Eliminating Health Disparities Initiative: Fiscal Years 2019 and 2020

REPORT TO THE MINNESOTA LEGISLATURE 2020
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Eliminating Health Disparities Initiative: Fiscal Years 2019 and 2020

Report to the Minnesota Legislature 2020

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List of Acronyms

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

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Commissioner's Letter

Dear Legislators,

Much has changed in the past two years. We have seen the impact of the COVID-19 pandemic across multiple areas of our lives: health, job security, housing, education and more. At the same time, we witnessed the killing of George Floyd and the continual push from community leaders for racial equity and racial justice. Through all of this, the Minnesota Department of Health's (MDH) Eliminating Health Disparities Initiative (EHDI) grantees have continued to press on in their work to address health disparities in Minnesota's communities of color and American Indian communities.

The year 2021 marks 20 years of EHDI funding. In the fall of 2020, MDH's Center for Health Equity released a comprehensive report looking at the lessons learned from EHDI grantees over the past two decades. The takeaways from that report align with what is shared in this legislative report of the past two years of EHDI impacts:

- We must continue investing in organizations that represent communities most impacted by health inequities and the strategies created by communities.
- EHDI grantees continually adapt and create programs tailored to community values which have impact at individual, institutional and systems levels.
- The cultural knowledge, wisdom, and expertise of EHDI grantees increases access to prevention and care among communities in which conventional approaches have failed.

In order to continue addressing health disparities during the pandemic, grantees modified in-person activities to virtual engagements, developed new strategies to engage community members remotely, and created safety protocols to ensure the well-being of staff and community members interacting in person. Meanwhile organizations pivoted to provide basic needs and ensure community members were equipped with ongoing COVID-19 related information.

The pandemic continues to reveal that the systems that we have in place were not designed for communities of color, American Indians, and many more communities who are often overlooked or underserved such as LGBTQ and rural communities and communities with disabilities. While it is critical to continue to support the exemplary practices implemented by EHDI grantees, this approach must be paired with work that addresses the social and economic factors that underlie and drive health disparities and institutional racism.

Sincerely,

Jan Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Executive Summary

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

Minnesota is an increasingly diverse state. The decennial census data show that in 1990, people of color and American Indians in Minnesota numbered 273,883, comprising just over 6% of our total population. By 2010, these communities had grown to 893,203, comprising 17% of the state's population. As of 2018, people of color in Minnesota make up 20% of the total population while Black Minnesotans were the fastest growing population between 2010-2018, followed by Asian Minnesotans.[1] As the trend continues, the prioritization of health for people of color and American Indians is crucial to the health of the state as a whole.

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

Investing in Community Solutions

This report covers the activities of grantees in FY2019 and FY2020. This spans the end of one grant cycle (FY2019) and the first year of a new grant cycle (FY2020).

From July 1, 2018 through June 30, 2019 (FY2019), EHDI invested $5,221,745 in 32 organizations to address eight community-identified priority health areas (PHAs); FY2019 was the culmination of the prior EHDI grant cycle. EHDI grants are awarded through a competitive grant application process every few years. Funding decisions are based on recommendations from a committee of community reviewers. A new RFP was released in 2018; FY2020 was the first year of the new grant cycle. The current grant cycle provides funds to a cohort of 25 organizations from 2019 to 2023. From July 1, 2019 through June 30, 2020 (FY2020), EHDI awarded $5,041,950 to 25 organizations. Organizations work in eight priority health areas (PHAs). They are Breast and Cervical Cancer; Diabetes; Heart Disease and Stroke; HIV/AIDS and Sexually Transmitted Infections (STIs); Immunizations (for children and adults); Infant Mortality; Teen Pregnancy; and Unintentional Injury and Violence. These

[1] 2018 Population Estimates, U.S. Census Bureau, as cited by Minnesota State Demographic Center. (2020). *Age, Race, and Ethnicity*. https://mn.gov/admin/demography/data-by-topic/age-race-ethnicity.

targeted efforts of EHDI grantees have made a real difference in the lives of the people they serve. In a testament to the impressive connections within their communities, FY 2019 and 2020, grantees reported reaching tens of thousands of people directly through programming and services and hundreds of thousands people through indirect contact, such as health fairs and educational social media. The largest number of people in target populations directly reached was Hispanic or Latinx Minnesotans, followed by Black/African/African Americans. The Immunization PHA reached the highest number of Minnesotans directly, with for example over 12,500 immunizations given across two years, while the HIV/AIDS and STIs PHA reached the highest number indirectly due to an impressive social media campaign.

Impact of COVID-19

EHDI grantees, like the rest of the world, were forced to adapt to the reality thrust upon them by the COVID-19 pandemic. Grantees modified in-person activities to virtual engagements, developed new strategies to engage community members remotely, and created safety protocols to ensure the well-being of staff and community members interacting in person. Meanwhile organizations pivoted to provide basic needs and ensure community members were equipped with ongoing COVID-19 related information. The achievement of reaching this magnitude of people of color and American Indians with priority health area information, prevention, targeted intervention, and system change efforts to improve health was accomplished despite the compounding public health emergencies created by COVID-19.

Approach and Impact

In response to community and stakeholder feedback and based on the community driven EHDI philosophy, funding is meant to be flexible and responsive to community needs. A key recommendation that emerged from a 2015 EHDI community input process was to encourage grantees to broaden program activities to address the social and economic conditions for health, also known as the social determinants of health. In FY20 MDH changed its approach from the previous grant cycle and recommended that grantees align their projects with three levels of change. This was intended to allow grantees to expand beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior, or skill) to focus on broader social determinants of health, such as changing policies, systems or environments that address the root causes of inequities. This is consistent with the MDH philosophy to work at multiple levels of change – including addressing the social determinants of health – in order to ultimately achieve health equity. Grantees could choose the level(s) of change that aligns best with their project and identified corresponding objectives. They worked on three levels of change pre and post COVID-19, which included:

1. Level 1 Change- Providing **direct service to people.**
2. Level 2 Change- Working to **dismantle organizational barriers to care.**
3. Level 3 Change- **Addressing root causes of disparities.**

In the first year of EHDI funding cycles, grantees usually spend significant time in program planning and resource development (conducting community listening sessions, updating curriculum and public health education tools, etc.). Conversely, during later years of a funding cycle, grantees have developed and implemented more robust evaluation practices. For this reason, it follows a trend that evaluation data from FY2019 is expected to be more robust than evaluation data from FY2020. Additionally, due to the unique pressures caused by the COVID-19 pandemic and the corresponding need for health-based organizations to prioritize COVID-19 related responses, evaluation reporting requirements were significantly reduced in FY2020.

A few highlights of FY 2019 and FY2020 are included below, by priority health area.

Breast and Cervical Cancer

- In FY 2019 four grantees working on **breast and cervical cancer** prevention provided 1,700 women with breast or cervical cancer screenings. In FY2020, one grantee working on breast and cervical cancer prevention provided 131 women with a cancer screening. These are examples of Level 1 Changes.

Diabetes

- Six grantees worked to prevent or control **diabetes** in FY2019. Level 1 Change interventions ranged from clinical practice aimed at helping maintain or reach healthy A1C levels to education efforts to prevent new diabetes cases. One clinical program reported that 73% of nearly 500 patients had A1C levels under control at the end of grant period. In FY2020, six grantees began working on diabetes prevention strategies including Level 1 Change strategies of working directly with patients who had diabetes or pre-diabetes on strategies to increase vegetable consumption and other wellness strategies and Level 3 strategies of ensuring more access to healthy fruits and vegetables through Farmer's markets and prescriptions for vegetables purchases.

Heart Disease

- Five grantees were funded to prevent or intervene with those within their communities who are disproportionately affected by **heart disease** in FY2019. Strategies and approaches included increasing screening and education; healthy behaviors such as physical activity, healthy eating, and general wellness; and creating tailored prevention plans for patients diagnosed with cardiovascular disease. Additionally, 744 additional patients were screened by one of the clinic grantees and received a care coordination based on a medical record review. The same clinic program was also able to use medical records to track blood pressure levels and noted that 62% of targeted patients had their hypertension controlled at the end of the grant period. As compared to baseline hypertension data prior to the EHDI grant for the clinic, this demonstrated a positive trend showing significant improvement in their African/African American population. Prior to this program the population of the clinic had a 13% disparities gap; over the course of three years the gap was reduced to 3%. In FY 2020, five grantees were funded to work on strategies for increasing awareness of, access to, and use of healthier foods and active living strategies.

Infant Mortality

- Three grantees worked to reduce infant mortality, with a primary focus on the two most affected populations: African American and American Indian in FY2019. One grantee worked to reduce **infant mortality** by preventing prematurity and promoting women's health. That grantee worked on Level 1 Change with 70 African American women (along with 10 additional women from other racial and ethnic backgrounds) to promote holistic healthcare needs during and after pregnancy. Grantees working with the American Indian community focused on preventing sleep-related unintentional injuries among infants under 6 months, as that is a leading risk factor. Each of these programs also work on Level 1 Changes, providing wraparound services to pregnant and post-partum mothers and their children to assess needs, address issues and create holistic education, care and resource referral plans for families. For FY2020, two grantees have been awarded funds to work with the American Indian community on reducing infant mortality. The two grantees both work holistically with families to provide wrap around services while also addressing Level 2 Changes by training health care providers on culturally relevant services to ensure access to quality care.

Immunizations

- Two **immunizations** grantees in FY 2019 worked on Level 1 Changes with 7,870 participants, with 88% (out of 6,954) receiving at least one needed immunization, including 6,294 flu shots. Similarly, in FY2020, two

grantees reported reaching nearly 8,000 people with information about vaccines and providing over 6,000 people with needed immunizations.

HIV/AIDS and STIs

- Eight **HIV/AIDS and STIs** prevention grantees used a variety of different approaches to promote sexual health among populations who experience higher rates of HIV/AIDS and STIs in FY 2019. Some grantees worked on community-level interventions aimed at adults while many focused on health promotion and risk reduction education for middle and high school youth. Eight grantees were funded and reported on reach activities during the FY2020, targeted towards African, African American, and Hispanic/Latinx communities. One grantee conducted multiple media and outreach campaigns which they estimated resulted in 94,000 contacts among the sub-Saharan African community in Minnesota.

Teen Pregnancy

- Consisting of fourteen organizations, **teen pregnancy** is the PHA with the highest number of grantees in FY2019. In examples of Level 1 Change strategies, grantees used a combination of evidence-based programs and culturally responsive practices to improve sexual health for youth in Minnesota. Surveys administered with 1,833 program participants show that high percentages of youth participants across racial and ethnic groups are endorsing key components of sexual health: knowing where to access resources (79-96%) and having supportive adults with whom they feel comfortable talking about sexual health topics (79%-100%). Eleven grantees were funded for FY 2020, while many of these grantees conduct pre-post surveys on their prevention programming, most were unable to collect post-survey data due to COVID-19 restrictions. Grantees in FY2020 also began work on Level 3 Change strategies, such as seeking to eliminate racism in the provision of comprehensive sexual health care to adolescents.

Unintentional Injury & Violence

- Two grantees worked to prevent unintentional injury and violence in FY 2019, with one focused on increasing awareness in the Karen, Asian-adoptee and other Asian communities of mental health and suicide prevention resources. Another was a clinical provider to the Hispanic/Latinx community. In FY2020, the number of grantees in this category expanded to five and the approaches and types of injury and violence they sought to prevent also expanded.

I. EHDI Overview

Background

While Minnesota ranks high in terms of general health status compared to other states, the health disparities that exist in Minnesota are among the worst in the nation. Such disparities mean that, compared to whites, Minnesota's people of color and American Indians populations experience shorter life spans; higher rates of infant mortality; higher incidences of diabetes, heart disease, cancer, and other diseases and conditions; and poorer general health. For example, infant mortality rates for the country as a whole have exhibited a declining trend. Rates in Minnesota are lower than U.S. rates, but they mask significant disparities in certain populations. Data from 2014-2018 show that the infant mortality rate for American Indians (5.6 or 6 deaths per 1,000 live births) and for African Americans (6.2) was more than double the rate for whites (2.6), which means American Indian and African American babies are more than twice as likely to die before their first birthday compared to white babies[2]. When such disparities are allowed to persist, they have a negative effect on the quality of life, the cost of healthcare, and the overall health of all Minnesotans.

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

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

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

From the outset, the creators, and stakeholders of EHDI recognized that the issues contributing to health disparities are broad and complex—an interplay of many economic, social, and individual factors. MDH, the Legislature, and EHDI community partners understood that effectively addressing this complex set of interrelated problems would require an approach that is comprehensive, community-driven, and long-term.

Proposals received were reviewed with community input. Grants have been awarded to faith-based organizations and social service organizations as well as community-based nonprofit organizations, health boards, and clinics for local or regional projects and initiatives. Attention to a strong, ongoing evaluation has

[2] Minnesota Department of Health (2020). Infant Mortality. Data are for 2014-2018. Source: Minnesota Center for Health Statistics. Retrieved from: https://data.web.health.state.mn.us/infant_mortality

helped MDH, EHDI grantees, community partners, and other stakeholders learn about what works and what does not, which has led to programming that continually evolves and practitioners who continually improve their methods. The years of EHDI investments have yielded not only advances on the mandated goals, but also valuable information and lessons, including the need to:

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

The Center for Health Equity

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

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

II. The Changing Face of Minnesota's Health

Population Diversity

Minnesota is an increasingly diverse state. The decennial census data show that in 1990, people of color and American Indian populations in Minnesota numbered 273,883, comprising just over 6% of our total population. By 2010, these communities had grown to 893,203 comprising 17% of the state's population. The Hispanic/ Latinx population grew by 364 percent during that time, and the Black/ African American population grew by 196 percent (Table 1). If the trend continues, Minnesota's populations of people of color and American Indians are expected to comprise 21.8% of the total population by 2025, and by 2035, this percent will increase to 24.8% of the state's population.

Table 1. Minnesota Population Change

Racial/ Ethnic Group	1990	2000	2010	2019
American Indian	49,909	54,967	67,325	57,414
Asian American/ Asian-PI	77,886	141,968	217,792	288,383
Black/ African American	94,944	171,731	280,949	370,291
Hispanic/ Latinx	53,884	143,382	250,258	314,217
Two or more races		82,742	111,440	186,583
White (non-Hispanic)	4,101,266	4,337,143	4,410,722	4,627,588
Total Minnesota	**4,375,099**	**4,919,479**	**5,303,925**	**5,639,632**

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

Much, but not all, of Minnesota's changing demographic profile results from the arrival of foreign-born residents. Minnesota's immigrants and refugees come from all over the world—including Mexico, Laos, Somalia, Vietnam, Canada, Ethiopia, Korea, Liberia, Germany, Burma, and Bhutan. Births within Minnesota have also become more racially diverse. In 2017, approximately 13,500 babies (20%) were born to (immigrant) mothers who were born outside of the U.S.[3]

Minnesota's growing racial and ethnic diversity is not limited to the Twin Cities metropolitan area; this growth is happening around the state. The seven-county metro area accounted for 74% of the increase in the number of persons of color, and southern and southwestern Minnesota combined follow at 14%. Table 2 details additional changes over time in regions across the state.

Table 2. People of color and American Indians in Minnesota by Region, 1990, 2010 and 2019

Geographic Area	1990	2010	2019
Central	11,082	51,607	77,371
Northland	11,273	24,860	29,516
Northwest	10,963	23,141	28,700
Southern	16,602	76,308	105,385
Southwest	6,158	29,669	41,082
Twin Cities 7-county	211,783	672,347	874,300

[3] Minnesota Department of Health (2020). Birth and Fertility. Retrieved from: https://mn.gov/admin/demography/data-by-topic/births-fertility/

West Central	5,972	15,271	23,129
MN Total Populations of Color	**273,833**	**893,203**	**1,179,483**
MN Total Population	**4,375,099**	**5,303,925**	**5,639,632**
MN Total Population of Color as % of Total Population	**6.3%**	**16.8%**	**21%**

Sources: Minnesota State Demographic Center and U.S. Census Bureau, Decennial Census, Population Estimates, and Population Projections. Data downloaded from http://www.mncompass.org on 11/30/2020

This demographic data points to the growing racial and ethnic diversity in Minnesota and underscores the importance of reducing the health disparities between white Minnesotans and people of color and American Indians so that all Minnesotans can be healthy. However, funding for EHDI has not increased to keep pace with the exponential growth in the population. Rather, funding has remained stagnant over time. When considered in light of the increase in the population levels, this limits the capacity of organizations to reach those in need of critical services.

Minnesota's Health Disparities

Although racial disparities in health exist between white Minnesotans and people of color and American Indian communities throughout the state and across the spectrum of health areas, they do not affect all populations of color and American Indian communities in the same way or to the same degree. Importantly, diversity exists not only between racial and ethnic categories but also within them. For example, if premature birth rates were reported for Asians/ Asian Americans as a single group, the number would be 7.3%, as compared to 6.5% for Minnesotans overall.[4] This number masks wide variation among descendants from Asia; the indicator is significantly better for some groups (Asian Indian, Chinese, and Japanese) than it is for Asians/ Asian Americans as a whole, while it is significantly worse for other groups (Cambodian and Laotian).

Factors beyond geographic and national origin, such as generation and circumstances of migration, traditional diet and lifestyle, educational level and transferable skills, language and literacy, spiritual beliefs and cultural practices make the experience, needs, and strengths of each group very different. These differences between and within broad racial categories is what makes the culturally responsive—and often culturally specific—approach to the work done by EHDI's stakeholders and community partners so important. Programming targeted toward large categories of people as if they are homogeneous has not been helpful. Additional data on health disparities related to each PHA can be found in this report under the Grantee Activity descriptions in section IV, Program Implementation.

III. Grant Awards

EHDI Grants awarded in 2019 and 2020 are described below by year, population, and PHA.

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

Funding Totals (FY19 and FY20)

From July 1, 2018 through June 30, 2019 (FY2019), EHDI invested $5,221,745 in 32 organizations to address eight community-identified priority health areas (PHAs); FY2019 was the culmination of the prior EHDI grant cycle. EHDI grants are awarded through a competitive grant application process every few years. Funding decisions are based on recommendations from a committee of community reviewers. A new RFP was released in 2018; FY2020 was the first year of the new grant cycle. The current grant cycle provides funds to a cohort of 25 organizations from 2019 to 2023. From July 1, 2019 through June 30, 2020 (FY2020), EHDI awarded $5,041,950 to 25 organizations. At the completion of FY 2020, $4,161,214 was spent; the remaining $101,367 will carry over into the next fiscal year.

Grants Awarded by Population and by PHA (FY19 and FY20)

Figure 1. Number of EHDI Grants by Population, 2019–2020

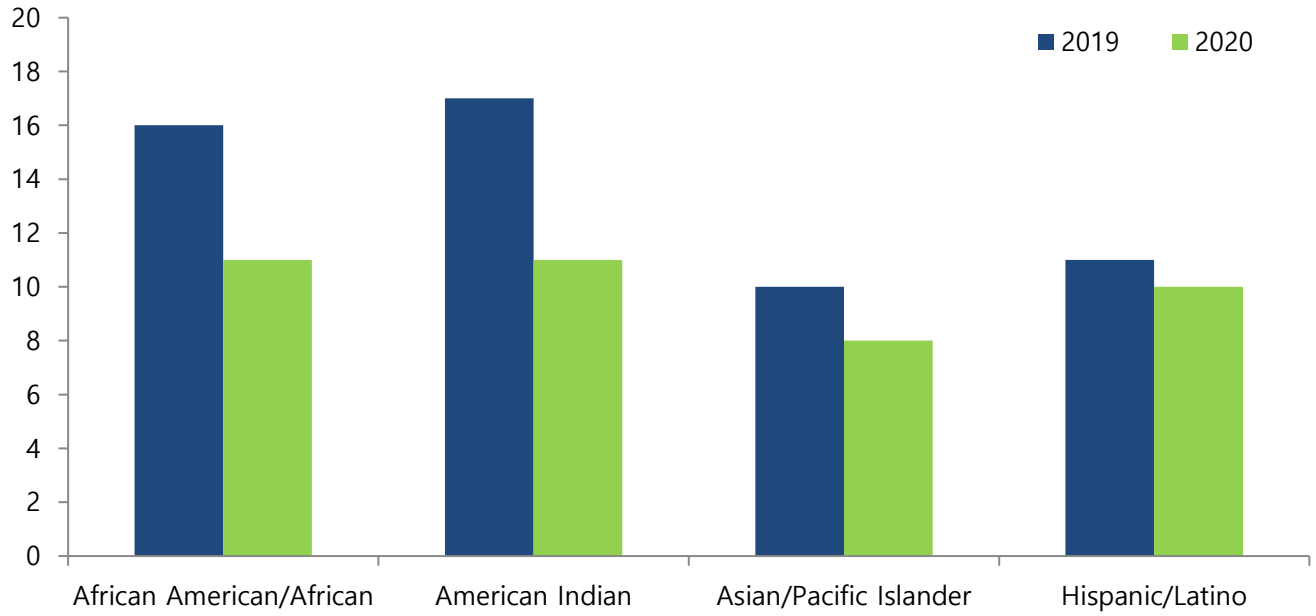


Figure 1 outlines the distribution of grants by population in 2019 and 2020. Table 3 provides a breakdown of the number of grantees funded in each PHA in 2019 and 2020.

Table 3. Number of EHDI Grants by PHA, 2019–2020

Priority Health Area	# of Grantees 2019	# of Grantees 2020
Breast & Cervical Cancer	2	1
Diabetes	6	6
Heart Disease & Stroke	5	4
HIV/AIDS & STIs	7	8
Immunizations	2	2
Infant Mortality	3	2

Teen Pregnancy	14	11
Unintentional Injury & Violence	2	5

Note: Some grantees provided services in more than one PHA

IV. Program Implementation

Evidence-Based, Promising & Culturally Responsive Practices

In FY2019, as part of the Request for Proposal (RFP) process, MDH recommended that grantees align their projects with MDH recommended key objectives, strategies, and associated evidence-based or promising practices. Specifically, grantees were encouraged to choose at least one of the objectives from the menu of options provided in the RFPs and incorporate activities to tailor their strategies to meet the needs of the communities they serve.

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

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

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

Dream of Wild Health; EHDI Grantee FY20

- meet the needs of people of color and American Indian populations already affected by one or more of the eight PHAs;
- provide individual or group-based services;
- address the underlying risk factors that contribute to one or more of the eight PHAs;
- change policies, systems, or the environment;
- meaningfully draw from or respond to the cultural values, knowledge, and practices of community members;
- are linguistically appropriate;
- give community members a voice in program planning, implementation, and evaluation; and

- strengthen working relationships and partnerships in the community.

In FY2020, in response to community feedback, MDH changed its approach and allowed grantees to align their projects with one or more level(s) of change that fit their work. The three level of changes were:

1. Level 1- Providing **direct service to people** to:
    - Overcome societal, structural barriers to access.
    - Change perspectives, gain knowledge and new skills.
    - Build trust, community, and relationships.
2. Level 2- Working to **dismantle organizational barriers to care**:
    - Building and maintaining existing partnerships, connecting to better serve communities.
    - Adapting policies and practices to better serve communities in pandemic (intra-organizational work)
    - Providing educational and technical resources to partners
3. Level 3**- Addressing root causes of disparities:**
    - Incorporating the impact of historical trauma and societal barriers into strategies
    - Ensuring strong connection to culture in advocacy and health initiatives

EHDI Grantee Objectives, Level of Change, Strategies & Activities (FY19 and FY20)

This section summarizes the objectives, strategies, and activities of EHDI grantees for each PHA. Appendix C features the work of some grantees in greater detail.

The 2018 EHDI Request for Proposals includes additional background information about the social determinants of health and the health disparity context pertaining to each PHA. In FY2019, MDH recommended that grantees align their projects with MDH recommended key objectives, strategies, and associated evidence-based or promising practices. Specifically, grantees were encouraged to choose at least one of the objectives from the menu of options provided in the RFPs and incorporate activities to tailor their strategies to meet the needs of the communities they serve. In FY2020, MDH changed its approach and allowed grantees to align their projects with one or more level(s) of change that fit their work including providing direct service to people, working to dismantle organizational barriers to care, and addressing root causes of disparities.

1. Breast and Cervical Cancer

Table 4. Program Objectives, Strategies & Activities: Breast & Cervical Cancer

Breast & Cervical Cancer EHDI Grantees (FY 2019=2; FY 2020=1)

Objectives

- Increase breast and cervical health awareness through direct and indirect outreach.
- Provide 1:1 education and navigation services enabling greater access to the health care system.
- Increase the capacity and ability of clinic coalition members to provide service the API community in a culturally competent manner.
- Create a coalition of stakeholders that are driven to achieve better health outcomes for the community by assisting policymakers in addressing critical health disparities facing API residents.

Strategies	# FY 2019 Grantees
Increase the number of women who receive complete diagnostic and treatment services in a timely manner	2
Increase the number of women who are screened for breast and cervical cancer in accordance with state or national health care guidelines	4

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	1
Level of change 2: Organizational/ Institutional Change	1
Level of change 3: Root Cause/Condition for Health	1

Type of Activities

- Review and modify existing materials on breast and cervical cancer.
- Conduct breast and cervical cancer education workshops at community sites.
- Provide cultural competency training to all clinic coalition partners.

Note: Objective and Type of activities mentioned above are for FY2020

2. Diabetes

Table 5. Program Objectives, Strategies & Activities: Diabetes

Diabetes EHDI Grantees (FY 2019=6; FY 2020=6)

Objectives

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

Strategies	# FY 2019 Grantees
Assist people with diabetes or pre-diabetes to maintain healthy lifestyles	4
Improve medical care for people with diabetes	1
Assist people with diabetes to manage their disease	3
Teach people with pre-diabetes how to prevent the development of diabetes	4
Detect diabetes earlier	2

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	6
Level of change 2: Organizational/ Institutional Change	5
Level of change 3: Root Cause/Condition for Health	5

Types of Activities

- Screening for family-level social determinants of health.
- Provide 1:1 wellness and fitness coaching to FIT Team members.
- Co-facilitate intergenerational listening sessions in communities.
- Organize/host community gardening/Healthy cooking workshops, and community event highlighting healthy Indigenous foods.
- Provide technical support and assistance to low income, Hmong farmers to grow fresh produce at a scale that meets the demand of the local food market, while securing and maintaining good agricultural practices (GAP) certification and compliance with the federally mandated Food Safety Modernizations Act (FSMA).

Note: Objective and Type of activities mentioned above are for FY2020

3. Heart Disease and Stroke

Table 6. Program Objectives, Strategies & Activities: Heart Disease & Stroke

Heart Disease & Stroke EHDI Grantees (FY 2019=7; FY 2020=5)

Objectives

- Lower the risks of heart disease by having access to and eating fresh, healthy, culturally appropriate, locally grown food.
- Create greater awareness for local food and farming anchor institutions in the Twin Cities about equity and understanding that community wealth is integral to community health.

Strategies	# FY 2019 Grantees
Improve the medical care given to people with heart disease and stroke	2
Assist people with heart disease or stroke to manage their disease	1

Assist people with high blood pressure, high cholesterol, or who use tobacco to reduce their risk	3
Decrease obesity by increasing physical activity and healthy eating	1

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	5
Level of change 2: Organizational/ Institutional Change	4
Level of change 3: Root Cause/Condition for Health	4

Types of Activities

- Identify, engage, and work with low income and food insecure families to improve their health.
- Work with farmers and legal experts to create by-laws and form a farmer owned marketing cooperative.

Note: Objective and Type of activities mentioned above are for FY2020

4. HIV/AIDS and Sexually Transmitted Infections

Table 7. Program Objectives, Strategies & Activities: HIV/AIDS & STIs

HIV/AIDS & STIs EHDI Grantees (FY 2019=7; FY 2020=8)

Objectives

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

Strategies	# FY 2019 Grantees
Increase the number of people who access complete diagnostic and treatment services in a timely manner after testing positive for HIV and/or STIs	3
Increase HIV and STI testing among members of high-risk groups	6
Reduce risky sexual behaviors which lead to the transmission of HIV/STIs	3

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	8
Level of change 2: Organizational/ Institutional Change	6
Level of change 3: Root Cause/Condition for Health	4

Types of Activities

- Coaching early teens on mindfulness, peer pressure, bullying, & advocating for self

- Use of social media to increase awareness and early intervention.
- Conduct clinic visits so that youth know where to go to get tested.
- Convene culturally specific community advisory board, community listening sessions.
- Conduct HIV and STI testing at LGBTQ community sites.
- Conduct training and education to professionals in the field on cultural competency.

Note: Objective and Type of activities mentioned above are for FY2020

5. Immunizations

Table 8. Program Objectives, Strategies & Activities: Immunizations

Immunizations EHDI Grantees (FY 2019=2; FY 2020=2)

Objectives

- Improve clinical immunization rates.
- Provide culturally competent immunization/health information and education.
- Provide free flu shots to children and adults affected by health disparities.

Strategies	# FY 2019 Grantees
Increase access to immunizations	3
Address knowledge, attitudes, and beliefs regarding immunizations	3
Ensure that patients receive all needed vaccines at all visits	3
Ensure that recordkeeping systems prompt for needed vaccines	3

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/ Institutional Change	1
Level of change 3: Root Cause/Condition for Health	1

Types of Activities

- For each clinic: Secure and organize all necessary immunization supplies and forms.
- Engage licensed vaccinators to work in the community under physician's standing orders.
- Train designated staff persons in partner organizations to present Is it a cold or the flu? educational sessions.
- Work with bi-lingual Community Health Workers
- Partnering with culturally specific community organizations and using community volunteers
- Screening and offering developmental and seasonally appropriate immunizations.
- Ensure that interpreters and translated materials are available.

Note: Objective and Type of activities mentioned above are for FY2020

6. Infant Mortality

Table 9. Program Objectives, Strategies & Activities: Infant Mortality

Infant Mortality EHDI Grantees (FY 2019=3; FY 2020=2)

Objectives

- Reduce risk factors that can lead to infant mortality and increase protective factors.
- Reduce Native maternal-child morbidity/mortality (including Infant Mortality).
- Avoid or reduce the unintentional violence and injury associated with Child Protection involvement.
- Build the capacity of service providers to provide culturally specific health services to American Indian women.
- Increase the amount of effective, culturally appropriate parenting program knowledge available to entities seeking to reduce Native maternal-child morbidity/mortality.
- Build the capacity of local social service organizations to provide culturally specific health services to American Indian women.
- Increase the capacity of MIWRC to advocate on behalf of urban Native American families for policies that support breastfeeding.
- Increase dominant-culture institutions' understanding of the historical roots of Native American/Alaska Native health disparities so that they can better address disparities via effective policy changes.

Strategies	# FY 2019 Grantees
Increase access to health and preventive care before, during and between pregnancies	3
Provide culturally responsive outreach and care coordination during pregnancy and birth	3
Change behaviors that lead to acute and chronic conditions	2
Provide education and support for pregnant and parenting teens	1
Provide education and support for pregnant and parenting teens	2
Ensure that all infants receive high-quality care at birth and infancy	2
Reduce infant deaths from SIDS and sleep-related unintentional injuries	2
Reduce infant deaths from unintentional injury and violence	2

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	2
Level of change 2: Organizational/ Institutional Change	2
Level of change 3: Root Cause/Condition for Health	1

Types of Activities

- Provide government workers with high quality, Native-developed training on the root causes of disproportional rates of Infant Mortality, experiences of injury and violence, and removal of Native children from their families.

- Provide training and capacity building to other state, local, and non-profit organizations to improve the quality and cultural competence of curriculum and parent education program delivery.
- Host Community Baby Showers to celebrate and welcome new babies and parents.

Note: Objective and Type of activities mentioned above are for FY2020

7. Teen Pregnancy

Table 10. Program Objectives, Strategies & Activities: Teen Pregnancy

Teen Pregnancy EHDI Grantees (FY 2019=14; FY 2020=11)

Objectives

- Provide culturally relevant, bilingual, LGBTQ+ inclusive sexual health education for Latinx teens ages 12-18.
- Improve relationship health for youth, increase knowledge about healthy relationships, and understand and know the importance of consent.
- Engage families in education and skills building related to teen sexual health and family communication.
- Provide pregnancy prevention education, access to health care and supportive services for themselves and their child and implemented their pregnancy prevention plan.

Strategies	# FY 2019 Grantees
Improve clinic practices to better reach young people	1
Improve sexual health education of young people	12
Increase parent-child connectedness and communication	7
Increase school connectedness	4
Increase opportunities for young people that help grow a sense of competence, connection, and contribution	6
Delay initiation of sexual activity with a special focus on young adolescents	5
Reduce the frequency of sex and number of partners and increase condom and contraceptive use among sexually active adolescents	6

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	10
Level of change 2: Organizational/ Institutional Change	7
Level of change 3: Root Cause/Condition for Health	4

Types of Activities

- Implement evidence-based programs in local schools or in after-school or community programs that discuss abstinence, contraception, and condom use.
- Implement sexuality education for American Indian youth.
- Implement a service-learning program.
- Implement comprehensive healthy youth development.
- Implement sexuality education for adults.

- Deliver professional trainings and participate in coalitions regarding inclusive strategies for health care.
- Implement an evidence-based program that increases parent and child communication about sexuality.

Note: Objective and Type of activities mentioned above are for FY2020

8. Unintentional Injury and Violence

Table 11. Program Objectives, Strategies & Activities: Unintentional Injury & Violence

Unintentional Injury & Violence EHDI Grantees (FY 2019=2; FY 2020=5)

Objectives

- Build Latinx parent's capacity and understanding to address youth Self-Harm, Suicide prevention, Sexual Violence and Dating violence.
- Increase parents and youth knowledge of cultural relevant support and services available to youth struggling with self-harm, suicide, and violence.
- Operate the North 4 Youth Violence Prevention Program
- Reduce the risk factors that can lead to unintentional injuries and violence.

Strategies	# FY 2019 Grantees
Prevent suicide and self-inflicted harm	1
Prevent injuries from assaults	1

Change Levels	# FY 2020 Grantees
Level of change 1: Health Promotion/Direct Service	5
Level of change 2: Organizational/Institutional Change	2
Level of change 3: Root Cause/Condition for Health	2

Types of Activities

- Review and adapt existing curricula and evidence- based/promising practices, develop new activities and tools to ensure alignment of curriculum and tools with learning from Latin@ youth and parents.
- Develop New tools for parents to talk with youth about self-harm, suicide, or violence.
- Conduct intergenerational conversations.
- Conduct culturally specific family education classes.
- Provide paid internships at sites that build skills and help youth establish a work history.
- Enhanced support for incarceration prevention, social-emotional skills development, and mentorship opportunities.

Note: Objective and Type of activities mentioned above are for FY2020.

V. Evaluation and Capacity Building

Technical Assistance and Support

CHE is committed to evaluating individual grantee outcomes and strengthening the capacity of organizations to reduce racial disparities in health through shared learning and evaluation. As such, CHE provides EHDI grantees

with individual evaluation technical assistance and support and has created a community of practice for grantees' ongoing learning.

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

- Providing customized, culturally responsive, one-to-one consultation.
- Assisting grantees in developing logic models, evaluation plans, and reports.
- Assisting grantees in involving stakeholders in their evaluations and practices to learn from data.
- Providing a series of web-based and in-person trainings in response to grantees' interests and expressed needs: logic model creation and introduction to evaluation; building evidence for a program; survey design and analysis; and focus group design.
- Facilitating interactive sessions for groups of grantees addressing similar populations and/or PHAs to share challenges, best practices, and resources.
- Developing and sharing ready-to-use evaluation resources and tools.
- Providing feedback on reports submitted to the Office of Minority & Multicultural Health.

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

During fiscal year 2020, CHE staff and the evaluation capacity building TA team worked with EHDI grantees to create four categories of program reach to better differentiate and explain the types of strategies used to address health disparities. Definitions and context are included for each fiscal year summary.

Community of Practice

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

EHDI Grantees; FY20

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

Program Reach (FY19 and FY20)

Family Tree Clinic; EHDI Grantee FY19 & FY20

During the fiscal year 2019, EHDI grantees reached more than 72,500 people in their target populations through both direct and indirect means (Table 13). More than 23,000 were engaged as direct contacts. A direct contact includes one-to-one contact (e.g., clinical services, screenings, education in private settings) and group contact (e.g., classes, workshops, and group education). There are likely duplicates because participants may both access services individually and participate in groups. The largest group reached directly was Hispanic/Latinx, at almost 7,730 or 32% of the total, followed by African American, at more than 7,300 or 31% of the total.

Table 12. Number of People Reached by EHDI Grantees (FY 2019) by Target Population

Target Population	Directly	Indirectly	# of Grantees Addressing the PHA*
African/ African American	7,360	13,173	17
American Indian	2,837	12,721	18
Asian American/ Asian-PI	5,730	14,310	17
Hispanic/ Latinx	7,730	8,496	16
Multi-racial	308	169	7
Total	**23,965**	**48,869**	

*Some grantees are providing programming targeted to multiple populations.

As described above, prior iterations of EHDI funding cycles (including the funding cycle culminating in FY2019) have reported direct and indirect reach. While this neatly summarized the types of contact grantees made, it did

not reflect the nuances around the manner and purpose of engagement. In an effort to improve upon this reporting practice for FY20, MDH first conducted a qualitative analysis[5] of the shared work grantees engaged in, prior to and during the COVID-19 crisis. Grantees' own proposed output categories from submitted evaluation plans were summarized into four categories- growing awareness, ensuring access, targeted prevention, and tailored intervention. *Growing awareness* and *ensuring access* roughly correspond to the idea of indirect contact – in that the strategies and activities undertaken in these categories in and of themselves may not be sufficient to change health conditions or disparities, but they are necessary due to the unequal access created by current social conditions. On the other hand, *targeted prevention* and *tailored intervention* strategies are often promising or evidence-based strategies that aim to directly influence protective or risk factors for specific health conditions in both holistic and targeted ways. Definitions of these strategies grantees use include:

1. **Growing Awareness** of health issues, and of solutions available through EHDI funded programs or other available resources. For example, they engage in media campaigns, host, and attend health fairs, and build community buy-in to advocate for policies that promote well-being.

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

3. **Providing Targeted Prevention** through individualized and/or group programming for prevention or wellness purposes to people who are at high risk or already at borderline for developing a health condition. For example, people may attend nutrition education or exercise classes, receive immunizations, or had a mammogram or other screening. People also learn about strategies for preventing unintended pregnancies and avoiding HIV/AIDS and STIs.

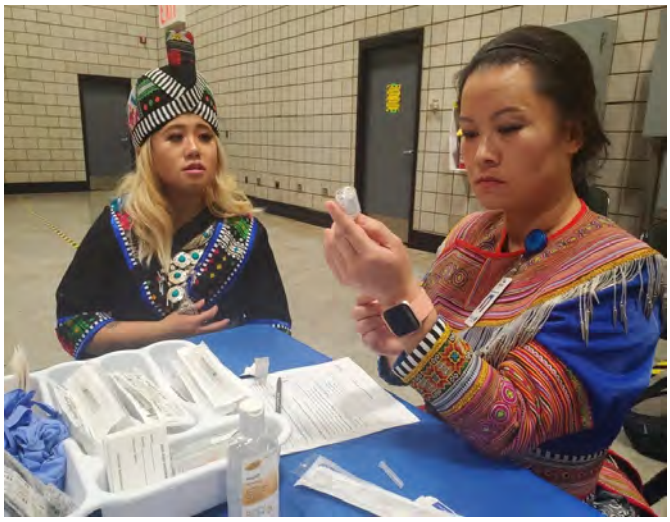
4. **Providing Tailored Interventions** such as disease management and containment services for people with

HAFA; EHDI Grantee FY20

HCMC; EHDI Grantee FY19 & FY20

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

underlying health conditions. For example, grantees may employ Community Health Workers who help people regularly monitor blood pressure and cholesterol levels or offer diabetes management classes. Grantees also provide safety and wellness interventions for people who have caused or survived violence. The four categories of strategies that correlated loosely with the idea of direct and indirect contacts measured in previous grantee cohorts were reported in FY2020.



MINI; EHDI Grantee FY19 & FY20

In fiscal year 2020, EHDI grantees reached 204,638 people with media campaigns and other outreach strategies aimed at growing awareness; 12,525 people received services or training aimed at ensuring access to culturally relevant healthcare; 15,841 people participated in targeted prevention activities and 895 people with diagnosed or identified health conditions received tailored intervention services (Table 13). It is likely there is significant duplication across and at times within reach categories, so we caution against adding these numbers together within target populations. The variation in numbers reached by target population and grant area are reflective of the number of grantees in each area and the types of programs and activities they implemented.

Table 13. Number of People Reached by EHDI Grantees (FY 2020) by Target Population

Population	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
African/ African American	107,780	2,569	2,808	258
American Indian	54,723	806	1,986	244
Asian/Pacific Islander	15,938	796	2,867	164
Hispanic/Latinx	20,636	950	6,584	385
All others (multi-racial, unknown, White)	7,120	7,616	2,408	118
Grand Total	206,197	12,737	16,653	1,169

Grantee annual reports allowed grantees to more specifically identify the populations with whom they partner to improve health. Reflecting the rich tapestry of diversity within Minnesota communities of color and American Indian communities, participants within the broader target populations described above self-identified as: American Indian, Native, Hispanic/Latinx, Mexican, Ecuadorian, multi-racial Latinx, African American, Black, multi-racial African American, African immigrant, Somali, Ethiopian, Amharic or Oromo speaking, African,

Asian/Pacific Islander, multi-racial Asian/Pacific Islander, Asian-Indian, Karen/Burmese, Korean adoptive, Korean immigrant, multi-racial, Southeast Asian, Asian, Iraqi.

Priority Health Areas

Within the priority health areas in fiscal year 2019, grantees indirectly reached 63,894 people and directly reached 28,361 (Table 14). Differences between total numbers of people reached for priority health areas versus target populations has to do with being able to accurately identify racial and ethnic identities for participating people. Especially for many indirect activities, data collection for participant demographics is not always feasible.

In FY 2019, the Immunization PHA reached the highest number of Minnesotans directly (7,870) while the Diabetes PHA reached the highest number indirectly (12,062) due to improved interventions that ranged from clinical practice aimed at helping maintain or reach healthy A1C levels to education efforts to prevent new diabetes cases (Table 14). The reach of grantees in the Infant Mortality PHA is smaller due to the relationship-intensive, cohort-based models adopted by some of the grantees that limit the number of participants.

Table 14. Number of People reached by EHDI Grantees (FY 2019) by PHA

Priority Health Area	Directly	Indirectly	# of Grantees Addressing the PHA*
Breast & Cervical Cancer	3,215	8,903	3
Diabetes	2,416	12,062	6
Heart Disease & Stroke	2,447	7,956	5
HIV/AIDS	4,214	8,814	7
Immunizations	7,870	5,422	2
Infant Mortality	819	1,744	3
Teen Pregnancy	6,176	11,993	14
Unintentional Injury & Violence	1,234	7,000	2
Total	**28,391**	**63,894**	

* Some grantees provided services in more than one PHA.

The total in Table 14 differs from the total in Table 13 (total # reached by target population) and is more accurate. This is due to grantees not always being able to identify the racial and ethnic backgrounds of those with whom they have brief contact, whether direct or indirect. Additionally, an increasing number of people in Minnesota identify as multiracial and/or do not identify with one specific EHDI population.

Within the priority health areas in FY 2020, grantees targeted the largest numbers of people with awareness campaigns about HIV/AIDS and STIs and Infant Mortality. Over 6,200 people were reached with information about accessing immunizations, while hundreds of people and families received wrap around care services to assess and meet needs for accessing care. In the category of targeted prevention, 6,611 people received a

needed immunization and 3,341 people participated in teen pregnancy prevention programming (Table 16). The largest number of people reached for tailored interventions was by grantees working with people who had been diagnosed with pre-diabetes or diabetes, high levels of hypertension, or who had been involved in violence, either as people who had caused or survived harm.

Table 15. Number of Duplicated People reached by FY 2020 EHDI Grantees by Priority Health Area

Population	Growing Awareness	Ensuring Access	Targeted Prevention	Tailored Interventions
Breast and cervical cancer screening	4,678	564	131	0
Diabetes	9,842	1,823	1,986	272
Heart disease and stroke	3,081	666	1,218	257
HIV/AIDS and STIs	104,795	1,521	2,155	166
Immunizations	7,909	6,204	6,611	0
Infant Mortality	51,440	29	265	78
TPP	11,894	1,763	3,341	154
Unintentional injury and violence	12,558	167	946	242
Grand Total	**206,197**	**12,737**	**16,653**	**1,169**

Evaluation Results

EHDI grantees are required to conduct an evaluation of their program activities, including the development of a logic model and an evaluation plan. Grantees are encouraged to develop and implement community-based solutions to address health disparities and utilize community input in the process. The EHDI grantees included in this document reported progress in program outcomes and outputs. Outcomes describe the changes experienced by participants because of their interaction with activities offered by grantee programs. Participants may self-report these changes, or program staff may observe them. Outputs describe the number or nature of activities or products that grantee programs offer. Unlike outcomes, outputs describe a single point in time rather than a change over time or difference across groups. The COVID-19 pandemic put significant pressures on grantees to prioritize community needs and provide them with COVID-19 resources and information. For this reason, the standard expectations for evaluation were waived in FY2020. Likewise, some grantees who were anticipating providing pre and post measures of their program participants had to forego post-surveys when in-person programming was rapidly canceled or restructured. This greatly limited the available evaluation data for FY20 grantees.

Shared Measurement System

The EHDI shared measurement system was first implemented in FY2018, marking an important first step in better understanding the potential collective impact of the EHDI program. The FY 2019 measures build on results first reported in FY 2018. As with program reach, other evaluation measures also changed between FY 2019 and

FY2020 with a new cohort of grantees. With the shared measurement system still in its infancy, it is important to note that the FY2019 numbers are likely undercounted because many grantees were still working through data collection processes that would allow them to report on the shared indicators. In addition, the shared reporting indicators were developed by finding commonalities within areas in which many grantees were working and who were also using a range of approaches from primary to tertiary. As a result, the shared measurement system misses the many meaningful ways grantees are tracking changes in the health of their participants. For example, there are clinics doing heart disease and stroke prevention work that were able to track actual improvements in blood pressure, but which is not among the shared indicators for that PHA. Nonetheless, the shared measurement system provides a picture of the collective impact grantees are making in a particular PHA.

An additional step in refining the shared measurement system for the new cohort of EHDI grantees was the qualitative analysis of grantee evaluation plans, to create opportunities to build on previous shared outcome measures. As seen in the examples below, grantees' intended outcomes involve preparing community to engage in their own healing through system change and more holistic well-being efforts.

- Incorporating traditional teachings in youth education;
- Improving one's ability to maintain hope and dreams for the future because leadership, curriculum, job opportunities, and educational opportunities, are all filled with people who look like them and are therefore seen as attainable;
- Deepening connections to and knowledge of family and kinship networks that provide advice and access;
- Improving the ability to navigate through institutions not designed with Black, American Indian, communities of color in mind, and to begin to transform those institutions to serve the linguistic, cultural, and technical needs of a multi-cultural Minnesota; and
- Gaining the knowledge of and motivation to transform oppressive structures through advocacy and community participation.

Because these intended outcomes are holistic in nature, the priority in expanding the shared measurement system for the remainder of this grant cycle is likely to be in areas that reach across priority health areas to these cross-cutting indicators of wellness.

Measures from FY 2019 are reported first, building on data from within PHA by target population first reported in FY2018. For FY 2020, only reach numbers by category within priority health areas are reported. Due to this being the first year in a new funding cycle in which grantees normally spend significant time building up program infrastructure (e.g., hiring and onboarding staff, updating curriculum, gathering of community feedback to inform programming) and the unique challenges posed by COVID-19, grantees were not required to report on organizational-specific or shared measurement system outcomes.

1. Breast and Cervical Cancer

In FY 2019, four grantees working on breast and cervical cancer prevention provided 1,700 women with a cancer screening. They were able to track and identify the racial and ethnic identities of 1,499 of the women, as show in Table 16.

Table 16. FY2019 Breast & Cervical Cancer Prevention Health Indicator Reporting (4 Grantees)

Breast & Cervical Cancer	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Total direct contacts	407	1,239	23	247
Total indirect contacts	750	6,162	25	1,438
# breast cancer screenings	126	484	5	94
# cervical cancer screenings	162	407	18	153
# participants in cancer screening education events	119	348		

Another 1,043 people received education whose specific racial and ethnic identity are not known.

In FY 2020, one grantee working on breast and cervical cancer prevention provided 131 women with a cancer screening while focusing much of their effort on social media campaigns and educational workshops to increase awareness of the need for screening (Table 17). They also assisted over 500 women with direct services including translation, scheduling, and system navigation.

Table 17. FY2020 Breast & Cervical Cancer Prevention Health Indicator Reporting (1 Grantee)

Breast & Cervical Cancer	Asian/Pacific Islander
Growing Awareness	4,678
Ensuring Access	564
Targeted Prevention	131

2. Diabetes

Six grantees worked to prevent or control diabetes within African, African American, Somali, Ethiopian, Amharic, Oromo, Black, African American, Iraqi, Karen, Hmong, Southeast Asian, Hispanic, and American Indian communities. Interventions ranged from clinical practice aimed at helping maintain or reach healthy A1C levels to education efforts to prevent new diabetes cases. Five of six grantees submitted evaluation results from the FY 2019 grant year (Table 18).

Table 18. FY 2019 Diabetes Health Indicator Reporting (6 Grantees)

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Total direct contacts	968	631	715	45

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Total indirect contacts	745	4,211	2,501	15
# diabetes or pre-diabetes screening	599	48	572	30
Identified as at risk through screening or referrals	92	17	217	18
# participants in prevention or mgmt. programs	143	114	185	3
# high risk/uncontrolled diabetes participants who received care coordination	343			
# who saw a provider during grant period	406			
# who reconnected with spiritual practices to support health	2	427	69	3

One clinical program reported that 73% of diabetic patients had A1C levels that were under control at the end of the grant period. The remaining programs work at increasing health but due to their non-clinical nature are unable to track A1C levels. Another grantee who runs community-based wellness-focused diabetes prevention program conducted surveys with 54 participants, 96% of whom identified as American Indian or Alaska Native. Survey responses indicated that, prior to the program, 33% of participants were getting 30 minutes of physical activity on 5 or more days in a typical week. While participating in the program, that number rose to 61%. Related, 59% of survey respondents reported that prior to the program they were not thinking about plans to increase their level of physical activity while 11% were working to change their activity levels. After participating in the wellness program, only 4% reported they were not thinking about changing their physical activity levels and 74% reported they were working to make the change. Both of these increases were significant at the $p<.05$ level.

In FY 2020, six grantees reported on reach data on diabetes strategies. Several grantees focused on nutrition, such as by ensuring access to healthy foods at farmers' markets or connecting to meaningful active living activities (Table 19). Approaches included ensuring communities have access to wellness by working with both those who grow and eat healthy foods. A couple of grantees also worked directly with patients who had diabetes or pre-diabetes on strategies to increase vegetable consumption and other wellness strategies.

Table 19. FY2020 Diabetes Prevention Health Indicator Reporting (6 Grantees)

Diabetes	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness	1,871	2,076	1,559	1,867
Ensuring Access	551	746	112	58
Targeted Prevention	271	715	360	301
Tailored Intervention	87	51	74	18

3. Heart Disease and Stroke

Five grantees were funded to work within their respective communities to prevent or intervene with communities who are disproportionately impacted by heart disease in FY2020. Four grantees submitted updated evaluation reports. They reached people who identified as Somali, Ethiopian, Amharic, Oromo, Black, African American, Iraqi, Karen, Hispanic and American Indian. Strategies and approaches included increasing screening and education; healthy behaviors such as physical activity, healthy eating, and general wellness; and creating tailored prevention plans for patients diagnosed with cardiovascular disease.

Table 20. FY2019 Health Disease and Stroke Health Indicator Reporting (5 Grantees)

Heart Disease and Stroke	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Total direct contacts	1,954	7	153	84
Total indirect contacts	1,380	0	3	12
# blood pressure screenings	1,337		151	77
# participants in wellness programs	867	7	3	46
# who saw provider for HDS during grant period	717			

Additionally, 744 clinical patients were screened by one of the clinic grantees and received care coordination based on a medical records review. The racial and ethnic identities or these persons were not tracked, so they are not included in the above table. The same clinic program also was able to use medical records to track blood pressure levels and noted that 62% of targeted patients had their hypertension controlled at the end of the grant period.

In FY 2020, four grantees submitted evaluation reports detailing strategies and numbers of people reached. Because some of the same social determinants of health affect both diabetes and heart disease, many grantees were funded to work on both and used similar strategies for increasing awareness or, access to, and use of healthier foods and active living strategies.

Table 21. FY2020 Heart Disease and Stroke Prevention Health Indicator Reporting (5 Grantees)

Heart Disease & Stroke	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness	1,871	1,150		
Ensuring Access	551	15	100	
Targeted Prevention	218	661		
Tailored Intervention	87	51	74	3

4. Infant Mortality

Three grantees worked in FY 2019, to reduce Infant Mortality, with a primary focus on the two most impacted populations. Given social disparities of health that impact the health of African American women, studies show that neonatal infant mortality rates (those within the first 28 days of life) are highest in the African American community. Therefore, one grantee is working to reduce those numbers by preventing prematurity and promoting women's health. That grantee worked with 70 African American women (along with 10 additional women from other racial and ethnic backgrounds) to promote holistic healthcare needs during and after pregnancy. Grantees working with the American Indian community focus more on the prevention of sleep-related unintentional injuries among infants under 6 months, as that is a leading risk factor. However, grantees were not able to assess the specific measures below for all participants, depending on longevity with the program and access to health care records.

Table 22. FY2019 Infant Mortality Health Indicator Reporting (3 Grantees)

Infant Mortality	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Total direct contacts	71	737	2	4
Total indirect contacts	171	1,541	18	6
% of 1-year-olds who had 5 of more well-child visits	50% (11 of 22)	52% (45 of 87)	n/a	100% (4 of 4)
% of mothers reporting safe sleep practices	53% (19 of 36)	100% (49 of 49)	n/a	n/a
% of mothers who initiated pre-natal care in first trimester	71% (35 of 49)	94% (33 of 35)	50% (1 of 2)	n/a

Each of the programs provide wraparound services to pregnant and post-partum mothers and their children to assess needs, address issues and create holistic education, care and resource referral plans for families. For the current EHDI cycle FY 2020, two grantees have been awarded funds to work with the American Indian community on reducing infant mortality. The two grantees both work holistically with families to provide wrap around services while also training health care providers on culturally relevant services to ensure access to quality care. The grantees also work directly with new moms to create contextualized and tailored safe sleep and breastfeeding plans.

Table 23. FY2020 Infant Mortality Prevention Health Indicator Reporting (2 Grantees)

Infant Mortality	American Indian
Growing Awareness	51,440
Ensuring Access	29
Targeted Prevention	265
Tailored Intervention	78

5. Immunizations

Two grantees in FY 2019 had direct contact with 7,870 people in 2018-19, with 88% (of 6,954 patients) receiving at least one needed immunization, including 6,294 flu shots.

Table 24. FY2019 Immunizations Health Indicator Reporting (2 Grantees)

Immunizations	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx	White/ Unknown
Total direct contacts	1,100	31	1,919	2,452	2,368
Total indirect contacts	2,422	0	500	2,000	500
Received needed immunization	630	31	1,825	2,100	2,368
In-person education on vaccines and vaccine-preventable illnesses	470		94	352	

Similarly in FY 2020, two grantees reported reaching nearly 8,000 people with information about vaccines and providing over 6,000 people with needed immunizations.

Table 25. FY2020 Immunizations Health Indicator Reporting (2 Grantees)

Immunizations	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness	797	55	1,939	4,313
Ensuring Access				58
Targeted Prevention	827	66	1,943	2,945

6. STIs and HIV/AIDS

Grantee's funding in FY 2019 used a range of approaches and strategies. There were a few clinics among grantees that were really well-positioned to provide testing. The large number of direct contacts is reflective of prevention programming that is also diverse in its approach: from community-focused prevention approaches with adults to education with school-aged youth.

Table 26. FY2019 STIS, HIV/AIDS Health Indicator Reporting (8 Grantees)

STIs, HIV/AIDS	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latinx	Multi-racial
Total direct contacts	1,145	15	950	1,937	76
Total indirect contacts	3,396	30	3,051	1,937	
# people tested for HIV	17			14	

STIs, HIV/AIDS	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latinx	Multi-racial
# positive results for HIV	0			0	
# tested for other STIs	379	15	18	136	76
# positive results for STIs	39	2	3	6	6
Youth in prevention program who have an adult they can talk to about STIs	377 (91%)	17 (89%)	150 (99%)	215 (77%)	134 (94%)
Youth intentions to prevent STI in next three months	Will not have sex: 75 (24%) Use barrier method: 211 (66%)	Will not have sex: 6 (30%) Use barrier method: 11 (55%)	Will not have sex: 147 (55%) Use barrier method: 102 (39%)	Will not have sex: 76 (51%) Use barrier method: 63 (42%)	Will not have sex: 38 (38%) Use barrier method: 59 (60%)

Of 709 youth in prevention programs who took both pre and post surveys, the proportion of youth who reported having an adult to talk with about STIs increased from 80% to 85% from pre- to-post test surveys, a statistically significant increase. The last row in the above chart showed those results were consistently positive across racial and ethnic groups, the Latinx teens had lower levels than other groups.
When interpreting data, it is important to note that different programs work with different ages of youth and younger youth are more likely to not be sexually active. Differences between racial and ethnic groups may be due to age differences of respondents.

Eight grantees reported on reach activities during the FY 2020 grant year, targeted towards African, African American, and Hispanic/Latinx communities. These grantees again reflected a range of community-based organizations, including clinics who conducted testing and agencies focused on prevention education in school and community settings. One grantee conducted multiple media and outreach campaigns which they estimated resulted in 94,000 contacts among the sub-Saharan African community in Minnesota.

Table 27. FY2020 HIV/AIDS and STIs Prevention Health Indicator Reporting (8 Grantees)

Breast & Cervical Cancer	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness	98,409	1		6,071
Ensuring Access	1,146			173
Targeted Prevention	718			1,063
Tailored Intervention	52			84

7. Teen Pregnancy Prevention

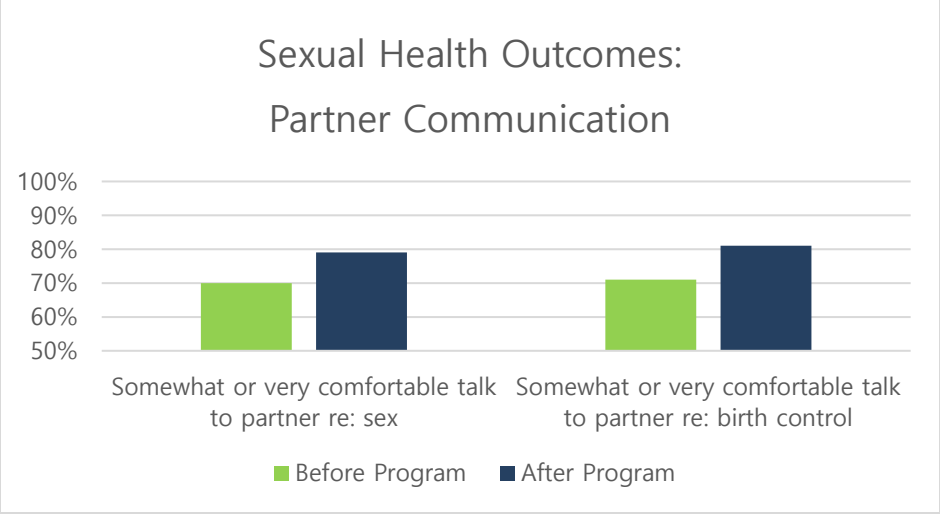
Eleven TPP grantees submitted data in FY 2019 from surveys administered with 1,833 program participants. Approximately 1,050 youth responded to surveys at the end of programming, while 750 youth from six grantees responded to surveys before and after their programs to be able to assess change over time. Numbers of surveyed

participants in each program ranged from 12 to 631. Survey versions differed slightly by age, with some students answering all shared measures questions and others responding to a shortened version of the survey more appropriate for younger youth.

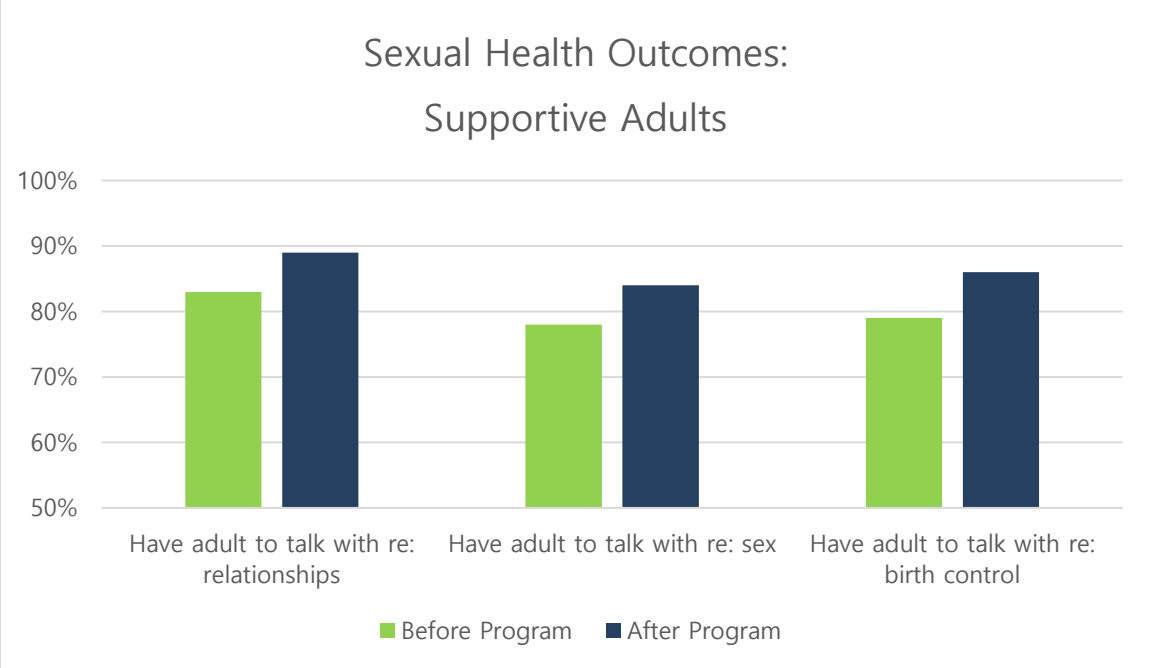
Table 28. FY2019 TPP Health Indicator Reporting (14 Grantees)

Teen Pregnancy Prevention	African/African American	American Indian	Asian/Pacific Islander	Hispanic/ Latinx	Multi-racial
Direct contacts	1,145	15	950	1,937	
Indirect contacts	3,396	30	3,051	1,937	
Knows where to find sexual health resources	394 (82%)	22 (79%)	277 (96%)	541 (89%)	129 (85%)
Somewhat or very comfortable talking to potential partner about sex	314 (77%)	12 (43%)	169 (58%)	160 (71%)	87 (69%)
Somewhat or very comfortable talking to potential partner about birth control	327 (79%)	14 (50%)	184 (64%)	162 (72%)	89 (70%)
Has adult to talk with about romantic relationships	388 (93%)	23 (100%)	227 (99%)	245 (88%)	136 (95%)
Has adult to talk with about sex	368 (89%)	22 (96%)	163 (97%)	221 (79%)	129 (94%)
Has adult to talk with about birth control	372 (91%)	21 (91%)	160 (98%)	221 (79%)	130 (96%)

Results in the table above show that high percentages of youth participants across racial and ethnic groups are endorsing key components of sexual health: knowing where to access resources, being comfortable discussing topics with partners and having supportive adults. Analyses of pre-post survey responses included below, indicate that programs are successfully increasing these key components of sexual health with their program participants. Participants who reported knowing where to access sexual health resources increased from 69% to 73% between pre- and post-surveys, a statistically significant increase among the 740-youth surveyed. On average, prior to the program about 70% of youth reported feeling somewhat or very comfortable talking with potential sexual partners regarding sex and birth control, while closer to 80% reported the same at the end of the program. Just over 500 youth responded to these questions at each time point. Increases in both types of communication were statistically significant.



Similarly, there were statistically significant increases in the number of young people who reported having adults in their lives with whom to talk about sexual health issues. About 740 young people responded to these questions at each time point.



In FY 2020, ten grantees working on teen pregnancy prevention submitted evaluation data. While many of these grantees conduct pre-post surveys on their prevention programming, most were unable to collect post-survey data due to COVID-19 restrictions. Grantees reported the following reach during the FY 2020 grant year, ranging from outreach and media campaigns to prevention classes in school and community settings, to clinical services for teens.

Table 29. FY2020 Teen Pregnancy Prevention Health Indicator Reporting (11 Grantees)

Teen Pregnancy	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness	4,832	1		6,506

Teen Pregnancy	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Ensuring Access	300	15	4	570
Targeted Prevention	774	100	120	1,821
Tailored Intervention	18			136

8. Unintentional Injury and Violence

In FY 2019, two grantees focused on unintentional injury and violence prevention, with one focused on increasing awareness in the Karen, Asian-adoptee and other Asian communities of mental health and suicide prevention resources. Another was a clinical provider to the Hispanic/Latinx community. Together, they reported the shared measures reported in Table 30.

Table 30. FY2019 Unintentional Injury & Violence Health Indicator Reporting (2 Grantees)

UIV	Asian/Pacific Islander	Hispanic/Latinx
Direct Contacts	667	567
Indirect Contacts	5,000	2,000
# participants in approaches aimed at helping parents better support children and youth	182	314
# mental health screenings		393
Of those screened, # whose scores required follow-up		194
Of those who required follow-up, # who attended follow-up appointment		162

In FY 2020, the number of grantees in this category expanded to five and the approaches and types of injury and violence they sought to prevent also expanded. Grantees worked with people, families, and communities harmed by social determinants of health that have concentrated poverty and isolation which are, in turn, drivers of violence. Grantees tailored strategies for communities disproportionately experiencing gun, interpersonal, and domestic violence as well as communities who experience disproportionate levels of self-harm due to mental health stigma and the stigma of structural, institutional, and interpersonal racism.

Table 31. FY2020 Unintentional Injury & Violence Prevention Health Indicator Reporting (5 Grantees)

Unintentional Injury & Violence	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Growing Awareness			7,762	1,879
Ensuring Access	21	1	179	64

Unintentional Injury & Violence	African/African American	American Indian	Asian/Pacific Islander	Hispanic/Latinx
Targeted Prevention		179	313	454
Tailored Intervention	14	64	16	144

VI. Conclusions

Evaluation results indicate that the EHDI grant program is a valuable investment. During the fiscal year 2019, EHDI grantees reached more than 72,500 people in their target populations through both direct and indirect means. In fiscal year 2020, EHDI grantees reached 204,638 people with media campaigns and other outreach strategies aimed at growing awareness; 12,525 people received services or training aimed at ensuring access to culturally relevant healthcare; 15,841 people participated in targeted prevention activities and 895 people with diagnosed or identified health conditions received tailored intervention services. While it is likely there is significant duplication across and at times within reach categories and caution against adding these numbers together, these number still represent a significant portion of all Black, American Indian, people of color in the state. Grantee program evaluations have documented a number of health improvement and prevention outcomes such as decreased A1C levels in people with diabetes; screening for breast and cervical cancer, diabetes, and heart disease; increased healthy eating and physical activity; and increased skills for providing inclusive services among professionals who work with Minnesota's populations of color and American Indian communities. Evaluation results also documented expanded capacity of grantee organizations to better serve people of color and American Indian populations through promising practices such as incorporating traditional spiritual or cultural practices to promote health.

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

- Amplify the impact grassroots community organizations can have in strengthening pandemic responses. Being deeply connected to community, grantees demonstrated incredible flexibility and agility in response to the COVID-19 pandemic by rapidly pivoting their operations in order to address the emergency and basic needs of the people they serve. Especially as the pandemic persists, support for these grantees through additional and flexible funding is even more critical, acknowledging that the programs may have to pivot their goals to continue being responsive to the communities' needs and requests. The community's grantees work with have been dealt great blows to their economic stability, and many have experienced re-traumatization as food insecurity, job loss, and general community crisis grows in this current pandemic. The pandemic itself has also disproportionately affected American Indian, Latinx, Black, and Asian American communities. Grantees are uniquely positioned to respond to emergent community needs and act as trusted messengers of public health- related information.
- Accommodate the time required for community-based organizations to adapt programming to remote-based formats; allow grantees time, flexibility, and the necessary freedom to adapt. Adult and youth participants alike have experienced significant barriers to participation in programming that doesn't address immediate needs. As community members' priorities shift to survival-based and immediate needs, participation in things such as sexual health or diabetes prevention, become secondary. Continued flexibility is required to support grantees in balancing the requests for basic needs with adapting PHA-specific program designs.
- Continue to connect grantees to within ongoing learning and opportunities within the EHDI cohort through the community of practice, but also within the broader MDH stakeholder community.

- Strengthen MDH's approach to health equity by identifying especially effective approaches being implemented by EHDI grantees and how they can influence other MDH investments and strategies.
- Increase the funding available through EHDI. Funding levels have decreased over time and have not kept up with the rapid growth of Minnesota's people of color and American Indian populations. The impact and reach of EHDI grantees clearly demonstrate that they have the relationships, trust, and effective strategies to serve some of the hardest to reach populations, who have some of the largest health disparities relative to whites, in the state. It would be in the state's best interest to invest additional funds into the program to support the consistently innovative, responsive, and effective work of EHDI grantees.
- Acknowledge the Social Determinants of Health and the common cultural perspective that health is interwoven with community, art, and spirituality by integrating zip codes into EHDI's analysis of disparities and by embedding health-related work into larger community-based initiatives. Doing so would support programmatic and organizational sustainability, as well. Grantees suggested using language that focuses on the social determinants as opposed to focusing on specific diseases or conditions. The former is often more accessible to program participants and community members and serves to shift the discussion away from deficits among people within marginalized groups to self-reflection about structural issues among public institutions and systems.

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

APPENDIX A. EHDI Legislation

MINNESOTA STATUTES 2020 145.928

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

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

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

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

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

Subd. 6.Process. (a) The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.

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

Subd. 7.Community grant program; immunization rates, prenatal care access and utilization, and infant mortality rates. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

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

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

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

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

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

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

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

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

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

(4) utilizes strategies that positively impact two or more priority areas;

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 7a. Minority-run health care professional associations. The commissioner shall award grants to minority-run health care professional associations to achieve the following:

(1) provide collaborative mental health services to minority residents;

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

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

Subd. 8. Community grant program; other health disparities. (a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

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

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

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

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

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

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

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

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

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

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

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

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

(5) reflects racially and ethnically appropriate approaches; and

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

Subd. 9. Health of foreign-born persons. (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B. EHDI FY 2019 and FY 2020 Grantees

Table 32. EHDI Grantees by PHA and Population, FY2020

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

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

Priority Health Area: Diabetes (N=7)

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

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

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

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

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

Priority Health Area: Immunizations (N=2)

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

Priority Health Area: Infant Mortality (N=2)

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

Priority Health Area: Teen Pregnancy (N=12)

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latinx
Centro Tyrone Guzman*				●
Communidades Latinas Unidas en Servicio (CLUES)		●		●
Division of Indian Labor		●		
Family Tree Clinic, Inc*	●			●

EHDI Grantees	African American/ African	American Indian	Asian American/ Asian Pacific Islander	Hispanic/ Latinx
Fond du Lac Band of Lake Superior Chippewa		●		
HealthFinders Collaborative, Inc*				●
Hennepin Healthcare System, Inc. (Aqui Para Ti) *				●
High School for Recording Arts	●			
KIPP Minnesota*	●			
Minnesota Community Care *	●	●	●	●
The Bridge for Youth	●	●		●
YWCA of Minneapolis	●	●	●	●

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

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

Table 33. EHDI Grantees by Organization, County & PHA, FY2019

Organization	Project Name	County of Residence	Breast/ Cervical Cancer	Heart/ Stroke	Diabetes	HIV/ STI	Immunizations	Infant Mortality	Teen Pregnancy	Injury/ Violence
African American AIDS Task Force	Community PROMISE	Hennepin				●				
American Indian Cancer Foundation	American Indian Cervical Cancer Screening Program	Hennepin	●							
American Indian Family Center	Wakanyeja Kin Wakan Pi (Our Children are Sacred) Program	Ramsey						●		
Annex Teen Clinic	Annex REACH Project	Hennepin				●			●	
Big Brothers Big Sisters of the Greater Twin Cities	Teen Pregnancy Prevention	Ramsey							●	
Cedar Riverside People's Center Dba People's Center Health Services	Project HEART	Hennepin		●	●					
Centro Tyrone Guzman	Raices Youth Development Program	Hennepin				●			●	
Comunidades Latinas Unidas en Servicio (CLUES)	A Two-Generation Approach to Teen Pregnancy Prevention	Aitkin							●	
Family Tree Clinic	Improving Sexual & Reproductive Health Outcomes	Ramsey				●			●	
Fond du Lac Band of Lake Superior Chippewa	Teen Pregnancy Prevention	Aitkin							●	
HealthFinders Collaborative, Inc.	Mejorando la Salud de los Adolescentes (MESA)	Rice				●			●	

Organization	Project Name	County of Residence	Breast/ Cervical Cancer	Heart/ Stroke	Diabetes	HIV/ STI	Immunizations	Infant Mortality	Teen Pregnancy	Injury/ Violence
Hennepin County Medical Center	Aqui Para Ti–Here for You	Hennepin				●			●	●
High School for Recording Arts (HSRA)	Check Yo'Self Health and Wellness Center	Ramsey							●	
Hmong American Partnership	Diabetes Education Project	Ramsey			●					
Indigenous Peoples Task Force	Ikidowin Youth Peer Education and Theater	Hennepin							●	
Interfaith Action of Greater Saint Paul	East Metro American Indian Diabetes	Ramsey			●					
Korean Service Center	Preventing unintentional injuries and suicide	Ramsey								●
Leech Lake Band of Ojibwe Health Division–Nursing Department	LLBO Family Spirit Home-Visiting Program	Cass						●		
Lutheran Social Service of Minnesota (LSS)	Seeing and Exploring Life's Future (SELF)	Ramsey							●	
Mayo Clinic	No Squeeze Can Defeat Me: Mammograms for Life!	Olmsted	●							
Mille Lacs Band of Ojibwe	Mille Lacs Band of Ojibwe Teen Pregnancy Prevention Program	Mille Lacs							●	
Minneapolis American Indian Center	Elders Health & Wellness Program	Hennepin		●	●					
Minnesota Academy of Pediatrics Foundation	Invest in Health for New and First Americans	Ramsey					●			
Minnesota Immunization Networking Initiative (MINI)	Minnesota Immunization Networking Initiative (MINI)	Hennepin					●			

Organization	Project Name	County of Residence	Breast/ Cervical Cancer	Heart/ Stroke	Diabetes	HIV/ STI	Immunizations	Infant Mortality	Teen Pregnancy	Injury/ Violence
Neighborhood HealthSource	Breast & Cervical Cancer Screening & Follow-up Care	Hennepin	●							
NorthPoint Health & Wellness Center, Inc.	NorthPoint OB Care Coordination—Phase II Program	Hennepin						●		
Partnership4Health CHB	PartnerSHIP 4 Health Equity project	Aitkin		●	●					
Planned Parenthood Minnesota, North Dakota, South Dakota	Youth Power and Hmong STAR	Ramsey				●			●	
Southside Community Health Services	Clippers N' Curls for the Heart	Grant		●						
WellShare International	Somali and American Indian Healthcare Initiative (SAIHI)	Hennepin	●	●						
YWCA of Minneapolis	YWCA of Minneapolis Girls & Youth Programs	Hennepin							●	

Dream of Wild Health, Indigenous Food Network—Diabetes; American Indian population; Hennepin County

Dream of Wild Health is a new EHDI grantee for the current funding cycle. The Indigenous Food Network (IFN) project addresses diabetes in the Native American community by creating a culturally based diabetes prevention curriculum and increasing healthy Indigenous food access and education opportunities in partnership with schools and community programs. The Indigenous Food Network provides an opportunity for Native-led community organizations in Minneapolis to work together to rebuild a sovereign food system by identifying and leveraging organizational and community assets as well as providing IFN farm-grown produce to schools and community locations. The work of the IFN builds on the cultural knowledge of community members and uses an intertribal and multigenerational approach. Collectively, IFN is creating a Native American urban model for food sovereignty. In addition, this project will advocate for healthy food access at the local and state government level.

Indigenous Food Network aims to:

- Increase access and consumption of indigenous foods in schools and programs serving Native American youth and families; increase knowledge of diabetes risk factors and lifestyle prevention strategies.
- Increase the capacity of IFN partner organizations to provide culturally based diabetes prevention education and access to healthy indigenous food.
- Increase the capacity of childcare centers that serve Native American youth to provide healthy indigenous food.
- Increase access for the Native American community in the Twin Cities to healthy, indigenous food.

Highlighted achievements of the past year:

- 10 IFN meetings, bringing together 34 participants representing 18 organizations in coordinating food accesses and promoting food sovereignty.
- Organized an Indigenous Food Tasting, engaging 700 people and celebrating the food of 5 Indigenous chefs.
- Hosted a Hominy Workshop, where nutritionist Austin Barthold prepared a hominy and buffalo recipe and Farm Manager Jessika Greendeer presented on nixtamalization (the process of using hardwood ash and corn to make hominy) with 50 participants.
- Hosted "Sacred Medicines and Garden Beginnings" virtual workshop with 219 attendees and 398 additional online views.
- Hosted "Wild Foods Early Gardens" workshop with 50 attendees and 327 web-bases responses.
- Completed the first 3 lessons of the IFN Youth Curriculum.
- Kicked off a Youth Chef Internship program with two cohorts. There were 9 youth participants who learned from an Indigenous chef how to prepare Indigenous foods. We made COVID adaptations to the program by switching to a virtual format. IFN staff delivered the ingredients to youth each week and they met via Zoom with the Indigenous chef. The youth were then able to share their meal with their families from the comfort of their homes.

Comunidades Latinas Unidas en Servicio (CLUES), A Multi-Generational Approach to Sexual Health Education- Teen Pregnancy Prevention, STI/HIV Prevention; Latinx Population; Hennepin, Kandiyohi, Mower, and Ramsey Counties

Comunidades Latinas Unidas en Servicio (CLUES) is an organization that was also funded in the previous EHDI cycle. This project addresses teen pregnancy prevention by providing school and community-based sexual health education for youth and adults. Talking about sexual health in a comprehensive way will contribute to breaking taboos and help youth and their caregivers to think critically about the sexuality-related messages they get from family, media, and other sources. In so doing, they will be empowered to create inclusive communities where they can have safe and healthy sexual experiences. Supporting safe and healthy sexuality in Latinx communities will reduce unintended teen pregnancy and rates of STIs and HIV. In addition, a peer leader program will be created for parents and caregivers who want to become stronger advocates for sexual health in their community. Lastly, CLUES will work with their Human Resources team to include foundational training on gender identity and sexual orientation for all staff.

CLUES aims to:

- Improve understanding of sexual development and caregiver-youth engagement around sexual health. After this project, parent and caregiver participants will be able to better understand sexual development and engage their child in regular, age-appropriate conversations about healthy sexuality.
- Increase youth participants' knowledge and skills to practice safe sex. Youth participants will also be able to identify a trusted adult in their lives.
- Increase community partners' and peer leaders' skills and knowledge to promote healthy sexuality in their communities.

Highlighted achievements of the past year:

- Community partners and youth were collaborators in designing the work, contributing ideas to how programming would best fit the participants. Direct requests from community partners - such as asking for a teacher training specific to gender and sexuality - informed the work that became part of the workplan.
- Expanded collaboration with Partnership Academy to provide technical assistance for teachers, after the school social worker approached CLUES, noting issues coming up among the students in regard to body boundaries, sexual harassment, and inappropriate jokes. School staff considered sexuality education a necessary step to better support the middle school population.
- Hosted workshops and provided technical assistance for teachers around creating a culture of consent in schools. Over 65 teachers at local schools received training on gender, sexual orientation, LGBTQ+ inclusivity, and consent.
- Facilitated a 10-session sex education class for 5^{th} – 8^{th} grade students.
- Over 300 youth participated in sexual education programming.
- 170 parents participated in one-time sexual health workshops.