



Community Collaborative Approach to Health Equity

A Community Health Needs & Assets Assessment

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8/22/2019

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CHAPTER 1: BACKGROUND

Minnesota Community Care is a federally qualified health center (FQHC) as funded by the Bureau of Primary Health Care (BPHC), Health Services and Resources Administration (HRSA). As a Health Center Program award recipient, Minnesota Community Care is obligated to assess the unmet needs for health services in its service area at least once every three years.¹ Historically, Minnesota Community Care satisfied this regulatory requirement through a desktop assessment of existing quantitative data; our most recent assessment was released in 2016. In this iteration, we committed to more deeply understanding the communities we serve; to do this, we invested in a participatory process that centers and amplifies the community's voice.

Our History

Since 1969, Minnesota Community Care has been a safety-net health care provider for historically marginalized and underserved communities. Our mission “to strengthen the well-being of our community through health care for all” is inspired by a living history rooted in the push for health equity and the fight for the fundamental human right of access to health care for all. To impact health disparities, we focus on the incredibly complex and substantial barriers our communities face to leading health lives; we serve people throughout their lives and across generations; and we make our communities stronger in the process.

Minnesota Community Care first incorporated in 1972 as West Side Health Center. Co-located within Neighborhood House, we served 1,900 patients that year. Today, we are the largest federally qualified health center (FQHC) in Minnesota. With an annual operating budget of \$30+ million, 400 employees, and over 100,000 square feet of service delivery space, we provide primary, specialty, behavioral/mental health, and oral health care, and enabling/supportive services to over 37,000 unduplicated individuals through 140,000 patient encounters annually in our service area (UDS, 2018). Our patients predominantly identify as people of color (87%), low-wealth (65% patients \leq 100% FPL), and un/under-insured (39% patients uninsured, 48% patients publicly insured) (UDS, 2018). As a community health center, our service delivery sites are located within the communities we serve: in addition to two ambulatory care clinics (La Clinica, East Side Clinic) and a freestanding dental clinic (West Side Dental), we operate 10 school-based clinics, 3 co-located Health Care for the Homeless sites, and a co-located Public Housing Primary Care clinic (McDonough Homes Clinic).

Over our 50-year history, we have adapted and expanded our programs and services in response to the community's need for accessible and affordable health care: we initiated our Health Care for the Homeless program in 1987, launched our HouseCalls homeless prevention program in partnership with Ramsey County in 1992, opened a Public Housing Primary Care clinic in partnership with the St. Paul Public Housing Agency in 1993, started delivering Ryan White-funded HIV primary care services in

¹ HRSA, BPHC, Health Center Program Compliance Manual, Chapter 3: Needs Assessment; accessed August 18, 2019 at <https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-3.html>

2000, opened onsite 340B pharmacies in 2002 (La Clinica) and 2008 (East Side Clinic), and acquired Health Start school-based clinics in 2003. Notably, Minnesota Community Care's network of 10 school-based clinics operating in 2019 grew out of the singular Maternal and Infant Care Clinic co-located in St. Paul Mechanic Arts High School; opened by Ramsey Hospital in 1972, this clinic was the genesis of school-based health in Minnesota. Over the years, our response to community need has also included establishing dental services (1978), opening an expanded dental clinic (West Side Dental Clinic, 2001), and extending dental services to the East Side neighborhood in St. Paul (2013).

Our historical reputation is as a fighter for the health of those less fortunate; building on this legacy we are proactively transitioning into a catalyst for "health for all" across Minnesota.

Scope of Project

Minnesota Community Care is one of three community health centers operating on the east side of the Mississippi River in the Twin Cities seven-county metropolitan area. Of the three, Minnesota Community Care has the broadest geographical reach (see Map B) and serves the highest number of unduplicated patients.

Minnesota Community Care's service area has a population of 473,512 as measured in 2017; 10.0% of people living in our service area receive care at community health centers, including at Minnesota Community Care.² Refer to Map A for a map of Minnesota Community Care's service area, and Map B for the dominant health center by zip code. Table A provides the neighborhood names used throughout this report for zip codes in our service area.

Service Area Demographics

Income

Within our service area (see Map A), 35.7% of the population is low-income, meaning that they make less than 200% of the Federal Poverty Level (FPL), and over 16% are in poverty, i.e. making less than 100% FPL.³ Of the low-income population, 28.3% are seen at community health centers (CHCs) with over 57% of the uninsured population being seen at CHCs.⁴ It is notable that Ramsey County has the lowest household income in the seven-county metropolitan area, with a growing disparity between low- and high-income residents.⁵

² UDS Mapper 2013-2017

³ UDS Mapper, 2017.

⁴ UDS Mapper, 2017.

⁵ 2018 Ramsey County Community Health Assessment. Saint Paul-Ramsey County Public Health (May 2019). Accessed online August 8, 2019 at https://www.ramseycounty.us/sites/default/files/Departments/Public%20Health/CHA/Poverty%20-%20All%20Ages_final.pdf

People of color have a lower median household income than white residents in Ramsey County (see Figure A), a larger disparity than the U.S. average. Ramsey County women's income is about \$9,500 less than men each year.⁶ Nearly one-fourth (24%) of children under age 18 are in poverty in Ramsey County, and 20% of those ages 18-35 years. Only 11% of adults ages 35-64 years and 8% of adults over 65 live in poverty.⁷

Race

Minnesota Community Care's service area is predominantly White, but has larger populations of Black/African American/African, Hispanic/Latino/a/x, and Asian/Asian Americans than are otherwise reflected in the state.⁸ (See Figure B, Table B, and Maps C, D, E, and F).

Age

Nearly 63% of people in our service area are adults ages 18- 65 years; one-fourth (24.5%) are children less than 18 years; over 12% are over age 65. These populations vary across zip code as seen in Maps G and H.

Household composition in St. Paul (2017) reflects this age distribution: 55% of households are families; 31% of households have children; 34.7% of households have only 1 person; and 29% of elders living with children are the primary caregivers.⁹

Languages

In Ramsey County, there are over 100 languages spoken; most commonly spoken languages are English, Spanish, Hmong, and Cushite (which includes Somali and Oromo).

Within our service area, 6% of households have limited English proficiency. This varies widely geographically, however: zip codes such as Payne-Phalen (55130) have over 20% limited English proficiency, Capitol Hill (55103) 14.6%, and East Side St. Paul (55106) 12.2%. This is lowest in the West Seventh neighborhood (55102) where only 1.8% of households have limited English proficiency (see Map I).¹⁰

Within the City of St. Paul, 70.8% of the population spoke only English at home (2017). Seven percent (7%) spoke Spanish, 15.2% spoke Asian and Pacific Islander languages. Of foreign-born residents in St. Paul, 54.9% are from Asia, 21.6% are from Africa, 18.2% are from Latin America, and 4.1% are from Europe. Almost 50% of those not born in the US are citizens.¹¹

⁶ 2018 Ramsey County Community Health Assessment

⁷ 2018 Ramsey County Community Health Assessment

⁸ UDS Mapper, 2017.

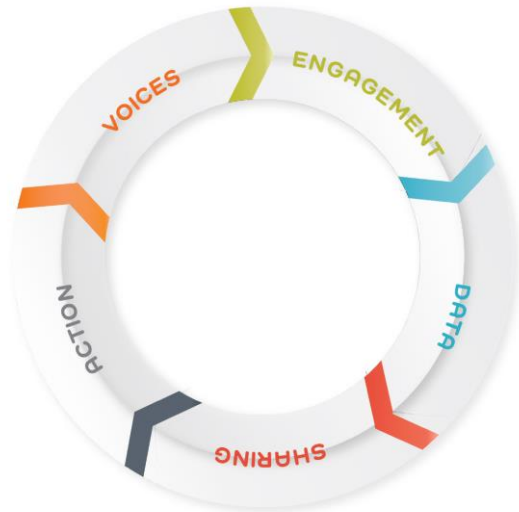
⁹ American Community Survey. "Social Characteristics - St. Paul city, MN" 2017. Accessed on August 6, 2019 at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

¹⁰ UDS Mapper, 2017.

¹¹ American Community Survey. "Social Characteristics - St. Paul city, MN" 2017. Accessed on August 6, 2019 at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

CHAPTER 2: METHODS

To understand more fully the assets and needs of our service area, Minnesota Community Care used a mixed methods approach, compiling data from qualitative and quantitative sources. The process was created by best practices and evidence-informed research. An intersectional framework was applied that aims to advance health equity and elevate the strengths of our community. An interdisciplinary and community representative Steering Committee was established to oversee, implement, and report on the Community Health Needs & Assets Assessment (CHNAA).



Voices from the Community

The SoLaHmo Partnership for Health and Wellness, the community-engaged research program of Minnesota Community Care, is rooted in an asset-oriented, Community Based Participatory Action Research (CBPAR) approach through which the voices and expertise of communities are given primacy alongside those of providers and academic researchers through egalitarian research partnerships. In 2017 and 2018, SoLaHmo worked with the Minnesota Safety Net Coalition on the Quality Measurement Enhancement Project (QMEP) to identify community members' and healthcare providers' perceptions of quality primary care. Community leaders from seven diverse urban communities identified five major characteristics of ideal primary care clinics.¹² Minnesota Community Care used these community-identified quality components as an overarching framework to explore, organize, and develop this Community Health Needs and Assets Assessment.

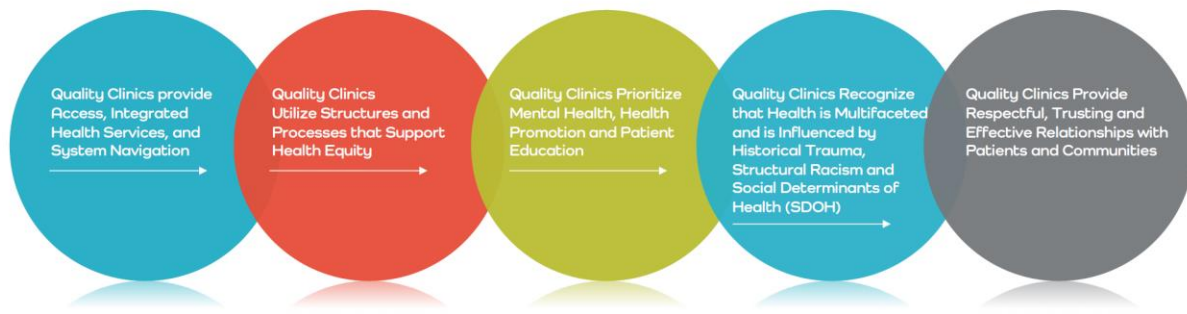
Direct quotations from QMEP participants are included throughout this document in italics. Quotes are attributed based on the speaker's chosen racial, ethnic, sexual, and/or gender identity. We recognize that identity is multifaceted and intersectional; in sharing quotes from our community members, however, we identify the speaker by a singular identity.

Community Listening Session

We invited community members familiar with the QMEP recommendations to participate in a Community Listening Session to think collaboratively about how Minnesota Community Care can apply these quality recommendations to our work.

¹² Quality Measurement Enhancement Project, MN Health Care Safety Net Coalition and SoLaHmo Partnership for Health and Wellness. *Community Leaders' Perspectives of Health, Quality, Primary Health Care, and Payment Based on Quality Measures*. Report to Minnesota Department of Health, February 9, 2018.

The Key Community Priorities for quality primary care clinics, in order of priority, are:



Nineteen (19) individuals representing 6 different communities of identity gathered on May 19, 2019 for a 2.5 hour session to discuss, prioritize, and apply the QMEP recommendations to the work of Minnesota Community Care. These six identity groups were asked individually and collectively to give recommendations and share insights about the needs and assets of their respective communities.

The CHNAA Steering Committee reviewed the results, expanded the original results with these new insights and ideas, applied the prioritization to the list, and then organized the recommendations for Minnesota Community Care to include in the CHNAA.

Existing Quantitative Data

The Steering Committee sought existing quantitative community data to expand each of these main ideas, using resources such as the recent Ramsey County Health Assessment (2018), Minnesota Title V Maternal and Child Health Needs Assessment (2018), 500 Cities, UDS Mapper, and Metro SHAPE study to contextualize the recommendations. Because community members are often inundated with questions about needs, we utilized this existing data and chose to refrain from additional needs-related questions. Quantitative data were iteratively reviewed and evaluated for relevance by our Steering Committee.

Recommendations

Pulling together the 5 key community priorities from our Community Listening Session and existing community data indicators, our Steering Committee organized the recommendations into specific goals and strategies. In alignment with the original QMEP process and our internal Quality Committee's organizational structure, the Steering Committee used the National Quality Forum's Domains of Health Equity Measurement to organize the recommendations into actionable goals. See Chapter 9 for Key Community Recommendations, as organized by NQF domain.

The National Quality Forum (NQF) framework has five guiding domains (as shown in Figure C) to achieve health equity in healthcare and in healthcare quality measurement.

Limitations

It is not in the scope of this assessment to perform primary data collection from our larger community. The Steering Committee decided to utilize current work of our internal community-driven research program to further contextualize the needs and strengths identified in our Community Listening Session. Further, this assessment does not seek to evaluate Minnesota Community Care's programs or the conditions of our existing and current patients. The scope of this project is to evaluate the needs of our larger service area. While the Steering Committee aimed to center community voice and community involvement in all steps of the assessment, we acknowledge there is more work to do in comprehensively incorporating our communities' voices and priorities into our organization's planning, implementation, and evaluation.

CHAPTER 3: PRIORITY 1 – ACCESS

The first priority of our community is:

Quality health centers provide access, integrated health services, and system navigation.

This means that Minnesota Community Care must understand and support access to care and the costs of care. Our health center must understand the impact of integrated health care services; an integrated system being one in which people can access support for multiple concerns in one place. We must understand the impact of transparent clinic processes and effective communication with all patients.

In action, health centers achieving this priority:

- Support access to care
- Support solutions to high cost of care
- Provide integrated health care services
- Provide transparent clinic processes
- Communicate effectively with all patients

Access to Care

Access to health and health care is complex and multifactorial. Improving our communities' access to care includes aspects outside of the clinic (e.g. insurance, transportation, location) and inside the clinic (e.g. hours, appointments, interpreters). Cost of care frequently influences access and is discussed separately in the next section.

Insurance status influences where and how frequently individuals receive care. As a federally qualified health center, Minnesota Community Care proudly serves all patients regardless of insurance. Understanding our community's access to insurance influences how we can expand and grow. When a population does not have access to primary care, the emergency department is often the only option for care and may reveal how we can better support patients.

Lack of Insurance

In our service area, 5.5% of the total population is uninsured (2017).¹³ This group includes both those who do not qualify for health insurance, as well as those who cannot afford or choose not to obtain health insurance. This may also include those who are eligible for health insurance, but have lapsed in coverage due to employment change or re-application status. (See Chapter 6 for additional discussion of employment status). Uninsured rates are highest in the East Side (55106, 7.6%), Payne-Phalen (55130, 7.4%), and West Side (55107, 7.1%) neighborhoods of Saint Paul. The

¹³ UDS Mapper, 2017.

proportion of uninsured patients is lowest in Oakdale (55128, 2.8%) and Inver Grove Heights (55076, 3.6%).¹⁴

The proportion of uninsured in our service area has changed since our last Community Health Needs Assessment in 2016. Between 2015 and 2017, our service area had a decrease of 7.7% in the proportion of uninsured population. In this same time period, however, there was an 11% increase of uninsured patients among community health centers. This implies that although un-insurance rates are decreasing among the population as a whole, this decrease is not mirrored among the populations accessing care at community health centers. As shown in Map J, among patients seen at health centers, the zip codes with largest growth of uninsured patients in the past two years are 55104 (40.3%), 55103 (23.6%), and 55337 (20.6%). Similarly, as shown in Figure D, growth in the un-insured in Ramsey County from 2015 to 2017 was predominantly shouldered by Black, not Hispanic people.¹⁵

Medicaid

Medical Assistance (MA) is Minnesota's Medicaid program; administered by the Minnesota Department of Human Services, MA provides health care coverage to over 1.1 million low income Minnesotans.¹⁶ In 2017, 26.7% of the total population in our service area was insured by Medical Assistance (see Map K). MA insurance rates were highest in Payne-Phalen (55130, 48%), Capitol Hill (55103, 43%), East Side (55106, 42%) and West Side (55107, 37.7%). Only 17.4% of those with MA in our service area receive care at community health centers.

From 2015 to 2017, there was a 7.7% increase in individuals in our service area covered by Medical Assistance. This growth was largest in Maplewood (55119, 24.8%), Payne-Phalen (55130, 19.9%), and Oakdale (55128, 15.4%). This increase in MA coverage was not reflected among patients who access care at a CHC: within the same time period (2015-2017), there was a 3.24% decrease in MA patients at CHCs. This means that while our service area has seen a growth in patients covered by MA, those patients are accessing care at organizations other than CHCs (see Map L).

Medicare/Private Insurance

Those with Medicare or private insurance make up a smaller proportion of the patients served at Minnesota Community Care. Nonetheless, in our service area population, most individuals are covered by either Medicare or private/employment-based insurance. In our service area in 2017, 67.9% of individuals had coverage through Medicare or private insurance (see Map M). This was lowest in Payne-Phalen (55130, 44.4%) and East Side (55106, 50.3%) and highest in Oakdale (55128, 81.8%) and Inver Grove Heights (55076, 81.2%).

Emergency Department Utilization

¹⁴ UDS Mapper, 2017.

¹⁵ 2018 Ramsey County Community Health Assessment

¹⁶ Minnesota Medicaid. www.benefits.gov. Accessed July 2019.

Without access to health insurance, many seek care at an emergency department where by law they cannot be turned away due to insurance status or inability to pay. In Ramsey County, potentially preventable emergency department (ED) visits went up from 2010 to 2014, with unnecessary visits rising most significantly (40% increase) among those with public insurance.¹⁷ (See Figures E and F, and Map N). Interestingly, the most common preventable visits adjusted for population size were in children under age 5.

Solutions to High Cost of Care

Cost of care, cost of medications, and cost of transportation are substantial barriers to access. Health centers, like Minnesota Community Care, are well-positioned to support short- and long-term solutions to reducing the financial burden of care for patients and the healthcare system.

Cost of Care

The financial burden of the cost of medical care deeply impacts access, affecting when and where our community members seek care. This is further complicated by the secrecy of medical billing: patients are routinely unclear which interventions will be most costly. Within our service area, 10.9% of adults have delayed or not sought care due to cost.¹⁸ This is highest in Rondo/North End/Frogtown (55103, 16.7%), West Side (55107, 15.7%) and Payne-Phalen (55130, 14.75%).¹⁹

In Ramsey County, 54.4% of individuals who desired mental health support had to delay care. Nearly 40% of those who delayed mental health care said it was due to cost or lack of insurance.²⁰ Those who lived in the suburban parts of Ramsey, Dakota, or Washington counties reported more concerns about cost and lack of insurance in regards to mental health (54.8%, 55.7%, and 57.8%, respectively).

Cost of Medications

The financial burden of care is also reflected in the cost of medications, and how patients attempt to control for that cost. In our service area, almost one-quarter (23.8%) of low-income individuals (<200% FPL) skipped doses of prescribed medications, reduced dosage size, and/or did not re-fill prescriptions in the past 12 months.²¹

Cost of Transportation

Over 6% of Ramsey County residents use public transportation, above the Healthy People 2020 target (5.5%). Yet, there are low-income neighborhoods in the county with persistently poor access (see Map P).²²

¹⁷ 2018 Ramsey County Community Health Assessment

¹⁸ UDS Mapper, 2017.

¹⁹ UDS Mapper, 2017.

²⁰ Metro Public Health Analyst Network. Metro SHAPE Six County Data Book. 2014. page 36

²¹ Metro SHAPE Six County Data Book, p. 40

²² 2018 Ramsey County Community Health Assessment

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

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

“(At some clinics) I don’t think they really explain what’s going on, I mean, when you’re at the community clinic...they don’t explain anything. They just move you through, and after sitting (there for) 2-3 hours, you just want to leave... and after spending the money for the bus to get there (in time for) your appointment, and you are going to try to get back (on time), but they sit you there for 2 hours. They’ll get you checked in, but you’re sitting there for 2 hours. Now my bus pass is (expired) and I’m going to have to walk home.” (LGBTQ2S)

Integrated Health Care Services

Research shows that a “one-stop shop” care environment that integrates physical, mental, oral, social, and spiritual health care positively influences long-term patient and community health outcomes. For example, cross-training in mental health and primary care reduces time, cost, and inefficiencies. External, community partnerships are critical to the success of health care integration, as is reimbursement for integrated services.

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

“The health system should not place so much emphasis on Western medicine... Rather, it would be better to have a new health system with traditional healers, and pay our community healers. Change the system and make it so that they can be able to bill.” (LGBTQ2S)

“For me it starts with continuum of care...(which) has two parts to it – in the clinic and out of the clinic. For example, in clinic let’s say you’re dealing with an addiction that

has also caused you to have mental health issues, and your addiction has also caused you to have some dental needs, so let's take care of those. Whereas now I'm in the clinic and I have some medication to deal with (the health issues resulting from the addiction), but I need some support when leave these four walls and I need some help making sure that access to those community resources are available...and (the clinic) makes the initial contact and referrals for you.... It could be both referrals to other health care services, or it could be to other types of services....When I didn't have a physical address, and I had to call just to get my basic antidepressants filled, it was a nightmare, it was so challenging.” (White)

Transparent Clinic Processes

Transparency in clinical processes and health literacy are interconnected. As defined by health.gov, health literacy is “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Individual health literacy cannot be achieved without clinics partnering with patients to help them understand how the clinic functions, how to access care, and how to get their health needs met.

“Transparency is a huge thing and maybe an outline of what this person is supposed to do...(Clinics should) not leave it to the individual directly and (they should be) more involved than just say ‘This is what you have and I expect you to manage it’....(Clinics should) have a guideline or help....to train someone on how to manage (their) care, or train family members to help them manage their care....don't expect them to figure out how to manage their own care when it's complicated enough that someone who is born in the state can't even manage it....” (Somali)

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

Communicate Effectively with All Patients

Effective communication considers a patient's preferred language, cultural norms, health literacy, numeracy fluency, and technology skills.

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

“Clinics should be able to assess and provide the appropriate care. For example, a client who has cancelled 15 appointments, needs to be looked up to understand the reason--it could be transportation (problem), so how can we help the patient?” (Black/African American)

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

Languages

As was reviewed in Chapter 1, there are over 100 languages spoken in Minnesota other than English. Language competency does not alone allow clear communication with others; however, providing care in a patient’s preferred language is essential to access. High-quality language services include using trained medical interpreters, and cross-training patient-serving staff in effective service delivery across languages.

“If there are trained Hmong professionals who understand the Hmong people, it is necessary that you speak Hmong that we understand. Young Hmong people can speak Hmong, they may know Hmong but not know how to communicate with the Hmong elders so that elders will understand.” (Hmong)

Education

In our service area, 12.0% of the population has less than high school education. This is lowest in Burnsville (55337, 6.4%) and Roseville (55113 6.5%), and highest in East Side (55106, 24.3%), Rondo/North End/Frogtown (55103, 24.6%), and Payne-Phalen (55130, 32.5%).²³ At 90%, the percentage of adults over age 25 with an education beyond a high school in Ramsey County is the lowest percent of any county in the Twin Cities seven-county metropolitan area.²⁴

Technology

In the city of St. Paul in 2017, 89.2% of households had access to a computer and 80.7% had broadband internet subscription. This is slightly lower than all of Ramsey County, (89.6% and 82.1% respectively), both of which are lower than Hennepin County (91.5% and 83.6% respectively).²⁵

²³ UDS Mapper, 2017.

²⁴ 2018 Ramsey County Community Health Assessment

²⁵ US Census Bureau, 2013-2017 American Community Survey. “Social Characteristics - Ramsey, Hennepin and St. Paul city.” 2017. Accessed on August 6, 2019 at factfinder.census.gov

CHAPTER 4: PRIORITY 2 – HEALTH EQUITY

The second priority of our community is:

Quality health centers utilize structures and processes that support health equity.

Minnesota Community Care should be representative of the community we serve and make sure community members have influence and power in health center processes and decision making. Part of achieving health equity is understanding where there are disparities in health. Hence, Minnesota Community Care should report and respond to health disparities in our area. Our health center should provide services that are relevant and important to our patients, particularly those people with a high burden of social determinants of health.

In action, health centers achieving this priority:

- Are representative of their patient populations
- Report on health disparities and equity data, goals, and efforts
- Provide services that are important to patients, particularly those with high burdens of SDOH

And:

- Community members have real representation, with influence and power

Representative of Patient Populations

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

“Clinic leadership should hire people who are Somali. For example, if the clinic is in neighborhood where Somalis live, they should hire interpreters from the community, but how much better (it would be) if they hired people from the community to provide services and to lead the clinic.” (Somali)

“In order to build trust, patients need (to) receive treatment from personnel who represent their own groups or from someone who is culturally competent in their language and culture. I heard a patient who was struggling with economic issues say, ‘The doctor is telling me I have to eat a healthy, balanced meal, with fruits and vegetables. How am I going to tell my wife that, since we hardly have enough money to get some food?’ When I asked the patient why he didn’t tell the doctor the truth, he explained that it was embarrassing enough to have to tell the non-Latino doctor, but that the Spanish interpreter also would hear it.” (Latino/a/x)

Nationally, research shows that when health center staff, clinicians, and leaders reflect the communities they serve, health care disparities are reduced and patients do better.²⁶ This is a central tenet of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities.

Report on Health Disparities and Equity Data, Goals, and Efforts

Health centers should report on their health disparities and equity efforts by creating an Equity Dashboard that highlights their existing health disparities and illustrates their directions for progress and improvement towards equity. Collecting and representing data can lead to improved understanding of current practices, improved goal setting to redress imbalances, and improved accountability. An Equity Dashboard should collect and display data (e.g. diseases, health care services, and patient experiences) by important equity factors, such as race, ethnicity, social status, insurance status, to illustrate how social and structural determinants of health affect families and communities, how structural racism impacts community health, how race and ethnicities are collected and reported, and how institutions respond to complaints of inequities and discrimination from indigenous people and people of color.

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

Health Disparities in Minnesota

As a whole, Minnesota has some of the best health outcomes in the nation; however, when outcome data is disaggregated by income and race/ethnicity, some of the country’s worst disparities are uncovered. Low-income populations and populations of color in Minnesota have heavier burdens of disease and worse outcomes.

One study from the Robert Wood Johnson Foundation looked at life expectancy along the Interstate 94 corridor and found that within 3 miles, there was up to a 13 year difference in life expectancy (see Figure G).²⁷ Of course, these differences are multifaceted and reflect differences in socio-economic status, race, physical

²⁶ Jackson CS, Gracia JN. Addressing health and health-care disparities: the role of a diverse workforce and the social determinants of health. *Public Health Rep.* 2014;129 Suppl 2(Suppl 2):57–61. doi:10.1177/00333549141291S211

²⁷ Robert Wood Johnson Commission to Build a Healthier America. Virginia Commonwealth University Center on Society and Health. Metro Map: Minneapolis and St. Paul, MN, 2014.

environment, education access, among many others factors, each of which should be further examined, understood, and redressed.

Health Disparities in Service Area

Within our service area, several key disparities deserve further examination.

Age-Adjusted Mortality and Overall Health Ratings

Within our service area, the age-adjusted mortality rate is 604 per 100,000 individuals, remarkably lower than the state rate of 648.1 per 100,000 individuals.²⁸ Looking geographically, however, there are 7 zip codes in our service area that are higher than the state average, the highest being 55103 and 55104 with a rate of 670/100,000 (see Map O).

Income level influences physical health. In the Twin Cities metro area, when asked how many days in a month individuals would rate their physical health as “not good,” 16.7% of those at less than 200% FPL said greater than 14 days, compared to only 4.7% of those at greater than 200% FPL.²⁹

Race influences adjusted death rates. Black/African Americans in Ramsey County have higher rates of death from cancer, heart disease, and unintentional injury in comparison to White populations (see Figure).³⁰

Prenatal Care Access

Establishing prenatal care within the first three months of pregnancy is important. Within the metro area, only Ramsey County is not meeting Healthy People 2020 guidelines (see Figure I).³¹

Low Birth Weight

Low birth weight (LBW) is a measure that reflects both pregnancy and neonatal well-being. Infants are born at low birth weight (less than 5.5 lbs or 2500 grams) due to complications of pregnancy, preterm birth, or fetal growth restriction. Low birth weight can also be a predictor for health complications in later life, including diabetes, obesity, and high blood pressure. In our service area, there is a low birth weight rate of 6.66 per 100 live births, just slightly higher than the state average of 6.6. This is markedly higher in zip codes 55103 (7.73%), 55130 (7.38%), 55104 (7.21%), and 55107 (7.19%).³²

In 2014-2016, LBW rates remained under the Healthy People 2020 goal (7.8%) for White, American Indian, Asian, and Latino/a/x populations in Ramsey County. It is notable, however, that rates did increase for both White (6.1% to 6.4%) and Latino/a/x (6.4% to 7.2%) populations from 2011-2013 to 2014-2016.³³ Although LBW rates decreased for African Americans in Ramsey County from 2011-2013 (10.8%) to 2014-

²⁸ UDS Mapper, 2013-2016.

²⁹ Metro SHAPE Six County Data Book

³⁰ 2018 Ramsey County Community Health Assessment

³¹ 2018 Ramsey County Community Health Assessment

³² UDS Mapper, Low Birth Weight Rate, 2012-2014.

³³ 2018 Ramsey County Community Health Assessment

2016 (9.3%), LBW rates among this population continue to be both well above the HP2020 goal and the highest in the county. (See Figure J).

Infant Mortality

While Minnesota's overall infant mortality rate scores are better than the national average (5.0 versus 5.9 deaths per 1000 live births), Ramsey County has among the highest infant mortality rates in the state at 6.3 deaths per 1000 live births (see Map Q).³⁴

When disaggregating by race, African American infants die at almost 3 times the rate and Asian American infants at twice the rate of White and Latino/a/x populations (see Figure K).³⁵ Notably, between 2010 and 2014, the infant mortality rate of Asian Americans was less than the White population; in the period 2014-2018, however, this trend reversed.

Drug Overdose

Nationally, in the past decade, there has been an increase in drug overdoses in general and a marked increase in opioid overdoses. This national trend is reflected in Ramsey County, which has experienced a steady increase in drug overdose deaths from 14 in 2000 to 89 in 2016.³⁶ In Minnesota in 2017, Native American/American Indians were 6 times more likely to die of drug use than non-Hispanic Whites (see Figure L).³⁷

Elevated Blood Pressure and Hypertension

In our service area, 19.2% of people have been told that they have high blood pressure, remarkably lower than the state average of 26.3%.³⁸ However, this rate varies by neighborhood in our service area, as shown in Map R.³⁹

Within the Twin Cities seven-county metropolitan area in 2014, those with lower education had higher rates of elevated blood pressure (44.5%) than those with a bachelor's degree or higher (15.6%).⁴⁰ There was nearly a 15-point percentage difference between those of lower income (<200% FPL, 34.4%) and those of higher income (≥200% FPL, 19.8%).

There are further disparities among those who have high blood pressure or hypertension. As this is a treatable condition, those who take needed medication can be protected from some of the long-term cardiovascular risks; medication adherence also varies by geographic location (see Map S).⁴¹

³⁴ Minnesota Public Health Data Access Portal, Minnesota Department of Health, 2016

³⁵ 2018 Ramsey County Community Health Assessment

³⁶ 2018 Ramsey County Community Health Assessment

³⁷ Minnesota Death Certificates, Injury and Violence Prevention Section, Minnesota Department of Health, 2017.

³⁸ UDS Mapper, 2016.

³⁹ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. 500 Cities Project Data [online]. 2016 [accessed Aug 18, 2019]. URL: <https://www.cdc.gov/500cities>.

⁴⁰ Metro SHAPE Six County Data Book

⁴¹ 500 Cities Project, CDC

Diabetes

In our service area, 5.8% of people have been told that they have diabetes, with the highest rates being in the West Side neighborhood (55107, 6.41%) and Roseville (55113, 6.41%), but all lower than the Minnesota state average of 8.4%.⁴² Similar to the prior measures, this is higher in some of the areas that we serve than others (see Map T).⁴³

In the Twin Cities seven-county metropolitan area, people with lower incomes have more than double the prevalence of diabetes than those with higher incomes (13.9% versus 5.4%). This disparity is larger yet between those with less education than those with more education (15.8% versus 4.3%).⁴⁴

Arthritis

Arthritis is a condition that frequently causes disability in elders. Its prevalence increases with age, but its disease burden is greatest on people with lower income and lower education, regardless of age (see Figure M).⁴⁵

Geographic disparities in arthritis disease burden are also present as shown in Map U.

Oral Health

In our service area, over 25% of adults had no dental visit in the past year. This was highest in some zip codes (55103, 55130, 55107, 55117, 55106), where the rate was above 30% in each.⁴⁶ There are areas of St. Paul where over 30% of adults ages 65 and older have no teeth, whereas rates in other neighborhoods are in the single digits (see Map V).⁴⁷ Those with less income and less education are far less likely to visit a dentist (see Figure N).⁴⁸

Sexually Transmitted Infections

Most HIV diagnoses in Minnesota occur in the metro (see Figure O); of those occurring in the metro, a small proportion is in Ramsey County (16.6% in 2016).⁴⁹ Notably, there was a spike in HIV diagnoses in Ramsey County in 2014: 39 diagnoses compared to 29 in 2013 (a 34% increase); however, by 2016, the number of diagnoses had dropped to 32.

Rates of other sexually transmitted infections, namely gonorrhea and chlamydia, are heightened among Black Non-Hispanic populations in Minnesota (see Figure P).⁵⁰ In 2017, among Black Non-Hispanics the gonorrhea rate was 875 per 100,000 and the chlamydia rate was 2020 per 100,000 (compared to 40 and 209 per 100,000, respectively, among Whites).

⁴² UDS Mapper, 2016

⁴³ 500 Cities Project, CDC

⁴⁴ Metro SHAPE Six County Data Book

⁴⁵ Metro SHAPE Six County Data Book

⁴⁶ UDS Mapper, 2016

⁴⁷ 500 Cities Project, CDC

⁴⁸ Metro SHAPE Six County Data Book

⁴⁹ 2018 Ramsey County Community Health Assessment

⁵⁰ 2018 Ramsey County Community Health Assessment

Cancer

Cancer rates in St. Paul range from 2.8%-7.3% of the general population with increased prevalence in different neighborhoods (see Map W).⁵¹ The most common cancer in Ramsey County is breast, followed by lung and colon (see Figure Q). While overall cancer mortality has been decreasing in Ramsey County, it is notable that rates are lowest among Asian/Pacific Islander and Latino/a/x populations, higher among white and African American populations, and highest among American Indian/Alaskan Native populations.⁵²

For breast, colorectal, lung, and cervical cancer, age-appropriate screening can help identify cancer early and improve survival. Across the City of St. Paul, the neighborhoods predominantly served by Minnesota Community Care are less likely to receive breast, colorectal, or cervical cancer screening (see Maps X, Y, and Z).⁵³

Provide Services Important to Patients, Particularly those with High Burdens of SDOH

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

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

Community Members have Real Representation, with Influence and Power

Beyond “mere” representation, “real” or “genuine” representation means that the community members play active full roles, participate in decisions, and can influence decisions. This authentic representation is counter to “token” representation without real power. The contemporary power structure in health care systems tells communities “you should be this.” Instead, communities should define health and health care, should be listened to, should be heard, and should be active shapers of and influencers within the organizational structure. Organizations need to be accountable to make positive changes.

⁵¹ 500 Cities Project, CDC

⁵² 2018 Ramsey County Community Health Assessment

⁵³ 500 Cities Project, CDC

“For me here in Minnesota, I mean, we have our (sexual health) programs, they’re mostly run by White women from suburbia, and we’re talking about sexual, minority health, and these are middle class White women who have no idea and take this framework that sex should be monogamous for a lifetime, and yet we don’t live in that world.... And then, when people from our communities are working in those clinics, they are just there, they do not have real power. We do not have real representation. What we need is real representation.” (LGBTQ2S)

CHAPTER 5: PRIORITY 3 – MENTAL HEALTH, HEALTH PROMOTION, AND PATIENT EDUCATION

The third priority of our community is:

Quality health centers prioritize mental health, health promotion, and patient education.

Health centers need to have expanded mental health services available for varying needs and at variable touch points. Moreover, clinics need to integrate family-based strategies for health promotion and provide culturally relevant education in order to improve people's health, not just treat disease.

In action, health centers achieving this priority:

- Expand mental health service across all areas of health care
- Integrate family-based strategies for health promotion
- Provide culturally relevant education

Mental Health Service Expansion

Traditionally, health care clinics focus on physical health and relegate mental health to special mental health services. Patients, families, and communities benefit from the expansion of mental health services that are integrated with primary care.

“Spiritual health, it’s not just physical but spiritual-emotional health. Western medicine just picks us apart and only deals with the physical self.” (LGBTQ2S)

Prevalence and Disparities of Adult Mental Health Concerns

In our service area, mental health concerns for adults and children are prevalent and concerning for the community. In Ramsey County, depression and anxiety are common. In a 2014 study of the metro area, urban Ramsey County had the highest prevalence of depression at over 33% (see Figure R).⁵⁴ The prevalence of adult mental health concerns in Ramsey County is greatest among low-income (i.e. less than 200% FPL) households: the rates of adult depression (32.3%), anxiety (30.7%), and psychological distress (10.4%) are heightened, as compared to households with income greater than 200% FPL (see Figure S).⁵⁵

Geographic disparities in mental health are also present. Within Ramsey County, 6.3% of St. Paul residents and 2.0% of suburban communities reported significant psychological distress, higher than any other county in the metropolitan area. In the City of St. Paul, different neighborhoods have different burdens of mental health. In the census tracts served by Minnesota Community Care, there is a higher burden of poor mental health than other areas (see Map AA).⁵⁶ In Dakota County, its most recent community health assessment reported suicide as a leading cause of death; suicide

⁵⁴ Metro SHAPE Six County Data Book, p 86

⁵⁵ Metro SHAPE Six County Data Book, pp. 86-88, 96

⁵⁶ 500 Cities Project, CDC

rates increased in Dakota County by 40% from 2004 to 2015, a faster increase than the Minnesota state average.⁵⁷

Prevalence and Disparities of Mental Health in Children and Adolescents

Adverse Childhood Experiences

Experiences and relationships during infancy and childhood deeply impact the developing brain and increase the likelihood of developing mental health concerns, and other chronic diseases, as an adult.⁵⁸ Adverse Childhood Experiences (ACEs), such as poverty, violence, witnessed violence, divorce, parental mental illness, parental alcohol or drug use, and experiencing racism, are common in early life. At 38.1%, Minnesota has the lowest prevalence in the country of children ages 0-17 years with one or more ACEs, a rate that is statistically lower than the national average (46.3%). Likewise, Minnesota has significantly lower rates of 2 or more ACEs in children ages 0-17 years (16.8% versus 21.7% nationally). Minnesota's rate for children birth to 5 with one or more ACEs (26.2%) is also lower than the national average (35%), but this rate (greater than 1 in 4 children birth to 5 with one or more ACEs) is striking nonetheless.⁵⁹ See Table D for ACEs rates disaggregated by race and income.

Among Ramsey County students in grades 8, 9 and 11, 24.7% report one or more ACEs. Similar to national data, this is higher in students of color (25% versus 21% of White students).⁶⁰ See Figure T for most common ACEs reported in Ramsey County among students in grades 8-11 (2016).

Suicide

In 2016, Ramsey County had the highest rate of suicide among 9th graders in the Metro. In Dakota County, adolescent mental health and suicide was highlighted as a critical concern in its most recent Community Health Needs Assessment.

The Minnesota School Survey found that 9th grade students who identified as gender non-binary, transgender, or LGBTQ2S were more likely to engage in self injurious behaviors and were more likely to contemplate or commit suicide across all counties served by Minnesota Community Care (see Figure U).⁶¹

Ramsey County had higher rates of suicide contemplation among Black, Latino/a/x, and Native American/American Indian peoples than amongst White or Asian populations (see Figure V).⁶²

⁵⁷ Dakota County Health Assessment, 2019

⁵⁸ Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med* 1998;14:245-58.

⁵⁹ Bethell, CD, Davis, MB, Gombojav, N, Stumbo, S, Powers, K. Issue Brief: A national and across state profile on adverse childhood experiences among children and possibilities to heal and thrive. Johns Hopkins Bloomberg School of Public Health, October 2017. <http://www.cahmi.org/projects/adverse-childhood-experiences-aces/>

⁶⁰ 2018 Ramsey County Community Health Assessment

⁶¹ Minnesota Student Survey 2016

⁶² 2018 Ramsey County Community Health Assessment

“As a mental health professional, I think it is very important that primary health care and mental health work together to minimize some of the issues that are overlooked at the first point of contact. Having people in primary health care that are cross-trained is a way to detect issues and follow up ... with families in need of mental health services. This is a way to keep families from falling out of the system.” (Black/African American)

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

“Mental health care is health care. Instead of separating different parts of our lives, we need to be seen as whole people, which includes our mental health state. Clinics should work towards removing the stigma attached to mental health and mental health checkups. The whole context of people’s lives, from housing to employment to transportation, affects people’s mental health and their physical health.” (White)

Integrate Family-Based Strategies for Health Promotion

Individually-focused care can fracture the family and community, and can isolate individuals from their support network. In contrast, because people’s support systems can empower them to improve their health, health education about healthy lifestyles that is family-focused can support family-based healthy lifestyles, and thus contribute to the individual’s health. Culturally sensitive healthcare for communities that value a collaborative rather than an individualistic view of health may mean including family and friends during patient visits, when patients want them there. People’s health depends greatly on how strong and involved their support group is.

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

“Family members could provide important information about the patient. Latino patients are used to going to their doctor’s appointment with their spouse, children, in-laws, godmother. Often times, these family members could provide information that is useful for the provider, to give better service to the patient.” (Latino/a/x)

Provide Culturally Relevant Education

Traditionally, clinics have focused on doctor-dominated disease diagnosis and treatment; in the patient-provider dichotomy, patients are dependent on the clinician. Recently, primary care has begun a shift towards focusing on prevention, health promotion, and patient empowerment for healthy goals and autonomy for chronic disease-self-management; this shift needs to continue. Effective patient education is

tailored to individuals in the context of their family, community, and culture; is consistent with their preferred language, literacy, and learning styles; considers people's cultural values of health and healing; is holistic; and recognizes and respects patient's intersectional identities.

“Clinics should use every possible opportunity to promote health. While patients sit in a clinic waiting room, trained personnel should provide education about health promotion, including healthy lifestyles, diabetes prevention, vaccinations and cancer screening.” (Latino/a/x)

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

“Sexual health is to be able to talk. Preparation protects you. Programs run by White middle-class women from suburbia do not address the needs of every community.” (LGBTQ2S)

“In terms of education, if your results aren't severe, they won't call you because they're busy, but they should at least partner with an agency to educate you about the disease. These agencies can do workshops about disease so have Hmong presenter if you don't understand, we can help you understand as an alternative to the education.” (Hmong)

If we constantly think about the notion of who's healthy and who's not, then our concept of ourselves is distorted. We have to decolonize everything. We have to get native people to a lake to walk around it. To some of our people, that is a white thing to do and we have to remind them that this has been our land. We've always roamed it, we've always foraged, and we've always hunted. (Native American)

CHAPTER 6: PRIORITY 4 – HISTORICAL TRAUMA, STRUCTURAL RACISM, AND SDOH

The fourth priority of our community is:

Quality health centers recognize that health is multifaceted and is influenced by historical trauma, structural racism and social determinants of health (SDOH).

This means that clinics and clinicians both recognize and address historical trauma and structural racism. Health centers should create clinic systems that are responsive to people’s unique needs and SDOH. Health centers should emphasize clinic-community collaborations and partnerships that address SDOH. Health systems and clinicians must recognize and prevent medical traumas, understanding how our existing structures may be promoting further inequity and disparities.

In action, health centers achieving this priority:

- Recognize and address historical trauma and structural racism
- Identify SDOH and create clinic systems responsive to people’s needs
- Create clinic-community collaborations to address SDOH

And, health center clinicians:

- Recognize and address historical trauma and SDOH
- Recognize, address, and prevent “medical traumas”

Recognize and Address Historical Trauma and Structural Racism

Recognizing and addressing historical trauma is relevant to specific health conditions that patients have, as well as important contributors to healing when the connections between trauma and poor health are acknowledged. Because of the violent history against members of these communities (e.g. history of slavery and police brutality of Black/African Americans, attacks on LGBTQ2S people, war time violence in their home countries for Hmong and Somalis, unfair deportation of Latino/a/x citizens, and genocide against Native Americans), and current discriminatory societal practices, these communities have higher rates of disease than the majority community. The mechanisms are complex and interconnected, but one is clear: the stress from daily racism increases cortisol production which contributes to chronic diseases such as hypertension, diabetes, heart disease, strokes, depression, and preterm birth rates.⁶³

Ramsey, Dakota, and Washington counties all have better racial integration than the state average, yet the segregation index indicates that there remains more segregation of Black/African American communities than other communities of color.^{64 65 66 67 68 69}

⁶³ David, RJ, and Collins, JW. Differing Birth Weight among Infants of U.S.-Born Blacks, African-Born Blacks, and U.S.-Born Whites. *N Engl J Med* 1997; 337:1209-1214

⁶⁴ County Health Ranking and Roadmaps. 2019. Minnesota - Residential Segregation. Accessed July 24, 2019 at <https://www.countyhealthrankings.org/app/minnesota/2019/measure/factors/142/data?sort=sc-2>.

“Disease is occurring, from historical traumas and daily traumas. In Native communities, we see how trauma impacts our health. ... Diabetes is about colonization. For example, when we were forced onto reservations and we weren’t able to gather and hunt, then the food rations were dropped off. In the 1800’s, it was a strategic way for the U.S. government to annihilate our people. When the food arrived, it was rotten and it was things we didn’t know how to cook, like carbohydrates and processed food. Starvation was a way that the government tried to kill us. Now, we are completely removed from our original ways of hunting, gathering and knowing traditional health practices. On reservations now, they are building diabetes clinics just as quick as they’re building jails, just as quick as they’re building opioid/methadone clinics because that’s what’s being reimbursed, that’s what’s being funded. There’s no funding for decolonization. You have community members who are trying to do this, but we’re putting band-aids on gunshot wounds. It’s like we’re on a ship and it’s sinking. Everybody has hands on deck, individually trying to pour out the water...dealing with the crisis. But we need someone on the ship who is designing and building a new ship.” (Native American)

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

“No assumptions about anything – gender, identity, pronouns, nothing. Just because I look female, doesn’t mean I identify as female.” (LGBTQ2S)

Identify SDOH and Create Responsive Clinic Systems

⁶⁵ Lu MC, Kotelchuck M, Hogan V, Jones L, Wright K, Halfon N. Closing the Black-White gap in birth outcomes: a life-course approach. *Ethnicity & Disease*. Vol 20, Winter 2010. S2 62-76.

⁶⁶ Trent M, Danielle G. Dooley DG, Dougé J. The Impact of Racism on Child and Adolescent Health. Section on Adolescent Health, Council on Community Pediatrics, Committee on Adolescence. *PEDIATRICS* Volume 144, number 2, August 2019: e20191765

⁶⁷ Cuffee YL, Hargraves JL, Rosal, M, Briesacher BA, Schoenthaler A, Person S, et al. Reported racial discrimination, trust in physicians, and medication adherence among inner-city African Americans with hypertension. *Am J Public Health*. 2013;103(11):e55–e62.

⁶⁸ Shavers VL, Fagan P, Jones D, Klein WM, Boyington J, Moten C, et al. The state of research on racial/ethnic discrimination in the receipt of health care. *Am J of Public Health*. 2012;102(5):953–66.

⁶⁹ Mustillo S, Krieger N, Gunderson EP, Sidney S, McCreath H, Kiefe CI. Self-reported experiences of racial discrimination and Black-White differences in preterm and low-birthweight deliveries: the CARDIA Study. *Am J Public Health*. 2004;94(12):2125–31.

Given that social determinants of health (SDOH) influence health and health disparities, health centers need to identify, understand, and address the context of people’s lives that influence health.

Across the country, health centers and healthcare systems are increasingly recognizing the impacts of SDOH and screening for them.^{70, 71} Responding to the identified needs of patients, however, is complicated and fundamentally different than traditional clinical care, requiring that organizations further adapt to understand the needs of their unique communities.⁷²

As part of the Title V Maternal Child Health Discovery Survey, the Minnesota Department of Health received survey responses from 322 people living in Ramsey County about their unmet needs. The most commonly reported unmet needs were:



In our Community Listening Session and the Community Health Assessments from Ramsey, Dakota, and Washington counties, these needs and themes resonated.

Access to affordable health care is discussed in Chapter 3; other social determinants of health (SDOH) are discussed here.

Housing

A safe and stable home is a basic need for all individuals. Ramsey, Dakota, and Washington counties all identify increasing costs of housing as a growing concern that impacts the health of their communities. Cost-burdened households are those paying more than 30% of their income on housing. In the Twin Cities metro area in the past 15 years, the percentage of households burdened by housing costs has increased from 25% to over 30%.⁷³ In Dakota and Washington counties, 18% of households are cost-burdened.^{74 75} In Ramsey County, 32.8% of households were cost-burdened in 2012-2016 (see Figure W).

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

⁷⁰ Alley DE, Asomugha CN, Conway PH, Sanghavi DM. Accountable health communities—addressing social needs through Medicare and Medicaid. *N Engl J Med.* 2016;374(1):8-11.

⁷¹ Daniel H, Bornstein SS, Kane GC, for the Health and Public Policy Committee of the American College of Physicians. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. *Ann Intern Med.* 2018;168:577–578.

⁷² Garg A, Boynton-Jarrett R, Dworkin PH. Avoiding the unintended consequences of screening for social determinants of health. *JAMA.* 2016 Aug 23;316(8):813-4.

⁷³ 2018 Ramsey County Community Health Assessment

⁷⁴ Dakota County Public Health

⁷⁵ Washington County Public Health

The burden of housing cost is most predominantly felt by low-income households, communities of color, and renters. In 2015, Black/African Americans experienced nearly double the rate of housing cost-burden. Even when communities of color make the same income as White communities, they are more likely to experience housing cost-burden in the Twin Cities.⁷⁶

Within Ramsey County, over 39% of housing units are rented⁷⁷ and the vacancy rate is very low, making it a very competitive housing market and driving up rental prices (see Map BB). Transience in St. Paul is relatively high: over 20% of St. Paul residents live in a different house than they did the prior year.⁷⁸ In Ramsey County, home owners are predominantly White: White individuals disproportionately own homes in comparison to all communities of color.⁷⁹

Homelessness and housing insecurity are explored more in-depth in Chapter 8.

Childcare

Access to quality and affordable childcare services is essential for families, providing them with essential nurturing child development and the opportunity for employment. Nearly 65% of children in Minnesota rely on some form of childcare. Of childcare provided in the metro area, approximately 15% is in home-based family childcare and 40% is center-based care.⁸⁰ A third of children in the metro area who live in high poverty areas (where at least 20% of children are in poverty) are also in a licensed child care desert (see Maps CC and DD).⁸¹

The availability of childcare slots in Minnesota has declined over the last 10 years, and subsidized childcare slots are even further constrained. This is further intensified by the increased cost of licensed childcare in the past 10 years and, specific to our service area, the increased cost in the metro area (see Map EE).⁸²

Financial Stability / Employment

Being financially stable hinges on multiple factors, including reliable, sufficient income, access to saving opportunities, safety net funding, and experience with budgeting.

In our service area, 34.4% of adults are not employed, much higher than the Minnesota state average of 22.6%. Every zip code in our service area has a higher unemployment

⁷⁶ 2018 Ramsey County Community Health Assessment

⁷⁷ U.S. Census Bureau, 2010 Census. Accessed on July 24, 2019 at

<https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

⁷⁸ American Community Survey. "Social Characteristics - St. Paul City, MN" 2017. Accessed on August 6, 2019 at <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkml>

⁷⁹ 2018 Ramsey County Community Health Assessment

⁸⁰ Understanding Licensed Child Care in Minnesota, 2016 Issue Brief. Accessed on July 24, 2019 at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3790-ENG>.

⁸¹ Understanding Licensed Child Care in Minnesota, 2016 Issue Brief. Accessed on July 24, 2019 at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3790-ENG>.

⁸² Kids Count Data Center, Minnesota Kids Count 2018. Accessed July 24, 2019 at <https://datacenter.kidscount.org/data/map/6154-average-annual-cost-for-licensed-center-based-child-care?loc=25&loct=5#5/any/false/false/37/2303/12841/Orange/-10393239,5864392.5,5,291,414>

rate than the Minnesota average (see Map FF); the highest rates are in Payne-Phalen (55130, 41.7%) and Capitol Hill (55103, 40.5%).⁸³

In Ramsey County, there are significantly higher rates of unemployment in Black/African American and Native American communities in comparison to White communities (see Figure X).⁸⁴

Education

Nearly 12% of people living in our service area have less than a high school education. This rate is highest in Payne-Phalen (55130, 32.5%) and Capitol Hill (55103, 24.6%), and lowest in Burnsville (55337, 6.4%) and Roseville (55113, 6.5%) (see Map GG).

Well-Being

Well-being is explored more in-depth in Chapter 5. Here, we examine well-being from the perspective of community and social connections. Social connections are strong in urban Ramsey County: more people report getting together or talking with friends/neighbors (including by phone and online) daily (40.0%) than the 6-county metro total (35.3%) and Dakota and Washington counties (32.8% and 32.6%, respectively).⁸⁵ Community connections are less strong, however: only 30.9% of Ramsey County urban residents “strongly agree” that people in their neighborhoods are willing to help one another, compared to the Ramsey County suburbs (44.2%), and Dakota and Washington counties (46.6% and 50.1%, respectively).⁸⁶ This percent drops further (to 29.0%) for people below 200% FPL (compared to 48.0% for people above 200% FPL).⁸⁷

Food Security

Food insecurity is more prevalent in households with children and those with single parent households.⁸⁸ In the metro area, the prevalence of food insecurity is greatest in St. Paul-Ramsey County: 18.5% compared to 9.7% in the 6-county area (see Figure Z).

Food insecurity and poverty are connected, but they are not the same. Ramsey County reports in its needs assessment (2018) that one-quarter of the people in Ramsey County who were food insecure in 2015 had incomes greater than 185% FPL.⁸⁹ Although true, food insecurity is greatest among low-income households: 40.5% of households <200% FPL (compared to 4.0% of households >200% FPL) reported worrying “often or sometimes” in the past 12 months that food would run out before they had money to buy more.⁹⁰

⁸³ UDS Mapper, 2017.

⁸⁴ American Community Survey. “Employment Status, Ramsey County.” 2013-2015 5 year Estimates. Accessed online August 6, 2019 at factfinder.census.gov

⁸⁵ Metro SHAPE Six County Data Book, p. 99.

⁸⁶ Metro SHAPE Six County Data Book, p. 104.

⁸⁷ Metro SHAPE Six County Data Book, p. 104.

⁸⁸ 2018 Ramsey County Community Health Assessment

⁸⁹ 2018 Ramsey County Community Health Assessment

⁹⁰ Metro SHAPE Six County Data Book, p. 107.

According to usage data collected by Hunger Solutions, food shelf visits in Ramsey County more than doubled from 2006 (164,348 visits) to 2017 (330,918 visits) (see Figure Y). The age group contributing greatest to this increase was adults (18-64 years).

Among 11th graders in Minnesota, 5% report that they had to skip meals in the past 30 days because their families did not have enough money to buy food; in St. Paul Public Schools rates of this level of food insecurity increase to nearly 9%.⁹¹

“Historical trauma in the Black/African American community impacts how much information patients will provide to the clinic. Patients are less likely to share personal information when they do not fully trust the clinic staff –because that information might be used against them. One family was having problems at home and lacked food but was scared to tell the doctor because they did not know what would happen to their children.” (Black/African American)

Clinic-Community Collaborations to Address SDOH

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

Clinicians Recognize and Address Historical Trauma and SDOH

How providers ask patients about issues of trauma and SDOH matters. Providers need to be trained to communicate with a non-judgmental approach that can ameliorate patients’ fears stemming from their historical traumatic experiences and from clinicians’ perpetuation of trauma based on cultural biases. Clinicians can ask patients about SDOH as they provide care.

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

“You know sometimes when people who just recently arrived, they have been through so much trauma. Like my grandma for example, when she came in, she said ‘I have body aches’ and later we ended up going to a therapist ... Understanding what these people went through helps so much. So, it is important for doctors to have background knowledge about what the person dealt with.” (Somali)

“(I) do not go in (to the clinic) unless I have to go. I have many friends (who) don’t go to clinics. They don’t feel safe and feel they could be physically attacked in public, as some of them have been physically assaulted just by walking down the street, going to the grocery store, doing things that other people normally don’t have to think

⁹¹ Minnesota Student Survey, 2016. Accessed online on August 3, 2019 at <http://w20.education.state.mn.us/MDEAnalytics/DataTopic.jsp?TOPICID=242>

about as far as safety....In the clinic, if they do go, are their pronouns going to be respected? Are they going to be treated as a person, not as this oddity? This is the reason for so many ER visits. Preventative care is important, but there are these safety barriers.” (LGBTQ2S)

Clinicians Recognize, Address, and Prevent “Medical Traumas”

People can experience “medical traumas” in medical settings; trauma can occur when a patient’s needs are not being met, when a patient is harmed, or when patient is traumatized or re-traumatized in clinics, hospitals, or emergency rooms. Medical professionals need to recognize and respond so that medical traumas do not occur.

“Shame and lack of trust is an issue. When I was sexually assaulted, I didn’t go to the doctor because I didn’t know how was I going to explain what happened—and there was so much shame. As a trans person, it is so sad to hear that we suffer in silence...with no one to talk to, and a lot of those domestic violence and sex assault programs don’t see trans-people as people. (There is no way that I’m going to) go down and do a rape kit, and you know, be victimized again.” (LGBTQ2S)

CHAPTER 7: PRIORITY 5 – RELATIONSHIPS

The fifth priority of our community is:

Quality health centers provide respectful, trusting and effective relationships with patients and communities.

This means that continuous, long-term relationships between clinicians and patients have structural supports to enhance their relationships. Health centers should have clinicians and staff who provide culturally responsive care, which is reinforced and prioritized through ongoing training. Physical spaces should be welcoming and safe. Health centers should ensure that their clinicians are competent and do not harm people.

In action, health centers achieving this priority:

- Support long-term, continuous clinician-patient relationships
- Provide culturally responsive training for all clinic staff
- Allocate adequate resources to support effective clinician-patient relationships
- Create welcoming, private, safe clinic environments

And, health center clinicians:

- Provide culturally responsive/respectful care without unconscious bias
- Are medically competent and do not harm people

Long-Term, Continuous Clinician-Patient Relationships

Patients want long-term personal relationships with their primary care clinicians. They want relationships where they are respected and known as individuals, where their concerns are listened to and not dismissed, where their bodily knowledge is respected, and where their life choices are incorporated. They want support and advice for their acute and long-term health concerns, mental health issues, chronic diseases, preventive care, cancer screening, healthy lifestyles, and commitment to overall wellness. Having a usual source of care is associated with improved health outcomes.⁹²

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

No Usual Source of Care

In our service area, over 21% of the adult population does not have access to a usual source of primary care, slightly lower than the Minnesota state average of 27% (see

⁹² Clancy C, Munier W, Brady J, et al. 2012 National healthcare quality report. Rockville, MD: Agency for Healthcare Research and Quality (AHRQ); 2013.

Map HH).⁹³ The lowest rate of not having a primary care source is in Burnsville (55337, 19.6%), while the highest rate of not having a usual primary care source is in the West Side neighborhood (55107, 26.2%).

Within the metro area, adults who are low-income are more likely to be disconnected from a personal provider; 25.3% with lower incomes do not have a personal health care provider versus 19.6% among higher income adults.⁹⁴

Looking more closely at the City of St. Paul, however, shows that there is great variability within the city, with some neighborhoods having as high as 37.9% of adults without an annual health exam (see Map II).⁹⁵

Proportion of Available Clinicians

In order to have long-term continuous relationships with primary care clinicians, there need to be available primary care clinicians. Ramsey County ranks well in comparison to the surrounding metropolitan counties, having among the lowest proportions of primary care physicians to population (942:1), dentists to population (1210:1), and mental health providers to population (272:1); these favorable ratios indicate greater clinician availability (see Figure AA).⁹⁶

Primary care clinicians or mental health clinicians with experience in Substance Use Disorders (SUD), however, are in low supply. There are far more clinicians available in the metro area than in greater Minnesota; opioid treatment centers outside of the metropolitan area are particularly sparse (see Map JJ).⁹⁷

“For those with drugs and alcohol problems, if you don’t have a supportive environment, it’s easy to slip back into using again. Creating the supports for long-term health is really important. Like mental health, one thing is to have a regular schedule with a provider. If you can only get it once a month, it’s hard to follow up with the positive that you’re getting from it. Sometimes that relationship ends when you decide you can only go so far with a therapist or the therapist thinks they need to end the working relationship.” (White)

Culturally Responsive/Respectful Care without Unconscious Bias

Patients want to feel valued and respected as individuals, without being stereotyped and demeaned. They want to be given culturally respectful and appropriate information, which can lead to increased trust, hopefulness, shared decision-making, and follow through with health care plans and goals. Patients (particularly from communities of color and LGBTQ2S) too often feel stereotyped, discriminated against, vulnerable, and unsafe. To provide respectful patient-centered care, clinicians need to be aware of their

⁹³ UDS Mapper, BRFSS data, 2016

⁹⁴ Metro SHAPE Six County Data Book, p. 37

⁹⁵ 500 Cities, “Model-based estimates for visits to doctor for routine checkup within the past year among adults aged >= 18 years,” 2016.

⁹⁶ 2018 Ramsey County Community Health Assessment

⁹⁷ UDS Mapper, 2019

conscious and unconscious biases, be open to learning from all patients, and act towards all patients without making assumptions and without stereotyping. Specifically, clinicians can benefit from learning about a group's historical past, culture of health, and traditional cultural healing practices (e.g. herbal medicine, massage, prayer, faith healing).

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

“Respect for elders, how the staff in the clinic acknowledge you, instead of calling you by your first name....I know that this is not the culture, but treating a client as Mr., and Mrs. first is respectful and you may give permission to call you by your first name.” (Black/African American)

“It is essential that bias against transgender/gender non-conforming/intersexed/ Two spirit people is acknowledged. It is so important that clinics have staff who know how to treat trans/GNC/intersexed people with respect and dignity. My trans/GNC/Intersexed/Two spirit community is one of the poorest because of discrimination when it comes to jobs. It’s one of the most housing insecure because of discrimination. And many trans/GNC/intersexed/two spirit people, especially BIPOC do survival sex work for basic necessities, i.e., food and a place to sleep. All of this is a huge impact when it comes to trauma and social determinants of health. Additionally, I would recommend adding gender discrimination to the above influences because it is so very important to recognize.” (LGBTQ2S)

“I laugh when I think about when I took (my son) to the clinic, and they asked me how I had my son, and how was my gynecological care. What you see is not always what is – no assumptions.” (LGBTQ2S)

In a 2019 study from the Mayo Clinic and University of Minnesota, resident physicians with symptoms of burnout, such as emotional exhaustion, depersonalization, and a decreased sense of efficacy, demonstrated greater explicit and implicit racial biases.⁹⁸ It is essential that health centers recognize this, and offer training and give support to clinicians and staff in order to address these implicit biases.

Culturally Responsive Training for All Clinic Staff

Clinic culture should not be generic “Minnesota Nice;” it should be culturally responsive to and respectful of the communities it serves. Culturally responsive training should be required for all staff, not just clinicians; appointment staff, front desk, and outreach staff need to provide respectful and helpful patient-centered customer service and provide

⁹⁸ Dyrbye, L., Herrin, J., West, C.P., Wittlin, N.M., Dovidio, J.F., Hardeman, R., Burke, S.E., Phelan, S., Onyeador, I.N., Cunningham, B. and van Ryn, M., 2019. Association of Racial Bias With Burnout Among Resident Physicians. *JAMA Network Open*, 2(7), pp.e197457-e197457.

transparent descriptions about how clinic processes work; triage staff needs to respond to patient's needs and make connections to appropriate staff and departments.

“Cultural training must be available to the clinic staff at all levels. Clinics can even invite patients to talk about ways to improve services so the services fit with patients’ culture desires and needs. My aunt has diabetes. I went with her to see a doctor and the doctor didn’t see her as she is. She is an elderly woman and has never been educated. He told her how to manage her diabetes, but she didn’t understand the whole scope of it or why. He told her ‘no more tea’ and didn’t discuss it further with her. He doesn’t understand how tea is a part of our culture. If he understood our culture he could treat her well, and he could reach her. Now she constantly goes to the ER instead of going to her doctor. She needs education and help to learn how she can eat.” (Somali)

“Health is about beating the norm and being seen as a person and not seen as an oddity. For example, I have the experience of a doctor calling in other doctors because they had “never seen one of you before” [reference to a gender non-conforming person/trans person]. (LGBTQ2S)

Adequate Resources to Support Effective Clinician-Patient Relationships

Clinicians need clinic resources to support therapeutic relationships. Clinicians need adequate time to establish personal relationships with their patients and provide culturally responsive care, including identifying, understanding, and responding to the social and cultural context of people’s health (i.e. social determinants of health). They need to effectively work with trained medical interpreters for non-English speaking and low-English proficiency patients.

“When people need interpreters, then they need more time, not only to interpret, but there is also a cultural piece. Hmong are relationship people, we need more time to build relationships with providers and explain things fully, so we don’t get embarrassed. Earlier we talked about how Hmong people don’t tell them (the doctors) fully about themselves because they don’t see how it is related to their health.” (Hmong)

A literature review from 2007 shared that the use of professional interpreters was associated with improved clinical care for patients with limited English proficiency.⁹⁹ A more recent study has examined the reasons why providers underutilize interpreters, including time constraints, type of messaging to the patient, urgency or complexity of care, and organizational-level considerations.¹⁰⁰

⁹⁹ Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health services research*. 2007 Apr;42(2):727-54.

¹⁰⁰ Hsieh E. Not just “getting by”: factors influencing providers’ choice of interpreters. *Journal of general internal medicine*. 2015 Jan 1;30(1):75-82.

Welcoming, Private, Safe Clinic Environments

A welcoming clinic environment can contribute to health by helping people feel cared for, respected, and valued, and by reducing the stress that occurs when people feel disrespected and unwanted. Depending on the communities that the clinics serve, this could include space and activities for children, work by local community artists on the walls, healing gardens, and quiet spaces for reflection and prayer. A welcoming environment also means that the clinics have a high standard of professionalism that reflects the needs of the communities that the clinics serve. The most important trait is excellent customer service: staff members do not make assumptions, reinforce stereotypes, or pass judgment based on how people look, dress, or speak. As the first and last people that patients see in the clinic, the front desk staff must embody this mentality of service so patients feel cared for at the clinics. Providing confidential care in a private environment is respectful of patients' lives and leads to a trusting relationship between patients and clinic staff. Providing safe care, where people are not harmed, demeaned, devalued, or discriminated against is essential for all communities.

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

“We know that we do not want to be in a clinic in the first place, so to get into this place and navigate I must be comfortable to stay and come back. The place must be welcoming, clean, there should be art work, music, activities for the children... In addition, have people who recognize you from the community... It gives you a communal feeling. It is not only a clinic, but the facility has people who care about you.” (Black/African American)

“Make sure that staff is trained in HIPAA. Privacy is important. Do not leave my private information for others to see. We do not trust doctors and we do not trust people with our information. Talk in a low voice instead of screaming. There are always people behind who can hear. ... Information should be private and treated with respect. This way I will come back to this clinic.” (Black/African American)

“What is it like when you go into the clinic, is it all straight, white people?...What's the literature in the waiting room? Are there gay magazines, are there people of color on them? And around bathrooms and bathroom management...are there single stall bathrooms available? How has the clinic chosen to label the bathrooms? How do I fit within the physicality of the clinic – do I see myself represented?” (LGBTQ2S)

“On those forms that you fill out, my doctor has Male, Female, Trans Male, Trans Female, Gender Nonconforming, Gender Fluid, as far as Gender. And under pronouns, he has He/Him, She/Her, They/Them/Theirs and then Your pronouns. How neat is that? It says 'I see you, you are valid' just on the form!..And they ask you 'how would you like to be addressed?' They have that in the forms too. You can

write in whatever you like. And then I feel welcomed right away. Oh you ARE listening! You ARE taking me into consideration. There are only two clinics that I've been into (that have done this)." (LGBTQ2S)

Research discusses specific attributes of design that transform a health center into a healing environment¹⁰¹ that is attuned to the unique needs of the communities served is essential.

Medically Competent Clinicians who Do Not Harm People

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

“Remember, the [opioid] epidemic started and continued because of doctors and pharmaceutical companies. They (healthcare professionals) are not always making healthy decisions for people.” (LGBTQ2S)

Federally Qualified Health Centers, such as Minnesota Community Care, are required to perform internal quarterly reviews of all clinicians to insure quality care.

Minnesota Community Measurement creates an annual Minnesota Health Score and evaluates the quality of care performed by individual clinics and clinical systems. In 2018, Minnesota Community Care ranked among the lowest in the state, similar to other community health centers (CHCs). Specifically, Minnesota Community Care ranked “below average” on a majority of indicators, including asthma care, breast cancer and colon cancer screening, diabetes care, and hypertension care; and ranked “average” in cervical cancer screening and childhood vaccinations. Patients did report “above average” positive experiences with providers and care coordination, and high rates of recommending the clinics to their families and friends.¹⁰² Many intertwining factors may be contributing to these low numbers. Clinician competence may be a factor, but a recent study of clinicians who had worked in CHCs and non-CHCs identified that caring for patients with low insurance rates and high burdens of SDOH make the usual clinic based care less effective than caring for people with high insurance rates and low burdens of SDOH.

Minnesota was the first state to mandate reporting of serious adverse health events in efforts to reign in medical errors. In the state of Minnesota in 2018, the 58% of adverse health events related to pressure ulcers and falls, similar to prior years; medication

¹⁰¹ Dijkstra K, Pieterse M, Pruy A. Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: systematic review. *Journal of advanced nursing*. 2006 Oct;56(2):166-81.

¹⁰² Minnesota Community Measurement, “MNHealthScores,” West Side Community Health Services. 2018. Accessed July 30, 2019 at <http://www.mnhealthscores.org/medical-group/west-side-community-health-services>.

errors accounted for 4.4% (17/384) of adverse health events, slightly higher than 3.2% in 2017 (11/342 events).¹⁰³

¹⁰³ Minnesota Department of Health. Adverse Health Events in Minnesota. March 2019. Accessed on July 30, 2019 at <https://www.health.state.mn.us/facilities/patientsafety/adverseevents/docs/2019ahereport.pdf>.

CHAPTER 8: SPECIAL POPULATIONS

Under federal Health Resources and Services Administration (HRSA) guidelines, “special populations” are defined as unique groups that require specific considerations, often due to increased vulnerability or need for dedicated funding. Minnesota Community Care receives two sources of special-population funding: Health Care for the Homeless (HCH) and Public Housing Primary Care (PHPC). We operate 3 co-located HCH sites in St. Paul, and are the designated HCH partner in the City of St. Paul. Additionally, we operate a PHPC clinic in McDonough Homes in partnership with the St. Paul Public Housing Agency. Additionally, Minnesota Community Care operates 10 school-based clinics in St. Paul Public Schools middle and high schools, providing school-based health to over 5,000 school-age youth annually.

Specific needs of these three special populations will be further explored in this chapter.

Health Care for the Homeless

People defined as “homeless” are those who live in a place not intended for human habitation, in emergency shelters, or in transitional housing.¹⁰⁴

Demographics

According to the 2018 Minnesota Homeless Study conducted by Wilder Research, over 10,000 individuals experienced homelessness in Minnesota in 2018, or 0.18% of the total population; a slightly higher proportion of the population in Ramsey County experienced homelessness in 2018: 0.35% (1,927 individuals).¹⁰⁵

The total number of people experiencing homelessness in Minnesota increased by 10% from 2015 to 2018, although the number of children experiencing homelessness remained steady between 2015 and 2018.¹⁰⁶ Since 1991, there has been a more than threefold increase in the total homeless population in Minnesota (3,079 in 1991 to 10,233 in 2018) and in the number of children without parents homeless (889 to 3,265) (see Figure BB).¹⁰⁷

While in the state of Minnesota 47% of those experiencing homelessness were children or youth ages 24 and younger, this was higher in the metropolitan area. In Ramsey County, this was 45%; in Dakota and Washington counties, this was higher at 57% and 52%, respectively. Across the state, there was a growth of 25% among older adults (age 55 and older) experiencing homelessness, a growth that also occurred in Ramsey County (see Figure CC).

¹⁰⁴ Changes in the HUD Definition of “Homeless.” Accessed on July 30, 2019 at <https://endhomelessness.org/resource/changes-in-the-hud-definition-of-homeless/>

¹⁰⁵ Wilder Research, Homelessness in Minnesota, 2018. Accessed on July 30, 2019 at www.mnhomeless.org

¹⁰⁶ Homelessness in Minnesota, 2018

¹⁰⁷ Homelessness in Minnesota, 2018

As compared to representation in the general Minnesota adult population, Black/African American, Native American/American Indian, and Latino/a/x populations are overrepresented amongst those experiencing homelessness (see Figure EE).¹⁰⁸

“If the person is homeless, (coordinators should) use tact to address the question. A question ... could be ‘Do you have stable home?’ If I tell you that I do not have a house, I am afraid you will report me to child protection. This information may be relevant, but first I must trust you to be able to share it.” (Black/African American)

Limited Access to Formal Shelters and Affordable Housing

Remarkably in the seven-county metropolitan area, there was a 93% increase in individuals not living in a formal shelter between 2015 and 2018 (see Figure DD). They were living in unsheltered locations, including encampments, cars, or public transit. Thirty-two percent (32%) of all adults experiencing homelessness reported that they were turned away from a shelter in the past 3 months due to lack of space.

In Minnesota, most adults experiencing homelessness stated that they left their last housing because of eviction (39%), they could no longer afford their housing (38%), or they had lost income (31%). Fifty percent are on a subsidized housing waiting list, on average for more than 12 months.

Health Status

Chronic physical and mental health concerns are common among those experiencing homelessness. Over half of homeless adults (57%) and more than a third of youth (39%) report a physical health condition; those experiencing homelessness are 3-4 times more likely to die prematurely.¹⁰⁹ In 2018, 64% of Minnesotans experiencing homelessness, both youth and adults, had a serious mental illness; an increase from 2015, this rate is the highest ever recorded.

“When I didn’t have a home address, I had trouble getting my antidepressants filled. It was a nightmare. It was so challenging.” (White)

Adverse Childhood Experiences (ACEs) are common in Minnesotans experiencing homelessness, and remarkably higher among youth. Nearly three-quarters of adults report at least 1 adverse childhood experience compared to 84% of youth ages 24 or younger (see Figure FF).¹¹⁰

Women and gender nonconforming/transgender populations are at high risk of violence and abuse. In 2018, over half of women experiencing homelessness in Minnesota had experienced violence or exploitation: 67% of adult females, 57% of youth females. This was much higher among gender nonconforming/transgender populations with 83% of

¹⁰⁸ Homelessness in Minnesota, 2018

¹⁰⁹ National Healthcare for the Homeless Council. 2011. Homelessness and Health: What’s the Connection. Accessed July 30, 2019 at https://www.nhchc.org/wp-content/uploads/2011/09/HIn_health_factsheet_Jan10.pdf

¹¹⁰ Characteristics and Trends among Minnesota’s Homeless Population. 2018 Minnesota Homeless Study. Accessed on July 30, 2019 at <http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2018/2018-homeless-characteristics-fact-sheet-5-19.pdf>

adults and 79% of youth reporting at least one experience of violent or sexual exploitation. More women reported fleeing domestic violence in 2018 than in prior years (37% vs 29% in 2009).

School-Based Health

Minnesota Community Care operates 10 school-based clinics, each co-located in a St. Paul Public Schools (SPPS) middle and/or high school. These “Health Start” clinics serve youth ages 11-22 years. This spotlight will focus on the health of school-age youth in St. Paul.

Health and education are closely intertwined: those who have education are more likely to be healthy and those who are healthy are more able to participate in educational services. Further, success in education allows a person more economic mobility, which in turn greatly benefits their health.

Demographics

In the City of St. Paul, over 16,000 youth are enrolled in grades 9-12 and almost 34,000 students in grades 1-8. Nearly 11,000 students are enrolled in SPPS in grades 9-12. The racial makeup of SPPS high schools differs from that of the city: there are higher proportions of Asian, Black/African/American, Latino/a/x/, and Native American/American Indian students in SPPS than St. Paul’s total population (see Figure GG). Approximately 34% of students in all grades of SPPS are English Language Learners, 15% require special education services, and 70% of all students are eligible for free or reduced price lunch.¹¹¹

Of SPPS 9th graders in 2016, 82.6% of students self-identified as heterosexual, 3.3% as bisexual, 2.2% as gay or lesbian, and 6.9% not sure or questioning. These proportions do not vary significantly among 11th graders: 83.6%, 6.0%, 2.2%, and 8.1%, respectively.¹¹²

Within SPPS, 3.7% of 9th graders and 3.6% of 11th graders consider themselves transgender, genderqueer, genderfluid, or unsure about their gender identity.¹¹³

Addressing the Achievement Gap and Health Disparities

Disparities in health are mirrored in education. The “achievement gap” reflects the differences in academic performance among groups of students. While Minnesota has had some of the highest average educational scores in math and reading, the state also reflects some of the greatest disparities between White and Black/African American youth and between White and Latino/a/x youth. For example, in 2013, Minnesota had the fourth highest average math scores among 8th graders, but ranked 30th among Black/African Americans and 23rd among Latino/a/x youth. This was the fifth largest

¹¹¹ Saint Paul Public Schools. Accessed online August 1, 2019 at <https://www.spps.org/domain/1235>

¹¹² Minnesota Student Survey, 2016. Accessed online on August 3, 2019 at <http://w20.education.state.mn.us/MDEAnalytics/DataTopic.jsp?TOPICID=242>

¹¹³ Minnesota Student Survey, 2016

achievement gap in the nation.¹¹⁴ Socioeconomic disparities between white populations and people of color likely contribute to the gap in achievement, but do not appear to be the sole cause.¹¹⁵

The Minnesota Comprehensive Assessment (MCA) is given to students to assess math, reading, and science knowledge. St. Paul Public Schools (SPPS) students perform below the state average across all three domains.¹¹⁶ Similar to many of the health measures discussed in this report, students of color and low-income students have lower proficiencies in comparison to their white peers (see Figure HH).¹¹⁷

On-time graduation rates in 2017 increased within Ramsey County and were higher than the Minnesota state average for students with limited English language proficiency. White students graduated at higher rates than students of color in Ramsey County (see Figure II).¹¹⁸ Among SPPS graduates, twice as many white students enroll in post-secondary institutions as Native American students (68.9% vs 33%, respectively).¹¹⁹

Health Status

Mental Health

Mental health concerns are common in youth and impact the functioning and outcomes of our schools. As we began to review in Chapter 5, youth and particularly youth of color experience a high number of adverse childhood experiences (ACEs) and have higher rates of contemplating or attempting suicide.¹²⁰ Among SPPS students in grades 8-11, the frequency of depressive symptoms overall increases in each grade, with over 25% of 11th graders reporting “feeling down, depressed, or hopeless” more than half the days or every day (see Figure JJ).¹²¹

Nutrition, Wellness, and Weight Status

Across the country, the number of children who are obese or overweight has increased and threatens to decrease the life expectancy of our future generations. Minnesota has one of the lower rates of childhood obesity or overweight, with an average of 26% compared to the national average of 31%.¹²² Rates of obesity and overweight in 2 to 5-year-olds have decreased over the last decade in Ramsey County; this rate is now

¹¹⁴ “Racial and Ethnic Achievement Gaps” Stanford Center for Education Policy Analysis. Accessed online August 1, 2019 at <https://cepa.stanford.edu/educational-opportunity-monitoring-project/achievement-gaps/race/>

¹¹⁵ Racial and Ethnic Achievement Gaps.

¹¹⁶ Minnesota Report Card. Minnesota Department of Education. 2018. Accessed online August 1, 2019 at <https://rc.education.state.mn.us>

¹¹⁷ 2018 MCA and ACCESS for ELLs 2.0 Results, St. Paul Public Schools. Accessed online on August 1, 2019 at <https://www.spps.org/cms/lib/MN01910242/Centricity/Domain/12699/2018MCA4.pdf>

¹¹⁸ 2018 Ramsey County Community Health Assessment

¹¹⁹ Post-Secondary Enrollment for the Graduating Classes of 2008-2018. St. Paul Public Schools. Accessed online August 1, 2019 at <https://www.spps.org/Page/28073>.

¹²⁰ Minnesota Student Survey 2016

¹²¹ Minnesota Student Survey 2016

¹²² “Children and teens overweight or obese by gender in the United States.” Kids Count Data Center, Annie E. Casey Foundation, 2016-2017. Accessed online on August 3, 2019 at <https://datacenter.kidscount.org/data/tables/9700-children-and-teens-overweight-or-obese-by-gender?loc=1&loct=2#detailed/1/any/false/1603/15,14,16/18944>

8.9%. This increases dramatically to 17.5% among 6 to 11-year-olds and 20.5% among 12 to 19-year-olds.¹²³ Among high school students in Ramsey County, 29.4% of students of color were overweight or obese, compared to 21.7% of white students.¹²⁴ SPPS students in grades 9 and 11 have higher rates of being overweight and obese than the Minnesota average: 16.1% of SPPS 9th graders and 15.6% of SPPS 11th graders were overweight in 2016 (MN average: 13.9%), and 13.4% and 13.1%, respectively, were obese (MN average: 10.2%) (see Figure KK).

St. Paul Public School (SPPS) students report to have limited intake of fruits and vegetables. Among 11th graders, 31% reported 3 or fewer fruits in the past week and 44.5% reported to have 3 or fewer vegetables.¹²⁵ Seventeen percent of 11th graders have less than 60 minutes of physical activity per week.¹²⁶

Sexual & Reproductive Health

Within St. Paul Public Schools (SPPS), 13.5% of 9th grade males and 12.2% of 9th grade females are sexually active, rising to 36.4% and 36.3% in 11th grade, respectively.¹²⁷ Discussing pregnancy prevention is key and while this increases across grades, there remains a large proportion of sexually active adolescents who do not discuss this with their partners (see Figure LL).¹²⁸

Condoms are nearly 98% effective at preventing pregnancy and sexually transmitted infections. Ramsey County 9th and 11th graders, both male and female, fell below the Healthy People 2020 benchmarks for condom use (see Figure MM).

While different pregnancy prevention methods were used among 11th graders, those in SPPS reported higher use of condoms and of long-acting reversible contraceptives (LARC) (i.e. injections, subdermal contraceptive implants, and intrauterine devices), than in both the larger Ramsey County and the state of Minnesota (see Figure NN).¹²⁹

Public Housing Primary Care

Minnesota Community Care opened a Public Housing Primary Care (PHPC) clinic in McDonough Homes in partnership with the St. Paul Public Housing Agency in 1993.

Limited Access to Public Housing

Public housing offers subsidized housing options to some of the most economically disadvantaged members of our community. In order to qualify, individuals and families must earn less than 80% of the mean family income for the area, adjusted for family size. Preference is given to elders and near elders, disabled applicants, veterans, students, and residents of St. Paul. Nationally, 56% of public housing residents are seniors or those with disabilities and 34% are families with children. Disabilities include

¹²³ 2018 Ramsey County Community Health Assessment

¹²⁴ 2018 Ramsey County Community Health Assessment

¹²⁵ Minnesota Student Survey, 2016

¹²⁶ Minnesota Student Survey, 2016

¹²⁷ Minnesota Student Survey, 2016

¹²⁸ 2018 Ramsey County Community Health Assessment

¹²⁹ Minnesota Student Survey, 2016

physical, mental, and sensory disabilities, but do not include alcohol or drug dependency. Nearly half (49%) of public housing residents have lived in public housing for over 5 years.¹³⁰

The St. Paul Public Housing Agency (SPPHA) is a designee of the U.S. Department of Housing and Urban Development (HUD) and manages 4,273 housing units in St. Paul for approximately 10,000 low income residents (see Map KK).¹³¹ With 592 units, McDonough Homes is the largest family housing development in the city. While most public housing units are located in high rise apartments (59.7%), 9.8% are in scattered site placements and 30.5% are in family housing developments.

In October 2018, the SPPHA stopped accepted applications for the public housing program, no longer adding additional individuals or families to the waitlist.¹³² Families and individuals are instead referred to shelters for additional support.

Health Status

A national study found that those who receive public housing assistance are more likely to have access to health insurance and have lower rates of unmet health care needs.¹³³ Several studies, however, report that there are higher burdens of poor health among those in public housing, including hypertension (50% of residents compared to 31.4% of the general population), diabetes (15-20% compared to 8.7%) and asthma (20-25% compared to 9.1%).¹³⁴ In New York City, senior public housing residents reported increased depression diagnoses (19% vs 13%). Further, residents were more likely to have impaired activities of daily living, requiring assistance with their daily tasks (40% vs 19%).¹³⁵

¹³⁰ “Connecting Public Housing and Health: A Health Impact Assessment of HUD’s Designated Housing Rule.” Health Impact Project, Pew Charitable Trusts. June 2015. Accessed online on August 6, 2019 at <https://www.pewtrusts.org/~media/assets/2015/06/connecting-public-housing-and-health.pdf>.

¹³¹ St. Paul Public Housing Agency, Annual Report 2018. Accessed online on August 6, 2019 at http://www.stpha.org/images/annual-reports/pha_2018_annuareport_1.pdf

¹³² “Public Housing Waiting List” St. Paul Public Housing Agency, 2018. Accessed online on August 6, 2019 at <http://www.stpha.org/public-housing/wait-list>

¹³³ Simon, A.E., Fenelon, A., Helms, V., Lloyd, P.C. and Rossen, L.M., 2017. HUD housing assistance associated with lower uninsurance rates and unmet medical need. *Health Affairs*, 36(6), pp.1016-1023.

¹³⁴ “Connecting Public Housing and Health: A Health Impact Assessment of HUD’s Designated Housing Rule.” Health Impact Project, Pew Charitable Trusts. June 2015. Accessed online on August 6, 2019 at <https://www.pewtrusts.org/~media/assets/2015/06/connecting-public-housing-and-health.pdf>.

¹³⁵ “Connecting Public Housing and Health: A Health Impact Assessment of HUD’s Designated Housing Rule.” Health Impact Project, Pew Charitable Trusts. June 2015. Accessed online on August 6, 2019 at <https://www.pewtrusts.org/~media/assets/2015/06/connecting-public-housing-and-health.pdf>.

CHAPTER 9: KEY COMMUNITY RECOMMENDATIONS

In discussing the five priorities of quality health centers (see Chapters 3-7) at the Community Listening Session, our community members identified a number of recommendations to enhance the care and services we provide. Notably, several recommendations were similar among the prioritized characteristics; to help us organize the recommendations, the Steering Committee agreed to use the National Quality Forum's Domains of Health Equity Measurement (see Figure C).

The Steering Committee aligned the community's words and recommendations, as collected in the Community Listening Session, to the five NQF domains. This process was iterative, collaborative, and purposefully respectful of the community voice. The outcome of this process is presented here; each NQF domain is tied to an illustrative, verbatim quote from a community member, and supported by key recommendations.

Please refer to Appendix IV for additional quotes from QMEP participants, sorted by NQF domain.

NQF Domain: Partnerships & Collaboration

“Clinics should know what they are doing and know about organizations which can help alongside. Clinics should do their job well and if they need services which are not covered by the clinic, they should find other organizations in the community that can help them.” (Black/African American)

Minnesota Community Care should:

1. Honor the strength of and authentically partner with community-led organizations to confront health inequities and influence social determinants of health that impact the wellbeing of communities.
2. Go to where the community is, with staff who represent that community, to engage with communities about whole-body health promotion and education.
3. Engage with partners to hold the State accountable for its role in reinforcing and perpetuating structural racism and other forms of institutional discrimination, and to advocate for public policy that deconstructs racism, discrimination, and trauma.
4. Promote equitable access for marginalized communities to pursue careers in health care delivery and leadership.

NQF Domain: Culture of Equity

“If we constantly think about the notion of who's healthy and who's not, then our concept of ourselves is distorted. We have to decolonize everything. We have to get native people to a lake to walk around it. To some of our people, that is a white thing to do and we have to remind them that this has been our land. We've always roamed it, we've always foraged, and we've always hunted. When we're trying to negotiate our health needs, we have to decolonize how we talk about fitness, how we talk about health and these concepts, especially in a community that is always in crisis mode.”

Our community is constantly trying to survive colonization because we are still being colonized.” (Native American)

Minnesota Community Care should:

1. Develop an equity plan that holds leadership accountable for measurable transformation.
2. (Re)design its physical spaces to be trauma-informed, culturally welcoming, inclusive environments to accommodate people from all communities.
3. Expand its applied definition of culturally-responsive care to include service delivery from a provider/patient shared understanding of health and wellness.
4. Provide ongoing, comprehensive training on bias and historical trauma that leads to an organizational culture shift.

NQF Domain: Structure for Equity

“Clinic leadership should hire people who are Somali. For example, if the clinic is in neighborhood where Somalis live, they should hire interpreters from the community, but how much better (it would be) if they hired people from the community to provide services and to lead the clinic.” (Somali)

Minnesota Community Care should:

1. Invest in building a workforce, contractor/vendor pool, and leadership team(s) that authentically represent the communities served.
2. Uplift its existing model for Community-Based Participatory Action Research to inform its models for quality, population health, and operations.
3. Actively seek to understand how individuals, families, and communities are impacted by social and structural determinants of health, and create respectful spaces for patients to share concerns and receive support.
4. Center health equity as an integral component of accountability to its Community Board and the communities it serves.
5. Apply a continuous timeline to its needs and assets assessments process.
6. Engage communities in designing community health improvement and/or action plans in response to findings from its needs and assets assessments.
7. Adopt policies and procedures that address structural racism, historical trauma, and social and structural determinants of health, and be accountable to its community-led Board of Directors to act upon such.

NQF Domain: Access to Care

“What about the person who: I got my baby, my rent’s not paid, my partner is being snarky, my kid’s sick. Figuring out how to navigate that system would be even more work. We are not seen not heard. Systems are really hard to navigate on purpose. How do you disrupt that? If you see your parole officer by 2:00 pm? How would one figure out where to go to see your patient advocate and find your patient advocate? What if I am taking the bus?” (LGBTQ2S)

Minnesota Community Care should:

1. Design operational and clinical processes that respect each patient's time, lived experience, and social and structural determinants of health.
2. Identify and understand the barriers to access unique to each community served.
3. Provide patients with affordable, accessible healthcare, and connect eligible patients to insurance and public benefits.
4. Assure that no existing or future funding restricts access to care for any subset of the community.
5. Proactively reflect on where vulnerable communities live and/or spend time to identify new sites for service delivery, programming, and outreach.

NQF Domain: High-Quality Care

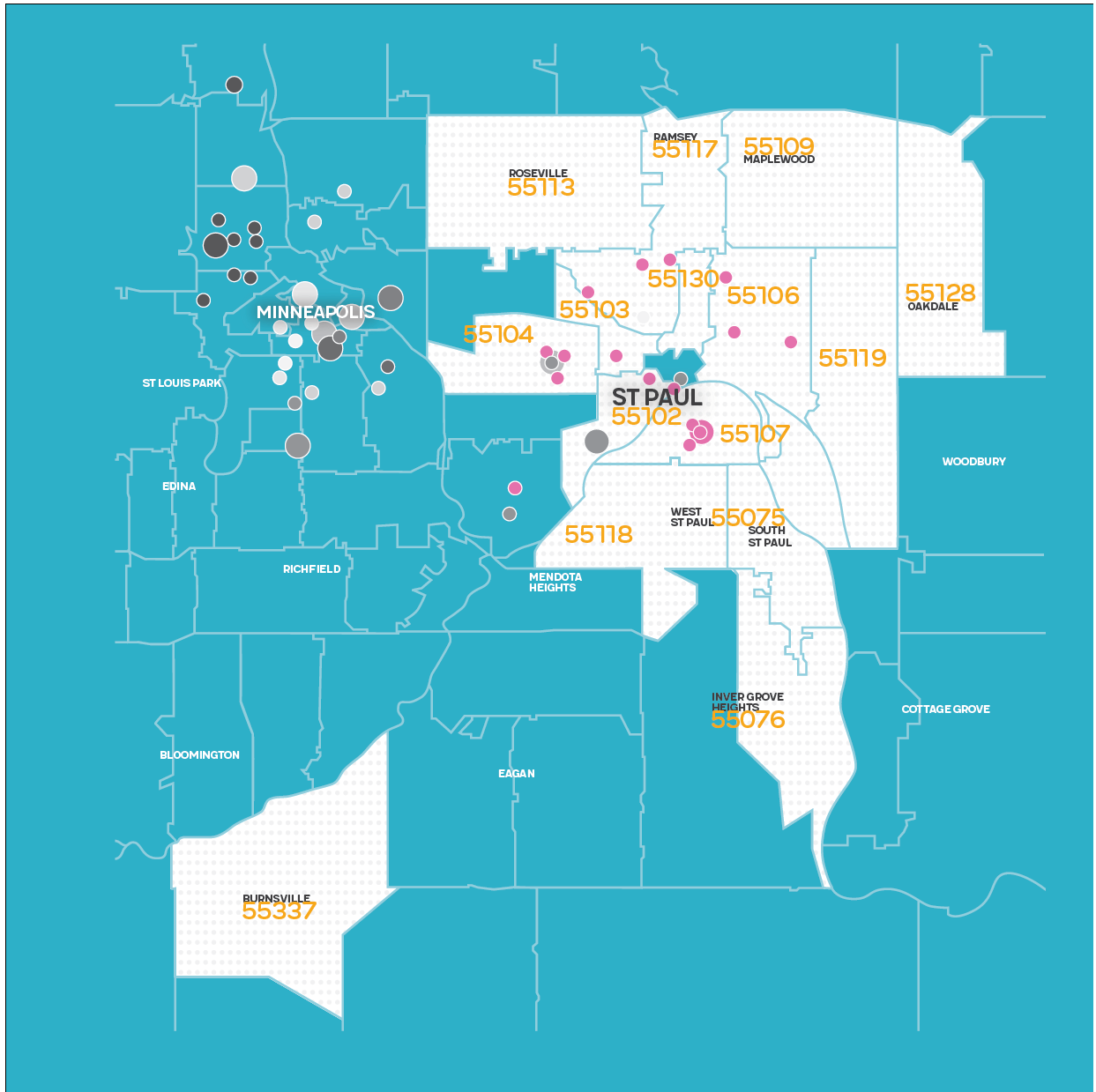
“We are a spiritual people. If a doctor or clinic won't let us follow our spiritual/traditional beliefs even after we explain how our beliefs might affect our health, and we explain to the doctor and they turn us away saying “No, that's no such thing” (then we close down.) But if a doctor knows and understands and says, “Okay, if that is what you think, then how about we can use both spirituality and medicine?”, this can help us open up., . (and) we can seek help in all areas. This is really important for Hmong, especially for those who still believe in the traditional ways.” (Hmong)

Minnesota Community Care should:

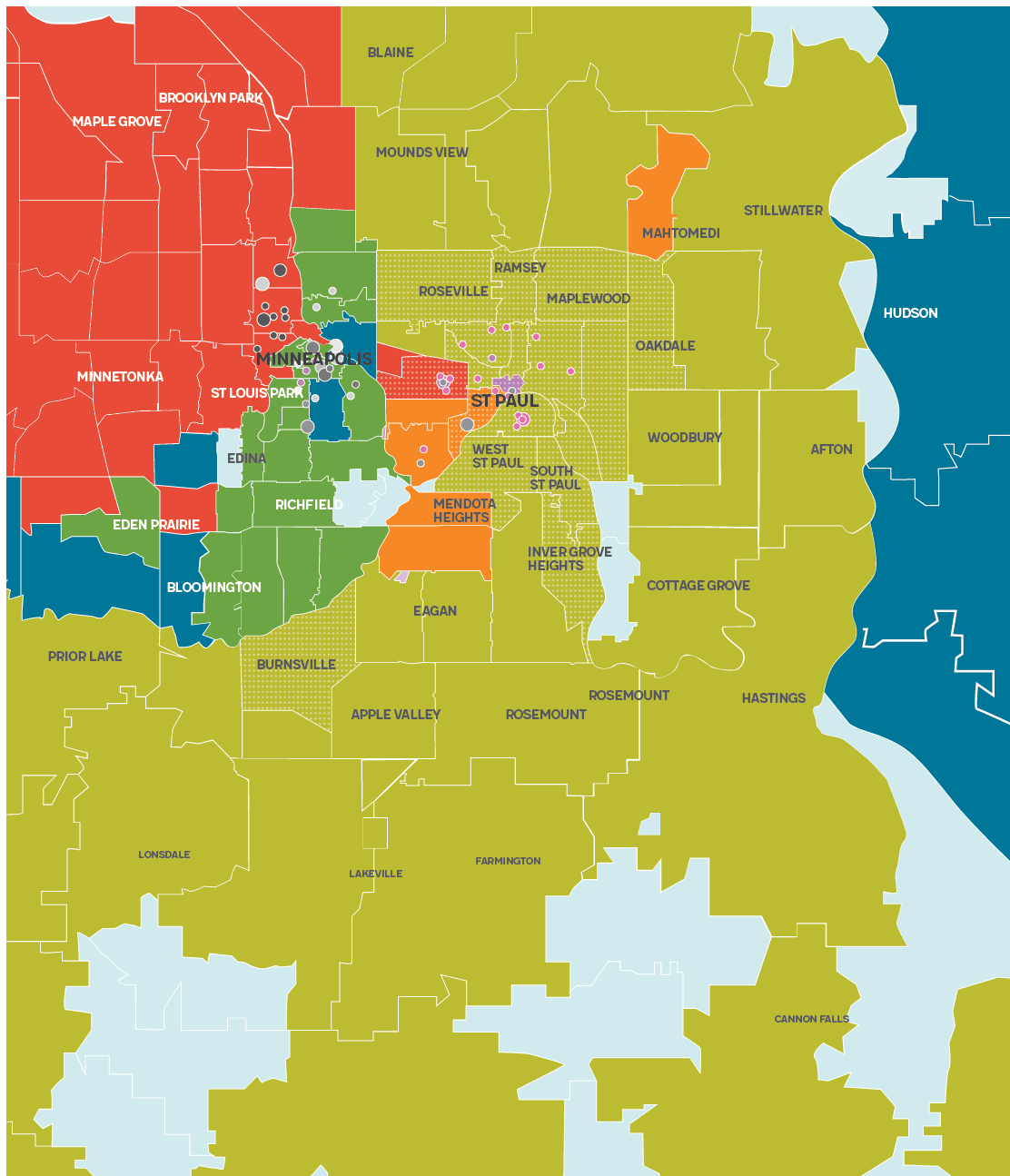
1. Provide patient- and family-centered care that values a patient's personal and cultural definition of health and wellbeing, and a family's contribution to individual health.
2. Develop operational policies and procedures that honor individual and familial cultural values, and that create safe spaces for patients to make decisions that promote health for themselves and their families.
3. Make data-informed operational and clinical decisions so that its care models are effective in reducing health disparities.
4. Understand the impact of integrated health care services, where people can receive support for multiple concerns in one place, and provide a “one-stop shop” for health, that includes physical, mental and dental health care, in order to improve overall patient and community health.

APPENDIX I: MAPS

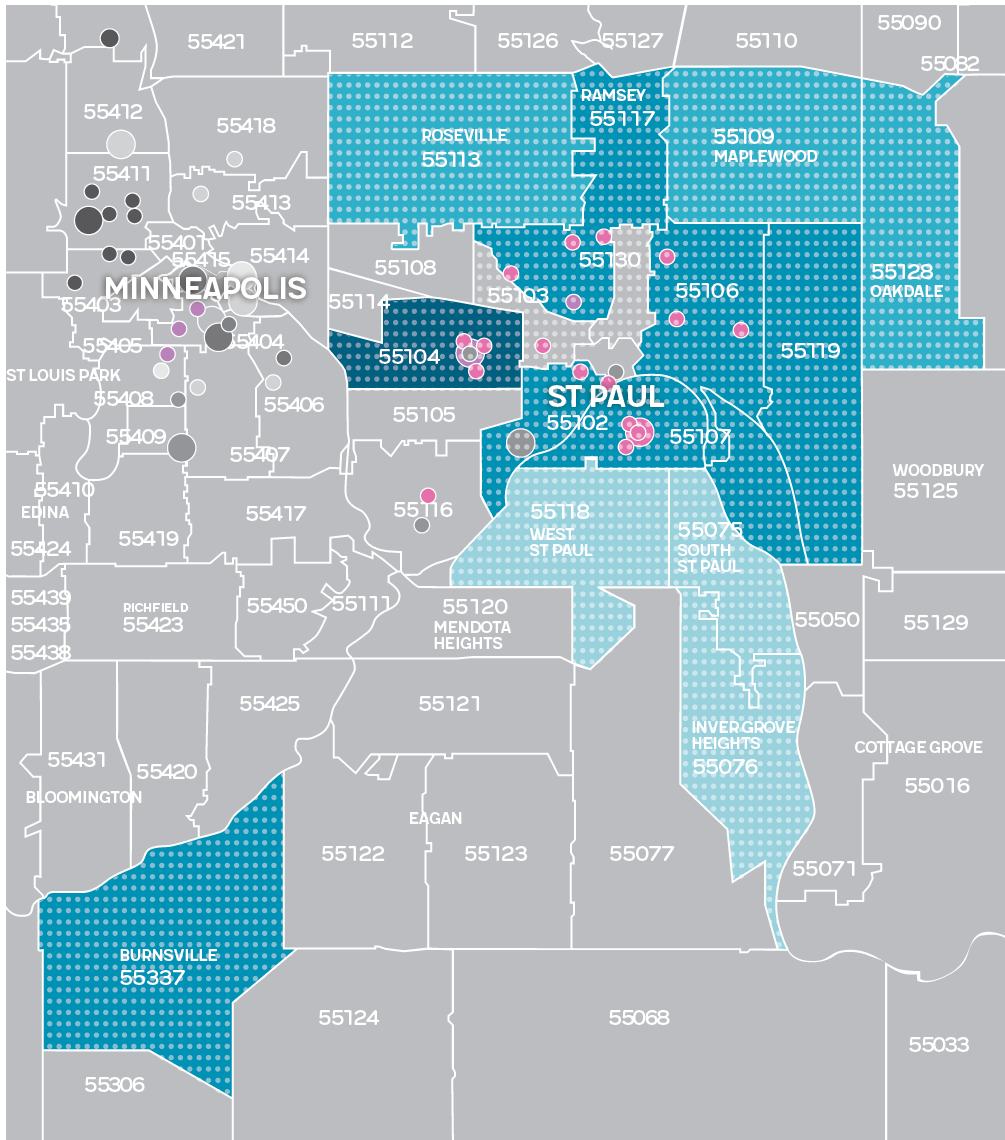
Map A. Service Area



Map B. Dominant Health Center by Zip Code



Map C. Black/African American Population in Service Area

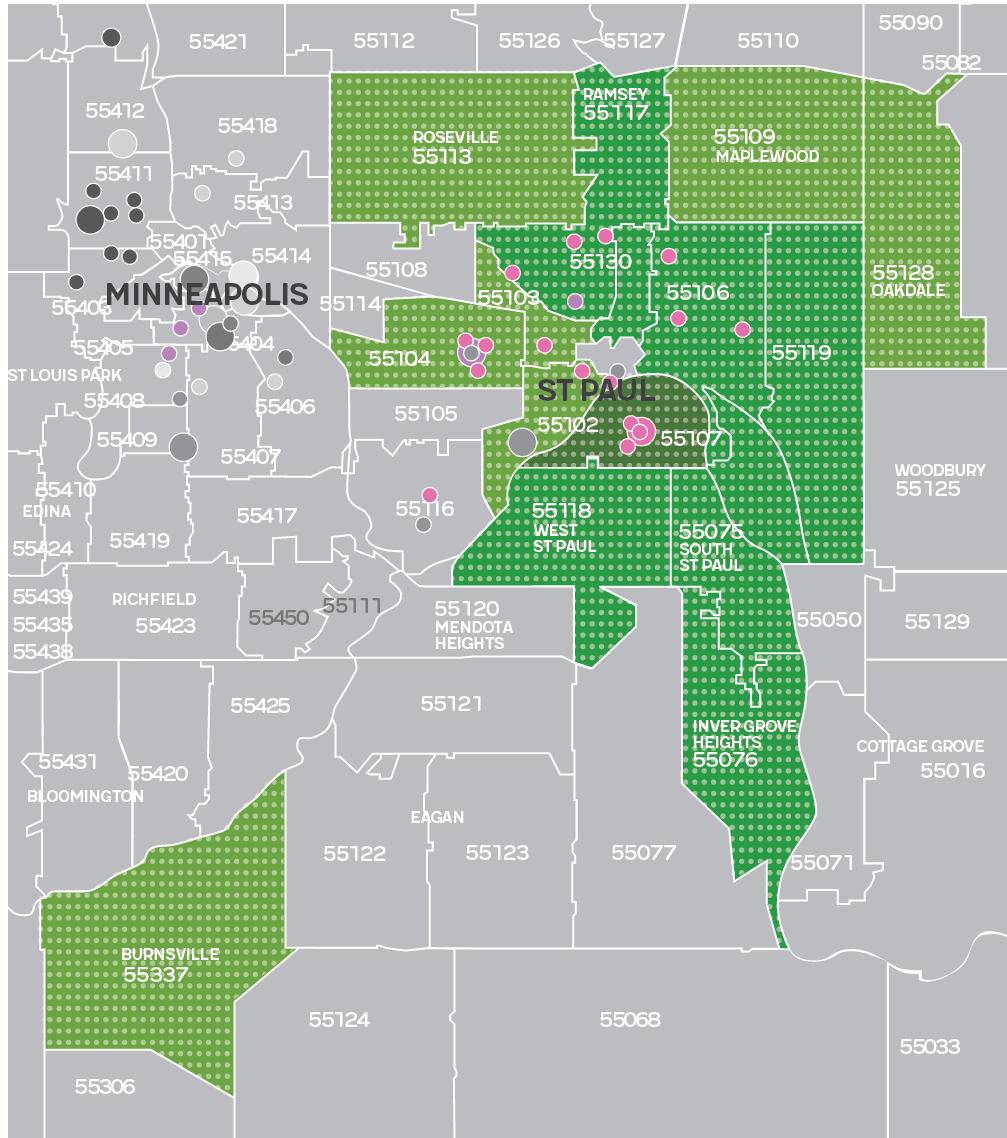


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POP: BLACK [%] 2013-2017



Map D. Latino/a/x Population in Service Area

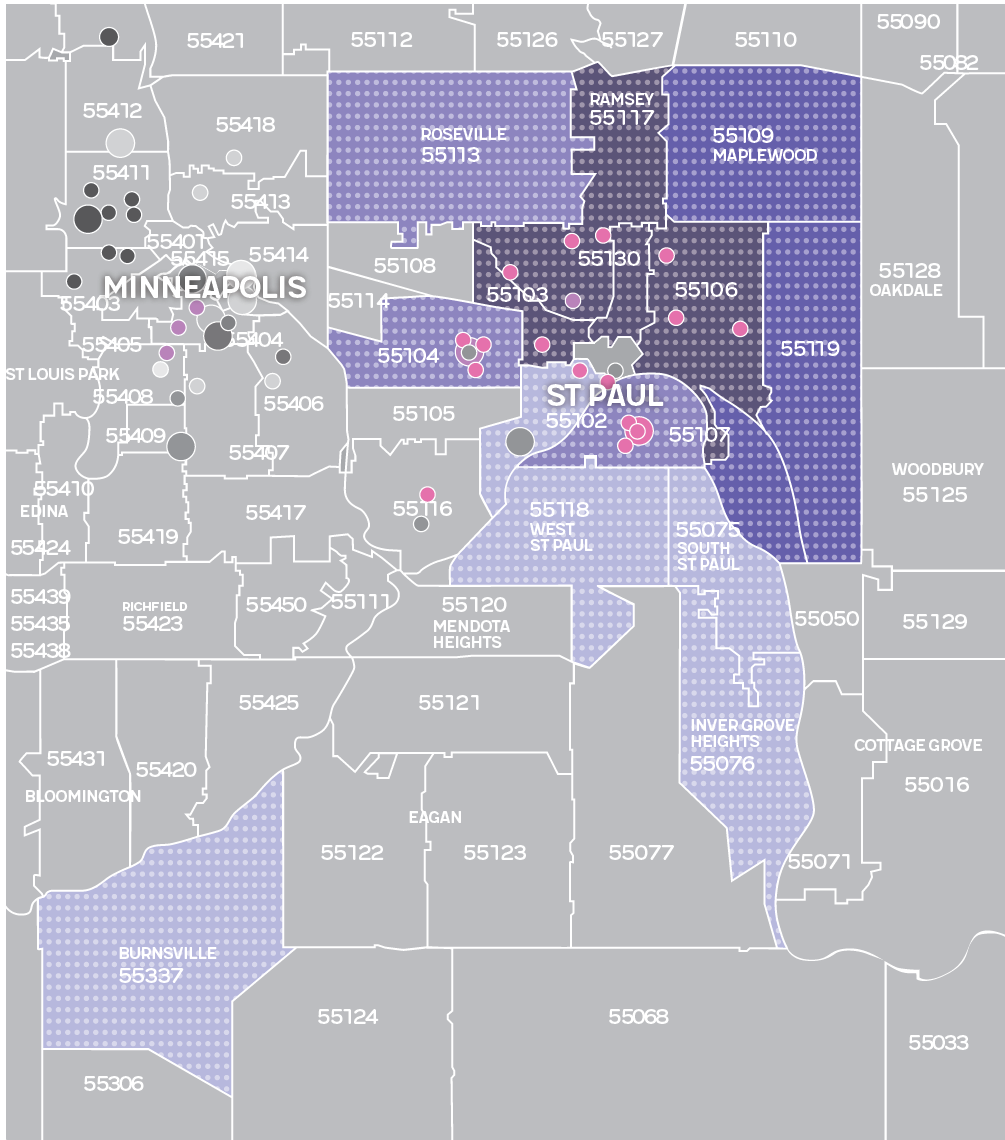


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POP: HISPANIC (%) 2013-2017



Map E. Asian/Asian American Population in Service Area

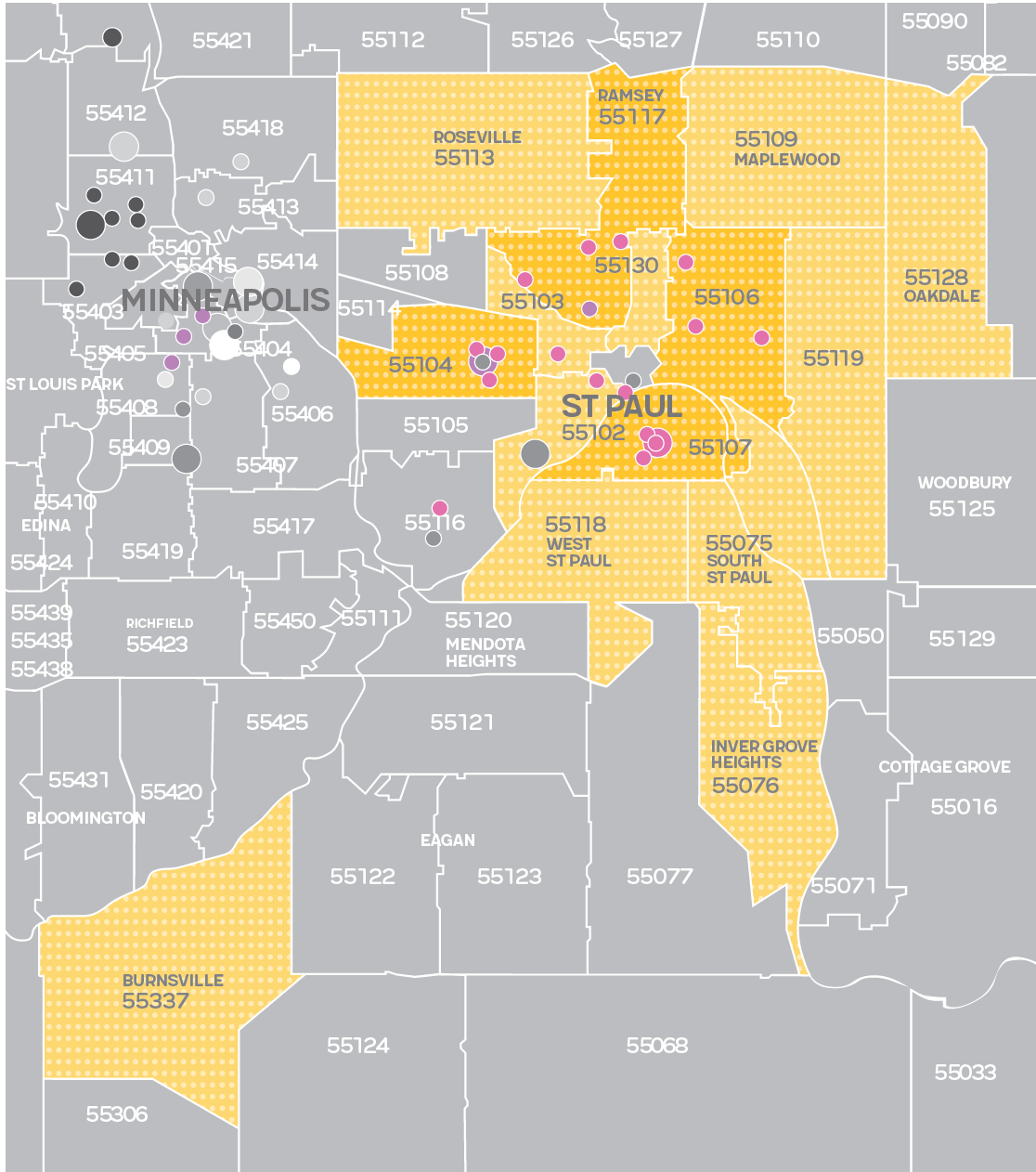


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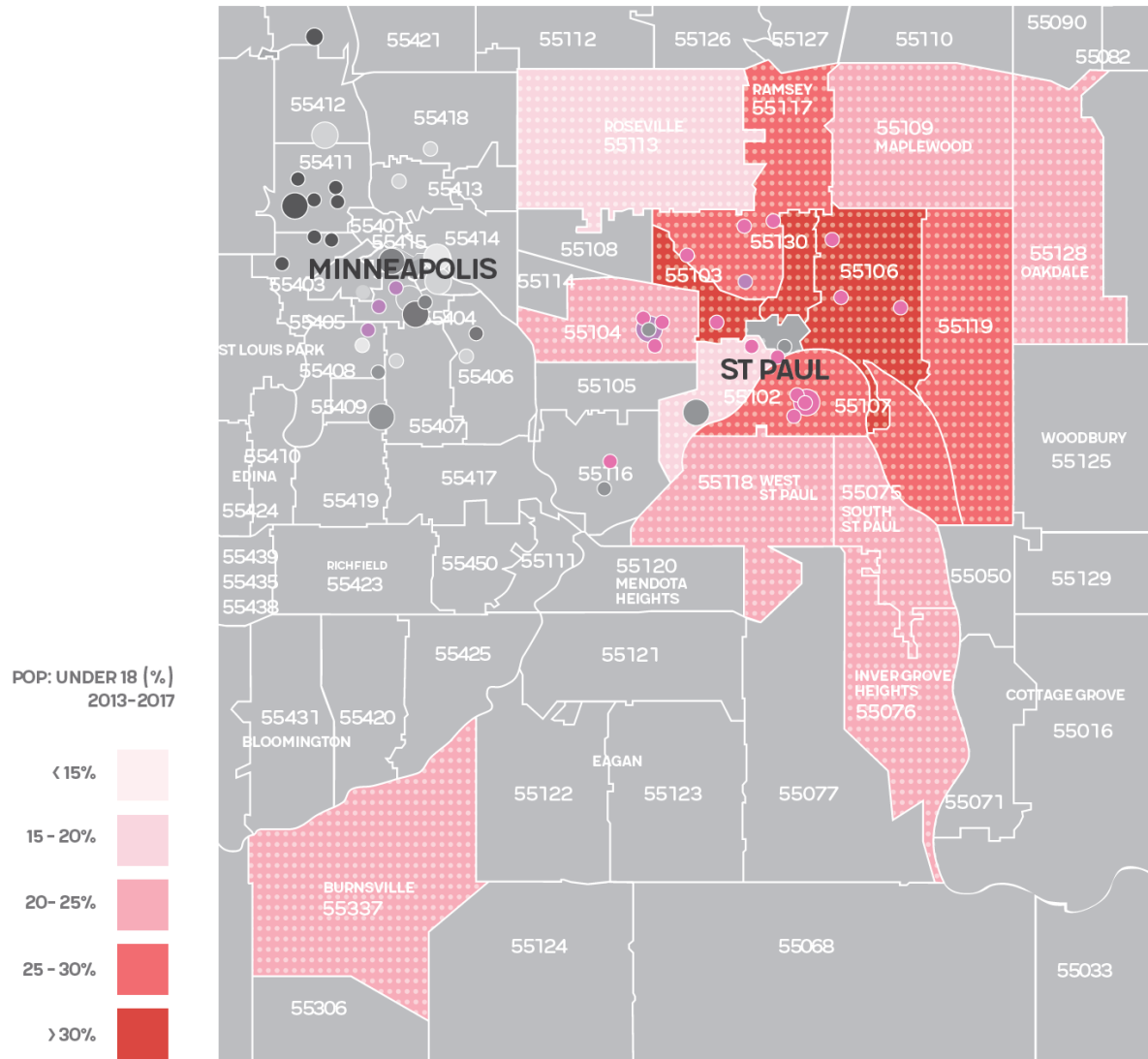
POP: ASIAN (%) 2013-2017



Map F. Native American/American Indian Population in Service Area

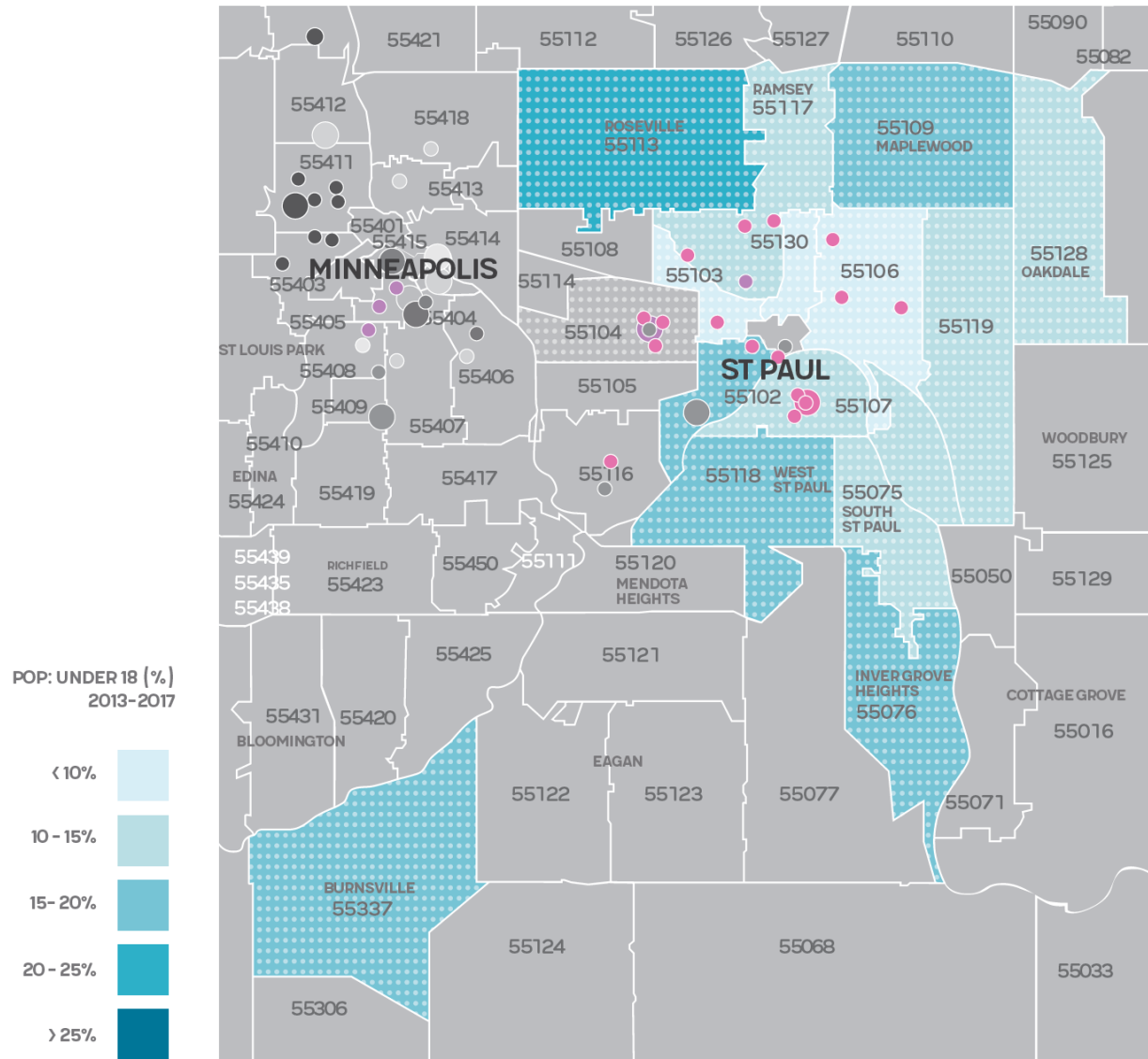


Map G. Population under 18 in Service Area



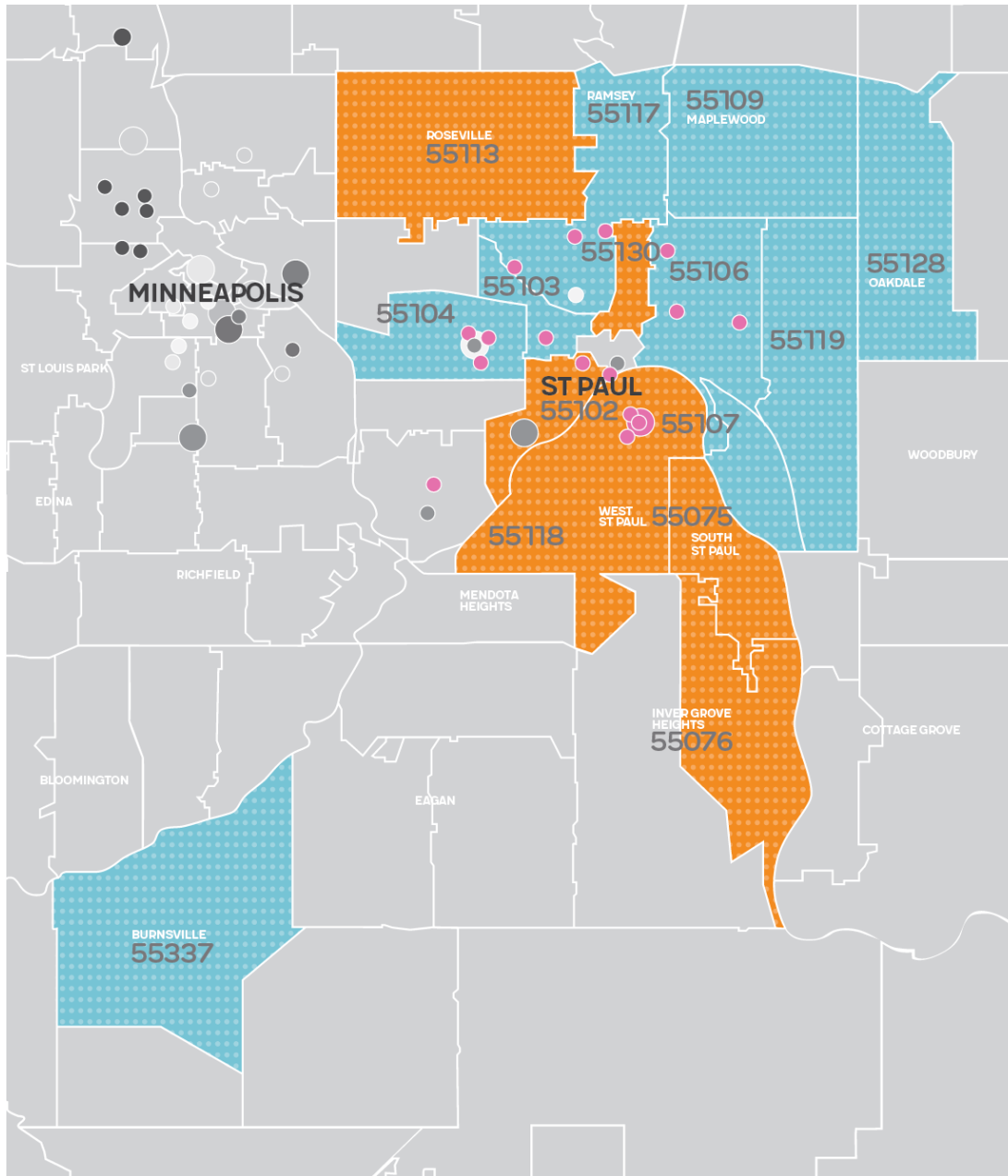
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Map H. Population 65 and Over in Service Area

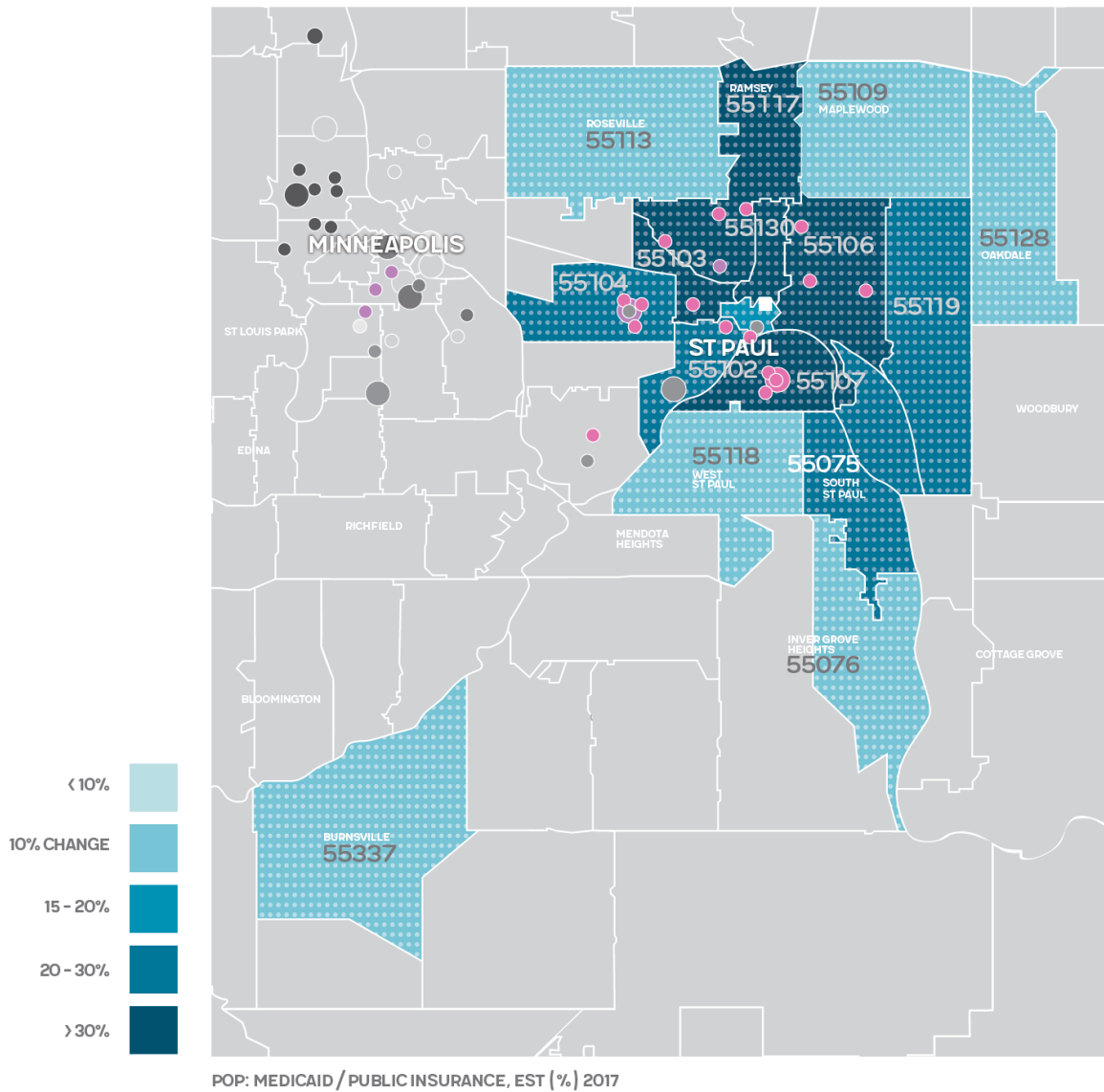


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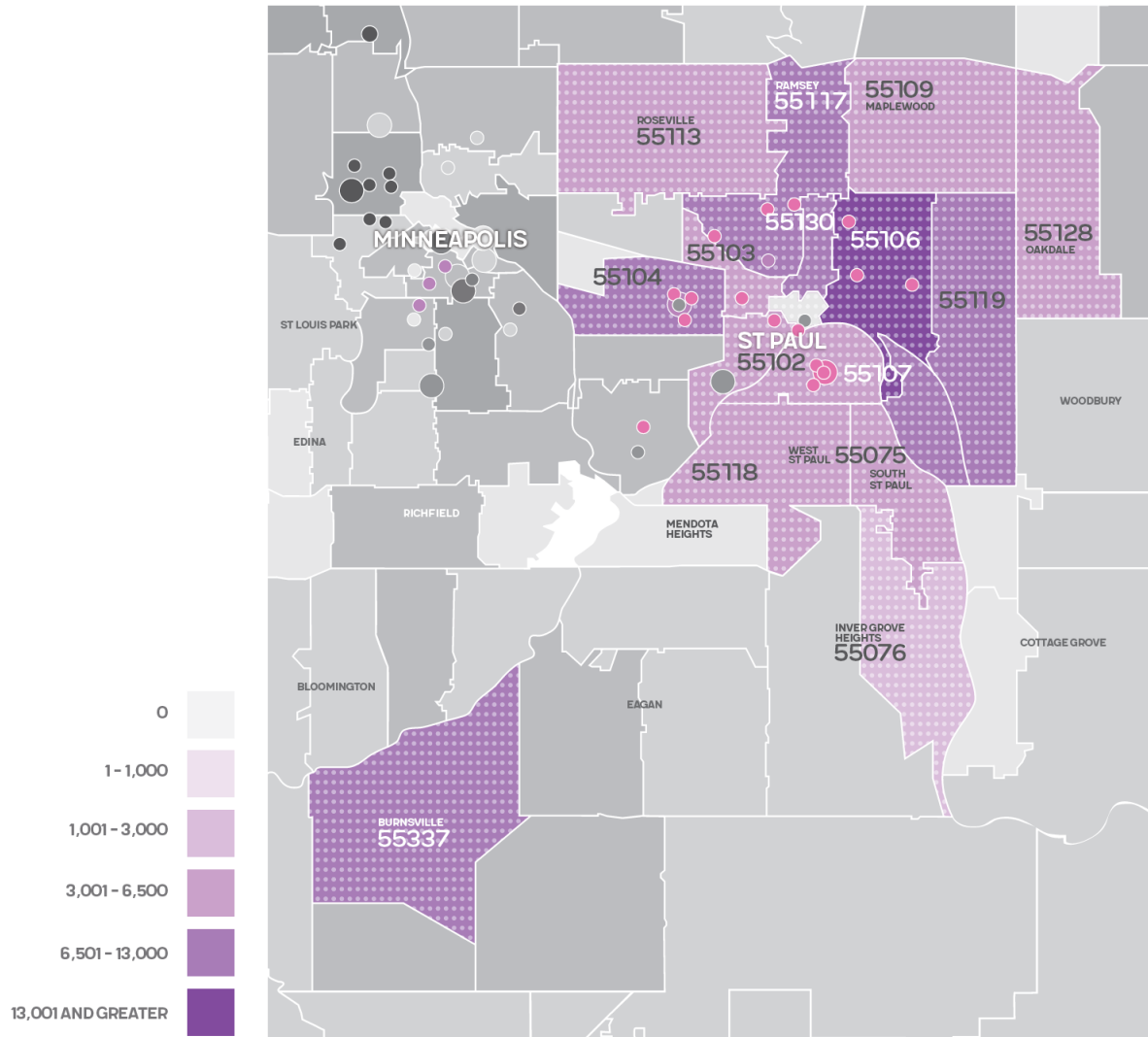
Map J. Increase in Uninsured Patients Seen at Health Centers in Service Area (2015-2017)



Map K. Medicaid Coverage in Service Area

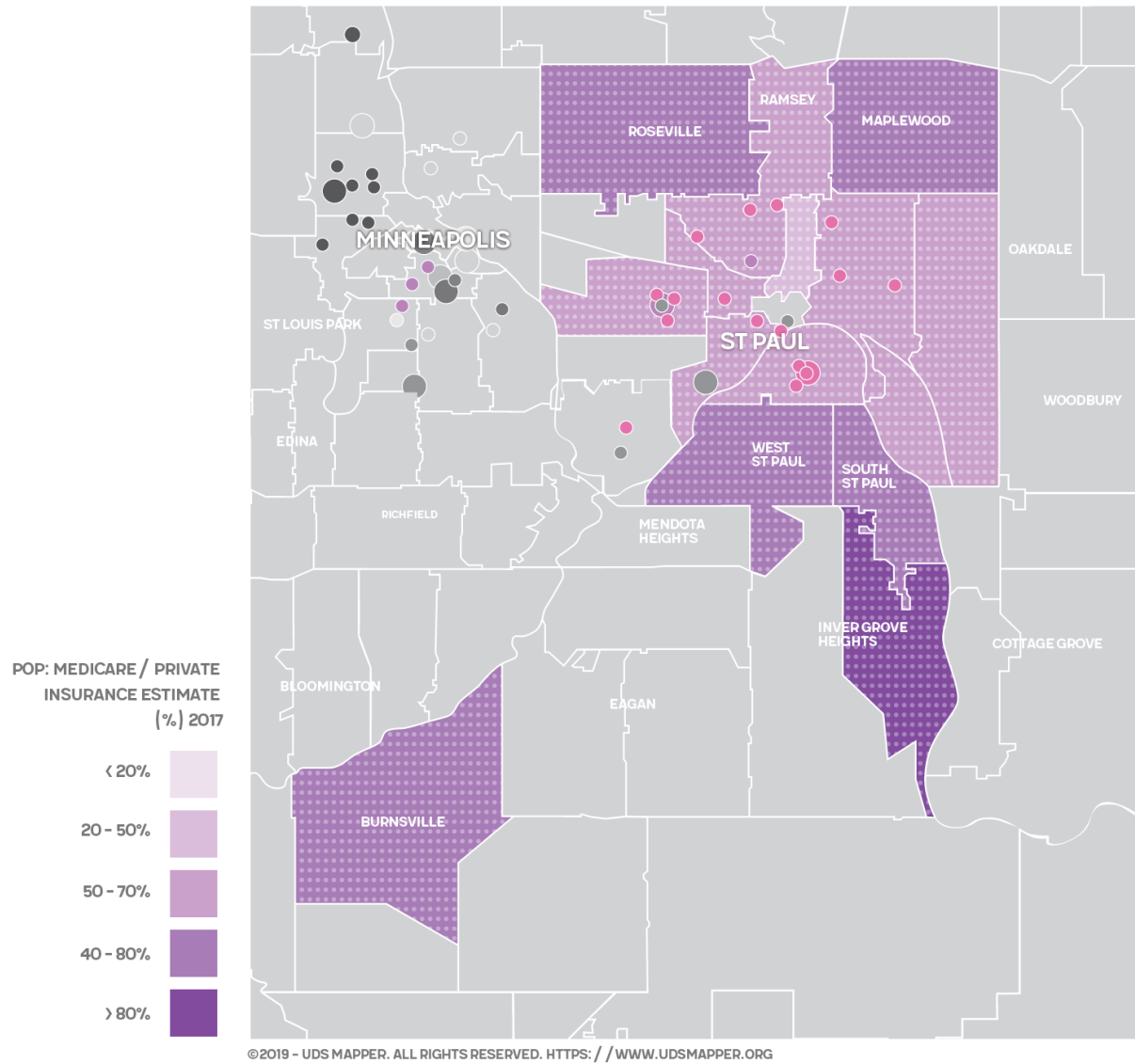


Map L. Medicaid Patients in Service Area Not Served by CHCs



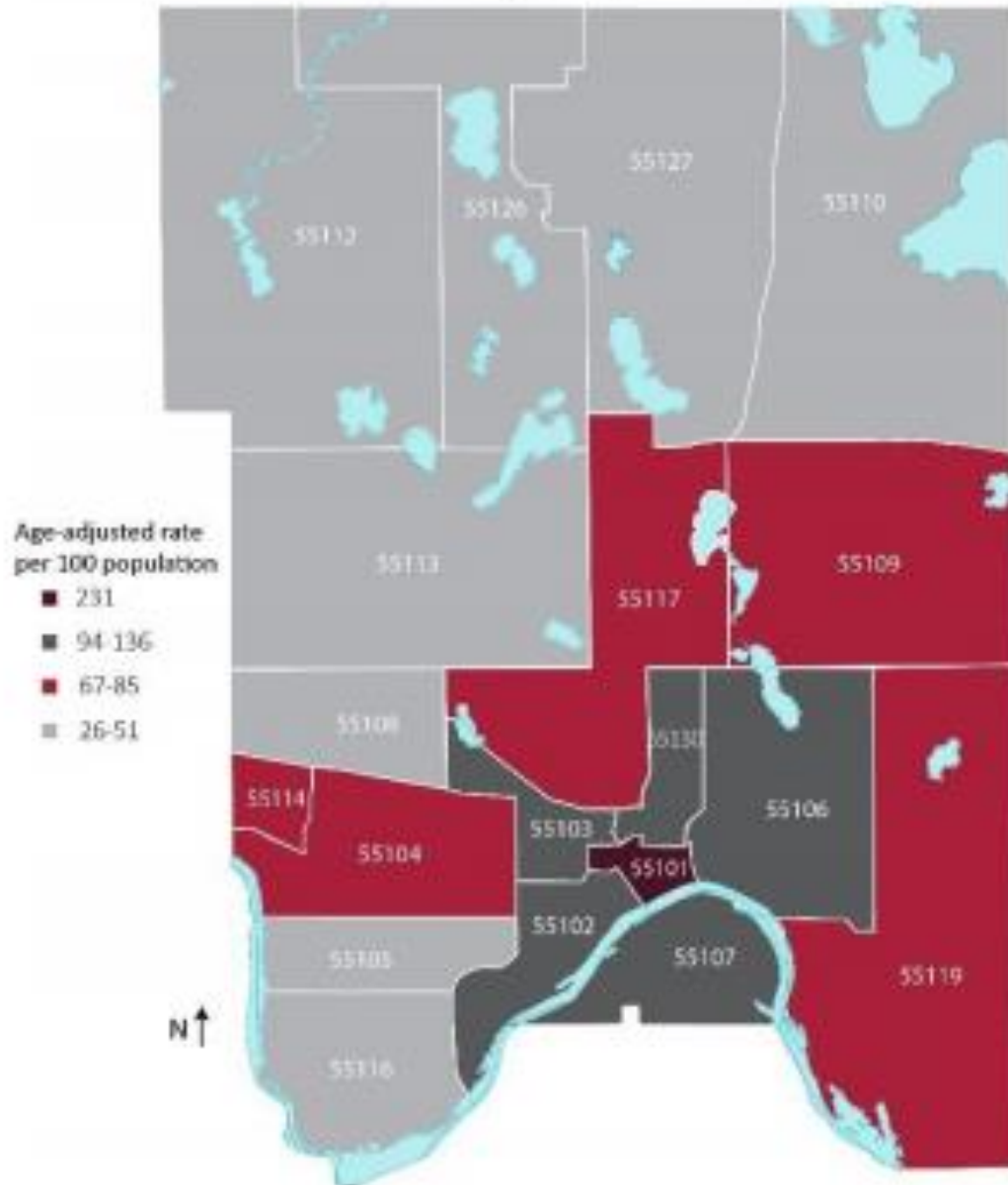
HCP: MEDICAID / PUBLIC INS. NOT SERVED BY HEALTH CENTERS (#) FOR COMBINED

Map M. Medicare / Private Insurance Coverage in Service Area

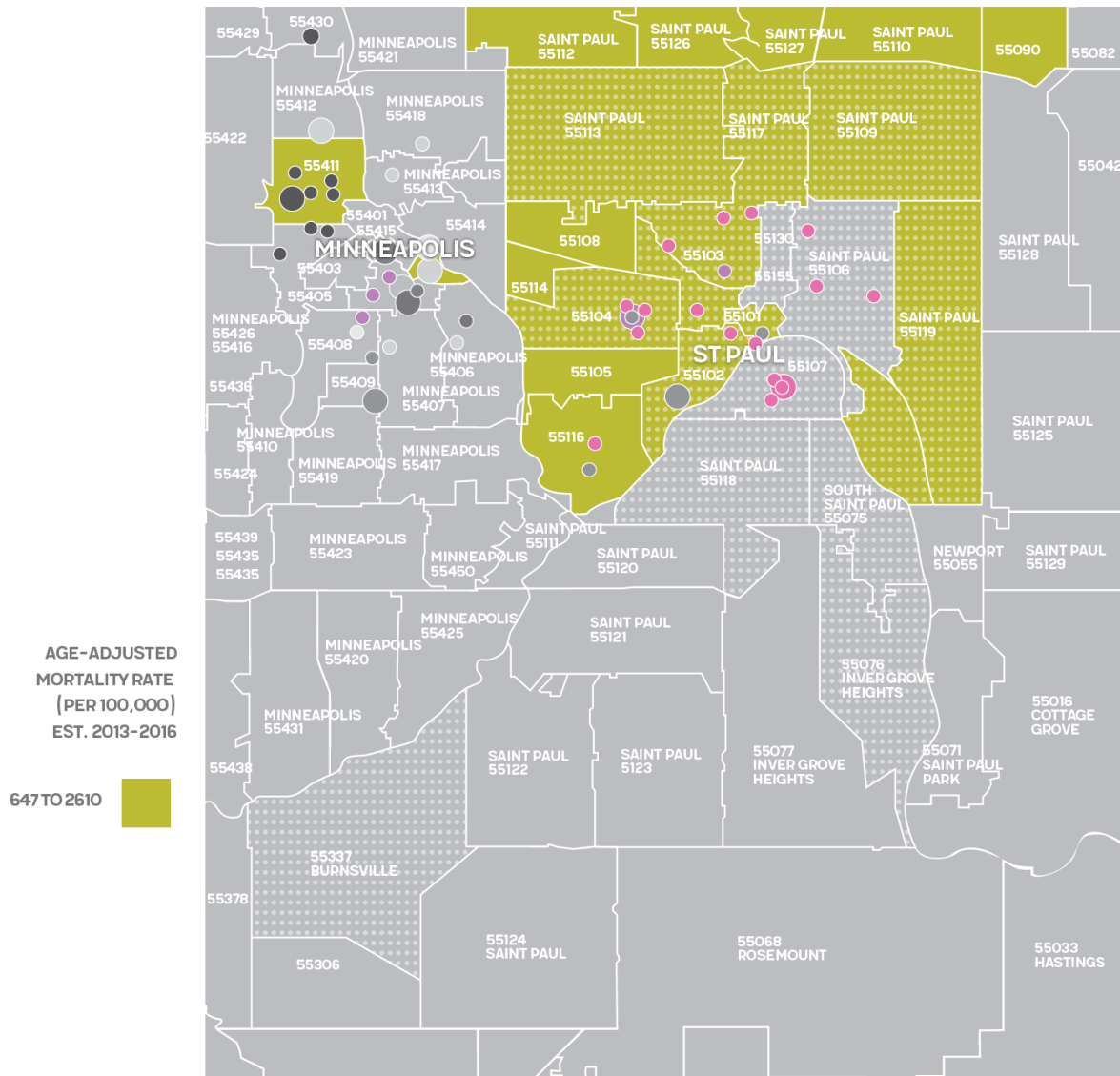


Map N. Rate of Potentially Preventable ED Visits by Zip Code

Rate (per 100 population) of Potentially Preventable ED Visits by Zip Code, Ramsey County, 2010-2014

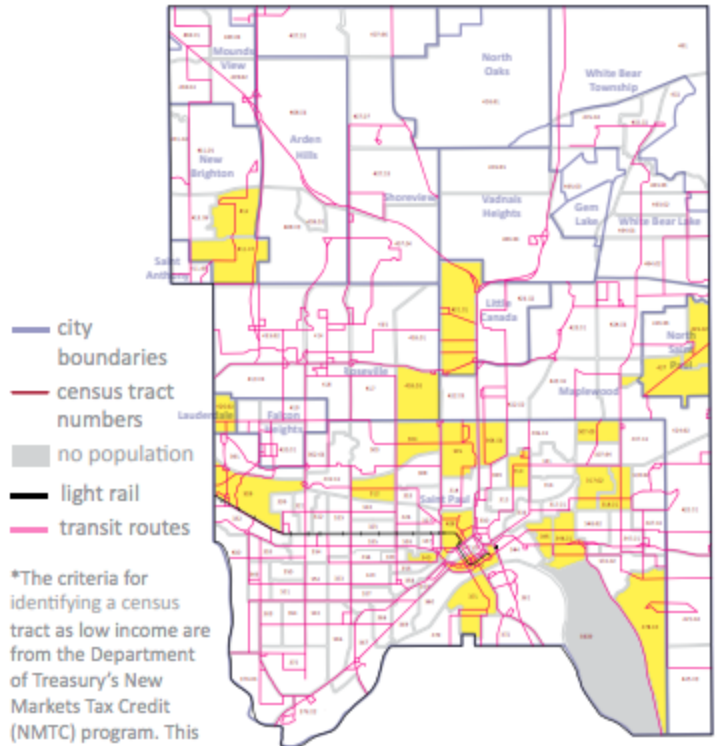


Map O. Age-Adjusted Mortality Rate in Service Area



Map P. Low-Income and Low Vehicle Access, Ramsey County

Low Income* and Low Vehicle Access by City and Census Tract, Ramsey County, 2015



*The criteria for identifying a census tract as low income are from the Department of Treasury's New Markets Tax Credit (NMTC) program. This program defines a

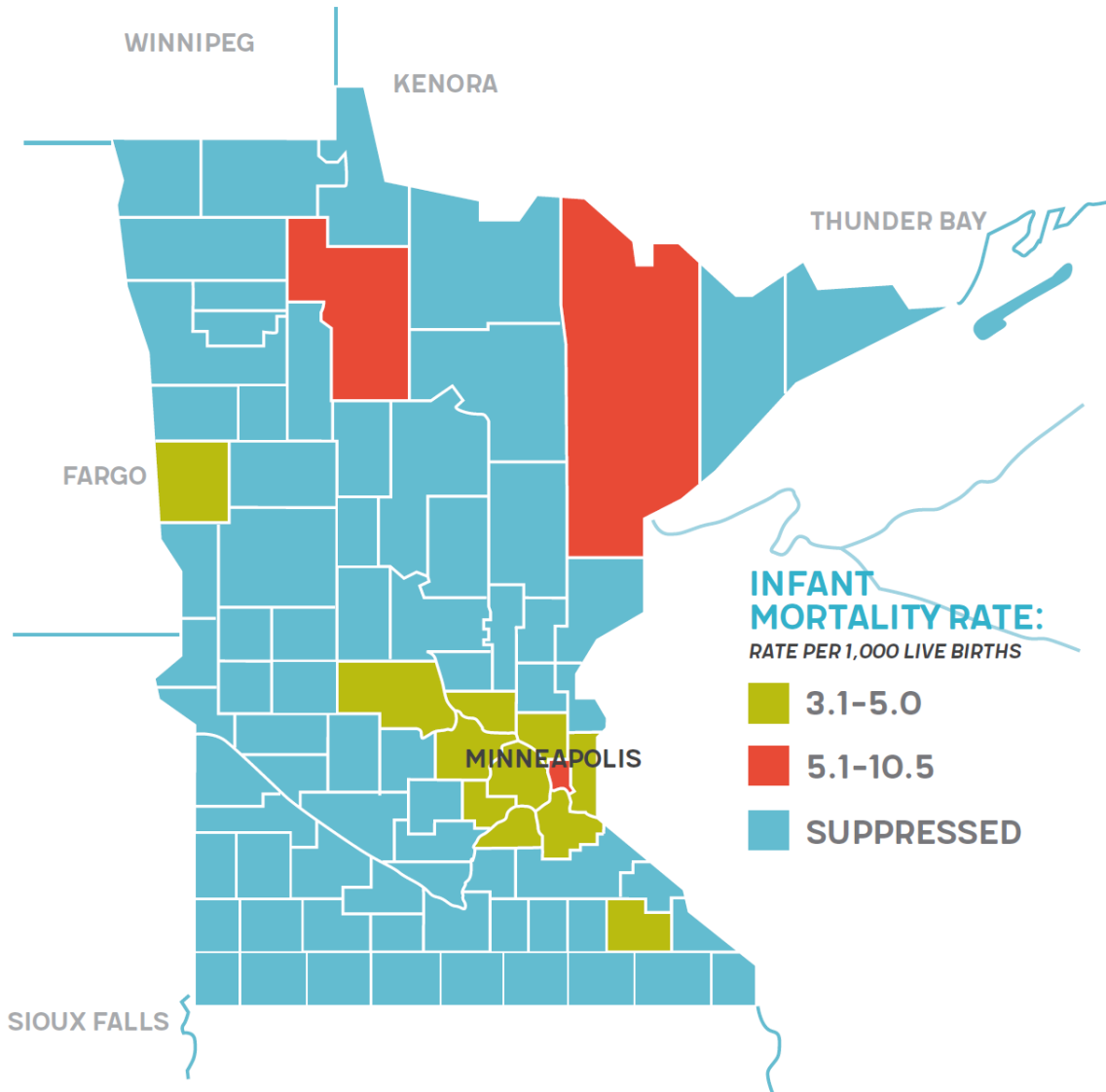
low-income census tract as any tract where:

- The tract's poverty rate is 20 percent or greater; or
- The tract's median family income is less than or equal to 80 percent of the State-wide median family income; or
- The tract is in a metropolitan area and has a median family income less than or equal to 80 percent of the metropolitan area's median family income.

Vehicle availability is defined in the American Community Survey as the number of passenger cars, vans, or trucks with a capacity of 1-ton or less kept at the home and available for use by household members.

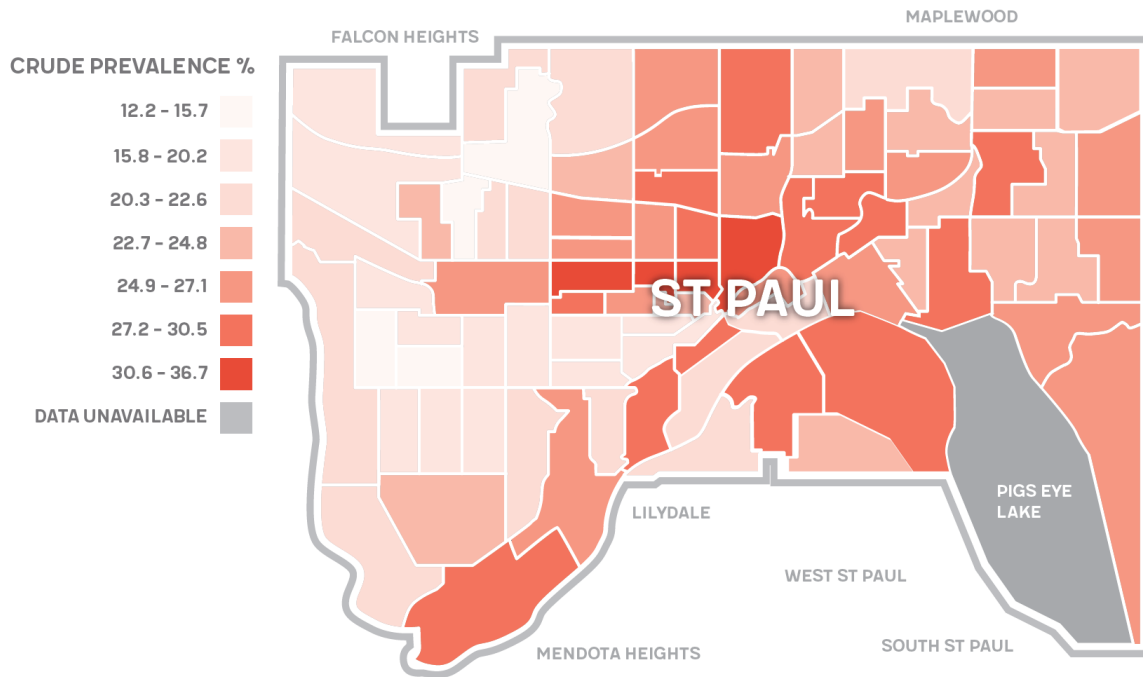
Source: USDA Food Environment Atlas. ⁸

Map Q. Infant Mortality Rates in Minnesota

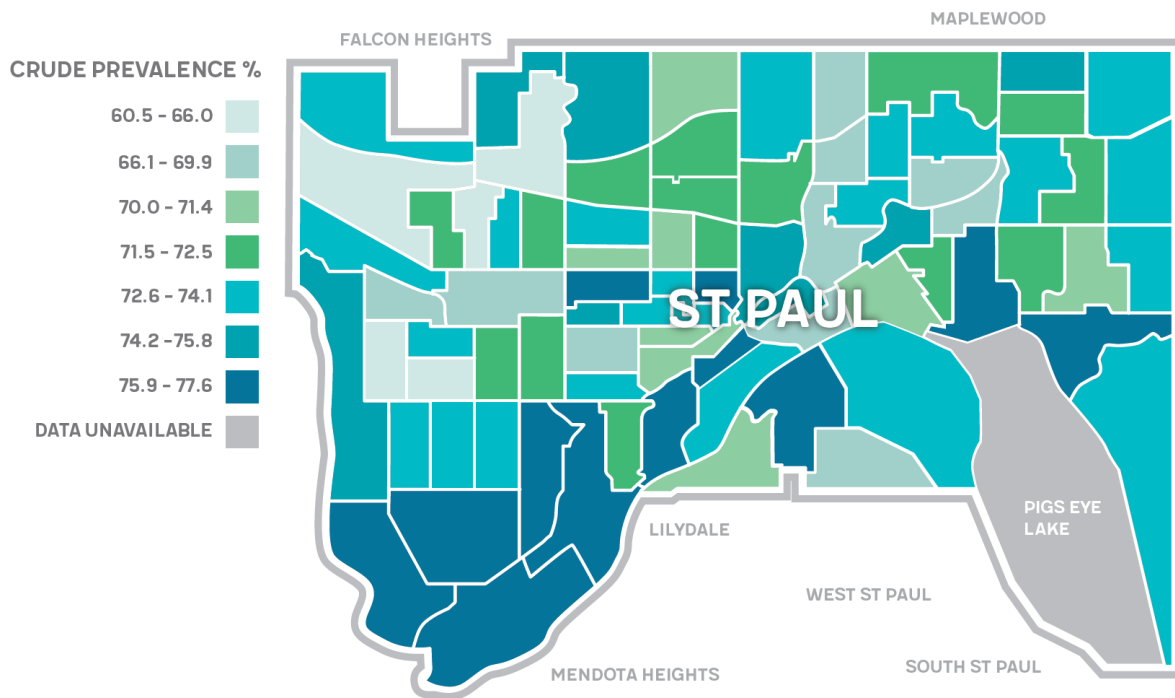


SOURCE: MINNESOTA PUBLIC HEALTH DATA ACCESS PORTAL
MINNESOTA DEPARTMENT OF HEALTH, 2016

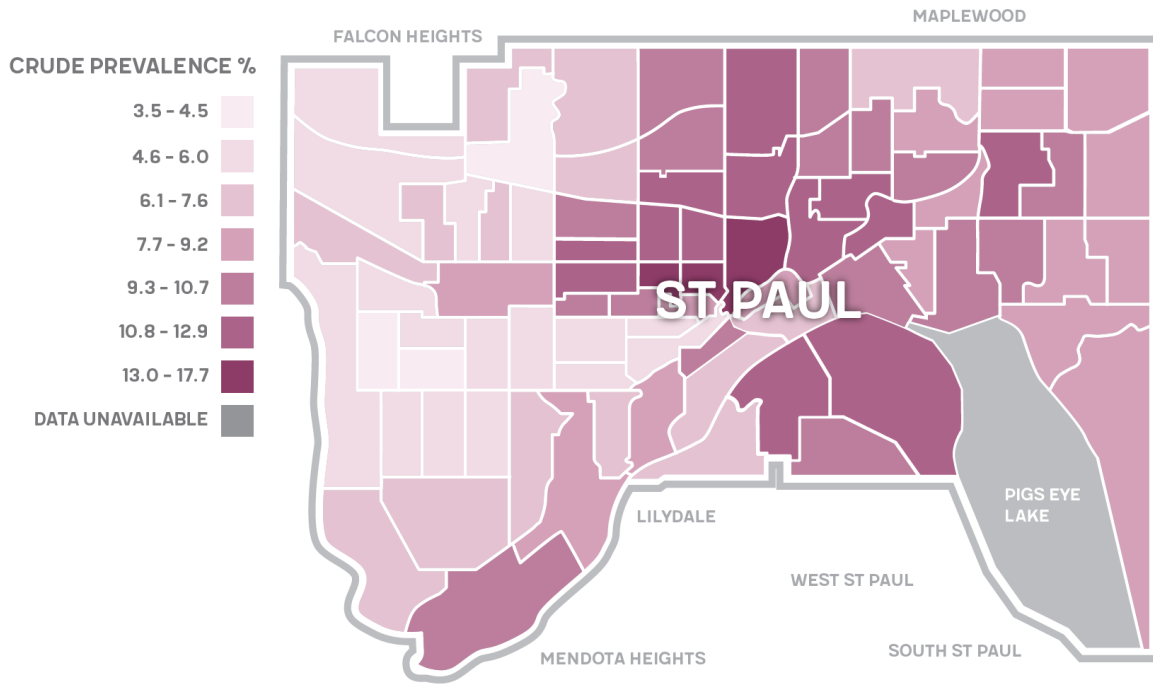
Map R. Prevalence of High Blood Pressure in St. Paul



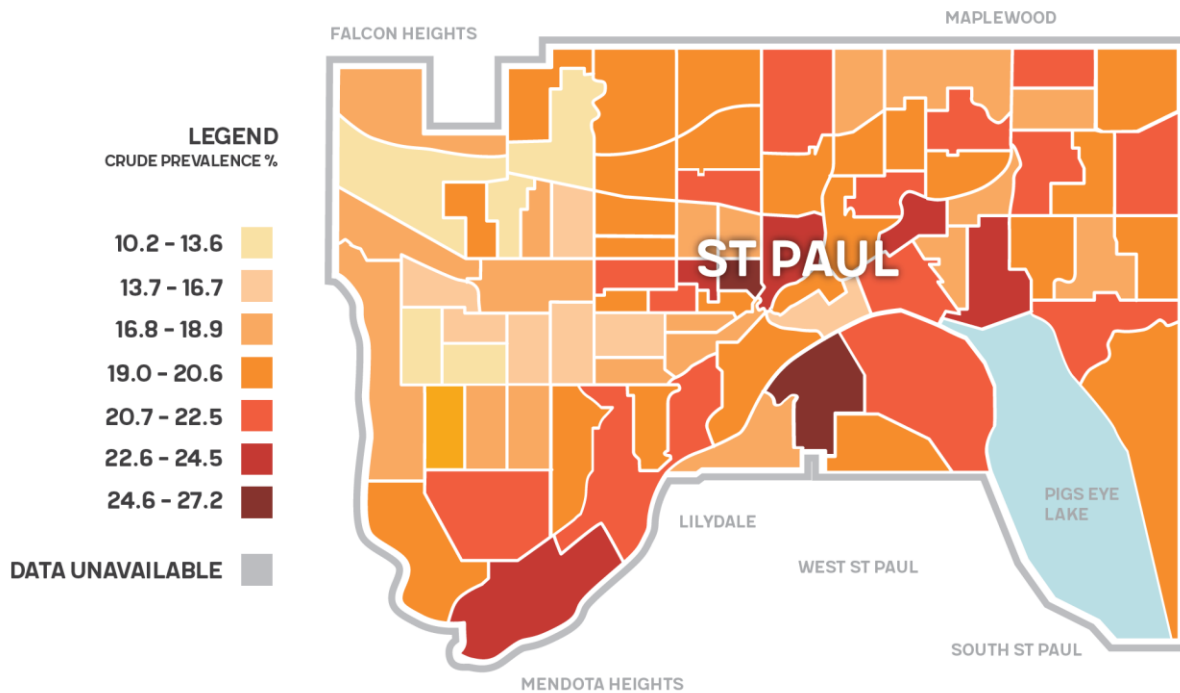
Map S. Medication Adherence among Those with Elevated BP



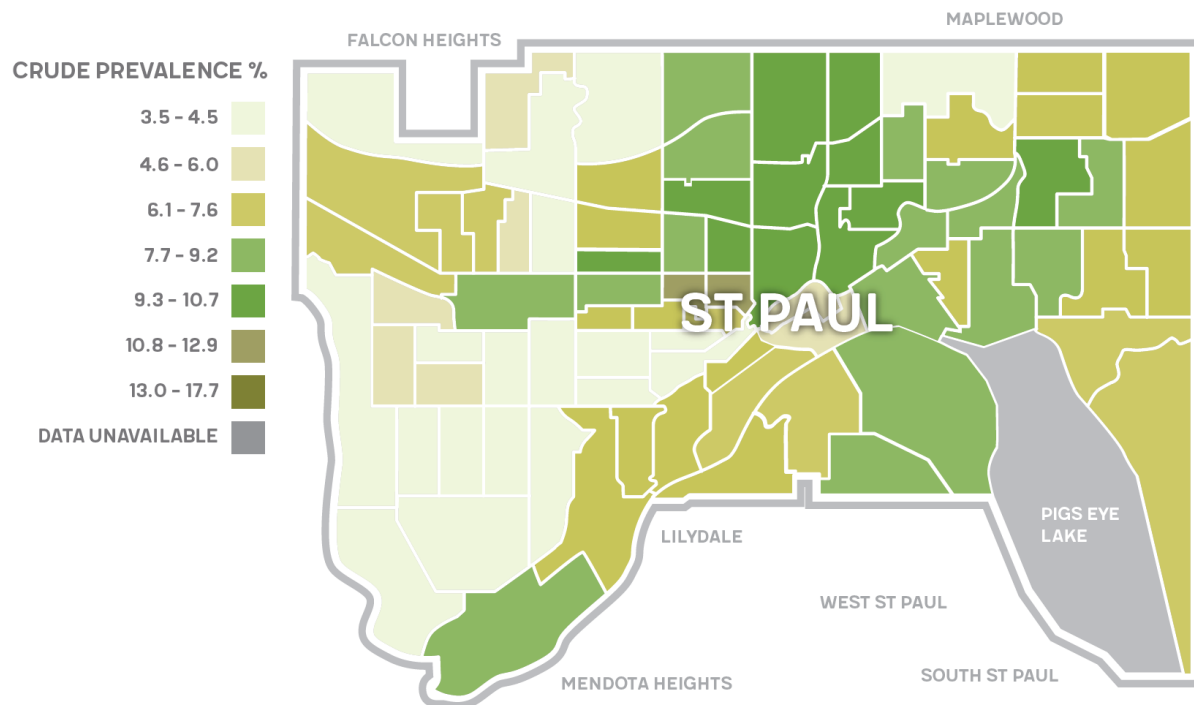
Map T. Prevalence of Diabetes in St. Paul



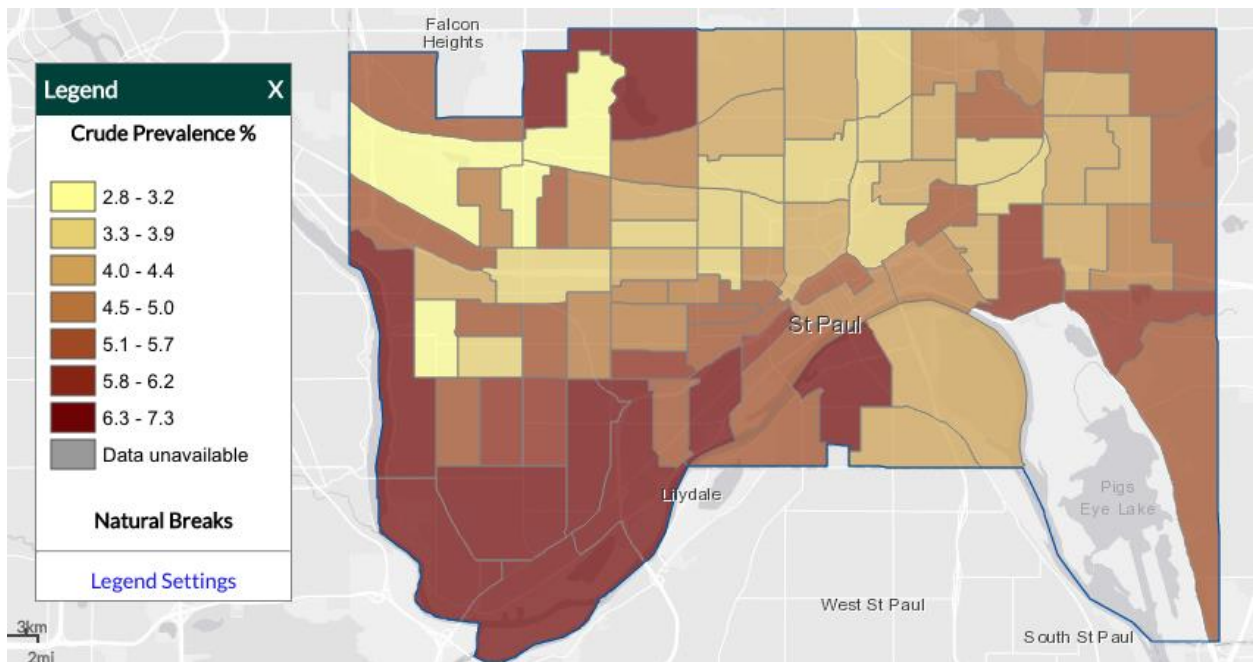
Map U. Prevalence of Arthritis in St. Paul



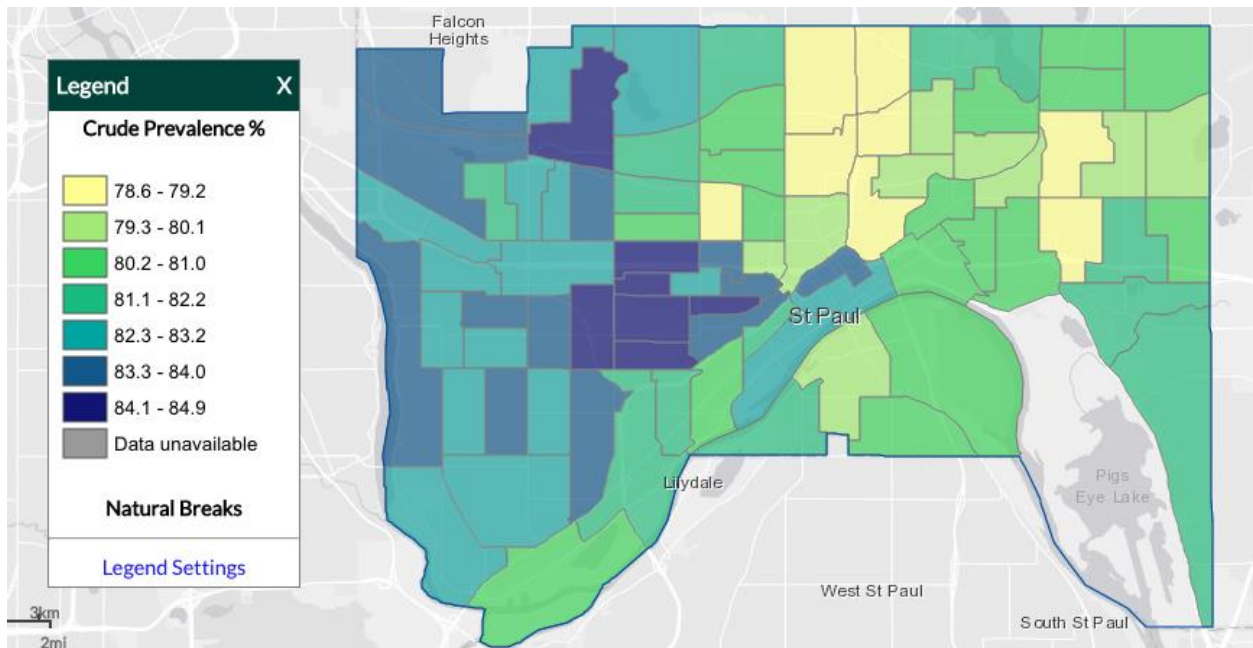
Map V. Prevalence of Complete Tooth Loss in Adults over Age 65 in St. Paul



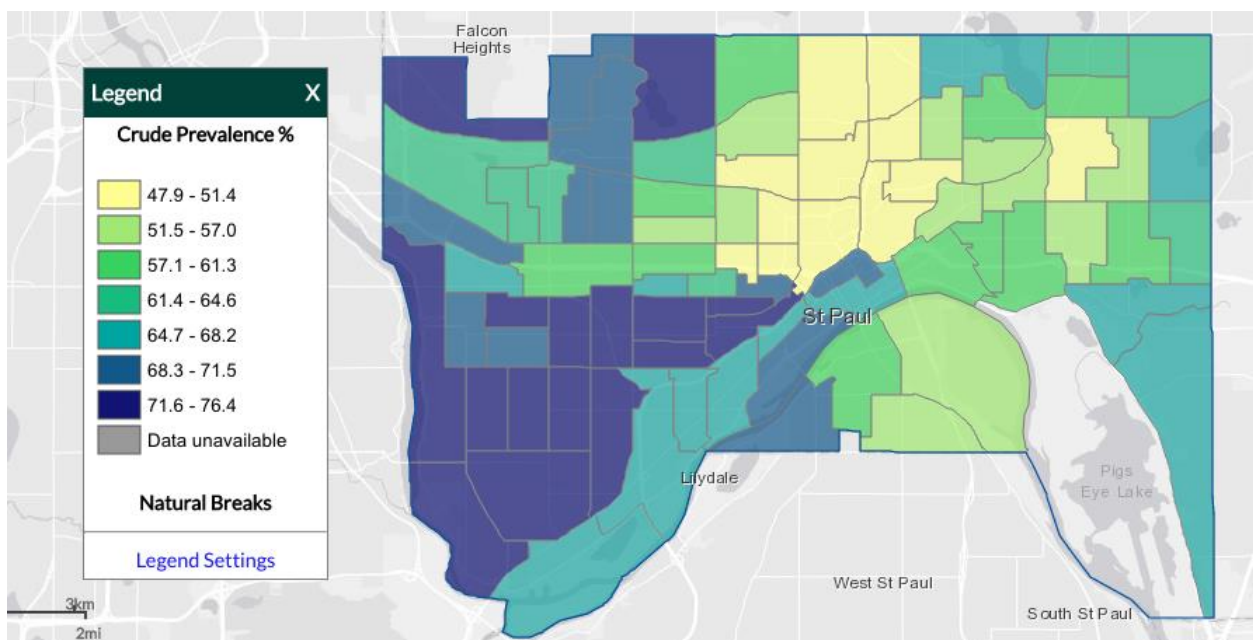
Map W. Prevalence of Cancer (excluding skin cancer) in St. Paul



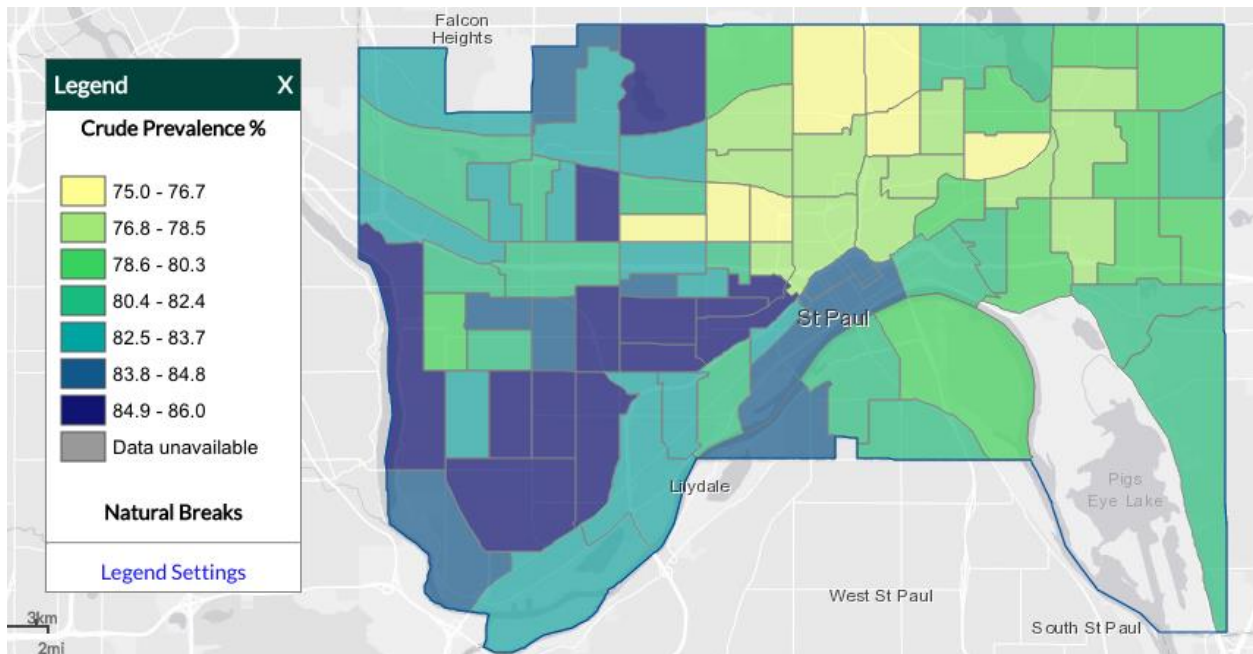
Map X. Breast Cancer Screening Prevalence in St. Paul, 2016



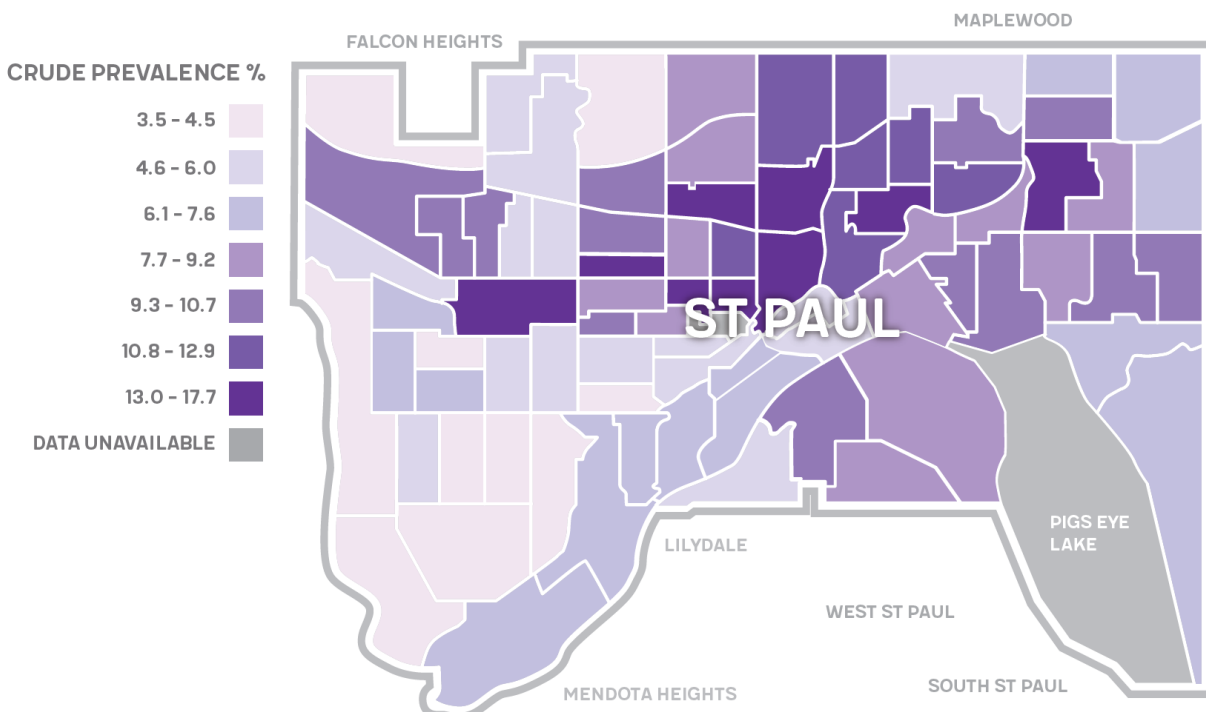
Map Y. Colorectal Cancer Screening Prevalence in St. Paul, 2016



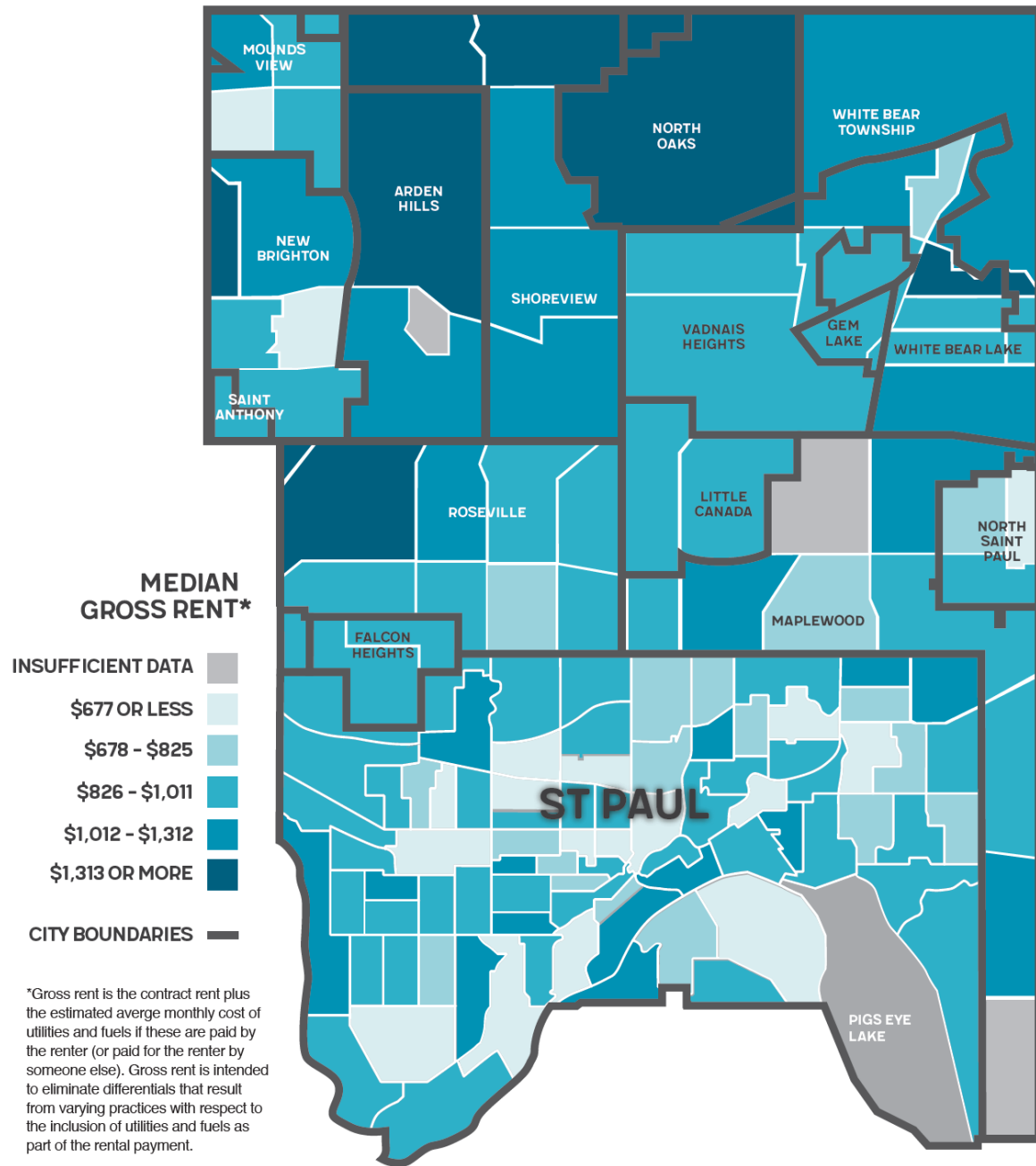
Map Z. Cervical Cancer Screening Prevalence in St. Paul, 2016



Map AA. Prevalence of St. Paul Adults over 18 Years with >14 Days per Month of “Not Good” Mental Health

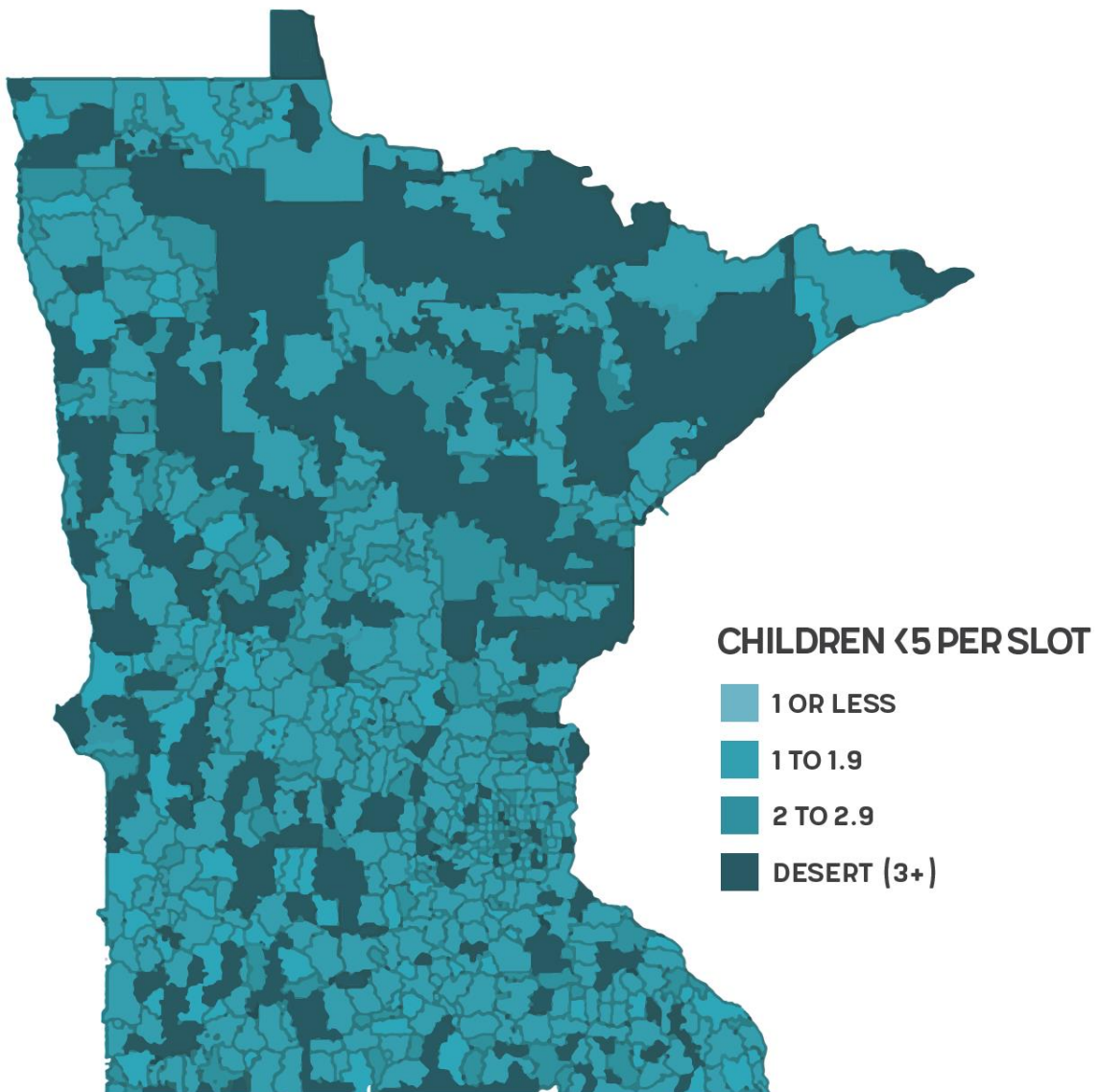


Map BB. Estimated Rent for Rental Units, Ramsey County, 2016.

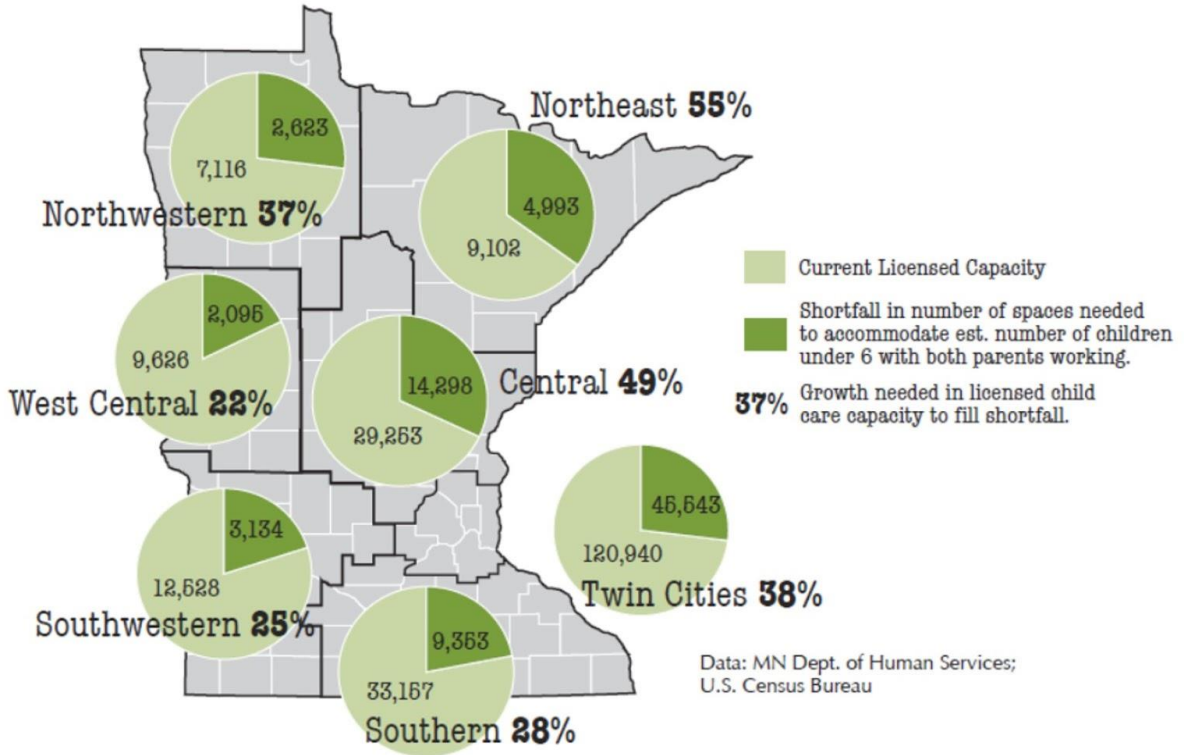


SOURCE: POLICYMAP. BASED ON U.S. CENSUS AMERICAN COMMUNITY SURVEY 2012-2016.

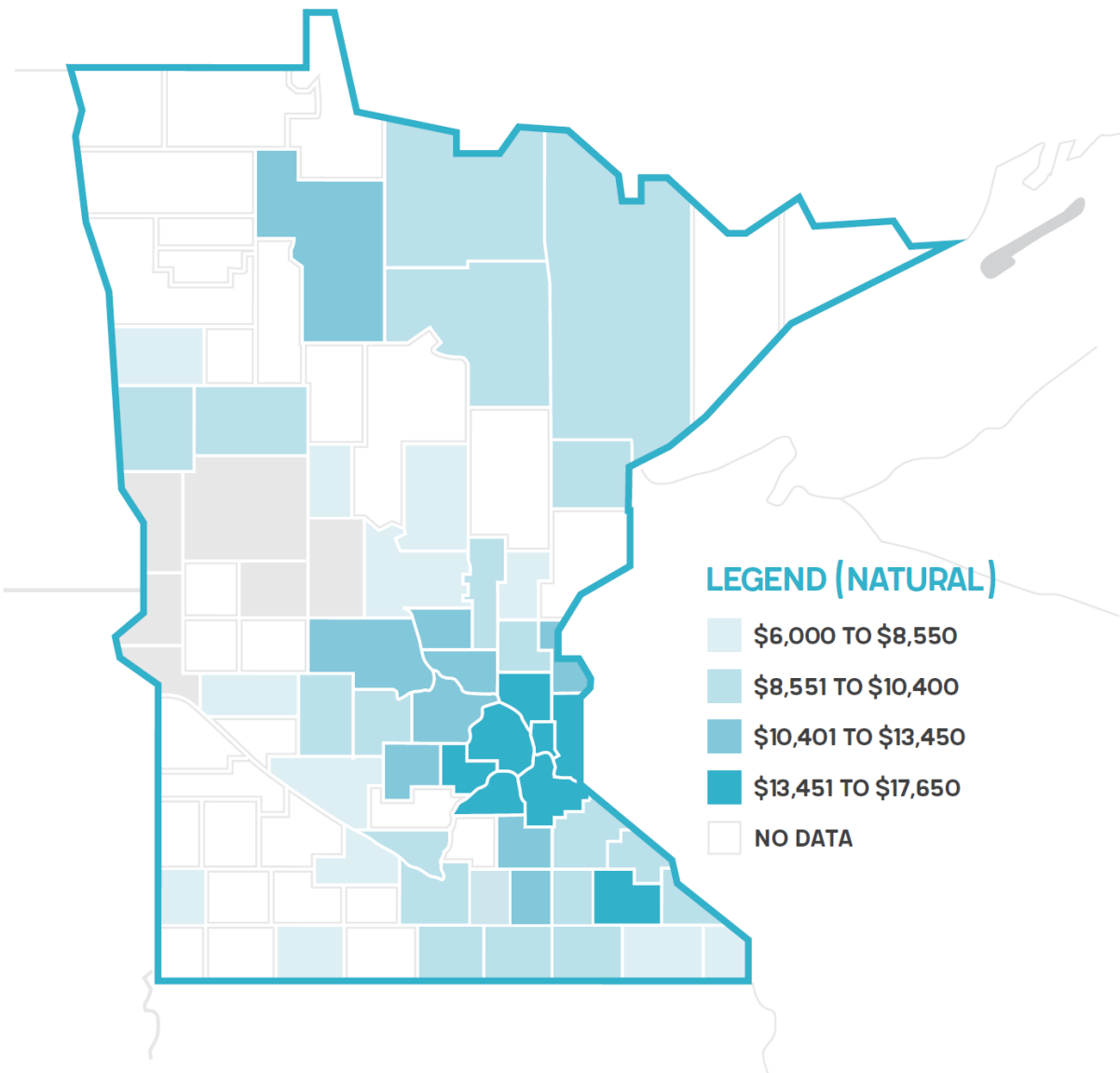
Map CC. Number of Children (birth-5) per Available Licensed Childcare Slot, by Zip Code



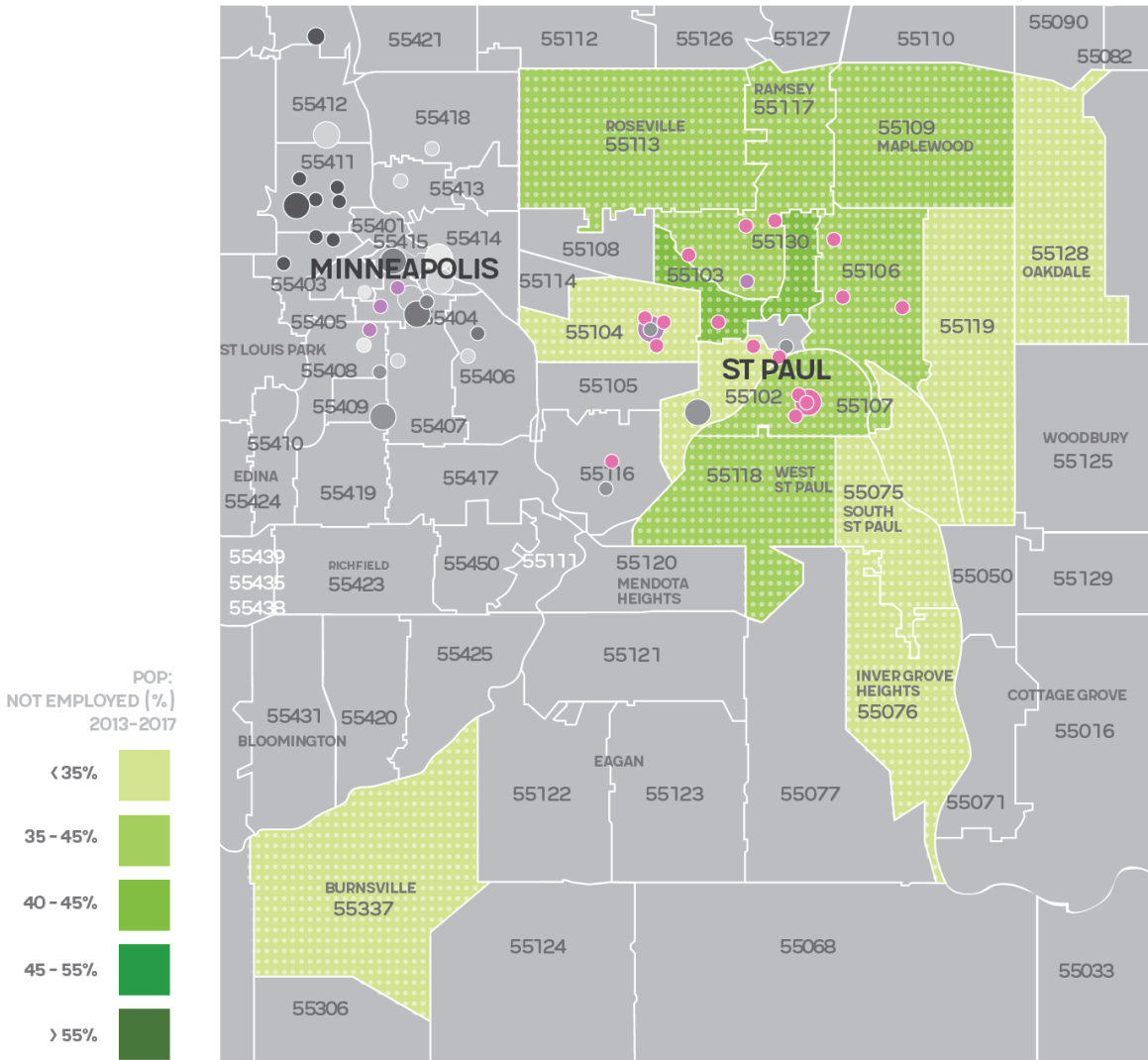
Map DD. Child Care Shortages across Minnesota, 2016.



Map EE. Annual Cost for Licensed Center-Based Childcare in MN

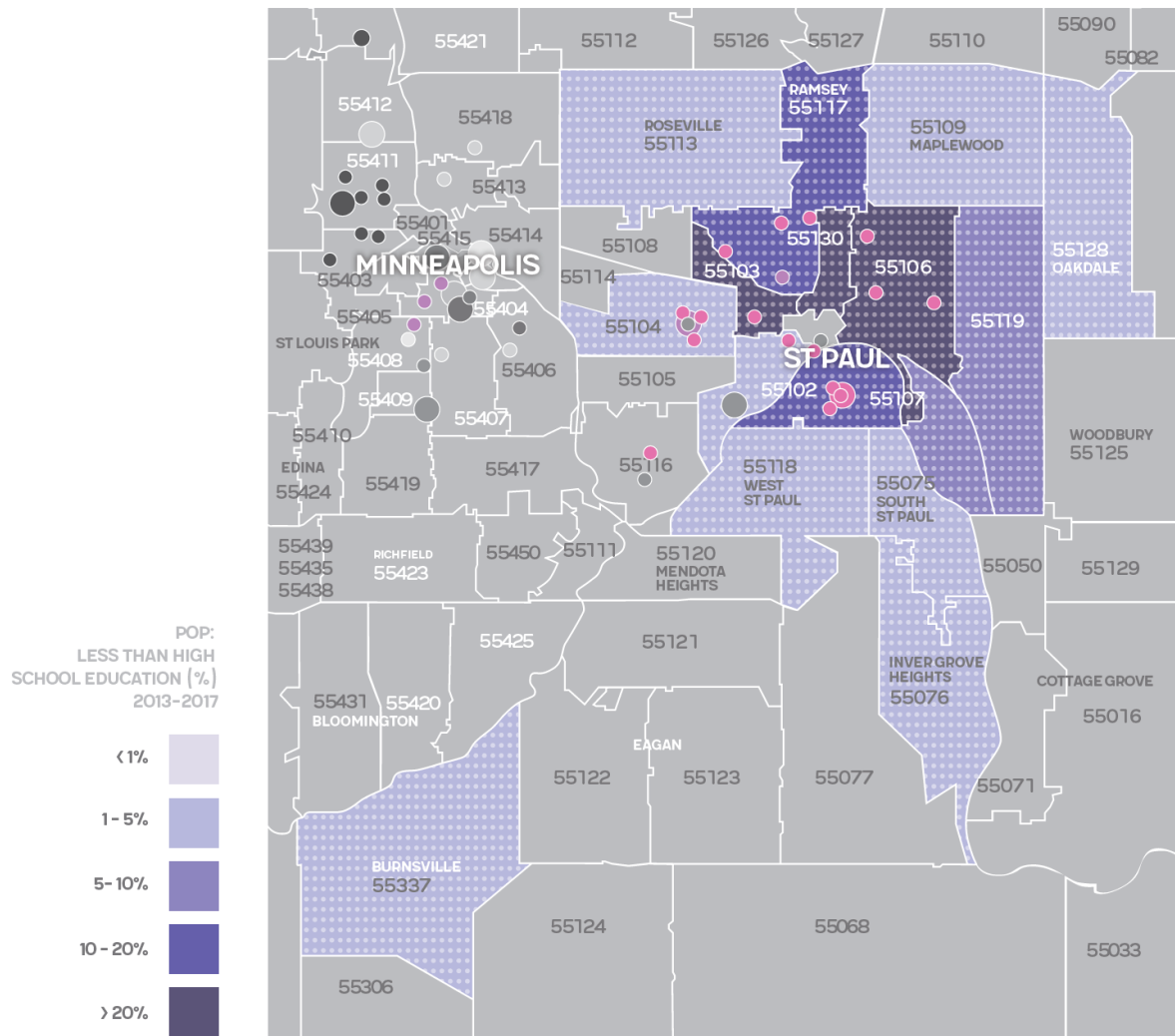


Map FF. Proportion of Population Unemployed

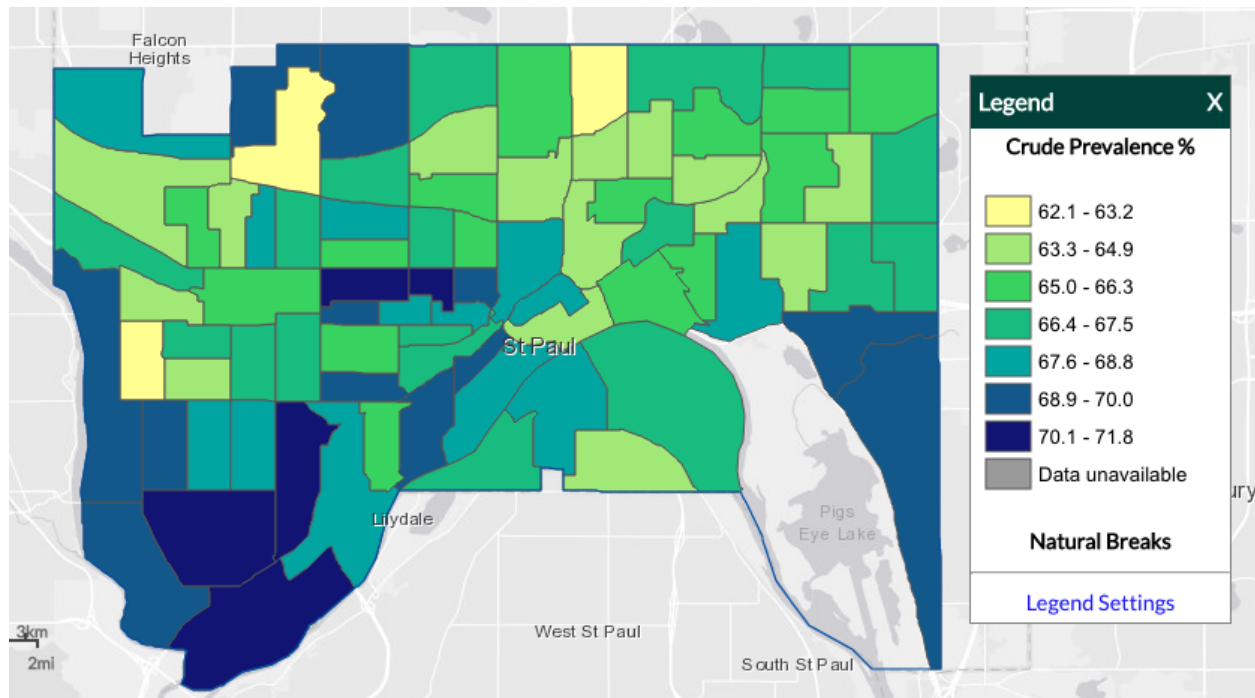


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Map GG. Population with Education Less than High School

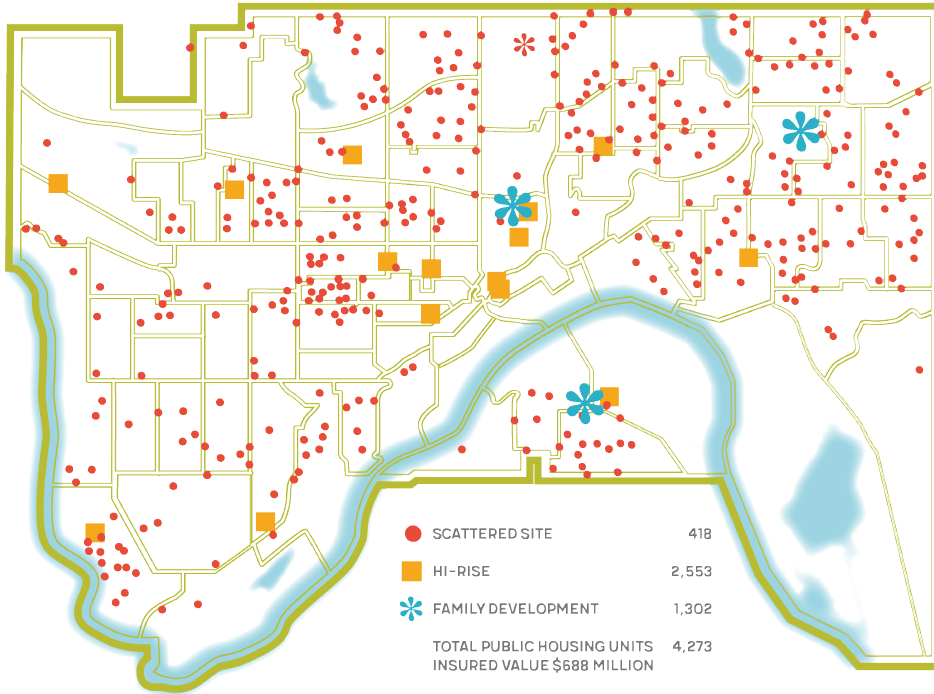


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Map II. Percent of Adults with Annual Routine Check-Up, 2016¹³⁶

¹³⁶ Please note that this measure is the opposite of the measures quoted in the text as it represents those who have had their annual check-up (and not those without an annual check-up).

Map KK. St. Paul Public Housing Agency Site Map



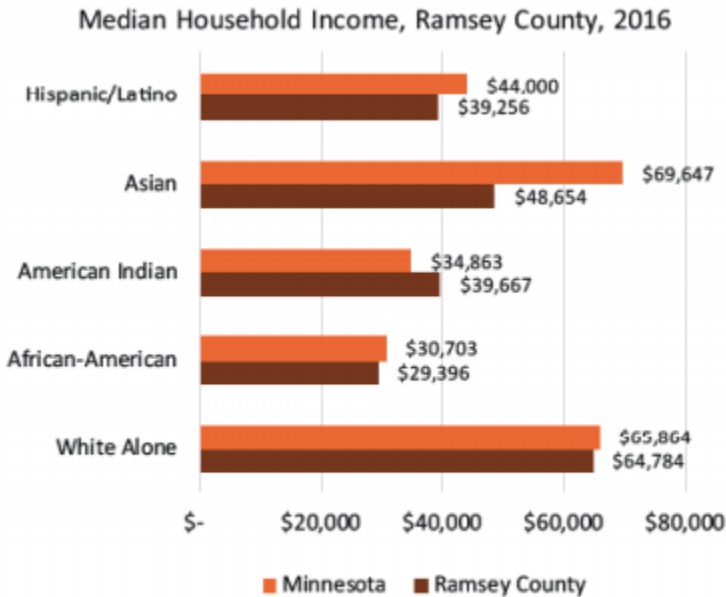
TOTAL PUBLIC HOUSING	4,273
TOTAL HOUSING CHOICE VOUCHER UNITS	4,714
TOTAL PHA-OWNED AND SECTION 8 UNITS	8,987

FAMILY HOUSING DEVELOPMENTS	UNITS
UNEDIN TERRACE	88
MCDONOUGH HOMES	592
MT. AIRY HOMES	302
ROOSEVELT HOMES	320
TOTAL HOUSIN DEVELOPMENTS	1,302

PHA HI-RISE APARTMENTS	UNITS
CENTRAL HI-RISE	144
CLEVELAND HI-RISE	144
DUNEDIN HI-RISE	143
EDGERTON HI-RISE	221
EXCHANGE HI-RISE	194
FRONT HI-RISE	151
HAMLIN HI-RISE	186
IOWA HI-RISE	148
MONTREAL	185
MT. AIRY HI-RISE	153
NEILL HI-RISE	104
RAVOUX HI-RISE	220
SEAL HI-RISE	144
VALLEY HI-RISE	158
WABASHA HI-RISE	71
WILSON HI-RISE	187
TOTAL HI-RISE UNITS	2,553

APPENDIX II: FIGURES & CHARTS

Figure A. Median Household Income by Race, Ramsey County



Source: American Community Survey 5-year Estimates. U.S. Census Bureau.⁶

Figure B. Service Area by Race, 2017

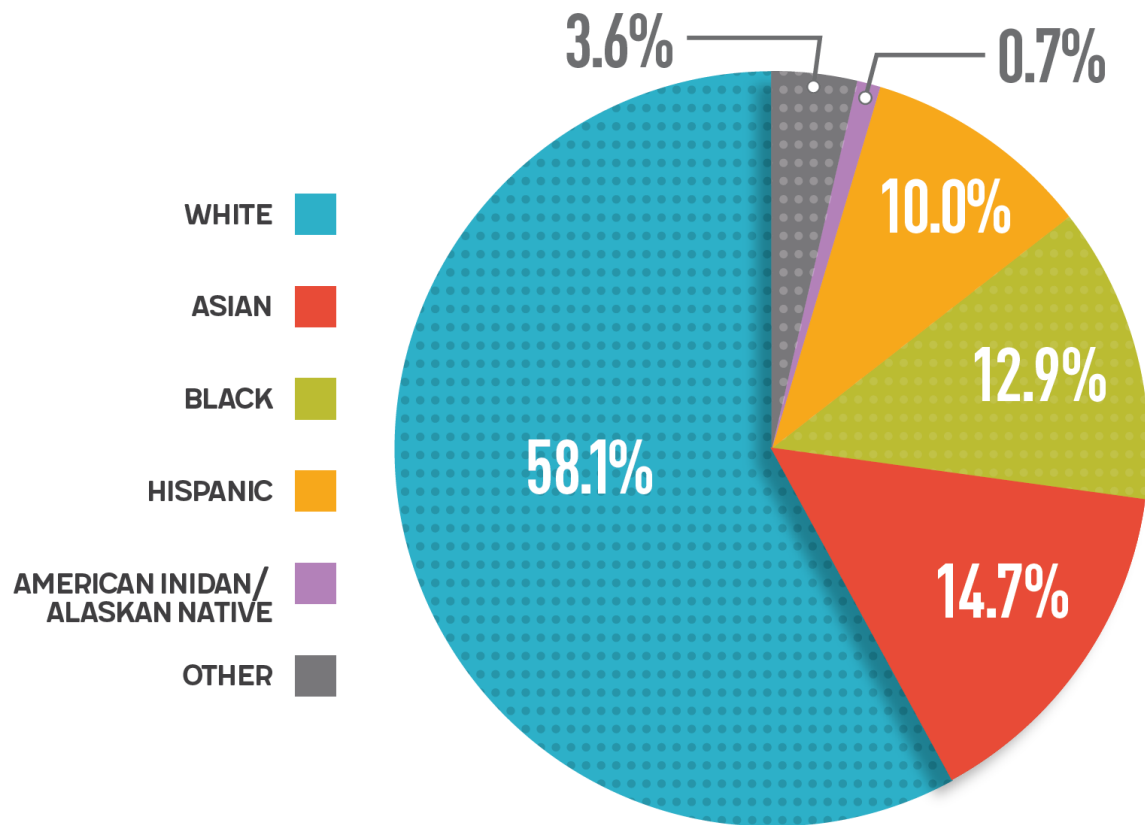


Figure C. National Quality Forum Domains of Health Equity Performance Measurement

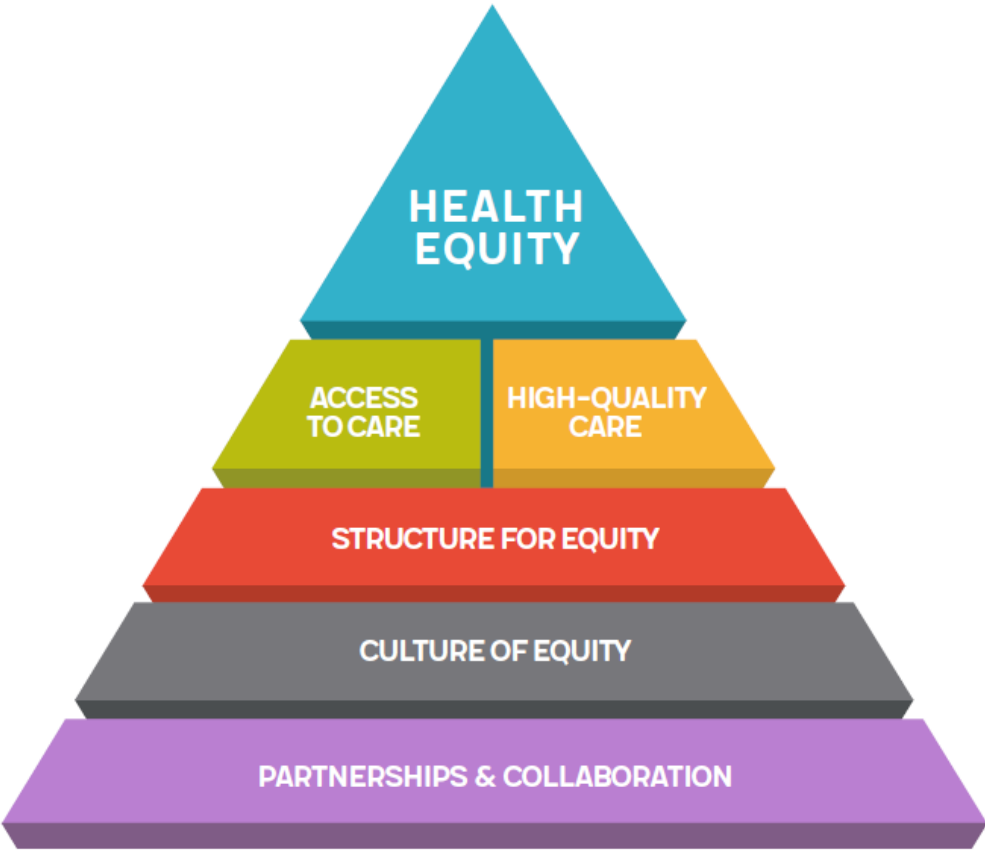
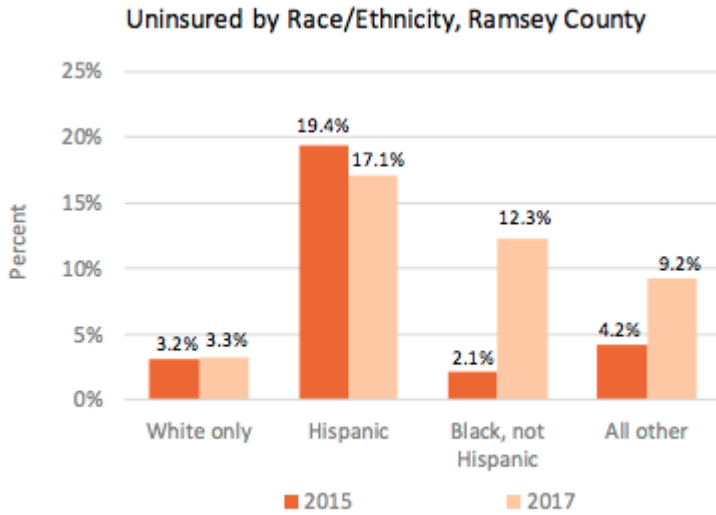


Figure D. Uninsured by Race/Ethnicity, Ramsey County



Source: Minnesota Health Access Survey.⁶

Figure E. Volume of Potentially Preventable ED visits by Payer Group and Year, Ramsey County, 2010-2014

Figure 3: Volume of potentially preventable visits by payer over time

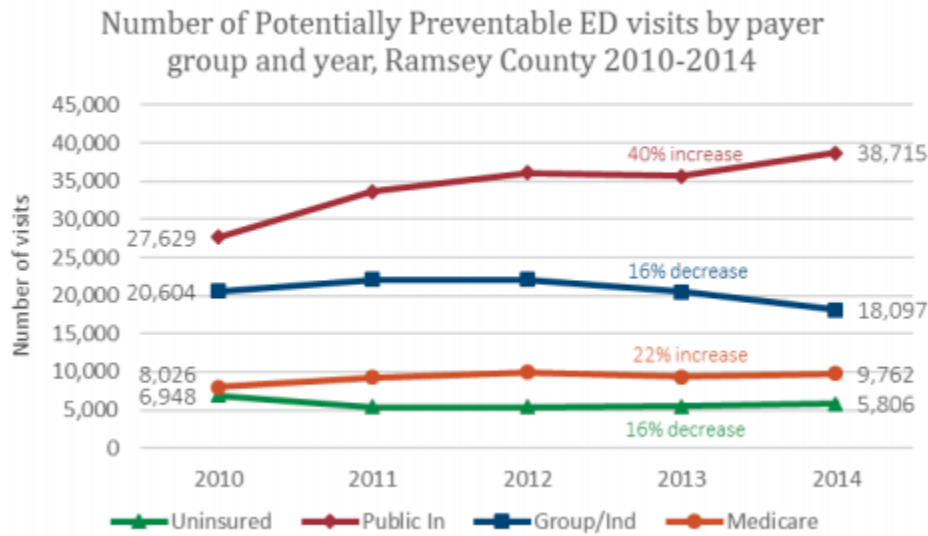


Figure F. Time of Preventable ED visits in Ramsey County

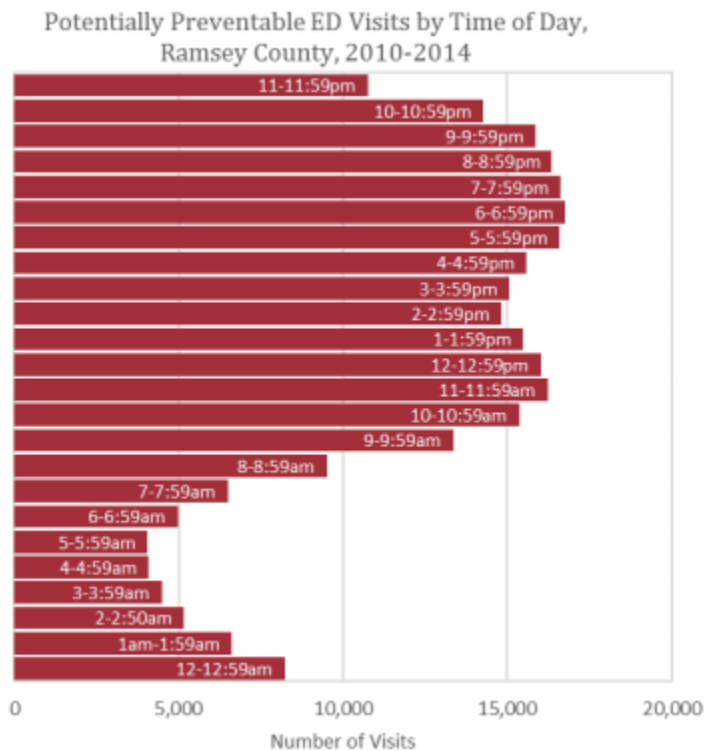


Figure G. Life Expectancy on I-94 Corridor

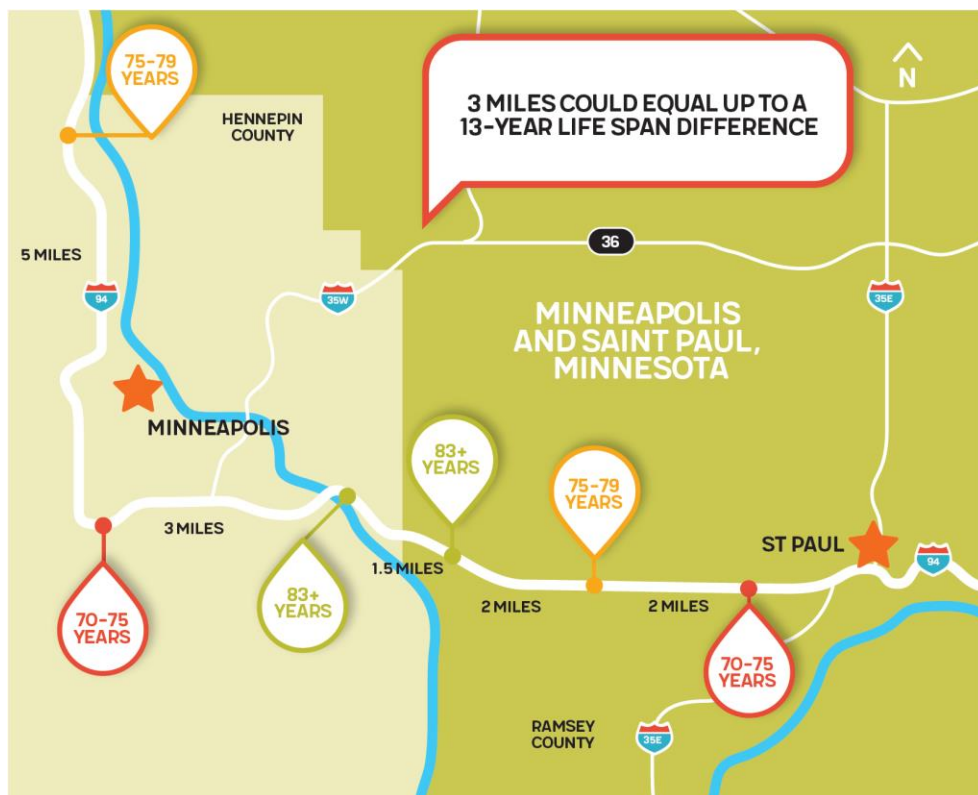


Figure H. Age-Adjusted Death Rate by Cause and Race, Ramsey County, 2016

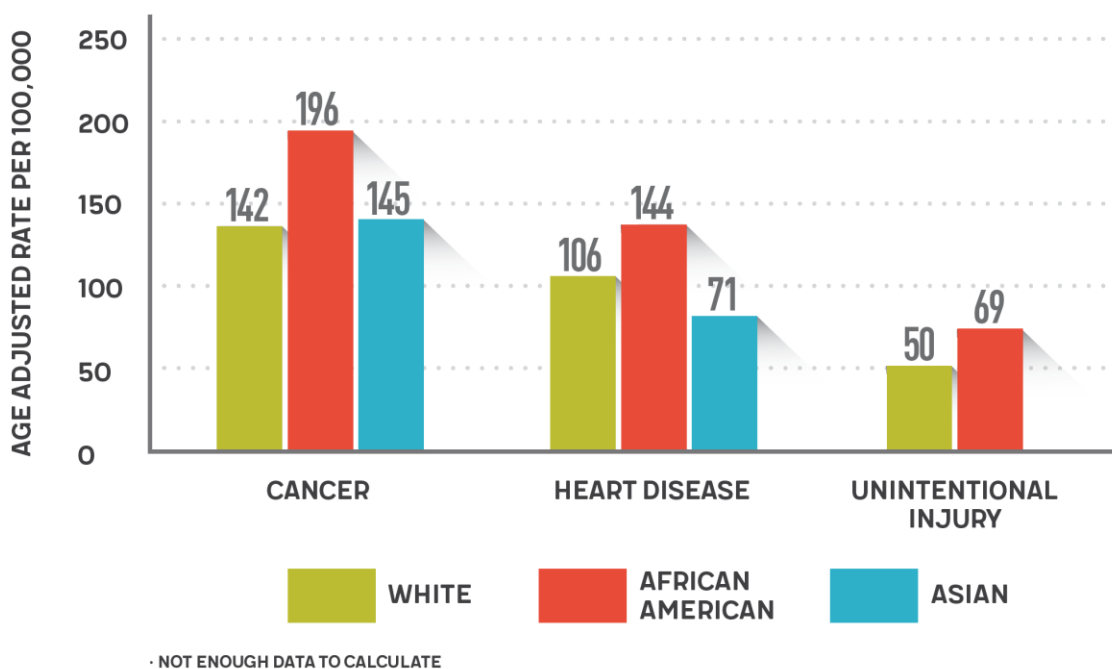
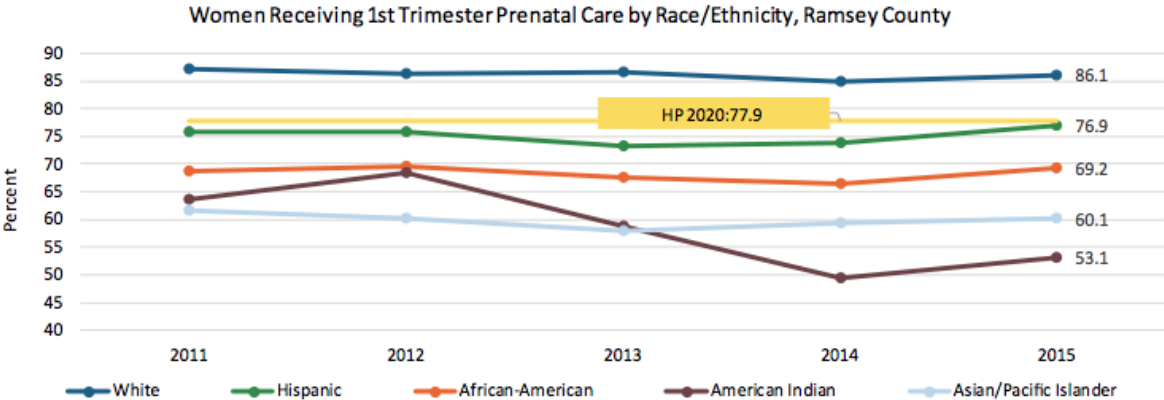


Figure I. 1st Trimester Prenatal Care by Race, Ramsey County



Source: Minnesota Department of Health.⁴

Figure J. Low Birth Weight Rates in Ramsey County by Race

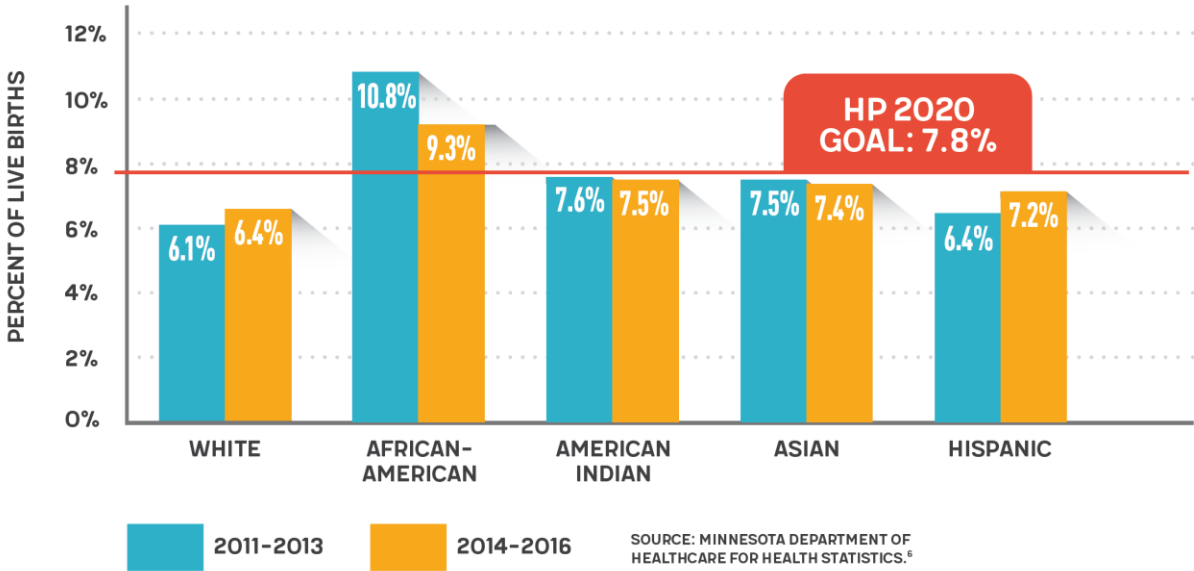
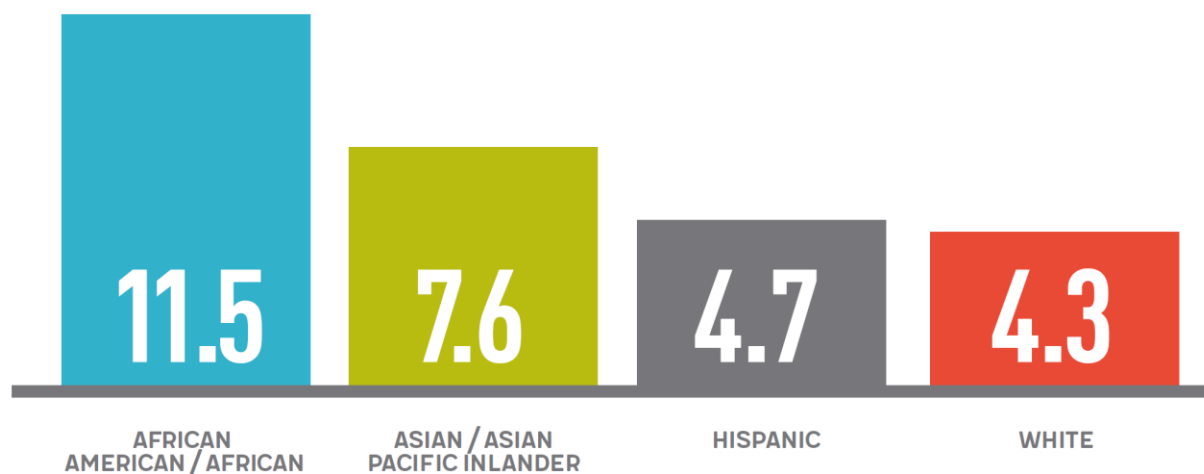


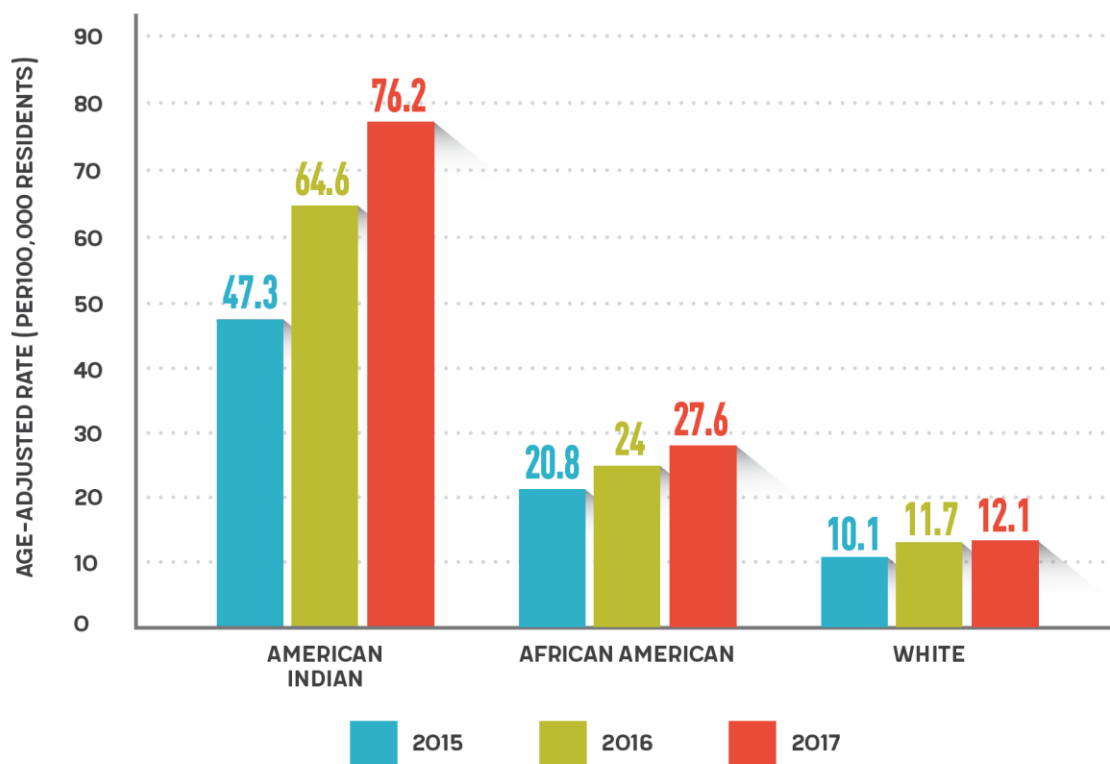
Figure K. Infant Mortality Rates in Ramsey County, 2014-2016

-RATE PER 1,000 LIVE BIRTHS



SOURCE: RAMSEY COUNTY COMMUNITY HEALTH ASSESSMENT, 2018

Figure L. Overdose Deaths in Minnesota by Race



SOURCE: MINNESOTA DEATH CERTIFICATES, INJURY AND VIOLENCE PREVENTION SECTION, MINNESOTA DEPARTMENT OF HEALTH

Figure M. Prevalence of Arthritis among Adults Ages 25+ by Household Income in 6-County Metro Area

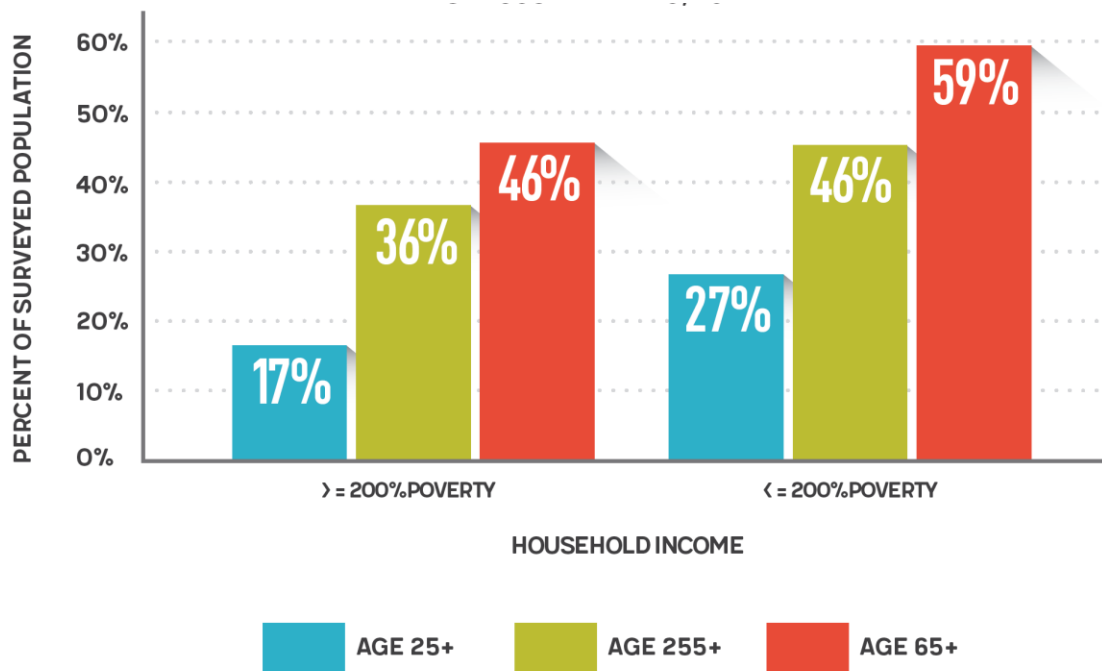
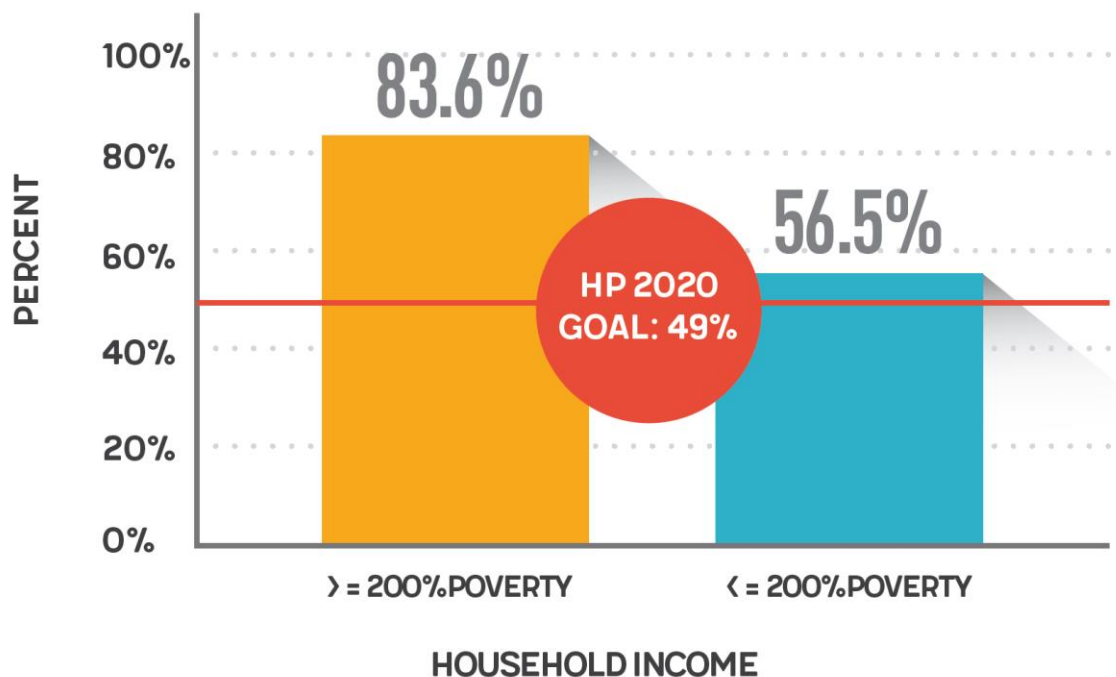
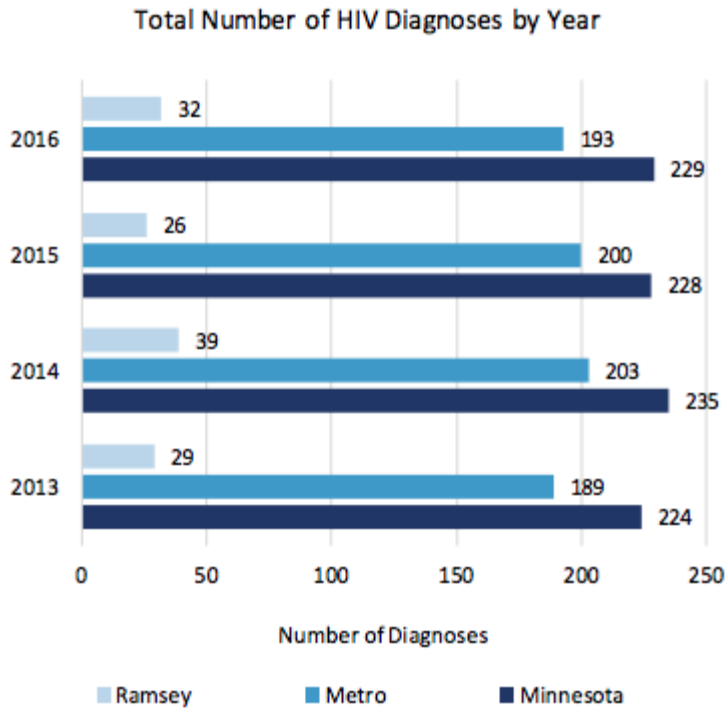


Figure N. Adults Ages 25+ who Visited Dentist within Past Year by Household Income in 6-County Metro Area



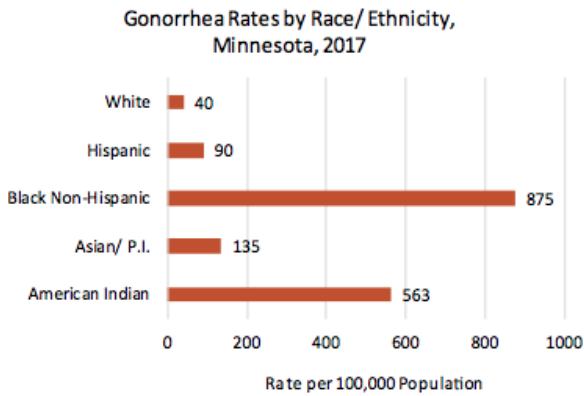
SOURCE: MINNESOTA DEPARTMENT OF HEALTH ANALYST NETWORK.
METRO SHAPE 2014 SIX COUNTY DATA BOOK.⁵

Figure O. Total Number HIV Diagnoses by Year

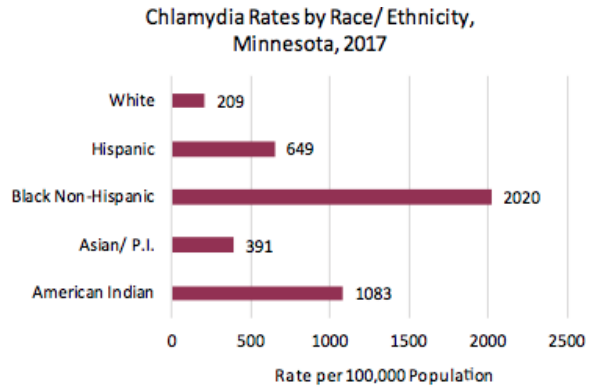


Source: Minnesota Department of Health.⁶

Figure P. Gonorrhea and Chlamydia Rates by Race



Source: Minnesota Department of Health.⁸



Source: Minnesota Department of Health.⁸

Figure Q. Incidence for Lung, Colon, and Breast Cancers

Cancer incidence for Lung, Colorectal and Breast Cancers in Ramsey County, 2011-2015

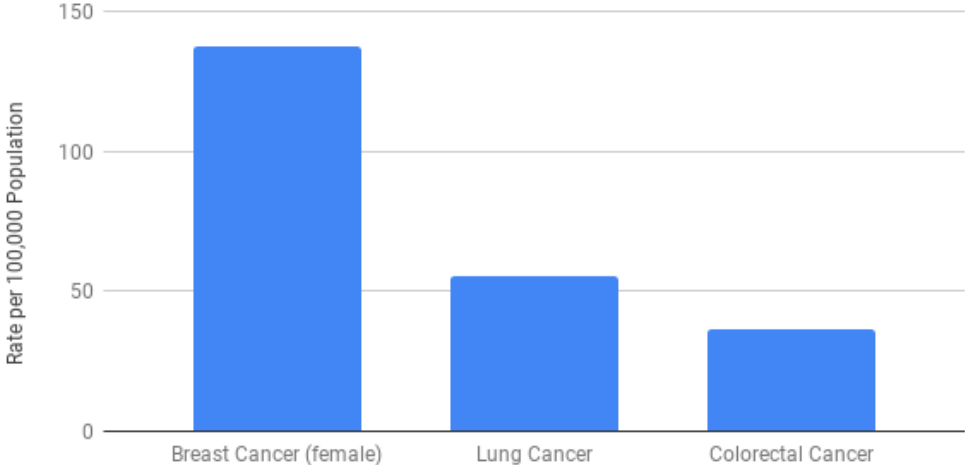


Figure R. Prevalence of Depression in 6-County Metro, 2014

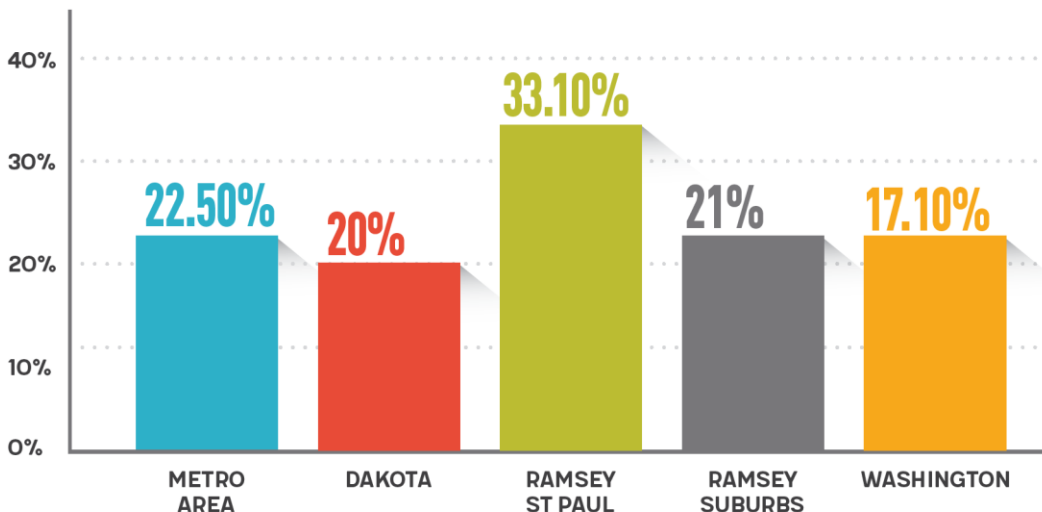
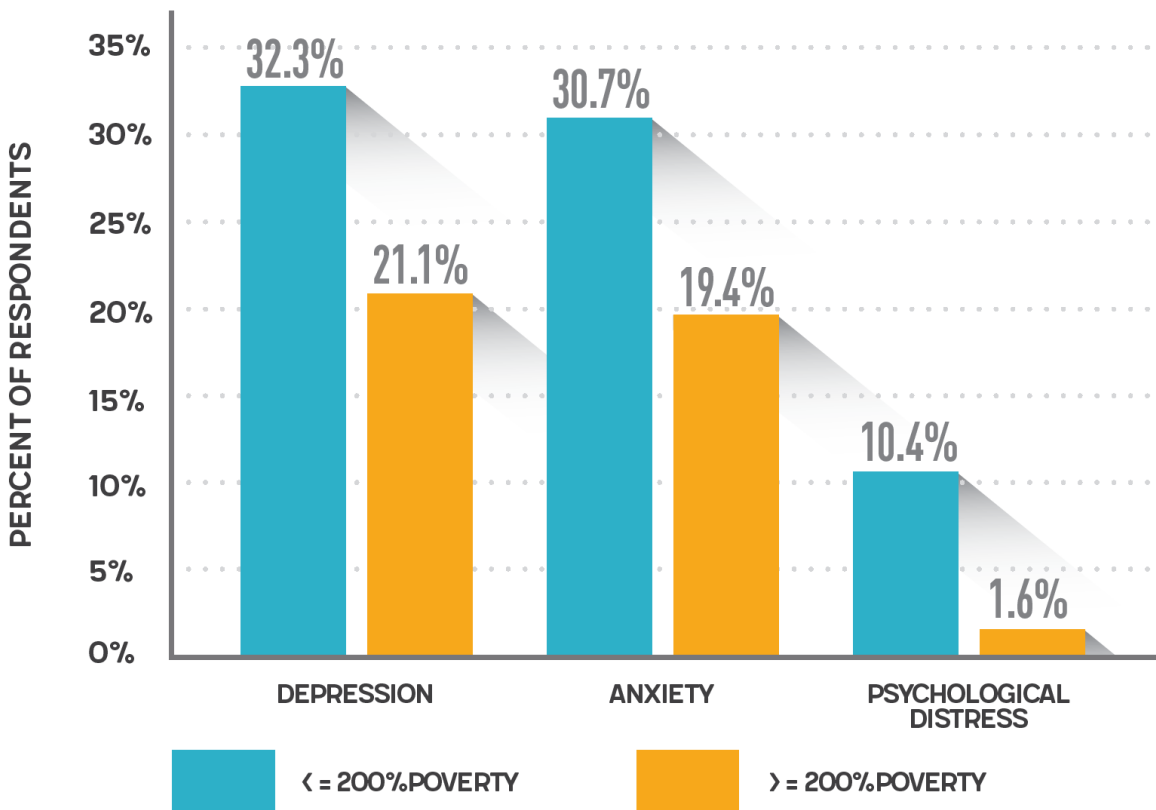
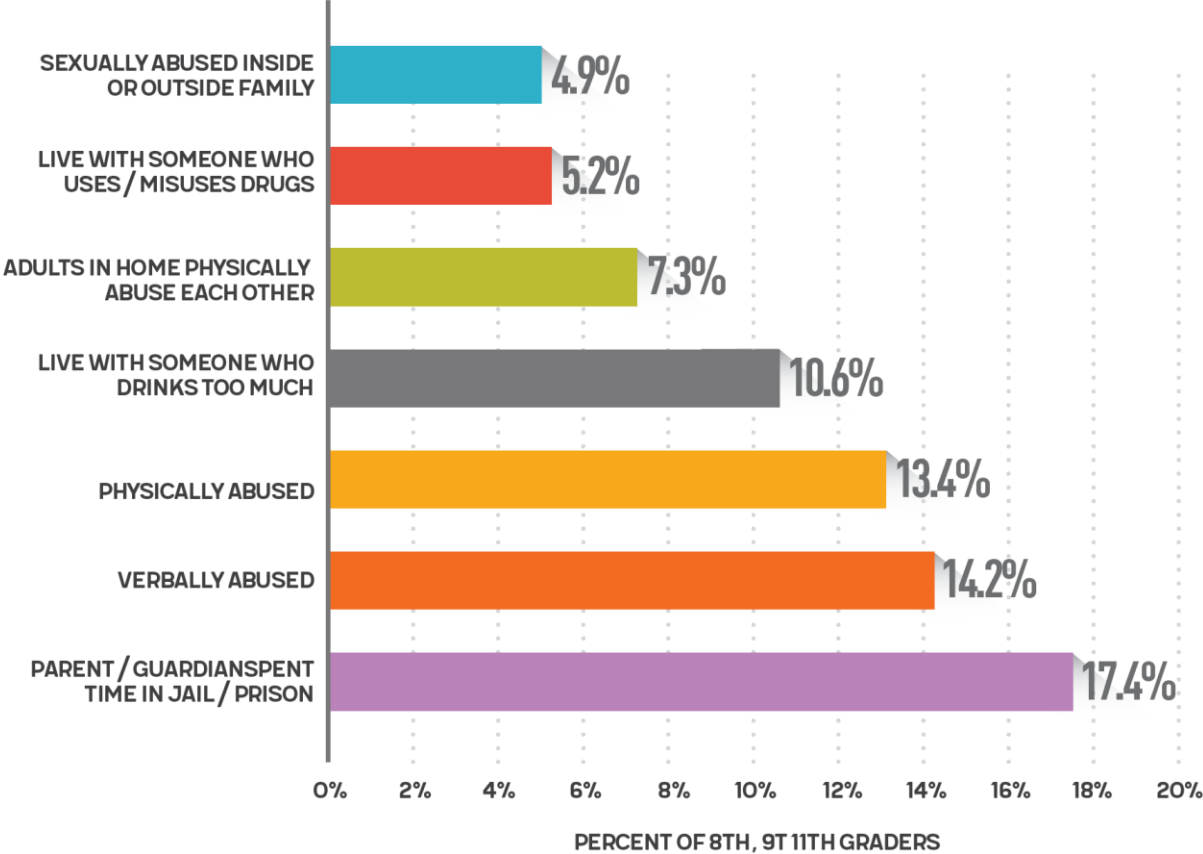


Figure S. Mental Health Conditions by Income, Ramsey County



SOURCE: METRO SHAPE 2014 RAMSEY COUNTY DATA BOOK.

Figure T. Most Common ACEs, Grades 8-11, in Ramsey County



SOURCE: MINNESOTA STUDENT SURVEY, 2016; SAINT PAUL RAMSEY COUNTY PUBLIC HEALTH

Figure U. Percentage of 9th graders who Attempted Suicide, by Sexual and Gender Identity, 2016

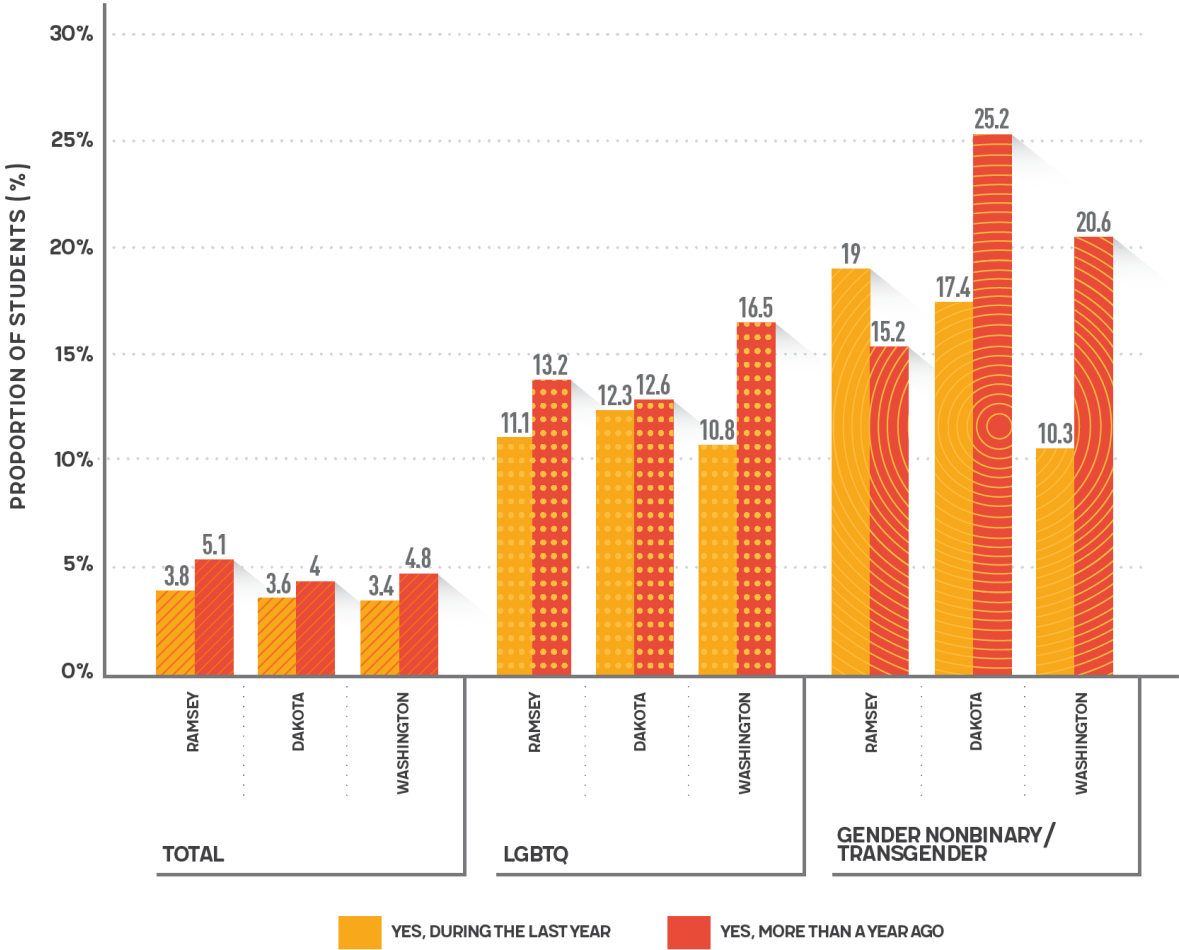
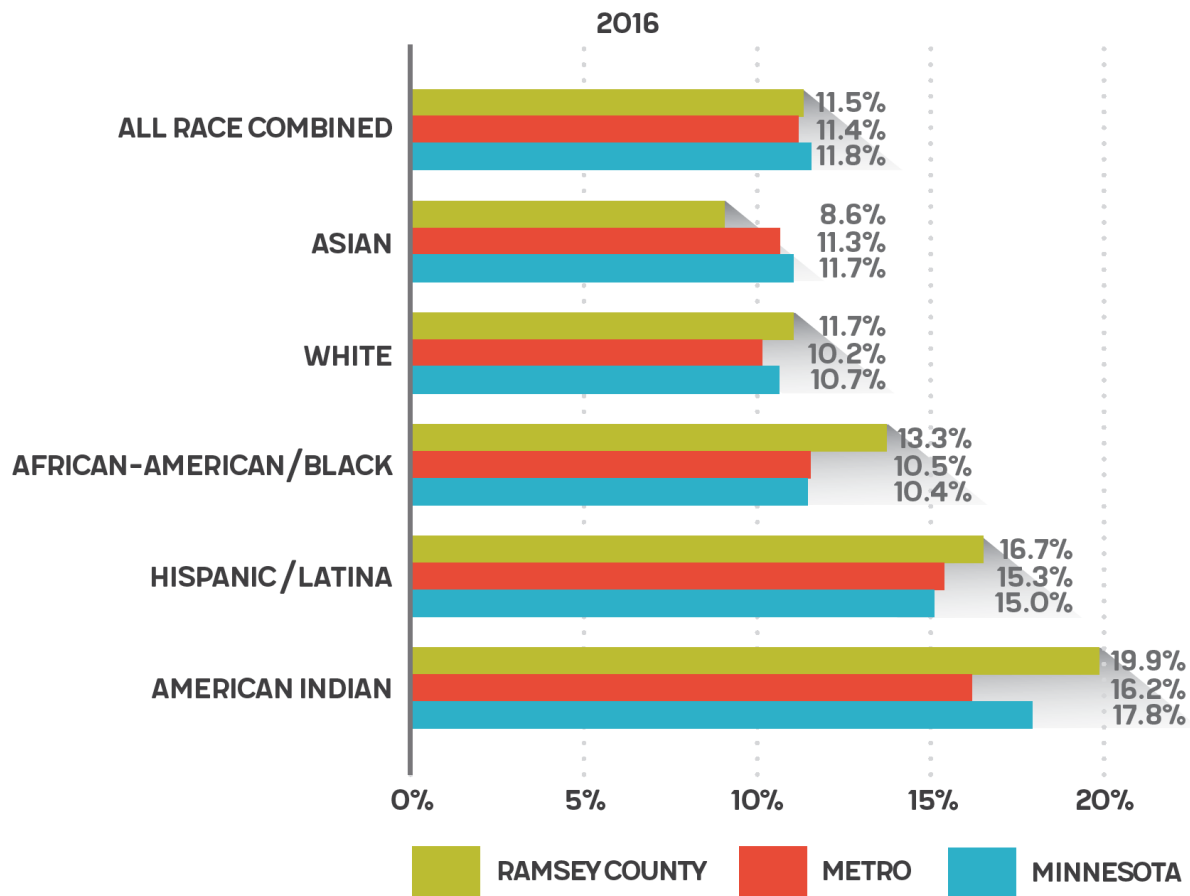


Figure V. 9th Graders who Seriously Considered Attempting Suicide in the Last Year, by Race



SOURCE: SAINT PAUL - RAMSEY COUNTY PUBLIC HEALTH DATA

Figure W. Cost-Burdened Households, 1990-2016

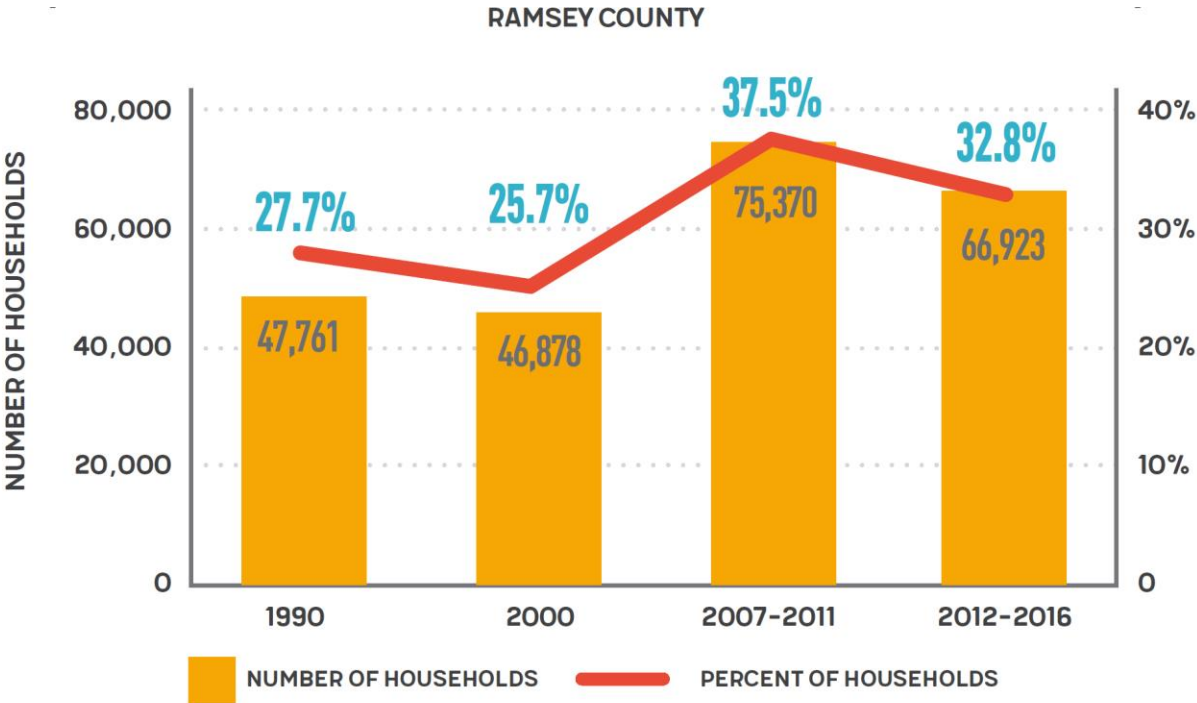


Figure X. Unemployment Rate by Race/Ethnicity in Ramsey County, 2017

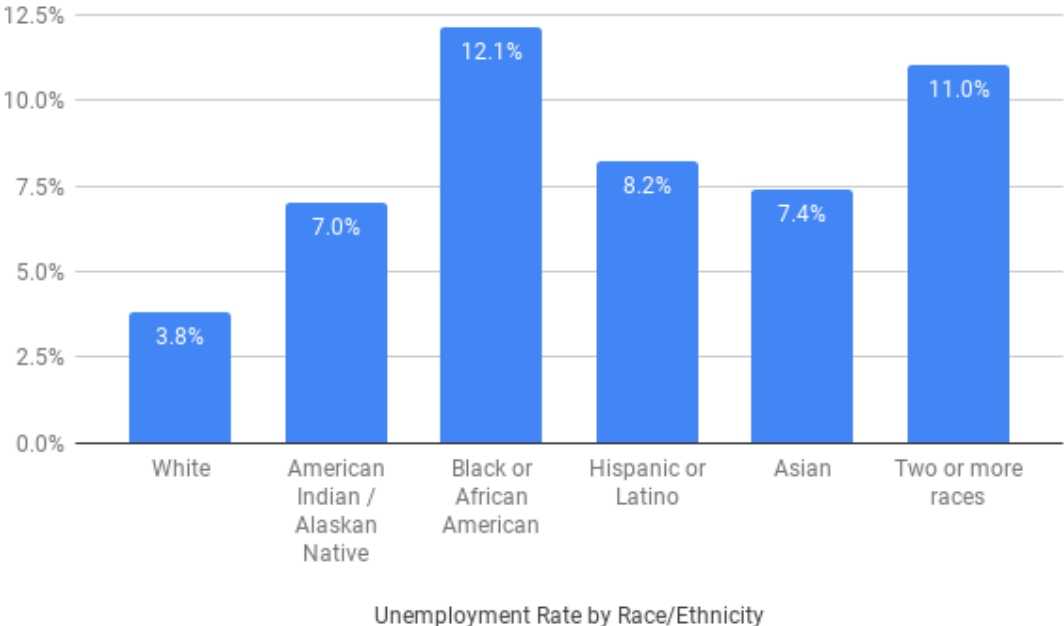
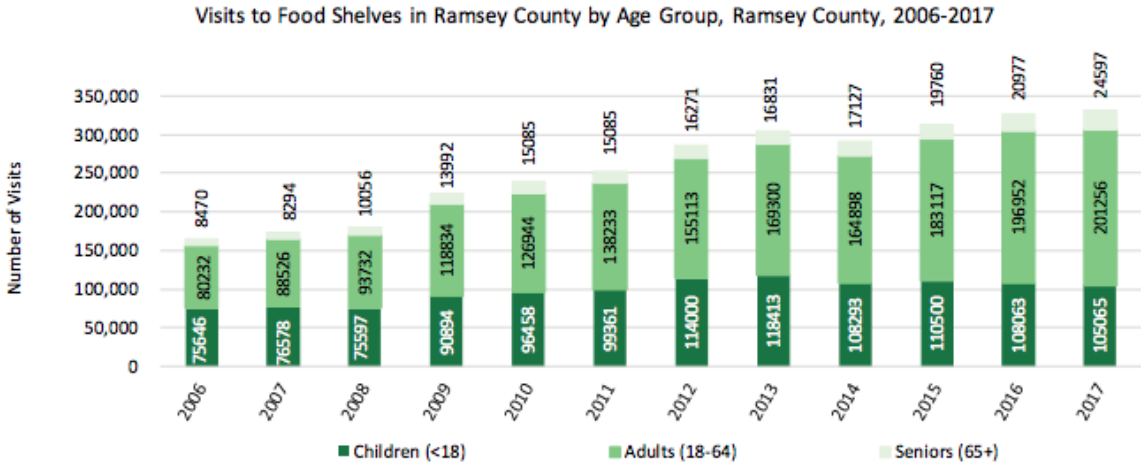


Figure Y. Food Shelf Use in Ramsey County Over Time, By Age



Note: Households and children were counted every time a person from the household visited a food shelf.
Source: Hunger Solutions.¹¹

Figure Z. Food Insecurity by County and Income

During the past 12 months, how often did you worry that your food would run out before you had money to buy more?

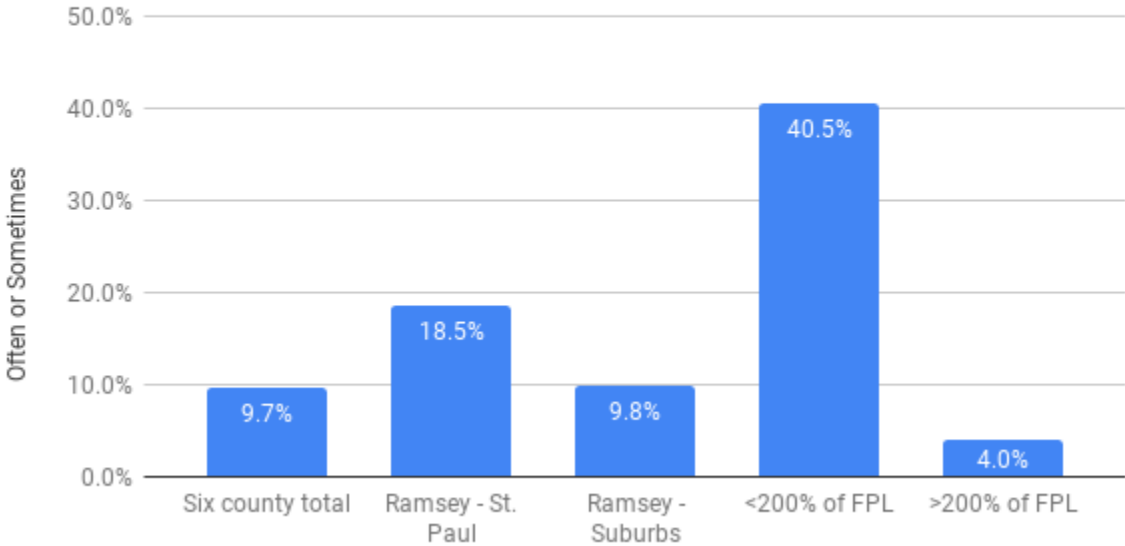
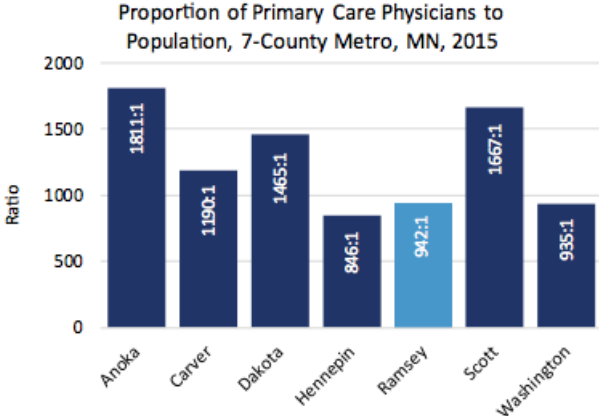
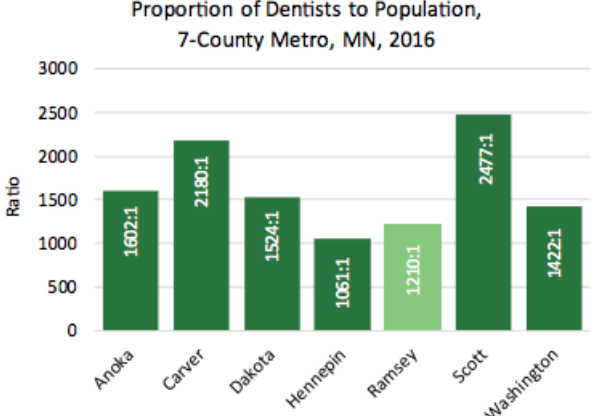


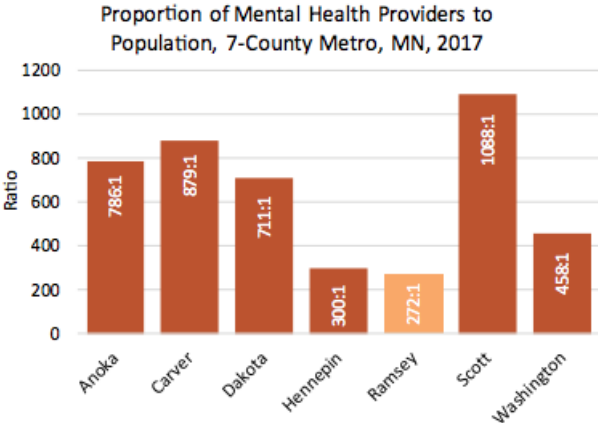
Figure AA. Proportion of Clinicians to Population



Source: Area Health Resource File/American Medical Association.⁶

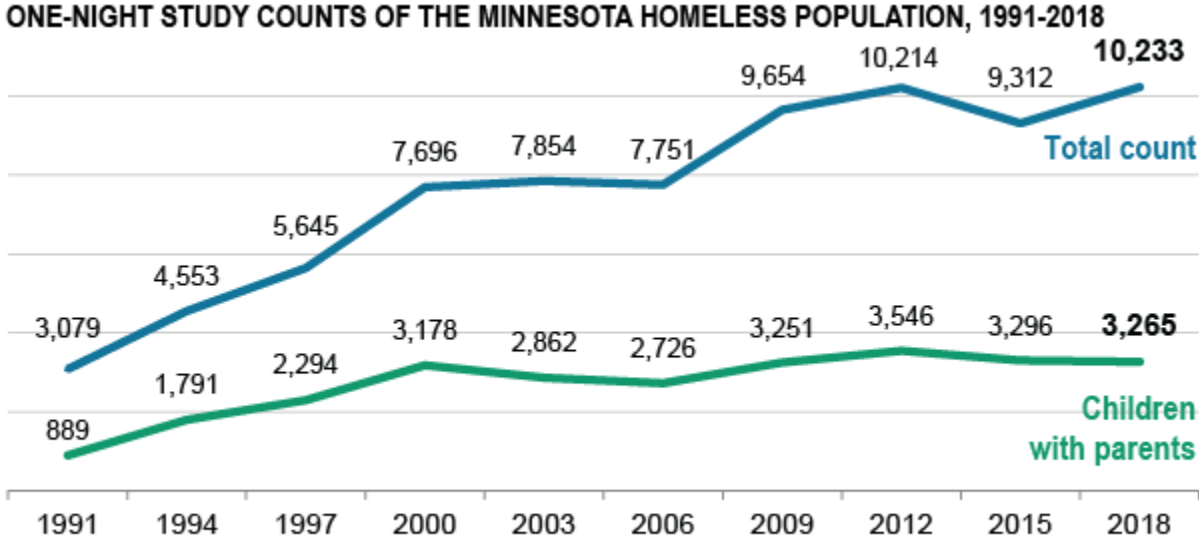


Source: Area Health Resource File/National Provider Identification file.⁷



Source: CMS/National Provider Identification file.⁸

Figure BB. One-Night Study Counts of the MN Homeless Population, 1991-2018



2018 Minnesota Homeless Study | mnhomeless.org

Figure CC. Homelessness by Age in 7-County Metro Area, 2018

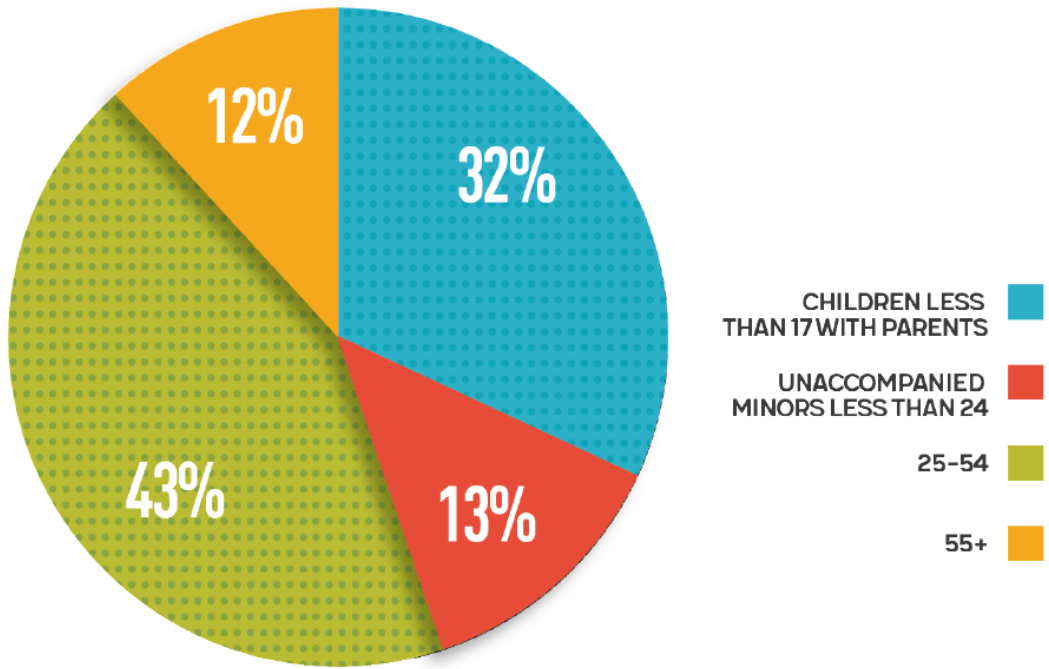


Figure DD. Minnesota Counts of Those Experiencing Homelessness Not in a Formal Shelter, 2009-2018

COUNTS OF THOSE NOT IN A FORMAL SHELTER (OUTSIDE OR DOUBLED UP), 2009-2018



2018 Minnesota Homeless Study | mnhomeless.org

Figure EE. Race of Homeless Adults Compared to Representation in Minnesota Population

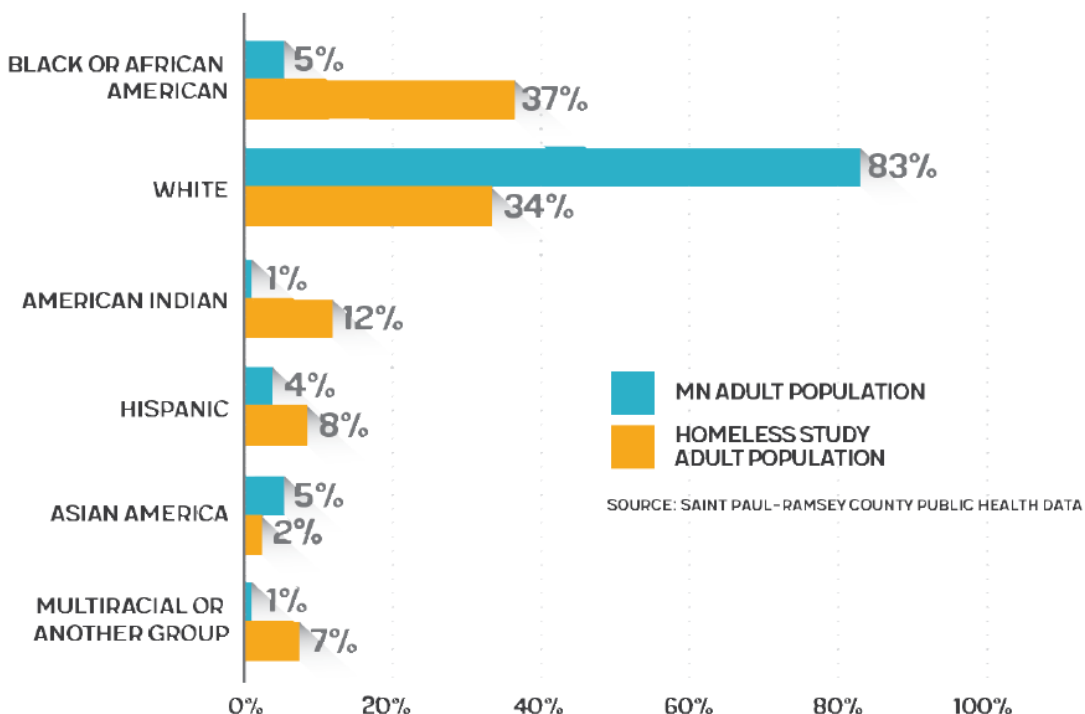


Figure FF. ACEs Among Minnesotans Experiencing Homelessness

ADVERSE CHILDHOOD EXPERIENCES (BEFORE AGE 18) AMONG THE HOMELESS POPULATION, BY AGE

	Adults (age 18 or older)	Youth (age 24 or younger)
At least one adverse childhood experience	73%	84%
Three or more adverse childhood experiences	46%	59%
Lived with someone who abused substances (alcohol or drugs)	52%	61%
Witnessed abuse of another family member	51%	60%
Had a parent or guardian with mental health issues	43%	59%
Was <i>physically</i> mistreated or abused	42%	48%
Was <i>sexually</i> mistreated or abused	28%	31%
Was neglected	22%	31%
Had a parent serve time in prison	20%	41%

Note. The Minnesota Homeless Study includes selected questions around adverse childhood experiences. It is important to note that the study does not include a comprehensive list of adverse childhood experiences. In addition, question wording differs from those on the Family Health History questionnaire used in the 1998 CDC-Kaiser Permanente Adverse Childhood Experiences Study.

Figure GG. Enrollment in SPPS Grades 9-12 by Race

Enrollment in St. Paul Public Schools Grades 9-12 vs Total St. Paul Population by Race, 2018

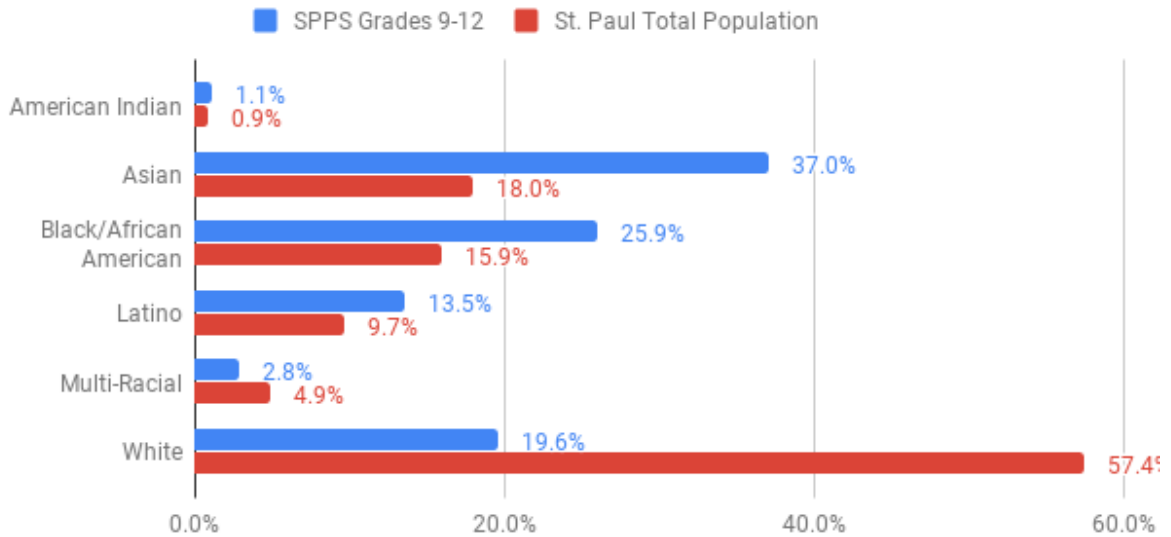
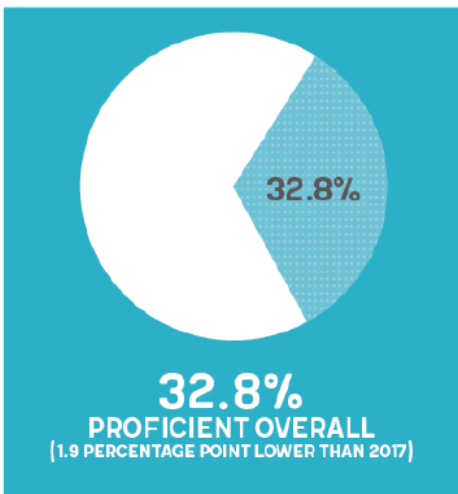


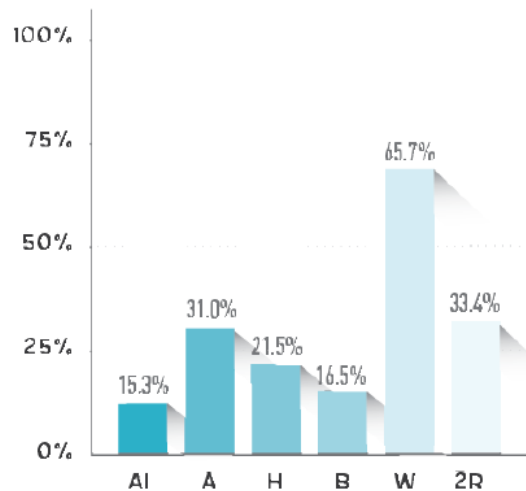
Figure HH. MCA Testing Proficiency by Race, 2018

MCA MATH

[DISTRICT-WIDE GRADES 5, 8 AND 11]

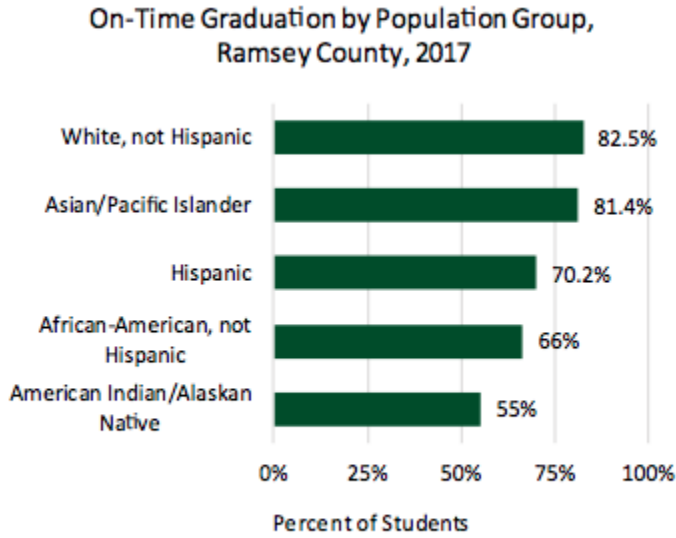


RACIAL / ETHNIC GROUPS



SOURCE: 2018 MCA AND ACCESS FOR ELLs RESULTS, ST. PAUL PUBLIC SCHOOLS

Figure II. On-Time Graduation Rates by Race, 2017



Source: Data Reports and Analytics.⁶

Figure JJ. Frequency of Depression Symptoms, SPPS, 2016

Frequency of Depression symptoms, St. Paul Public Schools, 2016

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

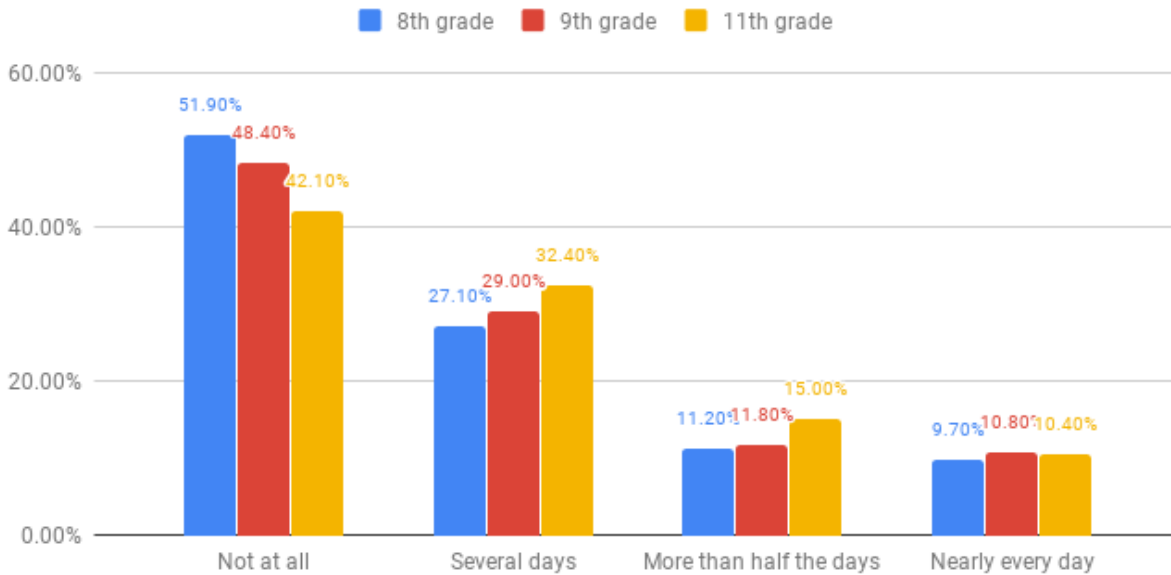


Figure KK. SPPS Student Weight Status, 2016

St. Paul Public School Student Weight Status, 2016

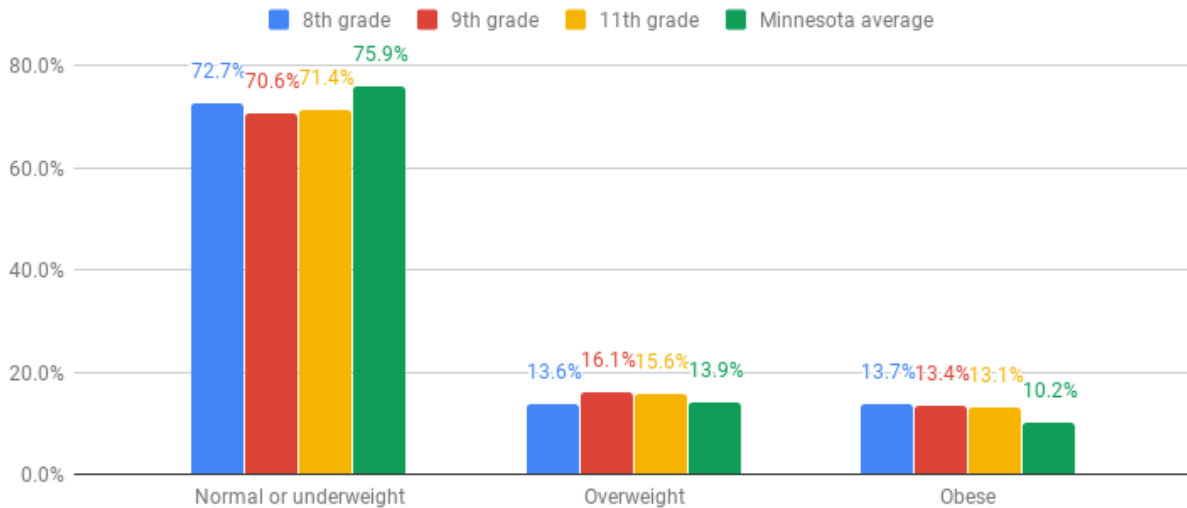
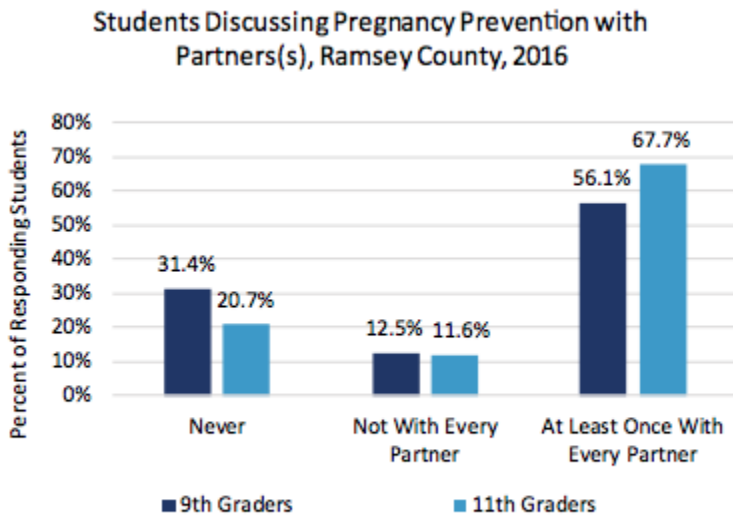


Figure LL. Students Discussing Pregnancy Prevention with Partner(s)



Source: Minnesota Student Survey, Minnesota Department of Education Web site.⁷

Figure MM. Students Using Condom at Last Sexual Intercourse

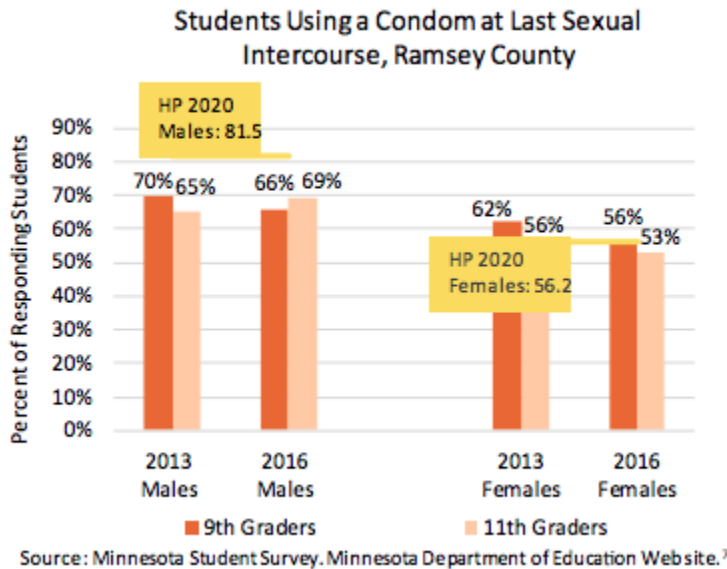
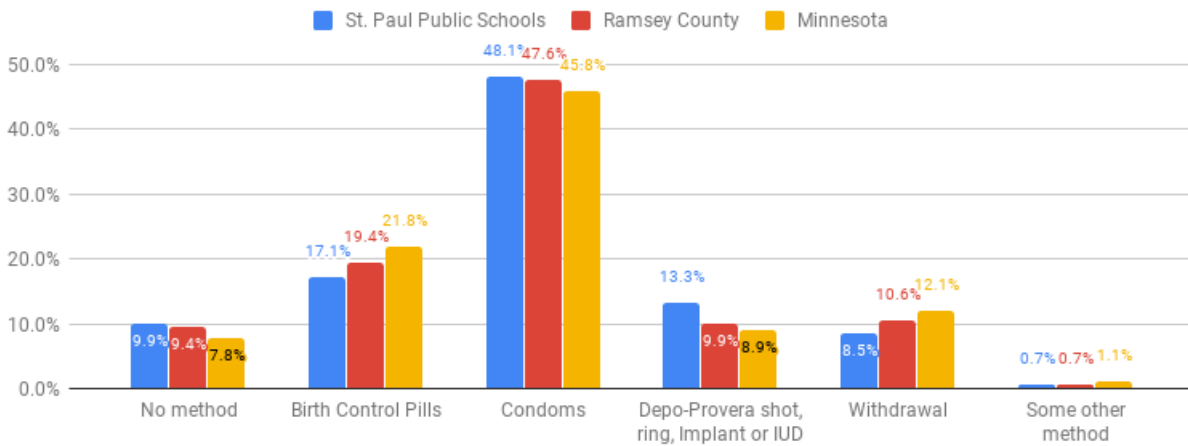


Figure NN. Pregnancy Prevention among SPPS 11th Graders

Pregnancy Prevention among 11th Graders in St. Paul Public Schools, 2016.
The LAST time you had sexual intercourse, what ONE method did you or your partner use to prevent pregnancy?



APPENDIX III: TABLES

Table A. Service Area Zip Codes and Neighborhood Names

Zip Code	Neighborhood Name
55075	South Saint Paul
55076	Inver Grove Heights
55102	West 7th / Summit Hill
55103	Rondo/North End / Frogtown
55104	Midway/Frogtown
55106	East Side St. Paul
55107	Westside St. Paul
55109	Maplewood
55113	Roseville
55117	Little Canada
55118	West St. Paul (city)
55119	Maplewood
55128	Oakdale
55130	Payne-Phalen
55337	Burnsville

Table B. Proportion of Low-Income Population in Service Area, by Zip Code, 2017

Zip Code	Low-Income (#)	Low-Income (%)	Poverty (%)	Proportion of Low-Income Residents seen at CHCs (%)
Total Service Area	166451	35.7%	16.1%	28.3%
55130	12120	68.1%	33.0%	30.1%
55103	8270	60.8%	32.2%	27.6%
55106	29088	50.8%	24.8%	35.5%
55107	7346	49.4%	25.0%	42.7%
55117	19174	43.1%	20.4%	26.6%
55104	15955	37.0%	20.4%	30.1%
55102	6120	35.2%	15.4%	60.8%
55119	14645	35.1%	14.4%	29.7%
55109	9985	29.8%	9.9%	17.0%
55075	5996	29.6%	12.1%	23.7%
55337	10803	24.3%	8.6%	10.8%
55113	9450	23.7%	10.7%	14.8%
55118	6570	23.4%	9.1%	33.6%
55128	6323	22.1%	7.6%	15.6%
55076	4606	21.8%	8.9%	20.0%

Table C. MN Community Care patients (2017) by Race, Zip Code

Zip Code (ZCTA)	Total Patients (#) 2017	White (%)	Racial/Ethnic Minority (%)	Hispanic (%)	Black (%)	Asian (%)	American Indian/Alaska Native (%)
Service Area Summary	47148	58.1%	41.9%	10.0%	12.9%	14.7%	0.7%
55106	10311	35.2%	64.8%	13.1%	13.2%	33.2%	1.5%
55117	5090	45.1%	54.9%	10.3%	15.6%	25.4%	1.1%
55104	4794	58.6%	41.4%	6.2%	20.0%	8.9%	1.1%
55119	4355	49.5%	50.5%	10.4%	17.3%	18.0%	0.4%
55102	3722	73.2%	26.8%	7.6%	11.7%	2.8%	0.9%
55130	3653	20.9%	79.1%	14.2%	20.6%	40.0%	0.8%
55107	3140	44.8%	55.2%	29.7%	14.0%	6.8%	1.8%
55103	2282	28.8%	71.2%	6.6%	33.7%	26.9%	0.4%
55118	2210	72.2%	27.8%	16.8%	4.5%	3.6%	0.3%
55109	1700	67.8%	32.2%	5.8%	9.7%	13.0%	0.3%
55075	1422	74.5%	25.5%	14.6%	3.7%	2.6%	0.8%
55113	1395	74.9%	25.1%	3.6%	8.0%	9.0%	0.6%
55337	1168	71.4%	28.6%	7.2%	12.4%	4.3%	0.2%
55128	987	74.2%	25.8%	6.4%	8.0%	8.4%	0.5%
55076	919	76.8%	23.2%	11.0%	4.4%	4.7%	0.2%

Table D. Percentage of Children Ages 0-17 with ACEs

	1 or more ACEs	2 or more ACEs
US	46.3%	21.7%
Minnesota	38.1%	16.8%
White	40.9%	19.2%
Hispanic	51.4%	21.9%
Black	63.7%	33.8%
Asian	25.0%	6.4%
Income <200% of FPL	61.9%	31.9%
Income 200-400% FPL	43.2%	19.0%
Income >400% FPL	26.4%	9.2%

APPENDIX IV: ADDITIONAL COMMUNITY QUOTES BY NQF DOMAIN

NQF Domain: Partnerships & Collaboration

Clinics should know what they are doing and know about organizations which can help alongside. Clinics should do their job well and if they need services which are not covered by the clinic, they should find other organizations in the community that can help them. (Black/African American)

Budgets and how we do budgets. Budgets are like financial compasses. They identify priorities, set the boundaries, when you identify something in the budget, it says how important it is. Who controls budget in our state. Ways that funding is dispersed has impact. Same 4 agencies. The only thing that they have to say is that we like brown people. Show up at gay events. No people from our communities are hired by these orgs. But the orgs are doing work in our orgs. (LGBTQ2S)

I think there needs to be more integration between prevention and public health. If we look at the chart earlier, only 10% goes to prevention, the rest is other social determinants, if it's health care dollars we need to build more relationships with non-health care providers and policy changes. It should help with education as well as policy changes. Even if there is education, there are other barriers, like financial issues and provide subsidies to help people afford things. Policy change and education. (Hmong)

But if you have big clinic they are detached from the community – for example if the clinics – state focus giving money to small clinics to provide better healthcare system. (Somali)

Give small clinics a hand b/c they can make big impact on community. (Somali)

Clinics should have physical mental and dental care are very basic. But I also think it is important to have a system, so you are not isolated (in a silo). The idea is to communicate. (Black/African American)

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

If a clinic has all the resources in terms of housing, employment, or legal information—such as domestic violence... (and) I can get help getting a restraining order—or if there is a person (like social worker from the clinic) to refer me (and) at the same time (tell me), 'We will care for your health, and this (resource) will relieve your pain and stress', (then) it's very important to me and the Hmong community because we

don't know the language, (we don't have the) knowledge, (and) so we don't know where the information is. (Hmong)

The health system should not place so much emphasis on Western medicine... Rather, it would be better to have a new health system with traditional healers, and pay our community healers. Change the system and make it so that they can be able to bill. (LGBTQ2S)

Health isn't just like I have a cold and I need to get better because if you don't have housing, you're not healthy. (Somali)

NQF Domain: Culture of Equity

It's important for doctors to know if a family is Hmong and believes in the traditional way and "ua neeg, ua yaig". If a doctor who understands Hmong well, "Hmong hais li no mas mean li no". If I am sick and tell my doctor that I want to "ua neeb", I want my doctor to tell me, "yes, you do that and let me help you more by giving you this treatment. If we combine these then you'll get better. (Hmong)

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

We cannot place everyone under one umbrella. Culture has different faces. The same situation could be perceived differently. There are many patients who are underserved. They lack financial support, they have challenges in their lives and it is hard to prevent health inequalities. For example. Not having insurance, not accepting MA, having to pay \$400 for dental care, being able to access quality care.

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

Elephant in the room: is the impact of race/racism/misogyny.

Don't say 'feminine products'...say 'menstrual products' - take the gender out of that language. (LGBTQ2S)

On those forms that you fill out, my doctor has Male, Female, Trans Male, Trans Female, Gender Nonconforming, Gender Fluid, as far as Gender. And under pronouns, he has He/Him, She/Her, They/Them/Theirs and then Your pronouns. How neat is that? It says 'I see you, you are valid' just on the form!..And they ask you 'how would you like to be addressed?' They have that in the forms too. You can write in whatever you like. And then I feel welcomed right away. Oh you ARE

listening! You ARE taking me into consideration. There are only two clinics that I've been into (that have done this). (LGBTQ2S)

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

Cultural training must be available to the clinic staff at all levels. Clinics can even invite patients to talk about ways to improve services so the services fit with patients' culture desires and needs. (Somali)

Respect for elders, how the staff in the clinic acknowledge you, instead of calling you by your first name....I know that this is not the culture, but treating a client as Mr., and Mrs. first is respectful and you may give permission to call you by your first name. (Black/African American)

My aunt has diabetes. I went with her to see a doctor and the doctor didn't see her as she is. She is an elderly woman and has never been educated. He told her how to manage her diabetes but she didn't understand the whole scope of it or why. He told her 'no more tea' and didn't discuss it further with her. He doesn't understand how tea is a part of our culture. If he understood our culture he could treat her well, and he could reach her. Now she constantly goes to the ER instead of going to her doctor. She needs education and help to learn how she can eat. (Somali)

Make sure that staff is trained in HIPPA. Privacy is important. Do not leave my private information for others to see. We do not trust doctors and we do not trust people with our information. Talk in a low voice instead of screaming. There are always people behind who can hear. ... Information should be private and treated with respect. This way I will come back to this clinic. (Black/African American)

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

Having a calming, healing environment (is important). I know that (my clinic) has a chaotic environment, and with anxiety, sometimes, I have trouble being in the waiting area (because) you're in everybody's business. I think it doesn't really respect patients' confidentiality and privacy. With patients coming in with things they don't want to share, but they have to shout over everybody. How do we make it feel more like a healing space when you have a lot of people coming in with complicated (situations)? It feels like a triage almost. (Good) facilities are like valuing the patients

as human beings and important to the fabric of life. I've seen things like having children's books available. They're cognizant that this is an issue. (White)

In our community it is common to come across trauma issues and because of the historical (mis)trust, the clinic should have trained staff to deal with trauma issues. For example, a patient said, 'I had a stop by a police officer and I ended with felony charges with no prior record and I am currently fighting the court', I told the patient 'You are experiencing trauma.' ... You cannot give quality care if you do not understand the historical trauma before they come to the clinic for any type of medical treatment. (Black/African American)

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

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

Make sure that staff is trained in HIPPA. Privacy is important. Do not leave my private information for others to see. We do not trust doctors and we do not trust people with our information. Talk in a low voice instead of screaming. There are always people behind who can hear. ... Information should be private and treated with respect. This way I will come back to this clinic. (Black/African American)

NQF Domain: Structure for Equity

Clinics work with patients to improve care (i.e., patient advisors, advisory councils, and patients on governing boards, quality improvement, patient safety, and ethics teams)

Your experience/voice does matter: Be creative, accurate; measure discrimination; quantify feelings; ethnicity data; measuring race/ethnicity data--- Report Equity Care (policy/leadership/race/ethnicity) -- standards, respond to inequities, number of projects, striving towards equity care.

Clinic leadership should hire people who are Somali. For example, if the clinic is in neighborhood where Somalis live, they should hire interpreters from the community, but how much better (it would be) if they hired people from the community to provide services and to lead the clinic. (Somali)

How do systems quantify feelings of discrimination? How do they collect that? Systems want to know what the racist action that their personnel said or did. Do they collect

discrimination complaints? Do they know how many families feel discriminated against, based on their care? Are they collecting this data and if not, why not? How will they know if they have a problem? If they do not collect the data, maybe they are saying they don't want to know....In order to make a complaint, patients have to feel empowered, feel safe and not worried that clinics or staff will retaliate. In native communities, they often don't feel empowered enough to even complain at an official level. [...]Can the clinic help people effectively complain? Because their voices collectively matter. How do we tell communities that their voices and experiences matter? This is how we can get the system to listen to them. We may have to craft our own creative ways to collect that. (Native American)

In order to build trust, patients need (to) receive treatment from personnel who represent their own groups or from someone who is culturally competent in their language and culture. I heard a patient who was struggling with economic issues say, 'The doctor is telling me I have to eat a healthy, balanced meal, with fruits and vegetables. How am I going to tell my wife that, since we hardly have enough money to get some food?' When I asked the patient why he didn't tell the doctor the truth, he explained that it was embarrassing enough to have to tell the non-Latino doctor, but that the Spanish interpreter also would hear it. (Latino/a/x)

In order to make a complaint, patients have to feel empowered, feel safe and not worried that clinics or staff will retaliate. In native communities, they often don't feel empowered enough to even complain at an official level. [...]Can the clinic help people effectively complain? Because their voices collectively matter. How do we tell communities that their voices and experiences matter? This is how we can get the system to listen to them. We may have to craft our own creative ways to collect that. (Native American)

NQF Domain: Access to Care

What about the person who: I got my baby, my rent's not paid, my partner is being snarky, my kid's sick. Figuring out how to navigate that system would be even more work. We are not seen not heard. Systems are really hard to navigate on purpose. How do you disrupt that? If you see your parole officer by 2:00 pm? How would one figure out where to go to see your patient advocate and find your patient advocate? What if I am taking the bus? (LGBTQ2S)

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

A lot of community members, such as our elders, do not drive, do not know how to call a cab, or do not know how to use the bus system. They are dependent on calling

family members or friends, who are busy, to take them. The community could benefit from clinics that provide transportation, and support their complex needs. (Somali)

When I didn't have a home address, I had trouble getting my antidepressants filled. It was a nightmare. It was so challenging. (White)

NQF Domain: High-Quality Care

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

Those who go to clinics in the suburbs know their rights and they demand it. Here, we're taken for granted and staff abuse their roles because people who come in may not know their rights. I think that if we're serving low income people, we need to double our attention and educate these people and pay them enough to provide quality service. A smile does not cost anything, but it's a must have. (Hmong)

Sexual health issues: Sexual health is to be able to talk. Preparation protects you. Programs run by white middle class women from suburbia who believe in monogamy. Doesn't understand or value poly-amory, kink/fetishes. They tell us that this is sexual deviance. I don't like slut shaming, the whole sexuality shaming. [Outside of the clinic setting] being catcalled and being called geisha, hyper-sexualized or being called submissive. Health is respecting that. How many doctors could you say that to? For primary care. Men will openly pursue you, if you are a young kid, wear women clothes, and/or look effeminate. Men assume they have access to your body. You are there for their sexual needs. (LGBTQ2S)

Patients prefer to see same provider regularly so as to form a trusting relationship. Scheduling staff does not or cannot schedule appointments with same provider, therefore the patient usually does not share information that may be relevant to the reason for the visit.

The feeling of knowing the people of the clinic where the patient goes to for services. A sense of belonging. Front desk staff should have a friendly approach and manners as well as all other personnel from the front desk to the provider.

The feeling of being welcome makes a difference When patients evaluate services, patients can forget the poor service, but they never forget how they felt. Front desk is the key to patient's access to the clinic. Reception area must show and treat patients with respect. This area sets the tone for how the patient will perceive services and will want to return.

Good relationship with clinic staff is key to patient's perception. The patient is aware when he/she is not valued. I agree that patients perceive when staff does not treat patients respectfully and translate it as poor service.

We are a spiritual people. If a doctor or clinic won't let us follow our spiritual/traditional beliefs even after we explain how our beliefs might affect our health, and we explain to the doctor and they turn us away saying "No, that's no such thing" (then we close down.) But if a doctor knows and understands and says, "Okay, if that is what you think, then how about we can use both spirituality and medicine?", this can help us open up., . (and) we can seek help in all areas. This is really important for Hmong, especially for those who still believe in the traditional ways. (Hmong)

If we constantly think about the notion of who's healthy and who's not, then our concept of ourselves is distorted. We have to decolonize everything. We have to get native people to a lake to walk around it. To some of our people, that is a white thing to do and we have to remind them that this has been our land. We've always roamed it, we've always foraged, and we've always hunted. When we're trying to negotiate our health needs, we have to decolonize how we talk about fitness, how we talk about health and these concepts, especially in a community that is always in crisis mode. Our community is constantly trying to survive colonization because we are still being colonized. (Native American)

Health and healing are synonymous, either from historical or daily traumas. In native communities, we see how trauma impacts our health, even though we don't have the words for it, we see how trauma is a part of the story of our health. We define health by understanding how policies and racism impact our health because we have a general notion – treaty heavy in this area, sign treaties to ensure healthcare, to be healthy is a right – we know this in our teachings. Native communities struggle with being worthy of even being healthy and that's in the same vein as trauma. (Native American)

APPENDIX V: KEY REFERENCES

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