



Advancing Health Equity at the Minnesota Department of Health

2014-2024

ADVANCING HEALTH EQUITY AT THE

MINNESOTA DEPARTMENT OF HEALTH

2014-2024

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FORWARD FROM THE

COMMISSIONER OF HEALTH

I was relatively new to Minnesota when, as luck would have it, the Minnesota Department of Health (MDH) published the “Advancing Health Equity in Minnesota: Report to the Legislature” in February 2014. With the courage of true leadership – that of Commissioner Ed Ehlinger and others – MDH broke new ground in public health by not just naming but also deeply engaging with structural racism, or the public policies, institutional practices, and cultural norms that, over time, have resulted in stubborn racial inequities.

The report reviewed many of the mechanisms through which structural racism contributes to worse socioeconomic outcomes and thereby adverse health outcomes, especially for Minnesotans who are Black and/or American Indian. In 2014, when there was very little discussion of racism as the fundamental cause of health inequities anywhere – including in public health – the 2014 report was a much-needed breakthrough and defining moment for the agency.

All the data compiled in one place became an incredible resource for the state. The recommendations were a roadmap for those serious about health equity. And its publication, like kindling, sparked important conversations in Minnesota and across the nation. Racism was no longer invisibly bundled in the umbrella language of “policy, systems, and environment,” “living conditions,” or “social determinants of health.” Also, to the agency’s credit, racism was not just a problem “out there” but also – modeling the humility and self-awareness of inclusive leadership – as something “in here,” by asking (my paraphrase) **“How might racism be shaping MDH culture, policies, practices, and priorities?”** This is a question we should continue to ask ourselves.



“How might racism be shaping MDH culture, policies, practices, and priorities?”

This is a question we should continue to ask ourselves.


The 10-year anniversary of its publication was an opportune time – especially given the lessons learned from the COVID-19 pandemic – to evaluate our progress implementing the report’s recommendations. The feedback that we received from community members and staff recognized improvements in our engagement and partnerships with communities most impacted by health inequities, including in more rural areas of the state. They expressed appreciation for improvements in data equity – including data disaggregation and accessibility – as well as efforts to enhance health in all policies and capacity building in local public health, Tribal health departments, and community-based organizations. They also called for more work to be done to truly transform health equity from a statement of values into measurable, consistent, and embedded practice. I hope this report demonstrates our commitment to continuous improvement and transparency.

Today, many are surprised that we find ourselves fighting battles we thought we had won.

While these are hard times for health equity and for public health, we at MDH remain steadfastly committed to creating the conditions for all of us – no matter who we are, where we come from, or what circumstances shape our lives – to thrive.

Brooke Cunningham, M.D., Ph.D.
Commissioner, Minnesota Department of Health

EXECUTIVE SUMMARY



Minnesota is often ranked among the healthiest states in the nation. Yet opportunities for good health are distributed unevenly among cultural communities, geographic areas, and other segments of the state. Building on years of work already underway to address these disparities, the Minnesota Department of Health (MDH) released a pivotal report in 2014 that charted a new course for advancing health equity in Minnesota. The “Advancing Health Equity in Minnesota: Report to the Legislature” was a first-of-its-kind report that named structural racism as a key driver of health inequities and offered guidance to address them, laying a foundation for and setting in motion efforts that continue to shape Minnesota’s health equity work today.

The report focused on the root causes of health inequities, calling for changes in systems and policies to improve health outcomes for populations historically burdened by inequity. The 2014 recommendations directed MDH, lawmakers, and community partners to advance health equity and improve health outcomes by identifying and addressing the underlying causes of health inequities and thereby allowing every Minnesotan the opportunity to reach their fullest health potential.

A decade later, Minnesota Commissioner of Health Dr. Brooke Cunningham requested an update on efforts to implement seven recommendations put forth in the 2014 report. This 10-year retrospective report examines a decade of MDH work, highlighting achievements, offering insights, and identifying areas that still need attention.

Recommendation 1: Advance health equity through a health in all policies approach across all sectors.

MDH has advanced the practice of health in all policies through multiple strategies, including developing and sharing public narratives that broaden understanding of what shapes health. The agency also provided research and advocated for policies that support health across all communities, while fostering cross-sector collaboration in housing, transportation, education, and economic development. To strengthen and sustain this approach, MDH will need to invest in coordinated internal efforts and comprehensive training, cultivate deeper legislative support, and build stronger partnerships with other state agencies and community partners. MDH must also leverage its role as a convener and mobilizer of diverse stakeholders to scale this approach statewide.

Recommendation 2: Continue investments in efforts that currently are working to advance health equity.

MDH has continued to invest in what works by supporting communities in their efforts to identify and advance solutions to health inequities. This includes expanding or replicating successful pilot projects and scaling community-driven strategies. Programs like the Eliminating Health Disparities Initiative and the COVID-19 Community Coordinators have supported promising practices tailored to specific cultural communities. With additional funding, MDH has expanded programs and services proven to advance health equity, including family home visiting, access to doulas, and partnerships with diverse media outlets to reach populations experiencing the most severe health inequities. To build on this momentum, additional investments are needed in community-led solutions along with more effective approaches to evaluate promising practices to improve the health of communities across the state.

Recommendation 3: Provide statewide leadership for advancing health equity.

MDH has strengthened the capacity of local and Tribal public health, healthcare systems, and other key partners through a coordinated set of efforts to advance health equity. These include launching an online resource library and a learning and action tool, providing funding and consultation, and creating new data processes to help local health departments identify and address health inequities. Leveraging relationships with clinics, MDH implemented a new healthcare homes certification system with health equity at its core and made critical investments in rural public health infrastructure. The agency also prioritized growing and supporting the public health and healthcare workforce, including efforts to advance and integrate the community health worker profession. As cross-sector partnerships grew in the years following the 2014 report, health equity gained traction in state legislative sessions, with new laws – such as paid family leave – reflecting the health in all policies approach. While these initiatives laid a strong foundation, more intentional efforts are needed for MDH to drive policy change across sectors. This includes deepening the health equity focus of MDH advisory councils and increasing public understanding of the conditions necessary for health and health equity statewide.

Recommendation 4: Strengthen community relationships.

MDH has long recognized the importance of partnerships in accomplishing its mission – protecting, maintaining, and improving the health of all Minnesotans. The agency remains committed to building trusting relationships, convening community partners, and creating avenues for those most impacted by health inequities to influence solutions. MDH invested in its internal capacity for authentic community engagement, deepened relationships with Tribal partners and disability communities, and expanded partnerships with diverse community organizations across the state. New advisory committees and task forces, including the Health Equity Advisory and Leadership Council, have helped ensure more strategic input from communities most impacted by health disparities. To truly advance health equity, MDH must go further – integrating community voices in all aspects of its work, from policy development to program design to implementation and evaluation.

Recommendation 5: Redesign MDH grantmaking to advance health equity.

MDH continues to strengthen the focus and impact that grants have on health equity. Dedicated working groups help improve internal coordination and share best practices to embed health equity in both grantmaking and contracting. The agency has also developed new tools and resources on topics such as reducing bias in the review process and promoting funding opportunities to communities across the state. To ensure grant programs align with community needs and produce meaningful outcomes, MDH has made progress in engaging stakeholders in the grantmaking process – including the Eliminating Health Disparities Initiative and the Tobacco Prevention and Control Program grants. Meanwhile, investments in grantee training and capacity include a new initiative focused on supporting those serving communities most impacted by health inequities. Continued progress in this area will require ongoing staff training and continued efforts to strengthen internal controls and modernize processes to ensure grant funds reach those who need them.

Recommendation 6: Make health equity an emphasis throughout MDH.

MDH made significant structural changes to advance health equity. MDH has embedded health equity and its core concepts to its vision, strategic plans, hiring and recruitment practices, program design and evaluation, and staff trainings. The success of the Minnesota Center for Health Equity led to the creation of the Health Equity Bureau and the Division of Health Equity Strategy and Innovation. The department also created offices that focus on the health African Americans and American Indians and work directly with these communities. Continued investment in embedding equity across the agency will be crucial to sustain organizational progress.

Recommendation 7: Strengthen the collection and analysis of data to advance health equity.

MDH made strides toward strengthening the use and analysis of health equity data across the department through efforts such as a new data vision and roadmap and an office specifically dedicated to data strategy and interoperability. Efforts continue to implement data disaggregation standards, engage with communities in data processes, and develop approaches to overcome barriers to data sharing. Moving forward, MDH must prioritize community collaboration in refining data collection and analysis, ensuring that data practices are transparent, equitable, and actionable in advancing health equity.



In the 10 years since the 2014 report, MDH has made significant strides, achieving progress on all seven primary recommendations and most sub-recommendations.

This sustained momentum reflects the department's deep commitment to health equity and the collective effort of its staff and partners. It is essential for MDH and its partners to remain both steadfast and strategic in their pursuit of health equity.

The path forward requires unwavering dedication to intentional action, strong partnerships, and innovative thinking. By centering authentic engagement, codeveloping responsive strategies, and rigorously measuring outcomes, MDH can sustain its progress and continue to lead the way in advancing health equity for all Minnesotans. Working together with community, local public health, Tribal, healthcare, federal, and other cross-sector partners, **a healthier Minnesota where all communities are thriving is possible.**

INTRODUCTION

The Minnesota Department of Health (MDH) published the landmark “Advancing Health Equity in Minnesota: Report to the Legislature” in 2014, describing the structural conditions that produce health inequities and offering recommendations to advance equity across the state. This report provided a foundation to reframe and reinvigorate the approach to attaining health equity for all people in Minnesota. It marked the first time a state agency named structural racism as a major contributor to health disparities, which sparked a much-needed conversation within Minnesota and across the country.

At the direction of Minnesota Commissioner of Health Dr. Brooke Cunningham, MDH revisited the 2014 report to assess progress made over the past decade. The MDH Health Equity Bureau assembled a cross-agency committee of more than 30 staff and leaders and partnered with community representatives from the Health Equity Advisory and Leadership Council. Together, they gathered perspectives of MDH staff and community members on progress made toward the seven primary recommendations and their sub-recommendations using questionnaires and focused conversations.

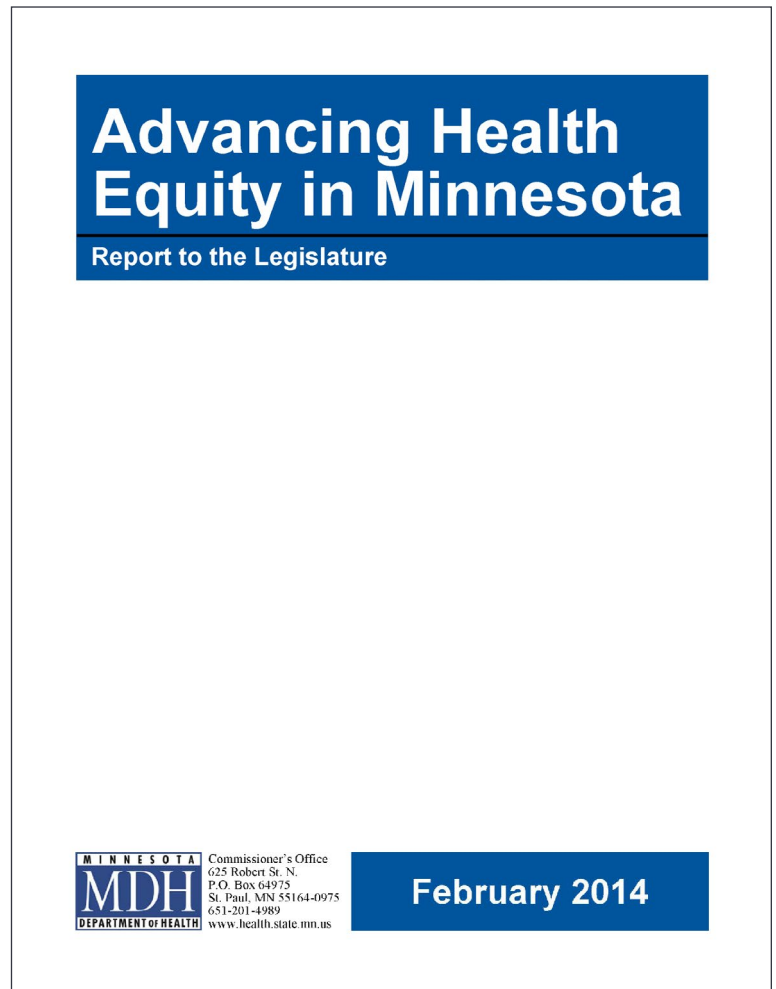


Figure 1: 2014 Advancing Health Equity in Minnesota: Report to the Legislature

This retrospective report outlines MDH actions taken since 2014, summarizes insights from staff and community feedback, and highlights where MDH stands after a decade of efforts to advance health equity. The report also offers steps MDH will take to continue advancing health equity in the years to come.

BACKGROUND

The 2014 Advancing Health Equity Report

Many people and organizations laid the groundwork for the 2014 report over the preceding decades (refer to Appendix A for a brief description of influential health equity efforts in prior years). By 2013, leaders in the community and at MDH recognized that past efforts to advance health equity were too limited in scope to make the kinds of progress necessary to eliminate health inequities. Frustrations had grown over the lack of impact, despite years of applying conventional approaches. It became clear that the state needed to support local, community-driven solutions while simultaneously addressing the social, economic, and political contexts that shape health outcomes for entire populations.

In response – and to strengthen, expand, and deepen Minnesota’s health equity efforts – community leaders worked with their legislative representatives and MDH to pass legislation requiring the department to do the following:

- Assess the health disparities in the state.
- Identify the policies, processes, and systems that contribute to health inequities in Minnesota.
- Recommend changes to policies, processes, and systems within MDH.
- Identify best practices for local public health, healthcare, and community partners to advance health equity.
- Recommend strategies to improve data for all the above.

These efforts resulted in the publication of the 2014 “Advancing Health Equity in Minnesota: Report to the Legislature.”

A collaboration

Under the leadership of former Commissioner Dr. Ed Ehlinger and Jeanne Ayers, assistant commissioner of the Health Improvement Bureau and chief health equity strategist, the 2014 Advancing Health Equity report engaged community partners and MDH staff at all levels. MDH held more than 180 conversations with over 1,000 participants and gathered 200 pages of feedback through an online survey and public comments. Community members and organizations offered positive feedback for the draft report, indicating appreciation that it began with a discussion on race and racism while also encouraging the inclusion of all populations experiencing health inequities. The final 2014 report reflects this collective energy and commitment to achieving health equity.

Health disparity:

A measurable difference or gap in health outcomes between specific population groups.

-Adapted from 2014 Advancing Health Equity in Minnesota: Report to the Legislature

Health inequity:

A health disparity based in inequitable, socially determined circumstances. Health inequities are avoidable, unfair, and unjust and should be eliminated.

-Adapted from 2014 Advancing Health Equity in Minnesota: Report to the Legislature

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The 2014 report described the extent of health disparities experienced across Minnesota communities and examined the complex issues that contribute to them. The report focused on how MDH, local public health departments, healthcare organizations, and community partners can improve their responses to health inequities. The report recommended key practices for advancing health equity, including applying a health in all policies approach, using health impact assessments, and making advancing health equity an integral aspect of all efforts. The report also listed some existing exemplary and emerging practices for advancing health equity that can provide a model for moving forward.

Opening with the intersection of race, racism, and health

MDH leaders made a critical decision to open the 2014 report with a discussion of race, racism, and health. Although the report addressed health inequities for many populations in Minnesota, including children, older Minnesotans, people facing mental health challenges, LGBTQ+ persons, and others, MDH stressed the importance of looking at racial inequities.

LGBTQ+:

An acronym for “lesbian, gay, bisexual, transgender and queer.” The Q can also refer to questioning, referring to those who are still exploring their own sexuality or gender. The plus sign recognizes the growing understanding of sex and gender and represents those who are part of the community but for whom LGBTQ does not accurately reflect their identity. LGBTQ+ is an evolving acronym and may sometimes include additional letters or numbers. The acronym LGBTQ+ is used in this report.

-Adapted from PFLAG National Glossary

Race is a social construct used to group people.

Race is a human-invented way that society has historically grouped people based on physical characteristics like skin color. These groupings have no basis in biology, yet race-based health disparities are persistent and exist across multiple health conditions.

Race does not cause these disparities, racism does – the system of advantage and disadvantage based on race. Structural racism is the way in which racism is embedded in policies, institutions, and social norms. It shapes access to resources and opportunities that influence health.

To make meaningful progress toward health equity, it is essential to explicitly name and address the harm caused by racism. If we fail to correctly identify the root causes of inequities, we risk choosing inefficient strategies and miss the opportunity to create lasting, systemic change.

The intent of this decision was for the 2014 report to overcome the reluctance of many to engage in open and honest conversations about race and racism. Avoiding the language of race and racism allows the structures and other mechanisms that reproduce racialized disadvantage to get lost in vague language about differences or be obscured behind other factors, such as poverty.

Emphasizing health in all policies

While talking about race and racism was important for changing the conversation about health inequities, so too was the emphasis on “health in all policies,” an emerging practice at MDH. This practice is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. That is, health in all policies recognizes that transportation, education, job security, stable housing, the environment – essentially all the conditions that shape human lives – are important for health. The health in all policies approach must have health equity as the goal to avoid unintended consequences and truly address the root causes of health inequities.

Root causes of health inequities:

Underlying systems and structures of social injustice that generate health inequity over time, including white supremacy, patriarchy, and class oppression. They interact with each other to produce social exclusion, marginalization and exploitation.

-Adapted from AMA: A Guide to Language, Narrative, and Concepts

2014 Advancing Health Equity Report recommendations

1. **Advance health equity through a health in all policies approach across all sectors.** Moving to a policy approach to advance health equity requires thinking more broadly and working across sectors to develop healthy public policy. Policies should be examined and resources targeted where efforts will have the greatest effect on populations with the greatest need, from housing to transportation, to education, and more.
2. **Continue investments in efforts that currently are working to advance health equity.** While it is necessary to address the social and economic factors that drive health disparities, this approach must be paired with a commitment to continue the exemplary practices that are already making a difference for the people currently experiencing the impact of these inequities and health disparities.
3. **Provide statewide leadership for advancing health equity.** MDH must build statewide capacity to implement a health in all policies approach; convene leaders and include health equity as a key component of policy discussions; and engage new and existing partnerships across all sectors in a shared sense of responsibility for the health of all people in Minnesota.
4. **Strengthen community relationships and partnerships to advance health equity.** MDH must expand the range and depth of relationships with multiple communities and create avenues for meaningful participation of Minnesota's diverse communities in project governance and oversight.
5. **Redesign Minnesota Department of Health grantmaking to advance health equity.** MDH must adapt grantmaking procedures and practices to support a wider range of organizational capacity among MDH grantees, improve training and evaluation methods to advance health equity, and engage a diverse range of stakeholders in the grant development process.
6. **Make health equity an emphasis throughout the Minnesota Department of Health.** MDH must assure that health equity and the analysis of structural inequities, including structural racism, become integral aspects of all MDH divisions and programs, and address changes needed in the MDH workforce to advance health equity.
7. **Strengthen the collection, analysis, and use of data to advance health equity.** MDH must strengthen coordination of data activities related to health equity across all divisions and programs and develop a long-term plan for improving the collection, analysis, reporting, dissemination, and use of health equity data.

Health equity in Minnesota today

Health equity reflects the distribution of resources and opportunities people need to be healthy. This distribution varies by populations, where those experiencing health inequities more often are poor, older, rural, LGBTQ+, people of color and American Indians, and people with disabilities. Understanding health equity in Minnesota, therefore, requires understanding the distribution of the populations that make up the state as well as how resources and opportunities for health are distributed across populations.

Health equity:

When everyone has what they need to be healthy, and no unjust or unfair barriers prevent a person from being healthy.

-Adapted from MDH Statewide Health Improvement Framework

Minnesota conducts a **statewide health assessment** every five years, weaving together data from across the state to assess the collective state of health and what resources and opportunities people need to be healthy. The assessment and subsequent **statewide health improvement framework** are co-developed by MDH and the Healthy Minnesota Partnership (described under Recommendation 1) – a cross-sectoral group that brings together community partners and state government to improve health and quality of life across Minnesota.

Both the assessment and framework are important for identifying persistent health inequities, determining public health priorities, and involving partners from across the state to work together toward solutions. Although they are not the only way MDH monitors, assesses, and plans to address health inequities, the assessment and framework provide a unique, holistic, and statewide view across many health indicators and determinants – weaving together an important story on the connection between our health and the conditions that surround our lives.

Statewide health assessment findings, 2024

As reported in the 2024 Minnesota Statewide Health Assessment and in a 2020 report from the Minnesota State Demographic Center, the state's population is growing, aging, becoming more racially diverse and less rural. Between 2018 and 2053:

- Minnesota is projected to gain nearly 900,000 residents.
- The number of Minnesotans ages 85 and older is expected to more than double.
- People of color and American Indians are projected to exceed one-third of the total state population. Virtually all the state's net population growth will come from communities of color.
- The seven-county metro region is projected to grow by about 924,000 residents and Greater Minnesota is expected to shrink by about 27,000 residents.

The 2024 statewide assessment found that persistent health inequities – rooted in a lack of resources and opportunities – continue to impact large segments of Black and American Indian communities in Minnesota. Similarly, immigrant and refugee populations across the state often experience challenges in accessing the resources and opportunities that share health. While smaller than the national average, the number of newcomers has been increasing steadily.

Younger generations identify more openly across the spectrum of sexual and gender identity, which intensifies the need for health services that are responsive and inclusive of LGBTQ+ youth. The intersection of race, ethnicity, age, language, gender, or social economic status can compound challenges for people with disabilities. People living in Greater Minnesota face daily inequities in conditions that impact their health, including limited access to healthcare, transportation options, employment opportunities.

Current health equity data presented in the 2024 assessment reflects the persistence of health inequities across the state:

- Minnesota’s overall infant mortality rate has improved significantly, declining 34.2% from 7.3 deaths per 1,000 live births in 1990 to 4.8 in 2021. However, deep disparities remain. From 2014-2018, Black and Indigenous infants experienced higher mortality rates of 8.8 and 9.8 deaths per 1,000 live births, respectively. These persistent gaps indicate ongoing inequities in maternal and child health.
- In 2021, Minnesotans reported having an average of 4.3 mentally unhealthy days in the previous 30 days, more than two times as many as reported in 2013. Mental health burdens are not felt equally: They are higher in communities that already face economic and social hurdles. Certain groups in Minnesota are more likely than others to report experiencing mentally unhealthy days, including American Indians, individuals with a high school diploma or less, people living at or below 200% of federal poverty guidelines, those with public health insurance, and members of LGBTQ+ communities.

Understanding health equity in Minnesota also requires examining the resources and opportunities necessary for good health and how they are distributed across different populations in the state. This includes whether healthy food is available and affordable, housing options are affordable, safe transportation options are available, the air is clean, and good educational and job opportunities are available. According to 2024 statewide assessment data:

- While homeownership rates have increased somewhat among communities of color, non-Hispanic White household homeownership rates remain higher. Home ownership is a pathway to economic and community stability. It creates opportunities for building wealth, which in turn affects future generations.
- Minnesota residents of color are more likely to live in poverty compared to non-Hispanic White residents. Income shapes where people can live, the stability of their living arrangements, the condition of their homes, the quality of neighborhood schools, the kinds of recreation available, the care options for family members, and more.
- Rural areas and Tribal communities are less likely than urban and suburban areas to have the infrastructure for broadband internet services. This can limit opportunities for and access to employment, education, healthcare, and social connections.

Overall, the 2024 statewide assessment shows that communities in Minnesota who experience health inequities are growing, and the resources and opportunities essential for good health continue to be unevenly available. Understanding these populations shifts and changing needs is critical for MDH and its partners to be able to act strategically and effectively to eliminate health inequities and ensure Minnesota is a place where everyone can thrive.

Statewide health improvement framework priorities, 2025-2029

The statewide health assessment sets the stage for a statewide framework designed to guide collective efforts to improve health and advance health equity. In describing the status of health equity in Minnesota today, the assessment informs the framework by illuminating the most important challenges for the state to address.

The 2025-2029 Statewide Health Improvement Framework highlights three, community-identified priorities:

- Wellbeing, belonging, and substance use prevention
- Health and housing
- Equitable access and care

The framework also sets forth describes objectives and strategies as a plan of action for addressing these health priorities over the next five years.

The purpose of the framework is to describe how MDH, its cross-sectoral partners, and the community will work together to improve the health of populations in Minnesota using a system and structural approach. Designed as a dynamic and living plan that includes building relationships and collaborating with cross-sectoral partners, MDH and the Healthy Minnesota Partnership encourage organizations and groups across the state to participate in joining and supporting the efforts outlined in the framework.

System and structural level approach:

Rather than focusing on individual-level changes (such as awareness, knowledge, behaviors, or skills), MDH aims to focus on broader structural changes — such as policies, systems, and environments — that address the root causes of inequities.

-Adapted from MDH Cultivating a Health Equity Ecosystem

PROGRESS ON ADVANCING HEALTH

EQUITY RECOMMENDATIONS

This section highlights MDH efforts in relation to each of the 2014 recommendations. The examples provided under each of the seven primary recommendations and their sub-recommendations represent a sample of the work undertaken by MDH over the past decade. Together, these examples underscore the breadth and depth of health equity efforts across the agency, reflect how health equity has become central to the agency's work, and demonstrate the agency's role in advancing health equity and improving health across the state. The report captures efforts through the end of 2024; some projects may no longer be active.

This section also summarizes the perspectives of community partners and MDH staff on progress MDH has made in relation to recommendations in the 2014 report. In the development of this retrospective report, MDH and its partners held more than 20 focused conversations and gathered feedback through nearly 2,000 completed surveys. The responses from community partners and staff highlight both the perceptions of progress MDH has made and the areas where its continued work is needed to fully realize its commitment to advancing health equity.

It is important to note that responses provide insights into a snapshot in time rather than a true measure of progress over the 10-year period, in part because baseline data was not established in 2014. Moving forward, MDH will commit to developing and using meaningful indicators that can evaluate both the advancement of equity goals and reductions in disparities across Minnesota.

Full descriptions of the methods used in surveys and conversations are in the appendices: Appendix B: Community partner survey and conversations, and Appendix C: MDH staff survey and conversations.

Program highlight

Program highlights

The projects highlighted in this type of box are examples of how MDH implemented the recommendation or sub-recommendation across the department's many divisions and programs.

Community data highlight

Community data highlights

MDH gathered feedback for this report through a survey of community partners February and May 2024. These boxes highlight important findings and community partner perspectives that shed light on MDH's progress to implement the recommendation or sub-recommendation.

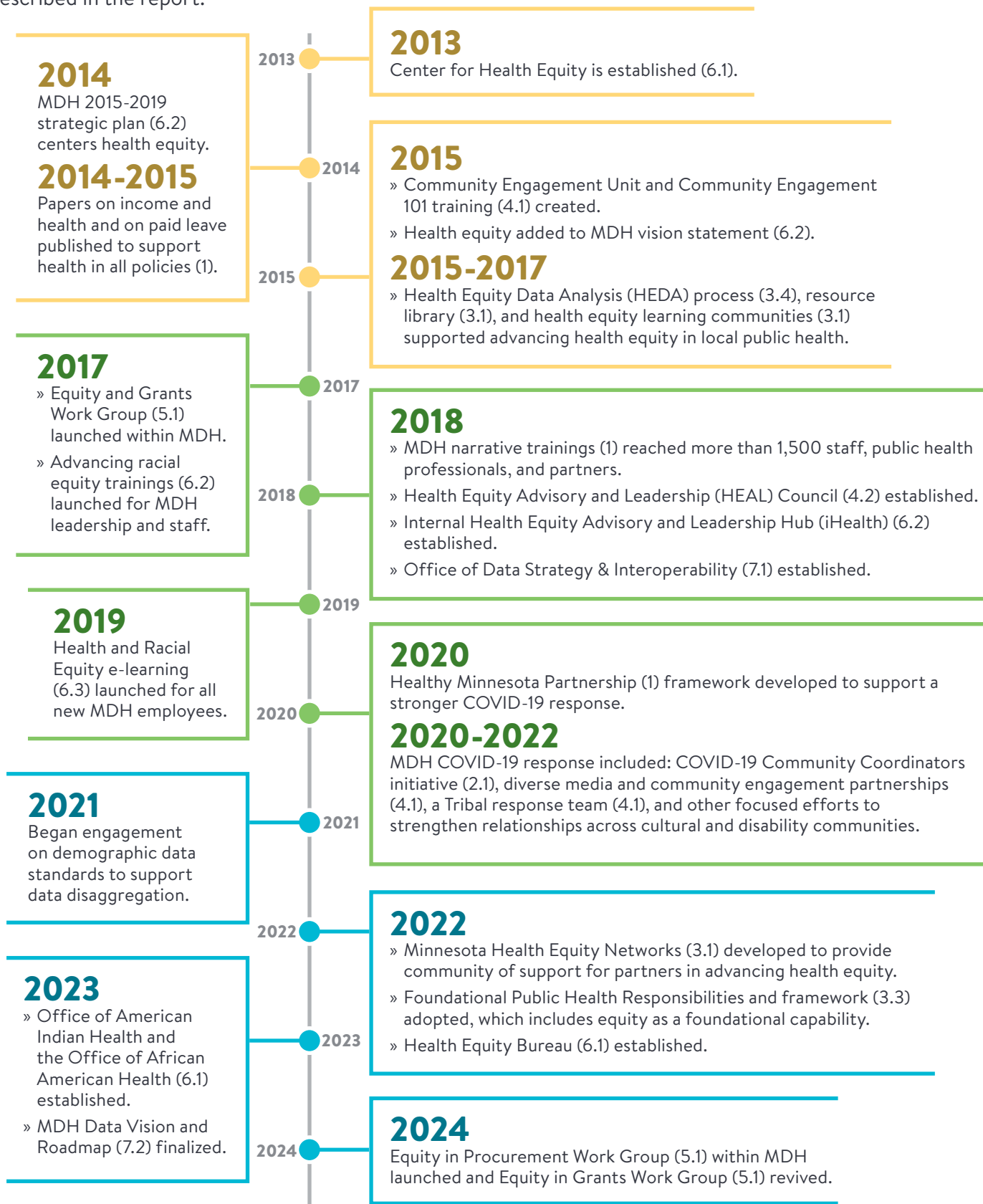
MDH staff data highlight

MDH staff data highlights

MDH gathered feedback for this report through an all-staff survey in December 2023 and January 2024. These boxes highlight important findings and MDH staff perspectives that shed light on MDH's progress to implement the recommendation or sub-recommendation.

A decade of progress

This timeline depicts some of the pivotal health equity efforts at the Minnesota Department of Health since the 2014 report. The numbers in parenthesis indicate in which recommendation the effort is described in the report.



Recommendation 1: Advance health equity through a health in all policies approach across all sectors.

Health in all policies is an approach that recognizes the health implications of policies in all sectors, such as housing, education, transportation, and economic development. It seeks to improve population health by leveraging the impact of policies outside of the health sector to foster more equitable health outcomes. With health equity as the goal, the health in all policies approach is a powerful strategy for addressing the many complex factors that influence health and create or perpetuate inequities. The 2014 report underscored that advancing health equity in Minnesota would not be achievable without pursuing a health in all policies approach.

The years following the report's publication were rich with activity within and outside of MDH. This period was also guided by what former Commissioner Ehlinger coined the **Triple Aim of Health Equity** (modeled after the Triple Aim framework for healthcare). This model relied heavily on a health in all policies approach along with expanding understanding of what creates health and strengthening community capacity to create their own healthy futures. Central to this model are social cohesion and social justice.



Figure 2: Triple Aim of Health Equity

Program highlight

ASTHO President's Challenge to advance health equity

Former MDH Commissioner Ehlinger initiated the ASTHO President's Challenge in 2016 to advance health equity and optimal health for all when he became president of the Association of State and Territorial Health Officials (ASTHO). The objective of the President's Challenge was to provide support to all states and territories in using strategies of the Triple Aim of Health Equity – including the health in all policies approach – to advance health equity and attain optimal health for all. ASTHO supported state and territorial health officials by providing technical assistance, sharing best practices, and facilitating opportunities for collaboration around health equity and health in all policies.

Ehlinger presented on the challenge and the importance of a health in all policies approach to the Centers for Disease Control and Prevention (CDC), the Institute of Medicine's Committee on Community-Based Solutions to Promote Health Equity in the United States, 23 state health departments, professional conferences, and multiple professional groups around the country. These efforts are one example of how Minnesota has become a national leader in advancing health equity and promoting the practice of health in all policies.

Broadening policy discussions through published papers

To provide a research background for the health in all policies work, MDH published papers on two topics connected to health: income and paid leave. These papers were prepared at the direction of the state legislature and written by the Center for Health Equity and the Center for Health Statistics to build understanding and awareness about the role policies play in promoting health and health equity.

The **2014 paper on income and health** documents the relationship between total household income and indicators of health and shows a clear link between income and health. The paper asserts that “policies that contribute to increasing income levels, especially among the lowest income groups where improvements in health are most evident in this review, would be expected to have a positive impact on the health of these groups.”

Likewise, the **2015 paper on paid leave** finds that paid sick leave and paid family leave are associated with positive health and employment outcomes for employees, families, and employers. Benefits of paid leave include lower infant mortality rates, higher rates of breastfeeding, more preventative care visits, as well as greater productivity and fewer injuries. The paper also cites inequitable access to paid leave: People with lower incomes, part-time workers, and single parents are least likely to have access to paid sick and family leave. These groups are disproportionately populations of color and American Indians.

These papers broadened policy discussions to include health impacts that might otherwise focus just on economics or other outcomes. In 2014, members of the state legislature and community advocates used both the 2014 report and the paper on income and health to successfully support an increase in the state minimum wage. Community advocates also used the MDH research during debates to increase the minimum wage in Minneapolis to \$15 per hour.

MDH also played a key part in igniting local and statewide conversations about paid family leave with advocates, local public health practitioners, and policymakers. Former Commissioner Ehlinger and former Commissioner Jan Malcolm used information from these papers when advocating for paid leave, including testimony at the state legislature in 2019. Former Assistant Commissioner Ayers also testified about the benefits of paid leave at a Minneapolis City Council meeting.

In 2016, the paper on paid leave and health was used successfully to advocate for paid leave ordinances passed in Minneapolis and St. Paul and to advocate for increases in paid parental leave for State of Minnesota workers. Minneapolis-St. Paul International Airport employees also referenced the report in a successful bid for paid sick days. As often happens in Minnesota, local policies are precursors to statewide action. The Minnesota Legislature in 2023 passed laws mandating that employers of all sizes provide paid sick and safe leave to employees and created a state-run, paid family and medical leave program for workers across the state.

Changing the narrative

With a health in all policies approach as the foundation, MDH and the **Healthy Minnesota Partnership** developed and used public narratives to engage with different sectors on health issues. The purpose of focusing on narratives is to move conversations from a narrow viewpoint that healthcare equals health to an awareness of the broad range of social and economic conditions that shape health and wellbeing. This work also aims to shift the conversation away from the pervasive – and false – narrative that personal or lifestyle choices are the dominant factor in determining one’s health. From these more expansive viewpoints, a new set of actions are possible to advance health equity through policy change. This broadening of understanding of what creates health is another pillar of the Triple Aim of Health Equity.

In the years following publication of the 2014 report, the health impacts of a broad range of societal topics were discussed, including African American infant mortality, burdensome debt, early childhood, food access, housing, incarceration, income, mental health and wellbeing, paid family leave, and transportation. Based on this work, the partnership promoted **narrative training** for MDH staff and local public health departments. This training helped participants understand public narratives and how they shape policy decisions. By the end of 2018, MDH staff had facilitated more than 40 narrative trainings for more than 1,500 public health professionals and others in Minnesota. As word of the trainings spread, MDH even received requests and conducted trainings for non-public health partners, including social service organizations, professional associations, and others.

Narrative:

A story that connects issues, actions, and values. Public narratives (rather than personal or family narratives) are narratives that many people share. They often reflect deeply held cultural perspectives and arise out of a shared history. Public narratives are especially powerful in their influence on public policy decisions. Using a public narrative approach can help us expand conversations across sectors to include the social and economic conditions that shape health and wellbeing and to suggest actions that advance health equity.

-MDH working definition

Program highlight

Healthy Minnesota Partnership

The Healthy Minnesota Partnership joins community partners with MDH to improve the health and quality of life in Minnesota for individuals, families, and communities. The partnership first convened in 2010 and continues to identify and act on strategic opportunities to improve health and wellbeing for all people in Minnesota.

The partnership develops a workplan to advance the priorities and strategic activities in the Statewide Health Improvement Framework, leads the development of the Statewide Health Assessment, and shares opportunities to advance health in all policies. Both the assessment and framework look at what conditions Minnesotans need to be healthy and highlight how systemic and structural factors, including policies, perpetuate inequities. The partnership develops policy profiles around issues like paid parental leave, tree canopy coverage, and broadband internet access which explain how these areas impact our health and how policies at all levels can increase or improve conditions around each area.

In 2020, the Healthy Minnesota Partnership also developed a policy framework to support a stronger COVID-19 response. The partnership supported policies to advance this framework, including family and medical leave, universal broadband and virtual access, and housing stability. Most recently, the partnership has strived to incorporate more input from community engagement and from people with lived experience.

Leading through partnerships

Meanwhile, work between MDH and partners included collaborations to develop frameworks, networks, and assessments to advance health in all policies.

In 2015, MDH was a lead partner in the **Minnesota Food Charter Network**, which encouraged cross-sector collaboration to implement strategies related to food access, affordability, availability, and environment. The network started as a grassroots movement to listen to communities about issues related to food, such as transportation barriers and unaffordable prices. These listening sessions led to the creation of 99 strategies that action teams worked to implement across the state. Offshoots of this work continue today, including a statewide work group led by MDH that brings together partners across state agencies to collaborate, network, and learn together about issues related to food systems.

Other cross-sector partnerships have also advanced health in all policies throughout the years, including a 2016 collaboration with the Minnesota Department of Transportation to publish **Minnesota Walks**, a framework for making walkable communities that are safe, convenient, accessible, and desirable. In the same year, MDH staff participated in a **health impact assessment** to propose policy recommendations on the potential health effects of drug sentencing reform in Minnesota.

MDH staff data highlight

Cross-sector partnerships

In the 2023-24 survey of MDH staff, 63% of staff agreed or strongly agreed that their division works across sectors to achieve health equity goals; 31% said they were unsure. A much smaller percentage (6%) disagreed or strongly disagreed.

The large portion of unsure responses could indicate that staff are unaware of efforts in their division to work across sectors or that cross-sector activity in their division is minimal. Increased communication within and across divisions about cross-sector work, including resources and training to support divisions in these efforts, could help improve this indicator.

Program highlight

African American Infant Mortality Project

From 2015 to 2020, the Center for Health Equity implemented a project to address the high infant mortality rate among U.S.-born African Americans living in Hennepin County. Hennepin County has the largest population of African Americans in Minnesota, and the infant mortality rate among U.S.-born African Americans in Minnesota is 3.4 times higher than White Minnesotans.

The project was designed to acknowledge the many factors contributing to this inequity, including the role that structural racism and societal and living conditions play in infant mortality. To gain deeper insight and to address this complex issue, MDH used a community engagement model to bring together community perspectives about what creates and sustains disparities, and it activated the community to pursue a health in all policies approach.

Together, project participants successfully enhanced Minnesota's community health worker curriculum to include more culturally specific maternal and child health content and hands-on training; developed a protocol for an equity-focused prenatal risk assessment at three community health clinics; and initiated community-designed and -led mini projects that addressed systemic issues affecting infant mortality. The mini projects included reforming homeless shelter policy to better serve pregnant people and children, redesigning a secondary schools health education curriculum to deepen young people's understanding of infant mortality disparities from a strength-based and historical perspective, and hosting a radio show series designed to increase the access to information on African American maternal and child health with specific emphasis on the role of men.

Community partner reflections

In the 2024 conversations with community partners, participants were asked to reflect on the partnerships their organizations had with MDH in advancing a health in all policies approach. Many highlighted how their work spans various sectors — such as housing, transportation, education, economic development, and healthcare — that are included in the social determinants of health. This multisectoral engagement aligns with health in all policies principles by addressing the big picture of people’s daily lives.

Social determinants of health:

The social, economic, and environmental conditions in which people live, learn, work, worship, play and age.

-Adapted from 2014 Advancing Health Equity in Minnesota: Report to the Legislature and MDH Cultivating a Health Equity Ecosystem

“One of the most impactful ways we’ve worked with MDH on health in all policies is by integrating health into educational settings. We’ve partnered with school districts to provide unified health classes throughout students’ middle school years, ensuring that no matter which school they attend, they receive the same health education. It’s a way of leveling the playing field and ensuring that all students have the same foundational understanding of health, which can shape healthier behaviors and decisions in the future.”

—2024 community conversation participant



Several participants shared that they have used MDH funding to support their housing efforts but noted that MDH involvement often stops there. They expressed interest in seeing MDH create more formalized ways to bridge health, healthcare, and housing efforts.

Community data highlight

Health equity in policy making

Well over half (69%) of the 2024 community survey respondents agreed or strongly agreed that MDH uses health equity and the social determinants of health as criteria in determining policy positions. About a quarter of those who responded (23%) were undecided and another 8% disagreed or strongly disagreed.

While it is encouraging that most respondents believe MDH uses a health equity lens in its policy work, the significant segment who were undecided and smaller segment who disagreed suggest there is room for improvement. MDH should assess its policy processes to ensure health equity and the social determinants of health are central to decision-making. MDH must also invest in more strategic engagement and communication with community partners to ensure transparency and collaboration in the policy-making process.

MDH staff reflections

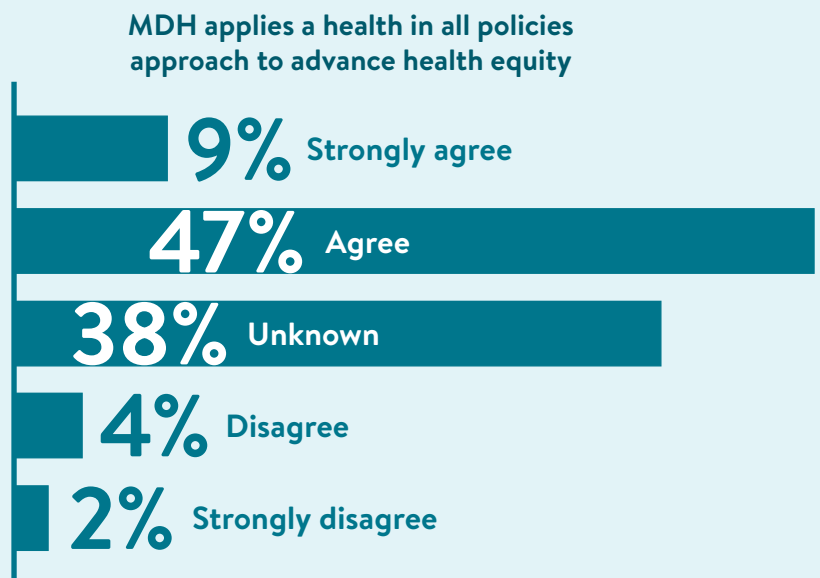
In the 2024 conversations with MDH staff, respondents indicated that the approach to policymaking at MDH and the inclusion of health equity in policy initiatives still varies across the agency. Some staff believe that policy is largely dependent on the legislative process and subsequent funding. Ambiguity exists around the policymaking process and who should ensure that health equity is embedded in policies and at what level this should happen within the agency. While some staff are unaware of the health in all policies approach, others report incorporating it in their work internally and externally. Many respondents said the policies approach is difficult to enact and that more training around this topic is needed to effectively meet policy mandates.

MDH staff data highlight

Health in all policies approach to health equity

In the 2023-24 survey of MDH staff, 56% of respondents agreed that MDH applies a health in all policies approach to advance health equity, while 38% responded that they did not know. A much smaller percentage (6%) responded that they disagreed or strongly disagreed.

Given the centrality of the health in all policies approach to the 2014 report recommendations, these results indicate ample opportunity for MDH to expand both use and awareness of the health in all policies approach.





Summary of progress on recommendation 1: **Advance the health in all policies approach.**

MDH has made notable progress with the health in all policies approach by developing clear alternative narratives, publishing position papers, promoting action on policies to assure health in every community, and encouraging cross-sector collaborations in housing, transportation, education, and economic development. These partnerships have been instrumental in illuminating the root causes of disparities and promoting sustainable, policy-driven solutions.

However, community respondents emphasized that MDH must take a more active role in bridging sectors, particularly between healthcare and housing, to improve health outcomes. Internally, MDH staff shared that the commitment to health in all policies varies across divisions, with inconsistent awareness and application of health in all policies principles.

Achieving a robust health in all policies approach will require more intentional executive-level leadership, stronger coordination across divisions, expanded legislative support, and deeper partnerships with other state agencies and community partners. MDH is committed to strengthening and developing new relationships to identify and partner with health equity champions at other agencies in accomplishing this mission. Comprehensive, agency-wide training on health in all policies and clearer roles and responsibilities are also needed to ensure consistent application of this approach. Continued investment in these areas, as well as leveraging MDH's role as a convener and mobilizer of stakeholders, is essential to fully realize the promise of health in all policies and advance equitable health outcomes statewide.

Recommendation 2: Continue investments in efforts that currently are working to advance health equity.

This recommendation recognizes that many individuals, organizations, and communities have been engaged in efforts to advance health equity, and that MDH should further support and expand these exemplary practices. Recommendation 2 includes one sub-recommendation: to identify and expand programs and policies that are working to advance equity across the state.

2.1 Identify and expand existing programs and policies that address health disparities and advance health equity.

Identifying and expanding existing programs and policies that address health disparities and advance health equity calls for developing measurement and evaluation tools to evaluate emerging practices; sharing and replicating successful programs and policies; and identifying successful pilot projects to fully fund.

Investing in community-driven initiatives

One way that MDH has demonstrated its commitment to advancing health equity is by funding innovative programs that are specifically designed to address health disparities. The **Eliminating Health Disparities Initiative (EHDI)** is a standout example of a program that serves as an incubator for emerging culturally specific practices.

Established by the Minnesota Legislature in 2001, this grant program funds community-driven and culturally specific approaches to address persistent health inequities to ensure that interventions resonate deeply with the populations they serve. These grants were among the first in the nation to address health inequities, and they remain a critical investment in projects developed for communities of color and American Indian communities.

Over the years, MDH has invested in efforts to strengthen grantee capacity related to evaluation. Beyond funding and technical assistance, this support has included documenting the promising practices grantees develop for specific cultural communities so they can be expanded and/or replicated where possible. The success of these capacity-building efforts was noted in conversations with community partners.

Survey data from grantees underscores the impact of these efforts. In 2019, 66% of grantees who completed a grant close-out survey reported that they agree or strongly agree with the statement, “EHDI funding enhanced my organization’s evaluation skills.” By the end of the next grant cycle in 2023, this number increased to 91% of grantee respondents. Survey data also highlighted the impact of the EHDI program on overall organizational capacity, with 90% of grantee respondents in both 2019 and 2023 agreeing or strongly agreeing that the program strengthened their organization for the future.

The *Aquí Para Ti* (“Here for you”) program is a longstanding example of how EHDI has helped cultivate and expand innovative, culturally specific models to address health inequities. This Latino-focused clinic within the larger Hennepin Healthcare system developed a new model for providing intergenerational care for youth and parents designed to honor cultural values, uncover unmet needs, and increase social connectedness. As *Aquí Para Ti* honed its model and expanded its services throughout the years, the program won numerous national awards and has shared their model and lessons learned through numerous presentations, academic papers, and conferences. Other clinics, including HealthFinders Inc., have since adopted parts of the *Aquí Para Ti* model, and Hennepin Healthcare began a spin-off program – *Between Us* – geared toward meeting the sexual and reproductive health needs of teens of all races and ethnicities.



“The EHDI program gave us the flexibility to design community-specific programs. It’s not just about reducing health disparities – it’s about empowering the community to take ownership of their health outcomes through support and capacity-building.”

–2024 community conversation participant

Other promising practices the EHDI program has invested in include the Division of Indian Work's Live It! curriculum, a culturally specific sexual health program designed for American Indian youth, and Annex Teen Clinic's Celebration of Change curriculum. After demonstrating positive outcomes, the Live It! curriculum was replicated by the Fond du Lac Band of Lake Superior Chippewa, another EHDI grantee, to improve the health of adolescents within the Tribe. Meanwhile, the Celebration of Change program, which was originally designed for African American youth, has since been adapted for the Hmong community to create space for mothers and daughters to talk about sexual health, healthy development, and puberty.

Another example of how MDH has invested in expanding successful models and supported grantee evaluation efforts is **family home visiting** – a voluntary, home-based service for pregnant people and families with young children. The service provides critical supports to families from a wide range of racial, ethnic, economic, and social backgrounds by meeting families where they are, connecting pregnant individuals with appropriate prenatal care, and empowering parents. MDH supports the implementation of six evidence-based home visiting models across the state.

Recognizing the success of these services across communities, MDH secured increased state funding for family home visiting in 2018 and expanded access to these funds to Tribal Nations. Funding recipients can select from various evidence-based models – including the Family Spirit Model, designed for and led by Indigenous communities – to ensure the program supports and addresses the needs of their communities. As of 2024, nine Tribal Nations across Minnesota receive funding from MDH for home visiting to support and empower community members with young children.

With the funding increase, Tribal Nations also gained access to a variety of MDH supports for their home visiting programs, including a nurse consultant to support with their chosen model, grant manager support with funding and grant administration, and evaluation team support for their data collection and analysis. MDH meets with each Tribe at least yearly to review their recent data and co-create areas for improvement.

Program highlight

COVID-19 Community Coordinators

The COVID-19 Community Coordinators initiative began in late 2020 as COVID-19 inequities grew, misinformation spread, and engaging trusted community partners became imperative. MDH contracted with trusted community organizations serving those hit hardest by COVID-19, including communities of color, American Indian communities, LGBTQ+ communities, and Minnesotans with disabilities, setting up hotlines to help community members find accurate information and to connect with basic resources like housing support and food assistance.

Early success with the model prompted MDH to expand its partnerships with community coordinators to host testing events in community spaces. The model expanded further when COVID-19 vaccines became available, and coordinators began offering vaccinations in trusted spaces. Between February 2021 and February 2025, coordinators hosted more than 4,000 vaccine events and gave more than 100,000 vaccinations.

Coordinators continued to play a pivotal role after the official pandemic response ended, supporting community recovery, increasing rates of annual vaccines, and addressing long-standing community needs beyond COVID-19. The model has been praised by partners for its holistic approach to community wellness and recovery – addressing everything from transportation to mental health to housing – and its focus on community empowerment, trust, and capacity building.

Replicating and expanding successful models

Another way that MDH demonstrated its commitment to advancing health equity is by identifying successful programs and expanding or replicating them throughout the state.

In 2020, MDH launched the **Minnesota model jail practices learning community** pilot project to promote and expand services in county jails and communities to support children of incarcerated parents. Since the pilot project started, the program has expanded from serving the original jail sites in six counties to serving 14 jurisdictions across the state. This program illustrates MDH efforts to work across sectors to advance health in all policies and aims to improve parent-child relationships, reduce the chances of someone convicted of a crime to reoffend, increase child wellbeing, and improve public safety.

Another pilot project expansion to note is the improved **mental health screening tool for refugees** to Minnesota. Prior to this initiative, there wasn't one brief, standardized mental health screening tool that could identify a wide range of symptoms and signs of distress. Most of the available tools were either too long or screened for a narrow range of symptoms, making them difficult to use with interpreters and impractical within the confines of a brief medical appointment.

To address the issue, MDH formed a work group to guide the development of a new, improved tool. Based on the group's input, MDH and the University of Minnesota developed a 5-question survey that allows providers to identify a wide range of symptoms and signs of distress, acknowledge trauma, normalize access to care, and connect newcomers to support within their first appointment in the system. The tool is pre-translated and uses standardized language to minimize interpreting errors. MDH piloted the new tool between 2016 and 2019 before it was implemented throughout the state.

MDH has also invested in efforts to increase the **availability of and access to doulas** in the state, particularly in communities with the most significant health disparities such as Black communities, Indigenous communities, other communities of color, rural communities, and low-income families. Doulas provide safe and culturally responsive services to support the needs of pregnant people before, during, and after birth; help improve birth outcomes; and foster trust between healthcare providers and their communities.

In 2021, the Minnesota Legislature authorized MDH to review and designate doula-certifying organizations, ensuring doulas meet consistent standards of training and practice. Since this practice began, the number of doula-certifying organizations in Minnesota has nearly tripled and more than 200 doulas have been registered to provide services to Minnesota communities. The expansion of doula-certifying organizations promotes health equity by increasing the availability of trained doulas, particularly in underserved communities where disparities in maternal and infant health outcomes persist.

To further expand access, MDH conducted a survey of doulas in 2023 to identify the most pressing barriers to working with families. The agency then convened a workgroup of doulas, midwives, obstetricians, nurses, and hospital administration staff to guide the development of trainings for all hospital staff in Minnesota with the goal of improving the relationship between doulas and hospitals. Beginning in April 2024, MDH has also curated a list of doulas on the Help Me Connect website – a resource connecting expectant families, families with young children, and those working with families – that allows families to search for doulas that share their cultural or lived experience or has experience with their specific needs.

MDH has also actively sought opportunities to share and replicate successful programs and policies within the agency that advance health equity. **The diverse media program** (also described in Recommendation 4.1) in the Infectious Disease Epidemiology, Prevention, and Control Division is one of these practices replicated across MDH. The division's international health team (which evolved to become the equity and engagement team) recognized that most of the agency's communications on public health information at the time lacked specific cultural tailoring and was disseminated through mainstream channels, which are often ineffective in reaching communities experiencing inequities.

In 2010, they experimented with a new approach and placed a few culturally tailored messages in community-specific media, such as on a Spanish language radio show and in a Hmong community newspaper. Program funding was unavailable, so they relied on their relationships with community leaders and the goodwill of media owners.

The messages were so well received that the team set aside funding the next year to buy ads on additional community-specific media platforms for messages about preventing and protecting against the spread of disease. The program has continued to grow each year, using an annual work plan to define priority communities based on current data trends.

Data showed, for example, that flu vaccinations among pregnant people in Minnesota dropped 10% during the pandemic, with the lowest flu vaccine coverage in African Americans, American Indians, rural communities, and in people under 25. After partnering with diverse media organizations to share culturally specific messages with links to information on the MDH website, webpage views and unique webpage viewers more than tripled.

The MDH Environmental Health Division replicated the model in 2015 to spread the word about drinking water protection. Many more divisions have followed suit since then.

This diverse media model and the relationships it strengthened served as the springboard for the agency's partnerships with more than 100 diverse media as part of the COVID-19 response (described under Recommendation 4.1). The ability of MDH to place prevention ads in diverse media across the state weeks before the first case of COVID-19 appeared in Minnesota is attributed to years of engagement with diverse media partners.

Community partner reflections

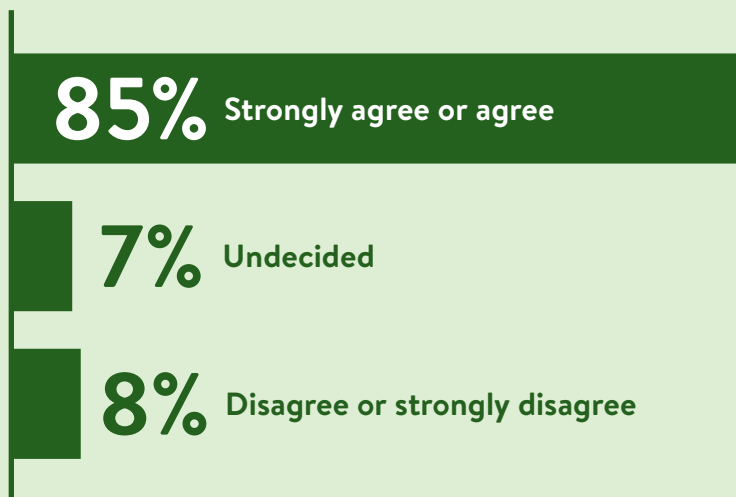
Community data highlight

Awareness of health equity efforts

The 2024 survey of community partners showed 85% of respondents agreed or strongly agreed that their organizations are aware of existing efforts to advance health equity at MDH. Just 8% disagreed or strongly disagreed and 7% were undecided.

This data suggests relatively strong awareness of MDH efforts to advance health equity among community partners. Continuing to partner with communities in the agency's efforts to advance health equity and communicate about these efforts broadly will be key to maintaining and even improving this indicator.

Our organization is aware of existing efforts to advance health equity at MDH



Many participants in the 2024 community conversations shared that their organizations currently use effective practices to promote health equity throughout the state and expressed the importance of continued MDH support for their programs. Several noted that MDH investments during the pandemic were crucial and enabled them to reshape service delivery, especially in healthcare, and significantly enhance their impact on advancing health equity.

“MDH was a very strong partner ... around the COVID vaccination efforts ... intention [was] given to making sure that underserved communities had access and that those doing the work in underserved communities were given the funding and the resources...”

—2024 community conversation participant

These investments have created strong partnerships with organizations across the state. Partnerships provide not only financial support, but technical assistance and logistics – which participants praised for helping build the capacity of their organizations.





Summary of progress on recommendation 2: Invest in efforts that are working.

MDH continues to invest in community-led efforts and other successful models to address disparities and target the root causes of health inequities. The Eliminating Health Disparities Initiative program and the expansion of the COVID-19 Community Coordinators are two notable examples of how the agency has successfully supported community-based organizations in advancing culturally specific approaches to persistent health inequities.

MDH has also invested in emerging practices and pilot programs to amplify the impact of successful models. By replicating and expanding the Infectious Disease Epidemiology, Prevention, and Control Division's diverse media program, MDH improved the reach and effectiveness of messaging in communities most impacted by inequities. Recent efforts to designate doula-certifying organizations and support doula integration in hospitals dramatically expanded access to doulas, who help improve infant and maternal health in underserved communities.

Strategic investments like these have helped accelerate health equity efforts across the state. This was underscored by community respondents who said they recognize that MDH has made significant efforts to advance health equity, noting the value of MDH technical and financial support to further their efforts.

Looking forward, MDH should continue investing in efforts that are working to advance health equity by supporting innovative culturally specific programs. By supporting community partners with measurement and evaluation tools to evaluate emerging practices, MDH can partner in bringing more community-driven solutions to inequities to scale. MDH is also committed to better assessing its own programs and practices to identify successful strategies and encourage expansion. With increased investment in programs that are already making a difference, MDH can more effectively advance health equity within diverse communities across the state.

Recommendation 3: Provide statewide leadership for advancing health equity.

MDH is a leader for health equity across Minnesota. This responsibility includes building public understanding of what creates health and health inequities and facilitating interagency, interdisciplinary, and cross-cultural efforts to guide policy development. Policy efforts to advance health equity need to cross all sectors and address topics like housing, transportation, energy, education, environmental regulation, incarceration, and health.

This multifaceted recommendation includes six sub-recommendations ranging from building the capacity of partners to implement health in all policies, to broadening relationships to strengthen community capacity to create their own healthy futures, to encouraging all health professions to build workforces that support health equity. These sub-recommendations, along with MDH actions to implement them, are described in this section.

3.1 Build statewide capacity to implement a health in all policies approach. Engage state, Tribal, and local governments and encourage all state agencies to adopt the health in all policies approach.

The longstanding partnership between MDH and local public health departments provided a foundation for building capacity for this work. In the years after the 2014 report, its relationship with the State Community Health Services Advisory Committee (SCHSAC) – a nonpartisan group of county commissioners, city council members, and local public health leaders from all regions of Minnesota – was a springboard for action.

Partnering with local public health

In 2015, SCHSAC formed the **Advancing Health Equity Work Group** to “provide local elected officials and local public health leaders with the language, understanding, and practical help to advance health equity throughout Minnesota’s public health system.” Together with MDH, the work group published a seminal 2016 report, “**Local Health Department Practices to Advance Health Equity**,” advising local public health agencies on ways to embed health equity across their programs.

The report provided six recommended practices for advancing health equity, including using a health in all policies approach to shape policies that impact the social and economic conditions in which people live. It also provided recommendations for MDH, local elected officials, and others on the role they must play in supporting this work.

In the years that followed, the MDH Center for Public Health Practice was central to many activities to build the capacity of local public health to advance health equity. They developed and facilitated several training modules for local public health to support them in implementing the recommended practices. Topics included health equity 101, health equity practices, and using a health equity lens.

Together with the SCHSAC work group, they developed an **online health equity resource library** with guides, videos, assessments, and other materials to increase local health department access to information and training, connect them with resources, and accelerate their efforts to advance health equity. Library resources have continuously received thousands of page views per quarter, with usage peaking at more than 10,000 views per quarter between 2020 and 2023.

Beginning in 2017, MDH convened two **Health Equity Learning Communities** to further support local health departments in integrating health equity practices into their work. MDH hosted recurring meetings to share foundational concepts to advance health equity and materials on health equity practices, implicit bias, health in all policies, structural racism, using an equity lens, and community engagement. Local health departments made use of slide decks, conversation starters, worksheets, videos on the learning community website, and materials in the health equity resource library.

A network approach

In the years after the COVID-19 pandemic, MDH experimented with a new model of providing statewide support and capacity building for advancing equity through the **Minnesota Health Equity Networks**. Launched in 2022, the networks offer a community of support for local public health, Tribal public health, and community organizations across the state by applying a regional and relational approach to address long-standing health equity issues. Network coordinators work alongside partners to build relationships; support existing work and activities that build capacity; provide a space to share expertise; and influence policy, structural, and system changes.

Attendance at statewide and regional Health Equity Network gatherings as of September 2024 numbered 2,285; network coordinators met with 478 partners; and 1,383 people participated in trainings. From January 2022 to March 2025, the networks provided grant funding for projects addressing long-standing health inequities made worse during the COVID-19 response. The projects aimed to foster successful partnerships and change the conditions that perpetuate health inequities.

3.2 Work with the Governor to convene and coordinate a cabinet-level team to include health equity as a key component of policy discussions.

The years after the publication of the 2014 report were rich with cabinet-level and cross-agency work to advance health equity. Following the release of the report, former Commissioner Ehlinger led efforts to embed health equity across state government. **Twenty-four state agency commissioners publicly affirmed their commitment by signing the report.** MDH also worked closely on policy issues with partners across the enterprise, and Commissioner Ehlinger reinforced this commitment by meeting directly with leadership teams, and often staff, at every state agency to define their roles in advancing health equity.

Meanwhile, former Governor Mark Dayton made **health equity a cabinet-level priority** and hired the state's first ever chief inclusion officer to ensure state government creates an inclusive environment and reflects the rich diversity of Minnesota. The Human Rights Department convened Governor Dayton's diversity and inclusion council a year after the 2014 Report was released.

In 2016, the Metropolitan Council published report titled "Diving Deeper: Understanding the Twin Cities Region's Racial and Ethnic Disparities" that asserts race and ethnicity are the driving forces behind the region's inequities, not other demographic differences like age, immigration status, and English skills. Governor Dayton urged state legislators to commit themselves to addressing these needs: "... the inequities afflicting Minnesotans of color in education, income, employment, and housing require additional state investments immediately."

Equity surged as a priority during the **2023 legislative session**, with lawmakers enacting dozens of laws supporting health in all policies, including paid family leave and universal free school meals (also described under Recommendation 1). Legislation in this session also formally codified a health subcabinet that brings together the commissioners of human services, commerce, management and budget, and health, and the executive director of MNsure to coordinate state agency and private sector efforts to reform the healthcare delivery and payment systems.

State statute governing the subcabinet requires that “reducing disparities and inequities in the experience or outcomes of healthcare” remains part of the subcabinet’s duties. Staffing for the subcabinet also includes a health equity director.

Meanwhile, another cross-agency work group has been working to address health disparities as part of the Walz administration’s One Minnesota goals. This group, currently led by leaders from health, human services, and commerce, is working to ensure all Minnesotans receive high quality healthcare that is free of provider or system bias. The group aims to reduce the percentage of Black Minnesotans and the percentage of trans and non-binary Minnesotans reporting unfair treatment by their providers by 50% by 2027.

Program highlight

Elevating racism as a public health crisis

The Health Equity Advisory and Leadership (HEAL) Council (described under Recommendation 4.2) wrote a letter in 2020 to former Commissioner Malcolm urging her to declare racism as a public health crisis. In response, MDH agreed that institutional and structural racism are two of the greatest barriers to advancing health equity across the state.

MDH then worked with the Minnesota Management and Budget’s consulting group, Management Analysis and Development, to facilitate the HEAL Council’s participation in a subcommittee on the One Minnesota Plan, elevate the concerns and wants of the HEAL Council, and co-develop the declaration and action plan. Several of the subcommittees’ recommendations were implemented. A resolution declaring racism as a public health crisis passed in the Minnesota House of Representatives in July of 2020, calling on the state to actively dismantle racism and encouraging the Governor and the Senate to follow suit.

3.3 Engage existing partnerships led by MDH to create a new and shared sense of responsibility and accountability for the health of all people in Minnesota across all sectors.

MDH leveraged existing partnerships with local and Tribal public health, stakeholder groups, advisory committees, and others to improve the health of all Minnesotans and create a shared responsibility for advancing health equity.

Cross-state efforts for foundational practices

MDH engaged local public health agencies (as described under Recommendation 3.1) in an array of activities following the 2014 report to ensure the state’s public health system is accountable for the health of all people in Minnesota. To further support agencies in translating theory into action, MDH engaged with local, state, and federal public health professionals from Illinois, Michigan, Wisconsin, and the CDC – to develop **“Foundational Practices for Health Equity: A Learning and Action Tool for Public Health Organizations.”**

The tool outlines seven foundational practices for health departments to advance health equity. These practices include: 1) expand the understanding of health in words and action; 2) assess and influence the policy context; 3) lead with an equity focus; 4) use data to advance health equity; 5) advance health equity through continuous learning; 6) support successful partnerships and strengthen community capacity; and 7) assure strategic and targeted use of resources.

The original tool, which was published in 2016, was updated in 2018 to include learnings from three state health departments that piloted the tool in their jurisdictions. Evaluation results from the pilot participants found that the tool helped generate dialogue, support understanding of challenging concepts, build health equity competencies, and lay the groundwork for actionable steps to improve health equity. Although originally piloted by states, the guide was also recommended for local health departments and community-based public health organizations seeking to improve their practice and move toward health equity.

Aligning and transforming the public health system

Around the same time, MDH recognized that providing technical assistance and tools was insufficient by itself and began shifting toward a more holistic, systems-level approach to improving the health of all Minnesotans. This approach emphasized how individual levels of government, including local, Tribal, and state, work together to create a strong system that protects and improves population health.

In 2019, MDH engaged local public health partners to create a **framework of public health responsibilities** tailored to Minnesota. While based on a national model, the national framework at the time lacked health equity as a core part of public health work – a component that MDH and SCHSAC felt was critical. The new Minnesota-specific model included health equity as one of nine foundational capabilities, affirming that every governmental public health agency should have the “ability to identify and respond to health inequities to assure the highest level of health for all populations through policies, programs, and strategies that respond to cultural factors affecting health.”

Informed in part by the work of MDH, as well as national conversations across the field of public health about the importance of health equity, the Public Health Accreditation Board updated the national framework in 2022 to include equity as a foundational capability that every health department must have. Satisfied with this addition, the following year, local and state public health leaders across Minnesota decided that the state would align with the national framework, which defines equity as the ability to:

- Address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity.
- Integrate equity and include equity-related accountability metrics into all programs and services.
- Build support for and foster a shared understanding of the critical importance of equity to achieve community health and wellbeing.
- Develop and support staff to address equity and to create a shared understanding of what creates health, including structural and systemic factors that create inequities.

Meanwhile, MDH embarked on a **process to assess the state’s capacity** to fulfill the agreed-upon foundational public health responsibilities. MDH knew that understanding current costs and capacity was critical for identifying and advocating for strategic future investments.

In 2022, MDH and the University of Minnesota conducted an assessment to identify the strengths, weaknesses, and needs of state and local public health. The assessment found specific gaps in policy development, data and epidemiology, and health equity. MDH also engaged consultants to create a Tribal-specific assessment – still underway at the time of publication of this report – and has been working individually with Tribal Nations to explore how MDH can help strengthen their public health capacity and infrastructure.

In addition to these efforts to build a solid foundation for health across the governmental public health system, MDH launched a new grant program in 2022 with funding from the state legislature – the **Minnesota Public Health Infrastructure Fund Innovation Projects** (highlights described in the box on the next page). Designed in 1976, Minnesota’s current public health system is outdated and not equipped to meet modern challenges. These ongoing grants were developed to support novel, creative approaches to address persistent public health challenges—like health equity—as well as emerging public health needs.

Through these grants, new ways of delivering foundational public health responsibilities are tested, adapted, and scaled. Funded projects bring together different government partners – including local public health, Tribal health, and others – to address gaps in public health infrastructure.

Program highlight

Highlights from Minnesota Public Health Infrastructure Fund Innovation Projects

These selected projects show how grants have supported new ways to advance health equity across several community health boards.

Integrating trauma-informed methods and practices: This work expanded methods across the community health boards of Bloomington, Edina, Richfield, Minneapolis, and Hennepin County, to become trauma-informed, healing organizations through community partnerships and by assessing policies, procedures, and systems. The organizations completed a trauma-informed assessment of their organizations, created and implemented a public health framework that recognizes and responds to racial trauma, and created a roadmap for collaboration on health and housing.

Supporting community work in new ways: Carver County Public Health created new initiatives to fund and partner with local nonprofit organizations to promote health equity, community engagement, and opportunity for all residents. The county supported local grassroots leadership to lead the way on health equity and address social determinants of health. Carver County received an additional two years of funding and has focused on improving community access to and use of mental health services with one of the trusted community organizations that became a registered nonprofit during the first two years of the project.

Co-creating with cultural communities: St. Paul-Ramsey County Public Health expanded work that began during the COVID-19 response to support a trusted messenger initiative that centers community voices and increases access to accurate, culturally specific, and linguistically appropriate public health information and healthcare services needed in the community.

Centering community voices:

The process of uplifting, trusting, and valuing the lived experiences of the people most impacted by health issues or inequities, especially those who have been historically marginalized.

-Adapted from AMA: A Guide to Language, Narrative, and Concepts

Engaging partners toward a common goal

In addition to its longstanding partnerships with local and Tribal public health, MDH has engaged advisory groups, councils, and other existing partners to create a shared sense of responsibility around health equity. For example, in 2018, the MDH Asthma Program in the Center for Health Promotion collaborated with the Minnesota Board of Cosmetology to improve **health and safety conditions for salon workers**. The workers, often immigrants or English language learners – who aren't covered by the same health and safety protections as other workers – were surveyed about respiratory issues and the training they received on breathing problems. The City of Minneapolis then completed a pilot project to test a ventilation system at a nail salon.

MDH continues to convene stakeholders to address health equity across many health issues. For example, the **migrant health roundtable** began in June 2024 as a forum for healthcare providers serving newcomer populations to network, share resources, ask questions, discuss challenges, and get answers.

MDH has also taken advantage of its relationships with clinics to support healthcare systems as they move toward health equity. The MDH **Health Care Homes program** is an innovative approach that promotes care coordination and collaboration between primary care clinicians and community resources to support whole-person care and facilitate the broader goals of improving population health and health equity. Starting in 2016, the MDH Health Policy Division engaged in a multiyear rulemaking process to create a new certification system for Health Care Homes with health equity at its core.

The new multilevel certification that went into effect in 2022 allows healthcare providers and organizations to certify at one of three levels: foundational, level two, or level three. Levels two and three signify working directly to advance health equity and achieve equitable outcomes within the clinic. Level two, for example, requires clinics to have a process for screening, identifying, and addressing the social determinants of health and to have strengthened their care coordination systems and partnerships across medical community supports. Clinics who reach level three demonstrate an even stronger focus on community health through efforts such as working with community partners to plan for population health improvements and sharing aggregated, de-identified data that describes health inequities. Since the new standards went into effect, 63 clinics have certified at level two and 252 at level three.



Figure 3: Health Care Homes certification seals
Levels two and three signify working directly to advance health equity and achieve equitable outcomes within the clinic.

3.4 Consider methods to strengthen communities to create their own healthy futures.

Three distinct approaches are suggested in the 2014 report to implement this sub-recommendation: 1) review the membership of advisory committees and investments in the training and capacity building of community leaders both within MDH and with partners; 2) identify strategies to increase the capacity of communities to participate in a health in all policies approach, including training and education, technical support on use and analysis of data, and health impact assessments; and 3) explore the establishment of a community-driven health impact assessment process.

Assessing advisory committees

Advisory committees often play important roles in setting the strategic direction of MDH programs and guiding the implementation of projects and initiatives. The MDH Community Engagement Unit (described under recommendation 4.1) completed an extensive **review of the department's advisory groups** in 2017 to better understand how well MDH was leveraging its advisory committees to engage diverse viewpoints and amplify the voices of communities to create their own healthy futures.

Among many findings, the unit found that participation in MDH advisory groups requires a significant time commitment, often during the work week and during working hours. This creates barriers for many individuals to participate, especially those from communities most heavily impacted by health inequities. The review also showed that most advisory committees did not provide a stipend, childcare support, or transportation assistance for members, which can alienate potential members who do not have support from their employers. The unit shared the results of the survey with MDH divisions and provided them with training on recruiting more diverse participants and facilitating inclusive conversations.

Despite these efforts, a preliminary inventory conducted by MDH in 2022 of information on its advisory committee webpage found that only 7% of the 45 advisory groups functioning under statutory authority described their work with a health equity lens. Efforts to further broaden the membership of advisory councils and leverage their power to advance health equity continue today.

Equity lens:

A way of evaluating policies, programs, or decisions to ensure they are fair and inclusive to all people, specifically including historically excluded or marginalized groups.

-MDH working definition

Program highlight

Minnesota Sickle Cell Collaborative

To better address sickle cell disease health disparities identified in the 2014 Report, the Newborn Screening Program began sickle cell trait notification directly to families and providers in 2015. At the same time, the Minnesota Sickle Cell Collaborative was created for MDH, community organizers, and clinicians to address needs and challenges for Minnesotans living with the disease. More than 60 people attended a 2018 Sickle Cell Stakeholder Forum organized by the collaborative to identify needs and concerns and to work in partnership toward solutions. This led to the creation of a roadmap that outlined areas for improvement called “Generations of Unmet Needs.”

As a result, MDH established the Sickle Cell Data Collection program in 2019 – one of 16 state programs supported by the Centers for Disease Control and Prevention to learn more about the experiences of those living with sickle cell disease. Staff from multiple programs within MDH are working with partners to establish a statewide data system to ultimately improve health, life expectancy, and overall quality of life.

Strengthening community capacity

To support the training needs of partners and strengthen their capacity to make local change, MDH staff designed the **Health Equity Data Analysis (HEDA)** process in 2015 help local public health departments improve their ability to identify health inequities in their jurisdictions. These inequities may be rooted in isolation, poverty, racism or other issues affecting rural and urban areas of the state.

The HEDA process is designed to not only identify inequities, but to connect inequities to the broader factors (policy and systems) that drive and further contribute to them. In addition, there is intentional engagement with key populations that experience health inequities to ensure they are included in the assessment process. Results can be used to provide direction for action to eliminate health inequities. Between 2016 and 2018, MDH staff trained all 41 local public health partners in the Statewide Health Improvement Partnership on how to conduct a HEDA in their jurisdictions.

MDH has used grants to further support the work of local health departments, hospitals, and community organizations to meet and address current needs, as well as to strengthen local capacity to create healthy futures. For example:

- Investment in rural public health infrastructure was a critical gap highlighted by the COVID-19 pandemic. Rural public health agencies are historically underfunded and struggled during the pandemic with aging systems, limited staff, and inadequate resources. In 2022, MDH secured federal grant funding to support rural hospitals and community health boards through new **Rural Health Assessment Grants**. The funds supported ongoing community health assessments and planning to improve health equity, reduce health disparities, and address social determinants of health.
- The **Community Solutions for Healthy Child Development Grant** program is designed to improve child development outcomes, reduce racial disparities in children's health and development, and promote racial and geographic equity. Since the program began in 2020, grant funding has supported community-based solutions for community-identified challenges, including mental health resources, early childhood education, and cultural identity. This approach strengthens the community's ability to create their own healthy futures. Initially established as a pilot program, the legislature allocated additional funds to continue and expand the program in 2023.
- In 2023, the legislature also provided funding for the **Emmett Louis Till Victims Recovery Program** to support culturally specific, community-led efforts to address historical and ongoing racialized trauma, discrimination, and violence. Two individual organizations and four collaborative partnerships became the first recipients of the grant program in May of 2024, to provide culturally grounded services like wellness retreats, community healing circles, grief and trauma therapy, remembrance events, and holistic supports to address physical, mental, cultural, and spiritual needs. In its first quarter, the program served 295 Minnesotans: 218 participated in collective healing activities and 77 accessed free individual therapy and wraparound supports. Community response to the grant opportunity far exceeded available funding, demonstrating an urgent and ongoing need for sustained investment in community healing and recovery.

Community health assessment:

An evaluation process that provides a picture of the health status of the community. It identifies and describes factors that affect the health of a community and the available resources to address those factors. The results of a community health assessments help determine local public health priorities.

-MDH working definition

Community-driven assessment and action

MDH has also invested in models designed to engage community members in co-creating action on issues that matter. In 2022, MDH created the **Community Voices in Data and Public Health work group** – also known as the long COVID-19 steering committee – to guide the agency’s community response to long COVID. The group brings together MDH staff and community members to design strategies to enhance understanding and awareness of the impacts of long COVID on Minnesotans and increase access to quality care and support.

The lived experience and expertise of work group members has led to state legislation and ongoing funding for community-driven improvements in awareness, identification, support, and coordination of care and services for patients with long COVID. The evolving community-based network is working together to develop culturally appropriate messaging, surveys, resources, and services for a variety of audiences – including healthcare providers and community service organizations – and identify trusted messengers to effectively share information and resources about long COVID to communities across the state.

In the 2024 conversations with community partners, the work group was praised for its intersectional, community-driven approach and viewed as a strong example of how MDH could apply health equity-focused frameworks across programs. MDH continues to build on this community-driven approach to assessment and action in other initiatives within the Health Promotion and Chronic Disease Division.

Intersectionality:

The complex, cumulative way in which the effects of multiple forms of discrimination combine, overlap, or intersect, especially in the experiences of marginalized individuals or groups, to produce and sustain complex inequities.

-Adapted from Minnesota Office of Inclusion, Inclusive Language Definitions

Program highlight

Equitable Health Care Task Force

In 2023, Commissioner Cunningham appointed 20 members to the Equitable Health Care Task Force. Established by the Minnesota Legislature, the task force was charged with examining inequities in healthcare experiences and identifying strategies to ensure care and coverage in Minnesota are respectful and promote optimal health outcomes.

Task force members brought together a broad array of communities, perspectives, and expertise to the work. The group also consulted with relevant individual and organizational stakeholders and conducted a robust public engagement process to ensure community perspectives were represented in their recommendations.

At the time of publication of this report, the task force had concluded its work by making recommendations to the commissioner on ways to provide meaningful access to care, bolster primary and whole-person care, strengthen and diversify the health workforce, and ensure system accountability to help create a more equitable healthcare system in the state.

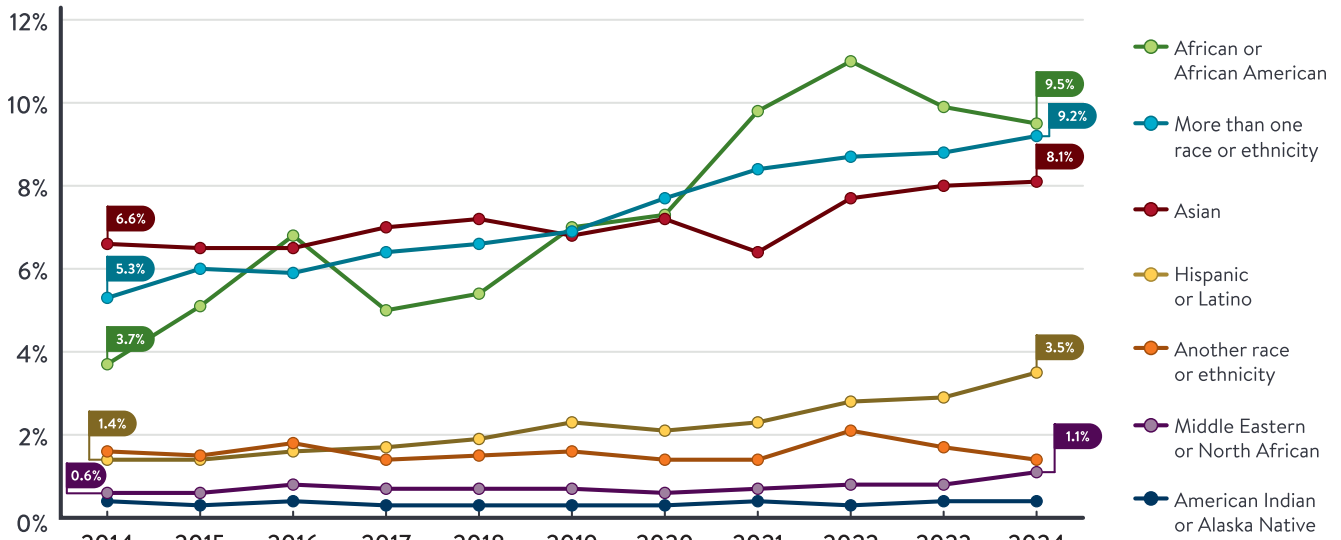
3.5 MDH should use its leverage as the lead public health agency to encourage all health professions to build workforces that will advance health equity.

Since 2014, MDH has taken several actions to strengthen and diversify the healthcare and public health workforce. This includes addressing gaps in the workforce, reducing barriers to health professions, and equipping the public health workforce to advance health equity.

Removing barriers to health professions

Achievements have been made to address gaps in the healthcare workforce and identify opportunities to reduce barriers for those with skills to meet community needs. Over the past decade, Minnesota’s healthcare workforce has grown more racially and ethnically diverse, as evidenced by data from the Minnesota Health Care Workforce Survey. Healthcare providers include physicians, physician assistants, nurses, mental health providers, and other licensed professionals. Together, the share of first-time licensees in this group who identify as African or African American increased the most, from 3.7% in 2014 to 9.5% in 2024. First-time licensed providers who identify as Hispanic, Latino, Asian, Middle Eastern, North African, or multiracial also grew during this period.

Diversity in first-time licensed healthcare professionals over time



Data includes all licensed providers except occupational therapists and occupational therapy assistants.

Year of initial license	African or African American	American Indian or Alaska Native	Asian	Hispanic or Latino	Middle Eastern or North African	More than one race or ethnicity	Another race or ethnicity
2014	3.7%	0.4%	6.6%	1.4%	0.6%	5.3%	1.6%
2015	5.1%	0.3%	6.5%	1.4%	0.6%	6.0%	1.5%
2016	6.8%	0.4%	6.5%	1.6%	0.8%	5.9%	1.8%
2017	5%	0.3%	7%	1.7%	0.7%	6.4%	1.4%
2018	5.4%	0.3%	7.2%	1.9%	0.7%	6.6%	1.5%
2019	7%	0.3%	6.8%	2.3%	0.7%	6.9%	1.6%
2020	7.3%	0.3%	7.2%	2.1%	0.6%	7.7%	1.4%
2021	9.8%	0.4%	6.4%	2.3%	0.7%	8.4%	1.4%
2022	11%	0.3%	7.7%	2.8%	0.8%	8.7%	2.1%
2023	9.9%	0.4%	8%	2.9%	0.8%	8.8%	1.7%
2024	9.5%	0.4%	8.1%	3.5%	1.1%	9.2%	1.4%

The MDH Office of Rural Health and Primary Care invested in the healthcare workforce through robust **grant programs and student loan repayment programs**. MDH also expanded the pathway to medical practice to allow physicians who graduated from international medical schools to care for Minnesotans. The **International Medical Graduate program**, established in 2015, has increased access to primary care services in rural and underserved areas. The program awards grants for career guidance, clinical preparation, and primary care residency. The primary care residency program has trained 18 international medical graduates to date, and the clinical preparation program has trained four graduates per year. Over the past two years, 81 graduates from nearly 30 countries received career guidance and support for practicing in Minnesota from program grantees.

Identifying and supporting emerging professions

Minnesota has also been a leader in identifying and supporting emerging healthcare professions as a way to advance health equity. In 2009, it was the first state to authorize **licensing dental therapists and advanced dental therapists**, with 32 licensed dental therapists in the state in 2014.

MDH has undertaken many efforts to support the dental therapist profession over the past 10 years, including a first-ever evaluation of the impact of dental therapists on access and safety, the development of a toolkit and other resources on how to integrate dental therapists into existing dental practices, and ongoing data collection and publications about the dental therapist workforce.

Since the 2014 report, the number of licensed dental therapists in Minnesota has steadily increased to 147 in 2024. This growth has increased access to dental care for those who suffer disproportionately from oral diseases, including low-income residents, people of color, and the elderly.

MDH has also led the advancement and integration of the **community health worker profession** as another vital health equity workforce within healthcare, local public health, and home visiting – especially in rural areas and other communities disproportionately affected by inequities. These professionals serve as liaisons between communities and the health or social services they need. They ensure cultural, linguistic, and other tailored services are available and advocate for the needs of individuals and communities.

Prior to the release of the 2014 report, the MDH Statewide Health Improvement Partnership identified this profession as a promising practice, encouraging grantees to support their work. In the years that followed, MDH funded the integration of community health workers within six healthcare organizations to reduce costs and improve care and overall population health. The program also developed an employer toolkit to increase workforce adoption of these workers across the state.

Between 2022-2024, MDH partnered with the Minnesota Community Health Workers Alliance to launch a program to train more than 200 new community health workers and to support six community health worker apprentices at four employer sites. State legislation in 2023 provided funding for MDH to support the alliance in further strengthening and expanding this growing part of the health workforce. The funds have helped improve collaboration between state and community partners to develop an infrastructure plan for workforce training, expansion, and sustainability. MDH and the alliance have also partnered to advance policies and financing that support community health worker employment and retention and develop a measurement plan to evaluate the impact of community health workers on healthcare access, cost, and health outcomes for populations experiencing disparities.

As of 2024, community health workers are providing services in 47 of the 87 Minnesota counties, and 64% of these workers who have completed a community health worker certificate program are from Greater Minnesota.

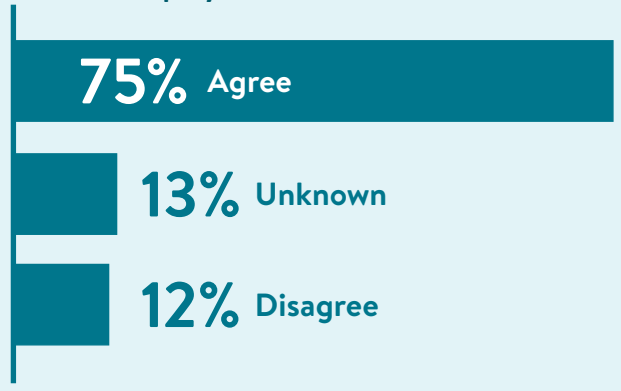
MDH staff data highlight

Advancing equity within staff roles

In the 2023-24 survey of MDH staff, 75% of staff agreed that they know how to advance health equity in the work that they do. The remaining participants responded with unknown (13%) or disagree (12%).

With a quarter of respondents indicating that they don't know how to advance health equity in their work, MDH has an opportunity to more clearly define how health equity connects to every employee's job responsibilities. The agency should consider steps to better understand current barriers and consider increasing staff and supervisor training, updating job descriptions to include health equity, and mobilizing the health equity strategist team to support divisions in this arena.

I understand how to advance health equity in the work that I do



3.6 MDH should work to build public understanding and awareness of the factors necessary for health, health disparities, and health equity. This includes developing a plan to share and disseminate the Advancing Health Equity Report.

The 2014 Advancing Health Equity Report was first-of-its-kind. To bring public attention to the report and its contents, MDH used multiple strategies, including a press release and press conference. Media coverage by Minnesota Public Radio, the Star Tribune, broadcast news, and other major outlets highlighted the report's focus on the relationship of race to the structural inequities that contribute to health disparities.

Former Commissioner Ehlinger was a stalwart champion for health equity. Following the publication of the 2014 report, he regularly integrated health disparities into his speaking engagements and appearances at local and national conferences and in front of national health organizations; at meetings with Tribal Nations, community organizations, healthcare and business leaders, and advisory groups; and on the road during his **"Pitch the Commissioner"** events, a series of informal meetings over a game of horseshoes, designed to hear directly from residents across the state.

Other efforts to broaden public understanding include the 2020 **"Cultivating a Health Equity Ecosystem"** report, which reflects on Minnesota's investment in the Eliminating Health Disparities Initiatives grant program (described under Recommendation 2.1) over the past 20 years. The report looks at the impact the initiative has had in adapting or creating programs tailored to specific values and situations of communities, increasing access to prevention and care among communities that conventional public health programs have failed, and effecting change at individual, institutional, and systems levels.

Despite clear and quantifiable grantee successes, the report advocates that effectively addressing health disparities and improving health for all Minnesotans requires a holistic approach — one that recognizes the role of all organizations and systems that impact individual and community health in eliminating structural inequities.

Community partner reflections

Participants in the 2024 community conversations shared a variety of views about the effectiveness of MDH efforts to build public understanding and awareness of the factors essential for health and health equity. While some noted a heightened awareness of health inequities overall, they noted inconsistent understanding and awareness of racial inequities across the state's geographic regions. Others shared that, despite growing awareness, meaningful progress feels slow and sometimes appears surface-level.

MDH staff data highlight

Building public understanding

In the 2023-24 survey of MDH staff, 67% agreed that they contribute to Minnesotans' awareness and understanding of health equity. Less than a quarter (19%) were undecided, and the remaining 14% either disagreed or strongly disagreed.

Job duties at MDH vary from division to division and role to role. Given the variety in roles, this data is a positive sign that most staff in related roles are making a difference in the general public's awareness and understanding of health equity.



Summary of progress on recommendation 3: Provide statewide leadership.

MDH built a strong foundation for advancing health equity and the health in all policies approach by mobilizing its relationships and resources across Minnesota. The creation of a resource library, learning community, and data analysis process empowered local public health to advance health equity in their jurisdictions and fostered a common understanding of the foundational practices for this work. MDH grants and guidance, coupled with its network approach to providing support and technical assistance, has engaged health equity champions across the state.

MDH also engaged local, regional, and national partners with the goal of transforming the public health system to improve the health of all Minnesotans. Investments in rural public health infrastructure and the statewide public health workforce further advanced health equity across the state. Meanwhile, the agency helped identify and support emerging healthcare professions, including dental therapists and community health workers, and developed a new healthcare homes certification system with health equity at its core.

Health equity also became a legislative and executive branch priority in the years following the report. Collaboration at the cabinet-level, including the recently codified health subcabinet and the One Minnesota health disparities group, has elevated health equity as a priority in efforts to improve healthcare policy, outcomes, and experiences. Former Commissioner Ehlinger led efforts to embed health equity across state government and MDH worked closely on policy issues with multiple state agencies. These efforts have been reflected at the state legislature in recent years through legislation reflecting health in all policies principles.

While community partners acknowledged MDH efforts to build public understanding and awareness of health equity, some consider the pace of change slow and the depth of change limited. Internally, most MDH staff indicated an understanding of how to advance health equity in their work and a sense that their work contributes to Minnesotans' awareness and understanding of health equity.

MDH is committed to continuing to provide bold leadership statewide by mobilizing public health and other partners, encouraging innovation in public health systems, and strengthening the public health workforce. To do this, MDH must continue to invest in its partnerships with other state agencies, as well as with local and Tribal public health, while strengthening the capacity of communities to create their own healthy futures. Improving the health equity focus of MDH advisory councils, coupled with renewed efforts to build public understanding of the factors necessary for health and health equity, is key to future success.

Recommendation 4: Strengthen community relationships and partnerships to advance health equity.

It is a longstanding commitment of MDH to partner with people and organizations across the state, including local public health departments, local jurisdictions and elected officials, the 11 Tribal Nations across Minnesota, and community organizations. Recommendation 4 stressed the need for MDH to broaden the scope of these partnerships and develop stronger connections with Minnesota communities. It includes two sub-recommendations: expand the range and depth of relationships and create avenues for diverse communities to meaningfully participate in the decisions that affect their wellbeing.

4.1 Expand the range and depth of MDH relationships with multiple communities.

Building and sustaining partnerships – both formal and informal – takes time and effort. MDH investment in community engagement and collaborative decision-making has progressed since 2014 from limited and often sporadic engagement around specific projects to engaging in more long-term relationships toward the broader, common goal of advancing health equity.

Strengthening capacity for engagement

To advance this work, MDH established a **Community Engagement Unit** in 2015 to provide technical support and capacity building for MDH staff and programs as well as local public health partners. This unit developed an agency engagement plan as well as **Community Engagement 101 training** for MDH staff designed to increase their capacity for community engagement work. Additional trainings were developed and offered to supervisors and managers.

In 2019, community members and MDH jointly co-wrote and co-designed the second iteration of the unit's plan: **Community Engagement Plan 2020-2023**. The foundation laid by this work – including the relationships strengthened and the capacity built among MDH staff and leaders – proved invaluable in the COVID-19 response, which solidified many partnerships and networks that remain active today.

Deepening Tribal partnerships

Relationships with the 11 federally recognized Tribal Nations that share geography with Minnesota are among those that have deepened since the 2014 report. Efforts to engage and partner with Tribes have become both more frequent and intentional. The **MDH Tribal Consultation Policy**, developed in response to a 2013 Minnesota Executive Order, acknowledges the unique political relationship between the State of Minnesota and Tribal Nations. The policy requires agency program areas and divisions to consult with Tribes before taking actions that significantly affect one or more of them.

The policy also further embedded the role of the newly created **MDH Tribal liaison** to Tribal Nations across Minnesota – a role that has expanded significantly since the 2014 report – to work collaboratively across all MDH divisions and programs. The department's commitment to strengthening relationships with Tribal Nations and urban American Indian communities is also evident in the creation of the Office of American Indian Health in 2022 (described under Recommendation 6.1), charged with improving the health and wellbeing of American Indian communities.

Community engagement:

The process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their wellbeing.

-Adapted from the Minnesota Statewide Health Assessment

As part of the COVID-19 response, MDH expanded the **Local Public Health/Tribal Health Branch of its response structure** to equip local and Tribal public health partners with health equity-focused strategies. Within this branch, a dedicated Tribal team addressed the unique needs of Tribal Nations, providing technical assistance, data reporting, disease prevention and control, guidance, communication, and grantmaking support. During this time, MDH and Tribal health directors opened their recurring meetings to staff from federal congressional offices, fostering information sharing and a more coordinated response to Tribal needs. This expansion strengthened MDH capacity to partner with and support Tribal Nations – a legacy that continues today through many American Indian-focused initiatives across the agency.

Partnering with community through COVID-19

The COVID-19 response also provided an opportunity for MDH to strengthen relationships with hundreds of diverse media agencies, community-based organizations, and leaders serving historically marginalized groups. Dedicated **MDH community liaisons** in the Cultural, Faith, and Disability Communities Branch of the response structure (described under Recommendation 4.2) fostered communication, deepened connections, and helped establish new partnerships – especially within the disability community. The COVID-19 Community Coordinators initiative (described under Recommendation 2.1) is a standout example of the emphasis placed on and investments made in community empowerment, trust, and capacity building.

The COVID-19 pandemic made apparent the agency’s need to increase engagement with the disability community to ensure recognition and the inclusion of the community’s perspectives. To address this gap, MDH partnered with the Minnesota Consortium for Citizens with Disabilities, to host seven **Let’s Talk Virtual Forums** between December 2020 and August 2021. These topic-based forums provided a safe space for community members to connect with MDH, share needs and concerns, and receive timely guidance, helping to reduce fear and anxiety.

MDH also formed an **Accessibility Work Group** that ensured accessibility was embedded in all aspects of the COVID-19 response. This included on-site testing and vaccine locations, procurement and contracting processes, coordination with vendors, and the development of accessible resources. Intentional outreach conducted through the work group, the virtual forums, as well as a new external disability advisory committee was instrumental in shaping a COVID-19 response that better met the needs of the disability community. The inclusion of disability in the Cultural, Faith and Disability Communities Branch created at the start of the pandemic response further elevated disability as a health equity issue.

Accessibility:

Ensuring that all people – including people with disabilities – can acquire the same information, engage in the same interactions, and enjoy the same services.

-Adapted from Minnesota Office of Inclusion. Inclusive Language Definitions

PROTECT OUR COMMUNITY



Program highlight

COVID-19 diverse media and community engagement partnerships

MDH relationships with more than 100 experienced, trusted, and diverse media vendors and community organizations were instrumental to keeping all communities and Tribes across Minnesota informed during the COVID-19 emergency response.

These relationships ensured access to needed, accurate, and timely messages that were also culturally relevant and linguistically appropriate for communities of color, American Indians, LGBTQ+ communities, people with disabilities, and those with limited English proficiency.

WEARING CLOTH FACE COVERINGS IN PUBLIC SETTINGS WILL LIMIT THE SPREAD OF COVID-19

STAY SAFE MN



DESIGNED BY

MNI SOTA FUND

5/2020

A @LUVEQUAY DESIGN

Figure 4: A COVID-19 flyer designed in 2020 by a partnership of organizations serving American Indian communities led by the Metropolitan Urban Indian Directors.

Continuing legacy: centering community

In recent years, MDH has continued to make intentional efforts to invest in and strengthen its relationships with the disability community and to build the capacity of its own staff to apply a disability equity lens across programs. As part of this work, MDH established the cross-agency **Disability Health Equity Collaborative**, which continues to center and elevate issues affecting people with disabilities. The agency also developed a COVID-19 resource webpage for individuals with disabilities, caregivers, health professionals, and school staff.

MDH's Emergency Preparedness and Response Division uses the whole community approach to ensure there is a shared understanding of community needs and capabilities, greater empowerment and integration of resources, and increased individual and collective preparedness. Using this approach starts before an emergency occurs and ensures that community members are engaged, that demographic data is used, and that barriers to a successful response are identified.

MDH efforts in the years after the 2014 report, throughout the COVID-19 response, and beyond represent a deliberate shift toward honoring community knowledge and lived experience and centering community voices in the work of the agency. The relationships strengthened throughout the years continue to shape how MDH approaches advancing health equity across Minnesota.

Community partner reflections

Community conversations in 2024 revealed that MDH partners highly value MDH use of the trusted messenger model, which allows community-based organizations to deliver health messages in culturally relevant ways. Having a trusted messenger makes a difference for building trust and reaching communities on sensitive health issues.

Participants also shared that they want more MDH staff to attend community events and engage with communities, further highlighting the importance of building trust with communities across the state.

Community data highlight

Approaching collaborations with humility

In the 2024 survey of community partners, 69% of respondents agreed or strongly agreed that MDH approaches community collaborations with humility. Nearly a quarter (23%) were undecided, while 8% disagreed or strongly disagreed.

With nearly a third of respondents either disagreeing or feeling unsure of whether MDH approaches collaborations with humility, the agency has an opportunity to ensure a more consistent approach to collaboration with communities across the agency, emphasizing active listening, mutual learning, and accountability.

Program highlight

Latinos Serving Latinos

A group of 70 Latino leaders representing nonprofits, community-based organizations, and local media formed as part of the community response to COVID-19 to share information, services, and resources, and to provide networking opportunities for members. The MDH Community Engagement Unit provided leadership and guidance. Group members built genuine relationships through their shared interests and concerns, and they continue to meet biweekly on topics ranging from health and education to immigration and safety. They identify pertinent concerns in the community, set agendas, and connect with the Governor's Office and other state agencies to advocate for community needs.

MDH approaches community collaborations with humility

69% Strongly agree or agree

23% Undecided

8% Strongly disagree or disagree

4.2 Create avenues for meaningful participation of Minnesota’s diverse communities in project governance and oversight, assuring that the people who are affected by various decisions are involved in the decision-making process.

MDH created multiple avenues for meaningful participation by Minnesota’s diverse communities in agency decision-making – both at an agency level and within its divisions and programs.

Guided by formal advisory bodies

External advisory bodies like the **African American Health State Advisory Council**, established in 2023 alongside the Office of African American Health (described under Recommendation 6.1), and the **Rural Health Advisory Committee** play key roles in advancing health equity. The examples below illustrate how councils and task forces contribute to this work:

- In 2017, MDH formed a **Community Voices and Solutions leadership team** to guide the African American Infant Mortality Project (described under Recommendation 1). Members represented various sectors, including social workers, doulas, midwives, physicians, educators, housing advocates, and more. Using a shared leadership and decision-making approach, the team partnered with MDH to engage the African American community in addressing the social determinants driving inequities through a health in all policies approach.
- In 2018, MDH established the **Health Equity Advisory and Leadership (HEAL) Council** to guide efforts to address health inequities across various ethnic, racial, and regional groups. The HEAL Council includes voices from many communities most severely impacted by health inequities, including communities of color and American Indian communities, rural Minnesotans, Minnesotans with disabilities, LGBTQ+ community members, refugees, and immigrants. The council advises on MDH policies and programs, supports the implementation of the department’s strategic plan and the 2014 report, and helps develop performance measures to advance health equity.
- In 2019, MDH convened the first **Community Solutions Advisory Council** – a group of community advocates that advises the agency on the Community Solutions for Healthy Child Development grant program (described under Recommendation 3.4). The advisory council guides the application process, reviews applications, and supports the agency’s health equity and early childhood grant efforts. It has become an effective model for co-developing and co-implementing a community-led grant program in partnership with community leaders.
- While not a formal advisory body, **Tribal Health Directors** across Minnesota meet quarterly with MDH to discuss key public health issues that impact Tribal Nations. These meetings provide an opportunity for MDH to deepen relationships with the 11 Tribal Nations that share geography with the state. Coordinated by the MDH Office of American Indian Health and Tribal Relations, these meetings recognize the state’s legal and moral obligations to Tribes as part of their government-to-government relationship.

Community data highlight

Community input in decision-making

Half (50%) of 2024 community survey respondents agreed or strongly agreed that MDH incorporates community feedback into its decisions. Nearly half (41%) were undecided, while 9% disagreed or strongly disagreed.

This data indicates ample opportunity for improvement in incorporating community feedback in decision-making. The large percentage of undecided respondents – coupled with a smaller percentage who disagree – suggests that MDH must improve its feedback loops with community partners and increase transparency about how community input is used.

Program highlight

Vaccine Allocation Advisory Group

With the rollout of COVID-19 vaccines, ensuring equity in Minnesota's vaccine allocation strategy became essential. In September 2020, MDH convened the Vaccine Allocation Advisory Group to adapt the CDC's Advisory Committee on Immunization Practices federal vaccine allocation recommendations to meet the needs of Minnesotans. The group included key medical and public health partners across the state and representatives from the HEAL Council and communities experiencing health inequities.

The group recommended using the CDC's Social Vulnerability Index to determine regional allocations across multiple phases. As phases rolled out, new members, such as representatives from frontline essential workers, were added to the group to represent emerging inequities. Public comment was also solicited, and feedback from communities and organizations statewide was incorporated into later phase recommendations.

Community engagement across programs

MDH also created avenues for meaningful participation outside of formal advisory bodies. The Child and Family Health Division centers community voices through community-engaged needs and strengths assessments. As part of the **Title V Maternal and Child Health Block Grant Program**, Minnesota is required to complete a needs assessment every five years.

In 2020, the program adopted a community-focused, trauma-informed, and intersectional approach to its needs assessment process, prioritizing populations most impacted by health disparities or typically underrepresented in engagement efforts. Progress on these strategies was tracked through yearly reports and data stories highlighting completed work. Success was measured using evidence-based and trauma-informed strategy, performance, and outcome measures.

Trauma-informed:

An approach that takes into account the unique needs, culture, history, and context of people who have experienced trauma in order to provide effective healthcare or other services with healing, safety, and empowerment in mind.

-Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)

Community data highlight

Participation in decision-making

In the 2024 survey of community partners, 63% of respondents agreed or strongly agreed that MDH creates opportunities for community members to participate in strategic decision-making to improve the health of Minnesotans. More than a fifth (21%) were undecided, while 17% disagreed or strongly disagreed.

While it is encouraging that a majority of respondents agree, the relatively large segments of those who are undecided or disagree suggest there is room for improvement. Whether this means creating more opportunities for community members to participate in strategic decision-making or ensuring existing opportunities are effectively promoted across cultural and geographic communities, MDH can do better to ensure community feedback continues to shape decision-making.

The **Cultural, Faith, and Disability Communities Branch** in the agency's pandemic response structure became a central hub for elevating community voices and insights to guide MDH efforts during the COVID-19 response. At its peak, the branch included up to 70 fully or partially reassigned staff and contractors dedicated to partnering with communities hit hardest by the pandemic. Dedicated teams served African American, African immigrant, American Indian, Asian and Pacific Islander, disability, faith-based, Latino and Hispanic, and LGBTQ+ communities, as well as recently arrived refugees and seasonal, agricultural, and migrant workers.

Branch staff focused on building relationships and trust, amplifying community feedback to decision-makers, convening community partners, coordinating with local public health and other state agencies to address urgent needs, and advocating for equitable systems and policy changes. They also coordinated translation reviews and multilingual voiceovers for COVID-19 communications, consulted on media projects for diverse communities, and developed culturally and linguistically appropriate resources. After the pandemic, this branch transitioned to the Cultural, Faith, and Disability Communities Collaborative to continue to provide a space for staff from across the agency to collaborate to meet community needs.

One early example of the work of this team was the development of **guidance for Hmong funerals during COVID-19**. In August 2020, the community liaison team worked closely with Hmong staff at MDH, community and business leaders, and Hmong cultural and spiritual leaders to create culturally specific guidance that summarized relevant executive orders and suggested ways to adapt cultural practices while honoring traditions. One example of culturally-specific guidance was to shorten a traditional three-day funeral ceremony to one day to reduce opportunities for disease transmission. The guidance was well received within the Hmong community and widely shared by diverse media outlets, funeral homes, and community-based organizations. It now serves as a model for developing culturally specific public health guidance on other topics.

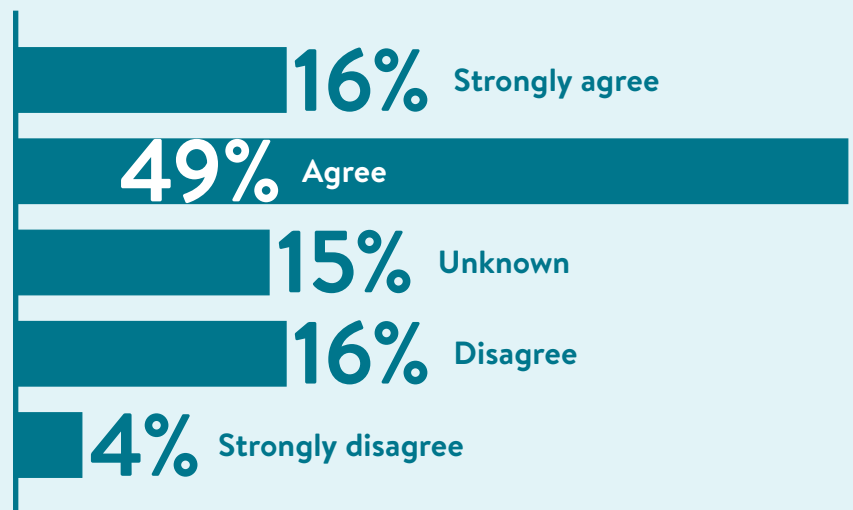
MDH staff data highlight

Community voices in decision making

In the 2023-24 survey of MDH staff, 65% of respondents agreed or strongly agreed that they use community perspectives, wisdom, and stories in their decision-making process; 15% responded that they didn't know and 20% disagreed or strongly disagreed.

Given the variety in staff roles and responsibilities, this data is a positive sign that most MDH staff in relevant roles are incorporating and prioritizing community perspectives in their decision-making process.

I use community perspectives, wisdom, and stories in my decision-making process



In the 2024 conversations with MDH staff, participants described community engagement as relationships between MDH programs and external stakeholder groups, such as advisory boards, councils, and community organizations. They noted the challenges in building these relationships, including compensation for community members' time, recognizing the value of staff engagement outside typical workday hours, and allowing sufficient time to build trust. They emphasized that community engagement should be central to MDH grantmaking and resource distribution, with greater involvement of communities in the grant application process, the promotion of grant opportunities, and the creation of community-centered resources for grantees.



Summary of progress on recommendation 4: **Strengthen community relationships.**

MDH recognizes that strong partnerships are essential to achieving its mission. Following the release of the 2014 report, MDH invested in more centralized community engagement planning and building internal capacity to partner with stakeholders across program areas. A new Tribal consultation policy laid the foundation for many efforts to ensure consistent engagement and strengthen relationships with Tribal Nations across Minnesota. Advisory councils and task forces were established to center the voices of communities most affected by inequities.

During the COVID-19 pandemic and in years since, MDH deepened existing relationships, formed new partnerships, and prioritized shared decision-making and community expertise. Through the work of the COVID-19 Cultural, Faith, and Disability Communities Branch and other cross-agency groups, MDH improved cultural communications and accessibility for all, regardless of culture, language, or disability status.

Community respondents praised the agency's commitment to culturally responsive strategies, particularly the trusted messenger model, for building trust and delivering culturally relevant health information. At the same time, MDH staff noted that authentic engagement requires time, fair compensation for partners, and flexibility for staff to participate in community events outside typical workday hours. While progress is evident, both community members and staff agree that more work is needed to strengthen partnerships and embed community feedback into decision-making.

Achieving long-term, mutually beneficial partnerships with communities across the state will require sustained commitment and intentional action. The agency must continue to focus on building trust, convening partners, and creating opportunities for those most impacted by inequities to shape solutions. MDH is also committed to reviewing and improving its policies and procedures to ensure they support authentic community engagement and partnership practices with stakeholders.

Recommendation 5: Redesign MDH grantmaking to advance health equity.

Every year, MDH awards millions of dollars in grants to local and Tribal public health departments, healthcare organizations, and other community partners who work in local communities to address health inequities and improve health outcomes across the state.

Redesigning MDH grantmaking to advance health equity is a complex process that requires steadfast commitment to accountability, compliance, and the careful stewardship of taxpayer dollars. In recent years, there has been renewed focus across state government on ensuring taxpayer dollars are distributed and used appropriately, resulting in broader conversations about the state's grantmaking practices and standards. MDH is committed to improving accountability, oversight, and performance management in grants while advancing more equitable practices.

The 2014 report includes three multi-pronged sub-recommendations related to grantmaking: changing procedures and practices to support community partners, improving training and evaluation methods, and engaging with stakeholders at every step in the grant development process. MDH embarked on this process by using an equity lens to evaluate grant policies, programs, and practices to ensure they are fair and inclusive to all people and to identify and eliminate systemic barriers to state grants that may favor or advantage some communities over others.

5.1 Change grantmaking procedures and practices to support a wider range of organizational capacity among MDH grantees.

The 2014 report included multiple strategies for advancing health equity through grantmaking, including identifying technical assistance needs of MDH staff and grantees to strengthen the health equity focus of grants, sharing best practices, strengthening grantee capacity to meet community health needs, and seeking opportunities to align efforts across state contracting. In the ensuing years, MDH made strides through internal adjustments to grant and contracting practices and embedding equity in grant policies.

Internal adjustments to improve grants and contracts

Many divisions and programs have made changes in recent years to review and improve their grantmaking practices through an equity lens. Across grant programs, staff have looked for opportunities to evaluate the impact of grant practices on communities across the state and address systemic barriers that contribute to health inequities.

Some of the practices that programs have adopted include simplifying request for proposal (RFP) language and requirements, streamlining application processes by introducing online submissions, and increasing technical assistance throughout the grant cycle. Some grant programs have also worked to strengthen relationships with grantees through regular site visits, grantee gatherings, and other touchpoints, designed to both provide needed support and to ensure proper oversight.

To provide leadership and coordinate improvement efforts across the agency, MDH formed an **Equity and Grants Work Group** in 2017. With representatives from multiple divisions, the group examined MDH grantmaking through an equity lens, shared equity practices across programs and divisions, and developed tools, resources, and recommendations for improvements to MDH grant practices, processes, and policies. The group also developed internal guides for staff use on embedding equity in RFPs, reducing bias in the review process, and promoting funding opportunities more broadly to all Minnesota communities, including communities experiencing inequities.

In 2020, MDH created a **centralized grants office** to better coordinate and standardize grantmaking across the agency by developing policy, streamlining processes, and supporting new grant managers. At the time of publication of this report, the office had grown to six full-time staff dedicated to promoting consistency and compliance across grant programs, providing training and resources to grant staff, and preventing fraud.

In 2024, MDH re-established an Equity in Grants Work Group in partnership with leadership from its Grants Office. Building upon lessons learned from working with hundreds of professional/technical contractors during the emergency response in the preceding years, MDH also launched the **Equity in Procurement Work Group** to improve agency policies, develop best practices, and increase MDH participation in the state’s Targeted Group Small Business Procurement program. Since its inception, the group has reviewed all procurement-related agency policies to ensure they are fair and inclusive to all people and to identify and eliminate any systemic barriers that may favor or advantage some communities over others.

Minnesota-based small businesses can be certified by the state as a targeted group business, which means that the business must be in an economically disadvantaged area or owned and operated by women, veterans, people of color, Indigenous people, or people with disabilities. Beginning in 2023, MDH set goals for working with targeted groups based on historic usage trends and availability of vendors to provide services and goods needed by the agency. In fiscal year 2024, MDH far exceeded the goal, spending \$7.77 million – more than twice the goal of \$2.72 million with vendors in this program.

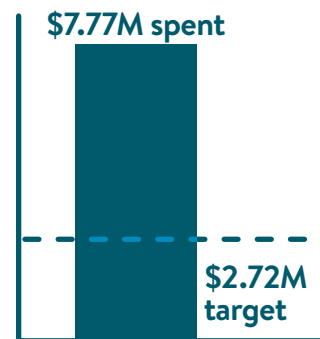


Figure 5: Fiscal Year 2024 MDH targeted vendor spending

Embedding equity in grant policies

MDH has been an active participant in the **enterprise-wide Diversity, Equity, and Inclusion Community of Practice** led by the State of Minnesota Office of Grants Management. MDH staff served on the planning work group to help define and jumpstart the community of practice in 2020 with the goal of supporting state agency capacity building and effective implementation of diversity, equity, and inclusion principles in state grantmaking. Over the years, this group has hosted a variety of panels, presentations, and other learning opportunities to support state agencies in improving grant processes while ensuring proper oversight and compliance with all state and federal laws and policies.

MDH has also worked to **strengthen agency policies and procedures** to ensure fair, equitable, and transparent grant processes. The agency’s conflict of interest standard, for example, was revised in 2022 to require grant applicants to also certify their knowledge and understanding of various conflict of interest policies for each grant application they submit. MDH also updated its incentives purchasing procedure in 2024 to strengthen internal controls and prevent misuse of public funds.

To increase transparency, MDH has made many important **grant forms available online** so that potential applicants can review and understand requirements ahead of time. Among the forms available to potential applicants include a sample MDH grant agreement template outlining legal responsibilities, the conflict-of-interest form required of all applicants, and the due diligence review form used to conduct a pre-award assessment of all grant recipients prior to the award of funds in accordance with federal, state, and agency policies.

Many of these forms, including the due diligence form, have been improved over the years to both strengthen controls and improve clarity and usability for applicants and grantees. The sample grant agreement was also made available in Hmong, Spanish, and Somali on the MDH website in 2024. This ensures a broader range of applicants can fully understand the terms and expectations of funding, reducing barriers to participation and supporting more equitable access to grant opportunities.

Community partner reflections

In the 2024 conversations with community members, participants identified opportunities for improvement in grantmaking. For example, they noted that sometimes grant requirements and timelines are not fully aligned with community needs. Engaging with communities earlier in the grant development process could help ensure that grants are set up with the full range of community needs in mind.

Finally, some participants wanted more feedback on why certain proposals were not selected in grant review processes. With limited understanding of how funding decisions were made, some shared concerns about whether reviewers fully understood culturally specific solutions to health inequities. MDH could do more to share constructive feedback with applicants when data from the review process becomes public.

MDH staff reflections

In the 2024 conversations with MDH staff, participants highlighted the tools developed by the Equity in Grants Work Group as progress and generally supported incorporating health equity into grantmaking. However, they stressed the need for more training on how to operationalize equity throughout the grant process.

5.2 Improve training and evaluation methods to advance health equity.

The 2014 report outlined several strategies to advance this sub-recommendation, including developing trainings for grant applicants and improving evaluation methods to ensure grants reach those in greatest need.

Strengthening applicant and grantee capacity

Over the years, many MDH grant programs have expanded applicant and grantee support through informational webinars, workshops, and other training opportunities. To more intentionally invest in these efforts, MDH created the **Capacity Strengthening Initiative** in 2023 to help community organizations improve their capacity to succeed in procuring grants and contracts to address inequities in their communities.

The initiative focuses on supporting community-based organizations and faith-based groups that serve people of color, American Indians, LGBTQ+ communities, and people with disabilities. This landmark program provides ongoing training and technical assistance as well as one-time grants to community organizations to build organizational capacity, enhance their infrastructure – including administrative and financial – and develop their workforce to improve health outcomes in their community.

Capacity strengthening grants were awarded in 2024 to 21 organizations across the state. Although the Minnesota Legislature allocated less than \$2 million for the grants, the department received 300 applications requesting \$27 million, highlighting the appetite for this kind of opportunity among community partners.

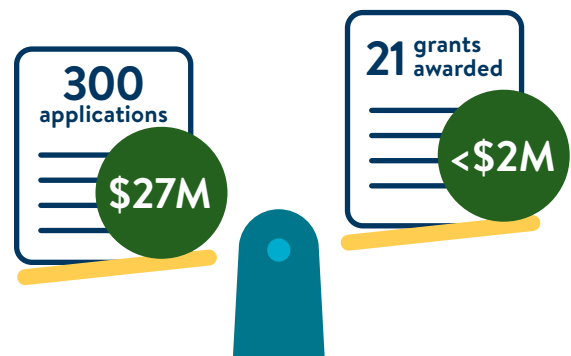


Figure 6: 2024 capacity strengthening grant applications far exceeded available funding

Improving evaluation methods

Part of the agency's work to improve evaluation methods involves recognizing and supporting culturally relevant forms of evaluation that more closely align with grantee community values. This has been an important step in ensuring that evaluation efforts generate meaningful findings that both grantees and the state value and use to both measure outcomes and improve practices.

In 2019, for example, the American Indian Community Initiatives Unit in the Office of Statewide Health Improvement Initiatives expanded its existing evaluation and monitoring work with grantees, adopting an **Indigenous evaluation framework** in partnership with North Dakota State University's American Indian Public Health Resource Center. The office collaborated with 10 Tribal Nations across Minnesota and the university to develop the framework, modeled after the American Indian Higher Education Consortium, and apply it to Tribal grant programs.

MDH has also made efforts to evaluate whether grant funds are being used in areas of greatest need or impact to improve health. In recent years, more grant programs have begun asking applicants to identify information like their size, their communities served, and their geographic locations reached so that they can **better assess reach of grant funds** – a specific recommendation of the 2014 report – and ultimately work to reduce bias in the application process.

5.3 Engage a diverse range of stakeholders in the grant development process.

This recommendation gave specific direction to several ongoing MDH grant programs to actively seek and integrate community member and partner voices in their work, including the Statewide Health Improvement Partnership, Tobacco Prevention and Control Program grants, and the Eliminating Health Disparities Initiative. In the years after publication of the 2014 report, MDH took concrete actions to engage with stakeholders within each of these programs.

Statewide Health Improvement Partnership

Established in 2008, the Statewide Health Improvement Partnership (SHIP) supports community-driven solutions to expand opportunities for active living, healthy eating, and commercial tobacco-free living. In 2013, the SHIP American Indian Community Initiatives Unit launched the **Stakeholder Input Process American Indian Community Project**. This project sought to determine how to culturally adapt evidence-based and promising practices to address modifiable risk factors that contribute to chronic disease, such as poor nutrition, limited physical activity, and commercial tobacco abuse and exposure in American Indian communities. It also aimed to help MDH improve its grantmaking model for American Indian communities, specifically for Tribal SHIP and Tribal Tobacco grants.

During this process, Tribal grantees expressed a need for many programmatic changes and cultural shifts, including a five-year grant funding cycle, rather than the typical two. They also requested MDH change the name of the Tobacco Free Communities grants to Tribal Tobacco to honor their relationship with tobacco as a sacred medicine. MDH responded by incorporating these changes into the 2014-2019 grant cycle.

MDH has continued to seek and incorporate feedback to improve its grantmaking with American Indian communities. As part of the **Tribal SHIP/Tribal Tobacco input process**, MDH hosted three engagement sessions beginning in fall 2024 focused on urban American Indian communities, followed by additional sessions with Tribal Nations and coordinators involved with Tribal SHIP and Tobacco programs. The goal was to gather feedback on the grant programs and incorporate the findings into the next five-year grant cycle starting in fall 2025.

Tobacco Prevention and Control Program

The Commercial Tobacco Prevention and Control Program has similarly embedded engagement with diverse communities in their program planning. In 2015, for example, the program formed an advisory committee to guide an input process consisting of members with expertise in tobacco prevention and control who could offer insight into community engagement, health equity, and strategic approaches. All members represented or served communities facing tobacco-related disparities. The input process ultimately gathered information from more than 300 community members through group sessions, interviews, and a survey. The method and results of the input process were published in a report: **“Community Voices: Reducing Tobacco-Related Health Inequities.”**

Insights from this process contributed to state strategic plans for commercial tobacco control, including the most recent **“Minnesota Comprehensive Commercial Tobacco Control Framework 2022-2026.”** This framework has shaped the direction of grant programs and supported long-term planning for MDH commercial tobacco prevention and cessation work, and continues to provide guidance for communities, partners, and other funders.

Eliminating Health Disparities Initiative

Meanwhile, the Eliminating Health Disparities Initiative (EHDI) grant program (also described under Recommendation 2.1) gathered input from community partners and other stakeholders in 2015 to inform the upcoming grant cycle. MDH convened a series of input meetings with current and former grantees, other community partners, MDH staff and subject matter experts, and local public health agency staff. A total of 11 meetings were held with more than 300 people. Participants shared their vision for a healthy community, feedback on four focus questions, and recommendations for the future of the grant program. MDH partnered with Minnesota Management and Budget to summarize the feedback in a public report: **“Eliminating Health Disparities Initiative: Input Summary of Themes.”**

MDH staff data reflections

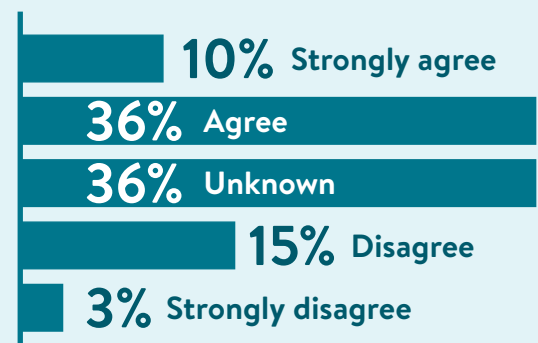
MDH staff data highlight

Engaging stakeholders in grant development

In the 2023-24 survey of MDH staff, 46% of respondents who work with grants agreed or strongly agreed that a diverse range of stakeholders, including Tribal governments, are engaged throughout the grant development process. More than a third (36%) were unsure, and 18% disagreed or strongly disagreed.

This data indicates ample opportunity for improvement in engaging a broad array of community stakeholders in grant development processes. With more than half of respondents indicating they were unsure or disagreed, MDH must work to ensure more consistent and systemic application of engagement practices across all grant programs.

A diverse range of stakeholders, including Tribal governments, are engaged throughout the grant development process



Although MDH made concrete progress with the grant programs and initiatives described above, MDH staff noted in the 2024 conversations that the agency has a way to go in making these practices a standard part of grant practice across programs. While some individuals and programs within the agency are working to integrate health equity into grant processes, these efforts are not yet systemic or widespread.



Summary of progress on recommendation 5: **Redesign MDH grantmaking.**

MDH continues to strengthen the health equity focus and impact of grants by improving coordination within the department, sharing best practices, and developing new tools and resources. Improving and streamlining policies and procedures takes time to ensure proper safeguards are in place and that processes are fair, inclusive, and equitable. This work requires a continuous process of improvement and adaptation to ensure public funds are used effectively to improve health outcomes in Minnesota.

Moving forward, MDH will continue working to ensure that grant funds reach communities who need them most. Strengthening internal controls, adapting and modernizing our processes, and continuing to invest in rigorous fraud prevention efforts helps to ensure funds are used effectively to achieve health equity objectives. As part of this commitment, MDH will continue to engage community partners, strengthen health equity practices across programs, and further invest in capacity building and training for both MDH staff and partners.

Recommendation 6: Make health equity an emphasis throughout MDH.

Advancing health equity is the responsibility of the entire department. Attaining this level of involvement requires structural changes, bold leadership, and significant workforce investments.

This multi-pronged recommendation included three sub-recommendations, two of which contain multiple specific actions for MDH. These actions range from amending the statutory mission of MDH to strengthening employee orientation and training. This section describes the sub-recommendations in the 2014 report along with actions MDH has taken to make health equity an emphasis throughout the agency.

6.1 Create the Minnesota Center for Health Equity.

In 2013, MDH created the **Minnesota Center for Health Equity** under the leadership of former Commissioner Ehlinger to coincide with the 2014 report – an intentional strategy to advance health equity across the agency and state. The center began as a small team with a large mission: connect, strengthen, and amplify health equity efforts both within MDH and across the state. Despite constraints in staffing and resources, the center led many health equity-centered initiatives, including managing grants with community partners, providing technical assistance, training, and coaching across the agency, and convening advisory councils – both internal and external – to guide the agency in its pursuit of health equity.

It became clear during the COVID-19 pandemic that MDH needed more focused resources and leadership dedicated to advancing health equity. For many years, the department had only four bureaus – Health Protection, Health Improvement, Health Systems, and Health Operations – each led by an assistant commissioner who worked closely with the commissioner. In 2022, former Commissioner Malcolm created the **Health Equity Bureau** and added an assistant commissioner dedicated exclusively to advancing health equity. The Center for Health Equity became a central office within the new bureau.

In 2023, the dramatic growth of the Center for Health Equity and its expanded role in providing support and technical assistance across the agency led to its elevation to a division, which is now the **Division of Health Equity Strategy and Innovation**.

Culturally specific offices

While these new structures dedicated to advancing health equity in general are critical, culturally specific approaches are also necessary to reverse centuries of racism and discrimination aimed at communities most impacted by health inequities. In 2022, American Indians comprised 2% of the state's population and U.S.-born African Americans comprised 7% of the population. Yet despite their relatively small size, both communities bear disproportionate burdens of poor health outcomes. This is due in part to cumulative and persistent disadvantages in factors such as housing, education, employment, and poverty. Historical trauma that began centuries ago is not completely relegated to the past – its impacts still affect these communities today. To combat these complex and deeply rooted contributors of inequities affecting American Indians and U.S.-born African Americans, it is essential to develop culturally specific ways to address root causes and support community healing, resilience, and wellbeing.

The groundwork for building the **Office of American Indian Health** began in 2021 with temporary grant funding to promote the health of American Indian communities through partnerships, initiatives, and investments. MDH secured more sustainable funding for the office in the 2023 Minnesota Legislative session, which also formally recognized the office in state statute. A primary goal of this office is to ensure that Tribal Nations and urban American Indian perspectives are included in all of Minnesota’s public health initiatives. Office staff work directly with the 11 sovereign Tribal Nations across Minnesota, manage multiple grant programs with Tribes and urban American Indian communities, and work collaboratively with the MDH Tribal Liaison (described under Recommendation 4.1) to ensure the MDH Tribal consultation policy is followed. The office is now known as the **Office of American Indian Health and Tribal Relations**.

Also in 2023, MDH established the **Office of African American Health**, which convened an African American Health State Advisory Council to address the root causes of health disparities that disproportionately impact Minnesota’s African American communities. The office focuses on the quality of and access to healthcare and education, economic stability, social and community context related to inclusion and representation in society, and neighborhood and built environment.

Together with the **Office of Diversity and Inclusion, Belonging, and Equity Strategy** (described under Recommendation 6.3), these offices and divisions comprise the Health Equity Bureau, working together across MDH and the state to build the capacity of Minnesota public health to address the root causes of disparities. Together, they work to transform systems, policies, practices, and relationships to better address health inequities.

Community partner reflections

Progress in making health equity integral to MDH is evident but slow, as expressed in the 2024 conversations with community partners. Participants expressed an appreciation for areas where they observed significant progress. These include MDH growth in cultural capacity, the community-driven approach of the long-COVID steering committee (described under Recommendation 3.4), and the culturally specific focus of the Office of American Indian Health and Tribal Relations.

“MDH is really working and increasing their cultural-specific capacity ... they have people who look like us, relate to us, and are a part of our community. For me, it’s one of the investments that is valuable for our community.”

—2024 community conversation participant



MDH staff reflections

The creation of the Health Equity Bureau was viewed favorably in the 2024 conversations with MDH staff, some of whom said during conversations that they feel proud the bureau exists, and that its infrastructure and many offices and teams are proof that health equity is a higher priority than it was previously. Participants generally wanted more engagement with the bureau and a clearer understanding of its role throughout the agency.

"... they have the Office for American Indian Health, which is very focused ... We need more focused funds like that, directed to specific communities and organizations that are representative of those communities. There needs to be more of that kind of partnership."

—2024 community conversation participant



6.2 Assure that health equity and the analysis of structural inequities, including structural racism, become integral aspects of all MDH divisions and programs.

The 2014 report outlined several major steps to accomplish this recommendation. They include:

- Amending the MDH statutory mission to include health equity
- Adding responsibilities for health equity to agency position descriptions
- Encouraging the application of health equity, structural racism, and class to the design and evaluation of all programs and activities
- Training MDH staff on the national standards for Culturally and Linguistically Appropriate Services (CLAS)
- Offering trainings in health equity and structural inequities, including structural racism

Strategy and vision

Plans underway in 2014 sought to ensure strategic, systemic, and coordinated advancement of health equity across the agency. The **MDH 2015-2019 Strategic Plan** laid the groundwork for many initiatives and structural changes in the years to come. The strategic planning process helped move MDH forward through six strategies linked closely to the recommendations in the report:

1. Build a shared understanding and internal capacity for advancing health equity.
2. Identify and creatively address barriers to working differently.
3. Change systems, structures, and policies that perpetuate inequities and structural racism.
4. Listen authentically to communities and partner with them.
5. Improve the collection, analysis, and use of data for advancing health equity.
6. Communicate the agency's commitment to advancing health equity.

The adoption of the 2015-2019 strategic plan signaled a cultural shift that laid the responsibility for advancing health equity across all MDH divisions, sections, units, and staff. Staff and leaders concluded that with advancing health equity being the central challenge facing public health, the existing vision statement – “keeping all Minnesotans healthy” – was insufficient. So, in November 2015, MDH adopted a new **vision statement**, which remains in use today:

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 statutory mission – *protecting, maintaining and improving the health of all Minnesotans* – remains the same.

Health equity remains integral to the MDH **2024-2027 Strategic Plan**. The plan was designed with health equity woven into each goal, objective, and strategy with the aim of disrupting the root causes of health disparities while advancing diversity, equity, inclusion, accessibility, and belonging internally.

Culturally and Linguistically Appropriate Services (CLAS):

A set of 15 action steps developed by the U.S. Department of Health and Human Services to help healthcare organizations provide equitable and effective care to diverse populations.

-Adapted from U.S. Department of Health and Human Services (HHS)

Program highlight

The evolution of the Infectious Disease Equity and Engagement team

In 2020, the international health team evolved and expanded its scope to become the new Infectious Disease Equity and Engagement Unit. This team initially grew out of the Refugee Health Program to address needs of immigrants and English Language Learners in 2014, particularly in relation to infectious disease. The unit includes program experts who coordinate engagement, promote equity, and provide support and crucial links to key groups, including immigrants, people experiencing homelessness, Tribal Nations and Indigenous communities, people in correctional settings, and workers in seasonal agricultural and food processing.

Program design and evaluation

Using an equity lens to create new and review all existing MDH policies, procedures, and standards began formally in 2018 with a **new equity policy review process**. The goal is to intentionally transform systems in human resources, financial management, grants and contracts, and other areas that perpetuate inequities and structural racism. This process resulted in revisions to communications policies to ensure the agency's work is accessible to all Minnesotans and to the employee recognition policy to elevate and celebrate work that advances health equity and a sense of belonging.

The agency also formed an **Internal Health Equity Advisory & Leadership Team Hub (I-HEALTH)** in 2018 with representatives from each MDH office and division. I-HEALTH works closely with the department's external advisory body, the HEAL Council (described under Recommendation 4.2), to advise and oversee implementation of health equity strategies; streamline coordination of health equity activities, policies, and projects; and foster greater collaboration among MDH divisions and offices. As MDH staff made efforts to center equity in the design and evaluation of their programs across divisions, I-HEALTH and the Center for Health Equity hosted a series of events in 2019 to showcase agency health equity work and facilitate the spread of ideas across the agency. The two events featured 20 innovative projects from across MDH divisions.

A **health equity strategists team** created in 2023 offers a new model for connecting, strengthening, and amplifying health equity efforts across the agency. Most MDH divisions now include a strategist from the Health Equity Bureau to support division leadership in identifying health equity priorities and integrating health equity strategies into the work of the respective division. Health equity strategists strengthen the capacity of divisions to advance health equity through consultation, assessment, training, monitoring and evaluation, and more.

MDH staff data highlight

Health equity in programs and policies

In the 2023-24 survey of MDH staff, 78% of staff said they were aware of existing efforts to advance health equity within MDH programs and policies. Only 6% said they were unaware, while 16% said they were unsure.

With more than three quarters of staff respondents indicating that they are aware of existing efforts, this is a positive sign that health equity efforts are underway and visible across the agency. Even so, there is room for improvement to ensure that all staff have the opportunity to understand and engage in efforts to advance health equity.

I am aware of existing efforts to advance health equity within programs and policies

78% True

6% False

16% Unsure

Program highlight

An equity lens in emergency preparedness and response

The MDH Emergency Preparedness and Response Division took a variety of steps to further embed equity actions into emergency planning beginning with the COVID-19 response in 2020. To support local and Tribal public health planning efforts, the division developed a clear and easy-to-use health equity assessment tool in 2024 to analyze preparedness plans using a whole community approach. This strategy emphasizes the involvement of all community members in preparedness and response efforts and ensures local and Tribal partners, responders, and volunteers can better address the diverse needs of their communities. The tool is part of a larger kit that was developed for use by healthcare coalitions and is shared on the MDH website.

To further strengthen health equity core competencies, the division developed exercise scenarios for preparedness at the state and local level. Based on the whole community approach, these scenarios support discussion to build a shared understanding of community members' needs in an emergency, taking into account factors such as disability and socioeconomic status, mistrust of the healthcare system, language access needs, and the need for refrigeration or specialized batteries for medical equipment.

The division also produced regional profiles to offer a comprehensive analysis of communities, populations, and groups who are essential to healthcare preparedness and response planning. These profiles assist emergency planners and responders by providing data that can be used to visualize a region's communities, populations, social vulnerability, and health equity issues.

Continued learning

The 2015-2019 strategic plan recognized that training, support, and space for personal growth are necessary for staff to apply an equity lens to their work. A key part of that goal involved increasing understanding of racial equity and how racism and systemic inequities have led to persistent racial inequities in health.

To this end, **Advancing Racial Equity Trainings** initially targeted leadership and management and then expanded between 2017-2019 to a train-the-trainer approach, eventually reaching more than 1,600 staff. These sessions on racial equity also provided employees with opportunities to have deep, challenging, and powerful conversations about the history and impact of institutional and structural racism.

Institutional racism:

The ways in which policies and practices in an institution either intentionally or unintentionally work better for one racial or ethnic group than for others.

-MDH working definition

Structural racism:

The overarching system of racial bias across institutions and society. These systems give privileges to white people resulting in disadvantages to people of color.

-Adapted from Minnesota Office of Inclusion, Inclusive Language Definitions

More than
89% of attendees

reported a better understanding of racial equity terminology like:

- **implicit bias**
- **institutional and structural racism**

92%
said they were motivated to take steps to advance racial equity.

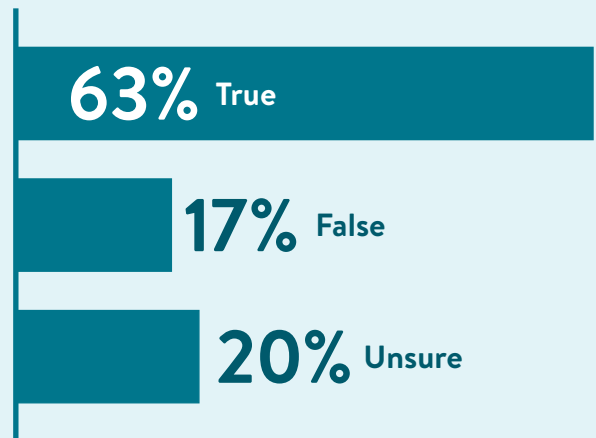
MDH staff data highlight

Equity-related training

In the 2023-24 survey of MDH staff, participants were asked about the equity-related training they have received. More than half (56%) reported completing training in the last year on racial equity and 63% reported completing training on health equity. Fewer staff (14%) responded that they have completed training on Culturally and Linguistically Appropriate Services (CLAS).

While MDH has implemented trainings on health and racial equity for all new employees, this data suggests a gap in ongoing training for staff. The 2024 conversations with MDH staff also indicated a desire for additional agency-wide trainings on equity-related topics to promote continued learning in this area.

I completed health equity-related training in the past year



Continued learning is also supported by many, often grassroots, health equity working groups that have formed across the agency. One example is an internal **work group on drinking water and health equity**, which was organized in 2022 to support development of tools and communications materials around drinking water equity in Minnesota. The work group launched an educational series in 2024 to build staff capacity and increase awareness about health equity. This series fostered connections within the agency and with partners at academic and other state organizations. This work has been possible by dedicating a staff position to strategic planning and communications for health equity in drinking water.

Program highlight

Interagency learning on equity in water resources

A commitment to learning more about how to apply health equity principles and environmental justice to programs supported by the Clean Water Fund brought together leaders in 2023 from across sectors. Members of the Metropolitan Council and assistant commissioners and other leaders from the six state agencies with vested interests in water issues (agriculture, water and soil resources, health, natural resources, public facilities, and pollution control) came together for a series of seven monthly meetings with the goal of being able to apply knowledge gained in ways that transform all aspects of water resources.

MDH staff facilitated the group discussions, introduced shared concepts, and suggested readings. Meeting topics ranged from explicit and implicit racism, tools for equitable distribution of resources, and fostering systems change, to definitions and an analysis of disparities and barriers in water resources. The series concluded with presentations from the cities of Portland, Oregon, and Milwaukee, Wisconsin, on how they integrated equity into their budgeting processes and accountability structures.

Improving cultural and linguistic capacity

Public health programs and policies that are based on data and designed with community diversity in mind are essential. CLAS Standards ensure that language assistance is available, designed materials are easy to understand and in languages used by the community, and demographic data is reliable and accurate.

Although a 2014 recommendation to train staff on Culturally and Linguistically Appropriate Services (CLAS) Standards has not advanced, MDH has invested in improving its cultural and linguistic capacity, most notably by creating a **Cultural Communications Team** within the MDH Communications Office. The team was developed when the agency's ability to produce timely translated and culturally relevant public health communications worsened during the COVID-19 pandemic. This multicultural, multi-lingual team supports all MDH staff in creating culturally and linguistically appropriate communication materials for multilingual audiences and offers other services like training, translation, "transcreation" (a hybrid word formed by combining creation and translation), material reviews, and more.

The long-running **Limited English Proficiency Communicators Work Group** also contributes to the goal of building internal capacity to better serve the diverse cultural communication needs and preferences of communities in Minnesota. The work group creates and compiles toolkits, guidance, best practices, communications materials, and other resources that MDH staff can use to support health professionals, local public health, Tribal health, and others to communicate effectively with their focus audiences. The group also serves as a learning community for MDH staff to share ideas and resources and to learn from one another. The work group evolved in 2024 to become the **Language Access Work Group** to include communication strategies for disability communities and move towards using asset-based language.

Transcreation:

The combination of the words translation and creation. It means adapting written materials for an audience with a different language and culture. This process goes beyond a word-for-word translation to reframe content to ensure it resonates with the audience while retaining the same message, tone, and emotional response as the source material.

-MDH working definition

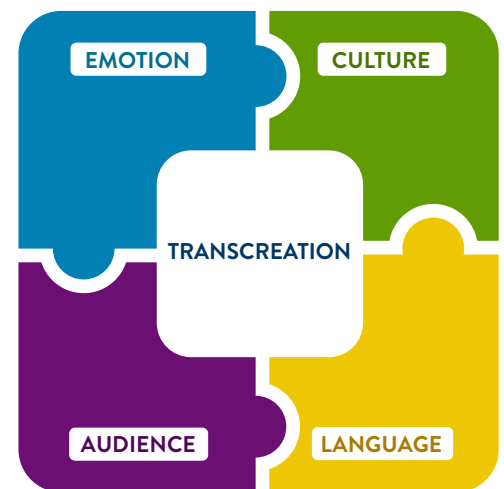


Figure 7: Transcreation in cultural communications

Program highlight

Bilingual/Multilingual/Sign Language Differential Pilot Program

A pilot program made possible by the 2021-2023 collective bargaining agreement with the Minnesota Association of Professional Employees (MAPE) enables MDH to compensate eligible and approved MAPE staff fairly for using language skills other than English at work. MDH previously did not compensate staff for the added value they provided when translating a fact sheet, interpreting a conversation into American Sign Language or another language, or other similar tasks.

The program strives to provide higher quality and more accurate translations and interpreting, to increase the agency's capacity to communicate effectively across languages and cultures, and to address structural racism internally and externally by recognizing the value of multilingual staff, thus advancing equity and enhancing recruitment and retention efforts.

Community partner reflections

Participants noted that government agencies have played a role in generating and perpetuating health inequities over many decades, underscoring the department's responsibility for rooting out structural racism in its policies, systems, and practices. While community participants in the 2024 conversations noted progress in making health equity integral to the agency, they also expressed concerns about how well the HEAL Council (described under Recommendation 4.2) is integrated into the department's work. Better incorporating the council into future initiatives could strengthen MDH capacity to collaborate with diverse stakeholders and further embed health equity across the department.

MDH staff reflections

In the 2024 conversations with MDH staff, participants considered the addition of health equity strategists to be a positive step toward integrating health equity into agency divisions. Staff also expressed hope of continued partnership with the strategists and other Health Equity Bureau staff to address equity issues.

MDH staff generally felt positive about the ways in which divisions have focused on health equity to address structures of power and privilege. Some of the ways these structures were addressed include using person-centric language and focusing on racial inequities.

Some staff respondents expressed concern over how health equity is tokenized or not prioritized by their divisions, such as delegating it to one staff member. Some also said they would like to see greater accountability at the managerial and leadership levels to embrace and incorporate health equity into daily practices and felt that the Health Equity Bureau had to assume too much responsibility for advancing health equity across the agency.

Participants encouraged the development of an agency-wide resource hub for staff and a health equity training program as part of the onboarding process. They requested additional trainings about health equity and how to incorporate it into their work, and they expressed the need for more dedicated time to read, reflect on, and contribute to health equity research and literature and to incorporate best practices into their work.

6.3 Identify and address changes needed in the MDH workforce to advance health equity.

The 2014 report included several suggested actions to identify and address gaps in the MDH workforce, including:

- Updating minimum qualifications for positions to remove unnecessary barriers to employment
- Reviewing and setting agency hiring expectations for recruiting people with health equity awareness and related skills
- Establishing a policy for the appropriate and necessary use of applicant background checks
- Strengthening employee orientation and training to introduce new staff to public health concepts and principles
- Creating a program to recruit and encourage high school students to consider jobs in the field of public health

Workforce initiatives

One MDH section charged with leading workforce initiatives is the Office of Diversity, Inclusion, Belonging, and Equity Strategy. This office grew in recent years from a single director position to an office of multiple staff with key roles across the agency. Its mission is to embed equity principles into internal agency policies, practices, and workforce culture.

The office houses the health equity strategists (described under 6.2) who work to increase the internal capacity of MDH to advance health equity across divisions. The office also includes consultants who work to embed diversity, equity, and inclusion (DEI) principles and practices across the agency. Office initiatives aim to nurture a sense of belonging for employees by cultivating a diverse, inclusive, and equitable workplace culture.

A weekly, 30-minute conversation series called **DEIBrew** started in early 2024 to foster a sense of inclusion and belonging among staff. Participants explored topics related to DEI in each session and actively participated in conversations aimed at changing hearts and challenging minds.

To nurture a welcoming, inclusive agency culture, the MDH Human Resources Management Division has developed workforce initiatives to support staff retention, including investing in **leadership development and learning**. For example, a leadership learning community brings together many managers, supervisors, and other leaders for monthly discussions on key leadership topics. A new onboarding experience for supervisors connects new leaders with existing ones, provides them with critical information as they begin their new roles, and offers courses to help them build new skills. The agency also offers a mentoring program to increase feelings of belonging and connection and a peer-coaching program to enhance a leader's approach to team leadership and development.

A **Health and Racial Equity e-learning** launched in 2019 continues to be a required part of onboarding for all new employees. This 35-minute training is designed to increase staff knowledge and understanding of health and racial equity and to emphasize that all MDH staff have a role in advancing health equity.

Other staff training programs have been redesigned to ensure a focus on health equity. For example, a one-hour session on health equity is now part of new employee orientations. An added focus on inclusive leadership and diversity, equity, and inclusion is also part of the remodeled Everyday Leaders Program, a 10-month development series to strengthen leadership capacity among agency staff.

Many divisions at MDH have also established their own practices to support an equitable workplace and inclusive culture. The **Diversity, Equity, Inclusion, and Belonging (DEIB) Collaborative**, established in 2021 by the Public Health Laboratory Division, focuses on building a foundation of DEIB principles throughout the division and promoting a sense of community.

MDH staff data highlight

Health equity in job descriptions

In the 2023-24 survey of MDH staff, 56% of respondents agreed or strongly agreed that their job description includes information or specific tasks related to health equity. Almost a quarter (22%) were unsure, and the same proportion of staff disagreed.

The 2014 report advised the agency to add responsibilities for health equity in job descriptions as appropriate. While the data shows progress in this area, more can be done to ensure that every staff member understands their role in advancing health equity.

The collaborative provides spaces for honest conversations through employee engagement and learning activities about various topics, including women’s history, pronouns, the LGBTQ+ community, and mental health awareness. The activities allow for relationship-building among staff of all levels from the Environmental Laboratory, the Infectious Disease Laboratory and the Newborn Screening Program. Members of the collaborative also meet with new employees as part of the onboarding process for the Public Health Laboratory Division to establish early connections with new staff.

Hiring and recruitment practices

To improve hiring and recruitment practices, the MDH Human Resources Management Division has implemented new tools and resources, including **best practices for interview questions** to highlight the department’s commitment to health equity. In 2022, MDH also updated the **process for criminal background checks** to reserve them only for job finalists – an explicit action item in the 2014 report. This avoids background checks earlier in the process that could potentially eliminate candidates unnecessarily from the applicant pool.

A year later, Governor Walz signed an executive order eliminating four-year college degree requirements for most state government jobs, opening opportunities for more people to apply for and secure employment with state agencies. This action coincided with an **MDH-wide compensation study** that contributed to standardizing minimum qualifications by job classification at the agency. This led to more consistency and less bias in recruitment for different roles and removed some barriers to employment, like unnecessarily requiring formal degrees when the combination of training and experience is a suitable equivalent. The study also evaluated pay for current employees to ensure fair and equitable compensation across MDH.

In 2024, the **Introducing Students to Public Health Initiatives Rooted in Experiences (INSPIRE)** program was created to recruit and encourage students to consider careers in public health and to increase diversity in the public health workforce by encouraging a broad range of students to become interested in the field. It organizes on-site opportunities at middle and high schools around the state for MDH staff to raise student awareness about public health and to introduce students to career options. The program prioritizes schools that serve students in communities most impacted by health disparities and economic disadvantages.

MDH staff reflections

In the 2024 conversations with MDH staff, participants expressed support for the executive order removing education requirements from job postings. However, they believe current recruitment and job posting procedures are less than optimal for reaching a broad range of suitable candidates. Their suggestions for improvement include using questions that assess health equity awareness and skills in interviews, assembling interview committees that bring a range of experiences and viewpoints, and ensuring health equity concepts are embedded in job descriptions. Many participants expressed concern about retention and a lack of upward movement for employees and wanted more transparency in internal hiring and promotion and more feedback when rejected.



Summary of progress on recommendation 6:

Emphasize health equity throughout MDH.

The agency has undertaken a range of actions to incorporate health equity across its programs and functions. These efforts included adopting a new vision statement, investing in staff training, and embedding health equity in its strategic plans. Structural changes began with the founding of the Minnesota Center for Health Equity and continued with the creation of the Health Equity Bureau. Dedicated offices for African American and American Indian communities focus on the health of and work directly with their respective communities.

Additions like the Cultural Communications Team and the Language Access Work Group demonstrate the agency's investment in culturally and linguistically appropriate communications, programs, services and other activities. And programs like INSPIRE highlight the agency's commitment to recruit, hire, and retain a high-quality workforce now and into the future.

Community conversation participants expressed appreciation for increased MDH staff diversity, the creation of culturally specific offices, and the use of community-driven approaches. They also advocated for better integration of the HEAL Council across MDH programs to support the incorporation of health equity throughout the department.

MDH staff observed increased and accelerated emphasis on health equity with the creation of the Health Equity Bureau and the addition of health equity strategists. As connectors and innovators, the health equity strategists have better positioned the Health Equity Bureau to support transformation across the agency. Nevertheless, MDH staff wanted to better understand the Health Equity Bureau's role and greater engagement with its staff and programs. They also endorsed a need for more comprehensive, agency-wide training on how to incorporate health equity into their work.

Staff supported the recent policy that standardizes multiple pathways for job candidates to meet minimum application requirements but continued to highlight challenges in reaching diverse job candidates. They called for more inclusive recruitment and retention practices and expressed concerns about perceived limits to career advancement, a lack of transparency in hiring, and limited internship opportunities. Improved hiring and retention practices will be crucial for MDH to advance health equity effectively and to sustain progress already made.

Continued investments are needed to embed health equity across programs and initiatives and to adequately train and support staff. MDH is committed to promoting further cultural shifts within the agency to elevate and celebrate health equity work, promote a shared understanding of health equity principles, and emphasize that health equity is the responsibility of all staff and programs.

Recommendation 7: Strengthen the collection and analysis of data to advance health equity.

Data is a key component of advancing health equity. Equitable data collection and usage can help ensure proper identification and examination of health inequities and provide a means to discover the reasons for persistent inequities.

This recommendation included two multi-pronged sub-recommendations focused on strengthening the coordination of MDH data and developing a long-term plan for improving the collection, analysis, reporting, interpretation, dissemination, and use of health equity data. This section describes MDH efforts to improve data practices and coordinate data collection and sharing data by population groups – an essential step for identifying health inequities – yet challenges remain.

7.1 Strengthen the coordination of MDH data activities related to health equity across all divisions and programs.

This sub-recommendation reflects the need for a more responsive, collaborative, and equitable approach to data collection, use, and sharing. This need has been echoed by MDH by staff, local and Tribal public health partners, community organizations, and other leaders over many years.

To do this, the 2014 report recommended that MDH assess the investments needed to increase the capacity and coordination of the MDH workforce and of governmental and community partners to collect, use, and apply health equity data. It also advised MDH to address barriers to sharing and disseminating data while maintaining strong privacy protections, whether resulting from limited staff and resources, data incompatibility, a lack of data coordination, or legislative language. To address these and other issues, it recommended that MDH partner with other state agencies, local health departments, and communities to explore the use of non-MDH data in the study of health equity, encourage data sharing and linking, and improve dissemination.

Strengthening coordination and capacity

The **Office of Data Strategy and Interoperability** was formed with a small staff in 2018 to coordinate data equity work across MDH. As the COVID-19 response drew new attention to data equity concerns, MDH further invested in this team to meet growing needs and take advantage of opportunities to partner in new ways and rethink the way the agency works with data.

A key aspect of the office's work includes a **Data Technical Assistance Unit** that provides support to programs addressing documented health inequities across the state. This unit was formed in 2022 in response to feedback from local and Tribal health departments who felt they needed more comprehensive data technical assistance from MDH following the COVID-19 response. The office conducted several rounds of meetings with partners to better understand their needs, especially those without designated data roles. This unit now provides training and technical data support for local and Tribal public health agencies and MDH programs. They also collaborate to support broader data system improvements, including facilitating regional data practice meetings with public health partners to improve communication, share innovations and updates on projects, and promote continuous learning around data.

The office also hosts and coordinates the **Data Equity Community of Practice** that brings together MDH staff from across the agency for shared learning opportunities related to data equity work. This initiative began informally during the COVID-19 response when staff felt the need to connect with one another around data equity needs and gaps. The monthly meetings were opened to all staff in September 2021 and now focus on a broad range of topics. The group continues to foster collaboration, crowdsourcing of ideas, and discussions about research methods. It also provides a forum of support around data collection, dissemination, and visualization; narrative development; authentic community engagement; and other topics relevant to advancing health equity. A quarterly internal newsletter, Data Equity Dialogues, provides MDH staff with additional opportunities for peer learning and engagement.

Data equity:

A set of principles that guide equitable practices throughout the entire data lifecycle.

-Adapted from CDC Foundation Health Equity Strategy Office

Improved data sharing

Data sharing is essential for improving collaboration, increasing transparency, enhancing efficiency, and strengthening the capacity of communities to create their own healthy futures. To make data more accessible and eliminate barriers for community use, MDH created an **inventory of every data set** within the agency. This internal inventory helps MDH staff and leaders respond to data requests from the public by making it easy to find and understand public health data on various topics and populations. MDH also created an external **publications library**, with work underway to tag the materials to easily identify relevant health equity data, topics, and literature.

MDH staff data highlight

Division-level data collection, use, and sharing

In the 2023-24 survey of MDH staff, 53% of respondents agreed that their division collects and analyzes data to understand the root causes of health disparities, while 31% indicated that they did not know. A smaller percentage (16%) of respondents disagreed or strongly disagreed.

When asked about whether their division collects and shares data in a manner that is appropriate for the cultural, linguistic, and literacy needs of the communities they work with, 52% of MDH staff respondents agreed. More than a third (37%) indicated that they did not know, and 11% disagreed or strongly disagreed.

With nearly half of respondents indicating that they are unsure or disagree, this data suggests that there may be a gap in awareness of how divisions collect, use, and share data. It could also suggest that divisions are not fully using their data to understand the root causes of disparities, a lack of data sharing in a manner appropriate for communities, or both. Improved communication and transparency within divisions, along with better coordination and sharing of best practices and resources across the agency, could help improve these indicators.

Data sharing with Tribal Nations can now be negotiated in advance. **Joint powers agreements** lay out how data sharing may flow between the MDH and Tribal Nations. These agreements recognize the unique government-to-government relationship between the state of Minnesota and Tribal Nations and outline procedures for sharing data over three-year periods. Once in place, the two can partner immediately when a need to share data arises, instead of spending weeks or months negotiating terms.

The first joint powers agreement was signed in 2022 with the Lower Sioux Indian Community. This laid the foundation for MDH and the Tribe to share data to better prevent and control infectious diseases in 2024.

Program highlight

Statewide Quality Reporting and Measurement System

In 2009, MDH established a standardized set of quality measures to create a more uniform approach to quality measurement for healthcare providers across the state. This set of quality measures is called the Minnesota Statewide Quality Reporting and Measurement System (SQRMS).

In 2014, the Minnesota Legislature directed MDH to create and implement a plan to separate these healthcare quality measures by socio-demographic factors in consultation with consumer, community, and advocacy organizations. To implement these requirements, MDH partnered with Voices for Racial Justice, a trusted community organization, to obtain input from diverse communities across the state.

Key findings from this process included the importance of building trusting relationships between patients and the healthcare system and of providing health equity data to communities to use for health improvement and advocacy. This process resulted in the release of public use files containing quality measure data by socio-demographic factors and ZIP codes. This increased access to data to diverse communities across the state — a practice that continues today.

MDH also has worked to better coordinate and share data across MDH programs and with other external partners. The Minnesota Refugee Health Program, for example, has worked with other programs to facilitate **data sharing among systems supporting refugee health**, including healthcare, public health, and education.

In 2015, the program started a pilot project to manually upload overseas vaccination data to the Minnesota Immunization Information Connection, the state's immunization information system. The success of this process led to its automation in 2017, allowing for timely access to refugee vaccination records for clinics, schools, and local public health. It also allowed public health partners to evaluate vaccination rates over time.

Building on the success of the vaccination record integration, the program partnered with the Minnesota Electronic Disease Surveillance System program to electronically share demographic and key health information with various disease prevention teams. The program now shares this information with MDH programs centered on hepatitis B, HIV, lead, syphilis, and tuberculosis to improve newcomer services and the assessment of long-term health outcomes. The teams are also working to build a way to establish bidirectional data exchange to ultimately support better health outcomes for refugees resettling in Minnesota.

The Child and Family Health Division has also worked to better coordinate and share data with other state agencies in recent years. Agreements with the Department of Human Services, for example, started in 2001 to guide how the agencies **share data to better coordinate state benefits**. Using shared data, MDH can now better identify eligible women and children who are not receiving nutrition benefits and reach out to encourage participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In 2021, the division also modernized their outreach methods to contact women eligible for WIC via text message. This shift to text messaging allowed outreach messages to be sent in multiple languages, which increased engagement with potential participants.

Program highlight

Vaccine Equity and Engagement Branch

In response to internal equity leaders and external partners calling for MDH to do more to address COVID-19 disparities, MDH established a Vaccine Equity Branch within the agency's incident command system and brought on an assistant commissioner to lead the effort and ensure a voice for equity in key decisions about Minnesota's vaccination approach. The urgency of vaccinating the population quickly, combined with the limited supply of vaccine, created a unique challenge for centering equity.

The Vaccine Equity Branch used place-based strategies like the CDC's Social Vulnerability Index to direct vaccine resources and set targets to measure equity in vaccine distribution. The goal was to ensure 40% of all doses administered were prioritized to communities most impacted by the COVID-19 pandemic. A particular focus for this branch was on equitable data collection and reporting to measure progress and remain accountable to community partners. This process led to the establishment of a weekly vaccine equity report that evaluated vaccine uptake by age, race, ethnicity, gender, and region.

Community partner reflections

Participants in the 2024 community conversations expressed some concerns about data equity, including a lack of transparency in how their data is used once they submit it to MDH and a lack of feedback about their data. While MDH collects a lot of data, communities have not always had access to the data they provide to MDH. Many expressed uncertainties about whether the data they collected and submitted was accurately reflected in state reports and said that they often received little feedback on how their data influenced decisions.

Other participants shared their vision for how MDH could improve its use of data with partners by creating an equitable data request process for community members to gain easy access to their data.

Among community participants, the tendency of MDH to focus on quantitative over qualitative data raised concerns, such as losing the human stories behind the numbers.

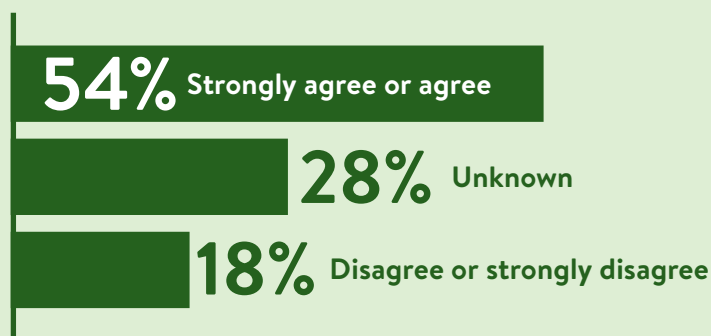
Community data highlight

Equity in data sharing

More than half (54%) of the 2024 community respondents agreed or strongly agreed that MDH shares data in a manner appropriate for the cultural, linguistic, and literacy needs of the community. More than a quarter (28%) of respondents were undecided, while the rest (18%) disagreed or strongly disagreed.

More work is needed to better understand whether additional data sharing is needed, whether the data currently shared needs to be adjusted to meet cultural, linguistic, and literacy needs, whether MDH should provide more technical assistance and training to community organizations to improve data usage, or a combination of all three. Moving forward, MDH should work to ensure that all publicly available data is understandable and actionable.

MDH shares data in a manner appropriate for the cultural, linguistic, and literacy needs of the community





"How do we go from data to people? It's faces, its people, not just numbers."

—2024 community conversation participant

"We submit the data, but we have no idea what data is being reported. We don't get to see the final reports and a lot of us feel like it doesn't match up with what we submitted."

—2024 community conversation participant



"It would be helpful if we could share our data and results with other organizations ... that way we can learn from each other and improve together."

—2024 community conversation participant



MDH staff reflections

In conversations with MDH staff, respondents expressed the need for technical assistance with health equity data collection and analysis, navigating Tribal data sovereignty, and understanding data limitations. They also noted concerns such as historical mistrust in government data collection among many marginalized groups. Respondents reported challenges with data disaggregation and small sample sizes as well as grant requirements that restrict data collection. Some staff respondents also highlighted inconsistent approaches to data sharing across the agency and said that data sharing feels disconnected across the department.

Tribal data sovereignty:

A Tribe's right to own and govern the collection and use of Tribal data. It is related to and derives from Tribal sovereignty, or the inherent authority of Tribal Nations to govern and protect the health, safety, and welfare of citizens.

-MDH working definition

Data disaggregation:

The process of breaking down data into its smaller parts, like specific age groups, genders, or races/ethnicities to reveal insights into inequities that are essential for effective action.

-MDH working definition

7.2 Develop a long-term plan for improving the collection, analysis, reporting, dissemination, and use of health equity data.

The 2014 report calls for intentional planning to improve the way MDH collects, analyzes, uses, and shares public health data to advance health equity. Suggestions include developing a race/ethnicity/language data collection standard and a standard set of social and economic determinants of health for MDH datasets, developing a list of key health equity indicators and a plan for annually monitoring these indicators, and identifying strategies for incorporating community perspectives and wisdom into the analysis of data.

The 2014 report also suggests approaches to improve the ability of public health to report results for smaller populations or geographies, and it advises MDH to address the education and training needs of MDH and public health partners to do this work well.

Community data highlight

Using data to understand and address health inequities

In the 2024 survey of community partners, 66% of respondents agreed or strongly agreed that their organization uses MDH data to understand the root causes of health disparities. A much smaller percentage (21%) of respondents were undecided, while 13% disagreed or strongly disagreed.

When asked about using MDH data to measure their effectiveness at addressing disparities in health outcomes, 55% of community respondents agreed or strongly agreed. Nearly a quarter (24%) of respondents were undecided, while 20% disagreed or strongly disagreed.

Altogether, this data suggests that MDH has an opportunity to improve data sharing in a way that enables community partners to better understand the causes of health inequities and evaluate their organizations' effectiveness in addressing them.

Guiding frameworks

In 2022-2023, MDH engaged hundreds of staff and community partners in the development of an agency-wide **Data Vision and Roadmap** designed to break down silos, establish transparent and intentional data sharing practices, build more trusting and reciprocal relationships with agency partners, and advance health equity. The process was the result of years of feedback from staff, communities, and partners on the ways that MDH collects, uses, and shares data.

To gather input on the new data vision, MDH held 12 listening sessions with over 100 attendees, including local public health, healthcare, academic and research partners, community members, and representatives from community-based organizations. The new vision is for MDH data systems to support the agency's strategic goals and advance health equity by being consistent, transparent, responsive, community-centered, and equity-driven whenever public health data is collected, analyzed, used, or shared.

The agency also engaged more than 250 staff and partners through 25 listening sessions and an online survey to gather ideas and foster dialogue around the development of the data roadmap. Using a set of shared guiding principles to ground all data efforts within MDH and with agency partners, this roadmap serves as a guide to achieve the vision, covering goals related to data collection, analysis, governance, modernization, and communication.

A key part of this project is promoting a culture shift within MDH to recognize that the data the agency works with also belongs to the communities MDH serves, not just to MDH and the State of Minnesota generally. This means MDH must share the responsibility of data and appreciate the diverse skills, needs, and perspectives surrounding it.

The data vision and roadmap are key parts of the agency's data modernization efforts, now led by the Office of Data and Analytics. At the time of publication of this report, MDH was in the process of building out this new office to lead the implementation of data modernization and support the agency's strategic goals related to data.

In partnership with communities, MDH also developed a framework to improve the way quality of health and healthcare is assessed in Minnesota. In 2017, the Minnesota Legislature directed MDH to work with a broad group of stakeholders to develop a **measurement framework for the Statewide Quality Reporting and Measurement System** (described under 7.1) – a standardized set of quality measures for healthcare providers.

From 2018 through 2020, MDH engaged people and organizations around the state to develop the framework. This process showed that communities most impacted by disparities must have a strong role in defining health and health quality and deciding how quality is measured. Partners also felt strongly that the framework should go beyond the healthcare system and include measures and actions related to policies, conditions, and factors that create and influence health.

Community members and other stakeholders emphasized that the authentic approach MDH took to community engagement for the first phase of framework development was transformational. The framework continues to be piloted by divisions across the agency prior to full implementation.

Standardizing data collection

MDH also made significant headway in developing and implementing a **data collection standard** to address the lack of agency-wide standards or guidance and gaps in available disaggregated data. In a 2019 memo to the commissioner, the HEAL Council (described under Recommendation 4.2) urged MDH to develop standards for data collection that would enable a more robust understanding of inequities in specific communities within larger aggregated groups. This would allow MDH to identify differences in health outcomes and social determinants as they apply to groups within broader categories, such as the differences that may arise between Hmong, Lao, or Vietnamese communities when they are not grouped together as Asian Americans.

Beginning in 2021, the Center for Health Statistics engaged hundreds of state enterprise and community stakeholders in the development of demographic data standards that include race, ethnicity, sexual orientation, gender identity, and disability. The development process relied heavily on a compensated community review panel and essential community reviews by more than 200 partners since the project's inception. In 2024, MDH began engaging with a new community review panel to inform how the agency implements the standards. Presentations on the development process and the standards themselves have been shared with national partners and set the foundation for the agency to co-develop a 2023 legislative budget proposal that secured funding to improve demographic data collection across the state enterprise.

With this new funding, Minnesota Management and Budget formed a workgroup bringing together data experts from MDH and other state agencies to give input on data collection standards for state government. The goal is for the state to collect more consistent, high-quality data about specific groups so that it is easier to share information across programs, understand which communities are most affected, improve data quality, and track progress toward goals. With clearer and more reliable data, MDH and other agencies can create more effective programs and policies that support Minnesota communities.

Program highlight

Disaggregating breastfeeding data

The Special Supplemental Nutrition Program for Women, Infants & Children (WIC) is a nutrition and breastfeeding program that supports eligible pregnant people, new birthing parents, babies, and young children. In 2015, MDH began a data project that allowed them to break out breastfeeding rates by cultural identity.

With this new disaggregated data, the MDH program identified a need for better breastfeeding supports in the Hmong community. As a result, public health and Hmong community partners created the Hmong Breastfeeding Initiative in 2018.

Since then, the program has used expanded race categories as part of their standard data collection. Having health information by cultural identity on indicators such as anemia, breastfeeding, weight status, and birth outcomes has enabled the program to more effectively identify and reach communities that can benefit from targeted support.

Honor the Past Embrace the Future

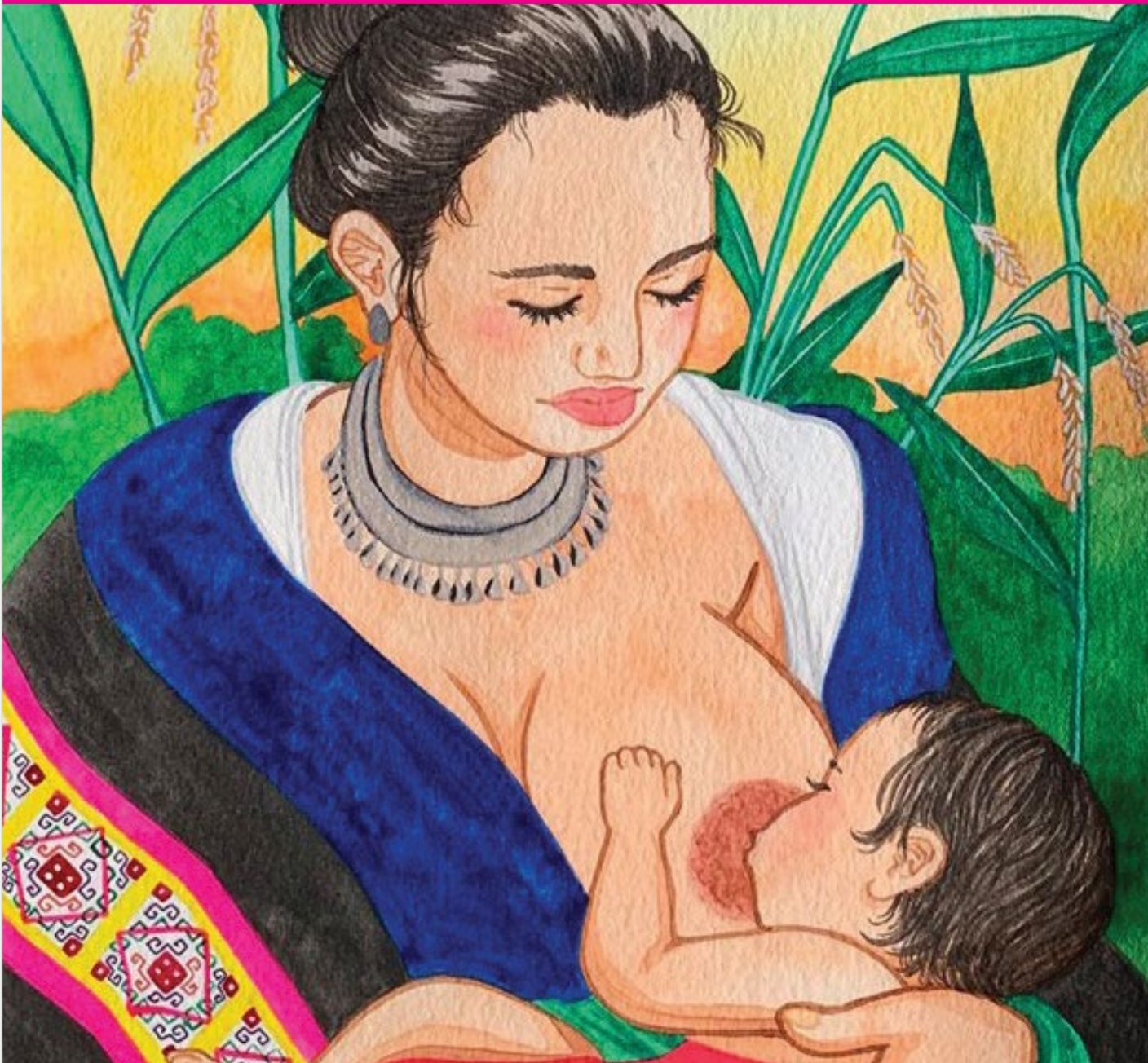


Image by: Leona Jacoby



**Hmong
Breastfeeding
Project**

For more information, visit: mnbreastfeedingcoalition.com/munities



Figure 8: Honor the Past. Embrace the Future. A flyer designed in 2019 as part of a Hmong art and photography contest hosted by MDH and the Minnesota Breastfeeding Coalition.



Summary of progress on recommendation 7: Strengthen data practices.

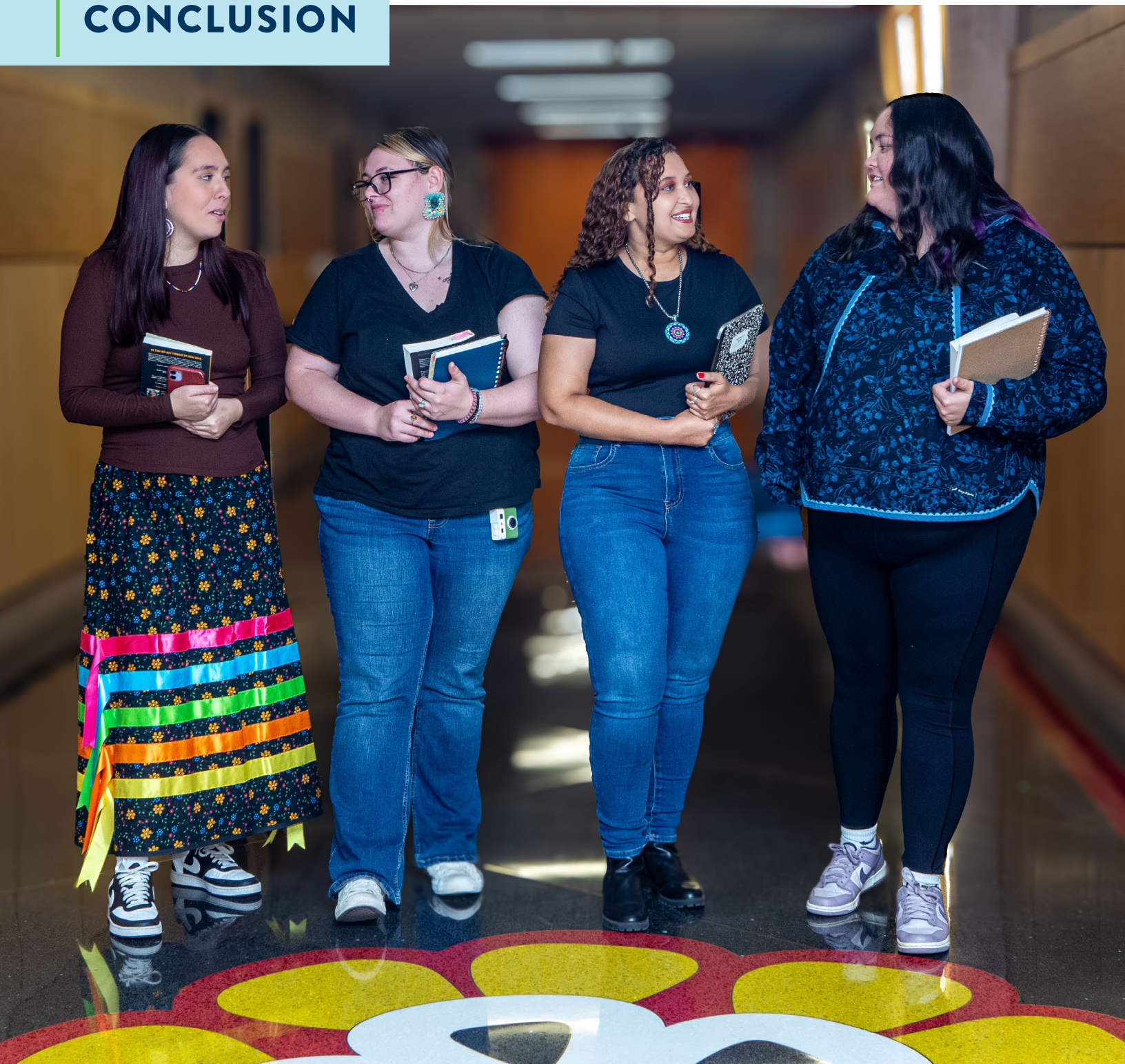
MDH made strides toward strengthening the use and analysis of health equity data across the department through the development of a coordinated data vision and roadmap and an office specifically dedicated to data strategy and interoperability. With a new data technical assistance unit and an active community of practice, MDH has also helped increase the capacity of its staff and partners in this area.

Efforts continue to implement data disaggregation standards, engage with communities in data processes, and develop approaches to overcome barriers to data sharing. These include the development of a publications library and establishing joint powers agreements to facilitate data sharing with Tribal Nations.

Community partners appreciated these steps but continued to emphasize the need for greater data transparency and accessibility. They called for more culturally relevant and understandable data reporting alongside improved feedback mechanisms to ensure that communities can see how their input shapes decisions. Balancing quantitative and qualitative data remains a challenge, as partners stressed the importance of capturing lived experiences to complement traditional metrics. Internally, MDH staff recognized the need for more coordinated and consistent data practices across divisions and expressed a desire for technical assistance with data equity practices.

Moving forward, MDH will continue to support the consistent implementation of the data vision and roadmap across the agency, strengthen data sharing practices, and support effective implementation of the new data collection standard. The agency will also work to ensure all publicly available data is understandable, culturally and linguistically appropriate, actionable for community partner use. Partnering with community and other stakeholders to further refine data disaggregation practices and promote greater transparency in data use and management will be key to ensuring data practices support the agency's commitment to advancing equity.

CONCLUSION



Looking back: The past 10 years

The 2014 report listed three initial actions: establish the Center for Health Equity, implement the report's recommendations, and initiate a cabinet-level health equity initiative. **Since then, MDH has created and expanded the Center for Health Equity and made substantial progress on all seven of the report's primary recommendations and most of the sub-recommendations.** MDH initiatives and departmental changes engaged all five of the agency's bureaus and have influenced the state legislature, local health departments, Tribal Nations, community organizations, and national discussions.

This work has unfolded within a constantly shifting environment. The years following the release of the 2014 report were marked by efforts to define, understand, and socialize health equity across MDH and with partners. The COVID-19 pandemic further exposed longstanding inequities, underscored their urgency, and mobilized public health support to act with greater speed and focus. Building on this momentum, 2023 marked a pivotal moment to accelerate progress through equity-centered legislation and to more deeply embed health equity into MDH's work.


Notable accomplishments from the last 10 years include:

- Strategic organizational changes to elevate health equity work across the department, including the creation of the Health Equity Bureau, the Office of African American Health, and the Office of American Indian Health and Tribal Relations.
- Introduction of new resources, investments, lived experiences, and attention focused on the persistent inequities affecting many communities and the need for a cultural shift within the agency itself.
- Incorporation of health equity in the department's strategic priorities and a shared understanding of health equity principles throughout the department.
- Stronger relationships with local public health, Tribal Nations, healthcare systems, and other community partners to build capacity and infrastructure for equity-driven efforts across Minnesota.

In conversations and survey feedback, both community partners and MDH staff applauded progress in key areas, including increased staff diversity, more equitable grantmaking practices, and stronger community engagement. Community members underscored the vital role of MDH funding and technical support in advancing health equity work in underserved communities. At the same time, they emphasized the need to build on this momentum by securing more sustainable funding, advancing data equity, deepening community partnerships, and ensuring community feedback continues to shape decision-making.

MDH staff believe they contribute to greater awareness of health equity across Minnesota. They identified opportunities to further strengthen grantmaking, improve data collection and sharing, and expand recruitment and retention of staff from a broad range of backgrounds. Many employees expressed interest in additional training, time to integrate health equity into their daily work, and deeper engagement in health equity research. Staff consistently recognized that health equity is becoming more firmly rooted across MDH, while highlighting the importance of greater consistency across divisions and programs.

Looking back, the past decade reflects both the complexity of advancing health equity and the significant progress achieved. MDH has laid a strong foundation by building internal capacity, strengthening relationships with communities, and elevating health equity across its work. Despite the accomplishments highlighted in this report, MDH faced challenges in advancing health equity. These efforts have taken place within complex governmental systems and while navigating unprecedented challenges such as the COVID-19 pandemic. Change at this scale is rarely linear; sometimes, progress can appear uneven, imperfect, and slow. It often requires persistence and adaptability.



Recognizing and reflecting on the progress made and the work still ahead is essential to advancing health equity. Eliminating deeply rooted health inequities is a long-term, complex endeavor, and MDH remains committed to this critical and ongoing work. Sustaining this momentum will require continued statewide leadership, deeper collaboration across agencies, and ongoing investment in a diverse workforce and authentic community engagement.

Looking ahead: The next 10 years

While Minnesota has made significant strides toward health equity, the broader social and political environment has dramatically shifted in recent years, creating new challenges and risks to progress. Across government, education, and private sectors, attacks on diversity, equity, and inclusion have intensified, accompanied by intimidation tactics, such as public pressure campaigns, boycotts, and efforts to defund organizations committed to equity and to health equity. Even the very language of “equity” is increasingly politicized.

These pressures have accelerated in 2025 under the federal administration. A growing anti-public-health agenda threatens the decades of collaboration, infrastructure, and workforce development that helped establish Minnesota as one of the healthiest states in the nation. Federal funding cuts, intentional administrative slowdowns, and rapidly changing guidance to critical programs supporting mental health, infectious diseases responses, and clean water, among others, have already curtailed or eliminated several MDH initiatives described in this report. Meanwhile, mis- and disinformation on critical public health issues from vaccines to water fluoridation, continue to erode public trust in the institutions charged with protecting, maintaining, and improving health.

The broader funding environment has also shifted drastically in recent years. Federal and state investments in public health programs surged in response to the COVID-19 pandemic. At the time of this report, those funding sources are nearing an end. Meanwhile, the State of Minnesota has moved from a surplus to a projected general fund shortfall, making additional state investments in MDH programs unlikely in the near future. The agency will need to identify new ways to sustain the work.

These shifting social, political, and financial environments threaten hard-won progress, underscoring the urgency of continuing work to advance health equity. To meet this moment, MDH must remain steadfast in its commitment to health equity, diversity, and inclusion by emphasizing their benefits for all Minnesotans. Post-pandemic, MDH has a pivotal opportunity to re-engage Minnesotans, restore confidence in public health, and demonstrate its value by ensuring preparedness for emergencies, access to culturally competent healthcare providers, protection from foodborne illness, and more. Fulfilling the agency’s mission to protect, maintain, and improve the health of all Minnesotans will require persistent, adaptive, and bold leadership, including identifying innovative funding solutions to ensure available resources align with strategic priorities.

Working in partnership with others, MDH can advance a vision where every person in Minnesota has the opportunity to thrive, regardless of race, ethnicity, geography, gender, sexual identity, disability status, or socioeconomic background. This includes advocating for equitable policies across all sectors that influence health, from housing and transportation to education and economic opportunity.

Next steps

Sustaining momentum amid increasing opposition to health equity efforts will require determination, ingenuity, and partnership. This report has allowed MDH to reflect on lessons learned with more intentionality and reaffirm its commitment to building a healthier, more equitable Minnesota together. To protect hard-fought gains and the agency's legacy of health equity leadership, MDH must:

- **Lead with authentic community engagement.** The 2014 recommendations were shaped through more than 180 conversations with Minnesotans. MDH must continue this tradition by creating new opportunities for communities most impacted by inequities to co-create solutions. Doing so will strengthen trust, rebuild public confidence in health systems, and ensure equity remains central to decision-making.
- **Confront emerging threats together.** Minnesota faces mounting challenges, from the mental health crisis and climate change to misinformation and the impacts of rapidly advancing technology. By working side by side with communities, Tribal Nations, other state agencies, local governments, and cross-sector partners, MDH can ensure Minnesota is prepared, resilient, and equitable in the face of these pressures.
- **Hold ourselves accountable through clear metrics.** Progress must be visible and measurable. MDH will develop and use meaningful indicators that track both the advancement of health equity goals and tangible reductions in disparities. These metrics will guide decisions, demonstrate impact, and hold MDH and its partners accountable to Minnesotans.

Over the coming months, the agency will begin building a roadmap for how it will advance these goals and address the gaps identified in this report in partnership with Tribal Nations, local public health, other state agencies, healthcare institutions, and community organizations. This roadmap will guide the agency in strengthening internal capacity and improving MDH systems and practices, developing a coordinated and strategic approach to building on and disseminating best practices – both internally and with partners – and creating a plan for collecting and sharing the successes and lessons learned in this work. For while progress is evident over the past ten years, breaking down barriers and creating systems that serve all Minnesotans will require sustained effort, strategic investment, and shared leadership. Real progress also depends on partnership – on listening to communities, collaborating across agencies, and joining forces with those who share this vision of a healthier future.

Advancing health equity is at the heart of building a stronger, more vibrant Minnesota.

Together, we can create a Minnesota where health and wellbeing is not the privilege of some, but a reality for all.

APPENDICES

Appendix A: A brief history of health equity at MDH

The roots of the 2014 report go back nearly 30 years both at MDH and in the United States.

Published in 1987, “Minority Populations in Minnesota: A Health Status Report” marked the first time MDH data detailed the health status of populations of color rather than relying solely on state averages. This was significant because data averages often obscure health inequities experienced by racially and ethnically diverse populations, LGBTQ+ communities, and people living with disabilities. A few years after the establishment of the federal Office of Minority Health in 1986, Minnesota created the Minnesota Office of Minority Health, which in 2001 became the Office of Minority and Multicultural Health.

Reducing health disparities was cited as a national goal for the first time in 1990, when the U.S. Department of Health and Human Services published Healthy People 2000. For the next 20 years, there was a lot of focused attention and action on health disparities, including:

- The 1990 Americans with Disabilities Act
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care in 2000
- A 2003 report from the Institute of Medicine titled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”

MDH published its first “Populations of Color Report” in 1997, followed by annual reports from 2002 through 2009. These reports documented the extent of health disparities in Minnesota and played a critical role in shaping future efforts to address them and advance health equity.

By 2000, language in the federal public health goals, “Healthy People 2010,” had shifted from reducing health disparities to eliminating them. In 2001, Minnesota’s minority health office succeeded in getting Minnesota legislative approval for the Eliminating Health Disparities Initiative grant program. That same year, the idea of social determinants of health was introduced broadly in Minnesota with the publication of “A Call to Action: Advancing Health for All Through Social and Economic Change,” which focused on changes in social and economic conditions as a strategy for health improvement and as a remedy to health disparities.

By 2010, conversations at both state and national levels centered on the root causes of health inequities, particularly the research surrounding social determinants of health. That same year, Healthy People 2020 identified “achieving health equity, eliminating disparities, and improving the health of all groups” as one of its overarching goals.

In 2011, new leadership at MDH – Commissioner Dr. Ed Ehlinger and Assistant Commissioner Jeanne Ayers – brought strong community connections and long-standing commitments to advancing health equity. The Healthy Minnesota Partnership, formed in late 2010, envisioned a state where all Minnesotans could enjoy healthy lives and healthy communities. Over the next several years and with guidance from former Assistant Commissioner Ayers, the partnership and others looked at the root causes of inequities as a path toward meaningful solutions.

The partnership made a landmark and controversial decision in 2012, marking a major shift in how state health is assessed, by focusing that year's statewide health assessment on the question of "what creates health" and moving data about outcomes to the back of the document. They introduced the statewide health improvement framework that same year, reinforcing the understanding that health is shaped by social and economic conditions and setting a purposeful goal: achieving health equity statewide.

By 2013, work was underway to publish the landmark "Advancing Health Equity in Minnesota: Report to the Legislature," which named structural racism as a major contributor to health disparities and sparking a much-needed conversation within Minnesota and across the country.

Appendix B: Community survey and conversations

Community survey

Overview

The Minnesota Department of Health (MDH) contracted with GrayHall LLP, an independent research firm in St. Paul, Minnesota, to distribute and analyze a community survey. MDH staff designed the survey and worked with GrayHall to administer it to provide respondent anonymity. The survey asked approximately 30 questions about community engagement and health equity data, perceptions of MDH efforts to advance health equity and to support community-driven solutions, and demographics of respondent organizations' target populations. The online survey was administered between February and May 2024.

Methods

The online survey was sent to 739 organizational and group email addresses throughout the state, including all 87 Minnesota counties. In some cases, surveys were sent to more than one person in an organization or group to include a variety of roles and responsibility levels among potential survey respondents.

The survey received 168 responses (a 23% response rate). All 168 respondents provided some information on each of the main topic areas. However, not all respondents answered each question. The number of survey question responses ranges from 82 to 168. Percentages have been rounded to whole numbers for consistency, with anything less than 0.50 rounded down.

A broad spectrum of organizations and community groups representing diverse demographics were invited to participate in the survey. These included healthcare systems; faith and religious communities, such as churches, synagogues, and mosques; service organizations focused on health, disability, and other areas for a range of age groups; communications and media organizations; and advocacy organizations. The organizations served a variety of racial, ethnic, cultural, and immigrant communities including LGBTQ+ individuals; people living with AIDS; and housed, unhoused, and sheltered populations.

All invitees had partnered with MDH in some way since the 2014 report, whether through MDH grants, contracts, advisory committees, or other more informal collaborations.

Limitations

Efforts were made to obtain a representative sample; however, responses are not generalizable to all partners or organizations who work or have worked with MDH. Local public health entities were underrepresented in the survey invitation list. Organizations serving American Indian communities were among the invitees, but Tribal partners were not included.

Because participation in the survey was voluntary, self-selection bias may have influenced the findings, potentially amplifying the perspectives of individuals already engaged in equity work. Thus, perspectives from non-respondents or those less engaged in equity work may be underrepresented.

It is also important to note that these results provide insights into a snapshot in time rather than a true measure of progress over the 10-year period, in part because no baseline data was established in 2014.

Community Conversations

Overview

A series of community conversations with representatives of various organizations were conducted across the state from July to September 2024 to gather valuable feedback and diverse perspectives on health equity efforts in Minnesota. The conversations were facilitated by Hispanic Advocacy and Community Empowerment through Research (HACER) in collaboration with MDH. Responses were analyzed from 10 community conversations: four in person, five through Zoom, and one hybrid.

Methods

The conversations included 74 participants from 50 different organizations throughout the state. Participant organizations served a variety of geographic areas, with 75% serving the metro area and 25% serving communities across the state, including Greater Minnesota.

As part of an ongoing effort to engage diverse voices in the conversations, MDH sought community-based organizations to assist with the process. The following organizations agreed to host and recruit participants for the community conversations:

- Access North Center for Independent Living of Northeastern Minnesota
- Comunidades Organizando el Poder y la Acción Latina (COPAL)
- Family Tree Clinic
- Hispanic Advocacy and Community Empowerment through Research (HACER)
- Hmong American Partnership
- Metropolitan Center for Independent Living
- Southeast Minnesota Center for Independent Living
- St. Mary's Health Clinic

Two conversations were hosted by MDH at the COVID-19 Community Coordinators Program orientation in July 2024. Seven conversations were hosted by local community organizations, and one conversation was hosted by HACER. One additional focus group was excluded from analysis due to an error in recruitment strategy that resulted in participants who did not meet intended criteria.

Limitations

Efforts were made to engage a representative sample; however, Tribal community partners were underrepresented compared to other groups who participated in conversations.

Because participation in these conversations was voluntary, self-selection bias could influence the findings, potentially amplifying the voices of those already engaged in equity work. It is also important to note that these results provide insights into a snapshot in time rather than a true measure of progress over the 10-year period, in part because no baseline data was established in 2014.

Appendix C: MDH staff survey and conversations

MDH staff survey

Overview

To capture internal perspectives, MDH conducted an online staff survey from Dec. 6, 2023 to Jan. 5, 2024. This 42-question survey explored various dimensions, including personal views on health equity, perceptions of MDH health equity initiatives, individual definitions of health equity, and views on progress and challenges relative to the 2014 recommendations.

Methods

The survey link was emailed to all MDH staff from MDH Commissioner Brooke Cunningham on Dec. 7, 2023, followed by an email to supervisors and managers. Reminders were sent via emails to all staff, multiple posts on the MDH Intranet, and virtual information sessions led by Health Equity Bureau staff.

Approximately 1,668 to 1,724 MDH staff members responded, representing an 83% to 86% response rate. Respondents were assured of confidentiality and had the option to skip any question, which resulted in completion rates that varied per question. Percentages have been rounded to whole numbers for consistency, with anything less than 0.50 rounded down.

The data was securely stored on a restricted-access server, managed by two researchers who handled the analysis. The dataset was cleaned to remove duplicate records. Identifiable information was de-identified or aggregated to protect privacy.

Limitations

Because participation in this survey was voluntary, self-selection bias could influence the findings, potentially amplifying the voices of those already engaged with equity work. Thus, perspectives from non-respondents or those less engaged in equity work may be underrepresented.

It is also important to note that these results provide insights into a snapshot in time rather than a true measure of progress over the 10-year period, in part because no baseline data was established in 2014. As with any perception-based survey, these results reflect participants' experiences and views at a particular point in time.

MDH staff conversations

Overview

A series of 15 in-depth group discussions on health equity were held with MDH staff members during a three-week period in early 2024. These conversations provided insights into staff perceptions of MDH progress made to advance health equity and the role of health equity across MDH offices and divisions.

Methods

Conversations included 72 volunteer participants. Invitations to participate were shared via a post on the MDH intranet and an email from MDH leadership. Staff were able to self-select into a conversation with an affinity group that provided added inclusivity. Staff members who did not select an affinity group were randomly placed in groups based on preferred date, time, or virtual versus in-person meeting.

Researchers assigned each participant a unique ID to protect anonymity. Conversations were held on different days and times to accommodate staff schedules. While 15 community conversations took place, 13 groups ultimately were created from the notes and transcripts. Three of the conversations were combined due to low attendance.

Focus group sessions were held via Microsoft Teams and in person to ensure accessibility. Every effort was made to ensure confidentiality to mitigate risks of identification, especially for staff from smaller divisions.

The conversations focused on perceptions of how equity is applied across the agency according to the seven key recommendations from the 2014 Report. The objectives of the conversations were to:

- Explore, describe, and interpret health equity activities within MDH.
- Analyze behaviors, attitudes, and perceptions related to equity-driven changes at MDH.
- Identify opportunities for MDH to improve its health equity efforts.

One or two health equity strategist(s) facilitated each conversation. The health equity strategists completed extensive focus group training and practice sessions prior to hosting the conversations with MDH staff. Major themes were identified in the conversations and are summarized in the report.

Limitations

Participation in these conversations was voluntary. Self-selection bias could influence the findings by potentially amplifying the voices of those already engaged in equity work. Thus, perspectives from staff who are less engaged in equity work may be underrepresented.

It is also important to note that these results provide insights into a snapshot in time rather than a true measure of progress over the 10-year period, in part because no baseline data was established in 2014.

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Definitions of Terms

Definitions are included throughout the report in gray boxes.

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