

**2004 INNOVATIONS AWARDS PROGRAM
Application Form**

- 1. Program Name:** Office of Minority and Multicultural Health
Eliminating Racial and Ethnic Health Disparities Initiative
- 2. Administering Agency:** Minnesota Department of Health
- 3. Contact Person:** Gloria Lewis, Director
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9. Please provide a two-sentence description of the program:

OMMH exists to promote the health of all Minnesota populations of color and American Indians. *EHDI* exists to eliminate racial and ethnic health disparities in Minnesota.

10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on May 1, 2004 to be considered.

EHDI was created by the Minnesota Legislature in 2001.

11. Why was the program created? (What problem[s] or issue[s] was it designed to address?)

Even though Minnesota ranks very high nationally in overall health status, those high marks start to plummet when the data are examined more closely. In Minnesota, although the overall health and life expectancy of residents consistently ranks among the top in the nation, populations of color and American Indians continually experience poorer health and disproportionately higher rates of illness and death. Barriers to improved health for populations of color, American Indians, and others often go beyond problems with access to prevention services and treatment. Social conditions of poverty, racism, language, culture, environmental conditions and other factors all contribute to lower health status. Disparities were also identified in data collection, policy, and program funding. The federal 2010 U.S. Public Health Goal #2, to eliminate health disparities, spurred MDH to make it a priority that Minnesota not accept a lower standard of health outcome for anyone in our state.

12. Describe the specific activities and operations of the program in chronological order:

Development of the EHDI began 1999-2000, and was passed by the Minnesota Legislature in 2001. As a result planning and implementation of specific related activities immediately began in earnest:

August 29, 2001: 150 representatives of communities across the state met to give MDH staff their input on the Community Grants award criteria, *Request for Proposals* content and structure, application and review processes, and technical assistance plans.

November 5: The *Request for Proposals (RFP) for the Community Grants* was published/distributed statewide.

November 7-20: Application workshops were held. In addition, 26 community-based organizations participated in a week-long grant writing workshop from the Grantsmanship Center, funded by a Office of Minority Health, U.S. Department of Health and Human Services grant.

December 17: The deadline for MDH's receipt of the proposals

January 7 and 8, 2002: Reviewer teams met to determine which proposals to recommend for funding.

January 15: Applicants' notice of the review process outcomes was mailed.

December 2001 and January 2002: Tribal Formula Grants proposals were submitted and funds distributed

February 5: Measurable outcomes were ready for distribution to grantees

February 26: First meeting of the Community Grants recipients was convened.

~ March 1: Contracts were negotiated with grantees and in place.

In addition, a two-day EHDI kick-off conference was held in October 2001, and Minority Community-specific Health Coordinators, representing the four major racial/ethnic/American Indian groups, were on board by February 2002. These coordinators are also grant managers for the Community and Tribal Grants. The RFP for evaluation capacity-building with the grantees was published in November 2001, with a contract in place by the following February. Two two-day training sessions were held each year (2002 – 2003), an Information Sharing System developed, semi-annual Interim Reports created, and Grantees' Evaluation Reports submitted by December 30, 2003. Coordination of MDH staff's technical assistance related to the initiative via the TAG (Technical Assistance Group) was and continues to be ongoing. January 2003 the first legislatively-required *Report to the Minnesota Legislature on the EHDI* was submitted. During 2003 the Community-specific Health Coordinators convened quarterly community-specific health committees, often in partnership with the state's councils of color. These committees and the grantees were instrumental in celebrating Minnesota's first *Minority Health Month* April 2003.

The state EHDI Community and Tribal Grants funds were available for the state fiscal biennium: July 1, 2001 to June 30, 2003. For the second fiscal biennium: July 1, 2003 – June 30, 2005, Community Continuation Grants were awarded to those grantees based on their progress, and the reduced amount of funds available. The EHDI Tribal Grant Funds joined several other allocations to become a formula-based Tribal Health allocation. The MDH Tribal Health Liaison joined OMMH in 2003 and administers these funds. The EHDI state general funds are in MDH's funding base for future biennia. OMMH successfully applied for a federal Office of Minority Health Community HIV Capacity-Building Grant providing a full time coordinator to work directly with community-based organizations to develop and expand their ability to provide HIV/AIDS-related services to their communities.

13. Why is the program a new and creative approach or method?

The approach that Minnesota took was to change from the usual top-down perspectives to a bottoms-up approach that gave the communities the opportunity to actively guide the process. From the writing of the Community Grants RFP to the review of the proposals and development of funding recommendations, communities participated fully in the process. The use of an asset-based approach was challenging and rewarding for staff as well as communities. It was the recognition of the strengths and skills brought to the table by both the state and the communities that guides the work of this initiative.

14. What were the program's start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

The first Annual Budget is \$6,950,000 as follows:

- \$600,000 for state level activities, including four fulltime Community Health Coordinators, their personal computers, and grantees' evaluation capacity-building work
- \$1,400,000 for Infant Mortality Prevention and Immunization Community Grants
- \$2,200,000 for Community Grants to address breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, and violence and unintentional injuries
- \$500,000 in formula grants to Tribal Governments to address the seven health priority areas above
- \$250,000 in formula grants to Community Health Boards for health screening and follow-up services for tuberculosis for foreign-born persons.
- \$2,000,000 additional funds for teen pregnancy prevention

15. What are the program's annual operational costs?

~\$7,500,000 per year all sources, all activities. The amount available for Community Grants has decreased several times.

16. How is the (overall OMMH/EHDI) program funded?

State General Funds, Federal TANF funds for the prevention of infant mortality, a federal OMH CHIV Grant, and Minnesota's federal Preventive Health Services Block Grant.

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

Yes – Minnesota Statutes 145.928.

18. What equipment, technology and software are used to operate and administer this program?

A dynamic leader in the person of OMMH Director Gloria Lewis, and staff knowledgeable of and with ever-growing relationships with their communities, and for equipment: personal computers, MS Word, Word, and PowerPoint, and e-mail, fax, website, etc.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator's name, present address, telephone number and e-mail address.

Yes and No (see #20.YES below for the NO here). As described earlier, this was a community grassroots movement guided by the director of the MDH Office of Minority Health (now deceased) and the minority health status data reported for several years, supported by the commissioner of health and the governor, and championed in the Minnesota Legislature. Federal REACH Grant materials were reviewed for structure, along with previous Minnesota Minority Health Reports to the Minnesota Legislature, in which communities identified issues and developed recommendations to address them. Once in statute, communities were actively involved in developing and implementing the initiative's elements.

20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

YES - Minnesota is only the second state in the US to take on this important work to address racial and ethnic health disparities. Florida's *Closing the Gap* Initiative was established in 2000. It funded \$6,000,000 in first year grants beginning November 1, 2000, with renewal of funding for up to two more years dependent on performance and availability of funds. Florida's *Closing the Gap* focused on decreasing disparities in similar health areas, although grantees were funded to focus on only one per grant cycle. Those grantees are to address the causes of illness and death, increase public awareness of the impact of unhealthy lifestyles, educate communities about the importance of screening and testing, increase community-based health promotion activities, and increase culturally sensitive community-based disease prevention activities. Minnesota was fortunate to gain from the lessons learned in Florida, and to be able to expand to cover so many health priority areas.

21. Has the program been fully implemented? If NO, what actions remain to be taken?

Again, Yes and No: The Community and Tribal Grants are now in place and developing and evaluating community-based activities. A Steering Committee of representatives of legislatively-identified partners guides the ongoing work. In addition, evaluation by grantees and of the initiative is developing. Six community-specific health coordinators are on staff and are developing and enhancing relationships with their community members. The Minnesota *Participatory Research Partnership* also formed as part of many of these activities, and it is actively working 1) to assure evaluation and research with communities is done according to participatory research principles, and 2) with communities to develop community-/culture-specific measures relative to eliminating health disparities as they experience them and the underlying social conditions leading to the disparities.

Still to be done are development of the legislatively-mandated coordinated and comprehensive state plan to eliminate racial and ethnic health disparities in Minnesota, short and long term strategic planning, and development of social marketing and additional capacity-building activities.

22. Briefly evaluate (pro and con) the program’s effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

The OMMH *EHDI* is charged with achieving the following goals:

- ↪ By 2010, decrease by 50% the disparities in infant mortality rates and adult and child immunizations rates for American Indians and populations of color (African/African American, Asian American, and Latino) in Minnesota as compared with the rates for whites; and

- ↪ Close the gap in health disparities of American Indians and populations of color (African/African American, Asian American, and Latino) as compared with the rates for whites in the following priority health areas:
 - * breast and cervical cancer
 - * cardiovascular disease
 - * diabetes
 - * HIV/AIDS and sexually transmitted infections
 - * violence and unintentional injuries

In addition, federal TANF funds for infant mortality prevention were directed to teen pregnancy prevention through this program.

Achieving these goals in nine years, across eight priority health areas, four major racial/ethnic populations, and with three priority-area-specific grants funding sources makes for a complicated and convoluted grants award and management process. (*But we are not complaining!*) In addition, with so many priority health areas to address, there is concern that the nine years to the goal is not long enough, especially considering the deeply entrenched social conditions and systemic barriers that must also change in order to achieve parity.

Qualitative and quantitative information to date on the effectiveness of the *EHDI*, however, tells us that communities and their community-based organizations are grateful for this opportunity to work from their assets and to participate in the development and evaluation of evidence-based strategies adapted to fit with their traditional cultural beliefs, values, and practices. In addition, the work they are conducting can be viewed and measured by the numbers of contacts, presentations, workshops, and other tangible descriptions.

23. How has the program grown and/or changed since its inception?

The activities and achievements described earlier in chronological order show the most apparent growth and change. In addition to the activities and staff funded by the state general funds and the federal TANF, CHIV, and PHSBG funds, other sources also have been pursued to enhance the core funding to achieve the goals. The in-kind contributions of expertise, technical assistance, resources, and training by the MDH staff working in program and data areas related to the OMMH *EHDI* have lead not only to greater effectiveness of the *EHDI*, but also to changing relationships inside and outside MDH, as well as to the early “buds” of state systems-change. An exciting example of this currently underway is the *Health Care Disparities Task Force* formed by MDH in partnership with the Minnesota Department of Human Services, the Council for Health Plans, and numerous health maintenance organizations serving the state. The “guiding light” of this

task force is the Institute of Medicine's seminal publication: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The task force meets on a regular basis, and has developed an ambitious and comprehensive work plan. Finally, the numerous and committed OMMH partners contribute time, passion, expertise, and ideas to, and constructive critique of OMMH *EHDI* so that it can assess and correct its course.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

The obstacles to adapting and adopting this exciting work in other states include:

- * Building and maintaining strong, ongoing legislative support for funding.
- * Securing adequate and long-term funding to address the long-standing health disparities.
- * Changing "business as usual" within a state agency.
- * Lack of proven best practices for eliminating racial and ethnic health disparities.
- * Developing a common language between community-based organizations and a state agency.
- * Lack of experience among community-based organizations in working with a state agency.
- * Measuring change across many, varied ethnic groups, health priority areas, and kinds of activities.

Add space as appropriate to this form. When complete, return to:

CSG Innovations Awards 2004

The Council of State Governments

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DEADLINE: All original applications must be received by April 20, 2004, to be considered for an Innovations Award for 2004.

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