



INSIGHTS & INNOVATIONS

CREATING OPPORTUNITIES TO ACHIEVE OPTIMAL HEALTH



Jeanne F. Ayers, RN, MPH

Assistant Commissioner and
Chief Health Equity Strategist
Minnesota Department of Health



RICHARD M. FAIRBANKS
SCHOOL OF PUBLIC HEALTH

Brought to you by the Center for Public Health Practice and
the Indiana Public Health Training Center

Advancing Health Equity Key to Our Nation's Health

Jeanne Ayers

Assistant Commissioner, Minnesota Department of Health

Webinar Series

IUPUI-Region V HRSA Training Center

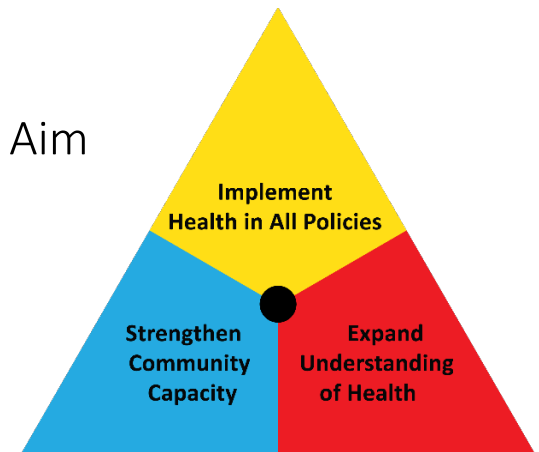
January 27, 2017



Minnesota
Department of Health

Presentation

- **Expand our understanding of what creates health and health disparities including structural inequities and structural racism.**
- **Introduce a framework for an emerging public health practice to advance health equity and decrease health disparities.**
- **Identify the core elements of the Triple Aim of Health Equity and describe the practices, tools and and examples in action.**
 - Expanding the understanding of health
 - Implement Health in All Policies with Equity as the Aim
 - Strengthen community capacity



Public Health

“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health

What is Health?

From WHO 1948 and Ottawa Charter for Health 1986

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the objective of living."

What is necessary for Health?

☀ **Peace**

☀ **Income**

☀ **Shelter**

☀ **Stable eco-system**

☀ **Education**

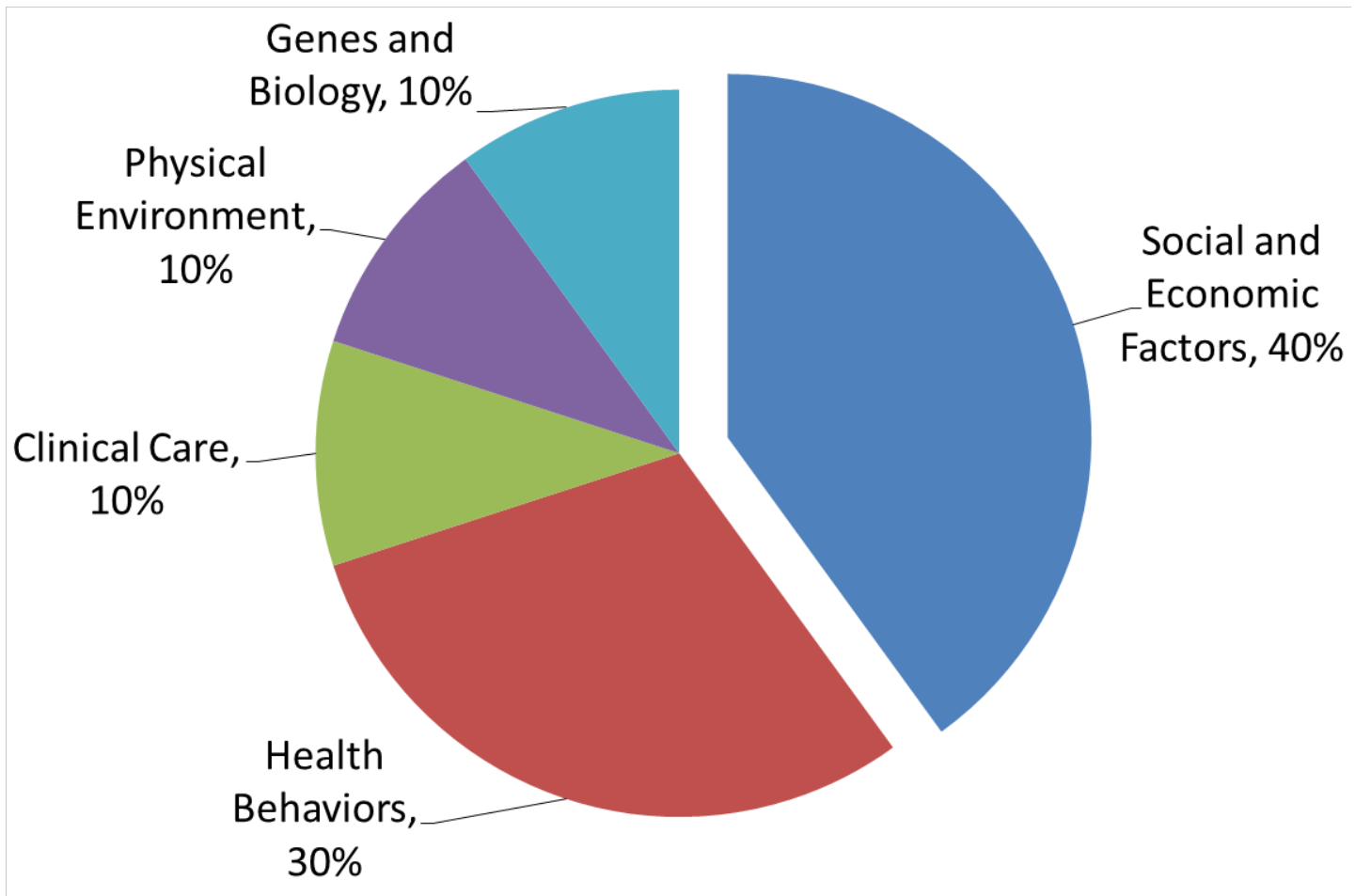
☀ **Sustainable resources**

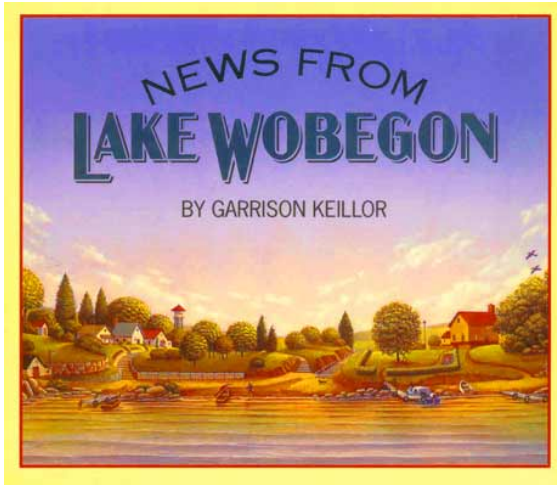
☀ **Food**

☀ **Social justice and equity**

World Health Organization. Ottawa charter for health promotion. International Conference on Health Promotion: The Move Towards a New Public Health, November 17-21, 1986 Ottawa, Ontario, Canada, 1986. Accessed July 12, 2002 at <<http://www.who.int/hpr/archive/docs/ottawa.html>>.

Factors that determine health





Garrison Keillor, born on August 7, 1942

Minnesota!
Where the women are strong,
The men are good looking,
And all our health statistics
are above average –
Unless you are
a person of color or
an American Indian.

Advancing Health Equity in Minnesota

Report to the Legislature

“...the opportunity to be healthy is not equally available everywhere or for everyone in the state.”

Health inequities in Minnesota are significant and persistent, especially by race:

In Minnesota, an African American or Native American infant has more than twice the chance of dying in the first year of life as a white baby.

Disparities in Birth Outcomes are the tip of the health disparities iceberg



Roots of Inequities - how did we get here?

- Disparities are not simply because of lack of access to health care or to poor individual choices.
- Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
 - Especially, populations of color and American Indians, GLBTQ, and low income
 - Structural Racism

Disparities in health are the tip of the societal disparities iceberg



Predictors of Health by Race

The connection between systemic disadvantage and health inequities by race is clear and **predictive of the future health** of our community.

What does “health equity” mean?

Health equity means achieving the conditions in which all people have the opportunity to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities.

Communities of Opportunity

- Social/economic inclusion
- Thriving small businesses and entrepreneurs
- Financial institutions
- Good transportation options and infrastructure
- Home ownership
- Better performing schools
- Sufficient healthy housing
- Grocery stores
- IT connectivity
- Strong local governance
- Parks & trails

Good Health Status

Poor Health Status

Contributes to health disparities:

- Diabetes
- Cancer
- Asthma
- Obesity
- Injury

Low-Opportunity Communities

- Social/economic exclusion
- Few small businesses
- Payday lenders
- Few transportation options
- Rental housing/foreclosure
- Poor performing schools
- Poor and limited housing stock
- Increased pollution and contaminated drinking water
- Fast food restaurants
- Limited IT connections
- Weak local governance
- Unsafe/limited parks

Structural/Institutional Racism

- Structural racism is the **normalization** of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

Structural Inequity: Housing

- 75% of white population in Minnesota owns their own home, compared to:
- **21% of African Americans**
- 45% of Hispanic/Latinos
- 47% of American Indians
- 54% Asian Pacific Islanders

Source: Advancing Health Equity Report 2014

Structural/Institutional Racism

- Ignores differential impacts on racial populations
- Ignores differences among racial populations (e.g. accumulated wealth, homeownership, transit dependence, employment, education, geography)
- Focuses on 'efficiency', cost, numbers to the exclusion of other criteria such as community impact
- Raises barriers to resources, such as grants or contracts
- Is based in dominant culture norms, experiences, approaches or expertise
- Reflects lack of cultural knowledge/background/awareness

Advancing Health Equity in Minnesota

Report to the Legislature

- Things are the way they are – because we designed them that way. The roots are deep in historical policies—Structural Racism
- Not a new program but a commitment, a commitment to fundamental shifts in paradigms about what constitutes evidence, who is involved in decision-making, and what creates health
- Greatest potential for change is effective policy development

Laws of Minnesota 2013, Chapter 108, Article 12, Section 102

Public Health

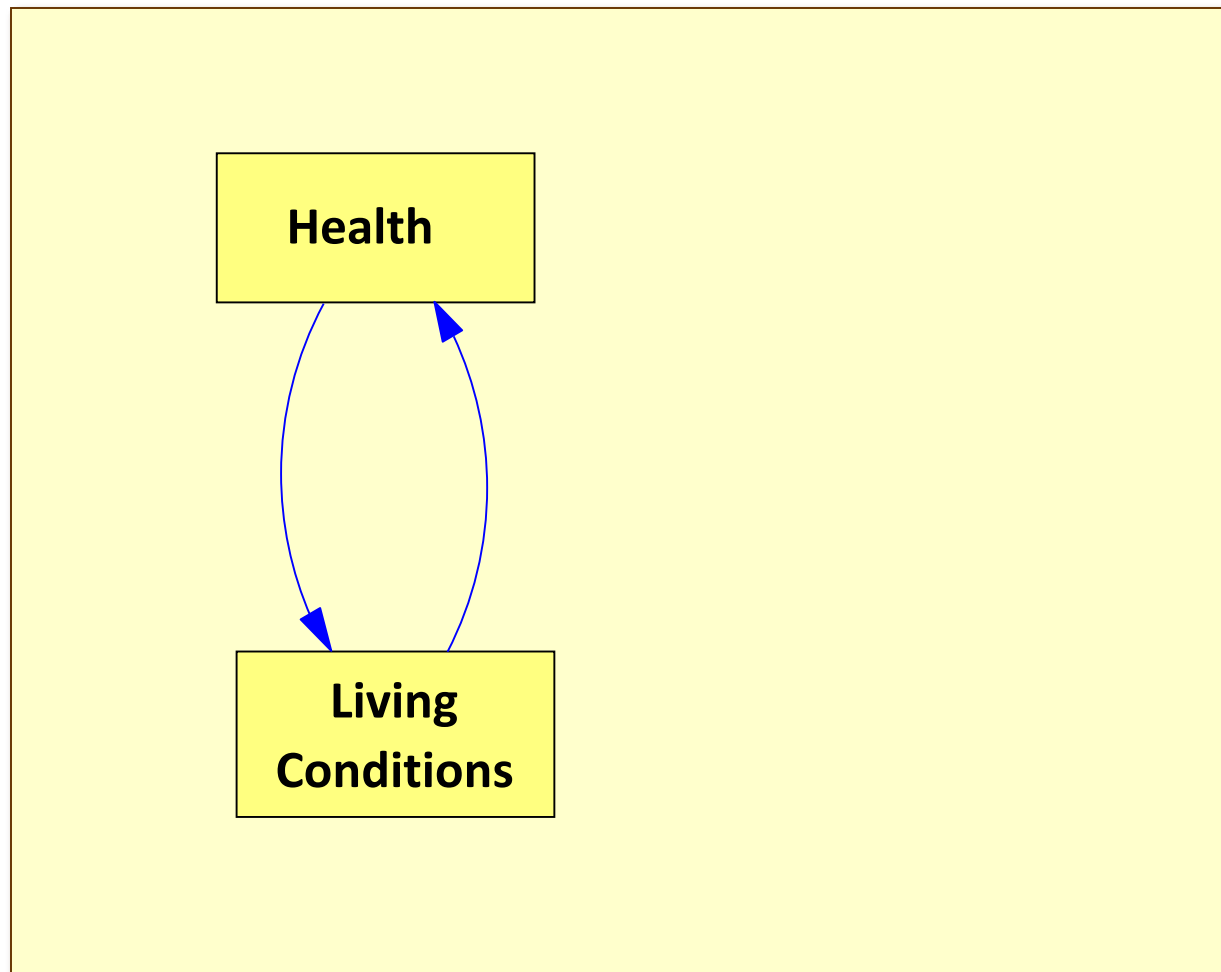
“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health

What is our Theory of Change?



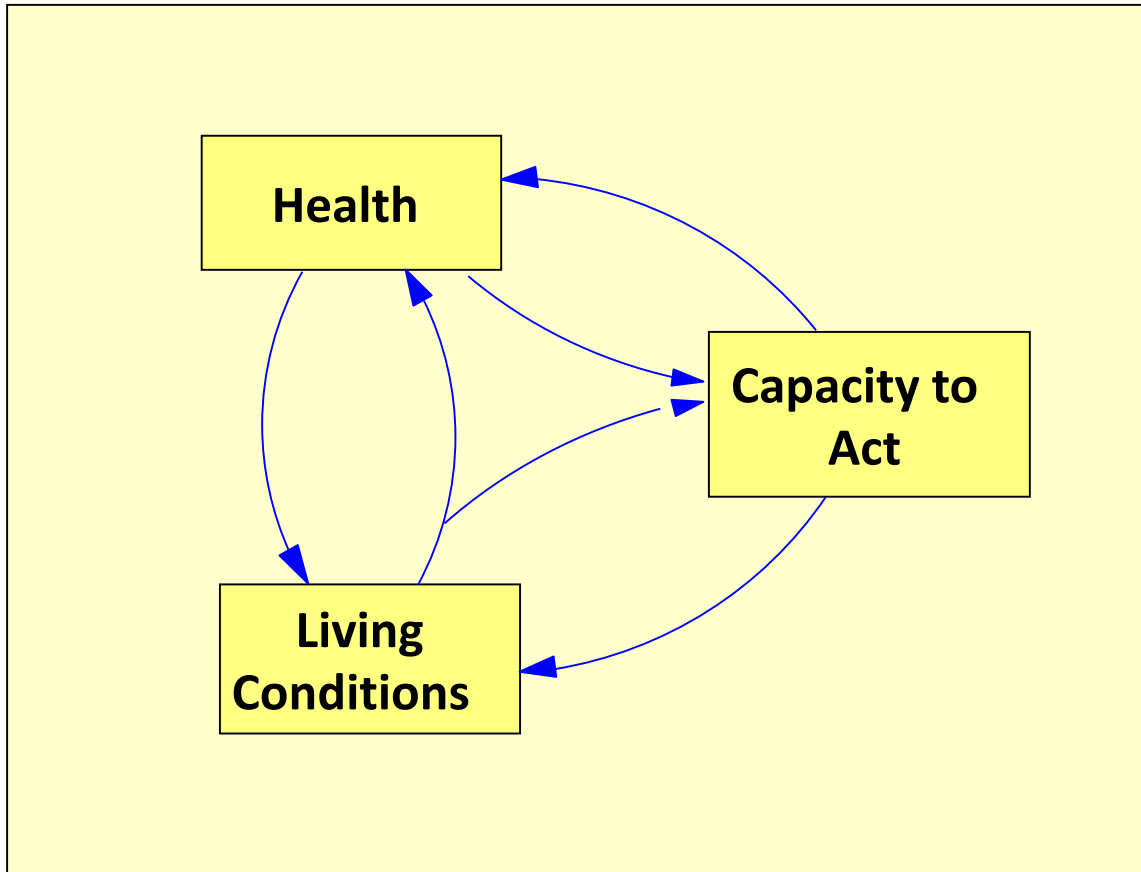
“Assuring Conditions” requires Seeing a Wider Set of Relationships



Social Determinants of Health

- The conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are **shaped by** a set of forces beyond the control of the individual: economics and the **distribution of money, power, social policies, and politics** at the global, national, state, and local levels.
 - WHO and CDC (adapted)

Changing the Conditions Requires the Capacity to Act



Public health must build its skills to foster the “capacity to act” (power)

“Power, properly understood, is the ability to achieve purpose.

It is the strength required to bring about social, political, or economic changes.

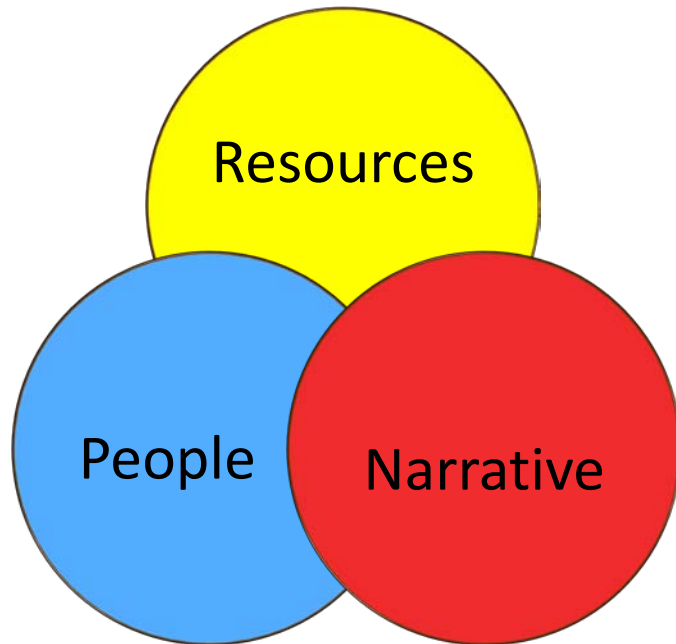
In this sense power is not only desirable but necessary in order to implement the demands of love and justice. ”



-Martin Luther King, Jr

Structure work to achieve our overall aim: Create/Strengthen “Capacity to Act”

Organize the:



- Narrative: Align the narrative to build public understanding and public will.
- People: Directly impact decision makers, develop relationships, align interests.
- Resources: Identify/shift the resources-infrastructure-the way systems and processes are structured.

Asking Questions as a Path to Action

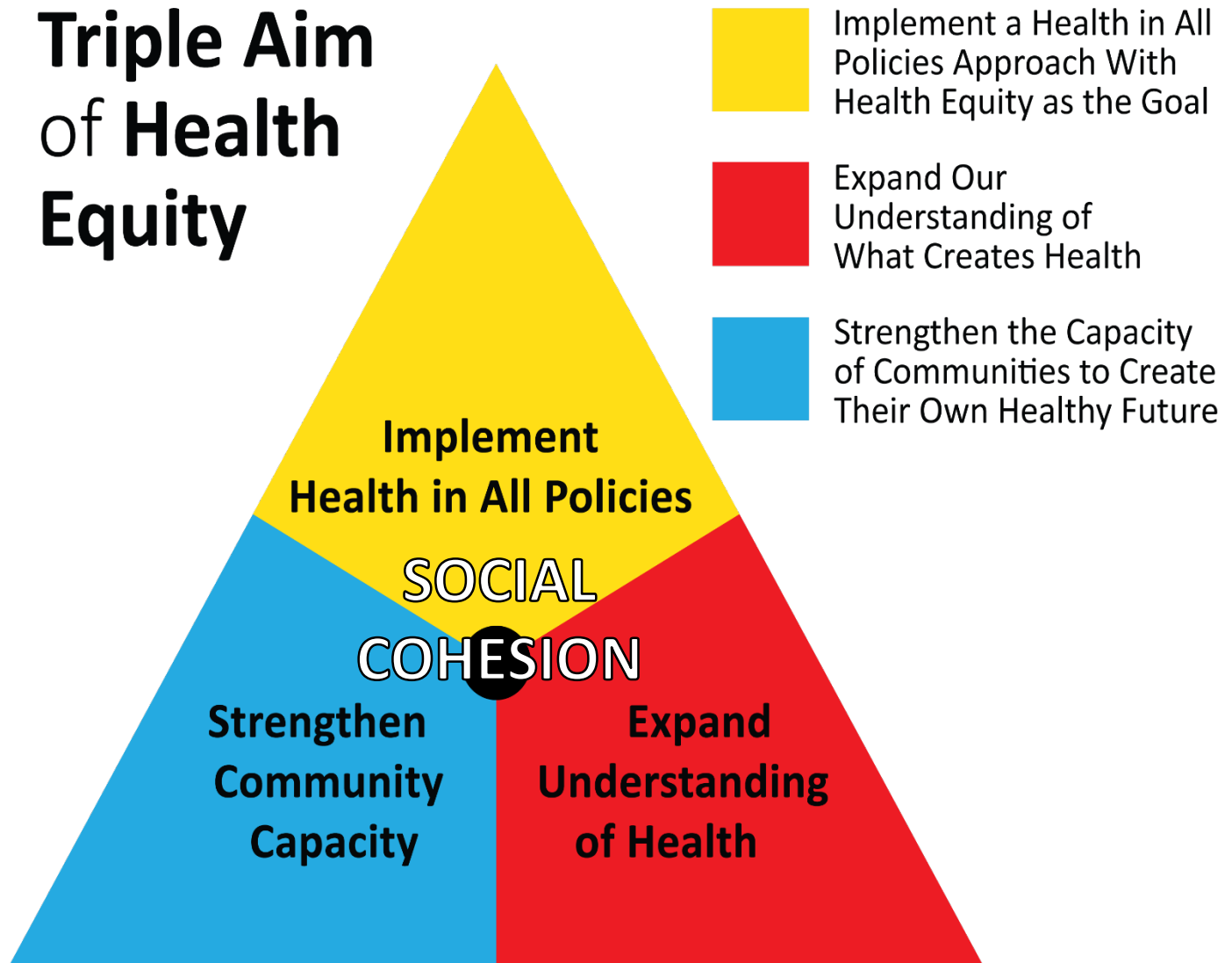
- **Inquiry Questions:**

- ✓ *What are the patterns that we are seeing?*
- ✓ *Are they “fit to purpose”? Will we achieve our aim?*
- ✓ *What are the assumptions, practices, processes, policies and beliefs that are creating inequities? At every level.*
- ✓ *How can we strengthen the practices that lead to equity and weaken those that lead to inequity?*
- ✓ *System change 3-7 “Simple practices”*

Foundational Practices to Advance Health Equity

- Purposefully expand the understanding and conversation of what creates health to include the “opportunity for health” (organize narrative-knowledge)
- Strengthen the capacity of communities to create their own healthy futures. Use public health tools: partnerships, engagement, convening ability, data, reports, education, policy, resources, legislation, “bully pulpit” (organize people)
- Implement a “health in all policies” approach with health equity as the goal in program and policymaking (organize resources-and how systems work)

Triple Aim of Health Equity

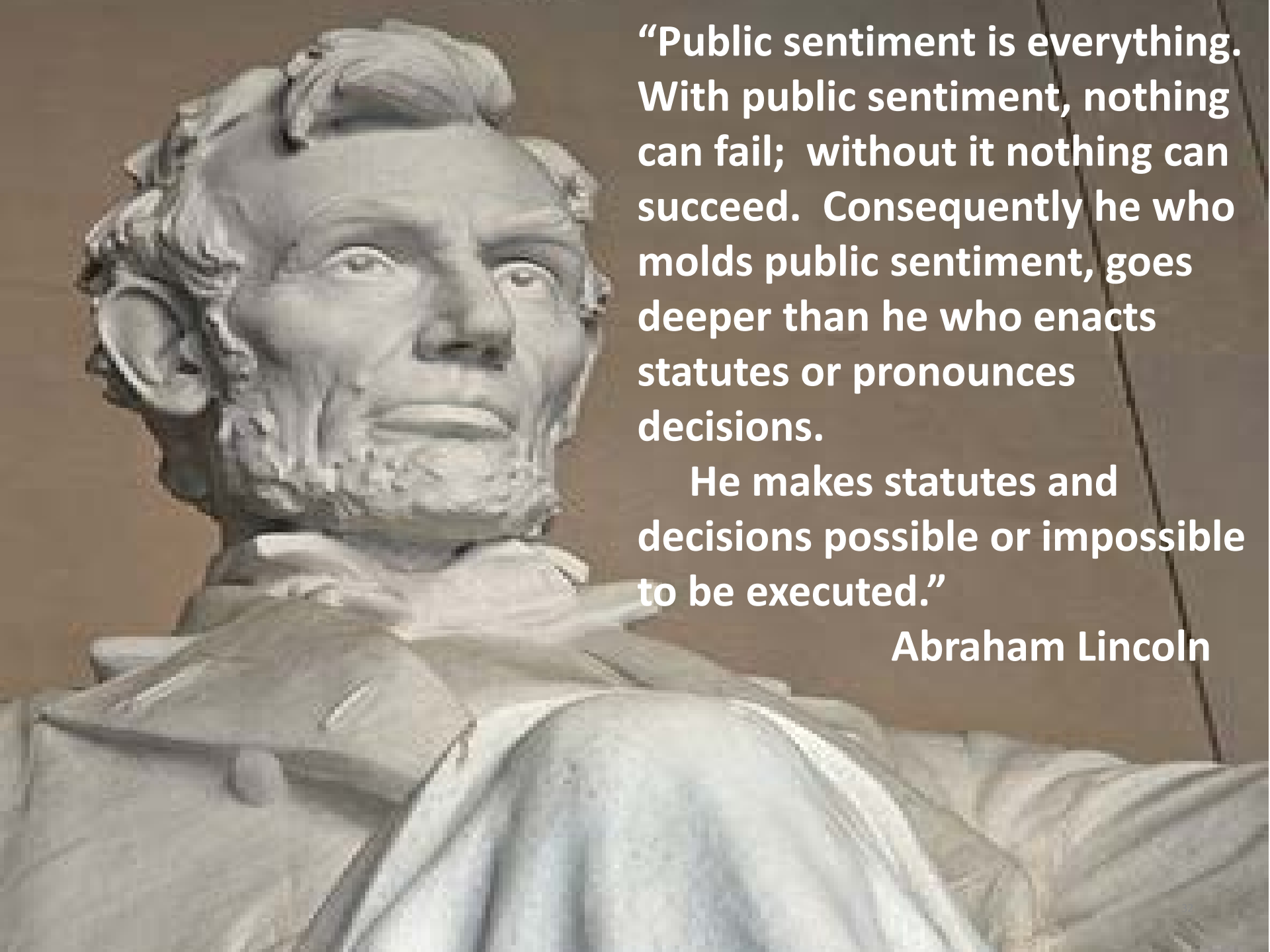


Structure our work to advance health equity

The Triple Aim of Health Equity is based upon a theory of change that blends an understanding of power and systems change

Introduces and strengthens a simple set of 3 practices versus specific programs or services

These 3 simple practices help us identify existing patterns in systems and create or strengthen patterns with the potential to create transformative change



“Public sentiment is everything. With public sentiment, nothing can fail; without it nothing can succeed. Consequently he who molds public sentiment, goes deeper than he who enacts statutes or pronounces decisions.

He makes statutes and decisions possible or impossible to be executed.”

Abraham Lincoln

Expand the understanding of what creates health: Change the Narrative

- Health is not determined by just clinical care and personal choices
- Health is determined mostly by physical and social determinants affecting individuals and communities
- Determinants are created & enhanced by policies and systems that impact the physical and social environment

And The Real Narrative of What Creates Health Inequities?

- Disparities are mostly the result of policy decisions that systematically disadvantage some populations over others.
 - Especially, populations of color and American Indians, LGBTQ, and low income
 - Structural Racism

Tools for Expanding our Understanding of Health

- Data Collection:** Include data on the opportunity for health-SDoH, Demographics, SES, Race, Ethnicity, Language, Sexual Identify, Gender identification
- Data Analysis:** Incorporate an understanding of the SDoH, structural inequities, structural racism...and the power of policy, system and environmental (PSE) approaches
- Reports:** Communication and dissemination—Develop and share reports with an analysis of the inter-relationship between health outcomes and health opportunities or inequities.
- Partners:** Partner with communities experiencing greatest health disparities and groups/agencies focused on improving the social determinants.

Asking the Right Questions About Assumptions Can Help Change the Narrative

- What values underlie the decision-making process?
- What is assumed to be true about the world and the role of the institution in the world?
- What standards of success are being applied at different decision points, and by whom?

Healthy Minnesota 2020: *Statewide Health Assessment and Statewide Health Improvement Framework*

- **Minnesota Department of Health
and the Healthy Minnesota
Partnership**

Healthy Minnesota 2020

Statewide Health Improvement Framework

December 2012

A Healthy Start for All • An Equal Opportunity for Health • Communities Creating Health

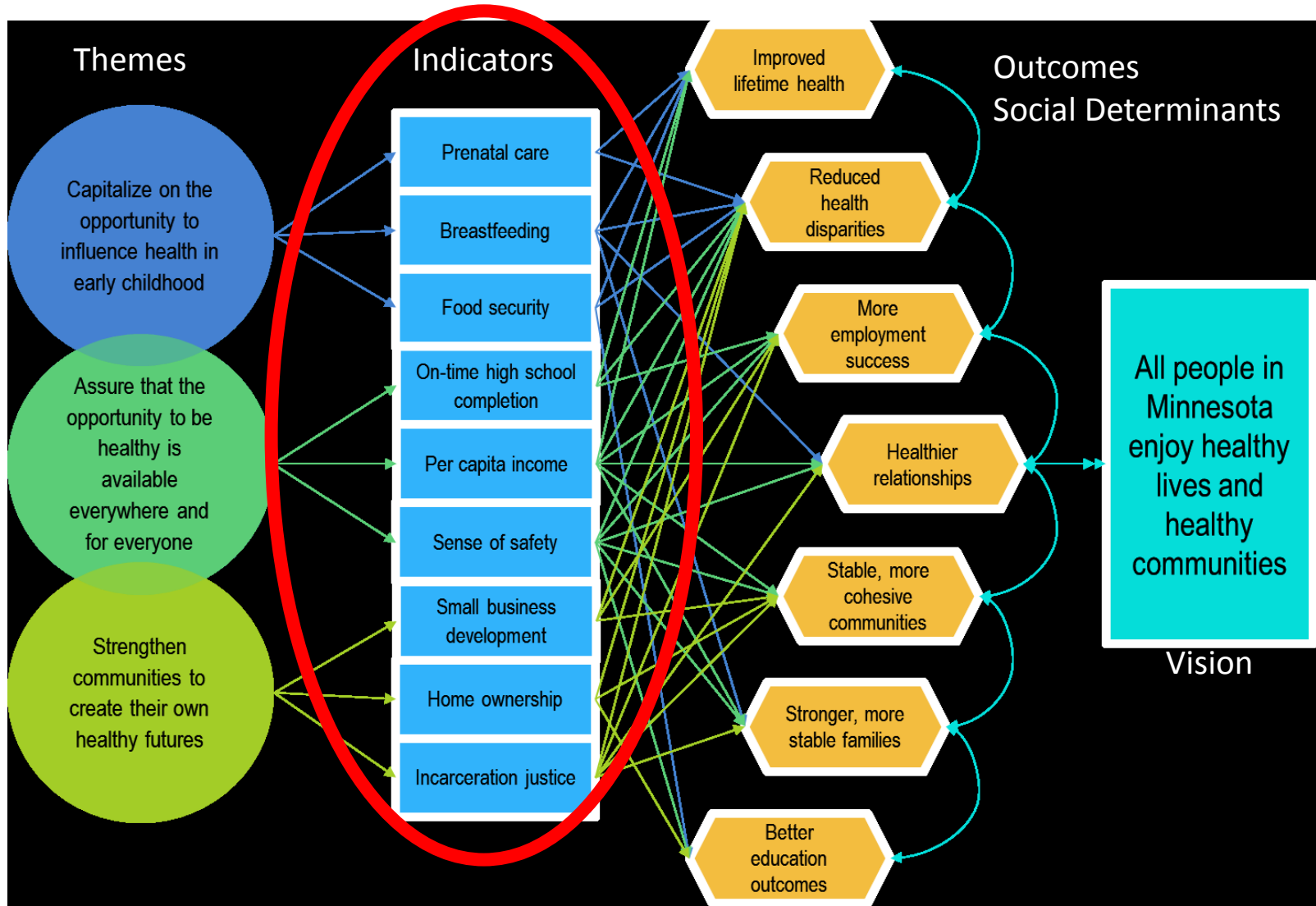


Minnesota Department of Health &
Healthy Minnesota Partnership
PO Box 64975 | 625 Robert Street N
Saint Paul, MN 55164-0975
Phone: (651) 201-5000
www.health.state.mn.us/healthymnpartnership

MDH

[http://www.health.state.mn.us/
healthymnpartnership/hm2020/](http://www.health.state.mn.us/healthymnpartnership/hm2020/)

Change the Narrative about What Creates Health Indicators in Statewide Health Assessment/Framework



Health in All Policies



Implement Health In All Policies-Equity

- Health in All Policies (HIAP) is a collaborative approach that integrates and articulates health considerations into policy making and programming across sectors, and at all levels, to improve the health of all communities and people.
 - HIAP requires practitioners in all sectors to collaborate to define and achieve mutually beneficial goals.
 - HiAP—with Equity as the Aim.

Tools in Health in All Policies Approach

- Data
- Reports
- Internal Policy Alignment
- White Papers
- Health Notes
- Health Impact Assessments
- Community Engagement--partners
- Asking Questions

Health in all Policies:

Questions to ask to advance health equity

- What do we know about who will benefit?
- What health impacts can we anticipate? Who will experience these impacts?
- What and whose values, beliefs and assumptions are guiding or influencing the decision?
- What do we know about impact(outcome) versus intent of the policy?
- Would the issue/policy benefit from further study or a health impact assessment(HIA)?

Policy and System Changes Related to Social Determinants of Health (selected)

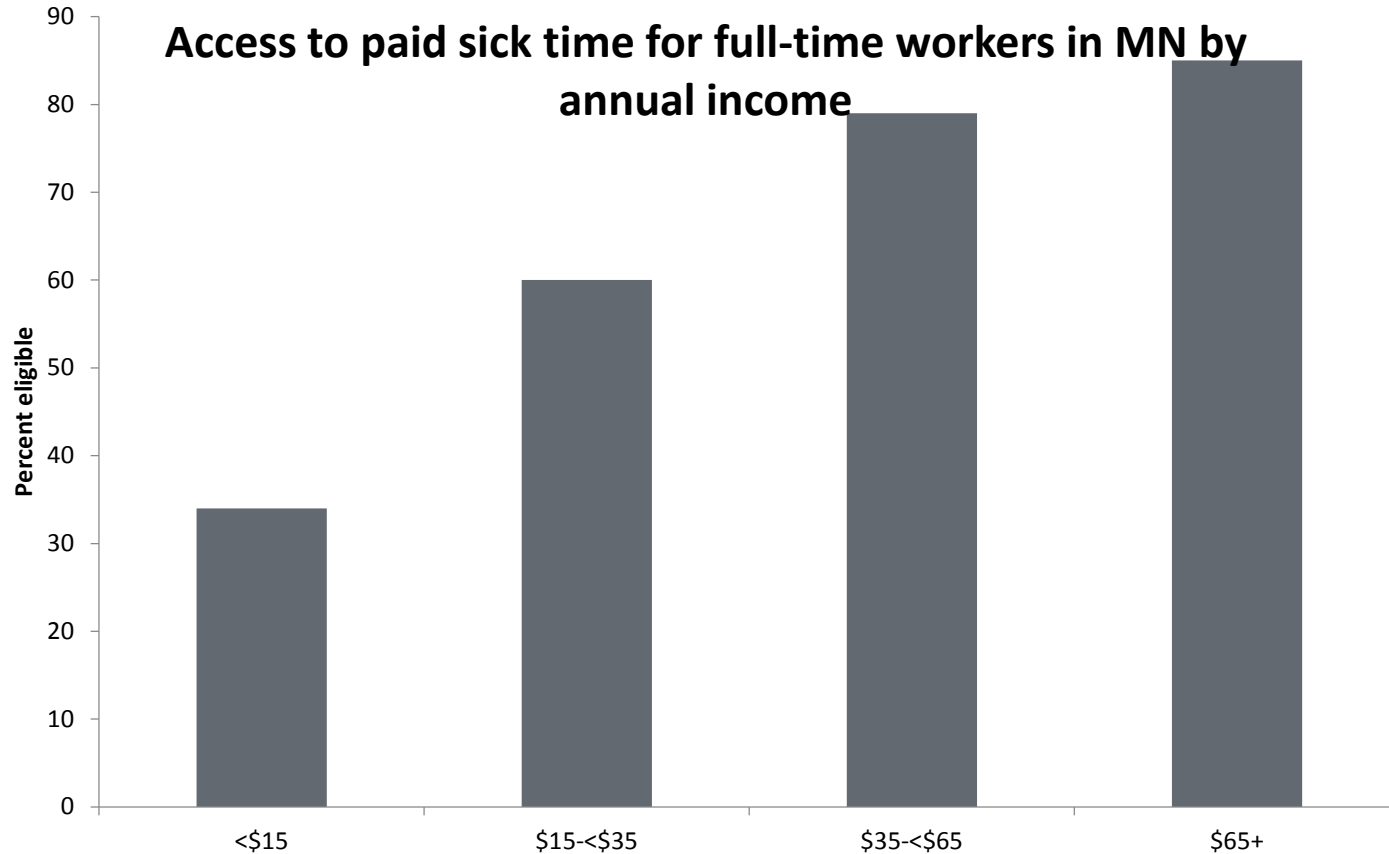
- **Income-Minimum Wage**
- **Paid Leave – Family and Sick**
- **State and Federal Transportation Policy**
- **Race Ethnicity Language data**
- **Broadband connectivity**
- **E-Health Policies**
- **Ban the Box-Sentencing reforms**
- **Bullying—School Discipline policies**
- **State and Foundation Grant-making**
- **Minnesota Food Charter**
- **State Agency-Inter-agency Policy Changes**
- **Statewide Health Improvement Program (SHIP)-complete streets, safe routes to school, smoke-free policies.....**

Paid Parental and Sick Leave

Linked to Improvements in:

- Infant mortality
- Health of infants and mothers
- Breastfeeding
- Vaccinations
- Well child check-ups
- Maternal depression
- Occupational injuries
- Routine cancer screenings
- Emergency room usage
- Days lost due to illness

Paid Leave Report: Those with lowest incomes least likely to have access to paid sick leave--MN



Health in All Policies Approach Helps Strengthen Community Capacity



Strengthen Community Capacity to achieve our overall aim

- Our efforts to broaden and shift our relationships with community organizations is rooted in our understanding of the limitations of our traditional approaches
- How do we transform the “distribution of money, power, social policies, and politics at all levels to assure the conditions for health are available to all?
- Assess our skills and intentionally build our internal capacity- race, power, assets, differences, similarities
- Tension and partnership work together

Community Partnerships - Where do we start?

- Who are you in relationship with? What interests do they represent? Do an analysis.
- Do they have a base? (*A source of authority, influence, or support? People they represent that they are accountable to?*)
- Different groups play different roles—all can bring value but not all the same depending upon the aim
- Be conscious of your power and impact

Tool Kit for Strengthening the Capacity of Communities

- Community engagement plan
- Stakeholder identification including interests
- Community governance models
- Advisory and Community Leadership Teams
- Community input on grant criteria
- Community benefit accountability
- Participatory Budgeting
- Set of questions

How we “set the table” matters

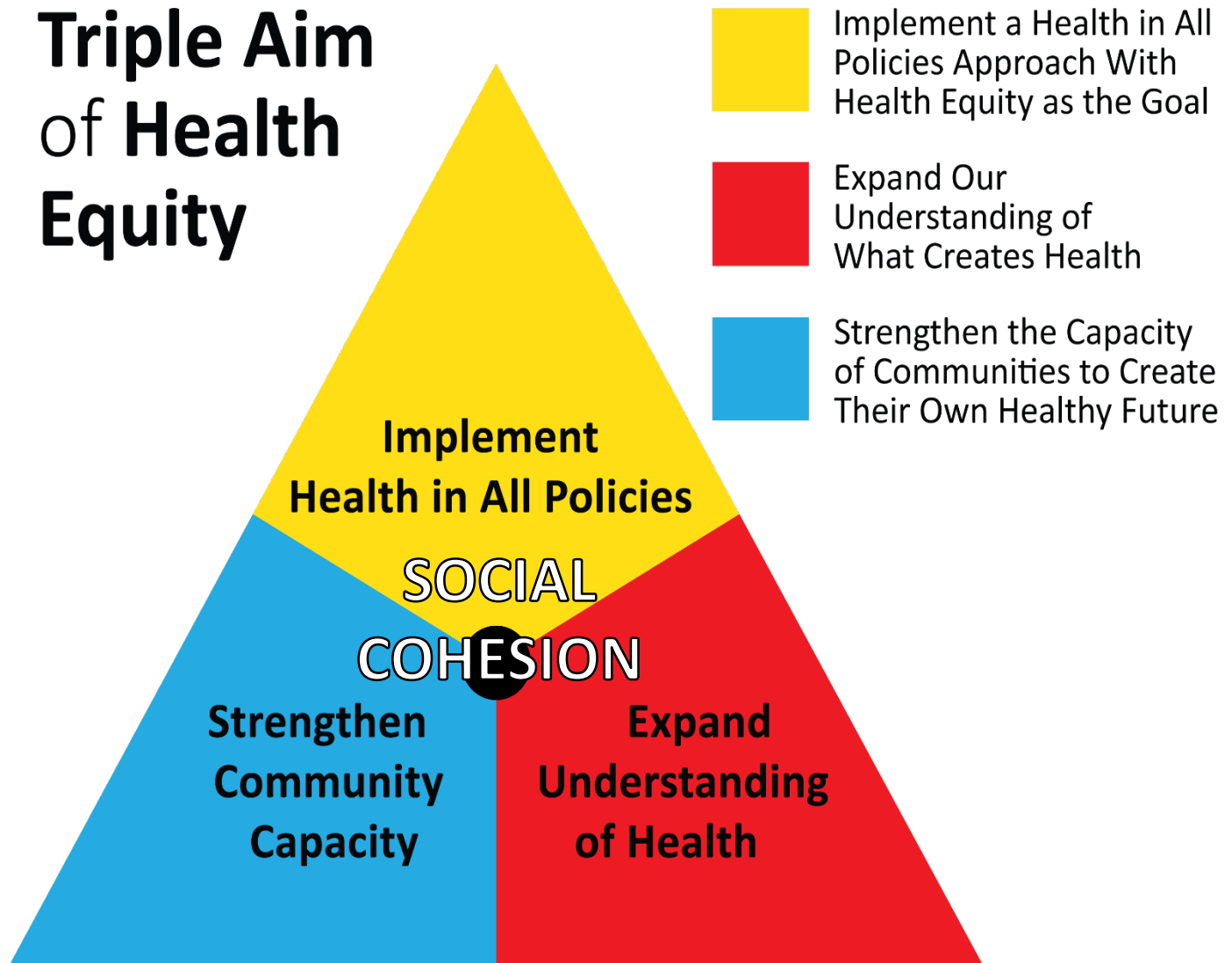
Reevaluate roles with eye to building power for change

- (Agreements on roles, Technical Expert panel, Decision-makers, 1 Consultant, Convener/Organizer, physical setting....)
- **Healthy Minnesota Partnership (Organize narrative, broaden relationships invest in alignment of partners)**
 - Minimum Wage, Income and Health Report, Paid Sick and Family Leave, Pay Day Lending, Incarceration Justice: Ban the Box
- **Advancing Health Equity in Minnesota Report (1000 people-- Built our capacity to deepen authentic engagement with communities experiencing greatest health inequities**

Asking the right questions helps strengthen community capacity to create their own healthy future

- Who is at the decision-making table, and who is not?
- Who has the power at the table?
- How should the decision-making table be set, and who should set it?
- Who is being held accountable and to whom or what are they accountable?

Triple Aim of Health Equity



Overall Lessons

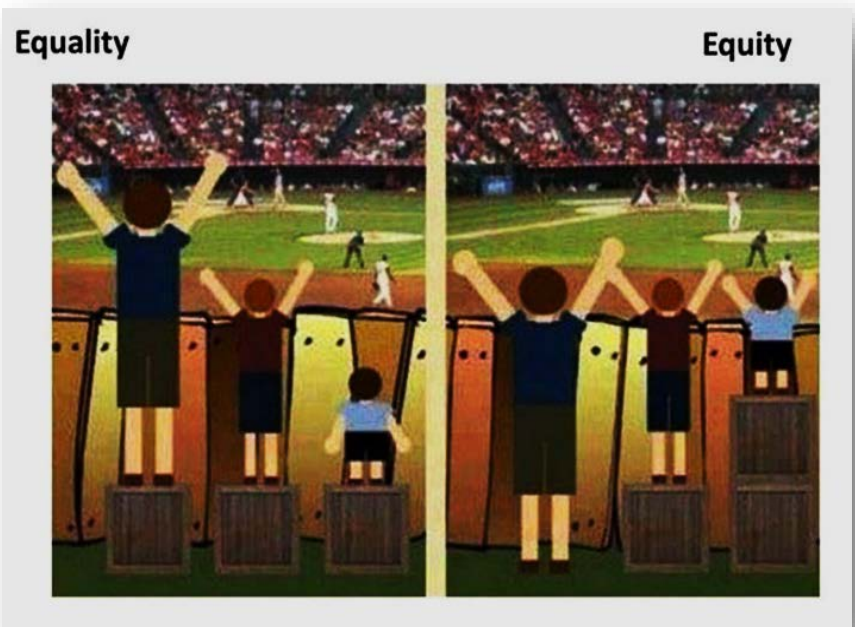
- Organic – must be interwoven with all other work-recognize it is iterative
- Must be intentional
- Commitment: Requires commitment to *building our organizational and community capacity --skills*
- Leadership – Hold our selves and each other accountable-bring more people into decision-making
- Imperfect-incomplete work--navigating toward health equity -- permission to make course corrections

“Public health is the constant redefinition of the unacceptable”

Geoffrey Vickers

Jeanne Ayers
Assistant Commissioner, MDH
P.O. Box 64975
St. Paul, MN 55164-0975

Jeanne.Ayers@state.mn.us



Links to Referenced Reports

- **The Health of Minnesota: Statewide Health Assessment:**
<http://www.health.state.mn.us/healthymnpartnership/sha/>
- **Healthy Minnesota 2020: Statewide Health Improvement Framework:**
<http://www.health.state.mn.us/healthymnpartnership/hm2020/#fw>
- **Advancing Health Equity: Report to the Legislature Report:**
<http://www.health.state.mn.us/divs/chs/healthequity/index.htm>
- **White Paper on Income and Health:**
<http://www.health.state.mn.us/divs/opa/2014incomeandhealth.pdf>

Links to Referenced Reports

- **White Paper on Paid Leave and Health** <http://www.health.state.mn.us/news/2015paidleave.pdf>
- **MDH 2015-2019 Strategic Plan and Community Engagement Plan**
 - <http://www.health.state.mn.us/about/strategicplan.pdf>
 - <http://www.health.state.mn.us/divs/opi/community/plan/>
 - http://www.health.state.mn.us/divs/opi/community/plan/docs/ce_workplan_2016_final.pdf
 - Foundational Practices for Health Equity: Learning and Action Tool
<http://www.health.state.mn.us/divs/opi/healthequity/resources/coiin-hrsa-foundational.html>