MDH needs to partner with communities not only to innovate the health care system but to institutionalize health equity

(Community conversations)

Voices for Racial Justice (VRJ), as part of its contract with Minnesota Department of Health to support authentic community engagement, recruited 5 Health Equity Champions (HEC) to conduct conversations with members of the American Indian community, communities of color and LGBTQ in Minnesota. VRJ and HEC intentionally selected community members who were working on or thinking about health equity and could provide generalizable feedback from a range of perspectives. Still, the views shared may not be exhaustively representative of all community perspectives.

During June of 2015, a total of 24 conversations were conducted, including representation from the following communities: American Indian/Native American, Black-African American, African Immigrant, Asian Pacific Islander, Latino/Hispanic, and Lesbian Gay Bisexual Transgender Queer/Questioning (LGBTQ) Two-Spirit.

Purpose

In order to address health equity, it's indispensable we bridge the gap between systems and communities and meet at an equitable point. In conversations rooted in trust and commitment, community leaders openly spoke to HEC about the challenges their communities face in achieving health equity. The communities' voices and leadership set the tone and the power to transform these conversations into actions, serving not only all communities, but serving each community with the resources each community needs to address health disparities.

This project highlights communities' knowledge and wisdom related to health and health equity with the purpose of elevating and inserting this wisdom into the State Innovation Model (SIM). SIM is a joint effort between the Department of Health (MDH) and the Department of Human Services (DHS), with a goal to improve health in communities. We firmly believe Minnesota is in a unique position to be bold and innovative in creating, with community, the best health system that works for all Minnesotans and its future generations.

Health Equity

Health equity is a state where all persons, regardless of race, income, creed, sexual orientation, age, gender, or gender identification, have the access, opportunity and availability of resources to be as healthy as possible — to reach their full health potential.

In order to achieve health equity in Minnesota, members of the communities experiencing health inequities need to be part of the conversation, making decisions about their health. These communities need to be active participants and leaders of the plans, processes, solutions, and implementation of any effort to make health equity real and sustainable. Communities know best what is and what is not working in their communities and are able to craft their own solutions to build a healthy community.

Findings

Community members interviewed spoke in a very honest, open and direct way. Here's what they said:

Structural Racism needs to be addressed and recognized as causing and maintaining health inequities.	**Systems** need to not only look more like us, but have people who care and are invested in enacting real change.
	Health systems have to stop looking at people as commodities but as people.
	Bureaucratic barriers with the ACA and MNsure have been a frustrating process for many American Indians, communities of color and LGBTQ people.
	Access to care and cost of care are big challenges to achieve the best health possible.
Minnesota's health is not great for all. Communities of color are affected the most, but it affects the state as a whole – we are all Minnesotans.	**Health** has to be viewed through a holistic lens.
	Mental health, we need to ask, talk and act about it. We need to address it within our communities and health care systems.
	Culture is core to all communities and healthcare providers need to be trained in cultural competency.
	Patients of color, American Indians and LGBTQ want to feel **valued** within clinic walls, they want to be respected and validated.
Communities of color, American Indians and LGBTQ are looking for **action rather than words** and want to be involved in the process and decision-making.	To **engage** communities in Greater MN, social media can be used, but MDH needs to physically go to **build relationships**.
	MDH needs to work on **building trust** with communities of color, American Indians and LGBTQ.
	MDH needs to forge more **partnerships** with other systems and especially with community organizers/organizations.
	MDH also needs to **invest more funding** if they are going to see change happen.

Health Care and the Health Care System

Interviewees defined health as a human right, a state of balanced physical, emotional, mental, social and environmental wellbeing, as the ability to take care of yourself, to do the activities you want and need, a stage of equitable opportunities to resources, and to a healthy and dignified life.

Interviewees perceive the unfair and unequal treatment from the health care system as systematic and rooted in policies, procedures and interactions at the individual, organizational and structural levels. Interviewees mentioned structural racism is not only contributing to inequities in health, but also responsible for the mistrust of the system from communities.

Most interviewees find the health care system complicated and difficult to navigate. The health care system is not crafted with the patient in mind; it is a system that serves the medical and insurance companies' interest. Culture is core to addressing health in our communities. Culture competency means understanding our backgrounds, needs, language, sexual orientation, barriers and successes. Understanding and valuing our culture means incorporating our traditions, wisdom and healing in the co-creation of programs and solutions targeted towards each community.

Quotes from our conversations:

- Health is a human right.
- Definition of health needs to be holistic and include physical, emotional, mental, social, and environmental wellbeing. Health it's not just about "health."
- We need a common understanding (community & MDH) on defining things like health equity, and authentic community engagement.
- Healthy communities have equitable access to opportunities.
- "A healthy community is one where everyone has dignity."
- Traditional and alternative medicines are important for American Indians and communities of color.
- Culture is core to everything and is also core to health.
- "Who cares about big TV's and modern facilities, if we are dealing with culturally insensitive people?" Cultural sensitivity is sharing stories, giving respect. The health care providers don't understand the land or people of this land." (Native interviewee)
- There is a huge need for culturally competent healthcare providers (and bilingual skills!). Cultural competence needs to include LGBTQ community.
- Health care system is run by greed. Current system helps health insurance companies; it's not on the road towards health equity.
- Healthcare is not affordable.
- Healthcare system is very resistant to change.
- Current system is not set up for healing and empowerment of communities.
- People of Color get unequal treatment in the clinic, leading to poorer health outcomes.

- There is a need for the creation of safe spaces where people of color (POC) can feel welcomed and respected when receiving health services.
- Healthcare process is very bureaucratic, with a lot of red tape ("excessive regulation or rigid conformity to formal rules"), which perpetuates structural barriers and racism.
- Systems are racist and classist and these contribute to the lack of trust communities have on the systems.
- Interactions with the healthcare system have been complicated because of frustrations around processes e.g. MNsure.
- Mental health is an issue that needs to be addressed by the health care system and within communities of color.

A Healthy Community

Based on conversations conducted for this project, a healthy community includes:

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Barriers to Achieve Health Equity

Interviewees expressed barriers to achieve healthy communities as ranging from the affordability and access to health care to the availability of affordable housing and living wage jobs. An interviewee said the system *"lacks a serious assessment of structural barriers and*

racism creating health inequities. As a result, there is no development of processes, practices and policies to dismantle structural and institutional racism." Communities acknowledge the intricate process of policy-making, but understand the process is political, designed for the few *"to exclude the communities experiencing inequities."*

In addition, *"dealing with systemic and chronic inequities is time consuming and exhausting. Thus, many members of communities facing these challenges have no time for exercise, or for cooking healthy meals."* Our communities need to be and feel physically, mentally, emotionally and spiritually healthy. This type of health is achieved through and by a combination of all aspects of the human life – a living wage, safety and meaningful work, affordable housing, public transportation, less stress and communal support, opportunities to share and create healthy and sustainable interactions with one another, child and aging care, affordable and exceptional education, access to safe and enriching recreational activities, environmental and food justice and, more importantly, an environment that accepts people for who they are regardless of the color of their skin, sexual orientation, weight, socio-economic status, gender, age and disability. These issues cannot be addressed by health care system alone; it's a system's overhaul approach – an interdisciplinary and intergovernmental collaboration with a multifaceted and intersectional strategies.

Finally, mistrust of the system and feeling used are great barriers. If the community cannot trust their health care providers, they will not provide accurate information, include important details about their health and they may not be confident while needing to advocate for themselves. Below are some quotes from interviewees

- There is a lack of legislation and policies to address the unequal opportunities to be healthy.
- The process to develop policy is slow and political, and design to exclude communities experiencing inequities.
- There is a lack of serious assessment of structural barriers and racism creating health inequities. As a result, there is no development of processes, practices and policies to dismantle structural and institutional racism.
- Classist systems and capitalism impede the progress of our communities, because people are not seen as people.
- Interviewees expressed great distrust in systems like the health care and MDH. There is great frustration out of perceiving those systems have no interest in their personal lives.
- Dealing with systemic and chronic inequities is time consuming and exhausting. Thus, many members of communities facing these challenges have no time for exercise, or for cooking healthy meals.
- It takes an interdisciplinary approach to bridge these gaps. MDH needs to have intentional interdisciplinary collaborations/ conversations as well as the other initiatives. It takes a combination of strategies.
- Health care cost is high. There is a lack of access to health care.

- There is a lack of representation of American Indians and POC in leadership positions within the health care system and MDH. Furthermore, communities experiencing inequities are not part of the health equity conversation or decision-making tables.
- There is a lack of cultural sensitivity, and cultural competence within the Health Care System.
- There are challenges to decolonize, restore food systems, and revitalize the language.
- Accessibility to healthy and affordable foods.
- No opportunities for/ lack of affordable housing.
- Low-wage jobs/job insecurity/lack of jobs.
- Lack of translators, and in some cases lack of well-trained translators.

Community Solutions

Communities know about their challenges best. Community leaders, members and professionals (of all ages) need to be heard and the system needs to listen. There is great value in systems recognition of failures, ignorance and embracing criticism. The system has and it will continue to fail communities as long as it doesn't acknowledge its wrongdoing and commits, with actions, to create a paradigm change in its vision and relationship with community.

Communities want and are eager to build health equity in partnership with the system. Interviewees emphasized the need for relationship building, community collaborations and partnerships, cultural competency, and trust building. There is a big need of health care providers who look like us and a gap on their leadership positions and their decision making power. The health care system should collaborate with educational institutions to create and support career pipelines for providers of color, American Indians and LGBTQ. The health care system needs to address and understand trauma, as well as co-create healing solutions for it.

Quotes from our conversations:

- Communities have solutions to issues impacting their health, but need to be HEARD & systems need to LISTEN.
- Systems need to show up, invest time and resources, develop and maintain relationships, work on communities' availability of time. Time is a highly prized resource, if systems truly want to engage with the community, they need to operate on community time.
- Connect with organizers and organizations that are already doing great work, and PAY THEM.
- Acknowledge that structural racism is prevalent and impeding health equity.
- Community needs to be acknowledged, respected, valued, and heard.
- Assess what are the best and most effective ways to communicate with a particular community. For instance, in Greater MN social media could be the venue to spread awareness of initiatives.

- Making systems accessible: having it be more representative of the communities they serve.
- Creating pipeline programs that allow people of color to get into healthcare systems.
- Systems need to partner with the community.
- Treat communities with dignity.
- Systems need to identify and support champions who are invested in the work (e.g Indian Infant Mortality Review).
- Community Health Clinics that are doing great work to the communities that they serve.
- Companies/businesses that don't adhere to MDH health equity standards should be penalized.
- Health Care System and MDH need to address trauma and its relationship to health.
- System needs to acknowledge and embrace communities' wisdom, and communities' ability in creating health e.g. Traditional medicine and faith-based healing.
- Health care providers need to stop shaming practices and stigma, and offer programs that are fun and engaging instead.
- Young people are key players but there are barriers in getting them introduced to the work.
- Develop or connect with media outlets that communities will actually use, some communities listen to the radio more than they use internet services.
- There is a growing support for urban gardening initiatives.

Current Programs/ Initiatives/ Efforts Addressing Health Equity

Interviewees were asked about their knowledge of programs/initiatives/efforts that are successfully addressing health inequities. Here are some of the things they mentioned:

- UMN – is doing work around mental health in AAPI communities.
- Rainbow Health Initiative is working on insurance access for transgender individuals.
- "Create Community" – a multiracial, multicultural table of leaders in St. Cloud addressing racism.
- Vida Sana (in Waite House): is a programming that invites whole families to join healthy living activities while cultivating connections to community.
- CLUES has a program called "Aging Well Services" giving services that are respectful to Elders while promoting health. CLUES is also renting bikes and baby strollers.
- Cradle Board Project, an initiative to reduce SIDS.
- Wilder is currently working on increasing food access and supporting gardening.
- Seward Co-Op is working on Economic equity/Food justice.
- "Health Fellowship," program aimed at ending tobacco disparities.

About MDH

The communities' solutions, barriers and criticism towards the system and health care system are also applied to MDH and its work. Some community members believed MDH is doing a good job, some expressed MDH is not doing a good job, and many said that it seems MDH wants to do the right thing but doesn't know how. In addition, most community leaders interviewed were unclear about MDH's role in achieving health equity. As mentioned above, interviewees expressed the root of health disparities is structural and institutional racism, which makes the systems like MDH unable to change, adapt and accept its mistakes. Equity should be institutionalized and meaningful data should be collected and shared with communities to empower and co-create change. Policy should be developed with community and "policies without programming and implementation are not enough."

MDH needs to invest in communities and foment a collaborative interdisciplinary environment. MDH's work with communities needs to be intentional, meaningful, based on relationships and trust and it needs to pay them. Communities knows best about community issues.

- MDH **not doing** a good job to advance health equity.
- MDH **wants to do** the right thing but just doesn't know how.
- **it's good that** MDH is starting to have this **conversation but** want to remind people that health disparities are caused by systems (white supremacy, capitalism, etc.), and those can only be changed by **engaging** the community as a whole.
- **Structural and institutional racism** must be addressed to achieve health equity.
- MDH needs to **institutionalize equity.**
- 'MDH has to realize that **criticism is a gift** and that MDH could learn a lot by listening to the criticism from the community.'
- 'MDH needs to **collect more meaningful data and then disseminate that information to community leaders** who can then interpret the information to their communities and they can empower themselves to make changes.'
- MDH needs to **educate communities about its role** and place within the health care system.
- **Policies without programming** and clear implementation are not enough.
- MDH needs to **develop policy** with community.
- MDH needs **to address environmental stressors, and historical trauma**.
- MDH is perceived as not addressing **social issues.** MDH needs to **address social issues** that are contributing to health inequities.
- MDH needs to **fund/take action** instead of merely talking about the benefits of health equity.
- MDH needs to truly **INVEST i**n American Indian and Communities of Color.
- MDH needs to 'create a more **collaborative environment** where organizations don't need to be fighting against each other to obtain a grant."
- MDH needs **an interdisciplinary** approach in solving health inequities, which needs to include work with other government agencies.

- MDH needs **to partner with more organizations** that know how to engage communities.
- There is a critical need to see **MDH and communities** developing creative solutions to achieve health equity.
- MDH **needs to engage in building trust** among communities.
- MDH needs to **hire community members** who are from communities experiencing inequities and who KNOW their communities. MDH needs **to look more** like the community.
- MDH needs to collaborate with **community leaders trusted by communities *AND PAY THEM!**
- Many community members just don't have time to be **engaged** because overcoming the burden of inequities is putting many in survival mode.
- Communities should **get paid** to have these conversations.
- MDH needs to be more **intentional about the work with refugee** and immigrant communities.
- MDH should use social media to **engage communities** in Greater MN.

Conclusion: based on VRJ's experience providing technical support to the State Innovation Model might be doing a good job around innovation within the health care system. However, based on the conversations we had as part of this community engagement effort, SIM is missing the opportunity to be part of the intentional work to tackle health inequities in MN. Communities are ready to work shoulder to shoulder with systems like MDH and DHS, and are very interested in achieving health equity in MN. Nevertheless to be able to work together SIM staff needs to develop a trustable relationship with communities, and to commit to address institutional and structural barriers.

Health Equity Champions for this project

Sara Cronquist, Ana Isabel Gabilondo, Gabriel Glissmeyer, Martha Ockenfels-Martinez and Lisa Skjefte

Attachments: suggested script to contact community member; SIM Script, questions & guidelines for community interviews; VRJ.SIM Definitions Sheet and 24 Interview Summaries