

Cultural and Ethnic Communities Leadership Council (CECLC)

Community Relations

February 15, 2014

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Table of Contents

I. Executive summary 4

II. Legislation 6

III. Introduction..... 9

V. Major problems and issues..... 15

VI. Report recommendations 17

VII. CECLC plan of action and implementation strategy for 2014-2015 19

VIII. Appendices..... 22

Appendix A. Disparities Reduction Advisory Committee (DRAC)..... 22

Appendix B. Cultural and Ethnic Communities Leadership Council Survey 23

Appendix C. Summary of Issues from January 17, 2014 CECLC meeting..... 34

Appendix D. Focussed Discussions of Recommendations, January 17, 2014 CECLC meeting 38

Appendix F. Example of coordinated efforts between DHS and MDH to collect and use Race, Ethnicity, and Language (REL) Data 42

Appendix G. Members of CECLC 43

I. **Executive summary**

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

Its purpose is to promote disparities reduction. Reducing disparities and achieving equity requires valuing everyone with focused and ongoing efforts to address avoidable, systematic inequalities, historical and contemporary injustices, and the elimination of disparities.

The council's membership is intended to represent the diversity of Minnesota's population. Its members include:

- The chairs and ranking minority members of the committees in the Minnesota House of Representatives and Senate with jurisdiction over human services
- Members appointed by the commissioner of the Minnesota Department of Human Services, in consultation with county, tribal, cultural, and ethnic communities
- Program participants
- Parent representatives from these communities. and
- Public members of the legislative councils of color established under Minnesota Statutes, chapter 3.

The CECLC has held three meetings: November 15, 2013; December 20, 2013; and January 17, 2014. In addition, a report-writing subcommittee met on Jan. 10, 2014.

These early meetings were chaired by Pam Cosby and facilitated by consultants from the Improve Group. Two questions focused the discussion:

1. What is needed to achieve equity in access and outcomes in Minnesota?
2. How can we align and activate our assets to inform, direct and guide the DHS equity agenda?

This report summarizes the initial work of the Cultural and Ethnic Communities Leadership Council (CECLC) as it prepares to advise the commissioner on ways to reduce disparities in access and outcomes for Minnesota's cultural and ethnic communities. The report provides a preliminary assessment of critical issues and problems and initial recommendations for the Department of Human Services, including requests of DHS to provide additional information to further the discussion of council members.

This report contains:

- An overview of the major problems and issues identified by members regarding access to human services by racial and ethnic groups.
- Objectives that the CECLC seeks to attain during the next biennium.
- Recommendations to address issues.
- Actions to be implemented during the next biennium.

Cultural and Ethnic Communities Leadership Council (CECLC)

As specified in the enabling legislation, this report should also contain a list of programs, groups, and grants used to reduce disparities. The legislation also requires a statistically valid report of outcomes on the reduction of the disparities. This information is not currently available from DHS, and it is hoped that information and findings will be reported in the next legislative report, due February 15, 2015.

Council members agreed on these core principles to guide its work processes:

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

Council members suggested that interdependence and collective action are required to achieve equity in access and outcomes in Minnesota. To model these qualities, the CECLC should:

- **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.

Members of the CECLC plan to address the following objectives:

1. Awareness
2. Leadership
3. Community Health and Health System Experience
4. Cultural and Linguistic Competency
5. Research and Evaluation

Framed to guide efforts that change long-term behavior within state agencies and institutionalizes health equity practice; obtains a baseline of projects, plans, services and policies that help or hinder equity; adds oversight and accountability through a culturally competent lens to the system, and helps policymakers to engage with communities impacted by disparate access and outcomes to services and develop policymaking that are responsive to community voices.

II. Legislation

Effective August 1, 2013.

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

ARTICLE 2

CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL

Section 1. 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. 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 Minnesota Statutes, chapter 3.

Subd. 3. Guidelines. (a) 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.

(b) 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;

Cultural and Ethnic Communities Leadership Council (CECLC)

- (8) Department of Human Services employees; and
- (9) any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

Subd. 4. **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.

Subd. 5. **Chair.** The commissioner shall appoint a chair.

Subd. 6. **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.

Subd. 7. **Terms.** Except for the first appointees, a term shall be for one year and appointees can be appointed to serve two terms. The commissioner shall make appointments to replace vacating members by January 15 every year.

Subd. 8. **Compensation.** Public members of the council shall receive no compensation from the council for their services.

Subd. 9. **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. 10. **Duties of 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 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;

Cultural and Ethnic Communities Leadership Council (CECLC)

(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.

Subd. 11. **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 deem appropriate and necessary to facilitate the goals and duties of the council.

Subd. 12. **Expiration.** The council expires on March 15, 2015.

III. Introduction

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

This report fulfills a mandate in the law, requiring that the council report annually beginning February 15, 2014, identifying major problems confronting racial and ethnic groups, making recommendations to address the issues and problems, and listing objectives for the next biennium.

History

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 was 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 delivered culturally and linguistically competent services to their specific cultural groups. Over the course of a period of four years, 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. It was a period of teaching and learning for both groups. Meetings used democratic participation and inclusion of all voices.

Community members learned about the legislative process from then Chief Compliance Officer Anne Barry (now DHS Deputy Commissioner for Direct Care and Treatment) as she explained the negotiations among legislators and the Governor's office. Community members also gained an understanding of the operations of an agency in the executive branch. State employees that engaged with the group learned that listening to community voices helped better inform their work in policy development in the agency. It also helped build relationships and trust.

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 senior services, medical homes, contracting with outreach agencies to seek and support eligible enrollees, reviewed a chemical health request for proposal for cultural communities, etc.

DRAC members requested that DHS consider changing the scope of the work of the group by establishing a more formal presence in the state agency. In response, DHS introduced the

Cultural and Ethnic Communities Leadership Council (CECLC)

legislative proposal to establish the Cultural and Ethnic Communities Leadership Council in the 2013 session. A similar effort had failed during the 2011 session. The DRAC members wanted to continue the community and agency engagement but sought to become a formal presence within the agency, rather than an informal committee.

DHS employees, who participated in the monthly meetings, reported gaining an increased knowledge. Their comments included:

- “The work of this health disparities workgroup provides a solid springboard for looking at and beginning to resolve these issues.”
- “I now realize how important it is for state agencies, which have such a strong impact on the well-being of our communities, work together in partnership with grass-roots leaders and organizations.”
- “Being together helped to gain a better understanding about needs, the challenges in our respective worlds to address some challenges, and the need to work together to make the best changes possible.”
- The community participation clearly demonstrates that there is great knowledge about the scope of disparities and lots of ideas about how to effectively address some of the causes. The question is who and how does this get done?”
- “I was surprised to learn that the state dropped in national rank when it came to health care because of the increase in the minority population.”

DRAC members received an update from Deputy Commissioner Anne Barry, a champion of this initiative, with the following actions DHS had taken to date, as a result of the committee’s recommendations:

1. DHS is diversifying its workforce by increasing Affirmative Action Goals
2. Senior leaders took Anti-Racism Training and developed actionable items *
3. An Equity Stewardship Work Group was established to implement actionable items
4. The Cultural and Ethnic Communities Leadership Council was established to advise the commissioner on disparities reduction

*Actionable items from senior leadership:

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

IV. Activities of the Cultural and Ethnic Communities Leadership Council (CECLC)

Selection of members

On May 30, 2013, the Secretary of State (SOS) posted the openings for the Cultural and Ethnic Leadership council to the SOS website. Applications were due by July 30, 2013. During this period, DHS utilized several avenues for seeking strong applicants to the Council. Outreach efforts included contacting a network of cultural providers, using community and diverse media outlets, sending press releases to neighborhood papers and disseminating information on the application process to members of the Disparities Reduction Advisory Committee.

The announcement was posted on the DHS homepage <http://mn.gov/dhs/> under “Latest News,” where it appeared for a number of days before it went into the archive: <http://mn.gov/dhs/media/news/news-detail.jsp?id=252-67813>. The information was also posted in the internal DHS website for dissemination internally and to external stakeholders and partners. A news release, sent to hundreds of media outlets (radio, TV, newspapers) statewide on July 12, was published in local papers statewide. Sixty applications were received. A diverse group of DHS employees assisted in the screening process. Final nominations were sent to the commissioner of human services.

Preparation of the report

The Cultural and Ethnic Communities Leadership Council members in collaboration with DHS staff, and consultants from The Improve Group prepared this report. The council used the first meetings starting November 15, 2014 to start defining language they would like to include in the report.

Meetings to date

The council had its first meeting on **November 15, 2013** as written in law. At that meeting council members were introduced and DHS deputy commissioner Chuck Johnson made a presentation about the agency’s organization chart. Discussion started at that meeting to provide items to be included in this report. Council members stated their reasons for applying to join the council as follows:

- “To contribute to the creation of appropriate access to services”
- “To contribute experiences in the field of mental health care and education disparities”

Cultural and Ethnic Communities Leadership Council (CECLC)

- “To work on prevention and health inequities; to explore ways to go upstream and on other sectors”
- “To learn about accountability pieces, sustainability, structural and metrics around equity issues”
- “Interested in cultural competency and policies, issues of diversity and inclusion”
- “Cultural competency and employee and clientele”
- “To learn about policies and rules that impact the community”
- “Promote children’s success in school so they do better”
- “I want to help my community. I live in an African American community and I want to learn so I can help my neighbors”
- “Mental health and education disparities”
- “To find ways for DHS to go upstream and on other sectors to learn about accountability, sustainability, structure and metrics around equity issues”
- “Economic development in minority communities”
- “To dispel the myth of the South Asian community as the ‘model minority’ and to explain that poverty, ESL barriers, represent challenges too for members of the Asian community”

In answer to the question: “what do you wish to see as a result of the work of the council?” these themes emerged:

- Governance (process and implementation)
- Pursuit of better data
- Inclusion and engagement
- Creation of an equity cabinet in collaboration with other agencies, entities
- Equity integrated into vision, project, plans and policies.

The second meeting held **December 20, 2013**, included a review of the work of DRAC, and additional input from CECLC members examining the term disparities and adding as the goal of the council’s work to advance and promote health equity. Bylaws reflect this added wording. The council members agreed to form a subcommittee to meet and dedicate time to prioritize contents of this report. The agency authorized the hiring of a consulting firm to lead the council members in the process.

The meeting also included suggestions from members about meeting attendance, and the possibility of shortening the length of meetings, once this report is finalized. During the public comment, a psychologist working with immigrant populations spoke about his work and the need for more community voices to become engaged.

With the assistance of consultants from the Improve Group, several recommendations and action steps described in this report emerged from the **January 10, 2014** subcommittee meeting. A survey was administered the following week. Extensive work of the full council at its meeting **January 17th, 2014** provided a major portion of the discussions and prioritization process.

Cultural and Ethnic Communities Leadership Council (CECLC)

Group discussions were lively and engaged the council members in a visioning process. Small group discussions asked questions such as major problem or issue, where Minnesota needs to be on this issue, and what would it take to narrow the gap, reduce disparities and achieve equity in access or improve outcomes. Responses varied from finding simple methods to best inform people with disabilities about services and application criteria, to suggestions such as obtaining more data in order to learn the status of this population. Discussion about the adult populations DHS serves included a request to use culturally and linguistically appropriate services standards, as committee members noted that they perceive that equity is not a priority for DHS. Comments encouraging DHS to engage the community to determine what the senior population needs, providing incentives for housing, providers and developers. CECLC members expressed concern about the conditions of children and families and their inability to access culturally competent services, which probably deters some families from seeking help.

What is equity?

Committee members offered these various definitions:

- It is across all state agencies
- Fair
- Just
- Authentic
- Equitable results
- Organically grown
- Everyone has a pair of shoes that fit
- Represents all of us
- It reduces disparities
- Policies are not the same for all groups
- No discrimination
- All Minnesotans (and those who call Minnesota home)
- Responsive
- It is not about equal treatment, but rather differential treatment that is responsive to the specific needs of communities in order to allow equal outcomes.
- Tied to rules and laws so we can measure, enforce (accountability)
- Involve other stakeholders

The discussion also highlighted the importance of **survey data to better understand disparities**, by seeking answers to questions such as:

- What are root causes?
- What about built environment? (Housing, safe neighborhoods, access to fresh fruits/vegetables, etc.
- Language is a factor
- Top – Down and Bottom Up Approach
- Engagement – is essential it has to be infused at all levels

Cultural and Ethnic Communities Leadership Council (CECLC)

- What are standards/laws and their impact on results?
- Cultural competency – cuts across
- How do we institutionalize equity?
- How do we need to define it?
- Needs to be committed
- Prioritize our communities, do not view as a marginal issue
- All Minnesotans? What is the role of immigrants? Un-documented?
- See our communities as assets
- Workforce diversity in providers
- What is cultural competence? It is a continuum, no one ever is fully competent

“It is the combined differential experiences in access to health care, quality of healthcare, and social determinants that result in inequalities in health for racial, ethnic and linguistic minority populations.”

<http://www.dhhs.nh.gov/omh/documents/disparities.pdf>

V. Major problems and issues

“Our zip code may be more important to our health than our genetic code.”

- Robert Wood Johnson Foundation
Commission to Build a Healthier America

CECLC members represent the diversity of populations impacted by disparities in access and outcomes to DHS services. They are aware of how their communities cope with the lack of access to culturally specific services, language barriers, lack of information about resources available to them, and isolation.

CECLC members hope the **council will address several key issues** in the next two years.

1. Disparities and societal factors: institutional and structural bias, poverty, classism
2. Cultural sensitivity/competence/relevancy, equity assessment of the agency
3. DHS leadership demographics match the broader community demographics
4. Increase the number of minority providers
5. Examine which programs are funding disparities reduction and results attained
6. Increase the cultural relevance of policies and the broader system so it is more attuned to the needs of diverse people
7. Engage the broader community, model civic engagement
8. Add oversight and accountability through a culturally competent lens to the system
9. Review DHS’s administrative policies and practices that intersect with affirmative action and equal opportunity laws. These laws include but are not limited to: 45 CFR Part 80, Ex Order 11246, Minn. Statute 16C (Targeted Vendor Program), Minn. Statute 43A, Minn. Statute 363A.(Reviewing the application of these federal and state equal opportunity laws as they intersect with DHS’ practices and procedures would highlight any issues of institutional racism or any areas where there is a lack of cultural competency).
10. Position Minnesota as a leader in culturally competent health integration
11. Increase language accessibility to non-English speaking populations.

This report is but a preliminary document of the initial conversations and thoughts of this new council. The CECLC members are eager to start delving into matters such as concrete definitions, review of reports on disparities in the state of Minnesota, reports published by DHS that documents efforts to reduce disparities and achieve equity, community reports, voices from advocacy communities, cultural leaders, and a review of successful models in the nation.

Cultural and Ethnic Communities Leadership Council (CECLC)

The next meetings will engage members, partners and entities in discussions that provide information for concrete change and an expectation of the agency's responses to this council's recommendations.

VI. Report recommendations

CECLC members have met only three times. The council requested DHS to provide the following items, so members can increase their knowledge about the nature of disparities and recommend efforts to reduce such disparities:

- A list of programs, groups, and grants used to reduce disparities.
- Statistically valid reports of outcomes on the reduction of the disparities.

CECLC members hope the **council will address several key issues** in the next two years:

- DHS leadership demographics that match broader community demographics
- Increase the number of minority providers
- Increase the cultural relevance of policies and the broader system so it is more attuned to the needs of diverse people
- Engage the broader community
- Add oversight and accountability through a culturally competent lens to the system
- Review administrative policies and practices to ensure they allow equal access

There are several **actions that state, local and private agencies can take** to promote equity. Among those the CECLC finds most important:

- Increase cultural competence, sensitivity and awareness
- Encouraging policymakers to engage with cultural and ethnic communities to inform equitable policymaking.
- Model civic engagement
- Position Minnesota as a leader in culturally competent health integration

The CECLC finds that **economic stability and education are urgent needs demanding attention**, health and health care, social and community context and the physical environment form strong interconnecting relationships. These factors demand balanced incremental and comprehensive approaches. Other factors that are critical to address are

- Culturally-specific care
- Mental health
- Access to healthy food and other basic needs
- Chronic health needs.

While there are many, many causes of disparities, several noted that **institutional racism and lack of cultural competency play a significant role.**

CECLC members hope that addressing these issues will lead to **policies that promote equity** rather than sustain disparities; a **broader, authentic perspective in setting priorities**; good **measures of equity** that are sensitive enough to include the priorities of diverse groups and measure outcomes within each group; and **improved health** specifically for those who have had disproportionately poor health. They want to see dollars spent where they are most needed.

The following Action Plan is a framework based on the National Partnership for Action to End Health Disparities. It will guide the work of the CECLC in the next biennium. CECLC members will meet in the next months to develop detailed action steps, indicators and outcomes to recommend to DHS for implementation. CECLC members voiced that DHS has to put funding and human resources to ensure durability of efforts. The next legislative report will contain a description of results attained, successes and challenges with potential recommendations for further action by DHS. The CECLC will engage several partners in this effort.

VII. CECLC plan of action and implementation strategy for 2014-2015

Action Plan: Present a collection of specific *Objectives, Action Steps, Potential Partners, and Measures* to address health and human services disparities and achieve equity in the state.

The Action Plan's main objectives include:

Objective 1: AWARENESS

- Increase awareness and promote the significance of health and human services disparities, and their impact on the state and local communities, and the actions necessary to improve health outcomes for Minnesota's cultural and ethnic populations.
- Increase public understanding of health disparities by developing partnerships, communication strategies, and new approaches to putting the issues prominently in the agency's organization agendas.

Objective 2: LEADERSHIP

- Diversify and broaden leadership for addressing health disparities and achieving equity at all levels.
- Use partnerships. This is critical to multiple and complex problems.
- Build the capacity to create community solutions, improve the coordination of funding, and set priorities.
- Identify best practices and work with the MN Department of Human Services and the legislature to effectively invest in youth, preparing them to be future leaders.

Objective 3: COMMUNITY HEALTH AND HEALTH SYSTEM EXPERIENCE

- Improve access to quality care, including: children's services for mental health, oral health, vision, hearing, nutrition and physical activities and services to older adults.
- Address social determinants of health through work on issues and policies intended to create social, emotional, physical, and economic environments in which children can succeed
- Improve health, health care and human services outcomes for cultural and ethnic communities and underserved populations and communities.

Objective 4: CULTURAL AND LINGUISTIC COMPETENCY

- Improve cultural and linguistic competency by integrating foreign trained health care professionals into the healthcare system..
- Adopt the enhanced CLAS standards, Non-Discrimination: mandated by federal civil rights, moral imperative and practical necessity to achieve health equity.

Cultural and Ethnic Communities Leadership Council (CECLC)

- Identify best practices and work with the MN Department of Human Services and the legislature to improve diversity in the work force, increasing opportunities to recruit minorities into the health professions.
- Improve cultural competency by supporting competent interpreting and translation services and training more community health workers to serve as liaisons between patients and clinicians/health providers.

Objective 5: RESEARCH AND EVALUATION

- Improve coordination and use of research and evaluation outcomes.
- Educate the public about the collection of race, ethnicity and language data
- Educate state agencies and DHS on the import of community-based participatory research methods in order to insert education as a mutual process and responsibility.
- Embrace mixed methods.
- Acquire and analyze data to enhance decisions through better research coordination, and promote translation of evidence-based research into practice.
- Review participants' complaints reported directly to DHS – have they been resolved? Is there a trend/pattern? Is there a need to address policies, procedures or clarify communication? etc.

(National Stakeholder Strategy for Achieving Health Equity; National Partnership for Action)

The strategy includes the following steps:

1. Form Action Committees for each of the five plan objectives;
2. Recruit partners to form a collaborative effort
3. Develop an Action Plan for the CECLC and partners;
4. Present the Action Steps to the full council and other stakeholders/partners;
5. Finalize the Action Plan with identified partners;
6. Begin Action Plan Implementation in partnership with identified agencies and community stakeholders.
7. Sustain activities by actively engaging partners
8. Continuously improve the CECLC and partners work through evaluation.
9. Develop a budget to support the planning and implementation of this plan.

10. Identify funding sources

Potential Partners in this effort:

- Health Partners
- Health East
- U-Care
- Fairview Hospitals
- Blue Cross Blue Shield
- FQHCs (see association website for list)
- Open Cities
- North Point
- Southside clinic
- Neighborhood Health Source
- La Clinica
- Washburn
- African American Family Services
- MFIP
- Health care homes
- Office of Minority and Cultural Health
- Minnesota Department of Health
- Cultural Wellness Center
- Other hospitals, clinics, health care organizations, etc.
- Organizations that offer other social services
- Other community-based organizations
- Other state agencies
- Advocacy organizations
- The Ethnic Councils
- The Office of Ombudspersons for Families
- The offices of Ombudsman for the various populations served by DHS
- University of Minnesota, School of Public Health
- University of Minnesota, Program in Health Disparities Research
- Minnesota Department of Human Rights
- Other entities

VIII. Appendices

Appendix A. Disparities Reduction Advisory Committee (DRAC)

The DRAC recommended that the fundamental goals of the National Partnership for Action (NPA) reflected the strategic lenses developed for DRAC members. At the final December 2012 meeting they agreed to adopt the principles.

They are listed as follows:

1. **Research and Evaluation.** What is it that we need to know about disparities at DHS? What are nationwide best practices?
2. **Partner to Educate about Disparities.** Learn together foundational topics, issues of historical trauma, discrimination, identify audiences, outreach to staff, partners, community.
3. **Reform Policies that Perpetuate Disparities.** History of policy making; analysis of specific policy, recommendations for change.
4. **Fund Reform and Transparency.** Focus on prevention, intervention and cost effectiveness; publish an annual “state of human services” by commissioner.
5. **Ensure Accountability.** Examine current policies and procedures; track findings, increase the participation of others.

Fundamental NPA Goals:

1. Awareness
2. Leadership
3. Health system and life experience
4. Cultural and linguistic competency
5. Data, research and evaluation

DRAC Strategic Lenses

Fund reform and transparency
Ensure accountability
Reform policies that perpetuate disparities,
Partner to educate about disparities
Research and Evaluation, Ensure ...

The DRAC also adopted the **fundamental principles of the NPA:**

Community engagement and leadership
Partnerships – critical to multiple and complex problems
Cultural and Linguistic Competency
Non-Discrimination: mandated by federal civil rights, moral imperative and practical necessity to achieve health equity.

DRAC Community Partners:

MDH, Office of Minority and Multicultural Health, Jose Gonzalez
Hmong American Partnership
Hennepin, Olmsted and Wright Counties
Ramsey County Commissioner Carter
CLUES
Cultural Councils
Office of Ombudspersons for Families
Health East Care System
Prevent Child Abuse Minnesota

Cultural and Ethnic Communities Leadership Council (CECLC)

Cultural Providers Network
Wilder Foundation
West Side Health Clinic
Minneapolis Urban League
Other community members not affiliated with an agency.

DHS Staff

Linda Atlas, Continuing Care
Geoffrey Barnes, SOS
Ruthie Dallas, Chemical Health
Jane Delage, Children and Family Services
Helen Ghebre, Adult Mental Health
Anna Lynn, Children's Mental Health
Vern LaPlante, Operations
James McRae, Health Care Administration
Constance Tuck, Office for Equity & Agency Development.
Carole Wilcox, Children and Family Services

Appendix B. Cultural and Ethnic Communities Leadership Council Survey

Summary

This survey was administered to the Cultural and Ethnic Communities Leadership Council (CECLC) January 13-16. The full results are attached. Key highlights are:

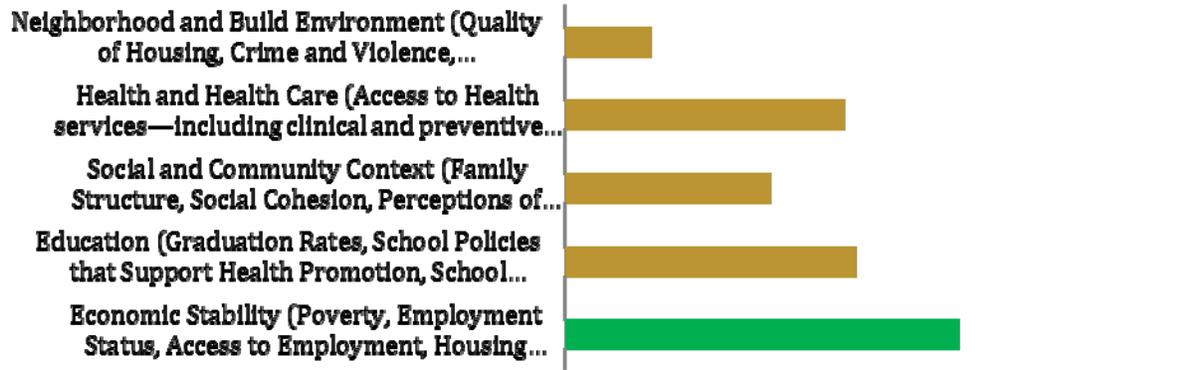
- The CECLC describes its work as **promoting health equity**. The CECLC has **core agreements to ensure its work is inclusive and productive**. These are:
 - Everyone is heard: practice active listening, build connections to others before and after meetings, and include opportunities for stakeholder input
 - All voices are honored: practice compassion 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 for input
 - Embrace tension: practice addressing issues where there isn't clear agreement, spend time ensuring everyone feels safe to discuss their point of view
- The CECLC should:
 - 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

Cultural and Ethnic Communities Leadership Council (CECLC)

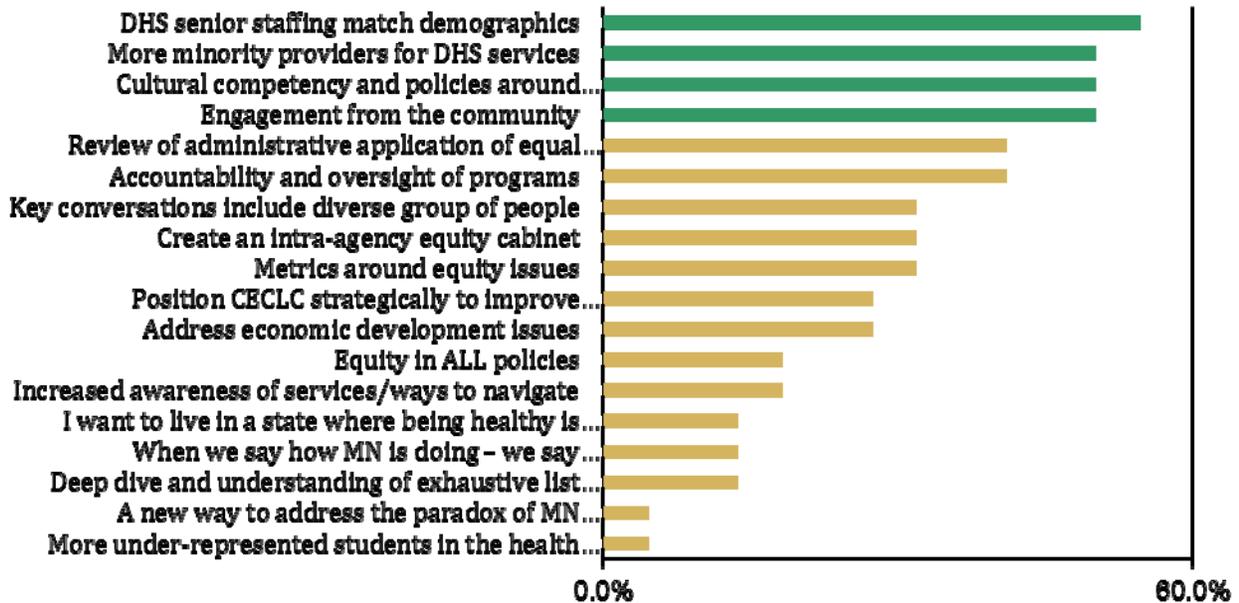
- DO reach out to a broader community to make sure they are represented and dig deep into the root issues and possible solutions
- CECLC members hope the **council will address several key issues** in the next two years; having DHS leadership demographics that match broader community demographics was very important, as was increasing the number of minority providers, increasing the cultural relevance of policies and the broader system so it is more attuned to the needs of diverse people, engaging the broader community, adding oversight and accountability through a culturally competent lens to the system, and reviewing administrative policies and practices to ensure they allow equal access
- There are several **actions that State, local and private agencies can take** to promote equity. Among those the CECLC finds important, increasing cultural competence, helping policy makers see diverse communities, modeling civic engagement, and positioning Minnesota as a leader in culturally competent health integration were among the top suggestions.
- The CECLC finds that **economic stability and education are the most urgent needs demanding attention**, but health and health care, social and community context and the physical environment all play important roles, too. Other factors that are critical to address are culturally-specific care, mental health, access to healthy food and other basic needs, and chronic health needs. While there are many, many causes of disparities, several noted that **institutional racism and lack of cultural competency play a significant role**.
- CECLC members hope that addressing these issues will lead to **policies that promote equity** rather than sustain disparities; a **broader, authentic perspective in setting priorities**; good **measures of equity** that are sensitive enough to include the priorities of diverse groups and measure outcomes within each group; and **improved health** specifically for those who have had disproportionately poor health. They want to see dollars spent where they are most needed.

Data

The CECLC rated the five Social Determinants of Health according to Healthy People 2020 (U.S. Department of Health and Human Services). Economic stability was identified as having the greatest urgency.



The CECLC has big visions for what its work will accomplish.



Cultural and Ethnic Communities Leadership Council (CECLC)

The CECLC has already begun forming recommendations for policy.



Long-answer responses

During the January 10 meeting, members suggested ways the Council could ensure its work is inclusive and productive. What would you change or add?

3. integrity

Agree with all points

I like these.

I would add that we come up with both long and short-term steps so that we can make some progress - sometimes we get too stuck in the big vision without considering the steps that can take us there, and then we don't make movement.

4. Transparency: sharing information between members in order to make an informed decision

Cannot think of anything right now.

I think this reflects well the conversation to date

Integrity: Attendance at meetings is a priority; Everyone is Heard: Round robin to hear from all. Some people won't always speak up and some people speak up every time.

Follow through: If someone volunteers to complete action item, the item should be completed on time and presented to the group.

Transparency: The ability to see the whole while elevating the expertise you have acquired to serve the good will of the whole. Empowerment: The motivation to support those who aren't able or savvy enough to navigate the legalistic dynamics that appear to separate the interest of the whole.

That our effort is focused on policy and systems change so that the change is impactful and durable

There is nothing that I would change or add at this time.

None

We just need to take full advantage of this opportunity and effect a systemic change.

These are good!

4) Intentionally and systematically distribute the report to the Legislature to a wider audience through the networks of the Council for Black Minnesotans, etc. 5) Sponsor and organize focus groups of service recipients to discuss and get their reaction to the primary or priority problems we identify in our initial report.

I would like to combine 1 and 6. I think we should at all-time be able to keep the lines of communication open and document differences.

4. Transparency - giving context to questions/responses/statements 5. Empowerment - speak up if you agree or have another example to strengthen an argument someone is making/point of view someone is trying to get across 6. Embrace tension - also add WHY we disagree to "talk about and report where we disagree"

None

Transparency; Create an environment of trust, security and openness between the members, so each member is informed and aware of the responsibilities, procedures, rules, regulations and other information that could help them to have an open participation. Empowerment; Being positive; Identify common goals; create synergy; to know where we want to go (Vision); changing old paradigms.

4. Publish the Department reviews of the administrative application of equal access and opportunity policies, rules and laws

5. Empower the community what equal access and opportunity laws intersect with the department and encourage them to hold the department accountable for their application.

6. Ensure frank discussions and ensure no prosecution for being frank and honest

Cultural and Ethnic Communities Leadership Council (CECLC)

During the January 10 meeting, members suggested that **interdependence and collective action are required to achieve equity in access and outcomes in Minnesota**. What should the Council BE, KNOW and DO to model these qualities?

BE...	KNOW...	DO...
a place and time to share what we share in terms of our hopes and vision.	that we're not all the same, no matter what everyone would like to say for political reasons. our communities of color are very different and as such, we require different approaches and messages.	recognize and practice what we know: communities can aspire to the same things, but we have different ways of going about them. an aggressive approach is not an approach for all of us.
inclusive	all members points of view in depth	facilitate common understanding
flexible and creative	about promising practices	engage to gain a deeper understanding
available, present, and engaged for the entire meetings - coming late/leaving early/missing meetings should be the exception	the expectation of the council	come up with both vision and tasks to achieve those guiding visions
skip		
thorough	the facts	action based on BEing and KNOWing
Public	This is societal change we are attempting to achieve (very difficult)	Work in broader circles to expand community understanding
A voice of their represented communities	the issues/concerns of their community	Educate communities with information learned
Diverse	Quantitative and qualitative data	requests all members to bring information to the council and share information from the council with their respective communities
respectful of our uniqueness	there is power in the collective wisdom of all	what you can to elevate the best interest for all.
powerful: have the ability to influence meaningful change, mobilize human/financial resources, and have high priority within DHS/state	key functions/structure of DHS and how equity is applied or missing in current practice, plans, and policy	create intellectual, cultural, and community based capital to advance equity with DHS
The council should be synergistic to achieve equity access.	Our differences provide us with the opportunity to hopefully better understand one another.	Actively embrace the six points for working together that are articulated in number one.
open	that the needs of individual groups could vary	listen and be open minded
Pro active	How to effect a real change	Dig deep into the root causes and address them head on
Consistent	The laws that pertain to our work on the committee	Read all materials, have principled conversations and develop relationships

Cultural and Ethnic Communities Leadership Council (CECLC)

BE...	KNOW...	DO...
proactive in learning from the experience of service recipients as they access the system.	that we are generating ideas for others to build upon, that we will not solve this issue with one set of recommendations, but that we can significantly move the needle.	with those we do not know. When appropriate talk with legislators about our recommendations identify some of the larger issues beyond programs within DHS, such as accessible, safe and affordable housing.
Represent and include the voice of all communities of MN		At all times transparent.
reflective of the community voices and the community experiences (speak as a member of the community & on behalf of the community that you work with and NOT from your point of view based on your position) transparent	that everyone (within the council and in the community) are from different backgrounds, different experiences, and different points in life; what is "common knowledge" or a simple solution/answer may not apply to every individual or group in the community. the impact of historical trauma and institutional racism	We should "meet people where they are at". This phrase, to me, at it's core ultimately means we should not have prerequisites that define when we will work with people but rather in the process of working with others help them understand the system/protocol/terminology/etc. we are working with. This will be a better way to promote collective action and reduce the "us versus them" mentality. no harm
It should be a forum for debate where all opinions, ideas and suggestions should be taken into account, respecting differences and working on the search for a common goal.	what is the vision that we have as a council	focused on the goals and vision
committed to the administrative application of equal access and opportunity policies, rules and laws	if the administrative application of equal access and opportunity policies, rules and laws is being done	reviews of the administrative application of equal access and opportunity policies, rules and laws, and publish

Cultural and Ethnic Communities Leadership Council (CECLC)

There are numerous gaps and root causes related to disparities/inequities. **What are the major problems or issues in your community or organization that need to be explored by DHS and the CECLC?** Access to healthier food Alcohol & Drug Abuse Asthma Cancer Incidence

Chronic health conditions - Diabetes, Stroke & Coronary Heart Disease Drug-induced deaths
Education Homicide HIV/AIDS Income Infant Mortality Infectious Diseases Mental Health Motor
vehicle-related death Obesity Physical Health Pre-Term Birth Smoking/Tobacco Suicide
Unemployment

Education; unemployment; mental health; income; chronic health conditions; physical health

- Unemployment has a correlation to poverty and mental health which often affects physical health. -
Access to health services for immigrant populations that don't meet the 5 year bar for MA or MCRE. -
High cost to buy coverage on private market and providers that lack cultural competency to address
health needs.

Education; Unemployment; Chronic health conditions; Mental health; Obesity; Smoking-Tobacco; Drug-
induced death

Income/Poverty; Mental Health; Chronic Health Conditions

Poverty; Obesity; Language barriers and cultural differences; Lack of understanding of the American
laws and/or the system; Lack of trust in the government system, the justice system, the health care
system, service providers, law officers, etc.; Mental Health; Unemployment; Chronic health conditions;
Violence domestic abuse and under reporting child maltreatment

lack of a diversified culturally appropriate workforce which delivers healthcare service (doctors, nurses,
etc.)

unemployment, education, obesity, mental health

All of these

Chronic health conditions - Diabetes, Stroke & Coronary Heart Disease; Income; Smoking/Tobacco;
Unemployment

Incarceration; Unemployment; Homicides; Cancer Incidence; Mental Health; Chronic Healthcare issues;
Obesity; Education

- Structural inequities in resources, competencies, and priorities to support and advance cultural
communities; - Lack of political priority to address inequities, this is less of a scientific or singular issue,
rather a political and systemic one. Policy makers and mainstream institutions need to value and
commit resources to advancing equity; - Lack of culturally and linguistically competent staff/services

Economic inequity.

Culturally specific care

Mental Health

Education, obesity, mental health, income, unemployment

1) Income 2) Unemployment 3) Education

Chronic Health Conditions; Education gap; Mental health; Access to healthier food....

A lot of things are interconnected but here is how I see things: * Income and poverty, which is often as a
result of unemployment or underemployment which is a result of lack of education or a strong skill set *
Mental health is also an issue due to stress and anxiety as a result of living in poverty/unemployment/an
individual's perception of not being able to improve their life * Chronic health conditions

Income; Mental Health; Education

Education; Mental health

Human/civil rights enforcement

Mental health; physical, suicide; access to healthier foods

Cultural and Ethnic Communities Leadership Council (CECLC)

Following are some of the causes of disparities/inequities that were mentioned at the January 10 meeting. **What would you add?** Economic Issues - e.g., poverty Access to education/training Isolation Violence/Crime Incarceration Internalized Racism Stress Cultural Insensitivity Dysfunctional Communication (within and across cultures)

-lack of knowledge and acknowledgement about how different racial groups are -need for disaggregated data -cultural/socio-historical and political histories of people

- Institutionalized and structural racism - we can deconstruct this with support and buy in from leadership and political will.

none

bureaucratic statutes

Language barriers/ cultural differences; Discrimination/Oppression; Bias

lack of a diversified culturally appropriate workforce which delivers healthcare service (doctors, nurses, etc.)

affordable housing

None

Learned helplessness Culture of poverty/welfare

Bullying; Microaggressions unaddressed; lack resources for family empowerment (individual and community); Reactive Thinking (No proactive services)

- Structural racism and the lack of understanding on what that is and how it manifests itself in the behavior of organizations and systems; - Inequities is still seen as a marginal issue for marginal communities, rather than a common good issue that impacts everyone

There is nothing that I would add to the list at this time.

health information in different languages; Health care navigation - lost in the system / process

Not having meaningful access to health care.

These are good

* Employment Opportunities; * View that this is a zero-sum game and as result the perceived benefit by majority community of maintaining a dominant position.

Race relations among policy makers.

I would like to flesh out "access to education/training" and add not only access but also creating awareness of how different issues can impact multiple areas of our lives

None. Good start

legal status.; language barriers; cultural differences in the perception of health

Institutional racism/bias

racism; lack of employment, educational equity

Cultural and Ethnic Communities Leadership Council (CECLC)

Imagine it is two years from today and that DHS, its partners and its stakeholders have lived up to its commitments to equity in access and outcomes. What is the single **MOST IMPORTANT OUTCOME** that you would like to see happen as a result of the CECLC's work?

that Asian Americans are brought into the conversations about disparities without people asking about them. currently, it's a black and white paradigm everyone is operating from, in, and toward.

systematic and structural changes to address equity. positive health outcomes for communities of color that receive services from DHS and more Diverse and equity minded executive leaders in the agency. coordination with the Public Health Department on these efforts and capacity building for county and servicing agencies/partners, etc.

reduced health disparities

Re-evaluation and structuring of DHS policies to allow greater and culturally competent access to health and mental health care

Put an end to inequities in accessing to MN public, private, and government services

increased diversity at the decision making level of DHS and increased diversity in the delivery of health care

More people of color and more people at the poverty level access DHS services

We see the MN qualities we all value more broadly available to all Minnesotans

Health disparities lessened

We have created a culture that has embraced the inclusivity of all cultures in policy and planning for all citizens in Minnesota.

Accountability structure to ensure continuation of equity advanced across state agencies. This can't be a one shot effort, needs to belong to a sustainable and structural change in how we govern and meet the needs of cultural and ethnic communities. This occurs when we have an accountability structure that has power (people, knowledge, money, and influence)

Barriers to equal health access no longer exist, or, if they do, that they barely exist.

Cultural sensitivity

more minority providers having contracts with DHS in order to deliver services to their communities.

Cultural understanding and sensitivity to everyone who lives in MN

Increase in the percentage of dollars used to provide earlier supports to the families we currently work with, especially communities of color.

Intentional efforts to decrease the imbalance in health outcomes

Most important outcome would be that being healthy and educated is not a privilege - multicultural communities and minority communities (minority as in the disabled population) are no longer the outliers or exceptions to the big picture (i.e. poverty has been significantly reduced within the state but only moderately when we look at communities of color and minority groups).

clear data indicating equitable outcomes (positive) for all populations regardless of race/ethnicity/language

Quality of services and social inclusion

The administrative application of equal access and opportunity policies, rules and laws

healthier poor people

Cultural and Ethnic Communities Leadership Council (CECLC)

Use this space to share **any additional thoughts, ideas, questions, requests or issues** about the January 17 meeting or CECLC's work.

A' Report" or summary of recs. to the legislature will be great. I hope to include some action steps and create a pathway for equity to become a reality. Visual tools and images can also help articulate what we want. Although we are working in the government structure, I think there is room for creativity i.e.- video footage, sound bites, quotes, etc. especially since our communities often communicate in this way.

good progress

skip this

None.

We need to dedicate some time for a deep examination of DHS programs and policies and apply equity lens to improving them. Also, we need to zoom out and make sure we're setting a powerful and optimal infrastructure ensure structural change.

Authentic effort will be evident in what this committee delivers as a end product.

NA

We need to not shy away from the fact that what we are talking about here is who gets the money to provide the services therefore we need to follow the money penny by penny.

I sincerely hope it is a very productive meeting.

How can we determine if we are doing something different than before. It is important not be status quo. We need to make sure the hard questions are answered. Can't be nice. We really have a job before us. On one hand, we need to be honest, then on the other we can't be ignored.

none

The administrative application of equal access and opportunity policies, rules and laws

Appendix C. Summary of Issues from January 17, 2014 CECLC meeting

PEOPLE WITH DISABILITIES		
<i>Major Problem or Issue</i>	<i>Where does Minnesota need to be on this?</i>	<i>What would it take to narrow the gap, achieve equity in access or improve outcomes?</i>
<ul style="list-style-type: none"> • Prioritize investigation of maltreatment reports for Cultural and Ethnic Communities, esp. when there are language challenges <p>Access:</p> <ul style="list-style-type: none"> • Simple methods to be informed about available services and application processes. Culturally and Linguistically Appropriate standards (CLAS)? • Simplified re-certification process • Culturally responsive testing (assessment) • -Mental health • If a person lives in MN, they are eligible. If people are assessed to have a disability, services should be provided. 	<ul style="list-style-type: none"> • Where are we now? Baseline statistics? • All maltreatment investigations must be responded to and resolved. • MN #'s • Strengthen Council on Disabilities to address Cultural and Ethnic Communities' concerns • Strengthen collaborations between Councils of color on/with issues of people with disabilities • Apply "PRISM" of cultural lens 	<ul style="list-style-type: none"> • Better data on: <ul style="list-style-type: none"> -Who gets identified as a person with disability? • -What are statistics on Race/Ethnicity for persons with disability? • Recommend improved race, ethnicity, language data collection standards • Culturally responsive assessment and treatment tools • Accessing or not services • Over/Under diagnoses

ADULTS		
<i>Major Problem or Issue</i>	<i>Where does MN need to be on this?</i>	<i>What would it take to narrow the gap, achieve equity in access or improve outcomes?</i>
<ul style="list-style-type: none"> • Prioritize investigation of maltreatment reports for cultural and ethnic communities, esp. when there are language challenges. • Access: utilize simple methods to be informed about available services and application processes. Use the Culturally and Linguistically Appropriate Services standards (CLAS) • Equity is not a priority • Culturally sensitive health centers, clinics, recreational sites • Certification process • Explore use of a simplified re-certification 	<ul style="list-style-type: none"> • Leading change, not last. • Equity notes/impact statement on bills • DHS leading it, based on our demographic. • Responsive to unique, changing demographic. (i.e., Large Somali population, where do they go for recreation that honors their religious traditions?) • Resources are available to prevent unlawful illegal diagnosed to get worse rather than better. • Assessment of placement locale and how to service the population of people being placed & communities they are placed in! 	<ul style="list-style-type: none"> • Data requirements on all outcomes • Frequency of reviews & scorecards -- backed by human & financial resources • Impact review tool constantly monitored • Communities are expected to meet the needs of all cultures--from their unique needs respectfully. • Include them in the decision process (Blanket expectations. YMCA does it.) • Review current practices for gaps in services • Culturally responsive research, resources, tools for triage services (No warehousing).

SENIORS		
Major Problem or Issue	Where does MN need to be on this?	What would it take to narrow the gap, achieve equity in access or improve outcomes?
<ul style="list-style-type: none"> • Growth: This demographic is going to grow tremendously and along with increasing diversity, the demand for culturally appropriate services will increase. • Also, increased stress to families • Long-term care: Capacity and reimbursement • Asset test • Staying in your own home (rather than other housing institutions) • Elder fraud/abuse • Transportation (esp. rural areas) • Access to healthy foods 	<ul style="list-style-type: none"> • "Getting ready" • Facilities (all levels of care) in the community to meet the diverse needs of the seniors in community • Strong protections for seniors 	<ul style="list-style-type: none"> • Engage the community to determine what the seniors need • Incentives for housing, providers, developers • Review the rates and adjust it, if necessary, to ensure that rates adequately encourage the use of PCA, etc., to meet the needs of seniors • Engagement of providers and legislators • Increase oversight and regulatory investigative authority • Increased funding for Metro Mobility • Work with Met Council to match transportation with housing

CHILDREN AND FAMILIES		
Major Problem or Issue	Where does MN need to be on this?	What would it take to narrow the gap, achieve equity in access or improve outcomes?
<ul style="list-style-type: none"> • Lack of culturally competent policies that drive culturally competent services: • leads to families lack of faith in systems, • deters instead of promoting participation • leads to pre-determined 'solution'/results even before situation is assessed • services don't serve the population • Solving problems of populations that "don't exist" (i.e. undocumented) • Not taking a whole family approach to treatment but individualistic approach • cultural communities are more group/community oriented • Turn policy into practice • Policies are in place but do not make an impact or play out 	<ul style="list-style-type: none"> • Eliminating assumptions, promoting understanding • Euro-ethnocentric model/philosophy does not apply or work with all groups • Culturally competent services <ul style="list-style-type: none"> -child protection services -safe houses for youth & battered women that are culturally competent • Defining what services/programs will be in place • Transparency of criteria/requirements to receive services • DHS requirements that enforce programs to align with community needs 	<ul style="list-style-type: none"> • Take a cultural approach to solving problems, to delivering services • Create more community providers

Appendix D. Focused Discussions of Recommendations, January 17, 2014 CECLC meeting

1. People with Disabilities (defined as mental, physical and behavioral)

At an individual level: learn what services are currently available

At a community level: engage to increase access, accessibility and competence; educate, advocate, lobby

At the Health Services level: rates for services through DHS should promote quality services and be fair (i.e., community health workers' training)

Policy Makers: as gatekeepers who are at the table where decisions are made, shift to community representative to advise, lessen the risk; acknowledgement of all Minnesotan, people with legal footing to be enforced/promote accountability; educate, advocate, lobby

CECLC: subsets with cultural groups, gender and class with cultural groups, LGBTQ

Other: accessibility in health services (documents and technical with legal compliance), to buildings, etc. authority; political consequence, standards.

2. Adults

Individual: knowledge: understanding, nuances/plethora of resources available; ability to navigate systems and services, competency

Community: empowerment to speak up and speak out

Health Services: policies and rules: are they perpetuating the social conditions? Common understanding, extra barriers (hurdles) for providers to jump through; rulings for mental health need to be compared/assessed; look at various domains, where is equity not playing a role?

Policy Makers: funding that will impact community and things that will impact us; funding programs and services for the population you serve; equity needs to be a political issue (aka political commodity)

CECLC: equitable process, systems, outcomes; deep community engagement that includes more perspectives, experiences, and more reflective as environment, time, challenges change; sustainable, short-term vs. long-term; focus on vision: don't lose sight of ultimate goal in process; accountability structure, authority beyond words and deeds, move from reactive to proactive; choosing proven action-based practices to guide (work)

Other: are policies and rules aligned with others in the nation? Have a scorecard for DHS services and programs

3. Seniors

Individual: know where to go where my needs will be met; understand and access all available services; choice and right to live in dignity in the environment of choice

Community: ownership, engagement, supports for individuals; engage the political process to support individuals

Health services: create policies that meet the need of the community; create policies that integrate foreign trained health professionals; utilize the assets of the community to meet needs of the community members; provide funding available for grants

CECLC: accountability practices

3. Children and Families

Individual: respectful, responsive accountability

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Community: education: equal resources for each school and after-school programs; relating to achievement gap: opportunity, staff qualifications; open enrollment process: charter schools serving specialty populations; English Language Learners: are being currently separated from their classmates, this creates barriers to student's learning English; knowledge and awareness available to families: housing, deduction, transportation, food, employment; language access: second language learners do not necessarily know the culture; need for quality translation; do not assume that everyone can read/write; community

Health services: DHS needs to have stringent requirements for vendors to work with communities, i.e., grants for families and immigrants (with legal status), health centers are funded by DHS, need more transparency, more empowerment and involvement in the community

Policy makers: invite people of color to the table when making policy impacting them; have diverse pagers and aides

CECLC: DHS should have cultural advisors for various populations to assist people who do not speak English

Other: Asian communities do not have a clear understanding of child protection; they don't know that their children can be removed and separated from families; education; competent and trained interpreters; persons who speak the language should provide the services, in family court they have trained interpreters; there needs to be a standard for interpreters; disproportionate representation of families of color in child protection services.

Appendix E. Identification of the major problems and issues confronting racial and ethnic groups in accessing human services, an exercise led by consultants generated the following comments. Items from this discussion will form an action steps for the CECLC Action Plan.

People with Disabilities

1. Baseline information about the status of cultural and ethnic communities in the Disabilities Services
2. Criteria for determining disability status for individuals
3. Race/ethnicity/language data collection standards
4. Baseline information on current maltreatment reports for cultural and ethnic communities
5. Use of culturally-responsive assessment and treatment tools
6. Learn what services are currently available
7. Engage to increase access, accessibility and competence; educate, advocate, lobby
8. What rates for services through DHS should promote quality services and be fair (i.e., community health workers' training)
9. Policy Makers: as gatekeepers who are at the table where decisions are made, shift to community representative to advise, lessen the risk; acknowledgement of all Minnesotan, people with legal footing to be enforced/promote accountability; educate, advocate, lobby
10. CECLC: subsets with cultural groups, gender and class with cultural groups, LGBTQ
11. Other: accessibility in health services (documents and technical with legal compliance), to buildings, etc. authority; political consequence, standards.

Adults

1. Data requirements on outcomes, community inclusion in decisions

Cultural and Ethnic Communities Leadership Council (CECLC)

2. Review administrative policies and practices to ensure they allow equal access.
3. Use of an impact review tool such as the one adopted by King County in the state of Washington
4. Data requirements currently in place, monitoring/scorecards
5. Culturally sensitive/responsive health centers, clinics, places of recreation
6. Individual: knowledge: understanding, nuances/plethora of resources available; ability to navigate systems and services, competency
7. Community empowerment to speak up and speak out
8. An analysis of the policies and rules: are they perpetuating the social conditions? Common understanding, extra barriers (hurdles) for providers to jump through; rulings for mental health need to be compared/assessed; look at various domains, where is equity not playing a role?
9. Policy Makers: funding that will impact community and things that will impact us; funding programs and services for the population you serve; equity needs to be a political issue (aka political commodity)
10. CECLC: equitable process, systems, outcomes; deep community engagement that includes more perspectives, experiences, and more reflective as environment, time, challenges change; sustainable, short-term vs. long-term; focus on vision: don't lose sight of ultimate goal in process; accountability structure, authority beyond words and deeds, move from reactive to proactive; choosing proven action-based practices to guide (work)
11. Other: are policies and rules aligned with others in the nation? Have a scorecard for DHS services and programs

Seniors

1. How is DHS getting ready for the changing demographics?
2. Long-term care reimbursement, asset-testing, elder protection
3. Engage community to determine needs and gaps in services
4. Increase oversight/regulatory investigative authority
5. Partner with Met Council to increase funding for transportation/housing
6. Know where to go where my needs will be met; understand and access all available services; choice and right to live in dignity in the environment of choice
7. Community: ownership, engagement, supports for individuals; engage the political process to support individuals
8. Health services: create policies that meet the needs of the community; create policies that integrate foreign trained health professionals; utilize the assets of the community to meet needs of the community members; provide funding available for grants
9. CECLC: accountability practices

Children and Families

1. Culturally competent policies that drive culturally competent services
2. Solving problems of the un-documented population
3. Taking a whole family approach to treatment/intervention
4. Taking a cultural approach to solving problems to delivering services
5. Increase awareness of the child welfare system to cultural and ethnic communities
6. Respectful, responsive accountability

Cultural and Ethnic Communities Leadership Council (CECLC)

7. Community: education: equal resources for each school and after-school programs; relating to achievement gap: opportunity, staff qualifications; open enrollment process: charter schools serving specialty populations; English Language Learners: are being currently separated from their classmates, this creates barriers to student's learning English;
8. Increase the knowledge and awareness of resources available to families: housing, deduction, transportation, food, employment; language access: second language learners do not necessarily know the culture; need for quality translation; do not assume that everyone can read/write; community
9. Health services: DHS needs to have stringent requirements for vendors to work with communities, i.e., grants for families and immigrants (with legal status), health centers are funded by DHS, need more transparency, more empowerment and involvement in the community
10. Policy makers: invite people of color to the table when making policy impacting them; have diverse pagers and aides
11. *CECLC: DHS should have cultural advisors for various populations to assist people who do not speak English*
12. Other: Asian communities do not have a clear understanding of child protection; they don't know that their children can be removed and separated from families; education; competent and trained interpreters; persons who speak the language should provide the services, in family court they have trained interpreters; there needs to be a standard for interpreters; disproportionate representation of families of color in child protection services.

Appendix F. Example of coordinated efforts between DHS and MDH to collect and use Race, Ethnicity, and Language (REL) Data

The Race, Ethnicity, and Language (REL) Data Work Group has identified several opportunities for the use of data on race, ethnicity, and language in the implementation of Minnesota's health care reform efforts.

The REL Data Work Group respectfully asks the Governor's Health Care Reform Task Force and its work groups to consider the following recommendations:

- 1) Health care organizations in Minnesota will collect data for the variables listed below, adhering to standards adopted by the State of Minnesota:
 - a. Race and Hispanic Ethnicity
 - b. Granular Ethnicity and Tribal Affiliation
 - c. Language
- 2) Standardized information on racial, ethnic, and language characteristics is needed to identify and target health disparities—just as critical are the reporting, sharing, benchmarking, and use of the data to improve health. The Minnesota Departments of Health and Human Services should continue to co-convene a multi-stakeholder work group with strong representation from communities most impacted by disparities. This group will identify principles and policy options to advance the reporting, sharing, benchmarking and use of standard race, ethnicity, and language data sets.
- 3) Future data collection might include socioeconomic position and acculturation. The Minnesota Departments of Health and Human Services **should explore, research, and develop a long-range plan for the inclusion of measures of socioeconomic position and acculturation in data collection efforts.**
- 4) The State's efforts to standardize, implement, and collect race, ethnicity, and language data elements shall be undertaken in consultation with the Administrative Uniformity Committee, electronic health records vendors, and others to develop implementation methodologies necessary to provide uniform coding of such elements.
- 5) Minnesota's efforts to address health care delivery, health care finance and payment, and patient outcomes (this includes, but is not limited to health care homes, statewide quality reporting, provider peer grouping, accountable care organizations, and total cost of care contracting) should incorporate the collection, reporting, and use of race, ethnicity, and language data into certification standards, reporting requirements, and statistical methodologies. The State's efforts shall include a timeline to allow sufficient time for affected parties to incorporate such methodologies into their operations and systems.
- 6) The multi-stakeholder work group shall develop recommendations for the use and sharing of race, ethnicity, and language data with stakeholders (including but not limited to local and state public health agencies, coalitions, advocacy groups, community-based organizations, and researchers) to identify incidence and prevalence of various health conditions and related risk factors among different racial and ethnic populations and used to eliminate disparities. Use and sharing of data will be consistent with state and federal regulations protecting the privacy of health information.

Cultural and Ethnic Communities Leadership Council (CECLC)

Appendix G. Members of CECLC

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

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

MEMBER	AFFILIATION
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Five members representing diverse cultural and ethnic communities:

<i>Jose Gonzalez</i>	<i>Office of Multicultural and Minority Health/MDH Term Expires:</i>
<i>Mitchell Davis Jr</i>	<i>Minneapolis Urban League Term Expires:</i>
<i>Kamaludin Hassan</i>	<i>Hennepin County Adult Mental Health Local Advisory Council Term Expires:</i>
<i>Pahoua Yang</i>	<i>Amherst Wilder Foundation, Southeast Asian Services Term Expires:</i>
<i>Sarita Ennis</i>	<i>Fernbrook Family Center Inc. Term Expires:</i>
<i>Two members representing culturally and linguistically specific advocacy groups:</i>	
<i>Samanthar Hassan</i>	<i>Multicultural parent advocate and trainer, PACER Term Expires:</i>
<i>Vayong Moua</i>	<i>Senior advocacy and health equity principal, Center for Prevention, Blue Cross and Blue Shield of Minnesota Term Expires:</i>
<i>Two members representing culturally specific human services providers</i>	
<i>Kamala Puram</i>	<i>executive director, SEWA-AIFW, Asian Indian Family Wellness Term Expires:</i>
<i>Titilayo Bediako</i>	<i>WE WIN Institute Inc., Multicultural Children's Issues Term Expires:</i>

Cultural and Ethnic Communities Leadership Council (CECLC)

<i>Two members representing tribal service providers:</i>	
<i>Vacant</i>	
<i>Vacant</i>	
<i>Two members representing counties serving large cultural and ethnic communities:</i>	
<i>Dave Haley</i>	<i>Ramsey County Human Services , Executive assistant to department director Term Expires:</i>
<i>Paula Haywood</i>	<i>Hennepin County Department of Community Corrections and Rehabilitation, Quality assurance and community engagement manager Term Expires:</i>
<i>One member who is a human services program participant member representing communities of color</i>	
<i>Pa H. Lor</i>	<i>Office Coordinator, Multicultural & International Programs and Services Office, St. Catherine University Term Expires:</i>
<i>One member who is a parent of a human services program participant, representing communities of color:</i>	
<i>Saciido Shaie</i>	<i>Prevent Child Abuse Minnesota, Parent leader for child safety and permanency, Term Expires:</i>
<i>The chairs ranking minority members of the committees in the House of Representatives and the Senate with jurisdiction over human services:</i>	
<i>Rep. Tom Huntley, House HHS Finance chair</i>	
<i>Rep. Jim Abeler, House HHS Finance minority lead</i>	
<i>Rep. Tina Liebling, House HHS Policy chair</i>	
<i>Rep. Tara Mack, House HHS Policy minority lead</i>	
<i>Sen. Tony Lourey, Senate HHS Finance chair</i>	
<i>Sen. Julie Rosen, Senate HHS Finance minority lead</i>	

Cultural and Ethnic Communities Leadership Council (CECLC)

<i>Sen. Kathy Sheran, Senate HHS Policy</i>	
<i>Sen. Michelle Benson, Senate HHS Policy minority lead</i>	
<i>Two members representing faith-based organizations ministering to ethnic communities:</i>	
<i>The Rev. Janet Johnson, Ordained Elder</i>	<i>Wayman African Methodist Episcopal Church Term Expires:</i>
<i>Vacant</i>	
<i>One member who is a representative of a private industry with an interest in inequity issues:</i>	
<i>LaJuana Whitmore</i>	<i>Target Corp. Term Expires:</i>
<i>One member representing the University of Minnesota program with expertise on health equity research</i>	
<i>Pam Cosby, Chair</i>	<i>University of Minnesota, Minnesota Urban Area Health Education Center Term Expires:</i>
<i>Four representatives of the state ethnic councils</i>	
<i>Edward McDonald, Council on Black Minnesotans</i>	
<i>Sia Her, Council on Pacific Islanders Minnesotans</i>	
<i>Hector Garcia, Chicano Latino Affairs Council</i>	
<i>Annamarie Hill, 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>Four DHS employees:</i>	
<i>LaRone Greer</i>	<i>Chemical and Mental Health Administration Term Expires:</i>
<i>Anna Mazig</i>	<i>Operations Term Expires:</i>
<i>Maria Sarabia</i>	<i>Health Care Administration</i>

Cultural and Ethnic Communities Leadership Council (CECLC)

	<i>Term Expires:</i>
<i>Scott Leitz</i>	<i>Assistant Commissioner for Health Care/Senior management team liaison</i> <i>Term Expires:</i>
<i>DHS staff to the CECLC:</i>	
<i>Antonia Wilcoxon</i>	<i>Community Relations Director</i>
<i>Mee Cheng</i>	<i>Graduate Student Intern (University of Minnesota/School of Public Health)</i>
<i>Rosalie Vollmar</i>	<i>Project Manager, Direct Care and Treatment Administration, on loan</i>
<i>Jane Delage</i>	<i>Children and Family Services Administration – reader/editor</i>