Eliminating Health Disparities Initiative Community Grants

2006-2007 Grant Reapplication Information and Materials

Minnesota Department of Health
Office of Minority and Multicultural Health

July 2005

Office of Minority and Multicultural Health
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882
www.health.state.mn.us/ommh
(651) 297-5813

RECLAIMING OUR HEALTH

HEALING OUR COMMUNITY

The 2006-2007 EHDI Community Grant Proposal Information and Materials are also available online at:

http://www.health.state.mn.us/ommh

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2006-07 Eliminating Health Disparities Initiative
Community Grants Reapplication Process
Summary

Timeline

Reapplication Materials Mailed……	July 18, 2005
Posted on Web. ..... ….	July 18, 2005
Reapplication Workshop in St. Paul..... ….	August 1, 2005
Reapplications due ..... ….	September 1, 2005
Notice to applicants..... ….	November 15, 2005
Grant Contracts Amended and Work begins..... ….	January 1, 2006

Eligibility: Only current EHDI Community Grantees are eligible to apply for 2006-07 EHDI Community Grant funds at this time.

Funds Available: The anticipated total Community Grant funds available for this 2-year period are $10,400,000, covering the eight priority areas in statute.
You may apply for an amount up to your current two year EHDI Community Grant.

Reapplication Submission Information: You must write your application in a 12-point font with one-inch margins.
You must submit one signed unbound original and 4 copies, along with the same document on a floppy diskette or CD.
You must meet the reapplication deadline below.
We will not accept faxed or e-mailed reapplications.
We will not accept or consider late reapplications.

To meet the deadline, your reapplication must be received at MDH before 4:30 p.m. on September 1, 2005, or have a legible postmark from the U.S. Post Office or a private carrier dated on or before September 1. 2005.

Delivery Address
Attention: Leah Jones-Handy
Minnesota Department of Health
Office of Minority and Multicultural Health
Golden Rule Building, Suite 400
85 East Seventh Place
St. Paul, MN 55101

Mailing Address
Attention: Leah Jones-Handy
Minnesota Department of Health
Office of Minority and Multicultural Health
P.O. Box 64882
St. Paul, MN 55164-0882

Please Note: Reapplying for an EHDI Community Grant does not guarantee funding. The content of the proposal must meet the criteria and standards noted on the following pages.

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Introduction

This document provides background and process information for the development of EHDI Grant Reapplication Proposals for the 2006-07 Eliminating Health Disparities Community Grants cycle.

Only current recipients of EHDI Community Grant funds are eligible for this grant funding.

If you have questions or concerns about developing the proposal, please contact your current grant manager.

EHDI Grant Manager	Phone	E-Mail
Nila Gouldin	651-281-9792	Nila.Gouldin@health.state.mn.us
Valerie Larsen	651-215-0701	Valerie.Larsen@health.state.mn.us
Rosemarie Rodriguez-Hager	651-215-5802	Rosemarie.Rodriguez-Hager@health.state.mn.us
Emily Williamson	651-281-9798	Emily.Williamson@health.state.mn.us

If you have questions or concerns about the priority health area(s) activities you want work with on this grant, you may also contact the following MDH program staff working in these areas:

Priority Health Areas	Contact Name	Phone	E-Mail
Breast & Cervical Cancer	Shelly Madigan Mary Jo Mehelich	612-676-5543 612-676-5551	Shelly.Madigan@health.state.mn.us Mary.Mehelich@health.state.mn.us
Cardiovascular Health	Elizabeth Gardner	651-215-8959	Elizabeth.Gardner@health.state.mn.us
Diabetes	Martha Roberts Anne Kollmeyer	651-282-2958 651-281-9846	Martha.Roberts@health.state.mn.us Anne.Kollmeyer@health.state.mn.us
HIV/AIDS & STIs	Rob Yaeger	612-676-4091	Rob.Yaeger@health.state.mn.us
Immunizations	Ka Vue	612-676-5693	Ka.Vue@health.state.mn.us
Infant Mortality	Cheryl Fogarty	651-281-9947	Cheryl.Fogarty@health.state.mn.us
Healthy Youth Development for Teen Pregnancy Prevention	Sarah Nafstad	651-281-9956	Sarah.Nafstad@health.state.mn.us
Violence and Unintentional Injuries	Mark Kinde Amy Okaya	651-281-9832 651-281-9874	Mark.Kinde@health.state.mn.us Amy.Okaya@health.state.mn.us

Background

Funds Available

Current EHDI Community Grant Recipients will be able to request continuing EHDI Community Grant funding for the period January 1, 2006– December 31, 2007. The anticipated total Community Grant funds available for this period are $10,400,000, covering the eight priority areas in statute.

You may apply for an amount up to your current two year EHDI Community Grant award. You may not, however, propose to address additional Priority Health Areas. OMMH review and award decisions will be made based on the proposal, your EHDI grant manager's site visit findings, and your evaluation reports.

Funds are available by Priority Health Areas (PHAs) as follows:

Immunizations for Adults and Children and Infant Mortality

Funds Available	$2,400,000
Funding Period - 24 months	1/1/06 - 12/31/07

Breast and Cervical Cancer, HIV/AIDS & Sexually Transmitted Infections, Cardiovascular Disease, Diabetes and Unintentional Injuries & Violence

Funds Available	$4,000,000
Funding Period - 24 months	1/1/06 - 12/31/07

Healthy Youth Development for Teen Pregnancy Prevention TANF Funds

Funds Available	$4,000,000
Funding Period - 24 months	1/1/06 - 12/31/07

Overview

As in previous grant cycles, 2006-07 EHDI Community Grants must be used to fund activities that will close the gap in the health status of American Indians and Populations of Color in Minnesota as compared to whites in eight priority health areas. The EHDI statute set measurable goals for the EHDI to reach by the year 2010. Therefore, MDH/OMMH supports continuing funding in areas where progress is being shown, lessons are being learned, and promising practices are emerging.

The populations to address are:

- African Americans and Africans
- American Indians
- Asian and Pacific Islanders
- Hispanics/Latinos

The eight priority health areas to address are:

- Breast and cervical cancer
- Cardiovascular disease
- Diabetes
- HIV/AIDS and sexually transmitted infections
- Immunizations for adults and children
- Infant mortality
- Healthy youth development for infant mortality reduction through teen pregnancy prevention
- Violence and unintentional injuries

Once again, we encourage you to propose activities or projects that prevent the development of illness or injury, foster healthy communities, and provide or institute support of good outcomes.

Strategies may:

* Address underlying contributing factors and protective factors
* Address social and/or economic conditions that affect one or more of the eight priority health areas
* Help to coordinate and integrate services delivered
* Give community residents a voice in program planning and implementation
* Encourage timely and appropriate use of health care services
* Strengthen working relationships and partnerships in the community
* Address health disparities more effectively
* Address multiple priority health areas
* Involve members of the community affected by the priority health area in developing the grant activities
* Strengthen the overall community commitment
* Appropriately design activities and reflect community culture, values, traditions, and expectations
* Address Principles of Community Engagement:

- Foster openness and participation in your proposed activities.
- Ensure that those who are representing a specific community in your proposed activities truly reflect that community's values, norms, beliefs, and traditions.
- Use strategies that ensure inclusion, representation, and equity in your proposed activities.
- Offer orientation and skill building opportunities so that everyone will have an equal voice in voting and other decision-making activities.
- Develop cultural competence within your organization's staff.
- Communicate with the community about your proposed activities.

These are only some examples. See Appendices B, C, D, E, and F for more examples of strategies, and for concepts, and approaches you might want to consider. See Appendix G for more information about community engagement.

Please Note: Reapplying for an EHDI Community Grant does not guarantee funding. The content of the proposal must meet the criteria and standards noted on the following pages.

Funding Criteria

2006-07 EHDI Community Grants Reapplication funding decisions will be made using information from the

* EHDI 2001-2003 Progress Report
* 2004 Integrated Grantee Evaluation and Activities Report
* 2005 Midcycle Report
* Information gathered by OMMH EHDI Grant Managers during site visits

as well as your 2006-07 grant reapplication proposal.

We will consider:

- Did you (the grantee) meet the requirements of the Request For (Re) Applications and the grant contract?
- Did you do what you proposed? If not, did you describe what changed?
- What did you do differently? Did you describe why?
- Were you successful in achieving what you planned?

The criteria by which the application narrative will be reviewed are included in each section below.

Current EHDI Community Grant contracts will be amended to incorporate approved 2006-2007 Community Grant funding.

What Should Be Included In Your Reapplication?

Your reapplication must be complete and signed where noted.

All of the required forms are located following page 17 and on the MDH/OMMH website. Go to http://www.health.state.mn.us/ommh. Click on "Request for Reapplication Proposals: Eliminating Health Disparities Initiative Community Grants Program" or call Leah Jones-Handy at 651/297-5813 to receive an electronic copy via e-mail or on floppy diskette or CD.

Use the checklist below to assure that you have completed all the parts of this application:

- ☐ MDH Grant Application Face Sheet
- ☐ MDH Project Information Sheet for EHDI Applications
- ☐ Project Description (Narrative) with Work Plan Framework
- ☐ Partners Chart
- ☐ Budget form and narrative

What Are The Reapplication Requirements?

You must write your application in a 12-point font with one-inch margins.

You must submit one signed unbound original and 4 copies, along with the same document on a floppy diskette or CD.

In order to be considered for 2006-07 EHDI Community Grant funding, you must
* Meet the reapplication deadline below
* Not fax or e-mail reapplications
* Not submit your reapplication late.

To meet the deadline, your reapplication must either:

* Be hand delivered to the address listed below and date-stamped upon delivery **before 4:30 p.m. on September 1, 2005**, or

* Have a legible postmark from the U.S. Post Office or a private carrier **dated on or before September 1, 2005**. We will not accept a postmark from a private, in-office metering machine as proof that you mailed your application on time.

If you send your reapplication via the U.S. Postal Service, you are encouraged to send it by registered mail and secure a receipt from the U.S. Postal Service.

WARNING: we will not be responsible for a reapplication lost in transit by a carrier.

Delivery Address

Attention: Leah Jones-Handy
Minnesota Department of Health
Office of Minority and Multicultural Health
Golden Rule Building, Suite 400
85 East Seventh Place
St. Paul, MN 55101

Mailing Address

Attention: Leah Jones-Handy
Minnesota Department of Health
Office of Minority and Multicultural Health
P.O. Box 64882
St. Paul, MN 55164-0882

You will be notified by November 15, 2005 by letter whether or not the Commissioner of Health has accepted your reapplication proposal; her decision is final. We reserve the right to negotiate changes to the budget you submit.

Following the Grant Award

What Will Be Required Of You Once 2006-07 EHDI Community Grant Funds are Awarded?

* Work with your OMMH EHDI Grant Manager to amend your current EHDI Community Grant contract.

* Comply with the requirements of your amended EHDI grant contract.

* Ensure that community representation is included in your EHDI project process.

* Participate in at least two (2) annual MDH-sponsored statewide or regional workshops for technical assistance, planning, evaluation, and other essential programmatic issues.

* Participate in the evaluation of the 2006-07 EHDI Community Grants Program. Your evaluation responsibilities will continue to include providing information to us twice a year using the integrated reporting system.

* Send OMMH a financial report (invoice) every three(3) months.

* Participate in conferences and workshops, and work with appropriate partners to make the results of your project available to the public health community and policy makers.

* Seek to establish relationships with other public and private groups to seek funding for your program when EHDI funding ends.

Final products produced with these funds must be reviewed and approved by OMMH staff prior to release. Please contact your grant manager for further guidance.

Reapplication Narrative:

Who Are You?

Briefly describe your organization, tribe, collaborative, etc. and the roles you and your partners play in this EHDI project.

- Describe your experiences working with the racial and/or ethnic group(s) you will address in this EHDI Community Grant reapplication proposal.
- Describe your experiences working with the priority health area(s) you will address in this 2006-07 EHDI Community Grant reapplication proposal.
- Describe the advisors and/or a board of directors that guides your work:
  - The make-up of that group
  - Their charge
  - How the members are or will be chosen
  - How they make their decisions
  - The racial/ethnic identities of members
- If you are a formal organization—such as a tribal government, private non-profit organization, community clinic, or faith-based organization:

  Describe:
  - What you do
  - How you do it
  - How you are organized and funded
  - How this proposal fits with your current work and resources
- If you are an informal group or unincorporated organization:
  - Describe
    - The makeup of your group or organization
    - Your past and present work together
  - Identify
    - What organization will take the lead in program implementation.
    - What legal entity will serve as your fiscal agent.
- Identify the race/ethnicity of key people involved in your EHDI project: management/ administration, and program positions. Describe their ability and experience to carry out your EHDI Community Grant activities.

- Describe partners, and their roles in your 2006-07 EHDI Community Grant work, and include them on your Reapplication Community Grant Partners Chart**. All partners are expected to complete a Memo of Understanding**. A model MOU is included in the forms following page 17, as is the Partners Chart.

The criteria considered here are:

- A description of the applicant, partners, and their roles in the EHDI project is provided.
- The applicant and partners have appropriate experience working with the intended racial/ethnic group(s).
- The applicant and partners have appropriate experience working on the intended priority health area(s).
- The group and/or board members and people in key program positions are appropriate for working with the intended racial/ethnic group(s).
- The applicant is well-suited for addressing the intended priority health area(s) with the intended racial/ethnic group(s) and for implementing the proposed continuation activities.

What Do You Plan To Do With the Grant Money?

The following pages contain specific instructions on describing in narrative form what you propose to accomplish with a 2006-07 EHDI Community Grant. **Please keep your narrative to 10 pages or fewer.** We encourage you to develop this reapplication with your community partners.

What will be your focus?

- What do you propose doing with 2006-07 EHDI Community Grant funding? How were these activities determined?
- Which priority health area(s) will you address, what is the extent of the racial/ethnic health disparity(ies), and how will you have an impact on it (them) (e.g., information, knowledge, behaviors, health status, etc.)?
- Describe the population(s) you will be working with, including race/ethnicity, gender, and age groups. Who will you try to reach?
- Identify the strengths and assets of the community and describe how they contribute to your work.

The criteria considered here are:

- The priority health area(s) to be addressed is (are) described.
- The 2006-07 EHDI Community Grant priority health area(s) described reflects community input, participation, and representation.
- The racial/ethnic population(s) chosen is identified and described.

- The health disparity between the racial/ethnic population(s) chosen and the white or general population and the extent of the disparity are described, and the extent of the disparity justifies the need for intervention.
- There is a logical connection between the chosen priority health area(s) and the racial/ethnic group(s).

What will you do?

- What activities will your 2006-07 EHDI Community Grant fund? How were they determined?
- Using the Work Plan Framework provided in the forms following page 17,

  list the grant activities and provide for each:

  1. The steps planned for the activity.

  2. Who will do the activities; describe the types and numbers of staff and partners needed. Include people already involved as well as new people who will be hired or become involved.

  3. The timeline for each activity.

  Here is what the framework looks like:

Work Plan Activities	**Who is Responsible:**		**Timeline:**	**Estimated Unduplicated Numbers to Be Reached**
	How Many and Which Staff?	**How Many and Which Partners?**		

In addition:

- Describe what you will develop, produce, or change. For example: policies or practices changed; events, workshops, or gatherings held; materials purchased or developed; curricula developed or implemented; and people screened at clinics.
- How will people in the communities you are proposing to serve be involved in activities development? How will they and others be involved in your 2006-07 EHDI Community Grant activities?
- Describe how the strengths and assets of the people and community will be incorporated into your proposed activities.
- As appropriate, how will you meaningfully include youth in your 2006-07 EHDI Community Grant planning and decision-making?

- How will your EHDI project relate to other activities? For example, describe how your EHDI activities will work with, coordinate with, and build on other activities in your community.
- **Please Note: Healthy youth development for teen pregnancy prevention grant funds cannot be used to provide cash benefits to individuals being served, including reimbursement for out-of-pocket expenses such as child care or transportation, because of restrictions by the federal funding source.**
- Other than EHDI Community Grant funding, what additional resources, if any, are needed for these activities? What are your strategies to acquire additional resources? What other organizational resources will you need to implement your activities that are not funded by EHDI? How will you get these? For example from:
    - Partners' resources
    - Philanthropic community
    - Other state and/or federal grants
    - Other public and/or private funding

The criteria considered here are:

- Information is provided and is adequate to understand and assess the appropriateness of the proposed activities.
- Proposed strategies are racially, ethnically, and culturally appropriate.
- Proposed strategies are appropriate for the priority health area(s).
- Proposed strategies reflect lessons learned in the previous grant cycles.
- Timelines and resources needed are reasonable.
- Steps needed to continue or implement the proposed strategies are appropriately identified.
- People who reflect the race and/or ethnicity of the community will continue to be meaningfully involved in the proposed activities.
- Community strengths and assets are identified and are incorporated appropriately.
- Appropriate cooperative relationships with other community organizations will continue to be established and in place.
- Proposed activities appropriately connect with related community activities, and will continue to appropriately connect.
- Needed resources not likely to be provided by this grant have been identified and a reasonable plan to pursue them is described.
- Explanation of how activities will improve the health status in the priority health area(s) is clear and convincing. The effectiveness of the proposed strategies will continue to be measured.
- Activities will likely contribute to a reduction in health disparities.
- Funding this EHDI project will continue to be a good use of these grant funds.

Evaluation

What are your plans for evaluation?

Evaluation has been an important part of the EHDI Community Grant funding in 2002-03 and 2004-05. It will continue to be so in the 2006-07 cycle. **The expectation in this funding cycle is that grantees should have outcomes for each Priority Health Area funded.**

Please submit the following evaluation materials in your proposal:

1. A current Outcome Model for your program
   The model should include each priority health area you plan to address along with outcomes and indicators for those areas.

2. Preliminary evaluation work plan
   The work plan should specify for each priority health area:
   - Outcome(s)
   - Indicator(s)
   - Data collection method(s)
   - Analysis
   - Reporting and utilization plans

If you have questions about developing this evaluation section, please review the EHDI Grantee materials on the Rainbow Research website: http://www.rainbowresearch.org/, click on Bulletin Board, the Eliminating Health Disparities Initiative. You may also contact your Rainbow Research Consultant.

The criteria considered here are:

- An outcome model is provided and addresses all proposed Priority Health Areas.
- The outcome model is appropriate to the activities and outcomes proposed.
- A preliminary evaluation work plan is provided and is appropriate to the outcome model.

Budget Materials

This grant money must be used to continue programs or activities currently funded by an EHDI Community Grant that reduce racial/ethnic health disparities. This money cannot be used to take the place of other funding you currently have for other organization and community activities.

Budget Form

Use the budget form in the materials following page 17. Show your proposed budget for the two-year 2006-07 Community Grant cycle. Include only the total amount for each line item; you do not need to include any detail on the budget form. You are applying for funding allocated for 24 months (January 1, 2006 – December 31, 2007).

Budget Description

Include with the budget form a narrative description (**three pages or fewer**) explaining the details of your 2006-07 EHDI Community Grant budget. Below are specific instructions on what to include in your budget description for each line item, as well as information about what you can and cannot spend this grant money on.

Remember that the total of your evaluation expenses must be at least 10 percent of your total proposed budget.

❖ Salary and Fringe Benefits

In your budget description, indicate for each position the name and title, the full time equivalent on this grant (see box below for a definition), the expected rate of pay, and the total amount you expect to pay the position for the entire 2006-07 Community Grant period. Grant funds can be used for salary and fringe benefits for staff members directly involved in your proposed activities.

> "Full time equivalent" (or FTE) is defined as the percentage of time a person will work on the EHDI project. To calculate the FTE, divide the hours the person will work by the standard number of work hours, which is 40 hours per week, 174 hours per month, or 2,088 hours per year. For example, a person who works 20 hours per week is a 0.5 FTE (20/40 = 0.5.)

Identify the FTEs for all bi/multilingual/cultural staff, as appropriate. How do they reflect the population(s) served?

Costs for other staff, such as supervisors or bookkeepers, should be reported on the administrative costs line item.

Indicate how much of the money you plan to spend on salary and fringe benefits will be used for evaluation-related activities.

❖ Contractual Services

In your budget description, list the services you expect to contract out, the contractor's name, whether the contractor is non-profit or for-profit, and the total amount you expect to pay the contractor for the entire grant period.

Grant funds can be used for small contracts such as facilitators, speakers, or trainers and for large contracts if other organizations are planning to provide different parts of your proposed activities. Before work begins, contractors must be approved by your EHDI Grant Manager.

Indicate how much of the money you plan to spend on contractual services will be used

for evaluation-related activities.

❖ Travel

In your budget description explain your expected travel costs, including mileage, hotel and meals. At a minimum, you must include the cost for at least one staff member to attend two MDH-sponsored statewide or regional meetings during each year. Grant funds cannot be used for out-of-state travel without prior written approval from us.

Indicate how much of the money you plan to spend on travel will be used for evaluation-related activities.

Travel paid for from these grant funds cannot be paid at a rate higher than:

Mileage	The current IRS rate is 40.5 cents per mile
Parking fees	Actual cost
Breakfast	$7.00
Lunch	$9.00
Dinner	$15.00
Hotel	Actual cost - within reason

❖ Supplies and Expenses

In your budget description, briefly explain your expected costs for such items as telephone equipment and service, postage, printing, photocopying, office supplies, materials, food at gatherings, and equipment. Include the costs you expect to have to ensure that community representatives who are included in your process can participate fully in the decision-making process. Examples include translators/interpreters, transportation, childcare, and stipends.

Grant funds may be used to purchase computers. We continue to rely on electronic means to communicate with you, so if you do not already have Internet access, include that cost. Grant funds may not be used to purchase any individual piece of equipment that costs more than $5,000.

Healthy Youth Development for Teen Pregnancy Prevention grant funds cannot be used to provide cash or reimbursement such as childcare or transportation.

Indicate how much of the money you plan to spend on supplies and expenses used for evaluation-related activities.

❖ Other Costs

In your budget description, explain very clearly any expenses you expect to have that do not fit on any other line item.

Grant funds cannot be used for:

* Direct patient medical services/care

* Treatment of disease or disability
* Capital improvements or alterations
* Cash assistance paid directly to individuals to meet their personal/family needs outside your proposed activities,
* Conference sponsorships
* Any cost not directly related to the grant

Indicate how much of the money you plan to spend on other costs will be used for evaluation-related activities.

❖ Administrative Costs

"Administrative costs" are defined as costs that represent the expenses of doing business that are not easily identified with a particular grant, contract, project, function, or activity but are necessary for the general operation of the organization and the conduct of activities it performs. Examples of such expenses include accounting, human resources, general agency administration, and costs to operate and maintain facilities. Administrative costs can be calculated as an indirect cost rate or through a cost allocation plan.

In your budget description, explain what kinds of administrative costs you expect to have. We will work with you to record how your administrative costs are calculated and how you charge them to this grant.

Your administrative costs cannot be more than 15 percent of the total of your other proposed expenses.

The criteria considered here are:

- The budget form is complete and correct.
- The information in the budget description is consistent with the proposed continuation activities.
- The costs projected are reasonable.

If you have any questions about anything in this proposal, please contact your grant manager.

Submitting Completed Proposals

Please complete the attached forms, and the required narrative portion of your proposal, and submit the original and 4 copies of these materials to:

Leah Jones-Handy
Office of Minority and Multicultural Health
Minnesota Department of Health

(US Postal Service mailing address)

PO Box 64882
St. Paul, MN 55164-0882

or

(Courier and street address)

Golden Rule Building Suite 400
85 East 7th Place
St. Paul, Minnesota 55101

To meet the deadline, your reapplication must be received at MDH before 4:30 p.m. on September 1, 2005, or have a legible postmark from the U.S. Post Office or a private carrier dated on or before September 1. 2005.

NO EXCEPTIONS

Resources

You may find the following additional resources and information useful in developing your proposal.

Rainbow Research, Inc. EHDI Grantee Materials:
http://www.rainbowresearch.org/ click on Bulletin Board, the Eliminating Health Disparities Initiative

Populations of Color in Minnesota Health Status Report, 2004
http://www.health.state.mn.us/divs/chs/POC/pocfall2004.pdf

Minnesota Census Data
http://factfinder.census.gov or call the Minnesota Center for Health Statistics at 651/297-1232

Minnesota County Health Tables 2004
http://www.health.state.mn.us/divs/chs/countytables/

Federal Office of Minority Health
http://www.omhrc.gov/omhhome.htm

Healthy People 2010
http://www.healthypeople.gov/About/goals.htm

Healthy Minnesotans – Public Health Improvement Goals for 2004
http://www.health.state.mn.us/divs/chs/phg/intro.html or call 651/296-9661

Strategies for Public Health
http://www.health.state.mn.us/strategies/

Community Engagement Website
http://www.health.state.mn.us/communityeng/

A Call to Action: Advancing Health for All Through Social and Economic Change
http://www.health.state.mn.us/divs/chs/mhip/action.pdf

And……

The Office of Minority and Multicultural Health website:

http://www.health.state.mn.us/ommh/

Click on the Eliminating Health Disparities Initiative, Fact Sheets & Publications, Resources, and Related Sites

ATTACHMENTS

Required Application Forms

Grant Application Face Sheet

Project Information Sheet

Partners Chart

Budget Sheet

Work Plan Framework

Memorandum of Understanding

Required Application Forms

An electronic version of these forms is available. Go to http://www.health.state.mn.us/ommh and click on "Request for Applications: Reapplying for Eliminating Health Disparities Initiative Community Grants Program" or call Leah Jones-Handy at 651/297-5813. You may also type or handwrite on the copy of the forms included in the paper copy of this Request for Proposals.

Minnesota Department of Health
Grant Application Face Sheet

Grant application for:
Eliminating Health Disparities Initiative Community Grants

1. Applicant agency with which grant contract is to be executed

Legal Name: | Street Address: | Telephone Number: ( ) | FAX Number: ( ) | E-Mail Address:

2. Director of applicant agency

Name and Title: | Street Address: | Telephone Number: ( ) | FAX Number: ( ) | E-Mail Address:

3. Fiscal management officer of applicant agency

Name and Title: | Street Address: | Telephone Number: ( ) | FAX Number: ( ) | E-Mail Address:

4. Operating agency *(if different from number 1 above)*

Name and Title: | Street Address: | Telephone Number: ( ) | FAX Number: ( ) | E-Mail Address:

5. Contact person for operating agency *(if different from number 2 above)*

Name and Title: | Address: | Telephone Number: ( ) | FAX Number: ( ) | E-Mail Address:

6. Contact person for further information on application *(if different from number 5 above)*

Name and Title: | Street Address: | Telephone Number: ( ) | FAX Number: ( ) | E- Mail Address:

7. Certification

I certify that the information contained herein is true and accurate to the best of my knowledge and that I submit this application on behalf of the applicant agency.

_____ _____ _____

Signature of Director of Applicant Agency	Title	Date

HE-01274-05 (4/01) - PART A IC# 140-428

Instructions for Completing Face Sheet

Please type or print all items on the Grant Application Form Face Sheet.

Applicants please note: The application form was designed to be used on all Special Project grants administered by the Minnesota Department of Health. If you have questions, or need assistance in completing the application form, please contact the program manager or consultant identified as responsible for the grant.

1. **Applicant Agency**
   Legal name of the agency authorized to enter into a grant contract with the Minnesota Department of Health, e.g., Community Health Board, Community Clinic, First Church/Synagogue/Temple, etc.

2. **Director of the Applicant Agency**
   Person responsible for directing the applicant agency.

3. **Fiscal Management Officer of Applicant Agency**
   The chief fiscal officer for the recipient of funds who has primary responsibility for grant and subsidy funds expenditure and reporting.

4. **Operating Agency**
   Complete only if other than the applicant agency listed in number 1 above.

5. **Contact Person for Operating Agency**
   Person who may be contacted concerning questions about implementation of this project.

6. **Contact Person for Further Information**
   Person who may be contacted for detailed information concerning the application or the project if different from number 5 above.

7. **Signature of Director of Applicant Agency**
   Provide original signature and date.

Minnesota Department of Health (MDH)

Project Information Sheet for Eliminating Health Disparities Initiative Community Grants Program Applications

1. Applicant Information		
Applicant Agency Name		
Minnesota Tax I.D. Number	**Federal Tax I.D. Number**	**Social Security Number**
Non-profit Status – 501.C3 form attached? ___ Yes ___ Not Applicable		

2. Proposal Information	
Project Funds Requested $	**Proposed Service Area (community, city, county or counties)**
Proposed Type of Grant 2006-07 Continuation Grant	
Proposed Target Population (indicate all that apply) ___ African American/African ___ American Indian ___ Asian American ___ Hispanic/Latino	
Proposed Priority Health Area (indicate all that apply) ❑ Breast & Cervical Cancer ❑ Cardiovascular Disease ❑ Diabetes ❑ Healthy Youth Development for Teen Pregnancy Prevention ❑ HIV/AIDS & Sexually Transmitted Infections ❑ Immunizations for Adults and Children ❑ Infant Mortality ❑ Unintentional Injuries & Violence	

HE-01274-05 (3/01) - PART B

Instructions for Completing Project Information Sheet for Eliminating Health Disparities Proposals

Please type or print all items on the Project Information Sheet for Eliminating Health Disparities Proposals.

1. Applicant Information

Provide name of applicant agency, Minnesota Tax I.D. Number (if applicable), Federal I.D. Number (if applicable), and/or Social Security Number (if applicable). Check the appropriate answer for 501.C3 status. Nonprofit agencies are required to provide a copy of their 501.C3 form with this form as evidence the agency is a non-profit institution, corporation or organization.

2. Proposal Information

Indicate the total amount requested, the proposed geographic service area, the proposed type of grant, the proposed target population(s), and the proposed priority health area(s).

Minnesota Department of Health

Partners Chart for Eliminating Health Disparities Initiative Community Grants Program Applications 2006-07 Continuation Grant Proposal

Applicant Agency: _____

Date Completed: _____

The EHDI emphasizes the importance of people working together in communities. We want to know who your partners are in your proposed planning or implementation activities, what experience you have already had in working together, and whom you contacted about this proposal. Use the grid below to provide information on your partners in your proposed activities. Attach as many copies of this form as you need.

Name of Partner Agency, Organization, Group, or Individual	Describe experiences you have already had in working together, if any	Describe the partner's role in your proposed activities	Key Contact Person and Phone Number

Minnesota Department of Health

Budget Sheet For
Eliminating Health Disparities Applications

Name of Applicant Agency:	
Name of Contact Person for Budget: **Phone:** **Fax:** **E-mail:**	
Proposed Type of Grant Continuation Grant (budget is for 24 months)	
Line Item	***Total Proposed Amount***
Salary and Fringe Benefits	$
Contractual Services	$
Travel	$
Supplies and Expenses	$
Other	$
Subtotal	$
Administrative Costs 15% maximum	$
Total	$

Include in the narrative section a description of your budget.

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The 2006-2007 EHDI Community Grant Proposal Work Plan Framework

Work Plan Activities	Who is Responsible:		Timeline:	Estimated Unduplicated Numbers to Be Reached
	How Many and Which Staff?	How Many and Which Partners?		

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Eliminating Health Disparities Initiative (EHDI)
Grantee Memorandum of Understanding

_____(Partner) will partner with

_____(EHDI Grantee) in the following Health Priority Area(s)*:*

____Breast & Cervical Cancer	____ Healthy Youth Development	_____ Infant Mortality
____Cardiovascular Disease	____ HIV/STIs	_____ Violence and Unint.
____Diabetes	____ Immunizations	Injury

Both the EHDI Grantee and the Partner commit to the following:
The Partner's role in project (Describe):

The Partner's resource contribution, if applicable (Describe):
(Example: staff time, meeting space, financial resources)

The benefit to EHDI grantee and/or EHDI project (Describe):

The benefit to the Partner (Describe):

Both parties understand this as a mutually beneficial agreement.

_____ _____
EHDI Grantee Representative Partner Representative

_____Date _____Date

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Appendices

A EHDI Statute

B Resource Information on the Eight Priority Health Areas

C Asset-Based Community Development

D Contributing Factors

E Social Conditions

F Potential Strategies and Community Partners

G Community Engagement

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Appendix A

Eliminating Health Disparities Initiative Statute

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Eliminating Health Disparities Initiative Statute

Minnesota Statute [145.928] ELIMINATING HEALTH DISPARITIES

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

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

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

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

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

Subd. 6. [PROCESS.] (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant

recipient with information on the outcomes established according to subdivision 3.

(b) A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. [COMMUNITY GRANT PROGRAM; IMMUNIZATION RATES AND INFANT MORTALITY RATES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

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

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

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

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

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

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

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

(3) is designed to complement other related community activities;

(4) utilizes strategies that positively impact both priority areas;

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 8. [COMMUNITY GRANT PROGRAM; OTHER HEALTH DISPARITIES.] (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

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

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

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

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

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

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

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social

service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

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

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

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

(3) is designed to complement other related community activities;

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 9. [HEALTH OF FOREIGN-BORN PERSONS.] (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

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

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

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

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

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

Subd. 10. [TRIBAL GOVERNMENTS.] The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

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

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

to conduct the evaluation.

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

Subd. 14. [SUPPLANTATION OF EXISTING FUNDS.] Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

Appendix B

Priority Health Areas Resource Information

Breast and Cervical Cancer
Cardiovascular Disease
Diabetes
HIV/AIDS/STIs
Immunizations
Infant Mortality
Teen Pregnancy Prevention
Violence and Injury Prevention

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Eliminating Health Disparities In Breast And Cervical Cancer

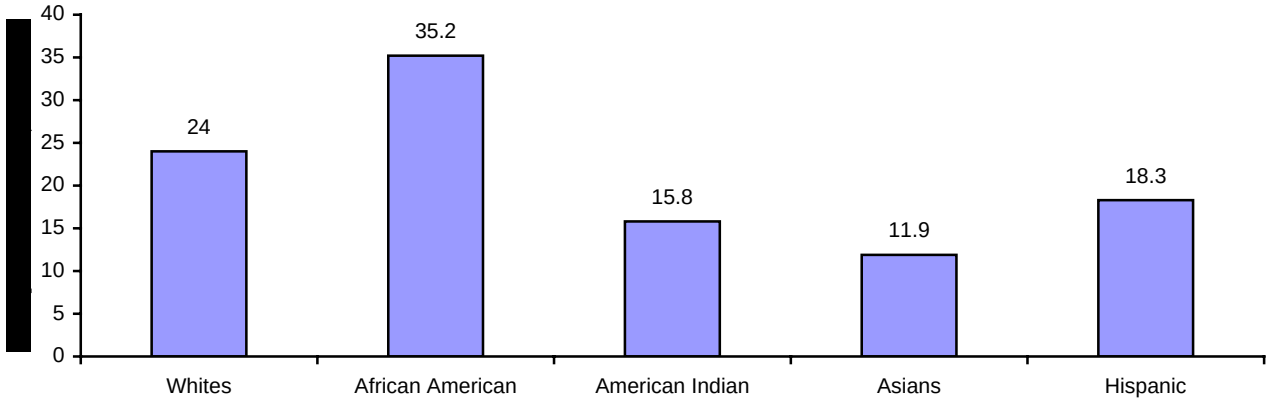
Background

Breast cancer. Breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer deaths. Each year approximately 3,600 women in the state are diagnosed with breast cancer and 670 die from it. Survival from breast cancer is directly related to the stage of the disease at the time of diagnosis. Approximately 97 percent of women who have their breast cancer detected in its earliest stages survive. The proportion of survivors drops to 21 percent for women whose breast cancer is diagnosed at a late stage.

The key to reducing deaths from breast cancer is routine screening with mammography and clinical breast examination so that the disease can be detected and treated in its earliest stages. Mammography is an especially effective early detection tool because it can identify a breast abnormality long before it can be felt by a woman or health care provider. Scientific trials have shown that widespread screening for breast cancer reduces mortality by 30 percent, which would translate into 210 fewer deaths per year in Minnesota.

Among the racial/ethnic groups in Minnesota, African American women have a breast cancer mortality rate that is 50 percent higher than that of white non- Hispanic/Latina women, despite similar incidence rates. A greater proportion of African American women have their breast cancers diagnosed at a later, less treatable stage. The other racial and ethnic minority groups have breast cancer mortality rates that are similar or significantly lower than that of white non-Hispanics.

Breast Cancer Mortality Rates by Race and Ethnicity
Minnesota 1990-99



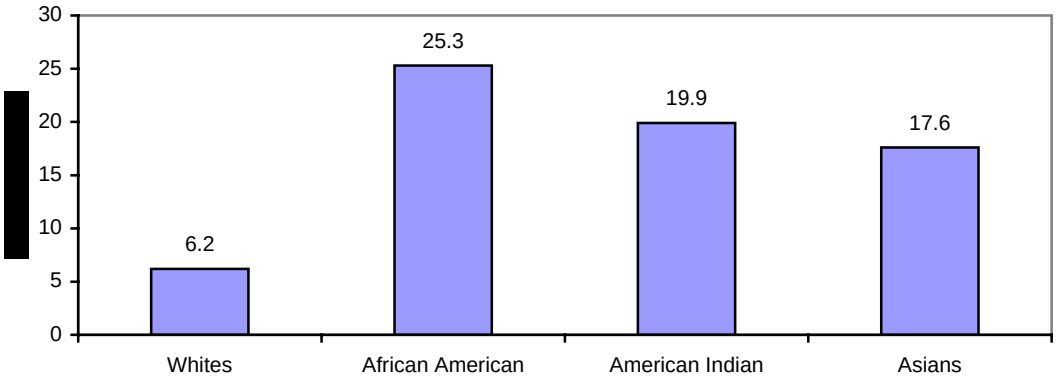
Source: Minnesota Department of Health, Minnesota Center for Health Statistics, mortality data

Cervical cancer. Approximately 200 women develop invasive cervical cancer and 50 die from

it every year in Minnesota. Thousands more develop pre-cancerous changes of the cervix that can progress to cancer if left untreated. Detected early, these pre-cancerous changes generally require less extensive treatment. Virtually all cervical cancer occurrence and death are preventable through regular screening with Pap smears and prompt treatment of pre-cancerous cervical changes.

Major health disparities exist among the state's racial and ethnic minority populations for cervical cancer. African American, American Indian, and Asian American women have cervical cancer incidence rates that are three to four times as high as the rate for white women. Deaths due to cervical cancer also occur at significantly higher rates among Asian Americans and African Americans compared with white non-Hispanics.

Cervical Cancer Incidence by Race
Minnesota 1995-1997



Source: Minnesota Department of Health, Minnesota Cancer Surveillance System

Contributing Factors

Breast cancer. All women are at risk for developing breast cancer. Most women have no identifiable risk factor other than age; the risk for developing the disease increases as women get older. The vast majority of women diagnosed with breast cancer have no family history of the disease.

In order to reduce deaths from breast cancer, all women age 40 and older should get regular mammograms and clinical breast examinations. Women with abnormal screening test results require prompt referral for diagnostic tests and treatment, if needed. Statewide survey data (2000 BRFSS) indicate that less than two thirds (61 percent) of women age 40 and over have had a mammogram in the past year. Minnesota's public health goal for 2004 targets a 90 percent screening rate for all women age 40 and over. Women cite economic, social, and cultural barriers to screening, referral, and treatment, such as cost, lack of or inadequate health insurance, poor access to health care, lack of physician recommendation, language, cultural beliefs and practices, fear, and knowledge gaps as reasons for not getting screened. Only 27 percent of

Minnesota women reported knowing that yearly mammograms were recommended for women starting at age 40. Lack of time and inconvenience have also been reported as barriers.

Cervical cancer. Invasive cervical cancer occurrence and death are entirely preventable. All women who are age 18 and older or sexually active should undergo regular screening with Pap tests and prompt treatment of significant pre-cancerous lesions. Statewide survey data indicate that 83 percent of women age 18 and over have had a Pap test within the past three years. Deaths from cervical cancer increase with age, yet screening rates drop among older women: 90 percent for women age 18-39 versus 64 percent for women age 65 and over. Minnesota's public health goal for 2004 targets a 99 percent screening rate for all women age 18 and over.

Barriers to screening for and treatment of cervical lesions include lack of health insurance, cultural beliefs and practices, and lack of knowledge about the need for on-going screening after childbearing years. African American women with significant cervical abnormalities may be less likely to get follow-up treatment.

Strategies For Intervention

The following strategies may be included in proposals to eliminate health disparities in breast and cervical cancer, but other strategies not listed here may also be included. Many of the strategies have been used successfully by the Minnesota Department of Health to recruit lower income, uninsured, and underinsured women to the Sage Screening Program (Sage). This program provides free breast and cervical cancer screening services at over 300 clinics statewide to women who meet certain age, income, and insurance eligibility guidelines.

< Hold "special screening days" that offer clinical breast exam, mammography, and Pap smear at convenient locations in the community (particularly lower income and rural communities), and use local outreach workers to promote the event and assist with patient navigation and follow-up. This strategy has been effective at recruiting different racial and ethnic minority groups, especially African American and Hispanic/Latina women, to Sage.

< Develop and disseminate culturally specific materials (brochures, pamphlets, videos, posters, flip charts) that have been peer-reviewed and tested with target audiences for cultural sensitivity, reading/comprehension level, and content accuracy. Use these materials in conjunction with other outreach strategies to educate and recruit women for screening.

< Hire and train a local lay recruiter or outreach worker to conduct "one-on-one" recruitment for screening to a community hospital or clinic, or to Sage. Lay recruiters who know their community can effectively identify and approach local businesses and organizations to directly recruit women for screening.

< Implement an "in-reach" system at a local health care setting (clinic, hospital, or private practice). Use nurses, lay health advisors, or senior aides to identify unscreened women in hospital specialty clinics and recruit them for screening. Conduct patient chart audits and develop a tickler system to identify women due for screening and prompt physicians to refer patients for screening. This strategy has been scientifically tested and shown to increase

breast and cervical cancer screening at a local clinic, particularly among American Indian women.

< Implement a peer-based program in a community setting to increase mammography use. This strategy uses social networks (e.g. churches, public housing, community groups) to influence women's screening behavior in groups by providing them with an opportunity to learn about the benefits of screening, share experiences and opinions about screening with peers, and commit to screening by making an appointment. This strategy has been scientifically tested and shown to increase breast cancer screening among low-income women in public housing.

< Develop a comprehensive appointment scheduling system that is convenient for women to use and assures that women complete their screening. Establish a toll-free phone line that women can call to locate free or low-cost screening services, obtain barriers counseling, and receive on-the-spot assistance with making an appointment, and that follows up with women to assure that they completed their appointments. This type of phone and follow-up system has been shown to greatly increase screening rates and reduce appointment no-shows for the Sage.

< Conduct local media campaigns using radio, television, or print combined with a toll-free number that women can call to learn about and access screening services. Offer to help women schedule appointments when they call.

< Improve access to free and low-cost screening services by targeting lower-income minority populations for the Sage using any of the strategies described above.

< Provide case management services for at-risk women. Case management is a collaborative process that involves individually focused assessment, planning, and coordination of services to meet an individual's health needs. It relies on good communication, knowledge of available community resources, and an ability to monitor the quality and outcomes of care for the individual.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in breast and cervical cancer in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

< More women are routinely screened for breast and cervical cancer according to guidelines.
< More women are knowledgeable about breast and cervical cancer screening guidelines.
< More women complete their screening appointments.
< More African American, Asian American, American Indian, and Hispanic/Latina women are screened through the Sage.
< More culturally specific cancer screening education materials are developed and disseminated.
< Fewer women are lost to follow-up, more women complete treatment, and time intervals

from screening abnormality to diagnosis and then from diagnosis to treatment are reduced.

< Propose to screen for breast and cervical cancer one woman per $200 in grant funds. As an example, the applicant proposes a budget of $20,000 to screen 100 women.

Resources

< Minnesota Sage Screening Program (Sage) website (www.health.state.mn.us/divs/hpcd/ccs/mbcccp.htm) or via the MDH website (www.health.state.mn.us)

< National Asian Women's Health Organization (NAWHO) (www.nawho.org) or 415/989-9747.

< Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program (www.cdc.gov/cancer/nbccedp/index.htm)

< American Cancer Society at (www.cancer.org) or 800/ACS-2345.

< Slater, J. et al. A Randomized Community Trial to Increase Mammography Utilization among Low-Income Women Living in Public Housing. Prev Med. 1998;27:862-870.

< Margolis, K. et al. Increasing Breast and Cervical Cancer Screening in Low-Income Women. J Gen Intern Med. 1998;13:515-521.

< Benard, V. et al. Race-Specific Results of Papanicolaou Testing and the Rate of Cervical Neoplasia in the National Breast and Cervical Cancer Early Detection Program, 1991-1998 (United States). Cancer Causes and Control. 2001;12:61-68.

< SHAPE 1998: Overall Comparison Report, Survey of the Health of Adults, the Population, and the Environment. Minneapolis, MN, December 1998. Hennepin County Community Health Department and Minneapolis Department of Health and Family Support. Call Hennepin County Community Health Department at (612) 348-3925 for a copy or visit the HCCHD website (www.co.hennepin.mn.us/commhlth/reports/shape.htm)

< Cancer in Minnesota: Racial and Ethnic Disparities. Minnesota Department of Health, Division of Chronic Disease Prevention and Control, October 2001.

MDH Contact

For more information about breast and cervical cancer, contact:

Mary Jo Mehelich
612/676-5551
mary.mehelich@health.state.mn.us

Eliminating Health Disparities In Cardiovascular Disease

Background

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease, stroke, high blood pressure, and rheumatic heart disease. Heart disease is the second and stroke is the third leading cause of death in Minnesota. Mortality rates for Minnesotans overall are lower than the nation as a whole; however, for certain segments of the population, including American Indians, African Americans, and Asians, mortality rates for heart disease or stroke are higher than the overall state population rates. American Indian death rates from 1990 through 1998 were 33 percent higher than the state's population rates and 44 percent higher than the total U.S. American Indian rates.

Among women, African Americans die from heart disease more frequently - particularly at younger ages - than whites and women of other race and ethnic groups. Asians living in Minnesota are more likely than other population groups to suffer from stroke. For additional data, refer to http://www.health.state.mn.us/cvh.

Contributing Factors

Arteriosclerosis (hardening of the arteries), the underlying disease process of the major forms of CVD, begins in childhood and slowly progresses throughout a person's lifespan. Arteriosclerosis is associated with several modifiable risk factors, including high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, obesity, and poor diet. Control of modifiable risk factors at the population and individual level is key to preventing CVD and its complications.

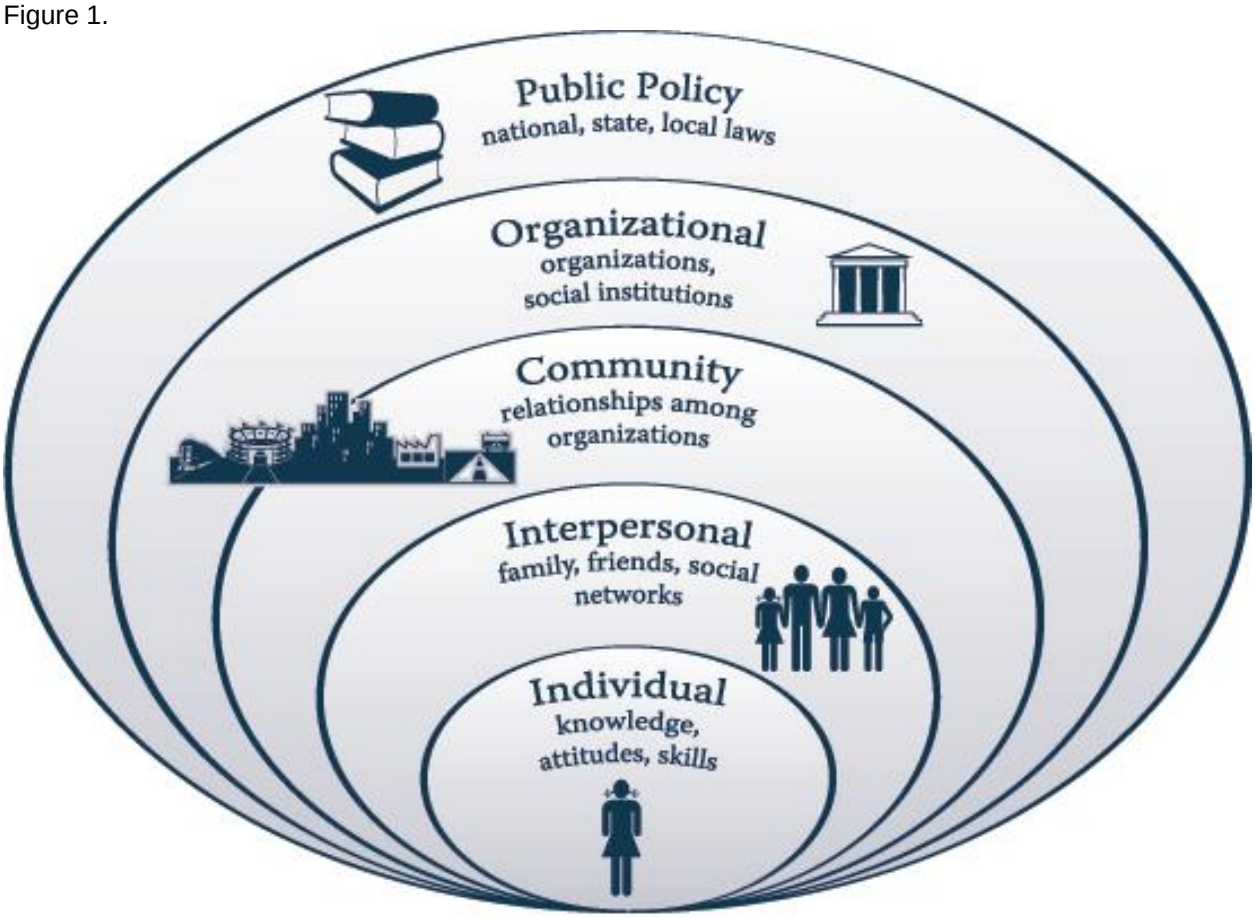
CVD incidence and mortality rates are higher among people of lower socioeconomic (SES) status. The greatest declines in CVD mortality over time have been among those at the highest income and educational levels. These differences have been attributed to the greater prevalence of risk factors (e.g., obesity, lack of exercise, high blood pressure, smoking) within lower SES populations and to the effects of neighborhood socioeconomic status.

Strategies For Intervention

There are many different strategies aimed at reducing risk factors for cardiovascular disease and thus improving the health of communities and individuals.

In the past, some health promotion interventions have primarily been focused on changing the behaviors of individuals or small groups of individuals, such as helping individual smokers to quit. Recently, more focus has been directed towards the systems (i.e., health care, education, community/neighborhood, organizations, etc.) that surround the individuals, and impact and influence behavior choices. The Socio-Ecological Model (Figure 1) depicts how the surrounding systems affect individual's behavior. These systems have the opportunity to promote, support, and reinforce healthy behaviors by implementing interventions that contribute to the reduction of heart disease and stroke.

Figure 1.



These system-level interventions are also referred to as population-based approaches, because they can impact larger segments of the population simultaneously. The two types of population-based approaches are called policy interventions and environmental interventions.

1.) Policies include laws, regulations, and rules (both formal and informal). Examples: organizational rules that provide time off during work hours for physical activity, or promoting heart-healthy, low-fat food options at community, organizational, social, and educational events.

2.) Environmental interventions are changes that are made to the economic, social, or physical environments. Examples: incorporating walking paths (or improving existing walking paths) into community development plans; removing ashtrays from conference meeting rooms; and making low-fat choices available in cafeterias and vending operations.

For the context of this grant, sample strategies, primarily directed at the policy and environmental level, are described. Prospective applicants may also propose other proven public health strategies to address cardiovascular disease disparities.

Note: This document includes references to tobacco, harm from tobacco, and creating smoke-free places. These references should be interpreted as commercial tobacco and its misuse. The EHDI grant recognizes the sacred use of tobacco in the American Indian community, which has an important cultural role.

Strategy 1. Setting: Communities

Create supportive environments that encourage physical activity, healthy food choices, and/or tobacco reduction in communities.

Neighborhoods and communities can work with community leaders to identify barriers and supporters of healthy diet, physical activity, and tobacco use. Some ideas of how partnerships can work toward developing a heart healthy community are: promoting access to affordable fresh fruits and vegetables by increasing and promoting farmers' markets, co-ops, green grocers, community gardens, and produce vendors; improving safety of public recreational spaces such as parks, neighborhood streets, sidewalks, and/or community centers; increasing time available for safe public use of recreational facilities, such as ice rinks, schools, and parks; collaborating with businesses, schools, city planners, and transportation officials to improve pedestrian safety and walkways to increase walkability; developing neighborhood and community walking clubs; promoting smoke-free environments that eliminate smoking through education about, and adoption of, policies at community events and parks; and, offering culturally appropriate heart healthy cooking classes in community-based locations. Some tools or examples are:

< Safe Routes to School Programs (http://www.saferoutestoschools.org/) are implemented in a variety of towns and cities. Parents, school staff, traffic engineers, and others are key players in improving the health of kids and the community by making walking and bicycling to school safer. A model Safe Routes program is in Marin County, a suburban community of San Francisco (http://www.saferoutestoschools.org/marin.html). Nine pilot schools in different geographic locations were recruited to participate, and each one received guidance, forms, newsletters and other promotional materials. Every school held periodic Walk and Bike to School Days and sponsored the Frequent Rider Miles contest which rewarded children who came to school walking, biking, by carpool, or bus. At the end of the pilot program the schools experienced a 57% increase in the number of children walking and biking and a 29% decrease in the number of children arriving alone in a car. Resource materials and starter kits are available at http://www.walktoschool-usa.org/srts-start/.

< Practical guides and tools are available for community members to assess their neighborhoods' conditions for walking or biking. These hands-on tools can be used to make neighborhoods more walking and biking friendly. Small changes can make a difference in promoting walking or biking. To view these tools and determine how to implement them in a Minnesota town, city, or tribal community, visit the National Center for Bicycling & Walking at http://www.bikewalk.org/index.htm or the Minnesota Department of Health at http://www.health.state.mn.us/divs/hpcd/chp/opach/pdf/walk.pdf .

< Starting or Promoting Farmers' Markets**.** Access to quality and reasonably priced produce is essential to increasing fruit and vegetable consumption. A farmers' market should provide an outlet for the farmer to profitably sell produce and to make fresh, wholesome produce available to people who would not have otherwise had an opportunity to receive it. Starting a farmers' market requires community planning and collaboration. The Minnesota Farmers Market Association (http://www.mfma.org) provides technical support and guidance. The Minnesota Department of Agriculture also provides many resources (http://www.mda.state.mn.us/mgo/farming/farmers_markets.htm) to support farmers' markets. Research findings from a Washington, D.C. case study are provided in *Improving and Facilitating a Farmers Market in a Low-Income Urban Neighborhood*:

http://www.ams.usda.gov/directmarketing/anacostia%5B1%5D.pdf. Prospective applicants can facilitate the development of a new farmers' market, or encourage and promote the utilization of existing farmers' markets.

< Adopting smoke-free community events. An effective tobacco prevention strategy is working with community leaders and organizers of community events to make them smoke-free, including pow-wows, ethnic events, and community celebrations. Smoke-free events can be promoted in flyers and brochures, and signs should be posted at events indicating that they are smoke-free.

< Promotoras model. In the Latino community, the promotoras model in Minnesota has been very successful. This model includes the recruitment and training of promotoras (i.e., community health workers) to educate the community on the harms of smoking and the harms of secondhand smoke and to educate on the importance of smoke-free policies.

< Not in Mama's Kitchen (www.pbs.org/ttc/health/afamtobacco.html) reduces exposure to secondhand smoke by encouraging African American women to prohibit smoking in their homes and cars. Similar types of programs can be implemented in other communities to encourage people to make their homes smoke-free. For example, in the American Indian community, an effective strategy can be posting "this is a smoke-free home" sign versus having to tell their guests not to smoke in the home.

< Work with local retailers who sell tobacco to place advertisements out of close view of children (for example, at a height that only adults would view) or to remove tobacco advertising altogether.

Strategy 2. Setting: Schools

Create supportive environments and conduct educational programs that encourage physical activity, healthy food choices, and/or tobacco-free communities in schools.

Schools provide an important opportunity to learn, practice, and enjoy physical activity and healthy eating behaviors. In recent years, schools have reduced time for physical education. Communities can work with the schools to implement policies that increase time for physical activity, including time for unstructured physical activity. Schools provide a setting where food and beverage choices are available not only for school meals, but also for social events and other snacks during and after school. Schools can consider the impact of these choices and identify ways they can maximize them as learning opportunities. Schools can develop and implement a nutrition policy that supports the development of healthy nutritional practices including healthier snacks and low-caloric beverages in vending machines.

Research demonstrating the effectiveness of school-based programs in influencing children's eating patterns has occurred at the elementary school level including the Child and Adolescent Trial for Cardiovascular Health—CATCH (http://www.epi.umn.edu/cyhp/r_catch.htm), the Minnesota Heart Health Program, and the 5 A Day Power Plus Program (http://www.epi.umn.edu/cyhp/r_5aday2.htm). The most successful programs are behaviorally focused, devote adequate time and intensity, incorporate self-evaluation or self-assessment and feedback, and intervene in the school environment to support behavioral change.

Schools are also an excellent environment to discourage smoking among youth by prohibiting tobacco use by students and staff in the school environment, including school grounds and school-related

activities.

Some examples:

< Food on the Run is a school-based program for high school age youth. It trains teens in physical activity, nutrition, policy and the media using the "Jump Start Teens" and "Playing the Policy Game" resource kits developed by the California Project Lean. Through this program, teens serve as advocates for increased physical activity opportunities and healthy eating in the community. In addition, high school students participate in advancing policy and environmental changes that promote healthy eating and physical activity at school and in the community. At the same time, students are motivated to make healthier choices themselves. For a list of materials, background reports and order information visit www.dhs.ca.gov/lean or contact the California Project Lean with the California Department of Health at (916) 552-9907.

< WOLF – Work Out Low Fat project grade 1-4 curriculum, was developed and revised by the MDH Diabetes Unit and partners, including the University of Minnesota, Ginew Golden Eagles, and representatives of Minnesota's American Indian tribes. WOLF is a school-based behavioral curriculum, promoting physical activity and healthy eating to prevent risk factors of type 2 diabetes. The curriculum incorporates American Indian traditions. Students actually learn and practice healthy behaviors during the sessions such as being physically active and tasting and preparing low-fat snacks in the classroom. For information on how this project can be integrated into other communities, or to receive an order form, contact the Minnesota Department of Health Diabetes Program at (651) 281-9849.

< American Indian Children Walking For Health. This pilot project for elementary school children has been completed in grades 3-4 at Red Lake Elementary and Ponemah Elementary Schools with approximately 100 children and 7 classrooms. The program promotes 20-30 minutes of daily walking during the school day. The goal of the pilot project has been to assess the feasibility of a school-based environmental change for promoting increased physical activity among American Indian children to reduce their risk of obesity. It included a policy change to incorporate the walking time into the school schedule, adjusting academic schedules to allow for walking and ensuring gym and hallway availability for indoor walking during poor weather. The program was developed as a collaborative project with the Red Lake School District, Red Lake Band of Chippewa Indians, Cass Lake School District, Leech Lake Band of Ojibwe, and the Minnesota Department of Health, funded by National Institute of Diabetes and Digestive and Kidney Diseases. The Walking for Health Advisory Team guided the program's development and implementation. Evaluation of effects of the walking program on body fat, body mass index (BMI), and attitudes towards physical activity are underway; initial results on body fat appear promising. For information on how to initiate and implement an elementary school walking program, contact Rita Mays, Project Coordinator, Minnesota Department of Health at (651) 281-9816.

< Implementing culturally-specific tobacco prevention curricula. Schools with a high ethnic population may require culturally specific tobacco prevention curriculum. In some cases a culturally specific curriculum may exist, and in other cases it may need to be developed based on the unique needs of the community in which the curricula will serve. Curricula may be implemented in school programs, in ESL classrooms, or in after school activities.

< Adoption and enforcement of school-based tobacco policies. It is important to have policies in place that eliminate smoking on school grounds and at school events to promote the social norm that (commercial) smoking is not an acceptable behavior. Most Minnesota schools should already have tobacco-free school policies in place, but they do not always include school grounds and/or school events. EHDI grantees could work with schools in their communities to assure that smoking is not allowed on school grounds or school events.

Strategy 3. Setting: Work Sites

Create supportive environments and conduct educational programs that encourage physical activity, healthy food choices and/or tobacco reduction in work sites.

Work sites offer important opportunities for providing healthy choices for adults; demonstrating ways to incorporate physical activity and healthy eating choices into their day-to-day lives; providing information and education to help workers and their families to live healthier lives; and, creating environments that support workers' healthy choices. Environmental supports include providing opportunities for physical activity at the work site and facilitating their use, providing healthy choices with on-site food service through vending machines or cafeteria food service, and developing work site nutrition policies that offer guidelines and suggestions for healthy food choices offered at meetings and events. Some work sites may be able to negotiate options for employee use of area recreation facilities at dedicated hours or for reduced fees. Flexibility in the use of lunch and other breaks will facilitate employees' use of some of this time for physical activity. Employee walking clubs or sports teams can also encourage regular physical activity. Work sites can provide education about healthy living through newsletters, presentations, and other materials.

Work site interventions are moving in the direction of a public health approach, designed to include all employees at the work site, rather than directed only at high-risk individuals. Detailed data are available demonstrating the success of highly targeted and individualized programs, including coordination with health care providers and risk-appropriate counseling and education. Intervention strategies involving a broader employee population with demonstrated success have included the tailoring of interventions to people's needs, experiences, and stages of change; timing of intervention strategies to reinforce new behaviors and prevent relapse; peer involvement and support; and community support at all levels.

The most successful work site programs are integrated with occupational health providers. These programs assess individual risk and tailor work site programs to meet individual needs. The work site, in many ways, becomes an extension of the health care system and provides the education and skill-building opportunities to support needed behavioral change.

Some examples:

< StairWELL to Better Health**.** The CDC's Division of Nutrition and Physical Activity conducted a study (http://www.cdc.gov/nccdphp/dnpa/stairwell/) to see if making physical changes to a stairwell in the Atlanta-based Koger Center Rhodes Building, combined with music and motivational signs would motivate employees to use the stairs. A four-stage intervention was implemented over 3½ years that included painting and carpeting, framed artwork, motivational signs, and music. StairWELL to Better Health was a low-cost intervention, and the data suggest that physical improvements, motivational signs, and music can increase physical activity among building occupants.

< Smoke-free work site policies. There has been a lot of momentum around the state related to smoke-free work site policies, including restaurants and bars. EHDI grantees can make an impact in their community by supporting existing work site policies and/or encouraging additional work site policies to take place. Support can come in a variety of forms, including providing educational materials in appropriate languages to ethnic work sites, such as ethnic restaurants that may be impacted by a smoking ordinance. Support may also come in the form of encouraging individual work sites to adopt smoke-free policies in order to support the overall movement towards creating tobacco-free communities. Education on the dangers of secondhand smoke, in order to impact policy change or support, is a critical element of effective policy and environmental change strategies.

Strategy 4. Setting: Health Care Organizations

In conjunction with health care organizations or programs, provide community-based screenings, referrals and follow-up protocols for underserved and at-risk populations.

Research has demonstrated that lowering blood cholesterol reduces the risk of heart disease and evidence strongly indicates the importance of blood pressure control in the prevention of stroke. Studies conducted in a variety of settings have demonstrated that targeted screening is effective when individuals needing interventions are identified, and given tailored referrals for services or programs that will facilitate treatment and behavioral changes.

Follow-up activities include assisting individuals to find appropriate community-based sites where high blood pressure and hypertension can be treated. Culturally appropriate programs for weight management, aerobic physical activity, smoking cessation, and low-fat cooking will support behavioral changes. Examples are described in the Heart Disease and Stroke Prevention Program's literature reviews at http://www.health.state.mn.us/divs/hpcd/chp/cvh/reports.htm.

Strategy 5. Setting: Health Care Organizations

Encourage regular physician communication and brief counseling regarding physical activity, eating habits, and tobacco cessation in health care settings.

Numerous studies have shown that physicians and other health care professionals have a central role in providing preventive services. Consumers also consistently identify physicians and nurses as primary sources of health information and consider their advice on health promotion activities to be a primary motivator for behavior change. Clinic staff may increase the consumers' motivation by participation in the activity.

Health care professionals should stress and encourage behavioral change, support individuals in overcoming barriers, make referrals to other providers or programs when appropriate, and recognize when patient changes are made. Special attention should be focused on populations who are disproportionately at risk, such as people with disabilities, low incomes, less education, American Indians and populations of color, the elderly, and those with other risk factors such as physical inactivity, smoking, and obesity. Tools and resources about health professional communication and counseling in health care delivery settings are available at http://www.preventioninstitute.org/sa/enact/healthcare/index.html and http://www.thecommunityguide.org/tobacco/.

Strategy 6. Setting: Health Care Organizations

Provide training to health professionals about screening and counseling in a culturally appropriate and sensitive manner.

According to the Guide to Community Preventive Services and the U.S. Department of Health and Human Services' Office of Minority Health, a significant need for culturally competent health care and health care systems exists. One suggested strategy has been to increase the cultural diversity training for health professionals. Providing health care professionals with adequate background information on how to communicate with people from various cultures is a step towards ensuring a trusting and safe health care environment for the health care patient.

The Center for Cross-Cultural Health (http://www.crosshealth.com/) and the California Endowment (http://www.calendow.org/reference/publications/pdf/cultural/managers_guide.pdf) provide tools and resources for cultural diversity training for professionals.

Strategy 7. Setting: All

Create supportive environments that encourage physical activity, healthy food choices, and discourage tobacco use through the media.

Effective public information campaigns can provide consumers with the information they need to incorporate healthy habits in their daily lives, including healthy eating habits, physical activity, and discouraging tobacco use. Public information campaigns support efforts to promote environments and community norms that lead to healthy eating, physical activity, and discourage tobacco use. Media coverage of campaigns or events can add additional reach and impact a message. For example, research on community-wide health promotion and disease prevention strategies that promote regular physical activity and/or nutrition has shown that public information is a critical component in changing a community's behavior and improving community health status. The presence of public information campaigns used in conjunction with active community coalitions, widespread community involvement, and well-organized community efforts are important in increasing physical activity levels and the level of readiness among community members to change their eating habits.

The primary goal of a public information strategy is to change perceived norms that are favorable to healthy behavior, such as tobacco cessation. Tobacco use norms can be changed by increasing people's exposure to negative messages about using tobacco or to positive messages about not using tobacco and by increasing people's ability to identify hidden messages (e.g., "smoking is glamorous and sophisticated") in tobacco advertising and tobacco-industry marketing tactics. This strategy has been most widely used with specific groups that are often targeted by tobacco industry advertising, including children, women, and populations of color. The research evidence strongly suggests that counter advertising is effective in changing the attitudes of adolescents about tobacco use.

Media advocacy can be an effective tool for promoting environmental change and supporting adoption of policies that promote health. Media can be purchased (e.g., TV or radio advertisements) or secured at no cost through community newspaper articles or cable TV station coverage.

Examples and resources include:

< Local media are often interested in stories and information that describe community activities or

provide useful information to their audiences. Plan a community event, for a targeted audience, which offers community members the opportunity to build skills or confidence in healthy eating patterns and promotes fun in physical activity. Nutrition events might focus on choosing or preparing new or unfamiliar foods, promoting healthy eating as a family or community activity, or informing community members about a new opportunity for healthy eating (e.g., a new restaurant with healthy menu items or the annual opening of a farmers' market). Physical activity events could focus on promoting physical activity as a family or community activity, or informing community members about a new opportunity for recreation (e.g., a new walking or biking trail, a new ice rink, or other facility).

< The American Heart Association (http://www.americanheart.org) and the National Heart, Lung, and Blood Institute (http://www.nhlbi.nih.gov/health/hearttruth/index.htm) have existing communication campaigns with tools that promote the message of heart disease prevention. These materials can be adapted and implemented for communities throughout Minnesota.

< do > is a social marketing program designed to promote everyday physical activity in three 10-minute bits each day. Several resources and tools are available for businesses, faith communities, schools and community groups to implement do>. Point of decision prompts, signage and other tools can be ordered on-line. For more information visit http://www.do-groove.com or http://www.do-groove.com/order, email do@bluecrossmn.com or contact Amy Lyons Sayers at BlueCross BlueShield of Minnesota at (651) 662-3378.

< An effective media strategy to support a policy change in the community (for example an ordinance restricting or eliminating smoking in restaurants and/or bars), may include placing advertisements in appropriate ethnic newspapers educating on the harms of secondhand smoke or encouraging people to support smoke-free restaurants in their community.

Strategy 8. Setting: Faith-Based Organizations

Creating supportive environments that encourage physical activity, healthy food, and/or tobacco- free choices in faith-based organizations.

Faith-based organizations can play an important role in supporting and promoting population-based health behaviors. Faith communities (e.g., synagogues, churches, mosques, etc.) are places that maintain contact with large groups of people throughout the life cycle—from birth until death. They also are a trusted resource for information and activities, thereby increasing the credibility of programs offered and the likelihood of participation. An example is:

> The North Carolina Black Churches United for Better Health (BCUBH) Project. The target audience for this project was 2,519 African American members of 24 black churches in rural North Carolina. Activities targeted predisposing factors (e.g. personalized bulletins to each church member; posters, banners, etc.), enabling factors (e.g. planting gardens for fruit trees, conducting educational sessions, etc.), and reinforcing factors (e.g. training lay health advisors in each church, forming coalitions, promoting farmers' markets, etc.). Serving more fruits and vegetables at church functions was the activity that had the highest overall impact. Other activities with high impact included the personalized, tailored bulletins, pastor sermons, and printed materials.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in cardiovascular disease in American

Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

Behavior Outcomes:
More people are physically active on a regular basis.

More people have a heart-healthy diet (increases in fruit and vegetable consumption, decreases in saturated fat and/or caloric intake).

Fewer people smoking.
More people diagnosed with high blood pressure or high blood cholesterol adhere to their medication regimens.

Health Outcomes:

Fewer people are overweight.
Fewer people are obese.
Fewer people have high blood pressure.
Fewer people have high blood cholesterol.
More people with diabetes whose diabetes is under control.

Resources

Articles

< Demark-Wahnefried, W. et al., (2000). *The North Carolina Black Churches United for Better Health Project: Intervention and Process Evaluation.* Health Education & Behavior, Vol. 27, No. 2, 241-253.

< Kerr, N.A., Yore, M.M., Ham, S.A., & Dietz, W.H. (2004). *Increasing Stair Use in a Worksite Through Environmental Changes.* American Journal of Health Promotion, 18 (4): 312–315.

< Pargee D, Lara-Albers E, Puckett K. (1999). *Building on Tradition: Promoting Physical Activity with American Indian Community Coalitions.* Journal of Health Education, 30 (supplement 2): s37-s43.

< Resnicow, K., et al., (2000). Dietary Change through African American Churches: Baseline Results and Program Description of the Eat for Life Trial. Journal of Cancer Education, Vol.15 (3): 156-16.

< Schmid, T.L. and Howze, E. (1995). Policy as Intervention: Environmental and Policy Approaches to the Prevention of Cardiovascular Disease. American Journal of Public Health. Vol 85. No 9, pp 1207-1211.

< Yanek. L.R., et al., (2001). *"Project Joy": Faith Based Cardiovascular Health Promotion for African American Women.* Public Health Rep. 2001;116 Suppl 1:68-81.

Reports

< Minnesota Department of Health. *2004 Minnesota Worksite Health Promotion Survey, Results and Recommendations.* Provides survey results and recommendations about the policies and environmental strategies Minnesota worksites employ to address cardiovascular health. http://www.health.state.mn.us/divs/hpcd/chp/cvh/pdfs/worksitereport.pdf .

< Minnesota Health Improvement Partnership Social Conditions and Health Action Team. (2001). *A Call to Action: Advancing Health for All through Social and Economic Change.* http://www.health.state.mn.us/divs/chs/mhip/action.pdf.

< National Heart, Lung and Blood Institute (2003). *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) Express*. http://www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm.

> Satter, E. (1987). *How to Get Your Kid to Eat But Not Too Much*. Palo Alto, CA: Bull Publishing Company.

< U. S. Department of Agriculture (2005). *Making it Happen! School Nutrition Success Stories.* http://www.fns.usda.gov/tn/Resources/makingithappen.html.

≤ U.S. Department of Health and Human Services. (1993). *Promoting Healthy Diets and Active Lifestyles to Lower-SES Adults, Market Research for Public Education.*

< U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (1997). *Unrealized Prevention Opportunities: Reducing the Health and Economic Burden of Chronic Disease*.

< U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (1999). *Promoting Physical Activity: A Guide for Community Action.* Note: A limited supply of these books are available free by contacting the Minnesota Department of Health staff listed at the end of this appendix.

Other websites

General:

< *American Heart Association*: http://www.americanheart.org.

< *Cardiovascular Health Program* – Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion: http://www.cdc.gov/cvh/ .

< *Diversity RX* – promotes language and cultural competence to improve the quality of health care for minority, immigrant and diverse communities: http://www.diversityrx.org/HTML/DIVRX.htm .

< *ENACT*, a tool developed by the Strategic Alliance, outlines healthy policies for several risk factors in children's environments, health care, business and government: http://www.preventioninstitute.org/sa/enactpriorities_WK.html .

< *Minority Populations Gateway* – a link to NHLBI information that is specifically designed for the American Indian, African American, Hispanic/Latino and Asian communities: http://hin.nhlbi.nih.gov/minority/minmain.htm.

< *Minnesota Department of Health, Heart Disease and Stroke Prevention Program:* http://www.health.state.mn.us/cvh

Descriptions of cardiovascular intervention strategies in various settings:

http://www.health.state.mn.us/divs/hpcd/chp/cvh/reports.htm
Data:
http://www.health.state.mn.us/divs/hpcd/chp/cvhdata/index.html
Resources and tools:
http://www.health.state.mn.us/divs/hpcd/chp/cvh/resources.htm

< *National Institute of Neurological Disorders and Stroke:* http://www.ninds.nih.gov/disorders/stroke/stroke.htm.

< *National Stroke Association, Minnesota Chapter*: http://www.strokemn.org.

< *The Center for Cross-Cultural Health* is a Minnesota-based organization that strives to integrate the role of culture in improving health: http://www.crosshealth.com.

< *The Guide to Community Preventive Services* provides recommendations regarding population-based interventions to promote health and prevent disease: http://www.thecommunityguide.org.

High Blood Cholesterol:
< *National Cholesterol Education Program:* http://www.nhlbi.nih.gov/about/ncep/.

High Blood Pressure:
< *National High Blood Pressure Education Program, Mission Possible*: http://www.nhlbi.nih.gov/.

Obesity:
< *National Heart, Lung, and Blood Institute, Obesity Education Initiative:* http://www.nhlbi.nih.gov/about/oei/index.htm.

< *Minnesota Department of Health:* http://www.health.state.mn.us/divs/hpcd/chp/obesity/.

Physical Activity and Nutrition:
< *5-A-Day* – a national partnership that seeks to increase consumption of fruits and vegetables to 5 or more servings each day. Materials and technical assistance are available: http://www.health.state.mn.us/divs/hpcd/chp/5aday/ or contact Fran Doring, MDH Obesity, Nutrition, Physical Activity and Chemical Health Unit, (651) 215-9843.

5 A Day Power Plus Program: School curriculum promoting fruits and vegetables intake among children: http://www.health.state.mn.us/divs/hpcd/chp/powerplus/index.htm.

< *ACES: Active Community Environments Initiative,* sponsored by the Centers of Disease Control and Prevention, promotes walking, bicycling, and the development of accessible recreation facilities: http://www.cdc.gov/nccdphp/dnpa/aces.htm.

< *Active Living Research* investigates policies and environments to support active communities: http://www.activelivingresearch.org/.

< *Fit, Healthy and Ready to Learn* – a resource tool that focuses on helping schools districts and schools adopt and implement effective policies. National Association of State Boards of Education (800) 220-5183, http://www.nasbe.org/healthyschools/fithealthy.html.

< *Kidswalk-to-School– A Guide to Promote Walking to School:* http://www.cdc.gov/nccdphp/dnpa/kidswalk/.

< *Minnesota Department of Transportation*, Office of Transit, Bicycle and Pedestrian Section: http://www.dot.state.mn.us/sti/.

< *Robert Wood Johnson Foundation,* provides several reports that discuss the relationship between the physical environmental and physical activity, such as:
- *Active Living Diversity Project Report*
- *Healthy Community Design: Success Stories from State and Local Leaders*

Retrieve information at http://www.rwjf.org/publications/otherlist.jsp or call (888) 631-9989.

< *School Health Index: A Self-Assessment and Planning Guide.* For more information call Centers for Disease Control and Prevention (888) 231-6405 or http://apps.nccd.cdc.gov/shi/.

< *The Metropolitan Design Center* provides expertise in how design can make the metropolitan landscape more liveable. The Center specializes in active and healthy cities, and provides technical assistance and consultation to select communities and organizations: http://www.designcenter.umn.edu.

< *VERB – It's What you do.* is a national social marketing campaign directed towards promoting physical activity in young people ages 9-13: http://www.cdc.gov/youthcampaign.

Tobacco:

< *California Black Health Network:* http://www.cbhn.org/CTEP.html.

< *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Community Actions and Practices:* http://apps.nccd.cdc.gov/CAPS/.

< *Minnesota Department of Health, tobacco prevention resources:* http://www.health.state.mn.us/divs/hpcd/tpc/TP-5d1.html and http://www.health.state.mn.us/divs/hpcd/tpc/TP-5d.html.

< *National Tribal Prevention Tobacco Network:* http:// www.tobaccoprevention.net.

Parents Association: **Smoking Prevention Strategies for Urban and Minority Youth** **http://www.parentsassociation.com/health/smoking_strategies.html.**

< *The National Latino Council on Alcohol and Tobacco Prevention:* http://216.197.111.229/index.cfm.

< *The National African American Tobacco Prevention Network:* http://www.naatpn.org/home/index.html.

MDH Contacts

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Eliminating Health Disparities In Diabetes

Background

Diabetes is a complex, serious and increasingly common chronic disease that affects nearly 18 million Americans. When people have diabetes, their bodies do not produce or properly use insulin. Insulin is an essential hormone that converts sugar, starches and other carbohydrates into energy needed for life. Without insulin, sugars build up in the blood, causing serious, life threatening complications and eventually death. The situation is much worse if the diabetes is accompanied by high blood pressure or elevated cholesterol.

Diabetes prevalence in Minnesota increased 45 percent, from 3.8 percent in 1994 to 5.5 percent in 2003. Diabetes is the sixth leading cause of death in Minnesota, and the leading cause of blindness, kidney failure, and lower-limb amputations. It increases the risk of heart disease two to four times. The disease costs Minnesotans an estimated $2 billion annually.

In Minnesota, glaring racial and ethnic disparities are reflected in diabetes prevalence, complications, death rates, and in preventive care received by those who have diabetes. Compared to non-Hispanic whites, diabetes as an underlying cause of death is 3 times more common among African Americans, and nearly 5 times more common among American Indians in Minnesota. Diabetes death rates are rising among Asian Americans and Hispanic Americans.

Non-Hispanic racial and ethnic populations have higher rates of diabetes complications. Among people with diabetes: kidney failure is two to six times greater in populations of color; lower-limb amputations are four times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos, and 40-50 percent greater in African Americans.

Infants of mothers who have diabetes before they become pregnant (pre-existing diabetes mellitus, or PDM) face increased risk of birth defects and perinatal death. Non-white and new immigrant mothers are also at greater risk of receiving inadequate prenatal care, further raising their risk of complications from PDM. Compared with the state's non-Hispanic white population, rates of PDM are over 2 times greater among births to African Americans and well over 7 times greater among births to American Indians.

Diabetes' disproportionate impact is increasing at alarming rates in racial and ethnic minority populations in Minnesota. This is evidenced by increasing trends in the overall prevalence of diabetes, its prevalence during pregnancy, and in diabetes-related deaths in these populations. Furthermore, it is likely that these trends will continue to worsen before they improve because rates of obesity (a major contributing risk factor for diabetes) are also increasing. Among Minnesotans without diabetes, obesity increased 60 percent, from 1 in 10 Minnesotans in 1991, to 1 in 6 Minnesotans in 2000. Currently, more than 3 out of every 5 Minnesotans without diabetes are overweight or obese, placing them at greater risk for developing the disease.

Contributing Factors

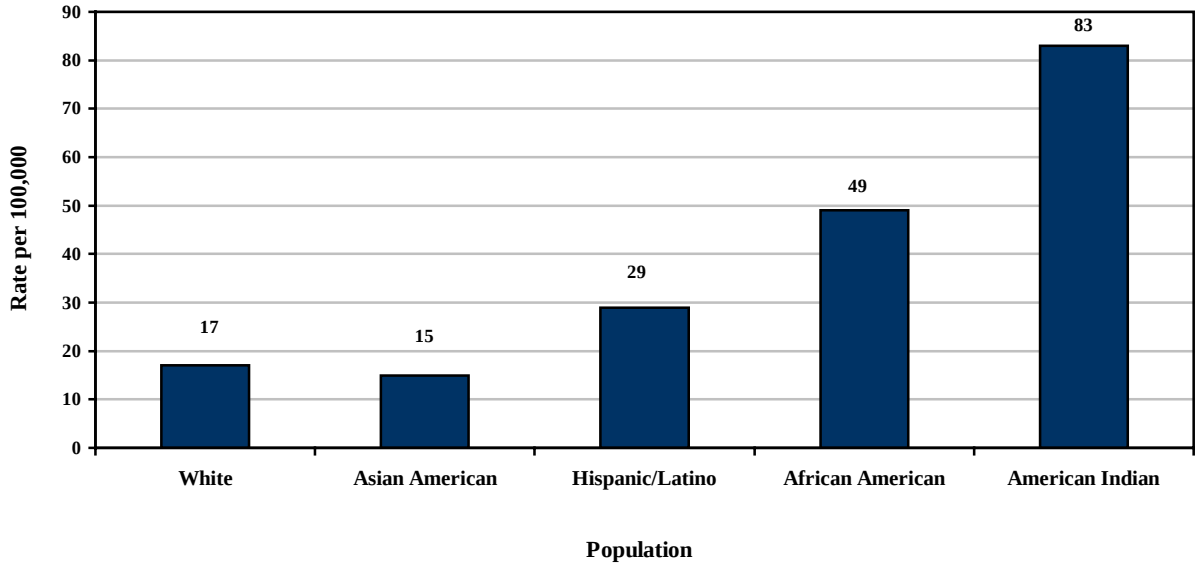
Disparities in the prevalence of diabetes and its complications are associated with a number of social, behavioral, and physiological factors. The rapid increase in the most common form of diabetes, type 2,

is related to changes in lifestyle associated with the increased urbanization of our culture. American Indian and other racial and ethnic minority populations have been especially vulnerable to these societal changes.

Obesity is a major risk factor for developing type 2 diabetes. Approximately 80 percent of people with type 2 diabetes are obese at the time they are first diagnosed. Other risk factors include a high-fat diet, and physical inactivity. For people with diabetes, potentially modifiable factors such as high blood sugar, smoking, and hypertension greatly increase the risk of complications such as vision loss, amputations, heart disease, kidney failure, stroke and heart disease.

Racial and ethnic disparities in diabetes complications and diabetes-related deaths are made worse by a variety of factors, including poor access among non-white populations to diabetes medicines, supplies, and culturally and linguistically appropriate preventive care. Lack of culturally and linguistically appropriate diabetes education materials and support systems further impede effective diabetes management in these populations.

Figure 1. Diabetes as an Underlying Cause of Death in Minnesota per 100,000, 1989-1998.



*Sources: Minnesota death certificates and the Minnesota Health Profiles (1998)

Strategies for Intervention:

Diabetes is a complex disease that affects all aspects of an individual's life. Effective prevention and management of diabetes requires significant lifestyle changes, on-going health care, and social support. As a result, the most effective interventions for the prevention and management of diabetes tend to be built upon diverse partnerships, have multiple components, and which support and involve people with or at risk for diabetes.

The following list of strategies provides a sample of what could be included in proposals to eliminate diabetes disparities. Comprehensive, multi-factorial programs may include combinations of the strategies.

While not all of the strategies listed have been "proven" effective for all communities. All of the strategies have been successfully implemented in Minnesota. Additional detail on these strategies, including information on indicators for evaluation can be found in the *Diabetes – Strategies for Public Health* document at: www.health.state.mn.us/diabetes/pdf/strategies.pdf

- Promote healthy behaviors.

  Research has demonstrated that engaging in healthy lifestyle behaviors such as regular, moderate physical activity and consuming a healthy diet can help prevent diabetes and can prevent the development of complications in people with diabetes.

  Examples:
  - Conduct culturally and linguistically appropriate, diabetes-awareness raising campaigns (e.g. using community-specific print, radio and television programs).
  - Assess individuals for diabetes risk in community settings (e.g. using a paper based "risk test" and counseling at community grocery stores, churches, etc).
  - Implement culturally specific educational programs focusing on healthy lifestyle behaviors in high-risk populations.
  - Create communities that support healthy lifestyles by identifying and addressing environmental and policy barriers in the community.

- Implement diabetes education and support programs.

  Because more than 90 percent of diabetes care is self-managed, on-going accessible education and support of people with diabetes is essential to preventing complications. Diabetes education may encompass many topics, including behavioral change, coping skills and use of complementary therapies.

  Examples:
  - Conduct a community needs assessment of the education, support and care needs of people with diabetes.
  - Utilize peer educators (respected, bilingual members of the community trained in diabetes) to provide culturally and linguistically appropriate programs.
  - Host education and support programs for people with diabetes and their families.
  - Encourage health care providers to counsel their diabetes patients on good diabetes self-care practices.
  - Provide reminders of routine diabetes preventive care, with messages tailored for your community.

- Convene a community diabetes coalition.

  A diabetes coalition is a group that is convened to develop a vision, goals and long-term strategies for diabetes in the community. A well-formed coalition has broad representation of local people with diverse expertise and a commitment to the community.

  Diabetes coalitions can:
  - Coordinate diabetes-related activities and provide a forum to facilitate new initiatives;
  - Ensure that multiple perspectives are considered when addressing diabetes;
  - Strengthen and support the capacity of local health systems; and
  - Ensure the success of community activities by gaining buy-in from stakeholders.

- Create a diabetes profile for your community**.**

A diabetes profile defines the impact of diabetes on individuals and the community, and highlights issues and unmet needs. The profile may include the number of people with diabetes and related demographic information, the clinical and social services available and diabetes-related concerns of the community.

Examples of profile uses:

- Identify and describe the diabetes population to help set goals, shape policies and provide direction to activities.
- Create an inventory of diabetes-related services and resources in the community.
- Raise awareness of the needs and concerns of people with diabetes in your community.

➢ Increase the diabetes and cultural competencies of local health professionals.

The science of diabetes care and prevention is changing and improving everyday. In addition, each community may have specific cultural needs and preferences when it comes to diabetes care. Improving health professionals' access to continuing education is essential to making the best health care available to people with diabetes.

Examples:

- Provide diabetes care and cultural competency training for health professionals.
- Distribute culturally and linguistically specific diabetes self-management education tools and resources to providers to use with patients in your community.
- Develop ways of communicating diabetes-related research findings quickly and effectively to health professionals who serve your community.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in diabetes in American Indians and populations of color as compared with Whites. Examples of possible local project outcomes include:

- Improved blood glucose and blood pressure control for people with diabetes.
- Increased physical activity for people with or at risk for diabetes
- Less overweight and obesity among people with or at risk for diabetes
- Improved access to culturally and linguistically appropriate diabetes educational resources
- Increased collaboration between health care and community organizations serving people with or at risk for diabetes

Resources

- Minnesota Diabetes Program, MDH (www.health.state.mn.us/diabetes)
- Diabetes in Minnesota Report (www.health.state.mn.us/diabetes/diabetesinminnesota/)
- *Diabetes Strategies for Public Health*: (www.health.state.mn.us/diabetes/pdf/strategies.pdf)
- Minnesota Diabetes Plan CENTRAL (www.health.state.mn.us/diabetesplancentral)
- National Diabetes Education Program (http://ndep.nih.gov/)
- National Diabetes Information Clearinghouse (http://diabetes.niddk.nih.gov/)

- The American Diabetes Association (www.diabetes.org)
- CDC Division of Diabetes Translation (www.cdc.gov/diabetes/)
- Indian Health Services (IHS) Division of Diabetes Treatment and Prevention (www.ihs.gov/MedicalPrograms/Diabetes)
- Guide to Community Preventive Services for Diabetes (www.thecommunityguide.org/diabetes/)
- National Health Disparities Collaborative www.healthdisparities.net/)

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Eliminating Health Disparities In HIV/AIDS And Sexually Transmitted Infections

Background

HIV/AIDS.

The number of newly reported HIV/AIDS cases has remained relatively stable in Minnesota over the past ten years with around 300 cases reported per year. While the numbers of new cases are highest in the white population, populations of color are disproportionately affected by HIV/AIDS. During 2003 rates (numbers of cases per 100,000 persons) among African Americans, Africans and Latinos were significantly higher than the rate among Whites (see Table 1). In particular, African American and African men experienced rates that were 12 and 150 times greater, respectively, than that among white men; the disparities for African American and African women were even greater with rates 87 and more than 400 times that of white women.

Table 1. Number of Cases and Rates (per 100,000 persons) of HIV Infection by Race/Ethnicity – Minnesota, 2003

Race/Ethnicity	*Cases*	*Rate*
White, non-Hispanic	**116**	**2.7**
Black, African-American	**53**	**31.6**
Black, African-born	**55**	**110-156**[†]
Hispanic	**26**	**18.1**
American Indian	**7**	**8.6**
Asian/Pacific Islander	**7**	**4.2**
Other/Unknown	**2**	**-**
Total	***266***	***5.4***

[†] Accurate population estimates for African-born persons living in Minnesota are unavailable – anecdotal (50,000) and 2000 US Census data (35,188)) were used to create the range of rates reported for African-born.

Source: Minnesota Department of Health HIV/AIDS urveillance system and 2000 U.S. Census data.

Sexually transmitted infections:

Gonorrhea and chlamydia infections are the most common reportable diseases in Minnesota with nearly 14,000 cases reported in 2003. Infection with these STIs can cause infertility in women and increase the chances of spreading HIV. While the numbers of new cases are highest in the white population, communities of color are also disproportionately affected by STIs. Among Minnesotans in 2003, African Americans had the highest rates of gonorrhea and chlamydia. As shown in Table 2, communities of color experienced rates of chlamydia 3 to 14 times that of Whites. Table 3 shows the same comparison for gonorrhea; communities of color experience rates of gonorrhea 1.3 to 33 times greater than that of Whites.

Table 2. Number of Cases and Rates (per 100,000 persons) of Chlamydia by Race/Ethnicity – Minnesota, 2003

Race/Ethnicity	*Cases*	*Rate*
White, non-Hispanic	**4,703**	**105**
Black, all groups	**3,025**	**1,490**
Hispanic	**804**	**561**
American Indian	**376**	**464**
Asian/Pacific Islander	**462**	**275**
Other/Unknown	**2,148**	**-**
Total	***10,714***	***218***

Source: Minnesota Department of Health STD surveillance system and 2000 U.S. Census data.

Table 3. Number of Cases and Rates (per 100,000 persons) of Gonorrhea by Race/Ethnicity – Minnesota, 2003

Race/Ethnicity	*Cases*	*Rate*
White, non-Hispanic	**995**	**22**
Black, all groups†	**1,475**	**727**
Hispanic	**152**	**106**
American Indian	**84**	**104**
Asian/Pacific Islander	**49**	**29**
Other/Unknown	**599**	**-**
Total	***3,202***	***65***

Source: Minnesota Department of Health STD surveillance system and 2000 U.S. Census data.
† Includes African Americans and Africans.

Contributing Factors

Factors that directly increase the risk of HIV and STI transmission include the following:

< Susceptibility of the uninfected individual
< Infectiousness of the infected individual
< Sex behaviors
< Drug behaviors
< Health care behaviors
< Prevalence

Through the process of community planning, a great deal of work has been done to identify cultural and other factors/issues that help to determine the nature of these risk factors within communities of color.

Racism

< External racism may promote low socio-economic status (see below)

< Internalized racism may induce feelings of hopelessness, despair, and self-destruction, which may prompt risky behaviors, including drug use.
< Lack of bilingual and bicultural health professionals and health education materials impact on ability to access effective health care.
< Non-western medical models make HIV disease hard to comprehend.
< Some immigrants do not seek medical care for fear of deportation or denial of citizenship.
< Some cultures believe that HIV is perpetrated by the government to rid society of people of color, resulting in a lack of motivation to internalize HIV prevention messages.

Socio-economic status (SES) factors (e.g., poverty, homelessness, joblessness, low education)
< Low SES level may induce feelings of lack of control, despair, and hopelessness, which may prompt risky behaviors.
< Low SES level may directly promote risky behaviors related to survival (sex for money, drug use to escape despair).
< Low SES level directly impacts on ability to access health care, including HIV and STI tests, treatment, and prevention messages.
< Low SES results in many personal survival issues that take precedence over personal investment in changing risk behaviors.
< Many school-aged, high-risk youth are not in school and do not receive HIV and STI prevention messages.

Homophobia/heterosexism
< In some cultures, men who have sex with men do not identify themselves as homosexual and therefore do not consider themselves at risk.
< Internalized homophobia may induce feelings of hopelessness, despair, and self-destruction, which may prompt risky behaviors.
< Externalized homophobia may create environmental and legal barriers to engaging in safe behaviors (e.g., criminalization of sodomy, lack of access to condoms in prisons, lack of safe environments for sex, lack of information and support for gay/bisexual youth).

Non-injecting substance use/abuse
< The culture that surrounds drug use may promote risky drug/sex behavior, as well as contribute to factors that support risky behaviors (e.g., alienation from family/friends/society, loss of job, low self-esteem, depression).
< Women drug users may be at particular risk since 1) there are fewer drug treatment options open to them; 2) their reliance on drug-using sex partners for financial/emotional support may reinforce their drug use; 3) they are likely to exchange sex for drugs to support drug addiction rather than, or in addition to, engaging in other criminal activities.

Societal, cultural, and peer norms
< Societal norms promoted through entertainment and media may increase risky behaviors.
< In some communities of color, cultural prejudices against homosexuality, and against the discussion of sexuality, particularly between parents and children, may contribute to high rates of STI and HIV.
< In some communities of color, condom use is embarrassing and threatening.
< HIV is associated with a fear of discrimination and stigma, which keeps homosexual and HIV-infected individuals silent about their orientation and/or their disease.

< Male privilege bestowed by society may increase feelings of invincibility, a need to procreate, or promote a view of promiscuity as masculine.
< Female oppression decreases ability of women to be assertive in sexual relationships, particularly regarding initiation of safer sexual practices and discussion with their partners of their sexual behaviors.

Strategies For Intervention

The following strategies (ways in which to implement interventions) may be included in proposals to eliminate health disparities in HIV/AIDS and STI, but other strategies not listed here may also be included. Based on several needs assessments, the following have been identified as important strategies for implementing interventions:

< Engage the efforts of church and other community leaders.
< Serve not just the client at risk, but also the clients' partners/spouses and family members.
< Deal not only with the person's disease or risk of disease but with the whole person, addressing issues of alcohol and substance use/abuse, depression, self-esteem, and healthy sexuality
< Embed the HIV/STI program within a variety of services to create "one-stop shopping."
< Peer educators tend to be more effective in communicating with and motivating at–risk clients
< Peer providers (providers from the same racial /ethnic background) tend to be more effective in communicating with and motivating at-risk clients.
< Health care providers need to consistently provide HIV/STI prevention information, and work to be perceived as trustworthy and able to maintain confidentiality.
< Culturally-appropriate chemical dependency services need to be available.
< Attitudes and beliefs of youth regarding violence, sexual promiscuity, and chemical use need to be addressed.
< Parents need to have the skills and motivation to discuss HIV/STI prevention issues with their children.
< Addressing cultural taboos around sexuality and homosexuality is critical. Consistent condom use needs to become a cultural norm for men and women.
< Prevention messages do help people to change their behavior.
< Individuals need to hear prevention messages face-to-face and more than once.
< Individuals injecting drugs must know where to obtain new needles.

Some ideas for specific interventions

A. Implement effective behavioral interventions identified by CDC as programs that work.

Healthy Relationships is a five-session, small-group intervention for men and women living with HIV/AIDS. It is based on Social Cognitive Theory and focuses on developing skills and building self-efficacy and positive expectations about new behaviors through modeling behaviors and practicing new skills. Core components include:
< Defining stress and reinforcing coping skills across three life areas—disclosing to family and friends, disclosing to sexual partners, and building healthier and safer relationships
< Using modeling, role-play, and feedback to teach and practice skills related to coping with stress.
< Teaching decision-making skills about disclosure of HIV status

< Providing personal feedback reports to motivate change of risky behaviors and continuance of protective behaviors.
< Using movie clips to set up scenarios about disclosure and risk reduction to stimulate discussions and role-plays

The Holistic Health Recovery Program (HHRP) is a 12-session, manual-guided, group level program to promote health and improve quality of life. HHRP targets HIV-positive injection drug users. The primary goal of HHRP is to provide group members with the resources (i.e., knowledge, motivation, and skills) they need to make choices that promote healthy recovery. Core components include:
< Deliver a 12-session multi-modal, manual-guided group intervention.
< Focus on reducing drug use and high-risk behaviors.
< Address medical, emotional, and social problems that may be associated with disease progression.
< Respect clients' spiritual and religious beliefs, help clients cope with stigma and grief, teach stress management techniques, and acknowledge/address fears of death and dying.
< Follow the IMB model so clients gain the skills to attain and realize treatment goals.
< Use multiple presentation strategies (e.g., slides, games) to increase understanding and retention of materials.

Many Men, Many Voices (3MV) is a six- or seven-session, group level STD/HIV prevention intervention for gay men of color. The intervention addresses behavioral influencing factors specific to gay men of color, including cultural/social norms, sexual relationship dynamics, and the social influences of racism and homophobia. Core components include:
< Educate clients about HIV risk and sensitize to personal risk.
< Develop risk reduction strategies.
< Train in behavioral skills.
< Provide social support and relapse prevention.

Mpowerment. This community-level intervention for young men who have sex with men uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages. Core components include:
< Recruiting a core group of young gay men to design and carry out project activities
< Establishing a project space where many of the project activities can be held
< Conducting entertaining, venue-based (e.g., bars, community events) outreach by teams of young gay men
< Sponsoring social events to promote community-building among young gay men.
< Convening peer-led, one-time discussion groups
< Conducting a publicity campaign about the project

Popular Opinion Leader This 4 session community-level intervention involves identifying, enlisting, and training key opinion leaders to encourage safer sexual norms and behaviors within their social networks through risk-reduction conversations. Core components include
< Identifying and enlisting the support of popular and well-liked opinion leaders to take on risk reduction advocacy roles;
< Training cadres of opinion leaders to disseminate risk-reduction endorsement messages within their own social networks; and

< Supporting and reinforcing successive waves of opinion leaders to help reshape social norms to encourage safer sex.

(PROMISE) Peers Reaching Out and Modeling Intervention Strategies: This community-level intervention is based on several behavior change theories. Core components include:
< Community identification process to collect information about the community, including HIV/STD risk behaviors and influencing factors
< Creating role model stories based on personal accounts from individuals in the target population who have made positive behavior change
< Recruiting and training peer advocates from the target population to distribute role model stories and prevention materials
< Continuous formative evaluation to capture behavior change within the target population.

Real AIDS Prevention Project (RAPP) A community mobilization program, designed to reduce risk for HIV and unintended pregnancy among women in communities at high risk by increasing condom use. This intervention relies on peer-led activities, including: outreach/one-on-one brief conversations with brochures, referrals, and condom distribution; small group safer sex discussions and presentations. Core components include:
< Conducting community outreach using peer volunteers
< Having one-on-one, safer sex discussions based on the client's stage of readiness to change;
< Using printed stories about community members and safer sex decisions (role model stories);
< Obtaining program support from community organizations and businesses; and
< Sponsoring small group activities, such as safer sex parties and presentations.

Safety Counts is an HIV prevention intervention for active injection drug and crack cocaine users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings. Core components include:
< Group Session One and Group Session Two (identify client's HIV risks and current stage of change, hear risk-reduction success stories, set personal goal, identify first step to reduce HIV risk, and make referrals to C&T and medical/social services);
< One (or more) Individual Counseling Session (discuss/refine risk-reduction goal, assess client's needs, and provide needed referrals to C&T and medical/social services);
< Two (or more) Social Events (share meal and socialize, participate in a planned HIV-related risk-reduction activity, and receive reinforcement for personal risk reduction)
< Two (or more) Follow-up Contacts (review client's progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next step and discuss possible barriers/solution, and make referrals to C&T and medical/social services); and
< HIV/HCV Counseling and Testing (offer the client this service either through referrals or at the implementing agency.

SISTA This group-level, gender- and culturally- relevant intervention, is designed to increase condom use with African American women. Five peer-led group sessions are conducted that focus on ethnic and gender pride, HIV knowledge, and skills training around sexual risk reduction behaviors and decision making. The intervention is based on Social Learning theory as well as the theory of Gender and Power. Core components include:
< Convening five group sessions facilitated by a peer health educator;
< Educating participants about condoms through hands-on exercises;

< Emphasizing gender and ethnic pride as a means to reduce HIV risk behaviors;
< Educating participants about HIV and other STDs; and
< Teaching sexual assertiveness and communication.

Street Smart. A multi-session, skills-building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use. Sessions address improving youths' social skills, assertiveness and coping through exercises on problem solving, identifying triggers, and reducing harmful behaviors. Agency staff also provide individual counseling and trips to community health providers. Core components include:
< Enhancing affective and cognitive awareness, expression, and control;
< Teaching HIV/AIDS risk hierarchy and its personal application
< Identifying personal triggers, using peer support and small group skills-building sessions; and
< Building participant's skills in problem solving, personal assertiveness, and HIV/AIDS harm reduction.

Teens Linked to Care (TLC) is an effective intervention for young people (ages 13 to 29) living with HIV. TLC is delivered in small groups using cognitive-behavioral strategies to change behavior. Young people meet regularly to provide social support, learn and practice new skills, and socialize. Core components include:
< Delivery of three modules consisting of 8-12 sessions each.
< Delivery of modules in interactive groups.
< Exercises in each session that are designed to be meaningful personal experiences, leading to development of knowledge and attitudes and increased skills to support adoption of new behaviors.
< Individualized homework tasks assigned following each session.

Video Opportunities for Innovative Condom Education & Safer Sex: A group-level, single-session video-based intervention designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics. Core components include
< Viewing culturally-specific videos portraying condom negotiation;
< Conducting small group skill-building sessions to work on overcoming barriers to condom use;
< Educating program participants about different types of condoms and their features; and
< Distributing samples of condoms identified by participants as best meeting their needs.

B. Implement innovative interventions that build upon proven and promising practices:

< Identify common risk factors for teen pregnancy and for teen STI acquisition. Target prevention information to individuals with those common risks.
< Perform universal STI /HIV/ hepatitis screening programs in selected high schools, in alternative schools or in other community settings where youth congregate. Provide on-going programming, educational planning and intervention to encourage youth to be tested, and provide treatment.
< Implement a basic public health media campaigns to promote HIV and STI testing. Messages about testing need to include the notion that it is cool and/or normal. Develop billboards featuring youth, rappers, entertainers, etc.
< Perform outreach in environments where high-risk behaviors occur (public sex sites, bars, shooting galleries), and provide brief prevention messages, safer sex and safer needle use products, referrals to health and community services, and field testing for HIV.
< Develop outreach programs to sites that reach individuals most at risk (such as prisons and jails,

chemical dependency treatment centers, detox sites, homeless shelters), to help those sites to integrate HIV/STI prevention messages and tests into their existing programs; and/or provide on-site HIV/STI testing, education and referral.

< Work one-on-one, or in groups to teach and practice sexual negotiation and coping skills
< Work one-on-one (prevention case management), or in groups (group support) to provide long-term positive reinforcement for behavior change.
< Give information out to those sitting in waiting areas of clinics, hospitals and service organizations via video and/or posters.
< Work with pre-sentencing for incarceration to develop routine HIV and STI screening, ensuring confidentiality of results and treatment.
< Provide training to health care providers regarding culturally sensitive and appropriate risk assessment, counseling, testing and treatment services, and on taking sexual histories. Work with teen or specialty clinics to provide services such as sexual health and life skills.
< Train adults in existing mentorship programs, e.g., college sororities and fraternities, and 100 Men to talk about HIV and STI prevention and testing.
< Provide training to pharmacists, barbers, etc. to talk about HIV and STI prevention and testing. Training should raise awareness, provide information designed for a specific environment (such as church, street, or sports) with quick, concise information that is culturally and age appropriate.
< Use existing youth theater organizations to provide presentations at group homes, etc.
< Provide community-based peer education among parents, teachers, block clubs, and churchgoers. Support for parent education is especially needed. Link the notion of safety for children with a health message. Provide information where parents gather -- school parent involvement days, parent conferences, etc. Provide parenting classes with food and support.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in HIV/AIDS and STIs in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

< Increase in the percentage of people using condoms.
< Decrease in the number of sexual partners within the last year.
< Decrease in the number of times needles are shared.
< Increase in the number of people getting tested for HIV and STI.

Resources

Much of the information listed above was taken from a variety of resources developed by the STD and HIV Section of MDH. Available reports include Minnesota Comprehensive HIV Prevention Plan and Statewide Plan to Address STDs in Minnesota. In addition to these reports there are a number of needs assessment reports available from the STD and HIV Section at MDH for specific populations.

Websites

- Minnesota Department of Health, HIV/AIDS web page (http://www.health.state.mn.us/divs/idepc/diseases/hiv/index.html)
- Minnesota Department of Health, STD web page (http://www.health.state.mn.us/divs/idepc/dtopics/stds/index.html)
- Diffusion of Effective Behavioral Interventions (http://www.effectiveinterventions.org/)
- CDC Division of HIV/AIDS Prevention (http://www.cdc.gov/hiv/pubs/facts.htm)
- CDC Division of HIV/AIDS Prevention Tools (http://www.cdc.gov/hiv/prevtools.htm)
- CDC Division of Sexually Transmitted Diseases (http://www.cdc.gov/std/)
- American Social Health Association (http://www.ashastd.org)
- Hidden Epidemic (http://www.nap.edu/books/0309062322/html)

MDH Contact

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Eliminating Health Disparities in Immunizations for Adults and Children

Background

A person's need for immunizations is life long. Children need protection against at least 11 serious vaccine-preventable diseases. To be fully protected, children should receive up to 20 doses of vaccine throughout the first two years of life, additional immunizations before kindergarten, and still more as adolescents. Adults also need shots: tetanus-diphtheria boosters, influenza, and pneumococcal vaccine. Medical conditions, environmental conditions, and work situations are other reasons for additional vaccines for many children and adults.

The use of vaccines has resulted in the lowest levels of vaccine-preventable disease ever reported, but the immunization rates of children and adults in certain socioeconomic and racial/ethnic groups remain low. Not only does this take an individual toll in unnecessary illness hospitalizations and medical costs but also these low immunization rates can lead to disease outbreaks at any time.

The most recent statewide retrospective kindergarten survey of immunization levels identified disparities in coverage levels between different racial/ethnic populations (Table 1). On average children from Minnesota's American Indian community and communities of color had immunization levels that were 27 percentage points lower than their white counterparts.

Table 1. Percentage Up to Date by Age and Race/Ethnicity, Minnesota Retrospective Kindergarten Survey, 2001-2002

Population Group	4 Months of Age	6 Months of Age	8 Months of Age	17 Months of Age	20 Months of Age	24 Months of Age
All Students	93%	87%	81%	78%	75%	81%
American Indian	91%	80%	67%	71%	65%	73%
Asian and Pacific Islander	82%	69%	59%	65%	58%	66%
African American	78%	68%	58%	61%	55%	62%
Hispanic/ Latino	87%	79%	70%	66%	58%	65%
All Non-White	83%	72%	62%	64%	57%	65%
White	95%	91%	86%	81%	80%	85%

Race/ethnicity information was available for 90 percent of kindergarteners statewide.

A similar trend is seen with adult immunization. The 1999 Minnesota Behavioral Risk Factor Surveillance Survey (BRFSS) identified that African Americans had rates for influenza and pneumococcal vaccines that were significantly lower than those for white adults. Although the Minnesota BRFSS sample is small, the data reflect national trends showing populations of color have lower levels of immunization for influenza and pneumococcal vaccine (Table 2).

Table 2. 1999 BRFSS Data for Influenza and Pneumococcal Vaccine Coverage for Persons 18 Years and Older

Population Group	Influenza MN Rates	Influenza National Rates	Pneumococcal MN Rates	Pneumococcal National Rates
Black	14.0 %	27.0 %	6.2 %	15.8%
Hispanic/Latinos	18.5 %	24.0 %	10.5 %	11.8%
Other	24.4 %	27.8%	11.3%	15.0%
White	29.7%	33.1%	17.0%	19.3%

Overall, immunization levels have shown recent improvements in both pediatric and adult populations, but American Indians and populations of color consistently have immunization levels significantly below those of the white population.

Contributing Factors

There are a number of factors that contribute to low immunization rates in people of color and American Indians in Minnesota. These factors include, but are not limited to the following:

< Income. Children who live in low-income areas are under-immunized. Childhood immunization levels are as low as 45 percent in some low-income zip code areas of Minnesota. Also, children on Prepaid Medical Assistance (PMAP) have lower immunization rates than children who have other health insurance plans.

< Lack of provider and community awareness of special vaccine recommendations. Persons with diabetes, cardiovascular disease, sexually transmitted diseases, breast and cervical cancer, and other medical conditions are at high risk of complications from certain vaccine-preventable diseases. Unfortunately, persons of color and American Indians are more likely to have these diseases and less likely to have received the recommended vaccines for these diseases than white Minnesotans.

In addition, adults at high risk for hepatitis B are disproportionately from communities of color. Despite the fact they have sought out medical care, they are not receiving hepatitis B vaccination.

American Indian children are at increased risk of hepatitis A. The last statewide hepatitis A outbreak in Minnesota spanned the years 1989 through 1993 and resulted in more than 2,500 cases. In 1992 alone there were 884 cases, 339 (38.3 percent) of which occurred among American Indians. The majority of these cases were in children 5-14 years of age. Hepatitis A outbreaks usually occur every five to 10 years.

Southeast Asian children, and children from areas of the world where hepatitis B is endemic, are at increased risk of hepatitis B. Studies show that older Southeast Asian children are less likely than other children to have received three doses of the hepatitis B vaccine.

< Common barriers to immunization. Common barriers include, but are not limited to, lack of transportation, lack of health insurance, lack of a “medical home”, need for interpreters, lack of

knowledge of the importance and safety of immunization, and lack of clinic reminders when shots are due.

< Misperceptions regarding influenza and pneumococcal vaccines. Studies indicate that many individuals do not receive flu shots for the very reason they are considered high priority--they had a health condition or chronic illness. In spite of the fact that flu and pneumococcal vaccines are safe and have minimal side effects, fear of potential side effects limits acceptance of these vaccines.

< Lack of transportation and accessibility are barriers to vaccine in African American and Hispanic/Latino communities according to studies of knowledge, attitudes and behavior. Individuals in these communities expressed mistrust of government. Additionally, people felt that influenza vaccine was for the "frail elderly" and they did not view themselves as such.

Strategies for Intervention

The following strategies may be included in proposals to eliminate disparities in immunization, but other strategies not listed here may also be included.

< Utilize community members to provide outreach and education.

< Develop volunteer programs to identify and follow-up with children and adults who are not properly immunized. Services may include transportation and childcare.

< Encourage religious leaders to include education programs on health issues, including immunizations, so that all infants, children, and adults receive needed immunizations on schedule. Utilize and/or enhance the parish nurse role to promote immunizations if available. Utilize religious-based gatherings (centers) as a forum for offering adult vaccination.

< Utilize block nurse programs.

< Provide transportation so that adults can receive influenza vaccination, as well as offering such clinics at neighborhood community centers and senior high-rise and retirement facilities.

< Educate providers about the importance of offering all recommended vaccines at every clinic.
< Access ECFE (Early Childhood Family Education) programs in neighborhood schools to include information about immunization and offering resources to assist parents in vaccinating their children.

< Conduct community media campaigns (neighborhood newspapers, Hmong, Hispanic/Latino radio and television programs, etc) about the serious complications of vaccine-preventable diseases and the benefits of vaccination.

< Place visual messages at day care centers, neighborhood community centers, social service agencies, WIC, and healthcare provider clinics and develop programs to remind parents and prospective parents to immunize their children.

< Create programs with private industry to help maintain high rates of childhood immunizations.

These programs may include posting immunization information on bulletin boards in employee break rooms, including immunization schedules and clinic information on paycheck stubs, and donating or offering to pay for billboard space, bus signs, and immunization brochures and posters. Programs should be executed in collaboration with members of the targeted communities.

< Develop culturally appropriate materials in collaboration with members of the community.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in immunization rates of Minnesota's American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

< Providers will not miss as many opportunities to vaccinate African American/African, Asian American, American Indian, and Hispanic/Latino children and adults.

< More African American/African, Asian American, American Indian, and Hispanic/Latino children and adults will receive the vaccines they need to be protected against vaccine-preventable diseases.

Resources

< Schneider EC, Cleary PD, Zaslavsky AM, Epstein AM. Racial Disparity in Influenza Vaccination: Does Managed Care Narrow the Gap Between African Americans and Whites? JAMA. 2001; 286:1455-1460.

< Minnesota Department of Health immunization www.health.state.mn.us/immunize

< Immunization Action Coalition www.immunize.org

< American Lung Association of Minnesota 651-223-9564

< Minnesota Coalition for Adult Immunization 651-725-2085

< National Coalition for Adult Immunization, 301-656-0003, adultimm@aol.com
Or www.medscape.com/NCAI

< CDC's National Immunization Program
- Immunization information for racial and ethnic populations, at http://www.cdc.gov/nip/menus/groups.htm#ethnic
- Protect the Circle of Life, Vaccinate Our Nations, at http://www.cdc.gov/nip/specint/ai-an/Default.htm#links
- READII (Racial & Ethnic Adult Disparities in Immunization Initiative), at http://www.cdc.gov/nip/specint/readii/default.htm

< CDC Spanish Immunization Hotline 1-800-232-0233

< Federal fact sheets called Vaccine Information Statements, which provide basic information about

various vaccinations, are available in multiple translations at www.health.state.mn.us/immunize.

< National Medical Association, a professional association of African American physicians, has a packet of information available on working with communities www.nmanet.org 202-347-1895

< National Foundation for Infectious Diseases

A Report on Reaching Underserved Ethnic and Minority Populations to Improve Adolescent and Adult Immunization Rates, at http://www.nfid.org/publications/adoladultwhitepaper.pdf

A Report on Reaching Underserved Ethnic and Minority Populations to Improve Pediatric Immunization Rates, at http://www.nfid.org/publications/pediatricwhitepaper.pdf

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< Shefer S, Mize J. Primary care providers and WIC: improving immunization coverage among high-risk children. *Ped Ann* 1996; 27:428-432.

< Task Force on Community Prevention Services. Recommendations regarding interventions to improve vaccination coverage in children, adolescents, and adults. *Am J Prevent Med* 2000; 18 (1S): 92-96.

Minnesota Department of Health Contact

For more information about immunizations for adults and children, contact:

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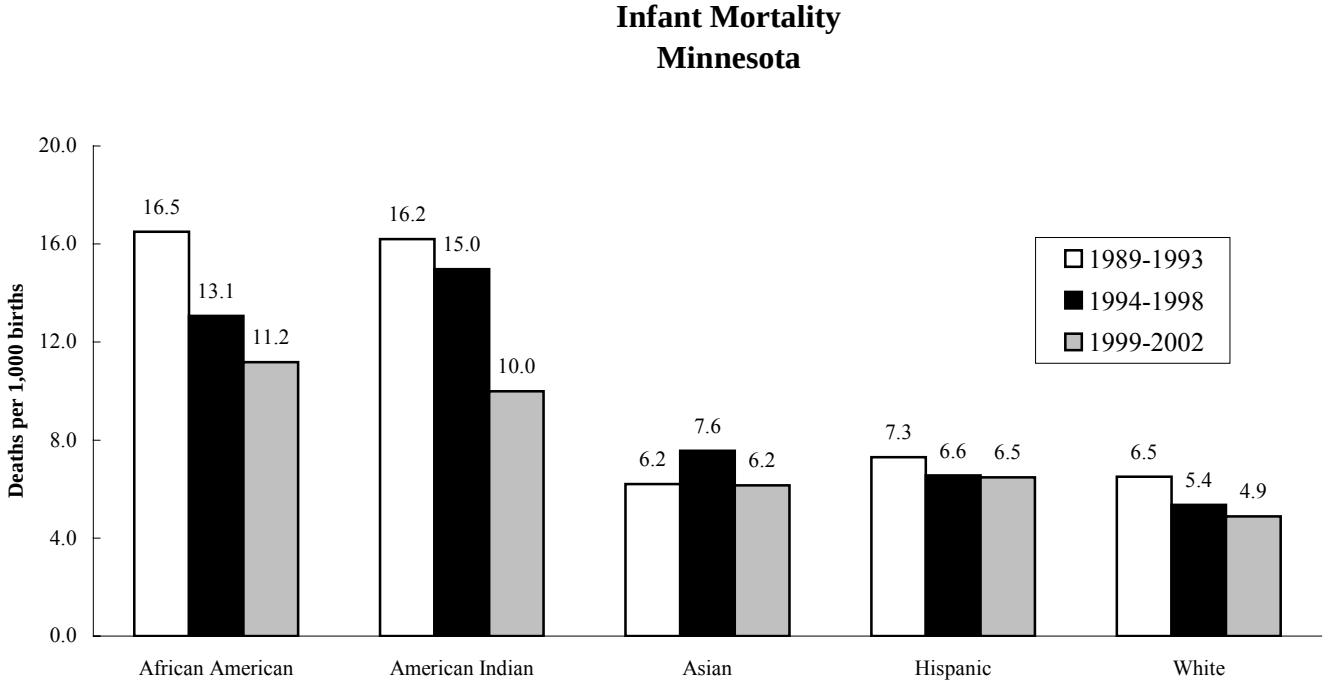
Eliminating Health Disparities In Infant Mortality

Background

Infant mortality is defined as the death of a live-born infant from any cause before the infant's first birthday. Infant deaths are usually expressed as rates that represent the number of infant deaths per 1,000 live births. Infant mortality rates (IMRs) are an important indicator of the health and well-being of families and communities. Minnesota's IMR in 2002 was 5.3 deaths per 1,000 live births representing a slight decline from 2001 when the rate was 5.4. Although Minnesota has one of the lowest state rates in the nation, this overall rate masks severe and longstanding disparities in infant mortality experienced by Minnesota's populations of color and American Indians.



Source: MN Center for Health Statistics

The above graph demonstrates that African American and American Indian infant deaths, although improving over time, remain significantly higher than those of white infants. Asian and Hispanic infant death rates are also higher than the white rate and have not improved much during the past decade. A recent article by former Surgeon General Dr. David Satcher indicates that the mortality disparity between black and white infants recorded in 2000 is worse than the disparity in 1960 (Satcher, 2005).

The populations experiencing this disparity in infant mortality have many strengths and traditions to draw upon for solutions. In the African American community, churches and other community gathering places provide connections and leadership on community issues. For American Indians, restoring cultural traditions such as native foods, cradle boards, and sacred use of tobacco could improve infant health. Hispanic/Latino and Asian communities have similar traditions around family, nutrition, and healing practices that promote healthy pregnancy, birth, and infancy.

Contributing Factors

Infant mortality is a summary statistic reflecting medical, environmental, and social/behavioral causes of death. Poverty, inadequate housing, segregated neighborhoods, less education, lack of health care insurance coverage, racism and chronic race-related stress, and the absence of social support networks—all are associated with increased rates of infant mortality.

< Access to health care. Access to primary preventive health care including family planning services, and medical care for acute and chronic disease conditions are essential health care components needed to promote women's health and their readiness and ability to give birth to healthy infants. Ideally, women should have at least one clinic visit for preconception care—health care and advice provided before pregnancy. Populations of color and American Indians tend to have higher rates of poverty than whites. With less economic security, they are less likely to have continuous health insurance, and, consequently, have less access to essential preventive, acute, and chronic health care services. Minnesota's uninsurance rate increased significantly between 2001 and 2004 throughout the state affecting Hispanics most of all populations. Hispanics, who already had the highest rate of uninsurance, experienced an increase from 17.3% in 2001 to 32.7% in 2004 (MN Health Economics Program, 2005).

< Primary causes. The primary causes of infant mortality in Minnesota during the period 1996-2000 are perinatal conditions, defined as preterm births (before 37 weeks of pregnancy) low birthweight (weighing less than 5½ pounds), and trauma resulting from a difficult or complicated birth. For African Americans, American Indians, and Hispanics, perinatal conditions were the leading cause of infant death. For Asians, birth defects (congenital anomalies) were the leading cause of death and the second leading cause of death for the other three populations. Sudden Infant Death Syndrome (SIDS) was the third leading cause of death among all four populations (MN Center for Health Statistics, 2004).

< Babies born too soon or too small. Preterm births (PTB) and low birthweight (LBW) births often occur because of poor maternal health before pregnancy. Some of these conditions can be successfully addressed by preconception care and early and ongoing prenatal care. Support during pregnancy, changing harmful behaviors, adequate nutrition and weight gain, adequate recovery time between pregnancies, practicing safe sex to prevent infections, learning about warning signs of early labor are all actions women and their families can take to reduce the number of babies born too soon and too small.

< Stress. Recent research has documented the contribution that stress has on low birth weight and preterm birth particularly among African Americans. There are multiple sources of stress for women of color and American Indian women including how "…gender inequity, racial discrimination, and class inequality impose limitations on access to health care and, perhaps more important, on secure jobs, adequate housing, good nutrition, adequate child care, a safe and healthy environment, and necessary social services—all of which are necessary for good health." (Mullings, 2001)

< Smoking. Smoking during pregnancy is a powerful known cause of low birth weight but one that can be modified by supportive, brief counseling to help pregnant smokers quit. Smoking during pregnancy triples the risk that an infant will die of SIDS (Wisborg, 2000). Additionally, infants

exposed to secondhand tobacco smoke are also more likely to die of SIDS and are more likely to suffer from illnesses such as ear infections, bronchitis, respiratory syncytial virus (RSV), pneumonia, and asthma. Data from birth certificates and WIC indicate that American Indian women have the highest rates of smoking during pregnancy (MN Center for Health Statistics, 2005 & PEDNSS, 2005).

< Birth defects. Congenital anomalies or birth defects account for many infant deaths. Some of these deaths may be preventable. Undiagnosed and/or uncontrolled diabetes may contribute to birth defects such as heart abnormalities that can lead to infant deaths (Moore, 2000). American Indians, Hispanic/Latinas, Asians, and African Americans all have higher rates of diabetes than whites. Preconception care and early and continuous prenatal care aimed at getting diabetes under control will promote good health for both mother and baby.

< Neural Tube Defects. Annually in the U.S., 2,500 babies are born with neural tube defects (NTDs), birth defects of the brain and spinal cord that can cause death or life long disability. Many additional pregnancies are miscarried or result in stillbirths because of NTDs. NTDs originate in the first month of pregnancy before many women know they are pregnant. Latina women and women who are obese before pregnancy have higher rates of births to babies with NTDs (Shaw, 1997 & 1996). Taking folic acid before and during pregnancy can prevent up to 70 percent of NTDs (March of Dimes, 1999).

< Births to teens. In Minnesota, a disproportionate number of infants born to teens die before their first birthday. Infants of teens have higher rates of deaths because of a combination of social and biological factors. Many of these deaths occur because of social conditions faced by these very young parents, especially when they have two or more children before the age of twenty (Amer. Academy of Pediatrics, 2001).

Strategies For Intervention

Infant mortality is a summary statistic reflecting multiple conditions and causes. Strategies must address the range of specific causes as well as the many social conditions that give rise to them. The following strategies may be included in proposals to eliminate health disparities in infant mortality, but other strategies not listed here may also be included. Strategies that promote, restore, or strengthen cultural or traditional health practices to promote women and infants' health, safety and well-being are encouraged.

< Prenatal care. High quality prenatal care begun early in pregnancy is essential to promote and maintain the health of both mother and infant and prepare for a healthy birth. Minnesota data indicate there is a wide disparity in rates of early and adequate prenatal care among populations of color and American Indians as compared to the white population. Projects that focus on culturally specific outreach, education, and pregnancy support programs, such as doula programs, have successfully improved rates of prenatal care for populations of color and American Indians.

Early and continuous prenatal care that includes assessment, education, and intervention for medical, social, and behavioral risks is an important component of a healthy pregnancy. Necessary components of good prenatal care include: monitoring and treating infections that can cause preterm delivery, monitoring weight gain and blood pressure; and counseling about nutrition, stress, and

reducing behavioral risks such as alcohol, tobacco, and drug use. Screening and referral for mental health issues and domestic violence are also key components. Prenatal care with care coordination to assure needed services (medical and psycho-social) are identified, intervention planned, services delivered, and follow-up accomplished will improve outcomes and better meet the needs of pregnant women, their newborns, and families.

< Family planning, child spacing, preconception counseling, and primary health care. Community interventions that help women plan their pregnancies, avoid closely-spaced pregnancies, obtain preconception counseling, and receive continuous primary health care are all associated with better health for mothers and lower infant death rates (Korenbrot, 2002). Especially important are programs that help teens delay additional pregnancies until they have achieved their own educational and vocational goals and are prepared to raise and support healthy children.

< Back to sleep. Infants who sleep prone—on their tummies—are at much higher risk for SIDS. Since this risk factor was identified, the Back To Sleep campaign was implemented nationwide to teach parents this important risk reduction technique. The campaign has been credited for a greater than 40 percent decline in SIDS (Amer. Academy of Pediatrics, 2000). A strategy to be considered by applicants would be to bring the Back To Sleep message and other infant safe sleep messages to the community they serve. Culturally specific materials for both African American and American Indian families are available from the MN SID Center or MDH Infant Mortality Consultant.

< Infant sleep safety education. Each year twenty or so Minnesota infants die of unintentional injury related to unsafe sleep conditions. These conditions include excess, soft bedding, sleeping in a bed with others, and sleeping in beds or surfaces not designed for infant safety. These preventable deaths may be caused by overlay by another person, suffocation, smothering, and entrapment. Comprehensive Infant Sleep Safety Education materials for new parents are available from the MDH Infant Mortality Consultant. An effective intervention strategy would be parent education combined with helping low income families obtain safe cribs for their babies.

< Prevention of unintentional injuries. Injury deaths, both unintentional and intentional are the third leading cause of death for infants one month or older (Brenner, 1999). Most commonly these deaths include motor vehicle crashes, inflicted head trauma known as Shaken Baby Syndrome (SBS), falls, burns, drownings, and choking. Interventions that help families obtain and use car seats properly, education to prevent SBS and other injuries are effective strategies to reduce infant deaths. Contact the MDH Infant Mortality Consultant for more information and materials on injury prevention.

< Smoking cessation and reduction. Quitting or reducing smoking during pregnancy has been shown to increase infant birth weight and sustaining cessation after delivery would improve the health of women, infants, and other family members. Information on an effective intervention tailored to pregnant women is available, specifically, the ***Five A's*** program: Ask, Assess, Advise, Assist, Arrange (Windsor, 2000). Contact the Infant Mortality Consultant for interactive training for administering this brief counseling as well as posters, self help smoking cessation materials for pregnant women, and a patient education video.

< Social support through home visiting programs. Social support provided through home visits to pregnant women by trained, racially/ethnically-matched paraprofessionals such as community health workers or doulas has been found to improve birth outcomes. In addition, these programs have been successful in assisting pregnant teens to access and participate in early and on-going prenatal services by reducing barriers that hinder access to needed prenatal services. The strength of paraprofessional home visiting programs is their impact on enhancing women's ability to improve their own health. The community health worker or doula provides needed social support to women whose lives are compounded by multiple and complex problems.

Home visiting programs using public health nurses and community health workers have also demonstrated a positive impact on birth outcomes. Repeated home visits by a trained nurse-community health worker team with on-going infant health monitoring plus individualized and culturally-sensitive teaching, helped mothers maintain good health practices, identify illnesses early, and decrease post neonatal mortality rates in the study group (Barnes, 1996).

Doulas provide important education and support to pregnant women, support during childbirth, and after the birth. Doula program evaluation has documented significant reduction in the use of pitocin, epidurals, forceps, and cesarean sections during labor and birth as well as increases in the confidence, sense of control, and self-esteem of the mother (Scott, 1999).

< Avoiding drugs and alcohol. Drug and alcohol abuse impact pregnancy and the infant by increasing rates of pre-term birth and low birth weight, intrauterine growth retardation, and fetal alcohol syndrome, and may contribute to overlay deaths and other infant injuries, including injuries as a result of abuse and neglect. Screening by asking women sensitive questions at regular intervals and referral for needed services are effective techniques to address these issues.

< Screening and referral for mental health issues/stress/perinatal depression. Women of childbearing age are at high risk of depression and pregnancy and new motherhood may increase the risk of depressive episodes. This can have devastating effects on the mother, her infant, and her family. Interventions that screen for depression and promote maternal mental health will improve the health and well being of mothers and their babies (Gaynes, 2005). Contact the Infant Mortality Consultant for more information.

< Parenting education and mother-infant attachment. Interventions to educate new parents about infant development, infant cues, and to promote bonding and attachment empower parents and promote infant health and well being as well as prevent abuse and neglect. Culturally specific strategies are encouraged (MDH Home Visiting Training Manual, 2001)

< Nutrition and weight gain. Maintaining a healthy weight before pregnancy and gaining weight during pregnancy according to the American College of Obstetricians & Gynecologists (ACOG) guidelines by eating nutritious foods will help women maintain good health and have a healthy weight baby. For low income women, the Women, Infants & Children Nutrition Program (WIC) can help. Projects that include helping women access WIC and teaching women about nutrition will improve birth outcomes.

< Folic acid. The March of Dimes estimates that folic acid taken before conception and during pregnancy reduces the rate of babies born with neural tube defects by 70 percent. These birth

defects of the brain and spinal cord occur in about 2,500 babies annually in the U.S. resulting in infant deaths and disabilities. Insufficient maternal folic acid has also been associated with other birth defects, stillbirths, and miscarriages. The key to success with this intervention is to get the message to women before they become pregnant. Research suggests that Latina women are at higher risk for giving birth to babies affected by neural tube defects (Shaw, 1997).

< Breastfeeding is best. It is well established that breastfeeding is the healthiest way for a newborn child to get the best nutrition possible, and breastfed babies have fewer infections and colds, higher I.Q.s, and less incidence of diabetes and childhood obesity than babies who are not breastfed (Amer. Academy of Pediatrics, 2005). In addition, breastfeeding can enhance maternal-infant attachment. A recent study (Forste, 2001) documented the impact of not breastfeeding on infant mortality rates among African American women. The results of this study indicate that breastfeeding accounts for the difference in infant mortality in the U.S. between African Americans and whites at least as well as low birth weight. Increasing breastfeeding rates could have a measurable effect on infant mortality in all populations.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in infant mortality rates of American Indians and populations of color as compared to whites. Examples of possible local project outcomes include:

< More planned pregnancies.
< More adult/teen women initiating care early in pregnancy and continuing care throughout pregnancy.
< More adult/teen women with adequate social and emotional support during pregnancy, labor and birth, and during infancy.
< More adult/teen women screened and treated for depression during pregnancy and after giving birth
< More adult/teen women screened for domestic violence and referred for help as needed.
< More adult/teen women/infants enrolled in WIC.
< More adult/teen women receiving appropriate care coordination during pregnancy and the first year of their child's life.
< More health education materials distributed in communities of color and among American Indians.
< Greater awareness of the community's role in reducing infant mortality.
< More new mothers initiating breastfeeding and continuing to breastfeed for at least 12 months.
< Fewer adult/teen women and fewer pregnant women who smoke.
< Fewer pregnant adult/teen women using alcohol and/or other drugs during pregnancy.
< More adult/teen women screened and treated before and during pregnancy for acute or chronic disease, such as STI/HIV, hypertension, and diabetes.
< More babies sleeping on their backs and in safe cribs.
< More adult/teen women taking folic acid prior to and during early months of pregnancy.
< Fewer uninsured adult/teen women and children.
< More parents of infants with knowledge of infant development and improved parent-infant attachment.
< More parents with knowledge of injury prevention and fewer infants experiencing injuries.

Resources

Local resources

< Infant Sleep Safety Education, Shaken Baby Prevention Education, Smoking Cessation in Pregnancy Resources, Low Birth Weight Prevention, injury prevention education. Available from MDH contact.

< SIDS information, Minnesota Sudden Infant Death Center, Kathleen Fernbach, Director 612/813-6285; Kathleen.fernbach@childrenshealthcare.org

Websites

< MDH's Infant Mortality Reduction Initiative (www.health.state.mn.us/divs/fh/mch/infamort.html)

< MDH's Family Home Visiting Website (www.health.state.mn.us/divs/fh/mch/fhv.html)

< Centers for Disease Control & Prevention, Infant Mortality (www.cdc.gov/nccdphp/drh/ih_idmort.htm)

< Safe Motherhood, Centers for Disease Control & Prevention, Pregnancy-related Health (www.cdc.gov/reproductivehealth/mh.htm)

< National Center for Education in Maternal & Child Health (NCEMCH) (www.ncemch.org) with links to the Maternal & Child Health (MCH) Library with Knowledge Paths for Spanish-Language Health Resources, preconception & pregnancy, infant mortality, racial & ethnic disparities in health, domestic violence, postpartum depression, and adolescent pregnancy prevention

< National Institute of Child Health & Human Development (NICHD) (www.nichd.nih.gov)

< National Black Child Development Institute (NBCDI) (www.nbcdi.org) with link to Parent Empowerment Project (PEP)

< Doulas of North America (www.dona.com)

< National SIDS Resource Center (www.sidscenter.org)

< National Healthy Start Association (www.healthystartassoc.org)

< March of Dimes Resource Center and Peristats (www.modimes.org)

< Annie E. Casey Foundation (www.aecf.org)

< National Partnership To Help Pregnant Smokers Quit (www.helppregnantsmokersquit.org)

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< MDH's Home Visitor Training Manual: Minnesota Training Partnership. Available from MDH contact or at: www.health.state.mn.us/divs/fh/mch/fhv/training

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Eliminating Health Disparities In Teen Pregnancy Prevention

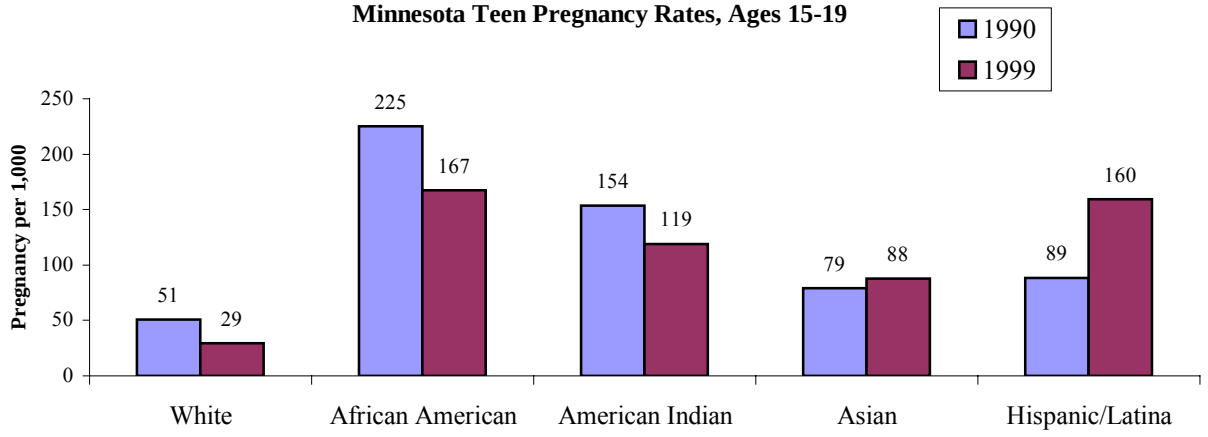
Background

Every day in Minnesota, more than 20 teens become pregnant and the vast majority of these pregnancies are unintended. Teen girls who become parents are less likely to graduate from high school and more likely to be single parents, live in poverty, have experienced sexual abuse, and depend on welfare programs, than women who wait to give birth beyond their teen years. Their infants are more likely to die before their first birthday than infants of adult women. Children of adolescent parents have poorer health outcomes, lower cognitive development, worse educational outcomes, higher rates of behavioral problems, and higher rates of teen childbearing themselves.

Nationally, half of all initial adolescent pregnancies occur within the first six months following the initiation of intercourse, and 20 percent occur within the first month. Thirty-nine percent of adolescents who never practice contraception become pregnant within six months. A sexually active teenager who does not use a contraceptive has, over the course of a year, an 89 percent chance of becoming pregnant.

It is estimated that 80 percent of all adolescent mothers will at sometime receive government assistance during the 10 years following the birth of their first child. Data from the Minnesota Department of Human Services indicates that approximately 48 percent of Minnesota families who received MFIP (Minnesota Family Investment Program) in December 1999 began with a teen birth. Decreasing teen pregnancy is one of the most significant steps we can take to increase self-sufficiency.

Minnesota has wide and unacceptable disparities in the rates of teen pregnancy across its population (see below). While Minnesota's teen pregnancy rate among whites is one of the lowest in the nation, the rates among African American and Hispanic/Latina teens are first and second respectively. While teen pregnancy rates among many Minnesota populations are decreasing, there is an alarming increase in pregnancy rates for Asian and Hispanic/Latina teens.



Funds for the teen pregnancy prevention grants included in this Request for Proposals come from the federal Temporary Assistance for Needy Families (TANF) program. TANF provides significant flexibility to states in designing and funding strategies to support TANF purposes and allows funding

to serve not only families on welfare but also families who may be at risk for needing welfare assistance in the future. The four federal TANF purposes are:

< to provide assistance to needy families so that children may be cared for in their homes or in the homes of relatives;
< to end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;
< to prevent and reduce the incidence of out-of-wedlock pregnancies; and
< to encourage the formation of two-parent families.

The focus of these grants is on the third federal purpose of TANF: the prevention and reduction in the incidence of out-of-wedlock pregnancies. In Minnesota, over 85 percent of teen pregnancies are to unwed mothers. Preventing teen pregnancy reduces infant mortality, child poverty, and out-of-wedlock childbearing and is an effective way to improve overall child and family well-being.

Contributing Factors

The reasons teens become pregnant are complex and varied. While all teens are at risk, some teens are at increased risk for early sexual activity, poor contraceptive use, and pregnancy. Knowing what factors put some youth at increased risk for teen pregnancy and what factors appear to be protective allows communities to target activities that can guide the development of effective programs. While no program can address all contributing factors, effective programs focus efforts on more than one factor. The following table identifies some of the risk and protective factors related to the family, the individual and the community. The recently published document *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* has a more comprehensive list of contributing factors to adolescent sexual behavior, use of contraception, pregnancy and childbearing and is an excellent resource for planning teen pregnancy prevention efforts. (See resource section).

Contributing Factors	Risk Factors	Protective Factors
Family Factors	< Living with a single parent < Having an older sibling who became pregnant < Disconnected from family with little parental monitoring of activities and poor child/parent communication < Mother who had sex and first birth early < Intergenerational dependency on welfare	< Living with biological parents < Close, warm parent-child relationship < High parental income < High parental educational attainment < Appropriate parental supervision and monitoring < Positive parental attitudes about contraception < Conservative parental attitudes about premarital or teen sex
Individual Factors	< Tobacco, alcohol or drug use < Problem behavior or delinquency < Depression < Early and frequent dating < Experienced sexual abuse < Having a partner three or more years older < Running away from home < School dropout	< Good school performance < Plans for the future < Perceived susceptibility to pregnancy, STDs/HIV < Greater knowledge about contraception < Greater participation in sports < Positive self-concept < Greater perceived negative consequences of pregnancy
Community Factors	< High unemployment rate < High crime rate	< High level of education < High income level

Contributing Factors	Risk Factors	Protective Factors
	< High rate of residential turn over < High percent of full-time working females < Higher teen non-marital birth rate	< Higher percent foreign born individuals < Higher percent religious adherents < Greater community monitoring by adults in the community

Strategies For Intervention

There is no simple solution or single approach to the complex issue of teen pregnancies. Ultimately we would like to enhance the factors that protect youth from an unplanned pregnancy while decreasing the risk factors that make it more likely that they will become pregnant. Teen pregnancy prevention projects: 1) can be evidence based, replicating an existing program that has been shown to be effective with similar populations of teens; 2) can choose to select or design programs with similar strategies of promising programs that have been effective with similar populations of teens; or 3) can design new innovative approaches to the problem that can be expected to affect particular behaviors by teens.

To enhance the chances of success, teen pregnancy prevention efforts should:

< Address the risk and/or protective factors contributing to teen pregnancy;
< Involve youth and their parents/caregivers in the development and implementation of the project;
< Be linked to other community efforts (e.g., school, local public health, non-profit activities, etc.) that can enhance or expand project strategies;
< Coordinate with other community efforts/activities that target the same population to prevent duplicative efforts or mixed messages; and
< Build partnerships to mobilize the community to come together to address the issue of teen pregnancy prevention.

Examples of evidence-based and promising strategies:

Focus Area	Evidence-Based and Promising Strategies
Reproductive Health **Effective programs share ten necessary characteristics (from *Emerging Answers*):** < Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD. < Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted. < Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of	< Implement evidence-based curricula identified by CDC as programs that work. These include: ▪ ***Reducing the Risk*** ▪ ***Safer Choices*** ▪ *Becoming a Responsible Teen* ▪ *Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention; and* ▪ *Making a Difference: A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention.* < Abstinence focused curriculum such as: ▪ *Postponing Sexual Involvement*; ▪ *Managing Pressures* (formerly known as *PSI Corollary*); ▪ *Abstinence Curriculum;* ▪ *Worth the Wait Program;* and ▪ *Removing the Risk* < As an adjunct to teacher-led instruction, train and support peer educators/leaders who can role model social skills and lead role-plays. < Implement educational programs to improve parent/child communication about healthy sexuality such as *Can We Talk*? or the Spanish version *Conversamos.* < Implement programs designed to improve access and/or correct use of

Focus Area	Evidence-Based and Promising Strategies
contraception. < Provide information about the risks of teen sexual activity and ways to avoid intercourse or use methods of protection. < Include activities that address social pressures. < Provide examples and practice with refusal skills, communication, and negotiation. < Employ teaching methods designed to involve participants. < Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of student. < Last a sufficient length of time. < Select teachers or peer leaders who believe in the program and provide them adequate training.	condoms or other contraceptives for sexually active adolescents. < Implement programs to address emotional, legal, financial etc. responsibilities of paternity. Programs to promote abstinence or sexual responsibility or to increase involvement of young fathers in their children's lives. An example would be *Dads Make a Difference.* < Provide training to health care workers and others who work with adolescents on how to talk to youth about reproductive health issues. < Implement a multi-faceted program such as *MN ENABL Program,* which uses a focused curriculum; has community-organizing activities; and is supported by media efforts.
Youth Development Programs for Adolescents **Effectiveness of youth development programs can be enhanced if sexuality education is included or programs are linked to community/school reproductive health education.** **Essential elements of an effective youth development program include (from the National Youth Development Information Center):** < A comprehensive strategy with clear mission and goals. < Committed, caring, professional leadership. < Youth-centered activities in youth accessible facilities. < Culturally competent and diverse programs. < Youth ownership and	< Implement effective Service Learning Programs such as *I Have A Future, Reach for Health Community Youth Service Learning,* and *Learn and Serve.* < *Teen Outreach Program* (TOP) and the Spanish version *Cambios* are youth development programs combining life skills and sexuality education with involvement in community service. < Provide assistance with academic subjects/homework beyond regular classes that will lead to school success. < Provide mentoring opportunities – one-on-one regular contact for an extended period of time with trained adult for recreation and skill/relationship building. < Implement programs that provide meaningful activities that enhance parent/youth communication and promote connectedness. < Implement programs that focus on parent/caregiver education skill building and involvement with their children. Classes on sexuality, positive parenting techniques, rules, behavior management, etc. to provide parents with age-appropriate information, resources, and skills to support, nurture, and affirm their children. < Implement after-school activities that are linked with community resources (schools, churches, synagogues, etc.) to engage youth in physical activity, technology, leadership, etc. < Implement life skills education/training for adolescents that include skills such as communications, decision-making, and goal setting. < Provide employment opportunities and skill development through apprenticeships with business/other employers to assist youth in learning marketable skills while experiencing work. < Provide supervised volunteer community service opportunities/activities for youth.

Focus Area	Evidence-Based and Promising Strategies
involvement. < A positive focus including all youth.	
Programs That Include Both Reproductive Health and Youth Development Components	< *California's Adolescent Sibling Pregnancy Prevention Program* targets sisters of teen girls who became pregnant; and offers individual case management and group activities and services. < Children's Aid Society *Carrera Teen Pregnancy Prevention Program*. This is an intensive program lasting through high school. It includes: family life and sex education; education component; a work-related intervention; self-expression through the arts; and individual sports. < *Girls Incorporated Preventing Adolescent Pregnancy* provides information and fosters skills in communication, assertiveness and refusal, contraception and STD prevention, and academic and career planning.
Programs That Prevent or Delay Second Teen Pregnancies	< Implement a program that provides opportunities to meet with other pregnant or parenting teens to develop problem-solving skills, sense of uniqueness, personal power, etc. < Provide case management services to coordinate the variety of services that pregnant or parenting teens need and to work with teen mothers to prevent subsequent pregnancies, encourage school completion, and strengthen parenting skills. < *A Health Care Program for First-Time Adolescent Mothers* uses a medical and counseling approach.

* Information on ordering curricula can be found at (www.health.state.mn.us/divs/fh/chp/yrbplan.htm)

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in teen pregnancy rates of American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:

Outcomes related to decreasing risk factors:
< Decrease the percentage of youth who drop out of school.
< Decrease the percentage of youth who skip school.
< Decrease the percentage of youth who cannot talk to their parents/caregivers about their problems.
< Decrease the percentage of youth who run away from home.
< Decrease the percentage of youth who use tobacco, alcohol, or other drugs.

Outcomes related to promoting or strengthening protective factors:
< Increase the percentage of youth that have goals/plans after high school graduation.
< Increase the percentage of youth who feel they can talk about problems with their parents/caregivers.
< Improved school performance.
< Increase the percentage of students who report feeling good about themselves.

< Increase the percentage of parents/caregivers who appropriately monitor their children's activities.

Outcomes related to sexual behaviors:
< Increase the percentage of youth who are abstinent.
< Increase the percentage of sexually active youth who report that they always use birth control.
< Increase the percentage of sexually active youth who correctly use contraception methods.
< Reduce the percent of subsequent births to teens.
< Increase birth spacing to 24 months.

Resources

The following resources provide excellent information on contributing factors and on effective strategies to reduce teen pregnancies:

< Centers for Disease Prevention and Control, Programs That Work (www.cdc.gov/nccdphp/dash/rtc
< Centers for Disease Prevention and Control, Unintended Pregnancy (www.cdc.gov/nccdphp/drh/up.htm)
< The U.S. Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior, June 2001 (www.surgeongeneral.gov/library/sexualhealth/call/htm)
< Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, Douglas Kirby, Ph.D., May 2001 (www.teenpregnancy.org)
< Communities Responding to the Challenge of Adolescent Pregnancy Prevention: "Linking Pregnancy Prevention to Youth Development." Volume V. Advocates for Youth, Washington, D.C. 1998. (www.advocatesforyouth.org)
< Adolescent Health Status. Population Health Assessment Quarterly, Volume 1, Issue 4, Special Issue 2000, Center for Health Statistics, Minnesota Department of Health. (www.health.state.mn.us/divs/chs/data/popassess.htm)
< Kirby, D. (2000) Logic models: A useful tool for designing, strengthening, and evaluating programs to reduce teen pregnancy. Santa Cruz, AA: ETR Associates.
< Get Organized: A Guide to Preventing Teen Pregnancy, National Campaign To Prevent Teen Pregnancy. (www.teenpregnancy.org)
< Blum, R.W., Beuhring, T., Rinehart, P.M., (2000) Protecting Teens: Beyond Race, Income and Family Structure, University of Minnesota, 200 Oak Street SE, Suite 260, Minneapolis, MN.

MDH Contact

For more information about teen pregnancy prevention, contact:

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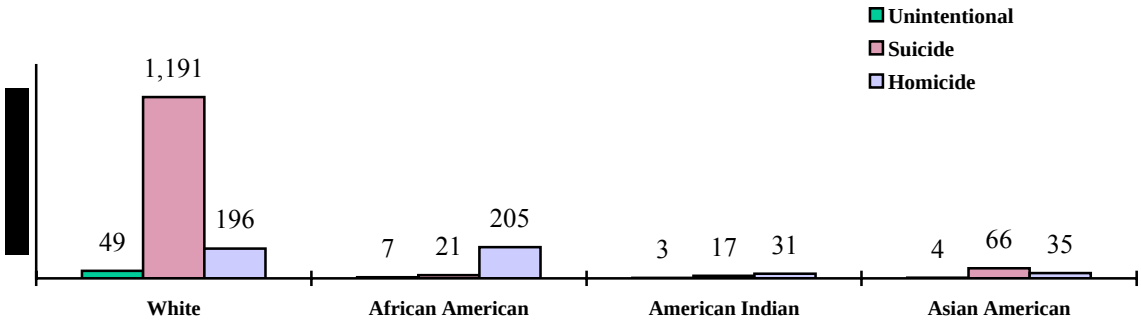
Eliminating Health Disparities In Violence and Unintentional Injuries

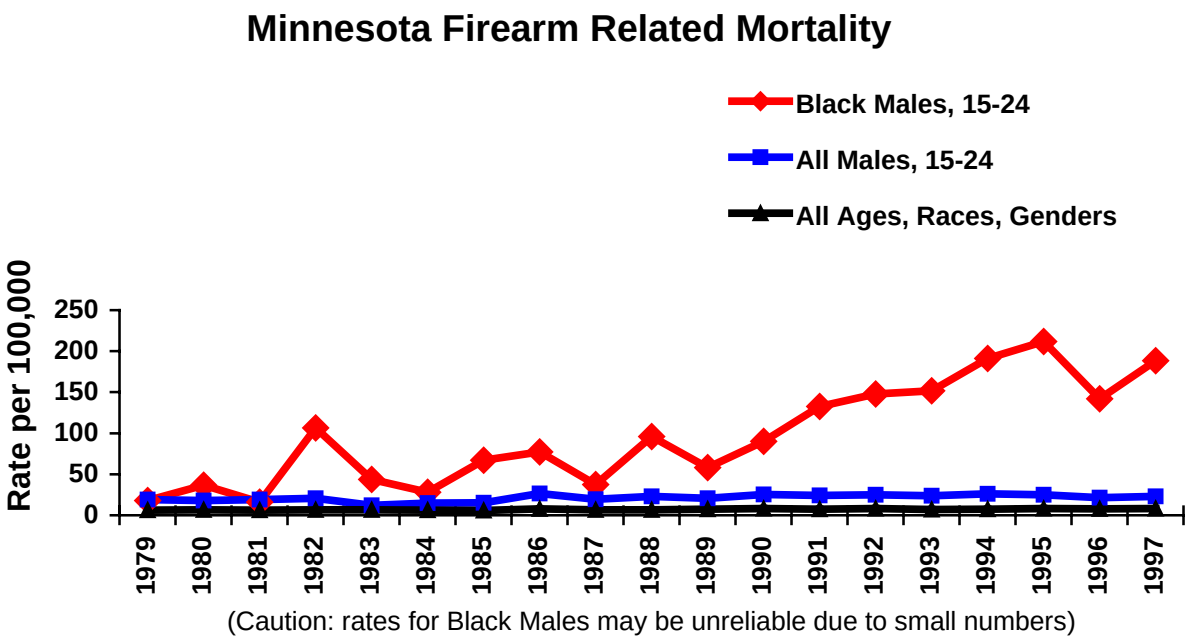
Background

Injuries are a substantial burden on our communities, resulting in lost time from work and school and in long-term disability. The burden of injury and violence in Minnesota is not shared equally. American Indian males aged 18 and 19 have suicide rates six times higher than in any other age or population group. African American youth aged 15 - 24 have firearm injury (FRI) mortality rates eight times greater than for all males 15 - 24 in Minnesota, and 15 times greater than the rates for all ages, races and genders combined. African Americans and American Indians in Minnesota have rates of Traumatic Brain Injury (TBI) more than four times higher than among the rest of the population. African American, American Indian, and Hispanic/Latino children have rates of child maltreatment five, three and two times greater, respectively, than Asian/Pacific Islander and white children in Minnesota. African American, American Indian and Hispanic/Latino sixth to twelfth grade students report sexual abuse more often than white or Asian youth. All minority groups in Minnesota report higher rates of intra-familial abuse compared to white Minnesotans.

Number of Firearm Related Deaths
1992-1996



Other important disparities also exist in Minnesota. Women experience more non-fatal injuries than men. Self-inflicted poisonings are the leading cause of hospitalization for women aged 10 - 39. Men sustain more fatal injuries than women. All Minnesotans have fall death rates one and one-half times higher than the U.S. fall death rates. Among the elderly, fall death rates are more than three times greater. Childhood TBI mortality rates are twice as high in non-metro Minnesota than in metropolitan Minnesota. Minnesota's poor (median household income less than $20,000 per year) are injured at twice the rate of all others. And this group sustains assault-related injuries at more than five times the rate of all others.



Contributing Factors

Known contributing modifiable factors for injury and violence include:

< Poverty,
< Unsupervised access to firearms and inadequately stored firearms,
< High rates of depression and hopelessness,
< Alcohol,
< Home hazards,
< Inadequate fall-prevention education, and
< Policies and programs that do not adequately support parents and families.

Strategies For Intervention

The following strategies may be included in proposals to eliminate health disparities in unintentional injury and violence, but other strategies not listed here may also be included. Community-driven and directed prevention programs and policies are the most effective way to address the disparity between those enjoying good health and those most affected by injury and violence.

Based upon the evidence to date, effective or promising strategies include:

< Strengthen asset-based parenting training and family support systems. This should occur when community and faith-based initiatives partner to support community and culturally

specific appropriate interventions and activities at the family and community level.
< Provide parenting education and youth mentorship programs.
< Provide for the safe storage of and limited access to firearms and ammunition.
< Provide broader availability of mental health services.
< Provide fall prevention programs for people of all ages including home safety, exercise, and medication management.
< Implement home safety programs using the Home Safety Checklist, which includes smoke alarm distribution and installation, fire safety training, and home hazard amelioration.
< Promote regular exercise (walk for 30 minutes each day) and support appropriate nutrition.
< Modify the environment to support community walking and other exercise programs (for example, install street or parking lot lighting; this will reduce risk of falls and will enhance safety).
< Encourage bicycling.
< Implement school-based and workplace non-violent conflict resolution and bullying prevention policies and training.
< Promote increased use of seat belts.
< Support legislation to lower the blood alcohol content level for legal driving to 0.08 or 0.06.
< Reduce community acceptance of alcohol use in general, alcohol use by women of childbearing age, and access to and use of alcohol by minors.
< Support and promote smoking cessation programs at the community level. This will reduce the risk of house fires, burn injuries, and deaths.
< Ensure access to information about sexual abuse for children, youth, parents, and other adults.

Anticipated Outcomes

The overall goal of this initiative is to reduce the disparities in violence and unintentional injuries in American Indians and populations of color as compared with whites. Examples of possible local project outcomes include:
< An increase in community and family assets.
< Fewer cases of suspected and confirmed child neglect and maltreatment.
< Fewer cases of sexual violence.
< Fewer firearm-related injuries (unintentional, self-inflicted, and assaultive).
< Fewer suicides and suicide attempts.
< An increase in seatbelt use and a decrease in injuries associated with motor vehicle crashes.
< Fewer alcohol-related motor vehicle crashes.
< Fewer house fires and a decrease in injuries and deaths associated with such fires.
< A decrease in fall injuries, especially those occurring in the home.

Resources

< Youth Violence: A Report of the Surgeon General (http://www.surgeongeneral.gov/library/youthviolence/chapter5/sec3.html)

< Thornton TN, Craft CA, Dahlberg LL, Lynch BS, Baer K. Best Practices of Youth Violence

Prevention: A Sourcebook for Community Action. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2000.

< Risks and Realities of Violence in Bloomington, Bloomington Advisory Board of Health, 1996.

< Violence-free Minnesota. 1994 Report to the Minnesota Legislature, Office of Drug Policy and Violence Prevention, Minnesota Department of Public Safety.

< The Future of Children: Unintentional Injuries in Childhood. The David and Lucille Packard Foundation, Volume 10 (1): spring/summer 2000.

< Thompson NJ, McClintock HO. Demonstrating Your Program's Worth: A Primer on Evaluation for Programs to Prevent Unintentional Injury. Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 1998.

< For youth violence prevention: (www.colorado.edu/cspv/blueprints)

< For violence against women: (http://www.ojp.usdoj.gov/vawo/)

< A Community Checklist: Important Steps to End Violence Against Women. Call the US Department of Justice at 202/616-8894.

< For sexual violence prevention: (www.health.state.mn.us/svprevent)

< Preventing Sexual Assault in Colorado: Multidisciplinary Strategies. Colorado Department of Public Health and Environment, Sexual Assault Prevention Advisory Committee; 303/782-0095.

< For Injury and Violence data (http://www.health.state.mn.us/divs/fh/chp/injury.htm) or 651/281-9857

< Raising Responsible and Resourceful Youth, Strengthening Families, Empowering Parents. Juvenile Justice, Volume VII, Number 3. Journal of the Office of Juvenile Justice and Delinquency Prevention. 202/307-5911.

< Guard A. Violence and Teen Pregnancy: A Resource Guide for MCH Practitioners. Newton, MA: Children's Safety Network, Education Development Center, Inc., 1997.

MDH Contact

For more information about violence and unintentional injury, contact:

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Appendix C

Asset-Based Community Development

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Asset-Based Community Development

Be Creative, Involve Others
Plan, Plan, Plan

What Is Asset-Based Community Development?

Asset-based community development (ABCD) is a strategy used to discover a community's capacities and assets and to mobilize those assets for community improvement. The information presented here is based on the work of John McKnight and John Kretzmann, co-directors of the Asset-Based Community Development Institute, Institute for Policy Research, Northwestern University. To learn more about their work you can go to their website at http://www.northwestern.edu/IPR/abcd.html.

The process of ABCD differs from the more traditional strategy of community needs assessment. Needs assessments typically focus attention on problems and deficiencies and negative images. The ABCD process focuses on the strengths of a community and how to bring those strengths to bear in community improvement activities. For example, a typical needs assessment starts with the questions, "What is wrong? What is the problem?" And leads to the question, "How can we fix it?" In ABCD work, we start with the question, "Where are the gifts of the individuals, local associations, and local businesses in the community?" And leads to the question, "How can our community assemble its strengths into new combinations, new structures of opportunity, new sources of income and control, and new possibilities?"

Each community boasts a unique combination of assets upon which to build its future. One can discover in every community a vast and often surprising array of individual talents and productive skills, few of which are being mobilized for community-building purposes. In many communities across the country, community builders are refocusing their attention on capacities and assets and are inventing new methods for mobilizing neighborhood residents.

Five Steps Toward Whole Community Mobilization

The following steps do not presume to add up to a complete blueprint for broad, asset-based community development. Rather, they identify some of the major challenges and point to a potential process. They could become part of your disparities grant proposal and could be adapted to the various priority areas for this community grants program. They include:

Step 1. Mapping the capacities and assets of individuals, citizens' associations, and local institutions that exist and that can be marshaled in the community. This mapping can be done at the individual, organizational, or the community level. It can be used to identify who to involve, which issue(s) to work on, or after the issue is prioritized to further plan and implement activities. Mapping tools are located on the web site mentioned above.

Step 2. Building and strengthening partnerships among local assets for mutually beneficial problem-solving within the community. The mapping mentioned above can be used to identify

and recruit potential partners in ways that are different than how we tend to recruit (e.g., recruit the "usual suspects" by going to the professional organizations in the community and asking for a representative). Again, this can be done at multiple levels and in the context of the different priority health areas. For example, groups have found and mobilized the capacities of individuals; the gifts of "strangers" (marginalized individuals who can be involved not as "clients" but as contributors); the existing associations and clubs; the local private, public and nonprofit institutions; the community's physical assets (land, buildings, streets, transportation systems) and the community's collaborative leaders who are interested in constantly expanding the numbers and kinds of people involved.

Step 3. Mobilizing the community's assets for economic development and information sharing purposes. Beyond locating assets and beginning to build relationships, ABCD involves mobilizing all of the community's assets. Each local association and institution can be urged to begin making its own set of contributions. For example, organizations can provide support (e.g., encouragement, direction, mentoring, guidance, linkages, transportation, etc.) to those who have contributions to make as part of the solutions/activities that are being implemented. The capacity to exchange information is central to the success of any community building project. So it is important to learn about all those places in the community where communication of a "public" nature takes place: churches, clubs, beauty and barber shops, even street corners. How can these be validated, strengthened and expanded?

Step 4. Convening as broadly representative a group as possible for the purposes of building a community vision and plan. Who are we in this community and what do we value most? Where would we like our community to go in the next five, ten, twenty years? These are simple but compelling questions that can be adapted to the work of eliminating health disparities. There are many community planning models and approaches. What works in one community will not necessarily work in another. The main ideas here are begin with assets, expand the table, and combine planning with problem-solving. Beginning with assets means starting with a thorough inventory of the capacities of individuals, associations, and institutions in the community. Expanding the table refers to making the planning process as open and participatory as possible, including participants not normally thought of as community leaders. Finally, combining planning with problem-solving means choosing practical activities that the group can start working on now, while at the same time planning longer term efforts.

Step 5. Leveraging activities, investments and resources from outside the community. Leveraging activities, investments, and resources from outside the community to support asset-based, locally-defined development, according to McKnight and Kretzmann, is only done when all of the steps above have begun. A community that has mobilized its internal assets offers opportunities for real partnerships, for investors who are interested in effective action and in a return on their investment.

For more information on these and other ideas see (http://www.northwestern.edu/IPR/abcd.html)

What Are Some Practical Ideas For Implementing Asset-Based Community Development Activities In A Community?

Listed below are examples of practical asset-based community development activities that emerged from an asset mapping project in the city of Savannah. Neighborhoods identified priority issues of crime prevention and youth development and developed projects through a small grants program. This list of activities is not exhaustive or even necessarily appropriate to the elimination of health disparities. It is offered to help jump start your own creative ideas. The Savannah activities included:

- Sponsoring community conversations on neighborhood safety issues.
- Supporting a parental-involvement workshop.
- Supporting local oral history projects.
- Holding workshops on health-related special needs.
- Finding ways to build partnerships between associations and churches.
- Using the local association mapping process to find associations that are willing to do similar projects and convening a meeting to determine how they can work together.
- Asking local business owners to become members of the neighborhood associations, valuing their unique perspective on the neighborhood, and making sure they feel that they have a role to play in community building efforts.
- Installing motion detector lights for yards and public areas.
- Holding a neighborhood anti-drug march.
- Participating in the National Night Out Festival.
- Providing after-school tutoring programs for young people.
- Offering mentoring programs for youth.
- Cleaning a vacant lot for the Soccer in the Streets Program.
- Taking young people on special interest field trips.
- Sponsoring membership in Boys and Girls Clubs.
- Promoting an Adopt-a-Grandparent Program.
- Organizing a Youth Working Together project.

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Appendix D

Contributing Factors That Cut Across Priority Health Areas

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Contributing Factors That Cut Across Priority Health Areas

Many factors contribute to the priority health areas that are the focus of the Eliminating Health Disparities Initiative. In some cases these factors "cut across" or contribute to more than one of the priority health areas.

As an applicant for these grant funds, you are encouraged to consider focusing your activities on one or more cross-cutting, contributing factors as a way to address your chosen priority health area(s). The table that follows illustrates some of those factors and indicates which priority health areas they affect (sources are cited under the title of the table).

Many of the social conditions and the asset-based activities mentioned throughout this Request for Re-Applications also cut across the priority health areas. Appendices C, E, F and G provide information and examples that may help you choose activities on which to focus your grant application. Specifically, those appendices are:

< Appendix C - Asset-Based Community Development Strategies
< Appendix E - Social Conditions
< Appendix F - Potential Strategies And Community Partners
< Appendix G - Community Engagement

Contributing Factors That Cut Across Priority Health Areas

[Sources: (1) Appendix B, "Priority Health Areas", of this Request for Proposals; (2) McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993; 270:2207-12; (3) Breastfeeding: A Guide for the Medical Profession, 5th edition 1998. Ruth Lawrence, Mosby, pages 388-389, 520-521; and (4) Singhal, A, Cole, T and Lucas, A. Early nutrition in pre-term infants and later blood pressure: two cohorts after randomized trials. Lancet; 357:413-419. Feb 2001.]

Cross-Cutting Contributing Factors	Breast & Cervical Cancer	Cardiovascular Disease	Diabetes	HIV/AIDS and Sexually Transmitted Infections	Immunizations for Adults and Children	Infant Mortality	Teenage Pregnancy Prevention	Unintentional Injuries and Violence
Alcohol Use				×		×	×	×
Breastfeeding		×[1]	×		×[2]	×		
Illegal Drug Use				×		×	×	×
Infectious Agents	×			×	×	×		
Motor Vehicles						×		×
Overweight and Obesity		×	×			×		
Physical Inactivity	×	×	×			×	×	×
Poor Diet/Nutrition	×	×	×			×		×
Sexual Behavior	×			×		×	×	×
Tobacco Use		×	×	×		×	×	×

[1] Breastfeeding is a factor in preventing obesity and hypertension later in life, both of which are strong contributing factors in cardiovascular disease.
[2] Breastfeeding does not replace immunizations. Breastfeeding does offer some additional protection for the infant or child who is breastfed and may also result in higher antibody titers after some types of immunizations.

Appendix E

Social Conditions

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Social Conditions

This appendix contains a portion of the Executive Summary of the report, *A Call To Action: Advancing Health For All Through Social and Economic Change.* The full report can be found on the internet at (http://www.health.state.mn.us/divs/chs/mhip/action.pdf). The findings in this report challenge us to change the way we implement health improvement efforts, examine the health impact of social and economic forces at play outside the traditional health sector, and renew attention to the roles we play as individuals and organizations in creating and perpetuating health disparities.

As you work on your application for the funds from The Eliminating Health Disparities Initiative Community Grants Program, consider focusing activity on the social conditions that affect your chosen priority health area(s) and/or the people with whom you will work on this project. The examples and ideas in this appendix are meant to stimulate your thinking and to encourage you to be creative about how you might implement them. This community grants program provides both an opportunity and a challenge to you to make a difference by developing "best practices" appropriate to the populations in your communities.

A CALL TO ACTION:
Advancing Health For All Through
Social and Economic Change

This report is a multi-disciplinary, inter-sector Call to Action produced by the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership (MHIP).

The purpose of this report is to deepen understanding of the impact that social and economic conditions have on health, and identify recommendations with potential to help create more health-enhancing social and economic environments in Minnesota.

A unique contribution of this report is its focus on social and economic change as a strategy for health improvement and as a remedy to health disparity. This report examines the importance of social interactions and policies within settings (e.g., places where we live, work, learn, worship and play) and systems (e.g., education, criminal justice, human services) outside of the health sector that have a profound impact on health.

VISION: All people in Minnesota have an equal opportunity to enjoy good health.

Minnesota ranks as one of the healthiest states in the nation, but mounting evidence shows that this great state of health is not shared by all – particularly American Indians, populations of color, foreign-born populations, and people with low income.

We are one Minnesota. Health disparities affect us all. Minnesota should commit to leading the nation in the health of all of its citizens, not only because this is the right thing to do, but because this will contribute to the overall health and prosperity of Minnesota.
Health is more than not being sick. Health is a resource for everyday life – the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. Health

has physical, mental, social and spiritual dimensions.
Achieving this vision is bigger than our systems of public health and health care. All individuals, systems and institutions in the community share responsibility for – and reap the rewards of – improved health.

America's strength is rooted in its diversity. Our history bears witness to that statement. E Pluribus Unum was a good motto in the early days of our country and it is a good motto today. From the many, one. It still identifies us – because we are Americans.—Barbara Jordan, former U.S. Senator

Summary Of Key Findings

Health is a product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with collective conditions (factors in the physical, social and economic environment).

The social and economic environment is a major determinant of population health that has not been a focus of most health improvement efforts in Minnesota.

Key aspects of the social and economic environment that affect health include income, education, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation and nutritious foods; employment and working conditions; and culture, religion and ethnicity. For example:

< People with a higher income generally enjoy better health and longer lives than people with a lower income. The rich are healthier than the middle class, who are in turn healthier than the poor. This is true for people of all racial and ethnic backgrounds.

< Disease and death rates are higher in populations that have a greater gap in income between the rich and poor. The effect of income inequality on health is not limited to people in poor and low income groups. The health of people in middle (and in some studies upper) income groups is worse in communities with a high degree of inequality when compared to communities with less inequality. The health of a population depends not just on the size of the economic pie, but on how the pie is shared.

< People are healthiest when they feel safe, supported and connected to others in their families, neighborhoods, workplaces and communities. More cohesive communities (those characterized by greater civic participation, volunteerism, trust, respect and concern for others) have lower rates of violence and death.

< Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe and there are ample opportunities for control, decision-making, advancement and personal growth.

< Culture, religion and ethnicity have an overarching influence on beliefs and practices related to health, illness and healing. This includes perceptions of health and illness, beliefs about

the causes of health and illness, decisions about whether to seek a health care provider, and decisions about the type of provider or healer that should be sought.

More research is needed to understand precisely how these factors affect health and health disparities, and how to translate these findings into the most promising policies and programs. Studies conducted to date point to conclusions such as:

< Social and economic factors influence a broad array of opportunities, exposures, decisions and behaviors that promote or threaten health (e.g., availability of safe and convenient parks and trails encourage recreation and neighborhood connections; oppression and marginalization contribute to violence and apathy; high housing costs leave fewer resources for other necessities; transportation eases isolation; farmer's markets encourage eating fresh produce; family leave and quality child care promote attachment and positive development; cultural insensitivity alienates community members; the concentration of liquor outlets in low income neighborhoods encourages alcohol use and abuse).

< Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), and chronic stress.

< People of color and American Indians do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). At every level of income, their health is worse than that of their white peers.

< People with low income do not experience worse health simply because of high risk personal behavior (although this is an important factor). In one recent study, health behaviors such as cigarette smoking, alcohol use, and physical inactivity explained less than 20 percent of the difference in death rates across income groups.

Conclusions

Good health enables Minnesotans to lead productive and fulfilling lives, and contributes to the competitiveness, prosperity and social stability of the state.

Good health results from good systems of public health and medical care, from sound public policies that create social and economic conditions that support health, and from individual decisions and behaviors that value health. A comprehensive health improvement agenda addresses each of these determinants and recognizes the inter-relationships between them.

More supportive social and economic conditions are needed to eliminate disparities and achieve Minnesota's overall health improvement goals.

The links between health and factors such as income, education, living and working conditions, culture, social support and community connectedness are clear. But more research is needed to understand more precisely how these factors affect health, and how to translate these findings

into the most promising policies and programs.

The eight priority areas are indicators of greater disparities experienced by racial and ethnic minority groups in Minnesota. The social determinants of health play an essential role in the priority health areas targeted in this initiative. Strategies that address these underlying social and economic factors can have positive and lasting affects the health of those groups experiencing the greatest health disparities.

Some Suggested Strategies

For example, strategies could focus on:

Addressing issues of unequal access to affordable, nutritious food

Unequal access to food is a well-documented issue. Over the years, commercial pressures have led to fresh food outlets in many low-income areas being closed down. The alternative way of obtaining fresh food is to make a journey to a supermarket – often not possible by public transportation. The spread of out-of-town supermarkets aimed at car users have caused big problems for many inner city communities, who are left with corner shops that do not carry a large or varied supply of nutritious foods.
People who cannot easily get to the supermarkets are thus surviving on corner shop food, usually canned or processed, or fast food. Their diet suffers, and consequently their health also. The overall effect is to increase the inequalities in health already suffered by disadvantaged communities.*

Examples of activities that have addressed this issue include:

< Develop community centers that grow or that buy and bring in fresh fruit and vegetables, then sell the produce at cost to community members and consumers.
< Provide shuttles that transport community members to shopping centers and supermarkets at convenient times.

Source: Linda Sheridan (unpublished), from The Report of HIA on the Greater London Authority draft economic development strategy; 2001.

Working to improve community environments that promote physical activity and wider mental well-being and quality of life

Unsafe, dirty environments present many barriers for community members attempting to increase their activity levels. Fear of crime keeps many people indoors, as does the lack of safe and pleasant parks and green spaces, or even usable sidewalks. Many residents from a low-income neighborhood would find it difficult, if not impossible, to afford fitness center memberships or undesirable to travel to cleaner, safer neighborhood with good facilities.
Examples of activities that have addressed this issue include:

< Increase feelings of community safety by developing working partnerships with local law

enforcement, community planners, and residents to address packets of crime.

< Offer free or low-cost fitness facilities, exercise classes, or outdoor recreation areas at community centers. Classes on diabetes management or parenting skills could be offered in conjunction with other health opportunities. Including young people could help them to develop healthy habits that may prevent the onset of many chronic conditions, such as diabetes, and promote self-esteem.

Advocate for good quality, affordable housing

The impact of housing on health cannot be overemphasized. Enabling people to obtain a safe, secure place to live can have far reaching health implications, from the environmental effects contributing to the control of asthma to mental health and well-being. Some strategies may include:

< Offer housing benefit workshops to link people with resources or programs that can help them afford housing. This can empower them to navigate the application processes. Many processes needed to receive benefits are complex and require a high level of literacy, and are barriers to access.
< Foster relationships between community members and housing developers to ensure that housing meets the needs of the community, as well as future residents.

Promoting education, literacy, and employment

Promoting education, literacy, and employment policy are major factors contributing to employment status. Addressing barriers to employment such as illiteracy or lack of education can open avenues of access to better housing, improved nutrition, leisure, and health care. Examples of strategies include:

< Connect elderly residents in the community with literacy programs. This has a two-pronged approach of addressing social isolation issues for the elderly, as well as offering the opportunity to learn to read to community members, which in turn can increase their ability to apply and qualify for jobs.
< Develop partnerships with local employers to develop innovative recruitment practices that are culturally sensitive or accessible to marginalized populations. This could also involve strategies to improve working conditions for current employees, such as assisting in the development of workplace safety or stress management programs, or to alter workplace policies to make jobs more accessible. Policy development could include, for instance, job share opportunities for people with child care issues, assistance with child care facilities, or culturally sensitive leave and vacation policies.

These are just a few examples of a broad approach to thinking about how we can tackle health disparities in Minnesota. Recognizing that health extends beyond indicators such as death, disease and disability is essential. Addressing factors such as mental and social well-being, quality of life, income, employment and working conditions, education and others factors known to influence health can have important, sustainable effects on health.

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Appendix F

Potential Strategies And Community Partners

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Potential Strategies And Community Partners

The strategy grids in this appendix provide a "menu" of strategies for the priority health areas and for the contributing factors that cut across the priority health areas (See Appendix D, "Contributing Factors That Cut Across Priority Health areas"). The strategies are listed down the left-hand side of each grid and potential community partners are listed across the top of each grid. Checkmarks appear in the intersections of the two and indicate the community partner(s) that could be involved in collaboratively implementing the strategy. Each community is unique and will need to adapt the list to its specific situation.

Because these strategy grids are taken directly from a 1999 MDH document called *Strategies for Public Health: A Compendium of Ideas, Experience and Research from Minnesota's Public Health Professionals*, some of the strategies are different from those described in Appendix B, "Priority Health Areas" of this Request For Proposals. They represent a broader range of strategies than may be fundable for this community grants program. To see if they are eligible to be funded through this community grants program, call the contact person for your chosen priority health area(s).

The grids in this appendix include strategies on the following topics:

- Alcohol and other drug use
- Early detection of cancer (breast and cervical cancer)
- Heart disease, heart attack and stroke (cardiovascular disease)
- Diabetes
- STD/HIV/AIDS
- Vaccine preventable diseases (immunization for adults and children)
- Infant mortality
- Nutrition
- Physical activity/inactivity
- Tobacco use
- Teenage pregnancy prevention (unintended pregnancies, parenting and youth development)
- Unintentional injuries (home hazard injury, residential fire-related injury)
- Violence (bias-motivated assaults; child maltreatment, including children with special health needs; domestic and intimate partner violence; maltreatment of vulnerable adults and the elderly; sexual violence; youth violence; suicide)

Detailed descriptions of the strategies on these grids, and information about additional strategies can be obtained from the original document, which can be found at (http://www.health.state.mn.us/divs/chs/strategies.

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: ALCOHOL, TOBACCO AND OTHER DRUGS
Problem: Alcohol and other drug use

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Reduce alcohol and other drug-related problems by examining the community norms and practices of their use, as well as their accessibility to youth	□			□	□	□	
Reduce preconception, prenatal and post-natal exposure to alcohol, tobacco and other drugs	□	□	□				Restaurants, bars, and other establish-ments that sell liquor
Decrease the appeal of alcohol products by examining, publicizing and reducing advertising and marketing that may influence their use as well as by conducting counter advertising	□			□	□		
Promote alternatives to alcohol use for those who choose not to or should not drink	□			□	□	□	

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Encourage work sites, schools, communities and others to examine their policies about alcohol, tobacco and other drugs	□	□	□	□	□	□	
Reduce alcohol-related problems by increasing the price of beverage alcohol products	□						
Encourage health care providers to screen and, if necessary, counsel and/or refer patients for alcohol and other drug abuse problems	□	□	□				Allied Health Care and Social Service Providers

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: CHRONIC/NONINFECTIOUS DISEASE
Problem: Early Detection of Cancer

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Create one-stop services@ in the community for breast and cervical cancer screening		□	□				
Develop quality improvement systems to increase rates of preventive service delivery in the health care setting		□	□				
Conduct in-reach@ in the health care setting to promote breast and cervical cancer screening		□	□				
Implement a peer-based program to increase mammography use among low-income, under-serviced women	□			□	□	□	
Create special events@ for breast and cervical cancer screening.	□	□	□		□	□	

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: CHRONIC/NONINFECTIOUS DISEASE
Problem: Heart Disease, Heart Attack and Stroke

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct targeted cholesterol screening and follow-up activities	□	□	□		□	□	
Conduct targeted hypertension detection and follow-up activities	□	□	□		□	□	

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: CHRONIC/NONINFECTIOUS DISEASE
Problem: Diabetes

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Implement diabetes-focused consumer education and support programs	State, and Local, Centers for Disease Control and Prevention (CDC)		Pharmacies, Eye Care Providers, Diabetes Patient Education Programs, Mental Health Providers	K-12, Technical Schools, Universities, Community Colleges, Adult Education Services	Local Advocacy and Professional Groups, Community Health Coalitions, and Organizations Representing At-risk Populations (i.e., Communities of Color, Senior Citizens)		Consumers, Medical Societies and Provider Trade Associations, Pharmaceutical Companies, Fitness Clubs, Community Social Services, Libraries
Promote healthy behaviors to prevent type 2 diabetes and other chronic diseases	Same		Same	Same	Same		Same

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Convene a diabetes coalition to address the issues of diabetes in the community	Same	□	Same	Same, plus School Health Services	Same	□	Same, plus Nursing Home and Long-term Care Facilities
Build a diabetes registry or database	State and Local	□	Pharmacies, Eye Care Providers, Diabetes Patient Education Programs		Same		Same, plus Local Communication Media (e.g., Radio, TV, Newsprint)
Create a profile of the impact of diabetes in the community	State and Local, CDC	□	□				Quality Monitoring Groups, Nursing Home and Long-term Care Facilities
Provide diabetes education and training for health professionals	State and Local, CDC National Institutes of Health (NIDDK)	□	Pharmacies, Eye Care Providers, Diabetes Patient Education Programs, Mental Health Providers	Universities, Medical Schools, Nursing Schools, Community Colleges	Local Advocacy And Professional Groups		Medical Societies and Provider Trade Associations, Pharmaceutical Companies, Guideline Development Groups, Nursing Home and Long-term Care Facilities

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Facilitate improvement of diabetes care in clinical settings	State and Local, CDC	□	Same		Same		Same

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: INFECTIOUS DISEASE
Problem: STD/HIV/AIDS

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Develop and implement standardized protocols for: sexual health risk assessment, testing and referral, partner notification, and care of infected individuals							
Provide HIV/STD testing, counseling, treatment, or all three at multiple sites				School Clinics			Jails
Conduct HIV/STD data surveillance, community assessments, and community planning							
Identify, and advocate the use of, effective HIV/STD prevention curricula in schools							Concerned Individuals and Parents
Provide one-to-one, group and community HIV/STD prevention education, including education in institutional settings							Jails, Chemical Dependency Treatment Programs

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Build community capacity through: □community organizing, □agency development, □agency collaborations, □and social support	□	□	□	□	□	□	Concerned Individuals
Establish street outreach services	□				□		
Reduce environmental and other risk factors that increase the risk of HIV/STD transmission	□	□	□	□	□	□	Concerned Individuals
Provide public information via mass media, hotlines, and clearinghouses	□	□	□		□	□	Concerned Individuals
Improve health care providers= skills and knowledge of adolescent sexuality issues, including STDs	□	□	□	□			

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: INFECTIOUS DISEASE
Problem: Vaccine-Preventable Diseases

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Plan and implement school-based programs to vaccinate adolescents against hepatitis B	□	□	□	middle, junior and high schools			
Implement strategies to increase rates of immunization against influenza among high-risk adults and others wishing to obtain immunity	□	□	□		□	□	
Implement and maintain a quality control system to insure that vaccines are viable	□	□	□				
Ensure that patients receive all needed vaccines at every visit	□	□	□				
Begin the incremental steps a medical clinic can take to prepare for full participation in a community immunization registry	□	□	□				

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Ensure that all newly arrived refugees receive a domestic refugee health assessment	□	□	□		□	□	

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: PREGNANCY AND BIRTH
Problem: Infant Mortality

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Promote educational messages to reduce the risk of infant death	□	□	□	□	□		
Create and disseminate educational messages to promote the concept of no primary or secondary tobacco exposure, and no alcohol and other drug use during pregnancy or while parenting or caretaking	□	□	□	□	□		

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: CHRONIC/NONINFECTIOUS DISEASE
Problem: Nutrition

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct public information campaigns and events to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	□	□	□	□	□	□	
Conduct school-based programs to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	□	□		□	□		
Implement Fitness Fever in communities, schools, and work sites	□	□	□	□	□	□	
Conduct work-site programs to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables and adequate calcium intake	□	□	□	□	□	□	

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide counseling and education by health care providers and organizations to promote healthy, low-fat eating, including promoting the daily consumption of five or more servings of fruits and vegetables, adequate calcium intake, and healthy weight management	□	□	□				

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: CHRONIC/NONINFECTIOUS DISEASE
Problem: Physical Activity/Inactivity

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct public information campaigns and events to promote regular physical activity	□	□	□	□	□	□	
Conduct school-based programs to promote regular physical activity	□	□		□	□		
Implement Fitness Fever in communities, schools, and work sites	□	□	□	□	□	□	
Increase the availability of recreational facilities in the community	□	□	□	□	□	□	
Conduct work site programs to promote regular physical activity	□	□	□	□	□	□	
Provide counseling and education by health care providers and organizations to promote physical activity, healthy weight management, and osteoporosis prevention and	□	□	□				

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
treatment							

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: UNINTENDED PREGNANCY
Problem: Unintended Pregnancy

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide or assure low-cost, comprehensive family planning services specifically designed to meet the cultural, age, and gender needs of clients in a variety of settings	□	□	□	□	□		Government Social Services
Develop and implement a social marketing plan to raise awareness of family planning services in the community	□				□		Media
Develop community-based comprehensive adolescent pregnancy prevention programs	□	□	□	□	□		
Train health care providers to communicate effectively with clients about sexual health issues and family planning	□	□	□		□		
Train school staff and social service professionals to communicate effectively with clients about sexual health issues and family planning	□			□	□		Government Social Services

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide assessment, policy development and planning, and assurance activities to support the provision of comprehensive family planning services	□						
Change community norms about the acceptability of adolescent contraceptive use and access to confidential family planning services	□			□	□		
Increase the proportion of all health insurance policies that cover contraceptive services and supplies with no co-payments or other cost-sharing requirements	□	□	□				
Promote healthy sexual behaviors	□	□	□	□	□		
Conduct information sessions in the community on family planning and how to access services	□			□	□		

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: HEALTH, GROWTH AND DEVELOPMENT OF CHILDREN AND ADOLESCENTS
Problem: Adolescent Health - Parenting and Youth Development

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Develop focus on the role of parents in adolescent health	□			□	□		
Increase awareness of parents about the importance of parenting in the healthy development of teens	□	□	□	□	□		
Improve the parenting skills of parents of adolescents	□	□		□	□		
Develop youth service and youth leadership opportunities	□	□		□	□	□	
Provide youth with career opportunities				□	□	□	
Develop an increased focus on healthy youth development in health care systems	□	□	□				
Expand data collection on adolescent health issues	□			□			
Teach youth social skills		□	□	□	□	□	

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide youth enrichment opportunities	□			□	□	□	
Help youth feel comfortable with and connected to schools	□			□	□		

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: ALCOHOL, TOBACCO AND OTHER DRUGS
Problem: Tobacco use

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Reduce youth access to tobacco products	□	□	□		□	□	
Restrict advertising and promotion of tobacco products	□				□	□	
Screen for tobacco use and treat nicotine addiction		□	□				
Create and integrate school, community and media programs	□			□	□		Media, Advertising Agencies
Increase the price of tobacco products	□				□		
Reduce exposure to environmental tobacco smoke	□				□	□	
Conduct counter advertising	□	□			□		Media, Advertising Agencies

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: UNINTENTIONAL INJURY
Problem: Home Hazard Injury

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct home visits to assess the home environment	□	□	□	□	□		Insurance Companies, MN Department of Human Services (DHS)
Distribute home safety supplies	□	□	□		□	□	Insurance Companies, Day Care, Head Start, Social Services
Offer home safety and injury prevention education to the public through day care providers, and community organizations and agencies	□	□	□		□		Insurance Companies, DHS
Provide academic instruction on injury prevention and control	□			□			Insurance Companies, DHS
	□	□	□				

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide age-appropriate and culturally sensitive counseling by primary care providers							Insurance Companies
Collect and analyze data, and support new prevention efforts	□	□	□	□	□		Insurance Companies, DHS

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: UNINTENTIONAL INJURY
Problem: Residential Fire-related Injury

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct home visits to assess presence, maintenance and functionality of smoke alarms	□	□	□				Insurance Companies, State Fire Marshal, Local Fire Department
Distribute (or offer at low cost) smoke alarms through community-based smoke alarm installation programs	□	□	□		□	□	Insurance Companies, State Fire Marshal, Local Fire Department
Offer fire safety education following a burn or visit to an emergency department	□	□	□	□			
Support legislation requiring smoke alarms on every floor of a dwelling	□	□	□		□		Insurance Companies, State Agencies
Provide age-appropriate and culturally sensitive counseling by primary care providers on fire safety and burn injury prevention	□	□	□				Insurance Companies

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide academic instruction and public education on fire safety and burn injury care	□			K-12, Professional Education	□	□	Insurance Companies, State Fire Marshal, Local Fire Department
Enforce current smoke alarm legislation							State Fire Marshal, Local Fire Department
Collect and analyze data, and support new prevention efforts	□	□	□	□	□		State Fire Marshal, Local Fire Department

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Interpersonal Violence - Bias-motivated Assaults

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Collect and analyze data to inform interventions, policies, and the community	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Educate the community to recognize the need for support and to refer victims, including self-reported victims, of bias-motivated assaults to law enforcement and necessary supports	□	□	□	□	□	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Promote culturally specific relational models of attachment, self-efficacy, community connectedness, coping, and conflict resolution skills	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problems: Interpersonal Violence - Child Maltreatment, Including Children with Special Health Needs

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Promote culturally- specific relational models of attachment, self-efficacy, community connectedness, and coping skills	□	□	□	□	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Promote healthy child development through early intervention	□	□	□	□	□		Policy Makers, Social Services
Facilitate access to universal and targeted home visiting	□	□	□	□			Policy Makers, Social Services

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Facilitate access to child development and disability information	□	□	□	□	Community Coalitions		Policy Makers, Social Services Mental Health Services
Facilitate access to culturally- and disability-specific parenting information and support	□	□	□	□	Community Coalitions	□	Policy Makers, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Facilitate referrals to mental and chemical health programs	□	□	□	□	Community Coalitions, Counseling Centers	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Collect and analyze data to inform interventions, policies, and the community	□	□	□	□	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for child maltreatment	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts Media and Entertainment
Educate the community to recognize and refer victims of child maltreatment to child protection, law enforcement, and supportive services	□	□	□	□	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Conduct child mortality reviews	□	□	□				Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Incorporate information on the maltreatment of children with special needs into mainstream child abuse prevention programs	□	□	□	□	Family & Children's Services Collaboratives Children's Mental Health Collaboratives		Faith Communities, Social Services, Advocacy Organizations

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Interpersonal Violence - Domestic and Intimate Partner Violence

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Educate the community to recognize and refer victims and their children who witness battering to safety and treatment	□	□	□	□	Community Coalitions	□	Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Collect and analyze data to inform interventions, policies, and the community	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Facilitate access to victim services and perpetrator programs	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Promote relational models specific to culture and sexual preference that focus on community connectedness, intimacy, and coping skills	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon those strengths to address risks for domestic and partner violence	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Interpersonal Violence - Maltreatment of Vulnerable Adults and the Elderly

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Collect and analyze data to inform interventions, policies, and the community	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, law Enforcement, Courts
Promote relational models of attachment, self-efficacy, community connectedness, and social skills	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Assess (including self-assessments) the strengths of individuals, families, communities, and systems and build upon these strengths to address risks for maltreatment of vulnerable adults and the elderly	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Educate the community to recognize and refer victims to safety, treatment, and related services	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Interpersonal Violence - Sexual Violence

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Increase the availability, accessibility, and utilization of services for victims and perpetrators of sexual violence	□	□	□	□	Civic, Cultural, Service, Political, Neighborhood, Educational, Social and Faith-based Groups	□	Policy Makers, Criminal Justice, Social Service Providers
Educate the community about prevalence, forms and effects of sexual violence	□	□	□	□	Same	□	Same
Identify and promote healthy community norms that discourage sexual abuse, including norms from a diversity of cultures	□	□	□	□	Same	□	Same

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Interpersonal Violence - Youth Violence

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Provide training and education on youth violence and violence prevention	□	□	□	□	□	□	
Promote culturally specific relational models of attachment, self-efficacy, community connectedness, coping, school success and conflict resolution	□	□	□	□	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Collect and analyze data to inform interventions, policies, and the community	□	□	□	□	Community Coalitions		Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment
Promote healthy development through early intervention	□	□	□	□			Policy Makers, Social Services
Facilitate access to culturally and disability-specific parenting information and support	□	□	□	□	Community Coalitions		Policy Makers, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Facilitate referrals to mental and chemical health programs	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts
Assess (including self-assessments) the strengths of youth, families, communities, and systems and build upon these strengths to address risks for youth violence	□	□	□	□	Community Coalitions	□	Policy Makers, Faith Communities, Social Services, Mental Health Services, Corrections, Law Enforcement, Courts, Media and Entertainment

Examples of Strategies & Organizational Roles

The list below represents a sampling of strategies that can be used to work on this public health problem. Organizations that may play a role in the implementation of a particular strategy are indicated.

Category: VIOLENCE
Problem: Suicide

Organizations with Potential Collaborative Roles

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community-based Organizations	Businesses/ Work Sites	Other
Educate professionals and the community to recognize suicidal ideation and behaviors in adolescents and adults, to respond appropriately, and to make referrals for treatment and necessary supports	□	□	□	□	Counseling Centers, Social Services, Faith Communities	□	
Facilitate access to crisis and mental and chemical health programs and support services	□	□	□	□	□	□	
Collect and analyze data to inform interventions, policies, and the community	□	□	□				
Promote relational models, specific to culture and sexual preference, of attachment, self-efficacy, community connectedness, and healthy coping	□	□	□	□	□	□	

	Governmental Public Health Agencies	**Health Plans**	**Hospitals & Clinics**	**Educational Systems**	**Community-based Organizations**	**Businesses/ Work Sites**	**Other**
Promote and enforce means restrictions, including limiting access to firearms, promoting safe storage of firearms, and encouraging use of trigger locks	□	□	□	□	□	□	Law Enforcement
Assess (including self assessments) families, communities, and systems and build upon those strengths to address risks for suicide and suicide attempts	□	□	□	□	□	□	

Appendix G

Community Engagement

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Community Engagement

"Go in search of people.
Begin with what they know.
Build on what they have."

Chinese proverb

Community engagement is a key ingredient in Minnesota's Eliminating Health Disparities Initiative Community Grants Program. Promoting a statewide community of informed, inspired, committed people who are actively engaged in confronting the challenges of eliminating health disparities will be critical to our success. Grantees will be expected to serve as catalysts, engaging people in ways that set the stage for a new level of communication and cooperation among community members, organizations, and government entities.

What Is Community Engagement?

Community engagement is the process of involving community residents in thinking, debating, talking about and together addressing issues that affect the quality of their lives. Effective community engagement brings people to the table—both community members and professionals—and nurtures their active participation in all aspects of planning and implementation processes. Community members are valued as equal partners. Cultural strengths are identified and valued as the process seeks to meld community "wisdom" with scientific and institutional expertise. Effective community engagement results in activities and programs that reflect the strengths, needs, and resources of the community, and outcomes that are understandable to community members and that reflect community expectations.

The Cycle Of Engagement

The cycle of engagement has three parts:

< Coming together—starting the conversation and dialogue; building trust and safe spaces for people to think, debate, reflect and make decisions.

< Moving forward—converting dialogue into activity; reaching out beyond the original planning group; creating dynamic partnerships to implement programs and provide services.

< Sustaining momentum—building structures; developing and sustaining leadership; assessing and improving programs; measuring change and communicating results.

The Move From Communication To Engagement

In the past, good communication meant informing community members about issues and publicizing information about programs. This grant program has strong expectations that people will move beyond these traditional communication efforts to truly engaging community

members in all aspects of planning and implementation processes. The chart below shows the differences between the old way of thinking about communication and this new way of thinking about community engagement.

Communication	Engagement
communicate to	deliberate with
public hearing	community conversation
talk to, tell	talk with, share
seeking to establish/protect turf	seeking/finding common ground
authority	responsibility
influencing the like-minded	understanding those not like-minded
top down	bottom up
building a hierarchy for decision-making	establishing a stakeholder network
goals/strategic plan	values/vision
products	process
public relations	public or community engagement

For more information on community engagement see (http://www.health.state.mn.us/communityeng/)