



Cultural and Ethnic Communities Leadership Council (CECLC)

Community Relations

2018 Report

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Letter from the Chair

The CECLC constantly balances gratitude and discontent on equitable progress. We anguish over the slow and sometimes retreating pace of cultural and structural prioritization of equity. How has the term “equity” even become political and polarizing? How can equity not be a common good and core element of who we are as Minnesotans? We live in a state of amazing averages that’s created by our high peaks and low valleys. The blanket appraisals and accolades of Minnesota’s prosperity continues to mask the preventable inequities across cultural communities. The pervasiveness of inequities in health, human services, education, wealth, and every sector is tragically unique for Minnesota. While structural racism and inequities exist everywhere, something about Minnesota’s cultural fabric and policy making sensibilities has produced some of the nation’s worst racial and economic inequities. We not only contend with implicit bias and structural racism, we now face brash explicit bias and overt racism spotlighted across issues. The false belief of immunity to racism and bigotry combined with organized xenophobia continues to rampage all of Minnesota. Yes, every state believes they’re unique, but consider Minnesota has the largest population of African and Southeast Asian refugees in the country and is home to the American Indian Movement. Coastal racial dynamics that primarily break along black, brown, and white lines are not fully resonate here in Minnesota. Until we see and tailor for Minnesota’s intergenerational, immigrant/refugee, and indigenous peoples, we can’t fully attach to the broader equity movement.

Within the mainstream power structures, often, equity is an amenity versus necessity for democracy. Perhaps, the single most important impact CECLC has made is to systematize equity practice and capacity within the core functions of DHS. We have an equity policy in place for integration tracking, accountability, and systems change. We’ve always cared about transforming hearts and minds to center cultural and ethnic communities. Equity can’t be actualized without the deliberate embrace of cultural difference. But the immediate goal is to transform institutional behavior and impact, while cultivating equity consciousness. The deep consideration of how a budget, service, program, or policy impacts diverse cultural and ethnic communities was the beginning. Now, the emphasis is on how DHS can behave and operate in ways that advance equity inside all of DHS’s scope of work and myriad external touchpoints. CECLC continues to address issues like food insecurity, dehumanizing narratives, overlooking research methodologies, and threats against essential public health care. But root causes are deeper at prioritization tables and long-term solutions are cross cutting across sectors, so we’ve organically expanded CECLC’s purpose to advocate ecologically for equity. Without relenting on our partnership with DHS, our work requires engagement with a continuum of agencies, community partners, and advocates. This report illuminates CECLC’s evolutionary capabilities, story, and activities. The shift towards internal architecture, substantive engagement of other agencies, and power building among CECLC members stand out as highlights. In your reading and sharing of this report, I ask for your vigilance and support of DHS and CECLC. Perhaps no state agency has farther to go on equity because of its enormous scope of impact, I can also confidently say that I’ve seen no other state agency in the country direct equity integration, organizational design, and core functions via policy change. In the equity movement, gratitude is not acceptance and solidarity is an action word. We are far from realizing this in Minnesota, but we’re on our way.

In Solidarity,
Vayong Moua, CECLC Chair

Executive Summary

The Minnesota Legislature established the Cultural and Ethnic Communities Leadership Council (CECLC) in 2013 in order to “advise the commissioner of human services on reducing disparities that affect racial and ethnic groups.” In 2015, the legislature extended the CECLC’s mandate through 2020. The full text of current CECLC statute is below and may be referenced at this address:

<https://www.revisor.mn.gov/statutes/?id=256.041>.

This report seeks to fulfill the following mandate:

“(11) by February 15 each year, prepare and submit to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services a report 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 lists 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 statistically valid reports of outcomes on the reduction of the disparities.”

During 2017, DHS approved the Implementation Plan for the Policy on Equity, which contains a combination of the recommendations advanced by the Council. CECLC members provided guidance and feedback to numerous requests from the agency and community at large on issues of disparities reduction, cultural and linguistic appropriate ways of working with communities, and performed ‘equity audits’ on programs and services to make them more equitable in design and outcome. Council members also attended meetings with various state agencies, made presentations, participated in working groups, and served as advocates at the legislature.

A significant portion of this report is the annual equity review. One of its purposes is to identify and report (in a statistically valid manner) the outcomes of the efforts in disparities reduction. After four years, the Minnesota Department of Human Services (DHS) continues to lack statistically meaningful updates in this area due to limitations in its data systems; DHS does not currently have the capacity to build performance measures and other qualitative indicators to understand the impact of its programs and services on people experiencing inequities at this time. Evaluation and measurement are often built after services are designed and implemented rather than built into the initial design of services and new initiatives. While progress is made each year, the inclusion of community members to define the solutions for the persistent disparities and inequities is not yet a part of the DHS culture.

Through the process of conducting the 2017 equity review,

- DHS reported 111 projects, with 56 being updates on continuing projects; this increased from last year (82 projects), showing committed efforts on disparities reduction work.
- The review found continued barriers toward realizing equity or disparities reduction including: limited funding, limited data, and lack of community member involvement in policy-making process.
- The review reported strengths in the efforts, including.

- Current administration's interest in equity (support throughout senior level management at DHS.
- External and internal collaborations and partnerships: equity initiatives welcomed internally to positively impact work done agency-wide.
- Internal and community engagement: many external agencies are also focusing on equity efforts and there is room to work collaboratively.

In 2017, the Cultural and Ethnic Communities Leadership Council (CECLC) identified the following priority areas to focus their work:

- Prioritize DHS areas to narrow focus, identify clear steps and strategies.
- Monitor implementation of the policy on equity.
- Engage in collaboration to find common purpose with allies.
- Increase public awareness, find new ideas, work with new people, and build a network of human connection and experiences.
- Organize to influence and create accountability – become informed to be an effective member and share information, show up in the community for one another.
- Measure: measure the impact, lead the effort in measuring success, and create durable lasting systemic equity response.

Progress toward these priority areas include:

- Leveraging DHS to influence other agencies and jurisdictions.
- Sharing the CECLC equity blueprint and approach with MN Management & Budget's Deputy Commissioner Edwin Hudson.
- Providing consultative support in the creation of the Minnesota Department of Health's Health Equity Advisory and Leadership Council. (HEAL)
- Meeting with leadership of the board of the Metropolitan Council (Chair Alene Tchourumoff and Mr. Wes Kooistra) to discuss the work of the CECLC and the equity policy adopted by DHS.
- Collecting letters of support and purpose/value proposition for the continuation of the CECLC existence. (in perpetuity)
- Engagement with Governor's office staff on institutionalizing equity beyond his administration.

Creating collaborations with organizations that members of the Council work with or have identified areas where issues of interest intersect.

- Voices for Racial Justice
- Take Action Minnesota
- Amherst H. Wilder Foundation
- Nexus Community Partners: At the CECLC December meeting, leaders from the Nexus Community Partners attended the CECLC meeting and talked about their Boards and Commissioners Leadership Institute and their Community Engagement Initiative. Meeting with other potential partners are being scheduled for 2018.
- Collecting stories to put the 'human face' and relevancy to examples that educate through letters/communication to legislators.
- The Community Relations Director continues to find resources in short-term interns seeking to complete their required field experiences.

Introduction, Background, and CECLC Recommendations

Introduction

The Legislature created the Cultural and Ethnic Communities Leadership Council (CECLC) in 2013 in order to advise the commissioner on ways to reduce disparities that affect racial and ethnic groups. The CECLC's mission is working together to advance health and human services equity. CECLC members work towards this mission through the development of community-supported policy recommendations that work to achieve health and human services equity for cultural and ethnic communities and all those who call Minnesota home.

Pursuant to their mission and vision, the CECLC operates within the following *agreements* in accordance with the following *values*:

Agreements

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

Values:

- BE consistent, proactive, and represent diverse communities.
- KNOW that within communities there is a lot of diversity; that there is a big task ahead because we are talking about ambitious changes; all the facts that inform our work; and that there are good practices we can draw on.
- DO reach out to a broader community to make sure they are represented and dig deep into the root issues and possible solutions. The CECLC adopted the following duties in order to fulfill their legislatively mandated purpose of advising DHS on reducing racial and ethnic disparities.

Duties:

- Recommend to the Commissioner for review identified policies in the Department of Human Services that maintain and create, magnify, etc. racial, ethnic, cultural, linguistic, and tribal inequities and advance and promote health equity.
- Identify issues regarding disparities by engaging diverse populations in human services programs.
- Engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients.
- Raise awareness about human services disparities and health equity needs to the legislature and media.
- Provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes.
- Provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies.
- Provide training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities.
- Facilitate culturally appropriate and culturally sensitive admissions, continued services, discharges, and utilization review for human services agencies and institutions.
- Form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish.
- Promote information-sharing in the human services community and statewide.
- Prepare and submit an annual 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.

See Appendix B for full text of CECLC bylaws.

History of the Council

The CECLC was preceded by a 30-member committee known as the Disparities Reduction Advisory Committee (DRAC) which was formed in 2010 and concluded its work in the summer of 2013. That committee provided the senior management team at DHS with recommended issues to identify and track the gaps in results experienced by populations in Minnesota.

Its purpose is to engage the communities impacted by disparities in access and outcomes to DHS services. The meetings engaged a diverse group of people, including recipients of services, advocates and providers who sought to deliver culturally and linguistically appropriate services to their specific cultural groups. Over a 4-year period, the committee discussed programs funded by DHS and engaged with a group of DHS employees appointed by their assistant commissioners in an effort to develop recommendations that promised more enduring results than previous efforts to address disparities.

Several employees from DHS, including leadership, regularly visited the monthly meetings to gain a better understanding of community issues and get feedback and advice from DRAC members on programs and policies that might impact a specific group. Members were consulted on a range of issues including aging services, medical homes, client outreach, chemical health, and contracting.

DRAC members requested that DHS change the scope of the work of the group by establishing a more formal presence in the state agency. In response, DHS developed the legislative proposal to establish the Cultural and Ethnic Communities Leadership Council. Passage of this proposal by the legislature led to the creation of the CECLC.

Membership

The CECLC consists of 15-25 members appointed by the Commissioner of Human Services, in consultation with county, tribal, cultural, ethnic communities, diverse program participants, and parent representatives from these communities. Appointments must include representation from racial and ethnic minorities, tribal service providers, advocacy groups, human services program participants, and members of the faith community, as well as the majority chairs and minority lead of the Human Services Legislative Committees. More specifically, the CECLC consists of the following members.

- Five members representing diverse cultural and ethnic communities.
- Two members representing culturally and linguistically specific advocacy groups.
- Two members representing culturally specific human services providers.
- Two members representing the America Indian community.
- Two members representing counties serving large cultural and ethnic communities.
- One member who is a parent of a human services program participant, representing communities of color.
- One member who is a human services program participant representing communities of color.
- The chairs and the ranking minority members of the committees in the House of Representatives and the Senate with jurisdiction over Human Services.
- Two members representing faith-based organizations ministering to ethnic communities.

- One member who is a representative of a private industry with an interest in inequity issues.
- One member representing the University of Minnesota program with expertise on health equity research.
- Four representatives of the state ethnic councils.
- One representative of the Ombudspersons for Families. (rotating)
- Three members who are DHS employees.

DHS Staff Support

DHS is responsible for providing staff support to maintain the CECLC and assist in its operation. In 2017, Antonia Wilcoxon, in her role as Director of Community Relations, along with Community Relations Division Project Managers and Interns provided the primary DHS staff support. Deputy Commissioner Santo Cruz, joined the CECLC as a representative of executive level DHS leadership.

CECLC Recommendations

A primary responsibility of the CECLC is to produce recommendations for DHS on disparities reduction. The CECLC dedicated a large portion of its time in 2014 to developing these recommendations, which were first presented to DHS senior leadership in 2015 and documented in the 2015 CECLC Legislative Report. The CECLC continues to stand by these recommendations as representing their priorities for DHS to reduce racial and ethnic disparities.

The CECLC framed their recommendations within the disparities reduction goals of the National Partnership for Action to End Health Disparities.¹ In order to develop recommendations, the Council formed 5 subcommittees based on these goals.

The subcommittees were:

- Awareness
- Leadership
- Community Health and Health Systems
- Culturally and Linguistically Competent Services
- Research Evaluation. Appendix E has an illustration of the goals

In 2014, each of the five subcommittees met for several months to study and review research, journal articles, best practices, information from other jurisdictions, and recommendations of DRAC related to their topic area. Based on this study, subcommittees identified recommendations which were later presented to and endorsed by the full council.

The CECLC's priority recommendations for action were as follows:

¹ <https://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=11>

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

- Community Engagement.
- Community Empowerment.
- Community and DHS Collaboration.

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

- Equity Analysis.
- Accountability of Existing Leadership.
- Support of New Leadership.
- Hiring and Retention.
- Contracting.

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.

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

4. 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.

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

5. 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

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

Urgency for Addressing Disparities

Background

The 2016 Minnesota Department of Health Center for Health Equity Legislative Report on the Eliminating Health Disparities Initiative reveals that the State of Minnesota ranks among the healthiest states in the nation. There are, however, great disparities between Whites, people of color and American Indians. Although Minnesota has made significant progress, there are still widespread disparities across the country. Many national reports, including those by the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ), show significant disparities between populations. The 2017 American's Health Ranking Report confirms similar findings. According to the report, Minnesota scored number 6 nationally, and number 1 on health outcomes when compared to other states on measures related to community and environment, policy, and clinical care. Although Minnesota ranked high in many categories, significant disparities remain.

Sources:

Minnesota Department of Health, Center for Health Equity. (2016). Eliminating Health Disparities Initiative Report to the Minnesota Legislature.

<http://www.health.state.mn.us/divs/che/reports/legreport2016.pdf>

United Health Foundation. (2017). America's Health Rankings.

https://assets.americashealthrankings.org/app/uploads/ahrannual17_complete-121817.pdf

Data

AHRQ's 2016 National Healthcare Quality (QDR) and Disparities Report

Measures of access to care tracked in the QDR include having health insurance, having a usual source of care, encountering difficulties when seeking care, and receiving care as soon as needed. Historically, Americans have experienced variable access to care based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

- Overall, some disparities were getting smaller from 2000 through 2014-2015, but they persist, especially for poor and uninsured populations in all priority areas. The insurance rate increased from 2010 to 2016, and significantly played a role in decreasing disparities. Quality of health care also impacted the disparities, as it improved overall from 2000 through 2014-2015, but the pace of improvement varied by priority area.
- While 20% of measures show disparities getting smaller for Blacks and Hispanics, most disparities have not changed significantly for any racial and ethnic groups.
- More than half of measures show that poor and low-income households have worse care than high-income households; for middle-income households, more than 40% of measures show worse care than high-income households.

- Nearly two-thirds of measures show that uninsured people had worse care than privately insured people
Sources:
Agency for Healthcare Research and Quality (AHRQ). (2016). 2016 national Healthcare Quality and Disparities Report.

<https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/nhqdr16/2016qdr.pdf>
<https://www.ahrq.gov/research/findings/nhqdr/nhqdr16/quality.html#Disparities>

Minnesota Community Measurement “2017 Health Equity of Care Report”

- Patients in the White racial group generally had better health care outcomes across most measures and most geographic areas. This is consistent with findings from past reports. White patients had rates above the statewide average on all five Patient Experience of Care domains and all seven quality measures; notably, this was the only racial group to have a Colorectal Cancer Screening rate above the statewide average.
- The Black or African American racial group did not have the highest rate for any quality measure. African Americans had the lowest rate for the Optimal Vascular Care measure. They also had rates below the statewide average across the board. This is similar to the results for this racial group in 2014 and 2015.
- The “2017 Health Equity Care Report” distinguish distinct differences in health care outcomes between patient populations and geographic regions in Minnesota. Outlining clear the fact that some racial, ethnic, language and country of origin groups have consistently poorer health care outcomes than other groups.
- Data collected shows that throughout clinical quality measures and state regions, White and Asian patients have higher rates than other racial groups. Still there was a clear observation that Asian patients reported less positive patient experiences than White patients. Also across measures and geographic areas, American Indian, Alaskan Native, Black and African American patients generally had lower rates both statewide and regionally. Concurrently, Hispanics generally had poorer healthcare outcomes than non-Hispanic throughout most of the quality measures and most of the geographic regions.

Source:

Minnesota Community Measurement. (2017). Health Equity of Care Report.

<http://mncm.org/health-equity-of-care-report/>

Minnesota Community Measurement “2016 Health Care Disparities Report for Minnesota Health Care Programs”

- Patients enrolled in Minnesota Health Care Programs (MHCP) represent a population considered at risk because of their low socioeconomic status, as well disproportionately made up of persons of color and American Indians and persons with disabilities and elderly adults. By using MHCP enrollment as a proxy for socioeconomic status, this report evaluates health care disparities that exist because of socioeconomic status.

Source:

Minnesota Community Measurement. (2016). 2016 Health Care Disparities Report For Minnesota Health Care Programs. <http://mncm.org/wp-content/uploads/2017/03/2016-Disparities-Report-Final-2.28.2017.pdf>

Stratis Health “Leading and Lagging: Health Disparities and the Differences in Minnesota’s Quality of Care”

- Minnesota has led in providing high quality care with the best overall health and health care ratings in the country, but concurrently data shows significant and long established differences in health and health care between the White population and the communities of color.
- The Agency for Healthcare Research and Quality (AHRQ) provided data showing that Minnesota is one of the 12 best states in the U.S for overall quality of care, however Minnesota is also one of the 13 worst performing states when it comes to the average difference in quality of care between Blacks, Hispanics, and Asians compared with Whites.

Source:

Stratis Health. (2017). Culture Care Connection.

http://www.culturecareconnection.org/documents/CCCNewsFall2017_R.pdf

Healthy Youth Development- Prevention Research Center- “2017 Minnesota Adolescent Sexual Health Report”

- Birth rates for American Indian, African American and Hispanic/Latina youth in Minnesota are more than three times greater than that of white youth.
- Pregnancy, birth and Sexually Transmitted Infections (STI) rates among youth vary across racial and ethnic groups in Minnesota. To eliminate these persistent disparities strategies to tackle the social determinants of health must be made (i.e. poverty, racism and unequal access to health care and education), which effect health of young people of color distinctively.
- Sexually Transmitted Infections (STI) rates are excessively high for populations of color in Minnesota. The rates for both chlamydia and gonorrhea were highest among black youth, following Hispanic/Latino youth. The gonorrhea rate is 29 times higher for black youth and chlamydia rate is 9 times higher for black youth when compared to the rate for white youth.

Source:

Farris, J., & Burt, J. (2017). 2017 Adolescent Sexual Health Report. Minneapolis, MN: University of Minnesota Healthy Youth Development • Prevention Research Center.

https://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/ashr_2017_final.pdf

Work Overview

In 2017, Department of Human Services' Commissioner Emily Piper appointed 20 members to the Cultural and Ethnic Communities Leadership Council, (CECLC), which was established on August 1, 2013. The council actively listens to the communities they represent, and who are experiencing disparities. They bring these issues to DHS during monthly meetings, and DHS then supports their work by advising the DHS commissioner on ways to address these disparate issues.

A panel of DHS employees and CECLC current members reviewed 41 applications to the vacant council appointments. The applications were received from the Office of the Secretary of State. There were twenty open appointments.

The application process was opened and applicants applied online to the Office of the Minnesota Secretary of State website to complete an application for open position on the Cultural and Ethnic Communities Leadership Council, which is: <https://commissionsandappointments.sos.state.mn.us/Agency/Details/205>

Applications for the CECLC vacant slots were received by DHS. Antonia Wilcoxon, Community Relations Director, formed a review committee of DHS employees/leaders and CECLC current members. Special thanks to Roberta Downing, Federal Relations Director, Linda Davis-Johnson, Chief Administrative Officer, Health Care Administration, and Dave Haley, CECLC Volunteer and former member.

Commissioner Piper received all application with ranking sheets for each candidate with recommendations. She appointed 20 Individuals for the following positions:

Representatives of Diverse Cultural and Ethnic Communities

- Rev. Dr. Jean Lee, President/Executive Director, Children's Hope International.
- Dr. Pahoua Yang, Vice President, Community Mental Health and Wellness, Wilder Foundation.
- Nyagatare Valens, Grant Specialist Intermediate, MDE.
- Sharon Lim, Council on Asian Pacific Minnesotans.

American Indian Community Representative

- Aaron Wittnebel, Greater Minnesota/Red Lake Nation.
- Beverly Bushyhead, Program Director, Propel Nonprofits.

Representative of Culturally and Linguistically Specific Advocacy Group

- Vayong Moua, Director of Health Equity Advocacy, Blue Cross Blue Shield of MN.
- Michael Birchard, Chief Diversity & Affirmative Action Officer, North Hennepin Community College.

DHS Employees

- Kia Moua, Income Maintenance Program Advisor, DHS.

- Brendabell Njee, Mental Health Program Assistant, DHS.
- Tikki Brown, Self-Sufficiency Program Director, DHS.

Representatives of Faith-Based Organizations Ministering to Ethnic Communities.

- Pastor Brian Herron, Senior Pastor at Zion Missionary Baptist Church.
- Pastor Emory Dively, Pastor at Assemblies of God U.S. Missions Department.

Representatives of Culturally Specific Human Services Providers

- Titilayo Bediako, Founder/Executive Director, WE WIN Institute, Inc.
- Hodan Hassan, Coalition of Somali American Leaders, Vice-Chair.

Members Representing Counties Serving Large Cultural and Ethnic Communities

- Adesola Oni, Train Coach Practice Unit, Hennepin County Corrections.
- Patricia Brady, Director, Workforce Solutions, Ramsey County.

Representative of the University of Minnesota Program with Expertise on Health Equity Research

- Dr. Marilyn Susie Nanney, Director, Population Health Research Division, University of Minnesota.

Parent of Human Services Program Participants Representing Communities of Color

- Saciido Shaie, Founder/President, Ummah Project.

Private Industry Representative with an interest in Inequities Issues

- Dr. Nkem Chirpich, CEO/President, TAP Diversity Navigators.

CECLC Policy and Strategy Committee

The CECLC’s Policy and Strategy Committee continued to support the council as a consistent and accessible representation with external community racial equity allies and with DHS internal leaders committed to racial equity. This committee is highly engaged and active with CECLC.

Members of the CECLC Policy and Strategy Committee are: Titilayo Bediako, Michael Birchard, Dave Haley, Vayong Moua, Anjuli Mishra, Brendabell Njee, Dr. Susie Nanney, and Rosa Tock.

Participation in Workgroups, Advisory Bodies, Conferences, or Exhibits

Members of the CECLC held monthly meetings during 2017.

The Council members also explored the following ideas/activities:

- Food Equity, SNAP utilization enhancement.
- Juvenile Justice Bill.
- PCA reimbursement rate: how is it calculated? Explored numbers and demographics.
- Child Protection: demographics of calls into intake/screeners at county level.
- Included equity lens and structure of input for policy work.
- Included stories and narratives about the impact of the equity policy at DHS and beyond.
- Deputy Commissioner Santo Cruz encouraged assistant commissioners to participate in monthly CECLC meetings to improve community engagement and understanding of inequities impacting disparate populations in access and outcomes services funded/delivered by DHS.
- Met with legislators from both parties while hosting a yearly legislative open house at the Capitol and met with the People of Color and Indigenous (POCI) Caucus during 2017 session to foster a shared equity agenda.
- Filled our membership seats with newly appointed and returning Council members.
- Reviewed, provided feedback, and recommended to the commissioner the endorsement of the Leadership L-4 team on their Action Learning Project: A Guide to Examine DHS Decisions Using an Equity Lens. Excerpt found in Appendix G.
- Held CECLC Strategic Planning Retreat.
- Case study of Equity Policy and CECLC was accepted by the Mitchell Hamline Law Review for publication.
- Overcoming Racism Conference: Members of the Council presented 'Advancing Structural Equity: Outside/Inside Strategies'. The conference session was well-attended by individuals working in various sectors. Assistant Commissioner Santo Cruz and chair Vayong Moua fielded audience questions about how an agency of the executive branch is engaging with cultural and ethnic communities to address disparities.

Presenters:

- Vayong Moua, Director of Health Equity Advocacy, BCBS of MN, CECLC Chair.
 - Santo Cruz, Deputy Commissioner, DHS - External Relations.
 - Titilayo Bediako, Executive Director, WE WIN Institute, Inc.,
 - Dr. Nkem Chirpich, President & CEO, TAP Diversity Navigators.
 - Antonia Wilcoxon, Community Relations Director, DHS.
-
- Some Council members participated in the community advisory group on the study “Economic Benefit of Achieving Health Equity in Minnesota,” a report to the Center for Prevention, Blue Cross & Blue Shield of Minnesota. It was a joint study of the University of Minnesota Health Equity Policy Initiative (HEPI), Health Disparities Research University of Minnesota Medical School, the Roy Wilkins Center for Human Relations and Social Justice, Hubert H. Humphrey School of Public Affairs, University of Minnesota, and the Minnesota Department of Human Services/CECLC.
 - Many other less visible, high impact activities to strengthen the capacity of the Council and further its mission.

2017 DHS Annual Equity Review

The Council’s enabling legislation requires a review of DHS programs, groups and grants used to reduce inequities, including any available outcome data on the reduction of inequities. This summary provides an overview of the agency’s projects aimed at inequities reduction and the promotion of equity for 2017. Although the bill language requires DHS to report “statistically valid measures and outcomes,” more coordination and resources are necessary to measure and report at a statistically valid level on the outcomes for communities targeted by these projects.

In 2017, DHS engaged in its fourth annual equity review where all administrations were asked to submit any *project, initiative, program, group, or grant* that had been undertaken by their administration an online survey. Numerous projects were initiated during 2017 while others are continued efforts beginning prior to 2017 and may have been included in previous reports. Administrations were asked to detail the purpose, activities, level of community involvement, tools to guide development and implementation, potential impacts, barriers and how they are monitoring project implementation and impact.

This review seeks to meet the bill requirement that the CECLC “*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*”(subdivision 8, paragraph 11).

Summary of Projects

A total of 111 projects, initiatives, programs, groups and grants that address the reduction of inequities were reported across the agency. (For ease of language, the term “project” is used throughout this report to encompass these types of activities.) Of these projects, 56 were updates of projects analyzed in the 2016 report, indicating ongoing efforts that were sustained through 2017. These projects provided updates on progress achieved in 2017. 54 of the projects are new submissions.

For purposes of analysis and reporting, projects were broken into two groups:

- *Projects with a DHS organizational focus* - projects that were directed at DHS’ internal organizational capacity to promote equity and address inequities at the agency-wide level or across a division or administration.
- *Projects with a programmatic or policy focus* - projects that were directed at externally-facing services, initiatives and policies of our program areas that are intended to more directly impact the people we serve.

Each of these groups was further broken down into categories on project purpose which are discussed in detail later in the report.

Table 1 on the next page summarizes the number of projects submitted by focus area and administration.

Table 1. Number of Projects by Project Focus and Lead DHS Administration

	Community Supports	Continuing Care for Older Adults	Children and Family Services	Direct Care and Treatment	Health Care	Policy and Operations ²	External Relations ³	Total Projects ⁴
<i>DHS Organizational Focus</i>	2	1	3	1	1	7	2	15
Contracting and Procurement	1	0	0	0	0	1	0	2
Equity Committee, Director, or Coordinator	0	0	1	1	0	0	0	2
Workforce and Leadership Development	1	0	2	0	0	3	0	6
Agency-wide	0	1	0	0	1	1	2	5
<i>Programmatic or Policy Focus</i>	43	21	8	10	12	4	0	97
Provider Development and Capacity	12	4	1	4	0	1	0	22
Outreach and Access	9	10	2	2	2	1	0	26
Culturally-specific	8	2	1	3	1	0	0	15

² Policy and Operations includes all areas that report to the Chief of Staff and include projects from Office for Equity, Performance, and Development, Human Resources, and Compliance Office, Agency-wide Development and Learning, and County Services Measurement and Performance.

³ External Relations includes all areas that report to the Assistant Commissioner for External Relations and include projects from County Relations, Federal Relations, Legislative Affairs, Communications, Office of Indian Policy, and Community Relations.

⁴ Two projects were submitted by more than one administration. These projects are counted for each administration but are not duplicated in total project counts.

Services								
Measurement, Research & Evaluation	1	4	0	1	5	1	0	11
Community Engagement	9	1	1	0	3	0	0	14
Service Model Development or Redesign	4	0	3	0	1	0	0	8
Other	0	0	0	0	0	1	0	1
Total Submissions	45	22	11	11	13	11	2	
Grand Total								112

DHS Organizational Projects

Fifteen projects⁵ were submitted that focused on internal organizational practices and the capacity of DHS to address inequities. These projects focused on workforce diversity and professional development as well as the building of new policies and practices that increase DHS' capacity and accountability around efforts to reduce inequities. Of these projects, six had an agency-wide impact focusing on multiple administrations or divisions. Although these projects focused internally on the capacity of the agency, they are ultimately focused on reducing inequities among the impacted communities we serve and all other Minnesotans.

⁵ The DHS administration listed after each project in this section is the lead DHS administration. Other administrations or divisions may also have a partnering or supportive role with the project.

Project Purpose

A total of 15 projects were submitted with an internal organizational focus. These projects were further broken down into categories based on the primary focus. (Please note many projects reported multiple categories, however this categorization addresses only the most predominate focus area.)

1. Equity Committee, Equity Director or Equity Coordinator Position.

Two projects focused on strengthening the administration's internal equity capacity. This includes creating new positions or committees.

- Advancing Equity Outcomes Externally and Internally: Children and Family Services.
- DCT Equity Review Project: Direct Care and Treatment.

Each of these projects are developing a more formalized approach to reducing inequities through establishment of new committees. The committees increase awareness of inequities and promote reduction both internally and externally. Children and Family Services is establishing a workgroup to develop a mission and charter of a formal equity committee to provide action steps to advance equity to their divisional leadership. Similarly, representatives from Direct Care and treatment divisions meet regularly to identify opportunities for reduction, exchange information, and serve as a sounding board on policy issues.

2. Workforce and Leadership Development

Several projects reported a focus on improving the inclusion of communities experiencing disparities in recruitment, hiring, onboarding, and retention, including training of staff on inclusive practices.

- Affirmative Action Plan: Policy and Operations, Office for Equity, Performance and Development.
- Child Support Division Workforce Diversity Initiative: Children and Family Services.
- Community Supports Administration (CSA) Managers: Intercultural Development Inventory and Follow Up: CSA.
- Employee Resource Group (ERG): Policy and Operations, Office for Equity Performance and Development.
- Recruitment Brochures: Policy and Operations; Human Resources.
- Tribal State Training of DHS Staff: Children and Family Services.

Projects in this area included various strategies to address diversity and inclusion at each stage of the recruitment, hiring and retention processes. Human Resources is creating updated content for recruitment brochures highlighting diversity of DHS staff to be used at recruiting events. Other strategies include re-evaluating use of preferred qualifications in hiring practices, writing effective job descriptions, and including questions regarding diversity, equity, and inclusion in the workplace in new hire interviews.

Professional development opportunities were a common strategy to create a more collaborative environment within the agency administrations for employee retention. Employee Resource Groups formed along common dimensions (often from underrepresented groups) meet and collaborate with community organizations to create a stronger sense of community as well as influence the organizational culture at DHS. Managers within Community Supports use the Intercultural Development Inventory to review baseline cultural competence and receive individual development plans. Staff of Children and Family Services are supported to attend training with tribal leaders.

3. Contracting and Procurement

Two projects reported a focus on improving inclusion of communities experiencing disparities in contracting and procurement.

- DHS Vendor Recruitment and Technical Assistance: Policy and Operations, Compliance Office.
- Equity Improvement in Contracting: Community Supports.

Projects in this area identify contractors that are underutilized in grant and contracting services and provide technical assistance. A division in the Community Supports Administration provides technical assistance to culturally specific agencies to support them in maintaining compliance. Many of these agencies have difficulty staying in compliance as they are small, lack resources, or have not previously contracted with the government. This measure addresses a long-awaited request from members of communities where disparities are critical and large organizations contracted by DHS lack the cultural understanding of cultural communities. They subcontract with small communities, however, their input is not included in DHS' grant making, or program development.

4. Agency-wide Impact

Several projects were submitted that were intended to have an agency-wide impact across administrations.

- Bush Community Innovation Grant: External Relations.
- Equity Initiative, Research and Data Analysis Workgroup: Continuing Care for Older Adults.
- Initiatives to Increase Workforce Diversity: Policy and Operations, Human Resources.
- Policy on Equity: External Relations.
- Racial Equity Dashboard Initiative: Health Care.

Projects in this area were wide-ranging in structure and purpose but impact all administrations within the agency. Strategies range from local administration efforts to examining how data are collected and used across the agency. After approval in 2017 of the DHS Policy on Equity in 2017, an implementation plan was developed and approved by the Commissioner, calling for each administration to create an equity committee. The Health Care administration continues to solicit feedback for the web-based dashboard to improve how data is presented and can be utilized.

5. Tools to Inform Work

Administrations were asked to describe any tools used to inform their work. Results are summarized in Table 2 below. Over half of the projects reported using at least one tool, with five projects using more than one tool.

Table 2. Number of Tools Used to Inform Work of Internal Projects by Purpose.

Tool	Total Projects
<i>DHS Policy on Equity</i>	7
<i>Social Determinants of Health</i>	4
<i>Enhanced Cultural and Linguistic Appropriate Services (CLAS) Standards</i>	2
<i>Equity Tool</i>	1
<i>Other</i>	2
<i>None of the Above</i>	6
<i>More than one tool used</i>	5

Divisions used the tools in several ways to inform their work on organizational projects. Many reported chartering the project to fulfill the components of the tool, particularly the DHS Policy on Equity, or using the measures to assess progress.

Other projects used the tool to provide context and guidance. Two projects report understanding of the social determinants of health as crucial to authentic community engagement and development of the Policy on Equity. The Social Determinants of Health Framework was foundational to integrating equity as it expands the definition of health and what creates it, to participate in more purposeful engagement with communities.

Other tools reported were the Intercultural Development Inventory to establish baseline cultural competence and the Affirmative Action Policy to develop goals and measures.

Programmatic or Policy Projects

Projects with an external-facing programmatic or policy focus were directed at policies, initiatives and services of our program areas that are intended to more directly impact the people we serve.

Project purpose

A total of 89 projects with a programmatic or policy focus were submitted⁶. These projects were further broken down into the following categories. Please note that many projects had components that applied to multiple categories, but the most predominate focus of the project was used for purposes of this categorization.

- *Provider development and capacity*: Projects that focused on building the capacity of service providers through training and workforce development to provide culturally and linguistically appropriate services.
- *Outreach and access*: Projects that included strategies to increase outreach and access for populations impacted by inequities to existing programs and services, including projects focused on language access.
- *Culturally-specific services*: Projects targeted to dedicating or prioritizing resources to developing new strategies for providing culturally-appropriate services targeted to specific communities.
- *Measurement, research & evaluation*: Projects that used measurement, research or evaluation to define and address inequities that exist in the populations served by DHS programs.
- *Community engagement*: Projects specifically focused on engaging communities in the planning, design, administration and evaluation of DHS programs and initiatives.
- *Service model development or redesign*: Projects reported by DHS administrations that include new service models that have inequities reduction built into the design.

1. Community Engagement

A total of fourteen projects focused on specific engagement of communities in the planning, design, administration and DHS programs and initiatives. Of note, many projects used community involvement as a strategy or tool in their initiative (see *Tools to Inform Work* and *Community Involvement* sections detailed later in the report).

- AIAC-American Indian Advisory Council: Community Supports.
- Behavioral Health Planning Council (BHPC): Community Supports.
- Community Engagement in Case Management Redesign: Health Care.

- Community engagement/measurement: Health Care.

⁶ The DHS administration listed after each project in this section is the lead DHS administration. Other administrations or divisions may also have a partnering or supportive role with the project.

- Cultural Lens to Reduce Mental Disparities: Community Supports.
- Early Childhood Systems Reform: Children and Family Services.
- Federal Block Grant: Community Supports.
- Lao Community Engagement Initiative on Gambling: Community Supports.
- Money Follow the Person Tribal Initiative: Continuing Care for Older Adults.
- Minnesota Accountable Health Model (MN SIM): Health Care.
- Person & Family-Centered Approaches in Mental Health and Co-occurring Disorders: Community Supports.
- Primary Prevention Planning and Intervention (P&I) Grants: Community Supports.
- State Advisory Council on Mental Health and Subcommittee on Children’s Mental Health: Community Supports.
- Strategic Prevention Framework Prevention Programs: Community Supports.

Each of these projects used innovative approaches to collaborate with and learn from communities in the planning and administration of community engagement events. Co-learning, community capacity building, structured stakeholder engagement sessions were strategies applied towards successful community engagement. Most projects involved multi-event meeting sessions to continue to build pathways for communication. Some administrations organized sessions open to community leaders and members, while others met with existing groups already convening.

Six projects describe developing new workgroups or recruiting representative members for existing groups from diverse communities. These initiatives are designed to increase representation of membership composition for project growth and support.

2. Culturally-Specific Services

Fourteen submitted projects were dedicated or prioritized resources and the development of new strategies for providing culturally-appropriate services for targeted racial and ethnic communities.

- Beltrami Jail Division Project: Community Supports.
- CBS Cultural Responsiveness and Diversity Committee: Direct Care and Treatment.
- Child Protection Grants to Address Child Welfare Disparities: Children and Family Services.
- Cultural Consultants Initiative 2017: Continuing Care for Older Adults.
- Culturally Affirmative, Linguistically Accessible Grant-Funded Services for People with Hearing Loss: Community Supports.
- Culturally Responsive Assessment within MHSATS: Direct Care and Treatment.
- Culturally-based Chemical Dependency Early Intervention and Recovery Support Services Grant: Community Supports.

- Individuals involved within the Criminal Justice System with a Substance Use Disorder: Community Supports.
- Integrated Care for High Risk Pregnancies (ICHiRP): Health Care.
- Live Well at Home Grants: Continuing Care for Older Adults.
- Mobile Crisis Team in Fond du Lac: Community Supports.
- Recovery Support Services to Deaf, Hard of Hearing and Deaf Blind: Community Supports.
- Traditional Healing: Community Supports.
- Tribal Chemical Health Grant CCDTF-ADAD-CW Grants: Community Supports.
- Update DCT Culturally Responsive Accommodations for Clients (except MSOP): Direct Care and Treatment.

Most of these projects included the administration of grants to DHS providers and other partners to provide culturally-responsive services. In many cases, the focus of grants is to create new services and approaches directed at culturally-responsive care. For example, the Community Supports, Mental Health Division is contracting with the Fond du Lac reservation to start a mobile crisis team that would meet cultural needs not provided by other services. Identifying current services, in addition to gaps in services, was a crucial element for many of these projects.

3. Data, Research and Evaluation

Eleven projects were submitted that focused on using measurement, research or evaluation to define and address inequities that exist in the populations served by DHS programs.

- Cultural responsiveness in treatment planning and data collection: Direct Care and Treatment.
- Gaps Analysis Study: Continuing Care for Older Adults.
- Health Care Eligibility Policy Documentation: Health Care.
- Identifying and addressing health disparities in Medicaid recipients: Health Care.
- Joint Asthma Report: Health Care.
- Missing race and ethnicity data-research of extent and imputation of effected population: Health Care.
- MNMCM Health Disparities Report: Health Care.
- National Core Indicators Survey: Community Supports & Continuing Care for Older Adults.
- Person Centered Adult Protection Data System: Continuing Care for Older Adults.
- Racial Equity Measures: Policy and Operations, Office for Equity, Performance and Development.

- Study of racial disparities in nursing homes and the relationship to the quality of life and care: Continuing Care for Older Adults.

Each of the projects in this area focused on how data is collected, managed, or used in disparities reduction. A few projects in this area used surveys to measure the experience and outcomes of program recipients by racial, ethnic, and other cultural demographics in addition to identifying current service gaps. Others focused on the methodologies, modifying systems for consistency in data collection, management, and decision making. Despite the diverse strategies, each of these projects seek to create a more complete and accurate representation of health disparities, eventually to inform policies or programs.

4. Provider Development and Capacity

Twenty-two projects submitted had an overall focus of building the capacity of service providers to provide culturally and linguistically appropriate services. Some of these projects focused on increasing cultural and linguistic competency among existing providers while others were aimed at recruitment, training, and support of providers from the target communities.

- ACA Section 1557 Policy and complaint form: Direct Care and Treatment.
- AI MH Curriculum: Community Supports.
- Autism Spectrum Disorder (ASD) multicultural outreach and training: Community Supports.
- Build Community Capacity to Address Adverse Childhood Experiences: Community Supports.
- Child Care Provider Outreach: Children and Family Services.
- Children’s Mental Health Respite Care for American Indians: Community Supports.
- Community Living Infrastructure Grants: Community Supports.
- Cultural and Ethnic Minority Infrastructure Grant (Workforce Development): Community Supports.
- Cultural responsiveness as a clinical approach to care: Direct Care and Treatment.
- Culturally specific peer training and curriculum: Community Supports.
- DCT Social Cognition: Direct Care and Treatment.
- Early Childhood Mental Health Grants: Community Supports.
- Group Residential Housing, Long Term Homeless Supportive Services Grants, SOAR Grants: Community Supports.
- Individuals with a Substance Use Disorder and either at risk or experiencing homelessness: Community Supports.
- Intercultural Development Inventory Pilot: Policy and Operations, Office for Equity, Performance, and Development.

- MBA Training Center: Cultural Responsiveness in Dementia Care 2017-2018, Continuing Care for Older Adults.
- MN School Mental Health Conference: Community Supports.
- MSOP Annual Diversity Plan: Direct Care and Treatment.
- Older Americans Act Senior Nutrition: Continuing Care for Older Adults.
- Older Americans Act Special Access projects: Continuing Care for Older Adults.
- The Early Intensive Developmental and Behavioral Intervention Benefit: Community Supports.
- Tribal Vulnerable Adults: Continuing Care for Older Adults.

More than half of these projects focused on providing professional development opportunities to practicing providers for improved cultural and linguistic competency. Capacity building strategies include providing trainings, disseminating information on culturally responsive care, and incorporating local knowledge through partnerships with local agencies or representatives to develop culture-specific resources.

The other projects in this area targeted recruitment and training of community representatives to provide services to their respective communities. These include dedicating funding, resources, and professional development opportunities for providers with diverse backgrounds. In some cases, projects focused on increasing availability of services while others sought to improve relevancy of services.

Given the capacity building component of this focus, most of these projects include strong elements of a culturally-specific service focus as well.

5. Outreach and Access

A total of 25 projects were submitted that, in part, or entirely provide targeted outreach and access to existing programs and services for populations impacted by inequities. This included targeted efforts to provide language access for individuals with Limited English Proficiency.

- Access to language policy: Direct Care and Treatment.
- Accessibility to Professional Development Services and Workforce Supports for the Child Care: Children and Family Services.
- American Indian Tribal Child Welfare Initiative: Children and Family Services.
- Caregiving for Older Adults: A Part of Our Culture: Continuing Care for Older Adults.
- Certified Community Behavioral Health Clinics (CCBHC): Community Supports.
- Deaf and Hard of Hearing Mental Health Services: Community Supports.
- Dept. of Corrections Pilot Project: Community Supports.
- Direct Support Worker Registry: Continuing Care for Older Adults.

- Housing with Supports for Adults with Serious Mental Illness (HSASMI) grant: Community Supports.
- Increasing Ethnically and Racially Diverse Crisis Responders in Minnesota: Community Supports.
- Integrated Health Partnerships (IHP 2.0): Health Care.
- MBA Dementia Grants: Continuing Care for Older Adults.
- MBA Indian Elder Desk: Continuing Care for Older Adults.
- MinnesotaHelp.Info Home and Community-based Services Finder: Continuing Care for Older Adults.
- MIPPA Grant: Continuing Care for Older Adults.
- Multi-Disciplinary Adult Protection Team: Continuing Care for Older Adults.
- National Governors Association Learning Laboratory about Project ECHO: Health Care.
- Older Americans Act Evidence Based Health Promotion: Continuing Care for Older Adults.
- Provider Fraud and Abuse Prevention Outreach Promotion: Policy and Operations.
- Senior LinkAge Line®: Continuing Care for Older Adults.
- Social Security Advocacy, Incentive Payment Data Sharing Project: Community Supports.
- State Targeted Response to Opioid Crisis, Statewide Awareness and Education Campaign: Community Supports
- Tribal LTSS and Vulnerable Adult Workgroup: Continuing Care for Older Adults.
- The Olmstead Plan: Community Supports.
- Video Remote Interpreting services: Direct Care and Treatment.
- Website/app for real-time housing openings: Community Supports.

In this area, increasing access and availability to services were implemented through a variety of activities. Some projects focused on expanding trainings, particularly among culturally and linguistically diverse communities, to directly increase diversity of service providers. Given this, there was a component of staff recruitment in some projects. Moreover, in a few cases, scholarships were provided to communities with known barriers to accessing services.

Other projects focused on improving access to tools and services that assist individuals in finding providers, housing, and other necessities. This included increasing awareness of tools as well as expanding the database and search options to include more culturally appropriate options.

6. Service Design and Redesign

Eight projects submitted include system-level strategies specifically focused on including service models that have inequities reduction built into the design.

- Behavioral Health Home Services: Health Care.
- External Program Review Committee: Community Supports.
- Family-Centered Framework for Community Supports Care: Community Supports.
- First Episode Psychosis: Community Supports.
- Human Service Programs Transfer to Tribal Nations- Child Care Assistance Program: Children and Family Services.
- Indian Child Welfare Act (ICWA) Minnesota Indian Family Preservation Act (MIFPA) Non-compliance: Children and Family Services.
- Model of Care Pilot Project: Community Supports.
- Transfer of Jurisdiction to Tribal Courts: Children and Family Services.

In this area, projects in a few cases, projects describe changing the organizational culture. Others note creating systemic changes to evaluate and impact services of providers on an individual level. Some administrations noted the incorporation of evidence-based strategies in service redesign to better serve the needs of communities.

7. Other

One project submitted describe a predominate focus as ‘other’ from the listed categories.

- Business Continuity Management– Equity and Recovery Priorities: Policy and Operations, Compliance Office.

This agency-wide project focuses on business continuity if DHS experiences a crisis or business disaster, using an equity lens in these recovery practices. Specifically, this project examines how equity works as a principle in business continuity and addresses how equity comes into play in prioritization where competing priorities present.

Tools to inform work

Administrations were asked to describe any tools used to inform their work and how they were used. Responses are summarized in Table 2 below, with various projects reporting the use of more than one tool. More than half of all programmatic or policy projects used at least one tool, and more than 25% of projects used more than one tool to inform their work. The DHS Policy on Equity was the most frequently used tool among both internal and external projects.

Table 2. Number of Projects by Tools Used to Inform Work of Project by Purpose.

Tool	Number of Projects
<i>DHS Policy on Equity</i>	27
<i>Social Determinants of Health</i>	22
<i>Enhanced Cultural and Linguistic Appropriate Services (CLAS) Standards</i>	18
<i>Equity Tool</i>	7
<i>Other</i>	22
<i>None of the Above</i>	37
<i>More than one tool used</i>	25

Projects referenced a variety of other tools incorporated in their work ranging from surveys and inventories to rules and guidelines, from existing data to individual expertise. Many projects reported referencing models or assessment tools, such as the DSM-5, to provide a blueprint. Specific surveys and research tools assisted in prioritization of tasks and communities for various projects. Data from the American Community Survey, the Behavioral Risk Factor Surveillance System, and the Minnesota Student Survey were all utilized in project development. More than ten specific rules, policies, and provisions, from the agency, state, and federal levels were also cited.

A few projects acknowledged human expertise, outside of formal research, as a tool to assist in planning, development, and implementation. Specifically, the Cultural and Ethnic Communities Leadership Council, TPT/ECHO staff and ambassadors, and local agencies were all sources of knowledge to inform project development.

Project Impacts and Evaluation

Administrations were also asked to report on the target communities along with intended impacts. Additionally, administrations were asked to describe how target communities were asked to detail strengths and barriers of projects towards disparities reduction along with measures for evaluation. Each of these areas are described below.

Target communities

DHS administrations were asked to indicate the target community or communities of the project, including any specific race, ethnicity, or language, and, when applicable subgroups. Table 3 below shows the number of projects by target community. While many projects targeted a single cultural or ethnic community, some projects had more than one target community with others noting that they target a more general population, such as “all” or “communities of color.”

Table 3. Target Communities of Programmatic or Policy Projects.

Target Community	Number of Projects ⁷
African/African American	20
American Indian	19
Asian/Pacific Islander	13
Hispanic or Latino	14
Multiple communities	29
No target community referenced	16

This year’s review revealed several projects focusing on services for people with disabilities and individuals experiencing mental health disorders, substance use disorders, or homelessness. In many cases, administrations did not focus on a specific racial or ethnic community experiencing these disparities, but rather these disparities themselves as a distinct category (i.e. people who are deaf, hard of hearing, individuals that are homeless or at risk of being homeless, etc.) Given the cross-sectional nature of these disparities, many projects are not easily classified by racial or ethnic category. However, some of these projects indicated specifically a focus on cultural and ethnic communities as subgroups which are reflected in the table. If the project mentioned was on mental health or homelessness referring to African

Americans, or Indian Americans or both then they each went into their own categories in terms of collecting data. If the project mentioned was on mental health or homelessness relating to African Americans, Indian Americans and Asian Americans then it was listed in “multiple targets specified”.

Not reflected in the table above, one project targeted communication modes of American Sign Language and other spatial-visual and tactile languages.

⁷ Projects indicating two specific target communities were tallied for each target community in the table. Projects indicating three or more target communities were singularly tallied as ‘multiple communities’.

Community involvement

Numerous projects reported engaging with target communities during planning, design, and implementation stages to capitalize on the strengths and knowledge of communities. Due to the variance in project focus and tasks, the degree of engagement along with how strengths were incorporated varied significantly among projects. However, in some cases, no efforts for community involvement were reported.

The most commonly reported method for gaining and incorporating the target community in program administration was through feedback and discussion from community members and other stakeholders. As previously noted, fourteen projects focused predominantly on community engagement. However, more than half of all projects reported meeting with members of the target community at least once. In many cases, the neither the number nor type of community representatives (i.e. community leader, local organization members, general population), nor the meeting framework were specified.

Some projects described development of a community panel to work with the administration through each phase of the project while others note general community outreach. In a few cases, projects report using a cultural expert to support creation of culturally-appropriate framework. However, it is not clear how community members were invited to participate in community engagement. For many of projects indicating a group or panel was established, no reference to how their voices were utilized.

One project reported working with communities to complete their own needs assessments, subsequently learning how to use and interpret data to enable them to understand and incorporate it at the local level.

Barriers to inequities reduction

Administrations described several potential barriers towards realizing their respective equity or disparities reduction goals. The most common barriers identified were as follows:

- Limited funding.
- Limited data.
- Lack of community member involvement in policy making process.

Many projects reported having limited funding and were concerned about the sustainability of equity initiatives. Numerous projects are funded by time-limited grants and do not have dedicated ongoing funding. In addition, some projects felt that the limited resources allocated for these projects might not guarantee that all people affected by disparities will have access to equitable services that are specialized, culturally affirmative, and linguistically accessible. Given the time-limited nature of many projects with

respect to funding, some expressed concerns that time alone may not be enough to achieve the goals of the community.

Another potential barrier was limited data due to DHS policies on collecting information from program recipients. One project acknowledged a limited ability to adequately report their community measures, as the questionnaire used to collect data limits inclusion of questions that are crucial to reducing disparities.

Furthermore, access to other DHS resources, were also reported as potential barriers to disparities reduction. For instance, the Mental Health division does not have a consistent and updated email list for communities of color, Native/American Indian, LGBT communities, and other underrepresented communities, making it difficult to do intentional outreach. Other resources described were more information on equity lens tools, along with how they can be used to address specific issues and processes in a way that DHS stands behind.

Some projects also noted the absence of community members in the decision-making process. Specifically, flexibility and time necessary for authentic community engagement were concerns of administrations planning community engagement sessions. The Mental Health division reported lacking a clear and consistent process for community and stakeholder outreach and engagement.

Another project reported a lack of adequate resources to appropriately engage communities of color and other underrepresented communities. Difficulties developing an effective method for communicating with people from culturally diverse was also seen as a constraint. It was noted that many families from underrepresented communities are not aware of services or programs because of language barriers in communications. The implementation of a more diverse and inclusive representation in council and subcommittee at DHS will enhance equity initiatives.

Administrations were also asked to identify structural or institutional challenges within DHS to be navigated or changed for the project to be successful in reducing disparities. Most challenges reported reflect the general barriers to disparities reduction reported above. Continued support from leadership was commonly reported as an institutional challenge independent of project focus, particularly when there is a change in leadership. Some projects identified cultural challenges such as the language we use in various contexts. Finally, funding and prioritization of resources was frequently reported by administrations as a challenge to long term efforts.

Strengths of inequities reduction

Despite the barriers identified, some administrations reported on strengths that exist at DHS:

- The current administration's interest on equity: One project reported receiving support from all levels of DHS' executives and senior level management.

- External and internal collaborations and partnerships: The equity policy has been welcomed internally. One project reported that the equity policy has received an internal receptiveness and has been perceived as a way to make important changes that will positively impact the work done agency-wide.
- Internal and stakeholder engagement: One project praised the fact that many divisions within DHS and many external agencies are putting efforts into equity activities and are working collaboratively.

Monitoring of project impact and evaluation

DHS administrations were asked to report on the performance measures used to evaluate performance of their projects. Most projects reported using quantitative indicators to measure the impact of the project specific to disparities reduction. Notably, among these, about half indicated using qualitative measures as well, however there was a wide variance. Eighteen projects were able to provide specific examples of quantitative indicators. In almost all cases, administrations provided process or outcomes evaluation measures. Among these projects, only a few indicated using population measures to evaluate disparities reduction in communities. Some projects indicated they were too early in implementation and have not yet developed measures, either at the process or population level, but plan to in the future.

Among projects using qualitative indicators, almost all administrations indicated using a combination of surveys, focus groups, and interviews. Satisfaction surveys were cited most often. In most other cases, it was unclear who would participate, what types of information would be collected, or how the information would be used to evaluate. No trends were identified between project focus and type of evaluation indicators used.

Fourteen projects noted they were not using quantitative or qualitative measures to evaluate projects at this time.

Conclusion

In the past few years there has been an increasing trend in the number of project submissions. This year's report includes 111 project submissions, compared to 82 projects in 2016. In addition to an increase in the number of overall projects, administrations continue to develop innovative strategies to address the health disparities racial and ethnic communities' experience. Notably, as many projects were included in previous analyses, this is a strong indication of committed efforts on behalf of administrations and the agency as a whole. This may also reflect an increased capacity among the agency to reduce health disparities.

This review of DHS disparities reduction efforts reflects an increased use of various tools informing disparities reduction work to provide more effective services that better meet the needs of target populations. Moreover, there was also a focused effort on community engagement to inform DHS' understanding of community needs and preferences to better utilize the strengths of the target community in project development and implementation. Continually working to define what authentic engagement are, which voices are heard, and how to appropriately incorporate these voices into service implementation will support the growth of community engagement as part of the DHS culture.

However, DHS continues to face a number of challenges towards disparities reduction efforts. Limited resources, particularly the constraints on financial and human capital resources, provide a barrier to achieving sustainable equity promotion. This requires prioritization and ongoing support of equity promotion across all levels of DHS.

In addition, measurement and evaluation uses continue to be obstacles to presenting meaningful updates in disparities reduction. Although an increased number of projects reported the use of qualitative or quantitative indicators to measure the success of programs, many projects were in the early phases and have yet to define indicators of success and how reduction of disparities will be defined. Building evaluation into the design of new programs and initiatives is essential to accurately understand the impact of the program at both individual and population levels.

DHS Initiatives and Actions to Address Disparities

Bush Community Innovation Grant

Bush Foundation Community Innovation Grants support communities to use problem-solving processes that lead to more effective, equitable and sustainable solutions⁸. Community Innovation Grants support communities to use problem solving processes that are inclusive, meaningfully engaging key stakeholders, collaborative, a true joint effort with partners willing to share ownership and decision-making in order to pursue innovation together, and resourceful, using existing resources and assets creatively to make the most of what a community already has. (Theory of Change co-developed by Bush Foundation and Wilder Research in Appendix H).

One of the goals in the recommendations of the CECLC for Awareness: “DHS moves to action to achieve equity utilizing: community engagement, community empowerment, community and DHS collaboration.” In 2015, the foundation awarded DHS a Community Innovation Grant, with leveraged funding from DHS. The grant was submitted with the objective of introducing community engagement practices into the department’s culture. The community engagement process means working with and through constituents to achieve common goals. The process demands that those implementing the engagement effort communicate with community leaders and members who have diverse backgrounds, values, priorities, and concerns. It is at this point that the principles and organizing concepts underlying community engagement come together with real-world activities.

The grant project is in alignment with the CECLC mission of “working together to advance health and human services equity,” and the Governor’s executive order 15-02 establishing the Diversity and Inclusion Council and stating among others,” the state of Minnesota is committed to being a leader across the United States on issues of diversity and inclusion.”

The initial phase of the Bush Core Team/Cohort included a focus on building awareness and historical context in which disparities exist and on building capacity in two participatory leadership techniques; The Art of Participatory Leadership/Art of Hosting and Technology of Participation. Grant participants, who

⁸ <https://www.bushfoundation.org/grants/community-innovation-grants>

were nominated from across DHS, joined by some community members, applied their learning by organizing a series of authentic community engagement events with communities affected by disparities (across five administrations at DHS). These events took place in 2016-2017.

As the Bush grant ends, the Core Team/Cohort is undergoing sustainability planning to carry forward the practices and lessons learned and continue this work beyond the life of the grant. The group engaged in a strategic planning process in December 2017 to identify and create an implementation plan post-Bush Foundation funding to DHS. They sought the question: “How can inclusive, collaborative, resourceful community engagement and community voice be integrated into our work at DHS in the next 3-5 years?” The team identified four strategic directions and created workgroups to plan and carry out the activities set to accomplish advancing those directions for 2018. The four directions are:

- Intentionally Building Trusting Relationships.
- Building Understanding of Community Needs & Preferences & Shifting Internal Culture.
- Developing & Measuring an Equity Based System to Gain A Clear Picture of Disparities.
- Expanding Accountability of Leadership to Ensure Community Impact on Decision Making.

Policy on Equity

The policy on equity was approved by Commissioner Piper at the senior management team meeting held, January 6, 2017. The implementation plan on the policy, approved in fall 2018 is found in Appendix D.

Equity Liaisons

DHS employees were appointed to serve as Equity Liaisons for their administrations. During the legislative session, at DHS each administration holds weekly one-hour meetings to discuss the bills moving through the legislative process that impact their respective policy area. Equity liaisons were established to engage in the legislative process that impact their administration/populations served and attend these meetings. The equity liaison’s role is to observe the legislative internal process the department undergoes when processing bills. They provide input as appropriate to the bills discussed/reviewed. The goal of the observation is three-fold:

- Employee exposure to the bills that are moving through committee.
- Employee professional growth.
- Should use equity lens to analyze potential inequity impact of the proposed bills on populations we serve.
- Provision of input and feedback (at the end of session).

After the initial run of the Equity Liaison project commenced, the liaisons have not fully participated in the legislative process at DHS. The initial project had six DHS employees participating agency-wide. Three of the employees are no longer employed by DHS, and the remaining three have not fully participated in the activities of the project. Scheduled monthly meetings with the project contact were periodically cancelled due to no-show/no-responses. It is hoped that with the implementation of the DHS policy on equity, the legislative proposal development Equity Liaison project can be reconfigured and reenergized in 2018.

Strategic Priorities for 2018

Members of CECLC met in January 2017 to plan strategies for the year. A short questionnaire completed by council members guided the agenda for the day. First, members participated in presentations and discussions about the current landscape of equity work, challenges the communities face, update on the work of the office of community relations, review of the responses to planning questionnaire.

Next, council members engaged in moving to action and agreed to work on the following in 2018:

- *Prioritize:* DHS areas to narrow focus, identify clear steps and strategies.
- *Monitor:* Implementation of the policy on equity.
- *Engage:* In collaboration to find common purpose with allies.
- *Increase public awareness:* Find new ideas, work with new people, and build a network of human connection and experiences.
- *Organize:* To influence and create accountability – become informed to be an effective member and share information, show up in the community for one another.
- *Measure:* Measure the impact, lead the effort in measuring success, and create durable lasting systemic equity response.

Some updates are listed below:

1. Leveraging DHS to influence other agencies and jurisdictions:

- Shared CECLC equity blueprint and approach with MN Management & Budget’s Deputy Commissioner Edwin Hudson. At that meeting, they explored endorsement of its adoption in other state agencies.

- Provided consultative support in the creation of the Minnesota Department of Health's Health Equity Advisory and Leadership Council. (HEAL)
 - Met with leadership of the board of the Metropolitan Council (Chair Alene Tchourumoff and Mr. Wes Kooistra) to discuss the work of the CECLC and the equity policy adopted by DHS.
 - Collected letters of support and purpose/value proposition for the continuation of the CECLC existence (in perpetuity): To be discussed with legislators in the People of Color and Indigenous Caucus (POCI) at a future meeting.
2. Created collaborations with agencies that members of the Council work with and develop strategies on how the collaboration will work. Staff to CECLC contacted the following organizations to explore collaboration:
- Voices for Racial Justice
 - Take Action Minnesota
 - Amherst H. Wilder Foundation
3. Nexus Community Partners: At the CECLC December meeting, leaders from the Nexus Community Partners attended the CECLC meeting and talked about their Boards and Commissioners Leadership Institute and their Community Engagement Initiative. Meeting with other potential partners are being scheduled for 2018.
4. Collect stories to put the 'human face' and relevancy to examples that educate through letters/communication to legislators: To be reviewed once staff or intern is hired to lead this effort.
5. The Community Relations Director continues to find resources in short-term interns seeking to complete their required field experiences.

The Minnesota Legislature established the Cultural and Ethnic Communities Leadership Council (CECLC) in 2013 in order to “advise the commissioner of human services on reducing disparities that affect racial and ethnic groups.” In 2015, the legislature extended the CECLC’s mandate through 2020. The full text of current CECLC statute is found in Appendix A.

Council members represent Health and Human Services committees at the Legislature; racial and ethnic minority groups; tribal service providers; culturally and linguistically specific advocacy groups and service providers; human services program participants; public and private institutions; parents of human services program participants; members of the faith community; and DHS employees.

256.041 CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL.

Subdivision 1. Establishment; purpose.

There is hereby established the Cultural and Ethnic Communities Leadership Council for the Department of Human Services. The purpose of the council is to advise the commissioner of human services on reducing disparities that affect racial and ethnic groups.

Subd. 2. Members.

(a) The council must consist of:

(1) The chairs and ranking minority members of the committees in the House of Representatives and the senate with jurisdiction over human services; and

(2) no fewer than 15 and no more than 25 members appointed by and serving at the pleasure of the commissioner of human services, in consultation with county, tribal, cultural, and ethnic communities; diverse program participants; and parent representatives from these communities.

(b) In making appointments under this section, the commissioner shall give priority consideration to public members of the legislative councils of color established under chapter 3.

(c) Members must be appointed to allow for representation of the following groups:

(1) Members representing counties serving large cultural and ethnic communities;

(2) American Indian community representatives;

(3) Representatives of culturally and linguistically specific advocacy groups;

(4) Representatives of diverse cultural and ethnic communities;

⁹ Legislation available online at: <https://www.revisor.mn.gov/statutes/?id=256.041>

- (5) Private industry representative;
 - (6) Parents of human services program participants;
 - (7) Representatives of faith-based organizations ministering to ethnic communities;
 - (8) Department of Human Services employees;
 - (9) Representatives of culturally specific human services providers;
 - (10) Representative of the University of Minnesota program with expertise on health equity research
- Any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

Subd. 3. Guidelines.

The commissioner shall direct the development of guidelines defining the membership of the council; setting out definitions; and developing duties of the commissioner, the council, and council members regarding racial and ethnic disparities reduction. The guidelines must be developed in consultation with:

- (1) The chairs of relevant committees; and
- (2) County, tribal, and cultural communities and program participants from these communities

Subd. 4. Chair.

The commissioner shall appoint a chair.

Subd. 5. Terms for first appointees.

The initial members appointed shall serve until January 15, 2016

Subd. 6. Terms.

A term shall be for two years and appointees may be reappointed to serve two additional terms. The commissioner shall make appointments to replace members vacating their positions by January 15 of each year.

Subd. 7. Duties of commissioner.

(a) The commissioner of human services or the commissioner's designee shall:

- (1) Maintain the council established in this section;
- (2) Supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;
- (3) Identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;
- (4) Investigate and implement cost-effective models of service delivery such as careful adaptation of clinically proven services that constitute one strategy for increasing the number of culturally relevant services available to currently underserved populations; and

(5) Based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities, and make adjustments to ensure those disparities are not perpetuated.

(b) The commissioner of human services or the commissioner's designee shall consult with the council and receive recommendations from the council when meeting the requirements in this subdivision.

Subd. 8. Duties of council. The council shall:

(1) Recommend to the commissioner for review identified policies in the Department of Human Services that maintain racial, ethnic, cultural, linguistic, and tribal disparities;

(2) Identify issues regarding disparities by engaging diverse populations in human services programs;

(3) Engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients;

(4) raise awareness about human services disparities to the legislature and media;

(5) provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(6) Provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies;

(7) Provide training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities;

(8) Facilitate culturally appropriate and culturally sensitive admissions, continued services, discharges, and utilization review for human services agencies and institutions;

(9) form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish;

(10) Promote information sharing in the human services community and statewide; and

(11) by February 15 each year, prepare and submit to the chairs and ranking minority members of the committees in the house of representatives and the senate with jurisdiction over human services a report 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 lists 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 statistically valid reports of outcomes on the reduction of the disparities.

Subd. 9. Duties of council members.

The members of the council shall:

(1) attend and participate in scheduled meetings and be prepared by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that could impact the timely completion of tasks;

(4) collaborate on disparity reduction efforts;

(5) communicate updates of the council's work progress and status on the Department of Human Services Web site; and

(6) participate in any activities the council or chair deems appropriate and necessary to facilitate the goals and duties of the council.

Subd. 10. Expiration.

The council expires on June 30, 2020

Cultural and Ethnic Communities Leadership Council (Council) Of the Minnesota Department of Human Services (DHS) Bylaws

Approved by the Council on: January 17, 2014

Part 1. General Provisions

Section A. Mission/Vision/Values of the Council

The Cultural and Ethnic Communities Leadership Council (Council) mission is “working together to advance health and human services equity.

The Vision is “the council develops community-supported policy recommendations that work to achieve health and human services equity for cultural and ethnic communities and all those who call Minnesota home.”

Core Agreements are:

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 compassionate accountability 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 and each other for input
6. Embrace tension: practice addressing issues where there isn't clear agreement, spend time and opportunity 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; 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

Section B. Creation of the Council. *Laws of Minnesota 2013, Chapter 107, Article 2, Section 1,* established the Cultural and Ethnic Communities Leadership Council for the Department of Human Services (DHS).

The purpose of the Council is to advise the commissioner of human services on advancing health equity and reducing disparities that affect racial and ethnic groups.

Section C. Cultural and Ethnic Communities Leadership Council. The council must consist of:

- (1) the chairs and ranking minority members of the committees in the House of Representatives and the Senate with jurisdiction over human Services; and
- (2) no fewer than 15 and no more than 25 members appointed by the commissioner of human services, in consultation with county, tribal, cultural, and ethnic communities; diverse program participants; and parent representatives from these communities. In making appointments under this subdivision, the commissioner shall give priority in consideration to public members of the legislative councils of color established under chapter 3. The commissioner shall direct the development of guidelines defining the membership of the council; setting out definitions; and developing duties of the commissioner, the council, and council members regarding racial and ethnic inequities reduction. The guidelines must be developed in consultation with:

(1) The chairs of the House of Representatives and Senate committees with jurisdiction over Human Services; and (2) County, tribal, and cultural communities and program participants from these communities.

Section D. Duties of the Council. The Cultural and Ethnic Communities Leadership Council shall:

(1) recommend to the commissioner for review identified policies in the Department of Human Services that maintain and create, magnify, etc. racial, ethnic, cultural, linguistic, and tribal inequities and advance and promote health equity; (2) identify issues regarding disparities by engaging diverse populations in human services programs; (3) engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients; (4) raise awareness about human services disparities and health equity needs to the legislature and media; (5) provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes; (6) provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies; (7) provide training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities; (8) facilitate culturally appropriate and culturally sensitive admissions, continued services, discharges, and utilization review for human services agencies and institutions; (9) form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish; (10) promote information-sharing in the human services community and statewide; and (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.

Section E. Governance and Decision-Making Guidelines

The council will strive to make decisions on a consensus basis.

- (1) A motion-second-pass/fail process will be utilized to memorialize all decisions.
- (2) Decisions that are required to approve group deliverables will be noted in advance on the meeting agenda.
- (3) Decisions and votes will be reflected in the meeting minutes.
- (4) Decisions will be voted on, with a minimum presence of at least 51% of members present.

Section F. Meeting Schedule. The council will meet monthly:

- (1) Minimum of monthly meetings through expiration date
- (2) At the call of the chair; meeting schedule will attempt to allow time for task completion.
- (3) A quorum is established when a majority (>50%) of the appointed members are present.
- (4) The agenda and meeting materials, including meeting minutes, will be sent to council members at least one week prior to scheduled meetings

Section G. Distribution of Meeting Materials

- (1) Quarterly updates of group progress and the year-long work schedule will be reported on the DHS website

(2) Agendas, approved meetings and adopted group documents will be published in the DHS website

Section H. Expiration. The council expires on June 30, 2020.

Part 2. Council Members.

Section A. Council Membership

Members must be appointed to allow for representation of the following groups:

(1) Racial and ethnic minority groups; (2) Tribal service providers; (3) Culturally and linguistically specific advocacy groups and service providers; (4) Human services program participants; (5) Public and private institutions; (6) Parents of human services program participants; (7) Members of the faith community; (8) Department of Human Services employees; and (9) Any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

Section B. First appointments and first meeting. The commissioner shall appoint at least 15 members by September 15, 2013, and shall convene the first meeting of the council by November 15, 2013.

Section C. Terms for first appointees. Seven of the first members shall serve until January 15, 2015. The remainder of the first members shall serve until January 15, 2016.

Section D. Terms. A term shall be for two years and appointees can be appointed to serve two terms. The commissioner shall make appointments to replace vacating members by January 15 every year.

Section E. Compensation. Public members of the council shall receive no compensation from the council for their services.

Section F. Duties of council members. The members of the council shall:

- (1) Attend and participate in at least 8 scheduled meetings and be prepared by reviewing meeting notes;
- (2) Maintain open communication channels with respective constituencies;
- (3) Identify and communicate issues and risks that could impact the timely completion of tasks;
- (4) Collaborate on disparity reduction efforts;
- (5) Communicate updates of the council's work progress and status on the Department of Human Services Web site; and
- (6) Participate in any activities the council or chair deem appropriate and necessary to facilitate the goals and duties of the council.

Section G. The Chair of the Council. The commissioner shall appoint a chair. Overall responsibilities of the chair are to:

- (1) Preside at meetings of the council.
- (2) Serve as the principal contact for the Council.
- (3) With approval of council members, appoint committees and committee chairs to carry out the duties of the council.
- (4) Call special meetings of the council as necessary.
- (5) Inform the commissioner of human services of a council member missing three consecutive meetings.
- (6) Attend regularly (quarterly at a minimum) scheduled meetings with DHS commissioner or designees for stronger collaboration and relationship-building.

Part 3. Duties of the Commissioner

Section A. The commissioner of human services or the commissioner's designee shall:

- (1) maintain the council established in this section;
- (2) supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;
- (3) identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;
- (4) investigate and implement cost-effective models of service delivery such as

careful adaptation of clinically proven services that constitute one strategy for increasing the number of culturally relevant services available to currently underserved populations; and
(5) based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities, and make adjustments to ensure those disparities are not perpetuated.
(b) The commissioner of human services or the commissioner's designee shall consult with the council and receive recommendations from the council when meeting the requirements in this subdivision.

Part 4. Code of Conduct.

- (1) Council members will adhere to the DHS standards of Ethics and Conflict of Interest and will comply with all pertinent state laws and regulations.
- (2) If a Council member has a conflict of interest in a matter before the Council, the member shall declare the conflict, refrain from discussion and will not vote on the matter.
- (3) If a council member misses three meetings or more consecutively, the council staff will so note and inform the council chair. The council chair will contact the member and discuss the potential dismissal of the member.
- (4) The council chair will inform the commissioner, as the appointing authority, the member's separation from the council membership.
- (5) Staff will notify the Office of the Secretary of State for posting vacancy.

Part 5. Data Practices and Open Meeting Law

- (1) The Minnesota Government Data Practices Act, Minnesota Statutes, and Chapter 13 govern the collection, creation, receipt, maintenance and dissemination of data maintained by the Council and DHS.
- (2) All meetings of the Council and its committees are subject to the Minnesota Open Meeting Law, Minnesota Statutes, Chapter 13D, and shall be open to the public, unless closed is required or authorized by law. Observers at all meetings will be given an opportunity to provide input for Council consideration.

Appendix C: DHS Policy on Equity

Policy Number 01

Overview

Description:

DHS is committed to advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for communities experiencing inequities. For the purpose of this policy, communities experiencing inequities refers to communities of color, American Indians, veterans, LGBT, and persons with disabilities.

DHS acknowledges and embraces the role we can play in developing policies and procedures to advance equity. DHS will utilize a health in all policies (HiAP) approach. This “is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy area. ... Ultimately the Health in All Policies approach seeks to institutionalize considerations of health, equity, and sustainability as a standard part of decision-making processes across a broad array of sectors.” ([Healthy Decisions Health Places](#)). In this context, health does not refer merely to the absence of disease, but to a complete state of physical, mental, and social wellbeing. Recognizing that Minnesota’s structural inequities cut across sectors, DHS’s HiAP approach will require solutions that both focus within DHS and also cut across agency and public-private sector boundaries and address the broad factors that make up the determinants of health ([Healthy People 2020](#)).

This policy requires that communities experiencing inequities be consulted when programs are designed, implemented, and evaluated. This policy aims to incorporate equity department-wide, ensuring that we will consider equity in all aspects of our business.

Reason for Policy:

In order to reduce inequities, it is necessary to address broad social, economic, and political factors that result in systemic disadvantages as well as the needs, assets, and challenges of communities experiencing inequities. The Department acknowledges and embraces the role it can play in developing policies, investments, and procedures that advance equity.

Failure to Comply:

The Department shall develop measures, monitor implementation, and enforce the policy on equity across the agency. The Department expects all department employees to comply with relevant provisions, but the policy is not intended to be punitive. The Department views this policy as a mechanism for all DHS employees to better understand and incorporate equity into their work.

Policy

The Minnesota Department of Human Services (DHS) will provide resources to make equity an integral part of all programs, policies and procedures it implements. This policy requires that considerations of equity, that is, fairness and justice, are embedded in decisions at all levels of DHS, including leadership, operations, programming, investments, and policy development. The goal of this policy is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation, which improves outcomes and reduces health and human services disparities and inequities for the people we serve.

The agency shall:

- I. Engage and empower all agency employees to advance equity through their daily work;
- II. Identify standards, processes, metrics and systems of accountability to advance equity goals, including:
 - Link agency service delivery of human services programs to the determinants of health;
 - Institutionalize an equity focus in decision-making;
 - Promote fairness and opportunity in agency practices;
 - Collaborate across program areas; and
 - Build community trust and capacity.
 - Invest in human, capital and infrastructures to meet the needs of communities experiencing inequities

Procedure(s) that Apply:

I. Equity Committee

- The person overseeing each administration will work on establishing an equity committee. This equity committee will be charged with advising the responsible leadership of that administration on advancing equitable outcomes for all people we serve and DHS employees.

II. Equity Analysis

- DHS managers and supervisors should consult their equity committee when reviewing administrative policies for renewal.
- Employees who are involved in developing legislative proposals will engage in an equity analysis and consult with equity liaisons when evaluating potential equity impact.

- Agency staff shall analyze equity impact when preparing legislative proposals, using the following questions contained in the Governor's 2018-2019 Change Item Template. Specific questions analyzed may be modified based on direction from the Governor's office and DHS's understanding of analyzing equity impact:

- What groups are impacted by the proposed change item? (Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans) What is the nature of the impact? Have representatives from these groups been consulted and collaborated with in order to determine how to address these impacts?

- Is the proposed change item submitted to reduce or eliminate any disparities for Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans? Please explain how implementation of the proposed item will reduce or eliminate these disparities;

- Are there potential positive or negative impacts on the identified groups? Explain those impacts. If negative, please adjust the proposal to achieve a more equitable outcome.

- Can the change item be sustainably successful? Discuss the on-going funding, implementation strategies/opportunities, and performance measures/accountability mechanisms.

III. Workforce and Leadership Development

- Affirmative Action Officer will provide hiring supervisors and senior management with data and advice to help them increase number of underrepresented group members in all levels of workforce.

- Human Resources Office will utilize data to inform hiring managers to increase members of underrepresented groups employed by DHS in all levels of workforce.

- Hiring Manager shall make every reasonable effort to include at least 1 underrepresented group member on interview panels.

- Human Resources and the Affirmative Action Officer will track and monitor data on employee separations and develop and implement interventions if there are statistically significant disparities in separation numbers between majority member employees and employees from communities experiencing inequities in all levels of workforce.

- Enterprise Learning and Development, in collaboration with Human Resources and others, will track and monitor participation of employees from communities experiencing inequities in agency and state-sponsored leadership development opportunities.

IV. Contracting and Procurement

- The Director of Contracts, Procurement, and Legal Compliance will develop and apply equity criteria throughout the contracting, grants, and procurement process, while maintaining compliance with local, state and federal contracting regulations, in order to increase vendor diversity
- “Equity select” procurement, authorized by 2016 MN Statute 16C.08 and 16C.16, shall be utilized in order to directly select vendors owned by targeted groups for procurement up to a value of \$25,000.
- DHS employees who engage in contracts and procurement should (a). be trained in applying an equity analysis or (b.) consult with an individual or equity committee that have been trained in applying equity analysis

V. Community Engagement and Inclusion

- When developing strategic initiatives and work plans, DHS managers and supervisors will ensure that communities experiencing inequities are engaged through the planning, program development, budgeting, program evaluation and decision-making process.
- Managers and supervisors who oversee staff who plan community engagement activities should consult with the Director of Community Relations for support and resources, when appropriate.

VI. Enhanced Cultural and Linguistic Appropriate Services (CLAS) Standards:

- The enhanced National CLAS standards are intended to advance health equity, improve quality, and help eliminate disparities in health care. DHS will endeavor to pilot and implement CLAS standards in the delivery of human services.

Forms that Apply:

N/A

Training:

DHS is developing required training.

Standards:

The following are standards to advance equity and disparity reduction work at DHS:

- DHS will regularly engage persons from communities experiencing inequities during the agency’s planning, program development, program evaluation, and decision-making process.
- DHS human resources department, managers, and supervisors will recruit, hire, welcome, develop, promote and support a workforce, which is diverse and inclusive of people from communities that

experience inequities. This includes leadership development and promotion of people from communities that experience inequities into positions of formal leadership at all levels within the agency.

- When contracting for services DHS managers, supervisors, and staff will conduct outreach, welcome, develop, promote and nurture a diverse group of vendors capable of meeting the needs of DHS clients and in accordance with Executive Order 15-2 and recommendations of the Governor’s Diversity and Inclusion Council.
- DHS will incorporate equity analysis into the development of policies, rules, procedures, budget, and legislative proposals, as well as program design and implementation.
- DHS will continue to provide staff support to the Cultural and Ethnic Communities Leadership Council (CECLC) in advising the agency on equity and disparity reduction efforts.
- DHS recognizes the variety of ways that human services programs impact the social determinants of health and the role that addressing them will have in improving equity.

Definition(s):

Community Engagement: process of co-creating solutions in partnership with people, who through their own experiences, know the barriers to opportunity best. It is grounded in building relationships based on mutual respect and that acknowledge each person’s added value to the developing solutions (Voices for Racial Justice).

Communities Experiencing Inequities: consist of the communities made of up the following populations:

- *People of Color:* individuals of non-Caucasian heritage who identify as non-white. *Houghton Mifflin Company (2005). The American Heritage Guide to Contemporary Usage and Style. Houghton Mifflin Harcourt. p. 356.*
- *American Indians:* Decedents of the native people of North America who identify as American Indian
- *Persons with Disabilities:* Any person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment.

Determinants of Health: structural determinants and conditions in which people are born, grow, live, work and age.”⁶ They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to health care. <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

Disparity: difference in health that is closely linked with social, economic, or environmental disadvantage. Health disparities impact groups that systematically experience greater obstacles including communities of color, American Indians, and persons with disabilities.

Engagement: process of collaboration and inclusion in which entities build ongoing relationships for the purpose of applying a collective vision to solve complex problems.

Enhanced National Culturally and Linguistically Appropriate Standards (CLAS): A series of standards that are intended to advance health equity, improve quality, and help eliminate health care disparities. Beyond healthcare delivery, CLAS standards should be understood as applicable to public institutions addressing individual, family, or community health, health care or well-being (National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, HHS 2014).

Equity: 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."

Equity Analysis: An analysis of the impact of proposals, policies, and programs on various populations, with a particular focus on impact on communities experiencing inequities. The analysis shall address the following questions, contained in the Governor's 2018-2019 Change Item Template. Specific questions analyzed may be modified based on direction from the Governor's office and DHS's understanding of analyzing equity impact

- What groups are impacted by the proposed policy or budget item? (Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans) What is the nature of the impact? Have representatives from these groups been consulted and collaborated with in order to determine how to address these impacts;
- Is the proposed item submitted to reduce or eliminate any disparities for Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans? Please explain how implementation of the proposed item(s) will reduce or eliminate these disparities;
- Are there potential positive or negative impacts on the identified groups? Explain those impacts. If negative, please adjust the proposal to achieve a more equitable outcome.
- Can the policy or budget idea be sustainably successful? Discuss the on-going funding, implementation strategies/opportunities, and performance measures/accountability mechanisms.

Health: Health encompasses many aspects, including physical, mental, social, and spiritual well-being (HHS IHS, n.d.; HHS OSG et al., 2012; WHO, 1946). Health is "not merely the absence of disease or infirmity" (WHO, 1946). How individuals experience health and define their well-being is greatly informed by their cultural identity.

Health in All Policies: “Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas...Ultimately the Health in All Policies approach seeks to institutionalize considerations of health, equity, and sustainability as a standard part of decision-making processes across a broad array of sectors.”
https://www.apha.org/~media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx

Inequities: Differences in outcomes that are systematic, avoidable and unjust.

Introduction

DHS is committed to addressing health and human services inequities and has undertaken initiatives to reduce them. In 2009, the DHS Disparities Reduction Advisory Committee (DRAC) met with numerous DHS employees to discuss disparities and recommended that DHS improve its understanding of cultural community members' needs and preferences for quality service and culturally responsive care.¹⁰ In 2013, the Cultural and Ethnic Communities Leadership Council (CECLC) was established by the Minnesota Legislature to represent people in communities experiencing health and human services access and outcome disparities. The CECLC analyzes input from many sources and advises the commissioner of DHS on ways to address those disparities.

The CECLC performed an equity analysis to evaluate what DHS was doing in its programs to address health and human services disparities. While many DHS focus areas showed some alignment, other areas of need had to be addressed.¹¹ In February 2015, the CECLC presented recommendations to the DHS Executive Team for reducing health and human services inequities and achieving equity at DHS. Elements from the recommendations were used to create the DHS Policy on Equity, an agencywide equity policy that creates a foundation on which to build specific equity-focused initiatives and procedures. Commissioner Emily Piper approved the policy in January 2017. This document recommends a course of implementation steps.

Goal

The goal of the Policy on Equity is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation that improves outcomes and reduces health and human services disparities and inequities for the people DHS serves.¹² The agency places a focus on communities of color, American Indians, and other groups in Minnesota experiencing disparities.¹³ For the purpose of this policy, communities experiencing inequities refers to communities of color, American Indians, veterans, LGBT, and persons with disabilities.

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

Current situation and context

The DHS Policy on Equity addresses both internal and external processes to reduce health and human services inequities and create a more equitable and inclusive culture within DHS. It calls on all DHS divisions to build tools, expertise, and cultural change based on authentic community engagement in the planning, implementation, and evaluation of DHS' policies and services.

¹⁰ 2015 Legislative Report, page 15

¹¹ 2015 Legislative Report, page 6

¹² DHS Policy on Equity, page 1

¹³ 2016 Legislative Report, page 13

Although Minnesota is among the healthiest states in the nation — ranking fourth in both 2015 and 2016 — these strong rankings are not consistent across all communities. Certain populations experience significant and persistent disparities that need to be addressed, and efforts need to be made to reduce them. In 2016, DHS performed its third annual equity review in which all business areas were asked to submit information about projects, initiatives, programs, groups and/or grants. Of these projects, 11 had an internal focus on DHS’s organizational practices and the capacity of the agency to address inequities. These projects sought to use an equity lens in the assessment and influencing of agency policy and practices, increasing workforce diversity and staff development. Although the focus of these projects was on the internal organizational capacity of DHS, they all have the ultimate goal of reducing inequities for the people served by DHS’ programs and the broader communities in Minnesota.

In addition to the internally focused projects, the review included some projects that were focused more directly on reducing inequities in collaboration with the people served by DHS programs. For example, the director of community relations obtained a grant from the Bush Foundation to carry out work to build and sustain authentic community engagement at DHS. The project focused on building awareness of the social and historical context in which inequities exist. Other examples include projects to increase culturally responsive services and increase the number of culturally specific providers.

Stakeholder expectations

DHS’s implementation of the Policy on Equity is an internal policy implementation, and the implementers of this project are DHS leaders and staff. While they are the primary implementers, counties, local governments, health plans, communities of color, American Indians, and other underserved and underrepresented populations experiencing inequities, form the circle of stakeholders and program participants who will be affected by the policy. Only through collaboration with all of these groups can DHS effectively implement the policy and revise its processes to reduce health inequities. Stakeholders will expect the following:¹⁴

- A. **Collaboration and inclusion:** Program participants will expect to be engaged with DHS in shared decision-making about changes to DHS processes and practices that impact their populations. Inclusion of communities of color, American Indians, veterans, LGBT, and persons with disabilities, and other impacted communities in DHS design and planning is especially important to address the significant health and human service inequities they experience.
- B. **Awareness:** Program participants will expect DHS to increase awareness of the significance of inequities, their impact on all Minnesotans and on specific populations, and move to action to reduce inequities and achieve equity.
- C. **Leadership:** Program participants will expect DHS to strengthen relations among the CECLC and state agencies to promote clear and meaningful dialogue about equity.
- D. **Community health and health systems:** Program participants expect that implementation efforts will lead to a health and human services system that addresses complex needs, respects cultural beliefs, and imbeds cultural practices in healing. Provider selection, preparation, and funding should be robust to meet the needs of the community and

¹⁴ 2016 Legislative Report, page 77

eligibility determination should be transparent. Community-based organizations should be seen as partners and powerful allies supporting the health of their communities. Utilization of community health workers should become the norm.

- E. **Data and research:** Program participants expect that DHS will collect, analyze, and share data that reflect characteristics and distinctions that are most important to their communities. Data should reflect the whole person, and DHS should adopt measurement strategies to obtain the most appropriate data with community-defined cultural and ethnic groups' input. DHS should promote both evidence-based research and practice-based evidence.
- F. **Performance management:** Program participants expect that DHS will undertake systematic performance improvement of DHS staff and service providers through creation and implementation of a department wide accountability system and cultural competency/anti-racism trainings.
- G. **Equity analysis:** Program participants expect that DHS will create and implement an analysis process to identify and reform statutes, rules, policies, and operating procedures that perpetuate health and human service inequities. Members of the CECLC should work in partnership with DHS in this analysis process.

Possible barriers

Under funding from the Bush Foundation, DHS leaders and employees, as well as community members, were surveyed to gauge how prepared the agency is to deal with matters of equity. Possible barriers identified from these surveys, as well as barriers described by administrations, are as follows: ^{15,16}

1. Limited resources, which impede the sustainability of program impacts.
2. Lack of continued and authentic community engagement and support.
3. Lack of staff diversity and inclusion of staff from diverse backgrounds in decision-making processes at DHS.
4. Failure to implement mechanisms for accountability.
5. Lack of available data disaggregation challenges DHS' efforts to focus on inequities reduction by race, ethnicity, language or other factors.
6. Lack of trust.
7. Lack of equity awareness and skills. The majority of community members do not believe that DHS leaders and staff have intermediate or advanced skills to address barriers to equity.
8. Community leaders do not feel they are part of the planning process because most meetings are held at DHS.
9. Community leaders do not believe that DHS recognizes assets of cultural and ethnic communities.

Proposed strategies

To move forward, DHS will provide the proper training and resources to employees to ensure that the agency is well-equipped to deal with matters related to equity. There is also a

¹⁵ 2017 Legislative Report Draft, page 29

¹⁶ 2017 Legislative Report Draft, page 42

recommendation from the CECLC on the need to improve trust with communities of color, due to past historical issues of exclusion and discrimination in need of redress.

Objective 1: Equity committees

- Each administration establishes an equity committee.
- Each administration commits to resourcing the equity committee to meet the goals of its strategic plan and implementation.
- It is highly recommended that an equity director be appointed to coordinate the work of the equity committee.
- Equity directors will receive support and guidance from the CECLC members as appropriate. The community relations division director will establish a path to information, training, development and monitoring.
- The equity committee is charged with advising administration leadership on advancing equitable outcomes for all people we serve and DHS employees.
- An Equity Stewardship Leadership Committee will coordinate equity efforts agencywide. This group will consist of the equity directors facilitated by the community relations director. This group makes regular reports to SMT.

Objective 2: Equity analysis

- All administrative and policy proposals will undergo an “equity analysis” to assess their potential impact on health inequities and on equity and inclusion both inside and outside DHS
- Staff in the Community Relations Division are prepared to provide training on the Equity Analysis package developed by the L-4 Group who presented to the CECLC and received good reviews. The CECLC chair sent a letter to the commissioner recommending that she consider endorsing the training to prepare DHS to utilize the tool.
- DHS managers and supervisors consult with their equity committee when reviewing administrative and policy proposals.
- DHS employees maintain ongoing relationships with communities to ensure that staff understand the circumstances and concerns of stakeholders. Staff who are involved in legislative proposals engage in equity analysis when evaluating potential impacts.
- With information from the equity analyses, managers will be accountable for ensuring that administrative and policy proposals are designed to maximize their impact on the reduction of health inequities.
- Yearly responses to the survey for the Equity Review will reflect efforts and use of an equity analysis.

Objective 3: Workforce and leadership development

- DHS focuses on the inclusion of communities experiencing disparities in DHS’s recruitment, hiring, and retention process for a more diverse and inclusive workforce. Because this policy was created to help improve the quality of services delivered to communities experiencing inequities, it is critical to include them in the process.

- The affirmative action officer provides hiring managers and Senior Management Team members with data and advice on increasing the number of underrepresented group members at all levels of the DHS workforce.
- The human resources director makes every reasonable effort to include at least one underrepresented group member in interview panels.
- The human resources director and affirmative action officer monitor data on employee separation and develop interventions for cultural majority member employees and members from communities experiencing disparities.
- The Enterprise Learning and Development director monitors participation of employees from communities experiencing inequities in agency and state-sponsored leadership development opportunities.
- Leaders and staff at DHS participate in regular assessments of their awareness and capacity to promote equity and inclusion. Aggregated data from these assessments is used to plan training and professional development for leaders and staff at all levels.
- Administrations' equity committees make recommendations for professional development programs and other activities to help build equitable and inclusive cultures within their workplaces.

Objective 4: Contracting and procurement

- The director of Contracts, Procurement and Legal Compliance develops and applies equity criteria in all contracts, grants, and procurement processes while maintaining compliance with local, state, and federal contracting regulations in order to increase vendor diversity.
- The director of Contracts, Procurement and Legal Compliance develops and applies equity criteria in all grants working with administrations to target resources, reach out to new/different organizations and increase the number of diverse providers. Equity committees in each administration may be resources in this activity.
- DHS staff responsible for managing request for proposals, managing grants and funded programs will receive training on how the equity analysis can be a useful tool to assess application of equity policy.

Objective 5: Enhanced Cultural and Linguistic Appropriate Services (CLAS) standards

- The enhanced national CLAS standards are intended to advance health equity, improve quality, and help eliminate disparities in health care. DHS will pilot and implement CLAS standards in the delivery of human services.
- Enterprise Learning and Development develops an assessment for employees, and managers to determine training needs.
- Enterprise Learning and Development develops training tailored to the identified training needs.
- Enterprise Learning and Development develops agencywide training to improve agency's knowledge, understanding and utilization of the CLAS standards.

Objective 6: Engagement and collaboration

- The community engagement process means working with and through constituents to achieve common goals. The process demands that those implementing the engagement

effort communicate with community leaders and members who have diverse backgrounds, values, priorities and concerns. It is at this point that the principles and organizing concepts underlying community engagement come together with real-world activities. To support collaboration and inclusion, the practice of authentic community engagement is of critical importance.

- Engagement is the process of collaboration and inclusion in which entities build ongoing relationships for the purpose of applying a collective vision. To support agencywide efforts the Bush Foundation Community Innovation cohort is planning long-term sustainability of engagement agencywide.
- The Community Relations Division will develop and circulate guidelines for stakeholder engagement.
- The Enterprise Learning and Development Division will develop a set of courses to help staff and managers develop capacity to better engage stakeholders, including identifying appropriate stakeholder groups, designing welcoming meetings, facilitating effectively, Art of Hosting techniques, etc.
- DHS will partner with the Civic Engagement Committee of the Governor’s Diversity and Inclusion on how to implement their civic engagement plan at DHS.

DHS Performance Measures

The following are suggested measurements; it is expected that each responsible area/division within DHS will develop a tracking/monitoring system and to regularly update it. CECLC members are interested in supporting DHS’s efforts in this process and can provide culturally relevant input and feedback at its monthly meetings or at other times, as DHS leadership/staff deems appropriate. Progress in the implementation of the policy on equity is expected to be an element in the yearly legislative report submitted by CECLC to the health and human services committees in the House and Senate of the Minnesota Legislature. The legislative report contains a segment titled Equity Review detailing DHS’s activities on disparities reduction. Communities experiencing inequities in access and outcomes to DHS services wish to see a marked decline in disparities in access and outcomes in their receipt and experience of such services.

Objective 1: Equity committees at DHS

Number of equity committees are operating at the end of year one

Number of equity committees in development to operation

Improved population satisfaction in culturally and linguistically appropriate services.

Objective 2: Equity analysis

1. Number of training presentations per division
2. Number of requests for training presentations per administration at the end of each year
3. Number of evidence of use of equity analysis in yearly equity review
4. Percentage of proposals which include equity analysis in detail.

Objective 3: Workforce and leadership development

1. Percentage of underrepresented group members at all levels of DHS
2. Percentage of underrepresented group members participating in job interviews
3. Human resources director and affirmative action officer provide regular reporting to senior management team on separation information and remedies applied
4. Enterprise Learning and Development director regularly reports to Senior Management Team on percentage of underrepresented group members in leadership development programs.

Objective 4: Contracting and procurement

1. The director of Contracts, Procurement, and Legal Compliance regularly reports on application of equity criteria in its contracts, grants and procurement processes and resulting change in vendor diversity.

Objective 5: Culturally and Linguistically Appropriate Services (CLAS) standards

1. Enterprise Learning and Development director develops a training needs assessment for all DHS employees.
2. Based upon results of assessment a training plan is developed to deliver training to all employees on the CLAS standards.
3. Enterprise Learning and Development director updates senior management team on progress of trained staff to achieve 50 percent or more employees trained.
4. Improved population satisfaction in culturally and linguistically appropriate services is reported.
5. Equity Review shows evidence of improved use of culturally and linguistically appropriate methods in program planning, design and funding.
6. Disparities reduction in certain areas of the agency show signs of change.

Objective 6: Stakeholder engagement and collaboration

1. To support collaboration and inclusion, the practice of authentic community engagement is endorsed in every DHS administration.
2. Review of the Bush Foundation Community Innovation Grant evaluation and lessons learned report (currently being prepared) inform implementation of this objective.
3. Approaches utilized in the Bush Grant are expanded in the agency.
4. Staff is hired to lead efforts of community engagement throughout the agency and is supported by Bush Cohort meetings and Stakeholders Engagement Community of Practice.
5. The agency is recognized for its inclusion and access to communities it serves as gauged by community surveys.

6. Processes of community engagement are inclusive, resourceful and collaborative: they invite the population affected by the problems to co-create solutions; community resources are recognized as critical as DHS resources, and community and DHS enjoy equal partnership and share power.
7. Real-world activities relevant to the communities DHS serves are examined jointly utilizing principles and organizing concepts of community engagement (diverse perspectives are negotiated to achieve common goals).

Equity Stewardship Working Group

The Equity Stewardship Working Group (ESWG) will be created to guide the implementation of the DHS Equity Policy through establishing action plans, monitoring administration activities, collaborating with outside stakeholder groups, and serving as both an internal and external resource for the equity policy.

Commissioner Piper will oversee the implementation of the DHS Policy on Equity, and the director of community relations will serve as the project director for the ESWG. The CECLC will provide review and advice to Commissioner Piper, the SMT, the director of community relations, and a new working group as the implementation is rolled out. For more information about the ESWG, see the companion document, “A Plan for the Equity Stewardship Working Group.” (Excerpt found directly below).

A Plan for the Equity Stewardship Working Group

Authority

- The implementation of the DHS Policy on Equity will be overseen by the Commissioner of DHS and the Senior Management Team (SMT). Project leader for the implementation will be the Director of Community Relations.
- The CECLC will provide review and advice to the Commissioner, the SMT, the Director of Community Relations, and a new working group as the implementation is rolled out.
- A new working group, the Equity Stewardship Working Group (ESWG), will be established. Its primary role will be to develop action plans and guide the implementation of activities related to the equity policy, and it will be coordinated by the Community Relations Director (Project Director).

Scope and Relationships

- Working group members develop action plans and work under the general direction of the Director of Community Relations.
- Working group members consist of DHS employees, managers and CECLC members, or other cultural communities and other stakeholder group members.
- Working group guides the implementation of activities as approved by the commissioner and members of the senior management team.
- Working group members will collaborate with other department projects, as appropriate, that involve implementation of elements of the equity policy.

- Working group members seek input from various cultural communities and other stakeholders and serve as a resource both internally and externally on an ongoing basis.
- Working group members, who are not DHS employees, will be funded at the rate of \$55.00 per meeting plus expenses. Resources are requested for this purpose.

Logistics and Resources

- This working group is staffed by the Director of Community Relations, two members of the community relations division staff, student interns, and other DHS employees representing various administrations.
- The working group will meet quarterly.
- The commissioner and senior management team will provide ongoing monitoring to approve, identify, discuss, and resolve resources, including structural challenges.
- The Director of Community Relations, or Project Director, will provide quarterly progress reports to the senior management team.
- The Project Director will coordinate resource needs as identified and make requests to the Project Sponsor, the Commissioner.
- Working group members will:
 - Plan to spend a minimum of three to five hours a month on this project.
 - Understand the project charter.
 - Communicate availability with Project Director.
 - Contribute and report progress to Project Director.
 - Participate in the resolution process when issues arise.
- This implementation project will require commitment of SMT staff appointments from the Community Supports, Children and Family Services, Health Care, Continuing Care for Older Adults, Direct Care and Treatment, and Operations administrations.
- Appointed DHS staff/managers may be requested to contribute to activities by joining goal-specific groups, by providing content expertise; and giving information that advances the work of this implementation team.

Working Group Performance Measures

- Appointed DHS staff/managers may be requested to contribute to activities by joining goal-specific groups, by providing content expertise; and giving information that advances the work of this implementation team.
- ESWG members may identify additional indicators of progress.

- Participation of at least 85% of membership as resources for DHS internal work groups, committees, advisory committees.
- DHS staff and leadership report satisfaction in 90% of partnership as productive.
- Training, support and guidance on culturally related matters are delivered and deemed 90% satisfactory.
- Publication on DHS Today of specific progress achieved, after careful review and approval by project sponsor.
- This project is time limited.

Appendix E: Council Membership

The commissioner of human services appointed members of the Cultural and Ethnic Communities Leadership Council (CECLC).¹⁷

MEMBER	AFFILIATION
<i>Five members representing diverse cultural and ethnic communities:</i>	
<i>Nyagatare Valens</i>	<i>Minnesota Department of Education Term Expires:7/20/19</i>
<i>Rev. Dr. Jean Lee</i>	<i>Children’s Hope International Term Expires:7/20/19</i>
<i>Sharon Lim</i>	<i>Council on Asian Pacific Minnesotans Term Expires:7/20/19</i>
<i>Pahoua Yang</i>	<i>Amherst Wilder Foundation, VP, Community Mental Health and Wellness Term Expires: 7/20/19</i>
<i>Vacant</i>	<i>Term Expires:</i>
<i>Two members representing culturally and linguistically specific advocacy groups:</i>	
<i>Michael Birchard</i>	<i>North Hennepin community College, Chief Diversity and Affirmative Action Officer Term Expires: 7/20/19</i>
<i>Vayong Moua</i>	<i>Center for Prevention, Blue Cross and Blue Shield of Minnesota, Senior Advocacy and Health Equity Principal Term Expires:7/20/19</i>
<i>Two members representing culturally specific human services providers</i>	
<i>Titilayo Bediako</i>	<i>WE WIN Institute, Inc. Founder/Executive Director</i>

¹⁷ <http://www.dhs.state.mn.us/CulturalEthnicLeadershipCouncil>

	<i>Term Expires: 7/20/19</i>
<i>Hodan Hassan</i>	<i>Coalition of Somali American Leaders, Vice-Chair Term Expires: 7/20/19</i>
<i>Two members representing the American Indian Community:</i>	
<i>Beverly Bushyhead</i>	<i>Program Director, Non-profits Assistance Fund Greater Minneapolis-St. Paul Area Term Expires: 8/3/19</i>
<i>Aaron Wittnebel</i>	<i>A Wittnebel Consulting, LLC Term Expires: 7/20/19</i>
<i>Two members representing counties serving large cultural and ethnic communities:</i>	
<i>Patricia Brady</i>	<i>Ramsey County Workforce Solutions, Director Term Expires: 7/20/19</i>
<i>Adesola Oni</i>	<i>Hennepin County Corrections, Train Coach Practice Unit Term Expires: 7/20/19</i>
<i>One member who is a parent of a human services program participant, representing communities of color:</i>	
<i>Saciido Shaie</i>	<i>Ummah Project, Co-founder, President and Executive Director, Term Expires: 7/20/19</i>
<i>One member who is a human services program participant member representing communities of color</i>	
<i>Vacant</i>	<i>Term Expires:</i>
<i>The chairs and ranking minority members of the Health and Human Services Committees in the House of Representatives and the Senate with jurisdiction over human services:</i>	
<i>Rep. Matt Dean, House Health and Human Services Finance chair, Ways and Means</i>	
<i>Rep. Erin Murphy, DFL Lead, Health and Human Services Finance Minority Lead, Rules and Legislative Administration, Ways and Means</i>	
<i>Rep. Tina Liebling, Health and Human Services Finance Reform Minority Lead (Health Care), Ways and Means</i>	
<i>Rep. Joe Schomacker, Health and Human Services Reform Chair, Agriculture Finance, Health and</i>	

<i>Human Services Finance</i>	
<i>Rep. Diane Loeffler, DFL Lead: Property Tax and Local Government Finance Division, Health and Human Services Finance, Taxes</i>	
<i>Rep. Rena Moran, Deputy Minority Leader, Education Finance, Health and Human Services Reform, Job Growth and Energy Affordability Policy and Finance</i>	
<i>Sen. Tony Lourey, Health and Human Services Finance and Policy Ranking Minority Lead</i>	
<i>Sen. Michelle Benson, Health and Human Services Finance and Policy Chair, Rules and Administration, Finance, Human Services Reform Finance and Policy</i>	
<i>Sen. Jim Abeler, Health and Human Services Reform Finance and Policy Chair, Aging and Long-Term Care Policy, Health and Human Services Finance and Policy, Higher Education Finance and Policy</i>	
<i>Sen. Jeff Hayden, Commerce and Consumer Protection Finance and Policy, Health and Human Services Finance and Policy, Human Services Reform Finance and Policy (Ranking Minority Member)</i>	
<i>Two members representing faith-based organizations ministering to ethnic communities:</i>	
<i>Pastor Brian C. Herron, Sr.</i>	<i>Zion Baptist Church, Senior Pastor Term Expires:7/20/19</i>
<i>Pastor Emory Dively</i>	<i>Deaf Life Church, Co-Pastor Term Expires:7/20/19</i>
<i>One member who is a representative of a private industry with an interest in inequity issues:</i>	
<i>Dr. Nkem Chirpich</i>	<i>TAP Diversity Navigators, President & CEO Term Expires: 7/20/19</i>
<i>One member representing the University of Minnesota program with expertise on health equity research</i>	
<i>Dr. Susie Nanney</i>	<i>University of Minnesota, Director, Population Health Research Division Term Expires:7/20/19</i>
<i>Four representatives of the state ethnic councils</i>	
<i>Justin Terrell, Council for Minnesotans of African Heritage Patrice Bailey, Outreach Coordinator</i>	
<i>Sia Her, Executive Director, Council on Pacific Islanders Minnesotans</i>	

<i>Anjali Mishra Cameron, Research Director</i>	
<i>Henry Jimenez, Executive Director, Minnesota Council on Latino Affairs</i>	
<i>Rosa Tock, Legislative and Policy Analyst</i>	
<i>Dennis Olson Jr., Executive Director, Minnesota Indian Affairs Council</i>	
<i>One representative of the Ombudspersons for Families (rotating):</i>	
<i>Bauz Nengchu, Muriel Gubasta, Jill Kehaulani Esch, and Ann Hill</i>	
<i>Three DHS employees:</i>	
<i>Kia Moua</i>	<i>DHS, Income Maintenance Program Advisor Term Expires: 7/20/19</i>
<i>Tikki Brown</i>	<i>DHS, Director, Child Services Division Term Expires:7/20/19</i>
<i>Brendabell Njee</i>	<i>DHS, Mental Health Program Assistant Term Expires: 7/20/19</i>
<i>DHS staff to the CECLC:</i>	
<i>Santo Cruz</i>	<i>Deputy Commissioner for External Relations; senior management team liaison</i>
<i>Antonia Wilcoxon</i>	<i>Community Relations Director</i>
<i>Nicole Juan</i>	<i>Community Relations Project Manager</i>
<i>Kevin Murray</i>	<i>Community Relations Project Manager</i>
<i>Sophie Bentson</i>	<i>Intern, University of St. Thomas graduate</i>
<i>Hani Ahmed</i>	<i>Intern, Hamline University</i>
<i>Sarah Thompson</i>	<i>Consultant</i>

Appendix F: The Five Goals of the National Partnership for Action to End Health Disparities

GOAL 1 AWARENESS

Increase awareness of the significance of health

What is an Equity Analysis Lens?

An equity analysis is not a new concept, however it can bring forward new ideas into focus or expand existing thoughts. The equity lens forces us to use a systematic examination of how different racial and ethnic groups will likely be impacted by a proposed action or decision. This process allows us to consider resources, decision-making and meaningful community engagement in that process. We can then recognize that a traditional “one size fits all” approach is no longer an effective or equitable way to plan for meeting the needs of the individuals that we serve in Minnesota. The guide and worksheets can be a tool for ensuring that racial equity and inclusion matters are considered when making decisions.

An equity analysis can be described as a process. The guide provides the user with some pre-work considerations prior to using the worksheet. The worksheet is a series of questions that can help identify areas that should be given a more in-depth review. There are no right or wrong answers, rather it is a tool that helps us to be more inclusive in how we do our work.

Why use an Equity Analysis?

Minnesota Department of Human Services (DHS) Established Equity Policy

The Minnesota Department of Human Services (DHS) will provide resources to make equity an integral part of all programs, policies and procedures it implements. This policy requires that considerations of equity, that is, fairness and justice, are embedded in decisions at all levels of DHS, including leadership, operations, programming, investments, and policy development. The goal of this policy is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation. With the goal to improve outcomes and reduce health and human services disparities and inequities for the people we serve.

In addition to ensuring that the DHS equity policy is followed, using an Equity Analysis will significantly increase the capacity of the agency to identify and eliminate racial and ethnic disparities. It will provide the user with an eye for quality improvement that focuses on both internal and external needs, increase awareness of individual and organizational roles in achieving equity and inclusion, provide an accurate assessment of client needs and understanding of how to improve satisfaction and services delivery, provide new opportunities to influence operational processes and decisions and lastly to increase the ability to explain what we do and the value of our services to clients and communities in Minnesota.

When to use an Equity Analysis

As stated in the DHS Equity policy, it requires that considerations of equity, that is, fairness and justice, are embedded in decisions at all levels of DHS, including leadership, operations, programming, investments, and policy development. The goal of this policy is to institutionalize an approach to decision-making, program and policy development, implementation, and evaluation, which improves outcomes and reduces health and human services disparities and inequities for the people we serve.

¹⁸ Excerpt from “How to Use an Equity Analysis: Program Guide” Minnesota Department of Human Services, April 2017. Available Upon Request.

An equity analysis should be applied early and throughout all phases of the decision-making process from development to implementation and evaluation. It should be used prior to developing new practices, program decisions, hiring, procurement and policy development. The goal is for DHS to incorporate an equity analysis into the development of policies, rules, procedures, budget, and legislative proposals, as well as program design and implementation.

The equity analysis can be used to improve planning, decision-making and resource allocation leading to more racially equitable policies and programs. The goal is to use a standardized set of principles, questions and processes that focuses at the individual, institutional and systemic levels by identifying:

- What is working and what is not working around racial equity
- Reviewing and improving what is working well
- Changing how we traditionally make decisions and include the community in our work (Civic Engagement), and
- Transforming our agency, culture and communities to become an inclusive environment.

How to Use an Equity Analysis

Prior to using an equity analysis process, be sure to invite all who may be impacted to the table. This includes; staffing, community members, management teams and any other stakeholders who may benefit or be impacted by the decision that will be made. It is important to include all potential perspectives in the decision-making process to ensure that different points of view are represented. Be sure to allocate adequate resources and time to this process.

The Equity Analysis process will guide the team to:

- Assess the department's current organizational capacity for equity work. What do you hope to accomplish?
- Describe the current work with equity and what direction and strategies are being used. What is the capacity to doing equity work?
- Identify what is the current issue? Use current data, who does this affect? Population, community?
- Review and understand your strengths and challenges. Who is at the table?
- Enhance and improve your strengths that is leading equity and empowerment work.
- Identify strategies and eliminate inequities and injustices.
- Celebrate successes and improvements.

Step 1: Review the Equity Analysis Guide and attached Appendices. It may be useful to set the stage and framework for the project and become familiar with the goals, terms and process at the beginning of the project. The guide provides an overview of the Equity Analysis and additional resources that were used in its development. Included in the attached appendices: A Racial Equity Best Practices Guide, Glossary of Commonly Used Terms, An Equity Analysis Chart, and a Draft of DHS Equity Policy.

Step 2: Use the Equity Analysis one-page tool: This is an initial look into to defining the project and analyzing its impacts. It can be used as a standalone process or in combination with the more detailed workbook. There are two sections to this one-pager tool.

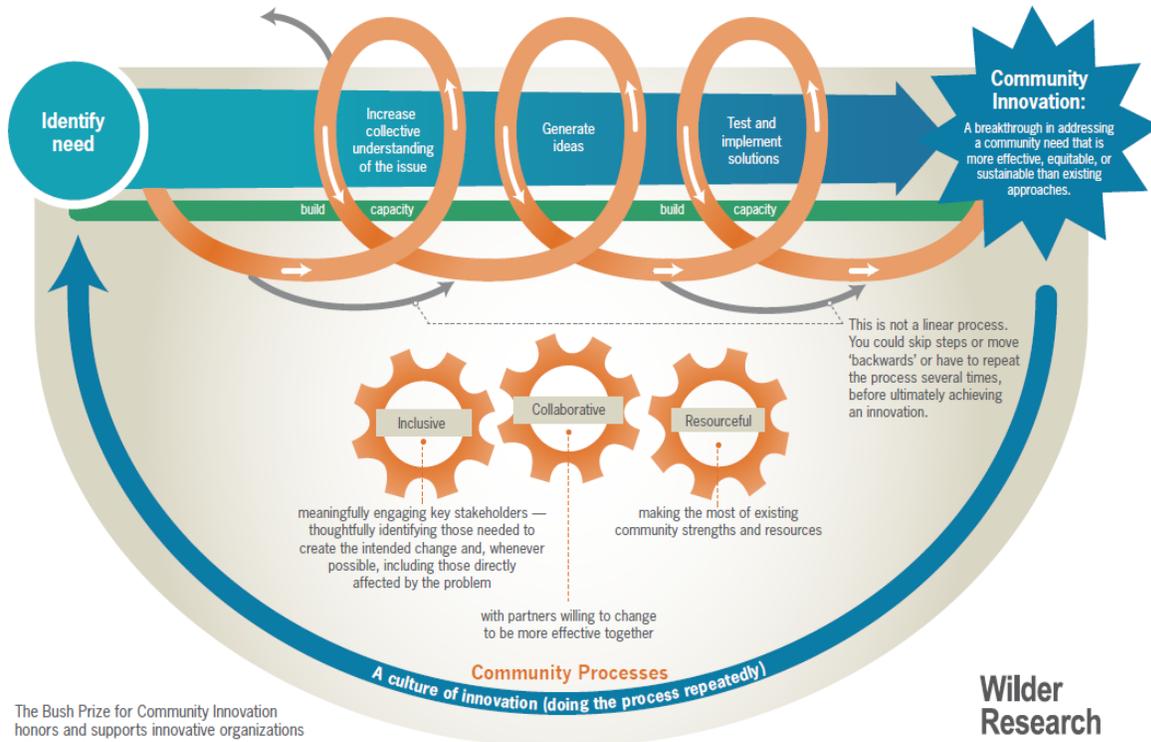
Describe the project - Provide the project goal, identify the project manager that will be responsible for the project. Identify the administration where the project is taking place. Document the date the equity analysis was completed and finally estimate the project complete date.

Assess the project – Walk through the five questions to examine and analyze; who is impacted by the project, describe the nature of the impacts, what is the intention of the project, are there potential positive or negative impacts to the project and lastly can the project be sustained successfully.

Step 3: Use the detailed workbook. The workbook provides a more in-depth analysis to examine how equity and inclusion may be impacted by the proposed decision. The workbook provides a series of six stages with specific questions to initially assess the project, collect and use data, engage stakeholders, examine and reassess using data and feedback, implement project and lastly review/revise from what was learned.

Appendix H: Bush Foundation/Wilder Research Community Innovation Theory of Change

Community Innovation Theory of Change



The Bush Prize for Community Innovation honors and supports innovative organizations with a track record of making great ideas happen.

Community Innovation grants support communities to use problem-solving processes that lead to more effective, equitable and sustainable solutions.

Wildier Research

Information. Insight. Impact.

This theory of change was co-developed by Bush Foundation and Wildier Research.

Community Based Participatory Action Research Partnership Protocol

Developed by SoLaHmo Partnership for Health & Wellness (SoLaHmo) at West Side Community Health Services, Inc. and the University of Minnesota's Program in Health Disparities Research (PHDR) Advisory Board

Community Based Participatory Action Research (CBPAR) is a way of doing research in which community members and academic researchers are equal partners in all stages of the research process. This approach is also known as community-based participatory research (CBPR), participatory research (PR), and participatory action research (PAR). CBPAR has many benefits for both communities and for research itself, including:

- Increasing community trust in research
- Increasing likelihood that research results will lead to effective programs and products that communities want and can use
- Increasing validity of research results
- Creating connections between community organizations, clinics, and researchers that support partnerships and that share effective and relevant programs and products
- Increasing skills, connections, and opportunities for growth for all partners

Successful CBPAR projects depend on strong partnerships. Partnerships across organizations that have different goals, priorities, and access to resources are not always easy to build. The purpose of this document is to support partnerships to be ready and able to do CBPAR.

This document represents a joint effort between the SoLaHmo Partnership for Health & Wellness (SoLaHmo) at West Side Community Health Services, Inc. and the University of Minnesota's Program in Health Disparities Research (PHDR) Advisory Board gold standard sub-committee. SoLaHmo contributed key action steps and ethical considerations for partnership success from their "Partnership Protocol for Community Based Participatory Action Research (CBPAR)" document, and PHDR contributed in-depth information about key CBPAR principles that support successful partnerships. The content in this document is the result of varied perspectives from both community members and academicians.

This document may be used for a number of purposes by SoLaHmo members, PHDR staff, community partners, and research faculty as well as broader research communities, including:

- Sharing a set of expectations for how to collaborate that potential community and university partners can discuss early in the partnership
- Establishing a base for training individuals new to CBPAR
- Setting standards that may reduce disagreements or resolve conflicts between partners

This protocol has three sections:

1. [Section 1](#) outlines key CBPAR principles that define how partners work together.

2. [Section 2](#) provides a detailed description of each CBPAR principle and examples of ethical considerations that SoLaHmo has identified through multiple research partnerships. These ethical principles are linked to the stages in the lifespan of a CBPAR research project, although each set of ethical considerations may be associated with more than one principle. Project lifespan stages are as follows:
 - [PROJECT STAGE 1: Partnership Development](#)
 - Partnership Exploration Phase
 - Collaborative Planning Phase
 - [PROJECT STAGE 2: Implementation](#)
 - Early Implementation Phase
 - Recruitment/Data Collection Phase
 - Data Analysis Phase
 - [PROJECT STAGE 3: Dissemination/Next Steps](#)
 - Sharing Research Findings Phase (Community/Academic)
 - Planning Next Steps or End of Project Phase
3. [Section 3](#) is a checklist for key steps in partnership building across the lifespan of a research project. This checklist can be used early in partnership development to make sure that all partners are on the same page in terms of expectations for how to collaborate at each step of the project. It can serve as a planning tool as the project moves forward.

Section 1: Community-Based Participatory Action Research (CBPAR) Principles

1. [Recognize that members of a community may have a shared identity that requires ethical protections in research](#)
 2. [Answer research questions that are important to the community, and that create solutions built on existing community strengths and resources](#)
 3. [Create pathways for the collaborative, equitable involvement of all partners in all phases of the research](#)
 4. [Create a balance between gaining knowledge and creating action for the benefit of all partners](#)
 5. [Empower partners to actively learn from each other and to pay attention to social inequalities](#)
 6. [Address how both social and environmental contexts affect health](#)
 7. [Share findings and knowledge gained with all partners and with communities, in a way that can be used to improve community health](#)
 8. [Involve long-term commitment by all partners](#)
- [References](#) are listed on the reference page at the end of the document.
- Links to [resources](#) are listed at the end of the document.

Section 2: Principles, Definitions, Best Practices, and Expectations

Principle 1: *Recognize that members of a community may have a shared identity that requires ethical protections in research*

It is important to emphasize that community members define “community.” Community may be a geographic area, a group of people with a common culture/ethnicity, or a network of people with shared interests and identity. Communities require ethical protections, as do individual research participants.

Activities and Action Steps:

- Engage in conversations in the community to understand historical research connections (how has academia worked with this community and/or organization before? What has the history of research looked like in this community?)
- Understand the community’s relationship with CBPAR
- Partners should listen carefully, interact respectfully, and be open to learning from each other.
- The community identifies how the research activities and findings could possibly be damaging to communities, and all partners work to prevent harm.
- Community researchers are “the face” of the research project in their own communities. As such, it is essential that the research project and its protocols are in line with core values of the community and community researchers. In order for community partners to maintain their integrity in the eyes of the community, community researchers should co-lead decisions related to processes of informed consent, recruitment strategies, and research methods, language used to inform and engage community participants, how results are interpreted, and how findings are disseminated.

Community and Researcher Perspectives

“You have to be comfortable not knowing a lot. Learning to walk in a new community is like being a child. You need introduction and instruction. You need to learn your place and how much you don’t know”. –Academic Partner

Principle 2: Answer research questions that are important to the community, and that create solutions built on existing community strengths and resources.

Improved health can be most effectively addressed with community members at the research table as equal partners. Communities know the most important health needs that they struggle with. Communities also know their own strengths and how those may be used to address the problem. Working with communities to identify problems and build on existing strengths is likely to produce the most valid research results and effective action programs based on the research results.

Activities and Action Steps:

- Establish accountable relationships among community leaders, community members and academic researchers before trying to intervene, address problems, or bring up possible solutions.
- Identify community strengths and resources and identify systemic challenges through conversations with community leaders, discussions in community forums, or formal assets assessments
 - Resource: Community Tool Box, Chapter 3, Section 8: Identifying Community Assets and Resources
 - Resource: Community Assets Brainstorming Activity (County Health Rankings & Roadmaps, 2013).
 - Resource: Asset-Based Community Development Toolkit (ABCDI, 2015)
- Ensure that the research is tailored to the specific community desires
- Utilize collaboration and engagement to support the development of the research process, which includes identifying research questions that reflect issues of community interests.
 - Resource: Concept Mapping as an Approach to Facilitate Participatory Intervention Building (Allen, Schaleben- Boateng, Hang, & Pergament, 2015).

Community and Researcher Perspectives

“Everyone was aware of the strong added value that this [CBPR project] was bringing to the community. When you are doing research for things that are really meaningful for the community you get the sustainability, the extra support.” – Community Partner

Principle 3: *Create pathways for the collaborative, equitable involvement of all partners in all phases of the research*

Projects are most likely to be successful when community members are involved from the very beginning of planning a study through the end of the project. Many communities have been asked to join research projects after the topics, questions, intervention, and implementation plans have already been decided. Sometimes these may fit well with community interests, but often communities have other priorities.

Activities and Action Steps:

- Develop or make use of documents that build partnership synergy, such as:
 - Tools to support early conversations about partnership processes, such as the Partnership Checklist. The Checklist is a series of questions that help partners talk through key partnership issues early in their relationship.
 - Resource: See references page for link
 - Memorandum of Understanding or Collaborative Agreement. These are partnership agreements that can change over time, as needed. They outline how partners will work together across the lifetime of the project. They address key aspects of collaboration such as communication, decision making processes, and sharing research findings (dissemination).
 - Resource: Memorandum of Understanding Template (UMNOPE, 2016)
 - Mission statement. Establishing a mission statement is a way to define common goals and priorities.
 - Data sharing and authorship agreement. This document formalizes who owns the data, who has access to the data, and who will be authors on future journal articles (for example, are community partners listed as authors on all publications, do they need to approve a final publication?).
- Establish group processes including:
 - Honest and frequent communication through agreed upon channels
 - Established roles and responsibilities
 - Equal representation for community and academic partners in all aspects of the work, including naming community researchers that are co-principal investigators or co-investigators in journal articles.
 - Decision making process that all partners have agreed upon (consensus, voting, etc.)
 - Openness about each partner's priorities and needs, as well as organizational

culture and potential barriers.

- Co-develop a budget
- Participate in partnership evaluation to understand how well the partnership is progressing and meeting its goals.

Community and Researcher Perspectives

“It’s important to talk about the money. The university is going to take their percentage. Put that stuff upfront.” – Community Partner

“I think the other piece is with having community partners on board. From very early on, what are the benefits to the community? They need to be articulated”. – Academic Partner

Principle 4: *Create a balance between gaining knowledge and creating action for the benefit of all partners*

CBPAR projects should identify community-oriented dissemination strategies, from early action steps of importance to communities to disseminating final results. Research is a slow process that may require years to produce results. Researchers may be accepting of this while communities may experience frustration, given their sense of urgent priorities that demand action. Early action steps made before final research outcomes are available can address this concern.

Research results need to be shared in ways that both community members and academicians can understand. When the community does not hear about the findings, does not have access to the findings, or does not understand the language in which the findings are shared, then the community cannot make use of the results and academic partners take away the knowledge for their own benefits. Clear agreements should be established early regarding dissemination strategies, ownership of data, location of raw data and analyses, and how all partners will have access to the data overtime and as new priorities or uses emerge.

Activities and Action Steps:

- An MOU/collaborative agreement should address dissemination plans for early and late outcomes to both community and academic audiences.
- Establish an early plan for action steps such as community dialogues, presentations to community boards, or opportunities for select organizations to use early results in a program.
- Make sure that the budget addresses the resources that will be needed for dissemination and for sharing findings at community events, including language translation/interpretation, food and child care transportation costs.
- Create a process that allows for community evaluation about the dissemination processes

Community and Researcher Perspectives

“We need more transparency. We need to put it on the table. People never talk about that they have to write papers. They need to get tenure. Let’s be up front and tell people why we’re doing what we’re doing”. – Community Partner

“The community leaders and members think the research topic is relevant and worth discovering. With both researchers and community leaders and members coming together to do the research, the hope is to create services that will benefit the community someday down the road”.- Community Partner

“I think it would be important to share with the community how academicians have to balance their own needs for promotion and what I call the “bean counting” that we are forced to do as faculty, with the realities of doing (CBPR) research. Again, if the community members haven’t been part of the academic world, they likely will not know what benchmarks we have to meet for our own careers”. – Academic Partner

Principle 5: Empower partners to actively learn from each other and to pay attention to social inequalities

Our society tends to legitimize the perspectives of certain people over others based on age, race, ethnicity, gender identity, sexual orientation, education level, and socio-economic status.

CBPAR works to create institutional change and promote actions to address social inequalities through building meaningful and collaborative processes, discovering valid truths and perspectives, and using the insights to redress health inequities.

Activities and Action Steps:

- Growing in cultural understanding allows partners to acknowledge their key differences and similarities. Partners value differences across cultures, ages, gender identities, institutional affiliations, abilities, education, socio-economic and other differences.
- Rely on community knowledge and expertise to establish roles, rules, and group processes that support all partners’ participation in creating meaningful, lasting action.
- Rely on community knowledge and expertise to establish meaningful, clear language so that research participants will understand the purpose of the research project and what their role is, and will feel that they and their community are respected in the process.
- Bring community perspectives and knowledge into: designing surveys, participatory data

analysis and interpretation

- Participate in partnership evaluation.
- Have a process to explore experiences and perspectives when disagreements or conflicts arise.
 - Resource: Dispute Resolution Center
 - Resource: University of Washington CBPR Partnership Curriculum, Unit 4, Section 4.5: Resolving Conflict

Community and Researcher Perspectives

“The native community can easily be so skirted around because of research and it is important to have conversations around developing trust when community in general has a big amount of distrust, due to many factors, including research that has previously been conducted in the community”- Community Partner

Principle 6: Address how both social and environmental contexts affect health

Communities may suffer from stigma by research that focuses on individual behaviors apart from the broader social and environmental forces that contribute to those behaviors. When research projects focus primarily on individual behaviors, the limited results lead to limited potential solutions.

Activities and Action Steps:

- Identify the social, cultural, historical, and political factors that affect the health issue being studied.
- Consider how these factors can change the response to the health topic being measured.
- Consider how these factors influence the research topic and results.
- Consider how these factors affect how the research results are presented. For example, communications director UMN General Pediatrics and Adolescent Health, Glynis Shea, encourages researchers to consider the messages that are being shared around health disparities. These messages may act as a barrier to public support because they focus on the individual rather than the broader social and environmental forces that lead to individual behavior.
 - Resource: Health Disparities Presentation by Glynis Shea
 - Resource: Health Disparities and Pediatrics Messaging Presentation by Glynis Shea

Community and Researcher Perspectives

“To truly understand the context contributing to behaviors you have to be working in partnership with the people experiencing those behaviors”. –Community Partner

“SoLaHmo recognizes that community-based research does not happen in a vacuum. Rather, it takes place within the context of historical and current social injustices. Throughout history, research has been used to stigmatize, racialize and disempower communities of color and other marginalized groups. SoLaHmo seeks partners who recognize this and who want to engage with us to utilize a CBPAR approach as a tool to advance community agency and self-determination in health equity.”- SoLaHmo Executive Committee

Principle 7: *Share findings and knowledge gained with all partners in a way that can be used to improve community health.*

CBPAR knowledge production is built on a strong collaboration that assumes community access to and ownership of data. The research results need to be shared equitably in ways that both community members and academics can understand. When the community hears about and has access to the findings, and understands the language in which the findings are shared, then they can make effective use of the results and share in the benefits of the research.

Activities and Action Steps:

- A MOU/collaborative agreement should outline location of raw and analyzed data. Will it reside at a community site with University researcher access? Will it reside at the University, and if so how will community have access to the data over the short term and long term? How will data security be maintained?
- Define together what equitable sharing looks like. How should research results be presented so that the community can understand and make use of them?
- Ensure that the results are presented to both the community and academic audiences. This should have been addressed in the MOU and data sharing agreements.

Principle 8: *Involves long-term commitment by all partners*

Many communities have experienced that academic researchers may enter and leave a community as funding varies, regardless of whether or not community goals have been met. In CBPAR, partners commit to a set of common goals with the expectation that every effort will be made to find funding to reach those goals.

Activities and Action Steps:

- Sustainability should be considered at the onset of a project

o Partners should always ask, what will happen when this project ends? What is the plan for community to hold the change that has happened?

- Commitment should be made to seek long term funding

Community and Researcher Perspectives

“Some of this work takes time. You are not going to get it done overnight. You need to have the long term commitment in mind”. – Community Partner

“Administrators need to recognize that we can’t go into community in an uncommitted way. We have to be there for the long term and the project may morph. You have to dive into the river and swim where the river takes you”. – Academic Partner

“The big motivator of this [CBPR] project is the need of the community. I was aware of the need, but we did not have the capacity, and I did not trust the university. The distrust was bigger than the need at that moment. In my mind: Yeah great, but they are going to do what? As always they do research, and then fly and go away, and we will have the same issue in three years, when the project is done. What’s the point?” – Community Partner

Section 3: SoLaHmo’s Partnership Action Steps Along a Project Stages Timeline

Note: Some stages are overlapping and repetitive so that there is flexibility in the stages.

PROJECT STAGE 1: PARTNERSHIP DEVELOPMENT

1. Partnership Exploration Phase

CBPAR Principles: 3,5,7 & 8

- 1-3 meetings to discuss topic and potential partnership
- Determine if all partners are interested in the topic and CBPAR process. Is there a fit?
- Present SoLaHmo decision-making process (typically Consensus)
- Identify research questions and methods together
- Identify grant opportunities
- Attend to ethical considerations:
 - Are community researchers Co-Investigators (Co-I’s)/Co-Principal Investigators (Co- PI’s)?
 - Are SoLaHmo/community members represented at project leadership level?
 - Have there been discussions about how knowledge production will benefit community and advance community health?

- Have there been discussions about how to frame the health topic within social, cultural, historical and political contexts?
- Is the partnership using SoLaHmo Cultural Asset Framework?

2. Collaborative Planning Phase

CBPAR Principle: 3

- Decision to move forward together has been made
- 1-2 initial meetings to develop specific ideas for proposal*
- Develop an initial collaborative agreement with Co-PI's and others as time permits (Project Goals, Decision-Making, Communication, Accountability, Data Access and Use, Conflict, Data Ownership, Dissemination of results, Sustainability)
- Write grant/s
- Develop budget/s: (consider: 6-8 hours for collaborative agreement; translation, transcription, travel, meeting costs with food, participant costs, including childcare and transportation)
- Develop timeline/s
- Complete IRB application when needed (i.e., federal grants)
- Discuss SoLaHmo translation protocol (or one that ensures meaning-for-meaning translation, as opposed to word-for-word translation of your documents and tools), Community Advisory Board processes, and participatory analysis process
- Build time into budget for partnership planning/partnership evaluation
- Attend to ethical considerations
 - Are community researchers Co-Is/Co-PIs?
 - Does the project budget include funds for research participant childcare, transportation, and food?
 - Does budget include funds for community dissemination, including translation of dissemination materials?

PROJECT STAGE 2: IMPLEMENTATION

1. Early Implementation Phase

CBPAR Principles: 2 & 7

- Secure funding
- Form team/s. Discuss individual expectations, reasons for being at the table, and personal assets.
- Develop Collaborative Agreement over 3-4 two-hour meetings: Project Goals, Decision-Making, Communication, Accountability, Data Access and Use, Conflict, Data Ownership, Dissemination of results, Sustainability
- Develop other partnership elements
- Review timeline and deliverables and revise if necessary
- Complete IRB application in collaborative manner. Consider protections for SoLaHmo researcher integrity in own communities, prevent individual & community harm.
- Complete appropriate trainings for academic partners and new SoLaHmo researchers (CBPAR; Optional: SoLaHmo's Community Research Ethics)
- Develop research tools collaboratively (consent forms, recruitment scripts/letters, surveys, interview questions, etc.)
- Develop research methods collaboratively (consider delayed interventions for pilot studies)
- Finalize recruitment strategy
- Discuss dissemination strategy (consider phasing over life of project instead of just at the end)
- Attend to ethical considerations:
 - ✓ Is the partnership applying cultural lens and literacy considerations when developing documents, methods, tools, etc?
 - ✓ Is the partnership utilizing SoLaHmo's translation protocol (or one that ensures meaning-for-meaning translation, as opposed to word-for-word translation to your documents and tools)?
 - ✓ Are SoLaHmo/community partners part of the application and IRB process? Are SoLaHmo/community partners' and organization's integrity being protected or being considered? Is the partnership considering how to prevent both individual and community harm?
 - ✓ Is the partnership using SoLaHmo community/cultural asset framework?

2. Recruitment/Data Collection Phase

CBPAR Principles: 1, 3, 5, 7, 8 & 9 %&
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- Conduct: Recruitment, Consent, Data Collection

- Manage data (data entry, transcription/translation)
- Attend to ethical considerations
 - ✓ Is the partnership applying SoLaHmo cultural asset framework in coding and interpretation?
 - ✓ Is the partnership taking steps to prevent contributing to current or possible stigma in data interpretation?
 - ✓ Are partnership members aware of personal and professional preferences, assumptions, and biases? And has the partnership team discussed these when they arise?

3. Data Analysis/Interpretation Phase

CBPAR Principles: 1, 3, 4 & 6

- Complete participatory analysis training
- Conduct participatory analysis
- Attend to ethical considerations
 - ✓ Is participatory analysis happening so that community partners are involved in each relevant aspect of analysis and interpretation?
 - ✓ Is the partnership discussing the CBPAR process with the entire team and how, when, and where findings will be shared?
 - ✓ Have you discussed how to present findings in a way doesn't reflect negatively on, or create stigma for, the communities that participated in the study?

PROJECT STAGE 3: SHARING RESEARCH FINDINGS & PLANNING NEXT STEPS

1. Sharing Research Findings Phase (Findings shared equitably with community & academic audiences)

CBPAR Principles: 3 & 7

- Share research findings with community members
- Share research findings with academic audiences
- Attend to ethical considerations
 - ✓ Is the partnership discussing the CBPAR process with the entire team and how, when, and where findings will be shared?
 - ✓ Is the partnership considering and discussing about how to present findings in a way that prevents community stigmatization?
 - ✓ Is the partnership developing parallel processes for community & academic

dissemination (make community dissemination a priority)?

- ✓ Are community researchers co-authors/co-presenters on both community and academic dissemination efforts?

2. Planning Next Steps or End of Project Phase

CBPAR Principles: 2, 3, 4, 6, 8 & 9

- Write reports
- Prepare for ongoing dissemination
- Identify next steps (New grants, New goals/methods identified, etc)
- Write further grants
- Attend to ethical considerations
- ✓ Do next steps reflect both community researcher and academic researcher priorities and interpretations?

References and Resources

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Resources Principle 2:

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*Partnership Checklist link:

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Resources Principle 6:

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Corresponding PPT slides: <https://drive.google.com/file/d/0B7ZA9EbqndaoX1h6WlZZQjFY>

Last revised 09/22/2017

Appendix J: Council Photo Gallery



DHS Community Relations Director Antonia Wilcoxon, center, speaks as a member of panel presentation on Organizational Change/Culture of Community Engagement Engaged Learning Series 2 at Neighborhood House in St. Paul.



Avinash Viswanathan, left, of the Community Engagement Institute, speaks at a CECLC meeting while council members Michael Birchard, center, and Dave Haley, listen.



CECLC Chair Vayong Moua, left, leads a council meeting while member Titilayo Bediako listens.



CECLC member Dr. Susie Nanney, left, speaks at a council meeting while DHS staff member Maria Bitanga, right, listens.



CECLC member Jean Lee, right, speaks at a council meeting while council member Patricia Brady listens.



DHS staff member Maria Bitanga gives a presentation at a CECLC meeting. From left are DHS Assistant Commissioner for Health Care Nathan Moracco, CECLC member Dr. Susie Nanney and DHS staff member Mark Foresman.



DHS Deputy Commissioner Chuck Johnson, second from left, provides an overview on the Policy on Equity implementation to CECLC members. CECLC Chair Vayong Moua, left, council member Titilayo Bediako, right, listen.



DHS Community Relations Director Antonia Wilcoxon, second from right, confers with community member Melvin Giles. Rosa Tock, center, from the Minnesota Council on Latino Affairs, and DHS staffer Nicole Juan, also are participants at the CECLC meeting.