DEPARTMENT OF HEALTH

HEALTHY MINNESOTA:

STATEWIDE HEALTH IMPROVEMENT FRAMEWORK

2025-2029

Adopted at Feb. 11, 2025 Healthy Minnesota Partnership meeting

HEALTHY MINNESOTA: STATEWIDE HEALTH IMPROVEMENT FRAMEWORK (2025-2029)

Minnesota Department of Health and Healthy Minnesota Partnership
625 Robert Street North, PO Box 64975
Saint Paul, MN 55164-0975
651-201-3880
health.healthymnpartnership@state.mn.us
www.health.mn.gov

To obtain this information in a different format: Please call 651-201-3880.

CONTENTS

IMPROVEMENT FRAMEWORK OVERVIEW

The Minnesota Statewide Health Improvement Framework is an action plan to the statewide health assessment (released in April 2024). The Minnesota Department of Health (MDH) convenes the Healthy Minnesota Partnership (the Partnership) to lead the collaborative process of developing and implementing the improvement framework.

The improvement framework outlines three health priorities and objectives and strategies to address them.

Groups and individuals interested in this work are encouraged to collaborate with the Partnership to tackle these priorities collectively or use the plan to guide their own organizational efforts.

The 2025-2029 Minnesota Statewide Health Improvement Framework is a living document expected to evolve throughout the implementation years.

Follow the Partnership's work on the Partnership website or sign up for Partnership email updates.

ABOUT THE IMPROVEMENT FRAMEWORK

Background

The Minnesota Statewide Health Improvement Framework is meant to inspire and mobilize collective action across the state to address key health priorities. It was developed through a collaborative and community-driven process led by the Healthy Minnesota Partnership (the Partnership), a statewide group of cross-sectoral organizations.

This improvement framework uses data and addresses issues from the most recent statewide health assessment. This is Minnesota's third iteration of this process, which takes place approximately every five years. Previous statewide health improvement frameworks were published in 2012 and 2018.

The Partnership builds on successes and lessons learned with each iteration of the assessment and improvement framework. New approaches included in this cycle ensured the process was collaborative and community-driven, such as:

Healthy Minnesota Partnership vision:
All people in Minnesota enjoy healthy lives and healthy communities.

MDH vision:
Health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy.

- Focused recruitment efforts increased representation of communities most impacted by health inequities. Many new people and organizations were involved.
- Informational sessions offered background and context to help partners understand the improvement framework and the development process.
- A newly formed steering committee gave timely oversight and guidance.
- Community engagement activities, including community conversations and a survey, invited input and discussion among people working in and directly impacted by conditions that impact health.
- Four newly formed health priority workgroups included a mix of participants from various sectors and lived experiences.

The improvement framework is equivalent to other statewide health improvement plans, Tribal health improvement plans, and community health improvement plans. Minnesota refers to its plan as a framework to set it apart from a Minnesota Department of Health program with the same acronym (the Statewide Health Improvement Partnership). The Partnership continues to discuss how the improvement framework can align with local and Tribal improvement plans across state.

The improvement framework is not a report or list of existing work. It is a living and evolving action plan with health priorities, objectives, and strategies that the Partnership will work on together between 2025 and 2029. Some work will include the Partnership as a whole, while other work may be led by one or multiple organizations. Everyone is invited to consider where there are opportunities to lead, support, or amplify this work within individual organizations or at the collective level.

Healthy Minnesota Partnership

The Minnesota Department of Health (MDH) first convened the Healthy Minnesota Partnership (the Partnership) in 2010 to bring together partners from across the state and different sectors, including local public health, health care, community-based organizations, other state agencies, non-profits, educational institutions, and more. The Partnership is charged with directing the health assessment and developing and implementing the improvement framework. It has two co-chairs and is supported by MDH staff. Quarterly Partnership meetings create a space where members and many cross-sectoral partners can collaborate around a shared vision, priorities, and strategies. It is not a legislative or statutory body, nor is it an advisory board to the health department. The Partnership does not have a funding stream for community grants or other program development. The Partnership plays a role in advancing health equity in Minnesota by highlighting the conditions that impact health, including structural racism, engaging community voices, and creating a space where everyone can discuss, learn, and act.

For more information about the Partnership, see Appendix A.

Statewide health assessment

The statewide health assessment and improvement framework work together to advance health equity through assessment and action. The statewide health assessment was released in April 2024 and tells the story of health in Minnesota. It weaves together data from various sources to understand how community conditions across our state allow us to live healthy lives. The assessment shares how the opportunities we have to thrive, our interactions with nature, and our sense of belonging intersect and shape the health of our communities. The assessment also shows how Minnesota has persistent health inequities which are not inevitable. The assessment explicitly names structural racism, how it impacts health, and how it builds on and compounds other inequities. By acknowledging how conditions and systems contribute to health outcomes, the assessment opens up a range of possible actions for health improvement.

Partnership values:

Health: Affirms that health is more than the absence of disease, is found in balance, connection, and wellbeing across every aspect of life – physical, mental and social.

Equity: Every person in Minnesota deserves to have the opportunity to be as healthy as they can be.

Inclusion: Everyone is welcome to the table.

Difference: We are all members of many communities. Those differences make us stronger together than we would be alone.

Partnership principles:

We are explicit about race and structural racism to create fair and just conditions for the health of all people in Minnesota.

We lead by doing.

We focus on the institutional and governmental policy discussions and decisions that shape opportunities for health equity.

We innovate and practice with a focus on asset-based approaches.

We convene statewide and community partners to co-create and determine priorities and conduct impactful work.

We value and seek out input from community members to inform our work.

Health equity

Healthy equity is the idea that everyone has what they need to be healthy, and that no unjust or unfair barriers exist that prevent a person from being healthy. Many of us assume that our health is a matter of individual responsibility, and that health is primarily determined by each person's individual efforts to make healthy choices and live a healthy lifestyle. However, research shows that our social conditions—the conditions in which we are born, grow, work, live, and age — determine our health, in addition to personal preferences and lifestyle decisions. Systems help determine what resources and opportunities are available to individuals and groups within a population. We can achieve health equity only when systemic problems are resolved—when all children get a loving and healthy start, when everyone is able to get a good education and has a stable income to cover the costs of living, when we all can take part in the decisions that shape our communities, and when we all have good living conditions. For more information on how systems and structures impact health, see pages 14-20 of the Minnesota Statewide Health Assessment.

Health equity is also a guiding value and framing consideration of the improvement framework. Throughout its development, members, partners, workgroups, and community reinforced the need to focus on health equity. Many discussions included advancing health equity by engaging populations experiencing and most impacted by inequities, centering community voice, and addressing disparities.

Purpose and use

The improvement framework's purpose is to describe how MDH, its cross-sectoral partners, and the community it serves, work together to improve population health in Minnesota.

Some ways the Partnership and others can support and use the improvement framework include:

- Exploring opportunities for alignment.
- Identifying areas for collective action and coordination to address the priorities.
- Elevating and supporting Health in All Policies (HiAP) approaches.
- Reviewing organizational policies, practices, and priorities.
- Shifting narratives or mental models (dominant beliefs).
- Implementing more asset-based approaches.

In addition, this improvement framework is one of many Public Health Accreditation Board standards and measures that must be met to maintain MDH's status as an accredited state health department.

The Partnership invites its members, partners, and community members to consider other ways this plan can advance individual and collective efforts to address the priorities. Success relies on participation from many sectors, entities, and communities across the state and public health system.

IMPROVEMENT FRAMEWORK

The improvement framework includes three health priorities, which combines four topics (mental health and wellbeing, housing and homelessness, health care systems, and substance use):

To address health priorities, the Healthy Minnesota Partnership uses a system and structural level approach, instead of focusing on individual behavior changes or interventions. Objectives and strategies outlined below reflect the scope of the Partnership work, which include:

- Policy approaches e.g., Health in All Policies
- Relationship building and collaborative work across sectors
- Addressing narratives or mental models (dominant beliefs)

Each health priority includes:

Health priority description: About the prioritized issue or topic from the statewide health assessment.

Objectives: Targets for achievement. Objectives are numbered for reference, the numbers do not reflect priority.

Strategies: The activities or action steps to achieve the objectives, listed as letters. Potential tactics are also included as examples of the work from the workgroups, but are not comprehensive and do not reflect the full work plans for each strategy.

Population health indicators: Outcomes or impact data at the health priority "level" meant to communicate the importance of the health priority. Indicators will be tracked annually but are not intended to measure what the Partnership will directly influence. These indicators highlight a few disaggregated data points from the statewide health assessment to communicate the importance of addressing disparities in the state. These do not represent the only populations or communities the improvement framework will address.

See the "What's ahead" section to learn more about process measures that will be used to monitor the Partnership's progress on the objectives and strategies. See Appendix F to learn more about secondary measures or ideas for additional data related to these priority areas.

Current resources: Assets and resources that may help address priority areas or implement strategies and activities. This is not exhaustive, but an initial list of existing groups or work aimed at addressing issues related to these health priorities. Additional assets and resources will be added during implementation.

This is a living document, meaning as implementation is underway, adjustments may be made to any of these components. Objectives and strategies listed below may be refined, revised, or added during implementation to reflect progress made, additional support from partners, or changes needs. To learn more about implementation plans, see the "What's ahead" section.

Health priority: Belonging, wellbeing, and substance use prevention

Description

Social connections and belonging are important to our overall health, including our mental health. Wellbeing includes being satisfied with life, having a sense of purpose, and being able to bounce back after setbacks. Our sense of wellbeing and belonging has positive benefits and helps us manage difficult experiences in our lives. It also may prevent the misuse or abuse of substances like alcohol, commercial tobacco, opioids, and cannabis. Social connections create a sense of belonging and our sense of belonging creates healthy communities.

Belonging, wellbeing, and substance use prevention encompass two topics that many communities are concerned about: mental health and substance use. Mental health impacts everything in life and overlaps with substance misuse. When individuals experience poor mental health and wellbeing—such as feeling disconnected, overwhelmed, or lacking purpose—they may turn to substances to cope or escape their challenges. Substance misuse often further disrupts mental health and overall wellbeing, creating a harmful cycle that reinforces unhealthy behaviors. These two topics were combined into one health priority after input on their connectedness from the Partnership, community engagement, and workgroup discussions. Communities shared concerns about stigma, isolation, stress, resources, and inequities. For a summary of community engagement responses, see Appendix C. To address these and other concerns, workgroups discussed the importance of culturally responsive approaches across the lifespan, as well as those that center communities and community-identified solutions. Discussions during the steering committee and November Partnership meetings emphasized the importance of the Partnership focusing on primary prevention efforts, including asset-based measures and activities.

Objectives:

1. Promote policy and system-level approaches to improve mental health and wellbeing, including community-identified policies and approaches.
2. Promote primary prevention approaches that support mental health and prevent substance misuse.

Strategies

Objective 1: Promote policy and system-level approaches to improve mental health and wellbeing, including community-identified policies and approaches.

A. From 2025 to 2029, identify, establish, and maintain relationships with cross-sectoral groups working to improve mental health and wellbeing, including groups representing impacted communities to coordinate, support, or amplify efforts.
   - o Create an asset map of groups, partnerships, and collaboratives working in mental health and wellbeing.
   - o Identify and address gaps in the Partnership and workgroup participation.
   - o Identify how Partnership members will communicate, participate, or have representatives in these groups.

B. From 2025 to 2029, identify and promote policy recommendations and practices that support social connection.
   - o Create and distribute a policy profile on social connection, including policy recommendations.
   - o Identify and promote policies that support social connection, including community-identified policies for populations impacted by health inequities.
   - o Update and share a narrative framework on mental health and wellbeing published in 2018 by the Partnership to support cross-sectoral conversations, collective action, and advocacy efforts.
   - o Identify a role for the Partnership to play in supporting policy advocacy efforts.

C. From 2025 to 2029, identify, discuss, and promote the use and analysis of data to increases understanding of the root causes and upstream factors that impact mental health and substance misuse.

Objective 2: Promote primary prevention approaches that support mental health and prevent substance misuse.

A. From 2025 to 2029, identify and promote policy recommendations and practices that support primary prevention approaches for mental health and substance misuse
   - o Create and distribute one or more policy profiles on preventing substance misuse, including policy recommendations.
   - o Identify and promote primary prevention policies for mental health and/or substance misuse.
   - o Create a narrative framework on substance misuse to decrease stigma and support positive, asset-based approaches.

B. From 2025 to 2029, promote information and engage in primary prevention dialogue to create a shared understanding with the Partnership about what primary prevention is and cross-sectoral partners' roles in these approaches.
   - o Review current primary prevention research and recommendations.
   - o Offer opportunities to learn and discuss what primary prevention is and is not.
   - o Identify and promote culturally appropriate primary prevention approaches, including a list of community values and assets.
   - o Identify and pursue primary prevention opportunities for the Partnership.

C. From 2025 to 2029, identify, discuss, and promote the use and analysis of data for mental health and substance misuse.
   - o Discuss and identify how the Partnership can promote and use data for primary prevention efforts.
   - o Promote benefits of increasing statewide participation in the Minnesota Student Survey or other culturally responsive surveys.

Population health indicators

- In 2023, a lower percentage of Black (68%), American Indian (66%), Asian (68%), Hispanic (65%), and multiracial (73%) adults reported always or usually getting the social and emotional support they need compared to the state (79%). *(Behavioral Risk Factor Surveillance Survey)*
- In 2022, American Indian (13%), Hispanic or Latino/a (16%), or Hawaiian or Pacific Islander (12%) youth all experience high positive mental well-being (8-10 components) at a rate 10 percentage points less than the state average (28%). *(Minnesota Student Survey)*
- In 2023, there were 1,011 opioid overdose deaths among Minnesota residents. *(Minnesota Death Certificates)*
- In 2022, people identifying as American Indian or Alaska Native had a higher suicide rate (25%) than the most populous racial or ethnic groups in Minnesota. *(Minnesota Department of Health)*

Assets and resources

The following groups or plans address, track, or do other work related to mental health and/or substance use. This is not an exhaustive list of current work in the state. Other assets and resources include the many communities and community-based organizations addressing these areas directly and indirectly.

- **Minnesota Department of Health Drug Overdose Dashboard** (www.health.mn.gov/communities/opioids/opioid-dashboard)
- **Minnesota Suicide Prevention State Plan** (www.health.mn.gov/communities/suicide/mnresponse/stateplan.html)
- **Minnesota Suicide Prevention Taskforce** (www.health.mn.gov/communities/suicide/mnresponse/taskforce.html)
- **Mental Health Minnesota** (https://mentalhealthmn.org/)
- **Hazelden Betty Ford Foundation** (https://www.hazeldenbettyford.org/)
- **Mental Health Collaboration Hub – Getting to Yes!** (https://mnpsychconsulthub.com/)
- **Minnesota Association of Community Mental Health Programs** (https://www.macmhp.org/)
- **MN Department of Human Services Local Mental Health Advisory Councils** (https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/resources/lac.jsp)
- **Minnesota Youth Council** (https://mnyouth.net/myc/)

Health priority: Health and housing

Description

Stable housing provides a critical foundation for daily living and health. Four broad housing issues impact health: the availability of stable housing, the cost of housing, safety conditions inside a home, and the safety of neighborhoods. Further exploration points to a robust community of organizations and government agencies working to identify specific challenges, create solutions, and serve those impacted by housing instability and homelessness.

Public health and housing advocates have long known that good, stable, affordable housing helps people live healthier lives, while poor housing or lack of housing can make people more vulnerable to health problems. However, making that connection for others in the community has sometimes been more difficult. The COVID-19 pandemic put a spotlight on the link between housing and health. Still, policy solutions have been slower to address the long-term causes of housing instability and homelessness and their health impacts. Discussions with workgroup members and the Partnership highlighted that understanding and respecting the work of others is an important first step. However, addressing the connection between housing and health and finding systemic policy solutions to housing challenges emerged as a top priority. For a summary of community engagement responses, see Appendix C.

Objective:

1. Promote policy approaches and practices that make connections between health, housing, and homelessness.

Strategies

Objective 1: Promote policy approaches and practices that make connections between health, housing, and homelessness.

A. From 2025 to 2029, identify, establish, and maintain relationships with cross-sectoral groups working on housing and homelessness, including groups representing impacted communities.
   - o Identify groups, partnerships, and collaboratives working on housing and homelessness.
   - o Identify how Partnership members will communicate, participate, or have representatives in these groups.
   - o Identify and work to address representation gaps in the Partnership's membership and workgroups.

B. By 2027, refine or create clear messaging guidance related to the connection between health, housing, and homelessness.
   - o Review existing messaging research and approaches from public health, housing, and homelessness experts.
   - o Conduct community engagement activities with housing partners, community organizations, those with lived experience, etc.
   - o Identify messaging and language translation needs for specific communities as identified through research and community engagement.
   - o Create clear messaging guidance and identify a role for the Partnership in communicating it.

C. By 2027, identify and explore policy recommendations and practices that establish safe, adequate housing as essential for health.
   - o Review existing research/identification on policy approaches or practices and consult with appropriate Partnership members.
   - o Conduct community engagement activities with housing partners, community organizations, local public health, etc.
   - o Share recommendations or practices with cross-sector groups and partners.

D. By 2027, determine and disseminate ways for the Partnership to support efforts to promote policy recommendations and practices that make connections between health and housing/homelessness.
   - o Support and share policy approaches and practices.
   - o Create and distribute a policy profile on housing and/or homelessness, including policy recommendations.
   - o Identify a role for the Partnership to play in supporting policy advocacy efforts.

Population health indicators

- In 2023, the rates for homeownership for people identifying as American Indian (47%) and Black (33%) were lower than the state rate overall (72%). *(U.S. Census Bureau, Decennial Census and American Community Survey)*
- Between 2018-2022, a larger share of Black households (47%) are housing cost-burdened compared to households of other races and ethnicities, and the state overall (25%). *(U.S. Census Bureau, Decennial Census and American Community Survey)*
- In 2023, the American Indian population was 28 times and the African American population was 13 times as likely to be homeless as the white, non-Latino population (as measured during point-in-time count)[1]. *(Housing and Urban Development Point-in-Time Count)*
- Between 2017-2021, American Indian people experiencing homelessness (PEH) have 1.5 times higher rates of death than other PEH and 5 times higher rates of death than the general Minnesota population. *(Minnesota Department of Health)*
- About 7 of every 1,000 children had an elevated blood lead level among those that were tested by 3 years of age. *(MDH Blood Lead Information System)*

Assets and resources

The following groups or plans address, track, or do other work related to increasing access to safe, stable, affordable housing and reducing homelessness and its impacts. This is not an exhaustive list of current work in the state.

- **Minnesota Housing Finance Agency** (https://mnhousing.gov/)
- **Minnesota Interagency Council on Homelessness** (https://mich.mn.gov/)
- **Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness | Minnesota Interagency Council on Homelessness** (https://mich.mn.gov/crossroads-justice-minnesotas-new-pathways-housing-racial-and-health-justice-people-facing-0)
- **Greater Minnesota Housing Partnership** (https://mhponline.org/)
- **Greater Minnesota Housing Fund** (https://gmhf.com/)
- **HOME Line** (https://homelinemn.org/)
- **Family Homeless Prevention and Assistance Program (FHPAP)** (www.mnhousing.gov/rental-housing/grant-programs/active-funding/fhpap.html)
- **Homes for All Coalition** (https://homesforallmn.org/)
- **Center of Excellence on Public Health and Homelessness** (www.health.mn.gov/communities/homeless/coe/index.html)

1 Counts are completed in January of every year by outreach workers. The unsheltered portion of the PIT count was not conducted statewide in 2021 and the data is not comparable to other years. This count should be treated as a minimum number of people experiencing homelessness as it does not account for people "doubling up," e.g., staying with family or friends because they have lost their housing.

Health priority: Equitable access and care

Description

It is important that our health care system supports all people in Minnesota, especially given the inequities experienced by different communities across the state. The health care system is made up of many parts, such as the number and types of providers and support staff available in each community, the range of available services, if and how providers reflect populations served, and whether providers serve people in culturally appropriate ways. Health care systems are accessible when people can get the right care at the right time, in a convenient location with a caring and competent provider, and the outcome is positive. When people feel like health care providers or systems fail to understand or respect them, their culture, or their unique health issues and needs, they may be reluctant to seek care, and it is more likely that their care will not be the best.

During the improvement framework's development, community engagement identified health care systems as one of the top areas of concern. Responses called out issues related to health care affordability, access and availability of care, lack of systems coordination, lack of preventative care, how implicit bias impacts care, and lack of bilingual providers and translators. For a summary of community engagement responses, see Appendix C. While confirming health care systems as one of the health priorities for this improvement framework, the steering committee called for a focus on access and culturally competent care (see Glossary for definitions). Finally, while discussing potential objectives and strategies, workgroup members brought up needs for supporting initiatives (education or training) that aim to increase access to community health workers and interpreters, and explore barriers to care, especially in rural areas.

Objectives:

1. Promote cross-sectoral collaboration to understand and reduce barriers to accessing health care for underserved populations.
2. Increase culturally competent and trauma-informed training, care, support, services, and policies across the state.

Strategies

Objective 1: Promote cross-sectoral collaboration to understand and reduce barriers to accessing health care for underserved populations.

A. From 2025 to 2029, identify, establish and maintain relationships with cross-sectoral groups working around health care access for underserved populations experiencing health inequities.
   - o Identify and work to address representation gaps in the workgroup participation.
   - o Identify and reach out to collaboratives across health care providers, health care plans, community organizations, and local public health working on health care access.
   - o Identify how Partnership members will communicate, participate, or have representatives in these groups.

B. By 2027, identify and explore root causes or barriers to accessing medical services for underserved populations experiencing health inequities.
   - o Conduct or identify assessment, environmental scan, or review existing research on barriers (may include transportation system, closures, provider shortages, reimbursement or insurance barriers, etc.).
   - o Conduct community engagement activities with patient populations, providers, support staff, trainers, transportation partners or health care organizations providing care for communities most impacted by health inequities.

C. By 2027, determine and disseminate ways for the Partnership to support efforts to address barriers to accessing health care for underserved populations.
   - o Develop a policy profile or narrative on policies access to health care.
   - o Support dissemination of best practices that decrease barriers to accessing health care with cross-sector partners.

Objective 2: Increase culturally competent and trauma-informed training, care, supports, services, and policies across the state.

A. From 2025 to 2029, identify, establish and maintain relationships with cross-sectoral groups working around increasing culturally competent and trauma-informed care.
   - o Identify and work to address representation gaps in the workgroup participation.
   - o Identify how Partnership members will communicate, participate, or have representatives in these groups

B. By 2027, identify barriers to providing culturally competent care and trauma-informed care, including barriers to having a diverse health care provider workforce.
   - o Conduct or identify an assessment, environmental scan, or review existing research on barriers (may include assessing existing and availability of trainings for providers, funding, policies at health care organizations, number/availability of community health workers, number/availability of interpreters and, root causes preventing a diverse workforce, or other resources, etc.)
   - o Conduct community engagement activities with patient populations, providers, support staff (community health workers or interpreters), trainers, or other partners doing work in culturally competent or trauma-informed care.
   - o Share barriers with cross-sectoral partners.

C. By 2027, determine and disseminate ways for the Partnership to support efforts to increase culturally competent and trauma-informed care.
   - o Develop a policy profile or narrative on policies supporting culturally competent and trauma-informed care.
   - o Share organizational policy recommendations and practices around culturally competent and trauma-informed care trainings.
   - o Support dissemination of best practices around culturally competent and trauma-informed care with cross-sector partners.

Population health indicators

- In 2023, higher percentages of people identifying as American Indian (41%), Black (31%), and Hispanic (34%) reported forgoing care due to cost compared to the state overall (25%). *(Minnesota Health Access Survey)*
- In 2023, 47% of Black and 69% of trans/non-binary Minnesotans reported unfair treatment by a health care provider. *(Minnesota Health Access Survey)*
- In 2025, 86% of health care providers completing the Healthcare Workforce survey identified as white. *(Minnesota Health Care Workforce Data)*
- Between 2020 and 2022, rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients (84 minutes compared to 25 minutes). *(Minnesota Department of Health)*

Assets and resources

The following groups or plans address, track, or do work to increase access to care or increase culturally competent or trauma-informed care. This is not an exhaustive list of current work in the state.

- **Center for Community Health** (https://www.mnmetrocch.org/)
- **Ensuring Health Across Rural Minnesota in 2030 (National Rural Health Resource Center)** (https://www.ruralcenter.org/resources/ensuring-health-across-rural-minnesota-2030)
- **Equitable Health Care Task Force - MN Dept. of Health**[2] (www.health.mn.gov/communities/equitablehc/index.html)
- **Great Plains Telehealth Resource and Assistance Center** (https://www.gptrac.org/)
- **Greater MN Transit Plan** (https://talk.dot.state.mn.us/greater-minnesota-transit-plan)
- **Minnesota Community Health Worker Alliance** (https://mnchwalliance.org/)
- **Minnesota Association of Community Health Centers** (https://www.mnachc.org/)
- **Minnesota Hospital Association** (https://mnhospitals.org/)
- **Minnesota Rural Health Association** (https://www.mnruralhealth.org/)
- **Minnesota Rural Health Cooperative** (https://mrhc.net/)
- **Rural Health Advisory Committee - MN Dept. of Health** (www.health.mn.gov/facilities/ruralhealth/rhac/index.html)
- **WellShare International** (https://wellshareinternational.org/)

2 The Equitable Health Care Task Force is charged with identifying strategies to ensure that people living in Minnesota receive care and coverage that is respectful and promotes optimal health outcomes. The task force is expected to conclude its work and deliver recommendations to the Commissioner of Health in 2025.

WHAT'S AHEAD

As described earlier, the improvement framework is an action plan for the Healthy Minnesota Partnership (the Partnership) and other partners across the state to implement between 2025 and 2029. It describes how the Minnesota Department of Health (MDH), its cross-sectoral partners, and the community it serves, can work together to improve population health in Minnesota. Implementation of the initial objectives and strategies outlined in this document will be led by the Partnership. As a dynamic and living plan that includes building relationships and collaborating with cross-sectoral partners, the Partnership encourages other organizations and groups to participate in supporting these efforts.

Implementation

Partnership co-chairs, the steering committee and Partnership staff will work together to oversee and direct overall implementation efforts, which will include:

- Quarterly Partnership meetings for updates, coordination and relationship building, and collective action around strategies.
- Health priority workgroups to support work on specific strategies.
- Work plans to outline activities, timelines, and define roles and responsible parties.
- Annual reports to provide updates on implementation efforts and changes.

Throughout implementation, member organizations and partners will support implementation efforts by participating in Partnership meetings, joining workgroups, and supporting other engagement activities. Members and partners are also encouraged to incorporate objectives or strategies within their own organizations or within their own community, when possible.

Tracking progress

For each objective and strategy, process measures will be developed to help track the actions taken on specific objectives and/or strategies for each health priority. Process measures will be written to align with SMARTIE objectives to ensure they are strategic, measurable, ambitious, realistic, time-bound, inclusive, and equitable. Tracking progress may also include the collection of storytelling, testimonials, or other qualitative data to support quantitative progress measures. Process measures will be tracked with annual work plans and shared in annual reports.

In addition to monitoring progress, the Partnership and workgroups will continue to work on identifying system and structural level data, and data that reflects aspirations and measures of wellbeing (versus deficits). Additional assets and resources to support health priorities will be added and reported as they are identified.

Next steps for year one

The Partnership will launch implementation efforts by working simultaneously on the following activities in 2025.

Establish and support ongoing workgroups

- Identify current and new members for health priority workgroups, including people with lived experiences, people of color, American Indians, and other key communities.
- Identify staff and partners to co-chair and support workgroups.
- Reconvene and establish processes to support workgroups to carry the work forward.

Determine and implement action

- Develop work plans that outline the actions, timelines, and partners needed to implement strategies.
- Engage people across the lifespan, people with lived experiences, and community partners representing communities most impacted by inequities.
- Continue ongoing health equity discussions and practices.
- Continue building Partnership's capacity to implement objectives and strategies.

Create a system to track progress

- Develop process measures, including measurable SMARTIE objectives and ways to collect stories, testimonials or other qualitative data.
- Track implementation progress by engaging the steering committee, Partnership, and health priority workgroups.
- Annually report progress and any changes or updates made to the improvement framework.

Looking forward

The Minnesota Statewide Health Improvement Framework is an optimistic plan. The Partnership is excited to release this plan and move into action. Implementation will require time, effort, brave conversations, and support from many across different sectors, but it is doable. It will shift thinking and push limits, but the Partnership believes that the growth and impact is worth the effort. The hope is that the improvement framework will add and complement collaborative efforts by other agencies, groups, and networks across that state. By working together and with the community, the Partnership can improve the health and wellbeing of all people living in Minnesota.

METHODS

This improvement framework was developed between May 2024 and February 2025. Health priorities, objectives, and strategies were identified in phases that built on each other. For each phase, input was collected, the steering committee discussed and used input to develop proposals, and proposals were then presented for feedback and adopted during the Partnership meetings.

The Partnership used the following **framing considerations** or goals to guide the improvement framework's development process and content:

- Be focused on systems – identify and implement system or structural-level actions.
- Be orientated to action – ensure activities are actionable for the Partnership.
- Highlight assets and strengths – include assets and strengths that support our health and wellbeing.
- Reflect and be shaped by community concerns – engage community members for input and feedback.
- Align with statewide, community, and hospital health improvement plans – ensure local concerns are reflected within statewide work.

A collaborative process

The improvement framework was developed using a collaborative and community-driven process led by the Partnership. It included a steering committee, community engagement activities, and health priority workgroups.

The improvement framework steering committee

The steering committee provided guidance and oversight throughout the development of the improvement framework. It was launched in February 2024. Members representing several sectors and agencies met monthly to provide leadership and guidance for the improvement framework. Members reviewed the improvement framework's development phases to ensure alignment with the Partnership's vision, values, and principles and to keep a health equity and statewide perspective in all recommendations and decisions.

The steering committee accomplished many tasks, beginning with creating prioritization criteria to help identify health priorities, using input from Partnership members. They reviewed and discussed input from community engagement activities and health priority workgroups to develop proposals for the Partnership to review and adopt.

For more information about the prioritization process and how prioritization criterion was defined and operationalized, see Appendix B.

Partner engagement

Partnership meetings were used to include and engage partners on each phases of developing the improvement framework. In 2024, the Partnership held five meetings with member organizations and many other active partners. Partnership meetings are open to the public and are participatory, allowing members and partners to discuss topics and provide input. Attendees input shaped the prioritization criteria, guiding principles, health priorities, objectives, and more.

Community engagement

Community engagement activities collected input from community members and partners across the state. This was done between June and August 2024 through multiple presentations, a survey, and community conversations. This input was used to identify top topics of concern from the health assessment and to understand perspectives and potential suggestions for action.

- Presentations included opportunities to ask questions and collect feedback from multiple organizations, networks, and coalitions.
- Over 85 people attended six virtual community conversations in July. Over 50 people representing American Indian communities in the Metro area attended two in-person community conversations in August.
- 717 people completed a survey about potential health priorities (survey available in English and Spanish).
- Over 20 youth attended a hybrid community conversation in November.

The steering committee reviewed and used community input to recommended moving forward with four topics: mental health and wellbeing, housing and homelessness, health care systems, and substance use. This proposal was presented and adopted during the September 10, 2024, Partnership meeting. Community input was also shared and used with workgroups in the fall.

More information on the community engagement activities can be found in Appendix C.

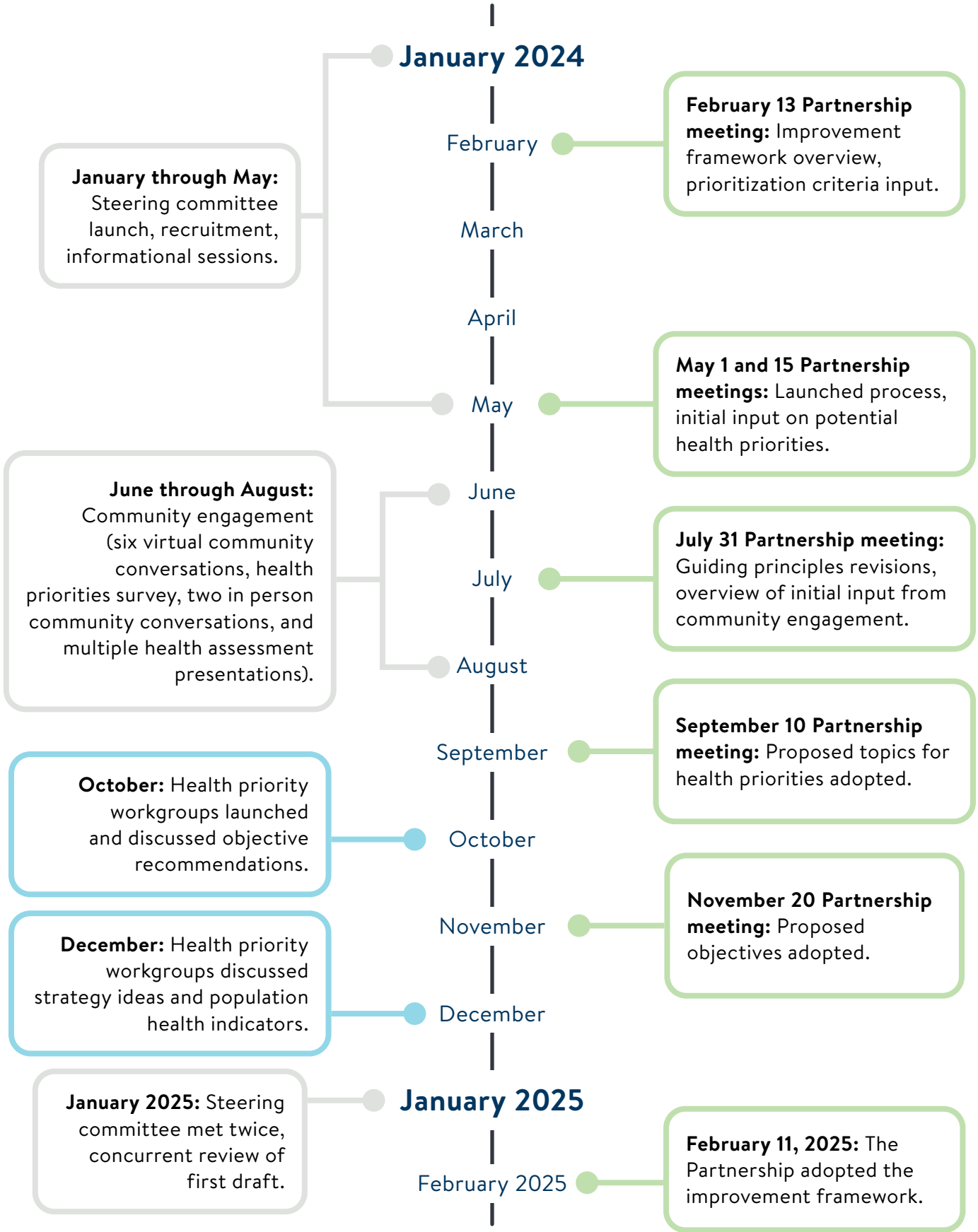
Health priority workgroups

After the Partnership approved the four topics, health priority workgroups were created for each. Over 65 people across various affiliations and lived experiences joined the workgroups. Workgroups were tasked with recommending ideas for objectives and strategies to address the health priority to the steering committee. Workgroups also provided input on potential health indicators and participated in reviewing and providing feedback on the first draft of the improvement framework. More information on the workgroups can be found in Appendix D.

In response to input, the four topics were combined and renamed into three health priorities. Mental health and well-being and substance use prevention were combined into one health priority after identifying an overlapping objective and in response to continued discussions about the interconnection and overlap between them. All health priorities were renamed to be more action or goal oriented.

For more information about the combined and renamed health priorities, see Appendix E.

2024 - 2025 timeline



ACKNOWLEDGMENTS

Development of this statewide health improvement framework was made possible by the ongoing participation and commitment from the Healthy Minnesota Partnership co-chairs, steering committee and the health priority workgroup members.

Partnership Co-chairs

Sarah Grosshuesch of Wright County, representing the Minnesota Local Public Health Association
(Past Chair) Former Assistant Commissioner Sarabia, Minnesota Department of Health
(Interim Chair) Chelsie Huntley, Minnesota Department of Health

Steering committee members

Steering committee members represented the following organizations:

- Malissa Adams (Minnesota Department of Human Services)
- Sarah Grosshuesch (Local Public Health Association, Wright County)
- Chelsie Huntley (Minnesota Department of Health)
- Amber Lightfeather (Essentia Institute of Rural Health)
- Tracy Morton (National Rural Health Resource Center)
- Victor Obisakin (Restore All)
- Amy Reineke (Local Public Health Association, Horizon Public Health)
- Nissa Tupper (Minnesota Department of Transportation)
- Past member: Chelsea Georgesen (Minnesota Council of Health Plans)

Health priority workgroup members

Mental health and wellbeing

- Stephanie Aasness (Northwest Regional Development Commission)
- Carly Argir (Ucare)
- Keith Bennett (Wright County Local Public Health)
- Jordan Burt-McGregor (MDH, Office of African American Health)
- Gladys Chuy (MN Association of Community Mental Health Programs)
- Jonda Crum (Community member)
- Crysil Dougherty (Ucare)
- Chelsie Falk (Sanford Health)
- Kelly Felton (MDH, Suicide Prevention)
- Grace Li (JADE)
- Anna Lynn (MDH - Child & Family Health)
- Sonja Mertz (MN Alliance on Problem Gambling)
- Melissa Mikkonen (Blue Cross Blue Shield)
- Jacinta Moss (Community member)
- Jessica Schmit (Windom Area Health)
- Richard Scott (Carver County Health & Human Services)
- Laura Stumvoll (St Cloud Veteran's Administration)
- Patty Takawir (MDH - Aging and Health Communities)

Housing and homelessness

- Shelly Barnes (Community member)
- Sophi Gilliland (Community member)
- Halie Gudmonson (Ucare)
- Natalie Halverson (Scott County Local Public Health)
- Blair Harrison (United Health Care)
- Andrea Hickle (Community member)
- Marlena Jasch (Public Health Homelessness consultant for MDH)
- Derek King (Minnesota Pollution Control Agency)
- Justin LaBeaux (UCare)
- Josh Leopold (MDH – IDEPC)
- Jim McKinstra (MN Board on Aging)
- Courtney Newgard (United Community Action Partnership)
- Cynthia Swanlaw (Public Health Homelessness consultant for MDH)
- Spoorthy Uddurhally (Community Health Board for Cook-Lake-Carlton & St. Louis County)
- Sue Watlov Phillips (Metropolitan Interfaith Council on Affordable Housing)
- Amanda Welliver (Minnesota Housing)
- Sandy Johnson (MDH, Office of African American Health)
- Amber Holmstrom (West Central Minnesota Communities Action)
- Aaron Johnson (PH Consultant for MDH)
- Nila Gouldin (MDH, Office of African American Health)

Substance use

- Adina Black (MN Alliance on Problem Gambling)
- Megan Coleman (Wright County Local Public Health)
- Crysil Dougherty (Ucare)
- Jessi Evjen (Council on Asian Pacific Minnesotans)
- Nila Gouldin (MDH, Office of African American Health)
- Emily Hill (Scott County Local Public Health)
- Alycia Lopez (Ucare)
- Lil Pinero (MDH, Health Promotion and Chronic Disease)
- Daniel Schaeppi (Minnesota Adult & Teen Challenge)
- Erin Schwab (Brown County Local Public Health)
- Cynthia Swanlaw (Public Health Homelessness consultant)

Health care systems

- Nicky Anderson (MDH - Health Promotion and Chronic Disease, Health Systems Unit)
- Gladys Chuy (MN Association of Community Mental Health Programs)
- Alexandra De Kesel Lofthus (Community member)
- Endurance Ehimen Eichie (MDH - Office of African American Health)
- Claire Fleming (American Heart Association)
- Annie Halland (UCare)
- Amber Lightfeather (Essentia Institute of Rural Health)
- Marie Malinowski (Blue Cross Blue Shield)
- Suzanna Newell (Team Humanity)
- Glenna Noska (Scott County LPH)
- Hannah Olson (Scott County LPH)
- Tina Peters (MDH - Health Care Homes)
- Amy Reineke (Horizon Public Health)
- Carrie Ruch (Ucare)
- Valarie Stofferahn (MDH - Office of Rural Health and Primary Care)
- Lily Rubenstein (MDH - Refugee Health Unit)
- Abbie Zahler (Hennepin County Public Health)
- Christy Dechaine (MN Hospital Association & Allina)
- Matt Flory (Minnesota Public Health Association PHA and American Cancer Society)
- DeDee Varner (Health Partners)

MDH staff to the Partnership

- Murphy Anderson
- Tara Carmean
- Audrey Hanson
- Deanna White
- Jeannette Raymond (retired, fall 2024)

GLOSSARY OF TERMS

Asset-based approach: An asset-based approach identifies and supports a community's own local resources that promote health, which could include cultural, social, and physical assets and capital. Action can be taken when knowing and understanding strengths and assets.

Community identified policies and approaches: These are identified and promoted by community, building upon and appreciating the strengths, desires, and capacities of community members and groups.

Health: Health is a dynamic state of complete physical, mental, spiritual and social-wellbeing and not merely the absence of disease or infirmity. Health, more than being simply the absence of disease, is found in balance, connection, and wellbeing across every aspect of life—physical, mental and social—and across families, communities, cultures and systems.

Health equity: Health equity is the idea that everyone has what they need to be healthy, and that no unjust or unfair barriers exist that prevent a person from being healthy.

Health in All Policies: Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

Health priority: A prioritized issue or topic from the statewide health assessment that is identified through a collaborative process.

Mental health and wellbeing: Mental health and wellbeing is about feeling good and functioning well in life. It includes taking care of emotional, psychological, and social health, as well as physical health. It means having the ability to cope with life's challenges, build strong relationships, and feel a sense of purpose and connection. When both the mind and body are healthy, individuals are better equipped to handle stress, work productively, and enjoy life.

Objectives: Targets for achievement. Objectives are time limited and measurable in all cases. There are different types of objectives that may include outcome, impact, or process.

Policy profiles: Overview of a policy area that includes how the issue impacts health, how different communities or populations are impacted, which systems and policies are at play at different levels and lists current policies or initiative happening in Minnesota. The Minnesota Statewide Health Assessment, included three policy profiles on paid leave, tree canopy coverage, and universal broadband internet access. Profiles may be used during implementation to share information, raise awareness, spark discussions, or identify collective action.

Strategies: The activities or action steps to achieve the objectives. Steps to reach the intended outcome of the priorities.

Culturally competent care: The ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patients' social, cultural and linguistic needs. A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care.

Trauma-informed care: An approach to care that acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — to provide effective health care services with a healing orientation.

APPENDIXES

Appendix A. Healthy Minnesota Partnership

The Healthy Minnesota Partnership (the Partnership) brings together organizations, community partners, and the Minnesota Department of Health (MDH) to improve the health and quality of life for individuals, families, and communities in Minnesota. Convened in 2010 by the Commissioner of Health, the Partnership was charged with developing the statewide health assessment and improvement framework.

Member organizations come from rural, suburban, and urban communities and represent four areas: public health and health care, cross-sectoral partnerships, communities impacted by health inequities, and advocacy organizations. Membership is based on organization. Each member organization designates individuals to attend and participate as a representative or an alternate.

As of December 2024, members of the Healthy Minnesota Partnership include:

- **American Heart Association:** Claire Fleming (Heather Peterson, alternate)
- **Blue Cross and Blue Shield of Minnesota:** Sasha Houston Brown (Carla Kohler, alternate)
- **Council on Asian Pacific Minnesotans**: Andrew Morris
- **Local Public Health Association (Metro area):** Diane Holmgren
- **Local Public Health Association (Greater MN):** Sarah Grosshuesch, (Amy Reineke, alternate)
- **Minnesota Board on Aging:** Jim McKinstra (Maureen Kenney, alternate)
- **Minnesota Council of Health Plans:** Chelsey Olson
- **Minnesota Council on Latino Affairs:** Rosa Tock (Ivette Izea-Martinez, alternate)
- **Minnesota Dept. of Corrections:** Kelley Heifort (Earl Miller, alternate)
- **Minnesota Dept. of Health:** Assistant Commissioner Maria Sarabia
- **Minnesota Dept. of Human Services:** Bonnie Abdurahman (Malissa Adams, alternate)
- **Minnesota Dept. of Transportation:** Nissa Tupper (Amber Dallman, alternate)
- **Minnesota Hospital Association:** Christy Dechaine
- **Minnesota Housing:** Alyssa Wetzel-Moore (Katherine Teiken, alternate)
- **Minnesota Public Health Association:** Matt Flory
- **National Rural Health Resource Center:** Tracy Morton
- **State Community Health Services Advisory Committee (SCHSAC):** Mai Chong Xiong (Jenna Carter, alternate)
- **University of Minnesota Boynton Health Services:** Colleen McDonald Diouf (Michelle Trumpy, alternate)
- **University of Minnesota School of Public Health:** Melinda Pettigrew (Rachel Windome, alternate)
- **Health plan representatives:** DeDee Varner (Annie Halland, alternate)

Joined in 2024

- **Essentia Institute of Rural Health:** Amber Lightfeather
- **JADE (Joint Action for Diversity and Engagement):** Grace Li (Hanbin Zhou, alternate)
- **Minnesota Pollution Control Agency:** Derek King (Michael Thiel, alternate)
- **YWCA of St. Paul:** Beatrice Laiser (Dalton Outlaw, alternate)

Partners

The Healthy Minnesota Partnership is also supported by many partners (non-members). Partners include anyone interested in the Partnership who attends and participates in meetings, subcommittees, and workgroups. In 2024, recruitment efforts were used to expand representation and fill gaps in the Partnership, including organizations working with people with disabilities, LGBTQ+ communities, and more racially and ethnically diverse communities. Recruitment efforts included individual outreach from staff and co-chairs, notices through multiple email listservs, social media postings, orientation and information sessions, and multiple presentations. As a result, 42 people attended orientations, four new organizations were added to the member roster, and all 2024 Partnership meetings saw a notable increase in the number of people attending for the first time.

Special thanks to all the long-standing and new partners who have attended meetings and participated in supporting the development of the improvement framework.

Collaborative planning process

National public health accreditation board standards require a collaborative planning and implementation process. The Partnership leads this collaborative planning process and includes involvement from MDH, cross sectoral partners, and communities. The Partnership, steering committee, and health priority workgroups fill different roles that worked together to develop the improvement framework:

- The Healthy Minnesota Partnership: Provided input during each development phase. Reviewed, discussed, and approved proposals for health priorities, objectives, and the final improvement framework.
- Partnership co-chairs: Provided overall guidance and ensured the improvement framework aligns with public health accreditation requirements, framing considerations and the Partnership scope and capacity. Assisted with meeting planning and co-facilitated Partnership meetings.
- Steering committee: Directed and oversaw the development of the improvement framework. Developed prioritization criteria for health priorities. Reviewed and used input from the Partnership, community engagement activities, and health priority workgroups to develop proposals for the Partnership's review.
- Health priority workgroups: Generated ideas and discussed options for addressing each health priority. Proposed objectives and identified strategy ideas for the steering committee and co-chairs review. Provided input on population health indicators. (See Appendix D for more information about workgroups)

Health priorities, objectives, and strategies for the improvement framework were identified in phases. Each phase followed the following steps:

1. Gathered input from partners and community.
   a. Health priorities: Input collected from May 2024 Partnership meetings and community engagement activities.
   b. Objectives and strategies: Developed by four health priority workgroups, including input from Partnership meeting attendees and community engagement activities.
2. Steering committee reviewed input to develop a proposal for the Partnership's review.
3. The Partnership reviewed and discussed the proposal, adopting the proposal using a five-point scale from fully approve to fully disapprove.

Appendix B. Prioritization criteria

Background and context

Prioritization criteria was used to narrow the many topics in the statewide health assessment to a shorter list of topics to consider as potential health priorities for the statewide health improvement framework. The "short list" was used during the May 2024 Partnership meetings and with community engagement activities. Input from partner and community input was used to identify the health priorities.

Figure 1: Prioritizing topics from the health assessment

Statewide Health Assessment	Prioritization Criteria	Engagement Activities	Steering Committee	Partnership meeting
Includes over 50 topics and subtopics that impact health	Identified 22 topics that met all six or at least five criterion	Identified top topics from Community Conversations and a survey	Considered a variation of the four topics	Four topics confirmed by the Partnership

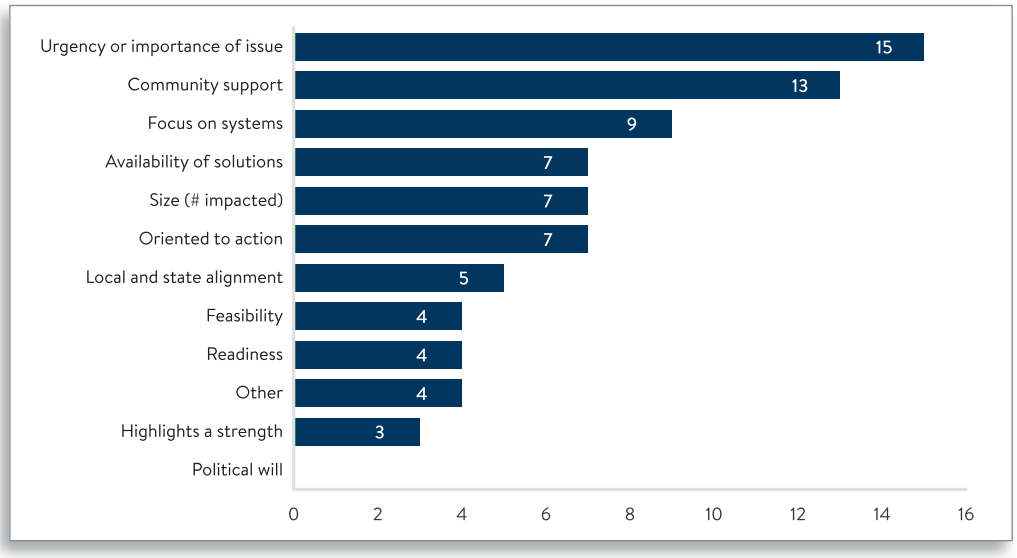
The Partnership and steering committee helped identify, define, and pilot the prioritization criteria. This appendix describes how prioritization criteria was developed, piloted, and used.

Identifying the criteria

Partnership staff researched and compiled a list of potential criteria from other state and national resources for consideration, including impact on health equity, community support, size of issue, urgency or importance of issue, availability of resources, feasibility, political will, and readiness. They also reviewed the statewide health improvement framework framing considerations. Since equity is a Partnership value and multiple resources recommended it, health equity was a criterion.

At the February 2024 Partnership meeting, attendees took a poll on what was most important to them to help identify other prioritization criteria.

Figure 2: Poll results from 2/13/2024 meeting | Which three options do you think should be used for prioritization criteria? n=26 responses



March 2024 steering committee meeting

In March 2024, the steering committee reviewed research, input from the February 2024 meeting, and criteria options and definitions. The goal of this meeting was to agree on the prioritization criteria so staff could pilot the application of the criteria to the topics in the statewide health assessment. Minnesota Department of Health (MDH) staff noted that the criteria would not be final and could be refined or adjusted.

The steering committee approved piloting the following criteria: Importance of issue, community support, local, tribal and state alignment, focus on systems, and readiness.

Pilot of prioritization criteria

Methods

Partnership staff applied the six criteria to all 58 health assessment topics (sections and sub-sections). The 'People' section was not included since it provided context about populations discussed across the health assessment.

Criteria were applied by using information from the health assessment, recognizing that additional information could be looked at during developing the improvement framework.

Findings

Six criteria were applied to 58 topics in the health assessment, including sections and sub-sections.

Figure 3: Proportion of health assessment topics meeting prioritization criteria

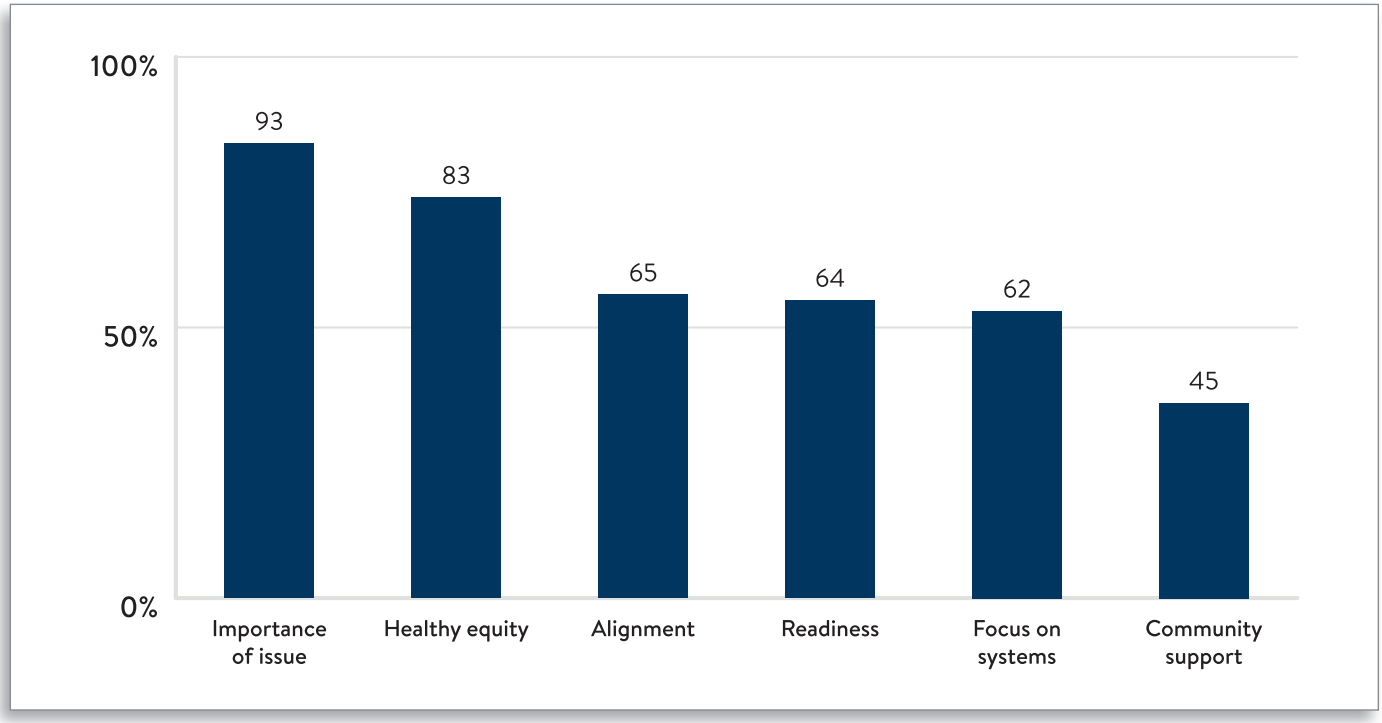


Figure 4: Health assessment topics meeting prioritization criteria

Topics that met six criteria (15)	Topics that met five criteria (14)	Topics that met four criteria (7)	Topics that met three criteria (11)	Topics that met two criteria (6)	Topics that met one criterion (5)
• Housing conditions and safety • Health care system • Access to HC services • Food • Mental health and wellbeing • Prenatal and early life experience • Racism during pregnancy, childbirth, and infancy • Substance use • Cannabis • Commercial tobacco and nicotine • Opioids • Living with chronic conditions • Isolation • Care for older adults • Disconnection	• COVID-19 • Income • Housing • Homelessness • Homeownership • Affordable housing • Transportation • Transit and active transportation • Transportation safety and use • Environmental justice • Climate • Belonging in school • Alcohol • Alcohol and drug overdose deaths	• Education • Employment benefits: health insurance • Quality of health care • Access to specific types of health care • Air • Recreation • Cultural isolation	• Employment • Industries, earnings, and vacancies • Paid family and medical leave (PP) • Tree canopy cover (PP) • Sexual health • Sexually transmitted diseases • HIV/AIDS • Physical and sexual violence • Suicide • Homicide • Leading causes of death	• Unemployment • Employment benefits: parental paid leave • Nitrogen • Civic participation • Gun violence • Universal broadband internet access (PP)	• Teleworking • Water • Lead in water • PFAS • Arsenic

April 2024 steering committee meeting

The steering committee reviewed and discussed the results of piloting the prioritization criteria during the April 2024 meeting.

- 15 of the 58 topics met all six criteria
- 14 topics met five criteria

Staff presented recommendations and the Partnership reviewed, discussed, and approved the final criteria (Figure 5).

Figure 5: Final criteria definitions from pilot

Criteria	Questions
Health equity	• Did the SHA identify structural racism as impacting the disparity? • Did the issue disproportionately affect marginalized communities and contribute to health inequities?
Community concern	• Phase 1 (piloted): Did one or more communities identify that the issue needs attention during the development of the SHA? (Input from SHA community engagement activities: state strengths survey, public comment, HMP meetings, etc.) • Phase 2 (HOLD to assess throughout SHIF development): Did one or more community identify that the issue during the development of the SHIF?
Local, State and Tribal Alignment	• Was the issue identified by other local community health improvement plans (CHIP)s or Tribal health improvement plans? • Does the issue align with priorities in other statewide or Tribal action plans? • Does the issue align with the MDH strategic goals or "one Minnesota" principles?
Focus on systems	• Did the SHA identify a systemic or structural cause or connection with the issue? • Does the issue require policy or upstream system level strategies?
Readiness	• Phase 1: Are any HMP members currently working on this? • Phase 2: to assess throughout SHIF development: Is there already work and movement on this issue that the HMP can amplify in a meaningful way? • Phase 2: Are other partners or groups working on the issue that the HMP can engage or collaborate with?
Importance of issue	• Phase 1: Re-defined 'importance of issue' as topics meeting all or high number of these other criteria • Phase 2: to assess through SHIF development (community engagement and workgroups): • Does the issue impact long-term outcomes? • Is there a new or emergent sense of urgency to address the issue? (Is it new or becoming more pressing?) • Does the issue affect health across the life span? • Is there linkage to other health issues?

MDH Executive Office feedback

Before the May 2024 Partnership meetings, MDH Executive Office leadership reviewed results of the piloted criteria and requested that water, gun violence, and suicide be added to the topics for consideration.

May 2024 Healthy Minnesota Partnership Meetings

Partnership staff presented the prioritization criteria developed by the steering committee during the May meetings and walked attendees through the results of piloting the prioritization criteria and the resulting "short list."

Appendix C. Community engagement

The statewide health improvement framework was developed with community input from people and communities representing multiple populations across the state. Input was collected through multiple engagement activities, including the May 2024 Partnership meetings, community conversations, and a health priority survey. These engagement activities are described later in this appendix and include a summary of the methods, findings, and demographics.

Partnership staff worked with the steering committee and MDH Health Equity Bureau staff to plan and develop community engagement activities. The input was compiled and shared with the steering committee, the Partnership, and health priority workgroup members during different phases of development. The input was used to inform decisions for the health priorities, objectives, and strategies. Community engagement directly led to the four topics of the improvement framework:

- Mental health and wellbeing
- Housing and homelessness
- Health care systems
- Substance use

May 2024 Healthy Minnesota Partnership meetings

The Partnership held two meetings in May 2024, an in-person meeting on May 1 and a virtual meeting on May 15. Many new people attended because of outreach and recruitment efforts. Of the people who registered, 60% of in-person attendees and 56% of virtual attendees reported not attending a previous Partnership meeting.

Attendees at the May 2024 Partnership meetings gave input on potential health priorities. During the May meetings, attendees participated in a polling activity to indicate which topics they would like to discuss more that day (results below).

May 1 meeting (in-person): 40 attendees were asked to place sticker dots on three topics to answer the following question: Which three issues or topics do you want to discuss more today during the world café conversations?

The six topics with the most dots were used for a world café activity: mental health, housing, health care systems, education, isolation, and prenatal and early life experiences.

May 15 meeting (virtual): 65 attendees were asked to complete a poll to select 3 topics, considering the following questions: Which three health priorities should the HMP focus on together between 2025 and2028? To simplify virtual polling, the list of topics and sub-topics was condensed by collapsing the sub-topics into topics for a shorter list.

The four topics with the most dots were identified and used for small group discussions in virtual breakout groups: mental health, substance use, health care, isolation, and housing.

Community conversations

Virtual and in-person community conversations were conducted in July, August, and November 2024. Community conversations collected input on the list of topics from the statewide health assessment that people were most concerned about, and to hear more about their concerns, perspectives, and suggestions for action. To learn more about how the list of topics were identified, see Appendix B.

Virtual conversations

Six virtual conversations were offered in July and open to anyone across the state. These were 90-minute sessions that included a polling activity to identify the health assessment topics that "concern you the most," virtual whiteboard activities focused on the top four concerns identified by the group, and smaller breakout rooms to discuss one topic in more depth.

A total of 85 people attended the six virtual sessions. Attendees represented local public health (40%), community-based organizations (25%), health care (16%), state employees (12%), other affiliations (4%), community members (2%) and education (1%). Optional demographics were collected with the online registration form and are listed below in tables 1-5.

Table 1: Virtual attendees by geographic region (County)

County	Count	Percent
Metro (7county)	28	33%
Greater Minnesota	43	51%
Other	1	1%
No response	13	15%

Table 2: Virtual attendees by ethnicity

Hispanic or Latino	Count	Percent
Yes	4	5%
No	69	81%
Prefer not to answer	2	2%
No response	10	12%

Table 3: Virtual attendees by race

Race	Count	Percent
American Indian or Alaska Native	4	5%
Asian or Asian American	3	4%
Black, African or African American	5	6%
Other	1	1%
2 or more races	2	2%
Prefer not to answer	3	4%
White	58	68%
No response	9	11%

Table 4: Virtual attendees by gender

Gender	Count	Percent
Female	63	74%
Male	9	11%
Prefer not to answer	2	2%
No response	11	13%

Table 5: Virtual attendees by age

Age range	Count	Percent
18-24 years	5	6%
25-43 year	31	37%
44-64 years	32	38%
65 years and older	3	4%
Prefer not to answer	3	4%
No response	11	13%

August 2024 in-person conversations

Partnership staff conducted two in-person community conversations in August 2024 with groups representing American Indians in the metro area, including Saint Paul Indians in Action's Unsheltered Relatives/Opioid Response subcommittee of Metropolitan Urban Indian Directors. Optional demographic questions were not requested from in-person attendees.

Partnership staff planned for these meeting in consultation with Ravyn Gibbs, Tribal Liaison at the Office of American Indian Health and Madison Anderson, Tribal Public Health System Consultant for the Center of Public Health Practice.

November 2024 in-person conversation

Partnership staff conducted a community conversation in November with the Minnesota Youth Council. This community conversation was modified from previous conversations to include background and information about the Partnership, health assessment and improvement framework process. It also contained an overview of the four community-identified topics approved during the September 2024 Partnership meeting. Youth council members gave valuable input on the community-identified topics, specifically their concerns and perspectives on mental health and substance use. About 30 youth attended this hybrid meeting. Optional demographic questions were not requested.

Health priority survey

A health priority survey was used to receive input from people across the state who were not able to attend a community conversation. The survey was available from July 25 to August 22, 2024, and available in English and Spanish. Partnership staff consulted with the MDH Cultural Communications staff to develop the survey and translate the results. The survey was distributed to Partnership members, multiple email lists, social media posts, health equity partners, and other connections made through previous community engagement efforts.

The survey included a mix of 10 multiple choice and open-ended questions to learn what three topics people thought were the most important topics and what concerned them most about the topics.

In total, 717 respondents completed the survey (five Spanish surveys and 712 English surveys). Optional demographic questions were included on the registration form to learn who was being engaged.

Table 6: Survey responses by county

County	Count	Percent
Metro (7county)	328	46%
Greater Minnesota	302	42%
Other	18	3%
No response	69	10%

Table 7: Survey responses by ethnicity | Are you Hispanic or Latino?

Hispanic or Latino	Count	Percent
Yes	26	4%
No	599	84%
Prefer not to answer	30	4%
Unknown	3	1%
No response	59	8%

Table 8: Survey responses by race | How do you describe yourself?

Race	Count	Percent
American Indian or Alaska Native	13	2%
Asian or Asian American	13	2%
Black, African or African American	25	4%
Native Hawaiian or Other Pacific Islander	0	0%
White	455	64%
Unknown	2	1%
Multiracial (2 or more races)	22	3%
Prefer not to answer	28	4%
No response	50	7%

Table 9: Survey responses by gender

Gender	Count	Percent
Female	534	74%
Genderqueer/Gender non-conforming	3	0%
Male	87	12%
Non-binary	13	2%
Transgender man	4	1%
Transgender woman	1	0%
Other	3	0%
Prefer not to answer	23	3%
No response	49	7%

Table 10: Survey responses by age

Age range	Count	Percent
18-24 years	19	3%
25-44 years	268	37%
45-64 years	289	40%
65 years and older	72	10%
Prefer not to answer	15	2%
No response	54	8%

Summary of community input

Partnership staff reviewed, compiled, and analyzed input from the May 2024 Partnership meetings, community conversations, and the health priority survey. Input included quantitative data from polling results and multiple-choice questions, and qualitative input from verbal comments during community conversations and open-ended survey questions.

Polling results

Attendees and respondents answered, "*What three topics concern you the most?*" (wording and question format varied slightly across activities). The table below summarizes response counts per topics across these activities.

Table 11: Overall responses to top concerns

Health assessment topic	May meetings (69 responses)	July Community Conversations (77 responses)	August Community Conversation (33 responses)	Survey responses (717 responses)	Total responses
Mental health and wellbeing	38	58	14	374	484
Housing and homelessness	19	27	28	381	455
Health care systems	25	20	2	246	293
Substance use	16	31	25	164	236
Food	7	9	3	116	135
Climate change	7	5	0	107	119
Transportation	9	15	0	94	118
Prenatal and early life	10	11	2	87	110
Education	7	7	4	91	109
Gun violence	0	6	11	75	92
Living with chronic conditions	5	11	2	74	92
Income	4	10	1	70	85
Isolation	13	5	0	46	64
Other	0	7	1	51	59
COVID-19	1	0	0	48	49
Environmental justice	6	1	3	38	48
Suicide	0	5	3	32	40
Water	2	1	0	20	23

Input profiles

Staff created "input profiles" for the top four identified priorities. These were shared and used during the August 2024 steering committee meetings, the September 2024 Partnership meeting, and health priority workgroup meetings. Each profile included cross-connecting topics and a summary of topics that came up during engagement activities.

For each profile you'll find:

Cross-connecting topics: A list of other assessment topics, named during engagement activities, that intersect or connect with the profile topic.

Engagement recap: Summaries of comments, contributing factors, inequities, trends in numbers, populations, and geographic areas impacted or related to the profile topic.

Prioritization criteria: Each profile contains how the topic is appearing in local assessment and improvement planning work.

MENTAL HEALTH and WELLBEING

Cross-connecting topics

The following topics were named as intersecting or connecting with mental health and wellbeing:

- Suicide
- Isolation
- Substance use
- Health care system
- Housing
- Many people mentioned mental health and wellbeing overlaps with all topics on the list of potential priorities

Engagement recap

What are the **contributing factors or causes** for issues related to mental health and wellbeing?

- Access to care or treatment, including lack of mental health providers and availability in rural areas, cost of care/reimbursement, long wait times, intersection with health care system/segmented, lack of trainings, and overflowing emergency rooms.
- Limited resources (not health care), including limited resources (outside of individual) for schools, families, workplaces, social services, community organizations, lack of trainings, lack of or limited awareness of resources.
- Stigma, including awareness, ability to talk about it, not knowing when or how to get help, not knowing warning signs, and connection to suicide.
- Isolation, including impact of pandemic on isolation and continued isolation, and impact on access to care or treatment.
- Substance use, people mentioning connection or overlap of mental health and substance use.
- Stress, including increasing feelings of anxiety and stress, stress from cost of living (housing, food, jobs, transportation, etc.), economy, climate change, political climate, and social media (youth).

What **inequities** were named related to mental health and wellbeing?

- Lack of culturally and linguistically appropriate services and resources for specific communities, especially immigrant communities.
- BIPOC populations and LGBTQIA+ communities have higher prevalence, but lack of providers.
- Infrastructures in Minnesota that have embedded racism and biases.

What **trends** (increases, decreases, etc.) were named related to mental health and wellbeing?

- Higher rates of anxiety, depression, suicidal ideation among youth (Minnesota Student Survey).
- High rates of suicide, specifically named among older adults and youth.
- Increasing prevalence of mental health conditions and symptoms across the state (see the statewide health assessment for a 2013 to 2021 comparison).

What **populations** were named to consider for issues related to mental health and wellbeing?

- Youth
- Aging/seniors
- People experiencing homelessness
- BIPOC and American Indian
- LGBTQ+
- Immigrant communities

What **geographic areas** were named to consider for issues related to mental health and wellbeing?

- Greater Minnesota/rural Minnesota: Lack of providers and facilities, lack of resources, and stigma.

Prioritization criteria

Alignment:

- 2020 review of community health improvement plans: "Mental health" was one of top five issues most frequently prioritized.
- 2023 and onwards review of community health improvement plans: Eight out of eight identified mental health and wellbeing as a priority; three out of eight said access to mental health services, and one said mental health stigma

HOUSING and HOMELESSNESS

Housing and homelessness were combined as polling option for all activities but the survey.

Cross-connecting topics
The following topics were named as intersecting or connecting with housing:

- Income
- Employment
- Substance use
- Mental health and wellbeing
- Transportation
- Domestic violence (physical and sexual violence)
- Climate change
- Many people mentioned housing overlaps with all topics on the list of potential priorities.

Engagement recap

What are the **contributing factors or causes** for issues related to housing?

- Lack of/limited affordable housing, including inventory shortages, rising prices/mortgages, high cost of rent, corporations/vacation rentals impact on housing market, zoning, landlords not accepting vouchers/financial programs, barriers with paperwork, etc.
- Lack of quality housing, including unsafe housing, landlords not fixing or maintaining rentals, concern for climate change and housing materials, lack of policies and regulations
- Increase in homelessness, comments about seeing more people experiencing homelessness, lack of resources available, and criminalization of homelessness
- Housing as a social determinant, comments about housing being essential to health and housing connecting to multiple other issues

What **inequities** were named related to housing?

- Redlining
- Disparate rates of homeownership, specifically between racial groups
- Gentrification
- Inequities in housing safety and conditions, and lack of housing available in neighborhoods with higher proportions BIPOC populations and people with lower incomes
- Racism and discrimination in housing programs.

What **trends** (increases, decreases, etc.) were named related to housing?

- Rising housing costs
- Rising number of people experiencing homelessness

What **populations** were named to consider for issues related to housing?

- People experiencing homelessness
- Lower income
- Aging
- Youth/children (homelessness)
- BIPOC and American Indians
- Immigrant communities
- People experiencing incarceration

What **geographic areas** were named to consider for issues related to housing?

- Greater Minnesota/rural Minnesota, including lack of affordable and quality housing, especially for older adults, and concern of housing availability near employment.

Prioritization criteria

Alignment:

- 2020 review of community health improvement plans: "Economic stability" and "neighborhood and built environment" were two of top five issues most frequently prioritized
- 2023 and onwards review of community health improvement plans: one out of eight identified economic stability as a priority

HEALTH CARE SYSTEM

Cross-connecting topics
The following topics were named as intersecting or connecting with health care systems:

- Mental health (and suicide)
- Income and cost of living
- Affordable housing
- Homelessness
- Transportation
- Living with chronic conditions
- Substance use
- COVID-19

Engagement recap

What are the **contributing factors or causes** for issues related to health care systems?

- Affordability comments about cost of insurance, deductibles, co-pays, services, medication, etc.
- Access and availability of services including comments about lack of insurance, difficulty scheduling appointments, provider shortages/ need for more providers (physicians, nurses, dental, birthing, mental health). Comments about closure of hospitals/clinics in rural areas (including clinics, dental offices, birthing services). Having to travel long distances for care. Lack of dental care offices and providers.
- System coordination including complexity and difficulty of navigating health care systems, and scheduling appointments. Also lack of care coordination, fragmented care. Comments include low reimbursement rates for services and need for oversight of insurance. Many comments stating "system is broken."
- Lack of preventative care.

What **inequities** were named related to health care systems?

- Implicit bias, racism, discrimination. Bias and negligence with non-white populations, including American Indians.
- Disparities in healthcare outcomes, treatment and access across different populations. Inadequate care for black women.
- Not enough bilingual providers and translators. Lack of culturally appropriate services.

What **trends** (increases, decreases, etc.) were named related to health care systems?

- Increasing number of hospital/ clinic closures in rural areas.
- Large number of health care providers retiring or leaving the field, especially in rural areas.
- Rising costs, changes in managing health care (move to businesses), increasing complexity of accessing care and insurance claims.

What **populations** were named to consider for issues related to health care systems?

- Immigrants, non-English speakers
- People of color, BIPOC, and American Indians
- People with disabilities
- Elderly, people who are aging
- People with cognitive disabilities
- Veterans

What **geographic areas** were named to consider for issues related to health care systems?

- Greater Minnesota, rural areas (gaps of services in general, having to travel long distances for car. Also, lack of maternal care and dental care.)

Prioritization criteria

Alignment: Health care systems in general isn't a health priority in any community health improvement plans submitted to MDH for review.

- 2020 review of community health improvement plans: health care systems or access was not one of top five issues most frequently prioritized
- 2023 and onwards review of community health improvement plans: one included access to dental care services, and one identified access to health care services.

SUBSTANCE USE

Cross-connecting topics
The following topics were named as intersecting or connecting with substance use:

- Mental health (and suicide)
- Social isolation
- Housing and homelessness
- Health care access and care
- Incarceration
- Several included concerns about crime, domestic violence, gun violence, and infectious diseases (like HIV) that are impacting unsheltered people who inject drugs.
- Many people mentioned substance use overlaps with all topics on the list of potential priorities

Engagement recap

What **types of substances** were named as concerns?

- During July 2024 community conversations, 48 attendees took a poll about the substances they were most concerned about: opioids (21 votes), cannabis (10 vote), alcohol (seven votes), commercial tobacco (five votes) or all/multiple substances (five votes)
- A review of written Survey comments show concern with multiple substances, including:
    - Cannabis/marijuana (25 comments): New adult laws, availability, impact on children, expecting changes in upcoming years, misconceptions
    - Drug use and opioids (18 comments): General drug use, dependency, overdoses. Comments about increased access and more visible in the community.
    - Alcohol (six comments): Alcohol abuse, alcoholism, underage drinking
    - Commercial tobacco (four comments): Teen or youth smoking and vaping

What are the **contributing factors or causes** for issues related to substance use?

- Stress: People using substances to cope with stress, address mental health and unhealed trauma. Related to shortage of mental health providers.
- Prevention or education: Lack of funding for prevention and awareness. Lack of education about new cannabis laws and impacts of cannabis on health.
- Limited or lack of services, including lack of mental health providers, quality treatment option or support resources. Also lack of access to harm reduction services, safe use sites, and harm reduction housing. Programs ending because of lack of funding.
- Lack of resources, including support resources, basic needs resource and housing.
- New cannabis law: Lack of information about health impacts, misconceptions, lack funding for education or prevention

What **inequities** were named related to health care systems?

- "Disparity in regard to American Indian population." Lack of culturally specific treatment and recovery, no holistic inpatient treatment for American Indians. American Indians are dying.
- Lack of culturally appropriate education for alcoholism
- BIPOC youth being targeted (drug use)
- Stigma

What **trends** (increases, decreases, etc.) were named related to health care systems?

- Increasing overdose and overdose deaths
- Increasing vaping use among youth. Increases in seizures due to vaping (especially cannabis products)
- Increasing number of people of all ages using substances, including adolescents.

What **populations** were named to consider for issues related to health care systems?

- Adolescences/youth: prevention needed, access and use (including smoking, vaping (tobacco and cannabis). Youth being targeted, including "BIPOC kids". Impact on children when there is substance use in homes
- LGBTQ+ communities
- People who are homeless or unstably housed

What **geographic areas** were named to consider for issues related to health care systems?

- Rural Minnesota (drug use, lack of services or treatment options, and trafficking)

Prioritization criteria

Alignment: Substance use has frequently been identified as a health priority in Minnesota community health improvement plans.

- 2020 review of community health improvement plans: Substance use was one of the top five issues most frequently prioritized.
- 2023 and onwards review of community health improvement plans: Four out of eight identified substance use as a priority including: focus on cannabis (1), commercial tobacco (1) and general substance use (2).

Appendix D. Health priority workgroups

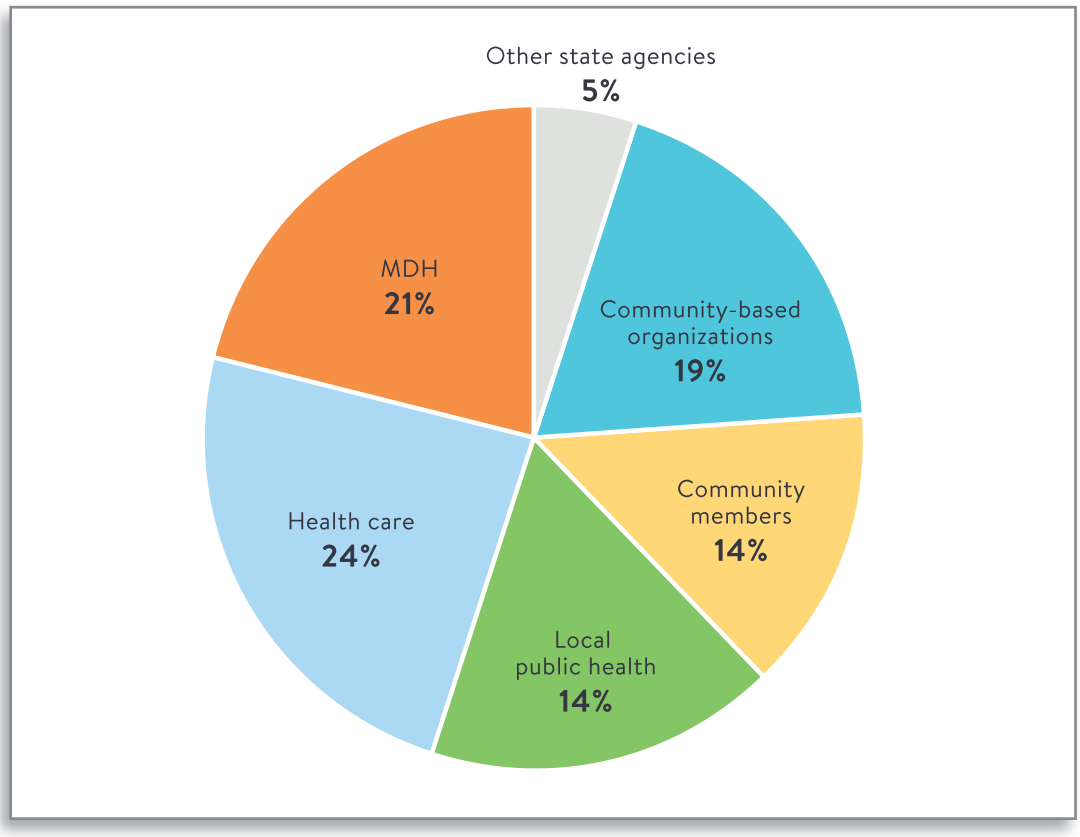
Background

On September 30, 2024, the Partnership approved moving forward with four topics for potential health priorities, identified by community input collected between May and August 2024. Workgroups were formed to help the Partnership clarify the goals of these topics and identify measurable objectives and strategies.

Workgroup structure

Workgroups were open to Partnership members and non-members. Each workgroup included a mix of voluntary participants from various sectors or lived experiences. Group size for each workgroup was targeted for approximately 15 members to ensure participation and discussion of topics during meetings.

Figure 6: Health Priority workgroup members by affiliation



Workgroup members were asked to participate in discussion and recommendations using the following:

- Health equity perspective
- System level and statewide perspective
- Asset-based approaches

October workgroup meetings

Each workgroup met for two 90-minute meetings in October.

Meeting 1: During the first workgroup meeting, members reviewed community engagement input profiles (summaries of community engagement findings) and the statewide health assessment and discussed potential focus areas for their health priority topic. Members reviewed guidelines and considerations for what might be in-bounds and out-of-bounds for objectives and generated initial ideas for objectives using a virtual whiteboard. Between meetings one and two, Partnership staff sorted and grouped ideas into similar themes and drafted potential objective recommendations for the workgroup to review.

Meeting 2: At the second workgroup meeting, members reviewed themed groupings and drafted objectives for consideration and feedback. Once reviewed and edited, workgroups prioritized one to three objectives to recommend to the steering committee.

Table 12: Examples of topics discussed by workgroups during October meetings:

Priority	Topics
Mental health	• Mental health as part of holistic health and well-being or wellness • Access (and affordability) to services is an area of concern • Distinction between education and awareness • Community-initiated or community-driven approaches are important • What is the role of policy work or how policies impact mental health?
Substance use	• Don't limit focus to specific substances; different communities have different experiences and needs • Concern for youth and Minnesota Student Survey participation • Identification and addressing root causes and risk factors
Housing and homelessness	• Crossroads to Justice plan and other groups doing similar work • Lack of affordable housing (noted in rural areas) • Increase in homelessness and causes • Housing is essential for health; awareness about this
Health care systems	• Cultural competency and cultural literacy; how community health workers and support staff can bridge gap • Provider trainings on implicit bias • MDH's Equitable Health Care Task Force • Factors and barriers to accessing care • Loss of providers and workforce shortages

December workgroup meetings

Each workgroup met for two more 90-minute meetings in December.

Meeting 3: During the third workgroup meeting, members were updated on takeaways from the November 2024 Partnership meeting and reviewed strategy ideas generated during the October meetings and community engagement. Members provided feedback on strategy ideas organized by objectives. Between meetings three and four, Partnership staff met with Partnership co-chairs and MDH leadership to revise objectives based on feedback from the November Partnership meeting and workgroup input. Partnership staff also worked on re-wording strategy ideas to fit the scope and capacity of the Partnership.

Meeting 4: At the fourth and final workgroup meeting, members reviewed an outline summarizing all their input on health priorities, objectives, and strategies. Members were asked if this captured what was discussed across meetings and were informed of review opportunity of first draft planned for January 2025. Members provided feedback and ideas on potential population health indicators for each health priority.

Table 13: Examples of topics discussed by workgroups during December meetings:

Priority	Topics
Mental health	• Culturally responsive messaging and values • Upstream and policy-level approaches • Sense of well-being or wellness is important – are there ways to measure?
Substance use	• Primary prevention and addressing risk and protective factors • Policy approaches and environmental impact • Overlap with mental health workgroup • Harm reduction • Minnesota Student Survey participation
Housing and homelessness	• Coordination across partners and agencies • How to effectively share information and resources with people experiencing homelessness • Policy changes and policies to advocate for/support (named specific examples) • Include and engage people with lived experience in this work
Health care systems	• Barriers and facilitators to culturally competent care • Trauma-informed care • Community health workers and interpreters • How to engage community experts and gain community voice on these issues

Appendix E. Revisions to the Health Priorities

In December 2024, Partnership co-chairs, MDH leadership, and Partnership staff reflected on input from the November Partnership meeting and other steering committee and workgroup meetings. A proposal was developed to update the health priorities by combining mental health and wellbeing with substance use and renaming the topic areas. The Partnership co-chairs reviewed the proposal and approved the three health priorities in Figure 7.

Figure 7: Prioritizing topics from the health assessment

Belonging, wellbeing and substance use prevention	Health and housing	Equitable access and care
Combine mental health and wellbeing, and substance use. The substance use objective overlaps with mental health so combining. Input has reflected the connection between topics. Combined topics may include both shared and unique activities.	**Rename** housing and homelessness to reflect workgroup discussions about the Partnership's role in connecting health to housing/homelessness.	**Rename** to reflect the focus of the health care system topic.

Rationale for combining and renaming health priorities

- The revised health priorities better communicate the goals and role for the Partnership. (For example, people often asked what was meant by "health care systems.")
- Revisions are more goal or action oriented than simply listing the topic area and is responsive to the framework framing consideration "be oriented to action."
- Other states have health priorities that combine mental health and substance use and include sub-categories for mental health and substance use.

Revision process

The revisions to health priorities were made using the following process:

1. Proposal drafted using input from the November Partnership, workgroup, and steering committee meetings.
2. Proposal reviewed and discussed with Partnership co-chairs, MDH leadership, and staff. Co-chairs approved changes.
3. All workgroup members were informed of the revisions via email and during workgroup meeting #4
4. Steering committee members were informed of the revisions via email, concurrent with workgroup meeting #4
5. Revisions included in the first draft of the improvement framework for feedback during the January review process with the steering committee, workgroup members, Partnership members, and other health equity partners.
6. Steering Committee decided to revise "Wellbeing and social connection" in response to feedback received during the January review period and questions about the health priority not naming substance misuse prevention. The health priority was renamed to "Belonging, wellbeing and substance use prevention."

Appendix F. Additional Indicators

The statewide health improvement framework is not a data document, however identifying indicators and measures to track and monitor progress is an important part of an action plan. The following list of secondary indicators and ideas for additional indicators that represent ideas generated throughout the development and review of the improvement framework. These lists will be shared with workgroups throughout implementation.

Secondary indicators

Secondary indicators are measures related to a health priority that may be reviewed and included in annual reports to add additional context to what is happening around these topics.

- Transportation and housing cost burden
- Number of physicians or physician patient ratios (metro vs. rural areas)
- Primary and specialty care clinics closures (metro vs. rural areas)

Ideas for additional indicators

Ideas for additional indicators are suggestions for data collection or analysis.

- Transportation access for medical purposes
- Community health workers (statewide number, CHW education/trainings)

Process measures

In addition to indicators, the improvement framework will also include process measures for the objectives and strategies. Process measures will be developed to help track the actions taken on specific objectives and/or strategies for each health priority. Process measures will be written to align with SMARTIE objectives to ensure they are strategic, measurable, ambitious, realistic, time-bound, inclusive, and equitable. Tracking progress may also include collection of storytelling, testimonials or other qualitative data to support quantitative progress measures. Process measures will be tracked with annual work plans and shared in annual reports.