Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

REPORT TO THE MINNESOTA LEGISLATURE 2019

March 2019

Eliminating Health Disparities Initiative: Report to Legislature

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Contents

List of Acronyms

CHE ..... Center for Health Equity
CHSDA ..... Contracted Health Service Delivery Area
CoP ..... Community of Practice
EHDI ..... Eliminating Health Disparities Initiative
MDH ..... Minnesota Department of Health
OMMH ..... Office of Minority and Multicultural Health
PHA ..... Priority Health Area
PRC ..... Prevention Research Center
RFP ..... Request for Proposals
STI ..... Sexually Transmitted Infection
TA ..... Technical Assistance

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Commissioner's Letter

March 25, 2019

Dear Legislators,

In many reports and headlines, Minnesota, on average, is listed as one of the healthiest states in the nation. However, those averages do not tell the whole story. When we dive deeper into the data, it is clear that Minnesota has some of the greatest health disparities in the country between whites and people of color and American Indians. This has been the case for decades. Why do these disparities persist? The common belief is that good health is due to personal choices and great medical care. These do influence health and are important. However, as MDH, the World Health Organization and multiple studies have found, health is created by much more than just individual factors or good medical care. As described in MDH's 2017 Statewide Health Assessment, optimal health is shaped by opportunity, belonging and nature. This includes excellent schools, economic opportunities, secure housing, good transportation, safe neighborhoods, and much more. Given this, it is not surprising that Minnesota has some of the worst health disparities in the country, because it has significant inequalities by both race and socio-economic factors such as income, education and more.

Since the creation of EHDI in 2001, Minnesota's population of communities of color and American Indians has grown from 582,336 (6% of total population) in 2000 to 893,203 (17% of total population) in 2010. It is projected that by 2020 people of color and American Indians will comprise 20% of the state's population. During the grant period July 1, 2016 to June 30, 2018, the EHDI grantees reached more than 335,000 people of color and American Indians. This represents one third of the state's people of color and American Indians. The targeted efforts of the EHDI grantees have made a real difference in the lives of the people they serve. Grantees report positive changes among their clients such as increasing screening and education for heart disease, reducing infant mortality, increasing immunization rates, and increasing cancer screenings. In addition, there has been increased cultural competence of health care providers and the creation of educational materials in different languages for individuals from linguistically diverse backgrounds.

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

This legislative report outlines the impact the EHDI has had by investing in community solutions that combine evidence-based and promising practices with the knowledge and wisdom of diverse communities. The report highlights the work of these critical partners and outlines strategies that Minnesota should continue to pursue to protect, maintain, and improve the health of all Minnesotans by eliminating health disparities in populations of color and American Indians.

Sincerely,

Jan Malcolm
Commissioner
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Executive Summary

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

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

The Center for Health Equity (CHE) provides leadership to make advancing health equity an essential goal for a healthy Minnesota and the work of MDH. Its mission is to connect, strengthen and amplify health equity efforts within MDH and across the state of Minnesota. The **Eliminating Health Disparities Initiative (EHDI)** is a grant program within CHE, designed to strengthen local control and decision-making in communities across the state toward the elimination of health disparities and advancement of health equity. Since 2002, EHDI has led eliminating health disparities work in the state by strengthening the capacity of communities of color and American Indian communities to create their own healthy futures and by capitalizing on opportunities to influence health in early childhood and throughout the lifespan.

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

This legislative report summarizes EHDI grant program activities from fiscal years 2015 to 2018.

EHDI has proven to be a valuable investment for the state of Minnesota. Evaluation results show that EHDI is making strides in reducing disparities and improving health for populations of color and American Indians in Minnesota. Through direct and indirect efforts to reach their target populations, the grantees reached 155,987 individuals in FY 2015; 281,676 individuals in FY 2016; and, 336,773 in FY 2017 and FY 2018 combined. Grantees documented a number of health improvement and prevention outcomes such as decreased blood pressure levels, increased rates of preventive cancer screening, lower body mass index and increased healthy eating and physical activity, increased up-to-date immunizations and improved mental health. They also reported outcomes such as increased knowledge or awareness of risk factors and protective factors; improved or new skills in areas such as parenting, leadership, advocacy, and participatory research; increase in physical activity levels; improved relationships and connections to family and school; increased confidence in their abilities; and increased access to resources. A number of grantees successfully developed and implemented policy and systems changes. They reported building an effective and culturally competent model of empowerment, leadership development, and advocacy on college campuses to cultivate the next generation of reproductive justice activists; developing a policy agenda that promotes a citywide healthy food policy; training youth leaders in community organizing to provide them the tools to affect community change; helping pass a behavioral health homes amendment in the legislature; developing a culturally specific teen pregnancy prevention curriculum used by a public school

system; and, establishing standards for a teen-friendly clinic. Evaluation results also documented expanded capacity of grantee organizations to better serve communities of color and American Indians through promising practices such as incorporating traditional practices to promote health.

In 2018 EHDI implemented a Shared Measurement System (SMS) which provides a glimpse into the collective impact across groups of grantees. In the 2018-2019 pilot period, the SMS has found statistically significant improvements in levels of physical activity, sexual health communication, and knowledge of sexual health resources for participants in grantee programs.

Factors that have contributed to EHDI success include:

- Using strategies and interventions that are grounded in community wisdom and experience
- Utilizing community skills, resources and leadership
- Respectful sustained engagement among stakeholders from the community, government entities, health care systems and other organizations to identify gaps in EHDI-based efforts and prioritize needs and services. Utilizing data to have a solid understanding of the disparities among populations of color and American Indians.
- Pairing strategies that focus on individual behavior change with strategies that address the social and economic factors that underlie and drive health disparities.
- Encouraging efforts to affect sustainable and long-lasting changes in policies, systems and environments, and providing needed support to translate policies into action.
- Providing technical assistance so that grantees are able to identify appropriate and measurable outcomes as part of their program monitoring and evaluation.

Effectively addressing health disparities and the underlying causes of these disparities require a comprehensive and community-driven approach. The EHDI grantees, in partnership with MDH and the Minnesota State Legislature, are committed to making an impact on these disparities and inequities through their efforts. The EHDI provides an avenue for moving this work forward and supporting the current and future health of all Minnesotans.

I. EHDI Overview

Background

While Minnesota ranks high in terms of general health status compared to other states, the health disparities that exist in Minnesota are among the worst in the nation. Such disparities have meant that, compared to whites, Minnesota's populations of color and American Indians experience shorter life spans; higher rates of infant mortality; higher incidences of diabetes, heart disease, cancer, and other diseases and conditions; and poorer general health. For example, Minnesota has one of the lowest overall infant mortality rates in the United States (4.9 infant deaths per 1,000 births). However, there is a persistent disparity in the infant mortality between whites (4.3/1,000) and Blacks/ African Americans (9.2/1,000) as well as American Indians (9.1/1,000)[1]. When such disparities are allowed to persist, they have a negative effect on the quality of life, the cost of healthcare, and the overall health of all Minnesotans.

In response to mounting evidence that disparities in health outcomes between Minnesota's white residents and residents from populations of color and American Indian communities were distressingly wide and on a clear trajectory to grow even wider, Minnesota enacted a groundbreaking legislative mandate to fund programs that will reduce such health disparities. In 2001, the Minnesota State Legislature established the Eliminating Health Disparities Initiative (EHDI), MN Statute 145.928 (Appendix A).

Minnesota is the second state in the nation to establish a program to eliminate health disparities. The EHDI competitive grant program provides funds to close the gap in the health status of African/African Americans, American Indians, Asians/Pacific Islanders and Hispanics/Latinos in Minnesota compared with whites in the following priority health areas (PHAs):

1. Breast and Cervical Cancer
2. Diabetes
3. Heart Disease and Stroke
4. HIV/AIDS and Sexually Transmitted Infections (STIs)
5. Immunizations for Adults and Children
6. Infant Mortality
7. Teen Pregnancy
8. Unintentional Injury and Violence

The purpose of the PHA grants was for local and regional programs to carry out activities that would reduce the gap in health status in one or more of the eight PHAs. Additionally in the 2012/13-2015/16 grant cycle, grants were also awarded in the area of Community Primary Prevention (CPP) whose purpose was to create the conditions in a community that would support health and slow the onset, or reverse the growth, of disease and injury through policy, systems and environmental changes.

From the outset, the creators and stakeholders of EHDI recognized that the issues contributing to health disparities are broad and complex, and result from an interplay of many economic, social, and individual factors.

[1] Minnesota Department of Health, Center for Health Statistics, 2008-2012 data. Rates are age-adjusted to the US 2000 Standard Population. Race is based on race of the mother. Hispanic can be of any race.

MDH, the Legislature, and EHDI community partners understood that effectively addressing this complex set of interrelated problems would require an approach that is comprehensive, community-driven, and long-term.

This understanding of the factors that influence health outcomes and a commitment to a community-driven process has guided the manner in which the Requests for Proposals (RFPs) have been disseminated across the state. Grant proposals are reviewed with community input. Grants have been awarded to faith-based organizations and social service organizations as well as community-based nonprofit organizations, health boards, and clinics for local or regional projects and initiatives. Attention to a strong, ongoing evaluation has helped MDH, EHDI grantees, community partners, and other stakeholders learn about what works and what does not, which has led to programming that continually evolves and practitioners who continually improve their methods. The years of EHDI investments have yielded not only advances on the mandated goals, but also valuable information and lessons, including the need to:

- Use strategies that are grounded in promising practices and the cultural knowledge and wisdom of Minnesota's diverse communities.
- Develop and improve behavior-based health improvement interventions that respect and reflect Minnesota's populations of color and American Indians.
- Identify policy, systems, and environmental changes that are needed to eliminate health disparities between whites and populations of color and American Indians
- Provide support for partnerships that combine the skills, resources, and leadership necessary to take action to remove barriers to progress.
- Provide grantees with technical assistance to identify, measure, and report on appropriate outcomes to build understanding of health disparities and evaluate solutions at programmatic and larger levels.

This legislative report describes grantee activities and accomplishments during fiscal years 2015 to 2018 based on annual reports submitted by grantees to the Center for Health Equity as part of their grant requirements. Included are grantees from the last two years (2014/15-2015/16) of the previous grant cycle, as well as the first two years (2016/17-2018/19) of the current grant cycle.

The Center for Health Equity

The Center for Health Equity (CHE) was created in 2013 to advance health equity within the Minnesota Department of Health (MDH) and across the state. CHE's mission is to connect, strengthen, and amplify health equity efforts within MDH and across the state. Within CHE are the Office of Minority and Multicultural Health (OMMH), which has historically housed and administered EHDI since its inception. OMMH, through CHE, continues to administer the legislative mandate that enables the work of EHDI and promotes critical strategies that Minnesota must pursue to protect, maintain, and improve the health of all Minnesotans. This includes eliminating health disparities between whites and populations of color and American Indians.

In February 2014, MDH released the landmark Advancing Health Equity Report, which called for Minnesota to pursue a comprehensive approach to achieving health equity that included a spectrum of public investments in housing, transportation, education, economic opportunity, and criminal justice. Recognizing the difference that EHDI grantees have made in the lives of the people they serve, it stated that a crucial part of this approach was to continue providing targeted grants through EHDI.

II. The Changing Face of Minnesota's Health

Population Diversity

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

Table 1. Minnesota Population Change

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

Sources: U.S. Census Bureau, Decennial Census and Population Estimates. Data downloaded from http://www.mncompass.org.

Much, but not all, of Minnesota's changing demographic profile results from the arrival of foreign-born residents. Minnesota's immigrants and refugees come from all over the world—including Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan. Births within Minnesota have also become more racially diverse. In 1990, births to non-Hispanic white mothers accounted for more than 89

percent of births in the state according to the Minnesota State Demographic Center. In 2012, this number has declined to 73 percent of all births.[2]

Minnesota's growing racial and ethnic diversity is not limited to the Twin Cities metropolitan area; this growth is happening around the state. The seven-county metro area accounted for 74% of the increase in the number of persons of color, and southern and southwestern Minnesota combined follow at 14%. This demographic data points to the growing racial and ethnic diversity in Minnesota and underscores the importance of reducing the health disparities between whites and populations of color and American Indians so that all Minnesotans can be healthy. Further, funding for EHDI has not increased to keep pace with the exponential growth in the population.

Minnesota's Health Disparities

Although racial disparities in health exist between whites and populations of color and American Indian communities throughout the state and across the spectrum of health areas, they do not affect all populations of color and American Indian communities in the same way or to the same degree. Importantly, diversity exists not only between racial and ethnic categories but also within them. For example, if premature birth rates were reported for Asians/Asian Americans as a single group, the number would be 9%, as compared to 8.3% for Minnesotans overall. This number masks wide variation among descendants from Asia; the indicator is significantly better for some groups (Asian Indian, Chinese, and Japanese) than it is for Asians/ Asian Americans as a whole, while it is significantly worse for other groups (Cambodian and Laotian).

Factors beyond geographic and national origin, such as generation and circumstances of migration, traditional diet and lifestyle, educational level and transferable skills, language and literacy, spiritual beliefs and cultural practices make the experience, needs, and strengths of each group very different. These differences between and within broad racial categories is what makes the culturally responsive—and often culturally specific—approach to the work done by EHDI's stakeholders and community partners so important. Section IV. Program Implementation gives more information about these unique approaches implemented by EHDI grantees under each PHA.

The health disparities context for each EHDI PHA as well as prevalence and incidence data and risk and protective factors both at the individual and community levels can be found in the appendix pages of the 2018 EHDI RFP.

III. EHDI Grants

This section describes EHDI grants awarded from FY 2015 through FY 2018 by population and PHA. Appendix B shows a complete list of funded organizations and tribes by PHA in fiscal years 2015 and 2016, and Appendix C shows the same information in fiscal years 2016 and 2017. The counts reflect a number of grantees that addressed more than one PHA and served more than one priority population.

[2] Dayton, M. (November 2014). *Minnesota births yet to rebound to pre-recession level: More diversity in state's nurseries*. Retrieved from http://mn.gov/admin/images/mn-births-yet-to-rebound-to-prerecession-level-popnotes-nov2014.pdf

EHDI initially funded 39 programs in the grant cycle that began in 2012. Funding was renewed for the same 39 grantees in fiscal year 2015 (July 1, 2014-June 30, 2015), and for 38 programs in fiscal year 2016 (July 1, 2015-June 30, 2016). Two of the funded programs in both years were CPP grants. In the next grant cycle that began in 2016, EHDI funded 33 programs representing 32 organizations and tribes in fiscal year 2017; there were one fewer programs and organizations/tribes in fiscal year 2018.

Grants Awarded by Population and by PHA

Table 2 and Table 3 show the number of EHDI grantees by population served in fiscal years 2015 and 2016 and in fiscal years 2017 and 2018, respectively.

Table 2. Number of EHDI grants awarded by PHA/CPP, FY 2015 and FY 2016[a]

Priority Health Area	FY 2015	FY 2016
Breast & Cervical Cancer Screening	5	5
Diabetes	12	12
Heart Disease & Stroke	3	3
HIV/AIDS & Sexually Transmitted Infections	11	11
Immunizations for Adults & Children	3	3
Infant Mortality	3	2[b]
Teen Pregnancy	13	13
Unintentional Injury & Violence	5	5
Community Primary Prevention	2	2

[a] Some grantees provided services in more than one priority health area

[b] MVNA declined funding in FY 2016 due to a change in organizational priorities following a merger with Hennepin County Medical Center.

Table 3. Number of EHDI Grants by PHA, FY 2017 and FY 2018[a]

Priority Health Area	FY 2017	FY 2018
Breast & Cervical Cancer Screening	5	4[b]
Diabetes	5	5
Heart Disease & Stroke	5	5
HIV/AIDS & Sexually Transmitted Infections	8	7[b]
Immunizations for Adults & Children	3	2[b]
Infant Mortality	3	3
Teen Pregnancy	14	14
Unintentional Injury & Violence	2	2

[a] Some grantees provided services in more than one priority health area

[b] St. Stephens declined funding in FY 2019 due to loss of program site (closed down).

Funding Levels

EHDI grant funding comes from two sources. Approximately $2 million in federal Temporary Assistance for Needy Families (TANF) funds are available for teen pregnancy prevention, and approximately $3.142 million in state general funds are available for other PHAs, for a total of approximately $5.142 million annually.

Appendices D and E provide a complete list of grantees and amount of funding they received in FY 2015 and FY 2016, and in FY 2017 and FY 2018. Total annual EHDI funding was roughly $5.1 million in FY 2015 and in FY 2016, and roughly $5.2 million in FY 2017 and $4.9 million in FY 2018.

IV. Program Implementation

Table 4 through Table 19 summarize grantee objectives, strategies and activities by PHA in FY 2015 and FY 2016 as well as in FY 2017 and FY 2018. Information in these tables came from grantees' approved work plans and annual reports.

EHDI grantees focusing on PHA areas during the 2012/13-2015/16 EHDI grant cycle were required to select at least one of the objectives, and incorporate activities corresponding to those objectives, from the menu of options provided in the 2012 RFP in order to meet the needs of the communities they served. In contrast, this was not a requirement for grantees in the 2016/17-2018/19 grant cycle, although grantees were encouraged to align their projects with MDH recommended key objectives, strategies, and associated evidence-based or promising practices.

EHDI defines evidence-based and promising practices as follows:

- Evidence-based practices are interventions that have documentation showing they have been effectively implemented in the past, multiple times, and in ways that consider scientific standards of evidence (including a theory of change tested through the systematic collection and analysis of empirical data).
- Promising practices are interventions that have demonstrated effectiveness based on the review of experts (including target community leaders), experience of practitioners, and/ or local or cultural knowledge rather than experimental data.

Additionally, the RFPs in both grant cycles emphasized cultural responsiveness as well as the role of culture with respect to health and the social determinants of health more generally. Culturally responsive practices automatically broaden the unit of analysis beyond individuals because culture is necessarily relational in that it is rooted in shared experience, understanding, and meaning.

As a result, EHDI grantees are working to reduce racial disparities by implementing a wide range of interventions that together:

- Meet the needs of populations of color and American Indians already affected by one or more of the eight PHAs;
- Provide individual or group-based services;
- Address the underlying risk factors that contribute to one or more of the eight PHAs;
- Change policies, systems, or the environment;
- Meaningfully draw from or respond to the cultural values, knowledge, and practices of community members;
- Are linguistically appropriate;
- Give community members a voice in program planning, implementation, and evaluation; and strengthen working relationships and partnerships in the community.

Parents and Teens Communication Workshop.
Big Brothers Big Sisters

EHDI Grantee Objectives, Strategies & Activities: FY15 and FY16

The information contained in Table 4 through Table 19 came from grantees' most recent work plan and 2016 annual reports. Grantee activities in fiscal years 2015 and 2016 reflected a mix of programs, practices, curriculums, workshops, models or approaches, policies or protocols and events that are either evidence-based or promising.

- Program: A comprehensive intervention with core components that typically include a curriculum that includes classroom instruction and activities and other experiential learning; staff recruitment, pre-service and in-service training; ongoing coaching and consultation from program developers; communication and other resource materials; and, program evaluation tools and measures. Grantees who implemented programs selected evidence-based programs (in their entirety or specific components) from the 2012 EHDI RFP menu.
- Practice: A specific skill, technique, or strategy taken from the 2012 EHDI RFP menu or adapted from an outside source, or that has been developed and fine-tuned through experience.
- Curriculum: A set of lessons pertaining to a specific topic (e.g., sexual health, peer educator training) developed by subject matter experts used alone or as part of a larger program.
- Resource Material: Materials obtained from outside sources used as companion pieces to a program or curriculum, for example, educational brochures or toolkits.
- Workshop: A class where participants engage in intensive discussions pertaining to a topic and/or learn specific skills, usually held alone on a separate day.
- Model or approach: Paradigms or principles developed by outside experts.
- Policy or protocol: An official policy or set of instructions formally adopted by the organization for use with all patients or participants.
- Event: An event held to share knowledge, increase personal connections or build cultural identity.

1. Breast and Cervical Cancer Screening

Table 4. Breast and Cervical Cancer Grantees' Objectives (N=5 Grantees)

Objectives	# Grantees
• Improve the medical care given to women who have abnormal findings from breast or cervical cancer screenings	3
• Detect breast and cervical cancer earlier	5

Table 5. Breast and Cervical Cancer Grantees' Strategies (N=5 Grantees)

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

• Provide group health education at African American congregations (Own)	1
• Provide education using a game format, i.e., Church Olympics (Own)	1

Activities

- Use of Kagawa-Singer model of cancer control among diverse ethnic populations (Model or Approach)
- Bringing a mobile mammogram unit to a Women's Health Days celebration at a clinic so the women only have to make one appointment instead of going to the clinic for a screening then to a breast center for follow-up (Practice)
- Sending reminder letters at the beginning of each month to women who are due for a Pap smear or mammogram to remind them to set up an appointment, and sending birthday card mammogram reminders to women over 40 that have never had a mammogram (Practice)
- Offering bundled care and services to address all the needs of women who receive screenings (Practice)
- Conducting targeted in-reach for cancer prevention screening by sending daily high risk patient reports (patients who fall within recommended screening guidelines) to the Health Navigator so that education and screening in-clinic can begin immediately (Practice)
- Conducting outreach at community events (Practice)
- Conducting outreach in trusted community settings, e.g., Mexican and Ecuadorian consulates and churches (Practice)

2. Diabetes

Table 6. Diabetes Grantees' Objectives (N=11 Grantees)

Objectives	# Grantees
• Improve the health status of people with diabetes	8
• Reduce risk factors that can lead to diabetes	9

Table 7. Diabetes Grantees' Strategies (N=11 Grantees)

Strategies	# Grantees
• Improve medical care for people with diabetes	3
• Assist people with diabetes to manage their disease	7
• Detect diabetes earlier	3

Strategies	# Grantees
• Teach people with pre-diabetes how to prevent the development of diabetes	6
• Assist people with diabetes or pre-diabetes to maintain healthy lifestyles	6
• Use ethnic media to increase awareness of available services	1
• Provide education using game format, e.g., Church Olympics	1

Activities

- Implementing National Diabetes Prevention Program, All4You, I CAN Prevent Diabetes program, the Diabetes Education and Empowerment (DEEP) program, Living Healthy with Diabetes, E3! Initiative, Chronic Disease Self-Management and There Is A Balm (Programs)
- Implementing Diabetes Education for Tribal Schools (DETS), Living With Diabetes, Living Well With Chronic Conditions, Matter of Balance, Hood Health, and Cooking Matters (Curriculums)
- Use of Positive Youth Development Principles and Health Champions (Models)
- Encouraging individuals with unhealthy weights to register at the clinic for health monitoring, e.g., BMI, weight, blood sugar, A1C (Practice)
- Using culturally specific exercise videos, cookbooks and ration plates (Practice)
- Making available food shelf items based on cultural and religious preferences and health needs
- Providing accessible physical activities (Practice)
- Incorporating smudging, prayer, talking circles and drumming in programming (Practices)
- Holding support groups (Practice)
- Recruiting and training youth as health advocates (Practice)

3. Heart Disease and Stroke

Table 8. Heart Disease and Stroke Grantees' Objectives (N=4 Grantees)

Objectives	# Grantees
• Improve the health status of people with heart disease and stroke	2
• Reduce the risk factors that can lead to heart disease and stroke	4

Table 9. Heart Disease and Stroke Grantees' Strategies (N=4 Grantees)

Strategies	# Grantees
• Improve the medical care given to people with heart disease and stroke	1
• Assist people with heart disease or stroke to manage their disease	1
• Assist people with high blood pressure, high cholesterol, or who use tobacco to reduce their risk	2
• Decrease obesity by increasing physical activity and healthy eating	4
• Reduce elder anxiety about risk of falls in order to increase mobility (Own)	1

Activities

- Implementing Chronic Self-Disease Management and Matter of Balance (Programs)
- Implementing Honoring the Gift of Heart and Cooking Matters (Curriculums)
- Using the Health Champions Model where respected community members connect other community members to health resources based on research that shows East Africans are more likely to trust information they receive orally from community connections (Model)
- Using culturally appropriate health messaging brochures and videos (Practice)
- Providing in-clinic individualized education when health educators screen patients for smoking status, hypertension or hypercholesterolemia (Practice)
- Implementing patient-centered care coordination where the Integrated Heart Health Educator and Health Programs Support Tech are integrated into the clinic workflow (Practice)

4. HIV/AIDS and Sexually Transmitted Infections

Table 10. HIV/AIDS and STIs Grantees' Objectives (N=11 Grantees)

Objectives	# Grantees
• Improve the health of people with HIV and STDs	2
• Identify new cases of HIV infection	3
• Reduce the rate of new infections of HIV and STDs	7

Table 11. HIV/AIDS and STIs Grantees' Strategies (N=11 Grantees)

Strategies	# Grantees
• Increase the number of people who access complete diagnostic and treatment servi ces in a timely manner after testing positive for HIV and/or STDs	2

Strategies	# Grantees
• Increase HIV and STD testing among members of high-risk groups	3
• Reduce risky sexual behaviors which lead to the transmission of HIV/STDs	7

Activities

- Implementing Becoming A Responsible Teen (BART), Between Us, Making Proud Choices!, Above The Waist, Safer Choices, ¡Cuidate!, Draw the Line/Respect the Line, Teen Outreach Program (TOP), WILLO W, Multimedia WILLOW (Programs)
- Holding It's That Easy workshop (Workshop)
- Implementing Celebration of Change, Family Life and Sexual Health (FLASH), Connecting Parents to Ed ucational Opportunities (CPEO), Padres Informados/Jovenes Preparados, Raíces, and Native STAND (C urriculums)
- Implementing Comprehensive Risk Counseling and Services (CRCS), Parallel Family Care, Family Syste ms, Health Care Home, Positive Youth Development paradigm, Systems of Care, and Social Ecological Model of Human Development (Models)
- Conducting condom use demonstration and distributing condoms (Practice)
- Collecting sexual activity information and conducting risk assessment (Practice)
- Recruiting and training neighborhood leaders as community organizers and advocates, recruiting and t raining youth as peer educators (Practice)
- Incorporating theater training and performance in peer education training
- Holding a Mother-Daughter retreat (Event)

5. Immunizations for Adults and Children

Table 12. Immunizations for Adults and Children Grantees' Objectives (N=3 Grantees)

Objectives	# Grantees
• Improve clinical immunization rates	2
• Remove barriers to accessing immunizations	3
• Enhance expertise in eliminating immunization disparities within immigrant comm unities (Own)	1

Table 13. Immunizations for Adults and Children Grantees' Strategies (N=3 Grantees)

Strategies	# Grantees
• Ensure that patients receive all needed vaccines at all visits	1

Strategies	# Grantees
• Ensure that recordkeeping systems prompt for needed vaccines	1
• Increase access to immunizations	3
• Address knowledge, attitudes, and beliefs regarding immunizations	2
• Develop relationships with community organizations to increase referrals for vaccines (Own)	1
• Strengthen capacity to eliminate immunization disparities through partnerships, training and participatory evaluation (Own)	1

Activities

- Providing immunization education in multiple settings (Practice)
- Integrating accurate race/ethnicity information into patient records (Practice)
- Integrating questions on stress and mental health questions into patient screening and intake forms both in-clinic and off-site vaccinations events for follow-up purposes (Practice)
- Providing culturally appropriate services, e.g., providing services in multiple languages, utilizing interpreters that represent patients' culture and gender, designating bilingual health navigators to provide immunization education at outreach events, one-on-one meetings and group presentations; ensuring materials are translated and accessible (Practice)
- Implementing processes to ensure immunizations are up to date, e.g., checking a patient's immunization record during every clinic visit, implementing a reminder/recall process when due for an immunization (Practice)
- Assessing community members' immunization knowledge and beliefs through discussions facilitated by culturally/linguistically appropriate staff to determine community strengths and emerging needs (Practice)
- Enrolling and participating in Minnesota Immunization Information Connection or MIIC (Practice)
- Offering immunizations in non-clinical and non-traditional settings; to make this possible, implementing standing orders from licenses physicians that authorize nurses to administer vaccines without a physician exam (Practice)
- Providing support services (transportation, child care, interpreters) to those needing immunizations (Practice)
- Eliminating financial barriers to immunizations, e.g., cost-free vaccinations, reducing co-payments, assistance in applying for health insurance (Practice)
- Developing and implementing policies and protocols on standards for providing immunizations in non-traditional settings, e.g., information and education, vaccine storage and handling, vaccine administration, adverse events (VAERS), etc. (Policies and Protocols)

6. Infant Mortality

Table 14. Infant Mortality Grantees' Objectives (N=3 Grantees)

Objectives	# Grantees
• Improve the health status of women before, during, and between pregnancies	3
• Improve the health status and safety of infants from birth to one year	2

Table 15. Infant Mortality Grantees' Strategies (N=3 Grantees)

Strategies	# Grantees
• Increase access to health and preventive care before, during and between pregnancies	2
• Provide culturally responsive outreach and care coordination during pregnancy and birth	3
• Change behaviors that lead to acute and chronic conditions	2
• Provide education and support for pregnant and parenting teens	1
• Reduce infant deaths from SIDS and sleep-related unintentional injuries	1
• Improve infant nutrition and health, physical growth and development	2

Activities

- Implementing Family Spirit, Parents as Teachers for home visiting (Programs)
- Implementing Positive Indian Parenting, Growing Great Kids (Curriculums)
- Conducting four-day traditional birthing educational sessions (Curriculum)
- Using motivational interviewing to increase awareness, encourage pursuit of goals, and strengthen client's commitment to change (Practice)
- Conducting "Men Make Babies Too" which included education around FASD and a talking circle for men to explore ways to support and promote a healthy pregnancy for the women in their lives (Workshop)
- Holding cultural immersion camps (Event)
- Holding traditional gathering camps (Event)

7. Teen Pregnancy Prevention

Table 16. Teen Pregnancy Prevention Grantees' Objectives (N=14 Grantees)

Objectives	# Grantees
• Improve the sexual health of young people	12
• Reduce the risk factors and increase the protective factors related to teen pregnancy	14

Table 17. Teen Pregnancy Prevention Grantees' Strategies (N=14 Grantees)

Strategies	# Grantees
• Improve clinic practices to better reach young people	4
• Improve sexual health education of young people	9
• Increase parent-child connectedness and communication	6
• Increase school connectedness	6
• Increase opportunities for young people that help grow a sense of competence, connection and contribution	6
• Delay early sexual activity with a special focus on young adolescents	7
• Reduce the frequency of sex and number of partners and increase condom and contraceptive use among sexually-active adolescents	7
• Identify community needs and assets by having youth participants conduct a community needs assessment study (Own)	1

Activities

- Implementing Becoming A Responsible Teen (BART), Between Us, Making Proud Choices!, Above The Waist, Safer Choices, ¡Cuidate!, Draw the Line/Respect the Line, Teen Outreach Program (TOP), Learning Dreams, Linked 4 Leadership Too!, Live It!, SIHLE, SELF (Programs)
- Implementing Connecting Parents to Educational Opportunities (CPEO), Padres Informados/Jovenes Preparados, Raíces, Native STAND, Building Foundations, Making the Connections, The Mask You Live In, The 3R's, Sexuality Education for Adults with Disabilities, Positive Prevention PLUS, Girls Inc. Preventing Adolescent Pregnancy (Curriculums)
- Implementing Parallel Family Care, Family Systems, Health Care Home, Positive Youth Development paradigm, Systems of Care, and Social Ecological Model of Human Development (Models)

- Recruiting and training neighborhood leaders as community organizers and advocates, recruiting and training youth as peer educators (Practice)
- Incorporating theater training and performance in peer education training
- Implementing the Intercultural Development Inventory (IDI) among program committee members (Practice)
- Holding a Mother-Daughter retreat (Event)

8. Unintentional Injury and Violence

Table 18. Unintentional Injury and Violence Grantees' Objectives (N=5 Grantees)

Objectives	# Grantees
• Prevent unintentional injuries and violence	6
• Reduce the risk factors that can lead to unintentional injuries and violence	1

Table 19. Unintentional Injury and Violence Grantees' Strategies (N=5 Grantees)

Strategies	# Grantees
• Improve home safety	1
• Prevent suicide and self-inflicted harm	3
• Prevent injuries from assaults	2
• Decrease sexual violence	2
• Increase physical activity	1
• Decrease alcohol misuse	1

Activities

- Implementing MNCASA Sexual Assault Advocate Training, Native Wellness Institute-Healthy Relationships, Strengthening the Spirit, 8 Principles of Parenting module (Curriculum)
- Applying the Paulo Freire model of education (Model)
- Holding Jingle Dressmaking, Beading (Workshops)
- Holding sweat lodge ceremony, naming ceremony, cultural nights (Events)
- Using Existe Ayuda Toolkit, National Resource Center Against Sexual Violence materials, Women in

Recovery workbook (Resource Materials)

9. Community Primary Prevention

Community Primary Prevention Grantees' Objectives (N=2 Grantees)

National Asian Pacific American Women's Forum (NAPAWF)

- Engage young Asian/Pacific Islander (API) women as health leaders to reduce health disparities in cancer screening rates and teen pregnancy.
- Collect disaggregated API young women's sexual health data that currently does not exist.
- Build community connections to foster greater effectiveness in meeting API women's health needs and disparities.

Neighborhood Hub

- Identify policy issues affecting the health of African American youth and work on issue campaigns around the issues.
- Provide safe, supportive environment for African American youth to discuss issues affecting them and to develop plans to create change in their community.

Community Primary Prevention Grantees' Strategies (N=2 Grantees)

National Asian Pacific American Women's Forum (NAPAWF)

- Short-term: Implement an innovative, collaborative and community-based participatory action research program.
- Long-term: Build an effective and culturally competent model of empowerment, leadership development, and advocacy on college campuses to cultivate the next generation of API reproductive justice activists committed to public health, movement building, and social change.

Neighborhood Hub

- Build youth understanding of Social Determinants of Health (SDOH).
- Develop youth civic engagement and leadership skills.
- Educate youth about the importance of a healthy lifestyle.
- Partner with organizations that support social, racial and economic justice and culturally competent service delivery.

Community Primary Prevention Grantees' Activities (N=2 Grantees)

National Asian Pacific American Women's Forum (NAPAWF)

- Taught U of MN Asian American Studies/Gender Women and Sexuality Studies course "Asian American Health and Research" on API identity, API women's reproductive and sexual health, and research methods; conducted education sessions with students in the Minnesota Young Women's Collaborative (MYWC) on API women's health issues and principles of community-based research (Curriculums)

- Developed and implemented social action research projects (Practice)
- Held MYWC Summit (Event)

Neighborhood Hub

- Recruited neighborhood youth as Youth Leaders who received education and training (SDOH, community organizing) and participated in civic engagement activities (Practice).
- Convened meetings between Youth Leaders and policy makers to push for policy actions (Practice).
- Collaborated with neighborhood organizations to promote healthy and culturally appropriate activities (Practice)
- Hosted community conversations (Event).

EHDI Grantee Objectives, Strategies & Activities: FY17 and FY18

The information in Table 20 through Table 27 came from grantees' most recent work plan and annual reports from 2017 and 2018.

1. Breast and Cervical Cancer Screening

Program Objectives: Breast and Cervical Cancer

Objectives

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

Table 20. Table 20. Program Strategies: Breast and Cervical Cancer

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Increase the number of women who receive complete diagnostic and treatment services in a timely manner	2	2
• Increase the number of women who are screened for breast and cervical cancer in accordance with state or national health care guidelines	4	4

Types of Activities

Example of Promising Practices

- Use of re-call reminders
- Educate and support coordination of care for women with abnormal findings

Example of Culturally Responsive Strategies

- Use of ethnic media to disseminate linguistically and culturally appropriate messages
- Revision of intake forms and processes to be culturally appropriate

2. Diabetes

Program Objectives: Diabetes

Objectives

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

Table 21. Program Strategies: Diabetes

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Assist people with diabetes or pre-diabetes to maintain healthy lifestyles	4	4
• Improve medical care for people with diabetes	1	1
• Assist people with diabetes to manage their disease	3	3
• Teach people with pre-diabetes how to prevent the development of diabetes	4	4
• Detect diabetes earlier	2	2

Types of Activities

Example of Evidence-Based Practices

- Use of the *Living with Chronic Disease* and the *I CAN Prevent Diabetes*, and *Community Preventive Services: Increasing Physical Activity* program
- Use of the community health worker model
- Provide case management and coaching for elders

Example of Promising Practices

- Offer culturally relevant nutrition classes including meal planning, preparation and cooking classes
- Recognition of patient improvement

Example of Culturally Responsive Practices

- Work with community organizations to increase awareness, prevention and early intervention
- Provide free culturally appropriate fitness facility
- Coordinate activities for Native Elders in culturally appropriate physical activities
- Community workshops guided by the teachings of the Quran
- Outreach at community events

- Increased physical activity incorporated into English Language Learner program

3. Heart Disease and Stroke

Program Objectives: Heart Disease & Stroke

Objectives

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

Table 22. Program Strategies: Heart Disease & Stroke

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Improve the medical care given to people with heart disease and stroke	2	2
• Assist people with heart disease or stroke to manage their disease	1	1
• Assist people with high blood pressure, high cholesterol, or who use tobacco to reduce their risk	3	3
• Decrease obesity by increasing physical activity and healthy eating	1	1

Types of Activities

Example of Evidence-Based Strategies

- Conduct disease self-management groups (e.g., Chronic Disease Self-Management Programs, Matter of Balance, Tai Ji Quan curriculum)
- Use of Community Health Worker model including bi-lingual CHWs

Example of Promising Practices

- Provide free exercise and nutrition classes
- Utilizing barbershops and beauty salons to increase awareness and blood pressure testing

Example of Culturally Responsive Strategies

- Use of culturally appropriate education materials
- Establish policies and procedures that will screen high risk people for high blood pressure and or high cholesterol in community settings and link them to culturally appropriate resources for treatment
- Promote opportunities for culturally appropriate nutrition education
- Promote opportunities for increased physical activity

4. HIV/AIDS and Sexually Transmitted Infections

Program Objectives: HIV/AIDS & STIs

Objectives

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

Table 23. Program Strategies: HIV/AIDS & STIs

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Increase the number of people who access complete diagnostic and treatment services in a timely manner after testing positive for HIV and/or STIs	3	3
• Increase HIV and STI testing among members of high-risk groups	6	6
• Reduce risky sexual behaviors which lead to the transmission of HIV/STIs	8	8

Types of Activities

Example of Evidence-Based Strategies

- Expand PROMISE DEBI (Diffusion of Evidence Behavioral Interventions) team training
- Implemented a group or individual intervention for high risk members of the target population with education and skills training to reduce risky sexual behaviors, improve safer sex skills, and increase knowledge of HIV and STIs (e.g., *Draw the Line/ Respect the Line, ¡Cuidate!* curricula)
- Use of culturally-specific Community Health Workers
- Implement It's That Easy, a parent education program

Example of Promising Practices

- Use of culturally-specific Peer Advocates
- Use of social media to increase awareness and early intervention
- Conduct clinic visits so that youth know where to go to get tested

Example of Culturally Responsive Strategies

- Use Role Model Stories
- Intensive culturally-specific community education and outreach
- Conduct culturally-specific needs assessment
- Convene culturally-specific community advisory board, community listening sessions
- Conduct HIV and STI testing at LGBTQ community sites
- Conduct training and education to professionals in the field on cultural competency

5. Immunizations for Adults and Children

Program Objectives: Immunizations

Objectives

- Improve clinical immunization rates
- Remove barriers to accessing immunizations

Table 24. Program Strategies: Immunizations

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Increase access to immunizations	3	3
• Address knowledge, attitudes, and beliefs regarding immunizations	3	3
• Ensure that patients receive all needed vaccines at all visits	3	3
• Ensure that recordkeeping systems prompt for needed vaccines	3	3

Types of Activities

Example of Evidence-Based Strategies

- Provide free influenza immunizations for persons six months and older by holding clinics in trusted non-traditional settings such as neighborhood centers and faith based entities
- Engage licensed vaccinators to work in the community under physician's standing orders
- Train designated staff persons in partner organizations to present *Is it a cold or the flu?* education al sessions

Example of Promising Practices

- Educate youth and parents on the benefits of immunizations and offer vaccinations to those need them
- Work with bi-lingual Community Health Workers
- Enter all vaccination records into MIIC

Example of Culturally Responsive Strategies

- Partnering with culturally-specific community organizations and using community volunteers
- Implement inclusive planning
- Ensure that interpreters and translated materials are available

6. Infant Mortality

Program Objectives: Infant Mortality

Objectives

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

Table 25. Program Strategies: Infant Mortality

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Increase access to health and preventive care before, during and between pregnancies	3	3
• Provide culturally responsive outreach and care coordination during pregnancy and birth	3	3
• Change behaviors that lead to acute and chronic conditions	2	2
• Provide education and support for pregnant and parenting teens	1	1
• Ensure that all infants receive high-quality care at birth and infancy	2	2
• Reduce infant deaths from SIDS and sleep-related unintentional injuries	2	2
• Improve infant nutrition and health, physical growth and development	2	2
• Reduce infant deaths from unintentional injury and violence	2	2

Types of Activities

Example of Evidence-Based Strategies

- Use of American Indians-specific curricula such as the Manidoo-Ningadoodem (Family Spirit) Progr am which is a core strategy to support young, Native parents from pregnancy to 3 years post-part um

Example of Culturally Responsive Strategies

- Use of Back to Sleep message, Cribs for Kids Program to prevent sleep-related injuries
- Host Community Baby Showers to celebrate and welcome new babies and parents

7. Teen Pregnancy Prevention

Program Objectives: Teen Pregnancy Prevention

Objectives

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

Table 26. Program Strategies: Teen Pregnancy Prevention

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Improve clinic practices to better reach young people	1	1
• Improve sexual health education of young people	12	12
• Increase parent-child connectedness and communication	7	7
• Increase school connectedness	4	4
• Increase opportunities for young people that help grow a sense of competence, connection and contribution	2	2
• Delay initiation of sexual activity with a special focus on young adolescents	2	2
• Improve infant nutrition and health, physical growth and development	2	2
• Reduce the frequency of sex and number of partners and increase condom and contraceptive use among sexually-active adolescents	2	2

Types of Activities

Example of Evidence-Based Strategies

- Implement evidence-based programs in local schools or in after-school or community programs that discuss abstinence, contraception, and condom use (e.g., *¡Cuidate!, Our Whole Lives, Be Proud! Be Responsible!, FLASH, Making Proud Choices, Becoming A Responsible Teen, Draw the Line/Respect the Line, Youth Power!, Hmong STAR*)
- Implement sexuality education for American Indian youth (e.g., *Live It!, Native Stand*)
- Implement a service learning program (e.g., *Teen Outreach Program/ TOP*)

Example of Promising Practices

- Implement comprehensive healthy youth development curriculum (*Raices Youth Development*, performed a play called “Everything is a Circle,” CRUSH)
- Implement sexuality education for adults (*It’s That Easy, Let’s Talk About Sexuality*, train Family Medicine interns)
- Deliver professional trainings and participate in coalitions regarding inclusive strategies for health care professionals

Example of Culturally Responsive Strategies

- Implement an evidence-based program that increases parent and child communication about sexuality (e.g., *Padres Informados, Jovenes Preparados* curriculum)

8. Unintentional Injury and Violence

Program Objectives: Unintentional Injury & Violence

Objectives

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

Table 27. Program Strategies: Unintentional Injury & Violence

Strategies	# FY 2017 Grantees	# FY 2018 Grantees
• Improve road and trail safety	0	0
• Improve home safety	0	0
• Prevent suicide and self-inflicted harm	1	1
• Prevent traumatic brain injuries	0	0
• Prevent injuries from assault	1	1
• Decrease sexual violence	0	0
• Increase physical activity	0	0
• Decrease alcohol misuse	0	0

Types of Activities

Example of Promising Practices

- Culturally-specific workshops on depression, post-partum depression, and mental health
- Conduct intergenerational conversations
- Conduct culturally-specific family education classes

Example of Culturally Responsive Strategies

- Design culturally-specific educational resources on mental health

V. Evaluation and Capacity Building

Technical Assistance and Support

CHE is committed to amplifying and celebrating grantee outcomes as well as strengthening the capacity of organizations to reduce racial disparities in health through shared learning and evaluation. To these ends, CHE has provided EHDI grantees with individual evaluation technical assistance and support, and has developed and maintained a community of practice for grantees' ongoing learning.

For much of EHDI's existence, since 2002, MDH has contracted with an evaluation consulting organization, Rainbow Research, Inc., to be the Evaluation Technical Assistance (TA) and Support provider for EHDI. Rainbow Research's Evaluation TA and Support Team has extensive experience working with populations of color and American Indians on program evaluation. Evaluation TA and Support services provided by MDH through Rainbow Research has consisted of:

- Providing customized, culturally responsive, one-to-one consultation
- Assisting grantees in developing logic models, evaluation plans, and reports
- Facilitating stakeholder involvement in their evaluation processes and practices
- Providing a series of web-based and in-person trainings in response to grantees' interests and expressed needs, for example, developing logic model and evaluation plans, introduction to evaluation, survey design and analysis, focus group design, and other topics of interest led by outside speakers
- Facilitating interactive sessions for groups of grantees addressing similar populations and/or PHAs to share challenges, best practices, and resources
- Developing and sharing ready-to-use evaluation resources and tools
- Providing feedback on reports submitted to CHE

Community of Practice

The EHDI Community of Practice (CoP) started in 2012 as a way to encourage grantees to strengthen their relationships with other organizations who are actively working to eliminate health disparities; share knowledge, tools and ideas; and, learn about strategies and approaches used locally and nationally. The CoP has evolved into a vibrant space where grantees engage in leadership development and peer learning to increase the efficacy and impact of their programs.

CHE developed and now maintains the EHDI Grantee Portal, a one-stop shop where grantees can access information about grant requirements, announcements, training presentations, tip sheets, and other templates.

In 2017, Rainbow Research's partner the Prevention Research Center (PRC) at the University of Minnesota created, and currently moderates, an online community using the Mobilize platform for EHDI grantees to meet and network virtually. Here grantees are able to post and receive announcements, connect with other grantees, and respond to online polls. Twenty-eight of 32 grantees (87%) count themselves as members.

Examples of CoP in-person conversations that Rainbow Research and PRC have facilitated include Design Thinking for grantees to discuss the best ways the CoP could be beneficial to them; three grantee-led opportunities to learn about others' work in the community, resources, and networks; and providing feedback to the design of the EHDI Grantee Fact Sheets template. [3]

2018 EHDI Grantees. *MDH*

Program Reach

EHDI grantees reach people through direct and indirect means. A direct contact includes one-to-one/individual contact (e.g. counseling, clinical services, screenings, education in private settings) and group contact (e.g. classes, workshops, and other group activities). There may be duplicate numbers if for example a person participated in both individual counseling and a class. An indirect contact occurs when grantees conduct outreach at large events, and is usually minimal or fleeting. For example, the number of pamphlets distributed during a health fair, the number of letters sent out as reminder for breast and cervical cancer screening, or the number of TV show viewers, radio show listeners or newspaper article readers.

Program Reach: FY15 and FY16

Table 28 to Table 31 show the number of people reached by EHDI grantees in FY 2015 and FY 2016. The variation in numbers are reflective of the number of grantees in each priority health area, the types of activities and settings. For example, programs that offered classes versus one-on-one counseling, or activities conducted in classrooms versus community settings. The difference in totals by target population and by PHA can be explained by how the numbers are reported. Grantees report unique number of individuals by target population, but if they have complementary programs and their clients participate in both programs, for example, Diabetes/Heart Disease & Stroke or HIV/AIDS/STIs/Teen Pregnancy Prevention, then they are counted in both programs.

In fiscal year 2015, EHDI grantees directly reached 67,408 individuals in their target populations and 73,974 in their priority health areas. In fiscal year 2016, EHDI grantees directly reached 56,969 individuals in their target populations and 61,511 individuals in their priority health areas. The lower numbers could be due to the loss of

[3] MDH did not contract for Evaluation TA and Support services in the years 2008-2010 and 2014-2016. However, since part of EHDI's evaluation sustainability efforts was to ensure that grantees identify internal and/or external evaluation staff, grantees were able to implement their evaluations continuously.

one grantee and the inactive status of another grantee in 2016. African/African American and Diabetes program participants were the largest groups directly reached.

In fiscal year 2015, EHDI grantees indirectly reached 88,579 individuals in their target populations, compared to 224,707 in fiscal year 2016. In the priority health areas, they indirectly reached 95,924 individuals in fiscal year 2015 and 224,221 in fiscal year 2016. As with direct contacts, African/African American and Diabetes participants were the largest groups reached through indirect means.

Table 28. Number of individuals reached by type of contact and by population, FY 2015

Target Population	Directly	Indirectly	# Grantees Serving the Target Population
African/African American	27,600	39,749	21
American Indian	14,586	10,755	14
Asian/Pacific Islander	6,826	11,612	11
Hispanic/Latino	18,396	26,463	10
Total	**67,408**	**88,579**	

Table 29. Number of individuals reached by type of contact and by PHA, FY 2015

Priority Health Area	Directly	Indirectly	# Grantees Addressing the PHA
Breast & Cervical Cancer	3,440	8,624	5
Diabetes	24,703	36,881	12
Heart Disease & Stroke	4,257	9,789	3

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Priority Health Area	Directly	Indirectly	# Grantees Addressing the PHA
HIV/AIDS	9,168	11,003	11
Immunizations	13,527	6,410	3
Infant Mortality	951	1,242	4
Teen Pregnancy Prevention	11,726	13,024	14
Unintentional Injury & Violence	4,517	7,251	5
Community Primary Prevention	1,685	1,700	2
Total	**73,974**	**95924**	

Table 30. Number of individuals reached by type of contact and by target population, FY 2016

Target Population	Directly	Indirectly	# Grantees Serving the Target Population
African/African American	23,966	152,225	20
American Indian	9,622	20,135	14
Asian/Pacific Islander	8,580	31,377	11
Hispanic/Latino	14,801	20,970	10
Total	**56,969**	**224,707**	

Table 31. Number of individuals reached by type of contact and by PHA, FY 2016

Priority Health Area	Directly	Indirectly	# Grantees Addressing the PHA
Breast & Cervical Cancer	3,135	8,627	5
Diabetes	22,834	76,134	12
Heart Disease & Stroke	5,545	55,658	3
HIV/AIDS	6,125	17,595	11
Immunizations	9,875	30,170	3
Infant Mortality	1,684	4,470	3
Teen Pregnancy Prevention	6,871	15,332	14
Unintentional Injury & Violence	2,068	9,965	5
Community Primary Prevention	1,637	6,290	2
Total	59,774	224,241	

Program Reach: FY17 and FY18

During the grant period July 1, 2016 to June 30, 2018, EHDI grantees reached more than 335,000 people in their target populations through both direct and indirect means (Table 32). This represents one third of all people of color and American Indians in the state of Minnesota. They engaged with 64,000 individuals directly. The largest group reached directly was African/African American, at almost 25,000 or 38% of the total, followed by Hispanic/Latino, at more than 21,000 or 33% of the total.

Grantees reached more than 270,000 through indirect contacts. Not all grantees have indirect means of reaching people. Indirect numbers vary as some grantees gave numeric estimates of their social media reach

while others who did education through radio, television, and social media did not estimate their reach. The largest group reached through indirect contacts was American Indian, at more than 182,000 or 67% of the total.

***Indirect contacts through community events*. African American AIDS Task Force**

Table 32. Number of individuals reached by EHDI grantees by population, FY 2017-2018 combined

Target Population	Directly	Indirectly	# Grantees Addressing PHA*
African/African American	24,916	53,053	16
American Indian	8,690	182,134	18
Asian/Pacific Islander	9,561	24,139	10
Hispanic/Latino	21,642	12,638	8
Total	**64,809**	**271,964**	

* Can be any race

EHDI's 2018–19 reporting system allowed grantees to identify the specific ethnic groups within the populations they work with to improve health. Participants within the four EHDI target populations self-identified as: Native, Mexican, Ecuadorian, multi-racial Latino, Black, multi-racial African American, African immigrant, Somali, Ethiopian, Amharic- or Oromo- speaking, African, Asian/ Pacific Islander, multi-racial Asian/ Pacific Islander, Asian Indian, Karen/ Burmese, Korean adoptive, Korean immigrant, Southeast Asian, Iraqi, and multi-racial.

These self-identified categories allow for more nuanced understanding of the results than broad racial categories allow.

Looking at program reach by PHA, in FY 2017 and 2018, the Teen Pregnancy PHA reached the highest number of Minnesotans directly (29,017) while the Breast & Cervical Cancer PHA reached the highest number indirectly (155,892) due to an innovative social media campaign aimed at raising awareness among American Indian women about the importance of cancer screening (Table 33). The reach of grantees in the Infant Mortality PHA is smaller due to the intensive, cohort-based models adopted by some of the grantees that limit the number of participants.

Table 33. Number of individuals reached by EHDI Grantees by PHA, FY 2017-2018 combined

Priority Health Area	Directly	Indirectly	# of Grantees Addressing the PHA*
Breast & Cervical Cancer	5,408	155,892	5
Diabetes	5,631	25,616	5
Heart Disease & Stroke	8,901	21,406	5
HIV/AIDS	22,538	21,663	8
Immunizations	13,200	32,599	3
Infant Mortality	2,192	3,658	3
Teen Pregnancy	29,017	23,957	14
Unintentional Injury & Violence	2,785	9,250	2
Total	**89,672**	**294,041**	

* Some grantees provided services in more than one PHA

The total in Table 33 differs from the total in Table 32 (total # reached by target population) and is more accurate. This is due to grantees not always being able to identify the racial and ethnic backgrounds of those with whom they have brief contact, whether direct or indirect. Additionally, an increasing number of people in Minnesota identify as multiracial and/or do not identify with one specific EHDI population.

Evaluation Findings

EHDI grantees are required to conduct an evaluation of their program activities and to set aside 10 percent of their grant funds for this purpose. Each grantee created a logic model and evaluation plan. There were no prescribed evaluation outcome measures; rather, grantees were encouraged to develop and implement community-based solutions to address health disparities and engage community stakeholders in the process. Their evaluations reflect these homegrown solutions and stakeholder input. The information in this section came from grantee annual reports.

Evaluation findings reported by EHDI grantees included program outcomes, outputs and processes. Outcomes describe the changes experienced by participants resulting from program activities, either self-reported by participants or observed by program staff. Outputs describe the number or nature of activities or products that grantee programs offer. Unlike outcomes, outputs describe a single point in time rather than a change over time or difference across groups. Processes are activities completed that serve to monitor activities for program improvement purposes.

Examples of outcomes achieved by PHA grantees are:

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

Examples of outputs reported by PHA grantees include:

- Events conducted such as classes, workshops, trainings, demonstrations, symposiums, campaigns, food drives and health fairs
- Participation levels in the events
- Services to the community such as screenings, testing, assessments, treatment, referrals and vaccinations
- Products, for example, brochures, flyers, educational modules, restaurant menus, cookbooks, food totes, fact sheets and hygiene kits
- Plans such as individualized care plans or housing and safety plans

Examples of processes reported by PHA grantees are:

- Formed collaborations
- Conducted satisfaction surveys with stakeholders and received suggestions for improving the program's education sessions and materials
- Developed monitoring processes, for example, if screening tests are being scheduled or if follow-ups

with participants with abnormal screening results are being conducted or entered client information into the state immunization database Minnesota Immunization Information Connection or MIIC
- Gathered participant health and behavior information in order to know their target population better and can design the program according to their needs

The two CPP grantees, whose programs focused on SDOH and policy and systems changes, reported the following accomplishments between 2015 and 2016:

NAPAWF (Minnesota Young Women's Coalition (MYWC) Twin Cities Chapter)

- MYWC participants in Fall 2015 included 9 students from the University of Minnesota Twin Cities (UMN) and 3 students from St. Cloud State University (SCSU), and 5 UMN students in Spring 2016
- The MYWC Coordinator conducted a course during 3 semesters at UMN and SCSU. This is a culturally relevant college course for Asian American and Pacific Islanders (AAPI) created by NAPAWF. The long-term strategy is to build an effective and culturally competent model of empowerment, leadership development, and advocacy on college campuses to cultivate the next generation of API reproductive justice activists who are committed to public health, movement building, and social change
- The students' experience participating in the MYWC course empowered them to advocate for the unique needs of the AAPI community.
- Hosted an AAPI Women's Leadership Summit.
- Conducted focus groups where participants reported that the MYWC program increased their understanding of community-based participatory research and enhanced their research, advocacy, activism, and leadership skills.
- MYWC participants completed three Campus Community Social Action Projects and one Media Social Action Project.
- MYWC participants developed and implemented the Health Behaviors of College Women Survey and analyzed data from the survey.
- Used data from the Health Behaviors of College Women Survey to create and distribute fact sheets on a number of AAPI women's health topics such as mental health, sexual assault, and Pap test.

Neighborhood Hub

- Recruited youth leaders and provided them training on SDOH and community organizing.
- Engaged the youth leaders in weekly meetings to develop a policy agenda and action plan.
- Convened meetings between the youth leaders and policy makers to present their policy agenda.
- Collaborated with neighborhood organizations to promote healthy, culturally appropriate activities and healthy eating and host community conversations.
- Through its Healthy Initiatives and Healthy Food Policy, the Neighborhood Hub has become a beacon in the neighborhood for healthy programming. As a result, the community has come to expect healthy snacks and/or fruit infused water in meetings, thus creating natural conversations about health issues and/or health disparities.
- By working hard to establish a good relationship with the Minneapolis Police Department, the community has come to look up to the Neighborhood Hub as a community group it could trust to facilitate conversations between the police and persons who feel victimized by the system.

- With Youthprise, successfully trained 11 youth leaders on SDOH and developing policy agendas and action items that can affect change in the community.
- The youth leaders attended two national conferences where they trained other youth leaders and community organizers on how to affect change in the community.
- Provided resources to the community to encourage healthy living such as Nice Rides bike memberships, helmets and water bottles the ReThink Your Drink campaign.

Shared Measurement System (SMS): FY 2018

CHE introduced the SMS in fiscal year 2018 to track, measure and report on outcomes common across grantees working in each of the eight PHAs. Having shared outcomes will facilitate more comprehensive reporting to the Minnesota Legislature and other MDH stakeholders in that it makes it possible to aggregate results across grantees, providing a picture of how EHDI grantees as a group are contributing to the elimination of health disparities in each PHA. EHDI grantees also benefit from a SMS in that they can learn from the evaluation process collectively, work collaboratively to evaluate their progress toward a set of mutually defined common outcomes, and gain a sense of community and collective accomplishment in the process. Individually, using common measures will allow grantees to learn how their program compares to statewide and national outcome measures in their PHA, better align their program strategies, use the results to strategize system-level improvements, and strengthen collaborations to enhance program delivery.

There are two points worth mentioning about the SMS: one, through facilitated conversations the grantees themselves selected the common measure(s) they would track in their PHA; and two, EHDI grantees may still specify their own outcomes owing to the fact that EHDI has always encouraged grantees to develop community-based solutions. The SMS is just another way for them to assess the value of their programs.

For the first time in EHDI history, CHE was able to report on important health indicators by target population and PHA. With 2017-2018 being the pilot year, these numbers represent only a portion of the shared impact of EHDI grantees. Within each PHA, grantees' approaches varied widely because in keeping with the EHDI intent, they have been tailored to their respective communities' situations and cultures. Some are engaged in primary prevention efforts whereas others are engaged in tertiary prevention efforts.[4] Consequently, not all proposed measures were relevant for all grantees. The resulting SMS indicators represent only those that are common across grantees within a PHA, and that they indicated they would be able to track. Additionally, it is still too early to compare the results with state or national indicators in the various PHAs, if there are comparable measures. CHE, the Evaluation TA & Support Team and grantees continue to work together to improve data collection,

[4] **Tertiary prevention** arrests the progress of an established health concern and controls its negative consequences by promoting affected individuals' adjustment. **Secondary prevention** stops or slows a health concern's progression by detecting it and intervening early, before symptoms appear. **Primary prevention** reduces the onset of a health concern by reducing risk and/ or promoting health in individuals or groups (e.g., vaccinations, diet). **Primordial prevention** avoids the emergence and establishment of the social, economic, and cultural patterns of living that are known to increase the risk of a health concern. Bonita, Ruth, Beaglehole, Robert, Kjellstrom, Tord & World Health Organization. (2006. *Basic epidemiology*, 2nd ed. Geneva: World Health Organization. Retrieved from http://www.who.int/iris/handle/10665/43541.)

management, and reporting processes to facilitate ongoing monitoring and understanding of indicators under the SMS.

The SMS reporting system was incorporated into the grantee annual report in 2018. Table 34 through Table 41 show the results from the SMS pilot year of 2017-2018.

1. Breast and Cervical Cancer

Four grantees working on breast and cervical cancer prevention provided 1,330 women with cancer screenings. They were able to track and identify the racial and ethnic identities of 1,159 of the women, as shown in Table 34.

Table 34. Breast and Cervical Cancer Health Indicator Reporting

Breast & Cervical Cancer	# Grantees reporting on this indicator	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino
Total direct contacts	5	319	1220	30	246
Total indirect contacts	5	140	142,478	0	100
# breast cancer screenings	4	138	517	11	95
# cervical cancer screenings	4	181	47	19	151

Another 1,367 individuals whose specific racial and ethnic identity are not known received education. The high number of indirect contacts is due to a media campaign aimed at raising awareness among American Indian women about the importance of cancer through Facebook, Twitter, and the program's website, as well as documenting online webinar sharing on Facebook and YouTube.

2. Diabetes

Five grantees worked to prevent or control diabetes within African, African American, Southeast Asian, Asian American/Asian-Pacific Islander, Iraqi, American Indian, and Latino/Hispanic populations. Interventions ranged from clinical practice aimed at helping maintain or reach healthy A1C levels to education efforts to prevent new diabetes cases.

Table 35. Diabetes Health Indicator Reporting

Diabetes	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino
Total direct contacts	667	1,002	822	9
Total indirect contacts	232	7,147	3,866	0
# diabetes or pre-diabetes screening	302	58	673	6
Identified as at risk through screening or referrals	39	103	303	2
# participants in prevention or mgmt. program	218	1,002	23	3
# participants who have diabetes or pre-diabetes	150	141		
# who reconnected with spiritual practices to support health	36	357	9	3

One clinical program reported that 38% of patients who had A1C levels that were out of range got their levels under control through the program, while 59% showed improvement of A1C levels. The remaining four programs work at increasing health but do not track A1C levels—two report on increased health skills such as better nutritional skills and healthy behavior changes.

3. Heart Disease and Stroke

Five grantees were funded to work within their respective communities to prevent or intervene with communities who are disproportionately affected by heart disease. They reached individuals who identified as Somali, Ethiopian, Amharic, Oromo, Black, African American, Iraqi, Hispanic, and American Indian. Strategies and approaches included increasing screening and education; improving behaviors such as physical activity, healthy eating and general wellness; and creating tailored prevention plans for patients diagnosed with cardiovascular disease.

Table 36. Heart Disease and Stroke Health Indicator Reporting

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Heart Disease and Stroke	African/African American	American Indian	Hispanic/ Latino
Total direct contacts	855	679	17
Total indirect contacts	682	2,697	0
# blood pressure screenings	719	65	6
# participants in wellness programs	291	645	7
# who saw provider for HDS referral	192		

One of the clinic grantees screened nearly 1,800 additional patients and provided additional outreach call to notify them that screening results indicated they should make a follow-up appointment with their primary care provider. Their racial and ethnic identities were not tracked, so they are not included in the above table. The same clinic program was also able to use medical records to track blood pressure levels and noted that 36% of targeted patients were able to get their levels under control.

Three grantees funded to prevent diabetes and/or health disease and stroke also used common methods to measures changes to physical activity. Results from a survey with 79 participants indicate significantly more physical activity when participating in the program, compared to before the program (2.86 to 4.08 days/week). In addition, prior to beginning the program, 39% of 32 program participants were not thinking about or planning to make changes to their physical activity levels. However, while participating in the physical activity program, that number reduced to 25%.

Chair Exercising at Elders Lodge.
Minneapolis American Indian Center

4. Infant Mortality

Three grantees work to reduce Infant Mortality, with a primary focus on the two populations most affected. Given SDOH that impact the health of Black/ African American women, studies show that neonatal infant mortality rates (those within the first 28 days of life) are highest in the Black/African American community. Therefore, one grantee is working to reduce those numbers by preventing prematurity and promoting women's health. That grantee worked with 75 Black/African American women (along with 17 additional women from other racial and ethnic backgrounds) to promote holistic healthcare needs during and after pregnancy. Grantees working with the American Indian community focused more on preventing sleep-related unintentional injuries among infants under 6 months, as that is a leading risk factor. However, grantees were not able to assess the specific measures below for all participants, depending on longevity with the program and access to health care records.

Table 37. Infant Mortality Health Indicator Reporting

Infant Mortality	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino
Total direct contacts	75	667	3	9
Total indirect contacts	174	1583	7	21

Infant Mortality	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino
% of infants under 12 months completed most recent well-child visits	52% (39 of 75)	64% (44 of 69)	67% (2 of 3)	56% (5 of 9)
% of 1-year-olds who had 5 or more well-child visits	36% (14 of 39)	66% (40 of 61)	N/A	N/A
% of mothers reporting safe sleep practices	78% (14 of 18)	90% (47 of 52)	N/A	N/A
% of mothers who initiated pre-natal care in first trimester		62% (24 of 39)	N/A	N/A

Each program provides wraparound services to pregnant and post-partum mothers and their children to assess needs, address issues, and create holistic education, care, and resource referral plans for families. While it is difficult to attain exact comparisons, the Pregnancy Risk Assessment Monitoring System (PRAMS) reports that women in Minnesota reported an 83% rate of beginning prenatal care in the first trimester and a 78% rate of safe sleep practices (specifically, laying baby on back to sleep).[5] As another point of comparison, 81.8% of mothers in Minnesota overall initiated pre-natal care in the first trimester in 2016.[6]

5. Immunizations for Adults and Children

Three grantees reached 7,390 participants, with 85% (n=6,271) receiving at least one needed immunization. The majority of immunizations were the flu shot. Importantly, 89% of participants (333 of 376 assessed) were brought fully up-to-date with recommended vaccinations through specific outreach about HPV and childhood vaccines.

Table 38. Immunizations Health Indicator Reporting

[5] Prevalence of Selected Maternal and Child Health Indicators* for Minnesota, Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2015. Retrieved from https://www.cdc.gov/prams/pramstat/pdfs/mch-indicators/Minnesota-508.pdf

[6] Osterman, Michelle J.K. and Martin, Joyce A. (May 30, 2018). Timing and Adequacy of Prenatal Care in the United States, 2016. National Vital Statistics Reports, Vol. 67, No. 3. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_03.pdf

Immunizations	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Other/ Unknown
Total direct contacts	1,503	70	1,809	2,107	1,901
Total indirect contacts	11,196		505	500	300
Received needed immunization	546	70	1,769	2,107	1,759
Received direct or indirect education on vaccines and vaccine-preventable illnesses	12,133		505	500	300

6. HIV/AIDS and STIs

HIV/AIDS and STIs prevention grantees used a variety of approaches to promote sexual health among populations who experience higher rates of HIV/AIDS and STIs. Some grantees implemented community-level interventions aimed at adults while many focused on health promotion and risk reduction education for middle and high school youth.

Table 39. HIV/AIDS and STIs Health Indicator Reporting

HIV/AIDS and STIs	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Other/ Multiracial/ Unknown
Total direct Contacts	3,002	14	819	1,397	50
Total indirect Contacts	1,805	77	3,344	1,954	8,960
# people tested for HIV or STI (TBD)	217	14	0	15	168
% with person to talk to about HIV/ STIs	95%	100%		81%	94%

HIV/AIDS and STIs	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Other/ Multiracial/ Unknown
	(87/92)	(22/22)		(123/151)	(31/33)

In addition to the reported measures above, 84% of 173 sexually active participants planned to use barrier methods to prevent the spread of HIV/AIDS and STIs.

7. Teen Pregnancy

Teen Pregnancy is the PHA with the highest number of grantees (14).

Grantees are using a combination of evidence-based programs and culturally responsive practices to most effectively improve sexual health for youth in Minnesota.

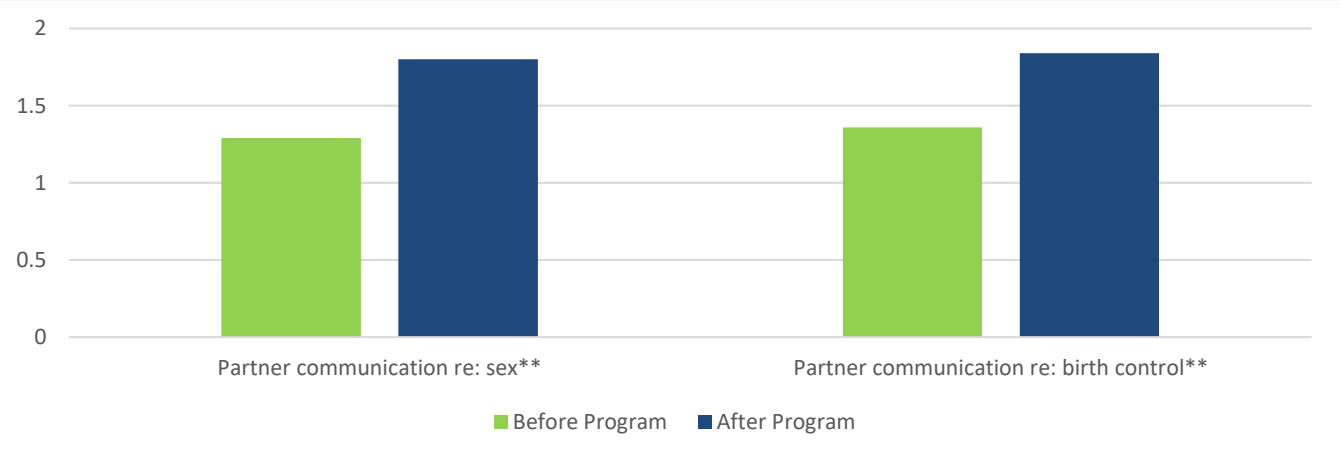
Peer Education in Action. *Annex Teen Clinic*

Table 40. Teen Pregnancy Health Indicator Reporting

Teen Pregnancy Prevention	African/ African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Other/ Multiracial/ Unknown
Total direct contacts	3,614	233	1,132	2,018	1,467
Total indirect contacts	2,688	651	3,401	3,158	1,900
# program participants who know where to get sexual health care	93% (411/441)	95% (40/42)	97% (267/274)	77% (979/1,271)	96% (419/436)

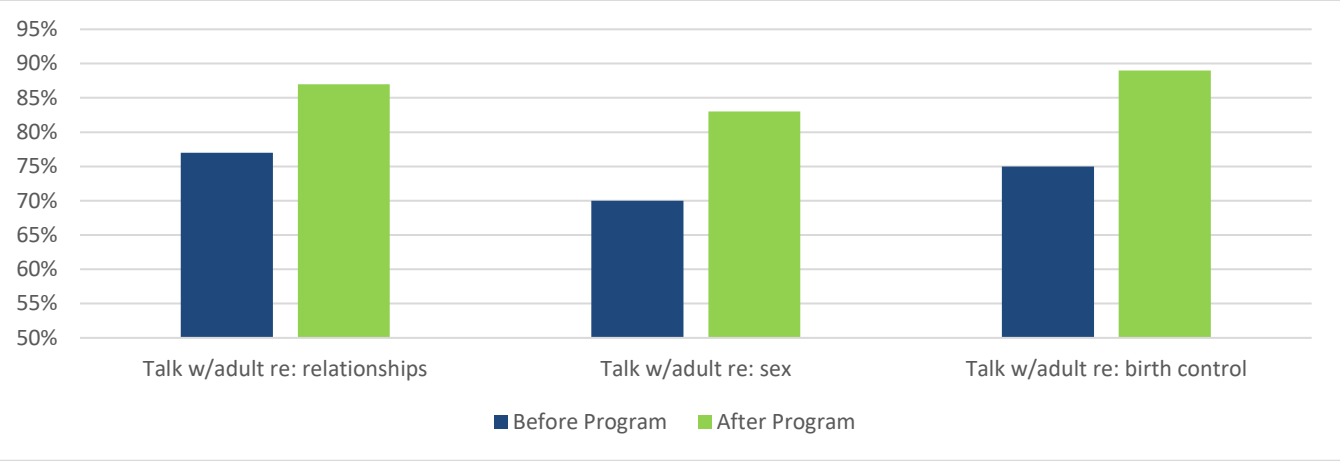
Twelve Teen Pregnancy grantees submitted data from surveys administered with program participants. Several of these grantees were able to administer surveys before and after their programs to be able to assess change over time. For example, 173 participants responded to questions about their comfort in talking to partners about sex or birth control. On a four-point scale (0 being "not at all comfortable" and 3 being "very comfortable"), participants reported statistically significant increases from before to after the program (Figure 1).

Figure 1. Sexual Health Outcomes: Partner Communication



There were also significant increases in the number of young people who reported having adults in their lives with whom to talk about sexual health issues (Figure 2). For example, 77% of young people reported having an adult to talk with about relations before participating in teen pregnancy prevention programs, compared to 87% after programs. More than 400 young people responded to each of these questions at each measurement point.

Figure 2. Sexual Health Outcomes: Having an Adult to Talk with about Sexual Health Topics



In addition to these youth who were served, 437 of the direct contact numbers represent parents/ caregivers of youth who received education about how best to support their youth to make healthy decisions about sex, sexuality, and relationships.

8. Unintentional Injury and Violence

Two grantees worked to prevent unintentional injury and violence. Both promoted mental health as well as suicide awareness and screening among their target population, one through clinical services and the other through outreach and education.

Table 41. Unintentional Injury & Violence Health Indicator Reporting

UIV	Asian/Pacific Islander	Hispanic/Latino
Total direct contacts	625	756
Total indirect contacts	3,450	600
# mental health screenings		267
Of those screened, # whose score required follow-up		68
Of those who required follow-up, # who attended follow-up appointment		34

VI. Conclusions and Recommendations

Evaluation results indicate that the community grantees highlighted in this report proved to be valuable investments. In their target populations and through both direct and indirect means, the grantees reached 155,987 individuals in FY 2015; 281,676 individuals in FY 2016; and, 336,773 in FY 2017 and FY 2018 combined. Grantee program evaluations have documented a number of health improvement and prevention outcomes such as decreased A1C levels in people with diabetes; screening for breast and cervical cancer, diabetes, and heart disease; increased healthy eating and physical activity; and increased skills for providing inclusive services among professionals who work with Minnesota's populations of color and American Indian communities. For the first time, EHDI is able to offer a glimpse into the collective impact across groups of grantees and find statistically significant improvements in levels of physical activity, sexual health communication, and knowledge of sexual health resources for participants in grantee programs. A number of grantees implemented policy and systems changes. They reported building an effective and culturally competent model of empowerment, leadership development, and advocacy on college campuses to cultivate the next generation of reproductive justice activists; developing a policy agenda that promotes a citywide healthy food policy; training youth leaders in community organizing to provide them the tools to affect community change; helping pass a behavioral health homes amendment in the legislature; developing an culturally specific teen pregnancy prevention curriculum used by a public school system; and, establishing standards for a teen-friendly clinic. Evaluation results also documented expanded capacity of grantee organizations to better serve populations of color and American Indians through promising practices such as incorporating traditional spiritual or cultural practices to promote health.

Looking forward, there are several considerations for action:

- Increase EHDI funding. Funding levels have not kept up with the rapid growth of Minnesota’s populations of color and American Indians. The impact and reach of EHDI grantees clearly demonstrates that across the state they have the relationships, trust, and effective strategies to serve some of the hardest to reach populations who experience some of the largest health disparities.
- Implement longer funding cycles (grantees recommended 5-year cycles). This would allow much-needed time to establish trusting relationships with community members and partners, develop and tweak programs for maximum impact, and support sustainability strategies. It takes considerable time even for organizations rooted in their communities to develop relationships because of their painful history with the health system. It takes time to develop and support sustainability strategies, including training of grantee organization staff in project management, polishing administrative processes and protocols, and networking with organizations working in similar PHAs or with similar populations. This involves thinking more broadly about EHDI-funded organizations as interventions beyond their funded programming. For example, some of their health prevention strategies could be considered workforce development strategies because they are employing people of color and American Indians, thus providing opportunities to build on community strengths and assets.
- Grantees suggested that EHDI foster collective work toward policy, systems, and environmental change since organizations funded by EHDI are generally small.
- Acknowledge the SDOH and the common cultural perspective that health is interwoven with community, art, and spirituality. Doing so would also support programmatic and organizational sustainability. Grantees suggested using language that focuses on the SDOH as opposed to diseases or

conditions. The former is often more accessible to community, and shifts the discussion away from deficits among individuals within marginalized groups to self-reflection about structural issues among public institutions and systems.

- Understand the limitations of evidence-based curricula by supporting translation, expanding the list to include more culturally and linguistically appropriate options, and assisting organizations using adapted curricula to build the evidence base for their program
- Continue to collaborate with grantees and PHA specialists to develop better ways of collecting and tracking data about participants' demographic characteristics, program participation, and outcomes. Innovative, tailored data policies and practices must make sense for participants engaging in grantee programs. They must also make sense for grantee staff who enter data into organizational data systems, including SMS data. Lastly, they must make sense for both grantees and MDH as together they monitor, learn from, and share with others the process and outcomes of disparities reduction work.

Appendix A. EHDI Legislation

MINNESOTA STATUTES 2010 145.928

145.928 ELIMINATING HEALTH DISPARITIES.

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

Subd. 2. State-community partnerships; plan. The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Council on Affairs of Chicano/ Latino People under section 3.9223; the Council on Black Minnesotans under section 3.9225; the Council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

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

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

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

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

Subd. 7. Community grant program; immunization rates and infant mortality rates.

a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

   1) decreasing racial and ethnic disparities in infant mortality rates; or

   2) increasing adult and child immunization rates in nonwhite racial and ethnic populations.

b) The commissioner may award up to 20 percent of the funds available as planning grants.

   Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.

c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner.

   A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

   1) is supported by the community the applicant will serve;

   2) is research-based or based on promising strategies;

   3) is designed to complement other related community activities;

   4) utilizes strategies that positively impact both priority areas;

   5) reflects racially and ethnically appropriate approaches; and

   6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 7a.Minority-run health care professional associations.

The commissioner shall award grants to minority-run health care professional associations to achieve the following:

   1) provide collaborative mental health services to minority residents;

   2) provide collaborative, holistic, and culturally competent health care services in communities with high concentrations of minority residents; and

   3) collaborate on recruitment, training, and placement of minorities with health care providers.

Subd. 8. Community grant program; other health disparities.

a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

   1) decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;

   2) decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;

3) decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;

4) decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or

5) decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

d) The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

1) is supported by the community the applicant will serve;

2) is research-based or based on promising strategies;

3) is designed to complement other related community activities;

4) utilizes strategies that positively impact more than one priority area;

5) reflects racially and ethnically appropriate approaches; and

6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. Health of foreign-born persons.

a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

1) $1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;

2) $500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;

3) $500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and

4) $50 per foreign-born person in the community health board's service area.

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

Subd. 10. Tribal governments. The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established

according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11. Coordination. The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

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

Subd. 13. Report. The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

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

Appendix B. EHDI Grantees by PHA and by Target Population, FY 2015 and FY 2016

Priority Health Area: Breast and Cervical Cancer Screening (N=5)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Hmong American Partnership			●	
Open Cities Health Center	●			
Saint Mary's Clinic				●
Stairstep Foundation		●		
The Indian Health Board of Minneapolis		●		

Priority Health Area: Diabetes (N=12)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Interfaith Action of Greater Saint Paul		●		
Minneapolis American Indian Center		●		
NorthPoint Health & Wellness Center, Inc.	●		●	
Open Cities Health Center	●			
Peta Wakan Tipi		●		
Pillsbury United Communities	●			
Sabathani Community Center	●			●
Saint Mary's Clinic				●
Stairstep Foundation		●		
The Indian Health Board of Minneapolis		●		
WellShare International	●			

Priority Health Area: Heart Disease and Stroke (N=3)

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
NorthPoint Health & Wellness Center, Inc.	●		●	
Pillsbury United Communities	●			
WellShare International	●			

Priority Health Area: HIV/AIDS and Sexually Transmitted Infections (N=11)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
African American AIDS Task Force	●			
Annex Teen Clinic	●			
Centro, Inc.				●
Division of Indian Work		●		
HealthFinders Collaborative				●
Hennepin County Aqui Para Ti				●
Indigenous Peoples Task Force		●		
MN African Women's Assn	●			
Planned Parenthood MN, ND, SD	●		●	
Sabathini Community Center	●			●
Turning Point, Inc.	●			

Priority Health Area: Immunizations for Adults and Children (N=3)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Axis Medical Center	●			
CAPI USA			●	
MN Immunization Networking Initiative	●	●	●	●

Priority Health Area: Infant Mortality (N=3)

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
American Indian Family Center		●		
Leech Lake Band of Ojibwe		●		
Minnesota Visiting Nurse Agency	●			

Priority Health Area: Teen Pregnancy (N=14)

Grantee Organization	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latino
Annex Teen Clinic	●			
Big Brothers Big Sisters of the Greater TC	●	●	●	●
Centro, Inc.				●
Division of Indian Work		●		
HealthFinders Collaborative				●
Hennepin County Aqui Para Ti				●
High School for Recording Arts	●			
Indigenous Peoples Task Force		●		
Lutheran Social Services of Minnesota	●	●	●	●
MN African Women's Assn	●			
Planned Parenthood MN, ND, SD	●		●	

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latino
Sabathani Community Center	●			●
St. Paul Ramsey County Public Health	●	●		
YWCA of Minneapolis	●	●	●	●

Priority Health Area: Unintentional Injury and Violence (N=5)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Community-University Health Care Center				●
Hennepin County Aqui Para Ti				●
Korean Service Center			●	
MN Indian Women's Resource Center		●		
Sabathani Community Center	●			●

Priority Health Area: Community Primary Prevention (N=2)

Grantee Organization	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
National Asian Pacific American Women's Forum			●	
The Neighborhood Hub	●			

Appendix C. EHDI Grantees by PHA and by Population, FY 2017 and FY 2018[a]

Priority Health Area: Breast and Cervical Cancer (N=5)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
American Indian Cancer Foundation		●		
WellShare International	●	●		
Mayo Clinic		●		
Neighborhood Health Source	●	●	●	●
St. Stephen's Human Services*		●		

Priority Health Area: Diabetes (N=5)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Hmong American Partnership			●	
Minneapolis American Indian Center		●		
Cedar Riverside People's Center, People's Center Health Services	●			
Interfaith Action of Greater Saint Paul		●		
Partnership4Health Community Health Board	●			

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Priority Health Area: Heart Disease and Stroke (N=5)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Southside Community Health Services	●			
Minneapolis American Indian Center		●		
Wellshare International	●	●		
Cedar Riverside People's Center, People's Center Health Services	●			
Partnership4Health Community Health Board	●			

Priority Health Area: HIV/AIDS and Sexually Transmitted Infections (N=8)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
African American AIDS Task Force	●			
Annex Teen Clinic	●			
Family Tree Clinic	●			●
Centro Tyrone Guzman				●
HealthFinders Collaborative, Inc.				●
Hennepin County Medical Center				●

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Planned Parenthood MN, ND, SD	●		●	
St. Stephen's Human Services*		●		

Priority Health Area: Immunizations (N=3)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Minnesota Academy of Pediatrics Foundation	●	●	●	
MN Immunization Networking Initiative	●	●	●	●
St. Stephen's Human Services[b]		●		

Priority Health Area: Infant Mortality (N=3)

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
American Indian Family Center		●		
Leech Lake Band of Ojibwe		●		
NorthPoint Health & Wellness Center	●	●	●	●

Priority Health Area: Teen Pregnancy (N=14)

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Annex Teen Clinic	●			
Big Brothers Big Sisters of the Greater TC	●	●	●	●
Centro Tyrone Guzman				●
Comunidades Latinas Unidas en Servicio		●		●
Family Tree Clinic	●			●
Fond du Lac Band of lake Superior Chippewa		●		
HealthFinders Collaborative				●
Hennepin County Medical Center				●
High School for Recording Arts	●			
Indigenous Peoples Task Force		●		
Lutheran Social Services of Minnesota	●	●	●	●
Mille Lacs Band of Ojibwe		●		
Planned Parenthood MN, ND, SD	●		●	
YWCA of Minneapolis	●	●	●	●

Priority Health Area: Unintentional Injury and Violence (N=2)

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

EHDI Grantees	African/ African American	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Hennepin County Medical Center				●
Korean Service Center			●	

[a] With the exception of St. Stephen's Human Services which was funded only in FY 2017, the grantees and their PHA and target population are the same for FY 2017 and FY 2018.

Appendix D. Amount of EHDI Funding by Grantee Organization, FY 2015 and FY 2016[a]

Fiscal Year 2015 ($)

Grantee Organization	TANF	GF	Total
African American AIDS Task Force		130,868	130,868
American Indian Family Center		114,373	114,373
Annex Teen Clinic	174,697	12,703	187,400
Axis Medical Center		102,544	102,544
Big Brothers Big Sisters	192,500	1,000	193,500
CAPI USA		134,299	134,299
Centro Tyrone Guzman	127,094.24	50,784	177,878
Community-University Health Care Clinic		80,850	80,850
Crown Medical		85,528	85,528
Division of Indian Work	192,500	1,000	193,500
HealthFinders Collaborative	101,316	69,874	171,190
Hennepin County Medical Center	125,338	51,209	176,547
High School Recording Arts	192,500	1,000	193,500
Hmong American Partnership		123,408	123,408

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Indian Health Board of Minneapolis		112,634	112,634
Indigenous People	101,692	45,388	147,080
Interfaith Action of Greater St. Paul		141,436	141,436
Korean Service Center		70,020	70,020
Leech Lake Reservation		37,228	37,228
Lutheran Social Services	101,637	1,000	102,637
Minneapolis American Indian Center		90,434	90,434
Minnesota African Women's Assoc.	101,619	1,000	102,619
Minnesota Immunization Networking Initiative		97,511	97,511
Minnesota Indian Women's Resource		141,434	141,434
Minnesota Visiting Nurse Agency[b]		124,390	124,390
National Asian Pacific American Women's Forum		118,030	118,030
Neighborhood Hub		115,799	115,799
NorthPoint Health & Wellness Center, Inc.		125,832	125,832
Open Cities Health Center Inc.		102,426	102,426
Peta Wakan Tipi		131,069	131,069
Pillsbury United Communities		99,305	99,305

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Planned Parenthood	192,500	1,000	193,500
Sabathani Community Center	44,105	92,954	137,059
St. Mary's Clinic		126,114	126,114
St. Paul Ramsey County	160,000	1,000	161,000
Stairstep Foundation		99,305.2	99,305.2
Turning Point		72,829	72,829
WellShare International		146,436	146,436
YWCA of Minneapolis	192,500	1,000	193,500
Total	**1,999,999**	**3,055,014**	**5,055,014**

Fiscal Year 2016 ($)

Grantee Organization	TANF	GF	Total
African American AIDS Task Force		132,180	132,180
American Indian Family Center		125,686	125,686
Annex Teen Clinic	174,696	14,016	188,712
Axis Medical Center		118,856	118,856
Big Brothers Big Sisters	177,000	1,000	178,000

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
CAPI USA		135,612	
Centro Tyrone Guzman	127,094	52,096	179,190
Community-University Health Care Clinic		82,162	82,162
Crown Medical		86,840	86,840
Division of Indian Work	192,500	1,000	193,500
HealthFinders Collaborative	101,316	71,186	172,502
Hennepin County Medical Center	125,338	52,520	177,858
High School Recording Arts	192,500	1,000	193,500
Hmong American Partnership		124,720	124,720
Indian Health Board of Minneapolis		134,946	134,946
Indigenous People	101,692	54,700	156,392
Interfaith Action of Greater St. Paul		142,748	142,748
Korean Service Center		80,332	80,332
Leech Lake Reservation		111,540	111,540
Lutheran Social Services	101,638	1,000	102,638
Minneapolis American Indian Center		91,746	91,746
Minnesota African Women's Assoc.	101,618	1,000	102,618

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Minnesota Immunization Networking Initiative		98,824	98,824
Minnesota Indian Women's Resource		142,746	142,746
Minnesota Visiting Nurse Agency[b]		0	0
National Asian Pacific American Women's Forum		119,342	119,342
Neighborhood Hub		142,110	142,110
NorthPoint Health & Wellness Center, Inc.		127,144	127,144
Open Cities Health Center Inc.		103,738	103,738
Peta Wakan Tipi		132,382	132,382
Pillsbury United Communities		100,618	100,618
Planned Parenthood	192,500	1,000	193,500
Sabathani Community Center	44,104	105,266	149,370
St. Mary's Clinic		127,426	127,426
St. Paul Ramsey County	160,000	1,000	161,000
Stairstep Foundation		100,618	100,618
Turning Point		74,142	74,142
WellShare International		147,748	147,748
YWCA of Minneapolis	192,500	1,000	193,500

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Total	**1,984,496**	**3,141,990**	**5,126,486**

Appendix E. Amount of EHDI Funding by Grantee Organization, FY 2017 and FY 2018[a]

Fiscal Year 2017 ($)

Grantee Organization	TANF	GF	Total
African American AIDS Task Force		168,402	164,792
American Indian Cancer Foundation		139,564	139,564
American Indian Family Center		123,232	123,232
Annex Teen Clinic	163,619	39,070	202,689
Big Brothers Big Sisters of the Greater Twin Cities	170,667		170,667
Cedar Riverside People's Center Health Services dba People's Center Health Services		168,812	168,812
Centro Tyrone Guzman	86,904	75,997	162,901
Comunidades Latinas Unidas En Servicio	247,286		247,286
Family Tree Clinic, Inc.	33,622	132,540	166,162
Fond du Lac Band of Lake Superior Chippewa	97,346		97,346
HealthFinders Collaborative, Inc.	149,767	66,763	216,530
Hennepin County Medical Center	101,207	100,006	201,213

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
High School for Recording Arts	247,286		247,286
Hmong American Partnership		150,168	150,168
Indigenous Peoples Task Force	123,550		123,550
Interfaith Action of Greater Saint Paul		169,294	169,294
Korean Service Center		169,294	169,294
Leech Lake Band of Objiwe Health Division-Nursing Department		138,161	138,161
Lutheran Social Services of Minnesota	183,825		183,825
Mayo Clinic		164,792	164,792
Mille Lacs Band of Ojibwe	115,500		115,500
Minneapolis American Indian Center		169,295	169,295
Minnesota Academy of Pediatrics Foundation		84,647	84,647
Minnesota Immunization Networking Initiative (MINI)		122,738	122,738
Neighborhood HealthSource		169,294	169,294
NorthPoint Health & Wellness Center, Inc.		169,295	169,295

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Partnership4Health Community Health Board		126,321	126,321
Planned Parenthood of MN, ND, SD (Hmong Star)	100,000		100,000
Planned Parenthood of MN, ND, SD (Youth Power)	147,286		147,286
Southside Community Health Services, Inc.		169,294	169,294
St. Stephen's Human Services[b]		56,055	56,055
WellShare International		169,192	169,192
YWCA of Minneapolis	247,286		247,286
Total	**2,215,151**	**3,042,226**	**5,253,767**

[a]TANF=federal Temporary Assistance for Needy Families (TANF) funds, GF=state General Funds. TANF is only for Teen Pregnancy Prevention grants.

[b]St. Stephens declined funding in FY 2019 due to loss of program site (closed down).

Fiscal Year 2018 ($)

Grantee Organization	TANF	GF	Total
African American AIDS Task Force		168,402	168,402
American Indian Cancer Foundation		139,564	139,564
American Indian Family Center		123,232	123,232
Annex Teen Clinic	172,237	36,058	208,295

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Big Brothers Big Sisters of the Greater Twin Cities	176,514		176,514
Cedar Riverside People's Center Health Services dba People's Center Health Services		168,812	168,812
Centro Tyrone Guzman	78,552	70,139	148,691
Comunidades Latinas Unidas En Servicio	206,852		206,852
Family Tree Clinic, Inc.	38,341	122,324	160,665
Fond du Lac Band of Lake Superior Chippewa	86,876		86,876
HealthFinders Collaborative, Inc.	130,424	61,617	192,041
Hennepin County Medical Center	92,367	92,298	184,665
High School for Recording Arts	206,852		206,852
Hmong American Partnership		150,168	150,168
Indigenous Peoples Task Force	103,349		103,349
Interfaith Action of Greater Saint Paul		169,295	169,295
Korean Service Center		169,294	169,294
Leech Lake Band of Objiwe Health Division-Nursing Department		138,161	138,161

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
Lutheran Social Services of Minnesota	159,415		159,415
Mayo Clinic		164,792	164,792
Mille Lacs Band of Ojibwe	84,516		84,516
Minneapolis American Indian Center		169,295	169,295
Minnesota Academy of Pediatrics Foundation		84,647	84,647
Minnesota Immunization Networking Initiative (MINI)		122,738	122,738
Neighborhood HealthSource		169,294	169,294
NorthPoint Health & Wellness Center, Inc.		169,294	169,294
Partnership4Health Community Health Board		126,321	126,321
Planned Parenthood of MN, ND, SD (Hmong Star)	103,426		103,426
Planned Parenthood of MN, ND, SD (Youth Power)	103,426		103,426
Southside Community Health Services, Inc.		103,033	103,033
St. Stephen's Human Services[b]		56,055	56,055
WellShare International		169,192	169,192

Eliminating Health Disparities Initiative: Fiscal Years 2015 to 2018

Grantee Organization	TANF	GF	Total
YWCA of Minneapolis	206,852		206,852
Total	**1,949,999**	**2,944,025**	**4,894,024**

[a]TANF=federal Temporary Assistance for Needy Families (TANF) funds, GF=state General Funds. TANF is only for Teen Pregnancy Prevention grants.

[b]St. Stephens declined funding in FY 2019 due to loss of program site (closed down).

Appendix F. Grantee Stories

DIABETES

Dream of Wild Health: "Youth Create a Policy to Guide Dream of Wild Health"

For many teenagers, making healthy food choices is a challenge. Oftentimes they do not know what a healthy diet looks like or what the health consequences of making poor choices are, such as drinking pop and snacking on pizza and hot Cheetos. The Youth Leaders at Dream of Wild Health (DWH) - a group of 18 Native American teens - chose to address this challenge by creating their own Healthy Food Policy to provide clear, easy to understand information for themselves and their peers. Through numerous meetings and conversations during the winter of 2016, they deepened their understanding of healthy foods.

As Native youth, they realized it was important to present this learning within a cultural context, using the Medicine Wheel to represent different food groups and various teachings, and translating key words into Dakota and Ojibwe. In the spring of 2016, the youth presented their Healthy Food Policy at a DWH Board of Directors meeting, which led to its adoption as a formal policy for the entire organization. Seeing their work endorsed by the organization was an immensely empowering experience for the Youth Leaders. They also identified a list of schools and organizations where they hoped to present the policy to their peers and encourage healthy lifestyles throughout the urban Native community.

HEART DISEASE AND STROKE

Pillsbury United Communities: "Somali Women Exercise at the Brian Coyle Center"

One of the key challenges for older Somali women living in Minnesota is that exercise is not built into their daily lives as it might have been back home. The Minnesota winters make exercise even more difficult. Older Somali women in Minnesota are at increased risk of obesity, diabetes and heart disease, partially due to the lack of options for regular exercise. Joining a co-ed gym is not an option for most elderly Somali women who prefer to exercise in a women-only, comfortable environment.

The Brian Coyle Center addressed this need by developing weekly culturally specific exercise classes for Somali women, providing them the space and freedom to exercise in a safe environment. Twenty-one women regularly took part in the exercise program which included walking, stretching and other exercises; information about how exercise improves health; and, discussions on a variety of topics including heart disease, high blood pressure, nutrition, obesity and BMI, usually in the context of religion, religious and cultural practices, and traditional healthy lifestyles. The women have a great time and at the same time learn about the importance of health within the Somali culture.

TEENAGE PREGNANCY PREVENTION

Centro Tyrone Guzman: "Changing Attitudes, One By One"

"Sandra" was one of the 96 Latino and Latina youth who participated in the HIV/AIDS/STIs and Teen Pregnancy Prevention components of the Raíces youth development program at Centro Tyrone Guzman. She was initially very embarrassed and "grossed out" by the sexual health education components of Raíces. Like many Latino families, her parents had also questioned whether it was Centro's role to be educating youth about sexual health. Over the course of the first month, however, Sandra began to engage in the program and appreciate what she was learning. She took part in a visit to the Red Door Clinic, as well as a presentation by Planned Parenthood, both of which helped Sandra and her peers learn how to access preventive care and STD/HIV testing. She reaffirmed her personal commitment not to engage in sexual activity at a young age, but then decided to bring home some free condoms to give to her parents.

Sandra developed a new level of comfort talking about sexual health, and she now encourages her peers to do the same. Her parents have also come to appreciate the importance of sexual health education at an early age, and the open parent-child communication they have established has served as a great role model for other Latino families.