DEPARTMENT OF HEALTH

Healthy Minnesota Partnership

Healthy Minnesota 2022 update

2020 ANNUAL REPORT OF THE HEALTHY MINNESOTA PARTNERSHIP

February 2021

Healthy Minnesota 2022 update: 2020 annual report of the Healthy Minnesota Partnership

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Contents

The 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.

Convened in 2010 by the commissioner of health, we identify and act on strategic opportunities to improve health and well-being for all people in Minnesota. Our members come from rural, suburban and urban communities; from hospitals, health plans and public health departments; from business and government agencies; from faith-based, advocacy, and community organizations; and from organizations led by those most impacted by health inequities. (For more information, see About the Healthy Minnesota Partnership on p. 11.)

Our vision

All people in Minnesota enjoy healthy lives and healthy communities.

Our values

We value… health. We affirm that health, more than being simply the absence of disease, is found in balance, connection and well-being across every aspect of life—physical, mental and social—and across families, communities, cultures, and systems. Health is a resource for living, deserved by all, that calls for the active participation of all.

We value… equity. We assert that every person in Minnesota deserves to have the opportunity to be as healthy as they can be.

We value… inclusion. We welcome everyone to the table to discuss, learn, and prepare for action to improve health in our communities. We welcome and value the wisdom, knowledge, skills, experience, and expertise of all those who are working to create conditions to support health across the state.

We value… difference. We recognize that we are all members of many communities, with great diversity of experience, perspectives, and strengths. We value the differences each person brings to the conversation because those differences make us stronger together than we would be alone.

Our guiding principles

We are explicit about race and racism. We focus on race and racism because racialization multiplies challenges to health.[1] We are intentional in our efforts to reveal the historical and contemporary actions that continue to limit the opportunities people of color and American Indians in Minnesota have to be healthy. Being explicit about race and racism opens the door to a wide range of conversations about structural barriers to health, including those based on gender, sexual orientation, age, and disability.

We lead by doing. While we welcome everyone to the table to discuss what creates health and to shape action for health equity, we also expect that each person will work in partnership with us and with others to expand the narrative about health and to reshape conditions in our communities so that everyone has the opportunity to be healthy. All who participate in our process are expected to bring

[1] Race is a social construct that assigns people to artificial categories based on superficial physical characteristics. Racialization is the assignment of people to those categories; racism discriminates on the basis of those categories.

what they learn to their constituencies and colleagues and to act on this knowledge to advance health equity in Minnesota.

We focus on the policy discussions and decisions that shape opportunities for health. While we recognize that many programs and services are essential for populations that currently experience health disparities, our attention is focused upstream, at the policy level. We work to expand the public conversation about health and to identify policy-level actions needed to improve equity and health across a broad spectrum of issues, from transportation to economic development to education and more. We support efforts to prevent future health disparities and to reshape our communities so that everyone will have the opportunity to be healthy.

We innovate and practice. We work to "build our muscle" to expand public conversations about health and implement a health in all policies approach in our work. We look for new ideas and new areas for conversations about and investments in what creates health. We learn together and look for opportunities to practice what we have learned and to generate change. We share our knowledge, work to strengthen our working relationships, and work to increase the capacity of our communities to shape conditions and increase the opportunity of every person to be healthy.

Healthy Minnesota Partnership: Considerations during the COVID-19 response

The COVID-19 pandemic and the response to it created challenges and opportunities for the Healthy Minnesota Partnership and its ability to advance its strategic approaches. This report documents activities of individual members and the Partnership as a whole. While a lot was accomplished, the challenges faced required adaptations and narrowed activities.

Many of the Partner member organizations were involved in clinical care and public health efforts to prevent the spread of COVID-19 and address health care needs of those who suffered from the virus. Others were involved in ensuring and advocating for system responses to other impacts around incarceration, transportation, employment, food security, housing security, etc.

The Partnership strategic approach to advance an expanded conversation about what creates health was evident in pandemic response activities. While the physical health of people in Minnesota was important, the conditions that create health such as housing, employment, etc. also were recognized as impacting health outcomes and were components of response activities. Partnership members brought their skills and abilities around expanded understanding about what create health to response and recovery activities.

In addition, the focus of the Partnership on systemic racism and the knowledge built on the disparate health outcomes for different populations, prepared members to elevate approaches that addressed these inequities.

The Partnership continued its meeting schedule in 2020—once in-person and three times virtually. The virtual meetings provided an opportunity for those across the state to participate. While a number of new members joined and participated in orientation, the virtual engagement may have made it more difficult for them to build relationships across the Partnership.

As this report indicates, Partnership's activities focused on advancing a health in all policies approach. However, COVID-19 response demands on member and staff time limited effort on further advancing its two addition strategic approaches and this may continue to be a challenge in 2021.

Healthy Minnesota 2022: Statewide Health Improvement Framework

The *Healthy Minnesota 2022* Statewide Health Improvement Framework lists three priorities to guide the Partnership's work to improve health and well-being across Minnesota. These three priorities build on the 2017 statewide health assessment, which uses the themes of opportunity, nature, and belonging as a way to understand health outcomes across Minnesota's populations. The 2022 statewide health improvement framework priorities are:

- Everyone, everywhere has the opportunity to be healthy.
- Places and systems are designed for health and well-being.
- All can participate in the decisions that shape health and well-being.

Within each priority, the Healthy Minnesota Partnership identified indicators that reflect potential opportunities that the Partnership may address over the next five years.

The framework also identified three strategic approaches (described in more detail below):

- Expand conversations about what creates health and well-being
- Shape policies and systems around health and well-being
- Promote and apply asset-focused approaches to advance health and well-being

Healthy Minnesota 2022 priorities, indicators, and strategic approaches

Priorities	Indicators	Strategic approaches
Everyone, everywhere has the opportunity to be healthy	Positive early life experience Economic well-being	Expand conversations about what creates health and well-being Shape policies and systems around health and well-being Promote and apply asset-focused approaches to advance health and well-being
Places and systems are designed for health and well-being	Healthy surroundings Supportive systems	
All can participate in the decisions that shape health and well-being	Just and violence-free communities Engaged populations	

Our framework is a guide for activity rather than a program for a single agency or organization to implement. It does not spell out action to take on specific diseases or conditions, but works to expand understanding and encourage activity across systems to make a difference in lifelong health for all people in Minnesota.

Partnership strategic approaches

Expand conversations about what creates health and well-being

"Public narratives" are a particular kind of story that shape thinking and action for groups of people (communities or societies). They are not stories in the sense of having a protagonist, hero, or even a

plot. They are broad-based images and ideas, based in shared values: that is, they express what is important to a larger group. They are often rooted in a shared history—or at least a shared understanding of history. Public narratives shape group decisions, such as the development of policies that guide a wide range of actions. Public narratives shape what actions are possible for improving population health.

Current public narratives that dominate policy conversations around health emphasize that health is created by clinical care and individual responsibility. For example, obesity is often viewed as an individual responsibility caused bad choices—this narrative or story underpins health education programs that teach people how to make healthy food choices. An expanded conversation or emerging narrative might include consideration of food distribution systems, transportation, ability to afford healthy food—all things that create the conditions that shape people's health and well-being.

The Partnership works to expand the conversations to draw attention to the conditions in the community that create and shape people's health and well-being.

Narratives that dominate the public sphere—the ones that are familiar and are repeated the most often—have more power than other ways of thinking. We recognize that to advance a different set of actions and produce a different set of results requires recognizing and unmasking the narratives that dominate thinking and policy decisions. It requires advancing a narrative—expanding a conversation—that will yield a fuller set of ideas, also rooted in shared values, to improve health for all. In other words, narratives frame solutions, and current narratives that emphasize health care and individual responsibility miss the enormous impact of social conditions on health. We need to expand the narratives about health so that solutions that will have the most impact—those targeting social conditions—will be part of the conversation about solutions.

The Partnership works consistently to expand the conversation about health by demonstrating the intersection of health with income, transportation, paid leave, access to healthy food, incarceration, early childhood, housing, and more.

Shape policies and systems around health and well-being

The work of the Partnership focuses on policies and systems—economic, social, educational, and more—that form the conditions for health. The design of these policies and systems determines both their effect on health and well-being and who does and who does not enjoy their intended benefits.

Policies are both **public**, such as laws and statutes that determine where priorities lie, where resources are spent, and what actions are taken, and **private**, such as corporate policies that determine where jobs are created, hiring practices and benefits offered. Policies can also take the shape of general guides to action, such as "every child will succeed in our school" or "we are a welcoming community."

Systems include large, formally organized bureaucracies such as the educational system or the transportation system, or loosely structured networks such as family systems or informal communications systems.

Promote and apply asset-focused approaches to advance health and well-being

An asset-focused approach to improving health and advancing health moves away from "fixing problems" based in an individual, deficit-oriented approach that reinforces negative stereotypes and contributes to ongoing inequities and traumatization.

The Partnership has not fully defined or implemented this strategic approach.

The elements of a potential approach were outlined for consideration by the Healthy Minnesota Partnership at its December 2019 meeting. Please find this attached in appendix A at the end of this report. The elements include included:

- Expand the narrative about health away from an individual focus to examine communities and systems
- Tell the truth about population-based inequities
- Work to create a common base of community-level evidence and data on well-being

2020 progress on *Healthy Minnesota 2022*

Ways in which Partnership members worked to expand the conversation about health in 2019:

The Partnership focus on expanding the conversation about what creates health has been a central part of its work since 2011. While the Partnership did not do a lot of new narrative development during 2020, the past foundation served the policy and systems and COVID-19 efforts.

- The Local Public Health Association featured the narrative strategic approach their annual legislative advocacy day. They practiced grounding their legislative initiatives in shared values in order to build support.
- An MHealth Fairview community advancement team received training on advancing assets-based narratives. They are applying insights gained in their work.
- The Healthy Minnesota Partnership narratives related to policies issues (housing, minimum wage, etc.) informed a Department of Human Services report on the health of people in deep poverty.
- Partnership members participated in an Association of State and Territorial Health Offices efforts to develop a voting and health narrative. See more information below in the work plan activities section of this report.
- The 2017 statewide health assessment frames—opportunity, belonging and nature—were used to advance healthy aging efforts in Northern MN.

Ways in which Partnership members shaped plans, policies, and systems for health in 2020:

During 2020, the Partnership turned more attention to this strategy. The murder of George Floyd in Minneapolis brought many partner organizations into public and organizational support of systems and policy changes to advance racial equity.

Most partners were part of the multi-sectoral efforts to address the spread of COVID-19 virus and the extensive impacts on the well-being of people in Minnesota including social, economic, educational, mental, etc. Partnership members recognized the disproportional impact of COVID-19 on communities most impacted by social and economic inequities. The Partnership's narrative work provided members ways to frame and address these inequities.

The following section highlights some of the actions of individual partnership member organizations shaped plans, policies, and systems.

Addressing systemic racism

- Multiple Partnership members either issued policy statements or statements of support for addressing racism as a public health crisis. For example: HealthPartners has signed a letter of support to the City of Bloomington that Racism is a Public Health Crisis. Itasca Project has a Regional Indicator Dashboard—a set of shared metrics that tracks the region's change on critical economic, environmental, and social outcomes. The ITASCA dashboard shares comparisons between white populations and populations of color.
- Local Public Health Association members worked in their own jurisdictions as policy statements on Racism as Public Health Emergency/Crisis were proposed and adopted. While each differed slightly, these statements elevated systems and policy changes along with accountability mechanisms.
- The Minnesota Public Health Association (MPHA) approved a racism is a public health crisis statement. MPHA also adopted a statement on Ancestral Lands and now uses this in for all the organizations gatherings.
- The Minnesota Department of Human Services (DHS) has an internal START group (anti-racism team). The goal of this work is to create a cultural shift where the new anti-racism norms of operations are adopted. Currently, the DHS performance review of upper management embeds diversity, equity and inclusion.
- UCare, an independent, nonprofit health plan, is focusing some Diversity, Equity, and Inclusion work on the employee level. They recently conducted a racial equity assessment in clinical settings.
- MHealth Fairview, a nonprofit, integrated health system, launched the HOPE (Healing, Opportunity, People, Equity) Commission to advance health equity and diversity, equity, and inclusion through MHealth Fairview's key roles as an employer, health care provider, academic institution, corporate institution. This process has included listening and learning sessions with staff. One common theme among employees was that policy shifts need to happen if the organization is to become anti-racist.
- Experience during the pandemic has created a demand from critical access hospitals for information and resources so that they can better meet the needs of racially and culturally diverse populations. National Rural Health Resource Center staff connected with Partnership staff to identify content and potential presenters for a Minnesota-specific session.
- The City of Minneapolis Health Department is making changes in its approaches to public safety. It has built up programs to work on violence as a public health issue. Its Office of Violence Prevention is implementing an international model where people in the community are violence interrupters. The violence interrupters who are drawn from the community are trained to address issues before they become matters for the police.
- HealthPartners has written a letter to legislators advocating for legislation to end police brutality and create more accountability.
- The Council on Asian Pacific Minnesotans is partnering with University of Minnesota Family Social Sciences to analyze data on refugee communities during COVID-19. The organization is also conducting a survey of API priorities on policy and health care access.

Systems changes related to COVID-19

- The University of Minnesota School of Public Health worked with the Minnesota Alliances of Community Health Workers to expand their work on racial and health equity. Community Health Workers conduct care navigation and management and but do not receive reimbursement for that work. This has become problematic in the time of COVID-19 as this is important for communities who have distrust of health care systems. Together they are identifying possible systems and policy changes to advance.
- The National Rural Health Resource Center has convened a National Rural Health Information Technology (HIT) Coalition since 2006. The Coalition for many years has been discussing access to broadband and rural adoption and utilization of telehealth. During the pandemic, utilization of and payment for telehealth services increased. Hopefully a silver lining from the pandemic will be the continued utilization (and payment) of telehealth to improve access to health care in rural areas after COVID-19. The majority of rural areas are health professional shortage areas, particularly for mental health providers. Telehealth can be an excellent bridge to care and address key conditions for health like transportation.
- The Minnesota Department of Corrections was able to use existing policies on early release to reduce the population of incarcerated people.

Other policy and systems change

- The health care provider for the University of Minnesota community of students, Boynton Health Services, worked with university provosts on supporting students with mental health needs. They encouraged staff, faculty and students to focus on self-care over productivity as a way of supporting the community.
- The State Community Health Services Advisory Committee (SCHSAC) has a focus on children of incarcerated parents. Sherburne County is working to enhance visitation for children to see incarcerated parents and make visitation for children more child friendly. A presentation for rural counties was developed to share how parental incarceration adversely impacts children.

Ways in which Partnership members applied an asset-focused approach to health equity in 2020 include:

- A member from the Minnesota Board on Aging facilitates a community healthy-aging committee with Fairview Range part of a nonprofit, integrated health system in North Eastern Minnesota. They created a logic model for integrating agency and community programs with clinical services, an asset-based approach, to achieve healthy aging outcomes. It is a “with us” vs a “for us” approach with older adults.
- The University of Minnesota College of Design leads co-design processes where customers work with services providers to design appropriate services. These have been shared with medical and public health partners. They stress the benefits of community and the importance of compensating and integrating community members in service design processes.
- The National Rural Health Resource Center met with a senator in Duluth as part of rural health workforce expert panel and roundtable discussion. They discussed some of the assets that rural America uses and how legislators can be more of an asset by influencing legislation that would advance equitable care provision.

- A Partnership member representing the MDH Eliminating Health Disparities Grantees shared Minnesota Community Care's recent needs and assets assessment which identified how social connection and factors contribute to health and health outcomes.

2020 Partnership work plan activities

In 2020, the Partnership developed and implemented a work plan to advance the Healthy Minnesota framework and strategic approach. After its February meeting, all activities of the Partnership were conducted virtually due to the COVID-19 pandemic.

Shape policies and systems around health and well being

The Partnership increased its capacity to recognize opportunities to and actually shape policies around health and well-being. It looked at both organizational policies and public policies.

Equity policy reviews

Members of the Partnership were introduced to a policy review tool at the February meeting and in a special virtual session held in September. The Department of Transportation held a special session for a staff team.

At the October meeting, the Co-Chair asked all members to conduct an equity policy review. A number of partnership members did this and reported back at the December meeting. More have made the commitment to do this in 2021.

- The Minnesota Department of Corrections Policy Coordinator said she will never look at the policies the same way again. It was very impactful and generated a thoughtful conversation about things not said before when drafting language. They quickly recognized that the people impacted by the policy are rarely, if ever, included in the policy development.
- A group in the Minneapolis Health Department conducted a review of a telework policy at the city of Minneapolis. This opened the reviewers to think more broadly about accessibility and the impact of the pandemic. The next step will be to consider how this kind of review will actually lead to policy change.
- HealthPartners convened a workgroup and used the policy review tool and another resource from Voices for Racial Justice. One policy reviewed was a professional attitude policy. The review led to them wondering if this policy was actually needed and for whom it was serving. They intend to create a policy review tool that anyone at HealthPartners can use.

Racism as a public health crisis/emergency

Members of the Partnership were provided a background on definitions of public health crisis, emergencies and issues. In addition to identifying systemic racism as a root cause of health outcomes, these statements include commitments to action. Actions include: educating staff; sharing data; increasing workforce diversity; changing practices, policies and procedures; intentionally allocating resources; strengthening community partnerships; and actively advocating for change. Some established accountability measures by requiring progress reports.

Many members' organizations supported or adopted resolutions as noted above.

2020/21 policy framework

At the June and October meetings, the Partnership considered the questions: ***What policies, had they been in place, might have reduced the impact of the COVID -19 pandemic? Or supported community resiliency?***

A small group was assigned to set prioritization criteria and explore and narrow the suggested policy areas. This group identified six policy areas that the Partnership narrowed to three headline policies at its December meeting.

A policy framework was then established from the three headline policies:

- Paid family & medical leave
- Universal access to broadband internet
- Housing stability

This policy framework will provide an opportunity for Partnership member organizations to support more specific public policy proposals or consider how to apply these within their own organization.

Expand conversations about what creates health and well-being

The Healthy Minnesota Partnership has worked for a number of years to "expand the conversation about what creates health" through a focus on developing and applying a series of public narratives that connect health to a range of conditions and actions.

In 2019, the Partnership published web pages that contained its series of public narratives and tools for expanding conversations. These web pages got hundreds of hits as others accessed the tools to advance their own efforts.

Voting and health transformation narrative

Members of the Partnership participated in a ASTHO VoteSAFE Public Health developed a transformational public narrative about the connection between voting and health.

In October, the Partnership considered these narrative frames and their potential uses in advance of the 2020 election.

Conducted narrative training

Partnership materials and approaches were shared in a number of presentations and trainings.

- Introductory presentation to MDH Leadership Group
- For the Local Public Health Association Day on the Hill to support members effectiveness in communicating their legislative priorities.
- A virtual presentation to the MPHA Health Equity committee. This used the voting and health narrative frames as an example of expanding the conversation about health.
- A training session for a national Collective Impact Conference focused on using narrative as a strategy to increase collective impact efforts,

Applying an asset-focused approach to health equity

Chakita Lewis, an intern working with the Healthy Minnesota Partnership, investigated ways that the presentation of public health data can support and affirm and not retraumatize communities. Often

communities most impacted by health inequities are described by their deficits in health outcomes, behaviors or opportunities.

Results from the research were shared at a forum sponsored by the Hamline Center for Justice and Law on Community Health, Research, and Trauma: Perspectives from Young Black Scholars. Ms. Lewis also shared results with the Region V Public Health Training Center and will be sharing findings with the Partnership to inform the next iteration of the statewide health assessment.

Looking ahead: 2021

Strategic opportunities for 2021

In 2021, the Partnership will continue its work by deepening and sharing its three adopted strategic approaches. It will also prepare to shape the development of the next statewide health assessment.

- Continue to develop capacity among Partners and others to apply narrative frames to specific policies, programs and procedures
  - Hold a narrative training for new Partnership members
- Inform and shape policies through an equity lens
  - Increase Partnership member ability to review institutional policies with an equity lens. Two additional Partnership Members are conducting the Policy Review training for their staff.
  - Support partner organizations to advance the 2020/21 policy framework adopted in Dec. 2020
    - Partnership member organizations will use the policy to look for more specific policy proposals they can support
    - Partnership members organizations can invite others to support their policy efforts
- Increase Partnership members understanding of asset-based approaches
  - Compile existing practices on collecting and sharing public health data that elevates assets and considers a trauma informed approach
  - Ensure these practices inform the development of the next iteration of the statewide health assessment
- Prepare for the statewide health assessment
  - At a Partnership Meeting Marleny Huerta-Apanco, student at school of public health, spoke about how her interest in attending the Partnership meeting stemmed from reading through the 2015 statewide health assessment. She stated that that in her review of the assessment her and her peers thought that the assessment needed to be more asset-based

    This will be one of a series of topics that the Partnership will consider as it prepares to direct the development of the next statewide health assessment. Other topics could include:
    - How assessments can reflect the impact of systemic racism on health
    - How to include policy environment indicators—such as percent of workers covered by paid leave policies
    - How to include COVID-19 and related data

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: 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. During 2020, the members and alternates of the Healthy Minnesota Partnership included:

Partnership members and alternates during 2020

Justin Bell, American Heart Association
Ken Bence, Minnesota Public Health Association
Barbara Burandt, State Community Health Services Advisory Committee (SCHSAC)
Deb Burns, Minnesota Department of Health
Anne Bussey, Minnesota Board on Aging
Kathleen Call, University of Minnesota School of Public Health
Cindi Callstrom, Minnesota Public Health Association
Anjuli Camerson, Council on Asian Pacific Minnesotans
Jenna Carter, The Center for Prevention at Blue Cross and Blue Shield of Minnesota
Foua Choa Khang, Eliminating Health Disparities grantee
Meghan Colman, Minnesota Board on Aging
Amber Dallman, Minnesota Department of Transportation
Linda Davis-Johnson, Minnesota Department of Human Services
Christen Donley, Minnesota Department of Corrections
Julia Dreier, Minnesota Council of Health Plans
Kate Elwell, University of Minnesota Boynton Health Services
John R. Finnegan, Jr., University of Minnesota School of Public Health
Thomas Fisher, University of Minnesota College of Design
Brett Grant, Voices for Racial Justice
Sarah Grosshuesch, Local Public Health Association (Greater Minnesota)
Kenza Hadj-Moussa, TakeAction Minnesota
Annie Hallard, Minnesota Public Health Association
Kelley Heifort, Minnesota Department of Corrections
Mary Hertel, Minnesota Board on Aging
Pam Houg, Minnesota Council of Health Plans
Aaron Johnson, Eliminating Health Disparities grantee
Dan Kitzberger, Minnesota Housing Finance Agency
Warren Larson, Sanford Health
Jan Malcolm, Minnesota Department of Health
Tracy Morton, National Rural Health Resource Center
Vayong Moua, The Center for Prevention at Blue Cross and Blue Shield of Minnesota
Gretchen Musicant, Local Public Health Association (Metro)
Lars Negstad, ISAIAH
Kim Nordin, National Rural Health Resource Center
Susan Palchick, Local Public Health Association (Metro)
Joan Pennington, Minnesota Hospital Association

Sarah Sanchez, American Heart Association
Rosa Tock, Minnesota Council on Latino Affairs
Nissa Tupper, Minnesota Department of Transportation
Kateri Tuttle, Eliminating Health Disparities grantee
DeDee Varner, Itasca Project
Donna Zimmerman, Itasca Project

Staff to the Partnership in 2020

Jeannette L. Raymond, Minnesota Department of Health
Shor Salkas, Minnesota Department of Health
Chakita Lewis, Intern, Minnesota Department of Health

Guests at 2020 Partnership meetings

Angela Schoffelman
Anna Lynn
Awol Windissa
Bridget Pouladian
Carrie McLachlan
Claire Neely
Derrick Fritz
Greg Brolsma
Jamie Bachaus
Jodi Gertken
Karah Lodge
Kimberly Johnson
Lyndsey Reece
Maria Regan Gonzalez
Marnie Falk
Megan Tong
Monisha Richard
Ora Hokes
Paige Risdal
Phits Nantharath
Robert Heider
Terri Greenberg
Trisha Reinwald
Ani Koch
Ashley Rosival
Bill Adams
Canan Karatekin
Cindy Kallstrom
Denise McCabe
Gary Sprynczbdatyk
Jacki Trelawny
Joan Brandt
Josh Ney
Kateri Tuttle
Kris Igo
Mandy Schmidt
Marisol Chiclana- Ayala
Maureen Collopy
Mohamed Hassan
Nicole Sowers
Paige Bowen
Pam Willow
Pleasant Radford
Stephanie Thomas
Tracy Pederson
Yolanda Roth

Appendix A: Using asset-focused approaches

HANDOUT FROM THE DECEMBER 2019 HEALTHY MINNESOTA PARTNERSHIP MEETING

Challenges

- Marginalized populations most often are described in terms of individual-level deficits, reinforcing stereotypes and contributing to ongoing inequities and traumatization.
- Legislatures (and other funders) tend to allocate resources to "fix" problems, reinforcing the deficit frame for describing health issues.
- The dominant narrative of individualism—and many data sources—keeps attention focused on the problems and needs (i.e., deficits) of individuals. Some efforts to switch to a "resilience" frame look at the positive attributes of individuals, but by doing so keep the attention on individuals instead of communities and systems. This creates the risk of what one author has called "relentless positivity."[2]

Some things we can do

1. Expand the narrative about health away from an individual focus to examine communities and systems.

The Healthy Minnesota Partnership narrative, which defines health as "being in safe, stable, and nurturing environments and relationships, sharing in the shaping of society's structures, and experiencing with our families and communities our best possible physical, mental and social well-being," and which asks, "How is health created?" is an asset-focused narrative. This provides some direction for the Partnership to use asset-focused and asset-based strategies for health.

Using the Healthy Minnesota emerging narrative:

Health is created by individuals of all races and communities—American Indian, African American, and people of Hispanic/Latino/Latina/Latinx, Asian, Pacific Islander, Middle Eastern, African and European descent—working together.

Are we working together? Who works together well? How can we expand that? What do we need to engage in collective action that will improve health for all? What works? What resources and strengths do communities have that can be harnessed for health?

Health is created by the economic, social and environmental conditions of our lives, shaped by historical and social forces, including racism, classism, and sexism, and by the personal behavior which is influenced by these conditions.

[2] The opposite of deficit-based language isn't asset-based language. it's truth-telling. Shelterforce. https://shelterforce.org/2019/11/12/the-opposite-of-deficit-based-language-isnt-asset-based-language-its-truth-telling/

Name the conditions that are shaping our health as communities, families, and individuals. Recognize the historical actions that have created these conditions. Identify a different set of conditions and work to create those.

People and communities, no matter what their race or circumstances, know intuitively what is important for their health, even if this is not consciously stated or clearly evident in the choices they are able to make.

Consider community wisdom and engage the community to determine what conditions are needed and how to collectively shape those conditions.

2. Tell the truth about the sources of population-based inequities.

Instead of individual problems, name systemic problems, structural racism, historical trauma, and then shift to talking about what communities need to create conditions that promote, protect, affirm, and maintain health.

Using the Healthy Minnesota emerging narrative:

Health today is influenced by events, decisions, and experiences of the past: these include the historical trauma and structures of racism put in place by genocide, slavery, internment and other oppressions. The events and decisions of today will influence our health in the future.

- Since no community is exempt from these forces, take time to identify the structural inequities and historical forces that have shaped health in the community. Be explicit about naming these. Work together to build capacity to talk about race, racism, and to expose and acknowledge the impact racism has had and continues to have on the whole community.
- Focus on working collectively to change policies, systems and structures in positive ways to shape community conditions for health that will benefit all.

3. Work to create a common based of community-level evidence and data on well-being

One of the greatest challenges to the asset-based approach is the almost exclusive reliance of public health (and others) on individual-level data sources, which are often deficit focused, (e.g., rates of disease and injury, violence, and drug and alcohol use, morbidity, and mortality). The measurement of disparities and inequities, likewise, necessarily points out gaps and deficiencies.

The challenge for asset-based approaches is not the theoretical foundation—this is well established. What is missing is a shared framework of indicators for measuring and evaluating the effectiveness of asset-based approaches.

Examples:

- **Wilder Foundation**, recognizing that quantitative data may not be available and that available indicators may not be useful for measuring assets and resilience, has developed a qualitative approach to use in situations where quantitative data either is not available or may not be the best way to analyze the situation. [3]

[3] Minnesota Compass, *Community-led solutions: Building evidence that counts.* September 2018. https://www.mncompass.org/trends/insights/2018-09-26-community-led-solutions

- The **Glasgow Centre for Population Health** has explored several methods for identifying and mobilizing assets and has a number of publications detailing this information. [4] For example, methods that can be used to identify assets include asset mapping, participatory appraisal, and appreciative inquiry (including storytelling, world café, and open space technology). Methods that can be used to mobilize assets include asset-based community development, time banking, co-production, social prescribing, and participatory budgeting.

  The Centre notes that measurement and evaluation of these efforts is important, and yet presents a variety of challenges, not least of which is the "considerable interconnectivity and complexity inherent in systems like neighborhoods and communities." While the theoretical and primary research evidence are well established, questions remain about how to generate evidence of the impact and effectiveness of these approaches. [5]

Other efforts to take an asset-focused approach includes emphases on attachment, relationships, neighbors, neighborhoods and community resilience, [6] and belonging. [7] Others affirm faith and cultural traditions, spirituality, rituals and relationships. Some examine cultural assets and various types of social capital, [8] or take an on-the-ground approach based in real-life experience. [9]

Overall, the application of asset-based approaches to improve population health has strong theoretical and research support, while the field continues to struggle to establish widespread, reliable forms of measurement and evaluation.

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[4] Glasgow Centre for Population Health. Asset-based approaches website, retrieved 11-25-19: https://www.gcph.co.uk/resilience_and_empowerment/asset_based_approaches

[5] *Putting asset-based approaches into practice: identification, mobilization and measurement of assets*, https://www.gcph.co.uk/publications/362_concepts_series_10-putting_asset_based_approaches_into_practice

[6] *Resilience 101*. Shelterforce. https://shelterforce.org/2019/05/13/resilience-101/

[7] Minnesota's 2017 Statewide Health Assessment identifies factors important for health, such as belonging. https://www.health.state.mn.us/communities/practice/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf

[8] Yosso, T., *Whose culture has capital? A critical race theory discussion of community cultural wealth.* https://www.tandfonline.com/doi/abs/10.1080/1361332052000341006

[9] *New Orleans brings a holistic focus to resilience.* Shelterforce. https://shelterforce.org/2019/05/13/nola-brings-a-holistic-focus-to-resilience/

Appendix B: Transformative narratives about voting and health

These narratives were developed under the auspices of the ASTHO VoteSAFE project. It is committed to promoting healthy communities and advancing health equity by assuring safe voting and participation in the electoral process is available to everyone. For more information on VoteSAFE go to https://www.astho.org/votesafepublichealth/

All people are deserving of dignity, respect, and social inclusion, which is affirmed by access to voting. Everyone's vote is equal. We must ensure everyone has what they need to vote by removing barriers to voting, meeting people's basic needs, and providing accommodations for those who need them. We must learn from our history of disenfranchisement, repair our mistakes, and build uncompromisingly inclusive systems.

When we all vote, our government truly reflects who we are and what we want. Voting unites us in common purpose and elections determine who we want to be as a community and as a country. Elections reflect our values and beliefs, and the policy choices we prioritize.

Voting helps us care for our family, our community, and one another. It is a form of radical openness: to others, to different opinions, to our future, and to hope.

Through voting, we improve our individual and collective health. Civic, political, and social involvement builds social cohesion and improves our individual health. Everything we vote on—housing, education, climate, jobs, healthcare—ties back to our physical and mental health and the well-being of our communities. Voting also ensures the health of our society and our democracy. Voting, therefore, is a means to ensuring our right to health.

Voting is a path to our collective liberation, to creating a world in which everyone can thrive. Voting is one way to lift up our voices and build political power across race, class, and other dimensions of identity to make the structural changes we need to end inequities.

By voting, we shape our future together. Through our individual agency and collective power, we can solve problems and shape the conditions that affect the health and well-being of our families and communities. We can claim our democracy and our government for the common good through voting and sustained civic engagement.