

Healthy Minnesota 2020 Update

2015 ANNUAL REPORT OF THE HEALTHY MINNESOTA PARTNERSHIP

JANUARY 2016



HEALTH PARTNERSHIPS DIVISION



HEALTHY MINNESOTA PARTNERSHIP

Healthy Minnesota 2020 Update: 2015 Annual Report of the Healthy Minnesota Partnership

Minnesota Department of Health,
Health Partnerships Division
PO Box 64975, St. Paul, MN 55164-0975
651-201-3880 | health.ophp@state.mn.us
www.health.state.mn.us/divs/opi/

Healthy Minnesota Partnership
www.health.state.mn.us/healthymnpartnership/

Contents

Healthy Minnesota Partnership.....	3
Healthy Minnesota 2020: Statewide Health Improvement Framework.....	4
2015 Progress on Healthy Minnesota 2020.....	5
Strategic Approach: Expanding the Conversation about What Creates Health	5
Partnership Progress.....	6
Strategy Team Progress	8
Progress on Core Indicators/Key Conditions	10
Looking Ahead: 2016	11
2016 Strategic Opportunities.....	11
2017 Statewide Health Assessment.....	12
Appendix A: Healthy Minnesota Partnership	14
Appendix B: 2015 Emerging Narrative Frames	17
Appendix C: Healthy Minnesota: Summary of 2015 Performance Measures	20
Appendix D: Healthy Minnesota 2020 Key Conditions Indicator Updates as of June 2015	21

Healthy Minnesota 2020 Update: 2015 Annual Report of the Healthy Minnesota Partnership was produced in collaboration by the Minnesota Department of Health and the Healthy Minnesota Partnership. This project was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, under #5U58CD001287. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

HEALTHY MINNESOTA PARTNERSHIP

The Healthy Minnesota Partnership brings community partners and the Minnesota Department of Health (MDH) together to improve the health and quality of life for individuals, families, and communities in Minnesota.

First convened in 2010 by the Commissioner of Health, the Partnership identifies and acts on strategic opportunities to improve health and well-being for all people in Minnesota. 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, advocacy, and community organizations (see membership in the Appendix).

In 2015, the Healthy Minnesota Partnership continued to implement the *Healthy Minnesota 2020 Framework* (page 4) with activities including:

- Development of performance measures to monitor progress on Partnership activities.
- Identification of two strategic opportunities to increase the opportunity of people in Minnesota to be healthy: paid leave and health, and multi-modal transportation and health.
- Development of narrative frames and messaging on both paid leave and transportation related to health as a means to advance a health in all policies approach to these strategic opportunities. Formation of “mini-partnerships” among the Partnership members and others to take action on the strategic opportunities.
- An annual review of the key conditions for health and chronic disease and injury indicators.

GUIDING PRINCIPLES OF THE HEALTHY MINNESOTA PARTNERSHIP

- 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.

HEALTHY MINNESOTA PARTNERSHIP VISION & 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.

HEALTHY MINNESOTA 2020: STATEWIDE HEALTH IMPROVEMENT FRAMEWORK

The Healthy Minnesota 2020 framework, published in December 2012, includes three key themes that guide the Healthy Minnesota Partnership's discussions and actions:

- **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**

The emphasis of *Healthy Minnesota 2020* that these themes reveal is on creating the conditions that allow people to be healthy: conditions that assure a healthy start, which set the stage for healthy choices, and which create the environments that will 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.

The themes of *Healthy Minnesota 2020* 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 efforts can fit within these themes, from transportation policy to access to health care to health behavior education. The framework creates opportunities for conversations about health involving all sectors of Minnesota. The themes have proved to be 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 of *Healthy Minnesota* have been used to shape intra-agency as well as inter-agency discussions of policy needs and possibilities for community action.



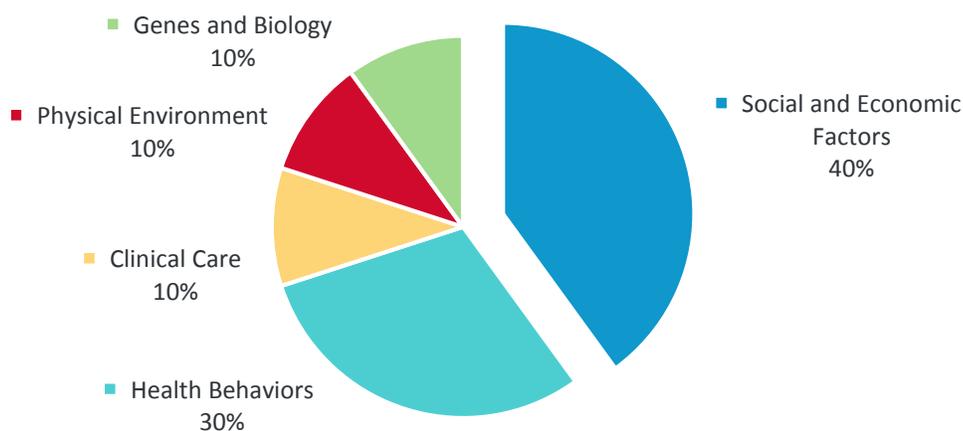
2015 PROGRESS ON HEALTHY MINNESOTA 2020

STRATEGIC APPROACH: EXPANDING THE CONVERSATION ABOUT WHAT CREATES HEALTH

As awareness of health disparities has grown, so also has the concern that progress is not being made. In Minnesota—a state with significant race-based health disparities—not only have the gaps in health status outcomes not lessened over the last ten years: they have grown larger. The strategic approach of the Partnership is focused on improving the conditions that are required for people to have the opportunity for health, which means examining the policies that shape those conditions. This approach requires expanding the nature of the public, policy conversation about health to consider the factors that create health.

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 figure below.)

DETERMINANTS OF HEALTH



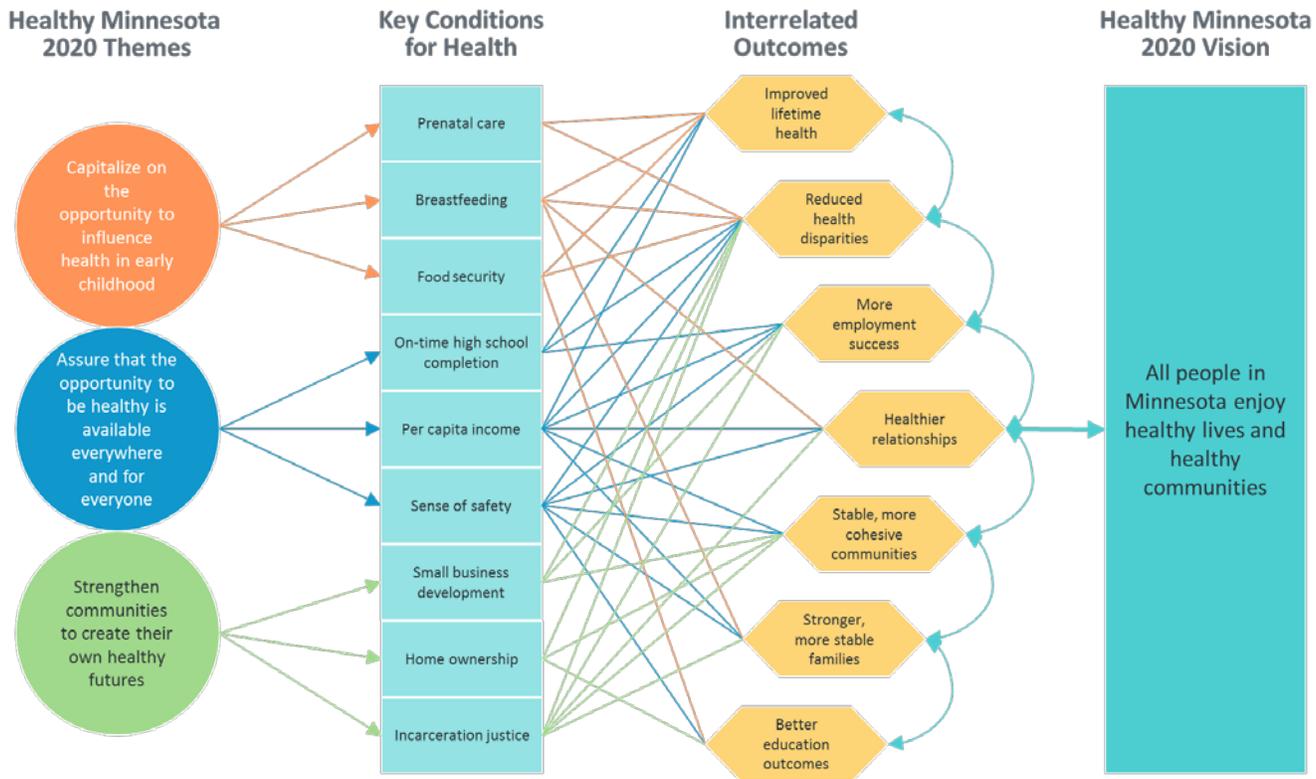
One of the key findings from these studies is that clinical care, which includes doctors' visits, hospital care, medication, and other medical treatment (and which is what many people think of when they talk about "health") contributes much less to health outcomes than do social and economic factors. 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."

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. The diagram on page 5 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.

The Partnership recognizes that these factors, including the "key conditions for health" identified in the framework, 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 discussions, 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 expanding of the nature of public discussions about health to consider what *creates* health.

HEALTHY MINNESOTA 2020: STATEWIDE HEALTH IMPROVEMENT FRAMEWORK



To implement this approach, in 2015 the Partnership focused on:

- Continuing to develop the capacity of partner organizations to use the narrative approach to policy change. The Partnership selected two strategic opportunities—paid leave and multi-modal transportation—as focus areas for 2015.
- Developing and promoting alternative narratives on paid leave and health and transportation and health to support a wide range of policy solutions.
- Encouraging the development of messages about creating opportunities for health.
- Engaging a wide range of people and populations in conversations about policy and health.

PARTNERSHIP PROGRESS

In 2015, the Healthy Minnesota Partners engaged in a wide range of activities to implement and support the Healthy Minnesota framework and strategic approach.

NARRATIVE WORK AND HEALTH IN ALL POLICIES

- Members have used the Healthy Minnesota narrative frames to influence policy discussions in their organizations, such as the discussion of a paid leave policy for the City of Minneapolis.

- Professionals at the Minnesota Department of Transportation (MnDOT) understand the connection between health and transportation and have responded positively to the Partnership’s narrative development, looking to see how they might apply in their own work the Healthy Minnesota Partnership narrative frames and messaging around transportation and health. The Commissioner of MnDOT also is talking about “health in all policies” and will share this with all staff. The MnDOT vision for the transportation system is to “maximize the health of people, the environment and our economy.”
- Partners have used multiple opportunities to connect the Partnership’s narrative and health in all policies work to other issues, including the League of Women Voters Healthy Legacy Forum; Minneapolis Mayor Betsy Hodges’ Cradle to K Cabinet; community meetings focused on what creates health (e.g., the City of Woodbury in Washington County): the Minnesota Public Health Association (MPHA)-sponsored Day on the Hill event with the American Heart Association and Healthy Kids Coalition; and a series sponsored by MPHA focused on Zip Code Matters, which explores the intersection between geography and public health. The theme of the annual Public Health Week sponsored by MPHA in 2015 was Place.
- Staff from MDH worked with the Environmental Health Division to engage a consultant and begin the process to develop narratives, consistent with the Healthy Minnesota 2020 framework, around clean drinking water. Much of the work that currently is being done related to the Clean Water Legacy Act is focused on surface water (recreational use), but ground water is critical for drinking water. Developing alternative narratives for this work will help change the nature of discussions on clean water and health.
- A Partner is working with the University Provost of Student Affairs to bring the narrative into what students are doing, and may bring students to future Partnership meetings from time to time. In addition, the Boynton Health Service at the University of Minnesota has put the Adverse Childhood Experiences (ACEs) module into the college student survey, which will be an important source of data on the factors that create health.
- Several Partners attended a gathering of public health and community organizers from seven states (Minnesota, Wisconsin, Florida, Louisiana, Michigan, Missouri, and Ohio), the National Association of City and County Health Officials (NACCHO) and the Centers for Disease Prevention and Control (CDC) in November 2015 to discuss the relationships among community conditions and health, with focused attention on mass incarceration. Commissioner Tom Roy from the Minnesota Department of Corrections (DOC) and Commissioner Ed Ehlinger from MDH had a discussion with the group about mass incarceration and participated on a panel discussion about what can be done at a policy level to reduce incarceration inequities. The day after this gathering (November 18) the Minnesota Sentencing Guidelines Commission met and approved changes to the controlled substances (drug) sentencing guidelines.
- A Partnership member met with Minnesota Governor Mark Dayton about physical activities in winter, to work together to engage with populations across Minnesota and highlight the opportunities and benefits of remaining active in winter. The Commissioner of the Department of Natural Resources (DNR) contacted MDH with their plan to make all state parks free of charge on the day after Thanksgiving, as a way of supporting health in all policies.

PAID LEAVE AND HEALTH

- MDH developed a white paper on paid leave and health upon the request of the MN Legislature, which received good media attention.
- Partnership member ISAIAH, a faith-based organization, held a press conference on paid leave and health that included parents, children, senior adults and clergy alongside the sponsors of the bill in the legislature. They also trained leaders around the state, utilizing the Healthy Minnesota paid leave narrative frames to guide their stories and to ground the work of their members in the experience of the families from various ministries they provide. Legislators met with concerned constituents to hear the stories and how paid sick and safe time can reduce homelessness.
- MPHA adopted policy resolutions on earned sick and safe time, and paid family leave.
- UCARE Minnesota started a paid parental leave benefit in January—the first of Minnesota’s leading health plans to offer this benefit. Their press release said: “We fully support new parents taking time to bond with their growing families and doing their best to give their children a healthy start. This new benefit builds on our family-friendly

offerings, which include...flexible work scheduling, and competitive paid time off. We believe this generous parent leave benefit will help us attract and retain talented employees as we build our workforce for the future.”

- The University of Minnesota, State Health Access Data Assistance Center, will be adjusting its questionnaire to include a paid family leave question as a part of its assessment. This will help to create more Minnesota-specific statistics that will be able to help influence future policy decisions around paid family leave.
- The Minneapolis Public Health Department held conversations with Minneapolis city council people as they considered paid time off for Minneapolis city workers. The city council unanimously approved 120 hours of paid parental leave in the beginning of May for the birth or adoption of a child. The new policy begins in July, 2015. The policy is expected to reduce the costs of rehiring and retraining replacement workers.
- A paid parental leave policy was also adopted by Hennepin County with a stated purpose “to give parents additional flexibility and time to bond with their new child, adjust to their new family situation, and balance their professional obligations.” Brooklyn Park and St. Louis Part also have adopted paid leave for their employees.
- A coalition in the Twin Cities planned to bring legislation to local representatives, which would include paid leave for individuals caring for children or elderly family members.

TRANSPORTATION AND HEALTH

- Social connectivity and the relationship to health is beginning to be a key discussion point amongst community activists and advocates.
- A transportation project (Snelling Avenue) currently underway is addressing the needs of pedestrians and not just vehicles; the MnDOT Statewide Transportation Plan will be reviewed and updated to include more of the Healthy Minnesota framework.
- Some state legislators supported funding for the Safe Routes to School program and for promoting an agenda around transportation that goes beyond roads and bridges to pedestrian safety and the healthy benefits of active transportation.
- Staff to the Partnership utilized the Healthy Minnesota Partnership to reflect on the statewide Pedestrian Plan planning process.
- While the Minnesota State Legislature failed to create a comprehensive, long-term transportation funding solution in 2015, two coalitions – Progress in Motion and Transportation Forward – will be focusing on a comprehensive transportation solution for future legislative consideration.

STRATEGY TEAM PROGRESS

In 2015 the Partnership also continued its two strategy teams to implement the Healthy Minnesota 2020 strategic approach: the Narrative Strategy Team and the Policy Strategy Team. Each team met several times over the course of the year to fulfill their charges.

NARRATIVE STRATEGY TEAM PROGRESS

The Narrative Strategy Team was created to identify and promote public narratives that emphasize health-generating factors and the opportunity to be healthy. The narrative approach is designed to move public thinking about health toward a greater understanding of the importance of assuring that conditions in the community support the opportunity for everyone to be healthy. In 2015, the Narrative Strategy Team developed narrative frames to help generate new conversations and effective messaging for the issues of paid leave and health and transportation and health, in support of the Partnership’s decision to focus on these strategic policy opportunities at the state legislature.

The emerging narrative frames developed by the Narrative Strategy Team on paid leave focus on the role of paid leave in creating economic security and family/financial stability and health. The narrative frames on transportation connect transportation to participation all aspects of the social and economic life of the community and health. The narrative frames are found in Appendix B.

Performance Measure: By 2015, one or more new ways of talking about the factors that create health for people in Minnesota (“meta narratives”) are developed, representing various perspectives.

Result: This performance measure was met. The Narrative Strategy team developed multiple narrative frames for the issues of paid leave and transportation and health (see Appendix B).

SUMMARY OF ACTIVITIES

The Narrative Strategy Team held one joint meeting with the Policy Strategy Team in January, 2015. Participants developed frames and messages in anticipation of legislative policy discussions around paid leave and transportation. The results of this discussion are in Appendix B.

In June 2015 the narrative approach of the Partnership and emerging frames were shared with an interagency team concerned with clean drinking water. Participants discussed ways to continue and expand this kind of work in the area of environmental health. The Narrative Team will continue to discuss ways to support the expansion of the narrative work into other areas of health.

POLICY STRATEGY TEAM PROGRESS

The Policy Strategy Team, created to promote and advocate for the incorporation of health considerations in the development of private and public policy, focused on identifying strategic opportunities for the Healthy Minnesota Partnership in 2016. Two opportunities were identified: incarceration and health, and debt and health.

Performance Measure: By 2015, 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).

Result: This performance measure was met. The Policy Strategy Team identified several strategic opportunities for 2015; the Partnership selected and developed narratives for paid leave and transportation.

SUMMARY OF ACTIVITIES

The team met three times in 2015. The first meeting was a joint meeting in January with the Narrative Strategy Team to develop narrative frames and messaging to explain and promote the connection between paid leave and health and transportation and health (see summary under the Narrative Strategy Team, above.)

The team held an in-person meeting in August 2015 to develop a range of potential strategic opportunities and partnerships for the Partnership to consider for the 2016 Minnesota legislation session.

- A list of potential strategic opportunities was generated through input from Partnership members, a survey of the Healthy Minnesota 2020 listserv (approximately 1,600 people), and a scan of other active policy initiatives related to the nine key conditions of the Healthy Minnesota 2020 framework.
- Each potential strategic opportunity was evaluated using the following criteria:
 - Must have momentum for action with an active campaign.
 - Must advance health equity for one of the nine key conditions for health.
 - HMP members are actively involved.
 - Communities experiencing disparities lead the campaign or actively involved in leadership decisions.

The potential strategic opportunities considered by the Policy Team for 2016 included:

- Restore the Vote, an initiative related to criminal justice and civic engagement
- Safe Roads Minnesota, an initiative to provide driver’s licenses for immigrants
- Minnesota Healthy Food Financing Initiative 2017
- Increasing the Minnesota Family Investment Program (MFIP) grant, which provides financial support for low income families
- Toxic Free Kids, a program in which MDH identifies and communicates the potential for hazardous chemical exposures

- Minnesota’s efforts on My Brother’s Keeper, a national challenge to fully include boys and young men of color in opportunities for success
- Housing/home ownership
- Follow-up to the 2015 transportation initiative

At the meeting, several additional opportunities were suggested: juvenile justice, predatory lending, MDH innovation grants, community engagement, and a requirement for every state agency to have a cultural and ethnic community council (modeled after the Department of Human Services). Clean drinking water was also noted as an area where health professionals are interested in developing a narrative to support efforts around the Clean Water Legacy Act.

As part of the team’s discussion, members decided to recommend to the Partnership that the definition of “strategic opportunity” be expanded from active policy initiatives to include “strategic conversations” that do not necessarily relate to a specific policy proposal. Until now, the Policy Team has only considered issues that would be in front of the state legislature, but other issues are stimulating robust statewide conversations that might provide additional opportunities to expand the conversation around health.

The team met via conference call in September to narrow the field of possibilities, and decided to present to the Partnership the issues of driver’s licenses for immigrants, predatory lending/excessive debt, community engagement, and criminal justice reform/mass incarceration.

At the October Partnership meeting, members supported the expansion of the concept of “strategic opportunity” to include “strategic conversations,” noting that many things happen at a local level before going statewide (e.g., indoor smoking ordinances), that some issues might be in development and will appear in a future legislative session, and that a series of events or conversations can elevate an issue to the policy level.

The Partnership selected the issues of incarceration/criminal justice reform and excessive debt as their strategic opportunities for 2016.

PROGRESS ON CORE INDICATORS/KEY CONDITIONS

Over the course of 2015 the Partnership continued to monitor the key conditions for health that are part of the overall Healthy Minnesota 2020 framework. As the Narrative and Policy Strategy Teams developed their efforts to implement the strategic approach of the Partnership, it became apparent that the key conditions for health are particularly useful for providing guidance both for shaping the narrative and for selecting strategic opportunities for expanding the conversation about what creates health (see the 2016 strategic opportunities, below).

Updated data on the key conditions for health are available in Appendix D.

LOOKING AHEAD: 2016

2016 STRATEGIC OPPORTUNITIES

In October 2015, the Partnership chose two strategic opportunities for the 2016 Minnesota legislative session:

INCARCERATION AND HEALTH

Minnesota has a high rate of racial disparities in the criminal justice system: for every nine African American males in Minnesota, one white male is incarcerated (ratio of 9:1). A Sentencing Project report shows that Minnesota's level of African-American disenfranchisement was between five and ten percent in 2010. Minnesota's rate of African-American disenfranchisement was worse than 26 states, including West Virginia, South Carolina, and Utah. This report also shows that thirteen other states had similar rates of African-American disenfranchisement, putting Minnesota in the company of states such as Texas, Georgia, and Louisiana. Other populations in Minnesota experiencing inequities in rates of incarceration include American Indians and Hispanics/Latinos.

The effects of high rates of incarceration in the particular communities have serious consequences for both the offender and the community. A prison term is a significant obstacle to gaining employment, restricts access to various public benefits, and leads to reduced lifetime earnings, all of which have significant impacts on health and well-being. Families of offenders experience the shame and stigma of incarceration, loss of financial and emotional support, and social and economic instability, again with serious health consequences, including increased stress and stress-related illness among adults, and the negative health effects of an adverse event for children. High numbers of incarcerated members in some communities diminishes overall civic participation and lessens community representation in decision-making processes. The challenges presented by reentry into society at large results in high rates of recidivism and raises costs for everyone by creating a burgeoning prison system.

EXCESSIVE DEBT AND HEALTH

High debt and its related stress can come from multiple sources, including predatory lending practices, accumulation of student loan debt, high home costs and mortgage lending practices, and major life crises that precipitate job loss. Among the people reporting high debt stress in a recent Associated Press poll:

- 27 percent had ulcers or digestive tract problems, compared with 8 percent of those with low levels of debt stress.
- 44 percent had migraines or other headaches, compared with 15 percent.
- 29 percent suffered severe anxiety, compared with 4 percent.
- 23 percent had severe depression, compared with 4 percent.
- 6 percent reported heart attacks, double the rate for those with low debt stress.
- More than half, 51 percent, had muscle tension, including pain in the lower back. That compared with 31 percent of those with low levels of debt stress.

People who reported high debt stress also were much more likely to have trouble concentrating and sleeping and were more prone to getting upset for no good reason.

Predatory lending is any type of lending practice that is deceptive and convinces borrowers to agree to unfair and abusive loan terms, or systematically violates those terms in ways that make it difficult for the borrower to understand. Any type of loan can be predatory including pay day loans, auto loans, home mortgages, student loans, and tax refund loans.

NEXT STEPS

The 2016 Minnesota legislative session creates a natural context for discussing and debating policy issues, providing a venue for applying the Healthy Minnesota approach and creating many opportunities to talk about health from the perspective of the conditions that create health in the community, and counteracting the dominant narratives of individual behavior and health care. The **Policy Strategy Team** identified two potential criminal justice-related policy changes for 2016: reinstating voting rights for people on probation or parole, and sentencing reform and halting prison expansion.

- **Reinstating voting rights:** Under current law, Minnesota denies the right to vote to over 45,000 citizens who have a past criminal conviction and remain on probation or parole. This policy would restore their right to vote once they are living in the community. People living, working and paying taxes in our communities should be able to vote for their elected representatives.

How does this relate to the key conditions for health? Once people have their right to vote restored and are able to be full participants in civic processes they feel a stronger connection to their community and to the future and are less likely to reoffend, which in turns increases community safety, family stability and children’s well-being.

- **Sentencing reform/halting prison expansion:** Sentencing guidelines determine the size of the prison population by establishing the forms of punishment for different levels of offenses, essentially deciding who goes to prison and who does not. An example is harsh sentencing for first-time and low-level drug offenders. Under current sentencing guidelines, Minnesota’s prison population is growing and currently exceeds capacity by 562 people. The Department of Corrections (DOC) is managing the overflow by leasing beds at county jails, double bunking, and adding housing at Faribault. The DOC will be requesting bonding funds to add 500 beds to the Rush City prison facility; interest also is growing in the possibility of reopening a privately operated, for-profit prison in Minnesota.

How does this relate to the key conditions for health? Expansion of prison capacity, especially for-profit prison beds, reduces the impetus to examine racially-based incarceration inequities and increases the possibility that a profit motive will influence sentencing guidelines and increase incarceration inequities, with subsequent consequences for communities and health.

The Policy Strategy Team also identified community activity around high debt. The **Fair Lending Coalition** is a broad coalition lead by Wilder Foundation and the Joint Religious Legislative Coalition (which includes Partnership members ISIAAH and TakeAction). Different versions of bills initiated by these coalitions passed both the House and Senate but did not get to a conference committee in 2014. No further action is planned by advocacy groups in 2015, as they intend to wait until the 2016 elections have concluded.

The **Narrative Strategy Team** will meet early in 2016 to develop frames and initial messages for both of the strategic opportunities noted above.

2017 STATEWIDE HEALTH ASSESSMENT

The next iteration of Minnesota’s statewide health assessment (SHA) is due by 2017. The SHA is guided by the Healthy Minnesota Partnership. In December, the Partnership reviewed the 2012 Statewide Health Assessment and made suggestions for shaping the 2017 assessment.

The 2012 SHA was foundational for organizing the efforts of the Partnership to change the narrative and expand the understanding of what creates health. The Partnership was reminded that the structure of the 2012 SHA resulted because of the narrative work of the Partnership, focusing on “what creates health” and getting different groups people together for an expanded conversation and subsequent action on health.

- The 2012 SHA was used to support work on criminal justice reform, including support for a funding request from the Robert Wood Johnson Foundation for the “Ban the Box” campaign.
- The SHA and the Healthy Minnesota 2020 narrative work supported the development of the Income and Health report and the Paid Leave and Health report from MDH.
- The 2012 SHA laid the foundation for MDH Commissioner Ed Ehlinger’s “Triple Aim of Health Equity,” a model presented to the Association of State and Territorial Health Officials (ASTHO). The Triple Aim of Health Equity reflects the organization of narrative, people, and resources: 1) expand the understanding of what creates health; 2) strengthen communities to create their own healthy future; and 3) implement a health in all policies approach with health equity as the goal.

For the 2017 Statewide Health Assessment, MDH wants to have an even more robust community engagement process, beginning early in 2016. Members were asked to provide suggestions based on the following questions:

- What is different since the 2012 Statewide Health Assessment?
- What do we need to know? Are there new data sources?

- What could the 2016 assessment accomplish? How do we address structural racism?
- What is the opportunity that the 2016 SHA can create/reinforce?

The feedback collected included the following:

- Look for non-traditional sources of data, which can be rich although not typical.
- Be sure to include populations and issues that were minimally represented in the 2012 SHA, such as people with disabilities, LGBTQ, relational and sexual health, people who are homeless, mental health, immigrants/refugees/migrants, etc.
- Keep the focus on the causes of health (what creates health).
- Explore “policy pathways,” link health outcomes to policies.
- Move beyond the “exploring” mode to change the indicators, make a difference, concrete paths to action, sense of direction.

Regarding “who needs to be involved,” the Partnership suggested including, in addition to the Partnership organizations, other state agencies, younger people, educators and students, faith communities, rural Minnesota community health workers, corporations, veterans, law enforcement, community groups, local public health, communities of color and American Indians, the disability community, software developers, housing advocates, and employers.

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 October 2014, the following were represented in the Healthy Minnesota Partnership.

2015 PARTNERSHIP MEMBERS

Karen Ahmann
State Community Health Services Advisory Committee

Yende Anderson
Council on Black Minnesotans

Jeanne Ayers
Minnesota Department of Health

Alfred Babington-Johnson
StairStep Foundation

Ken Bence
Minnesota Public Health Association

Kari Benson
Minnesota Board on Aging

Greg Brolsma
Association of Minnesota Energy Managers

Janny Dwyer Brust
Minnesota Council of Health Plans

Rachel Callanan
American Heart Association

Rhonda Degelau
Minnesota Association of Community Health Centers

Liz Doyle
TakeAction Minnesota

Ed Ehlinger
Minnesota Department of Health

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

Hector Garcia
Chicano Latino Affairs Council

Tim Henkel
Minnesota Department of Transportation

Neal Holtan
Medical Consultant

Warren Larson
Sanford Health

Vayong Moua
Blue Cross Blue Shield Center for Prevention

Gretchen Musicant
Local Public Health Association (Metro)

Lars Negstad
ISAIAH

Kami Norland
National Rural Health Resource Center

Martha Overby
Minnesota Chapter, March of Dimes

Joan Pennington
Minnesota Hospital Association

John Salisbury
LGBTQ Health Advocacy Roundtable

Ferd Schlapper
Boynton Health Services, University of Minnesota

Barb Sporlein
Minnesota Housing Finance Agency

Thomas Fisher
College of Design, University of Minnesota

Maria Veronica Svetaz
Hennepin County Medical Center

Sue Yost
Local Public Health Association, (Greater MN)

Donna Zimmerman
Itasca Project

2015 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

Mary Hertel
Minnesota Board on Aging

Stacey Housman
Blue Cross Blue Shield Center for Prevention

Kristin Loncorich
Minnesota Hospital Association

Alexa Howart
ISAIAH

Susan Palchick
Local Public Health Association (Metro)

STAFF TO THE PARTNERSHIP IN 2015

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

2015 NARRATIVES STRATEGY TEAM MEMBERS

PARTNERSHIP MEMBERS/ALTERNATES

Jeanne Ayers
Minnesota Department of Health

Carol Berg
Minnesota Council of Health Plans

Stacey Housman
Blue Cross Blue Shield Center for Prevention

Gretchen Musicant
Local Public Health Association (Metro)

Kami Norland
National Rural Health Resource Center

ADDITIONAL MEMBERS

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
Center for Applied Research and Educational
Improvement, University of Minnesota

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

Scott Smith
Minnesota Department of Health

CONSULTANT FOR THE NARRATIVE STRATEGY TEAM MEMBERS

Dave Mann
Grassroots Policy Project

2015 POLICY STRATEGY TEAM MEMBERS

PARTNERSHIP MEMBERS/ALTERNATES

Yende Anderson
Council on Black Minnesotans

Jeanne Ayers
Minnesota Department of Health

Alfred Babington-Johnson
StairStep Foundation

Janny Dwyer Brust
Minnesota Council of Health Plans

Rachel Callanan
American Heart Association

Liz Doyle
TakeAction Minnesota

Alexa Howart
ISAIAH

Warren Larson
Sanford Health

Deb Loy

Vayong Moua
Blue Cross Blue Shield Center for Prevention

Lars Negstad
ISAIAH

Ferd Schlapper
Boynton Health Services, University of Minnesota

Donna Zimmerman
Itasca Project

ADDITIONAL MEMBERS

Deb Burns
Minnesota Department of Health

Patty Bowler
Minneapolis Public Health

Tannie Eshenaur
Minnesota Department of Health

Ray Lewis
Minnesota Public Health Association

Vanne Owens Hayes
African American Leadership Forum

Kris Rhodes
American Indian Cancer Foundation

APPENDIX B: 2015 EMERGING NARRATIVE FRAMES

Narrative frames are important tools for engaging in current policy debates in a way that expands the conversation to focus on health equity and the factors that create health. The purpose of developing narrative frames for the Healthy Minnesota Partnership strategic opportunities is less about developing specific policy arguments and more about shifting the conversation, in the context of specific policy discussions, to what creates health and advances health equity.

Creating Health through Job Stability and Financial Security (Paid Leave): Emerging Narrative Frames

1. To be healthy, everyone needs the security of a steady income to provide for their daily and future needs.
2. When everyone in a community has stable employment and financial security, everyone's health benefits from the increased sense of permanence, safety, and interconnectedness in the community.
 - a. Job stability allows individuals and families to plan and care for their own and each other's health.
 - b. Financial security assures that no one has to choose between regular income and their own or a family member's health.
 - c. Stress is a significant negative influence on health. Stable employment and financial security reduce stress and improve the health of individuals and communities by assuring that people have flexibility to care for one another without jeopardizing their livelihoods.
 - d. Creating the conditions that assure health through job stability and financial security is the responsibility of all parts of the community.
3. Structural racism has created inequities in employment opportunities, employment stability, and financial security for American Indians and people of African, Hispanic, Asian, Pacific Islander, and Middle Eastern descent.
 - a. People of color and American Indians are more likely to be in low-paying, less secure jobs with few benefits, such as access to paid sick leave or paid family leave, than white persons.
 - b. Policies that promote job stability and financial security can improve health outcomes in communities that have concentrations of lower wage workers.
 - c. Policies that promote job stability and financial security also promote health equity by improving conditions the most for the most economically disadvantaged, including American Indians, people of African, Hispanic, Asian, Pacific Islander, and Middle Eastern descent.
4. Policies that promote job stability and financial security give families and communities more flexibility to care for one another and support cultural values of giving loving care throughout life, from beginning to end.
 - a. Every person deserves loving care. Families should be able to care for their loved ones when they are needed.
 - b. Every child deserves the healthy start provided through the loving care of their family in the first weeks of life. Early bonding, breastfeeding, and maternal well-being have positive and lasting effects on the health of children.
 - c. Women should be able to care for their children and families without jeopardizing their financial futures. Many women experience instability in employment and insecure financial positions because they typically bear the greatest burden of family caregiving and are more likely to put their careers on hold to care for family members.
5. Employment stability and financial security increase the ability of individuals and families to manage the challenges of life. Communities are healthier when everyone has a range of options available to meet the needs of themselves and their families.
 - a. Communities are healthier when people can care for one another.

- b. Policies such as paid family leave increase the ability of family members to care for one another without the worry of job loss; reduce the isolation of caregivers and recipients (such as the elderly); and increase the potential for mutual support among caregivers.
6. Every sector shares the responsibility for the health of the community by taking steps to assure that people do not have to make impossible choices between their personal lives and their jobs.
 - a. Businesses benefit from the improved physical and mental health, lower absenteeism, and continuity of work associated with policies that support job stability and financial security, such as paid leave.
 - b. Providing paid family leave across the spectrum of occupations improves the economic strength of the whole community.
 - c. Informal, family-based care provides both enormous economic and social benefits to the entire community.
7. When individuals and families have job stability and the financial security provided by policies such as having paid sick leave or paid family leave, they are more likely to stay home from work when they or their children are sick, reducing the spread of infectious disease and protecting both businesses and people.

Creating Health through Equitable Transportation Systems: Emerging Narrative Frames

1. Health is closely connected to all the daily activities of life, and transportation is a key component of those activities.
 - a. Work that pays a livable wage is essential for health. Creating health in the community means providing opportunities to find and keep a good job by having reliable forms of transportation.
 - b. Creating health in the community means providing access to the necessities of life, including food, health care, and connections to our family, friends, and faith community. Reliable and affordable transportation keeps us connected to the things and people that keep us healthy.
 - c. Creating health in the community means providing safe environments. Transportation systems form a large part of the everyday health and safety of all people in Minnesota.
2. All people need, but many do not have, safe and affordable transportation options.
 - a. Populations with concentrations of lower incomes, including populations of color and American Indians, are more likely to depend on public transit and often live in areas of historical underinvestment and disinvestment (i.e., structural racism). These burdens increase exposure to pollution and noise from the transportation system, increase transportation costs and stress, and create unequal access to economic and educational opportunities, housing, healthy foods, and opportunities for physical activity.
 - b. Rural populations, especially communities located outside a five-mile radius of a city or town, have very limited transportation options.
3. Transportation has many impacts on safety, including the condition of sidewalks, bike paths/bike lanes, roads and bridges, concentrated emissions from vehicles, the safety of pedestrian crossings, adequate lighting and signage, adequate bus shelters, and traffic speeds and controls. Every population in Minnesota should have the opportunity to influence the distribution of the benefits and burdens of transportation decisions.
4. Equitable transportation systems support the health of communities by assuring that everyone can get to where they need to go, reducing inequities, improving education and job security, strengthening social connections, supporting mental health, providing access to recreation, and contributing to economic development.
5. The processes for developing transportation systems are important for health equity. The meaningful involvement of communities in transportation decisions can shape a transportation infrastructure that maximizes the health of Minnesota's communities. Issues to consider in addition to getting from one place to another include creating equitable opportunities for recreation, assuring safe routes to school, and the need to promote social connectedness in the community.

6. A number of Minnesota communities (e.g., North Minneapolis and the Rondo neighborhood of St. Paul) have experienced the negative consequences of transportation decisions. Involving the community in the development of transportation systems is essential to repair the harms and avoid repeating the mistakes of the past. Widespread community participation in decision-making processes is empowering, builds capacity for leadership, and is essential for creating health. In addition to drivers, people to involve in these decisions include seniors, non-drivers, persons with disabilities, communities of color, and families with children.
7. Previous transportation decisions need to be examined to assure that inequities are not perpetuated over time, so that all people in Minnesota have equitable access to safe and reliable transportation.

APPENDIX C: HEALTHY MINNESOTA: SUMMARY OF 2015 PERFORMANCE MEASURES

Summary presented to Partnership on October 19, 2015

1. Partners report that they understand the main concepts of Healthy Minnesota 2020 and could explain them to someone else:

1.	2015	2014
Identification and development of narratives	67%	56%
What creates health	72%	56%
Health in all policies	83%	74%

2. Partners report that participation in the Healthy Minnesota Partnership has contributed to their understanding of the Partnership concepts:

2.	2015	2014
Identification and development of narratives	95%	91%
What creates health	100%	91%
Health in all policies	79%	74%

3. Partners report that participation in the Healthy Minnesota Partnership has increased their capacity to implement the Partnership strategies:

3.	2015	2014
Develop messages consistent with the HM2020 narrative	94%	91%
Change conversations about what creates health	94%	87%
Assess opportunities to promote health in all policies	89%	97%

4. Partners are using the Healthy Minnesota 2020 strategies in their work:

4.	2015	2014
Developing messages	53%	48%
Expanding conversations	59%	48%
Assessing opportunities for HiAP	65%	52%
Lifting up health in policy development	53%	56%
Participating in cross-sector partnerships for HiAP	59%	--

5. Partners say that using the Healthy Minnesota approaches has enhanced their efforts:

5.	2015	2014
Yes	79%	74%

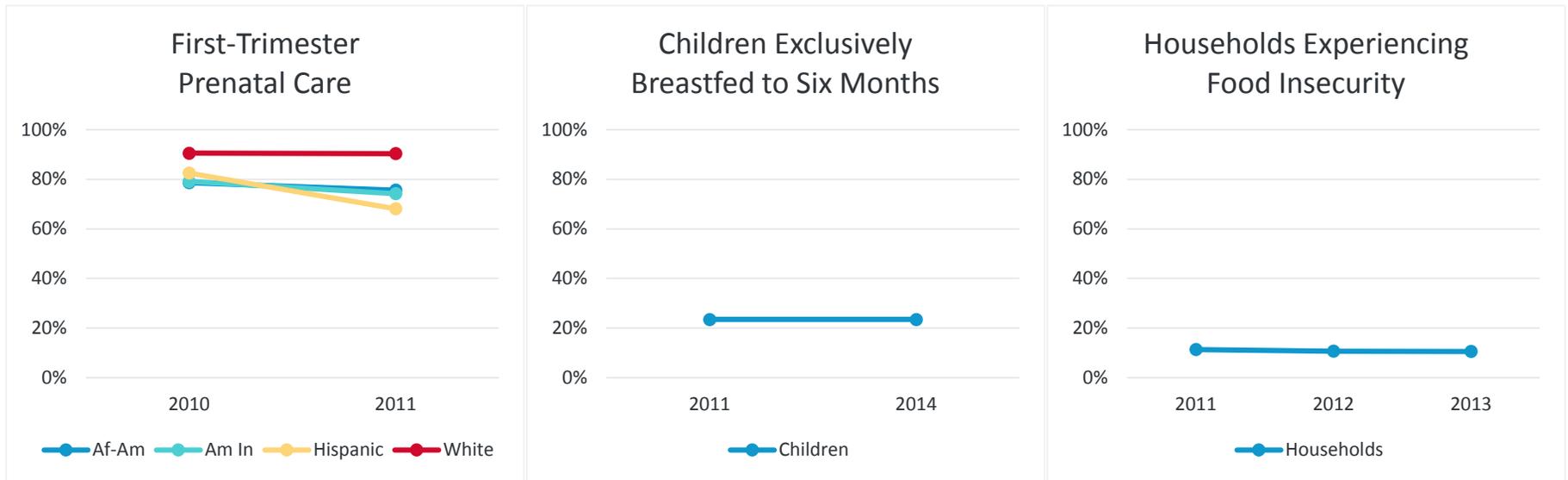
Examples:

- Making connections to learn more about the business role in supporting community health and to inform about opportunities to connect, e.g., with SHIP, national work such as the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement.
- Provided usability feedback on the HPHC.org website.
- Included these concepts in our new strategic plan.
- Got involved in interagency collaborations such as the Interagency Council on Homelessness, the Olmsted Plan, and the Olmsted Implementation Plan.
- Engaged in multidisciplinary partnerships, e.g., rental assistance for highly mobile families with school-age children, people with disabilities, and ex-offenders.
- City council is currently considering adopting policies related to paid sick leave; used Healthy Minnesota 2020 approach to inform elected officials and to support development of the policy.
- Participated in national leadership summit to help create a population health guide for critical access hospitals.

APPENDIX D: HEALTHY MINNESOTA 2020 KEY CONDITIONS INDICATOR UPDATES AS OF JUNE 2015

As of June 8, 2015

KEY CONDITION FOR HEALTH	SUBGROUP	PREVIOUS	MOST RECENT	CHANGE
By 2020, more mothers in every racial/ethnic population access first trimester prenatal care.¹ <i>*Sample size too small to report.</i>	African-American	78.6%	75.6%	Worse
	American Indian	79.1%	74.2%	Worse
	Asian	-- *	-- *	Not Available
	Hispanic	82.5%	68.1%	Worse
	White	90.5%	90.3%	No Change
By 2020, more Minnesota children are exclusively breastfed for six months.²	n/a	23.5%	23.5%	No Change
By 2020, fewer Minnesota households experience food security.³	n/a	10.4%	10.6%	No Change

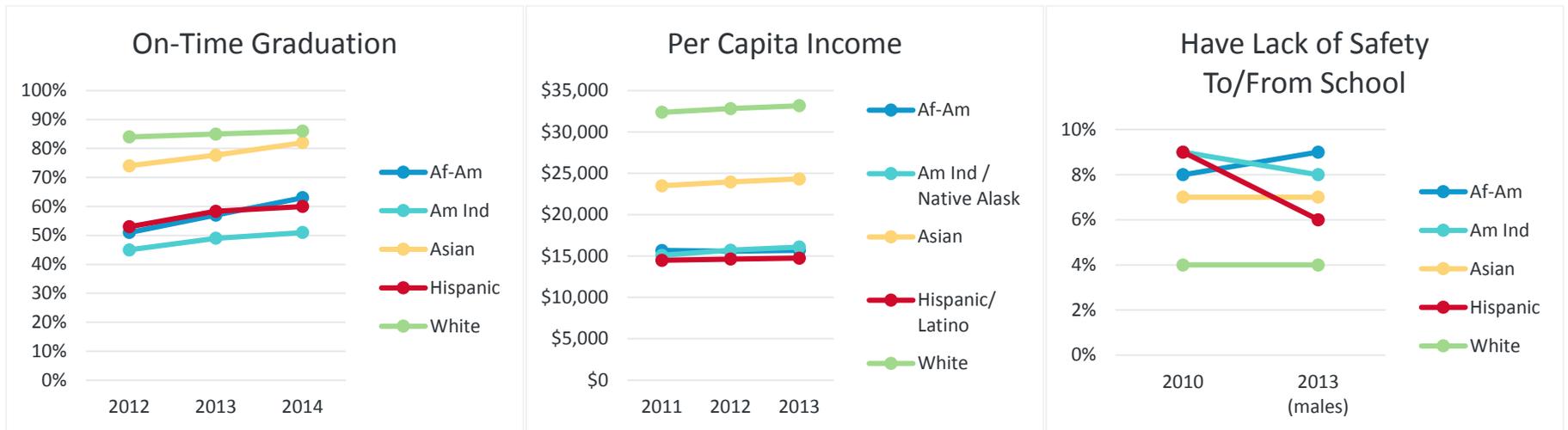


¹ Previous Data: Minnesota Pregnancy Risk Assessment Monitoring System, 2010. Most Recent Data: Minnesota Pregnancy Risk Assessment Monitoring System, 2011.

² Previous Data: CDC, 2011. Most Recent Data: 2014 Breastfeeding Report Card.

³ Previous Data: USDA, 2012. Most Recent Data: Household Food Security in the US, 2013.

KEY CONDITION FOR HEALTH	SUBGROUP	PREVIOUS	MOST RECENT	CHANGE
By 2020, more students from each population group graduate from high school within four years.⁴	African-American	57.0%	63.0%	Better
	American Indian	48.7%	51.0%	Better
	Asian	77.7%	82.0%	Better
	Hispanic	58.3%	60.0%	Better
	White	86.0%	86.0%	No Change
By 2020, Minnesota's racial and ethnic inequities in per capita income are reduced.⁵	African-American	\$15,577	\$15,688	
	Am. Indian/Native Alask.	\$15,713	\$16,096	
	Asian	\$23,958	\$24,311	
	Hispanic/Latino	\$14,646	\$14,762	
	White	\$32,819	\$33,174	
By 2020, fewer Minnesota students will have a lack of sense of safety going to and from school.⁶	African-American	8%	Male: 9% Female: 9%	No Change
	American Indian	9%	Male: 8% Female: 9%	No Change
	Asian	7%	Male: 7% Female: 7%	No Change
	Hispanic	9%	Male: 6% Female: 8%	Better (Male)
	White	4%	Male: 4% Female: 4%	No Change

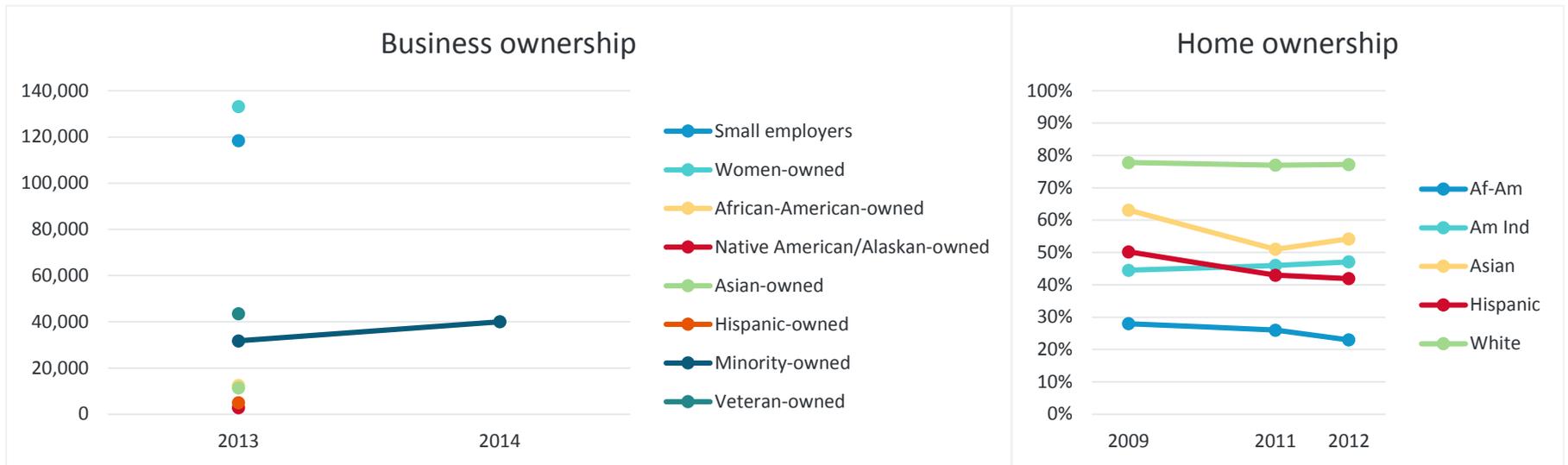


⁴ Previous Data: Minnesota Dept. of Education, 2013. Most Recent Data: Minnesota Dept. of Education, 2014.

⁵ Previous Data: US Census Bureau, 2008-2012 ACS five-year estimates; 2012 inflation-adjusted dollars. Most Recent Data: US Census Bureau, 2009-2013 ACS five-year estimates; 2013 inflation-adjusted dollars.

⁶ Previous Data: Minnesota Student Survey, 2010. Most Recent Data: Minnesota Student Survey, 2013.

KEY CONDITION FOR HEALTH	SUBGROUP	PREVIOUS	MOST RECENT	CHANGE
By 2020, more communities across Minnesota have more small business and more minority- and women-owned businesses.⁷	Small employers (<500 employees)	118,391	More recent results expected in summer/fall 2015	TBA
	Women-owned	133,141		
	African-American-owned	12,454		
	Asian-owned	11,407		
	Hispanic-owned	5,011		
	Native American/Alaskan-owned	2,891		
	Veteran-owned	43,548		
By 2020, populations that currently have low rates of home ownership are better able to afford and own homes.⁸	African-American	28.0%	23.0%	Worse
	American Indian	44.5%	47.1%	Better
	Asian	63.1%	54.2%	Worse
	Hispanic	50.2%	41.9%	Worse
	White	77.8%	77.2%	No change

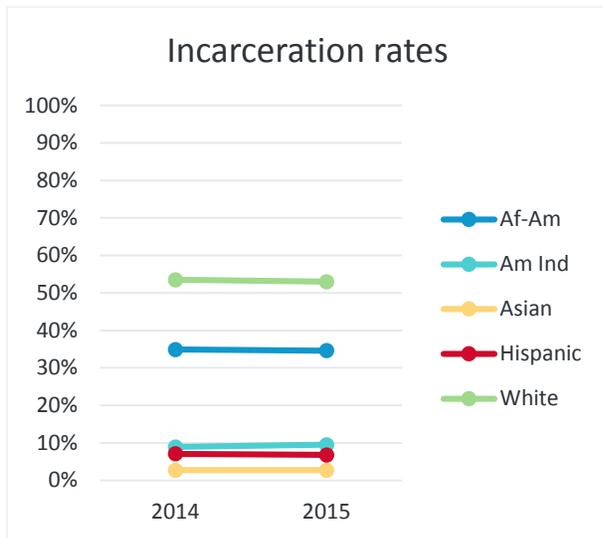


KEY CONDITION FOR HEALTH	SUBGROUP	PREVIOUS	MOST RECENT	CHANGE
	African American prison (state)	34.9% (5.7%)	34.6% (5.7%)	No change in inequity

⁷ Previous Data: [Data](#)

⁸ Previous Data: 2007-2009 3-year estimates, American Community Survey (accessed from MNCompass). Most Recent Data: 2010-2012 3-year estimates, American Community Survey (accessed from MNCompass).

KEY CONDITION FOR HEALTH	SUBGROUP	PREVIOUS	MOST RECENT	CHANGE
By 2020, racial/ethnic inequities in incarceration rates in Minnesota are diminished.⁹	American Indian prison (state)	8.9% (1.3%)	9.5% (1.3%)	No change in inequity
	Asian prison (state)	2.7% (4.5%)	2.7% (4.5%)	No change in inequity
	Hispanic prison (state)	7.1% (5.0%)	6.8% (5.0%)	No change in inequity
	White prison (state)	53.5% (81.9%)	53.0% (81.9%)	No change in inequity



⁹ Previous Data: Minnesota Dept. of Corrections Adult Inmate Profile (prison); US Census Bureau State & County QuickFacts (state). Most Recent Data: Minnesota Dept. of Corrections Adult Inmate Profile (prison); US Census Bureau State & County QuickFacts (state).