Minnesota has consistently ranked among the nation’s healthiest states, according to the United Health Foundation and American Public Health Association’s annual study. The Gopher State placed sixth overall in the rankings over the last three years and was third in 2008.

Despite that success, the state is still battling very significant health disparities, which primarily affect the fast-growing Latino, African-American, and American Indian populations. The Minnesota Department of Health’s (MDH) latest health status report on the state’s populations of color found that:

- Infant mortality rates among American Indians and African-Americans are still more than twice that of whites, despite recent progress lowering those disparities.
- Women of color were two to three times more likely than whites to receive inadequate or no prenatal care.
- Based on the 2004 MDH health access survey, Hispanic children were almost six times more likely to be uninsured than whites.
- Mortality rates for African-Americans from diabetes, kidney disease, and septicemia were more than twice the rate for whites and the rate for HIV/AIDS was 15 times as great.
- For American Indians, mortality rates from cirrhosis, diabetes, kidney disease, pneumonia, and suicide were two to six times the rates for whites.

“Our populations of color and American Indians still face significant health disparities, says Jose Gonzalez, director of the MDH Office of Minority and Multicultural Health (OMMH), “and their numbers continue to grow, from just 5 percent of the state’s population in 1990 to 15 percent now.”

A targeted approach

Despite budget cutbacks, MDH has been working systematically to reduce the disparities. In 2001, the Minnesota legislature passed the Eliminating Health Disparities Initiative (EHDI) to fund community grants and other strategies that address disparities in eight priority areas, as defined by research and community forums. They include infant mortality, adult and child immunizations, breast and cervical cancer screening, HIV/AIDS and sexually transmitted diseases, diabetes, cardiovascular disease and stroke, unintentional injuries and violence, and teen pregnancy.

In EHDI’s phase I, which lasted until 2009, MDH teamed with the federal Temporary Assistance for Needy Families (TANF) program to award $5 million worth of grants per year to 42 community projects and 11 tribal nations. In its 2011 report to the legislature, MDH cited several signs of progress from phase I, including:

- St. Mary’s Clinics of Minneapolis and St. Paul tackled the high rate of breast and cervical cancer in the Latino population. By cultivating a welcoming atmosphere and specifying that patients could receive care without insurance, the clinics’ work resulted in a 73 percent increase in the number of Latinas receiving mammograms.
• Grand Portage Band of Ojibwa, a Native American tribe, targeted the high rate of diabetes and cardiovascular disease. In 2006, 271 tribal members received screening and 13 percent of those were referred for further testing or treatment.

• CAPI (formerly the Center for Asian Pacific Islanders) helped new immigrants navigate the healthcare system. In 2006, 47 Asian Pacific Islanders were enrolled in MinnesotaCare, the state’s subsidized healthcare program, and an additional 234 were connected to a primary health clinic, which was a 58 percent increase from previous years.

• Camphor Foundation reduced the high rate of unplanned pregnancies in African-American teens through a faith-based community collaboration fostering healthy behaviors. The program served more than 100 African-American youth and reported no unplanned pregnancies among the participants.

Applying the lessons learned

Even with those achievements, Gonzalez notes that many issues needed to be resolved prior to launching EHDI’s phase II. The second phase began in fiscal year 2010 with grants totaling $5.8 million to 29 community organizations and nine tribal nations—again jointly funded by state funds and federal TANF funds.

“In the early days of the program, we were starting from scratch and there were very few evidence-based culturally appropriate models,” says Gonzalez, whose office administers EHDI. “Our legislature now is asking us to demonstrate the economic impact of our work.”

Among the biggest concerns that needed to be resolved for phase II:

• Improved data collection to create consistent—and preferably interoperable—information on race and ethnicity among state agencies, community clinics, and other providers.

• Improved cultural competency within healthcare systems and for health providers at all levels of patient care.

• Consistent evaluation focused on documented reduction in health disparities.

To better ensure a solid return on money spent, Gonzalez says that phase II asked grant applicants to demonstrate that their projects are based on the solid, evidence-based experiences of similar projects from around the country. To assist grantees, MDH specialists provided examples of evidence-based programs in several key areas, such as diabetes, teen pregnancy, and stroke.

In addition, MDH challenged grant applicants to describe obstacles to their success, such as factors linked to social determinants of health. For example, a program aimed at reducing diabetes could take place in a community with no easily accessible full-line supermarket.

Finally, phase II grant applicants needed to research other state and local community efforts dealing with similar health concerns to leverage resources, forge potential partnerships, and avoid duplication. For example, UCare, a nonprofit health plan for people enrolled in government healthcare programs
such as MinnesotaCare and Medical Assistance, works with several EHDI grant recipients on health promotion events and developing health education materials for a variety of ethnic, language, and cultural groups.

To assist grantees on program accountability, MDH contracted with Minneapolis-based Rainbow Research to provide culturally appropriate evaluation technical assistance. This support included face-to-face individualized support, interactive working sessions for small groups of grantees, and sharing evaluation resources through an interactive website.

Aqui Para Ti’s (“Here for You”) partnership with master’s degree students at the University of Minnesota School of Public Health is one example of the results from the increased focus on measuring outcomes. The students helped conduct surveys and focus groups with parents and teens involved in the clinic’s youth development program, which aims at reducing teen pregnancies, sexually transmitted diseases, and suicide among Latino youth in South Minneapolis.

A grant participant since the start of EHDI, Aqui Para Ti serves teens and their parents in a “parallel approach,” which addresses mental health issues and parenting skills. Among the clinic’s positive outcomes: A significant increase in birth control use among teens and a marked improvement in parents’ ability to communicate with their children and tap into available community resources for support. In addition, the vast majority (86 percent) of youth reported that their overall health had improved since using the program’s services.

“In terms of evidence-based results, we’ve tried to set the bar high,” says Maria Veronica Svetaz, MD, the project’s medical director. “You need to be up-to-date on what really works with youth, as well as being in close touch with what the community needs.”

Dr. Svetaz adds that in the last two years, the program has put increased emphasis on evaluation and data mining. Her organization is also applying for an NIH grant that could replicate the Aqui Para Ti model in several other locations.

**Essential steps for change**

Although EHDI is arguably the most targeted program to reduce disparities, it is not the only MDH strategy to bolster health equity. Like other states (see details in the Oregon case study), Minnesota is in the midst of health reform that has created new opportunities to directly impact disparities. Examples of these efforts include healthcare homes and accountable care organizations, which will reward hospitals and doctors for preventive and community-oriented care, and a new insurance exchange to provide affordable coverage to more individuals and families. Another opportunity that holds promise for community-level planning to address health disparities is the new IRS requirement that nonprofit hospitals conduct community needs assessments and identify those communities or populations that are experiencing the greatest health disparities. MDH is also applying for national accreditation through the new Public Health Accreditation Board, which requires health equity strategies in its standards. The Health Reform Minnesota website gives details on these and other initiatives.
MDH’s Statewide Health Improvement Program (SHIP) is also aligned with the increased emphasis on preventive care. SHIP has awarded $15 million in grants to 17 community health boards and one tribal government. Focusing on tobacco use, physical activity, and nutrition, SHIP seeks to change the social and physical environments of schools, workplaces, and communities, as well as encourage health providers to improve their performance on screening for risky behaviors.

“To improve health in Minnesota, we have to think in terms of prevention, not just treatment,” said MDH Commissioner Edward Ehlinger, MD, while announcing a new round of SHIP grants in December 2011. “In Minnesota and nationally, the two main causes of chronic disease and premature death are obesity, caused by poor nutrition and insufficient physical activity, and commercial tobacco use.”

But like the EHDI efforts, SHIP also has a dual mission of improving health while keeping costs in check. “It is critical that we know we are being effective, says Patricia Adams, SHIP office director.

Accordingly, SHIP takes proven best practices from CDC and other public health organizations and helps grantees implement these models in their own communities, including some populations that experience the greatest health disparities like tribal areas and North Minneapolis, home to a large concentration of African-Americans. For example, SHIP’s typical school projects offer more nutrition meals, allow more time for physical education, and even get students involved in planting their own gardens.

When shaping their strategies, SHIP grantees work with leadership teams in their communities and organizations like UCare, the nonprofit insurance provider. For example, UCare collaborated with SHIP on a billing guide for healthcare providers involved in weight management and tobacco cessation services.

“SHIP is all about partnerships, both at the state and local level,” says Adams, “including chambers of commerce, farmers, school board members, hospital boards, and city and transit planners.”

Martha Roberts, an MDH evaluation supervisor for SHIP, notes that, in addition to constructing the logic models that grantees follow when implementing their projects, MDH specialists also provide training, technical assistance, survey tools, and other methods for assessing how grantee efforts change behaviors and environments.

Better accountability is essential as MDH looks ahead to 2013, when it must again approach the legislature for more SHIP funds. Faced with mounting deficits, the state legislature in its last session slashed SHIP funding for the next biennium from $43 million to $15 million—a 70 percent cut.

The financial climate presents a clear challenge to those at the forefront of implementing prevention and health equity strategies. “It can take years to produce concrete results in bending the obesity and tobacco use curve,” says Adams, “but legislators often want to see instant results so we really must work to implement solid evaluation methods.”
You can learn more about health equity initiatives in Minnesota by consulting these sources:

Minnesota Department of Health (MDH)
http://www.health.state.mn.us/

Office of Minority and Multicultural Health
http://www.health.state.mn.us/ommh/index.html

Building Community Capacity for Prevention

Health Reform Minnesota (Health Disparities page)
http://mn.gov/health-reform/topics/prevention/health-disparities/index.jsp

MDH Populations of Color Health Status Report (2009)

The Unequal Distribution of Health in the Twin Cities Report (Oct. 2010)
http://www.bcbsmnfoundation.org/objects/Publications/F9790_web%20%20Wilder%20full%20report.pdf

Eliminating Health Disparities Initiatives (EHDI) Report to the Legislature 2011

MDH Web Portal for EHDI Phase II Grantees
http://www.health.state.mn.us/ommh/grants/ehdi/forgrantees/index.html

Health Reform Minnesota Web Site
http://mn.gov/health-reform/

Aqui Para Ti (EHDI-funded youth development program)
http://www.hcmc.org/depts/hcclinics/AquiparaTiProgram.htm