Eliminating Health Disparities Initiative: Fiscal Years 2021 and 2022

REPORT TO THE MINNESOTA LEGISLATURE 2022
02/23/23

Eliminating Health Disparities Initiative:
Fiscal Years 2021 and 2022

Report to the Minnesota Legislature 2022

Minnesota Department of Health Center
for Health Equity
P.O. Box 64975, St. Paul, MN 55164-0975 (651)
201-5813
https://www.health.state.mn.us/communities/equity/ehdi/index.html

As requested by Minnesota Statute 3.197: This report costs approximately $9484 to prepare, including staff time, printing, and mailing expenses.

Table of 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

List of Tables

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Dear Legislators:

Much has changed in the three years since the last Eliminating Health Disparities Initiative – Report to the Legislature 2020 (PDF). The COVID-19 pandemic greatly impacted multiple areas of our lives. Events in Minnesota and elsewhere sparked a national "racial reckoning" and renewed calls for racial equity and justice. Through it all, the Minnesota Department of Health's (MDH) Eliminating Health Disparities Initiative (EHDI) grantees have continued their work to close health gaps in Minnesota's communities most impacted by health inequities.

While there is a long way to go to transform the systems that perpetuate inequities, the enclosed legislative report demonstrates the key advantages of partnering with organizations that reflect the communities most impacted by inequities. We invest in community-driven solutions because community members are most aware of the approaches, practices, language, and measures of success that will resonate with their family members, friends, and neighbors. Cultural knowledge, the wisdom gained from lived experience, and a deep understanding of the intergenerational effects of persistent inequities inform community-driven strategies and contribute to their effectiveness. The approaches used by EHDI grantees to continually adapt and create programs tailored to community values generate positive outcomes for individuals, groups, institutions, and systems.

We have seen our EHDI grantees increase access to prevention and care among communities where conventional approaches have failed. EHDI grantees reached 427,207 individuals in fiscal year 2021 and 592,788 individuals in fiscal year 2022 across all eight EHDI priority health areas (breast and cervical cancer, cardiovascular Diseases, Diabetes, HIV/AIDS/STI, Immunization, Infant Mortality, teen pregnancy prevention, and unintentional injury and violence). They have provided screenings, immunizations, nutrition education, exercise classes, disease management assistance, and safety and wellness interventions to those experiencing trauma and violence; conducted outreach and informational campaigns to dismantle racism, discrimination, and stigma in health care; trained institutional partners so they are better equipped to provide culturally competent care; and joined coalitions that advocate for criminal justice reform and creating just food systems.

I am grateful for your continued support for such a critical program and many other MDH initiatives to eliminate health inequities. I am hopeful that through continued partnership efforts such as EHDI, we can empower Minnesotans and their communities, and accelerate our work toward health equity.

Sincerely,

Brooke Cunningham, MD, PHD
Commissioner, Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Executive Summary

Minnesota is consistently ranked among the healthiest states in the nation; however, Minnesota is also home to some of the most significant health disparities in the country between white residents and people of color, and American Indians. The Eliminating Health Disparities Initiative (EHDI) is a grants-based program administered by the Minnesota Department of Health (MDH) Center for Health Equity (CHE). Established in 2001 by the Minnesota Legislature (Minnesota Statute 145.928), the initiative was a response to mounting evidence that disparities in health outcomes between Minnesota's white residents and people of color and American Indian communities were distressingly wide and on a clear trajectory to grow even more comprehensive. Even though Minnesota ranks high in general health status compared to other states, it has some of the worst racial and ethnic health disparities.

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, becoming 17% of the state's population. As of 2020, people of color in Minnesota make up 23.7% of the total population, where 7% are Black or African American and 6% Hispanic or Latino.[1] [2]As the trend continues, prioritizing health for people of color and American Indians is crucial to the state's health.

EHDI provides funds to close the gap in the health status of Africans/African Americans, American Indians, Asian/Pacific Islanders, and Hispanics/Latinos in Minnesota compared to whites in eight priority health areas: Breast and Cervical Cancer Screening, Diabetes, Heart Disease & Stroke, HIV/AIDS and Sexually Transmitted Infections, Immunizations for Adults and Children, Teen Pregnancy Prevention, Unintentional Injury and Violence, and Infant Mortality. The ninth-priority prenatal care was a ninth-priority health area during the 2019 legislative session. No additional funds were allocated along with this other priority health area. The initiative was designed to strengthen local control and decision-making in communities across the state toward eliminating these disparities in the four priority populations. EHDI awards total $5,041,950 each year. Funding sources include state General Funds and Federal Temporary Assistance to Needy Families or TANF (only Teen Pregnancy Prevention grantees receive TANF funds).

This report covers grantees' activities in fiscal year 2021 or FY 21 (July 1, 2020 to June 30, 2021) and fiscal year 2022 or FY 22 (July 1, 2021 to June 30, 2022), the second and third years of a four-year EHDI grant cycle that began in FY 20. EHDI grants are awarded through a competitive grant application process every few years. Funding decisions are based on recommendations from a committee of community reviewers. Organizations work in eight priority health areas (PHAs): Breast and Cervical Cancer; Diabetes; Heart Disease and Stroke; HIV/AIDS and Sexually Transmitted Infections (STIs); Immunizations for Adults and Children; Infant Mortality; Teen Pregnancy Prevention; and Unintentional Injury and Violence. Under each PHA grantees work on one or more levels of change, namely, Level 1 or Health Promotion/Direct Service, Level 2 targeting

[1] Minnesota State Demographic Center- Department of Administration. (2020). Census 2020. https://mn.gov/admin/demography/data-by-topic/population-data/2020-decennial-census/

[2] United States Census Bureau. (2021). Racial and Ethnic Diversity in the United States: 2010 Census and 2020 Census. https://www.census.gov/library/visualizations/interactive/racial-and-ethnic-diversity-in-the-united-states-2010-and-2020-census.html

Organizational/Institutional Change, and Level 3 targeting Root Causes/Conditions for Health.

These targeted efforts of EHDI grantees have made a real difference in the lives of the people they serve. In a testament to the impressive connections within their communities, in FY 21, EHDI grantees had more than 400,000 interactions with people in their target populations. In FY 22, EHDI grantees had over 500,000 interactions with people. In addition, there were over 17,000 interactions aimed at providing direct assistance or training to ensure access to culturally appropriate healthcare and services. Grantees achieved 50,000 interactions in targeted prevention services across priority health areas. Finally, over 1,800 people with diagnosed or identified health conditions received tailored intervention services.

Despite the continuing challenges that the COVID-19 pandemic presented to their programming, EHDI grantees remain engaged with their participants virtually, developed new strategies to engage community members remotely using a hybrid model, and created safety protocols to ensure the well-being of staff and community members. Organizations continued providing resources to meet basic needs and ensured community members were equipped with current COVID-19 information. Being able to reach this magnitude of people of color and American Indians with priority health area information, prevention, and targeted intervention, coupled with system change efforts was indeed a towering achievement considering the compounding public health emergencies created by COVID-19.

Evaluation results show that the EHDI grant program is a valuable investment. Grantees have demonstrated that EHDI is a crucial part of Minnesota's public health infrastructure, that their community-driven solutions address wellness holistically, and that they seek to transform systems of injustice. The impressive reach, proximity, connection to local communities, and adaptability and flexibility of grantees to continue their work under extreme constraints speak to the importance of the EHDI community to Minnesota's health and wellness.

Recommendations for future action include amplifying the impact that grassroots community organizations can have in strengthening pandemic responses; allowing grantees the time, flexibility, and autonomy to adapt their program in response to pandemic situations; connecting grantees to ongoing learning and opportunities; strengthening MDH's approach to health equity by lifting up effective methods implemented by EHDI grantees and how they can influence other MDH investments and strategies; increasing EHDI funding; shifting EHDI language away from diseases or conditions that only draw attention to deficits in marginalized populations, and more towards social determinants of health which is often more accessible to program participants and draws out the historical and structural issues in public institutions and systems.

I. EHDI Overview

Background

While Minnesota ranks high in general health status compared to other states, the health disparities in Minnesota are among the worst in the nation. Such differences mean that compared to whites, people of color and American Indians in Minnesota 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, infant mortality rates in Minnesota and the United States have exhibited a declining trend in the last four decades, owing in large part to greater awareness and heightened prevention efforts. However, this masks significant disparities in specific populations. In 2020, Minnesota had the sixth lowest infant mortality rate in the country at 4.13 compared to 5.42 for the U.S.[3] However, the Black or African American infant mortality rate in the state (5.9) was almost double the rate for whites (3.5), which means Black or African American babies are about twice as likely to die before their first birthday compared to white babies. When such disparities are allowed to persist, they hurt the quality of life, increases the cost of healthcare, and impacts the overall health of all Minnesotans.

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

Minnesota was 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 Americans/ Africans, American Indians, Asian Americans/ Asian-Pacific Islanders, and Hispanics/ Latine 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 Infection (STIs)
5. Immunizations (for children and adults)
6. Infant Mortality
7. Teen Pregnancy
8. Unintentional Injury and Violence

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

Proposals received were reviewed with community input. Grants have been awarded to faith-based organizations, social service organizations, community-based nonprofit organizations, American Indian tribes, health boards, and clinics for local or regional projects and initiatives. Attention to a robust and ongoing

[3] CDC – National Center for Health Statistics – Stats of the State. https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm. December 15, 2022.

evaluation helped MDH, EHDI grantees, community partners, and other stakeholders learn what works well and what does not. This has led to continually evolving programming with practitioners constantly improving their approaches, strategies, and methods. The years of EHDI investments have yielded not only advances in the mandated goals but also valuable information and lessons, including the need to:

- Use strategies 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 people of color and American Indian populations.
- Identity policy, systems, and environmental changes are needed to eliminate health disparities between whites and people of color and American Indian populations.
- 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 an understanding of health disparities and evaluate solutions at programmatic, more significant levels.

The Center for Health Equity

The Center for Health Equity (CHE), created in 2013 to advance health equity within the Minnesota Department of Health (MDH) and across the state, administers the EHDI grant program (MDH's former Office of Minority and Multicultural Health performed this function from 2002 to 2013). CHE's mission is to connect, strengthen, and amplify health equity efforts within MDH and the state. CHE continues to carry out 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 white Minnesotans and people 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 had made in the lives of the people they served, it recommended that a crucial part of this approach is 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 Indian populations in Minnesota numbered 276,623, comprising just over 6% of our total population. By 2010, these communities numbered 927,764 comprising 17.5% of the state's population, and by 2020 these numbers had grown to 1,273,115 and 22.3%, respectively (Table 1). Between 1990 and 2020 the Hispanic population grew by 505%, and the Black population grew by 334%. The Minnesota State Demographic Center projects that the state's non-Hispanic White population will begin declining within the next decade, and its populations of Color will add more than one million residents between 2018 and 2053, eventually exceeding one-third of the total population.[4]

[4] Minnesota State Demographic Center. *Our Projections*. https://mn.gov/admin/demography/data-by-topic/population-data/our-

Table 1: Minnesota Population Change

Racial/ Ethnic Group	1990	2000	2010	2020	2021
American Indian	49,909	54,967	67,325	78,441	79,214
Asian	77,886	141,968	217,792	303,007	306,706
Black	94,944	171,731	280,949	412,501	423,656
Hispanic	53,884	143,382	250,258	325,911	333,474
Two or more races		82,742	111,440	153,255	157,274
White (non-Hispanic)	4,101,266	4,337,143	4,410,722	4,483,121	4,458,035
Total Minnesota	**4,375,099**	**4,919,479**	**5,303,925**	**5,706,494**	**5,707,390**

Source: Minnesota Compass. https://www.mncompass.org/topics/demographics/race-ethnicity?population-by-race#1-5104-g. December 14, 2022.

Much 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 2017, approximately 13,500 babies (20%) were born to (immigrant) mothers who were born outside of the U.S.[5]

Minnesota's growing racial and ethnic diversity is not limited to the Twin Cities metropolitan area; this growth is happening around the state. Table 2 details additional changes over time in regions across the state. Between 1990 and 2020, the central region saw the biggest increase in persons of color and American Indians with a 631% growth, followed by the southwest region with a 594% increase, and the southern region with a 563% increase. Looking at persons of color and American Indians as a percent of total population in each region, the Twin Cities saw the biggest jump, from 9% in 1990 to 29% in 2020, followed by the southwest region from 2% in 1990 to 15% in 2020.

Table 2: Persons of color and American Indians in Minnesota by Region, 1990-2021

Geographic Area	1990	2000	2010	2020	2021
Central	11,082	26,214	51,607	80,975	86,562
Northland	11,273	18,504	24,860	29,945	30,308
Northwest	10,963	17,889	23,141	28,532	28,955
Southern	16,602	45,561	76,308	110,140	113,744
Southwest	6,158	18,794	29,669	42,732	44,008
Twin Cities	211,783	444,430	672,347	906,997	920,959

projections/. December 14, 2022.

[5] Minnesota State Demographic Center- Department of Administration. (2020). *Birth and Fertility*. https://mn.gov/admin/demography/data-by-topic/births-fertility/

Geographic Area	1990	2000	2010	2020	2021
West Central	5,972	10,994	15,271	24,052	24,819
Minnesota	**273,833**	**582,366**	**893,203**	**1,223,373**	**1,249,355**

Source: Minnesota Compass https://www.mncompass.org/topics/demographics/race-ethnicity?population-by-race#1-5104-g

This demographic data points to the growing racial and ethnic diversity in Minnesota and underscores the importance of reducing the health disparities between white Minnesotans, people of color, and American Indians so that all Minnesotans can be healthy. However, funding for EHDI has failed to keep pace with the exponential growth in the population. Instead, funding has remained stagnant over time. When considering the increase in population levels, this limits the capacity of organizations to reach those in need of critical services.

Minnesota's Health Disparities

Although racial health disparities exist between white Minnesotans and people of color and American Indian communities throughout the state and across the spectrum of health areas, they do not affect all 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 (babies born before 37 weeks of pregnancy as a percent of all babies born) were reported for Asians/Asian Americans as a single group, the number would be 7.3% compared to 6.9% for Minnesotans overall.[6] This number masks wide variation among people of Asian descent; the indicator is significantly better for some groups (Asian Indian, Chinese, and Japanese) of Asians/Asian Americans, while it is markedly 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 lead to differences in each group's experience, needs, and strengths. These differences between and within broad racial categories make the culturally responsive—and often culturally specific— approach to the work done by EHDI's stakeholders and community partners so important. Programming targeted toward large categories of people as if they are homogeneous has not been helpful.

Additional data on health disparities related to each PHA can be found in this report under the Grantee Activity descriptions in section IV. Program Implementation. The 2022 EHDI Request for Proposals also includes more detailed information about the social determinants of health and the health disparity context of each PHA which can help provide interested readers with additional information about health disparities in Minnesota.

[6] Minnesota Department of Health (2020). *Premature Birth*. Data are for 2014-2018. Source: Minnesota Center for Health Statistics. https://data.web.health.state.mn.us/prematurity#byrace

III. Grant Awards

EHDI Grants awarded in state fiscal years (FY) 2021 and 2022 are described below by year, population, and PHA.

Funding Totals (FY 21 and FY 22)

The current grant cycle funds a cohort of 25 organizations for four years on a July/June grant period from July 1, 2019 through June 30, 2023. This report covers the second and third years of the grant. In each of those years, EHDI invested $5,041,950 in the 25 organizations to address eight community-identified priority health areas (PHAs). Figure 1 outlines the distribution of grants by population in FY 21 and FY 22. Table 3 summarize grantees funded in each PHA in FY 21 and FY 22.

Grants Awarded by Population and by PHA, FY 21 and FY 22

Table 3: Number of EHDI Grantees by Population, FY 21 and FY 22

Population	# Grantees*
African American/African	15
American Indian	15
Asian/Pacific Islander	7
Hispanic/Latino	15

*Some grantees provided services in more than one population

Table 4: Number of EHDI Grantees by PHA, FY 21 and-FY 22

Priority Health Area	# Grantees*
Breast & Cervical Cancer	1
Diabetes	7
Heart Disease & Stroke	4
HIV/AIDS & STIs	7
Immunizations	1
Infant Mortality	2
Teen Pregnancy	12
Unintentional Injury & Violence	6

*Some grantees provided services in more than one PHA

IV. Program Implementation

COVID-19 Impact & Adaptations

EHDI grantees were uniquely positioned to respond in culturally-specific ways to the COVID-19 pandemic, building on their knowledge of and relationships within communities of color and tribal communities. EHDI grantees had over 650,000 interactions with people in their community, providing essential information and resources in culturally-specific ways and in languages that were accessible. EHDI grantees were central to the ability of the State of Minnesota to provide rapid and sustained responses within cultural communities.

Evidence-Based, Promising & Culturally Responsive Practices

As part of the EHDI Request for Proposal (RFP) process, priority is given to proposed projects that are based on promising strategies and/or projects that are research-based, as is required by law. Promising strategies include practices that come from the local community that may be based on practice-based evidence (PBE) and/or lived experiences of communities of color and American Indians. PBE includes a range of approaches that are developed over time through practice and experience. PBE approaches are often embedded in the culture, accepted as effective by local communities and support community healing from a cultural framework.

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

It is important to note that EHDI grantees are not required to use evidence-based practices. The RFP also emphasizes cultural responsiveness, culture's role in health, and the social determinants of health. Culturally responsive practices automatically broaden the unit of analysis beyond people because culture is necessarily relational in that it is rooted in shared experience, understanding, and meaning.

Guided by law and the RFP stipulations, EHDI grantees altogether are working to reduce racial disparities in the eight PHAs by implementing a wide range of interventions that:

- meet the needs of people of color and American Indian populations 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.

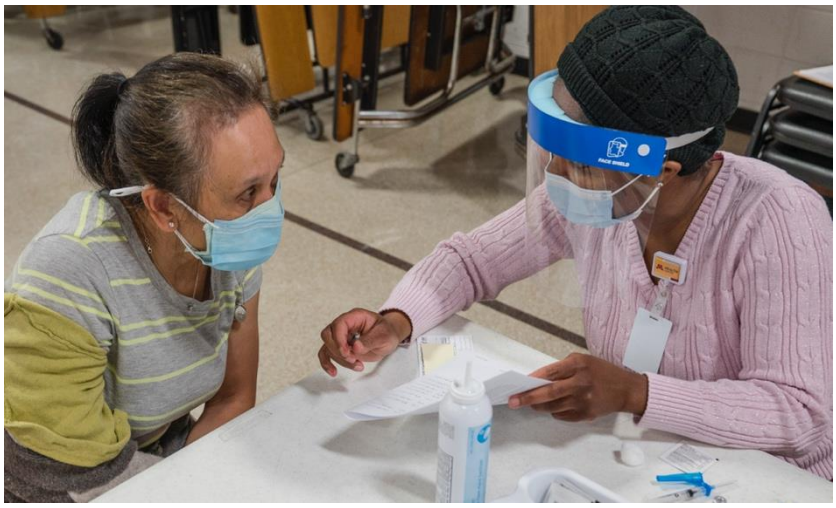

Figure 1: MINI EHDI Grantee FY 20-23

In response to community and stakeholder feedback and based on the EHDI philosophy that all work must be community-driven, the EHDI program allowed grantees to expand programming to go beyond targeting individual-level changes (such as awareness, knowledge, behavior or skill) to focus on broader social determinants of health, such as changing policies, systems or environments that address the root causes of inequities. Beginning in the FY 20-FY 23 grant cycle, EHDI allowed applicants to choose to work within one or more levels of change to address one or more of the PHAs. The three levels of change are:

Level 1: **Health Promotion/Direct Service**: Providing education or direct services to individuals

Level 2: **Organizational/Institutional Change**: Changing organizational or institutional policies or changing the way a system in an organization or institution works.

Level 3: **Root Causes/Conditions for Health:** Participating in or leading efforts that target specific social and economic conditions for health (also known as the social determinants of health) to address the root causes of health disparities.

EHDI Grantee Objectives, Level of Change, Strategies & Activities (FY 21 and FY 22)

This section summarizes the objectives, activities, and change levels of EHDI grantees for each PHA. Appendix C features two grantees and provides more details about their EHDI work.

1. Breast and Cervical Cancer (1 Grantee)

Objectives

- Increase breast and cervical health awareness through direct and indirect outreach (Level 1).
- Increase the capacity and ability of API coalition members to fully serve the varying age groups in the API community for their breast and cervical health needs (Level 2).
- Create a coalition of stakeholders driven to achieve better health outcomes for the community by assisting policymakers in addressing critical health disparities facing API residents (Level 3).

Activities

- Deliver culturally competent breast and cervical cancer education and services at community sites (e.g., mobile mammograms, education workshops, translation, interpretation, and systems navigation by

Community Health Liaisons).

- Provide cultural competency trainings to clinic coalition partners.
- Create and coordinate a coalition of stakeholders that will assist policymakers in addressing health disparities faced by the community.

Table 5: Breast and Cervical Cancer Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	1
Level of change 2: Organizational/ Institutional Change	1
Level of change 3: Root Cause/Condition for Health	1

2. Diabetes (7 Grantees)

Objectives

- Improve physical, mental, and social health (Level 1).
- Increase knowledge of diabetes risk factors and lifestyle prevention strategies (Level 1).
- Increase the capacity of Healing Homes and healthcare partners to prevent and intervene in diabetes and help improve health status (Level 2).
- Increase organizational capacity to provide culturally based diabetes prevention education and access to healthy, Indigenous foods (Level 2).
- Work with elected officials and thought leaders to pursue innovative strategies to save on healthcare costs for uninsured families (Level 3).
- Reduce racism (bias, discrimination, and stereotyping) (Level 3).

Examples of Activities

- Provide diabetic patients with self-monitoring home equipment
- Identify and collaborate with community and Indigenous food network partners to implement curriculum within their youth programs
- Screen for family-level social determinants of health.
- Provide one-one-one wellness and fitness coaching to FIT Team members.
- Co-facilitate intergenerational listening sessions in communities.
- Organize/host community gardening/healthy cooking workshops and community events highlighting healthy Indigenous foods.
- Provide technical support and assistance to low-income Hmong farmers to grow fresh produce at a scale that meets the demand of the local food market while securing and maintaining good agricultural practices (GAP) certification and compliance with the federally mandated Food Safety Modernization Act (FSMA).

Table 6: Diabetes Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	7
Level of change 2: Organizational/ Institutional Change	6
Level of change 3: Root Cause/Condition for Health	5

3. Heart Disease and Stroke (4 Grantees)

Objectives

- Lower the risks of heart disease by having access to and eating fresh, healthy, culturally appropriate, locally grown food (Level 1).
- Create greater awareness for local food and farming anchor institutions in the Twin Cities about equity and understanding that community wealth is integral to community health (Level 2).
- Increase the capacity of partners to prevent and intervene on cardiovascular diseases (Level 2).
- Educate elected officials and thought leaders and pursue innovative strategies to save on healthcare costs for food insecure families. (Level 3)

Examples of Activities

- Identify, engage, and work with low income and food insecure families to improve their health.
- Co-facilitate intergenerational listening sessions in African American and East African communities
- Provide case management, nutrition education, healthy living services, and home-based care.
- Work with farmers to increase families' access to fresh, locally grown, and culturally appropriate produce.
- Work with farmers and legal experts to create by-laws and form a farmer-owned marketing cooperative.
- Advocate for school-based access to culturally relevant comprehensive sexual health education in Minnesota.
- Increase front line health worker capacity to work with community most impacted by health inequities and increase Medicaid coverage for their services.
- Implement a bi-directional referral system between community and healthcare organizations.
- Work with tribal governments to advocate for laws that allow EBT benefits to be used for healthy foods and to discuss options for levying additional tax on unhealthy foods.
- Work with farming, health care, hunger free, farm to school, and early childcare advocates to educate elected officials, thought leaders, and leaders in the health insurance industry about Veggie Rx as a cost-effective method for preventive healthcare.
- Join local coalitions that advocate for increasing access to quality healthcare and nutritious food of communities most impacted by health inequities.

Table 7: Heart Disease and Stroke Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	4
Level of change 2: Organizational/ Institutional Change	3
Level of change 3: Root Cause/Condition for Health	3

4. HIV/AIDS and Sexually Transmitted Infections (7 Grantees)

Objectives

- Improve the sexual health of people with HIV and STIs (Level 1).
- Improve relationship health for youth, increase their knowledge about healthy relationships and understanding of the importance of consent (Level 1).
- Reduce the rate of new infections of HIV and STIs (Level 1).
- Promote mentally and socially healthy parents who practice positive parenting (Level 1).

- Add/Amend policies to support youth more strongly in school and clinical setting (Level 2).
- Promote the delivery of strength-based, trauma-informed, minority-friendly services (Level 2)
- Lead community-based and youth driven advocacy on social determinants of health and end stigma & discrimination against LGBTQ Latine individuals (Level 3)
- Advocate for the inclusion of the Latine voice across all ages to inform and change county-wide health and human service institutions to be more responsive to the needs of the underserved, and to create environments that advance health equity (Level 3)

Examples of Activities

- Provide culturally relevant, bilingual, LGBTQ inclusive sexual health education and services (e.g., free contraceptives and other sexual health resources, testing, counseling, recruit people living with HIV/AIDS to share their experiences with the community), and increase access to comprehensive clinical care
- Increase HIV/AIDS/STIs awareness and early intervention through education in-person and using social media and radio.
- Promote positive parenting and increase parent engagement in their child's education and health
- Hold community listening sessions to better understand barriers to accessing sexual healthcare services.
- Promote safe sex practices, healthy youth development, and positive peer relationships.
- Coach early teens on mindfulness, peer pressure, bullying, and self-advocacy
- Increase the capacity of health care professionals and community groups to provide culturally responsive sexual and reproductive health services by providing professional development and visible leadership in community coalitions or workgroups.
- Work with schools and clinics to change policies to better support Latine youth and family connection to care
- Increase the capacity of health care providers to deliver strength-based, trauma-informed, minority-friendly services through trainings
- Work with schools to expand school services by addressing the needs of students living in poverty and embedding sexual health information in their whole child support systems.
- Develop leadership among Latino parents and community members and ensure authentic Latino voice and leadership in the programs, as well as community-wide boards and commissions
- Lead community-based efforts to end stigma and discrimination against LGBTQ Latine individuals through awareness campaigns and youth-driven advocacy.
- Reduce racism by promoting awareness among healthcare providers, and partnering with community organizations to hold information and healing sessions, on the impact of racism on teen health
- Change established systems, policies, and power structures to be more responsive to Latine teen health by hosting forums, trainings on micro-inequities and implicit bias, creating a Latine youth board, and developing community leaders.

Table 8: HIV/AIDS and Sexually Transmitted Infections Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	7
Level of change 2: Organizational/ Institutional Change	6

Change Levels	# FY 21 & FY 22 Grantees
Level of change 3: Root Cause/Condition for Health	3

5. Immunizations (2 Grantees)

Objectives

- Promote physical health through provide developmentally and seasonally appropriate immunizations (Level 1).
- Provide culturally competent immunization/health information and education to partners (Level 1).
- Convene institutional and community partners to coordinate efforts and impact (Level 2)
- Reduce racism by promoting awareness among healthcare providers, and partnering with community organizations to hold information and healing sessions, on the impact of racism on teen health (Level 3).

Examples of Activities

- Provide HPV and meningococcal vaccinations to adolescents
- Provide free flu shots;
- Provide COVID-19 screening and vaccinations
- Partner with culturally specific community organizations and using community volunteers

Table 9: Immunizations Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/ Institutional Change	2
Level of change 3: Root Cause/Condition for Health	

6. Infant Mortality (2 Grantees)

Objectives

- Reduce risk factors and increase protective factors around infant mortality (Level 1).
- Reduce Native maternal-child morbidity/mortality (Level 1)
- Increase the amount of effective, culturally appropriate parenting program model knowledge available to entities seeking to reduce Native maternal-child morbidity/mortality (Level 1)
- Build the capacity of service providers to provide culturally specific health services to American Indian women (Level 2).
- Build the capacity of local social service organizations to provide culturally specific health services to American Indian women (Level 2).
- Increase organizational capacity to advocate on behalf of urban Native American families for policies that support breastfeeding (Level 2).
- Increase dominant-culture institutions' understanding of the historical roots of Native American/Alaska Native health disparities to better address disparities via effective policy changes (Level 3).

Examples of Activities

- Provide individual and group parenting education using a culturally specific curriculum; conduct

culturally specific home visits; conduct life skills classes.
- Provide coaching and mentorship to parents and train parents to be mentors to other parents.
- Co-facilitate American Indian specific Early Childhood Family Education (ECFE) classes.
- Provide support and resources for chemical dependency and screening for fetal alcohol.
- Host Community Baby Showers to celebrate and welcome new babies and parents.
- Provide training to other states and local and non-profit organizations using a culturally specific curriculum.
- Build the capacity of service providers to provide culturally specific health services to American Indian women by creating a guide of culturally specific health services that will be distributed to service providers.
- Develop partnerships with health and community organizations to collaboratively review and discuss culturally appropriate curriculums and service delivery models.
- Conduct historical trauma trainings to staff of state agencies involved in child protection services.
- Participate in food sovereignty movements and coalitions.

Table 10: Infant Mortality Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/ Institutional Change	2
Level of change 3: Root Cause/Condition for Health	1

7. Teen Pregnancy (12 Grantees)

Objectives

- Provide culturally relevant, bilingual, LGBTQ inclusive sexual health education for Hispanic/ Latine teens ages 12- 18 (Level 1).
- Improve relationship health for youth, increase knowledge about healthy relationships, and understand and know the importance of consent (Level 1).
- Engage families in education and skills-building related to teen sexual health and family communication (Level 1).
- Provide pregnancy prevention education, access to health care, and supportive services for themselves and their child and implement their pregnancy prevention plan (Level 1).
- Promote the delivery of strength-based, trauma-informed, minority-friendly services (Level 2)
- Support Latine community members in gaining skills and confidence to create culture change in support of healthy sexuality (Level 2).
- Increase capacity to educate about MN Minor Consent Law, to make and share youth referrals to services covered by the law (Level 2).
- Promote awareness on how racism (and general bias, discrimination, and stereotyping) affects health among youth and healthcare providers (Level 3).
- Support immigrant families' access to care by framing immigration as a social determinant of health (Level 3).
- Community engagement and youth driven advocacy on social determinants of health (Level 3).

Examples of Activities

- Implement evidence-based programs in local schools or after-school or community programs that discuss abstinence, contraception, and condom use.

- Provide pregnancy testing and culturally responsive all-options pregnancy counseling at community locations.
- Facilitate intergenerational relationship-building sessions between youth and elders.
- Lead internal efforts to become an organization that is more sensitive to and accepting of diverse gender identifies and sexual orientations by including gender and sexuality inclusivity content into the on-boarding process for all new employees and the organization's policies/staff handbook.
- Promote the delivery of strength-based, trauma-informed, minority-friendly services in the organization by training residents, fellows, and behavioral health program staff.
- Increase the capacity of health care professionals and community groups to provide culturally responsive sexual and reproductive health services by providing professional development and visible leadership in community coalitions or workgroups.
- Deliver on-going education about the Minor Consent Law, and will improve youth local referral systems, accountabilities, and health services that are covered by this law.
- Work with schools to expand school services by addressing the needs of students living in poverty and embedding sexual health information in their whole child support systems.
- Reduce racism by promoting awareness among healthcare providers, and partnering with community organizations to hold information and healing sessions, on the impact of racism on teen health
- Change established systems, policies, and power structures to be more responsive to Latine teen health by hosting forums, trainings on micro-inequities and implicit bias, creating a Latine youth board, and developing community leaders; implement evidence-based practices to change policies in schools and clinics to better support Latine youth and family connection to care.

Table 11: Teen Pregnancy Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	12
Level of change 2: Organizational/ Institutional Change	7
Level of change 3: Root Cause/Condition for Health	5

8. Unintentional Injury and Violence (6 Grantees)

Objectives

- Build Latine parents' capacity and understanding to address youth self-harm, suicide prevention, and sexual, violence and dating violence (Level 1).
- Increase parents' and youth's knowledge of culturally appropriate support and services available to youth struggling with self-harm, suicide, and violence (Level 1).
- Reduce North Minneapolis male youth's involvement in violence and/or criminal activity (Level 1).
- Reduce the rate of suicidality among Asian immigrants, refugees, and adoptees in Minnesota (Level 1).
- Increase the capacity of community/religious leaders, medical centers, and law enforcement to address the mental health needs of Asian immigrants, refugees, and adoptees (Level 2).
- Engage young African American men in creating solutions to health disparities in the larger community (Level 3).
- Increase community-level knowledge and confidence to take action to prevent suicide and abuse (Level 3).

Examples of Activities

- Review and adapt existing curricula and evidence-based/promising practices and develop new activities

and tools to ensure alignment with learning from Latin@ youth and parents.

- Develop tools for parents to talk with youth about self-harm, suicide, or violence; develop educational materials specific to depression, addiction, and domestic violence; provide families who are at risk for Child Protection Services with culturally grounded parenting education and life stabilization support; develop and deliver culturally responsive education and workshops regarding mental illness symptoms and coping skills.
- Operate the North 4 youth violence prevention program for men who are justice involved, gang affiliated, or have other risks for youth violence by providing paid internships to increase their employability and leadership skills; resources and programming around trauma recovery, mental health, incarceration prevention, and social emotional development; and access to mentorship and small group support.
- Organize healthy relationship/ conflict resolution workshops for couples and families in the household (parenting, recognizing signs of an unhealthy relationship, and conflict resolution skills)
- Engage young men in anti-racism work in Minneapolis.
- Provide training and support for community leaders, health providers, and law enforcement to better address suicide among Karen, Korean, and Indian communities, and launch an anti-stigma campaign for mental health issues throughout these communities.
- Promote awareness among healthcare providers on how racism affects teen health and hold community healing sessions on racism and health using traditional Latine knowledge.
- Engage community health advisory committee in campaign messaging and strategies to address mental health, domestic violence, drug and alcohol addiction, and family health in Asian immigrant and refugee communities.

Table 12: Unintentional Injury and Violence Grantees Using Strategies at Each Change Level

Change Levels	# FY 21 & FY 22 Grantees
Level of change 1: Health Promotion/Direct Service	6
Level of change 2: Organizational/Institutional Change	5
Level of change 3: Root Cause/Condition for Health	4

V. Evaluation and Capacity Building

Technical Assistance and Support

CHE is committed to evaluating individual grantee outcomes and strengthening the capacity of organizations to reduce racial disparities in health through shared learning and evaluation. As such, CHE provides EHDI grantees with tailored evaluation technical assistance and support and has created a community of practice for grantee education and learning.

In 2017, MDH contracted with an evaluation consulting organization, Rainbow Research, Inc., to be the Evaluation Technical Assistance (TA) and Support provider for EHDI. Rainbow Research's Evaluation TA and Support comprised five consultants and a sub-contract with the University of Minnesota's Healthy Youth Development Prevention Research Center. All team members have experience working with populations of color and American Indians on evaluation activities. Support from the Evaluation TA and Support Team included:

- Providing customized, culturally responsive, one-to-one consultation.
- Assisting grantees in developing logic models, evaluation plans, and reports.
- Assisting grantees in involving stakeholders in their evaluations and practices to learn from data.
- Providing web-based and in-person training in response to grantees' interests and expressed needs: logic model creation and introduction to evaluation; building evidence for a program; survey design and analysis; and focus group design.
- 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 the Center for Health Equity.

With this TA, grantees created evaluation logic models, developed detailed evaluation plans, conducted data collection activities, and reported annually on program outcomes.

Community of Practice

The EHDI Community of Practice (CoP) started in early 2017 to offer grantees a structured space to share their ideas, learning, and concerns. It has evolved into a vibrant space where grantees engage in leadership development and peer learning to increase the efficacy and impact of their programs.

In response to COVID-19 and the restriction on in-person meetings, the EHDI Community of Practice shifted to various remote-based webinars, half-day convenings, and unstructured online meetups to continue fostering connection and sharing challenges and adaptations across grantees. Additionally, grantees continued to use an online platform called Mobilize to share resources across grantees.

Shared Measurement System

A shared measurement system (SMS) was first implemented in FY 18, marking a critical first step in better understanding the collective impact of the EHDI program. Since then, changes to EHDI's SMS have included more granular reporting of program reach by population and PHA, and revised assessment methods to better understand outcomes achieved within and across populations. The SMS is now being implemented with the second cohort of grantees. However, the COVID-19 pandemic has dramatically impacted the expansion and adaptations . Data reported here still needs to catch up on the many meaningful ways grantees are tracking changes in the health of their participants, which is evident from individual evaluation reports. Nonetheless, this

section provides a picture of grantees' impact within and across target populations and priority health areas.

Program Reach (FY 21 and FY 22)

Figure 2: Pillsbury United Communities, EHDI Grantee FY 21-22

Reach categories aim to broadly capture the variety of strategies EHDI grantees employ within their priority health areas. These reporting categories were first used in FY 20, replacing direct and indirect contacts, based on a qualitative analysis[7] of the shared work grantees engaged in before and during the COVID-19 crisis.

Output categories from grantee evaluation plans were summarized into four categories as part of the EHDI SMS: growing awareness, ensuring access, targeted prevention, and tailored intervention. Increasing awareness and providing access correspond to the idea of indirect contact in that the strategies and activities undertaken in these categories may not be sufficient to change health conditions or disparities. Still, they are necessary due to the unequal access created by current social conditions. On the other hand, targeted prevention and interventions are culturally tailored, promising, or evidence-based strategies that aim to directly influence protective or risk factors for specific health conditions in holistic and targeted ways.
Summarized together, these reach categories are referred to as interactions rather than individuals reached because of the likelihood of substantial double-counting. For example, in clinic-based settings, individuals are routinely screened for health issues related to several priority health areas and are thus counted within each of them. Furthermore, categories of reach do not necessarily map directly onto the three levels of change indicated in the previous section, though the activities included in ensuring access include strategies aimed at institutional and structural changes.

The Reach categories are defined as follows:

- **Growing Awareness** of health issues and solutions available through EHDI-funded programs or other resources. Specific activities include media campaigns, hosting and attending health fairs, and building community buy-in to advocate for policies that promote well-being.

[7] Conceptual framework for thematic analysis came from Sablan, J.R. (2019). Can you Really Measure That? Combining Critical Race Theory and Quantitative Methods. American Educational Research Journal 56(1). 178-203. DOI: 10.3102/0002831218798325.

Figure 3: Dream of Wild Health, EHDI Grantee FY 21-22

- **Ensuring Access** to culturally relevant health services for people and families by providing transportation, translation, insurance enrollment, service referrals, or other wrap-around services that help stabilize and address needs that prevent impacted community members from prioritizing health. EHDI grantees also train and coordinate among institutional and policy partners to help them provide culturally relevant, trustworthy, and holistic services**.**

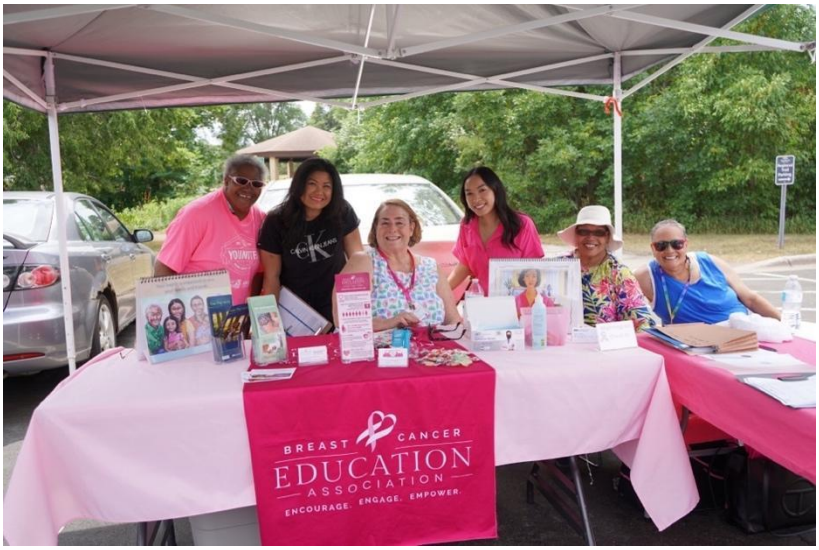

Figure 4: LAO Assistance Center of MN, EHDI Grantee FY 21-22

- **Providing Targeted Prevention** through individualized and/or group programming for prevention or wellness purposes to people at higher risk for developing a health condition. For example, people may attend nutrition education or exercise classes, workshops about mental health promotion and wellness, receive immunizations, or have a mammogram or other screening. People also learn about strategies for preventing unintended pregnancies and avoiding HIV/AIDS and STIs.
- **Providing Tailored Interventions** such as disease management and containment services for people with underlying health conditions. For example, grantees may employ Community Health Workers who help people regularly monitor blood pressure and cholesterol levels or offer diabetes management classes to people diagnosed with these conditions. Grantees also provide safety and wellness interventions for people who have caused or survived violence in their communities.

Reach by Target Population

During the FY 21, EHDI grantees had more than 400,000 interactions with people in their target populations (Table 12). These interactions ranged from outreach and awareness campaigns to tailored programs for disease management, such as for individuals with diabetes or heart disease. Overall numbers include duplicates because participants may access services individually and participate in groups. Of over 32,000 interactions within targeted prevention programs, the group reached the most was Hispanic/Latine, at over 11,270 or 35% of the total.

Table 13: Reach of EHDI Grantees by Target Population, FY 21

Population	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
African/ African American	116,543	32,606	1,933	582
American Indian	103,771	3,318	3,756	429
Asian/Pacific Islander	18,717	1,498	5,795	15
Hispanic/Latine	12,127	3,859	11,274	2,590
All others (multi-racial, White unknown)	55,677	43,108	9,444	165
Total*	**306,835**	**84,389**	**32,202**	**3,781**

*There is significant duplication across and, at times, within-reach categories, so we caution against adding these numbers together within target populations. The variation in numbers reached by the target population and grant areas is reflective of the number of grantees in each area and the types of programs and activities they implemented

In the FY 22, EHDI grantees had over 500,000 interactions with people (Table 13). The most interactions (n=498,777) were for growing awareness, consisting of media campaigns and other outreach activities. In addition, there were 21,710 reported interactions aimed at providing direct assistance or training to ensure access to appropriate, relevant healthcare and services. Grantees achieved 70,425 interactions in targeted prevention services across priority health areas. Finally, 1,876 people with diagnosed or identified health conditions received tailored intervention services.

Table 14: Reach of EHDI Grantees by Target Population, FY 22

Population	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
African/ African American	216,539	8,832	15,805	429
American Indian	114,942	1,145	738	132
Asian/Pacific Islander	126,372	2,799	16,958	63
Hispanic/Latine	17,999	3,243	16,328	357

Population	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
All others (multi-racial, White unknown)	22,625	5,691	20,596	895
Total*	**498,777**	**21,710**	**70,425**	**1,876**

*There is significant duplication across, and at times, within reach categories, so we caution against adding these numbers together within target populations. The variation in numbers reached by the target population and grant areas reflects the number of grantees in each area and the types of programs and activities they implement.

EHDI's online annual reporting system allows grantees to identify specific populations (i.e., disaggregate) with whom they partner to improve health. Reflecting the rich tapestry of diversity and preferred racial or ethnic identities within Minnesota communities of color and American Indian communities, the broader target population groups described above, either self-identified or collectively identified, break out into the following:

Asian American/Pacific Islander
African / Black /African American
African American
African American (North Minneapolis)
Black/non-U.S. born
African American/Black
African/African American
AI/AN
American Indian
Asian
Asian / Pacific Islander
Asian Indians
Bhutanese
BIPOC
Bi-racial
Black
Black/African American
Cambodian
Caucasian
Declined to identify
East African (Cedar-Riverside)
East African Born immigrants
Hispanic
Hispanic/Latino
Hmong / Asian American
Hmong
Karen
Karen/ Burmese
Korean Adoptive Community
Korean Immigrants
Latin@
Latino
Latine
Mixed
Multiracial
Native American
Native American or Alaskan Native
White
Unknown

Reach by Priority Health Area

This section reports reach (i.e., interactions within reach categories) for priority health areas (PHA). Differences between PHAs reflect the number of grantees working in a priority health area and the intensity of services provided by any grantee. For example, an intervention aimed at reducing disparities in immunizations can offer vaccine clinics and impact thousands of people with brief interactions. On the other side of that spectrum,

grantees working to prevent infant mortality typically provide relationship-intensive, holistic, cohort-based models of care to a smaller number of families throughout pregnancy, birth, and infancy.

As shown in Table 14, within PHAs in FY 21, the greatest number of interactions reported was related to awareness campaigns about HIV/AIDS and STIs (110,178). Grantees also reported close to 17,000 interactions to ensure people with or at risk for diabetes could access care. In the category of targeted prevention, 8,686 people participated in diabetes prevention programming or similar education/services, and 7,185 received a needed immunization.

The largest number of people reached for tailored interventions was by grantees working with participants to prevent transmission of STIs (1,460) and early pregnancy (1,398).

Table 15: Reach of EHDI Grantees (FY 21) by PHA

PHA	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
Breast and cervical cancer screening	8,216	1,494	2,903	15
Diabetes	33,877	16,953	8,686	242
Heart disease and stroke	7,364	15,931	3,831	100
HIV/AIDS and STIs	110,178	8,836	2,363	1,460
Immunizations	8,499	25,438	7,185	0
Infant Mortality	95,882	2,924	430	199
TPP	23,098	12,162	3,873	1,398
Unintentional injury and violence	19,721	651	2,931	367
Grand Total	**306,835**	**84,389**	**32,202**	**3,781**

Table 15 shows the grantee's expanded reach in FY 22 compared to the prior year. Grantees again reported extensive interactions related to awareness campaigns, especially for HIV/AIDS and STIs and Infant Mortality. Over 7,700 interactions happened in which information was shared about accessing HIV/AIDS and STIs testing, information, and services. In the category of targeted prevention, 20,617 people were immunized, and 14,576 people participated in teen pregnancy prevention programming. The largest count of people reached through tailored interventions was achieved by grantees working with participants diagnosed with pre-diabetes or diabetes (620) or with high hypertension levels (459).

Table 16: Reach of EHDI Grantees (FY 22) by PHA

PHA	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
Breast and cervical cancer screening	45,092	2,637	2,752	20
Diabetes	21,963	1,937	8,268	620
Heart disease and stroke	12,389	428	7,288	459

PHA	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
HIV/AIDS and STIs	219,223	7,767	13,377	358
Immunizations	2,215	4,479	20,617	0
Infant Mortality	113,028	256	107	40
TPP	20,147	3,120	14,576	170
Unintentional injury and violence	64,720	1,086	3,440	209
Grand Total	**498,777**	**21,710**	**70,425**	**1,876**

Target Populations within Priority Health Areas

Grantee reporting requirements also allow reporting of target populations reached within priority health areas, allowing stakeholders to understand better the specific pieces that make up the broad and collective reach of EHDI.

1. Breast and Cervical Cancer

In FY 21 & FY 22, one grantee was funded to work on breast and cervical cancer prevention in the Asian/Pacific Islander community. They conducted over 300 cancer screenings while focusing much of their effort on social media campaigns and group educational workshops to increase awareness of the need for screening (Table 16). They also assisted women with services, including translation, scheduling, insurance enrollment, and system navigation.

Table 17: Breast & Cervical Cancer Prevention Reach (1 Grantee–Asian/Pacific Islander)

Reach category	FY 21	FY 22
Growing Awareness	8,216	45,092
Ensuring Access	1,494	2,637
Targeted Prevention	2,903	2,752
Tailored Intervention	15	20

2. Diabetes

Seven grantees worked to prevent or control diabetes in multiple communities. Efforts to grow awareness for this PHA include providing educational materials at health fairs, workshops and demos, and media campaigns. Interventions included clinical practice aimed at helping maintain or reach healthy A1C levels. At the same time, prevention efforts focused on community education to prevent new diabetes or reverse prediabetic cases, and training staff to increase available lifestyle coaching.

Table 18 A: Diabetes Prevention Reach (7 Grantees), FY 21

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	All others
Growing Awareness	7,154	4,642	36	587	21,458

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	All others
Ensuring Access	15,902	364	2	522	163
Targeted Prevention	153	2,770	329	1,177	4,257
Tailored Intervention	100	95		37	10

Table 18 B: Diabetes Prevention Reach (7 Grantees), FY 22

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	All others
Growing Awareness	3,786	1,348	10,102	2,877	3,850
Ensuring Access	345	782	95	484	231
Targeted Prevention	2,254	204	2,504	1,923	1,383
Tailored Intervention	44	92	43	15	426

3. Heart Disease and Stroke

While all grantees submitted evaluation data in FY 21, only three were able to do so in FY 22. Because many of the same social determinants of health affect diabetes and heart disease, all three grantees were funded to work on both and used similar strategies (e.g., media campaigns, health education, screening, nutrition, or disease management coaching). Grantees also worked to increase awareness of, access to, and use of healthier foods and active living strategies.

Table 19 A: Heart Disease and Stroke Prevention Reach (4 Grantees), FY 21

Heart Disease & Stroke	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown
Growing Awareness	7154	60			150
Ensuring Access	15,900				31
Targeted Prevention	153	150	81		3,447
Tailored Intervention	100				

Table 3 B: Heart Disease and Stroke Prevention Reach (4 Grantees), FY 22

Heart Disease & Stroke	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown
Growing Awareness	3,786	299	3,072	1,977	3255
Ensuring Access	345	82	0	0	1

Heart Disease & Stroke	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown
Targeted Prevention	2,254	14	2,240	1,442	1,338
Tailored Intervention	44	0	0	0	415

Note: Missing HAFA's reach data in FY 22

4. HIV/AIDS and STIs

Seven grantees worked to prevent and control HIV/AIDS and STI's. All organizations engaged in extensive awareness-raising and outreach campaigns on social media and health fairs. Many provided education to parents, and professional health care organizations worked with faith leaders to build additional prevention supports in the community. Three organizations provided clinical services, including prevention and intervention, while social service agencies primarily provided sexual health education, mental health counseling, and screening or texting.

Table 20 A: HIV/AIDS and STIs Prevention Reach (7 grantees), FY 21

	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown/ Other
Growing Awareness	92,808	2		4,587	12,781
Ensuring Access	320	2		1,123	7,391
Targeted Prevention	385	4		1,707	267
Tailored Intervention	180			1,201	79

Table 20 B: HIV/AIDS and STIs Prevention Reach (7 grantees), FY 22

	African/African American	American Indian	Asian/Pacific Islander	Hispanic/	African/African American
Growing Awareness	204,235	0	3,072	5,393	6,523
Ensuring Access	6,452	0	0	883	432
Targeted Prevention	2,622	1	2,240	2,445	6,069
Tailored Intervention	249	0	0	84	25

5. Immunization

The two grantees funded to increase immunizations provided thousands of primary influenza and COVID-19 vaccines and meningococcal and other needed immunizations in young people. They also engaged in extensive awareness and education campaigns and ensured access to information by making vaccine information available in multiple languages.

Table 21 A: Immunization Reach (2 grantees), FY 21

Immunizations	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown
Growing Awareness	165	13	617	1,615	6,089
Ensuring Access				522	24,916
Targeted Prevention	476	41	1,899	4,153	616
Tailored Intervention			0		

Table 21 B: Immunization Reach (2 grantees), FY 22

Immunizations	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Immunizations
Growing Awareness	239	4	410	1,360	202
Ensuring Access	-	-	-	484	3,995
Targeted Prevention	5,920	328	4,455	6,417	3,497
Tailored Intervention	-	-		-	

6. Infant Mortality

Two grantees worked towards preventing infant mortality: both focused on the American Indian community. Outreach, training, and education included information on traditional teachings, trauma healing, parenting, safe sleep, and breastfeeding and were provided to caregivers, family members, and parents. Tailored interventions included mental health services.

Table 22: Infant Mortality Reach (2 grantees)

Infant Mortality	American Indian FY 21	American Indian FY 22
Growing Awareness	95,882	113,028
Ensuring Access	2,924	256
Targeted Prevention	430	107
Tailored Intervention	199	40

7. Teen Pregnancy Prevention

Twelve grantees reported evaluation based on teen pregnancy prevention-based programming and efforts. Prevention strategies, frequently offered alongside HIV/AIDS and STIs prevention education, included school-based programs, financial literacy curriculum, understanding of healthcare systems, and preventative care visits. Interventions included individual coaching and counseling.

Table 23 A: Teen Pregnancy Prevention Reach (12 grantees), FY 21

Teen Pregnancy	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown/ Other
Growing Awareness	9,221	5		4,617	9,255
Ensuring Access	416	19	2	1,131	10,594
Targeted Prevention	752	246	29	2,073	773
Tailored Intervention	140			1,191	67

Table 23 B: Teen Pregnancy Prevention Reach (12 grantees), FY 22

Teen Pregnancy	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Teen Pregnancy
Growing Awareness	4,464	200	3,072	5,427	6,984
Ensuring Access	1,670	21	-	899	530
Targeted Prevention	2,680	84	2,262	3,273	6,277
Tailored Intervention	55	-	-	88	27

8. Unintentional Injury and Violence

Five grantees focused on unintentional injury and violence. There were many prevention efforts, including increasing food access, street outreach, and safe spaces in schools. Tailored interventions and prevention include parent/guardian support, healing-focused programming, and career/job services.

Table 4 A: Unintentional Injury & Violence Prevention Reach (6 grantees), FY 21

Unintentional Injury & Violence	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown/ Other
Growing Awareness	41	3,167	9,848	721	5,944
Ensuring Access	68	9		561	13
Targeted Prevention	14	115	554	2,164	84
Tailored Intervention	62	135		161	9

Table 24 B: Unintentional Injury & Violence Prevention Reach (6 grantees), FY 22

Unintentional Injury & Violence	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown/ Other
Growing Awareness	29	63	61,852	965	1,811
Ensuring Access	20	4	67	493	502
Targeted Prevention	75	-	505	828	2,032

Unintentional Injury & Violence	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latino	Unknown/ Other
Tailored Intervention	37	-	-	170	2

Note: Missing HAFA's reach data FY 22

Additional Evaluation Results

EHDI grantees are required to evaluate their programs, including developing a logic model and an evaluation plan. Beyond annual reporting on shared measures, such as populations reached through specific strategies and individual counts, EHDI grantees have the option to report findings from their own evaluations. These evaluations are envisioned to increase evidence for the community-based solutions grantees develop to address health disparities. The COVID-19 pandemic put significant pressure on grantees to prioritize community needs and provide them with COVID-19 resources and information. For this reason, the standard expectations for evaluation have been waived since FY 20 in reporting other program outcomes, which limited the available evaluation data.

With the ongoing adaptations of program activities and related data collection strategies, shared outcome measures across grantees have not been feasible this grant cycle. That said, given the long history of the EHDI program having substantial evaluation requirements and providing capacity building, most EHDI grantees in FY 21 and FY 22 were able to document annual progress in program outcomes and outputs. The evaluation capacity building team conducted separate thematic content analysis of FY 21 and FY 22 evaluation reports.

The FY 21 analysis captured patterns within change levels regarding anecdotal, qualitative, and quantitative data reported and anticipated changes reported through change narratives. These identified patterns were then grouped into themes that collectively describe the approaches and changes EHDI grantees seek through their work. This section describes key themes identified from grantee data for each level of change.

Level 1: Health Promotion/Direct Service

Grantees' level 1 change work (i.e., work focused on individuals and families) is holistic and upstream. Beyond seeking individual health behavior change and specific disease prevention, grantees collaborate directly with impacted communities to strengthen resilience and wellness in individuals, families, and communities. These approaches help mitigate community members' unequal social and economic conditions. The six specific themes identified below in grantees' direct service work show the extent to which these broad approaches to wellness are present across priority health areas.

Theme 1: **Increased Social Support**

- Grantees aim to improve family connection through parenting education; connect youth to trusted adults, hopeful futures, and opportunities to thrive; and facilitate trauma healing from oppressive systems that have attempted to disconnect communities from cultural wellness practices
- Theme was evident with grantees working in PHAs of infant mortality, breast and cervical cancer, diabetes, heart disease, stroke, HIV/AIDS & STIs, teen pregnancy prevention, and unintentional injury and violence

Theme 2: Improved Mental Health/Coping

- Grantees build awareness about how trauma and stress are processed in the body and promote practices, often linked to cultural wellness practices, to recognize and cope with the stress or to recognize and reduce the stigma of needing mental health services

- Theme was evident with grantees working in PHAs of infant mortality, heart disease, stroke, and unintentional injury and violence

Theme 3: Helped meet basic needs

- Grantees help meet basic needs by ensuring youth are staying connected to school, and educational aspirations, employment opportunities and avoiding justice system involvement; and ensuring individuals and families have access to healthy food, stable housing, and health care for their infants and children (i.e., by providing wrap-around care)
- Theme was evident with grantees working in PHAs of infant mortality, teen pregnancy prevention, and unintentional injury and violence

Theme 4: Decreased Barriers to Care

- Grantees work to ensure healthcare institutions improve culturally affirming care, families can access that care, and youth know where and how to access sexual and reproductive health care.
- Theme was evident with grantees working in PHAs of infant mortality, breast and cervical cancer, diabetes, heart disease and stroke, HIV/AIDS & STIs, teen pregnancy prevention, and unintentional injury and violence

Theme 5: Reduced Stigma/Increased awareness

- Grantees work to address stigma and increase awareness for traditionally stigmatized health conditions like mental health, breast and cervical cancer, immunizations, sexually transmitted infections, and HIV/AIDS
- Theme was evident with grantees working in PHAs of immunizations, HIV/AIDS & STIs, teen pregnancy prevention, and unintentional injury and violence

Theme 6: Improved Health Behaviors

- Finally, grantees engage in direct work with individuals and families to promote improvements in healthy eating, physical activity levels, safe sleep, diabetes management, healthy relationships, life skills, condom & birth control use, and increases in screening, treatments, testing, and immunizations
- Theme was evident with grantees working in PHAs of infant mortality, diabetes, heart disease and stroke, HIV/AIDS & STIs, immunizations, teen pregnancy prevention, and unintentional injury and violence

Level of change 2 and 3: Organizational/ Institutional Change, Root Cause/Condition for Health

At the organizational and root cause levels, grantees work to mitigate and transform unequal social and economic conditions. Specifically, grantees aim to create healing institutions and just systems through their level 2 (institution-focused) and level 3 (root cause-focused) work. Themes, as shown below, indicate the patterns and approaches evident in FY 21 data. Because both the strategies within, and impact goals of, levels 2 and 3 change efforts are not PHA-specific, unlike above the relationship to PHA did not emerge as a salient them for these findings.

Theme 1: Train institutional partners in healthcare and educational institutions in:

- Providing culturally affirming care and implement anti-racist practices, train on historical trauma and actual causes of health disparities
- Providing gender-affirming care
- Providing care and sexual health education to young people that affirm their identities and developmental stage is aligned with state laws on minor's ability to consent for sexual and reproductive health
- Ensuring care and approaches that reduce the stigma of addressing mental health

Theme 2: Create and improve networks and organizations through:

- Conducting intersectionality analysis of own organization; reviewing policies to become more anti-racist
- Internal policy changes, reviewing systems, and making strategic decisions about efforts that address social determinants of health
- Improve services based on stakeholder feedback
- Ensure robust and meaningful connections and referrals systems

Theme 3: Dismantle systemic racism through:

- Promoting anti-racism-toolkit in medicine
- Advocate for criminal-legal reform
- Helping to create just food systems

Theme 4: Create just food systems by:

- Advocating for lowering prices on healthy foods, taxing unhealthy foods
- Preserving indigenous food systems and passing on indigenous food knowledge to future generations
- Ensuring supply and demand for food systems in indigenous and Asian communities: establish connections for institutions to purchase and distribute food grown by indigenous and Hmong growers
- Ensuring access to healthy and local foods at neighborhood markets

Theme 5: Heal from discrimination and prejudice through:

- Addressing LGBTQ discrimination in the Latine community & its connection to sexual and reproductive health
- Plan an anti-stigma campaign in Korean and Karen communities

Theme 6: Educate about the impact of systems, laws, and policies in:

- Immigration
- Maternal and child health policy, especially related to breastfeeding
- Ensuring Community Health Workers are a key and funded part of healthcare access
- Addressing root causes that create inequitable health outcomes

The FY 22 qualitative analysis captured patterns across annual reports. One primary data theme stood out which was continuing challenges to implement work plans. There were six overlapping themes reported by grantees as challenges for this third year of the EHDI cycle, with the most common being continuing challenges due to COVID-19 (Table 24).

Table 25: Totals of Grantees reporting each theme

Theme	Grantees (n)
Covid-19	9
Staff Turnover	6
Venue Limitations	5
Delayed Programming to Next Year	4
Lost Partnerships	3
Data Access/Analysis	2
Covid-19	9

For example, grantees reported that COVID-19 has moved services to a virtual space and has placed a hold on in-person programming and services. Staff turnover was a challenge that affected the performance capacity of six

grantees. Staff turnover caused the restructuring of relationships, delaying programming, and reprioritizing the organization's capability and efforts. Venue policies and availability (especially for grantees partnering with schools) presented an external challenge to the five grantees' ability to provide programming and services, such as venues prioritizing another programming over the grantee's offerings or changes in policy regarding use of the space.,

VI. Conclusions

In conclusion, the analysis of FY 21 and FY 22 EHDI grantee evaluation reports demonstrated that:

- EHDI grantees are a crucial part of Minnesota's public health infrastructure.
- EHDI grantees' community-driven solutions address wellness holistically.
- EHDI grantees seek to transform systems of oppression.

The impressive reach, proximity, connection to local communities, and adaptability and flexibility of grantees to continue their work under extreme constraints speak to the importance of the EHDI community to Minnesota's health and wellness.

Evaluation results indicate that the EHDI grant program is a valuable investment. During FY 21, EHDI grantees had more than 400,000 interactions with people in their target populations. In FY 22, EHDI grantees had over 500,000 interactions with people. In addition, there were over 17,000 interactions aimed at providing direct assistance or training to ensure access to culturally appropriate healthcare and services. Grantees achieved 50,000 interactions in targeted prevention services across priority health areas. Finally, over 1,800 people with diagnosed or identified health conditions received tailored intervention services. While it is likely there is significant duplication across and within reach categories and caution should be taken against adding these numbers, they still represent a considerable portion of all Black, American Indian, and people of color in the state. Grantee program evaluations have documented many of the 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. Evaluation results also documented the expanded capacity of grantee organizations to better serve people of color and American Indian populations through promising practices such as incorporating traditional spiritual or cultural practices to promote health.

EHDI Grantees are a key part of Minnesota's public health infrastructure

As noted in the 2018 EHDI Impact Report, EHDI came into being because "public health approaches and grant programs were neither effectively reaching their communities nor equipped to address the social and economic conditions that have created significant racial disparities in health."

Between July 2020 and June 2022, as social and viral pandemics changed daily life, grantees served as a critical connector between some of the most disproportionately impacted communities of the pandemics and state and local public health infrastructure. Grantees continued to reach hundreds of thousands of Minnesotans with key public health messages, connections to resources, and supportive and preventative services. At the same time, many grantees also shifted to provide food, housing, and other emergency relief services.

Further, many grantees leveraged EHDI and other funding while shifting their approaches to meet community members' basic needs and reinventing their programming to fit new realities. For example:

- Grantees' extended MDH's ability to address the COVID-19 pandemic
    - Pillsbury United Communities provided 112 households with emergency rent assistance and offered over 700 people access to holistic health resources and screenings, including COVID-19 vaccination and testing
    - MINI team provided more than 49,500 COVID-19 vaccinations at over 775 vaccination clinics between January 2021 and June 2022
    - Many others helped youth, families, and community members connect with community resources during the pandemic (AIFC, Centro, Emerge)
- Grantees continued their work on community-driven upstream solutions that promote resilience & wellness, and healing from historical trauma and oppression and aim to dismantle the systems that create health inequities

As shown in previous sections of this report, grantees collectively and within specific priority health areas reached large numbers of Minnesotans with key strategies to help mitigate the impact of structural inequities and eliminate health disparities, despite the challenges posed by COVID-19.

Appendix D summarizes in an infographic what the 25 EHDI grantees have accomplished amid the COVID-19 pandemic, in FY 21 and in FY 22. EHDI was enacted to address the state's persistent racial inequities and guarantee that the voice, wisdom, expertise, and resilience of BIPOC communities are valued and recognized. The infographic clearly shows that grantees, through their work, honored both the letter and spirit of the law.

EHDI grantees' community-driven solutions address wellness holistically

Grantees' level 1 change work (i.e., work focused on individuals and families) is centered upstream, beyond seeking individual health behavior change, to strengthen resilience and wellness in individuals, families, and communities. These approaches help mitigate community members' unequal social and economic conditions.

EHDI grantees seek to transform unjust systems

Grantees' work mitigates and seeks to change unequal social and economic conditions. Specifically, grantees aim to create healing institutions and just systems through their level 2 (institution-focused) and level 3 (root cause-focused) work.

As we move into the future, there are several considerations for action:

- Amplify the impact grassroots community organizations can have in strengthening pandemic responses. Being deeply connected to the community, grantees demonstrated incredible flexibility and agility in response to the COVID-19 pandemic by rapidly pivoting their operations to address the emergency and basic needs of the people they serve. Especially as the pandemic persists, support for these grantees through additional and flexible funding is even more critical, acknowledging that the programs may have to pivot their goals to continue being responsive to the communities needs and requests. The community grantees work with have dealt great blows to their economic stability, and many have experienced re-traumatization as food insecurity, job loss, and general community crisis grows in this current pandemic. The pandemic has also disproportionately affected American Indian, Latine, Black, and Asian American communities. Grantees are uniquely positioned to respond to emergent community needs and function as trusted messengers of public health-related information.
- Accommodate the time required for community-based organizations to adapt programming to remote-based formats; allow grantees time, flexibility, and the necessary freedom to adapt. Adult and youth participants have experienced significant barriers to participation in programming that does not address immediate needs. As community members' priorities shift to survival-based and immediate needs, involvement in, for example, sexual health or diabetes prevention becomes secondary. Continued flexibility is required to support grantees in balancing the requests for basic needs with adapting PHA-specific program designs.
- Continue connecting grantees to ongoing learning and opportunities within the EHDI cohort through the community of practice and within the broader MDH stakeholder community.
- Strengthen MDH's approach to health equity by lifting up effective methods implemented by EHDI grantees and how they can influence other MDH investments and strategies.
- Increase the funding available through EHDI. Funding levels have remained the same despite inflation and have not kept up with the rapid growth of Minnesota's people of color and American Indian populations and their needs. The impact and reach of EHDI grantees demonstrate that they have the relationships, trust, and practical strategies to serve some of the hardest-to-reach populations with some of the largest health disparities relative to white people in the state. It would be in Minnesota's

best interest to invest additional funds into the program to support the consistently innovative, responsive, and effective work of EHDI grantees.

- Acknowledge the Social Determinants of Health and the common cultural perspective that health is interwoven with community, art, and spirituality by integrating zip codes into EHDI's analysis of disparities and embedding health-related work into larger community-based initiatives. Doing so would support programmatic and organizational sustainability, as well. Grantees suggested language focusing on social determinants instead of specific diseases or conditions. The former is often more accessible to program participants and community members. It shifts the discussion away from deficits among people within marginalized groups to self-reflection about structural issues among public institutions and systems.

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

APPENDIX A. EHDI Legislation

MINNESOTA STATUTES 2020 145.928

Subdivision 1. Goal; establishment. It is the goal of the state to decrease 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, access to and utilization of high-quality prenatal care, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

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

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

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

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

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

Subd. 7.Community grant program; immunization rates, prenatal care access and utilization, 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 more of the following priority areas:

(1) decreasing racial and ethnic disparities in infant mortality rates.

(2) decreasing racial and ethnic disparities in access to and utilization of high-quality prenatal care; or

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

(b) The commissioner shall release an annual report to the public and submit the annual report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over public health on grants made under subdivision 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide specific information on the amount of each grant awarded to each agency or organization, an itemized list submitted to the commissioner by each agency or organization awarded a grant specifying all uses of grant funds and the amount expended for each use, the population served by each agency or organization, outcomes of the programs funded by each grant, and the amount of the appropriation retained by the commissioner for administrative and associated expenses. The commissioner shall issue a report each January 15 for the fiscal year beginning January 15, 2016.

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

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

APPENDIX B. EHDI FY 21 and FY 22 Grantees

Table 25. EHDI Grantees by PHA and Population, FY 20

Priority Health Area: Breast & Cervical Cancer (N=1)

EHDI Grantees	African American/ African	American Indian	Asian American/Asian Pacific Islander	Hispanic/Latine
Lao Assistance Center of Minnesota			●	

Priority Health Area: Diabetes (N=7)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/Latine
Bois Forte Band of Chippewa*		●		
Dream of Wild Health		●		
Hmong American Farmers Association*		●	●	●
Hmong American Partnership				
Minnesota Community Care*			●	
Hennepin Healthcare System, Inc. (Aqui Para Ti) *				●
Pillsbury United Communities*	●			

Priority Health Area: Heart Disease & Stroke (N=4)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/Latine
Bois Forte Band of Chippewa*		●		
Hmong American Farmers Association *		●		
Minnesota Community Care*	●			
Pillsbury United Communities	●			

Priority Health Area: HIV/AIDS & Sexually Transmitted Infections (N=7)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
Centro Tyrone Guzman *				●
Family Tree Clinic*	●			
HealthFinders Collaborative, Inc.*				●
Hennepin Healthcare System, Inc. (Aqui Para Ti)				●
KIPP Minnesota*	●			
Minnesota Community Care*	●			
Sub-Saharan African Youth and Family Services in MN	●			

Priority Health Area: Immunizations (N=2)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
Hennepin Healthcare System, Inc. (Aqui Para Ti)				●
Minnesota Immunization Networking Initiative		●		

Priority Health Area: Infant Mortality (N=2)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
American Indian Family Center	●	●	●	●
Minnesota Indian Women's Resource Center		●		

Priority Health Area: Teen Pregnancy (N=12)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
Centro Tyrone Guzman *				●
Communidades Latinas Unidas en Servicio (CLUES)		●		●
Division of Indian Labor		●		
Family Tree Clinic, Inc*	●			●
Fond du Lac Band of Lake Superior Chippewa		●		
HealthFinders Collaborative, Inc*				●
Hennepin Healthcare System, Inc. (Aqui Para Ti) *				●
High School for Recording Arts	●			

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
KIPP Minnesota*	●			
Minnesota Community Care *	●	●	●	●
The Bridge for Youth	●	●		●
YWCA of Minneapolis	●	●	●	●

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

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latine
Casa de Esperanza				●
EMERGE Community Development				
Hennepin Healthcare System, Inc. (Aqui Para Ti) *				●
Karen Organization of Minnesota			●	
Minnesota Indian Women's Resource Center		●		

*Grantee serves more than one priority health area.

Table 26. EHDI Grantees by Organization, County & PHA, FY 21 and FY 22

Organization	Project Name	County of Location	Breast & Cervical Cancer	Diabetes	Heart Disease & Stroke	HIV/AIDS/STIs	Immunizations	Infant Mortality	Teen Pregnancy Prevention	Unintentional Injury & Violence
American Indian Family Center	Wakanyeja Kin Wakan Pi (Our Children are Sacred) Program	Ramsey						•		
Bois Forte Band of Chippewa	Diabetes and Heart Disease Case Management Program	Koochiching	•	•						
Esperanza United (Former Casa de Esperanza)	Fuerza Unida Amig@s	Ramsey								•
Centro Tyrone Guzman	Raices Youth Development Program	Hennepin				•			•	
Comunidades Latinas Unidas en Servicio (CLUES)	A Multi-Generational Approach to Sexual Health Education	Ramsey							•	
Division of Indian Work	Live It! Teen Pregnancy Prevention Curriculum	Hennepin				•			•	
Dream of Wild Health	Indigenous Food Network	Hennepin		•						

Organization	Project Name	County of Location	Breast & Cervical Cancer	Diabetes	Heart Disease & Stroke	HIV/AIDS/STIs	Immunizations	Infant Mortality	Teen Pregnancy Prevention	Unintentional Injury & Violence
EMERGE Community Development	EMERGE North 4 & Youth Violence Prevention Programs	Hennepin								•
Fairview Health Services	Minnesota Immunization Networking Initiative (MINI)	Hennepin					•			
Family Tree Clinic	Improving Sexual & Reproductive Health Outcomes	Ramsey				•			•	
Fond du Lac Band of Lake Superior Chippewa	EHDI Teen Pregnancy Prevention	Carlton							•	
HealthFinders Collaborative, Inc.	Mejorando la Salud de los Adolescentes (MESA)	Rice				•			•	
Hennepin County Medical Center	Aqui Para Ti–Here for You	Hennepin		•		•	•		•	•
High School for Recording Arts (HSRA)	Check Yo'Self Health and Wellness Center	Ramsey							•	
Hmong American Partnership	Diabetes Education Project	Ramsey			•					
Karen Organization of Minnesota	Suicide Prevention in the	Ramsey								•

Organization	Project Name	County of Location	Breast & Cervical Cancer	Diabetes	Heart Disease & Stroke	HIV/AIDS/STIs	Immunizations	Infant Mortality	Teen Pregnancy Prevention	Unintentional Injury & Violence
	Asian Communities									
KIPP Minnesota	College and Career Before Parenthood	Hennepin				•			•	
Lao Assistance Center of Minnesota	API Women's Health Project	Hennepin Ramsey Roseau	•							
Minnesota Community Care	Youth POWER	Ramsey		•	•	•			•	
Minnesota Indian Women's Resource Center	Life Skills Parenting	Hennepin						•		•
Pillsbury United Communities	Healing Homes Minneapolis	Hennepin		•	•					
Sub-Saharan African Youth and Family Services in MN	EHDI in African-born Communities	Ramsey				•				
The Bridge for Youth	Teen Pregnancy Prevention Project	Hennepin							•	
YWCA Minneapolis	YWCA Culturally Responsive Girls and Youth Programs	Hennepin							•	

APPENDIX C. Featured Grantee

EMERGE Community Development, EMERGE North 4 & Youth Violence Prevention Programs – Focus on Unintentional Injury and Violence; Serving Africans/African Americans in Hennepin County

EMERGE Community Development's North 4 Violence Prevention Program targets north Minneapolis male youth ages 16-24 who possess high risk factors for youth violence (e.g., gang/criminal involvement, community violence exposure). "North 4" is a community-recognized youth job program that connects young African American men with work opportunities and builds life skills that reduce violence and promote positive decision-making. Youth who have participated in this program have experienced increased competencies related to social/economic status, life skills, community connections, work readiness, and leadership.

EMERGE aims to:

- Operate the North 4 Youth Violence Prevention Program to reduce involvement in violence and criminal activity.
  Increase employability and leadership skills through paid internships, thereby increasing protective factors and decreasing risk factors for involvement with violence or criminal activity.
- Enhance the North 4 program's capacity to respond to and prevent youth violence by engaging culturally specific community partners from the African American community in supporting trauma recovery, mental health, incarceration prevention, social-emotional development, and access to mentorship and small group support.

A major achievement in FY 22 was forming a partnership with the Nonviolent Peace Force which provided the young men training in de-escalation and situational awareness as well as additional hours with their agency. Two young men were promoted into full-time roles.

Participant Story:

Kevin (not his real name) is one of North 4's youngest participants. He came to us with court involvement, not in school, and arguing with and refusing to listen to his mom. At first, he was not too excited about North 4 and was pretty convinced he could do better being on the streets. Then he began to see both the adverse effects of street life and the positive effects of the brotherhood and support for older youth. Groups talked about how risky it was to be street-involved for both you and your friends and family. One program leader shared his past experience of facing incarceration as an adult while under age 18, and others spoke of losing people close to them to gun violence. They talked about the value of school and, in some cases, about wishing they had not dropped out and how much harder it was to graduate after returning. He began to look up to his peers in the program and wanted to make them proud. He expressed the feeling that he wanted to be something.

Kevin is now back in school and has started talking about really liking it. He says it is a lot more interesting than he thought it would be once he started paying attention. He even expressed pride in himself for being good at school. When the program leader, Mr. Will, called his school to check in, Kevin's teacher reported that his attitude had changed and that he was getting engaged and was a fun kid in the classroom. She shared that when she asked Kevin about the sudden change, he told her that his brothers at North 4 had helped him see that he needed school to be something in this life.

APPENDIX D. EHDI Grantees COVID-19 Adaptations, FY 20 and FY 21