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# Advancing Health Equity by Sharing Data from the Minnesota Statewide Quality Reporting and Measurement System

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Report to the Minnesota Department of  
Health

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By Voices For Racial Justice and Its  
Community Partners

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## Executive Summary

Minnesota’s serious and persistent health disparities experienced by racial, ethnic, and other populations cannot be effectively addressed unless the disparities experienced by each group can be identified and quantified through health data. Since 2009, our organization—Voices for Racial Justice (Voices)—has collaborated with other advocates in making recommendations to state agencies, task forces, and commissions that address the inadequacies of government data collection and reporting methods to identify and address health disparities experienced by different populations.

In 2014 and 2015, the Minnesota Legislature enacted requirements for the Minnesota Department of Health (MDH) to add data on the social determinants of health to health care quality measures in the Statewide Quality Reporting and Measurement System (Quality Reporting System). MDH asked us to assist them in implementing these new requirements by obtaining input from communities disproportionately impacted by health disparities (referred to as “communities” or “the community”) on the collection and use of these data. We trained community Health Equity Champions, and conducted interviews and held listening sessions with community members and representatives of community-based organizations.

## Findings and Recommendations

Those involved in this work—i.e., community members, Health Equity Champions, Voices staff, MDH staff—struggled with this project. Community members have been investing time and effort since 2009 on the broader issue of developing or getting data from government agencies. We have broad interests in this topic; yet, this data project was narrow in scope, primarily technical in its focus, and very limited in its usefulness to help us reach our goals to affect health disparities in Minnesota. The Quality Reporting System, by focusing on limited technical measures of clinical quality for a handful of health conditions, intersects with just a narrow aspect of what we value as the key contributors to healthy people and communities.

While we appreciate that MDH asked us to be a part of this project and value the MDH team’s effort to bring authentic engagement practices to it, the community members struggled deeply to stay within the bounds of the Quality Reporting System, and community conversations tended to focus on the upstream social determinants of health and related data.

In light of these challenges, MDH program staff encouraged us to share our feedback on the broader topic of government data: approach to research, issues concerning collection and analysis methods, use and dissemination of data and research findings, and **structural racism** (barriers) experienced by the community in becoming an equal participant and change agent.

### Findings

- **It is imperative that MDH makes progress on its goal of strengthening the collection, analysis, and use of data** to advance health equity that it put forth in its 2014 Advancing Health Equity report, and it can make great strides through meaningful community engagement.

- MDH’s data collection, analysis, and dissemination activities are largely lacking authentic community input. We are generally involved late in projects and asked to review finished projects.
- It is difficult for communities to systematically access and understand the various datasets MDH holds for a variety of reasons including: how MDH disseminates information (e.g., MDH communicates information exclusively in English, relies on listservs which people may not know about and its website which is difficult to navigate, etc.); how data access and use are governed in law and rule; and the lack of technical assistance to communities to make data and reports meaningful and understandable.
- There are substantial structural barriers to the community rising to become an equal partner in the effort to develop and use data to reduce health disparities. This includes the availability of resources to participate in discussions and gain technical experience, the fact that much of MDH’s work is embedded in complex legal and administrative processes into which the community has little insight (e.g., rulemaking), and MDH’s reporting style which is very technical and relies on the written word whereas the community benefits from storytelling and in-person discussions.
- There is significant community distrust of MDH due to historical barriers and trauma. The absence of the community’s voice and participation in MDH’s data activities exacerbates distrust and missed opportunities to co-create strategies to advance health equity. Additionally, distrust creates tension which MDH shies away from, and this avoidance compounds the community tension and distrust.
- While our projects with MDH on the Quality Reporting System have been promising and a step in the right direction to advance health equity, **MDH and its partners fail to use authentic community engagement in its evolution of the Quality Reporting System.**
  - MDH obtains data collection and analytics, provider education, and measure recommendation services, but does not obtain community engagement services. Additionally, the vendors that MDH works with are in the health care industry and do not represent communities that are impacted by health disparities.
  - The measures in the Quality Reporting System were developed largely by health care experts without the input of communities that experience health disparities.

## Recommendations

- MDH should create a Community Data Sharing Advisory Committee comprised of representatives of communities impacted by health disparities. This Committee will advise MDH on how to collect, analyze, and share health data and analyses with communities. The Committee will create a partnership between MDH and communities where communities are decision-makers, they are engaged throughout the entire process, trust is intentionally developed, and partnership strives to create solutions for the short- and long-term trajectory of data collection, analysis, and dissemination.
  - The Advisory Committee must be co-facilitated by a person from the communities of color impacted by health disparities and an MDH staff
  - The Advisory Committee will intentionally include members of the different communities disproportionately impacted by health disparities.

- The Advisory Committee will start by defining membership, the process they will follow, and the frequency with which they will meet.
  - This Advisory Committee will adhere to the Principles of Authentic Community Engagement.
- MDH should create a Community-Based Participatory Research Center to implement advisory committee research recommendations.
    - This Research Center will adhere to agreed-upon the principles of community-based participatory research.
    - The Advisory Committee will guide the work of the Research Center, providing advice on how to engage communities impacted by health disparities to be partners in setting priorities around data, as well as implementation of innovative practices. The ultimate goal of this coordination of efforts between the Advisory Committee and the Research Center will be to have more meaningful data available with the intentional purpose of addressing health disparities and achieving health equity.
  - The Community Data Sharing Advisory Committee and Community-Based Participatory Research Center could be launched with a Quality Reporting System project as a proof of concept, and then the Committee and Center’s scope could be expanded to include other MDH programs and datasets.
  - MDH should have ongoing, shared, high-level discussions with community leaders to work on legislative solutions that enable the agency to meet the expectation the community has with regard to technical support, process changes, and data access.
  - With regard to the Quality Reporting System in particular, we recommend that:
    - MDH include authentic community engagement in its structuring of the Quality Reporting System.
    - When MDH develops new quality measures, it authentically include the community.
    - MDH provide data to the community by ensuring raw data and companion materials are accessible through the MDH website and mobile site, and making reports and visuals available at events hosted by communities with staff on-hand who can explain the data using culturally competent methods.

## Introduction

This report provides the findings, conclusions and recommendations of community engagement activities undertaken by Voices for Racial Justice (VRJ)<sup>1</sup> under a contract with the Minnesota Department of Health (MDH) to, *“obtain feedback and participation from representatives of communities impacted by health disparities in support of MDH’s implementation of its duties under the Statewide Quality Reporting and Measurement System (Minnesota Statutes, 62U.02)<sup>2</sup> to stratify quality measures using socio-demographic factors and share results with the community through public reporting.”*

This project builds upon previous efforts to achieve health equity in which VRJ provided MDH with recommendations about collecting and using patient socio-demographic information for purposes of stratifying quality data; raising awareness of social determinants of health, structural racism, and discrimination; and identifying and eliminating health disparities. One of VRJ’s recommendations was, *“Make aggregate health equity data available to communities.”*

VRJ developed their findings and recommendations for this project in consultation with member of the communities most impacted by health disparities using the VRJ Principles of Authentic Community Engagement. VRJ always intends that these kinds of efforts will also be valuable in providing a larger context for public discussion of health and racial disparities. As stated in its previous report, VRJ aspires *“To present the perspectives of (racial, ethnic and socio-demographic (RESA) communities in a way that provides the context needed by policymakers, public officials, health care leaders and others to build authentic relationships, partnerships and communication channels for having the important continued conversations of the future and vitality of Minnesota’s communities who are disproportionately impacted by health inequities based on race, ethnicity, language, and socio-demographic factors (including but not limited to gender identity, sexual orientation and disabilities status.)”<sup>3</sup>.*

A core value of this report is that communities’ wisdom needs to be at the center of any effort authentically addressing the challenges communities are facing.

## Project Background

### Health Care Quality Measurement

A health care quality measure is a specific qualitative or quantitative indicator that measures health outcomes, processes, structures, or patient experience, access, or safety, or other desirable results for a defined population of patients.

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<sup>1</sup><http://voicesforracialjustice.org/>

<sup>2</sup><https://www.revisor.mn.gov/statutes/?id=62u.02>

<sup>3</sup><http://voicesforracialjustice.org/wp-content/uploads/2014/10/RESA-Report-VRJ-01-26-15.pdf> (page 6)

Quality measures can be used by different groups of people for various purposes. Patients can use quality measures to help make decisions about where to seek care, and to engage with their caregivers. Doctors and nurses can use measure results to improve care quality. Health care insurers and other purchasers may use quality measures to identify and financially reward high performing clinics and hospitals. Quality measures can also be used to identify disparities in care, and tell us more information about the relationships between people and the care received by looking at quality measure data along with patient socio-demographic data.

One of the ongoing challenges related to developing and evaluating programs to address and eliminate health disparities is the relative lack of data on many of the contributing socio-demographic factors including data directly available to communities that are most impacted by health disparities and inequities. Socio-demographic characteristics are important for understanding system-wide variations and disparities in quality of care because evidence shows that many of the factors that most heavily impact a person's health status exist outside of the healthcare system. These include factors such as income, education level, neighborhood assets, access to healthy food, and housing stability. While a health care provider may not be able to directly influence many of these factors, a deeper understanding of them can impact the type of care that the provider recommends, the likelihood that the care provide will actually improve the patient's health status, or the types of supportive services that may be necessary for the patient as part of any treatment regimen.

MDH, providers, organizations, advocates, and patients can use quality measures to identify care disparities through methods such as stratification. "Stratification" is a method that can be used to combine socio-demographic factors with quality measures to examine and report measure results by different groups or combinations of groups. Stratification enables the identification of healthcare disparities for certain patient groups and can unmask health care disparities by examining performance for groups who have been historically disadvantaged compared to groups who have not been disadvantaged.

## The Minnesota Statewide Quality Reporting and Measurement System

Minnesota clinics, hospitals, and health plans have a rich history of voluntarily collecting health care measure data, and these efforts used a variety of measures and metrics.<sup>4</sup> These voluntary measurement activities were standardized statewide through the passage of Minnesota's 2008 Health Reform Law which required the Commissioner of Health to establish a standardized set of quality measures for health care providers in Minnesota.<sup>5</sup> The goal is to create a more uniform approach to quality measurement to drive health care quality improvement through an evolving measurement and reporting strategy. This standardized quality measure set is called

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<sup>4</sup>Stratifying Health Care Quality Measures Using Socio-demographic Factors: Report to the Minnesota Legislature 2015. Minnesota Department of Health.

<sup>5</sup>Minnesota Statutes, section 62U.02.



the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System).<sup>6</sup>

More than 1,200 clinics report on 12 quality metrics, and 133 hospitals report a number of measures on an annual basis. The Quality Reporting System includes clinic and hospital quality measures that are submitted via different mechanisms from different sources. As a result, MDH's ability to stratify quality measures based on socio-demographic factors must recognize the different submission processes, data standards and capabilities that are currently in place for clinics and hospitals. The measures in the Quality Reporting System have three primary data sources:

1. Providers' patient medical records, which are increasingly stored in an electronic health record system;
2. Patient experience of care surveys that providers dispense to patients through survey vendors; and
3. Administrative claims, which are stored in a practice management system and are also referred to as "discharge data" in the hospital setting.

Community input and engagement inform MDH's development of quality measurement and reporting for the state. Each year, the Commissioner considers recommendations for the addition, removal, or modification of quality measures. MDH updates the quality measure set annually, drawing on community feedback. To cover essential roles such as data collection, measurement development and maintenance, provider education and making recommendations for changes to the measurement set, MDH contracts with a consortium of vendors that is led by MN Community Measurement and includes the Minnesota Hospital Association and Stratis Health.

## New Legislation and Collaboration between VRJ and MDH

In 2014, the Minnesota Legislature directed MDH to develop an implementation plan for stratifying Quality Reporting System measures based on race, ethnicity, language, and other socio-demographic factors that are correlated with health disparities and impact performance on quality measures.<sup>7</sup> The legislation directed MDH to develop the plan in consultation with organizations representing diverse communities and use culturally appropriate methods of consultation and engagement with organizations led by and representing diverse communities.

As a part of this plan, MDH contracted with Voices for Racial Justice (VRJ) to obtain input from community representatives using culturally appropriate methods. VRJ and community Health Equity Champions interviewed 85 members of diverse communities disproportionately impacted by health inequities. Based on the content of the community interviews, VRJ made 14 recommendations about collecting and using patient socio-demographic information for purposes of stratifying quality data; raising awareness of social determinants of health,

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<sup>6</sup>Minnesota Rules, chapter 4654.

<sup>7</sup>Minnesota Laws 2014, chapter 312, article 23, section 10.

**structural racism**, and discrimination; and identifying and eliminating health disparities. One of VRJ’s recommendations was, “Make aggregate health equity data available to communities.” VRJ’s full recommendations, results of community interviews, and other information is included in the stratification report. MDH submitted this report to the Legislature in 2015.<sup>8</sup>

In 2015, the Minnesota Legislature directed MDH to stratify five quality measures by race, ethnicity, preferred language, and country of origin.<sup>9</sup> MDH will stratify the following clinic measures by these socio-demographic factors: Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control for adults and children, and Colorectal Cancer Screening. MDH also collects other socio-demographic information for these measures including age, gender, and health insurance type which is a proxy for income.<sup>10</sup>

MDH continued its collaboration with VRJ to act on VRJ’s recommendation to “make aggregate health equity data available to communities” and fulfill its legislative requirements to stratify quality measures using socio-demographic factors. Specifically, MDH asked VRJ to consult with communities impacted by health disparities to develop findings and recommendations to MDH for providing summary results from the Quality Reporting System to communities. MDH’s goal is to provide quality measure data and analyses that will be useful for communities that are impacted by health disparities.

## Project Objectives and Methodology

### Objectives

Voices for Racial Justice had four key objectives for community engagement with RESD community members and leaders to obtain the RESD members recommendations on how *MDH should provide summary results from the Quality Reporting System to communities*.

1. To probe communities’ expectations on how information or data collected by health care providers should be used and shared with communities;
2. To identify what kind of information and analyses would be more helpful for communities;
3. To identify options for how MDH could share data and analyses with communities; and
4. To identify ways for communities disproportionately experiencing inequities to be engaged in the process of analyzing information collected by MDH.

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<sup>8</sup>Stratifying Health Care Quality Measures Using Socio-demographic Factors: Report to the Minnesota Legislature 2015. Minnesota Department of Health.

<sup>9</sup>Minnesota Laws 2015, chapter 71, article 9, sections 4-7.

<sup>10</sup>Health insurance type (also called “primary payer type”) includes commercial, Medicare, Minnesota Health Care Programs, and self-pay and uninsured.

# Methodology

## Health Equity Champions and Community Engagement

**Using the principles for Authentic Community Engagement, VRJ recruited five leaders—called “Health Equity Champions”—**from communities disproportionately impacted by health inequities to conduct interviews with individuals working within community-based organizations, and convene conversations with members of their respective communities through a series of listening sessions (see Appendix A). These communities include: American Indian/Native American; Black-African American, African Immigrant, Asian and Pacific Islander, and Latino/ Hispanic.

Although interviewees were expressing their own opinions, the project was very intentional in recruiting individuals who were part of community based organizations addressing issues related to health equity. In addition Interviewees were sought who may find Quality Reporting System data useful to advancing their organization’s objectives. The assumption was that their work, experiences and expectations informed and enriched their opinions. Therefore interviewees included mental health professionals, researchers, funders and policy advocates among others.

The project team (i.e., Health Equity Champions and the project coordinator) met on a regular basis for 12 weeks to develop questions, create protocols, analyze and code interview data, and prepare for and facilitate listening sessions. The involvement of these Health Equity Champions throughout the entire process was critical to authentically put the voice of the communities at the center of the project while developing the recommendations for this report. Project team participants are listed in Appendix B.

## Interviews

**The project team conducted a total of 23 interviews** (see Appendices C and D). The project was very intentional in recruiting individuals who were part of community based organizations addressing issues related to health equity. Additionally, interviewees were sought who may find Quality Reporting System data useful to advancing their organization’s objectives. The assumption was that their work, experiences, and expectations informed and enriched their opinions. Therefore, interviewees included mental health professionals, researchers, funders and policy advocates among others. Interviewees expressed their own opinions during these interviews which do not necessarily reflect those of the organizations with which they are associated.

Interviewees self-identified demographic information, and their summary demographic information is displayed in Tables 1 and 2. Since the team conducted a limited number of interviews, the findings in this report are not for the purpose of making generalizations but rather to delve deeper into different experiences and issues connected to different backgrounds.

**Table 1: Community Interviewees by Race**

Community Groups	Number of interviewees
American Indian/Native American	5
Black- African American	5
White	2
Asian Pacific Islander	6
Other*	5
Total	23

- Twenty-three interviewees; three self-identified multi-racial.
- Other\* represents interviewees who choose Some Other Race / Choose not to disclose-decline and Unknown
- Following U.S. Census recommendations, interviewees were first asked whether they are of Hispanic, Latino or Spanish origin. Then they were asked to choose one or more options that make up five race categories. Six of the 23 interviewees identified as Latino.

**Table 2: Community Interviewee Demographics**

Demographics	Percent (%)
Gender	
Female	78%
Male	13%
Other	9%
Sexual orientation	
heterosexual	83%
other sexual orientation	17%
Income	

Demographics	Percent (%)
Above 400% federal poverty level (fpl)	25%
Below 400% fpl	75%
Education	
At least some college	96%
Geography	
Living inside the Twin Cities	87%
Living outside the Twin Cities	13%
Age	
18 to 35 years	65%
36 to 88 years	35%
Country of origin	
United States	65%
Other	35%

## Listening Sessions

**The project team convened a listening session and invited those who participated in the interviews as well as other community members interested in discussing ways to make health care data more available and meaningful.** This listening session was an opportunity for the project team to share themes emerging from the interviews conducted and gather input on priorities to inform the report's recommendations. Fifteen community members attended the session. All were members of communities of color, including African Americans, African immigrants, Asian Pacific Islanders and Latinos. The agenda included an overview of the project, and a presentation of the main themes, and preliminary findings and recommendations that emerged from the interviews. Then the group did a participatory analysis voting for recommendations and themes they felt were the most relevant and were asked for possible

missing pieces. Finally, the group discussed what it will take to put the recommendations into action.

Community participants reviewed the preliminary recommendations that the Health Equity Champions gathered during the interviews. The goals of the listening session were to consider which recommendations are the most important and relevant to the community and determine priorities amongst the themes and within each theme's sub-theme. Participants expressed that some recommendations were more pressing for them and their community, and a clear trend emerged from the listening session. At the end of the first listening session community participants brainstormed possible steps MDH could take to make data more accessible and how to implement the recommendations emerging from this community-based participatory research.

**The project team and MDH co-convoked a second listening session to present the project team's preliminary findings and recommendations, and solicit community input.** The second listening session provided an opportunity for community members and MDH representatives to discuss sharing health care data. Thirteen community members and seven MDH representatives attended the session.

## Project Challenges

- The main challenges and barriers throughout this process have been **issues of trust** between communities and the system due to historical barriers (**structural racism**) and trauma, especially with regard to data collection and use, and the health care system. While it is recognized that this is a long-term, intentional, relationship-building process, tensions do exist due to the historical context and must be recognized and addressed accordingly in order to impact lasting change.
- There exists a community expectation to focus on big-picture themes that are department-wide to address health disparities. The scope of the project instead was so concrete and specific to create recommendations about quality measures. These **different expectations** created tensions especially when creating the recommendations.
  - Community expectations are in connection with conversations surrounding the 2014 MDH Advancing Health Equity report and recommendation #7 regarding data collection and availability.
  - Community members have been investing time and efforts in this issue of having health care data to address health disparities since 2009. Through the broad process, this project has arisen very specific in scope and it has been difficult to negotiate and to navigate structural racism (barriers).
  - The specificity and technicalities of the quality measures data and the fact that those were already determined and very medically oriented add challenges for community to find clarity with Quality Reporting System data and needs.
  - The conversations between MDH staff and Health Equity Champions have been challenging at times given the complexities of the language, difference in expectations and the fact that issues of historical distrust are still present. All participants of the project in both sides have been intentional in creating a safe space, developing trust and

having a transformational experience that can allow all of us to co-create and become authentic partners but is still work in progress.

See Appendix E for the full range of challenges and limitations.

## Findings

Five themes emerged through our community interviews and listening sessions:

- Responsibility and ethics;
- Accessibility and relevance;
- Cultural competency;
- Community engagement methods; and
- Uses of data.

We must note that the responsibility and ethics, and the accessibility and relevance themes had strong crossover with the cultural competency theme. During our community listening sessions, community members expressed that relevance and accessibility was the main priority overall, and cultural competency was the lens that shaped all of the themes. See Appendices F and G for detailed information on interviewee responses to closed-ended questions, and interview and listening session themes and feedback.

In terms of **responsibility and ethics**, MDH must make progress on its goal of strengthening the collection, analysis, and use of data to advance health equity that it put forth in its 2014 Advancing Health Equity report, and it can make great strides through **meaningful community engagement**. MDH's **data collection, analysis, and dissemination** activities are largely lacking authentic community input. We are generally involved late in projects and asked to review finished projects.

With respect to **accessibility and relevance**, it is difficult for communities to systematically access and understand the various datasets MDH holds for a variety of reasons including: how MDH disseminates information (e.g., MDH communicates information exclusively in English, relies on listservs which people may not know about and its website which is difficult to navigate, etc.); how data access and use are governed in law and rule; and the lack of technical assistance to communities to make data and reports meaningful and understandable.

Additionally, there are **substantial structural barriers** to the community rising to become an equal partner in the effort to develop and use data to reduce health disparities. This includes the availability of resources to participate in discussions and gain technical experience, the fact that much of MDH's work is embedded in complex legal and administrative processes into which the community has little insight (e.g., rulemaking), and MDH's reporting style which is very technical and relies on the written word whereas the community benefits from storytelling and in-person discussions.

There is **significant community distrust of MDH** due to historical barriers and trauma. The absence of the community's voice and participation in MDH's data activities exacerbates distrust and missed opportunities to co-create strategies to advance health equity. Additionally,

distrust creates tension which MDH shies away from, and this avoidance compounds the community tension and distrust.

While our projects with MDH on the Quality Reporting System have been promising and a step in the right direction to advance health equity, MDH and its partners **fail to use authentic community engagement** in its evolution of the Quality Reporting System. MDH obtains data collection and analytics, provider education, and measure recommendation services, but does not obtain community engagement services. Additionally, the vendors that MDH works with are in the health care industry and do not represent communities that are impacted by health disparities. Moreover, the measures in the Quality Reporting System were developed largely by health care experts without the input of communities that experience health disparities.

## Final Recommendations

Based on the themes of our community discussions, we have developed a series of recommendations for MDH to authentically engage with the community to make meaningful and immediate advancements in health equity broadly, and to make specific improvements to the Quality Reporting System.

MDH has an obligation to take our recommendations into full consideration, to move towards implementation, and to involve community partners in current and future processes. MDH must reach out to community partners to determine what appropriate and thorough collaborations look like for each respective community. To fully implement our recommendations:

- MDH needs to have an intentional conversation to allocate money for people and organizations that are already doing the work of validating the local expertise in the community.
- Translators are not enough. We must move beyond simply having White translators present, or translators that are outsiders from the community impacted.
- Research must be rooted in equity practices—research should provide the community with opportunities in receiving relevant trainings in the usefulness and application of data, their stakes in research gathered about them, and the process of doing research should promote social mobility and build community capacity.
- MDH should support initiatives that fund community-defined prevention and problem-solving of health disparities that supports community liaisons and is accessible to the communities impacted. Future grants should have community review panels.

## Advancing Health Equity

To make progress on its goal of strengthening the collection, analysis, and use of data to advance health equity that it put forth in its 2014 Advancing Health Equity report, MDH should:



- Create a Community Data Sharing Advisory Committee comprised of representatives of communities impacted by health disparities.<sup>11</sup> This Committee will advise MDH on how to collect, analyze, and share health data and analyses with communities. The Committee will create a partnership between MDH and communities where communities are decision-makers, they are engaged throughout the entire process, trust is intentionally developed, and partnership strives to create solutions for the short- and long-term trajectory of data collection, analysis, and dissemination.
  - The Advisory Committee must be co-facilitated by a person from the communities of color impacted by health disparities and an MDH staff.
  - The Advisory Committee will intentionally include members of the different communities disproportionately impacted by health disparities.
  - The Advisory Committee will start by defining the process they will follow and the frequency with which they will meet.
  - This Advisory Committee will adhere to the Principles of Authentic Community Engagement.
- Create a Community-Based Participatory Research Center to implement Advisory Committee research recommendations.<sup>12</sup>
  - This Research Center will adhere to agreed-upon the principles of community-based participatory research.
  - The Advisory Committee will guide the work of the Research Center, providing advice on how to engage communities impacted by health disparities to be partners in setting priorities around data, as well as implementation of innovative practices. The ultimate goal of this coordination of efforts between the Advisory Committee and the Research center will be to have more meaningful data available with the intentional purpose of addressing health disparities and achieving health equity.
- Have ongoing, shared, high-level discussions with community leaders to work on legislative solutions that enable the agency to meet the expectation the community has with regard to technical support, process changes, and data access.

The Community Data Sharing Advisory Committee and Community-Based Participatory Research Center could be launched with a Quality Reporting System project as a proof of concept, and then the Committee and Center’s scope could be expanded to include other MDH programs and datasets.

## Quality Reporting System

With regard to the Quality Reporting System in particular, we recommend that:

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<sup>11</sup>A model of community engagement that should be considered when creating the Advisory Committee, <https://mn.gov/dhs/general-public/about-dhs/advisory-councils-task-forces/cultural-ethnic-communities-council.jsp>.

<sup>12</sup>Available models to consider are: SoLaHmo, <http://www.healthdisparities.umn.edu/about/resources-community-based-research>; AHRQ, <http://archive.ahrq.gov/research/cbprrole.htm>; and CDC, [https://www.cdc.gov/pcd/issues/2007/jul/06\\_0182.htm](https://www.cdc.gov/pcd/issues/2007/jul/06_0182.htm).

- MDH include authentic community engagement in its structuring of the Quality Reporting System.
- When MDH develops new quality measures, it authentically include the community.
- MDH provide data to the community by ensuring raw data and companion materials are accessible through the MDH website and mobile site, and making reports and visuals available at events hosted by communities with staff on-hand who can explain the data using culturally competent methods.

# Appendix A. Principles of Authentic Community Engagement

Voices for Racial Justice: Advances racial, cultural, social, and economic equity

(Organizing, Advocacy and Policy) [voicesforracialjustice.org](http://voicesforracialjustice.org)

## Voices for Racial Justice Authentic Community Engagement: A Key to Racial Equity

### What is racial equity?

Racial equity exists when all people have access to the opportunities available and outcomes are not predictable by race.

### What is authentic community engagement?

Authentic community engagement is the intentional process of co-creating solutions to inequities in partnership with people who know through their own experiences and the barriers to opportunity best. Authentic community engagement is grounded in building relationships based on mutual respect and that acknowledge each person's added value to the developing solutions.

The Centers for Disease Control and Prevention (CDC) defines community engagement as “the process of working **collaboratively** with groups of people who are affiliated by geographic proximity, special interests or similar situations with respect to **issues affecting their well-being.**”

### Why community engagement?

“Relationships we develop with our coalition partners must be transformative, not transactional.” -- Reverend Dr. William Barber

Racial disparities are prevalent across multiple opportunity areas, from education to employment to health. These inequities hurt all of us – by weakening our economic, social, and cultural web of connection. Strengthening that web and building sustainable and transformative change requires deep partnership with communities for achieving racial, cultural, social and economic equity. This partnership is the backbone of community engagement. Rather than informing, educating, consulting, or merely having a dialogue with the community, true community engagement relies on partnerships and co-creation.

## Principles of Authentic Community Engagement

### A. Intention leads to better process and outcomes.

1. *Address racism.* Authentic community engagement intentionally addresses issues of race, institutional and structural racism, discrimination and exclusion, and embodies “cultural humility.”
2. *Agree on the process.* The expectations, values, purpose, and role of both the institutions/systems and the stakeholder communities should be discussed and negotiated at the very beginning of any engagement process.
3. *Balance power.* Stakeholders should be aware of any working assumptions, and of power dynamics and how they impact the development, sustainability, and success of partnerships. They should be intentional in addressing power imbalances especially those affecting the ability of the community to act as an equal partner.
4. *Self-determination is a right.* “Remember and accept that collective self-determination is the responsibility and right of all people in a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.” -- CDC *Principles of Authentic Community Engagement*
5. *Recognize different kinds of groups.* Groups often self-organize. For instance, communities organically organize beyond community-based organizations (e.g. Soccer Leagues, Churches, Barber Shops, and Coffee Shops).
6. *Notice assets.* Sustain efforts and support community ownership by using an asset approach, where community strengths are at the base of the work and the tool to develop capacity within communities and within your organization
7. *See different experiences.* Recognize, respect and appreciate the diversity/differences within and across communities. Awareness of the factors impacting communities’ ability to exercise their power (like historical trauma, oppression, disenfranchisement, etc.) must be intentionally addressed while co-creating, planning, designing, and implementing approaches to engage a community.
8. *Commit to communities.* Ensure that engagement efforts leave the community better.
9. *Stay in it for the long term.* Community collaboration requires long-term commitment by organizations involved and their partners.

### B. Grounded in respect and appreciation.

1. *Work with communities.* The goal of authentic community engagement is to work WITH communities NOT FOR, on behalf of, or to do things TO communities.
2. *Seek authentic representation.* Make sure that representative members of the communities are authentically representing their community. They should be well-respected and have honest and genuine relationships with other members of their community.
3. *Understand the historical context* in which previous attempts of engagement have been occurring. What are the stories of success, lessons learned, barriers, and tensions?
4. *Immerse yourself in the community,* “establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders” to co-create (create together) solutions. -- CDC *Principles of Authentic Community Engagement*

5. *Recognize the contributions* of the community.
6. *Allocate resources* for community members to be active participants, so that community engagement is valued for its contribution to the process (e.g. offer stipends, child care, food, interpreters).

**C. Tension and partnership work together.**

1. *Address challenges.* Develop a plan to address conflict, being intentional and strategic to transform challenges into opportunities.
2. *Share power.* Be ready to share power (release control of actions and/or interventions) with communities, and be flexible and creative to meet its changing challenges
3. *Expect tension.* Authentic engagement is not necessarily easy or peaceful. Partnership in a change process will sometimes result in tension. Partners will challenge and hold each other accountable for staying true to principles for engagement and to goals for racial equity.

**Appendix B. Project Team (Health Equity Champions)**

Name	Affiliation
Arianna Nason	Voices for Racial Justice
Emilia Gonzalez Avalos	Navigate MN
Fayise Abraham	Youthprise
Melissa Kwon	National Asian Pacific American Women’s Forum (NAPAWF)
Monica Hurtado	Voices for Racial Justice
Sarah Dar	American Muslim Health Professionals

## Appendix C. Introductory Script for Interviewer

**Script for interviewer to start the interview:** Hello (name of interviewee) \_\_\_\_\_, first of all let me thank you for taking the time to talk with me today. As I said when I contacted you before, my name is \_\_\_\_\_. I will read an introduction to our conversation, to make sure I do not forget to mention important information about this project.

### Background on the Project

First I want you to know the reason why we are doing this project. I am part of a group of 5 leaders, who are members of communities experiencing health disparities. We all are having conversations with members of our respective communities **to understand perspectives and explore recommendations on how Minnesota Department of Health (MDH) should share information with our communities. This is about information or data collected by clinics and hospitals about provider quality measure results in the context of health disparities.** MDH anticipates sharing *Quality Measure* results with the community beginning July 1, 2016.

For the purpose of this conversation, when we talk about **data** we are referring to the **Statewide Quality Reporting and Measurement System** (aka SQRMS or *Quality Measures* or Quality Reporting System). However **we hope that** this project will also inform efforts around other sources of information, not only within the health care system but other systems as well.

To provide some context, the Quality Measure system was created in 2009 by the Minnesota Commissioner of Health. The goal in creating this system was to establish a standardized set of Quality Measures for ALL health care providers in Minnesota. An example of this is to measure the quality of care a patient with diabetes has received. This specific measure includes the following five treatment goals: making sure the patient has blood sugar and blood pressure under control, lower bad cholesterol, does not smoke and takes aspirin as recommended. Other quality measures include ways to understand the quality of care provided to patients with asthma, depression, and vascular disease, knee and spinal surgeries, caesarian section surgeries, screening for colorectal cancer, and the patient experience of care.

Voices for Racial Justice and other community partners have been involved in efforts to ensure that data about patients that is collected by clinics and hospitals includes information about race, ethnicity, preferred language, country of origin, gender, residential zip code and health insurance type. Our main goal has been to improve data collection to better understand health disparities to make informed decisions about priorities and allocation of resources to achieve health equity in Minnesota. Furthermore, our interest in achieving health equity is the main reason why we agreed to be part of this project with MDH.

On a personal level I am part of this project because... (You could say things like *“as member of our community, I see great value in making sure our voice is at the center of the efforts to collect information about us. I think that data collected and shared in appropriate and meaningful ways, has the potential to make sure that our strengths and challenges become more visible, and will facilitate setting priorities and allocating resources for a healthier community”*).

## Appendix D. Questionnaire for Interviewees

### Questionnaire

1. What is your expectation of **how information or data collected by health care providers should be used and shared with your community?**

Please indicate the level of agreement with the following options on how data should be used and shared: Strongly agree; Agree; Neutral; Disagree; or Strongly disagree.

- a) This kind of data should be used **for research around health equity**
- b) This kind of data should be used to define actions to ensure that ALL members of the community have equal access to opportunities to be healthy
- c) This kind of data can be used to follow patient outcomes and improve health care system processes and services
- d) This kind of data should be used **for Community Organizing**
- e) This kind of data could be used **to apply for grants**
- f) This kind of data should be used **to set priorities for organizations and communities**
- g) This kind of data should be used **for work with policymakers (e.g. lobbying, talking to elected officials)**
- h) This kind of data should be used **for education of communities about key issues**

**2. What kind of information** (summaries, regional data, clinic data, some charts, reports, raw data), **and analyses would be helpful for you?**

Among the following options what are the most important kinds of data and analyses for you, and why?

- a) Raw data at the zip code level, county level, or clinic level (e.g., make data, or “public use files” available for download) (*Raw data is defined as Information that has been collected but not changed or analyzed. Raw data often is collected in a database where it can be analyzed and made useful*)
- b) Quantitative data analysis (for example: the total number of Latino patients with diabetes under control vs the total number of people with diabetes under control in other communities, prepared charts and maps)
- c) Qualitative data analysis (for example: understanding patients’ decisions about whether or not to take the aspirin recommended by provider, or data about patient’s experience, written policy briefs, written issue briefs)

d) Story telling

e) A combination of data, quantitative analysis, qualitative data analysis, and storytelling?

f) Other? Please explain

**3. The examples** in handout “DataReportSamplesxSQRMS” illustrate how health care quality measure information can be organized and presented Looking at the samples below which are showing how information is organized and presented by MDH

a) How likely is it that **you** would find it **useful** to have data presented in this way per example (1-7): Very useful; Somewhat useful; Neutral; Not very useful; or Not useful at all?

Why?

If useful, how?

If not useful, -what will make this data useful for you and your organization?

b) Using the same samples from above, how likely is it that **different members of your community** would find it useful to have data presented in this way (1-7): Very useful; Somewhat useful; Neutral; Not very useful; or Not useful at all?

Why?

If useful how?

If not what will make this data useful for you and your organization?

**4. What communication methods about the availability of this information to your community would be effective?**

-Looking at the following options please rate how effective do you think it would be for MDH to notify your organization or community about the availability of health care quality measure data and analyses: Very effective; Somewhat effective; Neutral; Not very effective; or Not effective at all?

a) Written reports

b) MDH Website

c) Community forums

d) Social media

e) Tv

f) Radio

g) Newspapers

h) Formal presentation with slides



i) Artistic ways (e.g. photography, spoken word, song, drama/theater)

Other: please explain

**5. How important is it for you that people in your community are engaged in the process to analyze information collected by MDH:** Very important; Somewhat important; Neutral; Not very important; or Not important at all?

\* analysis of data is defined as researching, organizing and changing data in order to bring out useful information

If somewhat important or very important, how should this engagement occur?

**6. What questions do you have about MDH's Quality Reporting System?**

a) What do you think is the purpose of MDH's collection of health care quality measure data? What, if any, questions do you have for MDH about the purpose of the Quality Reporting System?

b) What do you think are the roles and responsibilities of MDH in collecting and reporting health care quality measure data? What, if any, questions do you have for MDH about Quality Reporting System data collection and reporting?

c) Do you know how **confidentiality** is guaranteed while information flows from the patient to various organizations and then back to the community? In other words, do you know how information collected about patients is **protected**?

d) What other questions do you have about MDH's Quality Reporting System that you would like us to share with MDH?

**7. What else** would you like to share with us related to this conversation that we didn't already ask?

Comments/reactions from interviewee\_\_\_\_\_

**8. On a scale** of 1-5 (1 = not important, 5 = very important), please let me know how important this conversation is to you?

## Appendix E. Challenges and Limitations

### Broad Challenges

- Main challenges/barriers throughout this process have been issues of trust between communities and the system due to historical barriers and trauma, especially with regard to data collection and use, and the health care system. While it is recognized that this is a long-term, intentional, relationship-building process, tensions do exist due to the historical context and must be recognized and addressed accordingly in order to impact lasting change.
- There exists a community expectation to focus on big-picture themes that are department-wide to address health disparities. The scope of the project instead was so concrete and specific to create recommendations about quality measures. These different expectations created tensions especially when creating the recommendations.
- Community expectations are in connection with conversations surrounding the MDH Advancing Health Equity report (2014) and recommendation #7 regarding data collection and availability.
- Community members have been investing time and efforts in this issue of having health care data to address health disparities since 2009. Through the broad process, this project has arisen very specific in scope and it has been difficult to negotiate and to navigate structural barriers.
- The specificity and technicalities of the quality measures data and the fact that those were already determined and very medically oriented add challenges for community to find clarity with Statewide Quality Reporting and Measurement System (SQRMS) data and needs.
- The conversations between MDH staff and health equity champions have been challenging at times given the complexities of the language, difference in expectations and the fact that issues of historical distrust are still present. All participants of the project in both sides have been intentional in creating a safe space, developing trust and having a transformational experience that can allow all of us to co-create and become authentic partners, but it is still work in progress.

### SQRMS-Specific Challenges

The following are more specific **structural barriers** around SQRMS which make challenging to address health disparities, and to perform authentic community engagement.

- SQRMS was designed to assess providers performance which often have expressed the collection of data is burdensome and inconsistent. However, despite the fact that a lot of data is collected this process has been established by ‘experts’ in the health care system who are very medically oriented, and not considering the impact of social determinants of health in the creation of health. Furthermore, the process has been lacking the consideration of communities’ wisdom and expertise to define the collection, analysis and use of quality measures.
- The function of MN Community Measurement (MNCM) as an intermediary between MDH and providers is another structural barrier. Communities experiencing disparities in the

quality of care continued being marginalized and absent of the tables where decisions around SQRMS are being made.

- The set of quality measures that are used in the state have been pre-established by experts and very medical oriented.
- Another barrier is the fact that MDH administers SQRMS in partnership (and through a contract) with MNMCM, Stratis Health, and the Minnesota Hospital Association but not in partnership with communities disproportionately impacted by the quality of care and by health and racial disparities.
- The fact that MNMCM calculates the measure, performs a quality check and sends the data to MDH makes the whole process a “mystery” for the community. MNMCM is a mainstream organization and despite their good intentions, their decisions are informed by their privilege. Therefore, their decisions are not authentically considering the impact that unequal access to opportunities to be healthy are causing in communities of color and natives.
- MDH’s process for public to provide input when updating the SQRMS is another **structural barrier**. The technicalities and lingo of the SQRMS, in addition that most of these discussions happen through the website, and then public is invited to a forums full of “experts” in the lingo makes the process very unfriendly and intimidating for members of communities interested in having an impact on SQRMS and making it useful to address health disparities.
- The lack of a more diverse staff within SQRMS is another barrier to create an ongoing and healthy process where communities experiencing disparities can work in partnership to improve the SQRMS process.

## Appendix F. Interviewee Responses to Questionnaire

### “What is your expectation of how information or data collected by health care providers should be used and shared with your community?”

- All interviewees agree or strongly agree that data should be used for research around health equity and to define actions for equal access to opportunities to be healthy.
- Almost all of interviewees agree or strongly agree that data should be used to set priorities for organizations and communities.
- The vast majority of interviewees agree or strongly agree that data should be used for community organizing.
- Most interviewees agree or strongly agree that data should be used to apply for grants and for education of communities.
- Most interviewees agree or strongly agree that data should be used to follow patient outcomes and improve health care system processes and services.
- Most interviewees agree or strongly agree that data should be use for work with policymakers (e.g. lobbying, talking to elected officials).

### “What kind of information (Summaries, regional data, clinic data, some charts, reports, raw data), and analyses would be helpful for you?”

- All interviewees agreed that a combination of raw, quantitative, qualitative and storytelling will be the most helpful.

### “What Would be Helpful?” [i.e., Presentation of Data]

- Interviewees were shown samples of how health care quality measure information could be organized and presented by MDH. Many interviewees expressed that maps, and bar charts ranged from very useful to somewhat useful. On the other hand, many of them also expressed that examples were not as useful for members of their respective communities. It is challenging to conclude how useful and or effective these samples are because interviewees expressed concerns about technicalities, jargon, and the lack of context or background in how the information was organized in the samples. More conversations need to happen around this issue.

### “Looking at the following options please rate how effective do you think it would be for MDH to notify your organization or community about the availability of health care quality measure data and analyses”

- The vast majority of interviewees said community forums, and social media are very or somewhat effective.
- Most of interviewees said artistic ways are very or somewhat effective.
- The majority of interviewees said formal presentations are very or somewhat effective.
- The majority of interviewees said TV is very or somewhat effective.
- About half of interviewees said radio or newspapers are very or somewhat effective.

- About half of interviewees said written reports are very or somewhat effective.
- About half of interviewees said MDH website is very or somewhat effective.

### **“How important is it for you that people in your community are engaged in the process to analyze information collected by MDH?”**

- The vast majority said it is very important and some were neutral.
- In response to, “On a scale of 1-5 (1 = not important, 5 = very important), please let me know how important this conversation is to you”.
- Most said very important (5) while some said somewhat important and only a few were neutral.

## **Appendix G. Interview and Listening Session Themes and Feedback**

The following is a compilation of our analysis of the written evaluations and reports from the verbal interviews. It has been broken down into corresponding themes, which are responsibility and ethics; accessibility and relevance; cultural competency; community engagement methods; and uses of data. Within those themes are relevant sub-themes where community expressed interest in determining the necessary next steps for the Minnesota Department of Health (MDH). They are listed in rank order from highest to lowest priority based on the number of occurrences of the topic. Additionally, the sub-themes within each main theme are listed in rank order based on community members’ priorities obtained through the community listening session.

To provide additional clarity, we must note that the responsibility and ethics as well as the accessibility and relevance themes had strong crossover with the cultural competency theme. During our community listening session, community members expressed that relevance and accessibility was the main priority overall, but cultural competency was the baseline analysis lens for all other sections.

## **Themes and Feedback**

### **Responsibility and Ethics**

- For the purpose of sharing data, MDH needs to publicly commit to endorse and abide by the values and priorities of equity, access, reciprocity and transparency, as defined in this report.
- To create an advisory committee with the goal of accountability comprised of community based organizations with clear background and experience in racial equity analysis. These organizations should comprise of those who are most affected by these inequities, and the committee will oversee policies, processes and practices MDH will use to share data with communities.

## Accessibility and Relevance

- Make data accessible and available very publicly through community events, ideally ones that are already hosted by different ethnic communities.
- Ensure raw data is accessible through website and mobile site and that community knows that it is there.
- Clearly define terminology and measures.
- Provide visuals that are ethnic specific and accessible to lay people.
- Engage those most affected in conversation.
- Provide resources in language for community members.
- Have someone explain what data means so it is easier to understand.
- Communicate information in culturally competent and relevant ways.
- Include stories of experiences.

## Cultural Competency

- MDH needs to create a fully accessible community engagement when presenting data, focusing on community based participatory research practices when analyzing and sharing data.
- MDH will work with communities to identify and recruit cultural liaisons who can analyze and co-present the data.
- When collecting data, MDH will incorporate practices that give recognition of the patient as a whole. Questions that give room for context will be added into data collection. Those who are collecting the data will be trained in both appropriate motivational interviewing methods and trauma-informed care practices so that they may be more sensitive to the individual while more in-depth answers are gathered.
- When sharing data, use a variety of methods to give context. These methods can and should include raw data, quantitative and qualitative data, and versions of storytelling through narrative. With storytelling, MDH will use the designated cultural liaisons to assist in the dialogue so that it will be culturally relevant.

## Community Engagement Methods

- Narratives about Quality of Care and Health Equity need to be created in a partnership between MDH and communities disproportionately impacted by health disparities where:
  - Community needs to be engaged throughout the entire process;
  - Trust need to be intentionally developed; and
  - Partnership will answer questions like if data collected is the right one, if more data needs to be collected, what questions data will answer and how information will be analyzed and used.
- Information needs to be presented based on the audience and meeting community where they are at.
- Information needs to be accessible at any time/ publicly available without any additional process.
- Community's capacity needs to be developed in order to create authentic partnerships around data.

## Uses of Data

- Community should help decide how data is used, e.g.:
  - What questions are important to ask and what data should be collected in the first place; and
  - Once data is collected and analyzed, what implications the findings have and what the response should be.
- Data can be useful to see issues affecting specific groups which we would not otherwise see if those groups were not in their own separate category, e.g. Korean adoptees.
  - An example of a way communities could use the data is to illuminate the connection between health and food options.
- Communities can use data in their decision making about solutions to health inequities.
- Different communities can use data to make connections between their experiences.

Note: Limitations of traditional research and analysis do not offer a deeper understanding of certain issues or historic traumas affecting the community that can only be understood through engagement with the community.

## More Detailed Recommendation on Implementation Process

A Community Data Sharing Advisory Committee must be created to support the implementation of recommendations listed in this report. Below is an outline for the creation of this group.

- MDH needs to allocate resources to create an Advisory Committee that will assess data available as of now, its relevance, possible uses, and possible manners in which this data can be shared with communities on ongoing basis.
- This Advisory Committee must be co-facilitated by a person from the communities of color impacted by health disparities and an MDH staff.
- This Advisory Committee will follow principles of authentic community engagement (see Appendix A) and principles of community based participatory research (e.g., Youthprise Principles of Youth Participatory Action Research<sup>13</sup>).
- The Advisory Committee will intentionally include members of the different communities disproportionately impacted by health disparities.
- The Advisory Committee will start by defining the process they will follow but at the very least should include a discussion of the principles mentioned in recommendation #2, and a training on what MDH data is available, how it is analyzed, organized and publicly shared.
- While the advisory group is formed, the public will have direct access to MDH data with no need of special requests or procedure. For this purpose, all data will be made publicly available in the website (including raw data).
- The advisory group will move to explore and guide what are another effective ways to share MDH data available with communities, prioritizing its accessibility and relevance.

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<sup>13</sup> <https://youthprise.org/wp-content/uploads/2015/10/YRD-onepager-v1.3.pdf>

- The work of this Advisory Committee could be launched with a SQRMS project as a proof of concept, and then the group's scope should be expanded to include other MDH programs and datasets. Discussions should focus on possible processes and practices that can be adopted by MDH to inform the whole department in using data to advance health equity in the state.
  - The Advisory Committee will then explore best practices and innovations related to health care quality data collected by the health care system, and how that can be used to address health disparities. This conversation should explore how the health care quality measures, which now include race, ethnicity, language and country of origin, may include other socio-demographics in a way that data becomes more relevant for the communities.
  - The Advisory Committee will support MDH staff in defining other venues to share the SQRMS data with communities, like community forums and social media.
  - The advisory group will also explore and guide the process in which community members can be part of the analysis of the SQRMS data, and how data can be organized in a more culturally appropriate manners.



## Appendix H. Glossary of Terms

**Race** is a social concept used to categorize humans into large and distinct populations or groups based on factors like: color of skin, culture, ethnicity, geography, history, language, or social affiliation. Currently, the OMB requires five minimum categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander.

**Ethnicity:** The fact or state of belonging to a social group that has a common national or cultural tradition.

**Socio-demographics** are factors related to a group of individuals in our human society who share common characteristics such as age, race, ethnicity, socioeconomic status, urban/rural, gender, etc.

**Federal Poverty Guidelines:** The minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size.

**Structural racism** in the U.S. is the normalization and legitimization of dynamics—historical, cultural, institutional and interpersonal—that routinely advantage whites while producing cumulative and chronic adverse outcomes for American Indians and people of color.

**Health** is a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity. Health is created in the community through social, economic and environmental factors as well as individual behaviors and biology. When groups face serious social, economic and environmental disadvantages, such as structural racism and a widespread lack of economic and educational opportunities, health inequities are the result. Health is not only the result of making good choices (e.g. eating well, exercising, and not smoking). Health also includes good health care, and access to social and economic opportunities. In fact, those social and economic opportunities (community support, quality of schooling, neighborhoods, and cleanliness of water, healthful food, clean air, and so on) have a powerful impact on the range of choices people in Minnesota have.

**Social Determinants of Health (SDOH):** According to the World Health Organization (WHO) these are “the conditions in which people live and die are ... [which are] shaped by political, social and economic forces. Social and economic policies have a determining impact on whether a child can grow and develop to his/her full potential and live a flourishing life, or whether his/her life will be blighted [destroyed].” Social determinants of health include living and working conditions that influence individual and population health, e.g., place of residence, occupation, religion, education, income and health insurance status.

**Health Equity** is a state where all persons, regardless of race, income, creed, sexual orientation, gender identification, age or gender have the opportunity to be as healthy as they can — to reach their full “health potential.”