

DATE: June 4, 2026

TO: Members of the Health Equity Advisory and Leadership (HEAL) Council

FROM: Commissioner Brooke Cunningham, MD, Minnesota Department of Health

RE: MDH Response to the 2025 HEAL Council Letter to the Commissioner

Dear Members of the HEAL Council,

Thank you for the 2025 Letter to the Commissioner, "A Guide to Leading with Love Amidst a Budget Deficit." We appreciate that the letter roots its recommendations in the experience of communities most harmed by health inequities and asks MDH to lead with intention and love, rather than react from scarcity. Your letter reminds us that scarcity, when managed without an equity frame, often creates additional harm. The outgoing council's decision to document both its recommendations for MDH and a set of institutional recommendations for the incoming council is an act of remarkable stewardship. It demonstrates the council's care for communities most impacted by health inequities and a clear investment in our partnership, for which we are grateful.

We will heed your caution about a "scarcity mindset," and we would like to share additional details about the context in which we, as an agency, currently operate. As you may know, the last of our federal funding used to support our COVID-19 response and recovery ends in July, which means several important MDH-led programs are winding down. At the same time, we are fighting the federal government in court to prevent them from cutting other grants that fund critical services and programs in communities and that support people, services, and systems. At the state level, Minnesota anticipates a "structural deficit" next year, which means that if state spending remains the same, the state will spend more than it takes in. Meanwhile, public health workforce capacity and morale have eroded as our work has been adversely affected by ongoing uncertainty, layoffs, and the dismantling of public health at the federal level.

In times like these, it is more apparent than ever that MDH cannot advance health equity alone. We need our councils, community partners, Tribal nations, local public health departments, other state agencies, healthcare institutions – and all who share our vision that everyone should have the opportunity for good health – working together to reimagine a better future, which includes shaping public health programs. Our reflections and commitments in this letter are a first step toward acknowledging and responding to your recommendations. We look

forward to continuing the conversation at council meetings and other gatherings in the weeks and months to come.

Response to Recommendation 1

HEAL Council Ask: MDH should recommit to understanding and transforming the public health crisis that is racism, including a public statement on how MDH will challenge structural racism in the context of fiscal constraints.

Context

We agree that structural racism is a root cause of persistent racial health inequities in Minnesota. The evidence is in the agency's own data and in more than a decade of documented work, including the landmark "Advancing Health Equity in Minnesota: Report to the Legislature," published in 2014, that named structural racism, i.e., the public policies, institutional practices, and cultural norms that, over time, have disadvantaged communities of color and Indigenous Minnesotans and contributed to worse health outcomes.

While many MDH leaders and staff can define structural racism, know that it is a driver of health inequities, and continue to name structural racism even in today's climate, fewer of us have the knowledge, skills, tools, and partnerships to effectively dismantle it. And while we talk about the structural determinants of health, very few of our programs are directed towards systems change to mitigate the impacts of or to eliminate structural racism.

Our goals

We must move from talking about racism to dismantling it in our internal policies, practices, cultural norms, and public policy. There are several opportunities to act more intentionally now, including:

- **Equity-centered training and skill building.** MDH is committed to not only deepening staff understanding of the connection between structural racism and the longstanding health inequities experienced across Minnesota communities, but to equipping staff with the skills and tools needed to effect change.

MDH 101 currently serves as a required onboarding and training course for all new agency employees that includes an introduction to the Health Equity Bureau and foundational health equity concepts. Building from that foundation, the Health Equity Bureau is developing an MDH 201 learning series intended to support current

employees in deepening their knowledge and practice. This series will focus on practical health equity tools, systems change strategies, community engagement approaches, and implementation practices that help staff operationalize health equity in their day-to-day work. The goal is to create a pathway for MDH staff to move from understanding structural racism conceptually to building the practical skills necessary to address inequities through policy, systems, and programmatic change.

- **Policy and legislative review.** The Health Equity Bureau currently convenes a cross-functional review team that leads health equity and Tribal relations reviews of MDH policies, procedures, standards, and legislative proposals. These reviews assess potential population impacts, barriers to equity, Tribal consultation considerations, and unintended harm that may disproportionately affect communities experiencing inequities. In 2025, we expanded the existing process for equity reviews of internal systems to include the agency’s legislative proposals, which has created opportunities for division and policy staff to identify gaps in impact, equity considerations, consultation needs, and potential harms before proposals advance externally.

The Health Equity Bureau is currently exploring opportunities to formally incorporate the MMB Equity Analysis Toolkit and community-informed feedback processes into these reviews. Doing so would further ground the work in a consistent and enterprise-supported approach to mitigating inequities and structural racism while ensuring that the perspectives of communities most impacted by health disparities meaningfully inform policy. Together, these efforts strengthen the agency’s capacity to embed equity considerations into operational decision-making and policy development processes.

- **Disability focused systems change approaches.** The Health Equity Strategy and Innovation Division (HESI) is supporting systems change work across the agency that addresses racism at the intersection of race and disability equity. The division is leading planning for the MDH Disability Health Equity Summit, which will center lived experiences, advance practical system change strategies, and convene both state enterprise and community partners working to advance disability health equity. In collaboration with the Office of Data, Strategy and Interoperability, HESI is co-leading disability-related data disaggregation efforts to strengthen the agency’s ability to identify racial and other disparities within disability communities and better address inequities.

We recognize that one of the first steps in addressing racism as one of the root causes of health inequities is to clearly articulate and define the problem and then deploy resources to address it. In our landmark 2014 report to the legislature on advancing health equity in Minnesota, we

named and documented the effects of structural racism and its impacts on the health and wellbeing of communities across the state. We will be releasing an update to that report soon. It describes MDH's progress in addressing the seven core recommendations of the 2014 report and reaffirms our commitment to addressing structural racism as a root cause of health inequities.

Response to Recommendation 2

HEAL Council Ask: MDH should convene an emergency budget equity advisory group before March 2026, made up of statewide representatives from communities most impacted by inequity, to advise on fiscal decisions from a structural perspective.

Context

Although public health received more resources during the pandemic, that funding has ended or is ending now. The costs from uncompensated care are also expected increase with the implementation of H.R.1 in 2027 – which will make significant changes to Medicaid eligibility and financing – further straining the ability of the state to invest in public health and address Minnesotans' other needs. This, of course, is on top of ongoing threats to Minnesota's federal public health funding, which typically makes up 40-50% of MDH's total budget.

State policymakers determine the biennial state budget in odd years (e.g., 2025 legislative session), approving far fewer "supplemental" budget proposals in even years (e.g., 2026 legislative session). Agency budget proposals are presented in the governor's budget, which is released in January or February each year. **Final deadlines for agencies to submit budget proposals to the governor for consideration usually are in October. To meet the deadline, MDH's internal process usually begins before the conclusion of the previous legislative session and wraps up by the end of September.**

Looking ahead, Minnesota's gubernatorial election in fall 2026 will bring a new administration whose priorities, appetite for equity-centered work, and approach to public health funding are not yet known. Leadership transitions at the state level can shift agency direction in ways that are difficult to anticipate. The structures and processes that MDH puts in place now need to be grounded in systems and accountability frameworks durable enough to carry this work forward regardless of changes in administration.

Our goals

We recognize that when budget pressure becomes acute, decisions are made quickly and within existing structures that may not consistently or effectively address health equity. There are several opportunities to act more intentionally now to improve community engagement in legislative proposals and other decisions that affect our public health programs, including:

- **Developing a sustainable funding approach for health equity work across MDH.** Health equity is everyone's responsibility, and navigating budget constraints is a shared challenge. An equity lens requires MDH leaders to tackle longstanding silos that inhibit collaboration and overcome the scarcity model that can lead to resource imbalances that don't align with agency priorities. Division directors are expected to collaborate within and across agency bureaus on grant applications and legislative proposals and to incorporate feedback from community members and MDH health equity strategists as workplans are developed and finalized.
- **Making equity in grantmaking measurable.** MDH continues to foster cross-functional forums with agency partners for ongoing grant-related discussions to create a space to identify barriers, align practices, share emerging challenges, and support continuous improvement in equitable grantmaking statewide. We have embedded health equity criteria into RFP processes and developed guidance to help community-based organizations understand state requirements. Part of protecting health equity work is also strengthening our respective ability to demonstrate compliance with those requirements. Lastly, MDH also has started a process for better tracking outgoing grants to help us determine gaps in the communities our programs serve.
- **Building HEAL and other councils' input into MDH's legislative proposals.** MDH is planning a new legislative summit for members of our advisory councils and other interested community members to provide input into agency budget and policy proposals. The goal is for MDH to be able to incorporate community input into proposals and to increase our teams' awareness of and responsiveness to community needs and priorities.

Response to Recommendation 3

HEAL Council Ask: Beginning in 2026, MDH should work with existing advisory councils to incorporate innovative dialogue into ongoing meetings, treating fiscal constraint as an opening for reimagining care rather than defaulting to scarcity-driven cuts.

Context

As an agency, our primary functions are to collect and analyze data; administer the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); regulate healthcare providers, health plans, and public water systems; detect and respond to infectious disease outbreaks and risks; and design and administer grant programs to address community health needs. Advisory councils are an important way for state agencies to ensure the perspectives, needs, and priorities of the communities we serve are embedded in the way we work. When we incorporate the input of our 40 councils and taskforces, we improve the relevance of public health data science and the effectiveness of public health practice. In addition, when councils and task forces connect with each other on related problems and shared goals, they can more powerfully leverage the kind of cross-sector, community-rooted creativity your letter describes. Creating conditions for that dialogue to happen intentionally, rather than by chance, is a practical and relatively low-cost step toward the cross-council energy your letter calls for.

Although we do not pay for nor provide healthcare, MDH uses research to evaluate healthcare, including patient safety, workforce issues, new models of care (including those that employ community health workers) and healthcare costs. MDH supports inclusive participation in (a) task forces, such as the [Equitable Healthcare Taskforce](#), convened to identify strategies to ensure care and coverage in Minnesota better meets the needs of all Minnesotans, and in (b) the development of state health plans, such as the [Statewide Roadmap to Address Long Covid and Post-Viral Chronic Conditions](#). We are also addressing rural health inequities by improving access to care and strengthening health system infrastructure through Minnesota's [Rural Health Transformation Program](#). The need to reimagine care will only increase with higher costs of care, rising rates of patient dissatisfaction, and the growing strains on healthcare delivery organizations, especially safety net clinics and hospitals.

Our goals

To promote innovative dialogue and identify solutions to reimagine public health practice and healthcare, we will continue to work with councils by more intentionally creating shared spaces for council members and incorporating equity tools and frameworks in council and taskforce meetings. The examples below highlight some of the ways we are committed to doing so.

- **Health equity-centered strategic planning.** One important opportunity is to actively engage advisory councils in agency and divisions' strategic planning and implementation. Council members bring nuanced expertise, community-informed perspectives, and lived experience that are essential to advancing responsive and

equitable policy and systems change work. HESI will create regular opportunities for the HEAL council to advise on the design and implementation of the agency's advancing health equity roadmap, including measurable objectives, performance indicators, and key deliverables over the next 6, 12, and 18 months to ensure MDH delivers on its health equity goals.

- **Collaborating to transform rural healthcare.** Minnesota's Rural Health Transformation Program, which was awarded \$193 million in its first year by the Centers for Medicare & Medicaid Services, was developed through extensive community engagement, including more than 40 meetings with interested partners. The program's transformational goals include improving health outcomes and access to care for rural Minnesotans, sustainably expanding the rural healthcare workforce, strengthening partnerships between providers to expand service delivery in rural communities, and stabilizing rural provider financial health through strategic investments. MDH is planning a series of statewide and regional learning communities and listening sessions, and we will seek involvement from existing councils as part of our continued engagement.

Response to Recommendations 4 through 7: On the Council's Own Stewardship

Recommendations four through seven are directed primarily at the incoming HEAL Council and its strategic partnership with MDH, rather than at broader agency systems change.

Together, they ask the council to invest in its own foundation: building member relationships and completing onboarding in the first three months, standing up subcommittees within the first four months, strengthening ties with the Minnesota Commissioner of Health and MDH leadership through at least two annual convenings, and sustaining cross-council collaboration with MDH's broader network of advisory bodies through joint events and regular coordination.

MDH has taken concrete steps to support the council in each of these. HESI revised the incoming council's orientation process based on outgoing member feedback, and the first six months of the 2026–2028 term have been focused on deliberate relationship-building. Subcommittee planning is already underway as an early priority, drawing on the experience of the Strategic Planning and Legislative & Policy Subcommittees established in the prior term. Introductory engagements with the Minnesota Commissioner of Health, Deputy Commissioner, and HESI Director's Office have begun, with work underway to establish a regular cadence of partnership throughout the new term. Strategic conversations are also in process to identify MDH and Minnesota Enterprise advisory councils whose equity priorities overlap with the HEAL

Council's, building on the Joint Council Event model that brought the HEAL Council, the African American Health State Advisory Council, and the Community Solutions Advisory Council together in prior years.

Conclusion

In the face of current challenges, your letter asks MDH to put health equity at the forefront of fiscal decisions, center community leadership in designing solutions, and build accountability structures that hold even when the political environment is pushing in the other direction. Thank you for calling explicit attention to strategies that need greater investment. We hope this response letter is part of an ongoing dialogue, as operationalizing these recommendations will require engagement at all levels of the agency. As you know, our vision is for health equity in Minnesota, where all communities are thriving and all people have what they need to be healthy. We recognize Minnesotans cannot achieve their optimal health until structural racism is eliminated. Eliminating structural racism and creating systems that serve all Minnesotans well will require sustained commitment, strategic investment amid scarcity, and true partnership with those most impacted by health inequities.

The letters of 2019, 2020, and now 2025 show that communities and councils have asked consistently for the same thing: do the work, sustain it, and keep the people most affected at the center of how it gets done. MDH carries that responsibility seriously, and we look forward to the work ahead.

In partnership,

/s/

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