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THE PREAMBLE

This document is Volume 2 of *Strategies for Public Health: A Compendium of Ideas, Experience and Research from Minnesota's Public Health Professionals*. The previous version was published in 3 parts between November 1998 and March 1999. It was intended to complement *Healthy Minnesotans: Public Health Improvement Goals for 2004.* This new, updated version of *Strategies for Public Health, Volume 2,* is also intended to compliment *Healthy Minnesotans: Public Health Improvement Goals for 2004,* and the work being done at the state and local levels to achieve Minnesota's public health goals and objectives.

What is *Strategies for Pubic Health, Volume 2?* *Strategies for Public Health, Volume 2* is a compilation of strategies based on the ideas, experiences and research from Minnesota's public health professionals. It includes descriptions of key strategies available to address important public health issues.

This document also shares current evidence on the effectiveness of the strategies, and to the extent possible, identifies key partners that can play a collaborative role in implementing them. As such, it can support collaborative, community-wide efforts; can help evaluate whether efforts are making a difference; and can inform the planning, program design, implementation and evaluation of actions taken by state and local public health agencies, health plans, hospitals and clinics, the educational system, community-based organizations, and businesses.

Strategies for Public Health, Volume 2 is a step in a strategic process to build on the experience of Minnesota's public health professionals and to support the movement of public health practice in Minnesota toward the use of population-based public health interventions that are based on the best available evidence.

What is the Purpose of *Strategies for Public Health?* The purpose of this collection of strategies is to offer guidance for organizations in answering two questions:

< What are some effective strategies that can be implemented to address the health issues identified in *Healthy Minnesotans: Public Health Improvement Goals for 2004?*

< Does my organization have a potential role to play in working on this public health problem?

The wide array of strategies that might be considered by public health practitioners and their community partners to achieve public health goals can be overwhelming. Most organizations face finite resources that limit how much they can do in any given time period. They are equally interested in "what works." It is important that choices for actions are made using the most current and up-to-date information on the available resources in the community and on the potential effectiveness of the actions taken.

What is Included in This Document? Within each broad category of public health, several health problems have been identified, effective strategies to prevent or reduce the problem are described, the

evidence for each strategy is presented, and indicators of progress are offered.

This information can be useful in a variety of settings. For example, local public health agencies have found this document helpful during the development of their Community Health Services (CHS) Plans and in writing grants. They use the list of strategies as a "menu" from which to choose actions to include in their plans and grants. Health Plans have used the document during the collaboration planning process to consider and develop priorities for actions in collaboration with local public health agencies. Collaborative groups that are focusing on a specific public health problem or issue have used the menus of strategies as discussion guides to clarify their roles and to consider which effective strategies they might choose to implement.

Who is the Audience for This Document?
This document is for public health practitioners and their partners who are working together, either those that are currently engaged in or those who are considering getting involved in, public health interventions. In particular, this document will provide support for groups comprised of various community sectors working in collaboration to achieve public health goals. This includes but is not limited to community coalitions, advisory committees, local Boards of Health, healthy community teams, family services collaboratives, faith communities and other aggregate or collaborative groups. It is likely that many diverse organizations will find this document useful as they convene groups in their communities to address important public health issues.

Where Can I Find This Document?
For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Strategies". Many of the materials (e.g., articles, journals, manuals, books, videos, pamphlets) mentioned in this document are also available in the Minnesota Department of Health Library. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Library". Local public health, MDH department, and school health staff may borrow them by e-mail at: library@health.state.mn.us, or calling (612) 676-5090, or by FAX (612) 676-5385. Other interested individuals may borrow them through their corporate or public libraries.

The main MDH library in Room 370, 717 Delaware St. SE, Minneapolis is open from 8:00 a.m. to 4:30 p.m., Monday through Friday. The MDH Library Branch in St. Paul is on the 4th floor of the Golden Rule building, and is open 8:00 a.m. to 12:00 p.m. and 12:45 p.m. to 4:00 p.m. Monday-Thursday and on Fridays from 1:00 to 4:00. The public is welcome to use material on site at either location. Both areas are secure and visitors must check in at the desk in the 717 lobby or the reception area in St. Paul.

Who Worked on *Strategies for Public Health?* The document was originally developed in 1998-1999 by a strategies review workgroup comprised of members of the Minnesota Health Improvement Partnership (MHIP) and the State and Community Health Services Advisory Committee (SCHSAC). The MHIP is a group that represents more than 30 statewide organizations and advises the Commissioner

of Health on public health issues that cross the boundaries of the public, private and non-profit sectors. The SCHSAC is an advisory committee to the commissioner of health that is comprised of representatives of the 50 (as of January, 2003, there will be 51) Community Health Boards that make up the local public health system in Minnesota. The MHIP/SCHSAC Strategies Review Working Group reviewed the work of nearly 100 MDH staff and others who identified, compiled and described the strategies. It also developed a framework and reviewed examples of broad-based roles and responsibilities for the strategies. See Appendix A for the membership of the MHIP/SCHSAC Strategies Review Work Group.

Though some of the writers of the original strategies have moved on to other positions and organizations, most of them were able to update their work for Volume 2 of the document. See *Acknowledgements* in front of the Table of Contents of this document for a listing of those who contributed to the original version as well as Volume 2 of *Strategies for Public Health*.

What are the Limitations of the Strategies Document? This collection of strategies is intended to be used as a guide for local activity. **The document is NOT to be interpreted as a set of standards.** Similarly, it does not represent all the strategies available to address every public health problem. Rather, it represents the efforts of MDH staff to compile a collection or menu of the best strategies for addressing important public health problems and for which MDH staff have expertise.

Admittedly, there are gaps in the strategies offered. The gaps **DO NOT** indicate needs that have already been met. Moreover, offering these strategies does not guarantee that resources are available from the MDH to support them. *Strategies for Public Health, Volume 2* does not attempt to prioritize the strategies. Within each category of public health and on the strategy grids, the strategies are listed in no particular order. They are simply offered for users to pursue and consider.

Evidence-based Strategies. The evidence for each strategy is described using experience, research, literature and expert opinion. As such, *Strategies for Public Health, Volume 2* strengthens the evidence-based approach to population health. These efforts will continue on a systematic and increasingly rigorous basis, building on federal work as it is disseminated. For example, under the auspices of the Centers for Disease Control and Prevention, the Task Force on Community Preventive Services has been working for the past few years to develop the Guide to Community Preventive Services (also known as the Community Guide).

The Task Force on Community Preventive Services is an independent, non-federal Task Force and consists of 15 members, including a chair, appointed by the Director of CDC. The Task Force's membership is multi-disciplinary, and includes representatives of state and local health departments, managed care, academia, behavioral and social sciences, communications sciences, mental health, epidemiology, quantitative policy analysis, decision and cost-effectiveness

analysis, information systems, primary care, and management and policy.

The Community Guide addresses a variety of health topics important to communities, public health agencies and health care systems. It summarizes what is known about the effectiveness and cost-effectiveness of population based interventions designed to promote health, prevent disease, injury, disability and premature death as well as exposure to environmental hazards.

Based on systematic evaluations of the evidence, the Community Guide provides recommendations on population-based interventions for use by communities and healthcare systems to promote health and to prevent disease, injury, disability and premature death. The recommendations are: "strongly recommended", "recommended", or "insufficient evidence". For those interventions where there is insufficient evidence of effectiveness, the Community Guide provides guidance for further prevention research. **It is important to note that a determination that evidence is insufficient should not be confused with evidence of ineffectiveness.** The *Community Guide* is not yet complete. Work on it continues as the evidence on new topics is considered and analyzed. The Community Guide can be accessed at: http://www.thecommunityguide.org.

Future Directions. *Strategies for Public Health* is an evolutionary document. Initially it was published in stages during the fall of 1998 and the winter of 1999. "Volume 2" is being disseminated in the fall and winter of 2002-2003. It should be considered a "work in progress" and will continue to evolve over time. *Strategies for Public Health,* both the original document and Volume 2, represent steps in a strategic process to build on the experience of Minnesota's public health professionals and to integrate research into public health practice in Minnesota.

Public Health is Everybody's Business.
In *The Future of Public Health* (Institute of Medicine, 1988), public health is described as "…what we, as a society, do collectively to assure the conditions in which people can be healthy." While protecting the health of the public is a basic responsibility of government, no single business, organization or government agency has the resources to bring about the changes needed to improve the public's health. It is what we do collectively in our communities that will move us as individuals and as a state toward a healthier future. We all share the benefits of and the responsibility for a healthy society. Public health is everybody's business.

In Minnesota, the practice of public health has long depended upon a strong partnership between state and local health departments. Effective public health practice also depends upon teamwork with other governmental units (such as schools) and others in the community (such as businesses and consumers). With recent changes in the health care landscape, successful collaborative efforts are increasingly taking place between the public and private health sectors in Minnesota. More and more health plans, patient care providers, non-profit organizations and others recognize the importance of improving the health of populations. State and local public health agencies are working with these new partners to develop effective ways of improving the public's health. *Strategies for Public Health, Volume 2* is intended to support these collective efforts.

Governmental Public Health in Minnesota. Governmental public health agencies have a responsibility to provide certain services that will promote and protect the health of the population. How these responsibilities are carried out varies from state to state and community to community. In Minnesota these public health activities are carried out through a unique partnership between state and local governments. Minnesota has long been recognized for this partnership, strengthened over the years by joint efforts to achieve public health goals and improve the health of all Minnesotans.

Minnesota's system of local public health - known as Community Health Services (CHS) - includes both the state public health agency and 50 (and as of January 2003, 51) local Community Health Boards and is designed to "*…protect and promote the health of the general population…by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community"* (MN Statutes 145A.02). Minnesota's Community Health Boards provide direction, planning and coordination for local public health departments.

Community Health Plans. The CHS system exists to carry out the planning, administration and delivery of public health services in Minnesota. To qualify for CHS funds appropriated by the Minnesota Legislature, local Community Health Boards must periodically conduct a comprehensive public health planning process. This

planning culminates in the preparation of a four-year *Community Health Services Plan.* CHS plans include:

- a community-wide assessment of issues, needs, strengths, and resources;
- prioritization of public health problems;
- a plan for addressing and evaluating specific public health problems;
- a list and/or description of ongoing activities.

The development of the CHS plans helps make public health issues more visible to the public. The CHS plans lay the groundwork for the development and periodic updating of Minnesota's public health improvement goals, provide the foundation for collaborative work between local public health agencies and their partners, e.g., health plans, health systems and community based organizations; help each community to set priorities for the health of its citizens, identify the resources (staff time, funding, etc.) needed to address those priorities, and mobilize the community to act on those priorities.

Minnesota's Public Health Improvement Goals. We know we want people in our state to be healthy. But what exactly does "healthy" mean? To answer that question, Minnesota has a set of "public health improvement goals" that identifies what is needed for all citizens to live healthy, productive lives. These goals are regularly reviewed and updated to make sure they address emerging public health problems and changing societal conditions.

The most recent set of public health goals, *Healthy Minnesotans: Public Health Improvement Goals for 2004*, builds upon local and regional assessments, community planning activities, and national goals. The Commissioner of Health formed the Minnesota Health Improvement Partnership (MHIP) in order to engage statewide organizations and systems in the process of setting public health goals and action steps to achieve the goals. The partnership includes leaders from more than 30 statewide organizations that have some responsibility for the health of the public. *Healthy Minnesotans* has three purposes:

- provide a common direction for the many people and organizations that work to improve the public's health;
- stimulate and encourage additional efforts toward healthy communities; and
- present data that indicate the health status of Minnesota residents, and that can be used to determine if we are achieving our public health goals.

There are 18 goals in *Healthy Minnesotans: Public Health Improvement Goals for 2004*. They are:

- Reduce the behavioral risks, which are primary contributors to morbidity and mortality.
- Improve birth outcomes and early childhood development.
- Reduce unintended pregnancies.
- Promote health for all children, adolescents, and their families.
- Promote a violence-free society.
- Reduce the behavioral and environmental health risks which are primary contributors to unintentional injury.
- Improve the outcomes of medical emergencies.
- Reduce infectious disease.
- Promote the well-being of the elderly

and those with disabilities, disease and/or chronic illness.

- Reduce exposure to environmental health hazards.
- Promote early detection and improved management of non-infectious/chronic conditions.
- Promote optimum oral health for all Minnesotans.
- Reduce work-related injury and illness.
- Assure access to and improve the quality of health services.
- Ensure an effective state and local government public health system.
- Eliminate the disparities in health outcomes and the health profile of populations of color.
- Foster the understanding and promotion of the social conditions that support health.

Healthy People 2010, the public health goals for our nation, are designed to achieve two overarching goals or priorities: increase quality and years of healthy life, and eliminate health disparities. Similarly, three themes emerge as critical priorities for assuring a healthy future for all Minnesota residents. As in *Healthy Minnesotans*, this document, *Strategies for Public Health, Volume 2,* is a call to action to address the three priorities for improving the health of Minnesotans. All organizations are urged to consider carefully how they can address the three priority areas when looking at the strategies presented in this document. It is only through concerted attention to these priority areas that we will move ahead in improving the health of Minnesota residents. The three critical priority areas of opportunity for improving the health of all Minnesotans are:

- ✓ **Assuring a Foundation for Health Protection.** At no time is the need for a responsive and effective foundation for health protection more evident than when residents of Minnesota are dealing with the effects of natural or human-made disasters. A variety of organizations and systems carry out activities to protect health. Minnesota's governmental public health system is an integral part of this foundation for health protection. The state and local government public health system's statutory responsibilities for health protection include an ability to assure that appropriate health protection steps are taken. Thus, the ability to mobilize quickly to protect health rests, in part, on society's ongoing commitment to support and maintain the government's public health system. For more information, see the section within this Introduction on *Public Health Emergency Preparedness*.

- ✓ **Eliminating Disparities in Health Status.** Minnesota consistently scores near the top of national surveys ranking states on the health of their residents. However, these relatively good overall health outcomes, tend to mask severe disparities among certain groups in Minnesota. These disparities include geographic, economic, age, gender, race and ethnicity. Minnesota is among the states with the greatest gap of health status disparity between whites and African Americans, American Indians, and other groups. American Indians and populations of color in Minnesota are at greater risk of suffering from cancer, heart disease, stroke, chemical

dependency, diabetes, homicides, suicides, unintentional injuries, and HIV/AIDS. If action is not taken immediately, the problem will only worsen. Concerted action on the part of state and local public health agencies, community-based organizations, and the entire health care industry is needed to address existing health disparities. For more information see the section within this Introduction on *Eliminate Health Disparities*.

✓ **Increasing Years of Healthy Life.** While increased life expectancy represents one of the major success stories of the last 100 years, we are now poised to add a new dimension to the discussion, that of quality of life. The ultimate goal of Minnesota residents is to have not only a long life, but a long and healthy life. While this concept may seem intuitive, the addition of quality-of-life considerations into discussions of health has major implications for many of the organizations that work to improve health. This will be particularly true as Minnesota's large population of baby-boomers ages.

Healthy Minnesotans: Public Health Improvement Goals for 2004 will continue to be updated using information from the local CHS planning process and advice from representatives of a wide range of perspectives. This comprehensive goal-setting process helps to provide a common direction, a common language, a sense of ownership, and broad support for the efforts needed to improve the health of Minnesota residents. The next version of *Healthy* Minnesotans will be completed in December 2003 and will cover the period of time from the beginning of 2004 to the end of 2010.

Categories of Public Health. Minnesota's CHS agencies collect and organize the information in their CHS plans according to twelve "categories" of public health. These categories reflect the wide scope of issues with which the public health system is concerned. Each of the twelve public health categories correlates to one or more of the goals in *Healthy Minnesotans.* The categories were developed as an organizing framework for the collection, analysis, and reporting of information. The goals and their accompanying objectives, on the other hand, indicate where the state is headed and how to measure progress. See Appendix B for a list of the categories, the public health goals with which they correspond and the public health problem areas within the categories in which strategies are offered. While the categories will remain static over time, the goals are dynamic and can change in response to changes in the health of the people of Minnesota. The twelve categories of public health are:

- alcohol, tobacco and other drugs
- children and adolescents growth and development
- chronic/noninfectious disease
- disability/decreased independence
- environmental conditions
- infectious disease
- mental health
- pregnancy and birth
- service delivery systems
- unintended pregnancy
- unintentional injury
- violence

How to Use This Document. *Strategies for Public Health, Volume 2* is organized according to the previously mentioned categories of public health (see Appendix B, *List of Categories, Goals and Problem Areas*). Each category in this document contains: a title page that lists public health problem areas within the category for which strategies are presented, a general introduction to the category, and for each public health problem, an introduction, a strategy grid and descriptions for each strategy on the grid. The strategy grids in this document are also included in *Healthy Minnesotans: Public Health Improvement Goals for 2004.*

Strategy Grids. The strategy grids provide a visual representation of a "menu" of strategies for a specific public health problem and the community sectors that have a potential *collaborative* role in the implementation of each strategy. See Appendix C for definitions of community sectors on the strategy grids. The grids do NOT indicate mandated roles or activities, but are intended to indicate potential voluntary involvement (e.g., business and work sites). In addressing a particular public health problem, the grids are to be used as a guide in helping to determine what strategies to use, and who could be involved in implementing them. Conversely, if there is not a check-mark on the grid for a sector or an organization that perhaps should be involved in addressing the problem, or that wants to be involved in working on the problem, that's great! Don't let the grid limit creativity and the uniqueness of any particular community. Appendix D contains a blank grid for use by community groups as they determine which sectors might or should become involved.

Each strategy grid lists sectors in the community that have a potential collaborative role to play in implementing the strategies on the grid. The sectors on each grid are: governmental public health agencies, health plans, hospitals and clinics, educational system, community-based organizations, businesses/work sites, and other. Their definitions can be found in Appendix C, *Definitions of Community sectors on the Strategy Grids*.

Determining specific roles in any given community will be dependent on the availability of local resources, expertise and the level of readiness of a community to address the problem. This is a local process that needs to happen within communities. Appendix E contains a series of community prevention planning tools that can be used in making local decisions about roles and responsibilities with regard to any particular strategy, groups of strategies or workplans.

In 2000, the Minnesota Council of Health Plans produced a report called, *Putting Commitments into Practice*. It describes the roles for health plans in implementing activities in communities that support the 10 Essential Services of Public Health. This report can be accessed at: http://www.mnhealthplans.org/collateral/MCHP_Public_Health.pdf. In addition, the Minnesota Council of Health Plans has developed two documents, *Public Health Priorities 2002*, that provide examples of roles for health plans in achieving public health goals. These documents are in Appendix F, *Public Health Priorities 2002 –*

Minnesota's Health Plans in Action, and are also available on the Minnesota Council of Health Plans website at: http://www.mnhealthplans.org/. Hard copies can by attained by contacting the Minnesota Council of Health Plans, at (651) 645-0099, info@mnhealthplans.org. Court International Building, Suite 255 South, 2550 University Avenue West, St. Paul, MN 55114.

The Minnesota Hospital and Healthcare Partnership (MHHP) has information about roles for hospitals and clinics in achieving public health goals. In January 2003, MHHP will change its name to the Minnesota Hospital Association. The Minnesota Hospital Association will begin collecting stories in 2003 that provide current examples of roles of its association members in working on public health goals. For more information, see the Association's website, at www.mhhp.com or call (800) 462-5393.

Strategy Descriptions. Each strategy on a grid has a corresponding description. Within each strategy description are the following components:

- a small table that indicates the "levels of prevention" and the "levels of intervention";
- background and purpose;
- additional resources such as documents, monographs, organizations and journal articles that can be of value to anyone looking for more information about the strategy;
- a brief description of the evidence that supports the strategy;
- whether the strategy has been implemented in Minnesota and if so, where;
- indicators that can be used to mark progress on the strategy; and
- who at the MDH to contact for more information about the strategy.

Levels of Prevention and Intervention. Each strategy description contains a small table that indicates the "levels of prevention" and the "levels of intervention" of the strategy. The term "levels of prevention," refers to the points of the problem development at which the strategy intervenes (e.g., primary, secondary, tertiary). The term, "levels of intervention," refers to the focus of the strategy (e.g., individual-focused, systems-focused, community-focused). Together, the levels of prevention and the levels of intervention help to focus intervention efforts, to document progress toward their completion and to integrate research into practice. Definitions for these terms are found in Appendix G.

Setting the Stage. Health problems are heavily influenced by societal policies and environments that either sustain the behaviors and practices that contribute to the problems, or fail to foster healthier choices that could prevent the problems. The major public health problems of our time will not be solved solely by individual actions and health choices, but by individuals coming together to make our society one in which healthy choices are easy, fun and popular. Communities in which policies and environments focus on the latter approach will be healthier and more satisfying places to live, work and play.

Often policies that affect health are not under the purview of public health. Instead,

they may be in school districts, in parks and recreation departments, economic development or other arenas of local life. This means that health practitioners must engage with the non-health sectors of our society, so those sectors understand how they can contribute to the health of people in their communities.

Addressing these policies, environments and individual changes successfully, requires the implementation of several strategies aimed at multiple levels of the community, e.g., individuals, systems and communities themselves. Depending on the intended goal, these multiple strategies may also span the continuum from primary prevention to tertiary prevention (see Appendix G, *Levels of Prevention and Intervention*) for more information).

Choosing Your Strategies. The strategies presented in this document cover the spectrum from working with individuals to influencing policies in communities and systems; from preventing problems from occurring in the first place to treating them after they've become problematic. Some of these strategies are broad and global, others are very specific to certain situations.

So, how do you know which strategies to choose? How can you tell which strategies will achieve your goals and objectives? Essentially these are questions that must be answered by the communities in which they will be implemented. Involving community members in making decisions and taking action is critical to the success of that action. Effective community engagement results in activities and programs that reflect the strengths, needs and resources of the community, and outcomes that matter, that are understandable to community members and that reflect community expectations. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Community Engagement".

Of all the potential strategies that could be implemented, it is often confusing to know which ones you should implement. Appendix H, *How To Choose Strategies,* contains a series of questions that will help you determine which of several strategies to select.

Activities for All Problem Areas. No matter what strategies are implemented, most public health practitioners engage in activities that span many different problem areas. For example, whether addressing immunization or tobacco use, family planning or clean water, the public health practitioner may need to be skilled in such activities[1] as:

- **Advocacy** - Act on someone's behalf and/or for healthy public policy. Use with clients who lack resources of access to health care; includes a focus on developing a client's capacity to become their own advocate. Also includes

[1] *Many of these descriptions are taken from two sources: (1) a document called, "Public Health Interventions: Examples from Public Health Nursing;" and (2) an article, Keller, L., Strohschein, S., et al. Population-based public health nursing interventions: A model from practice. Public Health Nursing 15(3), 207-215. Both can be obtained by contacting Linda Olson Keller, R. N., M.S., Office of Public Health Practice, Minnesota Department of Health, Community Health Division, Metro Square, Suite 460, P. O. Box 64975, St. Paul, MN 55164-0975.*

actions to develop healthy public policy in other arenas, such as media advocacy (working with the media to tell your story), policy advocacy (working to advance formal and informal policies for the betterment of all), and empowering advocacy (working with individuals and groups to become their own advocates on issues in addition to health care access).

- **Assessment** - The regular and systematic collection, analysis and dissemination of information on the health of the community, including statistics on health status and community health needs and strengths, and epidemiologic and other studies of health problems.
- **Asset Building** - Identification of and building upon strengths of individuals and communities to promote the healthy development of youth, families and communities.
- **Coalition Building** - Promote development of alliances among different organizations or constituencies for a common purpose. Used to solve problems, build linkages and enhance local leadership to addresses health concerns.
- **Collaboration** - Enhance the capacity of another organization for mutual benefit and to achieve common goals. Used to exchange information and share risks, responsibilities, resources and rewards. Involves more complex processes, and financial and time commitments compared to coalitions.
- **Community Engagement** - A systematic process that provides an opportunity for citizens, planners, managers, and elected representatives to share their experience, knowledge, and goals, and combine their energy to create a plan that is technically sound, economically attractive, generally understood and accepted by most of those affected by it, and is thus politically viable.
- **Counseling, Screening, Referral and Follow-up** - Assist individuals/families to develop ability to assume increased responsibility for self-care and to cope with stressful events and situations. Identify at-risk populations and provide appropriate screening techniques and referral for follow-up relevant to findings. Assist individuals, families, groups, or organizations to use necessary resources available to prevent or resolve problems. Used to enhance client's self-care capabilities to access resources.
- **Data Collection, Analysis, Dissemination** - Gather information about specific health problems to determine the nature and relationships and share findings with the public.
- **Disease Surveillance** - Monitor for the occurrence of disease for a given population.
- **Evaluation** - Systematic efforts to collect and appraise information with the intent of improving the quality of the process(es) and/or improving the effect(s) or outcome(s).
- **Outreach** - Reach out to at-risk individuals/families. Used to provide information about services and make services more accessible to vulnerable populations.
- **Policy Development** - Contribute to the development of formal policies, e.g., legislation, regulations, ordinances; and informal policies, e.g., worksite,

community and family norms that support healthy communities. Includes policy implementation, evaluation, and community mobilization and involvement.

- **Program Planning** - A generic set of tasks to guide the development of a community intervention. The tasks are: (1) assess the needs and assets of the target population; (2) identify the problem(s); (3) develop appropriate goals and objectives; (4) create an intervention based on the needs and assets of the target population; (5) implement the intervention; and (6) evaluate the results.
- **Provider Education** - Provide information, resources, and training to individuals, groups, and organizations whose services affect public health-related community problems.
- **Public Information/Public Education/Consumer Education** - Provide communities and consumers with information pertinent to healthy behaviors or specific diseases and risks.
- **Social Marketing** - Adapt commercial marketing techniques to the analysis, planning, implementation, and evaluation of programs that are designed to influence and improve the health behaviors of target groups and populations.
- **Strategic Planning** - Making, doing or arranging something more effectively; creating a set of decisions for future action.

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Why Engage the Community? Community engagement is a cornerstone of effective public health practice. Involving community members in making decisions and taking action is critical. Successful community engagement builds skills and capacity within the community, which are fundamental factors for optimal health.

Community engagement is a process of involving community members and the reliance on a community's own resources and strengths as the foundation for designing, implementing, and evaluating solutions to problematic conditions that affect them. As such, community engagement involves interpersonal trust, communication, and collaboration. Such engagement, or participation, should focus on, and result from, the needs, expectations, and desires of a community's members.

Effective community engagement results in activities and programs that reflect the strengths, needs and resources of the community, and outcomes that are understandable to community members and that reflect community expectations.

Along with more traditional risk reduction activities, building community engagement is increasingly regarded as a priority for health improvement. The Institute of Medicine (IOM) recently noted that the next generation of prevention interventions must focus on building relationships with communities, and derive from the communities' assessments of their needs and priorities.

What is Community Engagement?
"Community" is a fluid concept and may be described as people (socioeconomics and demographics, health status and risk profiles, cultural and ethnic characteristics), location (geographic boundaries), connectors (shared values, interests, motivating forces), or power relationships (communication patterns, formal and informal lines of authority and influence, stakeholder relationships, resource flows).

Effective community engagement brings people to the table—both community members and professionals—and nurtures their active participation in all aspects of decision-making processes. The International Association for Public Participation defines "constructive citizen participation" as a systematic process that provides an opportunity for citizens, planners, managers, and elected representatives to share their experience, knowledge, and goals, and combine their energy to create a plan that is technically sound, economically attractive, generally understood and accepted by most of those affected by it, and is thus politically viable. Cultural strengths are identified and valued as the process seeks to meld community "wisdom" with scientific and institutional expertise. Community members are valued as equal partners. Information is gathered to inform action, and new understandings emerge as participants reflect on potential actions.

The Cycle of Engagement. The cycle of engagement typically has three parts to it: First is coming together - starting the conversation and dialogue; building trust and safe spaces for people to think, debate,

reflect and make decisions. Second is moving forward—converting dialogue into activity; reaching out beyond the original planning group; and creating dynamic partnerships to implement programs and provide services. And third is sustaining momentum—building structures; developing and sustaining leadership; assessing and improving programs; measuring change and communicating results. These three steps can bring many sectors of the community together, foster new alliances and relationships, provide community members with a better compass for understanding community problems and assets, and be used to drive community change.

Principles of Community Engagement. The Centers for Disease Control and Prevention/Agency for Toxic Substances and Disease Registry (CDC/ATSDR) Committee for Community Engagement suggests several underlying principles that can help guide community members in designing, implementing, and evaluating community engagement efforts, and form effective engagement partnerships.
Each principle covers a broad practice area of engagement, often addressing multiple issues, and is organized in three sections: items to consider before starting the engagement effort, what is necessary for engagement to occur, and what to consider for the engagement to be successful. The nine principles are discussed below. For more information see the website for strategies at: www.health.state.mn.us/strategies/. Click on "Community Engagement".

Before starting a community engagement effort it is important to:

- Principle 1 -- Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.
- Principle 2 -- Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts.

For effective engagement to occur, it is necessary to:

- Principle 3 -- Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.
- Principle 4 -- Remember and accept that community self-determination is the responsibility and right of all people who comprise a community.

For engagement to succeed it is necessary to:

- Principle 5 -- Partner with the community to create change and improve health.
- Principle 6 -- Recognize and respect community diversity.
- Principle 7 -- Identify and mobilize community assets, and develop capacities and resources for community health decisions and action.
- Principle 8 -- Release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.
- Principle 9 -- Commit to the activities for the long-term.

New Assumptions. Effectively engaging the public means adopting an entirely different set of assumptions about the public, it means doing things differently. For example:

- Professionals within public institutions must understand that under the right conditions, people can deal with complex issues, and that they are willing to take the time to do it thoughtfully.
- We must recognize that people think about public concerns not in isolated bits, but in inter-related webs of concerns; and that there is a wisdom in communities throughout the state that needs to be tapped in order to truly make sense of data and decide what actions to take.
- People need to learn from one another—have room for ambivalence and time and space to test ideas, explore, and listen—so they can sort out what they believe and learn together.
- People need a sense of possibility to engage in public discussions—a belief that something worthwhile might be produced from their efforts and involvement.
- It is essential for those engaging the community to adhere to the highest ethical standards. Failure to act ethically is not an option. Ethical action is the only hope for developing and maintaining the trust of communities.

Community Engagement and the Local Public Health Act. *"Governmental public health agencies must find ways to improve communication and openness with the public to maintain and increase their trustworthiness."* (IOM, Healthy Communities, 1996).

Community participation was a key ingredient in the original design of the Community Health System in Minnesota. The 1976 CHS Act established a system of local public health agencies across the state and required Citizen Advisory Committees and community involvement in community health assessment and planning. Since that time, local public health agencies have served as catalysts, engaging people in ways that allowed communication and cooperation among community members, organizations, and government entities.

The State's changing demographics and the recent priority focus on the elimination of health disparities is challenging the established ways this work has been done. Success in achieving public health goals will require a new level of communication and cooperation between community members who have not been a part of past decision-making processes and the organizations and governments that serve them. In the words of one public health practitioner, *"This work means making a commitment to change the way we do our work."*

Suggested Strategies. Successful community engagement calls for everyone to take responsibility—to step up to the plate, to be involved and to hold one another accountable. Multiple sectors must be involved in efforts to eliminate health disparities. Suggested strategies include:

- Take the time necessary for authentic participation.
- Initiate or expand dialogue within the broader systems and communities served.
- Periodically and systematically create the time and place needed for internal

discussions, planning, and training on community engagement strategies and tools.

- Recognize and plan for expanded timelines necessitated by identification, recruitment, and orientation of new partners and community members.
- Include adequate time in decision-making processes for representatives of organizations and communities to seek input.
- Communicate with the community every step of the way.
- Encourage and support community engagement training opportunities.
- Assure that community engagement principles are incorporated into contracts for capacity building and technical assistance, social marketing and evaluation, so that contractors include community engagement information and strategies in their activities.

"Go in search of people.
Begin with what they know.
Build on what they have."

Chinese proverb

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- CDC Public Health Practice Program Office , at www.cdc.gov/phppo/ or contact Michael Hatcher at Mail Stop K39, 4770 Buford Highway N.E., Atlanta, GA, 30341-3724, mthl@cdc.gov.
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Minnesota has been noted as one of the healthiest states in the nation; however, racial/ethnic minority populations in Minnesota experience poorer health in several areas. Overall, populations of color and American Indians experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, and cancer, as well as other diseases and conditions. These disparities also affect Minnesota's newly arrived immigrants and refugees. In some cases, the health disparities among these populations are the highest in the nation. Populations of color and American Indians have joined with MDH and its Office of Minority and Multicultural Health for increased attention to these issues.

Data on Health Disparities. Improved data collection now is more accurately uncovering the breadth of these health disparities in Minnesota. Highlights of those data are summarized on fact sheets covering Minnesota's four major racial/ethnic minority groups - African American, American Indian, Asian American and Hispanic/Latino. To locate these fact sheets see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "African American" for *Eliminating Disparities in the Health Status of* ***African Americans***; on "American Indian" for *Eliminating Disparities in the Health Status of* ***American Indians***; on "Asian American" for *Eliminating Disparities in the Health Status of* ***Asian Americans***; and on "Hispanic/Latino" for *Eliminating Disparities in the Health Status of* ***Hispanics/Latinos***.

Data on "subgroups" within several of these racial/ethnic groups, for example Somalis from Africa and the Asian Hmong community in Minnesota (one of the largest Hmong communities in the United States) are not specifically identified among the data for the respective larger racial/ethnic group. Without this identification of subgroups, accurate analysis and assessment of health status and specific health issues is very difficult, and is a disservice to the population subgroups.

More specifically, some examples of these racial/ethnic and American Indian health disparities include:

- Among the racial/ethnic groups in Minnesota, African American women have a breast cancer mortality rate that is 50 percent higher than that of white or Hispanic/Latina women, despite similar incidence rates. A greater proportion of African American women with breast cancer are diagnosed at a later, less treatable stage.
- African American, American Indian, and Asian American women have cervical cancer incidence rates that are three to four times higher than the rate for white women. Deaths due to cervical cancer also occur at significantly higher rates among Asian Americans and African Americans compared with whites.
- Mortality rates for Minnesotans overall are lower than for the nation as a whole; however, for some segments of the population, including American Indians, Asian Americans, and African American females, mortality rates for heart disease or stroke are higher than these rates for the overall state population. American Indian death rates from 1990 through

1998 were 33 percent higher than the state's population rates and 44 percent higher than the total U.S. American Indian rates. Age-adjusted death rates also indicate considerable disparities in heart disease for African American females living in Minnesota. Asian Americans living in Minnesota are more likely than other population groups to suffer from stroke.

- In Minnesota, glaring racial and ethnic disparities in diabetes exist. These are reflected in the prevalence, complications, death rates, and preventive care received by those who have diabetes. Compared to whites, diabetes, as an underlying cause of death in Minnesota, was between 1.5 and five times more common among African Americans, Hispanics/Latinos, and American Indians. The diabetes death rate among Asian Americans is increasing faster than among any other racial or ethnic group. Among people with diabetes: kidney failure is two to six times greater in populations of color; lower limb amputations are four times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos, and 40-50 percent greater in African Americans.
- In 2000, the number of newly reported cases of HIV among persons of color was greater than among whites for the first time in Minnesota, even though communities of color make up approximately 10 percent of Minnesota's population. African American men have the highest annual rate of newly reported HIV/AIDS infections, 21 times greater than white males in Minnesota. The disparity is even greater for African American women with an HIV/AIDS rate 91 times greater than that among white women.
- Infant mortality is a summary statistic reflecting multiple conditions and causes. Although Minnesota has one of the lowest state infant mortality rates in the nation, the overall state rate masks severe and longstanding disparities in infant mortality experienced by some of Minnesota's populations. American Indian infant deaths have been rising over time. In fact, the National Center for Health Statistics and the Bemidji Indian Health Service have reported that Minnesota's Indian infant death rate is the highest in the U.S. African American infant deaths, although improving over time, remain significantly higher than those of white infants. Asian infant deaths are also rising in the most recent time period measured.
- Minnesota has wide and unacceptable disparities in the rates of teen pregnancy across its population. While Minnesota's teen pregnancy rate among whites is one of the lowest in the nation, the rates among African American and Hispanic/Latina teens are first and second respectively. While teen pregnancy rates among many Minnesota populations are decreasing, there is an alarming increase in pregnancy rates for Asian and Hispanic/Latina teens. Preventing teen pregnancy reduces infant mortality, child poverty, and out-of-wedlock childbearing and is an effective way to improve overall child and family well-being.

Social and Economic Determinants of Health Disparities. According to the report

A Call to Action: Advancing Health for all through Social and Economic Change (July 2001), “health is the product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with the collective conditions (factors in the physical, social, and economic environment).” (For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on “Social Determinants”.)

In addition, factors and barriers to better health status have been identified as: lack of health care insurance and access to affordable health services; language differences and lack of interpreters; negative cultural history with western medicine and systems; lack of transportation to health services; lack of child care available to attend health-related appointments; and lack of health providers from and familiar with the varying cultural groups in Minnesota.

A Call to Action further identifies the key aspects of the social and economic environments that affect health as education, income, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation, and nutritious foods; racism and discrimination; employment and working conditions; and culture, religion, and ethnicity. In addition:

- The effect of income inequality on health is not limited to people in poor or low income groups. The health of people in middle (and, in some studies, upper) income groups is worse in communities with a high degree of income inequality (a large income gap) when compared to communities with less income inequality (a smaller income gap).
- Poverty is not the overarching factor for poor health. Regardless of income or health care coverage, people of color receive poorer services. (Institute of Medicine, 2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington D.C. Contact: National Academy Press, at (800) 624-6242, http://www.nap.edu/books/030908265X/html/).
- Culture, religion, and ethnicity have an overarching influence on beliefs and practices related to health, illness, and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about type of provider or healer that should be sought.

Underlying social and economic conditions affect health status as much as do individual health behaviors, access to health care, and genetics. Studies conducted to date point to conclusions, such as:

- Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), environmental hazards and chronic stress.
- People of color and American Indians do not experience poorer health simply because they are more likely to have lower income; at every level of income

the health of people of color and American Indians is poorer than that of their white peers.
- People of low income do not experience worse health simply because of high-risk personal behavior. In one recent study, (detrimental) health behaviors explained less than 20 percent of the difference in death rates across income groups.

It is clear that successfully addressing disparities cannot be done without also addressing the realm of social and economic conditions that influence health status. It is also clear that interventions to improve access to medical care and reduce behavioral risks must be combined with broader efforts to increase socioeconomic status and reduce racial/ethnic discrimination in eliminating health disparities.

While public health in Minnesota has the responsibility to address all populations and identify and address all health disparities, the Office of Minority and Multicultural Health (OMMH) exists within MDH to focus attention on the disparities in health status among Minnesota's American Indians and racial/ethnic populations.

The mission of the Office of Minority and Multicultural Health (OMMH) is *"... to strengthen the health and wellness of racial/ethnic, cultural, and tribal populations of the State of Minnesota by engaging diverse populations in health systems, mutual learning, and actions essential for achieving health parity and optimal wellness". (OMMH Mission Statement, 2002)*

The OMMH provides leadership within MDH to:
- Ensure that all health policies, initiatives, and strategies - throughout all levels of the Minnesota Department of Health - are inclusive of populations of color and American Indians.
- Collaborate on all levels regarding community health activities addressing racial/ethnic and American Indian health.
- Assist communities in assessing public health needs of populations of color and American Indians.
- Assist communities in assessing public health needs of populations of color and American Indians.
- Build state and community capacity to meet the needs of populations of color and American Indians in disease prevention, health promotion, and health care systems, and to close the gap on health disparities.
- Identify resources available to community-based organizations regarding racial/ethnic and American Indian health.
- Work in partnership with communities throughout the state to ensure the health issues of racial/ethnic and American Indian populations are addressed.

In addition, all of MDH is responsible for working with racial/ethnic communities and American Indians in Minnesota, with local public health, and with other organizations and groups to:
- Identify research issues on the health status of racial/ethnic populations and collaborate with internal and external partners to conduct research.

< Identify and develop policies to improve the health status of populations of color and American Indians.

< Promote collaboration and increased communication among local public health departments, state and local government officials, non-government agencies and organizations (such as voluntary agencies, community-based organizations and philanthropic groups), and populations of color and American Indians, in order to identify and address public health issues.

< Work to ensure that valid, available, and reliable health data are available on each population of color and on American Indians in Minnesota.

Implicit in this work is the philosophy that racial/ethnic community members must be able to design strategies and activities relevant to their cultures, traditions, customs, and beliefs.

OMMH's work is based in public health principles* in the following ways:

General Public Health Principles:	**Public Health Principles Specific to Addressing Racial and Ethnic Health Disparities:**
Aggregate: Public Health's focus is population-based, rather than individual-based as in medical practice. The whole population as well as population groups within the whole are identified and addressed as groups.	**Identify and Address Populations of Color:** Racial/ethnic groups are addressed from a population-based, whole group aggregate perspective to determine health status, spotlighting specific groups when indicators of health disparities are noted.
Prevention: Public Health's priority is to promote health and prevent health problems before risks are apparent and problems occur.	**Support Culturally-relevant Health Promotion and Prevention:** Community-determined, culturally-relevant strategies that enhance, promote, and improve the health status of communities and populations of color and American Indians are essential.

Community Organization: Public Health practice means identifying and bringing together community resources to meet needs.	**Support Communities' Coming Together for Strength:** Racial/ethnic and American Indian community groups develop their own cohesiveness, identify their strengths and assets, and develop their own strategies based in cultural beliefs and practices to enhance health and overall well-being of their people.
Greater Good: Public Health's first consideration is interventions that provide the greater good for the greatest number of people.	**Greatest Good:** The health of vulnerable populations affects us all and is all our responsibility. With improved quality of life, people have energy and resources to create stronger families and communities.
Leadership: Public Health does what others cannot or will not do.	**Support Leadership:** Work with, connect, and support local communities and their leaders to identify, take responsibility for, and address racial/ethnic health disparities, and to identify and publicize health disparities among their members, together developing strategies to address the disparities.
Epidemiology: Public Health describes the health status of populations, explains the causes of disease, predicts the occurrence of disease, and controls the distribution of disease. Public health relies on epidemiology as its method of inquiry.	**Epidemiology of Racial/Ethnic Health Disparities:** Reliable data on the health status of Minnesota's populations of color are almost non-existent, and data collection methods are not culturally-sensitive. Actions can be developed to prevent poor health outcomes by: appropriately identifying, collecting, and reporting racial/ethnic group-specific data; identifying where data are lacking and developing appropriate tools to collect those data; and linking poor health status indicators to social conditions and influences, as well as personal behaviors and genetics.

* For more information on public health principles, see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "CHS Planning Guidelines".

The Minnesota Eliminating Health Disparities Initiative (EHDI). The populations experiencing these disparities have many strengths and traditions to draw upon for solutions. For example, in the African American and Latino communities, churches provide connections and leadership on community issues. For American Indians, restoring cultural traditions such as native foods, cradleboards, and sacred use of tobacco can improve infant health. Hispanic/Latino and Asian communities have similar traditions around family, nutrition, and healing practices that are strong already and need support from mainstream providers to promote healthy pregnancy, birth, and infancy.

Recognizing these assets, along with the need to provide funding to the communities experiencing disparities, the Minnesota Legislature created in statute (MN. Stat. 145.928) a statewide initiative and funding to close the gap on health disparities in Minnesota. The resulting legislation has two main goals:

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

< Close the gap in health disparities of American Indians and populations of color as compared with the rates for whites in the following priority health areas:

    < breast and cervical cancer

    < cardiovascular disease

    < diabetes

    < HIV/AIDS and sexually transmitted infections

    < violence and unintentional injuries

In addition, federal TANF (Temporary Assistance to Needy Families) funds are distributed through this program for infant mortality prevention. These funds focus on preventing out-of-wedlock teen births through programs that support healthy youth development.

The Eliminating Health Disparities Initiative (EHDI) legislation focuses on African Americans/Africans, Latino/Hispanics, Asian/Pacific Islanders, and American Indians living in Minnesota. Eligible Community Grant applicants include, but are not limited to faith-based organizations, social service organizations, community non-profit organizations, community health boards, tribal governments, and community clinics.

The following are the major components of the EHDI:

< A partnership steering committee to address health disparities in a comprehensive way.

< A set of measurable outcomes to track Minnesota's progress in reducing health disparities.

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

< Competitive community grants directed at reducing health disparities in immunizations for adults and children and infant mortality; breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and violence and unintentional injuries; and teen pregnancy prevention through healthy youth development.

- Formula grants to Community Health Boards for health screening and follow-up services for tuberculosis in foreign-born persons.
- Formula grants to American Indian tribal governments for community interventions to reduce health disparities.
- Evaluation of the initiative.
- A biennial report to the legislature.

All aspects of the EHDI, from creation of the legislation to the Request for Community Grant Proposals to review and evaluation of the proposals received, have been developed with the input from and involvement of members of Minnesota's racial/ethnic and American Indian communities. The use of community engagement principles is encouraged throughout any state and local processes addressing eliminating health disparities, whether funded by this initiative or not. These community engagement principles include:

- Fostering openness and participation in the planning process.
- Ensuring that those representing a specific community truly represent that community's values, norms, and behaviors.
- Using strategies that insure inclusion, representation, and equality in the planning process. For example, ensuring that those representatives who are included in the process participate in a meaningful way and share fully in the decision making process; and offering orientation and skill building opportunities so that everyone will have an equal voice in voting and other decision making activities.
- Developing cultural competence in the organization's staff.
- Communicating with and involving the community in the planning process.

For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Community Engagement".

The 2002-2003 EHDI Community Grants Request for Proposals (RFP) provides information on the initiative, the legislation (Appendix A of the proposal), the grants, social conditions, asset-based community development, community engagement, the eight EHDI priority health areas (Appendix B of the proposal) and strategies shown effective in addressing these eight areas to-date. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "EHDI".

Some specific strategies suggested in Appendix E of the EHDI RFP (*Social Conditions*) and promoted and supported by Office of Minority and Multicultural Health, include:

- Addressing issues of unequal access to affordable, nutritious food.
- Working to improve community environments that promote physical activity and wider mental well-being and quality of life.
- Advocating for good quality, affordable housing.
- Promoting education, literacy, and employment.

The EHDI is unique in that it provides support for communities to determine their assets, as well as needs, and to develop and implement the strategies they create to employ those assets to address the needs.

Evaluation plans include steps to assess overall changes in health systems as well as lessons learned by the community-based strategies. Grantees are encouraged to try practical, common sense approaches; and new, culturally relevant health promotion, prevention, and improvement approaches including those proven effective in the mainstream science-based research. The lessons and specific effective strategies will be shared with other communities so that successful approaches can be promoted and additional new approaches tried. Racial/Ethnic and American Indian Health Committees are being organized in partnership with Minnesota's four statutory Councils, to further identify, support, coordinate, and share lessons learned in the EHDI and related communities.

The MDH Office of Minority and Multicultural Health has on staff Minority Health Coordinators for each of the racial/ethnic and American Indian groups designated in statute. These staff work closely with community grantees to assure members of communities are intricately involved in assessing the strengths, resources, and needs of the community, and in planning for and overseeing activities toward improved health status. Program staff of MDH working with the eight priority health (and related) areas in the statute meet with OMMH staff on a monthly basis to coordinate technical assistance, resources, and training opportunities for the EHDI grantees. For more information contact the Office of Minority and Multicultural Health, at (651) 297-5813. For additional information see the website for strategies resources at: www.health.state.mn.us/strategies. Click on "Minority Health".

In addition, staff of OMMH address the broader scope of minority and multicultural health and encourage local (geographic) communities to take on this important work. First steps include those identified in the *Service Delivery Systems* category of this strategies document. In addition, local (geographic) communities are encouraged to take the following first steps:

< Recognize that racial/ethnic and American Indian community members may not participate in offered programs and services because the programs do not fit for them.

< Actively involve community members in designing and implementing strategies will likely lead to more effective approaches.

< Build relationships that lead to increased mutual knowledge, comfort, familiarity and trust, before launching into major new efforts.

Prevention is the best investment. It has long been documented that money spent on prevention of sickness, chronic conditions, and injuries is an investment in preventing or reducing more serious and expensive health crises later. This philosophy extends to other arenas as well. For example:

< Healthy pregnancies reduce infant mortality and promote healthier infants.

< Healthy children learn better.

< Youth who are learning healthy attitudes and behaviors remain in school longer and can set better long-term goals for themselves.

< Healthy workers are more productive and take less medical leave.

< Healthy elders live longer and need fewer health resources.

Improved quality of life allows people to have energy and resources to create stronger families, and can become more involved with their communities. With the *Service Delivery System* category of this document there is a segment on *Eliminating Health Disparities.* Within this are the universal systemic strategies that every community in Minnesota should be doing, to assure that the health of all Minnesotans of racial/ethnic heritage is assessed, addressed, and assured.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

These are challenging times for public health. Our purpose is to protect and promote the health of the public, yet the events of September 11, 2001 and the October 2001 release of anthrax in Florida, Washington, DC, and New York have raised the need to protect our citizens from threats we hoped would never occur.

As a result of these events, state and local public health agencies receive funding from the Centers for Disease Control and Prevention (CDC) to prepare state and local public health agencies for bioterrorism, infectious diseases, and other threats to public health. This funding of approximately $16 million was received by MDH in June, 2002 and is supplemental to funding the MDH had received in the past. For each of the previous three years, the MDH has received $1.2 million for surveillance and epidemiology, biological lab support, and the Health Alert Network (HAN). Minnesota will use the additional funds for:

- Preparedness Planning and Readiness Assessment – determining how ready Minnesota is to manage a public health threat or emergency and preparing plans to respond to those threats.
- Surveillance and Epidemiology Capacity – making sure systems are in place within state and local health departments to rapidly detect and investigate unusual outbreaks of illness.
- Laboratory Capacity-Biologic Agents – ensuring that we can identify bioterrorist agents at public health laboratories.
- Health Alert Network/ Communications and Information Technology – enabling state and local public health agencies to rapidly exchange information and to make sure that information gets to all agencies, their partners, and the public in a safe and secure manner.
- Communicating Health Risks and Health Information Dissemination – providing timely and accurate information to citizens during a bioterrorism attack, outbreak of infectious disease, or other public health threat.
- Education and Training – ensuring that state and local public health staff, and their many partners, are adequately trained to respond to bioterrorism other public health threats and emergencies.

But is Minnesota Prepared? The need to plan and prepare for a public health threat is not new to public health. Each of Minnesota's 87 counties has been declared a federal disaster area at least once since 1965 and some have been declared a disaster areas seven or more times. This has taught us that successfully addressing a public health threat or disaster is not just the result of having a good plan, but to be continually planning and exercising those plans. A plan on the shelf, no matter how good, is seldom pulled down when a disaster strikes.

But there is still much to do. Not only does Minnesota have a lot of work to do to prepare for a bioterrorism attack or other public health threat, we need to be ready to respond to an event today, should the need arise. Community Health Boards, in coordination with the MDH, are being asked to undertake a number of activities to assure that Minnesota is prepared to respond to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. These activities include:

- providing leadership for the coordination and management of public health

planning and response;
- completing an assessment of local public health capacity;
- assuring the development and exercise of a comprehensive public health emergency preparedness and response plans;
- leading or participating in the response to an event;
- promoting provider compliance of infectious disease reporting as outlined in the Disease Prevention & Control (DP & C) Common Activities Framework (see the appendix to the Infectious Disease category in this document);
- maintaining and enhancing a local health alert network;
- developing a plan for communicating information to the media and the public during an event; and
- assuring a basic level of understanding among their staff and community partners.

Throughout 2002 and 2003, strategies, guidelines, and protocols will be developed to assure coordination of activities between state and local public health agencies and among local public health agencies. The strategies will be developed that can address several categories in this document including *Environmental Conditions, Infectious Disease, Mental Health, and Service Delivery Systems.*

Many of the strategies already included in these areas can be used by local agencies to prepare for and respond to an event. For example, strategies outline in the *Service Delivery Systems* category discuss working with local emergency medical services.

These relationships will be vital in the event of an attack of bioterrorism. In addition, the *Infectious Disease* category describes the DP&C Common Activities Framework (see the appendix of this category). This framework serves as the foundation for all surveillance activities, including monitoring for occurrences of bioterrorism.

Public health has always had a role to play in disaster and emergency response. The state and local public health system must now, more than ever, strengthen and clarify that role to assure that Minnesota is safe from bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Emergency Preparedness".

SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

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

Health is more than not being sick. Health is a resource for everyday living. It's the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. Health has physical, mental, social and spiritual dimensions. Achieving optimal health means attending to the important influences of health. This vision is bigger than our systems of public health and health care. All individuals, systems and institutions in the community share responsibility for – and reap the rewards of – optimal health.

Health is influenced by important factors such as the physical environment, health practices and coping skills, biology, health care service and the social and economic environment (the social conditions, or the social determinants of health) in which people live their daily lives. These influences of health are further described in the table below:

Social and Economic Environment: Interactions with families, friends, co-workers and others that shape everyday experiences in neighborhoods, communities, and institutions (such as schools, the workplace, places of worship, government agencies, etc.). This means that individual and community socioeconomic factors; social norms, social support and community connectedness; employment and working conditions; living conditions; and culture, religion, and ethnicity shape health. The social and economic environment of a community is created by the individual and combined actions of its members and is unique because of social norms and cultural customs.
Physical Environment: The safety, quality and sustainability of the environment, which provides basic necessities such as food, water, air, and sunshine; materials for shelter, clothing and industry; and opportunities for recreation.
Health Practices and Coping Skills: Individual health-promoting and health-compromising attitudes, beliefs and behaviors, and the ways in which people cope with stress.
Biology: Genetic makeup, family history, and physical and mental health problems acquired during life (aging, diet, physical activity, smoking and drug use, stress, injury, and infections affect one's biology over the lifecycle).
Health Care Services: Access to and quality of health services to promote health and prevent and treat disease and other threats to health.

Some examples of the ways that social conditions influence health include:

- People with higher income generally enjoy better health and live longer than people with a lower income.
- In communities where there is a greater gap in income between rich and poor (a higher degree of income inequality), the health of people in the middle and sometimes the upper income groups is worse than in those income groups that live in communities with a smaller income gap or have less income inequality.
- People are healthiest when they feel safe, supported and connected to and can trust others in their families, neighborhoods, workplaces, and communities.
- Workers are healthiest when they believe that their jobs are secure, when they feel that the work they do is important and valued, when the workplace is safe and there are ample opportunities for control over their work life, including decision-making, advancement and personal growth.
- Culture, religion and ethnicity have a broad influence on beliefs and practices related to health, illness and healing. This influence includes definitions of health and illness, beliefs about the causes of health and illness, decisions about whether or not to seek formal health care, and decisions about the type of health care provider to be sought.

Though more research is needed to understand exactly how these factors affect health and health disparities, studies have been conducted that point to such conclusions as:

- Social and economic factors can influence decisions and behaviors that promote or threaten health, can offer a broad array of opportunities to improve health, and can have negative or positive health effects.
- Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted employment and educational opportunities and mobility, limited access to and bias in medical care, limited access to safe recreation and healthful food, residential segregation, and chronic stress.
- People of color and American Indians do not experience worse health simply because they are more likely to have a low income. At every level of income, their health is worse than that of their white peers.
- High risk personal behaviors such as cigarette smoking, alcohol use, and physical inactivity are not the major cause of health disparities, explaining less than 20% of the difference in death rates across income groups.

Based on research into the social determinants of health, which you can find detailed in the report, *A Call to Action: Advancing Health for All through Social and Economic Change,* the following recommendations were made:

- Identify and advocate for healthy public policies.
- Build and fully utilize a representative and culturally competent workforce.
- Increase civic engagement and social capital.
- Re-orient funding.
- Strengthen assessment, evaluation and research.

- Create opportunities for dialogue and action.
- Focus coordinated commitment on priority strategies.
- Take this work to the next stage.

For more information on this report and its recommendations, see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on "Social Determinants".

These recommendations are being incorporated into public health work at the state and local levels by effectively engaging community members in developing solutions to issues that affect them (see the section, "Community Engagement" within this Introduction). One example of this is the Eliminating Health Disparities Initiative (EHDI) Community Grants Program (see the section, "Eliminate Disparities" within this Introduction).

Effective Strategies. Examples of effective strategies for addressing social and economic determinants of health include:

Address Issues of Unequal Access to Affordable, Nutritious Food. Unequal access to food is a well-documented issue. Over the years, commercial pressures have led to the closure of supermarkets in many low-income areas. Often the most affordable fresh food is available only at large discount supermarkets located in suburban areas – often not easily accessible by public transportation. The lack of convenient access to affordable urban supermarkets have caused problems for many inner city communities, who are left with corner convenience stores that do not carry a large or varied stock. People who cannot easily get to distant supermarkets are thus surviving on convenience store food, usually canned or processed, or fast food. Their diet suffers, and consequently their health. The overall effect is to increase the inequalities in health already suffered by disadvantaged communities.[i] Examples of activities to address this issue include:

- Community groups grow fresh fruit or vegetables at public garden space or community centers then sell the produce at neighborhood farmers' markets.
- Specially provided shuttles transport people to shopping centers and supermarkets at convenient times.

Improve Community Environments that Promote Physical Activity, Mental Well-being and Quality of Life. Unsafe, substandard living environments present many barriers for residents attempting to increase their activity levels. Fear of crime keeps many people indoors, as does lack of safe and pleasant parks and green spaces, or poorly maintained sidewalks. Many residents from low-income neighborhoods find it difficult, if not impossible, to afford memberships at fitness centers or to travel to cleaner, safer neighborhoods with good facilities. Some effective initiatives include:

- Increase feelings of community safety by tackling pockets of crime by developing working partnerships with local law enforcement, community planners, and residents.
- Community centers can offer free or low-cost fitness facilities, exercise classes, or outdoor recreation areas. Classes on diabetes management or parenting skills can be offered in conjunction with other health opportunities. Including young people

can help them develop healthy habits that may prevent the later onset of many chronic conditions, such as diabetes, and promote self-esteem.

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

- Offer housing benefit workshops to link people with programs or other initiatives that can help them afford housing, and to help them navigate the application processes. Many processes needed to receive benefits are complex and require a high level of literacy, and are barriers to access.
- Foster relationships between community residents and housing developers to ensure housing meets the needs of the community, as well as future residents of the new housing.

Develop and Promote Education, Literacy, and Employment Policies that Contribute to Employment Status. Many barriers to employment exist, such as illiteracy or lack of education. Removing these barriers can open avenues of access to better housing, improved nutrition, leisure, and health care. Strategies to address these barriers include:

- Connect elderly residents in the community with opportunities to assist younger residents with improving their literacy skills. This has a two-pronged approach of addressing social isolation issues for the elderly, as well as offering the opportunity to learn to read to community members, which in turn can increase the community members' ability to apply and qualify for jobs.
- Develop partnerships with local employers to implement innovative recruitment practices that are culturally sensitive or otherwise modified to be more accessible to marginalized populations. This could also involve strategies to improve working conditions for current employees, such as assisting in the development of workplace safety or stress management, or to alter workplace policies to make jobs more accessible. Policy development could include, for instance, job share opportunities for people with childcare issues, assistance with childcare facilities, or culturally sensitive leave and vacation policies.

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

Health Impact Assessment. Health Impact Assessment is an emerging approach to policy development and program planning designed to assure that current and future policies, programs, and/or organizational structures contribute to meeting public health improvement goals, or at least do not hamper achievement of those goals.

Since investments outside the health sector (e.g., in the areas of housing, transportation and economic development) have consequences for community health, the potential impact of social and economic policies on the health of Minnesotans should be an integral part of policy-making processes.

HIA is a structured method of assessing and identifying ways to improve the health consequences of policies and programs. It involves working in partnership with a range of agencies and the public to consult and draw together the available evidence on the benefits and drawbacks to health of a given policy or program. HIA is a process that can promote the development of healthy public policy, create dialogue between and among agencies and communities, and stress the role of assessment and evaluation.

How HIA Works. Ideally, HIA should be applied before a policy or program is implemented (prospectively), although it can be applied concurrently or retrospectively. It broadly comprises:

- Screening. Systematically deciding whether or not an HIA is worth doing. (The answer is probably 'no' if informed opinion and the available evidence suggests the health impacts are negligible or already well known).
- Developing a plan. Deciding which potential health effects in relation to a specific population and/or geographical area need investigation, which methods to use, what resources are needed and who needs to be involved.
- Identifying and appraising the evidence using both qualitative and quantitative research.
- Decision making. Recommending changes to a proposal to minimize harmful affects on health and maximize health gain.
- Monitoring and evaluation. Assessing the accuracy of predictions and ascertaining how the process can be improved.

HIA may be 'rapid' (carried out within days using minimal resources); 'intermediate' (more detailed over several weeks); or 'comprehensive' (an intensive investigation over a number of months). Experience of public health and community development and involvement may be needed, along with epidemiological and social science research skills.

Where HIA Can Be Used. So far most HIAs have been carried out on community revitalization or public transportation projects or proposals. However, HIA may be useful for a range of activities including: policy development and analysis, service provision, resource allocation, capital investment and community participation.

For more information please contact Lee Kingsbury, at (651) 296-9162, lee.kingsbury@health.state.mn.us. For more information see the website for strategies resources at: www.health.state.mn.us/strategies/. Click on the following search words for the following topics:

- For the information on the social determinants of health and for the report, *A Call to Action: Advancing Health for All Through Social and Economic Change*, click on “Social Determinants”.

- For the tools for community engagement, click on “Community Engagement”.
- For the Eliminating Health Disparities Initiative, click on “EHDI”.
- For Health Impact Assessment information, click on “Health Impact”.

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[i] *Source: Linda Sheridan (unpublished), from The Report of HIA on the Greater London Authority draft economic development strategy.*