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Changing Hearts, Minds, and Structures: Advancing Equity and Health Equity in State Government Policies, Operations, and Practices in Minnesota and Other States

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CHANGING HEARTS, MINDS, AND STRUCTURES: ADVANCING EQUITY AND HEALTH EQUITY IN STATE GOVERNMENT POLICIES, OPERATIONS, AND PRACTICES IN MINNESOTA AND OTHER STATES

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I. INTRODUCTION

The population of Minnesota is rapidly becoming more racially, ethnically, and culturally diverse.[1] People of color (those self-identifying as one or more races other than white and/or Latino) who made up 14 percent of the population in 2005 will increase to 25 percent by 2035, adding more than 500,000 people of color between now and 2035.[2] "Census data from 2000–2014

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1. Age, Race, & Ethnicity, Minn. St. Demographic Ctr., Dep't of Admin., https://mn.gov/admin/demography/data-by-topic/age-race-ethnicity/ [https://perma.cc/UJ73-ZA5T] (last visited Mar. 3, 2018) (citing U.S. Census Bureau data from the 2015 Population Estimates). In particular, this data indicates that people of color—those who identify as a race other than White alone and/or those who are Hispanic—represent 19 percent of the total population of Minnesota. *Id.* Non-Hispanic Whites represent 81 percent of Minnesota's population. *Id.* Although all race groups have grown recently in Minnesota, between 2010 and 2015, the state added four times as many people of color as Non-Hispanic Whites. *Id.* Populations of color are distributed unevenly across the state and are more likely to reside in metropolitan areas rather than rural areas. *Id.* Between 2010 and 2015, the Asian population was the fastest growing racial group in Minnesota (22 percent growth, adding nearly 48,000 people), followed by the Black population (16 percent growth, adding 45,000 people), and the Hispanic population (13 percent growth, adding 32,000 people). *Id.*

2. MINN. DEP'T OF HEALTH, MINNESOTA STATEWIDE HEALTH ASSESSMENT 8

indicates that the rate of growth among populations of color (74 percent) in Minnesota far outpaced that of the state's white population (2 percent)."[3] Similar demographic changes are occurring throughout the nation.[4] However, in Minnesota and other states, the structural components of how public and private entities operate day-to-day do not yet fully reflect and embrace the population's diversity with regard to race, ethnicity, culture, gender, gender identity, sexual orientation, individuals with disabilities, veterans, and others.[5] Customary ways of doing business—hiring, retention, advancement practices, contracting and procurement, and civic engagement—have failed to keep pace with, and be responsive to, the needs of the state's diverse population.[6]

(2017) http://www.health.state.mn.us/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf [https://perma.cc/HKL6-TN88].

3. *Id.* at 11.

4. KAREN R. HUMES ET AL., OVERVIEW OF RACE AND HISPANIC ORIGIN: 2010, U.S. CENSUS BUREAU 3–4 (2011), https://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf [https://perma.cc/2ADT-A7Y8]. According to the 2010 United States Census, approximately 36 percent of the population belongs to a racial or ethnic minority group. *Id.* at 4.

5. *See* Ibrahim Hirsi, *A Year In, Minnesota's Chief Inclusion Officer Reflects On the Successes and Challenges of Diversifying State Government*, MINNPOST (May 2, 2017), https://www.minnpost.com/good-jobs/2017/05/year-minnesotas-chief-inclusion-officer-reflects-successes-and-challenges-diversif [https://perma.cc/D2LQ-7YHF] (explaining that in meeting with leaders of underrepresented communities throughout Minnesota during his first few months on the job, Minnesota's Chief Inclusion Officer, James Burroughs, learned that many qualified professionals lack career opportunity networks and that many government hiring managers lack awareness of the availability of qualified persons of color).

> Burroughs also learned that professionals of color don't see the state government as an ideal destination for prospective employment . . . [having heard from] scores of leaders from the African-American, Hispanic-American and Asian-Americans [sic] communities . . . [that] professionals of color who have been with the state for decades oftentimes feel stymied in their efforts to get higher level jobs or leadership positions.

Id.; *see also* MINN. STATE DEMOGRAPHIC CTR., ECONOMIC STATUS MINNESOTANS: A CHARTBOOK WITH DATA FOR 17 CULTURAL GROUPS (Jan. 2016), https://mn.gov/bms-stat/assets/the-economic-status-of-minnesotans-chartbook-msdc-jan2016-post.pdf [https://perma.cc/5H4X-9L9V]; Jonathan M. Rose, *Disparity Analysis: A Review of Disparities Between White Minnesotans and Other Racial Groups*, ST. MINN. COUNCIL ON BLACK MINNESOTANS (2013), https://www.leg.state.mn.us/docs/2014/other/141227.pdf [https://perma.cc/P428-XK7Q].

6. *See* Hirsi, *supra* note 5; Rose, *supra* note 5; *see also* text accompanying

Community representatives, philanthropic foundations, public policy and public health advocacy groups, policymakers, and government officials have called for structural, comprehensive changes in governmental and private processes to reduce and eventually eradicate structural racism.[7] Structural racism and inequities stand in the way of a truly representative democracy where all individuals can thrive and achieve their full potential.[8] A growing body of evidence demonstrates the harmful effects of racism on health outcomes.[9] This research examines the costs to individuals and society of failing to implement changes that can reduce disparities and eliminate inequities in access to government services and in health and well-being outcomes. State government leaders and policymakers have responded with a rising sense of urgency by introducing a mix of legislated and non-legislated structural approaches to eliminate disparities.[10]

This article describes policy and programmatic approaches in four states, with a focus on a landmark equity policy recently adopted by the Minnesota Department of Human Services (DHS). Section II provides an overview of recent pioneering state-level efforts to

note 5.

7. *See* Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOC. REV. 465–80 (1997) (citing Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80–94 (1995)); Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8 DU BOIS REV. 115–132 (2011) (citing john a. powell, *Structural Racism: Building Upon the Insights of John Calmore*, 86 N.C. L. REV. 791–816 (2008)); Camara Phyllis Jones, *Levels of Racism: A Theoretic Framework and a Gardener's Tale*, 90 AM. J. PUB. HEALTH 1212–215 (2000). Jones defines "structural racism" as:

> [T]he macrolevel systems, social forces, institutions, ideologies and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups. The term *structural racism* emphasizes the most influential socio-ecologic levels at which racism may affect racial and ethnic health inequities. Structural mechanisms do not require the actions or intent of individuals. As fundamental causes, they are constantly reconstituting the conditions necessary to ensure their perpetuation. Even if interpersonal discrimination were completely eliminated, racial inequities would likely remain unchanged due to the persistence of structural racism.

Jones, *supra* note 7, at 1212.

8. *See* discussion *infra* Sections I, II.

9. Gee & Ford, *supra* note 7, at 115–132.

10. *See* discussion *infra* Sections I, II.

embed consideration of health equity and equity in government processes and decision-making.[11] Section III offers a detailed case study of the development and early steps toward implementation of the DHS Policy on Equity in Minnesota.[12] Section IV describes policy and programmatic approaches taken in the states of California, Washington, and Vermont.[13] Lastly, in Section V, we offer recommendations, drawing from our research, to inform future work and to stimulate discussion throughout the country.[14]

II. PIONEERING WORK ADDRESSING STATE-LEVEL EQUITY AND HEALTH EQUITY STRUCTURAL POLICIES AND PROCESSES

Although medical advances and a strong focus on preventive health care have contributed to improvements in health for many Americans, significant health disparities persist.[15] These disparities are based on race, ethnicity, gender, sexual orientation, disability status, age, and other demographics.[16] In 2016, the Metropolitan Council in Minnesota prepared a report on racial disparities in the Twin Cities region that suggested race and ethnicity—not other demographic differences such as age, immigration status, and English skills—are driving the disparities of that region, particularly

11. *See* discussion *infra* Section II.

12. *See* discussion *infra* Section III.

13. *See* discussion *infra* Section IV.

14. *See* discussion *infra* Section V.

15. Health disparities are the differences between population groups in health status and health outcomes, wherein one group experiences negative health status and health outcomes at higher rates than another group due to social disadvantage. MARGARET M. HECKLER, U.S. DEP'T HEALTH & HUMAN SERV., REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH: VOLUME I: EXECUTIVE SUMMARY (1985), https://www.minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf [https://perma.cc/YF7A-4EF5]. More than 30 years ago, this landmark report, known as the Heckler report, documented health disparities among racial and ethnic minorities in the United States, calling them "an affront both to our ideals and to the ongoing genius of American medicine." *Id.* at 11.

16. *See* CDC, NAT'L CENT. FOR HEALTH STATISTICS, DATA ON RACIAL & ETHNIC DISPARITIES, (Jul. 2014), https://www.cdc.gov/nchs/data/factsheets/factsheet_disparities.pdf [https://perma.cc/2SZR-T89V]; *New Study on Twin Cities Region's Racial Disparities Provides Further Evidence of Need for Action to Eliminate Disparities*, MINN. OFF. OF GOVERNOR MARK DAYTON (Apr. 12, 2016), https://mn.gov/governor/newsroom/?id=1055-217626 [https://perma.cc/72Y2-UBZF].

between white and black Minnesotans.[17] Governor Dayton urged all state legislators to read the report and commit themselves to addressing these needs, commenting that "[t]he inequities afflicting Minnesotans of color in education, income, employment, and housing require additional state investments immediately."[18] For example, life expectancy and rates of chronic disease vary greatly among population groups depending on social, economic, and environmental factors that affect populations' opportunities to access community resources, support, and assets.[19] These factors—often referred to as social determinants of health—include education, employment, health systems and services, housing, income and wealth, physical environment, public safety, social environment, and transportation.[20]

The prevalence of persistent health disparities and inequities not only takes a toll on the members of impacted populations—it also contributes to other societal costs.[21] For example, one study that looked at the economic burden of racial and ethnic inequities found that the indirect costs associated with illness and premature death would have been reduced by over one trillion dollars between 2003 and 2006 had the disparities been averted.[22] Then-Chair of the

17. *Id.*

18. *Id.*

19. *See* CTY. OF L.A. PUB. HEALTH, SOCIAL DETERMINANTS OF HEALTH: HOW SOCIAL AND ECONOMIC FACTORS AFFECT HEALTH 2 (Jan. 2013), http://publichealth.lacounty.gov/epi/docs/SocialD_Final_Web.pdf [https://perma.cc/XD7H-PPSQ].

20. OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, Social Determinants of Health, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health [https://perma.cc/5G4M-B3LR] (last visited May 17, 2018).

21. *See, e.g.*, NAT'L CONF. OF ST. LEGISLATURES, STATE APPROACHES TO REDUCING HEALTH DISPARITIES 1 (June 2017), http://www.ncsl.org/Portals/1/Documents/ Health/HealthDisparities_2017_31448.pdf [https://perma.cc/8YLF-RART] (noting that disparities in health status, such as those for premature babies or groups with high rates of diabetes, can cost states millions) [hereinafter NAT'L CONF. OF STATE LEGISLATURES]; *see also* THOMAS A. LAVEIST ET AL., JOINT CTR. FOR POLICY & ECON. STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 1 (2011), http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf [https://perma.cc/VKJ3-PN3P]; THE NAT'L ACADS. OF SCIS., ENGR'G, & MED., REPORT: COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 3–4 (Jan. 11, 2017) (estimating the projected cost to health insurers of racial health disparities alone to be $337 billion between 2009 and 2018).

22. *See* LAVEIST, *supra* note 21.

Federal Reserve Bank, Janet Yellen, "warned that health disparities threaten the US economy."[23] Indeed, multiple reports have concluded that eliminating health disparities has both equitable and financial benefits and that improving the well-being of our population also provides economic benefits.[24]

Federal, state, and local government—often in coordination with foundations, civic organizations, advocacy groups, and religious or cultural organizations—have undertaken a multitude of policy and programmatic efforts to reduce health disparities and eliminate inequities.[25] States, in particular, have pursued a combination of legislative and non-legislative approaches aiming to reduce health disparities and inequities, including legislative strategies to increase workforce diversity, improve cultural competency in the delivery of

23. Steven H. Woolf, *Progress in Achieving Health Equity Requires Attention to Root Causes*, 36 HEALTH AFFS. 984, 984 (2017), https://pdfs.semanticscholar.org/2d96/c5b6b9067ebfe3feed630a285a5c957898c5.pdf [https://perma.cc/FG3M-6WWA].

24. NAT'L CONF. OF ST. LEGISLATURES, *supra* note 21, at 5.

25. For example: (1) Federal legislation requires an Office of Minority Health within six agencies of the United States Department of Health and Human Services (DHHS). 42 U.S.C. §§ 300u-6a(a)–(b) (2017). (2) Minority health or health equity offices in every state monitor health status; inform, educate, and empower people; mobilize community partnerships and action; and develop policies and plans to support health efforts. *State Offices of Minority Health and Related State Information*, NAT'L PARTNERSHIP FOR ACTION TO END HEALTH DISPARITIES (May 17, 2016, 4:01 PM), https://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=35 [https://perma.cc/MUH8-C5ZV]. (3) Independent, non-governmental Regional Health Equity Councils, comprised of non-federal public and private leaders from multiple sectors, operate in ten regions "to eliminate health disparities from the grassroots." *Regional Health Equity Councils*, NAT'L PARTNERSHIP FOR ACTION TO END HEALTH DISPARITIES (Jan. 16, 2018, 10:43 PM), https://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=42 [https://perma.cc/UZ4P-9MLY].

health care services,[26] and address social determinants of health.[27] During the 2015 and 2016 legislative sessions alone, state lawmakers considered more than 150 bills specifically related to health disparities.[28]

Two approaches have gained traction for reducing health disparities and advancing health equity: (1) Policy, Systems, and Environment (PSE), and (2) Health in All Policies (HiAP) programmatic and policy work.[29] Federal, state, and local public health agencies have invested heavily in using PSE approaches to maximize positive impacts on population health.[30] PSE efforts recognize that achieving health requires more than encouraging people to make healthier personal choices and to obtain appropriate health care.[31] Without discounting the value of encouraging individual efforts to achieve behavior change, PSE strategies strive to modify population-level systems and environments through programmatic or policy changes, the idea being to reduce the prevalence of chronic diseases by making it practical for all

26.

> *Cultural competence* is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations." "Competence" in the term *cultural competence* implies that an individual or organization has the capacity to function effectively "within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities."

Definitions, CDC (Mar. 21, 2014), https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html [https://perma.cc/DY7W-PFM2] (quoting *What is Cultural Competency?*, U.S. DEP'T HEALTH & HUM. SERVS. (2001), https://www.cdc.gov/nchhstp/socialdeterminants/docs/what_is_cultural_competency.pdf [https://perma.cc/9GH5-NZZD]).

27. NAT'L CONF. OF ST. LEGISLATURES, *supra* note 20.

28. *Id.* at 3.

29. *See generally* CDC, A PRACTITIONER'S GUIDE FOR ADVANCING HEALTH EQUITY: COMMUNITY STRATEGIES FOR PREVENTING CHRONIC DISEASE 2 (2017) [hereinafter PRACTITIONER'S GUIDE], https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf [https://perma.cc/9ERF-NLXF] (discussing the PSE strategy); *Health in All Policies*, CDC (June 9, 2016), https://www.cdc.gov/policy/hiap/index.html [https://perma.cc/BW4V-3YGP] (discussing the HiAP strategy).

30. *See* Sally Honeycutt et al., *Evaluating Policy, Systems, and Environmental Change Interventions: Lessons Learned From CDC's Prevention Research Centers*, CDC (Oct. 15, 2015), https://www.cdc.gov/pcd/issues/2015/15_0281.htm [https://perma.cc/PPX5-NV6S].

31. *See* PRACTITIONER'S GUIDE, *supra* note 29, at 2–3.

community members to make healthy choices.[32] Many state or local initiatives, for example, support community efforts to improve streetscapes to encourage community members to walk or bicycle to school, work, and other locations.[33] Other examples of local government strategies include initiatives to increase the availability of local and fresh produce in local grocery stores or emergency food shelves to encourage community members to consume more fruits and vegetables.[34] The Centers for Disease Control and Prevention (CDC), state and local governments, and many foundations provide financial support and technical assistance for PSE initiatives.[35]

The Health in All Policies (HiAP) approach to state and local government and nonprofit planning and decision-making has also gained traction as a means of advancing health equity.[36] HiAP takes health impacts into account in decisions that are made in all government sectors.[37] The implementation of HiAP is built around a core set of ideas: (1) promoting health equity outside of the health sector; (2) collaborating across sectors; (3) benefitting multiple partners; (4) engaging with diverse communities and stakeholders; and (5) modifying existing structures and procedures.[38]

32. *See id.*

33. *See, e.g.*, *Making Strides: State Report Cards on Support for Walking, Bicycling, and Active Kids and Communities*, SAFE ROUTES TO SCH. NAT'L PARTNERSHIP (2016), https://www.saferoutespartnership.org/resources/2016-state-report-cards [https://perma.cc/JH9U-Z6M6]; *see also Beyond Safe Routes: Active Transportation*, SAFE ROUTES TO SCH. NAT'L PARTNERSHIP, https://www.saferoutespartnership.org/healthy-communities/101/active-transportation [https://perma.cc/9H75-7V34] (last visited May 17, 2018).

34. *See, e.g.*, CDC, THE CDC GUIDE TO FRUIT & VEGETABLE STRATEGIES TO INCREASE ACCESS, AVAILABILITY AND CONSUMPTION (2010), http://dhhs.ne.gov/publichealth/Documents/Guidance_Doc_Fruit_Veggie.pdf [https://perma.cc/U7Z9-Q5TY]; CITY OF MINNEAPOLIS HEALTH DEP'T, THE MINNEAPOLIS HEALTHY CORNER STORE PROGRAM: SUMMARY REPORT (2013), http://www.minneapolismn.gov/www/groups/public/@health/documents/webcontent/wcms1p-117774.pdf, [https://perma.cc/QZK5-TFF3].

35. *See, e.g.*, Honeycutt, *supra* note 30.

36. "Health equity" means achieving a high standard of health for everyone in a community while at the same time concentrating on populations within that community that are at a disproportionate risk for poor health because of social factors. *See* Paula Braveman, *What are Health Disparities and Health Equity? We Need to be Clear*, 129 (SUPP. 2) PUB. HEALTH REPS. 5 (2014).

37. WORLD HEALTH ORG., HEALTH IN ALL POLICIES (HIAP) FRAMEWORK FOR COUNTRY ACTION 3 (2014).

38. LINDA RUDOLPH ET AL., HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND

The use of Health Impact Assessments (HIA) has gained prominence as an effective tool for advancing health equity in non-health sectors of government.[39] HIA processes are intentionally highly collaborative, bringing together cross-sector and diverse advisors to conduct analyses and craft recommendations with the goal of informing policymakers' consideration of the health—and equity—impacts of proposed policy changes.[40]

A 2017 report commissioned by the Robert Wood Johnson Foundation summarized the three main conclusions of a yearlong analysis of health disparities in the United States.[41] First, health disparities are shaped by social, economic, environmental, and structural factors and their unequal distribution, more so than by health care.[42] Second, social inequities matter more than health care in shaping health disparities.[43] Third, health inequities are largely a consequence of poverty, structural racism, and discrimination.[44] Among the interventions recommended as demonstrating the greatest promise for achieving health equity were those that targeted: "institutional and systemic mechanisms . . . that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity."[45] Also recommended were interventions that targeted: "[t]he unequal allocation of power and resources . . . which manifests itself in unequal social, economic, and environmental conditions, also called the determinants of

LOCAL GOVERNMENTS 17–18 (2013), https://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf [https://perma.cc/ZV5G-U6QV].

39. *See* Andrew L. Dannenberg et al., *Use of Health Impact Assessment in the U.S.: 27 Case Studies, 1999-2007*, 34 AM. J. PREV. MED. 241, 241-256 (2008); *see also* JAMES G. HODGE, JR. ET AL., LEGAL REVIEW CONCERNING THE USE OF HEALTH IMPACT ASSESSMENTS IN NON-HEALTH SECTORS, http://www.pewtrusts.org/~/media/legacy/uploadedfiles/phg/content_level_pages/reports/asufullwebsitep15webpdf.pdf [https://perma.cc/U6QY-8QNW] (last visited Mar. 15, 2018).

40. *See* HODGE, JR. ET AL., *supra* note 39, at 6.

41. NAT'L ACADS. OF SCIS., ENGR, & MED., *COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY* 6–7 (2017), https://doi.org/10.17226/24624 [https://perma.cc/E9TZ-3BEU].

42. *Id.* at 2.

43. *Id.* at 6–7.

44. *Id.* at 6–7.

45. *Id.* at 7.

health."[46] The conclusions reached in this year-long analysis demonstrate breadth and growth in work that seeks to advance equity and health equity, offering a more targeted focus to addressing inequities in systemic and institutional settings.

The pioneering work being done by the states described in the next two sections builds on the foundational mix of federal, state, and local policies and programmatic work discussed above, and on basic tenets of civil and human rights. What sets this most recent policy work apart is the recognition that eliminating inequities cannot be achieved without also restructuring the basic operational framework and decision-making processes of governmental bodies.[47]

III. CASE STUDY OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES POLICY ON EQUITY

A. Introduction

What follows is a case study of the recent adoption of a landmark department-wide Policy on Equity at DHS.[48] The policy is the first of

46. *Id.*

47. *See* discussion *infra* Sections II, III.

48. While this case study focuses on a singular policy initiative at one Minnesota state agency, additional, varied programmatic and policy work is being undertaken to advance equity and health equity among state agencies and at the local level. *See, e.g.*, H.F. 2198, 2015 Leg., 89th Sess. (Minn. 2015), https://www.revisor.mn.gov/bills/text.php?number=HF2198&version=0&session=ls89&session_year=2015&session_number=0&format=pdf [https://perma.cc/9Z N2-5RUR], and S.F. 2054, 2015 Leg., 89th Sess. (Minn. 2015), https://www.revisor. mn.gov/bills/text.php?number=SF2054&version=0&session=ls89&session_year=2015&session_number=0&format=pdf [https://perma.cc/EA7Z-5A62]; MINNEAPOLIS, MINN. ORDINANCES tit. 2, ch. 21, §§ 21.10, 21.15 (2018), https://lims.m inneapolismn.gov/Download/MetaData/5371/2017-01321%20Ord%20074_Id_5371.pdf [https://perma.cc/X9LJ-MY4A]; *Executive Order 15-02: Establishing the Diversity and Inclusion Council; Rescinding Executive Order 91-14*, ST. MINN. EXECUTIVE DEP'T (Jan. 20, 2015), https://mn.gov/governor/assets/EO-15-02.pdf_tcm1055-91737.pdf [https://perma.cc/L4CW-Y4CL]; *Executive Order 16-01: Establishing the Diversity and Inclusion Council; Rescinding Executive Order 15-02*, ST. MINN. EXEC. DEP'T (Feb. 24, 2016), https://www.leg.state.mn.us/archive/execorders/16-01.pdf [https://perma.cc/XD4G-N2YH]; *Advancing Health Equity in Minn.*, MINN. DEP'T OF HEALTH (Feb. 2014), http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf [https://perma.cc/4Y6L-U39D]; INDEP. SCH. DIST. 279, POLICY 101 RACIAL EQUITY IN EDUCATIONAL ACHIEVEMENT (2016), http://district 279.org/images/

its kind to be adopted by a department of state government in the United States.[49]

DHS is the largest state agency in Minnesota, administering about one-third of the state's total budget and employing over 6,000 persons.[50] The agency serves more than a million Minnesotans across the state's eighty-seven counties and eleven tribes.[51] DHS works with many partners, largely counties, tribes, and nonprofits, in providing essential services and helping ensure that seniors, disabled persons, children, and others meet their basic needs and have the opportunity to reach their full potential.[52] The vast majority of direct human services are provided by DHS's partners, while the department, at the direction of the governor and state legislature, is responsible for setting policies and directing payments for many of the services delivered.[53]

Dept/SchoolBoard/Policy-Procedures/Policy_101.pdf [https:// perma.cc/34UJ-GN2L]; *Governor Mark Dayton's Diversity and Inclusion Council Report to Governor Mark Dayton*, ST. MINN. (Jan. 2016), https://mn.gov/admin/assets/ 2016_02_19_ diversity_and_inclusion_report_tcm36-242691.pdf [https://perma.c c/GUL3-X4H3].

49. MINN. DEP'T HUMAN SERVS., CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL (CECLC) LEGISLATIVE REPORT 3 (2016), https://www.leg.state.mn.us/docs/2016/mandated/160195.pdf [https://perma.cc/PR5W-PXCH].

50. *Ask the Budget Director*, MINN. DEP'T MGMT. & BUDGET, https://mn.gov/mmb/budget/state-budget-overview/faq/ [https://perma.cc/KH54-EEBW].

51. *Id.*

52. *See People We Serve*, MINN. DEP'T HUMAN SERVS., https://mn.gov/dhs/people-we-serve/ [https://perma.cc/YA4V-HNT2] (last visited Jan. 21, 2018).

53. *See What We Do*, MINN. DEP'T OF HUMAN SERVS., https://mn.gov/dhs/general-public/about-dhs/what-we-do/ [https://perma.cc/X5M3-ABKY] (last visited May 17, 2018). The site explains:

> As a steward of a significant amount of public dollars, DHS takes very seriously our responsibility to provide Minnesotans with high value in terms of both the quality and cost of services.
>
> Our largest financial responsibility is to provide health care coverage for low-income Minnesotans. We are also responsible for securing economic assistance for struggling families, providing food support, overseeing child protection and child welfare services, enforcing child support, and providing services for people with mental illness, chemical dependency, or physical or developmental disabilities.
>
> Through our licensing services, we ensure that certain minimum standards of care are met in private and public settings for children and vulnerable adults. DHS also provides direct service through our regional offices for people who are deaf or hard of hearing; through DHS Direct

This structure is somewhat atypical. In most states, departments of human services are state-run, meaning that most direct services are provided by department employees.[54] In Minnesota and relatively few other states, it is the other way around: the system is county-administered and state-supervised and most direct services are provided by county employees, while DHS provides oversight.[55]

This distinction is important with regard to the implementation of the DHS Policy on Equity. In the great majority of states, an equity policy such as this one would apply to the entire state's human services system. But in Minnesota, DHS's Policy on Equity will only directly apply to its operations, not to the state's individual tribal and county systems.[56] This raises challenges for embedding equity as a system-wide change. Still, as the agency responsible for oversight of the entire state's delivery of human services, DHS is well positioned to lead by example and encourage its partnering tribal governments and county agencies to follow suit.

B. Key Components of the DHS Policy on Equity

The DHS Policy on Equity states, "equity [is] achieved when every person in a community has the opportunity to reach their full health potential and no one is 'disadvantaged from achieving this

> Care and Treatment, which provides direct care to people with disabilities; and through the Minnesota Sex Offender Program.

Id.

54. *See, e.g.*, CHILDREN'S BUREAU, CHILD WELFARE INFO. GATEWAY, STATE VS. COUNTY ADMINISTRATION OF CHILD WELFARE SERVICES (2018), https://www.childwelfare.gov/pubPDFs/services.pdf [https://perma.cc/TEH3-SCJ9] (providing a brief overview of the majority of states having a centralized, state-administered child welfare program system, the nine states—including Minnesota—having a county administered system, and three states having a hybrid system); HEATHER HAHN ET AL., A DESCRIPTIVE STUDY OF COUNTY—VERSUS STATE—ADMINISTERED TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAMS (2015), https://www.acf.hhs.gov/sites/default/files/opre/county_tanf_final_report_submitted_to_acf_b508.pdf [https://perma.cc/8W3Q-DYUV] (examining TANF programs in four states—California, Colorado, Minnesota, and North Dakota—with state-supervised, county-administered systems, and twenty-nine states with state-administered TANF programs).

55. Interview with Santo Cruz, Deputy Comm'r, Minn. Dep't of Human Servs., in Minn. Dep't of Human Servs., St. Paul, Minn. (Nov. 7, 2017) [hereinafter Interview with Santo Cruz]. Santo Cruz left the Department at the end of March 2018.

56. *Id.*

potential because of social position or other socially determined circumstances.'"[57] The Policy on Equity defines several other key terms, including: "community engagement," "determinants of health," "disparity," "equity analysis," "health," "Health in All Policies," and "inequities."[58] As used in the Policy, "communities experiencing inequities" refers to communities of color, American Indians, veterans, LGBT, and persons with disabilities.[59] "Inequities" is defined as "[d]ifferences in outcomes that are systematic, avoidable and unjust."[60]

The DHS Policy on Equity requires DHS to use a HiAP[61] approach to achieve solutions that will "focus within DHS and also cut across agency and public-private sector boundaries and address the broad factors that make up the determinants of health."[62] Consultation with communities experiencing inequities is required when DHS programs are developed, implemented, and evaluated.[63] The Policy on Equity aims to ensure that equity will be considered in all aspects of DHS business—the policy specifically "acknowledges and embraces the role [DHS plays] in developing policies, investments, and procedures that advance equity."[64]

57. MINN. DEP'T OF HUMAN SERVS., CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL (CECLC): COMMUNITY RELATIONS DIVISION, 88 (2017) [hereinafter CECLC 2017 REPORT]. The CECLC's definition of "health equity" is similar to the definition used by the CDC, the World Health Organization, the United States Department of Health and Human Services' Healthy People 2020, and others. *See Definitions*, CDC, https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html [https://perma.cc/8S3Q-T3Z9] (last visited May 17, 2018).

58. CECLC 2017 REPORT, *supra* note 57, at 87–89.

59. *Id.* at 87.

60. *Id.* at 89.

61. *Id.* at 88. As defined in the Policy:

> Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas . . . Ultimately the Health in All Policies approach seeks to institutionalize considerations of health, equity, and sustainability as a standard part of decision-making processes across a broad array of sectors.

AM. PUB. HEALTH ASS'N, HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS, 6 (2013) https://www.apha.org/~/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx [https://perma.cc/YY77-U8R2].

62. CECLC 2017 REPORT, *supra* note 57, at 82.

63. *See* MINN. STAT. §§ 256.041 subdivs. 7, 8 (2017).

64. CECLC 2017 REPORT, *supra* note 57, at 83.

The DHS Policy on Equity establishes six department-wide procedures for advancing its aims.[65]

Figure 1: Procedures for Advancing Equity

Equity Committee	An equity committee will be established in each administration[66] of DHS to advise the leadership on advancing equitable outcomes for all people served by the administration and its employees.
Equity Analysis	Equity analysis[67] will be conducted in three areas of DHS operations: (1) DHS managers and supervisors will consult with their administration's equity committee when reviewing administrative policies for renewal; (2) Employees involved in developing legislative proposals will engage in equity analyses and consult with equity liaisons when evaluating potential equity impacts; and (3) Staff will use specified equity impact guidance questions to analyze equity impacts when preparing legislative proposals on behalf of DHS.[68]

65. MINN. DEP'T HUMAN SERVS., SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN 4–6 (2017) [hereinafter 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN].

66. CECLC 2017 REPORT, *supra* note 57, at 83. DHS' official administrations include: Children and Family Services, Community Supports, Continuing Care for Older Adults, Health Care, External Relations, and External Relations. *See Overview Organization Chart*, MINN. DEP'T HUM. SERVS. (Jan. 2018) https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6359-ENG [https://perma.cc/BNN8-XK8L].

67. CECLC 2017 REPORT, *supra* note 57, at 83.

68. *Id.* at 83–84. Equity Analysis requires the use of specific guidance questions contained in a template provided by the Governor's office, Governor Mark Dayton's 2018–2019 Change Item Template, subject to modification, as directed by the Governor's office and as deemed appropriate by DHS. *See FY 2018–19 Biennial*

Workforce and Leadership Development	Workforce and leadership development[69] procedures require DHS's Affirmative Action Officer to provide data and advice to hiring supervisors and senior management to help increase employment of underrepresented group members. DHS's Human Resources Office is required to use this data and advice for the same purpose. The Affirmative Action Officer and Human Resources are required to track and monitor data on employee separations and to implement interventions when there are statistically significant disparities between majority member employees and employees from communities experiencing inequities. Hiring managers are required to make "every reasonable effort" to include one or more members of underrepresented groups on interview panels. DHS's Enterprise Learning and Development division is required to collaborate with Human Resources and others to track and monitor the participation of employees from communities experiencing inequities in agency and state-sponsored leadership development opportunities.
Contracting and Procurement Procedures	Contracting and procurement procedures[70] require the Director of Contracts, Procurement, and Legal Compliance to develop and apply equity criteria in all contracting, grants, and procurement processes to increase vendor

Budget Instructions, MINN. MGMT. & BUDGET (2016), https://mn.gov/mmb/budget/budget-instructions/bibudprep/ [https://perma.cc/U2JK-369G]. The guidance questions aim to identify: groups impacted by a proposed change item; the nature of the impact; whether a proposed change item intends to reduce or eliminate disparities experienced by the impacted group(s); how implementation will succeed; whether there are potential positive or negative impacts on identified groups; and whether the proposed change item can be sustained successfully. *Id.*

69. CECLC 2017 REPORT, *supra* note 57, at 84.

70. *Id.*

	diversity, and to encourage employees to get training on how to apply an equity analysis or consult with staff who are familiar with equity analysis.
Community Engagement and Inclusion	Community engagement and inclusion procedures[71] require DHS managers and supervisors to ensure that communities with inequities are involved in developing strategic initiatives and work plans—engaging them through planning, program development, budgeting, evaluation, and decision-making processes. Managers and supervisors of staff who plan community engagement activities are encouraged to consult with the Director of Community Relations for support and resources.
DHS CLAS Standards	DHS will endeavor to pilot and implement enhanced Cultural and Linguistic Appropriate Services (CLAS) Standards[72] to improve quality, and help eliminate disparities in health care.

C. Compliance Expectations

Although the Policy on Equity sets an expectation that all DHS employees will comply with its terms, it is not intended to be

71. *Id.* at 84–85.

72. *Id.* at 85. *See also The National CLAS Standards*, U.S. DEP'T HEALTH & HUM. SERVS., OFF. MIN. HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53 [https://perma.cc/Q87N-RPF7] (last visited May 17, 2018). "The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities." *Id.* The CLAS Principal Standard is to "[p]rovide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs." *Id.*

punitive.[73] Still, it does require DHS to develop mandatory training and to "develop measures, monitor implementation, and enforce the policy on equity across the agency."[74]

1. Creation of the Cultural and Ethnic Communities Leadership Council (CECLC) at DHS

In 2013, the Minnesota legislature established the Cultural and Ethnic Communities Leadership Council (CECLC)[75] at DHS to advise the commissioner on reducing disparities affecting racial, ethnic, and other sub-populations served by DHS programs, and to recommend operational changes within the agency.[76] Earlier efforts—led by departmental committees, work groups, and internal champions—had been sporadic and not fully systemized, but helped ready the agency for deeper engagement.[77]

For example, in 2010 DHS formed an in-house working group on disparities reduction consisting of thirty staff members from

73. CECLC 2017 REPORT, *supra* note 57, at 85.

74. *Id.* at 85–86.

75. 2013 Minn. Laws ch.107, art. 2 § 1, https://www.revisor.mn.gov/laws/?id=107&year=2013&type=0 [https://perma.cc/EL3X-HSPF]. The Council was preceded by another advisory body, the Disparities Reduction Advisory Committee (DRAC), a thirty-member committee that was formed in 2010 and disbanded in mid-2013 as a result of the legislature's establishment of the CECLC, which DRAC had recommended. *See* CECLC 2017 REPORT, *supra* note 57, at 13.

> Over a 4 year period, the committee discussed programs funded by DHS and engaged with a group of DHS employees appointed by their assistant commissioners in an effort to develop recommendations that promised more enduring results than previous efforts to address disparities . . . Members were consulted on a range of issues including aging services, medical homes, client outreach, chemical health, and contracting. DRAC members requested that DHS change the scope of the work of the group by establishing a more formal presence in the state agency. In response, DHS developed the legislative proposal to establish the Cultural and Ethnic Communities Leadership Council.

Id. at 14.

76. CECLC 2017 REPORT, *supra* note 57, at 8.

77. Interview with Vayong Moua, Dir. Health Equity Advocacy, Ctr. for Prevention, Blue Cross & Blue Shield of Minn., in Blue Cross & Blue Shield of Minn., Eagan, Minn. (Oct. 17, 2017) (on file with author) [hereinafter Interview with Vayong Moua]; Interview with Antonia Wilcoxon, Dir. Cmty. Relations, Minn. Dep't Human Servs., in Minn. Dep't Human Services, St. Paul, Minn. (Nov. 7, 2017) (on file with author) [hereinafter Interview with Antonia Wilcoxon].

different areas within DHS.[78] Working group members reviewed internal reports to identify communities that experienced difficulties accessing DHS services and communities that accessed DHS services, but did not have positive outcomes.[79] In all, they identified more than eighty-five program-measure issues, including clients that failed to show up for needed services, struggled to graduate from services provided, and dropped out and later resumed services.[80] DHS's senior leadership asked the working group to select twelve to fifteen of these measures that the agency could focus on to make an impact.[81] One of the working group members, DHS Director of Community Relations Antonia Wilcoxon, spoke to a need for community involvement and recommended that DHS confer with impacted communities.[82] DHS approved Wilcoxon's recommendation with two goals in mind.[83] The first was to inform communities that DHS was concerned about and was working to reduce the level of disparities.[84] The second was for DHS leaders and staff to invite community members to participate in discussions about the impacts that disparities were having on their communities.[85]

Commissioner Cal R. Ludeman, Medicaid Director Brian Osberg, and Chief Compliance Officer Anne Barry, attended the first of two community engagement meetings,[86] and community

78. CECLC 2017 REPORT, *supra* note 57, at 13–14; Interview with Antonia Wilcoxon, *supra* note 77.

79. Interview with Antonia Wilcoxon, *supra* note 77.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. Anne Barry was the Chief Compliance Officer for DHS at the start of the community engagement work and the Disparities Reduction Advisory Group (DRAC). Correspondence with Anne Barry, Pub. Health Dir., Ramsey Cty. Pub. Health (Dec. 6, 2017) (on file with author) [hereinafter Correspondence with Anne Barry]. Barry was appointed to the position of deputy commissioner in November 2010 and acted briefly as commissioner, from January 8, 2011 until later that month, when Lucinda Jesson was named commissioner. *Id.* Barry then resumed the position of deputy commissioner and held that position until July 2015, at which time she was assigned to lead DHS's newly created Administration on Community and Partner Relations. *Id.* This administration led DHS's work on equity but was eliminated when Barry left DHS in July 2016. *Id.*

members voiced appreciation of the commissioner's candor in talking with them.[87] However, the second meeting, which was attended by the department's assistant commissioners but not by the commissioner or deputy commissioners, did not go as smoothly.[88] The assistant commissioners' poor reception at the second meeting amplified the department's need for deeper community engagement, and the commissioner and his cabinet resolved to continue its investment in reducing disparities.[89]

In 2010, the commissioner assigned Barry and Wilcoxon to lead this effort through a newly formed Disparities Reduction Advisory Group (DRAC).[90] Over the next three-and-a-half years, DRAC continued DHS's efforts to build trust and relationships with diverse community members throughout the state and took initial steps to address disparities within the department.[91] Toward the end of this period, DHS's leadership participated in anti-racism training recommended by DRAC.[92] The department also implemented "stretch goals" for hiring to voluntarily exceed the minimum percentiles required for affirmative action compliance.[93]

In 2013, with the support of DHS, the push to create the CECLC moved forward as a means of solidifying the community engagement that was already taking place.[94] The resulting legislation voiced the need for durable and institutionalized accountability with community oversight and integration.[95] Yet the Minnesota Legislature gave the CECLC a mere two-year window to accomplish its goals, setting its expiration for March 2015.[96] In 2015, legislators

87. Interview with Antonia Wilcoxon, *supra* note 77.

88. *Id.*

89. *Id.*

90. *Id.*; *see* CECLC 2017 REPORT, *supra* note 57, at 13–14.

91. Interview with Antonia Wilcoxon, *supra* note 77.

92. *Id.*

93. *Id.*; *see also* U.S. DEP'T LAB., SAMPLE AFFIRMATIVE ACTION PROGRAMS (AAPS), https://www.dol.gov/ofccp/regs/compliance/AAPs/Sample_AAP_final_JRF_QA_508c.pdf [https://perma.cc/NPR2-285W] (providing "styles and formats [of affirmative action programs] that meet regulatory requirements"). *See generally* JOE FEAGIN, THE WHITE RACIAL FRAME: CENTURIES OF RACIAL FRAMING AND COUNTER-FRAMING (2013) (containing the information DHS utilized in its anti-racism training).

94. Interview with Vayong Moua, *supra* note 77.

95. *Id.*

96. *Cultural and Ethnic Communities Leadership Council*, MINN. DEP'T HUM. SERVS., https://mn.gov/dhs/general-public/about-dhs/advisory-councils-task-forces/cult

recognized the inadequacy of the timeline and re-established the CECLC retroactive to its initial expiration date and set a new sunset date of June 30, 2020.[97]

2. Re-establishment of the CECLC & the Commissioner's Role

The 2015 legislation requires the DHS commissioner to appoint the CECLC chairperson and each councilmember to two-year terms, which may be renewed twice.[98] CECLC members must include "the chairs and ranking minority members of the committees in the [Minnesota House of Representatives] and the [S]enate with jurisdiction over human services."[99] Fifteen to twenty-five additional councilmembers are required, including two members of the American Indian community.[100] In selecting members, the commissioner must "give priority consideration to public members of the legislative councils of color."[101] Members must include representatives of "racial and ethnic minority groups," "culturally and linguistically specific advocacy groups and service providers," "[DHS] program participants," "public and private institutions," "parents of [DHS] program participants," and "members of the faith community."[102] Councilmembers must also include "[DHS] employees" and "any other group [deemed] . . . appropriate to facilitate the goals and duties of the council."[103] CECLC meetings are open to the public.[104] The council welcomes visitors and invites them to offer ideas or suggestions during a public comment portion of each meeting.[105]

ural-ethnic-communities-council.jsp [https://perma.cc/AF35-KE6R] (last visited May 17, 2016).

97. MINN. STAT. § 256.041 subdiv. 10 (2017); *see also* Interview with Vayong Moua, *supra* note 77. CECLC leadership is exploring mechanisms to extend the lifespan of the CECLC. *Id.*

98. MINN. STAT. §§ 256.041 subdivs. 4, 6.

99. *Id.* subdiv. 2(a)(1).

100. *Id.* subdivs. 2(a)(2), (c)(2).

101. *Id.* subdiv. 2(b).

102. *Id.* subdiv. 2(c).

103. *Id.*

104. CECLC 2017 REPORT, *supra* note 57, at 51.

105. *Id.*; *see also Cultural and Ethnic Communities Leadership Council*, MINN. DEP'T. HUM. SERVS., https://mn.gov/dhs/general-public/about-dhs/advisory-councils-task-forces/cultural-ethnic-communities-council.jsp [https://perma.cc/RZL3-QU6V] (last visited May 17, 2018) (click "Meetings" tab).

The commissioner, or designee, is required to maintain and consult with the CECLC; consider its recommendations; supervise and coordinate agency policies; identify and revise applicable DHS rules or statutes; and investigate and implement cost-effective service delivery models.[106] The commissioner must review policies that maintain tribal, racial, ethnic, cultural, and linguistic disparities, taking into account the Council's recommendations, and make adjustments to ensure that disparities are not perpetuated.[107]

3. CECLC Responsibilities and Roles

The CECLC is responsible for both identifying and alerting the commissioner to program policies and practices that perpetuate disparities in access and recommending changes.[108] The enabling legislation requires the CECLC to engage with the diverse populations served by DHS to help identify disparities and engage in mutual learning.[109] The legislation also requires the CECLC to raise awareness about disparities among legislators and the media and to provide technical assistance and consultations to counties, private nonprofits, and other service providers.[110] For example, the Council is specifically required to provide technical assistance to help develop statewide human services and policies that are culturally and linguistically appropriate, accessible, and cost-effective.[111] The Council must also provide outreach and training to increase community members' access to culturally and linguistically appropriate, accessible, and cost-effective human services.[112] The Council is also required facilitate culturally appropriate and sensitive admissions, continued services, discharges, and review of utilization for human services agencies.[113] To help it meet its legislated responsibilities, the legislation requires the CECLC to form work groups drawn, in part, from populations served by DHS and

106. MINN. STAT. § 256.041 subdiv. 7. An example of the latter is adapting proven strategies to increase the number of culturally relevant services made available to underserved populations.

107. *Id.*

108. *Id.* subdivs. 8(1)–(2).

109. *Id.* subdivs. 8(2)–(10).

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

advocacy group representatives.[114] The work groups provide councilmembers with guidelines, parameters, and specific tasks and promote information sharing statewide.[115]

The CECLC is required to prepare an annual report to the legislature, summarizing its activities.[116] The report identifies major problems and issues confronting racial and ethnic groups in access to DHS services, recommends actions, lists objectives for the next biennium, describes the Council's programs and grants to reduce disparities, and provides legislators with statistically valid reports of outcomes achieved.[117]

CECLC members serve on a voluntary basis.[118] They are required to attend and participate in scheduled monthly meetings and to maintain open communication channels with constituents.[119] They are also expected to note issues or risks that could affect timely completion of tasks, collaborate on efforts to reduce disparities, share information about CECLC's progress, and participate in other activities deemed appropriate by the CECLC or its chair.[120]

The CECLC's work is supported by the Office of Community Relations, including the Office's director, Antonia Wilcoxon.[121] The current CECLC chair, director of Health Equity Advocacy for the Center for Prevention of Blue Cross & Blue Shield of Minnesota, Vayong Moua, meets frequently with Wilcoxon.[122] The deputy commissioner, or another deputy or assistant commissioner from DHS, attends the monthly CECLC meetings and is allotted time on the agenda to update the Council on the Department's work in progress.[123]

114. *Id.* suvidv. 8(9).
115. *Id.* subvivs. 8(2)–(10).
116. *Id.* subdiv. 8(11).
117. *Id.*
118. CECLC 2017 REPORT, *supra* note 57, at 50 ("Public members of the council shall receive no compensation from the council for their services.").
119. *Id.* subdivs. 9(1)–(2).
120. *Id.* subdiv. 9.
121. *See* CECLC 2017 REPORT, *supra* note 57, at 15.
122. Interview with Vayong Moua, *supra* note 77.
123. *Id.*

D. Development of the DHS Policy on Equity

In 2014, the CECLC developed recommendations for advancing equity at DHS that stopped short of recommending a department-wide policy. The Council presented its recommendation to the department's executive leaders at a meeting in February 2015.[124] Soon afterward, others at DHS began approaching the CECLC for guidance on addressing disparities in various DHS administrations and programs.[125]

Despite these encouraging steps, the CECLC's ability to advance equity within the agency remained limited to reviewing specific programs and services such as a mental health program, Supplemental Nutrition Assistance Program (SNAP) food access, or research methodology.[126] CECLC members believed that a systemic approach was needed to succeed in addressing sources of inequities throughout DHS.[127] In the absence of a systemic approach, the CECLC found its success limited to identifying inequities and, upon tracing back to sources, discovering inadequate staffing, cultural capabilities, or budgets to address them.[128]

In the course of identifying racial, ethnic, and other disparities in DHS programs and services, CECLC members concluded that the inequities detected were symptomatic of weaknesses in the design of the department's staffing plan, leadership structure, contracting and procurement practices, and career advancement opportunities.[129] This, and Council members' observation that DHS's executive leadership lacked diversity and fluency in addressing equity, convinced the CECLC to develop department-wide equity policy recommendations that would focus on making changes to key aspects of DHS's institutional structure—"getting right at the heart of how an agency is designed and functions."[130]

In its pursuit of an agency-wide policy on equity, the CECLC demonstrated strength by advocating on behalf of impacted communities and applying principled pressure, agitation, and

124. CECLC 2017 REPORT, *supra* note 57, at 15.
125. *Id.*
126. Interview with Vayong Moua, *supra* note 77.
127. *Id.*
128. *See id.*
129. *See id.*
130. *Id.*

encouragement.[131] Throughout, councilmembers maintained an amiable posture in advising DHS's executive leadership.[132]

In 2015, CECLC Chair Vayong Moua proposed the idea of a formal department-wide equity policy.[133] The resulting draft was vetted by CECLC members, DHS' senior leadership, as well as external community representatives and policy experts.[134] Anne Barry observed that "[i]t takes a structure to take on another structure," and this statement resonated with CECLC Chair Moua.[135] He and the other CECLC members fully understood the Council *was* that structure and its members had the legislative authority and requisite strength to push for the policy changes they deemed necessary, timely, and appropriate.[136] Debates about how to hold DHS's employees accountable for adhering to a policy on equity created tensions,[137] and, much to the dismay of CECLC members, the Administration on Community and Partner Relations and Barry's position as Chief Compliance Officer were eliminated in July 2016.[138]

Following Barry's departure, deputy commissioner Santo Cruz was assigned to be the liaison between DHS's executive leadership and the CECLC, serving as proxy for Commissioner Emily Piper, whose tenure began in December 2015.[139] Barry's departure had left CECLC members skeptical about the executive leadership's commitment to its work and, in particular, the draft policy on equity.[140] Council members diligently grilled Cruz, setting an expectation for him, in his role as the commissioner's representative, to earn their trust and to enter the ". . . [CECLC] space with humility and conviction. . . ."[141] Cruz weathered this initial display of principled skepticism and developed a positive relationship with the Council. He became a champion in his own right, engaging with Council members effectively, and demonstrating a clear

131. *Id.*
132. *Id.*
133. Interview with Antonia Wilcoxon, *supra* note 77.
134. *Id.*
135. Interview with Vayong Moua, *supra* note 77.
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*

understanding of CECLC's efforts to fundamentally integrate equity into key DHS decision-making processes.[142]

Cruz's unique role as a deputy commissioner responsible for leading DHS' external affairs enabled him to advocate for the CECLC's equity policy goals in his formal interactions with the governor's office and the legislature. He was able to champion the Council's equity policy goals when meeting with other state agency leaders and helped initiate several meetings between the CECLC and state agencies.[143]

Formal adoption of the Policy on Equity had hit a snag when Commissioner Jesson, who had led DHS when the policy was formulated and initially approved, resigned in December 2015 to accept a seat on the Minnesota Court of Appeals.[144] Forward momentum slowed for many months after her departure while the incoming Commissioner, Emily Piper, took time to engage in further in-house dialogue about the proposed policy language.[145] A few modifications were made to the draft language, after taking into account CECLC members' feedback and assuring them that amendments could be requested later.[146] The policy was ratified in January 2017.[147]

1. Goals of the DHS Policy on Equity

The DHS Policy on Equity reflects a common understanding that it is necessary to institutionalize an equity policy.[148] The formal policy provides a responsive platform for engagement between DHS and the communities it serves,[149] and it enables DHS to make operational changes to reduce disparities in health and inequities experienced by these communities.[150] In the words of DHS Commissioner Emily Piper:

142. *Id.*
143. *Id.* For example, MMB has connected CECLC members with legislators and has actively represented DHS by participating in anti-racism conferences. *Id.*
144. *See* interview with Antonia Wilcoxon, *supra* note 77.
145. *See id.*
146. *Id.*
147. CECLC 2017 REPORT, *supra* note 57.
148. *Id.* at 5.
149. *Id.* at 60.
150. *Id.* at 41.

> The goal of our Equity Policy is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation that improves outcomes and reduces health and human services disparities and inequities for the people DHS serves. This policy is the platform for our implementation efforts. It gives us the ability to ask questions about our work and how we can do our work better for the people we serve. The policy wasn't created to solve all disparities issues. It helps guide us as we engage with the community and make decisions.[151]

To this end, the policy intends to "create a more equitable and inclusive culture within DHS [and] calls on all DHS divisions to build tools, expertise, and cultural change based on authentic community engagement in the planning, implementation, and evaluation of DHS's policies and services."[152] Although the Policy on Equity sets an expectation that all DHS employees will comply with its terms, it is not punitive. Still, the policy requires DHS to "develop measures, monitor implementation, and enforce the policy on equity across the agency,"[153] and calls for DHS to develop mandatory training.[154]

2. DHS Policy on Equity Implementation Plan

With the policy ratified, DHS's attention turned to the articulation and rollout of a clear and accountable implementation plan.[155] Wilcoxon presented a draft plan to DHS's Senior Management Team and the DHS Senior Management Policy on Equity Implementation Plan (Implementation Plan) was approved in October 2017.[156]

The Implementation Plan, currently being gradually phased in, seeks to balance accountability measures with the need to provide DHS' separate administrations[157] with sufficient flexibility to tailor

151. Email correspondence with Emily Piper, Comm'r, Minn. Dep't of Human Servs. (Nov. 16, 2017) (on file with author).

152. 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN, *supra* note 65, at 2.

153. CECLC 2017 REPORT, *supra* note 57, at 85.

154. *Id.* at 86.

155. Interview with Vayong Moua, *supra* note 77.

156. *Id.*; 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN, *supra* note 65; Interview with Santo Cruz, *supra* note 55.

157. 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN,

implementation processes.[158] The plan recommends steps that each DHS administration can take to support department-wide equity-policy goals and procedures.[159] For example, the Implementation Plan requires every DHS administration to provide resources for equity committee work, but gives each one the discretion to determine how to operationalize this requirement.[160] Communication components of the plan are designed to help normalize the policy, educate DHS staff about implementation steps, and celebrate and promote the policy.[161]

Again, the DHS Policy on Equity and Implementation Plan apply only to the department's internal operations, executive leaders, and staff—whereas "counties, local governments, health plans, communities of color, American Indians, and other underserved and underrepresented populations form the circle of affected stakeholders and program participants."[162] An anticipated external communications plan will highlight the department's progress to ensure that DHS's efforts and incremental successes become well known and are celebrated in Minnesota and elsewhere.[163] The Implementation Plan recognizes that "[o]nly through collaboration with all of these groups can DHS effectively implement the policy and revise its processes to reduce health inequities."[164]

Figure 2: DHS Policy on Equity Implementation Plan: Stakeholder Expectations.

Collaboration and Inclusion	DHS will engage authentically with impacted communities about proposed changes to

supra note 65. DHS has four main program areas: Children and Family Services, Health Care, Community Supports, and Continuing Care for Older Adults. *Id.*

158. *See id.* at 2.

159. *Id.* ("The overall goal of this Equity Stewardship Working Group (ESWG) is to implement the DHS Policy on Equity into actionable steps.").

160. *Id.* at 4; *see also* Interview with Antonia Wilcoxon, *supra* note 77.

161. Interview with Vayong Moua, *supra* note 77.

162. 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN, *supra* note 65, at 2.

163. Interview with Vayong Moua, *supra* note 77.

164. 2017 Senior Management Team Policy on Equity Implementation Plan, *supra* note 65, at 2.

	department processes and practices that affect them and will involve impacted communities when designing and planning changes.
Awareness	DHS leadership and staff will increase their awareness of the significance of inequities, their impact on all Minnesotans and impacted communities, and take active steps to reduce these inequities and achieve equity.
Leadership	DHS will strengthen relations among the CECLC and state agencies to promote meaningful engagement about equity.
Community Health and Health Systems	DHS's implementation efforts will lead to a system that addresses complex needs, respects cultural beliefs, and embeds cultural practices in healing, seeing community-based organizations as "partners and powerful allies supporting the health of their communities,"[165] and enabling community health workers to become the norm.
Data and Research	DHS will collect, analyze, and share data reflecting characteristics most important to program recipients' communities, to obtain the most appropriate data with community-defined cultural and ethnic groups' input, while promoting both evidence based research.
Performance Management	DHS will initiate systemic performance improvements among DHS staff and service providers by implementing a department-wide

165. *Id.* at 3.

	system including cultural competency and anti-racism trainings.
Equity Analysis	DHS will create and implement a process of analysis for identifying and reforming existing statutes, rules, policies, and operating procedures that perpetuate inequities in health and human services, working with CECLC members.[166]

The Implementation Plan also acknowledges the existence of potential barriers. These include a disbelief among community members that the department recognizes cultural and ethnic community assets, inadequate resources to scale efforts, a lack of diversity among staff, particularly among those involved in decision making, and a lack of equity awareness and skills among leadership and staff.[167] Other recognized potential barriers include failure to institute accountability measures, make appropriate use of available data, or involve community leaders in planning processes, for example, by holding most meetings at DHS.[168]

In addition to establishing administration-specific equity committees and deepening community engagement, the Implementation Plan incorporates structural equity components. For example, DHS's Enterprise of Learning and Development is designated to provide department-wide training. The agency's human resources and Affirmative Action offices are pegged to produce reports, track hiring and retention, and examine why DHS has struggled to retain persons of color, indigenous persons, and persons with disabilities.[169] The Implementation Plan speaks directly to DHS's ongoing need to take active steps to attain the trust of communities experiencing inequities, while recognizing that this lack of trust stems from historical experiences of exclusion and discrimination.[170]

166. *Id.*
167. *Id.* at 3–4.
168. *Id.*
169. Interview with Antonia Wilcoxon, *supra* note 77.
170. 2017 SENIOR MANAGEMENT TEAM POLICY ON EQUITY IMPLEMENTATION PLAN, *supra* note 65, at 4 ("To move forward, DHS will provide the proper training and

Recommended and required implementation action steps are stated as objectives in the Implementation Plan, in alignment with the procedures required by the Policy on Equity.[171] For example, the plan recommends performance measures for tracking DHS's progress in reducing disparities and achieving equity in access to services and outcomes, aligning them with the Policy's procedural processes.[172] These mechanisms are designed to provide DHS leaders and staff with collective and individual opportunities for self-improvement, and to ensure accountability.[173] The Implementation Plan also calls for the CECLC to summarize the department's progress as part of the Council's annual report to the legislature, by adding an "Equity Review" section.[174]

To help guide DHS's implementation of the Policy on Equity, the Implementation Plan creates an Equity Stewardship Working Group (ESWG), to be launched in autumn of 2018 and led by the director of community relations, with oversight by the commissioner.[175] The ESWG will be responsible for "establishing action plans, monitoring administration activities, collaborating with outside stakeholder groups, and serving as both an internal and external resource for the equity policy."[176]

3. Leadership Perspectives on Key Elements for Advancing Equity

In interviews for this article, Moua, in his role as Chair of the CECLC, Wilcoxon, in her role as director of community relations, and Cruz, in his role as deputy commissioner with responsibility for external affairs, each shared perspectives on key elements contributing to DHS's initial success in adopting and implementing the Policy on Equity.

Moua saw the alignment between CECLC's stature as a legislatively established body, its direct access to DHS leaders and

resources to employees to ensure that the agency is well-equipped to deal with matters related to equity.").

171. *Id.* at 4–6.

172. *See id.* at 7.

173. *Id.* at 5.

174. *Id.* at 7 ("Progress in the implementation of the policy on equity is expected to be an element in the yearly legislative report submitted . . . [to the] Minnesota Legislature.").

175. *Id.* at 8.

176. *Id.* at 8–9.

House and Senate leadership, and the Council's recommendation to embed equity in systems-level structures, as key elements leading to adoption of the policy.[177] He stressed the importance of having included in decision-making both internal champions at DHS and "strong, wise, and passionate" external leaders, including CECLC members and others from impacted communities,[178] noting that external prompts are sometimes needed to move department agendas.[179]

Moua saw the combined engagement of internal and external leaders as being instrumental to achieving strong, rigorous policy outcomes.[180] He also cited Governor Mark Dayton's leadership and track record on diversity and inclusion as a motivating influence.[181] Dayton set firm expectations for his cabinet members to make significant improvements in hiring, retention, and advancement opportunities for persons from communities experiencing disparities, and challenged his cabinet to prioritize and be thought leaders on eradicating structural racism.[182]

Wilcoxon emphasized the need for the DHS Policy on Equity to define and uphold "equity" as advancing social justice and basic principles of fairness.[183] She pointed to the policy's recognition that to reduce disparities, it is essential for impacted communities to be true partners in developing and implementing DHS policies.[184] Looking forward, she emphasized the need for DHS leadership and staff to listen to impacted community members' "wisdom . . . power . . . and . . . resilience . . . ." and to be forthright and transparent in community engagement, being careful to communicate clearly and not to over-promise.[185]

Cruz saw two key factors as integral to the department's adoption of the policy: the establishment of the CECLC, including

177. *See* Interview with Vayong Moua, *supra* note 77.
178. *Id.*
179. *Id.*
180. *Id.*
181. *Id.* In addition to establishing and staffing the Office of Diversity and Inclusion through issuance of Executive Orders 15-02 and 16-01, Governor Dayton has prioritized diversity in his Cabinet appointments. *Id.*
182. *Id.*
183. Interview with Antonia Wilcoxon, *supra* note 77.
184. *Id.*
185. *Id.*

its advocacy for structural change,[186] and Governor Dayton's establishment of the Office of Diversity and Inclusion.[187] He noted that the governor's issuance of two executive orders establishing the CECLC "set the tone for what the governor was looking for out of his state agencies."[188]

As a matter of strategy and influence, Cruz emphasized the importance of having someone who reports directly to the commissioner serve as the liaison between those advocating for policy change and the top decision-maker, and giving this person broad latitude to work closely with advocates and impacted communities.[189] Overall, Cruz credited the CECLC as the true driver of the DHS Policy on Equity.[190] In particular, he credited the Council's insistence on institutionalizing "authentic" community engagement and engaging stakeholders at the onset of decision-making processes to ensure internal and external components of inequities will be addressed.[191] Cruz cited CECLC's statutorily granted power to set and control its own agenda as another key factor contributing to the adoption and implementation of the policy, noting that the CECLC's independence in this regard required him and other leaders at DHS to be responsive.[192]

Moua and Wilcoxon both highlighted the importance of providing education and training to expand understanding of structural racism among all DHS leadership and staff,[193] calling out the need for staff to develop fluency in addressing stark disparities in health and well-being experienced by impacted communities.[194] However, Moua strongly emphasized that the Policy on Equity is *less* about beliefs and *more* about behaviors, noting that it clearly intends

186. Speaking to CECLC's advocacy for structural change, Cruz comments: "That was attractive to the commissioner, that was attractive to me. They had a lead from the governor communicating, 'that's the direction we clearly want you to go.'" Interview with Santo Cruz, *supra* note 55.

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*; *see also* MINN. STAT. § 256.041 subdiv. 8 (2017).

193. Interview with Vayong Moua, *supra* note 77; Interview with Antonia Wilcoxon, *supra* note 77.

194. *Id.*

to structurally change the way DHS does business and to serve as a model for other governmental bodies and private sector entities.[195]

Cruz expressed a similar point of view, declaring: "The implementation is really where it's at . . . the policy is really a way to have a conversation throughout an organization and to knock down some of our silos."[196] Cruz came to see that a formal policy was necessary to address equity across all programs at DHS as well as at other large bureaucracies having many distinct administrations and programs.[197]

Looking to the future, Cruz spoke of a need for the policy to always aim to eliminate persistent disparities and for the Implementation Plan to function as a living, breathing, adaptable tool in working toward this goal.[198] He emphasized that having "the appetite to take on things that have a risk of failing in some component . . . is a very necessary thing to make progress . . ." and noted that the nature of the inequities and disparities tackled will vary over time.[199]

Overall, Moua credited the CECLC for the vigor and urgency its members brought to the policy adoption process, their grounding in equity principles, and the resulting ability to back up the Council's recommendations.[200] He also credited DHS's top leaders for being thoughtful leaders and for prioritizing the adoption and implementation of the policy, including their early investment in building department-wide support, which helped make the creation of the CECLC and the formulation of the Policy on Equity accepted by staff as natural next steps.[201] That said, Moua, Wilcoxon, and Cruz each remarked that DHS has a long way to go to fully realize the potential of the Policy on Equity.[202] They also stressed the need for DHS to stay the course, maintain the CECLC, and invest sufficient resources in implementation to deliver on the promise of the Policy on Equity.[203]

195. Interview with Vayong Moua, *supra* note 77.
196. Interview with Santo Cruz, *supra* note 55.
197. *Id.*
198. *Id.*
199. *Id.*
200. Interview with Vayong Moua, *supra* note 77.
201. *Id.*
202. *Id.*; Interview with Santo Cruz, *supra* note 55; Interview with Antonia Wilcoxon, *supra* note 77.
203. Interview with Santo Cruz, *supra* note 55; Interview with Vayong Moua,

IV. EXAMPLES OF EQUITY AND HEALTH EQUITY POLICIES AND PRACTICES IN SELECTED STATES

Many states are doing impressive work to advance health equity and equity in general by using a variety of policy and programmatic mechanisms.[204] Three states with notable initiatives are California, Washington, and Vermont.[205]

A. California

1. HiAP Task Force

An Executive Order[206] issued in 2010 created a HiAP Task Force (Task Force), and assigned the role of staffing and facilitation to the California Department of Public Health (CDPH).[207] It also placed the Task Force under the auspices of the governor's Strategic Growth Council (SGC), which directs collaboration between state agencies to create healthy and environmentally sustainable communities.[208] The Task Force works with state agencies and organizations to develop relevant public policy within non-health

supra note 77; Interview with Antonia Wilcoxon, *supra* note 77 ("Ultimately we want to be a respected organization . . . . I think that vigilance is there . . . but ultimately it is Mrs. Smith down the street that I am accountable to. Because if her life doesn't improve, the many dollars that we are spending here are for naught. That is always center.").

204. *See generally 2014 Health Equity Minority Health Survey*, ASS'N STATE & TERRITORIAL HEALTH OFFICIALS, http://www.astho.org/Programs/Health-Equity/Minority-Health-Survey/2014/State-Snapshots/Map/ [https://perma.cc/6X8V-BPMT] (last visited Mar. 26, 2018) (giving a snapshot of health equity programs in different states).

205. *See* discussion *infra* Sections III.A–III.C.

206. *Executive Order S-04-10*, OFF. GOVERNOR CAL., http://sgc.ca.gov/programs/hiap/docs/20100401-Executive_Order_S_04_10.pdf [https://perma.cc/P5PE-EBD5].

207. *Id.* at 2 ("The Task Force shall be facilitated and staffed by the California Department of Public Health working with representatives from the agencies and departments represented on the SGC, in addition to representatives from other agencies or departments whose input may be necessary to achieve the Task Force's goals.").

208. See GOV'T. OF S. AUSTL. & WORLD HEALTH ORG., PROGRESSING THE SUSTAINABLE DEVELOPMENT GOALS THROUGH HEALTH IN ALL POLICIES: CASE STUDIES FROM AROUND THE WORLD 62–63 (2017), http://www.who.int/social_determinants/publications/progressing-sdg-case-studies-2017.pdf?ua=1 [https://perma.cc/D6SQ-KXUF] [hereinafter GOV'T OF S. AUSTL.].

sectors and systems that drive health outcomes.[209] By assessing how health is impacted by different laws and policies that relate to social determinants of health such as transportation, housing, and access to healthy food, the Task Force helps to improve policies that impact living conditions which facilitate or block health and well-being.[210]

The Task Force is comprised of representatives from twenty-two agencies who meet several times per year as a full body.[211] Its work is completed through actions by inter-agency teams.[212] The Task Force monitors the progress of projects, presents updates at public SGC meetings, and writes action reports that summarize outcomes and lessons learned from projects.[213] At these meetings, staff receive input from external stakeholders such as regional and local governments, advocacy organizations, and policy think tanks.[214]

The work of the Task Force was built in multiple stages over time. A proposal for a HiAP initiative was first developed in 2009 by governmental and non-governmental leaders, resulting in the 2010 Executive Order that created the Task Force.[215] Staffing was provided through a partnership between the California Department of Health, the Public Health Institute, and the California Endowment, and that staffing partnership has continued through the current year.[216] The Task Force began engaging stakeholders in 2010, and developed a report with a framework, goals, and thirty-nine recommendations for government action.[217] In 2011 and

209. *See* CAL. DEP'T PUB. HEALTH, OFFICE OF HEALTH EQUITY, PORTRAIT OF PROMISE: THE CALIFORNIA STATEWIDE PLAN TO PROMOTE HEALTH AND MENTAL HEALTH EQUITY 21 (2015), https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH_OHE_Disparity_Report_Final%20(2).pdf [https://perma.cc/GDP5-7Y8Q] [hereinafter CAL. DEP'T OF PUB. HEALTH, OFFICE OF HEALTH EQUITY].

210. *See id.*

211. *See id.* at 25, 88; *Council Meetings*, CAL. STRATEGIC GROWTH COUNCIL, http://www.sgc.ca.gov/meetings/council/ [https://perma.cc/2L4A-M8XF] (showing the scheduled meetings for the coming year.).

212. *See* CAL. DEP'T OF PUB. HEALTH, OFFICE OF HEALTH EQUITY, *supra* note 209, at 25.

213. *See id.*

214. *See id.* at 25–26.

215. *See* GOV'T. OF S. AUSTL., *supra* note 208, at 66.

216. Telephone Interview with Julia Caplan et al., Cal. Office of Health Equity & Health in All Policies Task Force (Nov. 29, 2017) (on file with author) [hereinafter Telephone Interview with Julia Caplan et al.].

217. *See* GOV'T. OF S. AUSTL., *supra* note 208, at 66.

2012, the Task Force identified early priorities and worked on securing commitments from stakeholders and other government bodies, developing nine action plans that outlined collaborative actions for multiple agencies to take.[218] The Task Force initially focused on small, achievable goals to build momentum and a reputation amongst the agencies, while also exploring the feasibility of larger impact actions.[219]

Since 2012, the Task Force has focused on the implementation of cross-sectoral action plans to foster collaboration and embed health and equity across government, and has created public accountability mechanisms, including public reports and stakeholder meetings.[220] Since 2016, the Task Force has emphasized systemizing its approach to make HiAP a normal part of government operations.[221] The Task Force has helped normalize conversations about equity in broader state government and is seen as an effective partner for agencies having equity goals.[222] The Task Force is currently developing a multi-agency action plan on equity in government practices and is launching a 2018 pilot program to build the capacity of state government staff to advance racial equity.[223]

The Task Force's success can be attributed to its ability to develop a common mission with state agencies and other stakeholders.[224] By formulating its own vision with others' input, it has created a shared vision that has yielded investments from stakeholders.[225] The Task Force has also learned to navigate differences by holding space for difficult conversations or creating working groups to address controversial issues.[226] Because the Task Force works to understand agencies' priorities and contextualizes its work on those priorities, and the staff of the Task Force make

218. *Id.* (explaining that these nine action plans often required the formation of multi-agency working groups to accomplish tasks and support deeper collaboration).

219. *Id.*

220. *Id.*

221. *See id.* at 67.

222. *Id.*

223. *Id.*

224. *Id.* at 69.

225. *Id.*

226. *See id.* ("[T]he opportunistic and collaborative style of the Task Force means that staff may not be able to predict the outcome of an action at the outset, making it difficult to set quantifiable goals.").

themselves available to address agencies' concerns and needs, participating agencies see a benefit to their staff and resources.[227]

The Task Force has accomplished several key policy and programmatic changes. For example, in 2012, the Departments of Education, Food and Agriculture, and Public Health established the California Farm to Fork Office to promote policies and strategies to improve public access to healthy, locally sourced food.[228] In 2015, the Department of Transportation added a health goal to its mission statement and active transportation metrics to its strategic management plan, consequently developing a health equity stakeholder group and incorporating health into its regional transportation planning guidelines.[229] In 2015, the Task Force also developed a cross-sectoral collaboration with ten agencies to address violence prevention.[230]

2. Office of Health Equity

In 2012, the California legislature established the Office of Health Equity (OHE) and an OHE Advisory Committee.[231] Together, these entities are tasked with advancing the following goals:

> (1) Achieve the highest level of health and mental health for all people, with a special focus on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.
> (2) Work collaboratively with the HiAP Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.
> (3) Advise and assist state agencies in their mission to increase quality and access to culturally and linguistically competent health and mental health care and services.

227. *Id.* at 66–68.

228. *History of the Office of Farm to Fork*, CDFA OFF. FARM TO FORK, http://cafarmtofork.com/history.htm [https://perma.cc/58T4-BCGS] (last visited Jan. 28, 2018).

229. *See* CALTRANS, STRATEGIC MANAGEMENT PLAN: 2015–2020, 3–4, 6 (2015).

230. GOV'T. OF S. AUSTL., *supra* note 208, at 69.

231. *See* CAL. DEP'T OF PUB. HEALTH, OFFICE OF HEALTH EQUITY, *supra* note 209, at 11.

> (4) Improve the health status of all populations and places, prioritizing the elimination of health and mental health disparities and inequities.[232]

The OHE develops and analyzes policies and plans on issues affecting historically vulnerable communities, with a focus on mitigating inequities in health and mental health outcomes.[233] Its Deputy Director is appointed by the Governor or by the State Public Health Officer and confirmed by the State Senate; the Deputy Director reports to the State Public Health Officer and works directly with the Director of Health Care Services to ensure departmental compliance with the OHE's plans and policies.[234]

The OHE Advisory Committee is composed of twenty-eight representatives from state agencies and departments, community based organizations, local health departments, and other government and community stakeholders.[235] Importantly, the Advisory Committee includes representatives from diverse demographics across the state, and the chair, Dalila Butler, represents a non-state entity.[236] The committee meets on a quarterly basis and has the power to form subcommittees, as determined by its chair.[237] In addition to informing OHE's work, committee members function as ambassadors for the committee's work throughout the state.[238]

The OHE has three units. The first is Community Development and Engagement, which aims to "strengthen the [California Department of Public Health's] . . . focus and ability to advise and assist other state departments in their mission to increase access to,

232. CAL. HEALTH & SAFETY CODE § 131019.5(f) (West 2012).

233. *Id.*

234. *Id.* § (e)(1)–(2).

235. *See Office of Health Equity Advisory Committee Member Bios*, CAL. DEP'T OF PUB. HEALTH (Aug. 3, 2017), https://www.cdph.ca.gov/Programs/OHE/Pages/OHEAdvisoryCommitteebios.aspx [https://perma.cc/7LGC-GSRQ].

236. *See id.* ("Dalila Butler, MPH, Senior Associate at PolicyLink, works with the PolicyLink Center for Health Equity and Place to promote social, economic, and health equity through environmental and policy change, particularly in low-income communities and communities of color.").

237. CAL. HEALTH AND HUMAN SERVS. AGENCY, CAL. DEP'T OF PUB. HEALTH, OFFICE OF HEALTH EQUITY, ADVISORY COMMITTEE BYLAWS 2, 7, https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Office%20of%20Health%20Equity%20Advisory%20Committee%20bylaws.pdf [https://perma.cc/XB9D-L6WC].

238. Telephone Interview with Julia Caplan et al., *supra* note 216.

and the quality of, culturally and linguistically competent mental health care and services."[239] The second is Health Equity Policy and Planning, which aims to provide statewide leadership across multiple agencies and departments on PSE change by embedding health, equity, and sustainability into governmental decision-making, guidance, practices, and policies.[240] The Health Equity Policy and Planning Unit coordinates OHE's work with the HiAP Task Force.[241] The third is Health Research and Statistics, which researches and produces data while providing information and technical assistance about health and mental health disparities and inequities.[242]

The OHE's mission is to "[p]romote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all."[243] This is done by assessing and addressing policies and practices that have led to health inequities, analyzing and disseminating data to inform policy, working across sectors to improve social determinants of health equity, building capacity of the public health field to improve health equity, and communicating about the meaning of health and mental health inequity to foster understanding.[244]

A key initiative of the OHE is the California Reducing Disparities Project.[245] This project awards $60 million to forty-one contractors and grantees over six years to evaluate mental health practices with community-defined evidence.[246] It aims to identify and

239. *Community Development and Engagement Unit (CDEU)*, CAL. DEP'T PUB. HEALTH, OFF. OF HEALTH EQUITY (Apr. 18, 2017), https://www.cdph.ca.gov/Programs/OHE/Pages/CDEU.aspx [https://perma.cc/V9MQ-F5ZP].

240. *Health Equity Policy & Planning (HEPP) Unit*, CAL. DEP'T PUB. HEALTH, OFF. HEALTH EQUITY (Aug. 30, 2017), https://www.cdph.ca.gov/Programs/ OHE/Pages/Policy-Unit.aspx [https://perma.cc/PV2N-9Z6C].

241. *Id.*

242. *Health Research and Statistics Unit (HRSU)*, CAL. DEP'T PUB. HEALTH (Dec. 7, 2017), https://www.cdph.ca.gov/Programs/OHE/Pages/HRSU.aspx [https://perma.cc/4GWY-X5JT].

243. *About Office of Health Equity*, CAL. DEP'T OF PUB. HEALTH (May 2, 2017), https://www.cdph.ca.gov/Programs/OHE/Pages/About_OHE.aspx [https:// perma.cc/5FBW-VJG3].

244. *Id.*

245. *California Reducing Disparities Project*, CAL. DEP'T PUB. HEALTH (Feb. 1, 2018), https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx [https://perma.cc/83R3-5ZS9].

246. *Id.* Community-defined evidence is based on a set of community-based practices that a community has used and determined to yield positive results, as

elevate practices that can be scaled for underserved communities across the state, specifically, African American, Asian and Pacific Islander, Latino, LGBTQ, and Native American communities.[247]

The OHE's alignment and relationship with the HiAP Task Force is essential to its work in developing and engaging state agencies and community organizations in cross-sectoral efforts. By housing the entire staff of the Task Force under the Department of Public Health during its first six years,[248] the Task Force grounded itself in public health principles and practice. Now, with its staff at both the SGC and the OHE, the Task Force functions as a cross-agency team.[249] The OHE assists the Task Force with data and research, subject matter expertise, and guidance on priorities.[250] While the OHE and the HiAP Task Force are different entities, they have a shared conceptual framework regarding how health inequities are produced and how to approach work to advance health equity.[251] They also work together to develop strategies, prioritize work, develop guidelines, and collaborate on projects.[252] The creation of the OHE helped catalyze a shift in bringing health equity to the forefront of policymaking.[253] The OHE and Task Force work cooperatively on projects, each entity drawing on the other's expertise and relationships.[254]

The OHE and HiAP Task Force also face challenges together. Both entities have limited staff who work on changes to multiple systems that produce health inequities and provide a high level of assistance and partnership to other organizations.[255] The number of requests for their assistance has increased as awareness has grown, and both entities have worked hard to build partnerships and to ensure that partners receive value from their work.[256] To this end, they also have strived to be available to support and enhance

determined by community consensus over time, which may or may not have been measured empirically but have reached a level of acceptance by the community. *Id.*

247. *Id.*
248. Telephone Interview with Julia Caplan et al., *supra* note 216.
249. *See id.*
250. *See id.* (describing the collaborative nature of the Task Force's staff).
251. *Id.*
252. *Id.*
253. *Id.*
254. *Id.*
255. *See id.*
256. See *id.*

partners' efforts to accomplish their respective missions on behalf of all California residents.[257]

B. Washington

In 2006, the Washington legislature established the Governor's Interagency Coordinating Council on Health Disparities ("The Council").[258] The Council is charged with creating an action plan stating its recommendations for eliminating disparities, convening advisory committees to help develop policy recommendations, and developing recommendations to the Governor and legislature to improve the availability of culturally and linguistically appropriate health literature and interpretive services.[259]

The Council is comprised of seventeen members, three of whom must be appointed by the Governor.[260] The Governor designates a Chair from the Governor's office and appoints two members of the public to represent health care consumers.[261] Other members of the Council include representatives of the state's racial and ethnic commissions and some, but not all, state agencies and boards.[262] A Vice Chair is elected from amongst the Council members.[263] The day-to-day work of the Council in meeting its legislated mandates is supported by one full-time member of the staff of the Washington State Board of Health.[264] The Council meets quarterly and its meetings are open to the public.[265] Since its inception, the Council has created several ad hoc advisory committees to assist in developing recommendations on selected topics like obesity, adverse birth outcomes, diabetes, and the

257. *Id.*

258. WASH. REV. CODE. § 43.20.270 (2006).

259. *The Council's Work*, GOVERNOR'S INTERAGENCY COUNCIL HEALTH DISPARITIES, http://healthequity.wa.gov/TheCouncilsWork [https://perma.cc/38FD-329R] (last visited Feb. 26, 2018).

260. GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, BYLAWS 1 (2007), http://qa.healthequity.wa.gov/Portals/9/Doc/Org/HDC-Org-Bylaws.pdf [https://perma.cc/4YS3-WARS].

261. *Id.*

262. *Id.*

263. *Id.* at 2.

264. Telephone Interview with Christy Curwick Hoff, Manager, Wash. State Bd. Health (Nov. 29, 2017). The Washington State Board of Health is currently supported by 7.5 FTE staff members. *Id.*

265. *Id.*

educational opportunity gap.[266] The Council submits its recommendations to the Governor for preliminary approval before final submission to the Governor and the legislature.[267]

In its first State Policy Action Plan to Eliminate Health Disparities, in 2010,[268] the Council approached health equity in a holistic way by discussing the connection between health and educational attainment, health insurance coverage, healthcare workforce diversity, obesity and diabetes, and language access.[269] Since 2012, the Council has provided the legislature with annual updates describing its achievements and revised goals.[270] The summary reports provide many examples of how equity work is being done on a departmental basis.[271]

In its 2016 report, the Council notes the Department of Social and Health Services is creating infrastructure to develop a more diverse healthcare workforce, and the Department of Health is assessing ways to positively impact health equity and tribal health.[272] The 2016 report also describes a goal set by the Department of Early Learning to ensure 90 percent of Washington children are ready for kindergarten by 2020, and steps the Department of Health has taken

266. *Id. See generally Advisory Committees*, GOVERNOR'S INTERAGENCY COUNCIL HEALTH DISPARITIES, http://healthequity.wa.gov/TheCouncilsWork/Advisory Committees [https://perma.cc/5XKB-7WDP] (last visited Feb. 28, 2018) (providing more information about the council's advisory committees) [hereinafter GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES].

267. Telephone Interview with Christy Curwick Hoff, *supra* note 264. The Council requires its members' approval as an earlier step, which can trigger a review and approval process at participating state agencies. For example, a state agency may oppose a recommendation because it lacks the resources for full-scale implementation, yet may support a portion of what was recommended. *Id.*

268. GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, STATE POLICY ACTION PLAN TO ELIMINATE HEALTH DISPARITIES (2010), http://healthequity.wa.gov/Portals/9/Doc/Publications/Reports/HDC-Reports-2010-Action-Plan.pdf [https://perma.cc/MTF8-SBB3].

269. *See generally id.*

270. GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, STATE ACTION PLAN TO ELIMINATE HEALTH DISPARITIES: DECEMBER 2016 UPDATE, 4 (2016), http://healthequity.wa.gov/Portals/9/Doc/Publications/Reports/HDC_December2016ActionPlanUpdate-Final.pdf [https://perma.cc/B7V7-KH5Y].

271. *See generally Reports*, GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, http://healthequity.wa.gov/CouncilPublications/Reports [https://perma.cc/K6VZ-DFFX] (last visited Jan. 30, 2018) (providing links to past annual reports).

272. GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES, *supra* note 268.

to realize this goal.[273] This includes creating a Racial Equity Team with representatives from divisions within the Department, and providing leadership to implement a department-wide comprehensive racial equity strategy.[274] The Team has a dedicated budget and is developing an Equity in Service Provision and Outcomes report for tracking and measuring results.[275]

The 2016 report also provides an update on the Department of Health's cross-agency Health Equity Workgroup.[276] The report describes the Workgroup's progress implementing a comprehensive strategy for analyzing agency bills through an equity lens,[277] noting as of the 2015 legislative session, the Department of Health added two items to its standard bill analysis form: (1) asking whether a proposed bill impacts tribal health; and (2) whether it impacts health equity or health disparities.[278]

The Council is currently working with the Governor's office, encouraging creation of a statewide equity initiative to institute a more comprehensive, state-level systemic approach for reducing disparities and inequities.[279] State agencies participating on the Council have already agreed to create individual agency action plans to implement, based on equity recommendations developed by the Council.[280] The Council intends to combine the individual plans into a statewide action plan to be submitted for approval, and plans to develop performance measures for tracking implementation of the recommendations.[281]

The Council is also statutorily required to work with the Washington State Board of Health to prepare Health Impact Reviews (HIR) of proposed legislation when requested by a state legislator or the governor.[282] HIRs provide research-supported information

273. *Id.* at 7.
274. *Id.*
275. *Id.*
276. *Id.* at 6.
277. *Id.*
278. *Id.*
279. Interview with Christy Curwick Hoff, *supra* note 264.
280. *Id.*
281. *Id.*
282. WASH. REV. CODE. § 43.20.285 (2006). An HIR is a non-partisan, objective, and rigorous evidence-based research tool for examining how proposed legislative policies may positively or negatively impact health. *Health Impact Reviews*, WASH. ST. BOARD HEALTH, http://sboh.wa.gov/OurWork/HealthImpactReviews [https://

about disproportionately impacted communities and how they may be affected by proposed bills, including analysis of potential positive and negative health impacts.[283] During legislative sessions, State Board of Health policy analysts must complete HIRs requested on active bills within ten days.[284] State Board of Health staff are available to testify about HIR findings, track bills for upcoming hearings, and send reminders of availability if not directly contacted already.[285]

The Council works to make HIRs more institutionalized and routine, reaching out to legislators to remind them that they can request HIRs and that there is a relatively short turnaround time for active bills during legislative sessions.[286] Requests for HIRs initially came from only a handful of legislators, predominantly Democrats.[287] As familiarity with HIRs has grown, requests have increased significantly.[288] Washington's introduction of HIRs has sparked other states' interest in piloting similar types of legislative policy analyses, such as health notes, analogous to the fiscal notes used by legislators to assist them in evaluating potential economic impacts of proposed bills.[289] Additionally, one Washington legislator expressed interest in creating a racial equity impact review process.[290]

perma.cc/RK6H-8M32] (last visited Jan. 30, 2018) [hereinafter *Health Impact Reviews*].

283. *See Health Impact Reviews*, *supra* note 282. When preparing HIRs, State Board of Health policy analysts rely on already-published research and quantify the relative strength of available evidence, indicating whether there is very strong, strong, fair, or not enough evidence that a proposed policy is likely to achieve positive or negative health impacts. *See, e.g.*, WASH. STATE BD. HEALTH, EXECUTIVE SUMMARY: HEALTH IMPACT REVIEW OF SB 6003 (2018).

284. WASH. REV. CODE § 43.20.285(2).

285. Interview with Christy Curwick Hoff, *supra* note 264.

286. *See id.*

287. *Id.*

288. *Id.*

289. *See id.*; LEGISLATIVE BUDGET BD., STATE OF TEX., FISCAL BUDGET BD., http://www.lbb.state.tx.us/Fiscal_Notes/Fiscal%20Note%20Overview.pdf [https://perma.cc/J7FY-568C] (explaining "fiscal notes"); *Pilot Program to Help States and Localities Consider Health in Policymaking*, PEW CHARITABLE TRUSTS (Nov. 7, 2017), http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2017/11/pilot-program-to-help-states-and-localities-consider-health-in-policymaking [https://perma.cc/TD2A-AAVU] (explaining "health notes").

290. Interview with Christy Curwick Hoff, *supra* note 264.

C. Vermont

A Vermont Department of Health study, published in 2010, determined that while Vermont is one of the nation's leaders in public health indicators, it had significant health inequities.[291] The report indicated that lower-income individuals reported higher rates of depression and chronic conditions such as asthma, heart disease and stroke, or diabetes, and that 15 percent of lower income adults had at least two chronic conditions, compared to 7 percent of adults with higher incomes.[292] Moreover, the study showed that differences in education, income, and race resulted in a wide breadth of disparate health outcomes, from teen pregnancy to smoking to cancer rates.[293]

As a result, when the Department of Health created a strategic plan to improve the work of the department, its leaders committed to the goal of increasing health equity by 2020.[294] The plan includes strategies for addressing health outcomes, recruiting diverse staff, and offering services to individuals with limited English proficiency.[295] Many of the strategies being pursued by the Department of Health to achieve health equity focus on making policy and infrastructure changes to create communities that support health and wellness.[296] This requires the Department of Health to engage non-health sector leaders in these efforts.[297]

Following years of collaborative work on healthy community design, the governor of Vermont issued Executive Order No. 07-15

291. VT. DEP'T OF HEALTH, THE HEALTH DISPARITIES OF VERMONTERS (2010), http://www.healthvermont.gov/sites/default/files/documents/2016/11/Healt%20Disparities%20of%20Vermonters%202010.pdf [https://perma.cc/N8GR-XPKJ].

292. *Id.* at 12.

293. *Id.* at 6–25, 50–63.

294. VT. DEP'T OF HEALTH, VT. DEP'T. OF HEALTH STRATEGIC PLAN (2014), http://www.healthvermont.gov/sites/default/files/documents/2016/11/Health_Dept_Strategic_Plan_2014-2018.pdf [https://perma.cc/Y7WT-VCYS]; *see also* VT. DEP'T. OF HEALTH, HEALTHY VERMONTERS 2020 (2012), http://www.healthvermont.gov/sites/default/files/documents/2016/11/Healthy%20Vermonters%202020%20Report.pdf [https://perma.cc/NP64-94XX].

295. *Id.* at 3–7.

296. Telephone Interview with Heidi Klein, Advisor, Vt. Pub. Health Inst. (Nov. 30, 2017) (on file with author).

297. *Id.* (explaining that the Department engages with leaders in transportation, economic development, housing, land use, and others).

in 2015, creating a Health in All Policies (HiAP) Task Force (Task Force) to integrate consideration of health impacts related to state policy, program, and budget decisions.[298] The cabinet-level Task Force is comprised of representatives from agencies and departments whose input helps the Task Force achieve the goals of increasing affordable housing, improving air and water quality, improving infrastructure, planning sustainable communities, and increasing educational attainment.[299]

The Task Force meets quarterly and its decisions are made by consensus.[300] The member agencies staff the Task Force and the Vermont Department of Health provides it with technical and logistical assistance.[301] Unlike the advisory group to the OHE and HiAP Task Force in California, the Task Force has no community representation.[302]

The Task Force has created a Health and Equity Framework, based on the core values of equity, affordability, and access, to guide its work.[303] This framework identifies several determinants of health and equity:

- affordable, healthy, local food;
- health and prevention services;
- recreation, parks and natural resources;
- safe and efficient transportation;
- affordable, safe, quality housing;
- safe, supported community early childhood development;
- economic prosperity, equitable law and justice system;
- livable/family wage jobs and job opportunities;
- clean and sustainable natural environments;
- quality education;
- strong, vibrant communities; and

298. *See* VT. STAT. ANN. tit. 3A, § 3-69 (2018).

299. VT. DEP'T. OF HEALTH, REPORT TO THE GOVERNOR: HEALTH IN ALL POLICIES 3–4 (2017), http://www.healthvermont.gov/sites/default/files/documents/2017/01/HIAP_annual-report-2017.pdf [https://perma.cc/U84M-6TEN] [hereinafter REPORT TO GOVERNOR].

300. *Id.* at 4.

301. *Id.*

302. *See* Telephone Interview with Heidi Klein, *supra* note 296.

303. REPORT TO GOVERNOR, *supra* note 299, at 4.

- civic engagement and community connections.[304]

The Task Force uses a variety of tools to help create well-informed policies, including Health Impact Assessments, which provide accurate data and recommendations regarding communities to be served, an inventory of current activities and best practices, and an expenditure analysis.[305] The Task Force has adopted two wellness programs: LiveWell Vermont, a state employees' worksite wellness program;[306] and a Healthy Food Procurement Tool Kit, which guides state agencies in purchasing and offering healthy food at cafés, concessions, and cafeterias on state property or at state-funded events.[307] Most of the Vermont HiAP Task Force's work has focused on policy change rather than program development.[308] Members of the Task Force have willingly committed staff time to carry out groundwork that aligns with the goals and priorities of their agencies, including identifying opportunities for increased collaboration and inclusion of health.[309]

In working toward its equity goals, the Task Force has added a health equity lens to existing projects.[310] For example, health equity has been inserted into criteria that will be used to determine how money from a settlement with a major car manufacturer will be spent.[311] Additionally, the health commissioner is participating in the state's outdoor recreation and economics collaborative.[312]

The Vermont HiAP Task Force builds upon a shared vision for Vermont's sustainable communities and continuous, cross-sector work that dates back to the early 1990's.[313] Notably, the Task Force continued its work seamlessly through the election of a new governor and all new cabinet members.[314] In its first year, the Task Force reviewed national best practices for including health

304. *Id.*
305. *Id.* at 4–5.
306. *Id.* at 6.
307. *Id.* at 7.
308. *Id.* at 8.
309. *See* Telephone Interview with Heidi Klein, *supra* note 296.
310. *Id.*
311. *Id.*; *see also VW Environmental Mitigation Funds*, DEP'T OF ENVTL. CONSERVATION, http://dec.vermont.gov/air-quality/vw#BeneficiaryMitigationPlan [https://perma.cc/V5BS-RV7Q] (last visited Mar. 3, 2018).
312. Telephone Interview with Heidi Klein, *supra* note 296.
313. *Id.*
314. *Id.*

considerations in non-health sectors, and highlighted practices already underway in Vermont.[315]

The Task Force is currently facilitating the formal alignment of goals, projects, and budgets across state agencies.[316] Specifically, it is identifying opportunities for collaborative work that effectively meets multiple agencies' primary goals while furthering health equity goals.[317] Director of Planning and Healthcare Quality, Heidi Klein, who staffs the Task Force on behalf of the Commissioner of Health, explains: "[W]e're trying to achieve the same thing but we come at it through different places. . . . [W]e all have this joint desire to create certain types of communities, and health is a vital component of that."[318]

V. LESSONS FOR ADVANCING EQUITY AND HEALTH EQUITY IN STATE-LEVEL GOVERNANCE

Approaches for advancing equity and health equity in state-level governance vary significantly among states, and understandably so. The different approaches reflect the many unique, and evolving characteristics of each state's make-up including, but not limited to, their histories, politics, populations, policies, practices, systems-level structures, and leadership. The structural approaches introduced by the four states profiled here are relatively recent, pioneering efforts—and the individuals who are most deeply engaged in moving the work forward are true pioneers.

The authors of this article interviewed individuals prominent in state-level efforts to advance equity and health equity in California, Minnesota, Washington, and Vermont. They were asked what advice they would give to pioneers in other jurisdictions based on their expertise and experience. The following elements stand out as key considerations, selected from the many perspectives shared:

While rooted in a values and principles-driven health and equity framework, equity policy development and implementation focuses primarily on structural change. Developing a common understanding of, and fluency in, applying foundational principles and values concerning, at a minimum, structural racism, health disparities among impacted

315. REPORT TO GOVERNOR, *supra* note 299, at 5.
316. *Id.* at 3–5.
317. Telephone Interview with Heidi Klein, *supra* note 296.
318. *Id.*

communities, social determinants of health and well-being, and cultural and linguistic competency, is essential to effectively advance and sustain systemic change in state government practices and processes. Commitment to equity policy, as characterized by structural change, must be clear, unequivocal, and adopted as a systemic practice to maintain progress regardless of inevitable turnovers in leadership and administrations. Education and implementation training to strengthen capacity among all staff, senior management, and leadership must be prioritized and routinized as a component of policy development and practice.

Meaningful engagement of external (non-government) representatives of impacted communities is essential for developing and implementing an equity policy. This enables genuine community engagement, holds agencies accountable, and furthers the goals of eradicating structural racism and reducing persistent disparities in health experienced by impacted communities. Building trust amongst disenfranchised communities cannot be accomplished without a deep and genuine commitment to community engagement that provides community representatives with seats at the decision-making table during all stages of policy formation, implementation, monitoring, and evaluation. Community representatives bring rich and diverse perspectives, experiences, and wisdom that benefit all aspects and stages of policy work and planning.

All stakeholders benefit greatly when an equity or health equity advisory group has the latitude to set and control its own agendas and to speak openly on policy matters. In the absence of such authority, an advisory group's power to stand behind its recommendations is diminished.

A cabinet-level official with direct access to the top decision-maker of the applicable governmental body can play a critical role on an advisory council, task force, or policy planning group on matters of equity, disparities, diversity, and inclusion. The direct, active engagement of high-level officials promotes transparency, provides access to the highest level of leadership, and affects decision-making and recommendations. High-level leaders can be instrumental in building internal and external buy-in for policy components, adoption, and implementation, and can play important roles in strengthening relationships between impacted communities and governmental bodies.

Formal adoption and implementation of equity and health equity policies and practices, with teeth, ensure that systems-wide change is an expectation

in all aspects of operations and delivery of services. A formal policy, when accompanied by a rigorous, formal implementation and communication plan, provides a structure that is well matched with the magnitude of the disparities and inequities experienced by communities. The presence of a formal policy also establishes an accountable and responsive pathway for addressing the disparities and inequities. Institutionalization of policies and practices sends a clear message to all employees, internal and external government and non-government leaders, members of impacted communities, and the public that buy-in has been achieved at the highest level of the agency's leadership. A formal policy also enables the work to progress with prescribed accountability measures in place. Institutionalization normalizes equity and health equity policy and practices and makes it less likely that a turnover in administration or party will upend the commitments made.

Including a reporting requirement as a component of policy design and implementation provides year-to-year internal and external accountability. A periodic reporting requirement provides a public-facing mechanism for tracking policy and practices' successes, weaknesses, gaps, opportunities for expansion, and cross-sector collaboration, and is an important mechanism for holding decision-makers accountable.

Encouraging and supporting the capacity of staff, high-level agency leaders, and representatives of impacted communities to prioritize cross-sector collaboration and partnerships is necessary to advance equity, health equity, and HiAP principles, practices, and policies across state government. To make steady progress toward reducing disparities and eliminating inequities throughout state government operations, cross-sectoral work must be encouraged and valued, and the viability of this work must be supported with sufficient resources. Staff and agency leaders assigned to perform cross-sectoral work function as ambassadors of equity and health equity goals. They help to build relationships and trust through formation of collaborative partnerships with non-health sector agencies. They can also facilitate discussions and help others see how progress toward their respective goals can be enhanced through adoption of equity and health equity goals.[319]

319. In Minnesota, for example, in addition to engagement in cross-sector work, DHS' leadership, in adopting the Policy on Equity, is encouraging the leadership of other state agencies to examine their practices and consider policy changes. Cruz, Wilcoxon, and CECLC chair Moua have met with leaders of other state agencies. Interview with Antonia Wilcoxon, *supra* note 77. Multiple health plans in Minnesota

Abundant use of well-honed communication and diplomacy skills is instrumental in this regard,[320] as is maintaining a positive outlook.[321]

Staff specializing in cross-sectoral work can help non-health sector agencies with policy research, analysis, consensus-building and developing accountability measures. A rather deep level of collaboration is characteristic of such work. Cross-sector engagement requires an openness to detailed discussions and work processes that support relationship building and cultivation of trust across sectors and with impacted communities. An important aspect of this work involves allowing staff sufficient flexibility to respond to windows of opportunity that present themselves. For example, when a department is preparing to update a strategic plan or revamp a decision-making process, or responding to an emergency or crisis such as changes to federal immigration policies that significantly affect a state's immigrant population.[322]

Documenting the work and establishing a mechanism for networking among states. Whether formal or informal, all states engaged in equity and health equity work have much to learn from each another. Those engaged in this work would benefit from establishing mechanisms such as periodic conference calls or a listserv to stay abreast of developments throughout the country, supporting one another, trouble-shooting challenges, and promoting successes.

VI. CONCLUSION

Opportunities to advance equity and health equity, reduce health disparities, and eliminate inequities are abundant in all states and at the federal level. The urgency of prioritizing this work cannot be understated. Structural changes that match the magnitude of the inequities they address are essential to eliminate those inequities and to ensure our nation's future productivity, health, and well-being. No matter how well or poorly resourced, all states can take steps to

have also initiated their own equity work. *Id.*

320. Telephone Interview with Julia Caplan et al., *supra* note 216.

321. Telephone Interview with Heidi Klein, *supra* note 296.

322. Telephone Interview with Julia Caplan et al., *supra* note 216. The OHE and the HiAP Task Force recently worked on an immigration brief that demonstrated explicit connections between immigration and health outcomes. The brief provided an opportunity for them to collaborate with the Governor's Office, the Office of Refugee Services, and advocates, to consider perspectives on how the State of California can best take actions on behalf of its immigrant populations. *Id.*

do something, do more, do better.[323] We appreciate this opportunity to elevate pioneering work underway and to encourage forums for sharing and expanding progress in the field.

323. *See* Caroline Costongs, *Do Something, Do More, Do Better*, EUROHEALTHNET MAG. (2013), http://www.eurohealthnet-magazine.eu/ehn-magazine-2/do-something-do-more-do-better/ [https://perma.cc/3NE4-VRWH] (referencing the conclusions of a 2013 World Health Organization (WHO) report); *see also* WORLD HEALTH ORG. REG'L OFFICE FOR EUR., REVIEW OF SOCIAL DETERMINANTS AND THE HEALTH DIVIDE IN THE WHO EUROPEAN REGION: FINAL REPORT (2014), http://www.euro.who.int/__data/assets/pdf_file/0004/251878/Review-of-social-determinants-and-the-health-divide-in-the-WHO-European-Region-FINAL-REPORT.pdf [https://perma.cc/UA6E-BFEF].

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