RAINBOWRESEARCH Inc.

MINNESOTA'S ELIMINATING HEALTH DISPARITIES INITIATIVE

Report 3: Exemplary Program Practices in Action

Prepared for

Minnesota Department of Health
Office of Minority and Multicultural Health

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Overview of Series of Reports

This report is the third in a series of seven documents detailing the work and accomplishments of the Eliminating Health Disparities Initiative of the Minnesota Department of Health's Office of Minority and Multicultural Health. This report focuses on nine exemplary program practices and the work of Eliminating Health Disparities Initiative grantees that exemplify these practices.

In 2001, Minnesota passed landmark legislation to address the persistent and growing problem of disparities in health status between the white population and populations of color and American Indians. Although Minnesota is one of the healthiest states in America, it has some of the greatest disparities in health between racial/ethnic groups. By competitively distributing funds to 52 community organizations and tribes across the state, Minnesota charged its populations of color and American Indian communities to develop strategies and approaches for eliminating disparities in eight key health areas. A history of the Eliminating Health Disparities Initiative is detailed in the first report of the series (Report #1).

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). This report (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 on the cultural strengths and assets of their communities—can serve as models for other states and communities. The next report (Report #4) describes the health disparity context in Minnesota, and the programmatic results achieved by Minnesota's 52 EHDI grantees. Additional outcomes related to capacity building and community impacts are described in Report #5. Report # 6 provides an in-depth description of a select group of these grantees, and the last document (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:	Building Capacities among Individuals, Organizations, Communities and Systems
	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.

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.

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 of what strategies were most important for programs to effectively address health disparities in their communities. The expert panel achieved consensus in two rounds on a list of 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 EHDI grantees exemplify these programmatic approaches and practices. It explores how grantees are organizing to reach the community and deliver services, the philosophies and values with which they approach their work and the innovative strategies they've developed to deliver key messages, mobilize the community and effect change.

This report is organized to explore each of nine exemplary program practices identified by the Health Disparities Expert Panel (see Table 1). Each of these exemplary program practices is illustrated with data collected from the EHDI grantees to show what this looks like "in practice" as these different programs address the eight priority health issues in their communities.

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

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

EXEMPLARY PRACTICE 1: THE COMMUNITY IS INVOLVED IN AUTHENTIC WAYS

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

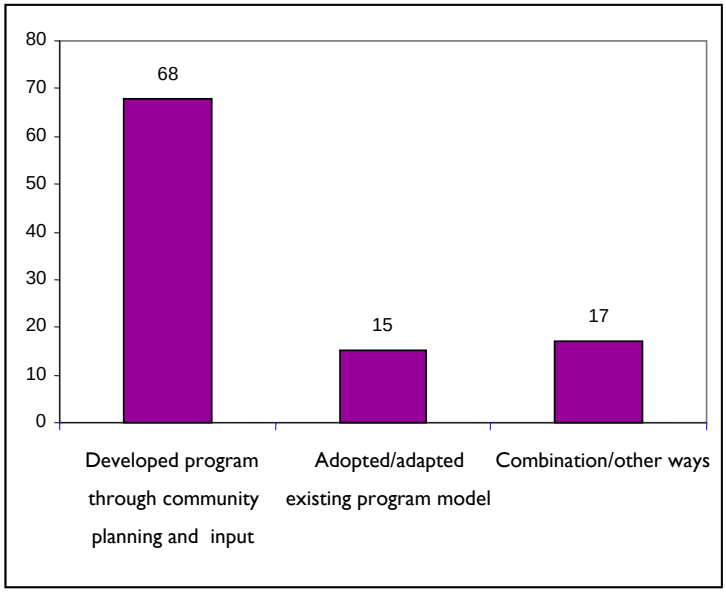
Authentic community involvement means engaging the community throughout the programming process--from conceptualizing and designing the program, to implementation and evaluation. It also means forming collaborations with community members and agencies not just in symbolic or token ways, but in authentic ways that respect, appreciate, and value their input.

RESULTS

1. Up-Front Community Involvement

Grantees were asked how their programs were initially developed, and who was involved in that process (see Figure 1).

Figure 1. Percent of Grantees Reporting How EHDI Program was Developed



Over three-quarters of the grantees involved community members in the up-front development process: Twenty-nine grantees described involving community members in assessment of the needs of the community and development of the program plan. Seven grantees described having a formal community advisory group at the inception of the EHDI program. Each community sought input and involved community members in ways that made sense for their program and their cultural norms.

PROGRAM SPOTLIGHT

Annex Teen Clinic: "We involve them (youth participants) in the development of the curriculum. I think that builds immediate trust. We're not coming in here with the solution to your problems. You have the wisdom in your community to identify the solutions to problems. We can all recognize the problem and state that, but what are the solutions? That's true with the youth development programming that's happening at Kwanzaa. The youth are directly engaged in the process of learning how to produce a DVD or CD or a dramatic presentation. They are the ones creating the script and messages so I think that woven throughout the whole collaboration is a message to the community that they're the ones creating the solutions, not us. We're giving you some resources and the microphone but you're the one creating the message."

2. Ongoing Community Involvement

Grantees were also asked about ongoing involvement of community members in the program. This ongoing involvement took two forms. Many programs had some type of community or advisory group such as elders, or community leaders that provide regular input into their program. Other programs did not have such a formal body but regularly sought input and feedback from program participants through evaluation.

Half of the grantees reported they have some type of community or advisory group that provides regular input into their EHDI program. The advisory groups perform a number of functions for EHDI programs. Some:

- Develop proposals, work plans and curricula.
- Provide input into programming activities (attend regular or ad hoc meetings, participate in focus groups).
- Volunteer to provide services to program participants.
- Promote or endorse the program in the community.
- Identify funding opportunities for the program.

EHDI advisory groups include:

Community members:

- Parents
- Current/former program participants
- Elders
- Health professionals Researchers
- Students
- Law enforcement
- Business owners
- Board members
- Medicine men & traditional healers

Collaborating partners:

- Other community agencies
- Research centers
- Hospitals and clinics
- City and state offices
- Church council representatives

EHDI grantees described a range of influence of these groups. Most grantees said the advisory group provides ongoing support and feedback, meets regularly, provides program direction and is involved in internal operations. Program staff contacts them for advice and suggestions on program improvements. Other grantees described their advisory group's influence as more sporadic or ad hoc.

The EHDI programs also involve the community in other ways such as consulting with traditional healers and elders, using Imams to spread the message about their program, asking for community feedback regarding their educational materials or asking participants to share their healthy food recipes for use in nutrition class. They also invite community members to participate in program events and celebrations.

EXEMPLARY PRACTICE 2: Programming is data-driven

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Successful programs conduct a needs assessment early on in order to identify the needs, interests and strengths of the target population; conduct research on best practices and implement those that work well with the populations they are targeting; conduct process evaluation so they can refine and improve the program in order to be effective at reaching and serving their target population; and, conduct outcome evaluation with clear and measurable outcomes for improving the health of the community.

RESULTS

Nearly all (91%) of grantees used data to develop their programs, and provided examples of how they did so. Data were also used for program improvement. Program modification occurred in some grantee programs through the use of evaluation results or when a new trend, such as an increase in violence or unintentional injuries, was identified in a community. In some cases, participant feedback provided impetus for change. The vast majority of grantees (94%) reported they had used their evaluation results to guide their work.

Table 2. Examples of How EHDI Grantees Use Data.

Data Used to Develop Programs	How Evaluation Data was Used
Needs assessments	Improve/strengthen their program
Community surveys	Seek other funding
Statistics on prevalence and risk factors related to their disease in their population	Add other services needed/start new programs that address unmet needs
Information on evidence-based practices	Communicate findings to others

PROGRAM SPOTLIGHTS

- **Minnesota International Health Volunteers:** "At the time that we were initially developing the program, no statistics existed on the health of the Somali community. We conducted a community mapping exercise, including a survey of needs, and a community-wide health survey with 300 Somali adults, inside and outside of metro area, to gauge the health status of the Somali community."

- **Southeast Asian Ministry:** "We have used the results of the evaluation with nurses to help in deciding on how to do the health teaching with Hmong elders. We know now better what the nurses need to learn and what the elders need to learn. One outcome of this is more exercise. We discovered that the elders wanted to be doing more exercises. They told us how happy they are now that they are doing more exercises."

EXEMPLARY PRACTICE 3: A Comprehensive Approach Is Utilized In Developing and Implementing Programming

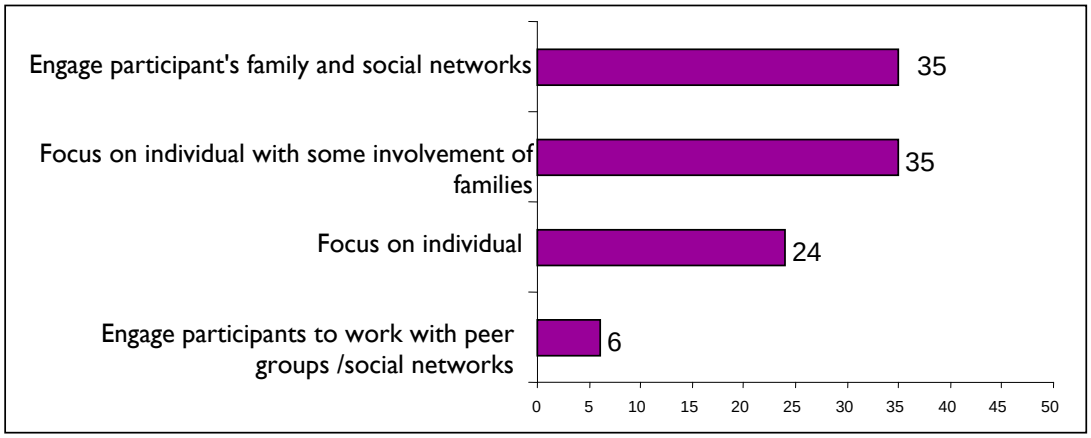
EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

A "comprehensive approach" can mean a number of things. The expert panel raised several aspects, two of which were explored with the EHDI grantees for this evaluation. The first aspect is to whom services are targeted—comprehensive approaches reach beyond the individual to include their family and or larger social networks. The extended family systems and collective orientation of many communities of color suggest a broader approach is more appropriate to promote enduring change in health behaviors for both the individual and their social systems.

RESULTS

Targeting services beyond the individual to include his/her social systems and networks (social-environmental approach) is a strategy often used by organizations working in cultural communities. Grantees were asked who they consider to be "the client" and who is involved in program activities. As Figure 2 shows, three-quarters of the grantees involve the participants' families, peers, social networks and larger social systems of which they are members in some way.

Figure 2. Percent of Grantees Reporting Targeted Focus of Program Services



PROGRAM SPOTLIGHT

- **Center for Asian and Pacific Islanders:** "We serve the whole family. In these kinds of communities it's not an individual outlook. If you serve the head of the family you end up serving the whole family."

Exemplary Practice Definition/Description

The second aspect of a comprehensive approach that was assessed involved the length of time the programs typically worked with participants and the range of services provided. Best practices in most prevention-oriented fields are based on the practical premise that enduring change, particularly in well-entrenched attitudes and behaviors cannot be achieved in single encounters, but must be introduced and then reinforced over time. For people coping with a health condition or disease, services are typically given across time, and may involve working with participants in a number of ways, such as helping to navigate services, providing support or case management.

Results

To assess the second aspect of using a comprehensive approach, grantee coordinators were asked: *Across how long a period of time do you typically work with your participants or clients?* As Table 3 shows, there are various configurations, all driven by participant needs. Some grantees provide structured time-limited services. Others provide ongoing services until the need is met or eligibility status changes. Many offer active follow-up on a schedule while others allow participants to return, as needed.

Table 3. Percent of Grantees Reporting How Program is Structured

Time Length of Program Services		Number (N=46)	Percent of total
Time-Limited Programming	Offer programming over a set period of time (e.g. an 8 week curriculum, or 6 months of case management).	18	39%
	Provide one time services (e.g. referral, screening or one-day class).	5	11%
Ongoing Services	Work with participants on an ongoing basis until the participants stop coming (e.g. youth center, community fitness center).	22	48%
	Work with participants on an ongoing basis until their needs are met or they no longer qualify (e.g. pregnant mother gives birth, person moves, immunizations, etc.)	13	28%
Follow-up	Provide follow-up services, (e.g. phone calling, case management and support groups).	18	39%
	Do not specifically follow-up but are available for participants to call/come in when necessary.	2	4%

Program Spotlight

- **Hennepin Care East Clinic:** "Services are ongoing. There is a plan, but the patient is the one that determines it. We do have some patients that have come here for five years and others that we were praying would come back but they never show. The ones that are the highest risk sometimes don't follow up--and they know where we are--then all of a sudden they reappear."

EXEMPLARY PRACTICE 4: Recruit participants or deliver services in community settings in which community members feel comfortable

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

EHDI grantees have learned to recruit and meet with participants in places that are comfortable and/or accessible. This serves to both reduce physical and logistical barriers to accessing services, and also helps community members feel more relaxed, at ease, and comfortable with the provider. Programming may take place in participants' homes, especially if the participant has no means of transportation, or at community gathering places such as churches and mosques.

RESULTS

Recruitment Strategies used by Grantees

Grantees were asked a series of questions about how they recruit participants, why those strategies were selected, the location or setting where services are provided, and why those locations were selected. When asked why they recruit and deliver services the way they did, grantees often responded by saying "because it works," it's how it's always been done in their community, and that they wouldn't have thought about doing it any other way. Table 4 below shows that EHDI grantees use a wide range of recruitment strategies.

Table 4. Recruitment Strategies used by EHDI Grantees

Recruitment Strategy	Number N=46	Percent
Outreach in community settings	23	50%
Word-of-mouth networks	15	33%
Referrals	11	24%
Post or hand out flyers, put up posters	11	24%
Work with faith-based organizations and institutions	6	13%
Advertise or write articles in newspapers or newsletters	6	13%
Advertise or appear on radio or TV	6	13%
Website. List serve groups	4	8%
Make home visits	3	7%
Reach out to migrant camps	2	4%
Other	12	26%

- A third of the grantees rely on word-of-mouth networks. Many grantees from American Indian, Southeast Asian, Latino, and African immigrant

communities believe that word of mouth is the best recruitment strategy in their communities.

- Half of the grantees conduct outreach in the community. They go to community events, forums, health fairs, powwows, clinics, schools, and conferences. They also reach out to other service providers, other programs within the organization, businesses and social workers. Some grantees also display their materials in faith-based and community settings as a way to reach their target population(s).

- Close to a quarter of the grantees work with and get referrals from other programs within the organization, public health agencies, clinics, doctors and nurses, social service agencies, social workers, schools, former clients or participants, parole officers and the court system.

- Grantees also heavily recruit through culturally specific media outlets such as Somali TV, Hmong magazines or Spanish-speaking radio stations. Whether through the distribution of flyers or brochures, radio or TV spots, newsletters, teen magazines, newspaper articles, posters, billboards or through the Internet, nearly all of the grantees utilize some type of mass communication strategy to their target population.

PROGRAM SPOTLIGHTS

- **Red Lake Comprehensive Health Services:** "Through experience we found that personal invitations to participate in something work better. Letters seem not personal enough. Our staff has worked here a long time and can connect with families--it raises the comfort level. Many nurses have been here a long time; people recognize them as part of our project."

- **The Storefront Group:** As Somalis, they know how to reach the people. Usually Somalis wouldn't care unless they know the person who is recruiting them. They need to build trust and relationships to motivate them to come. Mailed flyers don't work.

- **Olmsted County Public Health:** "We do outreach through groups that were already formed, like Bible studies. We put information in our newsletters."

Providing Services at Places and Times Convenient to Participants

EHDI grantees have proven that providing services in convenient locations and times is both a common and effective way to reach participants. Many people in the target populations do not have adequate transportation or may have other mobility or child care issues that limit their access to traditionally located services. Others may not feel comfortable in a conventional clinic setting. Bringing the service to the client – through home visits, convenient

locations and through co-location of services meets the needs of many and increases participation.

The EHDI grantees provide services in a variety of settings. Most of them provide services at community locations. Seventeen percent said they go to participant's homes and 13 percent provide services in a clinical setting. Twenty percent use all types of settings. Table 5 outlines the settings where services are most often provided.

Table 5. Locations of EHDI Service Provision.

Type of Setting	Number N=46	Percent
Community		
Various locations	31	67%
Churches/Faith-based	2	4%
Office	7	15%
Homes	8	17%
Clinics	6	13%
All other settings	9	20%

PROGRAM SPOTLIGHTS

- **Camphor Foundation:** "We figure the church in the past is the most central organization in Black Community; get buy-in from pastors, and we then have captive audiences—the congregations who have to listen to their pastors. We got over 300 kids from one congregation alone."

- **Centro Campesino:** The schedule. Many offices are only open 8-5, but people work 12 hours a day from 6am-6pm. Also they're only open Monday to Friday. The community is available on the weekends. That is why we have the *Promotores*. They live in the same community; they know the schedule of the family. So we won't go to knock on their door at 10 AM if they work the night shift, because if we don't know that they won't ever want to talk to us again."

- **The Dar Al-Hijrah Cultural Center** office is located in a large apartment complex that is home to many Somalis. Their location in a primary residential building, offers easy access and important information to the Somali community.

- Working in the prison system, the **Council on Crime and Justice** is the only one of its kind that provides on-going health and HIV prevention education directly to inmates in the prison system.

EXEMPLARY PRACTICE 5: Trust is established as the foundation for effective services

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

The EHDI programs often have to overcome barriers to trust rooted in history or institutionalized racism, language barriers, or barriers of social stigma attached to the problem for which services are sought, such as HIV, suicide or domestic violence. Establishing trust with community members is important because it forms the foundation for all relationships and subsequent buy-in into the EHDI program. It is also important that community members see that their community leaders have accepted and are working with the EHDI program. Trust takes time to build and effort to maintain.

RESULTS

Grantees were asked a series of questions designed to address the issue of trust. The first was "W*hat might be some of the barriers for mainstream organizations to establishing trust with community members*?" Many different reasons were given for lack of trust, but they fell into several broad categories, as Table 6 shows.

Table 6. Reasons Cited for Lack of Trust of Mainstream Providers.

Reason	Description
Distrust of the system	The community's members have had bad experiences with "the system" which could be the health care system, government agencies, law enforcement, or mainstream organizations.
Language barriers	Language barriers included not speaking the same language but also using technical terms and not speaking plainly.
Outsider vs. insider	Community members don't trust people from outside their community. *"If they don't see your face in the community at all, they're not going to trust you."*
Cultural differences	Providers who don't understand their culture, the traditions, or the systems they are used to.
Know-best/ don't listen	People from mainstream organizations think they know what participants need and tell them straight out, and don't bother to ask what they want or think
Other reasons	providers not taking time; youth not trusting adults; lack of respect or perceived caring; confidentiality issues, not having transportation/insurance.

PROGRAM SPOTLIGHT

- **Leech Lake Band of Ojibwe:** "Here on the reservation, people are very leery of people coming into their home because they are afraid you are going to take their kids or tell them they are doing something wrong. Many use substances and are afraid if they tell you that, they'll take away their baby. Trust is a huge barrier– many of our people have had so much taken away from them."

Grantees were asked to describe what they do during the first encounter with a potential program participant. In responding, half of the grantees, explicitly referred to making participants feel comfortable and establishing trust:

- The first person they meet is someone like them.
- They don't give detailed information about the program; instead they sit back, let the clients talk about themselves, or talk about life in general.
- Program staff try to "meet them where they're at." For some, this could mean home visits, while others prefer to have the first encounter in a place where other members of the community often gather such as a coffee shop or the church.
- Program staff share a personal experience of managing the same disease.
- When recruiting, the staff use simple language and do not try to overwhelm potential clients with program jargon. They do not use coercion; they let the person decide whether or not to join.
- Staff assures confidentiality. Program staff understands that some people are wary of revealing personal information that might jeopardize their resident status or that they don't want others to learn about their illness or disease.

PROGRAM SPOTLIGHTS

- **Vietnamese Social Services of Minnesota:** "Mainstream organizations, especially health providers, don't spend a lot of time with people. If the doctor says, 'Hi. How are you?' the Vietnamese women don't say much because they don't want to sound like they're complaining. Doctors assume there's nothing wrong with them."

- **Agape House for Mothers:** "Develop trust (in the first encounter). We try and make sure that it's a very relaxed environment including food, fun, just talking casually, ice breakers, just being visible, letting them know that we're there to help them. Not finding out what we think they need, but finding out from them what they need, developing a reputation of being competent and caring. I call it earning their trust."

- **Sisters in Harmony:** "The fact that I'm a two-time breast cancer survivor, I've been on every type of treatment and surgery. I try my best to look the best I can, to show women that you are going to survive, to go on being a woman and being beautiful; the whole attitude thing is key to survivorship. I try to model the positive, so I can pull the women in to me."

- **Centro:** "My vocabulary is simple, just like theirs. Also my ideas are comparable to theirs. I take into account their customs and traditions and from there I introduce them to the health system. Informing them about the health system, what they will find, including systems and administration steps, like registering a birth, and processes in the hospital."

EXEMPLARY PRACTICE 6: Programming builds upon cultural assets and strengths of community

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

The EHDI programs identify the strengths and resources of individuals, groups and institutions in the community and build them into programming. They also work to incorporate cultural values and traditional practices into interventions that promote health, or employ interventions that allow for creative uses of community assets and create connections between community members.

RESULTS

The EHDI program coordinators were asked to describe how their program builds on strengths of their community or are culturally supportive. Grantees described the following five ways that they build on their target populations' cultural strengths:

1. Building on Talents, Skills, and Other Qualities of Community Members

EHDI programs involve individual members of the community by asking them to become program advisers, speakers, mentors, researchers and data analysts, writers and reviewers, webmasters, and marketing and graphic designers. Some offer food and transportation. But community members also can be directly involved in providing program services as doulas, community health workers, *promotores*, peer educators or health screeners (nurse volunteers).

PROGRAM SPOTLIGHTS

- **Olmsted County Public Health:** "Miguel is very active in the community in his private life so if things come up when he's working on a different project as a volunteer, if it seems appropriate, he'll use those contacts to do other outreach."

- **Leech Lake Band of Ojibwe:** "We have on staff a pipe carrier in the Ojibwe tradition, we offer that help if people want it. Not all of our people follow their traditional ways, some are Christian, and we encourage them to get their support from where they want. We have an understanding of the history of what our people went through, having knowledge of historical trauma and its effect on people—personally and through training."

- **Agape House for Mothers:** "More than 75% of the service delivered to program participants is conducted by volunteers. Our advisory committee is made up of community volunteers from various different professions as well as community residents who provide us with a wealth of information, recruitment, fund-raising activities, community awareness, etc."

2. Accessing Community through Trusted Institutions

Grantees targeting the African American and Latino populations often work through faith-based institutions that are long-standing and trusted institutions in the community. The church has a "considerable degree of power to make changes" in the African American community, and is the "center of community life and support" in the Latino community. Having the support of the religious leaders and church staff is vital because this leads participants to view EHDI program staff as an extension of the faith-based institution—enabling the program to gain trust and confidence. In the Somali community, some grantees work with Imams to endorse their programs and get people to accept ideas like immunizations and screenings. EHDI grantees offer program services in conjunction with scheduled events or classes (e.g., Bible study) or offer health education classes or health screenings after religious services.

PROGRAM SPOTLIGHTS

- **St. Mary's Health Clinics:** Working with the church is a natural connection, a place where Latinos come for religious services and other services. They're a ministry of sisters and some of the people they see have difficulty trusting people. But the sisters have the trust. They're in a church and not somewhere else.

- **Stairstep Foundation: "**The church is a vital institution within the African American Community, that is where you get to the people."

3. Using Cultural/ethnic Media

Grantees utilize their community newspapers, magazines, and radio and television programs to discuss health topics and relay health information. This is effective because they area able to reach a wide audience within a short span of time, and because radio and television programs can reach segments of the population with low literacy. They are also viewed as trusted and respected sources of information.

PROGRAM SPOTLIGHTS

- **Centro** uses Radio Rey (Spanish language station) because it reaches almost all of the Latino community, and it also gets the lower income and those in the Twin Cities.

- **Hmong American Partnership** uses Hmong radio messages and a Hmong-specific teen magazine to reach members of their community. The radio messages have been successful in reaching elders in the Hmong community because of the emphasis of oral communication in this community. The teen magazine, tailored towards Hmong youth, provides specific messaging to young Hmong-Americans who straddle their traditional Hmong family life with that of the American culture.

4. Incorporating culture (including history) into program curricula and activities

All of the grantees designed their programs to be culturally supportive. This may mean education and activities that help reinforce strong positive cultural identities, bringing in history and traditional health promoting practices, or connecting with elders. Grantees incorporate cultural values, practices, artifacts, celebrations, history and traditional food into program curricula and activities.

- Grantees serving the African American and Latino populations use theater, music, dance, and visual art in health education classes to engage participants.
- Grantees serving the African and African American communities incorporate various aspects of history in their programming.
- Grantees serving the American Indian population incorporate their community's holistic health philosophy and spiritual/cultural practices into their programs such as sweat lodge and pipe ceremonies, and use herbs and medicine men in disease prevention and management.
- A number of the grantees, particularly those addressing healthy youth development have developed their own curricula. Some are exporting these programs to other communities in Minnesota and around the country, serving as national models for culturally-based programming.

PROGRAM SPOTLIGHTS

- **Division of Indian Works:** "Our curriculum is a culturally specific curriculum. It is flexible enough to adapt to different tribal communities, but has a basic Indian cultural framework."
- **White Earth Tribal Mental Health:** "We use a 27-week program for men who batter, adapted from another model to fit our community. We use sweat lodge ceremonies, traditional healers, speakers, and smudging ceremonies to help men change their behavior, and also change unhealthy community norms."
- **Camphor Foundation:** "Our program was originally developed by the National Black Church Initiative. We adapted it to use with our youth and also developed a lot of the curriculum and lessons ourselves. Ujima Curriculum lasts ten weeks, then we can have a celebration and they graduate."
- **Freeport West:** "The whole rite of passage is based around culture and African American culture specifically. It's a nine-week group so youth meet once a week and each group session focuses on some piece of African American culture, such as history or the hip hop generation. We focus on how they view themselves as a young African American so everything with that group focuses on culture."

5. Reinforcing cultural values

The Eliminating Health Disparities Initiative was designed with a community empowerment model--out of a recognition that community-based grantees are in the best position to understand what works and what doesn't in their communities. As a consequence, everything they do builds on cultural values, reinforces positive behaviors or helps individuals find their strength through cultural, spiritual or community connections.

PROGRAM SPOTLIGHTS

- **Family and Children's Services** is connecting the violence in today's family with historical violence the African American community has faced. We build on the strengths of families in this community.

- **Minnesota International Health Volunteers:** "We make sure we support very positive health behaviors. For example, in the Somali community, breast feeding is very common for over a year and up to two years. So with our education and messages, we work to reinforce the (positive) behaviors that Somalis bring from their home country."

- **Southeast Asian Ministry** serves traditional meals during group classes and uses the opportunity to model good nutrition by teaching participants about low-fat options and limiting portion sizes.

EXEMPLARY PRACTICE 7: Deliver services and information that is culturally or linguistically accessible and appropriate for the participants

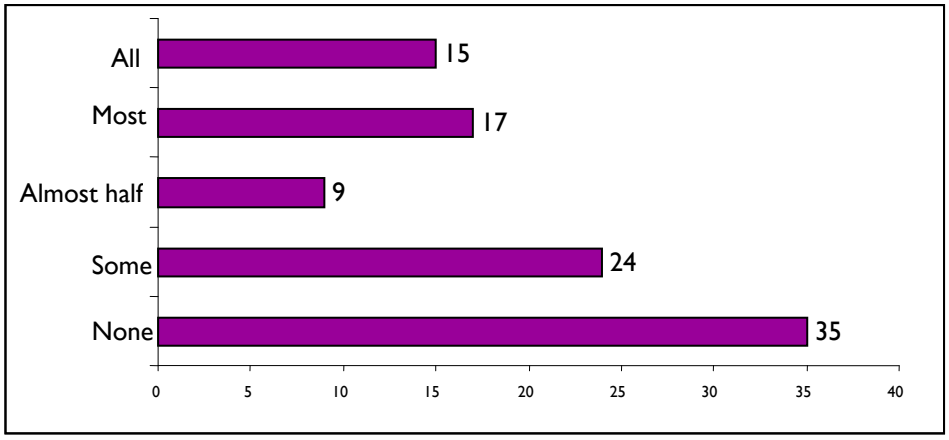
EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Delivering services and information that is culturally and linguistically accessible goes beyond simply translating information to the participants' language. It also means using interaction styles and teaching methods appropriate to the culture. Grantees are the most successful in delivering culturally and linguistically appropriate services when they utilize staff of the same cultural/linguistic background of the participants. Many grantees also invest time in cultural competence training for staff and organizational partners.

RESULTS

Thirty of the forty-six grantees (65%) who participated in the interview have at least some proportion of their participants with a first language other than English. For a third of the grantees, all or most of their participants speak a first language other than English.

Figure 3. Percent Of Grantees Reporting The Proportion of Their Participants Who Speak a First Language Other Than English.



PROGRAM SPOTLIGHT

- **Lao Family Community of Minnesota:** "First off, the staff speak the language and that's very important because a lot of the parents of these young mothers still don't speak English. We understand the community in that respect and there's that bridge. We work with that first and other people can do that but we have an advantage because we speak the language, we know the issue, and we live through the issue. The Hmong culture has a procedure on how to say things to each other and what's proper and what's not proper, how to introduce subjects to each other and we understand that piece."

The most common languages spoken by program participants are Spanish, Hmong, and Somali. Table 7 shows all of the languages spoken by program participants.

Table 7. First Languages Spoken by EHDI Program Participants.

EHDI Program Participants' Languages		
Amharic	Khmer	Quechua
Arabic	Korean	Somali
Chinese	Lakota	Spanish
Dakota	Laotian	Swahili
French	Ojibwe	Thai
Hmong	Oromo	Vietnamese
Karen		

Among the 30 grantees serving participants who speak a first language other than English, 76 percent provide services in those other languages, 17 percent do not while 7 percent reported that it varies.

Culturally appropriate language is a much bigger issue than whether the words are in English, Spanish or another language. Understanding the norms of how to address people, how to discuss certain subjects and the appropriate respectful eye contact and body language to use are essential components of cultural competence. Being able to explain how things relate from one culture to another are also important "translational skills" that grantees use.

PROGRAM SPOTLIGHTS

- **Centro:** "Everything is bilingual in English and Spanish. For two reasons, for youth to learn English and also so they can learn to read both English and Spanish."
- **The Storefront Group:** "The services are mostly in Somali. For technical terms, they continue to use the English words. If we invite non-Somali speakers then we provide translators."
- **Fremont Community Health Services:** "There is a way you have to approach church members, a certain way you have to address people, even if you know their first name, you don't use it . . . a code of respect."
- **Southeast Asian Ministry:** "Many of our clients do not speak English and need someone to translate for them in many situations. Our nurses speak Hmong and Khmer, so they can communicate effectively with both groups. Then there are the cultural perceptions of health and the health system we have here in the U.S. it is very different, and so many people avoid the U.S. health care system. It is critical to have someone who speaks their language and who understand their traditional health care systems and help them to engage in our system of health care."

EXEMPLARY PRACTICE 8: Program staff reflects the community being served and/or cultural competence is ensured among those who are delivering services

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

Those who deliver services should be culturally competent. This works best if the staff members reflect the community being served - they are of the community being targeted by the program and sometimes live and work in the community. These individuals have a natural bond with the community and know how to relate to community members. Many communities do have enough health professionals to meet their needs, so the community should also provide cultural competency training to physicians and other providers. Programs should also encourage the individuals they work with to share their newfound knowledge with the community and providers in the form of trainings or workshops.

RESULTS

Employing program staff who participants trust and feel comfortable with is important for many reasons. Programs reach the community faster if the health worker or spokesperson is someone from the community-- because the credibility of the messenger is readily established. Among Latinos, confidentiality is an issue because some have barriers to trust, and will only participate if they do not feel threatened. An American Indian doula can offer her knowledge of traditional medicine and care during pregnancy, birth and postpartum. Finally, having staff from the same background is important because they understand the nuances associated with language and culture and the life circumstances and challenges facing clients.

PROGRAM SPOTLIGHTS

- **Agape House** for Mothers: "My staff looks like the community that we serve. They are over-comers. Many of them have walked a mile in so many of their shoes."
- **Turning Point:** "I talk about my own experience so they can relate to me. I talk about my own experience having grown up in the community. I talk about family and what we went through. It relates to a majority of individuals that we're working with."
- **Council on Crime and Justice:** "We try to prioritize using formerly incarcerated people in our program."

Most EHDI grantees hire staff members of the same race and ethnicity as the people they serve and speak their language. In many cases, they also live in the community. These staff members serve as program coordinators, health

educators, outreach workers, and health service providers such as doctors, nurses, and doulas. A grantee that works to prevent pregnancy among Hmong youth cited specific examples. Staff must be careful that the vocabulary they use is not offensive in any way when discussing culturally sensitive topics such as sexually transmitted diseases. Also, staff need to know that in order to reach Hmong youth they have to go through the proper family channels and have to properly address members of the family based on age and status. Being attentive to these issues is made easier by employing staff with a cultural background in common with participants.

PROGRAM SPOTLIGHTS

- **Southeast Asian Community Council:** "Teen pregnancy prevention is a touchy subject in our culture. We have to find ways to do things or say things that don't go overboard with parents. There are some things you don't do or say, for example, we have a cultural belief that girls shouldn't take birth control and guys shouldn't use protection. So we have to choose the right language … We have to get trust from the parents first."

- **Centro:** "If you say [to the client], they [the doula] are Latina it means a lot to them – even though that they might be not from the same country, there is something common that is shared. You are already talking in the same language, same customs and this has a lot to do with it."

EHDI grantees were asked to specify the number of staff, contract/consultant workers and volunteers they utilize and the extent to which these workers reflect their targeted racial/cultural communities. Eighty-nine percent of grantees reported that some or all of their regular staff are of the same race or culture as their participants. The percentage of programs that utilize consultants/contract workers and volunteers of the same race and/or ethnicity of their target population was 93% and 88% respectively.

Table 8. Percent of EHDI Grantees with staff who reflect the ethnicity/ culture of the program's target population.

Staff reflect the culture/ethnicity of target population	Type of Staff in EHDI Program		
	Regular Staff	Consultants or Contract Workers	Volunteers
All	22 (47%)	16 (55%)	16 (61%)
Some or Most	20 (42%)	11 (38%)	7 (27%)
None	5 (11%)	2 (7%)	3 (12%)

Grantees also talked about being asked to provide training to other partner organizations and to health care providers about working with their community. In some cases, this training has to do with the culture and

language, and in other cases, working with a specific age-group such as adolescents, or elders. Some examples of how EHDI staff provided cultural training and capacity building to others are shown below.

PROGRAM SPOTLIGHTS

- **Minnesota International Health Volunteers:** "I think that our program has had an impact on how the healthcare system interacts with the Somali clans--we have done education with health care providers, about the difference between the healthcare system in Somalia, and the healthcare system in the U.S. . . . try to provide some context in which the Somali community views health."

- **Indian Health Board of Minneapolis:** "Western medical system is accepting traditional/spiritual component. Wanting us to be part of the healing plan/practice. They are realizing the value – getting down to the real issue of trusting native ways."

EXEMPLARY PRACTICE 9: Program model or components are innovative

EXEMPLARY PRACTICE DEFINITION/DESCRIPTION

The program model itself is innovative or unique and represents a new idea that works for that particular situation, or aspects or components of an existing program model are adapted or added to in new ways. Innovation often comes about by confronting challenges, solving problems, and overcoming barriers to success.

RESULTS

Innovative program strategies and approaches are a key component of success for many EHDI grantees. Many of these strategies have been used before, sometimes for a very long time. But what makes them innovative is the way these strategies are integrated with other organizational strategies, traditional cultural values, or linguistically-specific exemplary program practices to effectively reach populations with messages that resonate. Among the programs rated as most innovative, four overall categories of innovative strategies of the EHDI grantees were identified.

1. Blending Traditional Approaches with Modern Medicine

Several of the EHDI grantees have integrated culturally specific traditional approaches with contemporary information and services. One grantee helps connect urban American Indians who are receiving cancer treatments with traditional healers to help attend to their needs for healing on all levels—spiritual, mental, emotional as well as physical.

PROGRAM SPOTLIGHT

- **Indian Health Board of Minneapolis:** **"**We host the 'Gathering for Traditional Healing.' This event is one of the project's most successful activities. This event combines a comprehensive service approach with the community's desire for traditional ways and traditional healing. By sponsoring the event, we provide the Urban American Indian population—individuals with cancer, as well as their families-- resources and opportunities to reconnect with traditional medicine, medicine people and ways."

2. Using Technology to Reach Target Populations

Using technology to deliver culturally-specific programming is another innovative strategy used by several EHDI grantees. From culturally specific videos to websites and intra-agency referral systems, grantees are using technology in innovative ways to deliver services and to expand their program reach. For many EHDI grantees, the use of technology is both an efficient and effective use of their limited resources.

PROGRAM SPOTLIGHT

- **Park Avenue Family Practice:** Park Avenue's many programs build upon the strengths of the Hmong community. The diabetes website takes advantage of the internet proficiency of Hmong-American youth and their openness to new ideas, which makes them prime targets for initiating changes in health behaviors themselves as well as for those around them. The Hmong youth are more educated than many adults, are proficient in English, and have some background in health issues through school health classes, all of which make them more amenable to adopting a healthy lifestyle.

3. Developing Innovative Partnerships

Partnerships play a key role in most EHDI grantee programs. Strong partnerships and connections with other agencies help leverage efforts and often result in an expansion of services. Some of the partnerships developed by EHDI grantees are traditional, such as health organizations working together to serve a common client, whereas other partnerships reach across sectors to develop relationships and recruit participants. One unique EHDI partnership brings different racial/ethnic communities together based on their common values, shared experiences and mutual health challenges.

PROGRAM SPOTLIGHTS

- **African American AIDS Task Force:** The African American AIDS Task Force (AAATF) partners with Hennepin County Medical Center (HCMC) to provide immediate assistance to individuals seeking HIV testing. AAATF walks with clients through the process of HIV testing and HIV/AIDS follow-up care at HCMC. The presence of AAATF in the medical facility has closed a major gap in how individuals receive HIV/AIDS test results and follow-up care.

- **Grand Portage Band of Ojibwe:** "The relationships have grown significantly since we started working on the Health Disparities efforts. 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 the facility. The 'Hopes and Dreams Program' contributed to reducing some of the stress of hospitalization by supporting patients in accessing care, receiving traditional support and supporting family connections in the hospital."

4. Employing Team-based, Wrap-around Services

A number of grantees utilize an intensive team-based approach to deliver health services. This involves bringing a comprehensive and well-coordinated set of services to the client—instead of sending the client off with a handful of referrals. Coordinating services helps to overcome barriers of time, transportation and cost for the client. Again, none of this is new, but combining this model with culturally and linguistically appropriate services

maximizes participant buy-in, increasing the likelihood of follow-through and positive results.

PROGRAM SPOTLIGHT

- **Hennepin Care East Clinic:** "We address the Latino community needs for health, including mental health, sexual health, family, all the connections that the patients have. It's something that is unique to here. To be able to connect with different providers all in one place."

CONCLUSION

Minnesota's Eliminating Health Disparities Initiative (EHDI) funds local nonprofit organizations and American Indian tribes to develop and implement culturally specific, community-driven health improvement strategies. This report documents the exemplary program practices used by Minnesota's EHDI grantees in their efforts to eliminate health disparities. This report provides numerous examples of how EHDI grantees exemplify this set of programming practices, working in many different cultural and community settings addressing eight areas in which disparities of health between racial/cultural communities are some of the widest in the nation. This report is consistent with a number of national studies that have identified similar community-based approaches as the most effective way to reduce health disparities

Minnesota's Eliminating Health Disparities Initiative has much to offer to the national field of health disparities. Its programs build on strengths and assets of local communities and are based on the philosophy of community empowerment. The EHDI provided local community-based organizations and American Indian tribes the resources to define and address the health issues of their choosing and to identify and implement strategies to solve these problems. These community-based organizations authentically engaged community members in developing solutions, governing their programs and evaluating the results. They used data to drive the development, implementation and fine-tuning of their programs.

The grantees used creative strategies to overcome a plethora of historical, social and logistical barriers in order to reach community members and provide services in places people felt comfortable and were convenient. They worked to establish and maintain trust with communities that had endured racism, oppression, and culturally insensitive treatment at the hands of "the system" generally and health care providers specifically for decades and in some cases centuries. They did this by meeting the clients where they were-- in terms of language, cultural background, and life experience and by listening to what clients wanted and needed.

The programming approaches were comprehensive in nature as they engaged the relevant social, physical and institutional systems of participants, and worked with participants until services were no longer needed. In the process, grantees developed many new linguistically and culturally specific resources, curricula, and tools.

By putting faith in communities to develop their own solutions, the Minnesota Legislature and the Department of Health invested in the creation of innovative models of culture and community-based health promotion. These

exemplary program practices emerged from a process of grassroots program development that involved a partnership of community members, community-based organizations, with support provided by evaluators and the Minnesota Department of Health. These model programs are yielding positive results—benefiting their communities and the larger systems where they operate.

Minnesota's EHDI and Rainbow Research offer up these findings and lessons learned about the value of strengths-based/community-driven health initiatives so that they can be utilized by the grantees, by other Minnesota communities and by communities across the country to promote greater health and well-being among all people.

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The following are some of the national sources of best practices research on community-based health disparities programming:

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ELIMINATING HEALTH DISPARITIES INITIATIVE GRANTEES 2006 – 2008

Community Grantees

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

Tribal Grantees

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