DEPARTMENT OF HEALTH

Healthy Minnesota Partnership

Healthy Minnesota 2022 update

2021 ANNUAL REPORT OF THE HEALTHY MINNESOTA PARTNERSHIP

February 2022

Healthy Minnesota 2022 update: 2021 annual report of the Healthy Minnesota Partnership

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Healthy Minnesota 2022 Update: 2021 Annual Report of the Healthy Minnesota Partnership *is a collaboration of the Minnesota Department of Health and the Healthy Minnesota Partnership. This project was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, under #5U58CD001287. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.*

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, the Partnership identifies and acts on strategic opportunities to improve health and well-being for all people in Minnesota. 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 Appendix A in this document, About the Healthy Minnesota Partnership.)

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 to be healthy available to people of color and American Indians in Minnesota. 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 can be healthy. All who participate in our process are expected to bring what they learn to their constituencies and colleagues and to act on this knowledge to advance health equity in Minnesota.

[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.

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.

Some were involved in raising the issue of insufficient interpretation and translation of COVID-19 response information including vaccinations. While MDH was thought to have done a great job, other state agencies did not respond as quickly. There is a need for more coordinated efforts to make sure diverse linguistic communities are getting the materials they need.

The Partnership continued its meeting schedule in 2021—with all meetings being held virtually. Virtual meetings provided an opportunity for those across the state to participate. However, virtual meetings make it difficult to build the relationships needed to create strong partnerships. While several new members joined and participated in orientation, the virtual engagement may have made it more difficult for them to build relationships across the Partnership.

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 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 named 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 by 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, the 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 and the transportation system, or loosely structured networks such as family systems and informal communications systems.

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

An asset-focused approach to improving and advancing health moves away from "fixing problems" based on an individual, deficit-oriented approach which reinforces negative stereotypes and contributes to ongoing inequities and traumatization. The Partnership is still in the process of defining and implementing this strategic approach.

2021 progress on *Healthy Minnesota 2022*

How Partnership members worked to expand the conversation about health in 2021

The Partnership focus on expanding the conversation about what creates health has been a central part of its work since 2011. "Expanding" conversations can take many forms, such as teaching about health equity and the role of policy in shaping people's daily lives and moving beyond the issue of health care to talk about the connection to health of other policy areas (e.g., transportation, housing).

Teaching and training on equity and health

- The Department of Human Services held equity forums and encouraged hard conversations with staff and leadership about anti-racism, diversity, equity—and what these mean in the context of their day-to-day work. Also, staff is being trained to conduct an equity analysis section of legislative proposals and requests.
- The Minnesota Prenatal to Three network looked at how to improve equity though data, such as which data can influence policy, and how to measure the impact of policies on equity.
- MDH shared the health equity policy review process at the Minnesota Rural Health Conference. Over 40 people attended the session and practiced with sample policies. Participants intend to bring this process back to their organizations.
- Students in a public health nursing program at a local university learned how to advocate for equity in policy through an assignment that required them to meet with elected officials and promote a policy they are passionate about. These students also had clinical assignments to teach them about health and well-being from a prevention standpoint, framed by the social determinants of health.
- Sherburne County conducted equity training for staff, including support for policy reviews. They took a one-to-one approach, providing coaching and developing learning plans related to equity.

Connecting transportation and health

- The Minnesota Department of Transportation introduced health into conversations with communities about the transportation. MnDOT also piloted an equity health assessment and pulled best practices from community health assessments and health impact assessments to assure that community perspectives would be considered.

Narratives on children's health

- The West Central Initiative in Fergus Falls held a training for people who work with the children of incarcerated parents. This work highlighted the impact of parental incarceration on their children, including the child's social and emotional development.
- A review of literature (over 1300 articles) on adverse childhood events showed that 80 percent of articles focused on ACEs as the *predictor* and health as the *outcome*, while only 20 percent reviewed *social and structural determinants* as the predictors of ACEs. Hopefully findings like these will convince researchers that not enough research is being done to identify the factors that create adverse childhood events.

Connecting social isolation and health

- The U.S. Men's Shed Association emphasizes the connection of social isolation and loneliness to health and engages in efforts to help older men reduce isolation and improve their health and well-being. They worked with the University of Minnesota/School of Public Health, MDH, and the Minnesota Department of Agriculture to do a needs assessment of retired men for reducing loneliness and social isolation, connecting their efforts to other local assessments.

How Partnership members shaped plans, policies, and systems for health in 2021

Strategic activities in this area include examining current and proposed policies through an equity lens, bringing a health lens to policy discussions and engaging in partnerships to advance health equity across policy areas.

Examining policies for equity

- The Health Care Administration (HCA) within the Department of Human Services (DHS) is looking…is looking to increase and strengthen the use of equity reviews/tools both within HCA and by their collaborative partners. They are also looking to advance DHS system changes—for example, how to improve the enrollment system for Medicaid and MinnesotaCare. They want to examine this process with an equity lens to improve access to human centered services. They used an equity approach to review COVID waivers and applied an equity lens during the most recent legislative session, using the equity policy review process.
- MDH provided a policy review training for Department of Corrections, leading them to examine their policies more closely to improve a person-centered approach. The Department of Corrections (DOC) has been sharing the equity policy tool and putting that forward to their executive leadership team. The DOC was already working toward more of a person-centered approach in their policies, which made the equity policy tool very timely. A group within DOC is working to establish and implement an equity analysis approach for annual policy reviews starting this fiscal year, using the tool, and meeting with stakeholders and policy makers.
- Voices for Racial Justice is focused on making the racial equity impact assessment an integral part of the legislative process.
- Boynton Health Services at the University of Minnesota held a training through MDH on conducting policy equity reviews. This effort created conversations on the power of policy to build the kind of environment leadership and clients want to have at the clinic. Boynton is prioritizing which policies to start with and review, and they are planning what this process will look like moving forward.
- The National Rural Health Resource Center (NRHRC) introduced and encouraged the use of the policy process introduced to the Partnership earlier this year with five critical access hospitals in Minnesota. The NRHRC also shared this policy process with staff in their organization and established an expectation that they would use it in their work with hospitals.

Bringing a health lens to policy discussions

Broadband access:

- Older adults over 70 are less likely to have smart technology and the skills to use it well. The immediate concern this presented in the pandemic was that, because vaccine scheduling for older adults is done through online technology, parts of Minnesota could be missing over 40 percent of older adults due to broadband and technology inaccessibility. The Minnesota Board on Aging (MBA) considers technology to be a "must-have" for older adults and will be continuing to raise these inequities and their health implications with policy makers.
- The University of Minnesota offers a training program called Project REACH (Rural Experts Advancing Community Health) (https://ctsi.umn.edu/training/project-reach) to provide diverse community leaders in rural Minnesota with health policy and leadership training. Participants learn to frame health policy challenges and how to communicate effectively with state legislators and other policymakers. One of the Partnership members from the Minnesota Board on Aging is using this training to engage with community leaders and the state legislature on the increased isolation and decreased independence experienced by rural seniors during the COVID pandemic, with a particular focus on digital inclusion and literacy (e.g., broadband access**,** connection, adoption, and assistance targeted to older rural population). They are looking at working through the Minnesota Rural Library System, which receives funding for digital learning and has a wide reach in rural areas.
- The National Rural Health Coalition regularly provides education around the health implications of adoption of broadband expansion, telehealth, and other issues for hospitals and communities in rural Minnesota.
- HealthPartners is one of many organizations on a national collaboration called the American Connection Project (https://www.americanconnectionproject.com/) that supports broadband service and continued expansion of telehealth, including maintaining the regulatory flexibility that was granted during COVID so it can be sufficiently evaluated, with an emphasis on health, quality and equity.
- Broadband is at the top of Sherburne County's policy agenda.

Paid leave and health:

- During the 2021 legislative session, Commissioner Malcolm testified on paid leave and its impact on health. ISAIAH and TakeAction also testified on that issue in legislative committee. The work of Partnership has helped make the link between paid leave and health so that a range of advocates can make compelling arguments on this issue.
- COVID made it easier for people to understand the importance of paid leave for the health of the community, and for families and their ability to thrive. MDH heard from the disability community and others who are dependent on others to care for them, that without paid leave, people will show up for work when they are sick. This is especially important for people who are vulnerable and rely on home care services. (The City of Minneapolis was glad to have a paid leave ordinance in place before COVID hit, as that helped provide a safety net for many.)

Early childhood:

- The Minnesota Department of Corrections (DOC) created a new release program for pregnant women and new mothers who are committed to the custody of the department. Eligible women may be placed in community- based programming settings in the later term of their pregnancy and for a period post-partum. During placement, the mothers receive appropriate treatment and supportive

services, including prenatal care and parenting classes, which will have a positive impact on their health and the health of their babies. *(See more detail on this issue under assets-focused approaches.)*

Incarceration and health:

- The Department of Corrections was included in a couple of recent bills that have an impact on health equity, including the *Healthy Start Act*. The *Minnesota Rehabilitation and Reinvestment Act* (MRRA) codifies essentials for reentry into statute, including communication about voting rights, how to get engaged in the community, and some important work around identification and making sure the incarcerated have birth certificates, IDs, and social security cards before they leave. An additional item is ensuring they have an adequate supply of medications and access to health insurance.

Housing and health:

- Sherburne County has identified housing for low- and moderate-income people in their county as an important issue. It is selling a piece of property and considering how to ensure that the sale supports meeting this need. Sherburne County also has a Wellness Van that travels to citizens where they live, providing vaccinations and other health resources so that a lack of transportation doesn't keep them from receiving various health services.

How Partnership members applied an asset-focused approach to health equity in 2021

Through their asset-focused approaches, Partnership members look for ways to connect health issues with the resources, strengths, and current efforts in the community. Strategic activities in this area include working through close community partnerships, focusing resources in areas that strengthen families and children, and building on community efforts.

- Employers are an important asset and stakeholder for supporting families and children. The Itasca Project (an employer-led collaborative of about 70 large employers in the metro area) continues to work on First 1000 Days (https://itascaproject.org/first-1000-days/), which provides resources to raise awareness about the critical importance of early childhood development and to implement family-friendly practices to support it. This work has the potential to yield long-term social and economic benefits for the state.
- Mothers are essential to the health of their babies. The societal and fiscal benefits for keeping incarcerated mothers and newborns together include reduced recidivism, re-entry support for individuals being released into the community, improved parenting, enhanced child wellbeing, and community involvement, all of which prompt a cascade of long-term, compounding benefits. Babies born to mothers in prison used to be removed from their moms almost immediately after birth (within 72 hours, giving these babies and their mothers minimal time together). Now, however, the *Healthy Start Act,* which became law in 2021 (through the efforts of the Department of Corrections and the Walz Administration), improves conditions for mothers and newborns. The law allows the DOC to place incarcerated pregnant or postpartum parents into community alternatives, including halfway houses or residential treatment facilities, where parents can access treatment for the duration of their pregnancy and bond with their newborns for up to one year after giving birth. This bill is the next step in a broader push toward improving prenatal and postpartum care in prisons nationwide.
- Parenting classes are among the most frequently requested services for incarcerated men and women, and requests for parenting-related programming currently outpaces the DOC's ability to meet the demand. Another DOC initiative will provide funding to enhance and expand DOC-offered parent education programming, with long-term positive benefits for children and adults.

- The DOC has allowed some conditional resources during COVID, e.g., pregnancy. While the Healthy Start program is not officially launched, they did provide a conditional release for one mom who is due in March. She did not have a home to go to but did have some assets—she did well in recovery activities and with vocational classes. DOC and community organizations have provided support and with this support she is doing well. The DOC members will highlight what policy looks like and how things are rolling out.
- At the beginning of 2021, when Fairview was thinking about vaccines, most of the concern was centered around patients, especially clinic patients. However, as leaders saw the value of what was happening in the community, they completely embraced community vaccination efforts and became part of process, establishing a command center around vaccination. They have been in partnership with MDH and Ramsey County, and have conducted 140 clinics so far, with 22,000 vaccinated. This week there will be ten community-based clinics, mostly in communities of color and underserved communities, and more clinics are scheduled through the end of August. This was not a written policy, but it demonstrates how the organization is learning how to do their work differently by working with and in communities.
- A public health nursing program at a local university helps students conduct a community assessment project in Hennepin County and Ramsey County that is assets-based and includes a comprehensive windshield survey and key informant interviews, with a focus on structural racism..

Working through partnerships

- Voices for Racial Justice are joining in advocacy with multiple coalitions: 1) The Coalition to Increase Teachers of Color and American Indian Teachers in Minnesota; 2) Solutions not Suspensions; 3) the Ethnic Studies Coalition; 4) the Racial Equity ad Joy Coalition, focusing on racial equity in the state budget; and (5) the Together We Rise Coalition, focusing on revenue raising in the state budget. A Voices for Racial Justice blog entry describes this work: What we ALL should know about the 2021 legislative session and the state budget if we care about ending racial disparities and structural racism in Minnesota (https://voicesforracialjustice.org/voices/what-we-all-should-know-about-the-2021-legislative-session-and-the-state-budget-if-we-care-about-ending-racial-disparities-and-structural-racism-in-minnesota/).
- The Minnesota Council of Health Plans is engaged in a vaccine equity partnership to identify Minnesotans who have felt the greatest impacts of COVID-19 and continue to face barriers to getting vaccinated. The partnership is committed to connecting these populations with vaccination opportunities. Participating health plans engaged in this work include Blue Cross and Blue Shield of Minnesota, HealthPartners, Hennepin Health, Itasca Medical Care, Medica, PreferredOne, PrimeWest Health, South Country Health Alliance, and UCare.
- The Minnesota Department of Transportation has a team of equity and health neighborhood advisors from North Minneapolis, Brooklyn Center, and Brooklyn Park that help them with equity and health assessments as part of their environmental review. This assessment involves historically underserved and overburdened populations in transportation decisions that impact social disparities and the health of people and communities. For more information, visit: MnDOT: Equity and Health Assessment (https://www.dot.state.mn.us/metro/projects/hwy252study/eha.html).
- The federal Centers for Medicare and Medicaid Services (CMS) is allowing DHS to use some money for information technology (IT) systems that support community engagement with partners for health care. Through modernization of IT, DHS can improve outreach and learn ways to do its programs differently—e.g., not only through county or health care partners. One in four

Minnesotans is on Minnesota health care programs; this investment can advance systemic changes driven by the people that use this program.

- Through the First 1000 Days work, the Itasca Project (https://itascaproject.org/) is joining Little Moments Count, a Minnesota-based statewide movement to help parents, caregivers, and the community understand the importance of talking, playing, reading, and singing with infants and toddlers for brain development. Little Moments Count is a cross-sector collaborative of organizations led by HealthPartners and Minnesota Public Radio.
- The DOC team worked to assure the new *Healthy Start Act* and associated policies would be inclusive of all women across the state, including women's voices in the development of solutions.

2021 Partnership work plan activities

Expand conversations about what creates health and well-being

Framing the statewide health assessment

One of the roles of the Healthy Minnesota Partnership is to direct the development of Minnesota's periodic statewide health assessment. In 2021, the Partnership worked to prepare for the next statewide health assessment by examining the overall approach of the assessment and suggesting ways the assessment could benefit from the Partnership's work on narrative, assets, and policy.

The 2017 statewide health assessment revealed the impact of health inequities on Minnesota's populations but did not make an explicit link between systemic oppression and inequitable health outcomes. Understanding of the role of systems in health inequities has grown since the last statewide health assessment was completed, and the Partnership moved toward making those connections clearer.

A small group was convened and drafted several recommendations for the Partnership. The small group noted that because structural determinants of health are the root causes of health inequities, they are critical to an effective and actionable statewide health assessment. Consequently, the Partnership decided to recommend that the next statewide health assessment be organized around structural determinants of health and well-being.[2]

The Partnership also recommended that the next statewide health assessment be developed using the following principles:

- Make a clear connection between data in the assessment and potential action (and funding) to assure that the assessment informs action to advance health equity
- Assure that the statewide health assessment centers what matters most to communities, especially those experiencing the greatest health inequities

[2] Structural determinants of health include the governing process, economic and social policies that affect everyday life and living conditions, such as pay, working conditions, housing, and education. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual identity, or other socially defined group of people.

- Find ways to let communities lead in the assessment process
- Document ways communities are advancing healing while still recognizing and acknowledging how trauma has shaped health for entire populations, without retraumatizing those communities
- Share Minnesota's approach to create space for innovation in health assessment practices in Minnesota and nationally

In addition, the Partnership recommended that the work on the next statewide health assessment align with the Partnership's stated principles of 1) being explicit about race and racism; 2) lead by doing; 3) focusing on the policy discussions and decisions that shape opportunities for health; and 4) innovate and practice.

COVID in the next statewide health assessment

Because of the enormous impact of the COVID-19 pandemic on the health of people across Minnesota, the Partnership recognized that COVID would need be highlighted in the next statewide health assessment. They discussed issues such as: What COVID data are important to share? What is the story about COVID that needs to be told in the statewide health assessment?

Some of the COVID areas that the Partnership discussed potential issues for the next statewide health assessment include:

- Opportunities to highlight existing issues, such as the need for telemedicine, paid sick leave, unemployment and low-paying jobs, and the role of free meals in schools in child health
- The ways in which systems were able to make massive changes quickly—i.e., changes do not always have to be slow and deliberate
- The role of public trust and lack thereof (in government, in science, schools, authorities, etc.) and the impact in different communities (e.g., rates of vaccination, masking)
- The way politics influence what many thought was solely a public health issue
- Influences on vaccination rates and adherence to mandates and recommended behaviors
- The long-term impacts of COVID, e.g., health care worker burnout and trauma, isolation and social connection, mental health, education, and employment, etc.
- Inequities revealed by COVID (the disease and the response): e.g., existing inequities in rates of asthma, diabetes, and obesity; structural racism, poverty, education levels, geography: public health, health care, mental health care; transportation, housing, the natural environment; inequities in COVID response, including access to COVID testing and vaccinations and roll-out timelines

Shape policies and systems around health and well being

In 2021 the Partnership increased its capacity to recognize opportunities to shape policies, including both organizational policies and public policies, around health and well-being.

In 2021 the Partnership continued to build capacity to respond to the policy priorities identified in 2020:

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

The Partnership also heard about issues relating to voter registration and health.

The activities of the Partnership helped member organizations support specific public policy proposals and/or to consider how to apply these within their own organization. In addition to a focus on passing policies that would advance health, Partnership members advocated for health and equity in the ways these policies are implemented (see the individual Partnership member activities in the previous section).

Paid family and medical leave

In a White Paper on Paid Leave and Health (PDF) (https://www.health.state.mn.us/communities/equity/reports/2015paidleave.pdf), former Minnesota Health Commissioner Ed Ehlinger wrote:

> *With paid leave policies, people are healthier. People with paid leave use less sick time and health care and their children do better in school. Paid maternity leave contributes to better maternal mental and physical health, better prenatal and postnatal care, more breastfeeding, and greater parent/infant bonding. Elders cared for by family members with paid leave more often enjoy a higher quality of life.*
>
> *People with lower incomes, part-time workers, and single parents are least likely to have access to paid sick and family leave. These groups are disproportionately populations of color and American Indians. These disparities in access to paid leave have a cascading effect on families and communities, including children, the elderly, and people with disabilities.*

The Partnership discussed the cascading effect on communities most impacted by health inequities has been clearly evident in COVID-19 impacts. Many people were forced to make choices between earning income and taking time off to take care of themselves or family members. Paid sick time could cover time to get a COVID-19 test and to isolate or quarantine to protect others. It could cover the time needed to participate in case investigations and contact tracing which helps to slow the spread of COVID-19. Tracing means finding and talking to people who are infected with COVID-19 and then finding and talking to all the people they may have infected.

Short-term paid medical leave policies were established by emergency orders and put into place by some employers during COVID-19 response efforts—but a pre-existing statewide policy could have benefited essential workers, many of whom are from communities most impacted by heath inequities.

Universal access to broadband internet

Conversations around broadband across Minnesota generally include issues such as economic development, agriculture, and education, but do not often include the role of broadband in assuring health and equity. Partnership members were encouraged to play a role providing more health-centered messages to state and local elected officials on broadband internet access. For example, broadband access could reduce the social isolation of seniors, address the mental health crisis in rural areas, e.g., among farmers, make the adoption of telemedicine possible, and improve digital literacy.

The Partnership discussed the "digital divide"—difference in access across the state by geography—as a social and structural determinant of health, because so much of daily life is conducted via the internet: banking, school communications, applying for jobs, signing up for daycare, accessing health care, and connecting to family and friends. Broadband also can help connect people to rural transit options, instead of being a telephone and paper-based system. Rural transit connects people to health care, shopping, and social opportunities.

Housing stability and health

The Partnership discussed the profound connection between health and housing. The risk of displacement in unstable housing and traumatic effect of instability creates stress and can cause additional health problems. When housing is uncertain, people are forced to make trade-offs, such as foregoing food and health care to keep housing.

- The cities of both Minneapolis and St. Paul recently passed rent stabilization policies. Without stabilization, people would see rent increases without any improvements in housing quality. These increases had a disproportionate impact on the people with the lowest incomes. The new policies passed through an inclusive, transparent, process that shows people are being heard. Health as an issue of housing was critical for local decision makers. A safe, stable place to live creates better health outcomes overall and creates savings from other support systems.
- Stakeholders in the Department of Corrections' *Healthy Start Act* (incarcerated mothers and newborns) shared serious concerns about housing: 90 percent reported being worried about their next move; 50 percent reported needing to find a safe and stable space for kids and/or themselves; and 30 percent reported being discouraged by rejection for housing or wanting to give up. Safe housing upon reentry for them and their babies (away from other users or previous sites of trauma) was one of their biggest concerns.

Applying an asset-focused approach to health equity

The discussions in 2021 about using an assets-focused approach in the work of the Partnership were wide-ranging. This area of the Partnership's work intersects very closely with the other priority areas (to expand the narrative about what creates health and well-being and to shape policies and systems around health and well-being).

Communities contain human, social, and physical capital of many kinds. Focusing on deficits ignores the assets and seeks solutions that come from outside, rather than within communities. Focusing on deficits can also be traumatizing, leading to whole communities being defined by what they are not, instead of what they are. The Partnership suggested focusing on systems and therefore system deficits, rather than on an approach that can lead to blaming individuals for their situations.

An assets-focused strategy also can highlight contrasts in perspectives among different parts of the community. When considering what is important in a community, institutions and organizations might name governance issues or workplace policies, where community members might emphasize social connection, activity, purpose, and belonging. Organizations may be focused on types of services and programs, while community members might prefer to stress opportunities for being with friends and family, activity, exercise, and being safe, productive, purposeful, and grateful. An assets-focused approach, in actuality, may require elevating and exploring community values as opposed to focusing only on quantitative metrics.

Asset-focused data

Partnership members discussed the particular importance of an assets-focused approach in the use of data, whether in the statewide health assessment, in policy proposals, or in program development.

Data are essential for generating funding and influencing the use of resources. But data are not neutral: which indicators are chosen, who is involved in the collection of data, how the data are interpreted, and how this information is presented and used all are important. An assets-focused approach to data should:

- Reflect community voices and highlight community concerns
- Encourage communities to lead in the development and implementation of innovative solutions
- Reduce the burden of proof that marginalized communities typically bear
- Illustrate how systemic racism contributes to inequities in health outcomes
- Lead to innovative strategies and create leverage to advocate for resources

Looking ahead: 2022

Strategic opportunities for 2022

In 2021, the Partnership will continue discussing ways to frame the next statewide health assessment for a more systems-focused approach. The Partnership will also continue to deepen and share its three strategic approaches of narrative, policy, and assets-focused approaches.

Introduce systems change into the statewide health assessment

Discussions in 2022 about the next statewide health assessment will focus on assessing not just health outcomes but the systemic causes of poor health and inequitable outcomes across populations. The Partnership will learn about the conditions of system change (structural change, relational change, and transformative change) and will discuss how to describe systems impact on health outcomes.

Develop a more assets-focused approach to assessment and policy

The Partnership will continue discussing how to move away from deficit thinking to an assets-focused approach in both assessment and policy development. The discussions of assets will emphasize equity as an investment strategy, i.e., investing in communities to strengthen and build assets and not just providing services to address problems. The assets-focused approach will be important for framing the statewide health assessment as well as policy discussions.

Expand more conversations to include health in policy discussions

Partnership members will continue with existing conversations and seek new opportunities to apply an expanded narrative about health and well-being in the context of specific policies and programs. This may include development of narrative frames on aging and health.

Inform and shape more policies through an equity lens

The Partnership will continue to work on its ability to review policies through an equity lens. Members of the Partnership will support one another to advance the policy framework adopted in December of 2020 and will use this framework to look for more specific policy proposals they can support, implementation of policies, and new partners they can engage in these efforts.

Appendix A. About the Healthy Minnesota Partnership

Charge: The Healthy Minnesota Partnership came into being to develop innovative public health priorities, goals, objectives, and strategies to improve the health of all Minnesotans, and to ensure ownership of these objectives and priorities in communities across the state of Minnesota. The Healthy Minnesota Partnership resides online: www.health.state.mn.us/healthymnpartnership

Membership: The efforts of the Healthy Minnesota Partnership focus on the health of the whole state; the membership of the partnership reflects a broad spectrum of interests. During 2021 the members and alternates of the Healthy Minnesota Partnership included:

Partnership members and alternates during 2021

Barbara Burandt, State Community Health Services Advisory Committee (SCHSAC)
Justin Bell, American Heart Association
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
Diego Diaz-Rivero, Minnesota Department of Human Services
Christen Donley, Minnesota Department of Corrections
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
Chelsea Georgesen, MN Council of Health Plans
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
Alexa Howart, ISAIAH
Aaron Johnson, Eliminating Health Disparities grantee
Dan Kitzberger, Minnesota Housing Finance Agency
Warren Larson, Sanford Health
Jan Malcolm, Minnesota Department of Health
Mary Manning, 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, Center for Community Health
Jess Roberts, University of Minnesota
Sarah Sanchez, American Heart Association
Dave Sukharan, Council on Asian Pacific Minnesotans
Rosa Tock, Minnesota Council on Latino Affairs
Nissa Tupper, Minnesota Department of Transportation
Kateri Tuttle, Eliminating Health Disparities grantee
DeDee Varner, Itasca Project
Alyssa Wetzel-Moore, Minnesota Housing Finance Agency
Donna Zimmerman, Itasca Project

Staff to the Partnership in 2021

Dorothy Bliss, Contractor
Chakita Lewis, Intern, University of Minnesota School of Public Health
Jeannette L. Raymond, Minnesota Department of Health
Shor Salkas, Minnesota Department of Health

Community participants at 2021 Partnership meetings

Bill Adams
Leigh Arbes
Jamie Bachaus
Alicia Bauman
Keith Bennett
Paige Bowen
Joan Brandt
Greg Brolsma
Sarah Busch
Kristi Charles
Marisol Chiclana- Ayala
Johanna Christensen
Maureen Collopy
Rozalyn Davis
Alexandra De Kesel Lofthus
Julie Degn
Catherine Diamond
Luke Ewald
Marnie Falk
Daniel Fernandez-Baca
Alex Fossum
Derrick Fritz
Jodi Gertken
Tina Glenzinski
Terri Greenberg
Mohamed Hassan
Julia Havluck
Robert Heider
Ora Hokes
Wilhelmina Holder
S Holland
Kris Igo
Kimberly Johnson
Philip Johnson
Nancy Jost
Cindy Kallstrom
Canan Karatekin
Beverly Kimball
Ani Koch
Karla Kosel
Bob Kuziej
Sarah Lehman
Karah Lodge
Anna Lynn
Adrián Magaña
Denise McCabe
Carrie McLachlan
Kathleen Miller
Lydia Morken
Kate Murray
Phits Nantharath
Claire Neely
Josh Ney
Natalia Nice
Nancy O'Brien
Katie Peck
Tracy Pederson
Lauren Pipkin
Bridget Pouladian
Dani Protivinsky
Pleasant Radford
Lyndsey Reece
Maria Regan Gonzalez
Trisha Reinwald
Monisha Richard
Paige Risdal
Ashley Rosival
Yolanda Roth
Mandy Schmidt
Denise Schneekloth
Angela Schoffelman
Richard Scott
Keelia Silvis
Nicole Sowers
Gary Sprynczbdatyk
Katherine Teiken
Stephanie Thomas
Megan Tong
Jacki Trelawny
Kateri Tuttle
Pam Willow
Awol Windissa
Nathan Zacharias
Jodi Zastrow