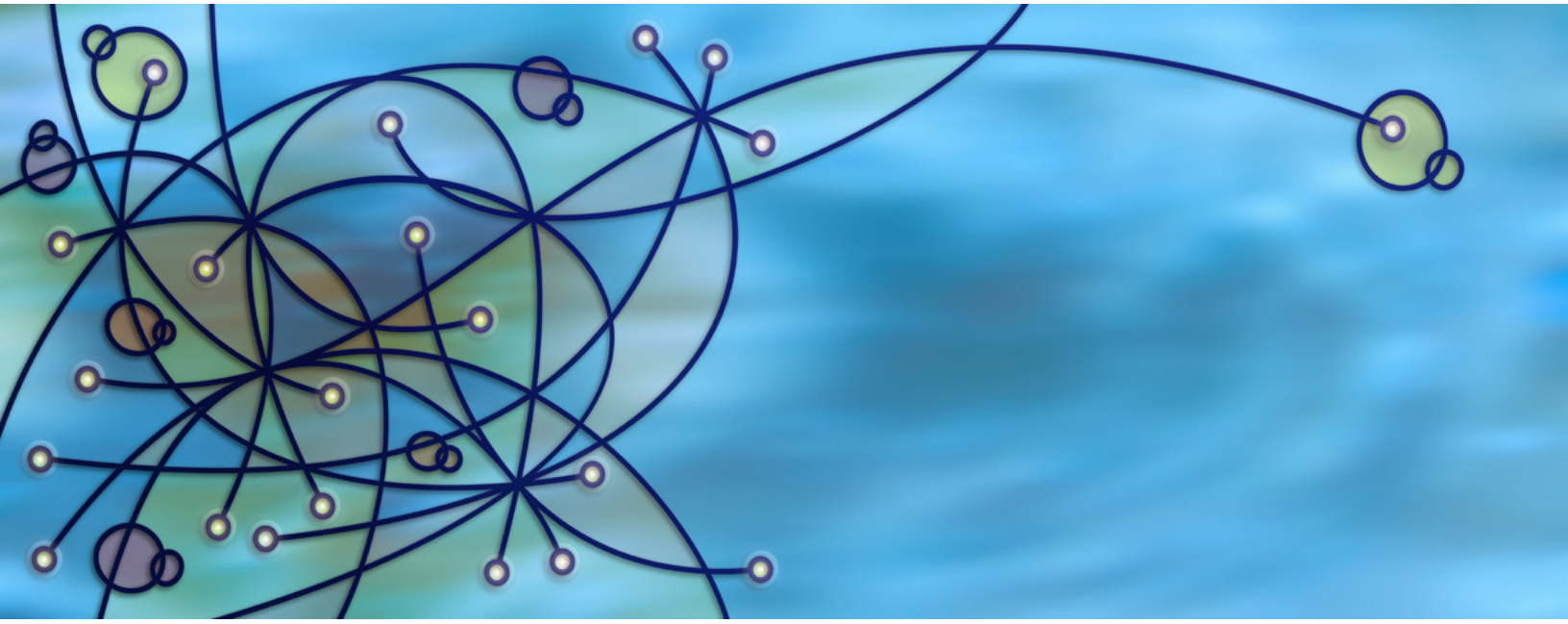
CONVERGENCE COLLOQUIA

Cultivating Serendipity for Action



Health Equity

September 25, 2015

Office of the Vice President for Research
University of Minnesota
Driven to Discover℠

Convergence Colloquia: Cultivating Serendipity for Action

The Convergence Colloquia are a new series of multi-disciplinary gatherings that advance cutting-edge research to develop innovative solutions and build long-term partnerships that improve our world. The University of Minnesota's Office of the Vice President for Research (OVPR) selected the topic of health equity for its third colloquium, held on Sept. 25, 2015.

The colloquia serve as action-oriented think tanks focusing on critical issues for our communities, from building smarter cities to exploring alternative energy sources to addressing water scarcity to securing our food supply, that bring together U of M researchers with private, public and nonprofit experts to identify strategic collaboration opportunities that can lead to significant impact at the local, state, national and global scales.

The colloquia grew out of recommendations from the U of M's research strategic plan, Five Years Forward, to promote a culture of serendipity that advances scientific discovery through collaborative thinking and action. Embedded in a strategic vision and action plan, the colloquia are grounded in a results-oriented approach that includes ongoing evaluation and reflection to ensure accountability and outcomes.

FIVE YEARS FORWARD - Vision and Cornerstones

Each workshop is intended to engage approximately 50-100 participants from a variety of disciplines and fields. Through facilitated sessions and focused dialogue, participants work to identify a set of strategic research priorities and explore opportunities for collaboration. Serendipity Grants are available to support follow-on collaborative research efforts that engage U of M researchers, along with public, private and nonprofit participants.

The health equity colloquium engaged nearly 80 participants from the U of M and public, private and nonprofit organizations. Participants represented 10 colleges and the University of Minnesota Duluth, as well as centers such as the Program in Health Disparities Research, Center for Integrative Leadership, U-Spatial, Institute for Child Development, and Institute on the Environment. Among experts from outside of the U of M were staff from 14 different nonprofit organizations, five local government agencies, the Minnesota Department of Health, Federal Reserve Bank of Minneapolis, and the Veteran's Administration Medical Center Minneapolis. A list of participants is included in Appendix A.

Colloquium attendees explored opportunities for collaborative research around health inequities as they relate to issues such as access to health care, exposure to health impacts and differential health outcomes. The event offered an opportunity to explore individual, social, community and environmental factors that contribute to inequity and consider innovative approaches to identifying health impacts and remedying inequities. The event convened experts from across a variety of topic areas to explore new research collaborations that can offer insights for policy and practice.

Converging on Health Equity

Health equity is emerging as a key topic of concern in Minnesota and the U.S. Evidence continues to mount relative to the nature of health inequities, their distribution across various populations and the multiple complex and often interacting factors that contribute to inequity. It is widely acknowledged that health inequities have significant costs for individuals and society and have impacts on quality of life and economic opportunity. Health equity also presents a significant challenge for health care providers and public health services, as they consider ways to meet the varying needs of the populations they serve and interface with structural inequities.

A significant influence on current discussions of health equity is the growing attention to social determinants of health. Figure 1 is a commonly referenced graphic that contextualizes individual characteristics (e.g. gender, age) and lifestyle factors relative to social and community networks, along with socioeconomic, cultural and environmental conditions such as housing, health care services, water and sanitation access, employment status and education. The U.S. Department of Health and Human Services' HealthyPeople.gov website identifies additional factors including availability of resources to meet daily needs, transportation options, public safety, social support, residential segregation, language/literacy, access to mass media and emerging technologies, social norms and attitudes such as discrimination, and culture.[1]

Figure 1. The Main Determinants of Health (Whitehead & Dahlgren. 1991. Policies and strategies to promote social equity in health. Stockholm: Institute for Future Studies)

This orientation toward social determinants expands the range of potential interventions and interveners beyond just individuals and health care providers. Health shifts to being understood as a community concern, wherein health can be hindered or enhanced by one's relationships, neighborhood characteristics, working conditions and more. Community physical characteristics are also relevant and include access to green space, exposure to toxic substances and hazards, physical barriers for people with disabilities and the built environment including sidewalks and bike lanes.[2]

[1]U.S. Department of Health and Human Services. 2015. HealthyPeople.gov. http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health.
[2]U.S. Department of Health and Human Services. HealthyPeople.gov.

The Centers for Disease Control and Prevention's (CDC) Healthy People 2020 report places particular emphasis on health equity and acknowledges the impacts of social determinants of health. In addition to its first goal of attaining high-quality, longer lives free of preventable disease, disability, injury and premature death, the remaining goals elevate equity and a broad view of health determinants:

- Achieve health equity, eliminate disparities and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development and health behaviors across all life stages[1]

CDC's 2013 Health Disparities and Inequalities Report offers data that highlights substantial inequities across a range of health outcomes, health risk behaviors and health care access by race, socioeconomic status, insurance status, education level, disability status and foreign born status.[2]

Participants share insights from small group discussions.

[1]U.S. Department of Health and Human Services. 2015. HealthyPeople.gov. http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health.
[2]Centers for Disease Control and Prevention. 2013. Health Disparities and Inequalities Report. http://stacks.cdc.gov/view/cdc/20865/cdc_20865_DS1.pdf.

The Minnesota Department of Health (MDH) has also elevated concerns related to health equity. In 2013, the agency established the Minnesota Center for Health Equity. MDH's 2014 Advancing Health Equity in Minnesota: Report to the Legislature acknowledged that while Minnesota, on average, ranks among the healthiest states in the U.S., health disparities are significant and persistent. The report takes the view that health "is a state of complete physical, social and mental well-being and not merely the absence of disease" and is affected by social, economic and environmental factors, as well as behavior and biology.[1] Acknowledging this broad range of determinants, factors such as structural racism and lack of economic and education opportunities are indicted as leading to inequity. The report calls out structural racism in particular as "producing cumulative and chronic adverse outcomes for people of color and American Indians."[2] The report offers seven recommendations intended to expand Minnesota's understanding and response to differences in health status that go beyond the individual to include social, historical and economic conditions. The recommendations include:

- Advance health equity through a health in all policies approach across all sectors
- Continue investments in efforts that currently are working to advance health equity
- Provide statewide leadership for advancing health equity
- Strengthen community relationships and partnerships to advance health equity
- Redesign MDH grant-making to advance health equity
- Make health equity an emphasis throughout the MDH
- Strengthen the collection, analysis and use of data to advance health equity[3]

MDH's recent focus on paid family leave and health, along with efforts by the City of Minneapolis to advance paid leave policies, have highlighted inequities in employment-related benefits. MDH's 2015 White Paper on Paid Leave and Health points to inequities in who has access to paid sick leave and family leave. Persons with lower incomes, part-time workers and single parents, including populations of color and American Indians, are less likely to have paid leave and are also experiencing disparities in health outcomes.[4] Equity in health care has also become a focus. Minnesota Community Measurement's 2014 Health Equity of Care Report highlights differences in health care outcomes, based on optimal care for chronic conditions and colorectal cancer screenings by race, ethnicity, preferred language and country of origin.[5] Another 2014 report targeted to MDH by Voices for Racial Justice and associated community partners, Advancing Health Equity by Making Racial, Ethnic and Socio-Demographic Disparities Visible in Minnesota's Health Care Quality Measurement System, calls for changes in how health

[1]MDH. 2014. Advancing Health Equity in Minnesota: Report to the Legislature. http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf, 5
[2]Ibid., 6.
[3]Ibid., 7.
[4]MDH. 2015. White Paper on Paid Leave and Health. http://www.health.state.mn.us/divs/che/2015paidleave.pdf.
[5]Minnesota Community Measurement. 2014. Health Equity of Care Report. http://mncm.org/wp-content/uploads/2015/02/2014-Health-Care-Quality-Report-FINAL-2.19.2015.pdf.

care data are collected and reported. The report offers a framework for improvements to the health data system to better identify and address disparities and calls for actions including improving the ways that health disparities are identified and measured; enhancing the consistency of measurement and data collection by agencies, health care providers and others; seeking better methods for obtaining data from patients by sharing information on how data will be used and why it is being requested; and protecting health data to ensure privacy and confidentiality.[1]

Directions in Health Equity Research

Research on health equity has seen a shift in recent years from a focus on healthcare and individual genetic and lifestyle factors to a broader set of social determinants of health. There is also growing attention to preparing health care professionals to serve the needs of underserved and disadvantaged communities. Indicative of this shift is the creation in the 1990s of the National Institutes of Health's (NIH) Office of Minority Programs. In 2010, NIH took further institutional action by forming the National Institute on Minority Health and Health Disparities (NIMHD) after recognition that there was still "unfinished business" toward "eliminating health disparities."[2] NIMHD provides research funding opportunities often focused on particular medical conditions or populations.[3] Another source of support for research on health equity is the Office of Health Equity in the NIH's National Institute for Child Health and Human Development. It provides research training grants to support engagement of diverse populations in health equity research and to build research capacity within universities in the U.S. and abroad.[4]

Outside of government, the Robert Wood Johnson Foundation has been a leader in advancing research and practice around health disparities. The Foundation is focused on building "a culture of health" that achieves its vision that "everyone has an equal chance to pursue a longer, healthier life."[5] Its current focus areas include child and family well-being, health coverage, health leadership and workforce, health system improvement, healthy communities and healthy weight. One of RWJF's current funding opportunities, Evidence for Action: Investigator-Initiated Research to Build a Culture of Health, is specifically focused on developing data and building a base of empirical

[1]Voices for Racial Justice. 2014. Advancing Health Equity by Making Racial, Ethnic, and Socio-Demographic Disparities Visible in Minnesota's Health Care Measurement System. http://voicesforracialjustice.org/wp-content/uploads/2014/10/RESD-Report-VRJ-01-26-15.
[2]National Institutes of Health. 2010. NIH Annonces Institute on Minority Health and Health Disparities. http://www.nih.gov/news-events/news-releases/nih-announces-institute-minority-health-health-disparities.
[3]NIMHD. 2015. Funding Opportunities. http://www.nimhd.nih.gov/funding.html.
[4]NIH National Institute of Child Health and Development. 2015. Office of Equity. https://www.nichd.nih.gov/about/org/od/ohe/Pages/overview.aspx.
[5]RWJF. 2015. How We Work. http://www.rwjf.org/en/how-we-work.html.

evidence to address key determinants of health, including around actions that can improve the health of marginalized populations. RWJF has also collaborated with the Pew Charitable Trusts on the Health Impact Project, which is building capacity and providing funding around health impact assessment (HIA) approaches that can be used to assess the health impacts of policies, projects, plans and programs, with a focus on revealing disproportionate health impacts on disadvantaged populations.[1] Blue Cross and Blue Shield of Minnesota has been a key partner with Pew on these efforts, providing grants for HIAs and related research in the state.

Health equity is also emerging as a key area of focus for the Committee on Institutional Cooperation (CIC), a collaboration of Big 10 universities plus the University of Chicago focused on sharing expertise and leveraging resources. The CIC's Health Equity Initiative is specifically focused on advancing collaboration between state departments of health and research universities to develop data around disparities, understand and address the social determinants of health and improve the health outcomes of vulnerable children and infants in the CIC region.[2] The U of M and MDH co-chair the leadership team for the Initiative.

Participants highlighted research needs and opportunities in small groups.

[1]Health Impact Project. 2015. http://www.pewtrusts.org/en/projects/health-impact-project.
[2]Committee on Institutional Cooperation. Health Equity Initiative. https://www.cic.net/projects/health-equity-initiative

Exploring Opportunities for Collaborative Research

The primary focus in organizing the colloquium was to advance dialogue and networking among attendees. The discussion was informed by a series of "catalyst presentations" that shared big ideas and innovations related to health equity. Presenters highlighted a range of health equity topics, including the social determinants of health and disparities, the availability and use of sociodemographic information within the health care system and innovative methods for positive intervention among underserved groups. The presenters shared information on these and other topics and explored the preliminary research and potential collaborators needed to move the work forward. Presentation abstracts, provided by the presenters, are provided below and on the next page. Presenter bios are included in Appendix C.

Catalyst Presentations

Integration: How Practical Research Agendas Can Launch (Institutional) Social Movements

Heather Britt, Director, Division of Applied Research, Allina Health

Curiosity about our own data around health disparities led to the initiation of a research agenda at Allina Health emphasizing equity. Secondary data analysis, small pilots, and an engaged clinical leader ultimately yielded the launch of a program focused on healthcare equity and closing the gaps in outcome data we see in our patient populations. Research endeavors currently span from sophisticated data analysis and understanding, internal and partner pilot interventions to close gaps, and understanding the equity environment within our institution. Programmatic focus areas reflect institutional needs and include data review and organizational scorecard alignment, efforts to increase and address diversity and inclusion in the workforce, scaled interventions to close gaps in care, and clinical leadership involvement and messaging for orghjanizational culture shift. Integration of meaningful efforts to yield institutional change and improvement in patient outcomes, coupled with an alignment of the research agenda with programmatic efforts, are all helping to meaningfully advance Allina Health's efforts around health equity.

The Importance of Place-Based Interventions in Promoting Health Equity

Yingling Fan, Associate Professor, Urban and Regional Planning Program, Humphrey School of Public Affairs, University of Minnesota

People with health disadvantages often live in segregated neighborhoods that suffer under-investment in infrastructure and amenities. In a special 2008 report on health equity, the World Health Organization recommended placing urban planning and neighborhood development at the heart of addressing health equity. Although residential segregation is part of the problem that has led to the unevenly-distributed resources in space, it points to the particular importance of spatially targeted health-promoting strategies. By modifying the environmental features in places people live and recreate, urban planners can be a powerful force in reducing avoidable health disparities. Yet, unlike family-based or individual-based interventions, place-based interventions by nature require deep community engagement. Access to the community is key to building a knowledge base at the intersection of urban planning and health equity.

Nothing About Us Without Us is For Us

Ana Isabel Gabilondo-Scholz, Health Equity Consultant, Voices for Racial Justice

This presentation will tell the story of a multiracial group of leaders who conducted conversations with members of their respective communities around their willingness to share sociodemographic information with the health care system. These conversations were rooted in the principles of Authentic Community Engagement and in elevating community's knowledge and power. Moreover, this participatory model is informing statewide policies around Data for Health Equity.

Catalyst Presentations (continued)

The Inner-City Epidemic: What's Driving Inequity in Asthma Hospitalization Rates?

Daniel Huff, Environmental Health Director, Health Department, City of Minneapolis

The rate of asthma hospitalizations is higher in poor and non-white populations. Multiple hypotheses are proposed for the cause of this disparity. Environmental Justice advocates point to the history of co-locating poor neighborhoods with polluting industry and major roadways, increasing resident's exposure to toxic pollution. Healthy Housing advocates cite studies showing increased incidence of asthma due to roaches, mold and other environmental conditions found in substandard housing. Health care experts highlight limited access to primary care in disenfranchised populations that leads to poor management of chronic conditions such as asthma. Each of these is likely drive disparities to some degree. Given limited resources, where do we, as a local public health agency, invest in order to achieve the best reductions in asthma disparities and return on our investment?

Innovation to Translation: Would Mobile App Intervention Improve Cancer Health Disparity?

Hee Yun Lee, Professor and Director of Research, School of Social Work, University of Minnesota

Korean American women have one of the lowest cervical and breast cancer screening rates across all racial/ethnic groups. To promote the receipt of Pap tests, HPV vaccination, and mammograms in this population, a Mobile Application based intervention to promote screening was developed and tested, and the interventions were found to be effective in promoting cancer screening. Current research focus is on translating the intervention model to other underserved racial/ethnic groups (e.g., Hmong/Somali American women) and other types of cancer screening (e.g., colorectal cancer screening). Next, translating the intervention method in a clinical setting by reaching out to health care insurance companies and hospitals will be pursed. While underserved communities in Minnesota are the target populations for this intervention, other parts of the country (e.g., western and southern states with high concentrations of underserved neighborhoods) and other countries (e.g., Rwanda or Ghana with high cancer mortality and morbidity rates) would certainly be impacted by the knowledge gained from this research and may benefit from a replication of this intervention model.

Optimizing Social, Environmental and Behavioral Change to Achieve Health Equity

Kola Okuyemi, Professor, Department of Family Medicine and Community Health; Director, Program in Health Disparities Research; Director, Minnesota Center for Cancer Collaborations, Medical School, University of Minnesota

The health of any community is determined by social, economic and environmental factors as well as individual behaviors and biology. A 2014 Report by the Minnesota Department of Health to the State Legislature documents significant and persistent health disparities experienced by minorities in the state that cannot be explained by biological factors alone. Inequities in social determinants of health including the physical environment of are major contributors to these health disparities. Therefore, in addition to promoting individual health behavior change, interventions designed to achieve health equity must identify ways to create social and physical environments that promote good health for everyone. In order to design and implement such innovative and comprehensive interventions, we envision the need to assemble transdisciplinary teams that include professionals not only from the health sciences but also from other disciplines such as education, social sciences, engineering, housing and urban development, business, policy, law, media, transportation, and agriculture, nutrition, and other related fields.

In addition to the catalyst presentations by U of M researchers and experts from Allina Health, the City of Minneapolis and Voices for Racial Justice, the Colloquium featured a presentation by MDH Commissioner Ed Ehlinger and U of M Senior Vice President for Academic Affairs and Provost Karen Hanson. The Commissioner shared comments around trends in health equity and the broadening focus on social determinants of health, including highlighting recent efforts by MDH around health equity. Provost Hanson offered insights on the CIC Health Equity Initiative, collaboration with MDH and next steps for interested researchers.

Key Questions and Potential Collaborations

Informed by the catalyst presentations, participants were invited to participate in small group discussions. The discussions focused on a set of questions about health equity that participants identified and expressed interest in exploring with others. A portion of the questions were identified at the meeting and others were identified from responses to a brief pre-survey completed at the time of registration.

Participants had the opportunity to self-select to table discussions that interested them and could participate in two rounds of discussion. For their table question, they were asked to explore three issues: (1) new insights or information needed to answer the question; (2) key assets (e.g. data, technology, expertise) that can be drawn upon to answer the question; and (3) new or existing collaborations that could be tapped to advance research on the question, including specific recommendations of stakeholders who should be involved. The table discussions were engaging and free-flowing. Key questions and insights from the table discussions are highlighted below.

1 ***How do we apply a racial justice lens to health equity?***

Participants noted a need for understanding the difference between individual views of what race is and more structural, societal constructions. They also noted the need to acknowledge multiple perspectives, removing the blame around racial disparities and understanding how to persuade people to see others' perspectives through non-polarizing stories about race. The group noted that data sets would be a valuable tool, especially those measuring resilience in the face of trauma, community assets and interactions among physical, emotional and spiritual health. The group targeted community assets as an antidote for health disparities and a source of resilience.

2 ***How can we better understand and account for the economic and societal costs of inequity?***

This discussion highlighted the need to understand correlation versus causation in health inequities. The participants also noted the importance of attaching political perspectives to the issue by moving the argument from moral grounds to economic grounds — for example, quantifying the value of correcting inequities and the costs of not acting on this issue. Participants also recognized the need to predict how much the gap, if not closed, may widen in the future. Models of successful efforts to advance greater equity are sought. As efforts take root in the community, researchers, stakeholders, politicians and community activists must work together to share stories about the groups who will benefit from raising social consciousness around health equity efforts.

3 ***How do we ensure authentic community engagement in research?***
In addressing this question, participants highlighted the need to engage communities to assess their own needs and identify their own strengths. Initial steps include establishing mechanisms and finding community advocates to conduct community-based participatory research (CBPR) and normalizing the research process within the community. Cultural beliefs and practices must be incorporated into the research methods to increase the authenticity of the data captured.

4 ***How can we better coordinate efforts of the health and social service sectors?***
Participants indicated a need to understand how health factors are incorporated into the evaluations that are conducted in all fields outside of public health, and to develop clarity around the problems of data and technology, including in "Health in All Policies" initiatives. The group also recognized a need to collect data across all population groups to locate disparities and to develop best practices based on insights from county models across the state. Geographically focused initiatives are key, though it is acknowledged that current systems can be difficult to access because they require residents to travel to receive support or services. Federally Qualified Health Centers (FQHCs), designated by the U.S. Department of Health and Human Services related to their provision of primary and preventive health care regardless of income and insurance status, are identified as a key partner. Linking FQHCs to social services, such as homeless shelters, food banks, etc. could help patients access a variety of services through health care facilities.

Heather Britt, Director of Applied Research at Allina Health, highlightss her organization's equity research agenda.

5 ***What do we need to know to better understand the intersection between health and environmental quality?***

In this discussion, participants highlighted the need to determine the most significant health impacts stemming from environmental quality and their intersection with income, race/ethnicity and other factors. Data available relative to the U.S. Environmental Protection Agency's National Ambient Air Quality Standards, along with local measurements, can help inform researchers about areas with poor air quality. To increase knowledge of air quality, mobile personal monitoring systems can be used, along with building inspections to investigate indoor conditions. An emphasis on natural and green spaces, which can buffer air pollutants, can also be included in city planning.

6 ***How do we measure health equity in Minnesota and ensure access to data?***

The discussion group highlighted a need to examine access to data, to re-examine the data that already exists and to assess data needs that advance key interventions for health equity. Participants identified an opportunity to create new partnerships and expand existing ones between the U of M and health care organizations to make better use of the data gathered. More flexible, responsive financing mechanisms are needed to support ala carte purchasing options, more tailored to the care needs of individuals. In rural areas, community service hubs can meet care needs and support rural economic development. Research needs specific to nursing homes include flexible workforce models supported by new technology and separating out post-acute care from nursing homes.

7 ***How can we better account for and understand social determinants of health?***

Participants targeted the need for more information about cultural factors that are important influences on health behaviors and beliefs. The group recommended implementing user-friendly means for identifying and connecting with people across disciplinary boundaries to form cross-disciplinary scientific collaborations. A community-engaged approach to research is seen as crucial to bringing various intellectual perspectives and areas of disciplinary expertise to the table. Data from all age groups will be needed to understand the impact of social determinants across the lifespan.

8 ***How do we create a public conversation about health, especially during an election year? How do we get the attention of decision makers?***

Participants in this discussion indicated a need for help from both communications and community experts in developing messages and framing the conversation around health equity. Public conversation on the subject must avoid "preaching to the choir." Participants also recognized a need to develop relationships with policymakers. Doing so can enhance understanding of how health equity can fit within policymakers' interests and agendas, identify barriers and explore the prospects for funding new models of achieving health equity.

9 ***How can we build community power and resilience to advance health equity?***

This discussion noted a need to identify the types of institutional racism that obstruct community integration. It was acknowledged that community input and engagement are essential to understanding why these obstructions persist. The U of M and nonprofit organizations must look to best practice models from around the country and work with strong community advocates to build community resilience and advance health equity.

10 ***What are the implications of the single payer system versus universal coverage for health equity?***

Participants discussed the need for information on the pros and cons of a single-payer health care system, as well as data on health equity in these systems and what problems such a system could solve, especially in terms of cost and complexity. Examining single-payer systems in different states and countries could provide useful insight on the system's effect on health disparities as well as highlight possible reductions in cost and possible benefits of de-coupling health care from employment. It was noted that future research would benefit from engaging state and local agencies, academics and health care providers.

11 ***What will it take for Minnesota to pay greater attention to communities of color and marginalized communities?***

In this discussion, participants identified the need for expanded decision making processes and engagement in order to advance health equity and public discourse around it. Involvement from industries, legislators and communities was specifically noted as essential to making progress. Participants indicated the importance of using technology, especially social media and data, to help spread knowledge of how inequity impacts everyone, as well as to spur political interest in the issue. New platforms have the potential to give communities, including smaller and underrepresented communities, the means and data they need to have a voice on health equity issues and build their cases for social and public policy change.

12 ***How do we establish mechanisms to do CBPR?***

In this discussion, participants aimed to address what was needed to establish community-based participatory research. It was emphasized that researchers must foster knowledge of the community and its issues, and build relationships and connections with the community. Interfacing with community organizations, especially those already accustomed to community-based research, can greatly help the effort. Inviting community leaders into regular meetings of the various organizations involved could help researchers understand local priorities and concerns that need to be accounted for.

13 ***How do we address new institutional barriers to health equity?***

Participants in this discussion group recognized the need to understand barriers related to health equity and determine the best ways to eliminate those barriers. Health equity was acknowledged as relating to more than just health institutions, but also intersecting with other institutions focused on, for example, transportation and social services. The discussion pointed to the need to examine models from other locations and disciplines and to the need for more university and community research.

14 ***How do we operationalize equity as distinct from diversity and inclusion?***

This group began its discussion by acknowledging that there are effective examples of relevant work and assets available. They also pointed to the need for greater attention to the resources that are available and especially to how they can be shared. Participants suggested that staff in health-related organizations need to understand the terminology of equity, especially as it is distinct from diversity (recognizing varied ways of being) and inclusion (access or being at the table). The group suggested that equity is about reducing health disparities among populations, particularly the prevalence of minority health concerns. Health equity was also positioned as the opportunity to be healthy and maintain health outcomes across varied populations. Key collaborators in advancing equity include workforce educators.

15 ***How do we encourage cross-sector collaboration to evaluate health equity using data?***

Participants highlighted that there are valuable research assets, such as health records, along with related data in social services, healthy eating, and community gardens. It was noted that chambers of commerce could look at the productivity of communities together with community organizations, faith-based organizations, horticultural societies and other groups to create a more complete health picture of a community using existing data. Such an effort would require significant collaboration across sectors.

16 ***How can we engage communities in an asset-based approach to health equity?***

Participants explored how an asset-based approach, as opposed to a deficit-based approach, to health equity might engage communities. Understanding what residents value about their communities as assets, such as faith, spirituality, healing, humor and food, can be helpful in revealing linkages to health. It was noted that engaging community members requires a non-judgmental setting in which stories can be shared that convey concepts of community resilience and at the same time maintains respect for cultural practices related to the community's health. Future collaborations should be proactive rather than reactive, bringing together community stakeholders to address health disparities and find out what can be done based on the data available.

Research Needs

Drawing on the questions and discussions highlighted above, some common themes emerge including the need for better data, engagement of decision makers, stronger cross-sector collaboration, and the development and sharing of best practices. As awareness of health equity continues to grow, addressing these needs will support ongoing actions and the emergence of new initiatives. The discussion points to an acknowledgement of the importance of the social determinants of health, reflecting an expanded view of health, its drivers and potential interventions that may be used to address inequities. In addition, linkages between health inequity and institutional racism are highlighted as a significant barrier that must be addressed in order to get to healthcare systems, health and social service systems and communities that foster equity.

Relative to future research on health equity, the discussion suggests a strong interest in community-engaged research. CBPR, with its focus on building knowledge of the community, building relationships and collaborating with community organizations, is positioned as a priority approach. Linkages between research and practice are seen as critical. Minnesota's strong base of health-focused nonprofits, healthcare organizations and public sector resources are acknowledged as priority assets. The ongoing collaboration of the U of M and the MDH relative to the CIC Health Equity Initiative represents an additional emerging opportunity. Priority research questions that emerged from the colloquium discussions and draw from across the topics noted on the previous pages are listed below.

Priority Research Questions:

1. What are the connections between community resilience and health equity and how can we enhance them in a manner that is responsive to local and cultural contexts?
2. What are the most effective methods for community engagement in research on health equity and how do we account for the long-term impacts of research – community collaborations?
3. How can we better account for and understand the full range of social determinants of health, such as the physical environment, working conditions, social networks and access to opportunity?

Colloquium Outcomes and Next Steps

The Health Equity Convergence Colloquium offered a valuable opportunity to build new networks and enhance existing connections among researchers and practitioners working on health equity issues. The event explored a range of individual, social, community and environmental factors that contribute to inequity and considered research, practice, community-based and institutional practices that might be pursued to advance health equity. The interactions allowed participants to share expertise and expanded the conversation about future priorities in health equity research and practice.

A post-event survey revealed favorable reactions to the colloquium, even though a smaller proportion of attendees completed the survey than for previous colloquia. Of those who responded to the survey, 94 percent strongly agreed or agreed that the event provided opportunities to meet people outside of their discipline and similar percentage indicated that it allowed them to meet people from both within and outside of the U of M. Nearly 44 percent noted that they met five or more new people at

Nearly 80 Colloquium participants shared their insights and networkd around health equity research and practice.

the event, with the remaining 56 percent indicating they had met three to four new people. All of the respondents agreed or strongly agreed that the colloquium provided productive opportunities for interaction among participants and half noted that the event revealed new prospects for engaging U of M and external partners. Over 60 percent expect to collaborate in the future with one or more people that they met at the event.

As noted earlier, attendees of each of the Convergence Colloquia are eligible to apply for Serendipity Grants to support the formation of and capacity building for new collaborative research teams. Qualifying research teams are required to engage diverse disciplinary perspectives and integrate U of M experts with those from the public, private and/or nonprofit sectors. Four proposals, engaging 29 unique participants, were submitted following the Health Equity Convergence Colloquium. Proposal participants included faculty and researchers from at least eight disciplines and from eight U of M colleges or centers. Practitioners from nine nonprofits, including health care organizations such as Allina Health, Blue Cross and Blue Shield of Minnesota and the Mayo Clinic, were included. Staff from two Minnesota state agencies and the Minneapolis Veteran's Administration Health Care Center were also represented on the proposal teams.

Proposals submitted for Serendipity Grants addressed the effects of providing frontline providers with demographic data on their patients, testing interventions to promote effective dialogue around race and racisim, addressing breast cancer disparities in rural Minnesota and examining health care knowledge and resources among parents and children enrolled in an early childhood education program. Funding decisions will be announced in December 2015.

Appendix A: List of Participants

Last	First	U of M Department/Center/Office	Employer
Allen	Michelle	Department of Family Medicine and Community Health, Medical School	University of Minnesota
Anugwom	Vivian		Allina Health
Apolinario-Wilcoxon	Antonia		MN Department of Human Services
Ayers	Jeanne		MN Department of Health
Ball	Jennifer	School of Journalism and Mass Communication	University of Minnesota
Bence	Ken		Medica
Bloomquist	Kristina		Medica Research Institute
Boone	Katy		Carver County Public Health
Britt	Heather		Allina Health
Burgess	Diana		Minneapolis Veteran's Affairs Health Care Center, University of Minnesota
Call	Kathleen	Division of Health Policy and Management, School of Public Health	University of Minnesota
Camp	Donna		Committee on Institutional Cooperation
Carbrey	Evelyn		
Carlson	Carla	Office of the Senior Vice President for Academic Affairs and Provost	University of Minnesota
Clark	Lara	Department of Civil, Environmental, and Geo-Engineering	Univeristy of Minnesota
Countryman	Melanie		Dakota County Public Health
Cunningham	Brooke	Department of Family Medicine and Community Health, Medical School	University of Minnesota
Dawood	Khatija		Hennepin County Public Health
Eder	Milton	Department of Family Medicine and Community Health, Medical School	University of Minnesota
Ehlinger	Ed		MN Department of Health
Englund	Michelle	Institute for Child Development	University of Minnesota
Epps-Burns	Dawn		Interfaith Action of Greater Saint Paul
Everson-Rose	Susan	Program in Health Disparities Research, Medical School	Univeristy of Minnesota
Fan	Yingling	Humphrey School of Public Affairs	University of Minnesota
Finnegan	John	School of Public Health	University of Minnesota
Fischer	Adam	University of Minnesota Foundation	University of Minnesota
Flores	Glenn		Medica Research Institute
Flynn	Eamon		MN Department of Health
Flynn	Priscilla	School of Dentistry	University of Minnesota
Forster	Jean	Division of Epidemiology and Community Health, School of Public Health	University of Minnesota
Gabilondo-Scholz	Ana Isabel		Voices for Racial Justice

Last	First	U of M Department/Center/Office	Employer
Grunewald	Rob		Federal Reserve Bank of Minneapolis
Hanson	Karen	Office of the Senior Vice President for Academic Affairs and Provost	University of Minnesota
Hardeman	Rachel		Mayo Clinic
Herman	Brian	Office of the Vice President for Research	University of Minnesota
Heyn	Michelle	University of Minnesota Foundation	University of Minnesota
Huff	Daniel		City of Minneapolis Public Health
Hunter	Lonna		MN Department of Health
Hurtado	Ali	Extension	University of Minnesota
Jefferson	Olivia		Blue Cross and Blue Shield of Minnesota
Johnson Athen	Alisa		Hennepin County Public Health
Keeler	Bonnie	Institute on the Environment	University of Minnesota
Kellerman	Brittany		CLUES
Kne	Len	U-Spatial	University of Minnesota
Knochel	Abel	Department of Social Work	University of Minnesota, Duluth
Kohler	Carla		CLUES
Krzyzanowski	Brittany	Department of Geography, Environment, and Society	University of Minnesota
Kwon	Melissa		National Asian Pacific American Women's Forum
Laird	Vanessa	Center for Integrative Leadership	University of Minnesota
Lee	Hee Yun	School of Social Work	University of Minnesota
Lewis	Ray		
Lindeke	Linda	School of Nursing	University of Minnesota
Maze	Haila		City of Minneapolis
McDonald	Lillian		tpt/ECHO
Moe	Vayong		Blue Cross and Blue Shield of Minnesota
Nguyen	Ruby	Division of Epidemiology and Community Health, Medical School	University of Minnesota
O'Brien	Mollie		Allina Health
Okuyemi	Kola	Program in Health Disparities Research, Medical School	University of Minnesota
Olson	Patricia	Extension	University of Minnesota
Orionzi	Dimpho		Allina Health
Osypuk	Theresa	Division of Epidemiology and Community Health, School of Public Health	University of Minnesota
Pergament	Shannon		West Side Community Services, SoLaHmo
Peterson-Hickey	Melanie		MN Department of Health
Plucinski	Melanie		American Indian Cancer Foundation
Pratt	Rebekah	Department of Family Medicine and Community Health, Medical School	University of Minnesota
Reilly	Jake		City of St. Paul
Riggs	Sheila	School of Dentistry	University of Minnesota
Ritchie	Mark		Minnesota World's Fair Bid Committee

Last	First	U of M Department/Center/Office	Employer
Schoen	Lynne	University of Minnesota Foundation	University of Minnesota
Scott	Doneka	College of Pharmacy	University of Minnesota
Seiber	Julianne		Saint Paul- Ramsey County Public Health
Shippee	Tetyana	Division of Health Policy and Management, School of Public Health	University of Minnesota
Sieving	Renee	School of Nursing	University of Minnesota
Silvis	Julia		Itasca Project, McKinsey and Company
Slotterback	Carissa	Office of the Vice President for Research	University of Minnesota
Snowden	Anne		Minnesota Community Measurement
van Ryn	Michelle		Mayo Clinic

Researchers and practitioners shared perspectives on key questions and research needs.

Appendix B: University of Minnesota Resources on Health Equity

The list below offers a sampling of U of M programs and centers that have the potential to connect to research on health equity. The list is not comprehensive, but offers valuable insights into the range of expertise and capacities for collaboration.

Center on Health Equity
http://www.umnche.umn.edu/
The Center for Health Equity (CHE), established in 2009, is a National Institutes of Health-designated Comprehensive Center of Excellence in Minority Health and Health Disparities supported by a grant from the National Institute on Minority Health and Health Disparities. The CHE is part of a network of more than 20 centers that focus on the elimination of disparities with the goal of achieving equity. In 2012, CHE integrated into the NIH Clinical and Translational Science Award-funded Clinical and Translational Sciences Institute, strengthening the University's efforts to promote health equity in Minnesota. The center works to create an informed, empowered and activated community that collaborates with researchers and practitioners to improve the health of their populations with the goal of health equity.

Center for Rural Mental Health Studies
http://www.med.umn.edu/about/our-campuses-duluth-and-twin-cities/duluth-campus/center-rural-mental-health-studies
The Center for Rural Mental Health Studies at the University of Minnesota Medical School, Duluth campus, seeks to better understand the factors that contribute to mental health and disorders in rural areas and the barriers to effective treatment. That knowledge will support the generation of better approaches to prevention, assessment and treatment that fit in rural settings financially, culturally and geographically. The center engages a multidisciplinary group bringing together the efforts of health care professionals in psychology, family medicine, psychiatry and nursing. Together, these experts develop initiatives in mental and behavioral health care, which includes prevention, intervention, health promotion and compliance with treatment recommendations. The center aims to create a system of mental health care that fits the unique challenges of a rural setting.

Health Equity Work Group
http://www.sph.umn.edu/research/hewg/
The U of M School of Public Health is committed to reducing health disparities through its research, teaching and community outreach programs. The school's Health Equity Work Group was founded with the goals of promoting and providing greater visibility to health inequalities research; strengthening collaborative efforts; creating lasting partnerships between faculty and community-based organizations; and ensuring public health students are well-trained to work in a diverse society. Disparities research broadly encompasses the study of inequities in attaining optimum health or accessing quality health care among social groups within a population.

Health disparities research further investigates how these gaps are created and sustained, and potential practice and policy solutions for eliminating disparities. Current research focuses on racial and ethnic disparities, but the theoretical and empirical models used have been extended to other types of social disparities, including socio-economic status, gender, sexual orientation, geographic location, disability and age.

Oral Health Disparities and Community Health Research Cluster
http://www.dentistry.umn.edu/research/clusters/disparities/index.htm
The Oral Health Disparities and Community Health Research Cluster, one of six research clusters at the U of M's School of Dentistry, focuses on decreasing parental risk-related behaviors for early childhood caries and dentist's attitudes towards the expanding role of non-dentists. Additional research in behavioral sciences measures patients' perception of effects of dental intervention, which will allow effects from all oral interventions to become comparable, aiding dentists and patients in their evaluation of treatment. The school maintains a network of outreach clinics that serve patients in rural and underserved communities, and increased collaborations are forming between dentistry faculty and the School of Public Health. Opportunities for increased research in this area are due to collaborations with HealthPartners of Minnesota and the recently awarded National Dental Practice Based Research Network, as well as the addition of the dental therapy program with a focus on underserved populations.

Program in Health Disparities Research
http://www.healthdisparities.umn.edu/
The Program in Health Disparities Research, housed within the U of M Medical School, brings together a transdisciplinary team to eliminate health inequities by developing, implementing and evaluating cutting-edge solutions through collaborative research, innovative education and trusted community partnerships in Minnesota and beyond. The program's objectives include creating a supportive academic home for outstanding health disparities researchers; engaging communities in initiatives aimed at reducing health inequities; building interdisciplinary collaborations within the University and beyond; conducting cutting-edge, extramurally-funded research that focuses on the independent and combined effects of biological, behavioral, social, community, and policy determinants of health disparities; developing the next generation of health disparity researchers through mentoring and training; supporting and expanding diverse academic and community educational programs; and promoting an organizational emphasis on meaningful research with potential for high community impact.

Research for Indigenous Community Health Center
http://www.pharmacy.umn.edu/rich/index.htm
As an intercollegiate collaboration between the U of M College of Pharmacy and the Medical School on the University's Duluth campus, the Research for Indigenous Community Health (RICH) Center aims to provide an interdisciplinary center for research collaborations with indigenous entities. RICH further aims to foster scholarly works that will identify health barriers and protective factors to increase healthcare equity for Indigenous patients. The center aims to decrease American Indian health disparities and increase American Indian health equity through culturally respectful and responsive research collaborations involving U researchers, U affiliates and interested tribal communities.

Dr. Yingling Fan, Associate Professor in the U of M' Humphrey School of Public Affairs, shared insights from her research on healthy communities.

Appendix C: Presenter Biographies

Integration: How Practical Research Agendas Can Launch (Institutional) Social Movements

Heather Britt, Director, Division of Applied Research, Allina Health

Heather Britt is a behavioral epidemiologist and catalyst for research at Allina Health. She is the director of the Division of Applied Research, Allina Health's care delivery and population health research team. Dr. Britt facilitates research agendas and collaborative conversations, participates actively in research teams, and seeks to grow and position research appropriately within the organization. She has special interests in population health and equity, primary care, and late life. Prior to her current role, Dr. Britt was a prevention research scientist with the Minnesota Department of Education's Safe and Healthy Learners team, following time as a researcher at the Urban Coalition, a community-based organization focused on research and advocacy with low-income communities and communities of color. Dr. Britt holds a bachelor's in biology from Cornell University, a master of public health degree in health behavior from the University of North Carolina, and a Ph.D. in epidemiology from the University of Minnesota. She lives in St. Paul and is a huge fan of her two children — Maddy, age 12, and Henry, almost 10.

The Importance of Place-Based Interventions in Promoting Health Equity

Yingling Fan, Associate Professor, Urban and Regional Planning Program, Humphrey School of Public Affairs, University of Minnesota

Yingling Fan is Associate Professor of Urban and Regional Planning at the University of Minnesota. She studies the health and social impacts of land use and transportation planning. Her recent work focuses on employment accessibility and social mobility, transit-oriented development, and access to green space and health disparities, all informed by a strong social equity perspective. Fan holds the title McKnight Land-Grant Professor — a special award that recognizes and honors the University of Minnesota's most promising junior faculty.

Nothing About Us Without Us is For Us

Ana Isabel Gabilondo-Scholz, Health Equity Consultant, Voices for Racial Justice

Ana Isabel Gabilondo-Scholz works alongside communities to change policies and practices to better serve their needs and overall well-being through participatory access and evaluation. She has worked on different research and community engagement projects with Voices for Racial Justice, Waite House, El Colegio Charter School, Governor Dayton's Office, National Community Reinvestment Coalition and Urban Research and Outreach Center. Gabilondo-Scholz recently graduated with a master of public policy degree from the Humphrey School of Public Affairs at the University of Minnesota. Gabilondo-Scholz is originally from the border, El Paso, Texas, and Ciudad Juarez, Mexico, where she learned the complexities and beauty of growing up in a binational and bicultural environment.

The Inner-City Epidemic: What's Driving Inequity in Asthma Hospitalization Rates?

Daniel Huff, Environmental Health Director, Health Department, City of Minneapolis

Daniel Huff serves as the Environmental Health Director for the Minneapolis Department of Health. Huff earned a bachelor's degree in biology from the University of North Carolina at Greensboro, a master of public affairs degree from the Humphrey Institute at the University of Minnesota, and is now a registered environmental health specialist. He began his professional career as a high school science teacher, where he earned multiple awards including teacher of the year. Subsequently, he operated a water treatment and hydroelectric plant for a retreat center in the north Cascade Mountains, coordinated water resource programs through the University of Minnesota Extension and directed policy and advocacy for a local nonprofit. Daniel has been at the City of Minneapolis for nine years.

Innovation to Translation: Would Mobile App Intervention Improve Cancer Health Disparity?

Hee Yun Lee, Professor and Director of Research, School of Social Work, University of Minnesota

Dr. Hee Yun Lee is a Professor and Director of Research at the School of Social Work, University of Minnesota, Twin Cities. She earned bachelor's and master's degrees at Seoul National University, Seoul, South Korea, and a master and Ph.D. in social welfare at the University of California, Los Angeles. Her major research areas is cancer health disparity among underserved populations, with particular attention to immigrants and refugees. Using mobile health (mHealth) technology and community-based participatory research approaches, she is developing, testing and translating intervention programs to promote cancer screening behavior. Dr. Lee is currently conducting four research projects that focus on developing interventions for cancer screening behavioral change in the United States and Korea, funded by NIH/NCI, U.S. Department of Defense, Susan G. Komen for the Cure Foundation and the Korean Ministry of Health and Welfare. Dr. Lee was selected as a 2012 NIH Clinical Translational Science Institute KL2 Scholar. Her work has been widely published in medical and public health journals, and she has been invited to speak at numerous national and international scientific conferences.

Optimizing Social, Environmental and Behavioral Change to Achieve Health Equity

Kola Okuyemi, Professor, Department of Family Medicine and Community Health; Director, Program in Health Disparities Research; Director, Minnesota Center for Cancer Collaborations, Medical School, University of Minnesota

Dr. Okuyemi is a tenured Professor in the Department of Family Medicine and Community Health at the University of Minnesota. He is also Director for the U of M Program in Health Disparities Research. His career over the past two decades has been devoted to research and programs to improve the health of underserved populations and eliminate health disparities using culturally tailored interventions. Over this period, Dr. Okuyemi's research has been continuously funded by several NIH institutes and centers. He has published more than 120 scientific papers in peer-reviewed journals.

Edward Ehlinger, Commissioner of Health, Minnesota Department of Health

Edward Ehlinger, M.D., MSPH, was appointed Commission of Health for the Minnesota Department of Health in January 2011. In this role, he is responsible for directing the work of the state's lead public health agency, which is responsible for protecting, maintaining and improving the health of all Minnesotans. Prior to being appointed commissioner, Ehlinger served as director and chief health officer for Boynton Health Service at the University of Minnesota from 1995 to 2011. He has served as an adjunct professor in the Division of Epidemiology and Community at the U of M School of Public Health and previously worked as director of Personal Health Services for the Minneapolis Health Department.

Karen Hanson, Senior Vice President for Academic Affairs and Provost, University of Minnesota

Karen Hanson, Ph.D., is senior vice president for academic affairs and provost of the University of Minnesota, a position she has held since February 2012. As the University's chief academic officer, she oversees colleges and academic units as well as the policies and practices that affect academic life. Previously, she was provost at the Bloomington campus of Indiana University and executive vice president of that university. A Minnesota native who began her career as a U of M undergraduate in philosophy and mathematics, Hanson is also a distinguished scholar and teacher of philosophy, with research interests in the philosophy of mind, ethics and aesthetics, and American philosophy.

For more information, visit: research.umn.edu/convergence

Produced by the Office of the Vice President for Research.