STRIDE toward Health Equity:
Health in All Policies in Minnesota

Findings and Recommendations for Advancing Health Equity through Multisector Collaborations

PUBLIC HEALTH LAW CENTER
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ON THE COVER:

CREATE: The Community Meal

Public Art Saint Paul and artist Seitu Jones created a public art project aimed at lowering barriers to making healthy food choices. On September 14, 2014, two thousand people gathered at a half-mile-long table in the middle of Saint Paul's Victoria Street for civic dinner table conversations about food access, food justice, and healthy eating. The project was funded through the Community Engagement Innovation program at the Center for Prevention at Blue Cross and Blue Shield of Minnesota.

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TABLE OF CONTENTS

PREFACE 1
EXECUTIVE SUMMARY 2
INTRODUCTION 4
PROJECT PURPOSE AND DESIGN 6
PART ONE — FINDINGS: HiAP ELEMENTS IN ACTION—MINNESOTA EXAMPLES 7
PROMOTING HEALTH EQUITY ACROSS MULTIPLE SECTORS 7
Efforts to Promote Health Equity across Sectors in Minnesota 7
Considerations Affecting Promotion of Health Equity across Sectors 10
CROSS-SECTOR COLLABORATION 12
Cross-Sector Collaboration around Health Equity in Minnesota 12
Considerations Affecting Cross-Sector Collaboration around Health Equity 13
BENEFITS TO MULTIPLE SECTORS 15
Examples of Minnesota Health-Equity Efforts that Benefit Multiple Sectors 15
Considerations Affecting Health-Equity Efforts that Benefit Multiple Sectors 16
COMMUNITY AND STAKEHOLDER ENGAGEMENT 17
Community and Stakeholder Engagement in Minnesota 17
Considerations Affecting Community and Stakeholder Engagement around Health Equity 20
STRUCTURAL AND PROCEDURAL CHANGE 21
Long-Term, Cross-Sector Problem-Solving that Affects Health Equity:
The Metropolitan Council 22
Innovative Structures and Procedures that Promote Health Equity in Minnesota 23
Considerations Affecting Structural and Procedural Change 25
SUMMARY OF FINDINGS 26
PART TWO — RECOMMENDATIONS: STRIDE TOWARD HEALTH EQUITY 27
STRIDE TOWARD HEALTH EQUITY 27
STRIDE TOWARD HEALTH EQUITY BY PROMOTING HiAP 28
HOW AND WHY TO STRIDE TOWARD HEALTH EQUITY 29
Support Health-Equity Efforts and Recognize that Social Factors Impact Health 30
Think Critically about Ways to Promote Cross-Sector Collaboration 31
Reach for Support from the Community and from the Highest Levels of Leadership 33
Incorporate Use of Aligned Data, Goals, and Funding across Sectors 35
Determine Effective Implementation Methods and Delegate Tasks 37
Encourage Systematic Consideration of Health Equity 38
SUMMARY OF RECOMMENDATIONS 40
CONCLUSION 41
GLOSSARY 42
REFERENCES 43

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PREFACE

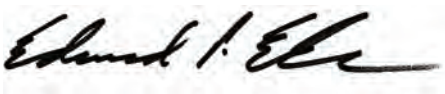
The health of the United States population has been steadily declining relative to that of other economically advanced countries. Challenges to our health care system are usually blamed for this decline. While our health care system is important, focusing solely on health care diverts our attention from the real reasons our country is not as healthy as it could be. Health care issues are the trees in the forest of health and make up only about 10% of that forest. The other 90% consists of factors like economic status, employment, housing, education, transportation, environmental quality, individual behaviors, and social cohesion. And these, including health care, are affected by the policies and systems that influence and control societal actions and priorities. That's why embracing the Health in All Policies approach articulated in this resource is crucial to improving our overall health.

However, a Health in All Policies approach alone will not help us achieve optimal health for all. Due to the huge inequities in all aspects of our society that are responsible for most health disparities, health equity must be the goal of all of our efforts to improve policies, systems, and our physical and socioeconomic environments. To do this, our multisector public health work must change. In particular, we need to:

- **Expand our understanding of what creates health**
- **Implement a Health in All Policies approach with health equity as the goal**
- **Support the capacity of communities to create their own healthy future**

These practices are the components of the Triple Aim of Health Equity and are foundational if we are to collectively assure the conditions in which all people can be healthy.

This resource is an invaluable addition to our list of strategies and tools for advancing the Triple Aim of Health Equity. It helps expand our understanding of what creates health beyond health care and individual choices, it supports a Health in All Policies approach with health equity as the goal, and it provides multiple strategies that communities can use to create their own healthy future. Most importantly, it highlights the fact that we are all essential parts of improving the health of our communities, as well as providing specific ways that each individual or agency can get engaged in advancing health equity and optimal health for all.



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EXECUTIVE SUMMARY

Public health experts have long agreed that health care is just one of many factors that determines health. They also agree that the social conditions in which people live, work, and play are critical in determining personal and community health. These conditions include the layout of neighborhoods, the availability of healthy foods, access to jobs, and educational and recreational opportunities. Improving social conditions like these enables people to make healthy choices about the foods they eat, how much they exercise, and how and where they spend their time. In large part, variations in these social conditions explain why some communities are healthier than others. Although social conditions are extremely important to health, many government decisions that impact social conditions are made without taking health into account.

The Health in All Policies (HiAP) approach to state and local government and nonprofit planning and decision-making takes health perspectives into account in decisions made in all sectors. Implementation of HiAP is built around a core set of key ideas. These ideas are: (1) promoting health equity outside of the health sector; (2) collaborating across sectors; (3) benefiting multiple partners; (4) engaging with diverse communities and stakeholders; and (5) modifying existing structures and procedures.[1]

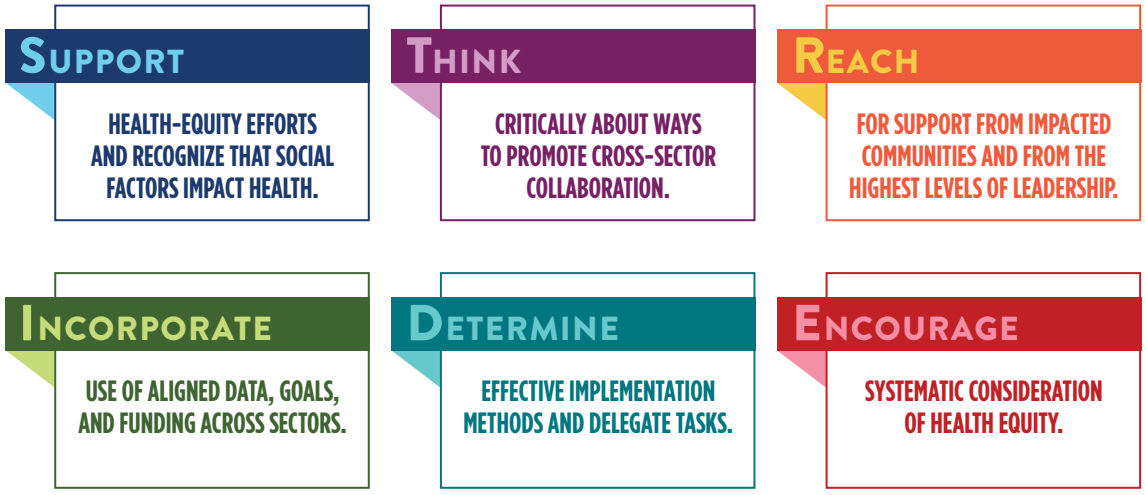
1. PROMOTING HEALTH EQUITY OUTSIDE OF THE HEALTH SECTOR
2. COLLABORATING ACROSS SECTORS
3. BENEFITING MULTIPLE PARTNERS
4. ENGAGING WITH DIVERSE COMMUNITIES AND STAKEHOLDERS
5. MODIFYING EXISTING STRUCTURES AND PROCEDURES

To help state agencies, local governments, health advocates, and communities learn how HiAP can be applied, we researched applicable policies, interviewed twenty-two key state and local leaders from government agencies and nonprofit organizations, and conducted a survey that provided guidance from an additional twenty-seven leaders.

We learned that many components of HiAP are already familiar to Minnesota government and nonprofit leaders. With considerable success, Minnesota's state, regional, and local governments are collaborating in mutually beneficial ways through community engagement with stakeholders. For example, several Minnesota government agencies are addressing the complex needs of the state's homeless population through cross-sector efforts.[2]

Leaders provided thoughtful feedback about health-equity efforts in Minnesota, raised critical issues to consider as Minnesota moves forward in its HiAP work, and offered suggestions on possible next steps. They shared nuanced observations and examples and reached meaningful consensus. Leaders widely agreed that considering health equity in planning and decision-making in sectors other than health is a fundamental key to improving the health of Minnesotans, especially those who tend to be the least healthy. Leaders also agreed that future HiAP efforts in Minnesota must be driven by engaged leaders, capable staff, a unified agenda, data, sustained funding, and community input. Leaders emphasized that increasing the use of HiAP in Minnesota will require making thoughtful and strategic choices about priorities, and will depend on providing opportunities for leaders and communities to learn more about the benefits of using HiAP.

This report recommends that Minnesota's government agencies and divisions, nonprofit and community organizations, community members, and private-sector businesses **STRIDE** toward health equity by implementing a mix of HiAP strategies that aim to reach six key targets: (1) **S**upport health-equity efforts and recognize that social factors impact health; (2) **T**hink critically about ways to promote cross-sector collaboration; (3) **R**each for support from disproportionately impacted communities and from the highest levels of leadership; (4) **I**ncorporate use of aligned data, goals, and funding across sectors; (5) **D**etermine effective implementation methods and delegate tasks; and (6) **E**ncourage systematic consideration of health equity.[3]



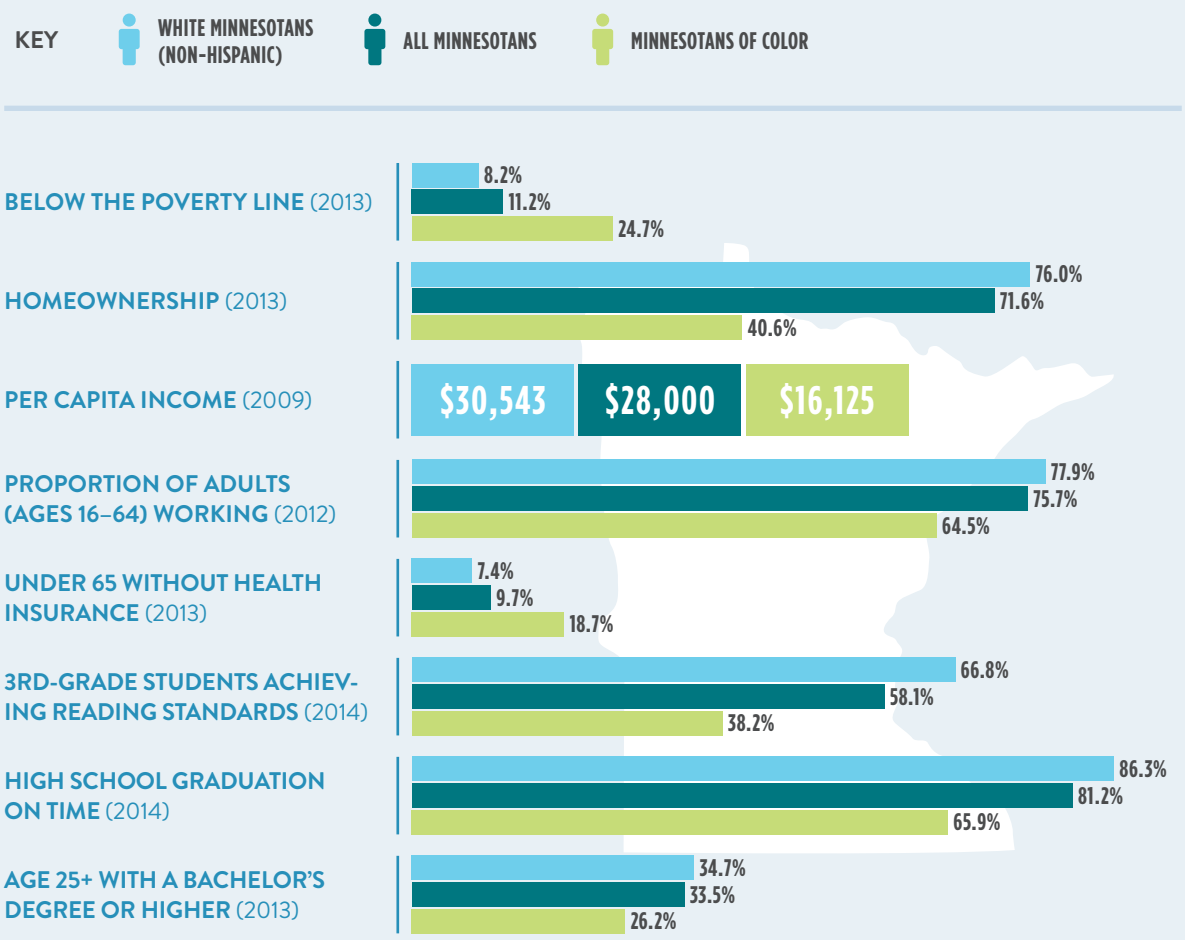
Adapted from: Linda Rudolph et al., Health in All Policies: A Guide for State and Local Governments (2013); Lauren N. Gase et al., *"Health in All Policies": Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. Pub. Health Mgmt. & Prac. 529, 529-40 (2013).

INTRODUCTION

Considerable evidence demonstrates connections between social factors and health. For example, higher levels of education and income within a community are associated with better health—i.e., as education and income levels increase, health improves.[4] Education, income, and other social factors are often referred to as "social determinants of health." Social determinants of health impact the environments or conditions in which people live, learn, work, and play (and how they get to and from those locations) and thereby shape choices, behaviors and, ultimately, health.[5]

The same social factors that shape health often lead to pervasive health inequities: Groups with greater access to power, resources, and opportunities have substantially better health than groups with less access.[6] For example, 94% of Minnesotans with a college degree report "good," "very good," or "excellent" health, compared to 71.5% of Minnesotans with less than a high school degree.[7] Similarly, cigarette smoking is more common among Minnesota's lowest wage earners than among its highest wage earners (34.7% of Minnesotans with an annual income of less than $15,000 smoke

RACE-BASED DISPARITIES IN MINNESOTA[11]



Source data: *Minnesota Compass*, Wilder Research, http://www.mncompass.org/.

cigarettes, compared with 11.9% of Minnesotans with an annual income of $50,000 or more).[8]

Race and ethnicity play critical roles in Minnesota's health inequities. Even when accounting for differences in socioeconomic status—including education and income—African-Americans tend to have worse health outcomes than White Americans on many health measures.[9] For example, data show that the racial and ethnic background of a Minnesota infant is linked to whether or not the infant lives past its first birthday. (Between 2002 and 2006, twice as many African-American and American Indian infants died before their first birthdays compared with infants of Asian, Hispanic, and White backgrounds.)[10]

Addressing the social determinants of health is necessary to improve community health and to increase health equity.[12] Notably, the U.S. Surgeon General has declared:

> *"To put it simply: health equity is a civil rights issue."*
>
> **—U.S. Surgeon General Vivek H. Murthy**[13]

A Health in All Policies (HiAP) approach to governmental and nonprofit planning and decision-making shows particular promise for reducing health inequities.[14] In general, a HiAP approach integrates health analysis into policies, projects, and programs that typically do not consider health. It encourages policymakers and implementers to consider the health impacts of all decisions across all sectors,[15] because decisions made in every sector impact health.[16] These sectors include education, energy, planning, commerce,[17] transportation, housing, employment, and agriculture.[18] HiAP is based on the idea that improving community health requires continuously considering the health-equity implications of all government actions.

Although additional evidence is needed to fully demonstrate the effectiveness of this approach,[19] a growing number of countries, states, and local communities have pursued implementation of HiAP and have demonstrated its promise.[20]

At the federal level, HiAP's potential has been recognized by:

- **THE NATIONAL PREVENTION STRATEGY, which is led by the U.S. Surgeon General to guide U.S. health-improvement efforts by integrating health into multiple settings;**[21]
- **HEALTHY PEOPLE 2020, which is led by the U.S. Department of Health and Human Services and recognizes HiAP as a promising strategy to address the social determinants of health;**[22] **and**
- **THE INSTITUTE OF MEDICINE, which recommends that federal and state governments use a HiAP approach to consider the health effects of major policies.**[23]

Using feedback from key Minnesota leaders and a review of Minnesota laws, policies, and programs, Part One of this report provides an overview of the key components of HiAP and presents findings about Minnesota's unique HiAP efforts. Part Two sets out recommendations that Minnesotans can apply to **STRIDE** toward health equity by implementing a range of available HiAP strategies.

- **Health equity**—achieving a "high standard of health" for everyone in a community while at the same time concentrating on populations within that community that are at a disproportionate risk for poor health because of social factors.[24]
- **Health in All Policies (HiAP)**—an approach to governmental and nonprofit planning and decision-making that promotes health equity by addressing the social determinants of health through health analysis across all sectors.[25]
- **Social determinants of health**—social opportunities, living conditions, and environments that contribute to population health and its upstream causes through knowledge, attitudes, beliefs, or behaviors.[26]

PROJECT PURPOSE AND DESIGN

This project aims to create a meaningful tool to help Minnesota state agencies, local governments, health advocates, and communities successfully integrate a HiAP approach in planning and decision-making in order to promote health equity across all sectors. To gain insight into the current use of HiAP in Minnesota, we conducted interviews with twenty-two leaders from state and local government agencies and nonprofit organizations. We asked these leaders for feedback on the use of HiAP, including perceived implementation barriers and opportunities to increase its use in ways that are responsive to Minnesota's particular needs. We supplemented this feedback with suggestions gathered from a survey we sent to additional government, nonprofit, and community leaders.*

Part One organizes the project findings into five major sections, each of which comprises a key element of effective HiAP practice:

- **promoting health equity;**
- **collaborating across sectors;**
- **simultaneously benefiting multiple partners;**
- **engaging diverse stakeholders; and**
- **changing existing structures and procedures.**[27]

Each element of HiAP is discussed separately. For each element, the report offers distinct examples of implementation efforts currently underway in sectors other than health and discusses implementation challenges and opportunities. Part Two recommends that government, nonprofit, and community organizations; disproportionately impacted community members; and private-sector businesses in Minnesota **STRIDE** toward health equity by pursuing six targets that can advance the key HiAP elements.

SUPPORT health-equity efforts and recognize that social factors impact health.

THINK critically about ways to promote cross-sector collaboration.

REACH for support from impacted communities and from the highest levels of leadership.

INCORPORATE use of aligned data, goals, and funding across sectors.

DETERMINE effective implementation methods and delegate tasks.

ENCOURAGE systematic consideration of health equity.

Adapted from: LINDA RUDOLPH ET AL., HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS (2013); Lauren N. Gase et al., *"Health in All Policies": Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. PUB. HEALTH MGMT. & PRAC. 529, 529–40 (2013).

This report presents a number of strategies for advancing each **STRIDE** target.[28]

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* We invited twenty-five leaders to participate in an interview. Twenty of them participated. In addition, two of the twenty leaders each invited a colleague to join their interviews. We distributed the survey to an additional eighty-four leaders, twenty-seven of whom provided feedback.

PART ONE

FINDINGS: HiAP ELEMENTS IN ACTION—MINNESOTA EXAMPLES

PROMOTING HEALTH EQUITY ACROSS MULTIPLE SECTORS

A key element of the HiAP approach to planning and decision-making is focusing all government efforts on health equity. This can be achieved by bringing a health lens into specific government decisions made outside of the health sector and by systematically embedding health equity into all public-sector work.[29]

Efforts to Promote Health Equity across Sectors in Minnesota

Minnesota government leaders and others have taken several important steps to integrate health equity into decisions made outside of the health sector.

- **Conducting Health Impact Assessments**

  Minnesota has emerged as a leader among states in using health impact assessments (HIAs) to inform decisions outside of the health sector. HIAs predict health effects of projects, policies, and programs *before they are implemented*. They involve a systematic process, based on existing standards of practice, that relies on multiple types of data, information, and analysis. With input from diverse stakeholders and communities, HIAs recommend ways to make decisions that promote health.[30] At least twenty-seven HIAs have been completed or are in progress in Minnesota, and most of these HIAs concern the health impacts of decisions about transportation and land use.[31] HIAs have also addressed decisions in other government sectors, including decisions about criminal justice, school siting, and school integration.[32]

- **Informing Decisions with Health-Related Data and Analysis**

  - ***Raising Minnesota's Minimum Wage.*** Minnesota's H.F. 2091—passed by the 2014 legislature—will gradually raise the state minimum wage paid by large employers from $6.15 to $9.50 by 2016. By 2018, the state minimum wage will be tied to inflation. "Large employers" are defined as enterprises with at least

HIAs involve six steps that are typically completed with stakeholder and community input:

1	2	3	4	5	6
SCREENING to determine whether a decision warrants an HIA.	**SCOPING** to determine the specific focus of the HIA and the practical steps needed to complete it.	**ASSESSMENT** to determine current health conditions and how the proposal could affect them.	**RECOMMENDATIONS** of practical suggestions on how the proposal could maximize health.	**REPORTING** findings and recommendations to decision makers, stakeholders, and the community before a decision is made.	**MONITORING** and evaluation to assess the value of the HIA and understand how the decision affected health.[33]

$500,000 in annual gross sales or business. H.F. 2091 also gradually raises the minimum wage paid by small employers to $7.75 by 2016, again tying the minimum wage to inflation rates by 2018.[34] During bill deliberations, the Minnesota Department of Health (MDH) created a white paper that used Minnesota-specific data to educate policymakers about connections between income and health. MDH concluded, in part, that: "The association of lower income with poorer health suggests policies that contribute to increasing income levels, especially among the lowest income groups where improvements in health are are most evident . . . , would expect to have a positive impact on the health of these groups."[35] The effort to raise the minimum wage involved multisector collaboration, including health, labor, industry, economic development, and business groups, and received substantial media attention.

- **Encouraging Government Agencies to Address Health Equity in Their Operations**

- ***MDH Outreach to Other State Agencies and Local Governments.*** In 2013, MDH created the Center for Health Equity. The center uses data, community engagement, and the HiAP approach to advance health equity.[36] Through its efforts, MDH has encouraged other state and local government agencies to consider health equity in their operations. For example, MDH has organized information sessions for local elected officials about what HiAP "means for local decision makers."[37] The MDH commissioner and senior leadership have reached out to the commissioners and senior leadership in other executive agencies.[38] MDH's 2014 report to the state legislature, *Advancing Health Equity in Minnesota*, contains a cover letter signed by all of the commissioners of Minnesota state agencies, which recognizes that:

  > *"For Minnesotans to have the brightest future possible, we need to eliminate . . . health disparities."*
  >
  > **—Minnesota State Commissioners**

The letter acknowledges that health "requires excellent schools, economic opportunities, environmental quality, secure housing, good transportation, safe neighborhoods, and much more." Ensuring these conditions requires working across government agencies and with communities.[39] Under MDH leadership, this multiagency work continues through cabinet-level convening, discussions, and plans to address health equity in various sectors. In July 2014, for example, MDH convened a meeting of several different executive agencies to consider ways each agency can contribute to improving health equity.

The Cultural and Ethnic Communities Leadership Council was created by the Minnesota Legislature in 2013 to advise the commissioner of the Department of Human Services (DHS) on reducing disparities that affect racial and ethnic groups within DHS programs. Council members are charged with reviewing DHS statutes, rules, and internal policies for racial, ethnic, cultural, linguistic and tribal disparities and recommending changes to promote health equity[40] and to ensure that disparities are not perpetuated.[41] The council has recommended a groundbreaking, comprehensive health-equity policy applicable to all DHS internal operations, activities, programs, services, and community engagement.

- **Creating Partnerships between Health and Other Sectors**

- ***Arrowhead Regional Development Commission and Community Health Boards.*** Community health boards have partnered with the Arrowhead Regional Development Commission (ARDC) to integrate health into regional planning decisions. Community Transformation Grant and State Health Improvement Program (SHIP) funds have supported this work[42] (see the "Structural and Procedural Change" section for a description of SHIP). These efforts have united the planning, transportation, and public health sectors to create the Arrowhead Active Transport Work Plan, which will be implemented by the Regional Transportation Advisory Committee. The plan's projects will improve sidewalk connections and bicycle-safety programs and help communities implement active transport and Safe Routes to Schools programs.[43] In addition, some communities, including the City of Babbitt, have partnered with the ARDC to improve

access to healthy foods by supporting local farmers' markets and preserving agricultural lands.[44]

• Addressing Health Equity and Other Needs Simultaneously

- ***Farm to School Leadership Team (MDH and University of Minnesota Extension) and the Minnesota Food Charter.*** In 2011, MDH and University of Minnesota Extension convened a statewide Farm to School Leadership Team that includes representatives from various state departments, the private sector, and academia. The team has worked across the state to "build farm-to-school initiatives that help kids eat healthy, support nearby farmers, foster economic vitality, and strengthen communities."[45] This work builds on the efforts of the Minnesota Department of Agriculture's *Minnesota Grown Program*, which for over twenty years has promoted the state's specialty crop and livestock producers and compiled an annual directory of Minnesota producers to help consumers find and purchase food grown and produced closer to home.[46] The Farm to School Leadership Team supports the Department of Agriculture's Farm to School Grant Program to increase consumption of locally produced foods by children and youth in Minnesota's public schools and child care centers.[47]

  Minnesota's health, agriculture, and education sectors have also addressed health equity through the Minnesota Food Charter. Created with robust community input, the Minnesota Food Charter highlights challenges to food access, availability, affordability, and infrastructure and their connections to obesity and chronic disease, and proposes strategies to help Minnesota communities address these challenges.[48] These efforts simultaneously support the needs of the agricultural sector, encourage economic development, and promote health equity.

• Integrating Health Equity into Other Sectors

- ***Complete Streets.*** State, regional, and local jurisdictions have been working to improve health, equity, safety, the environment, and economic development through Complete Streets efforts, which focus on laws, policies, and projects that aim to create streets that are accessible to all users—walkers, bicyclists, mass-transit users, as well as drivers of motor vehicles. Minnesota has been a national leader in the Complete Streets movement.

  Minnesota's state and local Complete Streets policies have been recognized by the National Complete Streets Coalition program of Smart Growth America (a national coalition of organizations that support developing healthy communities through coalition-building, policy, and research),[49] as some of the best Complete Streets policies among the over 600 that have been implemented nationwide.[50] Minnesota's Complete Streets policies are in place in the Rochester-Olmsted Council of Governments; Wilkin, Clay, and Hennepin counties; and the cities of Northfield, Battle Lake, Pipestone, St. Cloud, Breckenridge, Red Wing, Byron, Ottertail, Parkers Prairie, Stewartville, Worthington, Fergus Falls, and Frazee. Enacted in 2010, Minnesota's state-level Complete Streets legislation requires the Minnesota Department of Transportation to consider Complete Streets engineering design recommendations in granting variances for state-aid projects.[51]

- ***Transportation Infrastructure.*** Progress in Motion and Transportation Forward have succeeded Move MN as coalitions of Minnesota local governments, businesses, organizations, and others working toward a "comprehensive transportation solution" to address the state's long-term transportation issues.[52] Transportation Forward explicitly incorporates health-equity principles into the transportation sector through its support for diverse transportation options to improve "community health and vitality"[53] and based on the "belief that transportation underpins the quality of life, the way our communities function, access to economic opportunity, and the health of our residents and environment."[54] At the same time, the Minnesota Transportation Alliances' Progress in Motion supports "more choices for getting around—across Minnesota."[55]

Considerations Affecting Promotion of Health Equity across Sectors

Interview and survey comments conveyed several important ideas about cross-sector promotion of health equity in Minnesota:

- **Minnesotans genuinely want the state to be a good place to live and work and are open to new ideas about how to advance health equity.** One policymaker suggested that the HiAP approach fits well within the Minnesota ethic of striving to be above average and getting things done.

- **Most leaders agree that policies outside of medicine and public health have substantial health impacts.**

Survey respondents strongly agreed that:

> *"The health of community members is affected by decisions we make about education, transportation, the environment, employment, and other issues impacting our communities."* **—21 of the 27 respondents**

MDH and the Healthy Minnesota Partnership have been very intentional and systematic in describing factors that contribute to individual and population health. They have been explicit about the roles that education, the economy, climate, incarceration, and other factors play in health. MDH has emerged as a leader in advancing health equity.

> *"MDH is doing a really good job leading the way on [HiAP] and demonstrating its importance."* **—Policymaker**

> *"The tone [to collaborate] across sectors is set at the commissioner level."* **—State leader**

- **Integrating health equity into decisions made in sectors outside of health is not a new idea.** What is new, according to many of those interviewed, is using the term Health in All Policies. The term itself is, or may be, confusing to many, even to some who have been using a HiAP approach for a long time. The term may mean different things to different people. Also new is movement away from simply recognizing the importance of engaging other sectors toward a more formal and systematic integration of health equity into planning and decision-making among and across all sectors.

- **Addressing health equity outside of the health sector may help advance health equity as a larger public policy goal.** Connecting health equity to planning and decision-making in sectors other than health provides a way to inject health equity concerns into crossover areas. It also demonstrates that many issues we may not think of as health-related are truly connected to health.

- **HiAP must include both a health lens and an equity lens.** One interviewee said:

> *"Health in All Policies does not necessarily assure equity. Focusing on health impacts alone is not enough—the focus within all sectors should also be on health equity and on populations that experience disparities."* **—State leader**

- **Promoting health equity in sectors other than health may encounter criticism that such efforts amount to "health imperialism."** Although it is essential to demonstrate links between health and other sectors, all sectors may not share the same view of health equity. It is important to establish that health equity is connected to other sectors and is relevant to the concerns that other sectors share.

> *"Some people don't see health as important, but if you can frame it in their terms, it helps."* **—State leader**

- **Asking government agencies to incorporate a health-equity lens into their decisions may be challenging because many agency representatives already feel stretched thin in accomplishing their work.** One senior leader explained: "People are so overwhelmed in terms of what they are doing that when they see the need to use another lens, they can get nervous or intimidated about what that would require." Emphasizing shared goals, mutual benefits, and efficiencies that can result from promoting health equity in multiple sectors may help alleviate these concerns.

- **It is important to separate science and politics.** One senior leader noted that it is critical that HiAP efforts should "not be dominated by ideology, rather than [by] data and science."

- **Because integrating health equity into other sectors requires long-term, sustained efforts, it is critical to celebrate incremental change and seemingly small successes.**
- **There is a recognized need to be strategic in selecting opportunities to promote health equity across sectors.** Selected opportunities need to have momentum and potential to contribute substantially to health equity. Interviewees described "strategic opportunities" as ones that:
  - **are driven by impacted communities;**
  - **are grounded in available data;**
  - **align with other efforts—providing an opportunity for impact;**
  - **build on previous demonstrated successes;**
  - **appear achievable in light of resource constraints; and**
  - **are politically feasible.**
- **Local governments may be well positioned to engage in HiAP.** County and city officials typically have a nuanced grasp of the needs of their communities and may be able to coordinate implementation with community members and organizations. In addition, local government officials have existing cross-sector relationships that can be leveraged for health equity. Local government agencies are also (usually) smaller than state agencies, which may provide greater flexibility. Furthermore, local governments may be able to align SHIP-funded or similar initiatives to incorporate health-equity considerations into other sectors.

Minnesota government and nonprofit leaders generally recognize the need to promote health equity across all sectors through systematic and sustained efforts built around efficiencies and shared goals.

STRATEGIC OPPORTUNITIES

CROSS-SECTOR COLLABORATION

Promoting health equity through HiAP requires cross-sector collaboration that assembles representatives of different sectors to work together across traditional silos. The activities of cross-sector collaboration fall along a continuum of integration—from exchanging information to making and implementing decisions jointly.[56] Successful HiAP implementation requires cross-sector collaboration because decisions in the education, energy, planning, commerce,[57] transportation, housing, employment, agriculture,[58] and other sectors impact health.

Cross-Sector Collaboration around Health Equity in Minnesota

Minnesota's public and private sectors have a strong history of cross-sector collaboration around health equity. Current efforts include:

- **Collaborating across Sectors to Address the Needs of Populations Experiencing Inequities**

  Children's Cabinet. Since 1993, the governor's Children's Cabinet has brought together the commissioners of health, education, human services, employment, corrections, economic development, administration, management and budget, transportation, and others to address interconnected issues that impact Minnesota's children,[59] including delivering comprehensive care and services to children with mental and emotional health needs.[60] The Children's Cabinet is guided by a strategic plan that aligns the work of its member agencies to improve health outcomes for children in the state. Recent Cabinet efforts have focused on improving access to services for school children with mental illness; enhancing learning opportunities for infants and toddlers who live in poverty; and increasing access to child care assistance for teenage parents and their children.[61]

- **Creating Leadership-Level, Executive Agency Subcabinets that Address Health Equity**

  - ***Olmstead Planning.*** The governor's office has used executive orders to address numerous complex issues. For example, acting on a recommendation of the Minnesota Olmstead Planning Committee, in 2013 Governor Mark Dayton created a subcabinet that required the departments of human services, health, corrections, human rights, education, transportation, employment and economic development, and housing finance to collaborate on the Olmstead Plan, which aims to increase the services available to individuals with disabilities in the most appropriate settings.[62] Each agency must evaluate its "policies, programs, statutes, and regulations" to determine which ones need revision and whether any legislative actions or resources are necessary.[63] The subcabinet must continue to collaborate on developing, implementing, and monitoring the plan.[64] According to one senior official, this cross-sector work has increased "collaboration in the area of employment."

- **Assigning Specific Responsibilities to Entities Involved in Cross-Sector Collaboration**

  - ***Environmental Sustainability.*** To encourage sustainability, which affects community health, Governor Dayton has also issued an executive order to reduce the negative impacts of state operations on the environment. The order requires Minnesota's executive branch agencies, collectively, to decrease their generation of waste and air pollution and their use of water, energy, gasoline, and toxic products and to use "environmentally preferable products and services." To meet this challenge, the executive order creates several cross-sector teams and tasks each team with specific responsibilities. One team must make any necessary adjustments to the state's sustainability model plan. Other teams must decrease fuel use by state-owned vehicles, manage state-owned property sustainably, and incorporate sustainability practices into state procurement. Each agency also must create an annual sustainability plan and report its progress. The Minnesota Pollution Control Agency must assist other agencies in meeting sustainability requirements and may alter targets or timelines.[65]

Considerations Affecting Cross-Sector Collaboration around Health Equity

Interview participants and survey respondents provided feedback about cross-sector collaboration:

- All survey respondents strongly agreed or agreed that some of Minnesota's most pressing health, education, and socioeconomic issues are complex and require cross-sector collaboration, and that state and local government agencies must work together to resolve Minnesota's problems.

- Structurally and procedurally, government work seldom incentivizes cross-sector collaboration—yet efforts of this type are needed to promote health equity.

- Minnesota's government agencies and organizations have experience establishing cross-sector partnerships and gathering input from other sectors. In fact, several agencies and organizations already consult with other sectors when making decisions—90% of survey respondents indicated that when making decisions that may impact health or equity, their agencies or organizations "sometimes," "often," or "always" consult with others. These cross-sector interactions typically occur through ad hoc work groups, data exchange, and informal consultations.

- The public health community has expressed interest in asset mapping across sectors and communities to bolster cross-sector efforts. Asset mapping recognizes that each sector, organization, and community brings its own set of strengths and resources to cross-sector collaboration.

- Collaborative work can be far more challenging than work done independently. Although operating within silos may help manage the flow of work and support the development and exercise of subject-matter expertise, cross-sector collaboration requires (and nurtures) interdisciplinary teams that work across silos. One nonprofit leader noted, "Even under a very sympathetic agency head, there are still entrenched ways of doing things." Perceived lack of funding (65%), competing priorities (65%), and lack of time to work across sectors (58%) are the top barriers to cross-sector collaboration, according to nineteen survey respondents.

- **Effective cross-sector collaboration requires:**
  - A catalyst, which can be a subject-matter expert, engaged community members, or engaged institutions
  - A respected convener
  - A shared vision
  - Familiarity with partner organizations
  - Common language/terminology
  - Shared goals
  - Shared incentives
  - A workable structure/process that supports collaboration
  - Steady engagement of senior leadership
  - Thoughtful, regular communication
  - Adequate staff support
  - Adequate financial and in-kind resources

- Cross-sector collaboration must be intentional and strategic in order to succeed. It also must align with the core missions of all agencies. It is critical to include sectors other than health in decision-making processes from the outset—if most of the decision makers are from the health sector, others may feel their participation is undervalued or an afterthought.

- Cross-sector work around health equity should involve not only horizontal collaboration between state or local agencies representing different sectors, but also among different levels of government, e.g., state and local.

- The importance of effective relationships based on trust to advance cross-sector collaboration cannot be overstated.

- A cross-sector collaboration directive, written into a statute or an executive order, can be invaluable. At the state level, a HiAP subcabinet initiated by the governor or the legislature could bring multiple sectors together to establish useful collaboration.

> *"Many of the most successful collaborations are written into statutes."*
>
> **—State government leader**

An executive order may be a natural progression of cross-sector work that is already well underway. At the same time, formal directives may be a tough sell due to perceived limitations—such as competing priorities, inadequate staff support, or insufficient financial resources.

- An important distinction exists between a government unit's *authority* to collaborate and its *capacity* to do so. Some local government entities, including public health agencies, may face uncertainties in some instances about whether they have the statutory authority to collaborate around health equity. Many local government agencies, including counties and local public health agencies, lack the capacity to collaborate on health-equity initiatives due to insufficient staff and resources. Funding can enhance capacity and receptivity to change.

Although sometimes challenging and seldom incentivized, many Minnesota government sectors have significant experience with meaningful and mutually beneficial collaboration. Such collaboration is very much needed to advance health equity and requires a common understanding, strong cross-sector relationships, and encouragement from top leaders.

BENEFITS TO MULTIPLE SECTORS

Improving health equity while simultaneously furthering the core priorities of multiple sectors will likely bolster HiAP receptivity. Co-benefits, or benefits that improve outcomes in multiple government sectors (sometimes referred to as *win-wins*), can strengthen support for HiAP and promote efficiencies.[66] HiAP efforts that offer co-benefits can advance health equity while also supporting the efforts of other sectors.

Examples of Minnesota Health-Equity Efforts that Benefit Multiple Sectors

Much energy and momentum around mutually beneficial initiatives around health equity already exist in Minnesota. These efforts include:

- **Interventions that Originate in Other Sectors and Promote Health Equity**

  - ***Early Childhood Education Programs.*** Through an early-learning scholarship program, Minnesota funds "high-quality early childhood programs" for low-income children between ages three and five.[67] Currently, the program reaches approximately 9 percent of all eligible children.[68] Minnesota school districts can also employ school-readiness programs to prepare children for kindergarten. Although families must pay to participate, school districts must establish sliding scales and waive fees for lower-income families.[69] Once the Minnesota Department of Education approves a school-readiness program plan, districts can receive state dollars[70] for participating students (those who are at least three years old, are screened for health and development, and have at least one of several risk factors such as being an English-language learner or qualifying for free- or reduced-price lunch).[71] Evidence supports early education programs and suggests they can improve both educational and health outcomes. Comprehensive early childhood education programs are associated with better educational measures, including school readiness, academic achievement, retention, and placement in special education programs.[72] Research also shows that early childhood programs for disadvantaged children are associated with lower risks for cardiovascular and metabolic disease well into adulthood.[73]

  - ***Training in the Department of Corrections.*** The Department of Corrections (DOC) provides vocational education opportunities for offenders in custody to help them prepare for reentry into the community. In so doing, the DOC is contributing to improved health outcomes.[74] Evidence suggests that addressing inmates' human capital can improve their employability and earnings[75] and, thereby, health.[76]

- **Efficiency Requirements that Can Promote Health Equity**

  - ***Embracing Efficiency in Government Operations.*** Minnesota law currently encourages co-benefits by requiring some state agencies to embrace principles of government efficiency—though sometimes in ways that may be difficult to enforce. Several state agencies, including the departments of health, labor, public safety, and human rights, have such duties.[77] Legislation that requires agencies to act efficiently can be used to encourage sectors other than health to consider health equity in their decision-making processes. Provisions such as these require thinking outside of traditional silos so that, for example, public dollars do not fund programs, projects, and policies that exacerbate health-equity problems and, in turn, require additional investment of state funds to correct.

- **Issue-Specific Partnerships that Benefit Multiple Sectors**

  - ***The Minnesota Interagency Council on Homelessness.*** The Minnesota Interagency Council on Homelessness, cochaired by the commissioners of the Department of Human Services and Minnesota Housing, brings together eleven state agencies (including education, health, economic development, higher education, corrections, veterans affairs, transportation, human services, and housing) to reduce homelessness in the state. The Interagency Council's plan focuses on youth and veteran populations. It also establishes accountability of staff and leadership. The council pursues collaborations to maximize health care funding and services, improve corrections interventions, address transitions out of foster care, and tackle common

risk factors of homelessness.[78] This effort pulls together leaders from all levels of government within Minnesota—state, regional, city, and county—to align resources and improve systems around homelessness.[79] Several interviewees explained that addressing the needs of the state's homeless population through this collaborative process responds to the priorities of multiple agencies at once. It also capitalizes on the expertise of each participating agency. In addition to creating co-benefits, this cross-sector effort is bolstered by specific goals, bipartisan support, an energetic staff, invested commissioners, clear data, and backing by the governor and the private sector.

Considerations Affecting Health-Equity Efforts that Benefit Multiple Sectors

Interviewees made the following observations:

- Competing priorities—within and outside the health sector—make it critical to identify and engage in work that benefits multiple sectors at the same time. Cross-cutting initiatives should address issues that are important to multiple agencies. HiAP processes should complement the goals, missions, and funding streams of participating sectors. Cooperation without a vested interest among partnering agencies tends not to work well.

> *"Cross-sector collaboration [around health equity] is not just about health. You can get a lot farther [in the collaboration] if you are honest that it's not just about health. It's important to try to tap into the interests [of other sectors]. It doesn't matter what door they come through as long as the goal is the same, so trying to figure out what's important [to other sectors] is important."*
>
> **—State government leader**

- Participants involved in HiAP efforts must understand not only the priorities of the respective partners but also how each partner defines success; the reasons different sectors are working on the same issue may be less important than the fact that their goals are aligned.
- Collaboration works best and is most productive when partnering agencies share needed skills, expertise, and resources, and when they prioritize the collaborative work.
- Demonstrating opportunities for outcomes that benefit multiple sectors can be a function of framing. Sometimes this can be achieved by reframing an issue. For example, in the transportation context, connecting health to safety can be helpful, while in the education context, connecting health to academic achievement can be persuasive. One interviewee noted that cross-sector collaboration around health equity ". . . needs a clear definition of goals that everyone can get in line with. This doesn't necessarily happen easily. It may be a question of how issues are defined."
- Honesty and transparency are key to the ability of HiAP to benefit multiple partners.
- Engaging in work with the potential for co-benefits requires flexibility and the ability and willingness to make adjustments along the way.

Mutually beneficial health-equity efforts require participating sectors to understand each other's perspectives and share interests and priorities for achieving particular outcomes. Multisector efforts work best when built around shared resources and expertise—and characterized by flexibility, honesty, and transparency.

COMMUNITY AND STAKEHOLDER ENGAGEMENT

Community and stakeholder engagement is critical to health-equity efforts. Stakeholders include individuals, communities, and organizations whose key interests are very much affected by decisions that impact health disparities. HiAP encourages engaging with impacted communities and stakeholders to ensure that, through feedback, government is responsive to community needs.[80] Since promoting the implementation of equity-focused HiAP across all sectors requires feedback from communities experiencing health inequities, it is particularly important to include nontraditional public health partners and to ensure strong and meaningful community engagement. Minnesota's state agencies, local governments, and other organizations currently engage community members and stakeholders through numerous processes that can continue to be leveraged to advance HiAP in planning and decision-making.

Community and Stakeholder Engagement in Minnesota

Illustrative examples of community and stakeholder engagement to improve health equity in Minnesota include:

- **Engaging the Community to Promote Health Equity**

  - ***Minnesota Health Care Reform Task Force.*** In 2011, Governor Dayton charged the Minnesota Health Care Reform Task Force with leading the implementation of federal and state health reforms within Minnesota. The task force is led by the commissioner of the Department of Human Services and includes state legislators, representatives of the departments of health and commerce, and representatives from the private sector, the health care industry, philanthropy, and other sectors. The task force recommended focusing on at-risk populations, particularly children and first-time parents, and working with communities through SHIP and Accountable Communities of Health (transdisciplinary teams of professionals who provide patients with coordinated care). Stakeholder engagement efforts included sixty-five meetings held throughout Minnesota that were attended by about 1,500 people, with public testimony from 115 organizations and individuals as well as 750 comment letters related to various health reform issues[81] that contributed testimony on health disparities and the HiAP approach.[82]

FORMALLY ENGAGING POPULATIONS EXPERIENCING INEQUITIES

Minnesota law has created several structures that strive to gather input from populations experiencing inequities. For example, the Minnesota Council on Affairs of Chicano/Latino People (called the Chicano Latino Affairs Council [CLAC]), consists of eleven representatives who demographically mirror Minnesota's Chicano/Latino population, plus four nonvoting state legislators. The CLAC is required to advise the Minnesota legislature and governor on relevant issues, ensure access to state benefits and services, serve as a link to government agencies, recommend legislation to improve economic and social conditions, and implement programs to solve community problems.[83] The Council on Black Minnesotans (CBM)[84] and the Council on Asian-Pacific Minnesotans (CAPM)[85] serve many of the same functions with respect to their communities. In addition, CLAC and CAPM are represented on the Healthy Minnesota Partnership.* Since state law requires each council to "cooperate and coordinate its activities" with other state agencies and also requires all state agencies to provide each council with requested advisory assistance,[86] direct collaborations around health equity between state agencies and these councils could support each council's independent efforts to reduce health disparities.

CLAC
CHICANO LATINO AFFAIRS COUNCIL

CBM
THE COUNCIL ON BLACK MINNESOTANS

CAPM
COUNCIL ON ASIAN-PACIFIC MINNESOTANS

MIAC
MINNESOTA INDIAN AFFAIRS COUNCIL

Although a recent evaluation suggests that the role of these councils in the policymaking process could be bolstered,[87] they have done impressive work to meet their statutory duties. For example, the CAPM has hosted events at the Capitol, created legislative agendas, published policy documents, met with legislators and administrators, and participated in state initiatives like the Cultural and Ethnic Communities Leadership Council.[88] Similarly, in 2014, the CBM released a report to demonstrate how Minnesotans of African descent contribute to Minnesota's well-being, introduced twelve community-driven bills to address disparities affecting Minnesotans of African descent on topics that include health, criminal justice, education, and housing after holding community forums and events,[89] and hosted a Day on the Hill[90] to draw attention to their legislative priorities. In addition to actively pursuing its legislative agenda in 2014, the CLAC hosted four community forums to better understand issues that affect Minnesota's Chicano/Latino communities and identified immigration and education as two of its top priorities.[91]

Minnesota law has also created the Minnesota Indian Affairs Council (MIAC),[92] comprised of representatives of American Indian tribes and major state agencies, including the departments of transportation, health, human services, human rights, natural resources, and employment and economic development. To address the needs of American Indian tribes in Minnesota, MIAC advises tribal and state governments on policies, projects, and programs; helps deliver resources and services to tribes; reviews data; and provides educational programs.[93] MIAC has convened stakeholders, including hosting the Summit on the Crisis of Indian Children in Minnesota[94] and the American Indian Health Symposium.[95] Through its liaisons, MIAC has developed strong

relationships with certain state agencies[96] and has served as a forum for state agencies to keep tribal chairs up to date and obtain their feedback.[97]

MIAC also contributed to developing Executive Order (EO) 13-10, signed by Governor Dayton on August 8, 2013.[98] EO 13-10 focuses state executive agencies on the needs of Minnesota's tribal nations. Each state cabinet agency must "develop and implement tribal consultation policies to guide their work and interaction with the Minnesota Tribal Nations" and designate and train specific staff members to serve as principal liaisons to the tribal nations. EO 13-10 requires state government to consult with Minnesota's Tribal Nations to determine priority issues.[99] MIAC supports EO 13-10 and its proposed enactment as statute.[100]

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*It appears that while the Council on Affairs of Chicano/Latino People and the Council on Asian-Pacific Minnesotans are represented on the Healthy Minnesota Partnership, the other councils discussed are not. *About the Healthy Minnesota Partnership, infra.* note 99.

• Integrating Stakeholders' Input into Health-Equity Work

› ***The Healthy Minnesota Partnership.*** The Healthy Minnesota Partnership, in existence since 1997, has gathered representatives from various sectors and organizations to develop a statewide health assessment and plan with public health priorities and strategies. The partnership explicitly embraces a HiAP approach and health equity in its work by focusing on the connections between health equity and other sectors, e.g., employment. The partnership aims to serve as a voice for all Minnesotans and includes representatives from:

- **The American Heart Association**
- **Public health organizations, such as the Minnesota Public Health Association**
- **Government departments, including the state departments of health, transportation, and housing**
- **Government organizations representing populations that experience health inequities (including the Chicano/Latino Affairs Council, the LGBTQ Health Advisory Roundtable, and the Minnesota Board on Aging)**
- **Health care organizations, such as the Hennepin County Medical Center, Sanford Health, and the Minnesota Council of Health Plans**
- **Community-based projects and organizations, such as the Itasca Project and the Stairstep Foundation**[101]

These representatives have provided their expertise and perspectives to establish the Healthy Minnesota 2020 Framework and have coalesced around three major themes related to social determinants of health:

- **Early childhood health**
- **Universal opportunities for health**
- **Strong communities that encourage health and embrace HiAP**[102]

› ***Stakeholder and Community Engagement through Nonprofit Organizations.*** Minnesota public health organizations have actively engaged stakeholders around HiAP, demonstrating how prevalent HiAP concepts have become in efforts to improve community health. For example, the Minnesota Public Health Association (MPHA) has organized its last three annual conferences around HiAP and related concepts and has brought together stakeholders through a health-equity grant from the American Public Health Association. MPHA adopted a HiAP resolution in 2013 that encourages MPHA members to reach out to diverse partners to address the social determinants of health and to support HiAP implementation efforts.[103]

Considerations Affecting Community and Stakeholder Engagement around Health Equity

Interviewees pinpointed the following ideas about community and stakeholder engagement:

- Community engagement is critical in addressing the full spectrum of health, from its social determinants to its treatment, and can help determine the need for and level of interest in HiAP and options for moving forward. In the words of one interviewee whose work involves community engagement: "Community members want wellness but they call it something else. They want healthy and peaceful communities. They want the preservation of their communities." Government investments to understand the needs of different communities are very important. As one senior leader of a state department indicated: "We in government sometimes struggle with putting too much emphasis on statutes; we need to spend some time thinking about what the public is saying and why."

  > *"It is important to listen to and hear stories from the community. These stories can change the minds of leadership. They can also help us appreciate differences."*
  > **—State policymaker**

- For many people, equity and race can be difficult subjects to discuss. Minnesota's changing demographics demonstrate a need for these conversations to take place as well as a need to expand opportunities for meaningful community and stakeholder engagement. In the words of one key senior leader: "Demographics are important . . . . We can see that the future [in Minnesota] looks different than the present and the past. The demographic lens is a good strategy to start the conversation." Talking about these changes is particularly important because, as one interviewee noted, race, place, color, and class are critical in determining health.

  > *"People who are disenfranchised want to be part of arriving at the solution."* **—State leader**

- Effectively engaging communities and stakeholders by bringing partners together is an energy-intensive and sophisticated process for which resources are often insufficient, yet it can prove very worthwhile by building community capacity, which, in the words of one interviewee, "can improve quality, align goals, and increase transparency."

- Not every sector has deep experience engaging with community stakeholders, particularly those who are concerned about health equity. One interviewee noted that "communities in [this state] are determined to do better and better, to do what it takes to improve health for everyone" but that "many communities need to build additional capacity" to learn how to move forward.

- Efforts to engage stakeholders should include outreach to the private sector. In particular, large companies that pay employee health care costs can be critical partners. In addition, public-private partnerships can emerge through stakeholder engagement.

- Community and stakeholder engagement processes can prompt different types of input from different groups, highlighting the value of working with a wide array of communities and stakeholders. One interviewee stressed the importance of thinking about who is at the table and what is on the agenda: "If most of the people [at the table] are 'health people,' then the others are an afterthought. Collaborating in setting the agenda vastly changes the conversation."

- Local public health agencies have a strong and respected history of convening and engaging communities and stakeholders. They also have a thorough understanding of the overall HiAP framework and the potential benefits of using the HiAP approach in decision-making. As one interviewee commented, local public health is often "where the rubber meets the road," and can be strong at managing collaborations, communicating with stakeholders, and thinking creatively. These same qualities are attributes of successful HiAP work.

Engaging communities and stakeholders around health equity is a sophisticated process—one with which many agencies and organizations in Minnesota have experience. Expanding capacity in this area for all sectors is critical because doing so has the potential to generate and assess fresh ideas, align goals, and improve health outcomes.

STRUCTURAL AND PROCEDURAL CHANGE

Promoting health equity in community- and state-level policy planning and decision-making often requires modifying some existing structures and procedures. Existing structures and procedures—including requirements, practices, or processes that lead sectors to focus only on isolated issues, incentivize and reward short-term solutions, tie government action to budget cycles, and add layers of process—may hamper health-equity efforts across sectors. The use of a sustained HiAP approach for working across sectors to address health equity has significant potential to improve government decision-making[104] and make government more efficient, effective, and equity-oriented. Permanently embedding health-equity aims into all government decisions requires ongoing, concerted HiAP efforts.

At the same time, certain existing laws, programs, and policies in Minnesota demonstrate movement toward cooperative decision-making that considers the health-equity impacts of decisions made in all sectors. The strategies presented in this report build on Minnesota's existing efforts and encourage the purposeful and routine consideration of health equity in all government decision-making processes through sustained practice and culture change.

LONG-TERM, CROSS-SECTOR PROBLEM-SOLVING THAT AFFECTS HEALTH EQUITY: *The Metropolitan Council*

The Metropolitan Council, a policymaking body, planning agency, and provider of essential services for the Twin Cities metropolitan region, is comprised of sixteen leaders, each appointed by the governor. To fulfill its mission, the council has created a comprehensive development guide called THRIVE MSP 2040, which aligns with HiAP principles. THRIVE MSP 2040 serves as the foundation for the region's policies, programs, and systems and guides regional planning.

Through stakeholder and community engagement, including outreach to local governments and the private and nonprofit sectors, THRIVE MSP 2040 adheres to a set of five regional values and linked outcomes:

1. STEWARDSHIP
2. PROSPERITY
3. EQUITY
4. LIVABILITY
5. SUSTAINABILITY

These values and related outcomes were selected primarily to enhance regional planning efforts in ways that advance health-equity aims. For instance, THRIVE MSP 2040 defines "livability" based on many of the same factors that are relevant to health equity.

Livability factors relevant to health equity:

- **Access to recreation through trails.**
- **Choices in transportation and housing across demographic and economic characteristics.**
- **Healthy lifestyles through biking, transit-oriented development, and walkable communities.**
- **Healthy communities through land-use policies.**

- THRIVE MSP 2040 incorporates operational principles similar to those used in HiAP in that it proposes to accomplish its work through integration (leveraging activities for more effective results to address complex issues), collaboration (sharing effort across entities), and accountability (monitoring and evaluating effectiveness).[105]
- THRIVE MSP 2040 engages in reciprocal partnerships with state agencies—including health, transportation, human rights, housing, agriculture, and pollution control—and local government units, such as towns, counties, townships, and special districts.[106]
- THRIVE MSP 2040 is committed to making funding choices that will simultaneously advance multiple objectives.[107] For example, among the criteria for a transit expansion grant adopted in September 2014, "equity and housing performance" ranks third in its funding priorities. Measures of equity and housing performance include connecting transit to concentrated areas of poverty, racially concentrated areas of poverty, and census tracts with higher than average concentrations of populations of color or poverty.

- The council's focus on long-term problem-solving encompasses health equity. It examines race-based, place-based, and poverty-based disparities through an equity assessment and by working with the Partnership for Regional Opportunity to collect input from community partners on what has been accomplished and what more can be done to increase equity.[108]
- The council is currently conducting outreach to engage the community to move forward,[109] part of which involves a seven-week tour of the region by the council's chairperson "to listen to local officials and community members."[110] Collectively, the council's efforts focus on long-term, structural solutions to interconnected, complex problems that involve all sectors in the Twin Cities region.

Innovative Structures and Procedures that Promote Health Equity in Minnesota

There are many examples of innovative efforts to increase consideration of health equity in Minnesota government and nonprofit decision-making. Some illustrative examples include:

• Exploring the Role of Academia in Advancing HiAP

- ***MDH and the University of Minnesota.*** MDH and the University of Minnesota are working with other Big Ten Universities to explore how universities can support efforts to advance HiAP, from educating the workforce to providing hands-on, data-based assistance with analyses. One interviewee emphasized that the university (and other respected academic institutions) can play an important role in HiAP: "Science won't answer every question, but [the university] can be transparent and nonpolitical. It can be an arena for people to come together and have discussions."

• Reforming Traditional Government Practices

- ***Better Government for a Better Minnesota.*** Governor Dayton's Better Government for a Better Minnesota initiative involves efforts to transform business as usual in state government to "save money, reduce waste, make government better for people," and update systems and programs through technology, sustainability, performance improvement, and regulatory reform.[111] This initiative has (1) requested input from state employees and Minnesotans in general on how to improve state government services; (2) recognized state employees and agencies for reforming government and saving state dollars; (3) highlighted connections between education, economic growth, transportation, health, and the environment; and (4) recognized the need to continue addressing "poverty and inequality."[112] It has also included a plain-language initiative based on an executive order issued by Governor Dayton that requires executive branch agencies to communicate with Minnesotans in language commonly understood by the public that uses short, complete sentences and to present information in ways that are easy to find and understand.[113]

• Institutionalizing Health-Equity Aims in Allocating Funds

- ***SHIP Government Funding.*** SHIP, established by statute, provides competitive grants to local communities to address key risk factors related to preventable disease, including tobacco use, unhealthy weight, and lack of physical exercise, that are tied to health equity. Community health boards and tribal governments that receive these competitive grants must "address the health disparities and inequities" in their

communities.[114] Starting in November 2015, SHIP grant funds may also be used to address dementia.[115] In northwest Minnesota, SHIP efforts have included a Health Equity Summit on July 18, 2014, hosted by the PartnerSHIP4Health in the City of Moorhead, where more than 150 attendees focused on health equity.[116] Using SHIP funding, seven counties in northeast Minnesota have collaborated to reduce health disparities by focusing on certain policy priorities, including nutrition policies in public schools; breastfeeding policies in health care facilities; policies and practices that promote active-living communities; tobacco-free policies and quit-smoking resources in postsecondary schools; and comprehensive workplace wellness programs and policies.[117] With SHIP assistance, Olmsted County has established community gardens, physical-activity policies in child care centers, and a Complete Streets policy; introduced healthier vending policies in public schools; and trained tobacco-cessation facilitators.[118]

Several interviewees commented that SHIP has been tremendously successful at focusing efforts on health equity. One interviewee specifically noted that SHIP projects were quite successful in 2013, when more SHIP funding was available. In addition to directly funding health-equity work, SHIP may advance health equity in Minnesota by improving and harmonizing data collection methods, which can provide a more comprehensive understanding of health disparities statewide.[119]

- ***Philanthropy around Innovative Health-Equity Work.*** Minnesota's philanthropic sector has recognized the importance of health equity and has encouraged communities to promote health equity through their work and funding practices. For example, the Blue Cross and Blue Shield of Minnesota Foundation centers much of its work and grant-making on health equity by focusing upstream to enhance equitable systems, social connections, stable lives, and vibrant communities.[120] For instance, the foundation has granted funds to the Alliance for Metropolitan Stability to advance equity through community engagement centered on policy reform in the Twin Cities. In addition, the foundation has given funds to the Immigrant Development Center to support the needs of low-income immigrant and refugee populations in Moorhead for training and microlending for businesses.[121] Health equity is also a core component of the work of the Center for Prevention at Blue Cross and Blue Shield of Minnesota,[122] which funds community-based projects in Minnesota that use HiAP to advance health equity. The Otto Bremer Foundation also has funded equity-focused projects that build community capacity[123] as well as projects centered on the health of populations experiencing inequities.[124] The Minneapolis Foundation focuses its grant-making on "social, racial, and economic equity" and funds civic engagement activities that "advance equity in civic participation, economic vitality, and education."[125] Other Minnesota-focused foundations are engaged in similar endeavors.

Considerations Affecting Structural and Procedural Change

Interview participants shared the following observations about structural and procedural change related to health equity:

- HiAP has the potential to broaden how "successful" policies, projects, plans, and programs are defined. Efforts to promote health equity may conflict with existing practices and systems of siloed work that focus on quick implementation of programs and policies, two-year budget cycles, stop-and-start funding, and short-term expectations for returns on investments. Instead, a commitment to implementing HiAP requires a fundamental and sustained shift in thinking—a deep-rooted change in culture that comes with routine practice—about collaboration as well as the amount of time and the types of processes required to achieve structural solutions.

- Implementing HiAP envisions a longer-term timeline for achieving health equity and can help frame and quantify long-term costs and cost savings. For instance, a cross-sector approach to reducing recidivism that helps lessen barriers to employment often faced by individuals reentering the community from jails and prisons has the potential to save government dollars in the long run. Recognizing co-benefit connections, particularly for complex issues like health equity, may strengthen responsible stewardship of public funds. In the words of one interviewee:

  > *"By combining resources, sectors can achieve [health-equity] ends in a way that would get investment up front but [substantially impact] long-term outcomes. For example, allocating money to education could really reduce the number of prisoners and the cost of imprisonment down the line."* **—State leader**

- HiAP is both a value and a philosophy that, if shared by multiple sectors, can lead to cross-cutting connections. A variety of specific methodologies, including HIAs and targeted funding, are consistent with the HiAP approach.

- It is critical to understand that HiAP is a self-reinforcing, continual approach for improving public health; process steps cannot be done just once but must be repeated again and again. The collaborative nature of interagency HiAP working groups may facilitate this aspect of HiAP.

- **Change requires addressing social conditions as we find them.** In the words of one interviewee: "The fundamental system of where people live, work, and play is mostly set, making it hard to make big change. [Often, efforts to address social conditions] are playing at the margins."

- The HiAP approach is complex and requires flexibility and intentionality; there is no universal solution or method that will work in all settings. Maintaining reasonable, deliberate expectations is critical. Even with empathetic leadership, it takes time to overcome start-up obstacles.

- Agency heads must rely on their colleagues in other agencies to lead in their respective areas of expertise and to institute sector-specific changes that withstand time and turnover. Each agency is organized differently so each is in the best position to target HiAP efforts internally. Formal policies that institutionalize consideration of health equity in all decisions can catalyze change and withstand time and turnover. As one interviewee pointed out:

  > *"Policy can be the platform to develop system change."* **—State policymaker**

At the same time, requirements that are perceived as burdensome or that require HiAP without the necessary resources may limit HiAP's usefulness.

- For structural and procedural changes, data is key: HiAP practitioners must learn how to fund and facilitate cross-sector data-sharing and how to obtain granular data—data that are more specific than county-level.

- Local and regional governments are important vehicles for change. Structural and procedural change at these levels may be easier to accomplish because typically there are fewer employees and leaders are easier to access—so it may be easier to maintain relationships across disciplines and to engage in face-to-face problem solving.

HiAP efforts require shifting how problems are perceived, the types of solutions that are considered, and how those solutions are implemented. Changing existing structures and procedures to promote health equity in all decisions, over time, can have a significant impact.

SUMMARY OF FINDINGS

Public and private sectors in Minnesota are well-positioned to advance and promote health equity by implementing a HiAP approach to planning and decision-making. Minnesota has a proven record of promoting health equity in all sectors; collaborating across traditional silos; working in a mutually beneficial manner on projects, programs, and policies; seeking input from multiple stakeholders and communities; and changing planning and decision-making structures and procedures to advance health-promoting public policies. Key policy leaders in Minnesota overwhelmingly agree that sectors outside of health are critical to efforts to decrease disparities in the state and to improve the lives of all Minnesotans. They recognize interconnections and working collaboratively to tackle complex problems that involve health equity.

Advancing health equity through multisector collaborations requires a deliberate commitment to HiAP and the resources necessary to implement it. Advancing health equity will require additional, dedicated, and sustained funding as well as a workforce and stakeholders who recognize how social factors impact health equity and are willing and able to integrate a health-equity perspective into their work.

Input from key leaders suggests that moving forward on HiAP will require:

- **Strengthening support among leadership.**
- **Building cross-sector relationships.**
- **Determining specific actions that will internalize HiAP into day-to-day work.**
- **Educating the workforce, decision makers, and diverse communities about the impacts that decisions in all sectors have on health equity.**
- **Bolstering workforce capabilities.**
- **Demonstrating the value of HiAP-related work.**
- **Working to make collaboration, along with transparency and accountability, the normal way of doing business.**
- **Having conversations about social justice that resonate across all sectors.**

Part Two of this report, "Recommendations: **STRIDE** toward Health Equity," supplements the findings presented in Part One by offering a set of health-equity targets that builds on the state's recent momentum and suggests a number of strategies to help achieve health equity across all sectors.

PART TWO
RECOMMENDATIONS: STRIDE TOWARD HEALTH EQUITY

STRIDE TOWARD HEALTH EQUITY

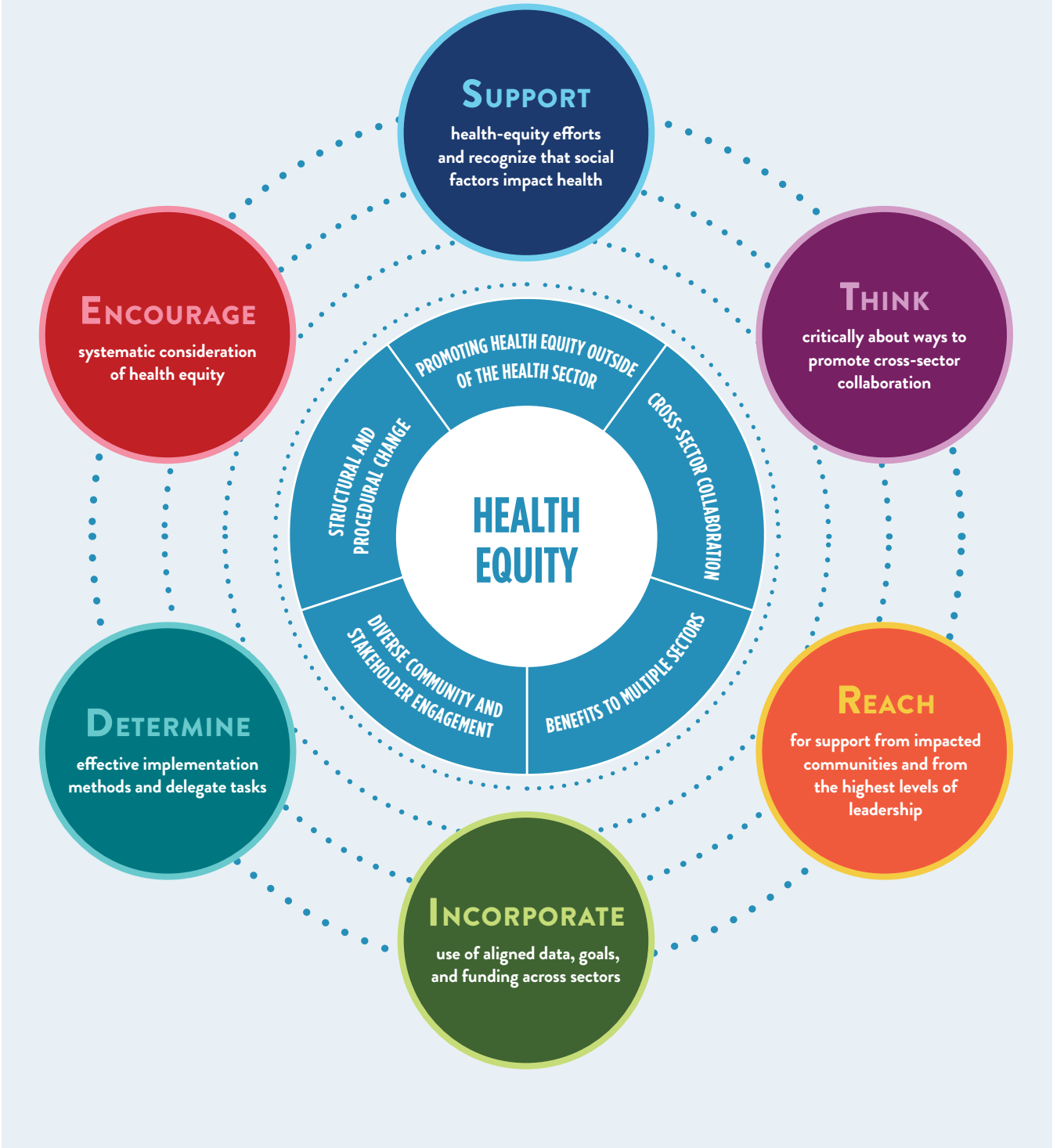
As discussed in Part One, social factors have a critical impact on health equity. While medical care is important, access to employment, education, healthy foods, recreation, and other opportunities helps explain why the residents of some communities—or some neighborhoods—are healthier than others.[126]

Health equity aims to improve health for everyone while at the same time focusing particularly on improving health for population groups whose health is disproportionally affected by social factors.[127] The Health in All Policies (HiAP) approach to decision-making and resulting healthy public policies can help support health-equity efforts. HiAP is a flexible approach to decision-making and operations—it recognizes that because social factors are so critical in determining the health of communities, decisions made in all sectors should consider health.[128] HiAP can be thought of as being comprised of five key, connected elements. HiAP (1) promotes health equity across multiple sectors, (2) benefits multiple sectors, (3) involves cross-sector collaboration, (4) engages diverse communities and stakeholders, and (5) focuses on sustained structural and procedural changes.[129]

As also discussed in Part One, Minnesota communities, local and regional governments, state agencies, philanthropies, and other organizations have made considerable progress in pursuing HiAP—whether they call it HiAP or something else.[130] For example, communities in Minnesota are promoting health equity across multiple sectors by conducting health-impact assessments to examine the health effects of decisions that typically do not consider them.[131] At the same time, state agencies are engaging in work that benefits multiple sectors, for example, through the Minnesota Interagency Council on Homelessness, which brings together eleven state agencies[132] and leaders from all levels of government to reduce homelessness in the state.[133] By using a HiAP approach, Minnesota's state, regional, and local governments, nonprofit community organizations, community members, and private sector businesses can continue to build health equity.

Aiming for these six targets will promote and reinforce the key elements of HiAP: (1) **S**upport health-equity efforts and recognize that social factors impact health; (2) **T**hink critically about ways to promote cross-sector collaboration; (3) **R**each for support from disproportionately impacted communities and from the highest levels of leadership; (4) **I**ncorporate use of aligned data, goals, and funding across sectors; (5) **D**etermine effective implementation methods and delegate tasks; and (6) **E**ncourage systematic consideration of health equity. Each target, in turn, can be pursued through various strategies, each of which may be appropriate in different contexts.[134] Many of the strategies listed in the tables below were generated through interviews, a survey, and supplemental research. Importantly, as with HiAP, the effort to **STRIDE** toward health equity is a continuous, self-reinforcing process.

STRIDE TOWARD HEALTH EQUITY BY PROMOTING HiAP[135]



Adapted from: Linda Rudolph et al., Health in All Policies: A Guide for State and Local Governments (2013).; Lauren N. Gase et al., *"Health in All Policies": Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. Pub. Health Mgmt. & Prac. 529, 529–40 (2013).

HOW AND WHY TO STRIDE TOWARD HEALTH EQUITY[136]

STEPS YOU CAN TAKE . . .	WHY DO IT . . . PROMOTE HEALTH EQUITY ACROSS MULTIPLE SECTORS	BENEFITS TO MULTIPLE SECTORS	CROSS-SECTOR COLLABORATION	COMMUNITY & STAKEHOLDER ENGAGEMENT	STRUCTURAL & PROCEDURAL CHANGE
SUPPORT health-equity efforts and recognize that social factors impact health	✓		✓	✓	
THINK critically about ways to promote cross-sector collaboration	✓	✓	✓	✓	✓
REACH or support from impacted communities and from the highest levels of leadership	✓	✓	✓	✓	✓
INCORPORATE use of aligned data, goals, and funding across sectors	✓	✓	✓		✓
DETERMINE effective implementation methods and delegate tasks	✓	✓	✓		
ENCOURAGE systematic consideration of health equity	✓		✓	✓	✓

Adapted from: Linda Rudolph et al., Health in All Policies: A Guide for State and Local Governments (2013).; Lauren N. Gase et al., *"Health in All Policies": Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. Pub. Health Mgmt. & Prac. 529, 529–40 (2013).

SUPPORT health-equity efforts and recognize that social factors impact health[137]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Train and learn about how various social factors and health-related behaviors contribute to health equity. Incentivize attending health-equity conferences, particularly for nontraditional public health partners such as nonprofit and community organizations that focus on factors that contribute to health equity through other lenses, like education or the environment.	✓	✓	✓	✓	✓
Discuss and apply the strategies and recommendations outlined in MDH's *Advancing Health Equity Report* through community and stakeholder engagement activities.	✓	✓	✓	✓	✓
Fund the Minnesota Center for Health Equity, created in December 2013,[138] at levels that provide sufficient personnel and financial resources to equip the center to work with other sectors.	✓		✓		✓
With key community leaders, discuss health equity in the context of a broader conversation about social justice in the state, connecting health-equity goals to larger social-justice issues. Define health equity as a function of race, place, color, and class.	✓	✓	✓	✓	✓
Gather input and convene disproportionately impacted communities and stakeholders to develop a community-supported and community-influenced broad equity agenda.	✓	✓	✓	✓	✓
Frame conversations about morbidity and mortality as conversations about walkability or healthy food.	✓	✓	✓		
Produce cross-agency communication materials that improve public familiarity with and understanding of HiAP and health equity.	✓	✓	✓		
Develop a succinct and accessible health-equity document for state and local government officials, using a strategic message framework that explains HiAP as a feasible tool.	✓		✓		

THINK critically about ways to promote cross-sector collaboration[139]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Consider if and how the mission and tasks of one's organization are consistent with health equity.	✓	✓	✓		✓
Reach out to other state and local governments for examples of sector-specific policies that maximize health equity and use them as a starting point to develop promising strategies for Minnesota. Other states and localities that have demonstrated leadership in promoting multisector health-equity efforts include California, Rhode Island, Seattle/King County, Chicago, and San Francisco.	✓	✓	✓		
Invest in sector-specific white papers to study in greater depth opportunities to integrate health equity into decisions made by education, transportation, planning, corrections, and other sectors.	✓	✓	✓		✓
Highlight concrete examples of health-equity efforts of diverse communities and stakeholders in Minnesota through blogs, social media, and other mechanisms.	✓	✓	✓		
Enhance the diversity of the workforce across sectors to help enhance community engagement and cultural competence.	✓	✓	✓		✓
Advocate for cross-sector collaborations that can advance health equity. Participate in cross-sector, collaborative efforts and coordinate work across issues. Take part in discussions and events across sectors to determine which health-equity issues resonate with others and to learn about best practices in cross-sector collaboration. Ask for, and listen to, ideas from management about ways to promote health equity through cross-sector collaboration.	✓	✓	✓	✓	✓
Learn about the collective impact model, which proposes that solving complex social problems like health equity requires the commitment and concerted actions of multiple sectors working together around a common agenda. Collective impact collaborations typically contain a central infrastructure; dedicated staff; shared processes; a shared agenda; shared measurements; constant communication; and actions and activities that reinforce each other.[140]	✓	✓	✓	✓	✓

THINK critically about ways to promote cross-sector collaboration[139] (CONT.)

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Convene and participate in a health care industry board of advisors to guide government HiAP efforts.	✓	✓	✓		✓
Engage private-sector business organizations and companies, including large companies, trade organizations, and chambers of commerce. Private-sector businesses' interest in health equity and peer-to-peer education can prompt action and help expedite the pace of change within government.	✓	✓	✓	✓	✓
Convene nonprofit and community organizations and researchers at the University of Minnesota and other colleges and universities to explore the connections between social justice and health equity. The university and other schools could play key roles in furthering HiAP work in Minnesota. With sufficient funding, academic input could provide scientifically sound, transdisciplinary, and apolitical data analyses to support the use of HiAP.			✓		
Identify roles that Minnesota counties and other local governments can play. Collaborate with Partnership for Regional Opportunity working groups, which identify action steps at the county level related to health equity.	✓	✓	✓	✓	
Create sector-specific information that highlights the expertise of each sector to inform different agencies about the work of colleagues in other sectors.	✓	✓			

REACH for support from impacted communities and from the highest levels of leadership[141]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Quantify projected cost savings or other quantifiable benefits of collaborative projects (such as time saved or increased effectiveness) to demonstrate the return on investment for both public and private entities.	✓	✓	✓		✓
Conduct sector-, organization-, and community-specific asset mapping to determine expertise and resources as well as limitations for addressing the health-equity issues of each sector, organization, and community.	✓	✓	✓	✓	✓
Convene agency leaders to discuss how to engage with disproportionately impacted communities and support promoting health equity within their respective sectors.	✓	✓	✓		
Seek diverse community input on decisions that affect health equity. Train government staff about ways to gather community input.	✓	✓	✓	✓	✓
Identify one or two central health-equity issues for all agencies to address. This process could demonstrate how multiple sectors can collaborate effectively and increase the number and range of examples of effective cross-sector collaboration.	✓	✓			
Require cabinet-level, cross-sector collaboration on health-equity issues through statute, executive order, policies, and unofficial guidance. Set goals, yet allow individual agencies and organizations the flexibility to determine how to achieve these goals.	✓	✓	✓		
Create and coalesce around department- and organization-specific policies, goals, and values statements that emphasize the importance of cross-sector collaboration around health equity.	✓	✓	✓		✓
Make savvy use of media to engage diverse and disproportionately impacted communities around health equity.	✓	✓	✓	✓	✓
Create a template for presentations that can be tailored to advocate for HiAP-related changes in multiple planning and decision-making settings and contexts.	✓	✓	✓	✓	✓

REACH for support from impacted communities and from the highest levels of leadership[141] (CONT.)

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Help communities learn how advocacy can spur change around social-justice issues connected to health equity.	✓	✓	✓	✓	
Continue to educate state and local elected officials, including city council members, county commissioners, and school board members, about the connections between various sectors and health equity. Create HiAP trainings for newly elected leaders and appointed government officials, demonstrating opportunities for participants in all sectors to advance health-equity aims.	✓	✓	✓	✓	✓

INCORPORATE use of aligned data, goals, and funding across sectors[142]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Ask workforce members for their suggestions on how sectors might accomplish their respective goals, while also addressing health.	✓	✓	✓		✓
Commit resources to cross-sector work.	✓	✓	✓		✓
Study and address the logistical, financial, and legal challenges to sharing data across departments in order to facilitate cross-sector use of all relevant data.	✓	✓	✓		
Build on existing efforts to embed health-equity metrics into all state and local government grant-making and contracting.	✓	✓			
Fund, empower, and support staff at every level of government who report to multiple sectors simultaneously and are tasked with integrating health equity into decisions made outside the health sector. Hire staff members with multidisciplinary expertise and experience. Identify means to pool or share financial resources across sectors. Incentivize collaboration by tying financial rewards to collaborative activities or accomplishments. Survey respondents cited the following as the top three strategies to incentivize cross-sector collaboration: dedicated funding (79%), dedicated time (63%), and encouragement and support of leadership (53%).	✓	✓	✓		
Modify state-funded health care program policies to incentivize health care providers to focus on health equity and prevention and study how HiAP-related work can be integrated into the state's Medicaid system.	✓				
Coordinate funding and investment decisions across agencies, including establishing systematic cross-agency discussions that relate to budget requests.	✓	✓			
Identify data-driven and strategic interagency opportunities to address health equity through cross-sector discussions about priorities.	✓	✓			

INCORPORATE use of aligned data, goals, and funding across sectors[142] (CONT.)

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Determine which sector-specific metrics and indices overlap and evaluate the data available for HiAP efforts in each agency and organization.	✓	✓	✓		
Advocate for and earmark funding to address long-term health-equity issues.	✓	✓	✓	✓	✓
Urge grant-giving organizations to design funding opportunities that incorporate cross-sector collaboration and diverse community engagement to advance health equity. Identify flexible funding streams and apply for grants to fund projects that include cross-agency collaboration and diverse community engagement around health equity.	✓	✓	✓	✓	✓
Study ways to measure progress in implementing cross-sector collaboration and metrics, consistent with long-term processes.	✓	✓			
Share messaging through partnerships among public information officers of different state agencies and local governments.	✓	✓			
Establish periodic meetings to engage in cross-agency strategic planning concerning health equity.	✓	✓			
Appoint leadership- and staff-level point persons at each agency and within divisions of local governments to facilitate cross-sector and interdepartmental collaboration around health equity.	✓	✓			
Continue to fund SHIP at a sustainable level and include fully integrated health-equity strategies.	✓				
Develop standardized HiAP definitions and vocabulary for use across all sectors and levels of government.	✓	✓	✓		
Designate or assign staff to cultivate health data capacity across government sectors.	✓	✓			
Increase the capacity of the University of Minnesota and other academic institutions to assist with data collection and analyses by involving interdisciplinary teams on an ad hoc basis.			✓		

DETERMINE effective implementation methods and delegate tasks[143]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Enhance leadership support and organization-specific implementation for promoting health equity in sectors other than health.	✓	✓	✓	✓	✓
Evaluate previous and current collaborations to determine the value that can be achieved through cross-sector work.	✓	✓	✓		✓
Establish an entity to focus on the long-term return on investment of policies that promote health equity through government-wide collaboration.	✓		✓		✓
Provide funds to deploy public health experts to help leaders in other sectors think through health-equity implications and support the collection of public health-related data in those agencies.	✓	✓	✓		✓
Allocate seed money for local governments to explore opportunities for HiAP-related structural and procedural change.	✓		✓		✓
Identify entities, including communities, that have the capacity to monitor HiAP work to ensure transparency and accountability, e.g., by establishing a HiAP advisory board or steering committee.	✓	✓	✓		✓
Develop a statewide framework or strategic map to demonstrate how different government actions can be coordinated to implement HiAP-related processes.	✓				
Enhance communication within and across government entities, and communication with disproportionately impacted communities, to share successes.	✓	✓	✓		
Ask neutral third parties to facilitate conversations about HiAP-related change.	✓	✓	✓	✓	✓
Convene advocates and community members from different sectors to coordinate efforts and determine specific tasks.	✓	✓	✓	✓	✓
Recognize individuals and communities that have played significant roles in successful collaborations.	✓	✓	✓	✓	✓

ENCOURAGE systematic consideration of health equity[144]

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Change business as usual. Nineteen survey respondents identified multiple strategies to motivate voluntary consideration of health equity in decision-making through changes in structures and procedures: interagency strategic planning or an action plan around health equity (74%); coordinating funding or investment (68%); serving on work groups or task forces (68%); consulting informally with others about pending decisions that could impact health equity (68%); and sharing a mission, vision, goals, or objectives related to health equity (68%).	✓	✓	✓		
Formalize value statements at multiple levels of government (city councils, boards of commissioners, state policymakers) and in impacted communities and organizations to stress the importance of health-equity analyses in planning and decision-making. Resolutions, mission or vision statements, and policy documents can serve as a catalyst for actionable steps. *"If you don't have a value statement to coalesce around, it's hard to have actionable steps."* — **Policymaker**	✓	✓	✓	✓	✓
Share scientific evidence that promoting health equity in all sectors is a worthy investment. Make an evidence-informed case that addressing social determinants of health can change environments and behaviors in ways that prevent disease and that, in turn, prevention saves money for the state, which covers health care costs for 20% of Minnesotans through Medicaid dollars. *"Money is really important and concrete—showing the possibility of cost savings in health care costs [can be a key initial step]."* — **Policymaker**	✓	✓	✓		
Develop capacity to produce health-impact notes to analyze the potential health-equity impacts of pending legislative decisions. In doing so, consider how to select appropriate bills (e.g., at the request of legislators). One option is to integrate a health-equity analysis into the local-impact note. This requires resources.	✓	✓	✓		

ENCOURAGE systematic consideration of health equity[144] (CONT.)

STRATEGIES	STATE GOVERNMENT	LOCAL AND REGIONAL GOVERNMENT	NONPROFIT AND COMMUNITY ORGANIZATIONS	COMMUNITY MEMBERS	PRIVATE-SECTOR BUSINESSES
Support efforts to conduct health impact assessments (HIAs) that address social policies, such as school expulsions or sentencing guidelines, across sectors. Support should include funding and should showcase the effects of HIAs on decisions and health outcomes.	✓	✓	✓	✓	✓
Create a set (template) of questions for all sectors and communities to use in planning to analyze the health-equity impacts of decisions. For example, systematically ask health- and equity-related questions such as: What are the intended benefits? What are the intended outcomes? Has anyone been left out? How will accountability be addressed?	✓	✓	✓		✓
Use diagrams to demonstrate how pending laws, policies, projects, and programs could impact health equity.	✓	✓	✓		✓
Require joint, cross-sector decisions on questions that simultaneously impact multiple sectors. A cross-sector approach may be particularly useful when decisions could impact health-equity measures that different sectors monitor and address.	✓	✓			
Convene diverse community stakeholders to focus on systematic reforms and health-specific impacts of public policies.	✓	✓	✓	✓	✓
Pilot HiAP-related structural and procedural changes in a few key contexts. Survey respondents stressed the particular importance of education and transportation on the health of Minnesotans. Two areas prioritized by the governor are children and families and transportation infrastructure.[145]	✓	✓			
Work with counties that are ready to make structural and procedural changes using HiAP; other counties are likely to follow.	✓	✓	✓		
Continue to partner with entities such as the Local and Regional Government Alliance on Race & Equity, a network of governments working on racial-equity issues through existing institutions and partnerships. The alliance provides technical assistance to governments seeking to improve racial equity and examples of best practices from jurisdictions that are leading such efforts.[146] The alliance has assisted the Metropolitan Council with racial equity tools and guidance on how they may apply in the Twin Cities.[147]		✓			

SUMMARY OF RECOMMENDATIONS

The evidence is clear: Social factors contribute to different health outcomes among different population groups and communities.[148] HiAP offers a flexible approach to planning and decision-making processes that shows promise for advancing health equity and improving the health of all populations and communities. As discussed in Part One, Minnesota leaders have embraced the elements of HiAP. As state, local, and regional governments, nonprofits, and diverse community organizations, community members, and private-sector businesses in Minnesota continue to **STRIDE** toward health equity, many different and complementary strategies can be pursued. The volume and breadth of these strategies demonstrate that HiAP is a flexible approach to policy planning and decision-making. Many of the strategies discussed in this report can be implemented simultaneously and can reinforce each other, thereby keeping health equity a top priority on all planning and policy agendas.[149]

CONCLUSION

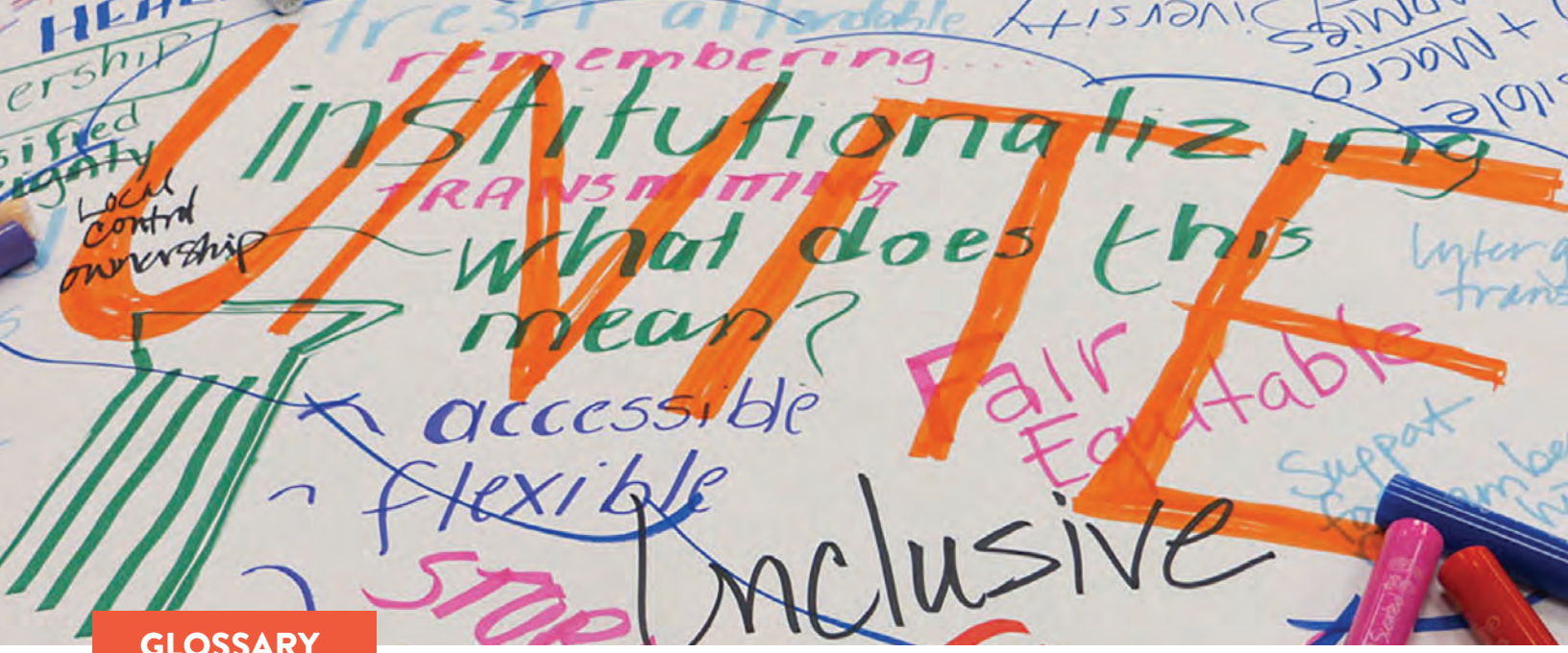
Factors including race, income, and education, along with influences such as transportation and housing options, availability of healthy food, and safety of communities, affect the environments in which people live, work, and play, and the lives they lead.[150] These factors influence and shape health directly and through choices and behaviors.[151] As a result, some population groups have substantially better health than others.[152]

Attaining health equity involves creating communities where all people are as healthy as they can be. Notably, health equity involves paying particular attention to those who bear the highest risk of poor health because of certain key social factors and influences.[153] Today, health equity stands as a pivotal issue facing Minnesota and the country as a whole.[154]

The Health in All Policies approach to planning and decision-making encourages consideration of health equity in decisions across all sectors. This inherently adaptable approach or practice is comprised of five key elements: promoting health equity outside of the health sector; fostering cross-sector collaboration; benefiting multiple partners at the same time; engaging with diverse communities and stakeholders; and reshaping existing structures and procedures.[155]

As described in Part One, Minnesota communities, state, local, and regional governments, nonprofit and community organizations, and private-sector businesses have, together, made considerable progress in all five of these areas. For example, Minnesota has emerged as a leader among all states in expanding the use of health impact assessments (HIAs) in multiple sectors[156] and the state enjoys some of the highest-rated Complete Streets policies in the nation.[157] Minnesota government agencies are experienced in working across sectors to address complex problems[158] and practiced at engaging impacted communities,[159] and all sectors are benefiting from the investments of philanthropic organizations in Minnesota that are dedicated to advancing health equity.[160] Many Minnesota leaders are committed to promoting health equity and to thinking through the challenges and opportunities related to implementation of HiAP strategies. Part One of this report captures many of these valuable insights.

Leaders of Minnesota communities, governments, nonprofit and community organizations, and private-sector businesses can consider a number of possible strategies as they continue to implement HiAP and **STRIDE** toward achieving health equity. The mix of strategies offered in Part Two of this report were collected from conversations with Minnesota leaders and organized into six target areas designed to help leaders continue to **STRIDE** toward the achievement of health equity: (1) **S**upport health-equity efforts and recognize that social factors impact health; (2) **T**hink critically about ways to promote cross-sector collaboration; (3) **R**each for support from disproportionately impacted communities and from the highest levels of leadership; (4) **I**ncorporate use of aligned data, goals, and funding across sectors; (5) **D**etermine effective implementation methods and delegate tasks; and (6) **E**ncourage systematic consideration of health equity. Pursuing specific strategies that aim to reach the **STRIDE** targets can help improve health for all Minnesotans.[161]



GLOSSARY

ASSET MAPPING—analyzing and itemizing the resources and strengths of a community, organization, or sector that could promote work around health equity.[162]

CO-BENEFITS—activities that further the agendas of multiple actors at the same time, producing win-wins, or simultaneous advantages to multiple actors.[163]

COLLABORATION—activities that use diverse, inter-sector teams to advance a common agenda.[164]

COLLECTIVE IMPACT—a method to solve complex social problems through the commitment and concerted actions of multiple sectors collaborating around a common agenda.[165]

HEALTH EQUITY—achieving a "high standard of health" for everyone in a community while at the same time concentrating on populations within that community that are at a disproportionate risk for poor health because of social factors.[166]

HEALTH IMPACT ASSESSMENT (HIA)—a systematic yet flexible process to assess likely health effects of pending decisions about projects, policies, and programs that originate outside of the health sector in order to inform how decisions could maximize health.[167]

HEALTH IN ALL POLICIES (HiAP)—an approach to governmental and nonprofit planning and decision-making that promotes health equity by addressing the social determinants of health through health analysis across all sectors.[168]

MAPPING BARRIERS—analyzing and itemizing the impediments to health-equity work in a community, organization, or sector.

SOCIAL DETERMINANTS OF HEALTH—social opportunities, living conditions, and environments that contribute to health and its upstream causes through knowledge, attitudes, beliefs, or behaviors.[169]

SOCIAL JUSTICE—equal opportunities for everyone, regardless of the population groups to which one belongs.[170]

STAKEHOLDERS—individuals, communities, and organizations whose key interests are affected by decisions made by government.[171]

UPSTREAM—the most critical and fundamental contributions to health equity that are related to social factors.[172]

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