

**MINNESOTA'S ELIMINATING HEALTH  
DISPARITIES INITIATIVE**

**Report 5:  
Building Capacities  
among Individuals, Organizations,  
Communities and Systems**

*Prepared for*

**Minnesota Department of Health  
Office of Minority and Multicultural Health**

**May 2008**



## OVERVIEW OF SERIES OF REPORTS

In 2001, Minnesota passed landmark legislation to address the persistent and growing problem of disparities in health status between the majority 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, collaboratives and tribes across the state, Minnesota provided the opportunity for its populations of color and American Indian communities to develop strategies and approaches to eliminate 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).

This report is the fifth in a series of seven reports detailing the work and accomplishments of the Eliminating Health Disparities Initiative (EHDI) of the Office of Minority and Multicultural Health, Minnesota Department of Health. It describes seven distinct ways that the Eliminating Health Disparities Initiative grantees had an impact on their communities.

Minnesota’s approach to eliminating health disparities, and the work of many of the EHDI grantees, are consistent with model program practices identified by national researchers documenting other initiatives addressing health disparities (Report #2). Report #3 documents the innovative programs and outreach strategies that grantees developed to overcome barriers and reach members of their communities with health promotion programs. These strategies—based in the cultural strengths and assets of their communities—can serve as a model for other states and communities. Report #4 describes the health disparity context in Minnesota and reviews the programmatic results achieved by Minnesota’s 52 EHDI grantees. Report # 6 provides an in-depth description of a select group of these grantees 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
⇒ Report #5:	<b>Building Capacities among Individuals, Organizations, Communities and Systems</b>
Report #6:	Grantee Case Studies
Report #7:	Catalogue of EHDI Programs

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## **BRIEF BACKGROUND OF THE ELIMINATING HEALTH DISPARITIES INITIATIVE (EHDI)**

Minnesota's Eliminating Health Disparities Initiative (EHDI) is a 10-year effort of the Minnesota Department of Health to address the deeply entrenched health disparities within Minnesota's communities of color. Since 2002, the Minnesota Department of Health's Office of Minority and Multicultural Health has provided funding and technical assistance to 52 community-based organizations and American Indian tribes. These grantees work to reduce health disparities in one or more of eight priority areas:

1. Breast and Cervical Cancer
2. Cardiovascular Disease
3. Diabetes
4. HIV/AIDS and Sexually Transmitted Infections
5. Immunizations
6. Infant Mortality
7. Healthy Youth Development
8. Unintentional Injury and Violence

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

## EVALUATION OVERVIEW

The EHDI Exemplary Practices Project is part of the evaluation of the Initiative being coordinated by Rainbow Research Inc. and the Minnesota Department of Health's Office of Minority and Multicultural Health and its Center for Health Statistics. 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 systematic impacts of the EHDI on organizations and communities.

This report addresses the second objective: to document and describe how EHDI grantees are utilizing effective practices to eliminate health disparities in their community. This report details how these program practices, based in cultural values and traditions, build on the assets within their communities.

## DATA SOURCES

Three sources of data were used in this report.

### 1. Annual evaluation report

Grantees submit an annual report to the Minnesota Department of Health detailing their program outputs, outcome evaluation results, challenges encountered, thoughts and recommendations. Forty-six grantees completed reports in 2006.<sup>1</sup>

### 2. In-depth semi-structured interviews

Hour-long, mostly qualitative interviews were conducted with program coordinators. This interview provided the primary vehicle for grantees to describe both their program and how it addresses the exemplary program practice characteristics (defined on page 3). Forty-six grantees completed the interview in May 2007.

### 3. Online survey

Grantees completed checklists about types of program services, program staff characteristics, partners and histories of leveraging funds. The survey was completed by 48 grantees in June 2007.

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<sup>1</sup> Tribal grantees are not required to submit evaluation reports.

## **ORGANIZING FRAMEWORK**

The EHDI organizing framework was generated through a Delphi study of Minnesota experts working in the field of health disparities. (A Delphi study is an iterative poll of experts conducted to achieve consensus on a set of ideas.) In 2005, thirty experts responded to an online survey to identify the strategies most important to effectively address health disparities in their communities. The expert panel achieved consensus on a list of program values, philosophies, organizing approaches, programmatic strategies and qualities of effective health disparities programs. This list (See Table 1) was validated and added to through a review of the literature on model programs and practices (see Report #2: A Model and Methodology for Identifying Exemplary Program Practices to Eliminate Health Disparities).

EHDI grantees were then assessed to determine whether and how they incorporated these seventeen philosophies and practices. The responses of grantees were reviewed by multi-cultural panels of program managers, researchers and community members to identify which activities and approaches stood out as exemplary program practices to address health disparities in community-based program settings. The Delphi study and programmatic review process are detailed in Report #2 of this series.

This report describes and provides examples of how the capacity building focus of the Eliminating Health Disparities Initiative has led to ripples of change throughout the participating communities and beyond. This capacity building has had impacts at all levels—by strengthening individuals involved in the initiative through training and support, by building capacities in the funded organizations, by forming innovative new partnerships that resulted in changing how things get done in those systems. This report also explores how EHDI is fostering leadership within the communities of color and American Indian tribes, how grantees have begun to leverage funds and how they are facing challenges and developing innovative solutions that change systems. This ripple of change starts within the EHDI programs and their participants, expands throughout organizations and into larger systems (i.e., health care system, corrections system, etc.)

The report is organized to explore the seven ways the initiative impacts individuals, organizations, communities and systems. These seven community capacities were identified by the Health Disparities Expert Panel (see Table 1 Exemplary Program Practices 11-17). Each of these is illustrated with data collected from the EHDI grantees to show how this capacity has been built or strengthened.

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

<b>A. EXEMPLARY PROGRAM PRACTICES IN ACTION</b>	<b>B. PROGRAMMATIC RESULTS ACHIEVED</b>	<b>C. BUILDING CAPACITIES AMONG INDIVIDUALS, ORGANIZATIONS, COMMUNITIES AND SYSTEMS</b>
<ol style="list-style-type: none"> <li>1. The community is involved in authentic ways</li> <li>2. Programming is data-driven</li> <li>3. A comprehensive approach is utilized in developing and implementing programming</li> <li>4. Recruit participants or deliver services in community settings in which community members feel comfortable</li> <li>5. Trust is established as the foundation for effective services</li> <li>6. Programming builds upon cultural assets and strengths of community</li> <li>7. Deliver services or information that are culturally or linguistically accessible and appropriate for the participants</li> <li>8. Staff reflect the community being served; and or cultural competence is ensured among those who are delivering services</li> <li>9. Program model or components are innovative</li> </ol>	<ol style="list-style-type: none"> <li>10. Program is able to document strong outcomes or results</li> </ol>	<ol style="list-style-type: none"> <li>11. <b>Leadership and commitment by staff are in evidence</b></li> <li>12. <b>Partnerships are essential to support effective programming</b></li> <li>13. <b>Funding and resources are available and leveraged to sustain the efforts</b></li> <li>14. <b>Staff issues are attended. Training and technical assistance are available for capacity building</b></li> <li>15. <b>Capacities are built in the organization and/or community (types other than evaluation)</b></li> <li>16. <b>Challenges are confronted</b></li> <li>17. <b>Systems change is undertaken</b></li> </ol>



## EXEMPLARY PRACTICE II: Leadership and Commitment by Staff are Evident

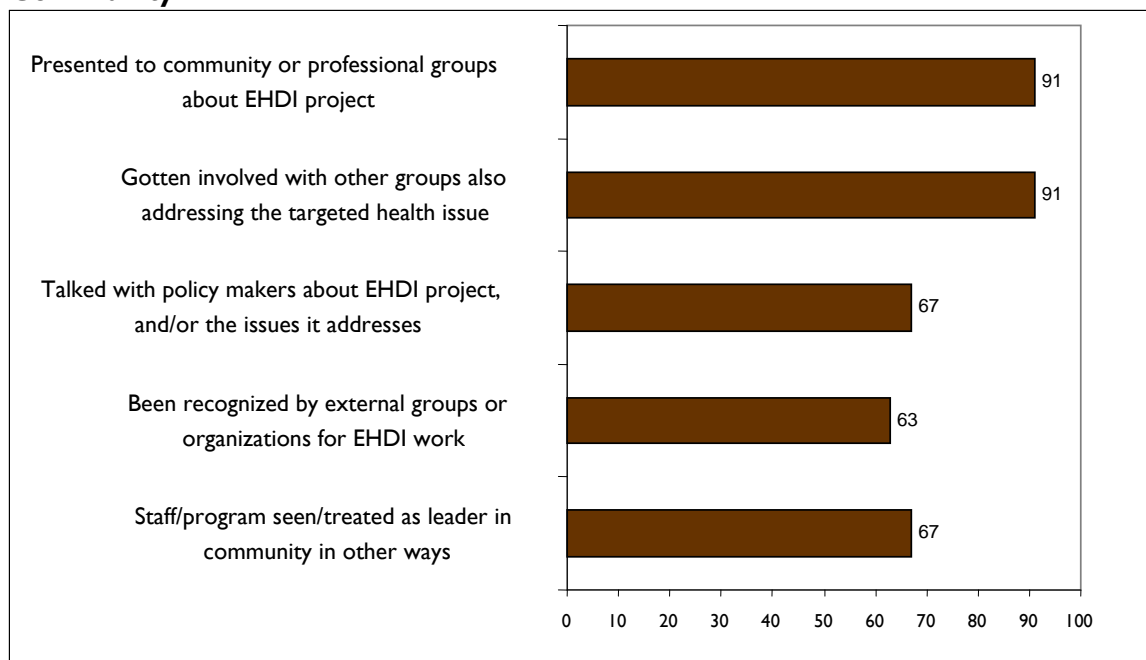
### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

There is a committed team whose foremost concern is the needs of the population. The team members work to effect change through a range of leadership activities, both within their own community, and with other communities. There is also a preponderance of other qualities associated with the leadership such as: cultural diversity, cultural competence, passion, compassion, persistence, and ownership.

### RESULTS

Grantee program coordinators were asked a series of questions about leadership activities related to their EHDI project and working on their health issues in their community. As Figure 1 shows, most were making presentations or sharing information with their racial/cultural and professional communities. Nearly all said they were actively working together with other organizations addressing their health issues. Two thirds of grantees had talked with policy makers about their EHDI project and the health issues being addressed. Just under two-thirds of grantees (63 percent) reported receiving recognition from external organizations such as receiving awards or being highlighted in a media report. Lastly, two-thirds said they were seen or treated as a leader in their own community as a result of their EHDI work.

**Figure 1. Percent of EHDI Grantees Reporting Leadership Activities in their Community**



## PRESENTATIONS IN THE COMMUNITY

Forty-two out of 46 EHDI programs coordinators (91 percent) reported that they or others from their organization gave presentations about the project to community or professional groups within the past three years. There were six main topics of the presentations (see inset box), which varied by the audience. The audiences or venues for these presentations fell into a number of areas—community groups and institutions, providers and professional groups, conferences, government and policy-makers and other types.

**Table 2. Percent of grantees presenting to community audiences**

Audience	Percent	Specific examples
Community Groups	91%	Groups of community members, organizations, events such as health fairs, school/district groups, churches, advisory groups and boards of directors
Conferences	60%	Conferences including 2004 OMMH conference, MOAPP and others. Six grantees presented at national conferences, and one at an international conference
Providers/professional groups	38%	Health care providers, health care workers, and health plans, professional groups, and academic institutions such as the University.
Government/policy-makers	38%	Legislature, city council meetings, county commissions, tribal councils, staff of different county departments, state agencies, members of US Congress
Other Audiences	14%	Funders or the media

### Topics of Talks

1. Educating others about the community's health issues
2. Describing the work of the EHDI project
3. Sharing effective strategies for working in the community
4. Recruiting participants or community health workers
5. Reporting research or evaluation findings
6. Seeking support for their issue, funding, or other resources

## PROGRAM SPOTLIGHTS

- **Hmong American Partnership:** “Our public health consultant and other members of the team presented to judges, judicial staff, and professionals serving Hmong families. “Presenting these topics helps educate the judicial system and mental health service providers to serve the Hmong community better.
- **Agape House for Mothers:** “I talked to our senators, congresswoman, city council people, and county commissioner. I [also] talked with some of the informal leaders within the community. We talk about what we do, how we do it, and why it’s important for us to work together to make a difference within the lives of the people in those communities.”
- **American Indian Family Collaborative:** “We’ve presented at countless clinics and to providers. We’ve gone to insurance providers and pitched the program to [them so they would] become providers within the system.” They have presented at the Doula International Conference, the MOAPP conference, and at a University of Minnesota conference (about their evaluation process). They have also been featured in the International Doula magazine, and Mothering magazine.

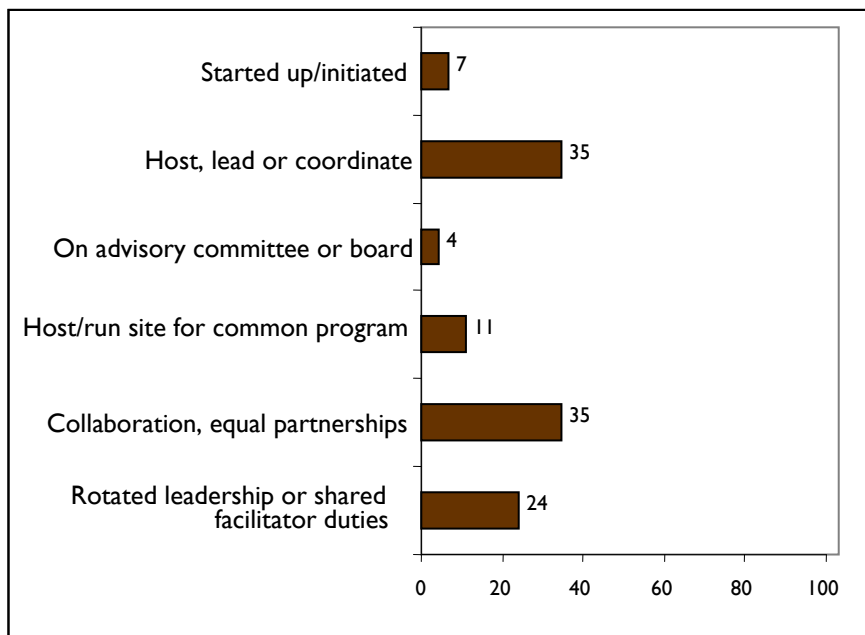
## HEALTH-TOPIC SPECIFIC COLLABORATIONS

Forty-two (91 percent) of the EHDI programs reported getting involved with other groups who address the same health issue:

- 72 percent collaborated with other organizations working in their community;
- 61 percent collaborated with mainstream or national level organizations; and
- 33 percent collaborated with organizations from other communities of color.

Grantees were also highly likely to play a leadership role in many of these collaborations. The leadership role took various forms as illustrated in Figure 2. Seven percent of grantees initiated or started the collaboration, 35 percent said they hosted, led or coordinated the collaboration, 4 percent served on boards or advisory committees, and 11 percent hosted or ran collaborative

**Figure 2. Percent of 46 grantees reporting different types of leadership roles in health-topic specific collaborations.**



program sites. Many grantees (35 percent) also participated in collaborations in which all partners are equal, or leadership rotated between members.

## PROGRAM SPOTLIGHTS

- **Upper Sioux Community:** The staff has been involved with a tobacco cessation project since its inception; the group does not have a leader, but do “things by consensus,” which is a cultural value in their community.
- **Lao Family Community of Minnesota:** “When it deals with our community, we’re leaders.”
- **Centro Campesino:** “In our work with the local clinics, we are the leaders. The clinics provide the services; we provide the preventive services and all the rest.”

● **Turning Point:** “We are working with a national organization, and they asked us to come out. We’re also putting a comprehensive state plan together for African American women and HIV/AIDS. I’m coordinating the team from Minnesota as we put the plan together.”

### EXTERNAL RECOGNITION

Twenty-nine (63 percent) of grantees reported they have been recognized for their EHDI work – such as receiving awards or being written about in newspapers or other publications. Among those having received recognition, the following types were reported:

**Table 3. Percent of grantees receiving recognition**

Type of Recognition	Percent	Specific examples
Publications or newspapers	41%	19 grantees were featured in articles in publications: most were in local newspapers, but 5 were written about in national, and 1 in an international publication.
Formal Organizational Awards	24%	11 grantees reported receiving a formal award. 1 was international, 4 were national, 4 were state level, and 2 were local.
Community members, groups, organizations	20%	9 grantees reported receiving recognition from community members, or other community organizations for their work.
Radio/TV	15%	7 grantees were highlighted in the media, 6 of these were on local radio or TV, and 1 was on national media.
Employee recognition	15%	7 grantees reported their staff members had been recognized by awards, or by being written about in a publication.

### PROGRAM SPOTLIGHTS

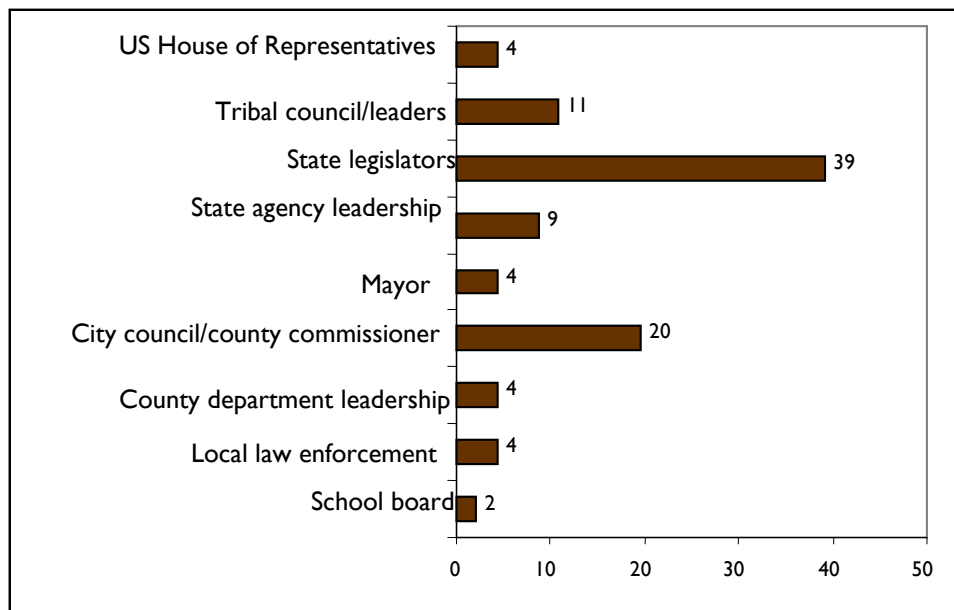
- **West Central Integration Collaborative:** “We were featured on NBC Nightly News with Brian Williams. Sports Illustrated had some of our students on there, also in the local newspaper, radio.”
- **Fremont Community Health Services:** “We received the Minnesota Non-Profit Award for Innovation in Health Care.”
- **Centro:** “Many parents and youth have sent us letters. And the best letters were from three youth that didn’t commit suicide, and are now going to college and say they will continue volunteering here.”
- **Stairstep Foundation:** “We received an award of excellence from the Minnesota Council on Physical Activity and Sports.”
- **Bois Forte Band of Chippewa:** “We were featured in Mesabi Daily News specifically on program services and activities we provide.” The program has also been featured in local papers and the program coordinator has been interviewed several times, including a recent “interview focusing on importance of exercise, physical activity.”
- **Hennepin Care East Clinic** received the 2003 Partners in Prevention Award from the CDC National Teen Pregnancy Prevention Research Center at the University of Minnesota.

● **Sisters in Harmony:** “Won third place award-- Outstanding Women of the Month, at Honoring Women Caregivers, very emotional event, got African American women involved in this event for the first time.”

**CONTACT WITH POLICY-MAKERS**

Thirty-one (67 percent) of grantees reported they had contacted political leaders and other policy-makers to talk about the health issues they work on, the needs of the community, and their work. Of those, 39 percent reported having contact with state legislators. Twenty percent had contact local leaders such as city council members or county commissioners and five grantees had contact with tribal leaders/council members. There were several other local policy-makers grantees contacted—mayors, county agency staff, law enforcement and school boards. A few grantees had contact with members of Congress.

**Figure 3. Percent of 46 grantees who have communicated with political leader or policy maker about EHDI program and health issues**



**PROGRAM SPOTLIGHTS**

● **Children’s Hospital and Clinics:** “We brought peer educators to talk to legislators about comprehensive sexuality education and why it’s important. It wasn’t so much us contacting them, but we helped the youth to contact them.”

● **Minneapolis American Indian Center:** “We’re involved in the East Phillips Park Community Design Project and have mobilized people to go to legislators so they can upgrade the park. We need a pool and a park. We were successful and were given \$3.5 million. Representative Karen Clark was part of that. In meetings with legislators, we

talked about the EHDl program and the value of exercise. We met with legislators 4 times this past year.”

- **Fond du Lac Band of Ojibwe:** “Just recently we discussed expanding lactation support to casino workers. We talked with the Reservation Business Committee and the Tribal Chairwoman.”

## OTHER INDICATORS OF LEADERSHIP

Two-thirds (31) of the grantees had other examples of how their staff or their program was seen as leaders in their community:

- Being asked by other organizations for technical assistance, or advice
- Program model is being copied or replicated in other communities
- Program frequently asked to collaborate, get involved in and lead other projects
- Program has expanded greatly, or had opportunities to expand
- Receive referrals from many new sources
- Program seen as the main source for help/information on that topic
- Staff seen as leaders because of work in community
- Staff respected because they “walk the talk”
- Staff able to pull together the community on related issues
- Asked by mainstream health organizations to help access community
- Program staff sought out as spokesperson for community by media or mainstream organizations

## PROGRAM SPOTLIGHTS

- **St. Mary’s Health Clinics:** “The fact that we’ve been approached to expand the program by other groups (17 parishes) says something about leadership. The other groups are finding that our model is successful in connecting with immigrants. For example, the county wants to reach out to the immigrant population, but knows the community is fearful to come forward and seek help due to their legal status. But then you also have Latino parish priests who are concerned that they’re officiating at more and more funerals for babies and wanted to know why this was happening and want to do something about it. We can be the conduit who can work with the county to bring [prenatal] services to the people.”
- **The Storefront Group:** “When a new family arrives, workers in Dakota County tell them to contact Storefront. Or if an agency wants to implement a program that will involve Somali kids, city officials tell the agency to contact Storefront first.”
- **Indian Health Board of Minneapolis:** “Because of the traditional component a lot of people have gained respect for me – they know I’m living [the traditional American Indian lifestyle]. More and more, people are asking me to come and talk to them. Women are traditional healers, leaders in that area.”

- **Council on Crime and Justice:** On broader issues of prisoner re-entry, the organization is looked to as a leader by developing policies for public agencies related to hiring practices for ex-offenders and other policy decisions related to ex-offenders.
- **White Earth Tribal Mental Health:** “We get referrals from the other agencies; they say ‘we have got the only show in town.’ Where we are getting our referrals is definitely stating something – we get referrals from places I never thought we would, like housing.”
- **Agape House for Mothers:** “People always look to us to find out how they can get a need met. Because we’ve had to be so innovative and creative to get more for less, they look at us as a resource or come to us to figure out how to do things.”

## EXEMPLARY PRACTICE 12: Partnerships are Essential to Support Effective Programming

### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Partnerships involve working with other individuals, agencies and institutions for effective delivery of health services. Included in this group is the larger health care system and social service system. Partnerships with systems allow programs to leverage support, thereby making it possible to address the other needs of individuals (education, housing and other social services) that lead to better health.

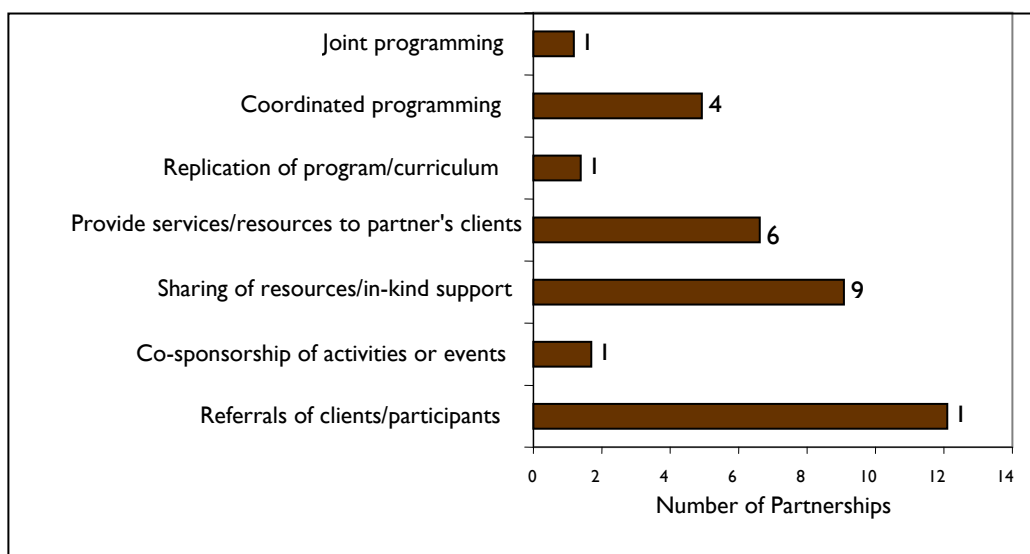
### RESULTS

Grantees were asked whether they worked in partnership with other organizations. Of the 48 grantees, 94 percent reported that partnerships play a major role in their their EHDI project, 6 percent said partnerships play only a minor role, and two did not respond to the question. Grantees were asked to name up to 10 of their partners and describe the work they did together. Across the 48 grantees with responses, 296 partners were named—an average of over six partners per grantee. Of these partners, 62 percent were said to play a major role in the EHDI program, and 38 percent played a minor role.

### NATURE OF RELATIONSHIP WITH PARTNERS

Grantees were asked to describe how they worked with their partners. Figure 4 shows the number of partnerships reported for each of seven types of relationships, in order from *most* involved to *less* involved relationships.

**Figure 4. Number of partnerships among EHDI grantee and their partners, by type of relationship**





## JOINT PROGRAMMING & COORDINATED PROGRAMMING

Twelve partnerships involved joint programming where two or more organizations work together as full partners to implement a program. Staff from both organizations work together to develop and jointly deliver the program. Joint programming also includes significant sharing of space, resources, curricula and other program materials. Grantees cited 49 instances of partnering through coordinated programming. This includes reliance on each others' resources and coordination of programming but actual service provision remains with one organization – either the EHDI grantee or their partner.

## PROGRAM SPOTLIGHTS

- **Minnesota International Health Volunteers:** “We work with the Confederation of Somali Community in Minnesota (CSCM), which is based in the heart of the Somali community in the Twin Cities. They host many of the community activities for the project. Our EHDI project supports a part-time Community Health Worker based at CSCM, who e community as well as co-leads the community-based exercise class.”
- **African American AIDS Task Force:** “Our EHDI Program staff works out of Hennepin County Medical Center. HCMC provides HIV screening, assessment & HIV/STD testing, and refers clients to us. We, in turn, provide full risk assessment, pre/post test counseling, give test results and provide follow-up, resources and referrals. This works for both agencies and the clients: we are able to reach more community members with information and services, and they are more likely to trust us, and as a result, follow-through with needed services or actions.”

## REPLICATION OF MODEL/SHARED CURRICULUM

There were fourteen instances cited of grantees working with partners to implement a program model or curriculum. In some cases, the grantee's program was being replicated by another and they were providing training and technical assistance. In other cases, the grantee was implementing a program model developed by others, or a national model and were receiving technical assistance and support from program developers or others implementing the model.

## PROGRAM SPOTLIGHT

- **Division of Indian Works:** “We are supporting various programs and tribes around the country to implement our curriculum—Cheyenne Rivers Sioux Tribe in Eagle Butte, South Dakota, Elbow Lake Sons and Daughters of Tradition, The Nest/Leech Lake Band of Ojibwe, St. Paul Public Schools Indian Education Program, Migizi Communications at Four Directions School.”

## PROVIDE EDUCATION, SERVICES OR OTHER RESOURCES TO EACH OTHERS' CLIENTS

Sixty-six partnerships involved grantees speaking or providing education to the participants of their partners' programs, or vice versa. In a few cases, partners assisted with community education efforts by providing media outlets (such as radio programs or newspapers). In other cases, the partners provided services or resources directly to participants, such as cribs, car seats, condoms, or other materials, or transportation.

## PROGRAM SPOTLIGHTS

- **Park Avenue Family Practice:** "Ramsey County and Hennepin County Public Health are distributing and promoting the breast feeding video we created for Hmong mothers through the WIC program."
- **Fremont Community Health Clinic:** "End Time Barber provided a blood pressure machine for use in his shop, and we provide educational materials. We now have five beauty and barber shops where we go and take customers' blood pressure readings while they are getting their hair done or waiting for an appointment."
- **Family and Children Services:** KMOJ radio supports 100 Men Take a Stand through the development and production of public service announcements, providing air time, and sponsoring programming aimed at the prevention of violence. In turn, 100 Men provides speakers for a variety of KMOJ shows.
- **Minneapolis American Indian Center:** The Healthy Options Program receives equipment, camping, canoeing and hiking safety workshops through Midwest Mountaineering and training from REI.

## SHARING OF SPACE, VOLUNTEERS, STAFF SUPPORT OR OTHER IN-KIND SUPPORT

Grantees reported 91 partnerships that involved sharing of resources, including space, volunteers or staff time, vehicles/transportation services, or other types of in-kind support.

## PROGRAM SPOTLIGHTS

- **West Central Integration Collaborative:** "The City of Willmar is very supportive of our EHDI [program]. [They provide] meeting space at no cost when needed, i.e., park shelters, swimming pools.
- **South East Asian Ministries:** Christ Lutheran Church on Capitol Hill provides rent-free space in which to hold programs.

## CO-SPONSORSHIP OF ACTIVITIES OR EVENTS

Seventeen grantees reported they work with partners to co-sponsor large community activities or events, such as health fairs, awareness-building events, or fund-raising events.

## PROGRAM SPOTLIGHTS

- **Centro:** “We co-sponsor monthly workshops [with the American Cancer Society] designed to inform the community about prevention, screening and other information related to breast, cervical and uterine cancer, as well as prostate and skin cancer.”
- **Olmsted County Public Health:** “The Association of Chicano, Hispanic and Latino Americans co-sponsors community events with us, such as health fairs, classes for youth and families.”

## REFERRALS OF CLIENTS/PARTICIPANTS:

Referral partnerships were the most common type of partnership—121 referral partnerships were reported. Referrals were made for services grantees do not provide, such as screenings or assessments, medical/clinical services, immunizations, counseling or medical health services, social services, continued programming, financial assistance/insurance issues, traditional healing, employment related services or housing.

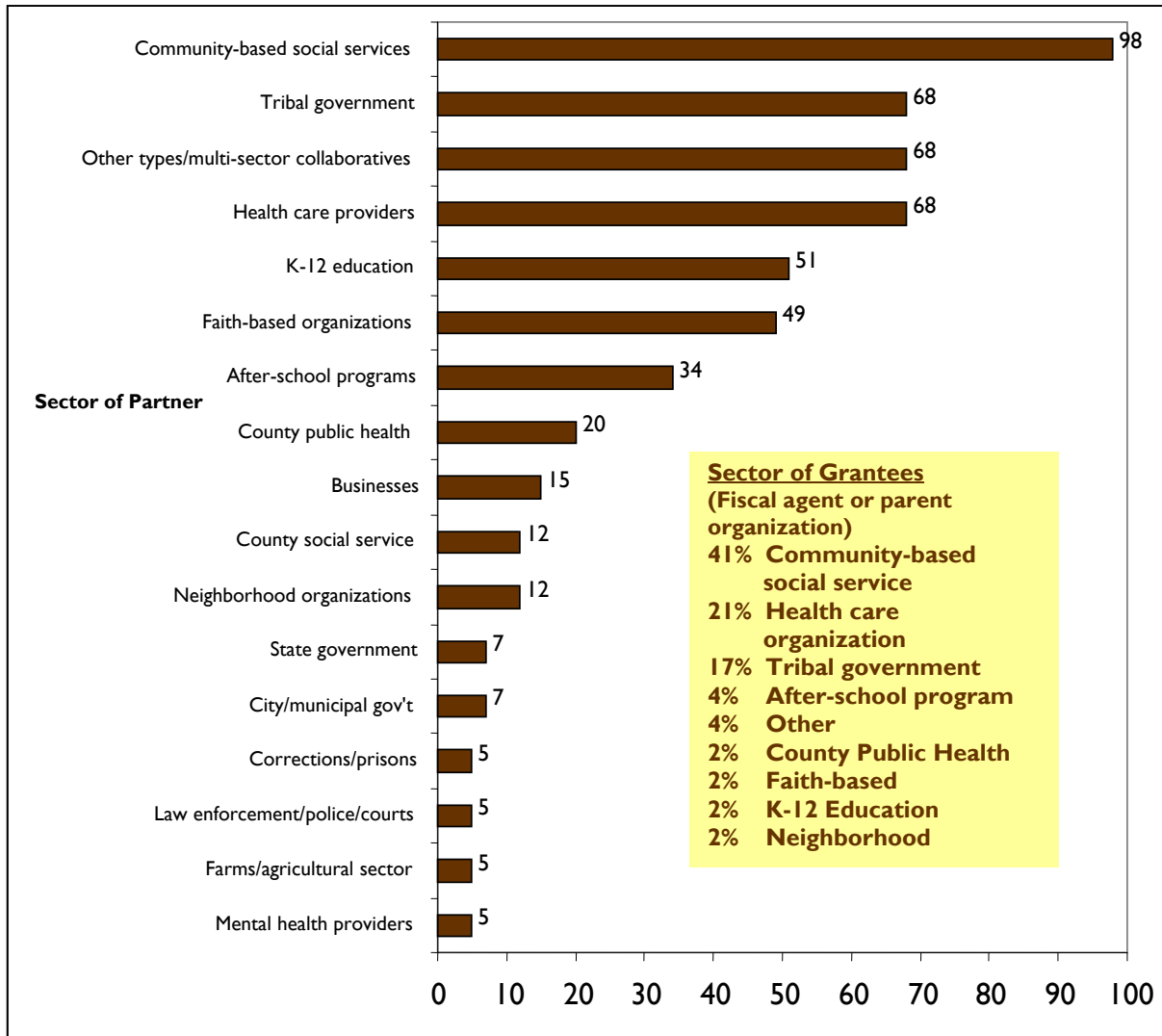
## PROGRAM SPOTLIGHTS

- **Lao Family Community of Minnesota:** The young mother case worker refers her young mother clients to Planned Parenthood or Face To Face Community Clinic for clinical services. “There is no need for insurance to visit these clinics and parents feel more comfortable when going there with Lao Family [staff].”
- **Agape House for Mothers:** “Bridges of Hope provides a leadership course to program participants that graduate from our program, demonstrate leadership skills and are interested.”
- **Bois Forte Band of Chippewa:** “We rely on providers, such as the Bois Forte Medical Clinic, to refer patients to the program and fitness center, and we refer clients to the medical clinic, as needed.”

## CROSS SECTOR PARTNERSHIPS

Seventy percent of the EHDI partnerships are cross-sector relationships. The various sectors that grantees partnered with are represented in Figure 5.

**Figure 5. Percent of Grantees reporting 1+ partners in each organizational sector**



Health care organizations were mostly likely to partner outside of their sector (87 percent). Community-based social service organizations were also likely to partner outside of their sector (70 percent). Tribal governments, on the other hand, were most likely to partner with other tribal entities, such as other divisions within tribal government and only a third named non-tribal partners.

## PROGRAM SPOTLIGHTS

- **Grand Portage Band of Ojibwe:** “The partnerships have grown significantly since we started working on the Health Disparities efforts. The relationships with the clinic are more formalized rather than casual, resulting in more consistent care for patients and better health care continuity. Our relationships have also resulted in greater access to care such as in the case of the Cook County North Shore Hospital. Physical Therapy service is provided on-site here in Grand Portage. This is the first time the hospital has ever provided care outside of their facility. Hopes and Dreams contributed to reducing the stress of hospitalization by supporting patients in accessing care, receiving traditional support and supporting family in the hospital.”
- **Annex Teen Clinic:** The partnerships between the collaborative organizations reflect a replicable model for a comprehensive, community-based approach to teen pregnancy prevention. Research is clear that effective pregnancy prevention programs must provide comprehensive and accurate information about adolescent sexual health, access to clinical services, and meaningful youth development programming with family involvement. The only realistic method for providing this breadth of programming is for several agencies to integrate their respective programming. Relationships between the partners have grown stronger and strengthened each agency's capacity to provide effective programming.
- **Minnesota International Health Volunteers:** “The partnership between us, Confederation of Somali Community of Minnesota (CSCM) and LEAD is unique because we are three agencies with distinct missions who have come together under a common goal – to reduce health disparities in the Somali community. Each agency brings a special skill set, and set of resources that complements the others. MIHV has over 28 years of community-based public health implementation experience, CSCM has over 20 years of experience providing services to the Somali community here in Minnesota, and LEAD Group provides cultural and leadership expertise. The assets of all agencies combined, along with a clear delineation of roles and responsibilities, created a strong partnership.”
- **Hennepin Care East Clinic:** “We work with many partners to get services for our adolescent and young adult clients, including CLUES, and MVNA. SICE at Hennepin County helps us to analyze patient data collected by our program staff. We have also partnered with the University of Minnesota Extension Service and Shoulder to Shoulder to develop a curriculum for Latino parents of adolescents, evaluate it, pursue funding, and replicate it.”
- **White Earth Tribal Mental Health:** “We work with over a dozen partners for our adult domestic abuse program and our school-based youth programs. We work with the tribal council, administrator's office, social services, and chemical dependency to meet the multiple needs of our clients. In addition, we get referrals from tribal court, tribal police, and courts/social services in counties around the reservation for men (and some women) who have been charged with domestic abuse. We work closely with corrections for two reasons—if they don't comply with program rules and attend, they get sent back to jail. We also share data on outcomes for our participants and can show how well our program reduces subsequent involvement in court for domestic abuse charges.”

## EXEMPLARY PRACTICE 13: Funding and Resources are Available and Leveraged to Sustain Efforts

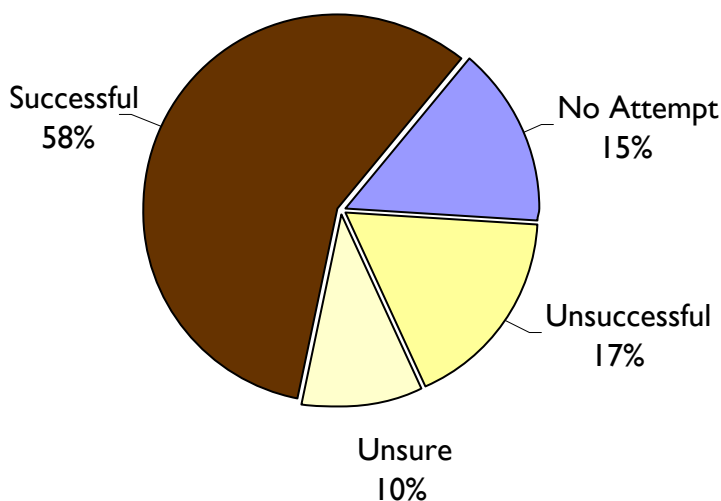
### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

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. Resources include not only dollars, but-in-kind resources of various types.

### RESULTS

Grantees were asked a series of questions on the online survey about their attempts and success at leveraging funding and in-kind resources. When asked how their EHDI program is funded, 28 grantees (58 percent) reported they had successfully leveraged non-EHDI funds for their program. Seventeen percent had tried but were not successful in leveraging other funds, 15 percent had not tried to leverage other funds and 10 percent (4) were unsure (see Figure 6).

Figure 6. Grantee's leveraging success



As Table 4 shows, of those who were able to secure non-EHDI funds, the median number of dollars raised across the lifetime of the EHDI grant was \$90,000 with a range of 150 dollars to over half a million. The total of funds leveraged over six years totaled three million dollars. The grantees successful in fundraising received grants from foundations, corporations and government, or were able to develop other revenue streams.

**Table 4. Profile of successful leveraging by 28 grantees**

	Number
Number of Grantees	28
Total Raised (Across all grantees)	\$3,000,000
Average raised (median)	\$90,000
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%

**In-Kind Resources:**

79% of grantees had leveraged in-kind resources, including:

- Space
- Administrative support
- Volunteer-time
- Supplies/goods
- Equipment
- Marketing Services

**FACTORS CONTRIBUTING TO SUCCESS IN LEVERAGING EHDI FUNDS**

Four themes emerged in response to the question, “What do you think has contributed to your success in leveraging other funding for your EHDI Program.”

**I. Utilize Core Grant as a Solid Foundation for Leveraging Other Funding**

Seven grantees indicated that the EHDI grant itself helped them to leverage other funds, directly or indirectly. In a few cases, having an adequate base or source of core funding (from the state) made them more attractive to funders. Because of the EHDI funding, grantees had opportunity for involvement in certain activities which in turn led to additional funding. One grantee wrote about their successful EHDI program in grant proposals--even for other programs. Some reported that funders were more likely to invest in successful ongoing programs with solid funding and demonstrated success, such as EHDI programs.

**PROGRAM SPOTLIGHTS**

**The Storefront Group:** “Our involvement with Eliminating Health Disparities has given us the opportunity to study and document other health needs in the community. We have identified the need for mental health services in our target group. We received a small grant from Park Nicollet foundation to assess the situation. We recently received a big grant for two years to provide children and adult mental health for East African immigrants. Today, the EHDI program, which was a single activity of immunization program, has turned to be a division within Storefront called Immigrants Health and Wellness Program. Without EHDI, we would not have the opportunity to develop this new program that consists of different health and wellness services for immigrant family and children.”

**Annex Teen Clinic:** “The stability of the EHDI funds provides a level of confidence that the REACH collaborative will have the capacity to truly produce the level of programming and outcomes that funders are looking for. In addition, the comprehensive nature of our model lends itself to addressing a multitude of interrelated risk behaviors and producing better outcomes than approaches that are more narrowly focused.”

## 2. Able to Demonstrate Outcomes & Outcomes are Valued

Eight grantees reported that the ability to describe and document outcomes helped them to secure additional funding.

### PROGRAM SPOTLIGHTS

- **Vietnamese Social Services of Minnesota:** “With the funding from EHDl as the foundation for the project, we were able to show the results of our work in bettering the lives of people in the community; therefore [others] want to provide their support.”
- **United Hospital Foundation:** “We have innovative programs that show results, plus the strength of having the EHDl funds to bolster other funding sources and the assistance in evaluating programs that EHDl has provided.”
- **Agape House for Mothers:** “We provide a comprehensive and full service program for our program participants, which yield us the types of outcomes that other funders support.”
- **Boys and Girls Club:** “It’s a program that works and has been tested across the country in other communities.”

## 3. Funders Interested in Their Issue, Population and/or Approach

Another six grantees believed their success was related to funders’ growing interests in the issue or needs addressed by their program and their approaches and /or that funders want to support the replication of successful programs.

### PROGRAM SPOTLIGHTS

- **Leech Lake Band of Ojibwe:** “I think our success of securing [funding] has to do with our focus on suicide prevention, which is a huge issue amongst American Indian Tribes.”
- **Family and Children’s Services:** “Funders were very interested in supporting African American men who wanted to strengthen their community. One of the grants came from a personal connection of one of the 100 Men Take a Stand committee members.”
- **Division of Indian Works** attributes their success at leveraging funds to the growing popularity of Doulas, the increased use of them, and an increased focus on infant mortality prevention.
- **Southeast Asian Ministry:** “People understand that there are health disparities and believe the education provided by the parish nurses can make a difference.”



#### **4. Adequate Infrastructure & Support for Fund Raising is Available**

Four grantees noted that having a grant-writer, as well as other administrative support from their organization and from partnering organizations contributed to their success in securing funds for their program. Four grantees also noted that they were able to secure funds because their organization was eligible for specific funding streams, such as funds aimed at school populations, MCH Block Grants from the State to Tribes and other tribally directed funds.

#### **PROGRAM SPOTLIGHTS**

- **Hennepin Care East Clinic** was successful at receiving funds because their grant-writer can put all the information together into a strong proposal.
- **West Central Integration Collaborative:** “Because we are youth focused, we are able to access integration dollars. So for example, we can access transportation dollars if we are doing an integrated activity during our health programming.”

## EXEMPLARY PRACTICE 14: Staff Issues are addressed

### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Addressing staff issues includes having a high rate of staff retention and low turnover, having a committed staff who can focus on their similarities and the needs of the population rather than getting mired in their differences, and hiring program coordinators to handle administrative responsibilities (fund development, disbursements, etc.) that often side-track the program staff.

### RESULTS

The three main staff issues EHDI programs reporting facing were:

- Recruiting well-qualified culturally competent staff and workers
- Managing workloads and stress to avoid burnout
- Retaining employees, and handling staff turnover smoothly

### SUCCESSFUL RECRUITMENT OF STAFF

One of the exemplary program practices previously reviewed—“Staff reflects the community being served; and or cultural competence is ensured among those who are delivering services” makes staff recruitment of key importance. This can be challenging for two reasons: continued under-representation of communities of color in health professions, and pay scales which are generally lower than in the private or public sectors. To counter this, EHDI programs:

- **Offer desirable benefits packages.** Though they often cannot offer high wages, many of the grantees reported offering reasonable wages in combination with other benefits, such as high quality health plans, retirement plans, and generous leave options.
- **Provide training opportunities.** Grantees also report providing substantial training opportunities to staff. This training may focus on technical skills with culturally competent employees or providing advanced training to help employees advance their careers.
- **Use contractors.** In the absence of full-time staff members, grantees used contractors to supplement needed skills and competencies.

### PROGRAM SPOTLIGHT

● **Fond du Lac Band of Ojibwe** provides staff generous benefits, holidays and personal leave days. They send staff to trainings – both in their specialty areas, as well as on other topics they are unfamiliar. In addition, they give staff the “opportunity to be creative [and make]

resources available for people to fund ideas.” They also have staff meetings and informal networks in which staff can share ideas, encourage each other and work together to resolve issues as they arise.

## RELIEVING STRESS AND REDUCING BURNOUT

In many EHDI programs it can be easy for staff to quickly experience burnout. Staff often serve multiple roles within their organizations and work with people facing difficult circumstances--which can be emotionally draining. Grantees utilized multiple approaches to support staff:

- **Recognize staff members’ limitations.** As one organization explained, they understand what staff can and cannot do: they “recognize staff’s limitations and do not ask them to do things for the program that is more than what they’re capable of doing.” Others make sure to give staff time to “regroup” or “take a mental health break” after a particularly difficult project or client encounter.
- **Compile documentation in an ongoing way for annual funder reporting.** This way, the task doesn’t wait until the end of the year and become every more of a burden.
- **Share work or rotate staff members working in the community with those working in the offices.** Staff often work in teams or have regular meetings, so they can share ideas and troubleshoot with each other.
- **Incorporate fun and/or stress relieving/recharging activities into work.** Recharging strategies include hosting retreats, social lunches, attending traditional ceremonies, doing Tai Chi, or having parties. These activities help staff de-stress and provide a break from the demanding nature of their jobs.

## PROGRAM SPOTLIGHTS

- **Indian Health Board of Minneapolis** attends to the personal needs of staff by incorporating traditional ways into their staff activities. For example, they do smudging or go to traditional ceremonies together on the weekends.
- **Agape House for Mothers:** “Staff goes in and out [of the community] because if you stayed out there in the community all the time you would suffer burnout very quickly.

## RETAINING STAFF AND HANDLING TURNOVER

Staff turnover and retention are critical issues organizations must address to stay productive. On their 2006 reports, 18 grantees (39 percent) said they experienced turnover in their program in the previous year. According to the Minnesota Council on Nonprofits 2006 Salary and Benefits survey, 73 percent of the 615 Minnesota nonprofits surveyed experienced turnover in 2006. This

statistic pertained to the entire agency, while the grantee statistic referred just to their EHDI program. EHDI grantees reported using the following strategies to retain staff:

- **Hire the right people.** Many organizations stressed the importance of hiring qualified and passionate individuals at the onset so they are less likely to leave. People that are passionate and dedicated to their communities are more likely to stay in their positions.
- **Maintain accountability.** Program coordinators talked about maintaining and communicating high expectations for staff performance. By providing staff with clear job performance standards, they know what is expected of them upfront and work towards those goals.
- **Provide support and open communication.** Managers and supervisors support staff when there are challenges and programs have built-in methods of communication between partners, staff members and leadership to provide support and growth.
- **Promote a feeling of ownership of the program.** Programs retain staff by giving them ownership of their programs and opportunities to try new ideas. A respondent in one organization explained, “One of the things we try to do with staff is match program responsibilities with areas of interest and expertise and allow latitude for developing and shaping the program so it ends up being rewarding work.”
- **Show appreciation.** Appreciating and recognizing staff accomplishments are critical to retaining staff. Staff members are more likely to stay when they feel like they are making a difference.
- **Allow flexible schedule.** Because many grantees cannot pay high salaries, they provide other benefits such as flexible scheduling, so that staff can attend to their personal lives when necessary. One grantee said, “They can have flex time or just work from home if they need to, as long as they finish their work.”

## PROGRAM SPOTLIGHTS

- **West Central Integration Collaborative** offers staff a lot of flexibility to work around their personal lives. They also work as a team, meaning that even the director will be out working in the program when necessary. They incorporate fun activities into their work day, such as social lunches. Finally, communication between their staff, their partners, and coordinators is a key component to making sure staff has support and appreciation.
- **Children’s Hospitals and Clinics:** Staff has fun and incorporate activities they enjoy that also benefit the community – they have “ownership” of programs.

## EXEMPLARY PRACTICE 15: Challenges are confronted

### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

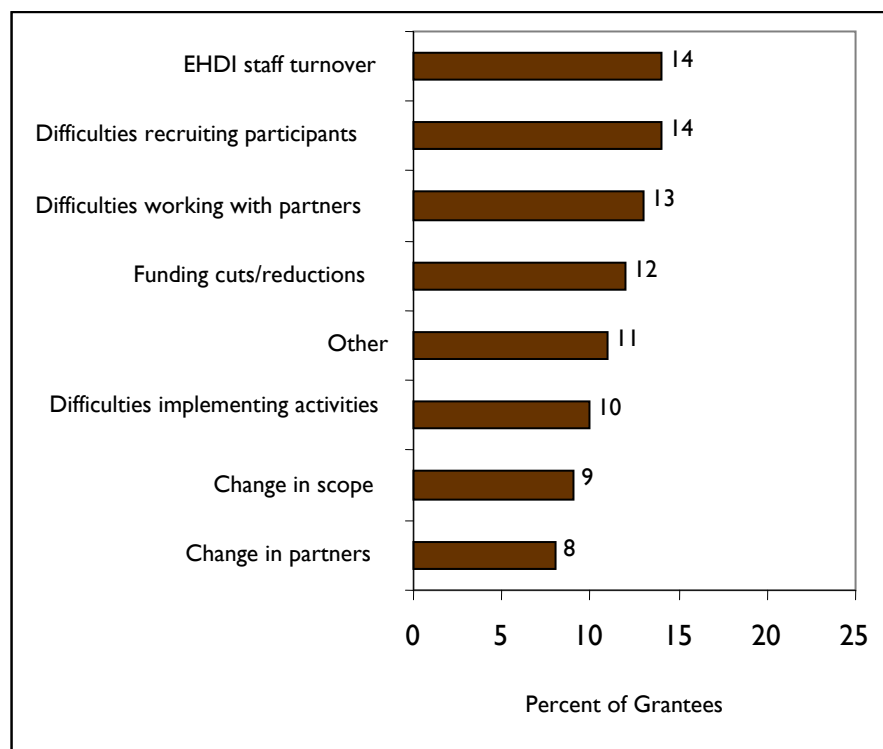
All organizations and programs that seek to promote change face challenges in accomplishing their objectives. Successful programs are willing to challenge mainstream ways, including cultural norms that promote unhealthy habits. Programs also are willing to engage the communities in discussions of previously hidden or buried issues (such as domestic violence), and raise these issues to a new level of visibility. They are willing to take risks, to try new, different, and untested ways to improve people's lives, and to persevere even in anticipation of, or in the midst of, failure.

### RESULTS

Learning about types of challenges faced by organizations focused on reducing health disparities and the solutions they employ, may help others embarking in this work. Grantees were asked which of eight challenges they experienced in 2006. The results are shown in Figure 7.

When asked to describe a major challenge faced in the past two or three years, and how they dealt with it, grantees offered 90 examples in six areas: funding and resources, staffing, program implementation, challenges working with participants, with partners, with different sectors or systems and confronting community norms.

**Figure 7. Challenges grantees reported experiencing in 2006**



## RESOURCE CHALLENGES

Twenty-one grantees cited challenges in securing adequate resources to support the program, meet the needs of their participants and provide transportation or childcare for participants.

**Table 5. Resource challenges encountered by EHDl programs**

Type of Challenge	Percent	Specific examples
Not having adequate resources	20%	9 grantees said they had challenges having adequate funding, or are having challenges developing revenue streams to become sustainable
Transportation	13%	6 grantees specifically talked about challenges in having adequate resources to provide transportation services for clients, or that clients had difficulties with transportation that impacted services
Can't meet needs with existing resources	11%	5 grantees described a situation where the need in their population was outstripping their ability to provide services with existing resources
Childcare	2%	1 grantee described challenges in having adequate resources to overcome barriers to accessing services for clients, such as childcare

Some of the strategies for dealing with these resource-related challenges included cutting back on services, trying to develop new revenue streams or leverage funds from other sources, developing partnerships to access additional resources, and making organizational investments in grant-writing and development.

## PROGRAM SPOTLIGHTS

- **Agape House for Mothers.** “The need is greater than the dollars. We’ve only touched the very tip of what was revealed to us in the focus group of what the needs really are in our community and it continues to grow on a regular and consistent basis.”
- **White Earth Tribal Mental Health.** “The biggest challenge is transportation. We used to provide gas vouchers, but were then forced to cut back; we try to hook guys up from the same community that can ride together; we also go out to the community during orientation [and provide services in] community based settings.”
- **Fremont Community Health Services.** “Transportation for peer educators is not funded in the budget; they use their own cars and pay for their own mileage. This limits our ability to expand the geographic area we serve.”

## STAFFING CHALLENGES

As seen in a previous section, staffing challenges were one of the most common challenges faced by 22 grantees. These included not only finding and retaining core program staff, but also recruiting community members to serve as community health workers and peer educators. Turnover in the larger

organization of which the program was a part, and in partnering agencies also impacted the EHDI programs.

**Table 6. Staffing challenges encountered by EHDI programs**

Type of Challenge	Percent	Specific examples
Finding and retaining staff	18%	7 grantees cited struggles in finding and hiring well-qualified culturally competent staff for the EHDI program. Finding the “right” staff was emphasized. Nurses were one type of staff cited as particularly difficult to find by two grantees
Retaining and managing peer educators, or community health workers	18%	7 grantees described challenges in finding, retaining and managing part-time community members who were providing services for the program. A major problem was keeping and managing these community workers, once trained, as conflicts with jobs and other responsibilities forced them to leave
Turnover in the EHDI program’s parent organization	7%	3 grantees talked about the impact that turnover in other parts of their organization had on the EHDI program, particularly if it involved positions that oversee the EHDI program
Turnover in partnering and collaborating agencies	4%	2 grantees talked about how turnover in key positions in their partner agencies impacted their work
Other	7%	3 grantees talked about other issues related to staffing, such as the difficulties in finding and managing staff that were expected to work odd hours when clients needed them

Specific solutions for these types of issues within the grantee organization were highlighted under the section “staffing issues addressed.”

## PROGRAM SPOTLIGHTS

- American Indian Family Collaborative:** The program was losing Doulas because they were not making consistent money. They tried to pilot a “core Doula program,” in which Doulas were salaried instead of consultants. That was not as successful as was hoped; instead, they raised the fees they pay certified Doulas. In addition, they made their expectations more clear after some Doulas were not seeing their clients often enough.
- United Hospital Foundation:** “I think the most sustained challenge is in finding and keeping population-specific educators. We have adapted and developed new ways of connecting and locating population specific education. Finally, it feels like in the last 12-18 months, we have developed a knack for it. We had a training last week where we found three new educators. We’ve reached out to different partners, that aren’t traditionally our partners, which have provided opportunities for others to become educators.”

## PROGRAMMATIC CHALLENGES

A number of grantees described challenges associated with managing programs, including the need to provide linguistically-appropriate and/or translation services in the face privacy and confidentiality policies. Programs working with partners to replicate their curriculum or program faced the

challenge of balancing the need for the new sites to adapt the program to fit the needs and culture, while maintaining quality and ensuring programmatic fidelity. Two grantees described major restructuring of their parent or organization, or adapting to new fiscal agents. One grantee was challenged by the need to offer creative and fun program services to retain program participants.

**Table 7. Programmatic challenges encountered by EHDI programs**

Type of Challenge	Percent	Specific examples
Language and translation	9%	4 grantees described challenges related to language such as providing services in multiple languages, providing translation services for clients at clinic visits and challenges reporting and preparing grant proposals.
Program replication or expansion	7%	3 grantees described problems managing the replication of their program in other sites—managing the quality and ensuring fidelity. 1 grantee described issues with expanding their EHDI program.
Restructuring of organization	4%	2 grantees said a restructuring of their organization, or finding new fiscal agent had impacted their ability to function.
Designing creative program activities	2%	1 grantee described the need to be creative in designing program activities that would continue to be of interest to youth participants.

The solutions employed by grantees for these problems centered on being creative with available resources, clearly communicating the needs and maintaining flexibility in dealing with others.

## PROGRAM SPOTLIGHTS

- Vietnamese Social Services:** The providers they work with don't allow a third party to be present at appointments to translate because of HIPAA rules and patient confidentiality. VSS explained to the providers that because of cultural and language issues, a translator needs to attend. They negotiated with providers to allow translators to attend appointments but they stand outside the room during the exam (e.g., during a pap smear).
- Hennepin Care East Clinic:** After they reorganized, it was difficult to maintain the programmatic values within a new organization that was less Latino. "We continue to educate management about the program. It was a new concept for them too. It isn't always clear at first and we have to advocate for a lot of things – like the protection of confidentiality."
- Division of Indian Works:** "The biggest challenge is trying to maintain the quality of services, because we are not delivering the services—our partners are; but we expand what we offer to help the people who are delivering the model....we try to be clear what



are our delivery expectations....get fiscal directors to sign service agreements to ensure the site organization understands its obligations.”

## CHALLENGES IN PARTNERSHIPS AND COLLABORATION

Nine grantees described challenges in working with partners or collaborating with others to accomplish the goals of their program. Such challenges ranged from building and maintaining partnerships, lack of cultural competency in partnering agencies, changes occurring in the partnering agencies, and lack of reciprocity between the grantee and their partner. Solutions involved clearly or formally stating each partner’s role and expectations, providing training on cultural issues to partners’ staff, and maintaining good communication with multiple people within the partnering agency to ensure positive transitions during turnover and change.

## PROGRAM SPOTLIGHT

● **Children’s Hospital and Clinics:** “One of the challenges we faced was that the primary place we’ve done our work is in the Minneapolis Public Schools and about a year ago, they [changed their policy and] said we couldn’t do “sex education with 5<sup>th</sup>-8<sup>th</sup> graders anymore.” I worked with the curriculum and instruction department to address their concerns. I ended up basically writing a scope and sequence document for them that would lay out exactly what could be covered at what ages. It was based on the school’s health education standards and we were able to eventually resolve it so they felt more comfortable having us in the schools again.”

## CHALLENGES WORKING WITH PARTICIPANTS

Sixteen grantees described issues in working with clients or participants as the most difficult. Three types of participant-related challenges were noted. Trying to maintain contact and stay involved with participants who were highly mobile was cited by eight grantees. Five grantees said it was often challenging getting clients to accept services and to make changes in their lives to protect their health. Lastly, three grantees described difficult situations encountered working with clients. Solutions to these types of problems required persistence, patience, good communication and education skills. Grantees also used creative ways to track down clients using friends, family, or community contacts, and maintained a presence in the community.

**Table 8. Challenges working with participants encountered by EHDI programs**

Type of Challenge	Percent	Specific examples
Retaining or maintaining contact with participants	17%	8 grantees cited challenges retaining clients and maintaining longer-term contact with participants given the mobile/transient nature of their population
Getting clients to accept services	11%	5 grantees deemed getting clients to accept services as a major challenge. This might involve the client’s recognition of their own need for services (denial), or difficulties establishing trust
Challenging situations	7%	3 grantees described challenges in working with clients with

with clients	multiple needs facing difficult situations
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## PROGRAM SPOTLIGHTS

- **Centro:** “The first challenge is that the community is scared of the government. And you have to explain to the community about that. To get them to go to program is harder.”
- **Freeport West:** “I think the biggest challenge we had, particularly when we first started, is that our population is so transient that it was hard to get them to make a commitment. Most of our services are ‘work at your own pace, come when you can.’ This was the first program where they had to make a 9 week commitment. That was a huge challenge to get youth to commit to show up for 9 weeks in a row, primarily because their lives are always in such a transition; they never know from day to day where they’re going to be living, if they’re going to have a job. It was really hard to get them to make a commitment so that was biggest challenge.”
- **Mille Lacs Band of Ojibwe:** “I guess one challenging situation would be a grandmother who had two young children. She was in a wheelchair, not wheelchair bound but she used a wheelchair to get around. I went weekly to ensure the children’s safety being with a grandmother who couldn’t get around very well and them being very young. I worked with her to get respite and then foster care. Now, for the children’s safety, she put them in foster care.”

## CHALLENGING COMMUNITY NORMS AND WORKING WITH SYSTEMS

Many of the challenges faced by grantees involved dealing with larger systems, such as the health care system, educational system, corrections system, or working with policy or governance bodies. They clashed over policies, practices, lack of cultural understanding and sensitivity. Working in their own communities, however, posed challenges as well—encountering norms of silence around difficult issues. Lastly, they confronted larger trends in health issues—changing population needs or issues, or lack of services/providers in their geographic areas.

It is difficult for grantees to deal with larger systems, that often don’t share their understanding of needs and appropriate ways to work with members of their community. They also had difficulties with policy makers with conflicting agendas. These challenges require clear and persistent, communication, effective marshalling of data, and communicating the mutual benefits of working together. Confronting norms of silence and denial in their own communities requires respectful education that appeals to the preventable or treatable nature of the problem when brought into the open.

**Table 9. Systems or community-level challenges**

Type of Challenge	Percent	Specific examples
Problems working with different systems of sectors	15%	7 grantees cited conflicts or problems that emerged in working with larger systems or different sectors, including health care system, educational system/schools, correctional systems, cultural clashes with organizations in mainstream community, or issues

Type of Challenge	Percent	Specific examples
		with funders.
Dealing with sensitive issues in the community	7%	3 grantees had to confront community norms of silence around their health issues, and the need to break down barriers to talk about issues including “sex”, “violence” and “suicide” in their communities.
Politics/buy-in from policy-makers	7%	3 grantees talked about issues in getting buy-in from policy-makers, or dealing with fallout from political upheavals or conflict
Lack of services available	4%	2 grantees talked about the lack of culturally competent services available in their area, particularly healthcare services
Other	4%	1 grantee talked about changing needs/nature of their population, 1 grantee talked about the need to counteract mainstream media messages that negatively influence youth.

## PROGRAM SPOTLIGHTS

- Council on Crime and Justice:** “One part of our project is training inmates to do peer education with other inmates. We have had ongoing challenges from prison staff because prisons have a policy that one inmate can’t have authority or control of another inmate and that can be interpreted to mean that an inmate can’t be a teacher or facilitator. We had hoped that inmates could do presentations in other parts of the prison and at orientation. That’s happened occasionally, but it is discouraged by the prison for security reasons and due to a lack of inmate privileges. We are trying to find other ways to do peer education.”
- African American AIDS Task Force.** “A challenge has been marrying a community-based organization with a major medical facility; our modes of operation are different.”
- Annex Teen Clinic:** “When it comes to conversations about sexual health, there are always varying levels of comfort and some people feel that some aspects of adolescent sexual health should be discussed and others that feel it shouldn’t. Being able to negotiate those disagreements in a skilled way is really important. I think the work that we have in front of us is being able to model talking openly and honestly about sexual health, acknowledging that we bring different values to the table, but acknowledging that young people deserve access to accurate information.”
- Leech Lake Band of Ojibwe:** “One of the biggest challenges is getting the community and leaders to understand what behavioral health is and what the program is, from tribal leaders all the way down. We deal with public health, not so much individual mental health. Suicide is public health issue affecting everyone in community and encompasses whole person; mental health has a stigma for people everywhere. We are trying to overcome the taboo of talking about mental health issues and suicide generally.”
- Lao Family Community of Minnesota:** “We thought we were just getting somewhere with the population and then this refugee population just throws us a curve ball. I don’t know what they learned at the refugee camps, but they didn’t learn about sexually transmitted infections. We have people coming over who are married at age 13 and their families aren’t together anymore. There are a lot of issues there and a lot of it is cultural.”

## EXEMPLARY PRACTICE 16: Capacities are Built in the Organization and Community

### EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Through the course of developing, implementing and evaluating the program, new skills, abilities, practices and competences are built both at the individual level among program staff in the organization and in the greater community. These new capacities are often a result of the training and experience that ripples from the individual throughout the organization and into the community.

### RESULTS

Capacities are built within organizations and communities in stages. At the start, staff members gain new knowledge and skills to implement their program. Once the program is underway, individual community members begin to gain new knowledge and skills. In turn, the newly gained capacities flow out into the community as participants share their knowledge and skills with others. Organizations gain more capacities through staff training, hiring new staff with different skills, and sharing skills among staff members. As a result, organizations are able to secure more funding, gain visibility and recognition and provide leadership in the community.

### CAPACITIES BUILT IN THE COMMUNITY

- **Participants serve as ambassadors by communicating information:** Ten grantees described how their participants are sharing new knowledge with their social networks and outward to wider networks. Participants are “out in public talking to each other about health issues,” “youth are becoming advocates for teen pregnancy prevention,” and “participants relay messages to others.”
- **Raised Awareness of Community Health Issues:** Eighteen of the grantees reported building the capacity of their communities by raising knowledge and awareness of health issues, health risks and healthy behaviors. While most individuals in mainstream communities are aware of unhealthy behaviors, this cannot be assumed when communities lack access to health information.

### PROGRAM SPOTLIGHTS

- **Lao Family Community of Minnesota.** “One of the goals of EHDI is to eliminate [the gap in] what [the community] knows right now versus what they should know.”

● **Council on Crime and Justice.** Their participants have been empowered by the project to do their own health education both formally and informally with other people in their communities.

**CAPACITIES BUILT AMONG STAFF**

- **Increased quantity and quality of staff:** Seventeen grantees reported that their EHDI grant enabled them to increase staffing levels and/or skills. 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.
  
- **Investment in staff development:** In the past three years, grantees sent staff to local, regional and national conferences, and workshops sponsored by universities, Minnesota Department of Health, US Department of Health and Human Services, American Heart Association, the Red Cross, Hennepin and Ramsey Counties and several local nonprofits. Some staff members completed degrees, certifications, or licensing programs (e.g. MPH, Doula certification). Training staff is important because it increases the capacity of the grantee organization, and the minority workforce.

EXAMPLES OF TRAININGS	
Topic-based trainings	Skill-based trainings
Adolescent Pregnancy Prevention	Case Management
Cancer 101	Community-based Participatory Research
Childhood Obesity	Community Health Worker
Diabetes	CPR
Hepatitis Prevention	Confidentiality / HIPAA
HIV / STIs	Crisis Management
Infant Mental Health	Glucose Screening
Lactation Consulting	Goal setting
SIDS	Mentoring Skills
Anti-racism	Mandatory Reporting
Gangs	Motivational Interviewing
Truancy Issues with Youth	Volunteer Management

**PROGRAM SPOTLIGHTS**

- **Mille Lacs Band of Ojibwe:** Their public health department as a whole has been strengthened as a result of their EHDI program. They are now fully staffed, are able to work with more clients, and have stronger relationships with their partners and clients.
  
- **Olmsted County Public Health.** What they learn through their EHDI program gets passed on to other departments within the county to better those programs. What is shared with other staff helps them be more effective.



## CAPACITIES BUILT IN GRANTEE ORGANIZATIONS

- **Organization 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. Several reported that prior to EHDI, their organizations had very singular foci, but are now beginning to expand 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.”
- **Expanded services offered:** 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.
- **Increased recognition and visibility:** Eight organizations report increased recognition and improvement in reputation as well as media attention for their health disparities work.
- **Stable funding/able to focus on services:** Nine grantees stabilized their funding sources as a result of EHDI. Stable funding sources allow them to maintain their staffing levels and programming to provide continuous services, and focus on service provision over fundraising.

## PROGRAM SPOTLIGHTS

- **Division of the Indian Work.** Prior to EHDI, they only served teen parents, whereas now they offer prevention services to many different audiences and conduct trainings throughout the state and in neighboring communities. EHDI “has really expanded our service provision structure.” In addition, the funding from EHDI “lends credibility” to the organization and they have been able to get other government contracts or grants as a result.
- **Hmong American Partnership.** Before EHDI, HAP focused solely on providing direct services. Now they define themselves as a “public health oriented agency,” providing direct service in combination with organizing information and leading efforts. “I don’t think we’ll ever go back to just being a direct service agency again- it wouldn’t feel like enough.”
- **Minnesota International Health Volunteers.** Through their community-based participatory research, they “have really been able to provide both the community and others a picture of what health is like in the Somali community; what the most important health issues are for the community; how to reach the community with health information, and how to target information to the Somali community.” This research is not only increasing their internal skills and capacities, but that of the larger community serving Somalis.

# EXEMPLARY PRACTICE 17: Systems Change is Undertaken

## EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Undertaking systems change recognizes that for the health status of communities of color and American Indian communities to change, the larger systems of care, service and governance must be engaged. Systems change can begin by improving the cultural competence of institutions; implementing policies to encourage better health and spreading the responsibility of prevention and health promotion work to individuals, communities, health professionals, health service institutions, other sectors, and government entities.

## RESULTS

Systems change, like capacities, often occurs in stages. In the early stages, grantees are changing systems simply by offering services that were previously unavailable. These organizations may also begin to change their own policies and procedures and contribute to literature or research in the field. Through partnerships and example, they influence others to make changes in policies and practices in the health care system, in schools, in government programming and in correctional facilities. Finally, community norms begin to change.

- **Making available culturally competent health services:** Twenty-three grantees report that the existence of their EHDI funded programs is in itself a systems change as they provide alternative services, access or culturally-competent services that were not previously available. Examples include providing access to healthy food, providing services in rural areas and implementing culturally specific programs that engage community members who would not otherwise access services.
- **Impacting policies and procedures in the health care system:** Twelve grantees reported improved policies and procedures for people of color and American Indians. One program is now an “official childbirth education provider for two large insurance companies.” Another has changed their check-in procedure to improve confidentiality for teens. Several reported changing their charting procedures and modifying their medical forms. Finally, “a work place policy passed by tribal council now states that all employees are allowed to utilize two hours of paid time per week for exercise.”
- **Developing a knowledge and research base in community:** Three grantees reported their EHDI efforts have contributed to literature or



research in their community. One has collected baseline data on the Somali community that did not exist before. Two others now have libraries of information for their community.

- **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 hired culturally specific doctors or addressed specific health disparity issues.
- **Helping K-12 system carry out mission for health and physical activity:** Six grantees have had an impact on educational systems. They developed new curricula or guidelines, or are providing programming around physical, health or violence education in schools. One school did not have any physical education and is now allowing an EHDI grantee to implement a new curriculum. Another added a new parental component to an existing violence prevention curriculum.
- **Impacting local government practices and delivery of services:** Four grantees had an impact on government (city or county) practices. One has had an impact on the practices of a county WIC program. Another had an impact on funding streams for pregnancy and HIV/AIDS services in Hennepin County. Two other grantees became service providers for county health and human services.
- **Changing perceptions of specific populations:** Four grantees reported changing the way that troubled youth and ex-offenders are viewed within government systems. In the past, these groups were seen as problems, whereas now people within the correctional and school systems are looking beyond the troubled behavior to identify the causes. For example, the Department of Corrections changed the requirements for an alternative program to be more inclusive. Another reported that they have developed relationships with judges, the county attorney, and the police. She said, "They're listening to us and they're participating."
- **Changing norms within communities:** Five reported their work is beginning to change community norms. Community organizations and members are becoming more open about talking about 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.

## PROGRAM SPOTLIGHTS

- **St. Mary's Health Clinics.** Through their EHDI program, St. Mary's was able to connect their hospital and clinic partners so that more clients are receiving health services through entry-level care, rather than through emergency care--which is more expensive for the health care system.
- **The Storefront Group.** The information they shared with Park Nicollet, through their program, led the clinic to hire a Muslim doctor at a Dakota County clinic. Now Muslim patients are no longer traveling to Minneapolis or Rochester to see a doctor, but developing a relationship with the new doctor in their area. The doctor fasts and prays with families. In addition to providing medical care, he has made several health presentations to the community to further their health education.
- **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.
- **White Earth Tribal Mental Health.** Their program provides an alternative to incarceration or expulsion. In the past, violent adult and youth offenders were immediately sent to correctional facilities. Through their program, men receive anger management and therapy services and learn new techniques to deal with their anger. The result is a reduction in the number of men incarcerated.
- **Vietnamese Social Services of Minnesota.** By working with their clinic partners, program staff members are now allowed to attend appointments with patients to translate and explain health procedures, while still maintaining patient confidentiality.
- **Center for Asian and Pacific Islanders.** CAPI partnered with a local clinic, which saw how CAPI interacted with clients, and restructured their own service model based on CAPI's.
- **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."

## CONCLUSION

In this report, we explored some of the ways the Eliminating Health Disparities Initiative has had an impact with people, organizations, systems and communities. The Initiative has reached beyond the programmatic outcomes demonstrated by individual funded programs (see Report #4). The goals of the Initiative (see Report #1) focused on increasing the capacities of communities of color and American Indian communities by:

- Providing capacity building support for the EHDI grantees that enabled them to document their outcomes and lessons learned;
- Providing capacity building support and training to develop the strengths of these organizations in reaching the targeted populations and effecting change;
- Leveraging additional resources and support for the broader Initiative—helping to sustain and grow the efforts to eliminate health disparities.

In this report we have documented how the Initiative built capacities and initiated changes in three areas:

### **I. IN THE FUNDED ORGANIZATIONS, AMONG THEIR PARTNERING ORGANIZATIONS, AND WITHIN LARGER SYSTEMS**

These capacities and changes included:

- Strengthened funded organizations' ability and interest to focus on a range of health issues impacting their target population.
- Developed new programming models, materials and resources that are being disseminated in Minnesota and in some cases nationally.
- Increased working relationships between organizations working in communities of color, between communities of color, and with mainstream organizations.
- Created the momentum for change in a variety of larger systems such as the health care system, government, education, and corrections. Changes involved changed policies and practices, ways that organizations work together, and changes in the way community members are seen and treated.
- Increased the reputation and recognition of EHDI funded organizations.

- Leveraged \$3,000,000 in new funding and in-kind resources.
- Generated new data and knowledge about health issues in communities of color as well as effective health promotion strategies.

**2. INCREASED SKILLS, KNOWLEDGE, AND AWARENESS AMONG INDIVIDUALS DIRECTLY INVOLVED IN THE FUNDED PROGRAMS AS STAFF, VOLUNTEERS OR PARTICIPANTS**

Individual level changes include:

- Increased the skills, knowledge-base and experience of staff members. In addition, some staff members also received new credentials.
- Increased the skills, knowledge-base, motivation and experience of community members who participated in the EHDI programs. Their participation took many forms such as volunteers, contract workers, community health workers and peer educators. In addition, many community members who attended events or participated in other ways were inspired to move into health professions or work to raise awareness of issues.
- Increased the leadership capacities and experience of EHDI staff members by making presentations, providing education, organizing groups and influencing policy-makers.

**3. INITIATED A “RIPPLE EFFECT” BY WHICH INFORMATION, AWARENESS, NORMS AND SKILLS ARE DISSEMINATED TO COMMUNITIES**

- Individuals who participate in EHDI program activities are taking their new knowledge and experience and applying it not only to their lives, but sharing it with their family, friends and associates--creating a wave of new awareness.
- Staff members in EHDI programs sometimes change jobs, taking the new knowledge, skills, experience and training they gained on the job to other organizations, thus spreading the impact of these investment in skills and knowledge development.
- Community norms are being changed as EHDI grantees persistently and respectfully raise awareness of sensitive or taboo subjects such as sex, violence and mental illness. The issues are being talked about by more people, in more settings. As a result, a new understanding is emerging about community and personal responsibility towards health.

- People and organizations in the larger systems involved in health issues are becoming increasingly knowledgeable about effectively and respectfully working with communities of color and American Indian communities. This is translating to new patterns of organizational practice, policy and staffing.

These impacts are long-lasting and will continue to ripple out from the Initiative, strengthening communities and relationships between communities to promote and preserve better health. Clearing, investing in capacity building in addition to grant-funding for EHDI programs was a sound strategy that created system-wide impacts.

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## ELIMINATING HEALTH DISPARITIES INITIATIVE GRANTEES 2006 – 2008

### Community Grantees

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

### Tribal Grantees

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