Strategic Plan: 2015-2019 Minnesota Department of Health

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MDH Minnesota Department *of* Health

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Central Challenge

The Minnesota Department of Health (MDH) exists to protect, maintain and improve the health of all Minnesotans. MDH is a premier state health department and has experienced many successes in its efforts to:

- Promote health throughout the lifespan;
- Make physical environments safe and healthy;
- Prevent the occurrence and spread of disease;
- Prepare for and respond to disasters and emergencies;
- Help all people get quality health care services; and
- Assure strong systems for health.

MDH works to meet its goals [PDF] through a variety of highly regarded programs and activities that range from education and technical assistance to regulation. While MDH is proud of its success in keeping Minnesotans healthy, we acknowledge (as stated in the 2014 report to the Legislature, *Advancing Health Equity in Minnesota* [PDF]) that "the opportunity to be healthy is not equally available everywhere or for everyone in Minnesota." The data in *The Health of Minnesota* are clear; there is ample evidence that the populations experiencing the greatest disparities in health status are also the populations experiencing the greatest inequities in the opportunity for health, in education, income, health care, and living environments. The data are also clear that race is a significant factor; greater inequities are evident for American Indians, African-Americans, and persons of Hispanic/Latino and Asian descent.

Because of this, MDH has identified advancing *health equity* as the central challenge facing state, local and tribal health departments in Minnesota and across the nation. Public health must move beyond addressing the symptoms of health inequities and begin to address the root causes including *structural inequities* and *structural racism*. If progress is not made towards health equity—where all persons, regardless of race, income, creed, sexual orientation, age, gender, or geography, have the opportunity to reach their full health potential—continued progression towards making Minnesota the healthiest state will not be possible.

Key Terms

Health Disparity: A population-based difference in health outcomes (e.g., women have more breast cancer than men).

Health Inequity: A health disparity based on inequitable, socially-determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). Because health inequities are socially determined, change is possible.
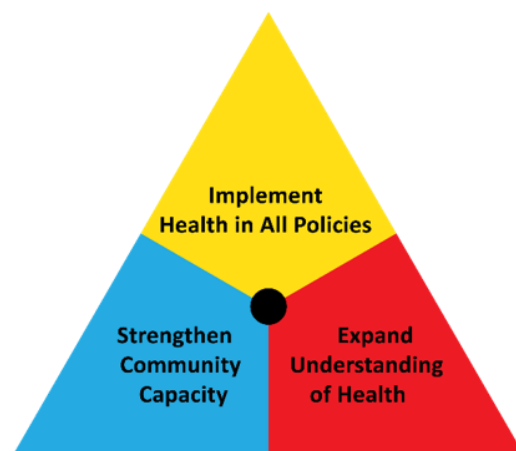
Health Equity: When every person has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Structural Inequities: Structures or systems of society—such as finance, housing, transportation, education, social opportunities, etc.—that are structured in such a way that they benefit one population unfairly (whether intended or not).

Structural Racism: The normalization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

Strategic Imperative

In order to reach its goals and ultimately achieve a state where everyone in Minnesota has the opportunity to be healthy, regardless of race, ethnicity, gender, social class, or geography, MDH must become better equipped to advance health equity by integrating the following **practices** into all of its work.

Many attribute good health to personal choices and excellent medical care. These do influence health and are important, but in reality, clinical care is a relatively small contributor to a person's overall health—around 10 percent. Some models suggest that the biggest contributors to health are socio-economic factors, like education, income, individual and community-level wealth, transportation and housing. Looking at the conditions that create or limit opportunity provides important perspectives for understanding both the nature and the sources of disparate health outcomes, and also helps point to viable and effective solutions. We need to **expand our understanding of what creates health**.

In order to advance health equity, the "science" of public health must be combined with lived experience and community wisdom. Minnesota has a long history of partnership between state and local health departments, as well as stakeholders in health care and community organizations. We should build upon this rich experience and expand relationships to include the communities experiencing the greatest health inequities as a means to identifying and implementing more effective solutions. We need to acknowledge that communities themselves need to be involved in creating policies and systems that improve conditions for their residents. We need to **strengthen the capacity of communities to create their own healthy future**.

By taking a broader view of what creates health, we can better understand how policies related to transportation, housing, education, public safety or environmental protection can affect health outcome. "Health in all policies" is a collaborative approach that integrates and articulates health considerations into policy making across sectors, and at all levels, to improve the health of all communities and people. Health in all policies emphasizes the need to collaborate across sectors to achieve common health goals, and is an innovative approach to the processes through which policies are created and implemented. Health in all policies without a focus on equity, may lead to unintended structural inequities. We need to **implement a "health in all policies" approach with health equity as the goal**.

Vision, Mission, and Values

The strategic planning process and the identification of advancing health equity as the central challenge facing public health led MDH to the conclusion that their existing vision statement—"keeping all Minnesotan's healthy"—had some limitations. For example, the vision started with the assumption that all Minnesotans are healthy; did not paint an inspiring picture for the future; nor did it convey a broader understanding about what creates health. In addition, MDH recognized that their attempt to be inclusive with the phrase "all Minnesotans" might have the unintended effect of excluding those who may not consider themselves "Minnesotan." In response to the concerns a number of new vision statements were drafted, discussed and vetted within MDH. Draft statements were also vetted with a targeted group of partners to insure the statement's inclusivity of all people in Minnesota.

In November 2015, MDH adopted a new vision:

The MDH vision is for health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy.

The MDH mission, as outlined in state statute is to:

Protect, maintain and improve the health of all Minnesotans

The MDH values were developed in 2008 through an extensive employee input process:

- *Integrity: We are honest, trustworthy, and transparent in all we do. We strive to do the right thing to achieve the best public health outcomes.*

- ***Collaboration****: We value the diversity and unique contributions of our employees and partners. We develop positive relationships, foster innovative solutions, and strengthen our capacity to accomplish our mission.*
- ***Respect****: We uphold a standard of conduct that recognizes and values the contributions of all. We foster a working environment in which listening to and understanding our differences is encouraged and confidences are protected.*
- ***Science****: We use the best scientific data and methods available to guide our policies and actions to promote healthy living in Minnesota. We rely on the objective facts of evidence-based science to build a strong foundation to address health needs and concerns.*
- ***Accountability****: We are effective and efficient managers of the public trust and public funds, and hold ourselves and others to appropriate high standards. We operate with open communication, transparency, timeliness, and continuous quality improvement.*

As a kick-off to this strategic planning process the values were revisited to ensure they were still relevant and to assess if they needed to change in light of the department's growing focus on health equity. Findings from an employee survey indicate that:

- Current MDH values resonate broadly.
- Equity, social justice, community, innovation, quality improvement, and compassion may be missing or understated in the current values statements.
- MDH is fairly divided on how to incorporate health equity into current values statements. Some felt it was already captured; some felt it should be explicitly incorporated as a value; and some felt health equity belonged in the vision and/or mission statements.
- Visible demonstration, support, and accountability of the values are more important than the words on paper.

In light of the findings, MDH decided to keep their current values statements and look for ways to use them more intentionally.

Environmental Scan

MDH sought to answer four key questions prior to moving into strategy development.

1. What are the external trends and factors we need to pay attention to?
2. What is the capacity of our workforce? What are the strengths and gaps?
3. How is MDH performing? Where do we excel and where do we need to improve?
4. What do our partners need from us?

In addition, the four questions were viewed with advancing heath equity in mind. The Organizational Characteristics and Workforce Competencies for Addressing Health Inequities (see table below) developed by the Bay Area Regional Health Inequities Initiative (BARHII)[1] and used by the National Association of Chronic Disease Directors[2] were adapted by MDH and considered as part of the environmental scan.

Organizational Characteristics	Workforce Competencies
Institutional commitment to and accountability for addressing health inequities Hiring to address health inequities Structure that supports true community partnerships Supporting staff to address health inequities Transparent and inclusive communications Institutional support for innovation Stable and adequate funding Community-accessible data and planning Streamlined administrative processes	Personal attributes such as passion, self-reflection, listening skills and a commitment to health and equity for all Knowledge of public health framework (e.g., Ten Essential Services, public policy development, advocacy, data) Understanding the social, environmental, and structural determinants of health Knowledge of affected communities Leadership Collaborative skills Community organizing skills Problem solving ability Cultural competency and humility

External Trends

MDH recognized a number of factors will impact the way public health departments do their work in the future including: changing demographics of our state and nation; advanced technological capabilities and the public's desire to have real-time data and information; and changes in access to and delivery of health care driven by the Affordable Care Act. In addition, there is an increased understanding of and focus among national public health organizations and leaders in the field on what creates health, the causes and impacts of racial inequities and the need to move even further upstream. These factors and context provide opportunities and challenges for public health departments to work differently. New practices are emerging in Minnesota and across the nation as seen in publications such as the National Association of City and County Health Officials' *Expanding the Boundaries: Health Equity and Public Health Practice*. There is also acknowledgement that public health originated with a focus on social justice and reform, thus moving forward, public health can draw on its past.

MDH Workforce

MDH has approximately 1,500 employees that carry out a broad array of functions including grant management, research, surveillance, regulation and policy development. The MDH 2014 all-employee survey highlighted a number of department strengths including 74 percent of respondents were satisfied with MDH as a place to work. Survey results also indicated that MDH employees respect and admire their colleagues; are dedicated and committed to the MDH mission; and are proud of the expertise and quality of work at the department. The 2014 survey also highlighted some challenges. Overall employee morale (56 percent) is lower than employee satisfaction (74 percent) and there was wide variation across the department (25-96 percent). Survey results also called attention to concerns about siloed programs, lack of advancement opportunities, outdated technology, and varied leadership skills.

The MDH workforce is largely white and female. MDH workforce data from April 2015 indicate 12 percent of its workforce are persons of color and 6 percent indicate they have a disability. These numbers are up slightly from the previous year and MDH is engaged in efforts, as outlined in their 2014-2016 Affirmative Action Plan, to hire both professional and technical employees from underrepresented groups. The 2014 MDH report to the legislature, *[Advancing Health Equity in Minnesota](...)* [PDF]outlined a number of actions MDH should take in order to identify and address changes needed in the MDH workforce to advance health equity including: commit additional resources in recruitment and retention efforts; review position minimum qualifications and remove barriers to employment at MDH; and strengthen employee orientation and training. Limited progress has been made on these recommendations to date.

While it is clear there is institutional commitment to advancing health equity, to-date there have been limited department-wide efforts to build workforce competencies in the areas of cultural competency and humility; community organizing skills; and understanding the social, environmental, and structural determinants of health.

MDH Performance

In June of 2014 MDH was accredited by the Public Health Accreditation Board. The review highlighted many strengths including Minnesota's state health assessment, *[The Health of Minnesota](...)*, which served as a foundation for this strategic plan. The review also highlighted areas where improvement is needed including the systematic use of performance management to monitor achievement of organizational objectives. Internal discussions have highlighted silos in funding and technology; challenges related to decision-making and communication; limited standardization in data collection, analysis and sharing; and administrative processes that hinder rather than support program implementation. Institutional support for innovation is not readily apparent and 2014 employee survey data indicates that employees do not feel like they can collaborate across agency programs.

MDH is proud of its strong partnership with local public health departments and recognizes the need to have stronger partnerships with others who have a role in improving population health including community leaders and community-

based organizations. MDH has recent examples of successful efforts to work with the community to address issues, such as Ebola monitoring and response. Yet, there remains a need for more authentic community engagement efforts.

Partner and Community Input

Over the course of the past two years MDH has initiated a number of structured engagement efforts to better understand the perspectives of those experiencing health inequities in Minnesota. These engagement efforts included inquiry sessions to inform the Advancing Health Equity in Minnesota report, American Indian Community Meeting and Stakeholder Input Process to inform health improvement strategies, community input to inform the Stratifying Health Care Quality Measures Using Socio-demographic Factors report, and input from the Eliminating Health Disparities Initiative grantees to inform future requests for proposals. In addition MDH reviewed feedback received from its traditional partners in local public health and healthcare. The following themes were identified across engagement efforts:

- MDH must recognize that its current policies, programs and practices reflect its largely white workforce.
- Silos and fragmentation across the MDH organizational structure and programs are visible and pose real internal and external barriers.
- MDH must recognize a community's experience and expertise.
- Data must be collected and shared in good faith.
- MDH partners are looking for leadership and follow-through.

Strategies for Moving Forward

While MDH has recognized the need to advance health equity for some time, efforts to advance health equity have not been systematic or coordinated across the department. This strategic plan moves beyond having a cross-cutting goal or a subset of employees assigned to advance health equity. The practices laid out above are meant to become a part of the cultural fabric of the organization. MDH realizes that a change of this magnitude will not happen overnight. We also recognize that we are not starting from scratch, some of this work is already happening and can serve as a starting point for others. MDH is committed to intentionally changing the way we approach our work over the next four years using the following strategies:

Build a shared understanding and internal capacity for advancing health equity.

MDH leadership and staff cannot be expected to do this work without support. In order to be successful, they need the space, time, skills and resources needed to look at their existing work through a different lens. This strategy cannot be accomplished through a training alone; we must provide the time and space for personal growth and the opportunity to learn from others.

Identify and creatively address barriers to working differently.

MDH operates in a governmental bureaucracy with formal lines of accountability, longstanding rules, and interpretations of those rules. Its primary funding sources are inflexible and while innovation exists it is not the norm. In order to operate differently, MDH must think differently. MDH must allow itself to challenge the status quo and think outside of the box. This work will require leadership at all levels of the organization.

Change systems, structures, and policies that perpetuate inequities and structural racism.

In order to reach beyond addressing the symptoms of health inequities and begin to address the root causes of health inequities MDH must understand that people created the systems within which we operate. Therefore, people can

dismantle and rebuild the systems to be more equitable. MDH not only has a role in changing public policies, but also taking a hard look at and changing its own policies.

Listen authentically to and partner with communities.

MDH has much to learn from communities. MDH must acknowledge and honor the knowledge and lived experience of communities. MDH must shift the way it partners with communities so that solutions are identified and implemented in partnership with communities. MDH should seek opportunities to share decision-making with populations experiencing inequities as a means of strengthening outcomes that will ultimately advance health equity.

Improve the collection, analysis, and use of data for advancing health equity.

Data is an important tool for spurring action. In order to support the need for action, MDH needs to expand the range of data we collect, including data describing smaller ethnic and cultural communities, and data that shows which conditions, public policies, and economic systems ultimately affect our health. Collection of data alone will not lead to better outcomes. MDH must engage the community to ensure we understand what the data is telling us and ensure its use. In addition, MDH needs the IT infrastructure to support the collection and sharing of data.

Communicate our commitment to advancing health equity.

MDH wants this plan to be used; we are committed to advancing health equity and believe this plan will move us in the right direction. We also recognize that this work cannot be done alone; we must support our partners in their efforts to advance health equity. In order to be successful we must be clear about our intentions both internally and publically; we must share and learn from our successes and failures; and we must hold ourselves accountable to making progress.

Four-Year Goals and Objectives

Strategy: Build a shared understanding and internal capacity for advancing health equity.

MDH employees have the space and time for conversations about structural racism.	60 percent of staff agree that colleagues they interact with at MDH are comfortable talking about race and racism by December 31, 2019.
MDH makes available training on how to advance health equity.	100 percent of staff agree that in the last year their section has engaged in group discussions about how their work could advance health equity by December 31, 2019. 80 percent agree they understand how to advance health equity as part of their job by December 31, 2019.
MDH shares tools, resources, and practices across the department.	At least one new tool, resource and/or practice will be added to an internal repository every quarter between June 2016 and December 2019.
MDH supports directors, managers, and supervisors to lead efforts to advance health equity.	75 percent of staff agree that directors, managers and supervisors at MDH are comfortable talking about race and racism by December 31, 2019. 90 percent of directors, managers, and supervisors agree they understand how to advance health equity as part of their job by December 31, 2019.

Strategy: Identify and creatively address barriers to working differently.

Funding supports the three practices for advancing health equity.	50 percent of grants applied for by MDH will include one or more of the three practices for advancing health equity by December 31, 2019. At least one new funding source for advancing health equity work is received each year between January 2016 and December 2019.
Internal administrative processes are efficient and effective.	80 percent of staff agree that administrative processes support program work by December 31, 2019. Two administrative processes will undergo a quality improvement process each year between January 2016 and December 2019.
MDH identifies and addresses barriers.	80 percent of staff agree they are supported to be creative in addressing new challenges or overcoming constraints to advancing health equity by December 31, 2019.

Strategy: Change systems, structures, and policies that perpetuate inequities and structural racism.

MDH partners with policymakers to make changes in public policy.	Identify two public policies (that are not traditionally public health or health care policies) and make the link to health each year between January 2016 and December 2019.
MDH applies health equity questions to all new and existing internal policies, programs, and practices.	100 percent of MDH policies have undergone a health equity review by December 31, 2019. 100 percent of MDH programs have completed a health equity review by December 31, 2019.
MDH examines and redesigns hiring processes to eliminate institutional barriers to diversity and inclusion.	Barriers to diversity and inclusion in the MDH hiring process will be identified and a plan will be developed to address them by December 31, 2016. Additional objectives will be added once barriers are identified.
MDH examines and redesigns its grant-making process with a health equity lens.	100 percent of new, MDH initiated RFPs undergo a health equity review by December 31, 2019. 50 percent of new, MDH initiated RFPs are developed with input from the communities they are intended to impact by December 31, 2019.

Strategy: Listen authentically to and partner with communities.

MDH develops and implements a community engagement plan.	80 percent of staff agree that MDH has clear expectations for how we work with the community by December 31, 2019.

MDH partners with communities experiencing health inequities.	75 percent of staff indicate that telling community leaders and/or community based organizations what changes were made as a result of their input is routine practice by December 31, 2019.
	50 percent of staff indicate that including community leaders and/or community based organizations in program decision-making is routine practice by December 31, 2019.
	60 percent of staff agree that MDH is responsive to community stakeholders' feedback on its work by December 31, 2019.
	75 percent of MDH programs that work with tribes will co-create strategies/objectives with tribal nations by December 31, 2019.
	50 percent of new, MDH initiated RFPs are developed with input from the communities they are intended to impact by December 31, 2019.
MDH aligns its advisory committees' structures, membership, and processes to advance health equity.	75 percent of MDH Advisory Committee members agree that they know how their input has made a difference by December 31, 2019.
	60 percent of MDH advisory committees meet or exceed their goals for membership from communities experiencing inequities by December 31, 2019.

Strategy: Improve the collection, analysis, and use of data for advancing health equity.

MDH programs collect race, ethnicity, and language (REL) data.	80 percent of datasets on individuals include race, ethnicity, and language (REL) data by December 31, 2019.
	50 percent of datasets on individuals that collect REL will meet the MDH REL data standard by December 31, 2019.
MDH incorporates social determinants of health into data collection and analysis.	80 percent of reports incorporate one or more of the social determinants of health in its data analysis by December 31, 2019.
The MDH IT infrastructure supports data collection and sharing.	Adopt a plan for interoperability by December 31, 2017.
MDH engages community members and partners in all phases of data collection, analysis, and reporting.	50 percent of staff indicate that engaging community leaders and/or community organizations in determining what data to collect in their community is routine practice by December 31, 2019.
	50 percent of staff indicate that engaging community leaders and/or community organizations in interpretation of data is routine practice by December 31, 2019.
	50 percent of staff indicate that engaging community leaders and/or community organizations in communicating data findings in their community is routine practice by December 31, 2019.

Strategy: Communicate our commitment to advancing health equity.

MDH develops and implements an internal communication plan.	The commissioner will communicate MDH specific efforts to advance health equity at least once per quarter to all staff between January 2016 and December 2019.
Everyone at MDH is held accountable for advancing health equity.	90 percent of staff agree that advancing health equity is part of their job by December 31, 2019.
Outgoing communications highlight an expanded narrative about what creates health.	30 percent of press releases will call attention to potential causes and solutions to health inequities by December 31, 2019. 40 percent of MDH Facebook posts will call attention to potential causes and solutions to health inequities by December 31, 2019.
MDH supports local public health and other partners advance health equity.	80 percent of staff agree that MDH supports its partners in their efforts to advance health equity December 31, 2019. 90 percent of Minnesota community health boards will have identified advancing health equity as a priority by December 31, 2019. 90 percent of community health boards agree they have built capacity to advance health equity by December 31, 2019.
MDH measures, monitors, and reports on progress.	The Health Steering Team will meet at least twice per year to monitor the implementation of the strategies and make necessary modifications between January 2016 and December 2019.

Next Steps

A number of groups and individuals across the department will have a role in implementing the strategic plan over the course of the next four years. A work plan will be developed each year to guide implementation efforts. The Health Steering Team will monitor progress and make revisions to the strategic plan and/or work plan as needed. The findings of Minnesota's Statewide Health Assessment, _The Health of Minnesota_, and Statewide Health Improvement Framework, _Healthy Minnesota 2020_, served as the foundation for this strategic plan. When those documents are updated by the Healthy Minnesota Partnership, the Health Steering Team will determine if modifications are needed to the strategic plan. In addition, the MDH Quality Council will work to align quality improvement (QI) efforts including the MDH QI Plan with the strategic plan.

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[1] Bay Area Regional Health Inequities Initiative. (2010). _Local health department organizational self-assessment for addressing health inequities_. Accessed 10 November 2015 from http://barhii.org/resources/barhii-toolkit/.

[2] National Association of Chronic Disease Directors. (2014). _State health department organizational self-assessment for achieving health equity: Toolkit and guide to implementation_. Accessed 10 November 2015 from http://barhii.org/download/toolkit/nacdd_he_toolkit.pdf.