

Healthy Minnesota 2020 Update

2016 ANNUAL REPORT OF THE HEALTHY MINNESOTA PARTNERSHIP



Healthy Minnesota 2020 Update

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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 Appendix A).

In 2016, the Healthy Minnesota Partnership continued to implement the *Healthy Minnesota 2020 Framework* (page 8) 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: incarceration and health, and burdensome debt and health.
- Development of narrative frames and messaging on both incarceration and debt related to health as a means to advance a health in all policies approach to these strategic opportunities.
- Ongoing discussion of the role of structural racism in health inequities. ¹
- An annual review of the key conditions for health and chronic disease and injury indicators.

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 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.

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.

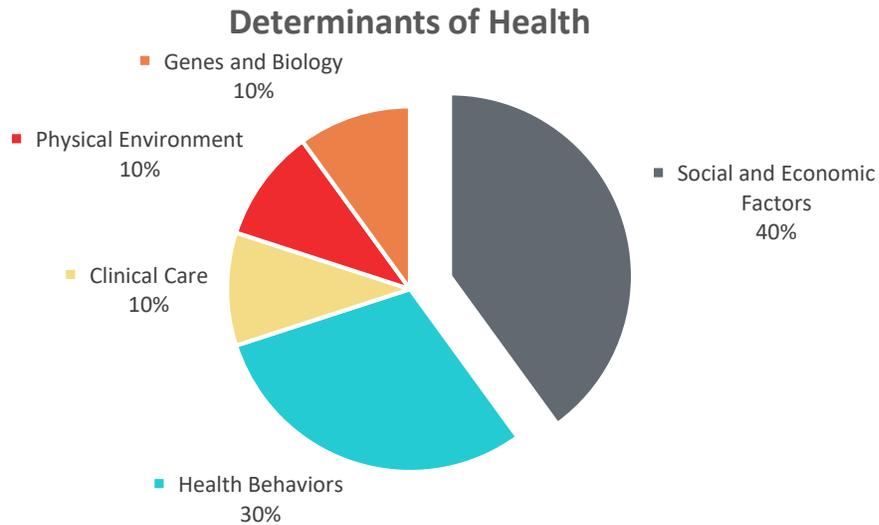
The themes of *Healthy Minnesota 2020* incorporate a sense of time and urgency (early childhood), shared responsibility (opportunity for everyone, everywhere), and the importance of self-determination (communities creating health). A wide range of efforts can fit within these themes, from transportation 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.

2016 Progress on Healthy Minnesota 2020

Strategic Approach: Expanding the Conversation about What Creates Health

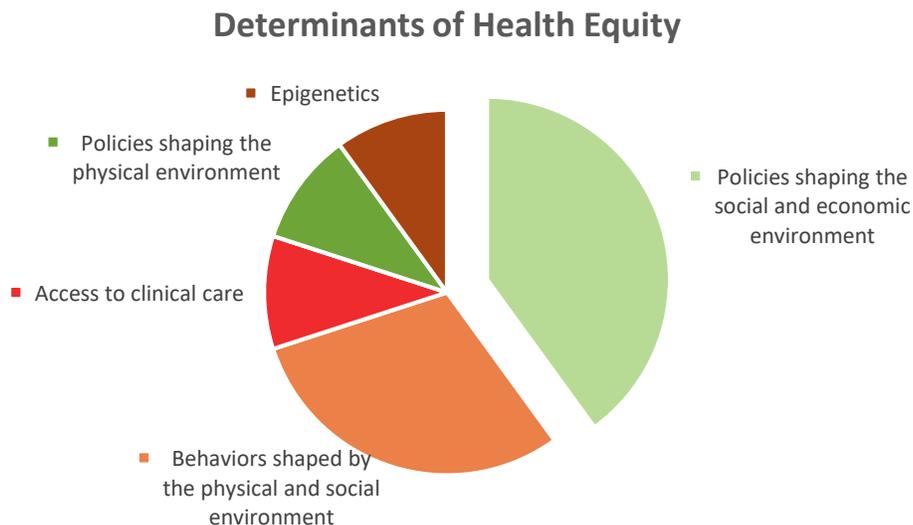
As awareness of health disparities has grown, so also has the concern that progress is not being made. In Minnesota—a state with significant race-based health disparities—the gaps in health status outcomes not lessened over the last ten years: they have grown larger. The strategic approach of the Partnership focuses on improving the conditions that are required for people to have the opportunity for health. This approach requires expanding the nature of public and private sector policy conversations about health to include consideration of the factors that create health. It recognizes that people shaped past policies that led to the current conditions and can shape policies to improve future conditions and health outcomes.

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 below²).



A key finding 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. 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.”

The important role of policy in shaping the conditions for health is reflected in the revised pie chart, below:

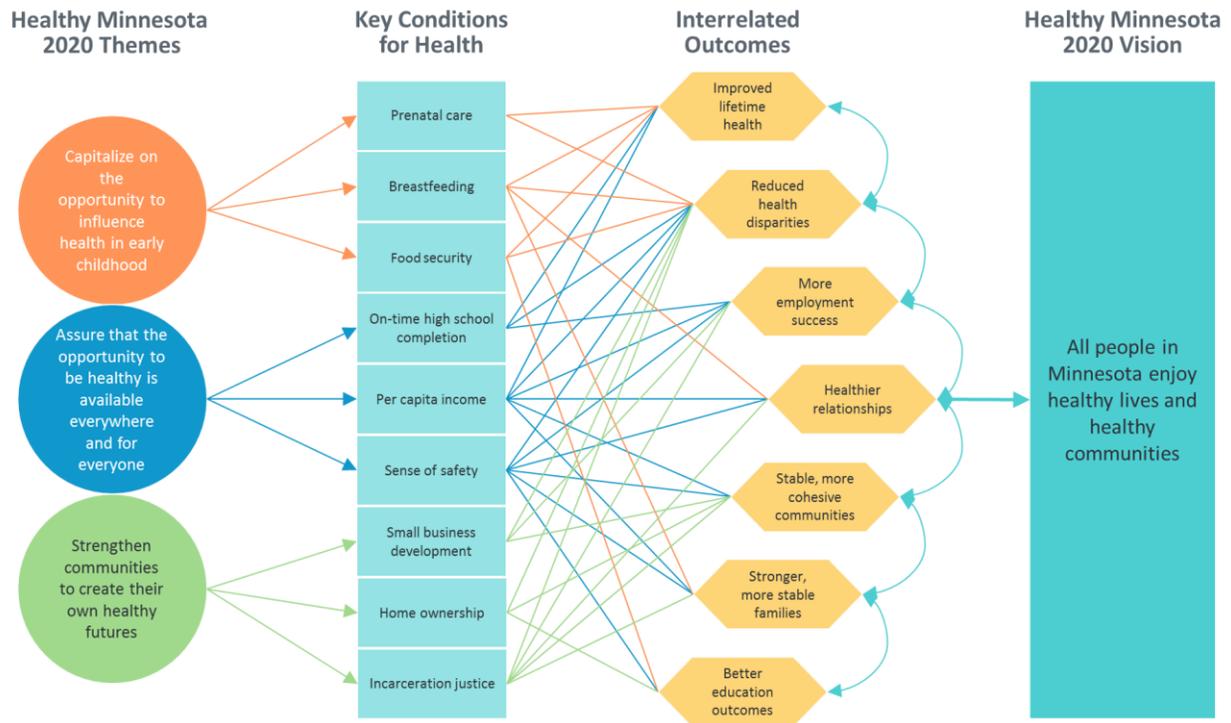


Reflecting this understanding that *conditions* create the opportunity to be healthy and that policy decisions shape these conditions, the Healthy Minnesota Partnership decided to focus the *Healthy Minnesota 2020* framework on social, economic and physical environments. The diagram below shows how the *Healthy Minnesota 2020* themes connect social and economic factors to 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 “key conditions for health” identified in the framework range beyond the scope of any single entity or sector to change. This is especially true when considering the pervasive effects of structural racism on the conditions for health. Outcomes are to a large extent dependent on policies, in both the public and private spheres, that shape these conditions. Policy discussions, in turn, are greatly influenced by the “narratives” or stories used in public conversations 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 include what creates health.**

Healthy Minnesota 2020: Statewide Health Improvement Framework



To implement this approach, in 2016 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—incarceration and burdensome debt—as focus areas for 2016.
- Developing and promoting alternative narratives on incarceration and health and burdensome debt and health to uncover where structural racism is at work and to broaden the scope of policy solutions.
- Encouraging the development of messages about creating opportunities for health for all people in Minnesota.
- Engaging a diverse array of people and populations in conversations about policy and health.

Partnership Progress

In 2016, the Healthy Minnesota partners engaged in a wide range of activities to implement and support the Healthy Minnesota framework and strategic approach.

In the four Partnership meetings of 2016, Partners shared a variety of activities they have engaged in that use the Healthy Minnesota 2020 strategic approach and narrative. These stories reflect the growing presence of the Partnership narrative about health in conversations on paid leave, income, housing, and more.

Paid Leave

In May 2016, the City of Minneapolis became the first city in Minnesota to require most employers to offer paid sick leave to workers. The Minneapolis city council gave unanimous approval to an ordinance that creates a mechanism by which the city will enforce paid sick leave rules on workplaces of six or more employees. The Minneapolis Department of Health and Family Support was influential in the conversations leading up to the passage of the ordinance, and also is helping to develop arguments in defense of the ordinance, which is currently being challenged in a lawsuit.

On September 7, 2016, the Saint Paul City Council passed an Earned Sick and Safe Time (ESST) ordinance requiring employers to provide paid sick and safe time to employees. Partnership member ISIAH was very active in working to establish the link between paid leave and health, and supporting passage of this ordinance. St. Paul's ordinance is the strongest one of its kind in the country, as it applies to all employers, and all employees are eligible for the benefit, including full time, part-time and temporary workers.

Income

The Minneapolis Department of Health and Family Support brought the MDH [White Paper on Income and Health \(PDF\)](#) to the City of Minneapolis, which helped to expand the conversation about wages in the city to incorporate issue about health.

Boynton Health at the University of Minnesota is requesting that the University of Minnesota raise the minimum wage for all workers to \$15/hour, basing their arguments on the Healthy Minnesota emerging narrative and the MDH white paper on income and health.

Housing and Homelessness

Because of the importance of housing to health, the Housing Finance Department, a Partnership Member, is conducting a pilot project that provides landlords with incentives through a safety net-like program to rent to people with imperfect records. The agency recognizes the importance of housing and health, with research that shows that homeless kids have the lowest test scores, because, "it's hard to do homework when you don't have a home."

The University of Minnesota, College of Design is working with the Hennepin County Medical Center and United Health to create new ways to connect health and housing by setting up a consortium of planning and design firms to integrate health research into planning decisions.

HealthPartners, HealthEast, and Allina health care providers are collaborating with Catholic Charities for medical respite beds at Higher Ground. Many individuals experiencing homelessness end up on the streets after receiving major medical treatments with nowhere to safely recover and heal. With this new model, homeless patients discharged from hospitals will be connected with temporary housing, nursing care and other support; the expectation is that this model will reduce re-hospitalizations and emergency room visits by 50 percent.

Public Narrative

Partnership members regularly share the Healthy Minnesota emerging narrative and graphics with others to continue to expand the understanding about what create health. For example, ISAIAH used the narrative to frame issues, including driver's licenses for immigrants, paid family leave, and mental health and caregiving, at a candidate forum in Willmar, Minnesota.

The Minnesota Department of Health has been working to build greater capacity among their staff and community partners on narrative. The narrative training uses the Healthy Minnesota emerging narrative as the basis of the training. To-date, this training has reached over 300 people both within and outside of MDH. MDH also has trained an additional 15 staff to conduct narrative trainings, which will be offered to MDH staff, local public health departments, and community-based organizations.

The University of Minnesota, College of Design uses the Healthy Minnesota framework and work on an expanded narrative about health to facilitate communication across "siloes" at the Centers for Disease Prevention and Control.

Health in All Policies

Members continue to advocate for knowing the health impact of many different kinds of policies. For example, the Minnesota Department of Transportation is considering transportation issues through a lens that includes community safety beyond the automobile to include bus, trains, pedestrians, social justice, environmental justice, social determinants of health, and racism.

A Minneapolis-area health plan initiative that engages community members in conversations about issues important to them regularly reflects on what policy areas might open up new opportunities, including policies that can have an impact on health. A Partnership member commented that for community members to realize that policy decisions are shaping their health is an important, powerful discovery, with both positive and negative overtones.

Partnership members who are involved with their Chambers of Commerce are bringing the Partnership narrative and perspective into these spaces, helping them think about health issues from a policy perspective rather than an individual service perspective.

In 2016 the Minnesota Department of Human Services released a draft policy on equity, with both internal (e.g., hiring) and external (e.g., interactions with the community) components. The policy raises questions such as what equity looks like for people on Minnesota health care programs and how to undo inequities in DHS programs.

Boynton Health has been using the health in all policies approach with students and faculty, for example, looking at how academic policy does or does not support optimal conditions for physical and mental health, and seeking faculty collaboration to address these issues.

The Minnesota Department of Health organized the State of Public Health Forum during National Public Health Week. Over 150 professionals heard from a panel of Partnership members that were convened by the Commissioner to discuss health equity in action. Participants then considered how they might “expand the conversation” about health through three policy issues—incarceration, paid leave and transportation—using the Healthy Minnesota Partnerships narrative frames.

Early Childhood; Mental Health

The University of Minnesota has incorporated the issue of adverse childhood experience into their student survey, which will connect health outcomes with early life experience. The transition of students from home to the university community is an opportunity for changing the nature of relationships from the ones that students experienced with their families to a new set of relationships at college.

Partnership members also are bringing the expanded narrative about health into a variety of settings where mental health, behavioral health, and substance abuse issues are discussed, such as a pilot program for integrating behavioral health care access into primary care settings and integrating behavioral health into hospital care. Critical access hospitals are being tasked to create coalitions with diverse constituents, so that law enforcement, schools, nursing homes, and emergency rooms, etc., engage with the community.

The Minnesota Public Health Association has begun a policy series, [Why is THIS Public Health?](#) The series explores topics that have stirred interest in the public health community, including mental health and the health care system.

Strategy Team Progress

In 2016 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

Performance Measure: By 2016, 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 teams developed multiple narrative frames for the issues of incarceration and health, and burdensome debt and health (see Appendix B).

Summary of Activities

The Partnership originally assigned a Narrative Strategy Team to identify and promote public narratives that emphasize the relationship between the conditions that create health and the opportunity to be healthy. In 2016, the Partnership moved away from a pre-defined narrative team to a set of ad-hoc teams based on the strategic opportunity issues chosen. This allows the Partnership to convene experts and advocates with knowledge of and passion for the specific issue being discussed.

In 2016, two teams were brought together to develop narrative frames: one on incarceration and health and one on burdensome debt and health (see Appendix B).

- On January 27 a Narrative Strategy Team meeting was held about the strategic opportunity of incarceration and health. A large group of participants was invited, in order to include the perspectives of people with more direct experience and expertise on the issue of incarceration to help shape the narrative frames. The emerging narrative on incarceration and health emphasizes that incarceration should be a path to wholeness and connection and not the source of poor health, exclusion, and disenfranchisement.
- On April 5, 2016 a session was held to frame the narratives about debt and health, including payday lending, burdensome student debt and housing debt. The narrative frames on burdensome debt emphasize that every community should have safe and affordable options available to meet the financial needs of all, and that no one, because of financial necessity, should have to turn to abusive and harmful lending practices.

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 2017. Two opportunities were identified: food access and health, and housing and health.

Performance Measure: By 2016, 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 exceeded. The Policy Strategy Team identified several strategic opportunities for 2016; the Partnership selected and developed narratives for incarceration and burdensome debt.

Summary of Activities

The team met two times in 2016. The team held an in-person meeting in August to develop a range of potential strategic opportunities and partnerships for the Partnership to consider. The Partnership defines a “strategic opportunity” to include active policy initiatives and statewide conversations that do not necessarily relate to a specific policy proposal.

- A list of potential strategic opportunities was generated through input from Partnership members at the June meeting, a survey of the Healthy Minnesota 2020 listserv (approximately 2,100 people), and a scan of other active policy initiatives related to the nine key conditions of the *Healthy Minnesota 2020* framework. At its June meeting, the Partnership was provided with an assessment of the strategic issues that had been addressed over the past few years and their relationship to the key conditions indicators in the *Healthy Minnesota 2020* framework. Food security, high school graduation rate, small business ownership and home ownership were the five key conditions that had not been addressed directly by the Partnership.
- 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:

- Safe communities
- Drivers licenses for immigrants
- Homes for all
- Advancing small business development
- Substance abuse, opioid use and mental health
- Equitable transportation

At the meeting, the group reflected that there were many aspects of the safe communities’ conversation, including body cameras for law enforcement, access to firearms, sentencing laws, school district discipline policies, community of color and policing. After the in-person meeting,

a member that was not present suggested the healthy food access policy conversation as a possible strategic opportunity.

The team met via conference call in September to narrow the field of possibilities, and decided to present to the Partnership the issues of homes for all; safety in schools; safety and policing; safety and substance misuse; and food access.

The Partnership selected the issues of homes for all and healthy food access for 2017.

2017 Statewide Health Assessment

In 2016 the Healthy Minnesota Partnership began the process of developing a new Statewide Health Assessment (SHA), which will provide a picture of health and well-being across the state of Minnesota. It will provide information about these key questions:

- Who is healthy and who is not?
- What conditions shape health for all the different populations in Minnesota?
- What do we have, and what do we need, to assure that all people in Minnesota can enjoy healthy lives and healthy communities?

The 2017 SHA is a collaborative effort led by the Partnership and supported by the Minnesota Department in Health. To build on the success of the previous assessment, this assessment will continue to emphasize the conditions that create health and will illuminate the health inequities that persist as a result. The assessment will also identify policy areas that structure conditions for health in Minnesota.

The Partnership has played an important leadership role in the development of the organization and content of the SHA. The Partnership set the following guiding principles for the assessment:

- A. The SHA uses plain language.
- B. The SHA as a whole reflects both community conditions for health (including social and economic forces), health across the individual life course, and intergenerational health issues.
- C. Minnesota's indicators in the SHA are consistent with national efforts to assess health equity.
- D. The SHA includes quantitative or qualitative information about populations often absent from data sets or obscured by averages, such as small racial/ethnic populations (the Karen, Oromo, Karenni, Somali, etc.) and other marginalized groups, such as the LGBTQ and disability communities.
- E. The SHA identifies intersections, interconnections, and compounding effects among the indicators/issues wherever possible.

- F. The SHA includes information on issues that are difficult to measure but have a significant impact on health and well-being (e.g., historical trauma; mental health; racism and other forms of discrimination; environmental justice, etc.).
- G. The SHA is explicit about issue of structural racism in Minnesota and supports this with data and examples.
- H. The SHA provides explanations/descriptions of the indicators as “the way things are” rather than descriptions of activities (i.e., plans for what is or will be done by programs at MDH or other organizations).
- I. The 2016 SHA links to the 2012 SHA by highlighting what is new or different, what has changed, what is notable in the new data, and the implications for the Healthy Minnesota framework.
- J. The SHA connects to and builds on the health equity work begun in the MDH *Advancing Health Equity: Report to the Legislature*.

In addition to establishing these principles, the Partnership:

- Articulated criteria for inclusion of data in the assessment
- Provided feedback on early outlines of the report
- Articulated key policy areas that structure the conditions that create health
- Participated in and helped disseminate a survey to gather input about characteristics of Minnesota that promote health and well-being

In 2017, the Partnership will finalize the assessment and use it to inform the development of an updated Statewide Health Improvement Framework.

Progress on Core Indicators/Key Conditions

Over the course of 2016 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 2017 strategic opportunities, below).

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

Looking Ahead: 2017

2017 Strategic Opportunities

In October 2016 the Partnership chose two strategic opportunities for 2017:

Healthy Food Access

Low income communities in Minnesota have limited retail access to healthy and affordable foods. In 2016, Wilder Research and the Federal Reserve of Minneapolis released a study that mapped the low-income communities and communities of color that experience limited healthy food access. The report found that more than 340,000 Minnesotans face both distance and income as a barrier to obtaining healthy, affordable food. Approximately 235,000 Minnesotans live more than 10 miles away from a large grocery store or supermarket. Many people in rural areas such as seniors, children, low income residents and diverse ethnic populations, face much greater challenges finding the foods necessary to maintain a healthy diet. ³

The Minnesotans for Healthy Kids Coalition (MHKC) passed legislation in 2016 to establish the Good Food Access Program at the Minnesota Department of Agriculture with an initial appropriation of \$250,000 in one-time funds. For the 2017 legislative session, the MHK Coalition and Good Food Access Fund campaign are working to secure \$10 million per year to fund a combination of grants, loans, and technical assistance to support expanding access to healthy food in underserved, low/moderate income communities. This initiative stemmed from the work of the Minnesota Food Charter and other previous work done by Minnesota stakeholders and The Food Trust.

MHKC has assembled over 40 coalition members representing both rural and urban Minnesota communities, and communities of color to champion the Good Food Access Fund Campaign. There was bipartisan support at the Minnesota Legislature for the legislation and the bill passed six committees in six weeks during the 2016 session. This resulted in a one-time this appropriation was \$250,000. This is an initiative that has the ability to gain significant traction across sectors and advance health equity in communities across our state.

This campaign has the opportunity to improve healthy food access in low-income communities with limited access to healthy food retailers. Having access to healthy foods is necessary to improving eating behaviors, and ultimately health. And without grocery stores and other healthy food retailers, communities are also missing the commercial vitality that makes neighborhoods livable and helps local economies thrive.

The campaign engaged community partners in every stage including drafting legislation, providing testimony, engaging communities most impacted by the lack of healthy food access,

and direct and grassroots lobbying efforts. This coalition is committed to health equity and ensuring that the Fund is meeting the needs of communities which are disproportionately affected by lack of access to healthy foods. The coalition has formally incorporated equity as a priority throughout their operating model and strategic plan with employment of an equity organizer and a strategy to hire six regional community engagement consultants across the state to organize the most underserved communities in Minnesota. The legislation passed in 2016 to establish the program includes an advisory committee comprised of key stakeholders who represent communities of color.

As part of the work of the Healthy Minnesota Partnership, this strategic opportunity relates to the key conditions of food security, small business development, and per capita income. Partnership members already involved in this issue include the American Heart Association, Blue Cross and Blue Shield Center for Prevention, Local Public Health Association, Minnesota Public Health Association

Housing and Health

There is a very large gap between the availability and the demand for affordable housing. Right now there are about 600,000 Minnesotans who are cost-burdened, which means they pay more than 30 percent of their income for housing.

Quality affordable housing is a foundation for success in so many areas of our lives and it absolutely has health impacts. For example, it:

- Makes available more household resources to pay for health care and healthy food
- Supports mental health by limiting stressors related to financial burden and frequent moves, or by offering an escape from an abusive home environment
- Reduces stress by allowing control over one's own environment
- Serves as a platform for providing supportive services to improve the health of vulnerable populations
- Plays a role in allowing seniors to age-in-place

Access to housing is a statewide issue. Greater Minnesota is severely impacted by this housing shortage. Many jobs go unfilled which leads to production companies to consider moving to other areas. Recently the state created programs dedicated to the problem and they are getting underway.

Housing Cost Burden Reduces Resources for Health Care and Food Security/ Nutrition

- People in unaffordable housing are more likely to have lower rates of health insurance participation and higher rates of food insecurity. According to a Joint Center for Housing study, compared to households that spent 30 percent or less of their income on housing, households that spent more than 50 percent of their income on housing were

found to spend 39 percent less on food and 65 percent less on healthcare. (Alexander 2014).

- Among families experiencing food insecurity, children in households without housing subsidies were twice as likely to have very low weight-for-age compared to children in households receiving subsidies (Meyers et al. 2005).
- Low-income households without housing subsidies were twice as likely to report having had a person that needed to see a doctor but did not see one for lack of money (Lee et al. 2003).

Mental Health

Affordable housing provides residents with greater housing stability, reducing stress and related adverse health outcomes and that is especially true with people who are experiencing mental health issues.

- Studies show homeless children are more vulnerable to mental health problems, developmental delays, poor cognitive outcomes, and depression (Newman et al. 2014).
- Frequent moves, living in over-crowded environments, eviction and foreclosure are linked with elevated stress levels, depression and hopelessness (Kyle et al. 2008).
- Positive benefit of length of tenure: Research shows longer tenures in housing are associated with lower levels of depression in seniors and fewer behavioral issues (such as anxiety and aggression) among adolescents (Coley et al 2013).
- Among adolescents, an association was found between moving four or more times before age 16 and early drug use (Bonney 2007).

As part of the work of the Healthy Minnesota Partnership, this strategic opportunity relates to the key conditions of home ownership, food security, sense of safety, and on-time high school graduation. Partnership members already involved in this issue include Minnesota Housing and Finance, MDH, local public health departments, and Minnesota Department of Human Services

Next Steps

The 2017 Minnesota legislative session creates a natural context for discussing and debating policy issues, providing a venue for applying the Healthy Minnesota expanded narrative approach and creating many opportunities to talk about health from the perspective of the conditions that create health in the community. The **Policy Strategy Team** identified two potential policy areas for 2017: healthy food access and homes for all.

The Partnership will convene ad-hoc **Narrative Strategy Teams** early in 2017 to develop narrative frames for both of the strategic opportunities noted above.

The Partnership will complete the 2017 Statewide Health Assessment and review the strategic approach in its current statewide health improvement framework. The Partnership will either reaffirm the current strategic approach or develop a new approach to advancing the conditions that create health.

Membership in the Partnership will be strengthened through the recruitment of new members and the confirmation of current members and alternates.

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 2016, the following were represented in the Healthy Minnesota Partnership.

2016 Partnership Members

Carl Anderson, Boynton Health Services (University of Minnesota)
Jeanne Ayers, Minnesota Department of Health
Annastacia Belladonna-Carrera, Minnesota Latino Affairs Council
Ken Bence, Minnesota Public Health Association
Kari Benson, Minnesota Board on Aging
Rachel Callanan, American Heart Association
Linda Davis-Johnson, Minnesota Department of Human Services
Julia Dreier, Minnesota Council of Health Plans
John R. Finnegan, Jr., University of Minnesota School of Public Health
Thomas Fisher, College of Design, University of Minnesota
Tim Henkel, Minnesota Department of Transportation
Neal Holtan, Medical Consultant
Warren Larson, Sanford Health
Vayong Moua, Blue Cross and Blue Shield Center for Prevention
Gretchen Musicant, Local Public Health Association (Metro)
Lars Negstad, ISIAAH
Kami Norland, National Rural Health Resource Center
Martha Overby, Minnesota Chapter, March of Dimes
Joan Pennington, Minnesota Hospital Association
Barb Sporlein, Minnesota Housing Finance Agency
Maria Veronica Svetaz, Hennepin County Medical Center
Joanne Usher, Rainbow Health Initiative
Marcia Ward, State Community Health Services Advisory Committee (SCHSAC)
Sue Yost, Local Public Health Association (Greater MN)
Donna Zimmerman, Itasca Project

2016 Partnership Alternates

Ann Bajari, Minnesota Public Health Association
Justin Bell, American Heart Association
Kathleen Call, University of Minnesota School of Public Health
Amber Dallman, Minnesota Department of Transportation
Ed Ehlinger, Minnesota Department of Health
Kate Elwell, Boynton Health Services, University of Minnesota
Mary Hertel, Minnesota Board on Aging
Stacey Housman, Blue Cross and Blue Shield Center for Prevention
Alexa Howart, ISAIAH
Kristin Loncorich, Minnesota Hospital Association
Tracy Morton, National Rural Health Resource Center
Susan Palchick, Local Public Health Association (Metro)
Katie Topnika, Minnesota Housing Finance Agency
DeeDee Varner, Itasca Project

Staff to the Partnership in 2016

Dorothy Bliss, Minnesota Department of Health
Marisol Chiclana-Ayala, Minnesota Department of Health
Sara Cronquist, Minnesota Department of Health
Jeannette L. Raymond, Minnesota Department of Health

2016 Narrative Strategy Team Participants

Incarceration and Health

Lindsey Alexander, ReThink Health
Jeanne Ayers, Minnesota Department of Health
Alfred Babington-Johnson, StairStep Foundation
Cumah Blake, Governor's Office
Dorothy Bliss, Minnesota Department of Health
Susan Brace-Adkins, Minnesota Department of Health
Jess Brennan, Minnesota Department of Human Rights
Marisol Chiclana-Ayala, Minnesota Department of Health
Sara Cronquist, Minnesota Department of Health
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Appendix B: 2016 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.

Incarceration and Health 4

The Dominant Narrative on Incarceration and Health

The dominant narrative limits our ability to think/imagine what needs to change and to make change possible, because it tends to focus solutions on increased/improved services and education to create individual behavior change. The dominant narrative includes the following elements:

- Don't really care about the health of incarcerated persons
- "We are punishing you"
- "Those people" – prison is a form of quarantine
- Anger that "bad decisions" of individuals cost "us" money
- Dehumanizing – they deserve less
- Incarcerated people are people who do things we don't like
- Medical care – some deserve to get it (or get high quality care), some do not (i.e., prisoners)
- Poor health is the consequence of poor individual decisions
- "You screwed up;" "you get what you deserve"
- Health is only physical health, not mental, social, spiritual
- Everyone in jail is sick
- All are "diagnosed" with an individual (not family, community, systemic) problem
- Focus for health in prison is on medical care
- Only concerned about the health of persons who are incarcerated (i.e., not their families)
- Only concerned about what happens in prison

Emerging Narrative Frames on Incarceration and Health

NOTE: Narrative frames are meant to provide context; to provide guidance; to be signposts for the things that we believe are important. They can help prioritize work; they can help guide a report; they can help identify potential action steps. Narrative frames are foundational for messaging and action. The elements of a new narrative on incarceration and health should lead to reduced rates of incarceration and the elimination of racial/ethnic inequities in incarceration.

1. Incarceration should be a path to wholeness and connection and not the source of poor health, exclusion, and disenfranchisement.
2. Incarcerated parents should be supported in their parenting role.
 - We don't punish innocent children.
 - Family support
 - Lowered economic stability for the family
 - Keep connections during incarceration
 - Nurturing breastfeeding
 - Parents and children need strong, healthy connections.
3. Protect the health of children of incarcerated parents, not just the persons who are incarcerated.
4. Community wisdom should have a voice in the criminal justice system.
5. Criminal justice reform means community reform (schools, jobs, resources, housing, including...); community reform IS criminal justice reform.
 - All systems/structures in the community (business (Ban the Box), housing, voting, etc.) have a role to play in creating the opportunity for health for current and former incarcerated persons.
 - Health is just as or more important for the community than criminal justice.
 - Health IS public safety.
 - Criminal justice should be about rehabilitation not retribution; retribution creates less public safety, not more.
 - Criminal justice reform means not having a one-size fits all response to every crime, and understanding the social and economic conditions that influence personal actions.
6. Our loved ones who are incarcerated and all our families are part of our communities. Many of us need new ways of connecting and embracing these folks to improve the health and safety of our community.
 - Individuals are part of the community before, during and after incarceration which requires shared accountability and community accountability.
 - Communities need everyone to be strong; no one should be "thrown away;" there is no "away"
 - There is a deep interconnectedness between the community and those persons who are incarcerated.

- There is human potential in all people.
 - Restore personal agency because it is fundamental to health equity and healthy communities
 - Restore voting rights
 - Disconnected from the “whole” of society; concept of “re-entry”
 - Connection to family and own social network
 - All incarcerated people are part of our community; everyone deserves a chance; reentry, voting, jobs
 - We are all connected to people that have experienced incarceration; families and communities need support
7. One’s health is everyone’s health, which will require us take Racial Equity into consideration.
- Our knowledge about Racial Equity should influence and help change our structures and systems, our approach and contribution to this issue (incarceration and health—thinking and taking racial equity to our work of transforming structures and systems)
8. Prison systems should not be our society’s way to address mental health challenges. We need to work together to find better solutions to support positive mental health.
- Mental health and substance abuse are health issues, not criminal justice issues
 - Incarceration is an inefficient and ineffective tool for addressing mental health and substance abuse issues
 - Address underlying issues like chemical dependence, mental health of incarcerated parents
9. Disparities/differences in all elements of the criminal justice system (arrest, pre-sentencing, sentencing, etc.) create differences in health.
10. Schools should not serve as a “pipeline” to prison. Officers in schools should not be involved in making diagnoses of students.
- Schools should be places that protect and care for all children; discipline policies must be applied equitably; racism and structural racism in school discipline must be exposed and eliminated.
 - Staying in school is essential for lifetime health.
11. The purpose and goal of incarceration need to be reconsidered, in order to contribute to health.
12. Talked about the irony that some laws were created to protect health as a rational—but actually create less health. Examples drug laws, others?
13. Incarceration protects the interests of some—leads to lack of health for others. For example: laws are created to protect people from negative health impacts + laws are unequally applied = less health for some communities.

Burdensome Debt and Health

The Dominant Narrative on Debt and Health

Dominant narratives limit our ability to think/imagine what needs to change and to make change possible. Solutions crafted in the current dominant narrative tend to focus on the individual, rather than systems; on increased/improved services rather than policy change; and on education to individuals instead of systemic changes that do not rely on individual actions. The dominant narrative about debt includes the following elements:

- “Your debt” is yours alone, does not affect me.
- The solution to debt is to declare bankruptcy.
- Debt has nothing to do with health.
- Anyone can be debt-free.
- Your debt has no consequences for my health.
- Debt keeps you from making healthy choices.
- Future earnings makes college debt worthwhile.
- Differences in the rates of home ownership among different populations reflects a lack of ambition by individuals and not system-based inequities.
- Health is shaped by individual choices, including the choice of where to live.
- Anyone can own a home if they really want to.
- The owning of a home is a personal accomplishment.
- The free market should determine who owns a home and who does not.
- Debt due to taking out payday loans is the responsibility of the debtor because it is the result of a bad decision.
- The free market should be allowed to determine the level of profit a lender can take; government should not impose restrictions on businesses.
- Evictions and loss of personal property due to taking out payday loans is not the concern of the community.
- Everyone has the same opportunities for financial assistance (e.g., loans); if they do not, it is due to personal failings.
- Payday lending is providing a necessary service to persons who have no other options.

Emerging Narrative Frames on Debt and Health

NOTE: Narrative frames are meant to provide context; to provide guidance; to be signposts for the things that we believe are important. They can help prioritize work; they can help guide a report; they can help identify potential action steps. Narrative frames are foundational for messaging and action. The elements of a new narrative on burdensome debt and health should lead to the elimination of inequities in lending practices and reduced rates of burdensome debt.

Foundational Assertions on Debt and Health

- Economic stability and financial health are essential for mental and physical health.
 - The health of a whole community can be impaired by economic exclusion and targeted predatory practices.
1. Every community should have the opportunity to build long-term assets and economic security, which are essential for lifetime health.
 - Everyone deserves to have access to affordable savings products and financial education.
 - No person or community should become impoverished due to predatory lending practices.
 - Everyone should have the opportunity for timely and relevant financial education and support to help manage their resources and resolve their debts, regardless of ability to pay.
 2. Every community should have safe and affordable options available to meet the financial needs of all. No one, because of financial necessity, should have to turn to abusive and harmful lending practices.
 - The practices of false representation of return on investment, lending money at unreasonably high rates of interest, misleading information about interest rates over time, making unethical or immoral monetary loans that unfairly enrich and lender and impoverish the borrower, or any other predatory practices should not be permitted in any community.
 3. Everyone has a role to play in creating an economic environment that supports health.
 - Governments must examine and shape policies to assure that all people, regardless of income, have the opportunity to develop economic security and are protected from predatory financial practices.
 - Mainstream financial institutions have an important role to play in creating the opportunity for all Minnesotans and Minnesota communities, regardless of income levels, to develop savings accounts and build long-term wealth.
 - All persons and communities should have the opportunity to participate in the development of policies, plans, products and other activities that will shape their economic futures, regardless of their current income levels.
 4. Everyone has a role to play in assuring the conditions in which people can experience economic security, assuring that no populations or communities are excluded from economic opportunity or targeted by financial predators.

Student Debt and Health

Assertions:

- Student debt is a barrier to a full range of options for life, including a healthy life (home ownership, employment, recreation, self-determination, etc.).
- The stress of student debt is linked to poor mental and physical health.
- Predatory recruiting practices by schools that encourage borrowing, such as overstating job prospects and future income, can be just as devastating as other forms of predatory lending.
- Student debt increases individual and family stress and contributes to the burden of mental health concerns for entire communities.
- Student debt impairs the community by reducing the time people have for full participation in the community and by increasing rates of transiency (i.e., renting), which also limits civic engagement, which affects the health of the whole community.
- Defaulting on private student loans can limit employment opportunities and make it impossible to get any kind of loan for years, with long-term impacts on the conditions that create health (e.g., employment, housing, or transportation).
- The high cost of college education limits employment and earning opportunities for persons of more limited financial means, and combined with student debt, contributes to eventual wage gaps and disparities in health outcomes.
- Student loan programs that target disadvantaged communities and misrepresent the real long-term costs of student loans increase the burden of debt and contribute to population-based health disparities.

Emerging Narrative Frames on Student Debt and Health

5. Everyone deserves to have the opportunity for an education that will allow them to earn a wage that supports a healthy life and family, without going into debt for a lifetime.
6. Education should not be the cause of long-term debt that limits income or employment opportunities.
7. All educational institutions, public or private, must be aboveboard and transparent in their promotion of degree programs and future job prospects, and should be held accountable if they falsely represent future earnings in order to lure prospective students into debt.

Mortgage Debt and Health

Assertions:

- Structural racism based in historical practices and continuing today has contributed to significant differences in home ownership rates between different racial and ethnic populations.

- Predatory lending practices and sub-prime mortgages are targeted to disadvantaged and marginalized communities; these communities were the most negatively impacted by the economic downturn and mortgage crisis.
- All Americans are and have been affected by mortgage lending practices, whether they have fallen prey to a sub-prime mortgage or not.
- The realty industry has been complicit in creating and maintaining racial and economic segregation in American communities.
- The economic advantage of European-Americans is to a large degree the result of home ownership, which has traditionally generated wealth that is transferred from one generation to the next. African Americans in particular have historically been prevented from owning homes with negative impacts on their own and their children financially and physical health.
- Home ownership contributes to the stability and safety of communities, with important impacts on physical and mental health. The impacts of foreclosures go far beyond individuals by decreasing neighborhood property values, diminishing local tax revenues, and reducing community purchasing power.

Emerging Narrative Frames on Mortgage Debt and Health

8. Everyone deserves to have a safe and healthy home in which to live.
9. No one, whether home owner or renter, should have to pay so much for their rent or mortgage that they are unable to take care of their other essential needs.
10. Every home owner deserves the opportunity to purchase a sustainable, affordable mortgage.
11. No population or community should be the target of predatory mortgage lending practices. Lenders must not be allowed to target certain populations or steer people into mortgages that they cannot afford to pay. Lenders should not reward mortgage brokers for steering people into loans that benefit the lender and put the borrower at risk.

Payday Lending and Health

Assertions:

- The current practice of payday lending targets the most vulnerable and entraps them into a cycle of certain financial destruction. Payday lenders typically locate in low income and racially segregated neighborhoods.
- Far from being an individual matter, payday lending has devastating effects on communities, including increased rates of crime, reduced social engagement, increased individual, family and community stress, and greater health disparities.

Emerging Narrative Frames on Payday Lending and Health

12. Anyone in urgent financial need should have access to safe and affordable financial help. No one should, because of financial necessity, have no recourse other than to abusive and harmful lending practices.
 - A range of fair and timely alternatives to predatory payday loans should be developed (with the participation of those most affected) and marketed to persons likely to be in need of financial assistance.

Appendix C: Healthy Minnesota: Summary of 2016 Performance Measures

Summary presented to Partnership on October 2016 Meeting

Measures	2014	2015	2016
1. Partners report that they understand the main concepts of Healthy Minnesota 2020 and could explain them to someone else:			
Identification and development of narratives	56%	67%	38%
What creates health	56%	72%	67%
Health in all policies	74%	83%	89%
2. Partners report that participation in the Healthy Minnesota Partnership has contributed to their understanding of the Partnership concepts:			
Identification and development of narratives	91%	95%	78%
What creates health	91%	100%	89%
Health in all policies	74%	79%	67%
3. Partners report that participation in the Healthy Minnesota Partnership has increased their capacity to implement the Partnership strategies:			
Develop messages consistent with the HM2020 narrative	91%	94%	100%
Change conversations about what creates health	87%	94%	100%
Assess opportunities to promote health in all policies	97%	89%	100%

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Measures	2014	2015	2016
4. Partners are using the Healthy Minnesota 2020 strategies in their work:			
Developing messages	48%	53%	56%
Expanding conversations	48%	59%	44%
Assessing opportunities for health in all policies	52%	65%	44%
Lifting up health in policy development	56%	53%	33%
Participating in cross-sector partnerships for health in all policies	---	59%	56%
5. Partners say that using the Healthy Minnesota approaches has enhanced their efforts:			
Yes	74%	79%	86%

Appendix D: Healthy Minnesota 2020 Key Conditions Indicator Updates as of June 2016

Reported to the Healthy Minnesota Partnership on June 9, 2016.

By 2020, More Mothers in Minnesota in Every Racial/Ethnic Population Access First Trimester Prenatal Care

Race/Ethnicity	2010	2011	2012	2013	2014	Change
African-American / Black	74.9%	72.9%	71.8%	69.7%	68.7%	Decreasing
American Indian	64.1%	58.0%	60.0%	58.9%	57.1%	Decreasing
Asian / Pacific Islander	73.3%	74.1%	72.3%	70.7%	70.7%	Decreasing
Hispanic	75.6%	76.5%	75.0%	76.7%	75.5%	Decreasing
Non-Hispanic White	90.5%	88.9%	88.5%	87.7%	87.0%	Decreasing
Minnesota (All)	85.6%	84.7%	83.9%	83.0%	82.3%	Decreasing

Source: Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS)/Center for Health Statistics

By 2020, More Minnesota Children are Exclusively Breastfed for Six Months

Region	2010	2011	2012	Change
United States	17.2%	18.8%	21.9%	Increasing
Minnesota	23.7%	23.5%	21.7%	Decreasing

Source: Center for Disease Control and Prevention (CDC)/National Immunization Survey

By 2020, Fewer Minnesota Households Experience Food Insecurity

Food Security	2008-2010	2011-2013	Change
Food insecurity	10.3%	10.8%	Increasing
Very low food security	4.4%	4.4%	No change

Source: U.S. Department of Agriculture, Economic Research Service

By 2020, More Students from Each Population Group in Minnesota Graduate From High School within Four Years

Race/Ethnicity	2010	2011	2012	2013	2014	2015	Change
Black	46.4%	49.1%	51.0%	57.0%	60.4%	62.0%	Increasing
American Indian	44.2%	42.4%	45.5%	48.7%	50.6%	51.9%	Increasing
Asian	70.1%	72.5%	74.0%	77.7%	81.7%	82.7%	Increasing
Hispanic	47.9%	50.5%	53.0%	58.3%	63.2%	65.6%	Increasing
White (Non-Hispanic)	82.5%	83.5%	83.9%	85.0%	86.3%	86.9%	Increasing
Minnesota (All)	75.5%	76.9%	77.6%	79.5%	81.2%	81.9%	Increasing

Source: MN Compass, Minnesota Department of Education

By 2020, Minnesota's Racial and Ethnic Inequities in Per Capita Income are Reduced

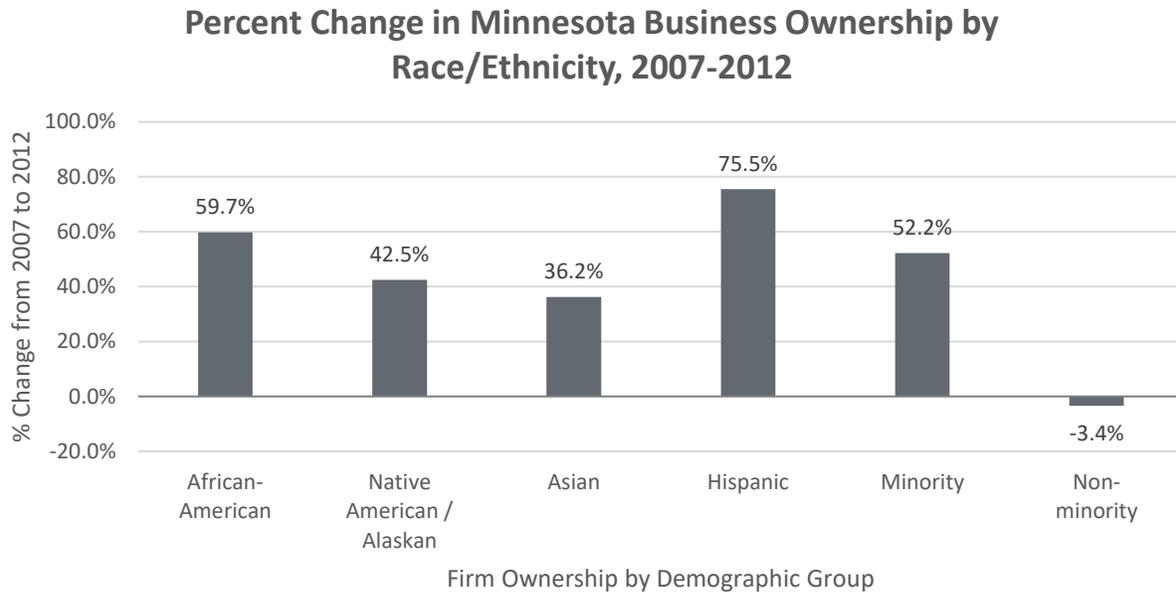
Race/Ethnicity	2010	2011	2012	2013	2014
Black or African-American	\$15,301	\$15,681	\$15,577	\$15,688	\$15,974
American Indian and Alaska Native	\$15,011	\$15,089	\$15,713	\$16,096	\$16,725
Asian	\$22,246	\$23,488	\$23,958	\$24,311	\$25,425
Hispanic or Latino	\$14,202	\$14,488	\$14,646	\$14,762	\$15,257
White	\$31,561	\$32,373	\$32,819	\$33,174	\$34,013
Minnesota (All)	\$29,582	\$30,310	\$30,656	\$30,913	\$31,642
Change	---	Increasing	Increasing	Increasing	Increasing

By 2020, More Minnesota Students Feel Safe Going To and From School

Race/Ethnicity	2010	2013	Change
Black / African / African-American	92.6%	91.7%	Decreasing
American Indian	92.3%	92.2%	No change
Asian	93.2%	93.2%	No change
Hispanic	92.6%	93.3%	Increasing
White	96.3%	95.7%	Decreasing

Source: Minnesota Student Survey, Grade 9

By 2020, More Communities across Minnesota Have More Small Business, and More Minority-Owned and Women-Owned Businesses



Source: U.S. Small Business Administration, Office of Advocacy, U.S. Census Bureau's Survey of Business Owners

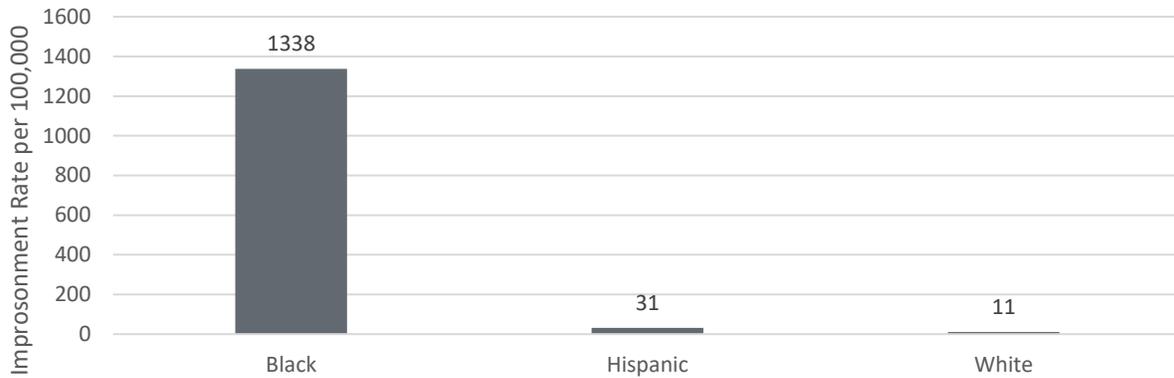
By 2020, Populations That Currently Have Low Rates of Home Ownership Are Better Able To Afford and Own Homes

Race/Ethnicity	2010	2011	2012	2013	2014	Change
Black	23.9	24.0	21.3	25.7	23.8	Decreasing
American Indian	46.1	45.9	47.1	44.8	46.7	Increasing
Asian	56.8	53.8	53.5	55.6	57.4	Increasing
Hispanic	43.5	39.2	45.1	44.6	43.5	Decreasing
White	77.4	77.5	76.2	76.0	76.4	Increasing
Minnesota (All)	73.0	72.8	71.4	71.6	71.7	No change

Source: MN Compass, U.S. Census Bureau, American Community Survey

By 2020, Racial/Ethnic Inequities in Incarceration Rates in Minnesota are Diminished

Minnesota Imprisonment Rate by Race/Ethnicity, 2014



Source: The Sentencing Project

¹ For a more detailed explanation of the role of structural racism in health outcomes, see the 2014 report: *Advancing Health Equity in Minnesota: Report to the Legislature*: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

² Determinants of Health Model based on frameworks developed by: Tarlov AR. *Ann N Y Acad Sci* 1999; 896: 281-93; and Kindig D, Asada Y, Booske B. *JAMA* 2008; 299(17): 2081-2083.

³ Healthy Food Access: A View of the Landscape in Minnesota and Lessons Learned From Healthy Food Financing Initiatives (April 2016). Retrieved October 2016 from: <http://www.wilder.org/Wilder-Research/Publications/Studies/Forms/Study/docsethomepage.aspx?ID=1693&RootFolder=%2FWilder-Research%2FPublications%2FStudies%2FHealthy%20Food%20Access>

⁴ Summary from the January 27, 2016 meeting to develop narrative frames on incarceration and health.