



Summary of Findings: Community Engagement Sessions, January–May 2019

HEALTH CARE HOMES PROGRAM

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Introduction and background

The Minnesota Department of Health (MDH) administers the state’s Health Care Homes (HCH) program. HCH is an approach to primary care in which primary care providers, families, and patients work in partnership to improve health outcomes and quality of life for individuals, especially those with chronic or complex health conditions.

The health care context has changed since the program began, and MDH (in consultation with an established advisory committee and other stakeholders) is engaged in rulemaking to update the rules and improve the program. In particular, MDH hopes to add different levels of HCH certification to focus on areas such as accountable care for populations¹ and community-integrated health care.² As part of the rulemaking process, MDH organized community engagement events to gather stakeholders’ input on proposed changes to the rules.

Community engagement process

From January to May 2019, MDH held seven community engagement events throughout the state. A total of 74 stakeholders attended events in Duluth, Eagan, Fergus Falls, Maplewood, Minneapolis, and St. Cloud. Seeking more direct input from persons with developmental disabilities, MDH also visited with the Self-Advocacy Advisory Committee of The ARC Minnesota, a St. Paul-based organization that serves and is led by people with intellectual and developmental disabilities. An additional event is scheduled for September 2019, after which this draft report will be updated to include those stakeholders’ feedback.

Participants at the seven events represented a wide range of stakeholder groups, including:

- Advocates
- Area agencies on aging
- Clinics
- Consumers
- Community health workers
- Emergency responders
- Foundations
- Health care quality improvement organizations
- Health systems (local, regional, and statewide)
- Higher education

¹ Accountable care for populations encompasses: screening and referrals for other health factors (e.g. food security or stable housing), improving wellness and early prevention, and strengthening partnerships among medical and community organizations. Source: MDH HCH presentation at community engagement events.

² Community-integrated health care refers to shifting health care’s focus to population-level health, with an emphasis on using data, sharing patients’ care management, having a shared responsibility for health, and integrating health efforts across a community’s many actors. Source: MDH HCH presentation.

- Home care organizations
- Hospitals
- Local government
- Local health and human services boards/departments
- Mental health organizations
- Networks of medical professionals
- Organizations serving and led by people with disabilities
- Rural health organizations
- Social services agencies
- State government agencies

During these sessions, the HCH program director gave a presentation on the program’s proposed changes and answered questions from participants. Next, a facilitator from Management Analysis and Development (MAD)³ divided participants into small groups to reflect on and discuss their ideas related to the three areas that HCH will explore in the next iteration of the program, described below. Note takers from MDH captured these small group discussions, as well as the closing discussion involving the large group. Comments from these discussions are shown as quotations in this report and may have been paraphrased for readability.

1. **Individual and community health:** Overall health is linked to more than just health care/clinical services. This topic area acknowledges that where we live, learn, work and play influences overall health. For instance, health may be affected by social and economic factors (e.g., education, employment, income, social support, community safety), the physical environment (housing, air and water quality, transportation, etc.), and health behaviors (diet and exercise, tobacco use, alcohol and drug use, etc.).⁴
2. **Community partnerships:** Clinic and community partnerships are important strategies for improving the health of a population and the quality of whole-person care. Partners could include organizations such as local public health, social service organizations, community-based resources, and other health care providers, i.e., mental health and specialists.⁵
3. **Health equity:** While Minnesota ranks as one of the healthiest states in the nation, it has one of the greatest health disparities between whites and people of color and American Indians, as well as between people with disabilities and people without disabilities. This is a systems-level issue, with policies and processes designed in such a way that certain groups are disadvantaged in factors such as access to care and health literacy.⁶

³ MAD is the Minnesota government’s in house fee-for-service management consulting group. MAD provides management consultation to local, regional, state, and federal government agencies and public institutions.

⁴ MDH HCH presentation.

⁵ MDH HCH presentation.

⁶ MDH HCH presentation.

Cross-cutting themes

Several common themes emerged in the discussions across the three topic areas as examples of “what works,” success factors, or barriers/solutions:

- Sharing information and establishing systems for ongoing communication and collaboration: An example of “what works” and a success factor
- Clarifying roles, responsibilities, and areas of expertise: A success factor—and a barrier to success when this practice isn’t in place
- Offering embedded and integrated services/resources, and making connections across services and resources for clients: An example of “what works”
- Integrating health resources and services into the places that people already frequent outside of the clinic: An example of “what works,” a success factor, and a proposed solution to a barrier
- Differing understanding of what “health” means: A success factor and a barrier
- Funding and reimbursement: A barrier

Each of these themes is explained in further detail under the respective topic area(s) in which participants mentioned it.

Findings

1. Individual and community health

Stakeholders in the “individual and community health” small group discussed examples of where they had seen (or could envision) primary care providers/clinics working to address social determinants of health (SDOH), such as the physical environment, health behaviors, or social and economic factors. Their ideas appear below in “What works.”

What works

- **Embedding services:** Stakeholders described clinics offering legal resources on-site, partnering with schools to set up wellness centers, or trying out an embedded behavioral health approach in which a licensed clinical social worker is available at the clinic for walk-in sessions. A public health department is also working with parents and schools, then sharing their priorities with clinics.
- **Coordinating with partners and aligning efforts:** One of the stakeholders collaborated with the county on a community health needs assessment, then used the results to align with the local hospital on shared goals. Another is participating in an Integrated Health Partnership (IHP)⁷ focusing on the needs of the Medicaid

⁷ IHPs are an initiative introduced under Minnesota’s 2008 health reform law that “strives to deliver higher quality and lower cost health care through innovative approaches to care and payment.” Minnesota Department of Human Services, “Integrated Health Partnerships (IHP),” MN.gov, June 7, 2019. <https://mn.gov/dhs/partners->

population. A major health system has coordination-of-care committees “that have been powerful to connect partners.” Some participants have found the Community Health Worker (CHW) care coordination model to be effective, insofar as it serves as a hub to connect individuals with other services. A self-advocate from The ARC described how her doctor coordinated with the human services department to help her retain her disability benefits.

- **Screening tools to explicitly identify patient needs:** A clinic is implementing a pilot in which they conduct “social needs screenings” (i.e., food security, safety, transportation, and housing quality) and scan them into the system to identify resources for these needs. Notably, “we do not screen for factors that we cannot address with solutions,” the participant said. A second participant described a grant their organization received from the Health Resources and Services Administration (HRSA) that reimburses patients with serious mental illness for completing an assessment, including biomarkers. Other participants described using SDOH screenings and assessments: “These are things that may come up in a regular conversation, but once explored, it opens up an opportunity. We cannot connect [patients] to services if we don’t know the need.” Similarly, another stakeholder is using Epic’s⁸ SDOH module: “We’re assessing on a community basis. We’re only using the modules when we have a solution to the identified problem.”

Success factors

Through their discussions of “what works,” participants highlighted success factors that contribute to primary care providers’/clinics’ efforts to address SDOH:

- **A focus at the provider level on whole-person health:** Instead of looking at the medical issue first, clinics should “address the person first,” stakeholders said. This means acknowledging that some patients cannot focus on the follow-up medical care because they are too busy dealing with other issues in their lives. “Ask them when they come in the door: ‘What are your three major issues?’” a participant suggested. “Even if you can’t do anything about it, it’s a matter of empathy.” Further, having such information could help providers connect patients to resources and inform how to put their care teams together.
- **Patient engagement and goal-setting:** Patients must be invested in efforts to examine other areas of their lives. Many stakeholders are asking clients about their barriers and setting goals together to overcome them. One clinic recalled a training on health coaching that had increased their patient engagement on SDOH. A disability-services organization said, “We have moved to ‘person-driven care,’ so that [services] are not ‘being done to them.’ The person is now making the decisions.”
- **Knowledge of available resources:** If patients do not know about existing tools or resources, they cannot access them, stakeholders said. Proposed solutions include resource directories or books, communication and education by providers, and more community partnerships to make providers aware of emerging opportunities. “In our community, we find out about new resources all of the time,” a participant commented. “Many are underutilized because we just do not know [about them].”
- **Communication and coordination:** Stakeholders cited sharing information, communicating across providers and community partners, and communicating across teams within an organization as success factors. At the

[and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/](#)

⁸ Epic is an electronic medical records platform.

patient level, “We have to ask the right questions or patients don’t identify all of the people helping in their care,” a participant said. Another commented, “It is hard if a patient cannot identify which service is helping with certain aspects of care.”

It is also important to coordinate resources in the community to ensure that clients’ needs are met, taking the time to “work to identify who can do the best job, and let them do it.” Otherwise, duplication of efforts affects both the patient and the organization: “We get referrals, but we find later that the patient has been through five other agencies.” Even simply communicating with community partners that a particular stakeholder is leading care coordination can be helpful.

- **Care teams/care coordination:** Care teams (also called care coordination) enable multiple service providers to support whole-patient health for their clients, stakeholders reported. “This is exactly the approach in care coordination, with a comprehensive care plan looking at all of the aspects—case worker, Meals on Wheels, county [services],” a participant said. Another gave an example of a care coordinator attending a patient’s discharge meetings.
- **Data for patient risk assessment:** Several stakeholders touched upon the need for better data on whole-person health, as well as a comprehensive “risk scale.” “We want to assess all patients for risk,” a participant said.
- **“Meet people where they are at”:** Provide health resources outside the clinic, in the community where people already are, for easier accessibility. One stakeholder commented that “we should be screening for SDOH in all settings.”

Other success factors participants identified include:

- Buy-in from leadership
- Putting structures in place to follow up on referrals
- Focusing on policy, systems, and environmental change

Top health priorities in the community: Access to care, mental health, and transportation

Stakeholders in the “individual and community health” small group also identified and discussed the top health priorities they had observed in their communities. The most common issues stakeholders mentioned were access to care, mental health, and transportation. One participant described the following example of how transportation intersects with health and other issues: “An elderly woman’s husband moved her to [a rural county]. They have minimal plumbing, an outhouse, and no transportation. Now her husband has Alzheimer’s disease. It’s complicated.”

Other health priorities stakeholders identified include:

- Cardiovascular disease
- Education
- Hepatitis C
- Home environments (challenging and unsafe)
- Narcotics

In the latter half of their discussion, participants were asked who could work with primary care on these health priorities. They proposed community partners, home care, nurses, other providers, public health, and social services. Participants also brainstormed who else could serve on care teams with primary providers, such as:

- Benefits enrollment managers
- Clinical pharmacists
- Faith community leaders/members
- Front desk attendants
- Home care nurses
- Housing navigators

Barriers and solutions

When asked what barriers must be overcome for primary care to better address SDOH, stakeholders highlighted the following challenges and possible solutions:

- **Differing understanding of what “health” means:** Some participants pointed out that “one size does not fit all” and that patients may have divergent ideas of what health means on many levels. “Is it attaining a lower A1C [a blood sugar level indicator], or having food and housing? This is different for everyone,” a stakeholder commented. Thus, providers should ask patients what their definition of health is, then speak to the person’s level of health based on that understanding, including expectations and goals. If the clinician uses a preset definition of health, “and I didn’t understand it, I am distrustful,” a participant said.
- **Doctors may not value or understand SDOH/“whole-person care”:** Nurses may typically understand these concepts better than doctors, a stakeholder said. “We need to change the training for practitioners,” one participant suggested. Another gave an example of a large health system working to address this by adding medical codes for SDOH.
- **More support needed for primary care:** “We want to have another conversation on how to improve the system to support primary care,” a participant commented. Many stakeholders expressed the view that primary care should be the party responsible for care coordination and that primary care needs more support from the larger health care system. For instance, the current health care system is new to the concept of whole-person health, does not support care coordination (e.g., payers, data managers), has not provided sufficient resources to primary care, and has not paid primary care for the resources needed to do this work. Lastly, a participant pointed out, the Centers for Medicare and Medicaid Services (CMS) should focus on primary care, as they have stopped paying for preventive care in a medical home.
- **The need to break down siloes and coordinate for patients’ behalf:** To truly address the SDOH, the health sector must break out of siloes and work in partnership with the community, stakeholders stated. “We need to be aware of community resources,” one participant said. “Clinics don’t always know this.” Further, health sector organizations sometimes seem possessive of their turf: “The primary care provider, hospital, and health plan don’t currently talk to each other. Each of these have a ‘What’s in it for me?’ . . . They are each trying to protect their work with the individual.” As a solution, participants proposed a single care coordinator who could work across organizations and connect the patient with a social worker and other providers. CHWs can play this role, but their value must be communicated to physicians, who may also feel protective of their roles. CHWs are “not there to take a person’s job, but to enhance the ability to improve health,” a stakeholder said.

Other barriers participants identified include:

- A shortage of care coordinators/care coordination resources
- Family members' own challenges (“Sometimes the need of a family member must be met before we can address [the patient’s] need;” “We communicate to our caregivers that it is OK to take care of yourself”)
- A need for better reimbursement from insurance for mental health services/access to mental health care, which would help make such services and programs more sustainable

2. Community partnerships

Stakeholders in the “community partnerships” small group reflected upon where they had observed (or could envision) efforts to coordinate care across community groups or between community groups and primary care. A summary of their ideas appears in the section below, “What works.”

What works

- **Connections across services and resources:** “Integrate the community into health-care setting—or use the community as the foundation [of partnerships], versus using clinics,” a stakeholder suggested. Some clinics have social workers and staff from schools present at their facilities. Others have embedded resources, such as referrals to social services, employment, and food shelves or do in-reach to community paramedics and the emergency department. “Innovate to make it easy for patients,” a participant said. A community paramedic program looks at home safety. A central Minnesota community action program helps people obtain housing and transportation. One clinic partners with mental health agencies, human services, schools, the local hospital, and the YMCA. “Engage community partners around the care plan,” another participant commented.
- **Local/regional coalitions and initiatives:** A clinic has joined with other agencies in the area to form an “Early Childhood Coalition” to address the childcare shortage. A city police department has launched “community outposts” to improve community relations and decrease arrests. In Fergus Falls, a LiveWell civic committee partnered with a local health system and mental health services organization to offer mental health trainings open to the public. Other organizations have used grant funding to create community partnerships, such as through a Community Wellness Grant, the Statewide Health Improvement Partnership (SHIP), or a State Innovation Model grant “where we began to learn each other’s roles,” a participant said.
- **Sharing information:** Community emergency medical technicians (EMTs) share 911 data with care teams to provide input into care planning and goal-setting. A clinic has easy access to electronic health records (EHRs), so the care coordinator follows up on SDOH scores, resources a social worker has identified, and access to care. Rural learning collaboratives were launched to address a health-information exchange and share information. The doctor of a self-advocate at The ARC connected her to the University of Minnesota Medical School, where she gave a presentation to first-year medical students on the intersection between sexuality and disability, as well as how to serve people with unique disabilities.
- **Integrating health resources and services into the places people already frequent:** In Central Minnesota, the “Feeling Good Minnesota” initiative focuses on healthy eating/active living, adverse childhood experiences, and tobacco prevention—such as by sharing antismoking information during parent/teacher conferences. A provider offers primary care to patients in residential facilities and in the community, such

as people with disabilities, “which allows them to receive appropriate care at the right time,” a participant said.

Success factors

By reflecting on what made these examples effective—or ineffective—stakeholders pinpointed several “success factors” in forming community partnerships to coordinate care:

- **Focus on “community-led”:** “Grassroots works better than top-down.” The community should serve as the foundation and the leader of the partnership, not the clinic or the health care system. This allows the partnership to be more directly shaped by the needs of people accessing services, instead of by the “brain trust.” While health care should *support* the partnership effort, “we need to know when to follow others in the community—the other 80 percent that influence health,” a participant said. Where feasible, consider offering resources in a central location, i.e., a community hub. Reach people where they already are, and not just in a clinic setting. “Community partners are the care team.”
- **Clarify roles and areas of expertise:** Think about who should be at the table for a partnership—including culturally diverse groups and individuals. Acknowledge various partners’ expertise and try to avoid duplicating efforts. Define the “swim lanes” for each; make sure each partner understands their role. Share this information across (and within) organizations.
- **Put trust and relationships first:** Relationships are critical to all community partnerships. Establishing trust contributes to success. Moreover, “the way that we communicate with partners makes a difference. Know your community’s needs.” Build a reciprocal relationship, with each party understanding how the services benefit their clients and how it contributes to measurable outcomes for their populations.
- **Invest in relationships between social services and health care:** There must be respect between medical providers and social services—an understanding that each has expertise and value. Acknowledge the differences in language (e.g., “care coordination” versus “care management”), technology, measurement, and accountability between these parties, but also recognize shared goals.
- **Establish systems for ongoing communication and collaboration:** Share information and close the loop whenever possible. Establish workflows for facilitating communication and obtaining consent to allow communication between organizations/agencies (e.g. obtaining consent from the client during a home visit to connect them with the clinic).

Other success factors stakeholders identified include:

- Passion and drive
- Innovation
- Funding aligned with goals
- Knowledge of how to move “outside the walls of the clinic/health care”
- Clinics better understanding the needs of their patients so they are able to see the value in partnering with other organizations
- Taking into consideration how *the patients themselves* define “health” and what it would take to achieve it, instead of letting health care define it

Barriers and solutions

Participants identified many barriers to coordinating care through community partnerships, as well as some potential solutions to overcome these barriers:

- **Knowing what resources are available and whom to work with:** Stakeholders don't always know which partnerships or groups already exist in a particular area, and "we don't want to waste resources if an issue is already being successfully addressed elsewhere." For instance, in one Metro-area county, there is redundancy in providing services because many groups have similar focus areas and coordination is not happening, a participant said. Thus, clients are receiving the same services from different places. Even if one is aware of these groups, it can be difficult to find the right person to connect with for support and information. What's more, the patients themselves may not be aware of available services, and "they don't know the 'magic words'" to ask for the services they need.
- **Restrictions around sharing information due to privacy laws:** Because of the Health Insurance Portability and Accountability Act (HIPAA), stakeholders face confusion and concern around sharing information with partners: "We never know who we can talk to." Minnesota data privacy laws are also a constraint. Furthermore, "EHRs are not designed for community health outcomes," a participant said. As a result, some partnerships and data resources are underutilized.
- **Funding:** Funders often award grants based on "a constantly changing landscape that is disease-/condition-driven, not health-driven" a participant said, and partnerships may end (e.g., Accountable Communities for Health⁹) when the grant funding runs out. In terms of incentives, "accountability for primary care is measured by health outcomes, while dedicating time to SDOH may not be financially supported or viewed as a measurement of success." Every organization—including government—needs a financial model to sustain it, and these efforts and initiatives require funding. "It's a challenge for someone to take on the work (funding, time, access, etc.)" a stakeholder commented. "We should not look at resources as free."
- **Knowledge and appreciation of new models:** Not all providers are knowledgeable about value-based care, population health, and how an expanded care team with team members can "make health happen." Some providers do not appreciate the value of dedicating staff time to this work, a participant said. Awareness must be disseminated from the organizational level to the individual level within health care.
- **Risk-taking:** Coming together for community partnerships can be challenging, as it requires a willingness to be transparent, have vulnerable conversations, and take risks. "Even in Accountable Care Organizations (ACOs)¹⁰ and IHPs, we have to take a lot of risks." What's more, although many stakeholders would like to

⁹ "An Accountable Community for Health (ACH) is a structured, cross-sectoral alliance of healthcare, public health, and other organizations that plans and implements strategies to improve population health and health equity for all residents in a geographic area." Prevention Institute, "Accountable Communities for Health (ACH)," [www.PreventionInstitute.org](https://www.preventioninstitute.org/projects/accountable-communities-health-ach), June 11, 2019, <https://www.preventioninstitute.org/projects/accountable-communities-health-ach>.

¹⁰ According to the Centers for Medicare & Medicaid Services, ACOs are "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients." Centers for Medicare & Medicaid Services, "Accountable Care Organizations (ACOs)," [CMS.gov](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/), March 8, 2019, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/>.

take risks and try out new initiatives, reimbursement is not always available. “We are being punished for trying to innovate.”

- **Staffing issues:** Stakeholders are concerned about the shortage of primary care physicians, as well as insufficient resources for behavioral health. Workforce turnover causes issues. Staff are already spread very thin—making it difficult to add new initiatives to their workloads. Some participants also feel there are “too many care coordinators.” “We need a care coordinator to ‘coordinate the care coordinators’” and avoid duplication of efforts, they said.

Participants mentioned a few additional barriers/solutions:

- It is important to first evaluate existing community partnerships, as well as ways to achieve greater efficiency. The Metro area suffers from “too many resources,” and thus patient populations and services are fragmented, a participant said. In Greater Minnesota, the reality of fewer resources requires organizations to coordinate, “but there is a lack of support.”
- It can be complicated to form community partnerships when “the folks who need to be at the table are competitors.”
- Because community engagement is not typically an area of focus for primary care clinics, public health and primary care should form partnerships. Yet oftentimes, “public health departments are not invited to the table.”
- Payer organizations, ACOs, Minnesota Community Measurement,¹¹ and the health care system should work together to coordinate initiatives.
- Partners should keep track of quick wins and establish ways to measure partnerships’ successes.

3. Health equity

Participants in the “health equity” small group discussed where they had observed (or could envision) examples of the health care sector or other fields working to advance health equity. A summary of their ideas appears in the section below, “What works.”

What works

- **MDH programs:** Stakeholders shared their experiences taking part in MDH’s health equity learning community and HCH program. “HCH certification is very helpful for mental health clients, people with disabilities, and people experiencing homelessness. It helps people understand what they need to do,” a participant said. Another said that HCH provides a structure and “opens the door to working with higher-need patients on SDOH.”
- **Local programs:** Stakeholders are organizing programs and collaborative efforts locally, such as:
 - Offering intercultural trainings

¹¹ “Minnesota Community Measurement is a nonprofit, multi-stakeholder collaborative organization that empowers the community with data and information to drive improvement in health care cost and quality. Collaborators include physicians, hospitals and health systems, health plans, employers, consumers, and state government.” Minnesota Community Measurement, “About Us,” <https://mncm.org>, June 13, 2019, <https://mncm.org/about-us/>.

- Hosting a “Bridges to Health Equity” meeting
 - Forming a diversity and inclusion group that uses an intercultural inventory
 - Holding a series of community conversations and working with Maria’s Table to build awareness
 - Hosting film screenings and inviting the White Earth Tribe to come to speak to the group
- **Improving upon and expanding existing services and resources:** Some groups have started to improve upon and expand their services and resources, including covering the cost of transporting patients to appointments, offering additional interpreter services, and summarizing the plan-of-care in plain language and printing it for the patient and family. One county health department said they are having “great results” with CHWs—from which many best practices are emerging.
- **Successes in serving specific populations:** Stakeholders have adopted new strategies and practices to serve specific patient groups that experience health disparities. One participant mentioned the importance of incorporating trauma-informed care, especially for people with severe mental illness. He also described advocating on behalf of these patients’ health: A situation arose in which county officials were asking a psychiatric hospital to admit people with severe mental illness whom police had in their custody. The hospital advocated for these patients to first see a primary care clinician to make sure they were healthy before being admitted. “We showed them the data, and that worked,” he said.

Participants also described using data to understand trends in colorectal cancer screening among the Somali population. As a solution, the organization developed a video for Somali TV to inform people on the importance of getting screened. CHWs have proven to be a helpful resource in educating newcomers on how the health care system works in the United States. “Cultures recognize preventative care in different ways or use resources differently,” a participant said. “Teaching them about the health care system is an important component of navigation and helping them to understand.” In another example, a local public health department’s Children and Teen Checkups outreach program visits new immigrant families to discuss their benefits, either at their homes or another preferred location.

Success factors

By reflecting on what made these examples effective, or ineffective, participants identified the following “success factors” in promoting health equity:

- **More collaborative work:** Health care actors (e.g., local public health, MDH, and clinics) can work to address this issue, but it must be a shared responsibility. Initiatives should be community-based. Consider a “community hub” resource. Groups should also share information and best practices so that “we are in it together” and “know what each other is doing.” One participant suggested “measuring [outcomes] together so that we know if we are making a difference.”
- **Involving diverse stakeholders with knowledge of particular groups’ needs:** Bring people to the table who are working on homelessness, prisoner reentry, and severe mental illness. These groups need specific resources, and this is an equity issue. People with severe mental illness have often experienced trauma in health care (e.g., being transported in police vehicles, having restraints used on them, being forced to take medication). Prepare clinics to “meet people where they are,” such as through practicing trauma-informed care.
- **Build cultural competency:** Be proactive, not reactive. Take the time to foster cultural competency among staff—including front desk staff. “Don’t rely on just one person” for cultural competency. As an example of

the importance of having cultural competency, one participant shared that some cultures would rather refer to end-of-life care as “advanced illness” conversations.

- **Invest in approaches that seem promising for populations with disparities:** CHWs and community outreach for specific populations both have yielded promising results. The ability to coordinate care between primary care and other agencies can also be very beneficial for those who have difficulty navigating the systems.

Barriers and solutions

Participants at the HCH community events identified many barriers to primary medicine effectively promoting health equity and culturally appropriate care. This section explores each of these themes, as well as several solutions that workshop participants proposed:

- **Unclear roles and responsibilities of various actors in working toward this goal:** Roles and “ownership” in working on health equity are unclear. Participants asked who should take the lead on this issue and stated that “the component parts of the system” must begin thinking and acting differently.
- **A lack of meaningful collaboration across these actors:** Collaboration and coordination on health equity among primary clinics, health systems, community groups, or government has not yet achieved its full potential. In some cases, stakeholders have not identified whom the best partners would be to work with, or have not reached out to learn about efforts currently underway. In other instances, groups are making an effort to collaborate, but those relationships are not yet strong enough to address difficult topics such as racism. “You have to start where a community is at,” a participant said. “Not all communities are in the same space to address health equity.”
- **Reasons why certain groups of patients cannot/do not access care:** Stakeholders identified personal finances, dealing with medical symptoms, prioritizing food over health care, and an inability to take time off from work as reasons why patients might not access medical services. “Equity is about more than just race,” one participant said. Cultural norms, language differences, and religious views may also act as barriers or complicating factors in health care. For instance, a participant with experience in the mental health field said that in his experience, the lengths of stay are longer for people who don’t speak English. At several sessions, transportation came up as a factor. Some self-advocates at The ARC described the difficulty they face in making arrangements to get to the clinic, requiring coordination between the patient, group home staff, a social worker, and the transit provider. And “when facilities move, it can be harder for us to get to the new location,” an ARC participant said. “They say take a bus, but the bus does not go to my clinic,” another commented.
- **Trust (or the lack thereof):** Trust is vital when serving patients with health disparities, stakeholders agreed. “We must recognize that there is community fear and distrust of the system. We need to regroup to address issues of fear and trust,” one participant commented. Another described their firsthand observations: “We work with a population that often feels there are a lot of stigmas. They don’t feel welcome and won’t engage in [health] care because of fear and lack of trust.” Thus, the first step for primary care could be to promote a sense of safety, significance, and belonging, participants said.
- **The need for self-reflection or self-assessment:** A related step is for health-care settings of all types “to monitor how welcoming their atmosphere is through the eyes of a patient—starting at the front desk, working their way all the way through.” In the spirit of self-reflection, health-care providers should look internally and address implicit bias and racism. “All staff need to ‘own’ this,” a participant commented. And, participants said, public health departments should strive to create a welcoming environment as well.

Some proposed solutions in this area included “listening to understand” and offering staff training on diversity, including the option for organizations in rural areas to participate remotely. Primary care providers should also listen to feedback and customer service surveys, especially within diverse or disadvantaged groups. One participant stated that patients with public health insurance sometimes feel like they are treated as “second-class citizens.”

Participants at The ARC shared some similar experiences. “They don’t take people with disabilities seriously. It’s like we don’t exist,” said an ARC self-advocate. Another described a situation in which she had symptoms of appendicitis, but the clinic staff did not believe her—because, she suspected, they were accustomed to hearing other residents of her home complaining of stomachaches. After she went to the emergency room, a scan revealed the seriousness of her condition. Asked what primary care could do to advance health equity for people with developmental disabilities and in other disadvantaged groups, an ARC self-advocate responded, “It’s simple—a doctor who listens to us and what our needs are, and comes up with solutions.”

- **Limited diversity within the workforce and management/leadership:** Although workforce diversity is improving, limited diversity among health care staff and management/leadership contributes to barriers to health equity, participants said. Regarding solutions to this issue, stakeholders suggested that providers make a greater effort to recruit from diverse communities. Engaging with professional organizations that represent people of color in health care (e.g., the Minnesota chapter of the Black Nurses Association) could help organizations better understand recruitment issues and address them collaboratively. Participants also suggested that health care organizations work with schools and secondary education institutions to recruit more diverse professionals.

At the management level, stakeholders commented that a lack of diversity can have far-reaching impact. “Decisions are typically made by a higher-level manager who isn’t familiar with the health of the community,” a participant said. “Are their approaches really meeting the needs of the community?” To address this, health-care organizations should invite community experts to provide information and ensure that leaders have professional pathways to expand their horizons beyond just awareness.

- **Funding and reimbursement:** Stakeholders said challenges related to funding and reimbursement serve as barriers to primary care promoting health equity. “It costs money to provide care/services to support equity,” one participant commented. Although several stakeholders cited care coordination as a helpful practice in serving patients experiencing health disparities, having the staff in place and getting reimbursed for those services has proven to be difficult. As a response, some stakeholders suggested measuring the return on investment for care coordination and making the “business case” to payers for focusing on health equity and SDOH. “We need more evidence on what works,” a participant said. “Incentives and reimbursement are inadequate.”

Another concern stakeholders raised in this area is that negotiated reimbursements do not match the actual cost of providing services. For instance, one provider said they lose large sums of money offering physical therapy because the reimbursement doesn’t cover the cost of paying staff—which reduces access to care.

- **Disability competency:** Awareness and sensitivity to the needs of people with disabilities should be integrated across approaches and solutions, stakeholders said. People with disabilities face many challenges that other populations do not:

- They may have more difficulty accessing primary care, which can lead to more urgent care and emergency department visits.
- Following up on referrals can require more resources and outreach for people with disabilities.
- There is a higher prevalence of abuse of people with disabilities, especially people with developmental disabilities.

However, there aren't easy ways to find doctors who have disability competency—i.e., who are knowledgeable about and adept at serving people with disabilities. “Competency cannot only be about physical access,” a participant commented. Another participant described a meeting with a major health system at which he asked, “How can we identify providers who have competency with the disability community?” The organization responded that there isn't a way to identify these providers, either publicly or internally. This stakeholder recommended to the health system that providers' bios indicate whether they are competent in treating people with disabilities.

People with disabilities' quality of life can be affected if a provider does not understand that a disability and a health condition are not necessarily connected. For instance, if a person with a disability presents as depressed, a provider may assume that it is due to their disability, but this may not be the case, this stakeholder said. The patient may be clinically depressed and need treatment. “Don't assume that you know what the issue is. Talk with the person,” commented a self-advocate at The ARC.

Participants touched upon two additional, overarching solutions for how primary care can advance health equity: integrating health services into places people already frequent, and promoting diverse local coalitions that know their communities' needs.

- **Integrating health services into places people already frequent:** People may be accessing health care in different ways. Thus, primary medicine should think differently about how care is provided, such as educating people at a place that is already familiar to that specific community. At The ARC, a participant recalled an example of a program to provide hearing screenings at the Special Olympics.
- **Promoting diverse local coalitions:** Because no two communities are alike, there is a need for localized community solutions and diverse players represented on local coalitions or councils. Stakeholders suggested assessing the adequacy of community resources, setting up an advisory body with paid stipends for members, and bringing employers and businesses into the discussion. Cast a broad net in forming these groups, one participant said, because typically the same people are tapped over and over again.

4. Next steps

MDH anticipates the following next steps in the rulemaking process:

- HCH Advisory Committee review
- HCH Rulemaking Advisory Committee review
- Review of rule and Statement of Need and Reasonableness (SONAR) by the Governor's Office
- Announcement of notice of intent to adopt rules
- Public hearings (if MDH receives 25 or more requests for such hearings)
- Office of Administrative Hearings review
- Governor's office final review
- Office of Administrative Hearings files publication of the notice of rule adoption
- Governor's veto period
- Publication of notice of final adoption