

# CULTIVATING A HEALTH EQUITY ECOSYSTEM



*Lessons  
Learned from  
the Eliminating  
Health Disparities  
Initiative*

*We put our programming in the hands of our community health workers. All our community health workers are from the communities in which they work. So they know and intimately understand the populations that we're trying to adapt these programs for or create these programs for.*

EHDI GRANTEE



# TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY</b> .....	2
<b>THE EHDl STORY</b> .....	6
The EHDl Approach .....	7
The EHDl Investment .....	10
<b>THE EHDl IMPACT</b> .....	12
Outcomes Across Grantees Organizations .....	13
Outcomes by Priority Health Areas Lessons Learned .....	14
Lessons Learned .....	18
Has Investment in EHDl Eliminated Health Disparities? .....	22
<b>CULTIVATING A HEALTH EQUITY ECOSYSTEM</b> .....	28
Core Components.....	28
One Part of a Disconnected Ecosystem .....	29
Looking Within: Examining Our Role within the Ecosystem .....	30
What is Your Role? .....	34
<b>CLOSING</b> .....	38
Recommendations for Additional Resources .....	38
Acknowledgments .....	39
Citation References.....	40

## ABOUT THIS REPORT

The year 2021 marks the 20th anniversary of the creation of the Eliminating Health Disparities Initiative (EHDl) grant program. As we approach two decades of EHDl, this report reflects back on our state's investment in these grants and its impact over the years. We also look ahead at what future investments are needed in order to strengthen Minnesota's ecosystem to advance health equity for all.

This report was written by the Minnesota Department of Health (MDH) Center for Health Equity in partnership with staff from Rainbow Research and the University of Minnesota Healthy Youth Development Prevention Research Center. A special thank you goes out to all of the EHDl grantees throughout the years for your commitment to advance equity in our communities and for teaching MDH important lessons about how we can better support your work.

A photograph of a man with a beard lifting a child into the air. Both are laughing joyfully. The man is wearing a green t-shirt and a brown belt. The child is wearing a blue jacket. The background is blurred with warm, golden light. The text 'EXECUTIVE SUMMARY' is overlaid in white, bold, sans-serif font in the center of the image.

# EXECUTIVE SUMMARY

## *The EHDI Story and Impact*

The Eliminating Health Disparities Initiative (EHDI) is a grant program within the Minnesota Department of Health's (MDH) Center for Health Equity. EHDI invests about \$5 million annually in community initiatives that address health inequities for populations of color and American Indian communities across eight priority health areas in Minnesota. The Minnesota State Legislature established EHDI in 2001 to address the growing health disparities in our state.

Over the years, the **EHDI approach has been to support organizations and projects that are developed and implemented by and for communities of color and American Indian communities**, based on cultural knowledge, wisdom, and community strengths. Investing in community-driven organizations and tribes increases access to, engagement with, and impact of health improvement strategies for communities of color and American Indian communities.

MDH and the Center for Health Equity (the center) have learned valuable lessons from our grantees over nearly two decades. This report is intended to both share the remarkable impact EHDI grantees continue to demonstrate as well as shed light on the immense work remaining to be done to truly eliminate health disparities.

**The impact of EHDI has been powerful and measurable.** As this report will show, grantees have succeeded in many areas:

- | Adapting or creating programs tailored to their communities' values and situations;
- | Increasing access to prevention and care among communities that conventional public health programs have failed;
- | Effecting change at individual, institutional, and systems levels.

Milestones toward disparities reduction include grantees' increased capacity and enhanced skills; grantees' increased effectiveness; increased connection, strength, and amplification of grantees' efforts across Minnesota; and improved outcomes in priority health areas. **The most recent grantee cohort (2016-2019) reached 409,607<sup>1</sup> people of color and American Indians** – 88,774 directly and 320,833 indirectly – with culturally appropriate preventive services and education across eight priority health areas.

**The breadth and depth of this work is made possible through the wisdom of communities most impacted by health inequities,** as articulated and put into practice by EHDI grantees. Some of the **lessons we have learned from our grantees** over the years include:

- | Organizations that reflect the communities most impacted by inequities are better equipped to understand and respond to community experiences.
- | Investing in community-driven solutions means recognizing that communities themselves possess the best approaches, practices, and language to suit their communities, and know the most appropriate measures of their success.
- | Effective strategies are those that are grounded in cultural knowledge and wisdom and that understand the intergenerational effects of collective oppression.

Despite clear and quantifiable successes, however, **the gap in overall health and wellness between white Minnesotans and Minnesota's communities of color and American Indian communities persists.** EHDI is a critically important and effective program for identifying community driven solutions to health disparities that could improve population level outcomes if taken to scale. It is also a single \$5.142 million annual grant program – whose funding is ever-shrinking relative to the growing populations that it serves. Its footprint alone is insufficient to reverse the effects of generations of structural and institutional racism that have shaped, and continue to shape, the systems and conditions that create health. Consider for a moment the \$5 million investment compared to the estimated \$2.26 billion that health disparities cost Minnesotans each year.<sup>2</sup> We must do more.

# Cultivating a Health Equity Ecosystem

MDH — and specifically the Center for Health Equity — supplements and supports EHDI grants through a broader approach to address health equity at a systems level. This strategy is rooted in the belief that effectively addressing health disparities and improving health for all Minnesotans requires a holistic approach — one that recognizes the role that all organizations and systems that impact individual and community health play in eliminating structural inequities. This report describes the center’s holistic approach — and all of our roles within it — using the metaphor of ecosystems.

**We encourage our partners and everyone invested in eliminating health disparities in Minnesota to use this report and take three actions:**

**ASSESS  
YOUR ROLE**  
in the health equity  
ecosystem

**INVEST**  
more significantly  
in community-driven  
solutions

**SHARE**  
this narrative about  
what is needed to  
achieve health equity  
in Minnesota

This report is one in a series of reports that will be released in the coming years as we approach 20 years of EHDI. Future reports will further explore how EHDI grantees have been able to eliminate disparities within their spheres of influence as well as take a closer look at trends across disparities data over the past two decades.





# THE EHDI STORY





## *The EHDI Approach*

Prior to the Eliminating Health Disparities Initiative (EHDI), communities of color and American Indian communities knew that despite the impressive average health of Minnesotans, traditional public health approaches and grant programs were neither effectively reaching their communities nor equipped to address the social and economic conditions that have created significant racial disparities in health. They knew this through both lived experience and population health data disaggregated by race. As a result of strong community advocacy in partnership with MDH, the State of Minnesota passed Minn. Stat. §145.928 to create the Eliminating Health Disparities Initiative in 2001.

This landmark legislation served as recognition that conventional approaches to public health were not necessarily effective for groups who have been historically and continuously excluded from health systems and nonprofit programs, and harmed by discriminatory government policies. EHDI was one of the first programs nationally to purposefully invest resources in community-driven solutions. The law allocated \$5.142 million dollars annually for grants and capacity building for community-driven organizations and tribes to close the gap in the health status between whites and populations of color and American Indian communities in eight priority health areas.

Today, EHDI continues to provide \$5.142 million annually to organizations and tribes to address health disparities in the following health areas: 1) breast and cervical cancer screening, 2) diabetes, 3) heart disease and stroke, 4) HIV/AIDS and sexually-transmitted infections, 5) immunizations for adults and children, 6) infant mortality, 7) teen pregnancy, and 8) unintentional injury and violence. Grantees use a variety of strategies, including promising strategies based on practice-based evidence — evidence developed over time through the experience of communities practicing healing grounded in their cultures — as well as research-based or evidence-based strategies.

Regardless of the type of strategy, all EHDI projects must be grounded in community knowledge and wisdom.

EHDI funding is meant to be flexible and responsive to community needs and values. A key recommendation that emerged from a 2015 EHDI community input process, which influenced the most recent grant cycle, was that the EHDI program should allow grantees to expand beyond providing programs that target individual-level changes (such as awareness, knowledge, behavior, or skill) to focus on broader structural changes — such as policies, systems, or environments — that address the root causes of inequities. This recommendation is consistent with the MDH’s philosophy that we must work at multiple levels of change, including addressing the social and economic conditions for health, to ultimately achieve health equity.

MDH and the Center for Health Equity have learned valuable lessons from our grantees over nearly two decades. This report is intended to both share the remarkable impact EHDI grantees continue to demonstrate as well as shed light on the immense work remaining to be done to truly eliminate health disparities.

***We must work at multiple levels of change, including addressing the social and economic conditions for health, to ultimately achieve health equity.***



*Today, EHDI continues to provide \$5.142 million annually to organizations and tribes to address health disparities in the following health areas:*



Breast and cervical cancer screening



Immunizations for adults and children



Diabetes



Infant mortality



Heart disease and stroke



Teen pregnancy



HIV/AIDS and sexually-transmitted infections



Unintentional injury and violence<sup>3</sup>

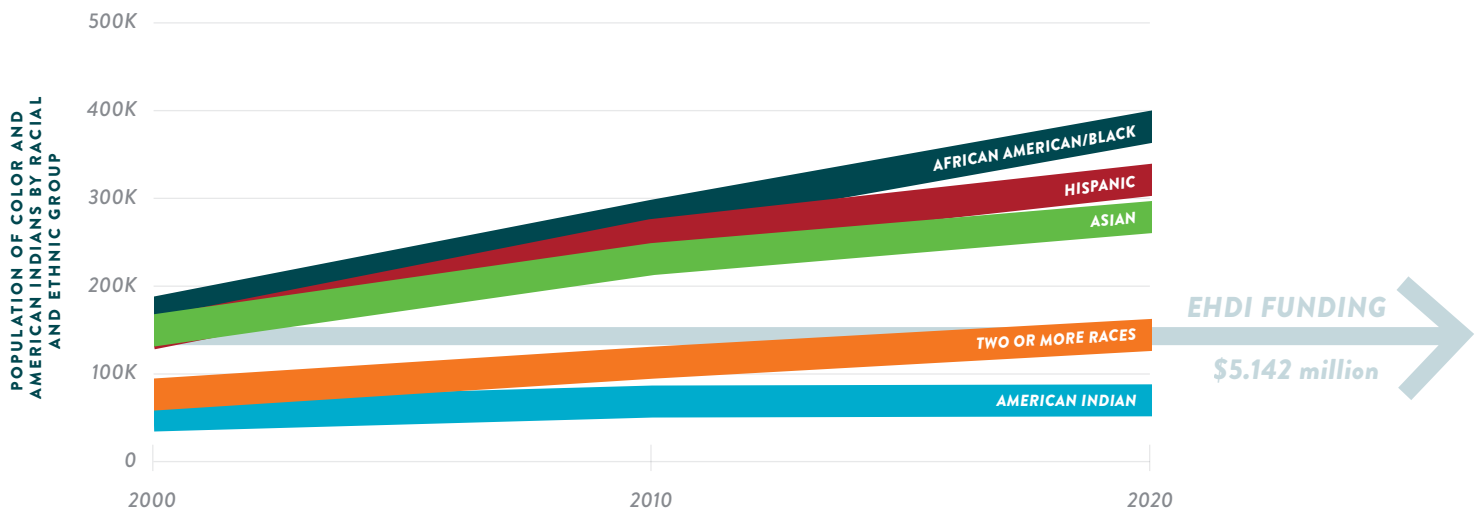
# The EHDI Investment

EHDI funds have been distributed to five cohorts of organizations and tribes since the program’s inception in 2001. Each cohort was selected through a competitive process consisting of the review of submissions to a request for proposals (RFP). During the first RFP process, 167 proposals were received, requesting a total of \$39,600,000 in funding – nearly seven times the amount of funds available at that time. In the most recent RFP, 130 applicants requested a total of \$27,309,289 – more than five times the \$5,142,000 that was available. The \$5.142 million a year in EHDI funding represents less than 2 percent of the approximately \$325 million that MDH awards in grants annually.

**Given that EHDI funding has never increased, the pool of funds is effectively shrinking relative to the rapid growth of populations of color and American Indians since 2001.** Of the \$5.142 million available, \$2 million are Federal TANF Funds, which are designated for teen pregnancy prevention alone, and \$3.142 million are Minnesota State Funds, which are designated for the remaining priority health areas. Dividing the state-level funding among the seven remaining priority health areas yields slightly less than \$450,000 per health area. This does not include

the recent addition of the ninth priority health area of prenatal care, which came as a directive from the legislature with no additional funding in 2019. Dividing \$450,000 among the four communities of color and American Indian communities specified by the grant (African/African American, American Indian, Asian/Pacific Islander, and Hispanic/Latinx) yields just over \$100,000 per community to address statewide disparities in complex and multi-faceted health areas.

**AMOUNT ALLOCATED OVER THE YEARS  
RELATIVE TO POPULATION SIZE/ GROWTH**



SOURCE: U.S. Census Bureau, Decennial Census; U.S. Census Bureau, Population Estimates. Data downloaded from <https://www.mncompass.org>.

## HOW DO HEALTH INEQUITIES AFFECT HEALTHY MINNESOTANS?

**Investments in health equity make economic sense.** Two ways that health disparities—and their elimination—affect society economically are (1) lives lost (or saved) and (2) labor market participation and productivity. Healthier workers have fewer sick days and lower medical care costs, and thus make greater economic contributions to communities. Healthier children miss fewer days of school and thus have higher educational outcomes, potentially disrupting intergenerational poverty by increasing their opportunities for employment and their income levels. A healthier population helps everyone by reducing insurance premiums for individuals, health care costs of employers, the financial burden on health care providers and insurers, and health-related public spending by governments.

## In Minnesota alone, addressing health inequities could:

save 766 lives

add 1,034 people of color and American Indians to the workforce

save the state a total of **\$2.26 billion** through increased employment and decreased sick time

## PER YEAR!<sup>6</sup>

**As of 2018, people of color in Minnesota make up 20% of the total population. Black Minnesotans were the fastest growing population between 2010-2018, followed by Asian Minnesotans.**



# \$337 BILLION

The estimated cost to health insurers in racial disparities in health between 2009 and 2018.<sup>5</sup>

# THE EHDI IMPACT

Through EHDI grants, MDH invests in communities most impacted by structural inequities, supporting innovative, community-driven solutions for addressing racial disparities. Milestones toward disparities reduction include grantees' increased capacity and enhanced skills; grantees' increased effectiveness; increased connection, strength, and amplification of grantees' efforts across Minnesota; and improved outcomes in priority health areas. Evaluation data from the most recent grantee cohort (2016-2019) demonstrates the importance of EHDI funding across these four milestones.



## Increased effectiveness in designing programs and providing access to preventive health

**73%** of grantees reported that their organization **knows how to find and access more resources**, such as educational materials, data, and supplies than they did previously.

**88%** of grantees reported that their organization **used EHDl funding to create or adapt a resource for their community**.

## Increased connection, strength, and amplification of efforts across Minnesota

**85%** of grantees reported that their organizations **developed deeper connections with their community**.

**85%** of grantees reported that **community voices had been amplified** (e.g., had broader reach, were more powerful) through this funding.

**95%** of grantees reported EHDl funding **enhanced their organization's skills in communicating** what they do and what they have accomplished through their EHDl-funded project.

**21,482** people participated in ongoing prevention programming (to reduce risk for diabetes, heart disease, teen pregnancy, sexually transmitted infections, infant mortality, and/or unintentional injuries or violence)

**10,563** people received one-time, in-person education (on cancer screening and prevention, immunizations, teen pregnancy and sexually transmitted infection prevention, and/or mental health awareness)

# SE ME W

ACROSS  
GRANTEES

# U T S



## Increased organizational capacity and enhanced skills

**90%** of grantees reported that through EHDl, their organizations **built capacity that strengthened them for the future**.

In 2017-18 alone, EHDl grantees **trained 917 professionals** (physicians, nurses, community health workers, social workers) **to better address health needs among target populations**.

## Engaged communities of color and American Indians in preventive health services or education leading to improved outcomes in priority health areas

In total, 2016-2019 grantees reached **409,607<sup>7</sup>** people of color and American Indians—88,774 directly and 320,833 indirectly—with culturally appropriate preventive health services and education.

**206,382** American Indian Minnesotans

**98,502** African and/or African American Minnesotans

**53,740** Asian and/or Pacific Islander Minnesotans

**50,506** Hispanic and/or Latinx Minnesotans

*While these numbers may be duplicated, it reflects the impressive reach that grantees have within their communities and represents Minnesotans who otherwise might not have received culturally rooted preventive care or education.*



# IMPACTS

BY  
PRIORITY  
HEALTH  
AREAS<sup>8</sup>

## Teen Pregnancy Prevention; Sexually Transmitted Infections and HIV

With \$2 million in federal funding each year, teen pregnancy prevention is consistently the priority health area with the highest number of grantees. The 14 grantees funded to address teen pregnancy in the 2016-19 cohort used a combination of evidence-based programs and culturally responsive practices to improve sexual health for youth in Minnesota. Eight HIV/AIDS and sexually transmitted infection (STI) prevention grantees used a variety of different approaches to promote sexual health among populations who experience higher rates of HIV/AIDS and STIs. Some grantees worked on community-level interventions aimed at adults while many focused on health promotion and risk reduction education for middle and high school youth.

**8,786** youth participated in ongoing teen pregnancy prevention programming.

**1,069** community members were tested for HIV or STIs.

**870** adults and youth received information on HIV, STIs, and testing.

**437** parents or caregivers received education about how to support their youth to make healthy decisions about sex, sexuality, and relationships.<sup>9</sup>

### By program end, youth participants across grantees reported:

**86%** *Having supportive adults with whom they could talk about sexual health<sup>10</sup>*

**80%** *Being comfortable discussing topics related to sexual health with partners<sup>11</sup>*

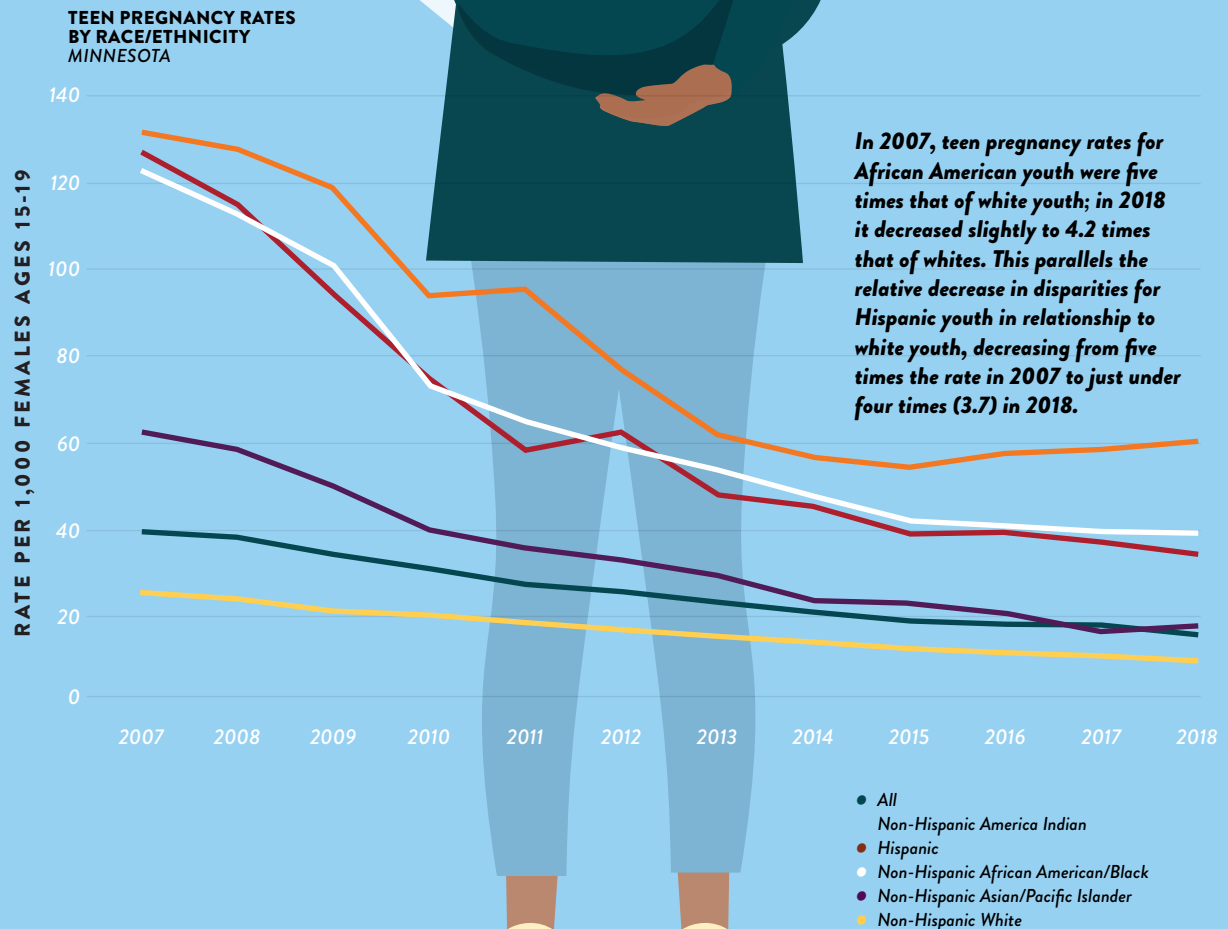
**73%** *Knowing where to access sexual health resources<sup>12</sup>*



## DECREASES IN MINNESOTAN TEEN PREGNANCY RATES IN THE LAST DECADE

Since 2007, Minnesota has achieved a steady decrease in teen pregnancy rates for all youth ages 15-19, including American Indian, Black/African American, Asian/Pacific Islander, and Hispanic/Latinx when disaggregated by race/ethnicity. While disparities between youth of color and

white youth continue to persist, they have decreased among certain populations. While these decreases cannot be attributed to the work of EHDI grantees alone, community-driven youth prevention programs play an integral role in this Minnesota achievement.



SOURCE: Minnesota Resident Final Birth File, Minnesota Resident Final Fetal Death File, Minnesota Resident Abortion File and U.S. Census - American Community Survey 2007-2018.

## Diabetes

Five grantees in the 2016-19 cohort worked to prevent or control diabetes. Interventions ranged from clinical practice aimed at helping maintain or reach healthy A1C levels to education efforts to prevent new diabetes cases. One clinical program reported that 59% of diabetes patients showed improvement in A1C levels during their participation in the program. Other programs worked at increasing health but did not track A1C levels; two of these programs reported increased health skills such as nutritional skills and healthy behavior changes.

Grantees conducted **2,288** diabetes screenings.

**74%** *After participating in a wellness program, 74% of adult participants across grantees reported that they were actively working to change their level of physical activity.<sup>13</sup>*

## Breast and Cervical Cancer

Four grantees working on breast and cervical cancer prevention reached 142,478 people with a culturally-rooted breast cancer awareness social media campaign and provided 2,608 women with cancer screenings. More than 3,000 community members received in-person information on cancer prevention.

## Heart Disease and Stroke

Five grantees were funded to prevent or intervene in cases of heart disease within their communities, which are disproportionately affected by the disease. Their strategies and approaches included increasing screening and education; promoting healthy behaviors such as physical activity, healthy

eating, and general wellness; and creating tailored prevention plans for patients diagnosed with heart disease. One of the clinical grantees screened nearly 1,800 patients who received follow-up calls notifying them if their screening results indicated that they should make a follow-up appointment with their primary care provider. The same clinic program was able to use medical records to track blood pressure levels and reported that 36% of patients with hypertension were able to lower their blood pressure into a controlled range.

**8,901** community members participated in prevention programs.

Grantees conducted **2,355** blood pressure screenings.

## Immunizations

Three grantees provided 13,205 needed immunizations. Most immunizations were for influenza. Eighty-nine percent of participants<sup>16</sup> received all their recommended vaccinations through specific outreach about HPV and childhood vaccines.

## Unintentional Injury and Violence

Two grantees worked to prevent unintentional injury and violence. Both promoted mental health and suicide awareness among their target population — one through clinical services and the other through outreach and education.

**1,630** community members attended mental health workshops.

Grantees conducted **660** mental health screenings.

## Infant Mortality

Three grantees worked to reduce infant mortality with a primary focus on the two most affected populations: African American and American Indian Minnesotans. One grantee worked to reduce infant mortality by preventing prematurity and promoting women's health. That grantee worked with women to promote holistic healthcare needs during and after pregnancy. Grantees working with the American Indian community focused on preventing sleep-related unintentional injuries among infants under 6 months, as that is a leading risk factor. Each of these programs

provides wraparound services to pregnant and post-partum mothers and their children to assess needs, address issues, and create holistic education, care, and resource referral plans for families.

Caregivers across grantees reported:

Over **50%** of one-year-olds had five or more well-child visits.<sup>14</sup>

**83%** of mothers of infants reported safe sleep practices for infants under 6 months of age.<sup>15</sup>



## INSTITUTIONAL AND SYSTEM-LEVEL CHANGE

Over the course of nearly twenty years and several cohorts, Minnesota's investments in EHDl grantees have led to institutional and system-level changes that continue to pay dividends.

Leveraging the use of non-medical staff from the community, such as cultural health workers, navigators, medical student interns, and promotoras de salud;

Developing promising practices such as the Division of Indian Work's Live It! curriculum, Annex Teen's Celebration of Change curriculum, and National Asian Pacific American Women's Forum's curriculum on Asian Pacific Islander (API) women's health issues;

Becoming certified as health care homes and behavioral health homes (Hennepin Healthcare, Aquí Para Ti and CAPI USA) which increases access to health care services.


## Lessons Learned

Beyond the direct impact of the EHDI program on grantees and the communities they serve, the collaboration between the state and local communities to address health disparities in Minnesota over nearly 20 years has amplified a wealth of knowledge sharing. Over the years, EHDI grantees have taught the center and MDH valuable lessons regarding how grant programs can build community capacity and honor the wisdom of communities most impacted by health inequities. These lessons can benefit other funders or health programs intending to reduce health disparities across the state.

**Organizations that reflect communities most impacted by inequities are better equipped to understand and respond to community experiences.**

Organizations whose leadership and staff reflect the communities that they serve are better positioned to identify and address the needs of community members in ways that align with their worldview and lived experiences. This alignment contributes toward the development of trusting relationships between organizations and communities — a process that takes time but that is perhaps the most critical ingredient to successful collaboration.

Trusting relationships allow organizations and communities to co-create strategy and programming. Grantees often lead focus groups and hold community meetings to better understand the values and most pressing needs of their communities and develop innovative activities with them. Rather than developing programming exclusively from reports and articles or single interactions, they engage community members in asking what would support health and envisioning how that could work programmatically. Grantees also use feedback from community members to examine their work and make internal changes to processes and practices.



*There are a lot of evidence-based practices out there that are translated. That does not necessarily mean they are responsive to the community needs or culturally affirming or relevant.*

EHDI GRANTEE

”

### **INCLUDING AND EXTENDING BEYOND TRANSLATION AND CULTURAL ADAPTATION**

**Changes in language are one of the main ways that grantees make evidence-based curricula work better for their communities. As important as grantees consider translation, changes in language extend beyond translation.**

Considerations of language require understanding the communities involved and how to incorporate the feedback they share.

Grantees also use their direct knowledge of their communities to adapt materials and practices to the local culture, values, trends, and norms. Recognizing the differences between first-generation and second-generation immigrants, for example, is vital to the success of many grantee programs. Doing adaptation well means that grantees work collaboratively with community members — even when they may remain connected to and be knowledgeable about their communities — to ensure that community members see themselves and their values in the programming, as described earlier.

The activities documented by grantees often reflect more intimate, complex, and nuanced understandings of the values and needs of their communities. Developing language that incorporates LGBTQ, intersexual, and asexual identities and experiences; activating existing leaders to provide access to wider sectors of the community; tailoring imagery in written and posted materials; and including parents and legal guardians in educational efforts for youth are all creative ways that grantees have deepened and expanded evidence-based programs.

**Communities know what they need to create better health.**

Investing in community-driven solutions means recognizing that communities themselves are the ones to develop the approaches, materials, practices, and language to suit their communities as well as the measures of their effectiveness. Grant programs can increase their impact by learning from communities rather than prescribing solutions to them.

**Effective strategies are grounded in cultural knowledge and wisdom.**

Evidence-based interventions do not necessarily transfer effectively or appropriately across communities, especially since many have been developed for and tested on white, middle-class men. After observing and supporting nearly two decades of EHDI grantee impact, MDH has learned that interventions that are grounded in community knowledge and wisdom, beyond simply being adapted linguistically and culturally, are more likely to be effective. Some grantees utilize a community-based participatory research model that engages community members in developing programming and documenting evidence.<sup>18</sup>

**An expansive narrative of health incorporates the intergenerational effects of collective oppression.**

Grantees are changing the narrative of health work by considering how different dimensions of oppression affect the overall health of marginalized communities. Much of the work of community-driven organizations involves bridging distrust of and access to medical systems and expanding and redefining the narrative about what creates health and how change happens.

**Flexible funding honors the social and economic conditions necessary for health.**

While funders may think the bulk of work lies in implementing particular interventions, what are too often considered “extras” of program implementation are in fact pivotal to any strategy’s success. These include covering participants’ transportation expenses, providing participants with healthy meals that they may otherwise have to plan around or buy on the go, providing participants with childcare, and paying participants for any time they may spend contributing their expertise to the program.

By attending to these conditions for health, especially for social connectedness, EHDI-funded organizations develop authentic relationships with community members and build trust with their communities. That trust allows them to recruit and retain participants. It also allows them to adapt or create meaningful strategies and to engage in the internal organizational work necessary to effect systems change. However, relationship-building is labor intensive and time consuming. Flexibility to fund a range of expenses is required to support this foundational work. Flexibility to fund a range of approaches — evidence-based practices as well as practice-based evidence — further allows grantees to think critically about the assumptions underlying evidence-based programs and challenge them.

*Because we have to undo the legacy of generations of systems of oppression and approaches in public health, health care, medicine, and research that exploit communities — particularly indigenous communities and communities of color — I think this has to be really intentional work. And the communities — community leaders and community members — that are going to be participating have to be part of the process. They have to be at the decision-making table.*

# Has Investment in EHDI Eliminated Health Disparities?

The Center for Health Equity is often asked whether its grantees have eliminated health disparities in the state. This is an understandable question given the origin—and name—of the grant program. However, over the past two decades, we have learned much more about the root causes of health inequities and the solutions needed to address them.

Community-driven approaches funded by EHDI have measurably improved community capacity, provided services, and improved outcomes within the populations that grantees were able to engage — those which conventional public health programs have failed to reach. Yet EHDI has not — and will not — eliminate the problem of racial disparities in health outcomes on its own.

Despite the investment in and success of community-driven solutions, health disparities across the eight priority health areas persist in

Minnesota along racial lines. While grantees have utilized the funding in innovative and effective ways to increase the well-being of their communities, there has not been the monumental shift in the health outcomes of populations of color and American Indians in the state that many had hoped for. This lack of measurable change at the population level is not surprising considering the scale of the investment relative to the growth of communities of color and American Indian communities. It is also not surprising considering the narrow focus of the investment — on physical

## **HOUSING AS A SOCIAL DETERMINANT OF HEALTH**

Among the social determinants of health is housing. Housing is a pivotal contributor to health because where we are born and raised affects everything else: our exposure to toxins inside and outside our home; our ability to access healthy food; our opportunities to play safely outside; engage in stimulating learning at school; generate a livable income under fair working conditions; and access quality financial, health, and social services. Each of these conditions interacts with the others—multiplying and compounding their effects exponentially within lifetimes, across lives, and over generations. Knowing this, it is not surprising that where a person lives in the U.S. can dramatically affect that person's chance of living a longer, healthier life—in some cases by as much as 22 years.<sup>21</sup>



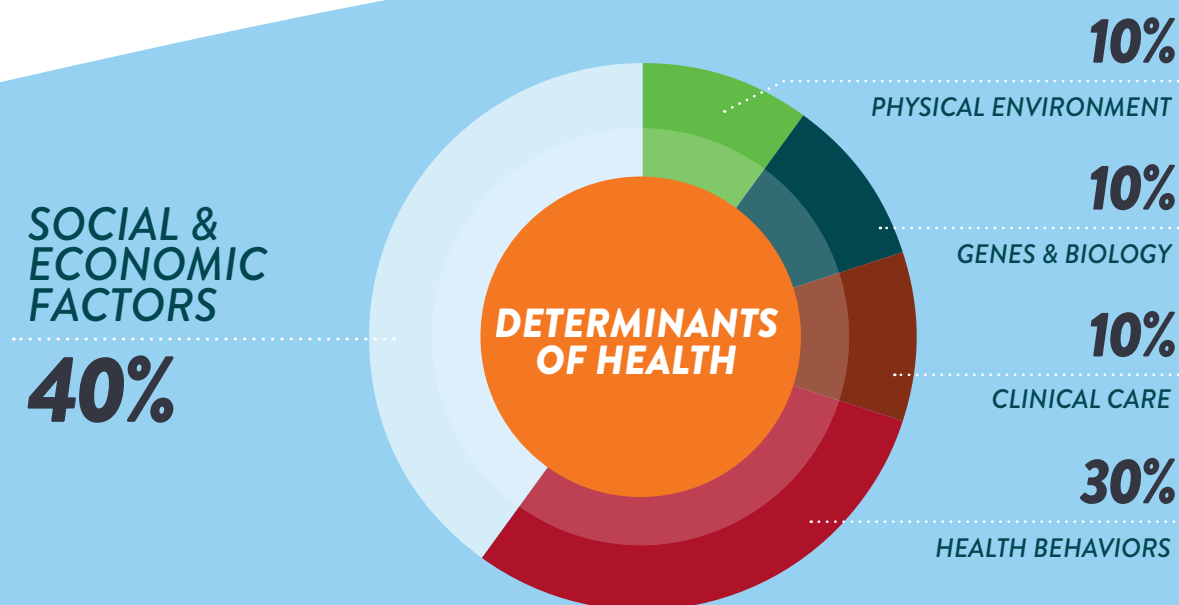
and mental health — relative to the multiple factors that contribute to and constitute health as well as the number of generations in which these factors have been inequitable.<sup>19</sup> These additional factors are often referred to as the **social determinants of health**. The social, economic, and environmental conditions in which people live, learn, work, worship, play and age account for 40% of community-level health outcomes, compared to individual-level genetics (10%), individual behavior (30%), or the clinical care that individuals receive (10%).<sup>20</sup>

### Reframing the Question

The Minnesota Department of Health's 2017 Statewide Health Assessment offers a helpful framework to understand what creates health.<sup>22</sup> The assessment discusses three factors: 1) our opportunities to create optimum health, such as housing, education, and employment, 2) our interactions with nature including both the natural and built environment, and 3) our sense

of belonging. This report also shares comprehensive data linking opportunity, nature, and belonging to health outcomes in Minnesota such as diabetes, suicide, nutrition, and much more. Using this expanded view of what creates health, it supports health improvement efforts ranging from community planning and community organizing to developing organizational policies and statewide laws.

MDH's landmark 2014 Advancing Health Equity Report<sup>23</sup> also makes the case for creating health equity through comprehensive solutions that include targeted grants and access to health care, but also goes beyond. The report emphasized how Minnesota must address health disparities as part of a broad spectrum of public investments in housing, transportation, education, economic opportunity, and criminal justice. At the same time, government and institutions must make intentional efforts to eliminate structural racism. In other words, investing in health programs and services is critical but insufficient to reverse decades — even centuries — of racial disparities in health.





77%

**THREE TIMES AS MANY WHITE MINNESOTANS OWN HOMES AS AFRICAN-AMERICAN MINNESOTANS.**

**77%** WHITE MINNESOTANS



**25%** AFRICAN-AMERICAN MINNESOTANS



SOURCE: Minnesota Compass



Given this holistic understanding of what creates health, new questions emerge such as: How can we further support and scale the impact that EHDI grantees have had? What additional efforts need to be made to improve housing stability, median income, and other social determinants of health? And how can we eliminate structural racism and create an ecosystem where communities flourish?

### **The Need to Cultivate a Health Equity Ecosystem**

EHDI grantees have demonstrated incredible successes with limited resources in an environment where inequities in the conditions that create health abound. In addition, they have made meaningful progress in their communities despite structural racism and other barriers that continue

to perpetuate those inequities. Given this, imagine the impact EHDI grantees could have if we simultaneously – and systemically – worked to remove structural barriers and improve the environment in which they worked.

Indeed, a broader investment to cultivate a health equity ecosystem in Minnesota is paramount to any effort to eliminate health disparities. We must repair inequities in the socio-economic conditions that create health to see population-level improvement in any of the eight priority health areas or beyond. Repairing inequities in the conditions that create health requires us to understand the ways in which systems and institutions are interconnected and how—together—we can foster an environment where health equity will flourish.

### **STRUCTURAL RACISM AND HOUSING**

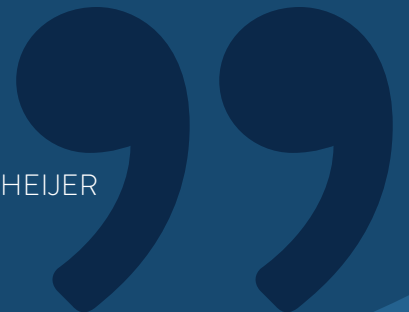
Structural racism is when historical and current institutional policies interact to create an entire system that negatively affects populations of color and American Indians. Housing opportunities are a prime example, as decades of policies and practices have created ripple effects across generations. For example, federal lending policies after World War II allowed discrimination on the basis of race and kept African-Americans from obtaining mortgages. During this same period, many white Americans bought homes and built wealth, and later passed it on to their children. Today, the rate of homeownership for white people in Minnesota is three times the rate for African-Americans (76 percent vs. 22 percent). This homeownership disparity creates new disparities when, for example, programs or policies are designed to benefit homeowners but not renters. Think about the positive impacts that homeownership has on wealth accumulation and that stable housing has on health. Because the original disparity was based on race, the new structures also have a disproportionately negative impact on people of color.<sup>24</sup> These harmful patterns persist across the social determinants of health and affect the opportunities we have, our connection to environment, and our sense of belonging.<sup>25</sup>



*When a flower  
doesn't bloom,...*

*...you fix the  
environment in  
which it grows,  
not the flower.*

ALEXANDER DEN HEIJER



# CULTIVATING A HEALTH EQUITY ECOSYSTEM

Nature provides great examples for understanding interconnection and flourishing environments. Natural systems in which living and nonliving beings share space and resources and depend on each other for survival and growth are called ecosystems. In nature, three conditions are necessary for a healthy and thriving ecosystem: biodiversity, interconnection, and nutrients. If we wish to see health equity flourish in Minnesota, we must ensure that we have a robust health equity ecosystem across the state.

## DIVERSITY, EQUITY, AND INCLUSION

Ecosystems thrive when there are many different plant and animal species living and growing together. **A health equity ecosystem requires a diversity of entities:** individuals and families, hospitals, clinics, non-profit organizations, government, health systems, affordable housing, transportation, and much more. Across this diversity of entities exists even greater diversity of identities: race/ethnicity, socio-economic status, gender identity, geographic location, different abilities, and more. For a health equity ecosystem to thrive we need diversity, equity, and inclusion.

## RELATIONSHIP AND COLLABORATION

The unique and diverse beings within an ecosystem rely on interconnection to survive. Ecosystems do not function if individual beings within them are effective but disconnected. Birds need trees to nest in and flowers need bees to pollinate. This interdependence is critical—no single entity could thrive without the others. **A health equity ecosystem requires relationships and intentional collaboration across sectors and communities to have population-level health impacts.** Eliminating health disparities will only be possible through coordinated efforts amongst communities most impacted by inequities, legislators, foundations, government agencies, schools, and many other entities within the health equity ecosystem.

## RESOURCES

Finally, ecosystems require nutrients. The interconnected webs of organisms need sunshine as well as shade, mineral-rich soil, and a clean and abundant watershed to flourish. If there is pollution blocking these nutrients, organisms will wither and die; this sets off ripple effects for other living beings that rely on them. **Within a health equity ecosystem, we must examine whether systems and institutions are providing life-giving resources or further polluting the environment.**



At the 2019 Health Equity Summit, co-hosted by the center, the Health Equity Leadership Network, and EHDl, nearly 200 health equity leaders from across sectors and across the state identified overarching factors such as institutional racism, historical trauma, and anti-immigrant bias as polluting our ecosystem. While often invisible, like pollution, they are all around us and affect everything they touch. If not addressed, they will continue to slowly kill us. Summit attendees agreed that we must work to address these factors but that there are few resources available to do so.

**TO LEARN MORE READ THE 2019 HEALTH EQUITY SUMMIT OVERVIEW.**<sup>26</sup>



## ONE PART OF A DISCONNECTED ECOSYSTEM

For nearly 20 years, EHDl has supported grantees to advance health equity within their local communities. But it is not enough. To truly eliminate health disparities statewide, all members of the health equity ecosystem must come together to center diversity, equity, and inclusion; build authentic relationships and cross-sector collaborations; and ensure that resources support health equity at multiple levels and without interference by structural barriers and racism. The following section shares how MDH and the Center for Health Equity have integrated the lessons learned from EHDl grantees to reflect on our role within the health equity ecosystem. This reflection led us to transform how we do business in an effort to end structural racism within our organization and instead contribute meaningfully to the health equity ecosystem.

# Looking Within: Examining Our Role within the Ecosystem

## Transforming the Minnesota Department of Health

Picture a tree with many branches. Without deep roots, it will eventually topple. These roots must grow from within before its branches can fully stretch outward. Similarly, MDH needed to become firmly rooted in our vision for health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy. This metaphor has provided useful imagery to inform the direction of the Center for Health Equity and the work that the center and MDH have done to look critically at our own policies and practices.

The 2014 Advancing Health Equity Report, informed by feedback from thousands of community members from across the state, highlighted how creating health equity requires a comprehensive solution that includes, but goes beyond, targeted grants and access to health care.<sup>27</sup> Minnesota must address health disparities as part of a broad spectrum of public investments in housing, transportation, education, economic opportunity, and criminal justice. In the years since the call to action to address structural racism in the 2014 report, MDH staff have been asking ourselves what our role is in advancing health equity within the ecosystem. In doing so, we have realized that it is not enough to only work externally, putting out reports and telling others what health equity is and how to achieve it. We also have had to look inward as an institution to examine how we may be perpetuating inequity or structural racism and what we can do to change.

Driven by the center and multiple partners within the agency, the focus of the MDH 2015-2019 strategic plan was transforming how we do business, with health equity as the central goal.<sup>28</sup>

## The Center's Role and Approach

**The mission of the center is to connect, strengthen, and amplify health equity efforts within MDH and across the state of Minnesota.**<sup>29</sup>

The center is grounded in a set of core values and approaches that shape our work, including the work of the EHDI program. Our values include honoring cultural knowledge and wisdom, fostering trust and belonging, listening deeply, and recognizing health equity as a human right. Our work is guided by a set of approaches that include racial equity, resilience, intersectionality, network leadership, community-driven data and decisions, and systems that heal rather than harm.

The Center for Health Equity's work toward this mission extends beyond EHDI and includes working both internally, within MDH, and externally, with our community partners and other state agencies. Internally, the center works across the agency to build shared knowledge and understanding of what creates health and strengthen employees' capacity to advance health equity. Externally, the center works to connect health equity champions across the state to eliminate silos and amplify the work of community partners. If MDH is one tree in the ecosystem, this interconnection work could be considered the underground network through which trees exchange information and resources.



# APPROACHES

We believe that leadership comes from within and across communities and that we are stronger when we bridge differences and unite around commonalities. We believe that effective leadership is adaptive, collaborative, and inclusive.

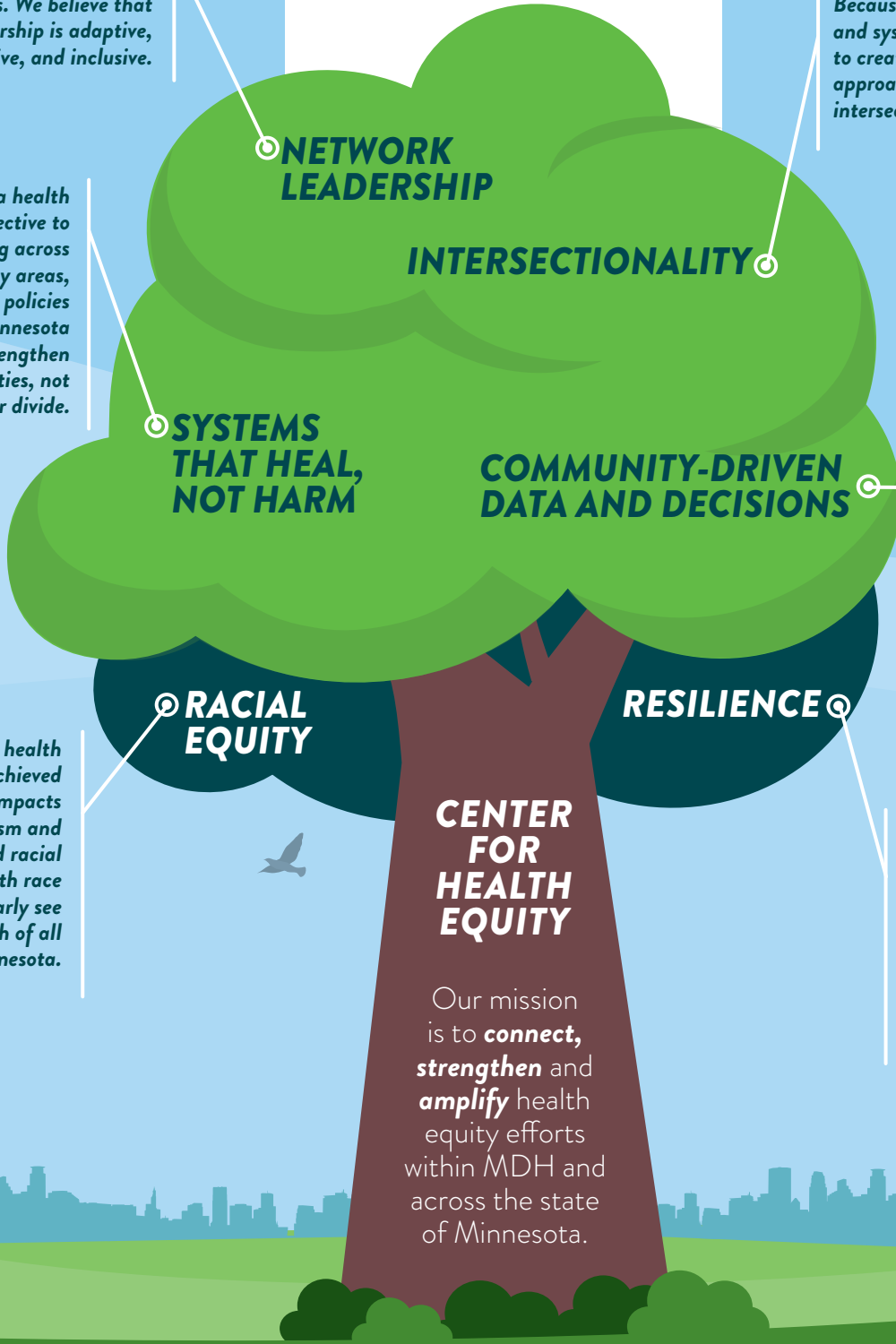
We value the many identities and lived experiences of each person. Because individual, community, and systems-level factors interact to create the world we live in, our approaches to equity are both intersectional and multipronged.

We strive to bring a health equity perspective to decision-making across sectors and policy areas, and to reshape our policies and systems in Minnesota so that they strengthen communities, not marginalize or divide.

We believe those most impacted by health inequities should have a say in how their data are collected and interpreted, and that communities should play a leading role identifying their own health challenges and developing solutions.

We recognize that health equity cannot be achieved without naming the impacts of structural racism and working toward racial equity. Leading with race allows us to more clearly see the state of the health of all communities in Minnesota.

We acknowledge that the roots of inequities are tied to a legacy of historical trauma in communities. We recognize that solutions to health inequities can often be found within the strength and resilience of communities.



**CENTER FOR HEALTH EQUITY**

Our mission is to **connect, strengthen and amplify** health equity efforts within MDH and across the state of Minnesota.

# VALUES

○ Honoring cultural knowledge & wisdom

○ Fostering trust & belonging

○ Listening deeply

○ Recognizing health equity as a human right

## Nurturing Our Ecosystem

Since the center's formation in 2013, MDH and the state have made considerable strides toward a healthier and more equitable ecosystem. These efforts have involved practicing the principles of thriving ecosystems: promoting diversity, equity, and inclusion; strengthening relationships and collaboration; and providing resources. Some highlights of this work are below:

### TRAINING

To create common understanding of health and racial equity at MDH, the center oversaw the training of over 1,500 staff in a half-day Advancing Racial Equity course. As a result of the training, 89% of staff reported a better understanding of racial equity, implicit bias and structural racism; 92% reported feeling motivated to advance racial equity. This training helped create shared understanding and language among staff and is one piece of a broader menu of equity trainings for staff.<sup>30</sup>

### EQUITY IN GRANTS

MDH distributes nearly \$325 million in grants throughout the state each year. The center spearheads an MDH work group that examines our grantmaking processes and policies through an equity lens. The group creates guidance for embedding equity into requests for proposals (RFPs), addressing bias in grant application reviews, and effectively reaching and informing community groups about grant opportunities.<sup>31</sup>

## Internal to MDH

*Internally, through training, conversation, technical assistance, and modeling of best practices, the Center for Health Equity, along with other MDH partners, helps strengthen the capacity of MDH programs and staff to work through an equity lens. We coach, train, and engage MDH staff with the expectation that MDH staff will have greater capacity to advance health equity in developing programs and policies throughout the agency's wide-ranging program areas.*



### **COMMUNITY VOICES TO REDUCE INFANT MORTALITY**

The center convenes Community Voices and Solutions, a committee of African American leaders paid for their time and expertise to advise the center on efforts to reduce infant mortality among U.S.-born African Americans. The initiative has launched five community-led projects and crafted guidance that embodies community beliefs, values and understanding around what creates health for African American babies. The group's Black Birth Summit in 2019 brought together over 100 black birth workers, doulas, hospital systems, and government agencies to identify cross-sector strategies to address one of the most tragic health disparities our community faces.<sup>32</sup>

### **HEAL COUNCIL**

The Health Equity Advisory and Leadership (HEAL) Council was created to embed community voice into decision-making at the highest levels of government and to ensure accountability. HEAL represents diverse communities most impacted by inequities from across the state. In January 2019, HEAL released a memo to the Commissioner of Health identifying issues and recommending solutions to MDH, focusing on: data, community engagement and systems change to advance health equity.<sup>34</sup>

### **HELN**

The Health Equity Leadership Network (HELN) is a member-driven initiative convened by MDH that brings together leaders, organizations, and institutions from across sectors to strategize, share best practices and identify common goals to advance health equity in Minnesota. The group has grown from 25 founding members to over 200 network members in the past year.<sup>33</sup>

## **External: beyond MDH**

*Outside of MDH, the center partners with health equity champions across Minnesota to connect ideas and initiatives, strengthen relationships and partnerships, and amplify the voices and work of communities throughout the state. To learn more about our internal and external work, refer to MDH's equity programming.*

# What is Your Role?

To truly eliminate health disparities, we need a flourishing health equity ecosystem where all entities play an active role within it to advance policies, practices, and conditions that promote health. As the center continues to refine its role in eliminating health disparities, we encourage all stakeholders across this interconnected ecosystem to do the same.

## ASSESS YOUR ROLE IN THE ECOSYSTEM

Regardless of our individual jobs or levels of authority and regardless of our sector or industry, we are all part of the health equity ecosystem. Let us take a moment to reflect: **What role do our organizations and the systems we are a part of play within the health equity ecosystem?**

### DIVERSITY, EQUITY, AND INCLUSION

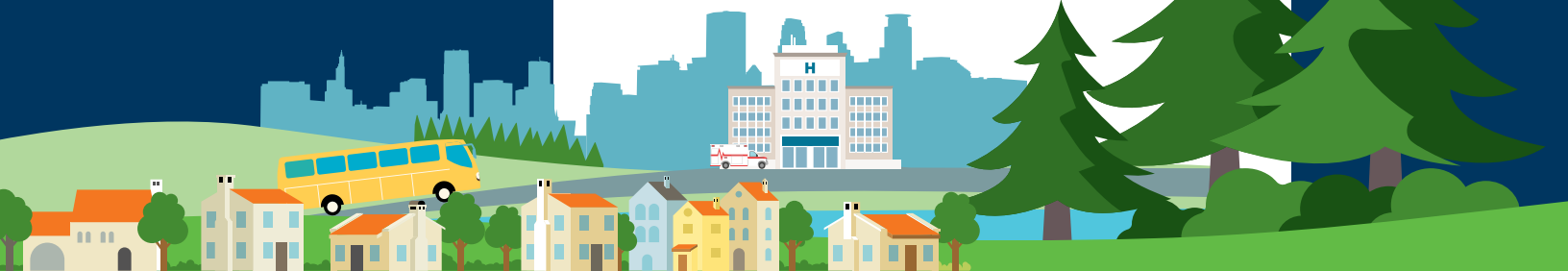
How is my organization, or the systems in which I work, intentionally cultivating diversity, equity, and inclusion in our work?

How does this show up (or not show up) in our policies, systems, or practices?

Do communities most impacted by inequities have decision-making power when we are making determinations about programming, funding, or policies?

If community members are invited, are the following considerations organized around community members' situations and the intention that they will actively participate: meeting relevance, structure, and process; time; location; and accessibility in terms of public transportation, parking, language, childcare, and physical and sensory formats and accommodations?

Are community members compensated for their time and expertise?



EHDI's approach to addressing health inequities focuses on resourcing and building the capacity of community-driven organizations and tribes to implement solutions that are rooted in their communities' values and experiences. Despite the relatively small amount of resources allocated, EHDI has increased access to health services, programs, and education among communities of color and American Indian communities. The legacy of accomplishments achieved by EHDI-funded community organizations and tribes shows what could be possible with more intentional collaboration as well as comprehensive and significant investment of resources.

Yet reducing health disparities in Minnesota will require more than relying on grant-funded organizations to solve the problem. Every entity that has a stake in the health of our communities in Minnesota must assess their role in the health equity ecosystem and intentionally work toward fostering the diversity, interconnection, and resources that we need to thrive as a state. Further, the lessons we have learned from our EHDI grantees demonstrate the necessity and impact of investing in community-driven solutions. Lastly, we encourage organizations and communities to discuss this narrative about the health equity ecosystem, inviting others to join us in reflection and action.

## RELATIONSHIP AND COLLABORATION

How is my organization, or the systems in which I work, collaborating across sectors, communities, or silos to advance health equity?

How is my organization, or the systems in which I work, sharing resources and information across systems and organizations to amplify the collective work?

Who do we engage in partnership in our work? Do these partners include leadership from communities most impacted by health inequities?

Do the partners we work with have equal power in setting strategy and making decisions?

Is the information my organization, or the systems in which I work, shares readily available, accessible and understandable to all, including availability in multiple languages and formats?

## RESOURCES

What resources does my organization, or the systems in which I work, have access to that would benefit the health equity ecosystem? Examples include funding, social capital, cultural knowledge and wisdom, relationships, and expertise.

Are we aware of how resources have historically been inaccessible to communities or entities within the ecosystem and why?

How are we circulating resources among those within the ecosystem that have been excluded historically and currently through policies, laws, and public and private investments?



## INVEST IN COMMUNITY-LED SOLUTIONS

To move forward together, we must also support investment in community-led solutions. Whether you are a decision-maker in how resources are allocated or you are an advocate for resources and policies, it is important to center communities most impacted by health inequities.

To address racial health disparities, we must invest in communities of color and American Indians and the organizations and tribes that they lead. At the same time, it is critical to acknowledge how multiple systems of oppression intersect to produce inequitable outcomes that extend beyond race. In addition to structural racism, many members of communities of color and American Indian communities simultaneously experience exclusion and harm because of their socio-economic class, their residence in rural communities, their disability or neurodiversity status, or their identification as LGBTQ. To ensure that these communities have the resources and relationships necessary to thrive within the health equity ecosystem, government, philanthropy, health systems, and other institutions must invest in them directly.

Using our ecosystems metaphor, we can think of significant investments in community-driven solutions as planting seeds in soil and cultivating a climate where they will get enough sun, shade, and water for their germination and growth. Even with the best intentions, seeds will not take root if they are not provided adequate resources and fertile environments.



## INVITE OTHERS TO ACT

We are not alone in the health equity ecosystem. MDH and the Center for Health Equity have been on a journey of reflection to identify our role in this ecosystem. This reflection was followed by strategic action, authentic collaboration, and investment of resources in communities most impacted by inequities to address structural racism and eliminate health disparities.

Nearly 20 years of EHDl and learning from the incredible work of our grantees has taught us many lessons that we have shared in this report. We now invite you to share these learnings with your networks. We challenge you to share the idea of a thriving health equity ecosystem so that others might similarly reflect upon their role and identify ways they can act.

*It takes a thriving  
ecosystem for a  
forest of trees to  
grow and flourish.*



## **SHARE** THIS NARRATIVE AND CONTINUE THE CONVERSATION



### **SEND**

this report to your colleagues and networks.



### **SIGN UP**

for the center's listserv to receive regular updates about other opportunities to continue the conversation and learn more.<sup>36</sup>



### **JOIN**

the Health Equity Leadership Network's (HELN) online platform to stay connected to others trying to build out the health equity ecosystem web through the HELN website.<sup>35</sup>

### **#EquityEcosystem**

### **POST**

your response to the question of "What is your role in the health equity ecosystem?" on social media (Facebook, Twitter, Instagram, or LinkedIn) with the hashtag #EquityEcosystem and tag a friend or colleague, challenging them to do the same.

# Recommendations for Additional Resources

Arjini, N. (September 24, 2019). Keeanga-Yamahtta Taylor Says There Is No Housing Crisis: 'It's Just Housing Under Capitalism.' *The Nation*. <https://www.thenation.com/article/archive/keeanga-yamahtta-taylor-race-profit/>

De Sousa Santos, B. (2007). *Cognitive Justice in a Global World. Prudent Knowledges for a Decent Life*. Lanham, Boulder, New York, Toronto, Plymouth, UK: Lexington Books.

Dubb, S. (September 3, 2019). Report Outlines Severe Environmental and Health Racial Disparities in St. Louis. *The Nonprofit Quarterly*. [https://nonprofitquarterly.org/report-outlines-severe-environmental-and-health-racial-disparities-in-st-louis/?utm\\_source=NPQ+Newsletters&utm\\_campaign=c9efe65373-EMAIL\\_CAMPAIGN\\_2018\\_01\\_11\\_COPY\\_01&utm\\_medium=email&utm\\_term=0\\_94063a1d17-c9efe65373-12598489&mc\\_cid=c9efe65373&mc\\_eid=3532bfa434](https://nonprofitquarterly.org/report-outlines-severe-environmental-and-health-racial-disparities-in-st-louis/?utm_source=NPQ+Newsletters&utm_campaign=c9efe65373-EMAIL_CAMPAIGN_2018_01_11_COPY_01&utm_medium=email&utm_term=0_94063a1d17-c9efe65373-12598489&mc_cid=c9efe65373&mc_eid=3532bfa434)

Gorman, J. (December 17, 2012). Ancient Bones That Tell a Story of Compassion. *The New York Times*. <https://www.nytimes.com/2012/12/18/science/ancient-bones-that-tell-a-story-of-compassion.html>

Jones, C. P. (Oct 4, 2019). Allegories on "Race," Racism, and Antiracism. Radcliffe College. <https://www.youtube.com/watch?v=2r1oQvleKX4&feature=youtu.be>

Kahlenberg, R. D. (October 24, 2019). Minneapolis Saw That NIMBYism Has Victims. *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2019/10/how-minneapolis-defeated-nimbyism/600601/>

Kamanetz, A. (June 1, 2018). Let's Stop Talking About the "30 Million Word Gap." *All Things Considered*. <https://www.npr.org/sections/ed/2018/06/01/615188051/lets-stop-talking-about-the-30-million-word-gap>

powell, j. a. (January 14, 2020). Bridging or Breaking? The Stories We Tell Will Create the Future We Inhabit. *The Nonprofit Quarterly*. <https://nonprofitquarterly.org/bridging-or-breaking-the-stories-we-tell-will-create-the-future-we-inhabit/>

Requarth, T. (May 30, 2019). Why Do So Many Researchers Still Treat Race as a Scientific Concept? Angela Saini's new book makes a compelling argument about how even scientists with good intentions end up perpetuating misleading ideas about race. *Slate*. <https://slate.com/technology/2019/05/race-science-angela-saini-new-book-superior-deconstructed.html>



# Acknowledgments

This report was made possible by the contributions of EHDI grantees, the Center for Health Equity, Rainbow Research, and University of Minnesota Healthy Youth Development Prevention Research Center staff.

## CENTER FOR HEALTH EQUITY

Sara Chute  
Darwin Flores Trujillo  
Mohamed Hassan  
Madison Olmsted  
Bridget Pouladian  
Mia Robillos  
Kou Thao

## RAINBOW RESEARCH

Lateesha Coleman  
Katie Fritz Fogel  
Iván López-Justiniano  
Mary McEathron  
Beki Saito  
Vidhya Shanker  
Dane Verret

## UNIVERSITY OF MINNESOTA HEALTHY YOUTH DEVELOPMENT PREVENTION RESEARCH CENTER

Kara Beckman  
Abigail Gadea  
Shari Plowman

## REVIEWERS

Deb Burns, MDH  
Kathy Denman-Wilke, MDH,  
formerly of Division of Indian Work  
Robin Johnson,  
Fond du Lac Band of Lake Superior Chippewa  
Roxana Linares, Centro Tyrone Guzman  
Wesley Petersen, Mayo Clinic  
Katie Rehani, YWCA of Minneapolis  
Scott Smith, MDH  
Juan Jackson, High School for the Recording Arts

## 2016-2019 EHDI GRANTEE COHORT

African American AIDS Task Force  
American Indian Cancer Foundation  
American Indian Family Center  
Annex Teen Clinic  
Centro Tyrone Guzman  
Big Brothers Big Sisters of the Greater Twin Cities  
Comunidades Latinas Unidas en Servicio  
Cedar Riverside People's Center  
Fond du Lac Band of Lake Superior Chippewa  
Family Tree Clinic  
Hmong American Partnership  
HealthFinders Collaborative  
Hennepin Healthcare - Aqui Para Ti  
High School for Recording Arts  
Hmong American Partnership  
Interfaith Action of Greater Saint Paul  
Indigenous Peoples Task Force  
Korean Service Center  
Leech Lake Band of Ojibwe  
Lutheran Social Service of Minnesota  
Minneapolis American Indian Center  
Mayo Clinic  
Mille Lacs Band of Ojibwe  
Minnesota Immunization Networking Initiative  
Minnesota Academy of Pediatrics Foundation  
Neighborhood HealthSource  
NorthPoint Health and Wellness Center  
Partnership for Health  
Planned Parenthood of Minnesota,  
South Dakota, North Dakota  
Southside Community Health Services  
St. Stephen's Human Services  
Wellshare International  
YWCA of Minneapolis

*For additional past grantees, please visit [www.health.state.mn.us/communities/equity/ehdi](http://www.health.state.mn.us/communities/equity/ehdi).*

# Citation References

<sup>1</sup>Duplicated counts

<sup>2</sup>Allen M, Myers S, Ahmed H, Durfee T, Kent K, Moua V, Xu M, Wilcoxon, A, Nanney MS. (2018). *Economic Benefit of Achieving Health Equity in Minnesota (Technical Report)*. University of Minnesota Health Equity in Policy Initiative. <https://www.healthdisparities.umn.edu/policy/hepihttps://www.healthdisparities.umn.edu/policy/hepi>

<sup>3</sup>In the 2019 legislative session, prenatal care was added as a ninth priority health area to EHDI without an increase in EHDI funding.

<sup>4</sup>2018 Population Estimates, U.S. Census Bureau, as cited by Minnesota State Demographic Center. (2020). **Age, Race, and Ethnicity**. <https://mn.gov/admin/demography/data-by-topic/age-race-ethnicity>.

<sup>5</sup>National Academies of Sciences, Engineering, and Medicine 2017. **Communities in Action: Pathways to Health Equity**. Washington, DC: The National Academies Press. <https://doi.org/10.17226/24624>. As cited by De Souza, R. & Iyer. L. (2019). **Health Care and the Competitive Advantage of Racial Equity**. FSG and PolicyLink. <https://www.policylink.org/resources-tools/competitive-advantage-racial-equity-health-care>.

<sup>6</sup>Allen, M., Myers, S., Ahmed, H., Durfee, T., Kent, K., Moua, V., Xu, M., Wilcoxon, A., Nanney, M.S. (2018). **Economic Benefit of Achieving Health Equity in Minnesota (Technical Report)**. University of Minnesota Health Equity in Policy Initiative. <https://www.healthdisparities.umn.edu/policy/hepi>

<sup>7</sup>Duplicated counts

<sup>8</sup>Reporting from fiscal year 2018 and 2019 combined, unless otherwise noted.

<sup>9</sup>Fiscal year 2018 only.

<sup>10</sup>Increased from 80% at program start; based on 740 youth responses from fiscal year 2019. Participants in EHDI-funded teen pregnancy programs in fiscal years 2017 and 2018 who reported having an adult in their lives with whom to talk about sexual relations increased significantly from 77% before participating to 87% after participating.

<sup>11</sup>Increased from 70% at program start; based on 740 youth responses from fiscal year 2019. Participants in EHDI-funded teen pregnancy programs in fiscal years 2017 and 2018 who responded to questions about their comfort in talking to partners about sex or birth control similarly reported statistically significant increases from before to after the program.

<sup>12</sup>Increased from 69% at program start; based on 740 youth responses from fiscal year 2019.

<sup>13</sup>Increased from 11% at program start; based on 54 participant responses from fiscal year 2019.

<sup>14</sup>Reported in fiscal year 2018 and 2019; based on 113213 responses.

<sup>15</sup>Reported in fiscal years 2018 and 2019; based on 155 responses.

<sup>16</sup>Reported in fiscal years 2017 and 2018; based on 376 responses.

<sup>17</sup>Minnesota Resident Final Birth File, Minnesota Resident Final Fetal Death File, Minnesota Resident Abortion File and U.S. Census - American Community Survey 2007-2018.

<sup>18</sup>AAPCHO, National Association of Community Health Centers (NACHC). (2020). **CBPR Toolkit**. [https://www.aapcho.org/resources\\_db/cbpr-toolkit/#sec3](https://www.aapcho.org/resources_db/cbpr-toolkit/#sec3).

<sup>19</sup>Tarlov AR. (1999). Public policy frameworks for improving population health. *Ann N Y Acad Sci*, 896, 281-93.

<sup>20</sup>Tarlov AR. (1999). Public policy frameworks for improving population health. *Ann N Y Acad Sci*, 896, 281-93.

<sup>21</sup>Joint Center for Political and Economic Studies Health Policy Institute and the Cook County, IL, Place Matters Team. (2012). *Place Matters for Health in Cook County: Ensuring Opportunities for Good Health for All. Health Inequities Report*. <http://jointcenter.org/research/place-matters-health-cook-countyensuring-opportunities-good-health-all>. As Cited in Turner, A. (2018). *The Business Case for Racial Equity: A Strategy for Growth*. W.K. Kellogg Foundation & Altarum.

<sup>22</sup>Minnesota Department of Health. (2017). **2017 Minnesota Statewide Health Assessment**. <https://www.health.state.mn.us/statewidehealthassessment>

<sup>23</sup>Minnesota Department of Health. (2014). **Advancing Health Equity in Minnesota: Report to the Legislature**. [https://www.health.state.mn.us/communities/equity/reports/ahe\\_leg\\_report\\_020114.pdf](https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf)

<sup>24</sup>Minnesota Department of Health. (2017). **2017 Minnesota Statewide Health Assessment**. <https://www.health.state.mn.us/statewidehealthassessment>

<sup>25</sup>Minnesota Department of Health. (2017). **2017 Minnesota Statewide Health Assessment**. <https://www.health.state.mn.us/statewidehealthassessment>

<sup>26</sup>[www.health.state.mn.us/communities/equity/projects/summit](http://www.health.state.mn.us/communities/equity/projects/summit)

<sup>27</sup>[https://www.health.state.mn.us/communities/equity/reports/ahe\\_leg\\_report\\_020114.pdf](https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf)

<sup>28</sup>Minnesota Department of Health. (2015). **Strategic Plan: 2015-2019 Minnesota Department of Health**. <https://www.health.state.mn.us/about/strategicplan1519.pdf>

<sup>29</sup>Minnesota Department of Health. (2018). Center for Health Equity. <https://www.health.state.mn.us/communities/equity/about/handout.pdf>

<sup>30</sup>[www.health.state.mn.us/communities/equity/about/handoutprograms.pdf](http://www.health.state.mn.us/communities/equity/about/handoutprograms.pdf)

<sup>31</sup>[www.health.state.mn.us/communities/equity/about/handoutprograms.pdf](http://www.health.state.mn.us/communities/equity/about/handoutprograms.pdf)

<sup>32</sup>[www.health.state.mn.us/communities/equity/projects/infantmortality/](http://www.health.state.mn.us/communities/equity/projects/infantmortality/)

<sup>33</sup>[www.health.state.mn.us/communities/equity/projects/heln.html](http://www.health.state.mn.us/communities/equity/projects/heln.html)

<sup>34</sup>[www.health.state.mn.us/communities/equity/about/committee.html](http://www.health.state.mn.us/communities/equity/about/committee.html)

<sup>35</sup>Minnesota Department of Health. (n.d.). **Health Equity Leadership Network (HELN)**. <https://www.health.state.mn.us/communities/equity/projects/heln.html>

<sup>36</sup>Minnesota Department of Health. (n.d). **Email Updates**. [https://service.govdelivery.com/accounts/MNMDH/subscriber/new?topic\\_id=MNMDH\\_273](https://service.govdelivery.com/accounts/MNMDH/subscriber/new?topic_id=MNMDH_273)



*Health equity will not exist if [we are] living only in silos. It is imperative for us to have opportunities to connect, collaborate, and learn from each other's strategies across the state in order to advance community health.*

JACKI TRELAWNY  
founding member of the Health  
Equity Leadership Network





## **CULTIVATING A HEALTH EQUITY ECOSYSTEM**

Lessons Learned from the Eliminating  
Health Disparities Initiative

**FOR MORE INFORMATION CONTACT**

**Minnesota Department of Health**  
*Center for Health Equity*

health.equity@state.mn.us | 651-201-5813  
[www.health.state.mn.us/communities/equity/](http://www.health.state.mn.us/communities/equity/)