From: Cathleen Urbain [mailto:cmurbain@pediatrichomeservice.com]
Sent: Tuesday, January 14, 2014 2:28 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK

I would like to propose that MDH include in its Advancing Health Equity Report a role as facilitator of inter-agency collaboration at the state and local levels to address health literacy, culture and language as they impact citizen understanding of

- Avenues to access medical care
- Resources for payment for medical care
- Health information itself

Efforts could include, but not be limited to,

- Education and non-financial incentives for medical providers to train staff and monitor performance quality in the areas of communication, treatment planning and adherence, and patient/provider problem solving as impacted by health literacy, culture and language.
- Adult education outreach and training in health care self-advocacy
- K-12 and college initiatives for student awareness of high frequency health care issues, the structure of health care systems, and health care self-advocacy.

Thank you for the opportunity to provide feedback.

Cathleen Urbain, Ph.D.
Patient Advocate

Pediatric Home Service
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Roseville, MN 55113

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thrive

From: Jane Hinrichsen [mailto:jane.hinrichsen@gmail.com]
Sent: Tuesday, January 14, 2014 4:04 PM
To: *MDH_Advancing-Health-Equity; Rachel Callanan; cherry cramer
Subject: Health equity

Health equity is an issue that should be addressed or continue to be addressed. It is my understanding that schools are no longer required to conduct Family and Consumer Sciences in junior high and middle schools. Because of this many schools are discontinuing Facs programs for more "academic" subjects. Why do we need to study this?

Shouldn't we just say we made a mistake by discontinuing Facs requirement and put this already in place program back in the forefront of education? Take this study money and give it to schools so that they can afford healthy food for food demonstrations and preparation.

Please stop with the red tape and move forward.

Jane Hinrichsen
Retired Facs teacher that cares

January 15 2014

ADVANCING HEALTH EQUITY IN MINNESOTA- ORAL HEALTH- FOR SCHOOL CURRICULUM

Thank you senator and member of the committee for affording me this opportunity to comment the draft of advancing health equity in Minnesota

My name is Dr. Abdulkadir Shire, dentist as a profession and member of Somali community in Minnesota, to this opportunity I want to discuss the importance of making School oral health education a top priority because is to motivate students to maintain and improve their oral health, prevent disease, and reduce health related risk behavior

This program will reduce oral health disparity and improve the oral health literacy by educating children the importance of good oral health in the schools and the mission of schools is to provide the knowledge and skills children need to become health and productive adult.

Whereas, ignoring oral health education can lead oral health disparity, causing devastating and oral health complications with financial cost that significantly burden American society.

Many people don't realize a tooth decay is one of the of the most chronic childhood disease, its preventable we believe it is imperative that oral health education be included in school curricula throughout Minnesota.

School Oral health education will help thousands of disadvantage children in our state by creating an educational system that is sensitized to the value of good oral health.

I am sure the wisdom of this body will not miss this opportunity to set the trend of the nation on oral health education using the innovative curriculum and the resource available,

I want to do all that we can to help to ensure oral health legislation that will make a meaningful difference in the lives of children and families living in poverty, often those who are disproportionally affected by dental disease.

Thanks you again for your years of dedication and leadership and for supporting oral health care in Minnesota

Dr.Abdulkadir Shire

2905 17TH AVE S MNP 55407 MN

TELL: 612-735-5598

Outline of Testimony

Thank you for the opportunity to provide testimony tonight. My name is Gretchen Vanderlinden-Wang, and I am a leader in ISAIAH, a multi-racial faith-based organization advocating for social and racial justice. I am also a medical social worker by profession, and I currently work in the public health field. I am proud to be a Minnesotan and am proud of the Minnesota Department of Health for naming structural racism as a key contributing factor to health disparities in our state. I hope that MDH will hold to its promise and will become a leader among other public state agencies in reversing health disparities through dismantling policies that promote structural racism.

1) a particular way that I see structural racism played out on a daily basis, which is minimully discussed in MDH's draft report is in public funding for programs supporting MN's aging and disabled residents
   a) You may be thinking, aging is a completely separate topic than racism.
   b) I am here to tell you, aging and disability is where RACISM is OFTEN played out.
   c) First, let me paint two pictures for you. I have a wheelchair bound Caucasian home care patient in her late 80s who lives in a spacious assisted living. With her pension and savings, she can easily afford the $2000 rent and the additional $1000 monthly fee for housekeeping and bathing help. She also has two children who live locally and who are able to take time off from their jobs whenever she needs help. The second picture is of a 60-year old wheelchair bound Native American patient, living in a deteriorating duplex infested with insects, which her landlord refused to fix. She has no savings or pension, so she depends on Medical Assistance and her publicly-funded CADI waiver and PCA in order to remain independent. Several of her children are homeless, and one works 2 minimum wage jobs, so they are not available to help with her care.
   d) You may be thinking, those are interesting stories, but where does the structural racism come in? And I answer you: When our State's funding for public aging/disability programs is cut year after year. When the nursing facility level of care definitions change and threaten to cause hundreds of older and disabled Minnesotans to lose their waivered Medicaid services. Whenever our public aging and disability programs are threatened, people of color are disproportionately affected. And while many white Minnesotans may have other informal supports to fall back on when public programs are cut, many aging and disabled people of color rely EXCLUSIVELY on these programs to survive. And THIS is where structural racism rears its ugly head.
   e) I want to stress that it is CRITICAL that MDH recognize that structural racism is played out in aging and disability policy at the state level.
   f) Finally, I would like to leave you with a vision I have. I have a vision that one day, when I sit down in front of my computer screen and look at my list of patients, that I will not be able to guess my patients' races based on their listed age and funding source. Because right now this happens to me every day. When I look at my list and I see a 40- or 50-year old patient on Medical Assistance, I know they are probably Native American or African American. And if I see an 80- or 90-year old with a Medicare Advantage plan on my list, I know with almost certainty that they are white.

g) As long as I can look at my patient list and guess their races, I know that we have health disparities in Minnesota. And I know that many of these disparities come from under-funded aging and disability public programs. I hope that MDH will be brave in its leadership position and will hold other state agencies accountable for aging and disability policy.

From: Liz Ehlinger [mailto:liz.ehlinger@gmail.com]
Sent: Thursday, January 16, 2014 3:20 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK

First of all, **thank you** for all your work creating this report. It represents an amazing step forward to improve the health of all Minnesotans. Seeing proof of a governmental organization acknowledging structural racism and the social determinants of health is very empowering, and I hope this document and its later forms will exert a great inspirational force to community groups and lawmakers both in and out of this state.

While I am absolutely on board with addressing the elements of structural racism outlined by the report, I would like to emphasize that **this is a perfect opportunity to simultaneously address issues faced by the LGBTQ community**. I know some of the local LGBTQ organizations, such as Rainbow Health Initiative, were involved in the early meetings about this document, and indeed the report does mention some ways in which this community's health is affected by social inequalities. However, in the push to emphasize all the evils of structural racism, I fear that we may miss a chance to fight the common battles against racism, homophobia, and transphobia. Below I outline some easy ways to incorporate actions to help the LGBTQ community into existing policy ideas in the report.

- **Data collection:** I heard at the Jan 15 community listening session that MDH is already looking into a report on how to include new and better language about race and ethnicity as they work on standardizing data collection. This is a perfect time to consult with the LGBTQ community about the proper language to use to ask questions about sexuality and gender identity as well. This entails adding just a few questions to a form, but can yield a treasure trove of information about the needs of our community - or even its exact numbers. **Until we are counted, we do not exist!** This is especially true of bisexual and transgender people, who have been further marginalized within an already marginalized community.

- **Grants**: I urge you not to pass over LGBTQ organizations when awarding health equity grants. Many of these organizations are particularly working with youth of color, who are disproportionately affected by disparities. The majority of LGBTQ organizations in this state have fewer than two staff members, and these groups with volunteer boards lack the time and expertise to submit extra-polished grants - however they do have a lot of expertise about how to make a difference in the lives of these youth.

- **Legislation**: If we are passing better anti-discrimination policies to address discrimination on the basis of race in employment, housing, education, etc, we should also be adding a clause about sexual orientation and gender identity/expression at the same time. Likewise, anti-bullying legislation can include that specific language to protect people no matter what their skin color or gender expression.

- **Community Collaboration**: Please reach out to LGBTQ organizations for input on how to

add more inclusive language. We want to help you help us! In this vein, **I propose that the Minnesota Center for Health Equity establish an LGBTQ Cultural Liaison** who can recommend community partners and make sure that LGBTQ interests do not get lost in the greater struggle for health equity in the state of Minnesota.

Thank you for your time, and please do not hesitate to contact me.

Liz Ehlinger
liz.ehlinger@gmail.com; 952-221-5777
University of Minnesota Medical School Class of 2016
Secretary of the Minnesota Transgender Health Coalition

From: Victoria Albright [mailto:v_albright@yahoo.com]
Sent: Tuesday, January 21, 2014 10:51 AM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity in Minnesota

To Whom It May Concern,

I am writing to encourage you to include language on the importance of breastfeeding in the report to legislature, Advancing Health Equity in Minnesota.

Disparity in health across economic, racial and geographic divisions can be significantly impacted by one very simple act: breastfeeding. Breastfeeding a baby provides short-term and long-term health benefits for both baby and mother. It is free and lowers health care costs dramatically. Breastfeeding is paramount to early childhood health for all children and this needs to be stated in writing in the document to be proposed to legislature. Benefits for children include lower rates of SIDS, respiratory illness, necrotizing enterocolitis, ear infections, diarrhea, common colds and influenzas, urinary tract infections. Long-term benefits for breastfed children later in life include lower rates of diabetes, obesity, asthma, eczema, high blood pressure and many autoimmune disorders. Benefits to breastfeeding mothers include decreased rates of breast cancer, ovarian cancer, heart disease and osteoporosis.

Not only is breastfeeding hugely important to childhood health, it also lowers rates of obesity and cancer. These are two issues noted in the draft where the importance of breastfeeding can also be included.

Thank you for your consideration.

Vickie Albright, IBCLC
15835 Woodgate Rd S
Minnetonka, MN 55345

MINNESOTA COUNCIL of HEALTH PLANS

COURT INTERNATIONAL BUILDING
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January 22, 2014

Ed Ehlinger, M.D., Commissioner
Minnesota Department of Health
625 Robert Street North
PO Box 64975
St. Paul, MN 55164-0975

Re: Advancing Health Equity Report Feedback

Dear Commissioner Ehlinger:

The Minnesota Council of Health Plans (Council) whose members include Minnesota's seven licensed non-profit health plans (Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, Preferred One, Sanford Health Plan and UCare) applaud the Department's work to advance health equity.

That health is created through a complex interplay of individual, social, economic and environmental decisions and policies is often not understood by the community at large. One challenge that the Minnesota Department of Health (MDH) will have is to educate all sectors (e.g., transportation, education, labor, law enforcement etc.) on their role in advancing health equity. Another challenge will be for MDH to identify, prioritize, and implement those programs and policies that will have the greatest impact.

The Council supports the six principles guiding MDH's recommendations. We also support the twelve recommendations cited in the draft report. We suggest one additional bullet under recommendation 12: "Identify existing data sources and reports, for example the Minnesota Community Measurement health disparities and clinical care reports, that provide useful information on health disparities." We also suggest adding a new recommendation: "Identify and expand existing programs and policies that address health disparities and advance health equity." Minnesota, as a community, has been working to address health disparities since 1987. Many community stakeholders have established successful programs and policies that should be the building blocks for the work moving forward.

On December 16, 2013 the Council submitted comments to the draft report, "Advancing Health Equity". We provided examples of ways that health plans address health disparities as employers, as health care organizations dedicated to improving access and quality care, and as community members. Additionally, individual health plans provided examples of their successful programs and policies. We hope that MDH builds on our work and others as part of their overall design. I've attached the December 16, 2013 letter with individual health plans' program examples as an addendum to this letter.

In terms of successful programs, on page 51 of the report, several areas are highlighted as practices that advance health equity. Under health systems, the SIM grant with the Accountable Communities for Health is given an example to advance health equity. Because SIM is in preliminary stages of implementation, it cannot be known if this will be a key program to advance health equity. We believe the report should also cite examples of existing programs that have proven successful such as those listed in our December 16th letter.

Page 54 provides examples of ways that the community is involved in advancing health equity. Another example is that many organizations, including health plans, obtain community input in a number of ways, such as actively recruiting representatives on the board of directors and various stakeholder committees. Many organizations also obtain diverse perspectives through focus groups, surveys and member input forums.

Page 60 of the report cites comments made about health equity. Under health care/health insurance, there is a comment that interpreter reimbursement is insufficient to meet need. It would be helpful to have a better understanding of what insufficient means and how the need isn't being met. Health plans reimburse interpreter services for every language spoken in Minnesota. Additionally, numerous other strategies are used to assure that language is not a barrier to health. Another comment made is that health plans do not reimburse traditional healers and traditional healing practices. Health plans use evidence based guidelines and best practices as ways to determine which services to cover. Ultimately, employers and the government make the decision on what services will be included in an insurance product.

The Council's vision is to strengthen Minnesota's position as one of the nation's healthiest states. We know that addressing health disparities and advancing health equity is critical to achieving that vision. We also know that it will take a community approach to achieve a State where everyone has an equal opportunity to attain optimal health. Health plans strongly support MDH's work on advancing health equity and look forward to working with MDH and the community on this important endeavor.

Very Truly,

Julie Brunner
Executive Director

Attachment

CC: Jeanne Ayers, Assistant Commissioner; Manny Munson-Regala, Assistant Commissioner

MINNESOTA COUNCIL of HEALTH PLANS

COURT INTERNATIONAL BUILDING
2550 UNIVERSITY AVENUE WEST
SUITE 255 SOUTH
ST. PAUL, MINNESOTA 55114
651-645-0099 FAX 651-645-0098

December 16, 2013

Ed Ehlinger, M.D., Commissioner
Minnesota Department of Health
625 Robert Street N
PO Box 64975
St. Paul, MN 55164-0975

RE: Advancing Health Equity Report

Dear Commissioner Ehlinger:

I am submitting the following comments regarding the "Advancing Health Equity" legislative report on behalf of the Minnesota Council of Health Plans (Council). The Council's membership includes Minnesota's seven licensed nonprofit health plans: Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan, and UCare.

Council members, as well as other community members, have made significant contributions to advance health equity in Minnesota. Through individual as well as collaborative efforts, Council members have worked tirelessly over many decades to reduce health disparities and improve the health of all.

Health plan organizations address health disparities in multiple ways: as an employer, as a health care organization dedicated to improving access and quality care and as a community member.

- As an employer health plans include training and educational sessions for employees about diversity, actively recruiting people from various ethnic groups for positions within the health plans, and creating supportive work environments for diverse staff.
- As health care organizations dedicated to improving access to care, health plans promote interpreter services among diverse populations, provide information in multiple languages, prioritize cultural competence and health disparities work within the Council as well as individual health plan organizations, and solicit community input on grants, strategic plans and other activities. Examples of ways health plans improve the quality of care for diverse populations include educating providers on cultural competence, reviewing data on health disparities as part of their planning process and goal setting, identifying, implementing and expanding best practices through quality initiatives (Reports can be found at: http://mn.gov/dhs; click on partners and providers; click on health care; click on managed care organizations; click on managed care reporting; the reports are under self-reported MCO quality improvement).

- As a community partner health plans lead and participate on more than 150 public health collaborative efforts across the state. The groups focus on improving health. (The list can be found at: www.mncouncilofhealthplans.org under tools, important links, plans to improve public health.) ***We recommend that the Minnesota Department of Health (MDH) identify ways to communicate and widely disseminate existing innovative and effective work that advances health equity.***

Minnesota's health disparities are well documented. For decades, commissions and task forces have been assessing disparities and issuing recommendations:

- 2001, MDH published a report, "A Call to Action: Advancing Health for All Through Social and Economic Change." Some, but not all recommendations, have been implemented.
- 2005, "Close the Gap: A Business Response to Our Region's Growing Disparities" was published. This report made the business case for addressing health equity and provided specific practices that employers could apply to have a positive impact.
- 2010, MDH issued a report, "Social Connectedness: Evaluating the Healthy People 2020 Framework: The Minnesota Project," which provides strategies for strengthening social connectedness – a significant contributor to improving social determinants of health and health equity.
- 2012, MDH published a report, "Healthy Minnesota 2020: Statewide Health Improvement Framework" that details the need for all Minnesotans to have an equal opportunity for health and provides recommendations on how to achieve better health outcomes.

The reports cited above were developed through a community process that engaged stakeholders from a multitude of perspectives and experiences, analyzed existing data, assessed best practices, and then made recommendations. ***We recommend that MDH review key existing reports' recommendations and begin implementing strategies versus developing a new set of recommendations.***

Since 2001, MDH Eliminating Health Disparities Initiatives (EHDI) grants have been provided to organizations for the purpose of reducing health disparities focused on public health priority areas. ***We recommend that MDH distill, communicate and widely disseminate EHDI best practices in a way that makes it easy to understand what does and doesn't work for specific populations and include links to more detailed reports.***

Since 2007, Minnesota Community Measurement (MNCM) has published reports comparing the clinical care of people on Minnesota Health Care Programs to those on other forms of coverage (e.g., private commercial, employer-based, and Medicare). In 2009, MNCM began comparing clinical care for various racial and ethnic groups. In 2010, MNCM published, "Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups" which provides uniform data definitions and a consistent collection and reporting methodology. ***We recommend that this work is continued and expanded with support from MDH.***

This past summer, the MDH Minority and Multi-Cultural Health ad hoc data work group studied racial and ethnic data needs. This group provided six recommendations in its Sept. 19, 2013 report. These recommendations incorporated recommendations from past work groups that are still not implemented. Additionally, the ad hoc work group recommended that MDH and DHS assess and align their data sets as a starting point. ***We recommend that MDH begin implementing this group's recommendations. We also recommend that MDH assess ways to make their existing public health data more widely available before moving to the creation of new data sets.***

Recently, MDH, under the Healthy Partnership initiative, established work groups focused on "Changing the Narrative on Health" and "Health in All Policies." This work is very promising. "Changing the Narrative on Health" will uncover the underlying perspectives and prejudices that people bring to discussions and policy decisions related to health equity. "Health in All Policies" will assess ways that other sectors (e.g. transportation, education, law enforcement) could reduce health inequity and health disparities through their policies and practices.

Health plans strongly support efforts that address health disparities and health equity and will continue to work with community partners to identify ways to assure that all Minnesotans have an equal opportunity to achieve optimal health. Attached please find additional examples of individual health plans' work in this area. We hope this information will be helpful and that it may prompt additional collaborative work. Thank you for this opportunity to provide comments.

Very Truly,

Julie Brunner

Julie Brunner
Executive Director

Attachment(s)

MDH Health Disparities Blue Cross and Blue Shield Response

While Minnesota is often recognized as one of the healthiest states in the nation, its low-income and minority populations suffer disproportionately from poorer health. In an effort to change this, Blue Cross and Blue Shield of Minnesota (Blue Cross) has numerous initiatives to impact health disparities.

The Center for Prevention at Blue Cross is committing up to $1.8 million dollars to support initiatives that reduce tobacco use, increase access to healthy food and make active living easier for communities that face the greatest disparities. Thirteen organizations across the state have been awarded Health Equity in Prevention funding and technical assistance.

The Blue Cross Foundation has three main initiatives focusing on reducing health disparities;
Access to Coverage: More than $1 million given to support outreach, screening, and application assistance for people eligible for state public health insurance programs in five regions. Those most likely to be eligible but uninsured include Latinos, African Americans, American Indians, and those born outside of the US.
Public Libraries for Health: Grants have been awarded to seven libraries to advance health equity by addressing one or more social and economic factors with their communities.
Health Impact Assessments: Nearly $1 million given over three years to support seven Health Impact Assessments and capacity building across the state.

Blue Cross and Blue Shield of Minnesota (Corporate)
Aligned Incentive Contracting: Aligned Incentives reward the value of care and cost containment, not the volume of care, to improve member's health and affordability. Providers receive a base rate, with additional revenue growth dependent upon incentive payments linked to lowering costs and improving quality in a number of areas, divided into four main categories: prevention and wellness, care integration, safety and appropriate care, treatment of conditions.

The current quality module of this program supports reducing disparities by including three measures focused on improving care within the non-Caucasian population. We measure and incent participating providers for improving colorectal cancer screening rates; BMI action planning rates and smoking cessation counseling efforts. Through this program we have seen a continued disparity, especially related to colorectal cancer screening rates when comparing full populations with the non-Caucasian subset. Because of this, in the next iteration of the program, beginning in 2014, we will be incenting providers on improvement of rates within the non-Caucasian group only for this measure.

Multilingual Health Resource Exchange (Exchange): Blue Cross is a founding member of the Multilingual Health Resource Exchange, a Minnesota collaborative supporting one of the largest warehouses for translated health education materials in the nation.

In addition, the Exchange promotes helpful tips for our clinical staff when communicating with the diverse populations we serve; provides an easy way to find translated materials without needing to search multiple libraries; and supports our health literacy and patient experience efforts.

Health Literacy: Blue Cross is also a founding member and active chair of the Minnesota Health Literacy Partnership. Founded in 2006 to encourage and support health literacy efforts across the state, the Minnesota Health Literacy Partnership (MHLP) is an independently funded program of the Minnesota

Literacy Council. The mission of the MHLP is to improve the health of all Minnesotans through clear health communication.
Our goals are threefold: Train health care providers about health literacy, empower patients to ask for clear communication, and share health literacy resources.

In addition to the community effort listed above, we have a dedication to health literacy through several internal activities at Blue Cross:

* The Health Literacy Ambassador program is comprised of internal advocates supporting health literacy best practices within their own departments and business units.
* Ongoing review of member facing communication for use of plain language and being simple and clear to understand .
* Annual focused messaging during October, health literacy month, to all employees encouraging them to be 1) more engaged consumers of health care and 2) better educators and communicators about health insurance and our business.
* A commitment to improving member experience through implementation of health literacy best practices at all levels of the business from front line service staff to clinical staff working long term with members through case management.

HealthPartners®

HealthPartners: The Triple Aim and Interpreter Services – incorporating interpreter services into achievement of the triple aim, simultaneously improving health, experience, and affordability.

Background: In 2004, HealthPartners invested in a formal approach to language access services, establishing a cross-organizational team, the HealthPartners Interpreter Services Work Group, and implementing formal structures, practices, and tools. One such tool is our organization-wide *Language Assistance Plan*, which sets organizational best practices and expectations, accompanied by a more practical *Your Guide to Interpreter Services* that provides answers to questions such as how to access an interpreter and how to talk with patients who wish to rely on family members to interpret. In the last ten years, HealthPartners has also established a robust care delivery and health plan set of best practices that support the triple aim.

Health Dimension

- **Innovative delivery models:** Ongoing review and piloting of innovative models to provide interpreter services, included dedicated staff in high volume locations and the use of video remote interpretation.
- **Care Model Process:** Embedding interpreter services into standardized appointment call center and clinic workflows throughout our system.
- **Focus on interpreter qualifications:** Setting minimum training and continuing education requirements for all staff and contracted interpreters and supporting national certification.
- **Engagement of interpreters:** Engaging interpreters in health prevention, quality improvement, and education projects (such as outreach calling for appointment reminders, scheduling assistance for preventive care screenings, community meetings on health topics, etc.)

Experience Dimension

- **Procedures for Interpreter Use:** Call-center procedures for the health plan and care delivery to set up an interpreter while scheduling clinical appointments and to engage a professional telephonic interpreter for all call center interactions with members and patients in need of language assistance services.
- **Provider Satisfaction:** Annual surveys of multiple care delivery sites for satisfaction with the quality and service of all interpreter types (agency; staff; telephonic; video). The results of these services are reviewed and acted upon by the Interpreter Services Work Group and also shared with contracted service providers.
- **Agency Partnerships:** Annual plenary meeting held with all contracted interpreter agencies to review satisfaction surveys and performance and engage agencies in the triple aim framework.
- **Innovative Research**: Collaboration with Critical Care Research to conduct a study on patient satisfaction with various interpreter delivery methods in the emergency room.

Affordability Dimension

- **Financial Reporting:** Annual reporting and monitoring of health plan and care delivery expenses and revenues for interpreter services. We now have multiple years of trend data and are able to identify changes in trends and adjust practices and interventions to address these trends.
- **Care Delivery Model:** Regular review of utilization data of agency interpreters to identify when a language's volume has reached a threshold to make a staff interpreter in the high volume language available to a clinic site.

Impact

- 100% of employed interpreters have a minimum of 40 hrs of professional training and 40% hold some form of national certification.
- Care delivery now has clear expectations and standardized mechanisms for accessing and utilizing interpreter services to support health and experience outcomes.
- HealthPartners providers have extremely high rates of satisfaction with employed interpreters and satisfaction with contracted interpreters has steadily improved over the past four years.
- HealthPartners has reduced the annual expense trend from double digit increases to single digit increases over the past five years.

HealthPartners®

HEALTH EQUITY REPORT
Health Disparities and Equity Work

Interpreter Services

- Invested $7.3 Million in FY2012 in on-site services
- Language access integral component
- Provide interpreter services in all key languages spoken by patients and members, and more than 150 other languages through telephone and video remote interpreter services
- Member Services department delivers services in multiple languages to assist members with questions and finding culturally appropriate providers.
- See page two for more information.

Closing the Gap on Health Equity

- Monitor health care equity and patient satisfaction
- Data collection on race, ethnicity, language
- Measure program effectiveness and language assistance appropriateness
- Identify health disparities and target quality improvement efforts
- See attachment for results in closing the gap.

Culturally Appropriate Providers

- Access to providers who can meet culturally specific needs of patients and members
- Long history of serving members from diverse cultural and ethnic backgrounds
- Cultural Humility work group leading effort in 2014 to build foundation across the organization to deliver Equitable Care.

Building Consistent Work Flows

- Allow caregivers to identify and offer needed services to all patients and customize those services based on cultural, linguistic, socioeconomic or other differences to help reduce health disparities.

Ongoing Initiatives

- *HealthPartners Equitable Care Sponsor Group* provides strategic leadership and oversight of initiatives related to language assistance and reducing health disparities. The group is made up of physicians, directors and leaders of our medical clinics, dental clinics, educators, hospitals and health plan.
- *HealthPartners Equitable Care Fellows* program engages staff members and providers to receive expert training so they can become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.
- *Diversity Ambassadors* are a group of volunteer leaders who meet once a month with a focus on creating diversity and inclusion in our work environment. They also serve as resources for organizational culture and cultural humility topics.
- *HealthPartners Interpreter Services Work Group* provides enterprise-wide leadership regarding the provision of spoken and American Sign Language services for limited English proficient, deaf and hard-of-hearing patients and members.
- *Extensive internal communications and resources* to build staff understanding and capabilities in cultural humility.

Ongoing Initiatives Continued

- *Language Assistance Plan and Your Guide to Interpreter Services*, which are the best practices and how-to guides for the organization.
- *Member of National Health Plan Collaborative to Reduce Disparities through America's Health Insurance Plans (AHIP),* which enables us to learn from other health plans about additional collaborative opportunities.
- *EBAN Experience™* an innovative approach to link quality improvement with the health of populations. This year-long initiative utilizes a collaborative format that incorporates teams of health professionals and community members, working side-by-side to understand cultural barriers to optimal care and improve care design.
- *EBAN 3D Collaborative™ (defeating diabetes disparities)* utilizes the same format as above and focuses on decreasing diabetes disparities in African and African American populations at five clinic sites across our system of care with the aim of building community relationships, changing behaviors, sharing solutions, outcomes and best practice for diabetes care across the system. Patients, caregivers, wellness service providers, restaurant owners, community leaders and health advocates are integral parts of the quality improvement teams.
- *Promise Neighborhood Work* partners with the St. Paul Public Schools, Ramsey County, City of St. Paul, St. Paul Foundation and Wilder Foundation to provide "cradle to career" continuum of supports for children in the St. Paul Promise Neighborhood to overcome socioeconomic barriers and ensure their success. Success have been achieved in prioritizing health needs to focus on 2 elementary schools and families; initiating school health program with a new clinical model, connecting to family resource centers; and integrating work with PMAP population health initiative.

Community-Based Collaborative Efforts

- Participate in *The Exchange*, a collaborative of Minnesota health-related organizations to share translated health material and disseminate information on literacy, class, culture, race and spirituality as they affect health disparities.
- Member of *Minnesota Health Literacy Partnership*, a collaborative of hospitals, clinic systems, health plans and community and public organizations that share information and engage in joint planning on health literacy issues.
- Participate with *Minnesota Community Measurement*, a collaborative to improve health by publically reporting health care information.
- Sponsor of *Honoring Choices Minnesota*, an initiative of Twin Cities Medical Society through its East Metro Foundation to encourage families and communities to have discussions regarding end-of-life in many languages.
- Collaborate with the *African American Leadership Forum* to bring together women from the African American community to talk about health issues in an event called Baraza.

MDH Health Disparities Response – Medica

Medica is Minnesota's highest rated Medicaid health plan, ranked at number eleven nationally by the National Committee for Quality Assurance (NCQA). At Medica, we believe our members are not just part of a health plan, but are part of a community that believes in better health for all. This philosophy is expressed in a number of ways.

Member Service: Medica is committed to providing our members with culturally appropriate customer service through our call center. We were the first Minnesota health plan to have dedicated telephone lines for our most commonly requested languages; we have dedicated phone numbers that are answered by individuals who speak Hmong, Russian, Somali, Spanish, and Vietnamese. We also hold language and culture-specific member input forums every year in an effort to get feedback from our members and the community.

Many of our informational and procedural documents have also been translated into various languages. Plus, we have been a collaborative partner in creating videos with ECHO Minnesota in English, Spanish, Somali and Hmong that explain to families how to access the health care system and the importance of preventive care. We even have two Medica employees on ECHO's Board of Directors.

Community Commitment: Medica has a long history of active engagement with the community. Medica staff participate in many community-based collaborative initiatives, including Healthy MN 2020, Health Literacy Partnership, Community Health Worker Alliance, Minnesota Chlamydia Partnership, Minnesota Cancer Alliance, county community health teams, various SHIP projects, and the Center for Community Health. There are also many employees that serve on boards of directors for non-profit and social service organizations in the areas of health and health equity. Some examples, in addition to ECHO Minnesota mentioned above, are NAMI Minnesota, the American Lung Association in Minnesota, Bolder Options, Hearth Connection, Neighborhood Involvement Program, Better Futures Minnesota, and the March of Dimes.

The Medica Foundation funds community-based programs and initiatives that provide sustainable, measurable improvements in the availability, access and quality of health care. In addition, the Medica Foundation supports efforts that reduce health care disparities and address the social issues driving health care costs. The 2012 funding priorities were primary care and prevention for people with disabilities, appropriate utilization of the health care system, behavioral health and early childhood health. Eighty-eight grants totaling $1.35 million were provided to organizations throughout Medica's service area in 2012. For 2013, the funding priorities include behavioral health, healthy lifestyles for people with disabilities, early childhood health and organizational core mission support.

The Medica Research Institute, launched in 2010, conducts research that can be translated into activities that protect health and improve lives. Current research is focused on three main themes: improving the efficiency and effectiveness of the provider system;

improving the way consumers get involved in their own health; and the importance of creating environments that make it easier for people to make healthy choices.

Reducing Health Disparities: Medica is committed to reducing health disparities and inequities in Minnesota. We have had representatives serve on the state's Healthcare Disparities Task Force, the Race, Ethnicity and Language Data Workgroup, and the Health Equity Working Committee. Medica also has employees that serve on the state's SIM grant Community Advisory and Multi-Payer Alignment Task Forces and the MNsure Health Industry Advisory Committee, each of which is dedicated to reducing the impact of health disparities.

For over 10 years, Medica's State Public Programs department has administered a member incentive program to improve preventive care for our Medicaid enrollees. My Health Rewards by Medica℠ encourages members to use preventive health services and lead healthy lifestyles. My Health Rewards encourages Medica members to follow through with pregnancy care, cancer screenings, smoking cessation, and Child and Teen Checkups screenings. The program also offers car seats to eligible pregnant women and children two years and under. Through materials produced in multiple languages, members can choose between Target GiftCards℠ and WALMART® gift cards for following through with preventive visits. In 2012, members received more than 61,000 incentives related to preventive visits.

Metropolitan Health Plan (MHP) is committed to improving the health of our members and reducing health disparities for the residents of Hennepin County.

Our enrollees have been identified as containing a large percentage of at risk individuals for disparities due to their social, economic, language and race. To address these disparities, MHP has worked diligently to identify and reduce health disparities, including partnering with County and Community stakeholders, to create better health outcomes. (See the Quality Program Transparency and Accountability 2013 Report for MHP and Hennepin Health at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_159905).

Member engagement: MHP is uniquely located in the downtown Minneapolis area and, as such, is able to work directly with our members in our Walk-In Service Center. MHP's Walk-In Center and Call Center are staffed with diverse employees from varying cultural backgrounds with several language capabilities. We also have an on-call Case Manager / Care Guide available to address member issues as they arise, working not only on health related concerns but also networking with our County and Community partners to address social and economic issues that may affect a member's health. This face-to-face contact with our members is invaluable to immediately address member needs.

MHP's Outreach staff regularly visit location, such as Community Centers, shelters and clinics, where our homeless members may be available for engagement. Quarterly member events are held to not only allow members to access health education, but also to receive direct member feedback on how MHP might better assist members in achieving better health outcomes.

Community Reinvestment: In 2013, MHP provided reinvestment funding to eleven community service agencies that served Medicaid SNBC members for development of new and existing programs. Applicants responded to an RFP and eleven recipients were awarded funding for their programs that have proven to be creative and supportive to the disabled population. Recipients were: YouthLink, Reach for Resources, Touchstone Mental Health, Vail Place, BeechWood, Community Involvement Programs, Community University Health Care Clinic, Pillsbury United Communities, Rise, Spectrum and The Link.

MDH Health Disparities PreferredOne Response

PreferredOne conducts an ongoing review of all member facing communications for inclusion of plain language and ensures that they are simple and clear to understand. PreferredOne is committed to our members through the implementation of health literacy best practices at all levels of our business operations. Additionally, PreferredOne translates member materials as necessary for groups and provides telephonic interpreter services for our customer service/case management/disease management programming.

PreferredOne is a supporting member of ECHO Minnesota. As a partner we promote ECHO resources and materials to our members via our website and through our employer groups. In an emergency, as an ECHO partner, we would work to spread culturally appropriate, multi-language emergency messages directly to the communities who need them most.

MDH Health Disparities—UCare

UCare is committed to improving health disparities for our members, our employees and the community.

UCare initiatives directed at engaging employees:

- UCare ensures compliance of initiatives related to cultural competency and diversity for members and providers through a specially designed council. This Council has representatives from the organization whose purpose is to meet the needs of the UCare membership and UCare's quality goals as well as support internal diversity training activities.
- As an Equal Opportunity/Affirmative Action Employer, we welcome and employ a diverse employee group committed to meeting the needs of UCare, our members, and the communities we serve.
- UCare's employee training program provides employees with activities and education that helps achieve cultural competency within the communities our health plan serves, and create an inclusive, welcoming corporate environment.

UCare improves access to care to diverse populations:

- **Diversity and Cultural Competency Council:** UCare's Diversity and Cultural Competency Council supports internal diversity training activities and develops, implements and evaluates health care initiatives aimed at reducing the disparities in health status among targeted UCare populations.
- **Provider and Member Focus Groups:** In 2013, UCare conducted member focus groups in the Somali, Hmong and Latino communities with discussions focused on building relationships with members, understanding cultural practices and beliefs about health care and sharing feedback so that UCare can provide quality service to their communities.
- **Translated brochures and pamphlets:** UCare has created over 30 brochures and pamphlets in multiple languages (Somali, Hmong and Spanish) on topics of parenting, pregnancy wellness and Child and Teen Health (incentive vouchers and immunization cards). Our MOMs brochure provides pre and post natal resources, tips and important health information in Spanish.
- **Health Literacy Councils:** UCare participates in various state and national health literacy councils that provide a voice about important health messages to our members. UCare is a founding member of the Multilingual Health Resource Exchange, a Minnesota collaborative supporting one of the largest warehouses for translated health education materials in the nation. MN Health Literacy Partnership and AHIP's Health Literacy Task Force. UCare also facilitates an annual roundtable discussion at the annual AHIP Communications Conference.
- **Interpreter network:** In 2012, UCare requested proposals seeking qualified language interpreters that strengthen network and provide training, consistency and quality.
- **UCare Fund:** Since 1998, the UCare Fund, has provided grants to non profits for initiatives that improve the health of underserved populations, and provide education and community outreach in Minnesota. Grant focus includes:

  Healthy Lifestyles: Organizations that provide resources to improve preventive health care and disease management in diverse populations.

  Disabilities: Organizations that reduce health disparities for people living with physical or developmental disabilities.

  Medical Home Initiatives: Community resources and local clinics and hospitals to improve the health of members.

Access to Health Coverage: Initiatives that focus on providing comprehensive outreach support services, including referrals and education, to eligible Minnesotans about health care choices and helping individuals gain access to appropriate coverage options.

Examples:

- *Health Commons:* Funding supported a center located in Cedar Riverside area that was created to provide nutritional counseling, diabetes education, health screenings, medication checks, parenting classes and fitness programs for the East African community.
- *SoLaHmo Radio Stories:* Grant provided community–based participatory guidance in several languages through the use of radio programming on family healthy eating behaviors.
- *Wellshare:* Funding provided support for Community Health Workers to educate Somali members on emergency room use.
- *Lao Assistance Center:* Funding support to provide education to families and local restaurants on the impact of healthy eating.

UCare also seeks to improve the quality of care for diverse populations through provider education on cultural competence.

- **Culture Care Connection (CCC):** UCare partnered with Stratis Health to create an online learning and resource center aimed at supporting health care providers, staff, and administrators in their ongoing efforts to provide culturally-competent care in Minnesota. The site provides information on cultural competence concepts, health topics, ethnicities, stakeholder organizations, and resources that are most reflective of the needs of Minnesota's diverse populations. CCC provides actionable tools to assist organizations in achieving their cultural competence goals.
- **CLAS Standards:** UCare meets and exceeds the standards.
- **Provider Contracts and Training:** UCare works to obtain and contract with providers who can serve the needs of our diverse population. Culture competency training is offered to all providers and clinics.
- **Pay for Performance Recognition:** UCare recognizes clinics that perform outstanding culturally competent health services.

UCare has wide and varied community partnerships.

- **Community Partnerships:** These relationships focus on collaborative efforts that educate and improve community health. UCare provides outreach at over 300 events each year.
  - Centro Campesino
  - Somali American Independence Soccer Tournament
  - Hmong Elder Camp – Volunteers of America
  - Wilder Foundation – Youth Health Fair
  - Broadway Family Medicine Clinic – Health Fair
  - Afrifest Celebration
  - Somali Information Fair
  - Flu Shot Clinics

Minnesota Health Care Safety Net Coalition

Greater Twin Cities United Way
Hennepin County Medical Center
Minnesota Association of Community Health Centers
Minnesota Association of Community Mental Health Centers
Regions Hospital

January 23, 2014

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
Minnesota Department of Health
P.O. Box 64975
Saint Paul, MN 55164

Dear Commissioner Ehlinger:

On behalf of the Minnesota Health Care Safety Net Coalition, thank you for your ongoing work to advance health equity in Minnesota. Overall, we strongly support the recommendations that have been included the draft *Advancing Health Equity in Minnesota: Report to the Legislature.* We appreciate this opportunity to provide comment on the draft report and urge the Department to continue to develop concrete steps to follow-through on these excellent recommendations.

The Safety Net Coalition (SNC) represents Minnesota's community-based safety net health centers, mental health centers, dental clinics, safety net hospitals, outreach and other nonprofit organizations that serve low-income, uninsured and disadvantaged Minnesotans. The patients served by the Coalition's members face the most serious barriers and challenges to accessing the services they need to be healthy, to manage a chronic disease or to receive treatment of an illness or injury.

The SNC strongly supports all of the recommendations included in the report, and is especially supportive of MDH Recommendation 12: Develop a long term plan for improving the collection, analysis, reporting, dissemination and use of health equity data. In addition, we support the corresponding steps outlined, including implementing a Race/Ethnicity/Language (REL) data collection standard with an emphasis on adding granular data, developing a standard set of social determinants of health, and developing a list of key health equity indicators.

We also encourage MDH to include recommendations within this section to address adjusting health care quality measures and financial reporting in order take into account social determinants of health. Extensive research literature, including findings from this report, clearly document that socio-economic factors profoundly impact a patient's health outcomes. Risk adjustment is vitally important to ensure that safety net providers who serve high proportions of patients with complex health and socio-economic needs are not penalized because they serve patients and communities

with the greatest health disparities. The current Statewide Quality Reporting and Measurement System (SQRMS) methodology and quality standards are inadequate to account for the social and health complexities of patients that we know affect access, health status and treatment outcomes. To address this shortcoming **we suggest strengthening recommendation #12 by adding:**

h) Using improved data collection standards adjust or enhance existing quality and performance measures to take into consideration REL/social determinants of health.

The SNC is ready to work with MDH, the State, and other partners in efforts to take action on the recommendations included in this report. Thank you again for this report and your commitment to continue to work on this issue.

Sincerely,

Emily B. Zylla

Emily B. Zylla
Staff, Safety Net Coalition

From: John Salisbury [mailto:john.salisbury@rainbowhealth.org]
Sent: Friday, January 24, 2014 9:40 AM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

Attached is the feedback on MDH's draft of its Advancing Health Equity Report from The LGBTQ Health Advocacy Roundtable, coalition of stakeholders who work to advance health equity for LGBTQ people in Minnesota.

I am both attaching these comments in a word document and also including them in the text of this email.

01-24-2014

Comments on the Minnesota Department of Health, Advancing Health Equity Report Draft

The LGBTQ Health Advocacy Roundtable
Senator Scott Dibble
Health Equity Working Committee
Minnesota AIDS Project
Minnesota Transgender Health Coalition
Outfront Minnesota
Rainbow Health Initiative
SEIU Healthcare Minnesota
Bethany Snyder, Office of Senator Al Franken

The Advancing Health Equity Report produced by the Minnesota Department of Health represents an important step in engaging in a more systematic discussion of health equity in Minnesota. The LGBTQ Health Advocacy Round Table applauds the report's discussion of these issues as they pertain to the health equity concerns of the LGBTQ community. There are some instances where language in the report should be adjusted to be address the entire LGBTQ community and those edits have been submitted in a separate document. This set of comments focuses more broadly on topics or sections that this coalition would like added or revised to better reflect the health issues of LGBTQ people in Minnesota.

On page 5, the report talks about the history of Minnesota's efforts to better understand issues related to health disparities by discussing a series of reports created by the Minnesota Department of Health and other state agencies. Missing from this section is a MDH report, "Health and Well-being: A Professional's Guide to Gay, Lesbian, Bisexual,

and Transgendered [sic] Youth Health." from 2002 which was one of the first times the state of Minnesota looked systematically at the health issues affecting the LGBTQ community.

The report would also benefit from more discussion of the disparities that LGBTQ individuals encounter in the following areas, particularly among LGBTQ communities of color: higher rates of HIV/AIDS in the LGBTQ community, the long-term health effects of HIV infection and treatment; lack of access to comprehensive sexual education around LGBTQ issues in schools; and the systematic legal and medical barriers for transgender people. Particularly, in the section starting on page 39 which discusses health disparity data, this group feels that it is important to include data on the higher rates of HIV and STI's among LGBTQ people, either from MDH's own HIV/AIDS Surveillance reports or the CDC's reports on HIV by priority populations http://www.cdc.gov/hiv/library/factsheets/index.html).

In several sections, the report discusses the need to create a standard set of social determinants of health (SDOH). However, gender identity is consistently not included in those discussions, even though research consistently shows that gender identity has a profound effect on health status. For example, on page 16 the list of social determinants of health includes race, ethnicity, language, birthplace, gender, sexual orientation, acculturation, educational attainment, socioeconomic position, occupation and employment status, but not gender identity. In addition to ensure that gender identity is included in discussions of social determinants of health, this group proposes that the standard set of SDOH (including questions pertaining to sexual orientation and gender identity) be incorporated in all data collection efforts by MDH.

In several places the report calls for a need for greater engagement with communities of color and people of diverse ethnic and racial backgrounds; however, greater engagement with the LGBTQ community is not included in those sections. This coalition would like to see this report include a commitment to increase engagement with the LGBTQ community.

The coalition proposes a re-write of paragraph on page 37 to reflect a broader understanding of LGBTQ health issues and their connection with negative experiences in school settings with revised language below:

> "This lack of research is a concern because what evidence there is points to, among other things, a greater frequency of negative school experiences (e.g., bullying) for LGBTQ adolescents, a point MDH made as early as 2002 in its report, "Health and Well-being: A Professional's Guide to Gay, Lesbian, Bisexual, and Transgendered [sic] Youth Health." These negative school experiences can diminish educational success, affect lifetime health outcomes, and elevate risks of depression and suicide for LGBTQ individuals. During adolescence or throughout life, LGBTQ individuals may experience higher rates of substance abuse or mental-health concerns (see pp.49-50), and may reduce or delay the seeking of health care due to fear of discrimination. LGBTQ persons of all ages, including the elderly, can experience poorer outcomes from encounters with the health-care system, due to a lack of providers who are knowledgeable about LGBTQ health needs. HIV remains a significant health concern within the LGBTQ community, particularly among LGBTQ persons of color, and transgender individuals who are undergoing a gender transition face challenges accessing appropriate health care and identity documents. In addition, being an LGBTQ person of color, or having a disability, or living in poverty, means facing multiple forms of structural inequities."

Finally, this group would like to request the creation of a state-wide task force or body within the Minnesota Department of Health dedicated to addressing issues around LGBTQ health equity.

John Salisbury, MPH
Program Manager
Rainbow Health Initiative
612-206-3180
john.salisbury@rainbowhealth.org,
www.rainbowhealth.org

01-22-2014

Comments on the Minnesota Department of Health, Advancing Health Equity Report Draft

The LGBTQ Health Advocacy Roundtable

Senator Scott Dibble

Health Equity Working Committee

Minnesota AIDS Project

Minnesota Transgender Health Coalition

Outfront Minnesota

Rainbow Health Initiative

SEIU Healthcare Minnesota

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Minnesota Association of
COMMUNITY HEALTH CENTERS

1113 E. Franklin Avenue, Suite 202 | Minneapolis, MN 55404 | 612.253.4715 | Fax 612.872.7849

www.mnachc.org

January 24, 2014

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
Minnesota Department of Health
P.O. Box 64975
Saint Paul, MN 55164

Dear Commissioner Ehlinger

The Minnesota Association of Community Health Centers (MNACHC) would like to thank you and your staff for the ***Advancing Health Equity*** report. After reading the report, it evident that you and your staff invested a tremendous amount of effort into one of the most pressing issues facing Minnesotans today – namely promoting health equity for an increasingly diverse state.

MNACHC is the state membership organization for 17 federally qualified health centers (FQHCs) throughout Minnesota. These FQHCs (hereinafter interchangeably referred to as "community health centers") serve 185,000 low-income Minnesotans.

As community-based organizations (50 percent patient-community board membership), Health Centers are in the unique position to view health through the lens of the uninsured, low income and medically underserved. Nearly 90 percent of Community Health Centers' patients have incomes below 200 percent of the federal poverty level. In addition, 40 percent of Health Center patients are uninsured.

Roughly two-thirds of Community Health Centers patients are from Minnesota's ethnic and priority communities. Moreover, Community Health Centers are located in medically underserved areas of Minnesota, where the communities are the poorest in Minnesota and experience the greatest number of health disparities.

This response conveys three themes.

- Recognition of the boldness of the report;
- Outline next steps to act upon the report;
- Convey the importance of this activity for the future of Minnesota.

Bold Report: For the first time in my memory, the report publicly acknowledges and demonstrates the need for traditionally difficult conversations in Minnesota regarding race, racism, institutional racism and health inequities. By having these conversations, we can begin the next steps to effective change that eliminates health care disparities.

Specifically, I would like to commend the report for recognizing our communities' long-standing pleas for incorporating the social determinants of health into data collection and (health) policy. Without this

key inclusion, providers serving low-income, disadvantaged or diverse populations would be placed at a disadvantage from both a measurement and potential payment perspective.

Urge for action – This draft report lays out very compelling arguments supporting long-standing MNACHC positions. Some of these arguments include -

- Invest more in low-income and diverse communities;
- Improve data collection to add granular data on Race/ Ethnicity/ Language;
- Collect standardized data on social determinants of health – including poverty, gender identity/ sexual orientation, geography, mental health;
    - All of this detailed data paints a more accurate picture of specific communities/ sub groups most impacted by health disparities influenced by social determinants of health
- Address the full continuum of contributing factors and solutions to health

We strongly urge you to take action on the recommendations in this report, and we will support your efforts needed.

- Intentionally expand relationships in community and assure meaningful participation of Minnesota's diverse communities in project governance and oversight. (Recommendation 4)
- Assure people who are affected by the various decisions are involved in the process. (Recommendation 5)
- Changes to grant procedures and practices to support a range of organizational capacity to promote health equity. (Recommendation 6)
- Engage a diverse range of stakeholders in the grant development process. (Recommendation 7)
- Strengthen data activities across all divisions and programs. (Recommendation 11)
- Developing a plan for improving the collection, analysis reporting/ dissemination and use of health data. (Recommendation 12)

We encourage the Department to continue to connect with MNACHC as partners in carrying out this work.

Impact on the future – In the spirit of health reform, MNACHC believes this health equity work can and will play an enormous part in transforming the care delivery and payment system within the larger context of community-health. As we move into a market with greater reliance on accountable care organizations (ACOs), value-based purchasing and pay-for-performance, the report reinforces the need for Statewide Quality and Reporting System risk adjustment that considers all the life complexities of people and communities most impacted by health disparities when measuring providers who serve them.

We strongly encourage the Department to approach risk adjustment and all its future work through this health equity lens. In support, we encourage MDH to continue to reach out to the Safety Net and MNACHC as partners.

On behalf of the 17 Community Health Centers and the 185,000 Minnesotans that rely on them for their care, I would like to personally thank you for taking bold action to develop the **Advancing Health Equity** report. If you have any questions or would like to learn how Health Centers fit into the vision outlined

by this report, do not hesitate to contact me at 612.253.4715, ext. 11 or at jonathan.watson@mnachc.org.

Respectfully submitted,

Jonathan Watson

Public Policy Director
Minnesota Association of Community Health Centers

Fartun Weli, MPH, MAPP
Executive Director
The Isuroon Project
Response To Inquiry Process

1. How can MDH improve it's tarnished relationship to communities of color and/or organizations serving communities of color?

Identity

It is critical that public health agencies to better understand the nuances that are present in communities of color. With Minnesota's increasingly diverse population, many of whom are recent immigrants, the conventional approach to public health must take into account differences in acculturation, language, ethnicity, religion and cultural customs. This approach to public health, not only facilitates trust and understanding between communities of color and Public Health agencies, it has a far greater propensity to produce public health interventions that work.

Proactivity

a. State public health agencies in their grant making processes need to drastically improve their understanding of the unique organizational issues that face community organizations that serve communities of color. It's important to understand the underlying capacity and operational deficiencies that are often faced by community led organizations and to implement policies that are simultaneously developing capacity building whilst addressing health disparities. e. g Working with community based organizations to document technological deficiencies, HR infrastructures, financial reporting e.t.c. Documenting these needs would be helpful in designing funding mechanisms that are not burdensome for organizations with very little administrational support.
Health Priority Setting

Community Based Participatory Issue Mapping

b. A stronger implementation of CBPR (Community Based Participatory Research) would drastically reduce the perceived mismatch between Public Health Agency's priorities and the health needs of a community that has traditionally faced health disparities. MDH's current priority setting process needs to be a lot less hierarchical and a lot more horizontal in order to incorporate the thoughts and ideas of traditionally under-represented communities. Subsequently, the RFP should directly identify the needs set forth by the CBPR process. [1]

[1] Community-Based Participatory Research for Health: From Process to Outcomes - edited by Meredith Minkler, Nina Wallerstein

Structural Racism

c.MDH would be well served to do a comprehensive analysis of structural racism within it's own organization and within organizations with whom it most partners with. This ensures that organizations serving the needs of communities of color are not themselves perpetuating structural racism. State public agencies would be well served to have policies in place that ensure grantees have appropriate courses in cultural competency and white privilege.

> i.) A clear example of this is embodied in current invoicing process. Many of COCLO's (Communities of Color Led Organizations) face capacity building and cash-flow issues. Having an invoicing process that requires organizations to get paid for work after work has been completed inadvertently set them up for a higher rate of failure. This gives an advantage to large and established organizations, few of whom are COCLO's. Many of these COCLO's are not only best positioned to solve contemporary health issues that face Communities of color; their organizational success is dependent on having policies that set them up for success. They are apart of the first line of preventative defence, it is critical MDH's invoicing and bureaucratic processes are informed of the unique challenges that face them so as not to impose rules and regulations that exacerbate them. The misuse of fund by Siera Young Family Institute should not be punished for all of the other amazing organizations that led by immigrants and other communities of color. It is critical that MDH see minority- led organization e.i immigrants as an ASSET and not a pool of RISK.

2. *Recommendations for the Health Equity Center*

Integration:

a. It is imperative that major divisions of the MDH have a direct connection to the proposed HEC (Health Equity Center), so that there is a comprehensive understanding of current health issues that are faced by communities affected by health disparities. This should go hand in hand with the standardization of data and the availability of easy to access and retrieve risk adjusted data. Health data experts at public health agencies should ensure the availability of this data alongside socio-economic and socio demographic information from sources like ACS (American Community Survey) and the Census. Data experts should strive to work with federal agencies to ensure that Minnesota's population of new americans are appropriately represented in population surveys by ensuring proper compliance. Demographers can overcome barriers like illiteracy and language barriers by setting up a representative committee that brainstorms creative and inclusive solutions. Having risk adjusted data, and accurate state demographics are among the first line of defence against health inequities as it ensures state budgets (and subsequently MDH) take into account recent changes in the state's demographic; to ensure equity in the way the state budgets for the needs of Minnesota's various communities.

In addition to aforementioned suggestions, we recommend that MDH do a better job of

1. Integrating Minnesota Refugee Health Center into the HEC, to ensure better data collection and a better understanding of real time trends.
2. Connecting with international health agencies to understand public the health threats that face refugees in their home countries. E.G Tuberculosis drug resistance in Somalia.[2]
3. Ensuring more culturally appropriate and easily accessible resources for preventative health and to do a far better job of surveilling emerging health epidemics among communities that traditionally face health disparities.

Relationship Building:

It's time that communities of color have direct relationship with directors, manager and leaders of major MDH divisions. Building trust and sustainable relationships require frequent interactions between communities and MDH leadership. We as an organization (and we suspect many others) would enjoy the opportunity to connect, interact and co-mentor with MDH leadership and program managers.

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[2] *Suggested citation for this article:* Sindani I, Fitzpatrick C, Falzon D, Suleiman B, Arube P, Adam I, et al. Multidrug-resistant Tuberculosis, Somalia, 2010–2011. Emerg Infect Dis [Internet]. 2013 Mar [*date cited*]. http://dx.doi.org/10.3201/eid1903.121287

From: Lloyd, Catherine (MDH)
Sent: Friday, January 24, 2014 10:41 AM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

Advancing Health Equity Team:

The Star Tribune ran a series of articles related to special education and the difference in how children are diagnosed and how they receive services and/or discipline as it relates to Emotional Behavior Disorders (EBT) and special education. The article summarized some findings in a GOA report published in February 2013 and provides data which may link well with certain sections of the Draft Report on "health in all policies"?

The series can be found at http://www.startribune.com/local/minneapolis/235894231.html
The GAO report can be found at
http://stmedia.startribune.com/documents/GAO+report+on+racial+overrpresentation+in+special+ed.pdf

1. ***Question & comments related to the Star Tribune series***:

How does the above report and the data support the MDH initiative to advance health in all policies, including health in education? How does this type of data intersect with the following comments:

Comment from page 56 of the January 15, 2014 DRAFT report?:
"There is fear of and misdiagnosis of African American youth and adults (and other populations of color and new immigrants), resulting in overuse of incarceration, underuse of culturally competent health and mental health services and barriers to competent education and employment opportunities"?

Comment from page 37 of 108, December 18, 2013 Info-to-Report-Team :
NAMI MN- National Alliance on Mental Illness Mental health is treated differently than other health care conditions when it comes to insurance, data privacy and the type and intensity of treatments offered. Within mental health care, there are great disparities especially among communities of color and new immigrant populations. You can see this reflected in the number of youth in the juvenile justice system who have a mental illness (70%) along with the disproportionate number of youth who are from communities of color. The prison system also experiences disproportionality and a large number of people in prison with a mental illness. We do know that many of these individuals in the criminal and juvenile justice systems have experienced significant trauma in their early years and yet were not provided any treatment. While access to insurance that covers mental health treatment is one barrier, access to culturally competent providers is also very limited.

Comment on page 72 of 108, December 18, 2013 Info-to-Report-Team:
Education: MDH and local health departments should partner with education departments, school districts, etc to develop health and education policies. This is particularly vital given what we know about

the relationship between education and health. In particular, equity in education and shutting down the school to prison pipeline should be seen as top priorities as they are contributing to one of the largest opportunity gaps in the U.S. and one of the worst incarceration rates of African Americans. Health Departments can conduct health impact assessments on things like out of school suspension to bring light to the racialized outcomes of seemingly color-blind policies. Additionally, fully funding a general education levy should be a high priority for equity in education and therefore improved health outcomes. Our schools are failing students of color and this is having devastating impacts on the health of our communities. Any sort of solution will require the efforts of health and education departments and stakeholders working together toward change. Additionally, efforts will require an understanding of and commitment to eliminating structural racism from our schools and health departments. Something as simply as a moratorium on school suspensions until they can be proven to not have racialized outcomes could set a precedent for evaluating policies not on their color-blind intents, but on the real and lived racialized outcomes.

The DRAFT REPORT addresses some of these issues on page 23-24. It might be helpful to the reader to examine a data table along with the analysis of policy areas, populations and those impacted by the social determinants of health and inequities.

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2. **The following recommendations are extracted from my unpublished Capstone Research Project (Hamline University), "The Regulator as a Partner in Diversity." The research findings recommend a more diverse, multicultural and culturally competent body of health professionals in order to advance health equity for all Minnesotans. Some of these ideas have already been included in the DRAFT report based on input from the AHE qualitative survey and inquiry sessions.**

Recommendations

Collaborate with allied health practitioners regulated by MDH, Advisory Councils and work groups, professional societies, minority and multicultural health staff/agencies, consumer advocates, the Council of Health Boards, and policy makers to discuss strategies to advance health equity in all Minnesota populations.

Amend sunrise acts, such as Minnesota Statute, §§ 214.001 and 214.002, to require an analysis of the demographic profile of the professions seeking regulation;

Amend the professional practice acts related continuing education requirements and require evidence of cultural competence in education and training;

Research methods to allow practitioners state-to-state mobility to improve recruitment of diverse candidates and respond to communities, health care and systems in underserved areas;

Consider regulatory changes in scope of practice acts that allow for new career pathways for technical and undergraduate students to explore and which support continuing education in the health professions;

Invite staff of the Office of Minority and Multicultural Health, and International Health staff to practitioner Advisory Council and Board meetings to present on cultural competence, health disparities

and workforce diversity;

Collect data on all health professions and occupations to fully explore shortage occupations and utilize data for use in targeted recruitment, retention and tuition reimbursement grants;

Collaborate with universities, think tanks and other researchers to conduct qualitative studies on issues in workforce diversity in the allied health professions;

Collaborate with K-12 education in order to provide information to students about careers in the allied health professions;

Collaborate with local public health, local communities and non-profit agencies on the full scope of public health professions, including attendance at health and communities events by regulators and credentialing bodies;

Provide links to an information clearinghouses on cultural competence for licensed practitioners; and

Collaborate with state regulators and professional associations in states that have more diverse allied health workforces to develop best practices, recruitment and mentoring strategies.

Thanks for your good work!

Catherine Dittberner Lloyd

Heart Disease and Stroke. You're the Cure.

American Heart Association | American Stroke Association
Learn and Live

January 23rd, 2014

Dear Commissioner Ehlinger,

As the American Heart Association seeks to improve the cardiovascular health of all Americans by 20% and reduce fatality from heart disease and stroke by 20% by the year 2020, we have made addressing racial, ethnic and cultural disparities a high priority. The American Heart Association advocates for public policies that aim to reduce these disparities. Accordingly, we applaud the efforts taken by the Minnesota Department of Health (MDH) to analyze and report on the state of Health Equity in Minnesota. By proactively identifying areas where MDH can focus future growth and development to achieve the shared goal of eliminating health disparities in our state, you are establishing new partnerships with the communities you serve.

We are pleased to see that the report on Health Equity highlights many of the underlying causes and related challenges to achieving our Health Equity goals in Minnesota. Recognizing the relationship that housing, mental health, transportation, childcare, employment and other areas of public policy have to our collective health and Health Disparities is an important step in changing and updating the way we approach our shared vision. We strongly recommend that this report be shared with legislative committees beyond just Health and Human Services in order to further illustrate the role that these other areas play in our state's population health picture and to highlight the significant challenges with health disparities that we face as a state.

We also appreciate that MDH needs stronger relationships and ties to the communities it seeks to serve with this report. Principle 3 in the Recommendations Section does an excellent job of recognizing the need for MDH to develop stronger relationships in the American Indian, African American, Latino, Asian-Pacific Islander, and other racial/ethnic/cultural communities. Through regular and ongoing communication and presence in these communities, relationships can be developed that will enable MDH to gain quality engagement in communities that may have limited trust of MDH or the state agencies generally. Sharing the *Advancing Health Equity in Minnesota* report directly with these communities, along with strategic questions that provide an opportunity for the community to inform recommendations, next steps and implementation would be an excellent start to getting more grassroots involvement in the processes that are already underway. Additionally, it may be necessary to reconsider methods of engagement in these communities, in order to solicit more reliable feedback and seek input from presently underrepresented groups.

For more information, please contact Justin Bell Government Relations Director 952.278.7921 justin.bell@heart.org.

Finally, transparency will be crucial as this process moves forward. Clear communication and public involvement in how these recommendations are implemented will add a much needed layer of support from these communities. Setting specific outcome measures and goals that can be reported back to the community will allow a growing atmosphere of trust as the shared vision takes shape.

Again, we commend the Department, the Commissioner and the entire staff at MDH for their ongoing support and focus on Health Equity in Minnesota, and the American Heart Association looks forward to being a partner with MDH as the recommendations presented here are implemented and evaluated.

Justin Bell – J.D.
Government Relations Director
American Heart Associaion

Health Equity Working Committee

January 24, 2014

Edward Ehlinger, MD, MSPH
Minnesota Commissioner of Health
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Ehlinger,

The Health Equity Working Committee (HEWC) is pleased to see the work of the Minnesota Department of Health (MDH) shift its paradigm by which it sees its relationship to community and transform the culture of the department consider in addition to the intended impact, the indirect and potential unintended consequences of its policies and practices in relation to smaller racial, ethnic or LGBTQ communities.

The HEWC is a collaborative of nonprofits, academia, and community leaders from or serving Asian, African, African American, American Indian, Latino, LGBTQ and allied communities, and emerged in 2010 to hold the State accountable to its commitment to eliminate health disparities by promoting a framework of health equity. Thus we look forward to seeing the vision and values provided in the *Advancing Health Equity in Minnesota* report to be implemented and come to life in Minnesota.

The *Advancing Health Equity in Minnesota* draft report provides an excellent vision for how the MDH could and ideally should conduct its work and best meet its mission for all who call Minnesota home. The principles provide a framework for holding the MDH's decision-making on policies, processes and programs accountable to both majority and minority communities, create access for communities to inform the MDH on the unique assets, opportunities and needs of traditionally marginalized communities, and ensure meaningful data that effectively captures baselines, progress and missed targets with which to monitor the MDH's proposed transformative approach to improving the health of Minnesota.

The HEWC supports the input provided on this draft report by the following groups and organizations:

- Community Health Workers Alliance
- Council on Asian Pacific Minnesotans
- Minnesota Association of Community Health Centers
- American Heart Association
- LGBTQ Health Advocacy Roundtable

Thus, to avoid duplication, we are refraining from additional comments to the body of the report, but rather focus our comments on next steps for the report once complete and submitted to the Legislature on February 1, 2014.

The HEWC recommends the following to the MDH in its next steps upon finalizing the *Advancing Health Equity in Minnesota* report:

1. Present report to more committees than just health: Given the strong emphasis of this report on social determinants of health and those determinants direct impact on disparities, the HEWC recommends the *Advancing Health Equity in Minnesota* report have a hearing in all committees that oversee the funding and policies touching those determinants of health. Discussions of equity, structural racism and intentional inclusion of communities most affected by inequities in decision-making and implementation of policies, programs and projects funded by or led by the State.

2. Continue and deepen community engagement in this process: The MDH has launched this initiative with a quick timeline. We believe the aggressive approach by the MDH to get into the community to engage and receive input has been good but not sufficient. Through regular and ongoing communication and presence in the community, relationships can be developed that will enable the MDH to gain the best and most quality engagement of our communities of color, Native and LGBTQ communities who have limited trust of the MDH. The HEWC recommends the MDH take the final *Advancing Health Equity in Minnesota* report back into the community with strategic questions that provide an opportunity for community to inform recommendations' workplans and their implementation. Additionally, it is necessary to reconsider methods of engagement and their formats, which may need to include childcare, food, and deeper and more diverse partnerships for further reach into communities.

3. Transparency and monitoring of the MDH's progress in advancing health equity: To ensure the *Advancing Health Equity in Minnesota* report and what it lays out do not remain only on paper on a shelf, the HEWC recommends the MDH create a process of transparency in how the report recommendations get implemented and that the MDH sets both process and outcome goals by which community can hold it accountable. These goals should be measured and reported back to community on a regular basis.

4. Institutionalize the principles, recommendations and vision of the report: Unfortunately, too often quality initiatives get lost when staff turnover happens and political leadership shifts. We believe that if such an occurrence were to happen with this report that it would be tragic in the loss of this difficult shift and effort by the MDH to transform how it addresses the health of Minnesota with a pursuit of equity, and it would drastically harm the trust and relationships developed between the MDH and communities of color, Native and LGBTQ communities who may lose hope that Minnesota will ever change, value equity, and/or value our communities. The HEWC recommends the MDH finds ways to institutionalize the principles, recommendations and framework laid out in the *Advancing Health Equity in Minnesota* draft report that ensures MDH (and hopefully the State's) policy, program and processes decision-making is led by the report's principles and recommendations.

5. There must be cabinet-level interest and collaboration in health equity: Also mentioned within the report, this vision and goal of equity cannot be achieved solely the MDH, it must be a shared effort met in solidarity by the leaders of the many State departments and offices who oversee the programs, policies and processes that affect social determinants of health contributing to the disparities in

health in Minnesota. The HEWC recommends the convening of a cabinet-level committee team who coordinates to ensure decisions across the state are led by the principles, recommendations and vision of the *Advancing Health Equity in Minnesota* draft report.

6. Principles, recommendations and vision must flow down to local governmental entities: Recognizing a significant portion of the State budget flow down to local governmental entities, the HEWC recommends an effort to shift the paradigms of local governments and entities to share the same values, vision and principles toward equity and health as the *Advancing Health Equity in Minnesota* report puts forward.

Thank you for this opportunity to provide additional input into the *Advancing Health Equity in Minnesota* draft report. The HEWC sees this as a groundbreaking piece that can positively transform the structures that perpetuate existing disparities in Minnesota. Thank you for your boldness in leading with equity, naming the root issue of structural racism, and recognizing the need for inclusion of the LGBTQ community as we move forward to establishing a healthier Minnesota for all.

You may reach the Health Equity Working Committee via mn.health.equity@gmail.com for any clarifications.

Sincerely,

Minnesota Health Equity Working Committee

From: Johnson, Mary.B (MDH)
Sent: Friday, January 24, 2014 2:01 PM
To: *MDH_Advancing-Health-Equity
Cc: Faulkner, Patricia (MDH); Clarke, Betsy (MDH); Dech, Linda (MDH); Johnson, Mary.B (MDH)
Subject: Advancing Health Equity REPORT FEEDBACK

The following comments are my own, as time did not permit a broader discussion within our unit.

Thanks for offering the opportunity to comment on the draft report Advancing Health Equity in Minnesota. Overall the report is well done.

Here are some of my thoughts as I reviewed the report.

- Interconceptual nutrition, nutrition during pregnancy, and breastfeeding are all important for reducing infant mortality.
- Breastfeeding is also important for the health and well- being of mother and baby, and encompasses all of the components of health as defined in this document.
- Breastfeeding is *primary prevention.*
- The American Institute for Cancer research has identified breastfeeding as a strategy for reducing cancer in both women who breastfeed and those who are breastfed.
- CDC requires breastfeeding as a component of obesity prevention grants.
- Breastfeeding may reduce the risk of diabetes.
- Some communities and population groups face more barriers to breastfeeding than others.
- *James Grant, former UNICEF director summarized the importance of breastfeeding this way: "Breastfeeding is a natural safety net against the worst effects of poverty. If a child survives the first months of life, exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence."*
- Strategies to support breastfeeding include: evidence based hospital practice; peer breastfeeding support; continuing work to develop supportive workplaces – with emphasis on workplaces such as retail, foodservice and factory that may employ more low income earners and have more workplace challenges; helping fathers, grandmothers, other family members and communities understand the importance of breastfeeding and their role in protecting breastfeeding; and also for health care providers to be trained to approach each woman as an individual with unique strengths and potential barriers and starting the discussion of infant feeding with an open question such as "What have you heard about breastfeeding?" or "What have people told you about breastfeeding?" to learn more about the individual and best support her.
- As I sometimes work late and meet those that clean MDH buildings, a diverse group, I wonder if they are making a livable wage and how the state might act to ensure that those that clean state buildings are making a living wage and are supported in achieving health. When the cleaners include pregnant women I would love to tell them to use the rooms for pumping, but I'm not certain what their employers say. It would be great to have a policy that would support these sometimes invisible workers in using the spaces within state buildings for pumping.
- I know that breastfeeding is only one piece of the very large puzzle that is advancing health

equity, but it is an important piece.

- Please request breastfeeding references and references related to prenatal and interconceptual nutrition if needed.

Again, thanks for the opportunity to comment.

Mary

Mary B Johnson
Breastfeeding Coordinator
Minnesota WIC Program
Division of Community & Family Health
Minnesota Department of Health

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Mary.B.Johnson@state.mn.us

From: Meghan Porter [mailto:MPorter@glitc.org]
Sent: Friday, January 24, 2014 2:36 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

This feedback relates to discussion of data in the Health Equity Report:

I encourage MDH to move the Pregnancy Risk Assessment Monitoring System (PRAMS), the Behavioral Risk Factor Surveillance System (BRFSS), and the Minnesota Student Survey into the new office of Health Equity. These are all complicated surveys monitoring the health of important populations in Minnesota. PRAMS in particular, with its oversample of American Indian and US-born African American mothers, and its complex sampling, will especially benefit from being located in Health Equity in close proximity to the Minnesota Center for Health Statistics.

I urge MDH to think about how it categorizes infants. Currently, MDH assigns an infant the race of its mother, and does not consider the race of the father. The American Indian community considers an infant to be American Indian when either of its parents are American Indian. I recognize that from an analysis standpoint, this is problematic, especially when comparing rates for racial and ethnic groups. However, this doesn't lessen its importance. Especially in this small population, an accurate count of infants is vital to understanding population health. This same problem may affect other small ethnic populations now or in the future. I recommend MDH work to develop strategies to ensure counts are accurate and meaningful for small populations.

I was glad to see oversampling of small populations mentioned as an important data objective. I would like to lend support to this, especially in regard to American Indian people. American Indians have some of the worst health disparities in Minnesota, and are hard to reach through traditional surveys. Exploring better ways of reaching these groups is key to accurate data.

I support suggestions regarding involving community members in data analysis, as well as exploring increased and improved use of qualitative data.

The report rightly discusses data for local public health. However, the report only mentions the need for county-level data. American Indian tribes are another smaller level of geography that lack adequate health data and would benefit from community-level data in order to understand their population's health.

Meghan Porter, MPH
Maternal and Child Health Epidemiologist
Great Lakes Inter-Tribal Epidemiology Center

From: Meghan Porter [mailto:MPorter@glitc.org]
Sent: Friday, January 24, 2014 2:36 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

This feedback relates to the inquiry process to gather information for the Health Equity Report:

Regarding outreach that was done to collect information for this report, I have to say I was disappointed. I only found out about this, and the ability to comment, due to one MDH employee I very occasionally have contact with. I was actually a member of the Race, Ethnicity, and Language workgroup featured in the report, yet surprisingly no information about this initiative was spread through that channel. I would have been extremely interested in participating in the inquiry process, especially regarding data. I also work with several community groups consisting working on issues of health disparities (with MDH membership) and this report was not mentioned until yesterday (the second to last day for written comments)- members of the groups were unaware of the inquiry process and report. Some members of those community groups could have offered extremely valuable information to the inquiry, and it's disappointing they did not have the opportunity.

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1300 South 2nd St #300
Minneapolis, MN 55454
Ph: 612-625-7804

From: Meghan Porter [mailto:MPorter@glitc.org]
Sent: Friday, January 24, 2014 2:36 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

This feedback relates to discussion of racism in the Health Equity Report:

MDH has a negative history regarding racism, and so I commend MDH for its interest in discussing this topic. However, framing it as a structural issue does not make the topic easier to discuss- people maintain and benefit from these structures and systems. It is somewhat easy to accept structural racism as a concept, but hearing specific, concrete ways in which a system has negatively affected people of color, American Indians, or GLBTQ people is often received poorly by people who are part of the system. I think if MDH honestly wants to move forward with this discussion they need to think about how to prepare their staff to deal with these kinds of issues- how to accept criticism gracefully, and how to proceed with reducing structural inequities.

MDH should also realize that the Department wields a lot of power. It is not easy for those with less power to speak up, knowing that doing so very well may result in their being penalized for doing so (having witnessed it in the past). How can MDH have the same amount as power as communities, community members, or groups when MDH has the authority of government and large budgets that few others have access to? A lot of thought must go into the ways in which MDH can truly commit to this ideal.

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January 20, 2014

Commissioner Dr. Edward Ehlinger
Minnesota Department of Health
Commissioner's Office
625 N. Robert St.,
St. Paul, MN 55155-2538

Dear Commissioner Ehlinger,

Hennepin County Medical Center would like thank you for the opportunity to provide the following feedback to the MDH draft "Advancing Health Equity in Minnesota: Report to the Legislature by the Minnesota Department of Health." We appreciate your strong leadership, as evidence by this draft report, to address the issue of health equity, one of the most important health policy concerns facing Minnesota. We have divided our suggestions for how to improve the report between general observations and specific ones.

General observations

The document would benefit from a clear description of its intended audience; is it the legislature, general public, MDH staff, or others? Unless MDH is the primary audience for this report, we feel too much of the draft is focused on internal MDH work, roles, and strategies. Once the audience is defined, the draft should be revised to include clearer definitions and wider perspectives. For example, as some of the included language could be interpreted as being highly politicized (i.e. structural racism, white privilege, etc.), it would be helpful to define these terms more broadly in order to make the document more accessible to its intended audience. Similarly, it would be helpful to include in the beginning of the document what MDH intends to do with the report. This sets the stage for the reader and then can set a road map for action with more pointed recommendations and next steps.

In general, the draft report does a good job of analyzing health equity issues through the perspective of structural racism. We appreciate this perspective and recognize that is not often discussed. The focus on racial inequity rather than socioeconomic status is an interesting choice, and the document should include more explanation and evidence as to why this focus was chosen. Additionally, the document would benefit from defining the concept of race/ethnicity before jumping straight into structural racism. The authors may want to consider adding data and information about the corrections and justice systems as it relates to structural racism and health.

We look forward to seeing the community feedback and listening session input from the latter half of the document expanded and addressed throughout more of the document. Citations and supporting data will be useful if some of those points are to be included in the final draft. Additionally, the document referenced several other states' health equity work but did not explain what exists legislatively in Minnesota. Including an inventory of existing relevant

information could help provide a framework for next steps. Finally, regarding those next steps, we would like to reiterate that creating more subcommittees to discuss the issue is not what is needed. In order to operationalize health equity work across the region, MDH may need to require, for example, that other health care organizations work together.

Specific feedback

- The bullet points on page 16 are confusing and don't seem to correspond with the subsequent recommendations.
- MDH Recommendation 1: The authors do not provide a mechanism for operationalizing this recommendation. One suggestion is to require that all fiscal notes completed on legislation include a section that addresses the health impact of that legislation. This "health impact assessment" should include intended and unintended consequences like local impact assessments do.

- MDH Recommendation 2: This item reads as an optional invitation to listen to the Commissioner of Health. This needs to be more than just a commissioner convening yet another sub-cabinet; the other commissioners need to be held accountable. This is crucial because in order to be successful, efforts related to structural racism need to go much further upstream than just the Commissioner of Health. Additionally, community members should be incorporated from the very beginning; a Commissioner alone cannot hold all the answers.

- MDH Recommendation 4: This section would benefit from the definition of "meaningful relationship" with clear examples and steps.

- MDH Recommendation 5: Please see comments under recommendation 2.

- MDH Recommendation 6: Grant processes could be much improved. As it currently exists, the grant-seeking process is nearly impossible for non-English speakers. To be more accessible to the community, MDH should use the MN Common Grant Application. MDH should also explore models such as the University of Minnesota's Center for Health Equity, which has started a mentorship program with non-profits to help prospective grantees better secure funding. It should also provide multi-year general operating funding, which is more useful for organizations implementing new initiatives. Additionally, there is an obvious need for additional funding to support this entire recommendation, and improved program evaluation efforts would be helpful.

- MDH Recommendation 8: MDH should consider working with DHS on Health Home models (section 2703 of the ACA, not the State's Health Care Home models) that focus on specific cultural communities. Utilizing cultural liaisons is another successful strategy to institutionalize health equity. For example, Hennepin County Medical Center has employed a Native American patient advocate to advance cross-cultural understanding and address health inequities.

- MDH Recommendation 10: As a teaching hospital dedicated to training tomorrow's health professionals, HCMC supports this recommendation and has also focused on this in its own health equity work. HCMC looks forward to working with MDH on this issue.

- MDH Recommendation 11, item 3: HCMC supports this recommendation and foresees a role for its Hennepin Regional Poison Center to conduct public health surveillance for MDH/local public health departments. HCMC is also partnering with local public health departments and other health care organizations on health equity, population health, and community health needs assessment projects.

- MDH Recommendation 12: MDH needs to lead an effort to educate communities as to why data is being collected about them. MDH can then work with health care institutions to educate medical providers as well, since the community members often trust and turn to them for information.

Thank you for the opportunity to comment on what could be a ground-breaking report to improve health equity in Minnesota.

Sincerely,

David Godfrey
Director of Advocacy and Public Policy
Hennepin County Medical Center
612-873-2196

From: Susan Lee-Rife [mailto:susan@susanleerife.com]
Sent: Friday, January 24, 2014 2:58 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK

Dear Madam/Sir:

Thank you for providing the public with the opportunity to comment on the Advancing Health Equity Report. I applaud the efforts of the State and MDH to address health inequities in Minnesota, and to include issues facing LGBTQ individuals and their families into this report.

However, I am concerned that in its efforts to attend to more "cutting edge" gender issues, the authors of this report have overlooked other fundamental gender-related issues, notably the disparities between males and females.

It is well-established that males and females exhibit different health-related behaviors and have different health-related experiences in part because of gender norms and other socially-determined causes, in addition to biologically-based differences. For example, women typically experience higher levels of depression, while men are more likely to be schizophrenic and to commit suicide. Women are more likely to experience intimate partner violence (including sexual violence and coercion) while men are more likely to experience physical violence. Women are more likely to be the sole caregivers of children. And because women become pregnant, women's health behaviors and chemical dependency are key determinants of infant and child health.

These issues are relevant to the population of Minnesota as a whole and must be addressed in prevention and mitigation efforts. However, these concerns may be especially pertinent in addressing health disparities in Minnesota's communities of new and recent immigrants from parts of Africa, the Middle East, and Asia. The cultures of these world regions have strong gender norms that work to restrict women's mobility and control of economic resources, limit discussions of sexuality, foster high fertility, and promote (or at least do not deter) gender-based violence. Moreover, girls and women often marry early and may thus exposed to the risks of pregnancy, childbearing, and intimate partner violence at earlier ages and to a greater extent than other groups. Thus, girls and women from these communities may lack critical information about their health and where to seek health care access, and lack the resources and ability to access health care, especially concerning reproductive health and gender-based violence.

Thus it is critical that the State take a closer look at differences in health status and behavior between males and females of all ages and consider carefully how gender norms and differences may influence both the persistence of these disparities and the effectiveness of prevention and intervention efforts.

--

Susan Lee-Rife, PhD, MHS
Social Demography Research and Communications
Gender ¤ Social and Behavioral Determinants of Health ¤ Poverty ¤ International and Domestic Contexts
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From: Stephen Nelson [mailto:Stephen.Nelson@childrensmn.org]
Sent: Friday, January 24, 2014 3:00 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK

I was thrilled to read the MDH's "Advancing Health Equity in Minnesota: Report to the Legislature." I was especially happy to see the brave and bold acknowledgment of the role of race and racism in the current health inequity in our state.

For 20 years, I have had the honor of caring for the majority of children with sickle cell disease in Minnesota. I have only recently begun to consider how, as a white male physician, my race may affect the health care delivery to our patients of color. This consideration is long overdue.

I have been working on this issue since completion of a Bush Fellowship in 2008. I continue to be troubled by the utter lack of awareness of health care disparities and their root causes. Specifically, many providers do not understand that race is an independent factor in health inequity much less the fact that institutional racism and our own stereotyping and unconscious biases contribute to racial health disparities.

Many providers are unaware of the Institute of Medicine's report "Unequal Treatment" that clearly spells out bias, stereotyping and prejudice on the part of health care providers as contributing to racial and ethnic disparities. This report recommends, among other things, that we raise awareness of disparities and train providers. Sadly, this report is 12 years old and things are not getting better. Health care providers get little to no training around issues of race, racism, and unconscious bias and awareness of these issues is poor.

I respectfully suggest that your action plan for reducing health disparities include training on issues of race, racism and whiteness. Training can be done for all types of health care providers as well as for administrators to affect organizational change. Dr. Heather Hackman and I have developed such a training module for health care providers. Our initial pilot at Broadway Family Practice yielded exciting results.

I liken the issue to the "canary in the coal mine". Current strategies are aimed at saving the canary without addressing the poisonous gas in the coal mine. The poisonous gas is structural racism, stereotyping, and unconscious biases. Until racial issues are honestly addressed by members of the healthcare team, it is unlikely that we will see significant improvements in racial healthcare disparities for Minnesotans.

I would be happy to share more information about our work. And, I offer our help in making Minnesota the healthiest state for all Minnesotans.

Best regards,

Stephen C. Nelson, MD

Director, Hemoglobinopathy Program

Co-Director, Vascular Anomalies Clinic

Adjunct Assistant Professor

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Advancing Health Equity Report
Comments from the Minnesota Medical Association
January 24, 2014

On behalf of the Minnesota Medical Association, thank you to the Minnesota Department of Health for their efforts to help address health disparities and health inequities in Minnesota. The Minnesota Medical Association looks forward to working with the Minnesota Department of Health and others in helping to advance this work. The following are comments on the draft report:

- The Minnesota Medical Association supports the report and the conversations it has started, and will continue to stimulate, about the work that can be done within and among organizations to improve health equity in Minnesota.
- The Minnesota Medical Association appreciates the acknowledgement within the report about the complexity of factors that influence health outcomes (disparities).
- Better data from clinics and hospitals will need to address how to balance reporting burden and privacy.
- In regards to the sections in the report that address health professions, the Minnesota Medical Association looks forward to hearing more about specific recommendations and how those recommendations will be implemented.

Thank you again to the Minnesota Department of Health for their efforts to advance health equity in Minnesota.

Sincerely,

Juliana Milhofer, Policy Analyst
Minnesota Medical Association
Phone: (612) 362-3735
Email: jmilhofer@mnmed.org

ClearWay[SM]
MINNESOTA

January 24, 2014

ClearWay Minnesota[SM] respectfully submits this feedback on the draft report "Advancing Health Equity in Minnesota: Report to the Legislature." We are an independent nonprofit organization funded with 3 percent of Minnesota's tobacco settlement. Our mission is to enhance life for all Minnesotans by reducing tobacco use and exposure to secondhand smoke through research, action and collaboration.

Overall, this draft report accurately described many of the health disparities that exist in Minnesota as well as potential systems approaches for advancing health equity throughout the state. Specifically, the definitions provided were strong, the guiding principles were well thought out and the focus on structural racism will allow for meaningful dialogue and potentially significant increases in health equity across our state. Most importantly, the report is actionable and clearly lays out plans for stakeholder engagement, including the creation of the Minnesota Center for Health Equity and a commitment by the Minnesota Department of Health (MDH) to begin implementing these recommendations immediately after submission to the Minnesota State Legislature.

We believe this draft report includes many recommendations that have potential to increase health equity across Minnesota. We also encourage MDH to strengthen this report by adding the following recommendations and concepts:

- **Address *culture* throughout the report.** This could include defining *culture* in the introductory sections of the report as well as acknowledging its importance within specific recommendations. Incorporating the notion of culture within Recommendation 1 would be especially impactful. ClearWay Minnesota includes culture as an important component when addressing commercial tobacco[1] use within American Indian communities and other priority populations.[2]

- **Ensure a strong community engagement component when implementing recommendations.** Community engagement, above all, is crucial to successful implementation of the recommendations outlined in this report. This component should be prioritized and should include meaningful, accessible ways to engage in dialogue about advancing health equity in Minnesota, with the communities that are most impacted by health disparities. The process for creating this report is a good model for such meaningful engagement, since it provided multiple opportunities for feedback (e.g., listening sessions, written comments, webinars and facilitated conversations).

- **Commit to funding initiatives that create leaders for the future.** Creating leaders and capacity within communities is one of the most important steps MDH could take to advance health equity. This type of leadership development should focus on creating leaders and capacity across all communities. In order to achieve this, organizations within these communities should be funded to facilitate the capacity building, with technical assistance provided by MDH in collaboration with other partners. Additionally, when funding opportunities are released, these opportunities should be targeted to and designed specifically for priority populations to ensure communities can competitively apply for these opportunities.

  Mainstream tobacco control has been built over decades, both locally and nationally. However, unequal and inadequate funding has resulted in disparities in diverse communities' capacity to

[1] Commercial tobacco is defined as commercially manufactured tobacco products, and does not include traditional, sacred tobacco use by American Indians.
[2] Priority populations are defined as populations that experience disproportionate harm from tobacco.

conduct effective tobacco control activities. ClearWay Minnesota is working to build a tobacco control movement in priority populations that is responsive to the history, culture, language, geography, socioeconomic status, gender and sexual orientation of Minnesota's growing and heterogeneous communities. Since 2005, we have conducted the Leadership and Advocacy Institute to Advance Parity for Minnesota's Priority Populations (LAAMPP), which builds advocacy and leadership skills for effective tobacco control among members of Minnesota's diverse communities. LAAMPP Fellows are supported to initiate tobacco control interventions and share knowledge within their communities. They have established tobacco control policies in their communities and have joined statewide efforts such as campaigns to pass the Freedom to Breathe Act and to increase the price of commercial tobacco.

After each leadership-building effort and other capacity-building activities are completed, funds should continue to support the grantees in their ongoing work in the community. This ensures continuing development of capacity and leadership skills while also supporting ongoing, community-based work to advance health equity. Those completing leadership institutes should also have opportunities to advance MDH's ongoing work and initiatives. For example, ClearWay Minnesota leveraged the expertise of LAAMPP Fellows to bring different perspectives to the campaign to increase the price of tobacco in Minnesota.

In addition to the LAAMPP Institute, another example of a successful leadership development program is the Emerging Leaders Network (http://www.health.state.mn.us/emergingleaders/) previously supported by MDH. Reinstating funding for programs such as this, with a health-equity lens, would help ensure a workforce of trained community leaders who will continue to strive toward health equity in Minnesota.

- **Add clear recommendation to support response-driven sampling.** We were encouraged to see response-driven sampling (RDS) identified as a new and evolving sampling method used to draw probability samples of hard-to-reach populations (pg. 33). Using this sampling method should also be a clear recommendation in this report. Methods like RDS will help reach populations that are traditionally undercounted or missing from conventional data collection approaches. RDS and other novel sampling approaches have the potential to fill data gaps especially for communities not currently represented in this report.

- **Support communities to collect their own public health data.** We encourage MDH to add a recommendation around supporting communities to collect their own public health data, such as advocating a community-based participatory research (CBPR) approach. Under this research model, community members are involved in every part of the process. CBPR is an applied collaborative approach that enables community residents to more actively participate in the full spectrum of research (encompassing conception, design, conduct, analysis, interpretation, conclusions and communication of results phases) with a goal of influencing change in community health, systems, programs or policies.

  One example of a successful initiative designed to engage community members in every aspect of the research process is the Tribal Tobacco Use Project (TTUP). TTUP sought to reveal data gaps by engaging tribes and American Indian communities in conducting a statewide survey about attitudes, behaviors and beliefs related to tobacco use among American Indians in Minnesota. This information, which was gathered for the first time ever, will help inform the development of tobacco prevention and control programs and policies. The information may also show the need for continued access to tobacco control resources and measure rates of commercial tobacco use.

This project is made possible through a unique collaborative partnership between the American Indian Community Tobacco Projects (AICTP), the American Indian Policy Center (AIPC), and an oversight group comprising members of American Indian communities across the state. A report of some initial urban findings can be found here: http://docs.sph.umn.edu/epich/resources/UrbanReport.pdf

The methods and model for collecting this data should serve as a best practice for collecting health data within priority population communities. Here is an excerpt from the report that provides a detailed description of the methods:

The TTUP urban survey participants were American Indian adults ages 18 years and older and living in Hennepin or Ramsey Counties. All of the 30-minute, in-person interviews were done at the participant's home or a community location by American Indian interviewers who received training on study protocol and human subjects protection. Signed inform consent was obtained before the interview. The Metropolitan Urban Indian Directors and St. Paul Indians in Action approved the protocols and community participation in this study. The University of Minnesota and the Indian Health Services Institutional Review Boards (IRB) also approved the study. Respondent-driven sampling (RDS) was used to generate the sample for this survey. This method was developed for sampling hard-to-reach populations, and is a variation on snowball sampling. This method was chosen because lists do not exist that identify American Indians living in the Hennepin- and Ramsey-county metropolitan area. Data collection started with five initial respondents, known as seeds, who were interviewed and then presented with three unique coupons apiece to give to people in their social network who met the eligibility criteria (18 years and older, self-identified American Indian, living in Hennepin or Ramsey County, and were not related to the person giving them the coupon). Upon completion of the second round of interviews, those respondents were also given three coupons to distribute to eligible participants in their social networks. The process continued, with respondents recruiting respondents, through as many as 12 waves, yielding 940 usable interviews completed between March-May, 2011. Two sample weights were applied to these data. First, a sample weight was applied to adjust for network size – that is, how many individuals known by the respondent to whom they could have given their coupons. Second, the sample was weighted to reflect the characteristics of the American Indian population of Hennepin and Ramsey counties as revealed by the 2010 U.S. Census. Sampling weights are used throughout this report to adjust the final estimates to provide an accurate picture of the opinions and experiences of all adults in the urban American Indian community.

Ensuring appropriate dissemination and engaging communities to disseminate their own data collection is also an important piece. This includes appropriate data-sharing agreements, data ownership by the communities, co-authorship and appropriate mediums for successful dissemination. MDH could benefit from supporting ongoing, future dissemination, which would allow further identification of health inequities and corresponding opportunities to advance health equity.

- **Develop and use culturally appropriate communications strategies.** ClearWay Minnesota uses various media to educate communities about the harms of commercial tobacco use and the benefits of quitting. These communications strategies include culturally appropriate messages that aim to achieve statewide reach. This statewide reach can only be achieved by looking beyond traditional media outreach and focusing on working with communities on word-of-mouth communications and testimonials such as digital storytelling. LAAMPP Fellows are also continually doing outreach on behalf of ClearWay Minnesota, demonstrating how statewide reach can be achieved if community members are talking to other community members about the harms of commercial tobacco and the resources available.

In order to advance health equity in Minnesota, it is important that all communications are linguistically appropriate and available in multiple languages. One example is ClearWay Minnesota's QUITPLAN® Services. Launched in 2001, the QUITPLAN Helpline helps tobacco users in both Spanish and English; eligible callers receive free nicotine replacement patches, gum or lozenges. Individuals who speak Cantonese, Mandarin, Korean and Vietnamese are transferred to the Asian Smokers' Quitline, a free nationwide service funded by CDC. For all other languages, the Helpline uses a third-party interpreter. quitplan.com is a free website that offers support from certified tobacco treatment specialists in both Spanish and English.

In 2012, ClearWay Minnesota coproduced two compelling programs with ***tpt's*** Minnesota Channel for its *ECHO TV* series. "Secondhand Smoke in Our Communities" and "The Harm of Commercial Tobacco in Our Community" were broadcast in English, Spanish, Hmong, Somali, Vietnamese and other languages. These programs are available at www.echominnesota.org. MDH could benefit from this type of tailored outreach.

Lastly, communications and media to be used within communities should be created by the communities. Priority populations should be given resources to develop and disseminate public health messaging for their communities, with technical assistance provided by MDH. This approach helps advance health equity by ensuring culturally appropriate messaging while building capacity within priority populations.

MDH could further address health inequities via media outreach that is translated universally into the multiple languages identified by the MDH/DHS-facilitated Race, Ethnicity and Language workgroup.

- **Collect data on the social-determinants of health via Statewide Quality Reporting and Measurement System (SQRMS).** Provisions of the 2008 Minnesota health care reform law required the Commissioner of Health to establish the Statewide Quality Reporting and Measurement System (SQRMS), a standardized set of quality measures that are used in both public and private sector health care services and coverage programs across the state. In the future, provider payments and eligibility for serving people on government programs will be tied to their ability to meet these standardized quality benchmarks for quality and cost.

  The process to develop these quality measures has been led by MN Community Measurement. Using these measures, the Commissioner of Health was also charged with establishing a system for risk-adjusting quality measures and publishing annual reports on provider quality. The current SQRMS measures do not include methods of adjusting for the impact of socio-economic factors on access, quality of care and patient health (such as poverty, race, language, culture, homelessness and other factors that have been shown to have a direct impact on health, access and treatment outcomes).

  Current Minnesota Community Measurement (MNCM) and SQRMS measurement systems do not measure this facet of quality of care and provider performance. The only existing "risk adjustment" for socio-economic risk factors is that provider performance data can be reported separately for patients enrolled in Medicaid (by definition low-income) compared to patients with other sources of health coverage (presumably higher-income than the Medicaid population). The data currently being collected and reported does not present a complete picture of the quality and effectiveness of providers or of the health care system in improving patient health and outcomes.

  Extensive research literature documents that socio-economic factors, including income level, homelessness, race and ethnicity, language, education and others, profoundly impact a patient's

health, access, quality of care, and treatment outcomes. For patients with these challenges, optimal clinical outcomes cannot be realized without addressing the non-clinical factors and barriers. Performance on this element of quality requires additional resources and expertise so that patients receive both optimal clinical care and effective services and supports to address socio-economic risk factors.

- **Adopt the recommendations of the 2011 MDH-DHS Report on Data on Race, Ethnicity and Language (REL).** The draft report currently discusses the work and recommendations of the Race, Ethnicity/Language workgroup. However, these recommendations have not yet been implemented. MDH should add a recommendation around implementing the ideas and strategies identified by this workgroup.

- **Include tobacco prevention and control health disparities data.** Data on health disparities and inequities, as discussed beginning on p. 39, should include the existing data highlighted on MDH's website regarding tobacco prevention and control health disparities. This data can be found at http://www.health.state.mn.us/divs/hpcd/tpc/facts/disparities.html. Additionally, tobacco use prevalence rates should be used as examples of health disparities within these communities. All communities listed within this report suffer disproportionately from tobacco use. Addressing tobacco use across Minnesota's priority populations will positively impact efforts to advance health equity across the state.

- **Integrate health equity coursework into the University of Minnesota's School of Public Health.** Building a strong partnership with the University of Minnesota around educating public health students on advancing health equity in their future work would build capacity across future public health professionals. The draft report recommends "creat[ing] a formal program to recruit and encourage high-school students of color to consider jobs in the field of public health" (p. 20). It is equally important to engage and educate public health students more broadly on existing health inequities and strategies for advancing health equity.

- **Public Health Fellowship Program.** Also in collaboration with the University of Minnesota School of Public Health, MDH should develop a fellowship program to support priority populations in obtaining advanced degrees related to public health and health care delivery, such as Masters of Public Health, licensed practical nurse (LPN) and registered nurse (RN). This would create a qualified workforce that is representative of continually changing demographics in Minnesota. This is also especially important as the demand for primary care services and health care professionals increases due to health care reform. This initiative would be similar to programs such as Robert Wood Johnson Foundation's "Ladders in Nursing Careers Program (L.I.N.C)".

ClearWay Minnesota applauds the efforts of MDH to advance health equity across our state and welcomes the opportunity to contribute to the ongoing dialogue around these recommendations. We appreciate your consideration.

Respectfully,

David J. Willoughby, M.A.
Chief Executive Officer
ClearWay Minnesota[SM]

January 24, 2014

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
Minnesota Department of Health
P.O. Box 64975
Saint Paul, MN 55164

Dear Commissioner Ehlinger

The Health Equity Data Collection Collaborative (Data Collaborative) would like to thank you and your staff for all the work that went into the ***Minnesota Department of Health Advancing Health Equity Report*** and for this opportunity to respond to this draft release of it.

The Data Collaborative consists of community groups, social service organizations, safety net providers, advocacy organizations, associations, academia and funder organizations who all are dedicated to promoting health equity through data collection, analysis, risk adjustment and dissemination.

Truly the first of its kind, this report publicly acknowledges and demonstrate the need for the difficult conversations regarding race, racism, institutional racism and health inequities to start advancing change. Only through these conversations, will we begin changes that reduce health disparities.

Specifically, we applaud the Department for recognizing our communities' long-standing pleas for incorporating social determinants of health and disaggregated reporting into data collection and (health) policy. This draft report lays out very compelling arguments supporting the Data Collaborative's positions, including -

- Improve data collection to add granular data on Race/ Ethnicity/ Language;
- Collect standardized data on social determinants of health – including poverty, gender identity/ sexual orientation, geography, mental health;
    - All of this detailed data paints a more accurate picture of specific communities/ sub groups most impacted by health disparities influenced by social determinants of health
- Address the full continuum of contributing factors and solutions to health
- Invest more in low-income and diverse communities;

This report reinforces the need for Statewide Quality and Reporting System risk adjustment that considers all the life complexities of people and communities most impacted by health disparities when measuring providers who serve them. While we know this plea does not fall on deaf ears, we strongly encourage the Department to approach risk adjustment and all its future work through this health equity lens.

In addition to our compliments, we emphasize the role we and our **Recommendation to Reduce Health Disparities by Improving Health Care Data** can play in implementing the recommendations laid out in this report. Our recommendations are attached.

We encourage the Department to partner with the Data Collaborative in carrying out this work. Please do not hesitate to contact us at jin.lee.johnson@mnachc.org.

Again, thank you for this report and step forward.

Sincerely,

Jin Lee Johnson
On behalf of The Health Equity Data Collection Collaborative

Health Equity Data Collection Collaborative

Recommendations to Reduce Health Disparities by Improving Health Care Data
Draft 12-03-13

1. Follow through on the recommendations of the 2011 MDH-DHS Report on Data on Race, Ethnicity and Language (REL). Attached.

2. Expand and standardize more detailed categories of race, ethnicity and language data to encompass a larger number of racial, ethnic and other "communities," with health disparities, and collect and report all health data with these categories. Categories of race, ethnicity and language should be established with the participation of the affected communities.

3. Establish a "Standard Construct" for data on health disparities to ensure that all health data is collected and reported with categories of REL/SES so that disparities can be identified and activities to eliminate disparities can be made more effective.

4. Collect and report all health data with additional data elements related to social determinants of health(Socio-Economic Status) that evidence shows have an impact on achieving the Triple Aim (Health, Patient Engagement, and Cost) for particular groups of patients. One such additional element that should be collected for all health data is gender identification and sexual orientation.

5. In partnership with community leaders and stakeholders develop a plan to implement collection of gender identification and sexual orientation.

    a. Align state goals with federal goals around the collection of gender identity and sexual orientation data: As stated in healthy people 2020:

        1. **LGBT-1.1** (Developmental) Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, and bisexual populations.
        2. **LGBT1.2** Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include the core a standardized set of questions that identify transgender populations.

    b. Follow recommendations in the Institute of Medicine's 2011 Report: The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding

i. Specifically Section 3: Conducting Research on the Health Status of LGBT Populations

And 2013 Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records: Workshop Summary

c. Assemble local experts on the collection of gender identity and sexual orientation data to inform data methods, collection, analysis, and dissemination.
d. Create and disseminate an implementation plan showing the steps that will be taken to integrate gender identity and sexual orientation questions and align with federal efforts to create a standardized method of collection.

6. Disaggregate data to the smallest level possible in order to identify disparities for particular REL/SES groups. Oversample and combine years for certain groups to get adequate data for small groups.

7. Use alternative data collection methods to supplement traditional methods in order to get data from REL/low SES groups that are underrepresented or inaccurately measured using traditional methods. Examples include participatory research methods, community-led convenings, and story-telling methods.

8. Implement new "community" engagement methods, in partnership (consultation) with "hard-to-reach"/ REL/low SES/ for REL/SES groups that can be used by state and local governments and health organizations to more meaningfully and genuinely engage with communities experiencing health disparities in order to better understand how REL/low SES affect health and engage communities as partners in planning, developing, implementing and evaluating health care and health policy changes for their impact on disparities.

    a. Provide funding to REL/low SES communities so that they can develop leadership and expertise within their communities in order to be effectively engaged as partners with health and governmental organizations.

9. Make health data more easily accessible to REL/low SES communities so that they can use the data to identify health needs and disparities within their communities, participate effectively as partners in planning and policymaking to eliminate disparities, and evaluate the performance and to continually ensure accountability of the State in ensuring that publicly funded as well as publicly-regulated health care organizations are making meaningful progress in eliminating disparities.

10. Conduct "community-wide needs assessments" of governmental and private health care organizations in a way that specifically identifies disparities for groups within the community and evaluate performance of these organizations based on their ability to eliminate disparities. This should be required of health-related nonprofits, health care providers, health plans, Health Care Homes (HCH), Accountable Care Organizations or HCDS (ACOs), Accountable Communities for Health (ACH), and state and local government health care agencies.

11. Incorporate into statewide quality and performance measures for providers' performance requirements relating to identifying and reducing health disparities within the communities and consumer populations they serve.

12. Adjust or enhance existing quality and performance measures to take into consideration REL/ low SES and other life complexities of those served by providers. Incorporating REL/ low SES and other life circumstance complexity variables into quality measure ensures that providers serving high-concentrations of REL/ low SES populations are measured appropriately relative to other providers. Failure to incorporate these measures will have unintended consequences, including exacerbating existing health disparities.

13. Expand payment methods for providers to recognize the additional services, resources and competencies to enable REL/ low SES populations to access primary health services. Examples of such services include, but are not limited to: transportation, community education and outreach and language translation

14. As part of the overall community engagement and community-led accountability monitoring process, incorporate community-based and community-led care data collection and reporting and evaluation practices that are responsive to the needs and preferences people with histories of complex and historic trauma.

From: Vayong_Moua@bluecrossmn.com [mailto:Vayong_Moua@bluecrossmn.com]
Sent: Friday, January 24, 2014 3:57 PM
To: *MDH_Advancing-Health-Equity
Subject: Feedback to draft HEq Report
Importance: High

Feedback to MDH's draft Health Equity Report

Submitted by Vayong Moua (LAAMPP Fellow)

Essential to advancing the practice of health equity in all policies, there needs to be an intra and interagency accountability structure with dedicated human and financial resource.

- Within MDH, the Center for Health Equity needs to be elevated within the agency and given authoritative and integrative power to influence all areas of MDH operations. The Center for Health Equity could provide internal and external technical assistance on cultural competence, structural racism, and best/promising practices in multicultural health. It's important that the executive office remains highly engaged and accountable to ensure full permeation of health equity into all layers of the agency and local public health agencies. MDH should strengthen ties with health equity based/focused organizations that are priority population led. Additionally, MDH can harness collective impact by partnering with philanthropy, direct service, and advocacy groups. Though health inequities are the result of insufficient data and financial resources, ultimately, it's magnified because of priority problem. Serious effort needs to go into how health equity is advances prosperity for all, not just specific cultural groups. More research and message framing needs to focus on the economic and common good benefits of health equity.

- It's clear that health inequities belong to broader societal and structural inequities that span across education, housing, employment, transportation, and community design. In line with what we know about the social determinants of health (SDOH) and the prevention spectrum (health care only 10% of health), it'll be vital for other state agencies to advance equity as well. Therefore, interagency collaboration and accountability is required to address structural inequities. I'd recommend the formation of a health equity cabinet, that includes MDH, DHS, MnDOT, DEED, MPCA, DNR, DHR, MDA, and MDE to begin with. These agencies cover many social determinants of health. While MDH is addressing health inequities, MDE is addressing the achievement gap, and DEED is facing unemployment gaps, thus, creating a structural solution for a structural problem is needed. The Governor and legislature can further support the health equity cabinet through high expectations, facilitation across domains, and assurance of public accountability. Such duties could include:

    - Baseline equity analysis of services, staff, programs, contracts, professional development opportunities, recruitment/hiring/retention practices, and data collection practices.

- Assessment of agency's community engagement process, especially with low income, communities of color, LGBTQ, refugee/immigrant, (dis)ability, and American Indian communities.

- Create agency specific Cultural and Ethnic Communities Leadership Council to advise Commissioner on health equity principles, practices, and policies to implement. The content and approach can be modeled after DHS's current CECLC. The Council should represent community based organizations and tribes.

- In addition to cabinet members being involved, assign high ranking staff to ensure community input, cultural competence, and implementation of recommendations. These recommendations need to lead towards policy, systems, and environmental change levers within and across state agencies.

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Feedback to MDH's draft Health Equity Report

Submitted by Vayong Moua (LAAMPP Fellow)

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- Within MDH, the Center for Health Equity needs to be elevated within the agency and given authoritative and integrative power to influence all areas of MDH operations. The Center for Health Equity could provide internal and external technical assistance on cultural competence, structural racism, and best/promising practices in multicultural health. It's important that the executive office remains highly engaged and accountable to ensure full permeation of health equity into all layers of the agency and local public health agencies. MDH should strengthen ties with health equity based/focused organizations that are priority population led. Additionally, MDH can harness collective impact by partnering with philanthropy, direct service, and advocacy groups. Though health inequities are the result of insufficient data and financial resources, ultimately, it's magnified because of priority problem. Serious effort needs to go into how health equity is advances prosperity for all, not just specific cultural groups. More research and message framing needs to focus on the economic and common good benefits of health equity.
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  - In addition to cabinet members being involved, assign high ranking staff to ensure community input, cultural competence, and implementation of recommendations. These recommendations need to lead towards policy, systems, and environmental change levers within and across state agencies.

From: Maria K Moore [mailto:Maria.Moore@hennepin.us] **On Behalf Of** Stella Whitney-West
Sent: Friday, January 24, 2014 4:21 PM
To: *MDH_Advancing-Health-Equity
Cc: Julie Nielsen; Stella Whitney-West
Subject: Advancing Health Equity REPORT FEEDBACK

cid:image001.png@01CF1912.AAB0E860

To: Minnesota Department of Health Advancing Health Equity Team
From: Stella Whitney-West, CEO, NorthPoint Health & Wellness Center
Date: January 24, 2014
Subject: Advancing Health Equity REPORT FEEDBACK

NorthPoint Health & Wellness Center is a Federally Qualified Health Center located in North Minneapolis. For nearly a half-century NorthPoint has anchored this community in access to high quality and culturally responsive health and human services. We are continuously aware of how structures have historically operated to systematically marginalize the people we serve, primarily non-White persons – and, that they continue to do so with considerable durability. NorthPoint applauds the Minnesota Department of Health for taking an important stand with a "race-first" analysis of health inequalities across the state and for formally acknowledging that health outcomes are not grounded primarily in personal responsibility nor cultural choice. It is our understanding that in dismantling structures that prevent the people we serve from accessing full health and opportunity, we not only contribute to improving their lives, but importantly, these investments improve opportunity for all Minnesotans.

NorthPoint recognizes that in focusing the report within a "race-first" framework, the authors had to make decisions about content to leave out. These omissions, while explainable in considering the necessary balancing of content, nonetheless have consequences for those experiencing inequality

In the report (p. 42) you note that "Persistent disparities in oral health are seen in among populations of color" *[sic].* At NorthPoint 's dental clinic we see the effects of structural inequality every day. The services needed by the people we serve across the age spectrum – not just our youngest clients - are often extensive *and* expensive. Inequality in dental care contributes deeply to inequality across health and well-being. One of the tools that Minnesota state agencies can use to address dental and other health disparities is equitable and need-based reimbursement to health care providers through Medicaid and other financial aid programs for services provided. Application of this reimbursement tool will go far to ensure that State policies do not continue to systematically deny populations of color access to the clinical and dental care they need.

An additional omission is found in the authors' neglect of adolescent health generally, and sexual health specifically. While the report briefly acknowledges health concerns related to high-risk behavior, sexual orientation and obesity, it ignores the high and increasing rates of sexually transmitted infections such as chlamydia, despite considerable clinical intervention. At NorthPoint we view this as a missed opportunity to highlight adolescent health, particularly since youth are often overlooked when policy discussions are being held. Those youth who live in neighborhoods of concentrated disadvantage face substantial social pressures that limit their ability to access and to use available services to support their health and well - being. Community agencies would welcome State investment in collective efforts to ensure that young people of color and those who are White have access to information and services they need.

Finally, we look forward to future technical assistance provided to community based organizations and clinics and to a more intentionally diverse State of Minnesota work force. Making changes at the local level to minimize silos, to work across multiple sectors and disciplines has a steep learning curve and requires considerable human investment. It is a new way of working for all of us. Staffs of Minnesota's state agencies should realize that structural racism is not a new concept for those of us living and serving in Minnesota's most disadvantaged communities. We recognize that poor health outcomes have multiple and complex causes and many of our organizations have been working for years to address these interrelated concerns. We hope that your agencies will go beyond "conversations" with us and be open to and actively seek technical assistance from us as well, as you begin to examine and correct policies and practices that have maintained health disparities.

Stella Whitney-West, MBA
Chief Executive Officer
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612-543-2575
Stella.Whitney-West@hennepin.us

January 24, 2014

Ed Ehlinger, MD, Commissioner
Minnesota Department of Health
625 Robert Street North
PO Box 64975
Saint Paul, MN 55164-0975

RE: Advancing Health Equity Report Feedback

Dear Dr. Ehlinger:

HealthPartners supports the leadership and work of the Minnesota Department of Health (MDH) to advance health equity. HealthPartners supports the six principles identified in the report to guide the recommendations. The strong community work, collaborations, and data already in existence demonstrate the robust base upon which we can continue to improve. HealthPartners also commends the report's recommendations.

We ask MDH to fully collaborate with other state agencies also focusing on health disparities. MDH is in an excellent position, for example, to collaborate on health equity with the Minnesota Department of Human Services (DHS). Programs, initiatives, data, advisory councils and task forces, and community input are all arenas in which these two important state agencies and leaders can demonstrate improved collaboration in the area of health equity. The new Center for Health Equity also provides an excellent mechanism for state agency collaboration and coordination.

In addition, HealthPartners asks MDH to look to, utilize, and align with existing state and community collaboratives. We are more successful as a state when we work through established and proven collaboratives (which often are public-private partnerships). Minnesota Community Measurement is one example. There is an existing infrastructure, there is existing community support, and there is collaborative discussion regarding priorities and initiatives. When the State is considering improvements to data collection, for example, we need to align with existing state collaborative and initiatives. We believe we do not need a new set of standards for data collection nor additional data collection. This would add a significant burden to data collection when there are still opportunities to optimize our existing, comprehensive, and available data.

Finally, it is helpful for Minnesota to monitor national initiatives, data, and results. Minnesota is a leader in health care and we also want to continue to improve. Participating in national learning collaborative

and monitoring national results supports our ability to continue to advance health equity for Minnesotans. Also, MDH could foster shared learning opportunities to promote equitable care, building on great examples of clinic, plan, and community-based collaborations around the state.

HealthPartners looks forward to continued work with the Minnesota Department of Health on the critically important mission to improve health equity for the State of Minnesota. Please refer to the attached appendices for summaries of the HealthPartners initiatives, investments, and results.

Sincerely,

Donna J. Zimmerman
Senior Vice President
HealthPartners

Attachments:

- Appendix I HealthPartners Equitable Care Triple Aim Approach
- Appendix II HealthPartners Health Equity Summary Report
- Appendix III HealthPartners Care Delivery Results

From: Maria Regan Gonzalez [mailto:m.reganglz@gmail.com]
Sent: Friday, January 24, 2014 4:31 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK.

Hello,

I would like to thank you for putting time and resources into the Advancing Health Equity Report and acknowledging that there is much work to be done in advancing health equity in the state of Minnesota.

You will find a list of comments and suggestions from multiple metro area residents in response to the draft report.

- Strong support for the report's recommendation for workforce development including 1. Breaking down barriers that inhibit community members from filling positions within local and state health departments. Supporting community members to develop and fill leadership positions within these agencies and in other community serving organizations is crucial, and 2. Comprehensive training in cross-cultural communications and collaboration for staff, particularly those who are new to working with groups and cultures different from their own and those who serve a diverse population base. Both efforts could be housed within the new center for health equity.
- The report places a strong emphasis on structural racism embedded within our culture, society and systems. As stated in the report, using a structural racism lenses can be effective in not placing blame on individuals. While this is true, it is important that individuals understand how their individual racism directly contributes to building racist systems, this point should not be overlooked.
- The Advancing Health Equity Report is full of excellent content explaining and walking through what health equity means, how structural racism contributes to poor health outcomes and concrete examples of disparities within the Minnesota community. It would be of great benefit to public health professionals, community members and decision makers to have access to a "health equity toolkit" designed for group to participate in in-depth learning about these concepts, evaluate health equity within their organization and community and create a plan to address barriers to advancing health equity. The MN Food Charter could serve as a potential model for community discussion, input and visioning for this process.
- ORGANIZE AND CONDUCT A PRE-GRANT PLANNING WORKSHOP
  - Participants: People who would fall into the health inequity category
  - Facilitor(s): Majority being culturally diverse
  - Use the participants input to base how the grant will be written.
  - Offer compensation (e.g. stipends, daycare, bus tokens, shuttle. healthy food)
- CONDUCT FOCUS GROUPS
  - Participants: People affected by health inequity and structural racism
  - Facilitator(s):Complimentary to the audience
  - Offer day and evening focus groups
  - Collect information expressing the needs of each group of people affected by health inequity, structural racism
  - Offer compensation (eg. stipends, daycare, bus tokens, shuttle, healthy lunch/dinner)

- CHANGES IN GRANT REQUIREMENTS
  - Allow more time for grantees to submit response
  - Offer in- person training on the RFP process/expectations
  - Hold trainings at local health agencies, community organizations, etc.

- REPLACE "GREATEST NEED" WITH "PEOPLE WHO FALL IN THE HEALTH INEQUITY CATEGORY"

  For equity in the health outcomes of persons to be possible, systems need to be in place that assure EVERY PERSON has 1) access to opportunity..... 2)capacity to make decisions.....3) social and environmental safety....4)cultural competent health care available." see page 3 of Advancing Health Equity n Minnesota: Report to the legislature.

- OFFER CAREER AND INTERNSHIP OPORTUNITIES THAT FOCUS AROUND HEALTH EQUITY

  Work with local community colleges and Universities to offer tuition breaks for community members enrolling in health equity focused programs

  Work with local community colleges and Universities to offer certification programs in health equity

  Work with local universities to address the lack of diversity in MPH students and other related fields

  Be more creative with public health postings to look outside required MPH or related degrees. Many community members have a wealth of experience and have the foundation and knowledge needed to be public health leaders but are rejected due to narrow requirements for positions. What skills set is really needed to advance health equity?

Please let me know if you have any questions. The comments come from multiple individuals and I wanted to make sure to get this to you on time.

Thanks,

Maria Regan Gonzalez

Minnesota Community Health Worker Alliance

CONTACT US

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Interim Director
Minnesota CHW Alliance
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cell: 612-250-0902
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January 24, 2014

Dear Commissioner Ehlinger:

On behalf of the board of the Minnesota Community Health Worker Alliance, thank you for the opportunity to provide feedback on the legislative report "Advancing Health Equity in Minnesota" drafted by the Minnesota Department of Health (MDH). We share our support for this report as well as offer feedback to strengthen MDH's recommendations.

By way of introduction, the Minnesota Community Health Worker Alliance is a nonprofit partnership that brings together community health workers (CHWs) and a broad-based set of stakeholder organizations to help achieve our shared vision of equitable and optimal health outcomes for all communities. We serve as a catalyst, convenor, partner and consultant to build community and systems' capacity for better health through the integration of CHW strategies. To learn more, please visit www.mnchwalliance.org and also see the accompanying infographic which displays our strategic directions.

CHWs are trusted and knowledgeable frontline health personnel who come from the communities they serve. They apply their training, culture, language skills, life experience and unique understanding of underserved communities to their roles which typically include culturally-responsive outreach, patient and community education, social support, informal counseling and advocacy. They also coordinate care, help patients navigate our complicated health system and address barriers to good health. In Minnesota, CHWs reflect our ever more diverse population in terms of race, ethnicity, culture, socioeconomic background, and life experience.

CHWs build individual and community capacity for better health, working downstream and upstream to help address the root causes of health inequity. They work in many different settings such as homes, communities, clinics, social service agencies, hospitals, schools and housing developments. They work under many different titles and serve patients of all ages. They bridge and link systems and communities, often serving as cultural mediators.

As a workforce with deep community roots and a long history but still new to many public health agencies and mainstream health providers, the CHW role is recognized as a health equity strategy by leading health authorities including the Institute of Medicine,

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the Center for Disease Control, the Centers for Medicare and Medicaid Services and the American Public Health Association, among others. In view of the growing body of evidence of CHW effectiveness, state public health agency leaders in the states of Massachusetts, New Mexico, and Oregon have prioritized CHW strategies to address health equity.

Here in Minnesota, the CHW field-building work of Alliance and its many allies is nationally-recognized. These key building blocks include:

- the nation's first and only statewide, competency-based CHW curriculum based in higher education, leading to a certificate recognized by the Minnesota Department of Human Services and the US Centers for Medicare and Medicaid Services
- CHW scope of practice
- Minnesota Health Care Program coverage for specific CHW certificate holder services to individuals and groups, delivered under clinical supervision
- Continuing education offered through the Minnesota CHW Peer Network.

However, greater support for role and its uptake by MDH, local public health agencies, providers, health plans and those in other sectors is needed to improve access to CHW services and help address persistent yet preventable health inequities in Minnesota.

Support for the Report

We'd like to express our support for the report and the implementation of its recommendations. We thank MDH leadership and your team for the inquiry process, the report's content, its tone and commitment to partnership and action.

We commend MDH for identifying and addressing structural racism as a central feature and for the formation of the new Center for Health Equity which is in line with other states such as Oregon and New Mexico.

And in view of the report's strong emphasis on collaborative and collective action, we look forward to partnering with MDH and others to further develop the initial plans.

Minnesota Community Health Worker Alliance

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Strengthening the Recommendations

The report draft references MDH leadership role across state agencies, community partnerships and business and industry relationships. It also speaks to the need for MDH to "encourage specific and visible steps to advance health equity across all sectors of Minnesota" (page 13). The root causes of health inequities are complex and require leadership along with multiple, sustained responses. The report describes key principles and initial starting-points with a focus on collaboration, leadership building, data collection efforts and the use of tools like health impact assessments. Alongside these major efforts, it's also important to include specific, proven health equity strategies that can be implemented now and contribute to closing the health equity gap today in culturally-competent ways—preventing suffering and premature death, contributing to quality of life and stronger, healthy communities.

One such strategy, integral to the larger, developing solution to health inequity, is the system-wide adoption and integration of CHW models by the health system and other sectors. We propose that MDH recommend the implementation of CHW strategies as an agency-wide, cross-cutting health equity priority for the state of Minnesota.

(1) We know that CHWs effectively address health equity. Please see the accompanying research matrix created by the Alliance's Research Committee co-chaired by Kathleen Call, PhD, University of Minnesota and Sueling Schardin, MPH, RD, Minnesota Department of Health which summarizes recent CHW studies in the peer-reviewed literature. In addition, the positive impacts of CHW interventions on health outcomes and costs based on a rigorous review of published studies are described in the 2013 report by the Institute for Clinical and Economic Review Effectiveness Review entitled "Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England" found at http://cepac.icer-review.org/?page_id=1066

(2) They help grow and diversify our public health, health care and social services workforce. Our model CHW curriculum based in post-secondary education also builds an educational pathway for CHWs interested in entering other health careers, building the pipeline mentioned in the report.

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(3) Team-based CHW strategies help address the Triple Aim (better health, better care, lower per capita costs) in culturally-responsive ways.

(4) As critical links and "mobile applications," CHWs cross sectors and deliver health benefits. For example, they help address key social determinants of health through their work in early childhood development, education, housing, employment, healthy food access, community development and other areas. They meet people where they are and help empower individuals and communities for better health.

(5) CHWs can also serve as helpful liaisons between the community and MDH, fostering communication and action that reflect and build on local assets, interests and needs.

On behalf of our board and our partners, thank you for your consideration of our feedback. We look forward to serving as a resource to MDH, the Legislature and organizations that share our commitment to health equity.

Sincerely,

Joan Cleary
Executive Director Interim

Enclosures:
Minnesota CHW Alliance Strategic Directions
CHW Research Matrix

MINNESOTA COMMUNITY HEALTH WORKER ALLIANCE

STRATEGIC DIRECTIONS 2014-2017

OUR CURRENT LANDSCAPE

Opportunities and challenges

- Increasingly diverse patient population and persistent disparities
- Health industry interest in Triple Aim and team-based approaches
- Metrics and payment reform focus on outcomes and total cost of care
- Growing recognition of need for clinical-community linkages and health equity strategies
- Workforce challenges related to expanded coverage and primary care shortages
- Broadening public and provider awareness of the role and benefits of community health workers (CHWs)

OUR ROLE

We serve as a catalyst, expert, partner, convenor and consultant

OUR VISION

Equitable and optimal health outcomes for all communities

OUR MISSION

Build community and systems' capacity for better health through the integration of community health worker strategies

OUR ASSETS

We will build on a decade of CHW field-building success in:

- Leading workforce innovation for improved access, lower costs and better health
- Galvanizing cross-sector partnership for model CHW education and payment
- Synthesizing and sharing CHW research and best practices
- Providing integrated CHW solutions and technical assistance
- Convening CHWs, CHW educators and CHW employers for shared learning
- Partnering to advance health equity

OUR FOCUS

Awareness-building: Increase the awareness of the CHW role in improving health outcomes, reducing total cost of care and improving community conditions of populations who are disproportionately affected by health disparities

Health Care, Public Health & Social Services Design and Delivery: Provide information and technical assistance to support the comprehensive statewide adoption and integration of CHW approaches across health care systems

Education and Research: Strengthen and broaden access to statewide competency-based CHW training, continuing education, interprofessional education and research

Policy: Expand the reach and positive impact of CHW strategies on health access, health equity, workforce diversity and the Triple Aim through federal, state, local and institutional policy change

Capacity-building: Grow and sustain our organizational capacity to effectively carry out our mission

OUR IMPACT

As a result of our partnership work, by 2017 we envision:

- Greater awareness of the CHW role and its benefits to communities and the health care field
- Increased integration of CHW strategies
- Growth in size and diversity of the health care workforce
- Increased expectations and accountability for health equity

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Minnesota Community Health Worker Alliance

From: Jacob Melson [mailto:JMelson@glitc.org]
Sent: Friday, January 24, 2014 5:27 PM
To: *MDH_Advancing-Health-Equity
Cc: Kristin Hill
Subject: Advancing Health Equity REPORT FEEDBACK

Hello,

Thanks for creating the *Advancing Health Equity in Minnesota: Report to the Legislature*. I have reviewed the report and attached my comments. Let me know if you have any questions.

Have a great day,

Jacob Melson, MS
Behavioral Health Epidemiologist
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- The report is very good! It is very long, providing a ton of information in various sections including complex abstract ideas and definitions; therefore, I wonder if it might be difficult for legislators who do not have a public health background to absorb all of this information, without getting lost or losing the point of the report.

- I wish someone from the Minnesota Department of Health would have contacted staff at Great Lakes Inter-Tribal Epidemiology Center about this project, and we were able to participate in the interviews.

- I wonder how many interviews were conducted outside of the Twin Cities?

- How many interviews were conducted with American Indian Tribes or American Indian urban organizations?

- The report includes a section on local data and some of the challenges with state level data not be being broken down to the county levels. Although it mentions local health departments conduct their own surveys, it doesn't mention any of the issues Tribes face in trying to find relevant data or efforts Tribes are making to collect their own Tribal specific data.

- Although the report mentions various populations who experience health inequities (e.g. American Indians, persons with mental health concerns, etc.), it only includes the word "alcohol" three times and the word "drug" once in the entire report! I am very surprised that "Persons with substance abuse or dependency issues" was not included as a population experience health inequities.

- I am excited to see how the Minnesota Department of Health will actually implement these recommendations. Right now with all the different sections and conceptual ideas, it is difficult to picture exactly how they are going to take action on each recommendation.

- Are any other departments, besides the Minnesota Department of Health required to implement these recommendations? I think there needs to be if Minnesota wants to truly address health equity.

- Are the recommendations only for the Minnesota Department of Health to implement? At times I felt like the report was geared only towards the Minnesota Department of Health; and at other times I felt the report was for all state departments, local community organizations, etc.

- Since overall wellness or health includes so many components (e.g. physical, mental, emotional, spiritual, etc.) I would give a copy of this report not only to chairs and ranking minority members of committees with jurisdiction over health policy and finance, but also to other committees such as transportation, housing, etc. Although it might be challenging for these individuals to

understand and absorb the entire report. Therefore, I might consider making an executive summary or suggesting they read specific sections of the report.

- I wish I had more time to review the report! I received an e-mail asking if I would give comments during the late afternoon of January 21, 2014. I do not think three days enough time to thoroughly review the entire report and give feedback.

- Good job! I'm really excited that the Minnesota Department of Health is working on addressing health equity instead of health disparities. I'm excited to see what will come of this project.

From: Marnie Falk [mailto:MarnieSFalk@gillettechildrens.com]
Sent: Friday, January 24, 2014 7:13 PM
To: *MDH_Advancing-Health-Equity
Subject: Advancing Health Equity REPORT FEEDBACK

I apologize that I missed the 4:30 PM deadline. I hope that you can still accept this feedback.

Attention needs to be paid to the system-based inequities that impact individuals with disabilities. There are growing financial disincentives to serve adolescents and adults with complex medical conditions who are on Medicaid and Medicare. The disincentives have the potential to widen the disparity in care. Individuals with mobility and spasticity challenges do not always get the preventative care their able-bodied peers receive and they encounter not only physical and programmatic barriers but also attitudinal barriers.

Thank you!
Marnie

Marnie Falk J.D. ▪ Government Relations & Advocacy
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-----Original Message-----
From: Lea Foushee [mailto:lfoushee@nawo.org]
Sent: Friday, January 24, 2014 8:41 PM
To: *MDH_Advancing-Health-Equity
Subject: report feedback

Late so you probably won't consider it, but

Health for Indigenous Peoples needs to include mental, spiritual, emotional and physical health. The whole being of a person if you can understand this.