State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3079

02/11/2020 Authored by Richardson, Christensen, Becker-Finn, Edelson, Howard and others
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health; adding disabilities to focus of health disparities; amending Minnesota Statutes 2018, section 145.928, subdivisions 2, 8, by adding a subdivision; Minnesota Statutes 2019 Supplement, section 145.928, subdivision 7.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2018, section 145.928, subdivision 2, is amended to read:

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; the Commission of the Deaf, DeafBlind and Hard of Hearing under section 256C.28; the governor's Council on Developmental Disabilities under section 16B.054; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan consistent with United States Code, title 42, sections 15001 to 15115, to address disabilities and reduce health disparities in the health disparity priority areas identified in subdivision 1.

Sec. 2. Minnesota Statutes 2018, section 145.928, is amended by adding a subdivision to read:

Subd. 2a. **Persons with disability and health disparity.** (a) In addition to the goals specified in subdivision 1, the commissioner shall focus on health disparities among individuals with disabilities in relation to access to health care, health behaviors, health status, and social factors that impact health. For example, use of accessible equipment in

medical practice such as facilities using wheelchair accessible scales and facilities complying with the Americans with Disabilities Act and the Affordable Care Act, that have accessibility guidelines, improves access. Improved data collection will advance improvement in public health standards. Routine use of disability status in data collection and analysis will provide information about the relationship of disability status with health and health behaviors and give health providers needed information on where to focus to improve the health of individuals with disabilities across the life span.

(b) Another critical focus area is increased training of health care providers that will: (1) support earlier identification and intervention for children with disabilities; (2) improve services for youth with disabilities to transition into the adult care system; and (3) improve health care and health promotion for all individuals with disabilities.

(c) The focus on health disparity among individuals with disabilities must include a plan for inclusion where: (1) organizations and health systems provide information that is accessible by individuals who have challenges with vision, hearing, or understanding complex information; and (2) inclusion in public health preparedness planning activities addresses the differing needs of individuals with disabilities during emergencies which might include needed assistive equipment and accessible shelter facilities.

Sec. 3. Minnesota Statutes 2019 Supplement, section 145.928, subdivision 7, is amended to read:

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~~.~~; or

(4) addressing health disparities for individuals with disabilities.

(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.

Sec. 4. Minnesota Statutes 2018, section 145.928, subdivision 8, is amended to read:

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~~.~~; or

(6) decreasing disparities in health care and early intervention programs for children with disabilities.

(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.