***Community Leaders’ Perspectives of Health, Quality Primary Health Care,  
and Payment Based on Quality Measures***

**Report to Minnesota Department of Health**

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**Executive Summary  
*Community Leaders’ Perspectives of Health, Quality Primary Health Care,  
and Payment Based on Quality Measures***

*Background* Responding to a changing health care environment and the development of new federal standardized measures for Medicare, the 2017 Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop a new framework for measuring health care quality. MDH recognized that developing a new framework requires consultation with stakeholders and communities. To help bring these perspectives to MDH, the Minnesota Health Care Safety Net Coalition’s Quality Measurement Enhancement Committee (QMEP) and West Side Community Health Service’s Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo) brought together community leaders from diverse urban communities to express their views and perspectives.

*Overall Objective*

Identify how community leaders from diverse urban communities in Minnesota characterize quality primary health care so that MDH and the Minnesota legislature can consider these characteristics as they design a new statewide quality framework to be used to measure and report health care quality.

*Methods and Analysis*

QMEP convened a Community Engagement Team consisting of one community member from each of seven urban communities —Black/African American, Gay-Lesbian-Bisexual-Transgender-Two Spirit-Queer (GLBTTQ), Hmong, Latino, Native American, Somali, and White—and two additional community-based researchers from SoLaHmo. We proposed a two-phase CBPAR process to gather from community members’ perspectives about quality primary healthcare: an initial Phase 1 of listening to community leaders’ perspectives (designed to respond to a 5-month time frame and a $25,000 budget) and a follow-up Phase 2 to elicit community members’ experiences and desires. Community Team Leads from these seven urban communities each identified and recruited 3-4 community leaders from their respective communities to attend a 4-hour listening session. Two listening sessions with a total of 19 people occurred, in addition to 1 individual interview, for a total of 20 participants. The listening sessions consisted of an introduction about quality measures, guided small group community-specific discussions, and a large group sharing of major points. The small community leader groups discussed 3 topics: definition of health; characteristics of quality primary health care; and aligning payment with quality. The individual interview consisted of an introduction about quality measures, and a guided interview about the same topics discussed in the small group discussions. The Community Engagement Team analyzed the listening sessions and interview information by coding the small group and large group discussions, identifying the major themes, documenting examples and quotes for the major ideas, and obtaining input on the analysis results from community leaders who attended the listening sessions. The final step was mapping the themes to both MN Department of Human Services’ (DHS) November 2017 proposed measurement categories in Table #2 of the *Outcomes-Based Purchasing Redesign and Next Generation IHP (Integrated Health Partnership)1* and to the health equity domains in the National Quality Forum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities2*.

*Results*

Topic 1 - Community Definitions and Experiences of HealthHealth goes beyond physical health to include mental and spiritual health. Communities’ health is impacted by historical trauma, current institutional racism, and pervasive social injustices.

Topic 2 - Characteristics of Quality Primary Healthcare ClinicsFive major themes emerged about the ideal characteristics of quality primary health care, each of which can be linked to known health care quality measures.

#1: Quality primary healthcare clinics have respectful trusting relationships with patients and communities  
1.1. Clinics support long-term continuous clinician-patient relationships

1.2. Skilled clinicians provide culturally responsive/respectful care and are attuned to discovering and not acting on their unconscious biases

1.3. Clinics provide culturally responsive training for all staff

1.4. Clinics allocate adequate resources, including adequate time and interpreters, to support effective clinician-patient relationships

1.5. Clinics create welcoming, private, and safe clinic environments

1.6. Clinicians are medically competent and do not harm people

#2: Quality primary healthcare clinics identify and address historical trauma, structural racism, and social-structural determinants of health

2.1. Clinics recognize and address historical trauma and structural racism through evaluation, training, monitoring and accountability

2.2. Clinics identify SDOH and create clinic systems that respond to people’s needs

2.3. Clinics create clinic-community collaborations to address SDOH

2.4. Clinicians recognize and address historical trauma and SDOH

#3: Quality primary healthcare clinics have structures and processes that support health equity

3.1. Clinic systems have representation from their patient populations

3.2. Community members have real representation, with influence and power

3.3. Clinics report on health disparities and equity data, goals, and efforts

#4: Quality primary healthcare clinics prioritize culturally responsive mental health, health promotion, and patient education

4.1. Clinics expand mental health services across all areas of healthcare4.2.Clinics integrate family-based strategies for health promotion

4.3. Clinic staff provide culturally relevant education

#5: Quality primary healthcare clinics provide access to care, with patient-centered integrated services and system navigation

5.1. Clinics support access to care

5.2. Clinics support solutions to high cost of care, which is a fundamental barrier to access to care

5.3. Clinics provide integrated health care services

5.4. Clinics provide transparent clinic processes

5.5. Clinics communicate effectively with all patients

Topic 3: Aligning State Funding with Results of Quality MeasuresA system of measuring quality and then paying based on quality scores supports the inequitable societal situation where impoverished patients and communities that need more resources to achieve the same health care outcome get fewer resources, and those without greater needs receive more, when the exact opposite is needed.

*Application*

These five ideal characteristics of quality primary health care clinics can be used to measure, evaluate, respond and improve quality healthcare. To show how the NQF Health Equity Roadmap aligns with quality measures that may be used for the state’s health care programs (Medical Assistance and MinnesotaCare), Table #1 (page 28) maps the five ideal characteristics both to the DHS November 2017 proposed measurement categories and to NQF’s domains of health equity measurement. Since Phase 1’s one listening session was inadequate for the community leaders to both articulate their ideal characteristics and grapple with how to measure them, the community leaders did not endorse any specific measurements. However, NQF document lists dozens of quality measures that DHS could consider using to measure quality in primary health care.

*Discussion*

By inviting community members to share their expertise, experiences, and knowledge about their communities’ definition of health, characteristics of quality primary care clinics, and how states should align funding to quality measures, we are able to understand and succinctly describe how these communities view quality primary care clinics. The quick pace and minimal resources for this CBPAR project, however, severely constrained our ability to present a full, rich and comprehensive analysis of the perspectives of the various groups and communities of Minnesotans who are currently experiencing deep disparities in health care access, quality and outcomes. These communities and their leaders expressed frustration and anger by the lack of resources and commitment that is given to ensuring that all Minnesotans are represented in policymaking and health care decision-making for improving both healthcare quality and the overall health care system. If the state, policymakers and health care leaders truly want better health care for all Minnesotans, they need to make this a high priority – which means resources and time to do this the right way both now and ongoing into the future.

*Conclusion*

Community leaders from seven urban communities (Black/African American, GLBTTQ, Hmong, Latino, Native American, Somali, and White) generally defined health as being beyond physical health and including spiritual, mental and social aspects of life; identified a range of ideal characteristics of quality primary healthcare that dovetail with the health equity issues identified by National Quality Forum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities*; and expressed concern that directly linking clinic payment with clinic quality metrics without considering communities’ social situation could perpetuate current social injustices in the health care system where privileged communities have better health care measures than impoverished communities. A truly community-informed legislative process to create a new quality metric system requires adequate time, energy, and resources for community-engaged processes, beyond this Phase 1 process. In addition, institutionalizing the resources and processes for full and authentic engagement of these communities is required for all policymaking if Minnesota is going to create an equitable health care system.

**Full Report  
*Community Leaders’ Perspectives of Health, Quality Primary Health Care,  
and Payment Based on Quality Measures*   
  
Background**

The current system of measuring healthcare quality in Minnesota has evolved over time, from the early days of the Buyers’ Club, to Minnesota Community Measurement (MNCM), to Minnesota’s statewide standardized measures mandated under the Statewide Quality Measurement and Reporting System (SQRMS) to today’s world of “pay for performance” and Accountable Care Organizations where provider payment is tied to quality of care. Responding to a changing health care environment and the development of new federal standardized measures for Medicare, the 2017 Minnesota Legislature directed the Minnesota Department of Health (MDH) to develop a new framework for measuring health care quality. MDH was directed to consult with stakeholders and communities in developing the new framework. One necessary step in this process is to elicit perspectives of different racial, ethnic and cultural communities who are impacted by health disparities about quality primary health care, about measuring quality and about tying financial payment to quality care. To help bring these perspectives to MDH, the Minnesota Health Care Safety Net Coalition’s Quality Measurement Enhancement Committee (QMEP) and West Side Community Health Service’s Somali, Latino and Hmong Partnership for Health and Wellness (SoLaHmo) brought together community leaders from diverse urban communities to express their views and perspectives. During the project, the Minnesota Department of Human Services (DHS) released Request for Public Comment on *Outcomes-Based Purchasing Redesign and Next Generation IHP (Integrated Health Partnership)1* a proposed purchasing system for services provided to people enrolled in Minnesota health care programs including Medical Assistance and MinnesotaCare, which we considered in reporting the findings. We also considered the findings in National Quality Forum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities2*, particularly the health equity domains.

**Objectives**

*Overall objective:*  
Identify how members from diverse urban communities in Minnesota characterize health and quality primary health care so that the Minnesota state legislature can consider these characteristics as they design a new framework to measure and financially reimburse primary clinics for quality care.

*Specific objectives:*  
1) Engage community members from seven urban communities (Black/African American, GLBTTQ, Hmong, Latino, Native American, Somali, and White) that experience a high burden of social and structural determinants of health (SDOH) in a community-based participatory action process (CBPAR) to

2) Identify their definitions of health  
3) Identify their perspectives about what quality primary health care means for them, and   
4) Identify their thoughts about aligning payment with quality measures in order to inform the MDH process of building a new framework for healthcare quality measures in Minnesota.

**Methods**

QMEP convened a Community Engagement Team consisting of one community member from each of seven urban communities —Black/African American, Gay-Lesbian-Bisexual-Transgender-Two Spirit-Queer (GLBTTQ), Hmong, Latino, Native American, Somali, and White—and two additional community-based researchers from SoLaHmo. We proposed a two-phase CBPAR process, responding to a 5-month time frame and a $25,000 budget ($20,000 from MDH supplemented with $5,000 from American Heart Association). Phase 1 is an initial process to conduct listening sessions with community leaders from the seven urban communities to elicit their perspectives about their communities’ experiences related to quality health care. Phase 2 is a proposed future process for larger numbers of community members to reflect and expand upon the community leaders’ perspectives.

For this Phase 1 project, the QMEP Community Engagement Team used a CBPAR approach to discuss and decide the goals, the format of the 4-hour listening sessions, and the small and large group discussion questions. Each of the seven QMEP Community Team Leads from the seven urban communities identified and recruited 3-4 community leaders from their respective communities to attend the community listening sessions. The process culminated in two four-hour “Listening Sessions” that were designed to elicit these community leaders’ perspectives about quality health care. (Appendix #1: Listening Sessions.) The listening sessions consisted of an orientation to the topic of quality measures in healthcare; community-specific small group guided discussions led by their respective QMEP Community Team Leads; and then a large group discussion about the major points from each small group. Information from each small group was captured by audiotape and by community member note takers and information from the large group discussion was captured by the note taker, supplemented by the written notes of each small group’s priorities.   
  
We inquired about community’s experiences with primary healthcare and did not include specialty care or hospital care because: all participants would have experiences with primary health care; focusing on one area would be more doable in the limited time frame; and because the Minnesota Association of Community Health Centers was sponsoring the study. We focused on eliciting community leaders’ perspectives about quality care and did not explore their perspectives about current MN quality measurements because: people’s prior understandings of quality measures may be limited, and there would be insufficient time in one 4-hour listening session to orient people to the measures and get their input. The small group questions were designed to elicit people’s ideas about 3 areas: 1) how their community defined health; 2) what their community wants in quality primary health care; and 3) what their community thinks about the state aligning payment with results of quality measures. We obtained input about the questions and listening session process from MDH in writing and in a face-to-face meeting.

**Qualitative Analysis**

Each Community Engagement Team Lead read the small group discussion notes from their note takers, listened to their audio-taped sessions, and expanded their notes to reflect the full content of each small group discussion. They subsequently coded these expanded notes according to a coding tree based on National Quality Forum’s 2017 Health Equity Framework and then entered their codes on to one spreadsheet, so that the ideas from all 7 groups were collated in one place. Reflecting on the ideas that emerged in the large and the small group discussions, the Community Engagement Team collectively identified the major themes for each of the three topics and then used the coded discussions to enhance the themes. The five major characteristics of quality primary health care clinics were ordered based on each communities’ prioritizations. We wrote preliminary results and sent them to 17 Community Leaders from the listening sessions who had expressed interested in reading and giving input on the results. The 7 people who responded expressed agreement with the major themes and gave additional input, which we included in the report. The final step was mapping the themes to both DHS’ proposed measurement categories in Table #2 of the *Outcomes-Based Purchasing Redesign and Next Generation IHP (Integrated Health Partnership)1* and to the health equity domains in the National Quality Forum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities2*.

**Results**

The Listening Session attendees described themselves as follows:

* Gender*:* 11 women, 7 men, 1 transgender, 1 non-binary
* Age:Participants ranged from 26-65 years of age (7 people 20-39 years; 11 people 40-59 years; 2 people =>60 years)
* Community leaders: 3 Black/African American, 3 GLBTTQ, 3 Hmong, 4 Latino, 1 Native American, 4 Somali, and 2 White
* Ethnic/Tribal identity: Participants further self-identified as: 3 African American, 1 Muslim Somali American, 1 Somali, 1 Somali/Black, 1 Asian, 1 Caucasian/white/western European, 1 white/European American/western/Caucasian/assimilated; 1 Citizen of the planet, 1 Hispanic Latina, 1 Latina, 1 Hmong, 1 Korean American, 1 Latino/Colombian/International, 1 Mixed race/Intersectional Person of Color, 1 Native American-Rosebud Sioux, 1 Non-Applicable, 1 Red Lake Ojibwe/Anishinaabe, 1 South American
* Country of Origin: 8 USA, 4 Somalia, 2 Colombia, 2 Laos, 1 Chile, 1 Korea, 1 Peru, 1 Turtle Island
* Languages Spoken: 13 English, 4 Somali, 4 Spanish, 3 Hmong, 1 Swedish, 1 colonizer language. Also, 8 participants speak 2 or more languages
* Community Leader Roles: 9 Advocates (sexual assault, oral and other health disparities, anti-poverty, Latino community, diverse communities, ISD #196, diverse communities, Mother of the Viking), 5 Mental Health Professional, 3 FQHC Patient or Non-Profit Board Member, 2 Homecare Services Administration, 2 Community/Political Organizer, 1 Teacher, 1 Block Club Leader, 1 Fundraiser, 1 Health Care Administration, 1 Social Services, 1 AA Sponsor, I Interpreter/Translator, 1 Business Owner, 1 Arts, 1 Health Educator, 1 Elder, 1 Mentor, 1 Political Leader, 1 Student

The listening session results are presented by the three topics covered in the small group discussions:*Topic #1:* Community definitions and experiences of health, *Topic #2:* Characteristics of quality primary health care, and *Topic #3:* Aligning state funding with health care quality.

***Results Topic 1:* Community Definitions and Experiences of Health**

Most community leaders described how their communities define health beyond physical health, including mental health and spiritual health, and they emphasized the need for patient and community education about healthy lifestyle practices that can prevent diseases and promote health. They also described the concept of health as being less specific to a state of being in good health, but rather defined by the absence of physical pain, the ability to tolerate existing pain, or even simply being able to stay alive. Most community leaders discussed how historical trauma negatively impacts the health of their communities, as these have contributed to the current social situation with institutional racism, structural inequities, and social injustices, all of which leave communities of color with more diseases, more challenges to health, more challenges to access health care, and lack of trust in the health care system and providers.

*Black/African American:*

* “For me, if I feel good, I am healthy, even if I may have things around me which may not be good, if I feel good, I am healthy.”
* “For many people, health is defined as ‘I do not have to go to the doctor’. As long as you do not need to go to the doctor, it is considered to be healthy.”
* “Being healthy could be that, despite feeling pain, if the individual has gotten accustomed to that pain and is managing it, it means that the person is healthy. It is part of life. You may say, ‘it runs in the family.’ Why do I have to go to the doctor if I can deal with this myself?”

*GLBTTQ:*

* “Being fully who you are.”
* “Spiritual health, it’s not just physical but spiritual/emotional health. Western medicine just picks us a part and only deals with the physical self.”
* “(It’s also about) chemical health…and sexual health.”
* “Health is waking up in the morning and actually falling asleep at night. Beating out the odds of death is health.”
* **“**Health is about beating the norm and being seen as a person and not seen as an oddity…***.***(I) do not go in (to the clinic) unless I have to go. I have many friends (who) don’t go to clinics. They don’t feel safe and feel they could be physically attacked in public, as some of them have been physically assaulted just by walking down the street, going to the grocery store, doing things that other people normally don’t have to think about as far as safety....In the clinic, if they do go, are their pronouns going to be respected? Are they going to be treated as a person, not as this oddity? This is the reason for so many ER visits. Preventative care is important, but there are these safety barriers.*”*

*Hmong:*

* “We are a spiritual people. If a doctor or clinic won’t let us follow our spiritual/traditional beliefs even after we explain how our beliefs might affect our health, and we explain to the doctor and they turn us away saying “No, that’s no such thing” (then we close down.) But if a doctor knows and understands and says, “Okay, if that is what you think, then how about we can use both spirituality and medicine?”, this can help us open up.., . (and) we can seek help in all areas. This is really important for Hmong, especially for those who still believe in the traditional ways.”
* “(W)e don’t know about prevention. We don’t understand the effects of other things (on health), such as conditions of the home, or we don’t know about food contamination and sharing foods. We don't have knowledge of how healthcare can help or begin understanding the effects of our daily lives on our health.”

*Latino*:

* “From the individual perspective, health is a sense of harmony, encompassing physical, spiritual and financial wellbeing. From the community perspective, Latino community sees health beyond health itself and expands to people who are important to them and support them, primarily family and friends who they feel comfortable talking about health issues.”
* “Latino people think of health as not having any illness. So, a person may not have access to services but since he/she does not have any illness, they are thankful because they feel that they do not have to go to the doctor.”

*Native American:*

* “The Native defines health in terms of wellness, in terms of holistic, mental, physical, spiritual, ancestors, looking into past as well as future. (Health is) about community, not really (about the) individual…We see being healthy as a right…it was written into our treaties and we see this in our (Native) teachings.”
* “If we constantly think about the notion of who’s healthy and who’s not, then our concept of ourselves is distorted. We have to decolonize everything. We have to get native people to a lake to walk around it. To some of our people, that is a white thing to do and we have to remind them that this has been our land. We’ve always roamed it, we’ve always foraged, and we’ve always hunted. When we’re trying to negotiate our health needs, we have to decolonize how we talk about fitness, how we talk about health and these concepts, especially in a community that is always in crisis mode. Our community is constantly trying to survive colonization because we are still being colonized.”
* “Health and healing are synonymous, either from historical or daily traumas. In native communities, we see how trauma impacts our health, even though we don’t have the words for it, we see how trauma is a part of the story of our health. We define health by understanding how policies and racism impact our health because we have a general notion – treaty heavy in this area, sign treaties to ensure healthcare, to be healthy is a right – we know this in our teachings. Native communities struggle with being worthy of even being healthy and that’s in the same vein as trauma.”

*Somali:*

* “Beyond pain, it’s mental anguish....I don’t think people see that as being unhealthy but (rather as being) unwell.”
* “When you are physically unwell you see doctor but (when) mentally unwell, you see religious leader.”
* “If you are not in pain, you are not sick. If you don’t have any pain, you don’t have to go to hospital.”
* “I see that the older generation still has mistrust for doctors. For example, if I go to urgent care, my mom will tell me ‘Don’t go or else they will take your kidneys’. They believe crazy things that don’t happen, that doctors are out to get them. .... So, they prefer to take advice from family member or friends instead of primary doctors.”

*White:*

* “Health is what you think of after you figure out your financial situation. Your health comes after the expense of all the other things in your life, like keeping the lights on or juggling two jobs and trying to get to a clinic that closes at 5, but it’s the sliding scale clinic in your neighborhood where you could afford to go if you don’t have insurance. If you could just get through another day of what is aching inside if you and you know you need to get it checked out, but you don’t because you’re scared of what it might cost. It can start off at a minor problem and you wait so long that it becomes a major problem.”

***Results Topic 2:* IdealCharacteristics of Quality Primary Healthcare Clinics**

Five major themes emerged about the ideal characteristics of quality primary health care.

#1: Quality primary healthcare clinics have respectful trusting relationships with patients and communities

#2: Quality primary healthcare clinics identify and address historical trauma, structural racism, and social-structural determinants of health

#3: Quality primary healthcare clinics have structures and processes that support health equity

#4: Quality primary healthcare clinics prioritize culturally responsive mental health, health promotion, and patient education

#5: Quality primary healthcare clinics provide access to care, with patient-centered integrated health care services and system navigation

**#1: Have Respectful Trusting Relationships with Patients and Communities**

**1.1 Clinics support long-term continuous clinician-patient relationships**

Patients want long-term personal relationships with their primary care clinicians. They want a relationship where they are respected and known as individuals, their concerns are listened to and not dismissed, their bodily knowledge is respected, and their life choices are incorporated. They want support and advice for their acute and long-term health concerns, mental health issues, chronic diseases, preventive care, cancer screening, healthy lifestyles, and commitment to overall wellness.

*Black/African American:*

* *“*If a person is not treated well at a clinic, that person will not come back. On the other hand, people will come back to clinics where they feel they are valued and treated well.”
* “People do not want to share a lot earlier in the relationship. The relationship must be built to have trust. Some clinics develop trust faster than others. If you trust the clinic you will be able to share more, your whole experience.”

*Latino*

* “Patients prefer to see the same provider regularly so as to form a trusting relationship. But when the scheduling staff does not or cannot schedule appointments with same provider, then the patient usually does not share information that may be relevant to the reason for the visit.”

*Somali:*

* *“*My sister recently had a miscarriage and from the moment she walked in and out (of the clinic) the relationship she had with not just with receptionist, (but also with the) doctors and nurse there was the sense that they were very open and welcoming. (They conveyed) trust and being open with patient. Having that relationship makes you want to come back.”

*White:*

* “With addiction, it’s easy to be sober in the doctor’s office, it’s hard to be sober out there. I’m a big believer of the 12 steps. It’s work for many people. In the medical community, it seems that they want to solve it medically instead of saying, “we don’t know why this works, but if you go to these meetings 2-3 times a week, your life gets a lot better. It’s free, it’s in your neighborhood.” It’s that continuum of care. There’s a lot of drug and alcohol care in our communities that are 6 month based and it might be really effective in those 3-6 months, but in my opinion, it’s longer than a 3-6 month battle. When you have a lot of those social and economic challenges and handicaps, that continuum of care is (crucial).”
* “For those with drugs and alcohol problems, if you don’t have a supportive environment, it’s easy to slip back into using again. Creating the supports for long-term health is really important. Like mental health, one thing is to have a regular schedule with a provider. If you can only get it once a month, it’s hard to follow up with the positive that you’re getting from it. Sometimes that relationship ends when you decide you can only go so far with a therapist or the therapist thinks they need to end the working relationship.”
* Quality care could look like a lot of different metrics, you have someone who is a chronic ER attendee, and now no ER visits in the next 6 months, by definition that’s a positive outcome….For alcoholism and addiction, it’s long-term sobriety, for me 90 days is great, but what’s going on after that? A lot of times that’s not what’s measured, as much as it should be, it’s the race to 6 months and then “they’re good.”
  1. **Skilled clinicians provide respectful culturally responsive/respectful care, and are attuned to discovering and not acting on their unconscious biases**  
     Patients want to feel valued and respected as individuals, without being stereotyped and demeaned. They want to be given culturally respectful and appropriate information, which could lead to increased trust, hopefulness, shared decision making, and follow through with health care plans and goals. Patients (particularly from these communities) too often feel stereotyped, discriminated against, vulnerable and unsafe. To provide respectful patient-centered care, clinicians need to be aware of their conscious and unconscious biases, be open to learning from all patients, and act towards all patients without making assumptions and without stereotyping. Specifically, clinicians can benefit from learning about a group’s historical past, culture of health, and traditional cultural healing practices (herbal medicine, massage, prayer, faith healing).

*Black/African American:*

* “Respect for elders, how the staff in the clinic acknowledge you, instead of calling you by your first name….I know that this is not the culture, but treating a client as Mr., and Mrs. first is respectful and you may give permission to call you by your first name.”
* “Clinics provide optimal personalized patient-centered care for each patient, which fits their culture, priorities, desires, and needs.”

*GLBTTQ:*

* “Health is about beating the norm and being seen as a person and not seen as an oddity. For example, I have the experience of a doctor calling in other doctors because they had “never seen one of you before”. [reference to a gender non-conforming person/trans person].
* “Western medicine just picks us a part and only deals with the physical self….and some doctors have really bad mojo…they’re misogynist…racist.”
* “Health is about beating the norm and being treated as a person and not seen as an oddity. For example, I have the experience of a doctor calling in other doctors because they had “never seen one of you before.” And it was…absolutely horrible for them, and it traumatized them to the point where they were like ‘I don’t even want to go in unless I have to’…so those ER visits…there’s a lot behind that [reference to a gender non-conforming person/trans person].
* “When you’re asking about sex, their assumption is that you’re in a monogamous relationship…and that’s because that’s the way they live their lives. ... But then they automatically jump to ‘Oh, then you’re at super high risk for HIV’ – they make those crappy assumptions too, that we don’t know about how to protect ourselves from STI’s. It’s really insulting. They say ‘Oh, you’re promiscuous’ and there’s nothing wrong with promiscuity anyway, who cares how many sexual partners you have?...Don’t do that value-based judging!”
* “I laugh when I think about when I took (my son) to the clinic, and they asked me how I had my son, and how was my gynecological care. What you see is not always what is – no assumptions.”
* “No assumptions about anything – gender, identity, pronouns, nothing. Just because I look female, doesn’t mean I identify as female.”

*Latino:*

* “Clinicians working with minorities need to be neutral, careful with assumptions. A Latino woman described (to) me a bad experience. She and her Caucasian husband took their daughter to the doctor’s appointment at a local clinic. The doctor’s comments and recommendations were directed exclusively to the child’s father. (She told me) ‘It was horrible! I felt excluded, as if I were invisible… and I’m fluent in English, but he didn’t even give me the opportunity to show it. Of course, I’m not going back to that clinic!’”

*Somali:*

* “My aunt has diabetes. I went with her to see a doctor and the doctor didn’t see her as she is. She is an elderly woman and has never been educated. He told her how to manage her diabetes but she didn’t understand the whole scope of it or why. He told her ‘no more tea’ and didn’t discuss it further with her. He doesn’t understand how tea is a part of our culture. If he understood our culture he could treat her well, and he could reach her. Now she constantly goes to the ER instead of going to her doctor. She needs education and help to learn how she can eat.”
  1. **Clinics provide culturally responsive training for all staff**

Clinic culture should not be generic MN Nice, but should be culturally responsive to and respectful of the communities it serves. Culturally responsive training should be required for all staff, not just clinicians; appointment staff, front desk, and outreach staff need to provide respectful and helpful patient-centered customer service and provide transparent descriptions about how clinic processes work; triage staff need to respond to patient’s needs and make connections to appropriate staff and departments.

*GLBTTQ:*

* “It’s a competency issue…like what is the competency of those staff members to even be able to empathize about the (people) coming in to use the services?...Educate…clinic staff about the needs of trans folks, so when trans folks come into those clinics, clinic staff have some knowledge and can empathize with the patients.”
* If you’re competent, then your forms and everything else will reflect that you have an understanding of who the people are that are coming in to use your services.”
* “On those forms that you fill out, my doctor has Male, Female, Trans Male, Trans Female, Gender Nonconforming, Gender Fluid, as far as Gender. And under pronouns, he has He/Him, She/Her, They/Them/Theirs and then Your pronouns. How neat is that? It says ‘I see you, you are valid’ just on the form!..And they ask you ‘how would you like to be addressed?’ They have that in the forms too. You can write in whatever you like. And then I feel welcomed right away. Oh you ARE listening! You ARE taking me into consideration. There are only two clinics that I’ve been into (that have done this).”
* “Don’t say ‘feminine products’…say ‘menstrual products’ - take the gender out of that language.”

*Hmong:* Doctors and clinic staff can learn about culture and how to build trust.

* **“**Showing respect can be as easy as asking for permission. For instance, when a doctor needs to examine a Hmong elder’s head, the doctor should ask for permission ahead of time. This act demonstrates that the doctor acknowledges and respects the patient’s control for their personal space and body. Small gestures like asking for permission contribute to building a trusting relationship between patients, doctors and staff.”

*Latino:*

* “Cultural training should be provided to all personnel at the clinic, but it should include people from the communities, the clinic’s own patients as part of the ones providing the training.”

*Somali:*

* “Cultural training must be available to the clinic staff at all levels. Clinics can even invite patients to talk about ways to improve services so the services fit with patients’ culture desires and needs.”

* 1. **Clinics allocate adequate resources, including adequate time and interpreters, to support effective clinician-patient relationships**Clinicians need clinic resources to support therapeutic relationships. Clinicians need adequate time (generally more time than is currently scheduled) to establish personal relationships with their patients and provide culturally responsive care, including identifying, understanding, and responding to the social and cultural context of people’s health (often referred to as Social Determinants of Health -SDOH). They need to effectively work with trained medical interpreters for non-English speaking and low-English proficiency patients.

*Somali:*

* “It seems that most of the staff focus on the interpreter, when they should focus on the patient --like when my mom comes in and no one acknowledges her- they should put an effort into acknowledging the patient rather than the interpreter.”
* “For someone who has a language barrier and cultural issues, it takes longer – the doc can’t just do a 10-15 min visit because it takes time to ask and listen about culturally relevant issues, and more time to work when there is an interpreter in the mix.”

*Hmong:*

* “For me, when we go to the clinic, we are scared and when we get there, we are constantly thinking that they (staff/doctors) might not know our language, maybe they’ll have an interpreter. Is the interpreter going to interpret correctly or not? Will they understand me?”
* “When people need interpreters, then they need more time, not only to interpret, but there is also a cultural piece. Hmong are relationship people, we need more time to build relationships with providers and explain things fully so we don’t get embarrassed. Earlier we talked about how Hmong people don’t tell them (the doctors) fully about themselves because they don’t see how it is related to their health.”   
  1. **Clinics create welcoming, private, and safe clinic environments**A welcoming clinic environment can contribute to health by helping people feel cared for, respected and valued, and by reducing the stress that occurs when people feel disrespected and unwanted. Depending on the communities that the clinics serves, this could include space and activities for children, local community artists’ art on the walls, healing gardens, and quiet spaces for reflection and prayer. A welcoming environment also means that the clinics have a high standard of professionalism that reflects the needs of the communities that the clinics serve. The most important trait is excellent customer service where staff members do not make assumptions, reinforce stereotypes, or pass judgment based on how people look, dress, or speak. As the first and last people that patients see in the clinic, the front desk staff need to embody this mentality of service so patients feel cared for at the clinics. Providing confidential care in a private environment is respectful of patients’ lives and leads to a trusting relationship between patients and clinic staff. Providing safe care, where people are not harmed, demeaned, devalued, discriminated against, is essential for all communities.

*Black/African American:*

* *“*In clinics, the receptionist and personnel in general must value the patient and treat them with respect. When staff does not value the client, they do not value the issues at hand.”
* “We know that we do not want to be in a clinic in the first place, so to get into this place and navigate I must be comfortable to stay and come back. The place must be welcoming, clean, there should be art work, music, activities for the children... In addition, have people who recognize you from the community... It gives you a communal feeling. It is not only a clinic, but the facility has people who care about you.
* “Make sure that staff is trained in HIPPA. Privacy is important. Do not leave my private information for others to see. We do not trust doctors and we do not trust people with our information. Talk in a low voice instead of screaming. There are always people behind who can hear. ... Information should be private and treated with respect. This way I will come back to this clinic.”

*GLBTTQ:*

* “Safety is really important, especially for gender non-conforming people. We don’t go to clinics because we are scared of being victims of attacks.”
* “What is it like when you go into the clinic, is it all straight, white people?….What’s the literature in the waiting room? Are there gay magazines, are there people of color on them? And around bathrooms and bathroom management…are there single stall bathrooms available? How has the clinic chosen to label the bathrooms? How do I fit within the physicality of the clinic – do I see myself represented?”
* “For me (quality), it’s about being friendly and about privacy. I can’t tell you how many times I’ve checked into a clinic and I’m standing there and they’re asking me why I’m here. I’m like, why am I announcing this to everybody in the room? Why am I explaining this to the front desk

*Hmong:*

* “It is important how you are treated at the front desk. When you are sick and you see the unhappy faces of the front desk staff, then it makes you twice as sick. Sometimes when you check in, they don’t even look up at you and it makes you angry and you don’t want to be there. The relationship between the mind and body is important. If you don’t value that, then you can’t contribute to the improvement of the patient’s health.”

*White:*

* “Something that is important is being in an environment where you can call out if something doesn’t go well. There have been different areas in my life that I’ve had medical treatment. There were a couple of times when feel I couldn’t say, “I didn’t like that doctor, I don’t want to see that doctor” or being able to communicate effectively that way. That comes down to overall relationships with the clinic. It’s not a business transaction. It’s a relationship.
* “Having a calming, healing environment (is important). I know that (my clinic) has a chaotic environment, and with anxiety, sometimes, I have trouble being in the waiting area (because) you’re in everybody’s business. I think it doesn’t really respect patients’ confidentiality and privacy. With patients coming in with things they don’t want to share, but they have to shout over everybody. How do we make it feel more like a healing space when you have a lot of people coming in with complicated (situations)? It feels like a triage almost. (Good) facilities are like valuing the patients as human beings and important to the fabric of life. I’ve seen things like having children’s books available. They’re cognizant that this is an issue.”

**1.6 Clinicians are medically competent and do not harm people**

Mostly, community leaders did not focus on “medical competence” and “medical outcomes” as high priorities to mention as an idealistic characteristic of quality primary care systems. Some expressed their expectation that health care professionals have the medical training, knowledge and skills that are needed to diagnose and treat medical conditions. Others, however, referenced people’s concerns that clinicians can, do, and have harmed people.

*GLBTTQ:*

* “Remember, the opiate epidemic started and continued because of doctors and pharmaceutical companies. They (healthcare professionals) are not always making healthy decisions for people.”
* “Not all trans folks are always adding and subtracting from our bodies….but become aware of what are the health issues that affect our communities, breast cancer, cervical cancer, rectal cancer, and be age appropriate in terms of testing folks at the right time…They should know about it, not me going in to teach you!”

*Hmong:*

* “When they go (to the clinic), they think doctors want to experiment on us. (So) Hmong go when it’s already too late and they need to get surgery.”

*White:*

* “Unless it’s my psychologist that I’m consistently seeing to make improvements with, I usually just want the best person who I’m trying to get treatment from in front of me. The other day, I went to a knee specialist. The guy had terrible bedside manner, but he was a knee specialist. I don’t feel super qualified to answer this one. It’s really my psychologist that I’m continuously seeing that’s important to me, personally.”
* “I really love how my daughter has a doctor that she sees consistently. I took my daughter in for a bump on her head. It was two male doctors. One was a resident and one was a regular doctor, but they were so gentle with her. The bedside manner was amazing because they made the visit about everything except the reason why she was there and then, “oh, by the way, can we check out the bump on your head?” I still want to write compliments and a thank you letter about that. It’s a new way of how health care is going with training.”

**#2: Identify and Address Historical Trauma, Structural Racism, and Social-Structural Determinants of Health (SDOH)**

**2.1 Clinics and providers recognize and address historical trauma and structural racism through training, monitoring, accountability, and evaluation**  
Recognizing and addressing historical trauma is relevant to specific health conditions that patients have, as well as important contributors to healing when the connections between trauma and poor health are acknowledged. Because of the violent history against members of these communities (e.g. history of slavery and police brutality of Black/African Americans, attacks on GLBTTQ people, war time violence in their home countries for Hmong and Somalis, unfair deportation of Latino citizens, and genocide against Native Americans), and current discriminatory societal practices, people have high rates of disease. The mechanisms are complex and interconnected, but one is clear: the stress from daily racism increases cortisol production which contributes to chronic diseases such as hypertension, diabetes, heart disease, strokes, depression, and preterm birth rates.

*Black/African American:*

* “Historical trauma in the Black/African American community impacts how much information patients will provide to the clinic. Patients are less likely to share personal information when they do not fully trust the clinic staff –because that information might be used against them. One family was having problems at home and lacked food but was scared to tell the doctor because they did not know what would happen to their children.”
* A therapist reported that county officers were coercing her to give a man a diagnosis that would automatically increase his time in jail, and she refused.
* “In our community it is common to come across trauma issues and because of the historical (mis)trust, the clinic should have trained staff to deal with trauma issues. For example, a patient said, ‘I had a stop by a police officer and I ended with felony charges with no prior record and I am currently fighting the court’, I told the patient ‘You are experiencing trauma.’ ... You cannot give quality care if you do not understand the historical trauma before they come to the clinic for any type of medical treatment.”

*GLBTTQ*

* “Regarding diabetes treatment, if patients continue to smoke, (then) the clinic automatically fails, doesn’t get their funding…but that (smoking) is a trauma thing, you know?”

*Latino:*

* “How about current societal stressors, for example, recent reports of police violence against African Americans or the current political negative atmosphere against new immigrants, specially Latinos? Is that considered part of social-structural determinants of health? As a psychotherapist I hear the perception among my patients is that the anti-immigrant, anti-Latino atmosphere in Minnesota is stronger/worse than ever... The mother of a patient told me she decided to stop bringing her son to therapy sessions out of fear that the police would stop her ... “Now, the police (are) profiling, and they stop you just for the way you look, the color of your skin. So now, every time I sit in my car I feel fear. I can’t live like that!’”

*Native American:*

* “Disease is occurring, from historical traumas and daily traumas. In native communities, we see how trauma impacts our health. ... Diabetes is about colonization. For example, when we were forced onto reservations and we weren’t able to gather and hunt, then the food rations were dropped off. In the1800’s, it was a strategic way for the U.S. government to annihilate our people. When the food arrived, it was rotten and it was things we didn’t know how to cook, like carbohydrates and processed food. Starvation was a way that the government tried to kill us. Now, we are completely removed from our original ways of hunting, gathering and knowing traditional health practices. On reservations now, they are building diabetes clinics just as quick as they’re building jails, just as quick as they’re building opioid/methadone clinics because that’s what’s being reimbursed, that’s what’s being funded. There’s no funding for decolonization. You have community members who are trying to do this, but we’re putting band aids on gunshot wounds. It’s like we’re on a ship and it’s sinking. Everybody has hands on deck, individually trying to pour out the water…dealing with the crisis. But we need someone on the ship who is designing and building a new ship.”

Many members of the GLBTTQ community have experienced historical trauma and therefore it is difficult for them to open up to health care providers. There is no consistent training and education for health care personnel to teach them how to address and treat individuals who do not fit into the historically and socially accepted female/male definition.

*GLBTTQ:*

* “Shame and lack of trust is an issue. When I was sexually assaulted, I didn’t go to doctor because I didn’t how was I going to explain what happened—and there was so much shame. As a trans person, it is so sad to hear that we suffer in silence…with no one to talk to, and a lot of those domestic violence and sex assault programs don’t see trans-people as people. (There is no way that I’m going to) go down and do a rape kit, and you know be victimized again.”

In addition, some communities felt they have been deprived of traditional knowledge, which could serve them well to deal with historical traumas.

*GLBTTQ:*

* “We don’t know how to get there, we don’t know what the ancestral roots are. It doesn’t feel right. It doesn’t feel holistic. But we don’t know why because we have been robbed of that ancestral knowledge. A large group of people don’t have tradition/ritual/custom lines to feed back to that ancestral knowledge and it feels like something missing.”  
  1. **Clinics identify SDOH and create clinic systems that respond to people’s needs**

Given that SDOH influence health and health disparities, primary health care clinics need to identify, understand, and then address the context of people’s lives that influence health. These SDOH needs and clinic services that respond to them could include: increased availability of same-day and future appointments; effective triage system to obtain care, decrease wait times and get appointments; culturally responsive patient education for the entire family; easily accessible communication in person or by phone, including access to a live person by phone (even more important if patient is in crisis, i.e., mental health needs); outreach to patients who have high appointment cancellation rates in order to understand possible additional SDOH barriers patient is facing and address health care needs (instead of punitive response); and transportation to and from appointments.

*Black/African American:*

* “Clinics should be able to assess and provide the appropriate care. For example, a client who has cancelled 15 appointments, needs to be looked up to understand the reason--it could be transportation (problem), so how can we help the patient?... Care coordinators should be able to do this and ask the questions appropriately. If the person is homeless, (coordinators should) use tact to address the question. A question ... could be ‘Do you have stable home?’ If I tell you that I do not have a house, I am afraid you will report me to child protection. This information may be relevant, but first I must trust you to be able to share it.”

*GLBTTQ:*

* “Clinics and clinicians should be prepared to treat the person as a “whole person”. That means that many patients have issues that make the specific disease almost non-important. For example, a patient’s dilemma is that her child is sick, but she also has another baby to take care of, her rent is not paid, her partner is “being snarky”, she does not know how to navigate the system and would take more time to learn. How can a patient find an advocate to help her through her many struggles?”

*Somali:*

* “Health isn’t just like I have a cold and I need to get better because if you don’t have housing, you’re not healthy.”

White:

* “A primary care visit, to me, it’s not just I’m treating you right now, today, it’s we’re treating your overall health and we understand that’s something bothering you today that’s why you’re coming in, but let’s take an overall view of your health, whether it is diabetes, asthma, addiction. Maybe there’s some mental health challenges or some social and economic challenges that is greatly affecting this person’s overall health.”
* “When I didn’t have a home address, I had trouble getting my antidepressants filled. It was a nightmare. It was so challenging.”
  1. **Clinics create clinic-community collaborations to address SDOH**

Clinics could take actions to address SDOH through authentically partnering, collaborating, and engaging with community organizations, whose missions include addressing the myriad of societal issues than influence health. These community organizations should be compensated monetarily as they partner to improve patient outcomes.

*Hmong*:

* “If a clinic has all the resources in terms of housing, employment, or legal information—such as domestic violence… (and) I can get help getting a restraining order—or if there is a person (like social worker from the clinic) to refer me (and) at the same time (tell me), ‘We will care for your health, and this (resource) will relieve your pain and stress’, (then) it’s very important to me and the Hmong community because we don’t know the language, (we don’t have the) knowledge, (and) so we don’t know where the information is.”

*Latino:*

* “One of the current issues for (the) Latino community is deportation, which has ripple effects: (the) deportation of one person could affect an entire group of people, from his children who will be unable to see their father at all, to a wife who will be suddenly a single mother. ...A clinic providing (connections) for those people with resources in the community, the entire group of people could find relief: churches, low-fee attorneys, organizations helping Latinos, food pantries, school counselors, county workers.”
  1. **Clinicians recognize and address historical trauma and SDOH**

How providers ask questions about trauma and SDOH matters. Providers need to be trained on non-judgmental approach, which could help alleviate patients’ fears about how they are treated, from their historical traumatic experiences and from providers’ perpetuation of trauma based on their cultural biases. Clinicians need to ask patients about SDOH, respond to their situations, make referrals to clinic-based and community-based activities, consider the issues in context of the diagnoses, exploring treatment options, and in creating health plans together with patients.   
  
Community members had mixed opinions about clinics asking and about the state requiring that clinics ask patients for SDOH information. People saw potential value in providers’ knowing this information, understanding patients in the context of their lives, responding to patients’ needs, and referring patients to specific agencies that can help with specific problems. However, people also saw potential harms: patients could be protective of their private information; patients could feel more vulnerable and more distrustful; information could be used against them, and increase discrimination. Perhaps the best way is for communities to be able to collect their own data, own their data, set their own priorities, and then create effective approaches using the information, rather than the information being collected, controlled, and responded to (or not responded to) by the majority society. Ultimately, perhaps the clinicians could respectfully ask patients about their situations, or the clinic could ask for the information anonymously.

*Black/African American:*

* “Clinicians should be aware of types of trauma in our community and understand what trauma is. Clinician should be trained on how trauma looks like. Sometimes the patient herself/himself does not know she/he has been traumatized. The clinic visit could be a trigger point to realize about a trauma if the clinician is trained properly.”

*Latino:*

* “A good number of Latino immigrants come undocumented, crossing the border, suffering severe trauma. But not every Latino came that way. And not all people that crossed the border suffered trauma. So, clinicians need to be prepared for the story the patient may provide, and the way (the patient) will answer (and what the clinician’s response will be), so that the patient leaves feeling better, not worse.”

*Native American:*

* We see being healthy as a right – it was written as a right into our treaties, and we see this in our (Native) teachings, but…because of trauma, I think Native communities struggle with feeling worthy of being healthy.

*Somali:*

* “I think a lot of us have PTSD, not just from being in America but stress can transfer, like the stress your parents experienced can transfer on to you...and there is not a lot of space or time to deal with it because we are all busy, we’re trying to survive.”
* “You know sometimes when people who just recently arrived, they have been through so much trauma. Like my grandma for example, when she came in, she said ‘I have body aches’ and later we ended up going to a therapist ... Understanding what these people went through helps so much. So, it is important for doctors to have background knowledge about what the person dealt with.”

**#3: Have Structures and Processes that Support Health Equity**

* 1. **Clinic systems have representation from their patient populations**

Community members of the patient populations that are served at each clinic need to be represented throughout the clinic: from staff, clinicians, clinic managers, and clinic system executive leaders to board members. Clinics need to intentionally cultivate relationships with trusted community members and community leaders to work on having effective partnerships. This can contribute to improved communication, connection, and healing relationships. In addition, it may allow patients to give input, or file complaints.

*GLBTTQ:*

* “For me here in Minnesota, I mean, we have our (sexual health) programs, they’re mostly run by white women from suburbia, and we’re talking about sexual, minority health, and these are middle class white women who have no idea, and take this framework that sex should be monogamous for a lifetime, and yet we don’t live in that world.”

*Latino:*

* *“*In order to build trust, patients need (to) receive treatment from personnel who represent their own groups or from someone who is culturally competent in their language and culture. I heard a patient who was struggling with economic issues say, ‘The doctor is telling me I have to eat a healthy, balanced meal, with fruits and vegetables. How am I going to tell my wife that, since we hardly have enough money to get some food?’ When I asked the patient why he didn’t tell the doctor the truth, he explained that it was embarrassing enough to have to tell the non-Latino doctor, but that the Spanish interpreter also would hear it.”
  1. **Community members have real representation, with influence and power**Beyond “mere” representation, “real” or “genuine” representation means that the community members play active full roles, participate in decisions, and can influence decisions, rather than “token” representation without real power. The current power structure means that health care systems tell communities "you should be this", when communities instead should be defining health and health care, should be listened to, should be heard, and should be active in the organizational structure. Organizations need to be accountable to make positive changes.

*GLBTTQ:*

* “And then, when people from our communities are working in those clinics, they are just there, they do not have real power. We do not have real representation. What we need is real representation.”

*Somali:*

* “Clinic leadership should hire people who are Somali. For example, if the clinic is in neighborhood where Somalis live, they should hire interpreters from the community, but how much better (it would be) if they hired people from the community to provide services and to lead the clinic.”  
  1. **Clinics report on health disparities and equity data, goals, and efforts**

Clinics should report on their health disparities and equity efforts by creating an Equity Dashboard, which highlights the existing the health disparities and illustrates directions for progress and improvement. Collecting and representing data can lead to improved understanding of current practices, improved goal setting to redress imbalances, and improved accountability. The dashboard could include:

a) Clinic policy leadership level data

b) Clinic process data

c) Clinic outcome data

d) Patients’ experiences with clinic processes and clinic relationships, such as being treated with disrespect/ discrimination/ stereotyping.

Native community leaders particularly advocated for an Equity Dashboard as a quality measures tool in order to ensure that health care systems are working towards providing equitable medical care to Native communities. An Equity Dashboard should explore and display how social and structural determinants of health affect the families and communities, how structural racism impacts community health, how race and ethnicities are collected and reported, and how institutions respond to complaints of inequities and discrimination from indigenous people of color.

*Native American:*

* “How do systems quantify feelings of discrimination? How do they collect that? Systems want to know what the racist action that their personnel said or did. Do they collect discrimination complaints? Do they know how many families feel discriminated against, based on their care? Are they collecting this data and if not, why not? How will they know if they have a problem? If they do not collect the data, maybe they are saying they don’t want to know.”
* “In order to make a complaint, patients have to feel empowered, feel safe and not worried that clinics or staff will retaliate.  In native communities, they often don’t feel empowered enough to even complain at an official level. […]Can the clinic help people effectively complain? Because their voices collectively matter. How do we tell communities that their voices and experiences matter? This is how we can get the system to listen to them. We may have to craft our own creative ways to collect that.”
* “Because systems don’t have to be accountable to address complaints, when people of color make them, how are the complaints being evaluated, adjusted?”

*GLBTTQ:*

* “I would love for communities of color to have a way to own and gather our own data. To set [the community’s] own [health] priorities. [This would have] a really different impact.”

**#4: Prioritize Culturally Responsive Mental Health, Health Promotion, and Patient Education**

* 1. **Clinics expand mental health services across all areas of healthcare**Traditionally, health care clinics have focused on physical health, and have relegated mental health to special mental health services. Patients, families, and communities could benefit from the expansion of mental health services to be diffused throughout the primary healthcare system.

*Black/African American:*

* “As a mental health professional, I think it is very important that primary health care and mental health work together to minimize some of the issues that are overlooked at the first point of contact. Having people in primary health care that are cross-trained is a way to detect issues and follow up ... with families in need of mental health services. This is a way to keep families from falling out of the system.”.
* “It is hard for (people from) certain cultures to accept mental health services. However, being informed in a non-threatening environment and working together to get them the help they need can make a difference. Bridging the gaps for those who are underserved is the focus.”

*GLBTTQ:*

* “Health encompasses physical, spiritual, and mental wellbeing, and to have a doctor who understands trauma-centered care as well is really important because I have had a lot of trauma growing up…so a Gyn(ocolgical) exam really terrifies me, and I need to disassociate… so if they understand that and can do what they need to do quickly and compassionately, that’s priceless to have that for any of the trauma that we might be living with.”

*Latino*:

* “An important part of (the) Latino population do(es) not want to be seen by a mental health professional. They have the idea that psychotherapists are for treating ‘psycho/crazy people.’ Having mental health services as part of a health care clinic could make a difference in that the patient could have access/exposure to a psychotherapist. ....It is definitely a holistic care.”

*White:*

* “To me, it starts with mental health. That’s where I see the biggest need in our community right now. Yes, that person hasn’t showered for a very long time, for me it stems from that point and if we can’t get that point addressed and figured out, (then) that’s where I see the most with people struggling. Caucasian or white urban is mental health and addiction.”
* “If there could be more ways in which people can get into looking more at mental health. More programs where maybe you don’t need to see a therapist every week, but maybe a group to talk with or activities for people who are going through similar things can do together. Build support for people. A lot of people in my community, white urban people are isolated. Just being on Facebook, I see it.”
  1. **Clinics integrate family-based strategies for health promotion**Individually-focused care can fracture the family and community, and can isolate individuals from their support network. In contrast, because people’s support system could empower them to improve their health, health promotion education about healthy lifestyles that is family-focused can support family-based healthy lifestyles, and thus contribute to individual’s health. Culturally sensitive healthcare for communities that value a collaborative versus individualistic view of health may mean including family and friends during patient visits, when patients want them there. People’s health depends greatly on how strong and involved their support group is.

*Hmong*:

* “When we talk about diet and changes, we need to consider the household. We are family-oriented so to eat healthier, exercise, can’t do that unless we change entire family lifestyles. We have to keep everyone accountable, to ask who lives in the household and asking others in the home and how to change the family structure and community to make every one healthy.”

*Latino:*

* “Family members could provide important information about the patient. Latino patients are used to going to their doctor’s appointment with their spouse, children, in-laws, godmother. Often times, these family members could provide information that is useful for the provider, to give better service to the patient.”  
  1. **Clinics provide culturally relevant education**

Traditionally, clinics have focused on doctor-dominated disease diagnosis and treatment with patients being dependent on clinicians. The shift towards focusing on prevention, health promotion, and patient empowerment for healthy goals and independence for chronic for disease-self-management needs to continue. Effective patient education is tailored to individuals in the context of their family and community; is consistent with their preferred language, literacy, and learning styles; considers people’s cultural values of health and healing; is holistic; and recognizes and respects patient’s intersectional identities.

*GLBTTQ:* Patient education done appropriately for communities is important for people to live healthy lifestyles.

* “Sexual health is to be able to talk. Preparation protects you. Programs run by white middle-class women from suburbia do not address the needs of every community.”
* “I don’t like slut shaming, the whole sexuality shaming.”
* “I think for the bisexual, pansexual, asexual communities, that they’re hardly spoken (about), or they’ll say bisexuality isn’t real or you’re just waiting to be gay…so when we talk about education, we need to say ‘hey it’s ok to be bisexual, poly, pansexual, asexual’…because I have friends who have absolutely been traumatized, going to a doctor to talk about it, and they go ‘well, why do you need to be here, you don’t even like sex!”

*Hmong*:

* “It is education about nutrition (that we need). For example, Hmong eat a lot of white rice. We now learn that it’s a lot of sugar. When we eat a lot of rice, its impact is going to create high sugar levels. It’s education and customer service (that we need). We are poorer and less likely to understand the healthcare system (than others), so we need more knowledge to care for ourselves.”

*Latino:*

* “Adopting healthy lifestyles is key to addressing many health issues in our community. However, there are many issues that block this useful tool to reaching many people in the community. From lack of healthcare access due to education and financial constraints to health system design, communities use the health system when they are sick or as a ‘last resort’ rather than as a tool to stay healthy and prevent diseases. For example, a patient may visit the clinic or emergency room because of extreme leg pain and then receives a diagnosis of long-time untreated diabetes, which should have been prevented. They need culturally and linguistically appropriate education and information about health promotion, so people can understand and can institute healthy lifestyles.”
* “Clinics should use every possible opportunity to promote health. While patients sit in a clinic waiting room, trained personnel should provide education about health promotion, including healthy lifestyles, diabetes prevention, vaccinations and cancer screening.”

*Somali:*

* “The community lives in a highly populated city. It would help if the clinic held monthly seminars for the community. If you teach twenty people, they are connected with hundreds of other different people, as people are inter-connected and related in the Somali community. The person leading the sessions should be someone from the community, otherwise people attending may say, ‘Wait a minute- this is another “cadaan” (white) person telling me what I should be doing with my life’, and then not listen.”

**#5: Provide Access to Care, with Patient-Centered Integrated Services and System Navigation**

* 1. **Clinics support access to care**Improving patient’s access to care includes aspects outside of the clinic (insurance, transportation, location, etc) and inside the clinic (hours, appointments, interpreters, etc).

*Latino:*

* “For many patients, transportation can be a main factor in accessing health care. There are many low-income patients who do not own a car or cannot afford car insurance, and they depend solely on public transportation. Most clinics cannot or do not accommodate late arrivals, and then deny services to patients who arrive late. Not receiving service blocks these patients from needed care, as well as produces a sense of rejection, impotence and discouragement as their time and financial efforts are wasted.”

*Somali:*

* “A lot of community members, such as our elders, do not drive, do not know how to call a cab, or do not know how to use the bus system. They are dependent on calling family members or friends, who are busy, to take them. The community could benefit from clinics that provide transportation, and support their complex needs.”

*White:*

* “The big barriers that I see, transportation is a huge one for me and for a lot of people. For a lot of our patients have to change their bus routes, their schedules. It’s not a flip of a switch.”

“Being able to schedule routine appointments online, like a vaccination. Being able to do some of those things online or contact a provider quickly and leave a message. I think if the system to check in and make appointments were split up a bit more because it’s really hard to check in when someone is trying to make a really long, complicated appointment or if they need an interpreter or one is not available. If you’re 5 minutes late checking in, you could be in line for 15 minutes, but you can’t get up there then you’re locked out of the system and they have to call and see if a provider will see you…. If they had a way to have separate lines or back each other up, then they can help each other out. Sometimes I feel that it’s the hardest part, is getting past the gatekeepers there.”

* 1. **Clinics support solutions to high cost of care, a fundamental barrier to access to care**While clinics are not directly responsible for creating solutions to reduce the financial burden of care, they could support both short-term and long-term solutions.a. Short-term solutions: 1) Clinics create discount programs; 2) Providers prescribe medications that patient can afford or that is covered by health insurance policy; 3) Pharmacists connect with pharmaceutical company assistance programs

b. Long-term solution: Universal Health Care Coverage. The government, health care systems, and insurance companies need to talk about universal coverage, and options including medical caps and ensuring care.  
  
*Latino:*

* “In my clinic, male clients between 20- 40 years of age feel that they have no access to services because they do not qualify (i.e., do not have insurance or are financially stressed to a pay sliding fee or a copayment), therefore, they are unable to receive services. Patients may say ‘I work but I do not have enough money for insurance’, hence they feel penalized by their financial situation.”
  1. **Clinics have integrated health care services**A “one-stop shop” for health, which includes physical, mental and dental health care, will improve patient and community health more effectively than this fragmented system. Mental health services need to be integrated across all areas of primary health care for all patients. Clinicians, triage nurses and even receptionists should be crossed-trained in mental health services; their receiving special training to identify people with mental health needs will reduce time, money, and inefficiency. Clinics should partner with community spiritual, social and mental health healers.

*Black/African American:*

* “It is hard for people from certain cultures to accept mental health services, including many in our community- there are too many people with mental health issues that are not being properly addressed. However, a healthcare system that combines mental and physical health services will bridge the gaps for those that are underserved. Being assessed and assisted in a non-threatening medical environment while being served with medical services may get people the mental health help they need. The sooner mental health issues are recognized and detected, the more likely they can be controlled with therapy or medicines. Also, coordination of care is essential and there must be consistent interaction with other providers so that everyone is well-informed and up to date on patient information.”

*GLBTTQ:*

* “The health system should not place so much emphasis on Western medicine... Rather, it would be better to have a new health system with traditional healers, and pay our community healers. Change the system and make it so that they can be able to bill.

*White:*

* “Mental health care is health care. Instead of separating different parts of our lives, we need to be seen as whole people, which includes our mental health state. Clinics should work towards removing the stigma attached to mental health and mental health checkups. The whole context of people’s lives, from housing to employment to transportation, affects people’s mental health and their physical health."
* “I guess when you look at the whole picture, what I like about \_\_\_\_\_\_ clinic, and they ask you about the big picture of your life, I guess that doesn’t really happen at a lot of clinics, it’s trying to get a big picture of who you are…. And I think when you start seeing positive things happen, like maybe you’ve been dealing with Mental health issues and you haven’t been able to work because of it, and you’re able to start working again, and manage that and have a stable job, and then you’re then able to buy a home, and that’s a positive outcome, and then you’re probably going to have better health because you have stable housing, and you’re probably able to buy better food and then you feel better. “
* For me it starts with continuum of care…(which) has two parts to it – in the clinic and out of the clinic. For example, in clinic let’s say you’re dealing with an addiction that has also caused you to have mental health issues, and your addiction has also caused you to have some dental needs, so let’s take care of those. Whereas now I’m in the clinic and I have some medication to deal with (the health issues resulting from the addiction), but I need some support when leave these four walls and I need some help making sure that access to those community resources are available…and (the clinic) makes the initial contact and referrals for you.... It could be both referrals to other health care services, or it could be to other types of services….When I didn’t have a physical address, and I had to call just to get my basic antidepressants filled, it was a nightmare, it was so challenging.

* 1. **Clinics provide transparent clinic processes**

Patients need to understand how clinics and the health care system work in order for them to get their needs met. Transparent clinic processes will results in patients understanding how clinic processes work, and how to get their needs met. Patients need to understand medical diagnoses, treatments, treatment plans, referrals, test results, medical referrals, community referrals and follow-up plans, etc, which is basic health literacy.

*Black/African American:*

* “One thing I think annoying is when I call to set up an appointment, they ask you what you need to be seen for. You explain, and you are asked this 3 times. The nurse ask you, then the doctor ask you the same. At that point, I have wasted nearly 10 minutes, not counting my time on the phone. What concerns me is that the doctor does not even know who I am, and I have been going to the same clinic for years and the questions are the same. If someone explained to me that there are some laws that expect staff to ask questions over and over…. Receptionists give you a bunch of papers to fill out to start with. They should warn you at that point that 3 other persons will ask you the same information.”

*GLBTTQ:*

* “(At some clinics) I don’t think they really explain what’s going on, I mean, when you’re at the community clinic…they don’t explain anything. They just move you through, and after sitting (there for) 2-3 hours, you just want to leave… and after spending the money for the bus to get there (in time for) your appointment, and you are going to try to get back (on time), but they sit you there for 2 hours. They’ll get you checked in, but you’re sitting there for 2 hours. Now my bus pass is (expired) and I’m going to have to walk home.”

*Somali:*

* “Transparency is a huge thing and maybe an outline of what this person is supposed to do…(Clinics should) not leave it to the individual directly and (they should be) more involved than just say ‘This is what you have and I expect you to manage it’….(Clinics should) have a guideline or help….to train someone on how to manage (their) care, or train family members to help them manage their care….don’t expect them to figure out how to manage their own care when it’s complicated enough that someone who is born in the state can’t even manage it….”
  1. **Clinic staff members communicate effectively with all patients**   
     Effective communication includes considering their preferred language, health literacy, numeracy fluency, and technology skills. Trained medical interpreters need to be available at all times; and clinic staff members need to be trained to work effectively with them.

*Native American*:

* “To build trust, (clinics should) have (a) liaison to help patients feel comfortable, have conversation to show support for the patient, (and) have a team that collaborates so that patients don’t have to repeat themselves because it is tiresome. (…) When a family doesn’t feel empowered to be their child’s advocate, you need to encourage them to ask questions and help them be empowered to be their own advocates.”

*Somali:*

* “The clinics should make sure (that) any translator needs to be competent in medical terminology and… always make sure (there is) someone who has some medical background to go with the family member.”

***Results Topic 3:* Aligning State Funding with Results of Quality Measures:**

These community leaders generally disparaged the reality of the current system, where privileged people have better health and better healthcare measures while impoverished people have worse health and worse healthcare measures, so that if the clinics serving privileged communities receive more money and the clinics serving impoverished communities receive less money, the social injustice of our inequitable health care system with our current health disparities will continue.

*GLBTTQ:*

* “The state will prioritize the taxpayer that pays the most and the one who screams the loudest—they are not the poor and not people of color, which is what creates great disparities.”
* “Let’s look at budgets and how we do budgets. Budgets are like financial compasses--they identify priorities and set the boundaries. When you identify something in the budget, it says how important it is. So, who controls budget in our state? Not the poor. The ways that funding is dispersed in this state has the largest impact, either positive or negative in our communities.”

*Hmong:*

* “Money allocated for (health) education is important. Priority for me is allocating money to (health) education, from eating (healthy diet) to prevention (of chronic diseases) to treatment (of illnesses).”

*Latino:*

* “Monies should be allocated to ensure connection with people/services outside the clinic, culturally sensitive training for staff, hiring people who represent the culture and (educating about) prevention and treatment of diseases that can affect people’s lifestyles.”
* “Ironically, the health care system pays for the quantity of the services but not for the quality of the services that patients receive. Since people only go to the clinic when they are sick, many patients do not know what they can do to improve their health.”

*Somali:*

* “But if you have a big clinic, they are detached from the community – for example if the state focus(ed on) giving money to small clinics (that are connected with the community) to provide better healthcare (that would be good).”
* “Clearly the system needs to change dramatically because it’s not done in an equitable way. If St. Cloud Clinic is the best and this clinic is the worst, (and they get more money, then that is not fair) …I think it should be tied to some kind of outcome still but, I think it needs to be more just.”
* “The current system for reimbursement is not the best practice for communities like ours. I don’t think that a clinic (in suburbia) is doing any better job than a clinic in Minneapolis that is dealing with other factors. We know that only 10% of clinical factors contribute to health, and the rest is related to social factors, so social factors are a bigger component of dealing with health problems and getting the results that would rank a clinic or provider higher or lower on the current scale. Another system (could be) based on time reimbursement.”
* “I agree, I don’t think it (payment) should be tied to it (services), because the community you are serving should be the community you are focused on, and you cannot talk about the Somali community without addressing housing issue, food issue, income issue, transportation issue. There are people that can’t even come to seek services because they are dealing with that. I think this whole rating system is deeply flawed and it seems like it benefits white people more than it benefits people of color and I think maybe the whole thing should just be scrapped and a new system should be approached based on our input. What I’m hearing is that the people most in need, those in clinic serving them could be reimbursed at a lower rate than ...other people and to me that sounds really bad. It (financial remuneration) should be based on the people they are serving. What services do you provide and how are the people you are serving receiving the services you provide?”

*White*:

* “The other thing that comes to mind when I see the disproportionate scoring is that there has to be a multiplier. Your overall score should be adjusted like with risk profiles in two different scenarios. You’re looking at a different population. In Edina, the population is very different than the population in North Minneapolis. In North Minneapolis, the folks are probably working a lot harder to get the lower outcomes than the folks in Edina are working to get the higher outcomes**.”**

**Application**

MDH, DHS, and the Minnesota legislature could choose many metrics to measure health care quality, evaluate the community leaders’ ideal characteristics, respond to the community leaders’ perspectives, and support health equity. Table #1 (page 28) maps the communities idea characteristics of quality primary health care to both DHS’s 2017 proposed quality categories in the *Outcomes-Based Purchasing Redesign and Next Generation IHP1* and to the health equity domains in the National QualityForum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities2*. These overlaps not only support the existing literature on patient-centered quality health care, but more importantly, they demonstrate what it looks like across multiple communities in Minnesota. The National Quality Forum’s 2017 *Roadmap* lists dozens of validated measures in Appendix E:Compendium of Measures by Domain, which could be utilized. Since Phase 1’s one listening session was inadequate for the community leaders to both articulate their ideal characteristics and grapple with how to measure them, the community leaders did not endorse any specific measurements. However, NQF document lists dozens of quality measures that DHS could consider using to measure quality in primary health care.

**Discussion**

What do these results mean for communities in Minnesota? By inviting community members to share their expertise, experiences, and knowledge about their communities’ definition of health, characteristics of quality primary care clinics, and how states should align funding to quality measures, we are able to hear and understand how these communities are affected by quality measures in primary care clinics. The relationship between quality measures and social justice is strong. With an underlying monetary value placed on quality measures, this relationship becomes problematic when clinics serving white suburban middleclass families “do better” and get more funding, incentives and resources, and clinics serving non-white, low/limited income families “do worse” and do not receive the necessary funding and resources to help their patient population. Equity should be at the heart of the quality measures framework and policies to ensure that quality patient-centered care is accessible across all communities in Minnesota.

However, this CBPAR process to engage community members was markedly limited in time and scope. The 5-month timeline was short: funded in mid-August 2017, the Community Engagement Team was formed by September 1, 2017, the Community Leader listening sessions occurred in early December 2017, and analysis was completed in January 2018. As such, there was limited time to engage the community leaders more fully in the process, and no time to engage broader representation from these communities. We planned the process to best accommodate the available timeline and resources, and must be seen as an initial Phase 1 step. We envisioned a follow-up Phase 2 process to provide a more in-depth interaction and assessment of community members’ experiences with quality and reactions to quality measurements related to payment. If the state legislature truly wants people’s input into a new framework of quality health care, then Phase 2 should be funded and completed.

The scope was limited to people known in the community as community leaders. As with all qualitative research, the limited number of people who participated limits the generalizability of the results. Nonetheless, it is a common first step in qualitative processes as it obtains input from “key informants” who know a lot about what others are experiencing before expanding processes to gain understanding from larger numbers of people. In addition, the process did not have equal representation from each of the seven communities; some community leaders were more flexible to attend the listening sessions than others, and while we were able to conduct one individual interview with a community leader who was unable to attend the group sessions, our timeline did not allow enough flexibility for scheduling additional individual interviews with others who were unable to attend.

The quick pace and minimal resources for this project severely constrained its ability to present a full, rich and comprehensive analysis of the perspectives of the various groups and communities of Minnesotans who are currently experiencing deep disparities in health care access, quality and outcomes. These communities and their leaders expressed frustration and anger by the lack of resources and commitment that is given to ensuring that all Minnesotans are represented in policymaking and health care decision-making for both the overall health care system and for decisions made for the specific purpose of improving health equity. This is yet another situation of how those who have the worst experiences and outcomes in the health care system are isolated from the opportunity to share their experiences and ideas for how the system can be made better. Despite repeated public statements of the importance of health disparities and the need to take action to reduce them, few if any meaningful steps have been taken and most of those steps have not fully and genuinely engaged the very communities they are intended to benefit. Resources speak louder than words. It is not possible to successfully reduce disparities unless substantial resources are invested in the hard and time-consuming work that is necessary to include these disenfranchised communities as partners and leaders in developing strategies. In this situation, what is minimally needed to develop a statewide quality framework that will reduce disparities is enough money and time to allow proper community-based participatory action research to be undertaken. Authentic community engagement and effective community research are needed to produce meaningful and actionable data on what people and communities impacted by disparities need in order to be healthier and have better treatment outcomes – which will also lower the total cost of care. What is needed is to institutionalize the resources and processes for full and authentic engagement of these communities in all policymaking about the health care system. If the state, policymakers and health care leaders truly want better health care for all Minnesotans, they need to make this a high priority – which means dedication of resources and time to do this the right way, both now and ongoing into the future.

The short process and the limited engagement with community members impaired our ability to really hear people’s experiences with health care, desires about quality primary care, and reactions to linking payment with specific measures. Several Community Engagement Team Leaders and multiple community leaders expressed these concerns. One Community Lead expressed these concerns thusly:

***While I feel a strong urgency around the topic area, I don't know if the timeline was realistic to do justice and advocate for community.***

*Five months was not enough time to do community engagement well. SoLaHmo has a great, inclusive process for community participatory research that has a long history of working with and within communities here in Minnesota.  In order to do community participatory research well, there needs to be time to familiarize community researchers with the overarching goals, the project budget, the framing of the project to broader community and the research process before proceeding to project design. Lots of ground work needs to be laid with community researchers before engaging with the larger community. With many community researchers working other jobs in addition to working on the QMEP project, coordinating schedules was difficult, and the project timeline should reflect both of these considerations. Ideally, to do justice to this particularly pressing issue, an iterative process, the chance to hear from community leaders and community members should have been repeated.*

***It was really hard to recruit people because of timeline, but also because of community members' lack of faith in the i****n t****he topic and/or audience. I think there is general fatigue with community conversations for MDH.***

*While everyone agreed that this was an important topic, and everyone was familiar with MDH and past MDH community engagement efforts, there was a common sentiment that tangible results are not often realized from these engagement efforts.*

***There is burnout from hearing of another way that the system (in this case payment) is stacked against this community with no time to process feelings and no change guaranteed.****First, it is alarming that this legislation exists to pay clinics based on “quality measures”. It is appalling that our state leaders, those elected to office to serve all communities, would not see how this payment system has damaging, unfair implications for communities with the highest health disparities and the clinics that serve them--communities of color, Native and tribal communities, individuals with disabilities, LGBTQ and two-spirit, and so on.*

*Again the issue of timeline is challenging here because of the short time allotted for data collection. What this timeline allowed for was half-day community conversations where community leaders were asked to report on a challenging topic with no time to process emotionally the injustice of the quality-payment system that they were just informed about. Also, there was no action promised from MDH that these efforts, thoughts, opinions would amount to any real change in response to the injustice of this payment system.*

**Conclusion**

Community leaders from seven urban communities (Black/African American, GLBTTQ, Hmong, Latino, Native American, Somali, and White) generally defined health as being beyond physical health and including spiritual, mental and social aspects of life; identified a range of ideal characteristics of quality primary healthcare that dovetail with the health equity issues identified by National Quality Forum’s 2017 *A Roadmap for Promoting Health Equity and Eliminating Disparities2*; and expressed concern that directly linking clinic payment with clinic quality metrics without considering communities’ social situation could perpetuate current social injustices in the health care system where privileged communities have better health care measures than impoverished communities. A truly community-informed legislative process to create a new quality metric system requires adequate time, energy, and resources for community-engaged processes, beyond this Phase 1 process. In addition, institutionalizing the resources and processes for full and authentic engagement of these communities is required for all policymaking if Minnesota is going to create an equitable health care system.

**References**

1. Minnesota Department of Health. Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP. November 15, 2017. Accessed February 9, 2018.

<https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign_tcm1053-318160.pdf>

2. National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities. Final report. September 14, 2017. Accessed February 9, 2018. <https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities__The_Four_I_s_for_Health_Equity.aspx>

**Table #1:  
Connecting Community Member’s Ideal Characteristics with  
DHS’ November 2017 Proposed Measurement Categories and  
NQF’s Domains of Health Equity**

|  |  |  |
| --- | --- | --- |
| **Ideal Characteristics of Quality Primary Health Care Clinics** | **DHS Proposed Categories** | **NQF Domains** |
| **#1: Have Respectful Trusting Relationships with Patients and Communities**  1.1. Clinics support long-term continuous clinician-patient relationships  1.2. Skilled clinicians provide culturally responsive/respectful care and are attuned to discovering and not acting on their unconscious biases  1.3. Clinics provide culturally responsive training for all staff  1.4. Clinics allocate adequate resources, including adequate time and interpreters, to support effective clinician-patient relationships  1.5. Clinics create welcoming, private, and safe clinic environments  1.6. Clinicians are medically competent and do not harm people | Prevention & Screening  Effectiveness of Care  Behavioral Health  Patient Centered Care | Culture of Equity  Equitable Access High Quality Care |
| **#2: Identify and Address Historical Trauma, Structural Racism, and Social-Structural Determinants of Health (SDOH)**  2.1. Clinics recognize and address historical trauma and structural racism through evaluation, training, monitoring and accountability  2.2. Clinics identify SDOH and create clinic systems that respond to people’s needs  2.3. Clinics create clinic-community collaborations to address SDOH  2.4. Clinicians recognize and address historical trauma and SDOH | Effectiveness of Care  Behavioral Health  Care Coordination | Partnership and Collaboration Culture of Equity  Structure for Equity |
| **#3: Have Structures and Processes that Support Health Equity**  3.1. Clinic systems have representation from their patient populations  3.2. Community members have real representation, with influence and power  3.3. Clinics report on health disparities and equity data, goals, and efforts | Prevention & Screening  Effectiveness of Care  Patient Centered Care  Care Coordination | Culture of Equity  Structure for Equity |
| **4: Prioritize Culturally Responsive Mental Health, Health Promotion, and Patient Education**  4.1. Clinics expand mental health services across all areas of healthcare4.2.Clinics integrate family-based strategies for health promotion  4.3. Clinic staff provide culturally relevant education | Prevention & Screening  Behavioral Health  Patient Centered Care  Effectiveness of Care  Care Coordination | Culture of Equity  Structure for Equity  High Quality Care |
| **#5: Provide Access to Care, with Patient-Centered Integrated Services and System Navigation**  5.1. Clinics support access to care  5.2. Clinics support solutions to high cost of care, which is a fundamental barrier to access to care  5.3. Clinics provide integrated health care services  5.4. Clinics provide transparent clinic processes  5.5. Clinics communicate effectively with all patients | Behavioral Health  Care Coordination  Access to Care  Patient Centered Care  Effectiveness of Care | Equitable Access  High Quality Care |

**Appendices about Listening Session**

**Listening Session Agenda**

**Introductions/Ice Breaker/hospitality**(15 minutes)

**Overview** (30 minutes)

* QMEP project
* Purpose of community engagement/CBPAR component
* Timeline
* Role of key community leaders
* Purpose of listening session and meeting agenda

**Small Group Breakout Sessions** (90 minutes)

* Small group focus groups facilitated by SoLaHmo community researchers in community- or language-specific groups to gain insights, set priorities, give feedback, identify effective approaches/strategies.

**Large Group Presentations of Findings & Analytic Discussion** (90 minutes)

* Small groups report 3-5 key findings back to larger group
* Large group discussion, analysis and synthesis of ideas presented:  The large group compares and contrasts the information shared by each small group to identify key similarities across and differences between each of the cultural communities. Key decisions for moving forward are made in the large group.

**Next Steps**(15 minutes)

* Analysis and Report Writing
  + - Key Community Leader Recruitment for Development of Report
    - The community-academic research team incorporates results of the Community Leader Engagement meeting, does further analysis and writes an initial draft report for community leader representatives to review.
    - Report reviewed by community leaders and QMEP team prior to submission to MN State Legislature
* Report Submitted to MDH (mid-February)

**Community Leaders:  
Attended listening session and agreed to be named in report**

**In alphabetical order:**

Nimo Afyare

Roxanne Anderson, Minnesota Transgender Health Coalition

Nathaniael Beske, Community University Health Care Center Patient Board Member

Janeth Guerra de Patino

Kim Hayden, Community University Health Care Center Patient Board Member

Natalie Johnson Lee, Girls Into Action

Clarence Jones, Hue-Man

Nicholas Metcalf

Maria L. Moya

Carmenza Preus, West Side Community Health Services, Inc.

Kim Sherva

Blanca Svedberg, Norte Therapy Services, LLC.

Demetrai Turnage, Minnesota Care Partner

Pa Houa Vang

**Community Leaders’ Listening Session Questions**

“Community Engagement about Healthcare Quality”

Quality Measurement Enhancement Project – QMEP

1. **Communities’ health**

*To start out, we want you to think broadly about your community in Minnesota (Hmong, Latino, Somali, African American-Black, Native American, White, LGBTTSQ).*

A. How do people in your community define health?

B. What are the most important things that positively or negatively affect the health of your community?

1. **Quality clinical health care**

*Now we want you to think about optimal health care in primary care clinics, for people in* your *community in MN. Think about your community, what makes for positive (good quality) patient experiences at primary care clinics, for relationships with clinic staff, clinic processes, and health results of good medical care.*

A. What aspects of relationships with clinic staff do people most want from good medical care?

*For example: how staff care about them, connect with them, communicate with them...*

B. What aspects of clinic process do people most want from good medical care?

*For example: schedules, hours, locations, getting results...*

C. What health results do people most want from good medical care?

*For example, good control of diseases like blood pressure, accurate diagnoses.*..

**III.** Recommendations

A. Let’s prioritize these items from A, B, C above.Which are your top 5 issues?

B.How do you feel about the state aligning financial payment with these prioritized issues?

C. Full context of people’s lives:

*Many things that are important for clinicians to know about the context of patient lives (for example: access to stable housing, food security, transportation, history of trauma, everyday racism, etc.) are called the Social and Structural Determinants of Health- SDOH.*

1. Do you think that clinics should ask patients about these SDOH aspects of their lives? How would people in your community respond to being asked?
2. If, so, how should clinics use or respond to that information?
3. Do you think the state of MN should require that clinics collect this information and consider these issues in terms of financial reimbursement?