PREVENTION INSTITUTE

To whom it may concern:

Thank you for the opportunity to inform the federal government's approach to advance equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. We applaud the Biden-Harris Administration for making this a priority and responsibility of the whole of government, and for its efforts to address some of the harms caused over centuries.

Prevention Institute (PI) is a national nonprofit with offices in Oakland, Los Angeles, Houston, and Washington, D.C. Our mission is to build prevention and health equity into key policies and actions at the federal, state, local, and organizational level to ensure that the places where all people live, work, play and learn to foster health, safety, and wellbeing. Since 1997, we have partnered with communities, local government entities, foundations, multiple sectors, and public health agencies to bring cutting-edge research, practice, strategy, and analysis to the pressing health and safety concerns of the day. We have applied our approach to injury and violence prevention, healthy eating and active living, land use, health systems transformation, and mental health and wellbeing, among other issues.

Health equity means that everyone has a fair and just opportunity to attain their full health potential and that no one is disadvantaged, excluded, or dismissed from achieving this potential. At Prevention Institute, we focus on how structural drivers of inequity—such as racism, sexism, and income inequality—impact communities. And we support community-based organizations and advocates in building power and capacity to change the systems that created these inequities in the first place. Racial justice is a primary focus of Prevention Institute's health equity work because racism, discrimination, and other forms of racial injustice have resulted in dramatic health and safety disparities for communities of color. Without closing racially unjust gaps in health outcomes, we will not be able to achieve health, safety, and wellbeing for our nation as a whole.

Health inequities are not coincidental or accidental, nor are health inequities a matter of poor choices or access to quality healthcare. They are produced by historic and current-day policies, laws, practices, and procedures that systematically determine the factors, including community conditions that undermine health. These policies and practices have disproportionately and negatively impacted the lives of people of color living in the US. As a result, many illnesses occur in higher frequency, earlier, and with greater severity among people of color, especially among people of color living in communities subjected to concentrated poverty.[1] These inequities have worsened for communities of color during the COVID-19 pandemic. Nationally,

[1] Smedley, BD, Stith, AY, and Nelson, AR (ed.) Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press, 2003. https://www.nap.edu/catalog/10260/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care

Black, Latinx, Native Hawaiian and Pacific Islander, American Indian or Alaska Native communities have had significantly higher COVID-19 infection and death rates than others and are more likely to bear long-term health and economic consequences.[2] Consequently, health inequity is a form of racial injustice, and we cannot address one without addressing the other. Working towards health equity without intentionally addressing racism and the multiple forms of discrimination associated with it, thwarts successful racial justice and health equity outcomes.

According to the Centers for Disease Control and Prevention, racism negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of the entire nation. Research shows that centuries of racism in the U.S. has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions, or social determinants of health,[3] drive health inequities within communities of color, placing them at greater risk for poor health outcomes.[4]

Since the onset of the COVID-19 pandemic, the brunt of the pandemic has fallen on Black, Indigenous People of Color (BIPOC) and communities. Concurrently, we are in the midst of a national uprising calling for racial justice and accountability in the face of ongoing violence against Black Americans, and increasingly, Asian and Pacific Islander Americans. This is an historic moment where we can all make a difference and implement bold and broad change.

Many states (including California, Connecticut, Massachusetts, Minnesota, North Carolina, Oklahoma, Oregon, Tennessee, and Vermont) have implemented Health in All Policies practices as a strong first step to addressing these harms, encouraging sectors and systems beyond health to consider the health impacts of their existing or proposed policies and practices. According to the CDC, Health in All Policies is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities.

But federal efforts must move beyond these first steps to broader and deeper approaches that also center community experiences and community voice in solutions; prioritize support for community-based organizations working on health equity and racial justice at the community level; and advance long-term systems change as well as short-term solutions.

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[2] Reductions in 2020 US life expectancy due to COVID-19 and the disproportionate impact on the Black and Latino populations. Theresa Andrasfay, Noreen Goldman. Proceedings of the National Academy of Sciences Feb 2021, 118 (5) e2014746118; DOI: 10.1073/pnas.2014746118. https://www.pnas.org/content/118/5/e2014746118

[3] https://www.cdc.gov/socialdeterminants/index.htm

[4] https://www.cdc.gov/healthequity/racism-disparities/impact-of-racism.html

Question 1. Equity Assessments and Strategies. Approaches and methods for holistic and program- or policy-specific assessments of equity for public sector entities, including but not limited to the development of public policy strategies that advance equity and the use of data to inform equitable public policy strategies.

A. Equity assessments

To address the request for approaches and methods for holistic and program- or policy-specific assessments of equity for public sector entities, including but not limited to the development of public policy strategies that advance equity and the use of data to inform equitable public policy strategies, we offer several examples of equity assessments and strategies:

- **Building Bridges: The Strategic Imperative for Advancing Health Equity and Racial Justice**: This resource from Prevention Institute explores how and why to bring together people working on health equity and racial justice, including understanding the tensions between the two approaches, recognizing shared goals, and identifying strategic opportunities for collaboration. https://preventioninstitute.org/publications/building-bridges-strategic-imperative-advancing-health-equity-and-racial-justice
- **Countering the Production of Health Inequities through Systems and Sectors**: This resource from Prevention Institute analyzes what has contributed to inequities to determine a pathway forward to produce health equity, including roles for various institutions, sectors, and systems working together to achieve health equity. https://preventioninstitute.org/countering-inequities
- **Government Alliance on Race and Equity tools**: GARE offers tools and resources to support local and regional government to proactively advance racial equity, including:
    - Racial Equity: Getting to Results: Assists jurisdictions to use a racial equity lens to identify metrics and implement community processes to have greater impact. https://www.racialequityalliance.org/resources/racial-equity-getting-results/
    - Racial Equity Action Plans: A How-to Manual: Provides guidance for local governments to develop Racial Equity Action Plans. https://www.racialequityalliance.org/resources/racial-equity-action-plans-manual/
    - Racial Equity Toolkit: An Opportunity to Operationalize Equity: Helps develop strategies and actions that reduce racial inequities and provide a structure for institutionalizing the consideration of racial equity. https://www.racialequityalliance.org/resources/racial-equity-toolkit-opportunity-operationalize-equity/
    - Advancing Racial Equity and Transforming Government: A Resource Guide to Put Ideas Into Action: Based on lessons learned from practitioners and experts to assist government leaders in operationalizing racial equity. https://www.racialequityalliance.org/resources/advancing-racial-equity-and-transforming-government-a-resource-guide-to-put-ideas-into-action/
- **Human Impact Partner's Strategic Practices for Advancing Health Equity**: This set of strategic practices provides guidance to health departments to systematically address power imbalances, racism, and other forms of oppression to advance health equity. https://healthequityguide.org/strategic-practices/

- **Big Cities Health Coalition's Health Equity Tool**: A tool for health officials to use in the context of COVID-related decision making so that health departments can ensure all policy decisions are made with equity as the priority. https://www.bigcitieshealth.org/equitytool
- **The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)**: The National CLAS Standards aim to improve healthcare quality and advance health equity by establishing a framework for organizations to serve the nation's diverse communities. Developed by the Federal HHS Office of Minority Health, they provide a model for moving toward cultural and linguistic appropriateness, a key component of health equity. https://thinkculturalhealth.hhs.gov/clas
- **City of Seattle and Washington State Racial Equity Toolkits:** A tool that interrupts and guards against implicit bias and institutional and structural racism. Based on and expanded from a toolkit developed by the City of Seattle in 2008, it is meant to be used at the inception of a policy, program, or budget decision to allow for alignment with racial equity goals and outcomes. http://www.seattle.gov/civilrights/what-we-do/race-and-social-justice-initiative/racial-equity-toolkit https://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf https://www.governor.wa.gov/sites/default/files/documents/PRWG_RacialEquityToolkit_Worksheet_12-20-2018.pdf
- **Declarations of Racism as a Public Health Crisis**: Across the country, local and state leaders are declaring racism a public health crisis or emergency, an important first step in advancing health equity and racial justice when followed by allocation of resources and strategic action. https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations)
- **Equity and Social Vulnerability Indices:** Policymakers are increasingly using social vulnerability indices to identify and prioritize disadvantaged communities during and beyond the public health crisis. The National Academies of Sciences, Engineering and Medicine has recommended place-based measures of social vulnerability, such as CDC's Social Vulnerability Index or the COVID-19 Vulnerability Index, for equitable vaccine allocation. California's state government developed a health equity index based on the California Healthy Places Index of social vulnerability so that each county's unique disparities are measured and addressed as part of its economic reopening efforts. Social vulnerability indices are powerful quantitative tools and an important step towards addressing health inequities in policy making. However, indices alone are not sufficient to correct for underlying structural issues that perpetuate disparities. https://www.atsdr.cdc.gov/placeandhealth/svi/index.html https://www.niehs.nih.gov/research/programs/coronavirus/covid19pvi/index.cfm https://healthyplacesindex.org/

B. Using data to inform equitable public policy strategies

One of the first essential steps for any federal department or agency to advance equity is to collect, analyze, and public report comprehensive and complete demographic data about the

users of its programs and services, as well as its own staffing, contractors, and recipients of grants and other funding. We strongly urge OMB to take leadership on establishing federal government-wide standards for collecting, analyzing, and reporting demographic data, including using the data to identify disparities and inequities, and implementing interventions to reduce those disparities and mitigate those inequities.

While the OMB has long-established federal government-wide standards for race and ethnicity data, those standards have not been updated since 1997 and are still not consistently followed. Given the Administration's priority on advancing racial equity, updating the federal race and ethnic data standards should be of the most urgent and highest priority, with sufficient staffing and resources to ensure full implementation. Moreover, there is a need for federal government-wide standards for other demographic data, including language, disability, sexual orientation, and gender identity.

We recognize that many state and local governments have made improvements to their own demographic data collection efforts, including collecting and reporting more granular and disaggregated data. We urge the OMB to review and consider whether any of these state- and local-level interventions could be scaled for adoption by federal departments and agencies.

The OMB is already participating in and supporting the Interagency Working Group on Equitable Data:

-Executive Order 13985 stated the importance of comprehensive and complete data as a vital first step towards identifying inequities to prioritize and focus efforts to advance equity:

> Many Federal datasets are not disaggregated by race, ethnicity, gender, disability, income, veteran status, or other key demographic variables. This lack of data has cascading effects and impedes efforts to measure and advance equity. A first step to promoting equity in Government action is to gather the data necessary to inform that effort.

-Executive Order 13985, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, January 20, 2021.[5] Accordingly, the executive order established the Interagency Working Group on Equitable Data, which will, through consultation with agencies, study and provide recommendations to the APDP [Assistant to the President for Domestic Policy] identifying inadequacies in existing Federal data collection programs, policies, and infrastructure across agencies, and strategies for addressing any deficiencies identified...and...support agencies in implementing actions, consistent with applicable law and privacy interests, that expand and refine the data available to the Federal Government to measure equity and capture the diversity of the American people.

The OMB is charged with providing administrative support to this Interagency Working Group on Equitable Data.

[5] https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

- ***Adopt and enforce updated "whole of government" standards for comprehensive, disaggregated/granular race and ethnicity data***

We note that OMB has not updated its standards for race and ethnicity since 1997, and unfortunately, those standards are still not fully implemented. For example, over a year into the COVID-19 pandemic where racial and ethnic disparities have been frequently acknowledged, federal agencies such as the Centers for Disease Control and Prevention continue to report data combining the separate Asian and Native Hawaiian and Other Pacific Islander categories, and often fail to report any data about Asians, Native Hawaiian and Other Pacific Islanders, and American Indians and Alaska Natives, lumping them into an "Other" category.[6]

In 2017, the OMB, in conjunction with the U.S. Census Bureau at the Department of Commerce already reviewed and made a proposal for updating these race and ethnicity standards.[7]

These proposed updated race and ethnicity standards already received significant public review and comment under the Administrative Procedure Act; nearly 7,200 comments were submitted, with an overwhelming majority in support of the updated standards.[8] Accordingly, we strongly urge the immediate adoption of these updated race and ethnicity standards. Specifically, we support the combination of the race and Hispanic ethnicity categories, the addition of a Middle Eastern and North African category, and the disaggregation of each race and ethnicity category by the top six most numerous subgroups, with a write-in option and examples for other subgroups. We also support changing the current race category of "Native Hawaiian and Other Pacific Islander" to "Native Hawaiian and Pacific Islander", ending the use of the term "Guamanian" and instead using "Chamorro", and ending the use of the term "principal minority race".

Disaggregation by more granular race and ethnicity categories is essential to understanding inequities and disparities and advancing equity. We emphasize that federal departments and agencies should consider any OMB standards as minimum standards and urge OMB to support even more granular disaggregation when appropriate, and to continue to work with state and local governments to support additional disaggregation where there are more diverse racial and ethnic subpopulations. For example, the COVID-19 pandemic has demonstrated the importance of collecting, analyzing, and publicly reporting more granular disaggregated race

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[6] See, Smith AR, DeVies J, Caruso E, et al. Emergency Department Visits for COVID-19 by Race and Ethnicity-13 States, October–December 2020. MMWR Morb Mortal Wkly Rep 2021;70:566-56 (data combined for "Asians and Pacific Islanders"), https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7015e3-H.pdf; and Romano SD, Blackstock AJ, Taylor EV, et al. Trends in Racial and Ethnic Disparities in COVID-19 Hospitalizations, by Region - United States, March-December 2020. MMWR Morb Mortal Wkly Rep 2021;70:560–565, https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7015e2-H.pdf (data only reported for Hispanic. White, Black, Asian, and Other).

[7] U.S. Office of Management and Budget, Proposals from the Federal Interagency Working Group for the Revision of the Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, 82 Fed. Reg. 12242-12247, March 1, 2017, https://www.gpo.gov/fdsys/pkg/FR-2017-03-01/pdf/2017-03973.pdf; U.S. Census Bureau. 2015 National Content Test Race and Ethnicity Analysis Report, 2017, https://www.census.gov/programs-surveys/decennial-census/decade/2020/planning-management/plan/final-analysis/2015nct-race-ethnicity-analysis.html

[8] https://www.regulations.gov/docket/OMB-2017-0003

and ethnicity data. Disaggregated data have been vital to understand the disproportionate impact of COVID-19 on Filipino nurses, Marshallese in Arkansas, and Bangladeshi in New York.[9]

In addition, we strongly recommend that the OMB set a firm deadline for all federal departments and agencies to comply with these new standards, no longer than three years. While we recognize that any changes to governmental demographic data categories requires updating of data collection, storage, and reporting systems, the COVID-19 pandemic has taught us that improving the collection and reporting of race and ethnicity data is possible, even during a crisis such as a national health emergency. With sufficient notice and time, all federal departments and agencies should be able to achieve compliance.

The OMB should make technical assistance available to federal departments and agencies to come into compliance with the new standards, as well as education and training for community-based organizations, consumer advocates, and other users of the data to understand how to access and use the updated data as they become available.

Moreover, we strongly recommend that the OMB provide additional guidance to federal departments and agencies to make full compliance with these standards an explicit condition and requirement for receiving federal funds, including federal funds received by tribal, state, local, territorial governments, departments, and agencies, and community-based organizations, and federal funds received by all federal contractors. This additional guidance will ensure that the OMB race and ethnicity data standards are, in fact, uniformly applied across "the whole of government" and at all levels of government.

Finally, we note that there is greater capacity to collect and use even more granular and disaggregated data in electronic data requirements, where additional response options are virtually unlimited. For example, we commend the comprehensive and granular demographic data standards included in the latest federal standards for health information technology, or electronic health records.[10]

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[9] Kelliher F. California's Filipino American nurses are dying from COVID-19 at alarming rates, Mercury News, October 4, 2020, https://www.mercurynews.com/2020/10/04/californias-filipino-american-nurses-are-dying-from-covid-19-at-alarming-rates/ (Filipino nurses had 70% of COVID-19 deaths among nurses in California while 20% of nursing workforce)
McFish PA, Purvis R, Willis DE, Riklon S. COVID-19 disparities among Marshallese Pacific Islanders. Prev Chronis Dis. 2021;18(E02):200407, https://www.cdc.gov/pcd/issues/2021/20_0407.htm
Eama A. Especially hard hit by coronavirus, City's Bangladeshi community see failure of government to protect vulnerable New Yorkers, Gotham Gazette, July 20, 2020, https://www.gothamgazette.com/city/9609-bangladeshi-community-hard-hit-coronavirus-government-failure-vulnerable-new-yorkers (over 230 Bangladeshis in New York City have died from COVID-19)

[10] U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759, October 16, 2015, https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf.

These ONC standards are consistent with 2009 recommendations by the Institute of Medicine for full disaggregation of race and ethnicity categories using CDC/HL7 codes.[11]
We strongly encourage the adoption and implementation of similar disaggregated and granular data collection in other contexts where data from users and consumers are collected electronically.

- ***Promote additional disaggregation of language data***

There is increased recognition of the importance of data about the primary and preferred languages that individuals speak, read, and write when communicating with federal departments and agencies about federal programs and services. Without basic language access, including access for individuals with visual, hearing, and other communications barriers, there will be inherent inequities and barriers to access and utilization of those federal programs and services.

Again, there are examples that the OMB can draw upon for developing whole of government standards for identifying and meeting language access needs. For example, the Federal Emergency Management Agency has a language access plan that provides individual assistance materials in 20 languages and alternate formats, including Braille and large print.[12]
The ONC health IT standards use full disaggregation of primary and preferred language data.[13]

All federal departments and agencies should review their websites, written materials, and all public facing/public contact communication channels (including call centers and social media) to ensure accessibility for individuals with disabilities, including facilitating use of assistive and adaptive communications devices. For example, all federal websites should meet standards for accessibility, and all call centers should have interfaces with telecommunications relay services operated by the Federal Communications Commission.[14]

- ***Standardize disability data***

We urge the OMB to standardize the collection, use, and reporting of disability data across all federal departments and agencies, using the six-question Census Bureau/American Community Survey definition of disability.[15]

However, we also urge the OMB to convene an interagency subject matter expert and stakeholder working group to review and consider alternative data standards for disability, such

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[11] Institute of Medicine, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement 2009, https://www.nap.edu/catalog/12696/race-ethnicity-and-language-data-standardization-for-health-care-quality; CDC/HL7, Race and Ethnicity Code Set
http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

[12] U.S. Department of Homeland Security Federal Emergency Management Agency, Language Access Plan, 2016, https://www.dhs.gov/sites/default/files/publications/FEMA%20Language%20Access%20Plan.pdf

[13] See also, International Organization for Standardization, Language Codes 639, http://www.iso.org/iso/home/standards/language_codes.htm.

[14] https://www.fcc.gov/consumers/guides/telecommunications-relay-service-trs

[15] https://www.census.gov/topics/health/disability/guidance/data-collection-acs.html.

as the questions developed by the Washington Group on Disability Statistics.[16] Subject matter experts and stakeholders representing a wide range of physical, developmental, and cognitive disabilities should be consulted and should participate in this working group.

- ***Need for standardization for sexual orientation and gender identity data***

While there has been some progress made in the collection of sexual orientation and gender identity data, there are no federal government-wide standards for such data.[17] For example, the ONC does include the collection of sexual orientation and gender identity in its health IT standards, using SNOMED categories, SNOMED Clinical Terms Value Set for Sexual Preference [sic],[18] and SNOMED Clinical Terms Value Set for Current Sex.[19]

We note a National Academies of Sciences, Engineering, and Medicine (NASEM) committee has been convened and will be making recommendations for standardization of sex, sexual orientation, and gender identity data.[20] We urge the adoption of these NASEM recommendations.

Question 2. Barrier and Burden Reduction. Approaches and methods for assessing and remedying barriers, burden, and inequities in public service delivery and access.

Despite equity-driven efforts, health inequities persist among racial and ethnic subgroups with significant differences in life expectancy and health outcomes. Public benefits programs including Medicaid, Medicare, the Children's Health Insurance Program, and the Supplemental Nutrition Assistance Program (SNAP) are critical to helping families stay healthy. However, many eligible individuals are not enrolled, and those who are enrolled frequently "churn" on and off programs over time, creating coverage gaps and increasing administrative barriers on recipients and federal and state agencies. Countering institutionalized racism will require a no-wrong door approach to public service delivery and access. The OMB should work with federal agencies to reduce unnecessary barriers to accessing benefits for communities of color including LGBTQ+ and people with disabilities including:

- ***Eliminate unnecessary data collection and requirements for programs and services such as paper forms, immigration status and Social Security Numbers (SSNs) and expand use of alternative identifiers such as Individual Taxpayer Identification Numbers (ITINs):*** Building off recommendations from the Center on Budget and Policy Priorities and the National Immigration Law Center,[21] federal agencies should:

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[16] https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

[17] Federal Interagency Working Group on Improving Measurement of Sexual Orientation and Gender Identity in Federal Surveys, Current Measures of Sexual Orientation and Gender Identity in Federal Surveys, 2016, https://nces.ed.gov/FCSM/pdf/buda5.pdf.

[18] http://phinvads.cdc.gov/vads/ViewValueSet.action?id=C5E597A1-C019-E011-87A0-00188B39829B

[19] http://phinvads.cdc.gov/vads/ViewValueSet.action?id=A16CF98F-A01C-E311-81F2-0017A477041A

[20] https://www.nationalacademies.org/our-work/measuring-sex-gender-identity-and-sexual-orientation-for-the-national-institutes-of-health.

[21] See: https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/

- *Reduce the number of paper verifications required* for applications and renewals, use electronic data sources and eliminate verification requests that are no longer needed.
- *Make self-attestation of income verification permanent.* States should have to ask for federal permission to require additional verification and show proof of waste, fraud and abuse.
- *Increase the number of applications that are determined in "real time" and require automated renewals* in order to allow individuals to obtain coverage more quickly and easily.
- *Eliminate unnecessary requests for SSNs:* The HHS/USDA issued "Tri-Agency Guidance" in 2000 and additional guidance related to CHIP in 2001 and SNAP in 2011 to help reduce the invasive, chilling effect of immigration status-related questions on benefits applications. However, despite these actions, rules that require benefit agencies to verify applicant's immigration or citizenship status have been misinterpreted by some agencies, leading to a demand for immigration documents or SSNs in situations when applicants are not required to submit such information. This in turn causes additional confusion and latitude for state agencies to set more stringent documentation requirements than are necessary.
- *Expand use of alternative identifiers such as ITINs* rather than SSNs wherever possible. For example, California expanded access to state Earned Income Tax Credit (CalEITC) to filers with an ITIN.
- *Guarantee applicants a "reasonable opportunity" to provide requested immigration documents*, including in some cases receipts confirming that the person has applied for replacement of lost documents. In federal programs that are required by law to use the Systematic Alien Verification for Entitlements (SAVE) Program, applicants who declare that they have satisfactory status and who provide documents within the reasonable opportunity period should remain eligible for assistance while verification of their status is pending.

- **Use a "no wrong door" approach for all public benefits programs:** OMB should work with federal agencies to:
  - Ensure beneficiaries can apply for benefits through whichever door they enter
  - Require states to adopt "express lane eligibility" (ELE) to facilitate enrollment in health coverage. Many states, including California, have adopted such strategies to boost enrollment.
  - Use a single streamlined application such as that developed for health care coverage, to apply for additional benefits such as SNAP or financial assistance.
  - Direct federal agencies to establish an income threshold across all programs in order to simplify eligibility screenings for benefits across all programs.
  - Make online application portals more user friendly and easy to understand. Research shows that vulnerable communities face significant challenges and technological barriers to accessing existing web portals. Some of the main drivers of these accessibility challenges are portals that feature small-font,

English-only, text-based content that is written at a very high literacy level. In addition, existing portals often employ user interfaces that are complex to navigate and difficult to customize. Very few vendors have begun to offer basic navigational elements of portal websites in Spanish and even fewer cases in Chinese. These fundamental accessibility gaps raise legal and ethical concerns, and ultimately jeopardize the return on public investment of federal portals.

- **Strengthen language assistance and accommodations for seniors and people with disabilities:** Approximately 25.1 million individuals in the United States are Limited English Proficient (LEP). These individuals who are more likely to have low reading literacy or low health literacy in comparison to their English-speaking counterparts may also identify as seniors and/or people with disabilities. Strengthening language assistance services and accommodations for LEP, seniors and people with disabilities is particularly critical as these populations are more likely to experience health and other disparities. Federal agencies should:
    - Ensure federal materials, forms and documents are user friendly, easy to read, and translated into threshold languages.
    - Ensure federal materials, forms and documents are available in alternative formats such as large font, Braille, or electronic formats; sign language interpretation should be provided.
    - Hire racially/ethnically diverse community-based organizations to "field test" translated materials for cultural and linguistic appropriateness. Such review of documents is not unprecedented. In California for example, the state and some Medi-Cal managed care plans have already undergone more extensive community reviews of some of their materials.[22] Covered California included community review in its most recent translation contract.[23]
    - Create a dedicated unit and hotline to assist seniors, disabled and LEP applicants with application questions, renewals and other needs. These hotlines should enable applicants to connect to assistance in their native language.]
    - Provide dedicated funding for community-based organization (CBO) navigators and assisters who are representative of the diverse communities they serve, play a critical role in facilitating enrollment through online application and automated renewal systems.

Question 3. Procurement and Contracting. Approaches and methods for assessing equity in agency procurement and contracting processes.

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[22] See e.g. CalOptima's presentation on lessons learned that includes community reviews of materials in English, Spanish, and Vietnamese available at https://www.iha4health.org/wp- content/uploads/2015/03/Learned-Lessons-from-Implementation-of-Californias-State-Policy-on- Readability-and-Suitability-of-Written-Health-Education-Materials.pdf.See also: DHCS MMCD Policy Letter 99-04. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1999/MMCDPL99004.pdf

[23] See the contract requirements in the model contract for RFP 2017-17 under Exhibit A, Scope of Work available at https://hbex.coveredca.com/solicitations/RFP-2017-17/downloads/Model-Contract- 5.2.18.zip

The federal government has significant purchasing power, awarding billions of dollars in federal contracts each fiscal year. In the health sector alone, health systems recently have pledged to increase contracts with minority- and women-owned businesses by $1 billion over the next five years.[24] Using a whole of government approach, every federal department and agency can begin to shift its contracting dollars towards increased investments in minority-owned businesses/contractors to help to address the persistent racial gaps in income and wealth equality that have resulted from decades of structural racism, discrimination, and exclusion.[25] It is also critical that payment schedules be re-examined since many minority-owned businesses that have been unable to secure or accumulate capital assets because of discriminatory loan, financing, bonding, and insurance policies cannot afford to "float" large sums of delayed accounts payable. Many of these practices, such as up-front payments and multi-year terms, are applicable to other federal government funding, e.g., through grants and cooperative agreements. Finally, since a lot of contracting requires "prior experience", especially in managing increasing larger projects and costs, this leveraging of federal contracting also builds the capacity of minority-owned businesses/contractors to become and remain competitive for all future contracting and procurement opportunities.

- ***Support minority-owned businesses/contractors as the primary contractors rather than subcontractors:*** As federal departments and agencies become more conscious of equity, one common strategy is to create sub-contracts in a large national initiative or program to address the needs of specific racial and ethnic populations. This is often done in federal public education and communications projects and campaigns, when a national advertising or public relations firm is contracted to develop and implement the project or campaign, and that prime contractor then awards sub-contracts to Black, Hispanic/Latino, Asian American and other minority-owned businesses as subcontractors to adapt and/or translate materials for their respective populations. As part of an equity strategy, we strongly encourage flipping this common arrangement and seeking a minority-owned business to lead the project as the prime contractor, bringing in other minority-owned businesses as partners as appropriate, and subcontracting with national advertising or public relations firms for scaling up the project as needed. If communities of color are an after-thought, with adaptation and translations of messages and communications strategies that have been developed for the general population by national firms who do not have experience and expertise with diverse racial and ethnic communities, then there will continue to be ineffective implementation of those projects and campaigns. On the other hand, if effectively reaching diverse communities is included as a primary element in the selection of the contractors, and the development of the project or campaign, then it is more likely to be effective in reaching those diverse audiences.[26] Finally, since success in federal contracting is often dependent on one's "track record" and past contracting experience,

[24] https://healthcareanchor.network/2021/06/health-systems-announce-commitment-to-increase-mwbe-spending-by-1b-to-improve-supplier-diversity-build-community-wealth/

[25] https://www.policylink.org/sites/default/files/InclusiveProcurement_final-3-5-18.pdf

[26] https://www.npr.org/2020/02/20/807126443/disparities-in-government-contracting-hurt-minority-owned-businesses

this shift in contracting strategies will build the books of business for minority-owned contractors to be more competitive for all future projects.

- ***Use cooperative agreement and other more flexible contracts to support minority-owned businesses and CBOs:*** Federal departments and agencies often use multi-year, cooperative agreements with key partners to implement programs. These cooperative agreements are different from contracts because of their flexibility, to be able to quickly adapt budgets, timelines, and deliverables to meet emerging or changing needs. They are useful mechanisms for public education and disseminating information about federal programs and services, and supporting partnerships with local community-based (and faith-based) organizations. Unfortunately, very few of these cooperative agreements are in place with national racial and ethnic community-based organizations. We urge the OMB to work with federal departments and agencies to establish cooperative agreement programs with tribal, national, regional, and local community-based organizations representing key racial and ethnic populations. Such cooperative agreements could be administered through the Offices of Civil Rights, or through federal offices already focused on racial and ethnic minority communities such as the Offices of Minority Health at the Department of Health and Human Services or the Minority Business Development Agency at the Department of Commerce.

- ***Leverage Minority-Serving Institutions (Historically Black Colleges and Universities, Hispanic-Serving Institutions, Tribal Colleges and Universities, Asian American and Native American Pacific Islander-Serving Institutions) for federal contracting:*** Minority-Serving Institutions[27] are trusted and credible institutions in racial and ethnic communities and by definition, have faculty, staff, and students who come from those racial and ethnic communities, and are well-connected with those communities. Minority-Serving Institutions often have strong partnerships and networks in their respective communities. The OMB should work with federal departments and agencies to always ask whether Minority-Serving Institutions would be an appropriate contractor for any existing or new federal program or initiative where there are contracting opportunities.

Question 4. Financial Assistance. Approaches and methods for assessing equity in the administration of agency grant programs and other forms of financial assistance.

A. Strategies to Ensure Equitable Grant-making and Financial Assistance Efforts: Federal agencies must develop and adopt anti-racist principles and dedicate budgetary commitment to the healing and health of impacted communities. OMB should work with federal agencies to identify opportunities to adopt more equitable business practices throughout each agency. This includes:

Grant-making to community-based organizations:

[27] https://www2.ed.gov/about/offices/list/ope/programs.html]

- *Fund capacity-building, multi-year grants* that will allow smaller organizations that focus on racially and ethnically diverse communities to engage more meaningfully in federal systems and reforms. Multi-year grants are particularly important for ensuring whatever capacity organizations build under these initiatives gets carried over into future administrations that may not share the same racial justice values.
- *Simplify and streamline federal grant application and reporting requirements* so community-based organizations with less staff and financial resources can more equitably access competitive federal grant opportunities. Federal applications which can run to more than 40-50 pages should be shortened. Agencies should reduce the frequency of grant reporting from quarterly reports to biannual or yearly and provide greater flexibility should contract amendments need to be made.
- *Provide technical assistance* so smaller, racially, ethnically diverse community-based organizations without access to additional resources for consulting or fundraising, can complete applications.
- *Clearly articulate and integrate equity goals as part of grant scoring rubrics* to ensure entities that receive grant and financial assistance are reflective of the populations served by federal agencies and capable of meeting agency aims and goals.
- *Provide sustainable funding opportunities for CBOs:* Federal agencies should look at shortening grant approval times which can take up to 12-18 months. The lag time between grant application and implementation can be difficult for smaller CBOs to absorb from a budget standpoint.
- *Invest in directly impacted communities:* Provide funding directly to community-based organizations instead of through state and local governments and block grants where funds can be "absorbed" by institutions rather than allocated equitably to those in need.

Direct financial assistance to individuals and families:
Given the continuing racial disparities in COVID-19 cases and deaths, the national reckoning on structural racism, and the disproportionate impact that the economic recession has had on BIPOC communities, we support calls by coalitions like the Movement for Black Lives (M4BL)[28] for federal assistance to prioritize redressing the centuries-long disinvestment in BIPOC communities and initiative's such as LA County's Anti-Racism, Diversity, and Inclusion Initiative.[29] This includes a sustained investment in making communities stronger and safer through quality, affordable housing, living wage employment, public transportation, education, and health care that includes voluntary, harm reduction and patient-driven, community-based mental health and substance abuse treatment. Echoing the Biden Administration, this federal framework should take a "whole-of-government" approach to racial equity, applying it to all levels of government focusing on healthy people and healthy communities. This includes:

Health4All:
- Provide Medicaid to low-income residents, regardless of immigration status

[28] M4BL: https://m4bl.org/
[29] LA County Anti-Racism, Diversity, and Inclusion Initiative: https://ceo.lacounty.gov/antiracism/#

- Authorization for all residents to purchase subsidized health coverage through federal and state marketplaces
- Provide culturally relevant health enrollment and navigation services to assist our most underserved populations
- Strengthen investments in community clinics and safety net infrastructure so everyone has access to the full range of health care including behavioral, reproductive, and oral health care

MentalHealth4All:

- Ensure all residents, regardless of immigration status, have a behavioral health home[30] access to culturally and linguistically appropriate, community-based mental health and substance use disorder services
- Invest in significant mental health prevention and treatment efforts that address adverse childhood experiences and trauma experienced by adults, including COVID-19 related trauma, and racial trauma
- und culturally responsive, community-based providers[31]
- Fund local pilot projects to expand and support a broad array of behavioral health integration models that extend beyond health plans to health systems, behavioral health systems, and communities

Opportunity4All:

- Expand grants for community colleges to allow all learners to attend their local community college tuition-free to pursue higher education, continue adult education, learn English or other languages, and otherwise pursue life-long learning; Institute a living wage as well as a universal basic income for residents building on the lessons learned from local communities in California such as Stockton and Long Beach
- Ensure federal relief dollars are available for all individuals who have faced economic hardship as a result of the pandemic, regardless of immigration status
- Invest in a green economy and small, local businesses; capital and technical assistance should be prioritized for minority-, women, disabled-, and veteran-owned small businesses
- Build the workforce of tomorrow by developing and scaling mentorship, apprenticeship, and leadership training programs that engage diverse communities in health and other careers starting in K-12 and extending through professional training to safety-net employment
- Fund a community health worker/navigator corps that can play a pivotal role in connecting individuals to health, public health, employment, housing and other social supports. and behavioral health

Resilience4All:

[30] SAMHSA-HRSA Center for Integrated Health Solutions. Behavioral Health Homes for People with Mental Health and Substance Use Conditions: Core Clinical Features.

[31] https://cpehn.org/publications/concept-paper-policy-options-for-community-defined-evidence-practices-cdeps/

- Invest in federal and state public health infrastructure to respond to the current pandemic and prepare for future public health crises
- Develop workforce/leadership that is inclusive of BIPOC and immigrant communities
- Strengthen and sustain authentic partnerships between federal departments and community-based organizations with legitimacy and knowledge of local communities
- Support partnerships and integration of local public health with other departments and institutions that oversee health care services, mental health, and social services and implement Health In All Policies approach
- Make deep and broad investments in building affordable and accessible housing, assisting renters, preventing foreclosures, and promoting home ownership
- The SNAP program should be available to all low-income individuals, and should expand its partnerships with farmers markets, food banks, and schools
- Every part of the United States – from inner cities to rural areas – should provide free access to high-speed broadband to its residents; expand the Lifeline Program and invest in the infrastructure needed to bring high-speed broadband to underserved areas
- The Federal government should build adequate infrastructure to ensure that every individual has regular access to clean and safe drinking water, is within walking distance of a park or green space, and lives in a community free from pollutants and pesticides

Justice4All:

- Break school-to-prison pipelines
- End private prison contracts, and implement authentic alternatives to policing
- Continue to provide funding for states and localities to invest in community-based crisis response teams that respond to a wide variety of emergencies without law enforcement
- Expand the right to counsel to ensure that any individual in need has adequate and free representation including in criminal court, immigration proceedings, and other civil proceedings
- Invest in medical-legal partnerships that address social determinants of health and mental health such as housing and employment

B. Training and Capacity Building within Federal Agencies to Support Equitable Grantmaking and Financial Assistance Efforts: Agencies should ensure staff are trained on diversity, cultural humility and implicit bias and hire or designate staff to design, implement and evaluate equity plans. Federal agencies should:

- *Hire an Equity Officer* who has the necessary qualifications and training to provide leadership in the design and implementation of each agency's strategies and programs to ensure health equity and racial justice are prioritized and addressed.
- *Ensure all agency policies and procedures consider inequities and are designed to promote equity* through trainings, hiring, contracting, financial assistance/grant-making programs, community engagement etc.

- *Ensure all agency staff and subcontractors receive mandatory sensitivity, diversity, implicit bias, communication skills, and cultural competency training* including reviewing training materials to ensure the materials are up to date with current standards of practice; and maintaining records of training completion. Develop quantifiable metrics that can track and evaluate the results of the targeted interventions designed to eliminate Inequities

C. Internal and external processes to support equity: A top-down strategy in racial justice reform will miss the point as it overlooks the experience, history, voice and power of community members and leaders. The federal government's reflections and actions must include directly impacted communities at the table in order not to further perpetuate systemic racism and harm. Federal agencies should:

- *Actively and effectively listen to and consult with directly impacted communities*
- *Organize listening sessions and establish working groups* that include non-profits and community based organizations to provide input in the design of grant and federal assistance programs, community and stakeholder engagement processes and pressing issues.

D. Benchmark and assessment techniques as well as data collection to support equitable grantmaking and financial assistance efforts:

- *Diversity metrics should be tracked at each stage of the process* including the quantity and quality of time spent with potential applicants. Lack of diversity at any stage indicates an equity gap.
- *Track race, ethnicity, gender, LGBTQ+, disability, geographic region and other sociodemographic factors* that can help to ensure funding allocations reach diverse, underserved communities and regions.
- *Survey grant recipients* to assess and identify opportunities to improve equity in grantmaking processes. Philanthropic consultants or national organizations like the Center for Effective Philanthropy can also act as third-party consultants assisting agencies in soliciting more open responses.
- *Assess and reassess outcomes regularly* to see if the types of changes that have been implemented are positively impacting results. Tools such as the D5 Coalition's DEI Assessment for grantmaking and the GARE tool for financial assistance can help to systematically track improvement from year to year.[32]

Question 5. Stakeholder and Community Engagement. Approaches and methods for accessible and meaningful agency engagement with underserved communities.

In many ways, this last topic that OMB seeks responses about should have been the first topic for OMB's Request for Information. At the heart of any equity strategy is proactive, intentional, and sustained engagement of stakeholders and communities most impacted. For the federal

[32] D5's Self-Assessment for Foundation Diversity, Equity & Inclusion (DEI): https://www.d5coalition.org/wp-content/uploads/2014/02/DEI-Self-Assessment-10.28.13.pdf

government, that means engagement of the users of its programs and services, whether the public, or users of specific health, educational, housing, business, and other federal programs and services.

- ***Adhere to a "people first" principle*** to all steps in the nation's journey to becoming anti-racist, as well as in ensuring an equitable and effective COVID-19 recovery

- ***Adopt guiding principles of co-design and evaluation of programs through the engagement of users/consumers of programs and services on all department and agency advisory groups and evaluation teams:*** We urge the OMB to adopt guiding principles of co-design, quality assurance, and continuous evaluation of programs through the engagement and active participation of users/consumers of programs and services on all department and agency advisory groups and evaluation teams. Unlike any successful business that is focused on meeting the needs of its consumers/ customers, when it comes to federal government programs and services, the needs of users/consumers are rarely given much attention, and often only as an after-thought. User experience and satisfaction, and accessibility and clarity of consumer-facing information and materials are rarely tested or evaluated. Access for individuals who speak, read, and write languages other than English, and individuals with disabilities is inconsistent. While there may be some focus group testing of some information and materials, often, such materials are drafted by department counsel or program staff in a centralized office seeking to minimize risk while staying faithful to the strict letter of the law rather than facilitating access and utilization by actual users/consumers. When there are complaints or consumer advocates raise concerns, these are often dismissed, or responded to with bureaucratic excuses about timeliness (too late to raise the concern since materials and processes have already been finalized without input or review by users/consumers), or that additional resources would be needed to address the issue (no budget for literacy/reading level review, or translations, or alternate formats).

  Accordingly, we strongly urge that principles of co-design, engagement, and accountability be built into program development processes and timelines, and appropriately resourced, including through travel and other support like stipends/honoraria for users/consumers participating in such activities. The expertise of lived experience that users/consumers bring to improve the design and implementation of federal programs and services has value and should be recognized (rather than extracted without compensation).

  For example, the California Department of Managed Health Care has a Consumer Participation Program that includes stipends for consumers participating in department

proceedings regarding regulations and policies, and administrative orders and decisions by the department director.[33]

- ***Support capacity-building, orientation, and training of consumer advocates:*** While it is the function of consumer advocates, including legal services organizations, to advocate for, and represent their constituents in effectively accessing and utilizing federal programs and services, we respectfully suggest that equity includes a commitment by all federal departments and agencies to build long-term, sustained working relationships with those consumer advocates. If it is not possible or appropriate to directly fund such not-for-profit consumer advocate organizations through federal grants and contracts, then every federal department and agency should develop and implement a plan to provide capacity-building, orientation, and training of such consumer advocates. This would include establishing clear communications channels and advance notice of changes in policies and procedures, inviting consumer advocates to provide early input on program design, working cooperatively to review and edit all user/consumer-facing information and materials, and actively partnering in all evaluation activities.

- ***Build long-term working relationships with underserved, under-invested, and under-represented communities and populations:*** Finally, federal departments and agencies have the opportunity to develop, build, and sustain long-term working relationships with communities and populations that have been underserved, under-invested, and under-represented. While we commend the attention in this RFI to identifying policies and procedures to eliminate barriers to access and utilization of federal programs and services by individuals, we highlight that systemic and institutional barriers, including structural racism, also have to be addressed. Dismantling these exclusionary and inequitable systems and structures cannot be achieved solely by assisting an increased number of individuals with accessing and utilizing federal programs and services. Federal departments and agencies must explicitly acknowledge their own history and roles in discrimination and exclusion of communities and populations that have been underserved, under-invested, and under-represented, and take proactive, affirmative steps to overcome those past and contemporary wrongs. Building such working relationships with underserved, under-invested, and under-represented communities and populations takes time, transparency, and trust; it also takes leaders and organizational cultures that are humble, reflective, and continuously learning. Finally, there must be acknowledgement of the inherent power and resource imbalance between "officials" representing the federal government, and communities and populations that have been disenfranchised and disempowered. It will take yielding some of that power - and beginning to shift real and significant resources - to those communities and populations to demonstrate the actual practice towards equity, beyond well-intentioned words and plans.

[33] https://www.dmhc.ca.gov/aboutthedmhc/opportunitiestoparticipate/consumerparticipationprogram-frequentlyaskedquestions.aspx

We appreciate this opportunity to inform the federal government's approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality and look forward to working with the Biden-Harris Administration in ensuring this directive is a success.

For more information about these comments, please contact me at ruben@preventioninstitute.org.

Sincerely,

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