

Healthy Minnesota 2022 Update: 2018 Annual Report of the Healthy Minnesota Partnership

MARCH 2019



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2018 Annual Report of the Healthy Minnesota Partnership**

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Contents

Healthy Minnesota Partnership.....	4
Guiding principles.....	4
Vision and values.....	4
Healthy Minnesota 2022: Statewide Health Improvement Framework.....	5
2018 progress on Healthy Minnesota 2022.....	6
Strategic approach: Expanding the conversation about what creates health and well-being.....	6
Strategic approach: Shape policies and systems around health and well-being.....	7
Strategic approach: Promote and apply an asset-based approach.....	7
Partner actions in 2018.....	8
Advance the emerging health narrative.....	8
Apply a health lens to policy issues.....	10
Contribute data and other information around key focus areas.....	11
Looking ahead: 2019.....	12
Strategic opportunities for 2019.....	12
Compiling the public narrative work of the Partnership.....	12
Partnership membership and structure.....	12
Appendix A: About the Healthy Minnesota Partnership.....	13
Partnership members and alternates during 2018.....	13
Staff to the Partnership in 2018.....	14
Guests at 2018 Partnership meetings.....	14
2018 narrative strategy participants.....	15
Appendix B: 2018 emerging narrative frames.....	16
Emerging narrative frames on early childhood.....	16
Emerging narrative frames on housing, home, and health.....	17

Healthy Minnesota Partnership

The Healthy Minnesota Partnership brings together community partners and the Minnesota Department of Health (MDH) to improve the health and quality of life for individuals, families, and communities in Minnesota.

First convened in 2010 by the commissioner of health, the Partnership identifies and acts on strategic opportunities to improve health and well-being for all people in Minnesota. The members come from rural, suburban and urban communities; from hospitals, health plans and public health departments; from business and government agencies; and from faith-based, advocacy, and community organizations, and from organizations led by those most impacted by health inequities (for more information, see [Appendix A: About the Healthy Minnesota Partnership](#)).

In 2018, the Partnership activities included:

- Directing the development and publication of the 2022 Statewide Health Improvement Framework. (**Figure 1**)
- Developing a discussion guide to help multiple audiences to consider the 2017 Minnesota Statewide Health Assessment (SHA), which provides a picture of health and well-being across Minnesota.¹
- Committing to housing as strategic opportunity.
- Convening nearly 50 participants from across the state to develop frames around housing, homes and health as a means to advance a health-in-all-policies approach to housing.
- Providing updates to the SHA through the collection and publication of primary data.
- Updating the Partnership charge and charter document.
- Preparing for state government administrative transitions after the 2018 gubernatorial election.
- As part of the development of the 2022 Statewide Health Improvement Framework, the Partnership updated its guiding principles, vision and values.

Guiding principles

- We are explicit about race and racism.
- We lead by doing.
- We focus on the policy discussions and decisions that shape opportunities for health.
- We innovate and practice.

Vision and values

All people in Minnesota enjoy healthy lives and healthy communities.

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.

¹ Learn more: [Minnesota statewide health assessment](http://www.health.state.mn.us/communities/practice/healthymnpartnership/sha.html)
(www.health.state.mn.us/communities/practice/healthymnpartnership/sha.html)

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.

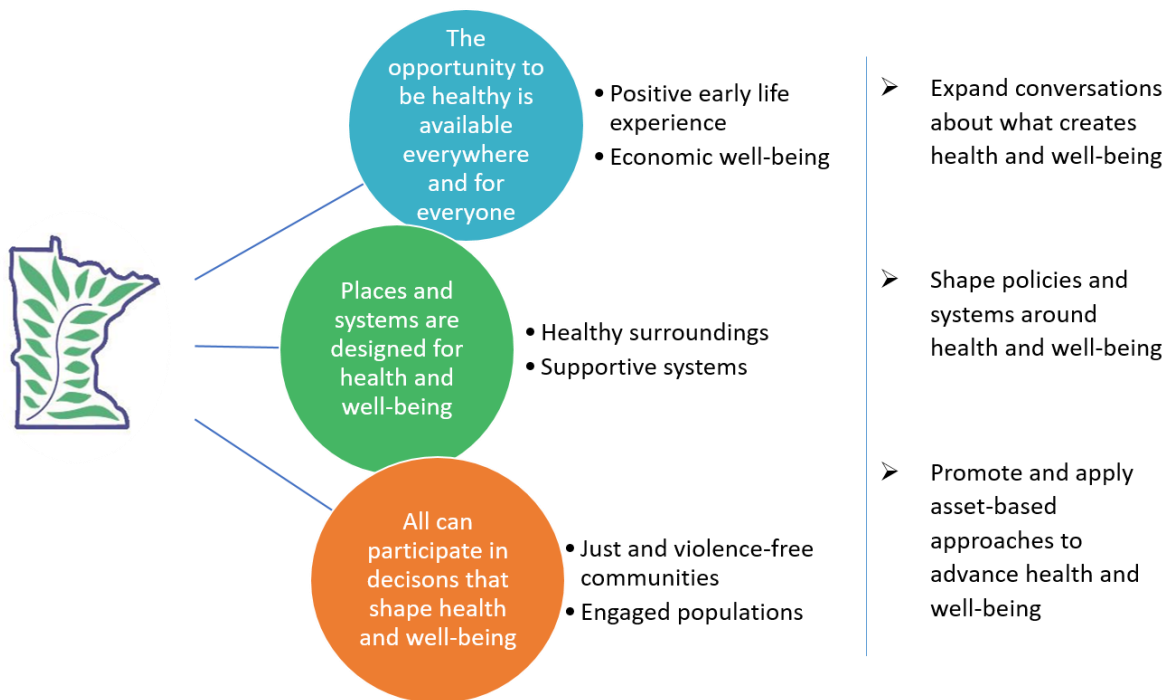
We value... difference. We recognize that we are all members of many communities, with great diversity of experience, perspectives, and strengths. We value the differences each person brings to the conversation because those differences make us stronger together than we would be alone.

Healthy Minnesota 2022: Statewide Health Improvement Framework

The Healthy Minnesota 2022 framework identifies three priorities to guide the Partnership’s work to improve health and well-being across Minnesota. These three priorities build on the 2017 SHA categories of opportunity, nature, and belonging and provide touchstones for future commitments:

- The opportunity to be healthy is available everywhere and for everyone
- Places and systems are designed for health and well-being
- All can participate in decisions that shape health and well-being

Figure 1. Healthy Minnesota 2022 vision



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

The Framework also identifies three strategic approaches:

- Expand conversations about what creates health and well-being
- Shape policies and systems around health and well-being

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

The first two strategies are similar to those included in the 2020 Statewide Health Improvement Framework. A new strategy, to apply asset-based approaches to advance health and well-being, comes from in the knowledge that the communities most impacted by inequities not only need to be at decision-making tables, but bring many strengths and assets to those tables and to the state as a whole. The intention of an asset-based approach is to bring balance to the typical approach of focusing only on deficits, i.e., the inequities and health disparities experienced by many people in Minnesota.

In addition, to make sure that policy decisions do not benefit the health and well-being of some populations at the expense of others requires the active participation of all potentially affected populations and communities in the decision-making process. The healthy future of Minnesota calls communities, systems, and institutions to come together to assure fair and just decision-making processes to support the health and well-being of all.

This framework is a guide for activity by many on many fronts, 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.

2018 progress on Healthy Minnesota 2022

Strategic approach: Expanding the conversation about what creates health and well-being

Current public narratives that dominate policy conversations around health emphasize that health is created by clinical care and individual responsibility. The Partnership works to expand these conversations to draw attention on the conditions in the community that create and shape people's 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.

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. 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 the past five years, the Partnership has worked to expand the conversation about health by demonstrating the intersection of health with income, transportation, paid leave, access to healthy food, incarceration, early childhood, water, housing, and burdensome debt.

To implement this approach in 2018, the Partnership:

- Developed a discussion guide to help multiple audiences to consider the 2017 Statewide Health Assessment (SHA), a picture of health and well-being across Minnesota.
- Prepared over 70 people to lead discussions of the SHA.
- Committed to housing as strategic opportunity.
- Convened nearly 50 participants from across the state to develop frames around housing, homes and health as a means to advance a health in all policies approach to housing.

Strategic approach: Shape policies and systems around health and well-being

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

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

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

Policies and systems can be, and often are, designed without consideration for the impact they may have on human health and well-being. Paying attention to the human health impacts of, for example, the way roads are designed and built, often turns out to be good not only for health and well-being but for businesses and the community as a whole—because human thriving and economic well-being are interconnected in many ways.

To implement this approach, in 2018 the Partnership:

- Held a webinar on how to apply the housing, home and health frames in different housing policy discussions.
- Dedicated time at a Partnership meeting on how to use the housing, home and health frames in different housing policy discussions.

Strategic approach: Promote and apply an asset-based approach

As noted in the 2017 Minnesota Statewide Health Assessment, a tension exists between the many documented deficits and disparities in health status experienced by populations in Minnesota, and the knowledge that these same populations embody tremendous strengths and assets, including resilience in the face of suffering and trauma. All people and populations bring both their challenges and their strengths to their situations.

Public health data have often focused on the deficit side of populations, a view of populations as needing health education or fixing. This approach may reflect attitudes of white supremacy² and can risk becoming paternalistic. A deficit and expert approach can reinforce the exclusion of those experiencing health inequities in shaping decisions about what might benefit the health of their communities because they are perceived as having no or limited expertise.

An asset-based approach to health and well-being necessitates the participation of communities and populations experiencing health inequities to connect those strengths and assets to policy decisions. It will encourage the development of effective solutions by amplifying communities' assets and strengths in decisions affecting health and well-being.

The Partnership did not conduct any activities related to this strategic approach in 2018.

Partner actions in 2018

- To implement and support the Healthy Minnesota Framework and strategic approaches Partnership members are expected to:
- Advance the emerging health narrative
- Apply a health lens to policy issues
- Advance an asset-based approach
- Contribute data and other information around key focus areas

In 2018, partners took part in a wide range of activities to implement and support the Healthy Minnesota framework and strategic approach, as follows.

Advance the emerging health narrative

2017 Minnesota Statewide Health Assessment

The Minnesota Board on Aging used the 2017 Minnesota Statewide Health Assessment (SHA) for the Department of Human Services (DHS) *MN2030 Looking Forward* strategic planning effort, to help assess how people in Minnesota are aging.

Partnership members have shared the SHA with numerous other states and their health offices. One office was very interested in implementing Minnesota's approach, the other felt it was too "out there." Another state seemed quite a long way from thinking about population health from a systems perspective, and said that Minnesota is clearly leading the work in this area.

The Center for Community Health (a consortium of metro-area hospital systems, local health departments, and health plans), heard a presentation and had a discussion of the SHA. A member noted that the conversation continued after the presentation, and said that while this group had not really used the 2012 assessment, they were very receptive to adopting the approach of the 2017 SHA.

² White supremacy—an ideology that white people are superior to any other race—is a feature of programs and structures that favor white, European concepts of problems and solutions over community wisdom and cultural practices.

A couple of University of Minnesota students facilitated a conversation about health with a dozen other students and faculty, using the overview and discussion guide developed for the SHA. The sections in the SHA on nature and belonging especially stimulated a rich discussion.

The Health Equity Work Group of the School of Public Health at the University of Minnesota sponsored a discussion of the “belonging” section of the SHA at their regular meeting, attended by over 100 students and faculty.

Over 400 people across the state participated in discussions, informed by the SHA and the Partnership approach, convened by a large hospital system as part of their community health needs assessment process. Focus groups were held in Somali, Spanish and English. Participants raised concerns in particular about mental health, a healthy life, and access to health care.

The narrative in the SHA is helping the Department of Corrections in their efforts to improve health for residents of state correctional facilities, such as working with DHS to sponsor two financial workers to help inmates to apply for health benefits prior to their release from prison. Having benefits upon release helps prevent them from than falling into a financial and health care gap, which reduces the risk of recidivism.

Narrative training and frame development

The Minnesota Cancer Alliance has a policy committee that looks at how to improve health and reduce rates of cancer. Because they recognize the importance of narrative for being more effective in policy development and the implementation of cancer plans, they requested a training on public narratives. Since having that training, the committee takes 15 minutes at every meeting to identify dominant narratives affecting their work. They also are working to expand the narrative relative to cancer.

Newly elected leaders in the city of Minneapolis are using some of the language and approach that the Partnership developed and uses, to expand their own narrative.

Staff at MDH have been facilitating meetings of a community group to develop narrative frames around infant mortality in the African-American community. This group will now be working to find ways to use those frames to influence programs and policies and improve health for African-Americans in Minnesota.

The Department of Human Services held a narrative training where over 50 participants were motivated to look at their work through a narrative and equity narrative.

Narrative frames related to early childhood were drafted through a series of narrative trainings across Minnesota (see Appendix).

The Minnesota Council on Latino Affairs is using the narrative approach of the Partnership to advocate at the legislature for medical interpreter skills, highlighting the importance of competent medical interpretation for health.

Other narrative work

MDH and others have been expanding the public narrative around the issue of opioids. This broader narrative acknowledges the increasing rates of death by suicide, alcohol, and other drugs as well as opioids. One approach is to call these deaths “deaths of despair and disconnection,” which is a way to link these deaths to issues of belonging, opportunity, early childhood, and more. Framing these deaths with disconnection and despair is an attempt to move the conversation toward identifying the root causes of these increases in mortality.

The Minnesota Public Health Association is taking a narrative approach to gun violence to help illuminate gun violence issues across urban, suburban, and rural areas (for example, the majority of suicides by firearms do not take place in the urban core).

A presentation to MDH staff showed the health impacts of environmental noise, which is linked to cardiovascular disease and mental health concerns. The discussion included how environmental noise could become part of a health narrative; how it is an equity issue (i.e., recognizing who experiences more environmental noise); and a good area to look at through a health in all policies lens. The presentation showed estimated noise levels, which differ across areas of the state.

A member contributed to and shared a position paper on racism and its harmful health effects with the Partnership. The research lifts up the critical need to address racism to improve the health and well-being of youth and youth-serving health care providers.

Apply a health lens to policy issues

MDH provided consultation and technical assistance to a health impact assessment conducted by the Fond du Lac Band of Lake Superior Chippewa. The HIA looks at the wide-ranging health and social effects of water quality on wild rice beds, including the impact on the culture of the community. The effort expanded the narrative for decision-making on this issue and added depth to the science and the conversations taking place.ⁱ

The Minnesota Public Health Association supported several pieces of legislation including background checks, trauma care for children affected by gun violence, and relaxing restrictions currently in state law so MDH can do health-focused research on the effects of gun violence.

The Department of Human Services (DHS) medical director is working with the governor on opioids and tracking various legislative efforts designed to address this issue.

The MDH State Community Health Services Advisory Committee (SCHSAC) convened a work group to look at how to improve the quality of life of children whose parents were or are incarcerated. They will consider implications for state and local criminal justice policies.

DHS is exploring possible policy options that would improve health outcomes for people in deep poverty. They are considering policies that could increase income, improve health outcomes and reduce health care costs. Reviews of relevant literature by a University of Minnesota partner and “deep dives” into DHS data sources are supporting this effort.

A Partnership member is working with the MDH Office of Rural Health and Primary Care to integrate behavioral health with critical access hospitals, and to reduce the stigma of mental health through the arts.

Minneapolis has been working for 10 years on violence as a public health issue (i.e., not a criminal justice issue), together with the police. Recently the city council moved to take funding from the police—with the support of the police—and give it to public health to look at how to prevent violent crimes across the city. Minneapolis also used health in all policies to support their mandated \$11.25/hour minimum wage.

Boynton Health, the University of Minnesota student clinic, used health in all policies to establish \$11.25 as the lowest wage for student workers at the clinic; some will achieve \$15 per hour soon as part of Boynton’s commitment to the connection between income and health.

To support their strategic plan, DHS developed an equity policy that advances a health in all policies approach and aims to improve outcomes and reduce disparities in human services. They have hired three equity coordinators and will be hiring one more.

Many state agencies, including MDH, DHS, and MHFA are working on the urgent issue of growing rates of unsheltered homelessness across the state.

MnDOT staff received an invitation to participate in a recent discussion of health and transportation with the governor's office as recognition grows across the country about the links between health and transportation. An ongoing study of rural transit needs is looking at the multiple health impacts of access to transit, including social connectedness, employment, and access to health care.

As different areas in Minnesota discuss Tobacco 21 (a national campaign taking a local approach to raising the tobacco sales age from 18 to 21 years of age), the Partnership narrative work has helped supporters shift the narrative from punishment to prevention. For example, commissioners in one county discussed eliminating penalties for purchase, use, and possession because they did not want police arresting kids; they said that the Tobacco 21 initiative should be about preventing kids from getting addicted to nicotine.

Contribute data and other information around key focus areas

During 2018, Healthy Minnesota Partnership members and their partners worked on a number of key public health issues and community assets identified in the 2017 Minnesota Statewide Health Assessment (SHA). At Partnership meetings, members and others discussed the new data and information these reports provide and how these contribute to increased understanding and action on these important issues. Links to the reports (in the meeting summaries and below) allow the Partnership and others to incorporate this information into their own actions to improve population health and health equity.

- **Voices for Racial Justice** published a report in 2018 on *health and incarceration*, called *Unfit for Human Consumption*. In this project, they listened to the stories of people who have been in prison and family members of people currently and formerly incarcerated (*contributes to the "Belonging" section of the 2017 SHA*). **Voices** learned that those who have experienced incarceration, either directly or indirectly, experience profound effects on their physical and mental health, with lasting impacts on rates of incarceration, rehabilitation, and reentry to the community.ⁱⁱ
- The **Minnesota Department of Health** was a consultant and partner with the Fond du Lac tribe of Ojibwe on a report detailing the effect of water quality on wild rice production (*contributes to the "Nature" section of the 2017 SHA*). The study documents and publicizes effect of water quality on wild rice production and the connections this has to cultural wellbeing, community health, social cohesion, access to healthy food, equity, and other important issues.ⁱⁱⁱ
- The **Minnesota Housing Finance Agency** and the **Minnesota Department of Health** were among the agencies involved in two significant reports containing data and describing the issues of housing, home and health (*contributes to the "Opportunity" section of the 2017 SHA*).^{iv}
- **ISAIAH** conducted over 400 door-to-door interviews on family care in Central Minnesota, including affordable childcare, funding for in-home care, paid leave for new parents and solutions for the elder care crisis. Over 84 percent of the people interviewed shared their struggles around getting care and care giving (*contributes to both the "Opportunity" and "Belonging" sections of the 2017 SHA*).^v

Looking ahead: 2019

Strategic opportunities for 2019

In 2018, Minnesota elected a new governor, with the changes in state department leadership it entails. The Healthy Minnesota Partnership recognizes that new leadership at many levels creates new opportunities: to engage additional partners; to expand conversation about what creates health in populations; and to advance health in more policies. Gretchen Musicant, a member of the Partnership, has agreed to serve as co-chair during the first months of 2019, during the transition to a new governor's administration. The Partnership will develop a process to choose co-chairs and assign these roles after the transition.

The Partnership will consider future topic-specific strategic opportunities at its March and June meetings in 2019. The Partnership will also look closely at how to identify and incorporate community assets and strengths into their strategic approach.

The Partnership will continue to engage stakeholders across the state on the connection between housing and health. These continuing conversations will look for ways to link community assets and strengths to housing challenges, identify threats and opposing forces to positive change, engage more communities in their efforts, and advance housing policies that will have a positive impact on health.

Compiling the public narrative work of the Partnership

In 2019, staff at MDH will compile the existing narrative frames developed by the Partnership with the goal of making them more accessible to a wider audience. They also will document the process the Partnership took and continues to take to expand public conversations about what creates health and the conditions that people need for health and well-being, all aimed at advancing health equity.

Tools for applying the emerging narratives around health will accompany the narrative frames to assist those who would like to bring a health lens to policy discussions.

Partnership membership and structure

Members of the Partnership will contact those who have not been active participants to find out what would bring them back into fuller participation. The Partnership will get a summary of these conversations to consider in membership and recruitment discussions. Staff will develop a new web-based portal for accepting nominations to the Partnership.

Appendix A: About the Healthy Minnesota Partnership

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

Membership: The efforts of the Healthy Minnesota Partnership focus on the health of the state as a whole, and the membership of the partnership reflects a broad spectrum of interests. During 2018, the members and alternates of the Healthy Minnesota Partnership included the following:

Partnership members and alternates during 2018

- Carl Anderson: Boynton Health Services (University of Minnesota)
- Jeanne Ayers: Minnesota Department of Health
- Justin Bell: American Heart Association
- Ken Bence: Minnesota Public Health Association
- Kari Benson: Minnesota Board on Aging
- Lee Buckley: Minnesota Department of Corrections
- Barbara Burandt: State Community Health Services Advisory Committee (SCHSAC)
- Kathleen Call: University of Minnesota School of Public Health
- Rachel Callanan: American Heart Association
- Jenna Carter: Blue Cross Blue Shield Center for Prevention
- Meghan Colman, Minnesota Board on Aging
- Chris Conroy: TakeAction Minnesota
- Amber Dallman: Minnesota Department of Transportation
- Linda Davis-Johnson: Minnesota Department of Human Services
- Julia Dreier: Minnesota Council of Health Plans
- Kate Elwell: Boynton Health Services, University of Minnesota
- John R. Finnegan, Jr.: School of Public Health, University of Minnesota
- Thomas Fisher: College of Design, University of Minnesota
- Brett Grant: Voices for Racial Justice
- Sarah Grosshuesch: Local Public Health Association (Greater Minnesota)
- Kelley Heifort: Minnesota Department of Corrections
- Tim Henkel: Minnesota Department of Transportation
- Mary Hertel: Minnesota Board on Aging
- Alexa Horwart: ISAIAH
- Dan Kitzberger; Minnesota Housing Finance Agency
- Warren Larson: Sanford Health
- Kristin Loncorich: Minnesota Hospital Association
- Jan Malcolm, Minnesota Department of Health
- Anjuli Mishra: Council on Asian Pacific Minnesotans
- Tracy Morton: National Rural Health Resource Center
- Vayong Moua: Blue Cross and Blue Shield Center for Prevention
- Gretchen Musicant: Local Public Health Association (Metro)
- Lars Negstad: ISAIAH
- Kami Norland: National Rural Health Resource Center

- Susan Palchick: Local Public Health Association (Metro)
- Joan Pennington: Minnesota Hospital Association
- Lorna Schmidt: American Heart Association
- Barb Sporlein: Minnesota Housing Finance Agency
- Dave Sukharan: Council on Asian Pacific Minnesotans
- Maria Veronica Svetaz: Eliminating Health Disparities Grantee
- Rosa Tock: Minnesota Council on Latino Affairs
- DeDee Varner: Itasca Project
- Donna Zimmerman: Itasca Project

Staff to the Partnership in 2018

- Dorothy Bliss: Minnesota Department of Health
- Frederick Ogugua: School of Public Health, University of Minnesota
- Rochell Joseph: School of Public Health, University of Minnesota
- Jeannette L. Raymond: Minnesota Department of Health

Guests at 2018 Partnership meetings

- | | | |
|---------------------|-------------------|--------------------|
| ▪ Bill Adams | ▪ Marco Hernandez | ▪ Karen Nikolai |
| ▪ Dawn Baddeley | ▪ Derek Hersch | ▪ Nancy O’Brian, |
| ▪ Gretchen Benson | ▪ Samantha Holte | ▪ Kathryn Pomeroy |
| ▪ Alvina Bruggemann | ▪ Canan Karatekin | ▪ Rebecca Ramsey |
| ▪ Phoebe Chastain | ▪ Sarah Lahr | ▪ Katherine Teiken |
| ▪ Erica Crouch | ▪ Ray Lewis | ▪ Sarah Van Petten |
| ▪ Renee DeVries | ▪ Jean Lee | ▪ Julia Wolfe |
| ▪ Lily Do | ▪ Ying Lee | ▪ Erika Yoney |
| ▪ Comfort Dondo | ▪ Julia McCarthy | ▪ Yi Zhou You |
| ▪ Matt Flanders | ▪ Beth McMullen | |
| ▪ Vanne Owen Hayes | ▪ Marsha Milgrom | |

2018 narrative strategy participants

Housing, home, and health frame development

- Jeanne Ayers
- Scott Beutel
- Sam Blackwell
- Dorothy Bliss
- Anna Bohanon
- Kelley Brim
- Joan Bulfer
- Barbara Burandt
- Marisol Chiclana-Ayala
- Gabrielle Clowdus
- Will Delany
- Peter Elwell
- Terry Forliti
- Judy Foster
- Hailey Freedlund
- Kim Gearin
- Wesley Grannes
- Beth Holger-Ambrose
- Karen Imholte
- Paul Imholte
- Kristen Kennedy
- Jane Lawrenz
- Justin Lewandowski
- Sida Ly-Xiong
- ChaQuana McEntryre
- Nicole McLain
- Suyapa Miranda
- Sandy Nadeau
- Karen Nikolai
- Kami Norland
- Jackie Peichel
- Ricardo Perez
- Rinal Ray
- Jeannette Raymond
- Nicole Ruhoff
- Michael Saindon
- Margaret Schuster
- Barb Sporlein
- Libby Starling
- Ruth Staus
- CeCe Terlouw
- Terri Thao
- Rosa Tock
- Joel Torkelson
- Ellie Vanasse
- Lori Vrolson
- Molly Weyrens
- Linda White
- Kelly Zelenka

Early childhood frame development

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

Appendix B: 2018 emerging narrative frames

Narrative frames are important tools for engaging in current policy debates in a way that expands the conversation to focus on health equity and the factors that create health. The purpose of developing narrative frames for the Healthy Minnesota Partnership strategic opportunities is less about developing specific policy arguments and more about shifting the conversation, in the context of specific policy discussions, to what creates health and advances health equity. Narrative frames provide context and guidance. Narrative frames can:

- Provide a foundation for messaging
- Guide the framing and language of a report
- Help identify potential action steps
- Help prioritize work

Emerging narrative frames on early childhood

Narrative training and framing sessions were held with over 50 participants at 3 locations in Minnesota: Owatonna, Duluth, and in the Twin Cities metropolitan area. This list of narrative frames may be added to over the coming months as more conversations are held in more communities.

Every child in every family deserves a healthy start.

1. Health is developed in a context of community that lifts up all voices—inclusive of all races, ethnicities, and backgrounds.
2. All parents want what's best for their children; it's the community's role to create the conditions in which this is actually possible.
3. Every child is attached to a family and every family is attached to a community.

Health care—medical and clinical care—is an important component of health but, over the span of people's lives, other factors have a greater overall impact on health.

4. Children will be successful in their families if families feel (are) included and successful within their communities.
5. Safe, stable, nurturing relationships and environments are created in multiple settings in multiple ways. All—families, businesses, government, and community organizations—have a role in creating these conditions.

The community has a key role as protector and caretaker of children; communities must be supported in this role.

6. Racism hurts the health and well-being of children, families, and communities.
7. Children thrive when they are in a safe environment where community wisdom shapes that environment.
8. Every child is inherently valuable to the community
9. Assimilation to whiteness is neither possible nor desirable for our children.

Emerging narrative frames on housing, home, and health

Public narrative training and framing sessions were held with over 50 participants in St. Paul and St. Joseph, Minnesota. The narrative frames below are based on these sessions. Participants and others can start with this language and develop their own frames, messages, and other ways of expressing the basic concepts and values that these reflect.

Who deserves a place to call home?

1. “Home” is a basic need of every person and every family.
2. Everyone deserves a place to call home, a place to be safe and welcomed, to grow, and to thrive. Everyone deserves a safe, stable home in which to care for one another and provide a place for healing and health.
3. “Place” includes not just “a roof over our heads” but our entire community—to belong includes belonging in a community.
 - Healthy communities are places that are welcoming, safe, appealing, and have places to call home for every family.
 - When communities thrive, the individual and families in the community are healthier.
 - For health equity to be possible, all people and populations need to have access to safe and stable homes in welcoming and thriving communities.

Why are homes important for the health of people?

4. A home creates a sense of place. Without a sense of place and belonging, it is impossible to be healthy and to thrive as a human person. Homes are where healing can take place. Having a safe, stable home is foundational if each person is to be healthy, to have a healthy start, and to live with respect, dignity and health.
5. Having a home helps children grow up healthy. Children need a safe, healthy and stable home in a nourishing community that is socially connected and welcoming, environmentally healthy, and provides educational, economic and recreational opportunity. The stability, safety and quality of a home is essential for the health and well-being of children, youth, adults, and elders, creating the foundation for health across the lifespan.
 - Current health disparities are the consequence of multiple overlapping conditions, from employment to income to education and more. The ability to afford a safe, stable home as a place for healing and health reflects many of the same factors that shape health, including historical trauma, discrimination, and exclusion.
 - Efforts to assure homes for all should prioritize historically marginalized populations. Naming barriers to housing (racial discrimination, prejudice toward former felons, etc.) is essential to creating equitable opportunities to find a home.

Why are homes important for the health of communities?

6. A healthy community intentionally assures access to transportation, housing, jobs, and education, and places to play, worship, engage with nature, and socialize.
 - Inequities in health and housing are not inevitable, and can be successfully addressed in communities working to create welcoming, inclusive and healthy places for all.
7. Social connections, inclusion, and belonging link people together to create health and a healthy, thriving community. The physical structures of homes are like nodes on a network—but it is the connections that make it possible for people to engage in a network, form a community, and have a healthy life.
 - Homes are essential for creating community because without a place to call home, people struggle to connect to the community in consistent and meaningful ways.

8. Population differences are a source of strength and resilience for communities. People of varying backgrounds, cultures, races and ethnicities, ages, genders, and more bring different assets and ideas to communities, increasing the community's potential to grow and thrive.
 - A multiplicity of housing types and a wide range of community voices engaged in planning and decision-making processes make communities better places to live.
 - Assuring safe and healthy neighborhood conditions for all improves the quality of life for everyone in the community.
 - A wide range of housing options increases the capacity of a community to embrace population differences and harness the strengths that variety brings. One size, one type of housing does not fit all. Multiple housing types increase the opportunity for all people to find a place to call home.

Who is responsible for assuring everyone has a home?

9. Housing and homes, like health, can only be created through the combined efforts of everyone and all parts of society.
10. Public policies and market forces, comprised of human decisions, shape the nature of housing and communities. The historical and contemporary forces that shape the housing market and that determine who has access to a home and who does not must be uncovered and better understood.
11. The economic viability of a community hinges on its capacity to provide safe and stable homes for all who live, work and play there.
12. Communities must provide access to opportunities that promote health and well-being, including homes for all, good schools, transit, and readily accessible social gathering spaces such as parks and playgrounds.
13. In addition to homes, communities have a responsibility to create a variety of social spaces—places to gather and socialize—that promote interaction, inclusion and communication between and among people of all kinds.

ⁱ Fond du Lac Band of Lake Superior Chippewa. *Expanding the Narrative of Tribal Health: The Effects of Wild Rice Water Quality Rule Changes on Tribal Health*: <http://www.fdlrez.com/RM/downloads/WQSHIA.pdf>.

ⁱⁱ Voices for Racial Justice. *Unfit for Human Consumption* (summary): <http://voicesforracialjustice.org/wp-content/uploads/2016/01/Unfit-for-Human-Consumption-Summary.pdf>. Link to the full report (104 pages): <http://voicesforracialjustice.org/wp-content/uploads/2016/01/Unfit-for-Human-Consumption-Full-Report.pdf>.

ⁱⁱⁱ *Expanding the Narrative of Tribal Health: The Effects of Wild Rice Water Quality Rule Changes on Tribal Health*, <http://www.fdlrez.com/RM/downloads/WQSHIA.pdf>

^{iv} *More Places to Call Home: Investing in Minnesota's Future. Report of the Governor's Task Force on Housing*: http://mn.gov/gov-stat/pdf/Housing%20Task%20Force%20Report_FINAL.pdf

^v ISIAIH web post. *New Report Shows St. Cloud Families Want Politicians to Focus on Care Issues*: <https://isaiahmn.org/2018/05/14/new-report-shows-st-cloud-families-want-politicians-to-focus-on-care-issues/>.