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Cultural and Ethnic Communities Leadership Council (CECLC)

Community Relations

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Legislative Report

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $4,000.00

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I. Executive summary

The Cultural and Ethnic Communities Leadership Council (CECLC) was established by the Minnesota Legislature under Laws of Minnesota 2013, chapter 107, article 2, section 1, and became effective August 1, 2013.

This report describes the work of the Cultural and Ethnic Communities Leadership Council (CECLC) of the past year, activities of the council and subcommittees, and the process of how the recommendations were developed in response to health disparities issues, to aid the Department of Human Services (DHS) in disparities reduction.

This report contains:

- Cultural and Ethnic Communities Leadership Council (CECLC) work and activities
- CECLC members' accomplishments
- CECLC membership experience survey
- Department of Human Services (DHS) program equity analysis
- Major problems and issues
- CECLC plan for action and implementation strategy for 2015-2016
- Details of CECLC Recommendations
- Resources for council work

The purpose of this council is to promote disparities reduction. We do this by valuing everyone, by focusing on ongoing efforts to address avoidable, systematic inequalities and by addressing historical and contemporary injustices.

The CECLC reached its one-year milestone and has met 14 times since Nov. 15, 2013. As a result of monthly meetings and the work of five subcommittees, the council recommends five overarching goals:

1. Awareness Goal: DHS increases awareness of the significance of inequities, their impact on the state's cultural populations, and then moves to action to achieve equity.
2. Leadership Goal: Strengthen relations among the council and state agency to promote clear and meaningful dialogue about equity in a governmental structure.
3. Community Health and Health Systems Goal: Families are well. They receive collaborative care giving; they trust and are comfortable with their providers. They actively engage in their health care. Providers are trained to deliver services that address complex needs, and culturally-based beliefs and practices are embedded in healing. Diagnosis need not be a criteria for care.
4. Culturally and Linguistically Competent Services Goal: Rigorous vendor selection meets community needs. Eligibility determination is more transparent. Community-based organizations are regarded as partners and powerful allies supporting the health of their communities. Utilization of community health workers and doulas becomes the norm.
5. Research and Evaluation Goal: Change attitudes about data: data must explain the whole person. Develop measurement strategies to best obtain most appropriate data with

community-defined cultural and ethnic groups' input. Promote evidence-based research into practice.

Problems and issues identified have concentrated around disparate outcomes for populations of color and the lack of meaningful and authentic involvement from communities in the design and implementation of DHS programs. Consequently, attention to gaps in income, healthy living environments and educational opportunities need to be central to discussions on solutions. The recommendations above put forward by the council, seek to address these issues.

In evaluating what DHS is currently doing in its programs to potentially address health disparity issues, an ***equity analysis*** of such programs was performed and detailed in this report. While there are a number of areas where CECLC representation and DHS focus areas show ***some*** alignment, there are considerable areas of need that still have to be addressed. With these areas identified, it is a goal of the council to ameliorate health disparities through collaborative programmatic change to cultivate greater health equity.

With much of the assessment completed, CECLC members wish to move into action steps and to collaborate with DHS staff on implementing some of the recommendations or increasing collaborative efforts between council and department. A broad timeline may include the following:

- **February 2015** – Meeting with DHS executive team. **Policy recommendations from CECLC to DHS.**

- **March: Strategic plan** – Finalized plan including action items to frame the 2015/2016 council work
- **April and Ongoing - Engagement** of DHS administrations, the CECLC, and with the larger community to increase the diversity of perspectives in the subcommittee work.
- **Ongoing: Exploration** of how agency's leadership can use community engagement as a tool to reduce disparities and achieve equity.
- **Review asset mapping research** completed by University of Minnesota Research and Outreach Center (UROC), and embed next steps in planning.

II. Legislation

Laws of Minnesota 2013, chapter 107, article 2, section 1

(11) by February 15, 2014, and annually thereafter, prepare and submit a report to the chairs and ranking minority members of the committees in the house of representatives and senate with jurisdiction over human services that summarizes the activities of the council, identifies the major problems and issues confronting racial and ethnic groups in accessing human services, makes recommendations to address issues, and list the specific objectives that the council seeks to attain during the next biennium. The report must also include a list of programs, groups, and grants used to reduce disparities, and also statistically valid reports of outcomes on the reduction of the disparities.

III. Introduction

The Laws of Minnesota 2013, chapter 107, article 2, section 1, established the Cultural and Ethnic Communities Leadership Council (CECLC) for the Department of Human Services. The purpose of the council is to advise the commissioner on reducing disparities that affect racial and ethnic groups.

This second annual report fulfills a mandate in the law, requiring that the council report annually, beginning February 15, 2014, to identify major problems confronting racial and ethnic groups, make recommendations to address the issues and problems, and list objectives for the next biennium. This report contains a summary of the council members' work and activities of this past year. Members identified high priorities for reducing disparities in access and outcomes for cultural and ethnic communities receiving services funded by DHS. These high priorities will be advanced later this month to the DHS executive team. In addition, a review of programs in which the agency is currently engaged to achieve equity for affected persons served by the agency's administrations is included in this report.

The Cultural and Ethnic Communities Leadership Council's (Council) **mission** is to promote health equity and disparities reduction. Working together the members ensure that their actions are inclusive and productive.

The **vision** is to develop recommendations that lead to policies that promote equity, offer a broader, authentic perspective in setting priorities, use good measures of equity that are sensitive enough to include the priorities of diverse groups, and influence improved health specifically for those that have had disproportionately poor health.

Core Council Agreements:

1. Everyone is heard: practice active listening, build connections to others before and after meetings, and include opportunities for stakeholder input
2. All voices are honored: practice compassion and withhold judgment
3. Have integrity: practice honesty, put aside personal gain, prioritize attending meetings
4. Be transparent: practice sharing information, describe your own experiences to give context, explain expectations for participation, share our work with others
5. Empower people: practice speaking up courageously; reach out to other communities for input
6. Embrace tension: practice addressing issues where there isn't clear agreement, spend time ensuring everyone feels safe to discuss their point of view

Values:

(1) BE consistent, proactive, and represent diverse communities.
(2) KNOW that within communities there is a lot of diversity; that there is a big task ahead because we are talking about ambitious changes; that we need all the facts that inform our work; and that there are good practices we can draw on.
(3) DO reach out to a broader community to make sure they are represented and dig deep into the root issues and possible solutions.

Background

People of color make up the fastest growing segment of Minnesota's population. These individuals will continue to make up an increasingly large part of the state's workforce. Many of these individuals will also be among the future parents, caregivers and leaders of the state. Data also show that these members of our community are:

- More likely to live in poverty
- Less likely to graduate from high school
- Less likely to own their own home
- More likely to suffer from chronic illness

All young people living here in Minnesota, from birth through early adulthood, need to acquire the skills necessary to succeed in jobs essential to our economy. Reducing income and racial disparities in education is key to maintaining a strong workforce.

While the root causes of disparities lie in historical experiences of oppression and exclusion, many gaps illustrated by current data can be compounded by insufficient income, unhealthy environments, and inadequate access to opportunities. We can address many of these issues. (Minnesota Compass: http://www.mncompass.org/disparities/overview, retrieved January 2015)

The DHS Dashboard on its website lists five measures under Equity:

1. Lower the number of children of color in foster care
2. Decrease the number of children waiting for adoption
3. Reduce gaps in access and outcomes
4. Increase quality child care in underserved communities, and
5. Hold managed care plans accountable for disparities.

Cultural and Ethnic Communities Leadership Council (CECLC) Work and Activities

The CECLC has reached its one-year milestone. Monthly meetings helped the council members to get acquainted with one another and to build community and appreciation for the cultures they represent. Tribal representation remained vacant as the Governor's Executive Order establishing protocols for communication with tribes clarified the error in language for membership in the council legislation. A request to the Secretary of State Open Appointment Offices for 'representatives of the American Indian community' generated strong candidates and will likely provide a much needed presence at the table. We will seek a change in statute to clarify tribal representation.

CECLC members participated in several learning activities, provided feedback to program areas of DHS who sought their opinion on planned efforts, and engaged in lively discussions during meetings. Chair Pam Cosby participated in several events in the community as well, representing CECLC by joining in equity efforts led by other state agencies such as the report from the Department of Health's Roundtable Group. She also attended the annual meeting of the Council on Asian Pacific Minnesotans and led a panel discussion at the Overcoming Racism Conference with other CECLC members.

A CECLC member who attended a legislative hearing regarding the Health Equity report at the state capitol shared an anecdote with the full CECLC council from Representative Diane Loeffler of District 60A, who noted society's interest in data and her belief that said data needs to come from community decision making and input.

Commissioner of Department of Human Services Lucinda Jesson visited the council meeting in June. Commissioner Jesson thanked everyone for inviting her to attend the meeting. She listened to the presentations of each subcommittee.

Commissioner Jesson said that she "appreciates that some of the points presented are concrete and already trying to put them in place, and how important it is to have some concrete steps. To be able to say, we recommended this and we did this. Leadership is such a key component. We need people thinking about these key steps at every turn for diversity. There is a new diversity recruiter at DHS and maybe she should get some input from this council or certain subcommittees."

The commissioner mentioned how she is "challenging" herself to "think about how DHS structures jobs at county level and agency level – how to be streamlined and productive all the time. Spend as much time as possible with the community that we are serving; and get out there and engage in conversation. How do we give ourselves the space to do this work so we can learn?" She acknowledged that, "being busy in our offices and with meetings, it is difficult to actually go out and interact with the communities."

The Leadership subcommittee recommended that DHS create an Equity Cabinet with other state agencies. In response, Senator Lourey asked members if they could help him develop a proposal to create a Legislative Equity Process that could be applied to future legislative proposals that come before his committee. Leadership subcommittee members scheduled separate meetings with the Senator and did a nationwide search to learn of any such model. Subcommittee

members presented some of the concepts they learned to the Senator who encouraged them to continue planning including advising on the level of staff needed to help legislators engage in Equity Analysis. DHS advanced the budget proposal initially requested by the council in its legislative agenda, however, due to budget constraints, the proposal did not ultimately make it into the Governor's budget bill.

Throughout the remainder of the year, subcommittee members continued to refine proposals, with the research assistance of University of Minnesota graduate interns, and started to ask what their proposals might look like in real-life, beyond the conceptual stages. With members working outside of the monthly council meetings, each of the five subcommittees developed specific recommendations. (See Appendix I for resources).

Subcommittees developed themes. For example, Research and Evaluation developed the theme that "What Gets Measured Gets Done" to emphasize the critical need of embedding community perspectives when collecting information. The "Kirwan Institute for Study of Race and Ethnicity" was cited as being a source of valuable information. Other subcommittees, such as Leadership, focused on incorporating equality into existing systems. Community Health and Health System Subcommittee members devised a focus of "Be better, feel better and get better." Subcommittee members looked at how people access care and how care is provided. They suggested using the Triple Aim as a framework, to build the foundation for the agency to successfully navigate the transition from a focus on health care to optimizing health for individuals and populations by: improving the experience of care, improving the health of populations, and reducing the long term per capita cost of health care. They noted recommendations to the Governor's Executive Order establishing a vision for health care reform in Minnesota, contained in the Roadmap for a Healthier Minnesota uses the Triple Aim as aims (http://mn.gov/health-reform/images/TaskForce-2012-12-14-Roadmap-Final.pdf).

The Awareness subcommittee similarly crafted recommendations to address access and awareness issues whilst the Cultural and Linguistically Competent Services subcommittee focused on a holistic set of recommendations aimed at improving interpretation services and elevating the important role that community health care workers can play in cultural communities.

Chair Pam Cosby met with the commissioner in the spring to bring an update of the council's work and to get the commissioner's reaction. In a second meeting later in the summer, the chair met with Chuck Johnson, DHS Deputy Commissioner. Pam Cosby began by providing an update, but also included her comment on the absence of the American Indian community representation.

CECLC members voted to adopt the term "health equity" in all deliberations with the understanding that when discussing research, results of inequities, the term "disparities" will be a clarifying term.

In July, Elizabeth Roe, manager, Child Care Assistance Program at DHS presented a new law, MN Statutes 119B.09 Subd. 9a to the CECLC. It is a bill modifying the Child Care Assistance Program (CCAP) which provides financial assistance to help families of low income to pay for

child care so parents can pursue employment or educational opportunities leading to employment. The modification addressed increased reporting of children attending the same child care center where most of the children's parents work. The law clarifies that no more than half of the children in a center may have their parents as center employees. Elizabeth Roe sought the guidance of the council members to help her with the implementation of this law and recommendations on how to do the necessary outreach to New Americans. Council members volunteered to assist Ms. Roe in convening informational sessions in the affected communities ahead of its January 2015 implementation and to prevent closure of centers.

At end of the year, the council members celebrated their accomplishments with a letter of thanks from the commissioner, and a letter acknowledging the hard work of the council members by Sen. Tony Lourey, listing the following CECLC's accomplishments for the past year. The letter also addressed the members' employers as CECLC members are volunteers.

CECLC Members Accomplishments

- The commissioner of human services appointed members of the CECLC in time for its first meeting.
- Members received orientation and; passed bylaws, and guidelines for working together.
- Members developed a legislative report which was submitted to the chairs and ranking minority members of the committees in the MN House of Representatives and the MN Senate with jurisdiction over human services, February 2014.
- Was featured in the spring national newsletter. "Health Equity by Design: NPA Goals Adopted as a Framework for the Minnesota Cultural and Ethnic Communities Leadership Council Action Plan." http://npanewsletter.com/subsites/NPAnewsletter/spring2014/
- Eight members attended the Equity Forum hosted by the mayors of Minneapolis and St. Paul.
- Provided feedback on the "Help Me Grow" program planning for the state of Minnesota
- Studied gap in access to services for populations of color in specialty courts.
- Members voted on budget and policy requests to DHS, which included the possibility of: reimbursement for some members, extension of expiration date, and extension of terms to two years.
- Leadership Subcommittee provided additional information to Sen. Lourey on the Equity Cabinet/Equity Note idea
- Members contributed to the DHS 2015 Framework for the Future.
- Over half of the CELC members attended a Leadership Institute at the University of Minnesota/Humphrey School of Public Policy/Roy Wilkins Center for Human Relations and Social Justice, to develop their capacity to apply principles, generalizations and theories in policy analysis to make policy recommendations and impact social change in equity issues. A CECLC member who participated in the previous Institute requested that DHS fund this training for CECLC members.
- At the request of CECLC members for information on the available benefits to undocumented persons in MN, a DHS supervisor facilitated a presentation on the DHS Health Care Administration's outreach efforts,

- Members offered recommendations to the Child and Family Services Administration on the Child Care Assistance Program law and issues of limiting the number of parents of child care providers from the Somali community on how to meet the intent of changes to the child care subsidy program to insure integrity and still have available needed child care services.
- Members continue to stay current on the health equity work at the Minnesota Department of Health and our encouragement of coordinated work between MDH and DHS to jointly promote equity work in health and other programs.
- Initial connection with the Wilder Foundation program to support the involvement of communities of color in policy making and in promoting leadership from communities of color in the policy making process. Reviewed Health Equity Planning Tool from the Washington State Department of Health, Division of Prevention and Community Health.
- Karen, Ben-Moshe, Project Coordinator, California Health in All Policies Office. This office was established by an Executive Order of Governor in Feb. 2010. We held a conference phone call with Karen and discussed experience of doing a very thorough Health Impact Assessment (80-90 hours per bill) on 2-3 legislative proposals.
- Kat DeBurgh, California Health Officers Association and Jonathan Heller, Human Impact Partners. They have jointly worked on training of California legislative staff on the concept and benefits of Health Impact Assessments.
- National Conference of State Legislators – contact with legislative staff to ask if they were aware of another state legislator that was conducting Equity Analysis or Health Impact Assessment on the majority of health and human services bills. They surveyed their state contacts. No other state responded that they were attempting this comprehensive effort.
- Reviewed Health Equity Planning Tool from the Washington State Department of Health, Division of Prevention and Community Health.

CECLC Interview Results

A survey was conducted on CECLC members in December 2014. The purpose of this survey was to gather input on their experience in participating in the council and provide them the opportunity to share feedback on action steps or changes in moving forward into the next year. Please see Appendix III. for detailed results.

Results were formative to providing change in the future operations of the CECLC. Some of the recommendations CECLC members provided in the survey included:

- Refocusing CECLC vision or operations into more action-oriented work now that brainstorming has produced some recommendations.
- Increase public and subcommittee awareness of the existence and function of the CECLC
- Organization and structural changes through the use of guides on how work is completed and more direction from the DHS on the work process.
- Increased interaction and feedback from DHS leadership on work completed.
- Occasional pauses in progress or periodic self-assessments of the work, as a group, to ensure a sustainable approach is being followed.
- Increase attendance of CECLC members in council meetings

Attendance at monthly meetings, or extra meetings of the subcommittee work posed challenges to some members' busy lives and schedules. However, they concluded the work with an impressive list of recommendations for DHS's leadership consideration. The work of the subcommittees framed by the goals of the National Partnership for Action to End Health Disparities (DHHS) produced considerable discussions each month. Subcommittee members presented to the full CECLC members, engaged in discussion, agreed on suggested changes, or brought clarification to the topics under each goal, and arrived at consensus:

1) Increase **awareness** of health disparities, their negative impact and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations, empower communities to be co-creators and co-managers of their own health (http://mn.gov/health-reform/images/TaskForce-2012-12-14-Roadmap-Final.pdf).
2) Strengthen and broaden **leadership** for addressing health disparities at all levels.
3) Strengthen the **health system** and improve **life experience** for racial, ethnic, and underserved populations.
4) Improve **cultural and linguistic competency** and the diversity of the health related workforce.
5) Improve **data** availability and coordination, and share **research and evaluation** outcomes.

IV. Report recommendations

Problems and Issues

While it is noteworthy that Minnesota is one of the healthiest states in the nation in health parameters ranging from life expectancy, quality of health care, levels of obesity and others, the state is also affected by some of the greatest health inequities in its communities of color.

The first problem is disparities or differential outcomes for populations of color, both in who gets access to or involuntarily forced into services (child protection) and then, once receiving services, having less successful outcomes from the services provided. The second problem is the limited meaningful involvement of the communities being served in the design of the programs intended to support them. This problem results in programs being designed from the dominant culture's perspective that makes it harder to reach the outcomes responsive to all communities. Thirdly, a barrier to developing interventions to lessen health inequity has been the comparative deficient and inconsistent collection of accurate race, ethnicity and language data which is an important instrument to informing evidence-based disparity reduction programs. As a result, these deficiencies can be harmful to the socioeconomic health of the entire state.

In response to these issues, the disparities reduction advisory committee was a diverse group of individuals who met with several DHS employees to discuss disparities. They recommended that DHS improve its understanding of cultural community members' needs to quality service and culturally-responsive care.

With the establishment of the Cultural and Ethnic Communities Leadership Council (CECLC), members recommended that DHS increase capacity in addressing institutional, structural, and individual racism to address these problems. Council members recommended that improving cultural competency will lead to policies that promote equity, establish equity measures that include the priorities of diverse groups and measure outcomes within each group; and improve health specifically for those who have experienced disproportionately poor health. (2014 Legislative Report) https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6891A-ENG

Each one of the five subcommittees met for several months to study, reviewed the research provided by University of Minnesota interns that informed their decisions, and agreed on recommendations. They also reviewed journal articles, information from other jurisdictions and prior recommendations from the Disparities Reduction Advisory Committee (DRAC) meetings.

The recommendations will be presented to the agency's executive team at the end of February. .. Members of CECLC understand that their recommendations may become changed through internal procedures of the department, legislative policy proposals or may not be implemented at all. They request to continue to receive communication regarding this set of recommendations.

These five areas **summarize recommendations from** CECLC members to DHS to endorse in order to achieve equity and reduce disparities. The high priority areas of recommendations are as follows:

Cultural and Ethnic Communities Leadership Council Recommendations for Action

A. Awareness goal: DHS increases awareness of the significance of inequities, impact on the state's cultural populations and moves to action to achieve equity.

a. Community Engagement
b. Community Empowerment
c. Community and DHS Collaboration

B. Leadership goal: strengthen relations among the council and state entity to promote clear and meaningful dialogue about equity in a governmental structure.

a. Equity Analysis
b. Accountability of Existing Leadership
c. Support of New Leadership
d. Hiring and Retention
e. Contracting

C. Community Health and Health Systems goal: Families are well. They receive collaborative care giving; they trust and are comfortable with their providers. They actively engage in their health care. Providers are capable and have appropriate resources to provide services that address complex needs, cultural beliefs, and practices are embedded in healing.

a. Modify rules, regulations and incentives relating to equity/disparities reduction
b. Increase recognition of foreign trained health care professionals
c. Improve understanding of the cultural perspective in understanding complex issues such as a mental health diagnosis in the Western world
d. Establish gender-specific fitness programs
e. Develop ongoing relationships with cultural communities
f. Require managed care organizations to contract with culturally specific providers
g. Redefine access to care
h. Repeal Child Care Assistance Program statute

D. Culturally and Linguistically Competent Services Goal: Vendor selection is rigorous to meet the needs of the community; there is transparent eligibility determination. Community-based organizations are partners and powerful allies supporting the health of their communities. Utilization of community health workers is the norm.

a. Improve interpreter training and add certification as a requirement
b. Vendor selection
c. Services and eligibility at the county level
d. Community Health Workers
e. More effective system of health and human services delivery
f. Culturally and linguistically appropriate services (CLAS) standards

E. Research and Evaluation Goal: change attitudes about data: data must explain the whole persons. Develop measurement strategies to best obtain most appropriate data with community-defined cultural and ethnic groups' input. Promotion of evidence-based research into practice

a. Establish mechanism for obtaining detailed data
b. Educate communities about the importance of race/ethnicity and language data collection
c. Coordination of data activities
d. DHS Equity Dashboard is more detailed with race/ethnicity/language data
e. Evidence-based practices and research
f. Community Based Participatory Research

DHS senior management team

The following chart is framed to reflect the focus areas established by senior management leaders for the agency. They established these focus areas after completion of a "White Racial Frame" training workshop

The focus areas include:

- Inclusion of communities of color and American Indians in DHS design and planning in order to attend to high priority areas related to health and human service disparities.
- Performance improvement of DHS staff and service providers through creation and implementation of a department-wide accountability system and cultural competency/anti-racism trainings.
- Creation of a rules analysis process to identify and reform structural patterns and policies that perpetuate health and human service disparities.
- Improve access to DHS program and services by communities of color and American Indians.

These CECLC recommendations contrast with the topics of an **Equity Report** requested by the community relations director to the assistant commissioners, after input from council members on question items on the survey.

Minnesota Department of Human Services Focus Areas

CECLC Recommendations that align with DHS' Focus Areas (Equity Report)

1. Awareness Goal: DHS increases awareness of the significance of inequities, impact on state's cultural populations and moves to action to achieve equity	
Council Recommendation:	**DHS Senior Leadership Focus Areas:**
Objective 1.1 **Institute community engagement in the agency** • DHS institutes professional development on topics that bring clarity and understanding about inequities • Issues of individual, institutional and structural racism are discussed openly and frankly • DHS intentionally engages with cultural communities for solution-focused discussion around equities, root causes of inequities, etc. • DHS with community sets measure-able goals for applying remedies that alleviate inequities experienced by cultural communities.	• **Accountable system creation, Direct Care and Treatment:** o *Inventory current and recent training related to reducing disparities* o *Continue Person-Centered Thinking and best practices.* o *Understand the influence culture has on health and healing* o *Provide better awareness of the needs of diverse supported persons* o *Increase knowledge and acceptance of diversity* o *Create diversity initiatives*
Objective 1.2 **Institute the practice of community empowerment** • DHS improves understanding of the critical importance of intentionally listening to the voices of those otherwise silenced/subjugated as they hold the stories of experiences that contain knowledge and wisdom for improvement. DHS learns how communities can impact their own healing.	• **Accountability system creation, Direct Care and Treatment:** o *Promote effective communication between the staff and supported person* o *Persons we support are able to clearly understand and can communicate wishes* • **Improved access to programs and services, Direct Care and Treatment:** o *Based on client request/needs, recruit volunteers from all cultural and socioeconomic groups of the community*
Objective 1.3 **Improve DHS-Community collaboration efforts** • DHS establishes opportunities for DHS staff and community to engage in order to build relationships, knowledge and understanding.	• **Inclusion in design and planning , Direct Care and Treatment:** o *Turning over the C.A.R.E.-Brainerd program to an American Indian tribe* • ***Children and Family Services**:* o *Support the development of tribal capacity and infrastructure to provide human services* o *Support county based child welfare delivery system to a tribal child welfare delivery system* o *Policies developed for African American families have input from African American community* o *Engage African American and American Indian participants of the Minnesota Family Investment Program in education and employment activities* o *Build successful partnerships between parents and those who work in the child*

	welfare system • ***Health Care Administration:*** o *Worked with American Indian staff in DHS and tribal health leadership to create a program* • ***Chem. and Mental Health Services Admin*:** o *Inclusion of communities of color and American Indians in DHS design and planning* • **Improved access to programs and services, Direct Care and treatment:** o *MSOP will assist clients who are at a certain stage in treatment the appropriate opportunities to give back to the community through volunteering.* o *Engage with peers (who often have similar ethnic and cultural backgrounds) increases the cultural sensitivity of the therapeutic process*

2. LEADERSHIP Goal: Strengthen relations among the Council and state entity to promote clear and meaningful dialogue about equity in a governmental structure	
Council Recommendation:	**DHS Senior Leadership Focus Areas:**
Objective 2.4 Hiring and Retention • Formal Inclusion of Equity Issues in Job Postings and Promotional Postings and to Assign Points in Evaluation Criteria • Develop culturally competent strategies to recruit talent in cultural communities. • Develop culturally competent orientation, onboarding and professional development programs. • Support culturally specific employee resource groups (ERGs) with adequate human and financial resources. • Establishment of ERGs within DHS • Increased type, frequency and number of recruitment events intended to reach diverse pool of potential candidates (regional, race/ethnicity, educational, professional background). • Increased number of underrepresented DHS employees retained/hired representing communities most impacted by inequities. • Percentage of DHS' current missed opportunities.	• **Inclusion in design and planning , Direct Care and Treatment:** o *Increase diversity of staff through recruitment and employment* o *Increase the numbers of disparate candidates interviewed and hired at all levels (MLB)* o *Increase diversity of staff through recruitment and employment* • **Improve access to programs and services, Direct Care and Treatment:** o *Increase diversity of staff through recruitment and employment* o *DCT will be working with MNSCU to develop relationships that will increase job opportunities for persons in many levels of the human services sector.*
Objective 2.5 Contracting • Formal inclusion of Equity issues in Request for Proposals and assign points in evaluation criteria • Build in equity criteria in RFP content, review process (point allocation/deduction and composition of reviewers), negotiation process to ensure optimal awards for minority and women-owned contracts. • Require contacts to demonstrate equitable practices and policies • Establish equity analysis that evaluates, reviews process, and reviews funding patterns. • Increase in contract awarded to targeted and economically disadvantaged businesses and individuals (TGEs)	• **Accountability system creation, Health Care Admin:** o *RFP process would require an accountability system for both the grantee and the grantor. The grantor must be accountable to the needs of the grantee to act in a culturally sensitive manner* • **Rules analysis process, Children and Family Services:** o *Performance funding which provides incentives and rewards for those entities that close the gaps.* • **Improved access to programs and services, Children and Family Services:** o *A portion of the Community Services Block Grant (CSBG) and Community Action grants are directed to all 11 Minnesota Reservations. Use of funding is determined at the community level for anti-poverty purposes.*

3. COMMUNITY HEALTH AND HEALTH SYSTEMS Goal: Families are well. They receive collaborative care giving: they trust and are comfortable with their providers. They actively engage in their health care. Providers are capable and have appropriate resources to provide services that address complex needs, cultural beliefs, and practices are embedded in healing.	
Council Recommendation:	**DHS Senior Leadership Focus Areas:**
Objective 3.1 DHS, managed care, and counties work with cultural communities and providers to examine, modify, and develop rules, regulations and incentives in order to promote culturally appropriate care and reduce barriers to receiving care (for example the work done in chemical health could be expanded agency-wide). • Establish an equity committee agency wide comprised of community members and DHS employees • DHS contracts providers who are able to deliver quality, culturally competent care	• **Rules analysis process, Children and Family Services*:*** o *In partnership with culturally specific communities, including Tribal Nations, prioritize funding efforts most successful at improving housing stability in communities disproportionately impacted by homelessness.* • **Improved access to programs and services, Children and Family Services:** o *The Office of Economic Opportunity Homeless Programs provide state funded support for drop-in centers, shelters, transitional housing and supportive housing programs operated by Tribal Governments and other American Indian organizations.* • ***Continuing Care:*** o *The DHS HIV/AIDS Unit currently contracts with a variety of agencies to address the HIV/AIDS healthcare needs of African Americans and other disproportionately impacted communities.*
Objective 3.2 Expand benefits that allow for outreach and psycho-education particularly for communities of color that are completed pre-diagnostic, increasing avenues to healthcare access, and examine current reimbursement and documentation standards to ensure reasonable parity between physical and mental health services.	• **Inclusion in design and planning, Children and Family Services:** o *Tribe's access to federal medical assistance dollars so tribal human services may make mental health decisions for their children in foster care.* • **Improved access to programs and services, Continuing Care:** o *Reduce disparities and improve timely, culturally appropriate access to Autism Spectrum Disorder diagnosis and treatment, parent and caregiver education and other medical, educational, health and human services for individuals from multicultural and linguistic, and American Indian communities living with ASD and their families.*
Objective 3.4 DHS develops an agency wide formal process for engaging cultural communities, providers, and stakeholders in developing an ongoing exchange of knowledge, understanding and pertinent information about access to healthcare**.** • Content materials translated in	• **Inclusion in design and planning, Continuing Care:** o *Provides a direct conduit of information sharing and collaboration with American Indian elders and their communities regarding their needs and preferences for home and community-based services administered through the Aging and Adult Services Division.* • **Improved access to programs and services, Health Care Admin:**

target language • Local partnerships promoting mental and physical health • Number of articles, op-ed/interviews in local/community that convey agency's concerns and action taken	○ *Possible mechanism for doing this work would be to create an RFP for culturally-specific community based organizations to provide information and member education about enrollment and benefits of MSHO.*
Objective 3.6 **Redefine access to care (Penchansky and Thomas, 1981)** • Increased number of families reporting receipt of culturally and linguistically competent care • Increased access and use of preventative care • Communities impacted by inequities report improvement on the consumer satisfaction survey (s) • Increased culturally competent workforce • Decrease inequities impacting cultural and ethnic communities.	• **Improved access to programs and services, Continuing Care:** ○ *Provide culturally appropriate home and community-based services to older adults who are members of diverse communities. The Metropolitan Area Agency on Aging works closely with an existing service provider in each community to develop service models that meet the needs and preferences of the community's elders.*
Objective 3.7 **DHS monitor, review and access managed care organizations accountability for how they are serving communities of color** • Establish an entity similar to the Human Services Performance Council (Counties) that is more inclusive to managed care organizations.	

4. CULTURALLY AND LINGUISTICALLY COMPETENT SERVICE GOAL: Vendor selection to meet the needs of the community; there is transparent eligibility determination. Community based organizations are partners and powerful allies supporting the health of their communities. Utilization of community health workers and doulas is the norm.	
Council Recommendation: **Objective 4.1** **Improve interpreter training and add certification as a requirement** • Increase DHS culturally competent staff; contracted vendors, and *health care interpreters*. • Contracted interpreters are culturally, linguistically, and programmatically competent in the disciplines they operate**.** • Empower community based organizations to serve their own communities, by providing training and technical assistance (is required), often CBO's are not given the technical assistance to be successful. • Engage with cultural communities for resources, capacity building, learning of standards required to be a successful grantee.	**DHS Senior Leadership Focus Areas:** • **Improved access to programs and services, Direct Care and Treatment:** o *MSOP will provide for effective communication between clients with Limited English Proficiency (LEP) and staff by making appropriate language assistance services available when those services are needed or requested*
Objective 4.6 **Statewide adoption of Culturally and Linguistically Appropriate Services Standards (CLAS)** • CLAS are updated and used agency wide; Limited English Proficiency (LEP) is updated, compliance process is in place to monitor • Overall satisfaction by cultural communities with health and human services is monitored for quality improvement purposes	• **Rules analysis process, Direct Care and Treatment:** o *To eliminate disparities by offering quality care that meets the needs of the supported person in a respectful manner and in plain language that is understood orally and in writing.* • **Improved access to programs and services, Direct Care and Treatment:** o *To assure high quality services for people with Limited English proficiency, their families, and others who do business with or come in contact with the MHSATS. A Limited English Proficiency Plan is being developed.*

5. RESEARCH AND EVALUATION GOAL: Change attitudes about data to explain the whole person. Develop measurement strategies to best obtain most appropriate data with community defined cultural and ethnic groups input. Promote evidence based research into practice.	
Council Recommendation: **Objective 5.3** **Coordination of data activities** • DHS must prioritize coordination of data activities related to health/human services equity across all divisions and programs; • Develop a long-term plan for improving the collection, analysis, reporting, dissemination and use of health equity data.	**DHS Senior Leadership Focus Areas:** • **Accountability system creation, Children and Family Services***:* ○ *The Child Safety and Permanency Division added questions to the Child Welfare Structured Decision Making Tools to get the family's perspective on their cultural identity and cultural needs.* • **Rules Analysis, Health Care Administration:** ○ *Survey administrator requests race and ethnicity information and makes interpreter services available*
Objective 5.5 **Evidence-based practices** • Promote translation of evidence-based research into practice. • Make data-driven decisions based upon community-defined cultural and linguistic groups and their members' input as practice • Engage communities so they can use information for their own benefit, such as being better users of publicly funded care. • Increase awareness , education and engagement on the impact of inequities • Invest in the application of knowledge, use of data, research and evaluation findings and community engagement in the design and improvement of equity • Evaluate number and type of evidence-based best practices evaluated, disseminated and applied in cultural communities.	• **Accountability system creation, Direct Care and Treatment:** ○ *When we have baseline and trend data, we will be more able to identify and correct ethnicity-related issues.* • **Children and Family Services:** ○ *Collaboration and community-led supports are essential to future progress to overcome disparities. Outcome data identifies areas where progress has been made and areas where disproportional representation exists.* • **Rules analysis process, Health Care Admin:** ○ *Understanding which specific racial and ethnic groups struggle with the grievance and appeals process and where in the process enrollees typically struggle, the Ombudsman Office has the potential to design very specific targeted outreach efforts.* ○ *To assess selected health performance measures in comparison to the commercial population for MCHP enrollees and among MCHP enrollees by the race and ethnicity categories collected by DHS enrollment. This information is available to describe the satisfaction of enrollees which can create awareness of disparities issues and could be used by some entity as the basis for further analysis and work.*
Objective 5.6 **Community Based Participatory Research** • DHS endorses use of CBPR and joins with other state agencies on the importance of community engaged research	• **Rules analysis process, Continuing Care (CCA):** ○ *CCA will work with internal staff that has connections to ethnic communities to build a stronger knowledge of the best ways to engage them in this initiative.(Survey)*

• Increase funding for CBPR to address inequities • Partner with Higher Ed committed to this effort • Demonstrate number of community-CBOs- academic partnerships using CBPR.	• **Inclusion in design and planning, Health Care Administration:** ○ *Research, with community, ways that people of color or people who are of a cultural minority group may be able to access and experience the MSHO program more equitably.*

CECLC members have identified gaps between council recommendations and DHS leadership focus areas for the agency's work on its Equity efforts. This information provides an opportunity for the agency to engage more intentionally with members of CECLC, pending DHS executive leadership endorsement at meeting late February 2015:

GAPS: Council Recommendations that do not Align with DHS Focus Areas	
Goal 1: Awareness DHS increases awareness of the significance of inequities, impact on state's cultural populations and moves to action to achieve equity.	
Awareness Objective 1.1 • *DHS engages in open dialogue about individual, institutional, and structural racism with staff and community;* • *DHS empowers populations most impacted by the disparities/inequities to speak about their experiences, offer opinions to create positive change, and participate in solution-focused conversations;* • *Trained staff and leadership will promote respect for diverse ideas, opinions, beliefs, and practices by acknowledging the legacy of historical, cultural and systemic oppression;* • *The agency is encouraged to invest in cultural competence and language competence training as vital elements to achieve equity.*	Institute **authentic** community engagement in the agency.
Awareness Objective 1.2 • *DHS empowers community members to become involved in their community and state by being more active in the democratic process and hold government officials accountable. In addition, be involved in the policy making process so the policies are reflective of their communities.*	Institute the practice of **authentic** community empowerment

Goal 2: Leadership Strengthen relations among the Council and state entity to promote clear and meaningful dialogue about equity in a governmental structure	
Leadership: Objective 2.1 • *Create an equity analysis (similar to a fiscal note) for all bills that will be considered by*	Develop an equity analysis in its policy processes

the Minnesota Legislatures Health and Human Services Committees. Analysis would be conducted by the administration for proposals introduced by the Governor's Office and the Department as part of bill introduction. • *Bills introduced by members of the legislature, the equity analysis could be requested by the author or a member of the Health and Human Services Policy or Finance Committees.*	
Leadership: Objective 2.2 • *Recommended actions from top leadership at DHS regarding management of the services and relations with cultural communities include continued engagement with communities through various councils and commissions* • *Embed equity criteria into performance metrics for staff, programs, and initiatives.* o *How do we embed equity through staff performance evaluations so it is not diminished?*	Accountability of existing leadership
Leadership: Objective 2.3 • *Create and nurture the next generation of diverse leaders through pipelines in the education system and community to proactively steer cultural communities to seek engagement and employment with DHS.*	Support for new leadership

Goal 3: Community Health and Health Systems Families are well. They receive collaborative care giving: they trust and are comfortable with their providers. They actively engage in their health care. Providers are capable and have appropriate resources to provide services that address complex needs, cultural beliefs, and practices are embedded in healing.	
Community/Health Systems: Objective 3.3 • *Modify rules, regulations, and incentives in order to promote culturally appropriate care and reduce barriers to receiving care* • *Increase recognition of foreign medical degrees and the value they can add to diverse cultural and ethnic communities*	Work with the professional licensing boards to develop recognize, and license foreign-educated and trained health care professionals and the value they can add to diverse cultural and ethnic communities.

Community/Health Systems: Objective 3.5 • *DHS should require MCOs to contract with culturally specific providers to make access easy for cultural and ethnic communities. Medicaid should not force people into MCOs and give them the choice to stay with fee-for- services if they want to.* • *DHS should publish annual financial report on how it gives to each MCO. DHS should require MCOs to publish their annual financial report for public scrutiny by repealing the exception from the MN data practices act.*	Require managed care organizations to contract with culturally specific providers to make access to quality, culturally competent services accessible.
Community/Health Systems: Objective 3.7	DHS examines studies and engages communities (particularly communities of color) on the impact of MN Statute 1198.09 Subd 91 - Child Care Assistance Program.
Community/Health Systems: Objective 3.8 • *Create a program to empower Muslim women to eat healthy foods, create support groups and dialogue in order to address issues facing Muslim women and reduce the stigmas facing young Muslim women to belong to the larger society.*	Establish fitness programs that Muslim women (gender specific) can participate in for health and wellness.

Goal 4: Culturally and Linguistically Appropriate Services Vendor selection to meet the needs of the community; there is transparent eligibility determination. Community based organizations are partners and powerful allies supporting the health of their communities. Utilization of community health workers and doulas is the norm.	
Cultural/Linguistic Service: Objective 4.2 • *Audit of DHS compliance with MN Statute 16c* • *More transparency needed in eligibility determination of procurements from small businesses, targeted group purchasing, Veteran-owned small businesses, economically disadvantaged areas* • *DHS should make the grant making process more transparent with key outcomes on equity.*	Vendor selection
Cultural/Linguistic Service: Objective 4.3 • *DHS (as the county human services*	Services and eligibility at county level

supervisor) should require transparency of services and eligibility being delivered at the county level	
Cultural/Linguistic Service: Objective 4.4 • *Elevate the role that CHW's and doulas can play as building bridges to cultural barriers*	Community health workers and doulas
Cultural/Linguistic Service: Objective 4.5 • *DHS needs to revise its established rules and policies to create a more effective and culturally and linguistically appropriate system for health and human services delivery*	More effective system of health and human services delivery

Goal 5: Research and Evaluation : Change attitudes about data to explain the whole person. Develop measurement strategies to best obtain most appropriate data with community defined cultural and ethnic groups' input. Promote evidence based research into practice.	
Research and Evaluation: Objective 5.1 • *DHS must prioritize coordination of data activities related to health/human services equity across all divisions and programs;* • *Develop a long-term plan for improving the collection, analysis, reporting, dissemination and use of health equity data.*	Establish mechanism for obtaining detailed data
Research and Evaluation: Objective 5.2 • *Identify various ethnic groups and educate the public about the collection of race, ethnicity, and language data.*	Educate the communities about the importance of Race, Ethnicity and Language (REL) data collection
Research and Evaluation: Objective 5.4 • *Change/update the DHS Equity Dashboard to fully reflect the status on reduction of disparities for target populations*	DHS Equity Dashboard

Next Steps

CECLC members agree that they are past the planning stages and want to move to action steps, partnering with DHS staff on the implementation of some of the recommendations or engagement of the council members in current work being done at DHS.

- **February** – Meeting with DHS executive team which consists of: the commissioner, her two deputy commissioners and her assistant commissioners. **Policy recommendations from CECLC to DHS.**

- **March: Strategic plan** – The finalized plan will include action plans to frame the work of the council for 2015/2016. The plan will also identify activities that will be implemented agencywide, depending on funding committed by the agency and the legislature.

- **March-April** - Preliminary discussions include:
    A. Members identified needs for its operations: community engagement plan, communication plan, staffing needs to support work of the subcommittees.
    B. Development of a budget to be submitted to DHS to support the operations and effectiveness of the CECLC.
    C. Should Bush Foundation Community Innovation Grant be funded (now in finalist stage), implementation of community engagement initiative to embed democratic participatory leadership methods in interfacing with cultural communities. Topics will be selected by each assistant commissioner according to the population they serve, and their question/invitation to a certain cultural group. ($75,000, with significant leverage by DHS)

- **Ongoing - Engagement** of DHS administrations, the CECLC, and with the larger community to increase the diversity of perspectives in the subcommittee and the agency's work.

V. Appendix I

Definitions

Health/Human Services Equity - The Center for Diseases Control (CDC) states that **"health 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 potential because of social position or other socially determined circumstances."

Health Inequities –Differences in health outcomes that are systematic, avoidable and unjust. Where systematic differences in health are judged to be avoidable, by reasonable action they are, quite simply, unfair. It is this that we label health inequities.
(World Health Organization, http://www.who.int/hia/about/glos/en/index1.html, retrieved January 2015)

Cultural and Ethnic Communities Leadership Council (CECLC) - Established by the Minnesota Legislature under Laws of Minnesota 2013, chapter 107, article 2, section 1, and became effective August 1, 2013, the purpose of CECLC is to advise the commissioner of the Minnesota Department of Human Services on reducing disparities that affect racial and ethnic groups.

Cultural and Linguistic Competence - 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. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities." (Adapted from Cross, 1989; DHHS, Office of Minority Health, 2001).

Cultural Specific Care - Care delivered by professionals possessing an enhanced self-awareness of attitudes toward people of different cultures and ethnic groups; knowledge of cultural beliefs, and practices, attitudes toward health care, health care seeking behaviors, and the burden of various diseases in different populations and skills in cross-cultural communication. (The Community Guide: What Works to Promote Health: http://thecommunityguide.org/healthequity/healthcare/competencytraining.html, retrieved August 2014)

Racial Equity Lenses - A transformative quality improvement tool used to improve planning, decision-making, and resource allocation leading to racially equitable policies and programs. (City of Seattle, https://multco.us/diversity-equity/equity-and-empowerment-lens, retrieved August 2014)

Community - A sense of "who is included and who is excluded from membership" (IOM, 1995). A person may be a member of a community by choice, as with voluntary associations, or by virtue of their innate personal characteristics, such as age, gender, race, or ethnicity (IOM,

1995). As a result, individuals may belong to multiple communities at any one time. (CDC, http://www.cdc.gov/phppo/pce/part1.htm, August 2014)

Appendix II

Detailed CECLC Recommendations

1. **Awareness.**
   A. Awareness and consciousness-raising. DHS needs to have an open dialogue about individual, institutional and structural racism. How can those with power be made to participate and make the necessary changes to right all the historical wrongs?
   B. DHS needs to create a space or opportunity for people to speak truthfully to one another and acknowledge that race matters and affects the DHS work life. People may be hesitant at first to discuss these issues due to fear of self-incrimination, judgment, and the potential negative repercussions that may arise. Victims of the system are rarely heard.
   C. Their opinions must be heard and addressed in order to create positive change. DHS needs to engage and empower community members to become involved in their community and state.
   D. Constituents need to play a more active role in the democratic process and hold government officials accountable. Constituents need to be involved in the policy making process so the policies are reflective of their communities.
   E. Without change in "will," there is little possibility for constructing a new system." Power is not conceded without a substantial demand." (Frederick Douglass, 1849).
   F. The agency is encouraged to invest in **c**ultural competence and language competence training as vital elements to achieve equity. Trained staff and leadership will promote respect for diverse ideas, opinions, beliefs, and practices by acknowledging the legacy of historical, cultural and systemic oppression.
   G. Trained staff and leadership have the capacity to use the racial lens in which the American "system" views immigrants vs. their "enslaved" populations (i.e., African Americans and American Indians)? The Black/African American and Native American experiences are not the same as the immigrant experience.

2. **Leadership**

   A. Cross Cultural communication is the responsibility of the Cultural and Ethnic Council. These recommendations are informed by practices, tools, and resources to achieve some agenda setting around the structure of the government in Minnesota using equity lenses. This will strengthen the dialogue among the Council and promote clear and meaningful dialogue about equity in a governmental structure.
   B. To create an equity analysis (similar to a fiscal note) for all bills that will be considered by the Minnesota Legislature's Health and Human Services Committees. This analysis would be conducted by the administration for proposals introduced by the Governor's Office and state agencies and expected as part of the bill introduction.

For bills introduced by members of the legislature, the equity analysis could be requested either by the author or a member of the Health and Human Services Policy or Finance Committees.

C. Accountability of Existing Leadership: Recommended actions from top leadership at DHS regarding management of the services and relations with cultural communities include continue to engage with communities through various councils and commissions; embed equity criteria into performance metrics for staff, programs, and initiatives. For example, job descriptions should outline clear expectations about employees' capacity to communicate cross culturally
D. Support for new leadership: create and nurture the next generation of diverse leaders through pipelines in the education system and community to proactively steer cultural communities to seek engagement and employment with DHS.
E. Hiring and Retention: beyond civil rights and equal opportunity compliance, develop culturally competent strategies to recruit talent in cultural communities. Develop culturally competent orientation, onboarding and professional development programs. Support culturally specific employee resource groups with adequate human and financial resources.
F. Contracting: the CECLC recommends an equity analysis on its contracting process and outcomes to ensure optimal awards for minority and women owned contracts. Build equity criteria into RFP content, review process (point allocation/deduction and composition of reviewers), and negotiation processes. Require contracts to demonstrate commitment to equitable practices and policies. The state Commissioners/Department heads recent meeting at the initiative of Dr. Ehlinger signaled the momentum for the development of equity analysis procedures within the administration of programs in many, if not most state departments.

3. Community Health and Health System Experience.

Currently, there are a range of issues which contribute to barriers to receiving culturally appropriate health and mental health care. It's often well intentioned policies that can have unintended consequences.

A. Modify rules, regulations, and incentives in order to promote culturally appropriate care and reduce barriers to receiving that care.
B. Muslims cannot use public gyms, pools or programs nor can they use private recreation centers (YMCA), because of the lack of gender-specific and culturally sensitive facilities and programs. Many Muslim immigrants in the United States are facing chronic diseases, such as diabetes, heart disease and high-blood pressure due to the lack of exercise. Therefore, they are experiencing hip and knee replacements because weight gain stresses their body structure. Many Muslim women wear skirts instead of pants in public, making exercise difficult. But in a female-only environment, they can wear workout pants and T-shirts.
C. Communities are not well informed about services offered by DHS and other providers and should be better informed about the physical and mental health problems that affect their communities.
D. DHS should require MCOs to contract with culturally specific providers to make access

easy for communities. Medicaid should not force people into MCOs and give them the choice to stay with fee for services if they want to. DHS should publish the annual financial report on how it gives money to each MCO. DHS should require MCOs to publish their annual financial report for public scrutiny by repealing the exception from the MN data practices act. DHS should require MCOs to account for their contracting practices with minority providers.

E. DHS needs a better understanding of community member needs – taking into consideration their cultural, ethnic, and religious identities.

Access: access to care needs to be re-defined by DHS:

- ***Affordability i***s determined by how the provider's charges relate to the client's ability and willingness to pay for services.
- ***Availability*** measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. For instance, is staff able to connect to this client? Do they speak the same language? Are they informed about the client as an individual and the context in which they live to better inform treatment?
- ***Accessibility*** refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location OR if provider can go to the client. Can clients physically access a provider in some way? When they need help, who can they talk to/call?
- ***Accommodation*** reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client – e.g., hours of operation, communication w/ the client prior, during, after appointment
- ***Acceptability*** captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of coverage of the client; however, also has to do with how the client conceptualizes the service, influences by family/community/culture, and what the client and other influences may think about the services and whether it will be helpful. This is the most difficult and often the least concrete because it starts to get into how people think and feel about healing and help and their experiences of "help." (Penchansky and Thomas. 1981).
- ***Outcomes*****:** families are well, they receive collaborative care giving; they trust and are comfortable with their providers, they actively engage in their health care; they can access the services, they know how to seek support, they support each other, they enjoy relational care giving, providers are capable to provide services that address complex needs, cultural beliefs and practices are embedded in healing. Patients' concerns do not need a diagnosis to be attended to.

4. Culturally and Linguistically Competent Services.

A. More rigorous vendors' selection – interpreters that are appropriately trained for specific needs, for ex. a mental health counseling session was disrupted when both client and interpreter shared similar trauma experiences. Interpreter was not able to

conduct the job of interpreting, he was too distressed to be able to translate; There needs to be medical/social services certification to align with needs of expertise for organizations serving specific needs;

B. More transparency needed in eligibility determination; DHS should conduct an audit of Minnesota Statute 16c, (Designation of procurements from small businesses, targeted group purchasing, veteran-owned small businesses, economically disadvantaged areas, etc.); DHS should conduct a 360 Survey to review the quality of translation/interpretation being carried out;
C. Empower/provide training and technical assistance to community based organizations that need resources, knowledge, support or capacity; DHS in its role as the county human services supervisor should require transparency in describing available services and eligibility to access such services delivered at the county level.
D. DHS should make the grant making process more transparent with key outcomes on Equity. When programs are funded without language clarifying how to address the unique needs and preferences of populations, that are culturally based, outcomes are not as successful. Elevate the role that community health workers can play as building bridges to cultural barriers.
E. DHS needs to revise its established rules and policies to create a more effective and culturally and linguistically appropriate system for health and human services delivery. For example, DHS should focus on creating health and human services environments that are client-centered and culture/language centered (i.e. providers have more time to devote to their diverse patients, higher focus on customer service).
F. DHS must encourage a statewide mandate for the usage of CLAS Standards at all points of patient contact in all types of medical settings. Medical professionals need to know their audience and understand their culture. Also, medical professionals need to be aware of a community's historical culture and how that impacts their current perspective of health and human services or their world view (i.e., the enslavement and abuse of the American Indian and African American communities).
G. How do we define race/ethnicity/culture? Checking a box is not sufficient as some individuals cannot clearly fit into one box. Attitudes towards data: When measuring outcomes and collecting data, researchers need to be cognizant of the fact that these data represent people, and include factors such as cultural mores, language, preferences, etc. Measurement strategies should be developed to obtain the most appropriate data.

5. Research and Evaluation.

- DHS must place a priority on coordination of data activities related to health/human services equity across all divisions and programs, and develop a long-term plan for improving the collection, analysis, reporting, dissemination and use of health equity data.
- The data currently collected on individuals and families is lacking in specificity. For example, populations grouped under Asian, assumes racial groups to be homogeneous when in reality they are diverse and have different cultures and beliefs, e.g., Hmong, Asian-Indian, Laotian, Burmese, Chinese, Karen, etc.

- Detailed data on health, human services, financial status, housing, and access to services for the various ethnic groups in Minnesota is not available in the level of detail needed for a thorough analysis to understand as to where the disparities exist.
- The agency lacks a consistent system to collect disaggregated demographics, which would provide a more accurate set of data on the status of populations of color and American Indians. For example, a population grouping under "Asian Americans" makes a generalization of racial groups homogeneity when in reality they are diverse, with different cultures and beliefs, e.g., Hmong, Asian-Indian, Laotian, Burmese, Chinese, Karen, etc. Detailed data on health, human services, financial status, housing, and access to services for the various ethnic groups in Minnesota is not available disaggregated at the level of detail needed for a thorough analysis to understand as to where the disparities exist.
- If DHS is to bring about the goal of equity to all populations, it is critical to establish a mechanism for obtaining the accurate and detailed data into specific populations. The Research and Evaluation subcommittee members discussed the following:
    - In order to collect better data, one has to identify various ethnic groups and also educate the public about the collection of race, ethnicity, and language data.
    - The need to educate the public and to leverage current partnerships with other entities such as counties, managed care organizations, foundations, etc.;
    - Improve coordination and use of research and evaluation outcomes;
    - Educate state agencies and DHS on the importance of community-based participatory research methods (CBPR);
    - Make data-driven decisions based on community-defined cultural and linguistic groups and their members' input, promote translation of evidence-based research into practice
    - Engage communities in this effort so they can use information for their own benefit, such as being better users of publicly funded care;
    - Change/update the DHS Equity Dashboard to more fully reflect the status on reduction of disparities for target populations.

The lack of detail in the collection of race/ethnicity and language data is an impediment in determining where disparities exist and the nature of these disparities. The CECLC subcommittee on Research and Evaluation proposed recommendations to address this problem.

Appendix III

Cultural and Ethnic Communities Leadership Council

Interview results — **December 2014**

INTRODUCTION

Interviews in December 2014 were conducted on members of the Cultural and Ethnic Communities Leadership Council (CECLC) to gather input on their experience in participating in the council. This factsheet contains an analysis of the interviews.

Survey dates	**12/9/14 – 12/17/14**
Data collection method	**Interviews**
Number of participants	**19**
Interviewer	**Tim Quan, DHS**

Could you please share with me the high points of this past year as a member of CECLC? Were there low points?

HIGH POINTS

	% of respondents
Group cooperation and alliances created	57.8 %
Knowledge gained from diverse perspectives	42.1 %
Foundation created for community betterment	31.5 %
Engagement of leadership (DHS/Legislative)	31.5 %
Positive learning experience	26.3 %
Raised awareness of important issues to DHS	21 %

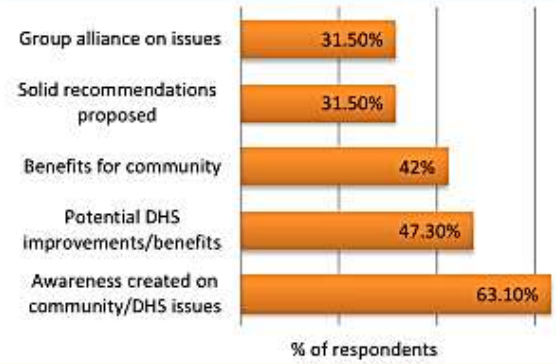
LOW POINTS

	% of respondents
Personal difficulties participating or attending	42.1%
Lack of attendance or participation of members	42.1%
Difficulty finding a focus w/conflicting perspectives	36.8%
Lack time for subcommittee work	36.8%
Communication difficulties	26.3%
Difficulties with engagement in early meetings	21%

57.8% of interview participants cited teamwork as a high point in their experience with the CECLC. 42.1% found the council aided their knowledge of diverse community perspectives. 31.5% felt their contribution would pave way for community betterment. Another 31.5% valued DHS senior leadership and legislators' participation at meetings. 26.3% appreciated the learning experience whilst 21% cited the virtues of raising awareness of issues to the DHS as a high point.

42.1% noted personal problems attending meetings to be a low point. 42.1% felt the lack of membership attendance to be problematic. 36.8% found difficulty aligning different perspectives with a focus amid diversity. 36.8% found it hard to allot time for subcommittee work. 26.3% felt communicating was challenging during meeting discussions. 26.3% felt lack of senior DHS leadership and legislator's participation raised questions about legislative and agency's leadership commitment to equity. 21% recalled engagement difficulties in early meetings as a low.

What do you feel are the most important tangible contributions the Cultural and Ethnic Communities Leadership Council have provided DHS?

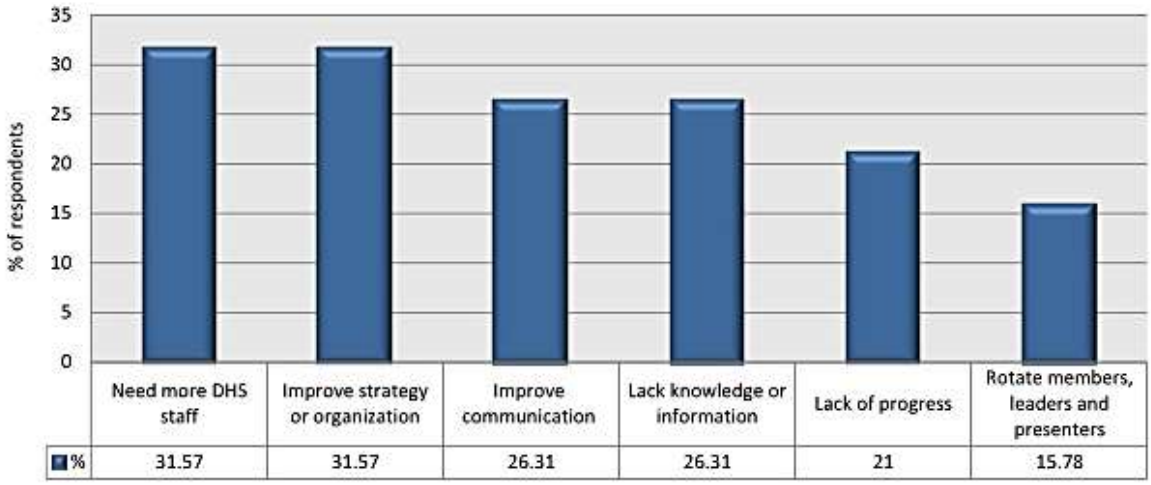


63.1% of interview participants believe, as a tangible contribution the CECLC has provided to the DHS, is the awareness of community health matters. 47.3% participants feel this council may improve DHS services. 42% believe the council will result in community benefits, especially as a communications platform. 31.5% feel the recommendations provided are tangible contributions, especially where it pertains to DHS services and community health. 31.5% felt group alliances to tackle issues to be a tangible contribution.

Cultural and Ethnic Communities Leadership Council

Interview results **December 2014**

Are there any resources that are currently lacking that prevent the council from being more effective?



31.5% of participants cite a lack of human resources relating to DHS staff and council needs. From research to gathering information, there is a perceived lack of personnel to assist member work. Another 31.5% felt there is a lack of strategic and directional vision, hastened by disparate knowledge levels in members. 26.3% wanted improvements in communication, especially with leadership feedback to work and promoting council work. 26.3% felt there was a lack of information around communities and their needs. 21% felt delays and a perceived lack of progress to be a deficiency. This coincided with a desire for periodic rotating of meeting leaders or presenters as 15.8% wished for speakers from other states, agencies or community programs to enrich the discussion. Other lacking resources includes an information repository to store and share information in a more accessible manner and technology to help increase membership attendance.

What should change for this coming year?

Regarding changes in the upcoming year, 36.8% of participants felt that the brainstorming level of the work has been completed and now, needs to refocus such as by embracing more actionable steps. 36.8% felt DHS functions/CECLC awareness should be increased. 31.5% of participants want organization and structural changes through the use of guides on how work is completed and more direction from the DHS on the work process. 26.3% of participants desire more interaction and feedback from DHS leadership on work completed. 21% wish for occasional pauses in progress or periodic self-assessments of the work as a group to ensure a sustainable approach is being followed. Additionally, 15.7% mentioned attendance from council members, as whole, to be important to showing dedication to council goals.

	% of respondents
Refocus strategy/timeline	36.8%
Increase DHS/CECLC awareness to public/subcommittee	36.8%
Improve organization/structural functions	31.5%
More interaction with DHS/legislative leadership	26.3%
Periodic self-reflection of CECLC work	21%
Increase member attendance	15.7%

Appendix IV

Resources identified for the CECLC members work by graduate student interns from the University of Minnesota, School of Public Health**.**

Subcommittees	Resources
Awareness	• **True democracy? Racial equity opportunities for government and our communities** http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5401071fe4b04c639f3fe76a/1409412795957/True%20Democracy%20(Plenary)%20Glenn%20Harris.pdf • **Innovative Partnerships to Support Place-Based Strategies for Racial Equity** http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/540506e8e4b086132f5f4625/1409615592446/InnovativePartnerships,%20Notes.pdf • **From Policy to Power-Sharing – Creating Change in Educational Equity** http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5404ee16e4b0cf67d96e4873/1409609238216/Education-Closing%20Racial%20Gaps%20Sessions,%20notes.pdf • **Center for Social Inclusion** works to identify and support policy strategies to transform structural inequity and exclusion into structural fairness and inclusion. The center works with community groups and national organizations to develop policy ideas, foster effective leadership, and develop communications tools for an opportunity-rich world in which we all will thrive no matter our race or ethnicity. Its vision is to translate America's changing demographics into a new source of power and prosperity for a society where all people can participate in solutions that help us all thrive. Link to website (http://www.centerforsocialinclusion.org) • **Frameworks Institute** designs, conducts and publishes communications research to prepare nonprofit organizations to expand their constituency base, to build public will, and to further public understanding of specific social issues. Link to website and case studies: http://www.frameworksinstitute.org/ • **Kirwan Institute for the Study of Race and Ethnicity** is designed to be actively used to solve problems in society. Its research and staff expertise are shared through an extensive network of colleagues and partners—ranging from other researchers, grassroots social justice advocates, policymakers, and community leaders nationally and globally, who can quickly put ideas into action. Kirwan Institute research works to create a just and inclusive society where all people and communities have opportunity to succeed. Learn more about our research here at http://kirwaninstitute.osu.edu/about/ • **Oklahoma State Department of Health—Office of Minority Health Community Health Chats** To assess Oklahoma's perception of racial and ethnic differences in health care, the Office of Minority Health conducts community health chats engaging communities in dialogue, to increase the public's awareness that differences exist. Link to 2011 report:

	http://www.ok.gov/health/Community_Health/Community_Development_Service/Office_of_Minority_Health/What_do_we_know/index.html • **Agency for Healthcare Research and Quality (AHRQ) National Health Care Disparities Report 2013 on Priority Populations**. Link to report: http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/chap11.html • Article to **Eliminating health disparities through transdisciplinary research, cross-agency collaboration, and public participation**. Link to article: http://www.ncbi.nlm.nih.gov/pubmed/19762652 • **Agency for Healthcare Research and Quality (AHRQ) Factsheet on Health Literacy:** http://www.ahrq.gov/research/findings/factsheets/literacy/healthlit/index.html • **The Community Tool Box** is a free, online resource for those working to build healthier communities and bring about social change. It offers thousands of pages of tips and tools for taking action in communities. Community Tool Box has over 300 educational modules for community assessment, planning, intervention, evaluation, advocacy, and other aspects of community practice. http://ctb.ku.edu/en/about-the-tool-box • The **San Francisco Indicator Project** is a neighborhood-level data system that measures how San Francisco performs in eight dimensions of a healthy, equitable community. The goal of this project is to support collaboration, planning, decision making, and advocacy for social and physical environments that meet the needs of all citizens. http://www.sfindicatorproject.org/ • **UMN Extension Center for Community Vitality** makes a difference by engaging Minnesotans to strengthen the social, civic, economic and technological capacity of their communities. We help communities choose their future by: Informing the decisions they make, Improving the processes they use when they make decisions, Enhancing the skills, ability and confidence of the people who lead and decide, and Increasing the number of people who step up to lead and decide. http://www.extension.umn.edu/Community/about • **Cost of Health Disparities:** The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006: $229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities. http://www.nashp.org/sites/default/files/costs.ethnic.racial.disparities.pdf • **Joint Center for Political and Economic Studies** http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf • **Dartmouth Atlas Project** has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system. It further forms the foundation for many of the ongoing efforts to improve health and health

	systems across America. http://www.dartmouthatlas.org/

Cultural and Linguistic Competency	• **Operating in Accordance with our Values – Improving Access to Government Contracting**
	  • http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5403e6dee4b0f72d40b99d72/1409541854429/Government%20contracting,%20Insight.pdf
	  • http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5405d2eae4b0e522f5dfdd08/1409667818074/govt%20contacting,%20notes%20.pdf
	• **Innovative Partnerships to Support Place-Based Strategies for Racial Equity** http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/540506e8e4b086132f5f4625/1409615592446/InnovativePartnerships,%20Notes.pdf
	• **Limited English Proficient Population of the United States Data** (Migration Policy Institute)
	Link to data: http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states
	• **Migration Policy Institute (MPI)** is an independent, nonpartisan, nonprofit think tank in Washington, DC dedicated to analysis of the movement of people worldwide. MPI provides analysis, development, and evaluation of migration and refugee policies at local, national, and international levels. It aims to meet the demand for pragmatic and thoughtful responses to the challenges and opportunities that large-scale migration, whether voluntary or forced, presents to communities and institutions in an increasingly integrated world. Link to website, data, and briefs: http://www.migrationpolicy.org
	• **Culture Care Connection** is an online learning and resource center, developed by Stratis Health, aimed at supporting health care providers, staff, and administrators in their ongoing efforts to provide culturally-competent care in Minnesota. http://www.culturecareconnection.org/index.html
	• **Stratis Health** is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities. Stratis Health envisions a health care system that supports an informed, activated consumer and competent, satisfied health care professionals working in settings that promote optimum care and reduce chance of error. Stratis helps health care providers understand and integrate quality improvement and safety into their work, and to support Medicare and all health care consumers in their quest for health education and quality information. http://www.stratishealth.org/expertise/disparities/index.html
	• Article on Race and Health Consequences: "**The Lived Experience of Race and its Health Consequences**" Link to article: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300643
	• **Community Health Worker Cost Effectiveness Studies**
	Social Return on Investment: CHWs in Cancer Research: Wilder Research Center's 2012 cost-benefit analysis of CHW services in cancer outreach found that for every dollar invested in CHWs, society receives $2.30 in return in benefits, a return of more than 200%.

	Download it here. • **Return on investment from employment of CHWs**: Author Carl Rush points out that there is a growing body of published research on the effectiveness of CHWs but that much of the evidence of CHW costs savings is still unpublished. He emphasizes in his 2012 article in the Journal of Ambulatory Care Management that ROI analysis for CHWs must consider a range of CHW roles and stakeholder points of view. Read it here. • **The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, with or without Hypertension**: shows that a CHW intervention program resulted in average savings of $2,245 per patient, and a total savings of $262,080 for 117 patients, along with improved quality of life. • **Measuring Return on Investment of Outreach by Community Health Workers**: a Denver Health study of 590 men in a CHW case management intervention shows increased use of primary and specialty care, and reduced use of urgent care, inpatient and outpatient behavioral health care use. The return on investment (program costs vs. overall reduced costs of care) was 2.28:1. • **A Community-Based Asthma Management Program: Effects on Resource Utilization and Quality of Life**: a CHW asthma intervention in Hawaii shows a decline in emergency room visits and increased quality of life. In one phase of the study, asthma-related per capita charges decreased from $735 to $181. • **Cost of Health Disparities:** The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006: $229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities. http://www.nashp.org/sites/default/files/costs.ethnic.racial.disparities.pdf • **Joint Center for Political and Economic Studies** http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf • **Dartmouth Atlas Project** has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America. http://www.dartmouthatlas.org/
Community Health and HC systems	• **Healthy people / healthy communities – closing the racial equity gaps in health and improving outcomes for all** http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/54052016e4b0e522f5df1495/1409622038673/Healthy%20people,%20healthy%20communities%20notes.pdf

- **Urban Agriculture Activity Plan**
  http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/540532ade4b0903f2ffa3e17/1409626797445/env%20justice,%20park%20board.pdf

- **Minnesota Public Health Data Access** (the Data Access portal) is an online query and information system designed to provide public access to Minnesota data about health, the environment, and other risk factors that may impact public health.
  https://apps.health.state.mn.us/mndata/home

- **Human Impact Project (HIP)** believes that health and equity should be considered in all decision making. We raise awareness of and collaboratively use innovative data, processes and tools that evaluate health impacts and inequities in order to transform the policies, institutions, and places people need to live healthy lives. Through training and mentorship we also build the capacity of impacted communities and their advocates, workers, public agencies, and elected officials to conduct health-based analyses and use them to take action. Learn more about our projects or one of our main tools, Health Impact Assessment at http://www.humanimpact.org/about-us/

- The **Commonwealth Fund** is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. Link to interactive data by state and health care related publications: http://www.commonwealthfund.org/publications/view-all-reports-and-briefs

- **Stratis Health** is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities. Stratis Health envisions a health care system that supports an informed, activated consumer and competent, satisfied health care professionals working in settings that promote optimum care and reduce chance of error. Our objectives are to help health care providers understand and integrate quality improvement and safety into their work, and to support Medicare and all health care consumers in their quest for health education and quality information.
  http://www.stratishealth.org/expertise/disparities/index.html

- **Robert Wood Johnson Foundation Datahub** tracks state-level data and allows users to customize and visualize facts and figures on key health and health care topics.
  http://www.rwjf.org/en/research-publications/research-features/rwjf-datahub.html

- **City of Seattle Parks and Recreation** department worked with community to establish "Women-only Swim" program, there are gender-specific swim times in the pool to meet the social, cultural and religious needs of all women. Idea of the program started 10 years ago when a community organization rented pool facility for their members to swim monthly—it was not a public program. In 2013, Seattle Parks department began public program with promotional price of $2/person. Program expanded to 3 public pools

	throughout the city. Program has been well-received but not without opposition from community members. Surrounding cities have similar program but admission fees are not lowered. Neighboring city of Tukwila offers men's only swim program. Link to the Seattle's women's only program: http://www.seattle.gov/parks/aquatics/WOW_poster.pdf • The **San Francisco Indicator Project** is a neighborhood-level data system that measures how San Francisco performs in eight dimensions of a healthy, equitable community. The goal of this project is to support collaboration, planning, decision making, and advocacy for social and physical environments that meet the needs of all citizens. http://www.sfindicatorproject.org/ • **Agency for Healthcare Research and Quality (AHRQ) Factsheet on Health Literacy:** http://www.ahrq.gov/research/findings/factsheets/literacy/healthlit/index.html • Article on **Ethnic Disparities Persist in Depression Diagnosis and Treatment Among Older Americans**. Link to article: http://www.nimh.nih.gov/news/science-news/2012/ethnic-disparities-persist-in-depression-diagnosis-and-treatment-among-older-americans.shtml • Article on **Immigrants to the United States and Canada have worse access to care than native-born counterparts.** Link to article: http://www.ahrq.gov/news/newsletters/research-activities/jun11/0611RA6.html • Article on **mental health disparities**. Link to article: http://www.ncbi.nlm.nih.gov/pubmed/19820213 • **CDC Sortable Risk Factors and Health Indicators**: Sortable Stats is an interactive dataset comprised of behavioral risk factors and health indicators. Dataset compiles state level data for all 50 states, plus D.C. This tool is intended to serve as a resource in the promotion of policy, system, and environmental changes. (http://wwwn.cdc.gov/sortablestats/) • **Cost of Health Disparities:** The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006: $229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities. http://www.nashp.org/sites/default/files/costs.ethnic.racial.disparities.pdf • **Joint Center for Political and Economic Studies** http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf • **Dartmouth Atlas Project** has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems

	across America. http://www.dartmouthatlas.org/

Leadership	• **Operating in Accordance with our Values – Improving Access to Government Contracting**
	  • http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5403e6dee4b0f72d40b99d72/1409541854429/Government%20contracting,%20Insight.pdf
	  • http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5405d2eae4b0e522f5dfdd08/1409667818074/govt%20contacting,%20notes%20.pdf
	• **Moving from Outreach to Engagement – Community Partnerships for Racial Equity**
	http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5403ac66e4b096fd0b9d8d63/1409526886627/Outreach%20to%20Engagement,%20notes.pdf
	• **Operating in Accordance with our Values – Improving Access to Government Jobs**
	http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5404d449e4b0c1de726598a5/1409602633113/gov%20jobs,%20summary.pdf
	• **Increasing and improving jobs – closing the racial equity gaps in jobs and improving success for all**
	http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/5404e8f8e4b0e522f5deb0ab/1409607928277/jobs,%20notes.pdf
	• **Innovative Partnerships to Support Place-Based Strategies for Racial Equity**
	http://static.squarespace.com/static/5393898ee4b0d1f9ffe75254/t/540506e8e4b086132f5f4625/1409615592446/InnovativePartnerships,%20Notes.pdf
	• **Human Impact Project (HIP)** believes that health and equity should be considered in all decision making. We raise awareness of and collaboratively use innovative data, processes and tools that evaluate health impacts and inequities in order to transform the policies, institutions, and places people need to live healthy lives. Through training and mentorship we also build the capacity of impacted communities and their advocates, workers, public agencies, and elected officials to conduct health-based analyses and use them to take action. Learn more about our projects or one of our main tools, Health Impact Assessment at http://www.humanimpact.org/about-us/
	• **Health Impact Assessment in Minnesota (MDH):** MDH is aware of 21 HIAs that have been completed or are in process in Minnesota. Most of the HIAs have focused on built environment projects and planning. More specifically, most of the HIAs have been performed on transportation-related projects and/or comprehensive plans. Link to HIA examples in MN: http://www.health.state.mn.us/divs/hia/hiainmn.html
	• **Health Impact Assessment Resources from CDC**:
	http://www.cdc.gov/healthyplaces/hiaresources.htm#methodology
	• The **Health Impact Project**, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, is a national initiative designed to promote the use of health impact assessments (HIAs) as a decision-making tool for policymakers. HIAs use a flexible, data-driven approach that identifies the health consequences of new policies

	and develops practical strategies to enhance their health benefits and minimize adverse effects. http://www.pewtrusts.org/en/projects/health-impact-project/about • The **UCLA Health Impact Assessment—Clearinghouse Learning and Information Center (HIA-CLIC)** website was developed by the UCLA Health Impact Assessment (UCLA-HIA) Project with support from the Robert Wood Johnson Foundation. The website is constantly growing and evolving as more HIA projects and resources are added. http://hiaguide.org/about • **Cost of Health Disparities:** The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006: $229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities. http://www.nashp.org/sites/default/files/costs.ethnic.racial.disparities.pdf • **Joint Center for Political and Economic Studies** http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf • **Dartmouth Atlas Project** has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America. http://www.dartmouthatlas.org/
Research and Evaluation	• **MDH Center for Health Statistics (CHS)** houses the collection and analysis of health-related data for MN. Link to (CHS) http://www.health.state.mn.us/divs/chs/ • **State Health Access Data Assistant Center (SHADAC)** is a health policy research center within the University of Minnesota, School of Public Health. SHADAC specializes in issues related to health insurance access, use, cost and quality with a particular focus on state implementation of health reform. Link to SHADAC: http://www.shadac.org/content/about-shadac • **Minnesota Public Health Data Access** (the Data Access portal) is an online query and information system designed to provide public access to Minnesota data about health, the environment, and other risk factors that may impact public health. https://apps.health.state.mn.us/mndata/home • The **Agency for Healthcare Research and Quality's (AHRQ)** mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the U.S. Department of Health and Human Services and with other partners to make sure that the evidence is understood and used. For research tools and data information, visit http://www.ahrq.gov/index.html • **Diversitydatakids.org (The Heller School for Social Policy and Management at Brandeis University)**: Explore hundreds of measures of child wellbeing and policy analysis from a unique information source that documents diversity, opportunity, and

equity among US children. http://www.diversitydatakids.org/

- **KIDS COUNT**, a project of the Annie E. Casey Foundation, is the premier source for data on child and family well-being in the United States. Access hundreds of indicators, download data and create reports and graphics on the KIDS COUNT Data Center that support smart decisions about children and families. http://datacenter.kidscount.org/

- **Kirwan Institute for the Study of Race and Ethnicity** is designed to be actively used to solve problems in society. Its research and staff expertise are shared through an extensive network of colleagues and partners—ranging from other researchers, grassroots social justice advocates, policymakers, and community leaders nationally and globally, who can quickly put ideas into action. Kirwan Institute research works to create a just and inclusive society where all people and communities have opportunity to succeed. Learn more about our research here at http://kirwaninstitute.osu.edu/about/

- **PolicyLink** connects the work of people on the ground to the creation of sustainable communities of opportunity that allow everyone to participate and prosper. Such communities offer access to quality jobs, affordable housing, good schools, transportation, and the benefits of healthy food and physical activity. Guided by the belief that those closest to the nation's challenges are central to finding solutions, PolicyLink relies on the wisdom, voice, and experience of local residents and organizations. Lifting Up What Works is our way of focusing attention on how people are working successfully to use local, state, and federal policy to create conditions that benefit everyone, especially people in low-income communities and communities of color. We share our findings and analysis through our publications, website and online tools, convening, national summits, and in briefings with national and local policymakers. http://www.policylink.org/about

- **Human Impact Project (HIP)** believes that health and equity should be considered in all decision making. We raise awareness of and collaboratively use innovative data, processes and tools that evaluate health impacts and inequities in order to transform the policies, institutions, and places people need to live healthy lives. Through training and mentorship we also build the capacity of impacted communities and their advocates, workers, public agencies, and elected officials to conduct health-based analyses and use them to take action. Learn more about our projects or one of our main tools, Health Impact Assessment at http://www.humanimpact.org/about-us/

- The **San Francisco Indicator Project** is a neighborhood-level data system that measures how San Francisco performs in eight dimensions of a healthy, equitable community. The goal of this project is to support collaboration, planning, decision making, and advocacy for social and physical environments that meet the needs of all citizens. http://www.sfindicatorproject.org/

- The **Commonwealth Fund** is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other

	industrialized countries. Link to interactive data by state and health care related publications: http://www.commonwealthfund.org/publications/view-all-reports-and-briefs • **Robert Wood Johnson Foundation Datahub** tracks state-level data and allows users to customize and visualize facts and figures on key health and health care topics. http://www.rwjf.org/en/research-publications/research-features/rwjf-datahub.html • **Article on "**The Role for Community-Based Participatory Research in Formulating Policy Initiatives: Promoting Safety and Health for In-Home Care Workers and Their Consumers". Link to article: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2774173/ • Article to **Eliminating health disparities through transdisciplinary research, cross-agency collaboration, and public participation**. Link to article: http://www.ncbi.nlm.nih.gov/pubmed/19762652 • Article on Race and Health Consequences: "**The Lived Experience of Race and its Health Consequences**" Link to article: http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300643 • **Cost of Health Disparities:** The Joint Center for Political and Economic Studies estimates racial and ethnic disparities to have cost this nation $1.24 trillion between 2003 and 2006: $229.4 billion for direct medical care expenditures associated with health disparities and another $1 trillion for the indirect costs of disparities. http://www.nashp.org/sites/default/files/costs.ethnic.racial.disparities.pdf • **Joint Center for Political and Economic Studies** http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf • **Dartmouth Atlas Project** has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America. http://www.dartmouthatlas.org/

Appendix V

CECLC Membership: The commissioner of human services appointed members of the Cultural and Ethnic Communities Leadership Council (CECLC) in October 2013.

http://www.dhs.state.mn.us/CulturalEthnicLeadershipCouncil

MEMBER	**AFFILIATION**
Five members representing diverse cultural and ethnic communities:	
Vacant	*Term Expires:*
Mitchell Davis Jr	*Minneapolis Urban League* *Term Expires:*
Kamaludin Hassan	*Hennepin County Adult Mental Health Local Advisory Council* *Term Expires:*
Pahoua Yang	*Amherst Wilder Foundation, Southeast Asian Services* *Term Expires:*
Vacant	*Term Expires:*
Two members representing culturally and linguistically specific advocacy groups:	
Vacant	*Term Expires:*
Vayong Moua	*Senior advocacy and health equity principal, Center for Prevention, Blue Cross and Blue Shield of Minnesota* *Term Expires:*
Two members representing culturally specific human services providers	
Kamala Puram	*executive director, SEWA-AIFW, Asian Indian Family Wellness* *Term Expires:*
Titilayo Bediako	*WE WIN Institute Inc., Multicultural Children's Issues* *Term Expires:*
Two members representing the American Indian Community:	
Vacant	
Vacant	

Two members representing counties serving large cultural and ethnic communities:	
Vacant	*Term Expires:*
Paula Haywood	*Hennepin County Department of Community Corrections and Rehabilitation, Quality assurance and community engagement manager* *Term Expires:*
One member who is a human services program participant member representing communities of color	
Pa H. Lor	*Office Coordinator, Multicultural & International Programs and Services Office, St. Catherine University* *Term Expires:*
One member who is a parent of a human services program participant, representing communities of color:	
Saciido Shaie	*Prevent Child Abuse Minnesota, Parent leader for child safety and permanency,* *Term Expires:*
The chairs ranking minority members of the committees in the House of Representatives and the Senate with jurisdiction over human services:	
Rep. Matt Dean, House Finance chair	
Rep. Tara Mack, House Policy Chair	
Rep. Tina Liebling, House Minority Lead (Health Care)	
Rep. Diane Loeffler, House Finance Minority Lead (Human Services)	
Rep. Joe Mullery, House Policy Minority	
Sen. Tony Lourey, Senate Finance chair	
Sen. Kathy Sheran, Senate Policy Chair	
Sen. Julie Rosen, Senate Minority Finance	
Sen. Michelle Benson, Senate Minority Policy	
Two members representing faith-based organizations ministering to ethnic communities:	
The Rev. Janet Johnson, Ordained Elder	*Wayman African Methodist Episcopal Church* *Term Expires:*

Vacant	
One member who is a representative of a private industry with an interest in inequity issues:	
LaJuana Whitmore	*Target Corp.* *Term Expires:*
One member representing the University of Minnesota program with expertise on health equity research	
Vacant	*Term Expires:*
Four representatives of the state ethnic councils	
Edward McDonald, Council on Black Minnesotans	
Sia Her, Council on Pacific Islanders Minnesotans	
Hector Garcia, Chicano Latino Affairs Council	
Annamarie Hill, Minnesota Indian Affairs Council	
One representative of the Ombudspersons for Families (rotating):	
Bauz Nengchu, Muriel Gubasta, Jill Kehaulani Esch, and Ann Hill	
Four DHS employees:	
LaRone Greer	*Chemical and Mental Health Administration* *Term Expires:*
Anna Mazig	*Operations* *Term Expires:*
Maria Sarabia	*Health Care Administration* *Term Expires:*
Nathan Moracco	*Assistant Commissioner for Health Care/Senior management team liaison* *Term Expires:*
DHS staff to the CECLC:	
Antonia Wilcoxon	*Community Relations Director*
Denise Flock	*Administrative Staff*
Tim Quan	*Community Relations Staff (Research Analysis)*

Appendix VI

Cultural and Ethnic Leadership Council photo gallery

Back row, left to right: Brian Ambuel, DHS intern; David Haley, Ramsey County Community Human Services; Kamaludin Hassan, Hennepin County; DHS Commissioner Lucinda Jesson; Mitchell Davis Jr., Minneapolis Urban League; DHS Health Care Assistant Commissioner Nathan Moracco; State Sen. Tony Lourey; Paula Haywood, Continuous Practice Improvement manager, Department of Community Corrections; Maria Sarabia, DHS Health Care Administration. Front row, left to right: Denise Flock, DHS; Antonia Wilcoxon, DHS community relations director; Vayong Moua, Blue Cross Blue Shield; Mee Cheng, DHS intern; Pam Cosby, Minnesota Urban Area Health Ed Center and council chair; Titilayo Bediako, WE WIN Institute Inc.; Pahoua Yang, Amherst Wilder Foundation; Bauz Nengchu, Office of the Ombudsperson for Families.

DHS Commissioner Lucinda Jesson speaks at a council meeting.

DHS Commissioner Lucinda Jesson, left, with Pam Cosby, Pahoua Yang, Sen. Tony Lourey and Maria Sarabia.

Left to right: DHS Assistant Commissioner Nathan Moracco, Denise Flock, LaRone Greer, Paula Haywood, Pahoua Yang, Vayong Moua, LaJuana Whitmore, Tenzin Dolkar, Anna Mazig, Pam Cosby, state Sen. Tony Lourey, Pa Lor, Kamala Puram, Tim Quan, Antonia Wilcoxon, DHS Deputy Commissioner Chuck Johnson, David Haley.

From left, Pahoua Yang, Anna Mazig, Sen. Tony Lourey, Deputy Commissioner Chuck Johnson, Pam Cosby.

From left, Vayong Moua, Paula Haywood, Kamaludin Hassan, LaRone Greer.

State Sen. Tony Lourey, Deputy Commissioner Chuck Johnson listen as Pam Cosby speaks.

Kamaludin Hassam, left, and LaRone Greer at a council meeting.

Members of DHS' Cultural and Ethnic Communities Leadership Council at the University of Minnesota Humphrey Institute Jan. 30. From left: former Minneapolis Mayor Sharon Sayles Belton, Pa Lor, Tim Quan, Vayong Moua, Antonia Apolinário-Wilcoxon, Maria Sarabia, Professor Samuel Myers, Paula Haywood, Ann Hill, the Rev. Dr. Janet Johnson, Dave Haley.

Members of DHS' Cultural and Ethnic Communities Leadership Council at the University of Minnesota Humphrey Institute Jan. 30. Back row, from left: Antonia Apolinário-Wilcoxon, Vayong Moua, Maria Sarabia, Paula Haywood, Professor Samuel Myers, former Minneapolis Mayor Sharon Sayles Belton, Dave Haley. Front row: Pa Lor, the Rev. Dr. Janet Johnson, state Sen. Patricia Torres Ray, Tim Quan, Ann Hill.