State-Level Approaches to Health Equity

In New England and the Midwest

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Methods

- **Background:** Little review or analysis of existing state-level approaches to health equity exists; furthermore, no qualitative research on efficacy or implementation has been done. While many states are making progress in legislative and executive infrastructure for health equity, there is no sharing of information about best practices or lessons learned.
- **Research Question:** In New England and the Midwest, was approaches are states making to build infrastructure for health equity?
- **Methods:** 30-45 minute telephone interviews conducted with department officials from each state, selected via online search and snowball sampling techniques. Interviews conducted with 8/10 intended states; unable to contact Maine and Minnesota despite efforts. 1-3 interviews conducted with remaining 8 states. Interview data supplemented by analysis of published health equity reports and bills. PubMed review found minimal existing literature, with scant articles producing brief overview of HiAP efforts in select cities.
  - New England: RI, MA, CT, NH, VT
  - Region V: IL, MI, OH, *MN*

Interview Questions

- What legislation exists to promote coordinated efforts for health equity on the state level?
- How does the legislation ensure collaboration among separate governmental agencies?
- How does the legislation ensure that health equity remains a key legislative issue?
- Are there active efforts to implement a HiAP approach?
- To what extent are these provisions written directly into the legislation?

Summary Of Findings

- Current paradigm shift towards "Health Equity" lens which emphasizes inter-agency collaboration and a "health in all policies" (HiAP) approach
- Of 6 of 9 states surveyed had formalized movement around health equity infrastructure
  - 4 actively operational including interagency collaboration, HiAP review, regular report
- Majority are housed within DOH/DPH
- Only CT commission has guaranteed funding and is independent from DOH
- 3 states without formalized HE structure in early stages of conversation, currently addressing HD through OMH, DOH
  - More access to funding, but no specific focus on HIAP or interagency collaboration

Inter-Agency Collaboration

- 4 states with operational health equity infrastructure created a commission with representatives from each government agency
  - Buy in from agencies an issue; functioned best when attendance **mandated by law** and **motivated by external requirements**
- In remaining states, interagency collaboration occurred only on a project based level
- State political climate played a large role: in self described "decentralized" states like NH and IL, it did not always make sense or seem possible to have state agency level buy in without community level movement first

Just saying we should do this collaborative process because it's the right thing to do is not enough; having it be a law and the benefit of being accredited are key anchors to keep the work going." - Leticia Reyes-Nash, SHIP, IL

HIAP Approach

- 3 of 4 active states had HiAP legislative review process
  - Limited significantly by funding, staffing
  - Most effective states had a commission member already involved in policy review in their primary employment
  - None introduce own legislation at this time
- In remaining states, legislative review occurred largely within DOH/DPH, with a health disparities approach but not a health equity approach
  - Robust process for legislative review with financial resources, able to produce weekly or monthly briefs and statements
  - Missing many policies which impact health
  - Issue of being tied to official DOH stance

Health Equity Reporting

- All states had some infrastructure for reporting on HD or HE, involving both data and recommendations
- All Health Equity commissions produced a regular report which was either disseminated to legislature or governor
  - Clear mandate for report dissemination key as motivation
  - Further research needed on impact of dissemination; presentation to one party responsible for action (ie Governor) may be more effective than to large body without (ie Legislature)
  - Staffing and funding essential for the capacity and accountability to actually produce a report
  - Report production required a significant amount of commission time

CHW Advancement

- **RI** law has explicit CHW focus: "make recommendations for the coordination of state, local and private sector efforts to develop a more racially and ethnically diverse healthcare workforce. Such recommendations shall include the evaluation and development of the community health workforce. The commission may make recommendations for the recruitment, assignment, training and employment of community health workers"

- **MA** efforts all include CHW focus:
  - **HD Commission** (2004): Subcommittee on "Workforce development and diversity"
  - **HD Council** (2006): via Health Reform Law, "The council shall make recommendations to increase racial and ethnic diversity in the health care workforce, including doctors, nurses and physician assistants."
  - **Chapt. 58 Legislation "An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth":** Currently in legislature, efforts to pass continue
    - Section 110 requires a Community Health Worker Study to be conducted by the Public Health Department to determine the effectiveness of community health workers in reducing racial and ethnic health disparities
    - The Office of Health Equity will run a competitive grant program to provide funds to hospitals, community health centers, and nonprofit community organizations to employ community health workers to better the health of the communities in which they live
    - The Office of Health Equity will establish a council to coordinate state, local, and private sector efforts to establish health care workforce diversity and development

Themes and Lessons Learned

Supportive context key

- Different meaning in different states: in "de-centralized" states, county and community groundwork may need to come first; in others, strong investment from governor's office important
- Political and staffing transitions very disruptive to processes tied to government offices
- State political, culture, and social climate must be considered; cannot advocate for a one size fits all approach

"We are at the stage in this department where we first are trying to actually get a mandatory training for staff and management, so they can understand the importance of health equity to begin with. Once we get that accomplished, the next step is to push for health equity review, racial equity impact assessment…." - Sheryl Weir, HDRMHS, Michigan

- Independent commissions may have more intellectual freedom than groups housed within a state agency, as their statements don't reflect directly on the government

"Because wherever the governor falls, the DOH is in line with that...the commission is independent,and created by legislation so it can have different opinions than governors office" Johnnie Chip Allen, Dir. Health Equity, OH

- Individuals count: strong leaders, commission members with ties to relevant outside organizations, and personal relationships played a large part in commission efficacy, success, and longevity

"The legislation is great but those that created it didn't realize what was needed, which was, the way it was placed in state system…. it has been difficult to get the commission situated to a point where it can do the work it needs to do, though composition is very good"
-Marie Spivey, Commission on Health Equity, CT

- Legislation is powerful but slow moving; commission creation may be years in the making and subject to legislative whi

MA Bill to create Office of Health Equity: stuck in legislature for several years and slowly losing support as special interests and changing sponsors lead to changes in bill text

State/Name	Since	Structure/Creation	Interagency Collaboration	Legislative Review	Orig. Legislation	Report presented to Legislators	Major Barrier
RI: Commission for Health Advocacy and Equity	2013	DOH, Legislative	Yes	Yes	No	Yes	Agency Representation/Accountability
CT: Commission on Health Equity	2008	Office of Healthcare Advocate/ Dept of Insurance, Legislative	Yes	Yes	Potentially	**Yes**	Funding/Consistent Staffing
VT: HIAP Task Force	2015	DOH, Executive Order	Yes	No	No	To Governor	Recently Created
NH: Health Equity Partnership	*2011*	*Public-Private partnership, endowment funding,* ***Legislative***	*Occasional/Project based*	*via Public Health Association*	*No*	*Attempt, with little buy in*	*Decentralized government/buy in/political climate*
MA: HD Commission/ HD Council	*2004/ 2006*	*State Congress/DPH, Legislative*	*No*	*Yes*	*No*	*No*	*Both non-operational due to funding, leadership, energy*

State/Name	Since	Structure/Creation	Interagency Collaboration	Legislative Review	Introduces Original Legislation	Equity Report presented to Legislators	Major Barrier
IL: State Health Improvement Plan	2006	DPH, Legislative	Yes	No	No	State Health Improvement Plan, Triennially	Lack of funding, decentralized state structure
MN: Center for Health Equity	2013	DOH, Commissioner for Health	Yes	**Yes**	No	Yes	Unable to determine
MI: Health Disparities Reduction and Minority Health Section	*2007*	*DHHS, Legislative*	*No*	*In DHHS without HIAP perspective*	*No*	*Yes*	*Small office, funding, early stages of health equity paradigm*
OH: Commission on Minority Health	*1987*	*Independent, Legislative*	*Rare/Project Based*	*Yes, without HiAP perspective*	*No*	*No; Plans to produce*	*No explicit health equity focus*

Note: Bolded items require confirmation

Sources

- RI: Angela Ankoma, Chief, Office of Minority Health
- MA:
  - Elmer R. Freeman, Director, Center for Community Health Education Research and Service
  - Roxanne Reddington-Wilde,
  - Georgia Simpson May, Director, MA Office of Health Equity
- CT: Marie Spivey, Vice President, CT Hospital Association
- NH:
  - Rebecca Sky, Project Director, Foundation for Healthy Communities
  - Nathalie Ahyi, Program Director, Foundation for Healthy Communities
- VT: Martha Friedman (email interview only), Healthy Equity Coordinator, Dept. Public Health
- IL:
  - Beth Fiorini, State Board of Health/Public Health Administrator
  - Leticia Reyes-Nash, Div. Chief, Office of Policy, Planning & Statistics, DPH
  - Juana Ballesteros, Manager of Community Public Health Outreach, DPH
- MI: Sheryl Weir, Manager, Health Disparities Reduction and Minority Health Section
- OH:
  - Johnnie Chip Allen, Director of Health Equity, DoH
  - Angela Dawson, Director, Commission on Minority Health
- MN: Unable to contact, data gathered through online publications of Office of Health Equity