The Role of Health Care in Eliminating Health Inequities in Minnesota

A Report to United States of Care and its Partners

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JANUARY 2020

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Eliminating health inequities in Minnesota: A framework for health care systems transformation

This feasibility study began with an audacious question: "What can be done to eliminate health inequities in Minnesota in the next decade?" Health inequities, which are rooted in unjust social and economic inequities, continue to persist. While progress has been made to eliminate health inequities, their entrenched nature means they are not easily solved. This report describes what contributes to health inequities, recognizes the work that has been taking place in Minnesota to mitigate these contributors, and considers what is necessary for meaningful and sustained change. While recognizing that health care as a sector does not hold sole responsibility for eliminating health inequities, it can leverage its influence though bold action done in collaboration with partners and a long-term commitment to change.

There is strong evidence that the places where people live, work, age and play have a much greater influence on health than health care. These factors, called social determinants of health, are wide ranging and include income and wealth, quality housing, education, employment, public safety, transportation, access to services, and social connectedness. When these factors are unjustly distributed, they result in health inequities — unfair and preventable differences in health outcomes between populations

Differences in health outcomes caused by social and economic inequities are pervasive and persistent in Minnesota, and impact multiple populations, including Indigenous communities, people of color, and residents of rural communities. While there are multiple strategies that can be used to improve health outcomes and address social determinants, this study asserts that a bold initiative to eliminate health inequities must advance collective action to focus on the root social and economic determinants of health. The recommendations from the study, if fully implemented, will support systems transformation within the health care sector and guide new efforts where health care can leverage its strengths to work in partnership with other sectors to eliminate health inequities in Minnesota.

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A bold vision for eliminating health inequities in Minnesota

This study began with a bold vision to eliminate health inequities in Minnesota in a decade. This moonshot goal is ambitious and, at first glance, seems unachievable. However, because health inequities are rooted in social injustices that routinely disadvantage certain populations, these differences are avoidable. It is clear that structural racism and socioeconomic status are the most influential drivers of health inequities. However, we face the challenge that, despite many efforts taking place in Minnesota and nationally, no best-practice model yet exists for certain and long-lasting success in truly eliminating inequities.

Health care has not traditionally focused on addressing the root causes of health inequities, yet the sector has a critical and influential role to play. Doing so requires changes within institutions to ensure policies and practices advance equity. It also necessitates a reimagining of the role of health care in the broader landscape of activities to reduce inequities happening in communities and across multiple sectors. Eliminating health inequities is possible, but it requires bold, collaborative, and sustained efforts to disrupt systems, policies, and practices that, intentionally or not, create and uphold these unjust differences in population health outcomes.

This report offers a framework and recommends initial collective action priorities for health care to further leverage its influence to address the root causes of health inequities. It also identifies the next steps needed to move the recommendations from this report into a clear plan for action. Given the data demonstrating the pervasiveness of health inequities in Minnesota, there is no question that action is needed. The challenge is building the momentum and will to work with a clear focus on shared goals that address the root causes of inequities rather than being content with work that can improve health, but that will not lead to long-lasting and sustained change. Doing so requires a different approach. **The *Systems Transformation Framework* and recommendations in this report outline the steps needed for health care, as a sector, to have the partnerships in place and infrastructure necessary to work toward the ultimate goal of eliminating health inequities in Minnesota.**

The case for addressing the key drivers of health inequities

Over the past three decades, a strong body of research has clearly demonstrated that the places where people live, work, age, and play, including underlying economic and social conditions, are the key factors that influence health outcomes (Braveman & Gottlieb, 2014; Galea, Tracy, Hoggart, Dimaggio, & Karparti, 2011; Jemel et al., 2001; McGinnis, Williams-Russo, & Knickman, 2002). These factors, called social determinants of health, are wide ranging and include income and wealth, quality housing, education, employment, public safety, transportation, access to services, and social connectedness (Figure 1). Together, these factors play a strong role in the degree to which people can access resources and adopt behaviors that support health and wellness.

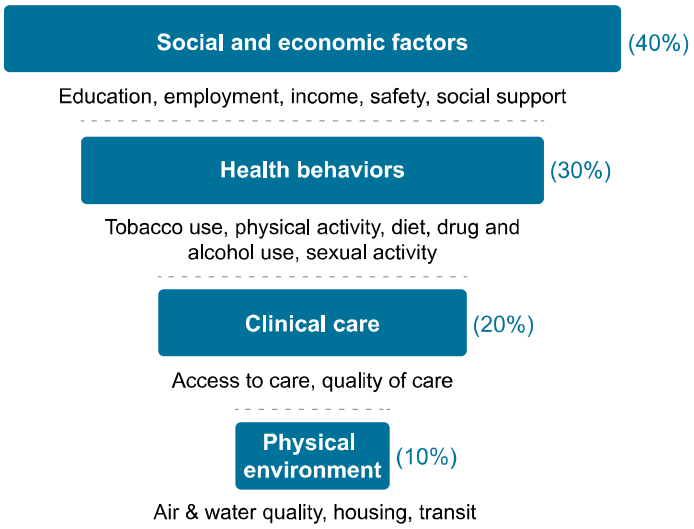
Social determinants of health refers to the social, economic, and environmental conditions where people live, work, age, and play. Inequities in these conditions in communities and neighborhoods lead to population-based differences in health outcomes (i.e., health inequities).

1. Examples of social determinants of health

Economic stability	Education	Social and community context	Health and health care	Neighborhood and built environment
Poverty Housing instability Food insecurity	Early childhood education Enrollment in higher education Access to job training Literacy	Civic participation Discrimination Incarceration Social cohesion Residential segregation	Access to health care Health literacy	Exposure to pollutants Housing quality Community safety Availability of resources Transportation

The County Health Rankings model, developed by the University of Wisconsin Population Health Institute, is one widely used framework that explains how social and environmental conditions shape overall health. Their model, which is similar to results found through a number of other studies, shows that social determinants of health play a much larger role in impacting overall health than clinical care (Figure 2). However, while there is clear agreement that social and economic determinants are primary factors influencing health outcomes, there is no consensus on the relative impact of each individual factor on overall health and well-being (Artiga & Hinton, 2018). This is, in large part, due to the interconnected nature of social determinants. Income, education, employment, access to resources, and other social determinants are often interrelated in multiple ways. Residents living in lower-income neighborhoods and communities, for example, may have lower access to jobs or limited transportation options. Without steady employment, these residents have difficulty accessing health insurance or affording what is needed to meet their basic needs, including health care, stable housing, and healthy foods. In addition to issues related to access and affordability, recent studies have also brought attention to the biological impacts that chronic exposure to social and environmental stressors, including economic insecurity, has on health.

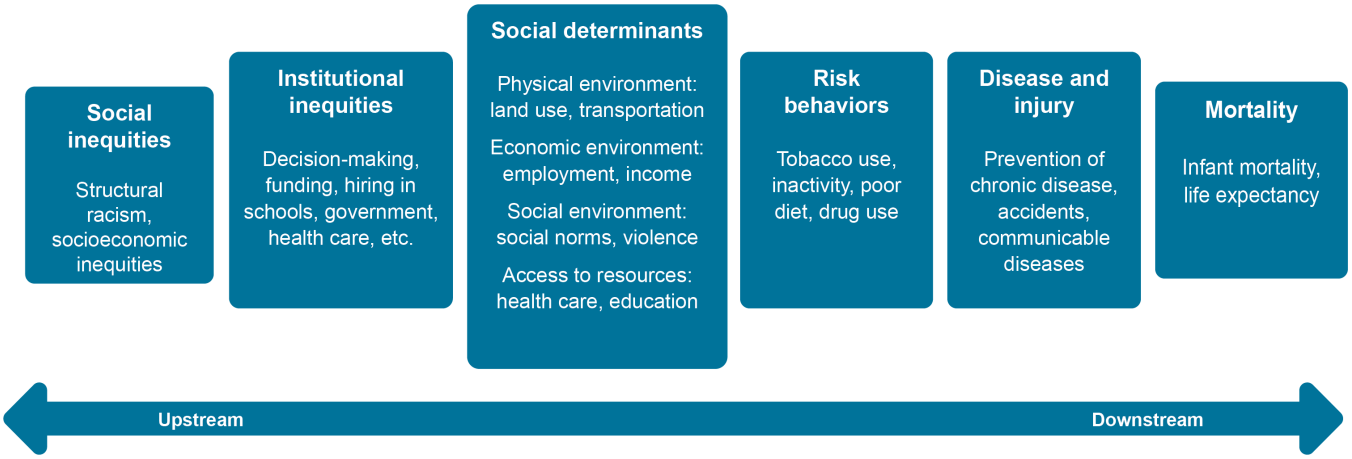
2. County Health Rankings Model



University of Wisconsin Population Health Institute. (2019). *County health rankings model.* Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

The role of health care has shifted from "downstream" individual interventions to improve health to include "midstream" initiatives to address social determinants of health and access to community resources. Strategies at multiple intervention points are needed to improve the quality of care, address social determinants, improve health outcomes, and eliminate health inequities. While there have been many promising efforts to address social determinants across Minnesota, there has not been collective action across the state to address the most upstream drivers of inequities. Targeting a future initiative to include work to address socioeconomic inequities and structural racism does not imply that work to improve quality of care and access to resources, including health care services, healthy food, and places for physical activity, should not occur. Instead, it recognizes that midstream interventions will not truly eliminate inequities without changing the policies, practices, and systems that routinely disadvantage some populations (Figure 3).

3. Intervention points for improving health outcomes



It is clear that social determinants influence health. It is also apparent that because of social and economic inequities, not all people in Minnesota have the same opportunity to be healthy. Across multiple measures, communities of color, particularly African American and Indigenous communities, tend to be disproportionately burdened by poor health outcomes. For example, although rates of infant mortality are decreasing statewide, American Indian and African American babies are twice as likely to die in their first year of life compared with Asian and white babies (Minnesota Department of Health, 2018). Among adults age 35-64, adults from Indigenous communities die from heart disease at nearly four times the rate of whites of the same age, while African American adults die at nearly twice the rate of whites (Minnesota Vital Statistics, 2013-17). African American women in Minnesota have a breast cancer mortality rate that is 24% higher than that of white women, due in part to disparities in early detection and treatment (Minnesota Department of Health, n.d.).

Health inequities are difference in heath that are unnecessary, avoidable, unfair, and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health and other groups.

Health equity is achieved when every person has the opportunity to realize their health potential – the highest level of health possible for that person – without limits improved by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

These inequities in health outcomes are caused by more upstream factors. Minnesota currently has some of the worst social and economic inequities by race in the nation. For example, among the 100 cities in the United States with the highest number of black households, Minneapolis has the largest gap in homeownership rates between white and black residents (McCargo & Strochak, 2018). In 2017, Minnesota high school graduation rates for black and Hispanic students were the worst in the nation, and Minnesota was among the 10 worst states for American Indian and Asian American students (Minnesota Compass, n.d.). There is a 13-point employment gap between white, non-Hispanic adults and adults of color in the Twin Cities metro region, ranking the region as 22nd among the 25 largest metropolitan areas in the United States (Itasca Project, 2017. Similar patterns are evidence across multiple social determinants (Figure 4, also see Appendix).

4. Social determinants indicators in Minnesota, by race/ethnicity, 2017

	American Indian	Asian	Black	Hispanic	More than one race	Another race	White	All Minnesotans
Persons (under age 65) without health insurance	18%	4%	7%	18%	7%	24%	4%	5%
Students graduating high school on time	51%	86%	54%	66%	71%	**	88%	83%
Adults (age 25+) with a bachelor's degree or higher	13%	44%	22%	17%	31%	12%	37%	36%
Proportion of adults (age 16-64) working	51%	72%	70%	75%	72%	75%	81%	79%
Individuals living below the poverty level	29%	12%	28%	19%	16%	21%	7%	10%
Homeownership rate	40%	56%	24%	46%	52%	40%	77%	72%

Sources. U.S. Census Bureau, American Community Survey; Retrieved from Minnesota Compass. (n.d.).
Note. Not all social determinants have data disaggregated at a state level by race/ethnicity.

When geography serves as the primary lens for identifying inequities, all 14 counties with the poorest overall health outcomes (defined as a combination of length and quality of life) in Minnesota are rural (University of Wisconsin Population Health Institute, 2019). A number of factors contribute to this, including social and economic inequities. Poverty rates and unemployment are higher in rural Minnesota compared to urban areas of the state (USDA Economic Research Service, 2018). Due to a lack of high-paying jobs, adults who work full time in rural areas and smaller towns are twice as likely to live in poverty as urban residents who work full time (Minnesota State Demographic Center, 2017). Rural areas of the state have been experiencing population losses since 2000, impacting the overall tax base and leading to workforce concerns, including the challenge of providing services to a growing aging population. Food deserts, where there are not options for residents to purchase healthy and affordable food, contribute to food insecurity among residents living in rural, small town, suburban, and urban areas throughout the state. Across multiple measures, residents in rural counties are less likely to have access to resources and fare worse across multiple social determinants indicators (see Appendix).

These patterns, called health inequities, must be addressed through upstream interventions. Health inequities are differences in health status or in the distribution of health resources between different population groups, caused by inequitable social and economic conditions. Health inequities are socially derived, they are not random; they are caused by policies, practices, and structures that create and uphold an uneven distribution of power and resources across groups of people, including by race, gender, class, sexual orientation, gender expression, ability, and geography. While these are pervasive issues that are challenging to address, health inequities cannot be eliminated without initiatives focused on creating more equitable systems, structures, and policies to support health and well-being.

> *…all people and all communities in Minnesota should have the opportunity to be healthy, but this is not true in Minnesota today. If we are able-bodied, gender-conforming, Judeo-Christian, and of European descent, we likely enjoy advantages that help us to be healthy — good schools, access to jobs and recreation, stable housing. Others of us struggle to meet our basic needs, and face daily obstacles to our opportunity to be healthy, particularly those of us who are of American Indian, African, Hispanic/Latino, and Asian descent, who have different religious beliefs and practices, sexual orientations or gender identities, or who are disabled.*
>
> — *Minnesota Statewide Health Assessment*, Minnesota Department of Health, 2017

Structural racism and socioeconomic status are key drivers of health inequities. As described in latter sections of the report, poverty is closely associated with poorer health outcomes. Evidence of economic inequities caused by unjust historical policies and disinvestment in communities are apparent across multiple measures, including homeownership rates, educational status, and access to health insurance. While economic inequities are critical to address, they do not fully explain differences in health outcomes by people of color and Indigenous communities. Racial inequities in health outcomes are evident across all income levels (Ferris, 2012). Structural racism has been increasingly understood as a key driver of health inequities (de Souza & Iyer, 2019).

These inequities come at significant cost. Between 2009 and 2018, health disparities are projected to cost insurers $337 billion nationally (Waidmann, 2009). It is clear that eliminating inequities is aligned with the mission of health care systems and is also critical in order for these institutions to remain profitable and competitive (de Souza & Iyer, 2019). A recent study estimated that eliminating health inequities in the state will lead to 766 saved lives annually and an annual savings of $2.26 billion resulting from saved lives, increased employment, and fewer days lost to illness and low productivity (Allen et al., 2018). A similar study estimated that eliminating health inequities by 2050 would add $230 billion to the national economy (Turner, 2018).

Now is the time for collective action. The work needed to eliminate inequities is daunting, but increasingly urgent to respond to the needs of an increasingly diverse population. Minnesota's immigrant and refugee population has tripled since 1990, a rate faster than the national average. Currently, 20% of Minnesotans are people of color; this is expected to increase to 25% by 2035 (Minnesota State Demographic Center, n.d.). In addition, specific strategies are needed to address health inequities impacting residents in rural areas of the state. Across multiple sectors, institutions and organizations have taken meaningful steps during the past decade to improve health outcomes for populations most disproportionately impacted by health inequities. However, these efforts have been inadequate, suggesting that sustained, cross-sector, deeply collaborative work is necessary in order to address these root drivers of health.

Collective action describes actions taken by a group to achieve a shared goal or objective. It supports opportunities for change that no single entity can achieve independently.

Key drivers of health inequities

While recognizing that a wide range of factors contribute to health inequities, this report focuses largely on two key drivers, socioeconomic status and structural racism. Both of these are pervasive issues that fundamentally impact community conditions, access to resources, and overall health and well-being.

Socioeconomic status

Socioeconomic status has been called the "fundamental cause" of disease and mortality, because it fundamentally shapes access to resources to prevent and treat health issues (Phelan et al., 2004; Zhang, Chen, McCubbin, & McCubbin, 2011). Low socioeconomic status is linked to a wide range of health problems, including low birth weight, cardiovascular disease, arthritis, diabetes, and cancer (Adler & Newman, 2002). Multiple factors, including employment opportunities and intergenerational wealth, contribute to disparities in socioeconomic status. In addition to a widening income gap, the percentage of people earning more than their parents has decreased (Chetty et al., 2016). The importance of socioeconomic status as a driver of health is clear, yet there are difficulties researching the direct association between the two due to the interconnectedness of socioeconomic status with other social determinants (e.g., education), and inconsistent definitions and measures of income and wealth (Braveman et al., 2006).

Structural racism

While recognizing that multiple populations are disproportionately impacted by poor health, it is critical to emphasize the role that structural racism contributes to health inequities. Structural racism is a system of mutually reinforcing policies, practices, and social norms that perpetuate racial inequity. While there has been some reluctance among policymakers, researchers, and health care leaders to name racism as a root cause of health inequities, there is clear evidence that racial inequities exist (Bailey et al., 2017). Across multiple measures, people of color in Minnesota and Indigenous communities are less likely to receive optimal health care services and have poorer health outcomes when compared with white, non-Hispanic Minnesotans (Minnesota Department of Health, 2017; Snowden et al., 2019). Discriminatory policies have disadvantaged people of color from education, employment, and homeownership opportunities, creating a strong association between race and socioeconomic status. However, racial disparities are not fully addressed by focusing on socioeconomic inequities; racial disparities in health outcomes are present at all income levels (Ferris, 2012).

Structural racism is the normalization of an array of history, cultural, institutional, and interpersonal dynamics that routinely advantage white people across mutually reinforcing systems while producing cumulative and chronic adverse outcomes for people of color and Indigenous communities.

The United States' history includes the use of discriminatory policies and practices grounded in racism, sexism, classism, and homophobia to unjustly disadvantage specific groups of people. While many of these policies have been removed from law, the impacts have remained and have shaped current systems and institutions. For example, the practice of redlining, where lenders and mortgage companies used restrictive underwriting practices and refused to approve loans in specific (often predominately African American) neighborhoods, created immense barriers to homeownership (Brown, Kijakazi, Runes, & Turner., 2019). The impacts of this policy and similar practices are apparent in the homeownership gap between white and black Minnesotans, and are a major contributor to current inequities in socioeconomic status because homeownership has been a longstanding driver of wealth. The impacts of these policies are long-lasting and pervasive. In addition to these actions and policies creating opportunity gaps that impact multiple generations, the trauma experienced by one generation is felt by subsequent generations and impacts overall health and well-being (Gee & Ford, 2011).

There is also a growing body of literature focused on the impact of interpersonal bias and discrimination in health care settings on health outcomes. For example, multiple studies have shown that when treating black patients, providers spend less time with patients, misinterpret or dismiss complaints, and undertreat pain, as compared with treatment for white patients (Hoffman, Trawalter, Axt, & Norman Oliver, 2016; Penner, Phelan, Earnshaw, Albrecht, & Dovidio, 2017; Van Ryn & Fu, 2003). Locally, data compiled and reported by Minnesota Community Measurement have brought attention to racial disparities in how care is provided. Across measures of colorectal screening and optimal care for chronic conditions (e.g., diabetes, heart disease, and asthma) and depression follow-up care, American Indian, black, and Hispanic patients have rates significantly below Minnesota's statewide rate (Snowden, Amo, Nelson, & Scholz, 2019). The Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* described how racial bias impacts overall clinic experience and treatment decisions and leads to poor health outcomes (Cooper & Roter, 2003). The report pointed out the need for greater training to improve communication, to center care on patients' needs, and to empower patients to be actively engaged in their care. The authors discussed a need for a more diverse workforce as well as medical practice norms that value and incentivize communication skills, interpersonal sensitivity, and cultural competence (p. 581). More holistic strategies are also needed, including equity-focused, place-based initiatives in neighborhoods impacted by discriminatory policies and disinvestment, and policy reform initiatives, particularly in the area of criminal justice (Bailey et al., 2017).

Moving to action

Health inequities in Minnesota are abhorrent and have been allowed to persist for far too long. While recognizing there are promising programs and initiatives in place across the state to address social determinants, it is also clear that more upstream, concerted efforts are needed to address the key drivers of inequities. The recommendations in this report set a vision for collective action to work toward the audacious goal of eliminating health inequities. This report describes the role that health care can play and offers the *Systems Transformation Framework* to guide collective action and establish common goals (see below). Moving to action requires not only a sustained commitment of time and resources, but also willingness to develop new skills, change policies and practices, and work in close partnership to confront fundamental issues often dismissed as being too large or too entrenched to address.

Over the next decade, health care will make measurable progress in reducing health inequities by:
Demonstrating leadership to address inequities through resource allocation, transparency, and commitment.
Understanding and working to dismantle structures, policies, and practices that uphold inequities.
Adopting practices that support whole person care, including dimensions of culture, language, sexual orientation, gender identity, and socioeconomic status.
Diversifying its workforce and strengthening a culture of diversity, equity, and inclusion.
Sharing power with communities to set direction and make decisions.
Focusing on advancing equity by addressing social determinants of health in collaboration with community partners.
Optimizing or developing financial mechanisms to incentivize the elimination of health inequities.

Background: About the study

Wilder Research and Wilder Center for Committees, two divisions of the Amherst H. Wilder Foundation, conducted this six-month feasibility study on behalf of United States of Care and the Steering Committee it convened to consider what, if any, initiatives could be undertaken to eliminate health inequities in Minnesota over the next decade. (See the Appendix for a list of Steering Committee members.) Given that the Steering Committee is comprised of a number of health care systems and plans, the study included an explicit focus on considering the potential role of health care in any future initiative. Beyond that emphasis, the feasibility study had a broad scope with few parameters that would limit the range of potential interventions.

The United States of Care and the Wilder project team invited a diverse group of individuals to participate in the Pathfinders Group. The participants in this group are familiar with many efforts underway across the state to improve health and advance health equity, and bring the perspectives and experiences of individuals deeply immersed in and impacted by this work. (See the Appendix for a list of Pathfinders Group members.) Members were asked to participate in four meetings to review information compiled through the study, shape next steps, and develop recommendations. Using information gathered through the study and drawing on their own experience and expertise, the Pathfinders Group created the *Systems Transformation Framework* as a guiding model for future collective action, and developed recommendations about the infrastructure and mechanisms necessary to support an initiative to eliminate health inequities.

This framework and recommendations for initiative infrastructure were presented to the Steering Committee in June 2019 for discussion and feedback. This final report builds on the Pathfinders Group's framework and identifies starting points that advance existing efforts and address critical gaps. These initial steps (or "entry points") into the *Systems Transformation Framework* are informed by information gathered throughout the study and shared with the Pathfinders Group. Because of limitations imposed by the study timeline, the Pathfinders Group was unable to meet together to review, refine, and prioritize the entry points identified in the report. However, individual feedback sent by Pathfinder Group members is incorporated into this final report.

Sources of information

The study included:

- A review of existing data describing health inequities in Minnesota
- Targeted literature reviews
- Interviews with representatives of initiatives in Minnesota and nationally

Throughout the report, these interviewees are referred to as representatives of organizations or local stakeholders. The interviews do not cover all initiatives taking place in Minnesota, but include a broad range of efforts taking place in urban and rural settings, in different sectors, and using a variety of approaches. The Appendix includes a list of organizations interviewed throughout the course of the study. Initiatives examined in this study should not be assumed to be more successful or impactful than other past or current efforts from organizations or initiatives not interviewed. Information gathered in a parallel effort by the Institute for Clinical Systems Improvement (ICSI) describes the programs and initiatives currently taking place in health care settings to address social determinants (see Appendix).

Current efforts and existing barriers to eliminating inequities

Current efforts

Across Minnesota, there are many efforts underway to reduce health inequities. These include efforts to address the most upstream determinants of health (e.g., socioeconomic status, housing, racism), as well as targeted initiatives to address specific disparities in health outcomes or improve access to services. While it was not within the scope of the study to identify all initiatives that do some type of work to reduce inequities at the individual level or by changing broader systems, we sought to illustrate the wide range of efforts underway. It is important to recognize that most of the representatives interviewed did not explicitly name eliminating health inequities as the goal of their work. Few felt they had the capacity or saw it as part of their role to work upstream to change the policies and systems that uphold inequities. Interviews with representatives from a broad range of existing initiatives highlighted a number of promising practices, but also pointed out barriers that made it difficult for these initiatives to have broader impact and sustained change. An overview of work happening in the state, based on these interviews, follows. (See the Appendix for a list of all organizations interviewed.)

Reducing inequities is a priority in Minnesota

Minnesota Department of Health (MDH) has been a strong leader both in bringing attention to the root causes of health inequities and in making changes within the institution to build capacity to identify address inequities, address structural racism, and work in closer partnership with communities. Its 2014 report, *Advancing health equity in Minnesota*, described inequities in the state with an explicit focus on race and outlined a more robust approach to addressing health disparities and health inequities in the state. These recommendations included changes in infrastructure, including the creation of the Center for Health Equity, changes in policy and practice to work in closer partnerships with communities, and improvements in the use of data to understand and address inequities (MDH, 2014).

The Eliminating Health Disparities Initiative (EHDI) was established through legislative mandate in 2001. While the initiative has changed over time from funding primary health promotion and direct service activities to address root causes, it has consistently had a focus on reducing specific health disparities for particular populations. The current priority areas are breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and sexually transmitted infections, immunizations, infant mortality, teen pregnancy prevention, and unintended injury and violence. Funding requests submitted by organizations far exceed the funding available through MDH, indicating high need. While many grantees demonstrate positive outcomes in their work each funding cycle, the overall initiative hasn't eliminated these health disparities at a state level.

Rather than focusing on rates of disease and clinical measures to determine the health priorities for the state, MDH focused its 2017 statewide assessment on the fundamental conditions all Minnesotans need to be healthy. Aligned with that approach, MDH has outlined the following three priority areas, each with two key conditions, as the focus of its *Healthy Minnesota 2022 Framework* (Figure 5). These priorities could be used to help clarify the complementary roles of health care and other sectors to advance broader statewide goals.

5. Minnesota Statewide 2022 Priorities

Priority area	**Key conditions,** followed by sample indicators
The opportunity to be healthy is available everywhere and for everyone	**Positive early life experiences**, including school readiness, student reading proficiency, family social support, economic stability **Economic well-being**, including employment, income, affordable housing, insurance status
Places and systems are designed for health and well-being	**Healthy surroundings,** including proximity to healthy foods, access to recreational opportunities, exposure to pollutants **Supportive systems**, including access to transportation, paid sick and family leave, school belonging, availability of health care providers
All can participate in decisions that shape health and well-being	**Just and violence-free communities,** including employment opportunities for former felons, safe and healthy relationships **Engaged populations**, including civic engagement, social connectedness, volunteerism, community-based collaboration

Additional efforts underway to reduce health inequities

Within the health care sector, there are a wide range of initiatives and activities underway, including cross-sector collaborations and networks that involve health care as a partner. In regard to statewide initiatives, there are multiple examples of a common strategy being implemented locally (such as community health needs assessments being conducted by hospital or local public health agencies), as well as a few statewide initiatives and coalitions focused on a specific social determinant (e.g., the Minnesota Food Charter, Minnesota Coalition for the Homeless). Although health care is involved with state-level networks convened by MDH (e.g., Healthy Minnesota Partnership, Health Equity Leadership Network), there is not currently a cross-sector network that more broadly engages health care in collective action to reduce health inequities. Professional associations and quality improvement initiatives have brought health care institutions together, largely around common data gathering and reporting.

Interviewees also included community-based organizations working to improve neighborhood conditions, increase access to stable housing and healthy foods, and establish training and education programs to create pathways to employment. While some of the initiative representatives interviewed have a primarily place-based (usually neighborhood) focus, others pursue a topic-focus or engage with a specific age group or cultural community. Community engagement that not only amplifies the voice of community members, but ensures that communities have influence and shared power in decision-making, is a primary focus for a number of these organizations. A number of these organizations have also increased their focus on improving health by prioritizing policies, systems, and environmental (PSE) changes. Attention to PSE change allows organizations to address barriers to their work in ways that will result in sustained change, and has been an emphasis of key funders of efforts to improve health and address disparities, including MDH and the Center for Prevention at Blue Cross and Blue Shield of Minnesota.

Examples of efforts to address social determinants

Hospitals are federally required to conduct Community Health Needs Assessments (CHNAs) every three years to understand community health needs and priorities, and to establish strategies to address them. A review conducted by the Minnesota Hospital Association (MHA) noted that access to health care and community resources, reducing obesity and related chronic conditions, and addressing mental health and substance abuse needs were commonly identified health priorities (MHA, n.d.). The degree to which these assessments emphasize health inequities as a key factor in what topics are identified as health priorities varies. Some health care organizations identify social and economic inequities as priorities, including Children's Minnesota, which identified structural racism as one if its priority health needs (Ferris & Rojas-Jahn, 2016). A number of hospitals and health care systems have focused attention on better identifying social determinants and developing stronger community partnerships to help patients access existing resources and supports. MHA, for example, has begun work to develop common social determinants screening measures. Multiple systems use NowPow as a platform to connect patients to available community resources, and some systems have begun new initiatives to partner with communities to develop programs that respond to unmet needs.

Examples of cross-sector collaborations

There are also examples of collaborative efforts taking place across the state to improve health that involve the health care sector. Silos to Circles has supported cross-sector collaboration in a number of communities across the state, with the goal of sharing findings that can inform policy and holistic approaches that support health and well-being. There have been multiple collaborative efforts focused on improving connections between behavioral health and health care. For example, the East Metro Mental Health Roundtable, which includes representatives of hospitals, health care systems, government entities, behavioral health providers, and advocates, came together to understand and address barriers to adults receiving the right level of mental health service at the right time. Similarly, the National Rural Health Resource Center supported work in multiple rural communities to engage in a planning and implementation process to improve referrals and communication between health care and behavioral health providers. Hennepin Health has developed strong partnerships with county social service programs, leading to patients more easily accessing resources through county social services and in the community. The Northside Achievement Zone and Saint Paul Promise Neighborhood are examples of place-based initiatives that engage a wide range of organizations, including health care systems, to improve youth academic achievement in a holistic way. Multiple interviewees identified the state's Comprehensive Tobacco Plan as a model for clearly describing the role of different sectors in achieving a clear health goal. Today, the Minnesota Food Charter uses a similar approach to identify the roles multiple sectors can play to create a more equitable food system in Minnesota. However, while the tobacco control work could move forward quickly to confront a dishonest industry with funding to support the work, food systems work is more nuanced and without a clear culprit to motivate changes in policies and systems.

Examples of efforts to eliminate disparities in health outcomes

Health care is also involved in identifying and addressing disparities in clinical care and health outcomes. Minnesota Community Measurement (MNCM) has developed key measures to report care quality and outcomes across a number of health topics. Data are available by system or institution, which helps health care partners see how their work compares with others and to identify areas of improvement. MNCM also produces a disparities report that presents these measures by race/ethnicity and type of insurance. Similarly, the Institute for Clinical Systems Improvement (ISCI), which has approximately 50 members, uses collaborative planning and data gathering to help medical groups develop and implement evidence-based clinical practice guidelines and other best practices to improve patient care. In each of these efforts, the organizations participating in work to improve health outcomes have common interests and may share lessons learned on complementary efforts; the degree to which a common goal drives collective action varies.

Training and learning networks

In addition to the many initiatives and organizations focused on making changes to improve health and reduce health disparities, there are multiple networks in place across the state comprised of individual champions, organizations, and institutions interested in eliminating health inequities. These include the Healthy Minnesota Partnership, convened by MDH. This group guides the statewide health assessment and has focused most recently on narrative change around health and health inequities.

The Health Equity Leadership Network is a relatively new group convened by the Center for Health Equity to determine how government, nonprofits, and community organizations can better align their efforts to advance health equity in Minnesota. The University of Minnesota also has workgroups and practice communities that come together to provide training and share information, including results from research focused on addressing health inequities. Multiple health care systems and system leaders participate in national networks to improve health and reduce health inequities. Individuals and organizations with interest in working to advance equity or to address a health issue come together through other types of gatherings and events, such as grantee convenings hosted by funders, local conferences, and most recently, a Health Equity Summit hosted by the Center for Health Equity. The presence of these networks is an indication of high interest among individuals and organizations involved in this work to come together for shared learning and aligned actions. However, given that these groups have not yet created a collective action agenda, it also suggests the challenges inherent in bringing together a diverse stakeholder group and establishing priorities for action.

Novel or innovative strategies

There are a number of examples of pilot programs and innovative approaches being tested in health care and community-based settings to address social determinants and improve health outcomes. Upstream Health Innovation, a new initiative of Hennepin Health, uses a design thinking approach to involve community members in designing strategies to overcome barriers to health, such as transportation, or to develop services to address unmet needs. Across Minnesota, there are examples of multiple pilot projects and initiatives working to increase access to healthy, affordable food. Similarly, telehealth models, efforts to increase the number of community health workers and community paramedics, and locating health care services in different types of settings, are all examples of strategies to improve access to health care services. These changes are often designed to creatively bypass the challenges inherent in current practices and systems. While these technical changes can lead to improved access to resources that improve health and build momentum, for long-term and sustained impact, adaptive changes are also needed to address the underlying factors that contribute to disparities in access to resources and to ultimately create more equitable systems. Therefore, while these midstream interventions can be part of a strategy to improve health outcomes, they alone are insufficient for eliminating inequities.

Current gaps and barriers

The scan of existing initiatives and interviews with individuals in health care and other sectors shows a number of initiatives doing important and impactful work to improve health and reduce health disparities. Information gathered through these activities highlights a number of gaps and system-level barriers that may impede efforts for a statewide effort to eliminate inequities.

Limited sharing and collaboration within and across systems

A common barrier identified across sectors, including health care, is the lack of opportunity to learn from other organizations about promising practices, as well as lessons learned from unsuccessful efforts. Within the health care sector, while there are efforts supported through professional organizations (e.g., ICSI, MHA), there is not a convening entity that brings organizations together for shared learning. Interviewees described this as a gap, and a potential missed opportunity to accelerate change across the sector and avoid redundancy. Some identified a history of competition, rather than vision for collaboration, as a barrier to shared learning. Within organizations health equity work often occurs in silos, rather than in efforts involving all parts of an organization, or is the focus of a specific new initiative, rather than integrated more holistically into the organization's mission and daily operations.

> *At a certain level, in particular, health plans in the hospitals, we are competing against one another. In some spaces, like community health, we are not - and should not - be competing, but it gets difficult at times.*

Structural racism

A few of the initiative representatives talked about redlining and racial covenant policies that restricted people of color from being able to own homes, and how that has contributed to inequities of wealth and segregation of neighborhoods today. In addition to recognizing how structural racism has contributed to community-level inequities, some representatives highlighted a need for institutions to recognize how systems and policies re-traumatize people who come to receive care, and to make changes to provide care as trauma-informed organizations. One representative suggested that the health care sector change how it defines "do no harm" to include not just medical errors, but interaction and experiences that lead to the loss of patient dignity. Another aspect of structural racism is the impact of implicit bias on decision-making that affect the timeliness of services, treatment decisions, and ultimately, patient health outcomes.

> *Structural racism has many forms in terms of decision-making processes, funding, or the ability to define the work that makes sense for us. At many times, it's having to do the work that [funders want] even if it's not the work that we think is the most important.*

Payment mechanisms, funding

In multiple ways, existing payment mechanisms do not incentivize the upstream work necessary to address social determinants and eliminate inequities. Within the health care sector, the fee-for-service reimbursement structure incentivizes acute treatment rather than preventive services and positive health outcomes. Community-based organizations described a number of challenges to seeking grant funding for work to reduce health inequities, including short funding cycles, an interest in funding projects that are novel or innovative rather than tested and effective, and pressure to demonstrate cost savings. One person expressed concern that organizations in rural areas are at a disadvantage when seeking grants, as they can't reach as many people as organizations located in densely populated cities. An investment is required to help people overcome issues like chronic homelessness or extreme poverty. While there may not be significant short-term cost savings, funding work to support health, rather than financing prisons and shelters, seem to many representatives a better social investment. Multiple people also noted that even when cost savings are likely, financial returns are not always realized by the institution or sector that made the investment in addressing social determinants and improving health.

Insufficient data

The issue of insufficient data was identified as a challenge in a number of ways. While it is increasingly common and expected that organizations and institutions collect and use race, ethnicity, and preferred language data, this is still a relatively new practice for many organizations and institutions. In addition, the broad race and ethnicity categories most often used are not helpful in identifying specific cultural communities experiencing disparities or measuring progress resulting from targeted interventions. Smaller organizations may not have the internal capacity to easily manipulate existing systems to enable staff and providers to easily collect this information and use it to inform decisions. There was also concern that population averages and metrics, commonly used by high-level executives and boards, may hide inequities, impacting how priorities are set and health needs are understood. Data sharing across organizations was also identified as a barrier to helping community members access the services they need. A few organizations described the challenge of measuring the impact of their work, particularly for upstream interventions and efforts that will take years or decades before long-term goals can be achieved.

Lack of political and institutional will

The social and economic factors that drive inequities are pervasive, and too large for any organization, institution, or sector to tackle alone. However, the people interviewed saw the potential for change, if there is enough will among leaders to champion work within their institution and work collaboratively with others outside their institution. One person interviewed noted that the current political divide presents challenges in finding policy positions that can help eliminate inequities.

The role of health care in addressing health inequities

National insights

Multiple provisions in the Affordable Care Act (ACA) were designed to promote health equity and eliminate health disparities (Grogan, 2017). These include changes within the health care system that establish fairer processes in legal structures and policies, as well as changes focused more directly on reducing disparities in health outcomes. Examples of these changes include disparities reporting, establishing plans to eliminate disparities, the creation of the Patient-Centered Outcomes Research Institute (PCORI), patient inclusion in treatment decisions, diverse workforce initiatives, cultural competency, improved coverage provisions, changes to financing and subsidies, research to track health disparities, and funding for prevention.

The various reforms outlined in the ACA prompted organizations to create and implement changes designed to promote health equity at the national, state, and local levels. National examples include:

- Families USA "A National Priority Agenda to Advance Health Equity through System Transformation," which outlines 19 recommendations for transforming health care with the intention of advancing health equity
- Institute for Healthcare Improvement (IHI) "Achieving Health Equity: A Guide for Healthcare Organizations", that includes a set of recommendations for implementing health equity (see Sidebar)
- Robert Wood Johnson Foundation Culture of Health Action Framework, which includes a systems transformation component with specific indicators and measures for health care

The IHI framework shows that a commitment to reducing disparities requires both internal and external work. The guide describes steps health care must take to clearly prioritize its commitment to advancing health equity and to change the structures and processes that act as barriers to this work. The external emphasis recognizes that work to reduce disparities cannot be done without partnering with other organizations. Elements of this guide are closely tied to the *Systems Transformation Framework* offered in this report.

The Culture of Health Action Framework consists of four action areas all designed to move the nation toward "improved population health, well-being, and equity" (Chandra et al., 2016). One of the four action areas is "strengthening integration of health services and systems." Equity is inherent in this action area because it is intended to create integrated systems of public health, health care, and social services that are responsive to the health needs of a diverse U.S. population across the life span and across the "health span" (Chandra et al., 2016). Beginning in November 2018, Health Affairs began publishing a series called *Leading Health* with support from the Robert Wood Johnson Foundation. The series focuses on innovative health systems transformations that demonstrate what it means "…to embrace team-based and whole-person care, integrate disparate elements of the health care system, collaborate across sectors, look upstream, and engage patients where they are" (Weil, 2018) and move us as a nation toward a Culture of Health.

IHI's Achieving Health Equity: A Guide for Healthcare Organizations

The IHI guide is intended to enable health care systems to reduce disparities related to racial or ethnic group, religion, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation or gender identity, geographic location, or other characteristics related to discrimination or exclusion (Wyatt et al., 2016. The five components of the framework are based on reviewing literature, interviews with experts, and site visits to health care systems that are conducting high quality work to improve health equity within their organizations and in communities:

- Make health equity a strategic priority
- Develop structure and processes to support health equity
- Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact, such as health care services, socioeconomic status, physical environment, and healthy behaviors
- Decrease structural racism within the organization
- Develop partnerships with community organizations to improve health and equity

Local insights

The role of health care in reducing health inequities

There are many local examples of the health care sector implementing upstream efforts to address social determinants, often in collaboration with community partners. Community Health Needs Assessments, required by the ACA to demonstrate community benefit, have helped guide a growing amount of work happening in health systems to address social determinants, work with community partners, and involve community members in developing local solutions to existing barriers. Health care systems interviewed for this study described being more involved in collaborations to improve health, including youth development initiatives, multiple strategies to increase access to healthy foods, screening and referral programs to help patients connect to community resources, as well as a range of other activities.

Some health care organizations are also enhancing community health and well-being by updating their procurement and vending practices to support the local community. One system is working toward supporting local and minority-owned businesses. Others have shifted toward purchasing local and seasonal foods, which supports local growers and stronger local food economy. A number of health care organizations are attempting to address homelessness and affordable housing using a range of strategies, from improved screening and referrals to community-based programs to more intensive programs that ensure patients with chronic health needs have secure housing. Multiple health care systems noted that their own employees suffer from the same needs identified by the patients and communities served by their system. One organization has a program in place to provide healthy foods to employees at a discounted rate. Housing is another issue impacting employees; one system representative noted that an entry-level nurse in greater Minnesota is able to afford housing while someone in the same position in the Twin Cities is unable to afford housing on their salary.

Through participation and investment in partnerships and collaborations, health care organizations are investing in their communities. An example of an intentional collaborative strategy is the Central Corridor Anchor Partnership. The partnership is enhancing community wealth by investing and focusing on procurement, workforce, and transit for their members, including employees and students.

> *Each Anchor Partner is invested in our physical infrastructure to serve patients, students, and employees along the Central Corridor. We use the term 'anchor' to indicate the important role each partner plays in our local economies and to describe how each partner is anchored to the health, vitality, and growth of the neighborhoods around us.*
>
> — From the Central Corridor Anchor Partnership website (https://www.centralcorridoranchorpartnership.org/)

Local stakeholders saw opportunities for the health care sector to play a larger role in reducing health inequities. Recognizing the influence of the health care sector in local communities, many individuals saw promise in health care working further upstream to address population-level inequities. Local stakeholders who saw that health care systems were often working independently on similar initiatives, also saw potential for greater impact through collective action. However, some individuals cautioned that health care's approach to partnership must change to learn from patients and community members, collaborate with community partners in ways that support their efforts instead of introducing competition, and make changes to standard practices and organizational policies that are barriers to working effectively with communities.

> *I would be most excited to see clarity about the fact that health care organizations can play one piece. What might be the most important thing they could do is to try to invest in their local communities outside of their health care delivery sphere.*

Barriers to advancing health equity in health care

Although the feasibility study did not include a comprehensive review of all work happening statewide, interviews with representatives of multiple health care systems and existing community-based initiatives provided insight into the steps that health care systems across Minnesota are taking to advance health equity. Some examples of changes include: the creation of new positions and internal infrastructure to champion diversity, inclusion and equity initiatives; staff training initiatives; improved use of data to identify and address health disparities; and changes in approach to external partnerships. However, the individuals interviewed also identified a number of barriers to this work. Common types of barriers include external factors, internal infrastructure and structural issues, and organizational culture. These barriers differ somewhat by geographic location, system size, access to leadership, and leaders' understanding of health equity.

Challenges collecting and sharing data

The Centers for Medicare and Medicaid (CMS) Office of Minority Health (OMH) supports entities across CMS and health systems across the country to increase awareness and understand their data. This includes using standardized data collection practices for race and language, producing reports by race/ethnicity, sex, and geography (rural vs. urban). In addition to demographic indicators, OMH is also standardizing social determinants of health measures such as transportation. The goal is share information that is easy to use, is readily accessible, and allows for stratification by race/ethnicity at the county level. However, Minnesota has very strict privacy and confidentiality laws regarding sharing personal information. In fact, the policies are stricter than the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. These laws have restricted health systems' ability to share information across platforms and has resulted in multiple convoluted systems. Interview participants spoke about the importance of being able to collect, review, and use meaningful data in order to guide their practice changes.

One participant described how the ability to review patient data through an "equity lens" or viewing the data by race, ethnicity, and language has enabled a greater awareness about health equity within their system, and has allowed the system to quickly implement changes based on outcomes. Another participant described introducing the "equity lens" to their employees in order to get a better systematic understanding of their experiences of discrimination. Although data are available within their systems, participants described the ability to share data across systems as a way to enhance the work and promote collaboration and coordination of care.

Organizational awareness and capacity

For organizations to address health equity, there needs to be awareness of inequities, a shared understanding of what it means to advance equity, and organizational readiness for change. Champions in an organization doing the difficult and emotional work of advancing equity cannot do the work in isolation; the organization needs to promote efforts to build knowledge and awareness among staff and to create a culture where all staff share accountability for advancing health equity. Some of the health systems in more rural areas of Minnesota described a general lack of awareness and knowledge about health equity, and instead focused their approach on the social determinants of health.

The level of experience organizations across the state have in addressing structural racism varies and, regardless of the starting point, there is more work that can be done. In the metro area, a few participants described health care as an environment that has not grappled with white privilege and struggles with acknowledging structural racism. Going further, because medical providers follow standard care practices designed to treat everyone equally, these systems are not accountable for producing inequities and disparities. Some participants described "Minnesota Nice" as a barrier. In essence, the culture of politeness prohibits hard conversations about structural racism and discrimination because very few individuals are willing to ruffle feathers. A statewide initiative focused on addressing structural racism will need to consider that organizations would be entering the work with different levels of experience, awareness, and readiness for change.

Health care systems are taking steps to increase awareness and knowledge around structural racism and health equity. One participant saw the Statewide Health Improvement Program (SHIP) and the Center for Health Equity at the Minnesota Department of Health as resources for information and guidance. A few participants talked about the importance of building knowledge and awareness by introducing health equity terminology. One participant described creating an environment in which employees have the opportunity to discuss their thoughts and feelings on race without the added pressure of reviewing health outcomes. This practice built trust among employees and made it okay to ask questions and share experiences. Challenges occur when an organization does not promote understanding of or prioritize equity at all levels. For example, in one system, some employees stated that health equity is foundational to the work they do; however, the vision and investment they see from their leadership does not match. In another system, a few leaders are working toward understanding issues related to health equity, but the majority of the workforce believes that racism and discrimination do not occur in their workplace.

Balancing health care delivery with upstream efforts

The primary purpose of health care systems is delivering care; however, health care is also a main economic driver in local communities and an influential sector in statewide policy. For health care systems, balancing the delivery of health care with their role as an enabler of community health and well-being has not been easy. Participants described the challenge of working on upstream factors in fee-for-service environment, while recognizing new value-based payment mechanisms are being established through multiple models (e.g., Accountable Care Organizations (ACOs), Accountable Care Communities (ACC), Accountable Health Communities (ACH)). Reducing health inequities requires upstream, system-level interventions to improve population health rather than downstream efforts to change individual health outcomes. A more holistic perspective, focused on understanding the patient experience for underserved populations and addressing barriers to care, has helped some health care systems develop strategies that reduce health disparities. Offering same-day mammogram appointments, for example, was an effective approach used by one health system to reduce disparities in care for women of color. In some situations, a more holistic understanding of health and cultural values, as well as greater patient engagement in identifying barriers and potential solutions, has led to changes in how organizations measure quality of care and define improvement goals.

Multiple health care systems are also integrating trauma-informed practices into their model of care, particularly in the areas of maternal and child health. Trauma-informed care is an approach made up of multiple components: a safe calm environment to reduce triggers and promote healing; education to understand the links between health and trauma; and regular inquiry about recent abuse, lifetime trauma, and health consequences of trauma. While the use of trauma-informed approaches is a benefit to all patients, specifically targeting these practices to better address the needs of communities who have experienced historical or recent trauma can help address disparities in health outcomes. Adopting trauma-informed approaches requires internal champions to help staff and providers develop the skills to adopt new practices and strength-based strategies.

Prioritization of resources

The majority of health care representatives stated that the current financial environment does not support the reduction of health inequities because there are very few avenues available to them to test new ideas or practices or to fully resource health equity. For example, one participant said that health equity was named as a strategic pillar of the organization, but moving the work forward was slow due to the lack of resources. Recently, the system made the decision to build a team with executive-level accountability and create an operational plan to move the work forward.

Health care organizations in more rural parts of Minnesota face different barriers from those in the Twin Cities metro. For example, in rural areas resources like fast, affordable, and reliable internet are expensive to maintain. In general, infrastructure to support new technology like telehealth or innovation and demonstration projects is hard to implement. Health care organizations in more rural areas in Minnesota are forced to use their development funds to cover the cost. One participant noted that more demonstration projects are needed in rural Minnesota because the organizations exist in a fee-for-service, not value-based, model. For any future statewide initiative, it is critical to recognize that different levels of investment and unique strategies may be needed to work toward common goals across rural and urban settings.

Policy misalignment with upstream action

Interviewees noted misaligned state and federal policy as a factor that prohibited health care systems from investing in reducing inequities and addressing social determinants of health. Most often, this was a reference to reimbursement that incentivizes utilization of high-cost treatment rather than rewarding improved patient health outcomes that reduce the demand for more costly interventions. One participant named the 1115 waiver as a policy mechanism that would enable reimbursement for the social determinants of health. However, each state must seek federal approval to cover non-medical costs using Medicaid funds. Minnesota does not currently have an 1115 waiver pertaining to addressing the social determinants of health (Kaiser Family Foundation, 2019).

Buy-in among leadership

Leadership at the executive and board level is important to advancing health equity. Representatives of organizations interviewed described varied degrees of leadership involvement and influence in efforts to advance equity. Some had leaders who were very engaged, gave power and voice to health equity initiatives, allocated resources, and supported the development of infrastructure including hiring staff solely dedicated to building the capacity of the organization. In addition, some leaders worked with other leaders both locally and nationally to figure out how to best share resources and expertise about their organizations' respective work, and to create partnerships that enabled better support of patients, families, and communities. Within other organizations, a lack of connection from top-level leaders meant that sometimes individual champions pushed the work forward by establishing a program that served a specific need, such as disparities in childhood nutrition or providing culturally sensitive care, while other types of work, such as dismantling structural racism, were slowed down. While individual champions can advance key efforts to reduce inequities, broader organizational buy-in is needed for changes to be adopted more widely, as well as for organizations to effectively collaborate with external partners on aligned efforts to reduce inequities.

Another participant described the importance of board members requesting information on what the organization was doing about health equity. This prompted leaders to create a workgroup dedicated to creating a health equity strategy. On the other end of the spectrum, lack of support from leadership can lead to a lack of dedicated resources or cohesive strategy. While individuals can champion initiatives to advance health equity, concerns about lack of diversity at leadership levels or other institutional barriers to change are unlikely to be addressed without support and buy-in among board members and high-level leadership.

Systems transformation in health care settings

Broadly speaking, eliminating health inequities requires focused efforts to address socioeconomic inequities and structural racism. While this has not been the traditional role for health care, individuals interviewed saw a role for the health care sector to increase its collective capacity and use its influence to help address this gap. Eliminating inequities requires technical changes, which address small, clearly defined issues that set the stage for the broader adaptive changes needed to transform systems (see sidebar). An example of technical change leading to adaptive change is implementing a social determinants of health screening protocol in a primary care setting. Screening protocols that ask patients about food insecurity, housing instability, and social support can lead to referrals to community organizations and greater access to resources. Adaptive change occurs when screening and referral processes are trauma-informed and culturally responsive so that needs are met sensitively and holistically. Similarly, multiple health care systems have developed technical strategies to ensure patients experiencing food insecurity can easily access healthy, affordable food options at a clinic or hospital location. These efforts can lead to more adaptive changes, such as changes in procurement practices and vendor contracts that support local growers and help build a more equitable food system.

Technical problems are easy to identify and can be addressed relatively quickly, often by implementing a known solution. Evidence-based models and standards of practice are examples of technical changes that can be implemented to address health disparities. **Adaptive change** is necessary when challenges are more difficult to define and require novel solutions and action in multiple places, often across systems. Adaptive change is hard to implement for multiple reasons. Solutions to these types of challenges cannot be addressed by implementing a well-established program or changing a single policy. Instead, to address pervasive and complex issues such as health inequities, changes must occur at multiple points, challenge underlying values, and lead to fundamental changes in how work is approached.

Technical changes can be starting points for broader, adaptive changes with community-level impact. Increasing the percentage of health care jobs that provide living wage salaries is an example of a technical change that is a benefit to individual employees. These types of strategies have been used nationally. For example, after finding that that about 10% of employees were making less than minimum wage, the University of Arkansas Medical Center pledged to raise the hourly minimum wage to the regional living wage for all employees who were under the rate within two years. However, for this type of initiative to have a larger community-level impact, adaptive change is required to create local training programs and career pipelines. Similarly, purchasing goods and services from local businesses may be easy for a health care system to do for smaller contracts, but more adaptive changes are needed to change contract terms and other policies for small, local businesses to be able to compete for larger contracts.

Adaptive change, by definition, requires change to take place within systems and organizations working to address inequities. While clear initial steps are necessary, the changes that will ultimately take place within a system are hard to anticipate. The example of Nuka System of Care describes the changes made in one health care institution to fully center their health care delivery model on the needs of its patients and the broader community (see below). The example illustrates how complementary technical and adaptive changes can contribute to systems transformation. For example, although many of the highlighted changes implemented focus on how services are delivered and appointments are scheduled, work to diversify the composition of the system's board of directors and implement approaches to routinely engage patients in identifying problems and potential solutions has enabled these changes to occur and evolve over time.

Nuka System of Care: An example of health care systems transformation

Southcentral Foundation's Nuka System of Care (Nuka), located in Anchorage, Alaska, is an example of health care system transformation. Nuka serves more than 60,000 Alaska Native and American Indian people living in the Cook Inlet region. Prior to Nuka, health services were delivered by Indian Health Services, a system that, while well intentioned, was highly bureaucratic and not centered around patient needs. Employees and patients were dissatisfied with long wait times and overall service delivery, and the system was not achieving improved patient health outcomes. When a compact was established that gave the Southcentral Foundation business and financial responsibility for owning and managing their own health care system, they created a system centered on the goals and values of the community. Nuka began by asking Alaska Native people what wasn't working and what they wanted to see in a new system. Consistent challenges were long wait times, poor customer satisfaction, and a lack of personal connection between providers and patients. Nuka made a number of simultaneous changes to ultimately create a managed care organization where Alaska Native people are no longer patients and recipients of services, but are referred to as "customer-owners" and seen as leaders making decisions in their own care and how the system itself functions.

Nuka looked to other sectors known for providing strong customer service to think about how to approach their work differently. Their approach centers on the experience of individuals seeking care, and building a strong, trusting relationship between the provider or care team and the customer-owner. Nuka has developed training to introduce their approach to new employees and people from other health care systems interested in adopting a similar practice. Ongoing training and coaching is one of multiple ways they support staff and help them develop new skills. Staff retention has increased because of these changes. Nuka seeks feedback from customer-owners regularly in a variety of ways. In addition, Nuka's board of directors is comprised of customer-owners, ensuring that decision-making reflects the values and priorities of community members.

After this system transformation, Nuka's performance outcomes improved dramatically across multiple measures. For example, they have made significant changes to scheduling practices, which has led to a majority of customer-owners receiving same-day care. The system relies heavily on data to monitor performance and improve quality. Care teams review performance for their panels regularly and Nuka leaders interviewed describe teams using the data to learn from one another. As a result of these changes, there was a 36% reduction in both emergency department visits and hospital admissions over a five-year period, and there has been demonstrated improvements across multiple HEDIS (Healthcare Effectiveness Data Information Set) benchmark measures (Southcentral Foundation, 2017). Because of their achievements, Nuka has twice been awarded the Baldridge National Quality Award for performance excellence and innovation.

A framework and action steps for eliminating health inequities

A fundamental question revisited throughout this study is, "What is the role of health care in eliminating health inequities?" While the answer to that question is important, it can also be limiting if considered only in the context of how health care should expand from its current role. Instead, it may be more helpful to ask, "How can health care play a meaningful role to address the barriers to eliminating health inequities statewide?" As stated previously, health care is not solely responsible for eliminating health inequities, but is uniquely positioned to leverage its influence and broaden its impact by redefining its multiple roles:

- **Health care as a provider.** Higher quality care can be supported by gathering and using disaggregated data at all levels of the organization to identify disparities, set goals, and monitor progress. Increasing awareness of structural racism and implicit bias is a first step in changing internal policies and practices that are not aligned with a mission focused on reducing inequities.
- **Health care as an employer**. As a key employer in many communities, health care can make steps to eliminate inequities by adopting goals to increase workforce diversity, establishing career pipelines, and ensuring all jobs offer a living wage.
- **Health care as an engaged and accountable community partner.** Eliminating inequities can only be done through cross-sector collaboration and in partnership with communities. Health care can work at multiple levels to improve access to community resources, as well as to work on higher-level initiatives (e.g., community development). Accountability to community comes through community members informing priorities, setting goals, and receiving updates on progress.
- **Health care as an advocate.** Health care can have a stronger advocacy voice in support of a full a range of policy changes needed to eliminate health inequities, from health care financing (e.g., value-based payment mechanisms) to housing policy and criminal justice reform.

The *Systems Transformation Framework* proposed in this report is based on an assertion that, in order to eliminate health inequities, action is needed at multiple levels. Using the framework as a guide, health care can build on existing efforts and increase its collective capacity to eliminate inequities.

Systems transformation and the role of health care

Eliminating health inequities will require an intentional, multi-pronged approach that focuses on addressing the fundamental social and economic inequities that lead to differences in health outcomes. This is not to say that initiatives focused further downstream to address a single social determinant or to improve access to health care won't have positive impacts. However, decades of work have shown that alone, these types of initiatives are insufficient. The *Systems Transformation Framework* was developed by the Pathfinders Group to guide improvements within health care systems and drive collective action in collaboration with community members and organizational partners.

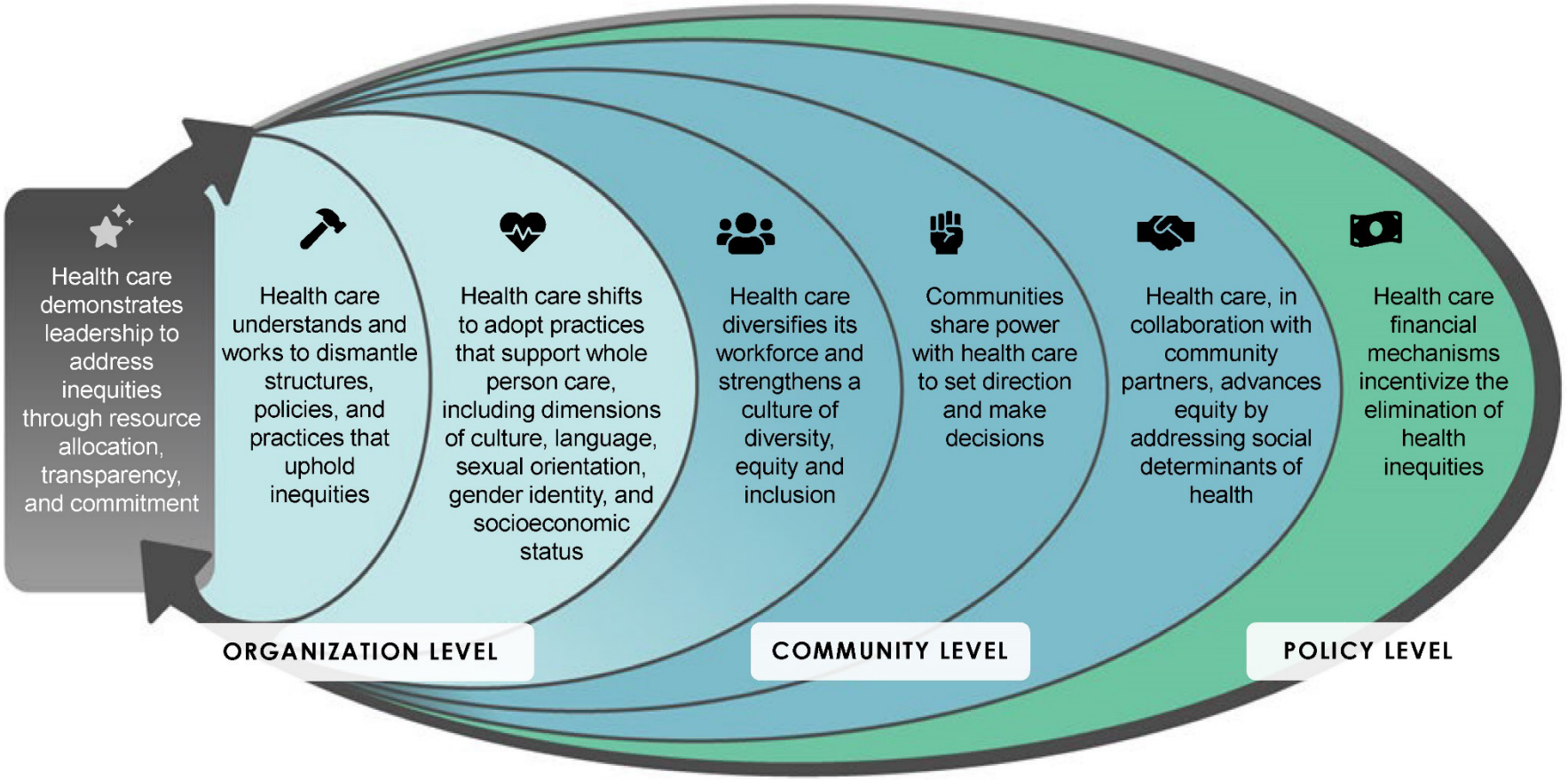
The framework was grounded in the following set of underlying assumptions, developed in partnership with the Pathfinders Group and informed by interviews completed with local stakeholders from multiple sectors.

- **Health care can leverage its influence to help eliminate health inequities in Minnesota.** United States of Care has demonstrated it is uniquely positioned to convene health care systems, health plans, and other key partners to consider how Minnesota can eliminate health inequities. For that reason, this study pays particular attention to the role of health care in this work, while recognizing that eliminating entrenched inequities requires action across multiple sectors and in partnership with communities most impacted.
- **Health inequities are maintained by policies and practices in place across multiple systems, including health care.** While a well-designed program to reduce health disparities can have positive results, to eliminate health inequities, changes must be made to the policies and practices that fundamentally shape how systems and institutions operate.
- **Structural racism is built into our social, economic, and political systems.** While health inequities impact multiple populations, data clearly show that in Minnesota people of color and Indigenous communities have disproportionately experienced poor health outcomes. Any future initiative must include an explicit focus on race, contain intentional actions to disrupt practices and policies shaped by structural racism, and transform systems with a goal of achieving equity for all.
- **Collective action is needed to address issues that no single entity can tackle alone.** As illustrated in this study, multiple entities, including in the health care sector, are already actively involved in implementing initiatives to reduce health disparities and address social determinants of health. Any future initiative should recognize these efforts, but strive for the bold actions and greater impact that can only be achieved through collective action.
- **Communities must be involved in shaping efforts to reduce health inequities, as leaders and with shared power.** In any future initiative, institutions can and should leverage their strengths, but in a way that recognizes and helps to build power in communities to drive change.
- **Eliminating health inequities requires both adaptive and technical change.** An initiative to eliminate health inequities can have multiple intervention points to address technical problems, including clearly defined pilot projects, demonstration programs, and initiatives that increase access to resources and address social determinants of health. However, if the final goal of a future initiative is truly to eliminate health inequities, it should be expected that entities engaged in this work would also address adaptive challenges that are barriers to advancing equity.

Systems transformation framework

The *Systems Transformation Framework* includes seven key elements that address barriers to broader change and that will build the capacity of health care and their partners to reduce health inequities through collaborative action (Figure 6). All elements can be advanced simultaneously and should build on work to advance equity already taking place. By implementing these elements, the health care sector can achieve a vision for having the partnerships in place and infrastructure needed to eliminate inequities through collective action. An expanded description of each element follows (Figure 7).

6. Systems Transformation Framework



7. Key elements of the Systems Transformation Framework

 Health care demonstrates leadership to address inequities through resource allocation, transparency, and commitment	By identifying shared goals and metrics and publically reporting progress, health care can show its commitment to the work necessary to create systems that can eliminate health inequities. This includes creating the infrastructure and governance for health equity and investing in the dedicated resources (human and fiscal) to execute the work. Examples of shared goals and common measures include: investment of community benefit dollars and other investments into community-driven efforts; inter-cultural competency and implicit bias training of workforce, leadership, and board; diverse workforce hiring and retention; transparent reporting of health access, service delivery, and outcomes meaningful to the community.
 Health care understands and works to dismantle structures, policies, and practices that uphold inequities	Disaggregated data needs to be used throughout health care institutions and at all levels to identify and monitor progress toward addressing inequities in access, service delivery, and outcomes. This may include routinely gathering detailed race and ethnicity data, and analyzing data to reflect the intersectionality of identities (e.g., race and sexual orientation). In addition, resource allocations and payment mechanisms should incentivize interventions that measurably reduce disparity gaps, and improve health care/outcomes for populations experiencing health disparities.
 Health care shifts to adopt practices that support whole person care, including dimensions of culture, language, sexual orientation, gender identity, and socioeconomic status	Health care services and payment mechanisms should support whole person care, including dimensions of culture, language, sexual orientation, gender identity, ability, mental health, and socioeconomic status. This includes providing culturally relevant services and resources, and integrating cultural ways of knowing into health care services and practices. Resources need to be allocated for providers to further demonstrate cultural humility and relationship-based care, organizations to offer trauma-informed services, and institutions to help increase the health literacy of patients and community members.
 Health care diversifies its workforce and leadership, and strengthens a culture of diversity, equity, and inclusion	In addition to building on existing initiatives to create a more diverse workforce, health care systems and plans can look inward to promote and hire diverse leadership, and to embed equity goals into job descriptions, performance reviews, and opportunities for advancement. Boards should reflect the communities served by the institution and its partners. Systems should also establish internal infrastructure to support health equity work that has representation and accountability across the organization. Jobs in the health care sector should pay a living wage.
 Communities share power with health care to set direction and make decisions	Communities most impacted by health inequities need to be actively involved, alongside health care leaders, in making collective decisions for directing resources, and to be involved in shaping programs and identifying solutions. Steering committees or patient councils, representative of the community, can provide structure, but require intentional listening and authentic partnership.
 Health care, in collaboration with community partners, advances equity by addressing social determinants of health	Health care should continue to expand efforts to invest in addressing social determinants of health, including navigation, closed-loop referrals, and improving access to care. In addition, health care should look for opportunities to work further upstream to address the root social and economic drivers of health inequities. However, this cannot replace the internal work necessary to dismantle structural racism.
 Health care financial mechanisms incentivize the elimination of health inequities	Health care systems can leverage existing payment models that support value-based care, but also need to advocate for additional changes that incentivize wellness. Pooled funding models can be used by health care systems to invest in strategies developed by or in partnership with communities to address social determinants of health and to eliminate inequities in access to services.

Implementing the framework to support action

The framework and the mechanisms that would support its implementation were developed as a holistic response to address the system-level barriers that impede progress to eliminating health inequities. This section provides additional insights into how the framework can be implemented, how it would address key barriers, its alignment with efforts already taking place, and a suggestion for advancing the work using an anchor mission strategy. While there are details to the approach that have yet to be determined and room for refinement, the next phase of planning work needs to be done with the buy-in of the systems, plans, associations, and institutions ultimately being asked to expand their role and leverage their influence to address health inequities in partnership with community.

Mechanisms needed to support collective action

Collaboration is needed to address the social and economic determinants that lead to health inequities. An initial step in advancing the framework is to secure commitment among health care institutions to ongoing work and collaboration to advance collective actions by forming a new collaborative, referred to in this report as the **Eliminating Health Inequities Partnership (EHIP).** Although eliminating health inequities is not the sole responsibility of the health care sector, a collaborative effort by health care systems, plans, associations, and aligned institutions can have significant influence and build momentum for future cross-sector action. Convening within the health care sector is a starting point for collective action, while also working to expand and diversify EHIP membership to include additional sectors and community partners. Currently, while health care system and plan representatives are involved in multiple networks and initiatives to improve health outcomes, there is not a space dedicated to convening the health care sector with the goals of supporting shared learning and collective action to eliminate health inequities. This lack of collaboration within the sector was identified by many people interviewed as a barrier to having greater impact to reduce inequities. Collaboration within and across sectors is a critical element of many successful initiatives to reduce health inequities (Mattessich & Rausch, 2014).

A backbone organization, or convening entity, is needed to provide infrastructure to move the framework into action. The convening entity would support goal setting and collective action, foster shared learning, encourage innovation, and establish tracking and reporting to ensure accountability. An ideal convener should be neutral, in terms of not giving preference to one partner over another, trusted by communities, and oriented toward a clear focus to expedite bold, collective action. Funding is needed to support the infrastructure required to convene partners, gather information and resources to support EHIP actions, and monitor progress. As further described later in the report, this financial support could come through multiple sources, including state dollars, ongoing commitment of a percentage of health care community benefit dollars, private business, social impact venture capital, social impact bonds, program-related investments (PRIs), or philanthropic sources.

EHIP's structure and approaches should reflect the principles that are embedded in the *Systems Transformation Framework.* A diverse group of community members, representative of the communities impacted by health inequities and active in efforts to advance equity, should be active participants of committees or groups that make decisions and assess progress. It is also critical that EHIP's goals are clearly started, informed by and available to community members, and that the collective actions of the partnership align with these goals.

Specific functions should be in place to support transparency and increase accountability for addressing health inequities, share promising approaches and lessons learned, and catalyze innovation and the expansion of effective approaches. The Pathfinders Group identified two mechanisms, for use after the EHIP partners establish their shared mission and goals, to help the partnership address systems barriers that impede progress toward eliminating health inequities:

- Transparent reporting of progress toward shared goals. Reporting on progress can take place in multiple ways, including some type of certification or rating system to show the degree to which EHIP partners have adopted practices or made changes.
- Support for testing promising practices and expanding effective models. This work, supported with pooled funding, grants, and private investment could be supported administratively through grantmaking functions or in a more robust way, with capacity to evaluate effectiveness and identify the policy change necessary for expansion and financial sustainability. The purpose of this mechanism is to help support sharing of current promising efforts, reduce the risk associated with piloting innovative ideas, and increase shared learning across EHIP members and more broadly.

Within each element of the framework, multiple actions are needed to ultimately achieve systems transformation. While the vision for the initiative is for all EHIP partners working collaboratively to achieve long-term goals, the initial steps and progress made by each partner will be influenced by past efforts, current readiness, dedication of resources, and organizational capacity. The amount of work that can be dedicated to each element of the framework will need to be paced so that the work is impactful and feasible. However, it is important to recognize that multi-faceted work is necessary, as "in most communities, no single initiative alone is transformative—it is only by moving a set of interventions that communities can achieve their goals" (Hacke & Deane, 2017, p. 14).

There are also important opportunities to leverage existing networks also focused on eliminating health inequities, such as with the Healthy Minnesota Partnership or Health Equity Leadership Network, both described earlier in the report. For example, as the EHIPs goals are clarified, understanding how they align with the statewide health priorities developed by the Healthy Minnesota Partnership will help clarify how initiatives happening in multiple sectors are complementary.

Alignment with barriers to reducing health inequities

As part of this feasibility study, representatives of existing initiatives, including leaders in the health care sector, identified a number of barriers that have impeded promising initiatives and other work to eliminate health inequities. The elements included in the framework and proposed mechanisms to implement changes in these areas were developed to address many these barriers (Figure 8). It is too simplistic to assert that these system-level challenges will be easy to overcome. However, the framework offers a holistic approach for the health care sector and its community partners to tackle these issues head-on rather than adopting creative work-around tactics that, although promising, are unsustainable and fail to address the fundamental root causes of inequities.

8. Overview: The framework as a response to barriers identified by stakeholders

Barriers to change	How barriers are addressed through the proposed approach
Information about promising practices and shared learnings is not routinely shared across the health care sector.	The EHIP will be formed, in part, to create opportunities for shared learning.
Data are not consistently used at all levels of an institution or system to understand and address health inequities.	The EHIP will identify common goals and share best practices focused on consistent collection and use of disaggregated data.
Health care services are not designed to address the needs and priorities of community members most impacted by health inequities.	The EHIP will include community partners with equal influence in determining priorities and collective action goals. An element of the framework will encourage EHIP partners to routinely gather community input and include community partners in meaningful decision-making roles.
The health care sector is not accountable for addressing inequities.	EHIP members will develop shared goals; progress toward goals will be reported with transparency.
Current initiatives are designed to address disparities or stop "midstream" to implement programs to improve health or access to resources, rather than addressing root causes of inequities.	Addressing social and economic inequities requires collaboration; the EHIP will focus on collective action and leverage its influence to engage additional partners in this work. EHIP members will develop strategies and best practices for addressing social and economic inequities at the institutional (e.g., procurement) and individual (e.g., livable wage) levels.
Current financial incentives are misaligned with preventive efforts to eliminate health inequities.	Pooling of resources, grants, and direct funding from private and public sources, can be sought to support innovative or promising approaches. The long-term work of the EHIP can include efforts to reform policy.
The current workforce does not reflect the communities served.	EHIP members will develop goals and share strategies and best practices designed for recruitment and retention of a diverse workforce.
Implicit and explicit biases impact patient care and contribute to disparities in health outcomes.	EHIP members will share strategies and best practices designed to increase awareness of implicit bias and tactics to address inequities in care delivery, and to support relationship-based, whole person care.
Leaders, providers, and staff do not have a shared understanding of equity or the practices that can be used to advance equity within institutions and in community.	EHIP members will share strategies and best practices to promote an equity climate; consider shared action steps to promote principles and values that support equity.
Challenges unique to rural settings (e.g., affordable and reliable internet connection, transportation, data infrastructure) are difficult to address by individual health care systems.	EHIP collective action goals can include priorities for rural communities, including coordinated advocacy; EHIP members will have opportunities to develop and test innovative strategies and share promising approaches.
Communities most impacted by inequities distrust the health care sector and systems that have not addressed barriers to health and well-being.	Representatives of communities impacted by inequities will be active partners, engaged in the work of identifying collective action goals, strategies, and mechanisms to ensure transparency and accountability.

Alignment with other initiatives

When working to eliminate health inequities, there aren't established best practice models to adopt that ensure success or that provide a clear roadmap to follow. Social and economic inequities are deeply entrenched and both caused and reinforced by multiple systems, current or historical unjust policies, and biased practices.

As previously noted, the Minnesota Statewide 2022 Priorities and many of the key conditions outlined in the plan align well with the proposed framework, particularly objectives to improve economic well-being and to engage populations in decisions that shape health and well-being. Further, because these priorities were created by the Healthy Minnesota Partnership and the various health care systems and professional associations who are members of the group, there is opportunity to determine how work taking place across multiple sectors can best align and act in complementary ways.

There are also national frameworks and initiatives seeking strategies to address structural racism and other root causes of inequities. A number of these initiatives include strategies that align closely with elements of the framework, or share a similar philosophy about what is needed to eliminate health inequities. These initiatives can be both resources to advancing a statewide initiative and collaborators to share lessons learned and promising approaches. Key initiatives include:

- **American Hospital Association (AHA). *#123for Equity Campaign.*** Launched in 2015, the #123for Equity pledge campaign was launched to ask hospital and health care leaders to take key steps to accelerate progress to a) increase the gathering and use of race, ethnicity, and language preference (REAL) and other demographic data; b) increase cultural competency training; c) increase diversity in leadership and governance; and d) improve and strengthen community partnerships. As of July 2019, the Minnesota Hospital Association and 57 additional organizations in Minnesota have taken this pledge (37% of organizations in Minnesota; American Hospital Association, n.d.). Through the campaign, organizations submit accomplishments related to their work toward achieving each of the four priority goals. AHA encourages progress with annual awards, brings attention to promising practices, and creates and shares resources.
- **Institute for Health Care Improvement (IHI), *Achieving health equity: A guide for health care organizations.*** The framework developed by IHI includes five components that align closely with the framework proposed in this report. These components are: a) make health equity a strategic priority; b) develop structure and processes to support health equity work; c) deploy specific strategies to address multiple determinants; d) decrease institutional racism within the organization; and e) develop partnerships with community organizations to improve health and equity. In their framework, IHI asserts that "most health care systems are designed to produce inequitable outcomes" and that "any organization that wants to improve equity must be prepared to fundamentally change the current system that is producing disparities in health outcomes" (Wyatt, Laderman, Botwinick, Mate, & Whittington, 2016, p. 10). An adaptation of the IHI Health Equity Self-Assessment Tool for Health Care Organizations included in the white paper could be used as a baseline assessment for EHIP partners to use to develop common language, determine existing capacity, and prioritize what is most important to address collaboratively.

- **Government Alliance on Race and Equity (GARE).** GARE is as a national network of over 170 government entities, including cities in Minnesota, working to achieve racial equity and advance opportunities for all. GARE's training and tools focus primarily on racial inequities, while recognizing that the same approaches can be used with other marginalized communities. Similar to this framework, GARE emphasizes the need for internal capacity building while also recognizing that government entities must work with partners to achieve meaningful results. Members of the network do not collaborate on collective actions, but receive similar training, access to resources, and opportunities to share with other network members to advance work in their own communities.
- **Rating scales, certification programs.** Multiple sectors and initiatives use ratings or certification programs to support quality improvement or adoption of best practices. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) has used ratings or categories as part of various initiatives, including efforts to encourage the integration of behavioral health services and primary care (Heath, Wise Romero, & Reynolds, 2013). These categories can be used for research purposes so that models that achieve positive outcomes can be identified, as well as to demonstrate adoption of best practices or achievement of specific goals. In this framework, the Pathfinders Group members were interested establishing ratings to encourage progress, improve transparency, and increase accountability to communities.

Entry points for adopting the full framework

Elements of the framework may look familiar, as many are aligned with work already happening in health care systems and across multiple sectors. The internal-facing elements presume that changes are needed within each EHIP organization to dismantle structures that uphold structural racism or that do not enable whole person care. The framework also recognizes that work to eliminate health inequities requires collective action, supported by cross-sector partnerships, community involvement, and sustainable policy and funding mechanisms. By committing to advance both the inward-facing and community-facing framework elements, implementing the framework strengthens and broadens the work health care is doing to reduce health inequities in each of its roles (e.g., provider, employer, partner, and advocate).

While recognizing that developing a model for collective action must be done in partnership with those committed to doing the work, some clearer options are needed to consider how this work could be pursued. The anchor mission strategy highlighted as a potential entry point is an approach that is becoming more widely used nationally. While it does not contain all the framework elements, it can be the basis for establishing a more holistic statewide approach. This section also provides examples of other initial steps or topic areas that could be integrated into an anchor mission strategy or advanced in other ways.

An anchor mission strategy as an entry point for collective action

An anchor mission strategy is a promising approach for addressing the root social and economic drivers of health inequities. Hospitals, clinics, and other health care institutions are anchor institutions in many local communities. They are tied to their local community by mission, as an employer, through their capital investments, and as an organizational partner. By adopting an anchor mission approach, these institutions commit to working in partnership with community to leverage their economic power to mutually benefit the long-term well-being of both (Norris & Howard, 2015).

> **Anchor institutions** are enterprises, such as universities and hospitals that are rooted in their local community through mission, invested capital, or relationships to customers, employees, and vendors. Institutions that adopt an **anchor mission** are committed to applying their long-term, place-based economic power in combination with their internal resources, to improve the health and wealth of the communities where they are located.
>
> — adapted from the Democracy Collaborative

Health care organizations, which are often among the largest employers in communities and spend millions of dollars on procurement of services, are among the institutions seen as having the capacity to help drive broader economic change in local communities and regionally. As the concept has evolved, it has become more solidly aligned with values of community engagement and adopting growth strategies that also benefit residents of local communities (Harkavy, Hartley, Hodges, Sorrentin, & Weeks, 2014). At a basic level, an anchor mission approach focuses on changing the business practices of large institutions to leverage their economic power in ways that help increase community wealth and improve the community conditions that influence health. Changing current hiring, procurement, investment, and land use policies and practices to more directly serve the needs of low-income and under-resourced communities can advance the goals of racial and economic equity (Ubhayakar, Capeless, Owens, Snorrason, & Zuckerman, 2017). A measurement dashboard developed by the Democracy Collaborative identifies key indicators that anchor institutions can use to assess the degree to which their current efforts benefit the community and to measure progress (Figure 9). Gathering this baseline information from health care systems can help inform clear goals for improvement.

9. Anchor Mission Community Benefit Dashboard

Topic	Indicators
Equitable local and minority hiring	■ Percentage of local and minority hires in staff positions ■ Percentage employed at livable wage or above
Equitable local and minority business procurement	■ Percentage of procurement dollars directed to local, minority-owned, and women-owned businesses
Affordable housing	■ Dollars invested in creating affordable housing ■ Dollars invested in community land trusts ■ Percentage of households below 200% of federal poverty line that spend more than 30% of income on housing

Source. Democracy Collaborative (2014)

9. Anchor Mission Community Benefit Dashboard (continued)

Topic	Indicators
Thriving business incubation	■ Jobs and businesses created and retained (1 year, 5 years) ■ Percentage of incubated businesses serving low-income and minority populations ■ Dollars directed toward seed funding for community-owned business
Vibrant arts and cultural development	■ Dollars spent on arts and culture-based economic development ■ Number of arts and cultural jobs and businesses created and retained
Sound community investment	■ Percentage of endowment and operating dollars directed toward community impact investment (e.g., support of community development financial institutions)

Source. Democracy Collaborative (2014)

An anchor mission approach provides a framework to reassess the policies and practices that influence how investment and procurement decisions are currently made and to align those decisions with a clear strategy to improve the health and wealth of communities (Kelly & McKinley, 2015). In that regard, the approach disrupts traditional economic development that focuses exclusively on the cost benefit to the institution. Institutions adopting an anchor mission strategy need to reassess the expectations for the financial impact of their work, aiming for revenue neutral approaches or taking a certain level of loss in order to increase social benefit (Ubhayakar et al., 2017).

Institutions that have adopted an anchor mission approach independently or as a collective with shared interests and priorities have used this approach in a variety of ways to bring economic and health benefits to communities. Workforce development and local hiring is often a primary focus in an anchor mission strategy. Affordable housing investment is another common area of focus that is advanced through the institution's own capital projects or through pooled funding models to support the development of affordable housing. The anchor mission approach can be applied more broadly, as well. For example, multiple institutions have begun their anchor mission work by focusing on food procurement and complementary initiatives to improve the quality of food purchased by the institution, support local food growers, and reduce food insecurity in the community. Other institutions have focused specifically on strategies that benefit a largely agricultural-based community or to support a goal to become carbon neutral.

Rush University Medical Center/West Side United - An anchor institution collaboration model

Rush University Medical Center, located in Chicago, Illinois is a member of West Side United, a collaboration of health care systems, institutions, and residents that have adopted an anchor mission strategy to improve community health. The collaborative has the shared goal of reducing the current 16-year gap in life expectancy between residents living in West Side neighborhoods by 50 percent by 2030. Together, these institutions employ more than 43,000 people, hiring 6,000 annually and spending $2.8 billion on supplies and services. Rush is currently the fiscal agent for the partners, and contracts with consultants to facilitate the work moving forward. They are in the process of establishing a community advisory committee and have a vision of eventually developing a 501(c)(3) to convene partners and manage collaborative efforts.

The group has adopted a five-point strategy to improve community wealth: 1) hiring locally and developing career pathways; 2) identifying and partnering with local businesses; 3) social impact investing; 4) volunteer activities that support the community; and 5) hiring local contractors for capital projects. Adopting these changes has required Rush and other participating hospitals to make changes to its existing policies and practices to pay vendors more quickly, remove unnecessary contract components that are burdensome to small businesses, and hire a local recruiter familiar with the community.

As part of its broader efforts to transform systems to improve health, all hospitals that are involved in West Side United have set goals for hiring residents living in the community and creating career pathways to provide education and training. In the past year, an 18-month medical assistant certification program was launched. Program participants receive training at no cost and additional support, such as transportation assistance or individual coaching, to address barriers to their involvement. The first pilot began with 35 participants. They plan to expand the career pathways work to reach 375 individuals through additional cohorts in areas of information technology, nursing assistants, and nursing. Other strategies include providing grants to local organizations to increase community health worker services, working with community development financial institutions (CDFIs) to help source local projects looking for capital investment, and smaller social impact investments.

Advantages to the approach

Alignment with the *Systems Transformation Framework*. Adopting the anchor mission model as a collective action to be implemented as part of the broader *Systems Transformation Framework* presented in this report would create shared accountability, opportunities for shared learning, and agreement to work toward bold goals that would not be possible for a single entity to achieve independently. Intentionally integrating principles of community investment into a statewide anchor mission approach would also help ensure economic benefits are directed to communities, which can help reduce economic inequities.

Redirection of existing dollars. Adopting an anchor mission strategy does require investment, but much is done by redirecting current spending and allocating resources in ways that invest in local communities.

Potential for addressing changing priorities. An anchor mission approach has been used to advance a number of different types of strategies for local hiring, procurement, investing, and land use to advance racial and economic goals. The first priority for a collective anchor mission strategy may be relatively small in scale to reflect current readiness and capacity. As the work matures and strengthens, the infrastructure can help support work to address more challenging issues.

Available tools and resources. The National Task Force on Anchor Institutions, the Build Healthy Places Network, and the Democracy Collective have supported the work of anchor institutions nationally. These organizations provide resources, technical assistance support, and help establish and foster networks of organizations focused on advancing this work. The experiences of the few health care systems and other institutions in Minnesota adopting an anchor mission strategy should also inform how the collective work can best be supported and strengthened.

Potential challenges

Maintaining alignment with the broader framework. While the anchor mission strategy can create some clear structure to a future initiative, the approach must be implemented in a way that aligns with the principles inherent in the *Systems Transformation Framework* in order to advance equity. Members of the Pathfinders Group and other local stakeholders clearly and consistently identified the need for health care to make changes to existing policies, practices, and structures to address structural racism, increase the diversity of staff, leaders, and board members, and provide holistic care to patients. To be responsive to communities experiencing inequities, the anchor mission strategy needs to be implemented as a component of the broader framework, not a stand-alone initiative.

Ensuring benefit to community. It is critical that community residents benefit from the financial investments made in the community and are partners in identifying priorities. The risk of gentrification and displacement is present in any type of community investment initiative, and has been the result of some early anchor institution initiatives (National Academies of Sciences, Engineering, and Medicine, 2017). Any initiative to increase investment in communities must be closely measured to ensure community members themselves experience benefits and are not displaced due to higher home values or increased rent. It is critical that measures of community benefit, as well as measures of potential negative impacts are developed in partnership with community members, reported with transparency, and used to quickly change, when needed.

Comfort as an early adopter. While there are local and national examples of promising anchor mission work, the approach is relatively new and does not have the same evidence base as more established programs or interventions. Being an early adopter of a promising approach may be an exciting opportunity for some health care systems and plans, while being perceived as introducing too much risk to others. Adopting an emerging strategy creates an opportunity for Minnesota to be a national leader in advancing a strong collective action initiative. However, implementation must be monitored to make adjustments to the pace and scope of work, particularly any unintended negative consequences in communities.

Organizational capacity. Adopting an anchor mission strategy requires buy-in from leadership and dedicated staff time to support the work across departments or business units most closely involved in the work. In addition, a number of institutions, particularly those focused on workforce development, have hired community liaisons to build the relationships needed for successful local hiring initiatives or career managers to better support advancement within the institution.

Financing. A key concept of an anchor mission strategy is redirecting current spending and investment in ways that benefit community. However, investment of time and resources within an organization and funding to support a strong backbone organization is also needed.

Additional examples of potential entry points

There are a number of other potential entry points for each of the framework elements. The figure below offers examples of early action steps that could be taken to share information across EHIP organizations, gather baseline information, develop shared goals, or implement common practice standards. In practice, these initial steps should be clearly aligned with goals defined collaboratively as part of the work moving forward.

10. Potential entry points for adoption of the Systems Transformation Framework

	Potential entry points
Health care demonstrates leadership to address inequities through resource allocation, transparency, and commitment	■ Provide dedicated support for the convening entity and commit staff time to participate in partnership meetings and activities. ■ Sign a statement to demonstrate organizational commitment to working to advance goals identified by the EHIP partners.
Health care understands and works to dismantle structures, policies, and practices that uphold inequities	■ Provide implicit bias training and workshops on addressing structural racism. ■ Adopt common practices to report patient outcome and experience information using disaggregated data at all levels of the organization (front line to board of directors).
Health care shifts to adopt practices that support whole person care, including dimensions of culture, language, sexual orientation, gender identity, and socioeconomic status	■ Provide training to providers and staff on trauma-informed models. ■ Conduct a baseline trauma-informed organizational assessment to identify how physical spaces, processes, and interactions can improve to reflect trauma-informed principles.
Health care diversifies its workforce and strengthens a culture of diversity, equity, and inclusion	■ Report baseline workforce, leadership, and board diversity data. ■ Convene representatives from local universities and colleges, health care, and other sectors, to identify alignment between workforce needs and current academic programs.
Communities share power with health care entities to set direction and make decisions	■ Establish a diverse group of community partners to participate in the EHIP and have influence in establishing priorities for collective action.
Health care, in collaboration with community partners, advances equity by addressing social determinants of health	■ Share current practices and lessons learned across organizations on best practices in closed-loop referrals to community resources.
Health care financial mechanisms incentivize the elimination of health inequities	■ Establish commitments among EHIP members to establish a pooled "innovation fund" to foster the development and piloting of new ideas.

In addition to considering the smaller action steps that align with each element of the framework, there are additional topics that could be advanced through an anchor mission strategy or by funding innovative programs using pooled resources.

- **Mental health, substance use.** Mental health and substance use are among the most common concerns identified by community members across hospitals' community health needs assessment processes. Individuals with mental illness, as well as individuals who abuse substances, experience poorer health outcomes than the population overall. These health concerns were mentioned in some interviews conducted with representatives of existing initiatives working to eliminate health inequities, who noted that these populations have difficulty maintaining employment and stable housing. There are a number of efforts in place in Minnesota to expand the continuum of services available to children and adults. Behavioral Health Homes and Certified Community Behavioral Health Centers are two models of integrated care that have recently been piloted in the state and that have received funding to continue or expand. A future initiative prioritizing workforce development could consider recognizing concerns about workforce shortages, particularly among child psychiatrists and mental health professionals.
- **Affordable housing, supportive housing.** Community grants or other philanthropic funds often used by individual hospitals and health systems to support community health and well-being are unsustainable or insufficient to support large projects or ongoing support (American Hospital Association, 2019). Models that pool resources across systems or that shift from spending to upstream investing for financial return are relatively new for health care, although are becoming more common. This is not an area where health care needs to take a lead, but where it can bring resources, influence, and support to strengthen and expand existing initiatives.

  A continuum of services and housing options, including supportive housing, is needed to eliminate and prevent homelessness (Minnesota Housing, n.d). A number of pilot Housing First models have shown positive results, as have supportive housing programs. These models and programs address housing along with meeting physical, mental, and chemical health needs. A barrier to these programs being adopted more widely is that they are resource-intensive and do not yield the financial returns of other types of initiatives. However, these types of programs are successful and critical to eliminating inequities resulting from homelessness.
- **Workforce development.** With the health care sector employing approximately 13% of the workforce in Minnesota, increasing the number of people from communities with lower employment rates who are seeking and obtaining employment in high-demand jobs in the health sector could be a step to reducing inequities (Kaiser Family Foundation, 2018). These jobs include registered nurses, nursing assistants, medical assistants, and mental health counselors (Minnesota Department of Employment and Economic Development, 2016). Hiring a more diverse workforce is also an important step in health care systems providing culturally responsive care and reducing bias in internal policies and practices. Multiple approaches may be needed to increase the number of people interested in and with the skills necessary to join the health care work force.

  Workforce development efforts, both in health care and in other sectors, are in place in some areas of the state, and can be models for expansion or development of new pathway programs. The California Endowment put significant support behind career pathway programs in its 10-year Building Healthy Communities initiative and could be a potential future collaborator in identifying effective strategies to build career pipelines.

- **Food insecurity.** Food insecurity has also be the focus of some anchor collaborative initiatives, as it is a topic where improvements can be made using technical strategies and where institutions tend to have some existing experience. There are a number of health systems that have already taken steps to address food access through various initiatives. In addition, the Minnesota Food Charter includes a wide range of potential strategies to address issues related to food insecurity (http://mnfoodcharter.com). However, if any statewide initiative is considered, it should be done so with the recognition that health care needs to engage in the work as a partner, rather than driver, particularly in local communities where there are community-led initiatives underway.

Additional considerations for a future initiative

A successful collaborative effort to eliminate health inequities will require a commitment to a clear vision and infrastructure that supports action. Information from the interviews with local stakeholders and representatives provided some additional insights into how to foster collaboration, innovation, and shared goal setting.

Role of a convening entity. A backbone organization or convening entity can play a major factor in the success of an initiative. A review of best practices among collaboratives that have adopted an anchor mission strategy found that "collaboratives can easily get stalled in their work and become unable to launch joint projects by under-resourcing their backbone organization or making the mistake of not having a back-bone role at all" (Porter, Fisher-Bruns, & Pham, 2019, p. 29). For the approach proposed in this report, a convening entity needs a broad set of skills and enough capacity to support collective goal setting and action across all elements of the framework. A self-organized alliance, may not have enough infrastructure to help the number of partners likely to be involved reach consensus, implement collective action, and regularly track and report progress.

Early wins and long-term goals. Eliminating health inequities requires long-term commitment and persistence. This study focuses on establishing a vision for success through collective action. However, long-term success cannot happen without short-term wins that build trust and shared confidence. The steps necessary for short-term wins depend in large part on the decisions made by the Steering Committee, buy-in among partners, and readiness for action. A critical component of the next phase of work, the commitment and capacity building phase, is identifying and taking action on these initial steps.

Considering rural, suburban, and urban needs in a statewide initiative. Although in this report, health care is described as a homogenous sector, there are important distinctions and unique considerations about where health care is delivered and in what type of setting. For example, health systems in rural settings face unique issues related to transportation, availability of resources, workforce shortages, and overall capacity (Taylor, 2019).

Fostering innovation. The Pathfinders Group envisioned the Center for Innovation as a mechanism to reduce the financial and reputational risks of piloting new strategies and to support shared learning. There are a number of ways that organizations have tried to create space and flexibility for new ideas, including broad grant initiatives open to community-based organizations and divisions within health care systems that use data to identify disparities and measure the impact of performance improvement strategies. Upstream Health Solutions (a project of Hennepin Health in Minneapolis, MN) and Avia (located in Chicago, IL) are two of many emerging businesses focused on improving health outcomes through innovative strategies. There are unique aspects to how each of these businesses approach their work. Upstream Health Solutions, for example, uses Human-Centered Design (HCD) to center the interests and experiences of patients in how they approach their work. The HCD approach, which focuses on learning from "extreme users" to understand the problem, brainstorm potential options, and use rapid prototyping to test and refine solutions, has also been used by multiple health care systems as part of their performance improvement efforts. Avia is a company that has focused on developing technology solutions that can be easily implemented by health care systems. These are just two companies that could be partners to the EHIP and help create technical solutions that can support eventual adaptive change.

Targeted universalism. Common goals are often difficult to identify and achieve, because multiple tactics are necessary in order to customize and adapt to meet the unique needs of specific populations. Negative consequences can occur without fully considering the impacts of changes in policy and practice on specific populations. For example, efforts to improve health that are not targeted to lower income residents are likely to increase socioeconomic inequities because they will be used more readily by people with more resources to act (Adler & Newman, 2002). Targeted universalism may be an important concept for the EHIP to use when developing its goals and determining how to measure progress. Targeted universalism is "based on exploring the gaps that exist between individuals, groups, and places that can benefit from a policy or program and the aspiration-establishing goal" (Powell, Menendian, & Ake, 2019, p. 7). For example, a school wanting to achieve a reading proficiency goal may create different types of learning opportunities to meet the needs of different groups of students in order to achieve a broader goal. This aligns with other recommendations to "center at the margins" to ensure that health care focuses on the experiences of marginalized groups most burdened by health inequities, rather than focusing on the dominant majority or average outcomes for all patients (Hardeman, Medina, & Kozhimannil, 2016). These frameworks can be useful in both ensuring interventions address the needs of marginalized populations, and developing smaller, manageable goals that align with an ambitious vision.

Collective versus individual action. Health care systems and community organizations working to improve health are balancing a number of competing priorities. The EHIP is intended to provide a platform for addressing the social and economic factors that contribute to health inequities, while recognizing that other work, unique to each partner and responsive to local community needs, must also move forward.

Financing considerations

Funding mechanisms will need to be created to support this work. The prevailing financial model prioritizes treatment for acute and emergency care, which reduces money available for more preventive health activities and establishes a reinforcing loop of disinvestment in upstream activities (Collective Action Lab, 2017). Sustainability and leveraging of potential funding sources are necessary aspects of any future initiative. The most appropriate funding mechanism should align with the breadth and depth of work undertaken by the EHIP and the infrastructure needed to support collective action. Potential options include:

- **Community benefit dollars.** According to data provided by the Minnesota Hospital Association, hospitals in the state invested nearly $70 million in 2017 to community benefit initiatives, a 58% increase from 2010 when the Affordable Care Act was implemented. These initiatives include community-driven programs to improve health, and services that increase access to health care services (e.g., free immunizations and dental services). A dedicated percentage of dollars from each EHIP member organization is another option to foster commitment and establish regular funding.
- **Pay for success financing.** While still in its infancy, pay for success (PFS) or "social impact bonds" have been used in some states and the United Kingdom to finance interventions to improve population health and advance equity, often through specific programs. In a PFS financing model, investors, which include investment banks, foundations, private investors, trusts, and nonprofit organizations, fund interventions and receive a return from a government payer if specific pre-determined outcomes are reached. This approach has been used to fund initiatives to improve early childhood education, reduce homelessness, and avoid criminal justice recidivism. The model is not viable in all circumstances, but does create a mechanism for private-public partnerships in some circumstances (Lanz, Rosenbaum, Ku, & Iovan, 2016).
- **Philanthropic sources.** Minnesota has a strong philanthropic sector that could be approached to support the initiative. However, philanthropic funding can present risks to sustainability, particularly if funders move away from supporting large, multi-year initiatives. Recognizing that the *Systems Transformation Framework* aligns closely with the four elements of the Robert Wood Johnson Foundation's Culture of Health Framework, grant opportunities from this national funder should be strongly considered. It is likely that a key aspect of the convening entity's work will be to seek ongoing grant dollars.
- **Program-Related Investment.** Recognizing that funding for any collective action will require funding from a variety of sources, program-related investments (PRIs) may provide the flexibility needed to support future work. PRIs are investments that private foundations and public charities can make to advance their charitable missions through the work of any type of entity. In addition to the benefits of pooling resources, PRIs can earn financial returns that can then be directed to new charitable uses.

- **Community investment.** A small number of bold and innovative health care systems have used community investment principles to expand their role into the area of community development and strategies that address income inequality and community wealth building (Hacke & Deane, 2017). A community investment approach can be embedded within a broader anchor mission strategy or to advance a specific topic area. Affordable housing is the most developed sector where this work is taking place, largely because there are experienced developers and investors in place across the county (Hacke & Deane, 2017). However, there are examples of health care investing in new technology, as well. Other types of community investment include low-interest loan programs for small businesses or investment in Low Income Housing Tax Credit funds to support new affordable housing projects for specific underserved populations. These types of initiatives require financial investment and draw more broadly on other strengths of the health care sector, including: organizational partnerships and networks, experience in contracting and procurement, and health data to inform action and measure progress.

Any future initiative should also consider the full range of options for the flexible use of Medicaid dollars, including the use of value-based purchasing, waivers, and alternate payment models. A number of factors need to be considered when determining the viability of these potential options, including: anticipated time before financial returns are realized, and confidence in the success of the intervention. A funding commitment from EHIP members, ideally supported by grant dollars, is likely necessary for the commitment and capacity building phase of work. Multiple funding sources will be necessary to support the infrastructure and investment required to support collective action and adoption of the framework.

Recommendations

This report sets a vision for the work needed to transform systems and create a stronger infrastructure to eliminate health inequities in Minnesota. It describes how to approach work in communities to address the social and economic drivers of health inequities and the way that, through collective action, health care can help accelerate change. Recognizing that this is challenging work, and that demands for health care reform have introduced new mandates and financial pressure to the health care sector, adopting a more holistic framework to support systems change may appear to be a daunting task. However, when it comes to addressing inequities, inaction is not neutral; it is acceptance of an unjust status quo. Structural racism, as well as social and economic inequities, are often seen as too large to tackle or beyond a sector's scope of responsibility. While it is true that health care is not solely responsible for addressing the root causes of health inequities in Minnesota, what sector has a greater opportunity to leverage its influence to champion the cross-sector work necessary to eliminate health inequities?

Inaction is not neutral; it is acceptance of an unjust status quo.

A key purpose of this project was to identify opportunities for health care and its partners to take collective action to eliminate health inequities in the state. Working in collaboration requires agreement among key partners to imagine what could be possible and to begin with actions that are feasible and strengthen partnerships. As the organizations involved in this initiative weigh possibilities for statewide collective action, there are a number of strategies identified in the framework that can be adopted by individual institutions or broader health care systems to begin or expand efforts to eliminate inequities:

- **Use disaggregated data to identify goals and measure progress.** At all levels of every health care and health promotion organization, from provider performance metrics to board of director reports, disaggregated race, ethnicity, and language data is needed to identify and reduce health inequities. Improvement goals should not only focus on improving outcomes for all population groups, but also on reducing disparity gaps between groups.
- **Move from gathering community input to sharing power with communities to direct action.** Without the involvement of communities most impacted by health inequities, actions to reduce inequities may be a better reflection of what institutions are willing to provide than what is truly needed to support health and well-being. Institutions can begin by broadening community representation in committees and workgroups that set priorities and direction action, and changing policies and practices in grantmaking and community initiatives to ensure action aligns with the interests and priorities of community members.
- **Identify and change internal policies and practices that contribute to inequities and uphold structural racism.** Eliminating health inequities requires health care systems themselves to change. This includes broadening existing workforce diversity and inclusion initiatives within institutions, providing training and revising practices to identify and address implicit bias, and ensuring champions working to advance equity within institutions are not siloed in their work, but positioned to have influence across the institutions. Health care systems can also take steps to recognize and mitigate the impacts of socioeconomic and health inequities among employees by increasing wages, offering robust benefits, establishing career pathway programs, and increasing access to community resources that support health and well-being. However, these efforts should be seen as alignment with, rather than an alternative to, focused efforts to address systemic causes of inequities in communities served by institutions, agencies, and systems.
- **Work to advance local, state, and federal policies that advance equity.** Health inequities are exacerbated by, and can be mitigated through, the policies and financing models present in multiple systems, including health care, education, housing, and corrections. Health care systems and institutions can adopt broader policy platforms to support holistic work across multiple sectors to eliminate inequities.

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Appendix

Participating organizations

Pathfinder Group description

Health Equity Pathfinders Group members provided insight and expertise on health equity. The group included individuals from across Minnesota, representing diverse communities, lived experiences, and expertise. Members brought experience working on health equity initiatives in a variety of contexts and on-the-ground knowledge about effective implementation strategies.

A1. Pathfinders Group

Name	Organization
Dr. Nathan Chomilo	MN Doctors for Health Equity
Santo Cruz	CentraCare
Dr. Julia Joseph-Di Caprio	UCare
Karina Forrest-Perkins	People's Center
Amy Harris Overby	Hennepin Health
Brian Lloyd	Health Partners
Betsy McDougall	Early Childhood Consultant
Mollie O'Brien	Allina Health
Tuleah Palmer	Northwest Indian Community Development Center
Denise Robertson	Health Access MN
Diane Tran	Fairview Health Services
Kuo Thao	Minnesota Department of Health - Center for Health Equity
Stephanie Hogenson	Children's Defense Fund
Anika Ward	Blue Cross Blue Shield Center for Prevention
Stella Whitney West	NorthPoint Health & Wellness Center
Pahoua Yang	Wilder Foundation - Community Mental Health & Wellness

Note: Pathfinders Group members were affiliated with these organizations during the study period.

A2. Steering committee

Name	Organization
Matt Anderson	Minnesota Hospital Association*
Dr. Lynn Blewett	SHADAC
David Crosby	Preferred One*
Senator Dave Durenberger	United States of Care*
Susie Emmert	This is Medicaid, Hennepin Health
Commissioner Jan Malcolm	Minnesota Department of Health
Anne Kanyusik Yoakum	Hennepin Health*
Dr. Rahul Koranne	Minnesota Hospital Association*
Dominic McQuerry	This is Medicaid, Amherst H. Wilder Foundation
John Naylor	Medica*
Allison O'Toole	Second Harvest Heartland
Dr. Craig Samitt	Blue Cross and Blue Shield of Minnesota*
Janet Silversmith	Minnesota Medical Association*
Andy Slavitt	United States of Care*
Mark Traynor	UCare
Dr. Penny Wheeler	Allina Health
Andrea Walsh	HealthPartners*
Jonathan Watson	Minnesota Association of Community Health Centers
Gary Wertish	Minnesota Farmers Union
Donna Zimmerman	HealthPartners*

Note: Organizations with an asterisk (*) provided financial support to the study. The Amherst H. Wilder Foundation also contributed in-kind resources.

A3. Organizations interviewed

Existing initiatives	
African American Babies Coalition	Lakewood Health System
The Alliance	Minnesota Community Measurement
Allina	Minnesota Department of Health, Center for Health Equity
Aqui Para Ti	Minnesota Department of Health
Avia	Minnesota Department of Human Services
Backyard Initiative	Minnesota Food Charter
Blue Cross and Blue Shield of Minnesota Foundation	Minnesota Hospital Association
Center for Community Health	Minnesota Housing
Centers for Medicare & Medicaid (CMS)	National Rural Health Resource Center
Central Minnesota Child Advocacy Center	Nuka System of Care – Southcentral Foundation
Children's MN	Nurse Family Partnership
CLUES	Project for Pride in Living
Commission to End Poverty in Minnesota by 2020	Rush Memorial/West Side United
Cultural Wellness Center	Second Harvest Heartland
Essentia	Silos to Circles
George Family Foundation	Stratis Health
Heart of New Ulm	The California Endowment
HealthPartners	University of Minnesota, School of Medicine – Program in Health Disparities Research
Hennepin Health	University of Minnesota, School of Public Health – Health Equity Work Group
Homes for All Coalition	Upstream Health Innovations
Homework Starts with Home	Voices for Racial Justice
Hope Community	

Social and economic inequities data summary

Access to care: Health insurance

There are notable racial disparities in access to health care insurance although overall percentage of Minnesotans without health insurance is quite low (5%). Nearly one in five (18%) of American Indians and Hispanic residents lack health insurance. Rates of uninsured individuals are also high among black (9%) Minnesotans and persons who identify as more than one race (9%) or another race (24%).

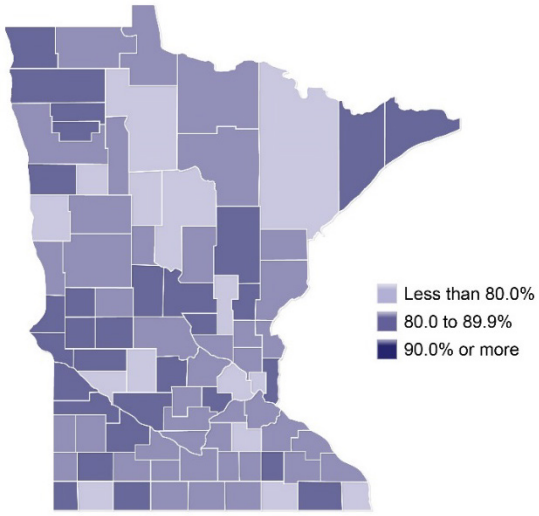
Source. U.S. Census Bureau, American Community Survey; Retrieved from Minnesota Compass. (n.d.).

Education: On-time graduation rate

Minnesota has some of the highest disparities in high school graduation rates in the nation. Graduation rates are lower among students who are English learners (65%) or who receive special education services (62%), than the rate for all students (83%). There are 15 counties with high school graduation rates under 80% (Figure A4). These are located in both urban and rural counties in the state.

Source. Minnesota Compass. (n.d.). *High school students graduating on time, by county, 2017*. Retrieved from https://www.mncompass.org/education/high-school-graduation#1-6079-g

A4. Percentage of high school students graduating on time, 2017



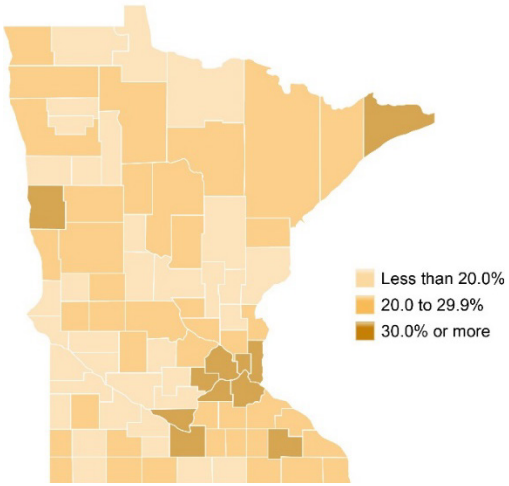
Education: Attainment of bachelor's degree or higher

There is a strong association between education and employment. Unemployment among Minnesotans age 25-64 who held a bachelor's degree or higher was 3% between 2010 and 2014, compared to 7% for those with only a high school diploma and 13% of those without a high school diploma.

Overall, 36% of Minnesota working age adults have received a bachelor's degree or higher, which is above the national average (32%). In 33 Minnesota counties, less than 20% of residents have bachelor's degrees (Figure A5).

Source. Minnesota Compass. (n.d.). *Percentage with a bachelor's degree or higher, by county, Minnesota, 2013-2017*. Retrieved from https://www.mncompass.org/workforce/educational-attainment#1-5285-g

A5. Percentage of adults (25+) with a bachelor's degree or higher (2013-17)

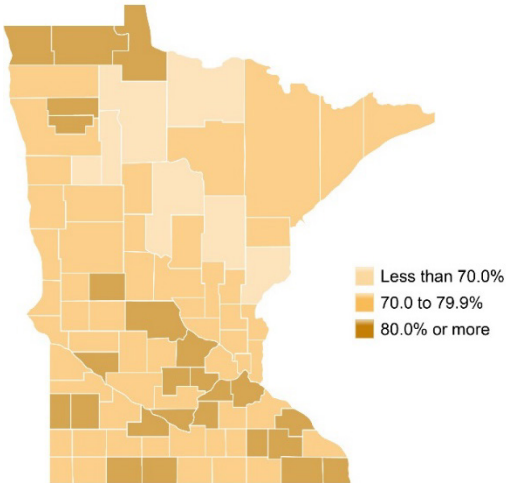


Employment: Percentage of adults working

In 2015, the overall employment rate returned to pre-recession levels (78%) and has remained fairly consistent since. However, this broad measure does not consider the quality of employment in terms of wages. Also, the employment rate excludes adults who have stopped seeking work. Nationwide, Minnesota has the 8th largest gap in employment rates between residents who are white and residents of color. Counties with the highest rates of employment are located in rural and urban areas of the state (Figure A6).

Source. Minnesota Compass. (n.d.). *Proportion of adults working, Minnesota counties, 2013-2017*. Retrieved from https://www.mncompass.org/workforce/proportion-of-adults-working#1-5118-g

A6. Percentage of adults (16-64) working, 2013-17



Socioeconomic status: Median household income and poverty status

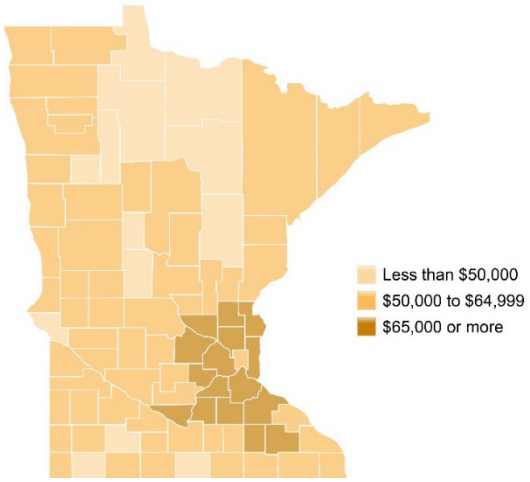
The median household income is twice as high in the most affluent counties in Minnesota (Carver, Scott, and Washington counties), compared to counties with the lowest median income levels (Figure A7). There are also notable differences by race. The median income for a household led by a person who is Asian is nearly $75,000, compared to approximately $38,000 when the head of the household is American Indian or black.

Source. Minnesota Compass. (n.d.). *Median household income, by county, 2017.* Retrieved from https://www.mncompass.org/economy/median-income#1-5354-g

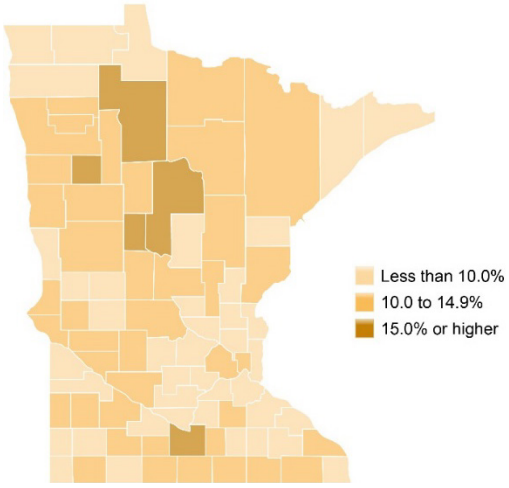
In Minnesota, nearly 520,000 people are experiencing poverty. (The federal poverty threshold for a household of two adults and two children was $24,858 in 2017.) While poverty rates recovered to pre-recession levels (9.5%) in 2017, a smaller percentage of residents were living in poverty in 1999 (7.9%) than today. Five of the six counties where 15% or more of residents are experiencing poverty are in north central Minnesota (Figure A8). Children are also more likely than any other age group to live in poverty. In 2017, the statewide poverty rate was 13% for young children (0-4) and 12% for school-aged children (5-17). Families headed by a single female with one or more children experience poverty at a rate nearly three times higher than the statewide rate.

Source. Minnesota Compass. (n.d.). *Individuals below the poverty level, by county, 2017.* https://www.mncompass.org/economy/poverty#1-5271-g

A7. Median household income, 2017



A8. Percentage of people living below the federal poverty level, 2017

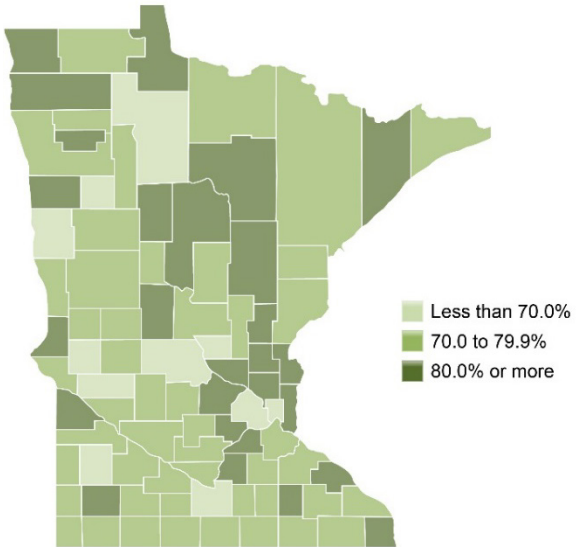


Homeownership rate

Homeownership has historically been a key driver of wealth. However, as a result of past policies, such as redlining and racial covenants that restricted people of color from owning homes, and current disparities in income and access to credit, the homeownership gap between white residents and residents of color in Minnesota is the 3rd highest in the nation (36%). Three counties have homeownership rates under 65%: Ramsey, Blue Earth, and Hennepin. Among homeowners, 18% pay more than 30% of their income toward housing. This is higher among rental households (46%).

Source. Minnesota Compass. (n.d.). *Homeownership rate, by county, Minnesota, 2013-2017.* https://www.mncompass.org/housing/homeownership-gap#1-5163-g

A9. Homeownership rate, 2013-17



ICSI review of existing programs in health care

In 2019, a survey was sent to Institute for Clinical Systems Improvement (ICSI) member health care organizations and systems, asking them to identify their current efforts to address social determinants of health. The following health care institutions and systems participated in the survey: Allina, Blue Cross Blue Shield of Minnesota, CentraCare, Children's Hospital, Fairview, HealthPartners, Hennepin Health, Hutchinson Health, Lakewood, North Clinic, North Memorial, UCare.

Results from the survey showed that a wide range of initiatives are already in place across the state to support economic stability, address food insecurity, support early childhood education and higher education, increase access to opportunities for physical activity, improve access to reliable transportation, prevent violence, increase access to mental health services, improve neighborhood conditions, and address other community needs. This wide-ranging list illustrated both the need for a broad set of strategies to respond to the priorities and interests of local communities and the potential benefits that could come through shared learning and greater collaboration across systems.

Acknowledgements

Our appreciation is extended to the members of the Pathfinders Group for sharing their time and expertise to develop this vision for collective action and a statewide initiative. We also appreciate the time given by the many organizational representatives who were interviewed over the course of this project, who shared their experiences and helped identify gaps that need to be addressed if health inequities are to be eliminated in Minnesota.

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