MINNESOTA'S ACTION PLAN TO ADDRESS CARDIOVASCULAR DISEASE, STROKE, AND DIABETES 2035

Reducing Disparities, Removing Barriers to Good Health, and Increasing Quality Care

Together we can create conditions where all Minnesotans can thrive

2035 PLAN

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The MN 2035 Plan provides a road map to prevent and treat cardiovascular disease, stroke, and diabetes.

INTRODUCTION

8,568
Minnesotans died of cardiovascular disease

2,384
Minnesotans died due to stroke

1,575
Minnesotans died due to diabetes

To the reader,

In 2021 alone, more than 8,568 Minnesotans died of cardiovascular disease, 2,384 of stroke, and another 1,575 of diabetes, respectively the second, fifth, and eighth leading causes of death in Minnesota. Combined, these three conditions are responsible for approximately one in every four deaths in Minnesota annually. These chronic diseases also diminish quality of life and create personal, financial, and emotional stress for families—and lead to significant increased costs for Minnesota's health care system and for those who use that system.

These diseases unfairly affect some Minnesotans more than others due to many long-standing structural and social inequities, biases, and barriers. Historically, people have been, and continue to be, segregated and excluded from important resources and social supports due to their age, gender, sexual preference, race, ethnicity, geographic location, disability status, cultural identity, and more. Bias and social inequities, which are outside of a person's individual control, often determine a person's income level and the conditions and environments where they are born, live, work, and learn. These basic life circumstances influence health and well-being, whether a person develops heart disease or diabetes, and what resources they have to manage their illnesses.

Together, we must strive for better diabetes, cardiovascular disease, and stroke outcomes. In Minnesota, we will fight these diseases not only within the health care sector but also by addressing the larger societal issues. We must focus on creating more prospects for good health, especially for communities and individuals faced with the greatest health disparities. It's essential to create a more equitable society that provides all people with the resources they need to live healthy lives and empower them to manage their diseases effectively.

DEFINITIONS YOU NEED TO KNOW

Cardiovascular disease
A group of diseases affecting one or more parts of the heart and/or blood vessels. It includes heart diseases such as coronary artery disease, heart attacks, arrhythmias, and heart failure as well as peripheral artery disease and stroke. Heart disease and stroke were the second and fifth leading causes of death in Minnesota in 2021.

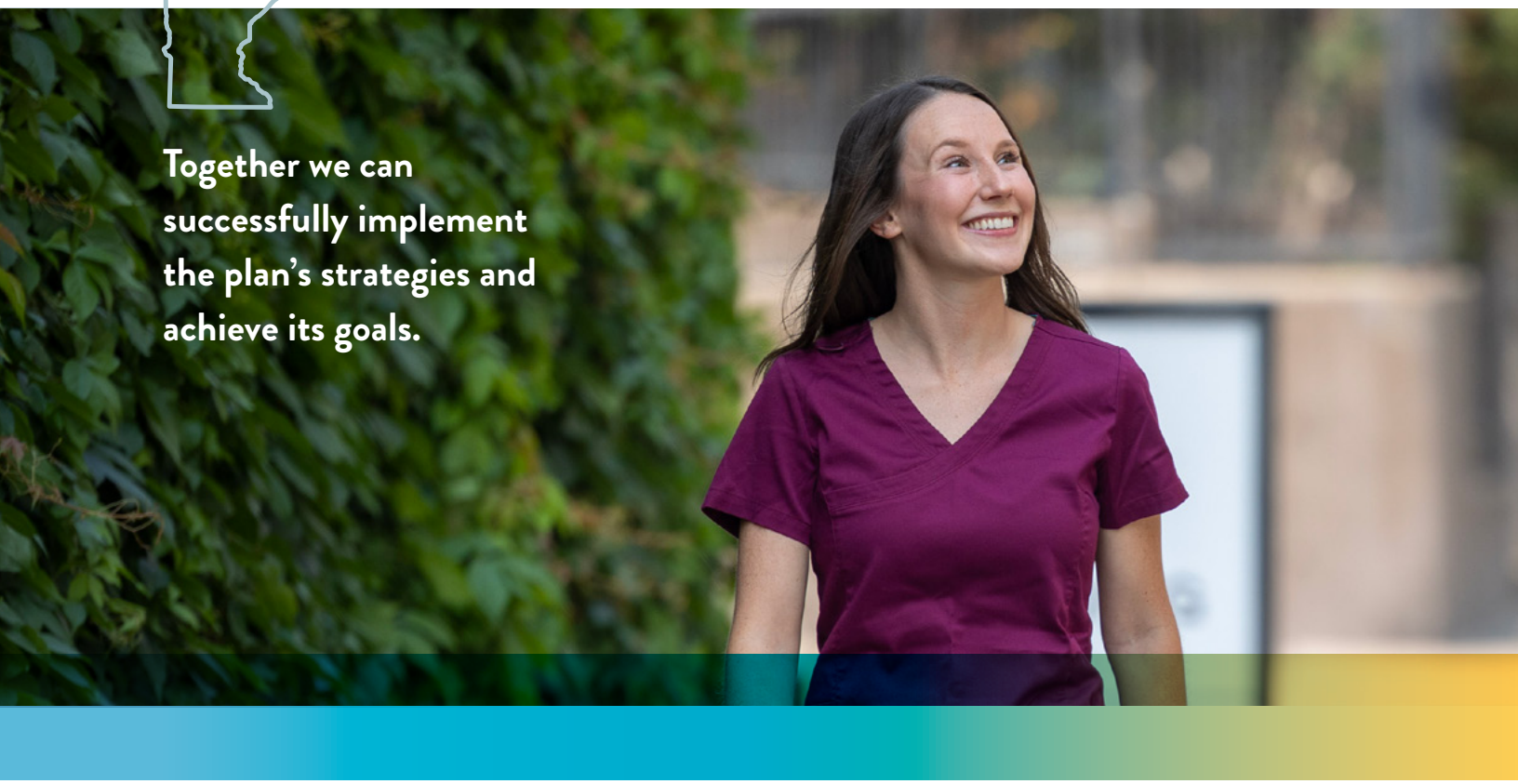
Stroke
A stroke, sometimes referred to as a brain attack, occurs when the blood supply to the brain is suddenly stopped. This can lead to parts of the brain becoming damaged, which can cause long-term disability or even death.

Diabetes
A disease, which comes in several forms, that results in the body not producing enough insulin or the body not being able to use insulin as well as it should. When that happens, over time it can cause serious health problems, such as heart disease, vision loss, and kidney disease.

Photo by Waqar Ahmad

Those goals are at the center of Minnesota's Action Plan to Address Cardiovascular Disease, Stroke, and Diabetes 2035. Created with the support and input of the communities and organizations most impacted by these diseases, the plan is a road map and a call to action for communities, health care organizations, community and organizational leaders, and individual advocates to collaborate to prevent, treat, and manage cardiovascular disease, stroke, and diabetes through 2035. That broad-based participation will help to save lives, minimize disability, and improve health and well-being, especially in those communities throughout Minnesota currently experiencing the most negative health outcomes.

The MN 2035 Plan consists of 10 priority outcomes, each of which is accompanied by a series of strategies designed to help achieve those outcomes. These outcomes and strategies were developed over a two-year period through input from Minnesotans representing groups most impacted by cardiovascular disease, stroke, and diabetes, as well as those



who work to prevent, treat, and manage these diseases. The Plan embedded health equity and community-centered approaches not only in its development but also in its implementation. Unlike previous efforts, the MN 2035 Plan combines cardiovascular disease and diabetes to create a single action plan.

Whether you work with a community-based organization; whether you are a health care professional, policymaker, community member, or business leader; whether you are someone impacted by diabetes, cardiovascular disease, or stroke; or whether you have an interest in prevention and management of these diseases, we invite you to get involved in implementing the MN 2035 Plan. Its success depends on champions like you working together with others to help implement the plan's strategies and achieve its objectives.

Dr. Courtney Jordan Baechler
MN 2035 Plan Leadership Team Co-Chair

Jesse Bethke Gomez
MN 2035 Plan Leadership Team Co-Chair

SECTION 1

THE IMPACTS OF CARDIOVASCULAR DISEASE, STROKE, AND DIABETES ON MINNESOTA

Watch why the MN 2035 Plan exists (https://youtu.be/QWiED4HXUQs?si=wMVk195WIFRJnqu8)

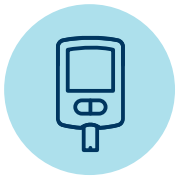
THE HEALTH IMPACTS

Cardiovascular disease, stroke, and diabetes—along with associated risk factors like high blood pressure and high cholesterol—have enormous impacts on Minnesotans and Minnesota's communities.

In 2021 alone, more than 8,568 Minnesotans died of cardiovascular disease,[1] 2,384 due to stroke[2] and another 1,575 due to diabetes,[3] respectively the second, fifth, and eighth leading causes of death in Minnesota.[4][5][6] Combined, these three conditions are responsible for approximately one in every four deaths in Minnesota annually, roughly equal to the populations of Cloquet or North St. Paul. Equally concerning is the fact that rates of these diseases are increasing in the state. Cardiovascular disease, stroke, and diabetes also increase risks for other health conditions, including kidney disease, vision loss, chronic pain and nerve problems, amputations, mobility challenges, oral health problems, depression, dementia, and other serious illnesses.

In 2021, approximately 40% of Minnesota adults were living with a cardiovascular condition, stroke, and/or diabetes.[7] Diabetes alone is estimated to affect as many as 400,000 Minnesotans.

The COVID-19 pandemic exposed these unfair conditions, environments, biases, and barriers that contribute to worse health outcomes for some more than others and highlights the vulnerability of Minnesotans living with these diseases. The U.S. Centers for Disease Control and Prevention (CDC) reported that adults with underlying medical conditions, such as heart conditions and diabetes, are more likely than others to become severely ill if infected with COVID-19.[8] As a result, these individuals are more likely to need hospitalization, be admitted into an intensive care unit, need a ventilator to help them breathe, or to potentially die.[9]



An estimated
400,000
Minnesotans are living with diabetes

40%
of MN adults were living with a diabetes or cardiovascular condition in 2021

50%

of people with incomes below $35,000 are living with cardiovascular disease, stroke, or diabetes[10]

$4.7 BILLION

Medical costs for Minnesotans with diabetes in 2017

RURAL

MN residents drive 2 times the distance for medical care[14]

THE HUMAN AND FINANCIAL COSTS

Whether or not an individual, a family member, a friend, or an acquaintance has been affected by cardiovascular disease, stroke, or diabetes, the rates and impacts of the diseases should be a concern for all, as they affect the well-being of individuals as well as families, communities, and Minnesota's workforce. They also negatively impact quality of life and create personal, financial, and emotional stress for families.

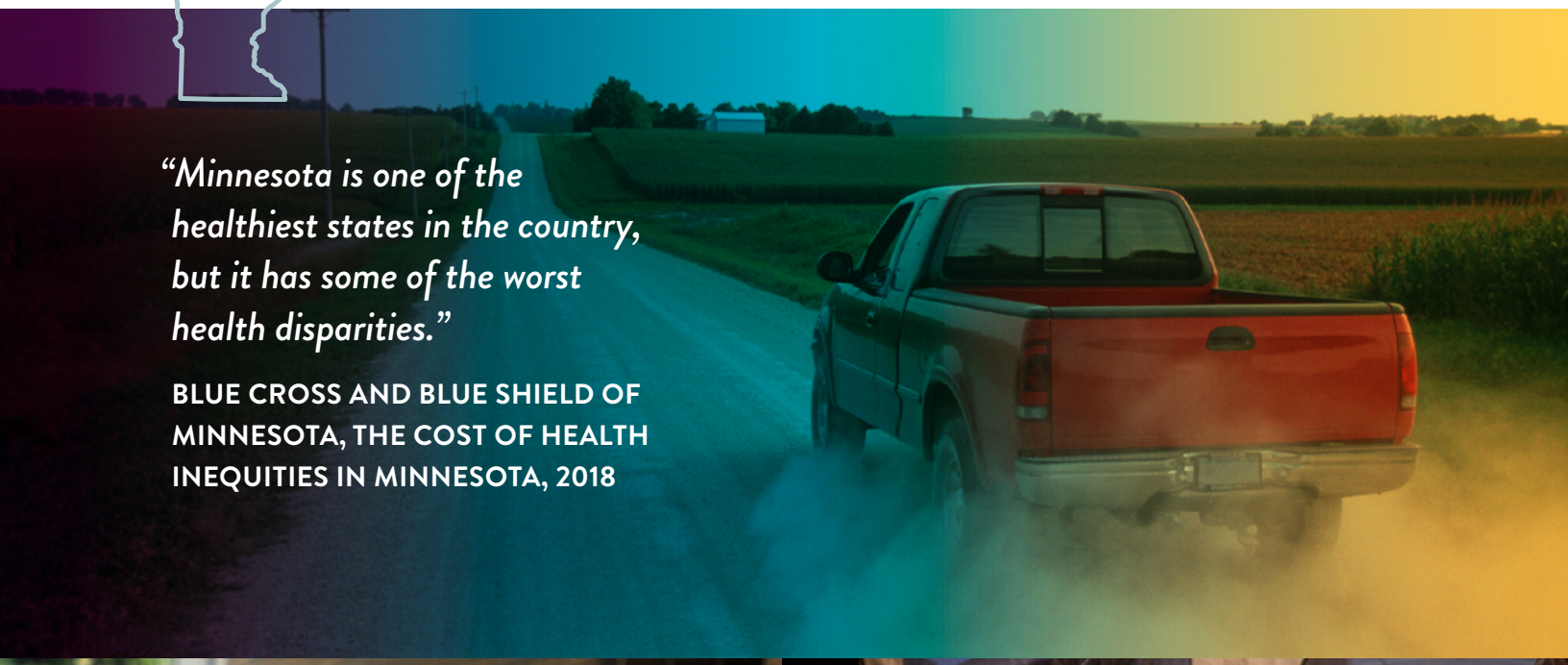
Cardiovascular disease, stroke, and diabetes also increase costs for Minnesota's health care system and for those who use that system, through increases in health care and health insurance costs and taxes, as well as lost productivity. In 2017, medical costs for people with diagnosed diabetes were $4.7 billion,[11] and missed work and lowered productivity related to this disease cost another $1.2 billion.[12] Medical debt, including from cardiovascular disease, stroke, and diabetes, is currently the largest cause of personal bankruptcy for Minnesotans.[13]

BARRIERS THAT PREVENT GOOD HEALTH

One of the most troubling facts about cardiovascular disease, stroke, and diabetes in Minnesota is how unequal the burden of these diseases is across the state's communities, due to inequities and other social determinants of health. American Indians; African Americans; Hispanics and Latinos; Somalis, Hmong, and other Asian communities; rural residents; low-income individuals and families; unemployed, uninsured, and underinsured individuals; members of the LGBTQIA+ community; people with physical and/or mental disabilities; new immigrants; and others are more likely to develop these chronic diseases and be negatively impacted by them.

For example, from 2018-2021, American Indians died from heart disease at much higher rates than every other race and ethnic group, at more than 50% higher than Minnesotans overall. American Indian adults, aged 35-54, die from heart disease at more than three times the rate of Minnesotans overall.[15]

Equally troubling statistics also exist for African Americans as well as other communities. African American adults, aged 35-64, die from heart disease at approximately two times the rate of Minnesotans overall.[16]



"Minnesota is one of the healthiest states in the country, but it has some of the worst health disparities."

BLUE CROSS AND BLUE SHIELD OF MINNESOTA, THE COST OF HEALTH INEQUITIES IN MINNESOTA, 2018

Photo by Paul Vincent

On average, Asians and Pacific Islanders suffer from diabetes, kidney disease, and cardiovascular disease at three times the rate of the general population.[17] And these are only a few of the disparities that health researchers are aware of. There are likely many other disparities that exist but have not yet been tracked.

35-64 YR OLD

MN American Indians and Black Americans are TWO TO FOUR TIMES more likely to die of heart disease or diabetes [18]

Structural racism and oppressive practices directed at certain groups of Minnesotans, as well as state geographic inequities, are the driving causes of health disparities in Minnesota that lead to chronic diseases and poor health. These disparities are diverse, complex, and intertwined. They result in unequal opportunities and access to goods, services, and the resources that create good health. Social determinants of health, such as a lack of access to healthy, affordable foods and clean water; safe and affordable housing; stable and fairly paid employment; good, quality education; easy access to nearby clinics and hospitals; safe and healthy neighborhoods with opportunities for physical activity; and social networks can also contribute to health disparities.[19]

These barriers often result in behaviors that impact health outcomes. According to the U.S. Centers for Disease Control and Prevention, 80% of heart attacks and strokes are preventable,[20] and it's been calculated that nearly 60% of all deaths in the population ages of 30 to 84 might be prevented or postponed through strategies designed to prevent heart disease.[21] This impact is due, in part, to the fact that the behaviors that reduce the risk of cardiovascular disease, stroke, and diabetes also reduce the risk of several cancers, lung disease, and dementia.[22]

Photo by MN DNR

70% OF PEOPLE

with self-reported disabilities have at least one of these conditions—cardiovascular disease, stroke, or diabetes—compared to only 40% of people without a self-reported disability.[23]

In addition to health disparities, there are many challenges within the health care system that further affect the ability of Minnesotans to achieve and maintain good health. The cost of care, treatment, medicines, and health insurance negatively impact the health of Minnesotans, as do challenges within health insurance programs that result in unequal treatment and services for Minnesotans, often based on income, demographics, and geography. For the elderly, people with lower incomes, and others, these factors contribute to the occurrence of chronic diseases including cardiovascular disease, stroke, and diabetes.

Photo by Ayssa Hei

DEFINITIONS YOU NEED TO KNOW

Health disparities
A type of preventable health difference that is closely linked with social, political, economic, and environmental disadvantages. Health disparities may occur because of where people live, race, ethnicity, sex, gender identity, sexual orientation, age, religion, disability, education, income, or other characteristics beyond one's control.

Social determinants of health
The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, learn, and age that affect a wide range of health outcomes and risks.

Health equity
The state in which everyone has a fair and just opportunity to attain their highest level of health.

Photo by Kurt Barclay Gear Junkie

"The MN 2035 Plan ... is a road map and call to action for communities, health care organizations, community and organizational leaders, and individuals to collaborate to prevent, treat, and manage cardiovascular disease, stroke, and diabetes through 2035. Its goal is to save lives and improve health and well-being, especially in those communities throughout Minnesota currently experiencing the greatest negative health outcomes."

A "ROAD MAP" TO PREVENT AND TREAT CARDIOVASCULAR DISEASE, STROKE, AND DIABETES

It is in the interest of all Minnesotans to reduce the occurrence and severity of these diseases by focusing on creating more prospects for good health and health equity, especially for the communities and individuals who face the largest barriers. Improving treatment and prevention of these diseases and empowering the individuals living with the diseases with the resources to better manage them will help Minnesotans live longer, healthier lives. There is tremendous insight, knowledge, and wisdom that exists at the community, state, and tribal levels throughout Minnesota that can be tapped into to help guide community-driven, local solutions.

Minnesota's Action Plan to Address Cardiovascular Disease, Stroke, and Diabetes 2035 (MN 2035 Plan) is designed to improve the health of Minnesotans and Minnesota. Created with the support and input of the communities and organizations most impacted by these diseases, the MN 2035 Plan is a road map and call to action for communities, health care organizations, community and organizational leaders, and individuals to collaborate to prevent, treat, and manage cardiovascular disease, stroke, and diabetes through 2035. Its goal is to save lives and improve health and well-being, especially in those communities throughout Minnesota currently experiencing the greatest negative health outcomes.

The MN 2035 Plan outlines the positive strategies that can be implemented throughout the state by organizations, communities, the health care system, and others to prevent these chronic diseases while helping those living with them to have healthier and more productive lives. Health care providers, advocacy organizations and networks, insurers, businesses, employers, policymakers, local public health agencies, educators, nonprofits, tribes, and governmental entities all can use the MN 2035 Plan's information and detailed strategies in their efforts to create a healthier Minnesota.

Photo by Lucy Hawthorne

SECTION 2

Photo by MN DNR

CREATING THE 2035 PLAN: MINNESOTANS COME TOGETHER TO ADDRESS AND IMPROVE HEALTH EQUITY

Watch the public input process for the MN 2035 Plan Video (https://youtu.be/I2t8DtGCVGA?si=j8hA9RC0r3tKwjcl)

COMBINING DISEASES INTO A SINGLE ACTION PLAN

Diabetes, cardiovascular disease, and stroke often go hand in hand. The factors that can lead to heart disease can sometimes also cause diabetes and vice versa. Having diabetes can also result in cardiovascular disease.[24] People with diabetes are twice as likely to have heart disease or a stroke than someone who doesn't have diabetes—and at a younger age. The longer you have diabetes, the more likely you are to have heart disease and stroke.[25]

For the first time, the MN 2035 Plan combines cardiovascular disease and diabetes to create a single action plan. By combining these strongly related chronic diseases into a single plan, everyone can have a greater impact on the effort to reduce the occurrence and impacts of both diseases, while also addressing disease-specific issues.

A PLAN BUILT BY MINNESOTANS, FOR MINNESOTA

The MN 2035 Plan was developed by bringing together advocates, organizations, and networks—including those who directly represent communities most impacted by these chronic diseases—individuals, insurers, businesses, employers, public health agencies, educators, representatives of American Indian communities, nonprofits, health care providers, governmental entities, and others.

For each of the chronic conditions addressed by the MN 2035 Plan, three focus areas were initially identified:

- **Disease prevention:** Preventing the occurrence of cardiovascular disease, stroke, and diabetes among Minnesotans, especially the populations who currently face the highest risk of these diseases.
- **Long-term management:** Ongoing clinical, community, and self-management activities that ensure cardiovascular disease risk factors and diabetes are managed in a way to help people live well.
- **Acute treatment:** The identification, diagnosis, and treatment of events for which time is of the essence, such as acute stroke, heart attack, or sudden cardiac arrest.

Through many conversations and additional community input, the network of partners incorporated these focus areas into the MN 2035 Plan. Three overall goals were identified to better prevent, manage, and treat cardiovascular disease, stroke, and diabetes. They include:

GOAL 1 *Eliminate racial, geographic, and other health inequities that lead to higher rates of cardiovascular disease, stroke, and diabetes for certain populations in Minnesota.*

GOAL 2 *Remove barriers to good health and well-being.*

GOAL 3 *Increase access to affordable and culturally appropriate prevention strategies, and clinical services and disease self-management options for those who have, or are at risk of experiencing, heart disease, stroke, and diabetes.*

MN 2035 PLAN GUIDING PRINCIPLES

Central to the creation of the MN 2035 Plan is a set of core guiding principles. They include:

- The creation of health equity for all Minnesotans
- Individual- and community-centered approaches
- Human right to quality health care services
- Authentic and ongoing community and stakeholder engagement
- Collaborative action among many partners to achieve common goals
- A sustained approach that creates opportunities for growth and change

Photo by Stephen Hoglund

AN IN-DEPTH PUBLIC ENGAGEMENT PROCESS

The Minnesota Department of Health and its partners reached out to communities most impacted by cardiovascular disease and diabetes—and those working to prevent and treat the diseases—to get ideas and input on what should be in the MN 2035 Plan. Over a two-year period, workgroups provided input and ideas, one-on-one conversations took place, internal and external group listening meetings were held, and surveys were conducted. During this same period, existing health data was reviewed. A leadership team composed of members with a range of perspectives from communities most impacted by cardiovascular disease, stroke, and diabetes, as well as health care professionals and others, was created to help guide the development of the MN 2035 Plan.

This public engagement process included:

- Thirteen meetings with the three work groups that were created around the focus areas of prevention, disease management, and acute treatment
- Three community engagement events attended by more than 35 individuals, many of whom represented health- and community-based organizations
- Twelve leadership team meetings
- A statewide survey of 540 Minnesotans, who detailed their cardiovascular, stroke, and diabetes health needs
- In-person and telephone key informant interviews with 45 individuals representing health- and community-based organizations; nonprofits; higher education; American Indian, Hmong, African American, and Hispanic and Latino communities; community health centers; those with disabilities; older adults; and others

SECTION 3

MINNESOTA'S ACTION PLAN TO ADDRESS CARDIOVASCULAR DISEASE, STROKE, AND DIABETES 2035

Photo by Leech Lake Band of Ojibwe

HOW TO USE THE 2035 PLAN

The MN 2035 Plan consists of 10 key outcomes, each of which is accompanied by a series of strategies designed to help achieve those outcomes.

These outcomes and strategies were developed over a two-year period through input from Minnesotans who are representative of the groups most impacted by cardiovascular disease, stroke, and diabetes, as well as those who work to prevent, treat, and manage those diseases. A leadership team composed of members with a broad array of perspectives from communities most impacted by these diseases, as well as health care professionals and others, reviewed and provided input on the outcomes and strategies. To see the organizations and individuals engaged in helping to create the MN 2035 Plan, please visit MN 2035 Plan (https://www.health.state.mn.us/2035plan).

Each outcome strategy also includes examples of actions that can be taken to help achieve the strategies. These examples are not meant to be prescriptive but rather as idea and thought starters to help inform action. Many of them mirror ongoing work currently taking place throughout Minnesota, highlighted in the success story videos that are included in the online version of the plan. To learn more about this ongoing work, please visit MN 2035 Plan (https://www.health.state.mn.us/2035plan).

The MN 2035 Plan is not the end point in the effort to reduce the occurrence of cardiovascular disease, stroke, and diabetes; to improve treatment of these diseases; and to empower individuals living with them. Rather it is a starting point meant to be built on and added to over the next decade and beyond.

OUTCOME 1

Invest in diverse, meaningful, long-term partnerships to improve community health, address social determinants of health, and enhance care practices.

Watch the Outcome 1 Success Story:
Partners in Prevention (https://youtu.be/JO1aayq7ORc?si=tHYiYSJLw1t4Uaqi)
Using a public health nursing model to foster conversations about health and wellness and to build a strong nursing workforce.

Strategy 1: Specifically budget time and resources for relationship building.

Example Actions:

- Budget time at the start of projects for listening and building relationships and trust.
- Identify realistic expectations about the time commitment needed for group meetings and projects to successfully build relationships.
- Financially pay community members and community-based organizations for their time and effort.

Strategy 2: Develop relationships around common goals.

Example Actions:

- Create space to learn about community or organizational goals and needs.
- Work to identify common goals shared across organizations that can bring organizations together.
- Partner with community groups or organizations to identify meaningful indicators of success.

Strategy 3: Seek out opportunities to engage and participate in partnerships with communities, health care networks, and other sectors.

Example Actions:

- Show up and participate in existing community and other multi-sector efforts to improve community health and well-being.
- Explore partnerships across sectors, disciplines, regions, and geographies that have not traditionally been included or pursued.

OUTCOME 2

Work toward health equity for all.

Watch the Outcome 2 Success Story: Butterfield Hardware (https://youtu.be/Zf33N9bding) Increasing access to healthy and affordable foods in Greater Minnesota with the support of the Minnesota Good Food Access Fund.

Strategy 1: Recognize and address how biases often operate together, in order to build equitable health and social systems.

Example Actions:

- Assess organizational practices and build a plan with concrete, time-bound actions to improve equity. Create and reinforce work cultures that remove bias from processes.
- Use a Health in All Policies (https://www.apha.org/topics-and-issues/health-in-all-policies) approach to evaluate potential policies and consider equity before implementation.
- Implement training programs on bias, racism, and other discriminatory attitudes that incorporate follow-up work.

Strategy 2: Acknowledge and address historical trauma using culturally responsive and holistic approaches.

Example Actions:

- Educate leaders about historical trauma and how it contributes to health outcomes and mistrust of health care and community health systems.
- Educate workers about how to be culturally responsive.
- Train providers to implement trauma-responsive care approaches and how to make referrals to trauma-related resources.

Outcome 2 continued on next page

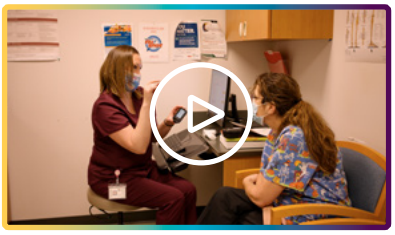
Strategy 3: Recognize the important role of social determinants of health (SDOH) and integrate steps to address them in all work.

Example Actions:

- Build partnerships between community, political, and health care leaders to address SDOH.
- Support and expand the use of workers who bridge health care and community to better address social needs.
- Gather and share data about SDOH for different groups of people so effective, community-informed interventions can be developed.

OUTCOME 3

Share power to effect change.



Watch the Outcome 3 Success Story: Bois Forte (https://youtu.be/ZB4BlQgFYBA) Connecting members to their traditional culture through multifaceted health and wellbeing efforts.

Strategy 1: Create and sustain authentic partnerships and power sharing.

Example Actions:

- Ensure funding supports long-term, dynamic engagement by community members and organizations.
- Implement effective strategies for power sharing.
  - Use community-based decision making in grant processes and other decisions.

Strategy 2: Engage community participation and leadership from the beginning.

Example Actions:

- Continuously expand community outreach and participation beyond existing partnerships through the inclusion of new communities and community members.
- Co-create with community members and organizations (e.g., working with communities, not directing communities).

Strategy 3: Recognize that communities have unique insight, therefore they contribute valuable knowledge that should be the basis for any solution.

Example Actions:

- Compensate community members and community-based organizations for their participation.
- View contributing community members and community-based organizations as expert consultants rather than volunteers.

Watch the Outcome 4 Success Story: NACC (https://www.youtube.com/watch?v=IKa6sYKFukk) Creating visual educational materials to make self-monitored blood pressure cuffs easier to use.

OUTCOME 4

Create systems that improve access to and integrate clinical and community health services.

Strategy 1: Increase collaboration between clinical and community-based organizations to integrate services to improve people's health and well-being.

Example Actions:

- Develop partnerships and work collectively across health care and community organizations to optimize resources to achieve greater goals and address community needs.
- Expand and improve coordination efforts among health care providers and across a variety of health care settings to better support patients seeking health care services and community supports.

Strategy 2: Build or enhance data sharing and coordination systems that respond to community needs for health and social services, prevention and self-management programs, and supporting activities.

Example Actions:

- Build or enhance health information exchange systems to improve access to patient health records so clinics can refer patients to community-based services and programs, and both clinical and community service providers can follow up on patient care and support.
- Coordinate real-time, simplified, and innovative data sharing to meet the needs of communities.
- Build partnerships to collaboratively conduct community health and health needs assessments and use them to implement coordinated projects.

Strategy 3: Increase access to community and clinical resources through improved planning, coordination, and integration of work.

Example Actions:

- Identify resources and create or improve methods to connect people and organizations to them.
- Use technology and innovative tools to make multi-directional referrals to programs and services and to create opportunities for feedback to make sure that the needs of individuals are being met.
- Use incentives to support participation in programming, care coordination, and other supportive services.

OUTCOME 5

Improve health data collection and enhance utilization.

> *"We don't change what we don't measure."*
>
> **KEVIN A. PETERSON, MD**
> **UNIVERSITY OF MINNESOTA MEDICAL SCHOOL**

Strategy 1: Strengthen and maintain data collection infrastructure for cardiovascular- and diabetes-related conditions and outcomes.

Example Actions:

- Expand and support surveillance data on chronic conditions to meet community and public health goals.
- Standardize community data measuring cardiovascular- and diabetes-related conditions and outcomes.

Strategy 2: Establish and maintain data collection standards that support equity goals and reporting that inform community and public health data needs.

Example Actions:

- Establish and maintain data standards that describe communities (e.g., race, ethnicity, disability status, sexual orientation, gender identity, country of origin, preferred language) and allow for breaking data apart so that what is happening for specific groups and communities can be better understood.
- Establish and maintain data collection methods that permit reporting data for small geographies.

Strategy 3: Co-develop and engage in assessment, evaluation, and research using participatory and community-driven approaches.

Example Actions:

- Engage with community to utilize diverse methods of data collection, analysis, and reporting (e.g., community-based participatory research models, Indigenous and non-Western perspectives, mixed qualitative and quantitative strategies, and outcome evaluation methods).
- Co-develop evaluation processes to measure community health goals with community data.

Strategy 4: Strengthen approaches and standards to share and use data.

Example Actions:

- Implement data-sharing practices centered on usability and community empowerment.
- Implement robust data-sharing practices for community benefit.
- Simplify and increase supports to help communities to effectively develop and use data.

OUTCOME 6

Expand and diversify health care and the community health workforces, including leadership.

Watch the Outcome 6 Success Story: HealthFinders (https://youtu.be/actgZSjSGYY) Using a community health worker model to improve community health.

Strategy 1: Train the workforce to understand and appreciate language and cultural differences and apply cultural humility in practices.

Example Actions:

- Create and reinforce cultures in the workplace that emphasize respect and self-reflection from health care providers.
- Build opportunities for the health care workforce and the community to learn from each other and co-create solutions.

Strategy 2: Cultivate a health care workforce that reflects the community's cultural makeup and understands its needs.

Example Actions:

- Use incentives, targeted recruitment and retention strategies, and technology (e.g., telehealth, mobile health) to expand the workforce.
- Create a path to train, recruit, support, and retain health care workers from Black and African American, American Indian, Asian, Latino/a, and other communities including rural, disability, and LGBTQIA+ communities. Build mechanisms for people to continue pursuing more advanced degrees.
- Hire health care providers who speak the languages of the communities being served.

Strategy 3: Expand the types of health care workers to reflect the needs of the community and increase their numbers.

Example Actions:

- Increase the number of health care workers in the community to meet community needs and address workforce shortages.
- Implement strategies to increase support for community-based health care workers by using train-the-trainer models, engaging community health workers across clinics, etc.

Strategy 4: Provide appropriate compensation to all health and community care workforce employees.

Example Actions:

- Ensure fair pay for community health workers, care coordinators, and others who help to connect health care with community resources, address social needs, and support care coordination.
- Pay people for work that benefits the organization even if the people are not employed by the organization (for example, community knowledge keepers, cultural resources, and translators).

OUTCOME 7

Expand shared learning and education to build knowledge, skills, and health.

Watch the Outcome 7 Success Story: Whitney Senior Center + CAIRO (https://youtu.be/Tf1lW2RZA0?si=zP1pqwscalC4QqL8) Offering the National Diabetes Prevention Program to Somali residents in a culturally relevant setting.

Strategy 1: Expand educational delivery through clinical and community channels and by using varied methods, locations, and messengers.

Example Actions:

- Increase access to, awareness of, and participation in proven prevention and disease management programs and include telemedicine and culturally and linguistically appropriate formats.
- Share messages in fun and engaging ways, such as storytelling, in community locations where gatherings already occur.

Strategy 2: Co-design education with community, keeping culture, language, and health literacy in mind.

Example Actions:

- Develop toolkits and other resources with community experts that support proven prevention or self-management strategies.

Strategy 3: Coordinate work within and across organizations and with community to support learning and delivery of education.

Example Actions:

- Bring people together across regions, sectors, and organizations to collaborate and learn about new and different perspectives on strategies and messaging from diverse communities.
- Fund collaborative work between diverse partners, including public health, schools, faith-based organizations, community organizations, etc.

Strategy 4: Reinforce a culture of health.

Example Actions:

- Identify and promote stories within communities that acknowledge and affirm the sources of strength and resilience communities hold that lead to improved health.
- Promote the fun side of nutrition and exercise that supports well-being, in addition to disease prevention, while creating awareness around the need to employ behaviors that support good health.
- Increase education to build awareness and engagement in efforts to change school policies to increase physical activity, healthy eating, and reduce access to commercial tobacco and nicotine.

Strategy 5: Increase understanding about reducing chronic disease risks, improving self-management, and responding to warning signs of heart disease, stroke, and diabetes-related problems.

Example Actions:

- Promote activities that support good health, including healthy eating through increased access to fruits and vegetables, safe access to physical activity, stopping the use of commercial tobacco products and nicotine, social support, stress management, mental well-being, oral health, and sleep.
- Create awareness of the benefits of adopting health-promoting behaviors related to healthy eating, increased physical activity, wellbeing, and commercial tobacco and nicotine use reduction.
- Raise awareness and share resources about the American Heart Association's Life's Essential 8 to lower the risk for heart disease, stroke, and other major health problems.
- Increase community knowledge of early warning signs for heart-related problems, stroke, and diabetes and what to do about them.

Strategy 6: Develop and expand education about policy and advocacy work to impact health. Recognize and uplift existing community policy and advocacy work.

Example Actions:

- Translate policy impacting the community to plain language so people feel empowered to support issues that are relevant to them.

Photo by Leslie Anderson

OUTCOME 8

Support the implementation of community-led programs and solutions in community settings.

Watch the Outcome 8 Success Story:
Rise (https://youtu.be/yWlBv0fH9pA)
Adapting physical activity programs to meet client's needs.

Strategy 1: Create systems and structures to support community members in developing and leading strategies, solutions, and programs.

Example Actions:

- Work with community members to develop programming and strategies that fit community needs (e.g., serving communities of color, refugees, rural communities, people experiencing homelessness, those with chronic diseases, etc.).
- Use community-based decision making in grant processes and other decisions.
- Lead organizations should provide funding to implement a community decision-making model to engage communities in planning and delivering prevention education.

Strategy 2: Provide services and/or programs in ways that are responsive to community needs and in familiar, trusted settings.

Example Actions:

- Develop or adapt health education and programs to be culturally, linguistically, and ability appropriate for different communities and settings.
- Encourage participation in screening programs outside of the health care system, such as in grocery stores, libraries, community centers, farmers markets, schools, and other locations.

OUTCOME 9

Enhance delivery of quality, whole-person care inside and outside the clinic.

Watch the Outcome 9 Success Story: Southside Community Health Services (https://www.youtube.com/watch?v=atCod2BilXg) Connecting their team members and supporting new ideas to better serve patients.

Strategy 1: Increase access to evidence-based preventive care, disease management, specialty care, and rehabilitation that follows guidelines and protocols for those most at risk for cardiovascular disease, stroke, and diabetes.

Example Actions:

- Offer multiple access points to care/care settings, including non-clinic-based care settings.
- Use technology to increase access.
- Ensure best practices and protocols are applied in a community-informed manner.
- Set up systems to screen patients for health-related social needs and make referrals, as needed, to social services and other supports.

Strategy 2: Provide whole-person care inside and outside the clinic by creating opportunities for patients to practice self-management, advocate for themselves, and shape their own care planning.

Example Actions:

- Include patient perspectives to help guide care planning.
- Teach patients to advocate for themselves.
- Explore patient peer-to-peer learning opportunities.

Outcome 9 continued on next page

Strategy 3: Improve and increase patient-provider engagement.

Example Actions:

- Improve provider and health care team communication methods and skills to successfully engage and serve patients.
- Allow providers and care team members to bill for communication time to effectively engage and support patients.

Strategy 4: Use team-based care and provide care coordination that is person-centered.

Example Actions:

- Use health information systems to support team-based care to monitor individual and population health with a focus on health disparities.
- Improve community-clinical linkages and information sharing to enhance services for patients.
- Set up clinical-community linkages to screen and refer patients for social needs and supports to advance disease management and treatment that improves patient health and well-being.

Strategy 5: Use data to inform screening, prevention, and disease management programs.

Example Actions:

- Use data to prioritize individuals for participation in prevention and disease management programs.
- Use patient record data to appropriately screen for cardiovascular disease, diabetes, and risk factors.

Watch the Outcome 10 Success Story: Hmong American Farmer's Association (https://www.youtube.com/watch?v=BIAjDltt8i8) Fostering a community-provider connection through fresh, locally grown produce.

OUTCOME 10

Ensure all people have access to resources and supports needed to prevent disease and promote health and well-being in policy and practice.

Strategy 1: Increase funding and supports for in-person and telehealth delivery of prevention, disease management, mental health, and other well-being resources.

Example Actions:

- Improve reimbursement policies and payment structures for allied health services, including telehealth services.
- Incorporate stress management or other mental health or well-being content with disease prevention and management programs.
- Expand reimbursement for delivery of the National Diabetes Prevention Program (National DPP) to people most at risk for acquiring diabetes and continue to promote and implement cost-effective and culturally appropriate program delivery methods.

Outcome 10 continued on next page

Strategy 2: Develop and advocate for community and systems-driven policy changes that address social determinants of health, including safe spaces to be physically active, access to healthy and affordable food, and affordable and dignified housing, as well as the reduction of commercial tobacco and nicotine use.

Example Actions:

- Advocate for policies that support health-promoting behaviors in workplaces, schools, childcare facilities, businesses, faith-based and government organizations, and other settings.
- Develop programs that cover or subsidize costs associated with making healthy choices readily available (e.g., access to healthy and affordable foods, safe places to exercise, commercial tobacco and nicotine prevention and cessation), particularly in rural and/or under-served communities.

Strategy 3: Improve funding and reimbursement to increase access to affordable and culturally responsive health care and supportive services.

Example Actions:

- Improve reimbursement policies and payment structures by shifting payment away from acute treatment and fee-for-service payment toward prevention, disease management and improved patient outcomes (e.g., pay for counseling, care coordination, community health worker support and patient improvements like reduced blood pressure and A1C blood glucose levels).
- Encourage insurers to cover wider sets of necessary services and build broader provider networks that decrease barriers to accessing health care and medicines.
- Improve availability of translation services and work to provide culturally responsive care.

Uniting Minnesotans together in a collaborative, community integrated effort.

SECTION 4

Photo by Ben Threinen and Lake City Sportsmans Club

HOW TO GET INVOLVED IN IMPLEMENTING THE MN 2035 PLAN

This plan was created by bringing together individuals with a wide variety of perspectives, experiences, roles, and knowledge of cardiovascular disease, stroke, and diabetes. Its success will depend on all of those same individuals, and others, working together in a collaborative, community-integrated effort.

There is room for every Minnesotan to help implement the MN 2035 Plan, from communities across the state, to health care professionals, to business leaders, and even to those with just an interest in heart disease, stroke, and diabetes. Its success depends on champions like you working together to help implement the plan's strategies.

Please visit the MN 2035 Plan (https://www.health.state.mn.us/2035plan) website to:

1. Stay updated on the MN 2035 Plan.
2. Seek out potential funding opportunities.
3. Get engaged in helping to implement the MN 2035 Plan.
4. Access ongoing strategies and actions others are doing that can be used as a model to reduce the rates and impacts of cardiovascular disease, stroke, and diabetes.
5. Learn about ongoing success stories.
6. Interact with others working to eliminate health disparities.

To learn more about how to get involved in implementing the MN 2035 Plan, visit MN 2035 Plan (https://www.health.state.mn.us/2035plan) or contact the Minnesota Department of Health:

- Cardiovascular Health Unit: health.heart@state.mn.us
- Diabetes and Health Behavior Unit: health.diabetes@state.mn.us

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