Healthy Minnesota 2020 Update
2013 Annual Report of the Healthy Minnesota Partnership

December 2013
Healthy Minnesota 2020 Update

Vision: All people in Minnesota enjoy healthy lives and healthy communities.

Contents

The Healthy Minnesota Partnership ..................................................................................................................................................................................... 3

Healthy Minnesota 2020: Statewide Health Improvement Framework ............................................................................................................. 4

2013 Progress on Healthy Minnesota 2020 ..................................................................................................................................................................... 5

   Strategic Approach: Changing the Conversation about Health .................................................................................................................. 5

   Sharing the Framework .......................................................................................................................................................................................................... 7

   Strategy Team Progress ......................................................................................................................................................................................................... 7

   Progress on Core Indicators/Key Conditions .............................................................................................................................................................. 9

Looking Ahead: 2014 ................................................................................................................................................................................................................. 10

   Refocus the Strategic Approach ..................................................................................................................................................................................... 10

   Develop New Performance Measures ......................................................................................................................................................................... 11

Appendix A: Healthy Minnesota Partnership ................................................................................................................................................................ 12

Appendix B: New Narrative Frames ................................................................................................................................................................................... 15

Appendix C: Healthy Minnesota 2020 Indicator Updates .................................................................................................................................................................. 17


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The Healthy Minnesota Partnership

The Healthy Minnesota Partnership was convened in 2010 by the Commissioner of Health to develop public health priorities, indicators and strategies to improve health and wellness for all Minnesotans. The members of the Healthy Minnesota Partnership come from rural, suburban and urban communities; from hospitals, health plans and public health departments; from business and government agencies; and from faith-based and community organizations (see membership in the Appendix).

The first tasks of the Partnership were to direct the development of a statewide health assessment and statewide health improvement plan. Guided by the vision—*all people in Minnesota enjoy healthy lives and healthy communities*—the Partnership set out to create an assessment and plan that would allow people throughout Minnesota to contribute to the realization of this vision. *The Health of Minnesota (2012)* and *Healthy Minnesota 2020* both were developed in 2012 under the guidance of the Healthy Minnesota Partnership.

To begin their work the Partnership developed a set of guiding principles:

- Strive to improve health equity and eliminate health disparities.
- Promote proactive, evidence-based, and innovative health improvement priorities and strategies, including policy, systems and environmental approaches.
- Maximize partnerships and advisory groups to bring a depth and breadth of experiences, skills and technical expertise to the table.
- Develop strategic goals and directions for health that complement the goals and priorities of member organizations and communities.
- Be a voice for the health of every Minnesota community.

As the Partnership continued, they also articulated a set of core values to reflect their goal of developing a framework that would help Minnesotans work together to create the conditions in which everyone can be healthy and achieve the vision of a healthy Minnesota (see highlight, above).

In 2013, the Healthy Minnesota Partnership began the work of implementing the *Healthy Minnesota 2020* framework with activities that included the following:

- A subgroup to promote and advocate that the opportunity to be healthy is incorporated and promoted in public and private policies. This team explored research and developed strategies for promoting and advocating for health in all policies, paying particular attention to the policies that affect the people and communities who experience the greatest health disparities.

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**Healthy Minnesota Partnership Vision and Values**

*All people in Minnesota enjoy healthy lives and healthy communities.*

**We Value... Connection**

We are committed to strategies and actions that reflect and encourage connectedness across the many parts of our community. Our collaboration, cooperation, and partnerships reflect our shared responsibility for ensuring health equity and creating healthy communities.

**We Value... Voice**

People know what they need to be healthy, and we need to listen. Every part of every community has an equal claim to having their voices heard and considered in new conversations about health.

**We Value... Difference**

We are all members of many communities, with great diversity of experience, perspectives, and strengths. Those differences make us stronger together than we would be alone.
Partnership discussions, held with a variety of sectors, to bring attention to public health issues, monitor progress on statewide efforts, and promote efforts toward the Healthy Minnesota 2020 themes. This effort engaged experts from various sectors in conversations about the ways in which their work does or could contribute to the accomplishment of the Healthy Minnesota 2020 vision.

- An annual review of key indicators. In addition to the subgroups and cross-sector discussions, the Partnership reviewed and discussed the key indicators of Healthy Minnesota 2020 and related health status outcomes.

Healthy Minnesota 2020: Statewide Health Improvement Framework

The emphasis in Healthy Minnesota 2020 is on creating conditions that allow people to be healthy, conditions that assure a healthy start, that set the stage for healthy choices, and that create environments that support health throughout life. Healthy Minnesota 2020 is not a program for any single agency or organization to implement, but is a guide for activity on many fronts. It does not spell out action to take on specific diseases or conditions, but hopes to expand understanding and encourage activity on creating the kinds of systems and opportunities for health that will make a difference for lifelong individual and collective health for all people in Minnesota.

In the Healthy Minnesota 2020 framework, the Partnership identified three key themes to guide future discussion and action for implementing health improvement strategies in Minnesota:

- **Capitalize on the opportunity to influence health in early childhood.**
- **Assure that the opportunity to be healthy is available everywhere and for everyone.**
- **Strengthen communities to create their own healthy futures.**

These themes incorporate a sense of time and urgency (early childhood), shared responsibility (opportunity for everyone, everywhere), and the importance of self-determination (communities creating health). A wide range of health-improvement efforts fit within these high-level themes, from transportation policy to access to health care to health behavior education. The intent is to create a framework for having conversations about health that will involve all sectors of Minnesota, so that together we can create the conditions that assure that all people can be healthy.

During the course of 2013 the Partnership came to recognize that not only do these themes reflect priority areas, but that they are powerful tools for shaping the conversations, policy directions, and actions that are needed to realize the vision of a healthy Minnesota. For example, the themes were adopted to guide MDH as the department developed a report on health equity. In addition, the themes of Healthy Minnesota have been used to shape intra-agency as well as inter-agency discussions of policy needs and possibilities for community action.
The realization of the powerful nature of the Healthy Minnesota 2020 framework helped to shape the decision of the Partnership to revise their strategy moving forward and focus more directly on influencing the direction of public policy in order to realize the vision of Healthy Minnesota 2020.

2013 Progress on Healthy Minnesota 2020

Strategic Approach: Changing the Conversation about Health

Health disparities have not improved over the last ten years: in fact, they have worsened. To achieve the broad and aspirational vision of Healthy Minnesota 2020, the Partnership recognized the obvious need to adopt a new approach to health improvement.

The factors that contribute to health outcomes are complex and go beyond the scope of any one sector. A number of theoretical models have been developed to explain the impact of different factors on health (see diagram\(^1\)). One of the key findings from these studies is that clinical care—which includes doctors’ visits, hospital care, medication, and other medical treatment, and which is what many people think of when they talk about “health”—contributes much less to health outcomes than do social and economic factors. That is because clinical care is often a response to existing health problems. Other factors, such as economic well-being, access to health care, social connectedness, and safe physical environments are what actually create the conditions in which health can flourish (or not). This understanding is consistent with the historical and national definition of public health, which is Public health is “what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”\(^2\)

Reflecting this growing understanding about the factors that create the opportunity to be healthy, the Healthy Minnesota Partnership decided to focus the Healthy Minnesota 2020 framework on the social and economic factors and the physical environment.\(^3\) The diagram below shows how the Healthy Minnesota 2020 themes connect with social and economic factors to lead to the realization of the Healthy Minnesota 2020 vision. The arrows show the complex web of relationships and activity among the many conditions that are necessary for health, and the various kinds of outcomes that these conditions assure.

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\(^3\) While clinical care and healthy behaviors may contribute less overall to health outcomes, nonetheless they do play an important contributing role. The Partnership chose to focus on social and economic factors, recognizing that clinical care and health behaviors are addressed in a variety of other arenas.
The Par­tnership recognized that these factors, including the “key conditions for health” identified in the diagram above, range beyond the scope of any single entity or sector to change. They also realized that the outcomes are to a large extent dependent on policies set in both the public and private spheres. Policy discussion, however, are greatly influenced by the “narratives” or stories used to understand health and to develop solutions to health concerns.

Public conversations take place in the policy arena, in media stories, in structured discussions (such as focus groups), and in informal conversations among friends and strangers. In most of these conversations two “narratives” tend to dominate: 1) that health is a product of health care, and 2) that health is a product of individual behaviors and therefore an individual responsibility. But these two narratives are limited and incomplete, as noted above. Thus the Partnership chose as their primary strategy to work toward changing of the nature of public discussions about health.

To implement this approach, in 2013 the Partnership focused on:

- Revealing the dominant narratives and consider how these restrict the conversations about policy solutions.
- Identifying alternative narratives that could support a broader range of policy solutions.
- Encouraging the development of narratives about creating opportunities for health.
- Engaging a wide range of people and populations in conversations about health.
- Learning to think and talk more effectively about the factors that create the opportunity to be healthy.
- Influencing decision makers to incorporate health considerations into the development of public and private policies and programs.
Sharing the Framework

The first step the Partnership took to implement the strategic approach of Healthy Minnesota 2020 was to introduce the framework to a wide range of audiences. In 2013 Healthy Minnesota 2020 was widely shared and affirmed through many presentations and discussions in the Partnership’s own organizations, and including:

- Many Faces of Community Health Conference
- DHS Odyssey Conference
- Minnesota Academy of Nutrition and Dietetics
- 2012 and 2013 Community Health Conferences
- “Pitch the Commissioner” gatherings with local elected officials and local public health leaders
- Tribal Health Directors
- Local Public Health Association
- Minnesota Public Health Association
- Minnesota Cancer Alliance
- Maternal and Child Health Advisory Task Force
- State Community Health Services Advisory Committee

In addition, the Healthy Minnesota 2020 statewide assessment and framework have been widely used to guide other work, including:

- Local health department community health assessments
- Hospital community health needs assessments
- Minnesota Public Health Association annual meeting on health in all policies
- Itasca Project disparities work group
- Center for Population Health 2.0
- Hennepin County Medical Center/HCMC Foundation SHIP grantees
- Community Transformation Grant (CTG) Leadership Team
- Various policy advocacy efforts, such as the 2013 MPHA legislative priorities, SHIP, ISAIAH, Minnesota Hospital Association, the Minnesota Board on Aging, and TakeAction Minnesota
- Minnesota Department of Health Advancing Health Equity Report development process
- MDH Commissioner’s discussions with other commissioners(some of these were recorded as part of the Public Health Journal cable television show)

National organizations also expressed interest during 2013 in Minnesota’s assessment, framework and strategic approach. These include the Association of State and Territorial Health Officials (ASTHO), the Robert Wood Johnson Foundation, the Centers for Disease Prevention and Control (CDC), the National Network of Public Health Institutes (NNPHI), and the National Association of County and City Health Officials (NACCHO).

Strategy Team Progress

As the framework was being shared across the state and the nation, the Partnership also established two “strategy teams” in 2013 to implement the strategic approach of Healthy Minnesota 2020: a strategy team focused on narratives, and a strategy team focused on policy.
Narratives Strategy Team: Promoting Narratives on the Opportunity to be Healthy

To help develop richer, more expansive and creative public conversations about health, in 2013 the Healthy Minnesota Partnership convened a subgroup to identify and promote public narratives that emphasize health-generating factors and the opportunity to be healthy.

A public narrative is more than a simple story; it is “a representation of a particular situation or process in such a way as to reflect or conform to an overarching set of aims or values.” As noted earlier, the prevailing narrative about health in our culture is health-care based: the idea that health is somehow generated by a visit to the doctor’s office. Another prevailing narrative is that health is individual-based: that it is the sole responsibility of the individual to engage in “healthy behavior,” such as exercising more or eating low-fat foods. In fact, however, behaviors are strongly influenced by the conditions in which people live, work, learn, and play. Public narratives are needed to support creating the opportunity to be healthy—such as ensuring safe housing, promoting on-time high school graduation, and providing a livable wage—in order to realize the vision of Healthy Minnesota 2020.

The charge of the Narratives Strategy Team was to identify, develop and promote alternative narratives that emphasize the opportunity to be healthy. The team was directed to support and guide the development of stories and narratives that will move public thinking about health toward a greater understanding of the importance of assuring that everyone has the opportunity to be healthy.

To measure the performance of this team, the following performance measure was adopted:

By 2014, one or more new ways of talking about the factors that create health for people in Minnesota (“meta narratives”) are developed, representing various perspectives.

Narrative Strategy Team Progress

The Narratives Strategy Team made clear progress toward their 2014 performance measure. The team not only developed a set of new “narrative frames” (see Appendix C), but also highlighted the importance of having explicit conversations about the role of race and structural racism in population health outcomes. The team identified race and structural racism as key factors for health, but also noted that these often go unspoken or hidden in “code” terminology, such as “health disparities.” The effort of this team to put issues of race into the conversation about “what creates health” was a key influence not only on the work of the Partnership but on the ongoing work of MDH.

Policy Strategy Team: Incorporating Health Considerations in Policy Development

A subgroup of the Healthy Minnesota Partnership was convened in 2013 to explore research and develop strategies for promoting and advocating for health in all policies, paying particular attention to the policies that affect the people and communities who experience the greatest health disparities.

Public and private policies can have both positive and negative effects on the opportunity for all people in Minnesota to be healthy and on the ability of communities to create their own healthy futures. A policy approach to health improvement has great potential to positively influence health outcomes. But when conversations about health are all about health care, health policy in turn becomes focused on health care issues and subsequent attention naturally turns to strategies for improving health care services.

According to a national public health organization,

Health in all policies (HiAP) is an innovative, systems change approach to the processes through which policies are created and implemented. HiAP involves a consideration of the health impacts of policies at all

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stages of the policymaking process, thereby ensuring that policy decisions result in positive health effects or do not contribute to the degradation of health status.\textsuperscript{5}

The charge of the Policy Strategy Team was to promote and advocate for the incorporation of health considerations in the development of private and public policy. The team was directed to explore the research and promote the consideration and incorporation of health effects in public and private policies (also known as “health in all policies” or HiAP) in Minnesota.

To measure the performance of this team, the following performance measure was adopted:

\textit{By 2014, health will be considered and promoted in the development of at least one new public policy in a sector other than public health or health care (e.g., through a health impact assessment).}

\textbf{Policy Strategy Team Progress}

The Policy Strategy Team also made clear progress toward their performance measure in 2013. They successfully identified several strategic opportunities for the Healthy Minnesota Partnership to add a health lens to public policy and program development in Minnesota in the upcoming 2014 legislative session, including an anticipated increase in the state’s minimum wage, the bonding bill, health reform discussions, and advancing health equity. At the September, 2013 meeting the Partnership chose to use the minimum wage policy discussion to work on changing the conversation around health to focus on social and economic factors (in this case, income and health). The Partnership also agreed to host a meeting in November for a broad community discussion of the issue of advancing health equity.

The Narratives and Policy teams are planning to hold a joint meeting in January to bring their work together and prepare narrative frames to bring a health perspective to the minimum wage debates anticipated during the 2014 Minnesota state legislative session.

\textbf{Progress on Core Indicators/Key Conditions}

A third activity of the Partnership in 2013 in the overall strategy to change the conversation about health was to bring attention to a wide range of public health issues and to monitor progress on statewide efforts. Throughout 2013, the Partnership was updated on the status of the core indicators/key conditions of Healthy Minnesota 2020 and Healthy Minnesota 2020/Chronic Disease and Injury (see dashboards in Appendix C). Experts were brought into Partnership meetings to present in-depth information on breastfeeding, school safety, and home ownership (one issue per theme of Healthy Minnesota 2020) and to discuss the ways in which these issues contribute to the accomplishment of the Healthy Minnesota 2020 vision.

As noted in the dashboard for the Healthy Minnesota 2020 core indicators for health (Appendix C), progress was made from in the areas of breastfeeding rates, on-time high school graduation rates (in every racial/ethnic group except American Indians), and Asian and White income rates. There was no change in the rates of food insecurity, and no new data for prenatal care, school safety, minority-owned small businesses, or incarceration disparities. And racial/ethnic income disparities and home ownership rates worsened between 2010 and 2012. The income and home ownership rate disparities were discussed in particular as an effect of the economic downturn, which had a greater impact on populations of color and American Indians in Minnesota.

\textsuperscript{5} National Association of County and City Health Officials,  \url{http://www.naccho.org/toolbox/program.cfm?id=32}
Looking Ahead: 2014

Based on their progress in 2013, the Partnership decided to make several adjustments to their overall focus and efforts. These are to: refocus the strategic approach, and develop new performance measures.

Refocus the Strategic Approach

Through evaluation of the progress of Healthy Minnesota 2020, the Partnership both affirmed and determined that an adjustment should be made to their strategic approach. The approach was affirmed by the overwhelmingly positive response to the three themes of the framework and the decision to focus on “changing the conversation” about health. The high level of local, state, and national interest and enthusiastic response to Healthy Minnesota 2020 has demonstrated the timeliness of a new way to approach health inequities and that the Partnership has chosen a positive direction. Both the Narratives and the Policy Strategy Teams made progress toward their own goals, successfully developing new ways of talking about health and identifying important strategic opportunities to influence policy direction for improved population health.

The Partnership decided that hearing status updates on the core indicators for health was neither a compelling activity and nor contributed meaningfully to the strategic direction of the Partnership. They wanted a stronger focus on developing narrative frames and the potential to influence public policy using the “health in all policies” approach. The Partnership decided to characterize the core indicators as “key conditions for health,” in order to focus on how they are part of the broader picture of community conditions, rather than as isolated health indicators.

Focus on annual strategic opportunities for policy change related to the key conditions for health

As part of revising their strategy for the year ahead the Partnership determined that these key conditions would be most useful as a way to identify strategic opportunities for policy changes. They also agreed that continued annual monitoring of the data would still be helpful as a way to identify conditions that might be improved through policy changes.

The Partnership intends to continue, therefore, with annual status updates of the key conditions for health, but to focus meetings and activities primarily on developing and advancing the narratives about what creates health/the opportunity to be healthy, on identifying strategic opportunities to engage in policy discussions, and on using the new narratives to assure that health is incorporated in policy development in both the private and public sectors.

Commitment to addressing race and structural racism in its work

During its September 2-13 meeting, the Partnership heard a report from its Narrative Strategy Team. The team reported on its discussion and conclusion on the importance of having explicit conversations about the role of race and structural racism in population health outcomes. The team asked the Partnership to consider making the same commitment. The Partnership members affirmed the need to keep race and racism central in its efforts to implement the Healthy Minnesota Framework and will seek ways to hold itself accountable to this commitment through the performance measures.
2013-2014 Strategic Opportunities

At the September 2013 meeting the Partnership chose two strategic opportunities for 2013/14:

- **The minimum wage policy discussion.** The Partnership will develop narratives frames and messages on the connection between income and health and use these to lift up the impact on health during the upcoming MN legislative session.

- **The MDH Advancing Health Equity Report.** The Partnership planned to host a meeting in November for a broad community discussion of the issue of advancing health equity. These discussions will focus on how MDH policies and practices can best impact health equity based on the HM 2020 narrative.

Develop New Performance Measures

During 2013 the Partnership identified a need to develop more specific performance measures for the Partnership as a whole; especially since the core indicators/key conditions now will be used as indicators of strategic policy areas rather than as outcomes for the Partnership itself.

Beginning in 2014 a draft set of measures will be developed and presented to the Partnership for approval. A monitoring and evaluation plan also will be developed. Additional performance measures may be added over the next several years to reflect a growing understanding of the Partner’s strategic approach and its power to realize the vision of *Healthy Minnesota 2020*. 
Appendix A: Healthy Minnesota Partnership

Charge

The Healthy Minnesota Partnership was created to develop innovative public health priorities, goals, objectives, and strategies to improve the health of all Minnesotans, and to ensure ownership of these objectives and priorities in communities across the state of Minnesota. The Healthy Minnesota Partnership resides online: http://www.health.state.mn.us/healthymnpartnership/

Membership

The efforts of the Healthy Minnesota Partnership are intended to benefit the state as a whole, and the membership of the partnership reflects a broad spectrum of interests. As of July 2012, the following organizations were represented in the Healthy Minnesota Partnership.

2013 Partnership Members

Jeanne Ayers  
Minnesota Department of Health

Hector Garcia  
Chicano Latino Affairs Council

Kami Norland  
National Rural Health Resource Center

Alfred Babington-Johnson  
StairStep Foundation

Jim Halstrom  
Association of Minnesota Emergency Managers

Martha Overby  
Minnesota Chapter, March of Dimes

Ken Bence  
Minnesota Public Health Association

Tim Henkel  
Minnesota Department of Transportation

Joan Pennington  
Minnesota Hospital Association

Kari Benson  
Minnesota Board on Aging

Neal Holtan  
Medical Consultant

Carmen Reckard  
Local Public Health Association (Greater MN)

Janny Dwyer Brust  
Minnesota Council of Health Plans

Warren Larson  
Sanford Health

John Salisbury  
LGBTQ Health Advocacy Roundtable

Rachel Callanan  
American Heart Association

Deb Loy  
Medical Consultant

Ferd Schlapper  
Boynton Health Services

Rhonda Degelau  
Minnesota Association of Community Health Centers

Minnesota Department of Transportation

Joan Pennington  
Minnesota Hospital Association

Kari Benson  
Minnesota Board on Aging

Neal Holtan  
Medical Consultant

Carmen Reckard  
Local Public Health Association (Greater MN)

John Salisbury  
LGBTQ Health Advocacy Roundtable

Liz Doyle  
TakeAction Minnesota

Warren Larson  
Sanford Health

Ferd Schlapper  
Boynton Health Services

Ed Ehlinger  
Minnesota Department of Health

Deb Loy  
Minnesota Department of Education

Lee Souvan  
Council on Asian Pacific Minnesotans

John R. Finnegan, Jr.  
University of Minnesota School of Public Health

Minnesota Department of Transportation

Barb Sporlein  
Minnesota Housing Finance Agency

University of Minnesota School of Public Health

Maria Veronica Svetaz  
Hennepin County Medical Center

ISAIAH

Itasca Project
Partnership Alternates

Ann Bajari  
Minnesota Public Health Association

Carol Berg  
Minnesota Council of Health Plans

Kathleen Call  
University of Minnesota School of Public Health

Dylan Flunker  
LGBTQ Health Advocacy Roundtable

Stacey Houseman  
Blue Cross Blue Shield Center for Prevention

Jackie Keaveny  
Minnesota Board on Aging

Kristin Loncorich  
Minnesota Hospital Association

Todd Monson  
Local Public Health Association (Metro)

Sue Yost  
Local Public Health Association (Greater MN)

Staff to the Partnership

Dorothy Bliss  
Minnesota Department of Health

Jodi Nelson  
Minnesota Department of Health

Jeannette L. Raymond  
Minnesota Department of Health

Marcus Howard  
Student Worker

Minnesota Department of Health

Policy Strategy Team Members

Partnership Members

Alfred Babington-Johnson  
Rachel Callanan  
Liz Doyle  
Janny Dwyer-Brust  
Warren Larson  
Deb Loy  
Carmen Reckard  
Ferdinand Schlapper  
Donna Zimmerman

Deb Burns  
Patty Bowler  
Tannie Eschenaur  
Ray Lewis  
Vanne Owens Hayes  
Kris Rhodes

Minnesota Department of Health  
Minneapolis Public Health  
Minnesota Department of Health  
Minnesota Public Health Association  
African American Leadership Forum  
American Indian Cancer Foundation
Narratives Strategy Team Members

**Partnership Members**

Jeanne Ayers  
Carol Berg  
Gretchen Musicant  
Kami Norland

Kari Bailey  
MEDICA

Jackie Dionne  
Minnesota Department of Health

Kristen Godfrey  
Hennepin County Medical Center

Monica Hurtado  
ARCHE

Clarence Jones  
South Side Community Clinic

Melissa Kwon  
Health Equity Working Committee, Center for Applied Research and Educational Improvement, U of M

Monica Nilsson  
St. Stephens Human Services

Steve Peterson  
Community Transformation Grant Leadership Team, Evangelical Lutheran Church in America

Scott Smith  
Minnesota Department of Health
What is health?
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

What is health equity?
Health equity means that all people have the opportunity to attain their highest level of health possible.

For equity in health outcomes to be possible, people of every race and ethnic background need to have: 1) access to political, economic and educational opportunity; 2) the capacity to make decisions and effect change for themselves, their families and their communities; and 3) social and environmental safety in the places they live, learn, work, worship and play. For people in Minnesota of American Indian, African American, Hispanic, Asian, Pacific Islander, Middle Eastern, and African descent, these opportunities are limited by structural inequities that are rooted in historical and individual racism, whether intended or not. These structures must be addressed if health equity is to be achieved.

How is health created?
- Health is created by individuals of all races and communities—American Indian, African American, and people of Hispanic, Asian, Pacific Islander, Middle-Eastern, African and European descent—working together.
- Health is created by the economic, social and environmental conditions of our lives, shaped by historical and social forces including racism, and by the personal behavior which is influenced by these conditions.
- People and communities, no matter what their race or circumstances, intuitively know what makes them healthy—even if it’s not conscious or clearly evident in the choices they are able to make.
- Health is created when everyone is healthy together. The health of American Indians and people of African, Hispanic, Asian, Pacific Islander, Middle Eastern, and European descent are all bound together. We have a fundamental, organic interconnectedness, like parts of the same body.
What else is important for creating health?

- Health care—medical and clinical care—is an important component of health but, over the span of peoples’ lives, other factors have a greater overall impact on health.
- The diversity of communities in Minnesota—men, women and children of American Indian, European, African, Hispanic, Asian, Pacific Islander, and Middle Eastern backgrounds, people of different faith traditions, people living in rural and urban settings, and people of differing abilities and orientations—makes us all healthier. Diversity creates balance by providing a variety of perspectives on what it means to be healthy and generating creative approaches to health.
- Our own understanding is enriched when we try to see things from another’s point of view, even when we might not agree.
- Health today is influenced by events, decisions, and experiences of the past: these include the historical trauma and structures of racism put in place by genocide, slavery, internment and other oppressions. The events and decisions of today will influence our health in the future.

On whom should our efforts to create health be focused?

- Every community and all people living in Minnesota, of every age and gender, regardless of sexual orientation or disability, whether American Indian, African American, or of European, Asian, Pacific Islander, Middle Eastern or African descent, should have the same opportunity to be healthy.
- All people deserve to live with respect, dignity and health.
- Every child in every family deserves a healthy start.
- Health disparities are not inevitable, especially at current levels, and can be minimized or eliminated.

Who is responsible for creating health?

- We are all responsible for creating health: individuals, communities, business sector, non-profit sector, public sector, public health professionals, health care providers, health insurers and more.
- We are all responsible for removing the structural and institutional barriers, especially those created by historical racism, which create an unequal opportunity for health.
- We are all capable of being generators of health.
- We are all needed if we are going to realize health for all people and communities in Minnesota.

What has to change in order to create more health and why?

- Communities are responsible for organizing individuals and their passions to articulate and advocate for improvements in health.
- We need transparency in decision-making and a better understanding and disclosure of how policies in every sector impact health.
- Community wisdom must have a place at decision-making tables. Government must ensure that there is a place at the decision table for people representing different ages, genders, racial and ethnic backgrounds, sexual orientations, and disabilities.
- The community has a key role as protector and caretaker of children; communities must be supported in this role.
- All parts of society must see creating health as a common purpose, connected to shared values, and change their assumptions and practices to move towards that purpose.
### Appendix C: *Healthy Minnesota 2020* Indicator Updates

<table>
<thead>
<tr>
<th>THEMES</th>
<th>LEAD INDICATOR</th>
<th>MOST RECENT</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capitalize on the opportunity to influence health in early childhood.</strong></td>
<td>By 2020, more mothers in every racial/ethnic population access first trimester prenatal care.</td>
<td>No new data available</td>
<td>No new data</td>
</tr>
<tr>
<td></td>
<td>More Minnesota children are exclusively breastfed for six months. (2011 CDC)</td>
<td>23.5%</td>
<td>Improving</td>
</tr>
<tr>
<td></td>
<td>Fewer Minnesota households experience food insecurity. (2010 USDA)</td>
<td>10.4%</td>
<td>No Change</td>
</tr>
<tr>
<td><strong>Assure the opportunity for health is available everywhere and for everyone.</strong></td>
<td>By 2020, more students from each population group graduate from high school within four years. (2012 MN Dept. of Ed.)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>By 2020, Minnesota’s racial and ethnic inequalities in income are reduced. Inflation-adjusted income at right. (2012 ACS)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>African-American: 51%</td>
<td>Improving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>American Indian: 45%</td>
<td>No Change</td>
<td></td>
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<tr>
<td></td>
<td>Asian: 74%</td>
<td>Improving</td>
<td></td>
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<tr>
<td></td>
<td>Hispanic: 53%</td>
<td>Improving</td>
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<tr>
<td></td>
<td>White: 84%</td>
<td>Improving</td>
<td></td>
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<tr>
<td></td>
<td>African-American: $14,740</td>
<td>Growing Worse</td>
<td></td>
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<tr>
<td></td>
<td>American Indian: $15,068</td>
<td>Growing Worse</td>
<td></td>
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<tr>
<td></td>
<td>Asian: $23,935</td>
<td>Improving</td>
<td></td>
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<tr>
<td></td>
<td>Hispanic: $13,461</td>
<td>Growing Worse</td>
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</tr>
<tr>
<td></td>
<td>White: $31,573</td>
<td>Improving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minnesota students feel safe at and on the way to school.</td>
<td>No new data available</td>
<td>No new data</td>
</tr>
<tr>
<td><strong>Strengthen communities to create their own health.</strong></td>
<td>By 2020, more communities across Minnesota have more small business and more minority- and woman-owned businesses.</td>
<td>No new data available</td>
<td>No new data</td>
</tr>
<tr>
<td></td>
<td>By 2020, populations that currently have low rates of home ownership are better able to afford and own homes. (2011 ACS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>African-American: 26%</td>
<td>Growing Worse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>American Indian: 46%</td>
<td>Growing Worse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asian: 51%</td>
<td>Growing Worse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic: 43%</td>
<td>Growing Worse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>White: 77%</td>
<td>Growing Worse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>By 2020, racial/ethnic inequities in incarceration rates in Minnesota are diminished.</td>
<td>No new data available</td>
<td>No new data</td>
</tr>
</tbody>
</table>

---

These data were presented to the Partnership at the September 2013 meeting.
## Chronic Disease Injury Dashboard Report

<table>
<thead>
<tr>
<th>LEAD INDICATOR</th>
<th>2020 TARGET</th>
<th>MOST RECENT</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy Eating</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth (9th-graders) who eat the recommended number of fruits and vegetables daily</td>
<td>30.0%</td>
<td>18% (2010)</td>
<td>No trend data available</td>
</tr>
<tr>
<td><strong>Physical Activity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults who meet physical activity guidelines</td>
<td>75.0%</td>
<td>54.0% (2011)</td>
<td>No Change</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young adults age 18-24 who smoke</td>
<td>18.6%</td>
<td>27.8% (2010)</td>
<td>Improving</td>
</tr>
<tr>
<td><strong>Alcohol Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult binge drinking</td>
<td>15.5%</td>
<td>21.9% (2012)</td>
<td>No Change</td>
</tr>
<tr>
<td><strong>Arthritis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with arthritis who participate in self-management programs</td>
<td>16.2%</td>
<td>13.8% (2011)</td>
<td>No Change</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children age 5-17 with asthma who achieve optimal asthma management</td>
<td>30.0%</td>
<td>37.0% (2011-12)</td>
<td>Goal Reached</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults age 50 and older who have had colorectal cancer screening</td>
<td>80.0%</td>
<td>68.0% (2011-12)</td>
<td>Improving</td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult vascular disease patients who achieve optimal vascular care treatment goals</td>
<td>50.0%</td>
<td>49.0% (2011)</td>
<td>Improving</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult diabetes patients who achieve optimal diabetes care outcomes</td>
<td>41.0%</td>
<td>38.2% (2011)</td>
<td>Improving</td>
</tr>
<tr>
<td><strong>Injury</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall deaths among the elderly age 65 and older</td>
<td>79^</td>
<td>90^ (2010)</td>
<td>Growing Worse</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults who are at a healthy weight</td>
<td>47.0%</td>
<td>37.0% (2012)</td>
<td>No Change</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with a dental visit in the last 12 months</td>
<td>82.8%</td>
<td>74.8% (2012)</td>
<td>No Change</td>
</tr>
</tbody>
</table>

^7 Per 100,000.