RAINBOW**RESEARCH** Inc.

MINNESOTA'S ELIMINATING HEALTH DISPARITIES INITIATIVE

Report 2:
A Model and Method for Identifying Exemplary Program Practices to Eliminate Health Disparities

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 second in a series of seven 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. This report lays out a model for identifying best practices in health disparities programming. Methods included an analysis of model program practices identified by national researchers and a Delphi study with a panel of Minnesota experts working in the field of health disparities. The report also describes a method for identifying these program practices and model programs among the EHDI grantees.

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. A history of the Eliminating Health Disparities Initiative is detailed in the first report of the series (Report #1).

Report #3 documents the innovative programs and outreach strategies grantees developed to overcome barriers. These culturally-based strategies can serve as a model for other states and communities as they work to address health 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 is a set of case studies of the grantee programs and Report #7 is a catalogue of all 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
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INTRODUCTION

Since 2001, 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, immunizations, infant mortality, healthy youth development, and violence and unintentional injury. The approach taken in 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 and impacting their communities. The philosophy underlying the EHDI funding approach is that health disparities have emerged in part because mainstream health organizations have not been effective in reaching communities of color, conveying needed health information, or effecting behavioral changes. By empowering community-based organizations to develop health improvement strategies built on cultural and community strengths, minority communities will experience improvements in health status. As one grantee working in the Hmong community expressed it:

> *"We rely on the cross-cultural wisdom of the staff and community members, instead of 'evidence-based or best-practice models.' While evidence based practices have strong merit due to their history of formal evaluation, the most meaningful responses for Hmong will be derived from the genius of our own history and culture in a convergence with western practices of social work and public health in America. It is not possible that the genius of these approaches have existed in western practices long enough to show up in our current scientific models."*

Six years into the initiative, some important lessons about this community/culture-based approaches are emerging. This report describes how a model of best practices was derived; how data were collected from the EHDI grantees, as well as the accomplishments of the EHDI grantees.

Documenting both a model and the implementation of best practices among 52 grantees was a challenging undertaking – given the tremendous variety among programming strategies used by grantees. The plethora of strategies was to be expected since they are tailored to be appropriate to the culture, language, age, gender and geographic location of their target populations across eight health priority areas. Underneath the variation, however, are several common principles and strategies that are explored later in this report.

REVIEW OF LITERATURE

The literature summarized in this section is intended to orient the reader to a high level understanding of health disparities, an introduction to the work that has been done on components of successful programs and a review of statewide efforts to reduce health disparities. Staff at Rainbow Research and the Minnesota Department of Health also used the information gleaned from these reviews to:

1) Identify how the Minnesota initiative builds on national-level knowledge about health disparities and to document what has been learned in Minnesota that moves this knowledge forward.

2) Understand the demonstrated critical components of successful programs for improving health and well-being. This will be used to document the extent to which programs to reduce health disparities in Minnesota contain these components and what additional components Minnesota programs have identified as critical.

3) Illustrate how Minnesota's EHDI complements and/or differs from others.

LITERATURE ON WHAT CONSTITUTES A SUCCESSFUL PROGRAM

In this section, a summary of findings are presented from the work of Lisbeth Schorr in her book <u>Common Purpose: Strengthening Families and Neighborhoods to Rebuild America</u> (Schorr, 1997). This review focuses on her findings regarding the *Seven Attributes of Highly Effective Programs*. While her work reflects programming focused on children and families broadly, they are directly relevant to community-based health disparities programming. Outlined below are the seven attributes and their characterizations.

1. Successful programs are comprehensive, flexible, responsive and persevering

- Staff is caring, compassionate, patient, persistent, persevering; this builds/restores trust.
- Staff goes the extra mile and participants see this.
- Staff is encouraged to use their discretion about what assistance they will provide.
- Staff sees and uses resources beyond governmental and social services.
- Programs do not provide everything to everyone, but are flexible.
- Organizations feel more like a family than a bureaucracy.

2. Successful programs see children in the context of their families

- Programs work with multiple generations within households and communities.
- Programs nurture parents so they can, in turn, nurture their children.
- Programs focus on family strengths while also assisting with serious problems.
- Programs see problems children experience usually linked to problems parents have.

3. Successful programs deal with families as parts of neighborhoods and communities

- Programs are organic – they emerge from the community not from outside it.
- Programs are not just in the community, but are 'of' the community.
- Programs recognize and acknowledge the role systems play in problems faced by individuals.
- Programs grow deep roots in the community.
- Programs listen to the community.
- Community members have a sense of ownership for the program.
- "Successful programs recognize and respond to the needs of the community; they reflect the character of its people.....they build capacity in people and in neighborhoods....'best practices' are whatever works in a given context." (Schorr, 1997, pg 7-8).

4. Successful programs have a long-term, preventive orientation, a clear mission and continue to evolve over time

- Programs focus their work on preventable risk factors that happen at early ages.
- Programs have 'tight' missions, but are loose about how the mission is carried out.
- Organizations aim for programs that will evolve in response to community needs and feedback.
- Organizations have a culture of focusing on outcomes rather than rules.
- Staff share common beliefs based on experience, research and theory.
- "Because so many of these programs operate in areas where there is little scientific certainty, it is particularly important that they be able to continue evolving, learning from their successes and failures and finding new and better ways to achieve their goals." (Schorr, 1997, pg 9).

5. Successful programs are well managed by competent and committed individuals with clearly identifiable skills

- Programs use identifiable management techniques.
- Organizations have inspiring missions that attract excellent staff.
- Programs have leaders with skills that can be taught.
- Leaders are willing to experiment and take risks.
- Managers create supportive settings for staff to learn from research and each other.
- Managers respect, nurture and support staff in ways similar to how staff work with clients.

6. Staff of successful programs are trained and supported to provide high-quality, responsive services

- Programs recognize that competence and quality are the foundation of effective services.
- Organizations ensure quality through excellent training, monitoring and supervision of staff.

7. Successful programs operate in settings that encourage practitioners to build strong relationships based on mutual trust and respect

- Special, sustained, caring relationships are the core of program success
- Staff workloads permit the time it takes to develop substantial relationships with clients.
- Program settings are warm and welcoming, clients feel safe and secure.
- Program volunteers working with clients are screened and receive training and supervision.
- "Caring relationships are critical to efforts to change life trajectories because they compensate, in some degree, for lost affiliation and influence with the old peer group." (Schorr, page 11).

In addition to these seven attributes, Schorr highlights the importance of a few other attributes of effective programs which include what she calls a "new practice" and a "new practitioner"; a spiritual dimension; and, how successful programs manage to succeed despite the major obstacles to success.

A New Practice and a New Practitioner

- Staff focuses on client strengths and assets rather than pathology.
- Interactions between staff and clients involve mutual problem solving and respect.

- Expertise is attributed to families and collaboration between staff and clients is authentic.
- Clients have a sense of the staff person's heart – their personal feelings.
- Staff interacts with clients in meaningful ways (attending significant events such as funerals, christenings, etc.).
- When hiring staff, attention is paid to personal characteristics, relevant life experience and formal training.
- An example of the new practitioner mindset told by a therapist who was out on a home visit: "[I appeared] at the front door of a family in crisis, to be greeted by a mother's declaration that the one thing she didn't need in her life was one more social worker telling her what to do. What she needed, she said, was to get her house cleaned up. [The therapist] ...responded by asking the mother if she wanted to start with the kitchen. After working together for an hour, the two women were able to talk..." (Schorr, page 13).

A Spiritual Dimension

- Programs acknowledge the importance of a spiritual dimension, or a shared meaning and purpose in fostering change and trust.
- Programs address the spiritual aspect of an individual's experience.
- Staff goes to funerals and perseveres in the face of rejection.
- Programs acknowledge individuals' and communities' need for healing.
- Programs understand the importance of faith in persevering through stress, uncertainty and disappointment.
- Programs cultivate transformative relationships.

Success Despite Obstacles to Success

- Successful programs 'run against the grain,' 'beat the system' and have staff that break or subvert rules.
- Successful programs flourish only under some form of protective bubble.
- "It is now absolutely clear that the attributes of effective programs are undermined by their systems' surroundings, especially when they attempt to expand to reach large numbers.....This is the great hidden paradox. Agreement around the elements of successful programs has grown and yet policy and practice have not recognized how poorly matched are the attributes of effectiveness and the requirements of institutions and systems within which programs must operate if they are to reach millions instead of hundreds." (Schorr, 1997, pg 18, 19).

RESEARCH ON MODEL HEALTH DISPARITIES PROGRAMS

Various states across the country are pursuing initiatives to reduce racial and ethnic disparities in health. States are creating task forces to collaborate with state health agencies; establishing offices of Minority Health; holding community forums to determine needs and service gaps; creating new positions to work collaboratively with established health agencies and creating grantmaking programs (EHDI, for example) to fund new, creative, innovative and community-based approaches to improving the health of racial and ethnic minority populations.

In 2001, the Association of State and Territorial Health Officials (ASTHO), in collaboration with the National Association of County and City Health Officials (NACCHO), released a joint report entitled, *Health Departments Take Action: A Compendium of State and Local Models Addressing Racial and Ethnic Health Disparities in Health*. The report contains information on over 60 state and local efforts to reduce health disparities among racial and ethnic minorities. The report is organized into 21 health areas, such as: cardiovascular disease, cancer prevention, diabetes, etc. Within each health area is a summary of various model programs including:

- Program title
- State health department
- Target population
- Health issue
- Funding source
- Program description
- Contact information

ASTHO and NACCHO also conducted focus groups with program leaders and community stakeholders from seven state and local public health programs featured in the 2001 report. The programs were chosen based on: innovation; ability to be replicated; capacity to address health disparities; collaboration; community involvement; evaluation and outcomes. The focus groups provided more in-depth information on how the programs were initiated; priority health areas addressed; key partnerships formed; barriers encountered and overcome; and strategies used to promote evaluation and sustainability.

Findings from the focus groups were reported in the March 2003 joint publication entitled *Case Studies of Model Programs Addressing Racial and Ethnic Disparities in Health*. The report identified components that were key to the programs' success:

1. **Developing partnerships with other agencies** – involvement of community stakeholders and partners who assisted in the program and provided continuous feedback.

2. **Targeting multiple audiences** – focusing on more than one population contributed to program efficacy.

3. **Involving the general community** – involving the community as workgroup and coalition members and community health and outreach workers helped develop a sense of trust and acceptance of the program.

4. **Conducting needs assessments** – communities and local and state public health agencies worked together to identify the needs, interests and strengths of the target population.

5. **Engaging in cultural competency** – developing culturally competent program materials, training program staff and understanding the health issues and beliefs from the perspective of the target population.

In May 2004, NACCHO again released an update on the Rhode Island, Tennessee and Florida case studies and highlighted new efforts in the states of Texas and Minnesota. The report, entitled *Reducing Racial and Ethnic Health Disparities: Five Statewide Approaches* found that although the five states use different approaches to reduce health disparities, they share similar concepts and themes, namely, community involvement and cultural competency. The programs, with the exception of the Minnesota program, are briefly described below.

Texas Health Disparities Task Force

The **Texas** legislature created a statewide Health Disparities Task Force (HDTF) to provide recommendations to the Texas Department of Health (TDH). The HDTF has nine members representing business, labor, government, charitable or community organizations, racial or ethnic populations and community-based health organizations. The task force made three major recommendations:

1. Elimination of health disparities must be an ongoing priority,

2. Development of performance measures to quantify progress, and

3. Development of models of best practices for addressing health disparities.

Additional recommendations were: prevention measures to fight smoking and obesity and related illnesses; increasing access to health insurance and improvement of quality of care; improving communication and providing the highest quality of care to a diverse population (cultural competency); and, helping practitioners continue to serve the most vulnerable patients (medical

malpractice tort reform). TDH's Office of Minority Health is working with the HDTF to implement the recommendations and continues to make cultural competency a priority, saying "culturally competent and linguistically appropriate health care is an overriding and essential theme of all the recommendations." Health areas targeted include: childhood immunization, physical activity and fitness, tobacco use, sexual behavior and prenatal care.

Rhode Island Department of Health

The Minority Health Promotion Act of 1992 was passed by the **Rhode Island** Department of Health (RIDOH) to improve the quality of health and health care experienced by minorities in the state. The act also established an Office of Minority Health and created the Minority Health Advisory Committee to support RIDOH on health disparities issues. In 1998 the advisory committee issued an internal assessment report that offered policy recommendations for reducing health disparities in Rhode Island. The top ten general policy recommendations for all RIDOH programs were:

1. Meet the needs of racial and ethnic minority populations by identifying target populations and setting specific goals and objectives for RIDOH programs.

2. Perform client-based needs assessments by relating health status and socio-demographic data to program relevance.

3. Provide a diversity profile of the board, staff and populations served by RIDOH programs.

4. Streamline the collection, use and analysis of data by updating the minimum standard guidelines.

5. Provide appropriate translation, interpretation and bilingual materials throughout all public information, educational resources and signage.

6. Involve minorities in the planning, monitoring and evaluation of programs.

7. Increase minority awareness of significant events and programs by using minority media, mailings and community organizations.

8. Allocate funds for disparity elimination and ensure minority participation in resource allocation decisions.

9. Increase workforce diversity at all levels of RIDOH and health care arenas.

10. Ensure cultural competency by using best practices, training staff and involving minorities in program evaluation.

The Office of Minority Health also launched a state funded program to develop Minority Health Promotion Centers where community-based agencies provide culturally sensitive education and health promotion programs to minority populations.

Tennessee Department of Health

The **Tennessee** Department of Health (TDH) created a position of Director of Disparity Elimination within the Commissioner's Office. Both the TDH and the Director are working together to reduce health disparities using several approaches:

1. Developing a Report CARD for the department which includes **C**oordination of functions and services, **A**ssessment of effectiveness using evaluation and **R**esource **D**evelopment to reallocate funds toward disparity elimination.

2. Formally defining the issue of health disparity to understand disparity as it affects policy, access, use, quality and outcomes.

3. Identifying priority health areas including infant mortality, prenatal care, adolescent pregnancy, diabetes, heart disease and stroke.

4. Meeting with organizations, communities and individual citizens from across the state to fully understand the effects of health disparities in the state.

5. Launching faith-based initiatives to educate the public about their health.

6. TDH has issued a guide for statewide agencies that highlights six areas vital to the reduction of health disparities: health and health-related education; health access; health and health-related research; statewide community resource development; evaluation and oversight; and enhancing OMH infrastructure.

Florida Reducing Racial and Ethnic Health Disparities

In **Florida**, the Patient Protection Act was signed into law in 2000 which appropriated $5 million to the Department of Health for its Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program. The program distributes funds to local counties and organizations to "increase community-based health promotion and disease prevention activities." It targets six health priority areas: cardiovascular disease, cancer, diabetes, HIV/AIDS, adult and child immunizations, and maternal and infant mortality. The Racial and Ethnic Health Disparities Advisory Committee was appointed by the Secretary of Health to: identify areas where public health is lacking; address access

issues and make recommendations for eliminating health disparities and increasing the public's awareness of the health gaps that exist among racial and ethnic minorities. A statewide commission was also created to improve health care delivery systems with representatives from medicine, nursing, health care facilities and consumer advocacy, among others.

Robert Wood Johnson Foundation

In 2001 the Robert Wood Johnson Foundation commissioned a report on community-based initiatives to reduce health disparities. The report, written by Sigel *et al.* and updated in 2003, is entitled *Addressing Health Disparities in Community Settings*. The authors studied community-based programs targeting minorities and disparities to identify success factors. To select the programs, criteria were developed in such a way that the selected programs would offer important lessons on the organization and implementation of the initiatives. The authors conducted internet and literature searches as well as 42 expert interviews with key researchers, policy makers and opinion leaders to compile a list of program candidates. A total of 89 community-based initiatives nationwide met the study criteria. The selected programs shared the following characteristics: 1) they were operational and fully implemented; 2) they had defined interventions to improve access to early detection and treatment; 3) they reported some method of outcomes evaluation; 4) they were targeted at different minority groups; 5) they were geographically diverse; 6) they represented a range of sponsors and governance models (i.e., government, private, public-private partnerships); and 7) they represented a range of program sizes and funding levels.

Electronic mail surveys were sent to the 89 programs requesting information such as: target population, program governance and design, budget, community partners and evaluated outcomes. Forty-six programs (52 percent) completed the survey and seven programs were selected for case study site visits. The report describes each program, identifies "best practices," and makes recommendations that might help to strengthen the programs.

The study identified the following success factors and critical challenges that exist within the organizations and the environments in which they operate:

  1. **Leadership** – strong leadership was observed at all the seven sites. The programs owed their existence to energetic and charismatic individuals who deeply believe in what they do and fight for their programs to persist even in the midst of financial and organizational adversity.

2. **Sponsorship by an existing entity** – the seven programs were built on a preexisting organizational structure that offered some advantages. For example, when funding expired the sponsor organizations were able to offer temporary support. Some experts who were interviewed advocated building disparity programs on preexisting community organizations because this set-up gave new initiatives some administrative and management capacity to begin the work.

3. **Strong local medical provider interest** – in every program, medical providers showed interest and support through program sponsorship or formal and informal linkages to the programs. The providers saw the programs as a way to fulfill their mission and ease their own clinical and financial burdens.

4. **Broad indigent care finance systems** – programs that were established in an environment of generous state and municipal health finance systems were successful because they were able to obtain free or low-cost services for their clients, e.g., cancer screening and treatment services. According to the authors, "The long-term success of initiatives such as those studied may be as much a function of the local health care environment as it is a function of the qualities of these programs."

Ten Practices that Hold Promise

The case studies revealed ten practices that hold promise for addressing health disparities.

1. **Mobilize and manage a continuum of disease-specific resources in the community** - the programs create a network of services and assist their clients in gaining access to those services in a coordinated way. This means, for example, that the care of a diabetic patient is coordinated between physicians' offices, hospitals, clinics and social services and nutrition classes are brought in to change eating behavior. Or, for breast and cervical cancer treatment it means assembling all the resources together including breast health education, clinical breast exams, mammography and further diagnostic and treatment resources.

2. **Provide one-to-one outreach** - common to the programs are one-to-one outreach and ongoing contact between the client and some form of health worker. The health workers facilitate health education and health system navigation for clients. Whether health care professionals or lay health workers, they form strong bonds with the client and their families, advocate for them to obtain services and overall, serve as the unifying factor in the community network.

3. **Improve physical access to care** – transportation was a challenge identified by all programs and many of the experts interviewed for the study. To make parts of the health care continuum more physically accessible to clients, the programs provided transportation services and also put multiple resources and services under one roof.

4. **Focus on multiple determinants of health** – the initiatives took a broad-based approach to health, that is, they saw the health of their clients as extending beyond a specific disease. They also understood the multiple factors that can determine an individual's health and the many ways that both the individual and environment must change before health can improve. For example, inquiring about family activity levels and television-viewing habits to gauge diabetes risk during a mental health assessment, or, assessing the water supply, sewage system and general housing conditions during a home visit.

5. **Enlarge the concept of community** – a few programs broadened their definition of community. For example, a health center in the New York Chinatown area used to serve only Chinese-Americans from Manhattan's Lower East Side. But, with the rapid spread of the Chinese population across New York City and arrival of new Asian immigrants, it has redefined "community" to mean citywide and now also serves Vietnamese and other Asian immigrants. A program in Nogales found itself serving clients not only in Arizona but also across the border in Sonora, Mexico.

6. **Practice cultural competence** – the experts interviewed for the study repeatedly cited the need for staff and the organization to be culturally competent. Linguistic competence was absolutely essential, but cultural competence also meant: understanding the clients' barriers to care; knowledge of the clients' predominant diet, lifestyle, culture and beliefs; learning non-verbal communication since staff have to be sensitive to non-verbal cues such as posture, facial expression and other signals; providing culturally competent program literature; having workers, volunteers and providers whose first language is the same as the clients' and, including minority representation on governing boards and upper-level management.

7. **Build formal and informal bridges to the provider community** – strong local provider interest was mentioned earlier as a contributing factor to success, however, it can be difficult to get providers interested given the lack of economic benefits from serving poor and often uninsured individuals. Therefore, linkages with doctors, hospitals and clinics must be constantly cultivated and reinforced. They can be a key source of referrals because there are

often very limited resources available for indigent specialty and
tertiary care in poor communities.

8. **Foster volunteerism** – several projects made wide use of lay and
clinical volunteers. The use of volunteers is a low-cost and culturally
competent strategy to strengthen community links and serve people.
They can serve as health educators, outreach workers, patient
navigators and advocates.

9. **Seek formal community input** – some of the study sites sought
community advice, a practice endorsed by the experts. They involved
the community in needs assessment and planning processes and
focus groups.

10. **Play an active role in policy and advocacy** – some programs
viewed political advocacy and efforts to influence policy and change
the environment as a core function. A program in Nogales used the
Spanish language radio station not only to promote health issues but
to invite candidates for local office to speak on their positions on
health issues. Other programs worked on specific policy and
legislative changes by lobbying state officials to enact changes in
health care.

A COMPARISON OF MINNESOTA'S EHDI WITH OTHER INITIATIVES

The review of the literature on model health disparities programs, including
other statewide initiatives to reduce health disparities and national studies on
effective programming reveals that Minnesota's initiative shares a number of
characteristics – the creation of a grantmaking program that funded both
planning efforts (which also made needs assessment studies possible) and
implementation efforts; the focus on major racial and ethnic groups (Native
Americans, Asian Americans, African Americans and Latinos/Hispanics); the
targeting of efforts on major health disparity areas and the emphases on
community-based solutions and service delivery by program staff from the
populations they serve. It appears, however, that Minnesota has a greater
focus on forging partnerships, building the evaluation capacity of grantee
organizations and enhancing the sustainability of the programs by leveraging
grant funds. Other initiatives have started to address the core causes of health
disparities. Examples include: addressing socio-economic issues that impact
health such as poverty, lack of education and inadequate housing; enhancing
social connectedness especially among immigrants who often face isolation and
initiating statewide efforts to enhance the cultural diversity of the overall
healthcare workforce. Some root causes of health disparities are being
addressed by Minnesota's EHDI grantees at an organizational level but not

through statewide efforts. These are areas that Minnesota might consider in the future.

This review of the literature found a growing body of knowledge documenting the program characteristics and qualities of effective health disparities programs. The studies commissioned by ASTHO/NACCHO and the Robert Wood Johnson Foundation provide analyses of the commonalties in successful health disparities programming and the different foci and strategies used to effectively eliminate health disparities. The context, structures and community dynamics that impact health among minority populations vary across states, yet a core of consistent principles of effective programming is beginning to emerge. We now turn to an analysis of the health disparity-focused programs underway in Minnesota.

Evaluation Focus and Methodology

Focus

The EHDI Exemplary Practices Project is part of the evaluation of the initiative being coordinated by Rainbow Research Inc., the Minnesota Department of Health's Office of Minority and Multicultural Health and its Center for Health Statistics. The evaluation was developed four years into the initiative and is focused on describing the results of the community empowerment funding strategy. This evaluation is designed to:

- Identify effective program practices being used by communities to eliminate health disparities.

- Describe how those practices are being implemented in programs in Minnesota.

- Assess programmatic outcomes of the work of EHDI grantees and impacts of the EHDI on organizations and communities.

This portion of the evaluation employs a descriptive strategy to identify the types of strategies grantees use, what has worked well and what can be learned from this culture-based method of addressing health disparities. The EHDI Exemplary Practices Project was developed to provide practical advice on what is important in building an effective program to address health disparities and to showcase some of the EHDI programs.

Limitations

The evaluation does not focus on examining health impacts statewide for the racial/ethnic groups participating in the projects for several reasons:

1. Grantees were charged with conducting their own evaluations. Capacity building assistance was provided to them across the six years of the initiative. An empowerment evaluation model was used, whereby grantees were supported to identify outcomes and indicators that made sense in terms of their community's needs and issues. Given the diversity of health disparity areas and consequent outcomes addressed by grantees, the different ways outcomes were measured and the different approaches of working with their target population, aggregating outcomes across grantees was not feasible.

2. Statewide health impacts across all populations in all areas of the state are unlikely to be seen, given that funds were distributed to 52 tribes and community organizations. The funded organizations focused on specific health disparities, usually working in one or two health areas. For example, the American Indian populations in northwestern Minnesota might have had access to services in two or three health disparity areas, but not all eight. Grantees working in the metropolitan areas tended to focus on their health disparity area within their specific communities in their neighborhood or area of the city. The outcomes need to be examined on a local level. Tracking changes in health status at this level is difficult utilizing statewide monitoring systems. These projects are best seen as "demonstration projects" for determining what types of culturally-based health disparities programs can be developed and implemented and what locally-focused outcomes can be documented.

3. Many of the health issues being addressed by the Eliminating Health Disparities Initiative, particularly the chronic diseases (i.e. cardiovascular disease, diabetes and cancer) develop across a number of years. Based on the type of prevention programs the grantees implemented, it may take many years to see results, such as reductions in mortality.

Although statewide data on the status of health disparities is presented, it is only intended to provide context on the nature, size and trends of the disparities in each health disparity area. It is not intended to document the statewide impact of the initiative.

THE EXEMPLARY PROGRAM PRACTICES MODEL

The methods used to identify and describe exemplary program practices among the EHDI grantees proceeded in three phases: 1) developing the model of exemplary program practices; 2) assessing those practices among the grantees; and 3) describing them through case studies. Each phase is described below.

PHASE I: DEVELOPING THE MODEL OF EXEMPLARY PROGRAM PRACTICES IN HEALTH DISPARITIES

The first question to be addressed was: What is important in building a model or exemplary health disparities program – what qualities or strategies are necessary? Two sources were consulted to answer this question. First, the national literature on health disparities programming efforts was reviewed. From this, a set of 28 criteria was distilled. Second, a panel of 31 Minnesota experts from public health or community health organizations in racial/cultural minority communities was consulted. These professionals participated in a Delphi Study and reported what they thought were the most important values, principles, qualities or approaches that community programs could or should employ to effectively address health disparities. After the second round, a consensus emerged among the experts with the identification of 23 criteria deemed to be important.

The findings from the Delphi study in Minnesota were then compared to three national published studies that had analyzed programming in programs that deal with disparities in health and related outcomes: Schorr's <u>Common Purpose: Strengthening Families and Neighborhoods to Rebuild America</u> , the ASTHO/NACCHO joint study *Health Departments Take Action: Case Studies of State and Local Models Addressing Racial and Ethnic Disparities in Health* and the Sigel study *Addressing Health Disparities in Community Settings: An Analysis of Best Practices in Community-Based Approaches to Ending Disparities in Health Care* commissioned by the Robert Wood Johnson Foundation. The findings from the modified Delphi study echoed those found by the national health disparity studies. There was a relatively high degree of commonalty across models, thus validating the themes that emerged from the Minnesota panel of experts.

The differences between the national lists and the Minnesota lists can be attributed to the type of experts who participated in the Delphi study and the focus of the health disparity initiatives being reviewed. More of Minnesota's experts were program practitioners or managers, whereas the experts polled in

the national studies were academicians, researchers or administrators in government health organizations. As a result, Minnesota's list of characteristics was more practice-oriented, while the national lists were more system-oriented. A number of the national studies cited health disparity efforts focused in healthcare settings and clinics where diverse populations were served. As a result, cultural competence and diversity were emphasized in the national studies. Minnesota's experts identified issues of prevention-oriented culturally-specific efforts in community-based, non-profit organizations and tribes—more reflective of Minnesota's health disparities initiative. As a result, the issues of building on cultural strengths and capacity building were greater emphases among Minnesota's experts.

The combined list of "exemplary practice criteria" derived from the Minnesota experts polled on the Delphi study and the national experts included 24 elements. These elements are a combination of values, philosophies, organizational qualities, management approaches and specific types of interventions. An organizing framework was developed which sorted the characteristics into types: service philosophies or values, organizational qualities or approaches, intervention strategies or programming approaches and resources and supports. A category was also introduced for program outcomes and outcome evaluation, which were components of most of the national studies but were subsumed under "programming is data-driven" by the Minnesota experts. These five categories are not intended to be mutually exclusive, but overlap and interrelate—service philosophies form the basis for organizational approaches, out of which specific intervention strategies can be developed that are supported by resources and then evaluated to demonstrate targeted outcomes.

These criteria or characteristics were then prioritized by the evaluation team for inclusion in the study of Minnesota's health disparity programs. Seven characteristics were removed from the list for a number of reasons: they were judged to be closely related to another characteristic and therefore redundant, some were not operationalizable given the resources for the study, not consistent with how Minnesota's initiative was structured or were conceived to be variables to be measured and described as opposed to being prioritized and rated. The final list of 17 criteria is shown on Table 1 on the following page.

Table 1. EHDI Organizing Framework of 17 Exemplary Program Practice Criteria

A. Exemplary Program Practices in Action	B. Programmatic Results Achieved	C. Capacities Built Among Individuals, Organizations, Communities and Systems
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

The findings from the modified Delphi study echoed those found by the reviewed studies. To illustrate, the Minnesota findings were compared to the three studies mentioned in the literature review section: Schorr's <u>Common Purpose: Strengthening Families and Neighborhoods to Rebuild America</u> and the ASTHO/NACCHO joint study *Health Departments Take Action: Case Studies of State and Local Models Addressing Racial and Ethnic Disparities in Health* and the Sigel study *Addressing Health Disparities in Community Settings: An Analysis of Best Practices in Community-Based Approaches to Ending Disparities in Health Care* commissioned by the Robert Wood Johnson Foundation.

The themes of the "Minnesota Model" were compared against the lists from Schorr, ASTHO/NACCHO and the Robert Wood Johnson Foundation by staff from Rainbow Research. As the number of filled cells on the right hand side of the Table 2 shows, there is a fair degree of commonalty across models. The high degree of overlap is validation for the Minnesota model. The most cross-over is found for Schorr's model, the most general of the models model which was developed to describe effective programs that serve children/families and not specifically health programs. Of the two models specifically developed to describe health disparity programs—ASTHO/NACCHO and Sigel's, there also were many overlaps. There were fewer overlaps for the ASTHO/NACCHO elements which were described as keys to the programs' success, but this model had only five elements—and all of these elements were represented in the Minnesota model.

The Robert Wood Johnson Foundation model developed by Sigel et al (2001/2003) contained fourteen elements, but was a bit different in that it focused in large part on the larger health care environment and systems, including financing, advocacy and provider linkages. The only element that was common to both Sigel and ASTHO/NACCHO, but didn't emerge in the Minnesota model, was the targeting of multiple communities/audiences. Minnesota's themes and the programs funded by the EHDI tend (though not exclusively) to be culturally-specific.

Table 2. Comparison of Minnesota findings with the findings of Schorr, ASTHO/NACCHO and Sigel/Robert Wood Johnson Foundation.

Minnesota Expert Panel	Schorr*	ASTHO / NACCHO*	RWJF*
1. The community is involved in authentic ways	S3	AN3	RWJ13
2. Programming is data-driven	S3, S4	AN4	RWJ13
3. A comprehensive approach is utilized in developing and implementing programming and a comprehensive view of health is taken	S1 S2, S3, S4		RWJ5, RWJ8
4. Recruit participants or deliver services in community settings in which community members feel comfortable.	S8	AN3	RWJ7
5. Trust is established as the foundation for effective services	S7	AN3	
6. Programming builds upon cultural assets and strengths of community	S3, S8, S9	AN4, AN5	RWJ10
7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants	S3, S6, S8	AN5	RWJ10
8. Staff reflect the community being served and/or cultural competence is ensured among those who are delivering services by recruiting community members or training on cultural competency	S3, S6, S7, S8	AN5	RWJ10, RWJ8, RWJ12
9. Innovation is valued	S1, S10		RWJ1
10. Program is able to document strong outcomes or results	S2, S3		
11. Leadership and commitment by staff are in evidence	S5		RWJ1
12. Partnerships are essential to support effective programming	S1	AN1	RWJ5, WJ7
13. Funding and resources are available and leveraged to sustain the efforts			RWJ5
14. Critical staff issues are attended to	S1, S5, S6		
15. Capacities are built in the organization and/or community			RWJ5
16. Challenges are confronted	S1, S10		RWJ1
17. System change is undertaken	S3	AN1	RWJ3, WJ4, RWJ5, WJ7

*The codes refer to the following characteristics/elements of these authors' models:
SCHORR (1997)
S1. Successful programs are comprehensive, flexible, responsive and persevering.
S2. Successful programs see children in the context of their families.
S3. Successful programs deal with families as parts of neighborhoods and communities.
S4. Successful programs have a long-term, preventive orientation, a clear mission and continue to evolve over time.
S5. Successful programs are well managed by competent and committed individuals with clearly identifiable skills.

S6. Staff of successful programs are trained and supported to provide high-quality, responsive services.
S7. Successful programs operate in settings that encourage practitioners to build strong relationships based on mutual trust and respect.
S8. A New Practice and a New Practitioner
S9. A Spiritual Dimension
S10. Success Despite Obstacles to Success

ASTHO/NACCHO (2001)
AN1.   Partnerships with other agencies
AN2.   Multiple target audiences
AN3.   Involving the community
AN4.   Conducting needs assessments
AN5.   Engaging in cultural competency.

Sigel/RWJ (2001/2003)
RWJ1.   Leadership
RWJ2.   Sponsorship by an existing entity
RWJ3.   Strong local provider interest
RWJ4.   Broad indigent care finance systems
RWJ5.   Mobilization and management of a continuum of disease-specific resources in the community.
RWJ6.   One-to-one outreach
RWJ7.   Improving physical access to care
RWJ8.   Focus on multiple determinants of health
RWJ9.   Enlarging the concept of community
RWJ10. Practicing cultural competence
RWJ11. Building formal and informal bridges to the provider community –Fostering volunteerism
RWJ12. Formally seeking community input.
RWJ13. An active role in policy and advocacy

PHASE II. ASSESSING EHDI PROGRAMS FOR EXEMPLARY PROGRAM PRACTICE CRITERIA

The next questions addressed by this study involved how and to what extent the programs funded by Minnesota's Eliminating Health Disparities Initiative embodied the "Exemplary Practice Criteria" outlined in Table 1. Phase II involved developing a set of data collection tools and measures to assess the EHDI grantees on these characteristics, collecting and compiling the data and then rating the programs for these characteristics. The measures that were developed were intended to elicit descriptive information from the grantees related to that characteristic.

Data Collection and Compilation
Four sources of data were compiled to assemble the information for the Model Program Characteristics:

1. Annual Evaluation Reports

Grantees submit an annual report to the Minnesota Department of Health detailing their program outputs, outcome evaluation results, challenges encountered, thoughts and recommendations. Grantees attend an annual training workshop where they are provided instruction and training for completing the annual report and submitting it using the online system developed by Rainbow for this purpose. Grantees are given technical assistance and support by Rainbow consultants to complete these reports. These reports were reviewed by Rainbow consultants and the OMMH Grant Managers who provide feedback to strengthen the report and improve evaluation methods for subsequent reports. Annual Evaluation reports from December of 2006 were used to assess the strength of their outcome evaluation results.

2. Evaluation Capacity Ratings

Grantees' capacities for conducting evaluation were rated based on their 2005 and 2006 evaluation report by a team of grant managers, researchers and evaluators. Each grantee's outcome evaluation was rated on eight objective criteria by a panel of three researchers. The objective criteria included: 1) outcomes stated as a change that will benefit the participant, community or systems; 2) outcomes state the intended beneficiary; 3) each outcome only encompasses one type of change; 4) outcomes are stated in the present tense; 5) outcomes are measurable, 6) indicators reflect changes targeted in outcome statement; 7) results are consistent with identified indicators; and 8) results are clearly interpreted in terms of what they mean about the outcomes. Points were then assigned and summed. Grantees were subsequently provided this feedback to improve their outcome evaluations and reporting and later reassessed.

3. Telephone Interviews

Hour-long, mostly qualitative interviews were conducted with program coordinators. The interview guide was developed by Rainbow staff to elicit information from the grantees on the degree to which and how they utilized the seventeen exemplary program practices. The interview questions were pilot-tested with staff of two other culturally-based programs not in the grantee pool. A set of interviewers was assembled and trained on the interview protocol. One of the interviewers was fluent in Spanish and conducted interviews with grantee program coordinators whose first language was Spanish. The other interviews were conducted in English. The responses of the grantee coordinators were recorded in intensive notes made by the interviewers and backed up, in most cases, with audio recordings, for

transcription if necessary. The notes were then entered into the computer as text narrative. The results were content analyzed for themes and summarized. Forty-six grantees completed the interview in May and June of 2007

4. Online Survey

Grantee coordinators were also asked to complete a self-administered survey online (using SurveyMonkey.com). This survey included a number of mostly close-ended questions including checklists about types of program services, descriptions of program staff characteristics, training opportunities in which staff had engaged, number and type of partnering organizations and histories of leveraging funds. The survey was conducted with 48 grantees in June 2007.

A data set of both qualitative and quantitative information was developed based on information provided by all grantees for each of the Exemplary Practice Criteria. Complete data from all five of these sources was available for 41 of the 52 grantees. Some information was missing for eight grantees and the majority of information was missing for three grantees (tribal grantees, for which evaluation activities were optional). These latter three grantees were excluded from the review process.

Rating Process

The next phase involved developing a process whereby each grantee would be rated on each of the 17 Exemplary Program Practice Criteria. This rating process was aimed at identifying exemplary practice criteria – practices that were rated as innovative, likely to be effective and exemplifying the "spirit of the model program criteria."

A set of rating criteria were developed for each Exemplary Program Criteria which specified how raters were to evaluate each criterion, based on the qualitative and quantitative data assembled in the previous step. Since the primary purpose was to differentiate exemplary programs and practices, the scale for most of the rating criteria was a three point scale—low, moderate or high. See the appendix for a complete description of the exemplary program practices and their measurement.

Four teams consisting of three to four persons were assembled. Each team had a public health researcher, an EHDI grant manager and an evaluator and most teams also included a student intern. Two out of four members of each team had a relatively high degree of familiarity with the EHDI Program. The raters were a racially/culturally diverse group—three quarters were members

of communities of color. Each team was given four criteria to rate for each grantee. An additional team was formed of grant managers who provided "expert judgment" ratings on the criteria for each of the dozen grantees they oversee. The grant managers' familiarity with the grantees was intended to help correct for differences in the ability of the grantees to articulate in writing or verbally on the surveys, interview and reports. Each grantee, therefore, was rated by at least four raters for each criterion.

Table 3 Participation by the population of 52 EHDI grantees in initiative evaluation data collection.

	Number of grantees N=52	Percent of grantees	Information/constructs reviewed from this source
Completed online evaluation report, 2006; reported outcome data	46	88%	Outcome evaluation results; program description/cultural strengths; systems changes
Participated in interview	46	88%	History of program development; community involvement, trust building strategies; recruitment/service strategies; linguistic issues; cultural strengths; challenges confronted; comprehensive service strategies; perceived impacts, outcomes and system engagement; use of data/evaluation
Participated in online survey	48	92%	Type of strategies used, partnerships; staffing configuration and diversity information; leveraging
Were rated for evaluation capacity in 2005 & 2006	50	96%	Evaluation capacity
Number of grantees excluded from rating process due to missing data	3	6%	Lacking 2006 evaluation report, interview and online survey

Raters attended a training session where they received instructions on rating grantees on their assigned criteria. They participated in a practice rating exercise with a discussion of the results where differences in interpretation of how to apply the rating criteria were resolved. The initial inter-rater reliability from this practice session was between 50 and 60 percent agreement prior to resolving differences on most criteria. Based on the shared understanding of the criteria, the rating teams then proceeded to complete the

ratings on their own across a two-week period. The data from the teams was compiled in a spreadsheet and examined by the team for discrepant ratings (ratings in which a spread of two points was evident, e.g. someone gave a zero and someone gave a two). The teams talked through their differences in perceptions and adjusted ratings in about a third of the cases, in the other third, they agreed to differ.

Compilation and Analyses of Data

The final scores given to grantees were calculated as a percentage—the percent of possible points on each characteristic, based on the number of scores given. For instance, if there were three raters, providing ratings on two criteria for a characteristic, there were six possible scores and with a range of 0 to two for each, the total possible score was 12 for the grantee for that characteristic. If the grantee's obtained score was 9, then the final score was 75 percent (9 out of 12).   Most criteria had 14 possible scores, including the grant managers' expert judgment score which was up weighted. Scores were not calculated for the three grantees for whom a majority of data was missing.

Reliability of the scores was assessed in terms of inter-rater reliability and internal consistency of the scoring components of each criterion. The inter-rater reliability scores (ICC's) on the final set of scores assigned by the raters ranged from 0.36 to 0.85. Each criterion was also assessed for internal consistency—how well the components of the total score for each criterion "hung together" in terms of correlation. These scores (Cronbach's alpha's) ranged from 0.56 to 0.85. The reliability coefficients for each criteria area shown in Table 4.

Summary of Rating Results

The rating of how well grantees utilized the exemplary program practice criteria generates information on the areas in which the grantees are strongest and weakest. This information is presented in Table 5 following. As this table shows, grantees were strongest on "program based in culture and strengths of the community"—the average score earned by grantees was 77 percent of the possible points. The second ranked criterion was "staff reflects the community," on which grantees earned 75 percent of possible points on average. Third, was "recruitment and services are provided in settings in which community members feel comfortable" in which the average percent of possible points earned was 75 percent. Fourth ranked was "trust was the foundation of services," of which the grantees earned 70 percent of possible points on average. Fifth strongest was "deliver services or information that are

culturally or linguistically accessible for the participants" for which grantees earned 65 percent on average.

It is not surprising that the EHDI grantees scored relatively high on many of these criteria – they were, after all, selected for funding because they put forward strong program plans that utilized strengths of their culture and communities and many if not most were community-based, grassroots organizations with close ties to the community and to other organizations working in the community.   Had the EHDI grantee pool been comprised differently, such as health care providers that serve diverse populations – as characterized other health disparities initiatives – the results on these criteria would likely have been very different. The aggregated rankings of the criteria are informative, as they suggest the areas in which EHDI grantees as a whole are particularly strong and weak. The ordering of criteria, based on percent of possible points (average value) across grantees is shown in Table 4.

Table 4. Reliability coefficients for each of the 17 model program criteria.

Construct	# Scoring components	Inter rater reliability	Internal reliability
1. The community is involved in authentic ways	3	.813	.819
2. Programming is data-driven	3	.718	.776
3. A comprehensive approach is utilized in developing and implementing programming: service provided across time and/or with follow-up contacts/work	3	.387	.647
4. Recruitment strategies geared to overcoming barriers & services provided in places comfortable to community	3	.845	.850
5. Trust is established as the foundation for effective services	4	.609	.654
6. Programming builds upon cultural assets and strengths of community	3	.671	.689
7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants	1	N/A	N/A
8. Staff reflect community being served; and or cultural competence is ensured among those who are delivering services	1	N/A	N/A
9. Program model or components are innovative	3	.774	.782
10. Program is able to document strong evaluation outcomes or results	3	.544	.567
11. Programs/ staff exercising leadership in their community	3	.541	.773

12. Partnerships are essential to support effective programming	2	.360	.639
13. Funding and resources are available and leveraged to sustain the efforts	1	N/A	N/A
14. Critical staff issues attended to	2	.721	.772
15. Capacities are built in the organization and/or community	2	.768	.808
16. Challenges are confronted	3	.795	.796
17. Internal or external systems change is undertaken	3	.418	.644
Total Score	**40/38**	**.685**	**.812**

The criteria on which the group of programs rank lower on aggregate may reflect areas that received relatively little investment and need strengthening, such as focusing on systems change, building of organizational or community capacities and leveraging resources. The criteria on which grantees were least well ranked – capacities built in organization and community and internal/external systems changes were also the most difficult questions for the grantee coordinators to answer.

Table 5. Ranking of Exemplary Program Practices Across EHDI Grantees.

Ranking	Exemplary Program Practice	Percent of Possible Points (Mean Value)
1	Program based in strengths of the culture/community	77%
2	Staff reflect the community	75%
3	Recruitment/services provided so that community members feel comfortable	75%
4	Trust established as a foundation for services	70%
5	Linguistically appropriate services	65%
6	Comprehensive services/services provided across time	65%
7	Leadership evident among staff	65%
8	Authentic community involvement	64%
9	Innovative partnerships	64%
10	Challenges are confronted	63%
11	Critical staff issues are attended to	62%
12	Strong evaluation results are obtained	60%
13	Programs are innovative	60%

14	Programs are data-driven	57%
15	Successful leveraging	50%
16	Capacities built in organization/community	49%
17	Internal/external systems change	33%

PHASE III. DESCRIBING EXEMPLARY PROGRAM PRACTICES IN ACTION

The purpose of this process of reviewing and rating EHDI programs was to gather data and utilize a panel of 'experts' to assess to what degree the programs were implementing or embodying the exemplary practice characteristics delineated by the Delphi experts and the national literature on health disparity programming.   This allows the exemplary program practices to be described as they are being implemented across diverse communities, addressing different health disparities. The description of these practices as implemented by EHDI grantees provides useful information for other efforts working to address health disparities. It is also useful information for funders in the public health realm to understand how to structure funding initiatives that support best practices.

As noted, the information from the four data sources was compiled into a set of databases. The information included in the datasets was the responses from the grantee coordinators, many of which were in narrative form to the open-ended, qualitative questions. Questions were content analyzed and coded to provide a summary of the patterns of responses. The data are presented in a series of reports, as described below. The structure of these reports is to take each exemplary program practice, define it, describe how it is being implemented across different populations and health disparity areas and provide spotlights in the grantees' words of how and why they are using these approaches and to what effect.

Report 3: "Exemplary Program Practices in Action" provides a description of how the EHDI grantees are utilizing the first nine exemplary program practices (focused on the philosophies underlying the services and approaches) to develop their programs, recruit and engage participants and to provide services.

Report 4: "Programmatic Results Achieved" documents the evaluation results achieved by grantees in terms of the reach of the programs – numbers served and demographics of participant populations. Exemplary practice number ten is the focus of this report: "program is able to document strong outcomes or results." The report also describes the evaluation capacities built among the

grantee programs and spotlights outcomes documented by the grantees through their evaluations.

Report 5: "Building Capacities among Individuals, Organizations, Communities and Systems" examines the final seven exemplary program practices that focus on how the grantee organizations are building capacities among individuals (staff and program participants) within their organization and in their communities. It also documents how grantees are catalyzing change within greater systems—creating a "ripple" effect among individuals, communities and larger systems.

Report 6: "Case Studies" describes how high performing grantees—grantees rated high on multiple exemplary program practices—developed their programs to embody these philosophies, values and practices and how they approached their work in the community and larger systems.

CONCLUSIONS

This report outlines the framework for a model of "best practices" for health disparities programs. This model utilized the growing literature on "best practices" in health disparities programming. Along with this, thirty-one experts working in a variety of capacities in Minnesota's communities of color and/or American Indian communities were consulted to suggest a set of criteria that describe characteristics or approaches of successful programs to reduce/eliminate health disparities.

These exemplary program practice characteristics are a combination of values and philosophies of service, organizational qualities and processes and specific types of strategies such as community education and cultural navigation. They are characteristics that could be construed as "internal" as well as "external" to the programs – although this model makes it clear that the best programs are more organic in nature and integrate the community authentically into the development, leadership and day-to-day operation of the programs. Relationships based on trust, authentic community involvement and partnerships are a critical factor in the effectiveness of these programs.

Another important aspect of this model is that "culture" is not a training afterthought or "add-on module"—it is, in fact, at the core of the program's values, inception, development and operation. While culture is explicitly referred to in a quarter of these criteria, it is implicit in at least half of them in references to "reflecting the community" and to concepts which are very culturally bound such as comprehensiveness, leadership and comfort-level.

One of the surprising findings is that relatively few of these "exemplary program practices" involved specific program models or strategies. Surprising because there is a current emphasis (particularly by federal funders) on adoption of and fidelity to existing well-validated program models published in the literature. None of the Minnesota experts recommended specific programs as published in the registries of effective programs. In fact, very few specific strategies were cited. The few that were cited were more generic strategies such as community health worker models, cultural navigation models and community education/health promotion. As a result, the seventeen exemplary program practices in the model represent more of a blueprint for a *process* of developing effective health disparities programs –with culture and community the central organizing theme.

The characteristics that emerged from the Minnesota panel of experts show a high degree of convergence with those found by other researchers, particularly those working in the field of health disparities. This suggests that the criteria are valid and robust indicators of quality programming and lends support for their use in selecting programs for the in-depth case studies.

The seventeen exemplary program practices were operationalized with data collected to demonstrate the extent they are embodied in EHDI programs. The evaluation findings document the outcomes of the EHDI programs – after six years of operation the grantees are making inroads in terms of changes in individuals and communities as well as making changes in systems and building capacities among participants, staff, organizations and partners. The subsequent reports provide descriptive detail on how grantees are carrying out these exemplary program practices and the impact of their work.

Appendix: Defining and Measuring the Exemplary Practice Criteria

A. Culture-based Service Philosophies & Practices

Service philosophies or practices refers to beliefs or values held by an organization or a philosophy an organization subscribes to regarding how best to serve their target population and get results, and how they put those beliefs, values and practices into practice in structuring their program, activities they undertake, or values embedded in their service approaches.

1. The community is involved in authentic ways

The Delphi experts described a model health disparities program as one that works to engage the community from the very beginning in the process of defining the problem, creating solutions, implementing the solutions and assessing outcomes. "Authentic involvement" means forming collaborations with community members/agencies not just in symbolic or token ways, but valuing and considering their input.

In order to get a sense of how this played out among EHDI grantee organizations, grantees were asked how their programs were initially developed and who was involved in that process. They were specifically asked about the role community members played in the development of the program. They were also asked about ongoing involvement of community members in the program—whether the program has some type of community or advisory group that regularly provide input into their EHDI program and if so, what type of people (e.g. staff, elders, community members, or clients, etc) are involved. Grantees described the role played by community advisory members and the level of influence the group had over the program. Program Coordinators were asked to cite examples where suggestions by community members played a part in shaping or changing their EHDI Program.

2. Programming is data-driven

Delphi experts talked about how model health disparity programs utilize information and data to make decisions about their program. This includes both the initial program development and how decisions are made about changing/modifying the program once it is developed. The type of information might vary, depending on what is available and most useful—official statistics, data collected systematically from the community through focus groups, surveys, interviews, observation or

chart reviews. Less formal mechanisms for input from participants, clients or advisory groups or observations of patterns of problems or issues are also types of data that influence decisions. In general, the "closer" the data is to the community being served, the better; locally collected data might be more valuable than national statistics, in some cases.

Grantees were asked whether data was initially used to develop the program, the type of data that was used and how it was collected. They were also asked whether evaluation data were used to improve the program or communicated to stakeholders. Reviewers rated each grantee on these criteria.

3. A comprehensive approach is utilized in developing and implementing programming: service provided across time and/or with follow-up contacts/work

A model health disparities program should provide services that span a length of time – how long will depend upon the type of issue being addressed and outcome sought. Best practices suggest that single-encounters or services of short duration are less effective in producing lasting change or impact. The Delphi experts suggested that services that are more comprehensive in nature and follow clients across time are more likely to result in the effective prevention and/or treatment of a health issue.

Grantees were asked to describe the services or activities they provide to community members and the length of time that they typically worked with participants. They were also queried about the types (if any) of follow-up or additional contact with participants. Raters scored programs more highly if they worked with people over a longer or ongoing period of time, compared to short-time periods or single encounters. They were also scored more highly if a program maintained contact with participants after the initial period of service, or if follow-up sessions were employed.

4. Recruit participants or deliver services in community settings in which community members feel comfortable

Model health disparities programs utilize a comprehensive range of outreach, recruitment and service strategies geared to overcoming barriers for and making participants/clients feel comfortable. In contrast to mainstream programs, health disparity programs might engage in outreach and recruitment strategies and provide services in community-based settings, such as homes, community agencies/centers,

or at events. Not all services (e.g. clinical services) can be provided in these settings, so there might be other ways such services are geared to make participants feel comfortable and welcomed.

Grantees were asked a series of questions about how they recruit participants; why those strategies were selected; the locations where services were provided and why those settings were chosen. They were rated on the extent to which recruitment or outreach strategies were developed to overcome barriers to reaching the community and the extent to which the type of settings in which services were provided was geared to overcoming barriers to participation and helping make participants feel comfortable.

5. Trust is established as the foundation for effective services

A model health disparities program and their service providers work to establish rapport and trusting relationships with community members and their leaders. Community members are more likely to accept what programs have to offer, fully participate and make any consequent changes in their lives when they feel like the program/ organization understands them, their life situations and the community to which they belong. Programs often have to overcome barriers to trust among community members that are based in historical factors and/or institutionalized racism, or involve the type of services being provided or sought (e.g. HIV, violence-related). Programs might build trust through a combination of approaches—how the program is staffed or structured, leadership in the program, where the services are provided and how the providers approach and deal with participants or clients to build a relationship, rapport and trust.

In order to assess how and the extent to which EHDI grantees worked to establish trust with their participants or clients, each program coordinator was asked to describe potential barriers for mainstream organizations to establishing trust with community members, whether their program faced barriers to establishing trust, and how their program worked to build trust between participants and the program. They were also asked to provide concrete examples from the first meetings with clients or participants on how they build trust. This information was then assessed by the team of raters for evidence of three factors 1) barriers existed; 2) the program structured their program services in some way to overcome barriers and build trust; and 3) the staff worked to build relationships with the participants/clients.

6. Programming builds upon cultural assets and strengths of community

The Delphi experts described model health disparity programs as building or capitalizing on cultural values or practices of the community, strengths or assets of individuals, institutions, or patterns of relationships in the community **and** incorporating them into programming. This might involve delivering culturally and linguistically appropriate services, using program materials in the languages of the populations being served, promoting cultural values and traditional practices that promote health, helping to build strong, positive identities that help build resilience, and/or employing interventions that allow for creative uses of community assets that draw on and connect people from the community. For example, strong, healthy and extensive relationships in the community often lead to change. A model program might make use of these relationships to recruit participants, or disseminate health promotion messages, or might seek to strengthen such relationships. As another example, programs might be involve strong, trusted institutions in the community, such as churches, to reach community members.

In order to assess how and the extent to which EHDI grantees embodied this practice, the program coordinator or spokesperson was asked to describe how their program builds on cultural strengths of their community and provide examples of the ways their staff or service providers work with clients or participants in culturally-supportive ways. This information was then assessed for evidence that programs demonstrated the cultural base and supportiveness.

7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants

An essential quality of effective health disparities programming is that education is provided that utilizes culturally-specific and effective teaching methods and uses a medium of instruction and educational materials that are in the language of the populations being served.

Grantees were asked what languages were spoken by their participants or clientele and whether services were provided in those languages. Points were awarded if there was a high degree of linguistic match between participants and service capabilities. Two-thirds of the EHDI programs had near total coverage for services in the needed languages in those programs. Programs that served a relatively diverse mix of clients in terms of first languages may have lost points on this criterion,

since it is difficult to have service providers on staff to accommodate three or more languages.

8. Staff reflect community being served; and/or cultural competence is ensured among those who are delivering services

This criterion relates to the cultural competency of the health disparity program staff. It means hiring staff that live and work in the community being targeted by the program. Programs reach targeted communities faster when health workers or spokespersons are from the community, because the credibility of the messenger is already established. These individuals have a natural bond with the community and know how to relate to community members. If the staff or providers of services are not members of the community, model programs then hire for cultural competent staff and support them through training.

The grantees were asked about the number of staff, contract or consultant workers, and volunteers who provide services within their EHDI program and the extent to which these people reflected the racial/cultural community targeted by the program. Raters gave the highest rating to grantees whose programs were staffed with a majority of persons from the communities being served.

9. Program model or components are innovative

Model health disparity programs demonstrate innovation or unique approaches to addressing their health disparities. According to the Delphi experts polled, successful health disparity programs willingly challenge mainstream ways, including cultural norms that lead to unhealthy habits in their communities. They are willing to take risks, try new, different and untested ways to improve people's lives, and persevere in anticipation of, or in the midst of failure. These innovative qualities or approaches might focus on outreach, recruitment or service strategies, or might focus on some type of culturally-based service offered that other programs addressing similar issues do not utilize. Another aspect of innovation might involve the types of partnerships developed or sectors worked with on a regular basis. Uniqueness as a characteristic might reflect the fact that the program is alone in providing a particular service to a particular community, or is providing a service in a one-of-a-kind way. Innovative programs are also willing to engage their communities in discussions of sensitive issues (such as domestic violence) and raise these issues to a new level of visibility. An example would be the issue of mental health in the Asian and Pacific Islander community—an issue that exists but is generally avoided and seldom treated due to its stigma.

Grantees were asked about how their overall program is innovative, as well as how specific components or activities of their EHDI program (recruitment, program workshops, etc.) were innovative, unique or special. Raters scored the results based on the degree to which they felt the programs and components were highly innovative and/or unique.

B. PROGRAMMATIC RESULTS ACHIEVED

10.   Program is able to document strong outcomes or results

A model program health disparities program is able to define the intended outcomes and impacts in terms of benefits to the participants and community, has a strong evaluation component to document these outcomes, and shows measurable progress towards reaching the intended outcomes.   EHDI grantees received training and individualized consulting from Rainbow Research for five years and in turn are expected to develop and implement their own outcome evaluation studies. Grantees, with the exception of tribes, are required to report their outcome evaluation results on an annual basis.

Many grantees implemented solid outcome evaluation protocol and generated a strong and convincing base of results. Other grantees had less success implementing their evaluations – as a result of staff turnover or other issues. This criterion, therefore, was intended to capture the impacts grantees feel they are achieving against the strength of the results generated and the capabilities to conduct evaluation. Four components were rated for this criterion: 1) Grantees' perceptions of benefits of the EHDI program; 2) Demonstrated, measurable outcomes, based on review of the grantee's reported outcome evaluation results in their 2006 report; 3) Evaluation capacities demonstrated in 2006 report, based on agreement between evaluation consultant and grant manager; and 4) Evaluation capacities demonstrated in 2005 report based on review by a team of researchers.

C. CAPACITIES BUILT AMONG INDIVIDUALS, ORGANIZATIONS, COMMUNITIES AND SYSTEMS

11. Leadership and commitment by staff are in evidence

One of the goals of the EHDI Initiative was to develop a range of capacities in the communities. Solid program leadership is a critical capacity. Staff from a model health disparity program should be exercising leadership in their community. This leadership may take many different forms: educating the community about health issues; working with other groups, agencies or institutions on their health issue; bringing attention to the issue of health disparities in their community; developing new approaches to addressing health disparities and helping their community; or advocating on behalf of their community. There may be more subtle forms or manifestations of leadership as well, such as being the "go to" person in a particular community for some issue or service, or being seen or respected as a leader in a particular area.

A series of questions about leadership activities was included in the grantee interview. These questions asked coordinators about presentations they have given in the community or to professional groups, their staff's involvement with other groups addressing the same health issues, recognition they received from external groups or organizations for their EHDI work (such as an award or being written about or highlighted in newspapers or other publications), communication they have had with policy makers (such as legislators or representatives, city council, or tribal council people) about their EHDI project, and other ways their EHDI program staff have been seen or treated as a leader in their community as a result of their EHDI work. Grantees were scored on the breadth of the leadership activities they engaged in, and the depth of their leadership experience, in terms of the actual leadership role they played in the activities cited.

12. Partnerships are essential to support effective programming

Delphi experts described the importance of working with other individuals, agencies and institutions to effectively deliver health services – in other words, partnerships. Partnerships may include the larger health care system, the social service system, or organizations from other sectors of the community, including faith-based, business, government agencies. Establishing partnerships across a broader spectrum of the community and service networks allows programs to

leverage support and services in their efforts to assist clients overcome barriers.

Grantees were asked to provide a list of up to ten agencies they partnered with, identify each partner's sector (e.g. health care, social services, business), describe what how partner was involved and their role, classify whether the partner played a major or minor role in their EHDI program and describe the overall contributions of each partner. Raters scored each grantee on the number of partners cited, the innovativeness of the relationships and on the overall importance of the partners to the program.

13.   Funding and resources are available and leveraged to sustain the efforts

Model health disparity programs have consistent long-term funding commitments to address health disparities and leverage resources, both dollars and in-kind support to help sustain and grow their programs.

Grantees were asked about their efforts and success at leveraging resources. They were asked whether they had other sources of funds in addition to EHDI funding, and if so, the sources and amounts of those funds. If they only had EHDI funds, they were asked whether they had sought other funding. They were also asked whether they had received in-kind support or resources, and, if so, what and from whom. Raters gave points to grantees that had sought and secured other funding and in-kind resources.

14.   Staff issues are attended to; Training and technical assistance are available for capacity building.

A model health disparity program addresses critical staff issues by recruiting qualified staff (qualified in the sense they can do the job and work effectively with the community), retaining and supporting staff. This can be particularly challenging in the EHDI communities because organizations are often under-funded and staff is stretched to capacity. The work can be difficult and emotional as staff members help people facing life threatening illnesses and other challenges. Secondly, because fewer members of EHDI target communities have advanced formal education, finding and keeping credentialed staff able to work effectively with the community is difficult. Lastly, staff that reflect the community being served are often impacted by the same barriers and challenges related to economics, logistics (e.g. transportation) and competing needs and stresses that the clients face.

A model health disparities program has a range of support mechanisms to keep and retain staff in the face of these challenges. Other criteria considered included their level of staff turnover and the amount and type of staff training offered. The scoring for this item is based on what the grantees reported they did to support and retain their staff members in the face of program demands and emotional stresses that sometimes were difficult to endure.

15. Capacities are built in the organization and/or community

One of the goals of the EHDI was to develop a range of capacities in the communities. EHDI Programs may impact their own organization by adding or developing new skills, services, or resources, or by providing access to a particular community or population not previously served. Partnerships built through EHDI Programs may also have benefited the larger organization in some way. Programs might also develop new evaluation, reporting, technical resources or financial capacities that are transferred to the larger organization. The range of capacities that may have been developed is likely to be wide, so no particular type of capacity was targeted here.

To assess capacities built, program coordinators were asked to list and describe the organizational capacities that were built as a result of the EHDI program. Many grantees had a difficult time with these questions. This may be due to their focus on programming rather than larger capacity issues, or due in part to the difficulty of thinking in terms of "capacities." Grant managers were also queried about this practice. Their responses provided another perspective and helped the reviewers as they considered the grantees' responses. Scoring was determined by both the quantity and significance of the capacities built.

16. Challenges are confronted

One of the characteristics cited by the panel of Delphi experts of a model health disparity program was that program or organizational challenges were confronted and innovative solutions were developed and employed to address challenges. This characteristic was echoed by many other sources in the literature. Clearly, many of the EHDI health disparity programs are forging new ground in their community or field and face a range of challenges – from reaching/working with clients, helping to overcome barriers to service, encountering cultural norms or stigmas, dealing with organizational challenges involving finances, staffing, etc., as well as facing community issues related to turf and politics. Encountering multiple challenges should not regarded as an indicator of

performance, rather, it is the solutions and strategies developed and employed to deal with difficult problems that determine the program's effectiveness.

Grantees were asked to cite examples of programmatic challenges they faced in the past two or three years and describe how they dealt with them. They were also asked about whether they made significant changes to their program, based on challenges faced, feedback or other information received. Raters were asked to assess the extent to which grantees' cited challenges, how they addressed the challenges and whether growth or change was evident. They were also asked to assess whether the program appeared to be growing or learning in response to lessons learned along the way.

17. Systems change is undertaken

One of the model program characteristics cited by the Delphi expert panel was that model programs "engage" the system. We know from the IOM report and broader experience that the health care system and other systems often perpetuate health disparities by providing unequal care and other forms of institutional racism. Therefore, model health disparity programs should be actively engaging larger systems and working towards systems change. Examples of this "engagement" might be forging new partnerships and relationships across sectors, or encouraging the healthcare sector to recognize and/or subsequently change the way they do things.

The concept of evaluating systems change was introduced to grantees in the summer of 2006. They were encouraged to begin thinking about how their work was impacting systems. Reviewers and experts were asked to consider the work of the grantees in terms of what they accomplished, who they worked with and whether their work engaged and/or changed larger systems. Scoring for this characteristic was based on two sets of information. Grantees were asked whether they thought their EHDI program had any impact on the systems with which they work (i.e. schools, health care systems, correctional systems, etc.). Points were given if strong examples of systems change were cited. Raters also looked at the grantee's outcome statements and awarded points to the grantee if they were evaluating systems change outcomes.

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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