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Healthy Minnesota Partnership

The Healthy Minnesota Partnership brings together community partners and the Minnesota Department of Health (MDH) 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 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 (for more information, see Appendix A).

In 2017, the Partnership continued to implement the Healthy Minnesota 2020 Framework (Figure 3) with activities including:

- Directed the development and publication of the 2017 Statewide Health Assessment, a picture of health and well-being across the state and within the communities of Minnesota.¹
- Identified healthy food access as a strategic opportunity and developed narrative frames and messaging as a means to advance a health in all policies approach to this issue.
- Continued discussion of the role of structural racism in health inequities.²
- Reviewed the key conditions for health.
- Updated the Partnership values and principles.³

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.

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,

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¹ Learn more: [2017 Minnesota Statewide Health Assessment](https://www.health.state.mn.us/divs/chp/reports/2017-statewide-health-assessment.pdf).
² For a more detailed explanation of the role of structural racism in health outcomes, see: [Advancing Health Equity in Minnesota: Report to the Legislature (PDF)](https://www.health.state.mn.us/divs/chp/reports/advancing-health-equity-report.pdf).
³ The Partnership updated their values and guiding principles in preparation for and inclusion in Healthy Minnesota 2022, the next statewide health improvement framework.
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. It 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 needed to realize the vision of a healthy Minnesota. For example, Partners and others have used the themes of Healthy Minnesota to shape intra-agency as well as inter-agency discussions of policy needs and possibilities for community action.

In the last months of 2016, the Partnership began a review of the 2012 framework as preparation for the development of Healthy Minnesota 2022: the next iteration of the statewide health improvement framework.

2017 Progress on Healthy Minnesota 2020

Strategic Approach: Expanding the Conversation About What Creates Health

As awareness of health disparities has grown, so has the concern that progress is slow. In Minnesota—a state with significant race-based health disparities—the gaps in health status outcomes have 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 help explain the impact of different factors on health (Figure 1).

Figure 1. Determinants of Health

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 that public health is “what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

The revised model, Figure 2, shows the important role of policy in shaping the conditions for health:

Figure 2. Determinants of Health Equity

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.

Figure 3 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 largely 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. These two narratives are limited and incomplete. Therefore, as their primary
strategy they chose: to work toward expanding of the nature of public discussions—especially policy—about health to include what creates health.

**Figure 3. Healthy Minnesota 2020: Statewide Health Improvement Framework**

To implement this approach, in 2017 the Partnership:

- Continued to develop the capacity of partner organizations to use the narrative approach to policy change. The Partnership:
  1. Gathered a variety of people working in the area of health food access to develop narrative frames on this issue ([Appendix A](#)); and
  2. Through MDH, continued to provide training on narrative and narrative framing.

- Encouraged member organizations to keep emphasizing creating opportunities for health for all people in Minnesota.
- Engaged a diverse array of people and populations in conversations about policy and health.

**Partner Actions in 2017**

In 2017, the Healthy Minnesota partners took part in a wide range of activities to implement and support the Healthy Minnesota framework and strategic approach.

- The Minnesota Housing Finance Agency (MHFA) wove the health aspects of housing into their legislative agenda for 2017, including proposals for the Governor’s budget and appropriations for affordable housing.
The Minnesota Department of Human Services (DHS) developed an administrative equity policy that covers all core functions of DHS and hired an equity coordinator to work internally and externally, including on policy.

A number of Partnership members worked toward a bill to provide access to healthy food across the state.

The City of Minneapolis Comprehensive Plan included a chapter on health and included health throughout the Plan; the City also strengthened their approach to equity.

The Minnesota Departments of Corrections (DOC) and Human Services (DHS) launched a pilot project to make it possible for offenders to apply for public assistance before leaving the corrections systems, which is critical for their first 30 days after release. The pilot will be assessed for broader implementation over the next year.

The Minneapolis Health Department organized community sessions to gather public input on the minimum wage issue, including legislative efforts to preempt local efforts to increase the minimum wage and assure paid family leave.

MDH provided technical support to a cohort of local health departments to conduct a health equity analysis, which involves identifying a measureable health inequity and then working with the populations most impacted to ask about the conditions and causes that contributed to that inequity.

Several Partnership members worked on expanding the narrative around addiction to approach it more like a chronic disease that requires a lifetime approach, rather than one-time treatment.

The Hennepin County Community Health Improvement Partnership built on the work of the Healthy Minnesota Partnership in the area of housing and health.

The University of Minnesota/Boynton Health Services developed an outline to help faculty and staff recognize how their policies affect the mental health of students, especially stress and anxiety. Boynton also provided training for staff on how better to support LGBTQ students.

The Minnesota Public Health Association collaborated to hold a conference on gun violence and worked toward a statewide action plan with a broad range of partners.

The DHS strategic plan included an emphasis on “equitable culture.”

The Minnesota Cancer Alliance moved toward a more policy-focused approach in the development of the Minnesota Cancer Plan.

Some churches in Minnesota have made a commitment to increase belonging through “get to know your neighbor” initiatives, including difficult conversations on race and developing a loving community.

The Minneapolis City Council voted to establish a Division of Race and Equity with the aim of helping city departments set goals to reduce and eliminate racial inequity in city government.

The Minnesota Council of Latino Affairs held listening sessions across the state to capture the voice of Latino communities and to prepare for working with the state legislature in 2018. The report connects the concerns of Latino and Hispanic Minnesotans to social and economic conditions in their communities and the state.
Healthy Minnesota Partnership 2017 Activities

Healthy Food Access

The Partnership chose healthy food access as a strategic opportunity for expanding policy conversations about health to include conditions for health.

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.

A campaign to secure funding for access to healthy food brought together a coalition representing rural and urban communities and communities of color. The campaign engaged community partners in every stage of the process including drafting legislation, providing testimony, direct and grassroots lobbying, and engaging people in communities experiencing the impact of a lack of healthy food access.

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

The Partnership sponsored a meeting in early January to develop narratives around healthy food access with a wide range of participants involved in this issue. Those present agreed that the dominant narrative around food focuses on the actions and behaviors of individuals. The dominant narrative characterizes sweets as rewarding, and reinforces the belief that healthy food “doesn’t taste good” and is not satisfying. The group developed new narrative frames focusing on what people deserve (e.g., “people deserve access to healthy food no matter where they live”), on communities (“healthy food is the foundation of a healthy community”), and on systems (“decisions at every point in the food system should encourage access to healthy food for all”). The narrative frames developed in this effort are included in Appendix B.

Early Childhood and Health

Conversations about early childhood and the narrative work of the Partnership began in 2017, with narrative trainings in two locations, one in Greater Minnesota and one in the Twin Cities. These sessions will:

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5 Amherst H. Wilder Foundation. (2016). Healthy food access – landscape in Minnesota and lessons learned from healthy food financing initiatives.
1. Provide the foundation needed to expand the conversation about what creates health and well-being for families with young children.
2. Help participants recognize dominant health and early childhood narratives and better understand emerging narratives to advance health and racial equity.
3. Encourage participants to be intentional about working out of an emerging health narrative and identify how their activities could look different.

Participants discussed the need to develop narrative frames that recognize the role of the community in creating conditions that support the success and health of young families. Another theme that arose was the importance of healthy families to the vitality of communities around the state. The narrative frames related to early childhood will be shared in the 2018 Healthy Minnesota Partnership annual report.

2017 Minnesota Statewide Health Assessment

The Healthy Minnesota Partnership, with support from the Minnesota Department of Health, led a collaborative effort that resulted in the 2017 Minnesota Statewide Health Assessment. People across the state contributed to the development of the statewide health assessment by answering surveys, participating in webinars, and attending Partnership meetings. The Partnership will prepare a statewide framework for action in 2018 in response to the findings of the assessment.

The assessment provides a picture of health and well-being across the state of Minnesota. It reveals:

▪ Who is healthy in Minnesota, 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?

To answer these questions, the 2017 Minnesota Statewide Health Assessment displays selected data on people, opportunity, belonging, and nature to tell the story of health in the state. The assessment describes:

▪ The current status of the things that shape our daily lives, such as our living environments, our access to food, housing, health care, and transportation, our opportunities for a good education and job, and the obstacles that get in the way of these, such as social exclusion and racism
▪ Rates and trends for specific diseases and conditions
▪ The strengths and resources of the state to make Minnesota a healthy place with healthy people

The scope of information in the assessment makes it a useful tool in support of a wide range of efforts to make Minnesota a healthy, thriving place, efforts such as community planning, civic engagement, and policy development. The information in the assessment makes it possible to identify where action is needed and where action can be taken so that everyone in Minnesota can be healthy and thrive.
Looking Ahead: 2018

Healthy Minnesota 2022

Early in 2018 the Partnership will develop a new five-year strategic framework for improving health in Minnesota. Late in 2017, the Partnership reviewed and revised their values and principles and revisited the themes of Healthy Minnesota 2020. These actions set the stage for preparation of Healthy Minnesota 2022.

Strategic Opportunities for 2018

Housing and Health

A large gap exists between the availability and the demand for affordable housing in Minnesota. About 600,000 Minnesotans are currently cost-burdened, which means they pay more than 30 percent of their income for housing.

Affordable housing is a statewide issue as both rural and urban areas face affordable housing shortages. Quality, affordable housing is a foundation for success in many areas, including health. For example, affordable housing:

▪ Supports mental health by limiting stressors related to financial burden and frequent moves
▪ Contributes to more balance in household resources (i.e., ability to purchase food and other necessities)
▪ Allows seniors to age in place
▪ Improves economic conditions by connecting jobs and workers

Information gathered in preparation for the discussion of housing as a strategic issue for the Partnership include:

▪ People in unaffordable housing are more likely to have lower rates of health insurance participation and higher rates of food insecurity.
▪ Among families experiencing food insecurity, children in households without housing subsidies are more likely to have very low weight-for-age compared to children in households receiving subsidies.
▪ Low-income households without housing subsidies are more likely to report having had a person that needed to see a doctor but did not see one for lack of money.
▪ Frequent moves, living in over-crowded environments, eviction and foreclosure can lead to elevated stress levels, depression and hopelessness. Homeless children are more vulnerable to mental health problems, developmental delays, poor cognitive outcomes, and depression.
▪ Among adolescents, moving four or more times before age 16 is associated with early drug use.
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. Housing also relates to the issue of homelessness. An Interagency Council on Homelessness involves multiple state agencies in a statewide plan, including MDH. Partnership members involved in the conversations about housing and homelessness include the Minnesota Housing Finance Agency, MDH, local public health departments, and DHS.

**Early Childhood and Health**

Conversations about early childhood and the narrative work of the Partnership will continue in 2018 and culminate with development of narratives frames on this issue. One session will take place in Duluth and an additional session will take place in the metro area.

**Compiling the Narrative Work of the Partnership**

As the narrative work of the Partnership continues, staff at MDH will be compiling the narrative frames coming out of this work and also will document the process the Partnership took and continues to take to expand public conversations about what creates health and the conditions that people need for health and well-being, all aimed at advancing health equity.
Appendix A: About the Healthy Minnesota Partnership

**Charge:** The Healthy Minnesota Partnership came into being 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/](http://www.health.state.mn.us/healthymnpartnership/)

**Membership:** The efforts of the Healthy Minnesota Partnership focus on the health of the state as a whole, and the membership of the partnership reflects a broad spectrum of interests. As of October 2016, the members of the Healthy Minnesota Partnership included the following:

### 2017 Partnership Members

- Carl Anderson: Boynton Health Services (University of Minnesota)
- Jeanne Ayers: Minnesota Department of Health
- Ken Bence: Minnesota Public Health Association
- Kari Benson: Minnesota Board on Aging
- Barbara Burandt: State Community Health Services Advisory Committee (SCHSAC)
- Rachel Callanan: American Heart Association
- Chris Conroy: TakeAction Minnesota
- Linda Davis-Johnson: Minnesota Department of Human Services
- Julia Dreier: Minnesota Council of Health Plans
- Ed Ehlinger: Minnesota Department of Health
- John R. Finnegan, Jr.: School of Public Health, University of Minnesota
- Thomas Fisher: College of Design, University of Minnesota
- Brett Grant: Voices for Racial Justice
- Sarah Grosshuesch: Local Public Health Association (Greater Minnesota)
- Kelley Heifort: Minnesota Department of Corrections
- Tim Henkel: Minnesota Department of Transportation
- Warren Larson: Sanford Health
- Anjuli Mishra: Council on Asian Pacific Minnesotans
- Vayong Moua: Blue Cross and Blue Shield Center for Prevention
- Gretchen Musicant: Local Public Health Association (Metro)
- Lars Negstad: ISAIAH
- Kami Norland: National Rural Health Resource Center
- Joan Pennington: Minnesota Hospital Association
- Barb Sporlein: Minnesota Housing Finance Agency
- Dave Sukharan: Council on Asian Pacific Minnesotans
- Maria Veronica Svetaz: Hennepin County Medical Center
- Angela Thies: Minnesota Chapter, March of Dimes
- Rosa Tock: Minnesota Council on Latino Affairs
- Donna Zimmerman: Itasca Project
2017 Partnership Alternates

- Ashlyn Christenson: Minnesota Public Health Association
- Justin Bell: American Heart Association
- Lee Buckley: Minnesota Department of Corrections
- Kathleen Call: University of Minnesota School of Public Health
- Amber Dallman: Minnesota Department of Transportation
- Kate Elwell: Boynton Health Services, University of Minnesota
- Mary Hertel: Minnesota Board on Aging
- Samantha Holte: Minnesota Latino Affairs Council
- Stacey Housman: Blue Cross and Blue Shield Center for Prevention
- Alexa Horwart: ISAIAH
- Kristin Loncorich: Minnesota Hospital Association
- Tracy Morton: National Rural Health Resource Center
- Susan Palchick: Local Public Health Association (Metro)
- Katie Topinka: Minnesota Housing Finance Agency
- DeDee Varner: Itasca Project

Staff to the Partnership in 2017

- Dorothy Bliss: Minnesota Department of Health
- Marisol Chiclana-Ayala: Minnesota Department of Health
- Jeannette L. Raymond: Minnesota Department of Health

2017 Narrative Strategy Participants

Healthy Food Access

- Teresa Ambroz
- Susan Bishop
- Rachel Callanan
- Jenna Carter
- Michael Dahl
- Leah Gardner
- Lisa Gemlo
- Cheryl Hills
- Christian Knight
- Steve Kinsella
- Lance Knuckles
- Warren Larson
- Colleen Moriarty
- Vayong Moua
- Joan Pennington
Early Childhood

- Susan Brace-Adkins
- Sasha Brown
- Marilyn Deling
- Rachel Garaghty
- Penny Hillemann
- Helen Jackson Lockett-El
- Sheila Kiscaden
- Ann McCully
- Charlotte McDonald
- Kelly Monson
- Kori Noble
- Melanie Peterson-Hickey
- Sandy Simar
- Rosa Tock
- Cody Tuttle
- Amy Ward
- Coya WhiteHat-Artichoker
- Jeffrey Wigren
- Kelly Wolfe
- Alana Wright

Consultant for the Narrative Strategy

- Dave Mann, Grassroots Policy Project
Appendix B: 2017 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.

The Dominant Narrative on Healthy Food Access

The dominant narrative on healthy food 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 on healthy food includes the following elements:

Healthy food access and the actions of individuals

- No matter what you do, people will make poor choices anyway
- The real problem is that parents are not doing their job
- If people would only demand healthy food, it would increase the supply
- If one person can do it (get access to healthy food), anyone can do it (exceptionalism)
- “You’re in America now; go to Cub [Foods] to shop” (i.e., don’t complain if you can’t find familiar cultural foods)
- Everyone already has access to healthy food
- Eating healthy food is an individual responsibility
- Marketing doesn’t affect me or my food decisions

The qualities or meaning of “healthy” food

- Healthy food is too expensive
- Healthy food doesn’t taste good
- Healthy food is not convenient
- Healthy food is not satisfying, i.e., kids are still hungry because they don’t get enough calories
- Eating healthy = deprivation, sugar = celebration.
- “Poor people deserve to have treats” (a food shelf narrative)

Healthy food and systems/structures

- Government is acting as the nanny state by telling us what to eat
- Schools don’t have the infrastructure to prepare and serve healthy food
- Healthy food offerings (e.g., in schools) create waste—they end up throwing it away (because of the qualities of healthy food and the behavior of people)
- It takes too long to make healthy meals
Healthy food is bad for business
• It is not necessary or important to know how food is grown (food consumption is disconnected from the care of the land)
• The important things about preparing and serving food are convenience and cost (a devaluing of food and cooking as important parts of culture)

Emerging Narrative Frames on Healthy Food Access
Narrative frames provide context and guidance and are 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.

On whom and where should efforts to assure access to healthy food be focused?
A diversity of food cultures and traditions should be embraced and celebrated.
• People are able to recognize healthy food choices through their own food traditions.
• Eating junk food should not be a symbol of assimilation/acceptance.

All people want healthy food; healthy food is not just a trend of the elite.
Food is central to families, communities and cultures. Foods are an expression of love of family, culture and community. We have an opportunity to provide access to foods that nurture health, knit families, and sustain communities.

What is equity in access to healthy food?
People should have access to healthy food no matter where they live.
• Where people live should not determine their access to healthy and affordable food, because healthy food is essential to support the health of everyone in Minnesota.
• Healthy food is not, but should be affordable and accessible to all people and all communities in Minnesota.
• Not all Minnesota communities enjoy the same opportunities that make access to healthy food possible.
• Communities are entitled to fair distribution of healthy food.

No one should be targeted with junk food messages and unhealthy food.
Healthy food is a right; food access must be fair and just.
All people deserve to live with dignity and health. “You are what you eat,” therefore, everyone deserves to have healthy food to eat.
• Everyone deserves ready access to healthy food.
• Access to healthy food is not just about cost; people deserve to have healthy food.
• We all eat healthier when we all can eat healthier.

Health disparities are not inevitable—we can eliminate them by improving access to healthy food.
We need a food access policy and practices that are based in a principle of, “do unto others, what they would want to be done.”

Current access to healthy and affordable food is created by past and current policies that often are driven solely by interests of business. New and revised policies need to account for a broader set of interests, e.g., community development, population health, healthy start for children, opportunity to age in place, etc.

**What is the role of healthy food in a healthy community?**

Healthy food is the foundation of a healthy community. Communities are vibrant and thriving when a healthy food system is in place. Economic vibrancy and healthy food access support each other.

Healthy food is essential for a healthy, productive workforce.

Healthy food is essential for educational success: when we eat better, we feel better, and we think better.

The future of the state (of America) is dependent on a healthy start for all children. Access to healthy and affordable food provides nutrients needed for brain development that can provide the foundation for good health over a whole lifetime. The community has a role to protect children and elderly (no specific frame identified on the elderly).

Healthy food is necessary for each person to reach their full (physical, social, educational, economic—in.e., human) potential.

- The overall food environment in the U.S. is not healthy and affects everyone, regardless of income (i.e., packaged, processed food dominates in every grocery store, even in “natural” food coops).
- The U.S. food industry produces 3800 calories per person per day, but we only need about 1500-2000 calories per day. Marketing promotes overconsumption. Just providing calories without considering nutrition undermines health.

People need to live in communities that have a healthy food system. People need a food environment, culture and systems that support:

- Healthy eating
- Healthy relationships
- Educational success
- Healthy land
- Healthy food norms
- A healthy workforce
- A healthy economy
- Food skills

Communities can be a part of developing innovative solutions to healthy food access that can be sustained over time.

Everyone in the community is healthy when we are healthy together.
What else is needed to assure access to healthy food?

People should not have to “swim upstream” to eat healthy food (i.e., have to make extraordinary effort in order to eat healthy food). People cannot make healthy choices if healthy food is not available or affordable.

The food system involves everything from growth to garbage. Decisions at every point in the food system should encourage access to healthy food for all people and communities (i.e., health in all policies).

Decisions about food access must involve all the people affected by those decisions, including decisions about distribution chains and cost of delivery.

Decisions about access to healthy foods should consider the needs of people as well as the need for businesses to be profitable.

Healthy communities need a basic array of businesses including those that could support basic access to healthy foods.

Policy should support access to foods that enhance the ability of communities to live healthy lives through foods grounded in their culture, families and communities.

Who is responsible for assuring access to healthy food?

We are all responsible for shaping the food system. It is our collective responsibility to create better access to healthy and affordable foods.

Consumers have power to shape the food systems (communities, individuals). Access and demand are inextricably linked.

The long-term costs of easy access to unhealthy foods are too expensive to ignore. Increased access to healthy foods now will reduce health care costs in the future.

Healthy food can be profitable and affordable.