



Management
Analysis
& Development

**Minnesota Department of
Health Center for Health Equity**

**Eliminating Health
Disparities Initiative:
Input Summary of
Themes**

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Introduction

The Minnesota Department of Health (MDH) published a report in 2014: *Advancing Health Equity in Minnesota: Report to the Legislature*. One of the first products that resulted from this process was the creation of the Center for Health Equity (CHE) in 2013 by the Commissioner of Health. The commissioner created the CHE to elevate attention and focus on the goal of creating a healthier state by addressing inequities and structural racism that contribute to health disparities. The CHE carries out its goal of advancing health equity by:

- engaging communities and citizens that are most affected by health inequities in decision-making and in addressing the contributors to health disparities;
- collecting and analyzing data on health disparities, health outcomes and health equity;
- investing in reducing health disparities by awarding grants to community organizations that serve populations of color and American Indians and other populations experiencing health disparities;
- increasing the public's understanding of these issues and building stronger relationships with communities; and
- focusing on a health in all policies approach for creating equal opportunities for all Minnesotans to be healthy.¹

The *Advancing Health Equity in Minnesota* report outlines seven recommendations for the state to make tangible progress on the goal of advancing health equity. Recommendation number five points to redesigning grant programs within MDH:

“Redesign the Minnesota Department of Health grant-making to advance health equity: MDH must adapt grant-making procedures and practices to support a wider range of organizational capacity among MDH grantees, improving training and evaluation methods to advance health equity, and engage a diverse range of stakeholders in the grant development process.”

One of the grant programs the CHE administers is the Eliminating Health Disparities Initiative (EHDI). The EHDI is a competitive grant-based program that the Minnesota Legislature created in 2001. The goal of the EHDI is to improve the health status of populations of color and American Indians. EHDI grant funds support community primary prevention and the development of strategies and approaches for eliminating disparities in eight Priority Health Areas (PHAs)². In 2013, EHDI invested \$5 million in 40 community-based organizations located in the Twin Cities and Greater Minnesota.

¹ MDH Center for Health Equity website: <http://www.health.state.mn.us/divs/che/>

² The eight PHAs are: breast and cervical cancer, heart disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations, infant mortality, teen pregnancy prevention, and violence and unintentional injury.

Purpose

The Center for Health Equity contracted with Management Analysis & Development (MAD) of Minnesota Management & Budget for assistance in managing a stakeholder engagement process to inform the development of the next EHDI RFP.

Input process

The EHDI input process took place between February and June 2015 (See Appendix A for project timeline). MDH convened input meetings with current grantees, community stakeholders, MDH staff and subject matter experts, and local public health agency staff. A total of eleven meetings were held (nine in-person and two webinars to accommodate people in Greater Minnesota)³. Approximately 303 people participated in the input process. (See meeting schedule in Appendix B and a list of participating organizations in Appendix C.) To avoid segregating groups, the EHDI project team decided early in the process that input meetings would not be scheduled by ethnic/racial population groups, but rather by broader categories of “current EHDI grantees,” “community members/stakeholders,” “local public health,” and “MDH employees.” One community meeting was also held in Spanish. To extend the opportunity for current EHDI grantee and stakeholders to provide input, MAD administered an anonymous online survey that was open from May 12 to June 4, 2015; thirty-two people responded to this survey⁴.

Input sessions were scheduled and organized with the assistance of MAD consultants and were facilitated by Karen DeYoung of DeYoung Consulting Services. Grantee and community stakeholder meetings were held at three accessible metro locations: Wilder Research and the Paul and Sheila Wellstone Building in St. Paul and The Center for Changes Lives in Minneapolis. A diverse group of facilitators (comprised of MDH and MAD staff and one facilitator from the Improve Group) attended each session to facilitate the small table discussions and document notes. A series of questions were asked at each meeting to keep the discussion focused on the topic (see focus questions in Appendix D). Questions differed by audience and experience with the EHDI grant program and were refined throughout the process by the project team based on participant feedback. Evaluations were completed by participants after each meeting (see Appendix E) so the project team could make improvements throughout the process as well.

After the input sessions were completed, MAD compiled all of the documented meeting notes, coded the qualitative data by themes (to gain a better understanding of which themes were discussed most frequently by participants), and created this summary document to guide the development of the new EHDI RFP. The new RFP will be issued in August 2015 and grant programs will begin January 1, 2016.

³ Data from the two meetings held on May 21 and June 5 are not included in this summary report. Notes from these meetings are forthcoming.

⁴ Data from the online survey are not included in this summary report. A summary of this data is forthcoming.

Beyond the EHDI grant program, there is hope among MDH staff that strengths, lessons and learnings from this process (and the next EHDI grant program) could be used to inform other MDH grant programs. For example, program criteria from the EHDI RFP (e.g., providing culturally competent services as a strategy for reducing health disparities) could be incorporated into grant programs administered by other MDH divisions/sections (e.g., Maternal & Child Health, Community and Family Health or Environmental Health).

Gaps in process

Feedback from community members most impacted by health inequities was not collected to the extent that it could have been during this process. The four community input meetings were well-attended; however, the majority of participants represented community-based organizations, healthcare organizations (HMOs), hospitals and clinics. Grantees were asked to extend invitations to their program participants, but it was clear that more targeted outreach would be needed to reach community members. Other possible reasons for low community member attendance could be that financial incentives/reimbursement, childcare, transportation or meals were not provided. The project team recognized early in the process that different strategies would be needed to effectively engage community members.

Reading this report

- Themes are organized by four focus questions that were asked in all of the input sessions (see Appendix D for focus questions).
 - Vision of a healthy community
 - Strengthening community capacity
 - Partnerships needed to advance health equity
 - Recommendations for EHDI grant
- Up to six themes are provided under each focus area. The themes are presented in the order of the frequency of participants' comments. Themes with the highest number of comments are listed at the beginning. However, all themes listed in this summary report were *key* themes that emerged during this process, which means that all of the topics were discussed by many participants.
- A narrative summary is provided to highlight the range of topics discussed by the participants within each theme. Examples of participants' comments, as recorded by small table facilitators, are included in *italics* in the shaded gray boxes to demonstrate the tenor of comments and to represent the voice of the participants. These are not exact quotes, but they are written in the participants' words as closely as possible.
- Unless otherwise noted, themes (including quotes) were determined by combining qualitative data from all audiences: current grantees, community members and stakeholders, MDH employees, and local public health personnel.

Executive Summary

Introduction

In response to the *Advancing Health Equity in Minnesota: Report to the Legislature* recommendation to redesign MDH grant-making to advance health equity in the state, the department engaged a range of stakeholders to inform the development of the next Eliminating Health Disparities Initiative (EHDI) request for proposal (RFP) and EHDI program. The Center for Health Equity contracted with Management Analysis & Development (MAD) of Minnesota Management & Budget to organize a stakeholder input process that took place between February and June 2015.

The EHDI RFP/input process was guided by two central questions:

- 1) What changes, if any, are needed in the EHDI RFP and grant program so they are in alignment with the Minnesota Center for Health Equity objectives and goals?
- 2) How could the EHDI RFP and grant program be redesigned to advance the recommendations in the 2014 *Advancing Health Equity in Minnesota: Report to the Legislature*?

Findings

- The following are the top six things that participants⁵ talked about to describe their vision of a healthy community. A healthy community:
 - is safe, engaged and connected;
 - has affordable and culturally appropriate healthcare and mental health services available;
 - has sustainable funding for programs and needed services;
 - has ample educational opportunities available for community members;
 - comprises empowered community leaders; and
 - has healthy food that is affordable and readily accessible.
- Stakeholders promote leadership development and training as one of the main vehicles for building communities' capacity to act to address health inequities and advance health equity. They also stressed the importance of listening to the community, empowering existing community leaders, involving and training other community service providers (e.g., housing, transportation, law enforcement, schools) and developing youth, as key strategies to build communities' capacity to act.
- Participants agreed that more coordinated cross-sector partnerships are needed to turn-the-curve⁵ on reducing health disparities in the state. Participants cited many types of

⁵ "Turn-the-curve" is terminology used in Results Based Accountability, a performance measurement framework developed by Mark Friedman. It refers to doing better and improving the results of a program or population indicator so that the trend line turns in the right direction.

organizations and community service providers: churches, law enforcement, schools/universities, immigration lawyers, businesses, youth programs, among others. Additionally, stakeholders noted that the partnership among EHDI grantees and the MDH, and among EHDI grantees, could be further developed.

- Current EHDI grantee participants talked about how the EHDI grant structure contributes to unintended consequences. Below is a sampling of examples they shared. As a result of the current EHDI grant structure, grantees said that they:
 - Provide clients with other needed services such as case management and care coordination or work on social determinants of health (e.g., assistance accessing transportation, housing/shelter, mental health services, and food) – services that are **not** reimbursed by EHDI grant funds.
 - Find it challenging to demonstrate long-term program outcomes due to being given limited (and often uncertain) grant timeframes and funding. (Grantees are funded for a year with the possibility of an extension based on available funding.) Grantees said it is difficult to operate as a sustainable program when they are not certain they will receive funding in the upcoming year.
 - Have difficulty relating to clients when they are required to implement evidence-based programs that do not incorporate culturally-specific activities and practices into the programming and are not created or tested with people of color or American Indians.
 - Feel the EHDI grant process breeds competition rather than unity among community organizations. For example, the RFP strongly encourages grantees to partner and collaborate with other organizations to carry out their grant objectives. However, because the grant is awarded the same amount regardless of the number of partnerships a grantee has, organizations are inclined to compete with each to get the full “pot” of money rather than partner with each other to split the same “pot” of money.
 - Find it challenging to take time away from providing programming to clients in order to collaborate with other EHDI grantees and community service providers to the extent they would like to.

Recommendations

Based on the key themes gathered from the EHDI input process, the Center for Health Equity should consider the following recommendations:

Grant modifications

- **Encourage grantees to broaden program activities to address social determinants of health.** Allow EHDI grantees to expand beyond providing programs that target individual behavior change to focus on broader social determinants of health; changing policies, systems or environments; and/or developing and strengthening communities and community leaders. For example, an organization could apply for a grant to support programming targeted to reduce teen pregnancy (primary program) and to support work aimed at changing a school policy that impacts teens (secondary focus).
- **Incorporate flexibility into the EHDI program model.** Allow grantees to use evidence-based strategies or promising practices/strategies⁶ to accomplish their program objectives.⁷
- **Build funding flexibility into the EHDI RFP program.** Allow community organizations to apply for funding based on their communities' needs and organizational capacity. Offer different levels of funding for grants with varying scope and purpose:
 - developmental or planning grants to assess community needs, develop and plan programming and build organizational capacity;
 - implementation grants to provide programming to address the current Priority Health Areas (PHAs) and/or expand to areas such as mental health and wellness or social determinants of health (housing/shelter, transportation, employment, food, etc.);
 - implementation grants for changing policies, systems and environments (PSE) to impact social determinants of health and to create healthy communities; and
 - implementation grants to strengthen community capacity and leadership.

⁶ The EHDI 2012 Request for Proposal included the following definitions: Evidence Based - Interventions that have demonstrated effectiveness based on the principles of scientific evidence, including systematic uses of data and information systems, and appropriate use of behavioral science theory in order to explicitly demonstrate effectiveness; Promising Practice - Interventions that have demonstrated effectiveness based on local practices and/or cultural experiences, for example, non-experimental data or the experience of practitioners.

⁷ The following statute change was introduced this session: Subd. 15. Promising strategies - For all grants awarded under this section, the commissioner shall consider applicants that present evidence of a promising strategy to accomplish the applicant's objective. A promising strategy shall be given the same weight as a research or evidence-based strategy based on potential value and measurable outcomes.

- **Award fewer grants.** Award a range of smaller and larger grant amounts based on the demonstrated community need and organizational capacity. Ensure grant funds are awarded to all areas of the state, including rural communities in Greater Minnesota.
- **Broaden the list of acceptable services and activities.** Allow EHDI grant funding to cover costs related to items such as mental health and wellness services; case management; healthy youth development; community organizing; community engagement; coordination of care; transportation; and, leadership development and training.

Leadership and community capacity

- **Invest resources into strengthening and building community leadership and capacity.** In partnership with a grantee organization, the Center for Health Equity should develop leadership development and community capacity-building opportunities for the EHDI grantee community and community members (from populations most impacted by health disparities). CHE should assist in developing content and curriculum for training and leadership development sessions. Ensure the leadership and capacity building activities are tied back to improving health outcomes. The following are examples of methods that were shared that could be implemented to accomplish this recommendation:
 - Convene a community of peers or learning circles of community members, grantees, and others to discuss issues that are impacting their communities' health, prioritize issues and identify solutions together
 - Organize a fellowship program, which includes training on health equity, for community members
 - Provide leadership development opportunities, internships and mentors for youth
 - Allow EHDI grantee staff to attend community advisory council and committee meetings so they can broaden their influence and be advocates in other arenas impacting their community
 - Provide opportunities for community members to participate on MDH decision-making councils and committees
 - Create a leadership development institute for community members and grantees
 - Build a toolkit of health equity resources for grantees and community members to assist in building community leadership and capacity
- **Encourage grantees to convene partners to talk about race and structural racism** in the context of advancing health equity. Advancing health equity and building healthy communities involves talking about race and structural racism. It is important for grantees to hold these conversations to acknowledge how racism can limit people's ability to be as healthy as they could be and to identify ways to remove these barriers.

Partnerships

- **Provide more funding to applicants/organizations that demonstrate a history of working in a partnership** with other organizations that goes beyond sharing information to sharing resources and shared decision-making.
- **Involve other partners** (e.g., local public health, Center for Health Statistics, MDH subject matter experts) in the grant development process (e.g., the grant workshop) and implementation phase to provide grantees with consultation, technical assistance and relevant data as needed.

Evaluation

- **Engage grantees in a performance measurement full-day training/workshop** to create a set of common program performance measures for the EHDI grant program. In addition, grantees could further refine program measures unique to their program. Consult with MDH's Health Partnerships Division and/or Management Analysis & Development for assistance with facilitating the training/work session. Results Based Accountability (RBA)⁸ is one example of a performance measurement framework that could be considered.
- **Allow grantees to demonstrate program outcomes on a continuum** based on their program's unique goals and organizational capacity. Work with grantees to determine the most appropriate measures of success. Depending on the program design, population being served and capacity of the organization, success may be measured by demonstrating process outcomes, outputs, immediate outcomes, intermediate outcomes (knowledge gained) or long-term behavior/attitude change.
- **Offer evaluation capacity-building resources** to grantee organizations to complement their internal grant program evaluation efforts.

Culturally competent public health, health and mental health services

- Include the goal of building and strengthening culturally competent public health, health and mental health and mental wellness services into the EHDI RFP.
- Allow EHDI grantees to implement programs that focus on creating healthy individuals in healthy communities.

Grant administration

- **Assess EHDI program/grantee needs** and provide adequate staffing to support these needs. Program activities to support may include:

⁸ Results Based Accountability is a performance measurement system developed by Mark Friedman. See: <http://resultsaccountability.com/> for more information.

- Organizing and convening an EHDI cohort⁹ for grantees to meet, learn from each other and partner on common issues.
- Providing timely data and health equity curriculum content for the leadership institute (mentioned above).
- Monitoring evaluation activities; ensuring grantees access evaluation capacity-building resources.

Next steps

To begin implementing the recommendations above, the Center for Health Equity should:

Short-term (within 6 months)

- Share this summary report with current grantees and participants of the EHDI input process.
- Schedule an EHDI grantee meeting to introduce new Center for Health Equity director, discuss the report summary, and allow time for grantees to share program information and successes.
- Identify and implement at least one recommendation from this report as a quick win.
- Use this report to inform the design of the next EHDI RFP (to be drafted in July).
- Post the EHDI RFP in August 2015 and hold grant application workshop the following week.
- Engage local public health, MDH subject matter experts and the Center for Health Statistics to participate in the grant application workshop.
- Plan, organize and develop a plan for convening an EHDI cohort with the new grant.
- Organize community and MDH internal RFP review process.
- Award and notify EHDI grantees and complete the grant contract process.
- Assess and ensure there is adequate staffing within the EHDI unit at MDH to support the grantees and implement the recommendations the department supports.

⁹ People referred to an EHDI cohort as the group of organizations who receive the EHDI grant funding. The intent of the cohort would be to convene as a community of practice to share strategies and practices and learn from one another (akin to the “affinity groups”).

Longer-term (within 1 year)

- Begin the new EHDI grant programs.
- Arrange the full-day training/work session. Consult with MDH's Health Partnerships Division and/or Management Analysis & Development for assistance with facilitating the one-day training/work session. Consider RBA as the performance measurement framework. (This step could also take place before or while the grantee work plans are being created.)
- Create an EHDI committee to involve community members and increase transparency and accountability among MDH and EHDI grantees. Consider consolidating another MDH committee with EHDI to encourage new partnerships and relationships, and give the committee decision-making authority as appropriate.
- Arrange a joint meeting with EHDI grantees and other MDH grantees (e.g., Statewide Health Improvement Program [SHIP]) to encourage information-sharing, peer-learning, and new partnerships.

The list of recommended short and long-term activities is not comprehensive. MDH and EHDI grantees should develop a one-year work plan so progress on the recommendations can be tracked and monitored.

Key Themes

“None of the health priority areas (as defined in the EHDI grant) are considered when choosing a neighborhood to live in.”

Vision of a healthy community

Participants in each input session were asked an introductory question to open up the conversation and encourage everyone to participate. The question asked them to describe their vision of a healthy community. Some participants were given a picture to look at and describe which ways their vision of a healthy community was reflected in the picture. Others were asked to share how their work contributes to creating healthy communities. Several components of healthy communities were described: infrastructure, such as roads, internet connection and water supply; access to green spaces, walking paths, parks and recreational opportunities; access to service systems, quality schools and affordable healthcare – to name a few. Below are the top six themes that emerged.

1. Safe, engaged and connected

Many people talked about safety in the context of safe neighborhoods and creating safe spaces for clients/participants to receive services. Various physical and environmental aspects of healthy neighborhoods were also mentioned: access to walking paths/sidewalks; clean water; green spaces; and community gardening. Many people described their ideal healthy community as having a strong sense of community where people can meet and connect and get to know one another. Other meeting participants talked about communities being healthier when community members are engaged, united and involved.

Examples of participants’ comments:

- *Sense of community is important.*
- *Community connections...ability to trust and rely on neighbors, ability to get help from one another, to feel safe; a lot of refugees are afraid of crime and getting lost. Trust is important.*
- *We need more communication and engagement among the communities – we need to identify common/similar practices that we have and work together. We’re not that different.*
- *It’s very helpful to create a safe environment...people found that it is ok to talk about sexual health if the foundation is set.*
- *Don’t separate the community – unite us. We need to think as a whole and network amongst ourselves. If one clinic does diabetes education but another does HIV, we can refer patients to each other. It’s a network of care and help. The communities need to unite.*
- *Safe neighborhoods: Policing and historical interactions with police do not make the residents feel safe.*

- *A healthy community would have walkable neighborhoods where people can walk freely without concern for personal safety. There are noticeable differences in high poverty areas of the Twin Cities where sidewalks are not walkable and a sense of fear for personal safety.*
- *Employment, affordable, stable housing, environmental conditions that support physical activity and healthy community, increased social connectedness.*

2. Affordable health insurance and culturally appropriate health and mental health services are available

Several participants said that in a healthy community, people need access to affordable health and mental health services. Moreover, healthcare services, providers and resources need to be culturally competent and appropriate for diverse communities. Many people said that there are significant gaps in mental health services in the state – especially culturally relevant mental health services for populations of color and American Indians and for people who live in rural Minnesota.

Examples of participants' comments:

- *MNSure has not made affordable health care coverage an option for many in our communities. Why isn't medical assistance extended to everyone?*
- *Need to acknowledge there has been trauma and offer appropriate trauma-informed mental health care.*
- *Traditional medical model is insufficient for our diverse communities.*
- *If there were jobs for everyone, if they had housing, if they had activities that catered to culture – culturally recognized activities that they could do, and health access that they can relate to, health care /system that they can relate to, that understands them. If these barriers were removed, then we would have a healthy community. So many cultural barriers to accessing resources, organizations don't understand them, fear of the health care system, afraid to open up, afraid it will be used against them.*
- *Significant gaps in mental health service capacity... seems as though we haven't started to think of mental health in same category as general health (MDH only has one staff person in mental health; soon to be two).*
- *If you can't move beyond day-to-day needs you can't think about health long-term. Mental health, if you aren't mentally healthy you aren't going to take care of yourself. Culturally competent mental health resources.*
- *Funding for culturally-responsive services by people who look like them and understand their culture; reflective of community; nuanced solutions (cookie-cutter programs will not work).*
- *More training for doctors and more cultural competency training for all health care providers. They are not as ready to work with grantees and communities to eliminate health disparities.*

3. Programs are adequately funded

It was very common to hear among all groups of participants that building a healthy community requires sustainable resources. Many people said they would like the EHDI grant program to be extended so programs could be funded three to five years and so that outcomes could be achieved. Furthermore, communities and current grantees want more discretion and flexibility to spend the resources the best way they see fit to meet their communities' needs.

Examples of participants' comments:

- *Grant program should be at least five years for getting longstanding behavior changes. The minute people improve, then the money is removed and the support leaves. There is no incentive to improve because then money will get yanked away. We need to sustain our programs. This "funding" issue affects our relationship with the community.*
- *Empower the community members themselves – people have their own potential and they can address their own problems. They need resources. There's only so much outside entities can do. Just give them the tools. Give the community leaders resources to come together.*
- *More resources (food, education, technology) are needed.*
- *The need for more funding resources is partially due to how complicated and expensive navigating systems have become (big money in politics, low wages in families, more costs without actually improving anything). Focus on individual community members' and families are not sufficient for change... change needs to be driven and supported from leadership (political and financial).*

4. Educational opportunities are available

The theme of education is broad and encompasses community education, the public education system, and general educational resources available to the community. Providing education about nutrition, cooking and healthy activities were commonly talked about as being important for a community to be healthy. Other frequently mentioned educational topics discussed were: cultural competency, independent living skills, health literacy, and diseases and health conditions. Additionally, having access to quality education and schools was also mentioned as very important. Some populations do not have the language to talk about health conditions such as diabetes, so providing education to these people presents additional challenges for the community.

Examples of participants' comments:

- *Teach kids life skills like gardening, nutrition; providing community gardens, healthy options and activities.*
- *Make sure educational resources are easily available to individuals and families.*
- *Elder education is missing.*

- *Public education needs to be revamped, changing the way teachers are trained. Kids spend the majority of their time at school. More social workers, more kid-focused training for teachers, smaller class sizes, schools need to help teach living skills: what minimum wage is, how things cost, what is relevant to children, how to get a job, how to keep a job.*
- *Community leaders need to have resources to lead their community (education, resources, etc.).*
- *Education about what is healthy in America vs back in countries of origin.*

5. Community leaders are empowered

Another key theme of healthy communities that was echoed in all of the input sessions was the significance of having and/or developing community leaders and decision-makers from within the community. Participants noted that healthy communities should have leaders who are empowered, have ownership of issues in his/her community, are well-informed to hold policymakers accountable, and have adequate resources to lead. Leadership development opportunities should also be available for community members.

Examples of participants' comments:

- *Leadership development is a long term investment – it's not just inviting someone to sit on an advisory panel. It's a big piece. We need to be able to give the leaders ownership – we don't want to pacify or tokenize. Typically leadership development is not included within grant funds.*
- *A healthy community would have political decision-makers that reflect their constituents. This is not often the case. In fact, many communities are not part of the decision-making structure in places like Minneapolis.*
- *Need community leaders amongst ourselves. In order to work with the community we need to have a sense of what it means to have our own leaders that can go back to the community to empower/strengthen our population to be healthy.*

6. Healthy food is affordable and accessible

Another frequently mentioned component of a healthy community discussed by participants was access to healthy food and water. People talked about the importance of having fresh fruits and vegetables at stores within walking distance, and remarked how community gardens are a great way to get fresh and local produce, but they are also a meeting place for community members to connect and get to know one another.

Examples of participants' comments:

- *Healthy, affordable and accessible food is seen as the most important.*
- *[Missing]: Grocery stores that sell healthy foods (some people have to take a bus to get healthy food – not within walking distance).*
- *Programs that are offered have to be catered to the diets of the communities.*

- *In South Minneapolis, Native American community gardens are working well. Community members are involved. They work in the garden and then pick their own food. There is a clinic across the street that also teaches cooking classes.*
- *Ethnically available and appropriate food, due to religion unfamiliarity with the foods for the food shelf, lack of fresh foods, and not sufficient or complete to build a meal.*

Other themes

While these themes are not highlighted in the “top six list” above, this does not mean they are insignificant. These other social determinants of health were discussed by several participants: jobs and livable wages, recreational/exercise options available, transportation/roads, childcare/family resources, and housing.

Examples of participants’ comments:

- *Wealth building in community – having jobs = hope.*
- *Many of the higher paying jobs exist in the Twin Cities suburbs, yet there is a lack of transit opportunities for lower-income people from the central cities (where affordable housing exists) to these jobs.*
- *Easy access to water, parks, bicycle trails and cultural attractions.*
- *Need clearer tie between education, housing, transportation and health issues.*
- *Housing and transportation are not connected; cars are an expected resource/infrastructure.*
- *Options for housing, transportation and food are limited and are focused on very low and very high income [families]. Not many options for middle class.*

“To build leadership and community capacity, the state needs to reach people where they are.”

Strengthening community capacity

Meeting participants were asked to share what they thought was needed to help strengthen local communities’ capacity to act (to reduce health disparities and build healthy communities). Unequivocally, the input pointed to leadership development training as the key to building community capacity. Other themes in this section include: listening to the community; empowering and educating the community and other service providers; and developing youth. An additional theme that several participants discussed (but is not listed below), is the need for more resources. People said that sustainable funding is needed for: policy and advocacy work; paying community members to participate (travel, childcare, etc.); direct services; programs; meeting with political leaders; building partners; leadership development programs; and more.

1. Provide leadership development and training opportunities

Participants shared several ideas for what a leadership development program to build community capacity could look like. Among others, specific leadership programs referred to include: LLAMP, Wilder leadership program, Northside Achievement Zone program, Nexus Community Partners, and Boisin Community Leadership Institute. Other general leadership development formats and training ideas shared were: peer mentorships, fellowships, board boot camp, sabbaticals, advocacy training, and health equity training.

Examples of participants’ comments:

- *MDH needs to assess leadership needs in the community through community forums and consistently engaging the community.*
- *We need to change the definition of what a leader is in order for more people to self-identify as leaders.*
- *LLAMP program is a great model. Leadership training is provided in teams. They do projects and attend conferences and leaders are offered stipends.*
- *There should be an organizing fellowship program for health equity for community members similar to the Northside Achievement Zone program. Leaders need skill-building to gain power.*
- *Provide mentorship opportunities for people who have leadership capacities – bring them into paid, formal leadership positions – enhance their role, stature and realm of influence.*
- *Your culture may not value leadership. In Native culture, everything is done via consensus; everyone joins together as peers.*
- *EHDI grantees should be able to use funds (per-diem or fellowship) for building community leadership capacity.*
- *You can’t just pop people in places – you need to authentically grow leaders. First help them get on boards, then in an executive role, then into the political world.*

2. Listen to the community

During the input sessions, participants were successful at getting this message across: “Listen to the community!” They noted that empowering community members entails giving a voice to the community and allowing them to decide what is needed most for their community. While many people agreed that community members need to be educated and given resources; others were quick to point out that community members already have the knowledge because they are the ones living and experiencing the health disparities. Nonetheless, there was agreement that the department should ask communities what they need rather than the department telling communities what they think the communities need.

Examples of participants’ comments:

- *Give community leaders a voice – ask them what they need. Host community forums and engage leaders. Connect them with one another so they can learn from each other.*
- *MDH doesn’t need to be in the lead position. They can convene, listen and be peers. Create a culture of peer-learning; acknowledge power dynamics.*
- *Communities don’t even feel like they have a voice so how can we even move to the political level? We need training: what equal rights are, how funding works, etc.*
- *Training is needed for people to understand and know who their elected officials are. Give them the tools and resources to advocate for themselves.*
- *Yes; MDH has funding, but they have lots of other resources. Most people don’t know that you can go to the Capitol and there’s staff that will help you write a bill. We don’t even know what kinds of laws might be proposed. Make this expertise available. Or could there be a process to get community input to inform MDH legislative priorities. What would it mean for community leaders to get involved with our priority areas?*
- *Create a safe place to talk about ideas (without being labeled radicals).*
- *Provide more opportunities for dialog and input with action.*

3. Convene community groups

Participants emphasized the importance of bringing community groups together to build capacity within their communities and advocate for change. They suggested that community service providers, churches, schools, law enforcement, community health workers, and others, should receive training and information about health disparities and health equity so they can disseminate and share the information back into their communities. Some people said that they would like consistency across the training and messaging and others discussed how essential it is for groups to work in unity and partnership towards shared goals. Participants also recommended building on existing partnerships.

Examples of participants' comments:

- *Need to train service providers who serve our communities.*
- *Charter schools and churches with traditional roots need to be included – could see more partnerships, more emphasis.*
- *Need to involve, train law enforcement – grantees could educate law enforcement.*
- *Allow for capacity building of existing organizations; partner with faith-based organizations and churches - especially in African American communities. Build partnerships with organizations you usually wouldn't partner with it. For example, the police department, DMV, and non-traditional partners. People are dealing with stress from all these [non-health] issues which impact their health. Minor issues start to snowball.*
- *Focus on church leaders to build the capacity to advocate for change.*
- *We should engage providers in conversations about health equity and culture to make sure they are sending consistent messages and know about our program.*
- *Community health workers could be appointed by the community. They could be educated and given resources to go back into the community to share information.*

4. Develop youth

Another key theme that emerged in the category of building local capacity was youth development. Participants talked about involving, developing and mentoring youth so they can become leaders in their community.

Examples of participants' comments:

- *Expose youth in our community so they know about the health inequalities that exist in the state/country. Start early.*
- *Everyone has something to contribute, including youth.*
- *Youth development: provide opportunities for them to be leaders in the future.*

“Relationships need to be strategic and long-lasting. If there is no sense of constancy – there will be a lack of community trust.”

Partnerships needed to advance health equity

Participants were asked to identify partnerships that are needed to advance health equity. As with the prior focus questions, participants provided ample examples and suggestions. They recommended that coordinated cross-sector partnerships of all kinds are needed and EHDI grantees need to work in partnership. Additionally, stakeholders and current EHDI grantees discussed three themes that were consistently mentioned throughout the input process: 1)

sustainable funding, 2) building leadership capacity and 3) youth development (these themes are not listed below since they have already been described earlier in the report).

1. Coordinated cross-sector partnerships

Participants identified a variety of partnerships – existing and new – that are needed to advance health equity. In the same vein as “it takes a village to raise a child,” “it takes a village to advance health equity.” It is clear that stakeholders recognize the complexity of these issues by the array of partnerships they suggested. Partnerships mentioned include:

- Schools and families
- Veterans, immigrants and farmers
- Schools, universities and technical schools
- Faith-based programs
- Federal and state government
- State agencies (DHS, DEED, MDH, etc.)
- Health departments, health plans and community health boards
- Legislature and Governor
- Non-traditional organizations and organizations not working directly with health (e.g., police departments, wellness programs, department of motor vehicle)
- Hospitals, clinics and local public health
- Businesses, housing and transportation
- Health navigators; food shelves; community based organizations; cultural organizations
- EHDI applicants who do not receive grant funding

Several people said that authentic and organic partnerships are the most successful, and stressed the significance of engaging the community, strengthening existing partnerships that are working, and having shared goals in partnerships. Many participants also expressed a need for better coordination among partnerships for them to be the most effective.

Other recommendations related to partnerships include: work with organizations with local expertise, use social media to connect organizations; allow flexibility within the grant around partnerships; and create a cross-cultural leadership team; and provide a definition of “partnership.”

Examples of participants' comments:

- *Allow for more intense collaboration based on previous collaboration and existing connections.*
- *There are a lot of partnerships and collaborations at certain levels, but it's not comprehensive. This causes duplication of efforts. Need more coordinated collaborations.*
- *We talked about the authenticity of relationships. For example, organizations that come together for a grant but do not have aligned missions. If the work isn't something that is institutionalized in the organization or aligned with the mission, it could get pushed down to interns.*
- *We see successes when we truly go into the community and form partnerships with small businesses and other community organizations.*
- *How do we include non-grantee organizations that don't receive EHDI funding but are doing great work? How can we include and collaborate with them?*
- *Bring activities together. We don't know what resources are out there. We need more ways to connect with each other - "community connectors."*
- *Does DHS collaborate with MDH – how do they collaborate? This partnership could be expanded for health policy and disparities.*
- *There is no definition by MDH of partnership, can the group define what this means?*
- *Connect with community-based organizations already working with individuals in the cultural groups.*
- *Resources are needed to support authentic partnerships, not to quiet dissent.*

2. Strengthened partnership among MDH and EHDI grantees

Several people noted that the partnership between MDH and the EHDI grantees could be stronger. Activities that participants suggested for MDH included: help facilitate partnerships by sharing ideas and information about what grantee organizations are doing (online tool or SharePoint site); create an EHDI grantee council; connect communities of color to the health equity work of the department; work with other state agencies and funders to leverage funds/resources; coordinate grant programs in the department; coordinate partnership between SHIP (Statewide Health Improvement Program) and EHDI grantees; help facilitate an EHDI cohort so grantees can partner and work together.

Examples of participants' comments:

- *MDH could model partnerships by working with other state agencies and funders to simplify process, evaluations and goals.*
- *MDH needs to coordinate internal grant programs – i.e. health disparities in all grant programs, not just EHDI.*

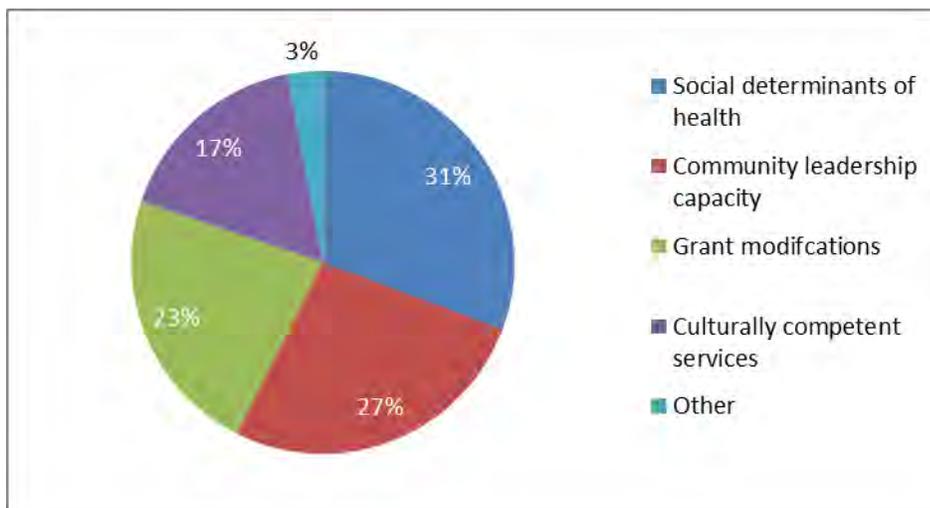
- *Stop focusing on requirements and focus on getting tools and resources to community to identify their own requirements.*
- *A good opportunity for MDH, "MDH not being so PC," allow MDH to be a facilitator of collaboration between organizations, use MDH's position at the state level to pair organizations of similar goals. The difficulty of creating these connections is outweighed by the benefits and reduces bad competition between organizations for money.*
- *Need stronger partnerships among grantees, MDH and commissioners.*
- *MDH could bring EHDI grantees together with SHIP grantees. Convene around social determinants (broaden beyond SHIP).*
- *EHDI grantees should work with other EHDI grantees/programs doing similar work.*

Recommendations for EHDI grant

Participants were asked to identify how they would spend the EHDI grant funds if given the chance. The four priorities that emerged from their comments were:

- Expand EHDI program to include work on social determinants of health
- Strengthen community leadership capacity
- Modify EHDI grant and RFP
- Increase access to culturally competent healthcare and mental health services

Approximate percentages of comments received are noted in the pie chart below.



Within each priority area, sub-themes are listed by frequency of participants' comments.

“Without affordable, safe and comfortable homes for individuals and families we are automatically increasing stress and risk factors that affect all areas of health and wellness.”

1. Expand EHDI program to include work on social determinants of health

Presentations were made at each of the input sessions to provide context about the EHDI grant program and input process, the Center for Health Equity goals and a framework for looking at how social, environmental and economic factors contribute to health disparities. It was not surprising to learn that social determinants of health emerged as the most frequently mentioned response from input session participants when they were asked what would have most impact in advancing health equity in the state. Within the category of social determinants of health, the following sub-themes included:

- Education
- Families and youth
- Transportation, food and housing
- Employment

Education

The most frequently mentioned sub-theme that was discussed by participants within the category of “social determinants of health” was education. System-level issues such as the education achievement gap, graduation rates and equal education opportunities were mentioned. Additionally, training and education for parents, youth and community members on topics such as self-empowerment/advocacy, healthy lifestyles and health literacy, were recommended by many people. Likewise, participants stated that legislators, decision-makers and the broader community should be educated about health disparities; roots of inequities; and policies, systems and environmental (PSEs) factors that contribute to health disparities. Potential vehicles for providing education and training included community forums; peer-educators; billboards/newspapers; community education; bilingual providers; and workshops.

Families and youth

The next sub-theme that was commonly discussed by participants related to topics associated with families and youth. Most of the input received focused on the need for more parent support groups, education and engagement; early childhood education and screening; youth mentorship and leadership programs; and programs to help build healthy families. Some people said they would like to see the voice of parents brought more into policy decision-making processes.

Transportation, food and housing

Basic needs such as access to transportation, healthy food and safe, affordable housing were three recurrent themes identified as having significant impact on reducing health disparities. Participants mentioned community gardens as one way for communities to gain access to healthy food choices. Others discussed how the lack of access to these basic needs creates stress, which often exacerbates physical and mental health conditions.

Employment

Another strong theme that emerged during the input sessions was employment and jobs. Many people said that they think health equity would improve if more people had access to jobs with livable wages. While the state unemployment rate is relatively low compared to other states, there are significant gaps in the unemployment and underemployment rates of harder to serve populations (people getting out of jail, for example). Additionally, access to employment training opportunities and a more equitable distribution of income would also contribute to reducing health disparities.

- *If we are moving toward intervention for social determinants of health, I think education is needed there as well. I am hearing frustration among my grantee colleagues because most of us do service delivery. We are a very important piece of addressing health disparities because we provide on-the-ground response within the respective communities. I think there is a lot of fear that the health equity focus will require a higher level of Policy, Systems and Environment (PSE) work and most are ill-equipped to do it.*
- *Address the aspects of social determinants in health where the disparities exist; quit talking and start doing something about this.*
- *EHDI focuses on “disease” which we know is only a small part of addressing health disparities. EHDI should refocus on social determinants. Of course – that would mean that most current recipients would need to restructure their work or at least how they talk about it.*
- *The conditions like housing, parks, places where people live work and play. Changing these inequities when there are huge political pulls for dollars. How do you balance it to change the climate? It will take time to change the social conditions.*
- *Grants that fund support services such as case management for vulnerable populations that help with basic needs such as housing, coordination of care, income, etc. Not clinic based, but agencies in the community.*
- *We have made strides in tobacco policy; would be great to take on housing as a policy issue. Support agencies that help with employment and education for low -income families.*
- *Social/economic factors focusing on women’s and children’s health. Also, make education a priority.*
- *Focus on youth and family. 1) Parent support/education, 2) youth mentoring, 3) collaboration with existing resources.*
- *Creating a safe space for community sharing and gathering.*
- *Could this grant be used to offer child care health consultant work to child care centers or home child cares? Child care health consultants (CCHC) assess, teach and are trained to go into child cares to make sure safe and healthy practices are being followed to prevent illness and injury of children, infants, and staff....*

“Build leadership capacity of communities of color to increase capacity to reduce health disparities.”

2. Strengthen community leadership capacity

The second priority area that participants in the EHDI input sessions clearly agreed upon was building community leadership capacity. Essentially three key takeaways were: Engage the community; strengthen community leaders; and let the community decide.

Other important aspects that participants discussed in support of building community leadership capacity included: connecting people and resources; working in partnership together; breaking down structural barriers; addressing institutional racism; and collecting appropriate data to understand the gaps.

Examples of participants’ comments:

- *Give small grants to individuals and groups to pull together members of their communities to identify problems they believe need addressing, and find solutions.*
- *Go to the non-white communities. Get buy-in from community leaders; help them spread awareness and mobilize regular community members.*
- *Community leaders should have a say in how the wealth is distributed.*
- *Need to address racism, both the perpetrators and the effect it has on people.*
- *There is institutional racism in MN that needs to be undone – we have to deal with it.*
- *Engage communities as active participants and co-creators of solutions (i.e., not top-down, provider driven).*
- *Sustaining, maintaining and strengthening existing community members, organizations, systems, etc. that are already leading this work.*
- *Educate the larger community about the roots of inequities –do not hide the problems.*
- *Community connectedness with the target populations; reaching out to those individuals; finding community connectors to identify the true needs.*
- *Powerful model: community decides on manageable issue they want to work on, and works on it, and learns in process. Exploring how decisions are made and influencing decision-making process.*
- *People need to see a different “we” / “us”: inequity hurts all of us, not just “them.” It’s everyone’s, all communities’ outcomes. Need to work together, care for each other, advance together.*

“We need to be addressing immediate needs while also thinking long-term about systems change.”

3. Modify EHDI grant and RFP

A significant amount of input received from current EHDI grantees, community members, MDH staff and local public health pointed to changes they would like in the grant. The changes discussed fell into the “buckets” of funding, program and administration. Suggestions for grant changes included:

Funding: Overall, participants said that more funding is needed to make an impact on advancing health equity. Some people suggested that MDH award different grant amounts so that smaller, grass-root organizations could use funding for assessing needs, planning or developing a program. Another suggestion was to fund programs based on community need rather than the size of the community or organization. Some participants stated that more funds and programming are needed in Greater Minnesota.

Program: Programmatic recommendations for improving the EHDI grant included:

- Let the community identify the priority areas and solutions
- Allow grantees to address immediate direct-service needs (e.g., individual behavior, basic social needs) and long-term system-level change
- Revisit the public health areas identified in EHDI statute
- Allow flexibility in the grant by not requiring grantees to base programs on evidence-based programs and allow promising strategies.
- Build evaluation capacity among grantee organizations; build more community-driven evaluation into program

Administration: Administrative recommendations for improving the EHDI grant included:

- Expand funding cycle to three to five years

Examples of participants’ comments:

- *Loosen the requirement to fit the community need – let community define the priority and allow flexibility, especially for mental health.*
- *\$5M is not enough money to make impact and difference on an issue that has existed for hundreds of years. You will need to give all \$5M to one organization or issue to make a difference.*
- *Focusing on social determinants might result in a loss of services. Need to be able to propose services in the context of social determinants.*
- *Revisit Public Health Areas. The “needs” should come from the community.*
- *Able to use funding on different levels – both direct services and systems level changes.*
- *Having the flexibility to be able to listen directly from the communities to identify focus areas.*

- *With small amounts of money, it is difficult to have a large impact. Need larger grants.*
- *Change RFP process/structure. Consider interviewing applicants rather than only accepting paper application.*
- *Be open to different priority health areas – is this focus supporting the greatest impact?*

“Staff should have the ability to help patients navigate the health system and the health needs of the whole person - not just targeted disease.”

4. Increase access to culturally competent healthcare and mental health services

The fourth priority area identified by participants of the EHDI input process was access to culturally competent healthcare and mental health services. Several people mentioned cultural navigators or community health workers as a vehicle for helping community members’ access resources and information about culturally appropriate healthcare. A few people said that EHDI funds would have the most impact addressing current priority health areas such as infant and reproductive health, teen pregnancy, cancer, heart disease and preventative healthcare.

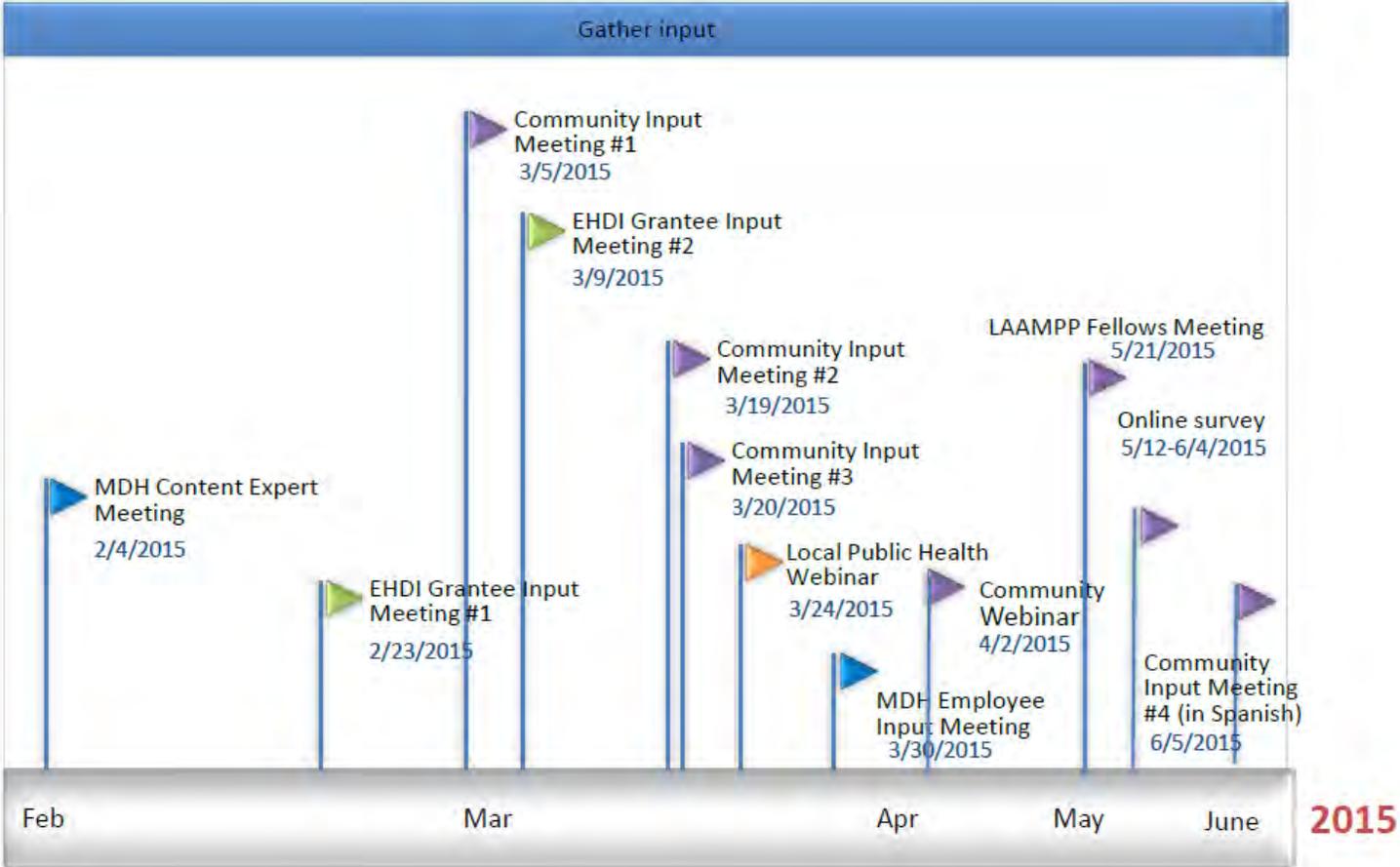
Examples of participants’ comments:

- *Loosen the requirement to fit the community need – let community define the priority and allow flexibility, especially for mental health.*
- *Support “alternative” traditional ways of healing that connect people to their roots.*
- *Culturally responsive providers. Not sure training is always the answer. Difficult to measure cultural competence—or at least, we don’t have a measure. Community members may be able to help create benchmarks / measures.*
- *Removing stigma to mental health by increasing opportunities to access mental health services for all ages and educate the population at large about mental health by supporting advocacy groups!*
- *Access to behavioral health and mental health services (that really help, not just push them off to another agency).*
- *Investment in the entire mental health system, continuum of services and prevention.*

Appendices

A. Project timeline

EHDI RFP Design Process Timeline – Phase 1: Gather Input



B. Meeting schedule

| | Meeting | Location | Date (2015) | Meeting Time |
|-----|-----------------------------|--|-------------|---------------------|
| 1. | MDH Content Experts | MDH - OLF B361 | February 4 | 11:00 am - 12:30 pm |
| 2. | MDH Employees | MDH - OLF B144/B145 | March 30 | 11:00 am – 12:30 pm |
| 3. | EHDI Grantees | Paul and Shelia Wellstone Building, St. Paul | February 23 | 1:30 - 4:30 pm |
| 4. | Local Public Health webinar | MAD conference room | March 24 | 10:00 – 11:30 am |
| 5. | EHDI Grantees | Neighborhood House | March 9 | 1:30 - 4:30 pm |
| 6. | Community meeting | Wilder Center, St. Paul | March 5 | 6:30 - 8:30 pm |
| 7. | Community meeting | Paul and Shelia Wellstone Building, St. Paul | March 19 | 1:00 - 3:00 pm |
| 8. | Community meeting | Center for Changing Lives, Minneapolis | March 20 | 9:00 - 11:00 am |
| 9. | Community webinar | MAD conference room | April 2 | 1:00 – 2:30 pm |
| 10. | LAAMPP Fellows meeting | Minnesota Humanities Center | May 21 | 5:30 – 8:30 pm |
| 11. | Community meeting | Paul and Shelia Wellstone Building, St. Paul | June 5 | 5:30 – 8:00 pm |

C. Participating organizations

Individuals representing the following organizations provided input during this process. This list does not include organizations that did not sign in at the input session. (*EHDI grantees)

180 Degrees
A Partnership of Diabetics
African American Leadership Forum
African American AIDS Task Force*
African Challenges
African Community Senior Services
American Cancer Society
American Indian Cancer Foundation
American Indian Family Center*
American Indian OIC
Angel Cancer Foundation
Annex Teen Clinic*
Axis Medical Center*
Be The Match/NMDP
Big Brothers Big Sisters of the Greater Twin Cities*
Bloomington Public Health
Blue Cross and Blue Shield of Minnesota Foundation
CAPI*
Catholic Charities of St. Paul and Minneapolis
CCLSL CHB
Centro Tyrone Guzman*
Century College – nursing students
Children's Hospitals and Clinics of Minnesota
Choices by Design LLC
Clare Housing
Clay County Public Health/PartnerSHIP 4 Health
ClearWay Minnesota
CLUES
Community Fitness Today, Inc.
Community University Health Care Center*
Cross Cultural Health
Crown Medical*
d.a.c.
Fairview Health Services*
FDL Reservation HSD CHS Dept
Firefly Sisterhood
Fond du Lac Reservation
G & K
Grand Portage Health Service
Greater Minneapolis Council of Churches*
Headway Emotional Health Services
Health and Wellness Table
Health Finders Collaborative, Inc.*
Healtheast
HealthPartners
Hennepin County Medical Center
Hennepin County Medical Center -Aqui Para Ti*
High School for Recording Arts - Check Yo' Self Health & Wellness*
Hmong American Partnership*
Independent Consultant
Indian Health Board Minneapolis*
Indigenous Peoples Task Force*
Innocent Technologies
ISD 840/St. James Area Schools
Karen Organization of Minnesota
Korean Service Center*
Kwanzaa's Northside Women's Space
Leech Lake Band of Ojibwe*
Lutheran Social Service of MN*
M3C
Masonic Cancer Center
MAWA, Minnesota African Women's Association*
Medtronic Philanthropy
Mewinzha Ondaadiziike Wiigaming
Minneapolis American Indian Center*
Minneapolis Health Department
Minneapolis Heart Institute Foundation
Minneapolis Public Housing Authority
Minnesota Communities Caring for Children

Minnesota Council of Churches Refugee Services
Minnesota Department of Human Services
Minnesota Immunization Networking Initiative - Fairview*
Minnesota Indian Women Resource Center*
Minority Liberty Alliance
MN CHW Alliance
MNAAP
MORE
MPHA
MSCOD
MVNA*
National Asian Pacific American Women's Forum (NAPAWF)*
Neighborhood HealthSource
Neighborhood Hub*
NorthPoint Health and Wellness Center, Inc.*
Open Cities Health Center*
Peoples Center
Peta Wakan Tipi / Dream of Wild Health*
Philippine Nurses Association
PICA Head Start
Pillsbury United Communities*

Planned Parenthood MN ND SD*
Portico Healthnet
Rainbow Health Initiative
Resource Inc.
Sabathani Community Center*
Saint Paul - Ramsey County Public Health*
SAYFSM
Sewa-Aifw
St. Mary's Health Clinics*
St. Paul Area Council of Churches – Department of Indian Work*
Stairstep Foundation*
The Welcome Place
Todd County HH
Turning Point INC*
Vietnamese Social Services of Minnesota
Watsonwan County Human Services
Wellshare International*
White Earth Child Care Program
White Earth Home Health/Public Health
Wilder Foundation
YAP
YWCA of Minneapolis*
Zandu Health Initiative

D. Focus questions

| | Focus Questions | 2/4 | 2/23 | 3/5 | 3/9 | 3/19 | 3/20 | 3/24 | 3/30 | 4/2 |
|----|---|-----|------|-----|-----|------|------|------|------|-----|
| 1 | In what ways is your vision of a healthy community currently reflected? What's missing? Who is experiencing these gaps? | | X | X | | X | X | X | | X |
| 2 | How does your work at MDH contribute to creating healthy communities? What are the gaps? Who is experiencing these gaps? | | | | | | | | X | |
| 3 | What would health equity look like in your area/jurisdiction? | | | | | | | X | | |
| 4 | What do you like about the current EHDI grant program focus and RFP process? | X | | | | | | | | |
| 5 | How would you change the EHDI grant program and RFP process to better address the longstanding health disparities as well as the factors that create the opportunity for everyone to be healthy? | X | | | | | | | | |
| 6 | What are the one or two things you heard today that would make the biggest difference in designing an effective EHDI grant program that moves the program from just focusing on individual behavior change to also focusing on the social and economic factors that impact health disparities | X | | | | | | | | |
| 7 | From your unique perspective, how would the changes mentioned above impact the application, determination, awarding and/or grant management process? | X | | | | | | | | |
| 8 | Moving forward, how would you like to be involved in shaping the newly designed EHDI RFP? (How should the employees who participated in the 2010-2012 EHDI grant development process be involved?) | X | | | | | | | | |
| 9 | Acknowledging that a lot of work is already being done by EHDI grantees and others to advance health equity in the state, going forward, what role could the EHDI grant program play in strengthening opportunities for communities to be the healthiest they can be? | | X | | | | | | | |
| 10 | How can the EHDI grant program strengthen community member's understanding of the roots of inequities? | | X | | | | | | | |
| 11 | What could be the EHDI grant program's role in strengthening community member's ability to advocate for needed changes to advance health equity? | | X | | | | | | | |
| 12 | What opportunities are needed to build leadership capacity in the community? | | | X | X | X | X | | | X |
| 13 | How would you design and/or change the EHDI RFP process, application, and administration of the grant? | | | | X | | | | | |
| 14 | What new partnerships are needed to advance health equity in the state? What existing partnerships need to be strengthened? | | | X | X | X | X | X | | X |
| 15 | Imagine updating a legislator in two to three years on the accomplishments of the EHDI program. What is the program's greatest accomplishment? In what ways is health equity advanced? | | | | X | | | | | |
| 16 | What should be the priorities for the EHDI grant program funds that would make the most impact and biggest difference in reducing health disparities and advancing health equity in the state? (Where would you spend the grant funds to have the greatest impact?) | | | X | | X | X | X | X | X |
| 17 | What are the one or two things you have heard today that would make the biggest difference and impact in reducing health disparities and inequities in your community? | | X | | | | | | | |
| 18 | Given the items on this list coupled with your knowledge and previous experiences, how would you design and/or change the EHDI grant program? (program focus and content) | | | | X | | | | | |

| | | | | | | | | | | |
|----|---|--|--|--|--|--|--|---|---|--|
| 19 | What kinds of roles do you see for LPH agencies related to the EHDI grant program? | | | | | | | X | | |
| 20 | Collectively, what needs to be put in place to reduce the longstanding health inequities that exist for populations of color and American Indians in Minnesota? | | | | | | | | X | |
| 21 | How can DHH's grant programs, advisory committees and stakeholder groups align and leverage their efforts towards advancing health equity? | | | | | | | | X | |

E. Meeting evaluations

February 23, 2015: EHDI Grantee Meeting #1 Evaluations

Received between 30-35 completed evaluations

What went well?

The small group discussions (22 comments)

- Generates great ideas
- Really helps me understand what everyone else is thinking
- Collaborative discussions
- Sharing ideas for improving EHDI grant outcomes
- Sharing stories of struggle in the communities
- Good brainstorming
- Cross-cultural conversation
- MDH staff joining our table conversation
- Fabulous discussion
- A lot of sharing
- Good table conversations
- The efforts to broaden the conversation up-stream. The process is becoming clearer.

Hearing each other's perspectives; getting feedback and hearing from each community (10 comments)

- I really enjoyed having the opportunity to talk with other organizations/grantees.
- Understanding of other participants projects.
- Talking with others in the Native American community.
- I felt heard and I felt others input was insightful.
- I think there is a sense of togetherness and willingness to come together as an entire community.
- I felt empowered as a grantee – thanks for making time to hear our input.
- All of the input and seeing the other EHDI grantees and knowing about their programs.

The questions were good, thoughtful, engaging (5 comments)

- Questions can guide the work we need to do
- Organization of questions
- I am glad that we were asked about our communities.

Helpful to have facilitator/recorder/assigned note-takers (4 comments)

Structure of the meeting/great meeting/well organized (3 comments)

Great getting the data back from 9/2014; presentation helpful (3 comments)

General feedback on questions (2 comments)

- The questions were inter-related and too much time for the questions.
- A bit redundant – more focus on solutions.

Healthy snacks (1 comment)

What are your suggestions for improvement?

Meeting content, questions and structure (10 comments)

- More time to stretch and move around; too much sitting.
- We've had similar meetings in the past discussing ideas. I would like the next meeting to be more action-oriented.
- Would like to hear more about individual organizations, but that may have occurred at other tables.
- The last question got to the meat.
- Focus on EHDI work. Too broad of a topic to handle.
- More time to meet and hear who is in the room.
- Re-wording the questions a little – a little hard to grasp.
- More prep work pre-small group work around sharing space...there were a couple of people who dominated.
- Less "pie in the sky."
- Too long of time per question.

Meeting preparation (8 comments)

- Preparing for the meeting I would have liked information on our discussion topics.
- It would've been nice to have the focus questions ahead of time so I could talk to other co-workers who couldn't come.
- All EHDI programs here. Plus, other departments like FPSP (?).
- Handouts of PowerPoint.
- More water available -2
- Morning meetings – afternoons can be long.
- It is a bit difficult to think after lunch but the conversation helped.

Continue these meetings (5 comments)

- Getting community together to reflect and deliberate is always necessary/needed; let's keep it going.
- Continue similar grantee meetings to share their experiences/experts.
- More of these conversations/meetings (2 comments)

Improvements to grant (4 comments)

- More time within grant stages to make a change in little patients.
- Education, jobs, housing and medical change
- More funding and longer grant times.
- Getting results.

None (4 comments)

Any other comments?

- It's always great to see people who are doing similar work. ☺
- I am excited that you are taking this input into consideration!
- Thanks! -2

- Scent-free meeting...please send a meeting notice about scent-free next time.
- I liked starting with the big picture.
- Can these conversations happen with groups of people that DO NOT know about social determinants of health – including legislators and agency/hospital board members?
- Look forward to part 2.
- Community health care as a whole. Large community engagement fair with provided transportation would make networking better among grantees.
- Need coffee ☺
- Great informative stuff.
- Interesting conversations. Hopefully information is used in crafting RFP.
- Great to have note-takers.
- I think the meeting went well.

March 9, 2015: EHDI Grantee Meeting #2 Evaluations

Received 33 completed evaluations

What do you think went well in the meeting today?

Small group discussions/good ideas shared (20 comments)

- “Think Tank”
- I like this facilitated small group format. It’s efficient and encourages everyone at the table to share their thinking.
- Good table conversation format
- Small group discussion and reporting back in the large group.
- Good conversations and ideas.
- I enjoyed the specific about the particulars of the great ideas that came up. We are all mostly dealing with similar frustrations.
- Honest responses from grantees that explain needs and wants.
- Talked about leadership possibilities in the community.
- Good idea flow and identification of barriers.
- This meeting seems more specific on the program changes so feels more relevant to the time.

Connecting with other grantees/organizations (7 comments)

- Sitting with other similar EHDI grantees (same population).
- I really appreciate the opportunity to hear the perspective of the other grantees.
- Get to know that other organizations have the same challenges we are going through. And, good ideas for solutions.
- Meeting other grantees.
- New organizations at my table – got to hear from different grantees than last time.
- Teamwork

Group discussions facilitated well (7 comments)

- Having a recorder and facilitator at the table
- Great facilitation! Marisol is great.
- Group discussions were facilitated well. I’m glad we had a facilitator at our table.
- Great facilitator
- Civil and everyone had opportunity to contribute.
- Asking tables to pick a speaker before asking for sharing.

Questions were thoughtful/liked questions (3 comments)

- The questions were well thought.
- Great guiding questions.
- The questions were good – I felt like the questions will help to build a stronger RFP and EHDI program.

Meeting space/environment (3 comments)

- The setting, accessibility (great parking).
- Making it scent free, Thank you. This allows the space to be safe for all.

- The healthy snacks ☺

What are your suggestions for improvement?

Ability to connect and share ideas with other grantees/content/issues (9 comments)

- Assigned seating? Gather similar population/grant groups together to learn from each other.
- More people around the table to cross-pollinate ideas.
- Linking up and having people and new connection with people (and organizations) to partner to improve in the community.
- Have intentional time for similar grantees to talk – like the cohort that was suggested; doesn't have to happen at this meeting, but could begin to be built.
- More conversation around other EHDI issues that can help to improve department.
- More time to talk about the question because there's so much to share and reflect on.
- We need to talk about Big issues and **not** be limited in talking about racism, safety and expectations of government departments/agencies working together.
- More grantees sharing best practices.

Things are good/no suggestions (6 comments)

- I can't think of anything – it's been great to have the opportunity to participate and that MDH opened up the opportunity.
- All good improvements, work together.
- None – 4

Meeting structure (6 comments)

- I don't think it's necessary to have all groups share their brainstorm. I'd like more time to discuss and I'd love to know when we'll get the notes from all the brainstorming.
- Not mandatory report-backs – becomes repetitive. Confusing to change format of data collection for each question – post-its, butcher paper on wall, notes, etc.
- Liked the diagram idea. This could be used sooner.
- Some of these questions could have been done on-line.
- Morning meetings.
- Shorten the meeting so more people could attend.

Food suggestions (5 comments)

- More fruit/snacks
- More chocolate! More snacks!
- Cheese and crackers.
- Coffee to avoid the post-lunch winding down.
- Have lunch first.

Send out notes in advance (3 comments)

- Send out notes taken.
- It would be great to get the handouts ahead of time – particularly the questions too – before the meeting. The process is flawed if we don't prioritize the information.

- To receive the notes from first meeting in advance.

Better understanding of next steps (2 comments)

- Better understanding of next steps.
- More clear direction/outcome/next steps of what we're doing with this information.

Look forward to seeing RFP (2 comments)

- We are looking forward to see how the RFP captures all the great ideas in the room.
- RFP....draft review

What one word would you use to describe today's meeting?

- Excellent – 4
- Hopeful - 2
- Focused -2
- Collaborative - 2
- Sleepy (time change)
- Easier
- Two words: a start!
- Useful
- Nebulous?
- Positive
- Energizing
- Big picture
- Change

March 5, 2015: EHDI Community Meeting #1 Evaluations

Received 19 completed evaluations

What do you think went well in the meeting today?

- Small group discussions/great discussion -5
- Well organized. Good meeting place. Interesting to hear that there is openness to change.
- Setting the foundations for discussion.
- Seeing the room filled with very concerned interested people. Feel change is possible.
- Change and sharing of ideas.
- Structure of questions and diversity of attendants.
- Interactive activities.
- Good voices from a variety of backgrounds (Aaron Berger)
- Input from many communities and different perspectives voiced.
- Grant program overview.
- Good ideas and respecting each other's ideas. Lots of "checking ourselves" so that we offer suggestions, not simply criticize.
- People came with great ideas. The PowerPoint was amazing. The snack was great.
- Presentation overview.
- Deleting barriers for [?] is especially for the first generation. To be able to have voices for equity.
- I enjoyed the suggestions and discussion.

What are your suggestions for improvement?

- Really listen to the community. Listen and look deeper within the gap of what is missing. Research is good, but that goes only so far.
- Engaging youth in this process.
- More time. Less background information and more small discussion.
- More time.
- Updated research. The pie chart (determinants of health) is 15 years old. Isn't there something more current? Liked the capacity model – but also very old.
- Share to audience what works in previous programs given funding.
- Regardless what new program is created the Legislature needs evidence base data to further funding of CDC, HHS, HRSA or other federal... We need to prove that for minorities that works. It has to be different than dominant culture. The best way to show the results/outcomes are present. Program needs to correlate with work plan. Evidence based the predetermined benchmarks/outcomes. To work with in the specified minority. And see similar outcomes to dominant culture. OR AT Least have a base and show how program that has been adapted to have behavioral changes in that culture AND yet use an evidence base curriculum.
- Contrast health opportunity with health outcomes and how communities can give them both justice.
- More focus on question #4 and 5!
- Spent too long on presentation and vision activity.
- More time to discuss and voice concerns from community members.

- The pictures were interesting but did not help raise discussion about what does a healthy community look like to you. It was more a beauty contest looking at temperate zone green vs. arid zone tan.
- Have main presenter speak more loudly and truly spread the news about these meetings so “regular” community members.
- More time for discussions. Follow the agenda.
- Spent too much time on introductions. Do one thing about yourself.
- Education on prevention.
- More time do discuss at tables.
- I think serve dinner next time and give less PowerPoint presentation and more discussion and feedback time. I would have loved that.

Any other comments?

- Thank you for inviting the communities. Please continue and share results... Thanks! ☺
- We needed more time. It was a good beginning of dialogue and wish list grants (?)
- Our group was not really able to use the pictures as instructed in answer to question #1. Is there a difference and better process you can use to elicit this information?
- Discuss what works in past/current, then do it again/expand to bigger communities.
- This should happen with more state organizations, federal organizations, and private companies.
- Required partnership requirements for grantees (i.e., schools, corporations, and police departments).
- I would have liked discussion time for questions 2 and 4.
- Have separate meetings with different ethnic groups to pinpoint specific needs because each group has different needs, desires and barriers to face.
- Introductions are nice, but we started 20 minutes late and it just got later as the time progressed so little time for the meat of the meeting (e.g., part 4 and 6).
- Thanks for having hummus to eat!
- Great event. I really enjoyed it. We need more community meetings like tonight.
- To educate minorities culturally sensitive and effective a health issues to have voice for equity.

March 19, 2015: EHDI Community Meeting #2 Evaluations

Received 32 completed evaluations

What do you think went well in the meeting today?

- Opportunity to share with one another
- Nice people. I'm glad we had this opportunity to participate. However, I'm the type that needs to think about questions. I let them marinate. I wish I could have had the questions ahead of time so I could think about them first. I don't feel I was able to participate **fully** because I couldn't think fast enough.
- Yes, good turnout
- Good table dialogue
- Table discussions, hearing each other out.
- Ability to discuss issues of the community
- Great discussion-ground rule: opportunity
- Was really glad to have a facilitator taking notes. We had great discussion.
- Opportunity to provide input
- Thanks for asking questions and listening.
- I thought it was great that the facilitators really allowed the group to talk and share experiences/opinions.
- Good conversation
- Get information from the community
- Group discussions
- Questions, table discussions, table facilitator
- Very good discussion and information sharing
- Everything – really interesting
- Learn
- Meeting new prospective partners. Listening and learning from others.
- The group's discussions/conversations.
- Enjoyed the open discussion with our table. Wonderful to share insights + perspectives from other lenses.
- All the information that organizations share and to agree with. Similar point of view.
- Well organized
- Small groups
- Everything was well done.
- Small group discussion, brainstorming ideas that can make a difference.
- Conversation + brainstorming among the group. Hearing other groups conversations.
- The questions and facilitators at table
- I enjoyed the discussion about the questions as a small group
- Small group discussion, learning about other views & perspectives.
- Finding out more information about the causes to health disparities
- Good turn out

What are your suggestions for improvement?

- More community member attendance!

- It's hard for me to see how this input actually impacts the RFP development
- More time to discuss. The issues being discussed are **heavy** and need more time.
- Need to talk more about specific issues of individual health disparities
- ^awareness for community members to attend.
- Might have been helpful to have the questions ahead of time so I could have put more thought into it, rather than off the top of my head today.
- Email survey/questions out prior to meeting.
- More time for answering questions
- I would have really liked to hear from more community members - maybe it was this way in other groups – but ours was largely people working in some public health capacity. Would love to see notes – the different perspectives could be extremely valuable in our own work as well.
- Include local health depts. in your pitch on whose responsibility it is. They are the boots on the ground and have the fingers on the pulse of their communities! Serve lunch – more people will come; lots of conversations happen around food in many cultures. Many local health depts. Have already had these conversations with their communities. Why not listen to the LHDs or at least [?] the LHDs to the table WITH the CBOs. Community engagement is a priority at the local **level**. Translate the [?] into more languages.
- Using this information – “suggestions”
- Be open to what info is shared
- Group similar organizations/work together.
- Good job
- Expectation of what on input will be used for and would we participate down the line in shaping the final suggestions.
- More time to discuss
- More time on interactive time.
- Stricter facilitation
- Be sure to state thru out meeting that this \$ is just for the health of persons of color + NAs. MN needs health care providers of the same race and culture of citizens of other races (Somali, Hispanic, other). Better health comes from providers who understand their patients.
- More discussion time. More advertisement for meetings like this.
- More directed discussion and time
- More allotted time
- Increasing awareness about these meetings
- Get word out there! Advertise on news & get more people aware of meetings!
- Getting to hear different groups' thoughts
- Would love to hear feedback from other input sessions

What one word would you use to describe today's meeting?

- Inclusive!
- Empowering
- Connections
- Collaborative
- “Refreshingly informal”
- Vague

- Inspiring
- Inspirational
- Engaging
- Hopeful -3
- Thanks
- Helpful -2
- Interesting -2
- Surprise
- Energizing
- Energetic
- Productive
- Great
- Wonderful; Thank you
- Improve
- Awesome
- Work
- Insightful
- GOOD meeting
- Eye-opening
- Informative -2
- Eye opening
- Encouraging

March 20, 2015: EHDI Community Meeting #3 Evaluations

Received 28 completed evaluations

What do you think went well in the meeting today?

- Discussion of what creates a healthy community
- People have a chance to speak
- Input from community based organization
- Presentations – Discussions at the table
- Shared values
- Good local discussion. Great exchange of ideas.
- Good
- I felt listened to.
- Primarily small table conversations --> good amount of time w/ small table talk
- I think it was a good idea to lay the ground work about the issues rather than just ask – Where would you spend the money.
- Focused on the task at hand. Well guided discussion.
- Different perspectives, where people are at in life? Companies/orgs/students/state
- I really enjoyed the structure of the meeting
- Everyone was able to share their thoughts + feedbacks. Voices were heard.
- The different perspectives around the table really promoted a good discussion.
- Really appreciated time to explore deep questions in small groups
- Collaborating w/ others. Hearing new and alternative ideas. Redefining health disparities. Starting from strength.
- The small focus groups. The questions were engaging and it produced good reflections/conversations.
- Really good conversation. Facilitator did good job of asking for specifics and “actionable” examples.
- Enjoyed seeing and hearing from many different people
- Small group conversations and large group sharing.
- Nicely structured + stayed on task. Great mix of people & ideas.
- New participants in the table. Value opinions.
- Meeting the wonderful people doing great work

What are your suggestions for improvement?

- More time to discuss RFP/scope of EHDI grants
- Good
- Please match issues to agencies and communities. Higher a community has issues Funding should go to them. And help build capacity for long term changes.
- Host listening sessions at locations addressing priority areas to listen to the community (not just the professionals working with the community).
- It would have been great to have more MDH staff around the table to hear what people were saying
- Too short. Could have lasted all day and not covered everything :)
- Longer session times. More large group discussion.

- Real broad big topics tackled in 2 hrs.
- Focus groups in communities hosted by MDH.
- More time to discuss and collaboratively address the issue(s)
- More relationship building time –More clarity about how MDH will report back
- Inviting more community members
- More time for conversation – not too much but a bit more.
- Where is all of this going? How will this information be used? Can the answer to these questions be more explicit?? Why didn't we talk about Q4?? Why not hear all ideas from everyone??
- Clarity of what would happen next how are we making an impact by coming
- Less tasks or more time
- Being more intentional to invite other community representatives like LGBT, disability, communities of color, large systems representatives, etc.
- Maybe switch tables to meet others?

What one word would you use to describe today's meeting?

- Starting
- Sharing -2
- Great & educational
- Information
- Engaging
- Excellent
- Feedback
- Eye-opening
- Improvements
- Insightful -2
- Satisfying
- Innovative
- Inspiring -2
- Frustrating -2
- Hopeful
- Fast
- Progress
- Connect