RAINBOWRESEARCH Inc.

MINNESOTA'S ELIMINATING HEALTH DISPARITIES INITIATIVE (EHDI)

Report 1: Overview and History

Prepared for

Minnesota Department of Health
Office of Minority and Multicultural Health

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Overview of Series of Reports

This report is the first in a series of documents detailing the work and accomplishments of the 52 grantees funded through the Eliminating Health Disparities Initiative of the Minnesota Department of Health's Office of Minority and Multicultural Health. The history of the Eliminating Health Disparities Initiative is described in this report.

In 2001, Minnesota passed landmark legislation to address the persistent and growing problem of disparities in health status between the white population and populations of color and American Indians. Although Minnesota is one of the healthiest states in America, it has some of the greatest disparities in health between racial/ethnic groups. By competitively distributing funds to 52 community organizations and tribes across the state, Minnesota charged its populations of color and American Indian communities to develop strategies and approaches for eliminating disparities in eight key health areas.

Minnesota's approach, and the work of many of the EHDI grantees are consistent with model program practices identified by national researchers documenting other initiatives addressing health disparities (Report #2). Report #3 documents the innovative programs and outreach strategies grantees developed to overcome barriers to reach members of their communities with health promotion programs and messages building on the communities' inherent strengths, values, traditions, institutions and other assets. These strengths and culturally-based strategies can serve as a model for other states and communities to learn from as they work to address disparities. Report #4 describes the health disparity context in Minnesota, and reviews programmatic outcomes being achieved by Minnesota's 52 EHDI grantees. Additional outcomes related to capacity building and community impacts are described in Report #5 of the series. Report #6 includes detailed case studies, and Report #7 is a catalogue of the grantee programs.

⇒	**Report #1:**	**Minnesota's Eliminating Health Disparities Initiative: Overview and History**
	Report #2:	A Model and Method for Identifying Exemplary Program Practices to Eliminate Health Disparities
	Report #3:	Exemplary Program Practices in Action
	Report #4:	Programmatic Results Achieved by Eliminating Health Disparities Initiative Grantees
	Report #5:	Building Capacities among Individuals, Organizations, Communities and Systems
	Report #6:	Grantee Case Studies
	Report #7:	Catalogue of EHDI Programs

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Introduction

This report documents the history of the Eliminating Health Disparities Initiative, its legislation, the health disparities addressed, the philosophy of the Initiative and a description of the current grantee organizations. This report is intended as a "primer" on the Initiative and background for the subsequent six reports in this series that document the work of the grantees, and the impacts generated to date.

Since 2002, the Minnesota Department of Health has funded more than fifty organizations and tribes to reduce racial and cultural disparities in eight priority health areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STI's, immunization, infant mortality, healthy youth development, and violence and unintentional injuries. The approach of Minnesota's Eliminating Health Disparities Initiative (EHDI) grant program is to support organizations and programs working in communities of color and American Indian tribes to develop and implement strategies that are effective in reaching their communities. By empowering community-based organizations to develop health improvement strategies built on cultural and community strengths, community members will be more likely to be reached, engaged, and impacted.

Minnesota's EHDI has chosen a community-based approach to address health disparities grounded in the philosophy that community issues require community solutions. EHDI exclusively funds and supports organizations and programs working in communities of color and American Indian tribes to develop and implement strategies targeted to their communities. Their work is focused on providing education, promoting healthy lifestyles and behaviors, and facilitating access to health care and building community capacity.

We believe the EHDI grantees are using "best practice models," that are the best, most appropriate and effective methods for the people of the targeted cultures and communities. Six years into this Initiative, some important lessons about this community/culture-based approach are emerging from the collective experience of the 52 grantees. This is the first in a series of reports that document the lessons learned from the implementation of the indigenous best practices of African, African-American, American Indian, Asian and Hispanic/Latinos communities, and what they have accomplished.

HISTORY OF THE ELIMINATING HEALTH DISPARITIES INITIATIVE[1]

The Minnesota Department of Health's first public recognition of health disparities occurred in 1987, with the publication of *Minority Populations in Minnesota – a Health Status Report* (MDH). This pioneering report detailed the demographics and health status of the state's populations of color. Another step to raise recognition of and address health disparities was the establishment of the Office of Minority Health (OMH). (Note: in 2001, the name of the OMH was changed to Office of Minority and Multicultural Health).

A second, more in-depth report on the health of populations of color was issued in 1997 as a joint project of the Minnesota Urban Coalition, OMH and the MDH Center for Health Statistics. This 1997 *Populations of Color in Minnesota – a Health Status Report* documented the extent of the state's health disparities and identified factors that contributed to the poor health of these communities. The *Populations of Color* report provided the groundwork for the program and policy recommendations published in the OMH 1998 *Minority Health Legislative Report: Current Status of Information Related to Minority Health Issues*. This report emphasized the need for better data and programming directed at populations of color.

Other activities at MDH during this time raised awareness of health disparities including: Healthy Minnesotans: Public Health Goals 2004, Minority Health Local Assessment Grants and the REACH infant mortality grant. These activities not only increased the visibility of health disparities in Minnesota but also helped develop crucial partnerships with community leaders and MDH. In 1999, based on OMH and community activities, the MDH Commissioner, Jan Malcolm, identified health disparities as one of the three strategic priorities for MDH.

The work of the OMH and its community partners, along with the support of Commissioner Jan Malcolm, laid the groundwork for a legislative proposal specifically aimed at reducing health disparities between populations of color and whites. In late 2000, MDH and community leaders began developing the EHDI legislation. The legislation was patterned after other state and federal efforts, including the community-driven approach used in the federal Racial and Ethnic Approaches to Community Health (REACH) 2010. In addition,

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[1] *Assessment of the Minnesota Department of Health's Office of Minority and Multicultural Health's Infrastructure and Capacity to Address Issues of Health Disparity*, August 2003, MDH Office of Minority and Multicultural Health

the EHDI legislation was shaped from lessons learned from the reports, projects (e.g. REACH and Minority Health Local Assessments Grants) and community partnerships in the late 1990s. From these activities, MDH learned that current efforts to address health disparities were inadequate and traditional public health programs were not always effective. The solutions must come from within the communities and be supported by community leaders. The legislation incorporated these lessons learned.

The passing of this legislation was a collaborative effort between MDH and communities of color. In early 2001, Asian, Latino, and African American rallies in support of the EHDI were held on the steps of the capital and attended by hundreds of community members. Meanwhile, small community groups actively lobbied their respective legislators, pressing for passage of the bill. As one legislator later explained, "It was politically difficult to go against the interests of the Governor, MDH leadership and community members on this legislation." During the spring 2001 session, the Minnesota Legislature passed the Eliminating Health Disparities Legislation, MN Statutes Section 48 [145.928].

Figure 1. Significant events across the twenty-three year history of EHDI

Year	Event
1987	▪ *Minority Populations in Minnesota – a Health Status Report* (MDH)
1997	▪ *Populations of Color in Minnesota – a Health Status Report (MDH)*
1998	▪ *Minority Health Legislative Report: Current Status of Information Related to Minority Health Issues* ▪ Other MDH Activities: Healthy Minnesotans: Public Health Goals 2004, Minority Health Local Assessment Grants, and the REACH infant mortality grant
1999	▪ Health disparities set as one of the three strategic priorities for MDH by Commissioner Malcolm
2000	▪ MDH and community leaders work together to craft legislation ▪ April. Community groups rally on steps of Capitol
2001	▪ May. Minnesota Legislature passed the $9.5 million Eliminating Health Disparities Legislation, MN Statutes Section 48 [145.928] ▪ August. Development of funding program with community input ▪ November. Release of Request for Proposals for community organizations, 139 organizations respond submit proposals
2002	▪ 49 community grantees selected, plus 10 tribes through a parallel process and contracts were executed ▪ Projects begin
2004	▪ Grantees submit non-competitive proposals and updated work plans--46 re-contracted ▪ December. *Moving Forward, Looking Back Conference*, OMMH, showcase grantees' programs and accomplishments
2005	▪ Initiative evaluation process begins
2006	▪ Grantees submit non-competitive proposals and updated work plans--42 re-contracted ▪ Preliminary Initiative evaluation results released
2008	▪ Fall. 2nd Conference showcasing grantees' programs and accomplishments
2010	▪ EHDI Funding under MN Statutes Section 48 [145.928] ends

EHDI Legislation

The 2001 Eliminating Health Disparities Initiative (EHDI) created a 9.5 million dollar fund to provide funding and capacity building to community-based organizations and American Indian tribes to address one or more of the eight targeted health disparities within their specific communities.

Goals of the Legislation

The language that created EHDI specified two main goals:

1. By 2010, decrease by 50 percent the disparities in infant mortality rates and adult and child immunizations rates for American Indians and populations of color in Minnesota (Asian Americans, African Americans, and Latinos/Hispanics) as compared with the rates for whites.

2. Close the gap in health disparities of American Indians and populations of color as compared with the rates for whites in the following priority health areas:
   - Breast and cervical cancer
   - Cardiovascular disease
   - Diabetes
   - HIV/AIDS and sexually transmitted infections
   - Violence and unintentional injuries
   - Immunizations for adults and children
   - Infant mortality, and
   - Healthy youth development

Baseline Disparities in Health

The goals of the Eliminating Health Disparities Initiative legislation are to reduce disparities by 50 percent for immunization and infant mortality rates and close the gap in the other six priority health areas. The baseline rates and 2010 targets for immunization and infant mortality are shown in Table 1. The targets set in legislation for immunization rates for infants require that the disparity be halved by 2010, and when applied to baseline data, this means immunization rates for infants would need to increase by 10 percent for African Americans, 8 percent for Asians and Latinos, and 5 percent for American Indians. For infant mortality, again, the target was to half the disparity between each population group and the majority (white) population by 2010. This would require a drop in infant mortality rates of 4 deaths per 1,000 births for American Indians, a drop of 3.8 per 1,000 births for African Americans, 0.8 deaths per 1,000 births for Asians and 0.7 deaths per 1,000 births for Latinos.

Table 1. Baseline Data and 2010 Targets for Immunization and Infant Mortality

Immunizations	Indicator: Percent Up-to date for Primary Series Immunization Levels at 17 Months of Age*				
	African American	American Indian	Asian	Latino	White
2000-01 Percent	61	71	65	66	81
Target **	71	76	73	74	--
Infant Mortality	**Indicator: Infant mortality rates per 1,000 births *** **				
	African American	**American Indian**	**Asian**	**Latino**	**White**
1995-99 Rate	13.2	13.5	7.1	7.0	5.5
Target **	9.4	9.5	6.3	6.3	--

**Targets = Population of Color Rate - [(White Rate – Population of Color Rate) *.50]
***Infant deaths: deaths to infants less than one year of age
Immunizations Source: MN Department of Health, Immunization, Tuberculosis, and International Health; Infant Mortality Data Source: MN Department of Health, Center for Health Statistics

The goals set for the other health priority areas were to "close the gap in health disparities of American Indians and populations of color as compared with the rates for whites" in the other six priority health areas. The baseline data for populations of color and American Indians for breast and cervical cancer incidence and mortality are shown in Table 2. Breast cancer incidence was actually highest among white Minnesotans, but African American women were far more likely to die from breast cancer. Women of color were also more likely to have cervical cancer, and Asian women in particular more likely to die from it.

Table 2. Minnesota Incidence and Mortality Rates for Breast and Cervical Cancer per 100,000 population by Race/Ethnicity, 1995-1999

Cancer	Baseline Indicators: Breast Cancer and Cervical Cancer Incidence & Mortality Rates per 100,000				
	African American	American Indian	Asian	Latino	White
Breast Cancer Incidence	109.7	55.5	70.3	NA	137.2
Breast Cancer Mortality	38.7	23.2	15.3	NA	27.7
Cervical Cancer Incidence	21.4	14.2	15.2	NA	7.0
Cervical Cancer Mortality	5.2	*	11.7	NA	1.8

Source: MN Department of Health, Center for Health Statistics & MN Cancer Surveillance System
Mortality rates are age adjusted to 2000 US standard population
NA: Data not available
* Numbers to small to report.

Mortality rates due to cardiovascular disease and diabetes are shown in Table 3. American Indians and African Americans have the higher rates of mortality from cardiovascular disease, followed by whites, then Latinos and lastly Asians. Mortality related to diabetes are four times as high among American Indians as whites, and mortality rates for African Americans are more than twice as high as whites.

Table 3. Minnesota Mortality Rates for Cardiovascular Disease and Diabetes per 100,000 population by Race/Ethnicity, 1995-1999

Cardiovascular Disease & Diabetes	Baseline Indicators: Mortality rates per 100,000 for Cardiovascular Disease and Diabetes				
	African American	American Indian	Asian	Latino	White
Cardiovascular Disease Mortality	221.6	263.3	112.4	155.5	205.7
Diabetes Mortality	59.7	108.8	21.1	37.7	22.3

Source: MN Department of Health, Center for Health Statistics & MN Cancer Surveillance System
Mortality rates are age adjusted to 2000 US standard population

Mortality rates for violence and unintentional injury are shown in Table 4. Mortality due to unintentional injuries (car crashes, accidental drowning, falls, etc.) was more than twice as high among American Indians as whites. Mortality due to homicide was 15 times as high for African Americans as for whites. These rates were also quite high for American Indians. Mortality due to suicide was highest for American Indians, followed by Latinos, Asians and African Americans.

Table 4. Minnesota Mortality Rates for Cardiovascular Disease and Diabetes per 100,000 population by Race/Ethnicity, 1995-1999

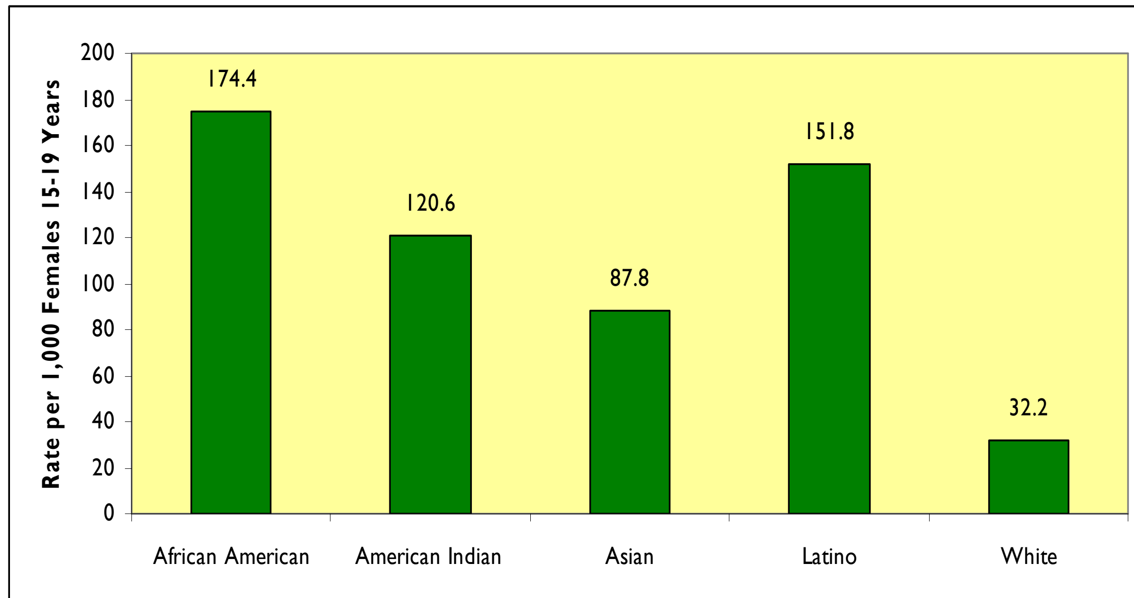
Violence and Unintentional Injury	Baseline Indicators: Mortality rates per 100,000 for Unintentional Injury, Homicide and Suicide				
	African American	American Indian	Asian	Latino	White
Unintentional Injury Mortality	40.7	75.8	36.1	40.2	34.4
Homicide Mortality	33.5	21.0	4.4	7.3	1.8
Suicide Mortality	9.6	15.7	10.0	11.5	9.9

Source: MN Department of Health, Center for Health Statistics & MN Cancer Surveillance System
Mortality rates are age adjusted to 2000 US standard population

The remaining two health priority areas are Healthy Youth Development and HIV/AIDS and other Sexually Transmitted Infections. The indicator used

for Healthy Youth Development is teen pregnancy rates. The baseline teen pregnancy rates for each racial/cultural group are shown in Figure 2 below.

Figure 2. Minnesota Pregnancy Rates per 1,000 Females Ages 15-19 by Race/Ethnicity, 1995-1999



Source: Minnesota Department of Health, Center for Health Statistics

Baseline data on rates of new infections for HIV/AIDS and for two other sexually transmitted infections (Chlamydia and Gonorrhea) for each racial/cultural group is shown in Table 5 below. The rate of new infections of HIV, Chlamydia and Gonorrhea is twenty times as high for African Americans as whites, and are also quite high among Latinos and American Indians.

Table 5. New HIV, Chlamydia and Gonorrhea Infection* Rates per 100,000 Population by Race/Ethnicity in Minnesota, 2000

HIV/AIDS and STI's	Infection Rates per 100,000 Population				
	African American	American Indian	Asian	Latino	White
New HIV Infection*	54.2	11.1	3.0	21.6	2.8
Chlamydia Incidence	1,769	540	314	652	73
Gonorrhea Incidence	1,149	123	34	135	18

Source: MN Department of Health, Infectious Disease Epidemiology, Prevention and Control
Rates are per 100,000 population
*HIV or AIDS at first diagnosis

Objectives of the Initiative

The specific objectives for the Eliminating Health Disparities Initiative were derived from the legislation and include:

- Develop and implement a funding program for community-based organizations and American Indian tribes to address health disparities in a culturally appropriate manner;
- Provide capacity building support for the EHDI grantees to enable them to document their outcomes and their lessons learned;
- Provide capacity building support and training to develop the strengths of these organizations in reaching the targeted populations and effecting change;
- Leverage additional resources and support for the broader Initiative, and to help sustain and grow the efforts to eliminate health disparities.

Components

EHDI has nine components as originally envisioned:

1. Partnership steering committee that will address health disparities in a comprehensive and coordinated way.
2. Set of measurable objectives to track Minnesota's progress in reducing health disparities.
3. Improved statewide assessment of risk behaviors among African American/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota.
4. Technical assistance for grant applicants and recipients.
5. Community grants directed at reducing health disparities in the eight health disparity areas.
6. Health screening and follow-up services for tuberculosis for foreign-born persons.
7. Grants to American Indian tribal governments for community interventions to reduce health disparities.
8. Evaluation of the initiative.
9. Biannual reports to the legislature.

The task of implementing the EHDI was immense, requiring a department-wide effort. In August 2001, 150 community members from across the state met with MDH OMMH staff to provide input for the design of the Community Grants Program, including the competitive process, the award criteria, the content and structure for the Request for Proposals (RFP), the application and review process and grantee technical assistance plan.

Community Empowerment Philosophy of EHDI

The philosophy underlying Minnesota's Eliminating Health Disparities Initiative is based in the principle of self-determination – change has to come from within communities and build on the communities' strengths, social and human capital. The EHDI grant program is structured so that the funded organizations build on the strengths and assets of their community—

- talent, skills, creativity, energy and commitment of individuals in the community,
- leadership of neighborhoods, communities and tribes,
- strong family and social networks within communities of color and American Indian tribes;
- many types of well-known and respected organizations serving communities of color, which sets Minnesota apart from many other states,
- strong and trusted institutions within communities of color and American Indian tribes that serve as both organizing centers, and keepers of the values of these communities;
- partnerships between these organizations, institutions, community members, and mainstream organizations, and
- values, history, and heritage of these communities that provide meaning and moral guides.

These, among others, are the assets that EHDI grantees can draw upon to build programs to promote the health and quality of life of individuals and communities, and work toward reducing the health disparities of racial and ethnic populations.

Under Minnesota's EHDI, communities also are charged to determine what the focus of their project should be, what strategies should be used to address

the focus, and what type of outcomes are important to measure to document progress towards eliminating the targeted health disparity/disparities in their community. The State of Minnesota, working as a partner with these communities, provides resources to build capacities for these efforts—funding, as well as technical assistance in health issues and grant management staff who are themselves community members, information on 'best-practices,' and skills building in the areas of planning, evaluation, and sustainability. The short-term goal is to support capacity development and sustainability within the communities with the longer-term goal of improved health outcomes in the targeted areas.

Key parts of the EHDI grant program are identifying or creating new and innovative strategies to address racial/ethnic disparities, as well as focusing on prevention and early detection. It is intended to promote active and full community involvement and build and strengthen relationships among community members and health service-providing organizations such as: faith-based organizations, culturally-based organizations, social service organizations, community nonprofit organizations, tribal governments, community health boards, community clinics and other health care providers, and the Minnesota Department of Health.

The grants are distributed through the Office of Minority and Multicultural Health (OMMH) within the Minnesota Department of Health. The mission of OMMH is entirely consistent with EHDI; it is concerned with "strengthening the health and wellness of racial/ethnic, cultural and tribal populations of the state of Minnesota by engaging diverse populations in health systems, mutual learning and actions essential for achieving health parity and optimal wellness."

Grantee Selection

In November of 2001, a Request for Proposals (RFP) was released for the Eliminating Health Disparities Initiative. This RFP was posted in the State Register, on the Minnesota Department of Health's website, and was widely disseminated through many channels to reach a wide spectrum of organizations and communities. MDH conducted workshops in communities across the state to educate communities about this new funding source, the funding process, and proposals preparation.

The response to this Request for Proposals was tremendous. One hundred and sixty-seven applications were received, requesting a total of $39,600,000—nearly four times the amount of funds available for the ten year period. This process brought in applications from community organizations that had never before applied for a grant from Minnesota

Department of Health, or chosen to work with MDH. In this regard, it was very successful at building a bridge to organizations serving communities of color. Ultimately 49 community grantees were selected. Ten of Minnesota's 11 American Indian tribes were also funded through another proposal process.

Table 6. Number of community grant applications and total funding requested and received in original EHDI grant making process in 2001.

	Requested	Funded
Number of applications	167	49
Dollars	$39,600,000	$9,570,000

The contracts were executed at the beginning of 2002. The community grantees that were funded on this initial round varied a great deal, including grassroots groups, public/private collaboratives, community centers, large social service organizations, health care clinics and faith-based organizations. Most of the organizations have staff members who reflect the community they work with in terms of culture, race and language.

Two additional non-competitive proposal rounds were held in 2004 and in 2006. Grantees were required to resubmit their program plans, organizational information and budgets for review. It provided an opportunity for grantees to rethink and retool their program plans and make changes in how their funds were allocated, based on these revised plans. Between 2002 and 2006, seven community grantees dropped out of the funding program. Several grantees were de-funded by OMMH due to performance issues, while others dropped out due to organizational changes.

Support and Training for Grantees

Grantees were required to participate in two large training workshops each year sponsored by the Office of Minority and Multicultural Health, and were also invited to participate in many smaller group sessions. Trainings were provided early-on in the assets framework and program development. Many of the required trainings were conducted by Rainbow Research and focused on developing evaluation skills, complying with reporting requirements and disseminating information about their projects. The Office of Minority and Multicultural Health also held many trainings and provided technical assistance.

Trainings were also provided by Rainbow on preparing and presenting information from their evaluation and constructing posters. At the 2004 OMMH conference, *Moving Forward, Looking Back* nearly all grantees participated on panels to share information about their projects and evaluation results.

Rainbow Research provided one-to-one technical assistance to grantees from 2002 to 2008 to help them develop program logic models, identify key outcomes for their programs, develop indicators and data collection strategies to document these outcomes and utilize comparative data to show relative gains. The level of technical assistance available to grantees was reduced across the years, from an early average of 15 to 20 hours per grantee per year, down to three hours per grantee.

In addition, each grantee worked with their Grant Manager on an ongoing basis to access resources, training, and technical assistance to develop capacities in areas needed. Other MDH staff constituted a "TAG" team—technical assistance experts in substantive areas such as cancer, HIV, or cardiovascular disease. The TAG team worked with grantees on the development of their programs and provided information and materials to ensure technical accuracy.

Reporting and Evaluation Requirements

As part of the community empowerment philosophy and the capacity building emphasis of the Initiative, grantees were charged with the responsibility to conduct their own evaluations. They were encouraged to involve their key stakeholders in developing program outcome models (logic models) to show how their program worked to create short, intermediate and longer-term outcomes. Through these community processes, grantees identified key programmatic outcomes related to reducing the health disparity. They then developed evaluation designs, data collection strategies, instruments and work plans to measure their outcomes. With technical assistance from Rainbow Research, they implemented their evaluation plans and collected and analyzed data.

The expectation for grantee evaluations was that in the first two years grantees would be able to execute a "small scale evaluation study" documenting at least one outcome. In the second two years, they had to document at least one outcome in each health disparity area in which they were working. In the third cycle, they had to develop a basis of comparison for their data to show relative change. They were also encouraged to begin documenting more intermediate-level and longer-term outcomes, as well as systems changes they had been involved in. Grantees were required to submit an evaluation report each year documenting numbers served and outcome results.

Description of the EHDI Grantees

The counties in which grantees reported recruiting participants and/or conducting significant program activities are shown in Figure 3.

Forty-two out of 87 counties in Minnesota have at least one EHDI grantee working in them. More than two-thirds (69 percent) of the grantees are located in the Twin Cities Metropolitan area (36 grantees), and 31 percent are located in outstate Minnesota (16 grantees).

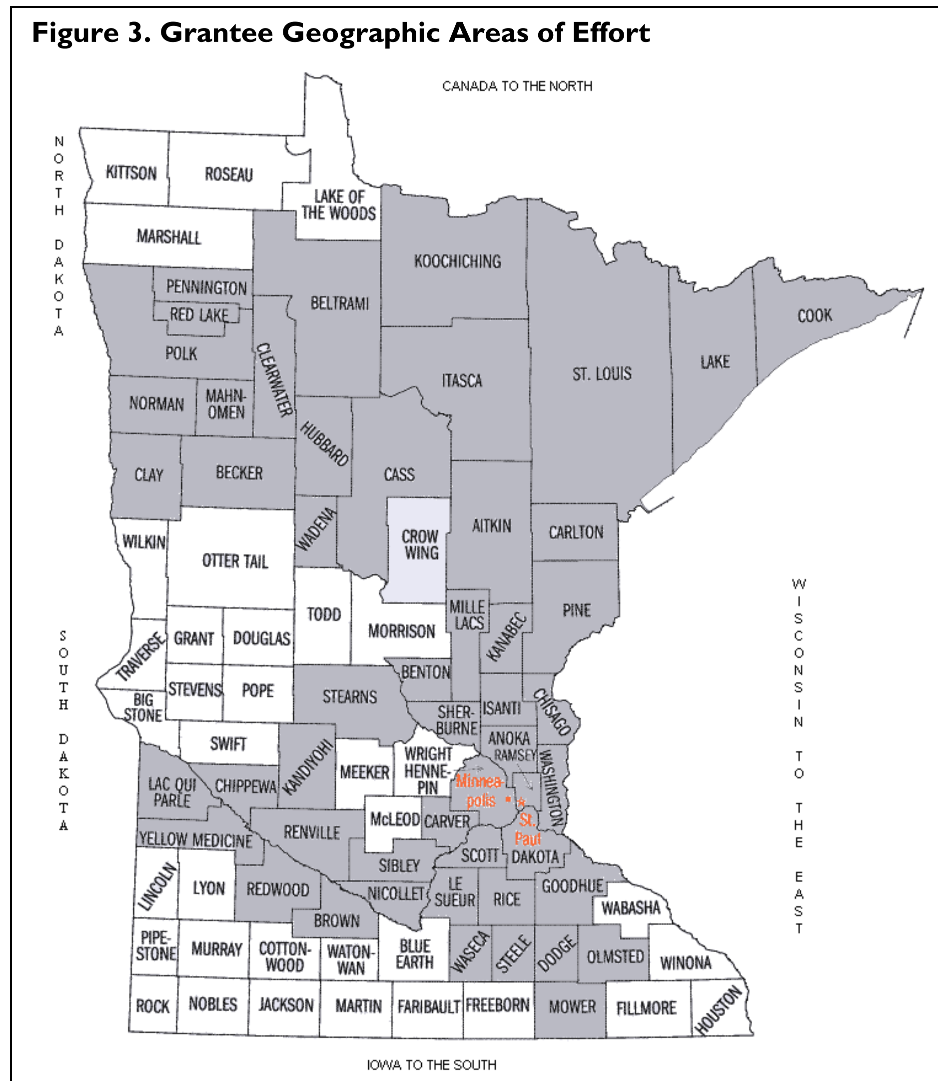


Figure 3. Grantee Geographic Areas of Effort

Table 7 describes the pool of 52 EHDI grantees currently being funded. Of the 52 entities, 42 (81 percent) are community grantees, and 10 (19 percent) are funded through tribal governments. As described earlier, tribes were funded under a separate mechanism with their funding distributed as part of their block grant of funds from MDH.

The grantees are required to work in at least one health disparity area and many address more than one. For instance, 33 percent work in the area of healthy youth development, 31 percent address disparities in diabetes, 23 percent address cardiovascular disease, 19 percent address infant mortality,

17 percent address breast and/or cervical cancer, 17 percent address violence or unintentional injuries, and 15 percent address HIV/AIDS.

In terms of the racial/cultural populations served, 48 percent work with African/African American populations, 46 percent work with American Indian tribes or communities, 38 percent work with diverse groups (more than two populations), 33 percent work with Hispanic/Latino populations, and 25 percent work with Asian/Southeast Asian populations.

Table 7. Description of Eliminating Health Disparities Grantees.

Characteristic of Grantee	Number	Percent of Total*
Total Funded Programs	**(52)**	
Type of Grantee		
Community grantee	42	81%
Tribal Grantee	10	19%
Location/Geographic Area		
Twin Cities Metro Area	36	69%
Outstate MN	16	31%
Health Disparity Area Addressed		
Breast and Cervical Cancer	9	17%
Cardiovascular Disease	12	23%
Diabetes	16	31%
Healthy Youth Development	17	33%
HIV/Sexually Transmitted Infections	8	15%
Immunizations	7	13%
Infant Mortality	10	19%
Violence and Unintended Injury	9	17%
Racial/Cultural Populations Served		
African/African American	25	48%
American Indian	24	46%
Asian/SE Asian	13	25%
Hispanic/Latino	17	33%
Diverse	20	38%

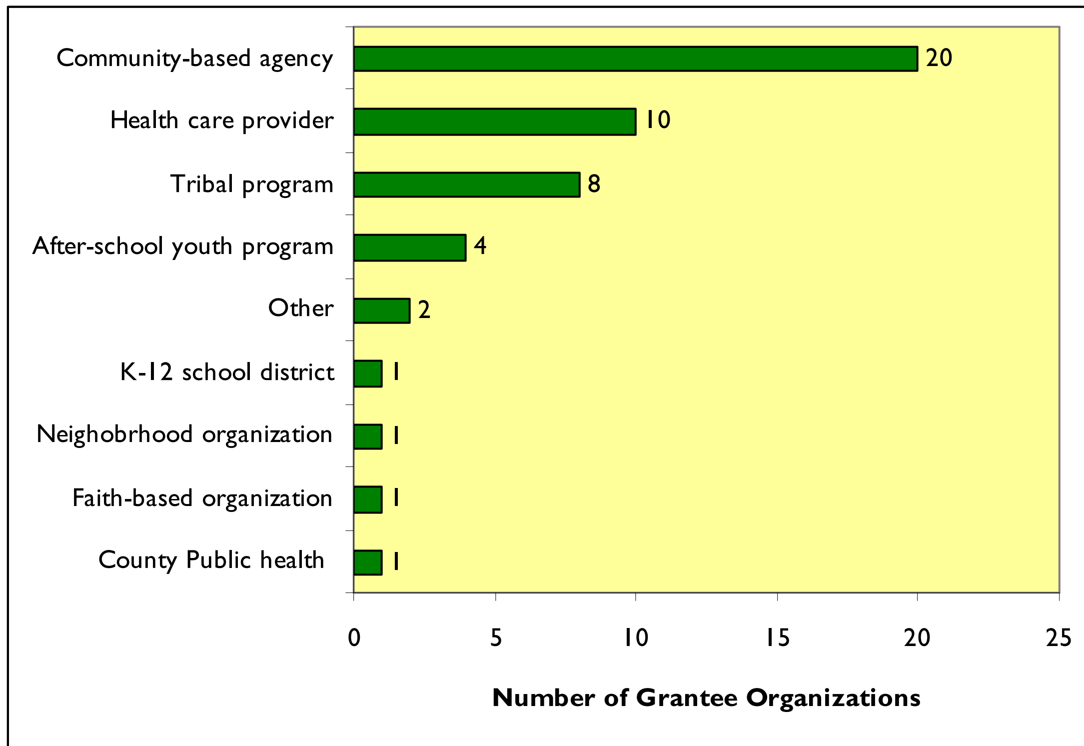
*Note: many grantees work in more than one health disparity area, and may serve more than one racial/cultural population, so the percentages may total to more than 100%.

Figure 4 shows the type of parent organizations with an EHDI program. Of the 52 grantees, most (44) were a community-based social or multi-service organization, ten were within a health-care provider setting (clinic or hospital), eight were within a tribal government or organization, four were within youth programs or after-school programs, two were "other" – a collaborative, or some other type of hybrid organization, and four grantees

did not respond to the online survey asking them to describe their home organization or fiscal agent.

There was an average of a little more than two paid staff persons employed by each of these EHDI programs, although the range was wide – from less than one FTE to ten part-time persons. The total number of staff persons employed full or part-time by the EHDI Initiative (among the 47 agencies who participated in the study) were approximately 143. There were also 177 contract staff or consultants, and over 316 volunteers reported as working with the EHDI programs to provide services.

Figure 4. Type of "Parent" Organization in which Grantee Program Housed



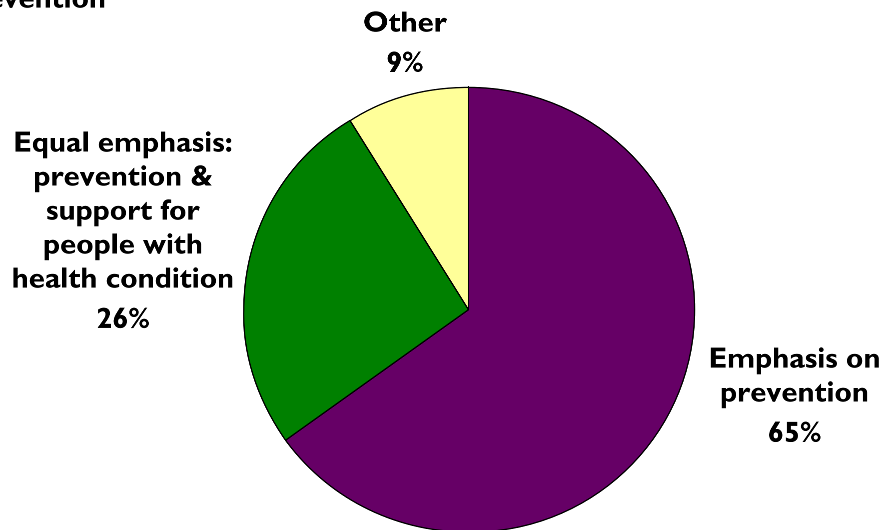
Activities Being Used by Grantees to Improve Community Health

This first part of this report describes the kinds of activities grantees are employing to improve the health of their community and eliminate health disparities.

Program Focus

Prevention is the primary emphasis of most EHDI grantees. When asked whether their program placed a greater emphasis on 1. Prevention or 2. Treatment or support for those who already have a disease, or 3. An equal emphasis on both supporting treatment and prevention, nearly two-thirds of grantees (65 percent) stated that their program(s) places a greater emphasis on prevention. A quarter (26 percent) of the EHDI grantee programs maintains an equal emphasis on prevention and treatment or support for those who already have a disease. The remaining nine percent reported their program has another type of focus such as awareness building or capacity building as their primary focus.

Figure 5. Percent of Grantees Reporting Approach is Primary vs. Secondary Prevention



Focus of Health Activities

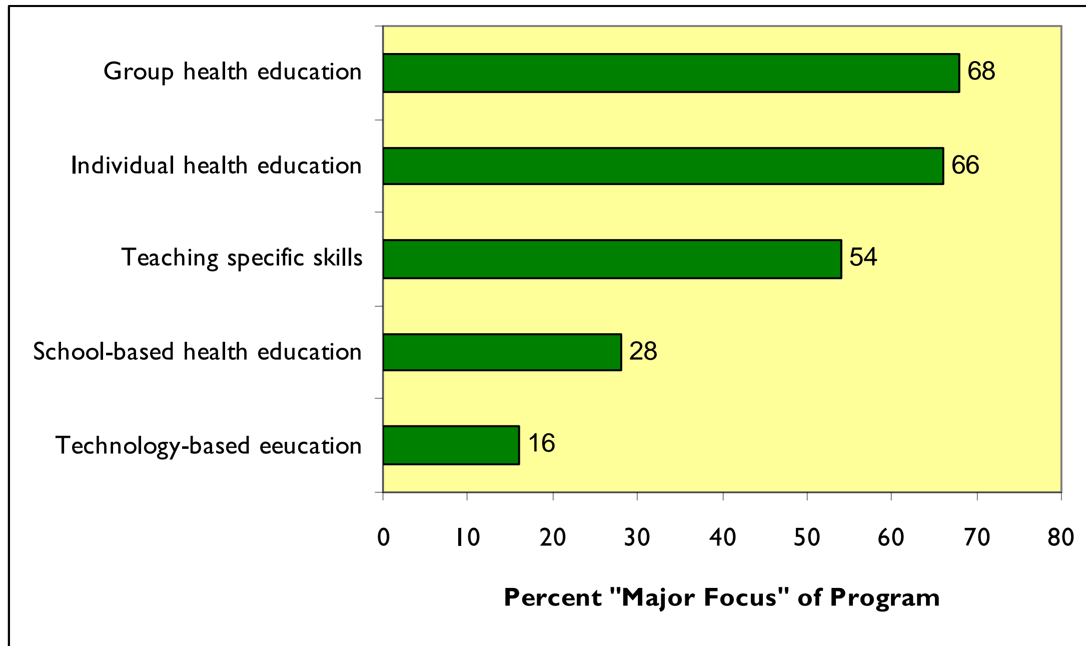
To explore the types of activities grantees are employing, grantees were asked to complete a checklist of various types of health education, health improvement strategies, community mobilization and service components. The list of activities was developed based on a content analysis of grantee program descriptions. Grantees were asked to indicate whether each activity was a "major focus," a "minor focus," or "not a focus" of their program. Grantees determined the level of focus for each activity based on the relative

effort put into each activity, and the degree to which it characterized their program's strategy.

Health Education and Skills Building

Health education and skills building are incorporated into nearly all grantee programs. Figure 6 highlights the specific types of health education and skills building that grantees identify as a major focus of their program.

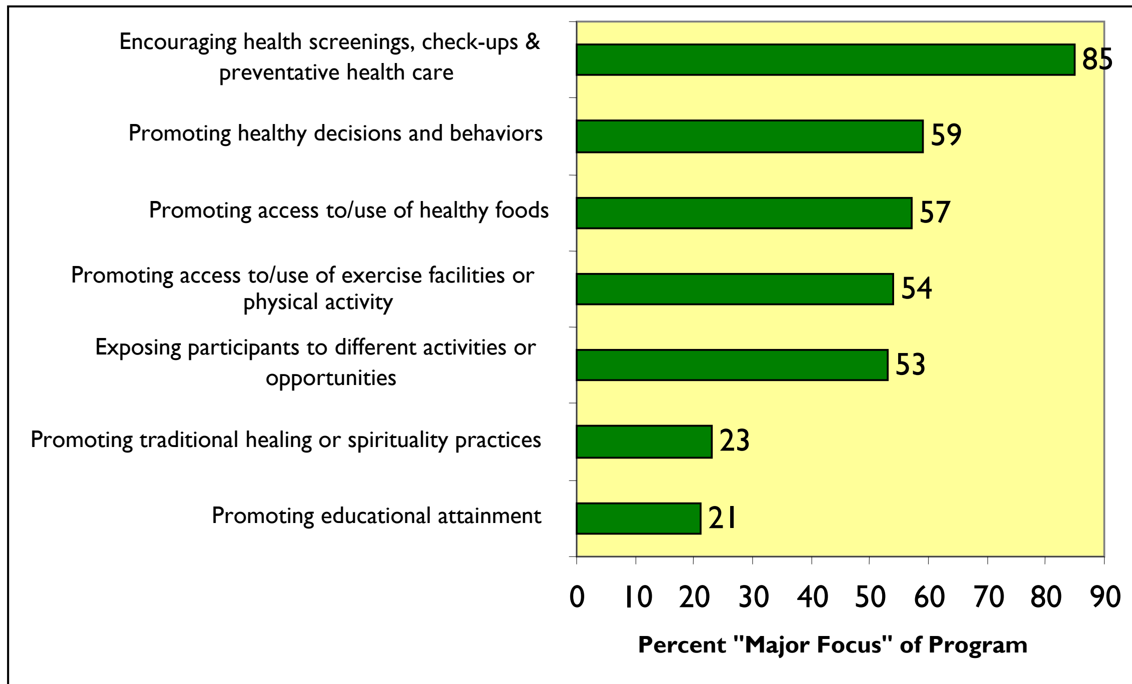
Figure 6. Grantee Program Focus: Health Education and Skills Building



Encouraging Healthy Lifestyle Practices or Behaviors

The encouragement of healthy lifestyle practices and behaviors is also a predominant focus of most grantee programs. Many grantees attempt to design programs that encourage regular screenings, check-ups and preventative health care. Figure 7 highlights the different methods grantees utilize to encourage healthy lifestyle practices or behaviors.

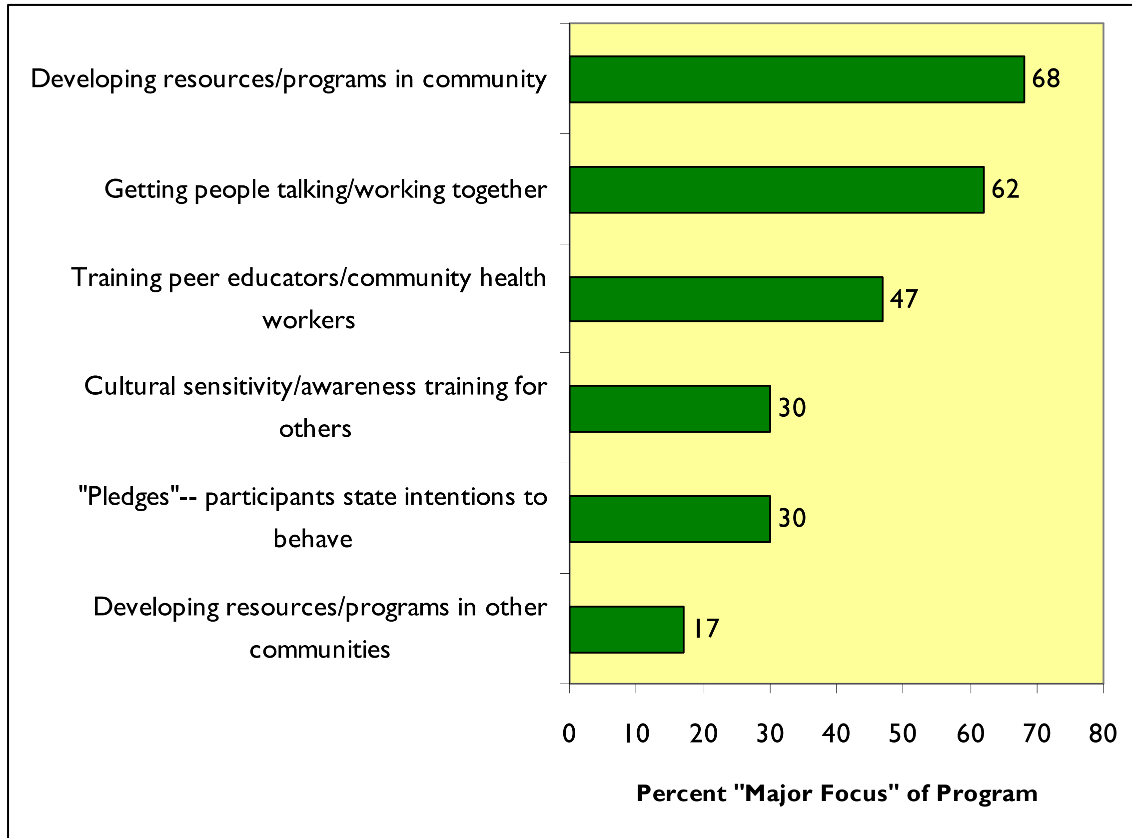
Figure 7. Grantee Program Focus: Encouraging Health Lifestyle Practices or Behaviors



Mobilizing the Community and Building Capacity

Community mobilization and capacity building is another area of focus for EHDI grantees. Many grantees labor to get community members working together on an issue, or build capacity through developing new program curricula, resources or build skills through training and outreach efforts in their target community. Figure 8 details how grantees carry out community mobilization and capacity building efforts.

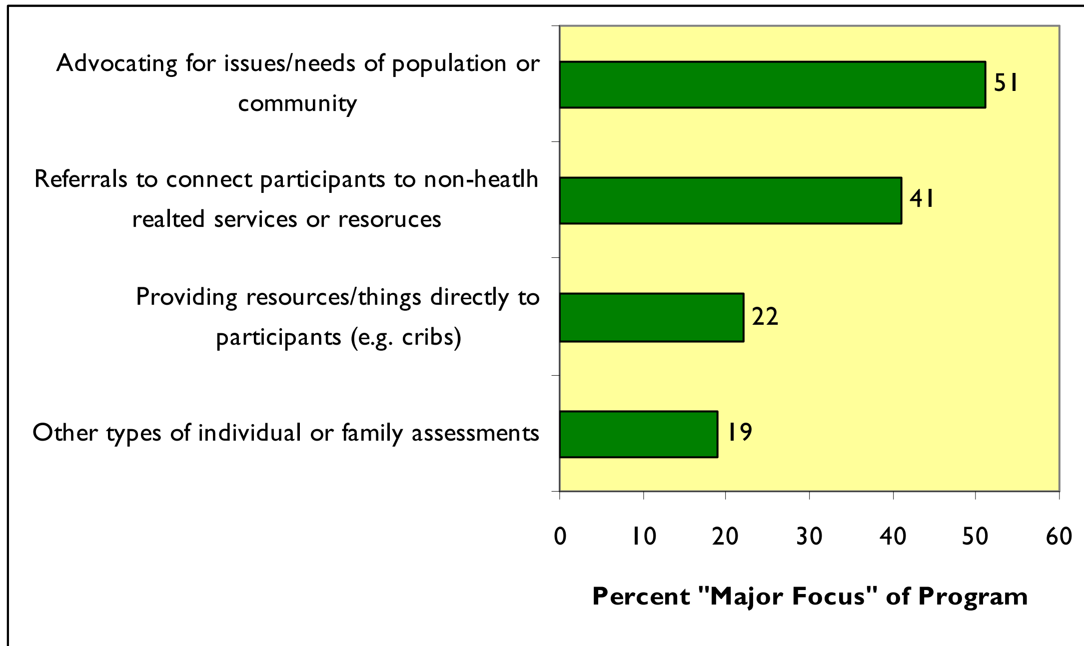
Figure 8. Grantee Program Focus: Community Mobilization & Capacity Building Efforts



Other Types of Activities

Grantees also carried out additional activities such as advocating for community needs, referring clients to non-health related resources and providing resources directly to participants (e.g. cribs, car seats). Figure 9 outlines some of the other activities of grantees.

Figure 9. Grantee Program Focus: Other Types of Activity, Service or Resources



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Additional information on approaches and activities being used by grantees to improve the health of their communities is detailed in Report #3.

EVALUATION OF THE INITIATIVE

In May 2002, OMMH contracted with Rainbow Research, Inc. of Minneapolis to provide evaluation capacity building and technical assistance to the grantees. Under the community empowerment philosophy, grantees were charged with the responsibility of conducting their own evaluations. To help them do this, they received training, technical assistance and coaching from a professional evaluation consultant.

In 2005, Rainbow Research was asked to develop a plan to evaluate the EHDI overall. The purpose of this overall evaluation was to build on what was learned by conducting more comprehensive evaluations of the individual EHDI grantee programs. Together with the staff of OMMH and Center for Health Statistics (CHS), an evaluation process was developed. The evaluation was designed to:

- Document the approaches and activities the grantees employ in their programs, and in so doing, understand how 'grassroots programming' based in community assets and cultural strengths is carried out and gain an understanding of the process of developing such programs. This entails looking at "model processes" of program development;

- Explore how these programs build on community assets and cultural strengths to reach community members and recruit participants, and effectively deliver messages that increase knowledge, change attitudes and behaviors. We call these "exemplary program practices" for addressing health disparities;

- Describe local-level impacts the program is having on participating community members;

- Examine the impacts of the Initiative on building the capacity of communities of color and American Indian tribes, and the organizations and networks of organizations that serve or are otherwise connected to these communities. In other words, determine how the Initiative strengthened grantee communities and left a legacy of additional skills, partners and resources; and,

- Provide useful information to guide the continued development of the Eliminating Health Disparities Initiative.

The primary audience for the EHDI overall evaluation is the Office of Minority and Multicultural Health of the Minnesota Department of Health. Information generated from this evaluation will be used in its report to the

Minnesota Legislature and other key stakeholders. Other potential audiences for the overall evaluation findings include: other states that are planning or currently undertaking health disparities work, other government units and agencies funding health disparities grants, foundations in Minnesota and across the country that are addressing health disparities issues, HMOs, health care providers, and the larger community. Community members and groups, in particular, are likely to benefit from the lessons learned by within the grantee-program of EHDI, the innovative approaches they use, the barriers encountered and solutions employed to overcome those barriers, the areas in which changes are taking place, and future directions of their own work.

Identifying Exemplary Practices and Strategies to Address Health Disparities

Under the guiding philosophy of self-determination and community empowerment, the EHDI grantees developed innovative programs to address and measure the outcomes they determined were most critical to eliminating health disparities. What is special about the EHDI is both the grass roots process of program development and the culturally-based programs that emerged. The "EHDI Exemplary Practices Project" is a component of the Initiative evaluation to identify and document those exemplary program practice and model programs developed by EHDI grantees so that other communities and organizations can learn from these experiences. The organizing framework, described briefly in the final section of this report and detailed in Report #2, guided the evaluation activities.

Organizing Framework & Methodology

This Exemplary Program Practices framework (see Table 8) was generated through a Delphi study of Minnesota experts working in the field of health disparities. (A Delphi study is an iterative poll of experts conducted to achieve consensus on a set of ideas.) In 2005, thirty experts responded to an online survey of what strategies were most important for programs to effectively address health disparities in their communities. The expert panel achieved consensus in two rounds on a list of seventeen program values, philosophies, organizing approaches, programmatic strategies and qualities of effective health disparities programs. This list was validated through a review of the literature on model programs and practices. The Delphi study and this programmatic review process are detailed in Report #2 of this series.

EHDI grantees were then assessed to determine whether and how they incorporated these seventeen philosophies and practices. The grantees'

practices were explored through a series of in-depth interviews, online surveys, and a review of their annual evaluation reports. The responses of grantees were then reviewed by multi-cultural panels of program managers, researchers, and community members to identify which activities and approaches stood out as exemplary program practices to address health disparities in community-based program settings.

The exemplary program practices and model programs are described at length in Reports 3, 4 and 5. Many examples to illustrate the exemplary practices in action were drawn from the grantees day-to-day work. These practices are documented and described so that other communities, agencies, and funders – both in Minnesota and across the country – can learn from these effective strategies developed by the communities to address health disparities.

Subsequent Reports

Report	Title and Description
Report #2	**Evaluating Community-based Health Disparities Programs: Identifying Culture-based Exemplary Program Practices** Details the development of the exemplary program practices framework based in the literature and opinion of experts in the health disparities field.
Report #3	**Eliminating Health Disparities Initiative: Exemplary Program Practices in Action** Provides documentation on how grantees incorporate the first nine exemplary practices from the framework of 17 practices in their program.
Report #4	**Programmatic Results Achieved by Eliminating Health Disparities Initiative Grantees** Focuses on the evaluation capacities built among grantees, and documents the outputs and outcomes of their EHDI Programs from 2006.
Report #5	**Strengthening Individuals, Organizations, and Communities: Impacts Achieved by the Eliminating Health Disparities Initiative** Documents the larger impacts of the Initiative on the organizations, communities and systems with which EHDI grantees. These exemplary program practices correspond to numbers 11 through 17.
Report #6	**Grantee Case Studies** Provides a more in-depth description of 10 grantees.

Table 8. EHDI Organizing Framework of 17 Exemplary Program Practice Criteria

A. Exemplary Program Practices in Action	B. Programmatic Results Achieved	C. Strengthening Individuals, Organizations & Communities: Systems Changes & Capacities built
1. The community is involved in authentic ways 2. Programming is data-driven 3. A comprehensive approach is utilized in developing and implementing programming 4. Recruit participants or deliver services in community settings in which community members feel comfortable 5. Trust is established as the foundation for effective services 6. Programming builds upon cultural assets and strengths of community 7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants 8. Staff reflect the community being served; and or cultural competence is ensured among those who are delivering services 9. Program model or components are innovative	10. Program is able to document strong outcomes or results	11. Leadership and commitment by staff are in evidence 12. Partnerships are essential to support effective programming 13. Funding and resources are available and leveraged to sustain the efforts 14. Staff issues are attended. Training and technical assistance are available for capacity building 15. Capacities are built in the organization and/or community (types other than evaluation) 16. Challenges are confronted 17. Systems change is undertaken

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Eliminating Health Disparities Initiative Grantees 2006 – 2008

Community Grantees

African American AIDS Task Force
Agape House for Mothers
American Indian Family Collaborative
Anishinaabe Center
Annex Teen Clinic
Bois Forte Band Community
Boys and Girls Club of the Twin Cities
Camphor Foundation
Center for Asian and Pacific Islanders
Centro (2 grants)
Centro Campesino
Children's Hospitals and Clinics
Council on Crime and Justice
Dar Al-Hijrah Cultural Center
Division of Indian Works (2 grants)
Family and Children's Services
Freeport West
Fremont Community Health Services
Hennepin Care East Clinic (formerly La Clinica en Lake)
Hmong American Partnership
Indian Health Board of Minneapolis
Lao Family Community of Minnesota
Leech Lake Band of Ojibwe
Minneapolis American Indian Center
Minneapolis Urban League
Minnesota International Health Volunteers
Olmsted County Public Health Services
Park Avenue Family Practice
Saint Mary's Health Clinics (formerly Carondelet LifeCare Ministries)
Sisters in Harmony Program
Southeast Asian Community Council
Southeast Asian Ministry
Stairstep Foundation
Summit University Teen Center
The Storefront Group
Turning Point
United Hospital Foundation
Vietnamese Social Services of Minnesota
West Central Integration Collaborative
Westside Community Health Services

Tribal Grantees

Bois Forte Band of Chippewa
Fond du Lac Band of Ojibwe
Grand Portage Band of Ojibwe
Leech Lake Band of Ojibwe
Lower Sioux Community
Mille Lacs Band of Ojibwe
Prairie Island Foundation
Red Lake Comprehensive Health Services
Upper Sioux Community
White Earth Tribal Mental Health