

Community Conversation Discussion Notes

June 26, 2017

A Community Conversation was hosted by the Minnesota Department of Health Center for Health Equity in St. Paul, MN on June 26, 2017. There were 177 individuals in attendance. A series of three questions were posed to participants. Participants discussed the questions in small groups at their tables in World Café style. After each question and discussion, participants found a new table to join. At the end, participants debriefed as a large group. Below are the notes from the table discussions. *An asterisk (*) indicates a comment that was raised multiple times. Comments are listed in order by those comments raised most often to least often.*

Question 1: What is needed to build a sense of trust and belonging between you and MDH?

- Action by all parties (not just talking); shared responsibility and follow through *****
- Going to communities where they meet – on their turf. Show up. Travel more. Need to go to where communities are and listen. Welcoming spaces to talk. *****
- Relationships across every part of MDH AND having diverse staff at MDH who reflect the community. *****
- Communicating about what community needs; clarify roles; Common understanding. *****
- Transparency and feedback. *****
- Include members of community in decisions about funding. *****
- Let communities be part of the design or creation of a project; don't just bring a project to us. *****
- Open communication. Listen and respond/deep listening. *****
- Time to build relationships and sufficient opportunities/respect. Trust = Words + Actions. *****
- Barriers for health equity: using cultural traditions is not supported by MDH because they are not “evidence-based”. If that’s the case, there needs to be funding or partnership opportunities to document the impact and importance of cultural practices and traditions to promote and advance health equity. *****
- Relationship has to be more than transactional (personal relationships and connections). *****
- Trust is reciprocal: MDH needs to believe what community organizations are seeing and reporting about their community. *****
- Communication that is sustained. *****
- Be clear on what MDH can and can't do for community organizations. Level-set expectations. *****
- Value as equal people; experts are sought from the community rather than assuming MDH is the expert on everything. *****
- Conversation creates a sense of belonging; allow communities to create solutions that work for them. ***

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- MDH feels more like “the police”; find more ways to partner as equals. ***
- Consistency. **
- Willingness to work together on shared goals. **
- Trust built so community can raise issues early on rather than when it is too late. **
- Relationships breaking down due to bureaucracy. Community organizations cannot rely on delays for payments. **
- Organization got grant prior to work, but not meeting goals of work plan. Fear of losing funding, but organization sees lack of meeting goals as need for more funding for ground work. **
- Stand up for public health and taking definitions of health into account. *
- Responsiveness. *
- Leadership.
- “Community is the world’s oldest institution.”
- Report back out to the community on actions that have been taken.
- Organizational hierarchy can create police-type power; makes it difficult to work with community.
- Community organizations do not always define a community and their needs. We need to look from the bottom up.
- Outreach programs to develop relationships with youth.
- Each individual gets a moccasin to fit them.
- Be responsive to what communities are bringing to the table.
- Equity in funding to build capacity in organizations that are really of the community.
- Agency support of individual employees to build strong partnerships.
- Meeting grantees.
- Data visualization.
- Forms: Gender, names, inclusive, ask for preferred gender pronouns, gender neutral.
- Childcare, time, stipends, mindful of loss of income to attend these meetings.
- Assessing individual household on how to improve their health.
- Don’t use acronyms! Speak in a way people can understand (for those who don’t work in MDH).
- Cross-fertilize between different grant programs.
- Too much time being spent “reporting” back to MDH.
- Political changes: constant adaptation to new leadership.
- Strength to speak against power.
- Continue to be on the cutting edge and lead in public health (in state and nationally).
- Up-to-date information, also more resources in different languages.
- Close gap between urban areas/greater Minnesota and how to address and talk about equity issues.
- Practice what we preach! Do not discriminate (i.e. people with disabilities feel excluded).
- Native staff.
- Federal level: cut BIA by \$371 million (government cuts).
- Funding on all levels.
- SHIP should have been instituted as a 10-year cycle as opposed to 3.
- Better food policy.
- Have coalition partners involved in conversation with health equity.

- Building effective cohesion.
- “I like that MDH is willing to have difficult conversations if it is the right thing to do.”
- What do communities truly need? How do they define health? How do we find a way to tailor interventions/resources to specific communities? How do we meet people where we are?

Question 2: Think about a time you were in a collaborative or partnership where you felt truly valued, heard, and respected. What made this possible?

- Inclusion, equality and a feeling of importance; everyone at the table. Sense of belonging (i.e. opportunity to get to know one another). *****
- Real interest and listening. Open communication. *****
- Transactional vs. relational. Head vs heart. *****
- Named common goals. *****
- Openness to authentic collaboration/compromise. *****
- Respect. *****
- Intentions and purpose. Ability to sustain the change that is sought and created. *****
- Reflect the community. Community-driven structure. The right representatives from community. More community involvement. *****
- Consideration for what is needed/wanted. Also, resource sharing and compensate members. *****
- Openness to learning/allowing vulnerability. Open mindedness. *****
- Expectations/defined roles. Clear guidelines. No surprises. *****
- Timely follow-through. Action-oriented. *****
- Face-to-face interaction. Share. Translating skills to new groups (especially youth). *****
- Accountability. ****
- Honoring and protecting time for reflection, not directed by agenda and clock. ***
- Autonomy. ***
- Ability to innovate.
- Tolerance of failure and acknowledging the highs. ***
- Change perspective. ***
- Transparency. ***
- Defined cultural norms. Cultural consideration/competence. ***
- Trust. **
- Highlighting one another’s strengths. **
- Co-creation; partnership doesn’t start after project is started. **
- Mindfulness of power hierarchies and power differentials. **
- Willingness to take risks. *
- Shared wisdom between women in the community. *
- Diversity, people who look like me; anti-racism approach.
- Potential networking opportunities.
- Funding guaranteed [soft vs. hard money].
- Healthy Home Fair.

- Access to more fitness centers.
- Tackle men's issues/help build strong men = strong families.
- Who does MDH trust? How do you show you trust the community?

Question 3a: Imagine MDH as a true partner to you and your community. What would MDH be doing?

- Come to communities and engage/educate communities about what is public health.

- Train staff to ask the right questions to get the most accurate data/recruit people from the community/diverse hiring. *****
- MDH would come to the community and share what they are doing/have done for the community. *****
- Defined roles/acknowledge power and roles. ****
- Support the needs identified by the communities themselves/ask the community what it needs.

- Capacity building for community-based organizations. ***
- Acceptance of evidence and value/wisdom from communities. ***
- MDH embedded in the community. **
- Culturally appropriate activities (true quality curriculum and translation takes time).
- Avoid tokenism in hiring practices. *
- Moving funding into policy, not just grants. *
- Follow through. *
- MDH score card for health equity for hospitals (collect data, report it out; tie it to quality and outcome). Race, disability, equity.
- Translation of terms into simple language or other languages.
- Research partnership to provide support and resources; help computer connectivity.
- Garnering support.
- RFP process.
- Consideration of qualitative research (not just quantitative) or something in-between.
- Not a 'one-size-fits-all' approach/don't do "business as usual."
- Listen.
- Why is violence against [Native American] women not part of the health equity conversation?
- 40- to 50-year-old population has needs that are not being addressed.
- How do we measure progress?
- Do you know how community defines success or health?
- Asset-based approach.
- Interpreters.
- Communication.

Question 3b: Imagine MDH as a true partner to you and your community. How would MDH employees be engaging with you?

- Shared decision making/community has a seat at the table. *****
- Two way/face to face conversations/"I would know people's names at MDH"/trust. *****
- Share resources into community/be a resource. *****
- Co-creating solutions. *****
- More community conversations and learn from them. ****
- Uncomfortable ≠ unproductive. Learning to deal with uncomfortableness = a good relationship. ****
- Transparency. ***
- Stop running from public when we know the public is right/acknowledgement that community is invisible. **
- Access to higher-level data and sharing data sets in a partnership /share research. *
- Utilize wisdom and strength of communities. *
- Accessible government – open door. *
- Less top-down. *
- Patience (relationships take time). *
- Need a way to communicate with medical community. *
- Need to hear more about work being done. *
- Transportation.
- Shared goal/work together.
- People need to feel safe.
- Help with preventative care.
- Have someone to call to ask questions.
- Accountability.
- Help at-risk grantees.
- Health equity legislation.
- Repository of organizations with similar interests in advancing health equity.
- Intention is there.
- Consistency.
- Tolerance for failure.
- Sustainable funding.
- Easy to use website.
- Social media engagement.

Question 3c: Imagine MDH as a true partner to you and your community. How are research or programs partnering with you?

- Work with community-based organizations.

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- Freedom from some of the restrictions of evidence-based models.
- Data on African, Asian, Spanish, etc. Separate the info so it can be tailored.
- Disaggregate data - New African immigrants are very different from those who have been here a long time. You can't aggregate social determinants of health.

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