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Eliminating Health Disparities Initiative

Minnesota Department of Health

Report to the Minnesota Legislature 2013

January 15, 2013

Eliminating Health Disparities Initiative

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Protecting, maintaining and improving the health of all Minnesotans

January 15, 2013

Dear Legislators,

In the past, Minnesota was consistently first or second in national health rankings. But in recent years Minnesota has fallen to as low as sixth. Reasons for this include alcohol consumption and declining funding for public health. But a significant factor that often gets overlooked is the health differences that exist in Minnesota between white populations and populations of color and American Indians. Minnesota has some of the worst income, employment, and health disparities in the country. Many of Minnesota's populations of color and American Indians lack the same opportunities to be healthy because of factors such as economic instability, unsafe neighborhoods, and inadequate access to health care. These differences ultimately result in poorer health outcomes, shorter life spans, higher health care costs, and lost productivity.

Given the growing racial and ethnic diversity of Minnesota, these disparities are of increasing importance and urgency. Minnesota's populations of color and American Indians have grown from just over 6 percent of the total population in 1990 to almost 17 percent in 2012. This growth is primarily through immigration and adds people who bring talents, energies, skills, as well as their own languages, customs, diets, and health care practices not only to the Twin Cities but to communities across the state.

The Minnesota Department of Health is working to eliminate disparities by partnering with populations of color and American Indians to create their own healthy futures. The department is focused on promoting health in early childhood and adolescence and by helping adults prevent and manage conditions such as diabetes, heart disease and cancer. The Eliminating Health Disparities Initiative (EHDI) was established by a legislative mandate in 2001. It is the result of a collective vision of leaders from various racial and ethnic communities, American Indian communities, local public health officials, and others. Over the years EHDI has invested in strategies that combine evidence-based practices and wisdom of elders and the insights of communities of color and American Indian communities. These community partners provide invaluable information about what does and does not work to eliminate health disparities in chronic diseases and other priority health areas in an efficient and cost-effective manner. The EHDI investment in 2010 was approximately $5 per person of color or American Indian in Minnesota, a relatively small amount compared to the $6,913 spent on health care per Minnesotan in 2009.

This legislative report offers examples of successes and lessons-learned, highlights potential partners, and outlines critical strategies that Minnesota should pursue to protect, maintain, and improve the health of all Minnesotans by eliminating health disparities in populations of color and American Indians.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
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Table of Contents

Executive Summary

In 2001 the Minnesota Legislature established the Eliminating Health Disparities Initiative (EHDI), MN Statute 145.928, in response to the growing health disparities between our state's white population and populations of color and American Indians (See Appendix A).

The causes of health disparities are complex. They include individual factors like genetics and levels of physical activity, as well as social determinants of health such as where people live, how well educated they are, or how much money they earn. Even more complex is the impact of racism or historical trauma on health outcomes.

The Minnesota Department of Health (MDH) began documenting these disparities in 1987 through its regular Populations of Color Health Status reports. Among many alarming findings, the health disparity data for the year 2000 revealed that:

- The African American and American Indian mortality rates were nearly three times higher than the white rate.
- The Latina teen pregnancy rate was nearly five times higher than the white rate
- African American and American Indian diabetes mortality rates were nearly three times higher than the white rate.

This data sparked a call for concerted community action. Legislators worked with members of our communities of color and tribes to shape the EHDI legislation that would provide funding for community grants and other strategies in support of effective and sustainable programs designed to address community-identified health needs in eight priority health areas (PHAs):

1) Infant Mortality
2) Adult and Child Immunizations
3) Breast & Cervical Cancer Screenings
4) Cardiovascular Disease & Stroke
5) Diabetes
6) HIV/AIDS/Sexually Transmitted Infections
7) Teen Pregnancy
8) Unintentional Injury and Violence

The EHDI established state General Fund dollars of $7.6 million each biennium for a community grants program focused on eliminating health disparities in each of these PHAs. An additional $4 million per biennium in federal Temporary Assistance for Needy Families (TANF) funds is allocated for teen pregnancy prevention. Tribal governments are allocated $1 million per biennium from the General Fund to eliminate health disparities. MDH's Office of Minority and Multicultural Health administers the community grants funded by the EHDI. Tribal grants are administered through MDH's Community and Family Health Division.

A Report to the Legislature is required by the EHDI statute and due by January 15 of every other year beginning in the year 2003. This current report is intended to inform the Legislature on efforts to eliminate health disparities in populations of color and American Indians funded

with EHDI dollars through community grants since the last EHDI Report to the Legislature in 2011.

EHDI Grant Activities 2010-2012

2010 Grants

In February of 2010 OMMH announced a Request for Proposals (RFP), the second RFP since the EHDI was created in 2001, to close the gap in the health status of American Indians and populations of color in Minnesota. In June of 2010, OMMH awarded grants totaling $4.8 million for the period of July 1, 2010 - June 30, 2012 ($2.8 million in state general funds and $2 million in federal TANF funds) to 29 community-based organizations in the following categories:

- 24 Priority Health Area (PHA) Grants
- 5 Social Determinants of Health Grants
- Of the 29 grantees, 23 operate in the Twin Cities metropolitan area, 5 in greater Minnesota, and 1 statewide.

Nine tribal nations were awarded EHDI grants in 2010:

- Bois Forte Band of Chippewa
- Fond du Lac Band of Lake Superior Chippewa
- Grand Portage Band of Lake Superior Chippewa
- Leech Lake Band of Ojibwe
- Mille Lacs Band of Ojibwe
- Red Lake Band of Chippewa Indians
- White Earth Band of Ojibwe
- Lower Sioux Indian Community
- Upper Sioux Community

2012 Grants

In June 2012 OMMH awarded $6.5 million for the period of July 1, 2012 - June 30, 2013 ($4 million in state general funds and $2.5 million in federal TANF funds) to 47 community based organizations. Grants were awarded in the following categories:

- 45 Priority Health Area Implementation (PHA) Grants
- 2 Community Primary Prevention (CPP) Grants
- 19 of the 2010 Grantees were renewed in 2012

Grants Awarded by Priority Health Area and by Population

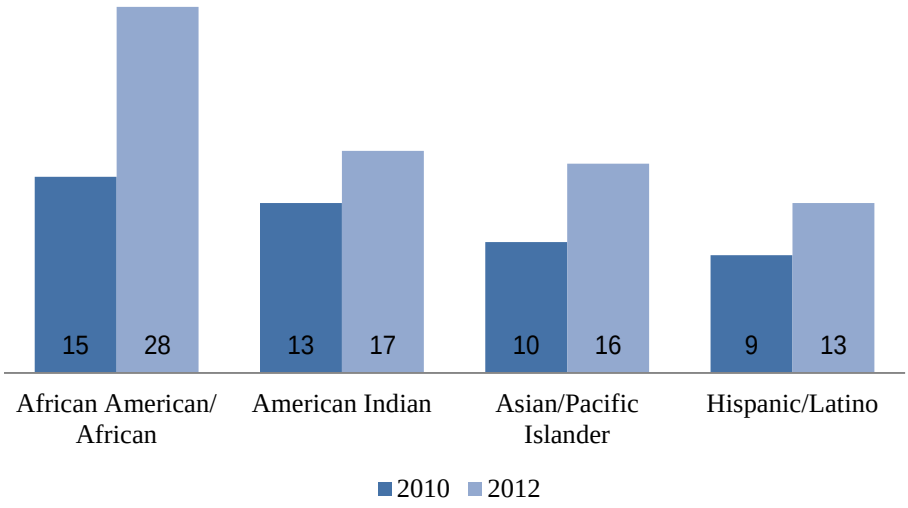
Table 1 provides a breakdown of the number of grantees funded in each priority health area. Figure 1 outlines the distribution of grants by community of color and American Indians

distributed in 2010 and 2012. At the end of the executive summary Tables 2-3 list the organizations funded by priority health area and the population served by each grant.

Table 1. EHDI Grants 2010-2012 – Number of Grants Awarded by Priority Health Area

Priority Health Area	# of Grantees 2010	# of Grantees 2012
Breast & Cervical Cancer screening	3	4
Diabetes	4	11
Heart Disease & Stroke	4	5
HIV/AIDS & Sexually Transmitted Diseases	9	8
Immunizations for Adults & Children	1	3
Infant Mortality	3	4
Teen Pregnancy	13	22
Unintentional Injury & Violence	4	5
Social Determinants of Health /Community Primary Prevention	5	2

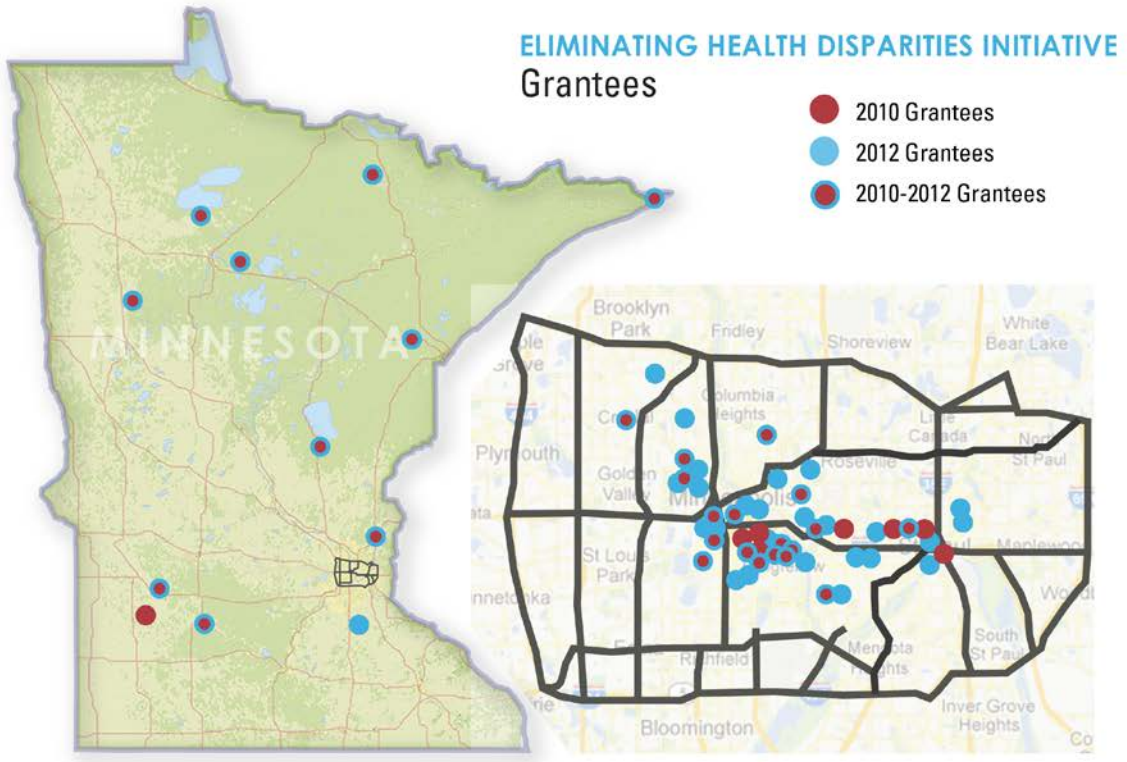
Figure 1. EHDI Grants 2010-2012 – Populations of Color/American Indian Served



Some grantees are providing services to more than one POC/AI

Despite statewide eligibility and outreach, few applications have been received in response to RFPs issued from organizations or groups in greater Minnesota, except from the tribal nations. Figure 2 provides a geographic map of funded grantees for 2010 and for 2012.

Figure 2. EHDI 2010 & 2012 Grantees



2010 Grantees

African & American Friendship Association for Cooperation & Development
Annex Teen Clinic
Bois Forte Band of Chippewa
Centro, Inc.
Children's Health Care
El Colegio Charter School
Fond du Lac Band of Lake Superior Chippewa
Freeport West
Grand Portage Band of Lake Superior Chippewa
GMCC Division of Indian Work
Hennepin County Medical Center
High School for Recording Arts
The Indian Health Board of Minneapolis
Indigenous Peoples Task Force
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lower Sioux Indian Community
Lutheran Social Services of Minnesota
Mille Lacs Band of Ojibwe
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Model Cities
The Neighborhood Hub
NorthPoint Health & Wellness Center, Inc
Peta Wakan Tipi
Planned Parenthood MN, ND, SD
Pillbury United Communities
Red Lake Band of Chippewa Indians
Saint Paul Area Council of Churches
Sierra Young Family Institute, Inc.
Southwest Health and Human Services
Upper Sioux Community
Vietnamese Social Services of Minnesota
WellShare International
White Earth Band of Ojibwe
YWCA of Minneapolis

2012 Grantees

African American AIDS Task Force
American Indian Family Center
Annex Teen Clinic
Asian Media Access
A.S.P.I.R.E. Project
Axis Medical Center
Big Brothers Big Sisters
Bois Forte Band of Chippewa
Boys & Girls Club of the Twin Cities
CAPI
Centro, Inc.
Community-University Health Care Center
Crown Medical Center
Fond du Lac Band of Lake Superior Chippewa
Grand Portage Band of Lake Superior Chippewa
GMCC Division of Indian Work
Health Finders Collaborative
Hennepin County Medical Center
High School for Recording Arts
Hmong American Partnership
The Indian Health Board of Minneapolis
Indigenous Peoples Task Force
Isuroon
Korean Service Center
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lower Sioux Indian Community
Lutheran Social Services of Minnesota
Mille Lacs Band of Ojibwe
Minnesota African Women's Association
Minneapolis American Indian Center
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Minnesota Visiting Nurse Agency
National Asian Pacific American Women's Forum
The Neighborhood Hub
NorthPoint Health & Wellness Center, Inc.
Open Cities Health Center
Peta Wakan Tipi
Planned Parenthood MN, ND, SD
Pillsbury United Communities
Red Lake Band of Chippewa Indians
Sabathani Community Center
Saint Mary's Clinic
Saint Paul Area Council of Churches
Saint Paul Ramsey County Public Health
Southeast Asian Community Council, Inc.
Stairstep Foundation
Summit University Teen Center, Inc.
TeenWise Minnesota
Turning Point, Inc.
Upper Sioux Community
WellShare International
White Earth Band of Ojibwe
YWCA of Minneapolis

An Increasingly Diverse State

Minnesota is an increasingly diverse state. In 1990, people of color and American Indians in Minnesota represented just over 6 percent of our total population. By 2010, these communities had grown to represent fully 15 percent of the population. The Hispanic/Latino population grew by 364 percent during that time, and the African-American population grew by 189 percent. By 2025, Minnesota's population of color is expected to be about 22 percent, if this trend continues.

The state's diversity is increasing primarily through immigration. Minnesota attracts a wide range of immigrants from other parts of the U.S. and from other countries, who move here to attend school, start businesses, work in Minnesota industries, and join family members.

Minnesota's recent immigrants come from diverse corners of the globe. The points of origin of our newest residents include Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan, to name just a few. The diversity that exists *within* racial and ethnic categories (especially from Asia and Africa) presents nearly as many challenges as diversity within the population as a whole: for example, at least 19 different countries are represented among Asian immigrants to Minnesota. The peoples from these areas bring a wide range of backgrounds, experiences, cultural practices, languages, and unique health concerns to Minnesota.

It is also important to remember that Minnesota's growing racial and ethnic diversity is not limited to the Twin Cities metropolitan area. The southwestern region of Minnesota, in particular, has experienced a dramatic increase in immigrant populations.

Much of the state's future youth and vitality will come from immigrant groups, since on average, immigrant groups are often younger and have more children. Consider that about one-quarter of the state's public school students today are children of color or American Indians. The state's future health depends on reducing the health differences between populations so that Minnesota can reach its potential as a healthy state for all Minnesotans.

EHDI: A Continuing Investment in Opportunities for Health

The EHDI is working to eliminate disparities by strengthening the capacity of communities of color and American Indian communities to create their own healthy futures and by capitalizing on opportunities that exists to influence health in early childhood.

In 2001, Minnesota's EHDI became one of the nation's first statewide efforts to focus on the health and well-being of populations of color and American Indians. The first nine years of EHDI investments have yielded not only advances on the mandated goals, but also valuable information and lessons, including the need to:

- Make use of practice-based strategies built on evidence-based and promising practices, including consistent attention to integrating culturally responsive approaches into all the Initiative's efforts
- Continue developing or improving culturally-responsive behavioral interventions to improve health outcomes in populations of color and American Indians
- Address critical policy, systems, or environmental barriers that challenge significant progress toward eliminating health disparities in populations of color and American Indians
- Provide support for partnerships that combine the necessary skills, resources and leadership to address barriers in eliminating health disparities in populations of color and American Indians
- Provide grantees with technical assistance in identifying appropriate and measurable outcomes, as well as development of a logic model in their program evaluation and to report on their efforts.

Twenty-nine community grantees highlighted in this report proved to be valuable EHDI investments and incorporated many of the lessons learned noted above. Examples of their accomplishments include:

- At least 90 percent of active participants in a Family Education Diabetes Series to American Indians in East Saint Paul had metabolic control scores at or below the recommended level
- 817 individuals attended at least nine health classes and 312 individuals received a cardio-vascular screening by Vietnamese Social Services of MN, an organization targeting Vietnamese, Chinese, and Karen Asian Pacific Islander communities
- 13,500 people were vaccinated through outreach at 200 clinics by Minnesota Immunization Networking Initiative, and over 180 Fairview healthcare professionals were trained as volunteer vaccinators
- Several programs expanded their outreach capacity through the use of trained Community Health Workers recruited from the communities themselves
- All grantees received evaluation technical assistance and support to evaluate their programs.

Forty-seven grants were awarded in 2012. In addition to efforts to increase the number of grants and grantees working to eliminate health disparities in populations of color and American Indians, grantees also are encouraged to partner as priority health area cohorts and align more closely with other MDH programs, e.g., SHIP, immunizations, diabetes, HIV/AIDS, teen pregnancy, or injury/violence prevention. These grants were awarded for one year with the possibility of extending for up to two more years depending on performance and availability of funding. Their outcomes will be documented in the 2015 Legislative Report.

Future MDH and OMMH efforts to strengthen EHDI will include:

- Engaging a broad array of stakeholders from the community, government, faith-based organizations, managed care and clinic health providers, and others, in order to develop

recommendations on gaps and priorities in future EHDI mandated efforts aimed at eliminating health disparities in populations of color and American Indians

- Improving data collection standards through critical partnerships to improve the quality and consistency of race-specific, ethnic-specific, and language-specific information that can be shared and compared within MDH and statewide
- Supporting partnerships that develop and implement the policy, systems and environmental change strategies necessary to maintain sustainable change focused on eliminating health disparities in populations of color and American Indians
- Developing and implementing strategies to explore the impact of institutional racism and historical trauma on the development and maintenance of health disparities in populations of color and American Indians
- Building the necessary capacity to implement and institutionalize long-term strategies to eliminate health disparities.

Healthy Lives for All Minnesotans

Minnesota's reputation as a healthy state obscures an important issue: health disparities.

When it comes to the differences in health status between populations, Minnesota is far from equal. In reality, populations of color and American Indians in Minnesota experience higher rates of many chronic and infectious diseases and premature death.

> *"Of all the forms of inequality, injustice in health is the most shocking and the most inhumane."*
>
> The Rev. Martin Luther King, Jr., at the Second Annual Convention of the Medical Committee for Human Rights, Chicago, March 25, 1966

It is important to recognize that good health is not the mere absence of disease, but a state of "well-being" in every aspect of life. The foundation of this state of personal well-being starts in homes and schools, jobs and workplaces, as well as in places of worship, socialization, and play. With this broader perspective on what good health means, the sources of health disparities become easier to identify. Many Minnesotans, especially populations of color and American Indians, experience inequitable living conditions and unequal treatment in many aspects of life. Data collected by the Minnesota Department of Health, the Blue Cross Blue Shield Foundation, the Wilder Foundation, and others reveals that disparities in health status and opportunities to be healthy for people of color and American Indians in Minnesota are widespread and persistent in Minnesota in areas such as living environments, safe communities, education, employment opportunities, and health care.

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. A department-wide goal is to eliminate health disparities and achieve health equity. The Office of Minority and Multicultural Health (OMMH) provides leadership within MDH to engage populations of color and American Indians in actions essential to the over-arching goal of eliminating health disparities. MDH recognizes the critical importance of effectively addressing these health disparities in order to ensure our vision of keeping all Minnesotans healthy. The Eliminating Health Disparities Initiative is a critical

strategy for strengthening local efforts that are at work in diverse communities across the state toward achieving this goal.

Table 2. EHDI 2010 Grantees by Priority Health Area (PHA) and Population

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=3**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		The Indian Health Board of Minneapolis		●		
		Vietnamese Social Services of MN			●	
Diabetes	**N=4**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		Peta Wakan Tipi		●		
		Saint Paul Area Council of Churches		●		
		WellShare International	●			
Heart Disease & Stroke	**N=4**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		The Indian Health Board of Minneapolis		●		
		Vietnamese Social Services of MN			●	
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=9**	Annex Teen Clinic	●			
		Centro, Inc.				●
		Children's Health Care				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Lutheran Social Services of Minnesota	●	●	●	●
		Planned Parenthood MN, ND, SD	●		●	
		Sierra Young Family Institute	●			
Immunizations for Adults & Children	**N=1**	MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=3**	Fond du Lac Band		●		
		Model Cities	●			
		WellShare International	●			
Teen Pregnancy	**N=13**	Annex Teen Clinic	●			
		Centro, Inc.				●
		Children's Health Care				●
		Freeport West	●	●		
		GMCC Division of Indian Work		●		
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Lao Family Community of Minnesota			●	
		Leech Lake Band of Ojibwe		●		
		Lutheran Social Services of Minnesota	●	●	●	●
		Planned Parenthood MN, ND, SD	●		●	
		Sierra Young Family Institute	●			
		YWCA of Minneapolis	●	●	●	●
Unintentional Injury & Violence	**N=4**	Hennepin County Medical Center				●
		MN Indian Women's Resource Center		●		
		Model Cities	●			
		WellShare International	●			
Social Determinants of Health – Planning	**N=3**	Jordan New Life Hub	●			
		Pillsbury United Communities	●			
		Southwest Health and Human Services	●	●	●	●
Social Determinants of Health – Implementation	**N=2**	African & American Friendship Association for Cooperation & Development, Inc.	●			
		El Colegio Charter School				●
Number of grantees serving each population of color/American Indian			**N=15**	**N=13**	**N=9**	**N=10**

Table 3. EHDI 2012 Grantees by Priority Health Area (PHA) and Population

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=4**	Hmong American Partnership			●	
		Open Cities Health Center	●		●	
		Saint Mary's Clinic				●
		The Indian Health Board of Minneapolis		●		
Diabetes	**N=11**	Crown Medical Center	●			
		Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Open Cities Health Center	●		●	
		Peta Wakan Tipi		●		
		Pillsbury United Communities	●			
		Sabathani Community Center	●			●
		Saint Mary's Clinic				●
		Saint Paul Area Council of Churches		●		
		Stairstep Foundation	●			
		WellShare International	●			
Heart Disease & Stroke	**N=5**	Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Pillsbury United Communities	●			
		The Indian Health Board of Minneapolis		●		
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=8**	African American AIDS Task Force	●			
		Annex Teen Clinic	●			
		Centro, Inc.				●
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		Indigenous Peoples Task Force		●		
		Planned Parenthood MN, ND, SD	●		●	
		Turning Point, Inc.	●			
Immunizations for Adults & Children	**N=3**	Axis Medical Center	●			
		CAPI USA	●		●	
		MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=4**	American Indian Family Center		●		
		Leech Lake Band of Ojibwe		●		
		Minnesota Visiting Nurse Agency	●	●		
		Open Cities Health Center	●		●	
Teen Pregnancy	**N=22**	Annex Teen Clinic	●			
		Asian Media Access	●		●	
		A.S.P.I.R.E. Project	●			
		Big Brothers Big Sisters of the Greater TC	●	●	●	●
		Boys & Girls Club of the Twin Cities	●	●	●	●
		Centro, Inc.				●
		GMCC Division of Indian Work		●		
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Isuroon	●			
		Lao Family Community of Minnesota			●	
		Lutheran Social Services of Minnesota	●	●	●	●
		Minnesota African Women's Association	●			
		Planned Parenthood MN, ND, SD	●		●	
		Sabathani Community Center	●			●
		Saint Paul Ramsey County Public Health	●	●		

		Southeast Asian Community Council, Inc.			●	
		Summit University Teen Center, Inc.	●	●	●	●
		TeenWise of Minnesota	●	●		
		YWCA of Minneapolis	●	●	●	●
Unintentional Injury & Violence	**N=5**	Community-University Health Care Center				●
		Hennepin County Medical Center				●
		Korean Service Center			●	
		MN Indian Women's Resource Center		●		
		Sabathani Community Center	●			●
Community Primary Prevention	**N=2**	National Asian Pacific American Women's Forum			●	
		The Neighborhood Hub	●			
Number of grantees serving each population of color/American Indian[1] [2]			**N=28**	**N=17**	**N=16**	**N=13**

[1] Grantees work in multiple PHA and POC/AI; number of grantees is smaller than number of dots in each column.
[2] Grantees self-identified POC/AI groups served in their original grant application.

I. EHDI Mission and Strategies

A Historical Overview

In 2001 the Minnesota State Legislature established the Eliminating Health Disparities Initiative [EHDI], MN Statute 145.928 (See Appendix A). This groundbreaking legislation was passed in response to mounting evidence that disparities in health outcomes between Minnesota's white residents of Minnesota and residents from communities of color and American Indian communities were distressingly wide, and on a clear trajectory to grow even wider. Such disparities have meant that Minnesota's communities of color and American Indians experience shorter life spans, higher rates of infant mortality, higher incidences of diabetes, heart disease, cancer and other diseases and conditions, and poorer general health. Even though Minnesota ranks high in terms of general health status compared to other states, some of the disparities that exist in Minnesota are among the worst in the nation. When such disparities are allowed to persist, they have a negative effect, both on the quality of life and the cost of healthcare for all Minnesotans.

Lack of regular access to health care, including preventive care for whatever combination of reasons, creates a situation in which the emergency rooms of our public hospitals become the source of primary care for too many Minnesotans. According to Blue Cross and Blue Shield of Minnesota, the average cost of a visit to a doctor's office in 2008 was $153. By comparison, the average cost of a visit to an emergency room was $947.[3] Whenever we can prevent serious health problems or effectively treat a potentially serious problem before it becomes chronic, we accomplish much more than alleviating unnecessary suffering – we also bring down the cost of medical care for all Minnesotans, and boost our state's productivity. A healthy population is good for our state's economy and for its resiliency: its ability to bounce back in tough times. Healthy families and a healthy work force elevate the fortunes of the entire state, reinforcing its image as a good place to live, work, and do business.

With the creation of this health disparities initiative, Minnesota became only the second state in the U.S. to enact a legislative mandate to reduce such health disparities. In order to respond to the data and address them, a diverse cross-section of people from Minnesota's American Indian communities and communities of color partnered with The Office of Minority and Multicultural Health and the Minnesota Legislature to design and implement a comprehensive, statewide program focused on strengthening and improving the health of the following four major ethnic groups:

- American Indian
- Asian/Pacific Islander
- African American/African
- Hispanic/Latino

From the outset, the creators and stakeholders of EHDI recognized that the issues contributing to health disparities are broad and complex – an interplay of many factors including access to

[3] Blue Cross and Blue Shield of Minnesota. (2008). One cold. Two remedies. Retrieved from: http://www.bluecrossmn.com/internet_core/en_US/ccurl/437/897/mbc1_ercosts2_dm.pdf

health care, genetics, the legacy of racism, social conditions, and a variety of longstanding health behaviors. More than half of a person's health status is driven by social factors: his or her income; education level; race, and/or the neighborhood in which he or she lives.[4] The MDH and OMMH staff, the State Legislature, and all the EHDI community partners understood that effectively addressing this complex set of interrelated problems would require an approach that is both comprehensive and community-driven. The Minnesotans of color and American Indians who answered the call to become an integral part of this effort as community partners have sustained their engagement, providing continuity and ensuring that EHDI's efforts remain true to its comprehensive, culturally-responsive, and community-driven roots.

The strategies for addressing health disparities created and implemented by EHDI and its community partners have been effective because they have consistently focused on:

- use of practice-based strategies built on evidence-based and promising practices, including a consistent attention to integrating culturally responsive approaches into all the Initiative's efforts
- building capacity in both our American Indian led/American Indian focused grantees, and in our community of color led/community of color focused grantees
- systems and policy changes
- collaboration
- provision of training and technical assistance to support outcome-focused evaluation and learning among grantees

A commitment to this philosophy guided the process through which requests for proposals were widely disseminated across the state, resulting in proposals that were reviewed with community input and grants that were awarded to faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics for local or regional projects and initiatives aligned with the goals of EHDI's partners and stakeholders. Attention to a strong, ongoing process of evaluation has helped EHDI's grantees, community partners and stakeholders learn about what works and what doesn't, which has led to programming that continually evolves and improves its methods.

The result has been that significant strides have been made in reducing health disparities in Minnesota. Through the legislative mandate which enables the work of this initiative, a powerful and lasting investment is being made in our state and its people. This investment should continue for Minnesota to continue to shine and to thrive.

[4] Blue Cross and Blue Shield of Minnesota Foundation. (2010). Revealing socioeconomic factors that influence your health: supplement to The unequal distribution of health in the Twin Cities.

II. Minnesota's Changing Demographics

Though strides have been made in lessening the health disparities gap between white residents of Minnesota and American Indians and people of color, significant gaps persist in large part because the last decade has seen a dramatic shift in the state's demographics. Our state's population of American Indians and people of color are growing. In 1990, less than five percent of Minnesota's population was comprised of American Indians and people of color. By 2012 that percentage had risen to seventeen percent, and it continues to rise.[5]

Persistent disparities in education, employment, and income place a disproportionate number of American Indians and people of color below the poverty line – and poverty is a powerful factor in many key measures of a community's health: overall life expectancy; infant mortality; homicide; obesity; mental illness; alcohol and other drug addiction, and more.[6]

Table 1. Minnesota Population Change

Racial/Ethnic Group	1990	2000	2010	1990-2010 Percent Change
African American	94,944	171,731	274,412	189%
American Indian	49,909	54,967	60,196	22%
Asian	77,886	143,947	216,390	178%
Hispanic	53,884	143,382	250,258	364%
White	4,130,395	4,400,282	4,524,062	9.5%
Total Population	4,375,099	4,919,479	5,303,925	21%

Table 2. Immigrants Living in Minnesota 2010

Racial/Ethnic Group	Foreign Born		Percent Foreign-Born Population	
	1990	2000	1990	2010
African American	4,929	75,517	5.2%	28%
American Indian	638	928	1.3%	1.6%
Asian	76,771	131,824	62.5%	62.8%
Hispanic	49,663	96,217	16%	39%
White	113,039	131,500	1.4%	2.9%

[5] Minnesota Department of Health & Healthy Minnesota Partnership. (2012). The Health of Minnesota: Statewide Health Assessment. Retrieved from: http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf

[6] Ehlinger, E. (2012). Health Disparities: Impact on Minnesota Implications for the Future. Minnesota's Health Insurance Exchange Challenges and Opportunities power point presentation. [Data contained in tables also from Ehlinger, E. (2012)].

Significantly higher numbers of American Indians and people of color in Minnesota have no health insurance compared to white residents.

Table 3. Population by Poverty Rate and Uninsurance 2011[7]

Racial/Ethnic Group	Poverty Rate	Median Income	Uninsurance Rate
All Minnesotans	11.9%	$56,954	8.8%
White (non-Hispanic)	8.7%	$59,870	6.8%
African American	37.1%	$29,266	15.1%
Asian	16.9%	$59,697	12.2%
American Indian	40.7%	$26,922	22.5%
Hispanic/Latino	24.9%	$37,795	29.7%

The advent of healthcare reform will bring with it an unprecedented opportunity to substantially address this gap, but there are barriers that will need to be overcome before this can be achieved. These include:

- Effective, culturally-responsive outreach campaigns must be created and sustained for each of the four major ethnic groups so that people do not feel challenged to become insured, and understand their choices and options
- Language and other cultural barriers will require simplifying application/reapplication processes
- Outreach efforts must acknowledge and take into account the widespread lack of trust in mainstream social institutions that stems from the legacy of institutional racism and historical trauma.

Minnesota's Health Disparities

Although American Indian communities and communities of color throughout the state all struggle with health disparities across the spectrum of EHDI's priority areas of focus, they are not all affected in the same way or to the same degree. Geography, cultural differences within very diverse communities of color and American Indians, and other factors make the experience and the needs of one group very different from another. For example, a quick look at the data on Asian American and Pacific Islander infant mortality rates (5.2 per 1,000 births)[8] makes it appear, at first blush, as if the Asian community's rates of low birth weight and premature birth are only slightly different from the rate found among Latino/Hispanics and whites. And in some communities within the larger Asian and Pacific Islander community, this is true, but a closer, culturally-responsive look at this highly-diverse grouping of peoples reveals that the rates of low birth weight and premature birth infant mortality found in our Cambodian, Thai and Filipino communities are significantly higher.

[7] Minnesota Budget Project. (2011).
[8] Minnesota Department of Health. (2009). Disparities in Infant Mortality. Retrieved from: http://www.health.state.mn.us/divs/chs/infantmortality/infantmortality09.pdf

Table 4. Selected Birth Indicators, Asian Race Groups and All Asians, Minnesota 2005-2008[9]

Asian Race Group	Percent of Births		
	Inadequate or No Prenatal Care[1]	Low Birth Weight[2]	Premature[3]
Asian Indian	2.7*	7.6***	7.2*
Cambodian	5.1***	8.6***	14.1**
Chinese	2.9*	3.2*	5.6*
Filipina	4.6***	8.3***	9.8***
Hmong	7.4**	6.2***	9.2***
Japanese	1.9*	6.5***	5.3*
Korean	2.6*	3.5*	7.5***
Laotian	7.2***	9.4**	12.3**
Thai	10.4**	8.9***	11.0***
Vietnamese	4.0*	5.2***	9.1***
All Asian	5.9	6.5	9.0

[1]Measured by GINDEX (number of prenatal care visits, when prenatal care was initiated, and gestational age)
[2] Less than 37 weeks gestation, singleton births
[3] Less than 2,500 grams (5 lbs, 8 oz) at birth, singleton births

*Significantly better than all Asian rate
**Significantly worse than all Asian rate
***Not statistically different from All Asian rate
(95% confidence intervals were used to determine significant differences

Note: 3.3% of Minnesota mothers received inadequate or no prenatal care, 4.9% of Minnesota singleton births were low birth weight, and 8.3% of Minnesota singleton births were premature (2005-2009).

This is why the culturally-responsive approach to the work done by EHDI's stakeholders and community partners is so important. Otherwise, programming targeted toward large ethnic groupings of people as if each of them was culturally monolithic would miss the mark.

The strategies chosen by EHDI grantees for addressing health disparities represent carefully-tailored approaches to each community based on an understanding of each community's diverse needs. MDH, OMMH, and their partners at Rainbow Research in Minneapolis work constantly with EHDI grantees to provide current research on the best practice-based strategies as they evolve. In turn, grantees share their own perspective on how these strategies can be transferred or adapted for their own communities here in Minnesota.

[9] Minnesota Department of Health. (2011). Birth Outcomes of Infants Born to Asian Mothers, Minnesota 2005-2009. Minnesota Vital Signs: Center for Health Statistics. April 2011 Vol.7, No. 2. Retrieved from: http://www.health.state.mn.us/divs/chs/vitalsigns/asianbirthoutcomes.pdf

Staff members at Peta Wakan Tipi provided the following example of what can result from such an approach:

> *"…Ten talented young American Indian leaders tell the story of Coyote's Adventure before a crowd of rapt students and community members who love the concept of a trickster story and teaching. Taking turns at narration and acting, these young people were illustrating the consequences of poor nutrition and no exercise within a cultural, yet modern day story that they created themselves. Going to the elders for advice and standing up to peer pressure when pushed to eat foods and pop that will increase your chances of getting diabetes were the messages of this play. Thanks to the investment by EHDI, these young people truly are emerging leaders in the American Indian community and have become effective advocates for good health*."

III. EHDI Grant Activities 2010-2012

2010 Grants

In February of 2010 OMMH announced a Request for Proposals (RFP), the second RFP since the EHDI was created in 2001, to close the gap in the health status of American Indians and populations of color in Minnesota. In June of 2010, OMMH awarded grants totaling $4.8 million for the period of July 1, 2010-June 30, 2012 ($2.8 million in state general funds and $2 million in federal TANF funds) to 29 community-based organizations in the following categories:

- 24 Priority Health Area (PHA) Grants
- 5 Social Determinants of Health Grants
- Of the 29 grantees, 23 operate in the Twin Cities metropolitan area, 5 in greater Minnesota, and 1 statewide.

Nine tribal nations were awarded EHDI grants in 2010:

- Bois Forte Band of Chippewa
- Fond du Lac Band of Lake Superior Chippewa
- Grand Portage Band of Lake Superior Chippewa
- Leech Lake Band of Ojibwe
- Mille Lacs Band of Ojibwe
- Red Lake Band of Chippewa Indians
- White Earth Band of Ojibwe
- Lower Sioux Indian Community
- Upper Sioux Community

A full report on tribal EHDI investments will be included in the 2015 Legislative Report.

2012 Grants

In June 2012 OMMH awarded $6.5 million for the period of July 1, 2012-June 30, 2013 ($4 million in state general funds and $2.5 million in federal TANF funds) to 47 community based organizations. Grants were awarded in the following categories:

- 45 Priority Health Area Implementation (PHA) Grants
- 2 Community Primary Prevention (CPP) Grants
- 19 of the 2010 Grantees were renewed in 2012

Grants Awarded by Priority Health Area (PHA) and by Population

Table 5 and figure 1 provide a breakdown of the number of grantees funded in each priority health area and a listing of the populations of color/American Indian served.

Table 5. EHDI Grants 2010-2012 – Number of Grants Awarded by Priority Health Area

Priority Health Area	# of Grantees 2010	# of Grantees 2012
Breast & Cervical Cancer screening	3	4
Diabetes	4	11
Heart Disease & Stroke	4	5
HIV/AIDS & Sexually Transmitted Diseases	9	8
Immunizations for Adults & Children	1	3
Infant Mortality	3	4
Teen Pregnancy	13	22
Unintentional Injury & Violence	4	5
Social Determinants of Health (SDoH) /Community Primary Prevention (CPP)	5	2

Figure 1 outlines the distribution of grants by community of color and American Indians distributed in 2010 and 2012.

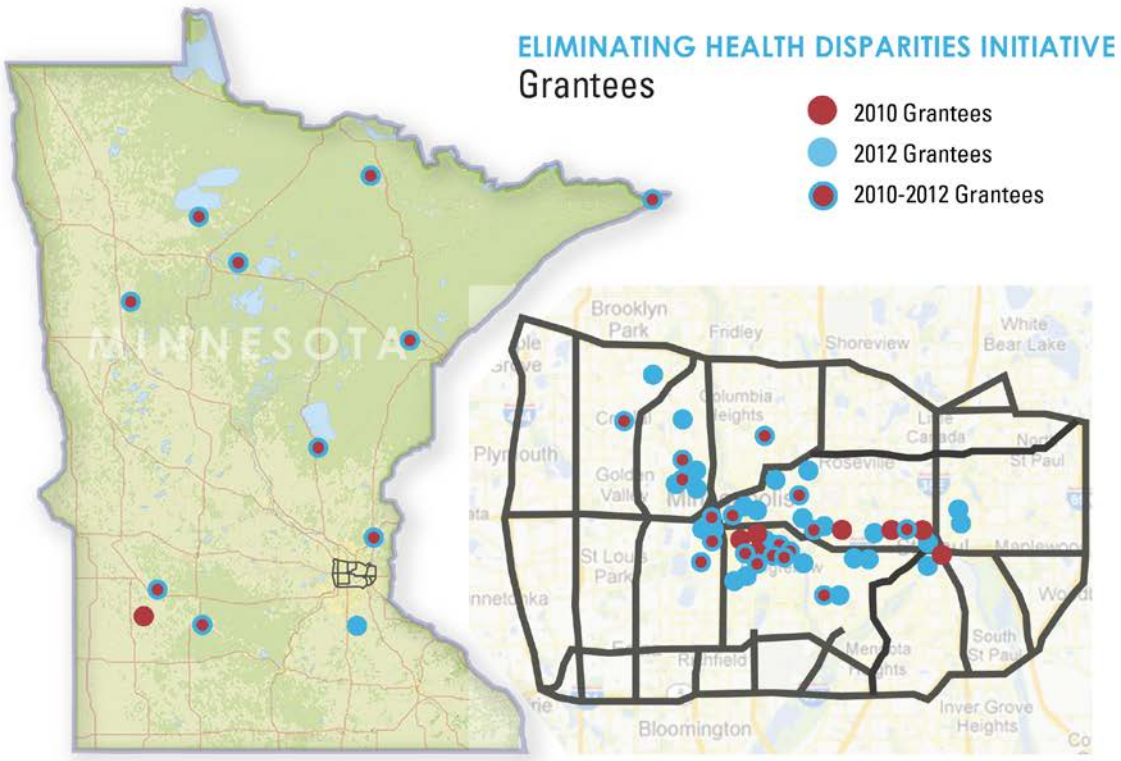
Figure 1. EHDI Grants 2010-2012 – Populations of Color/American Indian (POC/AI) Group Served

*Some grantees are providing services to more than one POC/AI

Figure 2 provides a geographic map of funded grantees for 2010 and 2012. Despite statewide outreach, few applications have been submitted in response to RFPs from organizations in greater Minnesota, except from tribal nations.

Tables 6 and 7 list the name of the grantees for 2010 and 2012 by priority health area and population served.

Figure 2. EHDI 2010 & 2012 Grantees



2010 Grantees

African & American Friendship Association for Cooperation & Development
Annex Teen Clinic
Bois Forte Band of Chippewa
Centro, Inc.
Children's Health Care
El Colegio Charter School
Fond du Lac Band of Lake Superior Chippewa
Freeport West
Grand Portage Band of Lake Superior Chippewa
GMCC Division of Indian Work
Hennepin County Medical Center
High School for Recording Arts
The Indian Health Board of Minneapolis
Indigenous Peoples Task Force
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lower Sioux Indian Community
Lutheran Social Services of Minnesota
Mille Lacs Band of Ojibwe
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Model Cities
The Neighborhood Hub
NorthPoint Health & Wellness Center, Inc
Peta Wakan Tipi
Planned Parenthood MN, ND, SD
Pillbury United Communities
Red Lake Band of Chippewa Indians
Saint Paul Area Council of Churches
Sierra Young Family Institute, Inc.
Southwest Health and Human Services
Upper Sioux Community
Vietnamese Social Services of Minnesota
WellShare International
White Earth Band of Ojibwe
YWCA of Minneapolis

2012 Grantees

African American AIDS Task Force
American Indian Family Center
Annex Teen Clinic
Asian Media Access
A.S.P.I.R.E. Project
Axis Medical Center
Big Brothers Big Sisters
Bois Forte Band of Chippewa
Boys & Girls Club of the Twin Cities
CAPI
Centro, Inc.
Community-University Health Care Center
Crown Medical Center
Fond du Lac Band of Lake Superior Chippewa
Grand Portage Band of Lake Superior Chippewa
GMCC Division of Indian Work
Health Finders Collaborative
Hennepin County Medical Center
High School for Recording Arts
Hmong American Partnership
The Indian Health Board of Minneapolis
Indigenous Peoples Task Force
Isuroon
Korean Service Center
Lao Family Community of Minnesota, Inc.
Leech Lake Band of Ojibwe
Lower Sioux Indian Community
Lutheran Social Services of Minnesota
Mille Lacs Band of Ojibwe
Minnesota African Women's Association
Minneapolis American Indian Center
Minnesota Immunization Networking Initiative
Minnesota Indian Women's Resource Center
Minnesota Visiting Nurse Agency
National Asian Pacific American Women's Forum
The Neighborhood Hub
NorthPoint Health & Wellness Center, Inc.
Open Cities Health Center
Peta Wakan Tipi
Planned Parenthood MN, ND, SD
Pillsbury United Communities
Red Lake Band of Chippewa Indians
Sabathani Community Center
Saint Mary's Clinic
Saint Paul Area Council of Churches
Saint Paul Ramsey County Public Health
Southeast Asian Community Council, Inc.
Stairstep Foundation
Summit University Teen Center, Inc.
TeenWise Minnesota
Turning Point, Inc.
Upper Sioux Community
WellShare International
White Earth Band of Ojibwe
YWCA of Minneapolis

Table 6. EHDI 2010 Grantees by Priority Health Area (PHA) and Population

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=3**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		The Indian Health Board of Minneapolis		●		
		Vietnamese Social Services of MN			●	
Diabetes	**N=4**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		Peta Wakan Tipi		●		
		Saint Paul Area Council of Churches		●		
		WellShare International	●			
Heart Disease & Stroke	**N=4**	NorthPoint Health & Wellness Center, Inc.	●		●	●
		The Indian Health Board of Minneapolis		●		
		Vietnamese Social Services of MN			●	
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=9**	Annex Teen Clinic	●			
		Centro, Inc.				●
		Children's Health Care				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Lutheran Social Services of Minnesota	●	●	●	●
		Planned Parenthood MN, ND, SD	●		●	
		Sierra Young Family Institute	●			
Immunizations for Adults & Children	**N=1**	MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=3**	Fond du Lac Band		●		
		Model Cities	●			
		WellShare International	●			
Teen Pregnancy	**N=13**	Annex Teen Clinic	●			
		Centro, Inc.				●
		Children's Health Care				●
		Freeport West	●	●		
		GMCC Division of Indian Work		●		
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Lao Family Community of Minnesota			●	
		Leech Lake Band of Ojibwe		●		
		Lutheran Social Services of Minnesota	●	●	●	●
		Planned Parenthood MN, ND, SD	●		●	
		Sierra Young Family Institute	●			
		YWCA of Minneapolis	●	●	●	●
Unintentional Injury & Violence	**N=4**	Hennepin County Medical Center				●
		MN Indian Women's Resource Center		●		
		Model Cities	●			
		WellShare International	●			
Social Determinants of Health – Planning	**N=3**	Jordan New Life Hub	●			
		Pillsbury United Communities	●			
		Southwest Health and Human Services	●	●	●	●
Social Determinants of Health – Implementation	**N=2**	African & American Friendship Association for Cooperation & Development, Inc.	●			
		El Colegio Charter School				●
Number of grantees serving each population of color/American Indian			**N=15**	**N=13**	**N=9**	**N=10**

Table 7. EHDI 2012 Grantees by Priority Health Area (PHA) and Population

Priority Health Area	Total	EHDI Grantees	African American/ African	American Indian	Asian/ Pacific Islander	Hispanic/ Latino
Breast & Cervical Cancer Screening	**N=4**	Hmong American Partnership			●	
		Open Cities Health Center	●		●	
		Saint Mary's Clinic				●
		The Indian Health Board of Minneapolis		●		
Diabetes	**N=11**	Crown Medical Center	●			
		Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Open Cities Health Center	●		●	
		Peta Wakan Tipi		●		
		Pillsbury United Communities	●			
		Sabathani Community Center	●			●
		Saint Mary's Clinic				●
		Saint Paul Area Council of Churches		●		
		Stairstep Foundation	●			
		WellShare International	●			
Heart Disease & Stroke	**N=5**	Minneapolis American Indian Center		●		
		NorthPoint Health & Wellness Center, Inc.	●		●	●
		Pillsbury United Communities	●			
		The Indian Health Board of Minneapolis		●		
		WellShare International	●			
HIV/AIDS & Sexually Transmitted Diseases	**N=8**	African American AIDS Task Force	●			
		Annex Teen Clinic	●			
		Centro, Inc.				●
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		Indigenous Peoples Task Force		●		
		Planned Parenthood MN, ND, SD	●		●	
		Turning Point, Inc.	●			
Immunizations for Adults & Children	**N=3**	Axis Medical Center	●			
		CAPI USA	●		●	
		MN Immunization Networking Initiative	●	●	●	●
Infant Mortality	**N=4**	American Indian Family Center		●		
		Leech Lake Band of Ojibwe		●		
		Minnesota Visiting Nurse Agency	●	●		
		Open Cities Health Center	●		●	
Teen Pregnancy	**N=22**	Annex Teen Clinic	●			
		Asian Media Access	●		●	
		A.S.P.I.R.E. Project	●			
		Big Brothers Big Sisters of the Greater TC	●	●	●	●
		Boys & Girls Club of the Twin Cities	●	●	●	●
		Centro, Inc.				●
		GMCC Division of Indian Work		●		
		HealthFinders Collaborative				●
		Hennepin County Medical Center				●
		High School for Recording Arts	●			
		Indigenous Peoples Task Force		●		
		Isuroon	●			
		Lao Family Community of Minnesota			●	
		Lutheran Social Services of Minnesota	●	●	●	●
		Minnesota African Women's Association	●			
		Planned Parenthood MN, ND, SD	●		●	
		Sabathani Community Center	●			●
		Saint Paul Ramsey County Public Health	●	●		
		Southeast Asian Community Council, Inc.			●	
		Summit University Teen Center, Inc.	●	●	●	●
		TeenWise of Minnesota	●	●		
		YWCA of Minneapolis	●	●	●	●

Unintentional Injury & Violence	**N=5**	Community-University Health Care Center				●
		Hennepin County Medical Center				●
		Korean Service Center			●	
		MN Indian Women's Resource Center		●		
		Sabathani Community Center	●			●
Community Primary Prevention	**N=2**	National Asian Pacific American Women's Forum			●	
		The Neighborhood Hub	●			
Number of grantees serving each population of color/American Indian[10] [11]			**N=28**	**N=17**	**N=16**	**N=13**

[10] Grantees work in multiple PHA and POC/AI; number of grantees is smaller than number of dots in each column.
[11] Grantees self-identified POC/AI groups served in their original grant application.

IV. EHDI 2010-2012 Program Accomplishments

EHDI grantees are implementing a wide range of culturally responsive, evidence-based and promising practices to reduce health disparities among communities of color and American Indians in eight priority health areas (PHAs). Project activities are designed to address key objectives and strategies recommended by the Minnesota Department of Health.

Evidence Based, Promising and Culturally Responsive Practices

EHDI grantees are required to implement evidence-based, promising or culturally responsive projects that:

- meet the needs of population of color and American Indians already affected by one or more of the eight PHAs or address the underlying contributing risk factors for these PHSAs;
- provide individual or group-based services or change policies, systems, or the environment;
- are culturally responsive and linguistically appropriate;
- give community residents a voice in program planning, implementation, and evaluation; and
- strengthen working relationships and partnerships in the community.

Figure 3. Definitions: Evidence-based and Promising Practices

Evidence-Based Practices	Promising Practices	Culturally Responsive Practices
Interventions that have demonstrated effectiveness based on the principles of scientific evidence, including systematic uses of data and information systems, and appropriate use of behavioral science theory in order to explicitly demonstrate effectiveness.	Interventions that have demonstrated effectiveness based on local practices and/or cultural experiences, for example, non-experimental data or the experience of practitioners.	Interventions that are adapted to meet the unique cultural needs of different communities but might not yet been demonstrated to be evidence-based or promising.

MDH Priority Objectives, Strategies, and Activities

As part of the RFP process, OMMH recommends grantees align their projects with MDH recommended key objectives, strategies, and associated evidence-based activities. Grantees selected strategies from the options provided in the RFP and incorporated additional activities tailoring strategies to meet the needs of the communities to be served.

This section of the report provides an overview of the objectives, strategies, and evidence-based activities being used by grantees by PHA. For each PHA, one grantees work is featured. Appendix C includes a comprehensive summary of all grantees projects. Grantee work summarized here does not include a summary of tribal grantees. A future report will include tribal grant summaries.

Summary of Grant Activities by Priority Health Area

1. Breast & Cervical Cancer Screening

Health Disparity Context

- Breast cancer is the most common form of cancer in Minnesota women and the second leading cause of cancer deaths.
- Although breast cancer incidence rates are 27 percent lower among African Americans/African compared to white women, mortality rates are 22 percent higher among African American/African women.
- In order to reduce deaths from breast cancer, all women age 40 and older should get regular mammograms and clinical breast examinations.
- 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. Lack of time and inconvenience has also been reported as barriers.[12]

Grantee Project Objectives, Strategies, & Evidence Based Activities

2010 Grantees

- Three grantee programs addressed disparities in breast and cervical cancer outcomes for the African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino communities in Minnesota.
- Key objectives included:
    1) Improving the medical care given to women who have abnormal findings from breast or cervical cancer screenings
    2) Detecting breast and cervical cancer earlier
- All three 2010 grantees utilized evidence-based and culturally-responsive strategies, including using Community Health Workers (CHWs) to help patients address key barriers to timely follow-up of abnormal results, maximizing electronic medical records to identify those in need of follow-up, and creating linguistically appropriate materials.

2012 Grantees

- Four 2012 grantee programs are addressing disparities in breast and cervical cancer outcomes in communities of color and American Indians.
- Please see the appendices for additional information about 2010 and 2012 grantees.

[12] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Breast and Cervical Cancer Screening
EHDI Grantee Project Objectives, Strategies and Activities (2010=3; 2012=4)

Objectives

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

Strategies	# 2010 Grantees	# 2012 Grantees
• Increase the number of women who receive complete diagnostic and treatment services in a timely manner	3	3
• Increase the number of women who are screened for breast and cervical cancer in accordance with state or national health care guidelines	2	4

Types of Activities

Example of Evidence-based Strategies

- American Cancer Society breast and cervical cancer guidelines were used to determine how often women should receive pap smears and mammograms
- Use of Community Health Worker (CHW) model

Example of Culturally-Responsive Strategies

- Use of Talking Circles to facilitate talking to Women's Empowerment Groups about women's health issues in the community
- Use of cultural media to disseminate linguist and culturally-appropriate messages

Featured Grantee – Breast and Cervical Cancer Screening

***Grantee*: NorthPoint Health and Wellness Center, Inc.**

Populations Served: African American/African, Asian/Pacific Islander, and Hispanic/Latino

Community Partners: Susan G. Komen Race for the Cure, American Cancer Society, Pathways Health Crisis Resource Center

Objectives/Strategies: NorthPoint Health and Wellness Center, Inc. is a comprehensive health and human services agency located in north Minneapolis. To address the objective of improving the medical care given to women who have abnormal findings from breast and cervical cancer screenings, NorthPoint is using the following strategies: 1) developing a multi-disciplinary team approach to care for the medical, socioeconomic, and cultural needs of patients and 2) identifying and incorporating culturally-appropriate patient care needs into the practices within the organization.

Example of Key Activities and Evidence-Based Practices: NorthPoint is using an integrated care coordination model in which Community Health Workers (CHWs) assist individuals and families by addressing health care barriers, work on individualized health care goals, and assure patients receive culturally appropriate care and referrals for additional services to community agencies. All patients receiving services through EHDI funding receive regular follow-up calls, culturally appropriate health education, assistance with scheduling and rescheduling, referrals to internal financial case aides as needed, and assistance in addressing any additional barriers (i.e. transportation, housing support, legal referrals, financial management assistance, community referrals, etc.). An incentive program was developed based on MDH's SagePlus and Healthy Heart incentive programs, but adapted to be appropriate for the population served through this grant. All patients served by EHDI (including breast and cervical patients) receive information about on-campus and/or community exercise programming and receive information on healthy eating.

Results: NorthPoint piloted this model with diabetes patients and moved to using it with women with abnormal breast and cervical cancer screening results later in the first year of funding. The CHW provided follow-up and care coordination services to seven patients with abnormal breast findings. The clinic is in the process of implementing cervical cancer follow-up and care coordination. An evaluation plan is in place to document behavioral and health outcome indicators at the end of Year 2.

Outcomes: The diabetes program served 134 patients, and the breast cancer and cardiovascular group served 23 patients. Community Health Workers (CHWs) made 288 monthly contacts exploring patient's resource needs with regards to medical care; lifestyle interventions; and psycho social factors such as healthy food access; transportation, housing, financial assistance, etc. More than 70 percent of NorthPoint's patients reported a high level of satisfaction with facility, providers and the care they receive as compared to other FHQCs and community clinics. However, many patients did not demonstrate substantial improvements in specific health indicators for various reasons. Due to the complexity of their health condition before enrollment as well as impeding social needs, change will take time.

Key Lessons Learned: Focusing on eliminating health disparities and improving the client experience required NorthPoint to address internal barriers to coordination between the Human Services Division and the Clinic. A decision was made to reinitiate a previously established internal Integration Team.

2. Diabetes

Health Disparity Context

- Diabetes is the sixth leading cause of death in Minnesota and the leading cause of blindness, kidney failure, and lower-limb amputations.
- The death rate from diabetes from African Americans is almost twice the rate for white, and the death rate for American Indians in Minnesota is almost four times higher.
- Kidney failure is two to five times greater in American Indians; and eye disease is two times greater in Hispanics/Latinos and 40-50 percent greater in African Americans.
- Lack of culturally and linguistically appropriate diabetes education materials and support systems, and lack of culturally diverse or culturally responsive health care providers are other barriers to effective diabetes management in these populations.[13]

Grantee Objectives, Strategies and Evidence-Based Activities

2010 Grantees

- Four 2010 grantee programs addressed disparities in diabetes outcomes for African American/African, American Indian, Asian/Pacific Islander and Hispanic/Latino populations in Minnesota.
- Key objectives include:
    1) Improving the health status of people with diabetes
    2) Reducing the risk factors that can lead to diabetes

[13] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

- Four 2010 grantees utilized evidence-based strategies, all four grantees utilized promising practices and culturally-responsive strategies, including using Community Health Workers (CHWs) to ensure that patients get culturally-appropriate case management and health care services, offering culturally-appropriate exercise classes, using evidenced-based curricula as the basis of support groups promoting healthy lifestyles, and using community theater and youth advocates to promote culturally-appropriate messages about the importance of detecting and treating diabetes.

2012 Grantees

- Eleven 2012 grantee programs are addressing disparities in diabetes outcomes for African American/African, American Indian, Asian/Pacific Islander and Hispanic/Latino populations in Minnesota.
- Please see appendices for additional information about 2010 and 2012 grantees.

Diabetes
EHDI Grantee Project Objectives, Strategies and Activities (2010=4; 2012=11)

Objectives

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

Strategies	# 2010 Grantees	# 2012 Grantees
• Assist people with diabetes or pre-diabetes to maintain healthy lifestyles	4	8
• Improve medical care for people with diabetes	2	4
• Assist people with diabetes to manage their disease	1	8
• Teach people with pre-diabetes how to prevent the development of diabetes	2	8
• Detect diabetes earlier	1	3

Types of Activities

Example of Evidence-Based Strategies

- Use of the I CAN Prevent Diabetes program, the Healthy Heart program, and the SAGE Plus program (MDH)

Example of Promising Practices

- Educated young people to be health advocates and leaders
- Used traditional dance as a means to increase physical activity

Example of Culturally-Responsive Strategies

- Use of Talking Circles to gather information in the community to help make program materials more effective
- Promote culturally appropriate food choices (e.g., expanded farmer's markets)

Featured Grantee - Diabetes

Grantee: **Saint Paul Area Council of Churches** (The East Metro American Indian Diabetes Collaborative)

Populations Served: American Indian

Community Partners: The Collaborative includes the Saint Paul Area Council of Churches Department of Indian Work (lead agency), Ain Dah Yung (Our Home) Center, American Indian

Family Center, Indian Education (Saint Paul Public Schools), and the University of Minnesota Medical School.

Objectives/Strategies: The East Metro American Indian Diabetes Collaborative is working on two objectives: 1) improving the health status of people living with diabetes, and 2) reducing risk factors that can lead to diabetes. To achieve the first objective, the Collaborative is assisting people with diabetes to manage their disease by offering culturally responsive support groups that encourage self-care and healthy lifestyles. To achieve the second objective, the Collaborative is teaching people with pre-diabetes how to prevent the development of diabetes by conducting lifestyle change and support programs in clinical and community settings for people with pre-diabetes.

Example of Key Activities and Evidence-Based Practices:

For people living with diabetes: The Collaborative offered the Family Education Diabetes Series (FEDS) to Native Americans in East St. Paul for families and for youth. FEDS is a community-based participatory research project, designed as a supplement to standard diabetes care and guided by the principles of the citizen health care model. FEDS participants include patients, families, tribal leaders, and health-care professionals who met every other week for 21 sessions. Each session included education, nutrition and cooking, and exercise and weight management components, and many included outside speakers on a range of topics such as the physical and emotional aspects of disease management. Activities were community-based, inter-generational and often planned and led by participants.

Results: A total of 60 American Indians participated in at least one FEDS session, with 18 adults participating in 50 percent or more of the 21 bi-weekly sessions hosted by FEDS. At completion of the year, 90 percent of the 35 most active participants had metabolic control scores at or below the recommended level. The Youth Diabetes Education facet of FEDS engaged 143 participants, ages 7-20 at four schools and the Ain Dah Yung Center. Youth participants kept food and activity journals, used games and learning activities to increase awareness of healthy living, and utilized Wii sports and dancing games, yoga and traditional dancing. More than half of the students showed a lowered BMI, while 45 percent reported being more physically active.

For people with pre-diabetes: The collaborative implemented two educational and support programs to prevent diabetes for those at-risk. First, cooperating agencies worked together to implement the Diabetes Education in Tribal Schools (DETS) Health is Life in Balance curriculum in two middle schools and six elementary schools. The DETS curriculum is an evidence-based program designed to increase American Indian students' understanding of health, diabetes, and maintaining life in balance, to increase their understanding and application of scientific and community knowledge, and to increase interest in science and health professions. The curriculum incorporates stories, art projects, skits, individualized computer research, field trips to a fitness center and organic food store, and physical activity such as outings to pow wows to begin learning Native dancing. Of the twelve who studied traditional Native dance, six completed their traditional regalia and one planned a pow wow at her high school. Second, the American Indian Family Center started a father's and men's group called "Ombi'ayaa Anishinabe Iniiiwug" (O.A.I.), which means, "rise up, original men" in the Ojibwe language. Cultural activities were used to promote healthy, cultural and traditional community togetherness. For example, field trips to Madeline Island, Wisconsin, and East Lake Mille Lacs Band of Ojibwe Indians offered participants opportunities to meet with elders to learn about responsibilities of the community to promote culture, traditions, and healthy lifestyles.

Results: DETS: Classes using the DETS curriculum reached 90 elementary school participants and 19 middle school participants (included as part of the 143 youth participants described above under FEDS.) O.A.I.: Over the course of the year, 44 evening meetings were held as part of O.A.I. involving

32 men. Each meeting included cooking activities to produce healthy meals and snacks. A summer league softball team participated in 12 games and 27 practice sessions. Men participated in 44 sweat lodge ceremonies in addition to trips to prepare and care for the sweat lodge. Drumming instruction and activities occurred 54 times and included opportunities to learn traditional songs.

Outcomes:

- 90 percent of youth and adult participants demonstrated an increased knowledge of diabetes, improved behavior (diet/exercise), and/or the physical benefits of healthy living behaviors.
- 121 youth demonstrated a positive behavioral change through the use of a tailored self-management plan or increased physical activity through an EHDI-sponsored class or group.
- 75 percent of regular FEDS participants achieved a positive health change by one or more measures (weight, blood pressure, blood sugar, increased physical activity, and increased consumption of fruits, vegetables, and water).
- 75 percent of student participants had improved health (healthy eating, weight loss or maintenance, and increased physical activity).
- Gaming systems and access to recreational activities and cardio-equipment are effective means of achieving increased physical activity for youth.
- Participation in the men's group has a positive impact on the adult males and a positive impact on the healthy lifestyles of their families. Families increased their physical activity through traditional activities, access to the YMCA, and participation in a recreational softball team.

Key Lessons Learned: Regular feedback from adult and youth participants and active participation by the community in planning and decision-making has been instrumental in the success of these strategies. The format of gathering people for food preparation, a shared meal, and instruction on healthy eating has worked well. Incorporating traditional learning and activities such as drumming, sweat lodge, and dancing has been noted by participants as being especially effective in sustaining changed behaviors.

3. Heart Disease & Stroke

Health Disparity Context

- Heart disease and stroke mortality rates for Minnesotans overall are lower than the nation as a whole; however, for populations of color and American Indians, rates for heart disease or stroke are higher than the overall state population rates.
- American Indian heart disease death rates from 2005-2009 were 40 percent higher than those for whites.
- African American men died from stroke at a rate 22 percent higher than for white men during the same time period, while African American women died from stroke at a rate 36 percent higher than for white women.
- Asian American men living in Minnesota are more likely than other populations groups to suffer from stroke.
- Arteriosclerosis (hardening of the arteries) is the underlying disease process of the major forms of heart disease and stroke. It is associated with several modifiable risk factors,

including high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, obesity, and poor diet.[14]

Grantee Objectives, Strategies, and Evidence-Based Activities

2010 Grantees

- Four 2010 grantee programs addressed disparities in heart disease and stroke outcomes for African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.
- Key objectives include:
    1) Improving the health status of people with heart disease and stroke
    2) Reducing the risk factors that can lead to heart disease and stroke
- Three 2010 grantees utilized evidence-based strategies, two utilized promising practices, and all four used culturally-responsive strategies, including using the best practice of Community Health Workers to improve medical care for those with cardiovascular disease, and several grantees are offering or referring patients to culturally appropriate exercise classes. Other evidence-based practices include implementing an evidence-based curriculum for Native American community members to manage and prevent heart disease and stroke, using electronic medical records to identify those whose blood pressure and cholesterol are high, and offering linguistically appropriate educational materials.

2012 Grantees

- Five 2012 grantee programs are addressing disparities in heart disease and stroke outcomes for African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.
- Please see appendices for additional information about 2010 and 2012 grantees.

[14] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Heart Disease and Stroke

EHDI Grantee Project Objectives, Strategies and Activities (2010=4; 2012=5)

Objectives

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

Strategies	# 2010 Grantees	# 2012 Grantees
• Improve the medical care given to people with heart disease and stroke	2	2
• Assist people with heart disease and stroke to manage their disease	1	3
• Assist people with high blood pressure, high cholesterol, or who use tobacco to reduce their risk	2	1
• Decrease obesity by increasing physical activity and healthy eating	3	4

Types of Activities

Example of Evidence-Based Strategies

- Conduct disease self-management groups (e.g., use of Honoring the Gift of Heart Health curriculum)
- Use of Community Health Worker (CHW) model

Example of Promising Practices

- Use of assessment tools to get baseline and follow-up information related to lifestyle, physical health, mental health, and other needs

Example of Culturally-Responsive Strategies

- Culturally-tailored fitness classes

Featured Grantee - Heart Disease & Stroke

Grantee: **Vietnamese Social Services of Minnesota** (Asian American Eliminating Health Disparities Initiative (AAEHDI): Vietnamese Social Services of Minnesota, Karen Community of Minnesota, and Chinese Social Services Center)

Populations Served: Asian/Pacific Islander

Community Partners: Minnesota Department of Health, Smoke-Free Living, University of Minnesota Physicians

Key Objectives, Strategies, Activities and Evidence-Based Practices: AAEHDI is working on two objectives: improving the health status of people with heart disease and stroke and reducing the risk factors that can lead to cardiovascular disease. To achieve the first objective, AAEHDI is using the strategy of community health workers (CHWs) to conduct education and coordinate care for patients who have heart conditions. To achieve the second objective, AAEHDI is focused on the strategy of educating Asian/Pacific Islanders about the dangers of second-hand smoke and establishing smoke-free policies.

Example of Key Activities and Evidence-Based Practices: To implement the best practice of offering linguistically appropriate materials, AAEHDI has placed health messages translated into Hmong and Karen in newspapers and on the radio as well as using CHWs to refer patients for screenings, remind them about appointments, and help to interpret results.

Results: While originally targeting 3,740 refugees to receive prevention education about both heart disease and stroke and breast and cervical cancer, the Initiative exceeded its goal. Project staff

collaborated with the MDH to write two prevention articles published in national Asian newspapers, based out of the Twin Cities which reach an estimated 90,000 readers. Both were translated into Karen and will be published in two online publications based in Thailand and Australia read by Karen people around the world. An additional 4,000 people were reached through community events. Eight organizations implemented smoke-free policies, including stores and apartment complexes.

Outcomes:

- 63 women received personal coaching from program staff for lifestyle change intervention services, and received ongoing treatment for heart disease and/or diabetes.
- 817 individuals attended at least one of nine health classes and 312 individuals received a Cardio Vascular screening.
- 90 percent of participants had an increased understanding of the symptoms of a heart attack and stroke, ways to prevent heart disease and stroke, what to do if they or someone they know has the symptoms of a heart attack or stroke, and how to call 911 for assistance.
- More than 70 percent of participants could correctly identify the symptoms of a stroke and more than 65 percent of participants could identify most symptoms of a heart attach, with the exception of weakness (34 percent) and excessive sweating (26 percent).
- 90 percent of participants could identify that exercise is a way to prevent heart disease and stroke, and 67 percent could identify that not smoking and lowering cholesterol were also prevention strategies.
- More than 80 percent of participants indicated an increased understanding of dietary strategies to help prevent heart disease and stroke (less red meat and more fruits and vegetables).

Key Lessons Learned: Partnering with multiple agencies in the Asian community required the investment of time for training and capacity-building. Vietnamese Social Services shared its multi-year experience of preventative health education and screening with the organization, Karen Community of Minnesota, which was just beginning this work. Home visits provided an opportunity for staff to build trusting relationships with clients and address a range of needs before raising issues of preventative health screenings.

4. HIV/AIDS & Sexually Transmitted Diseases

Health Disparity Context

HIV/AIDS:

- Between 2004 and 2008, populations of color or American Indians accounted for 51 percent of newly-reported HIV/AIDS cases in Minnesota, even though these communities made up approximately 10 percent of Minnesota's population. Rates are higher than those among whites, ranging from 26 times greater for African-born to twice that of whites for American Indians.
- Women of color or American Indians accounted for 72 percent of newly-reported HIV/AIDS cases among women in Minnesota.[15]

[15] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Sexually Transmitted Infections (STIs):

- Among Minnesotans in 2011, African Americans had the highest rates of gonorrhea and chlamydia. Incidence of chlamydia among African Americans was 11 times greater than for whites in 2011, and incidence of gonorrhea was 10 times higher.
- Compared to whites, new chlamydia cases were two times greater among Asians and five times greater among Latinos in 2011.
- Infection with these STIs can cause infertility in women and increase the chances of spreading HIV.[16]

Grantee Objectives, Strategies, and Evidence-Based Activities

2010 Grantees

- Nine 2010 grantees were funded to address disparities in HIV/AIDs and sexually transmitted diseases for African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota and seven completed the full grant period.
- Key objectives pursued by grantees include:
  1) Improving the health of people with HIV and STDs
  2) Identifying new cases of HIV infection
  3) Reducing the rate of new infections of HIV and STDs, with most grantees focusing on the final two objectives
- Grantees used a variety of evidence-based practices, with the two most common being 1) the use of evidence-based curricula to provide high-risk individuals with education and skills to reduce risky sexual behaviors and improve safer sex skills, and 2) the use of peer education programs. Most grantees are pursuing these activities with youth largely in community-based and school settings. All seven grantees are using at least one evidence-based practice, two are using at least one promising practice, and five are using culturally-responsive strategies.

2012 Grantees

- Eight grantees programs are addressing disparities in HIV/AIDs and sexually transmitted diseases for African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.

[16] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

HIV/AID & Sexually Transmitted Diseases
EHDI Grantee Project Objectives, Strategies and Activities (2010=9; 2012=8)

Objectives

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

Strategies	**# 2010 Grantees**	**# 2012 Grantees**
• Increase the number of people who access complete diagnostic and treatment services in a timely manner after testing positive for HIV and/or STDs	1	3
• Increase HIV and STD testing among members of high-risk groups	4	4
• Reduce risky sexual behaviors which lead to the transmission of HIV/STDs	8	7

Types of Activities

Example of Evidence-Based Strategies

- Implemented a group or individual intervention for high risk members of the target population with education and skills training to reduce risky sexual behaviors, improve safer sex skills, and increase knowledge of HIV and STDs (e.g., use of Making Proud Choices, Becoming a Responsible Teen, ¡Cuidate! curricula)
- Implemented peer education programs and/or media campaigns to encourage adoption of safer sex practices (e.g., Sisters Informing Healing Living and Empowering Intervention (SiHLE))
- Use of Comprehensive Risk Counseling and Services (CRCS) for high risk uninfected persons

Example of Promising Practices

- Implemented Padres Informados curriculum to improve family communication

Example of Culturally-Responsive Strategies

- Implemented culturally-responsive curricula (e.g., ¡Cuidate!, SiHLE)

Featured Grantee - HIV/AIDS & Sexually Transmitted Diseases

Grantee: **Indigenous Peoples Task Force**

Populations Served: American Indian

Community Partners: The White Earth Tribal Health Department's Health Education Group; the Dakota Wichoan, a women's program on the Upper Sioux Community reservation at Morton, MN; Minnesota AIDS Project; Native American Community Clinic; Indian Health Board; Red Door Clinic; Elders Lodge; Anishinabe Child Care

Key Objectives, Strategies, Activities and Evidence-Based Practices: The Indigenous People's Task Force (IPTF), formerly known as the Minnesota American Indian AIDS Task Force, is working on two objectives: 1) identifying new cases of HIV infections, and 2) reducing the rate of new infections of HIV and STDs. To achieve the first objective, IPTF is using the strategy of working to increase HIV and STD testing among members of high risk groups through a variety of outreach and communication strategies. To achieve the second objective, IPTF is working to reduce risky sexual behaviors which lead to the transmission of HIV and STDs through a peer education program.

Example of Key Activities and Evidence-Based Practices

HIV testing and referral: The project promoted HIV testing through various media channels, including a multi-media campaign include using posters with Native artwork, T---shirts that promoted the women's program and testing, advertising in the Circle Newspaper, and Facebook updates on testing events. IPTF also conducted a broad---based HIV testing campaign at community events and convenient locations.

HIV tests were offered at 27 different locations, including 8 reservations that are easily accessible to Native Americans, including Pow wows, health fairs, conferences, and a walk---in station at the IPTF office. IPTF also partnered with other programs to host large testing events, such as with Little Earth for World AIDS Day, with Minneapolis American Indian Center for the National Native American HIV/AIDS Awareness Day, and with Ain Dah Yung for National Condom Day. The effort also included incentives for those being tested and referred for further services. A case manager provided "active referrals" for individuals who tested positive for confirmatory testing, case management, medical care, and other screening and helped those who are HIV positive to look for specialty care and keep track of appointments.

Peer education program: The Honor Project of the IPTF is an HIV peer educator program that trains women and adolescent females to promote HIV/AIDS prevention in their own circle of friends and family by hosting "Safer Snaggin" parties. The training session includes approximately 12 hours of education in HIV 101, health issues at different stages of life, communicating about HIV prevention, and tips for hosting a "Safer Snaggin" party. Women who completed the training would host a "Safer Snaggin" party in their home or other places they find comfortable to share what they have learned about sexual reproductive health. The training curriculum was redesigned to incorporate culturally responsive components about relationships and love and video clips of interviews with elders and Native women living with HIV.

Results: As a result of their extensive outreach efforts, IPTF tested 317 people in 2010-11, far exceeding the original target of 150. One person tested positive, and 43 percent were assessed as being at high risk of being infected and received condoms, education about reducing risks, and other referrals. After start-up time for revising the curriculum, 34 women participated in the Honor Project, with 6 later hosting parties with a total of 44 participants and others in the planning stages. Of the 34 participants, 18 were also tested for HIV. IPTF hopes to reach 100-150 women annually in coming years.

Outcomes:

- 1,100 individuals were tested for HIV at 27 locations, including community events and Pow-wows
- 100 percent of individuals tested positive for HIV were referred for confirmatory testing and medical care
- 100 percent of individuals found to be high risk were given information and referrals
- 111 women were trained as peer educators; 56 of these women were tested for HIV
- 37 Safer Snaggin Parties were held; 290 individuals attended
- Five reunions of program participants were held during grant year two; 68 individuals were tested for HIV during these reunions
- Participants reported an:
  - Increase in the comfort level to talk with their children about HIV
  - Increase in comfort level to talk to friends and family about HIV and importance of getting tested
  - Increased knowledge of effective methods of preventing HIV, including condoms
  - Increased ability to put on a condom correctly
  - Increase in sense of responsibility to members in their community

Key Lessons Learned: The use of incentives greatly increased the numbers of community members who come in for testing, particularly those who were very low-income, homeless, or in unstable living situations, and who were assessed as being high-risk because of factors including having unprotected sex with multiple partners, being sex workers, and/or abusing drugs or alcohol. Another key lesson emerged through the creation of the Statewide Advisory Council on HIV to address a previous lack of coordination on HIV issues. The Advisory Council planned a Tribal Summit in September 2011 to bring together tribal council members, tribal health staff, health service professionals, and stakeholders

from other service and education organizations to discuss the importance of testing and ways people from different sectors could work in tandem to remove the barriers to expanded HIV testing.

5. Immunizations for Adults & Children

Health Disparity Context

Childhood Immunization:

- The recommended vaccination primary series for children age 19-35 months are 4 DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B, 1 varicella, and 4 PCV13, abbreviated as 4:3:1:3:3:1:4.
- According to the 2011 National Immunization Survey (NIS) 68.5 percent of children in the United States age 19-35 months have completed the recommended primary series, compared to 72 percent of Minnesota's children age 19-35.[17]
- Information from the Minnesota Immunization Information Connection (MIIC) in 2012 shows that overall vaccination coverage rates on Minnesota children age 19-35 months as of October 1, 2012 increased slightly over the previous year.[18]
    - White children had the highest vaccination coverage rates of 65 percent.
    - Hispanic/Latino and American Indian children were close behind with coverage rates of 63.7 percent and 63.1 percent respectively.
    - African American/African and Asian Pacific Islander children had lower coverage rates with 54.4 percent and 52.4 percent respectively.

Adult Immunization:

- Influenza Vaccination: Behavioral Risk Factor Surveillance System (BRFSS) indicates that among adults age 18 and older, influenza coverage for the 2011-2012 season for non-Hispanic whites (41.9 percent) was higher than all other racial/ethnic groups except for American Indians (42.6 percent). Asian Pacific Islander coverage was 37.3 percent; African/African American coverage was 32.7 percent; and Hispanic/Latino coverage was 29.4 percent.[19]
- Pneumococcal Vaccination: According to the National Health Interview Study (NHIS), coverage among high-risk adults age 19-64 was 18.5 percent overall;
    - Coverage among non-Hispanic whites was highest at 19 percent
    - Coverage among Hispanic/Latinos and Asian Pacific Islanders was lowest at 14.8 percent and 11.5 percent respectively
    - Coverage among adults age 65 and older was 59.7 percent overall
    - Coverage among non-Hispanic whites was highest at 63.5 percent
    - Coverage among Hispanic/Latinos was lowest at 39 percent.[20]

[17] National Immunization Survey. (2012).
[18] Minnesota Immunization Information Connection. (2012).
[19] Behavioral Risk Factor Surveillance System. (2012).
[20] National Health Interview Study. (2012).

Grantee Objectives, Strategies and Evidence-Based Activities

2010 Grantees

- One 2010 grantee program addressed disparities in immunization outcomes and offered extensive outreach to the African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino communities in Minnesota.
- Key objective include:
  1) Remove barriers to accessing immunizations
- The 2010 grantee utilized evidence-based and culturally-responsive strategies in clinic and community-based settings.

2012 Grantees

- Three 2012 grantee programs are addressing disparities in immunization outcomes and offered extensive outreach to the African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino communities in Minnesota.
- Please see appendices for additional information about 2010 and 2012 grantees.

Immunization for Adults and Children

EHDI Grantee Project Objectives, Strategies and Activities (2010=1; 2012=3)

Objectives

- Improve clinical immunization rates
- Remove barriers to accessing immunizations

Strategies	**# 2010 Grantees**	**# 2012 Grantees**
• Increase access to immunizations	1	2
• Address knowledge, attitudes, and beliefs regarding immunizations		1
• Ensure that patients receive all needed vaccines at all visits		2
• Ensure that recordkeeping systems prompt for needed vaccines		1

Types of Activities

Example of Evidence-Based Strategies

- Provide annual influenza vaccination to people in trusted, community-based settings such as neighborhood community centers and senior high-rise and retirement communities

Example of Culturally-Responsive Strategies

- Volunteers vaccinators are trained in cultural norms and nuances and all consent forms are available in multiple languages
- Partner with community organizations and have community volunteers

Featured Grantee - Immunizations for Adults & Children

Grantee: **The Minnesota Immunization Networking Initiative (MINI)**

Populations Served: African American/African, American Indian, Asian/Pacific Islander, Hispanic/Latino

Community Partners: Key partners include St. Mary's Health Clinics, Stairstep Foundation, American Indian Community Development Corporation, River Valley Nursing Center, Homeland Health Specialists, Inc., Open Cities Health Center, and Fairview Office of Diversity.

Key Objectives, Strategies, Activities and Evidence-Based Practices: The initiative's key objective is removing barriers to accessing immunizations, using the best practice of providing immunizations in non-clinical settings such as neighborhood community centers and senior high-rise and retirement communities. Key strategies include holding free flu shot clinics in trusted, community-based settings, offering pneumonia vaccine to adults age 65 or older, recruiting, training, and placing volunteer vaccinators from Fairview Health Service to expand the reach of services, and engaging new partners in the Asian/Pacific Islander community to host clinics.

Example of Key Activities and Evidence-Based Practices: MINI provides annual seasonal immunizations at no charge to uninsured and underserved individuals age three and older within non-white communities in Minnesota in non-clinical settings. MINI formed partnerships with organizations representing a broad range of races and ethnicities and built on the connections that faith- and community-based organizations have already established within their communities to increase people's awareness and willingness to get vaccinated.

Results: In 2010-11, MINI offered 98 clinics at new sites for flu shots, an increase of 75 percent over the previous year. At these clinics, 6,288 people received flu shots, 24 percent of whom received shots for the first time.

Outcomes:

- Held 200 clinics; 49 were new clinics
- 13,500 people were vaccinated
- 24 percent of participants in year one and 33 percent year two received a flu shot for the first time in their life
- Trained 74 Fairview healthcare professionals in year one and 108 in year two as volunteer vaccinators
- All MINI clinics and client information was entered into the State immunization registry, called MIIC- Minnesota Immunization Information Connection
- Barriers to immunizations were better understood through completed surveys: Reasons given for attending the MINI clinic were: shots were free; lack of health insurance, trusted setting, and convenience
- 15 Fairview departments helped expand MINI during EDHI grant period

Key Lessons Learned: MINI clients have identified expense, inconvenience, lack of health insurance or regular doctor, lack of trust in government and the medical profession, and language barriers as key reasons that POC/AI did not receive their annual flu vaccination. The strategy of going out to people in a trusted, safe, and familiar community setting, such as worship services or a community event, proved to be effective in enhancing service delivery. This required engaging community leaders, building relationships, and cultivating invitations to hold clinics. In partnership, MINI provides vaccine and licensed vaccinators, and the community site "owns" the clinic and provides the facility, publicity, interpreters, and registration assistance.

6. Infant Mortality

Health Disparity Context

- Infant mortality rates are a sentinel public health measure and an important indicator of the health and wellbeing of families and communities.
- While the five-year average mortality rate for white infants in Minnesota during 2005-2009 was 4.5 per 1,000 infants, the rate for African American infants was more than twice as high at 10.7. For American Indians, the rate was 9.4 per 1,000 infants.
- Timing of infant deaths provides guidance to strategies and interventions: the American Indian post-neonatal (28-364 days) infant mortality rate is almost 5 times higher than any other group. This suggests that specific program interventions focusing on preventing sleep-related infant deaths and SIDS risk reduction should be successful in reducing American Indian infant deaths; African Americans have a 4 times higher rate of neonatal (< 28 days) deaths than any other population, suggesting that successful program interventions should be focused on preventing prematurity.[21]

Grantee Objectives, Strategies and Evidence-Based Activities

2010 Grantees

- Three grantee programs addressed disparities in infant mortality outcomes for African American and American Indian populations in Minnesota (two grantees completed the first year of programming)
- Key objectives pursued by the grantees include:
  1) improving the health status of women before, during, and between pregnancies
  2) improving the health status and safety of infants from birth to one year
- Grantees used a variety of evidence-based, promising practices and culturally-responsive strategies, including educating women and their partners about culturally appropriate family planning and child spacing and conducting culturally and linguistically appropriate education for parents about topics including child development, positive interaction between parents and infants, infant nutrition, and infant weight management. Both grantees are pursuing these activities in community-based settings.

2012 Grantees

- Four grantee programs are addressing disparities in infant mortality outcomes for African American, American Indian, and Asian/Pacific Islander populations in Minnesota.

[21] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Infant Mortality
EHDI Grantee Project Objectives, Strategies and Activities (2010=3; 2012=4)

Objectives

- Improve the health status of women before, during, and between pregnancies
- Improve the health status and safety of infants from birth to one year

Strategies	# 2010 Grantees	# 2012 Grantees
• Increase access to health and preventive care before, during and between pregnancies	2	3
• Provide culturally-responsive outreach and care coordination during pregnancy and birth		2
• Change behaviors that lead to acute and chronic conditions		2
• Provide education and support for pregnancy and parenting teens		1
• Improve infant nutrition and healthy physical growth and development	1	3
• Ensure that all infants receive high-quality care at birth and infancy		1
• Reduce infant deaths from SIDS and sleep-related unintentional injuries		3
• Reduce infant deaths from unintentional injury and violence		2

Types of Activities

Example of Evidence-Based Strategies

- Use of Community Health Worker (CHW) model
- Use of Ages and Stages: Social and Emotional Development assessment tool model

Example of Culturally-Responsive Strategies

- Provide culturally-responsive education on achieving and maintaining healthy weight and good nutrition (e.g., Somali video shown at mosques, apartment buildings, etc.)

Featured Grantee - Infant Mortality

Grantee: **Model Cities**

Populations Served: African American/African

Community Partners: Family Supportive Housing Center, Bethel University, Metropolitan State University, Women Planting Seeds, Eagles Wings, Family Tree Clinic, Women's Advocate, Inc., Pathways Counseling Center

Key Objectives, Strategies, Activities and Evidence-Based Practices: Model Cities is working on two objectives: 1) improving the health status of women before, during, and between pregnancies and 2) improving the health status and safety of infants from birth to one year. To achieve the first objective, the grantee is offering women culturally appropriate information about family planning methods and sexual health. To achieve the second objective, Model Cities is working to promote the healthy social and emotional development of infants by offering child development and parent education workshops and using a child development assessment.

Example of Key Activities and Evidence-Based Practices:

Reproductive health. Model Cities offered reproductive health workshops for women at five locations, with facilitation by a consultant from Eagles Wings, a youth development organization, and Family Tree Clinic. During the workshops, participants received information on family planning, human anatomy, sexually transmitted infections and HIV/AIDS, and the importance of annual testing.

Parent education. To promote parental knowledge of the healthy physical, emotional, and social development of infants, Model Cities conducted several kinds of activities. First, the program offered two series of parenting classes focused on infant nutrition and healthy physical growth and development, facilitated by a consultant from Family Supportive Housing Center. Second, 44 child development assessments (Ages and Stages of Social and Emotional Development) were conducted with infants in client homes throughout Ramsey County. Third, the program offered four family-building activities at different Model Cities sites to allow parents to positively interact with the children. Finally, case managers were trained and increased their knowledge and skills to promote healthy infant development and provide appropriate follow-up referral services to families with infants.

Results: Of the 25 women attending the sexual health workshops, more than 80 percent reported an increase in accessing appropriate reproductive health screenings and testing on at least an annual basis. Approximately 20 percent reported increased use of contraception to prevent unintended pregnancy and sexually transmitted infections. Of the 29 parents who participated in the parent education and child development workshops, 86 percent reported increased knowledge of infant mental health; approximately 75 percent of parents with infants reported increased access to appropriate mental health services. Approximately 85 percent of the parents reported increased strengths, skills, and competency in responding to their child's social-emotional developmental needs.

Outcomes:

- 85% of clients reported an increase in knowledge of family planning services offered in their community
- 80% of clients reported increased access to appropriate reproductive health screenings and testing on at least an annual basis
- 100% of the case managers reported their increased knowledge and skills to promote healthy infant development and provide appropriate follow-up referral services to families with infants.
- 85% of parents reported increased strengths, skills and competency in responding to their child's social-emotional developmental needs.

Key Lessons Learned: Offering services in clients' homes or community settings has improved attendance. To eliminate barriers to service, the program provided transportation, child care, and meals. Community partnerships offered Model Cities the chance to provide programs and services (e.g., involvement by nursing and social work students from Bethel University and Metropolitan State University and a consultant from the Family Supportive Housing Center to participate in child development screenings).

7. Teen Pregnancy

Health Disparity Context

- Minnesota youth of color and American Indian have significantly higher birth and pregnancy rates than their white counterparts.
- In 2010, the adolescent birth rate for white females aged 15 to 19 was 14.9 per 1,000. Asian Pacific Islanders had a birth rate of 31.4; African/African Americans had a rate of 48.5; Latina teens had a birth rate of 63.2; and American Indian teens had a birth rate of 67.1 per 1,000 teens ages 15-19.

- In 2004, the estimated adolescent childbearing cost to Minnesota taxpayers (federal, state, and local) was approximately $142 million. Using an inflation rate of 21.9%, that cost would equal $173 million in 2012.[22]

Grantee Objectives, Strategies and Evidence-Based Activities

2010 Grantees

- Thirteen 2010 grantee programs addressed disparities in adolescent pregnancy outcomes for African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.
- Key objectives include:
    1) Improving the sexual health of young people
    2) Reducing the risk factors and increasing the protective factors related to teen pregnancy
- Grantees used evidence-based or promising curricula and programs for young people of various genders, ages, and backgrounds, while a smaller number are using the evidence-based practices of peer educators, curricula for parents to improve communication, or training for clinic staff on the reproductive health needs of teens. Eleven grantees are using at least one evidence-based practice, and nine are using at least one promising practice.

2012 Grantees

- Twenty-two 2012 grantee programs are addressing disparities in adolescent pregnancy outcomes for communities of color and American Indians.

[22] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Teen Pregnancy
EHDI Grantee Project Objectives, Strategies and Activities (2010=13; 2012=22)

Objectives

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

Strategies	**# 2010 Grantees**	**# 2012 Grantees**
• Improve clinic practices to better reach young people	2	5
• Improve sexual health education of young people	10	15
• Increase parent-child connectedness and communication	7	8
• Increase school connectedness		9
• Increase opportunities for young people that help grow a sense of competence, connection and contribution	2	8
• Delay early sexual activity with a special focus on young adolescents	3	10
• Reduce the frequency of sex and number of partners and increase condom and contraceptive use among sexually-active adolescents	7	10

Types of Activities

Example of Evidence-Based Strategies

- Implement evidence-based programs in local schools or in after-school or community programs that discuss abstinence, contraception, and condom use (e.g., *Celebration of Change for African American Females, Becoming a Responsible Teen, Making Proud Choices, SiHLE, Healthy Hmong Teen*)
- Implement sexuality education for American Indian youth (e.g., *Live It!*)
- Implement a service learning program (e.g., *Teen Outreach Program*)

Example of Promising Practices

- Establish policies and procedures that will ensure that all clinic staff are trained on the unique development and health needs of culturally-diverse adolescents

Example of Culturally-Responsive Strategies

- Implement an evidence-based program that increases parent and child communication about sexuality (e.g., *Padres Informados, Jovenes Preparados* curriculum; *Plain Talk/Hablando Claro*)
- Implemented Celebration of Change for African American females program, a culturally-responsive and evidence-base curriculum

Featured Grantee - Teen Pregnancy

Grantee: **Centro, Inc.**

Populations Served: Hispanic/Latino

Community Partners: Aqui Para Ti (Hennepin County Medical Center), University of Minnesota Extension, Minneapolis Public Schools, Planned Parenthood, TeenWise of Minnesota

Key Objectives, Strategies, Activities and Evidence-Based Practices: Centro is working on the objective of reducing the risk factors and increasing the protective factors related to teen pregnancy with two key strategies: 1) increasing parent-child connectedness and communication, and 2) reducing the frequency of sex and number of partners and increasing condom and contraceptive use among sexually-active adolescents.

Example of Key Activities and Evidence-Based Practices: Centro's evidence-based youth development model called Raices (the Spanish word for 'roots') focuses not just on Latino youth but on the whole family. The overall goal of the Raices program is to help Latino teens cultivate a strong identity and develop multiple skills to lead a healthy life. The program has four objectives: 1)

increasing the knowledge and skills of Latino teens using an evidence-based curriculum on pregnancy and HIV/STD prevention (*¡Cuidate!*) delivered through peer-support groups (*Sacred Circles*) 2) improving family connections through delivery of a curriculum for parents and some intergenerational sessions (*Padres Informados*) developed with input from parents and partners; 3) promoting self and cultural awareness among youth through culturally appropriate activities; and 4) fostering high school graduation and post-secondary enrollment through mentoring and education of teens and their parents.

In addition to school-based activities, youth in the program have developed and performed plays and dances and created art that reflect Latino culture; participated in experiential photography and critical thinking workshops; engaged in service-learning and volunteer activities serving Latino elders; and participated in a Dia de los Muertos exhibit. Family activities included sexuality education using the evidence-based curriculum *Hablando Claro*, a healthy cooking and nutrition course, and a family retreat.

***Results**:* Raices engaged 123 youth and 73 parents, both at Centro and in four Minneapolis secondary schools, none of whom became pregnant. In addition, 90 percent of parents reported increased communication with their teens, and 90 percent of teens reported increased communication with their parents. To expand the impact of *Padres Informados,* Centro initiated a community research project about implementation of the curriculum to six sites, including several in rural Minnesota.

Outcomes:

- 100% of 2011 and 75 % of new participants in 2012 had increased knowledge of how to prevent pregnancy
- 60% of youth feel comfortable talking about sexual relations with their parents
- 100% of 2011 participants and 75% of new participants in 20102 had increased knowledge of how to use a condom or contraceptive
- 42% of youth increased their knowledge of HIV/STDs
- 60% of youth feel comfortable talking about sexual relations with their parents
- 100% of teens do not contract HIV/STDs
- 100% of teens do not get pregnant or father a child
- 100% of youth demonstrate improved attendance; 91% of the youth achieve grades C or better
- 100% of seniors graduated or expect to graduate from high school in 2012

Key Lessons Learned: The family-focused intervention, a strong network of community support through multi-sector partnerships, and staff development enable Centro to affect systems-wide change. The skills that the teens learn to succeed in school and establish a positive foundation for their lives and the skills that parents learn to support their children and family combine to create the conditions that support healthy choices around sexuality, thus reducing the likelihood of teen pregnancy. Centro partnered with its youth and parents to develop the parent curriculum rather than imposing a top-down model or a pre-developed approach.

8. Unintentional Injury & Violence

Health Disparity Context

- Minnesotans are five times more likely to die from suicide than from homicide; compared to the national average of one suicide for every homicide.

- The suicide rate for American Indians is higher than for any other racial/ethnic group
- More than 90 percent of suicides are associated with mental illness and/or alcohol and substance abuse, but more than 95 percent of those with mental health problems, such as depression or post-traumatic stress disorder, do not complete suicide.
- All populations of color and American Indians are more likely to die from homicides compared to whites.[23]

Grantee Objectives, Strategies, Activities and Evidence-Based Practices

2010 Grantees

- Four grantee programs addressed disparities in unintentional injury and violence prevention outcomes for the African American/African, American Indian, and Hispanic/Latino populations in Minnesota.
- Key objectives included:
  1) Preventing unintentional injuries and violence
  2) Reducing the risk factors that can lead to unintentional injuries and violence
- Grantees are using a variety of evidence-based practices, including conducting home visits with checklists to reduce hazards and promote safety, creating screening tools to identify people at high risk for suicide or self-inflicted harm and refer them to culturally appropriate treatment programs, delivering a culturally appropriate treatment program for those with dual diagnoses of mental illness and chemical dependency, and using community health workers and culturally appropriate exercise programs to improve mental health. Two grantees are using at least one evidence-based practice, and three are using at least one promising practice.

2012 Grantees

- Five grantee programs are addressing disparities in unintentional injury and violence prevention outcomes for the African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.

[23] Health Disparities Context from EHDI 2012 RFP. Retrieved from: http://www.health.state.mn.us/ommh/funding/rfp120227/rfp120227.pdf

Unintentional Injury and Violence
EHDI Grantee Project Objectives, Strategies and Activities (2010=4; 2012=5)

Objectives

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

Strategies	# 2010 Grantees	# 2012 Grantees
• Improve home safety	1	2
• Prevent suicide and self-inflicted harm	3	3
• Prevent injuries from assaults		2
• Decrease sexual violence		2
• Increase physical activity	1	2
• Decrease alcohol misuse		1

Types of Activities

Example of Evidence-Based Strategies

- Use of the Positive Youth Development (PYD) paradigm
- Conduct home visits to reduce hazards and promote safety in homes, using such tools as the *Home Safety Checklist*

Example of Promising Practices

- Encourage people who at high risk for suicide or self-inflicted harm to exercise regularly, participate in culturally and linguistically appropriate counseling or therapy programs, and comply with prescribed medications

Example of Culturally-Responsive Strategies

- Use of Family Parallel Care to address needs of parents and youth in a parallel fashion with the core traditional Latino value, *familismo*
- Promote opportunities in the community for culturally-appropriate physical activity

Featured Grantee – Unintentional Injury & Violence

Grantee: **Hennepin County Medical Center (Aqui Para Ti)**

Populations Served: Hispanic/Latino

Community Partners: Centro, Inc., La Conexion, The Family Partnership, University of Minnesota Extension Service, Tergar International

Key Objectives, Strategies, Activities and Evidence-Based Practices: Aqui Para Ti (APT) is working on one objective in this priority health area - preventing unintentional injuries and violence. To achieve the objective, the project is focusing on preventing suicide and self-inflicted harm by establishing procedures to identify high risk individuals and link them to culturally and linguistically appropriate prevention resources.

Example of Key Activities and Evidence-Based Practices:

Aquí Para Ti (or "Here for you") is a comprehensive bicultural, clinic-based, youth development program that provides medical care, behavioral health consultations, coaching, health education, and referrals to Latino youths aged 11 to 24 years and their families in a clinical setting. APT provides a comprehensive approach to mental health that looks at the family as a unit, considers the social context in which the family is immersed, and identifies the systems that are in place to create a network of support for the family.

Patients are referred to APT through HCMC providers, Centro, Inc., other community programs, and by word of mouth. All new patients and their parents take a youth and parent questionnaire, the Beck

Inventory, and Scale of Well Being to give staff an initial look at the overall physical and mental health of the youth and his/her parent that will guide the best approach for each patient.

The Beck Inventory is administered every three months to both youth and their parents. APT staff organized a parent and youth advisory group (including people of various ages and countries of origin) that met in June 2011 as part of the process of revising the instruments to be inclusive of all patients and parents.

When a mental health diagnosis was made, APT staff educated the youth and parent about the meaning of the diagnosis and treatment options, including the benefits and side effects of medication. Parents were either provided with an internal referral to HCMC's Psychiatric Services or with an extensive list of mental health therapy locations within Minneapolis and St. Paul. The APT team also created lists of Spanish-speaking mental health and basic needs resources that were given to patients and parents when the needs were identified. APT actively managed each case and provided follow-up appointments until the patient/parent was connected with therapy or resources.

Patients and parents were educated about self injury and its association with a mental health diagnosis, first separately to protect the patient's confidential appointment and then with parents to ensure the patient's safety.

Results: APT assessed 62 new patients during the first year. Of the 62, 69 percent received a mental health diagnosis. Of those with a mental health diagnosis, 56 percent had depression and 26 percent had a mental health diagnosis combining at least two of the following: depression, mood disorder, ADHD, anger, adjustment disorder, PTSD, bipolar, and anxiety. Sixty-five percent of those with a mental health diagnosis were referred to therapy, and 35 percent started taking medication.
The GAPS youth questionnaire allowed staff to further evaluate patients who reported having suicidal thoughts or attempts. Of the 62 new patients, 16 reported having suicidal ideation and/or having made attempts to hurt themselves. These 16 patients were closely followed up and treated with medication, therapy or both. All of the patients and parents who were identified as having suicidal thoughts or plans or were diagnosed with a severe mental health condition were interviewed immediately by the team to assess safety and create a contract for safety signed by the patient. If patients were unable to contract for safety they were immediately referred to an emergency behavioral crisis center. Parents were also encouraged to closely supervise their youth and to call 911 in case of an emergency. In the past year, 6 of the 62 new patients were hospitalized at an emergency behavioral crisis center.

Outcomes:

- 171 patients completed one or more Beck assessments; 68 patients had data available from two or more Beck assessments. Patients exhibited significantly fewer depressive symptoms at their final assessment compared to their first assessment.
- 107 youth enrolled in APT's Health Care Home and created 230 individual goals (education, increased social support, physical activity, reproductive health, mental health, etc.) as part of the care coordination process.
- 25 parents completed the Parenting Styles and Efficacy assessment. Parents who reported more authoritative behaviors (characterized by warmth and involvement, reasoning, etc.) reported higher efficacy in their role as a parent
- 78 parents completed one or more Beck Depression Inventories. No significant correlations between parents' total Beck scores and their scores on either measure of parenting.

***Lessons Learned*:** By addressing parents' mental health, APT was better able to understand each patient's family situation and history. By addressing individuals in a family separately and then as a family unit assured improved mental health among youth and parents. Referring families to family therapy took into consideration the need for considering the whole family.

9. Social Determinants of Health (SDoH) & Community Primary Prevention (CPP)

2010 Social Determinants of Health Planning Grants

- Three Social Determinants of Health Planning Grants were given to organizations serving the African American/African, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations in Minnesota.
- Key objectives pursued by grantees include:
  1) Identifying which social determinants of health affect the community
  2) Assessing the status of the social determinants of health in the community
  3) Determining a plan of action to address social determinants of health

2010 Social Determinants of Health Implementation Grants

- Two Social Determinants of Health Implementation Grants were given to organizations serving the African American/African and Hispanic/Latino populations in Minnesota.
- Key objective pursued by grantees include:
  1) Addressing social determinants of health

2012 Community Primary Prevention Grants

- Two Community Primary Prevention Grants were given to organization serving African American/African and Asian/Pacific Islander populations in Minnesota.
- Key objectives pursued by grantees include:
  1) Engaging young women as health leaders
  2) Collecting young women's sexual health data
  3) Building community connections
  4) Increasing community participation

Social Determinants of Health (SDoH) and Community Primary Prevention (CPP) EHDI Grantee Project Objectives, Strategies and Activities (2010 =5; 2012=2)

Objectives

Social Determinants of Health

- Identify which social determinants of health affect the community
- Assess social determinants of health in the community
- Determine a plan of action to address social determinants of health
- Address social determinants of health

Community Primary Prevention

- Engage young API women as health leaders
- Collect API young women's sexual health data
- Build community connections
- Increase community participation

Strategies	**# 2010 Grantees**	**# 2012 Grantees**
SDoH Planning		
• Organize community members	3	
• Increase community engagement	3	
SDoH Implementation		
• Utilize foreign-trained health care professionals	1	
• Build the capacity of the community to address social determinants of health	1	
Community Primary Prevention		
• Innovative, collaborative, community-based participatory action research program		1
• Train youth and adults in community organizing		1
• Provide culturally competent educational and support systems		1

Types of Activities

Planning

- Form planning groups made up of community members
- Conduct individual interviews, focus groups, and community forums
- Develop and implement a culturally appropriate assets mapping tool
- Conduct community outreach (e.g., Community Outreach Specialists

Implementation

- Recruit and train foreign-trained health professionals as Community Health Agents
- Integrate foreign-trained health professionals into Minnesota healthcare workforce system
- Conduct community forums and workshops as a way to engage and organize community members
- Design and produce public murals as an education and community organizing tool

Featured Grantee

Social Determinants of Health & Community Primary Prevention

Grantee: **Southwest Human and Human Services** (Joining Hands for Healthier Living Community Coalition)

Populations Served: African American/African, American Indian, Asian/Pacific Islander, Hispanic/Latino

Community Partners: Key partners include: Insight Language Resources, Southwest Adult Basic Education

Approach: In 2010, Southwest Health and Human Services formed the Joining Hands for Healthier Living Community Coalition in order to address the social determinants of health affecting the local

Latino, Hmong, Native American, and Somali populations in Lyon, Murray, Pipestone, and Redwood Counties. The coalition was made up of local schools, businesses, non-profit organizations, and community members from the local Latino, Hmong, Native American and Somali populations. The project used Community Outreach Specialists, who were fluent in English and the native language of the community in which they were conducting outreach, to engage community members in the work of the coalition. The coalition conducted a community assessment through the use of a survey.

Results: The Joining Hands for Healthier Living Community Coalition included community members from all four targeted population groups and other important community stakeholders. The Coalition conducted a community assessment to assess how the social determinants of health affected the four target population groups in these communities and to address these factors through proposed policy, system, and/or environmental changes. An analysis of the results of the community assessment led to the development of actions plans for six future projects including:

- Interpreter Program (a reduced cost interpreter training program to increase the number of trained interpreters available and to decrease language barriers), a policy change
- Native American Community Garden (a traditional community garden with education on native history, culture, and cooking to increase access to health food), an environmental change,
- Open Door Health Center (assist the Open Door Health Center with marketing and community outreach to increase access to healthcare),
- I CAN Health Literacy Program (a health literacy program for Head Start families)
- Southwest Hmong Community Center (assist the organization with the implementation of programs to address social determinants of health in the Hmong community), and
- Work with Iftiin, Inc., an organization that seeks to create a healthy and self-sufficient community of African immigrants in the Marshall area (assist the organization with implementation of programs to address social determinants in the Somali community).

Key Lessons Learned: The Social Determinants of Health planning grant offered an opportunity to bring together diverse stakeholders from across counties and communities. The Community Outreach Specialists were instrumental to formation and maintenance of the coalition. In addition to the successful formation of a multi-county coalition to identify and assess social determinants of health, Southwest Health and Human Services was able to identify six feasible projects that would address social determinants of health through policy, system, or environmental change.

V. Evaluation Capacity Building & Technical Assistance

OMMH is committed to evaluating individual grantee outcomes and strengthening the capacity of organizations to reduce disparities through shared learning and evaluation. As part of this process, OMMH provides grantees with individual evaluation technical assistance and support and has created a community of practice for ongoing learning.

Evaluation Technical Assistance (TA) and Support

OMMH contracts with an evaluation consulting organization, Rainbow Research, Inc, to be the Evaluation Technical Assistance (TA) and Support provider. The Evaluation TA and Support Team is made up of five consultants who have extensive experience working with populations of color and American Indians on evaluation activities.

Support from the Evaluation TA and Support Team includes:

- Providing customized, culturally responsive, one-to-one consultation
- Assisting grantees to develop logic models, evaluation and reporting plans.
- Giving training on evaluation approaches and reporting outcomes
- Offering interactive work sessions for four to six grantees addressing similar populations and/or PHAs
- Developing and sharing ready-to-use evaluation resources and tools

With this technical assistance, grantees create evaluation logic models, develop detailed evaluation plans, conduct data collection activities, and report annually on program outcomes.

Community of Practice

In 2010, OMMH created a web portal for EHDI grantees with the goal of creating a "community of practice." Through an interactive website, professional development webinars and gatherings, grantees are encouraged to 1) strengthen their relationships with other organizations who are actively working to eliminate health disparities, 2) share with each other knowledge, tools and ideas, and 3) to learn about new strategies and approaches being used locally and nationally to address social determinants of health.

The EHDI grantee portal can be found on the MDH Office of Minority and Multicultural Health website at: www.health.state.mn.us/ommh/grants/ehdi/forgrantees/index.html.

Since 2010, OMMH offered seven webinars featuring national and local experts on topics related to social and economic determinants of health, policy systems and environmental change and evaluation reporting.

Table 8. OMMH Sponsored Webinars for EHDI Grantees 2010-2012

Title	**Speaker**
Social Determinants of Health and Equity: Frameworks and Definitions	Camara Phyllis Jones, MD, MPH, PhD, FACE Research Director on Social Determinants of Health and Equity Centers for Disease Control and Prevention
Building Capacity for Advocacy	Makani Themba Nixon Executive Director The Praxis Project
Community Health Workers - Panel Presentation by Grantees	Zobeida E. Bonilla, PhD, MPH Assistant Professor, Div. of Epidemiology & Community Health University of Minnesota School of Public Health Windy Fredkove MSN, RN, Public Health Nurse Donn Vargas, Outreach Coordinator NorthPoint Health and Wellness Center Marie Minh-Hien Tran, Program Coordinator Vietnamese Social Services of Minnesota Andrea Everson, MPH, MSW, Program Coordinator WellShare International
Speaking the Language of Return on Investment: How to capture the benefits of your work in dollars and sense	Dr. José Pagán Professor & Chair Department of Health Management and Policy, School of Public Health, University of North Texas Health Science Center at Fort Worth
How to Think About Your Work through a Policy, Systems and Environmental Change Framework	Dr. Kenneth D. Smith Lead Program Analyst for National Association of County and City Health Officials (NACCHO)
Effective Advocacy - Achieving Health Equity through Policy Change	Monica Hurtado Youth Program Developer for EHDI grantee “Aqui Para Ti/ Here For You” Michael Scandrett Policy Director for Halleland Health Consulting
Effective Reporting - Reporting Well: Advice on creating a compelling evaluation report	Dr. Stephanie Evergreen eLearning Initiatives Director American Evaluation Association (AEA)

In addition, grantees are brought together bi-annually to share their work with each other, receive updates from MDH and OMMH, and participate in evaluation training.

VI. Conclusions

An Increasingly Diverse State

Minnesota is an increasingly diverse state. In 1990, people of color and American Indians in Minnesota represented just over 6 percent of our total population. By 2010, these communities had grown to represent fully 15 percent of the population. The Hispanic/Latino population grew by 364 percent during that time, and the African-American population grew by 189 percent. By 2025, Minnesota's population of color is expected to be about 22 percent, if this trend continues.[24]

The state's diversity is increasing primarily through immigration. Minnesota attracts a wide range of immigrants from other parts of the U.S. and from other countries, who move here to attend school, start businesses, work in Minnesota industries, and join family members.

Minnesota's recent immigrants come from diverse corners of the globe. The points of origin of our newest residents include Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan, to name just a few.[25] The diversity that exists *within* racial and ethnic categories (especially from Asia and Africa) presents nearly as many challenges as diversity within the population as a whole: for example, at least 19 different countries are represented among Asian immigrants to Minnesota.[26] The peoples from these areas bring a wide range of backgrounds, experiences, cultural practices, languages, and unique health concerns to Minnesota.

It is also important to remember that Minnesota's growing racial and ethnic diversity is not limited to the Twin Cities metropolitan area. The southwestern region of Minnesota, in particular, has experienced a dramatic increase in immigrant populations.[27]

Much of the state's future youth and vitality will come from immigrant groups, since on average, immigrant groups are often younger and have more children. Consider that about one-quarter of

[24] Minnesota Department of Health & Healthy Minnesota Partnership. (2012). The Health of Minnesota: Statewide Health Assessment. Retrieved from: http://www.health.state.mn.us/healthymnpartnership/sha/docs/1204healthofminnesota.pdf

[25] Minnesota Department of Health. (2012). Primary Refugee* Arrival to Minnesota by Initial County of Resettlement and Country of Origin, 2011. Retrieved from: http://www.health.state.mn.us/divs/idepc/refugee/stats/11yrsum.pdf

[26] Council on Asian Pacific Minnesotans. (2012). State of the Asian Pacific Minnesotans: 2010 Census and 2008-2010 American Community Survey Report. Retrieved from: http://www.capm.state.mn.us/pdf/StateoftheAsianPacificMinnesotans.pdf

[27] U.S. Census Bureau. Distribution of people of color, 2010: Atlas of Minnesota.

the state's public school students today are children of color or American Indians.[28] The state's future health depends on reducing the health differences between populations so that Minnesota can reach its potential as a healthy state for all Minnesotans.

EHDI: A Continuing Investment in Opportunities for Health

The EHDI is working to eliminate disparities by strengthening the capacity of communities of color and American Indian communities to create their own healthy futures and by capitalizing on the opportunity that exists to influence health in early childhood.

In 2001, Minnesota's EHDI became one of the nation's first statewide efforts to focus on the health and well-being of populations of color and American Indians. The first nine years of EHDI investments have yielded not only advances on the mandated goals, but also valuable information and lessons, including the need to:

- Make use of practice-based strategies built on evidence-based and promising practices, including consistent attention to integrating culturally responsive approaches into all the Initiative's efforts
- Continue developing or improving culturally-responsive behavioral interventions to improve health outcomes in populations of color and American Indians
- Address critical policy, systems, or environmental barriers that challenge significant progress toward eliminating health disparities in populations of color and American Indians
- Provide support for partnerships that combine the necessary skills, resources and leadership to address barriers in eliminating health disparities in populations of color and American Indians
- Provide grantees with technical assistance in identifying appropriate and measurable outcomes, as well as development of a logic model in their program evaluation and to report on their efforts.

Twenty-nine community grantees highlighted in this report proved to be valuable EHDI investments and incorporated many of the lessons learned noted above. Examples of their accomplishments include:

- At least 90 percent of active participants in a Family Education Diabetes Series to American Indians in East Saint Paul had metabolic control scores at or below the recommended level
- 817 individuals attended at least nine health classes and 312 individuals received a cardio-vascular screening from Vietnamese Social Services of Minnesota, an organization targeting Vietnamese, Chinese, and Karen Asian Pacific Islander communities

[28] Minnesota Department of Health. (2012). The Health and Well-Being of Minnesota's Adolescents of Color: A Data Book. Retrieved from: http://www.health.state.mn.us/divs/chs/mss/specialreports/AdolescentsOfColor_REPORT_051412.pdf

- 13,500 people were vaccinated through outreach at 200 clinics by Minnesota Immunization Networking Initiative, and over 180 Fairview healthcare professionals were trained as volunteer vaccinators.
- Several programs expanded their outreach capacity through the use of trained Community Health Workers recruited from the communities themselves.
- All grantees received evaluation technical assistance and support to evaluate their programs.

Forty-seven grants were awarded in 2012. In addition to efforts to increase the number of grants and grantees working to eliminate health disparities in populations of color and American Indians, grantees also are encouraged to partner as priority health area cohorts and align more closely with other MDH programs, e.g., SHIP, immunizations, diabetes, HIV/AIDS, teen pregnancy, or injury/violence prevention. These grants were awarded for one year with the possibility of extending for up to two more years depending on performance and availability of funding. Their outcomes will be documented in the 2015 Legislative Report.

Future MDH and OMMH efforts to strengthen EHDI will include:

- Engaging a broad array of stakeholders from the community, government, faith-based organizations, managed care and clinic health providers, and others, in order to develop recommendations on gaps and priorities in future EHDI mandated efforts aimed at eliminating health disparities in populations of color and American Indians
- Improving data collection standards through critical partnerships to improve the quality and consistency of race-specific, ethnic-specific, and language-specific information that can be shared and compared within MDH and statewide
- Supporting partnerships that develop and implement the policy, systems and environmental change strategies necessary to maintain sustainable change focused on eliminating health disparities in populations of color and American Indians.
- Developing and implementing strategies to explore the impact of institutional racism and historical trauma on the development and maintenance of health disparities in populations of color and American Indians.
- Building the necessary capacity to implement and institutionalize long-term strategies to eliminate health disparities.

Healthy Lives for All Minnesotans

Minnesota's reputation as a healthy state obscures an important issue: health disparities.

When it comes to the differences in health status between populations, Minnesota is far from equal. In reality, populations of color and American Indians in Minnesota experience higher rates of many chronic and infectious diseases and premature death.

"Of all the forms of inequality, injustice in health is the most shocking and the most inhumane."

The Rev. Martin Luther King, Jr., at the Second Annual Convention of the Medical Committee for

It is important to recognize that good health is not the mere absence of disease, but a state of "well-being" in every aspect of life. The foundation of this state of personal well-being starts in homes and schools, jobs and workplaces, as well as in places of worship, socialization, and play. With this broader perspective on what good health means, the sources of health disparities become easier to identify. Many Minnesotans, especially populations of color and American Indians, experience inequitable living conditions and unequal treatment in many aspects of life. Data collected by the Minnesota Department of Health, the Blue Cross Blue Shield Foundation, the Wilder Foundation, and others reveals that disparities in health status and opportunities to be healthy for people of color and American Indians in Minnesota are widespread and persistent in Minnesota in areas such as living environments, safe communities, education, employment opportunities, and health care.

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. A department-wide goal is to eliminate health disparities and achieve health equity. The Office of Minority and Multicultural Health (OMMH) provides leadership within MDH to engage populations of color and American Indians in actions essential to the over-arching goal of eliminating health disparities. MDH recognizes the critical importance of effectively addressing these health disparities in order to ensure our vision of keeping all Minnesotans healthy. The Eliminating Health Disparities Initiative is a critical strategy for strengthening local efforts that are at work in diverse communities across the state toward achieving this goal.