

SELECTED MDH STORIES OF ADVANCING HEALTH EQUITY

ASKING DIFFERENT QUESTIONS, CHANGING PRACTICES

Sickle Cell Disease Trait Testing

* ADDRESSES RECOMMENDATIONS 4 & 6

As a part of a regional collaborative with colleagues from other newborn screening programs in the summer of 2014, MDH learned that our Public Health Lab does far less in attempting to inform parents and providers when we find sickle cell trait in a newborn screening test, compared to neighboring states.

A “trait” finding does not mean that the newborn has sickle cell disease. Trait status is important information for families, as it can help them understand the chances of having a child with the disease.

This realization led the lab to ask questions that they could not answer without African American and West African communities’ input: *Do parents want to know their child’s trait status? And what is important in how that information is given back to families?*

To find out the lab conducted five focus groups with parents from the Twin Cities African American and West African communities.

The focus group conversations revealed that the community did wish to know about a child’s trait status and helped identify the important qualities needed for this information to be given in a helpful way.

This knowledge set the MDH lab on a course to change their practices around reporting and informing of sickle cell trait results in newborns. They developed a model - *informed by the community* - which is now used to inform the community.

Asking a different set of questions – *what do African American and West African families want?* – instead of relying a long-standing (and incorrect) assumption led to a change in core practices.

Now, the MDH lab informs both parents and providers of a newborn’s trait status, which means over 1,200 Minnesota families each year are being directly notified of the trait result of their newborn.

This has improved the odds that a family will learn this information about their child. Previously only about 26% of families knew about this result. Now 60% of providers report that families are getting this information about their newborns.

Family Spirit American Indian Family Home Visiting Program

* ADDRESSES RECOMMENDATION 4

Family Spirit is a culturally based, evidence-based, family home visiting model. It was developed by and for the American Indian community with Johns Hopkins University. The program builds on cultural strengths, emphasizing family involvement and parental education and providing support.

Family Spirit provides structured home visits by American Indian care professionals and paraprofessionals (i.e., nurses, elders, community members). It offers education and provides referrals to community resources while identifying and decreasing substance use and maternal depression.

In order to be certified to offer the program, Johns Hopkins requires and provides rigorous training and mentoring on the model. When state and tribal family home visiting partners in Minnesota first learned of this program in 2012, it generated a lot of enthusiasm. Minnesota's tribal health departments and the MDH Family Home Visiting program asked this question: *How can we work together to bring this special, but intensive, training here, so Family Spirit can be implemented in Minnesota?*

In February 2014, the partners were successful in bringing the Johns Hopkins staff to Minnesota for a Family Spirit training and a "train-the-trainer" session. At that time, 29 people in Minnesota were trained in the Family Spirit model, including staff from tribal nations and MDH. An MDH staff person who was trained now serves as a resource, providing support to all Minnesota tribes implementing Family Spirit.

As the program gains ground, sites are looking to adapt the program further to meet their needs. Nearly all have plans to increase their enrollment numbers and further collaborate with tribal and county partners to expand the program.

There are seven tribal reservations in Minnesota currently implementing the Family Spirit program, each in their own way to best meet the needs of their

community: Bois Forte, Fond du Lac, Grand Portage, Leech Lake, Lower Sioux, Mille Lacs and Red Lake.

Advancing Health Equity Grants

* ADDRESSES RECOMMENDATIONS 1 & 5

During conversations with community members about the Eliminating Health Disparities grants, the Center for Health Equity learned that community-based organizations wanted resources and needed support to strengthen their efforts to improve the conditions that create health.

Simultaneously, in response to community requests, the Minnesota State Legislature provided MDH with one-time, flexible funding to advance health equity. These calls from the community converged to create an opportunity to offer two Advancing Health Equity grants.

While developing the Advancing Health Equity request for proposals (RFP), MDH asked: *How we could partner with community-based organizations to improve conditions? How could the activities in these grants strengthen communities' capability to create their own healthy futures?*

MDH designed a grant that requires grantees to conduct an assessment of a specific health inequity and to identify the structural inequities that have contributed to the resulting poor health outcomes.

Grantees must work with community members to identify the relationships between the health inequity and structural inequities, determine the policy and systems changes needed, and develop a plan to address an identified structural inequity.

MDH received a number of strong applications. Working with a community grant review group, two grantees were selected: *Neighborhood Hub* and *Voices for Racial Justice*.

Neighborhood Hub is looking at the connection between housing and health in North Minneapolis. Voices for Racial Justice is looking at the connection between incarceration and health from the perspective of those most directly impacted: currently and formerly incarcerated people and their families.

These projects began in July 2016 and will conclude in December 2017. The models for change advanced through these grants will be assessed. In addition to looking at the success of these models, many questions remain to be answered, including: *Can MDH obtain more funding for this kind of grant? Is there a way to integrate successes into other MDH RFPs? Could another funder implement this same idea?*

Making Connections: Incarceration and the Health of Communities

[* ADDRESSES RECOMMENDATIONS 1 & 3](#)

In 2015, a group of Minnesota senators asked MDH for information on the links between incarceration and health. MDH leadership realized that the department could not do this work alone and convened representatives from other state agencies, the Governor’s Office, community-based organizations that advocate on criminal justice issues, formerly incarcerated people, MDH staff and others to explore these links.

MDH engaged ReThink Health in 2016 to facilitate two working sessions to develop a

shared, high-level understanding of the systemic impacts of incarceration on health.

Participants discussed the question: *What are the issues, opportunities and obstacles that impact incarcerated individuals and their families as they attempt to lead truly healthy lives?*

The three major themes identified by the participants, and substantiated by research, were:

1. The health impacts of incarceration can be lifelong, because incarceration limits opportunities and exposes people to trauma, disease, chronic stress, social stigma and exclusion.
2. Health impacts are intergenerational; having an incarcerated parent is recognized as a traumatic experience for the child and is linked to lifelong negative health outcomes.
3. High rates of incarceration impair the community’s health.

Participants also discussed how racism and underlying social, political and economic values shape today’s system of incarceration. They stated emphatically that additional community conversations are needed in order to complete the picture of the impact of incarceration on health. This information was shared with legislators.

By convening a broad range of partners and approaching incarceration through a public health lens, MDH created the opportunity for a different kind of conversation, and a different set of solutions. Next steps include additional conversations about the values that influence our current system of incarceration and identifying policy options and community investments to address the major themes raised by participants.

A Guide for Using Data to Identify Health Inequities

* ADDRESSES RECOMMENDATION 7

In April 2016, the MDH Center for Health Statistics published new tool called “Using Data to Identify Health Inequities: A Guide for Local Health Departments in Minnesota”. In developing this tool, the Center for Health Statistics team asked themselves this question: *How can we use data to help advance health equity?*

Moving beyond the analysis of poor health outcomes, the guide proposes that data be used to move “upstream” and expand our understanding of what creates health. It does so by looking at how health, social, and economic conditions vary between groups of people, while also examining the policies and systems that influence health.

The guide is a tool for communities to use to increase their understanding of what creates health; it builds their capacity at each intersecting level to identify disparities, investigate different causes of inequities, and use the data as evidence for enacting policy change.

Staff from the Center for Health Statistics, in partnership with the Office of Statewide Health Improvement Initiatives, are currently working with 10 Statewide Health Improvement Program (SHIP) grantees to pilot test the tool.

Beginning in June 2016, local health departments and the Center for Health Statistics, were able to supply a wealth of quantitative survey data, which helped grantees (and their community teams) identify initial health differences and disparities within their communities. From

there, grantees were responsible for gathering qualitative data in partnership with community members, especially with those most impacted by the health inequities.

The pilot is expected to conclude before the end of this year and MDH staff are actively seeking input and feedback from pilot communities to further refine the tool, while strengthening technical assistance and support. During 2017 the rest of the SHIP grantees will begin their assessments, which are now an expectation of the SHIP grant.

The results will not only inform the work of SHIP, and the local communities, but will emphasize the importance of moving towards addressing the differences on the community level.

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