

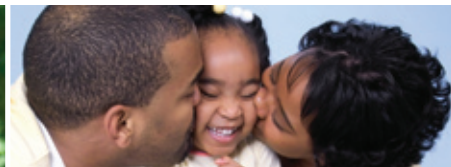
Eliminating Health Disparities Initiative

Report to the Legislature
January 2009



*Of all the forms of inequality, injustice in health care
is the most shocking and inhumane.*

– Martin Luther King, Jr.



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TABLE OF CONTENTS



I. Introduction	7
II: Description of EHDl	10
EHDl Framework	10
III. Outcomes	17
EHDl Goal 1	17
EHDl Goal 2	20
Grantee Outcomes	22
VI. Capacity Building	26
V. Conclusion and Recommendations.	30

Due to their length, the appendices referenced in this report appear in a separate volume titled “Eliminating Health Disparities Initiative 2009 Legislative Report: Appendices.” This companion report is available at www.health.state.mn.us/omh/publications/index.html.

Appendix A: EHDl Grantee Descriptions

Grantee Summary by Health Priority Area

Appendix B: Selected Grantee Outcomes by Health Area

Breast and Cervical Cancer

Cardiovascular Disease and Diabetes

Healthy Youth Development

HIV/AIDS and Sexually Transmitted Infections

Child and Adult Immunizations

Infant Mortality

Violence and Unintentional Injury

Appendix C: Other Health Priority Areas – Rates and Disparities

Appendix D: Eliminating Health Disparities Initiative Legislation

Appendix E: Counties Served by EHDl Grantees



EXECUTIVE SUMMARY

Minnesota is one of the healthiest states in the nation. On a variety of indicators, from insurance status to life expectancy to the overall quality of care available from healthcare providers, Minnesota ranks near the top among all states. But Minnesota also has some of the greatest disparities in health status and incidence of chronic disease between Populations of Color / American Indians and Whites.

In 2001, the Minnesota Legislature passed landmark legislation to address these persistent disparities, the Eliminating Health Disparities Initiative (EHD). In the most recent biennium, the EHD program awarded a total of \$10.4 million in competitive grants to local programs and projects statewide, challenging them to develop effective strategies and solutions for eliminating disparities in seven health priority areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STI's, immunization, infant mortality and violence and unintentional injuries. In addition, \$500,000 went to support tuberculosis programs for foreign-born persons through local public health agencies. Federal TANF funds were also directed to address disparities in the area of healthy youth development through the EHD. Healthy youth development is included as one of the eight health priority areas discussed in this report.

For two priority areas, infant mortality and immunization, the EHD statute provides a target of a 50 percent reduction in the magnitude of the disparity by 2010. A goal to reduce disparities in five other health priority areas is also included in the statute. Since the inception of the program, measurable and substantial progress has been achieved in many of these areas. Specifically:

- Infant mortality rates have declined for all population groups with decreases in disparities in infant mortality rates ranging from 26.3 percent to 75.0 percent for Populations of Color and American Indians.
- Disparities in gonorrheal incidence have decreased for American Indians (25.7 percent), African Americans/Africans (26.7 percent), and Hispanics (32.5 percent); although gonorrheal incidence remains an issue, disparities for Asians have been eliminated.
- Disparities in heart disease mortality rates have decreased for African Americans/Africans by 94.3 percent and while heart disease remains an issue for Asians and Hispanics, no disparities exist.
- Disparities in new HIV infections have decreased for American Indians by 51.8 percent.
- Disparities in homicide mortality have decreased for racial/ethnic groups ranging from 6.8 percent for American Indians to 48.3 percent for African Americans/Africans.
- Disparities in cervical cancer incidence have decreased for Asians (32.9 percent) and African Americans/Africans (54.2 percent).

However, we have not yet met all of the goals that were set out under the law. Specifically, while infant mortality disparities were substantially reduced for all Populations of Color and

American Indians, the goal of a 50 percent reduction was only met for Asians and Hispanics. In the area of immunization, the discontinuation of the Minnesota Kindergarten Retrospective Survey means that data are not available to assess progress in eliminating disparities, and Minnesota-specific data on adult immunization is also limited. In the other priority areas, of the 45 indicators that were measurable, 23 indicators have shown improvement, five of the indicators show that disparities have been eliminated, one indicator shows no change, six have gotten worse and 10 had no disparity in either the baseline or current period.

The mission of the EHDI program is to achieve sustainable statewide reductions in disparity levels in each priority area by allowing communities to build on their strengths and values and develop effective solutions to pressing health problems. Beyond the direct service provided by grantees, the EHDI grant program is a tool to support capacity-building in organizations and communities by fostering partnerships, supporting organizational development and leveraging resources. At the individual and community level, the EHDI program and its grantees have realized a number of successes that lay the groundwork for additional improvements in statewide rates:

- Directly serving over 37,000 members of racial/ethnic communities in 2007, with an additional 140,000 reached through community events such as health fairs.
- Increasing rates of early and prenatal care, increasing the number of community members who receive preventive health screenings such as cancer screenings, blood pressure, cholesterol and blood glucose checks, decreasing high-risk sexual behaviors and teen pregnancy, and reducing recidivism rates among perpetrators of domestic violence.
- Changing educational programming in local school districts, including the development of new curricula based on community needs and knowledge of effective strategies.
- 28 grantees have used EHDI grants to leverage three million dollars in additional funding from foundations, corporations, and government entities. Forty grantees have leveraged in-kind or non-monetary resources such as supplies, staff, and office space.

The EHDI program has been successful in accomplishing what many health organizations and providers have long had difficulty doing; effectively reaching out to and serving People of Color and American Indians and making positive health status changes in underserved communities. It has also helped to nurture promising approaches that can be used as models for other organizations or communities, and has improved our understanding of the dynamics of this complex issue. However, the initiative's focus on individual and small-community level change has, by necessity, limited its ability to impact broader systems changes, and the work of individual grantees is unable to reach all populations at risk. Additionally, a lack of reliable statewide data on Populations of Color and American Indians has made it difficult to comprehensively measure progress towards certain goals.

Despite the substantial improvements in health status and disparities that have been achieved since EHDI began, stark differences remain between health status, life expectancy, and quality of life for Populations of Color and American Indians compared with Whites. As Minnesota's population continues to become more diverse, our sense of urgency around this issue must also increase.

In order to meet the goal of eliminating health disparities statewide in each of the health priority areas, MDH will need to take several important steps to ensure that the EHDl program is as effective as possible in addressing this complex issue, and that we improve our ability to measure our progress. We are proud of the work accomplished to date and will move the Initiative from Version 1.0 to Version 2.0 by:

- *Maximizing the investment in EHDl by integrating strategies for eliminating health disparities into MDH programs, as well as coordinating and collaborating with other health promotion efforts and a range of state agencies, local public health, and other institutions.*
- *Developing policies and programs to address the environmental factors that contribute to poor health and health disparities.*
- *Improving data collection efforts toward common goals so that high-quality, reliable statewide data is available for the evaluation of EHDl outcomes and to hold the initiative accountable.*
- *Expanding and replicating innovative programs that systematically and sustainably reach as many people as possible and that work for Populations of Color and American Indians.*
- *Expanding the focus of the EHDl to explore and address policies and systems that impact health disparities to create sustainable change.*
- *Exploring how to increase social capital as part of the work in eliminating health disparities as the demographics of Minnesota diversify, so we embrace our rich cultural and ethnic heritage now and into the future.*

The next phase of the EHDl will focus on building on the gains that have been made in eliminating disparities while expanding our work at the system and policy level. In this way, we can move more rapidly towards the goal of eliminating health disparities for all Minnesotans.

INTRODUCTION



Life expectancy and overall health have shown substantial improvements in recent years as a result of a number of factors including a focus on prevention and advancements in medical technology. However, not all populations have benefitted from these changes.

For example, Minnesota is one of the healthiest states in the nation, yet it has some of the greatest disparities in health¹ between racial/ethnic groups. This means that racial/ethnic populations in Minnesota experience greater rates of disease, illness, premature death and poorer quality of life as compared to Whites. These inequities in health for some populations in Minnesota pose a threat to the health of all Minnesotans. In addition to the moral and ethical obligation to ensure that all populations in Minnesota have good health, disparities are costly. For example, poorly managed chronic illness or inadequate treatment of chronic illness can result in significantly more expensive interventions.

In 2001, Minnesota passed landmark legislation to address these persistent health disparities. The Eliminating Health Disparities Initiative legislation (MN Statute 145.928) specified that the commissioner of health establish a program to focus on two broad goals aimed at reducing disparities:

- By 2010, decrease by 50 percent the disparities in infant mortality rates and adult and child immunizations rates for American Indians and Populations of Color (Asians, African Americans/Africans, and Hispanics) in Minnesota as compared with the rates for Whites.
- Close the gap in health disparities of American Indians and Populations of Color as compared with Whites in the following priority health areas:
 - Breast and cervical cancer
 - Cardiovascular disease
 - Diabetes
 - HIV/AIDS and sexually transmitted infections
 - Violence and unintentional injuries

In addition, federal TANF funds were directed to healthy youth development through this initiative. This legislation provided critical support and funding to begin work on the complex, long-standing issue of health disparities in Minnesota by providing a tribal and community grant program to address the two broad goals outlined in statute. To address the legislative goals, MDH partnered with Populations of Color and American Indian communities, awarding grants to 52 community organizations to develop and implement evidence-based and promising strategies to eliminate disparities in these health priority areas.

¹ Under the direction of then-director Dr. Harold Varmus, an NIH-wide working group developed the first NIH definition of "health disparities:" as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations (NIH, 1999).

MDH has been tracking the progress towards achieving these goals using statewide outcomes data, and by measuring the results achieved by individual grantees. While substantial progress toward a reduction in statewide disparities has occurred in the health priority areas for Populations of Color and American Indians, Minnesota has yet to meet all of the EHDI goals as established in legislation.

EHDI Disparity Reduction Progress – Selected Areas

- **Infant mortality**

A reduction in the disparity for Asians (75.0%) and Hispanics (66.7%) exceeds the 50 percent reduction in disparity goal of the EHDI. For African Americans/Africans (36.4%) and American Indians (26.3%), the disparity is also significantly reduced but has not yet met the EHDI goal.

- **Diabetes mortality**

The goal to reduce disparities in diabetes mortality has been met for African Americans/Africans (17.1%), American Indians (18.7%) and Hispanics (25.3%). For Asians, there are no disparities in either the baseline or current time period.

- **New HIV infections**

The goal to reduce disparities in new HIV infection rate has been met for American Indians (51.8%), while the disparities for African Americans/Africans and Latinos has widened by 7.4 percent and 30.3 percent respectively. No disparity exists for Asians.

- **Cardiovascular mortality**

The goal to reduce disparities in cardiovascular mortality rate has been met for African Americans/Africans (94.2%) and Hispanics (42.6%). However, the disparity for American Indians increased by 37.5 percent. No disparity exists for Asians.

The EHDI has also changed the landscape of public health efforts in Minnesota and increased understanding of the contributing factors for health disparities among MDH and local public health agency staff, policy makers and other stakeholders. Health promotion and prevention efforts in Minnesota are now more apt to recognize the multiple and complex factors that contribute to disparities in health status among Populations of Color and American Indians, are aware of the differing causes and approaches for addressing health disparities in diverse communities, and are recognizing the need for community established priorities and initiatives. For example, Minnesota's State Health Improvement Plan is using many of the lessons learned through the EHDI to plan and implement this important initiative and the Diabetes Plan includes efforts to address racial/ethnic disparities in diabetes prevalence and mortality.

As we move into the next decade and beyond, ongoing efforts to eliminate health disparities will become even more important as Populations of Color and American Indians continue to

The EHDI has changed the landscape of public health efforts in Minnesota and increased understanding of the contributing factors for health disparities

comprise a greater share of Minnesota's population. Table 1 illustrates the significant changes in the composition of the population as evidenced by substantial increases in the 19 and under age group for African American/African, Asian, and Hispanic populations from 2000 to 2010; 2020 projections for these groups indicate even greater growth.

**Table 1:
Minnesota Population, Ages 19 and under, Actual and Projection**

Race and Ethnicity	2000	2010 Projected	Percent Change 2000 - 2010	2020 Projected
African American/African	69,036	95,000	37.6	104,200
American Indian	22,073	23,600	6.9	25,200
Asian	58,168	73,800	26.9	85,000
Hispanic*	60,621	93,500	54.2	110,200
White	1,205,993	1,198,900	-0.6	1,217,100

*Hispanic is an ethnicity which is a separate category from race, and includes persons from any race group.
Source: Minnesota Department of Administration, State Demographic Center, January 2005
<http://www.demography.state.mn.us/resource.html?Id=10959>

In the current phase of the Initiative, we have learned:

- The importance of community involvement in embracing the Initiative and understanding the direction;
- The importance of connecting programming efforts and successful modeling of programs with the goals established in the EHDI statute;
- The importance of capacity-building, partnerships and leadership in creating the environment for sustainable change.

But we have also identified several areas for improvement, particularly in how we monitor progress towards statewide goals and ensure that grantees' work is consistent with those goals, the degree to which we have integrated EHDI efforts into all of MDH's work, and the need to focus on policy and social determinant interventions that impact the multiple factors that contribute to health disparities.

In order to achieve health equity in Minnesota, much more needs to be done. The following sections of this report will describe the current efforts of the Eliminating Health Disparities Initiative, including a description of grantee programs, goals, and outcomes (statewide and grantee level) and a description of grantee capacities built. The report concludes with a set of recommendations for strengthening the EHDI to ensure that the gains we have made to date are sustained and expanded and that we are able to more accurately measure progress towards statewide goals.



II: DESCRIPTION OF EHDI

EHDI grantee programs serve as a testbed of models for effective strategies that can be adopted or adapted by other programs

The Eliminating Health Disparities Initiative (EHDI) serves as a cornerstone effort of the state of Minnesota, the Minnesota Department of Health, and local communities to eliminate racial and ethnic disparities in the health of Populations of Color and American Indians.

The core of the EHDI is a statewide grant program which provides funding to community-based organizations and Minnesota tribal communities to implement proven strategies and innovative practices that will contribute to statewide improvements in health status for Populations of Color and American Indians. The EHDI grantee programs serve as a testbed of models for effective strategies that can be adopted or adapted by other organizations or state programs addressing disparities. Another aspect of the EHDI is capacity building by strengthening organizations, building partnerships and leveraging resources.

Through the efforts of the EHDI, 52 community partners are supported in their work to establish community-based and culturally-appropriate programs to eliminate health disparities in the health priority areas² among African Americans/Africans, American Indians, Hispanics, and Asians. The underlying philosophy of the EHDI is that health improvement and elimination of health disparities emanate from the social, cultural, and human assets that are already present in these communities. The principles of the EHDI are based on respect for the healthy values, beliefs, and traditions of Minnesota’s diverse populations, and engaging communities to reclaim their health.

EHDI Framework

The approach of the EHDI is reflective of the complexity of the factors that create and sustain health disparities among Populations of Color and American Indians as compared to Whites. In recent years, we have improved our understanding of the connections between the environment, community, and health status. For instance, we have learned that health disparities are often the result of a number of contributing factors with varying levels of influence. These individual, social determinants/environmental factors and systems factors interact with varying effects to contribute to the health of individuals.

Individual factors are the characteristics or behaviors of individuals and populations including age, weight, smoking, genetic characteristics, and history of chronic illness.

Social Determinants and environmental factors are related to the physical environment (e.g. living and working conditions); the social environment (e.g. cultural and social cohesion); and the economic environment (e.g. income, insurance and affordable health care).

Systems factors relate to the health care delivery system, the social services system, and the state and local public health system.

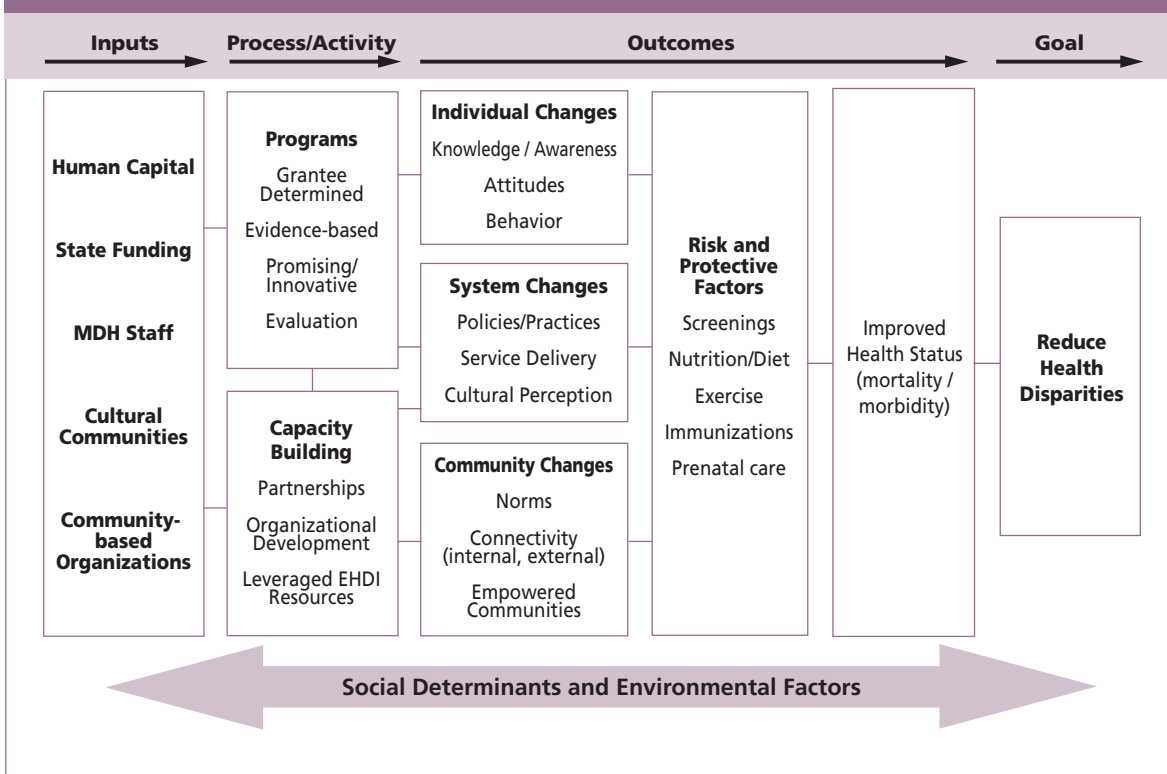
² breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, immunization, infant mortality, and violence and unintentional injury. In addition, federal TANF funds were directed to healthy youth development through this initiative.

Because of the far-reaching and complex nature of these factors, they also present challenges in identifying and implementing successful approaches to reducing health disparities. The EHDI has been a mechanism to learn about and address the multiple factors that contribute to health disparities and successful approaches to address these disparities among Populations of Color and American Indian communities.

Figure 1 displays the EHDI framework, within which the Initiative operates. The framework provides the rationale as to how the initiative contributes to the overall goal – *the reduction of health disparities in health priority areas among racial/ethnic groups in Minnesota*. The EHDI stakeholders (Populations of Color, American Indians, advisory groups, MDH staff, local public health staff, and community organizations) developed the framework based on their perceptions about what works to address the factors that contribute to health disparities among Populations of Color and American Indian communities. Data was used to define the problem, to develop a plan of action, and to monitor the progress of the EHDI. The basic elements of the framework are the inputs, process/activities, outcomes, external influences and overall goal.

This model illustrates the complexity of eliminating health disparities by showing outcomes relating to the multiple factors that contribute to disparities (individual, systems, and community) and the complex interrelationships between the outcomes and the goal of reducing health disparities. Complex interactions differ by community, by health priority area, and by the extent of the disparity. For example, to reduce infant mortality in the American Indian community, there may be a need to educate women about the importance of early prenatal care, hold evening clinic hours, provide transportation, increase the societal norm around smoke-free environments and train medical staff to address the cultural needs of this community. All of this might then lead to

**FIGURE 1:
EHDI Framework**



reduced risk behaviors (e.g. smoking during pregnancy) and increased protective behaviors (e.g. early and consistent prenatal care) – leading to a reduction in infant mortality and reduced health disparities. However, how the American Indian community is engaged in this initiative might look different than how the African American/African community is engaged in reducing infant mortality. In order to reach the overall goal of the Initiative, there is a complex combination of changes at many levels (e.g. individual, system and policy) that must occur – all of which contribute to the goal of reducing health disparities.

Framework Components

The Inputs column shows the resources that are drawn upon in implementing EHDl. Inputs include human capital, state funding, MDH staff, cultural communities (i.e. African Americans/Africans, American Indians, Asians and Hispanics), and community-based organizations. Human capital includes the workforce (e.g. public health, health care organizations, community organizations); state funding are the funds received through EHDl legislation; MDH staff is the technical assistance and support provided to grantees; cultural communities and community-based organizations are the many organizations adept in working in culturally appropriate ways to address the unique needs of targeted communities. Together, these inputs support the work of EHDl grantees to identify priority health areas and plan and implement programs and activities to address disparities in their communities.

The Process/Activity column highlights the existing activities of the EHDl. Two broad areas of activity – programs and capacity building – represent the primary work of the EHDl. Programs include a variety of community and culturally-based interventions designed and implemented by grantees (e.g. doula programs, nutrition classes using traditional foods to prevent diabetes, health screenings in churches). These grantee-designed programs are either evidence-based or promising strategies. Evidence-based programs include those that are based on published studies, demonstration projects, or best practices with theoretical backing. Many of the efforts are considered promising/innovative strategies because there is limited information on how these strategies work in racial/ethnic communities and because the grantees have the expertise to develop innovative strategies that are likely to be effective in their communities.

Each of the grantees have been encouraged to develop programs that focus on known risk and protective factors of the disparity area, involve the targeted group in development and implementation of the project, and are linked to other community efforts that enhance or expand project strategies. Grantees are required to evaluate their own programs, and use these evaluations to improve and modify their interventions.

The EHDl has also focused on capacity building in the areas of partnerships, organizational development, and leveraging of resources. Focusing on these areas results in a strong network of efforts aimed at improving health and eliminating disparities in racial/ethnic communities. The EHDl encourages grantees to strengthen current partnerships and establish new ones. Grantees use their partners for referrals, sharing resources and in-kind support, provision of services, coordination of programming, joint programming, replication of services, and co-sponsorship of activities and events.

The EHDI has also focused on building capacity in organizations. EHDI conducts trainings and provides individual consultations on many topics including asset building, grant writing, evaluation and programming. By strengthening skills of staff and organizations, grantees are able to expand services, improve credibility, stabilize funding and increase awareness of health disparities. Grantees leverage their funds (including non-monetary resources) in order to create long-term funding, an essential element required to sustain the effort needed to address disparities.

The Outcomes columns describe the results of the EHDI activities. Outcomes resulting from EHDI activities impact individuals, systems and communities, though the primary focus of grantees has been on individual-level outcomes related to knowledge, awareness, attitudes and behaviors. Examples of individual changes include increased understanding of the importance of immunizations, diet and exercise (knowledge) and increased immunizations and improved diets (behaviors). These changes are important precursors to improved health status; however, a focus on individual-level changes alone will not be as likely to lead to improved statewide outcomes as a more comprehensive approach that includes changes in the broader systems and communities in which individuals exist.

System and community changes refer to outcomes that alter the environment within which individuals and groups function. System changes occur within the grantee organization and in the broader health system (e.g. public health, health care delivery system, and social services). System changes include modifications of policies, programs and cultural practices while examples of community changes include increased leadership, strengthening connectivity and modification of community norms. Again, much of the focus of EHDI grantees to date has focused on changing “micro systems,” rather than changing systems at the statewide and national level. These smaller-level modifications are an important first step toward statewide change, one that will need to be expanded as EHDI moves forward.

Together, individual, systems and community changes lead to improvements in health status. For example, improved awareness of the importance of prenatal care during pregnancy (knowledge/awareness) can lead to women seeking earlier and consistent prenatal care (behavior) which may lead to decreased infant mortality (improved health status). Implementing systems and community changes to increase smoke-free environments (e.g., sudden infant death syndrome is associated with second hand smoke) and to increase educational status of pregnant women will contribute to a decrease in infant mortality.

The final column of the EHDI framework represents the goal to reduce health disparities statewide. The framework illustrates how the Initiative inputs lead to process/activities and outcomes which in turn contribute to meeting the Initiative goal.

EHDI Grantee Programs

As described in the framework, the grantee programs are grantee-designed. It is the philosophy of EHDI that communities have a critical role in identifying approaches and implementing programs to address disparities. Thus the programs that the grantees have implemented are evidence-based programs adapted to work in their communities or innovative, promising strate-

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gies created by the grantees and their communities. These programs are replicable, and merit consideration for expansion to other communities throughout the state.

Grantees often target services to more than one racial/cultural population: 49 percent of the grantees serve African Americans/Africans, 46 percent serve American Indian tribes or communities, 33 percent serve Hispanics, and 31 percent serve Asians. EHDl grantees provide services in 44 counties in Minnesota. Sixty-nine percent of the grantees serve the Twin Cities metropolitan area (36 grantees), and 31 percent provide services in outstate Minnesota (16 grantees).

Though the populations served and health priority areas targeted vary greatly, grantees share some common characteristics including the following:

- Prevention is the primary emphasis - nearly two-thirds of grantees (65 percent) stated that their programs place a greater emphasis on prevention.
- Communities are involved in planning and implementing programming - 68 percent of the grantees report involving the community in program development and 50 percent report continued community involvement.
- Grantees provide a comprehensive approach to addressing health disparities - 70 percent of the grantees report involving family members in program services, 48 percent work with clients on an ongoing basis and 39 percent provide follow up services.
- Cultural values and traditional practices are incorporated into programs - their programs reinforce strong positive cultural identities by incorporating the cultural history and traditional healing of their communities into program curricula and activities.

White Earth Tribal Mental Health uses a 27-week program for men who batter, adapted from another model to fit their community. They use sweat lodge ceremonies, traditional healers, speakers, and smudging ceremonies to help men change their behavior, and also change unhealthy community norms. Several measures document the success of this approach including reduced rates of recidivism for violence and decreased truancy rates among participants.

Table 2 provides a general description of the EHDl Grants Programs including numbers served by health area and population.

**TABLE 2:
Overview of EHDl Grants Programs, 2007**

	Community	Tribal																											
Number of Grantees:	42	10																											
Populations Served:	African American/African, Asian, American Indian and Hispanic	American Indian																											
Counties Served (44):	<p>See Appendix E for full size map</p>																												
Funded Programs by Health Area and Population Reached:	<table border="1"> <thead> <tr> <th>Health Area</th> <th>Grantees</th> <th>Population Reached¹</th> </tr> </thead> <tbody> <tr> <td>Breast and cervical cancer</td> <td>9</td> <td>4,380</td> </tr> <tr> <td>Cardiovascular disease</td> <td>12</td> <td>9,465</td> </tr> <tr> <td>Diabetes</td> <td>17</td> <td>11,950</td> </tr> <tr> <td>HIV/AIDS</td> <td>8</td> <td>8,314</td> </tr> <tr> <td>Immunizations</td> <td>8</td> <td>3,147</td> </tr> <tr> <td>Infant mortality</td> <td>10</td> <td>2,804</td> </tr> <tr> <td>Healthy youth development</td> <td>19</td> <td>12,092</td> </tr> <tr> <td>Violence/unintentional violence</td> <td>9</td> <td>3,669</td> </tr> </tbody> </table>	Health Area	Grantees	Population Reached ¹	Breast and cervical cancer	9	4,380	Cardiovascular disease	12	9,465	Diabetes	17	11,950	HIV/AIDS	8	8,314	Immunizations	8	3,147	Infant mortality	10	2,804	Healthy youth development	19	12,092	Violence/unintentional violence	9	3,669	
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¹through direct or group contact

Grantee Activities by Health Priority Area

By health priority, grantees have implemented a variety of programs aimed at reducing health disparities. The following section summarizes these activities by health area. For a more detailed description of the EHDI grant program by health priority area, go to Appendix A.

Breast and Cervical Cancer — Grantees help women apply for insurance, accompany them to screenings, provide transportation and help women navigate the health system.

Cardiovascular Disease — Grantees offer blood pressure, cholesterol and blood glucose screenings at barber shops, churches, mosques and coffee shops and use parish nurses, community health workers and other partners to conduct screenings. They also offer culturally appropriate exercise and nutrition classes.

Diabetes — Grantees use community health workers or parish nurses to make home visits for screenings, education and counseling. They provide educational classes for self-monitoring of diabetes and teach their youth about traditional diets to prevent diabetes.

Healthy Youth Development — Grantees provide peer networks that connect youth with positive role models; offer tutoring and after-school activities; involve youth community service and provide one-one and group services such as counseling and educational classes.

HIV/AIDS and Sexually Transmitted Infections — These grantees have trained community health workers and peer educators to raise awareness and provide prevention strategies. Grantees also test clients for HIV/AIDS and STIs. Finally, they work with people who have HIV/AIDS, and help them connect with resources such as health care and housing.

Adult and Childhood Immunizations — The services include education on the importance of immunizations and immunization clinics. Grantees help participants obtain insurance through which they are eligible for immunizations.

Infant mortality — Grantees target behaviors including utilization of prenatal care, breast feeding, and substance use among pregnant women. Grantees work to increase access to and utilization of doula services, prenatal care and substance abuse programs. Grantees also provide educational session in topics such as breast feeding and causes of infant mortality.

Violence and Unintentional Injury — Grantees have been promoting awareness and knowledge about domestic violence in the community through group and individual counseling, marches, pledges and media campaigns.

The characteristics of EHDI-funded programs are consistent with current “best practice” principles: their programs are comprehensive and prevention-focused, and involve communities in program planning and implementation. In fact, many EHDI programs surpass best practice criteria by incorporating cultural values and traditional practices into programming. The programs with improved outcomes and greatest impact can serve as best-practice models for eliminating health disparities in Minnesota. A next step is a greater integration of these promising strategies into existing public health programs at the state and local level.

For more information on EHDI best practices, see the 2007 EHDI Reports “Exemplary Program Practices in Action,” “Building Capacities among Individuals, Organizations, Communities and Systems” and “Grantee Case Studies” which can be found on the OMMH website: <http://www.health.state.mn.us/ommh/grants/ehdi/index.html>.

III. OUTCOMES



This section describes outcomes at the statewide and grantee level. The statewide outcomes document the progress made to reach the overarching EHDl goal of reducing health disparities, while the grantee-level outcomes document results including individual change, system change, and community change.

To date, the primary focus of EHDl grantees has been on individual-level changes, including changes in knowledge, awareness, attitudes, behaviors and health status, and on changes to systems within their communities. This focus has been necessary for testing the most effective strategies to reduce health disparities in grantee communities. But change will not be realized on a statewide level through a focus on individual change alone. In order to achieve these broader changes and achieve statewide goals, systems and community changes, the outcomes that alter the environment within which individuals and groups function will need to be a stronger focus of the initiative. The next sections, on EHDl goals I and II, report on the statewide outcomes.

EHDl Goal 1: Reduce disparities in infant mortality and immunization rates between Populations of Color and American Indians by 50 percent

Current data indicate that the goal for infant mortality has been met for Asians and Hispanics since the inception of the EHDl. Also, the disparities in infant mortality rates have decreased for African Americans/Africans and American Indians but not yet by the 50 percent established in the statute. For immunizations, it is not possible to assess whether the immunization goal has been met due to a lack of reliable statewide data on adult and child immunization rates.

Infant Mortality

Table 3 provides a summary of infant mortality rates and disparities between Populations of Color/American Indians and Whites. The 50 percent reduction in disparities for infant mortality has been met for Asians and Hispanics, with the disparities reduced by 75.0 and 66.7 percent respectively. While significant progress has been made for African Americans/Africans and American Indians, with a 36.4 percent reduction for African Americans/Africans and a 26.3 percent reduction for American Indians, the 50 percent reduction in disparities has not yet been achieved for these populations.

Baseline data (1995-1999) indicate that African American/African and American Indian rates were over twice as high as White rates; these rates were prior to the establishment of the EHDl. Current rates and percent mortality reduction indicate that while rates have declined considerably for all racial/ethnic groups, African American/African and American Indian rates remain twice as high as Whites, indicating that much more progress needs to be made before these groups see the same outcomes as Whites.

Disparity is defined as the difference between the Population of Color Rate and the White Rate.

Disparity reduction measures the percentage change in disparity between the baseline and current years.

**TABLE 3:
EHDI Infant Mortality Rates and Disparities**

	African American [^]	American Indian	Asian	Hispanic	White
Baseline Rate (1995-1999)	13.2	13.5	7.1	7.0	5.5
Current Rate (2001-2005)	9.3	10.3	4.8	4.9	4.4
Rate Reduction	29.6%	23.7%	32.3%	30.0%	20.0%
Disparity Reduction with Whites	36.4%	26.3%	75.0%	66.7%	
EHDI Disparity Goal Met*	no	no	yes	yes	

Disparity Reduction with Whites = the percentage change in disparity between the baseline and current years

[^]Includes African born

*EHDI Disparity Reduction Goal - 50 %

Immunization

MDH used the 2001 Minnesota Kindergarten Retrospective Survey to set the 2001 EHDI baseline, from which progress towards the goal of a 50 percent reduction in childhood immunization disparities would be measured. Based on the survey, the overall immunization rate for the 4:3:1 vaccine series for White children at 24 months of age in Minnesota was 85 percent in 2001 compared to 65 percent for non-White children, a gap of 20 percentage points. After Whites, American Indians had the highest immunization rates at 73 percent and African Americans/Africans had the lowest at 62 percent (Table 4).

**TABLE 4:
2001-2002 Immunization Levels for the 4:3:1 Series
by Race/Ethnicity at 24 Months in Minnesota**

Race (Number of Children)	Percent Up to Date at 24 Months
White, non-Hispanic (48,317)	85%
American Indian (1,072)	73%
Asian/Pacific Islander (3,331)	66%
Hispanic/Latino (3,079)	65%
African American, non-Hispanic/ Latino (4,599)	62%

Source: 2001 Minnesota Retrospective Kindergarten Survey

The Minnesota Retrospective Kindergarten Survey was discontinued after 2001, in part, because the survey was unsustainable for local public health and schools, requiring high cost and staff time. In addition, MDH had planned on using data from the Minnesota Immunization Information Connection (MIIC) as a replacement measure for the purposes of assessing progress towards

EHDI goals. However, MIIC has not been able to fill this role as quickly as hoped, meaning that no adequate comparative data are yet available to assess whether the gaps are increasing or decreasing.

The two main sources for the adult immunization data are the National Health Interview Survey (NHIS) and Medicare. Each dataset has its limitations: NHIS is not state specific and can only report on Whites and African Americans/Africans, and available Medicare data is only for adults 65 and over, and does not include those in managed care plans.

For the EHDI goal to reduce disparities in adult immunization rates by 50 percent by 2010, MDH used information from the 2000-2001 National Health Interview Survey for the Midwest region to establish a baseline (Table 5). While the NHIS shows a gap of nearly 20 percentage points between White and African American/African adults, the same data from 2007 show an increase of approximately 10 percentage points for influenza vaccine and approximately 13 percentage points for pneumococcal vaccine among African American/African adults. There was a small increase for White adults for both vaccines.

TABLE 5:

Percentage of Adults Vaccinated Against Influenza and Pneumococcal in the Midwest during the 2000-2001 and 2006-2007 Influenza Season

	Percent Vaccinated Against Influenza		Percent Vaccinated Against Pneumococcal	
	2000-2001	2006-2007	2000-2001	2006-2007
African American/African	49.5	59.1	35.3	48.0
White	67.3	69.3	58.8	62.0

Source: 2000-2001 and 2006-2007 National Health Interview Surveys

Among adults 65 and older, Minnesota-specific data indicate narrowing of the disparities among some racial and ethnic groups in flu shot coverage among Medicare recipients. Between 2001 and 2007, the gap between the White and African American rates shrank by roughly five percentage points, while the gap between Whites and Asians was reduced by roughly 14 points. However, it is not clear whether these changes are significant because of the limitations of the Medicare data.

While multiple sources of data on adult and child immunization rates exist, none of the available data sources are currently complete enough to allow an assessment of immunization rates for Populations of Color and American Indians, particularly for children. Going forward, it will be important to strengthen the available immunization data where possible, and to identify alternative strategies for measuring progress towards the reduction of health disparities in child and adult immunizations.

The Minnesota Department of Health has recently written two reports that detail disparities in immunization and infant mortality. The documents are available on the MDH website, www.health.state.mn.us/divs/chs/.

EHDI Goal 2: Reduce health disparities in other health priority areas

Table 6 summarizes progress made in reducing disparities in breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STIs, violence and unintentional injury and healthy youth development. The table lists the health indicators by population, along with the percent decrease or increase in the disparity from the baseline to current reporting periods (data used to calculate these disparities are included in Appendix C). The sources for these indicators are morbidity and mortality data from Minnesota Department of Health's surveillance systems and vital statistics. The indicators for diabetes, cardiovascular disease, and violence and unintentional injuries are measured by mortality data. Using these data alone limits our ability to measure the progress made in reducing health disparities because many years of intervention are often needed to change mortality rates

The data indicate that, although the goals have not yet been met for all populations, substantial progress has been made in reducing the disparities between Whites and Populations of Color and American Indians. Most evident is the success in reducing disparities in gonorrhea incidence, teen pregnancy, diabetes mortality and homicide for all racial/ethnic groups.

Though these reductions point toward progress, large disparities continue to exist in Populations of Color and American Indians. For example in Minnesota, teen pregnancy rates are still 2.3 to 4.8 times higher for Populations of Color and American Indians than the White rate; the Chlamydia incidence rates are 2.4 to 14.4 times higher, and the cervical cancer incidence rates are 1.9 to 2.8 times higher for Populations of Color and American Indians than for Whites.

A lack of data at the statewide level on Populations of Color and American Indians limits the ways in which progress towards statewide outcomes can be measured. For health priority areas such as diabetes and cardiovascular disease, for example, incidence data is not available for racial/ethnic groups, which means that the analysis of progress in these areas is limited solely to mortality data. Evaluating the success of programs using only mortality data provides a narrow perspective on progress. As a lagging indicator, mortality data will not detail improvements in health risk and protective behaviors until long after the changes have been made, and offer no ability to estimate differences in quality of life, use of preventive screenings or other tools, or ongoing management of a chronic condition. To more comprehensively measure progress, and target areas of greater need, incidence or behavioral risk data by race/ethnicity is needed.

In order to hold the initiative accountable for its success in meeting statewide goals, additional reliable data sources for Populations of Color and American Indians will need to be developed. Conversations with groups such as Minnesota Community Measurement, health plans and others are occurring to determine how other data sources might enhance and complement our efforts.

Table 6:

Disparity Reduction/Increase by Health Area and Population, 1995-1999 to 2002-2006*, Minnesota

Health Priority Area and Indicators	African American [^]	American Indian	Asian	Hispanic
Breast and Cervical Cancer				
Cervical Cancer Incidence	54.2%	15.3%	32.9%	#
Breast Cancer Incidence	---	---	---	#
Breast Cancer Mortality	55.5%	---	---	#
Cardiovascular Disease				
Heart Disease Mortality	94.3%	(37.5%)	---	---
Diabetes				
Diabetes Mortality	17.1%	18.7%	---	25.3%
Healthy Youth Development**				
Teen Pregnancy	39.1%	4.2%	36.6%	15.8%
HIV/AIDS and Sexually Transmitted Infections*				
New HIV Infection	(7.4%)	51.8%	0.0%	(30.3%)
Chlamydia Incidence	(2.7%)	19.9%	24.9%	10.9%
Gonorrheal Incidence	26.7%	25.7%	---	32.5%
Violence and Unintentional Injuries				
Unintentional Injury Mortality	---	(29.7%)	---	---
Homicide	48.3%	6.8%	23.1%	52.7%
Suicide	---	(65.5%)	---	---

The data in this table represent the percentage change in disparity between the baseline and current years.

[^] Includes African born

--- No current disparity

() Disparity increase

Baseline data not available, cannot measure disparity

*HIV and STI - Baseline Year = 2000, Current Year = 2007

**Though not specified in statute, federal TANF funds were directed to healthy youth development through this initiative.

All indicators are based on rates per 100,000 population except for teen pregnancy which is per 1,000 females 15-19

See Appendix C for rates and disparities

In 2007 alone, over 37,000 members of racial/ethnic communities were directly served by EHDl grantees

Grantee Outcomes

As indicated in the EHDl framework, before overall health status is improved and disparities reduced, changes need to occur in outcomes at the individual, system and community levels. Much of the focus of the EHDl to date has been on individual-level changes in knowledge and behavior within grantee communities, and grantees have achieved many positive outcomes at that level. At the systems level, grantees have also seen some success, particularly in changing internal systems and improving cultural competence among organizations within their communities. This work has helped to improve health status within grantee communities, and has served as a proving ground for innovative approaches to working effectively with communities of color.

But while individual and micro-system level change is a crucial precursor to statewide improvements, those changes alone will not be sufficient to meet the statewide goals established as part of the EHDl. To expand the impact of the initiative, the focus on broader system changes will need to increase. MDH and communities will need to take what has been learned from grantee organizations and communities and integrate those successes across larger populations and into the larger public health, social service, and healthcare delivery systems.

EHDl grantees have been provided with the resources to create culturally-specific innovative programs that improve these outcomes in their communities. This section briefly describes grantee level outcomes that have changed individuals, systems and communities.

Knowledge, Awareness, Behavioral and Health Status

In 2007 alone, over 37,000 members of racial/ethnic communities were directly served by EHDl grantees. Another 140,000 were reached through community events such as health fairs. The grantees of the Eliminating Health Disparities Initiative have documented impacts on program participants in important ways:

- Changes in knowledge and increased awareness among program participants and community members in all health disparity areas.
- Increased numbers of community members without insurance signed up for health coverage and access to primary health care including prenatal care.
- Increased preventive health screenings (e.g. mammograms, pap smears)

Selected Grantee Outcomes

92.5% of the participants believe that their knowledge about diabetes has increased through Centro Campesinos diabetes workshops (N=900).

208 clients served by Center for Asian and Pacific Islanders did not have a medical home and by the end of the program 169 were connected to a medical home.

In 2006, Turning Point tested an average of 20 men a month for HIV/AIDS, the average is now 30 to 40 men a month.

Olmsted County Public Health Services - 23 people with abnormal blood pressure test results who were not under a doctor's care were referred to a clinic.

and other types of cancer screenings, blood pressure and cholesterol checks for heart disease, blood glucose levels for diabetes, testing for HIV/AIDS and other sexually transmitted diseases).

- Obtained necessary immunizations for children, allowing them to start school.
- Supported community members to navigate the health care system, understand and receive needed treatment, and comply with provider recommendations.
- Changed behaviors of program participants in the areas of improved diet, increased exercise, decreased tobacco and other substance use during pregnancy, increased breast feeding among new mothers, decreased high risk sexual behaviors and reduced violent behaviors among domestic abusers.

Selected Grantee Outcomes

At Park Avenue Family Practice, 69.2% of Hmong mothers breastfed for at least 2 months compared to approximately <1% in 2005.

73% of West Central Intergration Collaborative's youth participants agreed that the after-school program helped them do better in school and increased their knowledge about exercise (N=22).

Based on Minnesota Department of Corrections and White Earth Tribal Court data, 14% of White Earth Tribal Mental Health's group participants re-offended compared to 37% of State and Tribal Court average.

- Changed attitudes such as improved self-image and confidence levels among youth participants, as well as intentions to change behavior, changed attitudes towards health care providers and traditional forms of healing and care and changed community norms about violence.
- Documented positive health outcomes such as healthy birth weight of infants, reduced recidivism among perpetrators of domestic violence and reduced rates of teen pregnancy among youth program participants.

This information is drawn from the annual evaluation reports submitted by each grantee for their work in 2007. Grantee outcomes by health area can be found in Appendix B.

Grantee Outcomes - System and Community Changes

Undertaking system changes recognizes that for the health status of communities of color and American Indian communities to improve, the larger systems of care, service and governance must be engaged. Systems change often occurs in stages – internal, external and community-wide.

Grantees have changed internal systems by modifying their own policies and programs. Grantees have also influenced changes in external systems (e.g. health care organizations, educational systems, governmental agencies). These changes include improving the cultural competency of providers, modifying programming and service delivery, and altering perceptions of communities. Finally, norms and behaviors have begun to change in grantee communities as the result of EHDI programs. These systems changes promote and facilitate behavior changes that lead to improvements in health status.

While some grantees have documented significant successes in achieving internal and external systems change, only a relatively small number of grantees have done work at this level, and their impact to date has, of necessity, largely been limited to the communities in which they work and the organizations with which they partner. Again, these changes at the micro-level are crucial, as they lay the groundwork for achieving community norms and behavior. But going forward, the initiative will need to do what it can to broaden this work to other communities and achieve a greater statewide impact.

Internal System Changes

Twenty-three grantees reported that they have changed their internal systems by providing alternative services, and culturally-competent services that were not previously available. Twelve grantees reported changes in systems through improved policies and procedures. Examples of internal policy changes include changing check-in and charting procedures, modifying medical forms and adding work-time exercise hours.

External System Changes

Increasing cultural competence of partnering agencies: As leaders in their area, nine organizations reported having an impact on their partners' work. Several educated healthcare providers on the cultural aspects of health within their community. As a result, these providers recruited medical professionals that reflected the culture of the community being served and addressed specific health disparity issues.

Modifying programming and services: Ten grantees have had an impact on modifying programs in the education system and government services. They developed new curricula in physical activity, health and violence prevention education in schools. Grantees have also had an impact on public health programming at the county level and have become service providers for county health and human service agencies.

Minneapolis American Indian Center. As part of their EHDI program, they developed a physical education curriculum for a local school that lacked a physical education program. Now a program staff member goes to the school twice a week to implement the curriculum with students. The school system is changing to allow for this culturally competent organization to work with students on important health and physical activity issues.

Agape House for Mothers. Through their program, they're having an impact on how schools and juvenile probation work with students who have behavioral issues. In the past, the emphasis was on discipline, but through Agape's work, administrators now work to address the root causes. They are also working with parents to address truancy issues. As a result, fewer students are being suspended.

Community-wide System Changes

Five grantees reported their work is beginning to change community norms. Grantee organizations reported an increased willingness of communities to discuss sensitive health issues with each other, particularly sexual health and violence. Grantees can have a greater impact when people are more open to talking about these issues.

Changes in community norms are necessary in order to impact disparities statewide. As people become more comfortable talking about sensitive issues, as well as about the steps they are taking to protect their own health, that openness can help others to make changes in their own lives. While relatively few grantees have yet been able to achieve this level of change in their communities on a large scale, their experiences, when shared, can serve as a model for other grantees on how to broaden their impact.

Annex Teen Clinic. By addressing sexual health issues openly, in a caring way, the community is beginning to change what is considered acceptable conversation. An “increasing number of community members agree that we need to be able to speak openly and honestly about sexual health.”

EHDI grantees have improved individual health outcomes (e.g. increased awareness of risk factors, increased exercise and improved birth outcomes); and influenced change in internal and external systems (e.g. modified education programs; facilitated the cultural competence of health care providers, and changed community norms). There is a need for continued work in these areas to maintain and improve on the gains that have been made and to reach an even greater number of community members.

In addition to health outcomes, grantees have also documented changes in some environmental factors that influence health. They have increased access to health care for their clients, and helped clients complete their education and find employment. There need to be more efforts aimed at addressing these factors at both the EHDI and statewide levels. Health disparities will not be eliminated until these and broader environmental factors as well as social determinants of health are addressed.



VI. CAPACITY BUILDING

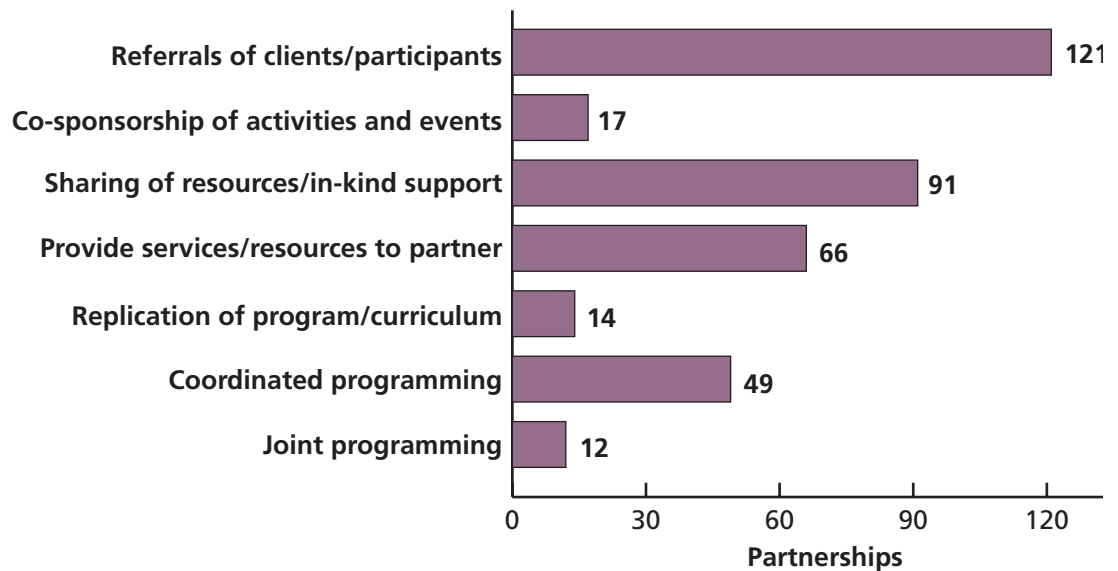
Grantees expanded their influence in their communities and in health systems through the cultivation of partnerships

Capacity building is a key process/activity of the EHDI. The focus of the EHDI capacity building work has been on partnerships, organizational development and leveraging. By building capacities, grantees have been able to expand services, improve credibility, stabilize funding, and increase awareness of health disparities. In turn, grantees are able to improve health outcomes of the people they serve.

Partnerships to Support Effective Programming

Grantees expanded their influence in their communities and in health systems through the cultivation of partnerships. Partnerships allow programs to leverage support, thereby making it possible to address the other individual needs (e.g. education and other social services) that lead to better health. Grantees reported 296 partners, with many of these partners being cross-sectional (e.g. health care providers, education, government, business). Grantees used their partners for referrals, sharing resources and in-kind support, provision of services, coordination of programming, joint programming, replication of services, and co-sponsorship of activities and events. The most common types of partnerships were referrals, sharing resources and provision of services (Figure 2).

FIGURE 2:
Number and Type of Partnerships, EHDI Grantees



Sixty-six partnerships involved the provision of services. Grantees provided education materials and services to their partners and vice versa. For example, KMOJ radio supports the Family and Children Services' 100 Men Take a Stand program through the developing and producing of public service announcements, providing air time, and sponsoring programming.

Ninety-one partnerships involved sharing resources including space, volunteers or staff time, and transportation services. For example, Midwest Mountaineering and REI provide equipment and training to the Minneapolis American Indian Center.

Grantees reported 121 partnerships in which referrals were the main reason for partnering. This meant either the partner referred participants to the EHDl program, or the EHDl program referred their participants to partners for services such as screenings, medical services, financial assistance, traditional healing, employment services. For example, the Agape House for Mothers refers their graduates to Bridges of Hope for leadership programming.

The benefits of partnerships are many. By using partners, grantees saved money, expanded their service network, created more comprehensive services, improved cross-sectional relationships and formalized relationships with health care providers.

Organizational Development

Organizational development has been a major focus of the EHDl. The EHDl has conducted training on various topics including evaluation, asset building, and grant writing. At these trainings, grantees have the opportunity to meet with MDH content experts and fellow grantees to discuss program challenges and successes. Grantees have also had individual consultations with evaluation experts and grant managers who have consulted with the grantees on the development and implementation of their program evaluations and provided technical assistance in the development, implementation and promotion of programs.

EHDl funding has helped improve the skills of grantee organization staff and increased staffing levels. It has also helped organizations expand services, improve credibility, stabilize funding, increase awareness within the organization and become leaders in their communities.

Capacities Built Among Staff

Increased staff: Seventeen grantees reported that their EHDl grant enabled them to increase staffing levels. They have hired for new positions, increased staff hours, hired staff members with new skills, and sent existing staff members to trainings. One organization grew from eight staff members to 25; another hired an outreach worker who speaks Spanish; and a third increased their physical therapist's hours from four to 16.

Improved staff skills: Several grantees reported that their EHDl grant enabled them to improve staff skills. In addition to the EHDl sponsored trainings, workshops and individual consultations, grantees have sent staff to local, regional and national conferences and workshops. Some staff

EHDl funding has helped organizations expand services, improve credibility, stabilize funding, increase awareness within the organization, and become leaders in their communities

members completed degrees, certifications, or licensing programs (e.g. Masters in Public Health, Doula certification, etc).

EHDI grantee staff are also increasing their evaluation skill set. Forty-one percent of the grantees showed improvements in their evaluation capacities over a two-year period (2004 and 2005) with seventy-five percent of the grantees having high to moderate evaluation capacity.

Grantees have become leaders in their communities and have gained reputations as experts in their health disparity areas. Twenty-nine (63%) of grantees reported they have been recognized by one or more external groups or organizations for the EHDI work. Eleven grantees have received a formal award (one international, four national, four state and two local). Grantees are also being asked by other organizations for advice and technical assistance on programming and their programs and materials are being replicated in Minnesota and nationally. Other examples of leadership include:

- Collaboration and involvement in other health promotion efforts
- Increased referrals from new sources
- Providing assistance to health organizations to access community
- Serving as community representatives for media or mainstream organizations on health topics

Capacities Built in Grantee Organizations

Organization is more aware of and focused on health issues: Eleven grantees reported that their EHDI work has increased the knowledge and awareness of their larger parent organization. As a result, several grantees reported an expansion in the focus of their programming. One tribal grantee explained that their EHDI program has “made the higher administration aware that there are issues in the community.”

Expanding services: Thirteen grantees have expanded their programming by adding education components, fitness programs, health services and referral networks to their service structures. As one grantee explained, the goal of their organization is to “provide a continuum of services,” which EHDI has helped them do.

Leveraged Funds and Resources to Sustain Efforts

A consistent, long-term funding commitment is essential to addressing health disparities, given the entrenched nature of the determinants of these health issues. A variety of revenue streams provide stability, flexibility and allow for expansion and unforeseen problems. Of the 36 grantees who sought outside funding, 28 successfully leveraged other funds for their EHDI programs (Table 7). These grantees received a total of \$3,000,000 in additional funding from various entities including foundations, corporations, and government agencies. And forty grantees reported receiving in-kind, non monetary resources such as office space, supplies and staff from other organizations.

**TABLE 7:
Profile of Successful Leveraging by 28 Grantees**

Number of Grantees	28
Total Raised	\$3,000,000
Range of Dollars Raised	\$150 to \$500,000
Source	Percent successful
Foundations/corporations	57%
Government grants/contracts	43%
Fee for service/insurance payments	18%
Other sources of funds	18%

Four factors contribute to the success of leveraging EHDI funds: the grant served as a solid foundation for funding; grantees were able to demonstrate positive outcomes; funders were interested in their issue, population or approach; and they had adequate infrastructure and support for fund-raising. While not all grantees were able to successfully leverage funds, those that did will now have a more stable base for their work in the future, beyond the life of their EHDI grant, and will be better positioned to build on their successes.

In the area of capacity building, the EHDI grantees are able to document many clear and positive outcomes. The EHDI grantees have become leaders and key resources in their communities, and will continue to improve health status for their clients and partners in the coming years. But statewide success in eliminating disparities will take much more than that. Going forward, there will be a need to ensure that the initiative is able to use the successes of these grantees as models for additional partnerships on multiple levels. Successful grantees and organizations need to be paired with other grantees to share strategies for partnering and leveraging funds. On a broader level, MDH will need to work to further strengthen relationships between the EHDI program and other potential partners in the provider, payer, education, social service and public health communities in order to ensure that the successes of EHDI are shared and can be implemented in new communities and new settings.

EHDI grantees have become leaders and key resources in their communities



V. CONCLUSION AND RECOMMENDATIONS

As racial/ethnic populations continue to increase in Minnesota, the moral and financial costs of health disparities will also grow unless the gains made to date are sustained and expanded

In 2001, the Minnesota Department of Health was charged with reducing health disparities through the landmark Eliminating Health Disparities Initiative (EHDI). This law was passed in recognition of the fact that health disparities among Populations of Color and American Indians lead to a lower life expectancy, higher rates of illness and disease, poorer quality of life, and increased costs of health care. The passage of EHDI legislation was a critical factor in starting Minnesota on the road to addressing these long-standing disparities in health status by helping to raise awareness of this crucial issue and serving as a catalyst for learning about why disparities exist, as well as for developing effective approaches to eliminating them.

The Eliminating Health Disparities Initiative set out clear goals for the Minnesota Department of Health – reduction in disparities in infant mortality and adult and childhood immunizations by 50 percent and closing the gap in five additional health priority areas by 2010. The Initiative also established goals for Healthy Youth Development. To meet these goals the EHDI has supported community-based organizations to develop and implement innovative culturally based programs that address the complex factors that contribute to health disparities and provides organizational capacity-building in key areas.

Since the inception of the EHDI, MDH and its partners have made progress in improving health status and reducing disparities across all health priority areas, and grantees have expanded their capacity to serve their communities by developing new partnerships and leveraging additional funds. Unfortunately, MDH and its partners have yet to fully meet the goals set out in statute. Specifically:

- While the goal of a 50 percent reduction in disparities in infant mortality rates has been met for Asians and Hispanics, this goal has not been achieved for African Americans/Africans and American Indians.
- For immunization, a lack of reliable state-level data means that MDH is unable to assess its progress towards the goal of a 50 percent disparity reduction.
- Progress for each of the other priority areas has been largely positive and significant, although stark differences remain between Populations of Color, American Indians, and Whites, particularly in the areas of sexually transmitted infections and teen pregnancy.

MDH continues its commitment to address the significant health disparities that exist. As racial/ethnic populations continue to increase in Minnesota, the moral and financial costs of health disparities will also grow unless the gains made to date are sustained and expanded. While the EHDI program has achieved significant successes in working with individuals and communities to increase knowledge and change behavior, that work alone will not be sufficient to achieve statewide goals. The lack of available data for more comprehensively measuring progress in certain priority areas also means that the program is not being fully held accountable for meeting those goals.

MDH is committed to ensuring that the elimination of health disparities is a high priority agency-wide and in the community, that EHDl is as effective as possible in meeting its goals, and that progress towards those goals is adequately measured. Looking forward to 2010 and beyond, MDH plans to take several steps to strengthen the EHDl and in essence move the initiative from Version 1.0 to Version 2.0. Specifically the MDH plan includes:

1. ***Maximizing the investment in EHDl by integrating strategies for eliminating health disparities into MDH programs, as well as coordinating and collaborating with other health promotion efforts and a range of state agencies, local public health, and other institutions.***

The elimination of health disparities is a priority for all of MDH. The Office of Minority and Multicultural Health has played a crucial role in building bridges with communities of color, and, through EHDl, fostering learning about how to successfully impact health status in these communities. These successes need to be shared with, and more fully incorporated into, MDH programs working in each of the health priority areas (e.g. diabetes, cardiovascular disease). MDH also needs to assume a larger role in sharing what has been learned with other stakeholders including healthcare providers, local public health, and other community organizations.

2. ***Developing policies and programs to address the environmental factors that contribute to poor health and health disparities.***

While the EHDl has been very successful in achieving change on the individual level, the initiative must also be working to achieve change on a broader level. Health disparities will not be eliminated until environmental factors including the physical environment, social and economic issues are addressed. MDH needs to reach out to other organizations that work on issues such as economic development, poverty, racism, and affordable high quality healthcare, to ensure that we are addressing those issues through our own programs to the extent possible. We also need to ensure that our health reform efforts are addressing quality, affordable, accessible health care for Populations of Color and American Indians.

3. ***Improving data collection efforts toward common goals so that high-quality, reliable statewide data is available for the evaluation of EHDl outcomes.*** In order to assure accountability for the EHDl, new and enhanced data collection mechanisms need to be developed to assess the health of Populations of Color and American Indians. Progress made on increasing immunization rates for adults and children could not be assessed due to a lack of reliable data. Measuring and reporting on progress was also limited for some priority areas because incidence data is not available by race (e.g. diabetes, cardiovascular disease), resulting in a need to rely on mortality data alone. In addition, Minnesota does not have statewide measures of behavioral risk factors (e.g. smoking, exercise, nutrition) for Populations of Color and American Indians. These data, along with data from healthcare providers, are needed to better understand where and why disparities exist, to confirm the progress being made in reducing disparities, and to ensure that the initiative is held accountable for the work that it is doing.

4. ***Expanding and replicating innovative programs that systematically and sustainably reach as many people as possible, and that work for Populations of Color and American Indians, to other communities.*** The grantee programs have been successful in reaching traditionally hard-to-reach populations, providing programming that incorporates cultural values and traditional practices, and are consistent with current “best practice” principles. The programs are prevention-focused and involve communities in program planning and implementation. However, the grantees are only able to work in selected communities, and are unable to reach all populations at risk. While important as a proving ground for innovative approaches, the grantee programs alone will not be enough to achieve sustainable statewide change. These programs with the greatest system approach must be expanded and replicated in a sustainable way to reach Populations of Color and American Indians in other counties and to serve as best-practice models for eliminating health disparities in Minnesota and in other states.
5. ***Expanding the focus of the EHDI to explore and address policies and systems that impact health disparities to create sustainable change.*** Current policies and systems need to be reviewed to address health disparities. For example, to create change that is sustainable, the capacity of the public health system to work with Populations of Color and American Indians must be assessed and improved, as well as addressing the capacity of the healthcare delivery. Policies and systems in many areas must also be reviewed, assessed, and improvements made including education, housing, and labor.
6. ***Exploring how to increase social capital as part of the work in eliminating health disparities as the demographics of Minnesota diversify, so we embrace our rich cultural and ethnic heritage now and into the future.*** Social capital is the inter-connectedness among individuals and communities. As our society evolves, building social capital is an important element in any foundational work such as EHDI, and helps us to explore how to increase citizens’ connections with each other, their understanding of each others perspectives and their collective solutions to common problems and goals. Therefore, we will work to increase social bonding within populations as well as increase social bridging across populations to build a Minnesota of the future which benefits from our rich ethnic and racial heritage

The Eliminating Health Disparities Initiative was one of the first statewide efforts to focus on the health and well being of Populations of Color and American Indians. Its ground-breaking philosophy and innovative approaches have served as a model for other states as well as the national Office of Minority Health to address the long-standing and complex issue of disparities.

The Initiative has been successful in many respects, yet there is much more to be accomplished. Successes at the individual and small community level need to be broadened to impact new communities and to begin changing community norms statewide. We need to improve our ability to measure our success and hold the Initiative accountable for its work. MDH is now poised to enter into the next phase of this Initiative in order to continue and build on the progress that has been made in eliminating disparities, learn from our experiences, and move forward.

Eliminating Health Disparities Initiative

Due to their length, the appendices referenced in this report appear in a separate volume titled “Eliminating Health Disparities Initiative 2009 Legislative Report: Appendices.” This companion report is available at www.health.state.mn.us/ommh/publications/index.html.

APPENDICES

- Appendix A: EHCI Grantee Descriptions
- Appendix B: Selected Grantee Outcomes by Health Area
- Appendix C: Other Health Priority Areas – Rates and Disparities
- Appendix D: Eliminating Health Disparities Initiative Legislation
- Appendix E: Counties Served by EHCI Grantees





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