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Eliminating Health Disparities Initiative

Minnesota Department of Health

Report to the Minnesota Legislature 2016

January 15, 2016

Eliminating Health Disparities Initiative

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January 15, 2016

Dear Legislators,

Minnesota, on average, ranks among the healthiest states in the nation. However, those averages do not tell the whole story. Minnesota has some of the greatest health disparities in the country between whites and people of color and American Indians.

Why do these disparities persist? The common belief is that good health is due to personal choices and great medical care. These do influence health and are important. However, health is created by much more than just good medical care. Optimal health for everyone requires excellent schools, economic opportunities, environmental quality, secure housing, good transportation, safe neighborhoods, and much more. Given this, it is not surprising that Minnesota has some of the worst health disparities in the country, because it has significant inequalities in socio-economic factors such as income, education and home ownership.

A crucial part of the Minnesota Department of Health's approach to address the health gap between whites and populations of color and American Indians is the Eliminating Health Disparities Initiative (EHDI), established by the legislature in 2001. Over the years, the EHDI has invested in strategies that combine evidence-based and promising practices, the wisdom of elders, and insights of communities of color and American Indians. The targeted efforts of the EHDI grantees have made a real difference in the lives of the people they serve. Grantees report positive changes among their clients such as improved blood pressure, better rates of cancer screening, weight loss, more healthful eating and increased physical activity. In addition, there has been an increase in grantee agency staff who share the race and ethnicity of participants, increased cultural competence of health care providers and the creation of educational materials in different languages for individuals from linguistically diverse backgrounds.

While it is critical to continue to support the exemplary practices implemented by EHDI grantees, this approach must be paired with work that addresses the social and economic factors that underlie and drive health disparities. Together these efforts will be able to address the complex and longstanding barriers that prevent populations of color and American Indian communities from gaining equal access to opportunities to attain optimal health. Only then can Minnesota reach its potential as a healthy state for all Minnesotans.

This legislative report offers examples of successes and lessons learned, highlights the work of these critical partners, and outlines strategies that Minnesota should continue to pursue to protect, maintain, and improve the health of all Minnesotans by eliminating health disparities in populations of color and American Indians.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
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Executive Summary

Minnesota consistently is ranked among the healthiest states in the nation. However, that ranking does not tell the whole story. Minnesota has some of the greatest health disparities in the country between whites and people of color and American Indians. The Minnesota Department of Health (MDH) takes a comprehensive approach to closing this gap that includes the Eliminating Health Disparities Initiative (EHDI). The Legislature established the EHDI program in 2001 to provide direct investments in organizations focused on improving the health and well-being of American Indians and Minnesotans of color. This initiative became part of the MDH Center for Health Equity when it was established in 2013.

Accomplishments

From July 1, 2012 through June 30, 2014, the EHDI was able to pair approximately $6.3 million in state dollars with approximately $4 million in federal dollars to invest about $10.3 million in 47 organizations.[1] These targeted efforts of EHDI grantees have made a real difference in the lives of the people they serve. In FY 2014, grantees reached over 66,000 individuals directly and over 220,000 individuals through indirect contact, such as large classes, workshops and health fairs (Table 1). The largest group directly reached was about 28,000 African/African American or 42 percent of the total direct reach, followed by about 22,000 Hispanic or Latino Minnesotans or 33 percent of the total.

Table 1. Number of individuals reached by FY 2014 EHDI Grantees by Target Population

Target Population	Directly	Indirectly	# Grantees Serving the Target Population*
African/African American	27,707	53,873	22
American Indian	9,284	31,761	17
Asian/Pacific Islander	7,519	16,766	11
Hispanic/Latino	21,625	117,757	12
Total	**66,135**	**220,157**	

*Some grantees serve more than one population

Changing Demographics across the State

Minnesota is an increasingly diverse state. In 1990, populations of color and American Indians in Minnesota represented just over six percent of Minnesota's population; by 2010 this share has grown to 17 percent. U.S. Census forecasts show these populations will grow to comprise 23 percent of the state's population by 2030.

This growth is happening around the state. For example, the Twin Cities metro area's population of color increased by 217 percent between 1990 and 2010 from 211,783 to 672,347; Southern Minnesota by 360 percent from 16,602 to 76,308; Central Minnesota by 366 percent from 11,082 to 51,607, and Southwest Minnesota by 382 percent from 6,158 to 29,660.

Grantee Focus Areas

[1] In this report, time periods for grant activity refer to state fiscal years. FY 2013 refers to grants for the period of July 1, 2012 – June 30, 2013 and FY 2014 refers to the period of July 1, 2013 – June 30, 2014.

Legislators and MDH have worked with members of Minnesota's populations of color and tribal communities to shape the EHDI founding legislation and ongoing activities. Based on that direction from the legislature, the initiative provides funding for community grants designed to address community-identified health needs in eight priority health areas (PHAs):

1) Infant Mortality
2) Adult and Child Immunizations
3) Breast & Cervical Cancer Screenings
4) Cardiovascular Disease & Stroke
5) Diabetes
6) HIV/AIDS/Sexually Transmitted Infections
7) Teen Pregnancy
8) Unintentional Injury and Violence

In FY 2014, the Diabetes priority health area reached the most number of Minnesotans directly (19,926) while the Teen Pregnancy Prevention area reached the most number indirectly (62,052) (Table 2).

Table 2. Number of individuals reached by FY 2014 EHDI Grantees by Grant Area

Grant Area	Directly	Indirectly	# Grantees Addressing the Grant Area*
Breast & Cervical Cancer	3,999	22,676	4
Diabetes	19,926	31,329	11
Heart Disease & Stroke	6,655	8,138	5
HIV/AIDS	7,765	43,675	8
Immunizations	14,154	10,381	3
Infant Mortality	767	4	3
Teen Pregnancy Prevention	10,647	62,052	15
Unintentional Injury & Violence	1,105	37,821	5
Community Primary Prevention	1,117	4,081	2
Total	**66,135**	**220,157**	

*Some grantees address more than one priority health area

I. EHDI Mission and Strategies

A Historical Overview

In 2001 the Minnesota State Legislature established the Eliminating Health Disparities Initiative (EHDI), Minnesota Statute 145.928 (Appendix A). This groundbreaking legislation was passed in response to mounting evidence that disparities in health outcomes between Minnesota's white residents and residents from populations of color and American Indian communities were distressingly wide, and on a clear trajectory to grow even wider. Such disparities have meant that Minnesota's populations of color and American Indians experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, cancer and other diseases and conditions, and poorer general health. **Even though Minnesota ranks high in terms of general health status compared to other states, Minnesota has some of the worst health care disparities or health differences between groups - in the nation.** For example, while Minnesota has one of the lowest overall infant mortality rates in the United States (4.8 infant deaths per 1,000 births), there is a persistent disparity, particularly between whites (4.1/1,000) and African Americans (8.5/1,000) and American Indians (9.6/1,000)[2]. When such disparities are allowed to persist, they have a negative effect on the quality of life, the cost of healthcare and the health of all Minnesotans.

Minnesota responded to these health disparities by enacting a legislative mandate to reduce such health disparities. Minnesota was only the second state to establish a program to eliminate health disparities. To address this issue, a diverse cross-section of people from Minnesota's populations of color and American Indian communities partnered with MDH and the Minnesota Legislature to design and implement a comprehensive, statewide program focused on strengthening and improving the health of the following four major ethnic groups:

- American Indian
- Asian/Pacific Islander
- African American/African
- Hispanic/Latino

From the outset, the creators and stakeholders of EHDI recognized that the issues contributing to health disparities are broad and complex – an interplay of many factors including, the legacy of racism, social and economic factors, access to health care, and individual health behaviors**. Some models suggest that 40 percent of a person's overall health outcomes are determined by social and economic factors such as his or her income, education level, race, and/or the neighborhood in which he or she lives.**[3] MDH, the Legislature, and EHDI community partners understood that effectively addressing this complex set of interrelated problems would require an approach that is comprehensive, community-driven and long-term. EHDI is one strategy to address the health disparities in Minnesota.

Grants were awarded to faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics for local or regional projects and initiatives. Attention to a strong, ongoing evaluation has helped MDH, EHDI grantees, community

[2] Minnesota Department of Health, Center for Health Statistics, 2009-2013 age-adjusted rates based on the US 2000 Standard Population. Race is based on the race of the mother. Hispanics can be of any race.
[3] Minnesota Department of Health, *Advancing Health Equity in Minnesota: Report to the Legislature. St. Paul, MN: 2014.* Retrieved from: http://www.health.state.mn.us/divs/chs/healthequity/

partners and stakeholders learn about what works and what doesn't, which has led to programming that continually evolves and improves its methods.

Lessons Learned

The years of EHDI investments have yielded not only advances on the mandated goals, but also valuable information and lessons, including the need to:

- Use strategies that are grounded in practice and research and that respect and reflect Minnesota's diverse cultures.
- Develop and improve behavior-based health improvement interventions that respect and reflect Minnesota's populations of color and American Indians.
- Recognize that policy, systems and environmental changes are needed to eliminate health disparities in populations of color and American Indians.
- Provide support for partnerships that combine the skills, resources and leadership necessary to eliminate health disparities in populations of color and American Indians.
- Provide grantees with technical assistance to identify appropriate and measurable outcomes as part of their program evaluation and to report on their efforts.
- Pair strategies that focus on individual behavior change with strategies that address the social and economic factors that underlie and drive health disparities.

Center for Health Equity

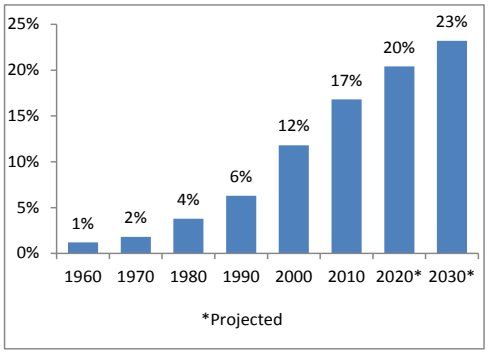
In order to bring an explicit focus to the efforts of MDH to advance health equity, in December 2013 the MDH Commissioner established the Center for Health Equity. The Center is comprised of three areas: the Center for Health Statistics, the Office of Minority and Multicultural Health, and EHDI. The Center continues to administer the legislative mandate which enables the work of the EHDI, and promotes critical strategies that Minnesota must pursue to protect, maintain, and improve the health of all Minnesotans including eliminating health disparities in populations of color and American Indians.

In February 2014, MDH released the landmark *Advancing Health Equity Report* which called for Minnesota to pursue a comprehensive approach to achieving health equity that includes a broad spectrum of public investments in housing, transportation, education, economic opportunity and criminal justice. The report also states that a crucial part of this comprehensive approach is to continue providing targeted grants through EHDI, recognizing that EHDI grantees have made a real difference in the lives of the people they serve.

II. Minnesota's Changing Demographics

Minnesota is an increasingly diverse state. The decennial census data show that in 1990, people of color and American Indians in Minnesota numbered 273,883, comprising just over 6 percent of our total population (Figure 1). By 2010, these communities had grown to 893,203 comprising 17 percent of the state's population. The Hispanic/Latino population grew by 364 percent during this 10-year period, and the African-American population grew by 196 percent (Table 3). If the trend continues, Minnesota's populations of color and American Indians are expected to be comprise 20 percent of the total population by 2020, and 23 percent by 2030 (Figure 1).

Figure 1. Percent Population of Color in Minnesota, 1960 to 2030.



SOURCES: Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census, Population Estimates, and Population Projections. Data downloaded

Table 3. Minnesota Population Change

Racial/Ethnic Group	1990	2000	2010	Percent Change 1990 to 2010
American Indian	49,909	54,967	67,325	35%
Asian	77,886	141,968	217,792	180%
Black	94,944	171,731	280,949	196%
Hispanic	53,884	143,382	250,258	364%
Two or more races		82,742	111,440	
Total Populations of Color	273,833	582,336	893,203	226%
Total White (non-Hispanic)	4,101,266	4,337,143	4,410,722	8%
Total Minnesota	4,375,099	4,919,479	5,303,925	21%

SOURCES: U.S. Census Bureau, Decennial Census and Population Estimates. Data downloaded from http://www.mncompass.org on 09/01/2015

The increasing diversity of the state is primarily the result of immigration and refugee arrival from other countries and relocation from other states. They come to Minnesota to attend school, start businesses, work in Minnesota industries, or join family members from whom they were separated when they fled their war-torn countries.

Minnesota's recent immigrants and refugees come from diverse corners of the globe. The points of origin of Minnesota's newest residents include Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan. Diversity also exists *within* racial and ethnic categories, especially from Asia and Africa. For example, at least 40 different countries are represented among Asian immigrants to Minnesota. Diversity among these groups include diversity in backgrounds, experiences, cultural practices, languages, and unique health concerns.

It is also important to recognize that Minnesota's growing racial and ethnic diversity is occurring across the state. The Twin Cities metro area's population of color increased by 217 percent between 1990 and 2010 from 211,783 to 672,347; Southern Minnesota by 360 percent from 16,602 to 76,308;

Central Minnesota by 366 percent from 11,082 to 51,607, and Southwest Minnesota by 382 percent from 6,158 to 29,660. (Table 4). All regions of the state saw an increase in the number of persons of color, with the 7-county metro accounting for the most growth followed by southern and southwestern Minnesota.

Table 4. Persons of Color in Minnesota, 1990 and 2010 (Number and Percent)

Geographic Area	1990	2010	Change, 1990 to 2010	Percent contribution to change, 1990 to 2010	Percent Change 1990 to 2010
Central	11,082	51,607	40,525	7%	366%
Northland	11,273	24,860	13,587	2%	121%
Northwest	10,963	23,141	12,178	2%	111%
Southern	16,602	76,308	59,706	10%	360%
Southwest	6,158	29,669	23,511	4%	382%
Twin Cities 7-county	211,783	672,347	460,564	74%	217%
West Central	5,972	15,271	9,299	2%	156%
MN Total Populations of Color	273,833	893,203	619,370	100%	226%
MN Total Population	4,375,099	5,303,925			
MN Total Population of Color as % of Total Population	6.3%	16.8%			

SOURCES: Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census, Population Estimates, and Population Projections.
Data downloaded from http://www.mncompass.org on 08/28/2015

Births also have become more racially diverse, another indicator of the increasing diversity of the total population. Births to non-Hispanic white mothers accounted for 90 percent of births in the state in 1990. Twenty-four years later, in 2014, this number has declined to 72 percent of all births.[4]

Financial Security and Health

Persistent disparities in education, employment, and income place a disproportionate number of American Indians and populations of color below the poverty line – and poverty is a powerful factor in many key measures of a community's health: overall life expectancy; infant mortality; homicide; obesity; mental illness; alcohol and other drug addiction, and more.[5]

U.S. Census data from the 2013 American Community Survey reveal that compared to whites, significantly higher numbers of American Indians and people of color in Minnesota are poorer, unemployed, in poverty, and have no health insurance (Table 5).

[4] Minnesota Department of Health, Center for Health Statistics.
[5] Ehlinger, E. (2012). Health Disparities: Impact on Minnesota Implications for the Future. Minnesota's Health Insurance Exchange Challenges and Opportunities power point presentation.

Table 5. Population by Income, Unemployment, Poverty Rate and Uninsured, 2013

Racial/Ethnic Group	Per Capita Income	Unemployment Rate (16+)	Poverty Rate (all)	Uninsured (all)
All	$30,902	5%	11%	8%
White, not Hispanic	$33,850	5%	8%	8%
American Indian	$16,299	17%	32%	23%
Asian	$24,678	6%	18%	11%
Black/African American	$15,702	15%	33%	15%
Hispanic (of any race)	$15,037	9%	23%	29%

SOURCE: U.S. Census Bureau. American Community Survey, 2013. Retrieved from: http://mn.gov/admin/media/news/newsdetail.jsp?id=447-141490 .

This demographic data points to the growing racial, ethnic and economic inequities in Minnesota and the link between promoting economic prosperity and opportunity for communities of color and American Indians and achieving a healthy future for all Minnesotans.

Minnesota's Health Disparities

Although populations of color and American Indian communities throughout the state struggle with health disparities across the spectrum of EHDI's priority areas of focus, they are not all affected in the same way or to the same degree. Geography, cultural differences within very diverse communities of color and American Indians, and other factors make the experience and the needs of one group very different from another.

It is these differences within large ethnic groupings that make the culturally responsive approach used by EHDI stakeholders and community partners so important. Otherwise, programming targeted toward large ethnic groupings of people and treating each one as a homogenous group would not be a culturally responsive approach to reducing health disparities.

For example, Table 6 shows selected birth indicators separated for different Asian groups. Between 2011 and 2014, 6.3 percent of Asian infants were born with low birthweight, and 9.5 percent of Asian infants were born prematurely, before 37 weeks of gestation. But these numbers obscure real differences between specific Asian groups. For example, Cambodian mothers were twice as likely as Chinese mothers to have babies with low birthweight or who were born prematurely.

Table 6. Selected Birth Indicators, Asian Race Groups and All Asians, Minnesota 2011-2014

Asian Race Group	Percent of Births	
	Low Birth Weight[1]	Premature[2]
Asian Indian	6.9	7.0*
Cambodian	8.6†	12.6†
Chinese	4.3*	6.6*
Filipina	7.4	11.9†
Hmong	6.2	9.6
Japanese	5.0	6.4*
Korean	5.1	8.9
Laotian	7.0	11.5†

Vietnamese	5.7	9.8
All Asian	**6.3**	**9.5**
Minnesota	4.8	8.1

[1] Less than 2,500 grams (5 lbs., 8 oz.) at birth, singleton births
[2] Less than 37 weeks gestation, singleton births

* Substantially better than all Asian rate (2 or more percentage points lower)
† Substantially worse than all Asian rate (2 or more percentage points higher)

SOURCE: Minnesota Department of Health, Center for Health Statistics

Additional data on health disparities related to each health priority area can be found in this report under the Grantee Activity descriptions in Section IV, Program Accomplishments.

III. EHDI Grant Activities FY 2013 and 2014

FY 2013 Grants (July 1, 2012 – June 30, 2013)

In June 2012, MDH awarded through a competitive grant process approximately $5.14 million for the period of July 1, 2012 - June 30, 2013 ($3.14 million in state general funds and $2 million in federal TANF funds) to 47 community-based organizations. Grants were awarded in the following categories:

- 45 Priority Health Area Implementation (PHA) Grants
- 2 Community Primary Prevention (CPP) Grants

FY 2014 Grants (July 1, 2013 – June 30, 2014)

MDH awarded a one-year extension to 40 out of the 47 grantees from FY 2013 for the period of July 1, 2013 - June 30, 2014, for a total award of $5.14 million ($3.14 million in state general funds and $2 million in federal TANF funds). Seven of the grants funded in FY 2013 were for time-limited projects focusing on teen pregnancy and not extended. Grants were again awarded in the following categories:

- 38 Priority Health Area Implementation (PHA) Grants
- 2 Community Primary Prevention (CPP) Grants

FY 2013 and 2014 Grants Awarded by Priority Health Area and by Population

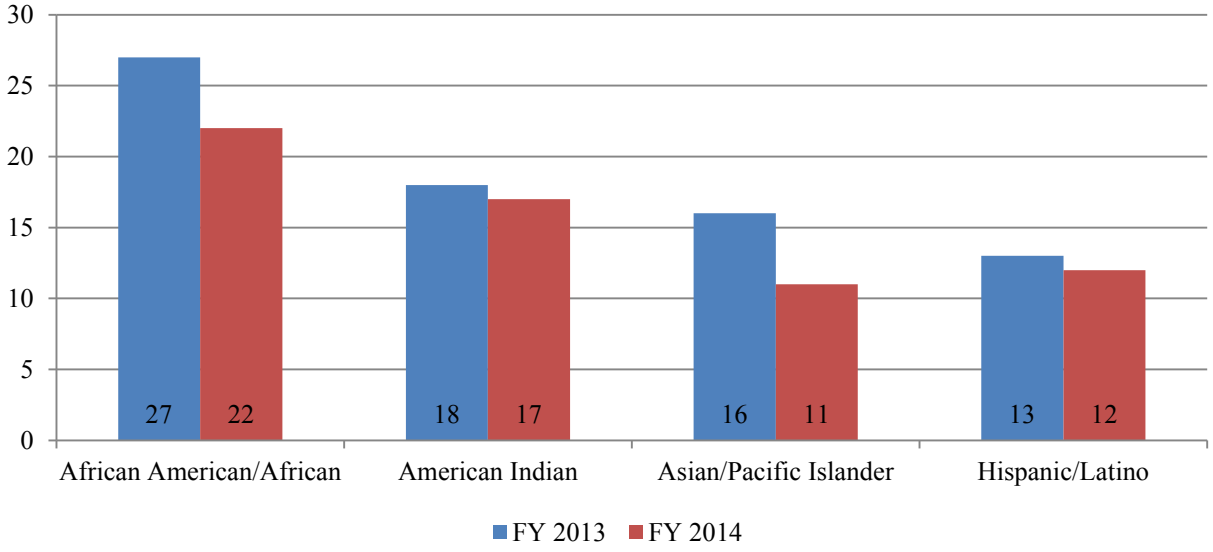
Table 7 provides a breakdown of the number of grantees funded in each priority health area in FY 2013 and FY 2014. Figure 2 outlines the distribution of grants by populations of color and American Indians in both years. Figure 3 shows the counties served by 2012-2013 and 2013-2014 grantees.

Table 7. Number of EHDI Grants Awarded by Priority Health Area, FY 2013 and 2014*

Priority Health Area	# of Grantees FY 2013	# of Grantees FY 2014
Breast & Cervical Cancer screening	4	4
Diabetes	11	11
Heart Disease & Stroke	5	5
HIV/AIDS & Sexually Transmitted Diseases	8	8
Immunizations for Adults & Children	3	3
Infant Mortality	4	3
Teen Pregnancy	22	15
Unintentional Injury & Violence	5	5
Community Primary Prevention	2	2

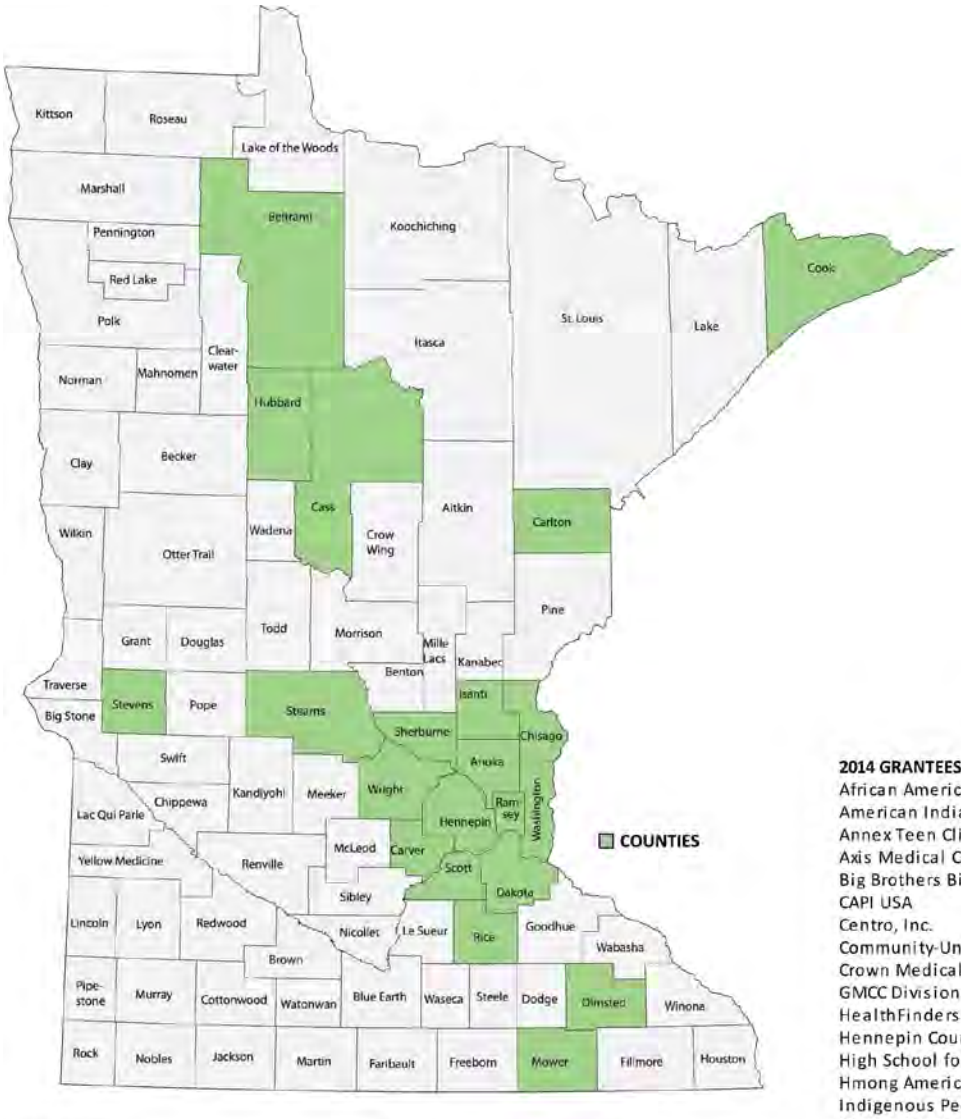
*Some grantees provided services in more than one priority health area

Figure 2. Number of EHDI Grantees Serving Populations of Color/American Indians, FY 2013 and 2014



Some grantees provided services to more than one population

Figure 3. Counties served by EHDI FY 2013 and FY 2014 Grantees



2013 GRANTEES

African American AIDS Task Force
American Indian Family Center
Annex Teen Clinic
Asian Media Access
A.S.P.I.R.E. Youth Agency
Axis Medical Center
Big Brothers Big Sisters of the Greater TC
Boys & Girls Club of the Twin Cities
CAPI USA
Centro, Inc.
Community-University Health Care Center
Crown Medical Center
GMCC Division of Indian Work
Health Finders Collaborative
Hennepin County Medical Center
High School for Recording Arts
Hmong American Partnership
Indigenous Peoples Task Force
Isuroon
Korean Service Center
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lutheran Social Services of Minnesota
Minneapolis American Indian Center
Minnesota African Women's Association
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Minnesota Visiting Nurse Agency
National Asian Pacific American Women's Forum
NorthPoint Health & Wellness Center, Inc.
Open Cities Health Center
Peta Wakan Tipi
Pillsbury United Communities
Planned Parenthood MN, ND, SD
Sabathani Community Center
Saint Mary's Health Clinics
Saint Paul Area Council of Churches
Saint Paul Ramsey County Public Health
Southeast Asian Community Council
Stairstep Foundation
Summit University Teen Center, Inc.
TeenWise
The Indian Health Board of Minneapolis
The Neighborhood Hub
Turning Point, Inc.
WellShare International
YWCA of Minneapolis

2014 GRANTEES

African American AIDS Task Force
American Indian Family Center
Annex Teen Clinic
Axis Medical Center
Big Brothers Big Sisters of the Greater TC
CAPI USA
Centro, Inc.
Community-University Health Care Center
Crown Medical Center
GMCC Division of Indian Work
HealthFinders Collaborative
Hennepin County Medical Center
High School for Recording Arts
Hmong American Partnership
Indigenous Peoples Task Force
Korean Service Center
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lutheran Social Services of Minnesota
Minneapolis American Indian Center
Minnesota African Women's Association
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Minnesota Visiting Nurse Agency
National Asian Pacific American Women's Forum
Neighborhood Hub
NorthPoint Health and Wellness Center, Inc.
Open Cities Health Center
Peta Wakan Tipi
Pillsbury United Communities
Planned Parenthood MN, ND, SD
Sabathini Community Center
Saint Mary's Health Clinics
Saint Paul Area Council of Churches
Saint Paul Ramsey County Public Health
Stairstep Foundation
The Indian Health Board of Minneapolis
Turning Point
WellShare International
YWCA of Minneapolis

Table 8 and Table 9 list grantees in each priority health area and population served for FY 2013 and 2014 respectively, providing the name of the grantees and the populations they serve. An alphabetical list of grantees by grant type and priority health area can be found in Appendix B.

Table 8. EHDI FY 2013 Grantees by Priority Health Area and Population*

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=4**	Hmong American Partnership			●	
		Open Cities Health Center	●		●	
		Saint Mary's Clinic				●
		The Indian Health Board of Minneapolis		●		
Diabetes	**N=11**	Crown Medical Center	●			
		Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Open Cities Health Center	●		●	
		Peta Wakan Tipi		●		
		Pillsbury United Communities	●			
		Sabathani Community Center	●			●
		Saint Mary's Clinic				●
		Saint Paul Area Council of Churches		●		
		Stairstep Foundation	●			
		WellShare International	●			
Heart Disease & Stroke	**N=5**	Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Pillsbury United Communities	●			
		The Indian Health Board of Minneapolis		●		
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=8**	African American AIDS Task Force	●			
		Annex Teen Clinic	●			
		Centro, Inc.				●
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		Indigenous Peoples Task Force		●		
		Planned Parenthood MN, ND, SD	●		●	
		Turning Point, Inc.	●			
Immunizations for Adults & Children	**N=3**	Axis Medical Center	●			
		CAPI USA	●		●	
		MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=4**	American Indian Family Center		●		
		Leech Lake Band of Ojibwe		●		
		Minnesota Visiting Nurse Agency	●	●		
		Open Cities Health Center	●		●	
Teen Pregnancy	**N=22**	Annex Teen Clinic	●			
		Asian Media Access	●		●	
		A.S.P.I.R.E. Project	●			
		Big Brothers Big Sisters of the Greater TC	●	●	●	●
		Boys & Girls Club of the Twin Cities	●	●	●	●
		Centro, Inc.				●
		GMCC Division of Indian Work		●		
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Isuroon	●			
		Lao Family Community of Minnesota			●	
		Lutheran Social Services of Minnesota	●	●	●	●
		Minnesota African Women's Association	●			
		Planned Parenthood MN, ND, SD	●		●	
		Sabathani Community Center	●			●
		Saint Paul Ramsey County Public Health	●	●		

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
		Southeast Asian Community Council, Inc.			●	
		Summit University Teen Center, Inc.	●	●	●	●
		TeenWise of Minnesota	●	●		
		YWCA of Minneapolis	●	●	●	●
Unintentional Injury & Violence	**N=5**	Community-University Health Care Center				●
		Hennepin County Medical Center				●
		Korean Service Center			●	
		MN Indian Women's Resource Center		●		
		Sabathani Community Center	●			●
Community Primary Prevention	**N=2**	National Asian Pacific American Women's Forum			●	
		The Neighborhood Hub	●			

* Grantees work in multiple PHA and serve multiple POC/AI; thus, the unique number of grantees serving a particular population is less than number of dots in each of the columns above. Grantees self-identified the POC/AI groups served in their grant application.

Table 9. EHDI FY 2014 Grantees by Priority Health Area and Population*

Grant Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=4**	Hmong American Partnership			●	
		NorthPoint Health & Wellness Center, Inc.				
		Open Cities Health Center	●	●	●	●
		Saint Mary's Health Clinics				●
		The Indian Health Board of Minneapolis		●		
Diabetes	**N=11**	Crown Medical Center	●			
		Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●	●	●	●
		Open Cities Health Center	●	●	●	●
		Peta Wakan Tipi		●		
		Pillsbury United Communities	●			
		Sabathani Community Center	●			●
		Saint Mary's Health Clinics				●
		Saint Paul Area Council of Churches		●		
		Stairstep Foundation	●			
		WellShare International	●			
Heart Disease & Stroke	**N=5**	Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●	●	●	●
		Pillsbury United Communities	●			
		The Indian Health Board of Minneapolis		●		
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=8**	African American AIDS Task Force	●			
		Annex Teen Clinic	●			
		Centro, Inc.				●
		HealthFinders Collaborative, Inc.				●
		Hennepin County Medical Center				●
		Indigenous Peoples Task Force		●		
		Planned Parenthood MN, ND, SD	●		●	
		Turning Point, Inc.	●			
Immunizations for Adults & Children	**N=3**	Axis Medical Center	●			
		CAPI USA	●		●	
		MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=3**	American Indian Family Center		●		
		Leech Lake Band of Ojibwe		●		
		Minnesota Visiting Nurse Agency	●	●		
Teen Pregnancy	**N=15**	Annex Teen Clinic	●			
		Big Brothers Big Sisters of the Greater TC	●	●	●	●
		Centro, Inc.				●
		GMCC Division of Indian Work		●		
		HealthFinders Collaborative, Inc.				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Lao Family Community of Minnesota			●	
		Lutheran Social Services of Minnesota	●	●		●
		MN African Women's Association	●			
		Planned Parenthood MN, ND, SD	●		●	
		Sabathani Community Center				●
		Saint Paul-Ramsey County Public Health	●	●		
		YWCA of Minneapolis	●	●	●	●
Unintentional Injury & Violence	**N=5**	Community-University Health Care Center				●
		Hennepin County Medical Center				●
		Korean Service Center			●	
		MN Indian Women's Resource Center		●		
		Sabathani Community Center	●			

Grant Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Community Primary Prevention	**N=2**	National Asian Pacific American Women's Forum			●	
		Neighborhood Hub	●			

* Grantees work in multiple PHA and serve multiple POC/AI; thus, the unique number of grantees serving a particular population is less than number of dots in each of the columns above. Grantees self-identified POC/AI groups served in their grant application.

IV. EHDI FY 2014 Program Accomplishments

Program Reach

During the grant period July 1, 2013 to June 30, 2014, EHDI grantees reached a large number of people in their target populations, both through direct and indirect means (Table 10 and Table 11). The variation in numbers reached by target population and grant area are reflective of the number of grantees in each area and the types of programs and activities they implemented.

Table 10. Number of individuals reached by FY 2014 EHDI Grantees by Target Population

Target Population	Directly	Indirectly	# Grantees Serving the Target Population*
African/African American	27,707	53,873	22
American Indian	9,284	31,761	17
Asian/Pacific Islander	7,519	16,766	11
Hispanic/Latino	21,625	117,757	12
Total	**66,135**	**220,157**	

*Some grantees served more than one population

Table 11. Number of individuals reached by FY 2014 EHDI Grantees by Priority Health Area

Priority Health Area	Directly	Indirectly	# Grantees Addressing the PHA*
Breast & Cervical Cancer	3,999	22,676	4
Diabetes	19,926	31,329	11
Heart Disease & Stroke	6,655	8,138	5
HIV/AIDS	7,765	43,675	8
Immunizations	14,154	10,381	3
Infant Mortality	767	4	3
Teen Pregnancy Prevention	10,647	62,052	15
Unintentional Injury & Violence	1,105	37,821	5
Community Primary Prevention	1,117	4,081	2
Total	**66,135**	**220,157**	

*Some grantees addressed more than one priority health area

Direct Contact

A direct contact includes one to one/individual contact (e.g. counseling, clinical services, screenings, education in private settings) and group contact (e.g. classes, workshops, and group education sessions). There may be duplicate numbers if for example a person participated in both individual counseling and a class.

From July 1, 2013 to June 30, 2014, EHDI grantees directly reached a total of 66,135 individuals. The largest group reached directly was the African/African American community at 27,707 or 42 percent of the total direct reach, followed by the Hispanic/Latino community at 21,625 or 33 percent of the total.

Grantees focused on diabetes reached the largest number of people directly, 19,926 or 30 percent of the total direct reach, followed by Immunizations, 14,154 (21 percent) and teen pregnancy prevention. 10,647 (16 percent).

Indirect Contact

An indirect contact occurs when grantees conduct outreach at large events, and is usually minimal or fleeting. For example, at health fairs this can be estimated by the number of pamphlets distributed, or the number of letters sent out as reminder for breast and cervical cancer screening.

From July 1, 2013 to June 30, 2014, Table 8 shows that EHDI grantees indirectly reached a total of 220,157 individuals. The largest groups reached indirectly were Hispanic/Latino at 117,757 or 53 percent of the total indirect reach, followed by African/African American at 53,873 (24 percent). It is worth noting that many of the indirect activities in the Hispanic/Latino and African American communities are church-based.

By grant area, teen pregnancy prevention programs reached the most number of people indirectly, 62,052 or 28 percent of the total indirect reach, followed by HIV/AIDS & STDs, 43,675 (20 percent). Teen pregnancy and HIV/AIDS and STD prevention programs are largely classroom-based.

Evidence-Based, Promising and Culturally Responsive Practices

As part of the 2013 EHDI Request for Proposal (RFP) process, MDH recommended that applicants align their projects with MDH recommended key objectives, strategies, and associated evidence-based or promising practices. Grant applicants, and later on grantees, were required to choose at least one of the objectives from the menu of options provided in the RFP and incorporated additional activities that used strategies tailored to meet the needs of the communities they served. As a result, EHDI grantees are implementing a wide range of culturally responsive, evidence-based and promising practices to reduce health disparities among populations of color and American Indians in the eight priority health areas (PHAs).

EHDI grantees were encouraged to implement evidenced-based and promising culturally responsive practices that:

- Meet the needs of population of color and American Indians already affected by one or more of the eight PHAs or address the underlying contributing risk factors for these PHAs
- Provide individual or group-based services; or change policies, systems, or the environment
- Are culturally responsive and linguistically appropriate
- Give community residents a voice in program planning, implementation, and evaluation
- Strengthen working relationships and partnerships in the community

These three types of practices are defined in Figure 4.

Figure 4. Definitions: Evidence-based, Promising and Culturally Responsive Practices[6]

Evidence-Based Practices	Promising Practices	Culturally Responsive Practices
Interventions that have demonstrated effectiveness based on the principles of scientific evidence, including systematic uses of data and information systems, and appropriate use of behavioral science theory in order to explicitly demonstrate effectiveness.	Interventions that have demonstrated effectiveness based on local practices and/or cultural experiences, for example, non-experimental data or the experience of practitioners.	Interventions that are adapted to meet the unique cultural needs of different communities but may lack evidence of effectiveness.

[6] 2013–2014 EHDI Evaluation Report Instructions and Template. Retrieved from the MDH EHDI grantee portal website (http:/www.health.state.mn.us/ommh/grants/ehdi/portal/2014evaltemplate.pdf).

Summary of Grant Activities by Priority Health Area

This section provides for each PHA: a health disparity context; an overview of the chosen objectives, strategies, and activities being used by grantees; and the featured work of one grantee. In addition, one Community Primary Prevention grantee is featured following this section.

1. Breast & Cervical Cancer Screening

Health Disparity Context

- Breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer deaths.
- White women in Minnesota are at the greatest risk of being diagnosed with breast cancer, but African American women are at greatest risk of dying from the disease (Table 12). The incidence rate for African American women is 41 percent lower than for white women, but their mortality rate is 8 percent higher.
- There are fewer cervical cancer cases compared to breast cancer in Minnesota; however, the racial/ethnic disparities have been consistent over the years. American Indian women are the most likely to develop cervical cancer in Minnesota. During 2008-2012, they were almost four times more likely to be diagnosed with this cancer than white women, followed by Asian/Pacific Islander women who were twice more likely to be diagnosed than whites. (Table 12)
- In order to reduce deaths from breast cancer, all women age 40 and older should get regular mammograms and clinical breast examinations. The American Cancer Society (ACS) screening guidelines recommend that women ages 40 to 44 should have the choice to start annual breast cancer screening with mammograms if they wish to do so, women age 45 to 54 should get it every year, women 55 and older every 2 years, and that screening should continue as long as a woman is in good health and is expected to live 10 or more years.
- ACS recommends that cervical cancer screening start at age 21. Screening guidelines for all women, including those who have been vaccinated against the human papillomavirus or HPV, are the following: women between 21 and 29 should have a Pap test done every three years, and an HPV test only after an abnormal Pap test result; women between 30 and 65 should have a Pap test plus an HPV test done every five years; women over age 65 who have had regular cervical cancer testing in the past 10 years with normal results should not be tested for cervical cancer.
- Women cite economic, social, and cultural barriers to screening, referral, and treatment, such as cost, lack of or inadequate health insurance, poor access to health care, lack of physician recommendation, language, cultural beliefs and practices, fear, and knowledge gaps as reasons for not getting screened. Lack of time and inconvenience have also been reported as barriers to screening.[7]

[7] Health Disparities Context from EHDI 2015 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp2015/2015ehdirfp.pdf

Table 12. Breast and cervical cancer incidence and mortality rates per 100,000 by race/ethnicity, females in Minnesota, 2008-2012

	African American	American Indian	Asian	Hispanic*	Non-Hispanic White
Breast Cancer					
Incidence	92.9	89.8	68.2	105.6	130.9
Mortality	22.0	14.5	10.2	9.3	20.3
Cervical Cancer					
Incidence	6.7	19.0	11.3	9.2	5.5
Mortality	2.6	~	6.5	~	1.3

* Hispanic can be any race
~ Fewer than 10 cases or deaths are not presented

SOURCE: Minnesota Cancer Facts and Figures 2015. Minnesota Department of Health, Minnesota Cancer Alliance, American Cancer Society. Retrieved from: http://www.health.state.mn.us/divs/healthimprovement/content/documents/CancerFandF.pdf

Breast and Cervical Cancer Screening
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=4; FY 2014=4)

Objectives

- Improve the medical care given to women who have abnormal findings from breast or cervical cancer screenings
- Detect breast and cervical cancer earlier

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Increase the number of women who receive complete diagnostic and treatment services in a timely manner	3	3
• Increase the number of women who are screened for breast and cervical cancer in accordance with state or national health care guidelines	4	4

Types of Activities

Example of Evidence-based Strategies

- American Cancer Society breast and cervical cancer guidelines were used to determine how often women should receive pap smears and mammograms
- Use of Community Health Worker model

Example of Promising Practice

- Bringing a mobile mammogram unit to a Women's Health Days celebration at a clinic so the women only have to make one appointment instead of going to the clinic for a screening then to a breast center for follow-up
- Sending reminder letters at the beginning of each month to women who are due for a Pap smear or mammogram to remind them to set up an appointment, and sending birthday card mammogram reminders to women over 40 that have never had a mammogram

Example of Culturally Responsive Strategies

- Use of Talking Circles to facilitate talking to Women's Empowerment Groups about women's health issues in the community
- Use of cultural media to disseminate linguistically and culturally appropriate messages

Featured Grantee – Saint Mary's Health Clinics

Population Served: Hispanic/Latino

Community Partners: Mexican Consulate, Ecuadorian Consulate, Assumption Church- La Misión, Holy Rosary Church-Centro Guadalupano, and Risen Christ Catholic School

Objectives/Strategies: The goal of the Saint Mary's Health Clinics (SMHC) project is to improve the health and quality of life in the Hispanic/Latino community, with a focus on breast and cervical cancer and on prevention and treatment of diabetes.* The project's core values include: focus on the whole person providing timely information, support and care; activities take place in accessible, trusted community locations including screening and prevention education at schools, churches and consulates; health care is provided in neighborhood locations; culturally appropriate programs, activities, and materials are delivered in Spanish at appropriate literacy levels; and, all screening, health care, specialty referrals and medications are provided at no cost to the patient.

Key Activities and Evidence-Based Practices: SMHC's activities are designed to eliminate barriers so that Latina women receive free screening, early diagnosis and proper follow up of abnormal breast and cervical cancer test results. SMHC partnered with the American Cancer Society to give incentives to women who got a pap smear and/or a mammogram and to coordinate breast and cervical cancer community events. SMHC helped uninsured women enroll in programs that provide breast and cervical cancer screening at no cost by having staff screen patients for eligibility and schedule appointments and MNsure navigators assist with MNsure applications and questions. SMHC provided pap smears and mammograms at no cost in convenient, friendly, trusted community sites; and, provided assistance, support and free follow-up treatment and referral to specialty care, if needed, to women who had abnormal breast and cervical screening results.

Results: 2,010 Latinas received information about breast and cervical cancer prevention and/or free screenings through direct one to one consultations at the Mexican Consulate, Ecuadorian Consulate, community churches, SMHC clinics and outreach events. It can be estimated that each women reached by SMHC passes on the information to two friends and relatives (Social Network Analysis), resulting in an estimated 4,020 indirect contacts. SMHC female providers held an average of one women-specific clinic session per week on well women exams.

Outcomes*:* In collaboration with the American Cancer Society, SMHC trained two lay Latino community members to become Community Health Workers specializing in breast and cervical cancer. 316 Latino women scheduled appointments for a pap smear and 134 for a mammogram at SMHC. Of these, 34 SMHC Latina patients had abnormal Pap smear results and were provided follow-up care, and all had successful outcomes. Of the 13 women who had abnormal breast exams and/or diagnostic mammography, none were found to have breast cancer. All Latinas with abnormal findings received assistance with appointment scheduling and received further diagnostic procedures and treatment at no cost to them.

Key Lessons Learned: The key to program success is to work closely with members of the target community in the planning and implementation of the program activities and use the expertise of community members to guide program activities. SMHC continues to learn that it needs to be flexible and be ready to change its activities based on the continuous observation and assessment of their work and the feedback received from patients and the target community.

*SMHC's EHDI project covers both breast and cervical cancer and diabetes; only the former program is featured here.

2. Diabetes

Health Disparity Context

- Diabetes is the seventh leading cause of death in Minnesota and the leading cause of blindness, kidney failure, and lower-limb amputations.
- The death rate from diabetes for African Americans is almost twice the rate for whites, and the death rate for American Indians is almost four times higher.
- Diabetes can damage kidneys and cause them to fail. Kidney failure is two to five times greater in American Indians. Diabetic eye disease refers to a group of eye problems that people with diabetes may face as a complication of diabetes. Eye disease is two times greater in Hispanics/Latinos and 40-50 percent greater in African Americans.
- Lack of culturally and linguistically appropriate diabetes education materials and support systems, and lack of culturally diverse or culturally responsive health care providers are barriers to effective diabetes prevention and management in these populations.[8]

Diabetes
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=11; FY 2014=11)

Objectives

- Improve the health status of people with diabetes
- Reduce risk factors that can lead to diabetes

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Assist people with diabetes or pre-diabetes to maintain healthy lifestyles	8	8
• Improve medical care for people with diabetes	4	10
• Assist people with diabetes to manage their disease	8	8
• Teach people with pre-diabetes how to prevent the development of diabetes	8	10
• Detect diabetes earlier	3	4

Types of Activities

Example of Evidence-Based Strategies

- Use of the *I CAN Prevent Diabetes* program, the *Diabetes Education and Empowerment* (DEEP) program, and the *Living Healthy* with Diabetes program
- Use of the community health worker model

Example of Promising Practices

- Used an electronic game system or traditional dance to increase motivation for physical activity among youth participants
- Distributed Wellness Walk Maps that show places in the Twin Cities to go for walks alone or with family

Example of Culturally Responsive Strategies

- Use of Talking Circles to gather information in the community to help make program materials more effective
- Promote culturally appropriate food choices (e.g., expanded farmer's markets)

[8] Health Disparities Context from EHDI 2015 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp2015/2015ehdirfp.pdf

Featured Grantee - Saint Paul Area Council of Churches (The East Metro American Indian Diabetes Collaborative)

Populations Served: American Indian

Community Partners: The East Metro American Indian Diabetes Collaborative includes the Saint Paul Area Council of Churches (now Interfaith Council of Greater Saint Paul, the lead agency), Department of Indian Work, Ain Dah Yung Center, American Indian Family Center, Indian Education (Saint Paul Public Schools), University of Minnesota (Medical, Public Health, Family Social Science, and Physical Therapy schools and programs), and Dream of Wild Health.

Objectives/Strategies: The Collaborative exists to empower the American Indian community to prevent and manage diabetes. The objectives are to improve the health status of people living with diabetes by offering support groups that encourage self-care and healthy lifestyles, and to reduce risk factors among individuals with pre-diabetes by conducting lifestyle change and support programs in clinical and community settings. All programs incorporate American Indian- specific and traditional approaches.

Key Activities and Evidence-Based Practices: *Family Education Diabetes Series* (FEDS) was offered to American Indian families and youth in East St. Paul. It is a community-based participatory research project designed to supplement standard diabetes care, and is guided by the principles of the citizen health care model. Participants include patients, families, tribal leaders, and healthcare professionals who met for 17 sessions which included education, nutrition and cooking, and exercise and weight management components. *Diabetes Education in Tribal Schools* (DETS), *Health is Life in Balance* curriculum, was offered in elementary and middle schools. It is an evidence-based program designed to: increase understanding of health, diabetes, and maintaining life in balance; increase understanding and application of scientific and community knowledge; and, increase interest in science and health professions.

Results: From July 1, 2013 to June 30, 2014, a total of 435 people participated in programs and 5,366 participated in outreach activities designed to increase knowledge and awareness of the risks of diabetes. Ain Dah Yung Center had 120 youth attend their 5th annual Tobacco Prevention and Wellness Symposium.

Outcomes: Regular, consistent participation in FEDS sessions led to improved self-management of health (weight, blood pressure, blood sugar, and increased physical activity). 96 percent committed to making healthier meals for their families, and 72 percent tracked their glucose and BMI levels. Classroom-based youth diabetes education empowered 70 youth from five St. Paul Public Schools and 30 girls from the American Indian Magnet School to change their diet or increase their physical activity. All increased their awareness of diabetes. At the American Indian Family Center, 17 adults participated in the men's group and 50 men participated in sport leagues throughout the year. Participation in the men's group had a positive impact on the adult males and a positive impact on the healthy lifestyles of their families. Families increased their physical activity through traditional activities, access to the YMCA, and participation in recreational athletic teams. One hundred percent of youth that attended the Ain Dah Yung Center's annual Tobacco Prevention and Wellness Symposium reported increased awareness of diabetes and how to prevent it.

Key Lessons Learned: Getting youth out of their comfort zone by performing can build self-confidence. Attendance is more consistent when cultural activities are added to the programming,. Youth respond well when they feel they are not only participating but contributing. It is important to know the stories and spiritual meaning behind the cultural activities in which youth participate or attend. Urban American Indian youth report feeling disconnected from their culture, but with much effort a program like this can help them feel comfortable around their people and their cultural teachings.

3. Heart Disease & Stroke

Health Disparity Context

- Heart disease and stroke mortality rates for Minnesotans overall are lower than the nation as a whole; however, for populations of color and American Indians, rates for heart disease or stroke are often higher than the overall state population rates.
- American Indian heart disease death rates from 2010-2014 were 58 percent higher than those for whites.
- Stroke is a major cause of death in Minnesota. African American men died from stroke at a rate 27 percent higher than for white men during the same time period, while African American women died from stroke at a rate 22 percent higher than for white women.
- Asian American men living in Minnesota are more likely to die from stroke than all other populations groups.
- Based on 2010-2014 data, compared to the white population, mortality due to stroke is higher for the Black/African American, American Indian and Asian populations in Minnesota (Table 13).
- Arteriosclerosis (hardening of the arteries) is the underlying disease process of the major forms of heart disease and stroke. It is associated with several modifiable risk factors, including high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, obesity, and poor diet.[9]

Table 13. Stroke mortality rates per 100,000 and disparity ratios, Minnesota 2010–2014

Race/Ethnicity	Number	Age Adjusted Rate	Disparity Ratio**
Black or African American	**252**	**41.5**	**1.3**
American Indian	**71**	**34.4**	**1.04**
Asian	**213**	**41.6**	**1.3**
Hispanic*	**85**	**25.2**	**0.8**
White	**10,010**	**32.9**	**1.0**

*Hispanic can be any race
**Disparity ratio = Population Adjusted Rate/White Adjusted Rate

SOURCE: Minnesota Department of Health, Center for Health Statistics.

[9] Health Disparities Context from EHDI 2015 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp2015/2015ehdirfp.pdf

Heart Disease and Stroke

EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=5; FY 2014=5)

Objectives

- Improve the health status of people with heart disease and stroke
- Reduce the risk factors that can lead to heart disease and stroke

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Improve the medical care given to people with heart disease and stroke	2	3
• Assist people with heart disease or stroke to manage their disease	3	1
• Assist people with high blood pressure, high cholesterol, or who use tobacco to reduce their risk	1	1
• Decrease obesity by increasing physical activity and healthy eating	4	3

Types of Activities

Example of Evidence-Based Strategies

- Conduct disease self-management groups (e.g., use of *Honoring the Gift of Heart Health* curriculum)
- Use of Community Health Worker model

Example of Promising Practices

- Implementing a Hypertension Management/Collaborative Practice protocol where patients referred by a provider with the diagnosis of hypertension or diabetes who have not reached their blood pressure or A1C goal will be managed by the pharmacist, and the pharmacist will monitor lab values, review medication, reinforce medication and lifestyle adherence
- Scheduling shared medical appointments, which are visits in which multiple patients are seen as a group, usually for follow up care so that patients have the benefit of a longer visit with the physician and when appropriate, access to other members of the health care team such as a nutritionist

Example of Culturally Responsive Strategies

- Implementing an evidence-based curriculum *Healthy Moves for Living Well* adapted for Somali elders so that movements are appropriate for individuals at all ability levels, single-gender opportunities to exercise are made available, and gatherings are used as opportunities to share preventive health messages on various topics
- Distributing health education brochures and DVDs containing messages that use culturally relevant proverbs and stories to promote evidence-based health prevention activities such as physical activity and healthy eating
- Using “champions” who are respected community members that connect community members to health resources through individual and group contacts while acknowledging cultural health assets

Featured Grantee - The Indian Health Board of Minneapolis

Population Served: American Indian (urban)

Community Partners*:* American Cancer Society, Shakopee Mdewakanton Sioux Community, Elders Lodge, Nice Ride MN

Objectives/Strategies: The objective of The Indian Health Board's (IHB) Cardiovascular Disease (CVD) Prevention Program is to reduce risk factors among American Indian adults that can lead to heart disease and stroke, to decrease obesity by increasing physical activity and healthy eating, and to increase knowledge of CVD risk factors.

Key Activities and Evidence-Based Practices: IHB conducts community blood pressure screenings to increase awareness of heart disease risk, and recruits community members for cholesterol screening and heart health education. IHB provides free memberships to the Nice Ride MN bike program for program participants. IHB also implements the *Honoring the Gift of Heart Health* curriculum, a comprehensive culturally appropriate, user-friendly 10-lesson course on heart-healthy living developed for American Indians by the National Heart, Lung and Blood Institute. It provides American Red Cross training on cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) for workplace and other professional emergency responders, school staff, healthcare providers, and the general public. IHB designed brochures and flyers that are specific to its clinic and the American Indian population. Staff attends pow-wows and other community events to educate the community about IHB's services.

Results: IHB worked with 19 American Indian community agencies and conducted 23 blood pressure screening events, successfully screening and providing results to 245 American Indian adults. Many of those were considered at risk because: 63 percent had a parent, grandparent, aunt or uncle that had experienced a heart attack or stroke; 46 percent reported being smokers; and 80 percent met the criteria for pre-hypertension, Stage 1 high blood pressure, or Stage 2 high blood pressure ranges. Of those at risk, 88 accepted referrals for cholesterol testing and medical care or to IHB's CVD prevention program or smoking cessation program. Thirty-one of those referred met with the CVD Educator and attended at least one CVD Education class. Seventy-two patients kept smoking cessation appointments, and 52 patients received blood pressure case management. Thirty eight American Indian adults participated in an exercise program and 17 Elder Lodge residents attended an alumni support group.

Outcomes: All of the 10 participants in the CVD education class who completed follow-up assessments reported "a lot or a "huge amount" of improvement in their knowledge of ways to prevent or control CVD, in their confidence to liviea full and healthy life, in the amount of time they feel good physically and in being able to get out and be active. Thirty-one of 38 adults (81 %) who participated in an exercise program reported becoming more physically active. 100 percent of the Elder Lodge Residents who attended the alumni support group reported an increase in their awareness of dietary and activity habits that increase the risk of CVD. 68 percent of individuals who met with a CVD educator and attended at least one class had an up-to-date cholesterol test.

Key Lessons Learned: IHB encountered many barriers related to program retention such as availability of transportation and childcare services and the transient nature of the population. Because of these, their numbers show that for most activities, only 30 percent of patients who are referred to the programs will attend at least one class or appointment. IHB continues to find ways to overcome the service barriers in order to improve participation rates and outcomes. It learned that looking to the community for already existing resources and collaborating with other agencies can help fill gaps in services. Also, being consistently available and visible in the community helps to establish trust, reconnect with lost participants, and form relationships with new participants and other agencies. Lastly, continually reevaluating the efficiency and effectiveness of methods improves programming. Evaluating the in-house referral system, for example, has allowed IHB to more effectively track and refer patients and participants to appropriate services.

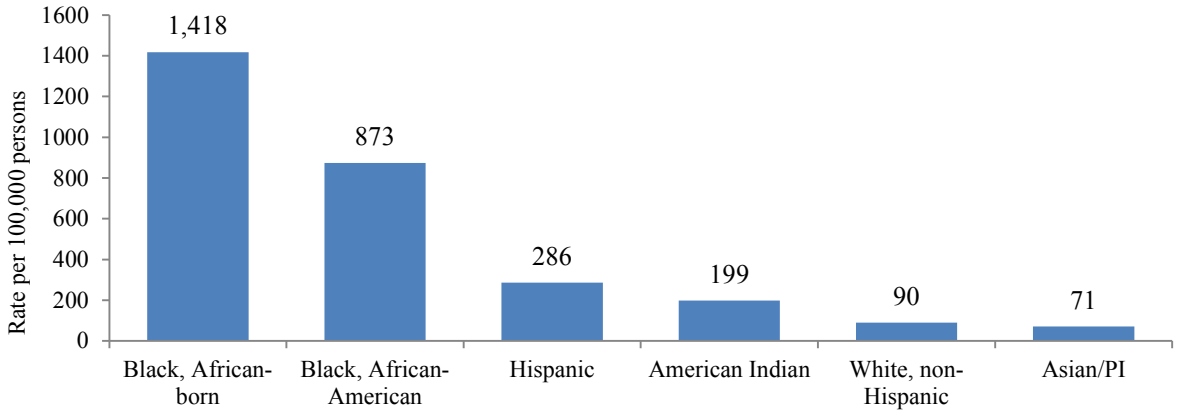
4. HIV/AIDS & Sexually Transmitted Diseases

Health Disparity Context

HIV/AIDS:

- As of December 31, 2014, nearly 8,000 (7,988) persons were known to be living with HIV/AIDS in Minnesota. This represents about a three percent increase from 2013, and a six percent increase from 2012.
- In Minnesota, the HIV/AIDS epidemic affects populations of color and American Indians disproportionately (Figure 5). While white, non-Hispanic persons account for the majority of people living with HIV/AIDS, the rate of white people living with HIV in Minnesota is 90.3 per 100,000 persons in 2014, which is much lower than the rates of other racial/ethnic groups, except Asians.

Figure 5. Persons living with HIV/AIDS in Minnesota (rate per 100,000) by race, 2014



SOURCE: Minnesota Department of Health. HIV/AIDS Prevalence and Mortality Report, 2014, and Minnesota HIV/AIDS Surveillance System. The population estimate for African-born persons was calculated by the Minnesota State Demographic Center from American Community Survey 2010-2012 data. Reports available at http://www.health.state.mn.us/divs/idepc/diseases/hiv/stats/2014/index.html

Sexually Transmitted Diseases (STDs):

- There were 24,599 STD cases reported in Minnesota in 2014.[10] Chlamydia is the most frequently reported infectious disease in Minnesota (and the U.S.) with about 19,900 cases in 2014 (at least one in every county in Minnesota).
- Among Minnesotans in 2014, African Americans had the highest rates of gonorrhea and chlamydia. Incidence of chlamydia in this group was nine times higher, and incidence of gonorrhea was 18 times higher, than whites.
- Disparities in rates of chlamydia are very high. In 2014, the rate among African Americans was nine times higher than among whites; among American Indians it was nearly five times higher, among Asian-Pacific Islanders nearly two times higher, and among Hispanic/Latinos more than two times higher. While the rates of chlamydia in all ages and races in Minnesota may be lower compared to other states, the rates in populations of color and American Indians remain high.

[10] Minnesota Department of Health STD/HIV/AIDS Surveillance System. Retrieved from http://www.health.state.mn.us/divs/idepc/dtopics/stds/stats/2014/stdreport2014.pdf.

HIV/AID & Sexually Transmitted Diseases
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=8; FY 2014=8)

Objectives

- Improve the health of people with HIV and STDs
- Identify new cases of HIV infection
- Reduce the rate of new infections of HIV and STDs

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Increase the number of people who access complete diagnostic and treatment services in a timely manner after testing positive for HIV and/or STDs	3	2
• Increase HIV and STD testing among members of high-risk groups	4	4
• Reduce risky sexual behaviors which lead to the transmission of HIV/STDs	7	7

Types of Activities

Example of Evidence-Based Strategies

- Implemented a group or individual intervention for high risk members of the target population with education and skills training to reduce risky sexual behaviors, improve safer sex skills, and increase knowledge of HIV and STDs (e.g., use of *Making Proud Choices, Becoming a Responsible Teen, ¡Cuidate!* curricula)
- Implemented peer education programs and/or media campaigns to encourage adoption of safer sex practices (e.g., *Sisters Informing Healing Living and Empowering Intervention* (*SiHLE*))
- Use of Comprehensive Risk Counseling and Services (CRCS) for high risk uninfected persons

Example of Promising Practices

- Implemented *Padres Informados* curriculum to improve family communication
- Formed Neighborhood Teams comprised of community members who worked with fellow community members to identify public health concerns facing their families and to advocate for changes to rectify these.

Example of Culturally Responsive Strategies

- Implemented culturally responsive curricula (e.g., ¡*Cuidate!, SiHLE*)

Featured Grantee - Annex Teen Clinic (R.E.A.C.H. Collaborative)

Populations Served: African /African American youth in grades 4-12, and young adults through age 21, living in North Minneapolis. The HIV outreach-based testing project area includes all areas of Minneapolis/St. Paul with primary focus on at-risk African-American females ages 13-45 and includes males and other individuals at high risk.

Community Partners: Neighborhood Hub, R.E.A.C.H. Collaborative Community Advisory Council (African/African American youth, parents, other adults, representatives from neighborhood organizations, businesses and schools, and volunteers)

Objectives/Strategies: The primary goal of R.E.A.C.H. is to provide intergenerational community programming (*Sister to Sister*) that is culturally appropriate, evidence-based, supports young African Americans' reproductive health, reduces the number of African American teens who get pregnant in North Minneapolis, and addresses issues to reduce the rates of HIV and other sexually transmitted diseases. R.E.A.C.H.'s objectives related to HIV & STD's are to improve the sexual health of young people, and reduce the rate of new infections and identify new cases of HIV/AIDS & STDs.

Key Activities and Evidence-Based Practices: Activities include: HIV and STD testing; education and risk assessments offered to at-risk teens at partner sites; presentations; workshops at community events, organizations, and schools; one-on-one individual interventions for African American teen girls who are high risk; media and marketing campaign to focusing on high risk populations and communities; culturally competent referrals for medical care, case management and counseling to Annex Teen Clinic and other clinics; and, education of clients who had positive test results on the need for follow-up.

Results: R.E.A.C.H.'s HIV/AIDS & STDs program reached 406 people directly and 2,800 people indirectly from July 1, 2013 to June 30, 2014. Over 500 received HIV information through brochures and educational pamphlets distributed at health fairs and other community events, and through e-mails and radio ads/announcements. HIV testing was done on a monthly basis at various community sites. 300 people were tested for HIV, 56 youth participated in HIV/STD-focused media arts programming, and 50 teen girls participated in the *Sister to Sister* program. A six-week STD pilot testing program (chlamydia specific) was implemented at a partner site.

Outcomes: The program is making progress in increasing community awareness and testing in the target population as indicated by the numbers reached, resource materials handed out, and number of people that completed risk assessment forms. All 50 teen girls in *Sister to Sister* indicated on their evaluation sheet that they have become more aware of the risks associated with HIV/STDs, and are taking appropriate steps to protect themselves.

Key Lessons Learned: Community member voices and support including youth are important and must be heard and followed up with actions that create healthier communities. An intergenerational family approach to teen pregnancy prevention and addressing health disparities related to Chlamydia and other STDs works. This means providing age-appropriate sexuality education for parents, peers and children. This education increases parents' comfort level with talking to their children about reproductive health and preventing pregnancy and sexually transmitted diseases. It is also important to view high rates of teen pregnancy and HIV/STDs from the frame of youth development. This means talking to children about these issues before they become teenagers. It also requires moving beyond viewing teen pregnancy and high rates of HIV/STDs solely as a teen behavior problem. Effective strategies view the teen as a whole person, acknowledging the economic and social conditions that contribute to unhealthy relationships and work to address these conditions in the context of the child and teen's efforts to develop to their full potential as a successful adult.

5. Immunizations for Adults & Children

Health Disparity Context

Childhood Immunization:

Childhood immunization rates are estimates of the number of children who have received recommended vaccines. They are based on the vaccination coverage rate – that is, estimates of the number of people who have received particular vaccines, for the primary series for children age 19-35 months (4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B, 1 varicella, and 4 PCV13, abbreviated as 4:3:1:3:3:1:4).

- According to the 2011 National Immunization Survey (NIS) 68.5 percent of children in the United States age 19-35 months have completed the recommended primary series, compared to 72 percent of Minnesota's children age 19-35 months.
- Information from the Minnesota Immunization Information Connection (MIIC) in 2012 shows that White children had the highest vaccination rates at 63 percent. In comparison, only 60 percent of American Indian or Alaskan Native children, 60 percent of Asian and Pacific Islander children, and 51 percent of African American children were vaccinated.

Adult Immunization:

Adult vaccination data for Minnesota from these sources reveal the following:

- Influenza Vaccination: Behavioral Risk Factor Surveillance System (BRFSS) indicates that among adults age 18 and older, influenza coverage for the 2011-2012 season for non-Hispanic whites (41.9 percent) was higher than all other racial/ethnic groups except for American Indians (42.6 percent). Asian Pacific Islander coverage was 37.3 percent; African/African American coverage was 32.7 percent; and Hispanic/Latino coverage was 29.4 percent
- Pneumococcal Vaccination: According to the National Health Interview Study (NHIS):
  - Coverage among high-risk adults age 19-64 was 18.5 percent overall;
    - Coverage among non-Hispanic whites was highest at 19 percent
    - Coverage among Hispanic/Latinos and Asian Pacific Islanders was lowest at 14.8 percent and 11.5 percent respectively
  - Coverage among adults age 65 and older was 59.7 percent overall
    - Coverage among non-Hispanic whites was highest at 63.5 percent
    - Coverage among Hispanic/Latinos was lowest at 39 percent.

Immunization for Adults and Children

EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=3; FY 2014=3)

Objectives

- Improve clinical immunization rates
- Remove barriers to accessing immunizations

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Increase access to immunizations	2	2
• Address knowledge, attitudes, and beliefs regarding immunizations	1	1
• Ensure that patients receive all needed vaccines at all visits	2	2
• Ensure that recordkeeping systems prompt for needed vaccines	1	1

Types of Activities

Example of Evidence-Based Strategies

- Providing annual influenza vaccination to people in trusted, community-based settings such as neighborhood community centers and senior high-rise and retirement communities

Example of Promising Practices

- Offering other services such as translations, transportation to and from clinics, and interpretation during appointments which can lead to improved immunization rates

Example of Culturally Responsive Strategies

- Training volunteer vaccinators in cultural norms and nuances and making available consent forms in multiple languages
- Partnering with community organizations and using community volunteers

Featured Grantee - The Minnesota Immunization Networking Initiative (MINI)

Populations Served: African American/African, American Indian, Asian/Pacific Islander, Hispanic/Latino

Community Partners: St. Mary's Health Clinics, Stairstep Foundation, Homeland Health Specialists, Inc., Open Cities Health Center, River Valley Nursing Center, American Indian Community Development Corporation/KOLA, St. Catherine's University School of Nursing, and MINI Advisory Committee.

Objectives/Strategies: The key objective is to remove barriers to immunization access. Key strategies include holding free flu shot clinics in trusted, non-traditional, community-based settings; offering pneumonia vaccine to adults age 65 or older; recruiting, training, and placing volunteer vaccinators from Fairview Health Service to expand the reach of services; and, engaging new partners in the Asian/Pacific Islander community to host clinics.

Key Activities and Evidence-Based Practices: MINI provides annual seasonal immunizations at no charge to uninsured and underserved individuals aged three and older within non-white communities in Minnesota in non-clinical settings. MINI formed partnerships with organizations representing a broad range of races and ethnicities and built on the connections that faith- and community-based organizations have already established within their communities to increase people's awareness and willingness to get vaccinated.

Results: In 2013-14, MINI held 147 flu clinics at various community sites. At these clinics, 8,743 people received flu shots, 13 percent of whom received shots for the first time, 839 were African/African American, 139 were American Indian, 3,193 were Asian/Pacific Islander, and 3,181 were Hispanic/Latino. 284 adults with chronic medical conditions also received pneumococcal vaccinations.

Outcomes: Entered 100 percent of all MINI clientele information into the Minnesota Immunization Information Connection (MIIC) database system. Enrolled in Vaccines for Children (VFC) and Uninsured Underinsured Adult Vaccine (UUAV) programs in order to increase vaccine supply for persons without insurance. Trained 63 Fairview Health Services employees as volunteer vaccinators, several of whom served in multiple clinics. Students from St. Catherine University School of Nursing served as volunteer vaccinators at two clinics, and students from St. Olaf College served as volunteer registrars at two clinics. An unanticipated outcome was that the engagement of Fairview healthcare professionals as volunteer vaccinators is making an impact on the Fairview Health System by creating an awareness of health disparities and a change in attitudes, and new knowledge of cultures.

Key Lessons Learned: The main reasons people attended the clinics were: free shots, convenience, lack of health insurance, and trusted setting. In a survey of Fairview volunteer vaccinators, 100 percent indicated they would serve again and indicated that serving in the MINI clinic helped them understand different cultures. MINI also learned that in providing free flu shots in the Native American community it is important to find a trusted "broker" who can make introductions to the community leaders. By leveraging resources from another grant, MIN built relationships with the residents of Little Earth residential community, which led to Little Earth inviting MINI to hold a free flu shot clinic and provide residents with education about influenza.

6. Infant Mortality

Health Disparity Context

- Minnesota consistently ranks among the states with the lowest infant mortality rates. In fact, infant mortality rates have declined for all racial and ethnic populations in Minnesota compared to 20 years ago. Nonetheless, significant disparities persist. Mortality rates among Black or African American and American Indian infants are twice those among white infants (Table 14).
- The causes of infant mortality vary by population: sleep-related causes, such as SIDS (sudden infant death syndrome), are a primary source of infant deaths in the American Indian community, while prematurity is the leading cause of death among African-Americans. Birth defects are the main source of infant deaths in the Asian, Hispanic, and White populations.
- The timing of infant deaths provides guidance to strategies and interventions: the American Indian post-neonatal (28-364 days) infant mortality rate is the highest among all races/ethnicities. This suggests that specific program interventions focusing on preventing sleep-related infant deaths and SIDS risk reduction would be successful in reducing American Indian infant deaths; African Americans have the highest rate of neonatal (< 28 days) deaths than other populations of color and American Indians, suggesting that successful program interventions should be focused on preventing prematurity.[11]
- Chronic stress, poverty, substance abuse, a lack of prenatal care, and lack of access to health care all contribute to infant mortality.

Table 14. Infant mortality per 1,000 births by race/ethnicity of mother, Minnesota 2009–2013 (birth year)

Race/Ethnicity of Mother	Rate	Disparity Ratio
Black or African American	9.2	2.1
American Indian	9.1	2.1
Asian	4.4	1.0
Hispanic*	5.1	1.2
White	4.3	1.0

* Hispanic can be any race

SOURCE: Minnesota Department of Health, Center for Health Statistics

[11] Health Disparities Context from EHDI 2015 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp2015/2015ehdirfp.pdf

Infant Mortality
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=3; FY 2014=3)

Objectives

- Improve system, community and family/individual factors that contribute to infant deaths
- Improve the health status of women before, during, and between pregnancies
- Improve the health status and safety of infants from birth to one year

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Increase access to health and preventive care before, during and between pregnancies	3	3
• Provide culturally responsive outreach and care coordination during pregnancy and birth	2	5
• Change behaviors that lead to acute and chronic conditions	2	2
• Provide education and support for pregnant and parenting teens	1	1
• Ensure that all infants receive high-quality care at birth and infancy	1	1
• Reduce infant deaths from SIDS and sleep-related unintentional injuries	3	1
• Improve infant nutrition and health, physical growth and development	3	3
• Reduce infant deaths from unintentional injury and violence	2	0

Types of Activities

Example of Evidence-Based Strategies

- Use of *Growing Great Kids*, an evidence-based model of home visiting devoted to the parent-child relationship and creating the right home environment for kids.
- Use of American Indians-specific curricula such as the *Positive Indian Parenting Curriculum* which utilizes traditional American Indian parenting techniques to promote wellness within the family, and the Manidoo-Ningadoodem (Family Spirit) Program which is a core strategy to support young, Native parents from pregnancy to 3 years post-partum.

Example of Culturally Responsive Strategies

- Use of the Prenatal Risk Overview (PRO) tool to assesses social support, tangible needs, mental health, substance abuse, and domestic violence. Tested with the African American and American Indian populations, it was developed to be strength-based and culturally open.

Featured Grantee – Minnesota Visiting Nurse Agency (MVNA)

Populations Served: African American/African and American Indian

Community Partners: The Family Partnership (TFP) and Twin Cities Healthy Start (TCHS)

Objectives/Strategies: The two main objectives of the MVNA are: to improve the health status of women before, during, and between pregnancies; and, to improve the health status and safety of infants from birth to one year. MVNA accomplishes these by providing weekly intensive home visits to participants with a focus on education and goal setting.

Key Activities and Evidence-Based Practices: Outreach to community organizations, schools, faith community, and medical community to identify potential at-risk pregnant and parenting clients. Case managers use an evidence-based curriculum with participants to provide education and increase parent-child interaction. Participants are encouraged to set their own goals and are supported in goal-setting through the use of motivational interviewing techniques and engagement sessions. Participants are referred to community resources for mental health needs, housing and other necessities. Project staff and partners undergo training in cultural competence, engagement and motivational interviewing techniques, and in Wellness Recovery Action Plan (WRAP) facilitation.

Results: MVNA served 46 women and 35 children aged 0-12. As a result, 100 percent now have a Medical Home, 93 percent of women and children served have insurance, 100 percent have up-to-date immunizations, and 85 percent of children over 4 months of age received developmental screening. 100 percent participated in education with 636 episodes of training, receiving information on 66 different topics. Professional development: two case managers were trained in Integrated Strategies, an evidence-based training to support home visitors; two case managers received a refresher course in the Engagement Sessions communication technique; and two case managers received training in the basic WRAP model as well as how to facilitate a group for participants.

Outcomes: *Families received education and support:* 26 referrals were made to community resources for identified needs (e.g., child care, dental, employment, education, etc.). *Case managers provided culturally sensitive services*: 13 respondents completed a satisfaction survey; 100 percent of the respondents felt their case manager respected their family traditions and values; 85-100 percent of the families said their home visitor helped them access necessary community resources; 85-100 percent said they were more confident as a parent because of the home visits; 100 percent of families would recommend this home visiting program to other parents. *At-risk families were identified and enrolled*: Using the Prenatal Risk Overview (PRO) assessment tool, 23 families were identified as potentially eligible for the program, 20 were screened and enrolled, and three could not be found. *Healthy birth outcomes*: For women pregnant at admission, three had low birth weight and one had very low birth weight babies; 75 percent of the babies had a healthy weight between 2501 and 4000 grams. *Infant and child injury*: Four children were seen by a medical provider for illness or injury.

Key Lessons Learned: Collaboration is key to providing for the needs of participants. Each participant is unique and no one person or organization has the skills or resources to meet every need. Through collaboration, resources to address immediate needs such as food, clothing, housing and transportation become available, and this also helps build trust with the case manager and improve participant retention. Train staff in evidence-based communication techniques that respect participants' past experiences and acknowledge that they are the experts on what they need to be healthy and successful parents. Through motivational interviewing and engagement sessions, individuals and their culture are respected while helping them find their own answers to their problems and set their own goals for themselves and their families. Involve participants in program development and give them a voice in how services are provided.

7. Teen Pregnancy

Health Disparity Context

- The teen birth rate has declined dramatically in Minnesota for all population groups over the past 25 years. Nevertheless, youth of color and American Indian still have significantly higher birth and pregnancy rates than their white counterparts.
- From 2010-2014, the birth rate for white females aged 15-19 was 12.8 per 1,000. On the other hand, birth rate for Asian Pacific Islander teens was 26.3; for African/African American teens it was 39.7; for Latinas it was 48.3; and for American Indians it was 57.7 per 1,000.
- The cost of teen childbearing for Minnesota taxpayers was at least $146 million in 2010. This includes costs such as cost of health care, foster care, incarceration, and lost tax revenue. The estimated cumulative cost to taxpayers associated with the 103,902 teen births in Minnesota between 1991 and 2010 are $4.0 billion for that period.[12]

Teen Pregnancy
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=22; FY 2014=15)

Objectives
- Improve the sexual health of young people
- Reduce the risk factors and increase the protective factors related to teen pregnancy

Strategies	# FY 2013 Grantees	# FY 2014 Grantees
• Improve clinic practices to better reach young people	5	**5**
• Improve sexual health education of young people	15	7
• Increase parent-child connectedness and communication	8	6
• Increase school connectedness	9	8
• Increase opportunities for young people that help grow a sense of competence, connection and contribution	8	10
• Delay early sexual activity with a special focus on young adolescents	10	6
• Reduce sexual activity or increase condom and contraceptive use	10	9

Types of Activities

Example of Evidence-Based Strategies
- Implement evidence-based programs in local schools or in after-school or community programs that discuss abstinence, contraception, and condom use (e.g., *Celebration of Change for African American Females, Becoming a Responsible Teen, Making Proud Choices, SiHLE, Healthy Hmong Teen*)
- Implement sexuality education for American Indian youth (e.g., *Live It!*)
- Implement a service learning program (e.g., *Teen Outreach Program (TOP)*

Example of Promising Practices
- Establish policies and procedures that will ensure that all clinic staff are trained on the unique development and health needs of culturally diverse adolescents

Example of Culturally Responsive Strategies
- Implement an evidence-based program that increases parent and child communication about adolescent development and relationships (e.g., *Padres Informados, Jovenes Preparados* curriculum; *Plain Talk/Hablando Claro*)
- Implemented *Celebration of Change for African American Females* program, a culturally responsive and evidence-base curriculum

[12] Health Disparities Context from EHDI 2015 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp2015/2015ehdirfp.pdf

Featured Grantee – HealthFinders Collaborative (Mejorando la Salud de los Adolescentes or MESA)

Populations Served: Hispanic/Latino population of Rice County

Community Partners*:* Growing Up Healthy, Rice County Family Services Collaborative, Rice County Chemical Health Coalition, Tackling Obstacles and Raising College Hopes (TORCH), Northfield and Faribault Public Schools, Northfield Healthy Community Initiative (HCI), Rice County Social Services, City of Northfield's Mayor's Task Force on Youth Alcohol & Drug Use, and local businesses.

Objectives/Strategies: The goal of the Rice County MESA (Mejorando la Salud de los Adolescentes) initiative is to reduce the teen pregnancy rates and improve the sexual health of Latino teens in Rice County in order to reduce the gaps in teen pregnancy and HIV/STD rates between the Latino and other populations in Rice County. The MESA model focuses on reducing risk factors and increasing protective factors, and stresses the importance of teens' connections with their families and other caring adults, schools, and medical providers. It also advocates for lasting systems change.

Key Activities and Evidence-Based Practices: MESA uses evidence-based or promising and culturally responsive models *Teen Outreach Program* (TOP), *¡Cuidate!, Draw the Line/Respect the Line*, and *Eat! Talk! Connect!* Latino-specific interventions include: TOP clubs for middle and high school students; *Comadres/ Compadres* for teens; free Teen Clinic; parent education and family connectedness initiatives; and Neighborhood Teams that promote leadership. MESA works with school administrators and health providers, educating them on Latino youth health issues and advocating for policy changes that increase school connectedness among Latino students and improve Latinos' experience at hospitals and clinics.

Results: MESA directly reached 4,492 individuals and indirectly reached 3,143 people in the area of teen pregnancy. Participation included: 174 Latino youth in TOP, 79 Latino youth in *Comadres/Compadres,* 44 Latino youth served by the Teen Clinic, 31 Latino parents in school policy change efforts, 22 school staff and 33 medical providers in Rice County received training on teen pregnancy rate disparities and serving the needs of Latino youth, 54 stakeholders participated in medical policy change efforts, and 52 Latino community members in Neighborhood Team activities.

Outcomes: In the TOP program, none got pregnant or caused a pregnancy, and 91 percent reported it's easy for them to stick to their plans and accomplish their goals. In *Comadres/Compadres*, 100 percent reported abstaining from sex or always using a condom. Post-training survey findings revealed that 77 percent of 22 school staff felt more knowledgeable about issues impacting Latino youth, and 100 percent of 33 medical providers learned new information about the cultural and developmental needs of Latino teens and available local resources for Latino/Latina teens. Of the 82 Latino parents who participated in *Eat! Talk! Connect*, 96 percent reported that they have enhanced their skills and/or confidence in talking with their teens about important issues like abstinence, and 67 percent reported having more meals together.

Key Lessons Learned: Making decisions collaboratively ensures ongoing buy-in to the project, its goals and outcomes. Ensuring youth and parents have an active role in the project improves programming and fosters leadership and gives them a voice. Community-specific solutions are important. Greater success is possible when the unique attributes of community life and systems are taken into account. It is important to be patient and take a longer view of community change, particularly at the systems level, and to recognize that smaller, incremental change can lead to larger change.

8. Unintentional Injury & Violence

Health Disparity Context

- Examples of unintentional injury and violence cases are motor vehicle crashes, falls, home fires, poisonings, suicide and self-inflicted harm, and sexual violence.
- From 2009-2013, accidents (unintentional injuries) were the third leading cause of death in Minnesota, comprising 5.9 percent of all deaths at 2,405 deaths or a rate of 44.4 per 100,000 Minnesotans. Intentional self-harm (suicides) was the ninth leading cause at 1.7 percent of all deaths, numbering 678 at the rate of 12.5 per 100,000.[13]
- The rates of unintentional injury and suicide were highest among American Indians. It is the only group that showed a disparity for these two causes, being 2.7 times and 1.5 times as likely to die as whites from unintentional injury and suicide, respectively (Table 15).
- All populations of color and American Indians are more likely to die from homicides compared to whites. The homicide rate for African Americans is ten times than for whites; for American Indians it is nine times higher (Table 15).
- Sexual violence is a major public health problem in Minnesota, and is a costly burden. In 2005, for example, 77,000 sexual assaults occurred in Minnesota, costing the state almost $8 billion or $1,500 per resident.[14]
- Some populations in Minnesota at a higher risk for being sexually assaulted: children and adolescents; females; people of color and American Indians; people with disabilities, are homeless, and with mental illness; human trafficking victims; and lesbian, gay, bisexual, transgender and questioning (LGBTQ) individuals.[15]

Table 15. Selected unintentional injury and violence mortality rates per 100,000 by race/ethnicity, Minnesota 2009-2013[1]

	African American	American Indian	Asian	Hispanic*	White
Unintentional Injury					
Current Rate	38.4	103.7	18.6	24.9	37.8
Current Ratio to White	1.0	2.7	0.5	0.7	
Homicide					
Current Rate	12.0	9.1	2.3	3.0	1.2
Current Ratio to White	10.4	7.9	1.7	2.6	
Suicide					
Current Rate	6.8	17.3	7.6	3.8	11.9
Current Ratio to White	0.6	1.5	0.6	0.3	

*Hispanic can be any race

[1]Mortality rates are age adjusted to the US 2000 Standard Population

SOURCE: Minnesota Department of Health, Center for Health Statistics

[13] CDC. (2014). *Deaths, percent of total deaths, and death rates for the 15 leading causes of death: United States and each State, 2009-2013*. Retrieved from: http://www.cdc.gov/nchs/data/dvs/LCWK9_2013.pdf

[14] Minnesota Department of Health. (2007). *Costs of sexual violence in Minnesota*. St. Paul: Minnesota Department of Health. Retrieved from: http://www.health.state.mn.us/injury/pub/svcosts.pdf

[15] Minnesota Department of Health. (2009). *The promise of primary prevention of sexual violence*. St. Paul: Minnesota Department of Health.

Unintentional Injury and Violence

EHDI Grantee Project Objectives, Strategies and Activities (FY 2013=5; FY 2014=5)

Objectives

- Prevent unintentional injuries and violence
- Reduce the risk factors that can lead to unintentional injuries and violence

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Improve road and trail safety	0	0
• Improve home safety	2	9
• Prevent suicide and self-inflicted harm	3	1
• Prevent traumatic brain injuries	0	3
• Prevent injuries from assaults	2	3
• Decrease sexual violence	2	3
• Increase physical activity	2	1
• Decrease alcohol misuse	1	1

Types of Activities

Example of Evidence-Based Strategies

- Use of the Health Care Home (HCH) model, a primary care approach in which primary care providers, families and patients work in partnership to improve the health and quality of life of individuals with chronic health conditions and disabilities.
- Use of the "*Girls Circle Heart*" curriculum which focuses on trauma recovery by addressing the issues of sexual abuse and violence in the lives of girls

Example of Promising Practices

- Encourage people who are at high risk for suicide or self-inflicted harm to exercise regularly, participate in culturally and linguistically appropriate counseling or therapy programs, and comply with prescribed medications
- Use of the Native Wellness Institute's Leading the Next Generation program, utilizing two Promising Practice curriculums for American Indian Women 21 years and older: '*Healthy Relationships*" and "*Healing & Wellness: Growing Beyond Multi-Generational Impacts of Historical Trauma*"

Example of Culturally Responsive Strategies

- Use of Family Parallel Care approach to address needs of parents and youth in a parallel fashion based on the core traditional Latino value of familismo
- Use of Durano Mother School, a culturally specific parenting and family enrichment module

Featured Grantee – Minnesota Indian Women's Resource Center (Healing Journey and Oshkiniigikwe)

Populations Served: American Indian

Community Partners: Minneapolis Police Department Sex Crimes Unit (MPD SCU), Native American Community Clinic (NACC), Ain Dah Yung Center, Community Advisors (Elders and other stakeholders in the urban and reservation-based American Indian communities), contractors (therapists).

Objectives/Strategies: Healing Journey and Oskiniigikwe ("young woman" in the Ojibwe language) are culturally-grounded programs offering supportive individual and group activities and counseling for American Indian women and girls at high risk for unintentional injury and violence. They are based on two proven-effective theories: harm reduction and the Ojibwe teaching zhoo-way-nah-dig, "taking care of each other." Clients are connected with a Native support system of staff, elders, peers, and consultants.

Key Activities and Evidence-Based Practices: The Healing Journey program serves adult American Indian women suffering from chronic chemical dependency and mental health issues, while the Oshkiniigikwe program serves American Indian females aged 11-21 who are at extremely high risk for developing chronic social and medical health problems related to ongoing violence and trauma exposure. Services for both programs include: individual case management, peer support group, sexual assault counseling, holistic health practices, traditional healing activities, and cultural recreational and educational activities. The Oshkiniigikwe program has partnered with a company to offer internships to older participants.

Results: Thirty American Indian women and girls were served by both programs. At intake, one-third of the Healing Journey clients were either homeless or living in a violent/unstable home; at the end of the grant year, 100 percent were living in safe/stable housing. Healing Journey had 16 participants who attended group activities and received case management assistance, and Oshkiniigikwe provided case management to 22 participants and 14 attended group activities. A Mental Health Case Manager was added for participants struggling with mental illness and/or have a history of being victims of commercial childhood sexual exploitation. MIWRC conducted 51 trainings and workshops and participated in 14 workgroups and collaborations on the trafficking of Native women and girls which reached 1,388 individuals.

Outcomes: 90 percent of Healing Journey and 75 percent of Oshkiniigikwe program participants increased their ability to identify and reduce avoidable risk factors. Participants in both programs were accruing 2 or more months of sobriety. 88 percent of Healing Journey participants and 100 percent of Oshkiniigikwe participants successfully completed safety and housing plans with program staff. 100 percent of participants in both programs felt they had made some improvement in life areas such as learning to accept help; taking care of their own physical, emotional and spiritual needs; and, having healthy and positive friends. MIWRC raised awareness around trafficked Native women/girls through the many trainings, workshops, presentations and collaborations in which it took part.

Lessons Learned: Taking a balanced, holistic approach to assisting clients facing immediate crises while also supporting their physical, emotional, psychological, and spiritual health on a consistent basis has positive impact on clients' overall healing process. Hiring a female Mental Health Case Manager added immensely to the quality of programing. Providing opportunities for youth program participants to share their experience and expertise has greatly contributed to boosting their self-esteem and self-confidence.

Summary of Grant Activities in Community Primary Prevention (CPP)

Community Primary Prevention (CPP) includes processes and initiatives that enable people to increase control over their health and to improve their health. CPP includes policy, system and environmental change strategies that encourage healthy lifestyles and foster healthy and safe environments. The purpose of CPP is to create the conditions in a community that will support health, and slow or reverse the growth in prevalence of disease and injury by preventing the onset of disease and injury. Policy, system and environment changes take place when community members are engaged, and all stakeholders share the decision making power through true collaboration. Grantees receiving CPP grants are using innovative ideas, concepts and approaches in creating partnerships and collaboration among entities that have the potential to impact the conditions that eliminate or reduce disparities in the EHDI PHAs among populations of color and American Indians.

Community Primary Prevention (CPP)
EHDI Grantee Project Objectives, Strategies and Activities (FY 2013 =2; FY 2014=2)

Objectives

Community Primary Prevention

- Engage young AAPI women as health leaders
- Collect AAPI young women's sexual health data
- Build community connections
- Increase community participation

Strategies	**# FY 2013 Grantees**	**# FY 2014 Grantees**
• Innovative, collaborative, community-based participatory action research program	1	1
• Train youth and adults in community organizing	1	2
• Forming partnerships to support social, racial and economic justice, and culturally competent service delivery	1	1

Types of Activities

Example of Promising Practices

- Conducted participatory action research with young people
- Hired youth from the community to engage other individuals and systems on creating an agenda to improve health by improving the social conditions in their community

Example of Culturally Responsive Strategies

- Developed a culturally relevant college course for Asian Americans using a culturally competent model of empowerment, leadership development, and advocacy
- Created a Youth Cooking Club for African-American youth to dispel myths about what African-Americans will or will not eat and introduce them to healthy foods they are unfamiliar with

Featured Grantee - National Asian Pacific American Women's Forum Minnesota Young Women's Collaborative

Populations Served: Asian American and Pacific Islander (AAPI) female college students in the Twin Cities.

Community Partners: Key partners include: University of Minnesota (UMN) Asian American Studies Department, UMN Women's Center, and UMN Center for Applied Research and Educational Improvement.

Objectives/ Strategies: The Minnesota Young Women's Collaborative (MYWC) is a culturally appropriate community-based participatory action research project based at the UMN. Through empowerment and skill building, AAPI college students lead and develop their own "research to action" campaigns on AAPI women's health issues that impact their communities. The strategy is to build an effective and culturally competent model of empowerment, leadership development, and advocacy on college campuses to cultivate the next generation of AAPI activists who are committed to public health, movement building, and social change.

Key Activities and Evidence-Based Practices: A year-long Asian American Studies/Gender, Women and Sexuality Studies course is taught at the UMN Twin Cities campus entitled "Asian American Health and Research" focusing on AAPI identity, AAPI women's reproductive and sexual health, and research methods. Students in the class develop and implement a community-based participatory research project and apply the results to support advocacy projects and campaigns.

Results: Nine students participated in fall 2013 classes and 12 participated in spring 2014 classes (8 continuing from fall 2013). Eleven students participated in the National Asian Pacific American Women's Forum (NAPAWF) Power Up! Summit and 12 participated in their advocacy training. Twelve students participated in the Council on Asian Pacific Minnesotans Advocacy Rally. Four AAPI reproductive health fact sheets were created based on data from the Health Behaviors of College Women Survey on topics that included: Pap test/HPV, sex education, relationships, and contraception. Students planned and implemented 12 social action projects on campus and in the larger AAPI community. They created and disseminated informational brochures on health-related topics and conducted workshops on domestic violence at two AAPI community organizations. They reached a total of 250 AAPI Minnesotans directly, and approximately 1,200 AAPI Minnesotans indirectly with current, research-based health information.

Outcomes: The fall class cohort learned about AAPI women's health issues, produced a research survey tool and interview protocol, gathered data using these instruments and learned the principles of community-based research and its role in supporting advocacy projects and campaigns. The spring 2013 cohort gained experience analyzing data from the Health Behaviors of College Women Survey and creating fact sheets on AAPI women's issues using the survey data. A pre-post survey and focus groups conducted with participants revealed that they: increased their understanding of, and developed skills conducting, community-based participatory research; gained experience disseminating research findings; developed and enhanced their advocacy, activism, and leadership skills; increased their knowledge of AAPI women's reproductive health and justice issues, have applied this knowledge to their own lives and shared it with others; and, became empowered to advocate for their AAPI community.

Lessons Learned: An effective way to recruit new participants is by program alumni spreading the word about the program to their peers. MYWC alumni are interested in staying connected to the program through summer internships and alumni networking events. Having the students present the course model and their research at a professional conference creates a tremendous impact on their experience in the program. It is important to allow students to create and conduct social action research projects on the topics that are interesting and relevant to them. Also, allowing them to collaborate with other community organizations that they are connected to or that serve their families and community creates a sense of agency for the students.

V. EHDI Evaluation and Capacity Building

EHDI grantees were required to conduct an evaluation of their program activities. Each grantee created a logic model and evaluation work plan for this purpose. There were no prescribed evaluation outcome measures; rather, grantees were encouraged to develop and implement community-based solutions to address health disparities and utilize community input in the process. The EHDI grantees included in this document reported progress in program outcomes, outputs and processes. Examples of specific program results by PHA can be found in the Featured Grantee pages in Section IV of this report.

Outcomes are changes observed in or reported by participants as a result of program interventions. Examples of grantee outcomes include the following:

- Increased knowledge/awareness/understanding of risk and protective factors, importance of prevention and screening, disease management, culture and cultural identity as protective factors, resources and assistance
- Improvement in health status indicators or conditions such as improved blood pressure or cholesterol, increased strength and flexibility or overall fitness, improved mental health or getting immunized
- Improved behavior such as increased physical activity and consumption and preparation of healthier foods, getting regular preventive screening for breast and cervical cancer
- Improved skills or new skills learned, for example, parenting skills and advocacy and leadership skills

Outputs are counts of people, events, or products at a single point in time (i.e., not comparing across time). Outputs reported by grantee include:

- Participation in classes, activities, or events
- Services to the community such as testing/screening/assessment, culturally supportive care coordination and navigation, case management, interpretation/translation, transportation, vaccination, monitoring of biometrics (height, weight, BMI, etc.), referral, or training
- Outreach sites, activities, or reach including the number of events, trainings, workshops, classes, health fairs, pow-wows, immunization, HIV testing, presentations, and farm tours
- Products, for example, number of cookbooks, garden totes, Gardens in a Box, home safety kits, health brochures or image-based nutrition education tools developed or distributed

Processes are activities completed that have helped improve EHDI grantee programs. Examples of processes that grantees reported are:

- Conducted satisfaction surveys with stakeholders and received suggestions for improving the program's education sessions and materials
- Developed monitoring processes, for example, if screening tests are being scheduled or if follow-ups with participants with abnormal screening results are being conducted
- Increased capacity to serve their populations, for example, improved use of online data management tools, hiring additional staff, stronger relationships with existing partners, and developed new partnerships, or improved program design by implementing an evidence-based curriculum

Evaluation Capacity Building & Technical Assistance

MDH is committed to evaluating individual grantee outcomes and strengthening the capacity of organizations to reduce disparities through shared learning and evaluation. As part of this process,

EHDI provides grantees with individual evaluation technical assistance and support and has created a community of practice for ongoing learning.

Evaluation Technical Assistance (TA) and Support

In FY 2013, MDH contracted with an evaluation consulting organization, Rainbow Research, Inc., to be the Evaluation Technical Assistance (TA) and Support provider for EHDI. Rainbow Research's Evaluation TA and Support Team was made up of five consultants with extensive experience working with populations of color and American Indians.

Support from the Evaluation TA and Support Team included:

- Customized, culturally responsive, one-to-one consultation
- Assistance with developing logic models and evaluation and reporting work plans
- Assistance with progress and final reports
- Training on evaluation approaches and outcomes reporting
- Interactive small group sessions for grantees serving similar populations and/or addressing similar PHAs
- Developing evaluation tools and resources and tools

In FY 2014, MDH renewed its contract with Rainbow Research, Inc. focused on reporting and dissemination of EHDI outcomes. Specifically, Rainbow would develop with MDH a final report template for grantees, create a two-page summary for each grantee based on data from their final reports, and develop a communication plan for EHDI grantees and CHE/MDH for publicly sharing the grantee two-page summaries.

Community of Practice

In 2010, MDH created a web portal for EHDI grantees with the goal of creating a "community of practice." Through the website, professional development webinars and grantee gatherings, grantees are encouraged to: 1) strengthen their relationships with other organizations who are actively working to eliminate health disparities, 2) share knowledge, tools and ideas, and 3) learn about new strategies and approaches being used locally and nationally to address social determinants of health. Evaluation materials developed by Rainbow Research including training presentations, tip sheets, templates and program summaries were uploaded to the grantee portal. Grantees are also brought together bi-annually to share work progress, receive updates from MDH and OMMH, and participate in evaluation training

The EHDI grantee portal can be found on the OMMH EHDI website (http://www.health.state.mn.us/ommh/grants/ehdi/portal/index.html).

VI. Conclusions

MDH's mission is to protect, maintain, and improve the health of all Minnesotans. The elimination of health disparities and advancement of health equity are department-wide goals. Achieving optimal health for all Minnesotans requires creating an environment where everyone has access to what they need to be healthy.

Minnesota's reputation as a healthy state obscures significant and longstanding health disparities that are the result of inequitable opportunities to achieve optimal health for some populations in Minnesota. Populations of color and American Indians in Minnesota experience higher rates of many chronic and infectious diseases and experience premature death at higher rates than whites in Minnesota.

> *"Of all the forms of inequality, injustice in health is the most shocking and the most inhumane."*
>
> The Rev. Martin Luther King, Jr., at the Second Annual Convention of the Medical Committee for Human Rights, Chicago, March 25, 1966

The Center for Health Equity (CHE) provides leadership to make advancing health equity an essential goal for a healthy Minnesota and the work of MDH. The Eliminating Health Disparities Initiative (EHDI) is a grant program within the CHE, designed to strengthen local control and decision-making in communities across the state toward the elimination of health disparities. Since 2002 when grants were first awarded, the EHDI has been at work to eliminate disparities by strengthening the capacity of communities of color and American Indian communities to create their own healthy futures and by capitalizing on the opportunity that exists to influence health in early childhood and throughout the lifespan.

EHDI is grounded in the philosophy that community issues require community solutions. By empowering community-based organizations to develop health improvement strategies that build on community strengths, community members are more likely to be reached, engaged, and impacted. Over the years EHDI grantees have built on these community strengths to guide their work: cultural values, history, and heritage; strong family and social networks; long-standing and trusted institutions such as faith-based organizations; and, respected community elders and leaders.

Evaluation results indicate that the community grantees highlighted in this report proved to be valuable investments. The grantees reached a total of 66,135 individuals through direct one-on-one contact and 220,157 individuals through indirect contact (e.g., large classes or workshops and health fairs) during FY 2014. Grantee program evaluations have documented a number of health improvement and prevention outcomes such as decreased blood pressure levels, increased rates of preventive cancer screening, lower body mass index and increased healthy eating and physical activity, increased up-to-date immunizations and improved mental health. They also reported improved or new skills in areas such as parenting, leadership, advocacy, and participatory research. Evaluation results also documented expanded capacity of grantee organizations to better serve communities of color and American Indians through efforts such as the hiring of individuals that represent the population to be served (e.g., community health workers), developing partnerships with other organizations, and improving project management.

We have learned a great deal from the EHDI grant program but as we move into the future, there are several considerations for action to support the work of EHDI grantees:

- Continued engagement of stakeholders from the community, government entities, faith-based organizations, health care systems and more to identify gaps in EHDI-based efforts and select priorities for action to eliminate health disparities in populations of color and American Indians.

- Forming expert partnerships to develop data collection standards and improve the quality and consistency of race-specific, ethnic-specific, and language-specific information that can be shared and compared within MDH and across the state.

- Continuing to support partnerships that are working toward the kinds of policy, systems and environmental changes that will make a long-term impact on the health of populations of color and American Indians.

- Building the capacity needed to make sure that action is taken to eliminate and prevent health disparities and assure that these efforts become part of ongoing practice in MDH and across the state.

- Supporting efforts to improve the negative social, economic and environmental conditions that create health disparities among populations of color and American Indians, including the long-standing effects of historical trauma and structural racism.

Effectively addressing health disparities and the underlying causes of these disparities requires a comprehensive and community-driven approach. The EHDI grantees in partnership with MDH and the Minnesota State Legislature are committed to making an impact on these disparities and inequities through their efforts. The EHDI provides an investment in moving this work forward and supporting the current and future health of Minnesota's populations of color and American Indians and the state a whole. Results indicate that the EHDI grant program is continually makes strides in reducing disparities and improving health for all Minnesotans.

APPENDIX A EHDI Legislation

MINNESOTA STATUTES 2010 145.928

145.928 ELIMINATING HEALTH DISPARITIES.

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

Subd. 2. State-community partnerships; plan. The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Minnesota Council on Latino Affairs under section 15.0145; the Council for Minnesotans of African Heritage under section 15.0145; the Council on Asian-Pacific Minnesotans under section 15.0145; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

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

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

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

Subd. 6. Process. (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3. (b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. Community grant program; immunization rates and infant mortality rates. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:
(1) decreasing racial and ethnic disparities in infant mortality rates; or
(2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.
(b) The commissioner may award up to 20 percent of the funds available as planning grants.
Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner.
A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.
(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:
1) is supported by the community the applicant will serve;
(2) is research-based or based on promising strategies;
(3) is designed to complement other related community activities;
(4) utilizes strategies that positively impact both priority areas;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7a.Minority-run health care professional associations.
The commissioner shall award grants to minority-run health care professional associations to achieve the following:
(1) provide collaborative mental health services to minority residents;
(2) provide collaborative, holistic, and culturally competent health care services in communities with high concentrations of minority residents; and
(3) collaborate on recruitment, training, and placement of minorities with health care providers.

Subd. 8. Community grant program; other health disparities. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:
(1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;
(2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;
(3) decreasing racial and ethnic disparities in morbidity and mortality rates from
cardiovascular disease;
(4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or
(5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.
(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.
(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.
(d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:
(1) is supported by the community the applicant will serve;
(2) is research-based or based on promising strategies;
(3) is designed to complement other related community activities;
(4) utilizes strategies that positively impact more than one priority area;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. Health of foreign-born persons. (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:
(1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;
(2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;
(3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and
(4) $50 per foreign-born person in the community health board's service area.

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

Subd. 10. Tribal governments. The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.
Subd. 11. Coordination. The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

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

Subd. 13. Report. (a) The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003. (b) The commissioner shall submit an annual report to the chairs and ranking minority members of the House of Representatives and senate committees with jurisdiction over public health on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the previous fiscal year beginning January 15, 2016.

Subd. 14. Supplantation of existing funds. Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

Subd. 15. Promising strategies. For all grants awarded under this section, the commissioner shall consider applicants that present evidence of a promising strategy to accomplish the applicant's objective. A promising strategy shall be given the same weight as a research or evidence-based strategy based on potential value and measurable outcomes.

APPENDIX B EHDI FY 2013 Grantees by Grant Type and Priority Health Area

EHDI FY 2013 Grantees (40)	Community Primary Prevention (CPP)	Priority Health Areas							
		Breast & Cervical Cancer Screening	Diabetes	Heart Disease & Stroke	HIV/AIDS & STDs	Immunizations for Adults & Children	Infant Mortality	Teen Pregnancy	Unintentional Injury & Violence
African American AIDS Task Force					●				
American Indian Family Center							●		
Annex Teen Clinic*					●			●	
Asian Media Access								●	
A.S.P.I.R.E. Youth Agency								●	
Axis Medical Center						●			
Big Brothers Big Sisters								●	
Boys & Girls Club of the Twin Cities								●	
CAPI						●			
Centro, Inc.*					●			●	
Community University Health Care Center									●
Crown Medical Center			●						
GMCC Division of Indian Works*								●	
Health Finders Collaborative					●			●	
Hennepin County Medical Center*					●			●	●
High School for Recording Arts*								●	
Hmong American Partnership		●							
Indigenous Peoples Task Force*					●			●	
Isuroon								●	
Korean Service Center									●
Lao Family Community of Minnesota, Inc.*								●	
Leech Lake Band*							●		
Lutheran Social Services of Minnesota*								●	
Minnesota African Women's Association								●	
Minnesota Immunization Networking Initiative*						●			
Minneapolis American Indian Center			●	●					
Minnesota Visiting Nurse Agency							●		
Minnesota Indian Women's Resource Center*									●
National Asian Pacific American Women's Forum	●								
NorthPoint Health & Wellness Center, Inc.*			●	●					
Open Cities Health Center		●	●				●		
Peta Wakan Tipi*			●						
Planned Parenthood MN, ND, SD*					●			●	
Pillsbury United Communities*			●	●					

EHDI FY 2013 Grantees (40)	Community Primary Prevention (CPP)	Priority Health Areas							
		Breast & Cervical Cancer Screening	Diabetes	Heart Disease & Stroke	HIV/AIDS & STDs	Immunizations for Adults & Children	Infant Mortality	Teen Pregnancy	Unintentional Injury & Violence
Sabathani Community Center			●					●	●
Saint Mary's Clinic		●	●						
Saint Paul Ramsey County Public Health								●	
Saint Paul Area Council of Churches*			●						
Southeast Asian Community Council								●	
Stairstep Foundation			●						
Summit University Teen Center								●	
TeenWise								●	
The Indian Health Board of Minneapolis*		●		●					
The Neighborhood Hub*	●								
Turning Point, Inc.					●				
WellShare International*			●	●					
YWCA of Minneapolis*								●	
Total Number of Grantees (47)	**2**	**4**	**11**	**5**	**8**	**3**	**4**	**22**	**5**

*Also a 2010-2012 grantee

APPENDIX B EHDI FY 2014 Grantees by Grant Type and Priority Health Area

EHDI FY 2014 Grantees (40)	Community Primary Prevention (CPP)	Priority Health Areas							
		Breast & Cervical Cancer Screening	Diabetes	Heart Disease & Stroke	HIV/AIDS & STDs	Immunizations for Adults & Children	Infant Mortality	Teen Pregnancy	Unintentional Injury & Violence
African American AIDS Task Force					●				
American Indian Family Center							●		
Annex Teen Clinic*					●			●	
Axis Medical Center						●			
Big Brothers Big Sisters of the Greater TC								●	
CAPI USA						●			
Centro, Inc.*					●			●	
Community-University Health Care Center									●
Crown Medical Center			●						
GMCC Division of Indian Work*								●	
HealthFinders Collaborative					●			●	
Hennepin County Medical Center*					●			●	●
High School for Recording Arts*								●	
Hmong American Partnership		●							
Indigenous Peoples Task Force*					●			●	
Korean Service Center									●
Lao Family Community of Minnesota*								●	
Leech Lake Band of Ojibwe							●		
Lutheran Social Services of Minnesota*								●	
Minnesota African Women's Association								●	
Minneapolis American Indian Center			●	●					
Minnesota Immunization Networking Initiative*						●			
Minnesota Indian Women's Resource Center*									●
Minnesota Visiting Nurse Agency							●		
National Asian Pacific American Women's Forum	●								
Neighborhood Hub*	●								
NorthPoint Health and Wellness Center, Inc.*			●	●					
Open Cities Health Center		●	●						
Peta Wakan Tipi*			●						
Pillsbury United Communities*			●	●					
Planned Parenthood MN, ND, SD*					●			●	
Saint Paul Ramsey County Public Health								●	
Sabathani Community Center			●					●	●
Saint Mary's Health Clinics		●	●						

EHDI FY 2014 Grantees (40)	Community Primary Prevention (CPP)	Priority Health Areas							
		Breast & Cervical Cancer Screening	Diabetes	Heart Disease & Stroke	HIV/AIDS & STDs	Immunizations for Adults & Children	Infant Mortality	Teen Pregnancy	Unintentional Injury & Violence
Saint Paul Area Council of Churches*			●						
Stairstep Foundation			●						
The Indian Health Board of Minneapolis*		●		●					
Turning Point					●				
WellShare International*			●	●					
YWCA of Minneapolis*								●	
Total Number of Grantees (40)	**2**	**4**	**11**	**5**	**8**	**3**	**3**	**15**	**5**

*Also a 2010-2012 grantee