style="list-style-type: none"> • Increased skills to reduce their personal stroke risks • Increased knowledge about stroke risk factors & their modifiable life style changes and that stroke is a medical emergency.
Freeport West and Powderhorn / Phillips Cultural Wellness Center	<ul style="list-style-type: none"> • Teens will make informed decisions regarding their sexual health and reduce the likelihood of pregnancy

Selected Program Level Outcomes

Grantee	Program Level Outcomes
Division of Indian Work (Greater Minneapolis Council of Churches)	<ul style="list-style-type: none"> • Women will be willing to fill the traditional role of birth partner. • Doulas will have increased knowledge of labor and delivery. • Women will have a certified birth partner. • Women will have an easier labor and delivery.
Hmong American Partnership	<ul style="list-style-type: none"> • Women attending talking circles: exhibit behavior that is less isolating, used different/new methods for resolving conflict, talked about formerly "taboo" subjects with their husbands (i.e., asked husbands to be at home more often, etc.) in the mental health talking circle process)
Hmong National Organization, Inc.	<ul style="list-style-type: none"> • Program staff have an effective tool that increases their understanding of the health related needs/ issues/ barriers of Hmong families • Program participants have individualized plans that are educational, supportive, and meet their health needs. Hmong families are uniquely "matched" to the services needed so that they obtain preventive health care services. • Hmong parents understand the value of preventive health care services and bring their children to their scheduled appointments. Hmong parents understand when to use clinic versus when to use emergency room services. 100-200 Hmong children receive preventive health care services.
La Clinica	<ul style="list-style-type: none"> • Acute health and medical needs of the adolescent are resolve • Adolescents have increased knowledge regarding state-wide medical confidentiality laws and have signed the form regarding confidentiality
Lao Family Community of Minnesota	<ul style="list-style-type: none"> • Enhance participants' understanding of benefits related to remaining abstinent and delaying marriage until age 18 • Enhance young Hmong parents' parenting skills and understanding of child development • Enhance participants' understanding of benefits related to delaying subsequent pregnancies • Enhance participants' access to the various social service program for which they are eligible

Selected Program Level Outcomes

Grantee	Program Level Outcomes
Mille Lacs Reservation	<ul style="list-style-type: none"> • Decrease in number of native women who smoke during pregnancy from 33.5% to 20%. • 80 % of pregnant Native women will have a home assessment visit and documentation of intervention needs prenatal and post natal.
Minnesota International Health Volunteers (MIHV)	<ul style="list-style-type: none"> • More Somali women know about breast and cervical cancer and recognize the value of early screening and a healthy lifestyle for cancer prevention. • More Somali women are screened for cervical cancer. • Greater awareness among health and other service providers about Somali immigrant health disparities. • Greater capacity of each partner organization to work on Somali health issues.
North Suburban Youth Health Clinic	<ul style="list-style-type: none"> • Increased parent/child communication • Broader community participation • Peers learn from peers about parenting • Decreased informant/educator barriers • Strengthened community attitudes, expectations regarding reducing teen pregnancy
Olmsted County Public Health Services	<ul style="list-style-type: none"> • On pre and post test, the participants report knowledge change regarding diabetes, CV disease, diet modifications regarding physical activity • Develop position paper on the importance of good nutrition & lifelong physical activity
Parent’s In Community Action Head Start (PICA)	<ul style="list-style-type: none"> • Staff participate in events, which include cholesterol and glucose screening, height and weight screening, blood pressure screening, and aerobic activity. • Knowledge of what diabetes is and why they could be at risk
Park Avenue Family Practice	<ul style="list-style-type: none"> • During the program period, Hmong clinic patients with diabetes that need attention from an eye specialist will understand that they need specialized care and will return to the clinic for a follow-up appointment to receive medical assessment and intervention, if necessary (i.e., prescription, cataract surgery, etc.), from an ophthalmologist

Selected Program Level Outcomes

Grantee	Program Level Outcomes
Partners for Violence Prevention / United Hospital Foundation	<ul style="list-style-type: none"> • Students, school leadership, citizens, local businesses, organizations, and leaders have increased awareness of violence issues in the community, how they can act to impact those issues, and they act to prevent violence and promote peace. • Students learn to act non-violently and respond to violence in a positive manner.
Red Lake Comprehensive Health Services	<ul style="list-style-type: none"> • 90% of the high-risk PN clients seen in the RL Service Unit will be referred to CHNS. • All referrals will have a MN Pregnancy Assessment Form that accompanies referral. • 50% referred high-risk prenatal clients attend 2 or more childbirth classes. • Incorporate findings focus group into development of high risk PN program for CHNS.
Region Nine Development Commission	<ul style="list-style-type: none"> • Increase in knowledge: symptoms, signs, risk and prevention factors • Changed attitudes/values towards improving health • Increase in disease prevention/management skills
Southeast Asian Ministry (SeAM)	<ul style="list-style-type: none"> • Hmong and Cambodian elders who attend SeAM Elder Programs better understand the dangers of diabetes and cardiovascular disease • Hmong and Cambodian elders who attend SeAM Elder Programs will understand the importance of exercise in relationship to diabetes and cardiovascular disease.
Stairstep Foundation	<ul style="list-style-type: none"> • People are contacting health care providers to schedule health priority screenings • Increased knowledge of cardiovascular disease risk, detection and control • Increase skills to access resources to reduce violence • Increase seatbelt usage in congregation
Turning Point, Inc.	<ul style="list-style-type: none"> • Complete weekly workshop for clients and community members regarding awareness and prevention information • Participate and/or Organize, health-fairs or community forums for purposes of distributing educational preventative information regarding this health disparity • Create culturally specific brochures, pamphlets, booklets, short videos etc. to distribute within the community

Selected Program Level Outcomes

Grantee	Program Level Outcomes
Twin Cities Healthy Nations Program	<ul style="list-style-type: none"> • Hard to reach population who would typically not access health care providers have increased knowledge of resources • Population becomes aware of the importance of prevention and early intervention of diabetes, heart disease and STD's
Vietnamese Social Services of Minnesota	<ul style="list-style-type: none"> • Women increase knowledge about breast & cervical cancer
Westside Community Health Services	<ul style="list-style-type: none"> • Diabetic adults are knowledgeable of basic Diabetes education and what Diabetes is • Diabetic adults are knowledgeable of the basic Diabetes health care guidelines
White Earth Tribal Mental Health	<ul style="list-style-type: none"> • A change in beliefs (anger does not necessarily cause violence, if one is hurt, it is not ok or natural for one to hurt back)
Women's Cancer Resource Center*	<ul style="list-style-type: none"> • Information about a culturally based health care system sensitive to African/African American women who are at risk for or diagnosed with breast or cervical cancer. • Use the assets/strengths of the African/African American community to model a continuum of health care sensitive to this population's needs

ELIMINATING HEALTH DISPARITIES INITIATIVE

"Mobilizing Community Assets for Action"

For additional information on Minnesota's
Eliminating Health Disparities Initiative,
go to the MDH website
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