



# Eliminating Health Disparities Initiative

GRANT REQUEST FOR PROPOSALS (RFP)

## IMPORTANT DATES

September 6, 2018	Request for Proposals (RFP) released
October 5, 2018	Notice of Intent due ( <i>strongly encouraged</i> )
November 28, 2018	Last day to submit RFP questions
December 10, 2018	Proposals due (until 11:59 pm)
July 1, 2019	Grants begin

Visit the **EHDI RFP webpage** at [www.health.state.mn.us/divs/che/funding/rfp2018/index.html](http://www.health.state.mn.us/divs/che/funding/rfp2018/index.html) for more information.

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9/6/2018

To obtain this information in a different format, call 651-201-5813.

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## RFP Part 1: Overview

### 1.1 General Information

- **Announcement Title:** Eliminating Health Disparities Initiative (EHDI) grants
- **Program Website:** [www.health.state.mn.us/divs/che](http://www.health.state.mn.us/divs/che)
- **Notice of Intent Deadline:** October 5, 2018 (*strongly encouraged but not required*)
- **Application Deadline:** December 10, 2018

### 1.2 Program Description

The Minnesota Legislature created the EHDI grant program in 2001 ([Minn. Stat. §145.928](#)). This law states that the goal of EHDI grants is to close the gap in the health status of populations of color and American Indians as compared with whites in the following priority health areas (PHAs):

- Breast and cervical cancer
- Cardiovascular disease
- Diabetes
- HIV/AIDS and sexually transmitted infections (STIs)
- Immunizations for adults and children
- Infant mortality
- Teen pregnancy prevention<sup>1</sup>
- Unintentional injuries and violence

Since 2001, the EHDI approach has been to support organizations and projects run by and for communities of color and American Indians to develop and implement strategies that are effective in reaching their communities. By investing in community-based organizations and tribes to develop health improvement strategies built on cultural knowledge and wisdom and community strengths, community members are more likely to be reached, engaged and impacted.

**The EHDI program is grounded in several principles, including:**

- Community issues require community solutions.
- Effective initiatives are co-created with and supported by the community served.
- Effective strategies are grounded in cultural knowledge and wisdom.
- Sustainable projects complement related community services and activities.
- Organizations that reflect the populations served are more likely to understand community experiences, connect with community and effectively support community solutions.

Applicants will be asked to show how their proposed project and their organization embody these principles in their application.

**The EHDI law states that priority will be given to projects based on promising strategies and/or projects that are research-based.**

- **Promising strategies** include practices that come from the local community that may be based on practice-based evidence (PBE) and/or lived experiences of communities of color and American Indians. PBE includes a range of approaches that are developed over time through practice and experience. PBE approaches are often embedded in the culture, accepted as effective by local communities and support community healing from a cultural framework.

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<sup>1</sup> Teen pregnancy prevention is not specified in state law. Federal TANF funding has been added to the state funding allocated for EHDI in order to address this particular health area.

- **Research-based projects** include projects that can be tied to and/or include elements that draw from published literature, including both qualitative and quantitative studies.

**EHDI grantees are not required to use evidence-based practices. Projects that are research-based and projects that are promising strategies will be given equal weight in the review process.** It is possible for projects to be both research-based and based on promising strategies; we do not view these two broad categories as mutually exclusive. All EHDI-funded projects must be grounded in community knowledge and wisdom.<sup>2</sup>

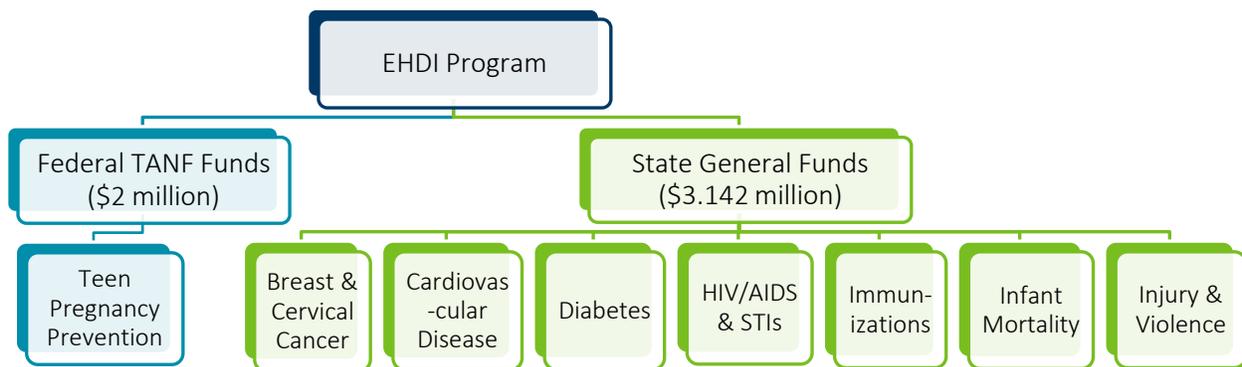
### 1.3 Funding and Project Dates

#### Funding

EHDI grant funding comes from two sources. Approximately **\$2 million in federal Temporary Assistance for Needy Families (TANF) funds** is available for grants for teen pregnancy prevention. Approximately **\$3.142 million in state general funds** is available for grants for breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, immunizations, infant mortality, and unintentional injuries and violence.<sup>3</sup> MDH anticipates awarding funding in all seven of these PHAs, but funding will not necessarily be equally distributed among the health areas; funding will depend on application scores and the need to balance funding to serve the breadth of populations, project strategies and geographic areas in Minnesota. Funding is contingent upon availability.

Funding will be allocated through a competitive process. If selected, you may only incur eligible expenditures when the grant agreement is fully executed and the grant has reached its effective date.

#### EHDI Funding Sources and Priority Health Areas



<sup>2</sup> Community knowledge and wisdom should be defined by the each project’s target populations. Within CHE, we view community knowledge and wisdom as valuing cultural ways of healing and recognizing health as a complete state of physical, mental, emotional and social wellbeing.

<sup>3</sup> A small portion of both the \$2 million in TANF funds and \$3.142 million state general funds will be retained for a separate RFP to fund an evaluation capacity-building provider to support EHDI grantees selected through this RFP.

Funding	Estimate
Estimated Amount to Grant	\$5,142,000 annually <sup>4</sup>
Estimated Number of Awards	25-30
Estimated Range of Award Amounts	\$100,000 - \$250,000 annually <sup>5</sup>

## Match Requirement

There is no match requirement.

## Project Dates

The estimated grant start date is July 1, 2019, and the projected end date is June 30, 2023. The grant period will be **four years**, contingent on satisfactory grantee performance and funding availability.

## 1.4 Eligible Applicants

Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, tribal governments, community health boards (CHBs) and community clinics<sup>6</sup>. Applicants must have state or federal recognition as a formal organization or entity, such as a Federal Employer Identification Number or 501c3 status. Organizations or groups that do not have state or federal recognition may apply with a fiscal agent<sup>7</sup>. Applicants must be located in and conduct grant activities in the state of Minnesota, but fiscal agents may be located outside of Minnesota. Eligible applicants who wish to work together but have not formed a legal partnership may designate one organization as a fiscal agent.

## Collaboration

Multi-organization collaboration is welcomed and encouraged. MDH recognizes that achieving health equity will happen only as we work together. Organizations that collaborate on proposals are encouraged to compensate partners appropriately for their contributions and to consider equity in deciding how resources are distributed among partner organizations. Depending on the number of collaborating organizations and the scope of their project, multi-organization collaborations may choose to request a higher award amount (toward the top of the estimated award range listed in the table above) than single-organization applicants.

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<sup>4</sup> Amount is contingent upon availability of funds.

<sup>5</sup> Depending on the strength and scope of proposals, final award amounts may be less than \$100,000 or more than \$250,000.

<sup>6</sup> **Community clinics** are defined by the Minnesota Association of Community Health Centers as “nonprofit clinics located in medically underserved areas – both rural and urban – throughout Minnesota. They share a mission of making comprehensive primary care accessible to anyone regardless of ability to pay.”

<sup>7</sup> A **fiscal agent** is an organization that assumes full legal and contractual responsibility for the fiscal management and award conditions of the grant funds and has authority to sign the grant agreement. A fiscal agent is often a different organization than the operating organization (which performs the work). In a multi-organization collaboration, however, one organization must be designated as the fiscal agent.

MDH recognizes the sovereignty of tribal nations. We will only fund non-tribal-led projects in tribal communities if the applicant has full support of the tribal government. If a non-tribal applicant proposes to work with a tribal government or tribal community, the applicant must be prepared to provide written verification that the tribal government approves of the project before a grant agreement can be made final. Written verification will be requested at the time an award is offered.

## Multiple Applications

An applicant may submit more than one application. Applicants should submit separate applications for each unrelated project.

Applicants may submit proposals for projects that address multiple PHAs. If a single project addresses multiple PHAs, the applicant should only submit one application. Applicants may apply for both state general funds and federal TANF funds for a single project if the project addresses a PHA funded by state general funds (breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, immunizations, infant mortality or unintentional injuries and violence) and teen pregnancy. Refer to the funding chart on page 4 for more information on funding sources and PHAs.

## 1.5 Questions and Answers

We request that all questions regarding this RFP be submitted through the online question submission form on the [EHDI RFP webpage](#). If for any reason you need to submit a question through an alternative format, please call 651-201-5813 for assistance.

MDH staff will post all questions and answers within seven business days on the [RFP Questions and Answers](#) page. Questions will generally be posted on Mondays; questions submitted by close of business Wednesday will generally be posted the following Monday. **Please submit questions no later than November 28, 2018.** To ensure all applicants have access to the same information, questions submitted after this date will not be answered nor posted to the website. The final questions and answers will be posted to the website on Monday, December 3.

To ensure the proper and fair evaluation of all applications, communications regarding this RFP, including verbal, telephone, written or internet, initiated by or on behalf of any applicant to any employee of MDH, other than questions submitted as outlined above, are prohibited. **Any violation of this prohibition may result in the disqualification of the applicant.**

While applicants may not communicate with MDH staff regarding the RFP itself, applicants may communicate with MDH staff regarding requests for data, information on health promotion or prevention practices and benchmarks and other content-related questions. Refer to Appendices C-J for contact information for MDH Priority Health Area (PHA) Specialists. MDH staff may not advise any grantees on their application or review drafts of proposals.

## RFP Information and Skill-Building Sessions

MDH will provide RFP information and guidance through one recorded webinar, four in-person information sessions (two in the Twin Cities metro area and two in Greater Minnesota) and two in-person skill-building sessions. Staff will not be able to help with the actual writing of applications or critiques of drafts, but can answer general questions about the process and requirements. There will be time set aside at each of the in-person sessions for applicants to network with each other with the goal of encouraging collaborative applications.

Though not required, prospective applicants are encouraged to participate in at least one information session or watch a recorded video of the webinar. Questions and answers from the in-person information sessions and materials from the in-person skill-building sessions will be posted on the [EHDI RFP webpage for those who are unable to attend](#).

For up-to-date information and to register for the sessions, visit the [EHDI RFP webpage](#). The recorded webinar will also be posted on the [EHDI RFP webpage](#).

### General Information Sessions

Type	Date	Time	Location
Webinar (will be recorded)	September 13, 2018	10-11 am	<a href="#">Register for the online session</a>
In-Person	September 14, 2018	2-3:30 pm	Government Services Center, 320 W. 2 <sup>nd</sup> St., Duluth, MN 55802
In-Person	October 2, 2018	6-8 pm	Wilder Foundation, 451 Lexington Pkwy N., St. Paul, MN 55104
In-Person	October 24, 2018	1-3 pm	UROC, 2001 Plymouth Ave. N., Minneapolis, MN 55411
In-Person	October 25, 2018	6-7:30 pm	Bemidji Northwest Indian Community Development Center 1819 Bemidji Avenue, Bemidji, MN 56601

### Skill-Building Sessions

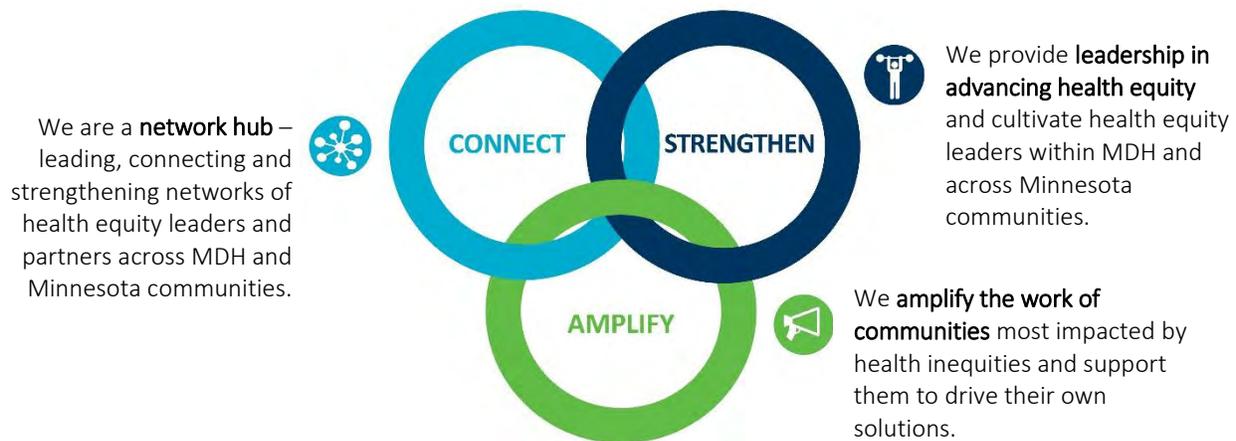
Topic	Description	Date and Time	Location
<b>Building a Case for Your Project</b>	<p>What are research-based projects and projects based on promising strategies? What if you use an evidence-based model that has been culturally adapted or a practice that does not have a research base but has been honed and developed from many years of experience of what works?</p> <p>This session is for potential applicants who want to:</p> <ul style="list-style-type: none"> <li>understand the different ways practices and strategies are classified to show their effectiveness (research-based, promising, emerging, practice-based, etc.), and</li> <li>learn about different ways to tell your story in your application.</li> </ul>	<p>October 17, 2018</p> <p>6-8 pm</p>	<p>Neighborhood House, 179 Robie St. E., St. Paul, MN 55107</p>
<b>Moving Your Project Upstream (to Levels of Change 2 &amp; 3)</b>	<p>This session is for potential applicants who want to:</p> <ul style="list-style-type: none"> <li>expand beyond providing programs that target individual behavior change/direct service,</li> <li>address the root causes of health inequities through institutional and societal changes, and</li> <li>identify program activities that address social and economic conditions for health.</li> </ul>	<p>October 30, 2018</p> <p>2-4 pm</p>	<p>UROC, 2001 Plymouth Ave. N., Minneapolis, MN 55411</p>

## RFP Part 2: Program Details and Requirements

### 2.1 Background Information

In 2001, Minnesota passed landmark legislation to address the persistent and growing problem of disparities in health status between the white population and populations of color and American Indians. Although Minnesota is often recognized as one of the healthiest states in America, it harbors some of the greatest disparities in health between racial/ethnic groups. The statute that created the EHD program recognized that current efforts to address health disparities were inadequate and traditional public health programs were not always effective. Rather, the solutions must come from within the communities most impacted by inequities and be supported by community leaders. The passing of the EHD legislation was a collaborative effort between MDH and communities of color. In early 2001, communities of color and American Indians rallied in support of EHD, bringing together hundreds of community members on the steps of the Capitol. Meanwhile, community groups reached out to their respective legislators, urging passage of the bill.

For more than a decade, the EHD grants were administered through the MDH Office of Minority and Multicultural Health (OMMH). In December 2013, the Commissioner of Health established the MDH Center for Health Equity (CHE) with the intent of bringing an overt and explicit focus to the efforts of MDH to advance health equity in Minnesota. The mission of CHE is to connect, strengthen and amplify health equity efforts within MDH and across the state of Minnesota. OMMH and EHD were reorganized within CHE and remain integral elements of the center.



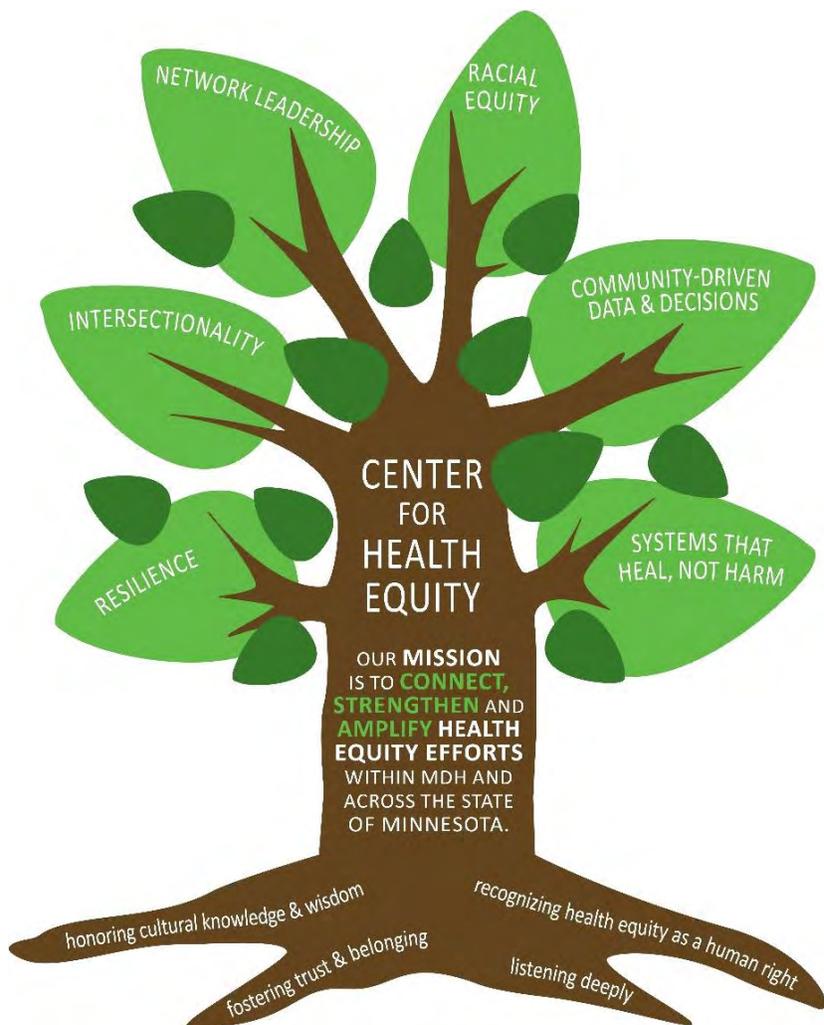
The EHD grant program embodies the mission of CHE by **connecting, strengthening and amplifying health equity efforts** in communities of color and American Indians across the state of Minnesota. First and foremost, the EHD program **amplifies** the work of communities most impacted by health inequities and supports them to drive their own solutions through targeted investments in their infrastructure, staff and resources. Through the EHD Community of Practice, community leaders are **connected** to a network of statewide leaders doing similar work in their own cultural communities and to resources, skills and knowledge within the Minnesota Department of Health and our partners across the state. Community leaders who become grantees are also **strengthened** through opportunities to enhance their leadership skills, grow their networks and connect across cultures and programs.

CHE is grounded in a set of [core values and approaches](#) that shape our work, including the work of the EHDl program. Our **values** include honoring cultural knowledge and wisdom; fostering trust and belonging; listening deeply; and recognizing health equity as a human right. Through EHDl grants, we seek to support and amplify indigenous and cultural ways of healing, and we strive to build a community of grantees that recognizes and honors everyone’s story, fosters trust between government and community, and allows grantees to define what health looks like for their communities.

Our work is guided by a set of **approaches**, including: racial equity; resilience; intersectionality; network leadership; community-driven data and decisions; and systems that heal, not harm. **Applicants are encouraged to learn more about our values and approaches through the [handout and webinar on our website](#).**

For definitions of health equity terms used throughout this RFP, applicants are encouraged to refer to the [ASTHO Glossary of Health Equity Terms](#).

The development of the EHDl program and this Request for Proposals (RFP) was guided by these values and approaches, by feedback from members of the CHE [Health Equity Advisory and Leadership \(HEAL\) Council](#) and by community and stakeholder input collected by MDH and CHE in recent years, including the 2015 [Eliminating Health Disparities Initiative: Input Summary of Themes](#).



## 2.2 Eligible Projects

### Eligible Populations

**As specified in the EHDl state statute ([Minn. Stat. §145.928](#)), this grant will serve populations of color<sup>8</sup> and American Indians.** EHDl exclusively funds and supports organizations and programs working in communities of color and American Indian communities to develop and implement strategies targeted

<sup>8</sup> Populations of color include, but are not limited to, Africans, African Americans, Hispanics/Latinos, Asians and Pacific Islanders.

to their communities. The EHDI philosophy is based on the principle of self-determination – that change must come from within communities and build on community strengths and social and human capital.

While EHDI funds are focused on racial and ethnic disparities in health, MDH recognizes the ways in which unjust systems (e.g., racism, sexism, homophobia, transphobia, ableism, xenophobia, classism) intersect to create interconnected layers of disadvantage and inequity. Because these systems are overlapping and interdependent, we will not unravel them in isolation. Rather, our approaches to equity should be both intersectional and multipronged. This concept of **intersectionality** is one of our [CHE core values](#). Therefore, applications focused at the intersections of race/ethnicity and other identities/communities experiencing inequities are welcome (e.g., projects may focus on serving LGBTQ people of color, American Indians with disabilities, etc.).

## Eligible Priority Health Areas

Projects must address one or more of the following PHAs:

- Breast and cervical cancer
- Cardiovascular disease
- Diabetes
- HIV/AIDS and sexually transmitted infections (STIs)
- Immunizations for adults and children
- Infant mortality
- Teen pregnancy prevention
- Unintentional injuries and violence<sup>9</sup>

## Eligible Levels of Change

In response to community and stakeholder feedback and based on the community-driven EHDI philosophy, funding is meant to be flexible and responsive to community needs. A key recommendation that emerged from a 2015 EHDI community input process was to encourage grantees to broaden program activities to address the social and economic conditions for health, also known as the social determinants of health. Community partners recommended that the EHDI program allow grantees to expand beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior or skill) to focus on broader social determinants of health, such as changing policies, systems or environments that address the root causes of inequities. This recommendation is consistent with the MDH philosophy that we must work at multiple levels of change – including addressing the social determinants of health – in order to ultimately achieve health equity.

Thus, depending on the needs of the community served, **applicants may choose to work within one or more of the following levels of change to address one or more of the PHAs listed above.**<sup>10</sup>

1. **Health Promotion/Direct Service:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities within one or more PHA through direct service. Level 1 activities often, but not always, focus on individual behavior change.



<sup>9</sup> Unintentional injuries and violence includes suicide prevention; refer to Appendix J for more details.

<sup>10</sup> Please note that these levels of change represent a continuum of ways to make change to eliminate health disparities and inequities. The purpose of identifying and describing three levels of change on this continuum is to help applicants think about the range of strategies and activities they can undertake with the ultimate goal of eliminating disparities in the PHAs – from providing direct services and promoting healthy behaviors to addressing the root causes of health inequities.

**Examples include:**

- Delivering a health promotion or prevention curriculum to prevent teen pregnancies
- Providing wrap-around services to high-risk pregnant or new moms to reduce infant mortality
- Providing exercise classes for older adults at risk of heart disease and stroke

2. **Organizational/Institutional Change:** Participating in or leading efforts that contribute to eliminating disparities in one or more PHAs by changing organizational or institutional policies or changing the way a system in an organization or institution works. Level 2 change often means modifying policies or systems to support individual behaviors and address risk and protective factors.



**Examples include:**

- Contributing to or promoting the adoption of teen-friendly clinic policies to support the prevention of HIV/STIs
- Contributing to or promoting a change in healthy food accessibility in a school, housing complex, etc. to reduce the incidence of diabetes
- Improving existing and/or developing new clinic procedures or workflows to improve HPV immunization rates
- Contributing to and/or implementing a new policy requiring age-appropriate comprehensive sexual health curricula in a school district
- Contributing to or leading the development of a statewide network for sharing best practices related to breast and cervical cancer screening in the American Indian community
- Spreading or disseminating a promising culturally appropriate model for health promotion or prevention initially developed within an organization to other organizations or institutions

3. **Root Causes/Conditions for Health:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) and contribute to eliminating disparities in one or more PHAs. Level 3 change often involves changing local, regional, tribal or state policy, changing the way systems work or changing the natural or built environment to address the root causes of health disparities.<sup>11,12</sup> For more information about social determinants of health, refer to Appendix A.



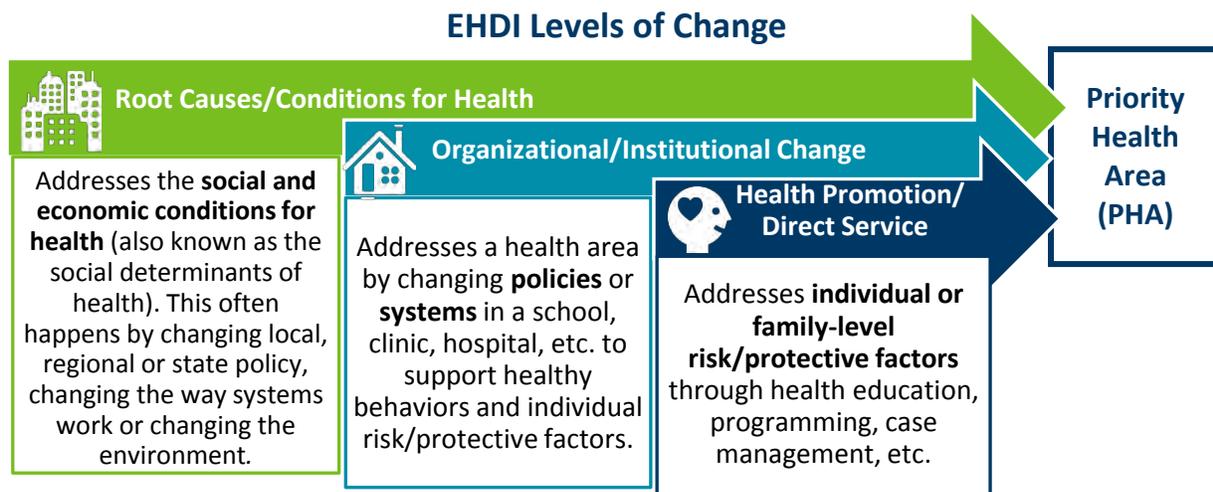

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<sup>11</sup> **Policy, systems and environmental change** are ways of modifying the environment to make healthy choices practical and available to all community members. Policy change includes ordinances, resolutions, requirements or procedures that govern behavior or practices within an organization, community, system, etc. Systems change includes changes in processes or procedures that impact all elements of an organization, institution or system so that people or departments within that organization, institution or system change the way they operate or do their work. Environmental change includes changes to the economic, social or physical environment to benefit entire populations.

<sup>12</sup> Grantees may lead or participate in advocacy work but may not engage in activities that are considered “lobbying.” **More information on advocacy versus lobbying is provided on page 13.**

**Examples, with the targeted social determinants of health in brackets, include:**

- Contributing to or leading the development of a coordinated policy agenda that will strengthen affordable and stable housing for pregnant moms in the state to reduce infant mortality [Housing]
- Contributing to or leading a local or statewide effort to increase community safety so that people can walk, bike and play outside to support the reductions of cardiovascular disease, diabetes, and violence [Neighborhood Conditions]
- Contributing to or leading an effort to create welcoming communities to reduce isolation and increase feelings of belonging so that community members can have active social and outdoor lives to reduce cardiovascular disease and diabetes [Social Connections and Support]
- Contributing to or leading an effort to eliminate stigma and discrimination against LGBTQ communities of color or American Indians so that people can feel included, welcomed and valued in order to reduce chronic stress and risk behaviors that can lead to HIV/AIDs, STIs or teen pregnancy [Racism and Discrimination]



**Projects addressing any of the levels of change listed above will be given equal weight in the selection process;** applicants will not be given priority consideration for pursuing more than one level of change, although applicants may choose to do so. Please keep in mind that the amount of funding requested by an applicant should be appropriate for the number and extent of the levels of change pursued in a proposal. For example, a project working on health promotion/direct service and root causes/conditions for health may potentially request a higher award amount (toward the top of the estimated award range on page 5) than an applicant working on health promotion/direct service alone.

**Eligible Activities**

The EHDI statute states that priority will be given to projects that are research-based or based on promising strategies.

- **Promising strategies** include practices that come from the local community that may be based on practice-based evidence (PBE) and/or lived experiences of communities of color and American Indians. PBE includes a range of approaches that are developed over time through practice and experience. PBE approaches are often embedded in the culture, accepted as

effective by local communities and support healing of youth and families from a cultural framework.

- **Research-based projects** include projects that can be tied to and/or include elements that draw from published literature, including both qualitative and quantitative studies.

**EHDI grantees are not required to use evidence-based practices.** Projects that are research-based or promising strategies will be given equal weight in the review process. **All EHDI-funded projects must be grounded in community knowledge and wisdom.**

Refer to Appendices C-J for examples of project objectives, strategies and activities that fall under each of the levels of change described above. **Applicants are not restricted to the examples in Appendices C-J; applicants are encouraged to propose their own practices based on community needs and/or adapt and build upon the practices listed in the appendices to meet community needs.**

## Lobbying vs. Advocacy

Projects within Level of Change 3 may potentially involve advocating for change in local, regional, tribal or state policy. Because grantees will be receiving state and/or federal funding, there are certain restrictions on how grant funds may be used. This section outlines the distinction between advocacy and lobbying to help applicants understand the limitations of activity in this arena. MDH staff will also be available throughout the grant period to provide technical assistance and guidance to grantees to support them in navigating the line between advocacy and lobbying.

Grant funds may not be used for lobbying, which MDH defines as advocating for a specific public policy after it has been formally introduced to a legislative body. However, **grantees may use grant funds to educate stakeholders about the importance of policies as a public health strategy.** Education includes providing facts, assessment data, reports, program descriptions and information about budget issues and population impacts without making a recommendation on a specific piece of legislation. Education may be provided to public policy makers, other decision makers, specific stakeholders and the general community. Lobbying restrictions do not apply to informal or private policies.<sup>13</sup>

Grantees may make educational materials related to their PHA(s) available to the public and governmental bodies, officials and employees. These materials may not advocate the adoption or rejection of an official action, but may contain facts, analysis, studies and research. Grantees may not use grant funds to participate or intervene in any political campaign on behalf of, or in opposition to, any candidate for public office.

Grantees may use other funding sources to influence an official action of a governmental unit or tribal government related to their selected PHA(s), in accordance with federal and state law, grantee policy and funding restrictions, but they must clearly document which activities are covered by which funding source. Volunteers of a grantee who spend more than \$250 of their own funds in any year to influence state legislation or administrative rules may need to register as a lobbyist under Minnesota Statute 10A.01, subdivision 21. Information about registration is available from the state Campaign Finance and Public Disclosure Board at 1-800-657-3889.

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<sup>13</sup> **Informal or private policies**, sometimes called “voluntary” policies, are policies passed by an organization. For example, an apartment building may establish its own smoke-free policy (one not required by law). Grantees may choose to advocate or lobby for or against these kinds of policies in support of their identified PHA(s).

## 2.3 Mandatory Project Requirements

Regardless of which level(s) of change the applicant chooses to pursue, all projects must include the following components.

### Community Engagement and Collaboration

Community engagement is a process through which community members are involved in issue identification, problem-solving and decision-making. EHDI projects must be rooted in and driven by the community served. One of our guiding approaches at the Center for Health Equity is network leadership; we believe that leadership comes from within and across communities and that we are stronger when we bridge differences and unite around commonalities. We believe that effective leadership is adaptive, collaborative and inclusive. **Grantees should authentically engage and work in partnership with community members experiencing inequities in their selected PHA to ensure activities and strategies are co-created, appropriate and welcomed by the community.**

EHDI projects should also be designed to complement and build on other related activities or initiatives in the community. To pursue their project goals, grantees should work together in partnership with relevant stakeholders, which may include other community organizations, local public health, other government agencies or health systems. Grantees are also encouraged to form and/or strengthen cross-sector partnerships as appropriate. Community engagement and partnership-building should be ongoing throughout the grant period.

### Evaluation

**Grantees will be required to use at least 10 percent of their grant award on evaluating their project.**

Evaluation is a required component for several reasons:

- It helps grantees know how they can improve their project.
- It helps grantees know if they are making progress toward their objectives and helps them report back to community partners and stakeholders.
- It helps MDH report to the state legislature, both to justify the use of public funds and to show the difference the funds make in the community.
- It helps document and spread the innovative projects and strategies grantees develop to address health issues in their community based on cultural knowledge and wisdom.
- When grantees evaluate their own programs, with MDH assistance, they build their own evaluation capacity for future projects and initiatives.

Grantees may use evaluation funds for internal staff time and work or to subcontract with external evaluation partners. All evaluation expenditures must be documented. Evaluation is expected to include, but is not limited to, developing a logic model and an evaluation plan, developing data collection tools, collecting and analyzing evaluation data and attending in-state evaluation training and technical assistance events. Grantees are expected to share evaluation results with MDH, community partners and project stakeholders.

**MDH will provide evaluation technical assistance to grantees as needed to help grantees meet grant requirements and build grantee evaluation capacity.** Refer to the Technical Assistance section on page 15 for more information.

## 2.4 Grant Expectations and Deliverables

### Grant Outcome Expectations

Because EHDI is grounded in the philosophy that community issues require community solutions, grant projects will be culturally specific and unique to each community served. Therefore, **each funded grantee will specify its own outcomes related to reducing disparities in the PHAs it works to address.** CHE staff and MDH priority health area specialists will provide technical assistance to grantees in determining and measuring outcomes. Grantees will also participate in a process with MDH staff to identify any common outcomes among grantees addressing similar PHAs and contribute to a shared measurement system among grantees.

### Key Tasks and Deliverables

With support and technical assistance from MDH, grantees will be required to:

- Work with MDH to revise and finalize the work plan and budget before the grant start date.
- Assign one staff person (at least 0.5 FTE dedicated to the project) to serve as the primary liaison between MDH and the grantee organization.
- Develop and submit a logic model and evaluation plan for their project within the first six months of the grant and submit updated versions when revisions are made, with support and technical assistance from MDH as needed.
- Submit semiannual progress reports and annual evaluation reports on grant activities and outcomes.
- Participate in biannual (twice per year) grantee gatherings and other occasional grantee trainings and technical assistance activities, including the annual Community Health Conference (typically held in the fall in the Brainerd area).
- Contribute to the development of and participate in a shared measurement system among grantees.
- Participate in the EHDI Community of Practice, which may take place at grantee gatherings, through additional in-person meetings and/or through online networking and sharing. Grantees are strongly encouraged to share with and learn from other grantees; however, each grantee may choose the extent to which they participate.
- Develop a budget and work plan for the second half of the grant period (July 2021 – June 2023) and work with MDH revise the work plan and budget as needed before June 30, 2021.
- Provide updates and/or grant summary information upon request to be included in EHDI and other MDH reports.
- Share project progress and evaluation results with community stakeholders on a regular basis.

### Technical Assistance

MDH will provide technical assistance to grantees to support them in fulfilling their grant objectives. **CHE staff, as well as specialists in each of the PHAs from across the agency, will be available to provide guidance and assistance on topics including budgeting, invoicing, data collection, evaluation and other effective practices.** MDH will also provide for a third party evaluation capacity-building team to support grantees in identifying appropriate and feasible measures and outcomes for their projects and provide general evaluation technical assistance. Grantees are also encouraged to seek support and learn from other grantees through the EHDI Community of Practice.

## 2.5 Eligible and Ineligible Expenses

### Eligible Expenses

Funds may be used for program and personnel costs at the discretion of the applicant in order to pursue one or more of the levels of change listed on pages 10-12.

Allowable uses of grant funds may include, but are not limited to:

- **Project planning**, including community assessment or data collection activities to inform project development (e.g., mapping community assets and needs; engaging stakeholders in developing creative, sustainable solutions).
- **Project implementation**, including program operations, staff salaries and benefits, etc.
- **Building networks and collaborations**, including supporting the organization's leaders to engage with other partners in collective efforts to inform policy, system and environmental conditions that increase health opportunities for priority populations (e.g., participating in advisory groups or building cross-sector partnerships to advance health equity related to one or more PHAs).
- **Developing and training community leaders**, including staff development related to the project, in order to build a community's capacity to act to address health inequities in one or more PHAs.

### Ineligible Expenses

According to the EHDI statute ([Minn. Stat. §145.928](#)), **grant funds must be used to develop new programs or expand current programs that reduce health disparities**. Funds may **not** be used to supplant current county or tribal expenditures.

Other ineligible expenses for **both general funds and TANF funds** include but are not limited to:

- Fundraising
- Taxes, except sales tax on goods and services
- Lobbying, lobbyists, political contributions (refer to Lobbying vs. Advocacy section on page 13)
- Bad debts, late payment feeds, finance charges or contingency funds
- Ongoing medical care or treatment of disease(s) or disability
- Capital improvements or alterations
- Cash assistance paid directly to individuals to meet their personal or family need
- Any individual piece of equipment that costs more than \$5,000
- Any cost not directly related to the grant
- Purchase of vehicle(s) for program use
- Cash payments to participants (incentives must be non-cash)

Ineligible expenses for **TANF funds**<sup>14</sup> (teen pregnancy prevention only) include but are not limited to:

- Providing *individual* services to teens (funds must be used to support *group* activities)
- Providing medical services
- Providing reimbursement for child care or transportation to participants (grantees may provide child care or transportation for a group of participants, but they may not directly reimburse individual participants for their child care and/or transportation costs)
- Hosting celebration events

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<sup>14</sup> Projects receiving TANF dollars must abide by these additional federal restrictions when using TANF funds.

## RFP Part 3: Application Process and Instructions

### 3.1 Notice of Intent to Apply

**Applicants are strongly encouraged to submit a non-binding notice of intent to apply by October 5, 2018.** The Notice of Intent Form helps us prepare for the number and types of applications we will receive, so that we can plan ahead for the review process. MDH will publish a list of applicants who have submitted a Notice of Intent Form on the [EHDl RFP webpage](#) by October 18, 2018 with the hope of encouraging collaboration among interested organizations and applicants.

**Prospective applicants can access the online Notice of Intent Form on the [EHDl RFP webpage](#).** Please submit one notice of intent for each application you plan to submit.

While prospective applicants are strongly encouraged to submit a notice of intent, it is not a mandatory requirement of this RFP. This means that an application may still be considered even if the applicant did not submit a notice of intent. Likewise, an applicant is not obligated to submit an application just because they submitted a notice. Applicants are not bound by the details submitted in a notice of intent; an applicant may change the intended level(s) of change, PHA(s), target populations(s) and/or geographic area(s) served after the notice of intent is submitted.

### 3.2 Application Deadline

**All applications submitted via email must be received by MDH no later than 11:59 p.m. Central Time on December 10, 2018.** If applications are mailed, they **must be postmarked by or on December 10, 2018 and received by MDH no later than December 17.**

**Late applications will not be accepted.** It is the applicant's sole responsibility to allow sufficient time to address all potential delays caused by any reason whatsoever. MDH will not be responsible for delays caused by mail, delivery, computer or technology problems. The applicant will incur all costs incurred in applying to this RFP.

### 3.3 Application Submission Instructions

**Applicants are strongly encouraged to submit applications via email to [health.equity@state.mn.us](mailto:health.equity@state.mn.us) with the subject line *EHDl RFP Application – [insert applicant organization name]*.**

Applicants who are unable to submit via email may submit their application via mail. If submitting by mail, please submit a single printed copy bound with a paper clip (do not staple). Applications may not be hand-delivered to MDH. Applications submitted by mail must be sent to:

Minnesota Department of Health  
Center for Health Equity  
PO Box 64975  
St. Paul, MN 55164-0975

**You must submit the following in order for the application to be considered complete:**

1. Application Form
2. Work Plan
3. Budget
4. Due Diligence Review Form

**Incomplete applications will be rejected and not evaluated.** Applications must include all four required application materials listed above. Do not provide any materials that are not requested in this RFP (e.g., memorandums of understanding [MOUs] or letters of support), as such materials will not be considered or evaluated. **MDH reserves the right to reject any application that does not meet these requirements.**

By submitting an application, each applicant warrants that the information provided is true, correct and reliable for purposes of evaluation for potential grant award. The submission of inaccurate or misleading information may be grounds for disqualification from the award, as well as subject the applicant to suspension or debarment proceedings and other remedies available by law.

## Part 1: Application Form

Applicants must submit a completed Application Form, which can be found on the [EHDI RFP webpage](#). Applicants must have Adobe Acrobat Reader to complete the form, which can be downloaded for free from the [Adobe Acrobat](#) website. Please complete all fields in the application. Character limits are enforced automatically and include spaces. To bold, italicize or underline in the application form, the following keyboard shortcuts can be used:

Style	Keyboard Shortcut (Mac)	Keyboard Shortcut (PC)
Bold	Command + B	Ctrl + B
Italics	Command + I	Ctrl + I
Underline	Command + U	Ctrl + U

Applicants who are unable to use the PDF application form on the website may craft their application question responses in another written format that does not exceed the character limits.

## Part 2: Work Plan

Applicants must submit a work plan that provides an overview of what the applicant plans to accomplish during the ***first two years of the grant (July 2019 – June 2021)***. **Applicants are strongly encouraged to use the Microsoft Word template provided on the [EHDI RFP webpage](#).** Most Minnesota libraries – including all metro county libraries and libraries in Rochester, Duluth, Mille Lacs, Morehead and Owatonna – provide free access to Microsoft Word. Applicants who are unable to use the Microsoft Word template provided on the website may submit their work plan in another format that does not exceed the page limit below.

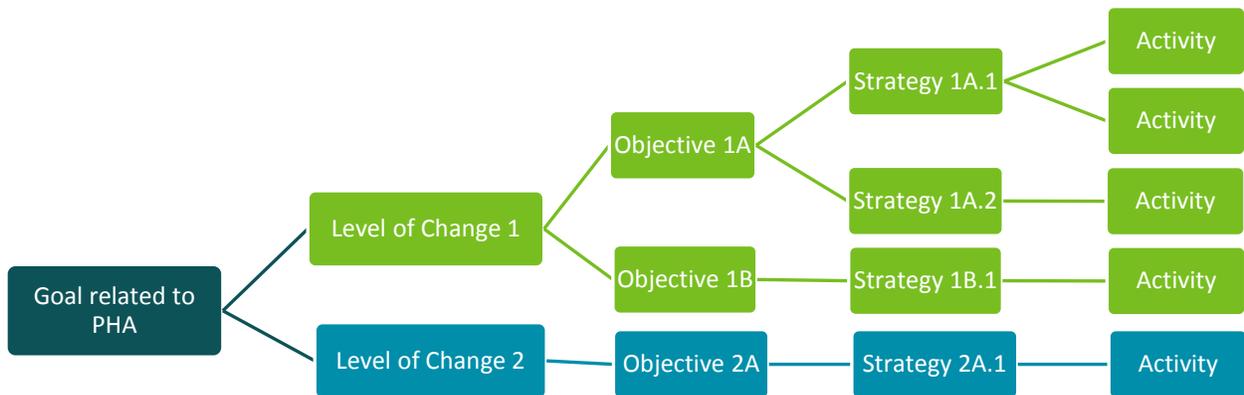
**The work plan may not exceed 12 pages.** To ensure that all applicants’ work plans have a similar format and length for the review process, we request that applicants use 11-point Calibri font in the work plan tables.

Applicants may find it useful to identify their level(s) of change and craft their objectives, strategies and activities in the work plan before completing the Project Narrative section of the application form. Please note that the work plan is only for two years, while the Project Narrative in the application form should provide a high-level description of your entire four-year project. **The figure below may be helpful in conceptualizing how the different components of the work plan (objectives, strategies, etc.) work together.** Please note that your project may vary significantly from the figure below depending on how many level(s) of change, objectives and strategies you have identified. Most applicants will have more activities than are pictured here.

### Sample EHDl Project Framework 1



### Sample EHDl Project Framework 2



### Project Objectives

Under each level of change in your project, list the **project objectives** that you plan to achieve. Although this work plan only is for two years, your objectives may be for the entire four-year period, if applicable. The following tips might be helpful as you craft your objectives:

- Think about objectives as major steps a program will take to attain its goal of reducing disparities in the identified PHA(s).
- Make your objectives “SMART”:
  - ✓ **Specific:** concrete and well-defined
  - ✓ **Measurable:** can determine what changed and how much it changed
  - ✓ **Achievable:** feasible to put into action

- ✓ **Realistic:** considers constraints such as resources, personnel, cost and time frame
  - ✓ **Time-Bound:** time frame for the objective; short-term to intermediate-term objectives must be achievable within a four-year time frame, from **July 1, 2019 to June 30, 2023**, the duration of the grant
- Make your objectives begin with action verbs (e.g., Increase, Decrease, Develop, Create).
  - Your objectives are where programmatic and evaluation outcome measures and indicators will likely come from.

**A common format for objectives is as follows:** By (when, date), (percent or number of change from a stated base) of (what population) will (indicator – do what, change how).

**For example:** *By June 30, 2023, 95 percent (compared to 86.5 percent in 2017) of American Indian women in Hennepin County will initiate prenatal care before the third trimester of pregnancy.*

Please note that the example objectives included in the priority health area appendices (Appendices C-J) are not examples of “SMART” objectives. We intentionally left these objectives broad to include a range of sample strategies and activities. For additional examples of “SMART” objectives, please refer to the sample work plan on the [EHDl RFP webpage](#).

## Project Strategies

For each objective identified, applicants must specify strategies. **Strategies are general approaches that will be taken in order to achieve an objective.** Sometimes people think of strategies as the “how” of your project (while your activities are the “what”). The strategies listed in the work plan should correspond with the strategies described in Question 8 of the application form.

**For example:** *Host Talking Circles to offer prenatal education and support in a group setting.*

## Project Activities – Work Plan Tables

The work plan tables must include all planning and implementation activities you plan to undertake **during the first two years of the grant** as they relate to:

- Activities to address health disparities
- Community engagement and collaboration
- Partnership development and coordination

For each activity, indicate the lead person and any supporting staff from your organization; the external partners involved; the anticipated timeline (start and end dates); and the output from the activity. Note that your outputs should be specific, measurable and realistic (e.g., 20 participants complete program).

**Applicants may add and/or delete headings, tables and rows as needed.** The activities in the work plan table should provide additional information about the activities described in Question 9 of the application form. We have provided examples for each EHDl level of change in the sample work plan on the [EHDl RFP webpage](#).

For application review and selection purposes, applicants do not need to list every activity in detail. If MDH requests additional information, applicants who are awarded a grant may be asked to provide additional details during negotiations before a grant agreement is signed.

## Part 3: Budget

Applicants must submit a budget narrative and budget summary that provides an overview of how funds will be used during the ***first two years of the grant (July 2019 – June 2021)***. Applicants are **strongly encouraged to use the Microsoft Excel template provided on the [EHDI RFP webpage](#)**. Most Minnesota libraries – including all metro county libraries and libraries in Rochester, Duluth, Mille Lacs, Moorhead and Owatonna – provide free access to Microsoft Excel. Applicants who are unable to use the Microsoft Excel template provided on the website may submit their budget in another format that provides the same information below.

There are four tabs/sheets in the Excel budget template:

1. EHDI Budget Template Instructions
2. MDH Policy and Guidance on Indirect Costs
3. Year 1 Budget Narrative (***applicants must complete this sheet***)
4. Year 2 Budget Narrative (***applicants must complete this sheet***)
5. Budget Summary (auto-fills once applicants complete Tabs 3 and 4)

### Budget Narratives

The budget narratives should provide a brief but sufficient explanation of how funds will be used. The budget must be consistent with the stated objectives, planned activities and time frame of the project. Where possible, the method for computing estimates should be explained by including quantities, unit costs and other similar numeric detail sufficient for the calculation to be duplicated.

**Please round expenditures to the nearest dollar and enter the total for each line item at the top of each section.** In line items that include evaluation expenses, please separate the total costs for evaluation from the rest of the line-item total. **Applicants' budgets should show how they plan to spend at least 10 percent of their total budget on evaluation expenses.**

Applicants should organize their expenditures into the following categories:

#### I. Salary and Fringe Benefits

For each proposed staff person who will work directly on the grant, applicants must list the following:

- a. Position title and name of the staff person, if known
- b. Full-time equivalent to be charged to the grant
- c. Actual or expected rate of pay
- d. Fringe benefits
- e. Total amount expected to be paid for the staff person

The staff included in this section of the budget narrative should be the same as the staff included in the work plan.

#### II. Contractual Services

For any proposed subcontractors, applicants must list the following:

- a. Name of contractor, if known, or selection process to be used
- b. Scope of work the contractor will provide
- c. Length of time the services will be provided
- d. Total amount you expect to pay the contractor

Grant funds may be used for small contracts – such as facilitators, speakers or trainers – as well as for large contracts if other organizations will be engaged to implement specific parts of proposed activities.

**III. Travel**

List the expected travel costs for staff working on the grant, including mileage, parking, lodging and meals. This line item may also include bus tokens or other travel for participants (please note TANF restrictions on page 16). Grant funds may be used for related professional development and trainings, but funds cannot be used for out-of-state travel without prior written approval from MDH.

In addition to travel for program activities and relevant professional development activities, applicants should include expenses related to travel/conference fees for the annual Community Health Conference (generally held in the Brainerd area) and annual all-day grantee gatherings in the metropolitan area. Estimated costs for the Community Health Conference are approximately \$500 per person per year.

Below is an overview of the [State of Minnesota Commissioner’s Plan](#), which outlines limits for allowable travel expenses. Use the following reimbursement rates to estimate travel expenses.

**Reimbursement Rates**

Expense	Rate (non-tribes)	Rate (tribes)
Mileage	Current IRS rate (\$0.545/mile as of January 1, 2018)	Current IRS rate (\$0.545/mile as of January 1, 2018)
Parking	Actual parking fees	Actual parking fees
Breakfast	\$9.00 maximum	Refer to <a href="#">current GSA Rate</a>
Lunch	\$11.00 maximum	Refer to <a href="#">current GSA Rate</a>
Dinner	\$16.00 maximum	Refer to <a href="#">current GSA Rate</a>
Lodging	Actual cost (charges should be reasonable and consistent with the facilities available)	Refer to <a href="#">current GSA Rate</a>

**IV. Supplies**

These costs may include office supplies, postage or mailing, duplication or copies, phone service and equipment and computer or internet expenses. Other expenses may include food or snacks for programming/events or program supplies.

**V. Other**

Describe any other expected grant-related costs that do not fit any other line item. Expenses in this line must be directly related to the program activities and linked to an activity in the work plan. Examples include staff training, media expenses, child care for participants during programming/events, participant incentives (capped at \$50/person per year) or stipends.

**VI. Indirect Costs**

MDH policy caps indirect costs at either a grantee’s federally negotiated rate or at 10 percent, as applied to a grant’s *total direct costs*. Grantees who wish to charge indirect at a federally

negotiated rate must be able to provide a copy of the federal rate agreement. If awarded a grant, a copy of the agreement will be requested before a grant agreement is signed.

If applicants do not have a federally negotiated rate, please list what is covered in your organization’s indirect cost pool. **For more information on how to calculate indirect costs and what may be included as indirect costs, please refer to Tab 2 of the budget template.**

Indirect costs on invoices to MDH for grant funds must be proportional to direct costs on the invoice; invoices that include only indirect costs will not be paid (direct costs must also be included). Expenses must be categorized as either direct or indirect consistently throughout the life of the grant. Grantees must maintain records that verify all grant expenses, including those categorized as indirect costs.

## Budget Summary

Line-item totals on the budget narrative tabs (Tabs 3 and 4) will automatically fill the budget summary tab (Tab 5). After completing Tabs 3 and 4, please make sure the information on Tab 5 is accurate.

## Part 4: Due Diligence

The Due Diligence Review Form can be found on the [EHDI RFP webpage](#).

## 3.4 Application Review and Selection Process

### Review Process

Funding will be allocated through a competitive process with review by a committee representing the communities served by the EHDI grants, as well as some MDH staff, agency partners and other state agency staff. The review committee will evaluate all eligible and complete applications received by the deadline. MDH will review all committee recommendations and is responsible for award decisions.

### Selection Criteria and Weight

Review committee members will be divided into teams of approximately 4 to 6 reviewers. Each reviewer will review and score the applications assigned to their team individually using a provided score sheet (refer to Appendix B for a sample score sheet). Reviewers will score each application on a 150-point scale. This standardized scoring system will determine the extent to which each applicant meets the selection criteria for this grant.

The review teams will then participate in a review meeting where applications are discussed as a team. Reviewers will be able to modify their individual scores based on discussions at the review meeting. At the end of the meeting, team members will make recommendations to MDH based on the scoring criteria and discussion.

MDH will make final decisions on all applications and will balance the recommendations by the review teams with other factors including, but not limited to:

- Review team scores
- Representativeness of the PHAs
- Representativeness of populations served by EHDI
- Representativeness of the three EHDI levels of change
- Geographic distribution of services
- Total funding available

## Grantee Past Performance and Due Diligence Review Process

It is the policy of the State of Minnesota to consider a grant applicant's past performance before awarding subsequent grants to them. State policy requires states to conduct a financial review prior to a grant award made of \$25,000 and higher to a nonprofit organization, in order to comply with [Policy on the Financial Review of Nongovernmental Organizations](#).

MDH staff will conduct a pre-award review of finalists prior to awarding funds in accordance with this policy. The review will include both the Due Diligence Review Form and a review of past performance for applicants who are previous grantees of MDH. These reviews allow MDH to better understand the capacity of applicants and identify opportunities for technical assistance to those that receive grants.

## Notification

**MDH anticipates notifying all applicants of funding decisions via email by April 1, 2019.** All notices of award and non-award will be sent via email to the contact person listed on the application.

Awarded applicants who are not current vendors in the State's SWIFT system will need to become vendors before a grant agreement can be made final. Instructions on how to become a vendor will be sent to awarded applicants when they are notified of the award.

There may be negotiations to finalize a grantee's work plan and/or budget before a grant agreement can be made final ("executed"). Once a work plan and/or budget have been agreed upon, a grant agreement can then be executed with the applicant agency being awarded the funds. The effective date of the agreement will be July 1, 2019 or the date on which all signatures for the agreement are obtained, whichever is later. The grant agreement will be in effect until June 30, 2023, contingent on satisfactory grantee performance and funding availability.

## RFP Part 4: Grant Responsibilities and Provisions

### 4.1 Grant Management Responsibilities

#### Grant Agreement

Each grantee must formally enter into a grant agreement. The grant agreement will address the conditions of the award, including implementation of the project. Once the grant agreement is signed, the grantee is expected to read and comply with all conditions of the grant agreement. **No work on grant activities can begin until a fully executed grant agreement is in place.**

A sample grant agreement for nonprofit organizations is available on the [EHDl RFP webpage](#). Please note that the grant agreement terms may vary slightly for CHBs, tribal governments and the University of Minnesota. Applicants should be aware of the terms and conditions of the standard grant agreement in preparing their applications. Much of the language reflected in the sample agreement is required by statute. If an applicant takes exception to any of the terms, conditions or language in the sample grant agreement, the applicant must indicate those exceptions, in writing, in their application in response to this RFP. Certain exceptions may result in an application being disqualified from further review and evaluation. Only those exceptions indicated in an application will be available for discussion or negotiation.

The funded applicant will be legally responsible for assuring implementation of the work plan and compliance with all applicable state requirements including worker’s compensation insurance, nondiscrimination, data privacy, budget compliance and reporting.

#### Accountability and Reporting Requirements

It is the policy of the State of Minnesota to monitor progress on state grants by requiring grantees to submit written progress reports at least annually until all grant funds have been expended and all of the terms in the grant agreement have been met.

The reporting schedule will be:

Due Date	Report Type
January 31, 2020	Year 1 Progress Report
July 31, 2020	Year 1 Annual Report
January 31, 2021	Year 2 Progress Report
July 31, 2021	Year 2 Annual Report
January 31, 2022	Year 3 Progress Report
July 31, 2022	Year 3 Annual Report
January 31, 2023	Year 4 Progress Report
July 31, 2023	Final/Year 4 Annual Report

#### Grant Monitoring

[Minn. Stat. §16B.97](#) and the state [Policy on Grant Monitoring](#) require the following:

- One monitoring visit during the grant period on all state grants over \$50,000

- Annual monitoring visits during the grant period on all grants over \$250,000
- Conducting a financial reconciliation of grantee's expenditures at least once during the grant period on grants over \$50,000

This EHD grant period will be **four years**, contingent on satisfactory grantee performance and funding availability. According to state policy, the purpose of a **monitoring visit** (often called a *site visit*) is to review and ensure progress against the grant's goals, address any problems or issues before the end of the grant period and build rapport between MDH and the grantee. Monitoring visits are an opportunity for MDH to meet grantee staff, learn more about grantee successes and challenges and see grantee work in action. CHE staff also view these visits as an opportunity to connect grantees with available resources, to learn how MDH can better support the grantee and provide technical assistance and to receive feedback from the grantee to help improve the EHD grant program.

The purpose of the **financial reconciliation** is to ensure that grant projects are in compliance with all state and federal laws and that expenses are allowable, appropriate, reasonable for the grant program and adequately verifiable by supporting documentation. The reconciliation involves a review of expenses included on a selected invoice and the relevant supporting documentation. Grantees will be notified at least 30 days prior to a financial reconciliation to allow sufficient time to gather and submit documentation. Please note that a financial reconciliation is not an audit.

## Grant Payments

Per the [State Policy on Grant Payments](#), reimbursement is the method for making grant payments. All grantee requests for reimbursement must correspond to the approved grant budget. The State shall review each request for reimbursement against the approved grant budget, grant expenditures to date and the latest grant progress report before approving payment. Grant payments shall not be made on grants with past due progress reports unless MDH has given the grantee a written extension.

State policy allows advance payments to be made to grantees only in certain exceptional situations. If a grantee requires advance payment to start up a program, negotiations will be made after a grant award is offered but before a grant agreement is executed.

Grantees will submit monthly invoices for payment. Invoices for each month's expenses should be submitted by the end of the following month (for example, the invoice for July 2019 expenses is due by August 31, 2019).

## 4.2 Grant Provisions

### Health Equity Priorities

The vision of the Minnesota Department of Health is for health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy. Achieving health equity means creating the conditions in which all people have the opportunity to attain their highest possible level of health without limits imposed by structural inequities. Find more information on health equity on the [CHE website](#).

It is the policy of the State of Minnesota to ensure fairness, precision, equity and consistency in competitive grant awards. This requires ensuring that diversity, equity and inclusion are core components in grant-making. The [Policy on Rating Criteria for Competitive Grant Review](#) establishes the expectation that grant programs intentionally identify how the grant serves diverse populations, especially populations experiencing inequities and/or disparities.

## Award Decisions

The award decisions of MDH are final and not subject to appeal. Additionally:

- MDH reserves the right to withhold the distribution of funds in cases where proposals submitted do not meet the necessary criteria.
- The RFP does not obligate MDH to award a grant agreement or complete the project, and MDH reserves the right to cancel this RFP if it is considered to be in its best interest.

MDH reserves the right to waive minor irregularities or request additional information to further clarify or validate information submitted in the application, provided the application, as submitted, substantially complies with the requirements of this RFP. There is, however, no guarantee MDH will look for information or clarification outside of the submitted written application. Therefore, it is important that all applicants ensure that all sections of their application are complete to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

## Conflicts of Interest

MDH will take steps to prevent individual and organizational conflicts of interest, both in reference to applicants and reviewers per [Minn. Stat. §16B.98](#) and the [Conflict of Interest Policy for State Grant-Making](#).

**Applicants must provide a list of all entities with which they have relationships that create, or appear to create, a conflict of interest with the work contemplated by this RFP.** The list must provide the name of the entity, the relationship and a discussion of the conflict. Submit the list as an attachment to the application. If an applicant does not submit a list of conflicts of interest, MDH will assume that no conflicts of interest exist for that applicant.

Organizational conflicts of interest occur when:

- a grantee or applicant is unable or potentially unable to render impartial assistance or advice to MDH due to competing duties or loyalties, or
- a grantee's or applicant's objectivity in carrying out the grant is or might be otherwise impaired due to competing duties or loyalties.

In cases where a conflict of interest is suspected, disclosed or discovered, the applicants or grantees will be notified and actions may be pursued, including but not limited to disqualification from eligibility for the grant award or termination of the grant agreement.

## Public Data and Trade Secret Materials

All applications submitted in response to this RFP will become property of the State. In accordance with Minnesota Statute Section 13.599, all applications and their contents are private or nonpublic until the applications are opened.

Once the applications are opened, the name and address of each applicant and the amount requested is public. All other data in an application is private or nonpublic data until completion of the evaluation process, which is defined by statute as when MDH has completed negotiating the grant agreement with the selected applicant.

After MDH has completed the evaluation process, all remaining data in the applications are public with the exception of trade secret data as defined and classified in Minn. Stat. § 13.37, Subd. 1(b). A statement by an applicant that the application is copyrighted or otherwise protected does not prevent public access to the application or its contents (Minn. Stat. § 13.599, subd. 3(a)).

If an applicant submits any information in an application that it believes to be trade secret information, as defined by Minnesota Statute Section 13.37, the applicant must:

- Clearly mark all trade secret materials in its application at the time it is submitted,
- Include a statement attached to its application justifying the trade secret designation for each item, and
- Defend any action seeking release of the materials it believes to be trade secret and indemnify and hold harmless MDH and the State of Minnesota, its agents and employees from any judgments or damages awarded against the State in favor of the party requesting the materials and any and all costs connected with that defense.
- This indemnification survives MDH's award of a grant agreement. In submitting an application in response to this RFP, the applicant agrees that this indemnification survives as long as the trade secret materials are in possession of MDH. The State will not consider the prices submitted by the responder to be proprietary or trade secret materials.

MDH reserves the right to reject a claim that any particular information in an application is trade secret information if it determines the applicant has not met the burden of establishing that the information constitutes a trade secret. MDH will not consider the budgets submitted by applicants to be proprietary or trade secret materials. Use of generic trade secret language encompassing substantial portions of the application or simple assertions of trade secret without substantial explanation of the basis for that designation will be insufficient to warrant a trade secret designation.

If a grant is awarded to an applicant, MDH may use or disclose the trade secret data to the extent provided by law. Any decision by the State to disclose information determined to be trade secret information will be made consistent with the Minnesota Government Data Practices Act (Minnesota Statutes chapter 13) and other relevant laws and regulations.

If certain information is found to constitute trade secret information, the remainder of the application will become public; in the event a data request is received for application information, only the trade secret data will be removed and remain nonpublic.

## Audits

Per [Minn. Stat. §16B.98](#) Subdivision 8, the books, records, documents and accounting procedures and practices of the grantee or other party that are relevant to the grant or transaction are subject to examination by the granting agency and either the legislative auditor or the state auditor, as appropriate. This requirement will last for a minimum of six years from the grant agreement end date, receipt and approval of all final reports or the required period of time to satisfy all state and program retention requirements, whichever is later.

## Affirmative Action and Non-Discrimination Requirements for all Grantees

The grantee agrees not to discriminate against any employee or applicant for employment because of race, color, creed, religion, national origin, sex, marital status, status in regard to public assistance, membership or activity in a local commission, disability, sexual orientation or age in regard to any position for which the employee or applicant for employment is qualified. [Minn. Stat. §363A.02](#). The grantee agrees to take affirmative steps to employ, advance in employment, upgrade, train and recruit minority persons, women, and persons with disabilities.

The grantee must not discriminate against any employee or applicant for employment because of physical or mental disability in regard to any position for which the employee or applicant for employment is qualified. The grantee agrees to take affirmative action to employ, advance in

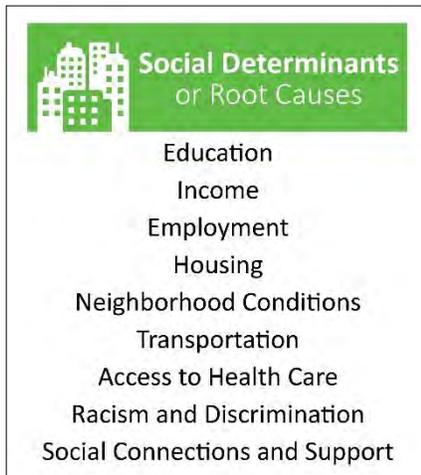
employment and otherwise treat qualified disabled persons without discrimination based upon their physical or mental disability in all employment practices such as the following: employment, upgrading, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation and selection for training, including apprenticeship. Minnesota Rules, part [5000.3500](#).

The grantee agrees to comply with the rules and relevant orders of the Minnesota Department of Human Rights issued pursuant to the Minnesota Human Rights Act.

## RFP Part 5: Appendices

### Appendix A: Root Causes/Conditions for Health

*For those working in Level of Change 3, the following list of root causes/conditions for health (also known as the social determinants of health) may help applicants think about the many complex and interconnected root causes of health disparities. Please note that the following list is not exhaustive. There are many different ways of thinking about and classifying the root causes of disparities or the conditions needed to achieve health and health equity. The social determinants listed below are also not in order of importance.*



#### Education

Education opens the doors to opportunities and resources that lead to a higher socioeconomic status<sup>15,16</sup>. More education is associated with higher-paying jobs and the benefits that come with those jobs, like financial security, health insurance, healthier working conditions and social connections. Education also gives us the tools we need to make choices about our health. People who have more years of education tend to live longer and have better health. Education also affects health across generations, because children of more educated parents tend to be healthier and do better in school.

#### Income

Income is one of the strongest predictors of health<sup>17,18</sup>. People with higher incomes and greater wealth generally enjoy better health and live longer than people with lower incomes. On average, the more money you make, the healthier you are. Individuals and communities with higher incomes are more likely to have safe homes and neighborhoods, access to health care, grocery stores with healthy foods and good schools. On the other hand, people living in poverty face many hardships that can lead to poor health, such as unsafe housing, lack of access to healthy foods, less time for physical activity, less education and more overall stress. Income also has a significant impact on the health and future income of children, and it can affect health across generations.

#### Employment

Employment provides income and other resources, such as health insurance, that lead to better health<sup>19,20</sup>. Our jobs can also give us a sense of identity and purpose, as well as social connections.

<sup>15</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>16</sup> Robert Wood Johnson Foundation, [Education and Health](#) (2011)

<sup>17</sup> Minnesota Department of Health, [White Paper on Income and Health](#) (2014)

<sup>18</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>19</sup> Robert Wood Johnson Foundation, [Work, Workplaces and Health](#) (2015)

<sup>20</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

Where we work, and the type of work we do, influences our health. People with lower socioeconomic status are more likely to work in jobs with unhealthy and/or unsafe working conditions. Unemployment can also contribute to poor health—and good health is often needed for employment. This creates a bad cycle for people who are unable to work because of illness or disability; without employment, they have fewer resources and opportunities to improve their health.

## Housing

Good health depends on having homes that are safe and healthy<sup>21,22</sup>. A safe and healthy home gives people security, privacy and stability, which can lower their stress. Homeowners often have better health than renters. Lower-income families in poor living conditions are more likely to suffer from serious illnesses – both infectious and chronic – and injuries. Unhealthy and unsafe living conditions can include run-down homes, pest infestations, mold, lead and other toxins in the home and overcrowding. These conditions can negatively affect children’s growth and development. Not having a home is even worse; homelessness has serious impacts on the health and well-being of individuals and families.

## Neighborhood Conditions

The neighborhoods we live in have powerful effects on our health and how long we live<sup>23,24</sup>. A safe and healthy neighborhood provides places for children to play and adults to exercise that are free from crime, violence and pollution. Experiencing nature and green spaces is beneficial to health, and having green spaces in your neighborhood makes them easier to access. Access to grocery stores selling fresh fruits and vegetables makes it easier for people to eat healthful foods. Good public transportation helps people get to their jobs, medical appointments and other places they need to go. Living in a neighborhood with good schools and public services, as well as connections and trust between neighbors, strengthens health. However, not everyone has access to healthy neighborhoods. Housing discrimination over many years has limited the ability of many low-income families, American Indians and people of color to move to healthy neighborhoods. Laws and policies may favor wealthier neighborhoods, leaving lower-income communities struggling with a lack of resources to make their neighborhoods safer and healthier. Many people in rural communities also have difficulty accessing healthy food, medical care, public services and other important resources for health.

## Transportation

Transportation is key to all of our daily activities, providing access to jobs, food and health care, as well as connections to family and friends. Having a range of transportation options improves social connectedness, supports mental health and provides access to economic opportunity. Reliable and affordable transportation is important for equity in health. Equitable transportation supports the health of communities by ensuring that everyone can get where they need to go. Older adults, youth and people with disabilities may rely on public transportation, when it is available. Rural populations may

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<sup>21</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>22</sup> Robert Wood Johnson Foundation, [Housing and Health](#) (2011)

<sup>23</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>24</sup> Robert Wood Johnson Foundation, [Housing and Health](#) (2011)

have very limited transportation options. In cities, heavy traffic may cause noise and air pollution, limit opportunities for walking and pose safety hazards.

## Access to Health Care

Access to quality health care is important for protecting health<sup>25,26</sup>. Without access to routine health care, people's health needs are often not met and they may become sicker and end up in the emergency room. People with health insurance are much more likely to have access to health care, including preventive services that can help them avoid chronic disease. Not having insurance is a major barrier to accessing health care. Transportation, language and cost can also be barriers. If people cannot get to medical appointments or have a hard time communicating with health care providers, their access is limited. Even if people have health insurance, it may not cover enough of the costs to make it affordable to access the care they need. Some communities, especially in rural areas, do not have enough doctors and clinics. Disparities in access to health care affect people's quality of life and ability to contribute fully to society.

## Racism and Discrimination

Many research studies show that racism leads to worse health for people of color<sup>27,28,29</sup>. People of color have higher rates of serious health issues than whites, including heart disease, stroke, diabetes, hypertension, certain cancers, respiratory illness and pain-related problems. On average, African Americans, American Indians, Pacific Islanders and some Asian American groups live shorter lives and have worse health outcomes than whites. Because of discrimination and structural racism, people of color are likely to be less wealthy, have less education and live in segregated communities with underfunded schools and public services, poor transportation and housing, and more environmental hazards. But even when people of color have higher incomes and education levels, their health can still be negatively impacted by racism. For example, infant mortality rates among babies born to college-educated African American women are higher than rates among babies born to white women who have not finished high school.

Racism and other forms of discrimination – including discrimination and stigma against people with disabilities, LGBTQ individuals, people who practice certain religions and immigrants – prevent people from accessing opportunities and services. People's health suffers when they experience discrimination from individuals. Even more damaging are institutions and systems that exclude, do not serve or harm some groups of people.

## Social Connections and Support

Social connections and support contribute to people's health by giving them the emotional and practical resources they need, such as encouraging words during a difficult time or rides to medical

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<sup>25</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>26</sup> Office of Disease Prevention and Health Promotion, [Healthy People 2020: Access to Health Services](#)

<sup>27</sup> World Health Organization, [The Solid Facts](#) (2003)

<sup>28</sup> Santa Clara County Public Health report, [Health and Social Equity in Santa Clara County](#) (2011)

<sup>29</sup> California Newsreel, [Unnatural Causes: Backgrounders from the Unnatural Causes Health Equity Database](#) (2008)

appointments<sup>30,31</sup>. Belonging to a social network makes people feel cared for and valued. Supportive relationships can reduce stress and promote healthier behaviors. Social support improves outcomes related to many health conditions, as well as pregnancy outcomes. Social support may be especially important for communities of color because of its role in protecting against the harmful health effects of discrimination.

Social isolation and exclusion, on the other hand, are associated with premature death. People who get less social and emotional support from others are more likely to experience health problems such as depression, pregnancy complications and disability from chronic diseases. Social isolation is a special concern for older adults, people with disabilities and people experiencing stigma related to certain health conditions or related to a certain part of their identity.

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<sup>30</sup> World Health Organization, [The Solid Facts](#) (2003)

<sup>31</sup> Office of Disease Prevention and Health Promotion, [Healthy People 2020: Social Cohesion](#)

## Appendix B: Application Scoring Criteria

A numerical scoring system will be used to evaluate eligible applications. Scores will be used to develop final recommendations.

Applicants are encouraged to score their own application using the evaluation score sheet before submitting their application. This step is not required, but may help ensure applications address the criteria evaluators will use to score applications.

### Rating Levels

Rating or Score	Description
Excellent or 5	Outstanding level of quality; significantly exceeds all aspects of the minimum requirements; no significant weaknesses.
Very Good or 4	Substantial response; meets in all aspects and in some cases exceeds, the minimum requirements; no significant weaknesses.
Good or 3	Generally meets minimum requirements; significant weaknesses, but correctable.
Marginal or 2	Lack of essential information; low probability for success; significant weaknesses, but correctable.
Unsatisfactory or 1	Fails to meet minimum requirements; needs major revision to make it acceptable.

### Scoring Sections

#### I. ORGANIZATIONAL VALUES AND CAPACITY (30 POINTS)

Criteria	Score (1-5)
1. a. Lead organization’s history, mission and major programing are aligned with and/or complement CHE’s mission, values and approaches and EHDI program principles.	
b. Lead organization shows a strong history of working to eliminate health disparities and advance racial equity.	
2. The EHDI grant complements and/or builds off the organization’s current programming and broader work.	
3. The organization fosters trust and belonging with the population(s) served by the grant, including: <ul style="list-style-type: none"> <li>the organization’s history of co-creation with the population(s) served, and</li> <li>the lived experience and/or training of their organization’s staff.</li> </ul>	
4. The organization’s staff, leadership and board reflect the population(s) they propose to serve. If staff, leadership and board are not reflective of the population(s) served, the applicant shows significant and genuine efforts being made to improve in this area.	
5. The organization demonstrates that it values the many identities and lived experiences of the population(s) served (e.g., people of color and American Indians who identify as LGBTQ, have a disability, live in rural areas and/or have low incomes) and cultivates a welcoming environment where people can be their full selves.	
<b>Total score points for this section:</b>	

II. PROJECT NARRATIVE (40 POINTS)

Criteria	Score (1-5)
6. The applicant shows an understanding of the extent of the disparity or disparities in the target population(s) for the identified priority health area(s).	
7. The identified <b>level(s) of change</b> are clear, reasonable and appropriate to address the priority health area(s) in the population(s) served ( <i>multiply points by 2</i> ). ( <i>The content of the response is more important than identifying the “correct” level of change. We view change on a continuum.</i> )	x 2 = _____
8. The proposed <b>strategies</b> are appropriate for the disparities in Question 6, grounded in cultural knowledge and wisdom and sound overall.	
9. The <b>activities</b> to address the identified priority health area(s) in the population(s) served will contribute to the level(s) of change identified in Question 7 ( <i>multiply points by 2</i> ).	x 2 = _____
10. a. The proposed activities value cultural knowledge and wisdom and build on community resilience.	
b. The applicant provides a convincing rationale that the strategies and activities will be effective in the target population(s). Rationale may include lived experiences, organizational experiences, research, etc. (all ways of knowing should be given equal weight).	
<b>Total score points for this section:</b>	

III. COMMUNITY ENGAGEMENT AND COLLABORATION (30 POINTS)

Criteria	Score (1-5)
11. The applicant’s strategies and activities were co-created with the proposed community served and/or the applicant shows that the community served will be involved in the co-creation of the project strategies and activities moving forward. Co-creation should involve listening deeply, sharing power and community-driven decision-making ( <i>multiply points by 2</i> ).	x 2 = _____
12. a. The applicant shows an understanding of related activities, projects or services in the community/communities served and shows how their proposed project fills an unmet need or gap in the field.	
b. The applicant shows how their proposed project will work together with related activities, projects or services in the community served in meaningful and mutually beneficial ways.	
13. The applicant describes how they will collaborate with stakeholders such as other community organizations, local public health, other government agencies or health systems, contributing to building systems that heal, not harm ( <i>multiply points by 2</i> ).	x 2 = _____
<b>Total score points for this section:</b>	

IV. EVALUATION AND IMPACT (20 POINTS)

Criteria	Score (1-5)
14. a. The <b>plan</b> to evaluate the components and impact of their project are clear, reasonable and appropriate. If the applicant has limited evaluation expertise and only has a tentative evaluation plan in place, the applicant shows a willingness and thoughtful plan to take advantage of MDH-provided technical assistance to increase its staff and organizational capacity to evaluate the project and its impact ( <i>out of 2.5 points</i> ).	

Criteria	Score (1-5)
b. <b>Staff and/or contractors</b> involved in the evaluation have relevant experience and/or interest in evaluation ( <i>out of 2.5 points</i> ).	
15. Community voices are included in the evaluation of the project, including how data are collected and interpreted.	
16. The proposed outcomes among the target population(s) are clear, feasible and appropriate for the proposed level(s) of change.	
17. The plan to integrate learning from their evaluation into their EHDI project activities is clear, reasonable and appropriate.	
<b>Total score points for this section:</b>	

#### V. WORK PLAN (15 POINTS)

Criteria	Score (1-5)
18. The project <b>objectives</b> are clear, measurable, feasible and appropriate for the target population(s).	
19. The <b>activities</b> are clear and comprehensive and will achieve the identified objectives and strategies. Each activity includes the staff involved; external partners involved; expected timeline; an estimate of the number of people reached by the activity; and outputs.	
20. The work plan as a whole provides a clear picture of the <b>scope and timeline</b> of the proposed project.	
<b>Total score points for this section:</b>	

#### VI. BUDGET (15 POINTS)

Criteria	Score (1-5)
21. The requested level of funding is reasonable and justified for the proposed scope of activities, level(s) of change and depth of partnerships.	
22. The budget narrative includes a clear and reasonable description of how funds will be used for the first two years of the grant.	
23. The expenditures in the budget narrative support activities outlined in the work plan, including meeting grant requirements, supporting community partners and evaluating the project activities and outcomes.	
<b>Total score points for this section:</b>	

## Appendix C: Breast and Cervical Cancer

### Part I. Background Information

**Breast cancer** is a disease in which cells in the breast grow out of control. Different kinds of breast cancer result from different cells in the breast growing abnormally. **Cervical cancer** is a cancer that occurs when the cells of the cervix grow abnormally and invade other tissues and organs of the body.

#### Breast Cancer in Minnesota

Breast cancer is the most common type of cancer found in any racial or ethnic group of Minnesota women and the second leading cause of cancer deaths. In Minnesota, 1 in 8 women will be diagnosed with breast cancer in their lifetime. The American Cancer Society (ACS) estimates that in 2018, 4,500 Minnesota women will be diagnosed with breast cancer and 630 of them will die from breast cancer.

#### Disparities in Breast Cancer

Disparities in breast cancer incidence and mortality are significant and longstanding, with death rates in Minnesota significantly higher for non-whites compared to whites.

- Breast cancer *incidence* (new cases) rates are lower among African American and African women in Minnesota compared to white women, but *mortality* (death) rates are significantly higher among African American and African women.
- Breast cancer incidence is lower in Hispanic women, but it continues to be the most common cancer diagnosed and is the leading cause of cancer-related death in this population.
- American Indian and Alaska Native women in Minnesota experience the second-highest rates of breast cancer incidence and third-highest mortality rate. For American Indian and Alaska Native women living in Contracted Health Service Delivery Areas or CHSDAs, geographical entities under contract with the Indian Health Service to provide services to American Indians in the area, incidence and mortality rates exceed statewide rates for American Indians and Alaska Natives.

#### Cervical Cancer in Minnesota

According to ACS, about 140 Minnesota women will develop invasive cervical cancer in 2018, with approximately 40 deaths. Thousands more women will develop precancerous changes of the cervix that may progress to cervical cancer if left untreated. Each year approximately 31,500 women and men will be diagnosed with a cancer related to human papillomavirus (HPV), a sexually transmitted infection. Cervical cancer is the most common form of HPV-related cancer.

#### Disparities in Cervical Cancer

While invasive cervical cancer and deaths related to cervical cancer are rare in non-Hispanic white women in Minnesota, the disease disproportionately affects communities of color.

- Incidence rates of cervical cancer are highest for women in the American Indian/Alaska Native population in CHDAs and/or statewide, followed (in decreasing order) by Asian American/Pacific Islander, Hispanic and African American/African-born populations.

- While the incidence rate for American Indian and Alaska Native women is the highest in CHSDAs, the overall statewide incidence rate for American Indian and Alaska Native women is still 3 to 4 times higher than the rate for white women.
- When detected early, precancerous changes generally require less treatment and cost, and treating precancerous changes can prevent them from developing into cervical cancer.

## Risk Factors

For *breast cancer*, one of the greatest risk factors for dying due to breast cancer is a lack of screening (mammography). According to the Centers for Disease Control and Prevention (CDC), all women age 40 and older should get regular annual mammograms. Approximately 98 percent of women who have breast cancer detected in its earliest stages survive. The proportion of survivors drops to 23 percent for women whose breast cancer has spread to other parts of the body.

- Minnesota's public health goal is a 90-percent screening rate for all women age 40 and over. The Statewide Behavioral Risk Factor Surveillance System (BRFSS) survey data from 2016 indicate that approximately 82 percent of women age 50 and older had a mammogram in the last two years. The rate of screening for breast cancer in Minnesota women is highest in white women.
- Among women diagnosed with breast cancer in Minnesota from 2010 to 2014, 51 percent of non-Hispanic black women, 59 percent of Asian/Pacific Islander women, 63 percent of American Indian women and 67 percent of Hispanic (all races) women were diagnosed in an early stage. These rates compare to 65 percent for non-Hispanic white women.
- According to a 2017 report, 61 percent of Minnesota women with insurance through Minnesota Health Care Programs (MHCP), such as Medical Assistance or MNCare, had breast cancer screening in the previous year. This rate is considerably lower than the 78 percent screening rate for women insured with other types of plans. Even within the MHCP coverage group, American Indian/Alaskan Native and Black/African American ranked the lowest in breast cancer screening completion.

Behavioral risk factors for *breast cancer* include alcohol consumption, smoking and diets high in fat. A study analyzing the dietary history of premenopausal women over 20 years showed higher intake of red meat contributing to increased risk of breast cancer. Additional risk factors for breast cancer include family history of breast cancer, advancing age, and exposure to excess estrogen via oral contraceptives and hormone replacement therapy.

Lack of screening is also a significant risk factor for *cervical cancer*. Prior to the initiation of cervical cancer screening with the Pap smear in the 1950s, cervical cancer was a leading cause of death for women in the U.S. and worldwide. The use of the Pap smear in cervical cancer screening has transformed the diagnosis of an invasive cervical cancer so that a death related to cervical cancer is almost entirely preventable.

- The available evidence suggests that women of color in Minnesota are at greater risk for cervical cancer due to less frequent screening and follow-up care.
- While approximately 90 percent of African American/African women reported having a Pap smear within the past 3 years, the screening rates for other populations were lower.

An additional risk factor for *cervical cancer* is the lack of immunization against HPV. Behavioral risk factors associated with greater exposure to HPV include early sexual contact and multiple sexual partners.

## Protective Factors

As noted in the risk factors, screening is perhaps the most protective of factors for preventing deaths due to breast and cervical cancer. Here are some other protective factors for reducing the risk of breast and cervical cancer:

- **HPV vaccination** before initiation of sexual activity, for both boys and girls, can be a powerful protective strategy, as studies have shown that HPV is responsible for virtually all cases of cervical cancer. Vaccination, however, does not eliminate the need for cervical cancer screening.
- **Breastfeeding** for at least one year after giving birth can lessen a woman's risk of both premenopausal and postmenopausal breast cancer by reducing her exposure to estrogen. An analysis of over 47 epidemiological studies across 30 countries found that the relative risk of breast cancer decreased 4.3 percent for every 12 months of breastfeeding.
- Developing **supportive, trauma-informed health care systems** that are culturally competent, flexible and responsive to patient circumstances assures that women have the information they need to prevent breast and cervical cancer, as well as timely and effective testing and treatment.
- Having **information and the capacity to act** on that information empowers women to create healthy environments for themselves, their families and their communities.

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to all people, with strong social connections and support, can encourage healthy behaviors by connecting people with resources and upholding positive social norms. Supportive environments help protect against trauma and stress that increase cancer risk. A strong social network also helps people stay active and engaged while undergoing cancer treatment and recovery. A [2012 Kaiser Permanent study](#) also found that patients diagnosed with early stage breast cancer who had strong social connections ultimately had a lower risk of breast cancer recurrence and reduced breast cancer death rate.
- **Racism and discrimination:** Early life circumstances, such as adverse childhood experiences, can contribute to developing breast and cervical cancer later in life. The experience of racism or other ongoing discrimination creates epigenetic changes (changes in people's genes) that pass to the next generation and increase risk for cancer. Racism and discrimination can also worsen people's health and keep them from accessing screenings, preventive care and treatment.
- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access primary health care, including screenings to detect cancer at an early stage. For those experiencing cancer, stable housing makes it easier to keep up with treatment.
- **Neighborhood conditions:** Neighborhood conditions can support healthy behaviors, such as helping people maintain a healthy diet and engage in regular physical activity, that are protective for cancer. These neighborhood conditions include safe and green places that are welcoming and accessible to all and the availability of affordable, fresh and healthy food.
- **Employment and benefits:** Employment with health insurance benefits is the primary way people in the U.S. obtain access to health care, which includes access to screening for breast and cervical cancer.

- **Income and wealth:** Like employment and benefits, income increases access to health care and screening. Higher-income populations are more likely to receive a timely diagnosis of cancer, increasing the possibility for effective treatment and reducing the risk of mortality. Lower-income populations are more likely to die from breast and cervical cancer. Because income is racialized in the U.S. (i.e., race is a strong predictor of income), the effects of income also follow racial lines.
- **Access to quality health care:** People who have experienced, or are at risk of, breast and cervical cancer benefit from access to high quality, affordable and culturally/linguistically competent care. Health care includes screenings to detect cancer at an early stage, preventive care, treatment and education about how to maintain health.
- **Transportation:** People need affordable, convenient transportation options to access cancer screenings, preventive care and treatment.

### Priority Health Area Specialist

**For more data, information on best practices or other cancer-related questions, contact:**

Elizabeth Wilson-Lopp  
 Regional Coordinator, Sage Screening Programs  
 651-201-5617  
[Elizabeth.wilson-lopp@state.mn.us](mailto:Elizabeth.wilson-lopp@state.mn.us)

## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHDI. **Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

**Goal:** To close the gap in the health status of populations of color and American Indians as compared to whites in breast and cervical cancer.

<p><b>Level of Change 1:</b> Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.</p>	
<p><b>Example Objective:</b> Increase screening rates for breast and cervical cancer in a specific population.</p>	
<p><b>Example Strategy:</b> Making cost effective or free breast and cervical cancer screening services available.</p>	
<p><b>Example Activity 1:</b></p>	<p>Provide free or low-cost screening options for uninsured, underinsured or those with high deductibles based on a threshold of annual income to promote screening services utilization.</p>
<p><b>Example Activity 2:</b></p>	<p>Leverage patient navigators and community health workers to help eligible population access and utilize free cancer screening services.</p>

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Strategy:** Partner with community organizations to develop culturally appropriate cancer screening education and outreach programs to increase health literacy and informed decision-making by patients.

**Example Activity 1:** Conduct “KAP” (Knowledge, Attitude and Practice) survey in the targeted community to understand their perspective about preventive health concepts.

**Example Activity 2:** Utilize the results from the KAP survey to develop, pilot, implement, and evaluate effectiveness of educational and outreach tools.

**Example Evaluation Measures:**

- 100 American Indian women receive free or low-cost mammograms (Output).
- 100 American Indian women receive free or low-cost Pap smears (Output).
- 80 percent of individuals who received free or low-cost screening from Project X return for at least one more screening (mammogram or Pap smear) after a year (Outcome).
- 90 percent of Project X participants increase their understanding of the risk factors for breast cancer/cervical cancer (Outcome).

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective:** Increase the capacity of the health care workforce to provide culturally appropriate breast and cervical cancer prevention initiatives.

**Example Strategy:** Implement a systems approach to encourage health care providers to use consistent messaging for patients around breast and cervical cancer screening.

**Example Activity 1:** Share best practices on how to increase screening in populations experiencing lower screening rates and higher late-stage cancer diagnoses.

**Activity 2:** Host a Best Practices in Cancer Prevention Summit for hospitals and clinics in 2020 to share best practices in breast and cervical cancer prevention.

**Example Activity 3:** Secure commitment from health care providers to utilize best practices in breast and cervical cancer prevention, and measure improvements in patient communication, patient satisfaction and screening completion rates.

**Example Strategy:** Expand the cancer workforce to include community health workers (CHWs), community health representatives (CHRs) and cancer navigators.

**Example Activity 1:** Promote cancer care training for CHWs, CHRs and lay health navigators by developing a cancer curriculum and certification program.

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

<b>Example Evaluation Measures:</b>	<p>100 percent of attendees in the Best Practices in Cancer Prevention Summit commit to utilizing best practices in breast and cervical cancer prevention as shared at the summit (Outcome).</p> <p>A cancer care curriculum and certification program for CHWs, CHRs and lay health navigators is developed (Output).</p> <p>100 CHWs, CHRs and lay navigators receive certification to provide cancer care (Output).</p> <p>Health care providers increase their hiring of CHWs, CHRs or lay health navigators for cancer care and prevention (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Increase food security (defined by Healthy People 2020 as the disruption of food intake or eating patterns because of lack of money and other resources).**

**Example Strategy: Increase nutritious food consumption for those who are food insecure.**

<b>Example Activity 1:</b>	Work with the Minnesota Department of Agriculture to increase use of food stamps (Electronic Benefits Transfer or EBT card) at farmers markets and neighborhood corner stores by providing financial assistance for the purchase of EBT machines.
<b>Example Activity 2:</b>	Partner with local public health or join coalition efforts to increase the number of farmers markets and neighborhood corner stores that accept EBT cards.

**Example Strategy: Increase use of parks by local residents, especially new immigrants and non-English-speaking communities.**

<b>Example Activity 1:</b>	Partner with local public health or join coalition efforts that are working with local, regional or state parks to increase park utilization by new immigrant and non-English-speaking communities.
<b>Example Activity 2:</b>	Work with the city parks and recreation department to conduct a survey of park users.
<b>Example Activity 3:</b>	Improve lighting and sidewalks on streets leading to local parks to encourage use.

<b>Example Evaluation Measures:</b>	<p>Number of farmers markets and neighborhood corner stores accepting EBT increases (Output).</p> <p>EBT sales of fresh produce at farmers markets and neighborhood corner stores increase (Output).</p> <p>Number of persons of color and American Indians (or new immigrants) who report visiting a city park in the past year increases (Outcome).</p> <p>Survey respondents report increased feelings of safety when visiting the parks in the past year (Outcome).</p>
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### Part III. Selected Resources

Breast cancer in Minnesota, American Cancer Society 2015:

<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/breast-cancer-facts-and-figures/breast-cancer-facts-and-figures-2015-2016.pdf>

Cancer Facts & Figures for African Americans 2016-2018, American Cancer Society 2016:

<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2016-2018.pdf>

Cancer Facts & Figures 2018, American Cancer Society 2018: <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/cancer-facts-figures-2018.html>

Health Care Disparities Report for Minnesota Health Care Programs, 2017: <http://mncm.org/wp-content/uploads/2018/03/2017-Disparities-Report-FINAL-3.26.2018.pdf>

Minnesota Cancer Facts & Figures, American Cancer Society 2015:

<http://www.health.state.mn.us/divs/healthimprovement/content/documents/CancerFandF.pdf>

Populations of Color in Minnesota Health Status Report, MDH 2009:

<https://www.leg.state.mn.us/docs/2009/other/090622.pdf>

## Appendix D: Cardiovascular Disease

### Part I. Background Information

**Cardiovascular disease**, also called heart and blood vessel disease, includes coronary heart disease, heart attack, stroke, high blood pressure and high blood cholesterol. Many heart and blood vessel diseases and conditions are related to a process called atherosclerosis, the hardening and narrowing of the arteries. The arteries narrow from plaque buildup in the vessel wall, making it harder for blood to flow through them. If a blood clot forms, stopping blood flow, it can cause a heart attack or stroke.

#### Heart Disease and Stroke in Minnesota

Heart disease and stroke are the second and sixth leading causes of death in Minnesota. Combined, they are responsible for about a quarter of all deaths in Minnesota, ranking just ahead of cancer as the number one cause of death.

#### Disparities

Death rates for Minnesotans overall are lower than the nation as a whole; however, for certain groups, including American Indians, African Americans and Asian Americans, age-adjusted death rates for heart disease and stroke are higher than the overall population rate.

From 2012 to 2016, the *heart disease* death rate was 55 percent higher in American Indians compared to whites in Minnesota. During the same time period, the *stroke* death rate was 26 percent higher in both African Americans and Asian Americans compared to whites. Individuals who have had a heart attack or stroke are at much higher risk of having a heart attack or stroke again, becoming permanently disabled or dying from complications in the months and years that follow.

In Minnesota, some racial and ethnic groups experience a higher burden of heart disease and stroke at younger ages. For example:

- From 2012 to 2016, the *heart disease* death rate for middle-aged adults ages 35 to 64 was twice as high for African Americans and more than three times higher for American Indians compared to white Minnesotans.
- More than half of African Americans and American Indians who die from *heart disease* in Minnesota are younger than age 65, compared to only 15 percent of white Minnesotans. Approximately half of white Minnesotans who die from heart disease are 85 years or older.
- A similar pattern is apparent for *stroke* for the 10-year period from 2007 to 2016. The data show that African Americans and American Indians die from heart disease and stroke at much younger ages than whites, Asian Americans and Hispanics or Latinos.

#### Risk Factors

- **High levels of total cholesterol** – Data from Minnesota’s 2015 Behavioral Risk Factor Surveillance System (BRFSS) reveal that while approximately 28 percent of adults in Minnesota had high cholesterol, 15.8 percent of white Minnesotans had *never* had their cholesterol checked compared to 25.3 percent of American Indians, 28.2 percent of blacks, 34.1 percent of Asians, and 36 percent of Hispanics.

- **High blood pressure/hypertension** – Approximately 1 in 4 adult Minnesotans report they have high blood pressure. About 69 percent of people who have a first heart attack have high blood pressure, a condition in which the pressure of the blood against blood vessel walls is too strong. High blood pressure can cause damage to the vessels and lead to other problems, including heart disease, stroke and kidney disease. National estimates suggest that up to one-third of hypertensive patients are unaware of their condition.
- **Obesity** – A growing body of evidence is showing that heart disease and stroke risk increases with increased weight. Minnesota’s 2016 BRFSS data show that 64 percent of adults were overweight, including more than 27 percent who are obese.
- **Diabetes** – The risk for heart disease and stroke is two to four times higher among people with diabetes. BRFSS data in 2016 show that approximately 7.6 percent of adults in Minnesota have been diagnosed with diabetes, but approximately a third of diabetics are unaware they have the disease.
- **Smoking** – Smoking doubles to triples the risk of dying from coronary heart disease. In addition, over 35,000 *nonsmokers* in the U.S. die from coronary heart disease each year due to environmental exposure to tobacco smoke. Smoking also doubles the risk of ischemic stroke, and may increase the risk for hemorrhagic stroke up to four times. Exposure to second-hand tobacco smoke nearly doubles the risk of stroke. According to 2016 BRFSS data, 15.5 percent of Minnesota adults were current smokers.
- **Physical inactivity** – Several studies have shown that physical *inactivity* increases the risk of heart disease anywhere from 1.5 to 2.4 times – comparable to the risk observed in high blood cholesterol, high blood pressure or cigarette smoking. According to 2015 BRFSS data, fewer than 23 percent of Minnesota adults were getting the [recommended amount of aerobic and strength exercise](#) (2015 BRFSS data), and 18 percent of adults in Minnesota were not physically active at all.
- **Stress** – Some health behaviors, such as smoking and overeating, are associated with high levels of daily stress.

## Protective Factors

- Having the tools and education necessary for preventing and managing diabetes (diabetes is a major risk factor for heart disease and stroke).
- Having information and the capacity to act on that information to engage in healthy behaviors and create healthy environments for individuals, their families and their communities.

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to all people, with strong social connections and support, can encourage healthy behaviors by connecting people with resources and upholding positive social norms. A strong social network helps people stay active and engaged during treatment and recovery. Supportive environments help protect against trauma and stress that increase heart disease and stroke risk. Research shows that social support can also serve as a buffer to prevent or reduce the harmful longer-term health effects associated with encountering traumatic events.
- **Racism and discrimination:** Early life circumstances, such as adverse childhood experiences, can contribute to developing heart disease and stroke later in life. The experience of racism or other

ongoing discrimination creates epigenetic changes (changes in people’s genes) that pass to the next generation and increase risk for heart disease and stroke. Racism and discrimination can also worsen people’s health and keep them from accessing screenings, preventive care and treatment.

- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access primary health care, including screenings to detect risk factors for heart disease and stroke. Stable housing also makes it easier to keep up with treatment and monitoring for heart disease and stroke.
- **Neighborhood conditions:** A safe and healthy neighborhood supports healthy behaviors that help protect against heart disease and stroke. For example, green spaces that are safe and accessible encourage people to engage in physical activity. Access to grocery stores selling fresh produce makes it easier for people to eat healthful foods.
- **Educational opportunity:** Minnesota has persistent disparities in four-year high school graduation rates by race/ethnicity and by disability status. Minnesotans with more education have fewer risk factors for heart disease and stroke. For example, they are much more likely to be employed, are less likely to be diagnosed with diabetes, are more likely to receive prenatal care and are less likely to smoke. Individuals with no formal education beyond a high school diploma report much higher rates of high blood pressure than those with at least a college degree (31 percent as compared to 22 percent).
- **Employment and benefits:** Meaningful work and adequate wages reduce stress, a significant risk factor for heart disease and stroke. Employment is also a form of social connection and support, as well as a source of access to health care.
- **Income and wealth:** Low income is a major source of stress, a significant risk factor for heart disease and stroke. The higher one’s income, the less likely one is to have heart disease or stroke, while the lower one’s income, the higher one’s risk for these diseases. A [2011 UC Davis study](#) found that people with lower socioeconomic status had a 50 percent greater risk of developing heart disease than other study participants. Income also affects the food people eat. According to the U.S. Department of Agriculture’s Current Population Survey, 13 percent of Minnesota households in 2018 were unable to provide adequate food for one or more household members due to lack of resources, a decline from 14.3 percent in 2016 and 14.6 percent in 2016.
- **Access to quality health care:** People who have experienced or are at risk of heart disease or stroke benefit from access to high quality, affordable and culturally/linguistically competent care. Health care includes screenings, preventive care, treatment and education about how to maintain health.
- **Transportation:** People need affordable, convenient transportation options to access screenings for risk factors, preventive care and treatment for heart disease and stroke.

## Priority Health Area Specialist

**For more data, information on best practices or other heart disease and stroke questions, contact:**

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## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHD. **Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

**Goal:** To close the gap in the health status of populations of color and American Indians as compared to whites in cardiovascular disease.

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Objective:** Increase awareness of the causes of cardiovascular disease and the recognition of cardiovascular events.

**Example Strategy:** Provide cardiovascular disease prevention education and activities.

<b>Example Activity 1:</b>	Implement culturally specific cardiovascular health curricula (e.g., Heart of Many Nations: Heart Attack Prevention & Response in Native Communities).
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<b>Example Activity 2:</b>	Utilize cultural gathering spaces (e.g., barber shops, hair salons, cafes, churches) to educate people about heart health by offering blood pressure screening and referring those with high blood pressure for follow-up services.
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<b>Example Activity 3:</b>	Hold group exercises twice a week for Project X participants.
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**Example Strategy:** Disseminate consistent, effective and culturally appropriate messaging around heart disease and stroke.

<b>Example Activity 1:</b>	Conduct public service announcements (PSAs) with culturally appropriate messaging using tribal community TV network and other ethnic media.
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<b>Example Activity 2:</b>	Create and disseminate written instructional/educational materials in various languages.
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<b>Example Evaluation Measures:</b>	80 percent of Project X participants diagnosed with or at risk for heart disease lower their blood pressure after one year (Outcome).
	80 percent of Project X participants diagnosed with or at risk for heart disease lower their blood cholesterol level after one year (Outcome).
	80 percent of Project X participants increase their knowledge of ways to reduce their risk of contracting heart disease (e.g., keeping blood pressure and blood cholesterol at recommended healthy levels) (Outcome).

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

	80 percent of Project X participants increase their amount and frequency of physical activity (Outcome).
	Number of PSAs conducted (Output).
	Cardiovascular disease handout translated and number of languages in which it is available (Outputs).

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective: Improve clinical practices to effectively serve communities experiencing health disparities related to cardiovascular disease.**

**Example Strategy: Link community resources and clinical services that support systematic referrals, self-management and lifestyle change for patients with high blood pressure and high blood cholesterol.**

<b>Example Activity 1:</b>	Implement electronic systems that can facilitate bidirectional referral between health care systems and community programs/resources that can help patients manage high blood pressure and high cholesterol. For example, use NowPow, an electronic community resource directory that can be integrated into electronic health records and care systems to generate e-prescriptions that match community services with a person’s health and social needs.
<b>Example Activity 2:</b>	Work with community food banks and food pantries to create a food choice list with heart healthy options that clients can use.
<b>Example Activity 3:</b>	Connect community organizations that operate a food bank or food pantry to food distribution programs (e.g., agricultural surplus program, grocery food diversion programs, urban farm programs) to increase their supply of fresh produce.

**Example Strategy: Increase monitoring of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol.**

<b>Example Activity 1:</b>	Develop a process for identifying potentially undiagnosed hypertensive patients in order to get them diagnosed and on the path to management of their hypertension.
<b>Example Activity 2:</b>	Assemble an interdisciplinary Quality Improvement (QI) team with appropriate clinical supports to monitor quality of services and clinical outcomes between population groups and recommend improvements.
<b>Example Activity 3:</b>	Recruit other clinics to adopt quality measures that use available clinic data to monitor health care disparities and implement activities to eliminate health care disparities (e.g., promote the use of dashboards to monitor clinical quality measures among population groups).

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

<b>Example Evaluation Measures:</b>	<p>Organization X decreases the average time (hours or days) between the time a client is identified as high-risk for diabetes (e.g., high blood pressure and high cholesterol) and the time the client is referred to culturally appropriate community resources for diabetes management (Outcome).</p> <p>Community organizations that operate a food bank or food pantry increase their stock of fresh produce at any given time (Outcome).</p> <p>An interdisciplinary QI team is assembled (Output).</p> <p>Organization X staff have ready access to data on their selected clinical measures on which to base quality improvement decisions (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Change the social norms (shared expectations of culturally appropriate and desirable behavior) around commercial tobacco use.**

**Example Strategy: Create a social environment and legal climate within institutions (e.g., schools, entertainment venues, workplaces, government agencies) in which there is less desirability, acceptability and accessibility around commercial tobacco.**

<b>Example Activity 1:</b>	<p>Join with local public health or other community efforts to raise the minimum sale age (MSA) for tobacco to age 21 (<a href="#">Tobacco 21 Campaign</a>) to delay or eliminate initiation of commercial tobacco use.</p> <p>The National Academy of Medicine reports that raising the age to purchase tobacco to 21 could lead to a 25 percent reduction in smoking initiation among 15-to-17-year-olds. Preventing youth from starting to smoke is essential to reducing smoking prevalence, considering that almost 95 percent of addicted adult smokers started before age 21.</p>
<b>Example Activity 2:</b>	<p>Join with community efforts to restrict the sale of flavored tobacco, including menthol cigarettes, to youth (e.g., implement ordinances that create a buffer zone so that sales are not allowed within a certain distance from youth gathering places, or allow their sale only in stores that primarily sell tobacco).</p>

**Example Objective: Modify the environment to make active transportation possible.**

**Example Strategy: Develop and implement comprehensive city plans that address built environment needs and ensure safe conditions for walking and biking.**

<b>Example Activity 1:</b>	<p>Work with community groups or local public health departments to implement a Safe Routes to School Program to make it safe, convenient and fun for children to bike and walk to school.</p>
<b>Example Activity 2:</b>	<p>Join comprehensive planning efforts to ensure the plans reflect the active transportation needs of communities experiencing health inequities (including ensuring that families who do not own cars can walk or bike safely to their destinations).</p>

<b>Level of Change 3:</b> Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.	
<b>Example Evaluation Measures:</b>	<p>The number of cities in Minnesota that implement ordinances to increase the tobacco buying age to 21 increases (Outcome).</p> <p>The Henderson city council passes an ordinance creating a buffer zone so that flavored tobacco sales are not allowed within a certain distance from youth gathering places (e.g., schools, parks, YMCA) (Output).</p> <p>The Henderson city council passes an ordinance allowing the sale of flavored tobacco only in stores that primarily sell tobacco (Output).</p> <p>Anderson County secures funding to implement a Safe Routes to School Program (Output).</p> <p>Miles of multi-use trails (for use by pedestrians, bicyclists and skaters) in Brown County increase by 2021 (Outcome).</p>

### Part III. Selected Resources

Check. Change. Control Program: An evidence-based hypertension management program that utilizes blood pressure self-monitoring to empower participants to take ownership of their cardiovascular health, AHA:

[http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/FindHBPToolsResources/Check-Change-iControli-Community-Partner-Resources\\_UCM\\_445512\\_Article.jsp#.W3ToH6Lhueh](http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/FindHBPToolsResources/Check-Change-iControli-Community-Partner-Resources_UCM_445512_Article.jsp#.W3ToH6Lhueh)

Find MN food access resources: <http://mnfoodcharter.com/resources/>

Find MN Safe Routes to School resources, MnDOT: <http://www.dot.state.mn.us/mnsaferoutes/>

Programs & Initiatives in Communities: Clipper N Curls for the Heart, MDH: <http://www.health.state.mn.us/divs/healthimprovement/programs-initiatives/in-communities/clippersncurls.html>

Minnesota “Ask about Aspirin” initiative, UMN: <http://askaboutaspirin.umn.edu/>

Programs & Initiatives in Communities: Heart of Many Nations: Heart Attack Prevention & Response in Native Communities curriculum, MDH:

<http://www.health.state.mn.us/divs/healthimprovement/programs-initiatives/in-communities/heartofmanynations.html>

## Appendix E: Diabetes

### Part I. Background Information

**Diabetes** is a group of diseases that occur when a person's body accumulates too much glucose (sugar) in the blood. This can lead to major chronic health problems, including cardiovascular disease, stroke, blindness, kidney disease and nerve damage.

**Prediabetes** means that a person's blood sugar level is higher than normal but not yet high enough to be type 2 diabetes. Prediabetes puts a person at greater risk for developing diabetes and other health conditions associated with diabetes, such as stroke, cardiovascular disease and eye problems.

### Diabetes in Minnesota

Diabetes is the seventh leading cause of death in Minnesota. It is also the leading cause of blindness, kidney failure and lower-limb amputations. In 2015, 7.6 percent of Minnesota adults (about 320,000) had ever been diagnosed with diabetes (type 1 or 2). More than 18,000 new cases of diabetes are diagnosed in Minnesota each year. About 1 in 4 people with diabetes do not know that they have the disease.

### Disparities

National data show clear racial and ethnic disparities in the percentage of people living with diabetes (prevalence). Nationally, the prevalence of *diabetes* for non-Hispanic whites and for Asian Americans is around 8 percent, while the prevalence for Hispanics, non-Hispanic blacks, and American Indians or Alaska Natives is 12.1, 12.7, and 15.1 percent, respectively. When data are disaggregated, Southeast Asian Americans also experience higher rates of diabetes. The [Centers for Disease Control and Prevention \(CDC\)](#) estimates that 84 million U.S. adults, approximately one in every three, had *prediabetes* in 2015.

Minnesota-specific data show that the death rate from diabetes for African Americans is almost twice the rate for whites, and the death rate for American Indians in Minnesota is almost four times higher than the rate for whites.

Minnesota also has disparities in the percentage of people who meet diabetes care guidelines, including all five diabetes goals for [Optimal Diabetes Care](#) (blood sugar and blood pressure control, cholesterol, aspirin and tobacco use). For example:

- Thirty-one percent of American Indians and Alaska Natives meet the Optimal Diabetes Care measure as compared to 59 percent of Asian adults.
- Forty-six percent of Hispanic or Latino adults meet the Optimal Diabetes Care measure as compared to 54 percent of non-Hispanic adults.
- Forty percent of adults who prefer to speak Hmong meet the Optimal Diabetes Care measure as compared to 67 percent of adults who prefer to speak Vietnamese.

### Risk Factors

- Overweight or obese
- Age 45 or older
- Family history of diabetes
- High blood pressure

- Not being physically active
- Smoking
- Low level of HDL (“good”) cholesterol or a high level of triglycerides
- Stress (often linked to social determinants, described below)
- Certain medical conditions or history, including gestational diabetes or having given birth to a baby weighing 9 pounds or more, polycystic ovary syndrome (PCOS), or history of heart disease or stroke
- Depression, trauma or adverse childhood experiences

### Protective Factors

- Equipping people with the tools, knowledge and ability to prevent and manage their own diabetes
- Creating environments that support healthy behaviors, such as eating nutritious foods and being physically active
- Assuring that children have safe, stable, nurturing environments to prevent trauma and future chronic conditions

### Social Determinants

- **Social connections and support:** Creating communities that are welcoming to all people, with strong social connections and support, can encourage healthy behaviors by connecting people with resources and upholding positive social norms. Supportive environments help protect against trauma and stress that increase diabetes risk. A strong social network also helps people stay active and engaged while managing their diabetes.
- **Racism and discrimination:** Early life circumstances, such as adverse childhood experiences, can contribute to developing diabetes later in life. The experience of racism or other ongoing discrimination creates epigenetic changes (changes in people’s genes) that pass to the next generation and increase risk for diabetes. Racism and discrimination can also worsen people’s health and keep them from accessing screenings, preventive care and treatment.
- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access health care, including screenings to detect risk factors for diabetes. For those with diabetes, stable housing also makes it easier to keep up with treatment and monitoring.
- **Neighborhood conditions:** A safe and healthy neighborhood supports healthy behaviors that help prevent and manage diabetes. For example, green spaces that are safe and accessible encourage people to engage in physical activity. Access to grocery stores selling fresh produce makes it easier for people to eat healthful foods.
- **Educational opportunity:** Educational opportunities, including extracurricular activities and post-high school education, improve health overall and reduce the incidence of diabetes. In 2015, about 5.4 percent of adults with a college degree reported having diabetes, compared with 8.5 percent of adults without a college degree.
- **Employment and benefits:** Meaningful work and adequate wages provide social connection and financial security, both of which reduce the stress that can contribute to diabetes (stress stimulates the release of various hormones, which can result in elevated blood glucose levels). Employment also provides access to health care for people with prediabetes and diabetes.

- **Income and wealth:** Health survey data from 2013 through 2015 show that self-reported diabetes rates are higher for people living in households with lower incomes. Low income contributes to stress, a risk factor for diabetes complications; low income also increases food insecurity, making it more difficult to manage diabetes through nutrition.
- **Access to quality health care:** People with diabetes or prediabetes benefit from access to high quality, affordable and culturally/linguistically competent care, including treatment and education about how to manage their condition. People at risk of diabetes also benefit from routine access to preventive care and screenings.
- **Transportation:** People need affordable, convenient transportation options to access diabetes screenings, preventive care and treatment.

### Priority Health Area Specialist

**For more data, information on best practices or other diabetes-related questions, contact:**

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## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHDl.

**Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

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

<p><b>Level of Change 1:</b> Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.</p>	
<p><b>Example Objective:</b> Improve the health status of people with diabetes.</p>	
<p><b>Example Strategy:</b> Deliver culturally responsive diabetes education programs and services.</p>	
<b>Example Activity 1:</b>	Organize and host workshops (e.g., <i>Living Well</i> ) in convenient community locations such as a church, senior center or public housing facility for people with diabetes in a community.
<b>Example Activity 2:</b>	Recruit and train workshop leaders and lifestyle coaches that represent the cultures and languages of high-risk populations.
<b>Example Activity 3:</b>	Deliver diabetes support services in other formats (e.g., cooking and meal planning classes, fitness or dance classes, grocery trips).

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

<b>Example Activity 4:</b>	Deliver diabetes support services in various languages by developing culturally specific modules.
<b>Example Evaluation Measures:</b>	<p>Living Well workshops held in x number and x types of community settings (Output).</p> <p>X number of workshop leaders and lifestyle coaches recruited and trained who represent the most at-risk populations (Output).</p> <p>X number of alternative language formats in which the curriculum was delivered (Output).</p> <p>70 percent of program participants report that they increased their knowledge of how to plan healthy meals (Outcome).</p> <p>70 percent of program participants report that they increased their knowledge of how to prepare healthy meals (Outcome).</p> <p>70 percent of program participants report that they increased their amount and frequency of physical activity (Outcome).</p>

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

<b>Example Objective: Increase organizational capacity to prevent diabetes.</b>	
<b>Example Strategy: Improve health care referral systems and protocols.</b>	
<b>Example Activity 1:</b>	Create referral systems and protocols for health care providers to identify at-risk patients and immediately refer them to appropriate diabetes prevention programs such as the <a href="#">National Diabetes Prevention Program (NDPP)</a> .
<b>Example Activity 2:</b>	Utilize team-based approaches to enhance coordination of care for patients to improve processes for identifying and referring patients to a diabetes prevention program.
<b>Example Activity 3:</b>	Incorporate feedback loops into electronic health record systems to enhance bi-directional communication between the health system and community diabetes prevention providers to more effectively manage patient care.
<b>Example Strategy: Develop infrastructure to support a diabetes prevention service provider network to improve practice and increase availability of services.</b>	
<b>Example Activity 1:</b>	Provide technical assistance in implementing specific diabetes prevention programs.
<b>Example Activity 2:</b>	Provide peer support to share best practices and lessons learned.

<b>Level of Change 2:</b> Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.	
<b>Example Activity 3:</b>	Work with large employers and insurers to offer diabetes prevention programs as a covered insurance benefit.
<b>Example Evaluation Measures:</b>	<p>90 percent of patients identified as high-risk for diabetes are referred to community diabetes prevention programs (Output).</p> <p>90 percent of patients identified as high-risk for diabetes are referred to a dietician (Output).</p> <p>80 percent of patients identified as high-risk for diabetes and receive ongoing diabetes prevention services report that they have made at least one healthy lifestyle change (Outcome).</p> <p>90 percent of Diabetes Prevention Services Provider Coalition members agree that membership in the coalition has helped them become a better diabetes educator (Outcome).</p> <p>Held 2 meetings with each of 5 companies to discuss the benefits of diabetes prevention (Output).</p>

<b>Level of Change 3:</b> Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.	
<b>Example Objective: Strengthen conditions for healthy lifestyles.</b>	
<b>Example Strategy: Create walkable and bikeable communities.</b>	
<b>Example Activity 1:</b>	Participate in local planning efforts that are creating master walk and bike plans, updating municipal plans to include "complete streets" with sidewalks and crosswalks, increasing access to walking and bicycling networks, connecting and promoting trail systems, and collaborating on projects that improve walkability in communities.
<b>Example Activity 2:</b>	Join local public health, AARP or other coalition efforts to advocate for policies that provide safe communities and walking conditions for seniors.
<b>Example Strategy: Increase vulnerable populations' access to healthy foods.</b>	
<b>Example Activity 1:</b>	Join local public health or other coalition efforts to increase access to and consumption of fruits and vegetables (e.g., increasing the number of farmers markets, expanding the <a href="#">Minneapolis Healthy Corner Store Program</a> , strengthening enforcement of the <a href="#">Minneapolis Staple Foods ordinance</a> ).
<b>Example Activity 2:</b>	Join advocacy efforts to ensure that treaty rights to hunt, fish, and gather in traditional places are honored. These are rights reserved by tribes when their sovereign nations ceded millions of acres of land in treaties with the United States.
<b>Example Evaluation Measures:</b>	<p>Number of miles of walkable and bikeable paths in Minneapolis increases (Output).</p> <p>85 percent of seniors in Minneapolis report they feel safe walking around the neighborhood (Outcome).</p> <p>Number of farmers markets in Hennepin County increases (Output).</p>

**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

<p>Number of stores participating in the Minneapolis Healthy Corner Store Program increases (Output).</p> <p>Percent compliance rate for Minneapolis Staple Foods ordinance increases (Output).</p> <p>Number of miles to nearest store selling fresh produce among Hennepin County households decreases (Output).</p> <p>85 percent of Hennepin County residents agree that they have easy access to good quality fresh produce in their own neighborhood (Outcome).</p>
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### Part III. Selected Resources

Comprehensive Tool Kit for Organizations Serving Asian and Pacific Islander Communities, CDC 2008: <https://www.cdc.gov/diabetes/ndep/pdfs/70-capacity-building-for-diabetes-outreach.pdf>

Diabetes Basics, CDC: <https://www.cdc.gov/diabetes/basics/index.html>

Find Living Well workshops offered by others, JUNIPER: <https://yourjuniper.org/>

Minority Population Profiles: Provides detailed demographic, language fluency, education, economic, insurance coverage and health status information, as well as full census reports, HHS: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlID=26>

National Diabetes Education Program (NDEP) [e-learning module](#) (in English and Spanish) and Training Courses, CDC: <https://www.cdc.gov/diabetes/ndep/training-tech-assistance/training-courses.html>

National Diabetes Statistics Report, CDC 2017: <https://www.cdc.gov/diabetes/data/statistics-report/index.html>

New Beginnings: A Discussion Guide from the National Diabetes Education Program (NDEP) for Living Well with Diabetes, CDC: <https://www.cdc.gov/diabetes/ndep/toolkits/new-beginnings.html>

Quick Facts: Diabetes in Minnesota, MDH: <http://www.health.state.mn.us/divs/healthimprovement/data/quick-facts/diabetes.html>

Quick Facts: Prediabetes in Minnesota, MDH: <http://www.health.state.mn.us/divs/healthimprovement/data/quick-facts/prediabetes.html>

The National Program to Eliminate Diabetes-Related Disparities in Vulnerable Populations, CDC: <https://www.cdc.gov/diabetes/prevention/pdf/VulnerablePopulationsFactSheet.pdf>

## Appendix F: HIV/AIDS and Sexually Transmitted Infections (STIs)

### Part 1: Background Information

**Sexually transmitted infections (STIs)** refer to more than 25 infectious organisms transmitted through sexual activity and the dozens of diseases or conditions that they cause. **HIV** is the virus that causes acquired immune deficiency syndrome (AIDS). Without treatment, HIV attacks and weakens the immune system, which makes people living with HIV vulnerable to a variety of infections and some cancers. This stage of HIV infection is called **AIDS**.

#### STIs in Minnesota

*Chlamydia* and *gonorrhea* infections are the two most common reportable STIs in Minnesota. In 2017, 23,528 cases of chlamydia and 6,519 cases of gonorrhea were reported to the Minnesota Department of Health (MDH). Both of these STIs are on the rise; from 2007 to 2017, the chlamydia rate increased by 71 percent, and the rate of gonorrhea increased by 84 percent.

The number of new *syphilis* infections has also risen over the past decade, especially among with men who have sex with men and among people with HIV. Rates of reported syphilis increased by 10 percent from 2016 to 2017, with 934 reported cases in 2017. While the majority of new cases are among men, the number of females with syphilis is near the record high for the last decade and is also continuing to rise.

STI rates are highest in the cities of Minneapolis and Saint Paul. Nonetheless, chlamydia and gonorrhea cases in the Twin Cities suburbs and Greater Minnesota account for 62 percent of the reported cases in 2017. Chlamydia and gonorrhea also disproportionately impact youth, with 62 percent of reported chlamydia and 45 percent of reported gonorrhea cases among youth ages 15-24 in 2017.

#### Disparities in STIs

- From 2007 to 2017, the chlamydia rate was 9.7 times higher in non-Hispanic blacks, 5 times higher in American Indians, 3 times higher among Hispanics, and twice as high in Asians/Pacific Islanders compared to whites.
- During the same time period, the gonorrhea rate was 20 times higher in non-Hispanic blacks, 13 times higher in American Indians, 3 times higher among Hispanics, and twice as high in Asians/Pacific Islanders.
- Since 2014, the rate of syphilis among American Indians has increased from around 5 cases per 100,000 persons to nearly 50 cases per 100,000 persons in 2017, while the rate among whites in Minnesota has remained stable.
- Rates of syphilis are also higher among black non-Hispanics, Hispanics and Asians/Pacific Islanders.

For more information and data on STIs in Minnesota, visit the [MDH STD Annual Data Release 2017](#) page. National data and information can be found on the [CDC STD Health Equity](#) page.

#### HIV in Minnesota

Despite innovations in HIV treatment, prevention and policy, the HIV epidemic remains a significant health issue for Minnesota. At the end of 2017, 8,789 people were estimated to be living with HIV/AIDS in Minnesota. For the past decade, the number of new HIV diagnoses in Minnesota has remained

relatively steady at approximately 300 new cases per year. The highest rates of new HIV infections are in the 20-29-year-old population. Geographically, new cases of HIV/AIDS are concentrated in the Twin Cities metropolitan area.

Male-to-male sexual contact has been the most commonly reported mode of exposure since the epidemic began. In 2017, male-to-male sexual contact accounted for 49 percent of new HIV diagnoses. Twenty-five percent of newly diagnosed HIV cases in 2017 reported heterosexual contact as their primary mode of exposure; 84 percent of these cases occurred in females.

## Disparities in HIV

- The highest burden of HIV disease is among black Minnesotans. African American and African-born blacks together make up 5 percent of the population in Minnesota but represent nearly half of all new HIV cases in 2017 (27 percent of new cases among African Americans and 21 percent among African-born individuals).
- Among males, 39 percent of the 2017 cases diagnosed in Minnesota were non-Hispanic white. Non-Hispanic African American and African-born males made up 40 percent of cases, while Hispanic males of any race accounted for 14 percent of cases.
- Among women the disparities are even more apparent, with women of color representing 80 percent of all the newly diagnosed cases in 2017. Black, African-born women account for almost half (47 percent) of cases, and non-Hispanic African American women account for 24 percent of cases.

Racial and ethnic disparities also exist in *HIV treatment and care*:

- The CDC reports that African Americans living with diagnosed HIV infection have percentages of linkage to care and viral suppression (low level of HIV in the blood) that are lower than whites and far below national goals.
- Data from the Ryan White HIV/AIDS Program shows that the viral suppression rates were lower among transgender women, youth between the ages of 13 to 24 and persons who did not have stable housing.

For more information and data on HIV/AIDS in Minnesota, visit the [MDH HIV/AIDS Annual Data Release 2017](#) page.

## Risk Factors

Individual-level risk factors for STIs and HIV include:

- Having unprotected anal or vaginal sex
- Having sexual contact with multiple partners
- Injection drug use (for HIV) and substance use generally
- Having an STI (for HIV) or having a history of STIs (for other STIs)
- Being forced to have sexual intercourse or sexual activity

*HIV testing* is key to prevention, and early diagnosis and treatment can prolong life for years. Despite the availability of testing and treatment, many cases of HIV infection continue to be diagnosed at advanced stages. The proportion of late testers (patients who receive an AIDS diagnosis at or within 12 months of their HIV diagnosis) has remained relatively stable in Minnesota over the past 10 years, and was 27 percent in 2016 (most recent year available). Approximately 85 percent of late testers are diagnosed with AIDS at the time of their initial HIV diagnosis.

Individual-level *barriers to testing* include:

- Fear of a positive result and/or lack of confidentiality
- Being unaware of risk factors
- Limited understanding of the benefits of treatment

## Protective Factors

- Consistent condom use
- Getting vaccinated (HPV, hepatitis A and hepatitis B)
- Limiting excessive alcohol and drug use
- Getting tested regularly while sexually active/between partners
- Receiving comprehensive sexuality education and/or growing up in a sex-positive culture
- Having a positive understanding and perception of sexuality

Removing structural barriers such as the lack of universal HIV screening (not all health care professionals offer HIV testing or are aware of CDC guidelines) and complex insurance systems can reduce health disparities for different populations.

For the first time, the knowledge and tools exist to end the HIV epidemic. Treating HIV prevents new infections from occurring, also referred to as the “treatment as prevention” approach. One highly effective HIV prevention strategy is antiretroviral therapy (ART) which decreases the amount of virus in the bodies of people living with HIV to undetectable levels, allowing them to live long, healthy lives. Key studies have shown that once people with HIV have undetectable amounts of virus in their body, they in effect bear no risk of sexually transmitting HIV to their partners, a concept known as Undetectable = Untransmittable (U=U).

Another highly effective HIV prevention strategy is pre-exposure prophylaxis (PrEP), a daily pill taken by people who do not have HIV in order to prevent infection. An HIV negative person exposed to HIV can take post-exposure prophylaxis (PEP) to reduce their risk of infection.

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to young people, LGBTQ people, people of color and others, with strong social connections and support, can help people avoid sexual risk-taking and other risky behaviors such as injection drug use. Supportive communities encourage positive parenting and caregiving, which also protect against risk-taking.
- **Racism and discrimination:** Racism and discrimination, along with stigma related to HIV, AIDS and STIs, can worsen people’s health and keep them from accessing screenings, preventive care and treatment. Creating welcoming environments for LGBTQ people also contributes to a sense of belonging and protects against sexual risk-taking.
- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access health care, including HIV and STI screenings. Stable housing makes it easier to keep up with treatment and monitoring for STIs, HIV and AIDS.
- **Neighborhood conditions:** A neighborhood that offers opportunities for young people—such as after-school programs, sports, and job training—supports positive sexual health and decreased sexual risk-taking.

- Educational opportunity:** Creating opportunities for youth – such as after-school programs, sports and job training – supports positive sexual health, including decreased sexual risk taking. Increasing school connectedness – such as involvement in school activities, liking school and finding it important, bonding with teachers and peers, feeling safe and fairly treated – improves students’ opportunities for success and protects against sexual risk-taking. Academic achievement and aspirations lead youth to make healthy decisions about sex.
- Employment and benefits:** In addition to being a key source of access to health care, employment is also a source of social connection and financial and food security. Unemployment, on the other hand, can lead to late testing and delayed treatment.
- Income and wealth:** HIV/AIDS affects populations of lower socioeconomic status and impoverished neighborhoods at a disproportionately high rate. According to the [American Psychological Association \(APA\)](#), limited economic opportunities and periods of homelessness have been associated with risky sexual practices, such as exchanging sex for money, drugs, housing, food and safety, placing individuals at risk for HIV. Living in poverty can also result in food insufficiency, weakening the body’s ability to fight off infection, as well as result in transactional sex and power differences in sexual relationships that place an individual at risk of infection. Individuals may continue to face hunger after contracting HIV. Refer to the [APA HIV/AIDS and socioeconomic status fact sheet](#) for more information.
- Access to quality health care:** People who are living with or are at risk for HIV, AIDS or STIs benefit from access to high quality, affordable and culturally/linguistically competent care. Health care includes screenings, preventive care, treatment and education about how to maintain health. Health care should be welcoming to all, including LGBTQ community members and young people.
- Transportation:** People need affordable, convenient transportation options to access screenings, preventive care and treatment for HIV, AIDS and STIs.

More information on risk and protective factors can be found on the [Act for Youth Risk and Protective Factors for Adolescent Sexual Health](#) website.

### Priority Health Area Specialists

If you need additional data not found on this page, please submit a specific data request through the [STD/HIV/TB Data and Presentation Request Form](#) and someone will get back to you within two weeks. Priority Health Area Specialists are also available to answer questions about data, best practices and other content-related questions.

Health Area	Name	Phone	Email
HIV/AIDS	Kathy Chinn	651-201-4046	<a href="mailto:Kathy.chinn@state.mn.us">Kathy.chinn@state.mn.us</a>
STIs	Candy Hadsall, RN, MA	651-201-4015	<a href="mailto:Candy.hadsall@state.mn.us">Candy.hadsall@state.mn.us</a>

## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHD. **Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.

**Goal:** To close the gap in the health status of populations of color and American Indians as compared to whites in HIV/AIDS and STIs.

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Objective: Increase HIV and STI awareness and screening and testing among members of high-risk groups.**

**Example Strategy: Facilitate and encourage screening and testing of sexual and/or needle-sharing partners of high-risk persons and refer clients to appropriate venues for testing.**

<b>Example Activity 1:</b>	Provide education and counseling (individual and group) regarding the importance and effectiveness of screening for HIV and STDs for high-risk members of the target population.
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<b>Example Activity 2:</b>	Provide education and counseling to groups and individuals regarding the availability of treatments and services for HIV and STDs to reduce stigma and anxiety over screening and testing.
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**Example Strategy: Provide HIV and/or STI screening or testing to individuals identified as at risk for STIs and/or HIV.**

<b>Example Activity 1:</b>	Train staff in CDC STI and HIV treatment guidelines and HIV and/or STI screening, testing and risk assessment.
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<b>Example Activity 2:</b>	Facilitate referral to clinics or facilities experienced in serving people with HIV and/or STIs for medical care, treatment and additional supportive services.
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<b>Example Evaluation Measures:</b>	<p>100 individuals receive individual and group education and counseling per program cycle (Output).</p> <p>At the end of the program cycle, 100 percent of program participants report that they believe in the importance of screening for HIV/AIDS/STIs prevention (Outcome).</p> <p>200 individuals are tested for HIV/AIDS/STIs per year (Output).</p> <p>100 percent of individuals identified as high-risk for HIV/AIDS/STIs receive referrals to appropriate services (Output).</p> <p>100 percent of individuals diagnosed with HIV/AIDS or STIs receive treatment and aftercare services (Output).</p>
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**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective: Increase institutional capacity to positively impact the health of individuals living with HIV and STIs and prevent the spread of HIV and STIs.**

<b>Level of Change 2:</b> Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.	
<b>Example Strategy: Reduce HIV/STI stigma and discrimination in organizations and programs serving populations of color and American Indians.</b>	
<b>Example Activity 1:</b>	Integrate stigma-reducing messages and education into existing programming throughout Organization ABC.
<b>Example Activity 2:</b>	Educate organizations and programs serving populations of color and American Indians on non-discrimination on the basis of one’s HIV/AIDS status, including protections afforded by laws such as Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA). Example of entities covered by such laws are hospitals, clinics, social services agencies, drug treatment centers, nursing homes, doctors’ offices, dentists’ offices, daycares, public pools and fitness gyms.
<b>Example Strategy: Institutionalize school-based sexual health education through collaboration with parent groups, the school district, community partners and others.</b>	
<b>Example Activity:</b>	Create or join a coalition of youth/students, parent groups, school personnel, school board members, community partners and local government to advocate for Minneapolis Public Schools to adopt, modify or establish policies and practices related to sexual health education and/or sexual and reproductive health services.
<b>Example Evaluation Measures:</b>	<p>Organization ABC and its partners incorporate stigma-reducing messages and education into their existing programming (Output).</p> <p>All Project X staff join coalitions advocating for Minneapolis Public Schools to adopt, modify or establish policies and practices related to sexual health education and/or sexual and reproductive health services (Output).</p> <p>All institutional partners require staff to receive training on non-discrimination in the context of HIV (e.g., health workers, teachers, religious leaders, prison staff, judges) (Outcome).</p> <p>95 percent of staff at Organization ABC and its partner organizations report believing that all people have the right to receive services irrespective of race, gender identity, sexual orientation and HIV status (Outcome).</p> <p>Minneapolis Public Schools changes its policy so that all schools have a sexual health educator on staff (Outcome).</p> <p>Minneapolis Public Schools changes its policy so that comprehensive, inclusive sexual health education is incorporated into the curriculum in all schools (Outcome).</p> <p>Minneapolis Public Schools changes its policy so that all school clinics offer sexual and reproductive health services (Outcome).</p> <p>80 percent of students at Minneapolis Public Schools report that they can easily access sexual health resources at their school (Outcome).</p>

<p><b>Level of Change 3:</b> Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.</p>	
<p><b>Example Objective: Improve postsecondary school success among LGBTQ communities of color and indigenous communities.</b></p>	
<p><b>Example Strategy: Increase on-time high school graduation rates for LGBTQ students from communities of color and indigenous communities.</b></p>	
<p><b>Example Activity 1:</b></p>	<p>Join efforts to improve school climate to ensure that Minneapolis Public Schools are welcoming to LGBTQ students from communities of color and indigenous communities and that harassment and bullying are eliminated.</p>
<p><b>Example Activity 2:</b></p>	<p>Join efforts to support adequate school counseling staff in Minneapolis Public Schools who are trained to support LGBTQ students and families from communities of color and indigenous communities.</p>
<p><b>Example Objective: Decrease stigma and discrimination.</b></p>	
<p><b>Example Strategy: Reduce fear of stigma in LGBTQ communities of color and indigenous communities.</b></p>	
<p><b>Example Activity 1:</b></p>	<p>Join efforts to organize recurring pride or empowerment events specific to indigenous people and/or people of color (POC).</p>
<p><b>Example Activity 2:</b></p>	<p>Join efforts to produce community-based social awareness campaign about LGBTQ issues in specific indigenous and/or POC communities or create community-generated messaging about same-gender loving issues in indigenous and/or POC communities.</p>
<p><b>Example Evaluation Measures:</b></p>	<p>Project X staff participate in social awareness campaign about LGBTQ issues (Output).</p> <p>On-time high school graduation rates for LGBTQ students, especially students of color, increase (Outcome).</p> <p>The percent of LGBT students in Minneapolis Public Schools who report homelessness decreases compared to 2016 (Minnesota Student Survey in 2019, 2022) (Outcome).</p> <p>Employment rates among LGBTQ adults in Minnesota increase (Outcome).</p> <p>The percentage of LGBT students in Minneapolis Public Schools who report that adults at their school treat students fairly increases compared to 2016 (Minnesota Student Survey in 2019, 2022) (Outcome).</p> <p>The percentage of LGBT students in Minneapolis Public Schools who report that they feel safe at school increases compared to 2016 (Minnesota Student Survey in 2019, 2022) (Outcome).</p> <p>The percentage of LGBT student in Minneapolis Public Schools who report bullying and harassment decreases compared to 2016 (Minnesota Student Survey in 2019, 2022) (Outcome).</p>

### Part III. Selected Resources

Addressing Sexual Health in Schools: Policy Considerations. Advocates for Youth, 2013:  
<http://www.advocatesforyouth.org/school-policy>

Brief overviews of CDC-supported High Impact HIV Prevention interventions and strategies, CDC:  
[www.effectiveinterventions.org](http://www.effectiveinterventions.org)

The Minnesota Chlamydia Strategy: Action Plan to Reduce and Prevent Chlamydia in Minnesota, MDH:  
<http://www.health.state.mn.us/divs/idepc/diseases/chlamydia/mcp/strategy/index.html>

Health Care Education and Training (HCET) provides comprehensive program development, education, and training to improve reproductive and sexual health outcomes. To learn about STD screening training: <http://www.hcet.org/our-services/education-training>

High Impact HIV Prevention (HIP): Overview of Select Interventions & Strategies, CDC:  
<https://effectiveinterventions.cdc.gov/docs/default-source/general-docs/16-0817-hip-overview-factsheet.pdf?sfvrsn=4>

HIV/STD/Hepatitis Training Opportunities, MDH:  
<http://www.health.state.mn.us/divs/idepc/diseases/hiv/training/>

Sexual health and its linkages to reproductive health: an Operational Approach, WHO:  
<http://apps.who.int/iris/bitstream/handle/10665/258738/9789241512886-eng.pdf;jsessionid=887890012E3253A07B6B4453066A1C89?sequence=1>

Sexually Transmitted Diseases Treatment Guidelines, CDC 2015:  
<https://www.cdc.gov/std/tg2015/default.htm>

The National STD Curriculum site offers self-study modules, clinical consultation and more:  
<https://www.std.uw.edu/>

World Health Organization (WHO) sexual and reproductive health website with resources, articles and data: [http://www.who.int/reproductivehealth/topics/sexual\\_health/en/](http://www.who.int/reproductivehealth/topics/sexual_health/en/)

## Appendix G: Immunizations for Adults and Children

### Part I. Background Information

Immunizations work with the body's natural defenses to help a person safely develop immunity to a disease. Since many serious diseases can be prevented by vaccines, it is important that people receive immunizations across the lifespan. Despite a variety of barriers to immunization, this remains one of the top ten public health successes. Each year two to three million lives are saved because of vaccines, and for every dollar spent \$10 are saved.

#### Immunizations in Minnesota

In 2017, 61 percent of Minnesota children ages 24 to 35 months received vaccinations in the childhood immunization series. While Minnesota children got close to the *Healthy People 2020* goal of a 90 percent coverage rate for some individual childhood vaccinations, the coverage rate for the full childhood series is below the 80 percent goal.

#### Disparities

While Minnesota's overall immunizations rates are strong, disparities in certain socioeconomic, racial and ethnic, and chronically ill populations continue to be a cause for concern. For example:

- From March 2013 to December 2014, rates of vaccination for tetanus, diphtheria and acellular pertussis (Tdap) and influenza were significantly lower among black and American Indian women when compared with white women, and vaccination coverage was lower among Hispanic women than non-Hispanic women (for Tdap only). Sixty percent of pregnant Asian American women in Minnesota received the Tdap vaccination coverage during pregnancy, compared to 58.7 percent for white, 55.7 percent for black, and 47.2 percent for American Indian women.
- Rates of Tdap vaccination were also significantly lower among women born in Africa (particularly Somalia), Eastern Europe, Western Europe and Canada compared with women born in the U.S.
- Tdap vaccination coverage was also lower among Hispanic women than non-Hispanic women, women with lower levels of education and women who were receiving medical assistance or were uninsured.
- In 2016, children with at least one foreign-born parent were less likely to be up-to-date on recommended immunizations at ages 2, 6, 18 and 36 months than were children with two U.S.-born parents. Vaccination coverage at age 36 months varied by mother's region of origin, ranging from 77.5 percent among children born to mothers from Central and South America and the Caribbean to 44.2 percent among children born to mothers from Somalia.

#### Risk Factors

Individuals are less likely to receive immunizations when they do not have health insurance, lack access to health care and/or lack a medical home. Children are less likely to be immunized if their parents/caregivers have concerns or lack of knowledge about the importance and safety of vaccines.

## Protective Factors

- Supportive, trauma-informed and culturally competent health care systems that are flexible and responsive to the unique needs of different racial, ethnic and cultural populations are important and include:
  - Interpreters
  - A sense of trust established between health care providers and the different populations in a community
  - Knowledgeable providers who make clear, appropriate recommendations
  - Clinic reminders when shots are due
- School immunization laws

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to all people, with strong social connections and support, can encourage immunization by connecting people with resources and upholding positive social norms.
- **Racism and discrimination:** Racism and discrimination in health care can prevent people from accessing immunizations.
- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access primary health care, including receiving immunizations on schedule.
- **Employment and benefits:** Employment with benefits is the primary way people in the U.S. obtain access to health care, which includes immunizations.
- **Income and wealth:** Rates of immunization are lower for populations with low socioeconomic status. Income plays a role in immunizations by making it more difficult for parents to learn about the benefits of vaccines (less access to information, especially if access to health care is lower) and presenting challenges in finding access to vaccines.
- **Access to quality health care:** Access to high quality, affordable and culturally/linguistically competent care is essential to ensuring that people receive comprehensive and timely immunizations.
- **Transportation:** People need affordable, convenient transportation options to obtain immunizations on schedule.

## Priority Health Area Specialists

**For more data, information on best practices or other immunization-related questions, contact:**

Michelle Dittrich, MPH

CDC Public Health Advisor

651-201-4567

[Michelle.dittrich@state.mn.us](mailto:Michelle.dittrich@state.mn.us)

## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHD.

**Applicants are not required to use the objectives, strategies and activities listed in the RFP**

**appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

**Goal:** To close the gap in the health status of populations of color and American Indians as compared to whites in immunization coverage.

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Objective: Increase the understanding of the purpose and importance of immunizations among communities experiencing immunization inequities.**

**Example Strategy: Develop community-informed education and outreach around immunization.**

**Example Activity 1:** Work with clinics and community members to conduct immunization education and outreach for populations with low immunization rates.

**Example Activity 2:** Recruit parents and other community members as peer educators to facilitate discussions with their peers (e.g., parents, high-risk adults, adolescents) around immunizations.

**Example Strategy: Increase the availability of immunization services in various community settings.**

**Example Activity 1:** Partner with community health workers (CHWs), pharmacists and pharmacy students to hold immunization clinics in child care facilities.

**Example Activity 2:** Link immunizations with other clinical and public health services (e.g., family home visits, WIC) utilized by populations with low immunization rates.

**Example Activity 3:** Organize immunization clinics in community gathering places such as community centers, churches, libraries and parks.

**Example Evaluation Measures:**

- Hold 20 immunization clinics in 2020 (Output).
- Vaccination coverage among adults in populations of color and American Indians in Hennepin County increases (Outcome).
- Influenza and pneumococcal vaccination rates among the elderly in populations of color and American Indians in Ramsey County increase (Outcome).
- Immunization rates among WIC enrollees in Minneapolis increase (Outcome).

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective: Ensure that patients receive all needed vaccines at all clinic visits.**

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Strategy: Support implementation of immunization best practices at clinics serving populations experiencing disparities in immunization coverage.**

<b>Example Activity 1:</b>	Implement a county-wide reminder, recall, and outreach (RRO) system for childhood immunizations on known disparities in immunization rates among populations of color and American Indians.
<b>Example Activity 2:</b>	Establish agreements between clinics and child care facilities or schools to do immunization audits and follow-up clinical visits.

**Example Strategy: Provide enabling services (translation/interpretation, transportation, and social support) to populations facing barriers to immunization access.**

<b>Example Activity 1:</b>	Establish clinic policies to ensure the availability of culturally competent care in clinic settings—for example, health care professionals who can speak the patients’ first language, available medical interpreters/translators and CHWs, additional time during visits, transportation, etc.
<b>Example Activity 2:</b>	Establish culturally specific immunization days in clinics with supportive staff and translated materials.

<b>Example Evaluation Measures:</b>	<p>Policies to ensure the availability of culturally competent care in clinic settings are developed (Output).</p> <p>Percentages of newborns, infants and toddlers in Minneapolis who receive their recommended vaccinations on schedule increase (Outcome).</p> <p>Clinics in Minneapolis that utilize the RRO system report an increase in immunization coverage (Outcome).</p> <p>Clinics in Minneapolis increase their vaccination catch-up rates among children and adolescents with delayed vaccinations (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Reduce barriers to immunization access.**

**Example Strategy: Build educational pathways for people of color and American Indians to participate in the health care workforce.**

<b>Example Activity 1:</b>	Join or lead efforts to develop or improve state education standards that provide for educational pathways into health care careers for students from communities of color and American Indian communities.
<b>Example Activity 2:</b>	Join or lead efforts to enhance training/licensure opportunities for international medical graduates.

<b>Level of Change 3:</b> Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.	
<b>Example Strategy: Support literacy efforts.</b>	
<b>Example Activity:</b>	Join efforts of groups such as the Minnesota Literacy Council to increase literacy among communities experiencing immunization inequities to help them succeed in school, find and keep a job and advocate for their health.
<b>Example Strategy: Establish a mobile community clinic.</b>	
<b>Example Activity:</b>	Secure funding and sponsorship to establish a mobile community clinic to reduce transportation barriers to on-schedule immunizations.
<b>Example Evaluation Measures:</b>	<p>10 high schools in Hennepin County implement a health care pathway program in 2021 (Output).</p> <p>Minnesota’s International Medical Graduate Assistance Program assists 25 international medical graduates in obtaining licenses to practice medicine in Minnesota (Output).</p> <p>80 percent of parents report that proximity to the mobile clinic was a primary reason for having their children vaccinated (Outcome).</p> <p>BeWell Mobile Clinic provides vaccination services to 500 people annually (Output).</p>

### Part III. Selected Resources

Adult Immunization Standards, CDC: <https://www.cdc.gov/vaccines/hcp/adults/for-practice/standards/index.html>

Childhood Immunization Champions Awards, CDC 2018: <https://www.cdc.gov/vaccines/events/niiw/champions/profiles-2018.html>

General Best Practice Guidelines for Immunization, CDC: <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html>

Standards for Pediatric Practice, HHS: <https://www.hhs.gov/nvpo/nvac/reports-and-recommendations/the-standards-for-pediatric-immunization-practice/index.html>

## Appendix H: Infant Mortality

### Part I. Background Information

Infant mortality refers to the death of a live-born infant from any cause before the infant's first birthday. The infant mortality rate is the number of infant deaths per 1,000 live births. It is an important indicator of the overall health and well-being of families, communities and entire societies.

#### Infant Mortality in Minnesota

Minnesota's infant mortality has declined by 29 percent since 1990, from a high of 7.2 deaths/1000 live births in 1990 to its present level of 5.1 in 2016. Not only is the current rate well below the national *Healthy People* target of 6.0 deaths per 1,000 live births by 2020, but it is also below the nation's rate overall of 5.9 per 1,000 live births in 2016.

#### Disparities

The overall state infant mortality rate masks longstanding disparities in infant mortality. For example:

- Infants born to black/African American and American Indian mothers die at twice the rate of infants born to white mothers.
- While the five-year average mortality rate for infants born to white mothers in Minnesota during the 2012 to 2016 period was 4.0 per 1,000 infants, the rate for black/African American infants was more than twice as high at 9.0 deaths per 1,000 live births.
- For American Indians, the rate was 10.1 per 1,000 infants – more than twice the white rate.

Disparities also exist in the timing of infant deaths. These differences in timing help determine the types of interventions that will be successful in reducing disparities. American Indians' post-neonatal (between 28 days and 1 year) infant mortality rate is higher than that of any other group and is more than four times the rate for whites. Sudden unexpected infant death (SUID) – which includes sudden infant deaths (SIDS) and sleep-related deaths – is the leading cause of post-neonatal deaths in this population.

#### Risk Factors

Infant mortality in Minnesota includes complications stemming from low birth weight, premature birth and unsafe sleep environments. Individual risk factors include:

- Lack of access to timely and high quality prenatal care
- Disease status
- Stress
- Smoking
- Alcohol consumption during pregnancy
- Poor nutrition and weight status
- Prematurity
- Low birth weight

#### Protective Factors

- Health insurance and access to timely, high quality, and culturally sensitive health care
- Adequate weight gain during pregnancy
- Strong social connections to family and friends

- Knowledge/education about the importance and benefits of breastfeeding, folic acid supplements to reduce neural tube birth defects, achieving appropriate pregnancy intervals, reducing stress, and accessing prenatal care

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to all people, with strong social connections and support, can help reduce infant mortality. Supportive communities give people a sense of belonging, connect them to resources and help protect against trauma and stress.
- **Racism and discrimination:** Maternal experiences before, during and after pregnancy can adversely affect their babies' health. Racism is a major contributor to racial inequities in birth outcomes because it is a source of toxic stress. Exposure to stress during pregnancy can harm the immune and endocrine systems, a likely explanation for the higher incidence of preterm and low-birth-weight births among black/African American mothers. Long-term exposure to stress from racism may also explain why factors such as having a college education are not as protective for infants born to American Indian and black mothers as they are for babies born to white mothers.
- **Housing:** Safe, stable and affordable housing reduces stress and makes it easier to establish and routinely access primary health care, including pregnancy testing, prenatal care and pediatric care.
- **Neighborhood conditions:** A safe and healthy neighborhood supports behaviors that contribute to healthy pregnancies, which helps reduce the risk of infant mortality. For example, green spaces that are safe and accessible encourage physical activity. Access to grocery stores selling fresh produce makes it easier to eat healthful foods.
- **Educational opportunity:** While more education is associated with improved rates of infant mortality – likely because of the associated improvements in opportunities for employment and income – the improvements in infant mortality by education are not as pronounced for women of color. For example, African American women with advanced degrees still experience higher rates of infant mortality than white women who have not graduated from high school.
- **Employment and benefits:** Meaningful work and adequate wages provide social connection and security, both of which reduce maternal stress, a significant contributor to infant mortality. Employment benefits are also an important source of access to prenatal and infant health care.
- **Income and wealth:** Infants of low-income families have a much higher risk of dying in the first year of life than infants of higher-income families. Income is linked to education and employment, sources of social support, options for health care and the resources for daily life that are crucial for the health of families and children.
- **Access to quality health care:** Access to high quality, affordable and culturally/linguistically competent care is essential to ensuring that people receive comprehensive and timely prenatal care. Prenatal care promotes healthy pregnancies and reduces the risk of infant mortality.
- **Transportation:** People need affordable, convenient transportation options to access prenatal and pediatric care, as well as educational and employment opportunities and other needs such as healthy food and safe housing.

## Priority Health Area Specialist

**For more data, information on best practices or other questions about infant mortality, contact:**

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## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHD. **Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

**Goal:** To close the gap in infant mortality for populations of color and American Indians as compared to whites.

<b>Level of Change 1:</b> Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.	
<b>Example Objective:</b> Increase breastfeeding continuation rates at 3 months in the American Indian population from 30.1 percent in 2016 to 33.1 percent by July 1, 2023.	
<b>Example Strategy:</b> Provide culturally appropriate peer breastfeeding support to pregnant and breastfeeding women, interested family members and others in their support network to increase breastfeeding initiation and exclusivity and women’s confidence in their ability to breastfeed their infants.	
<b>Example Activity 1:</b>	Gather information from program participants (through a survey, focus group or one-on-ones) about factors contributing to breastfeeding discontinuation.
<b>Example Activity 2:</b>	Provide culturally sensitive prenatal breastfeeding education and support.
<b>Example Activity 3:</b>	Provide community doula service to participants.
<b>Example Strategy:</b> Increase the percentage of eligible pregnant women participating in WIC for 3 or more months during pregnancy.	
<b>Example Activity 1:</b>	Work with local WIC programs to determine gaps in participation.
<b>Example Activity 2:</b>	Work with Medicaid, SNAP and primary care to increase referrals to WIC.

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

<b>Example Evaluation Measures:</b>	<p>Participant survey conducted (Output).</p> <p>Participants connected to a doula (Output).</p> <p>80 percent of program participants who are pregnant or breastfeeding report that they received adequate and culturally appropriate breastfeeding support (Outcome).</p> <p>70 percent of program participants who are pregnant or breastfeeding report that they found the program helpful (Outcome).</p> <p>10 percent increase in breastfeeding initiation among moms in the program (Outcome).</p> <p>10 percent increase in breastfeeding duration to three months or more among program participants (Outcome).</p> <p>10 percent increase in eligible pregnant U.S.-born black women who participate in WIC for 3 or more months during pregnancy (from 44 percent in 2017) (Outcome).</p> <p>10 percent increase in eligible pregnant American Indian women who participate in WIC for 3 or more months during pregnancy (from 44 percent in 2017) (Outcome).</p>
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**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective:** Increase the number of birthing hospitals in Minnesota that receive safe sleep certification by July 1, 2023.

**Example Strategy:** Work with the Minnesota Department of Health or local public health departments to recruit birthing hospitals in your service area(s) to become safe sleep certified through the [National Safe Sleep Hospital Certification Program](#).

<b>Example Activity 1:</b>	Identify hospitals that do not have safe sleep certification.
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<b>Example Activity 2:</b>	Meet with identified hospitals to share data on sleep-related sudden unexpected infant deaths (SUID), describe the certification program and process, determine the hospital’s readiness for certification at the bronze level (i.e., existing provider and patient education about safe sleep and an updated hospital safe sleep policy) and encourage certification as appropriate.
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**Example Strategy:** Build the capacity of providers to meet the needs of black and American Indian women.

<b>Example Activity 1:</b>	Increase the number of black and American Indian doulas, perinatal educators and other para-professionals who can support positive birth outcomes.
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<b>Example Activity 2:</b>	Develop and implement a standard of continuum of care from prenatal though postpartum periods.
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**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

<b>Example Evaluation Measures:</b>	<p>By July 2023, the number of birthing hospitals in Minnesota that receive safe sleep certification increases by at least 10 hospitals (Outcome).</p> <p>By July 2023, the number of black and American Indian doulas, perinatal educators and other para-professionals in Minnesota doubles (Outcome).</p> <p>By July 2023, all partner hospitals develop a standard of continuum of care from prenatal through postpartum periods (Outcome).</p> <p>By July 2023, at least half of partner hospitals fully implement a standard of continuum of care from prenatal through postpartum periods (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Develop programs or initiatives that address the social determinants of infant mortality.**

**Example Strategy: Advance policy to ensure safe, stable, and affordable housing for low-income, housing-insecure and medically at-risk pregnant mothers and their families in the U.S.-born black and American Indian populations to reduce stress and improve birth outcomes.**

<b>Example Activity 1:</b>	Research laws, policies and procedures that impede access to housing for pregnant women and their families.
<b>Example Activity 2:</b>	Join or partner with local housing agencies or coalitions to advocate for guaranteed housing for medically at-risk pregnant mothers.
<b>Example Strategy: Build a culture of respect for women’s decision-making power and bodily autonomy during care.</b>	
<b>Example Activity 1:</b>	Work with the Council of Health Plans, the Minnesota Hospital Association or other clinical care groups to develop standards around listening and responding to the concerns of women to improve birth outcomes.
<b>Example Activity 2:</b>	Conduct a survey of hospitals, clinics and birthing centers to determine adoption and implementation of standards around listening and responding to the concerns of women to improve birth outcomes.
<b>Example Activity 3:</b>	Develop a “Know Your Rights” campaign for U.S.-born black and American Indian women to support shared decision-making expectations during the prenatal, birthing and postpartum periods.
<b>Example Evaluation Measures:</b>	<p>Research on barriers to housing access completed (Output).</p> <p>Survey of hospitals, clinics and birthing centers completed (Output).</p>

**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

The city of Minneapolis designates guaranteed housing units for medically at-risk pregnant mothers (Outcome).

Statewide standards around developing a culture of respect for women’s decision-making power and bodily autonomy during care in health care facilities are developed (Outcome).

At least 70 percent of Minneapolis hospitals, clinics or birthing centers surveyed report that they have changed organizational culture around respecting women’s decision-making power and bodily autonomy during care per statewide standards (Outcome).

“Know Your Rights” campaign to support shared decision-making expectations during prenatal, birthing and postpartum periods for U.S.-born black and American Indian women launched in print, broadcast and social media (Output).

### Part III. Selected Resources

Black Mamas Matter Toolkit: [http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA\\_BMMA\\_Toolkit\\_Booklet-Final-Update\\_Web-Pages-1.pdf](http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf)

Collection of current and historical data on some of the health challenges facing women, their families and their communities, Women’s Health USA 2013: <https://mchb.hrsa.gov/whusa13/>

Developmental Milestones for Infants (newborns to 1 year old), Help Me Grow: <http://helpmegrowmn.org/HMG/DevelopMilestone/Newborn/index.html>

Doulas of North America: [www.dona.org](http://www.dona.org)

Folic Acid for a Healthy Pregnancy and Baby, March of Dimes: <http://www.marchofdimes.com/pnhec/887.asp>

Infant Mortality Reduction Plan for Minnesota, MDH 2015 (Part One): [www.health.state.mn.us/divs/cfh/program/infantmortality/content/document/pdf/infantmortality.pdf](http://www.health.state.mn.us/divs/cfh/program/infantmortality/content/document/pdf/infantmortality.pdf)

Sudden Unexpected Infant Death and Sudden Infant Deaths Syndrome, CDC: <https://www.cdc.gov/sids/AboutSUIDandSIDS.htm>

Sudden Unexpected Infant Deaths (SUID) in Minnesota: Data Brief: 2010-2016 SUID Trends, MDH: <http://www.health.state.mn.us/divs/healthimprovement/content/documents/SUIDdatabrief2018.pdf>

The National Safe Sleep Hospital Certification Program: <https://cribsforkids.org/hospitalcertification/>

WIC Peer Breastfeeding Support Program, MDH: <http://www.health.state.mn.us/divs/fh/wic/localagency/reports/bf/info/2017peer.pdf>

## Appendix I: Teen Pregnancy Prevention

### Part 1: Background Information

**Teen pregnancy** refers to youth who experience a pregnancy between the ages of 15 to 19. Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children.

#### Teen Pregnancy in Minnesota

Minnesota's teen pregnancy and teen birth rates are among the lowest in the country. In 2016, both the teen pregnancy and teen birth rate (births for females aged 15-19) in Minnesota fell to historic lows, 17.2 per 1,000 and 12.6 per 1,000, respectively. Currently, Minnesota ranks third-lowest of all states for overall teen pregnancy rate and sixth for teen birth rate.

The national teen birth rate in 2016 was 20.3 per 1,000 women, or 1.6 times higher than Minnesota's rate. Since 2009, the teen birth and pregnancy rates have fallen to new lows each year both nationally and in Minnesota. Nationally, the teen birth rate has declined 51 percent (or an average of 8 percent per year) since 2007, which was the most recent high at 41.5.

#### Disparities

While Minnesota has reduced racial and ethnic disparities in teen pregnancies and births, some differences persist. For example:

- Minnesota had 3,004 pregnancies among 15-19-year-olds in 2016. American Indians and African Americans had the highest rates, 56.1 and 39.6 per 1,000, respectively. The white rate was 10.6 per 1,000.
- Minnesota had 2,201 teen births in 2016. Among the teens giving birth, 393 were African American, 138 were American Indian and 1,066 were white.
- The American Indian teen birth rate increased from 45.8 per 1,000 in 2015 to 49.7 per 1,000 in 2016. The American Indian 2016 rate of 49.7 births per 1,000 females 15-19 years of age is nearly four times higher than the rate among whites (9.0) and also higher than the rates among Asian Americans (15.5), African Americans (26.0) and Hispanics (31.6).

#### Risk Factors

While all adolescents are at risk, some adolescents are at increased risk for early sexual activity, poor contraceptive use and pregnancy. Individual-level risk factors include:

- Early sexual activity
- Incorrect use of contraceptives
- Unemployment
- Adverse childhood experiences and/or family tension, divorce or trauma

#### Protective Factors

Research shows that youth who have the following protective factors are less likely to experience a pregnancy:

- Healthy relationships, including parent-child connectedness and communication. Parent/child discussions about sex and contraception that occur before the child becomes sexually active may delay the initiation of sex and increase condom or other contraceptive use.
- Experiencing a youth-oriented teen pregnancy prevention curriculum that provides education on delaying and reducing the frequency of sexual activity, reducing the number of partners and improving contraceptive use.
- Teen-friendly clinic services where adolescents feel comfortable accessing care that is confidential, private, respectful and culturally competent.

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to young people, LGBTQ people, people of color and others, with strong social connections and support, can help people avoid sexual risk-taking. Supportive communities encourage positive parenting and caregiving, which also protect against sexual risk-taking.
- **Racism and discrimination:** Racism and discrimination, along with stigma related to teen pregnancy, can prevent people from accessing contraceptive care and pregnancy testing. Young people who are LGBTQ, experiencing homelessness or in foster care may be especially vulnerable to stigma and discrimination.
- **Housing:** Safe, stable and affordable housing reduces stress and promotes family connectedness. Stable housing also makes it easier for young people to establish and routinely access primary health care, including contraception.
- **Neighborhood conditions:** A neighborhood that offers opportunities for young people—such as after-school programs, sports, and job training—supports positive sexual health and decreased sexual risk-taking.
- **Educational opportunity:** Pregnancy and birth are significant contributors to high school dropout rates among girls. Only about 50 percent of teen mothers receive a high school diploma by 22 years of age, whereas approximately 90 percent of women who do not give birth during adolescence graduate from high school. The children of teenage mothers are more likely to have lower school achievement and to drop out of high school. They are also more likely to have more health problems, be incarcerated at some time during adolescence, give birth as a teenager and face unemployment as a young adult.
- **Employment and benefits:** Employment can help young people avoid early sexual activity by helping them feel more connected to the community and giving them a sense of hope for the future. Teen pregnancy often has a negative impact on employment and future earnings potential.
- **Income and wealth:** A [\*study in Public Health Reports\*](#) found that unfavorable socioeconomic conditions at the community and family levels contribute to the high teen birth rate in the U.S. Poverty has been shown to both [contribute to teen parenthood and become a consequence of teen births](#). Adolescents living in poverty are more likely to become pregnant, and teen parents often have lower lifetime earnings.
- **Access to quality health care:** Access to high quality, affordable and culturally/linguistically competent care can help prevent teen pregnancy. A trusted health care provider can provide

education as well as contraception. Health care should be welcoming to all young people, including LGBTQ community members.

- **Transportation:** Young people need affordable, convenient transportation options to access health care, including contraception and pregnancy testing.

### Priority Health Area Specialist

**For more data, information on best practices or other teen pregnancy-related questions, contact:**

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## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHDl.

**Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

**Goal:** To close the gap in teen pregnancy rates for populations of color and American Indians as compared to whites.

**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Objective: Reduce the risk factors and increase the protective factors related to teen pregnancy.**

**Example Strategy: Improve sexual health education of young people.**

<b>Example Activity 1:</b>	Implement an evidence-based sexual health education program such as <i>Love Notes, Positive Prevention PLUS, All4You, Be Proud! Be Responsible!, !Cuidate!, Teen Health Project</i> or <i>Wise Guys</i> .
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<b>Example Activity 2:</b>	Implement after-school programs such as <i>Prime Time, Becoming a Responsible Teen (BART), Seventeen Days, Draw the Line/Respect the Line, TOPP</i> or <i>SiHLE</i> .
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<b>Example Activity 3:</b>	Conduct outreach to vulnerable teens such as youth in foster care, homeless youth, runaway youth or youth in or transitioning out of juvenile detention.
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**Example Strategy: Increase school and family connectedness among teens.**

<b>Example Activity 1:</b>	Implement an evidence-based program that increases parent and child communication about sexuality, such as <i>Project TALC, Pespeto/Proteger, AIM 4 Teen Moms, Families Talking Together, Generations</i> or the promising approach <i>It’s that Easy</i> .
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**Level of Change 1:** Delivering health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

<b>Example Activity 2:</b>	Utilize mobile phone texting apps as enhancements to teen pregnancy programs to increase social and school connectedness among teens (e.g., TOP® Plus Text).
<b>Example Activity 3:</b>	Promote positive peer norms and support for healthy sexual behaviors by training and supporting peer educators/leaders.
<b>Example Evaluation Measures:</b>	<p>25 homeless or runaway teens are recruited into the Prime Time program each year (Output).</p> <p>75 percent of SiHLE participants report that they learned new information about how HIV is passed from person to person (Outcome).</p> <p>80 percent of SiHLE participants report that they feel more confident they can start a discussion about condom use with their partner (Outcome).</p> <p>80 percent of TOPP participants report that they feel less isolated compared to when they started in the program (Outcome).</p>

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

**Example Objective: Establish policies and procedures to provide quality health services to young people.**

**Example Strategy: Improve clinic practices to better reach young people.**

<b>Example Activity 1:</b>	Establish clinic policies and procedures that ensure all staff are trained on the unique developmental and health needs of culturally diverse adolescents.
<b>Example Activity 2:</b>	Establish clinic policies and procedures that ensure young men feel comfortable accessing services such as family planning (e.g., hiring male staff including outreach workers, placing male-friendly magazines and posters in the clinic, providing male-specific outreach, and hiring male “secret shoppers” to provide feedback on the male-friendliness of the clinic).

**Example Strategy: Normalize sexual health education in schools.**

<b>Example Activity 1:</b>	Create or join a coalition of youth/students, parent groups, school personnel, school board members, community partners, and state/local government to adopt, modify or establish policies and practices in public school related to sexual health education and/or sexual and reproductive health services.
<b>Example Evaluation Measures:</b>	<p>The number of male teen patients at X Clinic increases (Outcome).</p> <p>70 percent of teen patients at X Clinic report that they intend to come back for their annual check-up (Outcome).</p> <p>Number of staff trained on the unique developmental and health needs of culturally diverse adolescents (Output).</p>

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

	<p>Clinics establish policies and procedures to ensure the unique developmental and health needs of culturally diverse adolescents are met (Outcome).</p> <p>60 percent of first-time teen patients make return visits to Clinic X within a year (Outcome).</p> <p>All Minneapolis Public Schools have a sexual health educator on staff (Outcome).</p> <p>All Minneapolis Public Schools incorporate sexual health education in their curriculum (Outcome).</p> <p>All Minneapolis Public School clinics offer sexual and reproductive health services (Outcome).</p> <p>80 percent of students at Minneapolis Public Schools report that they can easily access sexual health resources at their school (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Improve social and economic conditions to support teens.**

**Example Strategy: Increase four-year high school graduation rate.**

<b>Example Activity 1:</b>	Join or form a group that advances policies and procedures to increase educational equity (e.g., increasing access to financial aid, developing cultural competency in teachers, adding non-academic measure to assess student performance and growth).
<b>Example Activity 2:</b>	Utilize an electronic data system that notifies a student’s counselor if the student is off track for graduation due to factors such as excessive absences, disciplinary actions, low test scores or non-enrollment in college preparatory classes.

**Example Strategy: Increase employment opportunities for youth and their families.**

<b>Example Activity 1:</b>	Offer free work readiness training and financial literacy training to youth and their families.
<b>Example Activity 2:</b>	Increase paid internship opportunities for youth.
<b>Example Activity 3:</b>	Work with financial institutions to offer low-interest business startup loans to youth in underserved communities.

<b>Example Evaluation Measures:</b>	<p>2 combined work readiness/financial literacy trainings are held in 2020 (Output).</p> <p>4-year graduation rates in Minneapolis Public Schools increase (Outcome).</p> <p>90 percent of seniors in Minneapolis Public Schools are on track to graduate in 4 years (Outcome).</p> <p>85 percent of students of color and American Indian students in their senior year at Minneapolis Public Schools report that they feel ready for college (Outcome).</p>
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**Level of Change 3:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

60 percent of small business owners in Hennepin County report that they have paid internship opportunities for youth (Outcome).

Number of businesses owned by entrepreneurs of color and American Indian entrepreneurs increases (Survey of Business Owners or Annual Survey of Entrepreneurs) (Outcome).

### Part III. Selected Resources

Advocates for Youth: <http://www.advocatesforyouth.org>

Best Practices for Establishing a Youth Friendly Clinic, Advocates for Youth: <http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services>

Consent and Confidentiality, Guttmacher Institute: <https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law>

Effectiveness of Teen Pregnancy Prevention Programs Designed Specifically for Young Males, CDC: <https://www.cdc.gov/teenpregnancy/projects-initiatives/engaging-young-males.html>

Health Care Providers and Teen Pregnancy Prevention, CDC: <https://www.cdc.gov/teenpregnancy/health-care-providers/index.htm>

Power to Decide, the Campaign to Prevent Unplanned Pregnancy: <https://powertodecide.org/>

Reproductive Health: Teen Pregnancy, CDC: <https://www.cdc.gov/teenpregnancy/index.htm>

Sexuality Information and Education Council of the United States (SIECUS): <https://siecus.org/>

Teen and Male Friendly Clinic Check List, CDC: <https://www.cdc.gov/teenpregnancy/health-care-providers/teen-friendly-health-visit.htm>

The National Campaign to Prevent Teen and Unplanned Pregnancy, Emerging Answers 2007: <https://powertodecide.org/what-we-do/information/resource-library/emerging-answers-2007-new-research-findings-programs-reduce>

## Appendix J: Unintentional Injuries and Violence

### Part I. Background Information

Unintentional injuries and violence-related injuries can be caused by a number of events, including motor vehicle crashes, falls, home fires, poisonings, drownings, suicide and self-inflicted harm and sexual violence. No matter the circumstances of the event, and even when death does not occur, injuries can have serious, painful and debilitating physical and emotional health consequences affecting individuals, family members, friends, coworkers, employers and communities.

#### Motor Vehicle Crashes in Minnesota

More people have died in motor vehicle crashes in the U.S. than have died in all of our country's wars, accounting for nearly a third of all injury deaths in the U.S. and almost half of all unintentional injury deaths. More than 80 percent of crash deaths involve drivers or passengers of automobiles and trucks; the remaining 20 percent are bicyclists, pedestrians and motorcyclists.

In Minnesota, motor vehicle-related injuries are now the third leading cause of injury-related death overall but rank first or second among those ages five to 24. About half the serious traumatic brain injuries and 60 percent of spinal cord injuries are the result of motor vehicle crashes.

Increased seat belt use, declining rates of drinking and driving, safer road and vehicle designs, improvements in emergency medical services and new acute care technologies have contributed to a steady decline in motor vehicle crash fatalities.

#### Disparities in Motor Vehicle Crashes

- Those at greatest risk of dying in a motor vehicle crash are young (15 to 24 year old) drivers, elderly drivers, male drivers, unbelted occupants and unrestrained children.
- Pedestrian injuries are among the most expensive in terms of hospital charges, and elderly people are particularly vulnerable.
- For ages 15 to 34, American Indian and Alaskan Native males have significantly higher motor vehicle crash fatality rates than all other races (35.6 per 100,000 people for ages 15 to 24 and 48.6 per 100,000 for ages 25 to 34). The rates for white males in the same age groups are 16.4 per 100,000 and 13.7 per 100,000, respectively.

#### Falls, Home Fires, Poisonings and Drownings in Minnesota

**Falls:** Fall death rates in Minnesota are 1.5 times higher than the U.S. rates, and are three times higher among the elderly. Statewide, falls are the leading cause of nonfatal injury for children aged birth to nine, and for all adults aged 20 and older. They account for 36 percent of all hospital-treated injuries (both inpatient and injuries treated in emergency departments). Most fatal falls occur in the home, especially for children and the elderly.

One of every three Americans 65 years old or older falls each year, and falls are the leading cause of injury deaths and account for 87 percent of all fractures among this age group. They are the second leading cause of spinal cord and brain injury among older adults.

**Home fires:** The U.S. currently has the fourth highest overall fire death rate of all industrialized countries. While the fire death rate had been going down in Minnesota, in 2015 and 2017 home fire

deaths increased (57 and 63 deaths, respectively). Smoking and alcohol use are often involved; usually, those who die are the very young, persons with disabilities or senior Minnesotans.

**Poisoning:** Poisonings, both self-inflicted and unintentional, are the eighth leading cause of hospitalized injuries in Minnesota. Poisoning is the leading cause of injury death for Minnesotans ages 25 to 64 and the second leading cause for ages 20 to 24. Poisonings can occur from many different chemicals and substances, including carbon monoxide, lead and drugs. Carbon monoxide results in more fatal unintentional poisonings in the U.S. than any other agent, with the highest number occurring during the winter months. Childhood lead poisoning is considered one of the most preventable environmental diseases of young children, yet about one million children have elevated blood levels of lead. Preliminary drug overdose data from 2017 include 401 total opioid deaths (of these, 188 involved prescription opioids). For more information and detailed overdose data, refer to the [Preliminary 2017 Drug Overdose Deaths Factsheet](#).

**Drowning:** From 2005 to 2014, there were an average of 3,536 fatal unintentional drownings (non-boating related) annually in the United States – about ten deaths per day. An additional 332 people died each year from drowning in boating-related incidents. In Minnesota, 31 people died in non-boat related, unintentional drowning in 2017.

## Disparities in Falls, Home Fires, Poisonings and Drownings

### Falls:

- Males have higher rates of falls than females – almost double in the 74 to 85 age group – but equivalent among those 85 and older.
- White men have the highest fall-related death rate, followed by white women, African American or African men and African American or African women.
- Rates start to rise in the 65 to 74 age group (21.7 per 100,000 people) but climb significantly in ages 85 and older (461.7 per 100,000). The same pattern holds for African Americans and Asian Americans, but their rates are significantly lower than white rates.

### Home fires:

- Home fires disproportionately affect young children, older adults, those with disabilities, African Americans, American Indians and the poorest Americans.
- African American males have the highest rate of death due to home fires of any racial group in Minnesota.

### Poisonings (including drug overdose):

- Rates of poisoning in general are many times higher in the African American and American Indian populations than in other racial groups.
- Limited research suggests that Hispanic and black populations may be at greater risk for *carbon monoxide poisoning* than white populations.
- National data show racial and ethnic disparities in the prevalence of *lead poisoning*. A recent summary of 2007 to 2010 data for children ages 1 to 5 years showed higher average blood lead levels in black, non-Hispanic children than in white non-Hispanic children.
- Rates of *drug overdose* continue to increase in all races, but Minnesota has high disparities in overdose deaths for African Americans and American Indians. From 2015 to 2016, drug overdose mortality:

- increased from 47.3 to 64.6 per 100,000 residents in the American Indian community
- increased from 20.8 to 24 per 100,000 residents in the African American community
- increased from 10.1 to 11.7 per 100,000 white residents

More detailed data on drug overdoses can be found in the [Race Rate Disparity in Drug Overdose Death Report](#) and on the [Opioid Dashboard](#).

#### **Drownings:**

- Drowning rates are higher for African Americans, Asian Americans and American Indians compared to whites.
- Drowning rates among African American males aged 15 to 24 are three times higher than any other racial group in this age range in Minnesota. Overall, males account for nearly 80 percent of drowning deaths.

### Suicide and Self-Inflicted Harm in Minnesota

Since 2011, deaths by suicide in Minnesota have increased in number each year. Minnesotans are five times more likely to die from suicide than from homicide. In 2016, 745 Minnesotans died by suicide, making it the eighth leading cause of death in Minnesota. The state's age-adjusted suicide rate rose from 9.0 per 100,000 (440 deaths) in 1999 to 13.2 (745 deaths) in 2016. The U.S. rate in 2016 was 13.5 per 100,000, slightly above Minnesota's suicide rate. Learn about Minnesota's [State Suicide Prevention Plan](#) on the MDH website.

Death by suicide is complex and often due to many contributing and interrelated factors. While death occurs at the individual level, each person lives in the context of family, neighborhood, community and society. The impact of death by suicide is felt broadly and often in ways that differ from deaths due to other causes. In many cultures, death by suicide may not be discussed, often because of hesitancy to speak about mental health or mental illness issues; unease about conversations dealing with feelings of hopelessness, isolation and despair; or unease about spiritual or moral implications.

### Disparities in Suicide and Self-Inflicted Harm

- In 2016, males were more than three times as likely to die by suicide as females. Between 2013 and 2016, the most common mechanism for male suicides were firearms, suffocation and poisoning.
- Suicide is the sixth leading cause of death for Asian Americans in Minnesota, seventh for American Indians and Hispanics/Latinos and tenth for whites. Suicide is not in the top ten causes of death for African Americans.
- American Indians have the highest rate of suicide, although the rates have stabilized in the last two years. In 2013 and 2014, American Indians' suicide rate was 24.4 per 100,000 (42 deaths); the rate dropped to 21.7 per 100,000 (35 deaths) in 2015 and 2016.
- Suicide rates among blacks and African Americans decreased from 7.4 per 100,000 (49 deaths) in 2013-14 to 6.7 per 100,000 (50 deaths) in 2015-16 (the larger population in 2015-16 accounts for the lower rate despite the increase in the number of deaths). Suicide rates among Asian Americans and Pacific Islanders increased during the same time period, from 7.1 per 100,000 (33 deaths) to 8.3 per 100,000 (43 deaths).
- The increase in Minnesota's suicide rate in recent years appears to be due to suicide deaths outside the seven-county metro area. Between 2012 and 2016, the suicide rate in Greater

Minnesota increased from 13.1 to 15.9 per 100,000, whereas the seven-county metro area rate declined slightly from 11.2 to 11.1 per 100,000 during the same time period.

## Sexual Violence in Minnesota

In 2005, 61,000 Minnesota children and adults were sexually assaulted – some of them more than once – for a total of 77,000 assaults. Sexual violence remains an underreported problem in Minnesota. With no complete data source, MDH utilizes hospital discharge data. However, this paints an incomplete picture since only about a quarter of sexual violence victims and survivors seek hospital care.

Minnesota hospital discharge data for 2014 show that there were 1,411 patient visits for hospital-treated sexual violence. Patients ages 15 to 24 account for nearly half of those hospitalized for sexual violence and assault. Between 2010 and 2014, the rate of hospital-treated sexual violence for patients ages 15 to 19 decreased from 92.4 per 100,000 (339 patient visits) in 2010 to 76.96 per 100,000 (276 patient visits) in 2014.

Cultures differ in how they view and deal with sexual violence. For example, sexual violence is not discussed in some cultures because of factors such as stigma, strict gender norms or the importance of family honor. More information about sexual violence can be found on the MDH [Sexual Violence Prevention Program](#) website.

## Disparities in Sexual Violence

Minnesota lacks cultural, racial and ethnicity data for and about sexual violence. Data collection systems are improving, but significant gaps remain:

- Women of color (particularly American Indians), people with disabilities, people with limited income, people who are homeless, people with mental illness, human trafficking victims and LGBTQ individuals are at a higher risk for being sexually assaulted. They also face barriers to reporting the crime.
- The rate of hospital-treated sexual violence is higher in the Twin Cities metro area than in Greater Minnesota. In 2014, 63 percent of patient visits for hospital-treated sexual violence were Twin Cities metro area residents and 37 percent of patient visits were Greater Minnesota residents.
- The five-year average age-adjusted rate of hospital-treated sexual violence was 52.0 per 100,000 for females and 3.9 per 100,000 for males (hospital-identified gender is limited by uniform billing to male and female).

## Risk Factors

**Motor vehicle crashes:** Many factors can contribute to serious injury and death in a motor vehicle crash, but the leading modifiable risk factors include:

- Distraction while driving (including food, phones and texting)
- Lack of seatbelt use and improperly secured infant or toddler booster seats
- Speeding, close following and other risky driving
- Alcohol and the use of other substances that impair driving
- Driving at night
- Social norms that promote or encourage risky behavior or decision-making

The leading nonmodifiable risk factors include gender (males are at much greater risk) and age (both the very young and senior Minnesotans have increased injury rates).

**Falls:**

- Advanced age
- Previous falls
- Fear of falling
- Muscle weakness, gait/balance problems, poor vision, postural hypotension, and chronic conditions including arthritis, stroke, incontinence, diabetes, Parkinson's and dementia
- Psychoactive medications and improper use of assistive devices
- Lack of stair handrails or bathroom grab bars
- Poor stair design
- Dim lighting or glare
- Obstacles/tripping hazards
- Slippery or uneven surfaces

**Home fires:**

- Not having working smoke alarms
- Alcohol impairment
- Cigarettes

**Poisoning:**

- The most common poison exposures for children are ingestion of household products such as cosmetics and personal care products, cleaning substances, pain relievers, foreign bodies and plants; for adults they are prescription medications, pain relievers, sedatives, cleaning substances, antidepressants and bites/stings.
- Risk factors for *drug overdose* include opioid dependence, injecting opioids or using prescription opioids, using opioids in combination with other sedating substances, using opioids and having medical conditions such as HIV, liver or lung disease or suffering from depression and possession of opioids.
- The most common sources of *lead poisoning* are house paint, soil and tap water. Living in an older home, especially housing built before 1950, is a risk factor for contamination by lead paint. Old pipes in a home are a risk factor for contamination through drinking water.
- Risk factors for *carbon monoxide* poisoning include smoking, chronic heart disease, anemia (a reduced number of healthy red blood cells) and respiratory problems such as asthma.

**Suicide and self-inflicted harm:**

- Mental illness
- Alcohol and substance abuse
- Social isolation

**Sexual violence:** According to the Centers for Disease Control and Prevention, risk factors for perpetrating sexual violence include:

- Alcohol and drug use
- Delinquency
- Adherence to traditional gender role norms

- Suicidal behavior
- Sexual attitudes, behaviors and history: general aggressiveness and acceptance of violence; early sexual initiation; coercive sexual fantasies; preference for impersonal sex and sexual-risk taking; exposure to sexually explicit media; hostility towards women, hypermasculinity or association with sexually aggressive, hypermasculine, and delinquent peers; prior sexual victimization or perpetration
- Family factors: family environment characterized by physical violence and conflict; childhood history of physical, sexual or emotional abuse; emotionally unsupportive family environment; poor parent-child relationships, particularly with fathers; involvement in a violent or abusive intimate relationship

## Protective Factors

### **Motor vehicle crashes:**

- Wearing a seat belt
- Using child safety seats

### **Falls:**

- Staying healthy and active
- Monitoring medications to prevent untoward side effects or interactions
- Assuring that home, public and work environments are free of tripping and slipping hazards
- Improving vision

### **Home fires:**

- Working smoke alarms in homes

### **Poisoning:**

- Safe use and storage of potentially poisonous household products, out of the reach of children
- Use of non-toxic household products
- Reducing exposure to lead in the home
- Improving knowledge of risks associated with opioid use and changing practices to avoid overdose, including knowing how opioids interact with other medicines and altering prescribing practices

### **Suicide and self-inflicted harm:**

- The greatest success in dealing with depression is a combination of counseling therapy, medication and exercise (medicine or counseling alone does not necessarily reduce suicidal behavior).
- Acknowledging the presence of adverse childhood experiences (ACEs), promoting family strengths, community and social cohesion and reducing isolation are all important facets of promoting mental health and well-being.

### **Sexual violence:**

- School environments that support healthy relationships and engage youth and adults to speak up and out against sexism and violent behaviors and to intervene when someone is at risk.
- Policies in workplaces that address sexual harassment, support healthy relationships, encourage speaking out and create safer spaces for everyone.

- Neighborhoods and communities with job and economic opportunities, strong social connections and norms and higher socioeconomic status.

## Social Determinants

- **Social connections and support:** Creating communities that are welcoming to young people, LGBTQ people, people of color and others, with strong social connections and support, can help prevent injuries and violence. Supportive communities give people a sense of belonging and uphold social norms that discourage violence. Positive parenting / caregiving, including close supervision of young people, also protects against injuries and violence.
- **Racism and discrimination:** Racism and discrimination, along with stigma related to mental health needs, can keep people from accessing resources that help prevent injuries and violence.
- **Housing:** Safe, stable and affordable housing helps prevent injuries in the home and reduces stress that can contribute to suicide and violence.
- **Neighborhood conditions:** A neighborhood that offers opportunities for young people—such as after-school programs, sports, and job training—helps keep them safe from injuries and violence. Strong social organization, youth job opportunities, immigration, and residential stability are among several neighborhood characteristics associated with lower crime rates. More information on neighborhoods and violent crime can be found in the [U.S. Department of Housing and Urban Development’s Evidence Matters publication](#). Neighborhoods with many resources are more likely to have newer homes and/or homes in good repair, which limits lead poisoning.
- **Educational opportunity:** Rates of suicide are lower for those with a college education than for those with a high-school education, which may reflect the protective mental health effects of having greater economic opportunity and income.
- **Employment and benefits:** Employment with benefits provides social connection, meaning and purpose for many, as well as financial security and access to health care, making it a protective factor for suicide and interpersonal violence. One [study at Northwestern University](#) found a close connection between the unemployment rate and the number of school shootings.
- **Income and wealth:** [A study published in ScienceDirect](#) found an association between the socioeconomic status of parents and the risks of childhood injury deaths from traffic crashes, falls and fire/burns. Youth in populations with lower socioeconomic status are also likely to be exposed to violence earlier and more often than their higher-income peers. Exposure to and experience of violence are adverse childhood experiences that are associated with risky health behaviors, chronic health conditions and early death. More information can be found in the [American Psychological Association’s factsheet on violence and socioeconomic status](#). Additionally, families with more income and wealth are more likely to live in newer or renovated homes and have lower risk of lead poisoning.
- **Access to quality health care:** Access to high quality, affordable and culturally/linguistically competent care can help prevent injury and violence. A trusted health care provider may identify risk factors for suicide and sexual violence. Access to emergency services or specialty care helps address the effects of injuries and violence.
- **Transportation:** Affordable, convenient public transportation reduces the number of individual vehicle accidents. People need good transportation options to access screenings, preventive care and treatment that help prevent injuries and violence.

## Priority Health Area Specialists

Priority Health Area Specialists can answer questions about data, best practices and other content-related questions.

Health Area	Name	Phone	Email
Suicide Prevention	Amy Lopez	651-201-5723	<a href="mailto:Amy.lopez@state.mn.us">Amy.lopez@state.mn.us</a>
Mental Health	Anna Lynn	651-201-3627	<a href="mailto:Anna.lynn@state.mn.us">Anna.lynn@state.mn.us</a>
Sexual Violence	Amy Kenzie	651-201-5410	<a href="mailto:Amy.kenzie@state.mn.us">Amy.kenzie@state.mn.us</a>
Drug Overdose	Kate Erickson	651-201-5483	<a href="mailto:Kate.erickson@state.mn.us">Kate.erickson@state.mn.us</a>
Lead Poisoning	Todd Schaefer	651-201-4615	<a href="mailto:Todd.schaefer@state.mn.us">Todd.schaefer@state.mn.us</a>

## Part II. Examples of Objectives, Strategies and Activities

The following are examples of the types of projects that applicants may undertake through EHD.

**Applicants are not required to use the objectives, strategies and activities listed in the RFP appendices.** Applicants are encouraged to propose their own research-based or promising strategies and/or adapt and build upon these practices. Projects that are research-based or promising strategies will be given equal weight in the review process.

*Please note that the example objectives below are not “SMART” objectives. Examples of “SMART” objectives can be found in the work plan template.*

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

**Level of Change 1:** Deliver health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.

**Example Objective:** Reduce the rates of suicide in American Indian communities in Greater Minnesota.

**Example Strategy:** Increase public awareness about suicide prevention and available resources.

**Example Activity 1:** Implement a suicide prevention program developed for the American Indian community (e.g., [Native H.O.P.E.](#) or [Sources of Strength](#)).

**Example Activity 2:** Organize community gatherings to plan and guide program activities, address wellness promotion and practices, identify their own resources, and use the knowledge and wisdom of elders and other community members to promote change.

**Example Strategy:** Offer support to individuals and families to manage historical trauma.

**Example Activity 1:** Offer an intergenerational support group to families to learn how to cope with historical trauma and the stressors of daily life.

<p><b>Level of Change 1:</b> Deliver health promotion and prevention projects grounded in cultural knowledge and wisdom that contribute to eliminating disparities through direct service.</p>	
<b>Example Activity 2:</b>	Implement intervention programs that help youth address traumatic stress and related behavioral needs (e.g., <a href="#">Honoring Children, Mending the Circle</a> or <a href="#">Honoring Children, Respectful Ways</a> ).
<b>Example Activity 3:</b>	Organize activities that honor tribal history, values and beliefs to strengthen cultural identity (e.g., storytelling, drumming, singing, crafts, cooking).
<b>Example Evaluation Measures:</b>	<p>Number of intergenerational support groups held (Output).</p> <p>Number of drumming or singing events held (Output).</p> <p>At the end of the Native H.O.P.E. program, 80 percent of youth agreed with the following statement: “It’s okay to ask for help” (Outcome).</p> <p>75 percent of youth in the Honoring Children, Mending the Circle program say that talking about their traumatic experiences through stories has helped them respond more calmly to sudden and unexpected situations in life (Outcome).</p>

<p><b>Level of Change 2:</b> Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.</p>	
<p><b>Example Objective: Increase trauma-informed support systems.</b></p>	
<p><b>Example Strategy: Organize care systems to adopt a historical trauma lens.</b></p>	
<b>Example Activity 1:</b>	Train systems of behavioral health, chemical dependency and primary care clinics and hospitals to serve clients with historical trauma lens.
<b>Example Activity 2:</b>	Systems of care adopt operational procedures from a historical trauma lens for communities that are greatly affected by historical trauma.
<b>Example Activity 3:</b>	Join with advocacy groups to ensure historical trauma is a required part of behavioral health and chemical dependency programs.
<p><b>Example Strategy: Promote the use of traditional healers.</b></p>	
<b>Example Activity 1:</b>	Advocate for behavioral health systems, chemical dependency and primary care clinics to certify traditional healers.
<b>Example Activity 2:</b>	Work with behavioral health systems, chemical dependency and primary care clinics to increase the number of insurers who reimburse for the services of traditional healers.
<b>Example Evaluation Measures:</b>	70 percent of behavioral, chemical dependency and primary care health providers report that trauma-informed care has increased their competency level (Outcome).

**Level of Change 2:** Participating in or leading efforts that contribute to eliminating disparities by changing organizational or institutional policies or changing the way a system in an organization or institution works.

	<p>70 percent of behavioral, chemical dependency and primary care health providers report that at least one patient has responded better to treatment after the provider made an effort to understand their experience with trauma (Outcome).</p> <p>Traditional healer certification program established (Output).</p> <p>Number of traditional healers who become certified (Output).</p> <p>Number of organizations with an employee benefits program offering a traditional healing benefit (Output).</p> <p>70 percent of primary care clinics surveyed report that there is greater integration of traditional healers into the health care system (Outcome).</p>
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**Level of Change 3:** Participate in or lead efforts that target specific social and economic conditions for health (also known as the social determinants of health) that contribute to eliminating disparities.

**Example Objective: Provide a supportive environment to protect against unintentional injury and violence.**

**Example Strategy: Reduce stigma, prejudice and discrimination surrounding suicidal behaviors and mental illness.**

<b>Example Activity 1:</b>	Conduct a <a href="#">Community Readiness Assessment (CRA)</a> to understand and measure a community’s readiness to address an issue such as suicide or mental illness, and determine how to use that knowledge to stimulate change.
<b>Example Activity 2:</b>	Plan and implement an anti-stigma campaign like the <a href="#">Make It OK</a> campaign in a cultural context (e.g., how to how to talk and write about suicide and mental illness in the American Indian community).
<b>Example Activity 3:</b>	Develop and distribute protocols and best practices to various types of organizations (e.g., companies, schools, government agencies, clubs) on how they can provide a safer and more accepting environment for their employees or members.
<b>Example Activity 4:</b>	Propose a statewide policy that allocates funds annually for programs to reduce the stigma of mental health diagnosis and treatment and discrimination against people with mental illness.

**Example Strategy: Increase transportation options for geographically isolated mental health patients.**

<b>Example Activity 1:</b>	Create a volunteer driver program for patients released from a hospital for mental illness or suicidal behavior who lack the ability to transport themselves to an inpatient unit, which in Greater Minnesota may be far away.
<b>Example Activity 2:</b>	Train volunteer drivers in evidence-based suicide prevention or Mental Health First Aid.

<p><b>Example Activity 3:</b></p>	<p>Provide mental health treatment in school-based settings so that youth in need of treatment will not be burdened with finding transportation.</p>
<p><b>Example Evaluation Measures:</b></p>	<p>Community Readiness Assessment (CRA) conducted (Output).</p> <p>Number of volunteer drivers recruited (Output).</p> <p>Number of volunteer drivers trained in suicide prevention and Mental Health First Aid (Output).</p> <p>[Six months after training] 70 percent of employees in X organizations feel that employees are nonjudgmental (or empathetic) towards others (Outcome).</p> <p>[12 months after developing protocols to provide a safer and more accepting environment] 80 percent of organizations experience zero traumatic events at work in the past year (Outcome).</p> <p>70 percent of students who sought mental health treatment through their school clinic indicate that they did so because they trusted the staff (Outcome).</p>

### Part III. Selected Resources

Community Guide, a collection of evidence-based findings of the Community Preventive Services Task Force: <https://www.thecommunityguide.org/>

Community Readiness Assessment, SAMHSA: [https://www.samhsa.gov/sites/default/files/tribal\\_tta\\_center\\_2.3.b\\_commreadinessmanual\\_final\\_3.6.14.pdf](https://www.samhsa.gov/sites/default/files/tribal_tta_center_2.3.b_commreadinessmanual_final_3.6.14.pdf)

Mending the Sacred Hoop: [www.mshoop.org/](http://www.mshoop.org/)

Minnesota Coalition for Battered Women: [www.mcbw.org](http://www.mcbw.org)

Minnesota Coalition Against Sexual Assault: [www.mncasa.org](http://www.mncasa.org)

Minnesota Indian Women’s Sexual Assault Coalition: [www.miwsac.org](http://www.miwsac.org)

Minnesota Injury Data Access System (MIDAS), MDH, allows easy access to injury and violence data for Minnesotans, whether for a specific county, for a type of injury, or by gender, timeframe or other factor: <http://www.health.state.mn.us/injury/midas/>

National Action Alliance for Suicide Prevention: <http://actionallianceforsuicideprevention.org/>

National Alliance for Mental Illness (NAMI): <http://www.namihelps.org/>

National Sexual Violence Resource Center: [www.nsvrc.org](http://www.nsvrc.org)

National Registry of Evidence-based Programs and Practices, SAMHSA: <https://www.samhsa.gov/ebp-resource-center>

Rape Prevention and Education Program, CDC: [www.cdc.gov/violenceprevention/rpe](http://www.cdc.gov/violenceprevention/rpe)

Suicide Prevention Resource Center (promotes a public health approach to suicide prevention): <http://www.sprc.org/>

WONDER, CDC, contains national and state-level data on deaths and hospitalizations: <https://wonder.cdc.gov/>

WISQARS, CDC, allows users to create a customized report of fatal and nonfatal injury-related data: <https://www.cdc.gov/injury/wisqars/index.html>